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.

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

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

	Is this information correct?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: UM Charles Regional Medical Center	◉	○	
Your hospital's ID is: 210035	◉	○	
Your hospital is part of the hospital system called University of Maryland Medical System	◉	○	
The primary hospital community benefit (HCB) Narrative contact at your hospital is Mary Levy & Dr. Roderick King	◉	○	
The primary HCB Narrative contact email address at your hospital is Mary.Levy@umm.edu; Roderick.King@umm.edu	◉	○	
The primary HCB Financial report contact at your hospital is Albert Zanger	◉	○	
The primary HCB Financial report contact email at your hospital is azanger@umm.edu	◉	○	

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

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

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

The 2021 Maryland Vital Statistics Report is used for birth and death data by race, along with life expectancy data, infant mortality data by race. The Maryland Department of Planning is also a source of population data for Charles County. The Maryland State Health Improvement Process data measures and CRISP Public Health dashboard data provide information on health disparities and hospitalization/ED visit rates by health condition such as diabetes and heart disease prevalence and mental health and substance use ED visit rates. Additionally, cancer incidence and mortality are available through the 2021 Cigarette Restitution Fund Program's Cancer in Maryland Report. The Maryland Behavioral Risk Factor Surveillance System is used to determine estimates for adult obesity and overweight. The Youth Risk Behavior Survey provides an obesity estimate for youth aged 13-18 years. The Maryland Sexually Transmitted Infections Program at the Maryland Department of Health provides Chlamydia and gonorrhea rates for the county. The Maryland Physician Workforce Study provides information on physician shortages in Southern Maryland. Health Professional Shortage Areas are viewed on the HRSA website. Medicaid data is accessed through the e-health Medicaid database for Maryland.

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

FY24UMCRMCCommunityStatistics.docx
31.8KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

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

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

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

☑ 20601	☑ 20617	☑ 20658
☑ 20602	☑ 20622	☑ 20659
☑ 20603	☑ 20625	☑ 20661
☑ 20604	☑ 20632	☑ 20662
☑ 20607	☑ 20637	☑ 20664
☑ 20611	☑ 20640	☑ 20675
☑ 20612	☑ 20643	☑ 20677

- [x] 20613
- [x] 20616
- [x] 20645
- [x] 20646
- [x] 20693
- [x] 20695

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.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

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

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

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

- [x] Other. Please describe.

The Community Benefit Service Area for the University of Maryland Charles Regional Medical Center includes our primary service area, which includes all zip codes located within the borders of Charles County, Maryland. UM Charles Regional Medical Center is Charles County's only hospital.

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

https://www.umms.org/charles/about/mission-values

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

The Primary Service Area for the University of Maryland Charles Regional Medical Center is all 28 zip codes located within the borders of Charles County. This includes the seven zip codes identified as the Community Benefit Service Area. The University of Maryland Charles Regional Medical Center is Charles County's only hospital and, as such, serves the residents of the entire county. Zip code level data shows where the most vulnerable populations reside in Charles County. The zip codes of Waldorf (20601, 20602, 20603), White Plains (20695), and Indian Head (20640) represent the geographic areas where the most vulnerable populations reside in Charles County. The 2019 heart disease hospital encounters rate per 1000 residents was highest in the zip codes: 20658, Marbury: 76.15 20693, Welcome: 67.31 20612, Benedict: 67.04 The 2019 Diabetes admission rate per 1000 residents was highest in the zip codes: 20695, White Plains: 2.84 20640, Indian Head: 2.72 The 2019 Hypertension hospital encounter rate per 1000 residents was highest in the zip codes: 20658, Marbury: 251.44 20695, White Plains: 193.72 20617, Bryantown: 189.57 The 2019 Mental Health Emergency Department Visit Rate per 1000 residents was highest in the zip codes: 20612, Benedict: 100.56 20664, Newburg: 62.84 The 2019 Substance Use Emergency Department Visit Rate per 1000 residents was highest in the zip codes: 20625, Cobb Island: 71.54 20658, Marbury: 70.86 The 2019 Asthma Emergency Department Visit Rate per 1000 residents was highest in the zip codes: 20625, Cobb Island: 19.51 20695, White Plains: 16.91 The zip codes with the highest percentages of low-birth-weight babies in 2019 included: 20616, Bryans Road: 18.52% 20602, Waldorf: 12.99% The zip codes with the highest percentages of people living in poverty in 2019 included: 20662, Nanjemoy: 14.7% 20664, Newburg: 14.4% The unemployment rate is the highest in 20658, Marbury, at 14.2%. The zip code with the highest percentage of people without a high school diploma is 20662, Nanjemoy, at 18.9%.

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)

06/30/2024

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.umms.org/charles/community/assessment-implementation-plan

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

2024 CRMC_CommunityHealthNeedsAssessment.pdf
35.6MB
application/pdf

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

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

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

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

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

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

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

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

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

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

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

Refer to the FY 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:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	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: Charles County Department of Health	☐	☐	☐	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Improvement Coalition -- Please list the LHICs here: Partnerships for a Healthier Charles County	☐	☐	☐	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Maryland Department of Health	☐	☐	☑	☐	☐	☐	☐	☐	☑	☐	☐	☐	☐	☑
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other State Agencies -- Please list the agencies here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	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: Charles County Government	☑	☐	☐	☐	☐	☐	☑	☑	☐	☐	☐	☐	☐	☐

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

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Community/Neighborhood Organizations -- Please list the organizations here: Health Partners Inc, United Way of Southern Maryland, Lifelong Learning Center, UM Extension, Lifestyles of MD	☐	☐	☐	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	☑
Consumer/Public Advocacy Organizations -- Please list the organizations here: Charles County Service and Advocacy Council	☐	☐	☐	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	☑
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.

June 22, 2022

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

https://www.umms.org/charles/community/assessment-implementation-plan

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

CHIP 202520227 FINAL.pdf

5.2MB
application/pdf

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

This question was not displayed to the respondent.

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

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

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

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

- (●) Yes
- ( ) No

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

This question was not displayed to the respondent.

Q60. Why were these needs unaddressed?

This question was not displayed to the respondent.

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

The University of Maryland Charles Regional Medical Center contracts with Amber Starn, an epidemiologist, to complete the Charles County Community Health Needs Assessment every 3 years. All data is analyzed by demographic, racial, geographical, and ethnic populations when available. This data is used to select our health priorities, to determine the locations most in need of health education programs, and to establish partners who can help us to reach the populations who are underserved and disproportionately affected by those health conditions. Work plans with short- and long-term objectives are developed to track any changes in individual and population data. Differences in population level data help us to determine if our efforts have led to a community impact.

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
- [x] 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.

FY24UMCRMCCB Initiatives.docx
118.3KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q64. Section III - CB Administration

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

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

Q66. Please describe the third party audit process used.

Ernst and Young

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

- (●) Yes
- ( ) No

Q68. Please describe the community benefit narrative audit process.

Albert Zanger, Chief Financial Officer (CF)) oversees all HSCRC and 990 Reporting. In this capacity he internally audits Community Benefit (CB) reports and allocates resources for CB operations. The CFO reviews the report (narrative and spreadsheet) and presents the final report to the Finance Committee of the Board of Directors for approval. The Finance Committee of the Board conducts the review and approval of the report, and a summary of key points are presented to the full Board. Craig Renner, Director, Marketing and Community Health, administers CB reporting operations including plan implementation, collaboration with strategic community partners, oversees data collection and reporting, provides management for LHIC, and compiles reports. Jim Clague, Decision Support Analyst, inputs financial data into the CB data collection tool for reporting and assists with internal audits. Ruth Case, Revenue Integrity Analyst inputs salary data into CB data collection tool. Mary Levy, Community Health Specialist implements community benefit qualifying activities and community outreach programs, collaborates with strategic community partners, trains departmental CB reporters, manages data collection and provides LHIC management and support. Consultant and Epidemiologist, Amber Starn, MPH provides data and reporting for CB planning, monitors and reports outcomes of the CB Strategic Plan and reports SHIP data to CCDOH and UM Charles Regional. Hospital system contracted staff: UMMS Community Benefits Staff provide the final audit for the hospital.

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

- (●) Yes
- ( ) No

Q70. Please explain:

This question was not displayed to the respondent.

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

- (●) Yes
- ( ) No

Q72. Please explain:

This question was not displayed to the respondent.

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

- (●) Yes
- ( ) No

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

UM CRMC's current strategic plan, which covers fiscal years 2022 through 2024, includes significant investments in programs and initiatives that benefit members of our community who are uninsured or underinsured. The plan outlines efforts for CRMC to work collaboratively with key community stakeholders such as Partners for a Healthier Charles County to address chronic disease issues, mental health, substance abuse and access to care. Since many of the individuals who are targeted to benefit from these initiatives are uninsured, UM Charles Regional and its partners absorb the costs of treatment. Our Mobile Integrated Health (MIH) visitation program is an example of community benefits planning and investment. This program, which is geared to reduce readmissions and over-utilization of emergency services, is jointly funded by financial support from UM Charles Regional and the Charles County Government. Further, the UM Charles Regional's annual budget includes approximately $1 million to cover the cost of providing care that addresses local health needs. Our population health initiatives, which include health literacy, chronic care management, education and training for our patients are additional examples that demonstrate our efforts at strategic community benefit planning.

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

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

- [x]

Diabetes - Reduce the mean BMI for Maryland residents

Diabetes Prevention Program:
Number of workshops: 7

Average participants per workshop: 11.7
Number of participants: 70
Participants with attendance data: 69
DPRP-Attend-Qual. Participants: 20 of 69 (29%)
DPRP-Qual. Participants: 19 of 70 (27%)
Number who are caregivers: 0 of 0

A1c	Count	Pre	Post	Decrease
No A1c	30			
One A1c	37	6.0		
Two A1c's	3	6.2	6.1	0.1

ACL Gender Long	Count	Percent
No answer	70	100%

Age	Count	Percent
0-44	10	14%
44-49	4	6%
50-54	7	10%
55-59	10	14%
60-64	11	16%
65-69	12	17%
70-74	8	11%
75-79	5	7%
80-84	2	3%
85-89	1	1%

Attended Group Session	Count	Percent
1	62	90%
2	60	87%
3	61	88%
4	59	86%
5	59	86%
6	62	90%
7	62	90%
8	59	86%
9	57	83%
10	57	83%
11	55	80%
12	59	86%
13	48	70%
14	59	86%
15	51	74%
16	52	75%
17	48	70%
18	46	67%
19	46	67%
20	38	55%
21	35	51%
22	19	28%
23	9	13%
24	5	7%

CDC Gender	Count	Percent
Female	51	84%
Male	10	16%
Unknown	9	

Chronic Condition	Count	Percent
Hypertension	38	93%
Diabetes	9	22%

Completers	Count	Percent
No	50	71%
Yes	20	29%

Condition Count	Count	Percent
One chronic condition	35	50%
No chronic conditions	29	41%
Multiple chronic conditions	6	9%

Disabilities	Count	Percent
Diff. walking or climbing stairs	11	16%
Hearing impaired	7	10%
Diff. remembering	6	9%
Diff. with errands	6	9%
Visually impaired	3	4%
Diff. dressing	3	4%

Disability Count	Count	Percent
No disabilities	47	73%
One disability	9	14%
Multiple disabilities	8	12%

Unknown 6

Education	Count	Percent
Completed College	30	45%
Some College	22	33%
Completed High School	12	18%
Some High School	2	3%

Unknown 4

Ethnicity/Race	Count	Percent
Black or African American	40	59%
White/Caucasian	25	37%
American Indian or AK Native	2	3%
Asian or Asian American	2	3%
Hispanic/Latino	2	3%

Unknown 2

GDM	Count	Percent
No	55	79%
Yes	1	1%

Gender	Count	Percent
Female	56	80%
Male	14	20%

How Did You Hear	Count	Percent
Media: poster/flyer, etc.	12	21%
Doctor/Health Care Provider	11	19%
Friends or family	9	16%
Other: mail	7	12%
Organization	4	7%
Social media	4	7%
Other: community outreach events	2	4%
Media: billboard	1	2%
Other	7	12%

Insurance	Count	Percent
Medicare	12	39%
Carefirst BlueCross BlueShield	10	32%
BlueCross	4	13%
TriCare	3	10%
Aetna	3	10%
Kaiser Permanente	3	10%
Cigna	2	6%
No Insurance	1	3%
Medicare Part B ("Regular" Medicare)	1	3%
Medicaid FFS (Fee For Service)	1	3%

Unknown 39

Last Group Session Attended	Count	Percent
1	0	0%
2	0	0%
3	1	1%
4	0	0%
5	0	0%
6	0	0%
7	0	0%
8	0	0%
9	0	0%
10	0	0%
11	1	1%
12	1	1%
13	1	1%
14	1	1%
15	7	10%
16	2	3%
17	1	1%
18	3	4%
19	11	16%
20	3	4%
21	17	25%
22	11	16%
23	4	6%
24	5	7%

Minutes of Activity for DPRP-Qual. Participants	Count	Percent
0-19 Minutes	0	0%
30-74 Minutes	1	5%
75-149 Minutes	8	42%
150+ Minutes	10	53%

Number of Group Sessions Attended	Count	Percent
1	0	0%
2	0	0%
3	1	1%

4	0	0%
5	0	0%
6	1	1%
7	1	1%
8	0	0%
9	4	6%
10	3	4%
11	1	1%
12	5	7%
13	2	3%
14	3	4%
15	0	0%
16	5	7%
17	3	4%
18	6	9%
19	13	19%
20	3	4%
21	5	7%
22	7	10%
23	2	3%
24	4	6%

Organization	Count	Percent
Charles County Department of Health	70	100%

Participant County	Count	Percent
Charles, MD	70	100%

Participant Funding	Count	Percent
Prevention Link 10	100%	
None	60	

Payment Source	Count	Percent
Not reported	70	100%

Percent Weight Change For DPRP-Qual.

Participants	Count	Percent
7.00%+ Loss	4	21%
5.00%-6.99% Loss	2	11%
3.00%-4.99% Loss	5	26%
1.00%-2.99% Loss	5	26%
0.99% Loss-0.99% Gain	3	16%
1.00%-2.99% Gain	0	0%
3.00%-4.99% Gain	0	0%
5.00%-6.99% Gain	0	0%
7.00%+ Gain	0	0%

Average Weight Loss Percent
4.46%

Prediabetes	Count	Percent
Yes	45	85%
No	8	15%
Unknown	17	

Served in Military	Count	Percent
No	70	100%

Type of Test	Count	Percent
A1C	40	57%
Risk Test	30	43%
Fasting Glucose	2	3%

Workshop Funding	Count	Percent
None	70	

Diabetes Self-Management (DSMP)
July 1, 2023 - June 30, 2024
Number of workshops: 1

Average participants per workshop: 8.0
Number of participants: 8
Participants with attendance data: 8
Completers: 7 of 8 (88%)
Number who are caregivers: 2 of 5 (40%)
May 7, 24—Indian Head Senior Center

A1c	Count	Pre	Post	Decrease
No A1c	8			
One A1c	0			
Two A1c's	0	0	0	0

ACL Gender	Count	Percent	Bar
Woman	6	86%	

.....
.....

Man 1 14%
Unknown 1

ACL Gender Long Count Percent Bar
Straight 6 75%
Noanswer 2 25%

Age Count Percent Bar
0-44 1 14%
60-64 1 14%
70-74 2 29%
80-84 1 14%
85-89 2 29%
Unknown 1

Caregiver Count Percent Bar
No 3 60%
Yes 2 40%
Unknown 3

Chronic Condition Count Percent Bar
Diabetes 4 57%
Obesity 4 57%
Hypertension 4 57%
Cancer 2 29%
Arthritis 2 29%
Chronic Pain 1 14%
Kidney Disease 1 14%

Completers Count Percent Bar
Yes 7 88%
No 1 12%

Condition Count Count Percent Bar
Multiple chronic conditions 6 75%
No chronic conditions 1 12%
One chronic condition 1 12%

Disabilities Count Percent Bar
Diff. remembering 1 12%
Hearing impaired 1 12%
Visually impaired 1 12%
Diff. walking or climbing stairs 1 12%
Diff. with errands 1 12%

Disability Count Count Percent Bar
No disabilities 4 57%
One disability 2 29%
Multiple disabilities 1 14%
Unknown 1

Education Count Percent Bar
Some College 4 57%

.....
Completed High School 2 29%
.....
Completed College 1 14%
.....
Unknown 1

Ethnicity/Race Count Percent Bar
Black or African American 5
71%
.....
.....
White/Caucasian 2 29%
.....
Unknown 1

Impacted by COVID-19 Count
Percent Bar
No 8 100%
.....
.....
.....

Lives Alone Count Percent Bar
Yes 4 57%
.....
.....
No 3 43%
.....
.....
Unknown 1

Number of Group Sessions Attended
Count Percent Bar
1 0 0% .
2 0 0% .
3 1 12% .....
4 3 38%
.....
.
5 0 0% .
6 4 50%
.....
.....

Organization Count Percent Bar
Charles County Department of Community
Services, Aging & Human Services
Division 8 100%
.....
.....
.....

Participant County Count
Percent Bar
Charles 7 88%
.....
.....
.....
Charles, MD, MD 1 12%
.....

Participant Funding Count
Percent Bar
None 8

Payment Source Count Percent Bar
Not reported 8 100%
.....
.....
.....

Referred Count Percent Bar
No 4 67%
.....
.....
Yes 2 33%
.....
Unknown 2

Served in Military Count
Percent Bar
No 6 86%
.....
.....
.....
Yes 1 14%
.....
Unknown 1

Virtual Workshop Count
Percent Bar
No 8 100%
.....

Workshop Funding Count
Percent Bar
None 8

Felt welcomed Count Percent Bar
Strongly Agree (1) 7 100%
Average Value 1

Teaching was shared Count
Percent Bar
Strongly Agree (1) 6 86%
Average Value 1

Leaders were prepared Count
Percent Bar
Strongly Agree (1) 7 100%
Average Value 1

I have more self-confidence Count
Percent Bar
Strongly Agree (1) 5 71%
Agree (2) 2 29%
Average Value 1.3

Book was helpful Count
Percent Bar
Strongly Agree (1) 7 100%
Average Value 1

Learned action plans Count
Percent Bar
Strongly Agree (1) 7 100%
Average Value 1

Better manage symptoms Count
Percent Bar
Strongly Agree (1) 4 57%
Agree (2) 3 43%
Average Value 1.4

Site was conducive Count
Percent Bar
Strongly Agree (1) 7 100%
Average Value 1

Part. valued contributions Count
Percent Bar
Strongly Agree (1) 6 86%
Agree (2) 1 14%
Average Value 1.1

Leaders managed group Count
Percent Bar
Strongly Agree (1) 7 100%
Average Value 1

Leaders valued contributions Count
Percent Bar
Strongly Agree (1) 5 71%

```
Agree (2)       2       29%
Average Value   1.3


Leaders got along       Count
Percent Bar
Strongly Agree (1)      7       100%
Average Value   1


Valued break time       Count
Percent Bar
Strongly Agree (1)      7       100%
Average Value   1


Noticed participants missing    Count
Percent Bar
Strongly Agree (1)      1       14%
Agree (2)       3       43%
Disagree (3)    1       14%
Strongly Disagree (4)   2       29%
Average Value   2.6


Feel more motivated     Count
Percent Bar
Strongly Agree (1)      6       86%
Agree (2)       1       14%
Average Value   1.1

Diabetes Support Group: held
once a month. Total participation:
154.
```

☑ Opioid Use Disorder - Improve overdose mortality

Peer Recovery Program: The UM Charles Regional Peer Recovery Coach Program places trained recovery coaches – who are themselves recovered from substance use disorders – with people who need help getting on a path to sobriety from alcohol or drug use. The CareFirst grant allows the hospital to cover costs for salary and training of peer recovery coaches who take shifts in the Emergency Department to help patients that need their support and assistance. Currently, two coaches cover 16 hours a day, five days a week. The new grant funds will allow the broader coverage by adding an evening shift mental health social worker to their team. Until the fulltime evening shift SW is hired, this is being covered intermittently by 4 PRN Social Workers. FY2024: Patient seen with intervention: 529

☑ Maternal and Child Health - Reduce severe maternal morbidity rate

Every year in the United States, about 23,000 babies who are born alive do not survive to their first birthday. An almost equal number of babies are stillborn, without signs of life. While fetal and infant mortality in the United States has improved, disparities persist between whites and persons of color, especially African Americans, Latinos and Native Americans. Fetal and Infant Mortality Review (FIMR) is a community based, action-oriented process aimed at improving services, systems, and resources for women, infants, and families. FIMR brings a multidisciplinary community team together to examine confidential, de-identified cases of fetal and infant deaths. Review of individual cases helps teams understand families' experiences, including racism, and how those experiences may have impacted maternal and child outcomes. Members of the hospital staff to include: Jennifer Wood, RN, Manager of Labor & Delivery and Mary Levy, Community Outreach Manager attend meetings held once a month. In 2022 UM Charles Regional Medical Center opened the Baby Closet to assist families with diapers, wipes, car seats, pack n plays, and other baby essentials. FY 2024 the closet served 56 families.

☐ 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.)

FY24UMCRMCDataonPhysicianGapsubsidiesjustification.docx
3.8MB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q80. Section V - Financial Assistance Policy (FAP)

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

UMMS Financial Assistance Policy 070124 English.pdf
310KB
application/pdf

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

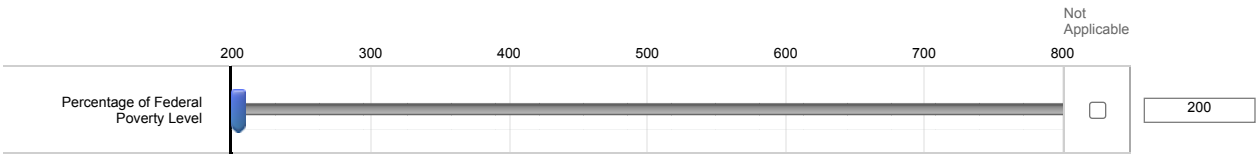
https://www.umms.org/patients-visitors/umms-financial-assistance

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: Federal Poverty Level and Maryland Department of Health Annual Income Eligibility Limit Updated

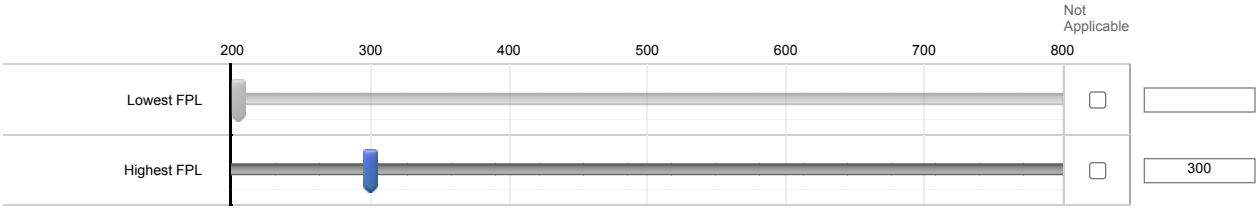
Q84. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



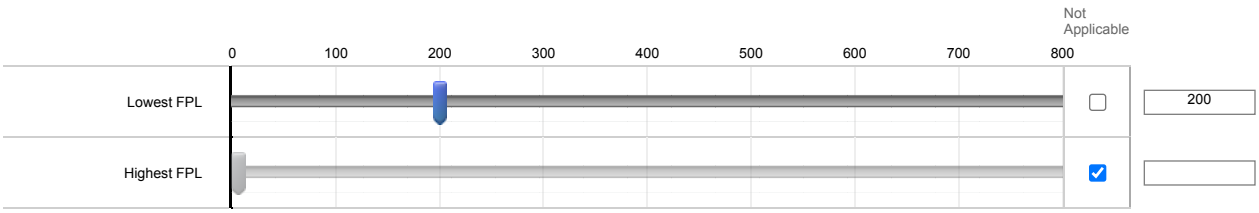
Q85. Maryland acute care and chronic care hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

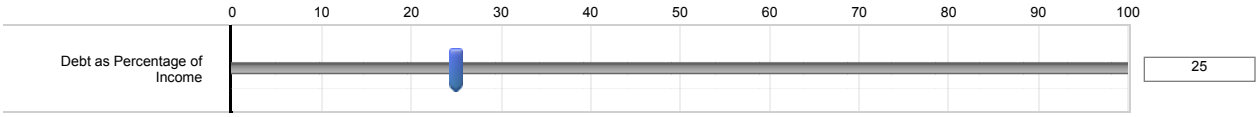


Q86. Maryland acute care and chronic care hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3)(a) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial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

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



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



Q88. Section VI - Tax Exemptions

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

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

Q90. Summary & Report Submission

Q91.

Attention Hospital Staff! IMPORTANT!

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

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

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

Location Data

Location: (39.26, -76.7125)

Source: GeoIP Estimation

The Community Benefit Service Area for the University of Maryland Charles Regional Medical Center is all 28 zip codes located within the borders of Charles County. This includes the seven zip codes identified above as the Primary Service Area. The University of Maryland Charles Regional Medical Center is Charles County's only hospital and, as such, serves the residents of the entire county.

Geography

Charles County is located 23 miles south of Washington, D.C. It is one of five Maryland counties, which are part of the Washington, DC-MD-VA metropolitan area. At 458 square miles, Charles County is the eighth largest of Maryland's twenty-four counties and accounts for about 5 percent of Maryland's total landmass. The northern part of the county is the "development district" where commercial, residential, and business growth is focused. The major communities of Charles County are La Plata (the county seat), Port Tobacco, Indian Head, and St Charles, and the main commercial cluster of Hughesville-Waldorf-White Plains. Approximately 60 percent of the county's residents live in the greater Waldorf-La Plata area. By contrast, the southern (Cobb Neck area) and western (Nanjemoy, Indian Head, Marbury) areas of the region remain very rural with smaller populations.

Population

Charles County has experienced rapid growth since 1970, expanding its population from 47,678 in 1970 to 171,973 in the 2023 Census population estimate. The magnitude of growth can be seen in the changes in population density. The 1990 census showed that there were 219.4 individuals per square mile, which increased to 261.5 individuals per square mile by 2000, an increase of 19.2%, to 320.2 individuals per square mile by 2010, an increase of 22.5%. It has further increased to 363.9 in 2020.
Source: 2000, 2010, and 2020 US Census Bureau's Census, 2023 Census Population Estimate

Transportation

The percent change in the population growth for Charles County has been slightly greater than the change seen in the Maryland population growth. This growth has created transportation issues for the
County, in particular for the "development district" in the northern part of the county where many residents commute to Washington D.C. to work. The average work commute time for a Charles County resident is 44.2 minutes which is higher than the Maryland average of 32.0 minutes (Source US Census Bureau's 2018-2022 American Community Survey 5-year estimates). Public transportation consists of commuter buses for out-of-county travel and the county-run Van Go bus service for in-county transportation.
Source: 2018-2022 US Census Bureau's American Community Survey 5 year estimates

Diversity

As the population of the county changes, the diversity of the county also increases. The African American population has experienced the greatest increase. In 2000, African Americans made up 26% of the total Charles County population; by 2023, they comprise 54.2% of the total county population. As of 2023, minorities comprise roughly 68.5% of the Charles County population. The Hispanic community has also seen increases over the past few years. They now comprise 8.2% of the total county population. This is the one of the highest percentages among the 24 Maryland jurisdictions. Charles County also has one of the largest American Indian/Native American populations in the state of Maryland at 0.8% of the total county population.

The 2022 Charles County gender breakdown is approximately 50/50. Males make up 48.1% of the population, and females make up 51.9% of the county population.
Source: 2023 US Census Bureau's American Community Survey 1 year estimate

Economy

Employment and economic indicators for the county are fairly strong. The 2018-2022 US Census American Community Survey estimates that 67.3% of the Charles County population is currently in the labor work force. The 2018-2022 5-year estimate for Charles County found that approximately 8.0% of Charles County individuals are living below the poverty level; however, this is lower than the Maryland rate of 9.5%. The Charles County median household income was $116,882, well above the Maryland median household income of $98,461. The diversity of the county is also represented in the business community with 46% of all Charles County businesses being minority-owned firms. This is higher than the State of Maryland at 38%.
Source: 2017-2021 US Census Bureau's American Community Survey 5-year estimates

Education

Charles County has a larger percentage of high school graduates than Maryland (94.4% vs. 91.0%); however, Charles County has a smaller percentage than Maryland of individuals with a bachelor's degree or higher (31.1% vs. 42.2%).
Source: 2018-20212US Census Bureau's American Community Survey 5 year estimates

Housing

There is a high level of home ownership in Charles County (79.8%). There is a greater percentage of home owners in Charles County than the percentage of homeowners for Maryland (79.8% vs. 67.5%). The median value of a housing unit in Charles County is greater than the Maryland average ($382,800 vs. $380,500). The average household size in Charles County is 2.80 persons.
Source: 2018-2022 US Census Bureau's American Community Survey 5 year estimates

Life Expectancy

The life expectancy for a Charles County resident, as calculated for 2019-2021, was 77.2 years. This is slightly below the state average life expectancy of 78.2 years. Life expectancy is higher for Non-Hispanic Whites in Charles County (77.0 years) than it is for Non-Hispanic Blacks in Charles County (75.8 years). This data is not available for other races due to small sample sizes and unreliable statistics.
Source: 2021 Maryland Vital Statistics Report

Births

There were 1,850 births in Charles County in 2021. Charles County represents 43.7% of the births in Southern Maryland and 2.71% of the total births in Maryland for 2021.

Minorities made up over half of the babies born in Charles County in 2021 (70.4%).

Source: 2021 Maryland Vital Statistics Report

Health Disparities

Health topics where health disparities are seen for the minority population in Charles County:

Health Topic	Indicator	Rate	Source
Heart Disease Prevalence and Mortality	Rate of ED visits for hypertension per 100,000 population Age-adjusted heart disease mortality rate	White: 95.2 Black: 120.1 Other: 57.2 Asian: 39.5 All races: 103.1 White: 164.3 Black: 173.3 All races: 164.0	Hypertension Hospital Encounters Age-Adjusted Rate for 2023, CRISP Health Equity Explorer Heart Disease Mortality Rate 2019-2021 from Maryland Open Data Source Portal
Colon and Rectal Cancer Incidence Mortality	Incidence Rates per 100,000 Mortality Rates per 100,000	White: 40.9 Black: 41.1 All races: 40.1 White: 14.7 Black: 17.5 All races: 15.8	2021 Cigarette Restitution Fund Program Cancer Report (2014-2018 rates)
Breast Cancer Incidence Mortality	Incidence Rates per 100,000 Mortality Rates per 100,000	White: 124.0 Black: 117.3 All races: 118.9 White: 23.6 Black: 31.0 All races: 26.8	2021 Cigarette Restitution Fund Program Cancer Report (2014-2018 rates)
Prostate Cancer Incidence Mortality	Incidence Rates per 100,000 Mortality Rates per 100,000	White: 117.7 Black: 190.4 All races: 147.1 White: 17.9 Black: 29.3 All races: 20.5	2021 Cigarette Restitution Fund Program Cancer Report (2014-2018 rates)

Diabetes Prevalence	Unadjusted Diabetes ED Visit Rates by Race	White: 46.43 Black: 63.29 Other: 30.73 Asian: 24.06 All races: 52.64	Diabetes Hospital Encounters Age-Adjusted Rate for 2023, CRISP Health Equity Explorer
Obesity	Age-adjusted % Adults at Healthy Weight	Overall: 23.5% White: 27.6% Black: 14.9%	Maryland 2022 BRFSS
STD	Rate of Chlamydia infection for all ages per 100,000 (all ages)	Overall: 488.5 Data not available by race and ethnicity	2022 Annual Maryland STD Report
Asthma	Rate of ED visits for asthma per 100,000	Overall: 13.06 White-9.21 Black-17.06 Other: 9.93 Asian: 3.83	Asthma ED Encounters Age-Adjusted Rate for 2023, CRISP Health Equity Explorer
Infant Mortality	Infant Mortality Rate per 1,000 births	In 2021, there were only 9 infant deaths in Charles County. Rates could not be calculated. However, among those 9 deaths, 7 were Black and 2 were Multi-race.	2021 Maryland Infant Mortality Report, Vital Statistics Admin.

1. 2023 Charles County Current Population Survey Data. United States Census Bureau. Available at: https://www.census.gov/quickfacts/fact/table/charlescountymaryland,US/PST045222.

2. 2021 Maryland Vital Statistics Report. Charles County Demographic and Population Data. Maryland Department of Health. Available at https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2021AnnualReport_Final_v1023.pdf.

3. 2018-2022 US Census Bureau, American Community Survey 5-year estimates, Charles County and Maryland. Available at https://www.census.gov/quickfacts/fact/table/charlescountymaryland,US/PST045222.

4. CRISP Health Equity Explorer. 2023 Emergency Department Hospital Encounters for Hypertension, Diabetes, and Asthma for Charles County for Calendar Year 2022. Available at: https://idp.crisphealth.org/#login.

5. 2021 Maryland Cigarette Restitution Fund Program's Cancer Report. Maryland Department of Health. Available at: https://health.maryland.gov/phpa/cancer/Documents/2021%20CRF%20Cancer%20Report_FINAL.pdf.

6. 2022 Adults with Healthy Weight by Race. Maryland Behavioral Risk Factor Surveillance System. Maryland Department of Health. Available at: https://ibis.health.maryland.gov.

7. 2022 Chlamydia Infection Rates by Race. Maryland Department of Health Center for STI Prevention. Available at: https://health.maryland.gov/phpa/OIDPCS/CSTIP/CSTIPDocuments/2403_PHA_CSTIP_2022-Annual-Report%20%282%29.pdf.

8. 2021 Maryland Infant Mortality Report. Maryland Vital Statistics Administration. Available at: https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2021AnnualReport_Final_v1023.pdf.

Service Area Demographic Characteristics and Social Determinants:

Demographic Characteristic	***Description***	***Source***
Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside.	*The Community Benefit Service Area for the University of Maryland Charles Regional Medical Center is all 28 zip codes located within the borders of Charles County. This includes the seven zip codes identified as the Primary Service Area. The University of Maryland Charles Regional Medical Center is Charles County's only hospital and, as such, serves the residents of the entire county. Heart disparities and vulnerable populations reside in all regions of the county as evidenced by the data below.*	*2019 HSCRC Hospital Case-Mix Data*

	The 2019 heart disease hospital encounters rate per 1000 residents was highest in the zip codes: *20658, Marbury: 76.15* *20693, Welcome: 67.31* *20612, Benedict: 67.04* *The 2019 Diabetes admission rate per 1000 residents was highest in the zip codes:* *20695, White Plains: 2.84* *20640, Indian Head: 2.72* *The 2019 Hypertension hospital encounter rate per 1000 residents was highest in the zip codes:* *20658, Marbury: 251.44* *20695, White Plains: 193.72* *20617, Bryantown: 189.57* *The 2019 Mental Health Emergency Department Visit Rate per 1000 residents was highest in the zip codes:* *20612, Benedict: 100.56*	

	20664, Newburg: 62.84 *The 2019 Substance Use Emergency Department Visit Rate per 1000 residents was highest in the zip codes:* *20625, Cobb Island: 71.54* *20658, Marbury: 70.86* *The 2019 Asthma Emergency Department Visit Rate per 1000 residents was highest in the zip codes:* *20625, Cobb Island: 19.51* *20695, White Plains: 16.91* *The zip codes with the highest percentages of low-birth-weight babies in 2019 included:* *20616, Bryans Road: 18.52%* *20602, Waldorf: 12.99%* *The zip codes with the highest percentages of people living in poverty in 2019 included:* *20662, Nanjemoy: 14.7%* *20664, Newburg: 14.4%*	

	The unemployment rate is the highest in 20658, Marbury, at 14.2%. *The zip code with the highest percentage of people without a high school diploma is 20662, Nanjemoy, at 18.9%.*	
Median Household Income within the CBSA	*$116,882*	*2018-20212US Census American Community Survey 5 year estimate*
Percentage of households with incomes below the federal poverty guidelines within the CBSA	*8.0%*	*2018-2022 US Census American Community Survey 5 year estimate*
For counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links: http://census.gov/hhes/www/hlthins/data/acs/aff.html http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	*4.9%*	*2018-2022 American Community Survey 5-Year Estimate*
Percentage of Medicaid recipients by County within the CBSA.	*27.8%*	*Calendar Year 2023 Maryland Medicaid e-Health Statistics:*

		Medicaid Enrollment Rates
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).	*The life expectancy from birth for a Charles County resident as calculated for 2019-2021 was 77.2 years. This is slightly below the state average life expectancy of 78.2 years.* *White: 77.0* *Black: 75.8*	*2021 Maryland Vital Statistics Report. Charles County Demographic and Population Data. MDH*
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	*All-cause death rate for Charles County for 2021 was 877.6 per 100,000 population. This is below the Maryland state average death rate of 941.4 per 100,000.* *White: 1281.0* *Black: 766.2* *Asian/PI: 535.5* *Hispanic: 217.5* *The rate among the White population is greater than the other races because they make up the majority of the aging population in the county. Two-thirds of the 65+ population in Charles County (66%) are White. The minority populations are moving into Charles County and are a younger population; therefore,*	*2021 Charles Co. Death data, 2010 Maryland Vital Statistics Report*

	they have lower mortality rates. The median age in Charles County is 38.5 years.	
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources)	***Access to healthy food**:* • *3 Census tracts with low income and low access to food: 2 in Indian Head and 1 in Waldorf (Both primary service area zip codes)* ***Transportation:*** • *Mean travel time to work: 44.2 min* ***Environmental Factors:*** • *% of children tested who have blood lead levels ≥ 10 mg/dl: 0.20% (2017) (Goal: .288)* ***Housing:*** • *Home ownership: 79.8%* • *Renter occupied housing: 20.2%* • *Affordable housing: the % of houses sold that are affordable on a median teacher's salary: 41.7%* ***Access to Care:*** • *84% of Charles County residents travel outside of the county for medical care at some point.*	*USDA 2022, Food Access Research Atlas, updated on July 6, 2023* *2018-2022 US Census ACS* *2020 MD Dept of Planning from Maryland Open Data Portal* *2018-2022 US Census Data, American Community Survey 5-year estimates,* 2020 affordable housing data from MD Open Data Portal *FY24 Charles Co CHNA*

	• *% Mothers who received prenatal care 1st trimester; 66.8%* ○ *White/ NH: 69.1%* ○ *Black: 69.8%* ○ *Hispanic: 49.8%* ○ *Asian/ Pacific Islander: 65.1%* ○ *Multi-Race: 67.1%* • *Infant Mortality Rate: Not calculated due to small case count. 7/9 deaths in Charles County were Black.* • *Number of federally designated medically underserved areas in Charles County: 3 for primary care* ○ *Brandywine* ○ *Allens Fresh* ○ *Thompkinsville* ○ *Hughesville* ○ *Marbury* ○ *Nanjemoy* • *Number of physician shortage specialties in Southern Maryland: 28* • 2 HPSA designations for	*2021 Maryland Vital Statistics Report* *2021 Maryland Vital Statistics Report* *HPSA MUS/MUP Designations as of October 25, 2024* *2007 Maryland Physician Workforce Study*

	primary care, 2 for dental health, and 2 for mental health. *Physician-to-population ratios in Southern Maryland below the HRSA benchmark for all types of physician* ***Education:*** • *94.4% persons 25+ high school graduates* • *31.1% persons 25+ bachelor's degree or higher*	*2011 MD workforce Study Health Resources and Services* *2018-20212US Census Bureau's American Community Survey 5 year estimates*
Available detail on race, ethnicity, and language within CBSA	***Population****: 171,973* ***Sex****:* • *Female 51.9%* • *Male: 48.1%* ***Race and Ethnicity:*** • *White 37.2%* • *Black 54.2%* • *American Indian and Alaska native 0.8%* • *Asian alone 3.5%* • *Native Hawaiian and Other Pacific Islanders 0.2%* • *Person reporting 2 or more races 4.1%* • *Hispanic or Latino 8.2%* • *White not Hispanic 31.5%*	*2018-2022 US Census, American Community Survey 5 year estimate and 2022 1-year estimates and 2022 1 year estimates*

	Age: • *Persons under 5 years 5.6%* • *Persons under 18 years 23.7%* • *Persons 65 years and over 14.2%* ***Language:*** • *Language other than English spoken at home: 9.8%*	

2024 CHARLES COUNTY

Community Health Needs Assessment

In Conjunction with the Charles County Department of Health and Partnerships for a Healthier Charles County

UM CHARLES REGIONAL MEDICAL CENTER

UNIVERSITY of MARYLAND MEDICAL SYSTEM

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Charles County health needs assessment executive summary

From July 2023 to February 2024, the University of Maryland Charles Regional Medical Center, the Charles County Department of Health, and the Partnerships for a Healthier Charles County undertook a comprehensive assessment of the health needs of Charles County, Maryland.

To provide a comprehensive assessment of the health needs of the county, a four-method plan was developed which included 5 different sources of data: a long online survey of Charles County residents' perceptions of health and health behaviors, a short paper survey on health perceptions throughout the county, focus groups with community members and leaders, a quantitative data analysis of secondary, published data. Data collection occurred between July 2023 and December 2023.

The use of the multiple data collection methods strengthened the validity of the assessment's findings as well as ensuring that Charles County residents had an opportunity to participate in the assessment process and to provide recommendations and suggestions for programming to address their communities.

Six focus groups were conducted with the participation from community members with various backgrounds. The goal of each focus group was to gain feedback, gather insights, and obtain opinions and perceptions of the current health status in Charles County. The six focus groups included: the Charles County school nurses, members of the Partnerships for a Healthier Charles County Local Health Improvement Coalition, Charles County Access to Care Coalition members, Healthcare Consumers and Community Leaders, Chronic Disease Prevention and Management Coalition members, and Charles County Overdose Fatality Review Team members.

The biggest issues to emerge from the focus groups included:

- Behavioral Health Services and Resources
- Transportation
- Access to Care
- Specialty Services
- Obesity/Overweight
- Cost of Living (health care costs, housing, food, inflation)

755 people completed the 51-question online survey between July 1, 2023, and December 31, 2023. It was designed using Survey Monkey, and a link was provided on the University of Maryland Charles Regional Medical Center website and the Charles County Department of Health website. The first set of question gathered demographic information for all participants. A second set of questions asked people about their own health status and their access to needed health care. A third set of questions asked participants about their risk factors for health conditions (example, fruit and vegetable intake, physical activity level, alcohol/tobacco use) to determine if they are at risk for certain health conditions and chronic diseases. The fourth set of questions asked

Charles County health needs assessment executive summary

participants about their perceptions of the state of health and health conditions within Charles County. A fifth set of questions asked participants perceptions of improvements within the county to improve health. Lastly, survey respondents were given the opportunity to comment on the state of health in the county and provide suggestions on how to improve the health status of Charles County.

Most of the respondents were from Charles County (85.4%). The second largest percentage is from St. Mary's County (5.6%). Only 5.68% of respondents reported living outside of Southern Maryland (Charles, Calvert, St Mary's, or Prince George's). Approximately 67.15% of the respondents were between the ages of 45-74 years. The highest percentage was in the 45-54-year age group (25.66%). The overwhelming majority of the respondents were assigned female at birth (79.52%).

This report represents a more diverse group of respondents. Minorities made up 47.16% of the total survey population. This is a large increase from 26% reported in the last needs assessment report. African Americans comprised 41.49% of the respondents. This is an increase from 22% in the FY21 needs assessment report. Approximately 4.47% of the survey respondents self-identified as Hispanic.

The survey participants were a highly educated group with 91.16% reporting having had any amount of college education. Just over half of the group had completed an undergraduate degree or higher (59.12%). Most of the participants were employed and working full-time.

Individuals from all income levels were represented in the survey population. Individuals who reported household income of $180,000 or more per year represented 19.49% of the respondents. Individuals with a household income less than $60,000 made up one-sixth of the 2023 survey (15.4%). This represents all individuals responding that their household income was either $0-$29,999 or $30,000-$59,999.

Nearly all the survey participants (96.32%) reported having health insurance. Most of the participants also reported having dental insurance (84.72%) though this percentage is smaller than those reporting health insurance. Many of the respondents also had vision insurance (74.62%). Only 1.5% of the survey population reported having no type of insurance.

The top 5 serious health issues for Charles County residents were affordable housing, obesity, crime, drug use, and affordable healthcare. Social determinants of health, such as housing and crime, have come to the forefront during this needs assessment.

The protective health behaviors that Charles County residents were displaying included: always wearing a seat belt, washing hands after using bathroom or making food, practicing safe sex, getting a flu shot, and following road safety rules.

Charles County health needs assessment executive summary

Some risk factors that Charles County residents possessed that may lead to chronic disease included: not participating in physical activity each day, not eating enough fruits and vegetables, not performing self-exams for cancer, not getting enough sleep at night, and not using sunscreen regularly.

The online survey participants were also asked about access to health care. 84.9% have had a routine doctor's visit in the past 12 months. 93.37% receive their routine health care in a primary care physician or provider's office.

64.94% were always able to see a doctor when needed. If they were unable to see the doctor when needed, the most common reasons were that there were no available appointments (41.3%) or that it was too expensive, and they could not afford it (3.75%).

78.26% travel outside of Charles County for medical care at some point. Only 13.18% reported that they always travel outside the county for care. The most common medical services that people receive outside of Charles County are specialist doctor appointments (60.62%), dental appointments (21.68%), primary care doctor appointments (30.24%), and surgeries (20.94%). The most common responses among participants were that the quality is better elsewhere (41.12%) and services are not available in Charles County (24.67%).

A short 5 question survey was developed to distribute throughout the county for additional qualitative data from July 1, 2023, through December 31, 2023. A total of 1,189 surveys were completed throughout the community. Short survey data collection was performed at various community events throughout the county.

Emphasis was given to the collection of data among the county's vulnerable populations including the medically underserved, the homeless, and the geographically isolated. An ongoing survey collection was conducted at the Charles County Department of Health and the University of Maryland Charles Regional Medical Center. Short surveys were collected during blood drives at the University of Maryland Charles Regional Medical Center (CRMC), the Red Cross Blood Drive, and church Blood Drives. CRMC also coordinated with the Charles County Department of Health to distribute surveys at the Charles County Fair. The Charles County Department of Health conducted survey collection at all community outreach events attended from July to December 2023. Emphasis was given to the western region of the county that is more geographically isolated. Surveys collection was conducted at Fruit and Vegetable distribution sites and at the Nanjemoy Heritage Day. The community was also surveyed at large events such as the Charles County Fair, blood drives, Charles County Government Wellness Fair and Rodeo, Recovery Day, food drives, and other community outreach events.

The biggest health problems identified by the short community survey included: obesity, drug and alcohol use, mental health, heart disease, cancer, and high blood pressure/stroke. Common themes

for recommendations included access to care, mental health, transportation, substance use, and outreach.

The most cited barriers to needed health care were care is too expensive/can't afford it (56.6%) and lack of health insurance (41.0%). Over 20% of respondents also identified transportation and not being able to get an appointment with their doctor as barriers to needed health care as well. Under "Other", several respondents explained that there is an issue trying to get in to see a provider. Respondents expressed that there's not enough health care providers, no available appointments for months, hard to find new doctors when needed, not enough doctor's offices, hard to get appointments, not enough specialist providers, hard to find a primary care doctor they like, providers not accepting new patients, and lack of providers that take Medicaid in the psychiatric department. Other barriers were distrust of health care providers, no time off from work, poverty, lack of education, unreliable services, overcrowded ER facility, insurance is not accepted, limited eye doctors, and no prevention.

Short survey participants were asked if sufficient services are available to address the health conditions in Charles County. Many of the respondents answered that they did not know, or they left it blank. This leads us to believe that additional outreach and awareness campaigns are needed to educate people on available services in Charles County.

There were very few survey respondents who believed there were no services available for the listed health conditions. Of those who did answer there were no services available in the county, Mental Health, Traffic Safety/Injuries, and Access to healthcare in rural Charles County had the most responses.

Quantitative data was analyzed for various health topics including: mortality, population and demographic data, natality, infant mortality, social determinants of health, heart disease, stroke, hypertension, access to health care/health un-insurance, cancer, asthma, injuries, diabetes, food, physical activity, obesity, arthritis, dementia/Alzheimer's disease, infectious disease, environmental health, sexually transmitted diseases, HIV/AIDS, mental health, dental health, substance use, disabilities, violence, social determinants of health, and tobacco use.

The current assessment findings are an update from the Fiscal Year 2021 community health needs assessment report and health improvement plan. 25% of the objectives outlined in the Charles County Health Improvement Plan reached their anticipated goals in the given time frame.

Thanks to the work of the Partnerships for a Healthier Charles County and its teams, the Charles County Health Improvement Plan objectives have been met for:

- Preventable Hospital Stay Rate decreased
- Number of medical practices increased

Charles County health needs assessment executive summary

Charles County Health Improvement Plan objectives that were not met include:

- Percentage of residents who did not see a doctor in the last year due to cost increased
- Percentage of Charles County residents who received a flu vaccination increased but did not reach goal
- Drug-induced death rate decreased but did not reach goal
- Childhood obesity percentage increased
- Adult obesity percentage increased

3 Charles County Health Improvement Plan objectives where updated data was not available: mental health, hypertension, and diabetes emergency department visit rates.

The data from this community health needs assessment will be used to develop the next Charles County health improvement plan and subsequent action plans. They provide the county with measurable outcomes and benchmarks for 3-year program implementation.

Focus Groups:

A critical part of the needs assessment process is to invite the community to express their perceptions of health status. Qualitative data accumulated from this process is used in conjunction with quantitative health data to determine the most important health issues within the county.

Throughout the data collection phase of the Charles County Community Health Needs Assessment, six focus groups were conducted with the participation from community members with various backgrounds. The goal of each focus group was to gain feedback, gather insights, and obtain opinions and perceptions of the current health status in Charles County. The six focus groups included: the Charles County school nurses, members of the Partnerships for a Healthier Charles County Local Health Improvement Coalition, Charles County Access to Care Coalition members, Healthcare Consumers and Community Leaders, Chronic Disease Prevention and Management Coalition members, and Charles County Overdose Fatality Review Team members.

The focus group followed a pattern of health-related questioning. The questions included:

Question 1: What do you believe is the health condition most affecting Charles County?

Question 2: Are there barriers and gaps in services affecting health in Charles County?

Question 3: Since the FY 2021 community health needs assessment, do you feel health improvements have been made in the county in respect to healthcare?

Question 4: What are the strengths of the community?

Question 5: Do you feel there are adequate resources in Charles County to address health?

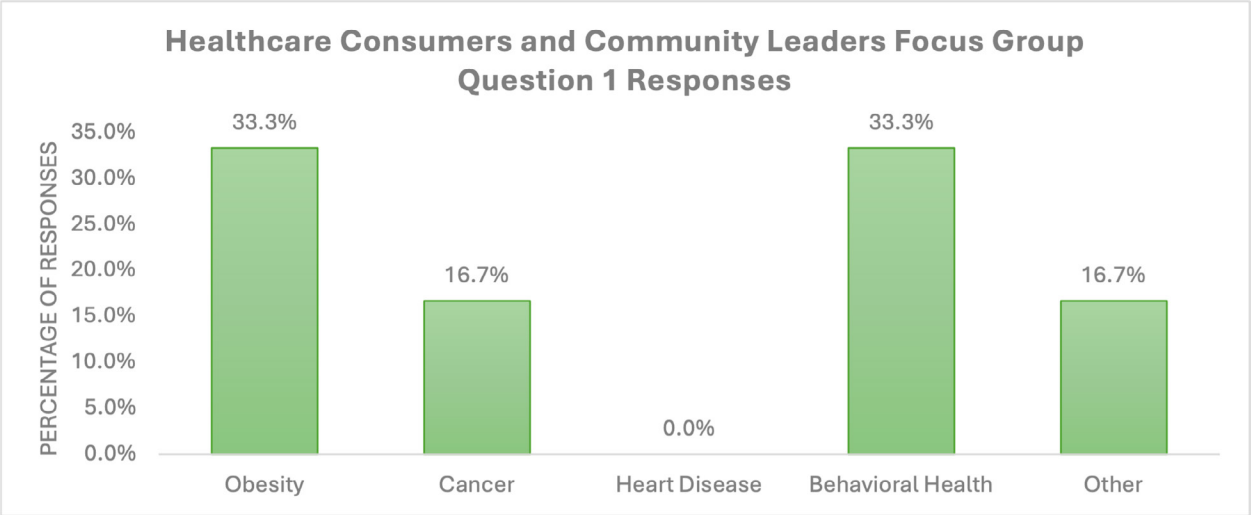
Question 6: What key changes could the community implement to improve health locally?

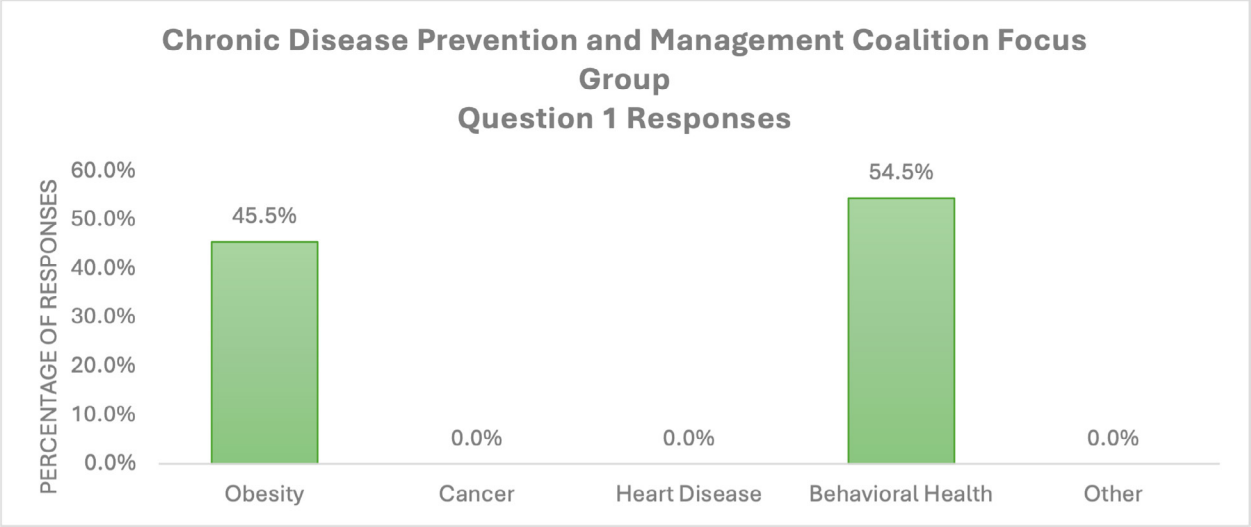
Interactive Question 1: What do you believe is the health condition most affecting Charles County?

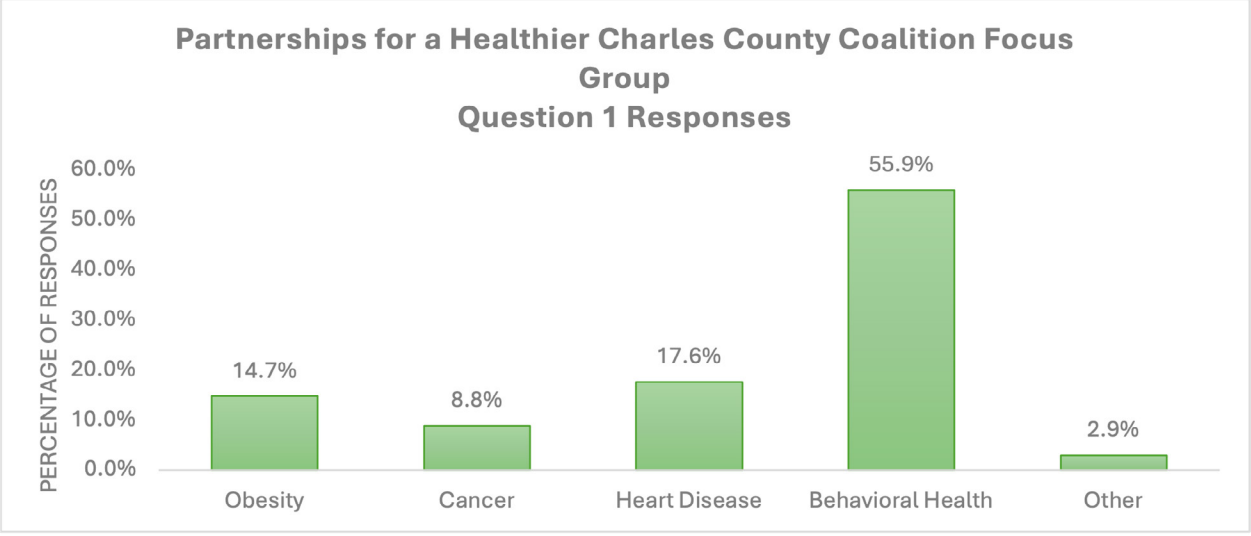
Focus group participants had the following answer options for Question 1: Obesity, Cancer, Heart Disease, Behavioral Health, or Other. Across all six focus groups, Behavioral Health and Obesity were the top health conditions that participants believed to be affecting Charles County the most. Behavioral Health had the most responses among focus group participants, followed by Obesity. Although Behavioral Health and Obesity were the top responses among participants, responses varied among each of the different focus groups. The Healthcare Consumers and Community Leaders focus group had more varied answers, with 33.3% of participants choosing Obesity and 33.3% choosing Behavioral Health. While the Chronic Disease Prevention and Management Coalition members had 54.5% of participants choosing Behavioral Health and 45.5% of participants choosing Obesity. Lastly, in the Partnership for a Healthier Charles County focus group almost 56% of participants believed Behavioral Health to be the health condition most affecting Charles County, followed by heart disease at 17.6%. Obesity came in third for that group with 14.7%. Other responses that focus group participants mentioned were Cancer, Chronic Kidney Disease, Sexually Transmitted Infections (Syphilis, Chlamydia), Diabetes, and Infectious Disease.

In past needs assessments, Behavioral Health and Obesity were also the most common responses

among participants. In the last needs assessment, approximately 87.5% of focus group participants felt that Behavioral Health was the greatest health problem in Charles County, followed by 12.5% for Obesity.







Question 2: Are there barriers and gaps in services affecting health in Charles County?

The perceived barriers and gaps were very similar among focus group participants. A large majority of participants stated that barriers related to transportation and access to care were greatest in Charles County.

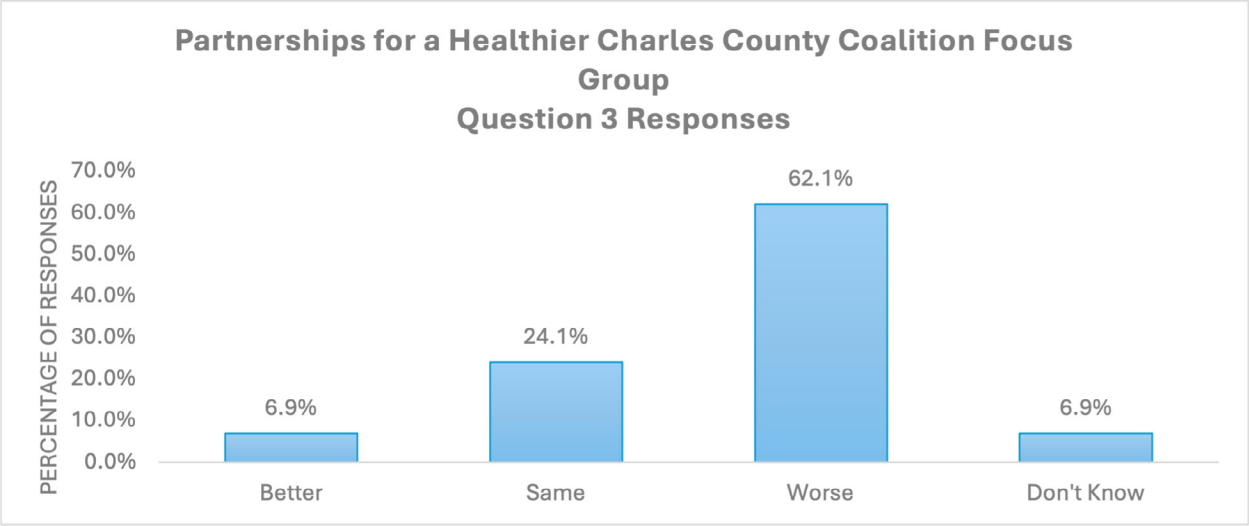
Across all six focus groups, transportation was identified as a barrier in accessing or receiving healthcare services in Charles County. From childhood and adolescence to the elderly population of the county, the lack of transportation is a countywide barrier. Focus group participants stated that the lack of transportation to and from after school programs is causing a sedentary lifestyle among the youth in Charles County. In the Partnerships for a Healthier Charles County focus group, participants stated that transportation to and from health services is a barrier. Participants also stated that children need to be involved in more activities, but transportation becomes a barrier to those activities. In the Chronic Disease Prevention and Management Coalition focus group, participants mentioned that more services are becoming available in the county, but the issue is getting to those services. Lastly, in the Healthcare Consumers and Community Leaders focus group, participants stated that there is a lack of transportation throughout the county, but specifically in more rural areas of the county including Nanjemoy, Indian Head and Welcome.

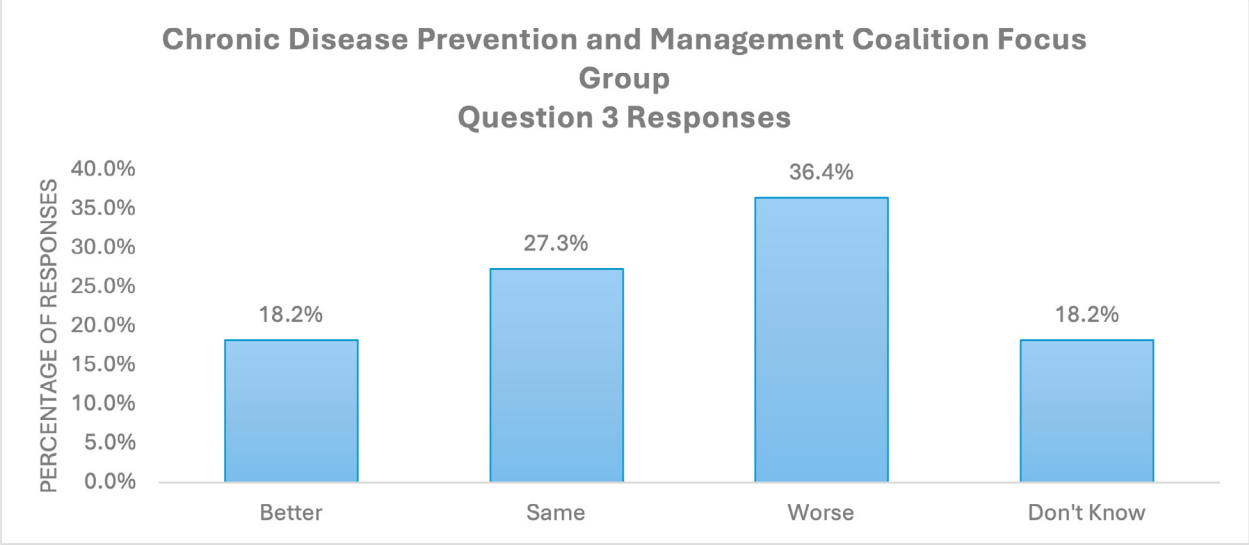
Access to care was also seen as a major barrier to healthcare services in Charles County among focus group participants. Across the six focus groups, participants mentioned there is a lack of facilities in the county and inpatient beds. A lack of proximity to services was also expressed as a barrier. Many of the perceived barriers in the community that were mentioned were related to mental health services. In the Healthcare Consumers and Community Leaders focus group, participants stated that there is a lack of psychiatrists in the county and that there needs to be more education on how to access mental health services. Focus group members within the Partnerships for a Healthier Charles County Coalition also stated that behavioral health practitioners are limited in Charles County. Among the school nurses, many agreed that there was a lack of mental health providers and services for youth, and too much screen time. Also related to mental health, participants mentioned that there is a lack of behavioral health prescribers in Charles County and trouble with the school systems filling their school psychiatrist positions. Lastly, barriers of commercial insurance and behavioral health services were identified. Focus group participants stated that those with public insurance have access to community-based services and case management. If those services can be offered through Medicaid, they should also be available for those with commercial insurance. It was also mentioned that most people develop behavioral health conditions in childhood or adolescence, yet if they have commercial insurance, they have limited options when it comes to accessing services. Other barriers mentioned among participants related to access to care included the need for a bigger hospital, more specialists in the county, long wait-times, health literacy, the lack of health care centers and urgent care centers, and the care for Drug Affected Newborns (DAN) babies that is not offered in the county. Those patients currently must travel outside of the county to receive those services and parents may not be able to make that trip.

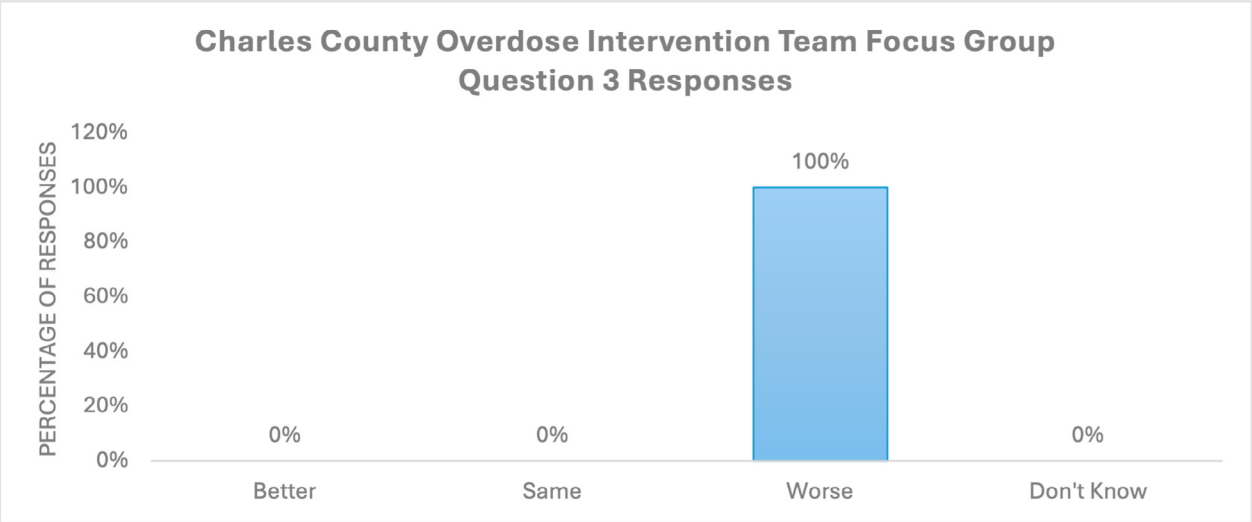
Other barriers that were identified in the focus groups were food deserts within the county and the need for more healthy food options, the cost of healthcare services, health insurance issues (providers only accepting certain plans), lack of physical activity, affordable housing, access to veteran's services, physician recruitment and retention, safety issues within the county, and issues with telehealth services that have limited the patient-provider relationship.

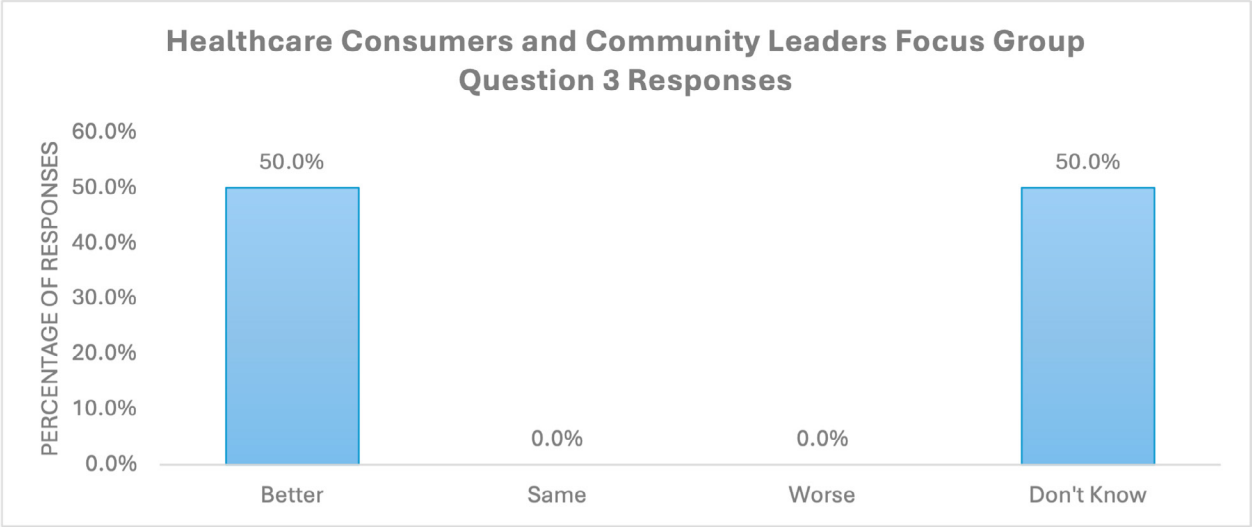
Question 3: Since the FY 2021 community health needs assessment, do you feel health improvements have been made in the county in respect to healthcare?

Perceptions of health improvements in the county since the last needs assessment varied among focus group participants. While there were a handful of participants who believed health improvements have been made, many others believed that it has stayed the same or gotten worse. Among participants in the Partnerships for a Healthier Charles County focus group, over 62% responded that healthcare got worse in the county and over 24% felt it stayed the same. The Charles County Overdose Intervention Team focus group had 100% responses for healthcare got worse since the last needs assessment. While participants of the Healthcare Consumers and Community Leaders focus group had split responses with 50% believing healthcare improved in the county and 50% did not know.









Of those who believed improvements have been made, participants gave examples of more acute care health centers in the county, an increase in primary care providers and facilities, and more access to behavioral health services.

Of those who believed healthcare got worse, some examples were related to specialty providers (long wait times, proximity, youth access, and staffing issues), behavioral health in Emergency Departments, communication with the community, and no inpatient treatment in the county. Although many participants believed healthcare in the county got worse since the last needs assessment, there was agreement that providers and facilities have increased but with the population growth of the county those achievements are not being noticed.

Question 4: What are the strengths of the community?

There was overwhelming agreement among focus group participants that partnerships and collaborations within Charles County are a major strength of the community. Participants stated that organizations are interested in improving and obtaining feedback from community members on how they can improve. One of the products of great collaboration in the county is the school

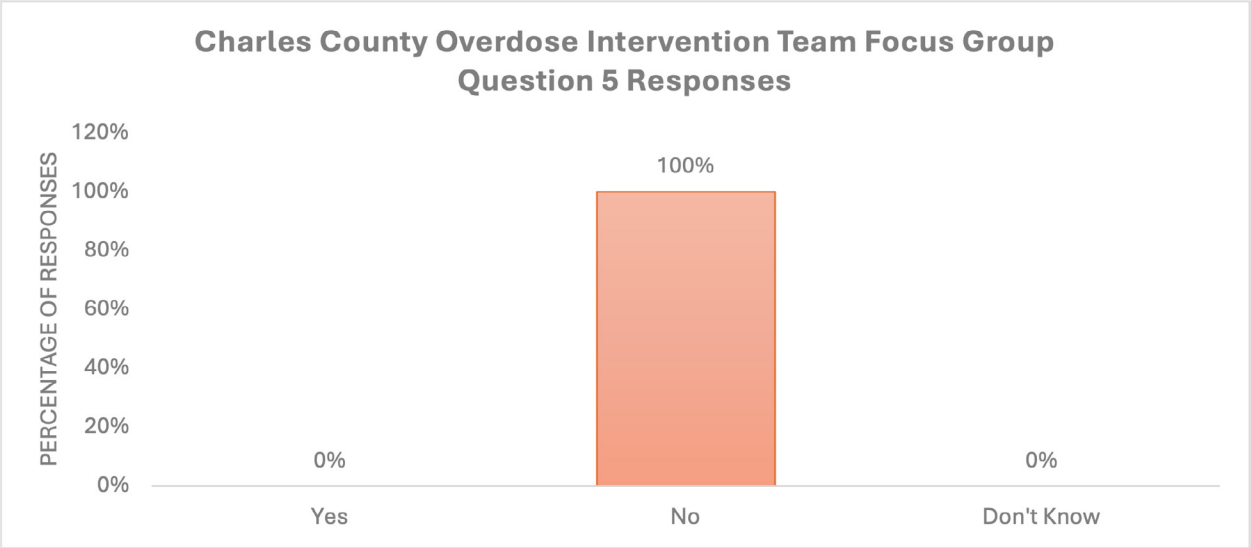
nurses. The school nurses are through the health department and there is great communication and collaboration between the two. The relationship between the Charles County Department of Health and the school nurses has not only created a pivotal collaboration but has also strengthened the connection with the public school system and community as well. A major accomplishment within Charles County is the first school-based health center at Indian Head Elementary School, which plans to open in Fall 2024. The health center is the result of strong partnerships between Charles County Public Schools and the Charles County Department of Health. The goal of the health center is to provide a multitude of different health care needs to the community. Lastly, the relationship between the health department and the hospital, and all community partners is amazing. Focus group participants stated that they believe partnerships between hospital systems in the community are also a strength.

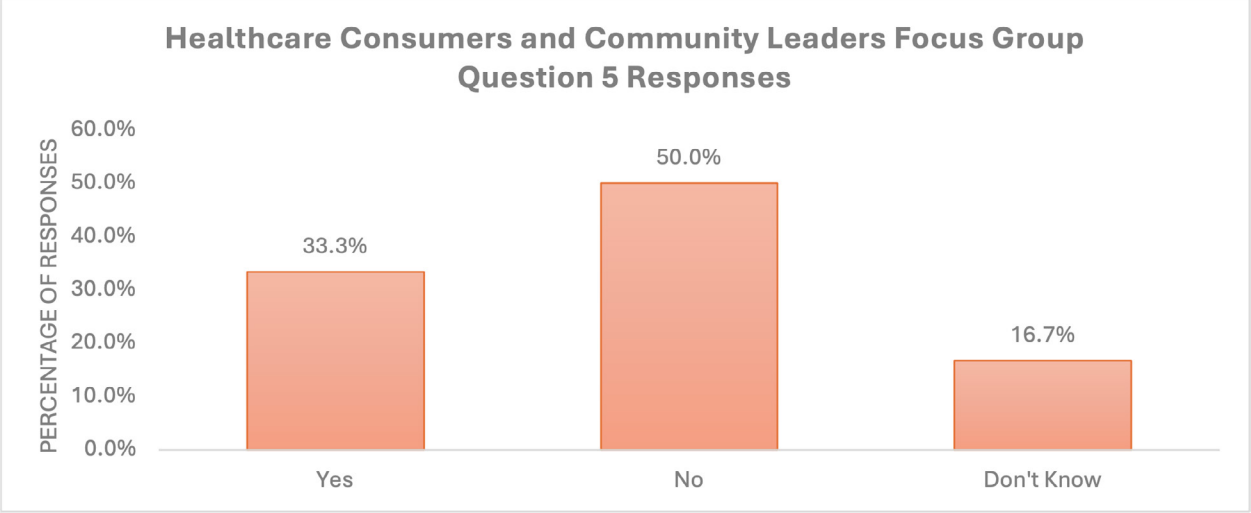
Outreach was another strength mentioned among the focus groups. Outreach programs and events bring resources and information out into the community and gives programs the ability to meet people where they are. Other strengths that were mentioned in the focus groups were food pantries, school meal programs, farmer's markets accepting SNAP, the new provider in Bryans Road, telehealth services, the Diabetes Prevention Program, Building Better Caregivers program, the Tobacco Prevention, Enforcement, and Cessation Program, and people who work in those programs are passionate about what they do and helping the community.

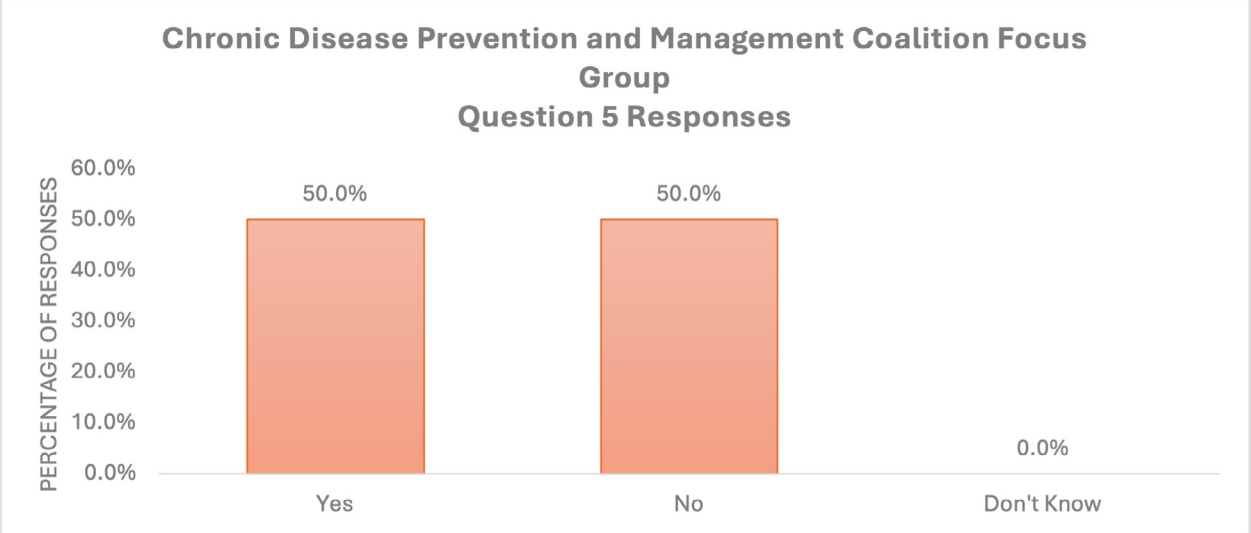
Question 5: Do you feel there are adequate resources in Charles County to address health?

Across all six focus groups, there were mixed feelings on if there are adequate resources in Charles County to address health. For those who believe there are adequate resources in the community, they mentioned that more providers have been brought into the county and that new senior centers have opened. The reality is that people who know about the services use them; it is the issue of people who are not aware these services exist. Some said this question was multi-faceted because resources are available, but people might not be able to access them.

The issue of accessing resources was a common theme among focus group participants. There was a strong feeling that people do not know where to start when it comes to accessing services. Participants also stated that people do not understand that services work with everyone, with any income level. There is a stereotype that services are only for people of certain demographics, but that is far from true. Transportation and getting people to the services that are available is also a barrier. There was agreement among focus group participants that people must have the want to access services, and that it is sometimes a struggle motivating people to commit to change. There was also a mention of disparities among services in the county. There are some services that are in abundance and others that are lacking.


Charles County Overdose Intervention Team Focus Group
Question 5 Responses
PERCENTAGE OF RESPONSES
120%
100%
80%
60%
40%
20%
0%
0%
100%
0%
Yes
No
Don't Know


Healthcare Consumers and Community Leaders Focus Group
Question 5 Responses
PERCENTAGE OF RESPONSES
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
33.3%
50.0%
16.7%
Yes
No
Don't Know


Chronic Disease Prevention and Management Coalition Focus Group
Question 5 Responses
PERCENTAGE OF RESPONSES
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
50.0%
50.0%
0.0%
Yes
No
Don't Know

Question 6: What key changes could the community implement to improve health locally?

There was much agreement among the focus groups that services and resources need to be provided to the less populated areas of the county, specifically the Western part of Charles County. Participants stated that Waldorf and La Plata are so populated and that there is a need to branch out to other areas throughout the county. A few ideas emerged from these focus groups on how to target these areas of the county. Participants stated that a mobile health service, like a van, could help reach these communities and provide health services and education. The need for more urgent care centers in rural areas in the county was also mentioned.

Another key change was to focus on the senior population in the county. Participants mentioned that seniors want to be more active and that there is a need for more fitness activities for the senior population, including giving them better access to the pools. Senior isolation was also brought up in the focus group, and participants believe there needs to be more resources for those seniors who live in isolation, either by choice or by circumstance. Many seniors do not want to leave their homes for an assisted living facility. There is a need in the community to provide seniors with resources that will assist them when they are living alone in their own home. Overall, since COVID-19, the world has become more mobile (ordering groceries, shopping online) and there is less interaction for people resulting in lonelier lifestyles. Lastly, another key change that would help the senior community is having specialists who understand the aging population. There are currently no specialists in geriatric behavioral health.

Lastly, there was agreement across the focus groups that Charles County is growing and that the health services and resources also need to grow with the population. This includes expanding the hospital and the emergency department. Many participants believed there needs to be more inpatient beds at CRMC to accommodate the growth of the population. With the growing population, the addition of more providers, specifically specialist providers, are also needed in the county. Closely related to expanding services in the community, there was also a need to expand the hours of services. Urgent care centers and other health services are open during the workday, when most people are at work and do not have the time to take off to go to an appointment. Expanding the hours would allow those people to receive the services they need without taking time off work. Lastly, there is a need for more pharmacies in Charles County, and more pharmacies that deliver.

Another key change that is important to note is the need to increase the capacity around trauma-informed care and improve the competence of providers for individuals with co-occurring behavioral health conditions and intellectual disabilities. The people that are the most vulnerable are left out in the cold with limited resources.

A few other key changes that were mentioned in the focus groups were adding more back to basics classes, including cooking classes and knife skills classes, starting more classes in Nanjemoy, Swan Point, Cobb Island, and libraries, creating an access point for Charles County services that will help direct people to the services they need and how to access them, more peer recovery specialists for families and individuals, and adding behavioral health clinics in the schools.

The biggest issues to emerge from the focus groups included:

- Behavioral Health services and resources
- Transportation
- Access to Care

- Specialty services
- Obesity/Overweight
- Cost of Living (health care costs, housing, food, inflation)

Qualitative data from the focus groups on specific health topics has been incorporated into those sections of the needs assessment report.

Recruitment and facilitation of all focus groups was the shared responsibility of the University of Maryland Charles Regional Medical Center, the Charles County Department of Health, the Partnerships for a Healthier Charles County, the Charles County Public Schools, and the College of Southern Maryland.

Long Survey Analysis:

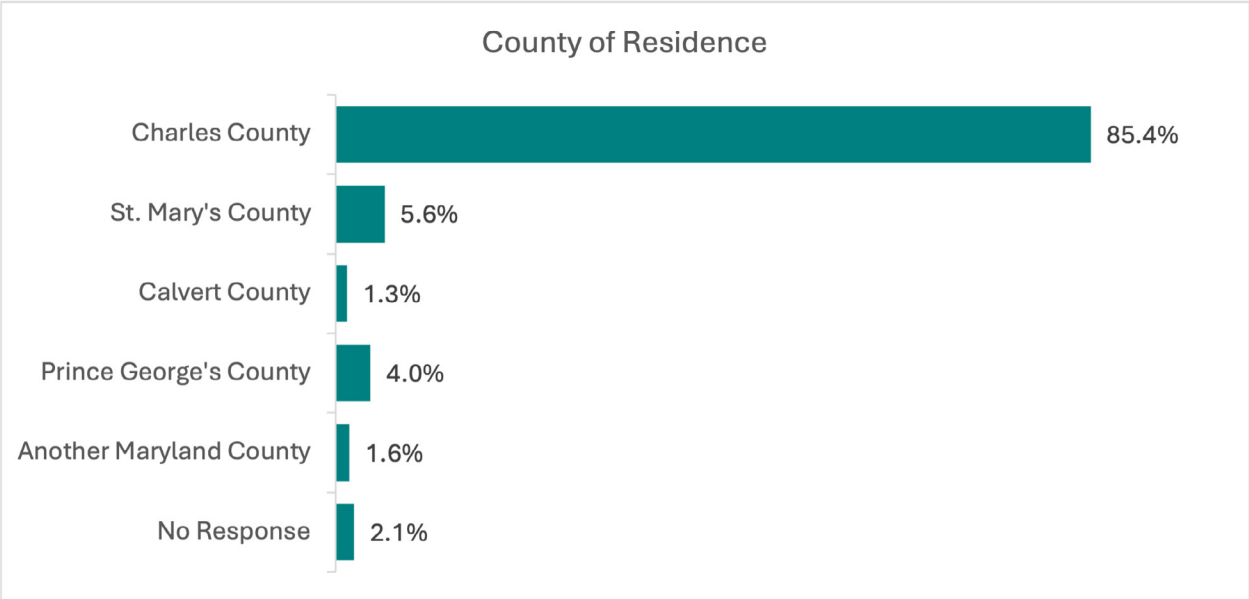
Introduction

A 51-question online survey was developed in the summer of 2023. Some of the questions had several components. It was designed using Survey Monkey, and a link was provided on the University of Maryland Charles Regional Medical Center website and the Charles County Department of Health website. The first set of question gathered demographic information for all participants. A second set of questions asked people about their own health status and their access to needed health care. A third set of questions asked participants about their risk factors for health conditions (example, fruit and vegetable intake, physical activity level, alcohol/tobacco use) to determine if they are at risk for certain health conditions and chronic diseases. The fourth set of questions asked participants about their perceptions of the state of health and health conditions within Charles County. A fifth set of questions asked participants perceptions of improvements within the county to improve health. Lastly, survey respondents were given the opportunity to comment on the state of health in the county and provide suggestions on how to improve the health status of Charles County.

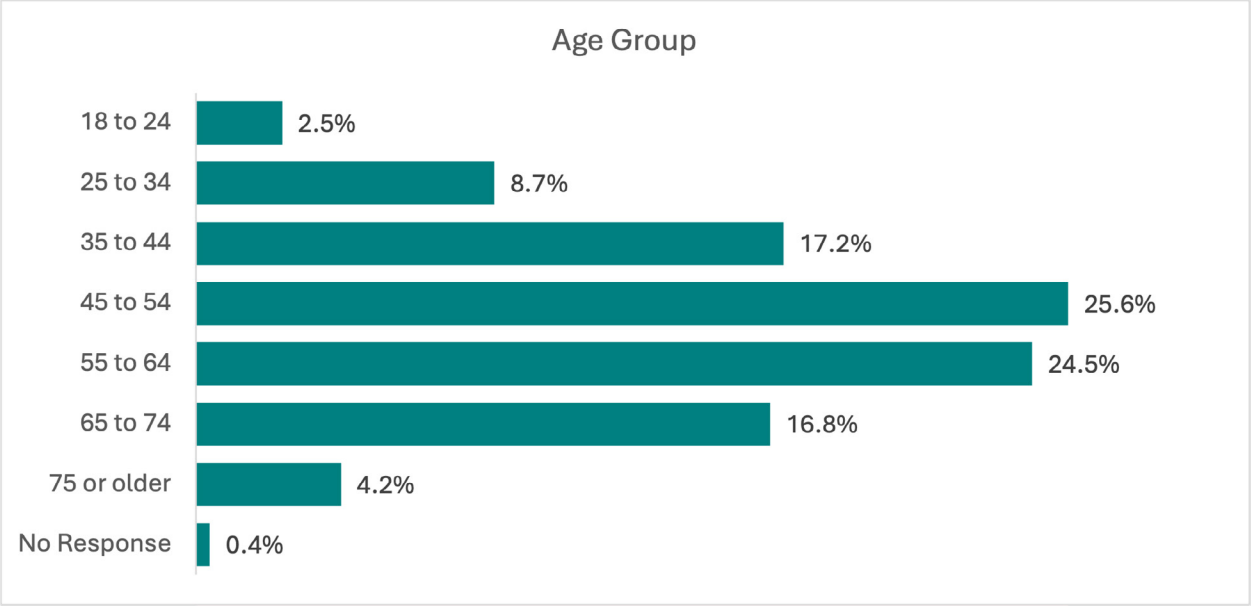
There were a total of 755 participants that took the survey. Some questions were not completed by all survey participants. Not every question was applicable to every participant. Some questions were skipped. Data for each question was compiled and analyzed.

Demographic Information

Most of the survey participants were residents of Charles County (85.4%). The second largest population was from the neighboring St. Mary's County. Residents of neighboring counties were included in the analysis since there is a lot of movement between the counties. A large portion of individuals work and spend time in Charles County.

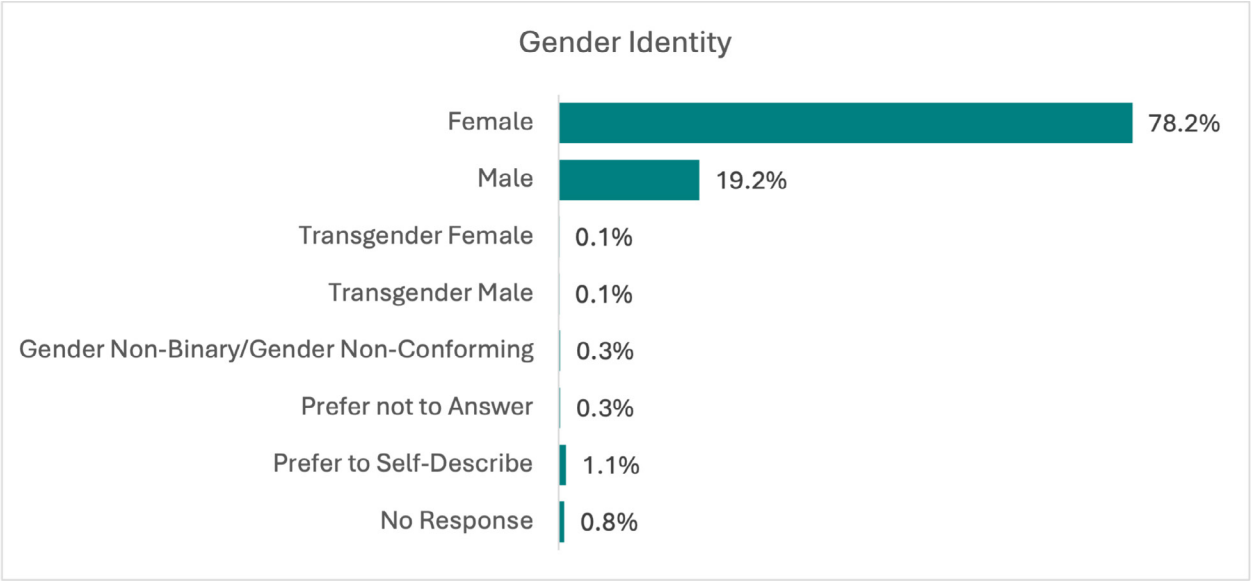


Survey participants varied among all age groups, with most of the participants being between the ages of 35 and 74. The largest percentage of participants were from the 45 to 54 age group with 25.6% of participants, followed by the 55 to 64 age group with 24.5% of participants. The youngest age group of 18 to 24 years had the lowest number participants with a percentage of 2.5%.

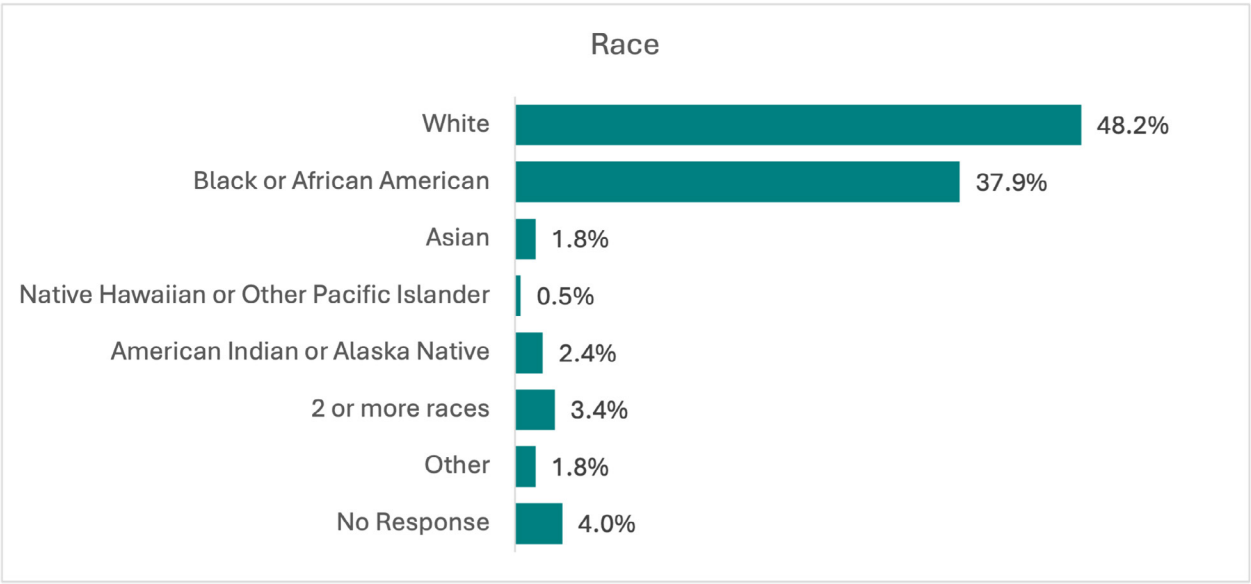


Almost 80% of survey respondents were assigned the sex of female at birth, or female was on their original birth certificate. Historically, males have had low participation percentages for the needs assessment. In the 2024 survey, males comprised of 20.4% of respondents, a slight decrease from the 2021 survey when the male percentage was 22.6%.

Over 78% of survey respondents identify as female, and 19.2% identify as male. 0.1% of respondents identify as transgender female and 0.1% identify as transgender male. 0.3% of respondents identify as gender non-binary/non-conforming.

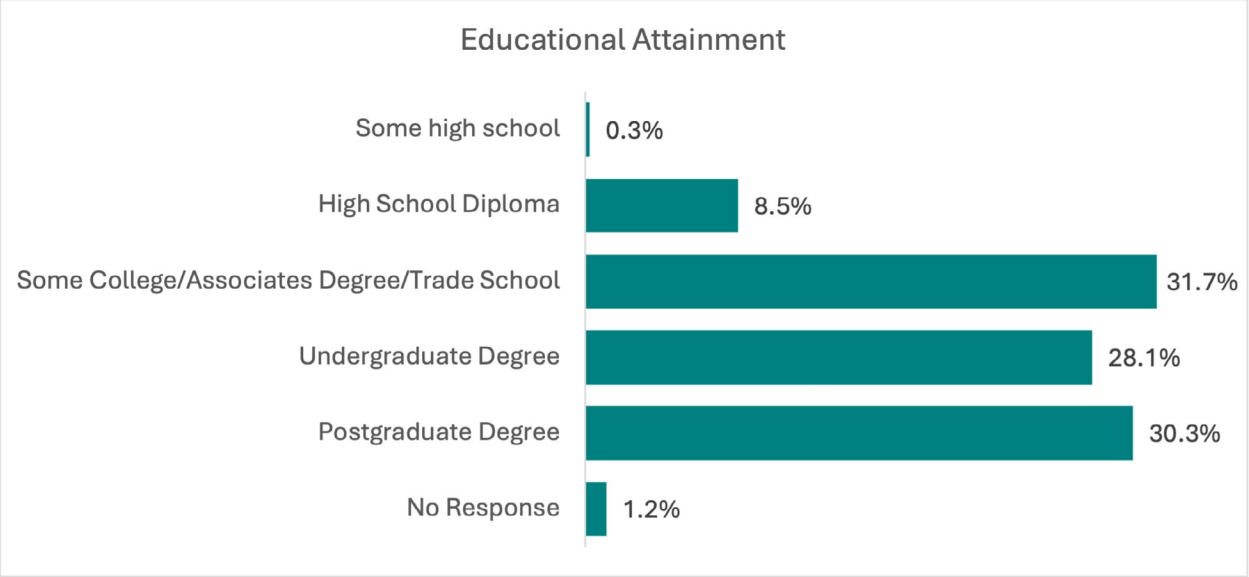


During the survey collection phase of the needs assessment, efforts were made to obtain representation from all racial populations of the community. Historically, the White population has made up a substantial proportion of survey respondents in past needs assessment surveys. However, this year, the minority population had a greater representation. Minorities made up 44.4% of survey respondents. This is an increase from the percentage of 26% reported from the last needs assessment survey. Black or African American comprised of 37.9% of survey respondents, an increase from 22.5% from the previous needs assessment.

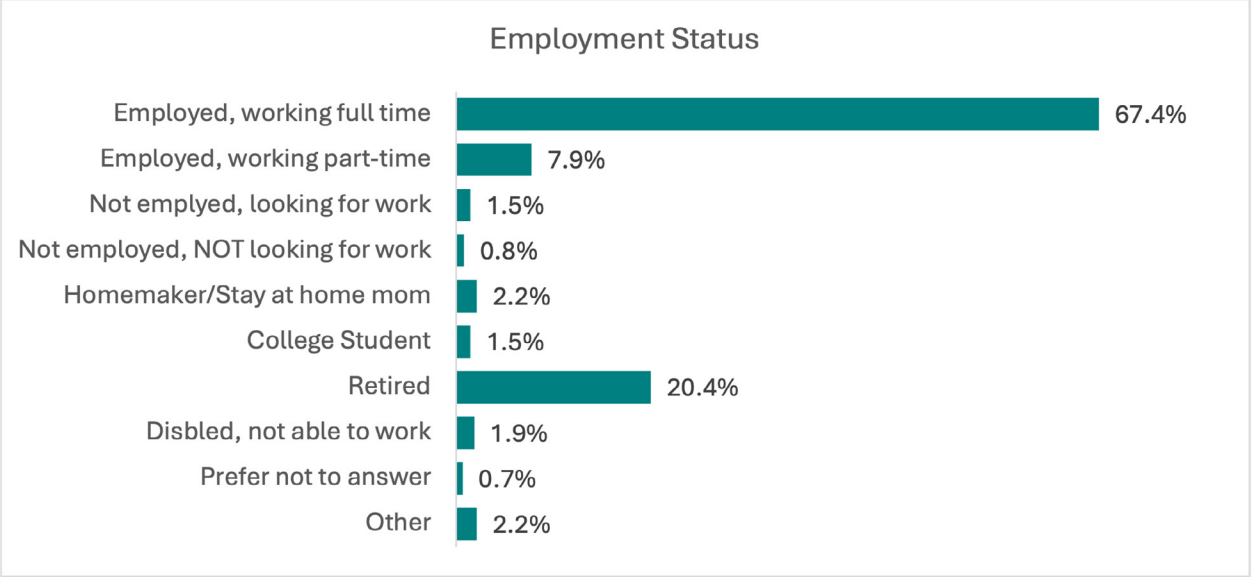


Around 4% of survey respondents self-identified as Hispanic. This percentage is slightly higher than last needs assessment, where 3% of participants identified as Hispanic. The county's overall population is about 7.5% (U.S. Census Bureau).

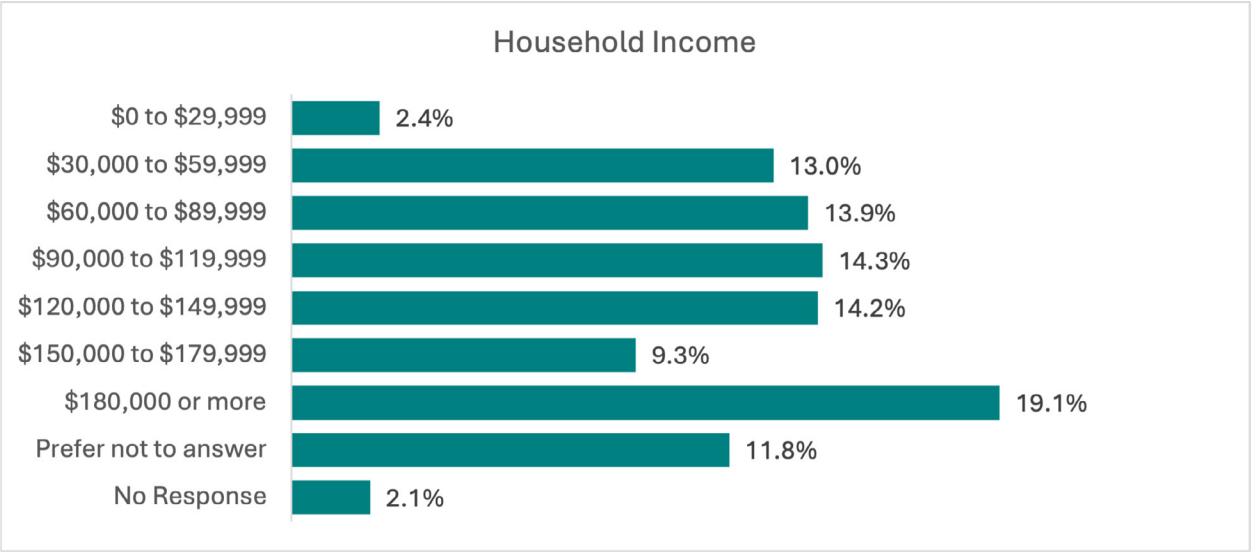
The majority of survey respondents were highly educated (90.1%) having at least some type of college education. The largest participant group had some college, associate degree, or trade school with 31.7% of total respondents. 28.1% had an undergraduate degree and 30.3% had a postgraduate degree. Only 8.5% of respondents had a high school diploma and less than 1% had some high school education.



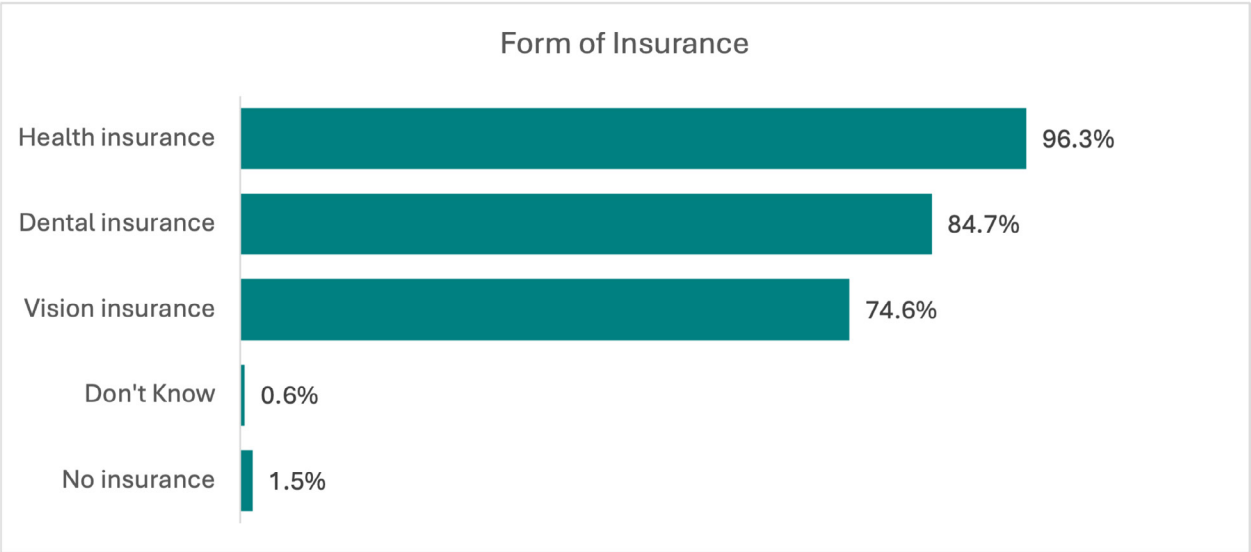
Participants were also asked their employment status. Most survey respondents reported being employed full time, with 67.4% of total responses. The second largest group were those who reported as being Retired, with 20.4% of total survey responses. The percentage of respondents who were employed full time increased from the 2021 needs assessment from 44.9% to 67.4%. The percentage of respondents who reported as being Retired decreased from 39.7% to 20.4%. This difference may be based on the age of survey respondents. In the 2021 needs assessment survey, almost 40% of respondents were 65 years of age or older. In 2024 needs assessment, this percentage decreased to 21%.



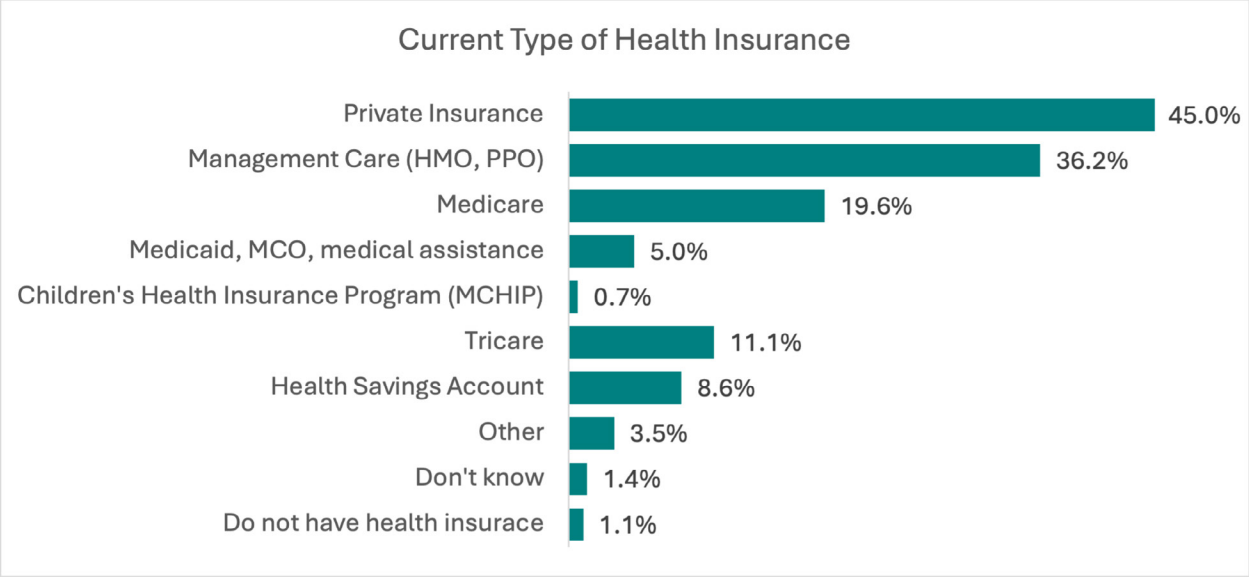
Survey participants were asked to report their household income. The household income with the most responses from participants was $180,000 or more, with 19.1% of total responses. The percentage of respondents with a household income of $180,000 or more increased from the 2021 needs assessment from 9.6% to 19.1%. The income ranges between $30,000 and $149,999 had very similar response rates, with around 13-14% of total responses for each income group. The percentage of respondents who preferred not to answer the question decreased from the previous needs assessment survey from 21.3% to 11.8%.



The participants were also asked to report all types of health insurance they currently have. Most respondents reported having at least one form of health insurance. Over 96% of survey respondents reported having health insurance, almost 85% reported having dental insurance, and almost 75% reported having vision insurance. 1.5% of survey respondents reported having no health insurance of any type. The largest increase in insurance coverage since the last needs assessment was seen in vision insurance, with an increase from 64.3% to 74.6%.

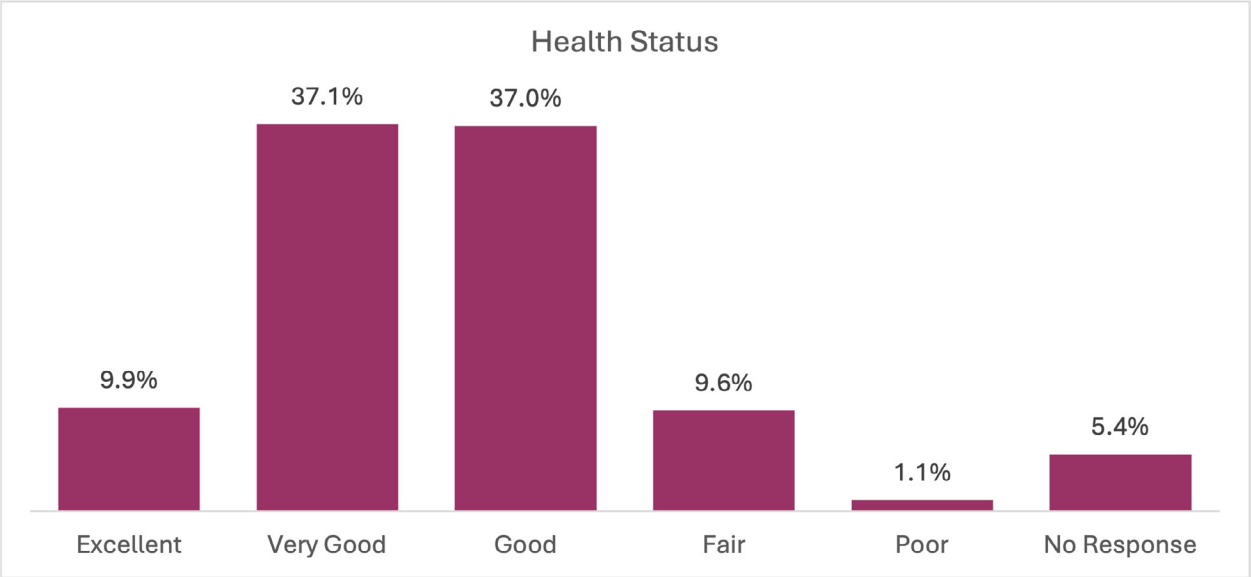


Among those having health insurance, Private Insurance, Management Care (HMO, PPO), and Medicare were the most common among survey participants, with 45.0%, 36.2%, and 19.6% respectively. 1.1% of survey respondents reported not having health insurance.

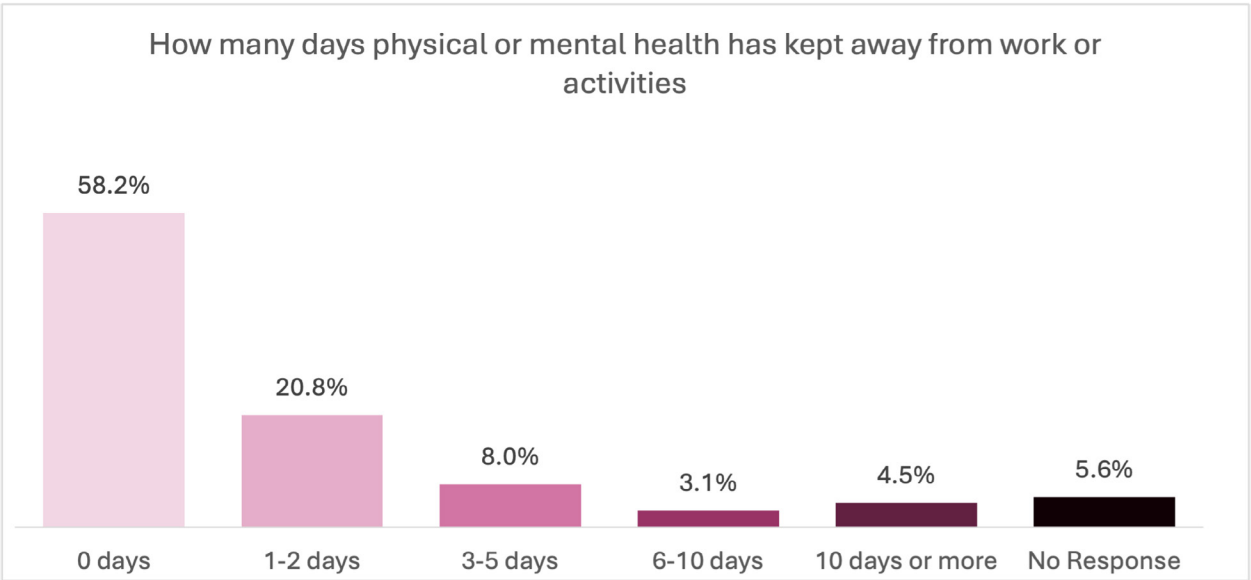


Health Status

Participants were asked to rate their current health status as poor, fair, good, very good, or excellent. The most common responses among participants were “very good” or “good” with 37.1% and 37.0%, respectively. The percentage of respondents who rated their health as “very good” increased slightly since the last needs assessment from 36.6% to 37.1%, while those who rated their health as “good” decreased from 41.5% to 37.0%. A small percentage of participants rated their health status as “excellent” at 9.9%, however this percentage is an increase from the 2021 needs assessment where only 7.9% of respondents rated their health status as “excellent”.

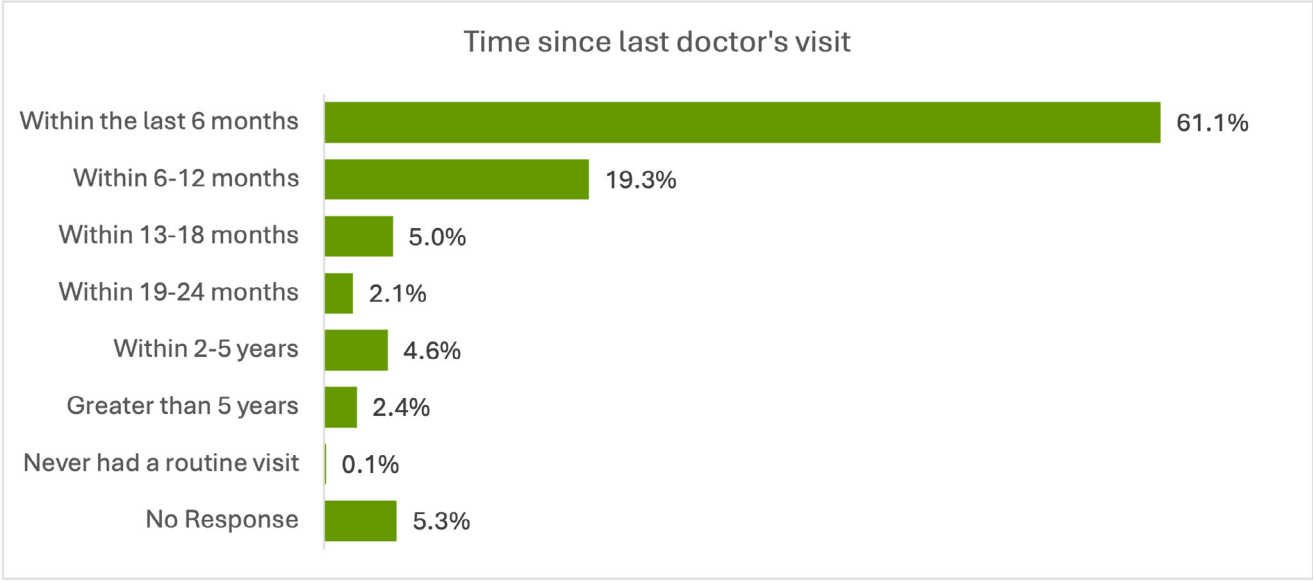


Participants were also asked how many days in the past month their physical or mental health kept them from work or normal activities. A little over 58% of participants reported that there were no days in the past month that prevented them from work or activities. This percentage is a decrease from 62.9% reported in the 2021 needs assessment. Over 20% of participants reported that their physical or mental health has kept them from work or activities for 1-2 days in the past month. This is a slight increase from 18.7% reported during the previous needs assessment. The percentage of participants that reported 10 or more days decreased from the previous need assessment from 8.4% to 4.5% of total responses.



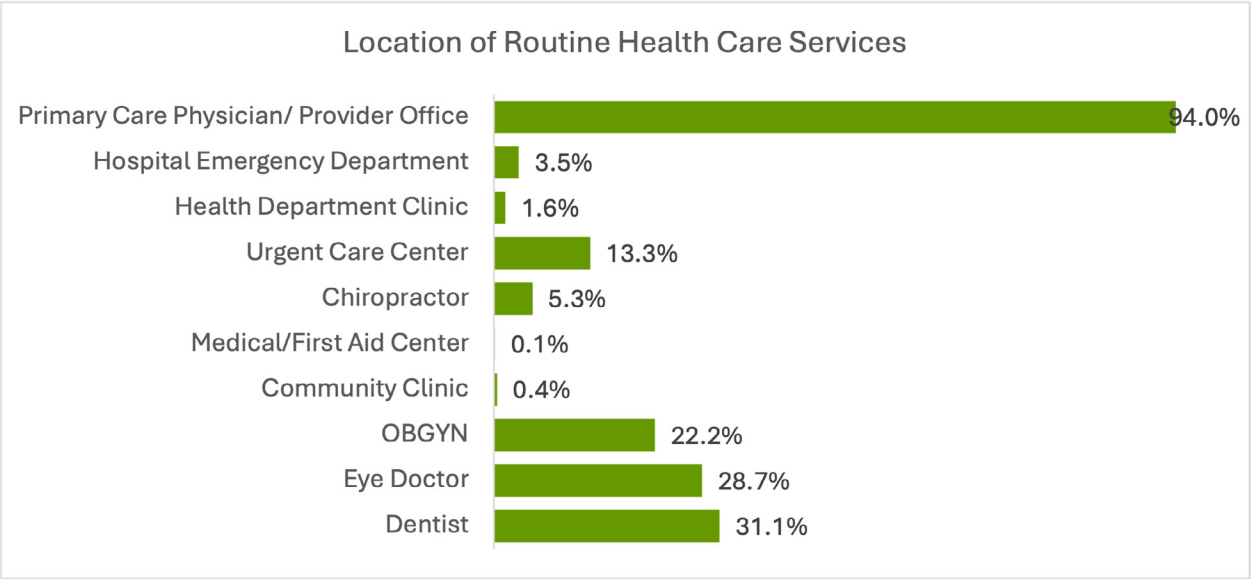
Access to Care

Most of the survey participants reported having a routine doctor's visit within the last 12 months (80.4%). This percentage is down from the 2021 survey where 88.2% of participants reported having a routine doctor's visit in the last 12 months. 4.6% of participants reported that their last routine doctor's visit was within the last 2-5 years, which is an increase from 2.3% reported on the previous needs assessment. Those who haven't been to a doctor for a routine visit in more than 5 years also increased from 1.3% in 2021 to 2.4% in 2023. Only 0.1% of participants reported that they have never had a routine doctor's visit.

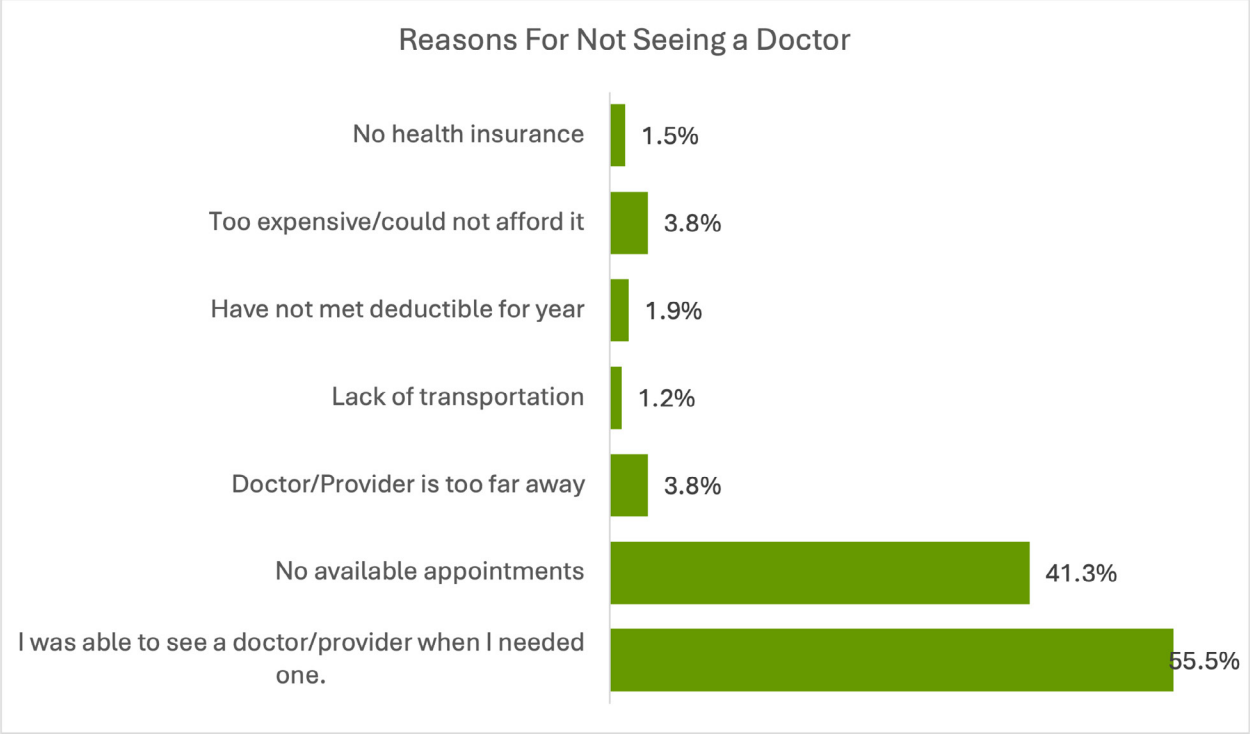


About 94% of survey participants reported that they receive their routine health care at a Primary Care Physician or Provider Office. Just under one third of participants reported receiving routine care from a Dentist (31.1%), followed by 28.7% from an Eye Doctor, and 22.2% from an OBGYN. 13.3% of survey respondents reported that they receive their routine health care from an Urgent Care Center. This percentage is a slight increase from 13% reported in the 2021 survey.

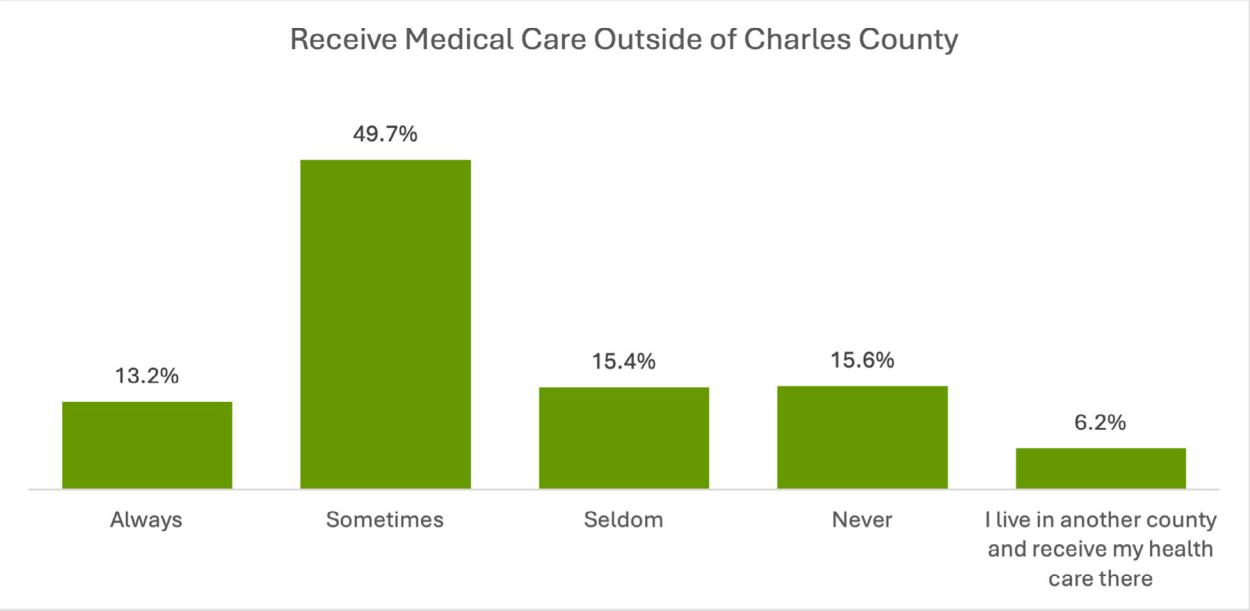
The percentage of survey participants who reported receiving routine health care from the hospital emergency department decreased from 4.2% in 2021 to 3.5% in 2023. However, this is still up from the 2018 survey where only 2.4% of participants reporting receiving routine care from the hospital emergency department.



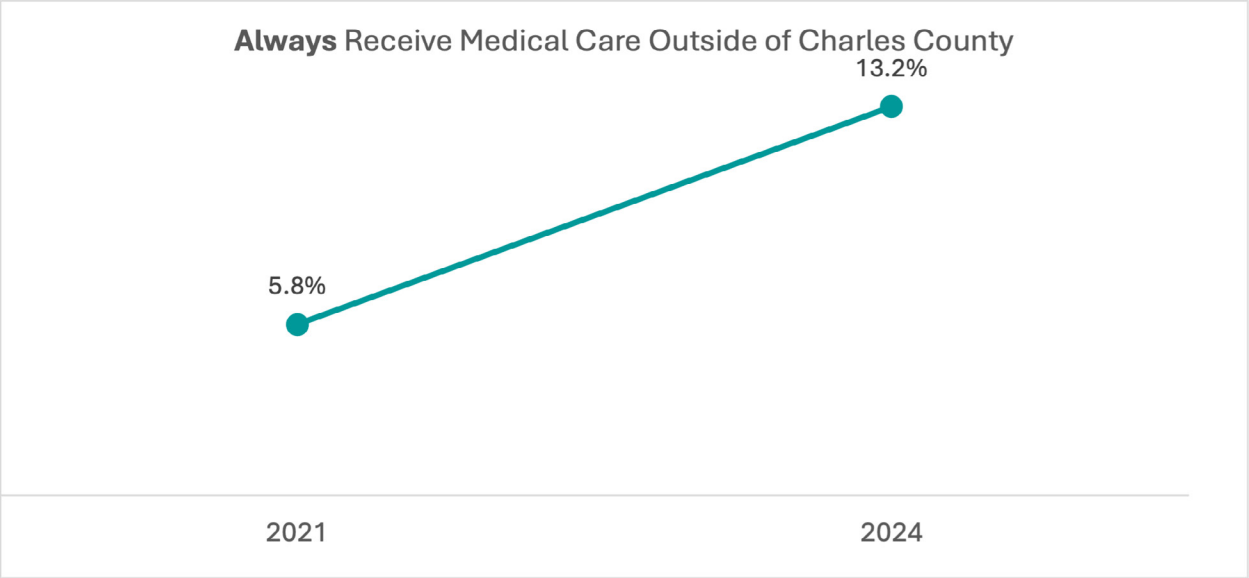
61.3% of survey respondents were able to see a doctor when needed. This percentage is a decrease from 75.3% reported in the 2021 survey. Just under 5% of respondents reported that they were seldom or never able to see a doctor when needed. This is an increase from 1.9% reported in 2021. If participants were unable to see a doctor when needed, the most common reasons were that there were no available appointments (41.3%), that it was too expensive/could not afford it (3.8%), or the doctor/provider was too far away (3.8%). The percentage of respondents who reported they were unable to see a provider when needed because there were no available appointments saw a 41% increase since the 2021 needs assessment survey when the percentage was 29.3%. However, 55.5% of survey respondents reported that they were able to see a doctor/provider when they needed one.

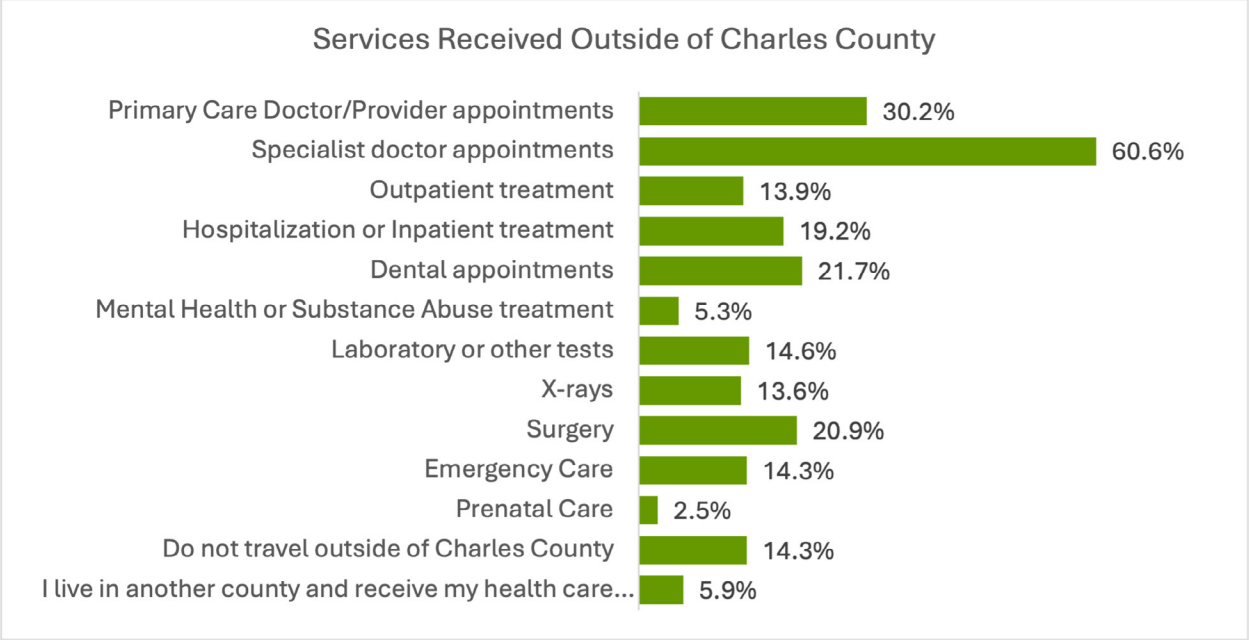


When asked if they receive medical care outside of Charles County, almost 16% of respondents reported that they never receive care outside of Charles County. This is a decrease from 22% reported in the 2021 survey. Almost half of respondents reported that they sometimes receive medical care outside of Charles County. The largest increase since the 2021 survey was in those who reported they always receive medical care outside of Charles County. 13.2% of respondents reported always receiving care outside of the county, compared to 5.8% in 2021.

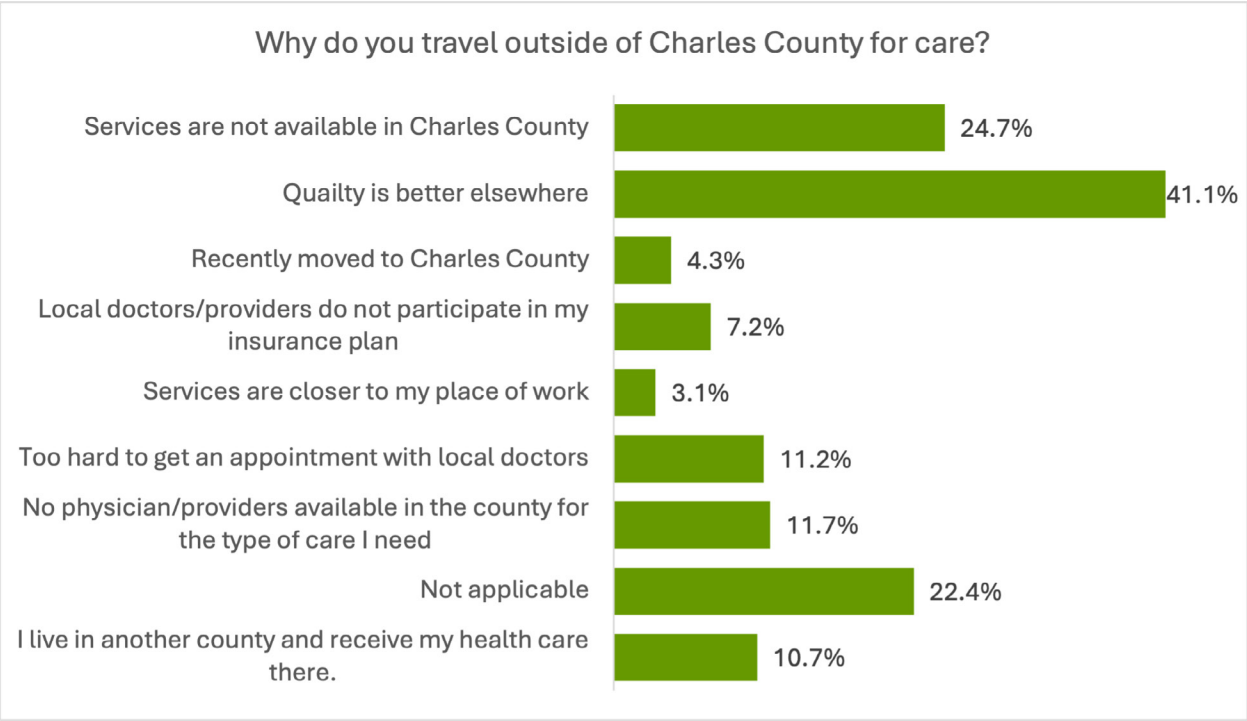


Participants were asked what medical services they receive outside of Charles County. They were asked to check all services that were applicable. The most common services that people receive outside of Charles County are specialist doctor appointments (60.6%), Primary Care Doctor/Provider appointments (30.2%), Dental appointments (21.7%), and Surgeries (20.9%). These were the most common responses reported in the 2021 survey as well. The percentage of respondents who reported receiving primary care services outside of Charles County increased to 30.2% from 19.0% reported in the 2021 survey.

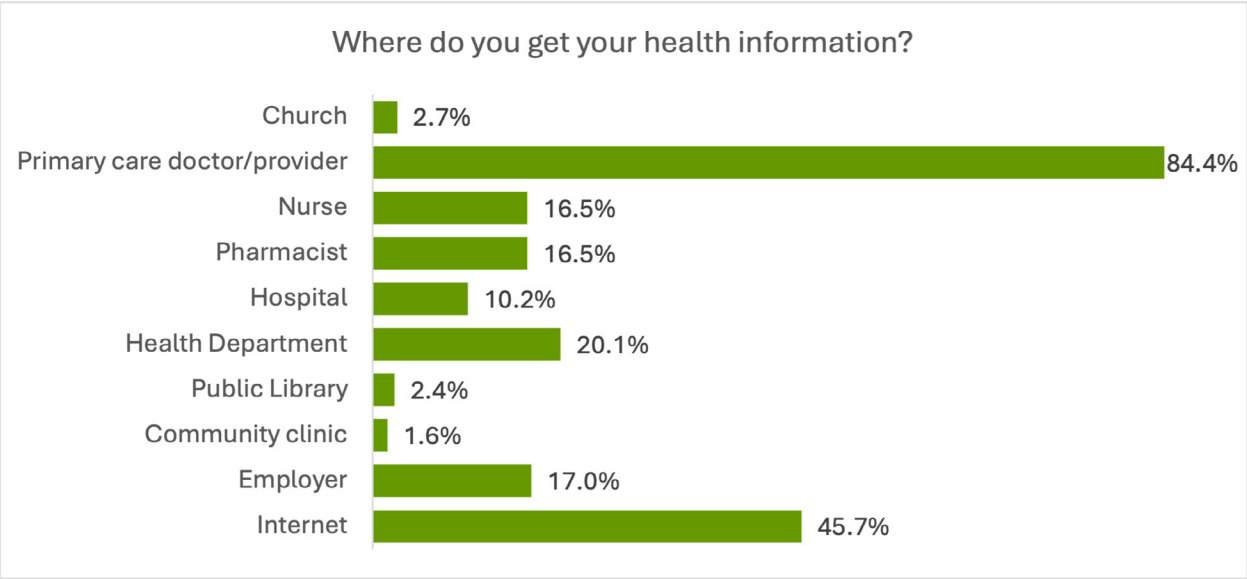




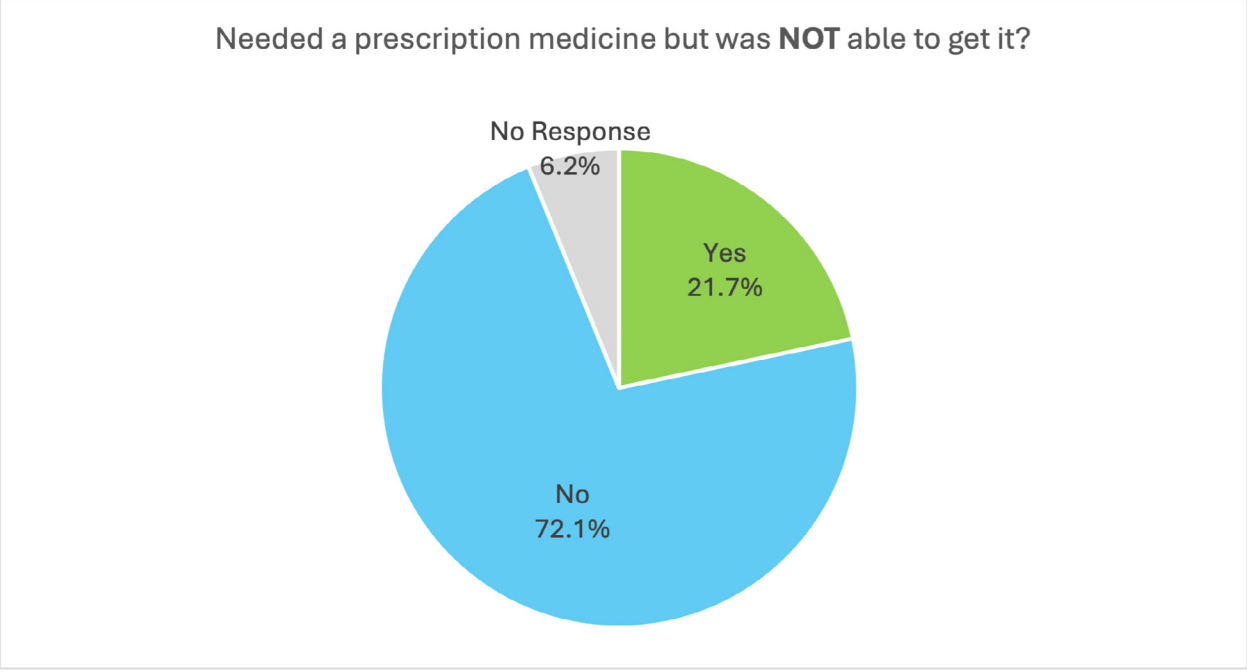
Participants were also asked why they choose to receive those medical services outside of Charles County. The most common responses were that quality is better elsewhere (41.1%) and that those services are not available in Charles County (24.7%). These were also the most common responses in the 2021 survey. The percentage of respondents that reported quality is better elsewhere increase from the 2021 survey from 37.1% to 41.1%.



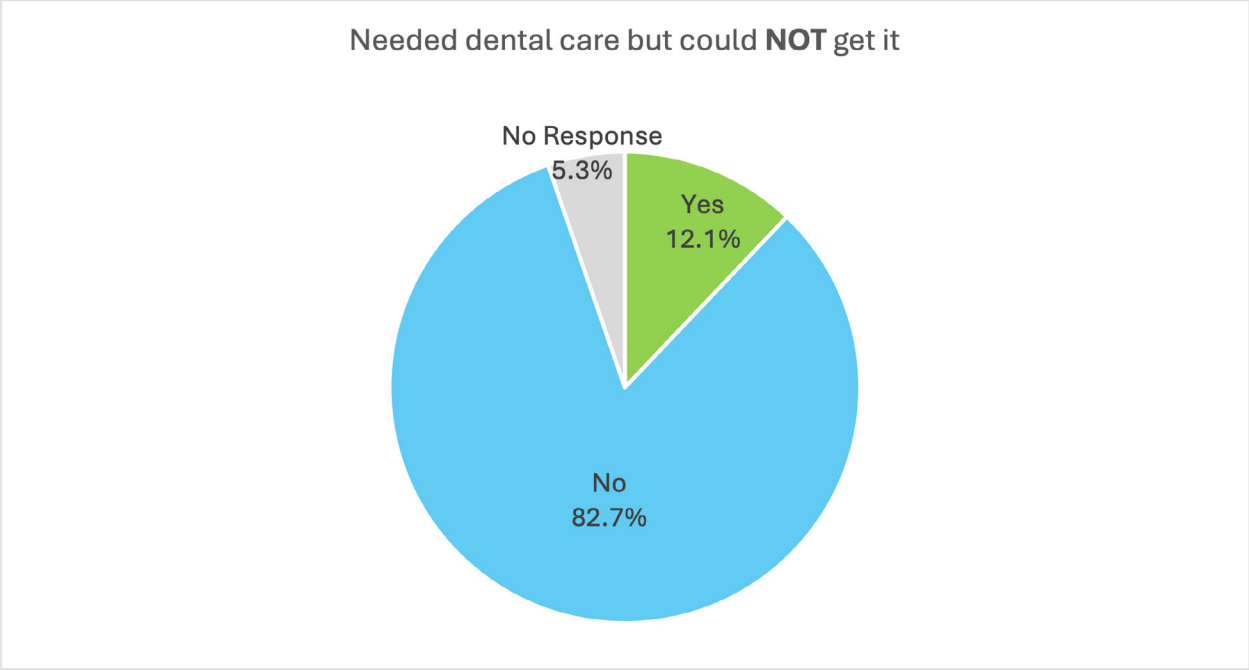
There are various sources in which individuals can get health information. The majority of survey respondents reported getting their health information from a Primary Care doctor/provider (84.4%). The second highest response was the Internet at 45.7% of responses. The percentage of respondents who reported receiving health information from the health department increased from 16.0% in 2021 to 20.1% in 2024.



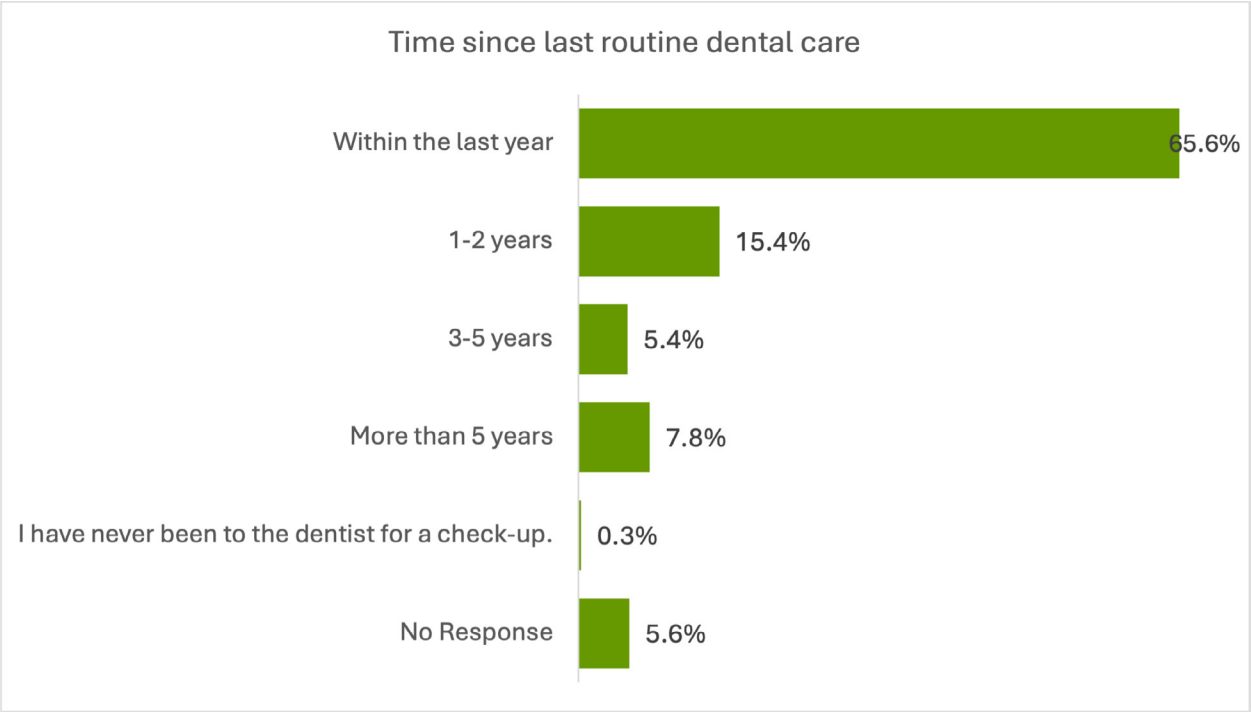
Various questions were asked to determine specific barriers in the county around access to care. The first question for respondents was in the last year, did they need a prescription medicine but were not able to get it? Almost 22% of respondents reported that in the last year they needed prescription medicine but were unable to get it.



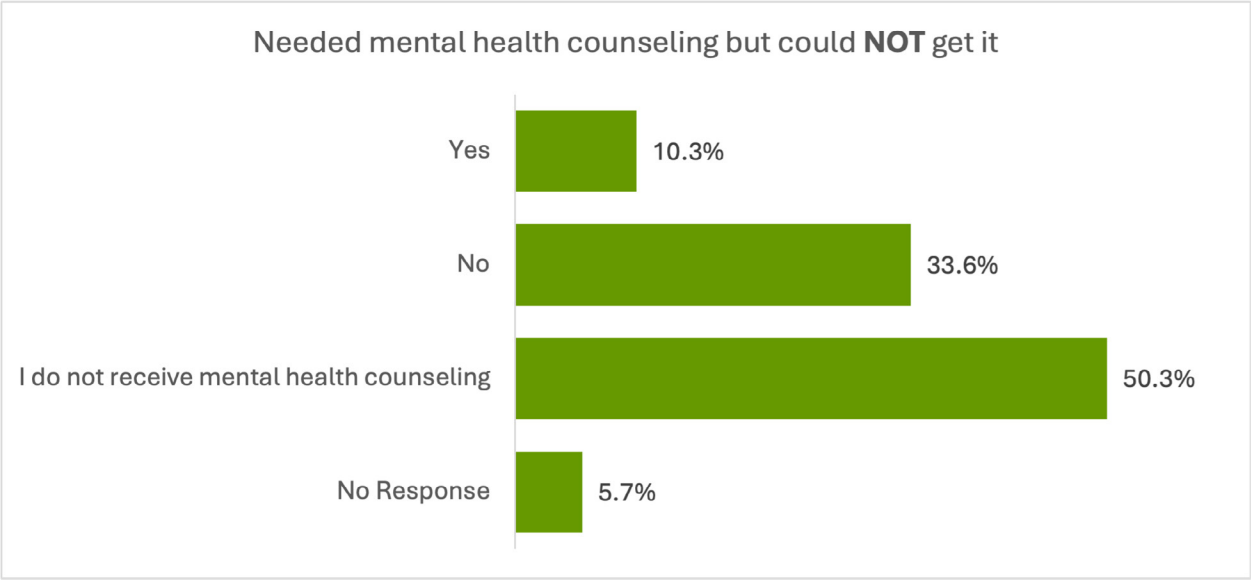
Access to care questions regarding oral health were also asked. Most survey respondents reported that in the last year they were able to receive dental care if they needed it (82.7%). Around 12% of respondents reported that in the last year they needed dental care but could not get it.



65.6% of survey respondents reported having routine dental care within the last year. However, over 10% of respondents reported not having routine dental care in over 3 years (13.2%). Only 0.3% of respondents have never been to the dentist for a check-up.

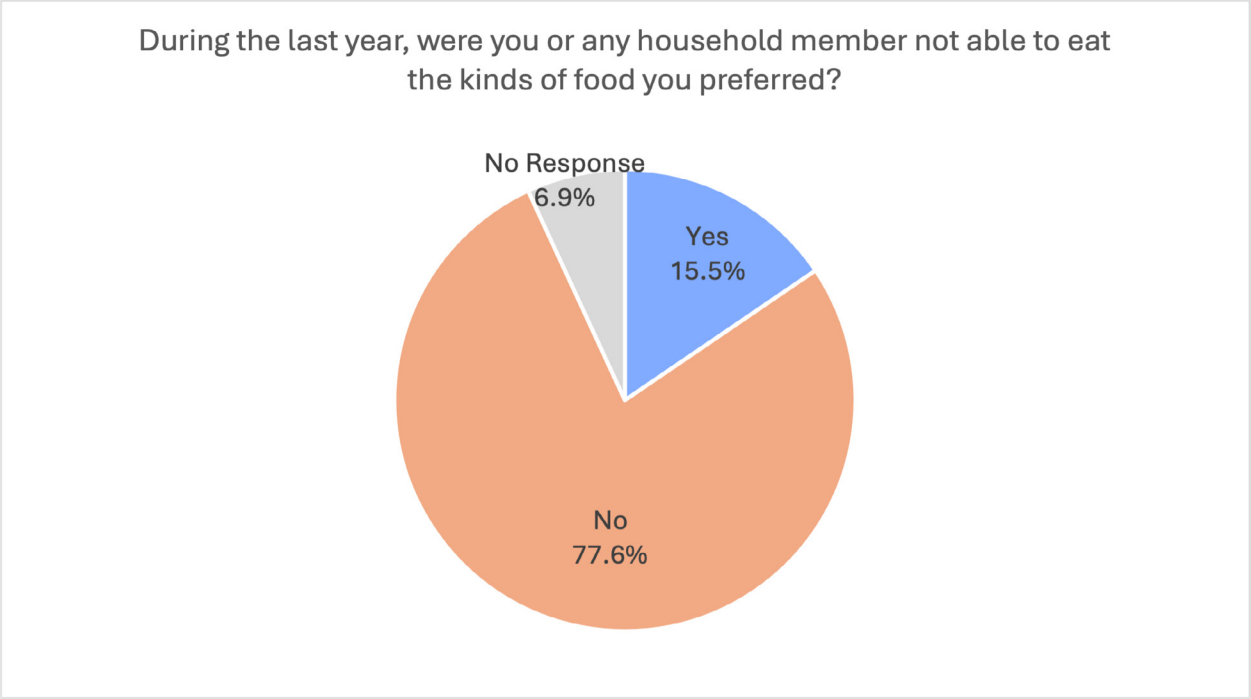


Survey participants were also asked in the last year if they needed mental health counseling but were unable to get it. About half of respondents reported that they do not receive mental health counseling. 33.6% of respondents reported they were able to receive mental health counseling when they needed it, and 10.3% reported they were not able to receive mental health counseling when they needed it.

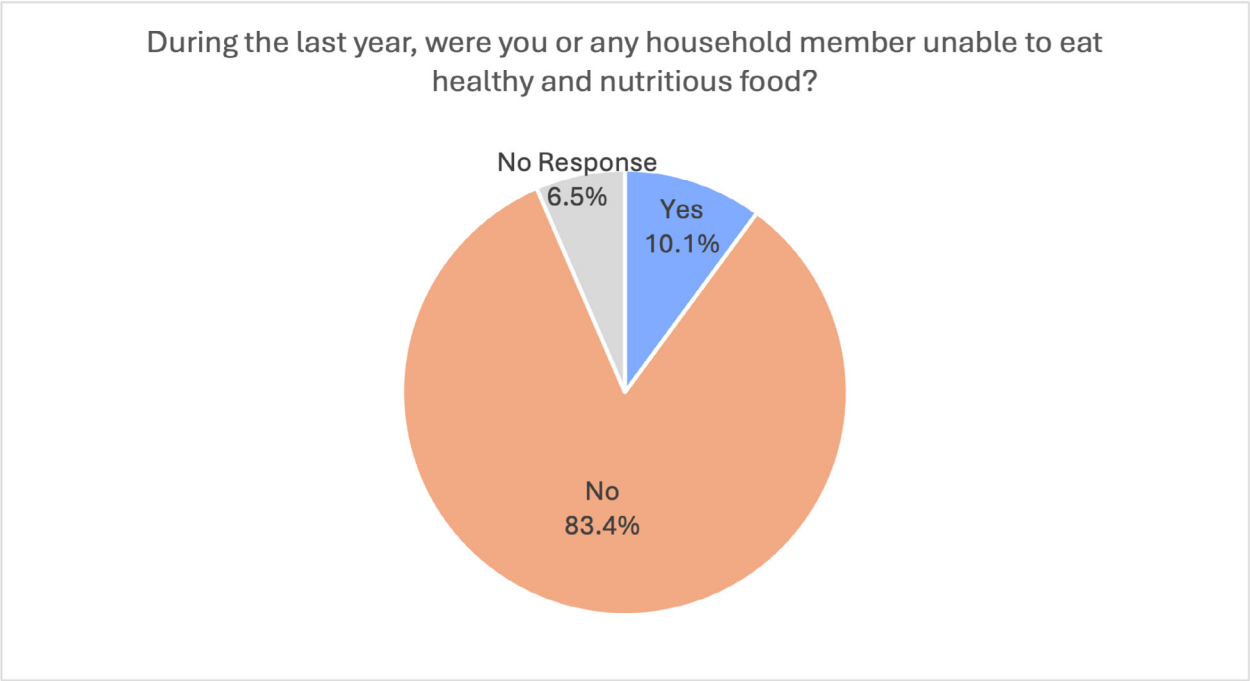


Food Insecurity

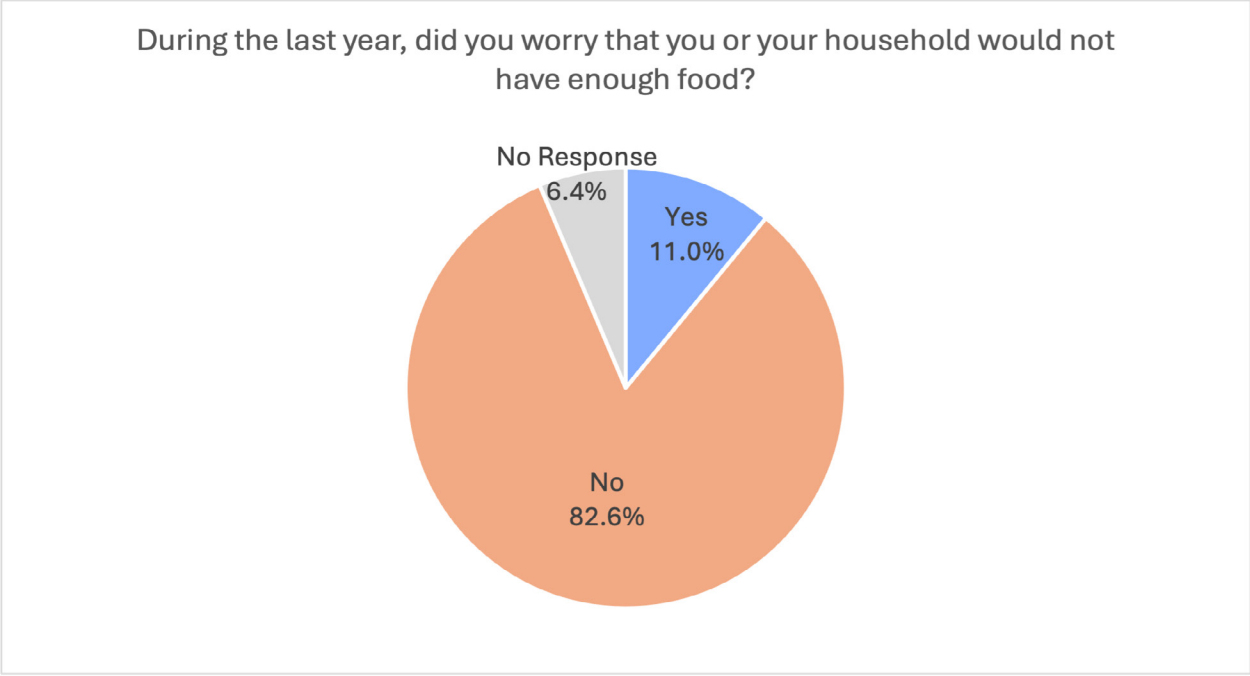
Survey respondents were also asked questions related to food insecurity. These questions were designed to understand the community needs and concerns around food and obtaining food. Almost 83% of survey respondents reported not worrying about food for themselves or their household in the last year. However, 11% of survey respondents did worry about having enough food in the last year.



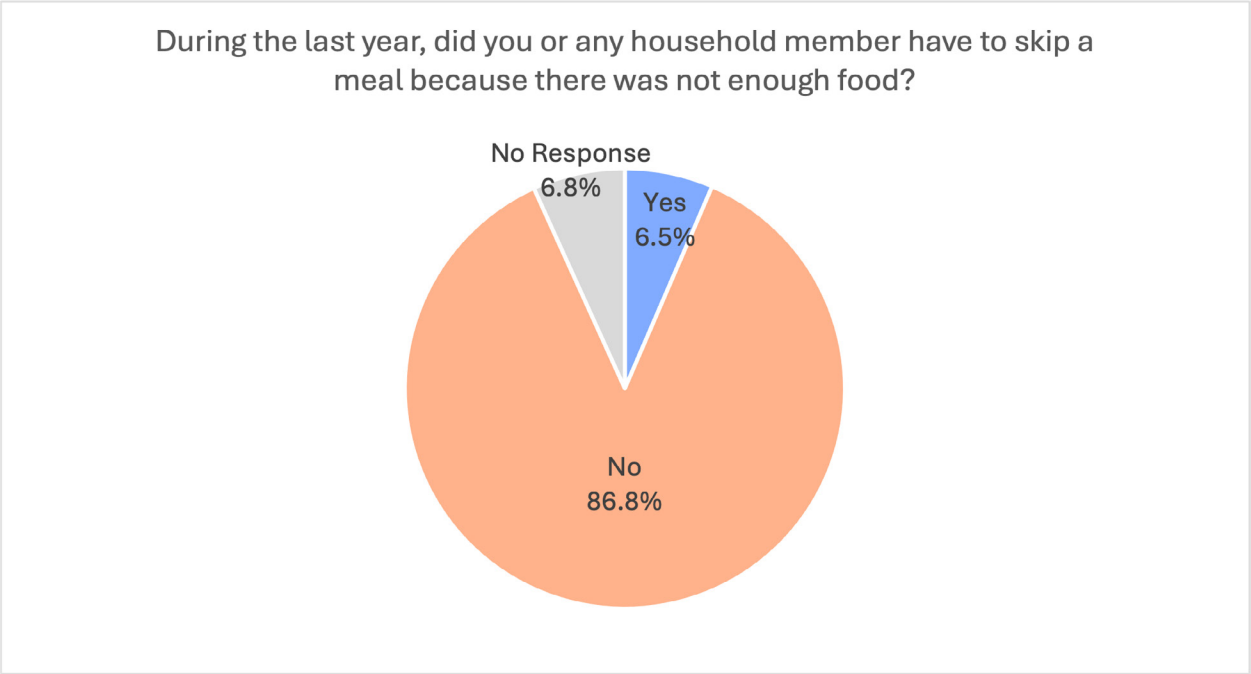
A very similar percentage of survey respondents also reported not being able to eat healthy and nutritious food in the last year (10.1%)



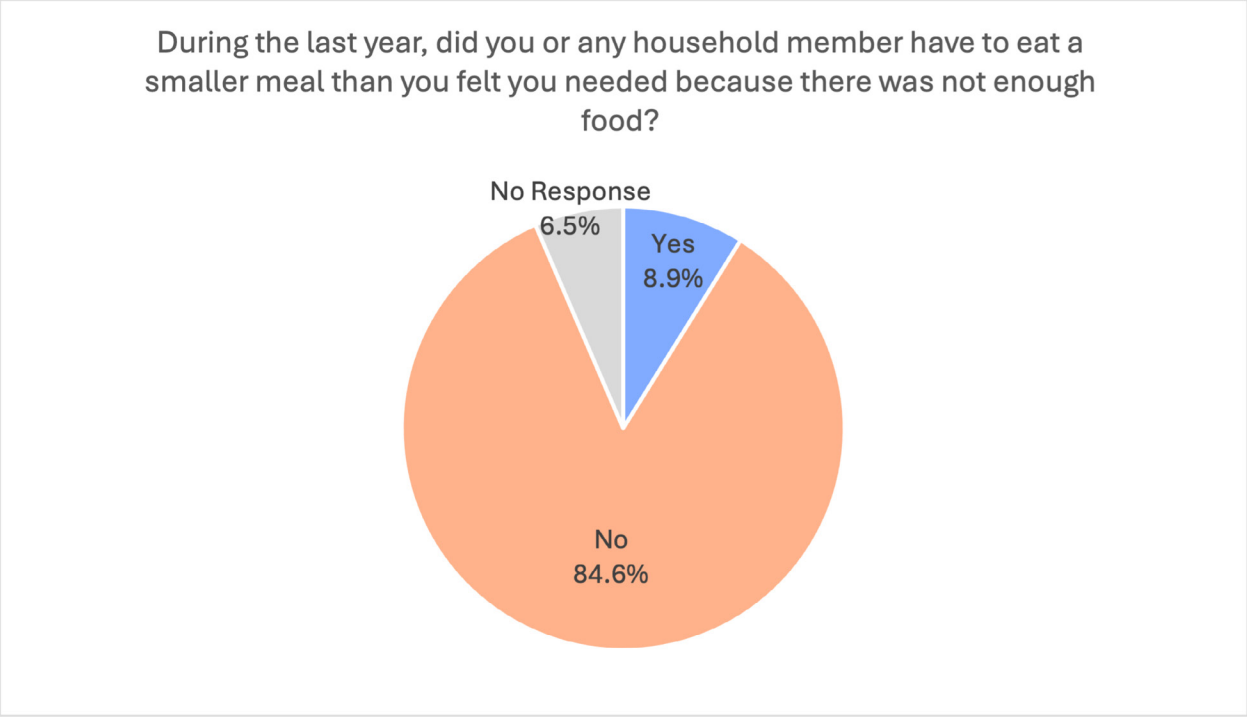
A larger percentage of survey respondents reporting not being able to eat the kinds of food they preferred in the last year, at 15.5%.



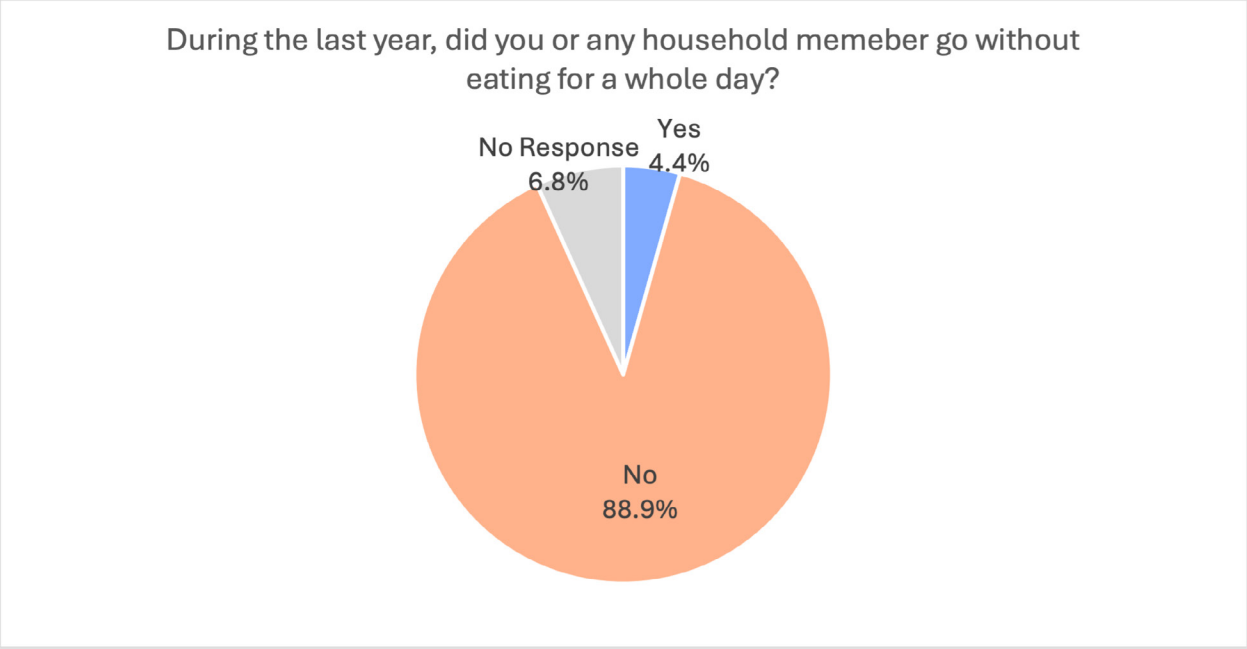
Over 86% of survey participants reported that they or a household member did not have to skip a meal because there was not enough food in the last year. 6.5% of respondents did report that they or a household member had to skip a meal in the last year.



Similarly, almost 85% of respondents reported that in the last year they or a household member did not have to eat a smaller meal than they felt they needed because there was not enough food. Almost 9% of survey respondents reported “Yes” to this question.

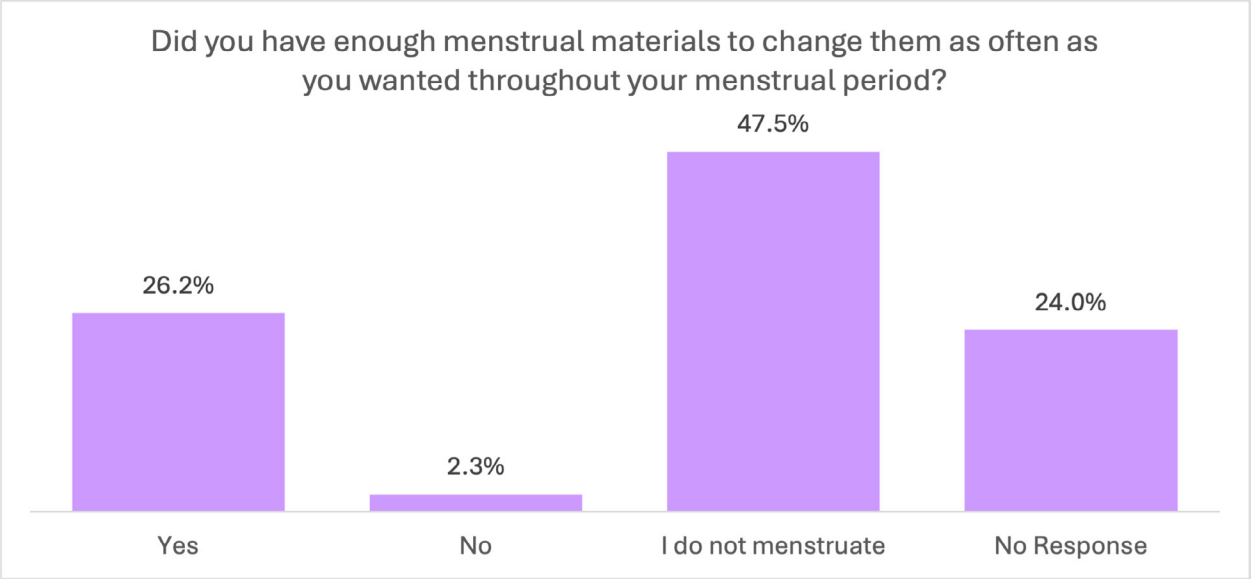


Almost 89% of survey respondents reported that in the last year they or a household member did not go without eating for a whole day. 4.4% of respondents reported that either they or a household member did go a whole day without eating in the last year.

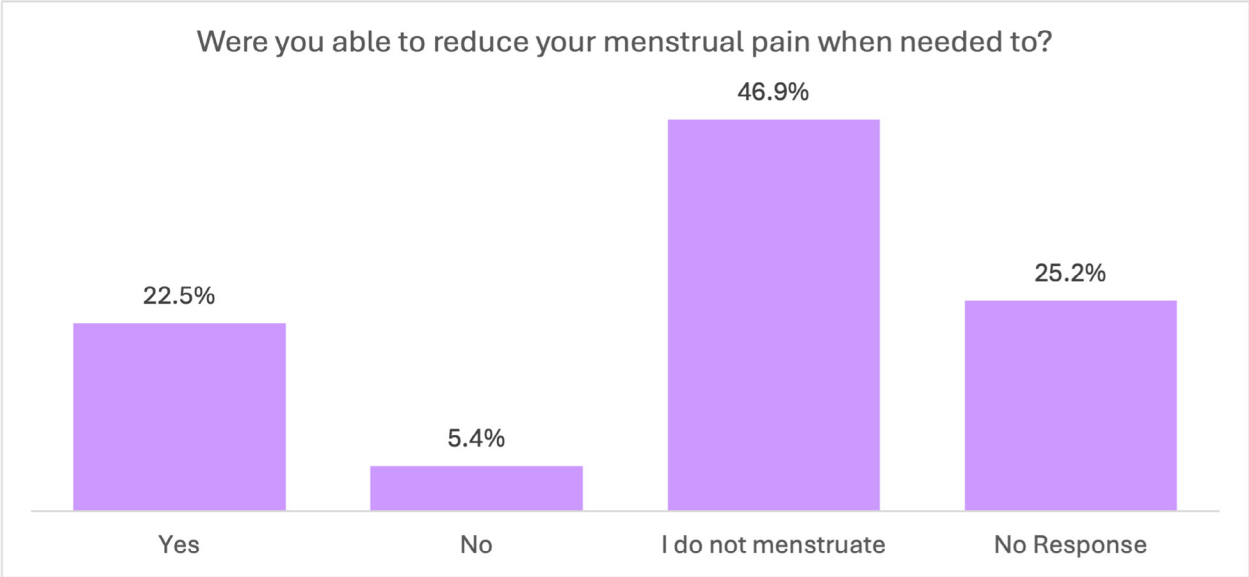


Menstrual Health/Period Poverty

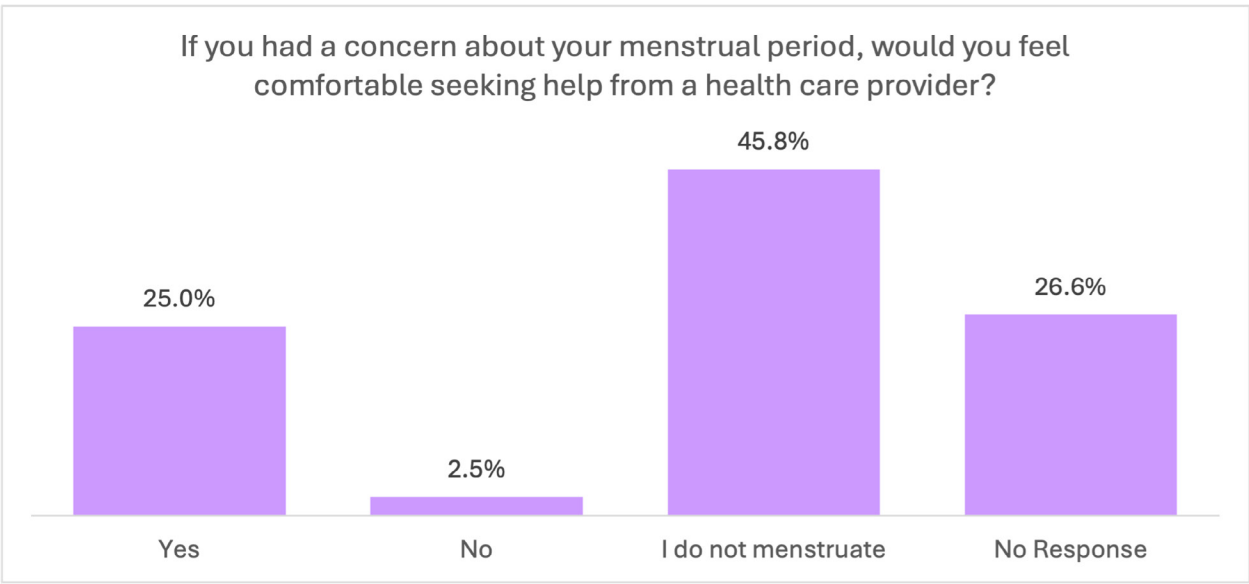
Questions relating to menstrual health and period poverty were also asked in this year's needs assessment survey. Although a large majority of survey respondents either reported they did not menstruate or did not respond (71.5%), 26.2% of respondents reported that they did have enough menstrual materials throughout their menstrual period. 2.3% of respondents reported they did not.



Over 22% of respondents reported being able to reduce their menstrual pain when they needed to during their last menstrual period. 5.4% of respondents reported they were not able to reduce their menstrual pain when they needed to. Again, a large percentage of survey respondents reported they did not menstruate, or they did not respond (72.1%).



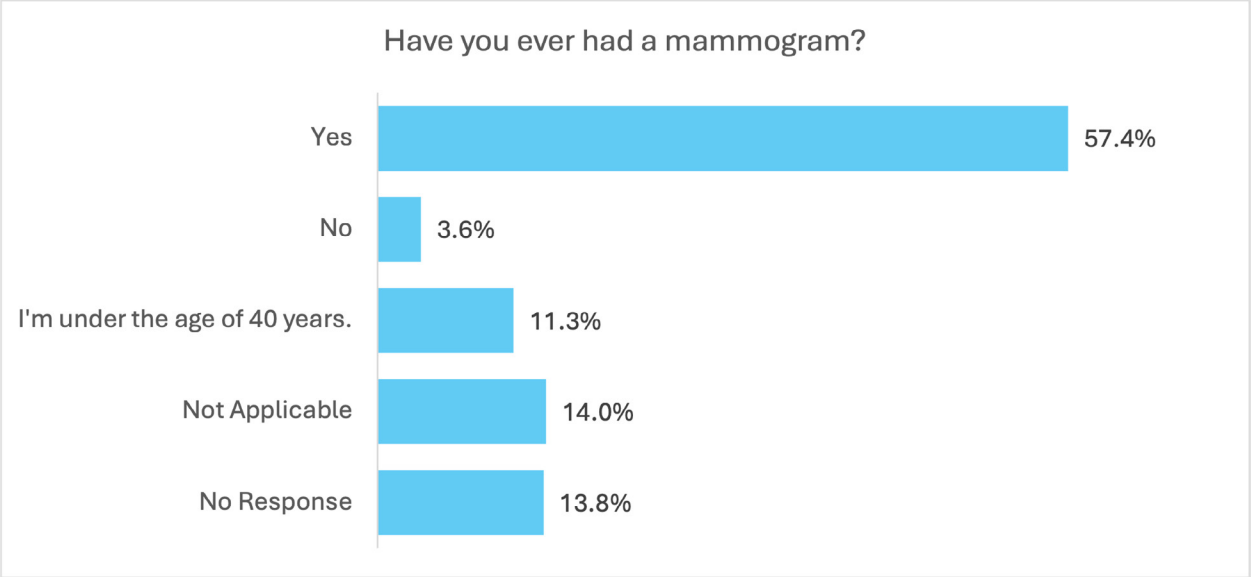
A quarter of survey respondents reported that if they had a concern about their menstrual period, they would feel comfortable seeking help from a health care provider. Meanwhile, 2.5% of respondents reported they would not feel comfortable seeking help from a health care provider. Similarly, to the other menstrual health questions, a large percentage of respondents reported they did not menstruate (45.8%) or they did not respond to the question (26.6%).



Cancer Screenings/Prevention

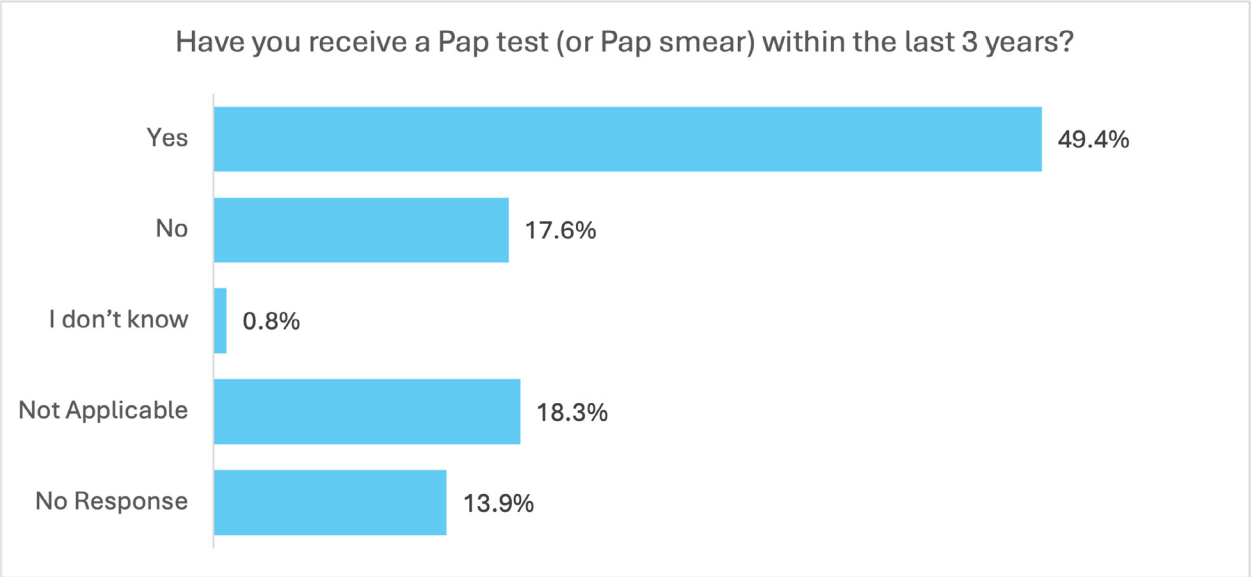
Screening for cancer has become a vital prevention strategy in detecting cancer early in patients and increasing the chances of survival. Survey participants were asked to answer questions regarding their own cancer prevention strategies by using screenings.

When asked if they have ever had a mammogram, 57.4% of participants reported that they have had a mammogram in the past compared to 3.6% who reported they have not had a mammogram. Over 11% of survey participants reported that they are under the age of 40, meaning they are too young to have mammogram.

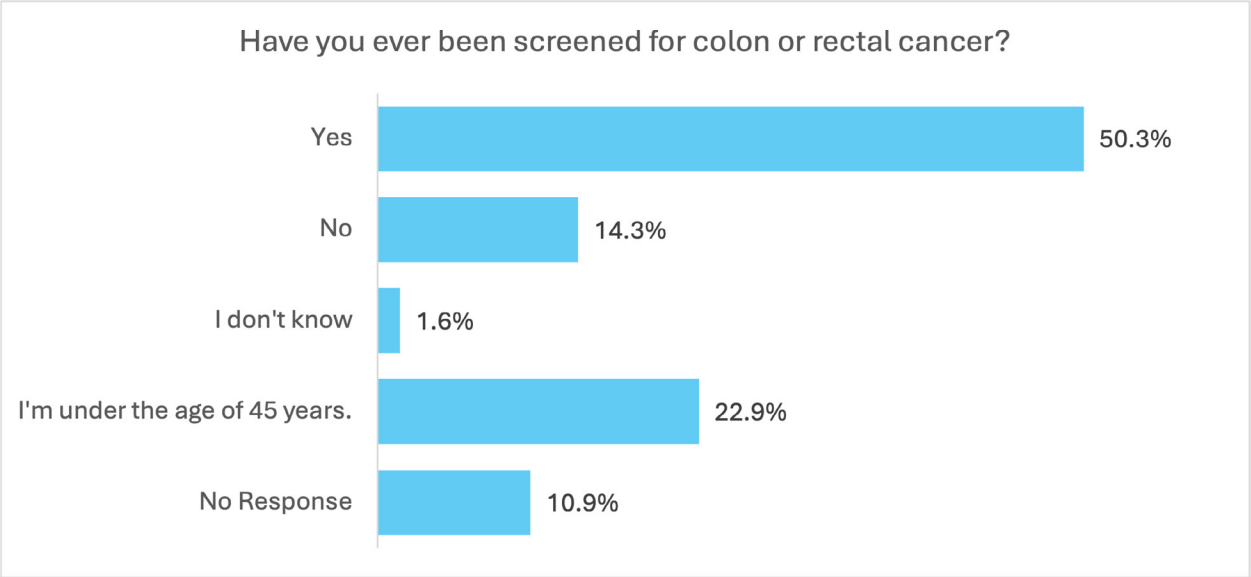


Almost 50% of survey participants reported that they have received a Pap test or Pap smear in the last 3 years, while over 17% of participants reported that they have not received a Pap test in the last 3 years.

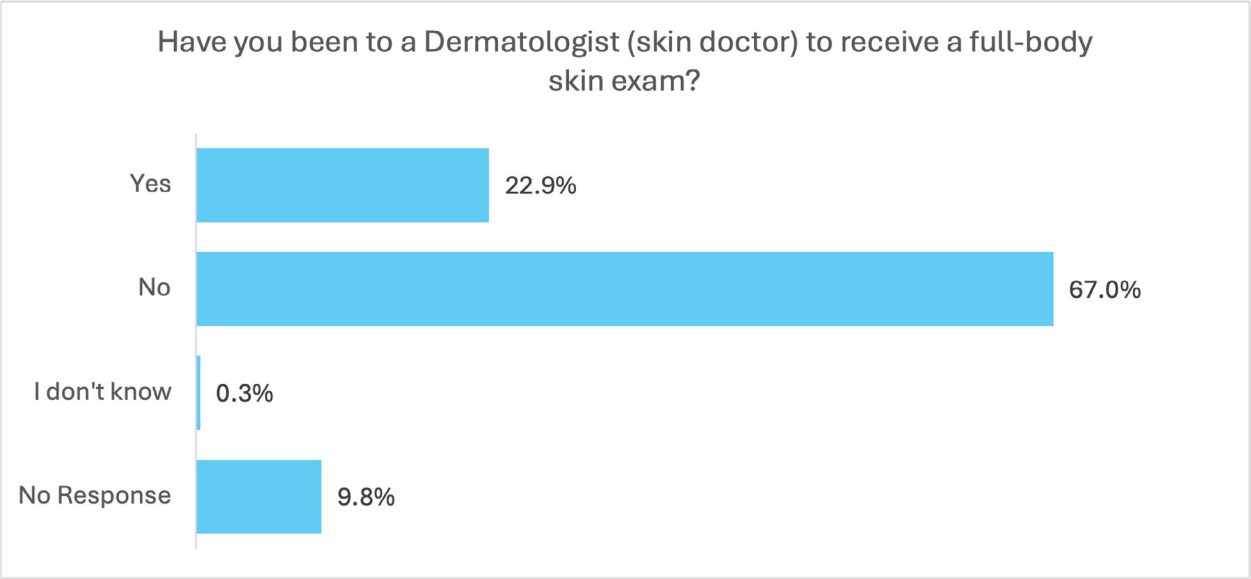
A smaller percentage of participants reported having a PSA test in the last 3 years, at 7.5%. This small percentage may be due to the fact that almost 80% of survey participants reported female as their sex assigned at birth. 53.1% reported that this question was not applicable to them.



50.3% of survey respondents reported that they have been screened for colon or rectal cancer in the past, while 14.3% of respondents reported they have not been screened for colon or rectal cancer. About 23% of respondents reported that they are under the age of 45, resulting in them being too young for colon or rectal screenings at this time.

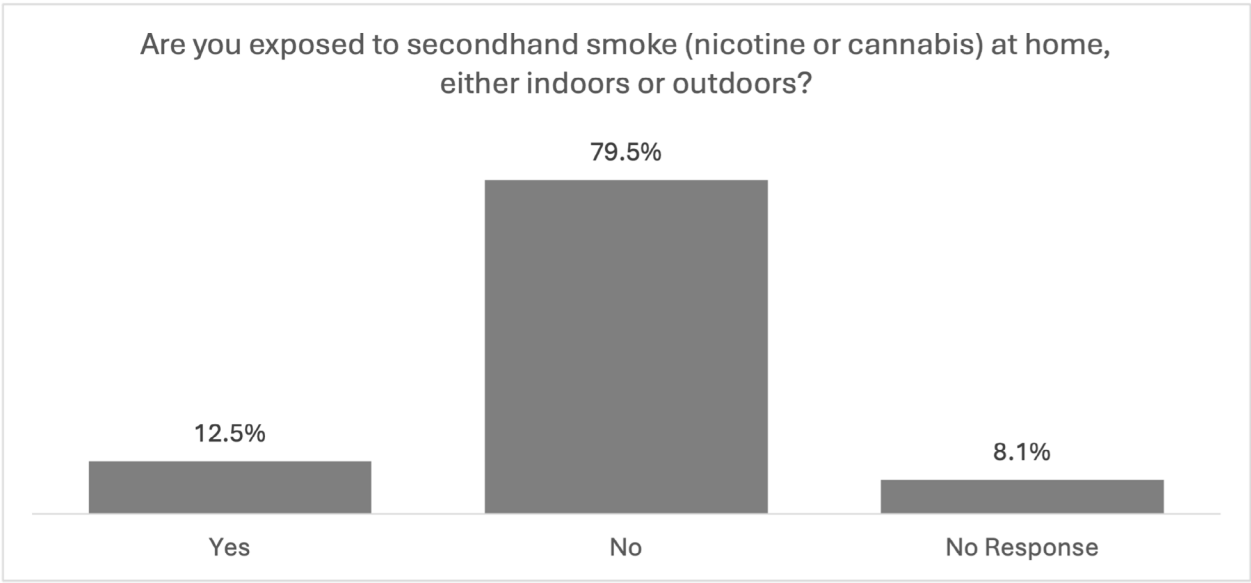


The majority of survey respondents reported that they have not been to a Dermatologist in the last year for a full-body skin exam (67.0%). About 23% of respondents reported that they have received a full-body skin exam in the last year.

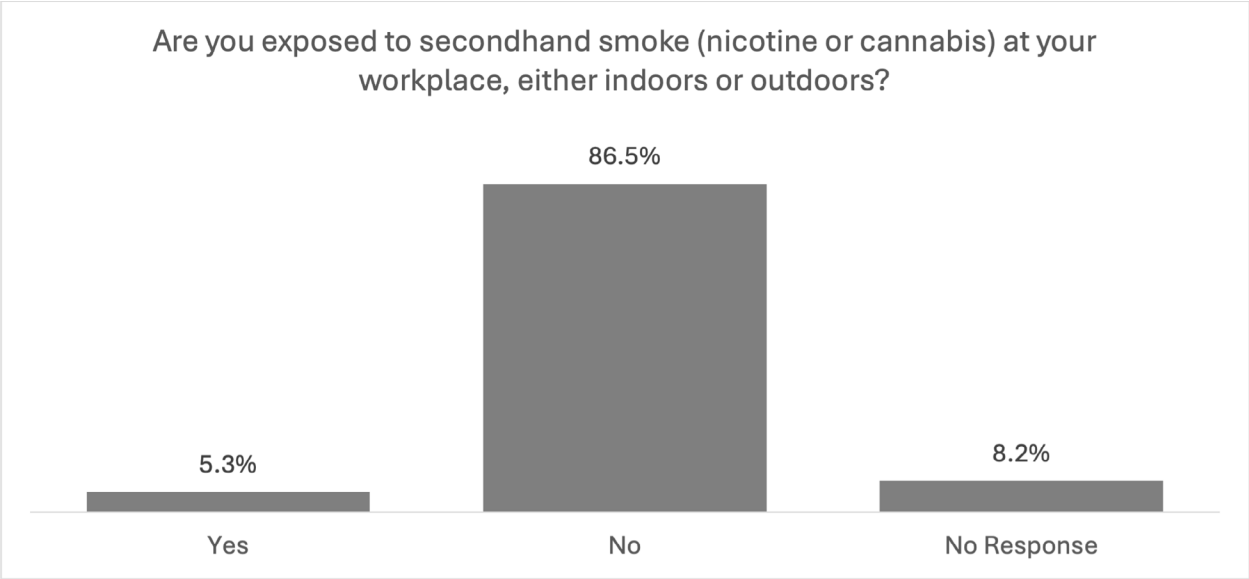


Secondhand Smoke

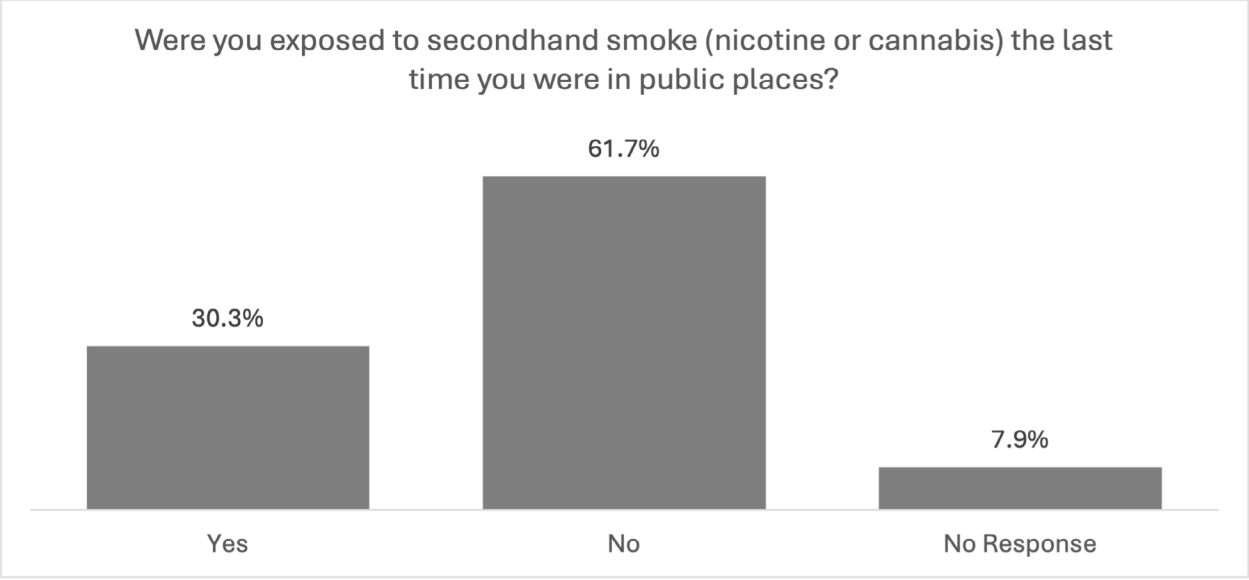
Survey respondents were also asked about their exposure to secondhand smoke, in their home or out in the community. Almost 80% of respondents reported that they are not exposed to secondhand smoke at home. 12.5% of respondents reported that they are exposed to secondhand smoke at their home, either indoors or outdoors.



A larger percentage of respondents reported that they are not exposed to secondhand smoke at their workplace. Just over 5% of respondents reported that they are exposed to secondhand smoke at work.



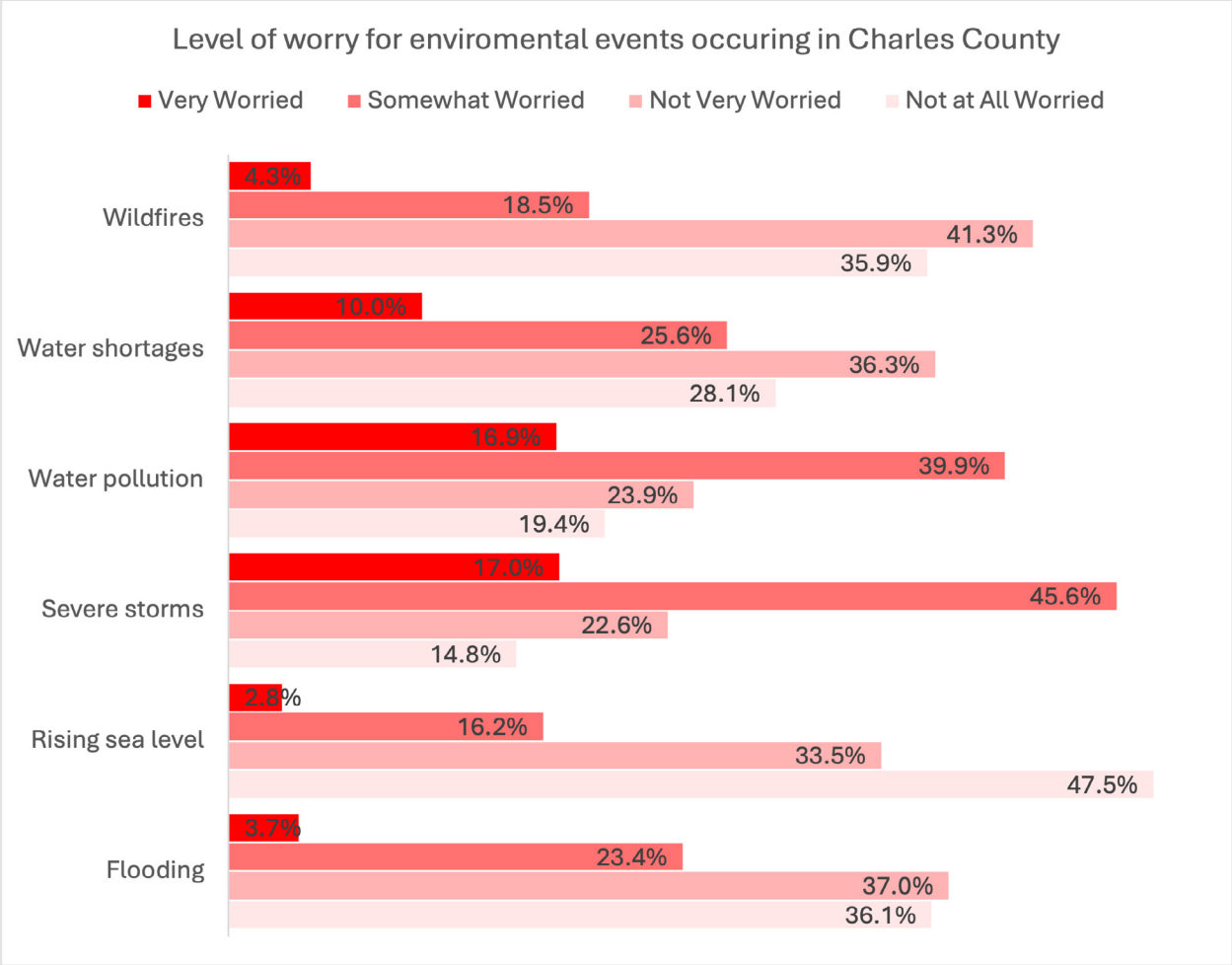
When asked if they were exposed to secondhand smoke in public places, a larger percentage of survey respondents reported that they were (30.3%). Just under 62% of respondents reported that they were not exposed to secondhand smoke the last time they were in public places.



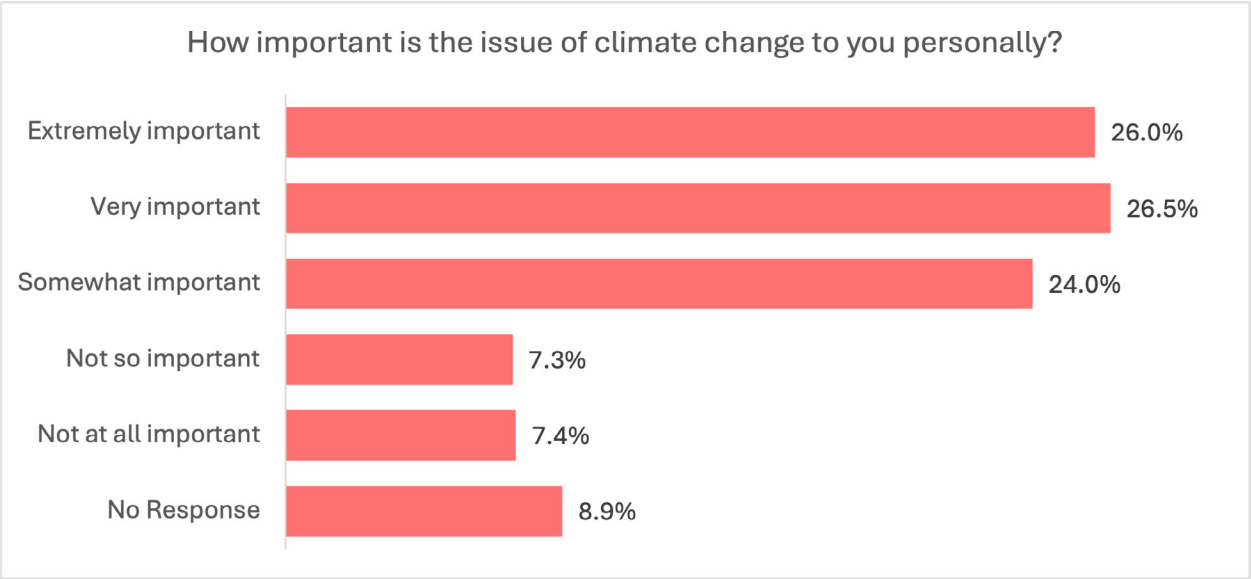
Environmental Health

Participants were asked to rate their level of worry about various environmental events that could occur in the county. Overall, many participants were not worried about these events occurring in Charles County. Water pollution and severe storms had the highest percentage of participants who reported being either very or somewhat worried that they could harm the community. About 17% of participants reported they were very worried about water pollution and severe storms harming the community. Water pollution and severe storms also had the highest percentage of participants

who reported being somewhat worried about these events harming Charles County, at 39.9% and 45.6% respectively. Rising sea level was the environmental event most participants reported not being worried about. 81% of survey participants reported not being very worried or not at all worried about rising sea levels harming Charles County.



Although many participants were not worried about specific environmental events harming Charles County, a large percentage reported that climate change was important to them. Over half of survey respondents reported that the issue of climate change was either very or extremely important to them (52.5%). Over a quarter of participants reported that climate change was extremely important to them (26.0%). Only 14.7% of respondents reported that climate change is not so important to them or not at all important to them.



Behavioral Risk Factors

The Top Protective Factors (greatest percentage reporting that they consistently do these activities) include:

- Always wear a seatbelt (95.1%)
- Always wash hands after using the bathroom or before making food (86.2%)
- Always follow road safety rules (55.6%)
- Never use other illegal drugs (81.7%)
- Never misuse prescription opioids or use heroin (81.6%)
- Never use smokeless tobacco (chew, snuff, dip) (77.7%)
- Never smoke e-cigarettes (75.6%)
- Never use marijuana (73.5%)
- Never smoke cigarettes, cigars, pipes, or cigarillos (70.7%)
- Never get exposed to secondhand smoke at home or work (62.9%)
- Never drink more than three alcoholic beverages per day (61.7%)
- Never drink more than 5 alcoholic beverages in one sitting (60.3%)

The Top Risk Factors that increase the chances of chronic/infectious disease or injury (lowest percentage reporting that they always do these activities) include:

- Always perform self-exams for cancer (8.3%)
- Always eat 5 or more servings of fruits and vegetables each day (8.5%)

- Always get 7-9 hours of sleep each night (15.3%)
- Always participate in 30 minutes of physical activity each day (16.2%)
- Always use sunscreen regularly (17.9%)
- Always practice safe sex (ex. use a condom, get tested) (29.4%)

Risk and Behavioral Factors	Always	Most of the time	Sometimes	Rarely	Never	Not applicable	Total
Use a seatbelt?	645	21	7	1	2	2	678
Wear a helmet while riding a bicycle?	170	40	37	45	55	330	677
Wear a helmet while riding a scooter, ATV, or motorcycle?	135	14	20	8	10	489	676
Eat 5 or more servings of fruits and vegetables each day?	58	176	278	134	32	2	680
Eat fast food more than once a week?	47	78	243	232	67	10	677
Drink more than 5 alcoholic beverages in one sitting?	2	9	43	128	409	87	678
Drink more than three alcoholic beverages per day?	1	2	40	125	419	92	679
Smoke cigarettes, cigars, pipes, or cigarillos?	16	8	11	26	479	138	678
Smoke e-cigarettes?	5	3	9	10	510	138	675
Use smokeless tobacco (chew, snuff, dip)?	1	2	2	2	526	144	677
Get exposed to secondhand smoke at home or work?	13	14	46	67	427	112	679
Use marijuana?	11	9	20	20	499	120	679
Misuse prescription opioids or use heroin?	0	1	1	1	553	122	678
Use other illegal drugs?	0	1	5	0	554	118	678
Perform self-exams for cancer?	56	99	235	110	140	36	676
Wash hands after using the bathroom or before making food?	586	75	13	1	3	2	680
Use sunscreen regularly?	121	217	196	74	55	13	676
Get a flu shot every year?	332	90	78	50	112	16	678
Practice safe sex (ex. use a condom, get tested)?	198	45	27	21	60	322	673
Take a vitamin or supplement daily?	317	109	118	57	68	8	677
Get 7-9 hours of sleep each night?	104	220	199	114	37	4	678
Feel stressed out or overwhelmed?	69	139	295	129	42	5	679
Follow road safety rules?	374	259	32	2	3	3	673
Participate in 30 minutes of physical activity each day?	110	208	241	92	24	4	679

Health Issues

Participants were given a list of 34 different health issues and conditions that affect Charles County residents. They were asked their perceptions of health by rating what problem level these particular issues present to the community: not a problem, slight problem, a moderate problem, a serious problem, or not sure.

Health Problems/Conditions	Serious Problem	Moderate Problem	Slight Problem	Not a Problem	Not Sure/Don't Know	Total
Drug Use	305	152	33	44	125	659
Alcohol Use	227	195	44	46	144	656
Tobacco Use	202	190	63	51	144	650
Asthma and lung diseases	122	170	62	38	266	658
Cancer	186	154	35	43	240	658
Child Abuse and Neglect	124	156	70	44	263	657
Crime	313	178	55	43	67	656
Domestic Violence	195	167	49	41	203	655
Prenatal and Infant health	86	140	84	47	296	653
Diabetes/Sugar	237	153	40	35	190	655
Affordable health care	284	125	47	39	161	656
Health Insurance	228	143	57	48	178	654
Access to health care	232	152	74	51	149	658
Affordable housing	332	119	55	45	105	656
Dental health	171	159	63	55	204	652
Flu/Pneumonia	66	135	135	78	241	655
Infectious Diseases (i.e. COVID-19)	84	155	159	74	185	657
Mental health	279	153	48	33	137	650
Obesity/Overweight	318	172	37	21	107	655
Disability Services	161	154	64	49	223	651
After school programs for kids	162	152	80	56	203	653
Sexually transmitted diseases	85	116	78	43	331	653
HIV/AIDS	64	97	92	47	350	650
Suicide	115	139	81	47	263	645
Heart Disease	180	161	41	36	228	646
High Blood Pressure	245	159	37	24	187	652
Stroke	166	160	51	39	235	651
Injuries	88	153	95	42	267	645
Highway Safety/Traffic Accidents	248	183	80	46	96	653
Public Transportation	209	163	85	58	138	653
Homelessness	243	191	79	39	100	652
Environmental Health/Air Quality	126	165	128	68	165	652
Veteran Health	194	119	67	36	237	653
Traumatic Brain Injuries and Concussions	73	96	95	49	340	653

The top 5 serious health issues for Charles County residents were Affordable Housing, Obesity, Crime, Drug Use, and Affordable Healthcare. Social determinants of health, such as housing and crime, have come to the forefront during this needs assessment.

When examining the top serious health issues in Charles County by race and ethnicity, there is a lot of variation. Obesity, Mental Health, and Affordable Housing are the three conditions that appeared in the Top 5 for every race and ethnicity.

Top 5 Most Serious Problems in Charles County by Race and Ethnicity

American Indian/Alaska Native	***Asian/Pacific Islander***	***Non-Hispanic Black***	***Hispanic***	***Non-Hispanic White***	***All Races***
Affordable Healthcare	Drug Use	Affordable Housing	Affordable Healthcare	Crime	Affordable Housing
Health Insurance	Crime	Obesity	Mental Health	Drug Use	Obesity
Affordable Housing	Diabetes	Homelessness	Affordable Housing	Obesity	Crime
Obesity	Affordable Housing	Mental Health	Obesity	Affordable Housing	Drug Use
Access to Healthcare	Mental Health and Obesity (Tie)	Affordable Healthcare	High Blood Pressure	Mental Health	Affordable healthcare

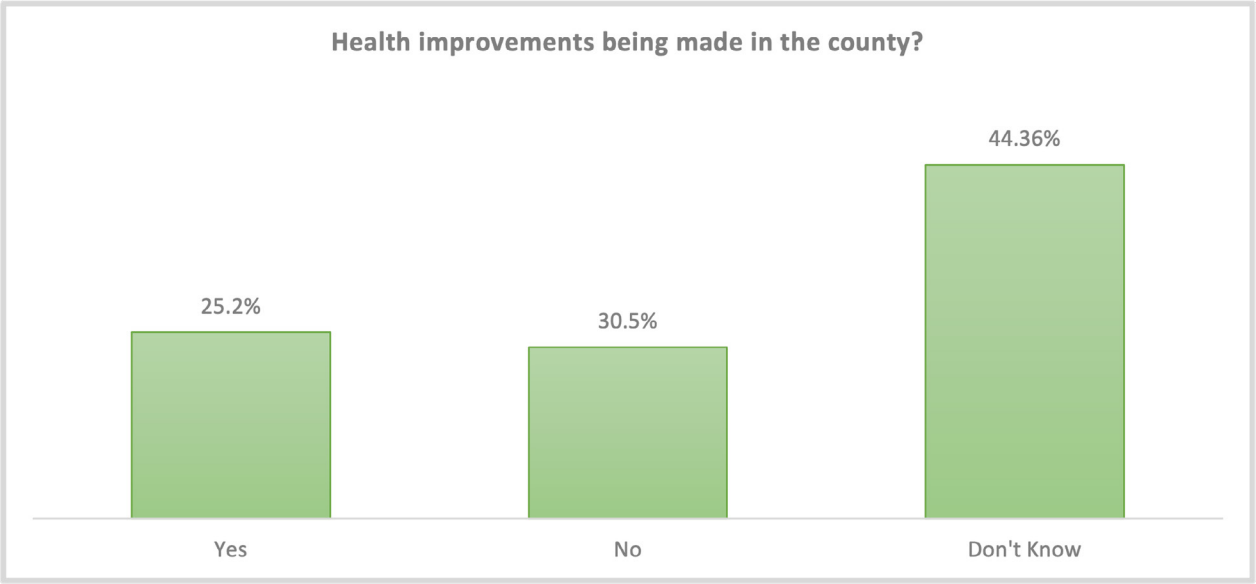
When breaking down the top 5 serious health conditions by gender, the health issues are the basically the same, just in a different order.

Top 5 Most Serious Problems in Charles County by Gender

Male	***Female***
Obesity	Affordable Housing
Crime	Obesity
Affordable Housing	Drug Use
Drug Use	Crime
High Blood Pressure	Affordable Healthcare

Health Improvements in Charles County

25.19% of survey participants claimed they have seen health improvements in Charles County. This percentage is similar to the 2021 survey, where 26.2% of participants claimed they saw health improvements in Charles County.



The top five health issues where participants have seen improvements include: infectious diseases, diabetes, access to health care, mental health, and high blood pressure.

Heart Disease	18.03%
Cancer	16.31%
Diabetes	36.91%
Asthma/Lung Diseases	9.44%
Tobacco use	22.32%
Substance Use	15.02%
Mental health	30.04%
High Blood Pressure	24.03%
Stroke	12.45%
Traffic Safety	12.02%
Injuries	4.29%
Obesity/Overweight	19.74%
Access to health care	31.76%
Access to needed medications	15.02%
Infectious Diseases (like COVID-19, Influenza)	39.48%

Agency Responsibility

Promotion of the long survey to community agencies, non-profit partners, and community members was the shared responsibility of the University of Maryland Charles Regional Medical Center, the Charles County Department of Health, and all members of the Partnerships for a Healthier Charles County. Flyers were made with a QR code to the long survey were taken to all community events from July-December 2023 so residents could quickly access the survey online. For those who were not comfortable with technology, paper copies were provided, and data was entered at a later date. The University of Maryland Charles Regional Medical Center also sent out postcards to households with the link and QR code to complete the survey.

Short Survey Analysis:

Introduction

A short 5 question survey was developed to distribute throughout the county for additional qualitative data from July 1, 2023, through December 31, 2023. A total of 1,189 surveys were completed throughout the community. Short survey data collection was performed at various community events throughout the county.

Particular emphasis was given to the collection of data among the county's vulnerable populations including the medically underserved, the homeless, and the geographically isolated. An ongoing survey collection was conducted at the Charles County Department of Health and the University of Maryland Charles Regional Medical Center. Short surveys were collected during blood drives at the University of Maryland Charles Regional Medical Center (CRMC), the Red Cross Blood Drive, and church Blood Drives. CRMC also coordinated with the Charles County Department of Health to distribute surveys at the Charles County Fair. The Charles County Department of Health conducted survey collection at all community outreach events attended from July to December 2023. Emphasis was given to the western region of the county that is more geographically isolated. Surveys collection was conducted at Fruit and Vegetable distribution sites and at the Nanjemoy Heritage Day. The community was also surveyed at large events such as the Charles County Fair, blood drives, Charles County Government Wellness Fair and Rodeo, Recovery Day, food drives, and other community outreach events.

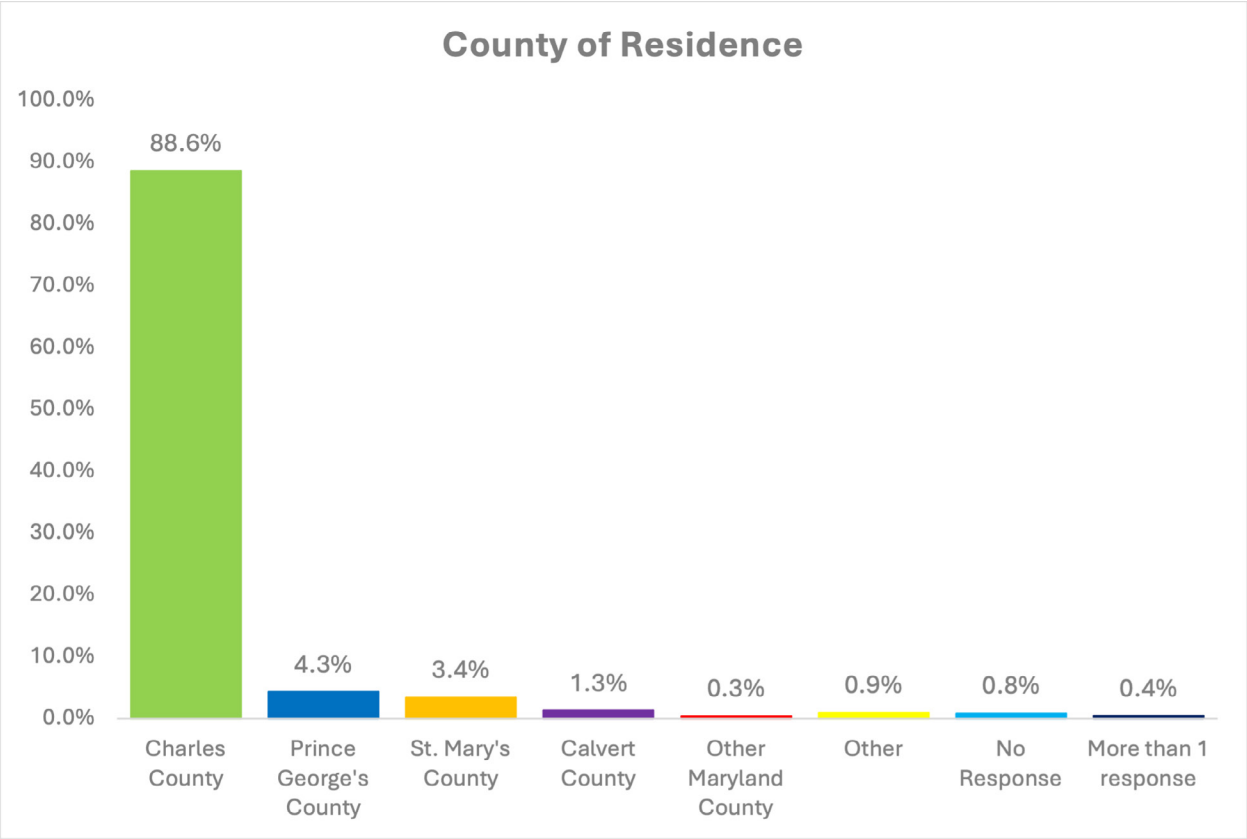
The results of all the surveys combined are presented below.

All Accumulated Surveys

Question 1: County of residence

The majority of the short survey respondents were residents of Charles County (88.6%). 4.3% of short survey respondents were residents of Prince George's County and 3.4% were residents of St. Mary's County. Other counties respondents resided in were Calvert County (1.3%), King George County, VA (0.3%), and Washington D.C. (0.2%) Their answers were included since individuals may work, spend time, or access medical care in Charles County.

County of Residence	Count (N)	Percentage (%)
Charles County	1053	88.6%
St. Mary's County	40	3.4%
Calvert County	15	1.3%
Prince George's County	51	4.3%
Other Maryland County	4	0.3%
Other	11	0.9%
No Response	10	0.8%
More than 1 Response	5	0.4%



Question 1: What do you believe to be the biggest health problems in Charles County today?

Over half of respondents (51.7%) felt that Diabetes was the biggest health issue in Charles County. Overweight/Obesity followed as the second most commonly cited health issue at 46.9%. These responses differed slightly from the previous needs assessment. In the last needs assessment, Obesity was biggest the health issue selected among respondents at 50.3%. Diabetes came in second among short survey respondents at 47.7%.

Mental Health was also a common response among respondents with a percentage of 45.8%. Other responses that were popular among short survey respondents were Alcohol or Drug Use (40.7%), High Blood Pressure/Stroke (38.5%), Heart Disease (38.2%), and Cancer (36.2%).

Issues that participants rarely reported as significant health problems included Injuries (5.8%), Infectious Diseases (10.6%), Asthma/Lung Diseases (14.5%), and Dental Health (14.8%). Infectious Diseases was a newly added health issue to Fiscal Year 2021 needs assessment short survey. With the recent COVID-19 pandemic, Infectious Diseases was added to understand the impact of disease on the community and their perceptions. However, only 10.6% of short survey respondents felt Infectious Diseases were the biggest health problem in Charles County.

Percentages will not equal 100% since short survey participants were permitted to check as many health conditions that applied.

Biggest Health Problems:	Response Count (N)	Response Percent (%)
Access to care/no health insurance	206	17.3%
Alcohol and Drug Use	484	40.7%
Asthma/ Lung Diseases	172	14.5%
Cancer	430	36.2%
Dental Health	176	14.8%
Diabetes	615	51.7%
High Blood Pressure/Stroke	458	38.5%
Heart Disease	454	38.2%
Infectious Diseases	126	10.6%
Injuries	69	5.8%
Mental Health	544	45.8%
Other	57	4.8%
Overweight/Obesity	557	46.9%
Tobacco/Smoking	390	32.8%
Traffic Accidents/Highway Safety	251	21.1%

Write ins included homelessness, children's mental health, seizure, dementia, crime, ortho issues, access to health care for seniors, autism, HIV/AIDS, overdoses, hit and runs, poor nutrition, ambulance service, sexually transmitted diseases, and lack of healthy food facilities.

Question 3: What prevents you or other Charles County residents from getting the health care needed?

The most commonly cited barriers to needed health care were care is too expensive/can't afford it (56.6%) and lack of health insurance (41.0%). Over 20% of respondents also identified transportation and not being able to get an appointment with their doctor as barriers to needed health care as well. Under "Other", several respondents explained that there is an issue trying to get in to see a provider. Respondents expressed that there's not enough health care providers, no available appointments for months, hard to find new doctors when needed, not enough doctor's offices, hard to get appointments, not enough specialist providers, hard to find a primary care doctor they like, providers not accepting new patients, and lack of providers that take Medicaid in the psychiatric department. Other barriers were distrust of health care providers, no time off from work, poverty, lack of education, unreliable services, overcrowded ER facility, insurance is not accepted, limited eye doctors, and no prevention.

Barriers to getting health care:	Response Count (N)	Response Percent (%)
Couldn't get an appointment with my doctor	265	22.3%
Doctor is too far away from my home	135	11.4%
Local doctors are not on insurance plan	225	18.9%
No health insurance	487	41.0%
No transportation	262	22.0%
Service is not available in my own county	128	10.8%
Too expensive/Can't afford it	673	56.6%
Other	121	10.1%
No Response	5	0.4%

Question 4: Do you have any ideas or recommendations to help decrease the health problems in the county or to help solve the problems with access to health service?

Access to care

- Affordable healthcare/insurance
  — *Many respondents expressed the need for lower health care costs and more affordable health care. Better insurance policies and lower costs for health insurance were also noted.*

- Public Transportation
  — *Recommendations for more VanGo stops, partnering with Uber or Lyft to provide transportation to appointments, provide rides to the hospital, and creating a transportation program were all mentioned by respondents.*

- Increase the number of doctors, hospitals/facilities, and provider hours.
  — *Many short survey respondents expressed the need to expand the hospital to meet the county population, addition of weekend or holiday hours, increase the number of doctors in the county, build more doctor's offices, and add more primary care doctors.*

- Other access to care ideas and recommendations from short survey respondents included the addition of mobile health services in the community and the need for better providers in the county (ENTs, providers in Indian Head, and more reputable doctors).

Mental Health/Substance Use

- Short survey respondents expressed the need for fentanyl awareness and more Narcan training throughout the county. Also, more support for drug addictions, prescription pill addicts, and cut down on the number of tobacco and alcohol stores in the area.

- Mental health emergency services separate from traditional emergencies, more mental health care for schools, the need for a full-time mental health facility, and better mental health options.

Outreach

- The need for more outreach within the community was a popular response among survey respondents. Recommendations for more classes and outreach events in the county was expressed. Respondents stated that events and programs are helpful, but there needs to be more awareness of these events, such as public service announcements. More services for those who are homebound and support for care givers was another recommendation.

Other

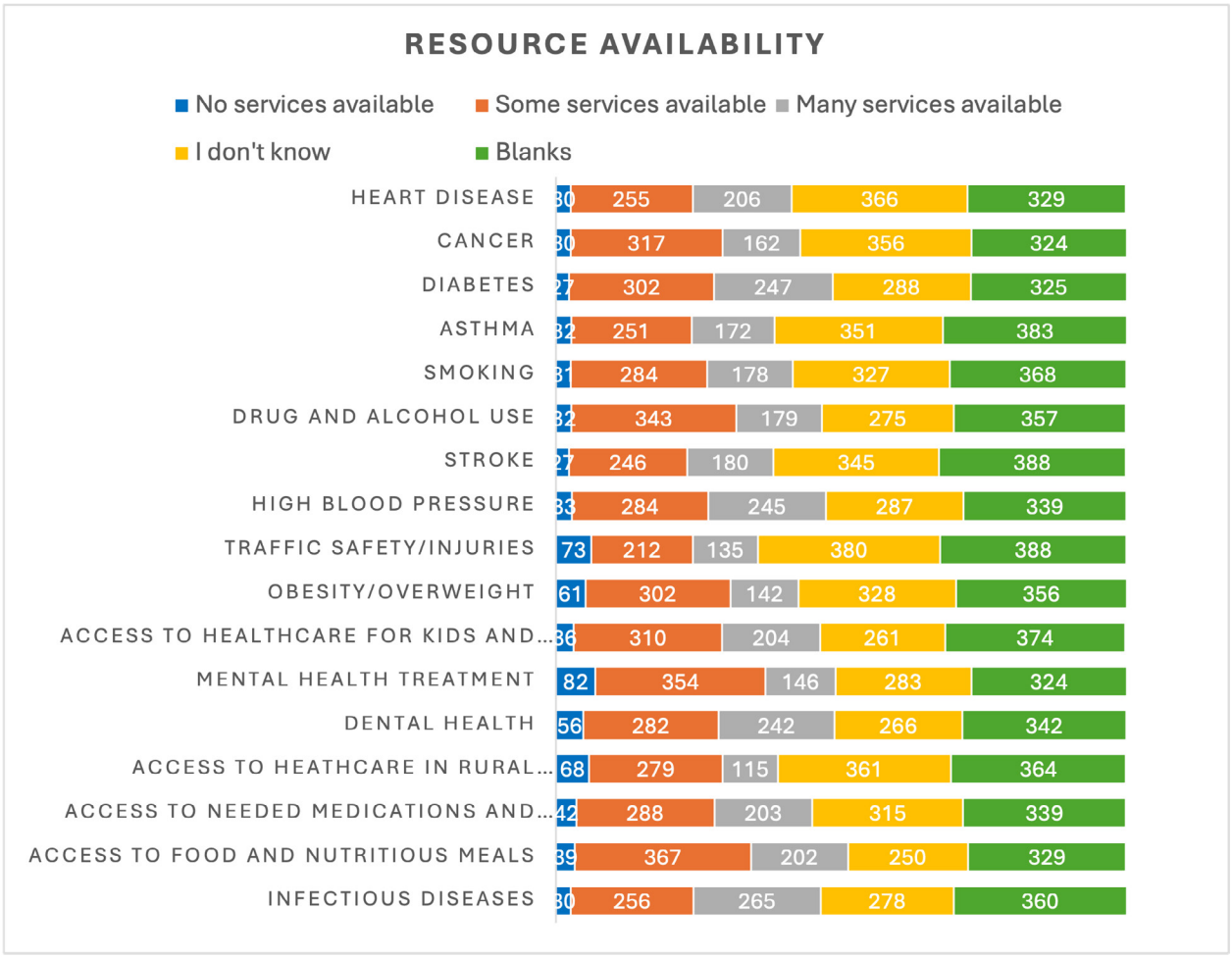
- Other recommendations from respondents included stop building more communities in the county, reduce crime, free healthcare, more healthier food options, and better access to fresh produce.

Question 5: Are sufficient services and resources available in Charles County to address these health issues/conditions?

Responses varied for every health condition listed. Many of the respondents answered that they did not know, or they left it blank. This leads us to believe that additional outreach and awareness campaigns are needed to educate people on available services in Charles County.

There were very few survey respondents who believed there were no services available for the listed health conditions. Of those who did answer there were no services available in the county, Mental Health, Traffic Safety/Injuries, and Access to healthcare in rural Charles County had the most responses.

A response of “some services available” and “many services available” were more common among short survey respondents.


RESOURCE AVAILABILITY
No services available
Some services available
Many services available
I don't know
Blanks
HEART DISEASE 30 255 206 366 329
CANCER 30 317 162 356 324
DIABETES 27 302 247 288 325
ASTHMA 32 251 172 351 383
SMOKING 31 284 178 327 368
DRUG AND ALCOHOL USE 32 343 179 275 357
STROKE 27 246 180 345 388
HIGH BLOOD PRESSURE 33 284 245 287 339
TRAFFIC SAFETY/INJURIES 73 212 135 380 388
OBESITY/OVERWEIGHT 61 302 142 328 356
ACCESS TO HEALTHCARE FOR KIDS AND... 36 310 204 261 374
MENTAL HEALTH TREATMENT 82 354 146 283 324
DENTAL HEALTH 56 282 242 266 342
ACCESS TO HEATHCARE IN RURAL... 68 279 115 361 364
ACCESS TO NEEDED MEDICATIONS AND... 42 288 203 315 339
ACCESS TO FOOD AND NUTRITIOUS MEALS 39 367 202 250 329
INFECTIOUS DISEASES 30 256 265 278 360

Resource Availability:	No services available	Some services available	Many services available	I don't know	Blanks
Heart Disease	30	255	206	366	329
Cancer	30	317	162	356	324
Diabetes	27	302	247	288	325
Asthma	32	251	172	351	383
Smoking/Tobacco Use	31	284	178	327	368
Drugs and Alcohol Use	32	343	179	275	357
Stroke	27	246	180	345	388
High Blood Pressure	33	284	245	287	339
Traffic/Highway Safety	73	212	135	380	388
Overweight/Obesity	61	302	142	328	356
Access to care for children and adults	36	310	204	261	374
Mental Health	82	354	146	283	324
Dental Health	56	282	242	266	342
Access to care in rural Charles County	68	279	115	361	364
Access to needed prescriptions	42	288	203	315	339
Access to food and nutritious meals	39	367	202	250	329
Infectious Diseases/COVID-19	30	256	265	278	360

Location

The location of data collection was recorded to ensure that all county populations have had a chance to voice their opinions on health in the county. The medically underserved population was surveyed at the Charles County Department of Health clinics and Wellness Fair. The elderly were surveyed at senior centers and hospital outpatient clinics and centers. The western and rural regions of the county were surveyed at fruit and vegetable distribution sites and the Nanjemoy Heritage Day. Families were surveyed at the health department and the University of Maryland Charles Regional Medical Center. Surveys were also available in Spanish and made available at the health department and community events.

Location of Data Collection	Count (N)
Charles County Fair (Health dept and hospital booths)	456
Health Dept Flu Vaccination Clinics	24
Health Dept Fruit + Veg Box Distributions	91
Charles County Senior Centers	36
UMCMG Medical Offices	8
UMCMG Women's Health	6
St. Peter's Church Food Drive	67
Agua Class St. Charles High School	12
Hospital Focus Group	8
ESL Community Night	14
Diabetes Support Group/Diabetes 101	67
Red Cross Blood Drive	15
Hospital Blood Drive	50
Kent Ave. Block Party	28
Charles County Govt Wellness Fair and Rodeo	59
Homeshow Capital Clubhouse	36
Metropolitan Church Food Pantry	24
Charles County Citizens Academy	11
Viking-Con	14
Kris Kringle Holiday Market	4
Thomas Stone HS Craft Fair	12
Free Gospel Church of Bryans Road Fall Fest	13
Nanjemoy Heritage Day	26
Davis Middle School Community Day	12
Town of La Plata Event	14
Patient Advisory Council	1
Charles Regional Medical Center	24
UMCMG Primary Care Office	6
Cornerstone AME Community Day	5
Health Dept Recovery Day Event	20
Charles County Public Schools (CCPS) Staff	9
Reese	17

Conclusions of Short Survey Analysis

Over half of the respondents (51.7%) felt that Diabetes is the biggest health issue in Charles County. It was the most commonly marked answer to Question 2. The second health issue most commonly cited by survey respondents was Overweight/Obesity (46.9%).

The most commonly cited barriers to needed health care were too expensive/can't afford it (56.6%) and lack of health insurance (41.0%). Charles County residents felt that there were no services in the county for Mental Health, Traffic Safety/Injuries, and access to healthcare in rural Charles County.

Many of the suggestions and ideas presented by survey respondents focused on affordable health care and increasing the number of providers and healthcare facilities in the county. Survey respondents also expressed the need for more healthy food options in the county and more transportation.

Agency responsibilities for the short surveys:

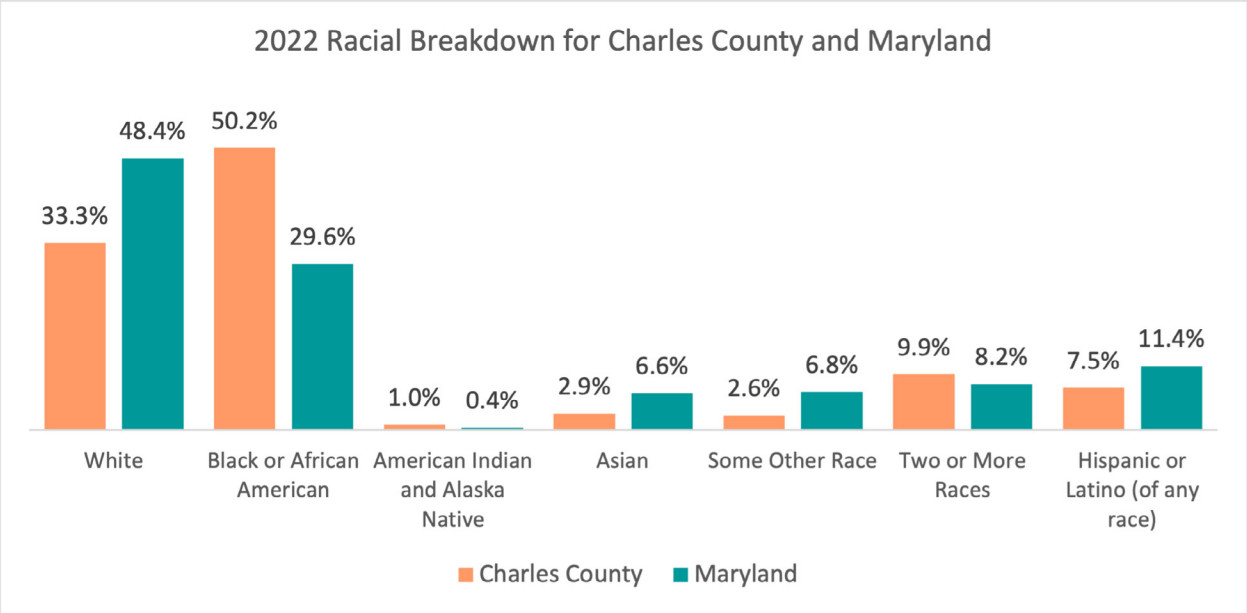
The University of Maryland Charles Regional Medical Center and the Charles County Department of Health shared responsibility for the collection of short surveys in the community. Each agency surveyed county residents in clinics and at community events. Each agency's outreach team took short surveys to every community event that they attended from July 1, 2023 to December 31, 2023.

Charles County Geographic and Demographic Profile:

Charles County is a largely rural jurisdiction located approximately 23 miles south of Washington, D.C. It is one of five Maryland counties, which are part of the Washington, DC-MD-VA metropolitan area. At 458 square miles, Charles County is the ninth largest of Maryland's twenty-four counties and accounts for about 5 percent of Maryland's total landmass. The northern part of the county is the "development district" where commercial, residential, and business growth is focused. The major communities of Charles County are La Plata, the county seat; Port Tobacco, Indian Head, and St Charles; and the main commercial cluster of Hughesville-Waldorf-White Plains. Approximately 66 percent of the county's residents live in the greater Waldorf-La Plata area. Charles County has experienced rapid growth since 1970, expanding its population from 47,678 to 166,617 in the 2020 census.

In 2022, the population estimate for Charles County was 170,102. The Charles County population has seen almost a 16% increase since 2010, when the population estimate was 147,086. The population growth of Charles County since 2010 was larger than the Maryland population growth, which saw only a 6.5% increase in population since 2010.

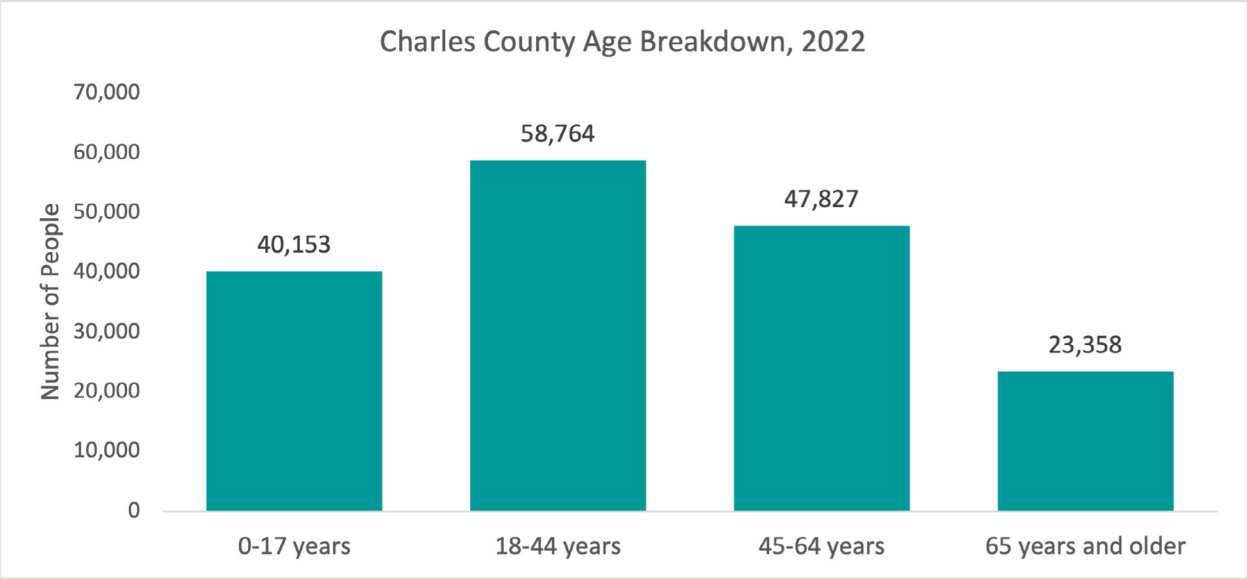
The population growth among various racial groups within Charles County has also been seen throughout the years. The Black or African American population has experienced the greatest increase among racial groups. In 2022, Black or African Americans made up 50.2% of the Charles County population, an increase from 26% in 2000. Minorites now make up two-thirds of the Charles County population. The White population has experienced decreases in population over the years. In 2022, Whites made up one-third of the Charles County population (33.3%), a decrease from 58.9% reported in 2010. After a steady increase in population since 2010, the Hispanic and Latino population in Charles County experienced a decrease in 2022, to 7.5%. Just one year prior, Hispanic and Latinos made up 11.1% of the Charles County population. Lastly, the American Indian and Alaska Native population is important to note because Charles County has one of the largest American Indian/Alaska Native populations in the state, at 1.0%. This population saw an increase in 2022, from 0.8% reported in 2019.



Source: U.S. Census Bureau; 2022 ACS 1-year Estimates Data Profiles

The 2022 Charles County gender breakdown is approximately 50/50. Males make up 48.4% of the population, and females make up 51.6% of the county population.

With the population growth of Charles County, all age groups have experienced increases in numbers over the years. The largest age group in Charles County are those between the ages of 18-44 years, with a percentage of 34.5% of the total population. This percentage has stayed the same since 2018. The 65 year and older population has seen the greatest increase in population, now comprising 13.7% of the total population. This is an increase from 12.4% reported in 2018. The juvenile population (under 18 years) experienced a slight decrease in 2022, making up 23.6% of the total population, compared to 24.0% reported in 2018. The 45-64 age group also saw a decrease since 2018, from 29.1% to 28.1% in 2022.



Source: U.S. Census Bureau; 2022 ACS 1-year Estimates Data Profiles

Transportation

The percent change in the population growth for Charles County has been slightly greater than the change seen in the Maryland population growth. This growth has created transportation issues for the County, in particular for the "development district" in the northern part of the county where many residents commute to Washington D.C. to work. The average work commute time for a Charles County resident is 44.2 minutes which is higher than the Maryland average of 32.0 minutes. Almost one-third of commuters in Charles County has a commute to work that is an hour or longer. (Source US Census Bureau's 2018-2022 American Community Survey 5-year estimates). Public transportation consists of commuter buses for out-of-county travel and the county-run Van Go bus service for in-county transportation.

Source: 2018-2022 US Census Bureau's American Community Survey 5-year estimates

Economy

Employment and economic indicators for the county are fairly strong. The 2018-2022 US Census

American Community Survey estimates that 68.8% of the Charles County population is currently in the labor work force. The 2018-2022 5-year estimate for Charles County found that approximately 8.5% of Charles County individuals are living below the poverty level. This is the same as the Maryland rate of 8.5%. The percentage of individuals living below the poverty level increased since the 2015-2019 5-year estimate when the percentage was 6.4%. The Charles County median household income was $116,882, well above the Maryland median household income of $98,461.

Source: 2018-2022 US Census Bureau's American Community Survey 5-year estimates

Education

94.4% of Charles County residents over the age of 25 have a high school degree or higher. This is above the Maryland percentage of 91.0%. However, Maryland has a higher percentage of residents with a bachelor's degree or higher at 42.2%, compared to Charles County at 31.1%.

Source: 2018-2022 US Census Bureau's American Community Survey 5-year estimates

Housing

In Charles County, 79.8% of homes are owner-occupied, compared to 20.2% renter occupied. Maryland has a slightly higher renter occupied percentage at 32.3%. The percentage of owner-occupied houses in Maryland is 67.7%.

Social, Economic, and Housing Factors	Charles County	Maryland
Total Housing Units	59,205	2,318,124
Owner Occupied	79.8%	67.7%
Renter Occupied	20.2%	32.3%
Median Gross Rent (dollars)	$1,839	$1,550
Median Household Income (dollars)	$116,882	$98,461
Language Spoken at Home: Other than English	9.8%	19.8%
Foreign-Born Population	12,581	965,638
High School Graduate or Higher	94.4%	91.0%
Bachelor's degree or Higher	31.1%	42.4%
In Labor Force (16 years and older)	68.8%	67.2%
Average Commute Time to work (minutes)	44.2	32.0
Persons Below Poverty Level	8.5%	8.5%
Civilian Veterans	16,942	345,104

Source: 2018-2022 US Census Bureau's American Community Survey 5-year estimates

Life Expectancy

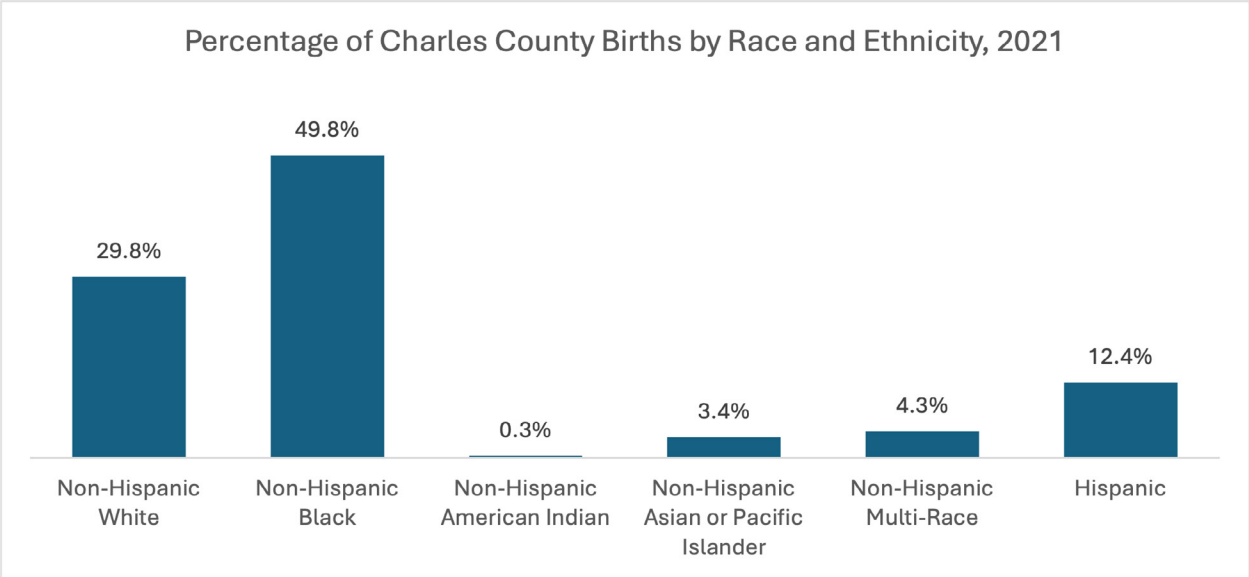
The life expectancy for a Charles County resident from 2019-2021 was 77.2 years. This is slightly lower than the Maryland life expectancy of 78.2 years.

Life Expectancy at Birth by Race, 2019-2021	Charles County	Maryland
All Races	77.2	78.2
Non-Hispanic White	77.0	78.7
Non-Hispanic Black	75.8	74.8

Source: 2021 Maryland Vital Statistics Report

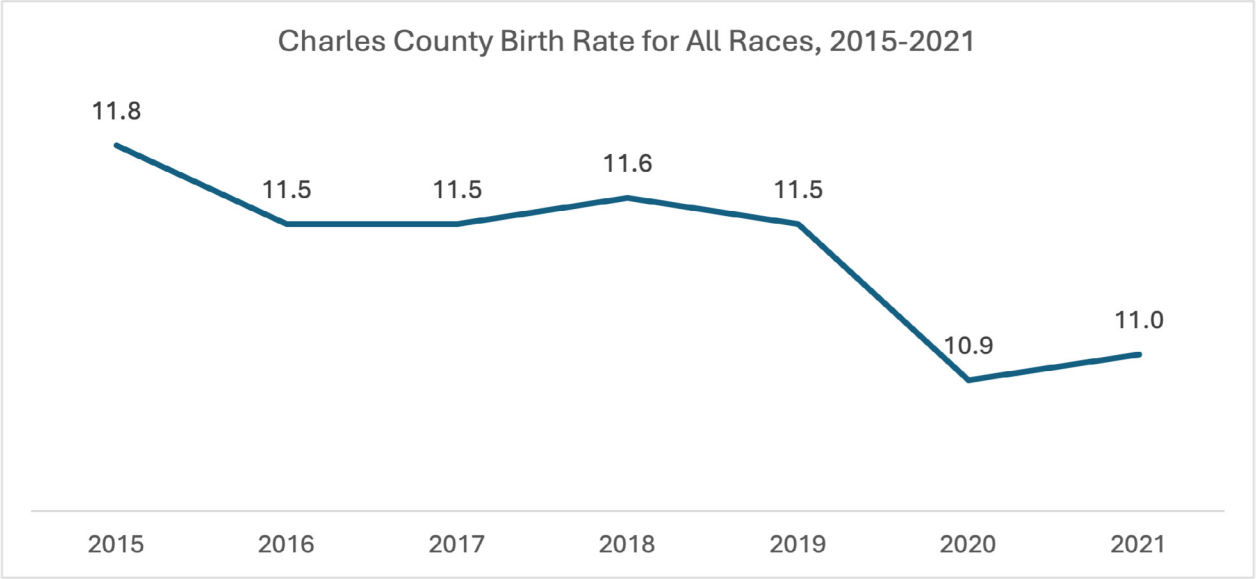
Births

In 2021, there were 1,850 births in Charles County. Charles County represents 2.7% of total births in the state of Maryland in 2021, and 43.7% of births in the Southern Area of Maryland (Charles County, Calvert County, St. Mary's County). Minorities made up almost 70% of the births in Charles County in 2021, at 69.8%.



Source: 2021 Maryland Vital Statistics Report

The birth rate in Charles County for 2021 was 11.0 per 1,000, with Non-Hispanic Blacks having a birth rate of 10.6 per 1,000 compared to Non-Hispanic Whites at 9.4 per 1,000. The Charles County Hispanic population had the highest birth rate in 2021, at 19.2 per 1,000.



Source: 2015-2021 Maryland Vital Statistics Report

Among all births in Charles County, the most common age group for the mother was between 30-34 years. Non-Hispanic White, Non-Hispanic Black, and Hispanic mothers within this age range had the most births during the 2021 year. The second most common age range was 25-29 years. Since 2018, there has been a shift in the age of mothers in Charles County. In 2018, the most common age range was 25-29 years, this range has now increased in 2021 to 30-34 years.

In 2021, the birth rate for mothers between the ages of 30-34 years was 103.9 per 1,000, the highest rate among all age groups. The Maryland birth rate for mothers between the ages of 30-34 years was 107.4 per 1,000.

Births by Age of Mother, 2021	All Ages	Under 15	15-17	18-19	20-24	25-29	30-34	35-39	40-44	45-49	50 & over	Not Stated
Charles County Total	1,850	1	12	41	273	498	579	356	82	8	0	0
Non-Hispanic White	547	0	3	13	85	164	176	83	22	1	0	0
Non-Hispanic Black	915	0	5	13	116	238	289	208	44	2	0	0
Hispanic	229	1	3	11	47	61	62	37	6	1	0	0

Source: 2021 Maryland Vital Statistics Report

Almost 38% of babies born in Charles County in 2021 were in the first birth order (37.4%), and about one third of babies born were in the second birth order (33.2%). Only a small percentage of babies were in the fifth or more birth order at 4.2%.

Charles County- Birth Order	Number of Births (N)	Percent (%)
1st	692	37.4%
2nd	614	33.2%
3rd	318	17.2%
4th	148	8.0%
5 or more	78	4.2%
Total	1850	100%

Source: 2021 Maryland Vital Statistics Report

About two-thirds of mothers in Charles County received prenatal care during the first trimester of their pregnancy in 2021. This percentage is slightly below the Maryland percentage of 69.1%. Among all births in 2021, 6.5% of Charles County mothers received late prenatal care or had no prenatal care during their pregnancy.

About half of Charles County Hispanic mothers who gave birth in 2021 received first trimester prenatal care. This was the lowest percentage among any racial or ethnic group in Charles County. However, this percentage is higher than the Maryland percentage of 39.8% for Hispanic mothers. The percentage of Charles County Non-Hispanic White and Non-Hispanic Black mothers who received first trimester prenatal care were very comparable at 69.1% and 69.8%, respectively.

Percentage of Births to Women Receiving Prenatal Care	Charles County (All Races)	Maryland (All Races)
First Trimester Prenatal Care	66.8%	69.1%
Late or No Prenatal Care	6.5%	6.2%

Source: 2021 Maryland Vital Statistics Report

Number and Percentage of Births to Women Receiving 1st Trimester Prenatal Care	All Races	Non-Hispanic White	Non-Hispanic Black	Non-Hispanic American Indian	Non-Hispanic Asian or Pacific Islander	Non-Hispanic Multi-Race	Hispanic
Charles County	1,236 (66.8%)	378 (69.1%)	639 (69.8%)	0 (0.0%)	41 (65.1%)	53 (67.1%)	114 (49.8%)
Maryland	47,149 (69.1%)	22,538 (80.2%)	13,529 (66.4%)	52 (62.7%)	3,355 (75.1%)	1,191 (70.4%)	5,240 (39.8%)

Source: 2021 Maryland Vital Statistics Report

Over 10% of babies born in Charles County in 2021 were low birth weight. Low birth weight is defined as a baby weighing less than 2,500 grams or 5.5 pounds. In 2021, the Charles County percentage of low-birth-weight infants exceeded the Maryland percentage of 8.9%. The percentage of low-birth-weight infants was also higher among Non-Hispanic Blacks (12.9%) compared to Non-Hispanic Whites (7.7%).

Number and Percentage of Low-Birth-Weight Infants	All Races	Non-Hispanic White	Non-Hispanic Black	Non-Hispanic American Indian	Non-Hispanic Asian or Pacific Islander	Non-Hispanic Multi-Race	Hispanic
Charles County	198 (10.7%)	42 (7.7%)	118 (12.9%)	1 (*)	113 (*)	5 (*)	16 (*)
Maryland	6,094 (8.9%)	1,872 (6.7%)	2,613 (12.8%)	6 (*)	394 (8.8%)	161 (9.5%)	997 (7.5%)

Source: 2021 Maryland Vital Statistics Report

**Percentages based on <20 events in the numerator are not presented since such percentages are subject to instability.*

Almost 40% of births in Charles County were delivered by cesarean section in 2021. Births by Non-Hispanic Black mothers had a higher percentage of delivery by cesarean section out of all racial and ethnic groups at 45.5%. Non-Hispanic Asian or Pacific Islander had the second highest percentage at 39.7%. Births to Charles County Non-Hispanic White mothers had the lowest percentage of delivery by cesarean section out of all racial and ethnic groups, at 32.7%.

Number and Percentage of Births Delivered by Cesarean Section	All Races	Non-Hispanic White	Non-Hispanic Black	Non-Hispanic American Indian	Non-Hispanic Asian or Pacific Islander	Non-Hispanic Multi-Race	Hispanic
Charles County	730 (39.5%)	179 (32.7%)	416 (45.5%)	1 (*)	25 (39.7%)	28 (35.4%)	75 (32.8%)
Maryland	23,428 (34.3%)	9,108 (32.4%)	8,025 (39.4%)	27 (32.5%)	1,584 (35.5%)	569 (33.6%)	3,987 (30.3%)

Source: 2021 Maryland Vital Statistics Report

**Percentages based on <20 events in the numerator are not presented since such percentages are subject to instability.*

In 2021, 1,430 out of the 1,850 Charles County babies were born in the state of Maryland (77.3%). However, only 444 babies were born in Charles County (24.0%). This percentage is lower than the 2018 percentage of 37.2%. Compared to our neighboring counties, Charles County has the lowest percentage, with St. Mary's at 72.6% and Calvert County at 47.6%. Over half of babies born to residents of Charles County were born in another Maryland county (53.3%).

Number of Births to Residents by Place of Occurrence	All Births	State Totals	MD. County Same as Residence	MD. County Other than Residence	District of Columbia	Other States
Charles County	1,850	1,430	444	986	148	272

Source: 2021 Maryland Vital Statistics Report

Demographic Data by Charles County Zip Code

Over the years, Charles County has experienced variations in demographic structure among zip codes. The northern part of the county, which has the largest zip codes and most populated areas have historically been the most diverse in the county whereas the smaller zip codes in the south and west of the county have remained less diverse. However, even the smaller zip codes have experienced a shift in demographic structure.

The Waldorf zip codes of 20601, 20602, and 20603 are the most populated zip codes in Charles County. These zip codes are located in the northern part of the county and are home to a large percentage of minorities in Charles County.

The zip codes with the largest Black or African American alone population in Charles County are Bryans Road (20616) at 75.6% and Accokeek (20607) at 65.8%. Brandywine (20613), Waldorf (20602), and Waldorf (20603) follow at 64.5%, 64,2%, and 61.1% respectively. These zip codes are all located in the northern part of the county.

The zip codes with the largest White alone population are Benedict (20612) at 100%, Cobb Island (20625) at 94.9%, and Issue (20659) at 92.7%. Benedict is located on the eastern side of the county whereas Cobb Island and Issue are located at the southern tip of Charles County.

The zip codes with the largest Hispanic population in Charles County are Bel Alton (20611) at 18.0%, Faulkner (20632) at 15.3%, and Newburg (20664) at 14.9%. These three zip codes are all located in the southern region of the county.

Zip Code Racial Composition	Total Pop.	White Alone	Black or African American Alone	American Indian/Alaska Native	Asian/Pacific Islander	Some Other Race	2 or more Races	Hispanic
20601 Waldorf	27,328	8,135 (29.8%)	15,387 (56.3%)	195 (0.7%)	847 (3.1%)	697 (2.6%)	2,050 (7.5%)	2,182 (8.0%)
20602 Waldorf	28,988	6,531 (22.5%)	18,607 (64.2%)	113 (0.4%)	567 (2.0%)	0 (0.0%)	675 (2.3%)	2,242 (7.7%)
20603 Waldorf	32,495	7,389 (22.7%)	19,857 (61.1%)	108 (0.3%)	1,836 (5.7%)	0 (0.0%)	748 (2.3%)	3,093 (9.5%)
20607 Accokeek	12,080	2,257 (18.7%)	7,944 (65.8%)	93 (0.8%)	646 (5.3%)	0 (0.0%)	117 (1.0%)	257 (2.1%)
20611 Bel Alton	1,127	803 (71.3%)	105 (9.3%)	0 (0.0%)	6 (0.5)	0 (0.0%)	0 (0.0%)	203 (18.0%)
20612 Benedict	147	147 (100%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
20613 Brandywine	14,800	3,388 (22.9%)	9,540 (64.5%)	12 (0.1%)	377 (2.5%)	0 (0.0%)	361 (2.4%)	919 (6.2%)
20616 Bryans Road	6,792	884 (13.0%)	5,137 (75.6%)	0 (0.0%)	180 (2.7%)	0 (0.0%)	100 (1.5%)	431 (6.3%)
20617 Bryantown	630	444 (70.5%)	121 (19.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	65 (10.3%)
20622 Charlotte Hall	5,471	4,318 (78.9%)	413 (7.5%)	7 (0.1%)	166 (3.0%)	0 (0.0%)	28 (0.5%)	236 (4.3)
20625 Cobb Island	1,248	1,184 (94.9%)	0 (0.0%)	0 (0.0%)	19 (1.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
20632 Faulkner	802	384 (47.9%)	121 (15.1%)	0 (0.0%)	270 (33.7%)	0 (0.0%)	0 (0.0%)	123 (15.3%)
20637 Hughesville	6,221	3,508 (56.4%)	1,753 (28.2%)	70 (1.1%)	155 (2.5%)	0 (0.0%)	0 (0.0%)	248 (4.0%)
20640 Indian Head	10,629	4,013 (37.8%)	5,815 (54.7%)	32 (0.3%)	250 (2.4%)	8 (0.1%)	94 (0.9%)	439 (4.1%)
20645 Issue	763	707 (92.7%)	0 (0.0%)	4 (0.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
20646 La Plata	21,248	14,213 (66.9%)	5,152 (24.2%)	102 (0.5%)	564 (2.7%)	0 (0.0%)	238 (1.1%)	816 (3.8%)
20658 Marbury	978	694 (71.0%)	230 (23.5%)	6 (0.6%)	18 (1.8%)	0 (0.0%)	0 (0.0%)	23 (2.4%)
20659 Mechanicsville	23,346	20,555 (88.0%)	1,577 (6.8%)	81 (0.3%)	0 (0.0%)	193 (0.8%)	935 (4.0%)	669 (2.9%)
20662 Nanjemoy	2,590	1,575 (60.8%)	745 (28.8%)	53 (2.0%)	27 (1.0%)	0 (0.0%)	107 (4.1%)	0 (0.0%)
20664 Newburg	2,780	1,821 (65.5%)	476 (17.1%)	139 (5.0%)	39 (1.4%)	0 (0.0%)	71 (2.6%)	413 (14.9%)
20675 Pomfret	2,060	934 (45.3%)	714 (34.7%)	0 (0.0%)	27 (1.3%)	0 (0.0%)	125 (6.1%)	101 (4.9%)
20677 Port Tobacco	2,055	1,590 (77.4%)	273 (13.3%)	0 (0.0%)	56 (2.7%)	0 (0.0%)	14 (0.7%)	152 (7.4%)
20693 Welcome	1,210	735 (60.7%)	194 (16.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	87 (7.2%)
20695 White Plains	11,455	3,313 (28.9%)	6,592 (57.5%)	0 (0.0%)	299 (2.6%)	0 (0.0%)	345 (3.0%)	431 (3.8%)

Source: 2018-2022 US Census Bureau's American Community Survey 5-year estimates

Age Data by Zip Code

In 2022, the median age in Charles County was 38.3 years. This is only a slight increase from the average median age of 38.1 years reported in 2017. The populated Waldorf zip codes in the northern part of the county have a younger population of residents, with an average median age of 36.8 years for 20601, 34.9 years for 20602, and 38.5 years for 20603. This may be due to the influx of young professionals living in the suburban areas of Waldorf and commuting to Washington DC or Northern Virginia. However, the zip code with the lowest median age in the county is Welcome (20693) at 29.5 years.

The zip code with the highest average median age in Charles County is Benedict (20612) at 91.2 years. This is a very small zip code located in the eastern side of the county. The second highest average median age is Pomfret (20675) at 51.5 years.

2018-2022 Average Median Age, By Zip Code	Median Age (in years)		
20601 Waldorf	36.8	**20637 Hughesville**	44.0
20602 Waldorf	34.9	**20640 Indian Head**	37.4
20603 Waldorf	38.5	**20645 Issue**	50.4
20607 Accokeek	42.8	**20646 La Plata**	43.1
20611 Bel Alton	47.0	**20658 Marbury**	43.1
20612 Benedict	91.2	**20659 Mechanicsville**	38.1
20613 Brandywine	44.2	**20662 Nanjemoy**	44.5
20616 Bryans Road	37.4	**20664 Newburg**	37.9
20617 Bryantown	41.1	**20675 Pomfret**	51.5
20622 Charlotte Hall	45.0	**20677 Port Tobacco**	50.2
20625 Cobb Island	46.6	**20693 Welcome**	29.5
20632 Faulkner	39.3	**20695 White Plains**	40.2

Source: 2018-2022 US Census Bureau's American Community Survey 5-year estimates

Geographic and Demographic Profile References

1. 2022 US Census Bureau, American Community Survey 1-year estimates, Charles County and Maryland. Available at https://data.census.gov/profile/Charles_County,_Maryland?g=050XX00US24017

2. 2021 Maryland Vital Statistics Report. Charles County Demographic and Population Data. Maryland Department of Health. Available at https://health.maryland.gov/vsa/Pages/reports.aspx

3. 2018-2022 US Census Bureau, American Community Survey 5-year estimates, Charles County and Maryland. Available at https://data.census.gov/profile/Charles_County,_Maryland?g=050XX00US24017

4. Charles County Demographic and Population Data, County and Zip Code Level. 2018-2022 average and 2022 American Community Survey. United States Census Bureau. American FactFinder. Available at www.census.gov

Charles County Vital Statistics Profile:

Marriage and Divorce

A total of 861 marriage ceremonies were conducted in Charles County in 2021. Most of those marriages were Maryland residents (820).

Marriage	Total Marriages	Maryland Residents*	Non-MD Residents	% to non-MD residents
Charles County	861	820 (95.2%)	41	4.8%

**One or both of the partners are residents of Maryland.*

Data on the age of the bride and groom and previous marital status are not available on a county level.

In 2021, there were 665 divorces and annulments in Charles County. Data on the number of years of marriage was not available on a county level.

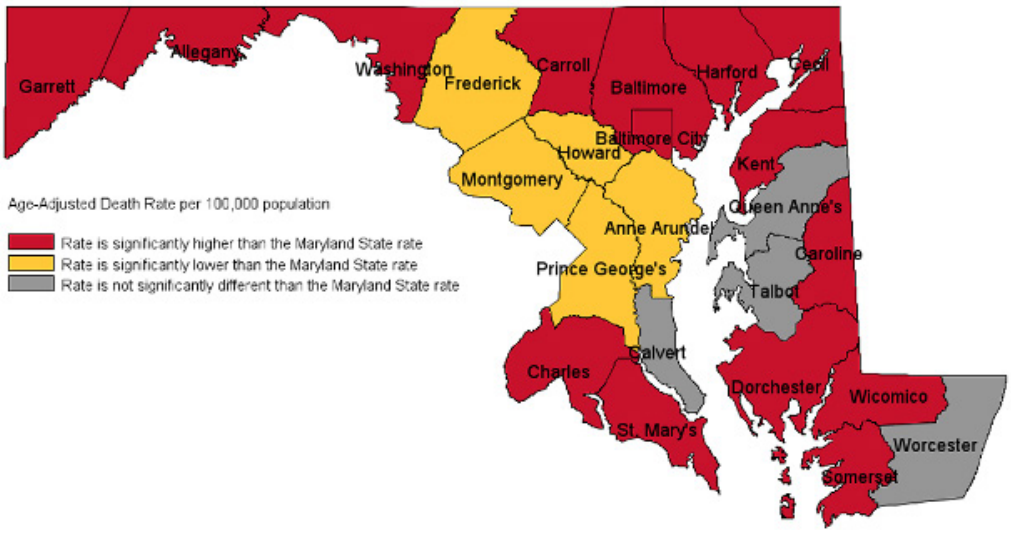
Mortality

Death Rates:

There were a total of 1,482 deaths in Charles County in 2021.

The 2021 Charles County age-adjusted all-cause mortality rate was 854.4 per 100,000 population. This rate is higher than the Maryland state all-cause mortality rate of 786.3 per 100,000 population.

Comparison of Jurisdiction Age-adjusted Death Rates* for All Causes with the Maryland State Rate, 2021



The leading causes of death for 2021 were Cancer and Heart Disease. They have very similar counts of deaths and similar age-adjusted death rates. The 2021 Charles County heart disease death rate was 150.4 per 100,000. The 2021 Charles County cancer death rate was 149.2 per 100,000.

The Charles County death rates with the greatest disparities compared to the Maryland state rates included COVID-19 (89.1 vs. 69.7), Cerebrovascular Disease (67.4 vs. 45.5), Diabetes (39.6 vs. 22.7), and Influenza and Pneumonia (15.4 vs. 8.4).

2021 Ten Leading Causes of Death by Count and Rate, Charles County and Maryland

Cause of Death	Charles County Number, 2021	Charles County Rate, 2021	Maryland Number, 2021	Maryland Rate 2021
All Causes	1482	854.4	58,130	786.3
Cancer	277	149.2	10,540	136.8
Diseases of the Heart	266	150.4	12119	160.1
COVID-19	160	89.1	5,249	69.7
Cerebrovascular Diseases	109	67.4	3409	45.5
Accidents	70	40.6	3071	45.1
Diabetes Mellitus	70	39.6	1731	22.7
Chronic Lower Respiratory Disease	44	26.0	1813	23.8
Influenza and Pneumonia	26	15.4	627	8.4
Septicemia	23	13.4	915	12.1
Chronic Liver Disease and Cirrhosis	21	11.1	680	9.2

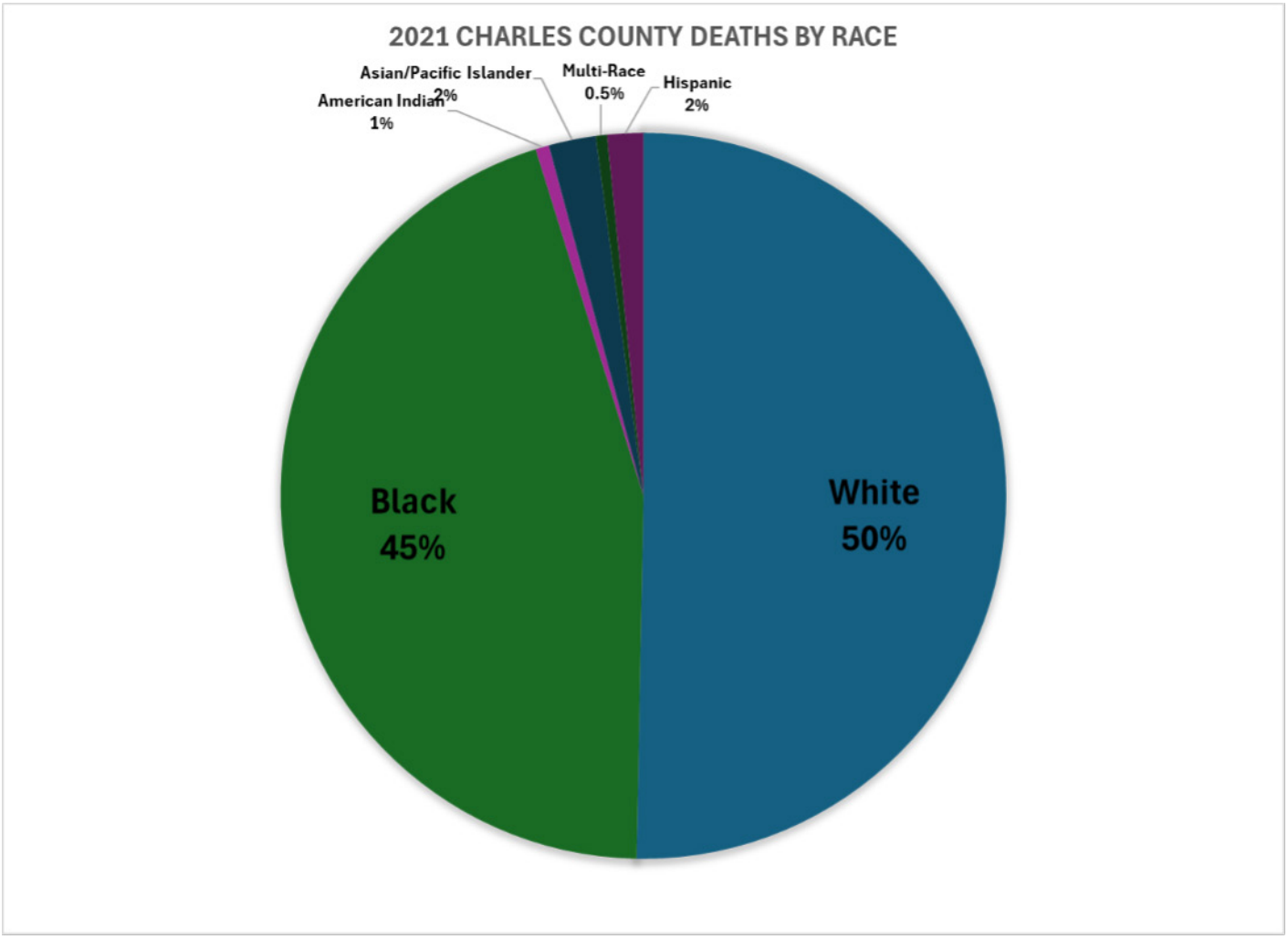
**Per 100,000 population*

**** Age-adjusted death rates not calculated for jurisdictions with fewer than 20 deaths.*

All Cause Deaths by Race:

Whites make up 50.3% of the deaths in Charles County. African Americans make up the second highest at 44.9% of the total deaths.

The rate among the White population is greater than the other races because they make up the majority of the aging population in the county. Almost two-thirds of the 65+ population in Charles County (60.2%) are White. The minority populations are moving into Charles County and are a younger population; therefore, they have lower mortality rates. The median age in Charles County is 34 years.



When comparing by 2021 calculated crude death rates, the rate is much higher in the White population. The 2021 Charles County White death rate was 1,281.0 per 100,000. This is much higher than the Charles County total 2021 crude death rate of 877.6 per 100,000 and higher than the death rates for Blacks (766.2), for Asians and Pacific Islanders (535.5), and for Hispanics (217.5). American Indian was suppressed because the rate was based on less than 20 events and would not be stable.

2021 Crude Death Rates:	All Races	White	Black	American Indian	Asian/PI	Hispanic
Charles County	877.6	1281.0	766.2	Not Available	535.5	217.5

All Cause Deaths by Age:

The number of reported deaths increased with age. The greatest numbers of deaths were seen in the 75-84 years age group. This age group accounted for one-quarter of the total county deaths for 2021.

Deaths by Age	All ages	<1 yr.	1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Charles County	1482	9	1	6	20	30	60	136	237	325	370	388

In 2021, there were 23 deaths in Charles County for children and adolescents ages 0-21 years.

Child Deaths	0-21 yrs.	<1 yr.	1-4 yrs.	5-9 yrs.	10-14 yrs.	15-17 yrs.	18-19 yrs.	20-21 yrs.
Charles County	23	9	1	5	1	1	2	4

Adolescent Violent Deaths:

There were 2 violent deaths to adolescents in Charles County in 2021. There was 1 accident and 1 assault. There were no reported incidents of intentional self-harm (suicide).

Deaths from Selected Causes:

The number of deaths in Charles County for selected causes is presented below.

All Causes of Death	1482
Tuberculosis	0
Septicemia	23
HIV Disease	3
COVID-19	160
Total Malignant Neoplasms	277
Malignant Neoplasms of Stomach	12
Malignant Neoplasms of Rectum, Colon, and Anus	30
Malignant Neoplasms of Pancreas	30
Malignant Neoplasms of Trachea, Bronchus, and Lung	63
Malignant Neoplasms of Breast	24
Malignant Neoplasms of Cervix, Uteri, Corpus Uteri, and Ovary	14
Malignant Neoplasms of Prostate	13
Malignant Neoplasms of Urinary Tract	9
Non-Hodgkin's Lymphoma	4
Leukemia	4
Other Malignant Neoplasms	74
Diabetes Mellitus	70
Alzheimer's Disease	10
Total Major Cardiovascular Diseases	401
Total Diseases of the Heart	266
Hypertensive Heart Disease	35
Ischemic Heart Disease	153
Other Diseases of the Heart	78
Essential Hypertension and Hypertensive Renal Disease	16
Cerebrovascular Diseases	109
Atherosclerosis	1
Other Diseases of the Circulatory System	9
Influenza and Pneumonia	26
Chronic Lower Respiratory Diseases	44
Peptic Ulcer	1
Chronic Liver Disease and Cirrhosis	21
Nephritis, Nephrotic Syndrome and Nephrosis	15
Pregnancy, Childbirth, and the Puerperium	0
Certain Conditions Originating in the Perinatal Period	5
Congenital Abnormalities	2
Sudden Infant Death Syndrome	2
Symptoms, Signs, and Abnormal Clinical and lab findings	11
All other Disease (residual)	284
Total Accidents	70
Motor Vehicle Accidents	24
All Other Accidents	46
Intentional Self Harm (Suicide)	19
Assault (Homicide)	11
All Other External Causes	27

Place of Death:

42.2% of Charles County deaths occurred in a hospital. 9.7% occurred within a nursing home. 3.2% were in a hospice. The other county deaths occurred outside of an institution such as a home. The percentage of deaths occurring in a hospital doubled from 21% in 2018 to 42% in 2021. This may be due to the COVID-19 pandemic where an advanced level of care was needed. Hospice saw a decrease from 11% of deaths in 2018 to 3% in 2021. Again, this may be due to the increase in infectious disease deaths due to COVID-19.

Deaths in Hospitals	Number of Deaths Occurring in Hospitals: All Races	Number of Deaths Occurring in Hospitals: White	Number of Deaths Occurring in Hospitals: Black	Number of Deaths Occurring in Hospitals: Hispanic
Charles County	625	282	302	14

Deaths in Nursing Homes	Number of Deaths Occurring in Nursing Homes: All Races	Number of Deaths Occurring in Nursing Homes: White	Number of Deaths Occurring in Nursing Homes: Black	Number of Deaths Occurring in Nursing Homes: Hispanic
Charles County	144	75	64	3

Deaths in Hospices	Number of Deaths Occurring in Hospices: All Races	Number of Deaths Occurring in Hospices: White	Number of Deaths Occurring in Hospices: Black	Number of Deaths Occurring in Hospices: Hispanic
Charles County	48	24	21	2

Deaths in Institutions	Percent of All Deaths Occurring in Hospitals, Hospice, and Nursing Homes: All Races	Percent of All Deaths Occurring in Hospitals, hospice, and Nursing Homes: White	Percent of All Deaths Occurring in Hospitals, hospice, and Nursing Homes: Black	Percent of All Deaths Occurring in Hospitals, Hospice, and Nursing Homes: Hispanic
Charles County	55.1%	51.1%	58.0%	63.3%

Infant Mortality:

For 2021, Charles County infant mortality rate was lower than the Maryland state rate. When the Charles County infant mortality rates are compared by race, the rates appear to be higher in the African American population than the general county population.

2021 Data	Charles County Number	Charles County Rate	Maryland Number	Maryland Rate
Infant Mortality Rate (per 1000 live births)	9	4.9	415	6.1
Neonatal Mortality Rates (per 1,000 births)	6	***	282	4.1
Post neonatal Mortality Rates (per 1,000 births)	3	***	133	1.9
Fetal death rates (per 1,000 total deliveries: live births and fetal deaths)	17	***	479	7.0
Perinatal Mortality Rates (per 1,000 fetal deaths)	11	***	437	6.4

****Rates based on less than 20 events are not presented since such rates are not stable. Mortality Rates per 1,000 live births are presented in parentheses when available. Rates could not be calculated for cells with fewer than 20 deaths.*

2021 Vital Statistics Data: Charles County Counts	All Races	Non-Hispanic White	Non-Hispanic Black	Non-Hispanic American Indian	Non-Hispanic Asian or Pacific Islander	Non-Hispanic Multi Race	Hispanic
Infant Deaths	9	0	7	0	0	2	0
Fetal Deaths	17	7	7	0	1	0	2
Perinatal Deaths	11	0	7	0	0	0	0
Neonatal Deaths	6	0	5	0	0	1	0
Post neonatal Deaths	3	0	2	0	0	1	0

Infant Mortality Definitions

Infant death: Death occurring to a person under one year of age.

Neonatal death: Death occurring to an infant under 28 days of age.

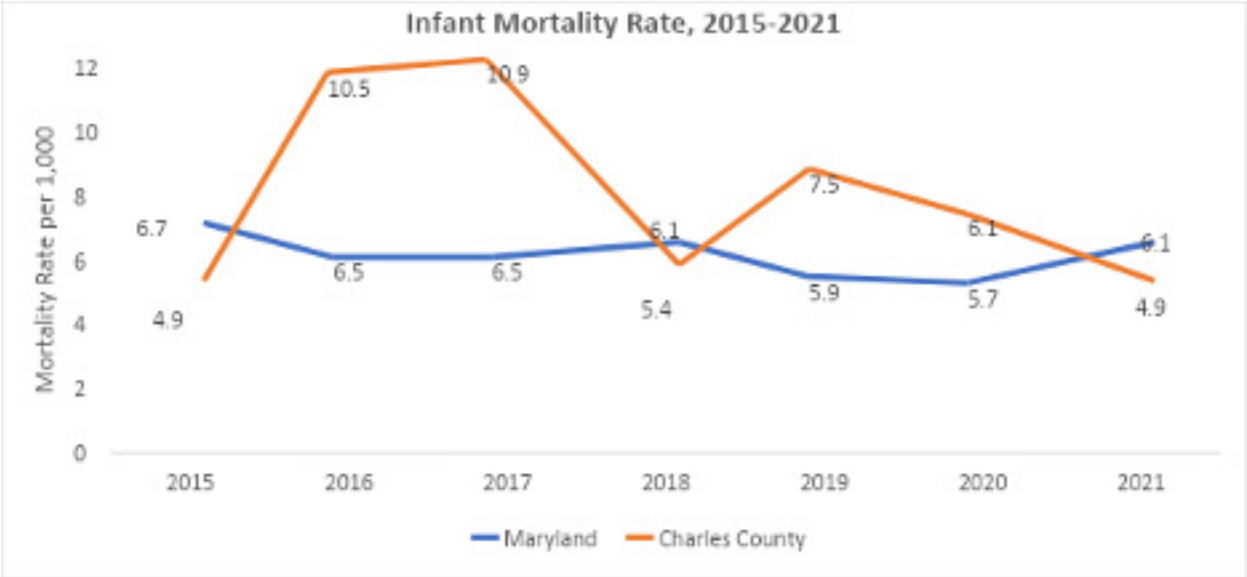
Post neonatal death: Death occurring to an infant between 28 days and one year of age.

Fetal death: Death before the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy.

Perinatal death: Death of a fetus of 28 or more weeks of gestation or of an infant less than 7 days of age.

Looking at the trends in infant mortality for Charles County, there appears to be a downward trend in infant mortality. However, there is a lot of fluctuation each year in the rate due to small sample sizes. It is also difficult to make any conclusions based on race or ethnicity due to the small numbers of deaths each year.

Infant Mortality Rates per 1,000	*2015*	*2016*	*2017*	*2018*	*2019*	*2020*	*2021*
Maryland (All Races)	6.7	6.5	6.5	6.1	5.9	5.7	6.1
Charles County (All Races)	4.9	10.5	10.9	5.4	7.5	6.1	4.9
Non-Hispanic White	***	***	12.2	***	***	***	****
Non-Hispanic Black	8.3	14.9	10.0	8.4	11.1	9.9	7.7
Non-Hispanic American Indian	***	***	***	***	***	***	****
Non-Hispanic Asian or Pacific Islander	***	***	***	***	***	***	****
Hispanic	***	***	***	***	***	***	****



Vital Statistics References

1. 2021 Charles County Marriage, Divorce, Mortality and Infant Mortality Statistics. 2021 Maryland Vital Statistics Report. Maryland Department of Health. Available at https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2021AnnualReport_Final_v1023.pdf.

Social Determinants of Health:

The social determinants of health are the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national and local levels.

The places where we live, learn, work and play have a tremendous impact on our health. Receiving proper medical care and regular physicians' visits are essential for detecting and curing illness. Access to health care can only account for 10-15% of preventable deaths. Social factors such as housing, education, income, transportation, access to healthy affordable food, and employment greatly influence the health and quality of life in communities. These social factors, generally referred to as the social determinants of health, determine whether individuals have parks and playgrounds to exercise, full-service supermarkets to buy fresh and affordable fruits and vegetables, living wage paying job opportunities to support their families, and other, necessary resources that allow them to thrive. As public health advocates, educators, and leaders, we must encourage people to make healthy choices, but must also remember that people can only make healthy choices if they have healthy options. (Robert Wood Johnson Commission to Build a Healthier America)

Data on the social determinants of health was extracted for Charles County using the American Factfinder tool from the United States Census Bureau. Data is based on 5-year average estimates from 2018-2022 American Community Surveys. Data is aggregated for a five-year period to increase the sample size and the validity of the statistics.

Disability

Public health acknowledges that what defines individuals with disabilities, their abilities, and their health outcomes is directly related to their community, including their social and environmental circumstances. To be healthy, people of all abilities should have access to meaningful daily activities that add to their growth, development, fulfillment, and community contribution.

7.6% of Charles County residents under the age of 65 years have a disability. This percentage is less than the Maryland state average percentage of 7.8% and the US percentage of 8.9%.

Language

Certain groups are at higher risk for having limited English language skills and low literacy, such as individuals who do not speak English at home and immigrants. Limited language skills and low literacy skills are associated with lower educational attainment and worse health outcomes. Having limited English proficiency in the United States can be a barrier to accessing health care services and understanding health information. For example, compared to older individuals who only speak English, older individuals with limited English proficiency are more likely to have no usual source of care, report lower self-rated health, and report feeling sad most or all of the time.

Language Other Than English Spoken at Home

Most of the Charles County population speaks English in the home. Only 9.8% of residents reported speaking a language other than English at home. This is much lower than the Maryland percentage of 19.8% and the US percentage of 21.7%.

Foreign Born

Charles County also has a low percentage of individuals who report being foreign-born at 7.5%.

This is much lower than the Maryland state percentage of 15.7% and the US percentage of 13.7%.

Housing

Housing quality refers to the physical condition of a person's home as well as the quality of the social and physical environment in which the home is located. Aspects of housing quality include air quality, home safety, space per individual, and the presence of mold, asbestos, or lead. Housing quality is affected by factors like a home's design and age. Poor-quality housing is associated with various negative health outcomes, including chronic disease and injury and poor mental health. The quality of a home's neighborhood is shaped in part by how well individual homes are maintained, and widespread residential deterioration in a neighborhood can negatively affect mental health.

Both home design and structure significantly influence housing quality and may affect mental and physical health. Steps, balconies, and windows are features of home design that may present a threat to safety, especially for individuals with physical disabilities. Breakable glass, low windowsills, and poorly constructed stairs may increase the risk of injury from a fall.

Lack of housing maintenance may lead to poor housing conditions inside the home (e.g., damaged appliances, exposed nails, or peeling paint) as well as poor housing conditions outside the home (e.g., damage to stairs and windows). These conditions may harm health by increasing exposure to hazards such as carbon monoxide, allergens, and lead in paint, pipes, and faucets. Carbon monoxide has been shown to cause heart damage, neurological impairment, and death. Likewise, even low levels of lead exposure can have serious effects on children's health and behavior.

Inadequate plumbing and lack of air conditioning in homes may also impact health. Corroded plumbing infrastructure (e.g., in Flint, Michigan) increases residents' exposure to lead and their risk of lead poisoning. Living in a home without air conditioning may increase the risk of vector-borne diseases, like dengue fever, if people leave unscreened windows open for ventilation.

Low-income families may be more likely to live in poor-quality housing that can damage health. These homes may be under-insulated, lack air conditioning, and cost more to heat, leaving homes either too hot or too cold, which has been linked to poorer health outcomes. For example, spending time in a cold home may raise blood pressure or even lead to a heart attack. In addition, residents of overcrowded homes may be at risk for poor mental health, food insecurity, and infectious diseases. Additionally, the homes of low-income families are more likely to have water leaks; these leaks are associated with mold growth, which has been shown to affect respiratory health and increase the likelihood of asthma, coughing, and wheezing.

Children and older adults with physical limitations may be especially susceptible to negative health outcomes when living in poor quality housing. Inadequately vented appliances in the home may result in increased exposure to carbon monoxide in utero, which may affect fetal development or even result in fetal death. Children's behaviors, such as hand-to-mouth activity, may increase their exposure to home pollutants. Older adults may experience serious injury from falls in the home, especially in homes with stairs, narrow doorways, or other obstacles.

Housing Data and Housing Values

There are 63,772 housing units in Charles County. 79.8% of those housing units are owner occupied. The median value of the owner-occupied housing units is $382,800. This median value is higher than the Maryland median value of $380,500 and higher than the US median value of $281,900.

The median selected monthly owner costs with a mortgage for Charles County was $2,411. This was higher than the median cost of $2,245 for Maryland and the median cost of $1,828 for the US.

Rent is also high in Charles County. The median gross rent in Charles County is $1,839. This is higher than the median gross rent of $1,598 for Maryland and the median gross rent of $1,268 f or the US.

Affordable housing is also an indicator of the Maryland State Health Improvement Process. This indicator shows the percentage of housing units sold that are affordable on the median teacher's salary. 2020 data from the Maryland Department of Planning found that 41.7% of housing units sold in Charles County were affordable on the median teacher's salary. This was far below the Maryland state percentage of 56.7%.

Household Size

There is a total of 59,205 households in Charles County. The average household size in Charles County is 2.80 persons. 88.7% of Charles County residents have been living in the same house from the previous year.

Income

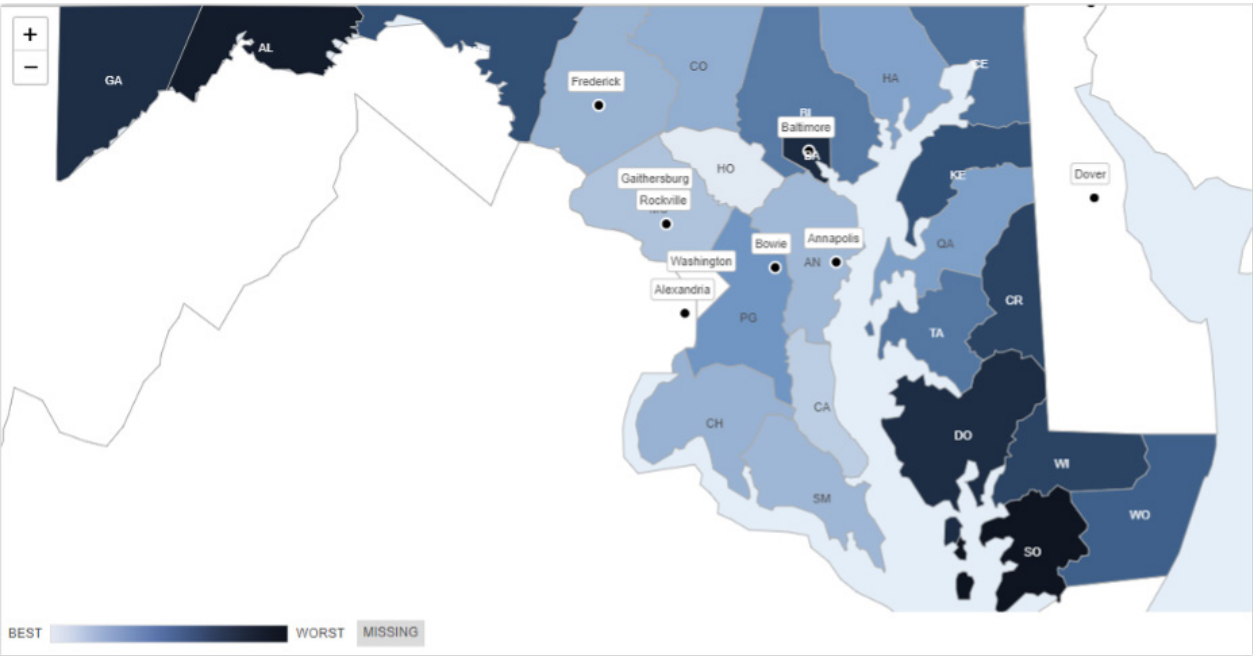
Public health has long recognized the link between poor health and poverty. Science consistently shows that low incomes are a significant risk factor in disease incidence and severity as well as life expectancy.

A study published in April 2016 in the Journal of the American Medical Association examined more than 1 billion U.S. tax records from 1999 through 2014. They found that higher income was linked with longer life, with differences in life expectancy across income groups increasing over time.

In particular, the study found that the gap in life expectancy between the richest 1 percent and poorest 1 percent was more than 14 years for men and more than a decade for women. Inequality in life expectancy increased as well, with men and women in the top 5 percent of income distribution gaining about three years of life expectancy, while those in the bottom 5 percent gained virtually no additional years of life.

Median Income and Poverty

Employment and economic indicators for the county are fairly strong. The 2018-2022 US Census American Community Survey estimates that 67.3% of the Charles County population is currently in the labor work force. The 2018-2022 5-year estimate for Charles County found that approximately 8.0% of Charles County individuals are living below the poverty level; however, this is lower than the Maryland rate of 9.6%. The Charles County median household income was $116,882, well above the Maryland median household income of $98,461 and the US median of $75,149.

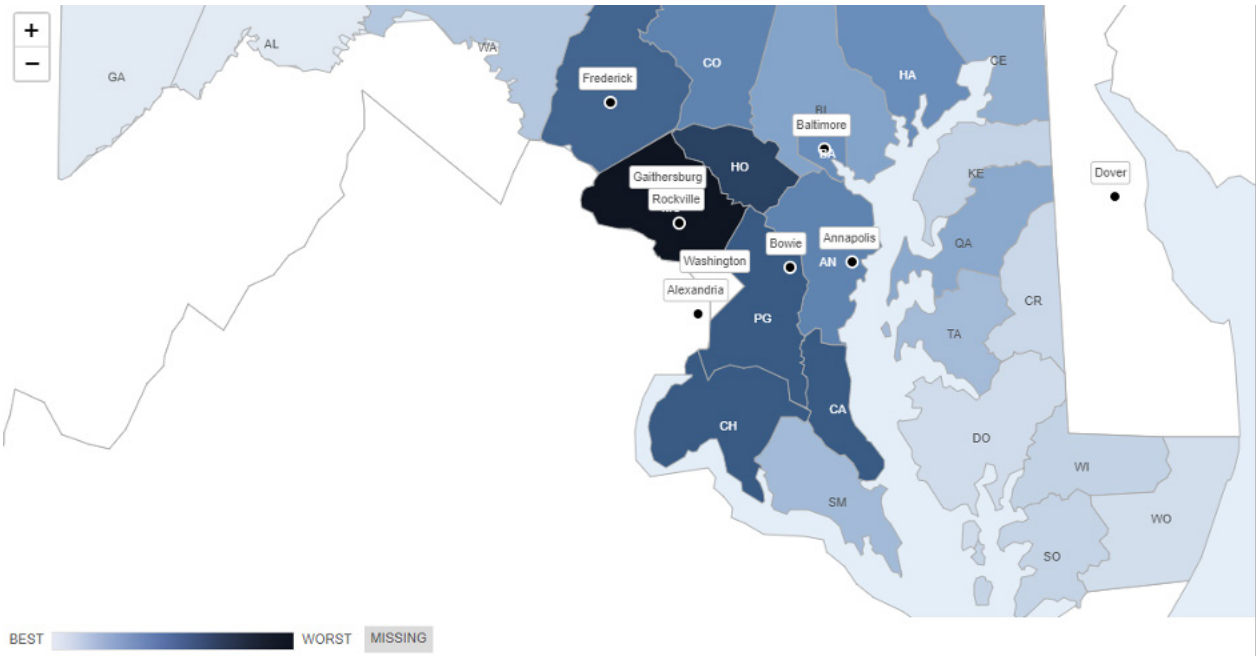


Livable Wage

According to the Robert Wood Johnson Foundation's County Health Rankings, the livable wage is "The hourly wage needed to cover basic household expenses plus all relevant taxes for a household of one adult and two children." This living wage estimate is calculated by Dr. Amy Glasmeier and colleagues at the Massachusetts Institute of Technology for twelve different household compositions. We include a measure of Living Wage reflecting a household of three with one adult working full-time and two children.

Living wage represents the minimum income necessary for financial independence to meet the basic needs of an individual or family without requiring public assistance in the form of income-conditioned benefits like the Supplemental Nutrition Assistance Program (SNAP), Supplemental Security Income (SSI), Earned Income Tax Credit (EITC), and Temporary Assistance for Needy Families (TANF).1 The Living Wage measure specifically accounts for basic household needs, including food, child care, health care, housing, transportation, and other necessities such as clothing, broadband service, and cell phone service. The costs of many elements of the basic needs budget are based on market-derived data which vary according to geographic region. This makes the Living Wage measure a much more accurate determination of household need as compared to the U.S. poverty thresholds.

For Charles County, the 2022 hourly wage needed to cover basic household expenses plus all relevant taxes for a household of one adult and two children is $52.84. This is the third highest in the state of Maryland and is greater than the Maryland state hourly living wage of $50.60.



Food Insecurity

According to the Robert Wood Johnson Foundation's County Health Rankings, 7% of Charles County residents do not have a reliable source of food. This is lower than the Maryland percentage of 9% and the US percentage of 12%. This measure is based on 2020 data from Feeding America's Map the Meal Gap project.

In addition, 5% of Charles County residents are considered low income and without a close grocery store. This limits their ability to access healthy and fresh foods. This is higher than the Maryland state average percentage of 4%.

Children Eligible for Free or Reduced-Price Lunch:

Food insecurity and hunger are known to impair child development and increase risk of poor health outcomes. The 2020-2021 percentage of Charles County children eligible for free or reduced-price lunch was 40%.

Poverty

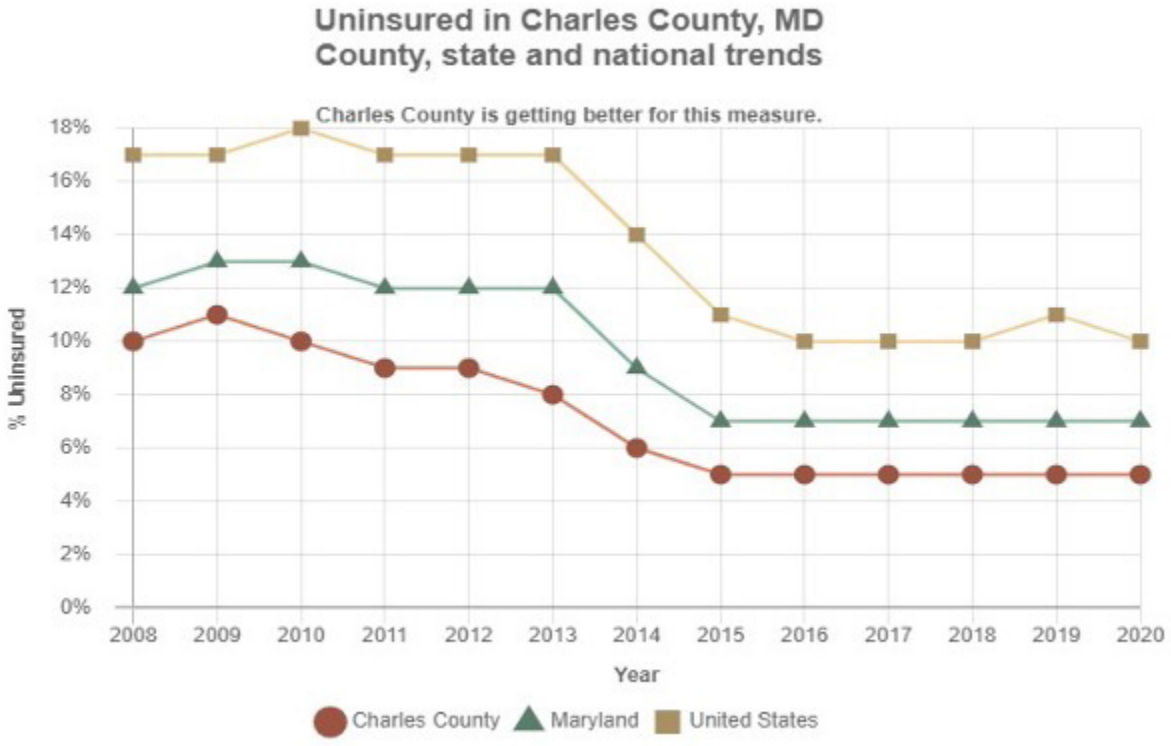
According to the 2018-2022 US Census Bureau's American Community Survey, 8.0% of Charles County residents are living in poverty.

Another indicator for assessing income is to examine the percentage of people who are spending greater than 35% of their income on gross rent. Gross rent is the contract rent plus the estimated average monthly cost of utilities (electricity, gas, and water and sewer) and fuels (oil, coal, kerosene, wood, etc.) if these are paid by the renter (or paid for the renter by someone else). Gross rent eliminates the differences resulting from a variety of practices associated with including utilities and fuels as part of the rental payment. The estimated costs of water, sewer and fuels are reported on a 12-month basis but are converted to monthly figures for the tabulations. The median gross rent in Charles County is $1,598. This is above the national average gross rent of $1,268.

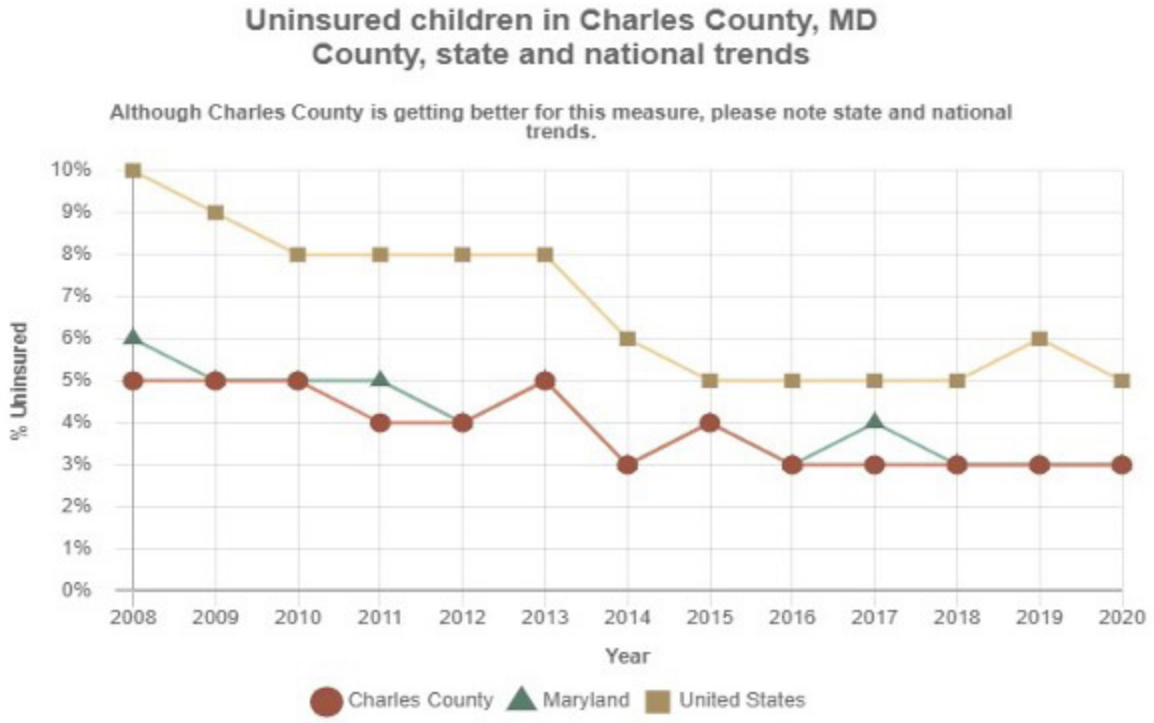
Health Insurance Coverage

One of the key components of access to health care is the availability to health insurance coverage. According to the short survey respondents, the most commonly cited barriers to needed health care were care is too expensive/can't afford it (56.6%) and lack of health insurance (41.0%).

The 2018-2022 Census American Community Survey estimates that 5.2% of Charles County residents do not have health insurance. Looking at the trends in the uninsured data from 2008-2020, the percent of uninsured in Charles County has gone down and is below both the state and federal levels.



Charles County is also below the state when examining the percentage of county children who are uninsured.



Internet Access

In the digital age, many forms of health information and education have moved online. Those with access to a computer and the internet can participate in online health education or telehealth services. 95.0% of Charles County households have a computer, and 91.3% of Charles County households have a broadband internet subscription. However, there are parts of the county where broadband internet access is still unavailable.

Education

"Education is the single most important modifiable social determinant of health," Iton, MD, JD, MPH, senior vice president for healthy communities at the California Endowment. "Income and education are the two big ones that correlate most strongly with life expectancy and most health status measures."

Education is not just about what is learned in the classroom; it is also about the doors it unlocks to future well-being. U.S. women who were aged 25 years in 2005 who never finished high school could expect to live another 52 years, compared to another 57.3 years for women who completed high school, according to a 2010 National Center for Health Statistics report. Men who never finished high school could expect to live another 46.2 years, compared with 51.5 for those with high school diplomas.

Because of the relationship between education and health, Healthy People 2020 set goals related to education access. One of those goals, boosting the number of kids who graduate in four years as of ninth grade, is a Leading Health Indicator, meaning it is a priority for U.S. health under Healthy People 2020. Seventy-nine percent of public-school students completed high school in four years as of the 2010-2011 school year. The goal is to increase that to 87 percent by 2020.

The building blocks of good health have their foundation in social and emotional skills learned

during early childhood. “Early childhood programs such as preschool use games and social interactions to expose children to the concepts of problem solving and thinking ahead, which forces them to think about the consequences of their actions”, said W. Steven Barnett, PhD, director of the National Institute for Early Education Research at Rutgers University. “That is a practice carried into adulthood that may lead to better decision making about situations that could impact health.”

Charles County has a larger percentage of high school graduates than Maryland (94.4% vs. 91.0%); however, Charles County has a smaller percentage than Maryland of individuals with a bachelor’s degree or higher (31.1% vs. 42.2%).

Transportation

Access to affordable, convenient transportation plays a crucial role in health. The cost and time required for daily travel between home, work, school, daycare, and groceries greatly impacts the quality of life for us all. Those who can afford it live where getting around is easier. Those who cannot afford it face long commutes, crowded buses, and often miss out on life-improving opportunities that they simply cannot get to on a reliable basis. A robust, affordable, and reliable transit system means better access to education and jobs, recreational and after-school activities, healthier food options, health care facilities, as well as friends and family.

The percent change in the population growth for Charles County has been slightly greater than the change seen in the Maryland population growth. This growth has created transportation issues for the County, in particular for the “development district” in the northern part of the county where many residents commute to Washington D.C. to work. The average work commute time for a Charles County resident is 44.6 minutes which is higher than the Maryland average of 26.8 minutes (Source US Census Bureau’s 2017-2021 American Community Survey 5-year estimates). Public transportation consists of commuter buses for out-of-county travel and the county-run Van Go bus service for in-county transportation.

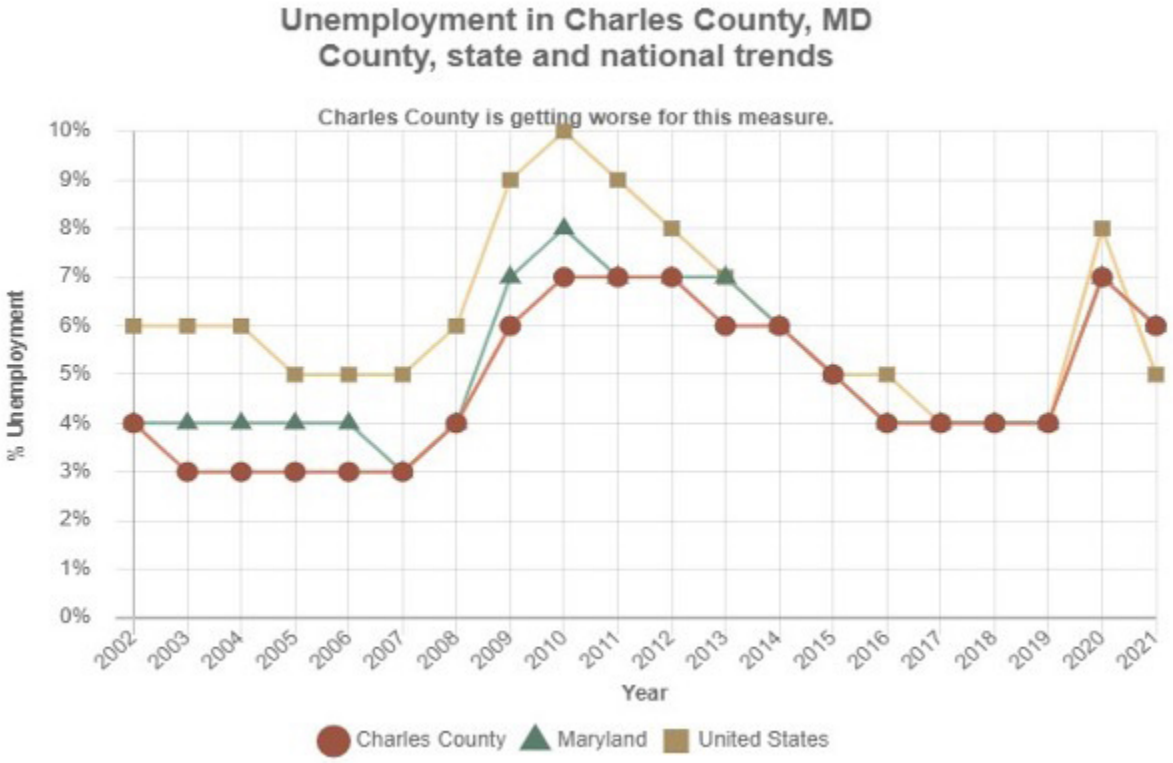
Employment

Every day, many Americans are either working or looking for work. Multiple aspects of employment—including job security, the work environment, financial compensation, and job demands—may affect health.

Job benefits such as health insurance, paid sick leave, and parental leave can affect the health of employed individuals. Two key functions of health insurance are access to affordable medical care and financial protection from unexpected health care costs. Paid sick leave, another benefit offered by some employers, allows employees to seek medical care for themselves or dependent family members without losing wages. In addition, some employers offer maternity leave after the birth of a child; this leave is frequently unpaid. Maternity leave has been associated with several positive health outcomes for both women and children.

Unemployment can also have negative health consequences. Those who are unemployed report feelings of depression, anxiety, low self-esteem, demoralization, worry, and physical pain. Unemployed individuals tend to suffer more from stress-related illnesses such as high blood pressure, stroke, heart attack, heart disease, and arthritis. In addition, experiences such as perceived job insecurity, downsizing or workplace closure, and underemployment also have implications for physical and mental health.

Unemployment in Charles County has risen since 2019. The 2021 Charles County unemployment rate was 5.7%. This is like the Maryland percentage of 5.8% and above the US percentage of 5.4%.



Social Determinants of Health References

1. Social Determinants of Health data on Employment, Education, Income, Transportation, Computer Access, Disability, Health Insurance, Poverty, Housing, Language. 2018-2022 average and 2017 American Community Survey. United States Census Bureau. American FactFinder. Available at www.census.gov.

2. Data on median household income, livable wage, food insecurity, children eligible for free or reduced-price meals, uninsured, and unemployment. The Robert Wood Johnson Foundation's County health rankings. Available at countyhealthrankings.org.

Qualitative Data Pertaining to Social Determinants of Health

Social determinants of health were often highlighted in focus group discussions. The perceived barriers and gaps were very similar among focus group participants. A large majority of participants stated that barriers related to transportation and access to care were greatest in Charles County.

Across all six focus groups, transportation was identified as a barrier in accessing or receiving healthcare services in Charles County. From childhood and adolescence to the elderly population of the county, the lack of transportation is a countywide barrier. Focus group participants stated that the lack of transportation to and from after school programs is causing a sedentary lifestyle among the youth in Charles County. In the Partnerships for a Healthier Charles County focus group,

participants stated that transportation to and from health services is a barrier. Participants also stated that children need to be involved in more activities, but transportation becomes a barrier to those activities. In the Chronic Disease Prevention and Management Coalition focus group, participants mentioned that more services are becoming available in the county, but the issue is getting to those services. Lastly, in the Healthcare Consumers and Community Leaders focus group, participants stated that there is a lack of transportation throughout the county, but specifically in more rural areas of the county including Nanjemoy, Indian Head and Welcome.

Other social barriers that were identified in the focus groups were food deserts within the county and the need for more healthy food options, the cost of healthcare services, health insurance issues (providers only accepting certain plans), and affordable housing.

When asked what prevents people in Charles County from accessing the services that they need, the short survey participants often cited social determinants of health. The most commonly cited barriers to needed health care were care is too expensive/can't afford it (56.6%) and lack of health insurance (41.0%). Over 20% of respondents also identified transportation and not being able to get an appointment with their doctor as barriers to needed health care as well.

Short Survey Participants Also Asked for Improved Access to Care Through:

Affordable healthcare/insurance: Many respondents expressed the need for lower health care costs and more affordable health care. Better insurance policies and lower costs for health insurance were also noted.

Public Transportation: They provided recommendations for more VanGo stops, partnering with Uber or Lyft to provide transportation to appointments, provide rides to the hospital, and creating a transportation program were all mentioned by respondents.

Other determinants: Short survey respondents expressed the need to reduce crime, to provide free healthcare, to offer more healthier food options, and to have better access to fresh produce.

Several additional questions were added to the long survey to ask respondents about social determinants of health including food insecurity.

Long survey respondents were also asked questions related to food insecurity. These questions were designed to understand the community needs and concerns around food and obtaining food. Almost 83% of survey respondents reported not worrying about food for themselves or their household in the last year. However, 11% of survey respondents did worry about having enough food in the last year.

The top 5 serious health issues for Charles County residents were Affordable Housing, Obesity, Crime, Drug Use, and Affordable Healthcare. Social determinants of health, such as housing and crime, have come to the forefront during this needs assessment.

The Burden of Heart Disease, Stroke, and Their Risk Factors:

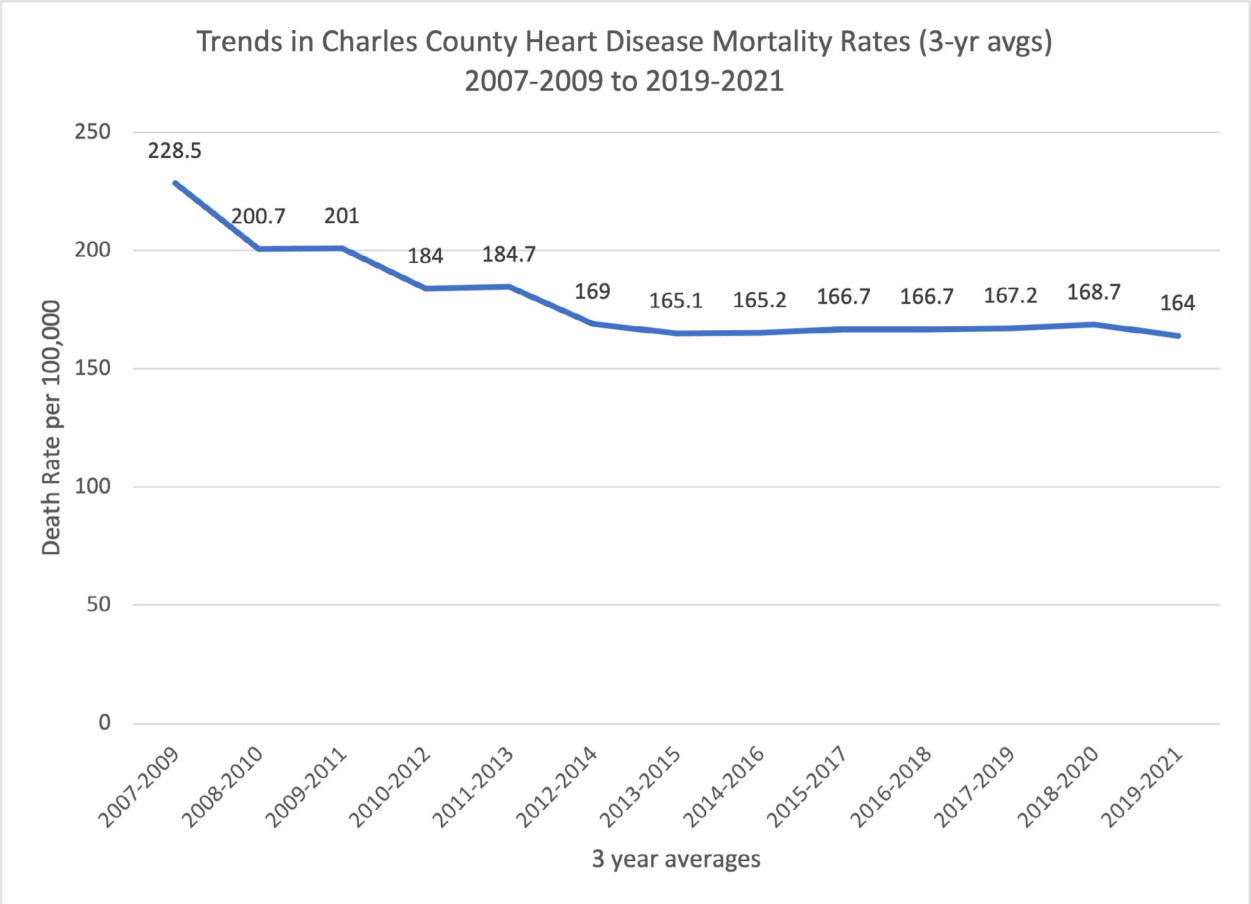
Heart Disease

Mortality:

Heart disease is the second leading cause of death in Charles County. In 2021, a total of 401 Charles County residents died from major cardiovascular diseases, and 266 of those deaths were from heart disease (66%). Deaths due to heart disease made up 18% of the total Charles County deaths in 2018.

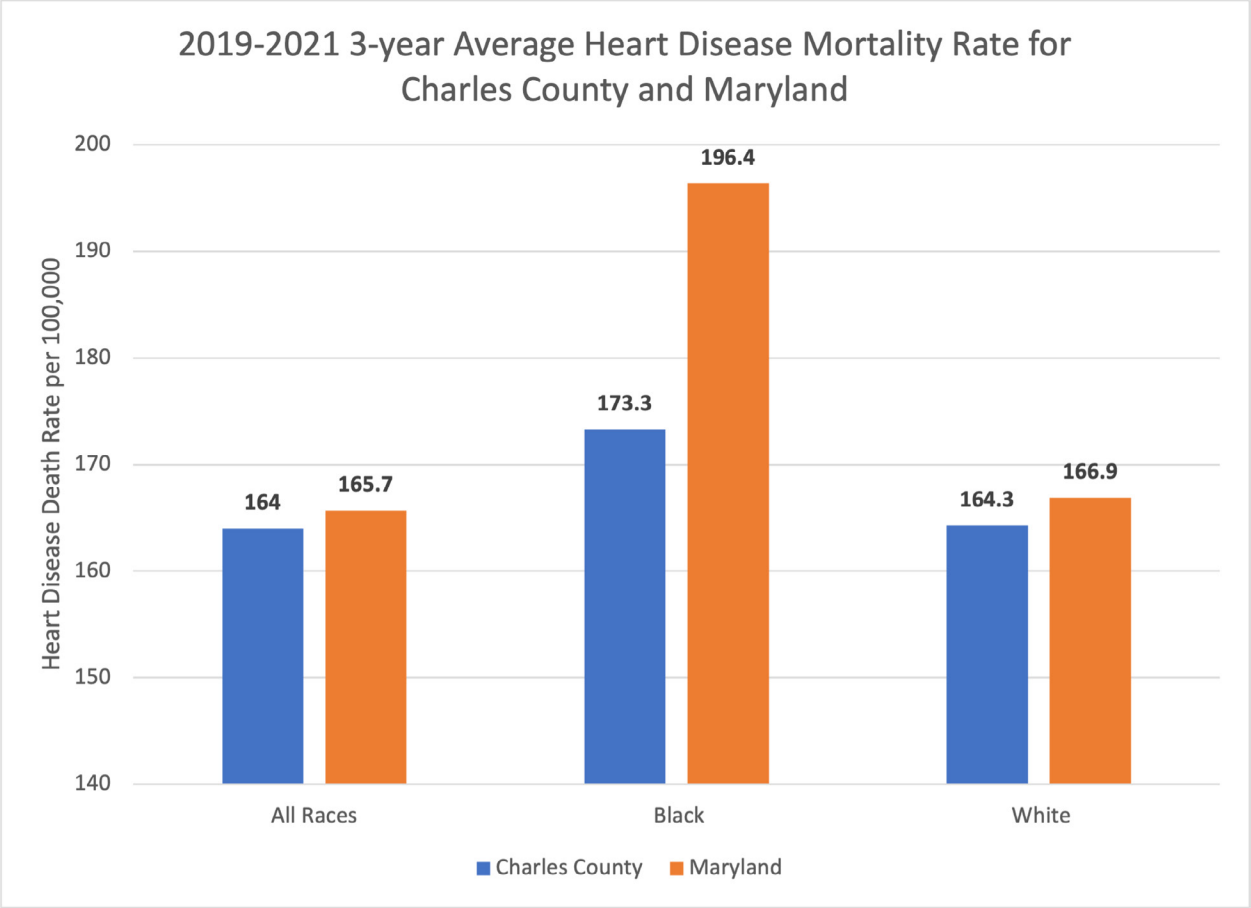
The 2021 Charles County age-adjusted heart disease death rate was 150.4 per 100,000. This was the highest rate for any cause of death in Charles County. The Charles County heart disease death rate is above than the Maryland state average rate of 136.8 per 100,000. However, this difference is not statistically significant.

The 2019-2021 (3-year average) Charles County heart disease mortality rate was 164.0 per 100,000. This is slightly below the Maryland state average rate of 165.7 per 100,000. The Charles County heart disease mortality is the 10th lowest among the Maryland jurisdictions. The 2019-2021 Charles County heart disease mortality rate is a decrease from the 2016-2018 Charles County heart disease mortality rate of 166.7 per 100,000 that was reported on the last needs assessment. Heart disease mortality rates were trending downward from 2007-2009 to 2012-2014. Rates have remained stable since that time.



Racial disparities exist on a county level for heart disease mortality. Charles County Blacks have a slightly higher heart disease mortality rate than Charles County Whites (173.3 vs. 164.3). Due to small case counts, heart disease mortality rates cannot be calculated on a county level for Hispanics and Asians.

The heart disease mortality rate for Charles County African Americans of 173.3 per 100,000 was well below the Maryland African American rate of 196.4 per 100,000. The heart disease mortality rate for Charles County White of 164.3 per 100,000 was similar to the Maryland White rate of 166.9 per 100,000.



Prevalence:

Estimates on the prevalence of coronary heart disease and angina in Charles County can be calculated using the Maryland Behavioral Risk Factor Surveillance System or BRFSS. The BRFSS also provides estimates on the number of Charles County residents who have suffered a heart attack. 2021 BRFSS data is available with age-adjusted and weighted responses for the Charles County population.

Heart Attack Prevalence:

2021 Charles County BRFSS participants were asked if they have ever had a heart attack. Once

weighted and age-adjusted, it is estimated that 3.4% of Charles County residents have ever suffered a heart attack. This is above the 2.7% reported for Maryland.

Ever had a heart attack:	*weighted percentage*
Charles County	3.4%
Maryland	2.7%

Angina and Coronary Heart Disease Prevalence:

When asked if a doctor or health professional has ever told them that they have angina or coronary heart disease, 3.6% of Charles County residents reported having angina or coronary heart disease. This is above the 3.0% reported for Maryland.

Ever have angina or coronary heart disease:	*weighted percentage*
Charles County	3.6%
Maryland	3.0%

Doctor Diagnosed Heart Disease:

When asked if a doctor or health professional has ever told them that they have heart disease (angina, coronary heart disease, and/or heart attack), 5.3% of Charles County reported having heart disease. This is above the 4.5% reported for Maryland.

Ever have heart disease:	*weighted percentage*
Charles County	5.3%
Maryland	4.5%

Doctor Diagnosed Cardiovascular Disease:

When asked if a doctor or health professional has ever told them that they have cardiovascular disease (angina, coronary heart disease, stroke, and/or heart attack), 6.7% of Charles County reported having cardiovascular disease. This is above the 6.4% reported for Maryland.

Ever have cardiovascular disease:	*weighted percentage*
Charles County	6.7%
Maryland	6.4%

Stroke

Mortality:

Stroke, or Cerebrovascular disease, is the 4th leading cause of death in Charles County. In 2021, a total of 109 Charles County residents died from a stroke. This constitutes a 2021 Charles County age-adjusted stroke death rate of 67.4 per 100,000. Deaths due to stroke made up 7.4% of the total Charles County deaths in 2021.

Atherosclerosis is the build-up of cholesterol plaque in the walls of arteries causing obstruction of blood flow. Plaques may rupture causing acute occlusion of the artery by clot. In 2021, there was 1 death in Charles County due to atherosclerosis.

Prevalence:

Estimates on the prevalence of stroke in Charles County can be calculated using the Maryland Behavioral Risk Factor Surveillance System or BRFSS. 2021 BRFSS age-adjusted and weighted estimates were used for this analysis.

2021 Charles County stroke prevalence is suppressed because the observed number of events is very small and not appropriate for publication. Variation is too great to calculate a prevalence. The 2021 Maryland stroke prevalence was 2.5% and has remained stable since the last needs assessment.

Ever had a stroke:	*weighted percentage*
Charles County	**
Maryland	2.5%

Hypertension or High Blood Pressure

Mortality:

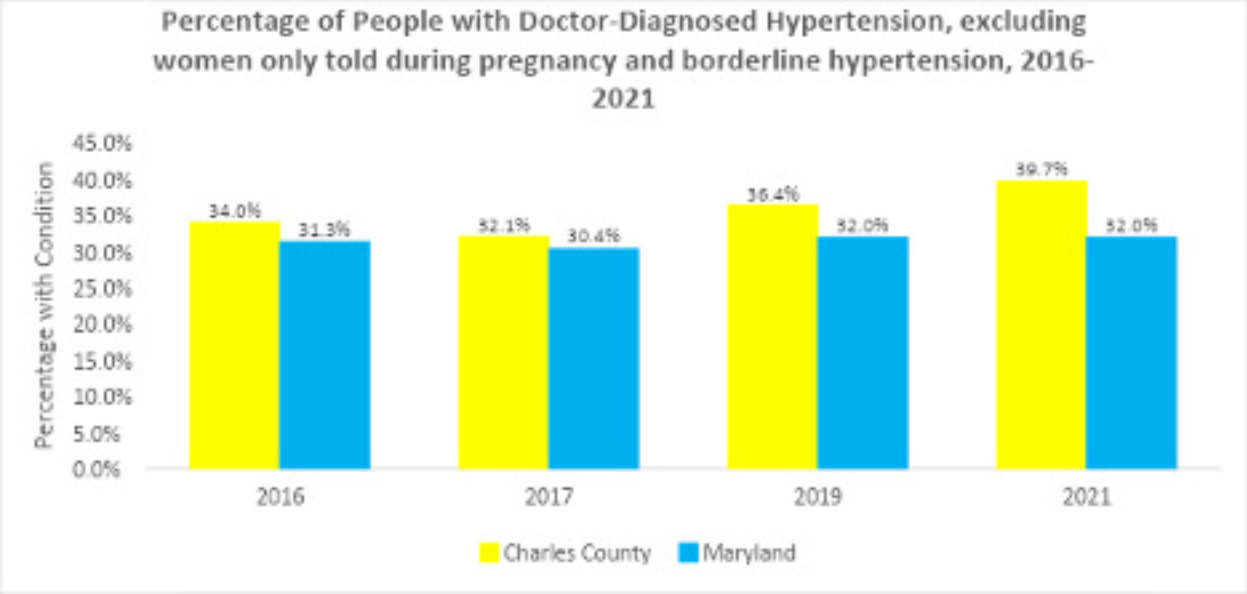
Hypertension, or high blood pressure, is the 11th leading cause of death in Charles County. In 2021, a total of 16 Charles County residents died from essential hypertension or hypertensive renal disease. Hypertension deaths make up 1.1% of the total deaths in Charles County (2021).

Prevalence:

Maryland 2021 BRFSS data was used to determine Charles County's hypertension prevalence estimates. All percentage estimates are weighted to reflect the county population.

The 2021 BRFSS asked participants if they have ever been told by a health professional that they have high blood pressure. 39.7% of Charles County residents reported that they have been told by a health professional that they have high blood pressure. This is higher than the Maryland percentage of 32.0%.

The percentage of individuals with high blood pressure has remained fairly stable for Maryland; however, the hypertension percentage in Charles County has risen each year since 2016.



Among those who reported that they have hypertension, 68.2% reported that they are currently taking medication to control their high blood pressure. This percentage is higher than the Maryland state average percentage of 63.2%.

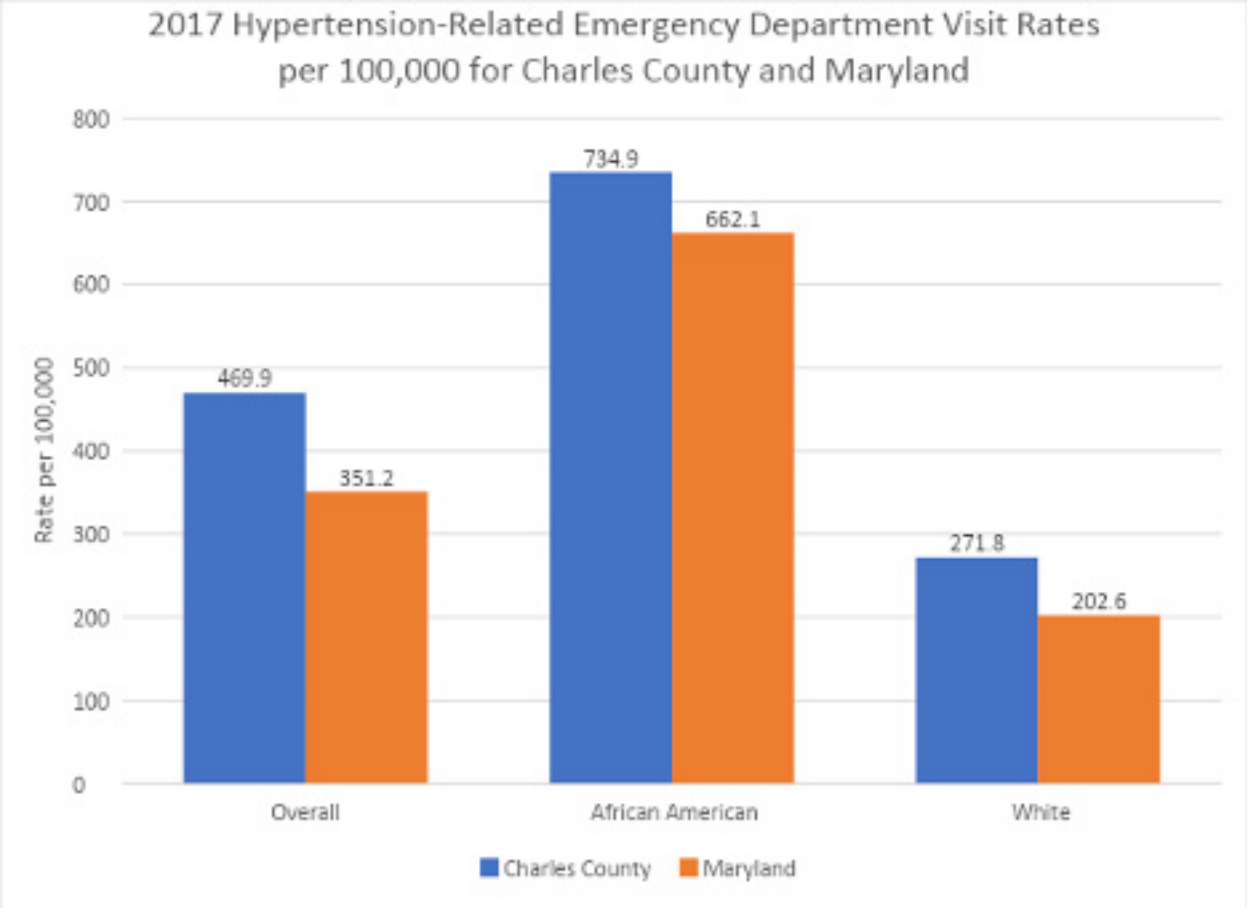
2021 BRFSS: Taking Medication to Control Hypertension	Percentage
Charles County	68.2%
Maryland	63.2%

Emergency Department Visit Rates for Hypertension:

The 2017 Charles County Emergency Department (ED) Visit Rate for Hypertension was 469.9 per 100,000 population. This rate was higher than the Maryland ED hypertension visit rate of 351.2. It was also an increase from the 2014 Charles County Hypertension ED visit rate of 347.7 per 100,000 population reported in the last needs assessment report. Charles County has seen an increase in the hypertension ED visit rate each year starting from a rate of 201.4 per 100,000 in

2008 to 469.9 per 100,000 in 2017.

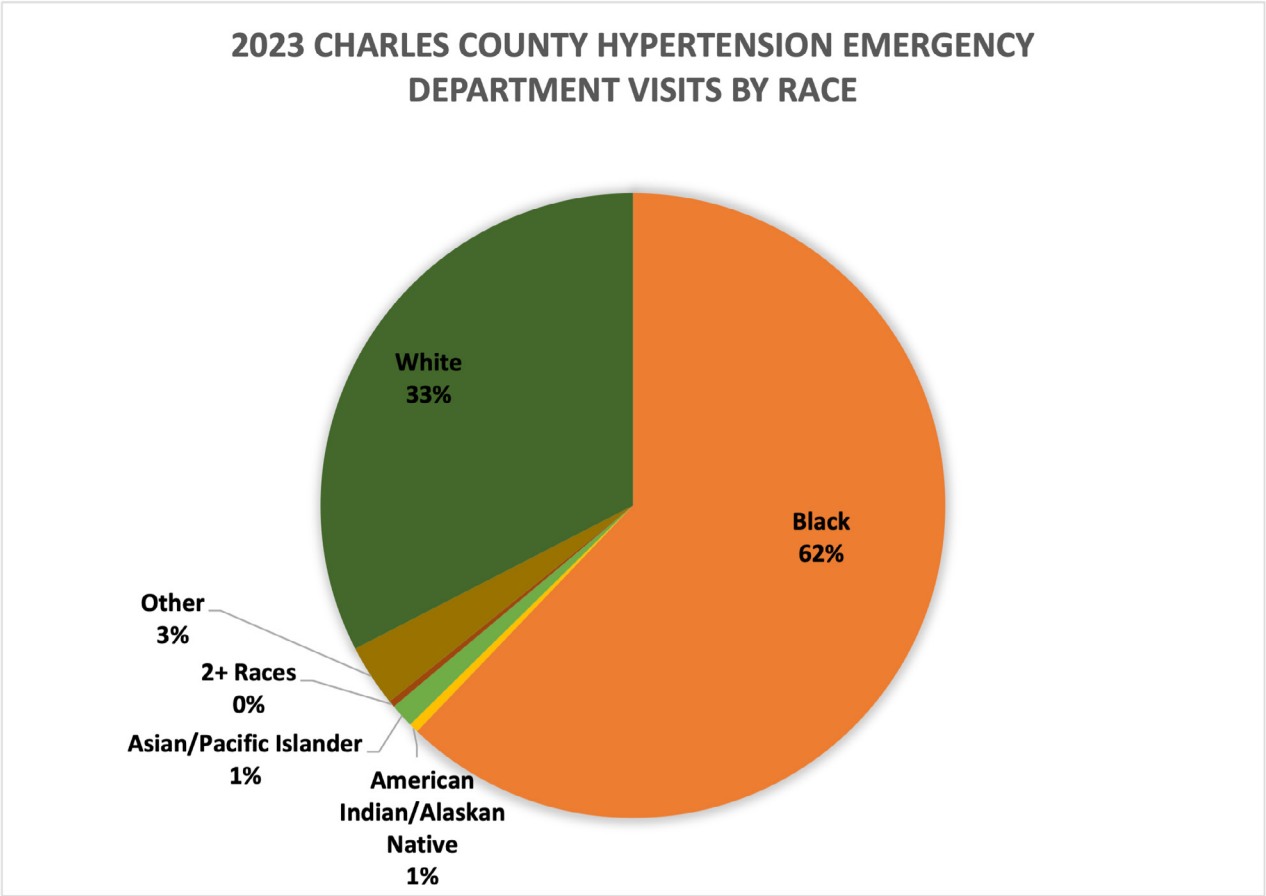
There are racial disparities in the hypertension ED visit rate in Charles County. Charles County African Americans had a hypertension ED visit rate of 734.9 per 100,000 compared to 271.8 per 100,000 for Charles County Whites.



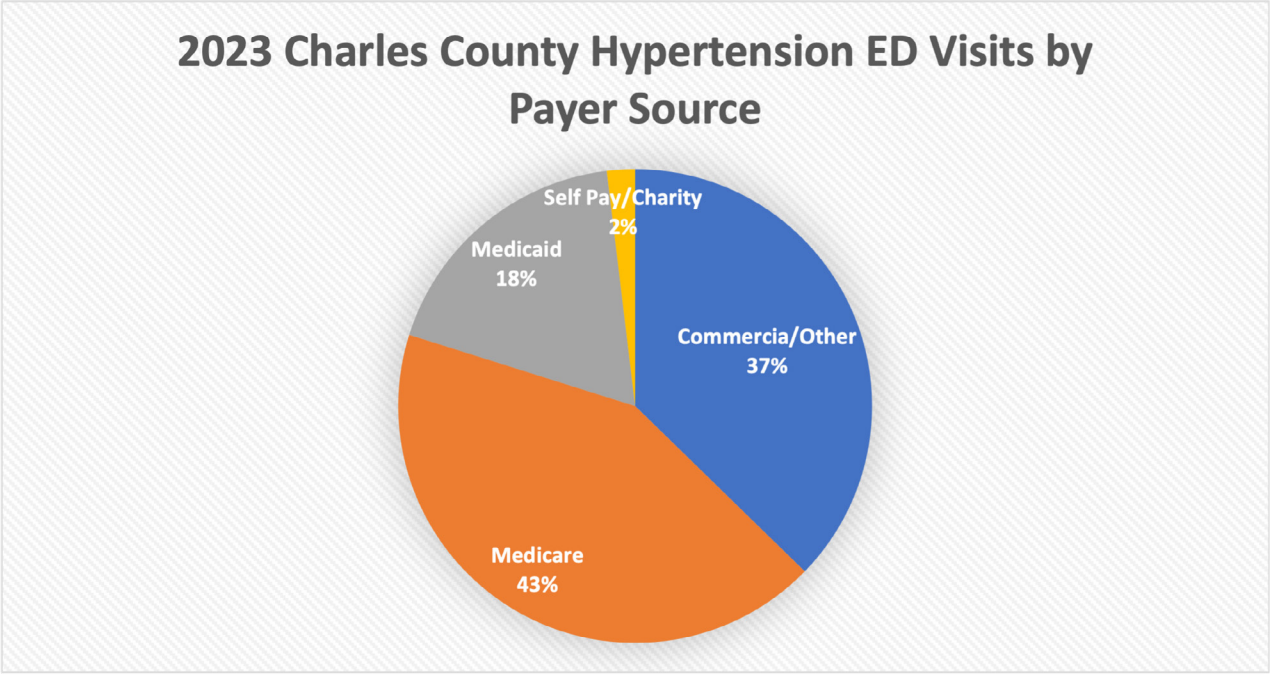
The Chesapeake Regional Information Sharing for our Patients or CRISP, is the health information exchange for the state of Maryland. CRISP Reporting Services provides public health dashboards with queries for emergency department and inpatient stays by demographics for many health conditions, including hypertension.

In 2023, there were 6,472 emergency department (ED) visits for Charles County residents related to hypertension. 64.1% of those ED visits were at the University of Maryland Charles Regional Medical Center. The next highest facility was MedStar Southern Maryland Hospital with 13.7% of the ED visits. In Charles County, females have more hypertension-related ED visits than males (3,833 vs. 2,639).

Charles County African Americans are disproportionately affected by hypertension-related ED visits and make up 62% of the total hypertension-related ED visits for Charles County residents.



When examining by payer source, the largest payer is Medicare followed by Commercial/Other insurance.

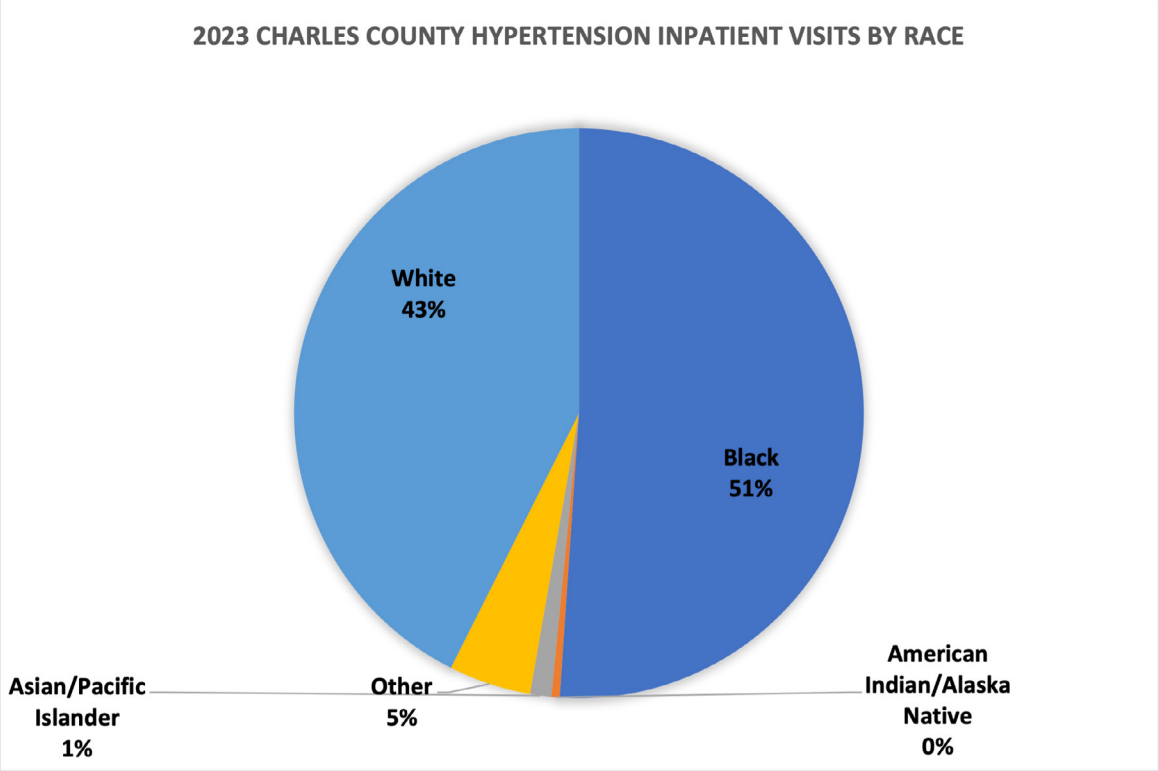


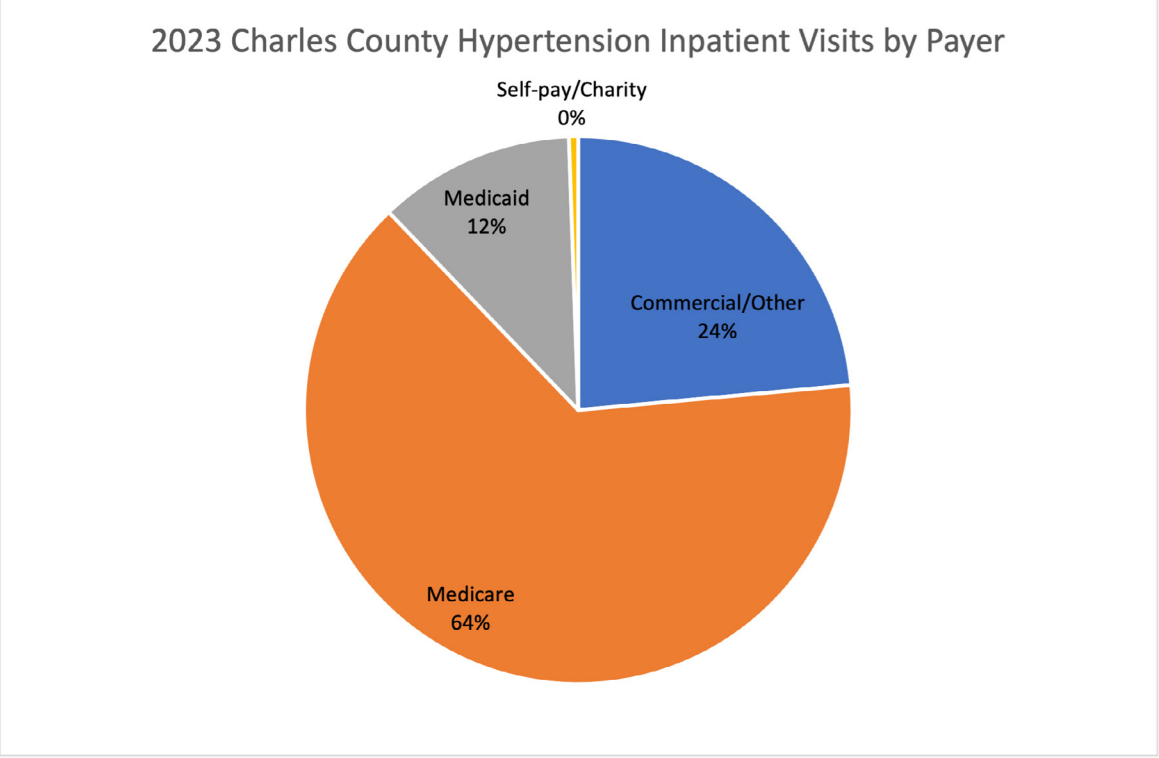
The age group with the largest number of hypertension-related ED visits is the 60-64-year-old age group who had 808 visits in 2021. They are followed closely by those aged 55-59 years.

2021 Charles County Hypertension-Related ED Visits by Age Group	Count
0-4 years	<11
5-9 years	<11
10-14 years	<11
15-17 years	<11
18-24 years	34
25-29 years	79
30-34 years	176
35-39 years	300
40-44 years	430
45-49 years	421
50-54 years	658
55-59 years	795
60-64 years	808
65-69 years	669
70-74 years	579
75-79 years	604
80-84 years	471
85+ years	433

The same data source can be used to examine hypertension-related Inpatient visits for Charles County for 2023. There was a total of 5,139 hypertension related inpatient visits for Charles County residents in 2023. 56.0% of the hypertension inpatient visits for Charles County residents occurred at the University of Maryland Charles Regional Medical Center followed by the neighboring hospitals of MedStar Southern Maryland and MedStar St Mary's. Females have more hypertension-related inpatient visits than males (2,737 vs. 2,402). Charles County Whites and

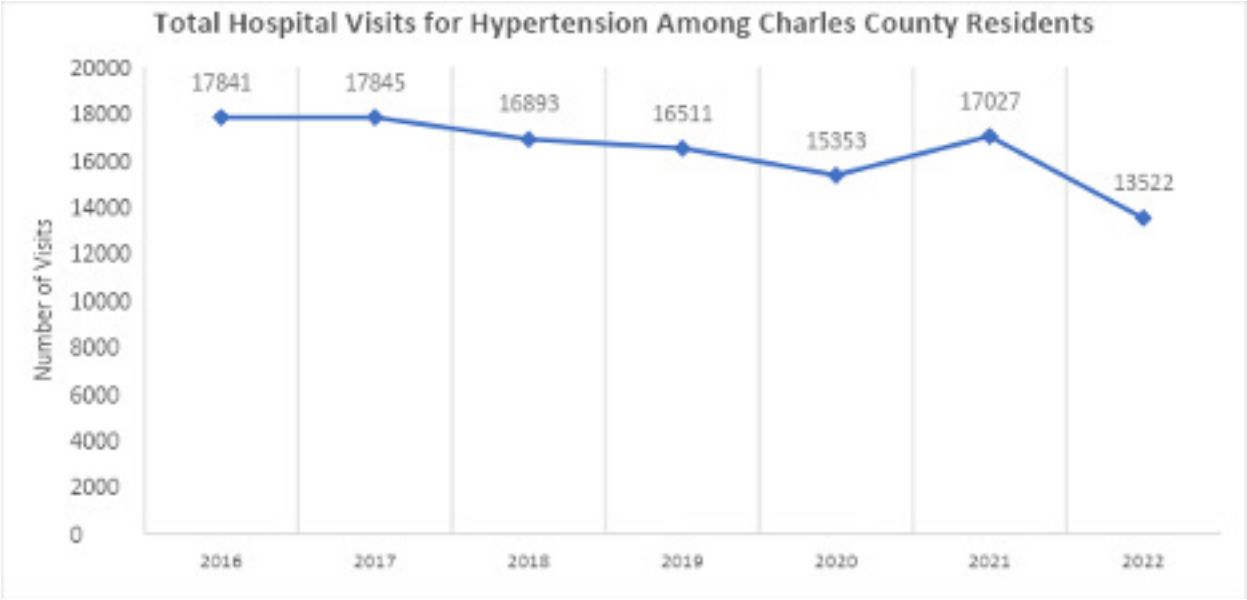
African Americans make up the majority of the hypertension-related inpatient visits (94%). Medicare is the largest payer source for hypertension-related patient stays (65%). The age group with the most inpatient visits are those aged 75-79 years.

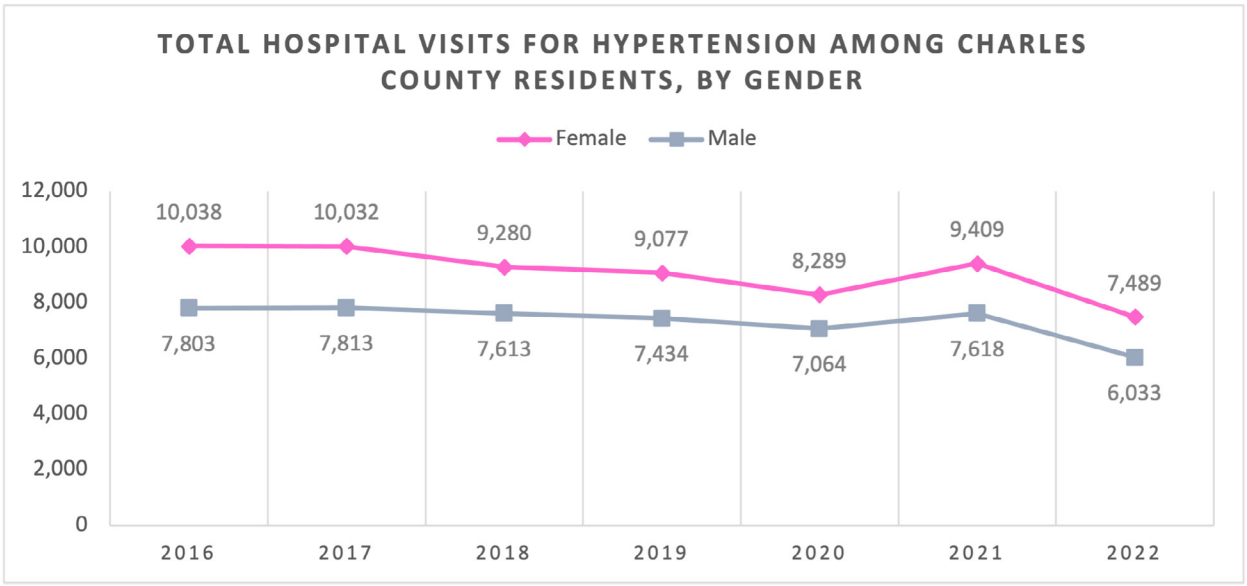




2023 Charles County Hypertension-Related Inpatient Visits by Age Group	Count
0-4 years	<11
5-9 years	0
10-14 years	<11
15-17 years	<11
18-24 years	41
25-29 years	39
30-34 years	72
35-39 years	116
40-44 years	160
45-49 years	189
50-54 years	354
55-59 years	483
60-64 years	550
65-69 years	614
70-74 years	628
75-79 years	725
80-84 years	525
85+ years	636

Looking at all types of hospital visits for Hypertension, trends show stability from 2016-2022, even with the 2020 COVID-19 pandemic. Rates are slightly higher for females than males.





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4. 2016-2023 Charles County Emergency Department and Inpatient Visits by Demographic. CRISP Reporting Services. Public Health Dashboards. Chesapeake Regional Information Sharing for our Patients (CRISP). Available at https://reports.crisphealth.org.

Qualitative Data Relating to Heart Disease, Stroke, and High Blood Pressure

On the long community health survey, 26 health issues were listed, and participants were asked to rate the severity of those issues in Charles County. Two-thirds of the participants (67.6%) viewed high blood pressure as a health problem in the county. Over one-third of the participants (37.6%) listed high blood pressure as a "serious problem." On the same listing, heart disease was listed as a health problem by 59.1% of the survey participants. One-quarter of the participants (27.9%) felt that heart disease was a serious problem in the county. Stroke was listed as a health problem by 57.9% of the respondents. 25.5% viewed stroke as a "serious problem."

Looking at the top 5 serious health problems by groups, high blood pressure was the 5th most common answer for Males and for Hispanics. It did not rise to the top for any other races, gender, or ethnicities.

Long survey participants were asked if they have seen improvements in the county on any of 13 listed health topics. 18.03% reported that they have seen improvements in the county regarding heart disease, 24.03% reported that they have seen improvements in the county regarding high blood pressure, and 12.45% reported that they have seen improvements in the county regarding stroke.

Long survey participants were also asked a series of questions regarding risk factors that might increase their chances for chronic disease such as high blood pressure/stroke and heart disease. Some of the risk factors included physical activity, healthy eating, and stress levels. Only 8.5% reported that they always eat 5 or more servings of fruits and vegetables each day; 16.2% always get an hour of physical activity each day; 46.8% take a vitamin each day, and 6.2% never feel stressed out.

Short survey participants were asked what the biggest health problems are in Charles County. High blood pressure/stroke was the 3rd most answered health topics on the short survey with 38.5% of respondents listing it as the one of the biggest health problems. Heart disease was the 4th most common response with 38.2% of respondents listing it as a big health problem in Charles County.

Short survey respondents recognized community resources to address heart disease, stroke, and high blood pressure. 40% reported that the county had some or many resources for heart disease. 36.9% reported that the county had some or many resources to address stroke. 45.8% felt that the county had some or many resources for high blood pressure.

Heart disease, high blood pressure, and stroke were not commonly discussed health conditions at the 6 focus groups. There was discussion on chronic disease and availability of programs within Charles County to address self-management such as the Stanford Chronic Disease Self-Management Program and Building Better Caregivers.

Charles County Cancer Incidence and Mortality – A State and Jurisdictional Comparison:

Introduction

2021 Maryland Vital Statistics Report:

Cancer is the leading cause of in Charles County for 2021. In 2021, a total of 277 deaths occurred in Charles County due to cancer (2021 Maryland Vital Statistics Report).

The 2021 Charles County all-cancer site age-adjusted death rate was 149.2 per 100,000 population. This rate was higher than the Maryland state average cancer death rate of 136.8 per 100,000.

The greatest numbers of cancer deaths were from cancer of the lung, trachea, or bronchus (63) and other sites (74). Lung, trachea, and bronchus cancer accounted for nearly one-quarter of all 2021 cancer deaths (23%) in Charles County. This cancer site was followed by "Other" cancer sites, pancreas, and colon/rectum/anus.

Charles County Deaths by Cancer Site:	Number of Deaths
Stomach	12
Colon/Rectum/Anus	30
Pancreas	30
Trachea, Lung, Bronchus	63
Breast	24
Cervix, Uteri, Ovary	14
Prostate	13
Urinary Tract	9
Non-Hodgkin's Lymphoma	4
Leukemia	4
Other	74

Charles County Deaths by Cancer Site:	Number of Deaths
Stomach	12
Colon/Rectum/Anus	30
Pancreas	30
Trachea, Lung, Bronchus	63
Breast	24
Cervix, Uteri, Ovary	14
Prostate	13
Urinary Tract	9
Non-Hodgkin's Lymphoma	4
Leukemia	4
Other	74

2021 Maryland DHMH Cigarette Restitution Fund Program's Cancer Reports:

Cancer incidence and mortality data for the time period 2014-2018 and for 2018 only are presented below. Data was extracted from the Cigarette Restitution Fund Program's 2021 Cancer Data Report. Charles County rates for overall cancer rates, as well as site specific rates, were compared to the United States and Maryland average rates as well as the rates for the neighboring southern jurisdictions of Calvert and St Mary's counties.

All Cancer Sites Incidence

2018 Results:

For the year 2018, Charles County had a total of 752 new cases of cancer overall; this corresponds to a 2018 all site incidence rate of 420.9 per 100,000 population. Charles County had the 5th lowest all cancer site incidence rate among the 24 Maryland jurisdictions. This rate is lower than the Maryland average rate (445.9), the US national rate (431.4), the Calvert County rate (427.9), and the St Mary's County rate (460.7).

When stratified by gender, the Charles County males have generally higher cancer incidence rates than Charles County females. The 2018 all cancer site incidence rate for Charles County males was 460.4 versus 390.4 for Charles County females.

When stratified by race, rates are higher for the White population than the African American population in Charles County. The white all site incidence rate was 426.2 compared to the black all site rate of 418.5, and the other race all site rate was suppressed (Rates based on case counts of 1-15 are suppressed).

When compared with the Maryland state average rate for all cancer site incidences, Charles County males have a lower rate than Maryland males (460.4 vs. 488.1). Charles County females also have a lower rate than Maryland females (390.4 vs. 417.6). Charles County African Americans have a lower incidence rate compared to the rate for Maryland African American males (418.5 vs. 441.9). Charles County Whites also have a lower rate than Maryland Whites (426.2 vs. 454.6).

2018 Number of New Cancer Cases: All Cancer Sites Combined

	Total	Male	Female	White	Black	Other
Maryland	32,569	16,325	16,241	21,806	9,029	1,314
Charles County	752	377	373	416	313	15
Calvert County	479	263	216	406	60	10
St Mary's County	570	292	278	470	93	6

2018 All Cancer Site Age-Adjusted Incidence Rates (per 100,000 population)

	Total	Male	Female	White	Black	Other
Maryland	445.9	488.1	417.6	454.6	441.9	267.4
Charles County	420.9	460.4	390.4	426.2	418.5	**
Calvert County	427.9	482.2	389.3	434.9	364.7	**
St Mary's County	460.7	491.4	437.1	461.6	536.4	**

*** Rates are not calculated for case counts less than 15.*

All site cancer incidence rates were also examined for the Hispanic population in Maryland. A total of 986 Hispanic Marylanders were diagnosed with cancer in 2018; this corresponds to an all-site incidence rate of 252.6 per 100,000 population. For the Southern Maryland region, there were 23 new cancer cases in the Hispanic population with an all-site incidence rate of 258.8 per 100,000. There were 14 cases from Charles County. Rates based on case counts of 1-15 are suppressed.

2014-2018 Combined Age-Adjusted Incidence Rate Results:

The 2014-2018 Charles County all site incidence rate was 436.1 per 100,000. This rate is less than the Maryland state average rate of 446.1 and less than the US average rate of 442.4. The Charles County rate is lower than the Calvert County rate of 442.2 but higher than the St. Mary's County rate of 427.6. For this time period, Charles County has the 6th lowest all cancer site incidence rate among the 24 Maryland jurisdictions.

Disparities between the White and Black populations in Charles County are seen for the time period 2014-2018. The all-site incidence rate for the White population was 468.6 which was higher than the Black all site incidence rate of 400.4. The "Other Race" all site incidence rate was much lower at 2,37.1 per 100,000. This may be due to small numbers of people in the county who represent the "Other Race" category. This population has been migrating into Charles County in the last decade and tends to be younger. Therefore, they are a small portion of the county's overall deaths and cancer deaths each year.

Consistent with rates from 2012-2016, cancer continues to disproportionately affect the male population. From 2014-2018, the Charles County all cancer site incidence rate for males was 499.2 compared to 389.8 for females. Charles County males have a higher all cancer site incidence rate compared to males in Calvert County (486.6), St Mary's County (452.9), and the state of Maryland (485.7). The Charles County female all site incidence rate was the 4th lowest for that category among the 24 Maryland jurisdictions; the Charles County male all site incidence rate is the 10th lowest in the state.

2014-2018 All Cancer Site Incidence Rates (per 100,000 population)

	Total	Male	Female	White	Black	Other
Maryland	446.1	485.7	420.4	456.7	438.7	265.5
Charles County	436.1	499.2	389.8	468.6	400.4	237.1
Calvert County	442.2	486.6	410.5	447.4	435.6	205.4
St Mary's County	427.6	452.9	407.2	427.1	458.3	223.9

*** Rates are not calculated for case counts less than 15.*

All Cancer Sites Mortality

2018 Results:

In 2018, there were 285 deaths in Charles County attributed to cancer. This constitutes a mortality rate of 171.3 per 100,000. Charles County had the 18th lowest (6th highest) all sites mortality rate among the 24 Maryland jurisdictions for 2018. In 2016, Charles County had the 10th lowest all sites mortality rate. This rate is significantly higher than the Maryland state average rate (149.9) and the Calvert County rate (136.6). This rate is slightly higher than the St. Mary's County rate (169.5).

On a county level, Charles County African Americans experienced higher all cancer site mortality rates than Charles County Whites (159.6 for Whites and 197.7 for African Americans). A disparity is also seen on a state level where African Americans have a higher all-site mortality rate than Whites or Asian/Pacific Islander (170.4 vs. 147.3 vs. 82.9).

All site mortality rates by gender mirror the same trends as the incidence rates. Males experienced greater all cancer site mortality rates than females. This was true for Charles County, Maryland, and Calvert County. St. Mary's County females experienced a slightly higher mortality rate than males (172.5 for females and 168.6 for males. In Charles County, the 2018 all site mortality rate for males was 196.7 compared to 150.9 for females in the county.

2018 Number of Deaths: All Cancer Site Combined

	Total	Male	Female	White	Black	Other
Maryland	10,927	5,591	5,336	7,263	3,282	382
Charles County	285	145	140	157	s	<10
Calvert County	155	86	69	123	s	<10
St Mary's County	203	95	108	167	s	<10

<10= Case counts were suppressed to prevent disclosure of data in other cells.
s = Death counts are suppressed to prevent disclosure of data in other cell(s).

2018 All Cancer Sites Age-Adjusted Mortality Rates (per 100,000 population)

	Total	Male	Female	White	Black	Other
Maryland	149.5	177.5	130.6	147.3	140.4	82.9
Charles County	171.3	196.7	150.9	159.6	197.7	**
Calvert County	136.6	162.9	115.7	128.5	183.9	**
St Mary's County	169.5	168.6	172.5	167.7	199.2	**

*** Rates are not calculated for case counts less than 15.*

2014-2018 Results:

For the time period 2014-2018, the Charles County all cancer site mortality rate was 161.4 per 100,000. Charles County had a higher rate than Calvert County (158.2), a lower rate than St. Mary's County (169.9), and a higher rate than Maryland (154.8). Charles County's rate is the 12th lowest all site mortality rate among the Maryland jurisdictions. The Charles County rate falls between 10% below and 10% above the United States national rate (155.5. per 100,000).

The 2014-2018 Charles County all cancer sites mortality rate is higher in white individuals than black individuals (164.4 vs. 161.5). The Charles County White all site mortality rate was higher than the Maryland White state average rate (164.4 vs. 153.0). The Charles County African American all site mortality rate was below than the state average rate for African Americans (161.5 vs. 174.0). The Charles County Other Race all site mortality rate was higher than the Maryland Other Race state average rate (93.6 vs. 83.1).

From 2014-2018, males were more likely to die from cancer than females. Charles County males had an all-site mortality rate of 189.6 vs. 141.8 for Charles County females. The Charles County rates for males and females were slightly higher than Maryland state average rates.

2014-2018 All Cancer Site Mortality Rates (per 100,000 population)

	Total	Male	Female	White	Black	Other
Maryland	154.8	182.7	135.5	153.0	174.0	83.1
Charles County	161.4	189.6	141.8	164.4	161.5	93.6
Calvert County	158.2	187.6	137.0	157.4	179.0	**
St Mary's County	169.9	197.0	147.1	171.9	174.9	**

*** Rates are not calculated for case counts less than 15.*

Lung/Bronchus Cancer Incidence

2018 Results:

The 2018 Charles County lung and bronchus cancer incidence rate was 53.0 per 100,000 population, which is an increase from the 2016 rate of 40.7 per 100,000 population. This is the 11th lowest lung cancer incidence rate in the state of Maryland, while it was the 5th lowest incidence rate in the state of Maryland in 2016. The Charles County lung and bronchus cancer incidence rate is now above the Maryland state average rate of 50.6 per 100,000.

A comparison of Maryland lung cancer incidence by race found that rates for Whites exceeded the rates of African Americans (53.1 vs. 49.6). If you compare White lung cancer incidence rates, Charles County has a higher rate than the Maryland state average rate (59.1 vs. 53.1). Charles County African Americans had a lower rate than the Maryland state average rate (42.6 vs. 49.6).

The incidence of lung cancer was also higher among men than women in Charles County (58.0 vs. 49.1). Charles County men have a lower rate (58.0) than the Maryland state average incidence rate of 55.6 for men.

2018 Number of New Cases: Lung Cancer

	Total	Male	Female	White	Black	Other
Maryland	3807	1839	1967	2691	984	127
Charles County	92	43	48	61	28	<6
Calvert County	54	31	23	51	<6	0
St Mary's County	76	40	36	70	<6	<6

2018 Lung Cancer Incidence Rates

	Total	Male	Female	White	Black	Other
Maryland	50.6	55.6	47.0	53.1	49.6	27.0
Charles County	53	58.0	49.1	59.1	42.6	**
Calvert County	47.0	61.5	36.6	53.2	**	0.0
St Mary's County	63.5	69.4	58.9	70.4	**	**

*** Rates are not calculated for case counts less than 15.*

2014-2018 Results:

Between 2014-2018, the Charles County lung cancer incidence rate was 51.5 per 100,000

population. This rate is lower than the Maryland state average rate (54.1). This rate is lower than the rates for the other Southern Maryland jurisdictions. The Charles County rate is similar to the United States average rate of 51.4 per 100,000 population.

The lung cancer incidence rate for this time period for African Americans in Charles County is less than the rate for the Charles County white population (40.4 vs. 60.1). The African American lung cancer incidence rate is lower than the Maryland state average rate (52.3). It is higher than the Calvert County rate and higher than the St Mary's County rate. The Charles County White lung cancer incidence rate is higher than the Maryland state average rate (60.1 vs. 56.9) and is higher than the rates in the Calvert County and lower than the rate in St. Mary's County.

The rate of lung cancer incidence in Charles County was much higher for men than women (60.6 vs. 44.9). This difference is significant ($p<.05$). The rate among Charles County females was lower than the state; the rate among males was slightly higher than the state. The highest male lung cancer incidence rate in the Southern Maryland region was St Mary's County (69.9); the highest female lung cancer incidence rate in the Southern Maryland region was St. Mary's County (both at 62.6).

2014-2018 Lung Cancer Incidence Rates

	Total	Male	Female	White	Black	Other
Maryland	54.1	59.9	49.9	56.9	52.3	26.6
Charles County	51.5	60.6	44.9	60.1	40.4	**
Calvert County	52.7	56.7	51.1	56.5	33.1	**
St Mary's County	66.1	69.9	62.6	69.8	52.3	**

*** Rates are not calculated for case counts less than 15.*

Lung/Bronchus Cancer Mortality

2018 Results:

In 2018, the lung cancer mortality rate in Charles County was 28.6 per 100,000, which is lower than the Maryland state average rate of 33.4 per 100,000. The Charles County 2018 lung cancer mortality rate was higher than the Calvert County rate of 27.7 and lower than the St Mary's County rate of 45.2.

For all jurisdictions analyzed, the lung cancer mortality rate for men was greater than the rate for women. In Charles County, men were 1.2 times more likely to die from lung cancer in 2018 than women.

2018 lung cancer mortality rate for Black individuals in Charles County was higher than the mortality rate for Charles County Whites (37.3 vs. 24.9).

2018 Number of Lung Cancer Deaths

	Total	Male	Female	White	Black	Other
Maryland	2,468	1,267	1,201	1,705	686	77
Charles County	50	35	25	26	s	<10
Calvert County	33	19	14	27	<10	<10
St Mary's County	56	29	27	50	<10	<10

S= Case counts were suppressed to prevent disclosure of data in other cells.

2018 Lung Cancer Mortality Rates

	Total	Male	Female	White	Black	Other
Maryland	33.4	39.2	28.8	34.1	35.4	17.4
Charles County	28.6	31.1	26.7	24.9	37.3	**
Calvert County	27.7	**	**	26.3	**	**
St Mary's County	45.2	46.8	44.3	48.8	**	**

*** Rates are not calculated for case counts less than 15.*

2014-2018 Lung and Bronchus Age-Adjusted Mortality Results:

The Charles County 2014-2018 lung and bronchus cancer age-adjusted mortality rate was 35.7 per 100,000. This rate is similar to the Maryland state average rate of 37.1. The Charles County rate is lower than the other 2 Southern Maryland counties: 36.5 in Calvert and 49.0 in St. Mary's. The Charles County lung cancer mortality rate also falls 10% below and 10% above the United State national rate of 38.5 per 100,000.

The Charles County lung and bronchus cancer mortality rates were higher for men than women. Charles County men were 1.4 times more likely to die from lung cancer from 2014-2018 than Charles County women. The Charles County rate for men was similar to the state average rate (43.5 vs 43.9) and the Charles County rate for women was similar to the state average (30.1 vs 32.0).

When comparing rates by race, White individuals in Charles County had a greater rate of lung and bronchus cancer mortality than African Americans (39.8 vs 31.4). The lung and bronchus cancer mortality rate among Charles County White individuals was similar to the Maryland state average rate (39.8 vs 38.6), and the lung and bronchus cancer mortality rate among Charles County African Americans was lower than the Maryland state average rate (31.4 vs 37.3).

2014-2018 Lung Cancer Mortality Rates

	Total	Male	Female	White	Black	Other
Maryland	37.1	43.9	32.0	38.6	37.3	17.4
Charles County	35.7	43.5	30.1	39.8	31.4	**
Calvert County	36.5	39.1	34.6	37.7	30.5	**
St Mary's County	49.0	57.5	41.5	49.4	52.3	**

*** Rates are not calculated for case counts less than 15.*

Colon and Rectal Incidence

2018 Results:

For 2018, Charles County had a colon and rectal cancer incidence rate of 34.6 per 100,000. This rate is slightly lower than the Maryland state average rate of 36.4 per 100,000.

The colon and rectal cancer incidence rates for Charles County males is higher than Charles County females for 2018 (38.4 vs 32.0). The Charles County male colon and rectal cancer incidence rate for 2018 was 38.4 per 100,000, which is slightly lower than the Maryland state average rate for males at 41.1. The Charles County female colon and rectal cancer rate is 32.0, like the Maryland state rate of 32.8.

The 2018 Charles County colon and rectal cancer incidence rate was higher for African Americans compared to White individuals (46.6 vs 26.3). This is a significant change from 2016, where White individuals (43.9) had a higher rate compared to African Americans (37.4). The 2018 Charles County White colon and rectal cancer incidence rate was lower than the Maryland state rate (26.3 vs 35.0), lower than the Calvert County rate (36.6), and lower than the St. Mary's County rate (32.7). The 2018 Charles County African American colon and rectal cancer incidence rate was higher than the Maryland African American colon and rectal cancer incidence rate (46.6 vs 40.8).

Number of New Colon and Rectal Cancer Cases, 2018

	Total	Male	Female	White	Black	Other
Maryland	2,597	1,327	1,270	1,635	801	129
Charles County	60	30	30	26	31	<6
Calvert County	39	23	16	32	6	0
St Mary's County	42	21	21	33	s	<6

s= Case counts were suppressed to prevent disclosure of data in other cells.

2018 Colon and Rectal Cancer Incidence Rates

	Total	Male	Female	White	Black	Other
Maryland	36.4	41.1	32.8	35.0	40.8	26.7
Charles County	34.6	38.4	32.0	26.3	46.6	**
Calvert County	37.3	44.5	32.5	36.6	**	0.0
St Mary's County	33.3	35.5	31.7	32.7	**	**

*** Rates are not calculated for case counts less than 15.*

2014-2018 Results:

For the time period 2014-2018, Charles County had a colon and rectal cancer incidence rate higher than the Maryland state average rate (40.1 vs. 36.1). This rate is between 10% below to 10% above the United States rate of 38.0 per 100,000.

Rates were higher for Charles County men than Charles County women (42.9 vs. 37.8). This gender disparity was much larger for the state of Maryland (40.6 for MD males vs. 32.5 for MD females).

Charles County Whites and African Americans had a similar colon and rectal incidence rate (40.9 vs. 41.1). Charles County Whites had a higher rate than Maryland Whites (40.9 vs. 35.1), and Charles County African Americans also had a slightly higher rate compared to Maryland African Americans (41.1 vs. 39.6).

2014-2018 Colon and Rectal Cancer Incidence Rates

	Total	**Male**	**Female**	**White**	**Black**	**Other**
Maryland	36.1	40.6	32.5	35.1	39.6	24.8
Charles County	40.1	42.9	37.8	40.9	41.1	**
Calvert County	40.9	46.8	35.9	40.1	50.9	0
St Mary's County	32.9	37.5	29.0	32.6	38.3	**

*** Rates are not calculated for case counts less than 15.*

Colon and Rectal Cancer Mortality

2018 Results:

The Charles County colon and rectal cancer mortality rate for 2018 was 15.0 per 100,000. This is slightly above than the Maryland state average rate of 13.6. Rates for Calvert and St. Mary's are not available due to small case counts.

Gender and race comparisons cannot be done since case counts were too few to calculate mortality rates.

Number of Colon and Rectal Cancer Deaths, 2018

	Total	Male	Female	White	Black	Other
Maryland	982	528	454	617	327	38
Charles County	24	s	<10	<10	16	<10
Calvert County	<10	<10	<10	<10	<10	<10
St Mary's County	15	<10	<10	14	<10	<10

s= Case counts were suppressed to prevent disclosure of data in other cells.

2018 Colon and Rectal Cancer Mortality Rates

	Total	Male	Female	White	Black	Other
Maryland	13.6	16.5	11.3	12.7	17.3	8.0
Charles County	15.0	**	**	**	**	**
Calvert County	**	**	**	**	**	**
St Mary's County	**	**	**	**	**	**

*** Rates are not calculated for case counts less than 15.*

2014-2018 Results:

The 2014-2018 Charles County colon and rectal cancer mortality rate of 15.8 per 100,000 is higher than the Maryland state average rate of 13.7 and the other Southern Maryland counties (12.6 for Calvert and 12.6 for St. Mary's County).

Charles County males were more likely to die from colon and rectal cancer than Charles County females (17.6 vs. 13.8) from 2014-2018. This trend was also seen for Maryland and the other Southern Maryland counties.

2014-2018 Charles County colon and rectal cancer mortality rates for African Americans were higher than the rates for Charles County Whites (17.5 vs. 14.7).

2014-2018 Colon and Rectal Cancer Mortality Rates

	Total	Male	Female	White	Black	Other
Maryland	13.7	16.4	11.6	13.0	17.0	7.3
Charles County	15.8	17.6	13.8	14.7	17.5	**
Calvert County	12.6	16.3	9.7	12.2	**	**
St. Mary's County	12.6	16.6	8.9	13.1	**	**

*** Rates are not calculated for case counts less than 15.*

Breast Cancer Incidence

2018 Results:

The 2018 Charles County female breast cancer incidence rate was 110.9, which was lower than the Maryland state average rate of 129.9 per 100,000. The 2018 female Charles County rate (110.9) was lower than the rate of St. Mary's County (133.5) and lower than the rate of Calvert County (148.0). This is significantly different from 2016, where the Charles County rate (122.6) was higher than the St. Mary's County rate (106.2) and the Calvert County rate (106.7).

The 2018 Charles County female breast cancer incidence rate was higher for Black individuals (126.8) compared to White (104.2). This is different from 2016, where the Charles County incidence for Black individuals was 120.8 and the White incidence rate was 125.1. The 2018 Charles County breast cancer incidence for White individuals was lower than the Maryland rate (104.2 vs. 132.3) and the rate for Black individuals was similar to the Maryland rate (126.8 vs. 126.5). The Maryland rate for White individuals was higher than Black Individuals in 2018 (132.3 vs. 126.5).

Number of New Breast Cancer Cases, 2018

	Total	White	Black	Other
Maryland	4,967	3,179	1,472	255
Charles County	108	s	58	<6
Calvert County	80	67	10	<6
St. Mary's County	86	68	s	<6

s= Case counts were suppressed to prevent disclosure of data in other cells.

2018 Breast Cancer Incidence Rates

	Total	White	Black	Other
Maryland	129.9	132.3	126.5	92.2
Charles County	110.9	104.2	126.8	**
Calvert County	148.0	151.3	**	**
St Mary's County	133.5	129.0	189.8	**

*** Rates are not calculated for case counts less than 15.*

2014-2018 Results:

From 2014-2018, Charles County had a female breast cancer incidence rate of 118.6. This rate was lower than the Maryland state average rate of 130.8 and the Calvert County rate of 129.5, and similar to the St. Mary's County rate of 118.9. It is below the US rate of 127.4 per 100,000.

The Charles County White breast cancer incidence rate was 124.0, which was less than the Maryland White state average rate (132.3). The Charles County Black breast cancer incidence rate was also below the Maryland state average rate (117.3 vs. 129.3).

Charles County African Americans had a lower incidence of breast cancer (117.3) than Charles County White women (124.0) from 2014-2018.

2014-2018 Breast Cancer Incidence Rates

	Total	White	Black	Other
Maryland	130.8	132.3	129.3	90.4
Charles County	118.6	124.0	117.3	**
Calvert County	129.5	128.1	137.7	**
St Mary's County	118.9	118.7	135.5	**

*** Rates are not calculated for case counts less than 15.*

Breast Cancer Mortality

2018 Results:

The 2018 Charles County female breast cancer mortality rate was 32.4 per 100,000. This rate was higher than Maryland state average rate of 21.2 per 100,000. This was the highest rate among the other Maryland jurisdictions with a calculated rate. The Maryland rate for White Individuals was lower than the rate for Black Individuals (19.1 vs. 27.7). County Breast cancer mortality rates could not be calculated by race or gender for 2018 due to small case counts in Charles County and other jurisdictions.

Number of Breast Cancer Deaths, 2018

	Total	White	Black	Other
Maryland	838	499	311	28
Charles County	29	14	s	<10
Calvert County	12	<10	<10	<10
St Mary's County	17	11	<10	<10

s= Case counts were suppressed to prevent disclosure of data in other cells.

2018 Breast Cancer Mortality Rates

	Total	White	Black	Other
Maryland	21.2	19.1	27.7	10.6
Charles County	32.4	**	**	**
Calvert County	**	**	**	**
St Mary's County	**	**	**	**

*** Rates are not calculated for case counts less than 15.*

2014-2018 Results:

From 2014-2018, Charles County experienced a breast cancer mortality rate of 26.8 per 100,000. The 2014-2018 Charles County rate is higher than the Maryland state average rate of 21.8. The Charles County rate is higher than the rate for St. Mary's County (22.7) and higher than the rate for Calvert County (23.9). The Charles County breast cancer mortality rate is 25-30% above the United States breast cancer mortality rate of 20.1 per 100,000.

The 2014-2018 Charles County African American female breast cancer mortality rate was 31.0, which was higher than the rate for Charles County Caucasians of 23.6 per 100,000. Rates by race could not be calculated for the other Southern Maryland counties due to small case counts.

2014-2018 Breast Cancer Mortality Rates

	Total	White	Black	Other
Maryland	21.8	19.8	27.8	10.3
Charles County	26.8	23.6	31.0	**
Calvert County	23.9	22.1	**	**
St Mary's County	22.7	20.5	**	**

*** Rates are not calculated for case counts less than 15.*

Prostate Cancer Incidence

2018 Results:

The 2018 Charles County prostate cancer incidence rate was 144.2 per 100,000. This rate was higher than the Maryland state average rate of 135.3. The Charles County incidence rate is higher than the rates in the other Southern Maryland counties (104.7 in Calvert and 102.5 in St. Mary's counties).

Disparities are evident for African Americans in terms of prostate cancer incidence. The 2018 Charles County African American prostate cancer incidence rate was 189.7, which was higher than the rate for Charles County Caucasians of 111.3 per 100,000. This disparity is also seen on the state level where Maryland African Americans had a rate of 191.0 and Maryland Whites had a rate of 117.4 per 100,000. These disparities are statistically significant.

Number of New Prostate Cancer Cases, 2018

	Total	White	Black	Other
Maryland	4,849	2,874	1,776	119
Charles County	125	56	65	<6
Calvert County	65	50	13	<6
St Mary's County	65	48	15	<6

S= Case counts were suppressed to prevent disclosure of data in other cells.

2018 Prostate Cancer Incidence Rates

	Total	White	Black	Other
Maryland	135.3	117.4	191.0	53.2
Charles County	144.2	111.3	189.7	**
Calvert County	104.7	96.9	**	**
St Mary's County	102.5	90.3	**	**

*** Rates are not calculated for case counts less than 15.*

2014-2018 Results:

The Charles County prostate cancer incidence rate for 2014-2018 was 147.1 per 100,000 population. This rate is higher than the Maryland state average rate of 126.3. Charles County had the second highest 2014-2018 prostate cancer incidence rate among the 24 Maryland jurisdictions. The Charles County rate was also higher than the other Southern Maryland counties for this time period (112.4 for Calvert and 89.7 for St Mary's). The Charles County rate is more than 25% above the United States rate of 108.2 per 100,000.

Disparities are again visible for African Americans. The 2014-2018 Charles County African American prostate cancer incidence rate was 190.4, which was significantly higher than the rate for

Charles County Caucasians of 117.7 per 100,000. This disparity is also seen on the state level where Maryland African Americans had a rate of 186.7 and Maryland Whites had a rate of 107.2. The same disparities were also seen for Calvert and St Mary's counties.

The 2014-2018 Charles County African American prostate cancer incidence rate was higher than the Maryland state average rate and the other Southern Maryland counties (112.4 for Calvert and 89.7 for St. Mary's County). It is the second highest rate among the Maryland jurisdictions.

2014-2018 Prostate Cancer Incidence Rates

	Total	White	Black	Other
Maryland	126.3	107.2	186.7	59.6
Charles County	147.1	117.7	190.4	**
Calvert County	112.4	102.6	190.8	**
St Mary's County	89.7	80.0	149.6	**

*** Rates are not calculated for case counts less than 15.*

Prostate Cancer Mortality

2018 Results:

For 2018, case counts for Charles, St Mary's, and Calvert counties were too small to calculate prostate cancer mortality rates. The Maryland prostate cancer rate was 19.1 per 100,00 in 2018. The number of case counts is presented in the table below.

Number of Prostate Cancer Deaths, 2018

	Total	White	Black	Other
Maryland	559	337	210	12
Charles County	15	<10	<10	<10
Calvert County	<10	<10	<10	<10
St Mary's County	12	11	<10	<10

2014-2018 Results:

The 2014-2018 Charles County prostate cancer mortality rate was 20.5 per 100,000. This rate is above the Maryland state average rate of 19.9. The Charles County rate is similar to the Calvert County rate (22.1) and the St. Mary's rate (18.9). The county prostate cancer mortality rate is similar to the United States rate of 19.0 per 100,000.

Disparities are again seen for the African American population. Charles County African Americans have a higher prostate cancer mortality rate of 29.3 compared to 17.9 for Charles County Caucasians.

2014-2018 Prostate Cancer Mortality Rates

	Total	White	Black	Other
Maryland	19.9	16.3	35.4	7.4
Charles County	20.5	17.9	29.3	**
Calvert County	22.1	18.9	**	**
St Mary's County	18.9	18.9	**	**

*** Rates are not calculated for case counts less than 15.*

Note: For three of the remaining cancer sites: oral, melanoma of the skin, and cervical, only 2014-2018 incidence data will be presented. Case counts for 2018 alone were few, and rate calculations could not be performed.

Oral Cancer Incidence

The Charles County oral cancer incidence rate for 2014-2018 was 13.2. This rate is greater than the Maryland state average rate of 11.1. The Charles County oral cancer incidence rate is about 15% above the United States rate of 11.5 per 100,000.

Charles County White individuals had a higher oral cancer incidence rate than Charles County Black individuals (16.6 vs. 8.0).

Males are disproportionately affected by oral cancer compared to women. The 2014-2018 Charles County oral cancer incidence rate for males was 23.3, which is significantly higher than the oral cancer incidence rate for women (5.0).

2014-2018 Oral Cancer Incidence Rates

	Total	Male	Female	White	Black	Other
Maryland	11.1	16.9	6.2	12.7	8.0	6.2
Charles County	13.2	23.3	5.0	16.6	8.0	**
Calvert County	11.7	16.3	6.9	12.1	**	0.0
St Mary's County	17.5	25.6	9.6	17.7	17.9	**

*** Rates are not calculated for case counts less than 15.*

Note: For the remaining three cancer sites: oral, melanoma of the skin, and cervical, only 2014-2018 mortality data will be presented. Charles County case counts for 2018 alone were few, and rate calculations could not be performed.

Oral Cancer Mortality

For 2014-2018, the Charles County oral cancer mortality rate was 3.4 per 100,000. This is higher than the Maryland state average rate of 2.5 per 100,000. The Charles County oral cancer mortality for 2014-2018 was about 35% above the US average rate of 2.5 per 100,000.

Even for a combined time period of 2014-2018, deaths due to oral cancer are few, and rate calculations by race and gender were not possible.

2014-2018 Oral Cancer Mortality Rates

	Total	Male	Female	White	Black	Other
Maryland	2.5	3.9	1.3	2.6	2.4	1.5
Charles County	3.4	5.8	**	**	**	**
Calvert County	**	**	**	**	**	**
St Mary's County	3.4	**	**	4.0	**	**

*** Rates are not calculated for case counts less than 15.*

Melanoma of the Skin Incidence

2014-2018 Results:

For 2014-2018, the Charles County melanoma cancer incidence rate of 15.9 was per 100,000. This rate was less than the Maryland state average rate of 24.1 per 100,000, and it was less than the rates in the other Southern Maryland counties (Calvert 30.8 and St Mary's 27.5). The Charles County rate was about 33% below the United States rate of 23.9 per 100,000.

The incidence rate for melanoma cancer is higher for Charles County males than females (24.3 vs. 9.7). This rate difference is also seen on the state level for men and women (31.8 vs. 18.5).

A comparison of incidence rates by race can't be done due to small case counts for minorities in Charles County. However, it should be noted that Charles County Whites had a lower melanoma cancer incidence rate (26.9) than Maryland Whites (35.6). On a state level, Maryland Whites were disproportionately affected by melanoma cancer incidence compared to Maryland African Americans (35.6 vs. 1.0).

2014-2018 Melanoma Incidence Rates

	Total	Male	Female	White	Black	Other
Maryland	24.1	31.8	18.5	35.6	1.0	1.7
Charles County	15.9	24.3	9.7	26.9	**	**
Calvert County	30.8	39.6	23.8	35.9	0.0	0.0
St Mary's County	27.5	32.6	23.0	31.8	**	0.0

*** Rates are not calculated for case counts less than 15.*

Melanoma of the Skin Mortality

Mortality rates on a county level are not available due to small case counts. For the state of Maryland, the 2014-2018 melanoma of the skin cancer mortality rate was 1.9 per 100,000. The rates were higher for males than females (2.8 vs. 1.2), and the rates were much higher for Whites than Blacks (2.6 vs. 0.3).

2014-2018 Melanoma of the Skin Mortality Rate

	Total	Male	Female	White	Black	Other
Maryland	1.9	2.8	1.2	2.6	0.3	**
Charles County	**	**	**	**	**	**
Calvert County	**	**	**	**	**	**
St Mary's County	**	**	**	**	**	**

*** Rates are not calculated for case counts less than 15.*

Cervical Cancer Incidence

The 2014-2018 Charles County cervical cancer incidence rate was 6.2 per 100,000, which is slightly below the Maryland state average rate of 6.6. Rates could not be calculated for Calvert County due to a small case count. St Mary's County had a rate of 5.4. Charles County had a cervical cancer incidence rate that was greater than 18% below the United States rate of 7.6 per 100,000.

A rate comparison by gender and race is not included due to small case counts and the inability to calculate specific rates on a county level.

2014-2018 Cervical Cancer Incidence Rates

	Total	White	Black	Other
Maryland	6.6	6.5	6.9	4.6
Charles County	6.2	**	**	**
Calvert County	**	**	0.0	0.0
St Mary's County	5.4	**	**	0.0

*** Rates are not calculated for case counts less than 15.*

Cervical Cancer Mortality

Mortality rates on a county level are not available due to small case counts. For the state of Maryland, the 2014-2018 cervical cancer mortality rate was 1.9 per 100,000. The rate was double for Maryland African Americans compared to Maryland Caucasians (2.8 vs. 1.6).

2014-2018 Cervical Cancer Mortality Rates

	Total	White	Black	Other
Maryland	1.9	1.6	2.8	1.7
Charles County	**	**	**	**
Calvert County	**	**	**	**
St Mary's County	**	**	**	**

*** Rates are not calculated for case counts less than 15.*

Cancer References

1. 2021 Maryland Vital Statistics Report. Available at: https://health.maryland.gov/vsa/Pages/reports.aspx
2. 2021 Cancer in Maryland Report. Available at: https://health.maryland.gov/phpa/cancer/Documents/2021%20CRF%20Cancer%20Report_FINAL.pdf

Qualitative Data Relating to Cancer

On the long survey, Cancer had the 18th highest percentage of people reporting it as a serious health problem. 57% felt that it was a health problem in Charles County on any level, and 27.4% reported it as a "serious problem."

16.31% of long survey participants reported that they have seen improvements in Charles County in terms of cancer. There are many long-standing programs for early screening, detection, treatment, and support of cancer.

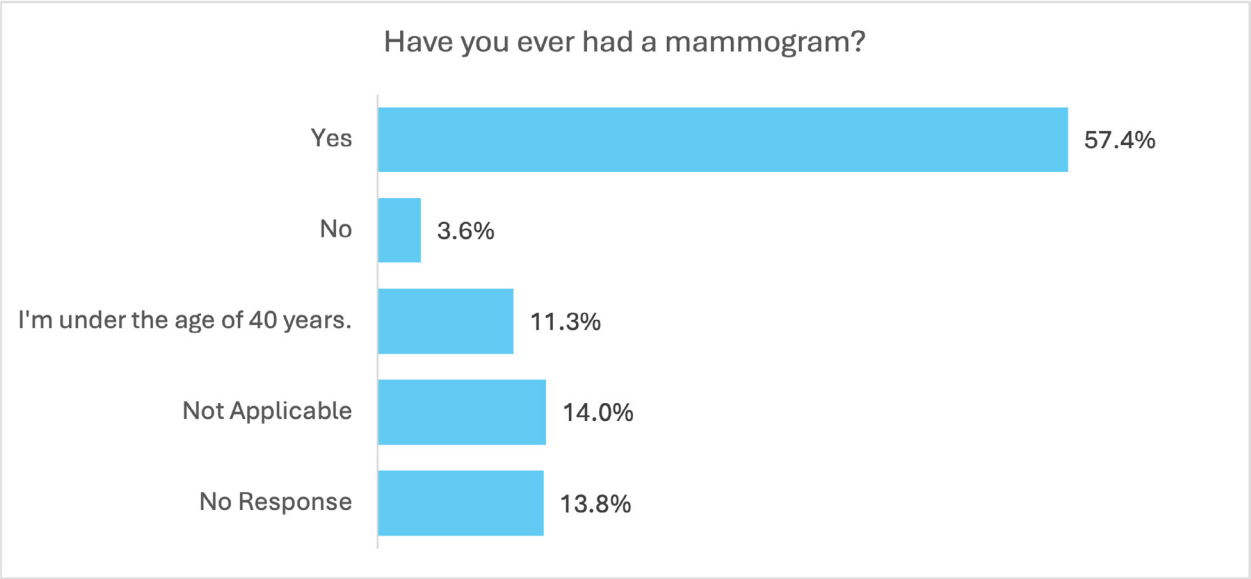
In regard to health behaviors and risk factors that could increase or decrease county residents' chances of developing cancer, 9.0% smoke cigarettes or cigars, 4% use e-cigarettes, 20.6% are exposed to secondhand smoke at home or work, 8.5% eat 5 or more servings of fruit and vegetables each day, 8.3% always perform cancer self-exams, 17.9% report always using sunscreen, and 16.2% participate in physical activity each day.

Long survey participants were asked a series of questions regarding cancer screenings and exposure to secondhand smoke.

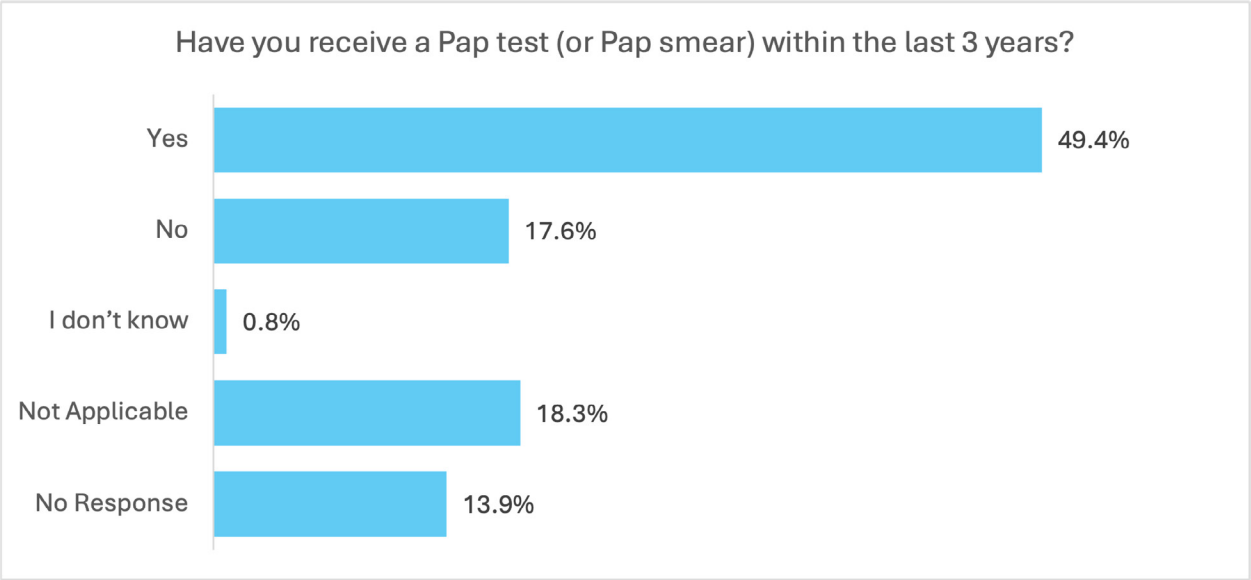
Cancer Screenings/Prevention

Screening for cancer has become a vital prevention strategy in detecting cancer early in patients and increasing the chances of survival. Survey participants were asked to answer questions regarding their own cancer prevention strategies by using screenings.

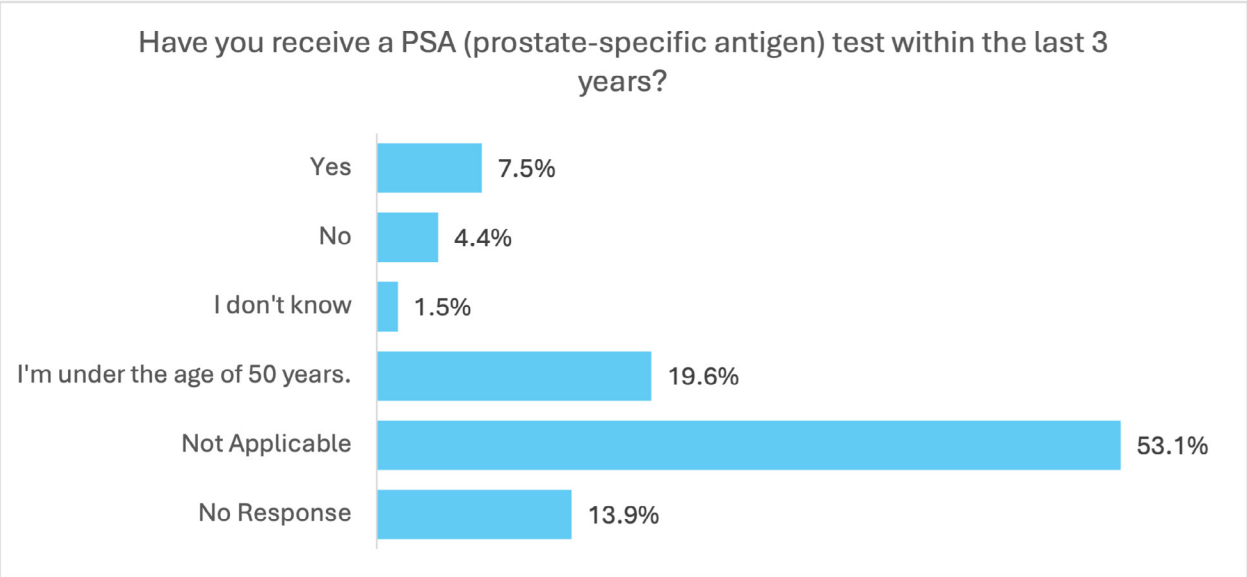
When asked if they have ever had a mammogram, 57.4% of participants reported that they have had a mammogram in the past compared to 3.6% who reported they have not had a mammogram. Over 11% of survey participants reported that they are under the age of 40, meaning they are too young to have mammogram.



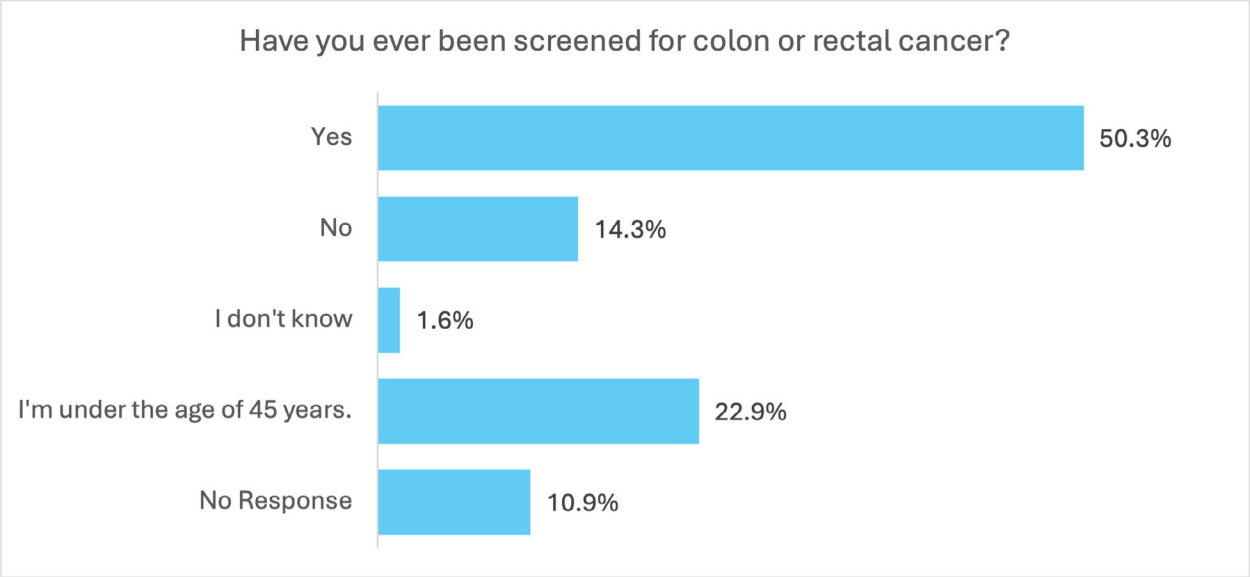
Almost 50% of survey participants reported that they have received a Pap test or Pap smear in the last 3 years, while over 17% of participants reported that they have not received a Pap test in the last 3 years.



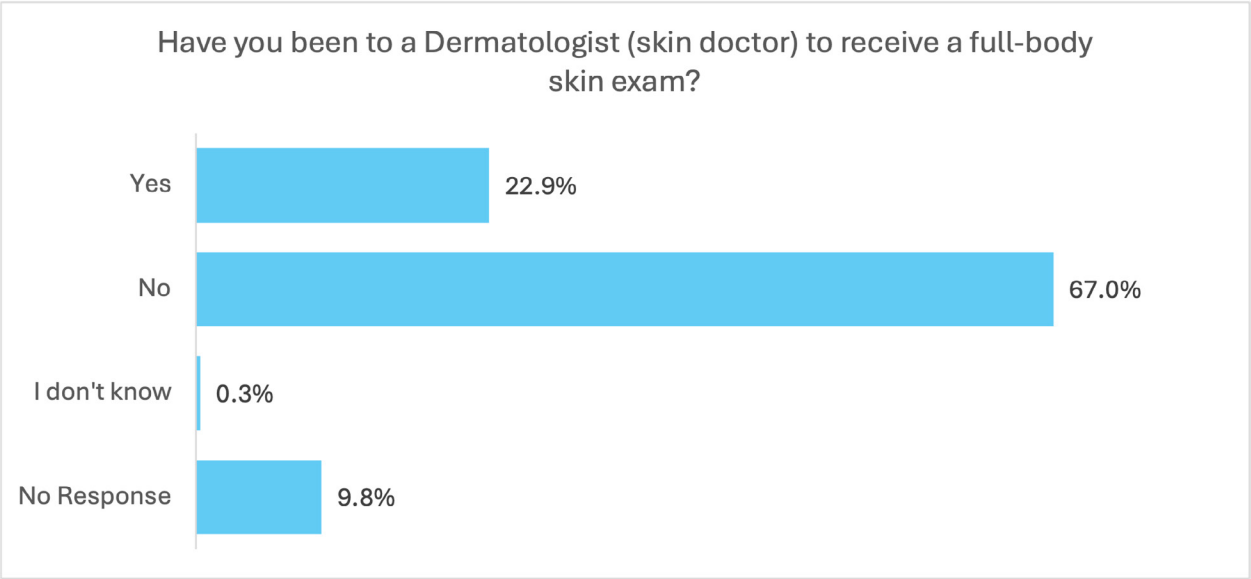
A smaller percentage of participants reported having a PSA test in the last 3 years, at 7.5%. This small percentage may be due to the fact that almost 80% of survey participants reported female as their sex assigned at birth. 53.1% reported that this question was not applicable to them.



0.3% of survey respondents reported that they have been screened for colon or rectal cancer in the past, while 14.3% of respondents reported they have not been screened for colon or rectal cancer. About 23% of respondents reported that they are under the age of 45, resulting in them being too young for colon or rectal screenings at this time.

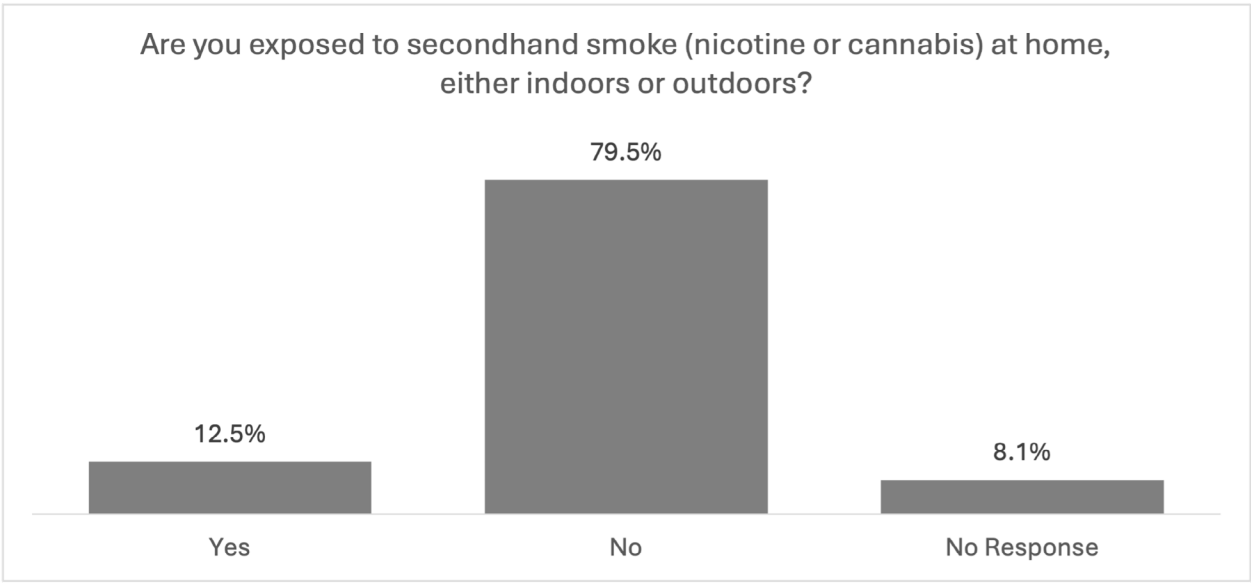


The majority of survey respondents reported that they have not been to a Dermatologist in the last year for a full-body skin exam (67.0%). About 23% of respondents reported that they have received a full-body skin exam in the last year.

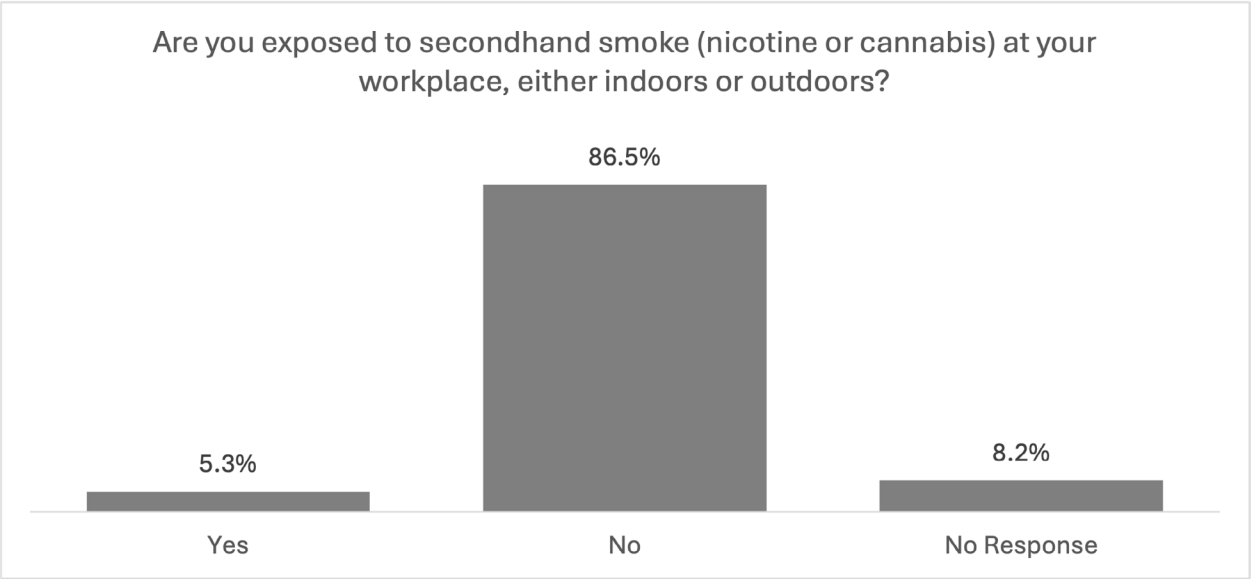


Secondhand Smoke

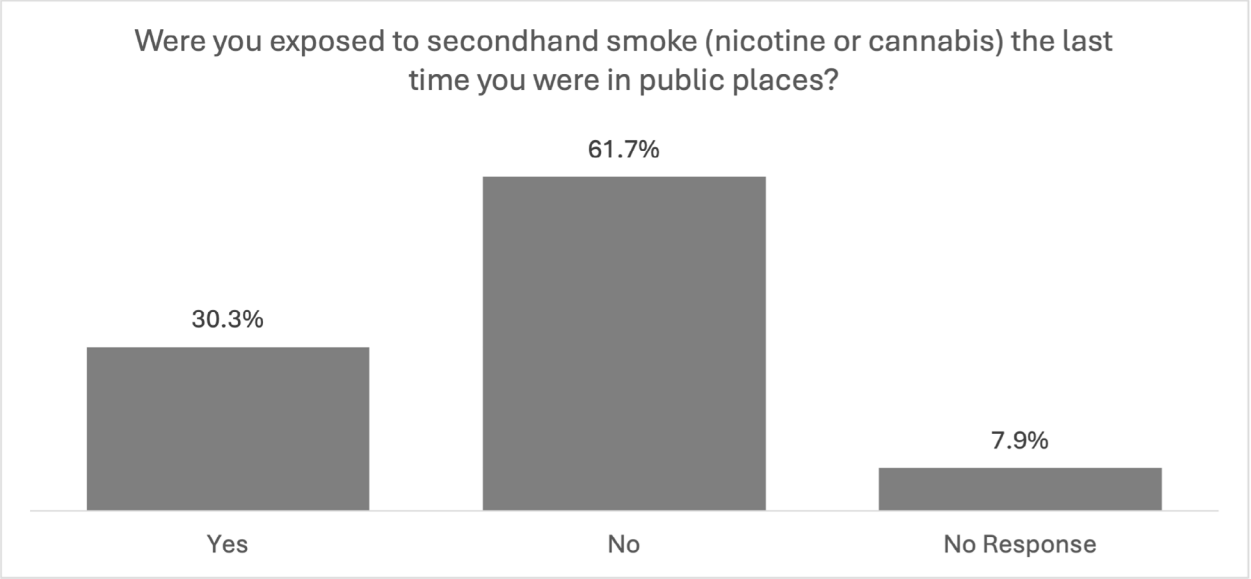
Survey respondents were also asked about their exposure to secondhand smoke, in their home or out in the community. Almost 80% of respondents reported that they are not exposed to secondhand smoke at home. 12.5% of respondents reported that they are exposed to secondhand smoke at their home, either indoors or outdoors.



A larger percentage of respondents reported that they are not exposed to secondhand smoke at their workplace. Just over 5% of respondents reported that they are exposed to secondhand smoke at work.



When asked if they were exposed to secondhand smoke in public places, a larger percentage of survey respondents reported that they were (30.3%). Just under 62% of respondents reported that they were not exposed to secondhand smoke the last time they were in public places.



Over one-third of short survey participants (36.2%) felt that Cancer is big health problems in Charles County. 40.3% of respondents believe that there are some or many resources available in Charles County for cancer.

The Access to Care focus group participants discussed the need for preventive cancer screenings. It is important for women to get mammograms. The University of Maryland Charles Regional Imaging offers services such as 3D mammography to detect smaller masses and provide a

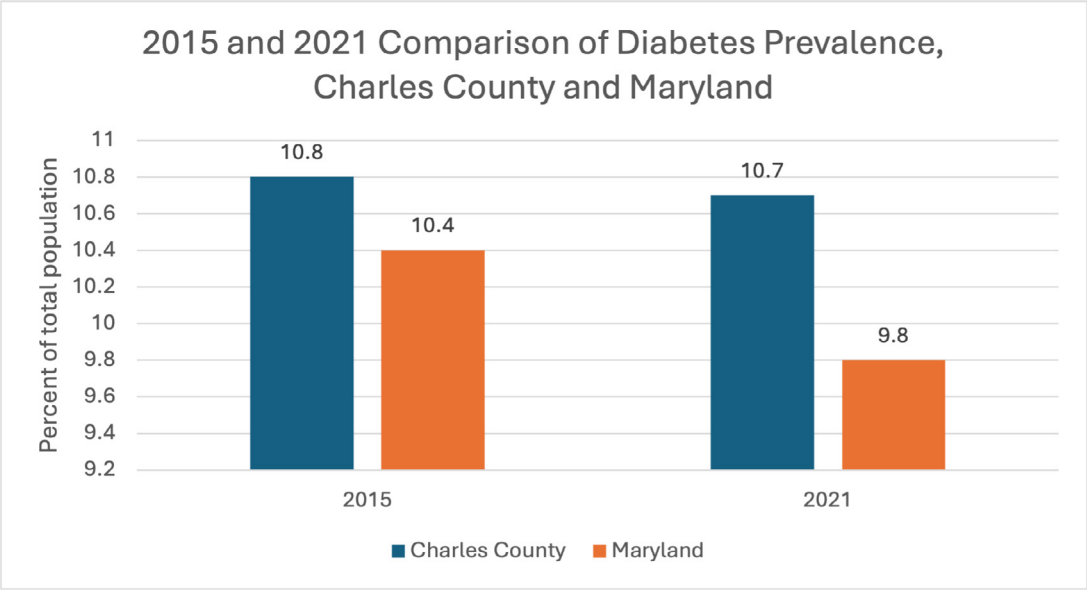
holistic view of breast tissue, ultrasound (with extended hours), low dose CT, walk-in x-rays, and provides lower rates than hospitals (40-60% less for uninsured). The Charles County Department of Health offer a cancer program to assist residents with access to recommended cancer screening services at no cost to them. The following services may be provided based on screening and medical history: Clinical Breast Exam, Mammogram, PAP test, Diagnostic services following an abnormal breast or cervical cancer screening, and Colonoscopy. They must be a Maryland resident, be uninsured or underinsured, and have limited income.

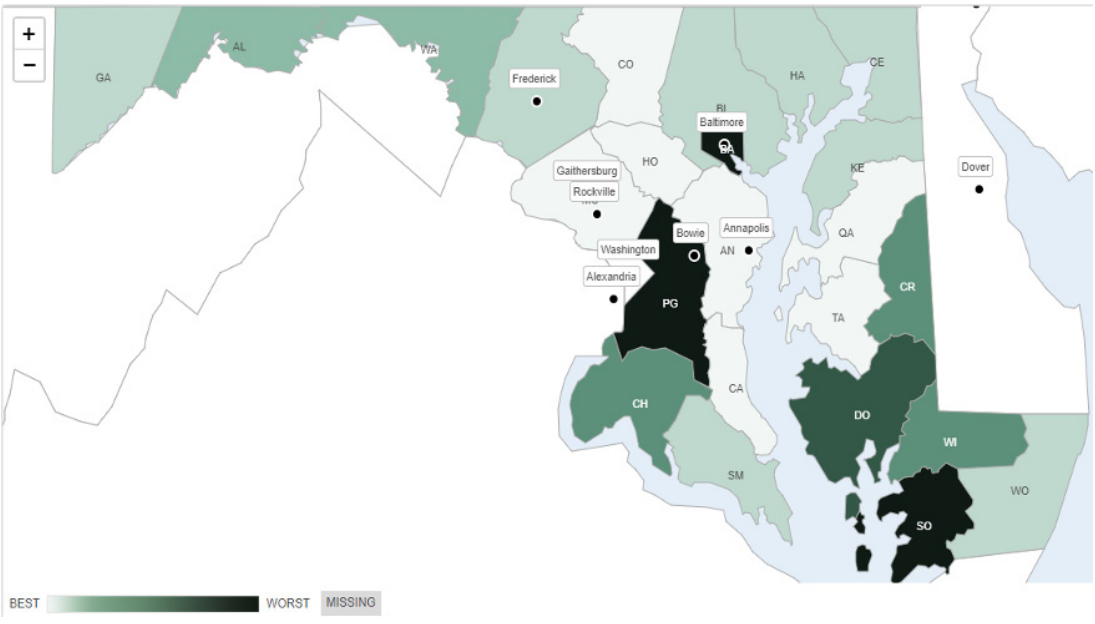
Diabetes Mellitus:

Diabetes Prevalence

2021 Maryland Behavioral Risk Factor Surveillance System (BRFSS) can be used to estimate diabetes prevalence within Charles County and Maryland. Diabetes prevalence percentages have been age-adjusted and weighted to reflect the Maryland and Charles County populations.

BRFSS participants were asked the question, "Have you ever been told by a doctor that you have diabetes?" The estimated prevalence of diabetes in Charles County is 10.7%, higher than the state diabetes prevalence of 9.8%. The county diabetes prevalence has remained stable over the last few years, and the 2021 rate is similar to the 2019 rate from the last needs assessment report (10.7% vs. 10.4%).





Diabetes Mellitus Death Rates

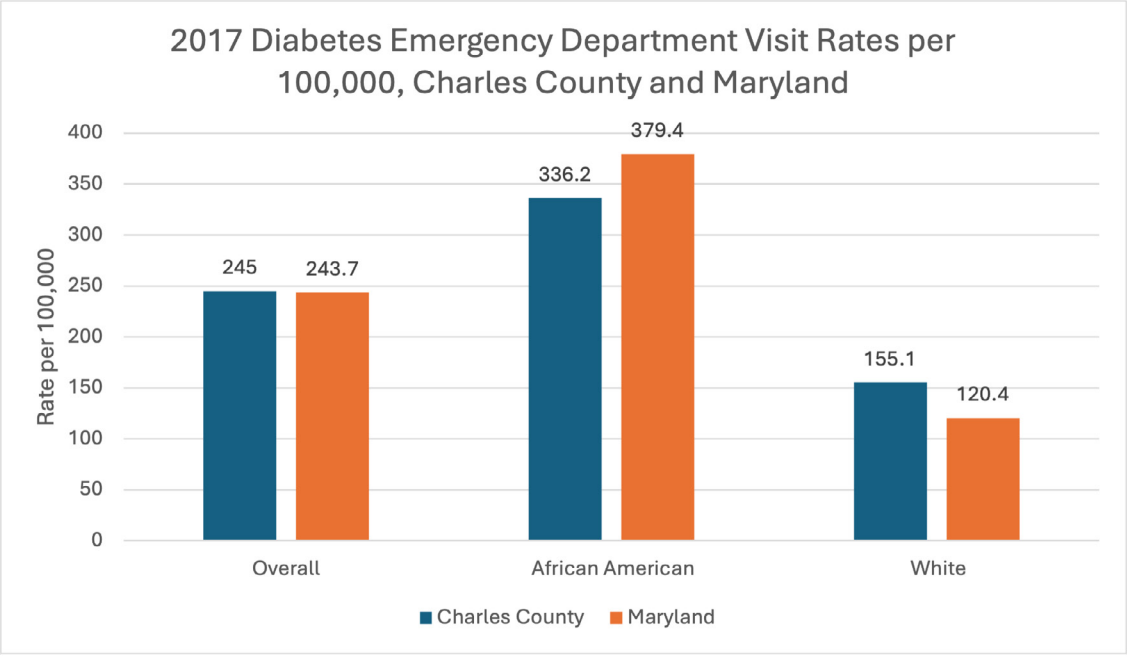
According to the 2021 Maryland Vital Statistics Report, there were 70 deaths in Charles County attributed to Diabetes mellitus in 2021. When comparing the 2021 crude diabetes death rates per 100,000 population, the Charles County rate of 41.5 per 100,000 was greater than the state rate of 28.0 per 100,000. This is a large increase from the 2018 diabetes death rate of 29.1 per 100,000 reported in the previous needs assessment report.

Number of Diabetes Deaths and Crude Diabetes Death Rates, Charles County vs. Maryland, 2021		
Jurisdiction	Number of Deaths	Death Rate per 100,000
Charles County	70	41.5
Maryland	1731	28.0

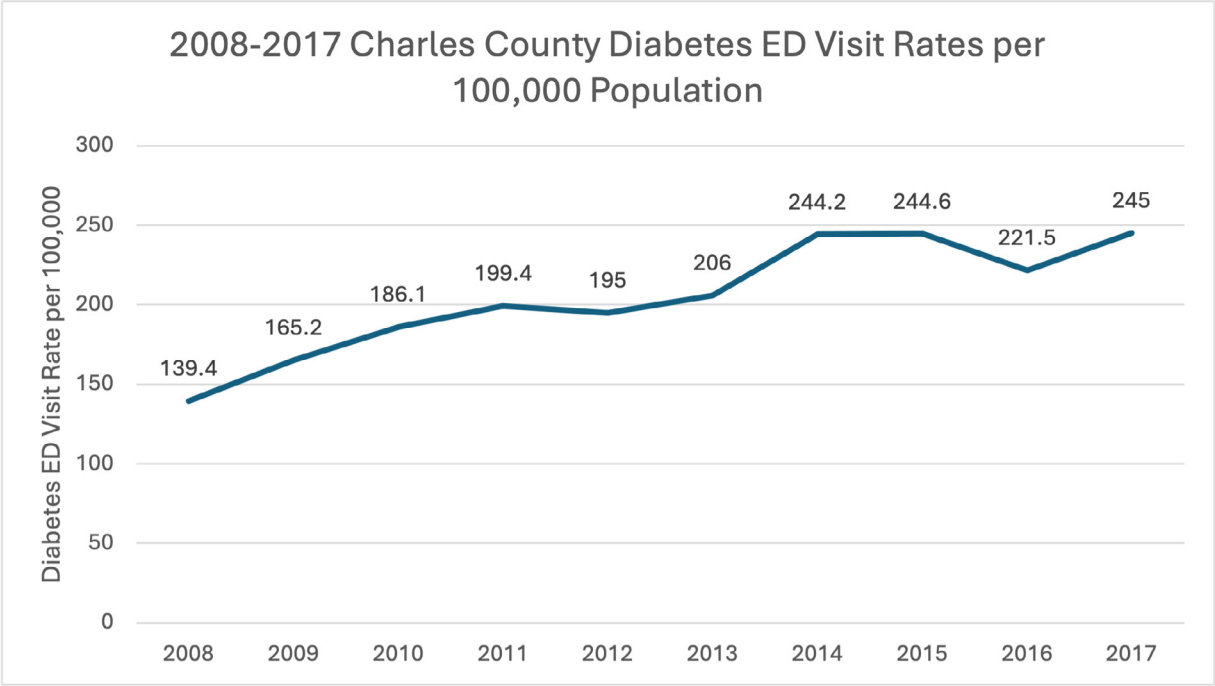
The age-adjusted death rate for Diabetes mellitus for 2021 in Charles County was 39.6 (per 100,000 populations). It was higher than the state diabetes death rate of 22.7 per 100,000.

Diabetes Emergency Department Visit Rates

The 2017 Charles County Diabetes Emergency Department (ED) Visit Rate was 245.0 per 100,000. This rate was similar to the Maryland state average rate of 243.7 per 100,000. Disparities can be seen on a state and county level where African Americans have a much higher diabetes ED visit rate than Whites. For Charles County, the African American diabetes ED visit rate was 336.2, which was significantly higher than the White rate of 155.1 per 100,000.

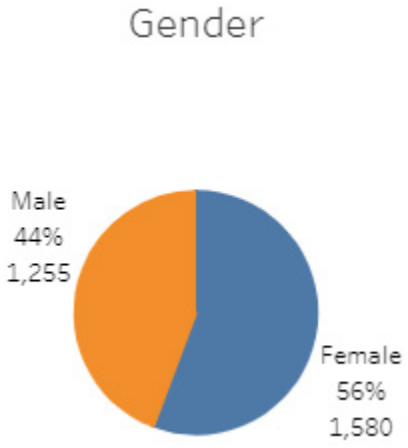


Looking at trends over the past 7 years, the Charles County Diabetes ED visit rate has increased from 139.4 in 2008 to 245 in 2017.

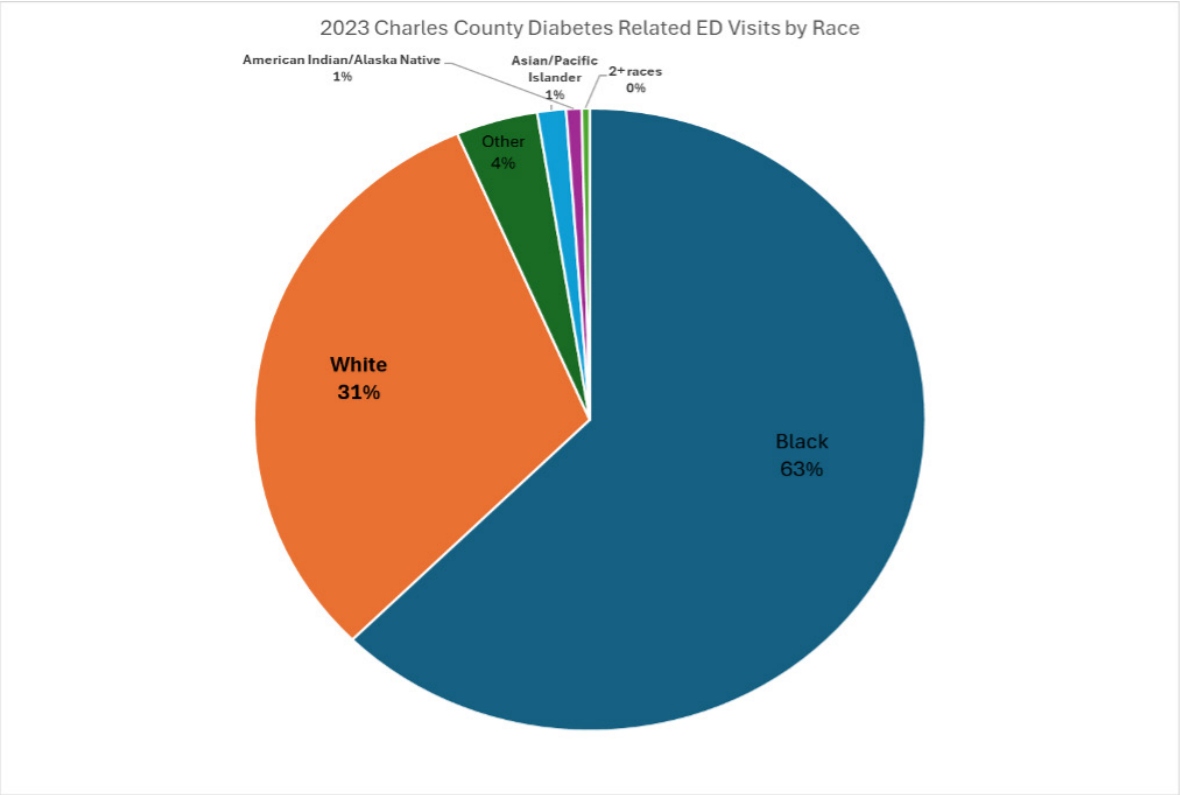


The Chesapeake Regional Information Sharing for our Patients or CRISP, is the health information exchange for the state of Maryland. CRISP Reporting Services provides public health dashboards with queries for emergency department and inpatient stays by demographics for many health conditions including diabetes.

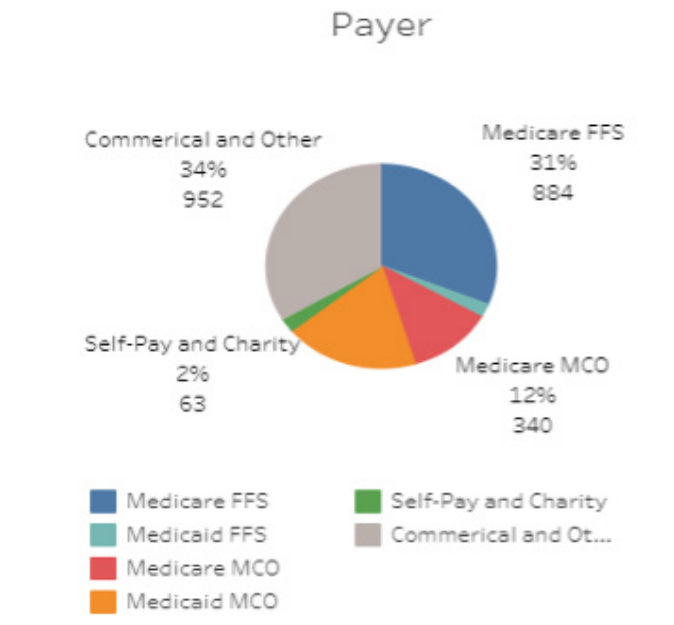
In 2023, there were 2,835 emergency department (ED) visits for Charles County residents related to diabetes. 66.3% of those ED visits were at the University of Maryland Charles Regional Medical Center. The next highest facility was MedStar Southern Maryland Hospital with 13.7% of the ED visits. In Charles County, females have more diabetes-related ED visits than males (1,580 vs. 1,255).



Charles County African Americans are disproportionately affected by diabetes-related ED visits and make up 63% of the total diabetes-related ED visits for Charles County residents.



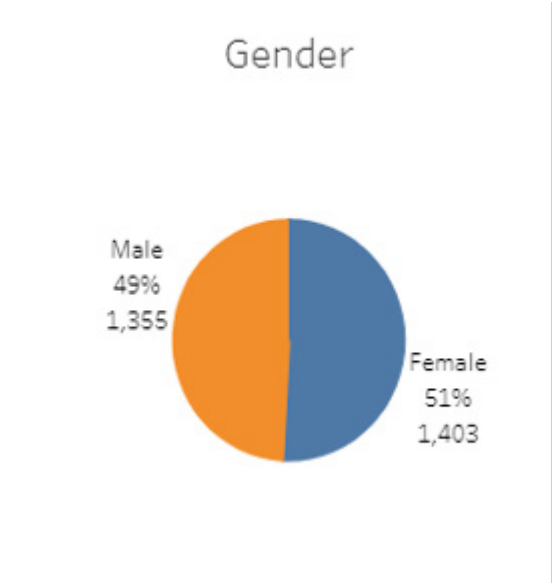
When examining by payer source, the largest payer is Medicare followed by Commercial/Other insurance.

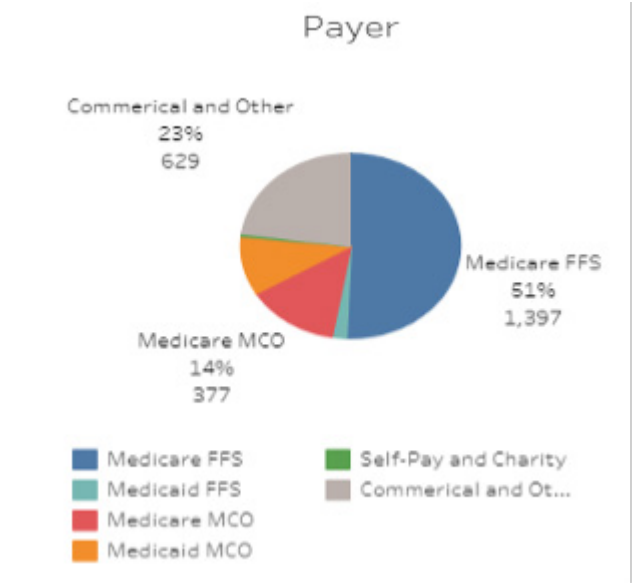


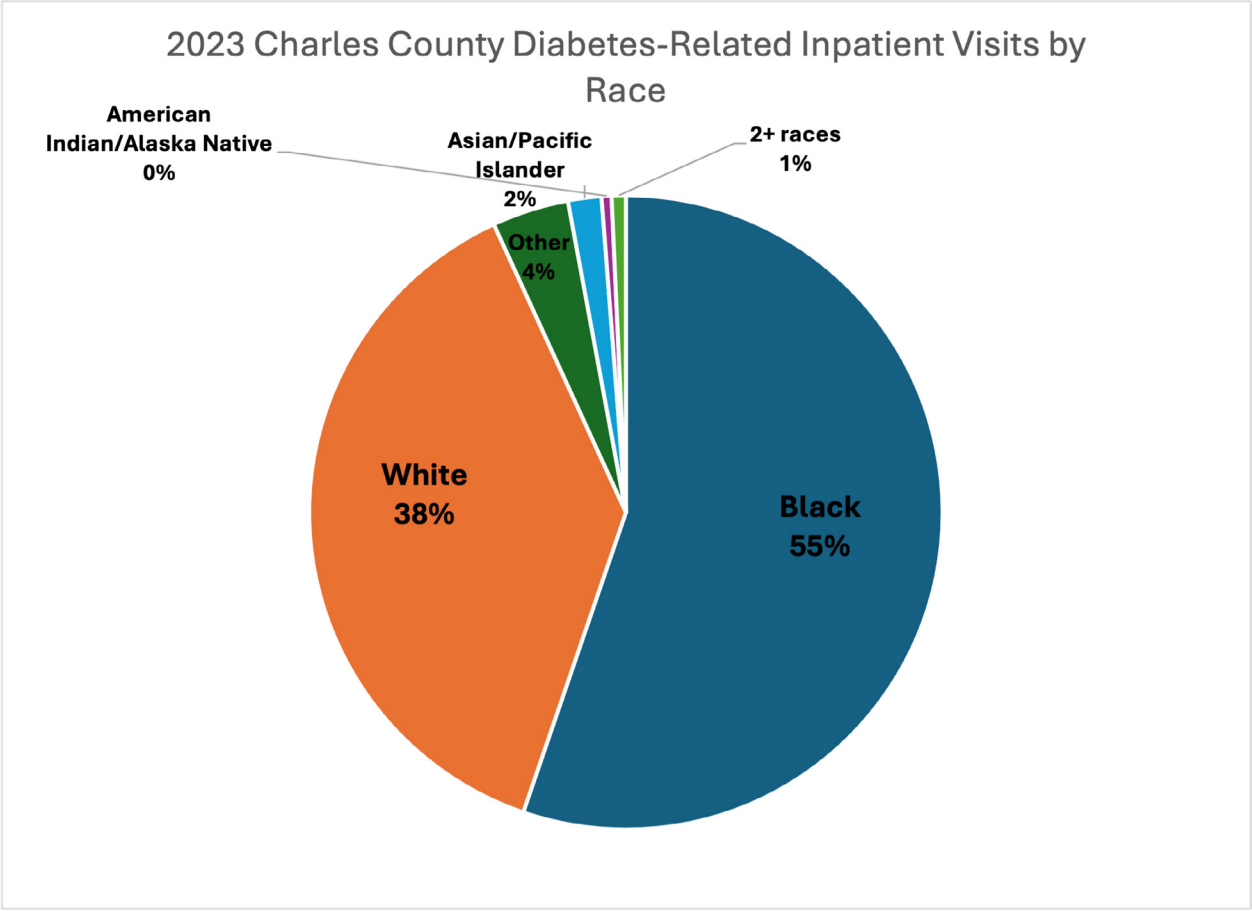
The age group with the largest number of diabetes-related ED visits is the 55-59-year-old age group who had 394 visits in 2023. They are followed closely by those aged 60-64 years.

2023 Charles County Diabetes-Related ED Visits by Age Group	Count
0-4 years	<11
5-9 years	<11
10-14 years	17
15-17 years	<11
18-24 years	38
25-29 years	59
30-34 years	73
35-39 years	109
40-44 years	152
45-49 years	167
50-54 years	304
55-59 years	394
60-64 years	374
65-69 years	332
70-74 years	277
75-79 years	230
80-84 years	168
85+ years	123

The same data source can be used to examine diabetes-related Inpatient visits for Charles County for 2023. There were a total of 2,758 diabetes-related inpatient visits for Charles County residents in 2023. Females have more diabetes-related inpatient visits than males (1,403 vs. 1,355). Charles County Whites and African Americans make up the majority of the diabetes-related inpatient visits (93%). Medicare is the largest payer source for diabetes-related patient stays (65%). The age group with the most inpatient visits are those aged 75-79 years.


Gender
Male
49%
1,355
Female
51%
1,403


Payer
Commerical and Other
23%
629
Medicare FFS
51%
1,397
Medicare MCO
14%
377
Medicare FFS
Medicaid FFS
Medicare MCO
Medicaid MCO
Self-Pay and Charity
Commerical and Ot...


2023 Charles County Diabetes-Related Inpatient Visits by Race
American Indian/Alaska Native 0%
Asian/Pacific Islander 2%
2+ races 1%
Other 4%
White 38%
Black 55%

2023 Charles County Diabetes-Related Inpatient Visits by Age Group	Count
0-17 years	<11
18-24 years	40
25-29 years	25
30-34 years	36
35-39 years	60
40-44 years	81
45-49 years	110
50-54 years	189
55-59 years	298
60-64 years	307
65-69 years	347
70-74 years	334
75-79 years	391
80-84 years	275
85+ years	265

Pre-Diabetes

The 2020 Maryland Behavioral Risk Factor Surveillance System asked respondents if they have ever been diagnosed with pre-diabetes or borderline diabetes. 13.8% of Charles County adults and 13.5% of Maryland adults reported that they have been diagnosed with pre-diabetes.

Additionally, BRFSS respondents were asked if they had a blood sugar test in the last 3 years. 51.4% of Charles County adults reported that they have had a blood sugar test in the last 3 years. This is similar to the state percentage of 53.7%.

Diabetes Care

In 2020, the Maryland Behavioral Risk Factor Surveillance System asked respondents with diabetes a series of questions regarding diabetes care. The percentages of Charles County adults reporting that they engage in diabetes care activities were below the Maryland state average percentages.

- 66.7% of Charles County adults with diabetes and 59.3% of Maryland adults with diabetes ever took a class or course to manage diabetes themselves.
- 8.6% of Charles County adults with diabetes and 15.7% of Maryland adults with diabetes reported that they have had a fully dilated eye exam in the last month.
- 64.9% of Charles County adults with diabetes and 52.7% of Maryland adults with diabetes check feet daily or more frequently.

Diabetes References

1. 2021 Charles County and Maryland Diabetes Prevalence Data. Maryland Behavioral Risk Factor Surveillance System. Maryland Department of Health. Available at: https://ibis.health.maryland.gov/.
2. 2021 Charles County Diabetes mellitus mortality counts and rates. 2021 Maryland Vital Statistics Report. Maryland Department of Health. Available at: https://health.maryland.gov/vsa/Pages/reports.aspx.
3. 2008-2017 Charles County Diabetes Emergency Department Visit Rates. Maryland Health Services Cost Review Commission. Accessed through the Maryland State Health Improvement Process website. Available at https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx.
4. 2023 Charles County Diabetes Emergency Department Visits and Inpatient Stays by Demographic. CRISP Reporting Services. Public Health Dashboards. Chesapeake Regional Information Sharing for our Patients (CRISP). Available at https://reports.crisphealth.org.
5. 2020 Charles County Pre-Diabetes and Diabetes Care data. Maryland Behavioral Risk Factor Surveillance System. Maryland Department of Health. Available at: https://ibis.health.maryland.gov/.

Qualitative Data Relating to Diabetes

65.6% of long survey participants felt that diabetes was a health problem in Charles County. Approximately one-third (36.2%) felt that diabetes is a “serious problem” in Charles County. 36.91% of long survey respondents reported that they have seen improvements in Charles County in terms of Diabetes.

Some health behaviors exhibited by Charles County survey respondents that might affect their chances of diabetes included: only 8.5% always eat 5 or more servings of fruits and vegetables each day, 18.5% always or most of time eat fast food at least once a week, and 16.2% participate in physical activity each day.

51.7% of the short survey participants felt that Diabetes is the greatest health problem in Charles County. This was the highest-ranking health condition on the short survey. Additionally, 46.2% of the respondents felt that there are “many” or “some” services available in Charles County to address diabetes.

Focus group participants expressed concern for Diabetes and the need for more prevention education, especially among those with pre-diabetes. Participants also felt that education campaigns and programs need to be in place for chronic conditions, including diabetes.

The Access to Care focus group discussed the disparities in diabetes within the county. Resources

must be allocated to those who are most impacted by the condition. Efforts must be directed to areas of the county where resources are limited, including the western and southern regions of the county.

The Chronic Disease focus group discussed the lack of providers in the county to address diabetes and obesity. There are limited specialists for weight loss. Health Partners was cited as a good source for care as their new provider works with individuals with diabetes.

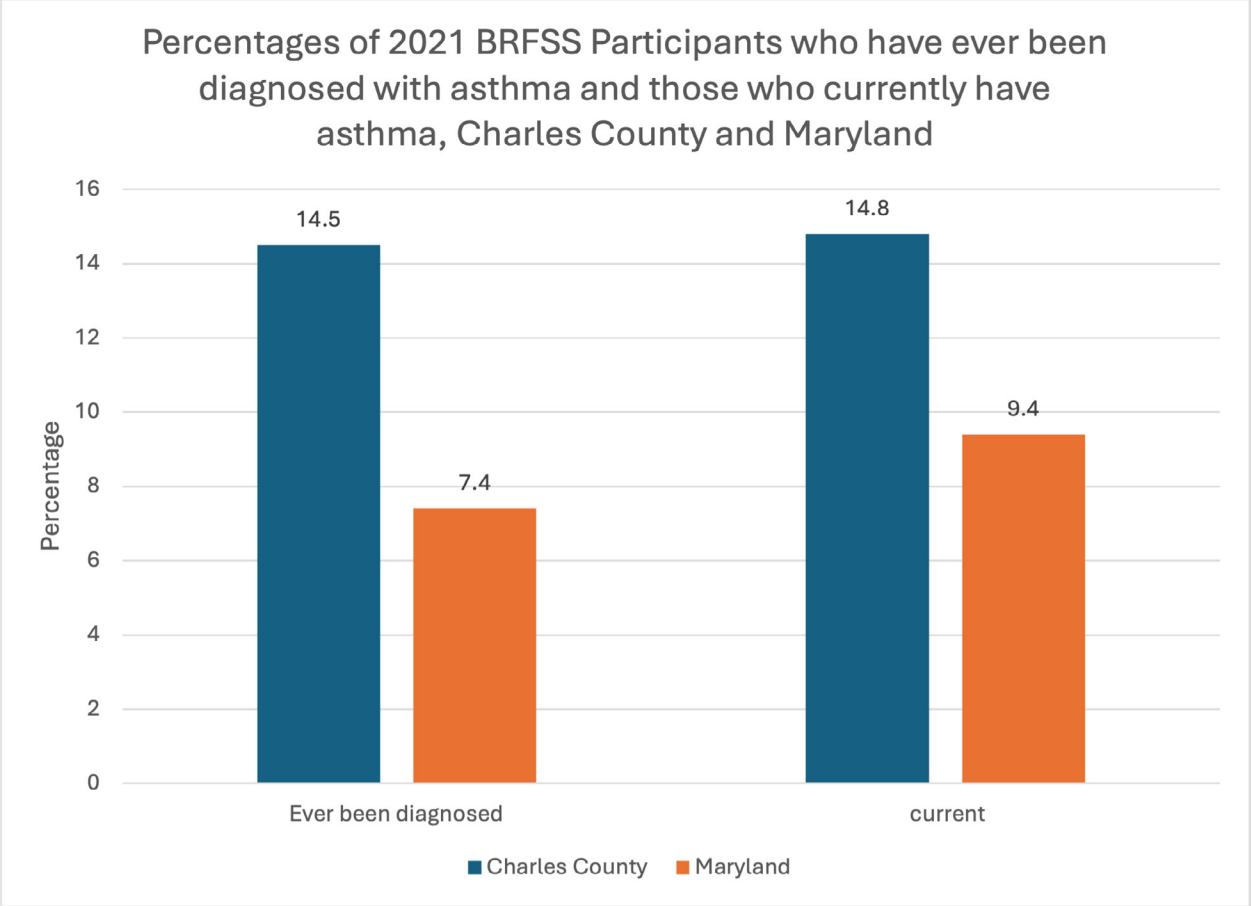
Individuals with diabetes need to see an endocrinologist. The University of Maryland Charles Regional Medical Center has brought more specialists like endocrinology, GI, general surgery, urology. However, for endocrinology, the wait is 2-3 months for an appointment.

Focus group cited the Living Well, chronic disease self-management program, diabetes self-management program, and the Diabetes Prevention Program are strengths and valuable resources within the county. The facilitators show compassion to participants.

Charles County Asthma Prevalence:

Adult Asthma Prevalence

Asthma is an emerging health problem in the United States and in Maryland. The problems associated with asthma have been felt at the local level as well. In 2021, approximately 14.8% of adults in Maryland and 14.5% of adults in Charles County have ever been diagnosed with asthma (2021 Maryland BRFSS). An estimated 9.4% of Maryland adults and 7.4% of Charles County adults reported that they currently have asthma (2021 Maryland BRFSS).



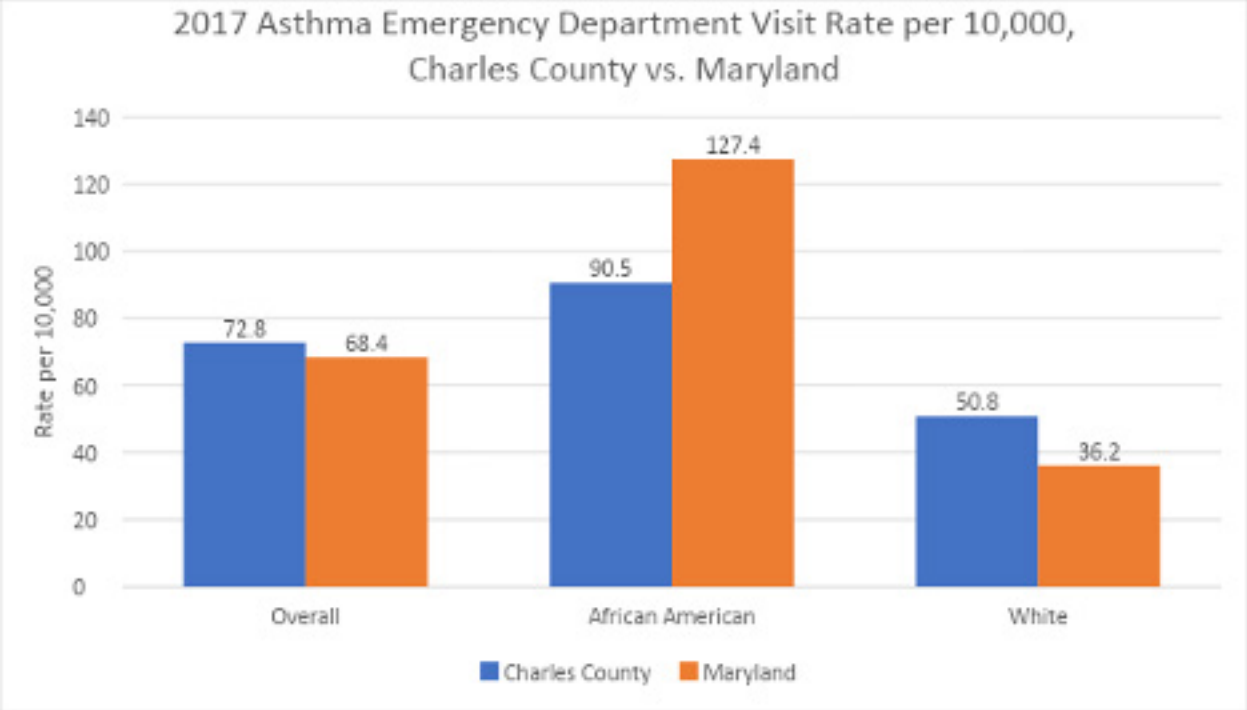
2021 BRFSS participants with children were also asked if their child has ever been diagnosed with asthma. 13.4% of Charles County respondents reported that their children have been diagnosed with asthma. This is higher than the Maryland percentage of 11.5%.

Asthma Emergency Department and Hospitalization Rates

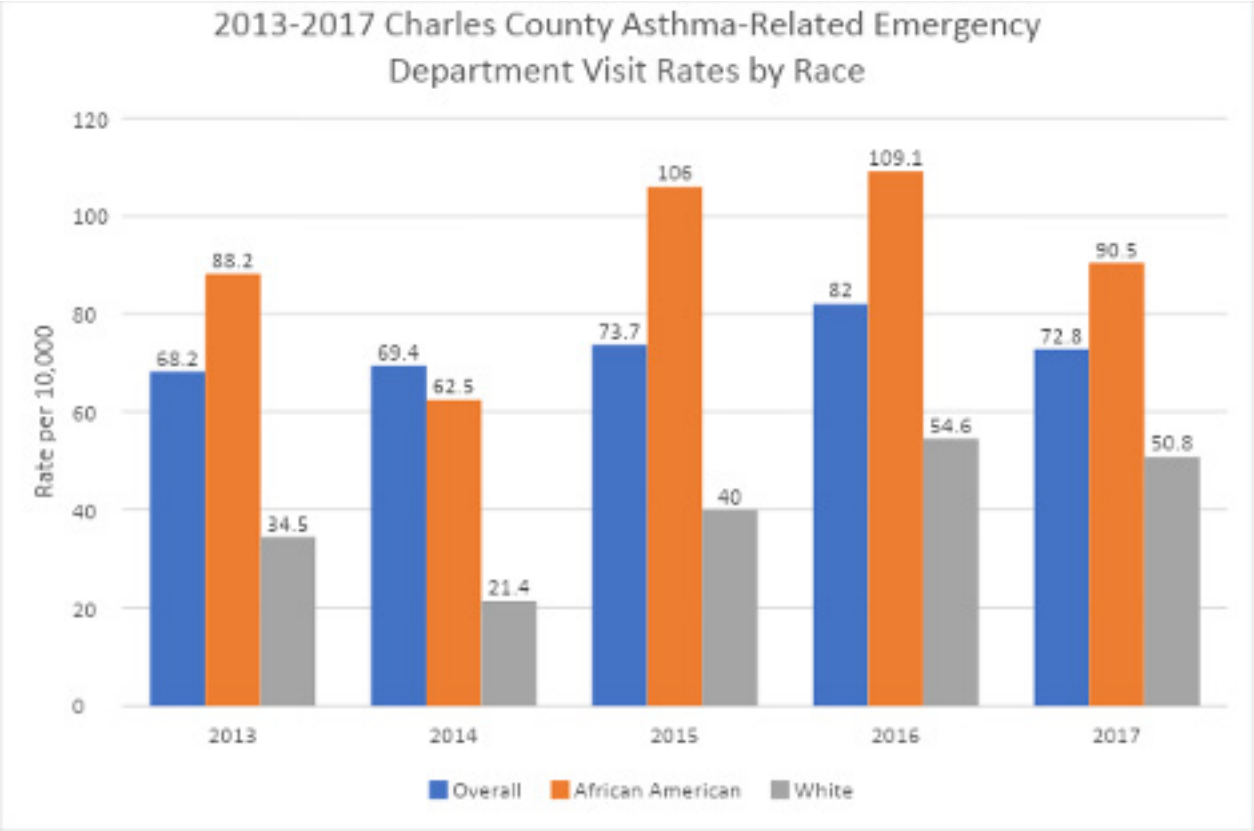
This indicator shows the rate of emergency department (ED) visits due to asthma per 10,000 population in 2017. Asthma is a chronic health condition which causes very serious breathing problems. When properly controlled through close outpatient medical supervision, individuals and families can manage their asthma without costly emergency intervention. In Maryland, there are nearly 50,000 emergency department visit related to asthma each year.

The 2017 Charles County asthma ED visit rate was 72.8 per 10,000 population. This rate is slightly above the Maryland state asthma ED visit rate of 68.4 per 10,000. Racial disparities are clearly seen on the state and county level. Charles County African Americans had a 2017 asthma ED visit rate of 90.5 per 10,000 population. This was significantly higher than the rate for Charles County Whites (50.8).

The 2017 Charles County asthma ED visit rate of 72.8 per 10,000 is a small decrease from the rate reported in the last needs assessment report of 69.4 per 10,000 for 2014. Additionally, the 2017 Charles County asthma ED visit rate is the 8th highest among the Maryland jurisdictions.



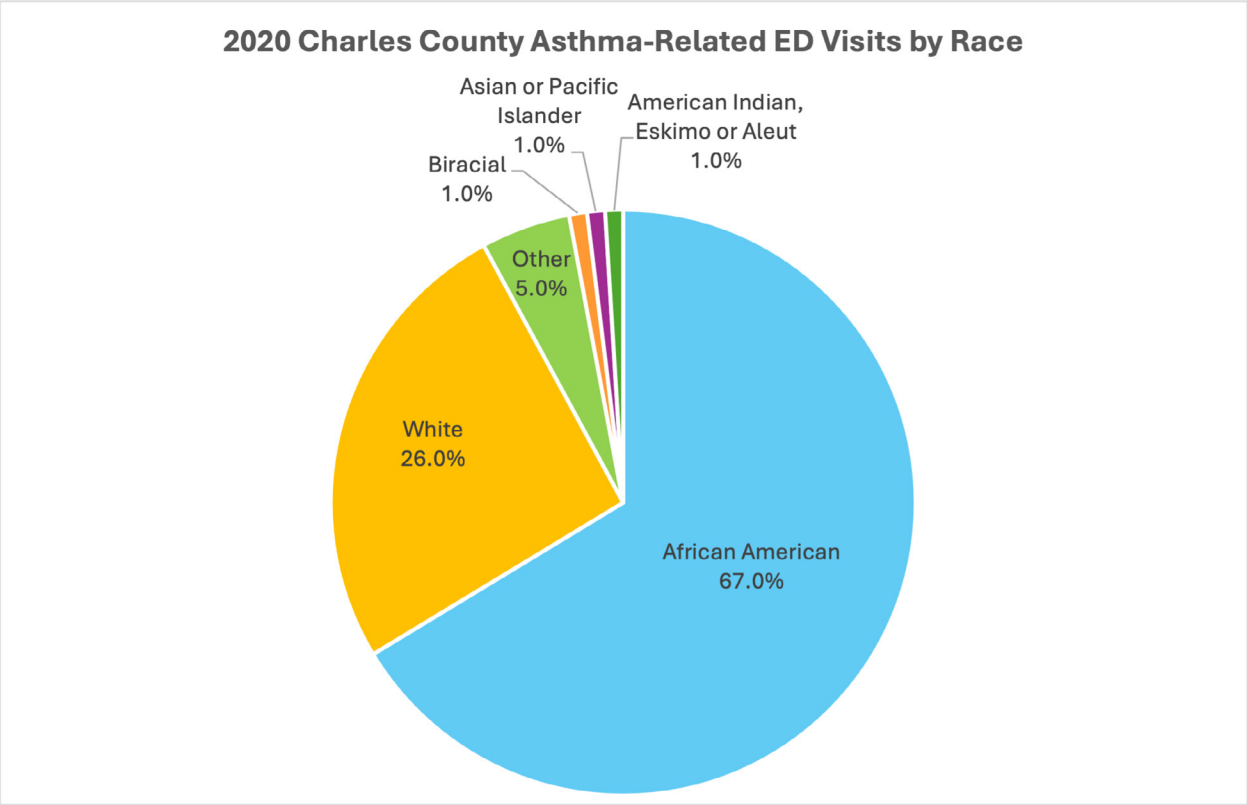
Charles County has seen a lot of fluctuation in the asthma-related ED visit rates from 2013-2017. The 2013 Charles County asthma ED visit rate was 68.2 versus 73.7 in 2017. The Charles County African American population have seen an increase from 88.2 in 2013 to 90.5 in 2017. Charles County Whites have seen an increase from 34.5 in 2013 to 50.8 in 2017.



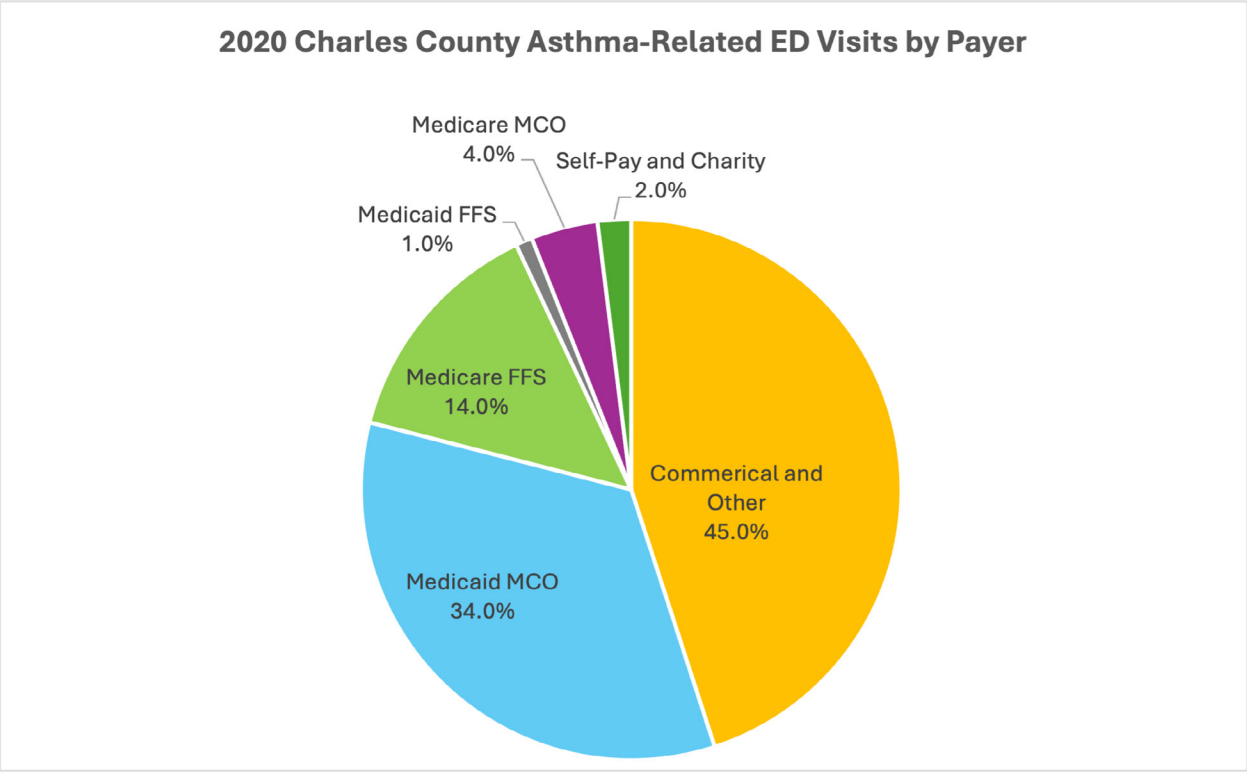
The Chesapeake Regional Information Sharing for our Patients or CRISP, is the health information exchange for the state of Maryland. CRISP Reporting Services provides public health dashboards with queries for emergency department and inpatient stays by demographics for many health conditions including asthma.

In 2022, there were 2,563 emergency department (ED) visits for Charles County residents related to asthma. 60.0% of those ED visits were at the University of Maryland Charles Regional Medical Center. In Charles County, females have more asthma-related ED visits than males (1,751 vs. 812).

Charles County African Americans are disproportionately affected by asthma-related ED visits and make up 67% of the total asthma-related ED visits for Charles County residents.



When examining by payer source, the largest payer is Commercial/Other insurance (45.0%) followed by Medicaid MCO (34.0%).

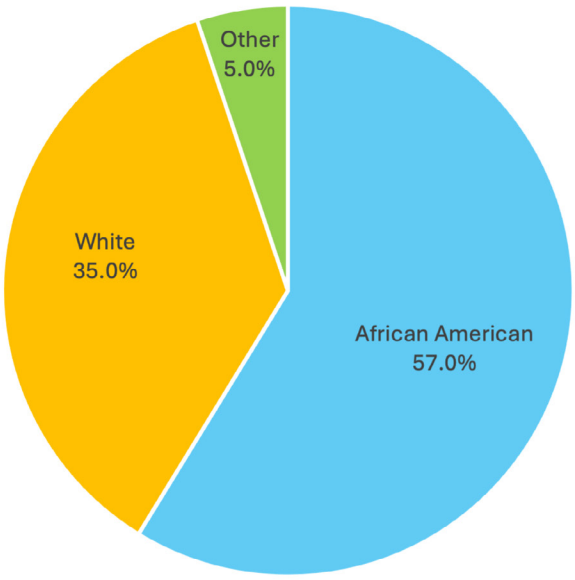


The age group with the largest number of asthma-related ED visits is the 18-24-year-old age group who had 258 visits in 2022. They are followed closely by those aged 30-34 years.

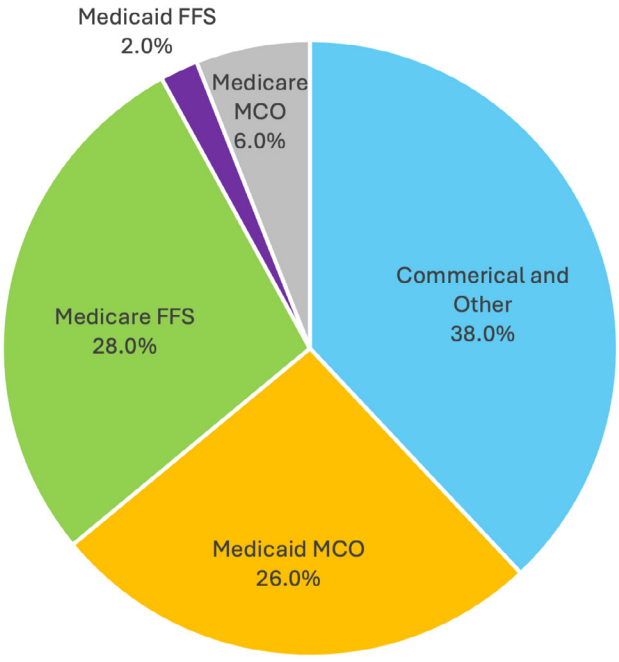
2022 Charles County Asthma-Related ED Visits by Age Group	Count
0-4 years	127
5-9 years	175
10-14 years	115
15-17 years	75
18-24 years	258
25-29 years	182
30-34 years	230
35-39 years	226
40-44 years	181
45-49 years	169
50-54 years	202
55-59 years	166
60-64 years	109
65-69 years	114
70-74 years	72
75-79 years	71
80-84 years	51
85+ years	40

The same data source can be used to examine asthma-related Inpatient visits for Charles County for 2022. There were 673 asthma-related inpatient visits in 2022. Females have more asthma-related inpatient visits than males (520 vs. 153). Charles County Whites and African Americans make up the majority of the asthma-related inpatient visits (92%). Commercial or Other insurance is the largest payer source for asthma-related patient stays (38%). The age group with the most inpatient visits are those aged 30-34 years.

2022 Charles County Asthma-Related Inpatient Visits by Race



2022 Charles County Asthma-Related Inpatient Visits by Payer



2022 Charles County Asthma-Related Inpatient Visits by Age Group	Count
0-17 years	Data Suppressed
18-24 years	61
25-29 years	43
30-34 years	67
35-39 years	57
40-44 years	46
45-49 years	42
50-54 years	53
55-59 years	55
60-64 years	40
65-69 years	51
70-74 years	34
75-79 years	42
80-84 years	33
85+ years	23

Asthma Prevalence Among Middle and High School Students

In the 2018-2019 Maryland Youth Risk Behavior Survey for Middle and High School students, participants are asked if they have ever been told by a doctor or nurse that they have asthma. For the 2018-2019 school year, 21.5% of Charles County middle school students and 29.2% of Charles County high school students report that they have been told by a doctor or a nurse that they have asthma. Data on asthma prevalence was not available in the 2021-2022 Maryland YRBS results.

2018-2019 Middle and High School Asthma Prevalence	Middle School	High School
Charles County	21.5%	29.2%
Maryland	21.0%	25.9%

COPD Prevalence

The 2021 Maryland Behavioral Risk Factor Surveillance System provides estimates on the prevalence of Chronic Obstructive Pulmonary Disease (COPD) in the community. The 2021 Charles County COPD prevalence was 6.2%. This is much higher than the 2021 Maryland state average COPD prevalence of 4.3%.

Asthma References

1. 2021 Charles County and Maryland Adult Asthma Prevalence. Maryland Behavioral Risk Factor Surveillance System. Maryland Department of Health. Available at: https://ibis.health.maryland.gov/.
2. 2017 Charles County and Maryland Asthma Emergency Department Visit rates. Maryland Health Services Cost Review Commission. Accessed through the Maryland State Health Improvement Process website. Available at: https://opendata.maryland.gov/Health-and-Human-Services/SHIP-Emergency-Department-Visit-Rate-Due-To-Asthma/b5i6-2qym.
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4. 2018-2019 Middle and High School Asthma Prevalence for Charles County and Maryland. 2018-2019 Maryland Youth Risk Behavior Survey. Available at https://ibis.health.maryland.gov/ibisph-view/query/result/yrbs2021/HS_AsthmaCurYN/Crude.html.
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Qualitative Data Pertaining to Asthma

School nurse focus group and chronic disease focus group participants mentioned the need for increased specialists in Charles County including pulmonologists. They explained that many individuals have to wait up to a month to be seen.

Short survey participants did not feel that asthma is a significant problem in Charles County. Only 14.5% of short survey respondents felt that asthma was the biggest health problem in Charles County. This was the third lowest percentage among the listed health conditions. 35.6% of short survey respondents felt that the county has “many” or “some” services regarding asthma.

On the long survey, 53.8% of respondents felt that asthma was a problem on some level in Charles County. 18.5% thought that asthma is a serious problem in Charles County. 9.44% reported that they have seen improvements in Charles County regarding asthma.

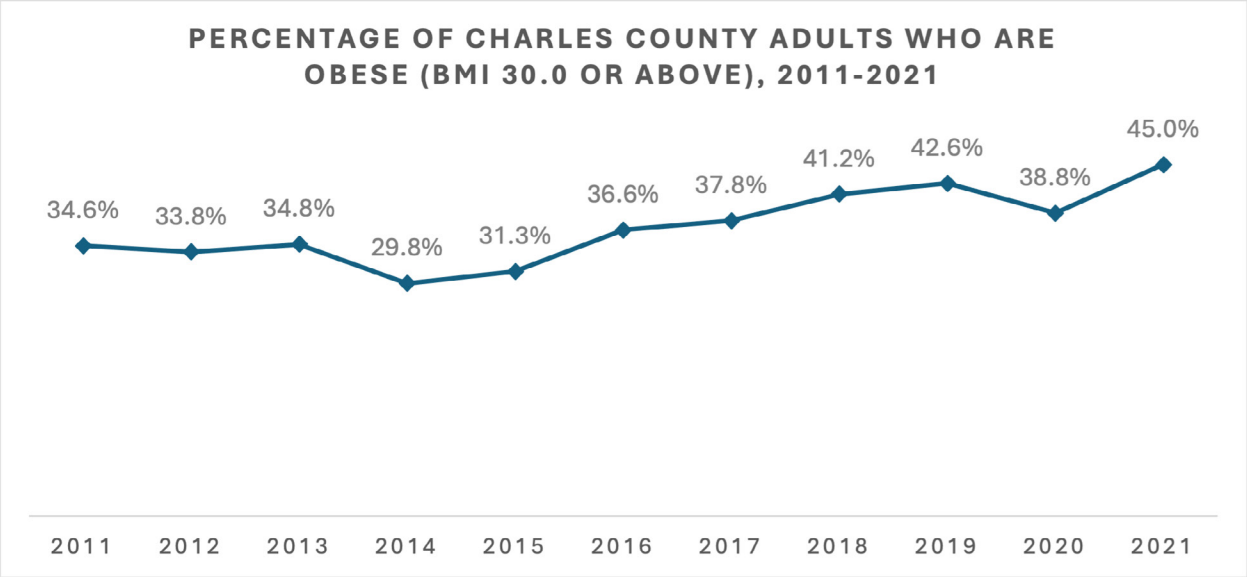
Food, Physical Activity, and Weight Classification:

Maryland Behavioral Risk Factor Surveillance System

In 2021, 76.8% of Charles County adults were either overweight or obese. This is an increase from 71.9% reported during the last Community Health Needs Assessment survey. 31.8% of Charles County adults were overweight (BMI 25.0-29.9), and 45.0% were Obese (BMI 30.0 or above). The percentage of Charles County adults who are obese is much higher than the Maryland state percentage of 34.7%. However, the percentage of Charles County adults who are overweight is lower than the Maryland percentage of 34.0%.

BMI Status: Charles County	Healthy Weight	Overweight	Obese
2021	23.2%	31.8%	45.0%
Previous CHNA	28.2%	28.4%	43.5%

Source: 2021 Maryland BRFSS



Source: 2021 Maryland BRFSS

Childhood Obesity

High School Students Aged 15-18 Years:

In the 2021-2022 Youth Risk Behavior Survey, 16.1% of Charles County High School students reported being overweight and 15.5% reported being obese. The Maryland percentage of High School students who are overweight is lower than Charles County (15.3% vs 16.1%), whereas the Maryland percentage of High School students who are obese is slightly higher than Charles County (15.9% vs 15.5%).

Breaking down the data by demographics, Charles County Black High School students had the highest percentage of being overweight, at 17.6%, compared to any other race or ethnic group.

However, multiracial non-Hispanic High School students had the highest percentage of obesity, at 19.7%.

Charles County High School females had a higher percentage of being overweight compared to males at 17.3% vs 15.0%, but Charles County High School males had a higher percentage of obesity at 17.2% compared to 13.8% for females.

9th grade students had the highest percentage of being overweight and obese, compared to all other High School grade levels. 17.6% of 9th graders were overweight and 17.0% were obese. High School students under the age of 16 had the highest percentage of being overweight at 18.3%, but High School students between the ages of 16 and 17 had the highest percentage of obesity at 16.0%.

Overweight and Obesity Prevalence in Charles County High School Students: 2021-2022 YRBS	Overweight	Obese
Total		
Total	16.1%	15.5%
Race/Ethnicity		
Asian	15.2%	18.1%
Black	17.6%	16.8%
Hispanic/Latino	16.7%	15.4%
Multiracial non-Hispanic	14.6%	19.7%
White	13.5%	10.1%
Age		
15 or younger	18.3%	15.6%
16 or 17	14.1%	16.0%
18 or older	17.6%	10.3%
Sex		
Female	17.3%	13.8%
Male	15.0%	17.2%
Grade		
9th Grade	17.6%	17.0%
10th Grade	17.4%	14.6%
11th Grade	14.8%	15.0%
12th Grade	14.6%	15.2%

Source: 2021-2022 Maryland YRBS/YTS

In addition, Charles County high school students were asked several questions regarding their perceptions of their weight and questions regarding their diet and activities. All these factors could impact obesity and overweight.

- 27.1% consider themselves slightly or very overweight.
- 21.4% did not eat fruit in the past week.
- 10.2% did not eat vegetables in the past week.
- 11.2% drank soda one or more times a day.
- 34.2% were physically active for at least 60 minutes 5 times a week.
- 76.0% spent 3 or more hours per day on screen time.

These same questions were also asked of Charles County middle school students on the 2021-2022 YRBS.

- 25.3% describe themselves as slightly or very overweight.
- 43.9% are trying to lose weight.
- 21.1% did not eat breakfast each day.
- 39.3% were physically active at least 60 minutes 5 times a week.
- 21.8% did not participate in physical activity at least 1 day a week.
- 77.1% spent 3 or more hours per day on screen time.

The State of Childhood Obesity report by the Robert Wood Johnson Foundation provides data on low-income children 2-4 years of age in the WIC Program. The 2020 average obesity rate for Maryland children 2-4 years was 17.0%. This is the 4th highest obesity rate in the United States. The 2020 obesity rate of 17.0% is an increase from 15.6% reported in 2016.

The National Survey of Children's Health (NSCH) provides data on youth aged 10-17. The 2021-2022 average obesity rate for Maryland children 10-17 years was 20.5%. This is the 9th highest obesity rate in the United States. This percentage is an increase from the 2018-2019 report where the obesity rate for Maryland children aged 10-17 was 17.6%.

Determinants of Health

Physical Activity:

A sedentary lifestyle increases the risk of obesity, heart disease, hypertension, diabetes, and other chronic diseases and conditions. The Healthy People 2030 objective recommends engaging in moderate physical activity for at least 150 minutes/week, or at least 75 minutes/week of vigorous intensity, for health benefits. Despite the benefits of physical activity, 2021 Maryland BRFSS data found that 74.8% of Charles County residents report leisure time physical activity. This is lower than the Maryland state average percentage of 78.8%.

Leisure Time Physical Activity 2021 BRFSS	Yes, leisure time physical activity	No leisure time physical activity
Charles County	74.8%	25.2%
Maryland	78.8%	21.2%

Source: 2021 Maryland BRFSS

High Cholesterol:

An indicator of poor nutrition is high cholesterol. The 2021 BRFSS found that an estimated 29.2% of Charles County residents and 33.5% of Marylanders have been told that their cholesterol is high.

Daily Fruit and Vegetable Consumption:

According to the 2021 BRFSS, 55.8% of Charles County residents reported consuming at least 1 fruit each day, and 78.1% of Charles County residents reported consuming at least 1 vegetable per day.

Daily Fruit and Vegetable Consumption, 2021 BRFSS	Percent who consume at least 1 fruit per day	Percent who consume at least 1 vegetable per day
Charles County	55.8%	78.1%
Maryland	62.5%	80.4%

Source: 2021 Maryland BRFSS

The 2020 Robert Wood Johnson Foundation's County Health Rankings calculate a food environment index based on factors that contribute to a good food environment. They calculate a score for each county with 0 being the worst and 10 being the best. For 2020, Charles County's food environment index was 8.3. This is a fairly strong score based on the fact that 5% of Charles County residents have limited access to healthy foods and 11% food insecurity in Charles County. It is below the Maryland average score of 9.0.

Additionally, the Robert Wood Johnson Foundation calculates the percentage of Charles County residents with access to exercise opportunities. In 2020, 77% of county residents had adequate access to exercise opportunities. This is below the Maryland state percentage of 93%.

Community Support:

2020 BRFSS collected data on various community support indictors. These indicators may influence health behaviors within a community. When asked if there are sidewalks in their neighborhood, 52.8% reported having sidewalks. Sidewalks in a community promote safe physical activity such as walking or running.

The 2020 BRFSS captured data on the safety and promotion of bicycling in Charles County. Residents were asked how many of the roads and streets in their neighborhood have shoulders or lanes that are marked for bicycling. 73.8% of Charles County residents reported no shoulders or lanes being marked for bicycling.

62.6% of Charles County residents described the lighting in their neighborhood as “poor” or “very poor” for walking at night. 34.4% of that percentage described the street lighting in their neighborhood as “very poor”.

Walking at Night, 2020 BRFSS	Percent
Very Good	*
Good	25.1%
Poor	28.2%
Very Poor	34.4%

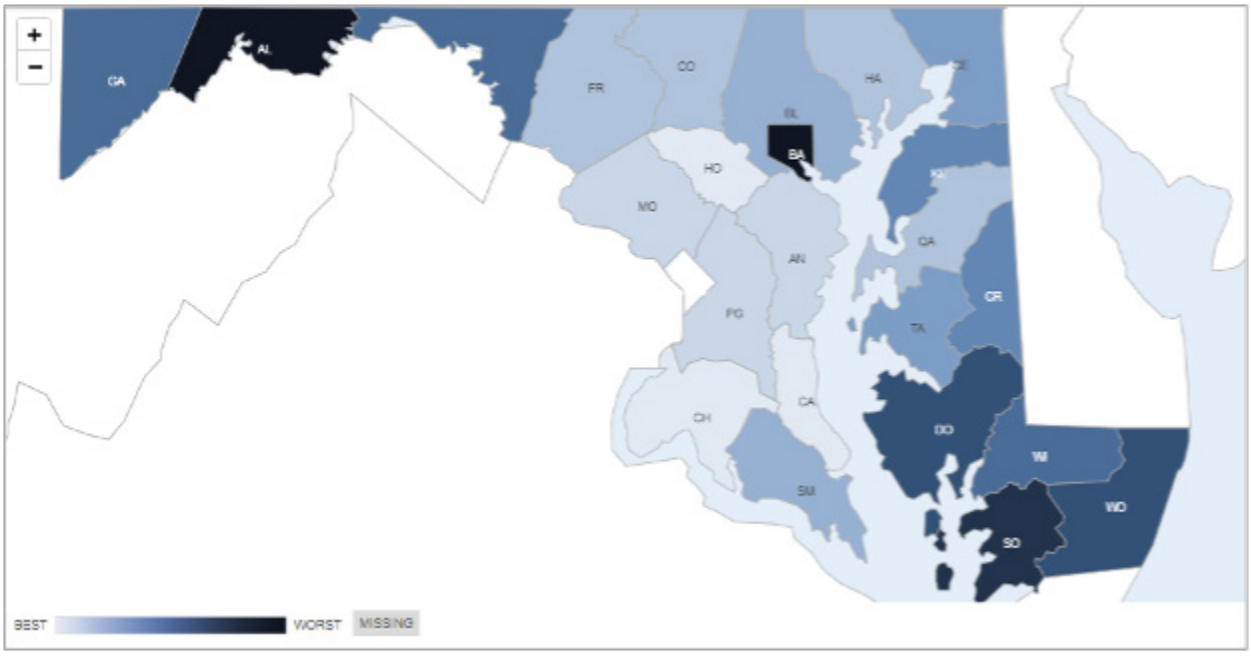
Source: 2020 Maryland BRFSS
**Estimate has been suppressed*

In the past 30 days, 46.2% of Charles County adults reported not walking in their neighborhood for leisure or as a way to get to their destination. 29.7% of Charles County adults reported walking between 1-7 days in the past month around their neighborhood or to get to their destination.

When asked how often Charles County residents felt safe in their neighborhood, 63.5% said they felt safe all the time, and 33.4% reported feeling safe most of the time.

Food Insecurity

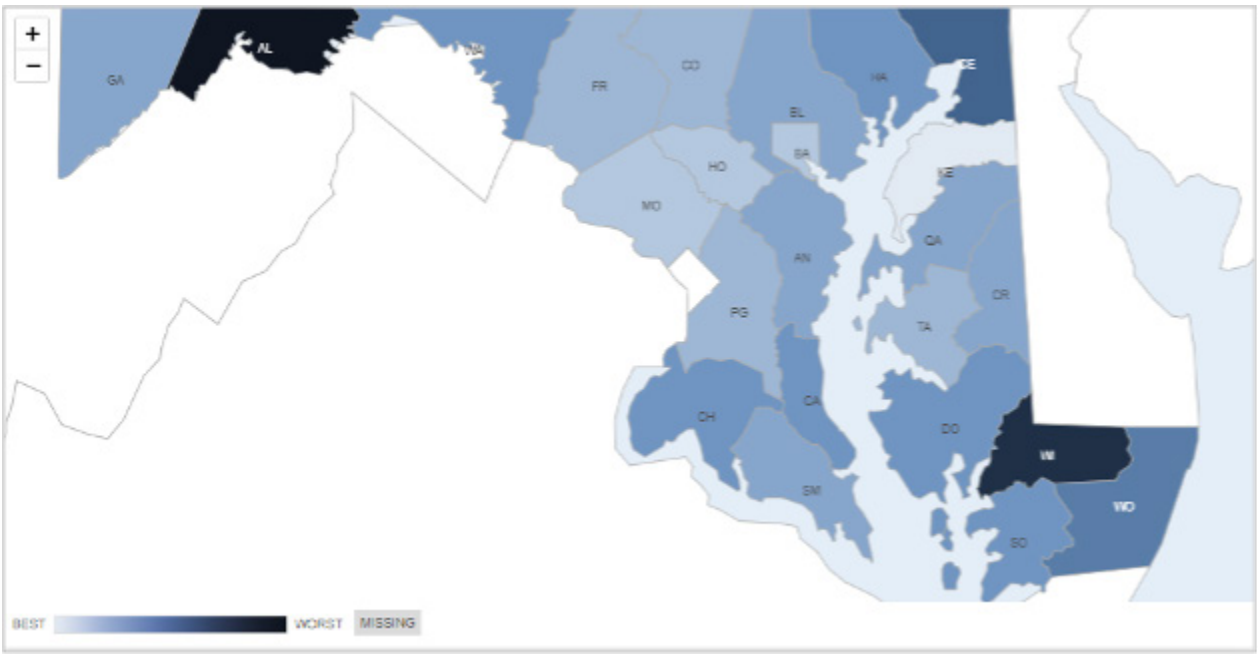
According to the 2020 Robert Wood Johnson Foundation’s County Health Rankings, in Charles County 7% of people did not have a reliable source of food in 2020. This is lower than the Maryland percentage of 9%, and the United States percentage of 12%. Charles County had one of the lowest percentages of food insecurity in the state of Maryland, tied with Calvert County and Howard County at 7%. Allegany County and Baltimore City had the highest percentage of food insecurity in the state of Maryland in 2020 at 16%.



Source: 2023 County Health Rankings

Limited Access to Healthy Foods

In 2019, 5% of people in Charles County had low incomes and did not live close to a grocery store, limiting their ability to access healthy foods. Charles County is higher than the Maryland percentage of 4%, but lower than the Unites States percentage of 6%.



Source: 2023 County Health Rankings

Youth Risk Behavior Survey- Food Insecurity

In 2021, 14.6% of Charles County High School students and 17.3% of Charles County Middle School students reported that their family was often or sometimes worried that their food money would run out before they got money to buy more. Among Charles County High School students, Asian students had the highest percentage of those who reported their family was often or sometimes worried food money would run out, at 19.2%, followed by Hispanic/Latino students at 16.5%. Among Charles County Middle School students, Hispanic/Latino students had the highest percentage of those who reported their family was often or sometimes worried food money would run out, at 23.0%.

Percentage of students who reported that their family was often or sometimes worried that their food money would run out, 2021	High School	Middle School
Total		
Total	14.6%	17.3%
Race/Ethnicity		
Asian	19.2%	*
Black	15.3%	18.9%
Hispanic/Latino	16.5%	23.0%
Multiracial non-Hispanic	12.7%	19.0%
White	9.5%	10.1%
Sex		
Female	14.1%	19.1%
Male	14.8%	15.3%

**Middle School Asian population data not available*

In 2021, 11.5% of Charles County High School students and 15.8% of Charles County Middle School students reported that often or sometimes the food their family bought did not last and they did not have money to get more. The Charles County High School percentage is slightly lower than the Maryland percentage of 12.2%, and Charles County Middle School percentage is higher than the Maryland percentage of 13.0%. Hispanic/Latino High School students had the highest percentage of reported food not lasting at 15.9%, whereas Black Middle School students had the highest percentage of reported food not lasting at 18.8%.

Percentage of students who reported that often or sometimes the food their family bought did not last and they did not have money to get more, 2021	High School	Middle School
Total		
Total	11.5%	15.8%
Race/Ethnicity		
Asian	4.6%	*
Black	12.5%	18.8%
Hispanic/Latino	15.9%	14.6%
Multiracial non-Hispanic	13.0%	15.2%
White	6.8%	10.8%
Sex		
Female	10.8%	15.5%
Male	11.6%	16.5%

**Middle School Asian population data not available*

Community Health Needs Assessment

Long Survey Data

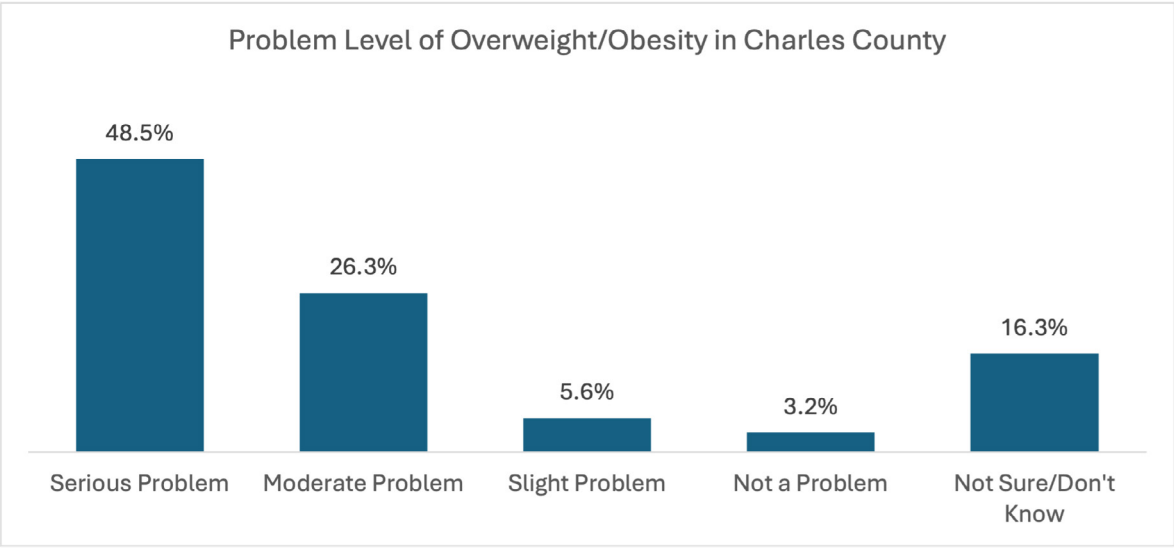
40.9% of survey respondents reported sometimes eating 5 or more servings of fruits and vegetables each day. Almost 20% responded that they rarely eat 5 or more servings of fruits and vegetables each day.

35.9% of survey respondents reported that they sometimes eat fast food more than once a week, and 34.3% reported that they rarely eat fast food more than once a week. 11.5% of survey respondents reported that they eat fast food more than once a week most of the time.

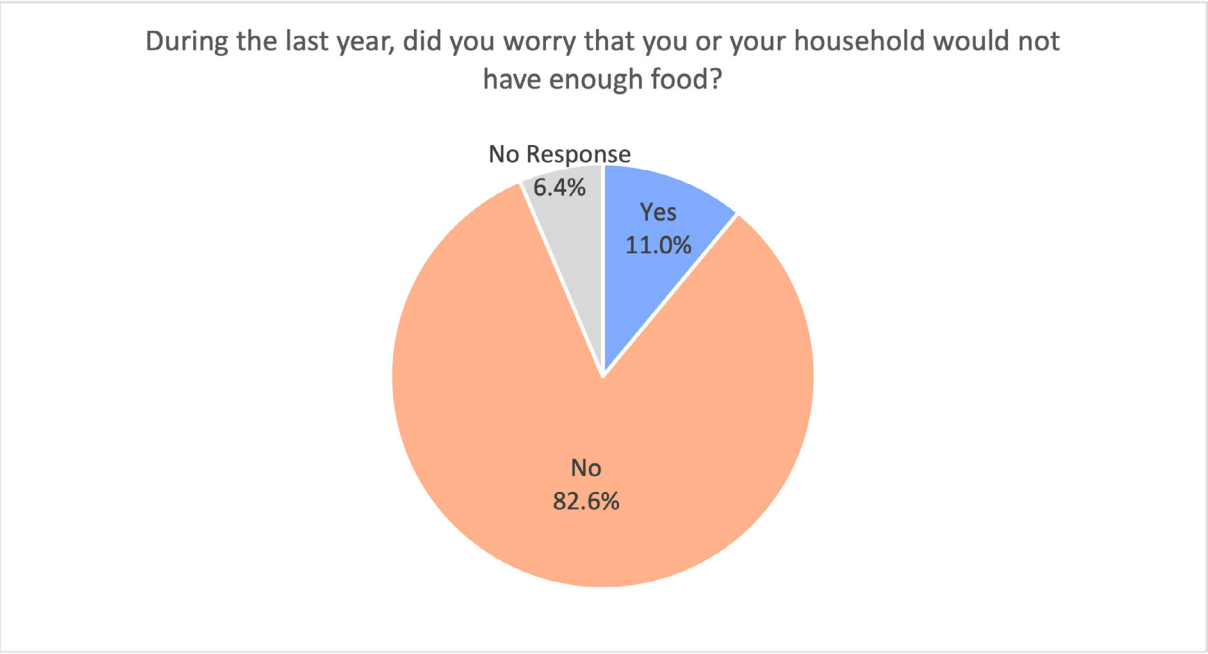
16.2% of survey respondents reported that they always participate in 30 minutes of physical activity each day. 30.6% reported that they participate in 30 minutes of physical activity each day most of the time. Only 3.5% reported that they never participate in 30 minutes of physical activity each day.

Risk and Behavioral Factors	Always	Most of the time	Sometimes	Rarely	Never	Not applicable
Eat 5 or more servings of fruits and vegetables each day?	8.5%	25.9%	40.9%	19.7%	4.7%	0.3%
Eat fast food more than once a week?	6.9%	11.5%	35.9%	34.3%	9.9%	1.5%
Participate in 30 minutes of physical activity each day?	16.2%	30.6%	35.5%	13.5%	3.5%	0.6%

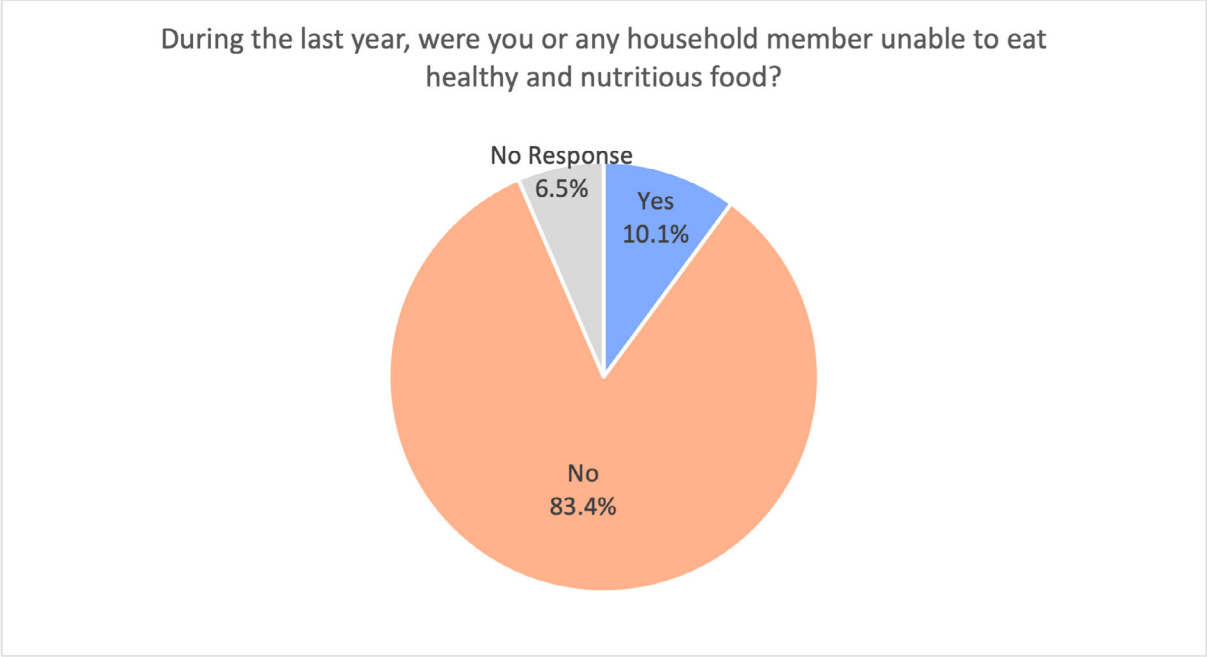
Almost half of survey respondents felt that overweight and obesity was a serious problem in Charles County (48.5%), and only 3.2% felt that overweight and obesity was not a problem in Charles County.



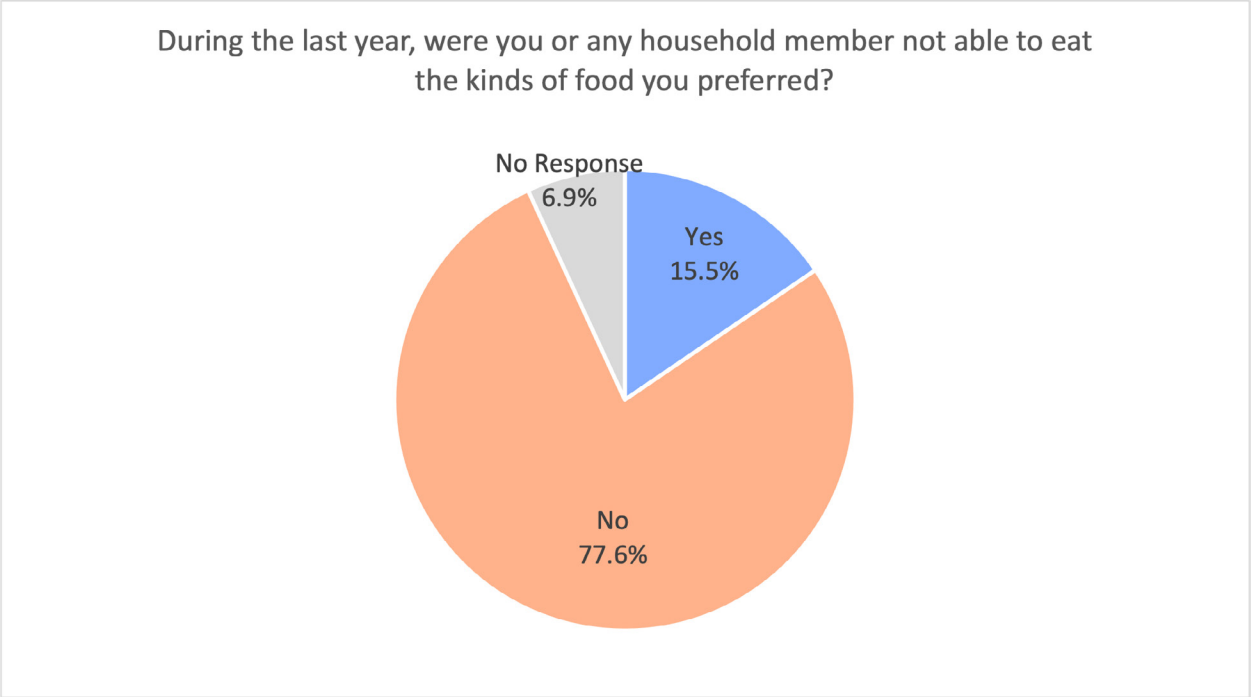
Survey respondents were asked questions related to food insecurity. These questions were designed to understand the community needs and concerns around food and obtaining food. Almost 83% of survey respondents reported not worrying about food for themselves or their household in the last year. However, 11% of survey respondents did worry about having enough food in the last year.



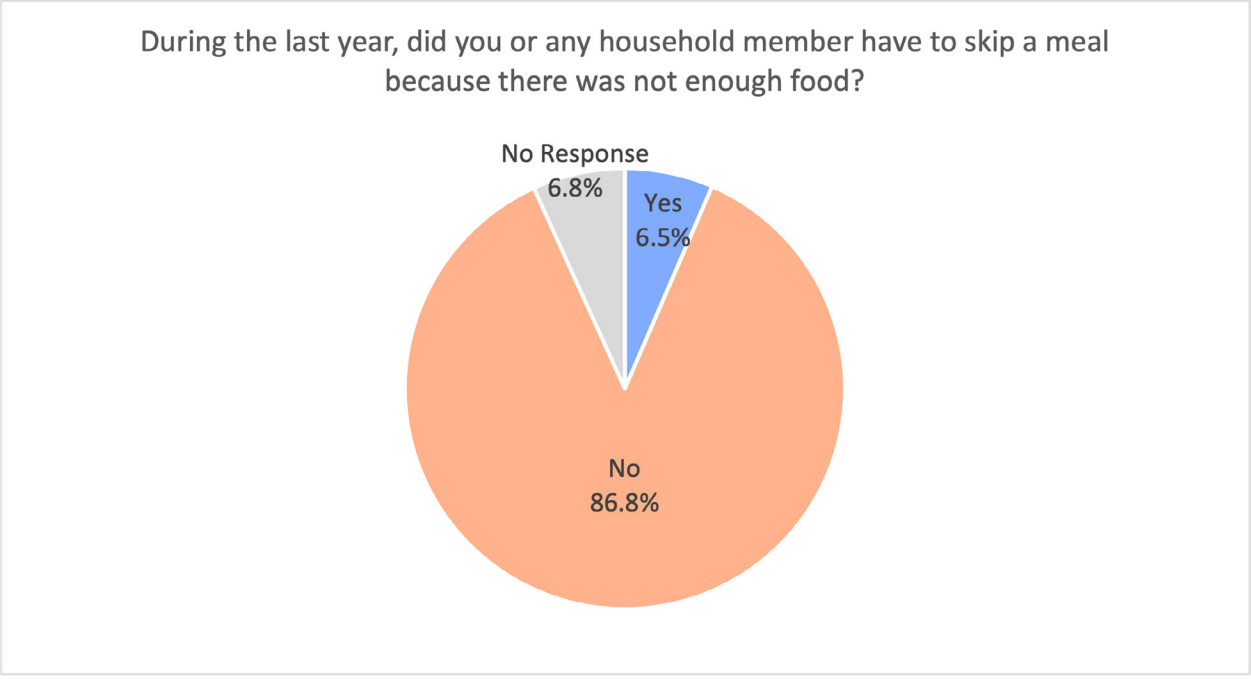
A very similar percentage of survey respondents also reported not being able to eat healthy and nutritious food in the last year (10.1%).



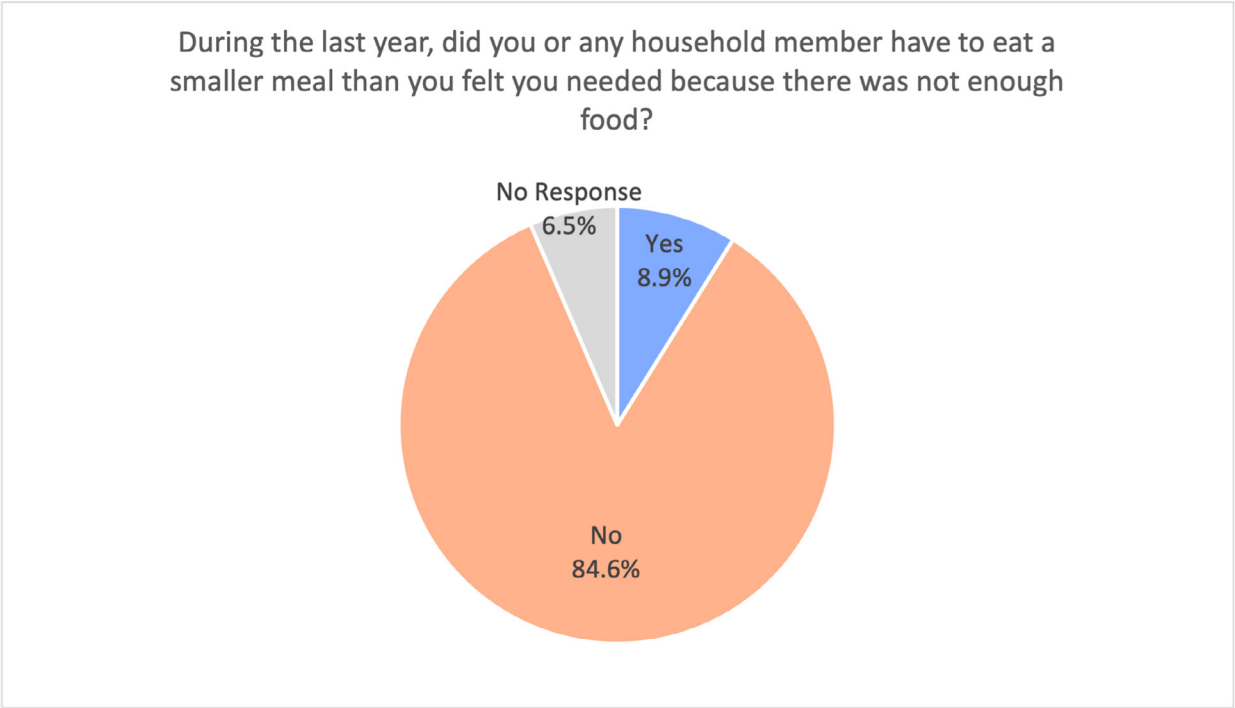
A larger percentage of survey respondents reporting not being able to eat the kinds of food they preferred in the last year, at 15.5%.



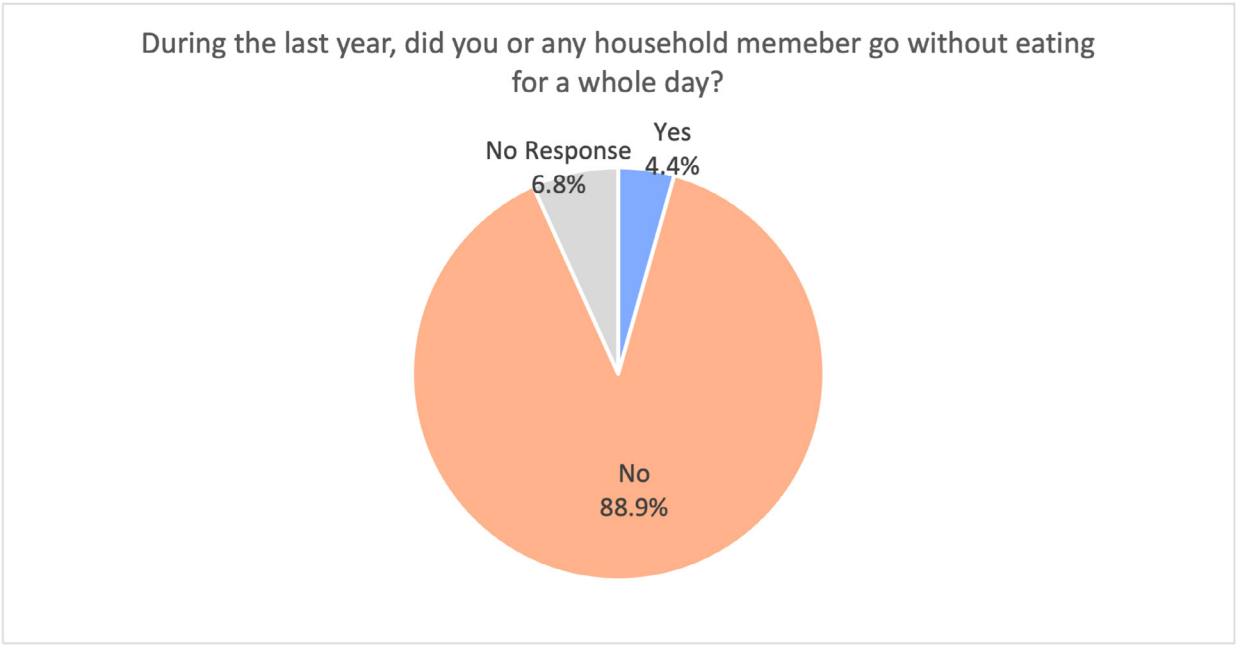
Over 86% of survey participants reported that they or a household member did not have to skip a meal because there was not enough food in the last year. 6.5% of respondents did report that they or a household member had to skip a meal in the last year.



Similarly, almost 85% of respondents reported that in the last year they or a household member did not have to eat a smaller meal than they felt they needed because there was not enough food. Almost 9% of survey respondents reported “Yes” to this question.



Almost 89% of survey respondents reported that in the last year they or a household member did not go without eating for a whole day. 4.4% of respondents reported that either they or a household member did go a whole day without eating in the last year.



Short Survey Data

When asked to identify the biggest health problems in Charles County, Overweight/Obesity was a common response among short survey respondents. 46.9% of respondents felt that Overweight/Obesity was the biggest health problem in Charles County. This was the second most commonly cited health problem among short survey respondents, behind Diabetes.

Short survey respondents were also asked if there are sufficient services or resources for Overweight/Obesity in Charles County. Of those who responded to the question, 36.3% felt that there are some Overweight/Obesity services available in Charles County. This was the highest percentage among survey respondents. 17% felt that there are many Overweight/Obesity services available, and 7.3% felt that there are no Overweight/Obesity services available in the county. 39.4% of respondents did not know if there were Overweight/Obesity services in Charles County.

When asked if there were sufficient services or resources around access to food and nutritious meals, 42.8% of short survey respondents believed there were some services available in Charles County. This was the highest percentage among survey respondents. Almost one quarter of respondents believed there were many services available for access to food and nutritious meals, at 23.5%. Only 4.5% of respondents believe there were no services available, and 29.1% did not know.

	No Services Available	Some Services Available	Many Services Available	I don't know
Overweight/Obesity	7.3%	36.3%	17.0%	39.4%
Access to food and nutritious meals	4.5%	42.8%	23.5%	29.1%

**Percentages based on those who answered the question. Blanks are not included in the denominator.*

Focus Groups

Amongst the focus groups conducted for this year's needs assessment, participants agreed that Obesity was one of the health conditions most affecting Charles County. Obesity was the second most common response among focus groups members, behind Behavioral Health. In past need's assessments, Obesity was also a common response among focus groups.

Barriers and gaps associated with Obesity were expressed in the focus groups. Transportation was a common barrier that focus group members felt impacted active lifestyles for school-aged children. Participants stated that children need to be involved in more activities, but transportation becomes a barrier to those activities. Whether it's the lack of after school activity buses or the inability of parents to get their children to after school activities, the lack of transportation has limited the access of physical activity opportunities for kids after school. The increase in screen time among children was also mentioned. When there are no activities for children to participate in after school, they fall back to screen time for entertainment.

Other barriers that were identified in the focus groups related to Obesity were food deserts within the county and the need for more healthy food options, and the lack of physical activity.

Focus group participants were also asked to identify any strengths in the community. Many

strengths relating to Obesity were mentioned. Strengths such as food pantries, school meal programs, and farmer's markets accepting SNAP were mentioned among focus group members. They believed all these programs were providing healthy food options for community members and targeting those who may have limited access to resources for healthy food.

Lastly, focus group participants were asked to provide any key changes the community could implement to improve health. Some key changes that were mentioned in the focus groups were adding more back to basics classes, including cooking classes and knife skills classes, and starting more classes in Nanjemoy, Swan Point, Cobb Island, and the libraries. Back to basics classes would help educate the community on how to make basic recipes with healthy ingredients, and help individuals learn their way around a kitchen. This would promote cooking at home and healthy eating, as opposed to eating fast food or take out.

Overweight and Obesity References

1. 2011- 2021 Maryland BRFSS accessed at ibis.health.maryland.gov on March 1, 2024.
2. 2021-2022 Maryland YRBS/YTS accessed at ibis.health.maryland.gov on March 1, 2024.
3. 2020 2–4-year-old and 2021-22 10–17-year-old Maryland Obesity Estimates. The State of Obesity Report. The Robert Wood Johnson Foundation. Available at: https://stateofchildhoodobesity.org/state-data/?state=md
4. 2020 Maryland BRFSS or Maryland YRBS/YTS accessed at ibis.health.maryland.gov on March 4, 2024.
5. 2023 Charles County and Maryland Food Environment Indexes. Robert Wood Johnson Foundation's County Health Rankings. Available at: https://www.countyhealthrankings.org/app/maryland/2020/measure/factors/133/map.
6. 2023 Charles County and Maryland Access to Exercise Opportunities Percentages. Robert Wood Johnson Foundation's County Health Rankings. Available at: https://www.countyhealthrankings.org/app/maryland/2020/measure/factors/132/map.
7. 2023 Charles County and Maryland Food Insecurity Percentages. Robert Wood Johnson Foundation's County Health Rankings. Available at: https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/health-behaviors/diet-and-exercise/food-insecurity?state=24&year=2023#map-anchor
8. 2023 Charles County and Maryland Limited Access to Health Foods. Robert Wood Johnson Foundation's County Health Rankings. Available at: https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/health-behaviors/diet-and-exercise/limited-access-to-healthy-foods?state=24&year=2023&tab=1

Charles County Aging Population Health Statistics:

Life Expectancy

The 2019-2021 average life expectancy at birth for a Charles County resident was 77.2 years. This is below the Maryland average life expectancy at 78.2 years. Charles County Non-Hispanic Whites have a higher life expectancy at 77.0 years, compared to Non-Hispanic Blacks at 75.8 years.

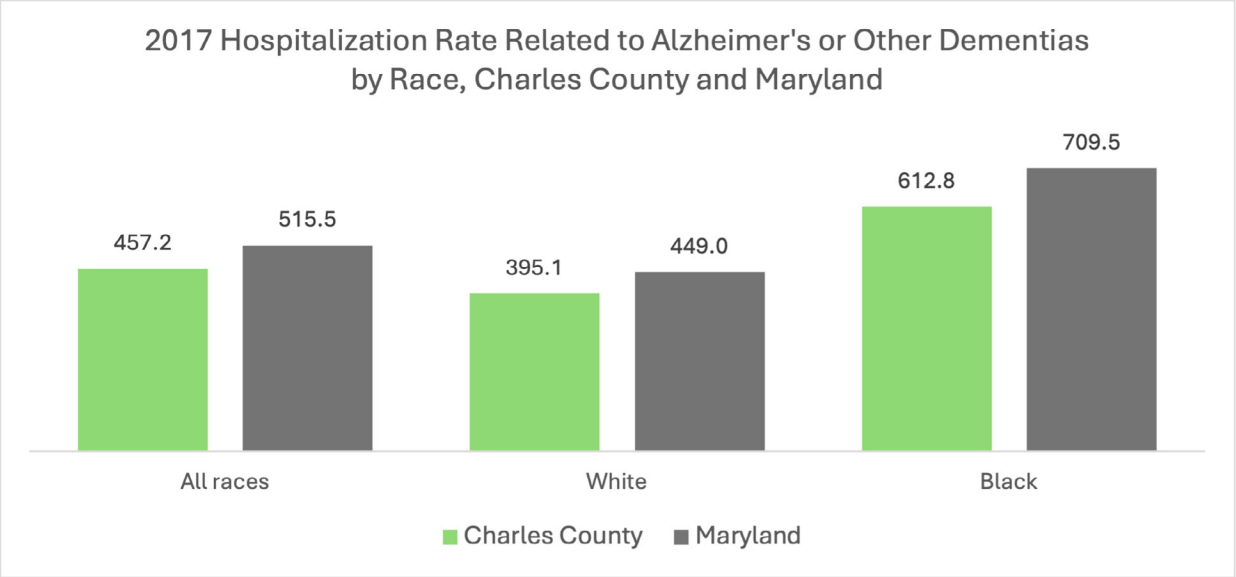
Alzheimer's Disease

In 2021, there were a total of 1,130 Alzheimer's Disease deaths reported in Maryland. About 71% of deaths were among females and 29% were among males. The 2021 Maryland Alzheimer's Disease crude death rate was 18.3 per 100,000. The female crude death rate was higher than males at 25.5 per 100,000 compared to 10.8 per 100,000. In 2021, Alzheimer's Disease was the 8th leading cause of death across all age groups in the state of Maryland.

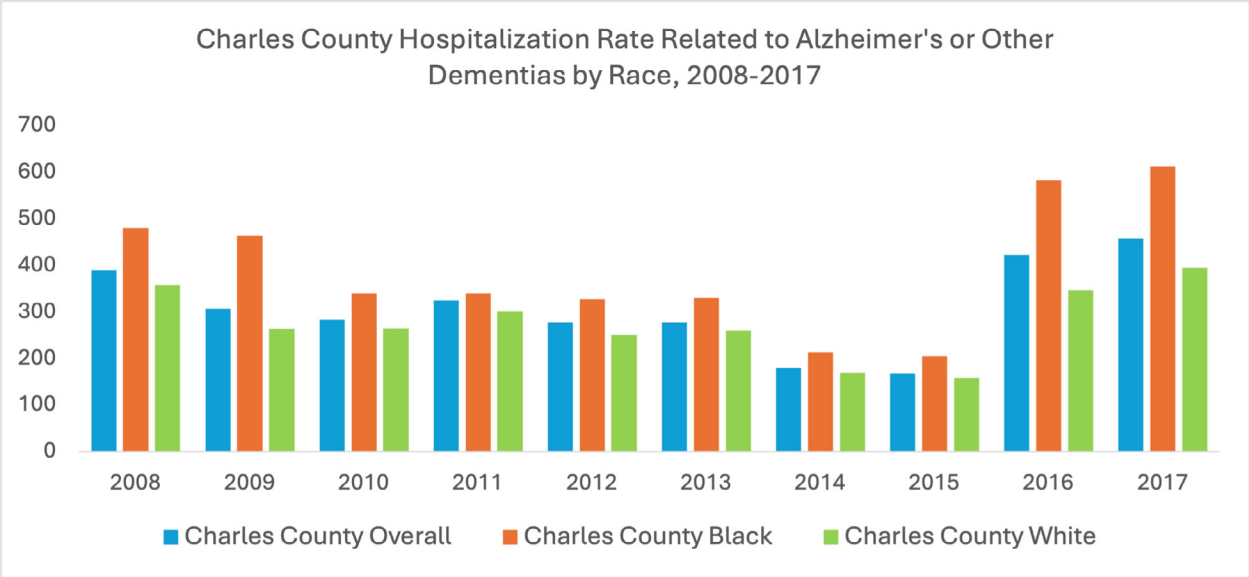
In 2021, Charles County had a total of 10 Alzheimer's Disease deaths. This was 27% of the total Alzheimer's Disease deaths reported in the Southern Area of Maryland in 2021. The Southern Area of Maryland (Calvert County, Charles County, and St. Mary's County) had a total of 37 Alzheimer's Disease deaths in 2021. The Southern Area of Maryland had an Alzheimer's crude death rate of 9.8 per 100,000 in 2021. This was below the Maryland crude death rate of 18.3 per 100,000.

Hospitalization Rate Related to Alzheimer's or Other Dementias

In 2017, the Charles County hospitalization rate for Alzheimer's disease and other dementias was 457.2 per 100,000. This is slightly below the Maryland state average rate of 515.5 per 100,000. The Charles County rates are lower than the state overall, for African Americans, and for Whites. Racial disparities are seen on a county level where Charles County African Americans have a higher Alzheimer's disease hospitalization rate than Charles County Whites (612.8 vs. 395.1).



When looking at trends in the hospitalization rates from 2008 to 2017, increases can be seen in the last 2 years of data for Charles County Overall, for Charles County African Americans, and Charles County Whites. The disparity in rates between African Americans and Whites appears to be widening.



Arthritis

As of 2021, 25.6% of Charles County adults had been diagnosed with arthritis. This is above the Maryland percentage of 23.6% of adults. Of those adults who are currently living with arthritis, 48.0% reported that they are limited in their usual activities. Further questions were asked to determine the level of pain adults with diagnosed arthritis were living with. The largest percentage of adults rated their pain between 4 to 6, at 39.5%. 13.8% of adults reported their pain a 7 to 8. All other levels of pain were suppressed due to low numbers. Lastly, 65.4% of Charles County adults living with arthritis in 2021 reported that their doctor or other health professional has suggested physical activity or exercise to help with their arthritis or joint pain.

Chronic Kidney Disease

The CDC estimates that more than 1 in 7 U.S. adults, or 14%, have chronic kidney disease. In 2021, 2.3% of Charles County adults reported having doctor diagnosed kidney disease. This is slightly lower than the Maryland percentage of 2.6%. Compared to other Maryland counties, Charles County falls in the middle, with the highest percentage of chronic kidney disease in the state at 4.7% in Allegany County and the lowest percentage at 1.4% in Worcester County.

Disability and Health Impairment

In 2021, almost 20% of Charles County adults reported having one or more disabilities, including hearing disability. This is lower than the Maryland percentage of 22.5%. Among Charles County adults, 10.6% reported having a cognitive disability. This was the highest percentage among all the disabilities presented in the 2021 BRFSS. The Charles County percentage is just slightly above the Maryland percentage of 10.0%. The second highest percentage among Charles County adults was mobility disability at 7.9%.

2021 BRFSS Disability and Health Impairment, Charles County and Maryland	Charles County	Maryland
One or more disability	19.9%	22.5%
Vision Disability	4.5%	4.1%
Cognitive Disability	10.6%	10.0%
Mobility Disability	7.9%	9.5%
Self-Care Disability	*	2.5%
Independent Living Disability	4.6%	5.1%
Hearing Disability	3.4%	4.5%

**Estimate has been suppressed*

Chronic Lower Respiratory Disease

Mortality

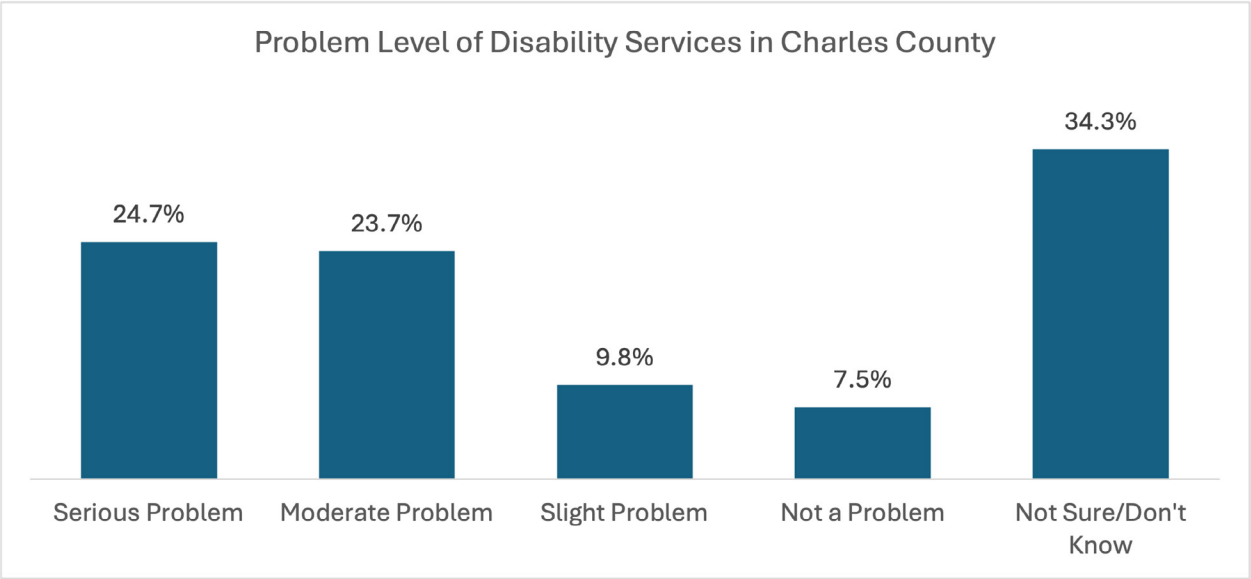
In 2021, there were a total of 1,813 deaths from chronic lower respiratory disease in Maryland. About 85% of these deaths were aged 65 years or older. Chronic lower respiratory disease was the 6th leading cause of death in Maryland in 2021. The 2021 age-adjusted death rate for chronic lower respiratory disease was 23.8 per 100,000 across all races.

In Charles County, there were a total of 44 deaths from chronic lower respiratory disease in 2021. The age-adjusted death rate for Charles County was 26.0 per 100,000, which is higher than the Maryland age-adjusted death rate of 23.8 per 100,000.

Community Health Needs Assessment

Long Survey Data

When asked to rate the problem level of Disability Services in Charles County, many survey respondents were not sure or did not know (34.3%). This could mean that community members are not aware of the various disability services offered in Charles County. Almost a quarter of survey respondents believed Disability Services was a serious problem in Charles County (24.7%), and 23.7% believed Disability Services was a moderate problem in Charles County. 7.5% of survey respondents believed that Disability Services was not a problem in the county.



Focus Groups

The senior population of Charles County was a popular topic amongst focus group participants. Many believed a key change that could be implemented in the county was to put more focus on the senior population. Participants mentioned that seniors want to be more active and that there is a need for more fitness activities for the senior population, including giving them better access to the pools. Senior isolation was also brought up in the focus group, and participants believe there needs to be more resources for those seniors who live in isolation, either by choice or by circumstance.

Another key change that was discussed was establishing a contractor in Charles County that can help the senior population with home repairs. The goal of this program is to help people age in their homes and keep their independence and mental health.

Lastly, focus group members mentioned the importance of medication adherence and understanding amongst the senior population. Sometimes older individuals do not understand how to take their medication and they can make mistakes on dosage timing and amounts. Having a support system, either a health professional or family member, assisting with their medications could make a difference.

The topic of chronic kidney disease in Charles County was also discussed in the focus group. Focus group members mentioned that there is a need for dialysis in Charles County. Currently, there is only 1 skilled nursing facility (Formerly Sagepoint now available at Green Acres) that can provide dialysis, and there are no other services in Charles County for chronic kidney failure. Focus group participants also mentioned that dialysis is only available at the hospital for acute inpatients, but not chronic patients. Lastly, it was discussed that there needs to be more education on the signs and symptoms of chronic kidney disease before it progresses to end-stage renal disease (ESRD), and more overall kidney disease prevention.

Aging Resources

1. 2021 Maryland Vital Statistics Annual Report Accessed at https://health.maryland.gov/vsa/Pages/reports.aspx
2. 2008-2017 and 2017 Charles County Alzheimer's disease and other dementia hospitalization rates. Maryland Health Services Cost Review Commission. Accessed at https://opendata.maryland.gov/Health-and-Human-Services/Hospitalization-Rate-Related-To-Alzheimer-s-Or-Oth/bp3u-42uv/about_data
3. 2021 Maryland BRFSS accessed at ibis.health.maryland.gov on March 6, 2024.
4. Chronic Kidney Disease Initiative. Centers for Disease Control and Prevention. Accessed at https://www.cdc.gov/kidneydisease/basics.html

Injury and Violence Statistics:

Injury-Related Mortality

There are various deaths recorded in the Maryland Vital Statistics Report related to accidental and intentional injuries. Accidents were the fourth leading cause of death in Charles County and the number one cause of death in individuals under the age of 24 years. In 2021, there were 70 deaths in Charles County and 3,071 deaths in Maryland due to accidents. 24 of the Charles County accident deaths were due to motor vehicle accidents. There were also 46 deaths due to other accidents, 19 deaths due to intentional self-harm or suicide and 11 homicides.

The 2021 Charles County crude accident death rate was 41.5 per 100,000. This is below the Maryland state rate of 49.7 per 100,000. However, Charles County has seen an increase in the accident rate from 31.0 in 2018 to 41.5 in 2021.

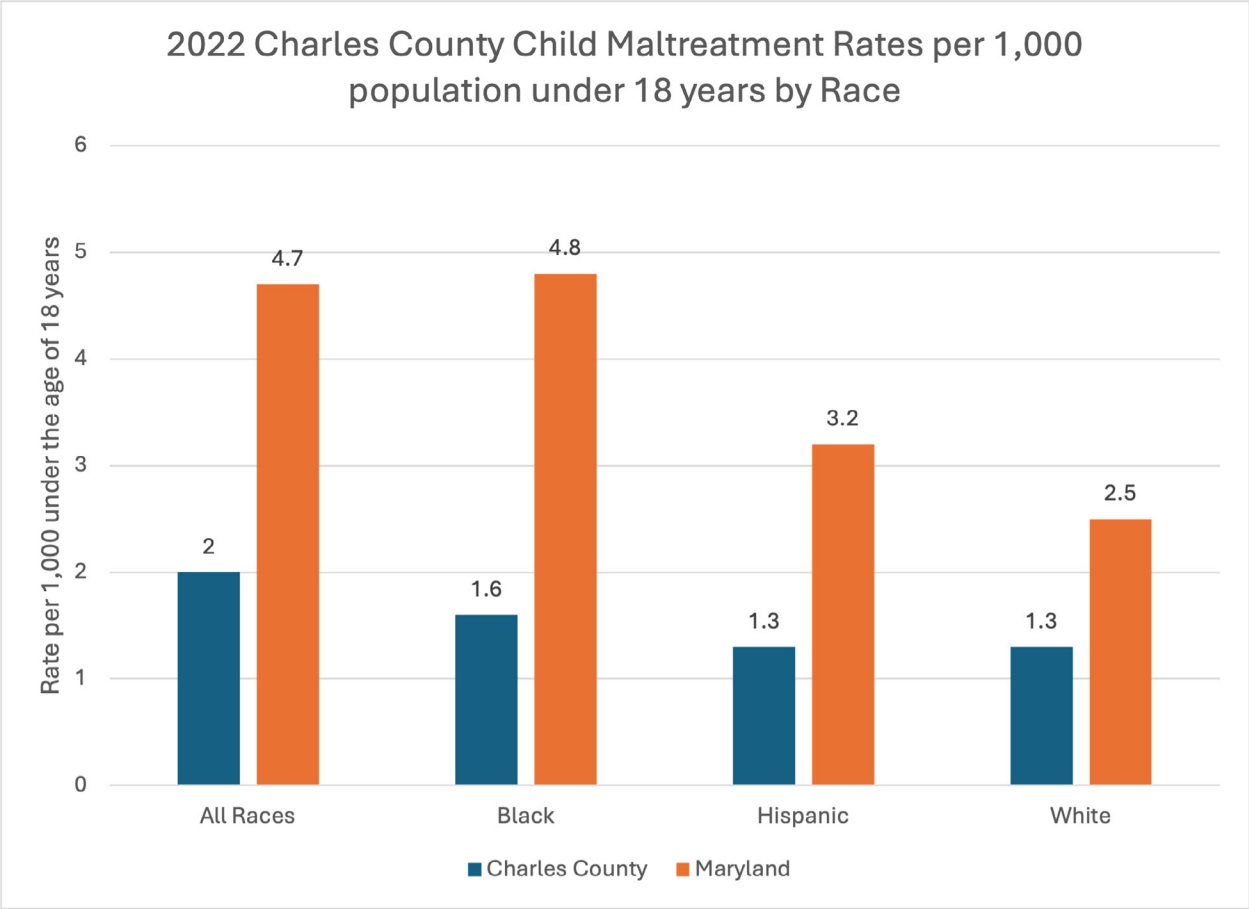
The 2021 age-adjusted Charles County accident death rate was 40.6 per 100,000 compared to 45.1 for the state of Maryland.

When looking at Charles County violent deaths among adolescents aged 10-19 years, there were 2 violent deaths in 2021. One was classified as an accident. The other was due to Assault/Homicide. No violent adolescent deaths were reported as intentional self-harm or suicide. Both violent deaths occurred among individuals who were Non-Hispanic Black.

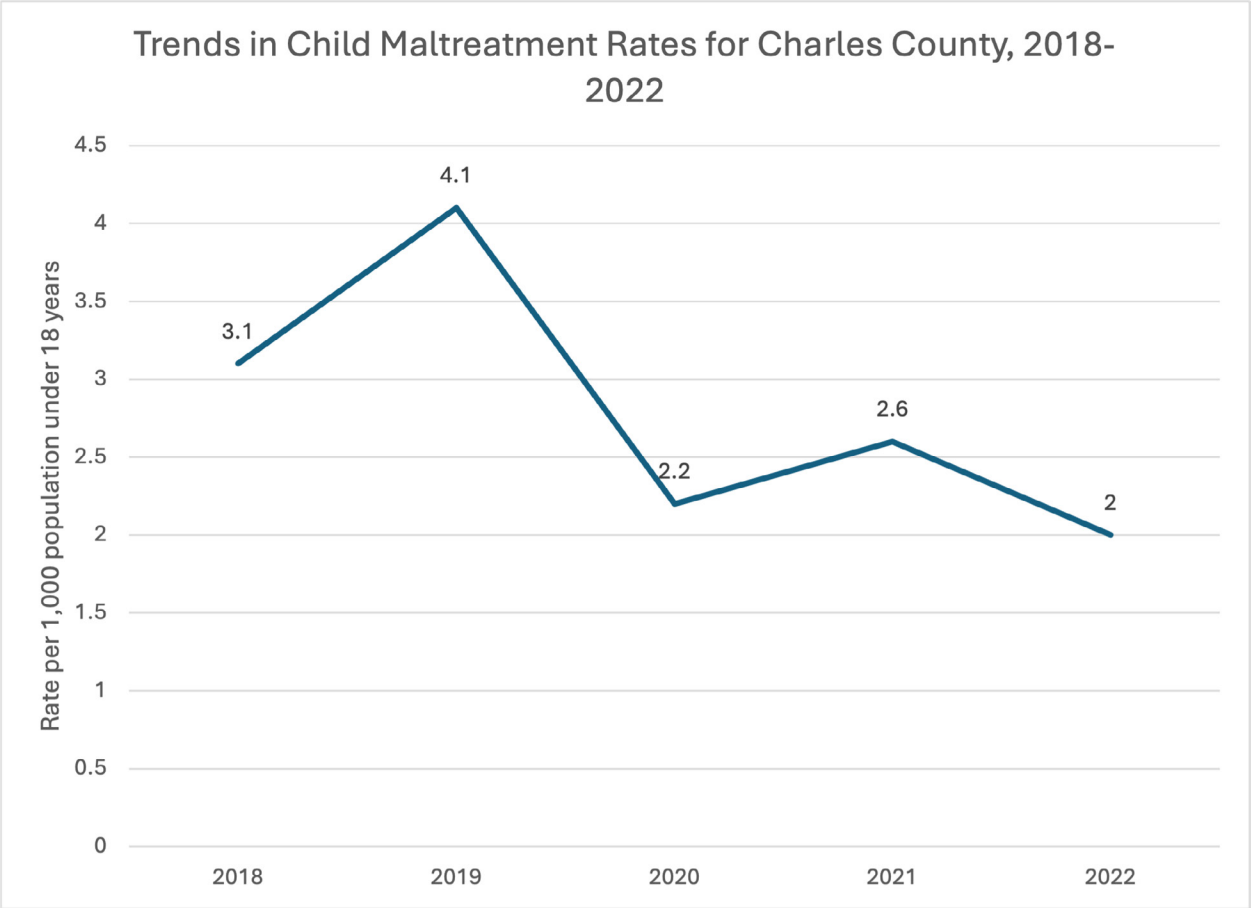
Injury-Related Morbidity

Child Maltreatment:

This indicator shows the rate of children who are maltreated per 1,000 population under the age of 18. Child abuse or neglect can result in physical harm, developmental delays, behavioral problems, or death. Abused and neglected children are at greater risk than other children for delinquency and mistreatment of their own children. The 2022 Charles County rate of children who were maltreated per 1,000 population was 2.0. This is below the Maryland state average rate of 4.7 per 1,000 population under the age of 18 years.


2022 Charles County Child Maltreatment Rates per 1,000 population under 18 years by Race
Rate per 1,000 under the age of 18 years
6
5
4
3
2
1
0
4.7
4.8
3.2
2.5
2
1.6
1.3
1.3
All Races
Black
Hispanic
White
Charles County
Maryland

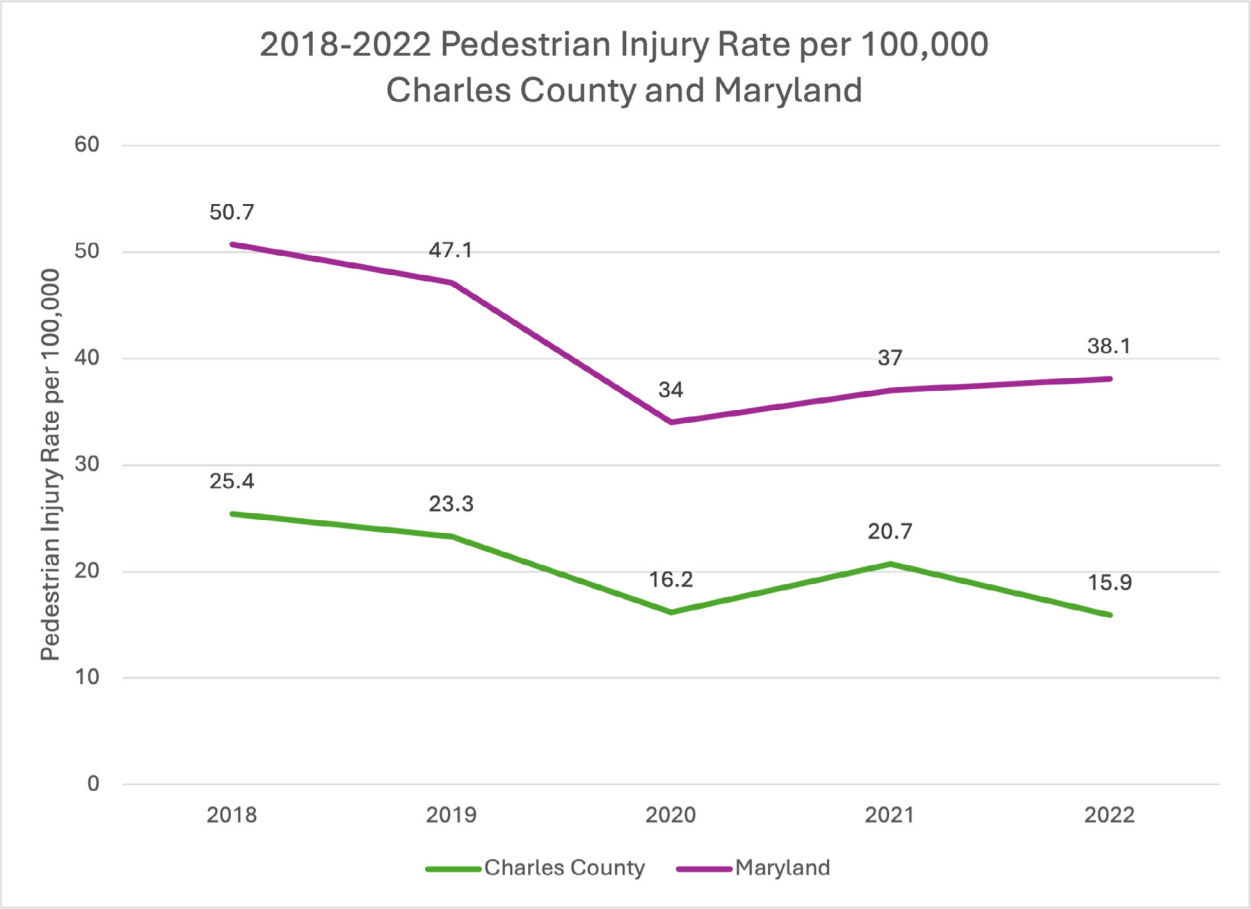
Looking at the trends in the Charles County child maltreatment rate, there has been a lot of fluctuation in the last 5 years; however, it does appear to be on the decline.



Pedestrian Injury Rate:

This indicator shows the rate of pedestrian injuries on public roads per 100,000 population. Maintaining pedestrian safety is a key element in preventing motor vehicle injuries and fatalities. Children are especially at risk for pedestrian injuries and fatalities.

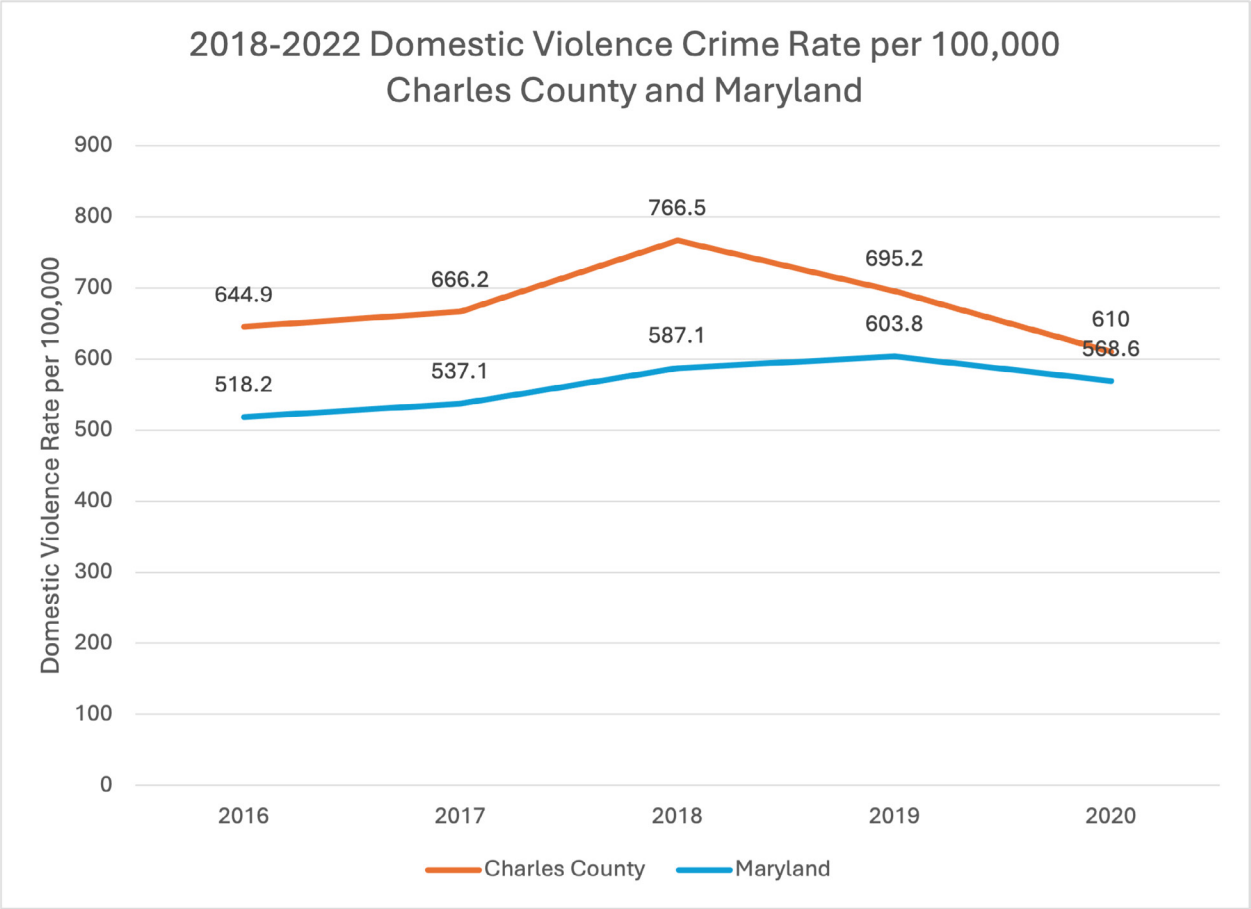
The 2022 Charles County pedestrian injury rate on public roads was 15.9 per 100,000. This is significantly lower than the Maryland state average rate of 38.1 per 100,000.



Domestic Violence:

Domestic violence contributes greatly to the morbidity and mortality of Maryland citizens. Up to 40% of violent juvenile offenders witnessed domestic violence in the homes, and 63% of homeless women and children have been victims of intimate partner violence as adults.

Charles County has consistently had a higher rate of domestic violence crimes than Maryland as whole. The 2020 Charles County domestic violence rate was 610 per 100,000 population. This is higher than the Maryland state rate of 568.6. Looking at trends, the rate of domestic violence crimes has been on the decline for Charles County.



Brain Injury:

The 2021 Maryland BRFSS asked, "In your lifetime, have you ever injured your head or neck in a fall or from being hit by something (for example, falling from a bike or horse, rollerblading, falling on ice, being hit by a rock, playing sports, or on the playground)?" 29.6% of Charles County respondents reported Yes. This is similar to the Maryland percentage of 28.5%.

An additional question asked about possible brain injury. Respondents were asked if they had ever experienced multiple blows to the head. 12.3% of Charles County respondents reported Yes. This is higher than the state percentage of 8.3%.

26.7% of Charles County BRFSS respondents reported that they have been hospitalized in their lifetime for a head or neck injury. The Maryland state percentage was 29.7%.

Fall Prevalence:

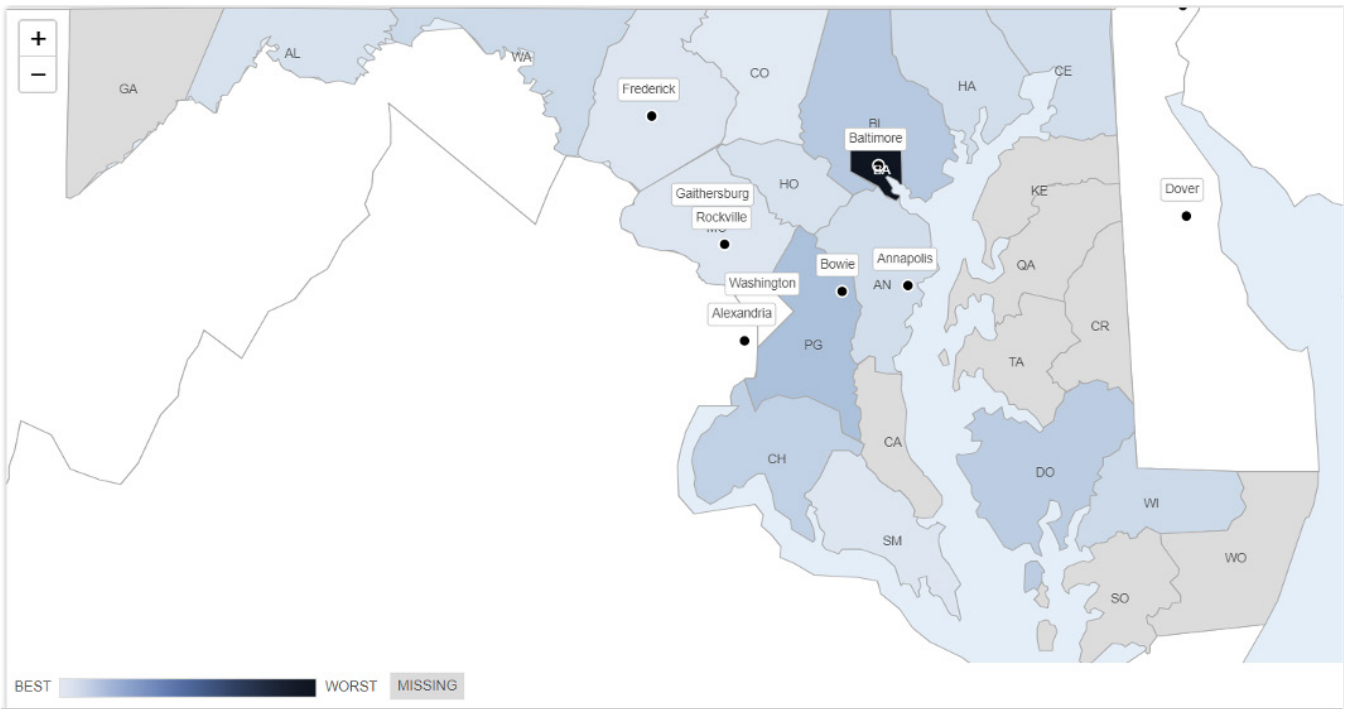
The 2020 BRFSS asked respondents if they have fallen in the last 12 months. 21.7% of Charles County respondents reported that they have fallen in the last 12 months. This percentage is identical to the Maryland state level percentage for this question.

They were also asked if the fall resulted in an injury. 78.3% of Charles County respondents reported that they had not had a fall in the last year. 16.4% reported that they had fallen, but they were not injured. 5.3% reported that they had been injured by 1 or more falls in the last year.

Homicides:

From 2014-2020, the average homicide rate in Charles County was 7 per 100,000 people. The Charles County rate is below the state rate of 9 per 100,000 people. Charles County and Maryland are above the US rate of 6 per 100,000.

In Maryland, the highest homicide rate was seen in Baltimore City.



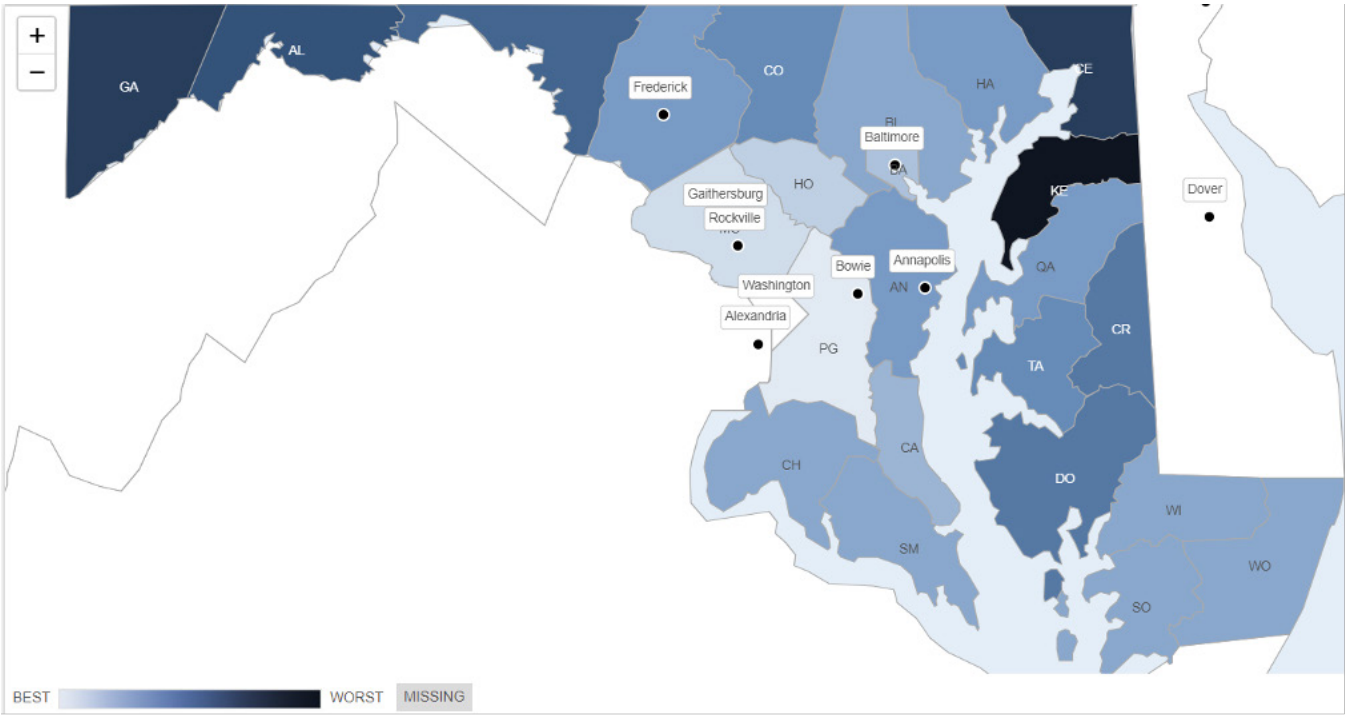
When examining rates by race, there is a clear disparity between Charles County Blacks and Charles County Whites. The homicide rate among Charles County Blacks was 12 per 100,000 compared to 3 for Charles County Whites. All other race data was suppressed due to small sample sizes.

Suicides:

The 2016-2020 age-adjusted suicide rate in Charles County was 11 per 100,000 people. The Charles County rate is slightly higher than the Maryland rate of 10 but below the national rate of 14 per 100,000.

When analyzing the suicide rate by race, Charles County Whites have a higher suicide rate than Charles County Blacks (15 vs. 4).

In Maryland, the highest suicide rates were in Kent, Cecil, and Garrett Counties.

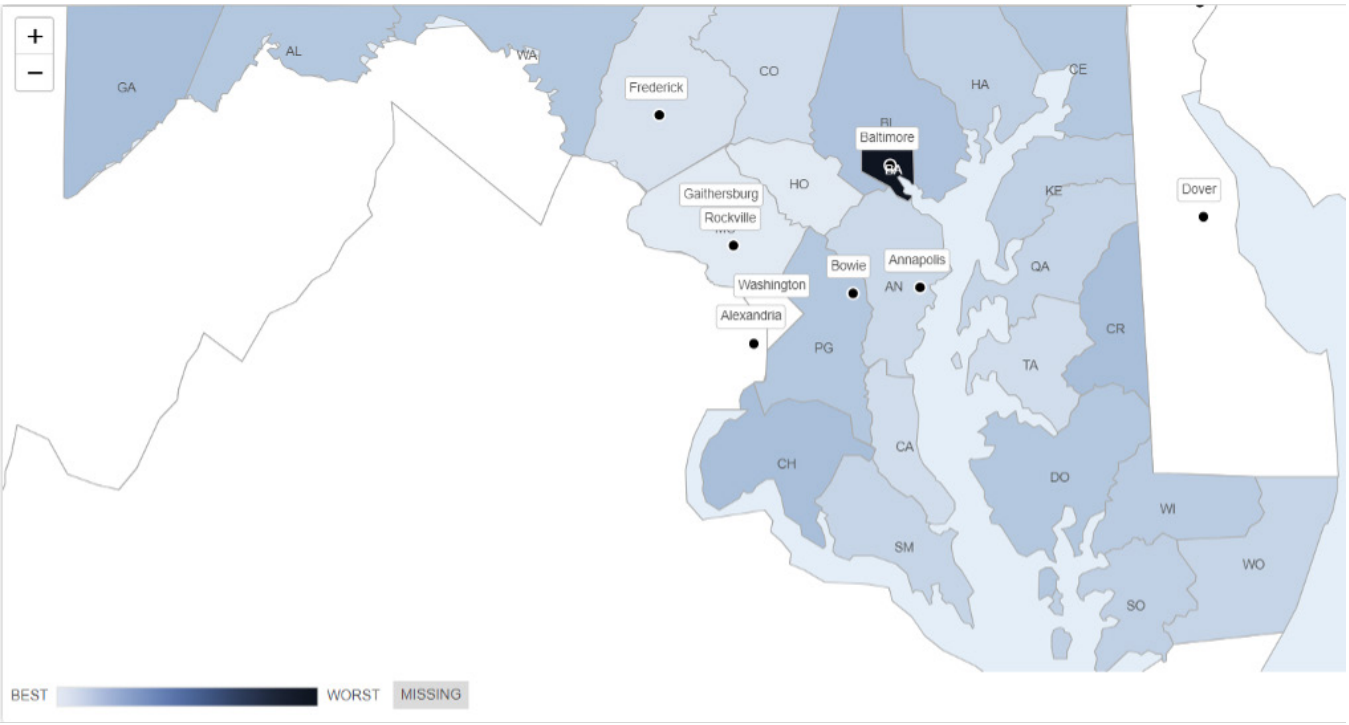


Firearm Fatalities:

From 2016-2020, the Charles County firearm fatality rate was 14 per 100,000. This is higher than the Maryland and US rates which were both 12 per 100,000.

The firearm fatality rates were similar when examined by race. The Charles County Black firearm fatality rate was 14 per 100,000. The Charles County White firearm fatality rate was 15 per 100,000.

In Maryland, the highest firearm fatality rate was in Baltimore City at 44 per 100,000.

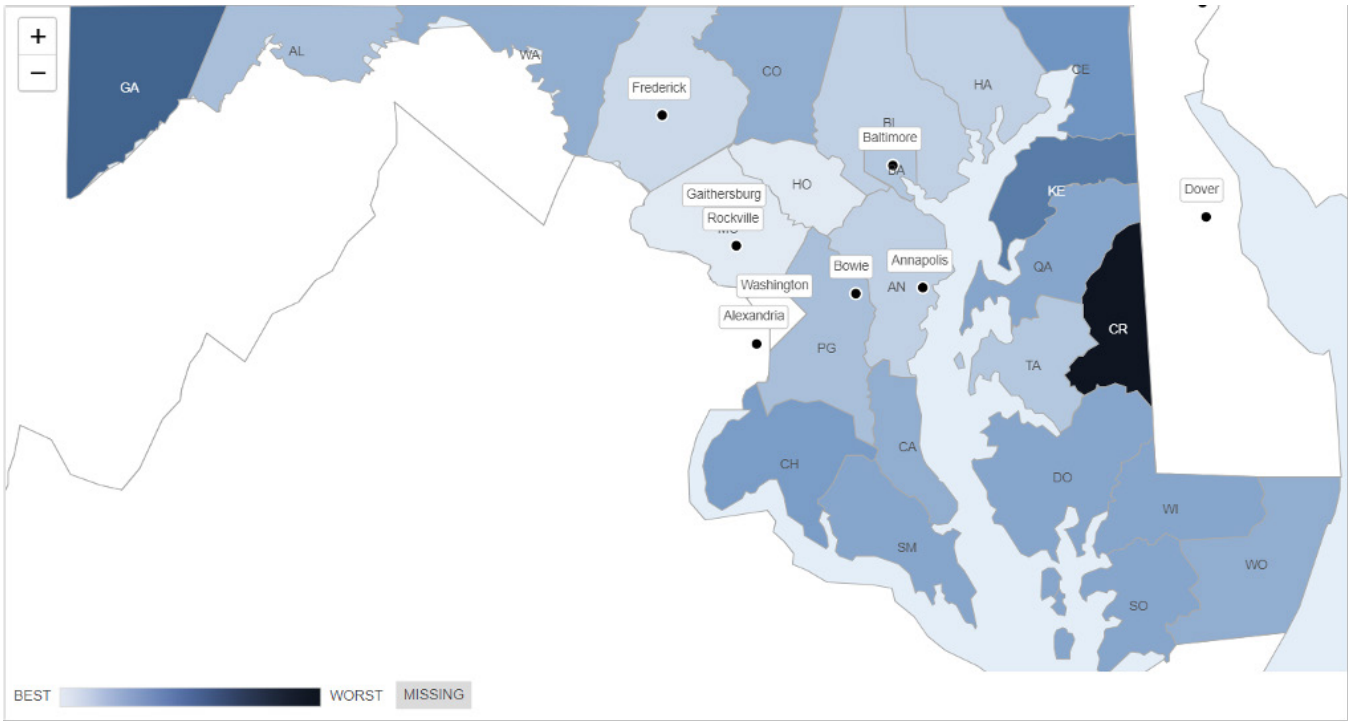


Motor Vehicle Crash Deaths:

From 2016-2020, the Charles County motor vehicle crash death rate was 14 per 100,000. This is higher than the Maryland rate of 9 and the US rate, which was 12 per 100,000.

The motor vehicle crash death rates were similar when examined by race. The Charles County Black firearm fatality rate was 15 per 100,000. The Charles County White motor vehicle fatality rate was 14 per 100,000.

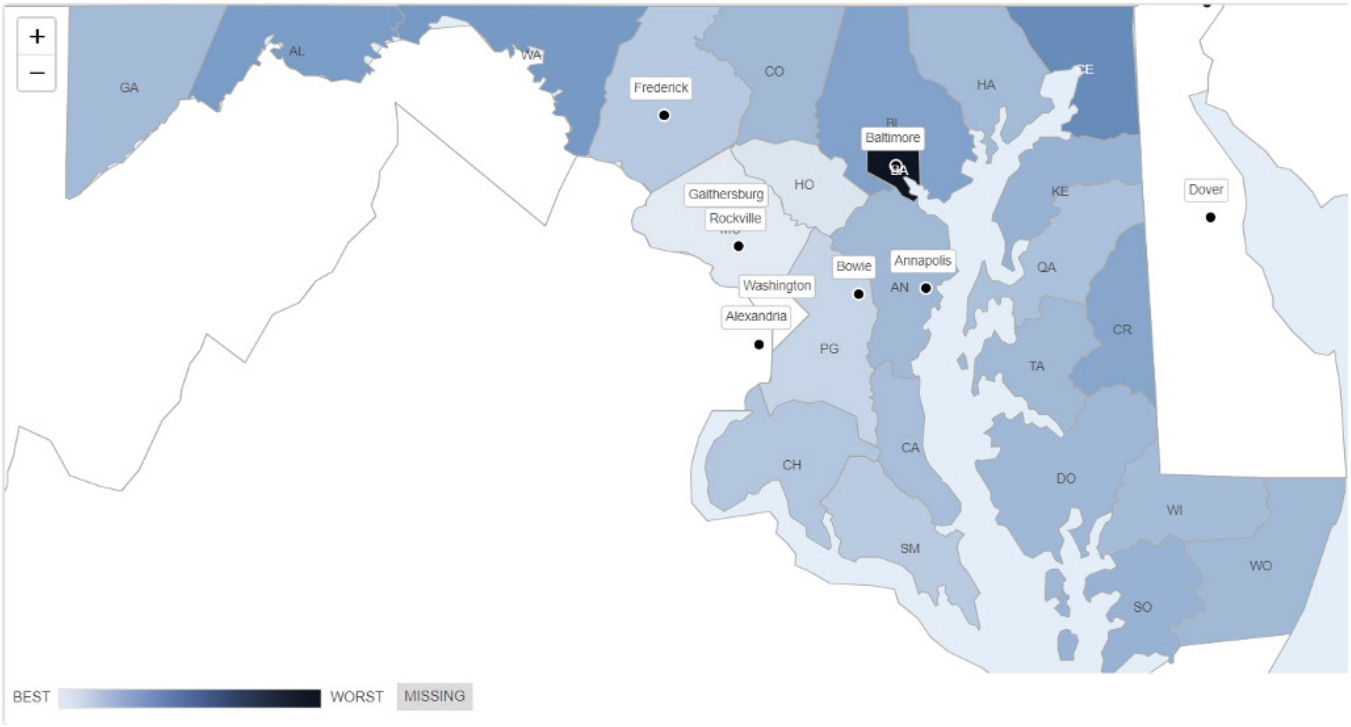
In Maryland, the highest motor vehicle fatality rate was in Caroline County.



Injury Death Rate:

The 2016-2020 rate of deaths due to injury per 100,000 in Charles County was 76 per 100,000. The Charles County injury death rate was lower than the Maryland state average rate of 88 per 100,000. There are disparities when examining the Charles County injury death rates by race. The rate is highest in Whites at 107 per 100,000.

In Maryland, the highest injury death rate was in Baltimore City.



Injury-related Death Rates per 100,000 people by Race/Ethnicity, 2016-2020:	Count
White	107
African American	59
Hispanic	53

Maryland Violence and Injury Prevention Data

Maryland state level data was extracted from the 2016 Maryland Violence and Injury Prevention Resource Guide for all-terrain vehicle safety, child abuse and neglect, distracted driving, home fires, intimate partner violence, teen driver safety, motorcycle safety, and traumatic brain injury.

All-Terrain Vehicle (ATV) Safety:

- From 1982-2011, ATV-related crashes accounted for 91 deaths in Maryland.
- From 2001-2006, more than 9,000 individuals were injured in off-road vehicle incidents and required treatment at Maryland emergency departments.
- Approximately two-thirds of trauma patients in ATV-related incidents were not wearing a helmet.

Child Abuse and Neglect:

- In 2014, there were an estimated 31,469 referrals screened for investigation for child abuse and neglect by Child Protective Services in Maryland.
- Of those screened reports, about 15,762 victims were indicated, at a rate of 11.7 per 1,000 children (1-17 years of age).
- In 2014, 11 children in Maryland died as the results of child abuse and neglect.

Distracted Driving:

- From 2009-2013, an average of 232 people were killed and 2,348 people were injured each year in crashes involving a distracted driver.
- Distracted driving in Maryland in 2013 led to 182 deaths and 26,995 injuries.

Home Fires:

The 2010-2014 Charles County fire-related death rate was 0.4 per 100,000. This is below the Maryland fire-related death rate of 1.1 per 100,000 for the same time period.

Intimate Partner Violence:

- In 2010, 1.23 of women in Maryland reported being a victim of rape, physical violence, and/or stalking by an intimate partner in their lifetime.
- Maryland has the 6th highest lifetime rate of Intimate Partner Violence in the country
- In 2010, 2.97 million men in Maryland reported being a victim of rape, physical violence, and/or stalking by an intimate partner in their lifetime.
- In 2010, 18 women and 3 men in Maryland were murdered as a result of Intimate Partner Violence.

Teen Driver Safety:

- From 2008-2014, motor vehicle crashes were the leading cause of death for Maryland teenagers, with 279 deaths and a rate of 13 per 100,000.
- In 2014, 26 teen drivers were killed in Maryland due to a motor vehicle crash.

Motorcycle Safety:

- In 2014, there were 69 motorcycle rider deaths in Maryland with a rate of 55 deaths per 100,000 registered drivers.

Traumatic Brain Injury:

- In 2013, approximately 43,600 Marylanders suffered from a traumatic brain injury (TBI).
- Most common causes of TBI-related hospitalizations in Maryland were falls and motor vehicle crashes.
- In 2013, TBI-related Emergency Department visits were highest in people aged 15-24 years. Deaths due to TBI were highest among those 85 and older.

Injury References

1. 2021 Charles County Injury/Motor Vehicle Accident Mortality Data. 2021 Maryland Vital Statistics Report. Maryland Department of Health. Available at https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Annual%20Reports/2021AnnualReport_Final_v1023.pdf.
2. 2018-2022 Child maltreatment data. Maryland Department of Human Resources. Accessed through the Maryland State Health Improvement Process website. Available at: https://health.maryland.gov/pophealth/Pages/SHIP-Lite-Home.aspx.
3. 2018-2022 Pedestrian Injury Rate on public roads. Maryland State Highway Administration. Accessed through the Maryland State Health Improvement Process website. Available at: https://health.maryland.gov/pophealth/Pages/SHIP-Lite-Home.aspx.
4. 2020 Domestic Violence Data, 2021 Brain Injury Data, and 2020 Fall Prevalence Data for Charles County and Maryland. 2020 and 2021 Maryland Behavioral Risk Factor Surveillance System. Available at: https://ibis.health.maryland.gov/.
5. 2016-2020 Homicide Rates, Injury related death rates, Suicide Rates, Firearm Fatality Rates, and Motor Vehicle Crash Death Rates for Charles County, Maryland, and US. Accessed through the Robert Wood Johnson Foundation's County Health Rankings. Available at www.countyhealthrankings.org.
6. Injury-related data on all-terrain vehicles, child abuse and neglect, distracted driving, home fires, intimate partner violence, teen driver safety, motorcycle safety, traumatic brain injury. 2016 Maryland Violence and Injury Prevention Resource Guide. Maryland Department of Health Violence and Injury Prevention Program. Available at https://phpa.health.maryland.gov/ohpet-up/Pages/EIPResourceGuide.aspx.

Qualitative Data Relating to Traffic Safety, Violence, and Injury

On the long health survey, participants were asked the severity of several health issues in Charles County. The community perceives crime as a problem in Charles County. Crime had the highest percentage reporting it as a problem on a slight, moderate, and serious problem combined (83.2%). Crime also had the 3rd highest number of people who felt that it is a serious problem in Charles County.

Traffic safety was also seen as a problem in Charles County. 78.3% of the long survey participants thought it was a problem on some level.

Health Issue/Condition:	Percent Reporting No Problem in county	Percent Reporting this as a problem at any level	Percent Reporting this as a serious problem
Injuries	6.5	52.1	13.6
Highway Safety/Traffic Accidents	7.0	78.3	38.0
Child Abuse and Neglect	6.7	53.3	18.9
Domestic Violence	6.3	62.7	29.8
Traumatic brain injury	7.5	40.4	11.2
Crime	6.6	83.2	47.7

Survey participants reported improvements in traffic safety in Charles County (12.02%). This was the 13th highest percentage among the health conditions. Injuries reported the lowest percentage of people reporting any improvement (4.29%).

Health Issues where improvements have been seen	Response Percent
Traffic Accidents	12.02%
Injuries	4.29%

Long survey behavioral risk factor data related to Traffic Safety or Injury:

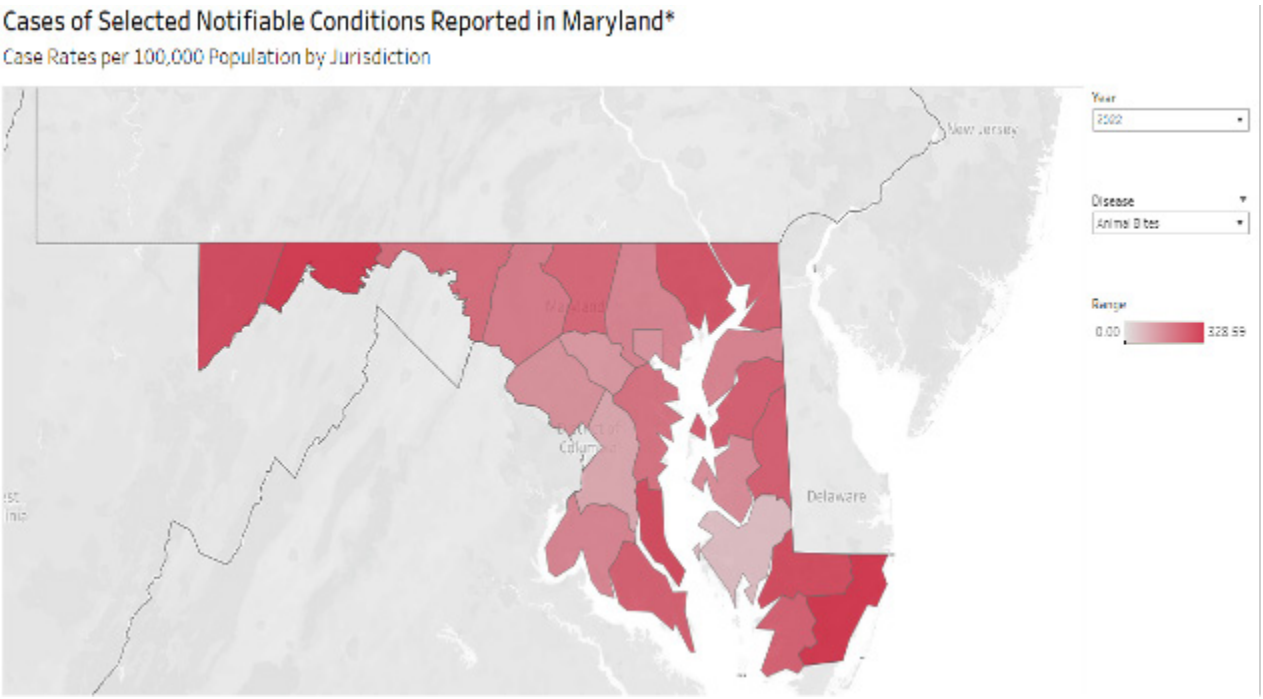
- 95.13% always wear a seat belt
- 55.57% always follow road safety rules
- 25.11% always wear a helmet when riding a bike
- 19.97% always wear a helmet when riding an ATV, scooter, or motorcycle
- 16.20% always participate in daily physical activity

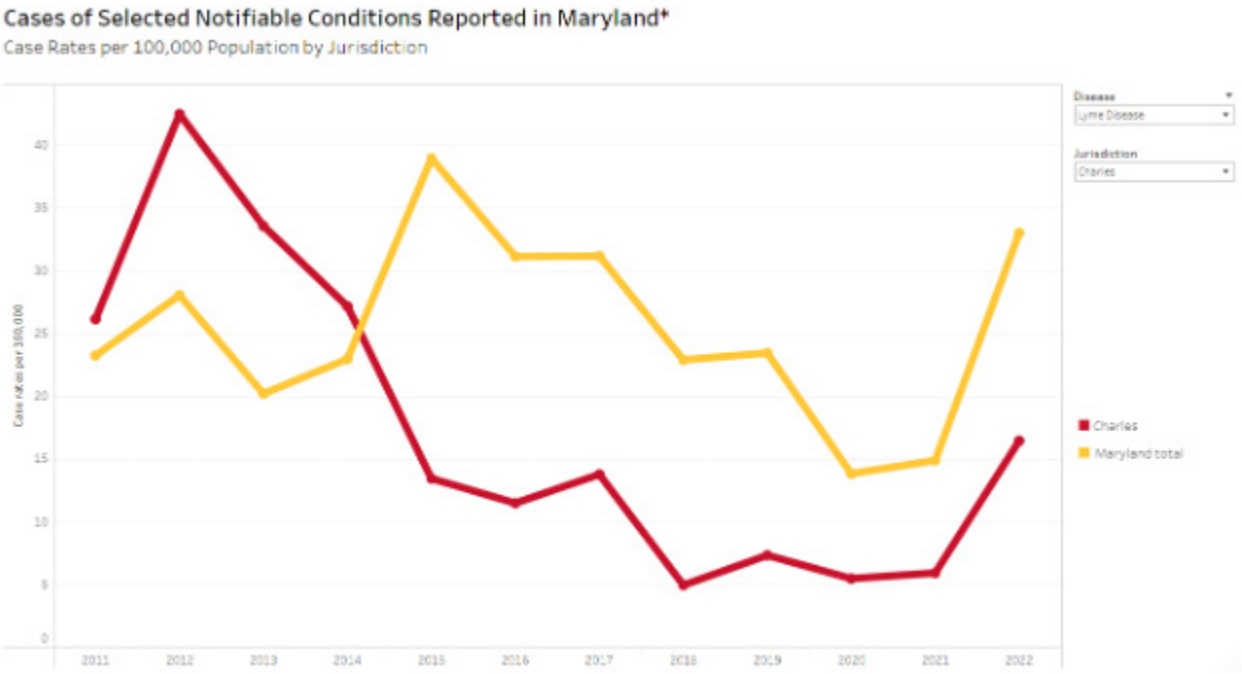
Injuries and Traffic Safety scored low on the short survey when participants were asked to choose the biggest health problems in Charles County. 5.8% felt that injuries were the biggest health problem in Charles County. This was the lowest among the health conditions listed. 21.1% of the short survey participants chose Traffic Safety as the biggest health problem in Charles County. This was the 7th lowest percentage among the health conditions listed. Several short survey participants recommended programming to help reduce crime in Charles County.

Charles County Infectious Disease and Environmental Health Data:

The table below shows the incidence for the twelve most reported communicable diseases in Charles County in 2022. Chlamydia had the highest incidence rate in Charles County for 2022 at 506.66 per 100,000. The top two communicable diseases with the highest incident counts in 2022 in Charles County were both sexually transmitted diseases, Chlamydia and Gonorrhea. The next two most reported conditions were animal bites and Lyme Disease.

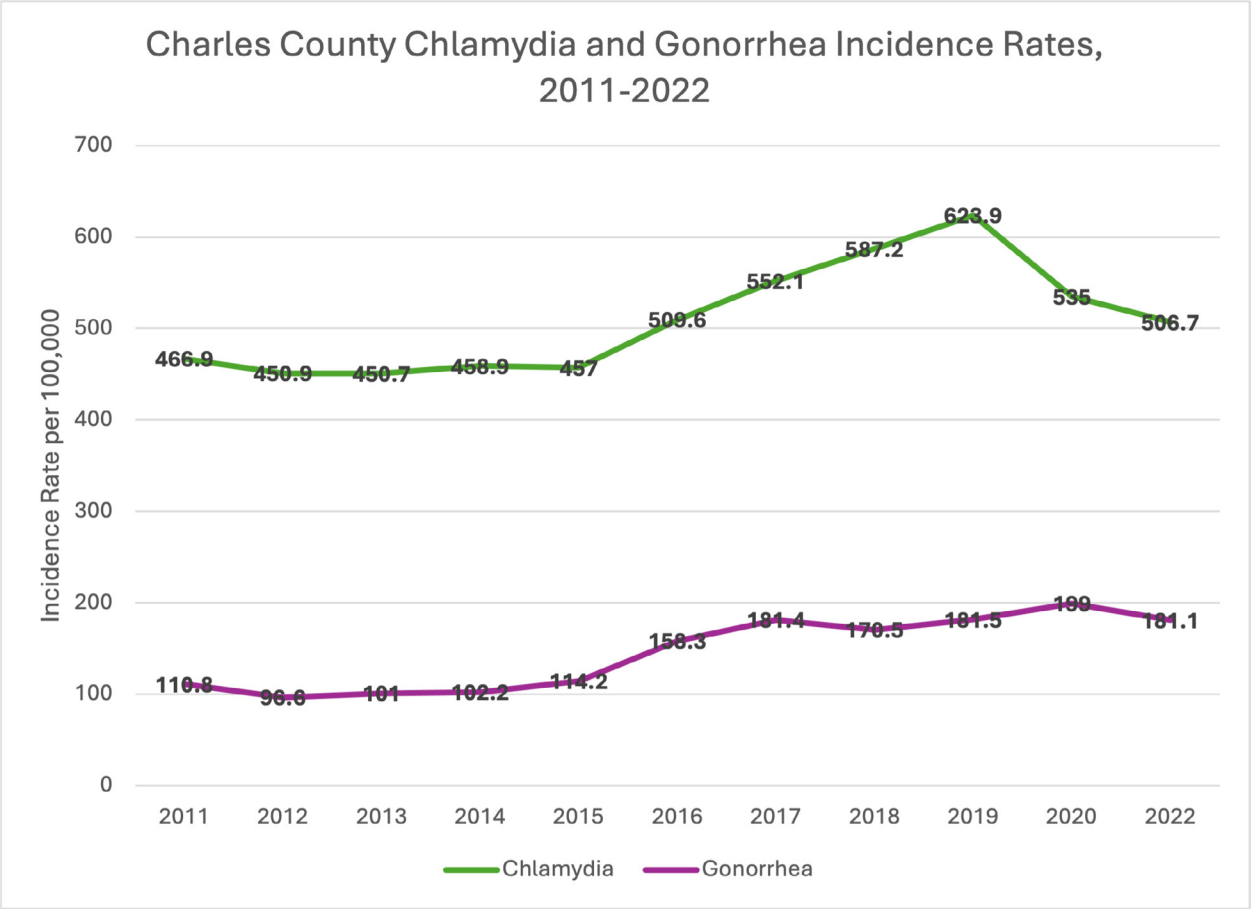
Selected Notifiable Conditions Reported in Charles County, 2022	Case Counts	Incidence Rates per 100,000 population
Chlamydia	826	506.66
Gonorrhea	267	181.10
Animal Bites	295	175.55
Invasive Strep Group B	20	8.74
Invasive Strep Group A	7	6.10
Legionellosis	4	3.29
Mycobacteriosis, Other than TB & Leprosy	14	11.66
Salmonellosis- Other than Typhoid Fever	18	13.95
Syphilis- Primary and Secondary	9	12.67
Invasive Strep pneumoniae	10	6.52
Campylobacteriosis	9	17.71
Lyme Disease	28	33.03
Invasive H. influenzae	4	1.78
Aseptic Meningitis	4	2.38
Shiga toxin producing E coli	4	4.87





Chlamydia and Gonorrhea incidence rates are on the decline after a steady increase from 2015-2019. Data for 2021 is not available due to a network security incident at the Maryland Department of Health.

The 2022 incidence rate for Chlamydia in Charles County was 506.66 per 100,000, compared to the 2011 incident rate of 466.9 per 100,000. The 2022 Gonorrhea incident rate in Charles County was 181.1 per 100,000, compared to the 2011 rate of 110.80 per 100,000.



Rabies

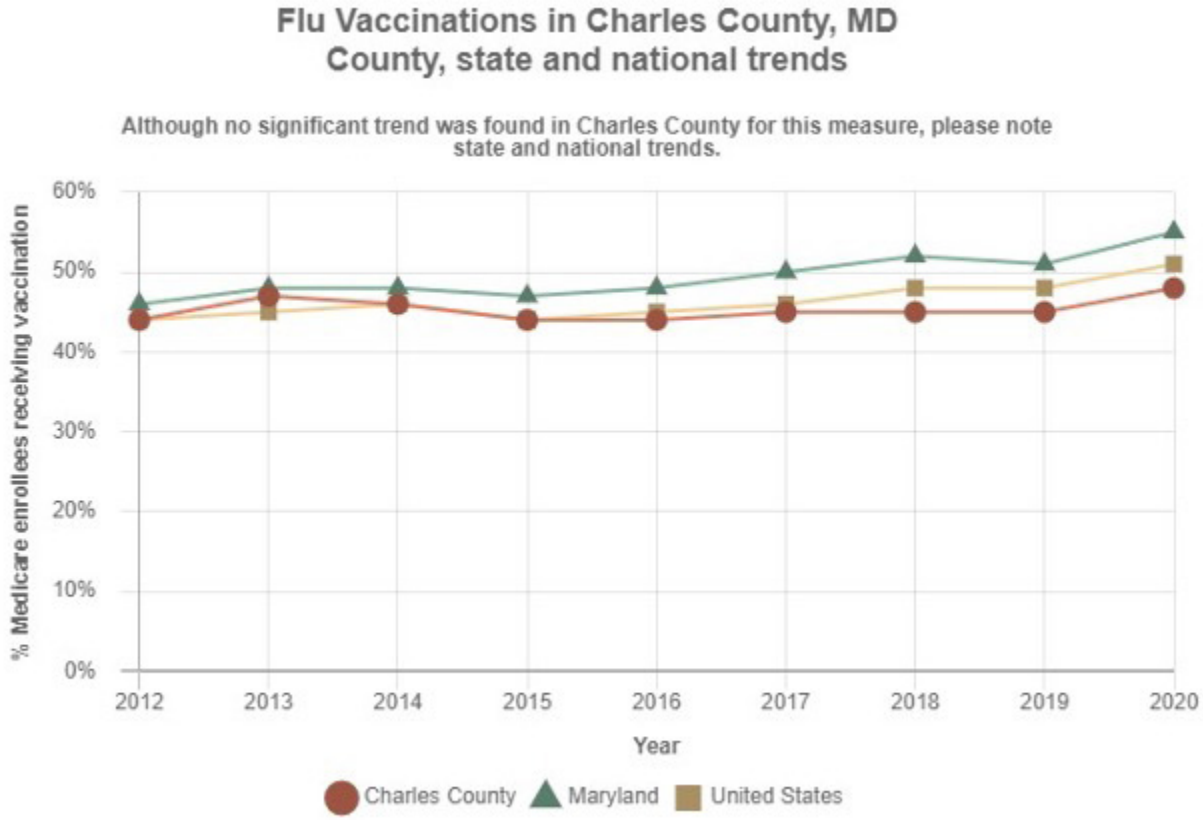
No human rabies cases were reported in Charles County from 2010-2022. Charles County has seen a decline in animal rabies cases from 12 in 2010 to 3 in 2022. With such small case counts, it is not uncommon to see fluctuation in counts from year to year. Raccoons and bats are commonly reported animal rabies cases. Case counts from 2010 to 2022 are presented below for overall animal rabies cases, bats, raccoons, and skunks.

2010-2020 Animal Rabies Case Counts for Charles County	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
Total Animal Rabies Cases	12	14	14	9	11	5	7	8	6	7	6	4	3
Bat Rabies Cases	1	0	7	1	1	0	1	3	0	1	1	1	1
Raccoon Rabies Cases	7	6	6	3	5	1	1	3	4	4	3	1	0
Skunk Rabies Cases	1	1	1	0	3	1	3	0	2	0	0	0	1

Vaccinations

Influenza/Flu:

In 2020, 48% of Charles County adult Medicare enrollees received the flu vaccine. This percentage has been increasing each year since 2015.

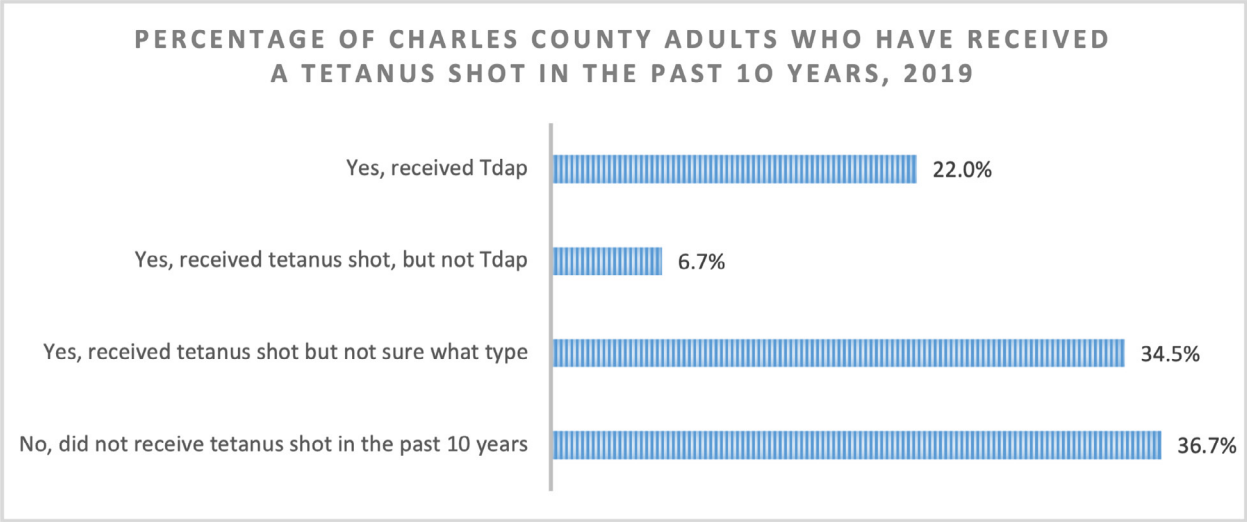


Pneumonia:

In 2019, 37.0% of Charles County adults received the pneumonia shot at some point. This percentage is an increase from the 2018 percentage of 28.1%. The Maryland state average percentage in 2019 for adults who received the pneumonia shot was 36.9%.

Tetanus:

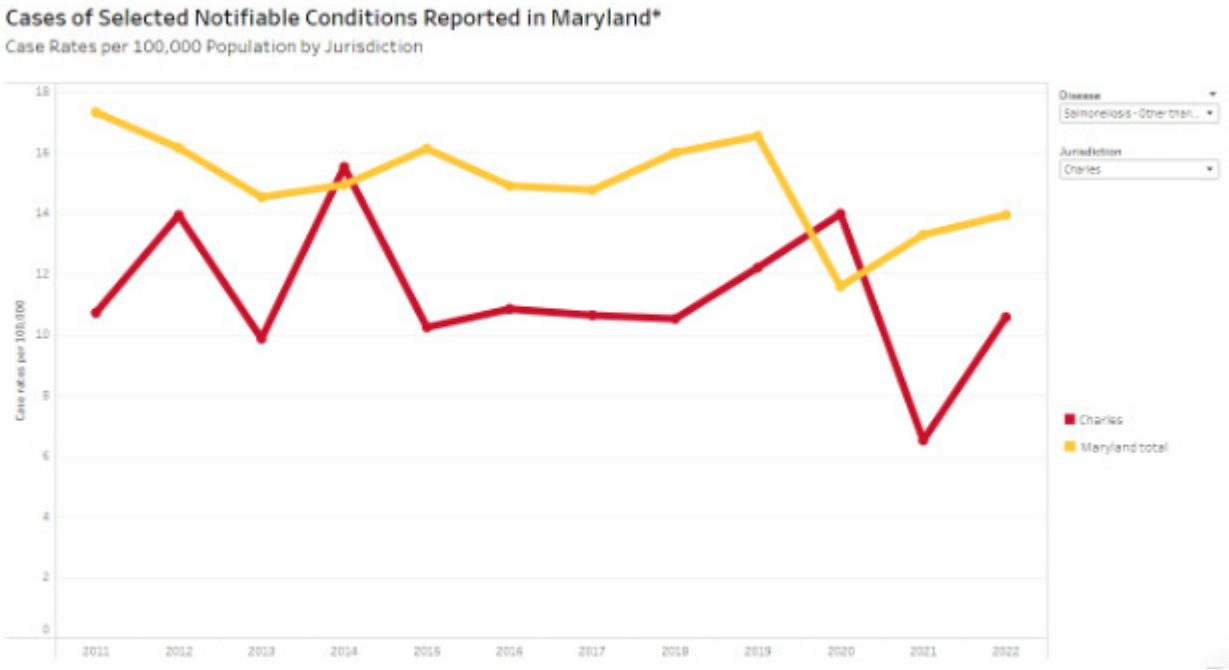
The BRFSS captured data on the percentage of adults who received a tetanus shot in the past ten years. In 2019, 63.2% of Charles County adults reported receiving a tetanus shot of some kind; 36.7% reported not receiving a tetanus shot in the past ten years. This data is also broken down into the whether individuals received Tdap specifically.



The Maryland state average percent of adults who received a tetanus shot in the past ten years was 72.7% in 2019. 27.2% of Maryland adults reported not receiving a tetanus shot in the past 10 years.

Salmonella

The 2022 Charles County case rate for Salmonella was 13.95 per 100,000. This is higher than the 2018 rate of 10.5 per 100,000. Trends cannot be established since the rate fluctuates each year.



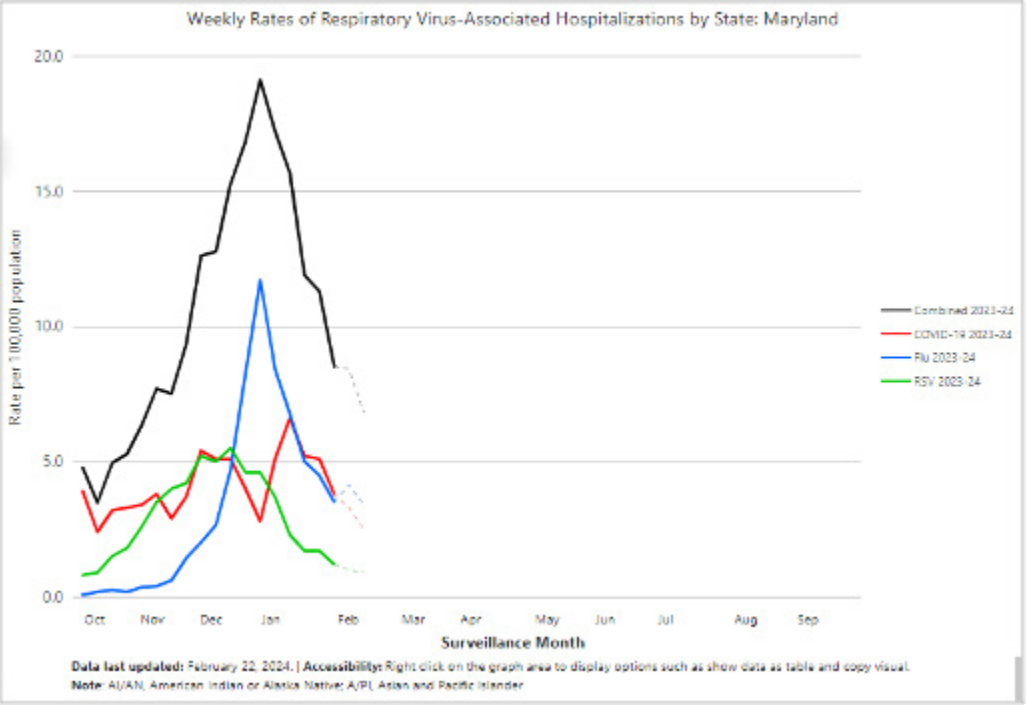
Respiratory Viruses

COVID-19, Influenza, and RSV:

At the time of this report, there have been 40,723 confirmed cases of COVID-19 in Charles County since the start of the COVID-19 pandemic. Additionally, there have been 438 confirmed and 3 probable deaths since the start of the pandemic in 2020.

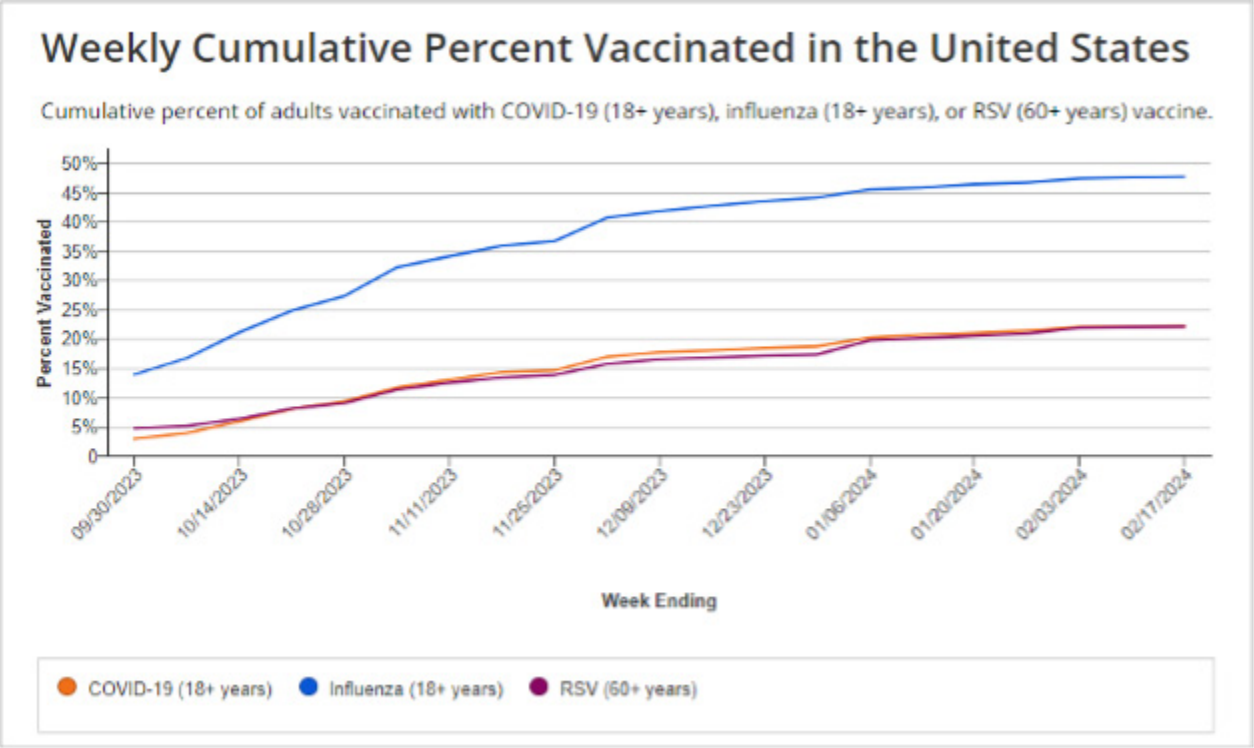
Respiratory Viruses include COVID-19, Influenza, and RSV. Hospitalization rates are monitored in Maryland to determine what prevention and surveillance measures are needed. The graph below shows the weekly respiratory virus associated hospitalization for Maryland for the 2023-2024 respiratory virus season.

Weekly Rates of Respiratory Virus-Associated Hospitalizations by State: Maryland



Maryland Weekly Rate of Respiratory Virus-Associated Hospitalizations (Combined): 8.5

**Weekly Cumulative Percent Vaccinated in the United States:
Adults for the 2023-24 Respiratory Virus Season**



COVID-19 (18+ years): 22.3%

Influenza (18+ years): 47.8%

RSV (60+ years): 22.2%

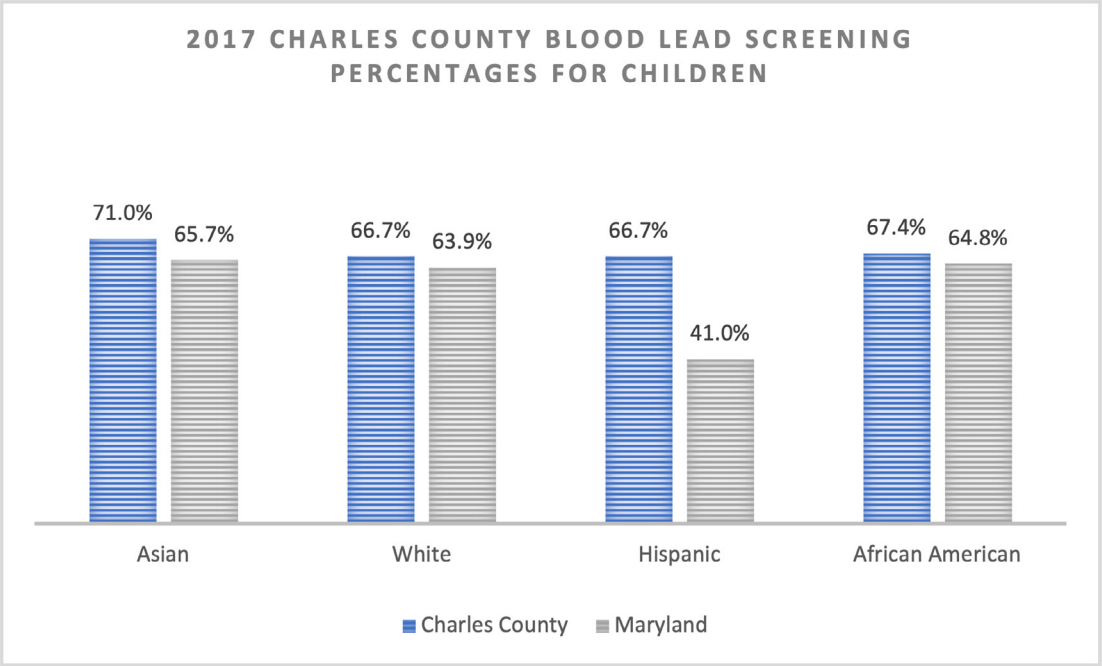
Environmental Health

Blood Lead Levels:

This indicator reflects the percentage of children (aged 12-35 months) enrolled in Medicaid (90+ days) screened for lead in their blood. Each pediatric Medicaid enrollee should be screened for blood lead during their 12 and 24 month well child visit. Common sources of pediatric lead exposure include dust and paint chips from chipping or peeling lead paint, as well as lead contaminated: soil, toys, water, cosmetics, and folk medicines.

In 2017, 65.7% of Charles County children enrolled in Medicaid had a blood lead screening. This is equal to the state percentage of 65.7%. Blood lead screenings were highest in Charles County Asians (71.0%) and lowest in Charles County Hispanics and Charles County Whites (66.7%).

The Charles County blood lead screening percentage has increased from 61.6% of Medicaid children in 2016 to 65.7% in 2017.

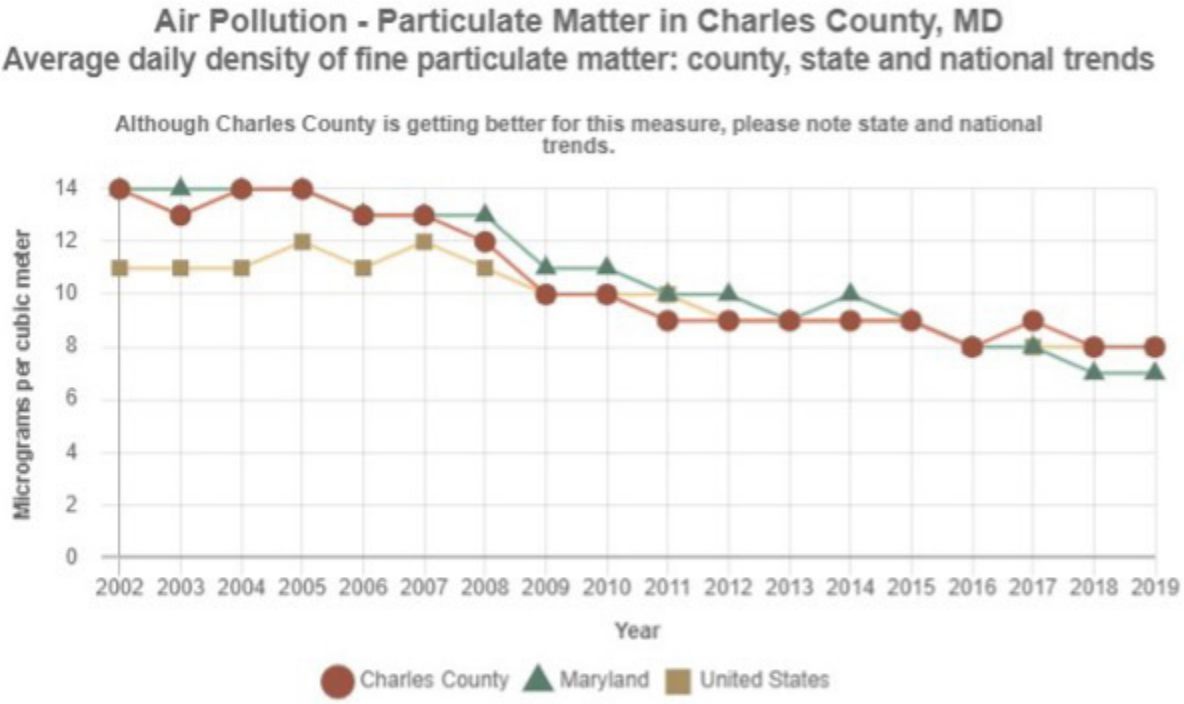


In 2020, among those screened for blood lead, 0.2% of Charles County children had a blood lead levels greater than 10 mg/dL. This is the same as the Maryland state percentage of 0.2%.

Percent of children with blood lead levels above 10 mcg/dL	Ch0.1arles County	Maryland
2016	0.1	0.3
2017	0.1	0.3
2018	0	0.3
2019	0	0.2
2020	0.2	0.2

Air Pollution: Particulate Matter

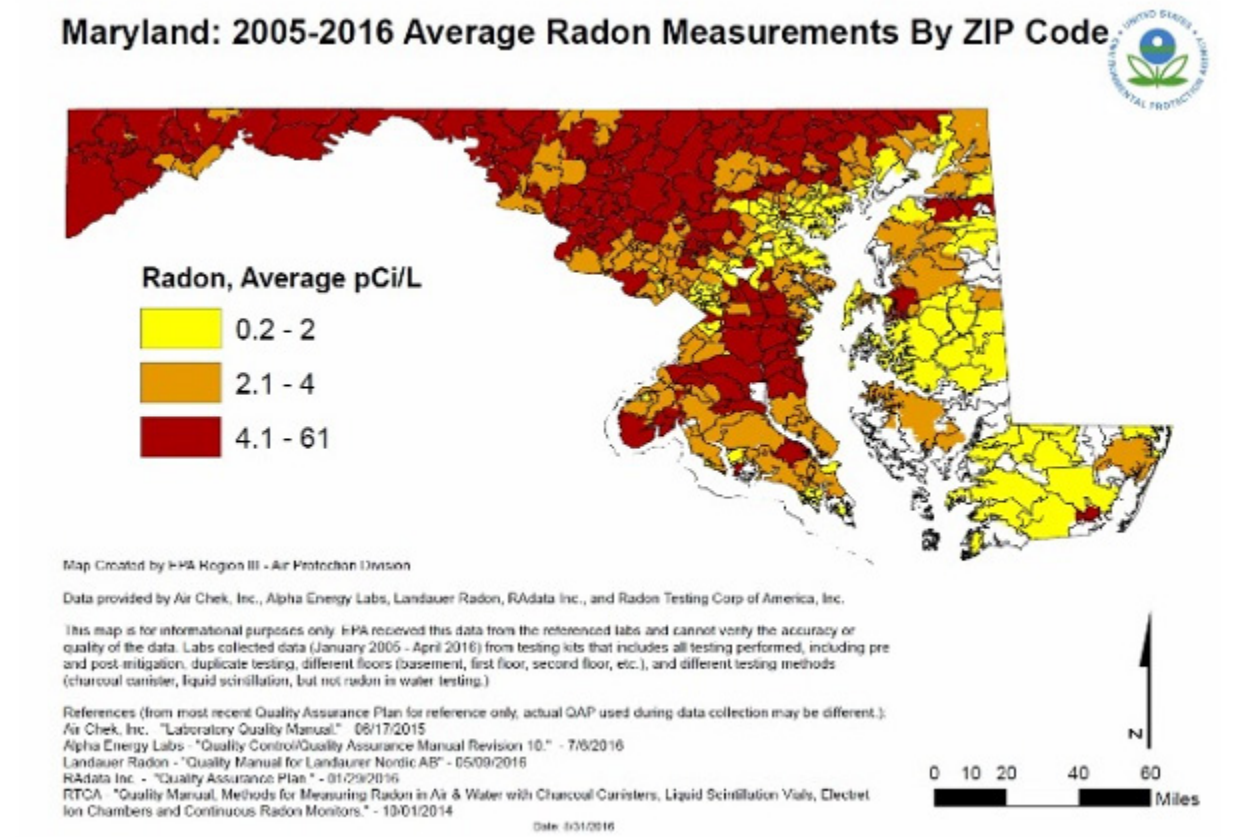
The 2019 average daily density of fine particulate matter in micrograms per cubic meter in Charles County was 8 micrograms per cubic meter. The county measure is above the Maryland measure of 7 micrograms per cubic meter. The Environmental Protection Agency (EPA) has primary annual average standards of 12.0 micrograms per cubic meter. Charles County and Maryland are well below those standards.



Notes:
Data in this trend graph are taken from the Environmental Public Health Tracking Network, and will not match data used in the 2014-2016 Rankings.

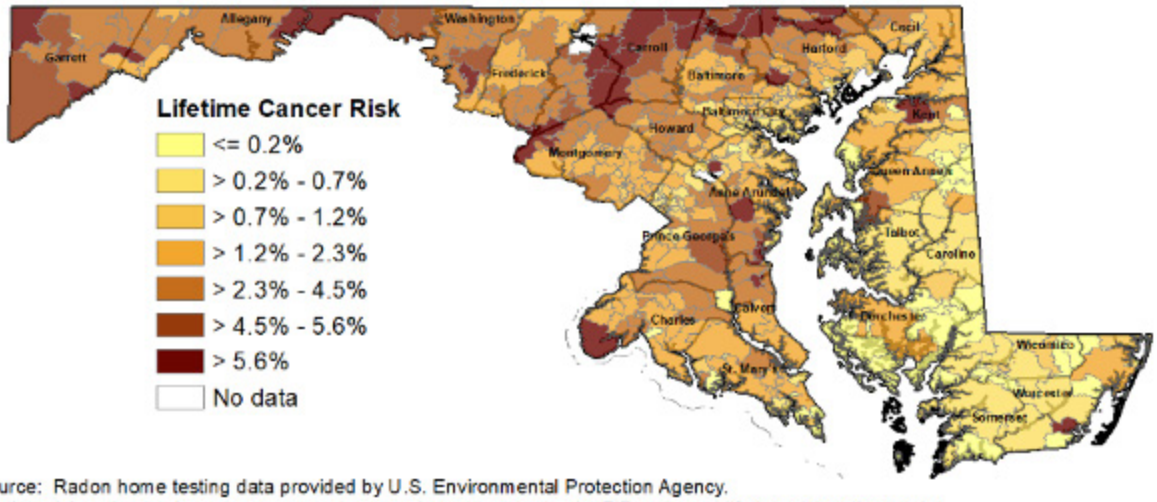
Radon:

The map below shows radon levels measured in homes by ZIP code in Maryland from 2005-2016. The U.S. Environmental Protection Agency (EPA) recommends testing all homes for radon, and fixing homes if their levels are higher than 4 picocuries per liter (pCi/L).



After smoking, radon is the most important preventable cause of lung cancer in the United States and in Maryland. The map below, based on the radon test data from 2005 - 2016, shows how much radon could increase the lifetime risk of lung cancer if it were not tested and abated in homes. The highest risk appears to be in the zip code of Nanjemoy, 20662, located in the western region of the county.

Lifetime Maryland Radon Lung Cancer Risk by ZIP Code
Based on Measured Home Radon Concentrations 2005 - 2016



Source: Radon home testing data provided by U.S. Environmental Protection Agency.
Lifetime risk estimates based on average home radon concentration by ZIP code and lifetime risk estimates in:
U.S. EPA. "EPA Assessment of Risks from Radon in Homes," EPA 402-R-03-003, June, 2003, Washington, DC: Appendix D, p. 82.

Qualitative Data Relating to Infectious Disease and Environmental Health

60.6% of long survey participants believed Infectious Disease (i.e. COVID-19) was a problem on some level in Charles County. 12.8% of participants believed Infectious Disease was a serious problem in Charles County; this is a large decrease from 30.4% reported on the last needs assessment when the county was amid the COVID-19 pandemic.

64.3% of long survey participants believed Environmental Health was a problem on some level in Charles County. 19.3% of participants believed Environmental Health was a serious problem in Charles County.

Protective factors that can reduce transmission of infectious diseases:

1. 86% of participants report always washing their hands after using the bathroom or before making food.

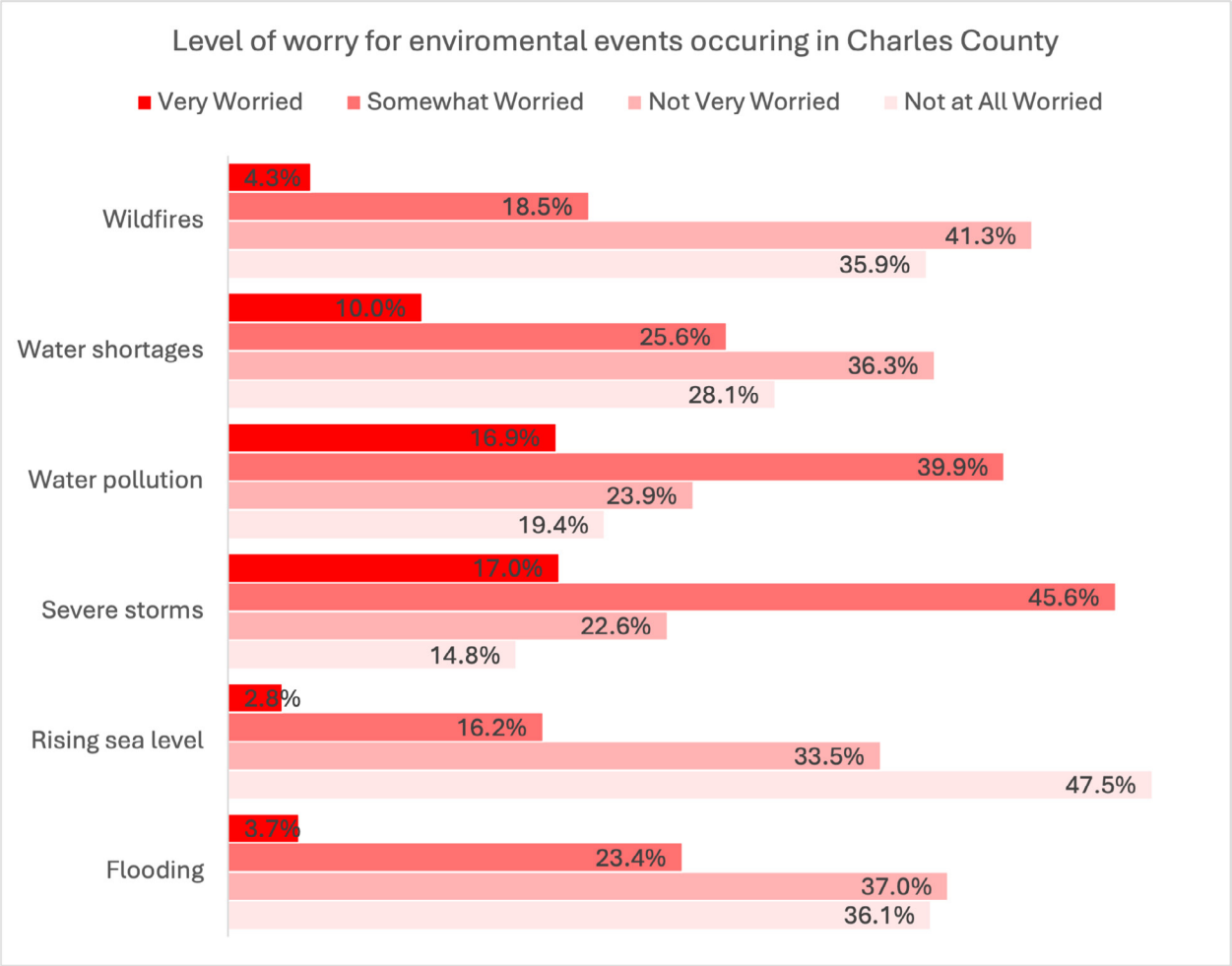
2. 49% of participants report always receiving a flu shot every year.

Risk factors that can increase transmission of infectious diseases:

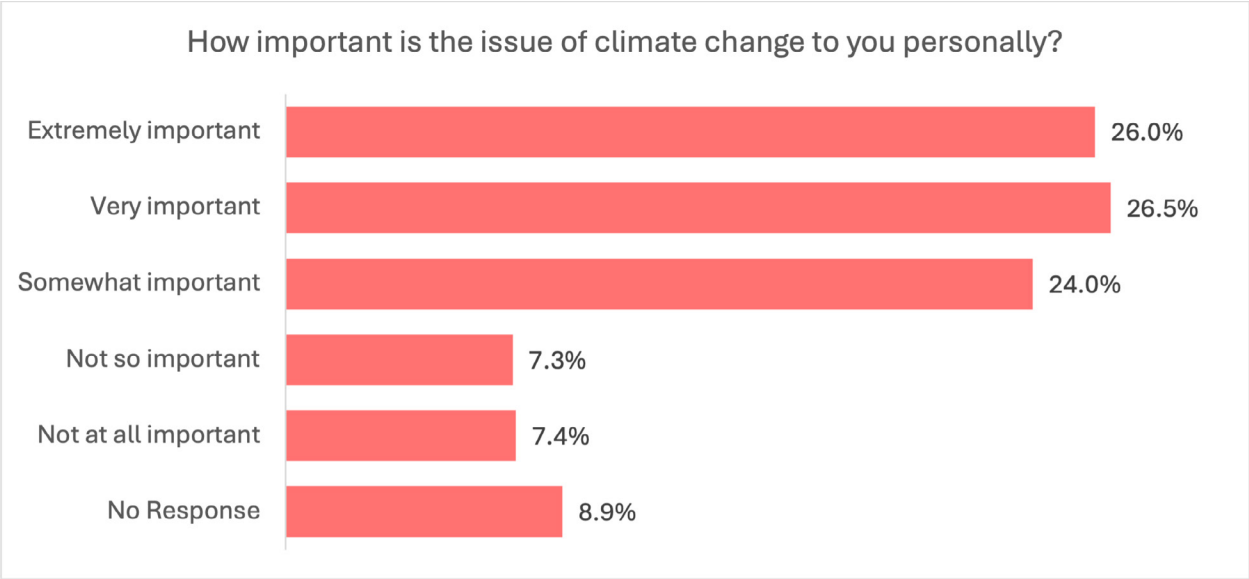
1. 29.4% of participants report always practicing safe sex (ex. use a condom, get tested)

Few short survey participants reported COVID-19 and sexually transmitted diseases as some of the biggest health problems in Charles County. When asked if there are sufficient services and resources available in Charles County for infectious disease specifically, 43.8% of participants reported some or many services are available. 10.6% reported Infectious Diseases as a big health problem in the county.

Long survey participants were asked to rate their level of worry about various environmental events that could occur in the county. Overall, many participants were not worried about these events occurring in Charles County. Water pollution and severe storms had the highest percentage of participants who reported being either very or somewhat worried that they could harm the community. About 17% of participants reported they were very worried about water pollution and severe storms harming the community. Water pollution and severe storms also had the highest percentage of participants who reported being somewhat worried about these events harming Charles County, at 39.9% and 45.6% respectively. Rising sea level was the environmental event most participants reported not being worried about. 81% of survey participants reported not being very worried or not at all worried about rising sea levels harming Charles County.



Although many participants were not worried about specific environmental events harming Charles County, a large percentage reported that climate change was important to them. Over half of survey respondents reported that the issue of climate change was either very or extremely important to them (52.5%). Over a quarter of participants reported that climate change was extremely important to them (26.0%). Only 14.7% of respondents reported that climate change is not so important to them or not at all important to them.



Infectious Disease and Environmental Health References:

1. 2011-2022 Charles County Reportable Communicable Disease Data, Salmonella data, Respiratory Virus Data. Infectious Disease Bureau. Maryland Department of Health. Available at: https://phpa.health.maryland.gov/Pages/infectious_disease.aspx.

2. 2010-2022 Charles County and Maryland Rabies Data. Infectious Disease Bureau. Maryland Department of Health. Available at: http://phpa.dhmh.maryland.gov/Pages/infectious_disease.aspx.

3. 2020 Charles County and Maryland Influenza Vaccination Rates. Centers for Medicare and Medicaid. Office of Minority Health's Mapping Medicare Disparities Tool. Measure accessed through the Robert Wood Johnson Foundation's County Health Rankings. Available at: countyhealthrankings.org.

4. 2019 Pneumonia and Tetanus Vaccination Rates. Maryland Behavioral Risk Factor Surveillance System and the National Immunization Survey Estimates. Accessed through the Maryland State Health Improvement Process website (Under Quality Preventative Care). Available at: https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx

5. 2011-2017 Charles County Blood Screening (Under Healthy Beginnings) and 2016-2020 elevated blood lead Percentages in Medicaid enrolled children (Under Healthy Communities). 2017 and 2020 Maryland Medicaid Service Utilization data. Accessed through the Maryland State Health Improvement Process website. Available at https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx

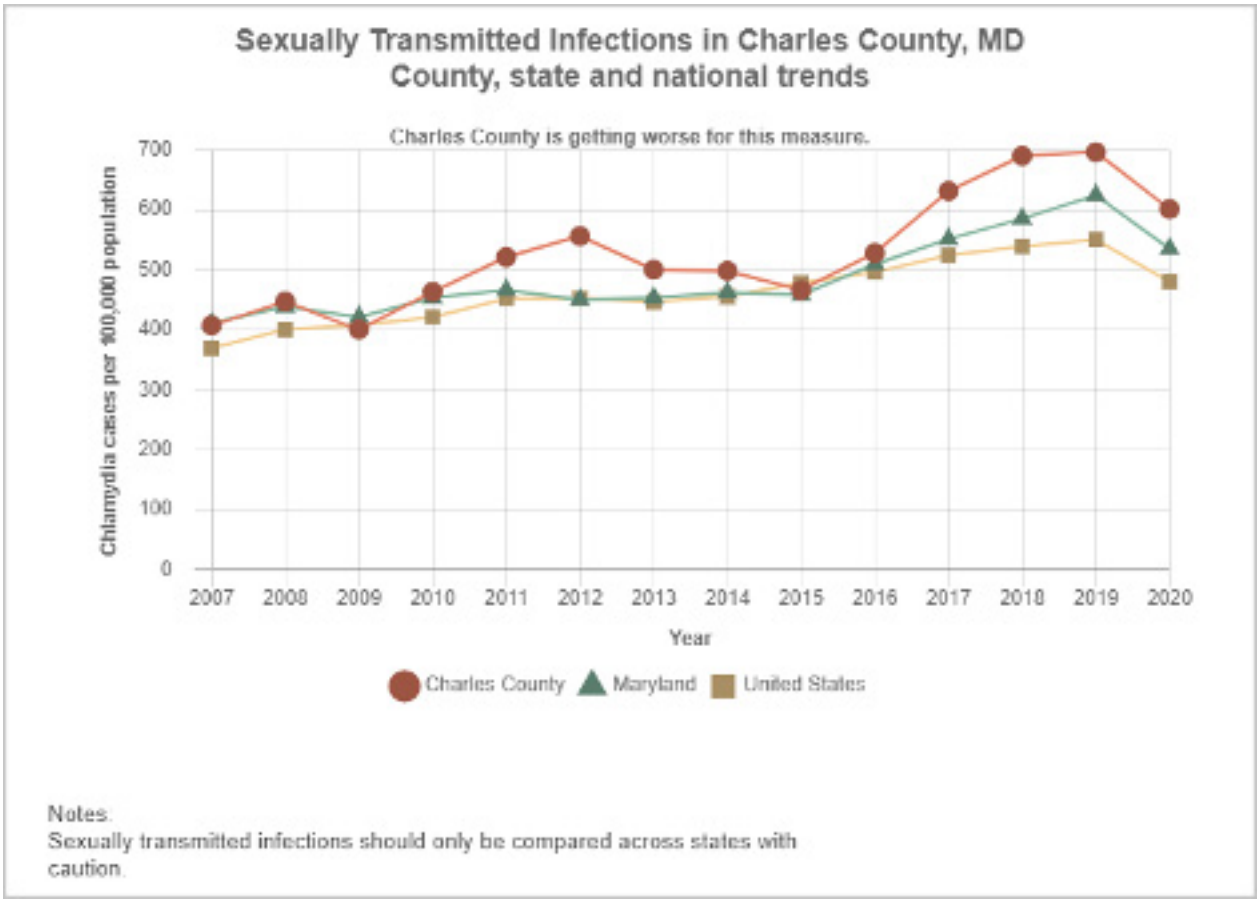
6. 2019 Air pollution data for Charles County and Maryland. Robert Wood Johnson Foundation's County Health Rankings. Available at countyhealthrankings.org.

7. Radon maps by Maryland zip codes. Maryland Department of Health. Environmental Health Bureau. Available at: https://health.maryland.gov/phpa/OEHFP/EH/Pages/Radon.aspx.

HIV/AIDS and STI's:

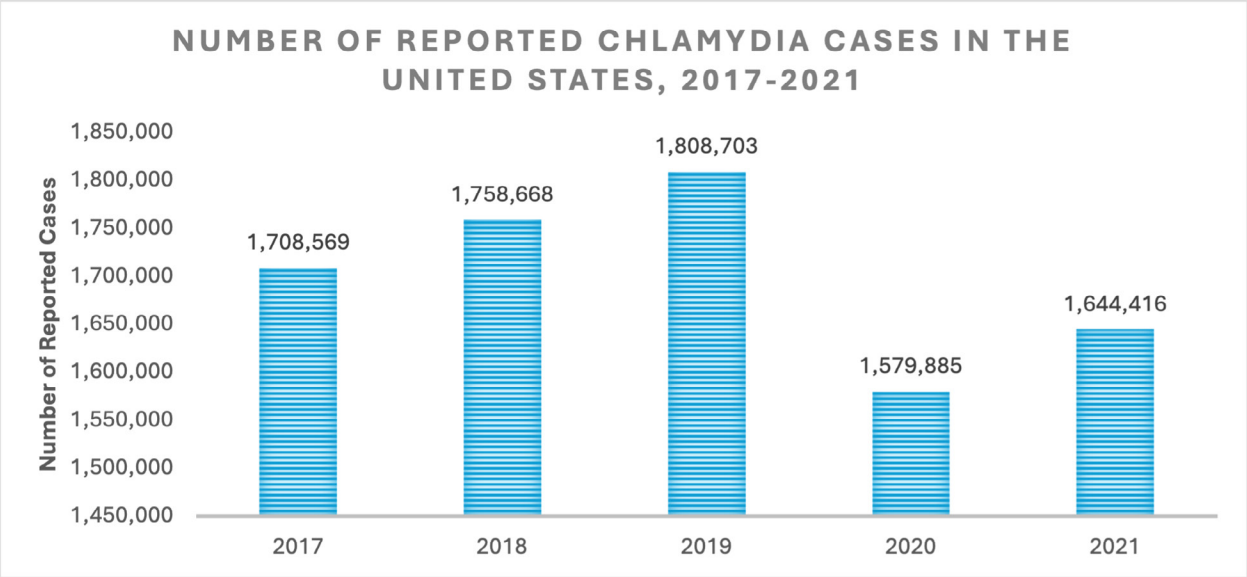
Sexually Transmitted Infections

The incidence of sexually transmitted infections in Charles County continued to increase from the years 2015 to 2019, but recently saw a decrease in infections in 2020. According to the Robert Wood Johnson Foundation County Health Rankings, the 2020 Charles County Chlamydia incidence rate was 602.1 per 100,000, down from 697 per 100,000 in 2019. Although there was a decline, the Charles County incidence rate remains higher than the state of Maryland (535.9 per 100,000) and the United States (481.3 per 100,000).



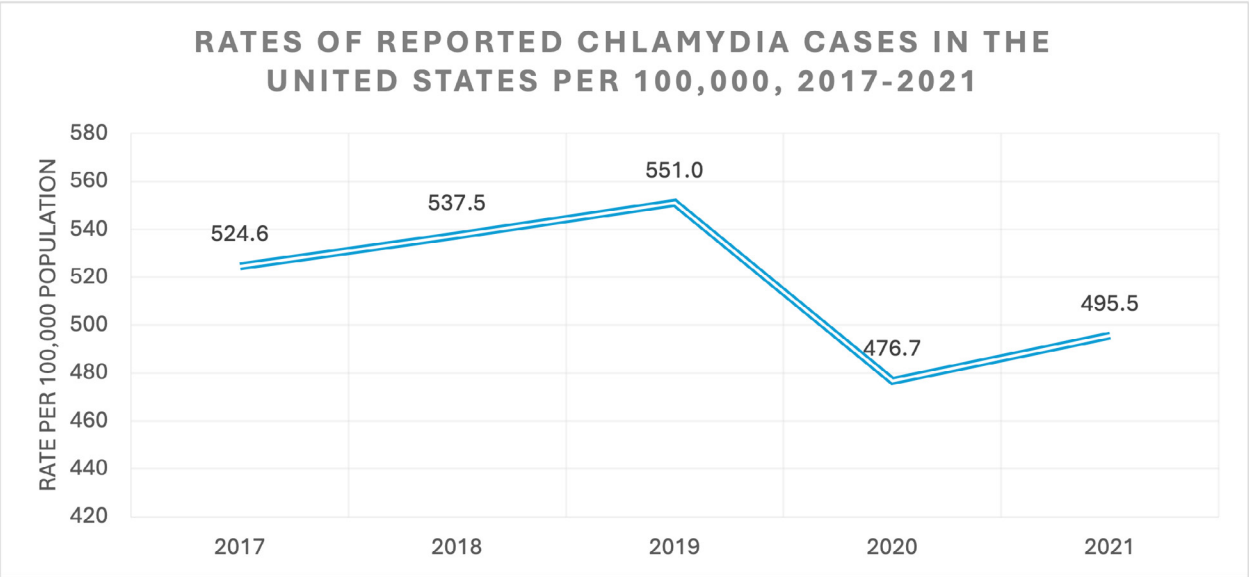
Chlamydia:

The STI incidence rates for Chlamydia, Gonorrhea, and Syphilis were all seeing increases on the national, state, and local level, prior to the COVID-19 pandemic. In the United States, there were over 1.6 million reported cases of chlamydia in 2021. This total is lower than the 2019 total of over 1.8 million cases, but higher than the 2020 total. However, the COVID-19 pandemic may have had an impact on the lower number of cases in 2020 and 2021.



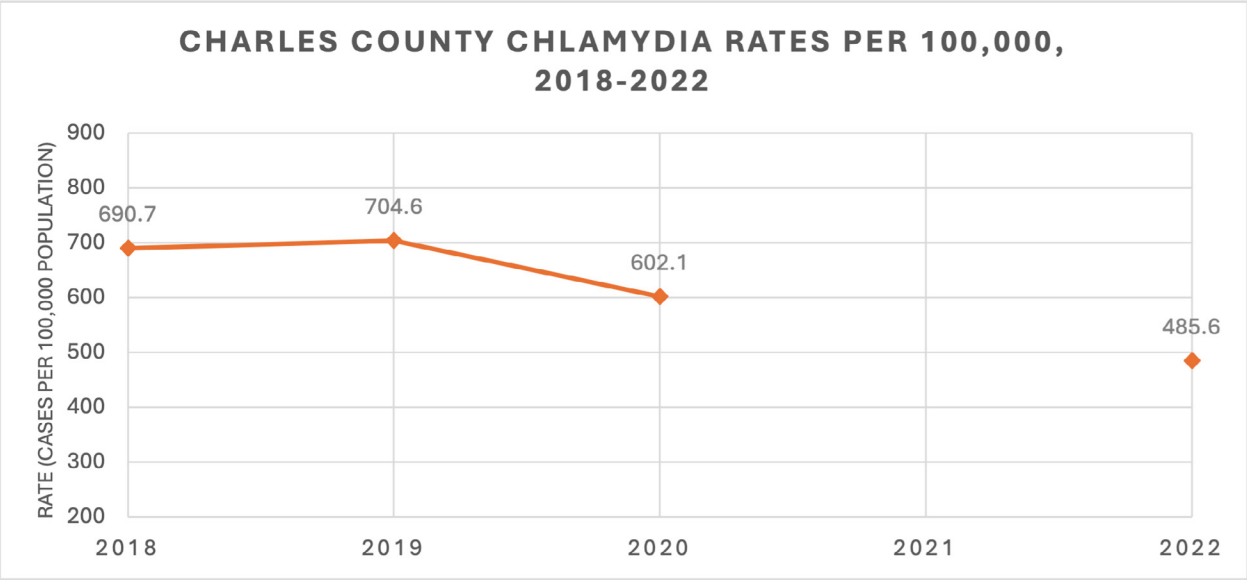
Source: CDC. Sexually Transmitted Disease Surveillance 2021.

The rate of reported chlamydia cases in the United States in 2021 was 495.5 per 100,000, an increase from 476.6 per 100,000 reported in 2020. Before the pandemic, rates were on the rise from 2017 to 2019, with the rate reaching 551.0 per 100,000 in 2019.

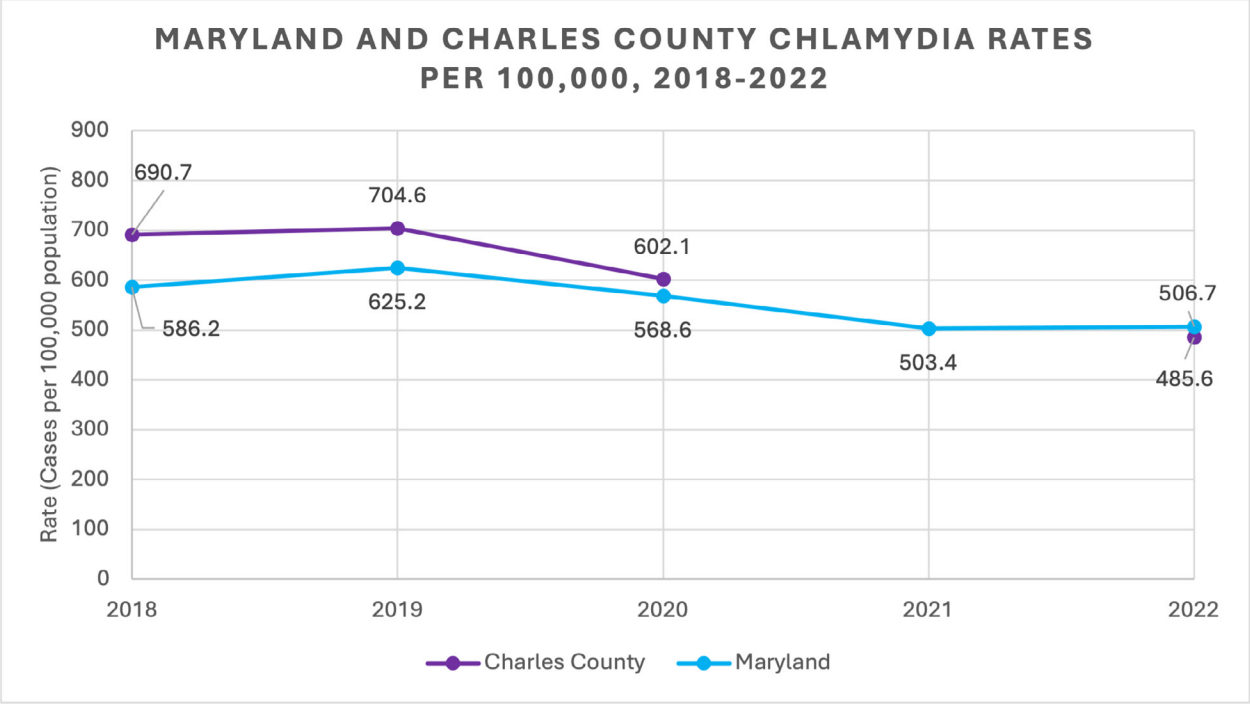


Source: CDC. Sexually Transmitted Disease Surveillance 2021.

Similar to the United States chlamydia trend, Charles County also saw a decrease in cases in 2020. Unfortunately, due to a security incident in 2021, cases for chlamydia in Charles County are not available. In 2022, the Charles County chlamydia rate was 485.6 per 100,000. Up until 2021, Charles County had a higher chlamydia rate than the state of Maryland from 2018 to 2020. In 2022, the Charles County chlamydia rate (485.6) fell below the Maryland rate of 506.7 per 100,000.



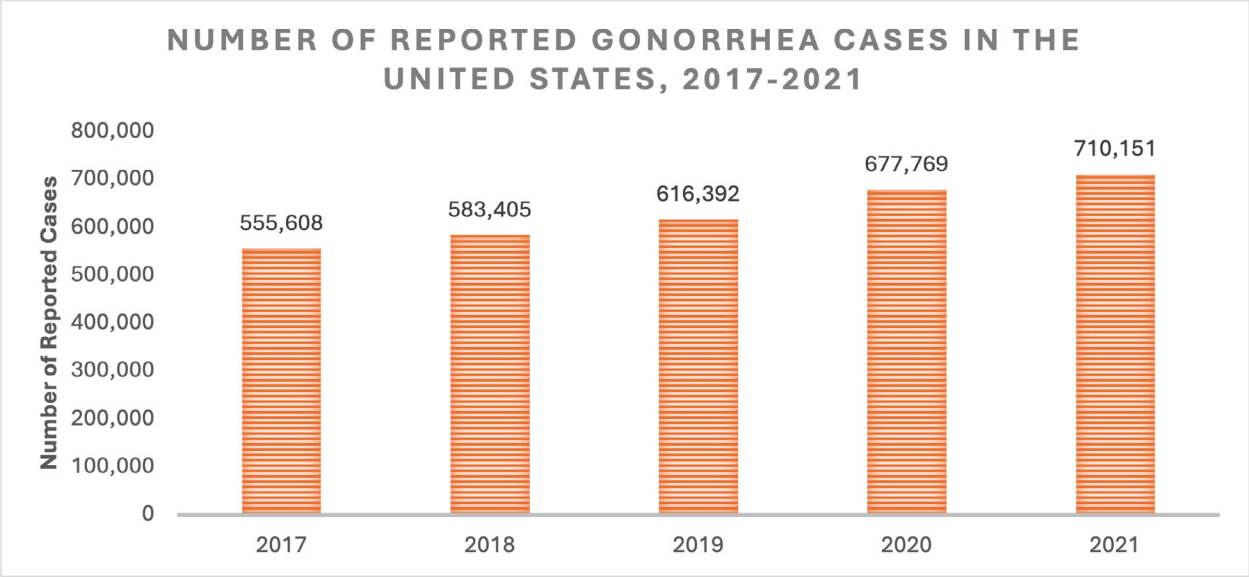
Source: Maryland Department of Health. 2022



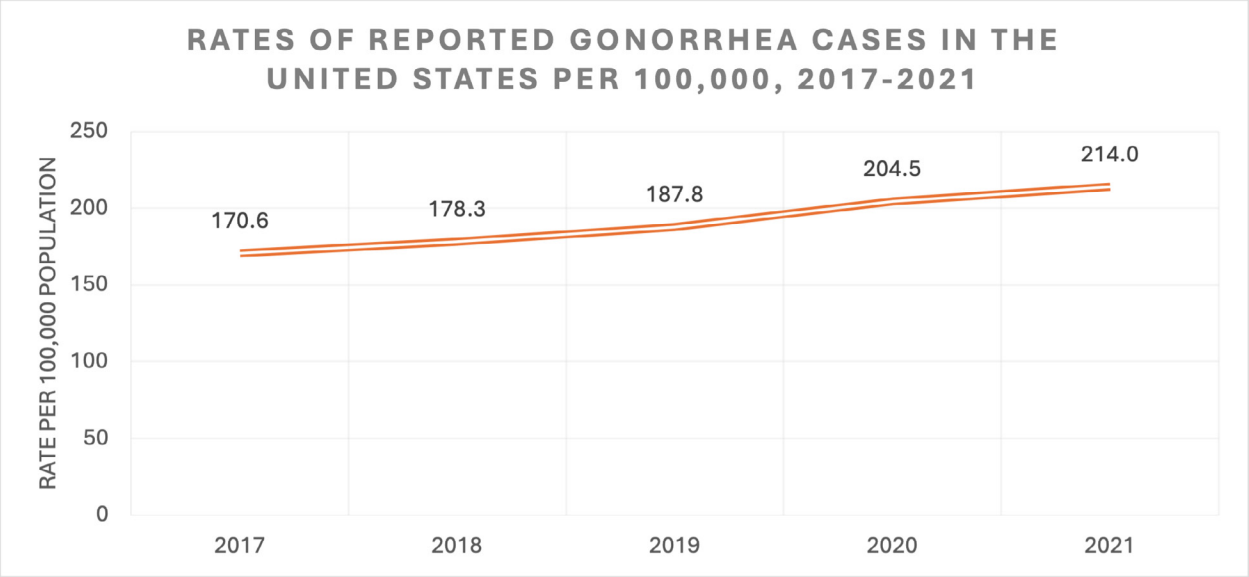
Source: Maryland Department of Health. 2022

Gonorrhea:

In the United States, gonorrhea cases have been on the rise since 2017. The CDC reports that rates of reported gonorrhea have increased 118% since a historic low in 2009. In 2021, the number of reported gonorrhea cases in the United States reached 710,151. The rate of gonorrhea in the United States was 214.0 in 2021, with a continuing increase since 2017 when the rate was 170.6 per 100,000.



Source: CDC. Sexually Transmitted Disease Surveillance 2021

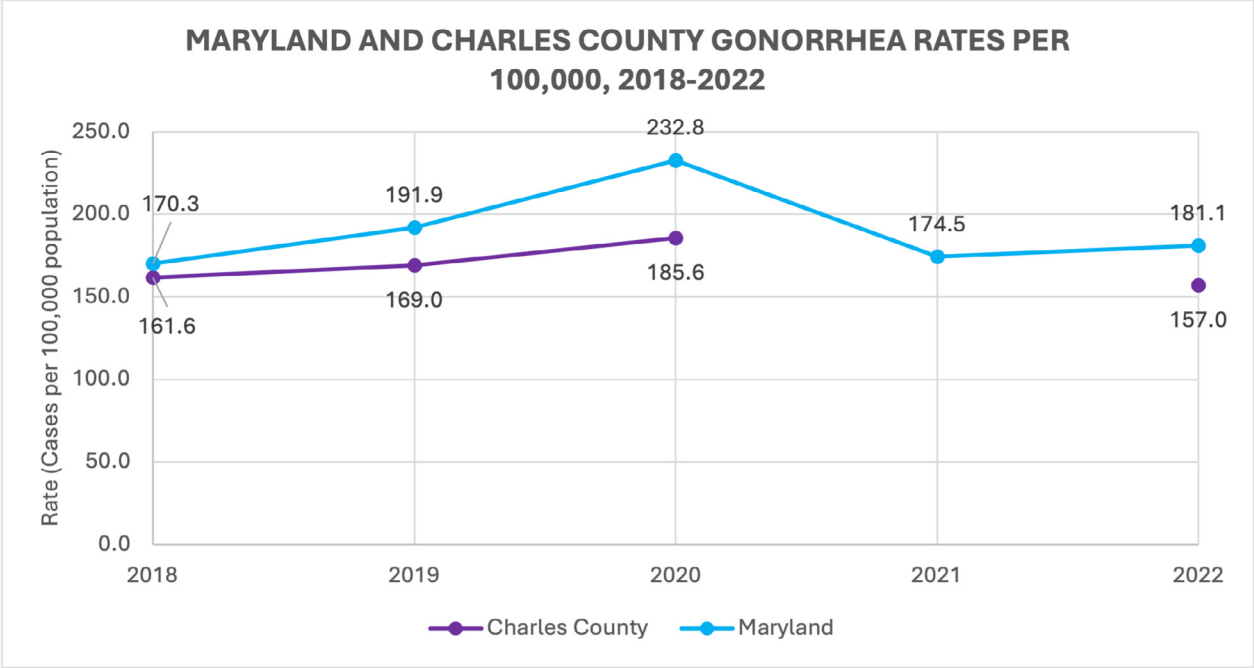


Source: CDC. Sexually Transmitted Disease Surveillance 2021

In Maryland and in Charles County, gonorrhea rates are experiencing the same trends as the United States. From 2018 to 2020, Maryland had an increasing rate of gonorrhea. In 2020, the Maryland

gonorrhea rate reached 232.8 per 100,000, but dropped in 2021 to 174.5 per 100,000. This decrease in reported cases was most likely due to the COVID-19 pandemic. Rates increased again in 2022 to 181.1 per 100,000.

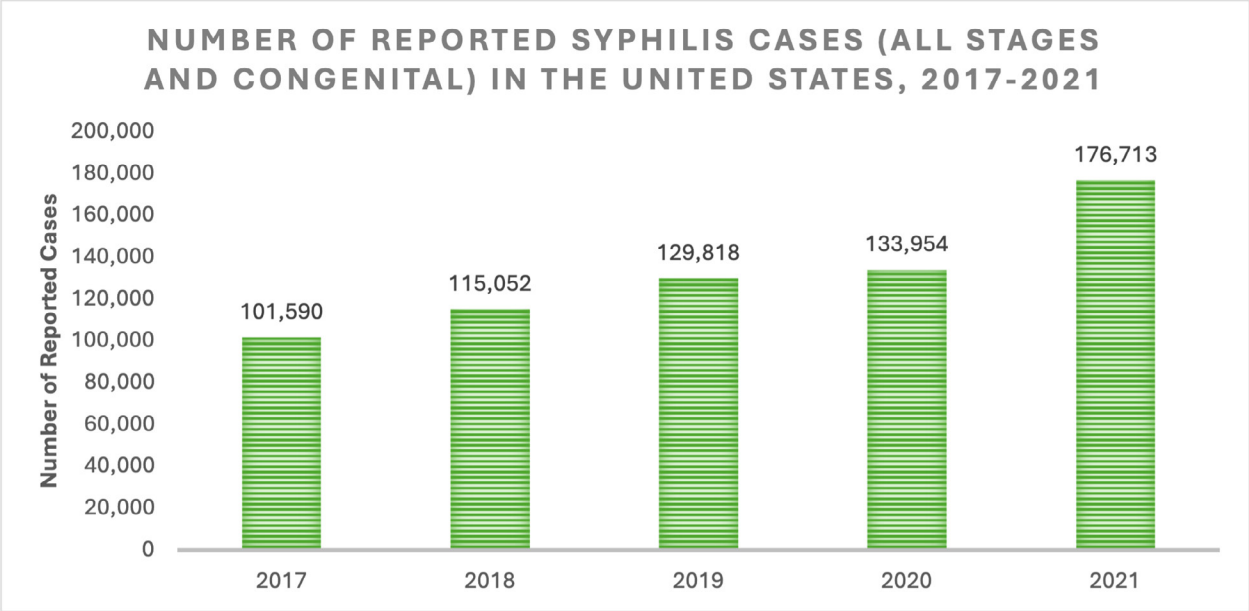
In Charles County gonorrhea rates were below the state, but still increasing from 2018 to 2020. In 2020, the Charles County gonorrhea rate was 185.6 per 100,000. The 2021 data for Charles County is unavailable, but in 2022 the gonorrhea rate dropped to 157.0 per 100,000 which is below the state rate of 181.1 per 100,000.



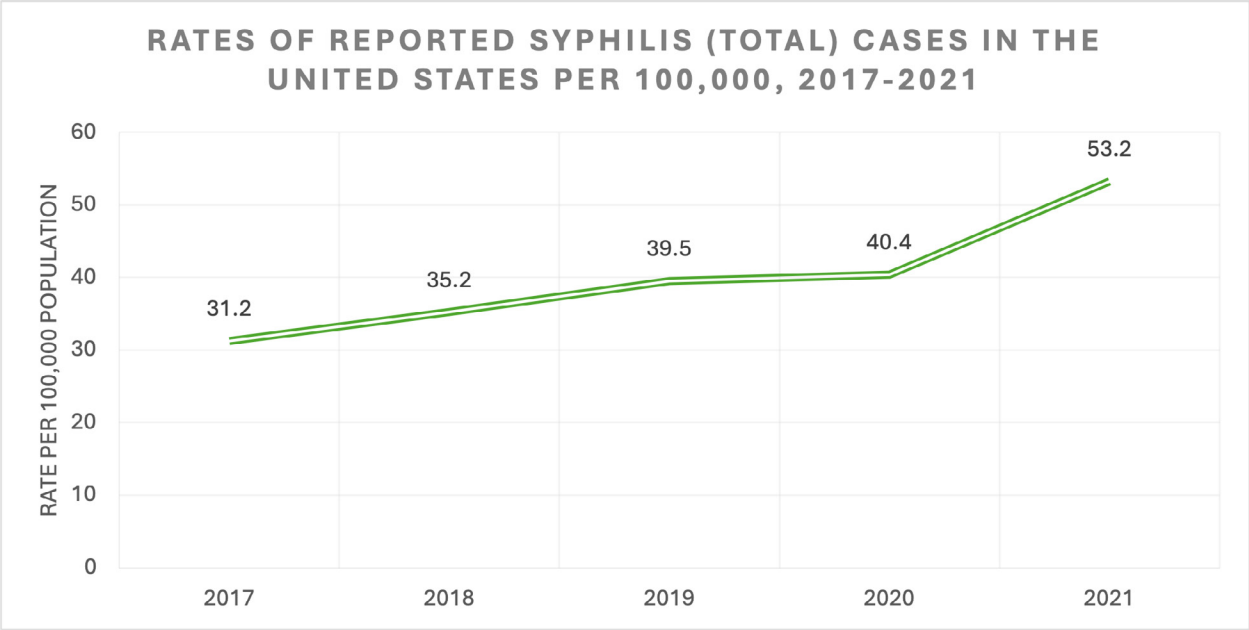
Source: Maryland Department of Health. 2022.

Syphilis:

In the United States the number of syphilis cases (all stages and congenital) have increased every year, with almost a 29% increase from 2020 to 2021. In 2021, the total number of reported syphilis cases reached 176,713. The rate of total syphilis hit 53.2 per 100,000 in 2021, an increase from 40.4 per 100,000 reported in 2020.



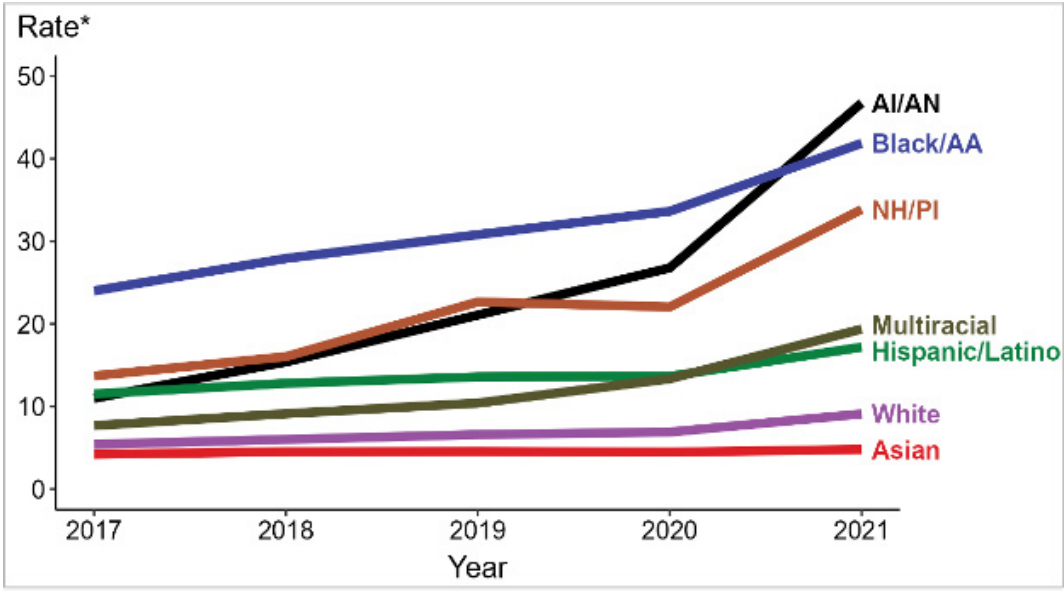
DC. Sexually Transmitted Disease Surveillance 2021.



DC. Sexually Transmitted Disease Surveillance 2021.

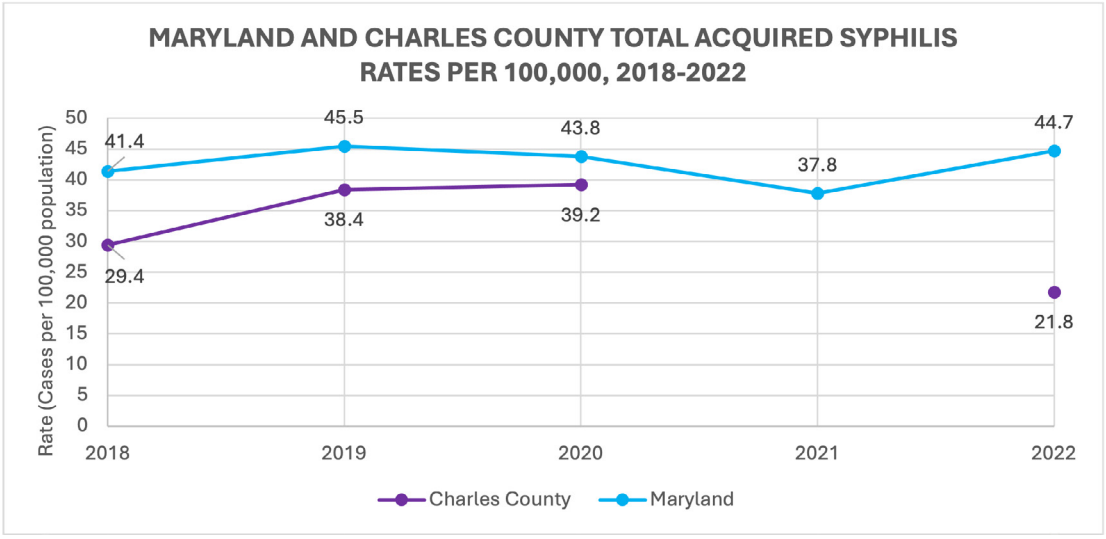
All racial groups in the United States have experienced increases in the rate of primary and secondary syphilis. However, the greatest increases have been seen among non-Hispanic American Indian or Alaska Native persons.

Primary and Secondary Syphilis Rates of Reported Cases by Race/Hispanic Ethnicity, United States, 2017-2021



DC. Sexually Transmitted Disease Surveillance 2021.

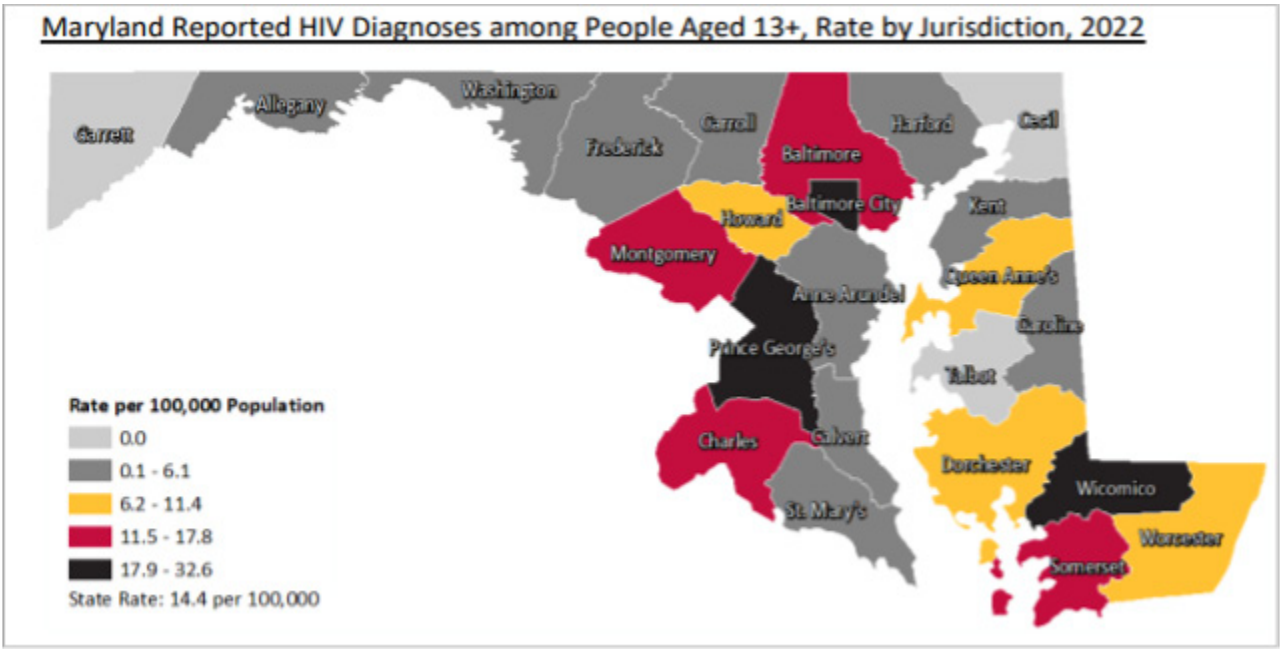
In 2020, the Maryland total acquired syphilis rate was 44.7 per 100,000, which is above the Charles County rate of 21.8 per 100,000. The 2020 rate for Maryland was an increase from the rate of 37.8 reported in 2021. From 2019 to 2021, the Maryland total acquired syphilis rate was on the decline, most likely due to the pandemic, but saw an increase again in 2022.



Source: Maryland Department of Health. 2022.

HIV Incidence:

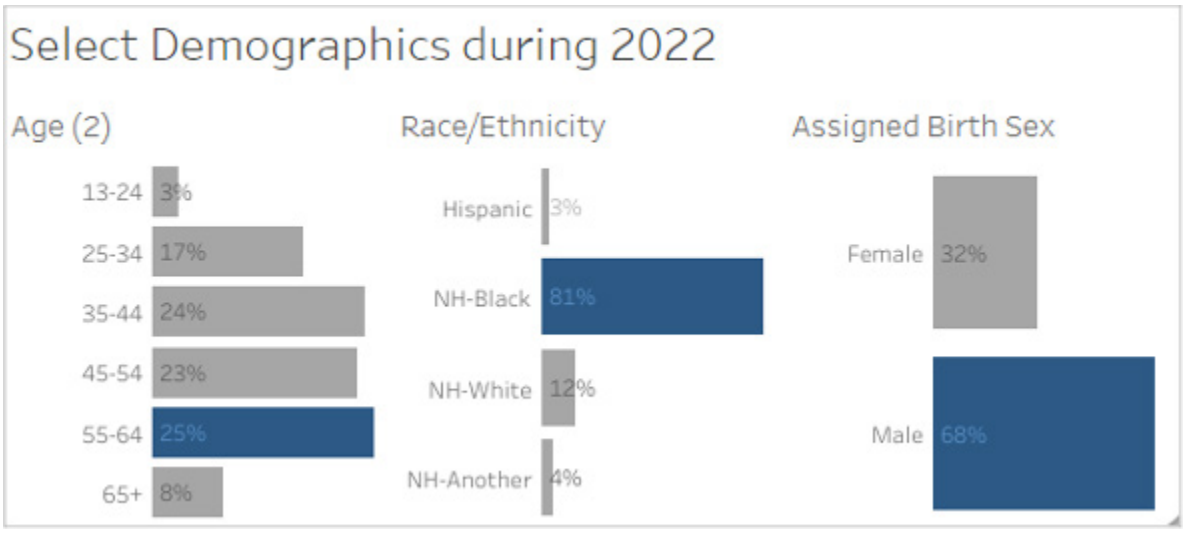
This indicator shows the rate of adult/adolescent cases (age 13+) diagnosed with HIV (per 100,000 population). HIV is a significant and preventable public health problem. An estimated 9.1% of people with HIV in Maryland are undiagnosed, as of 2021. We have the knowledge and tools needed to slow the spread of HIV infection and improve the health of people living with HIV.

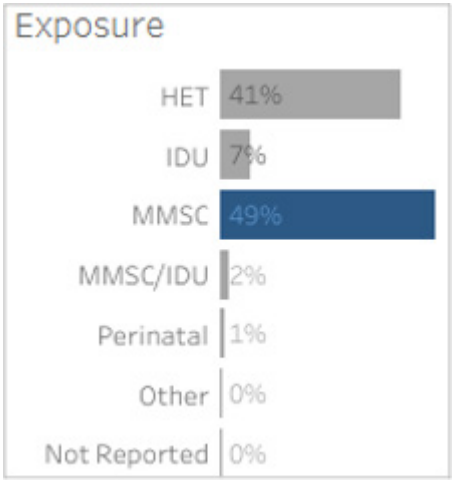


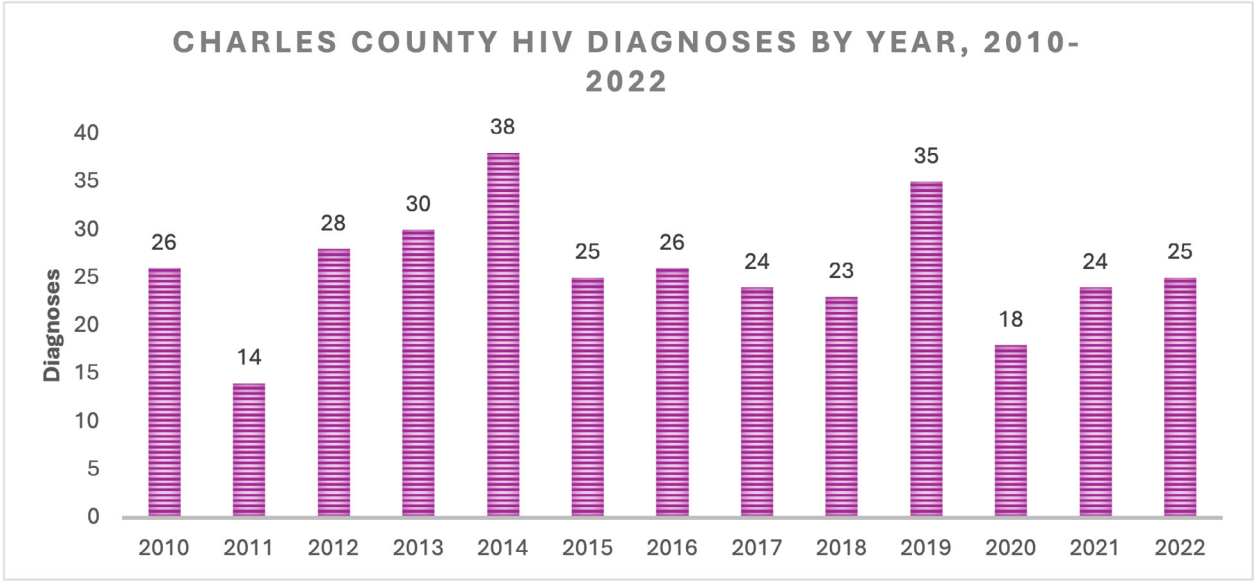
Source: 2022 Maryland Annual HIV Epidemiological Profile. Center for HIV Surveillance, Epidemiology and Evaluation. Infectious Disease Prevention and Health Services Bureau. Maryland Department of Health.

The 2022 Charles County rate of new HIV diagnoses was 17.6 per 100,000. This is above the Maryland state average rate of 14.4 per 100,000. The Charles County rate is the 4th highest among the Maryland jurisdictions, behind Baltimore City (32.6), Prince George's County (32.3) and Wicomico County (21.5).

In 2022, there were 25 adult/adolescent (age 13+) HIV cases diagnosed in Charles County. Of the 697-living adult/adolescent cases in Charles County at the end of 2022, 68% were male, 25% were among adults aged 55-64 years old, and 24% were among adults aged 35-44 years old. Non-Hispanic (NH) Blacks made up the majority (81%) of living adult/adolescent cases. Among living adult/adolescent cases, the most common estimated or reported exposure category was men who have sex with men (MSM) (49%), followed by heterosexual exposure (HET) (41%), and injection drug use (IDU) (7%).


Select Demographics during 2022
Age (2)
13-24 3%
25-34 17%
35-44 24%
45-54 23%
55-64 25%
65+ 8%
Race/Ethnicity
Hispanic 3%
NH-Black 81%
NH-White 12%
NH-Another 4%
Assigned Birth Sex
Female 32%
Male 68%


Exposure
HET 41%
IDU 7%
MMSC 49%
MMSC/IDU 2%
Perinatal 1%
Other 0%
Not Reported 0%


CHARLES COUNTY HIV DIAGNOSES BY YEAR, 2010-2022
Diagnoses
0
5
10
15
20
25
30
35
40
2010 26
2011 14
2012 28
2013 30
2014 38
2015 25
2016 26
2017 24
2018 23
2019 35
2020 18
2021 24
2022 25

HIV/AIDS/STI References

1. 2007-2020 Chlamydia Rates for Charles County, Maryland, and United States. Robert Wood Johnson Foundation County Health Rankings. Available at: https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/health-behaviors/sexual-activity/sexually-transmitted-infections?state=24&year=2023&tab=1#map-anchor.

1. Sexually Transmitted Disease Surveillance 2021. The Centers for Disease Control and Prevention. Available at: https://www.cdc.gov/std/statistics/2021/default.htm.

1. 2018-2022 Charles County STI Data. Maryland Department of Health. Accessed 20 December 2023.

1. Maryland HIV 5-year Aggregate County Dashboard. Maryland Department of Health HIV Surveillance. Available at: https://public.tableau.com/app/profile/maryland.department.of.health.hiv.surveillance/viz/MarylandHIV5-yearAggregateCountyDashboard/Dashboard?publish=yes.

1. Maryland HIV County Overview Dashboard. Maryland Department of Health HIV Surveillance. Available at: https://public.tableau.com/app/profile/maryland.department.of.health.hiv.surveillance/viz/MarylandHIVCountyOverviewDashboard/Dashboard-Menu?publish=yes.

1. 2022 Maryland Annual HIV Epidemiological Profile. Center for HIV Surveillance Epidemiology and Evaluation. Infectious Disease Prevention and Health Services Bureau. Prevention and Health Promotion Administration. Maryland Department of Health. Available at: https://health.maryland.gov/phpa/OIDEOR/CHSE/SiteAssets/Pages/statistics/Maryland-Annual-HIV-Epidemiological-Profile-2022.pdf.

Qualitative Data Relating to Sexually Transmitted Infections and HIV/AIDS

Over one-third of the long survey participants reported that HIV/AIDS (38.9%) and sexually transmitted diseases (42.7%) are a problem in Charles County on some level. Only 9.8% felt that HIV/AIDS is a "serious problem." 13.0% reported that sexually transmitted diseases are a "serious problem" in the county.

Health Issue/Condition:	Percent Reporting No Problem in county	% Reporting this as a problem at any level	Percent Reporting this as a serious problem
HIV/AIDS	7.2%	38.9%	9.8%
Sexually transmitted diseases	6.6%	42.7%	13.0%

Behavioral risk factor data relating to STI's, HIV/AIDS included:

- 29.4% always practice safe sex;
- 81.7% never use illegal drugs.

Tobacco Statistics:

Adult Current Tobacco Use By Product (Any Tobacco, Cigarettes, Cigars, Smokeless, ESDs) 2014-2021

The Maryland Behavior Risk Factor Surveillance System is used to provide estimates for Maryland and Charles County on smoking status. In 2021, approximately 17.5% of Charles County residents reported use of any tobacco product. This is similar to the Maryland percentage of 16.9% of Maryland residents who use any tobacco product. Charles County has seen a decrease in tobacco product usage from 20.3% in 2014 to 17.5% in 2021. This same trend was seen on a state level.

Use of cigarettes in Charles County has decreased significantly from 12.2% in 2014 to 9.1% in 2021. The 2021 cigarette percentage for Charles County is lower than the Maryland percentage of 10.1%.

The 2021 Charles County cigar use percentage was 5.5%. This is higher than the Maryland state cigar percentage of 3.3%. 2021 data is not available on a county level for smokeless tobacco usage.

Lastly, the use of electronic smoking devices or ESD's was available for Charles County in 2016 only. 4.0% of Charles County residents reported use of an ESD. This is slightly higher than the percentage reported for Maryland overall (3.2%). 2021 data was not available on a county level due to an insufficient sample size.

Maryland

CURRENT USE OF TOBACCO/ELECTRONIC SMOKING DEVICES (ESDs)					
Estimated Prevalence (%) Confidence Interval (CI) Estimated Number (N)	***2014*** ***% CI N***	***2016*** ***% CI N***	***2018*** ***% CI N***	***2020*** ***% CI N***	***2021*** ***% CI N***
Any Tobacco *(Any tobacco includes cigarettes, cigars, smokeless tobacco, other tobacco products, and ESDs)*	**21.6** (20.1-23.1) **918,606**	**20.3** (19.3-21.3) **842,991**	**20.0** (19.0-21.1) **865,325**	**18.0** (17.0-19.1) **728,537**	**16.9** (15.7-18.1) **738,034**
Cigarettes	**14.6** (13.4-15.9) **655,824**	**13.7** (12.9-14.5) **608,816**	**12.5** (11.7-13.4) **569,871**	**10.9** (10.1-11.7) **477,204**	**10.1** (9.4-10.8) **449,567**
Cigars	**4.5** (3.6-5.4) **192,448**	**3.7** (3.2-4.2) **154,865**	**4.6** (4.0-5.2) **199,575**	**3.3** (2.8-3.8) **137,923**	**3.3** (2.8-3.9) **146,795**
Smokeless Tobacco	**1.7** (1.3-2.2) **76,683**	**1.6** (1.3-1.9) **70,410**	**2.0** (1.7-2.4) **93,401**	**1.7** (1.3-2.1) **74,868**	**1.4** (1.1-1.6) **62,041**
ESDs	**3.2** (2.5-3.8) **135,090**	**3.2** (2.8-3.7) **141,529**	**4.3** (3.7-4.9) **185,728**	**3.8** (3.2-4.4) **150,720**	**4.5** (3.9-5.0) **198,161**

Charles County

CURRENT USE OF TOBACCO/ELECTRONIC SMOKING DEVICES (ESDs)					
Estimated Prevalence (%) *Confidence Interval (CI)* *Estimated Number (N)*	*2014* *% CI N*	*2016* *% CI N*	*2018* *% CI N*	*2020* *% CI N*	*2021* *% CI N*
Any Tobacco *(Any tobacco includes cigarettes, cigars, smokeless tobacco, other tobacco products, and ESDs)*	**20.3** (13.7-26.8) **22,966**	**19.7** (15.4-24.1) **21,877**	**19.7** (14.2-25.1) **22,841**	**26.0** (19.5-32.5) **28,370**	**17.5** (12.5-22.4) **28,334**
Cigarettes	**12.2** (7.2-17.1) **13,972**	**13.1** (9.8-16.5) **15,086**	**12.4** (8.6-16.2) **14,953**	**13.9** (9.3-18.6) **16,082**	**9.1** (6.1-12.0) **10,993**
Cigars	**BRFSS Data Not Available**	**BRFSS Data Not Available**	**BRFSS Data Not Available**	**BRFSS Data Not Available**	**5.5** (2.5-8.6) **8,988**
Smokeless Tobacco	**BRFSS Data Not Available**	**BRFSS Data Not Available**	**BRFSS Data Not Available**	**BRFSS Data Not Available**	**BRFSS Data Not Available**
ESDs	**BRFSS Data Not Available**	**4.0** (1.7-6.3) **4,485**	**BRFSS Data Not Available**	**BRFSS Data Not Available**	**BRFSS Data Not Available**

Adult Current Tobacco Uses By Gender and Race/Ethnicity
(White, AA/Black, Asian, Hispanic/Latino, American Indian/Alaskan Native) 2014-2021

When examining current tobacco use by gender, males are more likely to report use than females. For Charles County, 24.7% of men and 10.2% of women reported current tobacco use in 2021. The percentage of Charles County men reporting current tobacco use decreased from 2014 to 2021. The same trend has been seen for Charles County females. On a state level, current tobacco usage for both males and females decreased from 2014 to 2021.

When analyzing rates by race and ethnicity, current tobacco use percentages are only available for Whites, Blacks, and all minority combined in Charles County. Due to small case counts, percentages cannot be calculated for Asian, Hispanic, and American Indian/Alaskan Native. Current tobacco use is higher for Charles County Whites than Blacks or All Minorities Combined (20.9% vs. 14.0% and 15.5%). The same was true on a state level. The county rates of current tobacco use have fluctuated yearly for Whites, African Americans, and All Minorities Combined. Therefore, data is unstable, and caution must be taken when making any conclusions based on this data.

Maryland

CURRENT TOBACCO USE — Gender and Race/Ethnicity					
Estimated Prevalence (%) Confidence Interval (CI) Estimated Number (N)	*2014*	*2016*	*2018*	*2020*	*2021*
	% CI N	*% CI N*	*% CI N*	*% CI N*	*% CI N*
Female	16.7 (14.9-18.4) 371,735	15.4 (14.2-16.6) 333,588	15.2 (14.0-16.4) 345,157	12.5 (11.4-13.6) 263,293	14.0 (12.5-15.5) 322,118
Male	27.0 (24.5-29.4) 546,871	25.5 (23.9-27.2) 509,403	25.3 (23.6-27.0) 519,099	24.2 (22.5-25.9) 465,244	20.1 (18.3-21.9) 415,915
White	22.8 (20.9-24.6) 521,532	21.6 (20.3-22.9) 484,462	20.5 (19.2-21.8) 467,068	18.8 (17.5-20.0) 383,733	18.6 (17.0-20.1) 410,529
Black	24.2 (20.9-27.5) 294,004	20.6 (18.5-22.7) 238,933	22.1 (19.9-24.3) 275,274	19.9 (17.7-22.0) 231,686	17.1 (14.8-19.4) 211,841
Asian	8.7 (3.7-13.7) 21,057	7.0 (4.1-9.9) 17,381	11.8 (7.4-16.3) 31,327	14.9 (9.7-20.1) 39,627	8.0 (4.1-12.0) 21,691
Hispanic/Latino	14.2 (8.8-19.5) 49,841	16.6 (12.8-20.5) 57,237	14.4 (10.7-18.2) 55,505	10.2 (7.6-12.9) 40,500	10.1 (6.7-13.4) 43,057
All Other Races	24.8 (17.5-32.1) 22,041	31.3 (25.6-37.0) 31,234	27.2 (21.8-32.6) 26,034	20.8 (15.9-25.7) 17,649	28.1 (19.2-37.1) 34,500
*****Minority Combined (Race & Female)***	19.5 (17.8-21.3) 609,873	17.8 (16.7-18.9) 541,501	18.6 (17.4-19.8) 595,771	15.8 (14.7-17.0) 475,942	15.6 (14.3-17.0) 507,447

Charles County

CURRENT TOBACCO USE — Gender and Race/Ethnicity					
Estimated Prevalence (%) Confidence Interval (CI) Estimated Number (N)	*2014*	*2016*	*2018*	*2020*	*2021*
	% CI N	*% CI N*	*% CI N*	*% CI N*	*% CI N*
Female	13.7 (6.4-20.9) 8,336	14.1 (9.1-19.0) 8,071	17.1 (10.8-23.4) 10,359	14.6 (7.9-21.4) 8,124	10.2 (4.9-15.5) 8,245
Male	28.0 (17.1-39.0) 14,629	25.8 (18.4-33.1) 13,806	22.5 (13.5-31.5) 12,482	37.7 (27.5-47.8) 20,246	24.7 (16.3-33.0) 20,088
White	21.8 (15.0-28.7) 11,781	26.1 (19.6-32.6) 12,852	20.4 (12.4-28.5) 9,507	29.2 (19.8-38.7) 12,004	20.9 (12.7-29.1) 12,255
Black	BRFSS Data Not Available	15.1 (8.6-21.7) 7,006	21.0 (12.0-30.0) 11,297	24.9 (15.2-34.6) 14,125	14.0 (7.4-20.6) 10,980
Asian	BRFSS Data Not Available	BRFSS Data Not Available	BRFSS Data Not Available	BRFSS Data Not Available	BRFSS Data Not Available
Hispanic/Latino	BRFSS Data Not Available	BRFSS Data Not Available	BRFSS Data Not Available	BRFSS Data Not Available	BRFSS Data Not Available
All Other Races	BRFSS Data Not Available	BRFSS Data Not Available	BRFSS Data Not Available	BRFSS Data Not Available	BRFSS Data Not Available
*****Minority Combined (Race & Female)***	17.7 (10.0-25.4) 15,743	16.0 (11.4-20.7) 13,724	19.6 (13.5-25.7) 18,191	22.3 (15.2-29.4) 18,994	15.5 (10.0-20.9) 20,194

Adult Current Tobacco Use By Education Level (No HS diploma, HS diploma/GED, Some College, 4-Yr. College Degree) 2014-2021

As the level of education increases, the rate of tobacco use decreases. For Maryland, those without a high school diploma are more likely to report tobacco use than those with a high school diploma or some college. Information on tobacco use for individuals with no high school diploma is not available for Charles County. The tobacco use rate among those with a high school diploma/GED is lower in Charles County than Maryland (15.5% vs. 23.4%). The opposite trend is seen for some college and college graduates. The Charles County tobacco use rate for individuals with some college was 19.8% compared to 18.1% for Maryland. The Charles County tobacco use rate for individuals with a college degree was 14.2%, substantially higher than the Maryland rate of 9.3%. Tobacco use among individuals with a college degree has been increasing each year for Charles County but decreasing for Maryland.

Maryland

Education	2014	2016	2018	2020	2021
No High School	35.0 (28.6-41.5) 183,917	31.5 (26.9-36.1) 149,219	31.2 (26.7-35.8) 143,879	28.8 (24.4-33.2) 119,893	26.6 (21.1-32.0) 110,670
High School or GED	27.6 (24.4-30.7) 316,375	26.6 (24.5-28.6) 294,537	26.6 (24.4-28.7) 301,876	25.0 (22.7-27.2) 254,199	23.4 (20.8-26.0) 252,900
Some College	21.7 (19.0-24.4) 261,390	21.8 (19.8-23.8) 254,639	22.3 (20.1-24.4) 269,755	19.4 (17.3-21.5) 214,683	18.1 (15.7-20.4) 218,421
College Grad	11.3 (9.7-12.9) 154,655	10.3 (9.3-11.4) 144,147	9.9 (8.8-10.9) 148,573	9.4 (8.3-10.4) 137,852	9.3 (8.1-10.5) 151,437

Charles County

Education	2014	2016	2018	2020	2021
No High School	BRFSS Data Not Available	BRFSS Data Not Available	BRFSS Data Not Available	BRFSS Data Not Available	BRFSS Data Not Available
High School or GED	22.2 (10.3-34.0) 8,917	32.0 (22.7-41.3) 10,921	24.3 (15.5-33.2) 10,394	29.0 (16.1-41.9) 9,250	15.5 (7.8-23.2) 8,895
Some College	15.7 (8.3-23.1) 5,712	15.0 (8.6-21.4) 6,168	14.4 (6.1-22.8) 5,560	25.0 (14.4-35.7) 11,082	19.8 (10.4-29.2) 11,599
College Grad	BRFSS Data Not Available	11.6 (6.3-17.0) 3,382	10.3 (5.1-15.5) 2,891	14.4 (7.3-21.4) 3,729	14.2 (6.2-22.3) 5,494

Adult Current Tobacco Use By Annual Household Income (<$15K, Up to $25K, Up to $50K, Up to $75K, >$75K) 2014-2021

The following tables demonstrate that the higher the income level, the lower the rate of tobacco use among adults. Those earning more than $50,000 per year in Charles County are less likely to report tobacco use than those who make less than $50,000 (16.9% vs. 21.0%). Charles County has seen decreases in tobacco use among those who earn more than $50,000 a year and those who make less than $50,000 a year.

Maryland

Estimated Prevalence (%) Confidence Interval (CI) Estimated Number (N)	*2014* % CI N	*2016* % CI N	*2018* % CI N	*2020* % CI N	*2021* % CI N
Income					
< $35k	**28.4** (24.9-31.9) **317,520**	**28.4** (25.9-30.9) **277,182**	**28.1** (25.5-30.8) **268,606**	**27.8** (25.3-30.3) **231,913**	**25.5** (22.3-28.7) **201,312**
$35k- $75k	**25.1** (21.7-28.6) **228,050**	**21.7** (19.5-23.9) **194,103**	**21.0** (18.8-23.2) **190,405**	**19.6** (17.3-21.8) **167,419**	**18.5** (15.8-21.2) **162,411**
>$75k	**15.2** (13.4-17.0) **239,536**	**15.1** (13.7-16.5) **236,119**	**15.3** (13.8-16.8) **257,634**	**14.2** (12.8-15.6) **233,621**	**13.6** (12.0-15.2) **244,242**

Charles County

Estimated Prevalence (%) Confidence Interval (CI) Estimated Number (N)	*2014* % CI N	*2016* % CI N	*2018* % CI N	*2020* % CI N	*2021* % CI N
Income					
< $50k	**30.2** (13.2-47.2) **9,123**	**27.0** (16.4-37.7) **6,392**	**34.3** (19.8-48.7) **8,296**	**30.6** (15.5-45.7) **7,338**	**21.0** (9.2-32.8) **5,991**
> $50k	**18.5** (11.7-25.3) **12,665**	**17.4** (12.3-22.5) **11,902**	**15.4** (9.7-21.1) **11,910**	**27.4** (19.1-35.6) **19,687**	**16.9** (10.5-23.3) **16,989**

Middle School Tobacco Use By Product (Any Tobacco, Cigarettes, Cigars, Smokeless, ESDs) 2014-2021

7.0% of Charles County middle school students reported use of any tobacco product in 2021. There has been stability in this percentage for 2016, 2018, and 2021. The 2021 Charles County middle school tobacco use percentage is above the Maryland state average percentage (7.0% vs. 6.3%). Cigarette usage (2.8% to 1.3%) and cigar usage (3.2% to 1.5%) have decreased in Charles County middle school students. The percentage of Charles County middle school students reporting smokeless tobacco use has also decreased from 2.4% to 1.0% and is now similar to the Maryland percentage of 1.4%. Charles County saw a decline in middle school students reporting use of electronic smoking devices (ESD's) from 9.3% in 2014 to 5.7% in 2021. The 2021 Charles County ESD percentage of 5.7% is still greater than the Maryland percentage of 5.2%, but the disparity gap is closing.

Maryland

CURRENT TOBACCO USE				
Estimated Prevalence (%) *Confidence Interval (CI)* *Estimated Number (N)*	***2014*** ***% CI N***	***2016*** ***% CI N***	***2018*** ***% CI N***	***2021*** ***% CI N***
Middle School Students				
Any Tobacco *(Any tobacco includes cigarettes, cigars, smokeless tobacco, and ESDs)*	**9.3** (8.4-10.1) **15,483**	**5.4** (4.9-5.8) **9,105**	**7.1** (6.5-7.6) **12,292**	**6.3** (5.7-6.9) **12,107**
Cigarettes	**2.5** (2.2-2.9) **4,431**	**1.3** (1.1-1.6) **2,513**	**1.1** (0.9-1.3) **2,158**	**1.3** (1.0-1.5) **2,581**
Cigars	**3.6** (3.1-4.1) **6,416**	**2.5** (2.2-2.9) **4,743**	**1.8** (1.6-2.1) **3,482**	**1.9** (1.6-2.2) **3,820**
Smokeless Tobacco	**1.9** (1.6-2.2) **3,349**	**1.9** (1.6-2.2) **3,545**	**2.2** (1.9-2.5) **4,068**	**1.4** (1.1-1.6) **2,735**
ESDs	**7.6** (6.9-8.4) **13,318**	**4.7** (4.3-5.2) **8,396**	**5.9** (5.4-6.5) **10,799**	**5.2** (4.7-5.8) **10,331**

Charles County

CURRENT TOBACCO USE				
Estimated Prevalence (%) *Confidence Interval (CI)* *Estimated Number (N)*	***2014*** ***% CI N***	***2016*** ***% CI N***	***2018*** ***% CI N***	***2021*** ***% CI N***
Middle School Students				
Any Tobacco *(Any tobacco includes cigarettes, cigars, smokeless tobacco, and ESDs)*	**10.6** (8.3-12.9) **557**	**7.1** (5.2-9.1) **362**	**7.5** (5.3-9.6) **391**	**7.0** (5.5-8.5) **428**
Cigarettes	**2.8** (1.8-4.2) **154**	**1.6** (0.7-2.5) **92**	**1.7** (0.7-2.7) **103**	**1.3** (0.7-1.9) **83**
Cigars	**3.2** (2.2-4.7) **181**	**2.7** (1.6-3.7) **153**	**2.5** (1.5-3.5) **146**	**1.5** (0.7-2.2) **92**
Smokeless Tobacco	**2.4** (1.1-5.1) **137**	**2.6** (1.4-3.8) **151**	**3.3** (2.0-4.6) **187**	**1.0** (0.4-1.6) **62**
ESDs	**9.3** (7.3-11.3) **508**	**5.7** (3.9-7.5) **303**	**6.3** (4.3-8.2) **350**	**5.7** (4.1-7.2) **353**

Middle School Current Tobacco Use By Gender and Race/Ethnicity (White, AA/Black, Asian, Hispanic/Latino, American Indian/Alaskan Native) 2014-2021

Charles County male middle school students had similar levels of current tobacco use to Charles County female middle school students (6.9% vs. 7.0%). The percentages of middle school males and females using tobacco in Charles County have decreased since 2014. The percentage for males in Charles County is higher than those reported for Maryland males (males 6.9% vs. 5.2%). For females, the percentages are nearly identical (7.0% for CC vs. 7.3% for MD).

On a county level, data is only available for White, African American/Black, All Other Races, and Hispanic middle school students in Charles County. The highest rate of current tobacco use is in the Hispanic/Latino population at 10.5%.

Maryland

CURRENT TOBACCO USE — Gender and Race/Ethnicity				
Estimated Prevalence (%) *Confidence Interval (CI)* *Estimated Number (N)*	***2014*** ***% CI N***	***2016*** ***% CI N***	***2018*** ***% CI N***	***2021*** ***% CI N***
Middle School Students				
Middle School Female	**8.3** (7.5-9.2) **6,919**	**5.4** (4.8-6.1) **4,561**	**7.1** (6.4-7.7) **6,083**	**7.3** (6.4-8.3) **6,810**
Middle School Male	**10.0** (9.0-11.1) **8,401**	**5.2** (4.6-5.8) **4,441**	**7.0** (6.3-7.6) **6,059**	**5.2** (4.6-5.8) **5,077**
White	**7.4** (6.5-8.3) **4,937**	**4.3** (3.6-5.0) **2,852**	**7.0** (6.2-7.7) **4,482**	**5.1** (4.4-5.7) **3,178**
African American/Black	**11.7** (10.4-13.0) **5,961**	**5.2** (4.4-6.0) **2,750**	**6.6** (5.6-7.6) **3,488**	**6.8** (5.8-7.9) **4,209**
Asian	**3.7** (2.2-5.2) **345**	**2.2** (1.2-3.2) **200**	**3.1** (2.0-4.2) **334**	**2.3** (1.3-3.4) **277**
Hispanic/Latino	**11.6** (9.9-13.4) **2,394**	**9.2** (7.7-10.8) **2,076**	**8.9** (8.0-9.9) **2,312**	**7.9** (6.5-9.3) **2,784**
American Indian/Alaskan Native	**13.7** (9.7-17.8) **296**	**10.4** (6.6-14.1) **194**	**8.8** (6.1-11.5) **165**	**9.6** (5.2-14.0) **214**
Native Hawaiian/Other Pacific Islander	**6.9** (2.1-11.6) **50**	**12.7** (5.2-20.2) **103**	**10.7** (4.4-17.0) **73**	**YRBS Data Not Available**
Multiracial-Non Hispanic	**10.7** (8.5-12.8) **658**	**6.4** (5.0-7.9) **468**	**9.9** (8.0-11.8) **672**	**9.5** (6.7-12.2) **745**

Charles County

CURRENT TOBACCO USE — Gender and Race/Ethnicity				
Estimated Prevalence (%) *Confidence Interval (CI)* *Estimated Number (N)*	*2014* *% CI N*	*2016* *% CI N*	*2018* *% CI N*	*2021* *% CI N*
Middle School Students				
Middle School Female	9.0 (6.4-11.6) 228	6.5 (3.9-9.0) 156	7.3 (4.6-10.0) 192	7.0 (4.7-9.2) 204
Middle School Male	11.9 (8.8-15.0) 322	7.8 (5.3-10.4) 207	7.5 (4.8-10.1) 190	6.9 (4.6-9.1) 211
White	10.5 (7.5-13.5) 156	7.8 (3.4-12.1) 101	5.4 (2.3-8.6) 69	6.7 (3.3-10.2) 75
African American/Black	10.3 (7.1-13.4) 275	6.5 (4.2-8.7) 166	7.9 (4.8-11.0) 219	6.6 (4.6-8.6) 222
Asian	YRBS Data Not Available	YRBS Data Not Available	YRBS Data Not Available	YRBS Data Not Available
Hispanic/Latino	9.7 (3.9-15.4) 27	9.5 (1.7-17.3) 26	9.0 (3.7-14.3) 30	10.5 (6.1-14.9) 68
All Other Races	14.9 (9.4-20.4) 59	5.9 (1.5-10.2) 24	7.2 (1.2-13.2) 29	8.6 (3.4-13.7) 42

High School Tobacco Use By Product
(Any Tobacco, Cigarettes, Cigars, Smokeless, ESDs) 2014-2021

13.2% of Charles County high school students reported using any type of tobacco product in 2021. This is a large decrease from the percentages reported in both 2014 and 2016 (27.1% and 18.8%). Charles County high school students have reported less use of cigarettes, smokeless, electronic smoking devices, and cigars from 2014 to 2021.This same trend can be seen on a state level. The percentage of Charles County high school students reporting use of smokeless tobacco has fluctuated and is currently lower than the percentage reported in 2016 (5.4% vs. 7.4%). The Charles County tobacco use percentage of 13.2% in 2021 is lower than the state percentage of 15.6%.

The reported use of ESD's among Charles County high school students decreased from 23.1% in 2014 to 12.6% in 2021. This may be due to extensive efforts of the local CRF tobacco program to educate students on the dangers associated with use of ESD's. The Charles County high school ESD percentage is below the Maryland ESD percentage of 14.7%.

Maryland

	2014	2016	2018	2021
High School Students				
Any Tobacco *(Any tobacco includes cigarettes, cigars, smokeless tobacco, and ESDs)*	23.5 (22.8-24.2) 51,945	17.8 (17.1-18.5) 39,428	24.5 (23.2-25.8) 55,921	15.6 (14.8-16.4) 37,744
Cigarettes	8.7 (8.2-9.1) 20,677	8.2 (7.8-8.6) 20,653	5.0 (4.5-5.4) 12,557	3.6 (3.2-3.9) 9,398
Cigars	10.3 (9.9-10.8) 25,460	9.0 (8.5-9.5) 22,136	6.0 (5.5-6.5) 15,135	3.2 (2.8-3.5) 8,235
Smokeless Tobacco	5.8 (5.4-6.1) 13,769	6.2 (5.8-6.6) 15,225	4.6 (4.1-5.1) 11,524	3.0 (2.7-3.4) 7,829
ESDs	20.0 (19.4-20.5) 47,542	13.3 (12.7-13.9) 30,026	23.0 (21.9-24.1) 53,920	14.7 (13.8-15.5) 36,640

Charles County

	2014	2016	2018	2021
High School Students				
Any Tobacco *(Any tobacco includes cigarettes, cigars, smokeless tobacco, and ESDs)*	27.1 (25.1-29.1) 2,021	18.8 (16.9-20.8) 1,356	19.3 (17.3-21.4) 1,415	13.2 (11.7-14.7) 1,044
Cigarettes	9.2 (8.0-10.7) 744	8.6 (7.3-9.9) 720	5.0 (4.0-6.0) 412	3.4 (2.5-4.3) 291
Cigars	10.5 (9.2-12.0) 886	9.2 (7.8-10.6) 748	6.0 (4.9-7.1) 494	2.3 (1.5-3.2) 198
Smokeless Tobacco	6.7 (5.5-8.1) 543	7.4 (6.2-8.7) 606	5.4 (4.3-6.6) 449	2.6 (1.8-3.4) 215
ESDs	23.1 (21.3-24.8) 1,883	15.2 (13.4-17.0) 1,115	17.7 (15.8-19.6) 1,329	12.6 (11.1-14.0) 1,030

High School Current Tobacco Use By Gender and Race/Ethnicity (White, AA/Black, Asian, Hispanic/Latino, American Indian/Alaskan Native) 2014-2021

Charles County high school females are more likely to report use of tobacco products than males (14.9% vs. 11.1%). Tobacco use percentage for Charles County high school males and females remain slightly lower than the Maryland state average percentages (Males 11.1% vs. 13.0% and Females 14.9% vs. 17.8%). The percentages for Charles County males and females have been decreasing since 2014.

When examining by race, Charles County Whites and Hispanic/Latinos have similar percentages (18.9% and 18.8%) that are well above the percentage for Charles County African Americans (9.7%) and Charles County Asians (11.0%). Charles County tobacco use percentages for all races have seen decreases from 2014 to 2021.

Maryland

	2014	2016	2018	2021
High School Students				
High School Female	**22.2** (21.2-23.1) **24,511**	**15.9** (15.1-16.7) **17,310**	**24.5** (23.0-26.0) **27,659**	**17.8** (16.7-19.0) **21,180**
High School Male	**24.7** (23.9-25.5) **26,935**	**19.3** (18.4-20.2) **21,374**	**24.2** (22.7-25.8) **27,515**	**13.0** (12.1-13.9) **15,637**
White	**26.6** (25.7-27.4) **25,066**	**20.5** (19.6-21.5) **18,650**	**34.0** (32.4-35.7) **30,568**	**19.4** (18.2-20.6) **17,047**
African American/Black	**19.7** (18.6-20.9) **14,001**	**14.1** (13.0-15.1) **10,181**	**15.6** (14.1-17.1) **11,046**	**11.4** (10.2-12.7) **8,621**
Asian	**10.4** (8.7-12.1) **1,341**	**7.0** (5.7-8.4) **878**	**13.5** (10.8-16.1) **1,979**	**7.7** (5.3-10.1) **1,231**
Hispanic/Latino	**25.5** (24.0-26.9) **6,648**	**19.0** (17.6-20.5) **5,265**	**21.2** (19.0-23.4) **7,234**	**16.3** (14.5-18.2) **6,919**
American Indian/Alaskan Native	**33.0** (28.0-37.9) **447**	**29.2** (24.2-34.2) **358**	**23.6** (16.8-30.4) **295**	**24.4** (16.6-32.2) **342**
Native Hawaiian/Other Pacific Islander	**33.0** (26.8-39.3) **334**	**35.5** (28.3-42.7) **279**	**36.7** (26.2-47.1) **328**	**17.1** (7.6-26.6) **110**
Multiracial-Non Hispanic	**26.8** (24.9-28.6) **2,065**	**20.7** (18.8-22.6) **1,933**	**26.9** (23.6-30.1) **2,523**	**18.9** (16.3-21.6) **1,939**

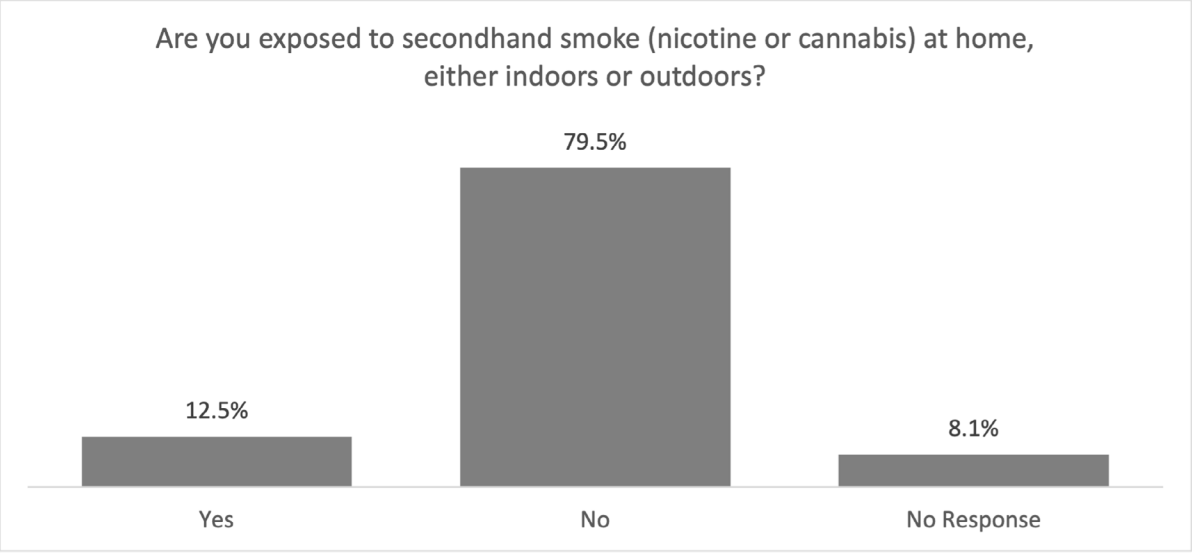
Charles County

	2014	2016	2018	2021
High School Students				
High School Female	**26.4** (24.1-28.7) **990**	**17.3** (14.8-19.9) **603**	**17.3** (14.5-20.2) **617**	**14.9** (12.8-16.9) **585**
High School Male	**27.5** (24.4-30.7) **1,010**	**20.1** (17.5-22.7) **739**	**20.7** (17.6-23.8) **762**	**11.1** (9.1-13.2) **429**
White	**32.6** (29.0-36.2) **769**	**24.8** (21.1-28.6) **523**	**32.1** (27.3-36.8) **617**	**18.9** (15.4-22.5) **326**
African American/Black	**23.4** (20.8-26.0) **913**	**15.0** (12.6-17.4) **581**	**12.2** (10.2-14.3) **488**	**9.7** (7.9-11.4) **433**
Asian	**20.6** (11.5-29.8) **24**	**17.8** (9.6-25.9) **25**	**10.2** (3.5-16.8) **20**	**11.0** (4.3-17.7) **27**
Hispanic/Latino	**26.9** (20.6-33.1) **91**	**20.1** (14.8-25.3) **72**	**25.5** (19.7-31.4) **121**	**18.8** (13.9-23.7) **124**
All Other Races	**30.3** (24.6-36.1) **161**	**20.6** (15.8-25.4) **99**	**19.1** (13.6-24.6) **97**	**15.5** (10.7-20.3) **89**

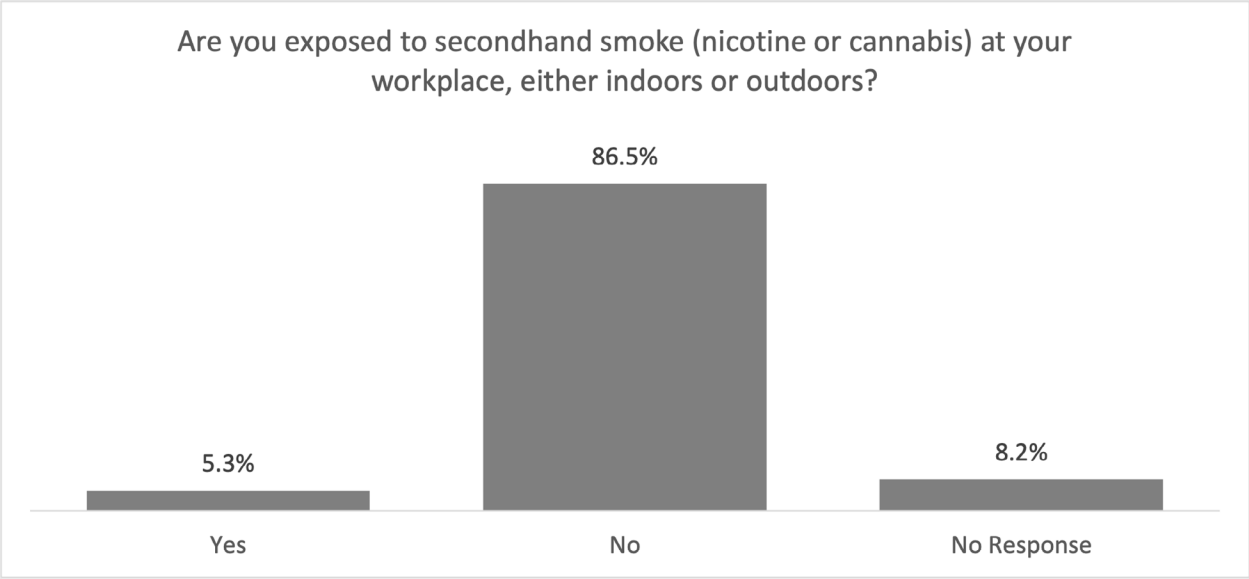
Qualitative Data on Tobacco Use and Smoking

Long Survey Questions On Secondhand Smoke:

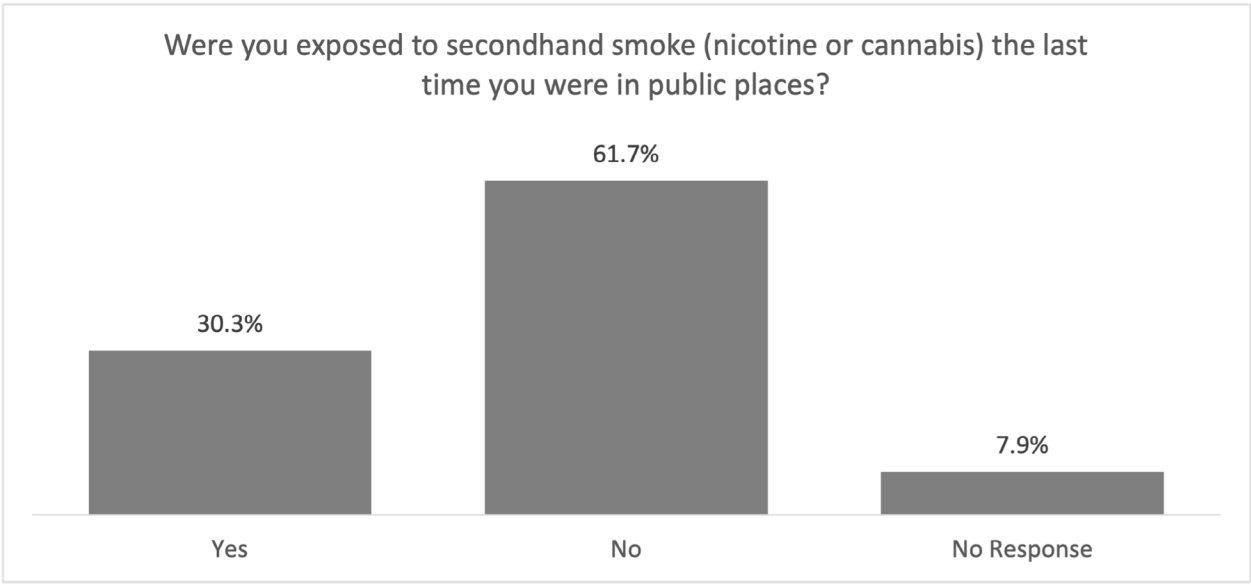
Survey respondents were also asked about their exposure to secondhand smoke, in their home or out in the community. Almost 80% of respondents reported that they are not exposed to secondhand smoke at home. 12.5% of respondents reported that they are exposed to secondhand smoke at their home, either indoors or outdoors.



A larger percentage of respondents reported that they are not exposed to secondhand smoke at their workplace. Just over 5% of respondents reported that they are exposed to secondhand smoke at work.



When asked if they were exposed to secondhand smoke in public places, a larger percentage of survey respondents reported that they were (30.3%). Just under 62% of respondents reported that they were not exposed to secondhand smoke the last time they were in public places.

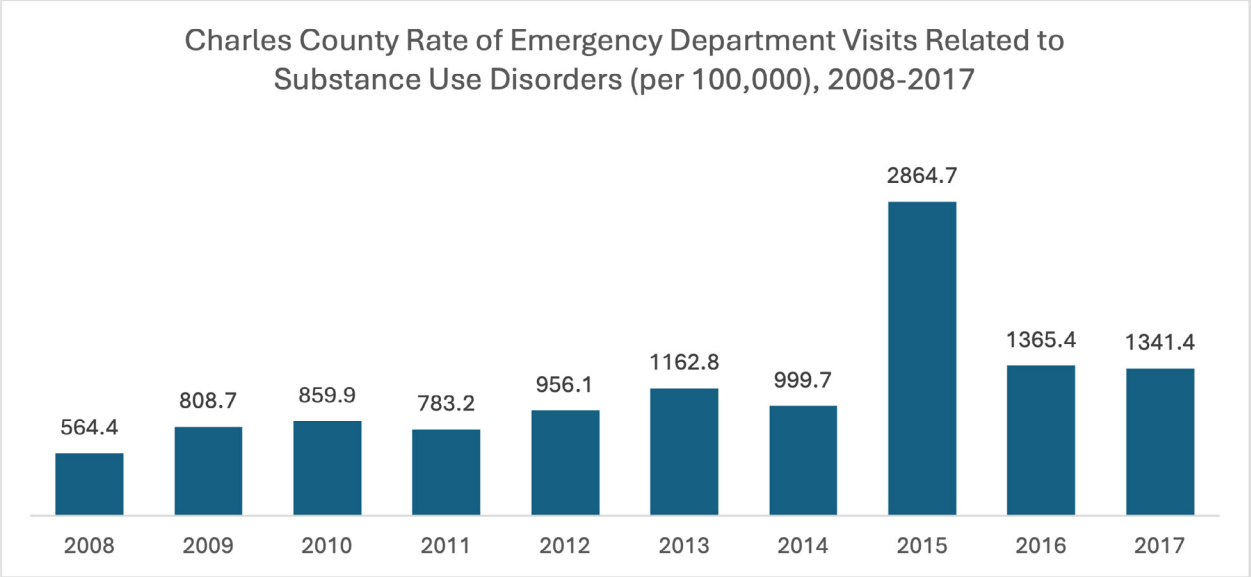


Charles County Substance Use Disorder Data:

Substance Use Disorder Hospitalization and Emergency Department Visit Rates

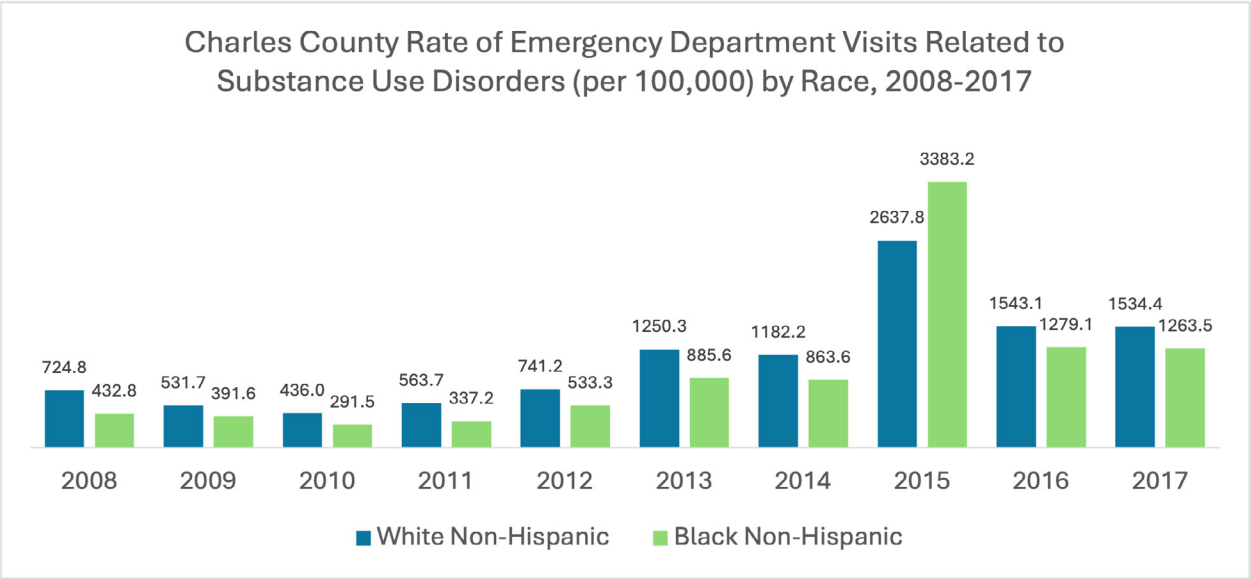
Emergency department visits for addiction-related have continued to increase in Maryland and in Charles County. The 2017 Charles County emergency department visit rate for addiction-related conditions was 1,341.4 per 100,000. This rate is below the state average rate of 2,017.0 per 100,000. The county rate is highest among Non-Hispanic Whites with an ED visit rate of 1,534.4 compared to 1,263.5 for Charles County Blacks and 1,095.5 for Charles County Hispanics. The 2017 Addictions-related ED visit rate for Maryland Hispanics was not calculated and presented.

The Charles County Addiction-related ED visit rate has continued to climb each year from 564.4 in 2008 to 1,341.4 in 2017. There has been a great deal of fluctuation in this yearly rate with a large spike in the rate for 2015. The 2016 and 2017 rates have remained fairly consistent.



Source: Maryland SHIP Emergency Department Visits for Addictions-Related Conditions 2008-2017
**Diagnoses include alcohol-related disorders and drug-related disorders*

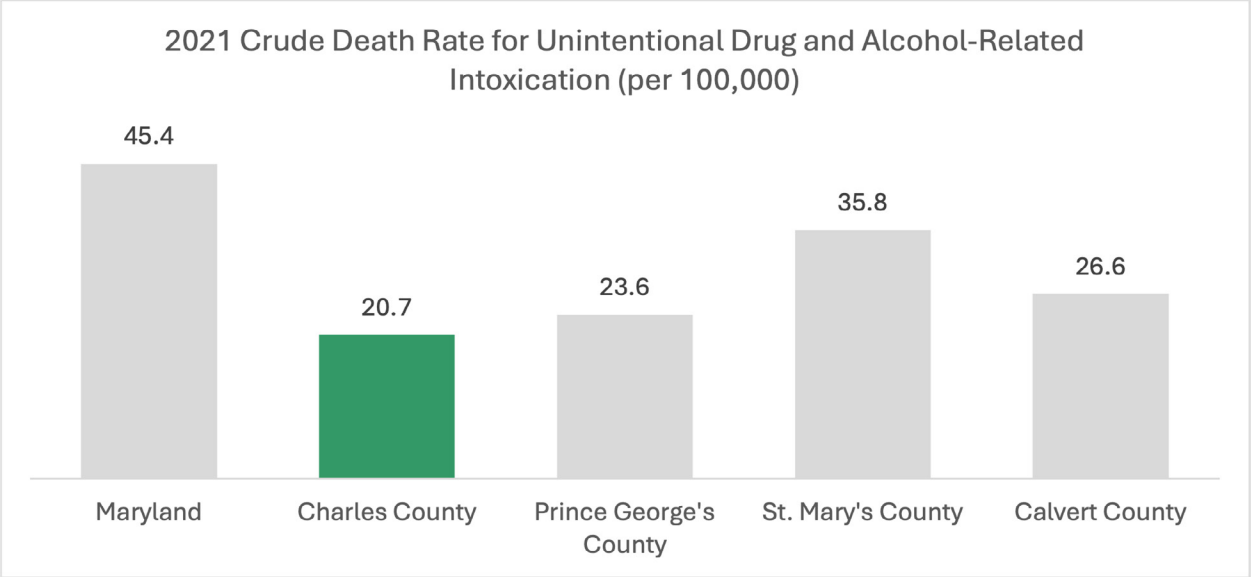
Since 2008, Non-Hispanic Whites have consistently had higher rates of emergency department visits related to substance use disorders in Charles County, compared to Non-Hispanic Blacks. However, in 2015 this trend shifted. In 2015, the rate of emergency department visits for Non-Hispanic Blacks increased to 3,383.2 per 100,000, exceeding the Non-Hispanic White rate of 2,637.8 per 100,000. However, in 2016 and 2017, the rate for Non-Hispanic Blacks decreased and fell below the Non-Hispanic White rate again for both years.



Source: Maryland SHIP Emergency Department Visits for Addictions-Related Conditions 2008-2017
**Diagnoses include alcohol-related disorders and drug-related disorders*

The CDC reports that in 2021, there were 106,699 drug overdose deaths in the United States. The age-adjusted rate of overdose deaths increased by 14% from 2020 (28.3 per 100,000) to 2021 (32.4 per 100,000). Of these deaths, Opioids were involved in 75.4%.

Since 2012, Charles County has seen an increase in the number of intoxication deaths, both drug and alcohol related. In 2021, Charles County had a crude death rate of 20.7 per 100,000 for unintentional drug and alcohol-related intoxications. This rate was lower than Maryland rate of 45.4 per 100,000 and lower than all surrounding counties (Prince George's County, St. Mary's County, and Calvert County).



Source: 2021 Maryland Vital Statistics Unintentional Drug- and Alcohol-Related Intoxication Deaths Report

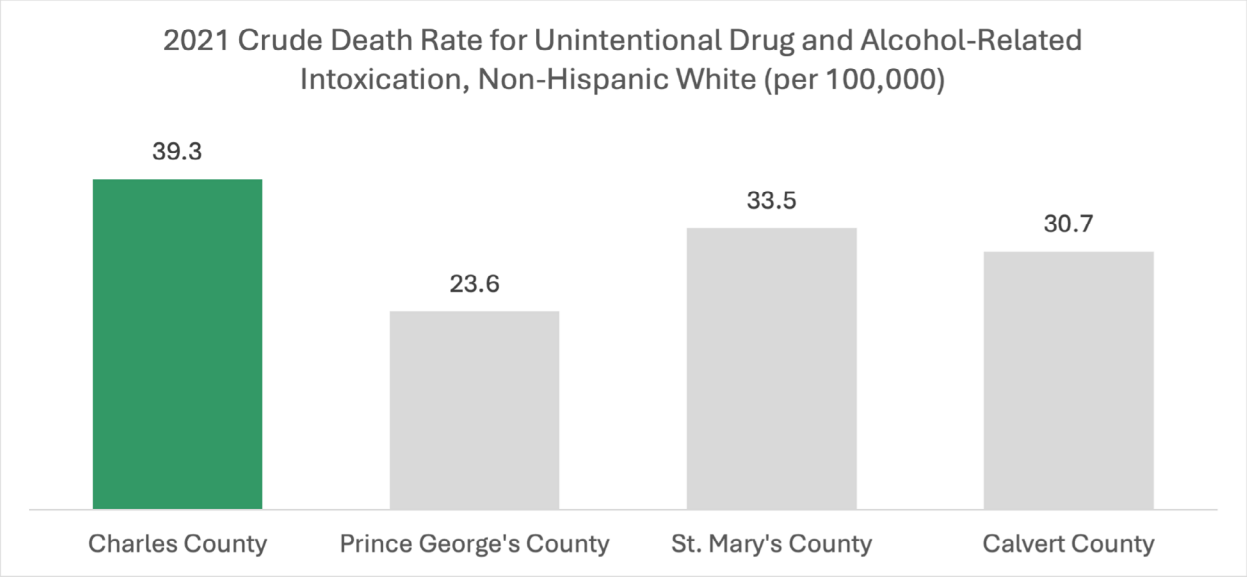
Unintentional drug and alcohol-related intoxication deaths vary by racial and ethnic groups, both in Maryland and in Charles County. In Maryland, Non-Hispanic Whites accounted for 1,427 out of the 2,800 total intoxication deaths in 2021. In Charles County, Non-Hispanic Whites accounted for 23 out of the 35 intoxication deaths.

Total Number of Drug- and Alcohol-Related Intoxication Deaths by Race and Hispanic Origin, 2021	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic
Maryland	2,800	1,427	1,198	124
Charles County	35	23	12	0

Source: 2021 Maryland Vital Statistics Unintentional Drug- and Alcohol-Related Intoxication Deaths Report

Although Non-Hispanic Whites had a higher number of deaths compared to Non-Hispanic Blacks in Maryland, the crude death rate for Non-Hispanic Blacks was significantly higher at 64.3 per 100,000 compared to 47.2 per 100,000 for Non-Hispanic Whites.

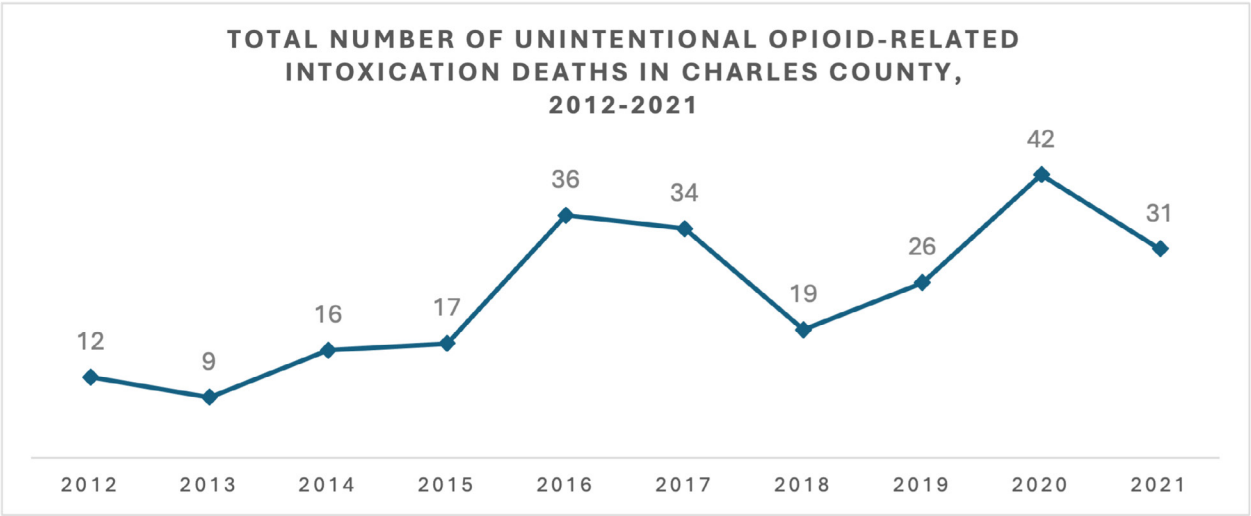
In Charles County, the drug and alcohol-related intoxication crude death rate for Non-Hispanic Whites is lower than the Maryland rate, but higher than surrounding counties. In 2021, the crude death rate for Non-Hispanic Whites in Charles County was 39.3 per 100,000. The next highest county was St. Mary's with a rate of 33.5 per 100,000.



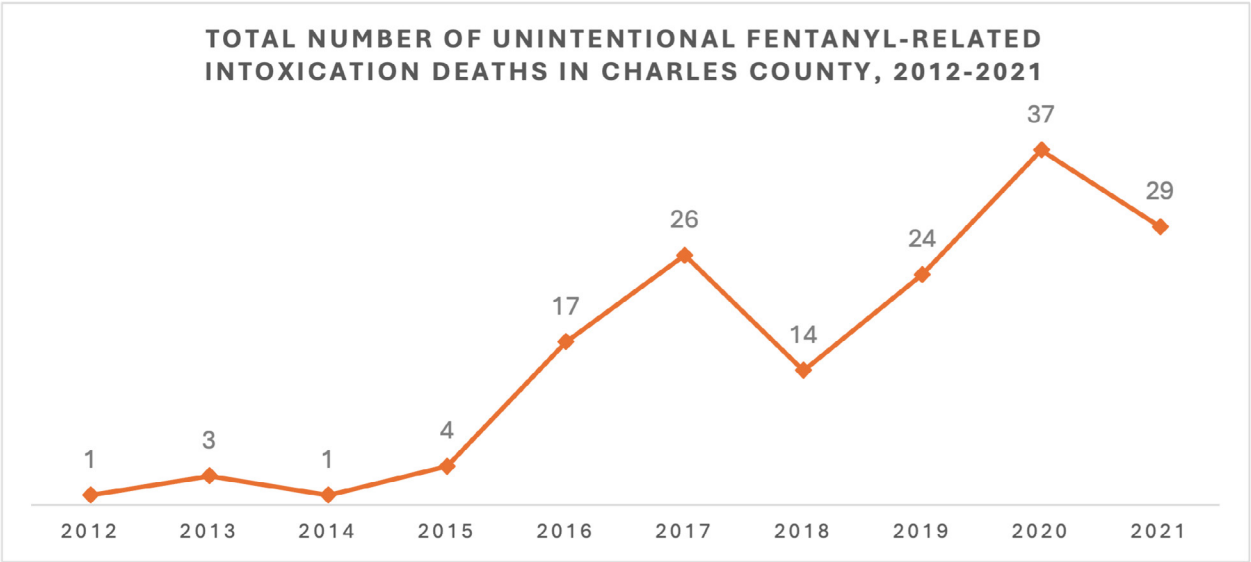
Source: 2021 Maryland Vital Statistics Unintentional Drug- and Alcohol-Related Intoxication Deaths Report

Since 2012, Charles County has seen an increase in the number of unintentional intoxication deaths, with the largest increases being in opioid-related deaths and fentanyl-related deaths. In 2021, there were a total of 31 opioid-related intoxication deaths reported in Charles County. This number is less than the 2020 total of 42 reported deaths. However, the 2021 total of 31 deaths

is more than double the number of deaths reported in 2012, which had a total of 12 opioid-related intoxication deaths.



Along with opioid-related deaths, fentanyl-related deaths have also been on the rise in Charles County. The increases in fentanyl-related deaths have exceeded any other drug or alcohol-related deaths in the county. In 2021, there were a total of 29 reported fentanyl-related intoxication deaths in Charles County. This number is a decrease from 37 deaths reported in 2020. However, the total of 29 deaths in 2021 is a large increase from 1 death reported in 2012. From 2012 to 2015, fentanyl-related deaths in Charles County remained low, with a high of 4 deaths reported in 2015. This number jumped to 17 deaths in 2016 and then to 26 deaths in 2017. After a decrease in deaths in 2018, fentanyl-related deaths were on the rise again until they fell in 2021.

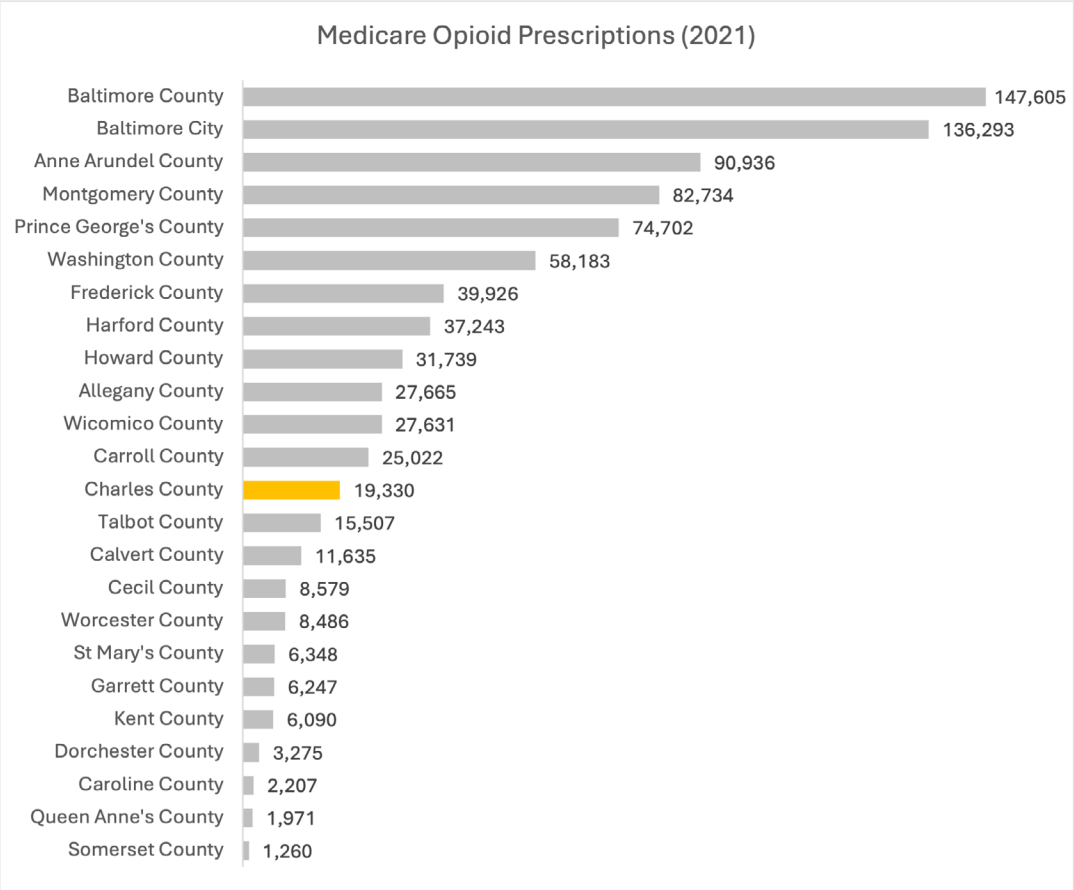


Total Number of Unintentional Intoxication Deaths in Charles County	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total
Opioid-Related Deaths	12	9	16	17	36	34	19	26	42	31	**242**
Heroin-Related Deaths	5	5	10	8	22	16	11	12	15	5	**109**
Prescription Opioid-Related Deaths	7	5	9	8	10	11	8	7	8	5	**78**
Oxycodone-Related Deaths	3	1	5	8	4	7	5	4	3	1	**41**
Fentanyl-Related Deaths	1	3	1	4	17	26	14	24	37	29	**156**
Cocaine-Related Deaths	1	0	0	2	4	10	13	12	16	8	**66**
Alcohol-Related Deaths	2	4	5	4	12	9	3	10	14	7	**70**

Source: 2021 Maryland Vital Statistics Unintentional Drug- and Alcohol-Related Intoxication Deaths Report

Medicare Opioid Prescriptions

The following data reflects Medicare Part D opioid drug claims, including original prescriptions and refills. In 2021, Maryland had a total of 870,614 Medicare Opioid prescriptions. Of this total, Charles County comprised of 2.2% of Maryland opioid prescriptions with a total of 19,330 in 2021.



Source: 2021 CMS Medicare Opioid Prescriptions

Maryland Youth Risk Behavior Survey

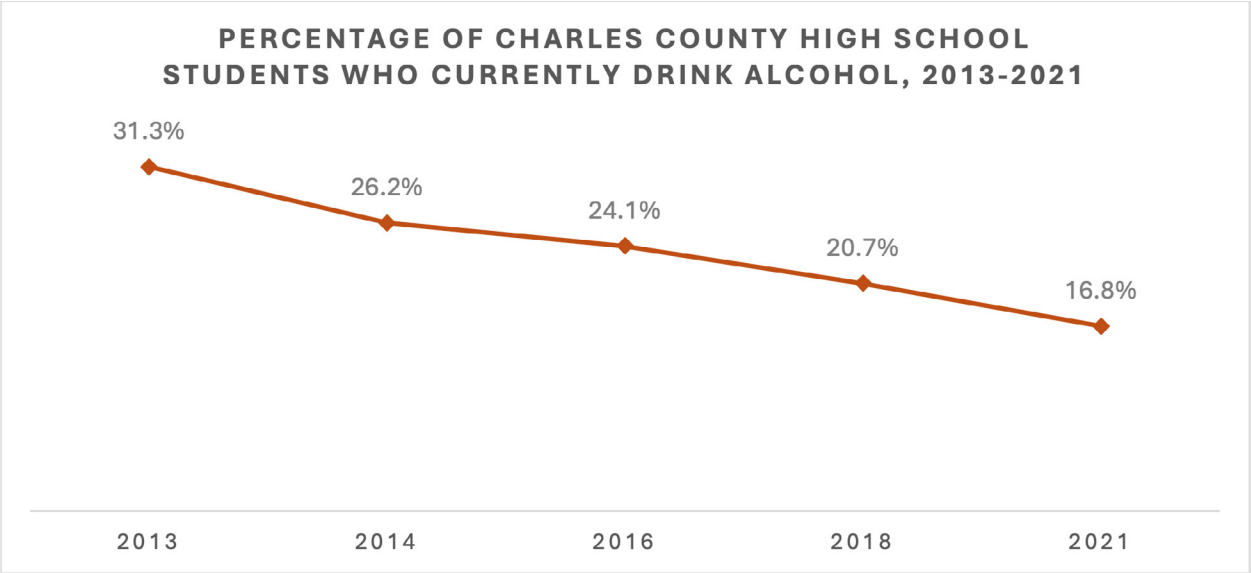
Charles County middle and high school students participated in the 2021-2022 Maryland Youth Risk Behavior Survey (YTRBS) to determine any changes in the percentage of children engaging in high-risk behaviors that can lead to chronic and infectious disease conditions. All responses have been weighed to reflect the county's school-aged population.

Among Charles County High School students, 16.8% reported currently drinking alcohol (at least one drink of alcohol, on at least 1 day during the 30 days before the survey). This was the highest percentage among all substances for High School students. However, the percentage of High School students who currently drink alcohol has been on the decline since 2013, when the percentage was 31.3%. High School students who currently use marijuana had the second highest percentage at 14.7%, followed by ever taking prescription pain medications at 14.5%.

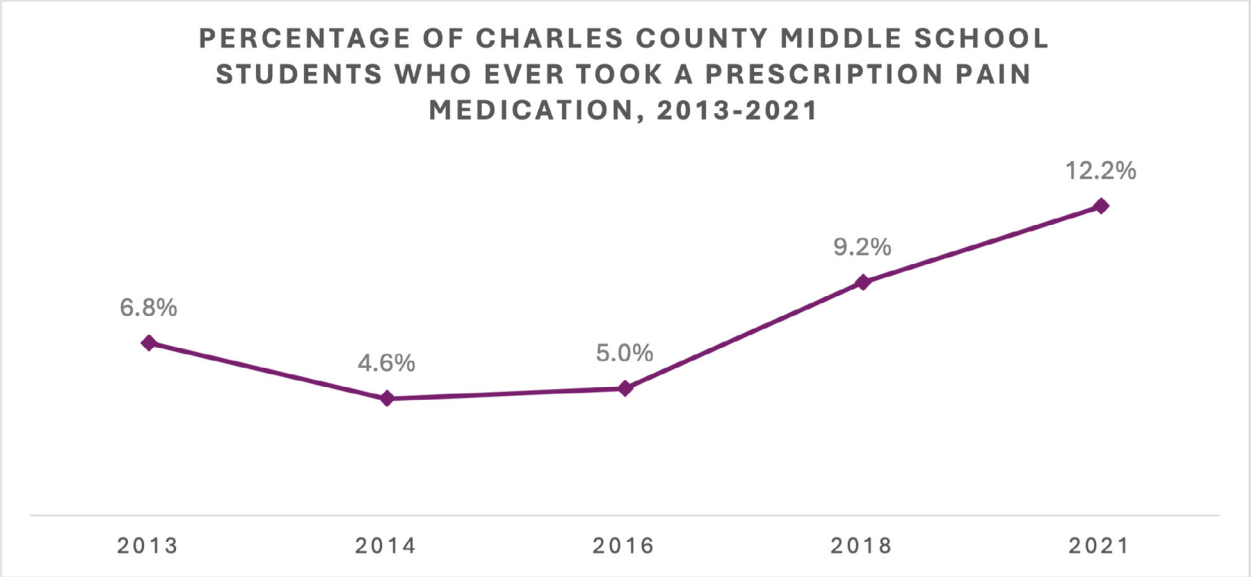
Among Charles County Middle School students, 12.2% reported ever taking a prescription pain medication. This was an increase from 9.2% reported in 2018. Since 2013, prescription pain medication use has increased among Charles County Middle School students. Middle school students who reported currently drinking alcohol had the second highest percentage at 6.7%. This is a decrease from 10.4% reported in 2018.

Charles County Alcohol and Other Drug Use Among Middle and High School Students	Middle School	High School
Currently drink alcohol	6.7%	16.8%
Currently use Marijuana	3.8%	14.7%
Ever took prescription pain medication without a doctor's prescription or differently than how a doctor told them to use it	12.2%	14.5%
Ever used Cocaine	2.1%	3.4%
Ever used Heroin	NA	2.8%
Ever used Methamphetamines	NA	2.7%
Ever used Ecstasy	NA	3.2%
Ever inject any illegal drug	NA	3.1%

NA: Not applicable. This question was not asked on the middle school survey.
Source: 2021-2022 Maryland Youth Risk Behavior Survey



Source: 2021-2022 Maryland Youth Risk Behavior Survey

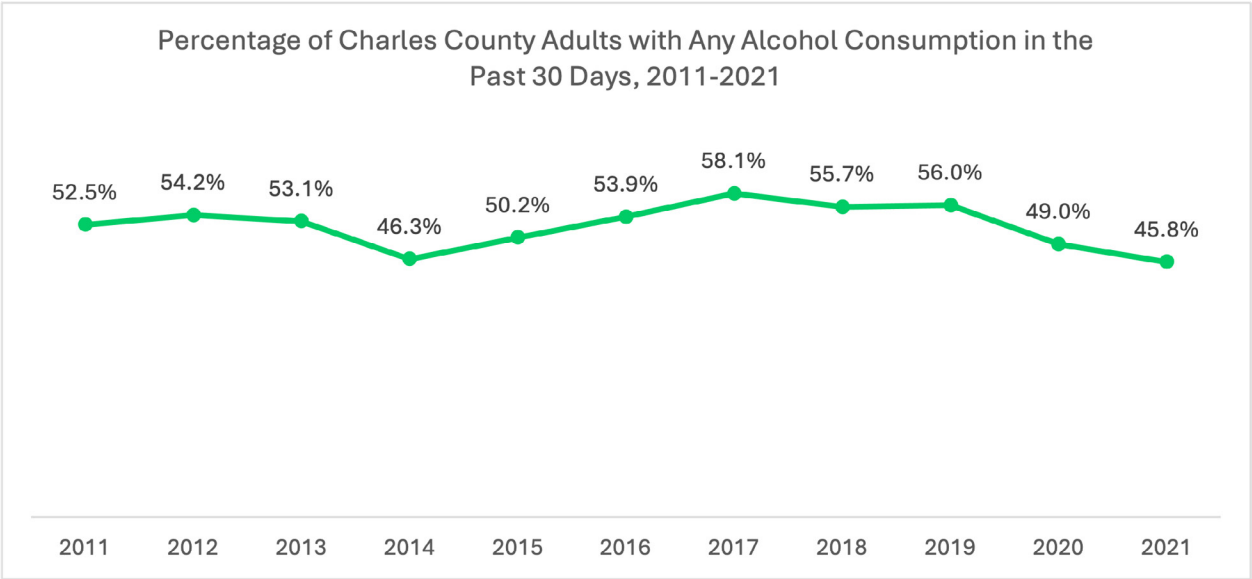


Source: 2021-2022 Maryland Youth Risk Behavior Survey

Maryland Behavior Risk Factor Surveillance System Data

Alcohol Consumption:

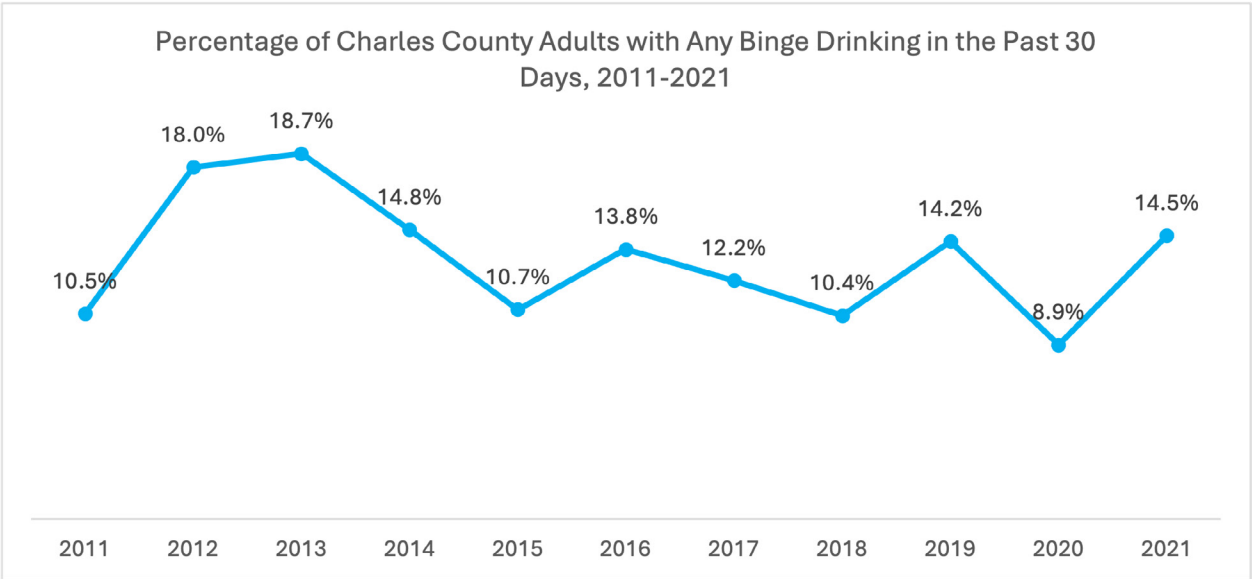
In 2021, 45.8% of Charles County adults reported consuming alcohol in the past 30 days. This percentage is lower than the Maryland percentage of 53.1%. In 2017, the percentage of Charles County adults who reported any alcohol consumption in the past 30 days reached 58.1% but has since been on the decline.



Source: 2011-2021 Maryland BRFSS

Binge Drinking

Binge drinking is considered as 5 or more drinks on any occasion for men, and 4 or more drinks for women. In 2021, 14.5% of Charles County adults reported binge drinking in the past 30 days. This is slightly higher than the Maryland percentage of 14.1%. From 2020 to 2021, there was an increase in the percentage of adults who reported binge drinking. In 2020, 8.9% of Charles County adults reported binge drinking in the past 30 days. Since 2011, the trend in binge drinking among Charles County adults has been very unstable. In 2012 and 2013, Charles County reached the highest percentage of binge drinking among adults at 18.0% and 18.7%, respectively. Since 2015, the percentage of binge drinking did not reach over 14% again until 2019 (14.2%), and 2021 (14.5%).



Source: 2011-2021 Maryland BRFSS

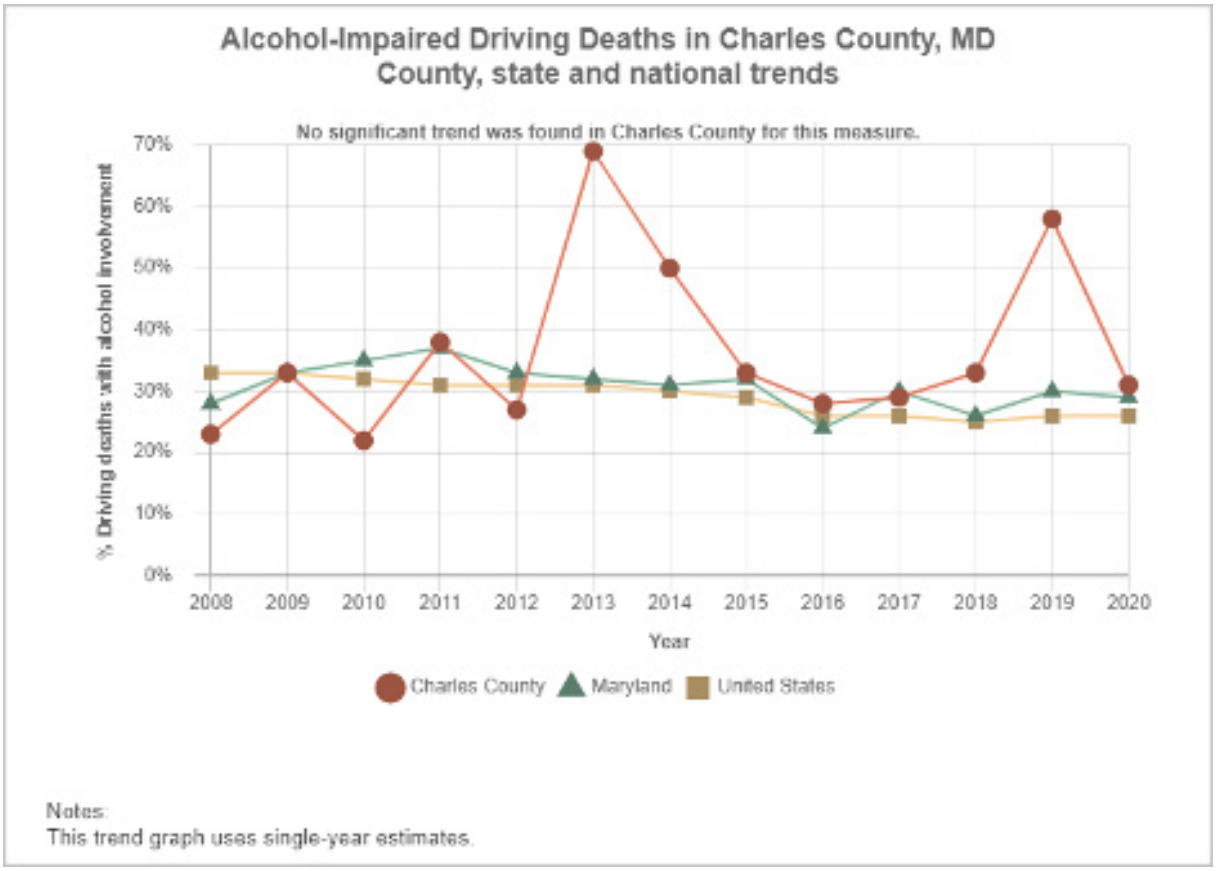
Chronic Drinking

In 2021, 4.2% of Charles County adults reported being chronic drinkers. This is considered as adult men having more than 14 drinks per week and adult women having more than 7 drinks per week. The percentage of Charles County adults who are chronic drinkers is below the Maryland percentage of 5.0% for 2021.

Alcohol Involved Driving Deaths

According to County Health Rankings, 35% of motor vehicle crash deaths in Charles County involved alcohol. This is higher than the Maryland percentage of 28%. Out of the surrounding counties, Charles County has the second highest percentage of driving deaths involving alcohol, behind St. Mary's County at a percentage of 42%.

	Percentage of Driving Deaths with Alcohol Involvement
Maryland	28%
Charles County	35%
Calvert County	30%
Prince George's County	31%
St. Mary's County	42%



Source: 2023 County Health Rankings

Qualitative Data Regarding Substance Use

Long Survey Data:

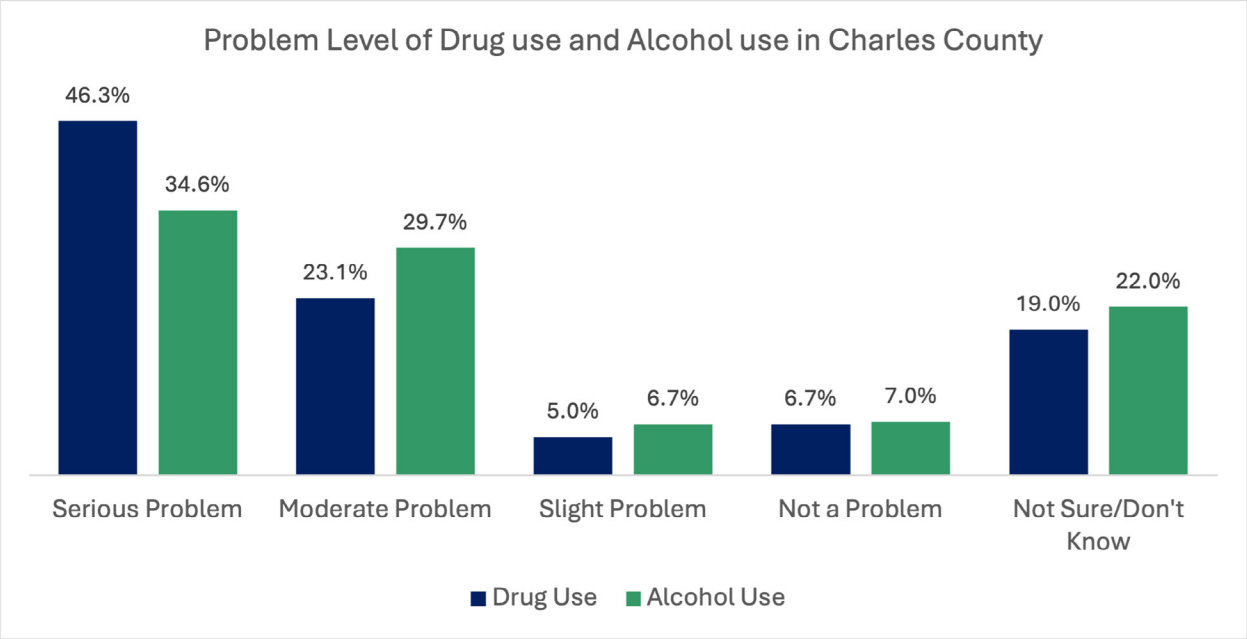
Charles County survey participants reported how often they engage in various behaviors related to substance use. A large majority of survey participants reported never engaging in substance use behaviors. About 60% of respondents reported they never drink more than 5 alcoholic beverages in one sitting. An even higher percentage of respondents reported never drinking more than three alcoholic beverages per day (61.7%). 6.3% of respondents reported that they sometimes drink more than 5 alcoholic beverages in one sitting, and 5.9% reported that they sometimes drink more than three alcoholic beverages per day.

When asked if they use marijuana, 73.5% of survey respondents reported that they have never used marijuana. 2.9% of respondents reported that they rarely use marijuana, and 2.9% also reported that they sometimes use marijuana. A small percentage of respondents reported that they always use marijuana, at 1.6%.

A large percentage of respondents reported that they have never misused prescription opioids or used heroin, and 81.0%. A slightly higher percentage reported that they have never used any other illegal drug (81.7%). There were zero survey respondents who reported always using illegal drugs or misuse of prescription opioids.

Risk and Behavioral Factors	Always	Most of the time	Sometimes	Rarely	Never	Not applicable
Drink more than 5 alcoholic beverages in one sitting?	0.3%	1.3%	6.3%	18.9%	60.3%	12.8%
Drink more than three alcoholic beverages per day?	0.1%	0.3%	5.9%	18.4%	61.7%	13.5%
Use Marijuana?	1.6%	1.3%	2.9%	2.9%	73.5%	17.7%
Misuse prescription opioids or use heroin?	0.0%	0.2%	0.2%	0.2%	81.0%	18.5%
Use other illegal drugs?	0.0%	0.1%	0.7%	0.0%	81.7%	17.4%

Survey participants were also asked to rank the problem level of drug use and alcohol use in Charles County. Just under half of survey respondents felt that drug use was a serious problem in Charles County at 46.3%, compared to 34.6% of respondents that felt alcohol use was a serious problem. Almost 30% of respondents felt that alcohol use was a moderate problem in the county, compared to 23.1% for drug use.



Short Survey Data:

Short survey respondents were asked to identify the biggest health problems in Charles County. 40.7% reported that alcohol and drug use were the biggest health problems in the county. This was the fourth most commonly cited health problem after Diabetes, Overweight/Obesity, and Mental Health.

Short survey respondents also provided ideas and recommendations to help decrease health problems in the county. Many respondents expressed ideas and recommendations related to substance use. Recommendations such as, the need for fentanyl awareness and more Narcan training throughout the county. Also, more support for drug addictions, prescription pill addicts, and cut down on the number of tobacco and alcohol stores in the area.

Lastly, short survey respondents were asked if there are sufficient services or resources for drug and alcohol use in Charles County. Of those who responded to this question, 41.3% felt that there are some services available for drug and alcohol use in the county. 21.6% felt there are many services available in the county, and 3.9% felt that there are no services available. 33.1% of respondents did not know if there were services available for drug or alcohol use in Charles County.

	No Services Available	Some Services Available	Many Services Available	I don't know
Drug and Alcohol Use	3.9%	41.3%	21.6%	33.1%

**Percentages based on those who answered the question. Blanks are not included in the denominator.*

Focus Groups:

Across all six focus groups, Behavioral Health was one of the top health conditions that participants believed to be affecting Charles County the most. Behavioral health includes both mental health and substance use disorders. In past needs assessments, Behavioral health was also seen as a top health condition affecting Charles County among focus group participants.

Focus group members expressed that behavioral health practitioners are limited in Charles County. Barriers of commercial insurance and behavioral health services were also identified in the focus groups. Focus group participants mentioned that most people develop behavioral health conditions in childhood or adolescence, yet if they have commercial insurance, they have limited options when it comes to accessing services. Related to substance use, drug affected newborn (DAN) babies were brought up as a concern among focus group members. Drug affected newborns refers to newborns who are exposed to drugs in the womb. Focus group participants expressed that the care for drug affected newborn babies is not offered in Charles County, and families need to travel out of the county to receive care.

Focus group participants also mentioned the current issue of behavioral health services in the Emergency Department. They believe this is one of many reasons why healthcare has gotten worse in Charles County since the last needs assessment. The lack of behavioral health providers or the resources needed to treat individuals with behavioral health needs. There was also discussion around the growth of the community, and that the behavioral health services also need to expand to meet the growing population.

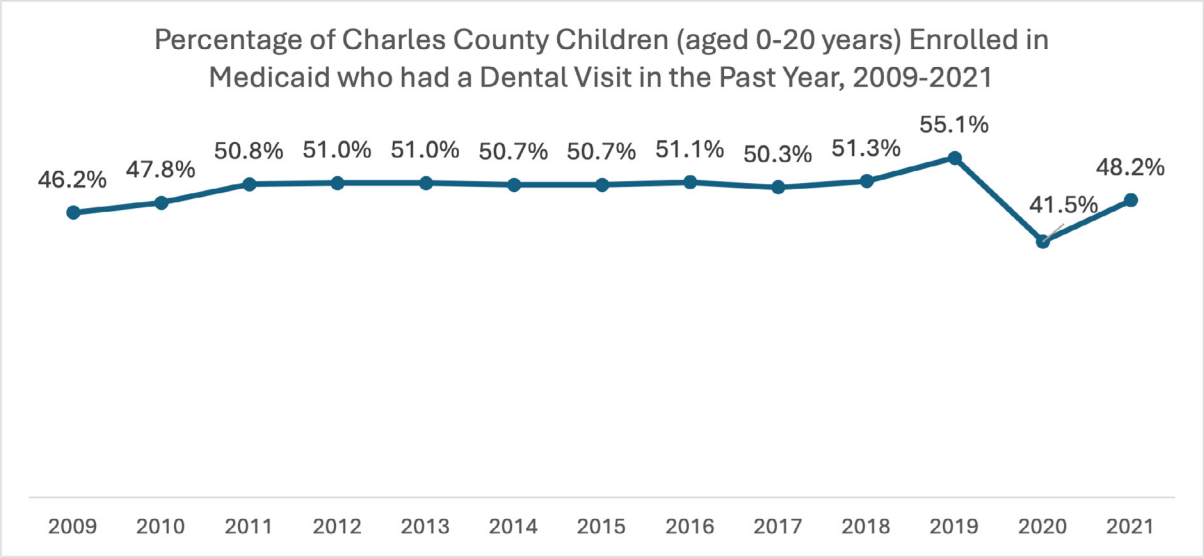
Overall, substance use was a common topic survey participants and focus group members expressed as a top health issue facing Charles County. From the increases in opioid and fentanyl-related intoxication deaths to the limited resources available to care for substance use disorders. The Charles County community has expressed concern for the growing substance

Substance Use Disorder References

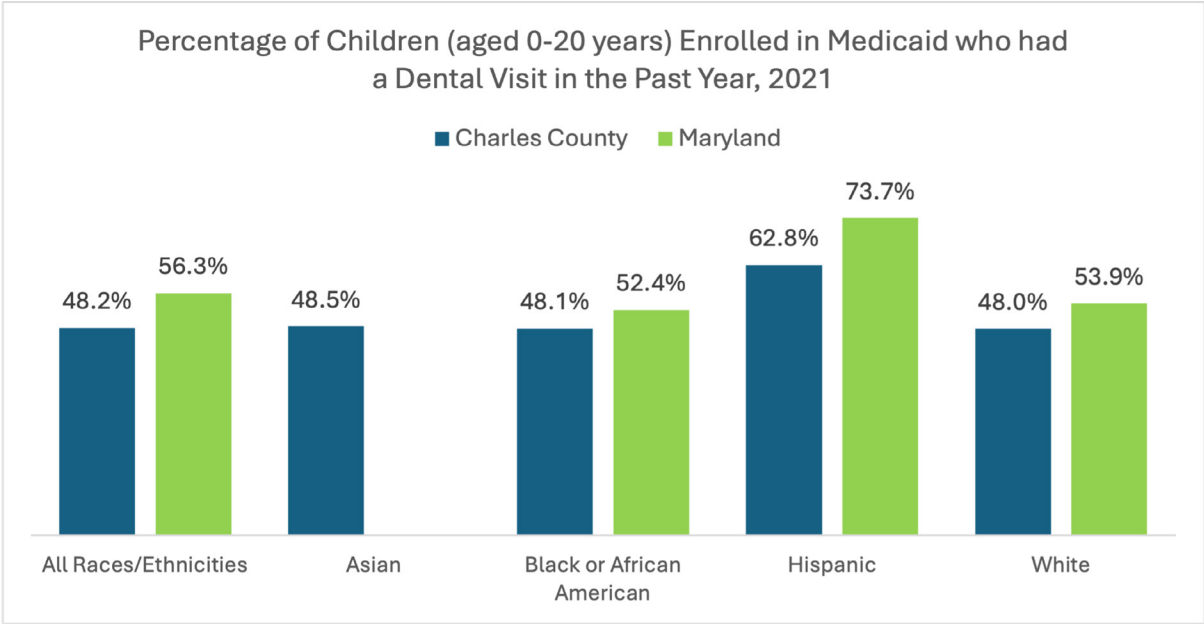
1. 2008-2017 Maryland SHIP Emergency Department Visits for Addictions-Related Conditions accessed at https://health.maryland.gov/pophealth/Pages/SHIP-Lite-Home.aspx
2. 2021 Maryland Vital Statistics Unintentional Drug- and Alcohol-Related Intoxication Deaths Report accessed at https://health.maryland.gov/vsa/Pages/overdose.aspx
3. 2021 CMS Medicare Opioid Prescriptions accessed at https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-medicaid-opioid-prescribing-rates/medicare-part-d-opioid-prescribing-rates-by-geography
4. 2011- 2021 Maryland BRFSS or Maryland YRBS/YTS accessed at ibis.health.maryland.gov on February 28, 2024.
5. 2023 County Health Rankings accessed at https://www.countyhealthrankings.org/

Charles County Dental/Oral Health Statistics:

In 2021, less than half of Charles County children enrolled in Medicaid have had a dental visit in the past year (48.2%). This is an increase from the 2020 percentage of 41.5%. The Charles County 2021 percentage is the 3rd lowest percentage in the state of Maryland following Dorchester County (47.7%) and Washington County (45.9%).



Across all racial and ethnic populations, Charles County had a lower percentage of children who had received a dental visit in the past year, compared to the Maryland state percentages. The percentage for Asian children was not available at the state level. In both Charles County and Maryland, Hispanic children enrolled in Medicaid had the highest percentage of receiving a dental visit in the past year compared to any other race or ethnic group.



Routine Dental Care for Adults

The 2018 Maryland Behavioral Risk Factor Surveillance System asked 2 questions regarding oral health. The Charles County BRFSS data for 2018 has been evaluated below.

How long since you last visited a dentist for any reason?

The majority of the Charles County participants reported that they had seen a dentist in the last year (66.6%). This is similar to the state average percentage of 66.3%.

Number of Permanent Teeth Removed:

Over half of the Charles County BRFSS participants have not had any of their permanent teeth removed (57.4%).

Oral Cancer Statistics

Incidence (New Cases)

In 2018, there were a total of 857 oral cancer cases in Maryland. Oral cancer is cancer of the oral cavity and pharynx. The age-adjusted incidence rate for oral cancer in Maryland in 2018 was 11.3 per 100,000. In 2018, Charles County had a total of 27 oral cancer cases, with an age-adjusted incidence rate of 14.0 per 100,000. From 2014-2018, there have been a total of 4,023 oral cancer cases in Maryland and 113 oral cancer cases in Charles County.

Oral Cancer Cases and Incidence Rates, 2018	Cases	Incidence Rate
Charles County	27	14.0
Maryland	857	11.3

Source: Maryland Department of Health 2021 Cancer Data

In 2018, Charles County males comprised of over 80% of the oral cancer cases, resulting in an age-adjusted incidence rate of 24.9 per 100,000. This is well above the Maryland age-adjusted incidence rate for males at 17.2 per 100,000. The age-adjusted incidence rate for Charles County females was suppressed due to low case counts.

Charles County Whites also had a higher incidence rate than that of Maryland, at 17.2 per 100,000 compared to 13.0 per 100,000.

Oral Cancer Incidence Rates, 2018	Male	Female	White	Black	Other
Charles County	17.2	6.4	13.0	7.8	7.2
Maryland	24.9	*	17.2	*	0.0

**Rates based on case counts less than 15 are suppressed.*
Source: Maryland Department of Health 2021 Cancer Data

From 2014 to 2018, Charles County males have a higher oral cancer age-adjusted incidence rate than females at 23.3 per 100,000 compared to 5.0 per 100,000. The Charles County males age-adjusted incidence rate is also higher than the Maryland incidence rate of 16.9 per 100,000. Between the years 2014-2018, Charles County Whites have been impacted more by oral cancer compared to any other race or ethnicity. The Charles County White oral cancer incidence rate from 2014-2018 was 16.6 per 100,000, compared to 8.0 per 100,000 for Charles County Blacks. This is also higher than the Maryland incidence rate for Whites at 12.7 per 100,000.

Oral Cancer Incidence Rates, 2014-2018	Male	Female	White	Black	Other
Charles County	16.9	6.2	12.7	8.0	6.2
Maryland	23.3	5.0	16.6	8.0	*

**Rates based on case counts less than 15 are suppressed.*
Source: Maryland Department of Health 2021 Cancer Data

Oral Cancer Mortality:

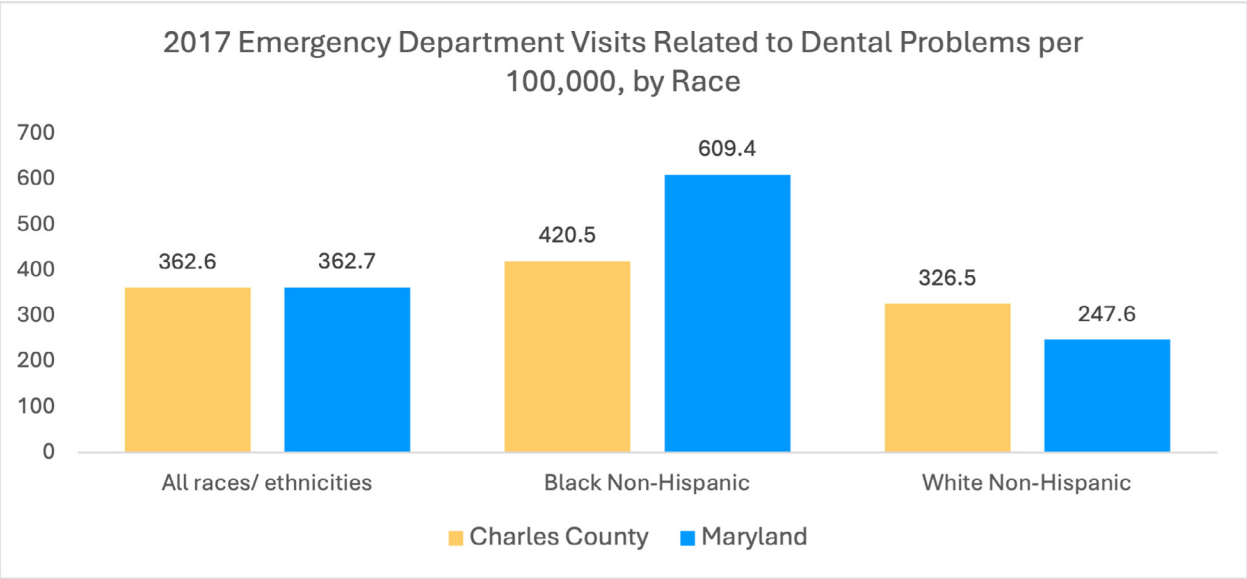
From 2014-2018, the Charles County oral cancer mortality rate was 3.4 per 100,000, this is greater than the Maryland incidence rate of 2.5 per 100,000. Charles County males also had a higher mortality rate than Maryland at 5.8 per 100,000 compared to 3.9 per 100,000.

Oral Cancer Mortality Rates, 2014-2018	Total	Male	Female	White	Black	Other
Charles County	3.4	5.8	*	*	*	*
Maryland	2.5	3.9	1.3	2.6	2.4	1.5

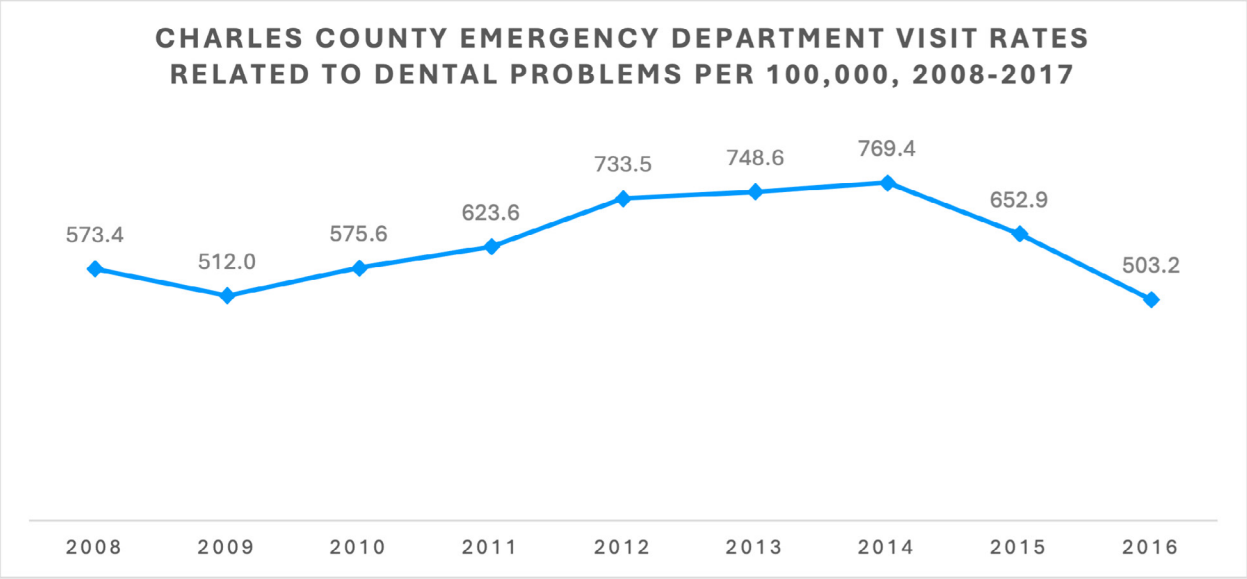
**Rates based on case counts less than 19 are suppressed.*
Source: Maryland Department of Health 2021 Cancer Data

Emergency Department Visit Rates for Dental Care

The 2017 Charles County ED visit rate for dental care was 362.6 per 100,000. This is similar to the Maryland state average rate of 362.7 per 100,000. For Charles County, the ED dental visit rate was higher for Blacks vs Whites (420.5 vs. 326.5). The dental ED visit rate for Charles County African Americans is far below the rate for Maryland African Americans (420.5 vs. 609.4). The dental ED visit rate for Charles County Whites is above the rate for Maryland Whites (326.5 vs. 247.6).

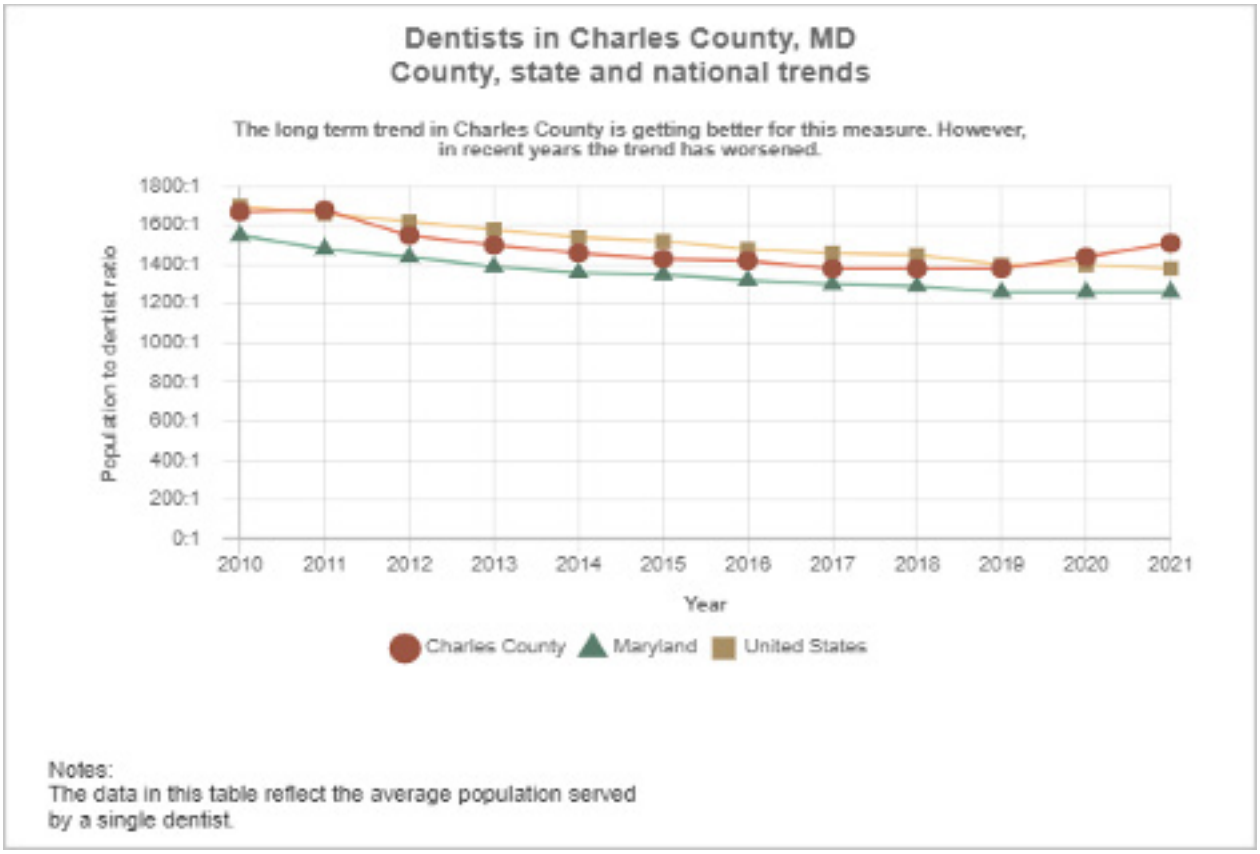


The Charles County ED visit rate for dental care increased every year from 512 per 100,000 in 2009 to 769.4 in 2014. Since then, Charles County has seen a decline in ED visit rates for dental care.



Dentist to Population Ratio

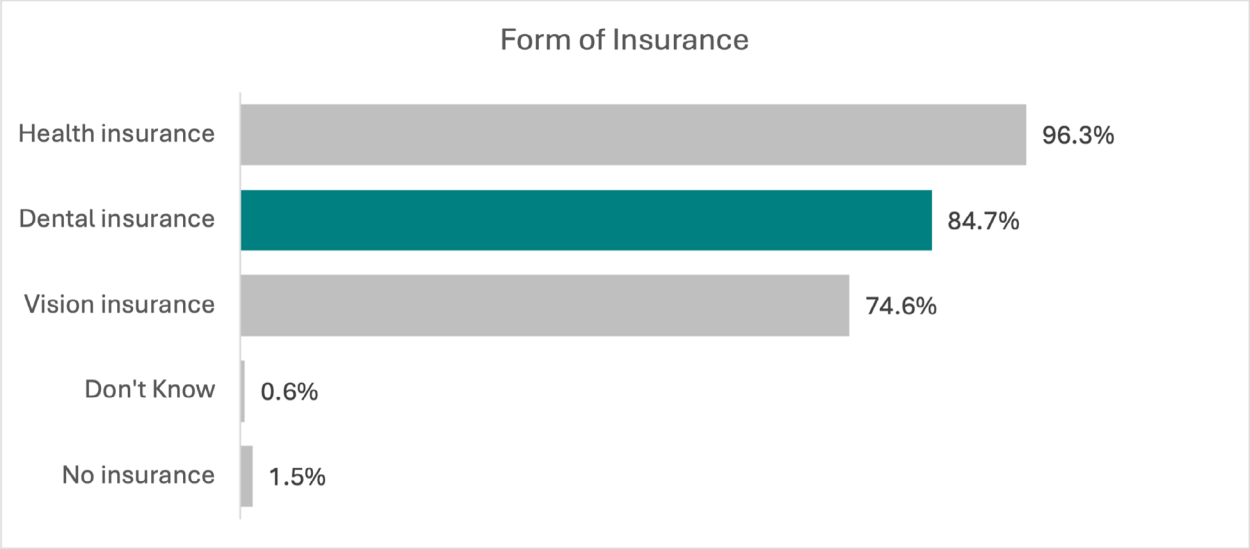
The 2023 dentist ratio in Charles County was 1,510:1. This is greater than the Maryland ratio of one dentist to 1,260 people. Since 2021, the dentist to population ratio has been increasing in Charles County. In 2021 the ratio was 1,380:1, in 2022 the ratio was 1,440:1, and 2023 is 1,510:1.



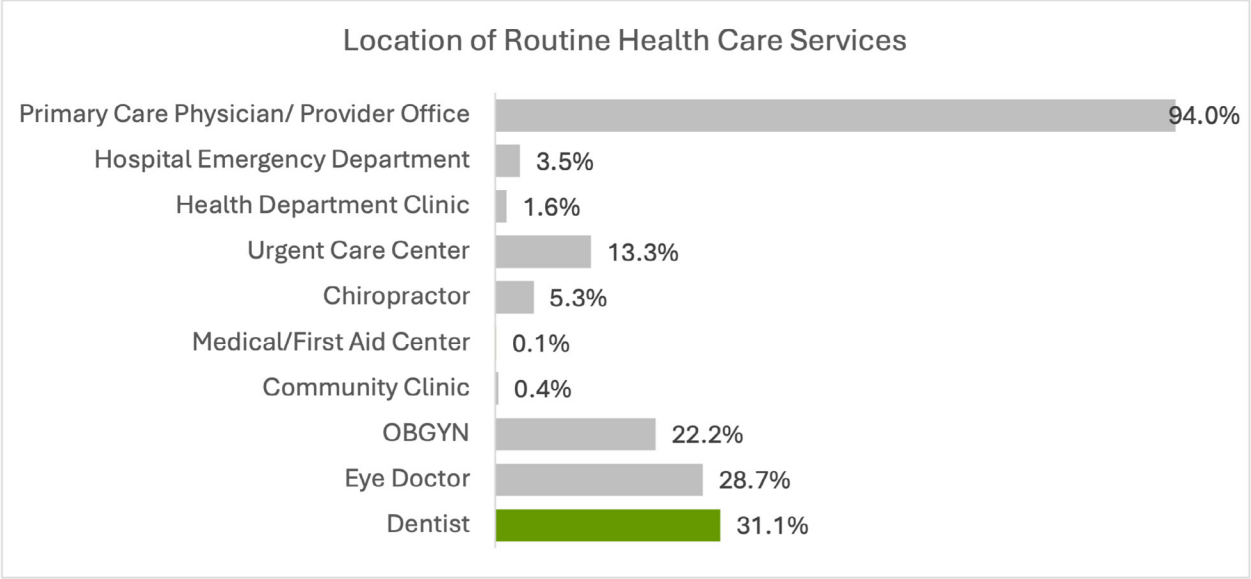
Community Health Needs Assessment

Long Survey Data:

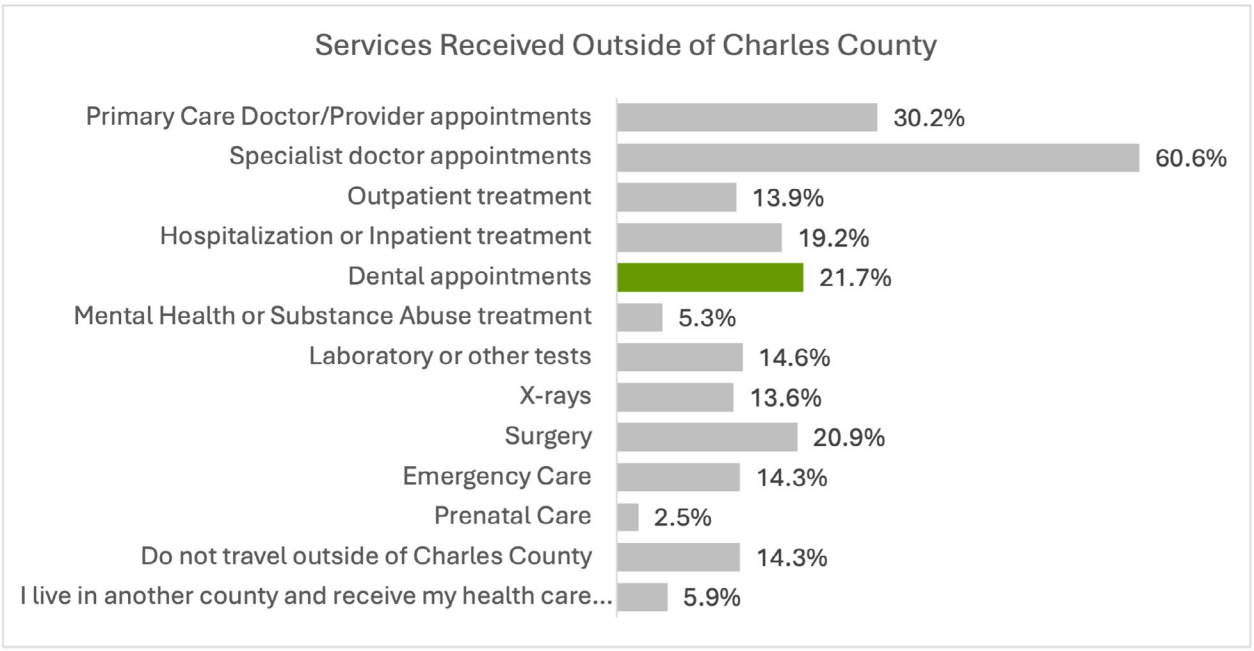
A large percentage of survey respondents reported having dental insurance, at 84.7%. This was the second most common form of insurance after health insurance at 96.3%.



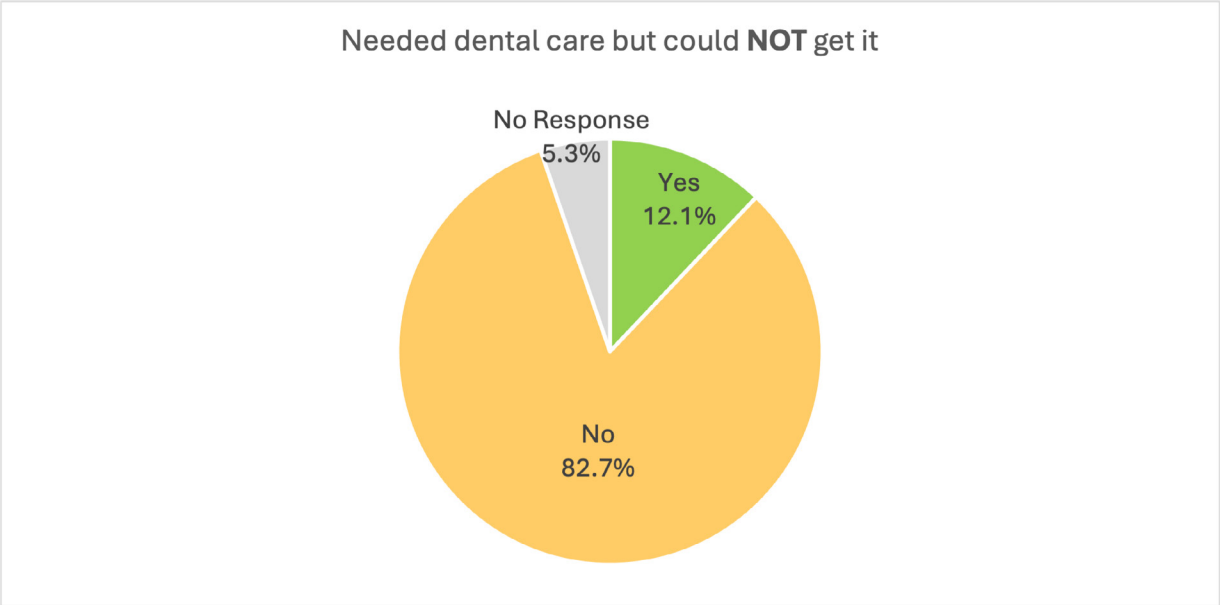
Over 30% of survey respondents reported receiving routine health care services from a dentist (31.1%). This was the second most common response among survey respondents after Primary Care Physician/Provider Office, where 94% of respondents reported receiving their routine health care services.



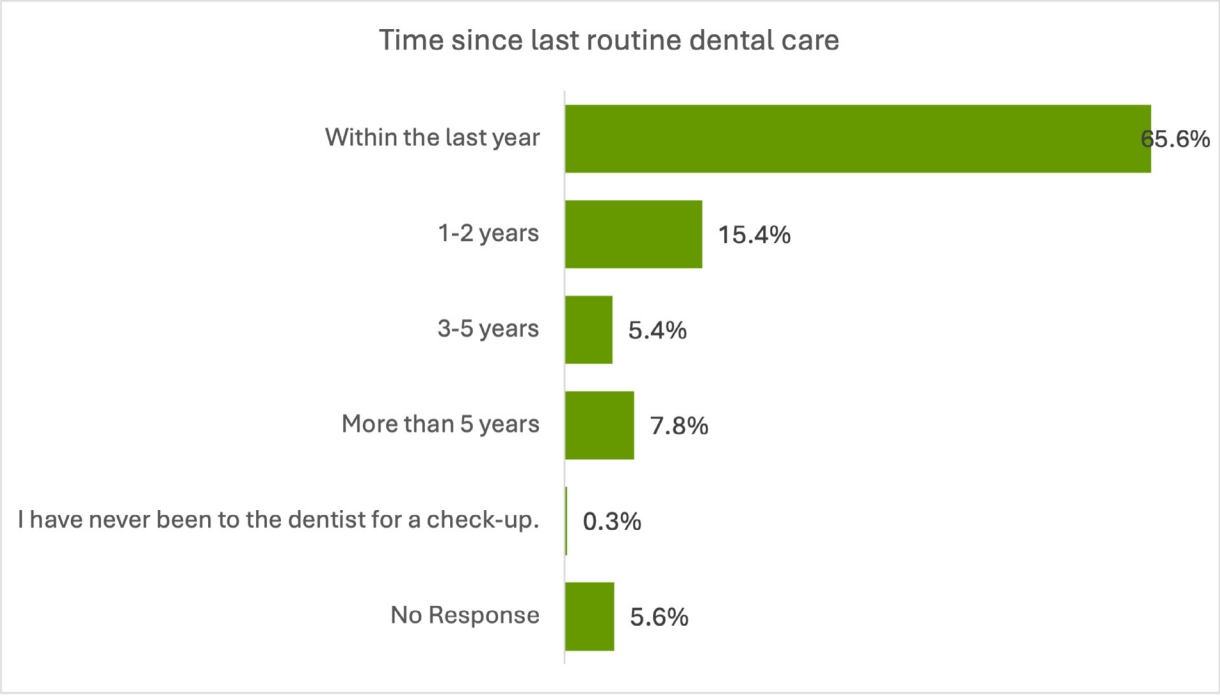
When asked what services survey respondents receive outside of Charles County, 21.7% reported they receive their dental care services outside of Charles County. This was the third most common response among survey respondents, behind specialist doctor appointments and primary care provider appointments.



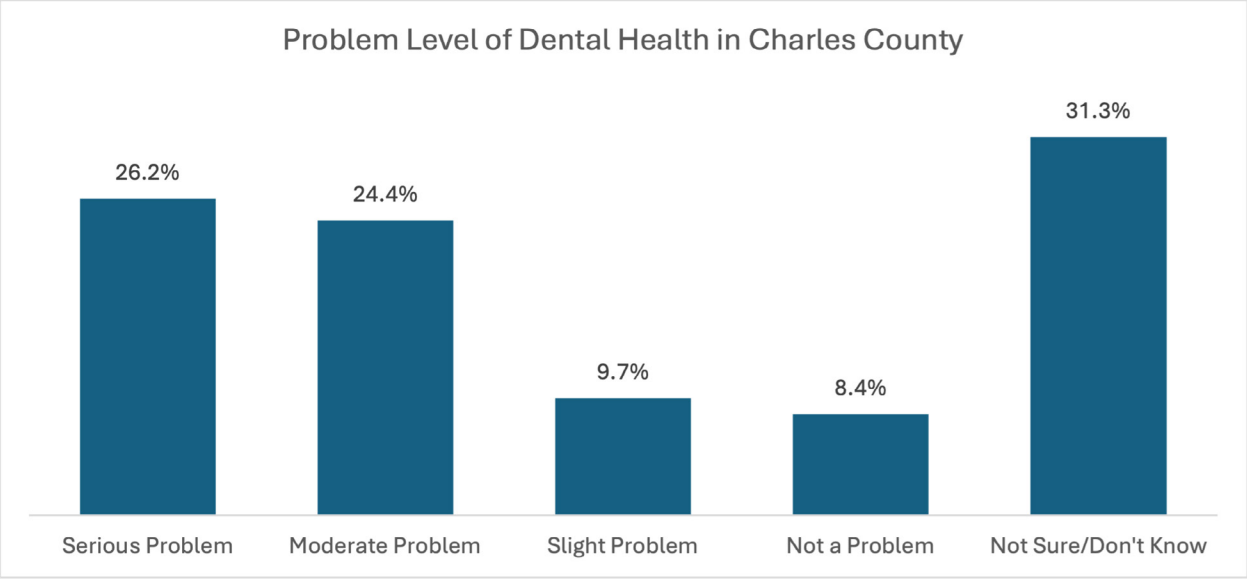
Access to care questions regarding oral health were asked among survey respondents. The majority of survey respondents reported that in the last year they were able to receive dental care if they needed it (82.7%). Around 12% of respondents reported that in the last year they needed dental care but could not get it.



65.6% of survey respondents reported having routine dental care within the last year. However, over 10% of respondents reported not having routine dental care in over 3 years (13.2%). Only 0.3% of respondents have never been to the dentist for a check-up.



When asked how serious of a problem dental health was in Charles County, about half of survey respondents believed dental health was a serious problem or a moderate problem in the county. 26.2% believe dental health was a serious problem, and 24.4% believed it was a moderate problem. 31.3% were not sure or did not know.



Short Survey:

When asked what the biggest health problems in Charles County are, only a small percentage of survey respondents believed Dental Health was the biggest problem. 14.8% of survey respondents believed Dental Health was the biggest problem facing Charles County. This was the 5th lowest percentage response amongst short survey respondents.

Short survey respondents were also asked if there are sufficient services or resources for Dental Health in Charles County. Of those who responded to this question, one third believed that there are some dental health services available in Charles County. 31.4% of respondents did not know if there were services available in the county, which was the second highest response percentage. 28.6% of respondents believed there are many dental health services available in Charles County, and 6.6% believed there are no dental health services available.

	No Services Available	Some Services Available	Many Services Available	I don't know
Dental Health	6.6%	33.3%	28.6%	31.4%

**Percentages based on those who answered the question. Blanks are not included in the denominator.*

Oral Health Resources

1. 2021 Charles County Percentages of Children with Dental Visit in past year. Medicaid data 2021 for Maryland. Accessed through the Maryland State Health Improvement Process website. Available at: https://opendata.maryland.gov/Health-and-Human-Services/SHIP-Children-Receiving-Dental-Care-In-The-Last-Ye/g72j-3f3c/about_data

2. 2018 Charles County Oral Cancer Incidence and Mortality Rates. 2019 Maryland Cigarette Restitution Fund Program's Cancer Reports. Maryland Department of Health. Available at: https://health.maryland.gov/phpa/cancer/Documents/2021%20CRF%20Cancer%20Report_FINAL.pdf

3. 2014-2018 Charles County Oral Cancer Incidence and Mortality Rates. 2019 Maryland Cigarette Restitution Fund Program's Cancer Reports. Maryland Department of Health. Available at: https://health.maryland.gov/phpa/cancer/Documents/2021%20CRF%20Cancer%20Report_FINAL.pdf

4. 2008- 2017 Charles County and Maryland Emergency Department Visit Rates for Dental Care. Maryland Health Services Cost Review Commission Outpatient Discharge File. Accessed through the Maryland State Health Improvement Process website. Available at: https://opendata.maryland.gov/Health-and-Human-Services/SHIP-Emergency-Department-Visit-Rate-For-Dental-Ca/uwst-7igm/data

5. 2023 Charles County dentist to population ratio. Area Health Resource File. Robert Wood Johnson Foundation's County Health Rankings. Available at: https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/clinical-care/access-to-care/dentists?year=2023&county=24017

Mental Health:

Maryland Behavioral Risk Factor Surveillance System

The Maryland Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing telephone surveillance program designed to collect data on the behaviors and conditions that place Marylanders at risk for chronic diseases, injuries, and preventable infectious diseases.

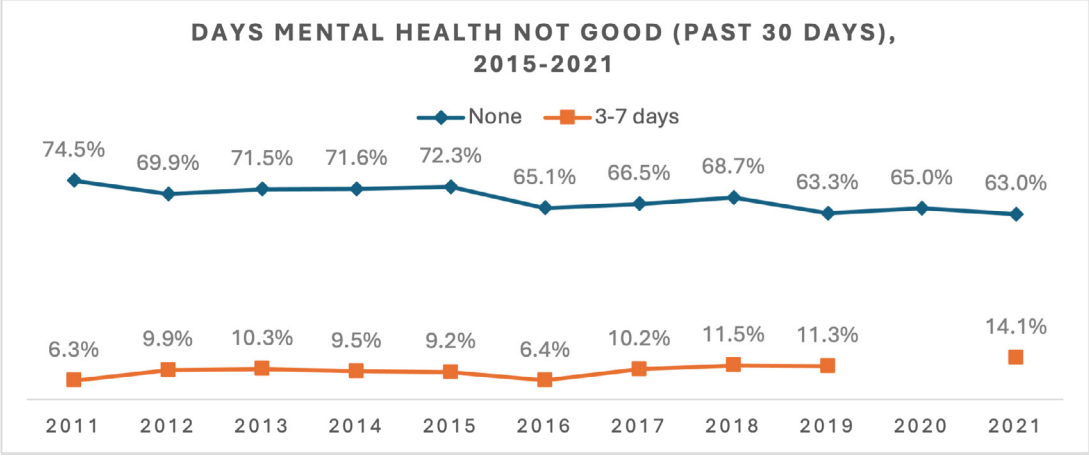
The data collected are used to characterize health behaviors, ascertain the prevalence of risk factors, and target demographic groups with increased needs. Knowing the type and frequency of health issues and risky behaviors enables the public health professionals to devise and implement programs geared toward the prevention of chronic diseases, injury, and disability. Questions pertaining to mental health were extracted and analyzed for Charles County and Maryland as a whole.

In 2021, 63.0% of Charles County adults reported that in the past 30 days, there were no days that their mental health was not good. This is above the Maryland percentage of 57.3%. However, 14.1% reported that their mental health was not good between 3 to 7 days, in the past month. This percentage is also lower than the Maryland percentage of 15.4%.

Days Mental Health Not Good (Past 30 Days), 2021	Charles County	Maryland
None	63.0%	57.3%
1 to 2 days	8.7%	8.7%
3 to 7 days	14.1%	15.4%
8 to 29 days	10.3%	13.3%
30 days	3.9%	5.3%

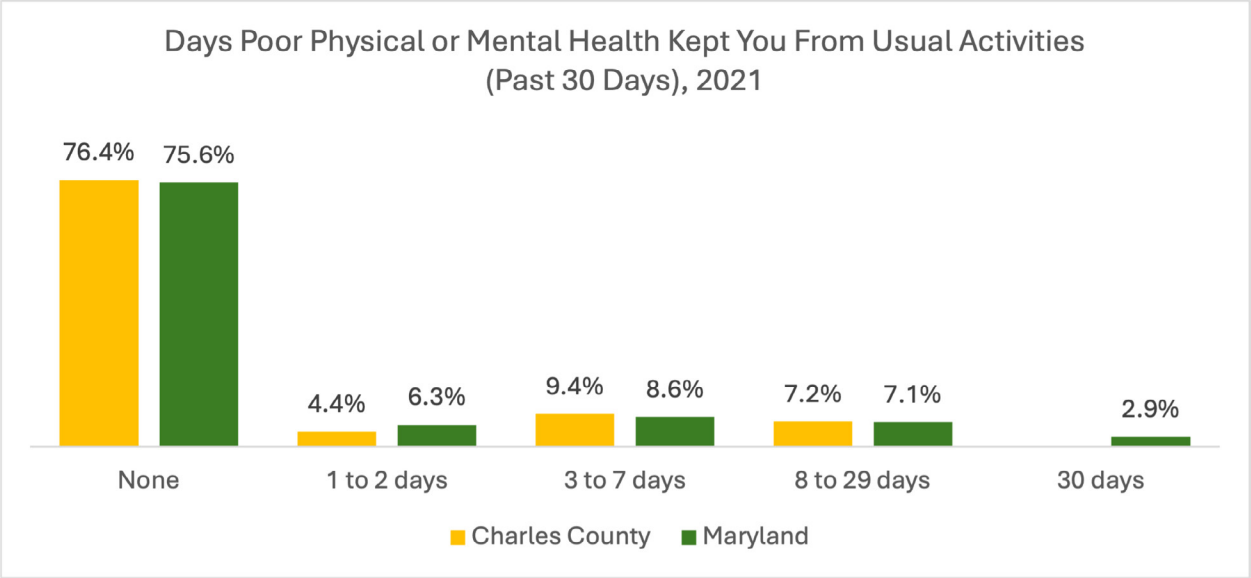
Source: 2021 Maryland BRFSS

Since 2011, the percentage of Charles County adults who reported no bad mental health days in the past 30 days has slowly decreased, from 74.5% in 2011 to 63.0% In 2021. While there has been a slight increase in the percentage of adults who reported 3 to 7 days of not good mental health, from 6.3% in 2011 to 14.1% in 2021. The 2020 Charles County estimate was suppressed for this measure.



Source: 2015-2021 Maryland BRFSS

When examining the number of days poor physical or mental health has kept adults from usual activities, Charles County and Maryland were very comparable in 2021. 76.4% of Charles County adults reported no days due to poor physical or mental health, compared to the slightly lower 75.6% for Maryland adults. The largest difference between the two populations was in those adults reporting that poor physical or mental health kept them from usual activities 1 to 2 days in the past month, with Charles County at 6.3% and Maryland at 4.4%.



Source: 2021 Maryland BRFSS

Adverse Childhood Experiences

Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years). For example:

- Experiencing violence, abuse, or neglect
- Witnessing violence in the home or community
- Having a family member attempt or die by suicide

Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding such as growing up in a household with:

- Substance misuse
- Mental health problems
- Instability due to parental separation or household members being in jail or prison.

ACEs are common and are also preventable. ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood. ACEs can also negatively impact education and job opportunities.

An ACE score is a tally of different types of abuse, neglect, and other hallmarks of a rough

childhood. First developed in the 1990s, the 10 questions of the Adverse Childhood Experiences test are designed to measure the occurrence of common traumatic experiences in early life. Since higher numbers of ACEs often correlate to challenges later in life, including higher risk of certain health problems, the quiz is intended as an indicator of how likely a person might be to face these challenges.

According to the 2020 BRFSS, 64.2% of Charles County reported having at least one ACE. This is higher than the Maryland state average percentage of 61.6%. Charles County also had a higher percentage than Maryland of people who reported an ACE score of 3 to 8 (32.5% vs. 23.3%).

Number of ACEs	Charles County	Maryland
0 ACEs	35.8%	38.4%
1 to 2 ACEs	31.7%	38.3%
3 to 8 ACEs	32.5%	23.3%

Source: 2020 Maryland BRFSS

The 2020 BRFSS looked at the prevalence of each ACE. The table below displays this data for Charles County and Maryland. The most commonly reported ACEs in Charles County included Parental Separation or Divorce (32.1%) and Emotional Abuse (30.7%).

2020 BRFSS ACE Prevalence	Charles County	Maryland
Household Substance Abuse	20.9%	23.2%
Parental Separation or Divorce	32.1%	29.7%
Emotional Abuse	30.7%	30.5%
Physical Abuse	20.5%	22.3%
Sexual Abuse	13.0%	11.0%

Source: 2020 Maryland BRFSS

Suicide

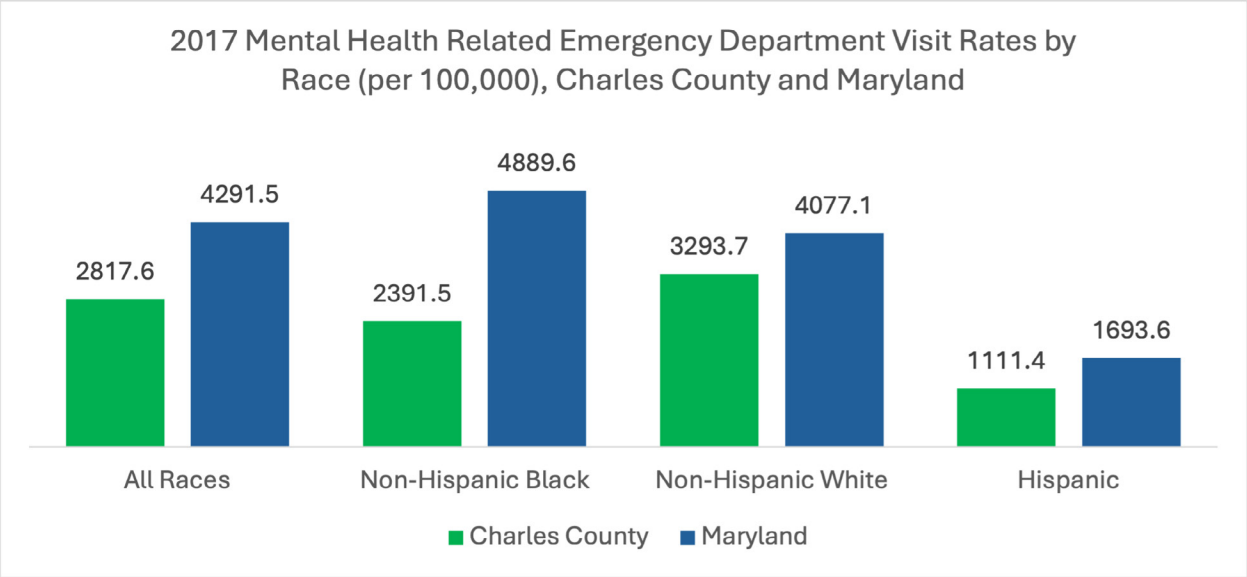
In 2021, there were 19 suicides reported in Charles County and 623 suicides in Maryland. The 2021 age-adjusted Maryland Suicide death rate was 9.7 per 100,000. The 2021 Southern Maryland suicide rate was 13.2 per 100,000. A Charles County level suicide rate could not be calculated due to small case counts. Rates based on less than 20 events are subject to instability.

Emergency Department Visit Rates for Mental Health Conditions

This indicator shows the 2017 rate of emergency department visits related to mental health disorders (per 100,000 population). Mental health problems can place a heavy burden on the healthcare system, particularly when persons in crisis utilize emergency departments instead of other sources of care when available. Mental health disorder diagnoses include adjustment disorders, anxiety disorders, attention deficit disorders, disruptive behavior disorders, mood disorders, personality disorders, schizophrenia and other psychotic disorders, suicide and

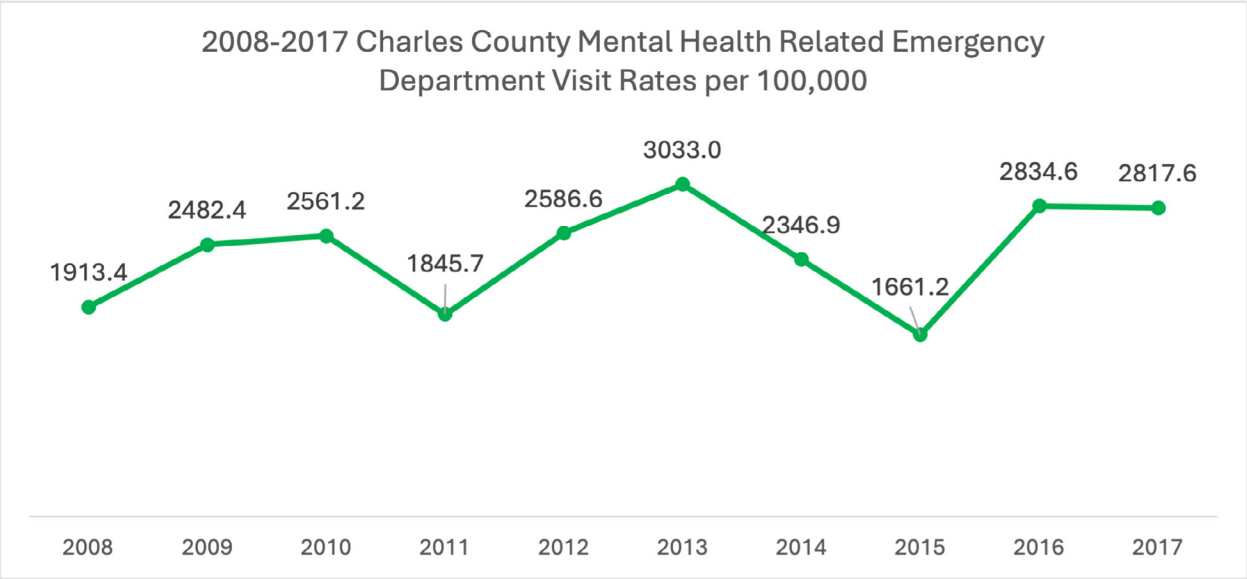
intentional self-inflicted injury and miscellaneous mental disorders.

The 2017 Charles County Mental Health ED Visit Rate was 2,817.6 per 100,000. This is below the Maryland state average mental health ED visit rate of 4,291.5 per 100,000. The Charles County mental health ED visit rate is the 4th lowest rate in the state of Maryland. When examining rates by race, Charles County Non-Hispanic Whites had a higher ED visit rate for mental health than Charles County Non-Hispanic Blacks or Hispanics (3,293.7 vs. 2,391.5 and 1,111.4). All Charles County rates are well below the state average rates.



Source: Maryland SHIP Emergency Department Visits Related to Mental Health Conditions 2008-2017

The ED visit rate for mental health conditions in Charles County has fluctuated yearly since 2008. The 2016 and 2017 rates have remained fairly stable.



Source: Maryland SHIP Emergency Department Visits Related to Mental Health Conditions 2008-2017

Health Professional Shortage Areas (HPSA) for Mental Health Services in Charles County, Maryland

As of August 27, 2021, Charles County is a federally designated health professional shortage area (HPSA) for mental health services. The whole county is designated as a HPSA geographic area, not just one population or facility within the county.

Mental Health HPSA Scoring

Mental Health HPSAs can receive a score between 0-25.

What goes into the score?

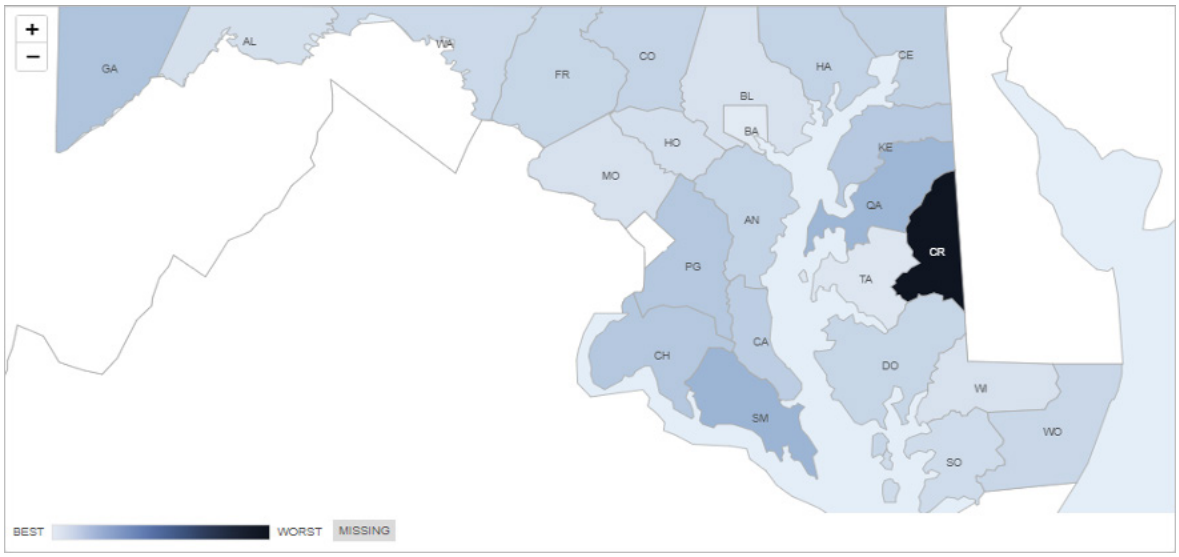
- Population-to-Provider Ratio
- Percent of population below 100% Federal Poverty Level (FPL)
- Elderly Ratio (percent of people over the age 65)
- Youth Ratio (percent of people under age 18)
- Alcohol Abuse Prevalence
- Substance Abuse Prevalence
- Travel time to Nearest Source of Care (NSC) outside the HPSA designation area.

The Charles County HPSA score for mental health is 11. This is an increase from the HPSA score of 9 reported during the last needs assessment survey. There is a shortage of 6.86 FTE mental health providers. This is an increase from 4.01 FTE last reported. The National Health Services Corps uses a scaling system from 0-26 to determine priorities for assignment of mental health clinicians. The higher the score is the greater the priority.

Information on HPSA designations can be found on the US Health Resources and Services Administration's HPSA website at: https://data.hrsa.gov/tools/shortage-area/hpsa-find.

Availability of Mental Health Providers

The population to mental health provider ratio in Charles County is 520:1. This is well above the Maryland state average ratio of 310:1. The Charles County ratio is the 6th worst ratio in the state of Maryland.



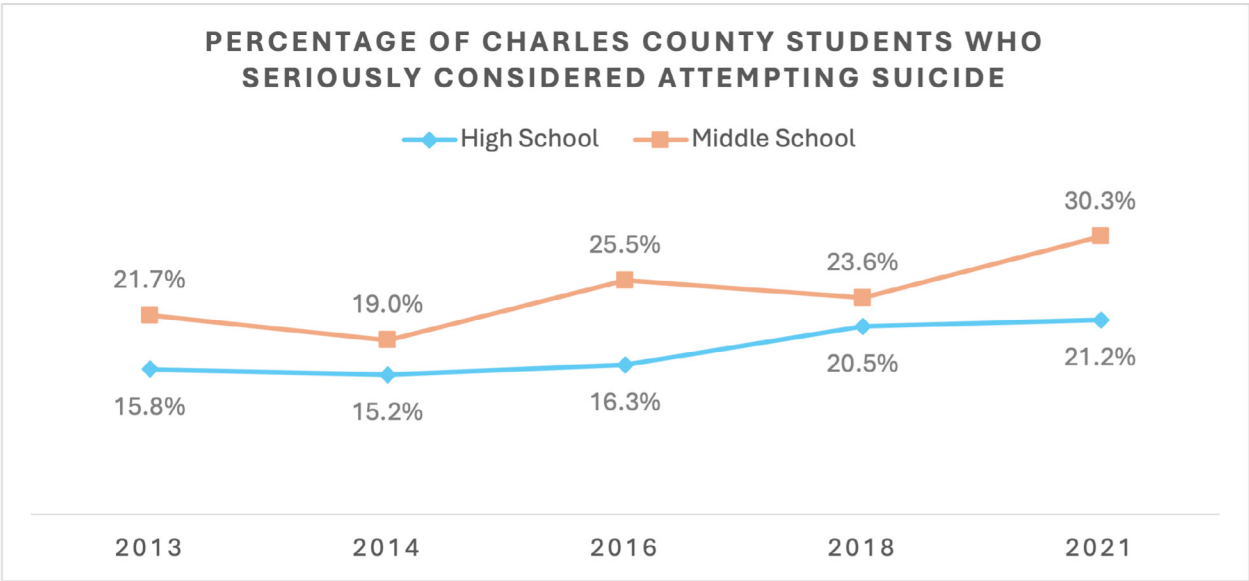
Source: 2022 National Provider Identification Registry data from the 2023 Robert Wood Johnson Foundation's County Health Rankings

2021-2022 Maryland Youth Risk Behavior Survey

Suicide:

In 2021-2022, 21.2% of Charles County High School students reported seriously considering attempting suicide during the past 12 months. This is higher than the Maryland percentage of 20.6%. This percentage has been on the rise since 2013 and 2014 when the percentage of students was around 15%.

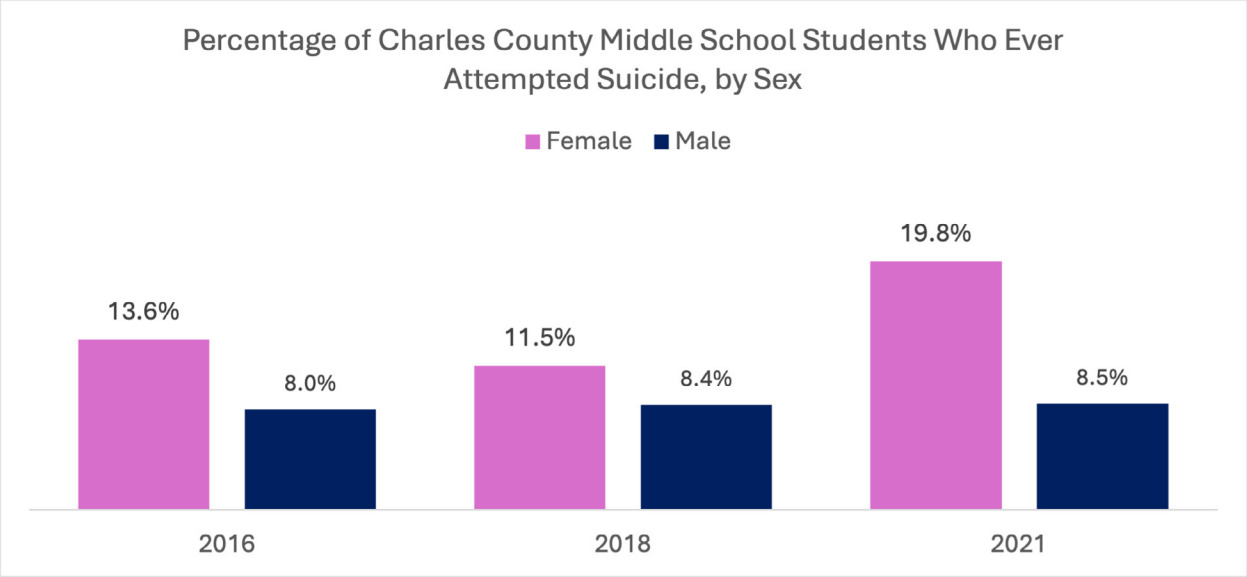
30.3% of Charles County Middle School students reported seriously considering attempting suicide during the past 12 months. This is an increase from 23.6% reported in 2018. This is also higher than the Maryland percentage of 26.8%.



Source: 2021-2022 Maryland YRBS/YTS

In 2021, 15.9% of Charles County High School students reported planning how they would attempt suicide. This is a decrease from 18.8% reported in 2018. Charles County Middle School students reported a higher percentage of planned suicide at 21.8% for 2021. This is an increase from 14.6% reported in 2018. Among both Middle School and High School students, females had a higher percentage of planning how they would attempt suicide over males. In 2021, 20.5% of High School females reporting planning suicide compared to 10.5% for High School males. 28.3% of Middle School females reported planning suicide compared to 15.1% for Middle School males.

In 2021, 14.2% of Charles County Middle School students reported attempting suicide. This is an increase from 9.9% reported in 2018. 19.8% of Middle School females reported attempting suicide compared to 8.5% of Middle School males.



Source: 2021-2022 Maryland YRBS/YTS

Bullying:

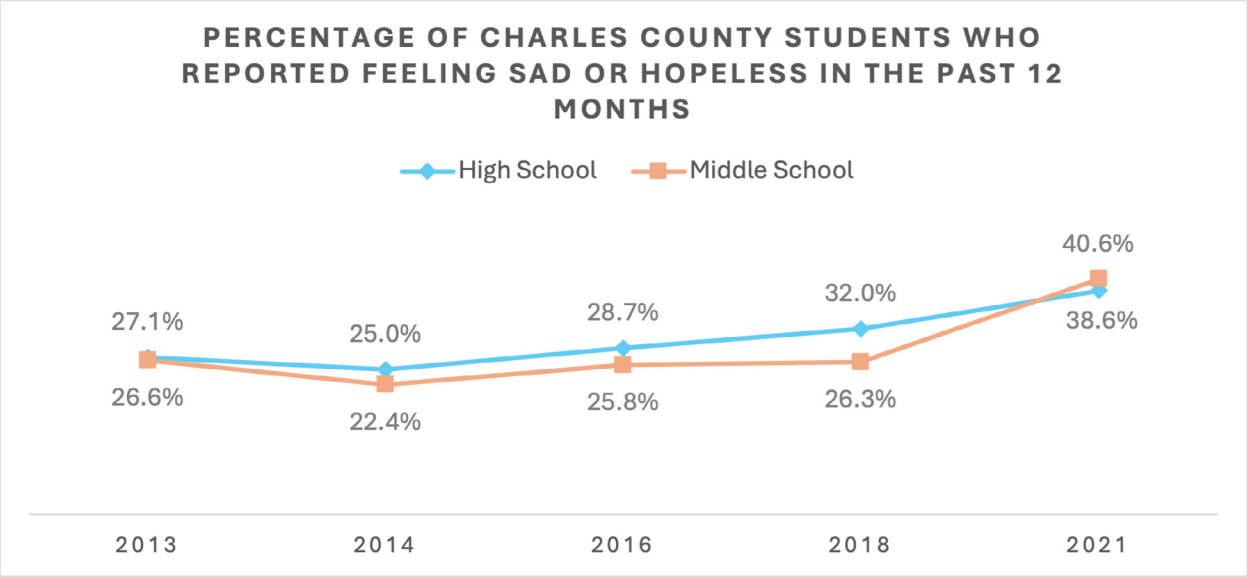
12.0% of Charles County High School students and 37.8% of Charles County Middle School students reported that they have been bullied at school in the past 12 months.

For High School students, females are more likely to report being bullied than males (14.6% vs. 8.9%). Younger students under 15 years of age (13.0%), All Other Races (29.7%), and 9th grade students (15.3%) had higher rates of bullying than older students in the other grades in high school.

Students were also asked if they have ever been bullied electronically. A slightly higher percentage of Charles County High School students reported that they have been bullied electronically in the past 12 months, at 12.9%. The percentage of Middle School students who have bullied electronically in the past 12 months was 26.0%. For high school students, females were more likely to report being electronically bullied than males (14.2% vs. 11.1%). Younger students under 15 years of age (13.9%), Asian and White students (19.1%), and 9th grade students (16.0%) had higher rates of electronic bullying than older students in the other grades in high school.

Feeling of Hopelessness:

Since 2013, both Charles County High School students and Middle School students have seen an increase in the percentage of those who have felt sad and hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months. In 2021, 38.6% of High School students reported feeling sad and hopeless compared to 40.6% of Middle School students. Females, both High School and Middle School students, had a higher percentage of those feeling sad or hopeless than those of males. 51.7% of High School females reported feeling sad and hopeless, compared to 24.9% for males. 50.5% of Middle School females reported feeling sad and hopeless compared to 30.6% of males.

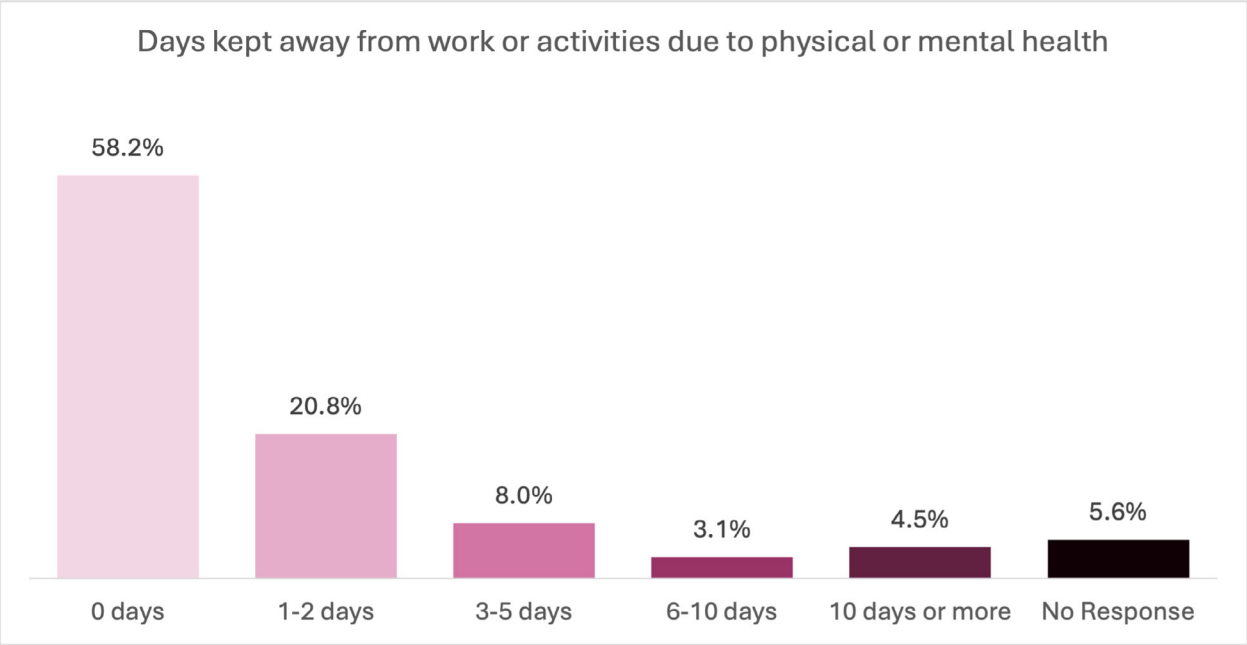


Source: 2021-2022 Maryland YRBS/YTS

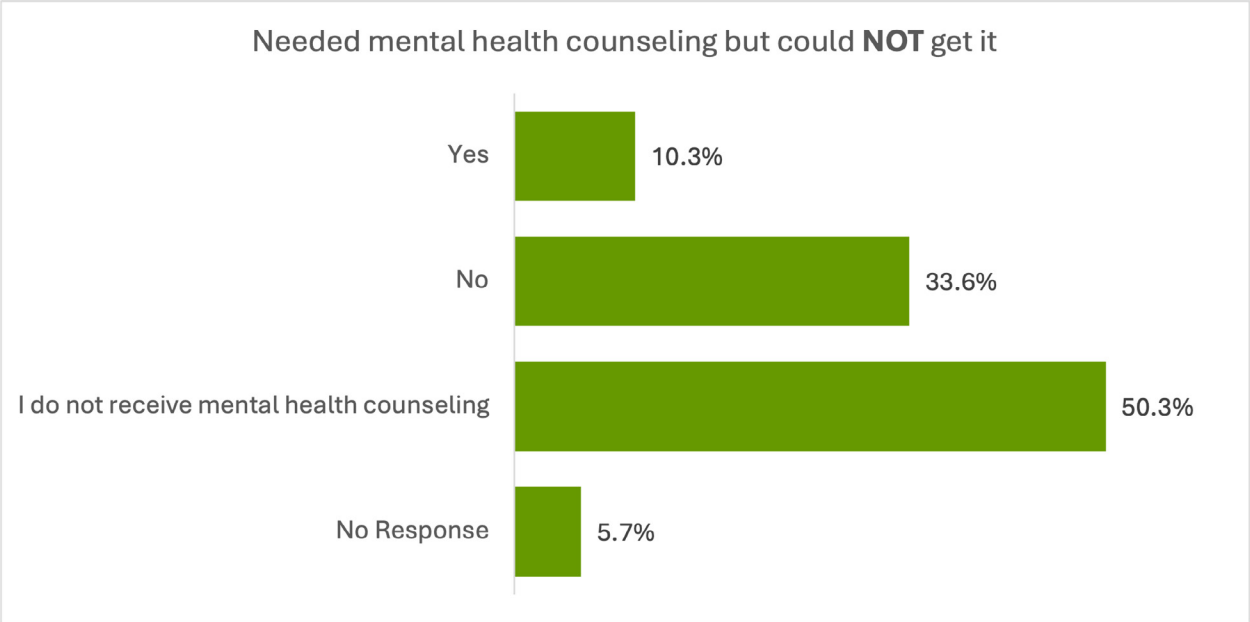
Community Health Needs Assessment

Long Survey Data:

A little over 58% of participants reported that there were no days in the past month that prevented them from working or activities. This percentage is a decrease from 62.9% reported in the 2021 needs assessment. Over 20% of participants reported that their physical or mental health has kept them from work or activities for 1-2 days in the past month. This is a slight increase from 18.7% reported during the previous needs assessment. The percentage of participants that reported 10 or more days decreased from the previous need assessment from 8.4% to 4.5% of total responses.



Survey participants were also asked in the last year if they needed mental health counseling but were unable to get it. About half of respondents reported that they do not receive mental health counseling. 33.6% of respondents reported they were able to receive mental health counseling when they needed it, and 10.3% reported they were not able to receive mental health counseling when they needed it.

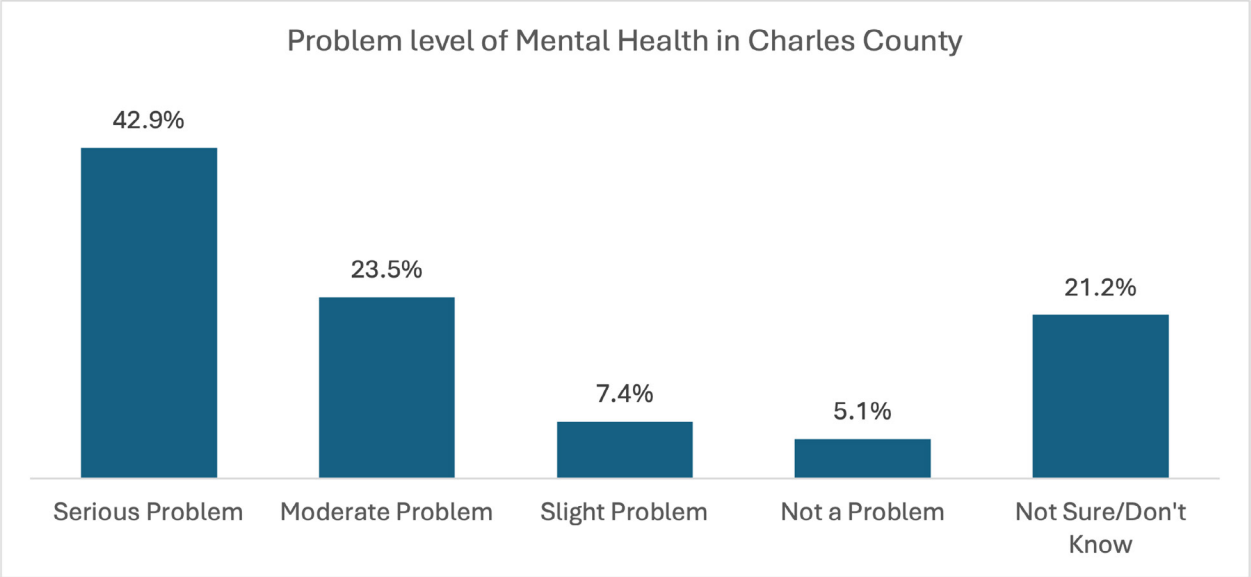


Charles County survey participants were asked how often they feel stressed out or overwhelmed. The largest percentage of respondents reported sometimes feeling stressed out or overwhelmed,

at 43.4%. 20.5% of respondents reported feeling stressed out or overwhelmed most of the time, and 10.2% reported always feeling stressed out or overwhelmed.

Risk and Behavioral Factors	Always	Most of the time	Sometimes	Rarely	Never	Not applicable
Feel stressed out or overwhelmed?	10.2%	20.5%	43.4%	19.0%	6.2%	0.7%

42.9% of survey respondents felt that mental health was a serious problem in Charles County. The second highest percentage of respondents felt that mental health was a moderate problem in Charles County, at 23.5%. Only 5.1% of respondents felt that mental health was not a problem in Charles County.



Short Survey Data:

When asked to identify the biggest health problems in Charles County, Mental Health was a common response among short survey respondents. 45.8% of respondents felt that Mental Health was the biggest health problem in Charles County. This was the third most commonly cited health problem among short survey respondents, behind Diabetes and Overweight/Obesity.

Ideas and recommendations to help solve health problems in the county were mentioned by survey respondents, a few related to Mental Health. Respondents expressed the need for mental health emergency services to be separate from traditional emergencies, and the need for better mental health options in Charles County.

Lastly, short survey respondents were asked if there are sufficient services or resources for Mental Health in Charles County. Of those who responded to the question, 40.9% felt that there are some

Mental Health services available in Charles County. This was the highest percentage among survey respondents. Almost 17% felt that there are many mental health services available, and 9.5% felt that there are no mental health services available in the county. 32.7% of respondents did not know if there were mental health services in Charles County.

	No Services Available	Some Services Available	Many Services Available	I don't know
Mental Health	9.5%	40.9%	16.9%	32.7%

**Percentages based on those who answered the question. Blanks are not included in the denominator.*

Focus Groups:

Amongst the focus groups conducted for this year's needs assessment, participants agreed that Behavioral health was the health condition most affecting Charles County. Behavioral Health includes both Mental Health and Substance Use Disorder. Some focus groups members specifically chose Behavioral Health because of the homeless population in the county. They stated that a homeless population is visible in the woods of Walmart in La Plata, and there may be a correlation between homelessness and mental health. Other focus group members mentioned that there is a high level of depression and anxiety in tobacco cessation clients. They stated that it is difficult for these clients to get into behavioral health services. The long wait lists for these services are a barrier for clients.

Barriers and gaps associated with mental health were expressed in the focus groups. Participants stated that there is a lack of psychiatrists in the county and that there needs to be more education on how to access mental health services. Focus group members also mentioned that behavioral health practitioners are limited in Charles County. Among the school nurses, many agreed that there was a lack of mental health providers and services for youth, and too much screen time. Also related to mental health, participants mentioned that there is a lack of behavioral health prescribers in Charles County and trouble with the school systems filling their school psychiatrist positions.

Some key changes that focus group members believed would improve health in Charles County involve tackling the loneliness and isolation of people that may have been brought on by the COVID-19 pandemic. Senior isolation was identified in the focus groups, and participants believe there needs to be more resources for those seniors who live in isolation, either by choice or by circumstance. Many seniors do not want to leave their homes for an assisted living facility. There is a need in the community to provide seniors with resources that will assist them when they are living alone in their own home. Overall, since COVID-19, the world has become more mobile (ordering groceries, shopping online) and there is less interaction for people resulting in lonelier lifestyles. Isolation and loneliness can have an impact on one's mental health, so finding solutions to reach these individuals would help the overall mental health of those impacted.

Mental Health References

1. 2011- 2021 Maryland BRFSS or Maryland YRBS/YTS accessed at ibis.health.maryland.gov on February 29, 2024.
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3. 2021 Charles County and Maryland Suicide Counts and Rates. 2021 Maryland Vital Statistics Report. Maryland Department of Health. Available at: https://health.maryland.gov/vsa/Pages/reports.aspx
4. 2008-2017 Charles County and Maryland Emergency Department Visit Rates for Mental Health Conditions. Maryland Health Services Cost Review Commission. Accessed through the Maryland State Health Improvement Process website. Available at: https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx.
5. Charles County Health Professional Shortage Area Designation for Mental Health. US Department of Health and Human Services: Health Resources and Services Administration. February 29, 2024. Health Professional Shortage Area Update. Available at: https://data.hrsa.gov/tools/shortage-area/hpsa-find.
6. 2022 Charles County Population to mental health provider ratio. Robert Wood Johnson Foundation's County Health Rankings. Available at https://www.countyhealthrankings.org/explore-health-rankings/maryland?year=2023&measure=Mental+Health+Providers&tab=0

Access to Care:

Access to Routine Exams

From 2021, 84.4% of Charles County Behavioral Risk Factor Surveillance System (BRFSS) respondents reported that they had been to a doctor for a routine checkup in the last year.

Time since last routine checkup	< 1 year	1-2 years	2-5 years	5+ years or never
Charles County	84.4%	9.8%	4.2%	1.6%

2021 Charles County BRFSS respondents were also asked if there was a time in the past 12 months when they were unable to see a doctor when needed due to cost. 8.8% of Charles County residents reported that there was time in the past 12 months when they were unable to see a doctor due to cost. This is below the Maryland state average percentage of 9.3%.

Charles County BRFSS respondents were asked if they have one or people that they think of as their personal doctor or health care provider. The majority of those surveyed (87.7%) reported that they do have a personal doctor or health care provider. Among those with a personal doctor, 50.5% reported that they have one doctor. 37.2% reported that they have more than one personal doctor.

Health Status

2021 Charles County BRFSS data indicates that the health status of most county residents is positive. Most county residents report themselves in Good, Very Good to Excellent health (83.1%). A small portion considers their health to be fair to poor (16.9%).

There was an increase from the last needs assessment in the percentage reporting that they are in Fair or Poor Health (11.4% to 16.9%). Charles County has a greater portion of people who report fair or poor health than Maryland as a whole (16.9% vs. 13.1%).

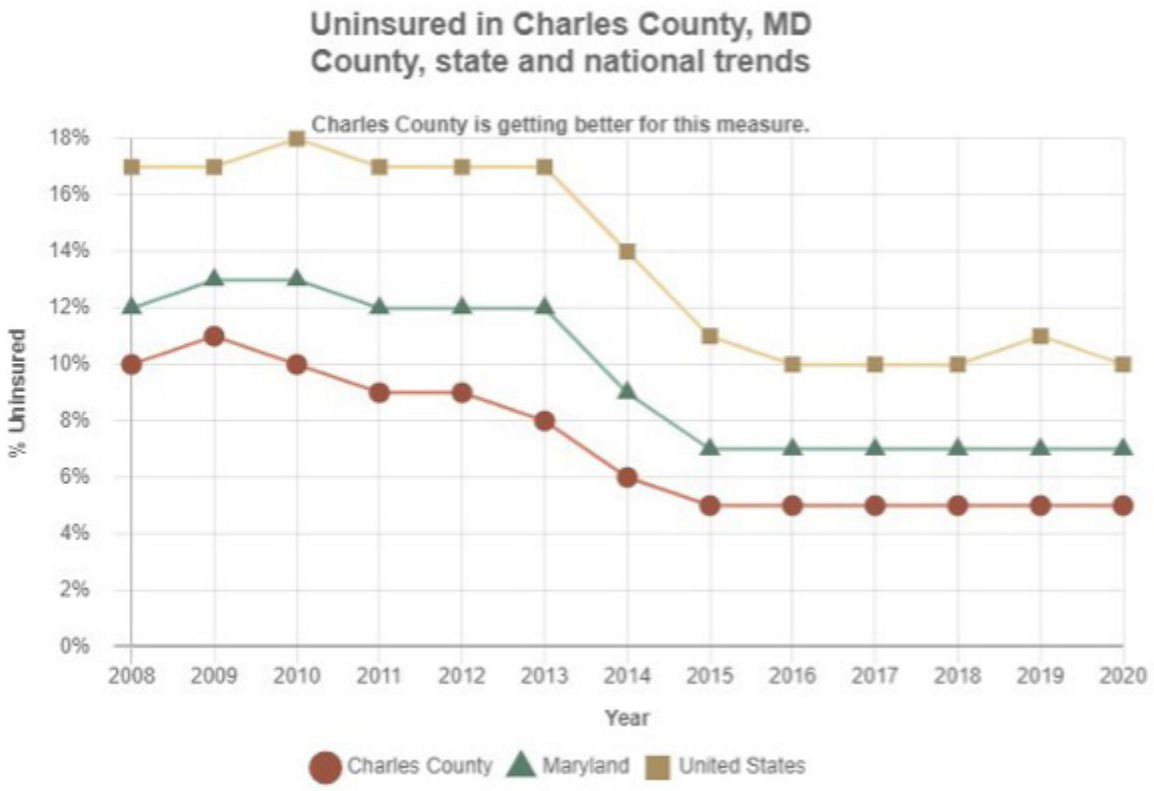
Health Status:	Good, Very Good, or Excellent	Fair or Poor
Charles County	83.1%	16.9%
Maryland	86.9%	13.1%

Health Insurance

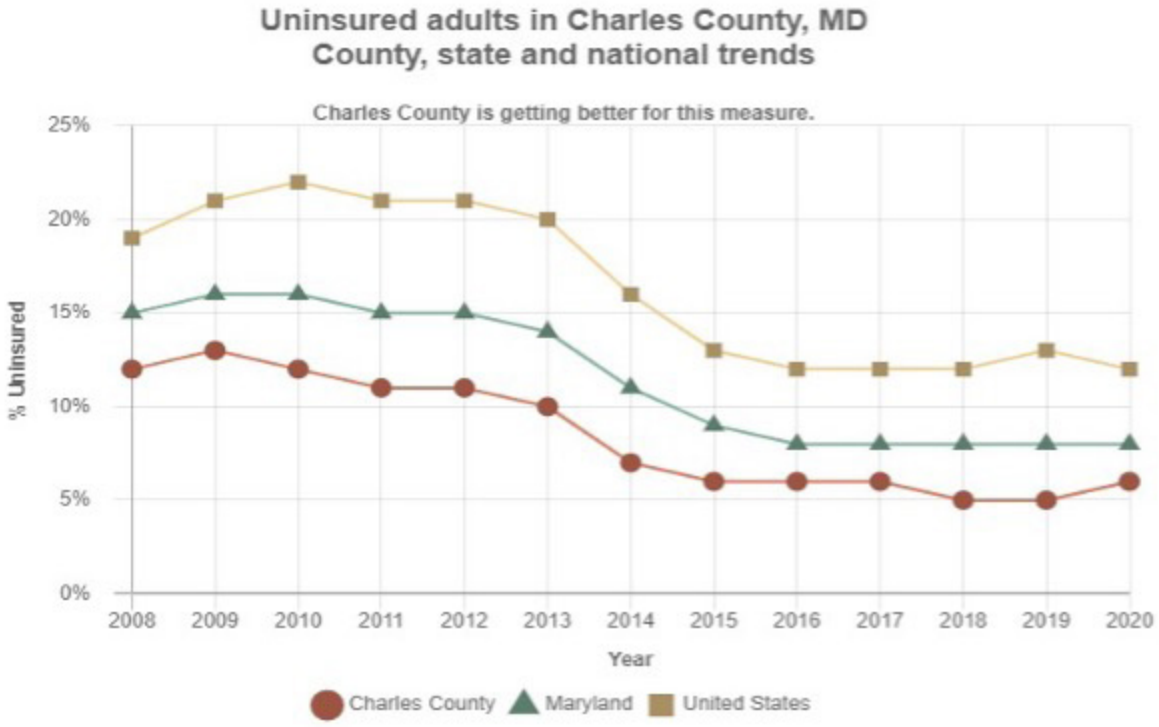
The 2021 Charles County BRFSS estimates the prevalence of different sources of health insurance among Charles County residents. 48.8% of Charles County BRFSS respondents reported that they have an employer or union purchased plan. 5.8% have a private, non-governmental plan that they buy on their own. 16.3% of Charles County BRFSS respondents reported that they have Medicare. 8.2% have a military-related healthcare such as Tricare, VA healthcare or CHAMP-VA. The

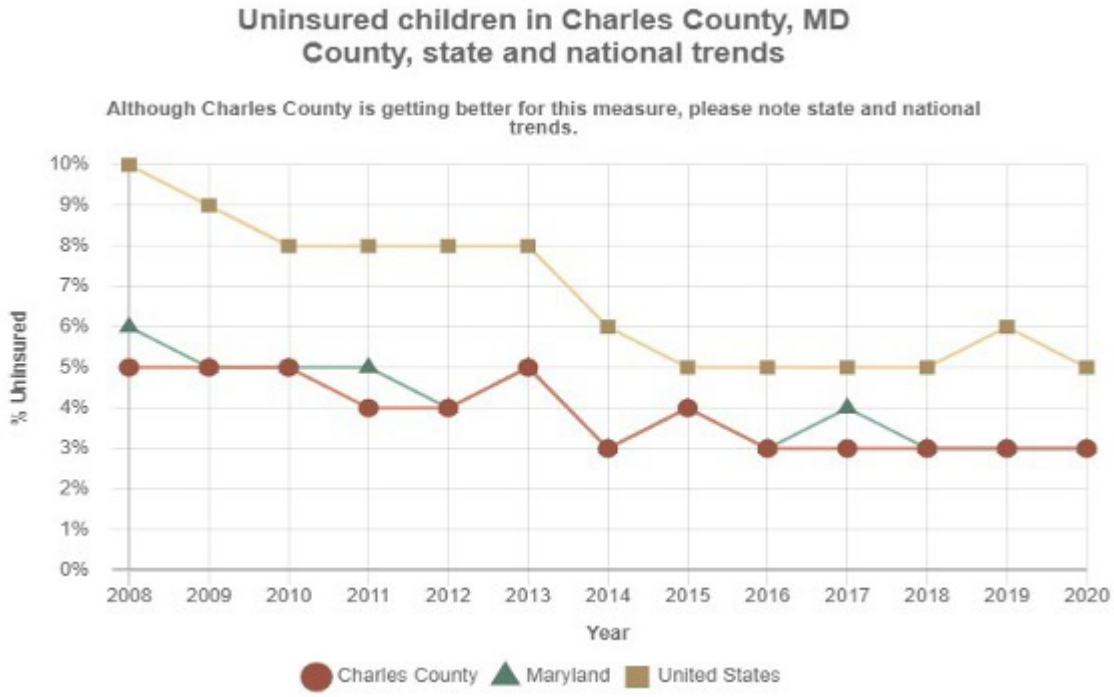
remaining group of respondents were either a state or government sponsored program such as Medicaid, or they did not have health insurance coverage. The exact percentages were suppressed due to small case counts and unreliable statistics.

2020 Charles County health un-insurance estimate as determined by the US Census Bureau's Current Population Survey is 5%. This data accessed through the Robert Wood Johnson Foundation's County Health Rankings. This is identical to the 2017 Charles County health un-insurance rate of 5% that was reported in the previous needs assessment report. The 2020 Charles County estimate is below the Maryland state health un-insurance estimate of 7% for 2020. The Charles County estimate has remained consistent for the last 6 years.



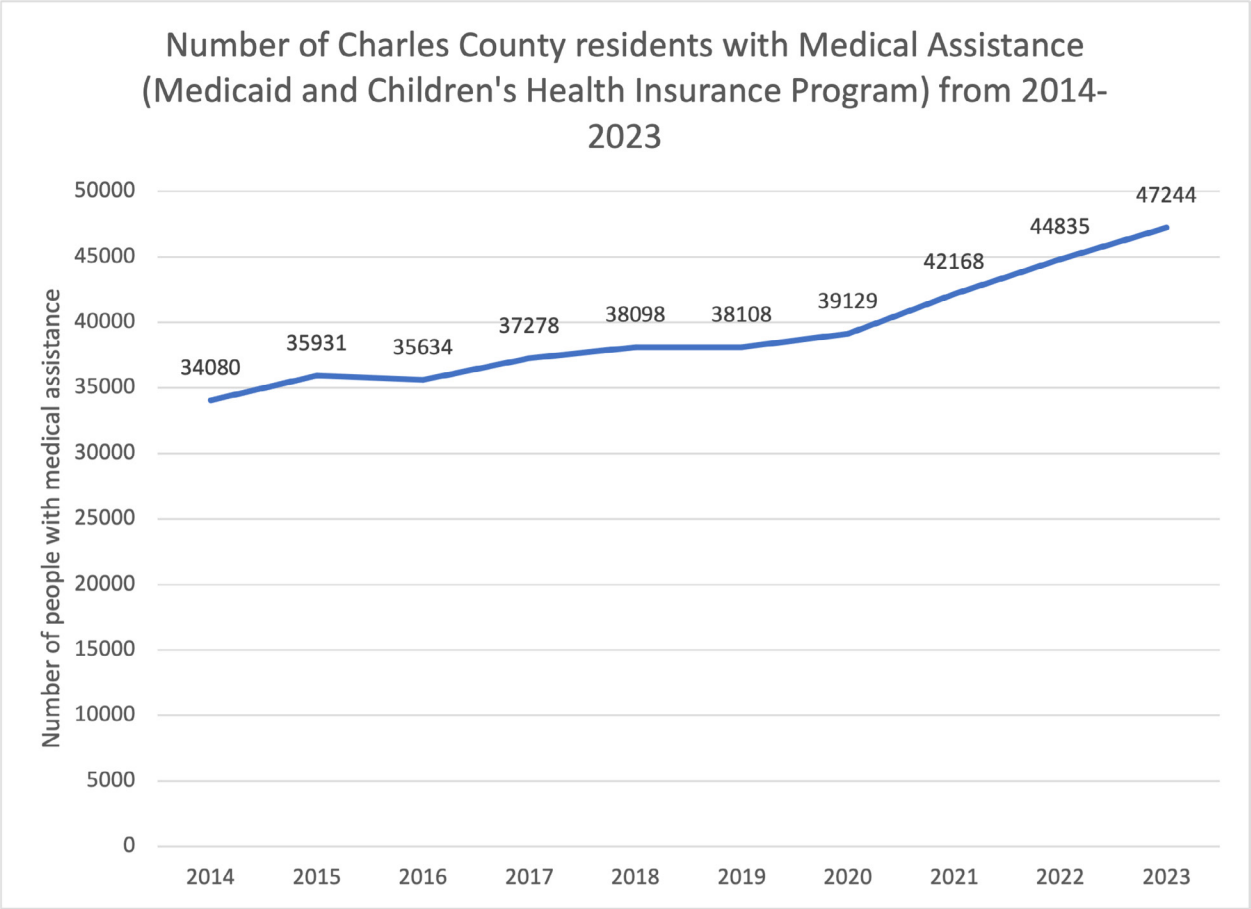
The percent of the population who are uninsured is also broken down by adults and children. 6% of Charles County adults are uninsured, compared to 8% for Maryland. 3% of Charles County children are uninsured, which is identical to the percentage for Maryland. The US rate is a little higher at 5%.





Medicaid Enrollment Rates

For the past decade, Charles County has seen an increase in the number of persons with medical assistance. Medical assistance can be either Medicaid or the Children's Health Insurance Program (CHIP).

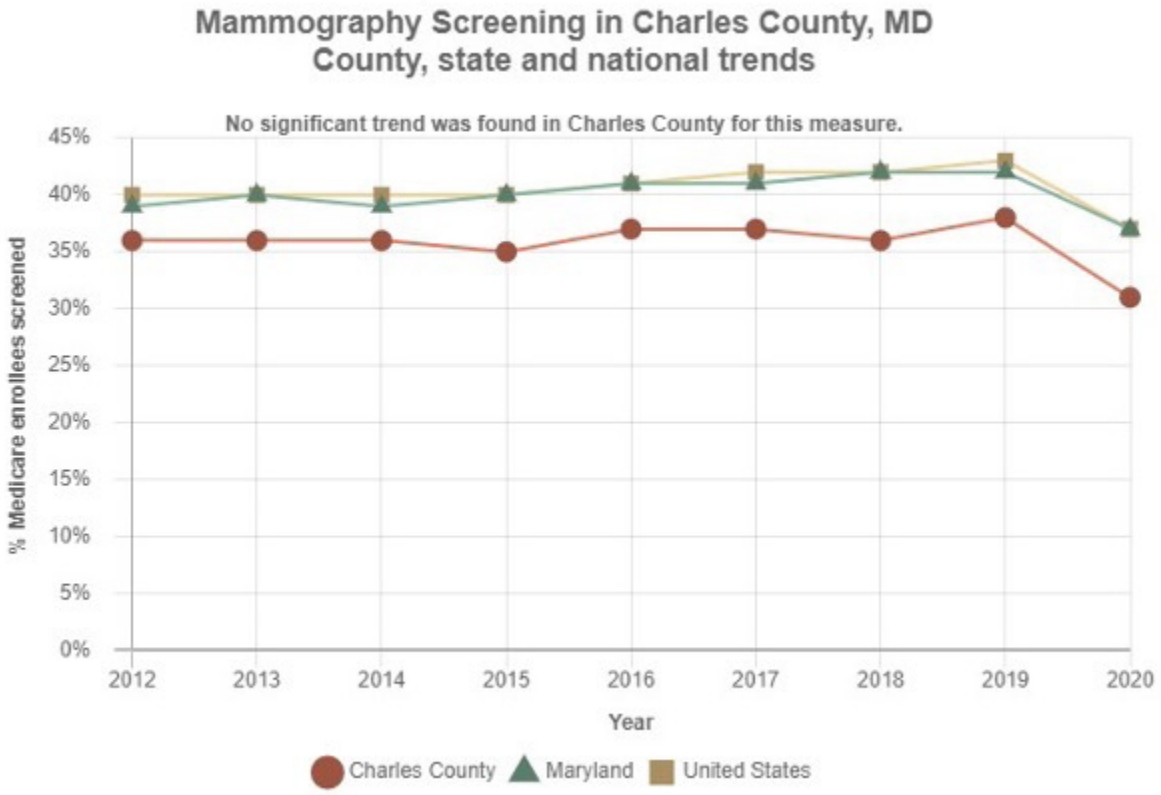


Screening Practices

The Robert Wood Johnson Foundation's County Health Rankings provide roadmaps for each state and its jurisdictions for data measures relating to health outcomes and social determinants of health. One of the health outcomes is access to mammograms health screenings for women aged 65-74 currently enrolled in Medicare. 31% of Charles County individuals assigned female at birth who are aged 65-74 years and enrolled in Medicare who received a mammography screening in 2020. The county percentage is lower than the Maryland state percentage of 37%. The 2020 Charles County rate of mammography screening is a reduction from previous years when the rate appeared to be stable.

The mammogram screening rate can also be compared by race. The highest rate of screening was seen for Hispanic and Black individuals. The lowest mammogram screening rate was seen in the Asian population.

Mammogram Screening	Percentage of Medicare enrollees aged 65-74 years
Total	31%
Asian	19%
Black	32%
Hispanic	32%
White	30%



Health Professional Shortage Areas/ Medically Underserved Populations and Areas

Health Professional Shortage Areas (HPSA):

There is 1 federally designated health professional shortage area in Charles County for dental health. The dental health HPSA is for Greater Baden Medical Services in Bryans Road and La Plata in Charles County. This HPSA was updated on September 11, 2021. The HPSA score is 26, the highest score you can get for dental health. Scores range from 1 to 26 for dental. The higher the score is, the greater the priority.

There is a federally designated mental health professional shortage area for the entire county. This

was last updated on August 27, 2021. Charles County received a score of 11 out of 25. HPSA Scores are developed for use by the National Health Service Corps in determining priorities for assignment of clinicians. Scores range from 1 to 25 for primary care and mental health, 1 to 26 for dental. The higher the score is, the greater the priority. An additional HPSA was identified for Greater Baden Medical Services located in Bryan's Road and La Plata for Charles County. The Greater Baden HPSA score is 23 for mental health.

There is a federally designated primary care professional shortage area for the Medicaid eligible population. Charles County received a score of 16 out of 25. HRSA estimates that 9.46 full-time equivalent (FTE) practitioners are needed in the Health Professional Shortage Area (HPSA) so that it will achieve the population to practitioner target ratio. This HPSA was last updated on 4/5/2022. There is also a second primary care HPSA identified for Greater Baden Medical Services located in Bryan's Road and La Plata for Charles County. The Greater Baden HPSA score is 22 for primary care. HPSA Scores are developed for use by the National Health Service Corps in determining priorities for assignment of clinicians. Scores range from 1 to 25 for primary care and mental health, 1 to 26 for dental. The higher the score is, the greater the priority.

Medically Underserved Populations and Areas:

Medically Underserved Areas/Populations (MUA/MUP) are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty and/or high elderly population.

There are 6 population/areas in Charles County with MUA/MUP designation.

There is one medically underserved population (MUP) in Charles County. An MUP is a group of people who face economic, cultural, or linguistic barriers to health care. In Charles County, the MUP is located in the Brandywine Service Area. This population is a government MUP, which means it was designated at the request of a State Governor based to documented unusual local conditions and barriers to accessing personal health services. This designation has been in place since 1992 and was last updated on February 1, 1994.

The Index of Medical Underservice (IMU) score. The lowest score (highest need) is 0; and the highest score (lowest need) is 100. The Brandywine MUP received a 0 IMU score. That means the need for medical services in this region is of the highest priority.

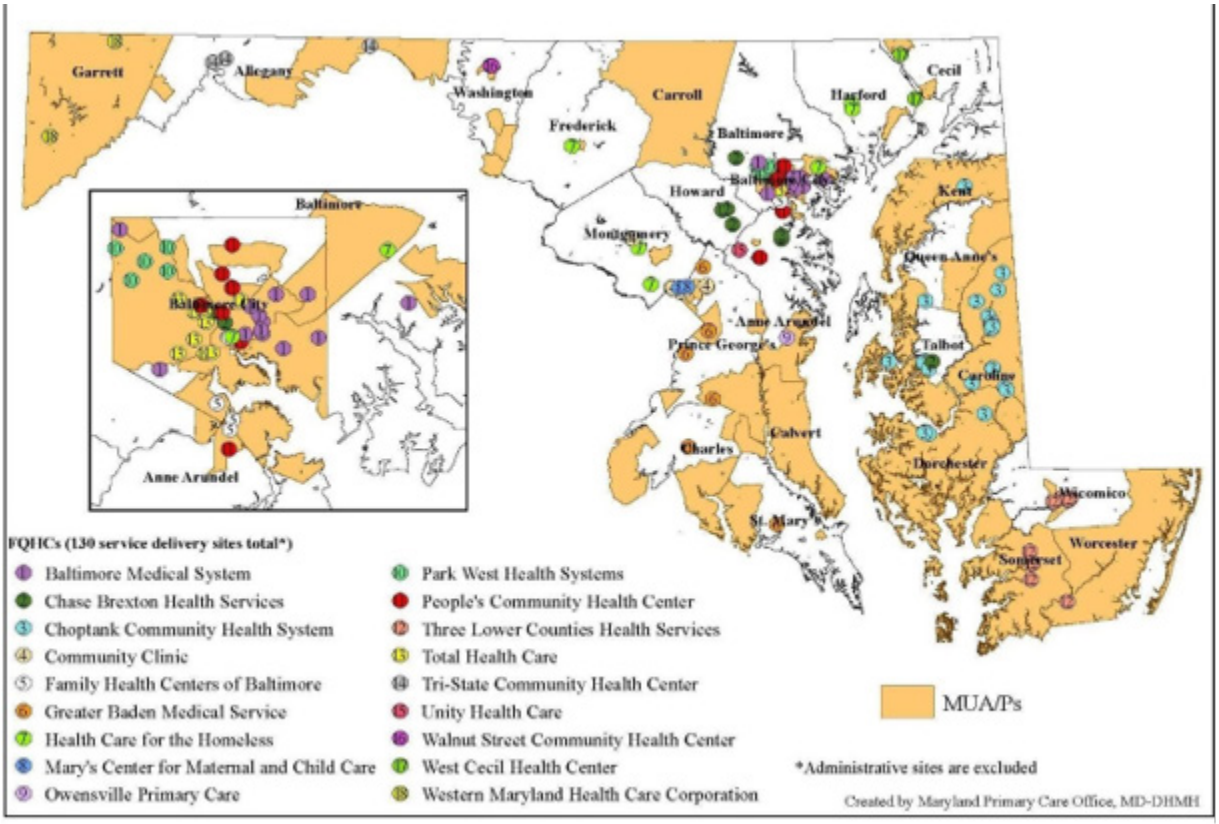
In addition to the MUP, there are 5 medically underserved areas (MUA) in Charles County. Medically Underserved Areas may be a whole county or a group of contiguous counties, groups of county or civil divisions or a group of urban census tracts in which residents have a shortage of personal health services. Those areas include:

- **Medically Underserved Area (MUA):** Score 52.0
    - District 4, Allens Fresh
    - District 5, Thompkinsville
    - District 9, Hughesville
- **Medically Underserved Area:** Score 61.3
    - District 10, Marbury
    - District 3, Nanjemoy

The IMU scale for Medically Underserved Areas is from 0 to 100, where 0 represents completely underserved and 100 represents best served or least underserved. Under the established criteria, each service area found to have an IMU of 62.0 or less qualifies for designation as an MUA.

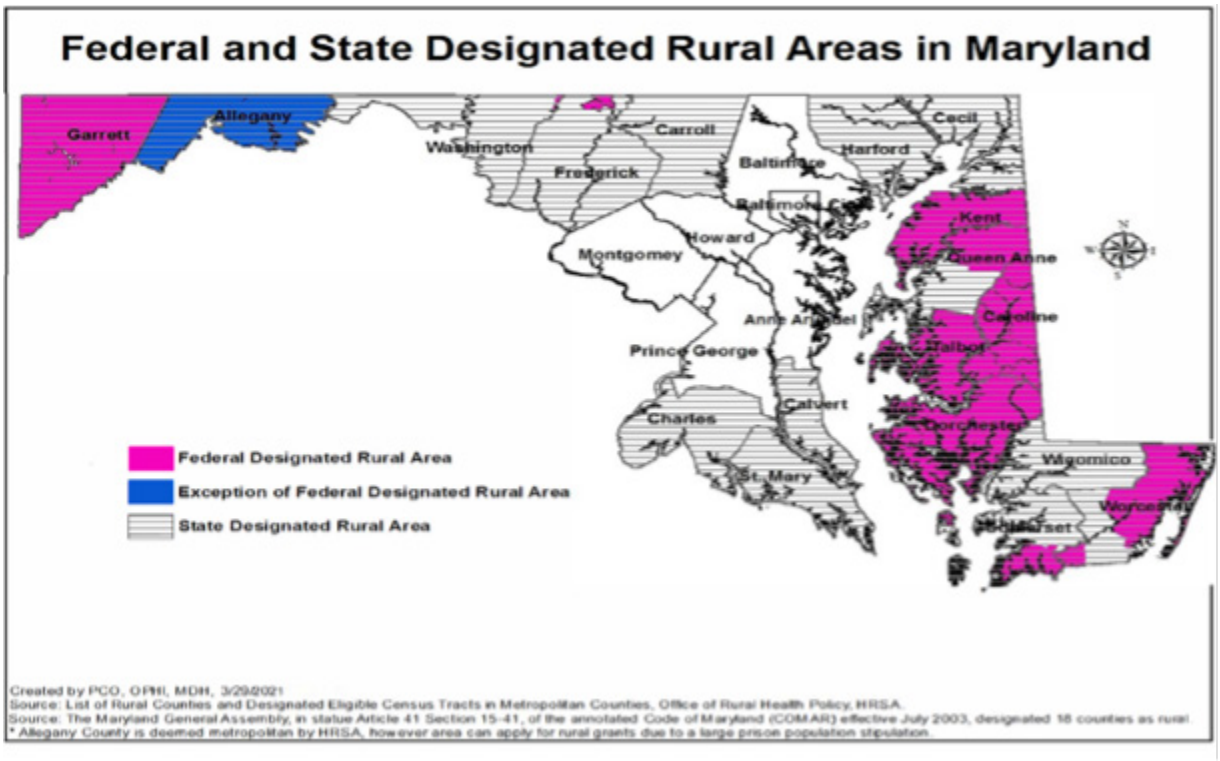
The IMU involves four variables - ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. The value of each of these variables for the service area is converted to a weighted value, according to established criteria. The four values are summed to obtain the area's IMU score.

The Allens Fresh/Thompkinsville/Hughesville areas received an IMU score of 52.0. The Marbury/ Nanjemoy areas received an IMU score of 61.3, which is close to the 62 cut off for MUA designation. These designations have been in place since 1994.



Rural Health Designation:

Charles County no longer holds a federal designation as a rural area. All Southern Maryland counties have lost their rural designation. However, Charles County has hold a state rural designation.



Availability of Health Services

Maryland Primary Care Needs Assessment 2021:

The 2021 Maryland Primary Care Office Needs Assessment was based on the integration of two health data tracking methods: Prevention Quality Indicators (PQIs) and the State Health Improvement Process (SHIP) measures.

Based on this Needs Assessment findings, the Primary Care Office (PCO) will prioritize in the following ways:

- For any competing requests from stakeholders for shortage analyses, workforce development, or technical assistance, the PCO will give priority first to those that pertain to areas of the state with greatest need as demonstrated by the results of the analyses of PQI and SHIP indicators for jurisdictions within the Bottom Quartile.
- The PCO will continue to pursue shortage analyses in all parts of the state, with priority given to the areas of greater need in the state before proceeding to others.
- The PCO will also continue to monitor health status and health care access in Maryland and will update the PCO Needs Assessment per HRSA grant requirements.

A quartile ranking was used to order the PQI, and SHIP indicator results by Maryland jurisdictions. The Health Indicator Rankings by Jurisdiction matrix can be found in Appendix A, Table 1. The information in this matrix was compiled from data from the Maryland Vital Statistics Administration, and the SHIP. The matrix focuses on 49 indicators and ranks those indicators at the jurisdictional level. Charles County is ranked 14th out of the 24 jurisdictions. This is an improvement from the 2016 needs assessment when Charles County was ranked 16th in the state. Charles County has remained in the third quartile.

Chart 1: Quartile Rankings by Jurisdiction Based on PQI & SHIP Indicators, 2021 PCO Needs Assessment*

2021 Jurisdictions	Rate	Rankings	Quartile
Montgomery County	221	1	First Quartile (Best)
Howard County	227	2	
Frederick County	279	3	
Queen Anne's County	284	4	
Talbot County* (↑ from 11)	308	5	
Carroll County	324	6	
Calvert County	366	7	Second Quartile
Anne Arundel	387	8	
Harford County* (↓ from 6)	409	9	
Caroline County* (↑ from 15)	424	10	
Kent County* (↑ from 19)	430	11	
Prince George's County* (↑ from 13)	432	12	
Garrett County* (↓ from 8)	438	13	Third Quartile
Charles County	439	14	
Worcester County* (↓ from 10)	469	15	
Somerset County	491	16	
Cecil County* (↓ from 12)	492	17	
Baltimore County	508	18	
Saint Mary's County* (↓ from 14)	515	19	Fourth Quartile (Worst)
Washington County	536	20	
Wicomico County	566	21	
Dorchester County	587	22	
Allegany	602	23	
Baltimore City	718	24	

*Quartile ranking changed from the 2016 Needs Assessment.

Data on the 49 health indicators is listed below for each county. Health indicators where Charles County scored favorably: Diabetes with long term complications, COPD or asthma in older adults, students entering kindergarten ready to learn, and children with elevated blood levels. Health indicators where Charles County scored the lowest in the state: Chlamydia infection rate, domestic violence, affordable housing, children receiving dental care in the last year, emergency department visits for hypertension, annual flu vaccinations, early prenatal care, and adults who are at a healthy weight.

Table 1: Health Indicator Rankings by Jurisdiction, Maryland, 2021 (PQI and SHIP)

Prevention Quality Indictors (PQI) & State Health Improvement Process (SHIP) Rankings by Jurisdiction																										
	Jurisdictions	Allegany	Anne Arundel	Baltimore City	Baltimore County	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince Georges	Queen Annes	Saint Marys	Somerset	Talbot	Washington	Wicomico	Worcester
Indicators/Tables																										
PQI Data																										
2. Diabetes with short-term complications		20	7	24	12	17	14	4	10	16	18	5	11	6	2	21	3	9	1	13	19	8	22	23	15
3. Diabetes with long-term complications		23	9	24	21	19	22	10	18	4	15	8	12	14	3	20	2	16	11	13	5	7	17	6	1
4. Chronic Obstructive Pulmonary Disease (COPD) or asthma in older adults		23	14	24	21	11	7	10	19	3	15	6	12	17	1	9	2	8	5	20	16	4	22	13	18
5. Hypertension		22	8	23	21	9	2	10	8	11	19	6	12	15	3	1	13	17	4	14	20	5	18	16	7
6. Heart failure		22	10	24	21	16	3	14	4	8	18	5	2	15	6	11	1	13	7	17	19	9	12	20	23
7. Community Acquired Bacterial pneumonia		20	8	21	13	3	19	22	18	6	24	9	7	11	2	10	1	4	5	16	14	15	23	12	17
8. Urinary tract infection		17	14	24	23	5	1	22	15	7	19	9	10	18	3	8	11	13	6	12	16	2	4	20	21
9. Uncontrolled diabetes without complications		20	11	24	16	12	5	4	13	6	22	3	8	10	9	23	7	17	1	14	19	2	15	18	21
10. Asthma in younger adults		19	5	24	21	4	14	10	22	8	16	11	9	20	12	3	7	15	2	18	13	1	23	17	6
11. Lower extremity amputations among admissions for diabetes		23	11	24	21	7	3	8	12	4	10	5	20	13	2	22	1	6	19	15	18	9	17	14	16
SHIP Data																										
Healthy Beginnings																										
12. Infant Death Rate			2	9	6	7				11		5		1	4		3	8		7	13		10	11	12
13. Babies With Low Birth Weight		3	10	20	14	10	8	4	8	19	7	5	18	6	11	17	9	15	12	2	21	7	13	16	1
14. Sudden Unexpected Infant Death Rate (SUIDs)			2	5	3				5					4			1	3					4		
15. Teen Birth Rate		21	11	23	9	3	15	2	17	14	20	4	16	6	1	5	8	18	7	6	13	10	22	19	12
16. Early Prenatal Care		8	17	20	19	9	16	1	7	21	6	3	5	8	14	2	18	22	11	12	10	13	15	15	4
17. Students Entering Kindergarten Ready to Learn		14	8	13	9	7	10	3	12	14	11	6	2	10	6	1	9	16	8	12	4	10	15	9	5
18. High School Graduation Rate		13	14	21	11	2	20		9	1	18	4	5	12	6	9	10	19		3	16	15	7	17	8
19. Children Receiving Blood Lead Screening		1	10	6	4	22	5	17	14	8	11	10	19	12	13	21	3	9	15	16	2	7	20	13	18
Healthy Living																										
20. Adults Who are a Healthy Weight		9	6	13	11	3	15	14	12	21	20	8	16	4	5	1	2	23	19	22		10	18	17	7
21. Adolescents Who Have Obesity (2018)		18	7	21	9	6	15	3	8	12	22	4	19	6	1	17	2	16	5	11	23	14	13	20	10
22. Adults Who Currently Smoke		19	10	16	4	14	17	7	18	6	20	5	13	8		3	1	2	8	15	21	8	11	9	12
23. Public High School Students Currently Using Tobacco (2018)		18	7	4	5	14	16	11	17	4	19	8	21	6	2	22	3	1	20	12	9	13	10	11	15
24. HIV Incidence Rate		6	11	19	13	7	1	4	5	14	17	9	2	12	8	5	16	18		7			10	15	3

Table 1: Health Indicator Rankings by Jurisdiction, Maryland, 2021 (PQI and SHIP)

Prevention Quality Indictors (PQI) & State Health Improvement Process (SHIP) Rankings by Jurisdiction																										
Jurisdictions		Allegany	Anne Arundel	Baltimore City	Baltimore County	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince Georges	Queen Annes	Saint Marys	Somerset	Talbot	Washington	Wicomico	Worcester
25. Chlamydia Infection Rate		14	15	24	18	6	7	4	8	21	19	10	3	9	11	1	13	23	2	12	22	5	16	20	17
26. Life Expectancy		19	6	21	12	7	17	10	18	11	18	4	13	10	2	9	1	9	5	8	20	3	15	16	14
27. Increase Physical Activity		19	9	17	10	1	20	22	11	18	23	2	21	14	3	16	5	8	7	12	15	4	10	13	6
Healthy Communities																									
28. Child Maltreatment Rate		21	9	20	10	6	17	4	18	8	22	3	23	16	1	15	2	11		5	14	7	12	13	19
29. Suicide Rate			8	4	5		17	9				6		7	3		2	1					10		
30. Domestic Violence		19	16	21	24	11	5	7	12	20	18	15	8	14	17	6	4	3	9	23	10	1	2	22	13
31. Children with Elevated Blood Levels		6	2	7	3	3	5	3	3	2	8	3	1	2	3	1	2	4	2	3	1	4	3	4	2
32. Fall-Related Death Rate			3	6	10			9				4		7	5		1	2					8		
33. Pedestrian Injury Rate on Public Roads			7	15	12			1	6	5		3		4	2		10	11			14		8	9	13
34. Affordable Housing (needs more recent data)		1	24	3	9	14	6	21	5	20	10	17	12	13	23	11	19	16	18	15	4	22	7	2	8
Access to Healthcare																									
35. Adolescents who Received a Wellness Checkup in the Last Year		15	9	12	8	21	4	20	17	13	7	11	23	16	5	19	1	3	14	22	4	2	18	6	10
36. Children Receiving Dental Care in the Last Year		22	14	13	11	18	4	20	16	23	9	5	10	17	7	3	2	8	6	21	1	1	19	15	12
37. Persons with a Usual Primary Care Provider		19	14	16	8	10	20	1	13	17	3	12	7	15	9	2	22	21	5	23	18	4	6	11	10
38. Uninsured ED Visits*		5	18	16	17	6	11	3	5	15	7	20	10	1	12	2	21	22	8	4	13	9	14	19	13
Quality Preventative Care																									
39. Age Adjusted Cancer Mortality Rate		15	9	24	17	13	18	7	22	10	21	8	5	14	2	6	1	11	4	16	20	3	12	23	19
40. Emergency Department Visit Rate Due to Diabetes*		13	6	24	8	12	17	3	11	10	22	5	21	7	1	16	2	9	4	15	20	19	14	23	18
41. Emergency Department Visit Rate Due to Hypertension*		18	5	23	11	12	14	1	6	20	24	4	8	13	2	17	3	10	7	21	19	15	9	22	16
42. Drug-Induced Death Rate		15	8	17	13	11		10	16	5		7		9	3		1	2		4			12	6	14
43. Emergency Department Visits Related To Mental Health Conditions*		10	15	22	12	6	18	13	21	4	23	8	20	7	9	24	2	1	16	17	3	19	14	5	11
44. Hospitalization Rate Related to Alzheimer's or Other Dementias*		23	13	24	22	7	15	9	17	10	11	14	4	12	16	8	5	20	2	21	3	1	19	18	6
45. Annual Season Influenza Vaccinations		22	14	18	11	7	23	5	12	20	4	16	24	13	8	15	3	19	2	21	1	6	17	9	10
46. Emergency Department Visit Rate Due to Asthma		19	5	24	13	9	10	3	17	16	23	4	11	8	2	21	1	6	7	14	22	15	12	20	18
47. Age-Adjusted Mortality Rate From Heart Disease		20	5	22	12	13	15	10	17	8	19	7	18	9	2	6	1	11	8	4	23	3	14	21	16
48. Emergency Department Visits For Addictions-Related		18	15	24	16	6	5	4	21	7	23	3	2	14	1	17	11	8	10	9	12	20	22	13	19

Table 1: Health Indicator Rankings by Jurisdiction, Maryland, 2021 (PQI and SHIP)

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49. Emergency Department Visit Rate For Dental Care		13	6	20	7	10	15	3	18	9	23	4	14	8	1	17	2	5	9	11	19	16	12	22	21

Top Quartile (Best)
Second Quartile
Third Quartile
Bottom Quartile (Worst)
No Data Available/Sample Size Too Small

Created by PCO, OPHI, MDH 1/14/21
Source: HSCRC, 2019. Data results after application of AHRQ PQI 2020 methodology.
* Includes only Maryland Residents.

The following table displays the healthcare provider ratios for Charles County zip code and the county as a whole.

County/Neighborhoods by Census Tracts		Resident Civilian Population[1,2]	Primary Care FTE[3, 5]	Primary Care Provider to Population Ratio[6]	Mental Health FTE[4, 5]	Mental Health Provider to Population Ratio[6]
Charles County	Nanjemoy (850400)	3,562	0.0	0 : 3,562	0.0	0 : 3,562
	Welcome (850500)	2,884	0.0	0 : 2,884	0.0	0 : 2,884
	La Plata (850600, 850904, 851001, 851002)	26,422	18.9	1 : 1,400	0.0	0 : 26,422
	Waldorf (850706, 850708, 850709, 850710, 850711, 850712, 850713, 850801, 850802, 850901, 850902, 850905, 850906, 851500)	80,964	52.8	1 : 1,533	1.0	1 : 80,964
	Port Tobacco/Charlotte Hall (851100, 851301, 851302)	12,381	0.0	0 : 12,381	0.0	0 : 12,381
	Newburg (851200)	4,960	0.0	0 : 4,960	0.0	0 : 4,960
	Hughesville (851400)	8,692	0.0	0 : 8,692	0.0	0 : 8,692
Charles County	**Whole County**	**163,257**	**73.7**	**1 : 2,216**	**1.0**	**1 : 163,257**
	Bryans Road (850101, 850102)	8,038	1.0	1 : 8,038	0.0	0 : 8,038
	Indian Head/Marbury (850201, 850202, 850300)	7,432	1.0	1 : 7,432	0.0	0 : 7,432

[1] **Annual Estimates of Resident Population in 2019.**

[2] **Annual Estimates of Resident Population in 2018.**

[3] Primary Care FTE: Includes family practice, general practice, internal medicine, obstetric and gynecology and pediatric.

[4] **Mental Health FTE: Only includes psychiatrists**

[5] Excluded FTE: Physicians solely working at hospitals, non-acute care facilities, or providing academia or research services.

[6] Blue font indicates possible eligibility for a Mental Health or Primary Care Geographic HPSA based on provider to population ratio factors below:

Primary Care Geographic HPSA

- If FTE = 0, then population should be at least 500
- FTE > 0, then provider: population ratio should be at least 1:3,500 and include a minimum population of 20,000 unless a full county.

Mental Health Geographic HPSA

- If FTE = 0, then population should be at least 3,000
- If FTE > 0, then provider: population ratio should be 1:30,000 for only psychs and include a minimum population of 20,000 unless a full county.

Source: U.S. Census Bureau, Population Division, https://www.census.gov/data/tables/time-series/demo/popest/2010s-counties-total.html; Health Resources and Services Administration (HRSA), HPSA Find, https://data.hrsa.gov/tools/shortage-area/hpsa-find

The report also identified safety net providers for each county. For Charles County, 3 organizations were identified.

CHARLES COUNTY SAFETY NET SITES														
Site Type	Site Name	Site Address	Telephone Number	Web Address	Location Type	Type Description	Contact Name	Migrant Health	Homeless	Medical	Dental	Mental Health	Vision	Substance Use
FQHC	Greater Baden Medical Services at La Plata	6 Garrett Ave La Plata, MD 20646-5959	301-539-5100	www.gbms.org	Permanent	Service Delivery Site	Unknown	Yes	No	Yes	Yes	Yes	No	Yes
Hospital	University of Maryland Charles Regional Medical Center	5 Garrett Avenue, La Plata, MD 20646	301-609-4000	https://www.umms.org/charles	Permanent	Service Delivery Site	Unknown	No	Yes	Yes	Unknown	Yes	No	Yes
LHD	Charles County Health Department	4545 Crain Hwy, White Plains, MD 20695	301-609-6900	https://charlescountyhealth.org/	Permanent	Administra-tive/Service Delivery Site	Unknown	Unknown	Unknown	Yes	Yes	Yes	Unknown	Yes

FQHC - Federally Qualified Health Center
LHD - Local Health Department
SBHC - School Based Health Center

Sources:
1. 2019 Program Awardee Data
https://data.hrsa.gov/tools/data-reporting/program-data?type=AWARDEE&state=MD, 2/8/21
2. Health Resources and Services Administration, accessed 2/1/2021
http://datawarehouse.hrsa.gov/tools/hdwreports/reports.aspx
3. Maryland Hosptial Association, accessed 3/22/2021
https://www.mhaonline.org/about-mha/member-hospitals
4. University of Maryland Charles Regional Medical Center, accessed 3/24/21
https://www.umms.org/charles
5. Charles County Health Department, accessed 3/24/21
https://charlescountyhealth.org/

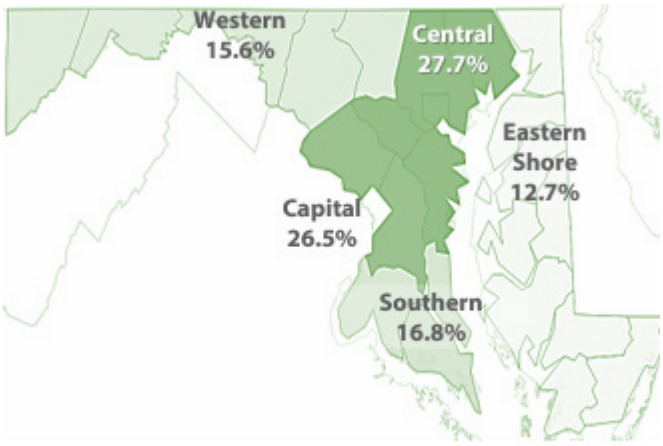
Maryland Hospital Association 2022 State of Maryland's Health Care Workforce Report:

The 2022 State of Maryland's Health Care Workforce Report looked at the healthcare professions with high vacancy rates. Nursing positions were at the top of the list. They were higher than the overall Maryland vacancy rate of 21.2%.

Top 10 Hospital Occupations by Vacancy Rate[2] (as of 12/31/2021)	
Licensed Practical (Vocational) Nurses	**37.7%**
Registered Nurses	**25.4%**
Respiratory Therapists	**23.7%**
Nursing Assistive Personnel	**22.9%**
Overall Vacancy Rate	**21.2%**
Nurse Practitioners	21.0%
Surgical Technicians	20.5%
Pharmacy Technicians	19.0%
Sterile Processing Technicians	17.2%
Laboratory Technicians	17.1%
Radiology Technicians	16.9%

Southern Maryland has a registered nurse vacancy rate of 16.8%. This is the third highest in the state.

Registered Nurse Vacancy Rates by Region[2]



Note: Data represents submissions by 49 of 51 Maryland hospitals (Survey Response Rate = 96.1%). Data will be updated as new submissions are received.

Maryland Health Workforce Study Phase 2 Report, January 2014:

In January 2014, the Maryland Health Care Commission (MHCC) released a second report detailing Phase 2 of the Maryland Health Workforce Study. This study assessed health workforce distribution and the adequacy of supply. Using funding from the Robert Wood Johnson Foundation, the MHCC was able to study the Maryland healthcare workforce on the state and jurisdictional level. Phase II presents estimates of current supply and demand for health professions designated by MHCC has high priority in supporting Maryland's transition to health reform, and for which data were readily available for estimating supply and demand. These professions included primary care specialties and psychiatrists. Current supply estimates were also presented for psychologists, social workers, counselors, physician assistants, pharmacists, registered nurses, and dentists.

Demand modeling: Estimates of the current demand for healthcare providers were developed using the IHS Healthcare Demand Micro-simulation Model. The major components of this model include: 1. A population database that contains characteristics and health risk factors for a representative sample of the population in each Maryland county; 2. Equations that relate a person's characteristics to his or her demand for healthcare services by care delivery setting; and 3. Staffing patterns that convert demand for healthcare services to demand for full time equivalent (FTE) providers.

This report has not been updated since 2014.

In Charles County, the primary care FTE demand is greater than the primary care FTE supply (7.4 vs. 6.1). There is an 18% shortfall in the demand for primary care services. Charles County falls in the up to 20% shortage area for primary care physician supply.

Map 1: Maryland County-Level Adequacy of FTE Primary Care Physician Supply

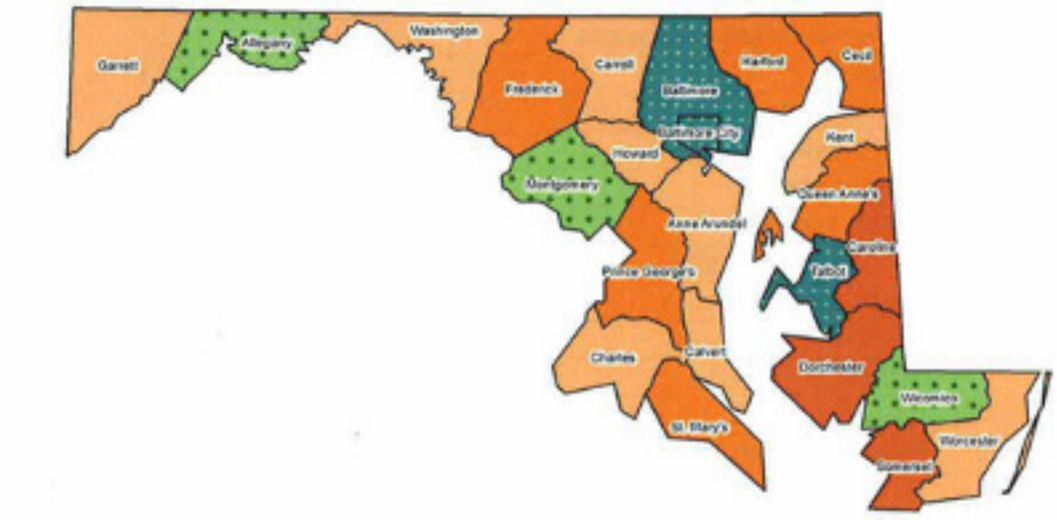


Exhibit 3: Adequacy of Supply for Primary Care Physicians by County, 2012

County	Total FTEs			FTEs/10,000 Population	
	FTE Demand	FTE Supply	Supply - Demand	FTE Demand	FTE Supply
Allegany	57	63	6	7.6	8.5
Anne Arundel	407	379	(28)	7.4	6.9
Baltimore City	464	817	353	7.5	13.1
Baltimore County	621	788	167	7.6	9.6
Calvert	66	56	(10)	7.5	6.2
Caroline	25	14	(11)	7.5	4.2
Carroll	125	103	(22)	7.5	6.2
Cecil	75	60	(15)	7.5	5.9
Charles	111	91	(20)	7.4	6.1
Dorchester	25	14	(11)	7.9	4.1
Frederick	176	140	(36)	7.4	5.8
Garrett	23	20	(3)	7.7	6.6
Harford	186	142	(44)	7.5	5.7
Howard	218	197	(21)	7.3	6.6
Kent	16	16	0	8.0	7.9
Montgomery	729	833	104	7.2	8.3
Prince George's	637	471	(166)	7.2	5.3
Queen Anne's	37	25	(12)	7.6	5.1
St. Mary's	80	53	(27)	7.3	4.9
Somerset	19	8	(11)	7.3	2.9
Talbot	31	42	11	8.1	11.0
Washington	112	111	(1)	7.5	7.4
Wicomico	75	81	6	7.5	8.0
Worcester	42	41	(1)	8.0	7.9
Total	**4,357**	**4,565**	**208**	7.4	**7.8**

Note: Primary care specialties include general and family practice, general internal medicine, geriatrics, and general pediatrics.

The supply versus demand for pediatric services in Charles County is similar.

Exhibit 4: Adequacy of Supply for Pediatricians by County, 2012

County	Total FTEs			FTEs/10,000 Children	
	FTE Demand	FTE Supply	Supply - Demand	FTE Demand	FTE Supply
Allegany	10	11	1	7.0	7.9
Anne Arundel	87	85	(2)	7.1	6.9
Baltimore County	125	185	60	7.1	10.4
Baltimore City	99	168	69	7.3	12.3
Calvert	15	13	(2)	7.0	6.1
Caroline	6	1	(5)	7.0	0.9
Carroll	26	21	(5)	6.9	5.4
Cecil	16	9	(7)	7.0	3.9
Charles	26	26	0	7.1	7.0
Dorchester	5	1	(4)	7.1	1.9
Frederick	40	34	(6)	7.0	5.9
Garrett	4	-	(4)	6.9	-
Harford	40	40	0	7.0	7.0
Howard	51	52	1	7.1	7.2
Kent	2	1	(1)	7.0	2.6
Montgomery	163	234	71	7.1	10.1
Prince George's	148	104	(44)	7.2	5.1
Queen Anne's	7	6	(1)	6.9	5.7
St. Mary's	19	12	(7)	7.0	4.3
Somerset	3	2	(1)	7.1	3.6
Talbot	5	9	4	7.0	13.4
Washington	23	21	(2)	7.0	6.5
Wicomico	16	26	10	7.1	11.1
Worcester	7	-	(7)	7.0	-
Total	**943**	**1,061**	**118**	**7.1**	**8.0**

The FTE per 10,000 supply rates for professional counselors, social workers, and psychologists in Charles County is much lower than the rates for Maryland. The Charles County FTE rate for physician assistants is the only rate that came close to the Maryland state supply rate.

Exhibit 6: Supply of Selected Health Professions by County, 2012

County	Professional Counselors		Social Workers		Psychologists		Physician Assistants	
	FTEs	FTE/ 10,000	FTEs	FTE/ 10,000	FTEs	FTE/ 10,000	FTEs	FTE/ 10,000
Allegany	267	36.1	222	29.9	27	3.6	27	3.6
Anne Arundel	684	12.4	833	15.1	144	2.6	162	2.9
Baltimore City	2,132	34.3	4,030	64.9	405	6.5	570	9.2
Baltimore County	1,294	15.8	2,124	26.0	357	4.4	330	4.0
Calvert	118	13.2	128	14.2	8	0.8	20	2.2
Caroline	17	5.2	61	18.6	-	-	1	0.3
Carroll	277	16.5	315	18.8	48	2.9	52	3.1
Cecil	97	9.5	175	17.2	25	2.4	23	2.3
Charles	193	12.8	126	8.4	14	0.9	49	3.2
Dorchester	79	24.3	150	45.9	5	1.4	3	0.8
Frederick	320	13.3	530	22.1	56	2.3	62	2.6
Garrett	53	17.6	73	24.3	1	0.2	5	1.5
Harford	351	14.1	355	14.3	46	1.9	63	2.5
Howard	407	13.6	667	22.3	181	6.0	40	1.3
Kent	41	20.1	52	25.5	8	3.7	3	1.5
Montgomery	1,200	11.9	2,927	29.1	754	7.5	300	3.0
Prince George's	833	9.4	913	10.4	129	1.5	154	1.7
Queen Anne's	29	5.9	70	14.4	9	1.7	3	0.5
St. Mary's	105	40.0	115	43.8	18	1.6	22	8.4
Somerset	45	4.1	79	7.2	-	-	4	0.3
Talbot	62	16.3	167	43.8	7	1.8	11	2.8
Washington	273	18.3	435	29.1	18	1.2	65	4.4
Wicomico	193	19.1	334	33.2	20	1.9	72	7.1
Worcester	67	12.9	106	20.6	5	0.9	11	2.1
Total	**9,131**	**15.5**	**14,982**	**25.5**	**2,278**	**3.9**	**2,045**	**3.5**

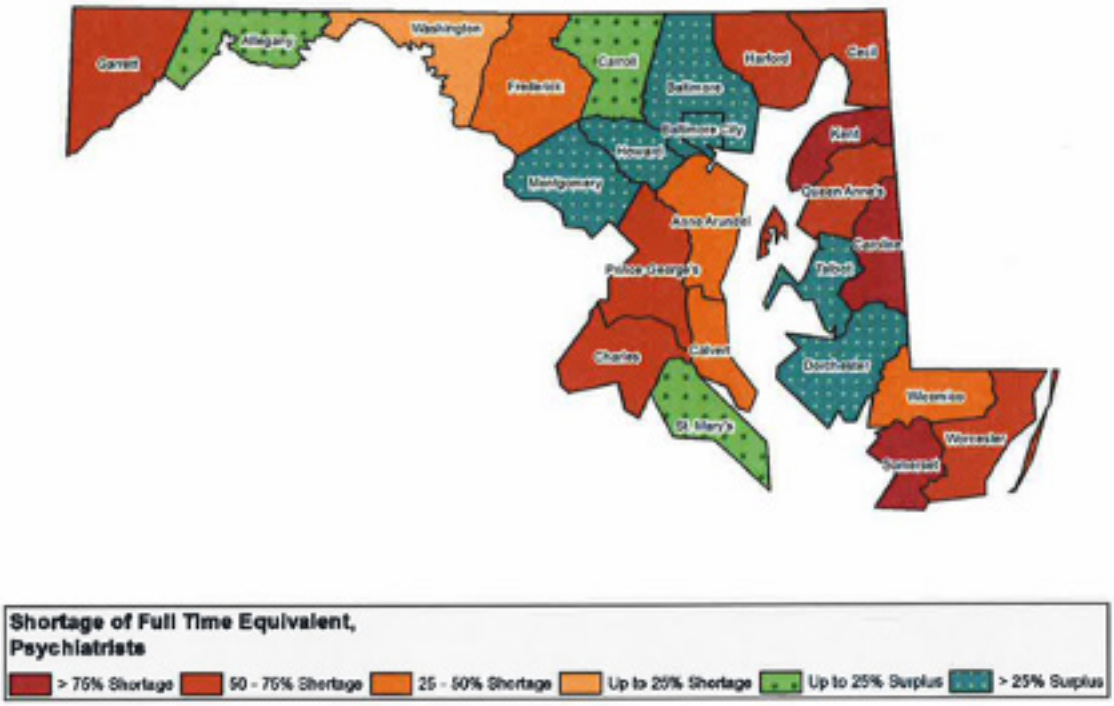
Note: These are professions for which only FTE supply analysis was possible at this time.

The demand for psychiatrists in Charles County is much higher than the county supply for psychiatry. Charles County has a shortage between 50-75% of full time equivalent psychiatrists.

Exhibit 5: Adequacy of Supply for Psychiatrists by County, 2012

County	Total FTEs			FTEs/10,000 Population	
	FTE Demand	FTE Supply	Supply - Demand	FTE Demand	FTE Supply
Allegany	10	10	0	1.3	1.4
Anne Arundel	74	41	(33)	1.3	0.7
Baltimore City	94	233	139	1.5	3.7
Baltimore County	113	242	129	1.4	3.0
Calvert	12	6	(6)	1.3	0.7
Caroline	4	-	(4)	1.3	-
Carroll	22	26	4	1.3	1.6
Cecil	13	6	(7)	1.3	0.6
Charles	22	6	(16)	1.5	0.4
Dorchester	5	8	3	1.4	2.5
Frederick	32	18	(14)	1.3	0.8
Garrett	4	2	(2)	1.3	0.5
Harford	33	15	(18)	1.3	0.6
Howard	40	64	24	1.3	2.1
Kent	3	-	(3)	1.4	-
Montgomery	134	214	80	1.3	2.1
Prince George s	135	47	(88)	1.5	0.5
Queen Anne's	6	3	(3)	1.3	0.6
St. Mary's	14	5	(9)	1.3	0.4
Somerset	4	1	(3)	1.5	0.3
Talbot	5	8	3	1.3	2.2
Washington	20	18	(2)	1.3	1.2
Wicomico	14	8	(6)	1.4	0.8
Worcester	7	2	(5)	1.3	0.5
Total	**820**	**983**	**163**	**1.4**	**1.7**

Map 2: Maryland county-Level Adequacy of FTE Psychiatrist Supply



2019-2020 Maryland Physician Workforce Profile:

The current state of the physician workforce in Maryland is present below in the following three charts. The data is based on the American Medical Association's Masterfile and is compiled each year into the State Physician Workforce Data Report. The results for Maryland from the 2019-2020 State Physician Workforce Data Report state that there are 23,791 active physicians and 7,075 primary care physicians practicing in Maryland.

Maryland Physician Workforce Profile

2019-2020				
State Population:	6,045,680	Total Female Physicians:	9,984	
Population ≤ age 24	1,861,822	Total MD or DO Students:	1,939	
Total Active Physicians:	23,791	Total Residents:	3,031	
Primary Care Physicians:	7,075			

For additional data, including maps and tables, please see the 2021 State Physician Workforce Data Report online at www.aamc.org/workforce

		MD	MD Rank	State Median
Physician Supply	Active Physicians per 100,000 Population, 2020	393.5	2	272.0
	Total Active Patient Care Physicians per 100,000 Population, 2020	309.4	6	239.8
	Active Primary Care Physicians per 100,000 Population, 2020	117.0	7	94.7
	Active Patient Care Primary Care Physicians per 100,000 Population, 2020	98.0	9	84.5
	Active General Surgeons per 100,000 Population, 2020	9.2	14	7.7
	Active Patient Care General Surgeons per 100,000 Population, 2020	7.3	17	7.0
	Percentage of Active Physicians Who Are Female, 2020	42.0%	4	36.1%
	Percentage of Active Physicians Who Are International Medical Graduates (IMGs), 2020	27.0%	9	19.7%
	Percentage of Active Physicians Who Are Age 60 or Older, 2020	35.8%	13	32.9%
	Percent of Active Physicians Who Identify as Asian, 2020	20.5%	9	13.7%
	Percent of Active Physicians Who Identify as Black or African American, 2020	12.3%	2	3.8%
	Percent of Active Physicians Who Identify as Hispanic, Latino or of Spanish Origin, 2020	3.3%	22	3.2%
	Percent of Active Physicians Who Identify as American Indian or Alaska Native, 2020	0.3%	40	0.4%
	Percent of Active Physicians Who Identify as Native Hawaiian or Other Pacific Islander, 2020	0.2%	18	0.1%
	Percent of Active Physicians Who Identify as Other Race/Ethnicity, 2020	1.6%	19	1.4%
	Percent of Active Physicians Who Identify as White, 2020	50.6%	46	67.3%
Undergraduate Medical Education (UME)	MD and DO Student Enrollment per 100,000 Population, AY 2019-2020 & 2020-2021	32.1	28	38.6
	Student Enrollment at Public MD and DO Schools per 100,000 Population, AY 2019-2020 & 2020-2021	22.3	19	21.5
	Percentage Change in Student Enrollment at MD and DO Schools, 2010-2020	0.1%	44	31.2%
	Percentage of MD Students Matriculating In-State, AY 2020-2021	24.8%	42	67.6%
Graduate Medical Education (GME)	Total Residents/Fellows in ACGME Programs per 100,000 Population as of December 31, 2019	50.1	12	32.7
	Total Residents/Fellows in Primary Care ACGME Programs per 100,000 Population as of Dec. 31, 2019	16.4	15	12.7
	Percentage of Residents in ACGME Programs Who Are IMGs as of December 31, 2019	24.7%	14	19.2%
	Ratio of Residents and Fellows (GME) to Medical Students (UME), AY 2019-2020 & 2020-2021	1.6	6	1.0
	Percent Change in Residents and Fellows in ACGME-Accredited Programs, 2010-2020	5.2%	48	24.4%
Retention	Percentage of Physicians Retained in State from Undergraduate Medical Education (UME), 2020	21.6%	40	39.7%
	Percentage of Physicians Retained in State from Public UME, 2020	24.1%	40	43.7%
	Percentage of Physicians Retained in State from Graduate Medical Education (GME), 2020	37.6%	43	45.1%
	Percentage of Physicians Retained in State from UME and GME Combined, 2020	52.6%	43	69.7%

State Rank: How the state ranks compared to the other 49. Rank of 1 goes to the state with the highest value for the category.
State Median: The value in the middle of the 50 states, with 25 states above the median and 25 states below (excludes the District of Columbia and Puerto Rico).
Due to changes in the Census data tables, population data was only available for ages ≤ 24, compared to ages ≤ 21 in previous reports.
* Data not shown, for states with less than 10 physicians.
--- Indicated that category is not applicable because some states do not have data on this
N.R. = "Not Ranked"

Source: 2021 State Physician Workforce Data Report.Population estimates as of July 1, 2019 are from the U.S. Census Bureau (Release date: December 2019).

The specialty with the highest people to physician ratios was pediatric cardiology. Females make up 42.0% of all specialists. Additionally, 35.8% of specialists in Maryland are 60 years of age and older.

Maryland Physician Workforce Profile

Specialty	Total Active Physicians	People Per Physician	Female		Age 60 or Older	
			Number	Percent	Number	Percent
All Specialties	23,791	254	9,984	42.0	8,507	35.8
Allergy & Immunology	215	28,119	98	45.6	105	48.8
Anatomic/Clinical Pathology	384	15,744	160	41.7	211	54.9
Anesthesiology	974	6,207	342	35.1	374	38.4
Cardiovascular Disease	561	10,777	105	18.8	310	55.3
Child & Adolescent Psychiatry**	334	5,574	213	64.0	102	30.5
Clinical Cardiac Electrophisiology	54	111,957	*	*	*	*
Critical Care Medicine	410	14,746	126	30.8	57	13.9
Dermatology	307	19,693	166	54.1	106	34.5
Emergency Medicine	939	6,438	346	36.8	199	21.2
Endocrinology, Diabetes & Metabolism	301	20,085	177	58.8	103	34.2
Family Medicine/General Practice	1,627	3,716	899	55.3	569	35.0
Gastroenterology	391	15,462	104	26.6	167	42.7
General Surgery	555	10,893	135	24.3	226	40.7
Geriatric Medicine***	181	7,553	89	49.2	57	31.5
Hematology & Oncology	541	11,175	205	37.9	194	35.9
Infectious Disease	498	12,140	209	42.0	164	32.9
Internal Medicine	3,537	1,709	1,432	40.5	1,360	38.5
Internal Medicine/Pediatrics	119	50,804	81	68.1	*	*
Interventional Cardiology	61	99,110	*	*	*	*
Neonatal-Perinatal Medicine	131	46,150	91	69.5	52	39.7
Nephrology	279	21,669	102	36.6	86	30.8
Neurological Surgery	124	48,755	13	10.5	42	33.9
Neurology	458	13,200	151	33.0	217	47.4
Neuroradiology	105	57,578	25	23.8	12	11.4
Obstetrics & Gynecology	1,073	5,634	723	67.4	349	32.5
Ophthalmology	577	10,478	196	34.0	218	37.8
Orthopedic Surgery	403	15,002	28	6.9	187	46.4
Otolaryngology	240	25,190	64	26.7	85	35.4
Pain Medicine & Pain Management	152	39,774	38	25.0	17	11.2
Pediatric Anesthesiology & Anesthesia	57	106,065	33	57.9	*	*
Pediatric Cardiology	50	120,914	20	40.0	15	30.0
Pediatric Critica Care Medicine	64	94,464	44	68.8	*	*
Pediatric Hematology & Oncology	135	44,783	72	53.3	34	25.2
Pediatrics**	1,591	1,170	1,058	66.7	627	39.5
Physical Medicine & Rehabilitation	252	23,991	96	38.4	77	30.6
Plastic Surgery	182	33,218	37	20.3	77	42.3
Preventive Medicine	395	15,306	174	44.1	219	55.4
Psychiatry	1,111	5,442	490	44.1	599	53.9
Pulmonary Disease	121	49,964	16	13.2	108	89.3
Radiation Oncology	134	45,117	56	41.8	36	26.9
Radiology & Diagnostic Radiology	628	9,627	222	35.5	274	43.6
Rheumatology	220	27,480	110	50.0	80	36.4
Sports Medicine	56	107,959	18	32.1	*	*
Sports Medicine Orthopedic Surgery	64	94,464	*	*	11	17.2
Thoracic Surgery	100	60,457	*	*	46	46.0
Urology	240	25,190	26	10.8	84	35.0
Vascular & Interventional Radiology	76	79,548	13	17.1	*	*
Vascular Surgery	114	53,032	23	20.2	29	25.4

Sources: AMA Physician Masterfile (December 31, 2020), Population estimates as of July 1, 2019 are from the U.S. Census Bureau (Release date: December 2019)

* Counts and percentages for specialties with fewer than 10 physicians are not shown

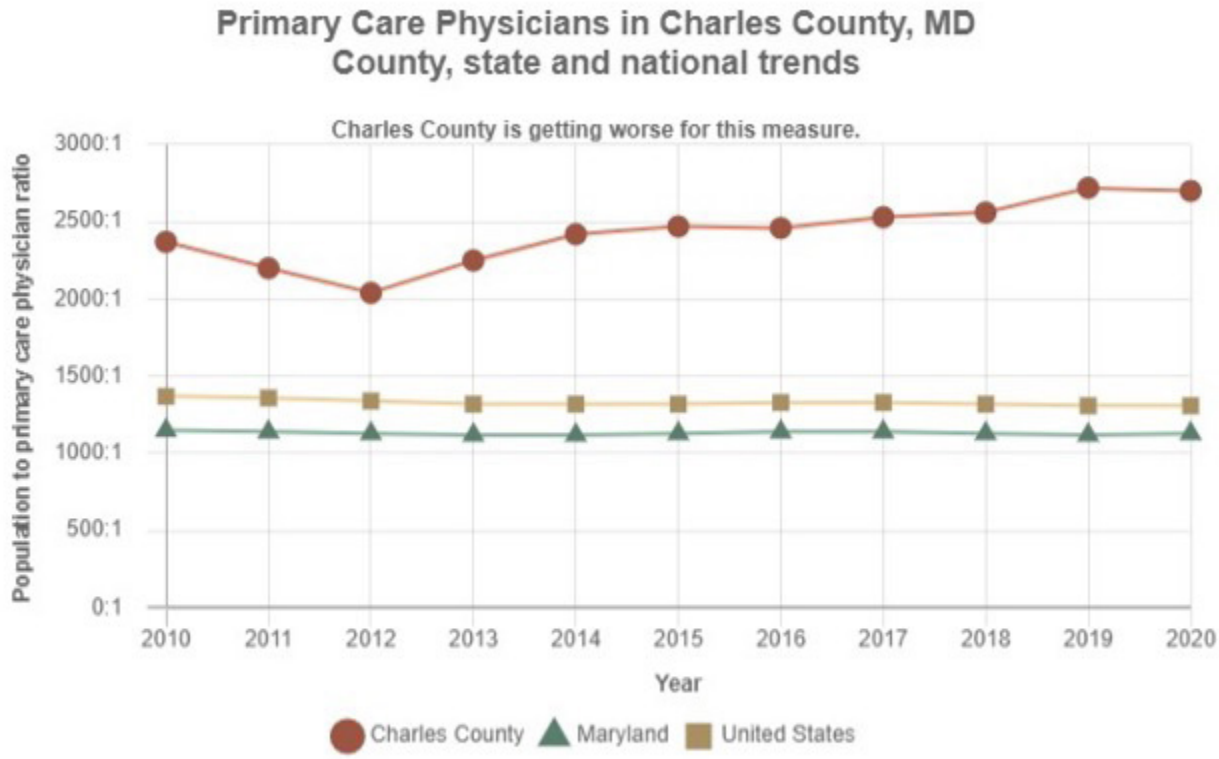
** Only those 24 years or younger are included in People Per Physician

*** Only those 60 years or older are included in People Per Physician

Primary Care Physicians and Mental Health Provider Ratios:

Access to care requires not only financial coverage, but also, access to providers. While high rates of specialist physicians have been shown to be associated with higher, and perhaps unnecessary utilization, sufficient availability of primary care physicians is essential for preventive and primary care, and when needed, referrals to appropriate specialty care. Using data from the Area Health Resource File and the American Medical Association, the County Health Rankings were able to provide 2020 primary care physician ratios for all United States counties. For 2020, the Charles County primary care physician ratio was 2,700:1. Primary Care Physicians (PCP) is the ratio of the population to total primary care physicians. Primary care physicians include non-federal, practicing physicians (M.D.'s and D.O.'s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. The 2020 Charles County PCP ratio is more than twice

as high as the Maryland state ratio of 1,130:1. The Charles County PCP ratio has gotten worse since the last needs assessment report when the ratio was 2,530:1.



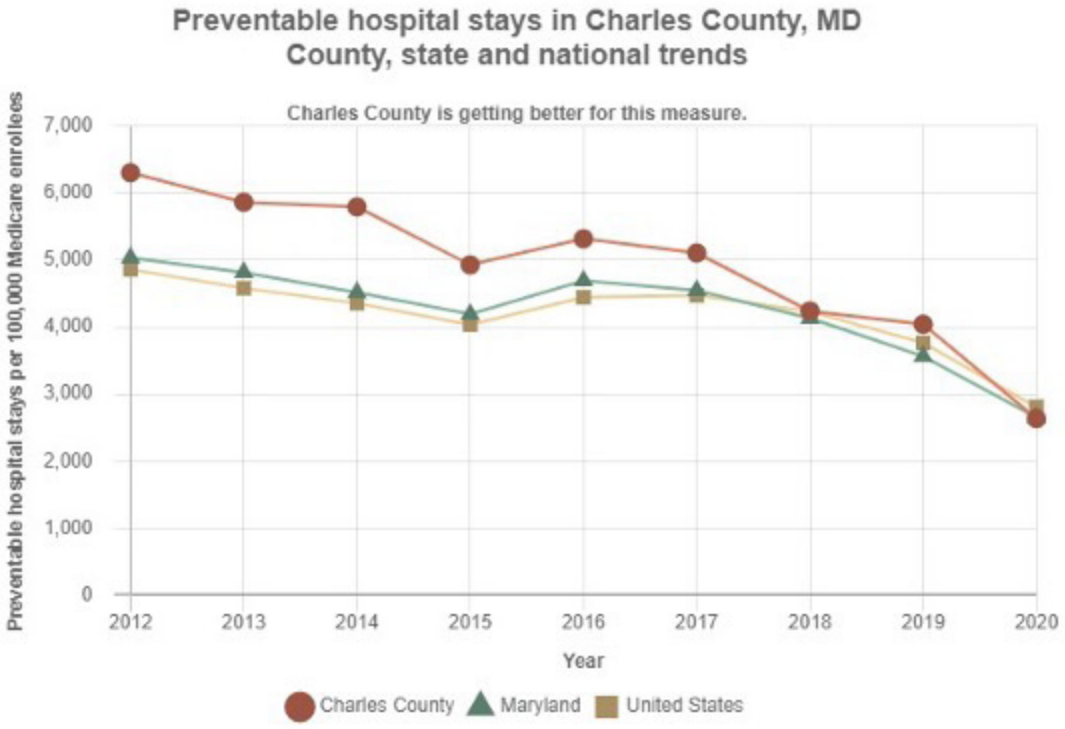
Notes:
The data in this table reflect the average population served by a single primary care physician.

The 2022 ratio of population to primary care providers other than physicians for Charles County was 1,030:1. This was higher than the Maryland other primary care provider ratio of 770:1 and the national ratio of 810:1.

The 2022 ratio of population to mental health providers for Charles County was 520:1. This was higher than the Maryland mental health provider ratio of 310:1 and the national ratio of 340:1.

Preventive Hospital Stays:

The Robert Wood Johnson Foundation's County Health Rankings examine the number of hospital stays for ambulatory care sensitive conditions among county Medicare enrollees. The 2020 Charles County preventive hospital stay rate was 2,635 per 100,000 Medicare enrollees and is similar to the Maryland state average rate of 2,653 per 100,000 Medicare enrollees. Charles County has seen decreases since 2008, and the Charles County rate is now similar to the state and national rates. The 2020 Charles County preventable hospital stay rate is a decrease from the 2017 rate of 5,108 per 100,000 Medicare enrollees reported in the last needs assessment.

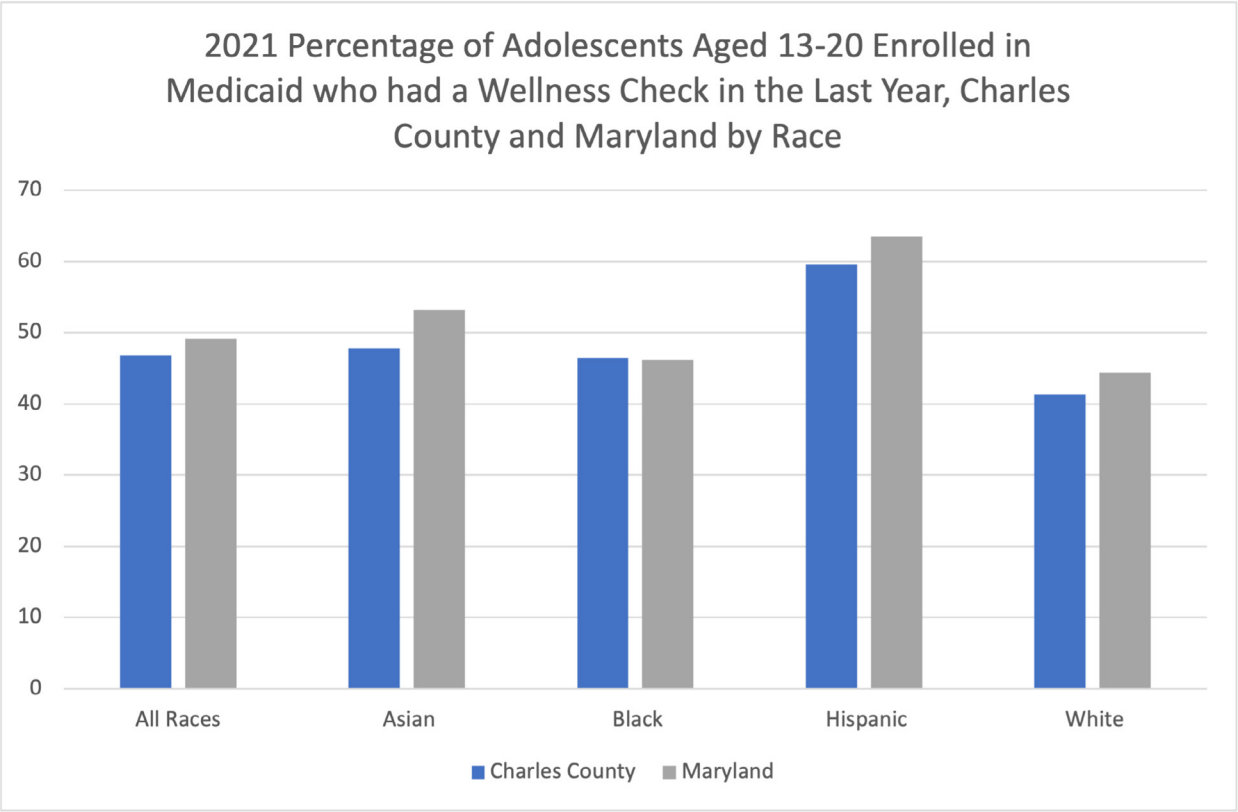


Data on this measure is also available by race for Charles County. The preventable hospital stay rate is highest for Blacks in Charles County at 2849 per 100,000 population. It is lowest for Hispanics at 976 per 100,000.

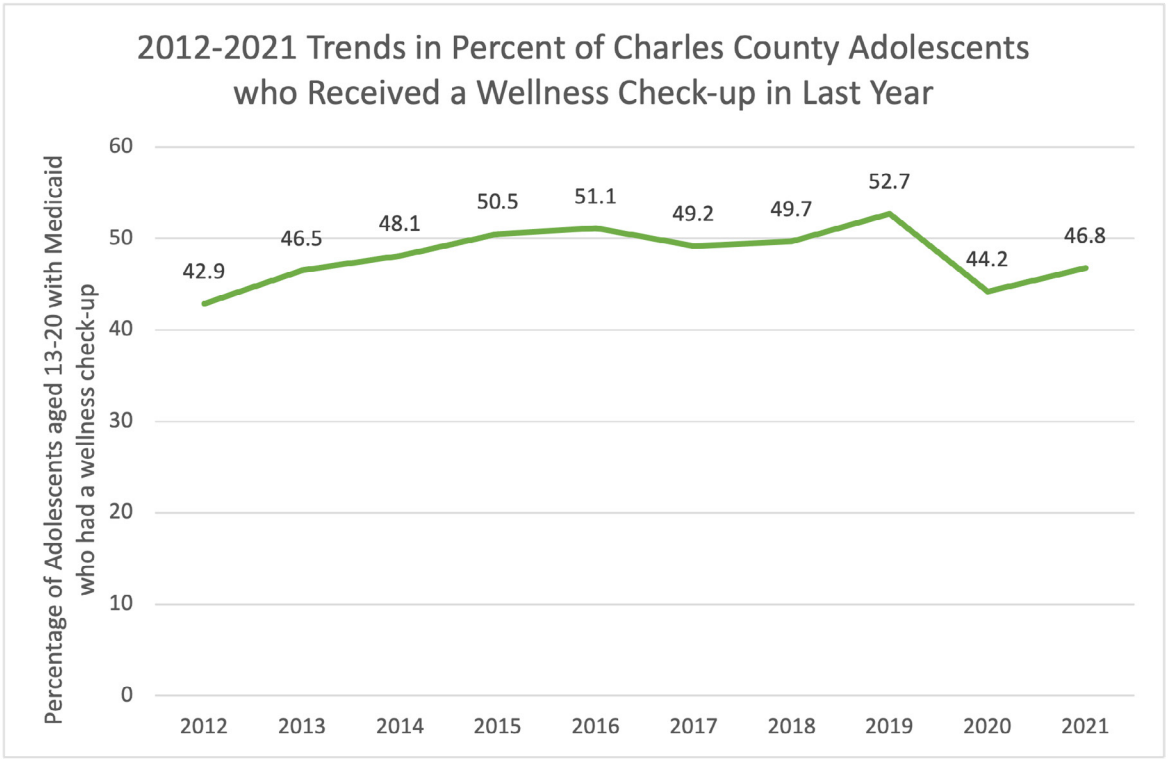
2020 Preventable Hospital Stay Rate	Rate per 100,000
Total	2635
Asian	1315
Black	2849
Hispanic	976
White	2622

Adolescent Wellness Check-Ups:

In 2021, 46.8% of Charles County adolescents aged 13-20 years enrolled in Medicaid had a wellness checkup. This is below the Maryland state average percentage of 49.2% of adolescents with a wellness checkup. The percentage of wellness checkups is highest for Charles County Hispanics (59.6%) and lowest among Charles County Whites (41.3%). The same racial disparities are seen on a state level.



The percentage of Charles County adolescents receiving a wellness checkup has remained fairly steady with some increases over the past decade.



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Qualitative Data Relating to Access to Care

Long Survey Responses:

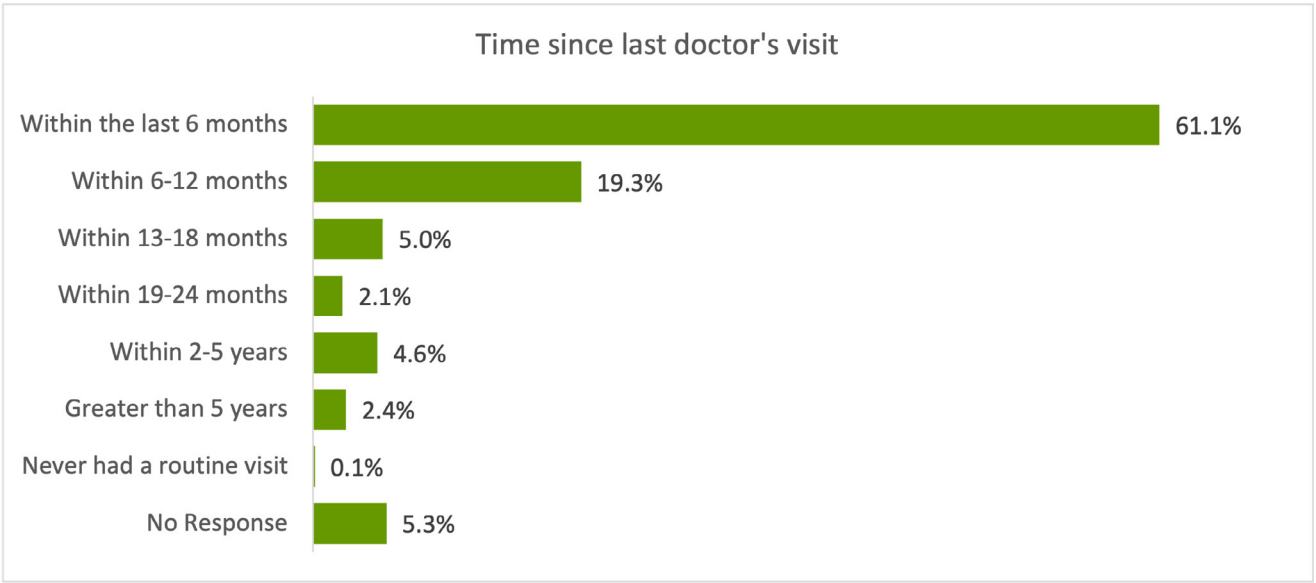
Approximately two-thirds or 69.6% of long survey participants reported that access to healthcare is a health problem in Charles County on some level. 35.3% felt that access to health care is a "serious problem" in the county.

69.5% of the long survey participants reported that affordable health care is a health problem in Charles County on some level. Almost half or 43.3% felt that access to affordable health care is a "serious problem" in Charles County.

65.4% of the long survey participants reported that health insurance is a health problem in Charles County on some level. 34.9% felt that health insurance is a "serious problem" in Charles County.

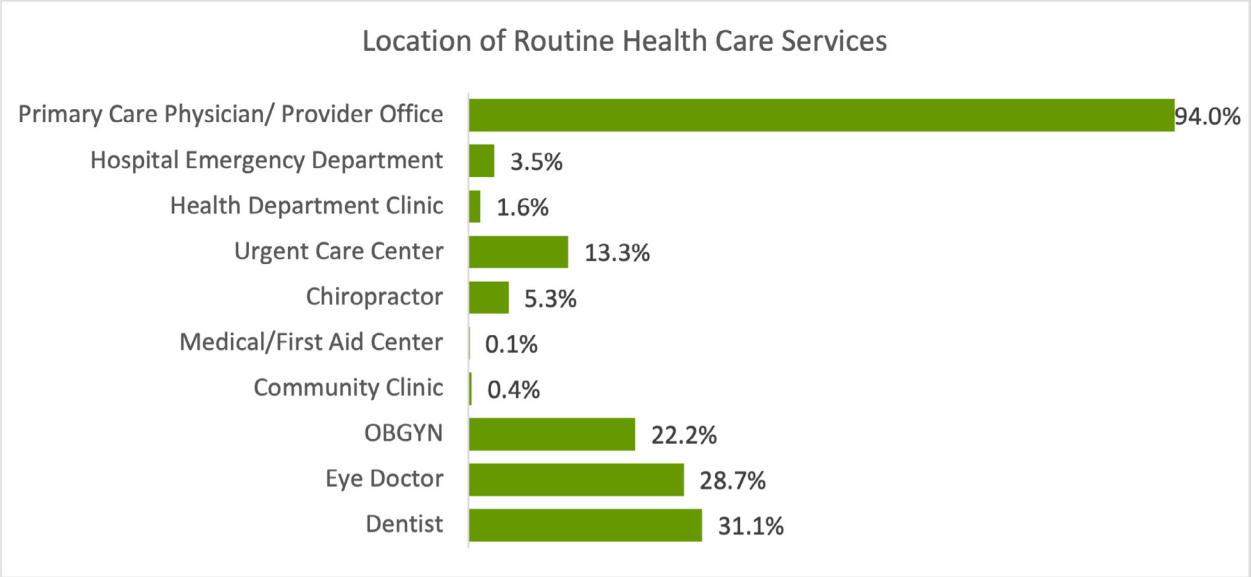
Long survey participants were also asked if they have seen improvements in Charles County in terms of health. Almost one-third of the respondents to this question (31.76%) have seen improvements to increase access to health care within the county. 15.02% reported improvements in access to needed medications.

Most of the survey participants reported having a routine doctor's visit within the last 12 months (80.4%). This percentage is down from the 2021 survey where 88.2% of participants reported having a routine doctor's visit in the last 12 months. 4.6% of participants reported that their last routine doctor's visit was within the last 2-5 years, which is an increase from 2.3% reported on the previous needs assessment. Those who haven't been to a doctor for a routine visit in more than 5 years also increased from 1.3% in 2021 to 2.4% in 2023. Only 0.1% of participants reported that they have never had a routine doctor's visit.

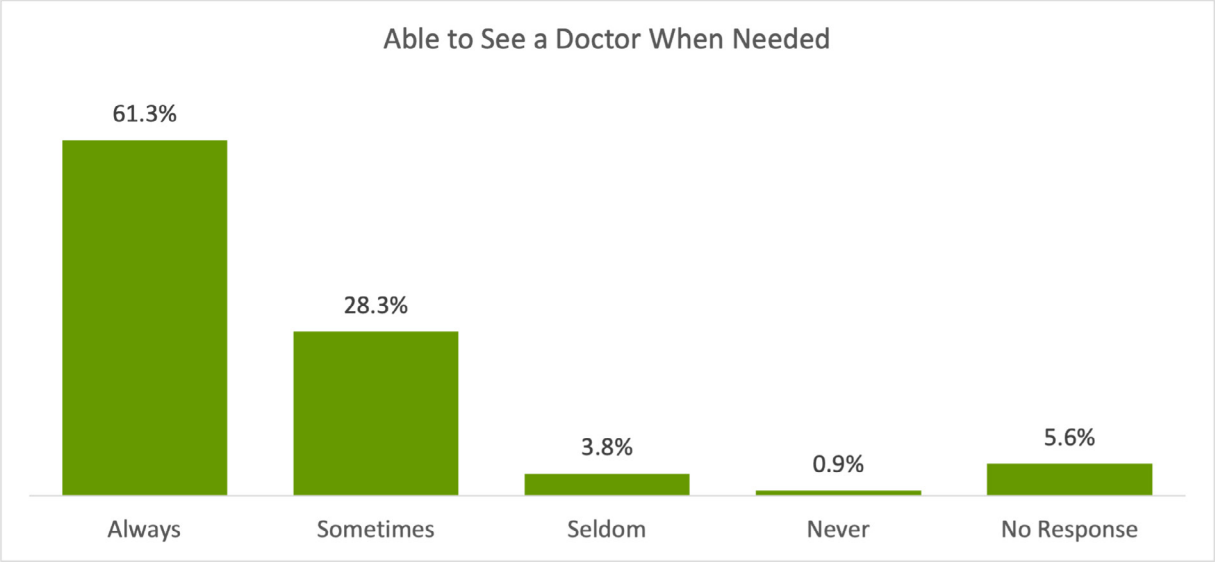


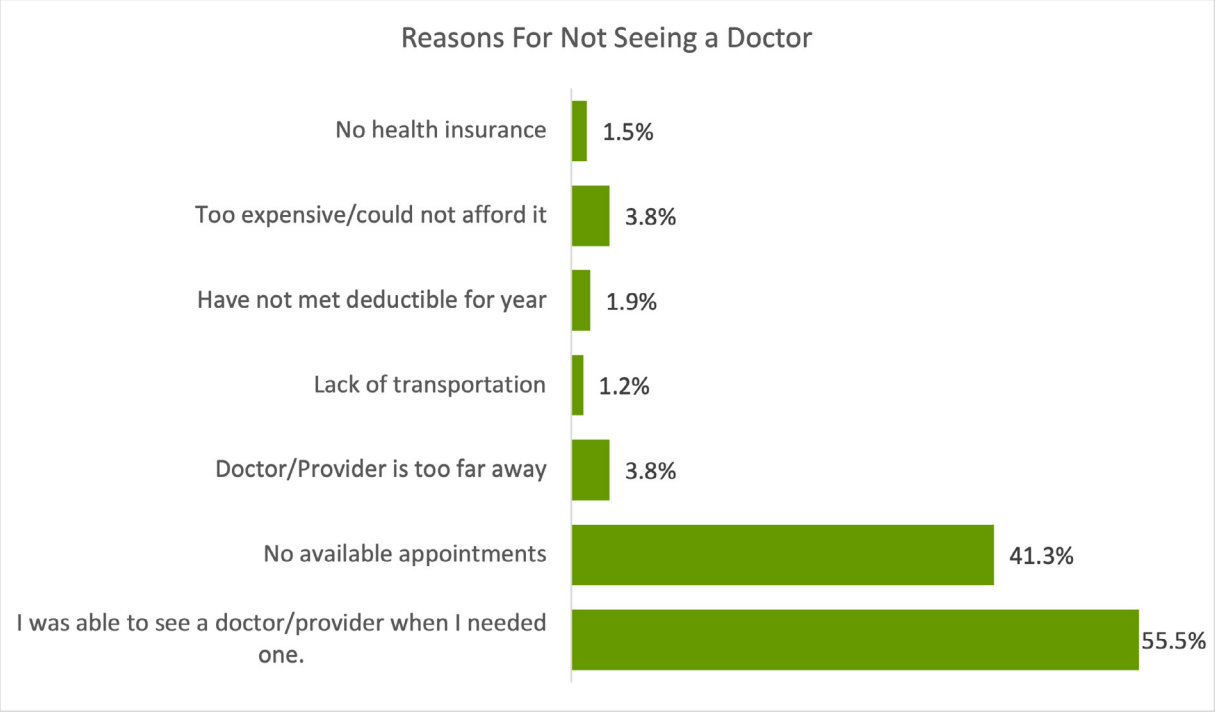
About 94% of survey participants reported that they receive their routine health care at a Primary Care Physician or Provider Office. Just under one third of participants reported receiving routine care from a Dentist (31.1%), followed by 28.7% from an Eye Doctor, and 22.2% from an OBGYN. 13.3% of survey respondents reported that they receive their routine health care from an Urgent Care Center. This percentage is a slight increase from 13% reported in the 2021 survey.

The percentage of survey participants who reported receiving routine health care from the hospital emergency department decreased from 4.2% in 2021 to 3.5% in 2023. However, this is still up from the 2018 survey where only 2.4% of participants reporting receiving routine care from the hospital emergency department.

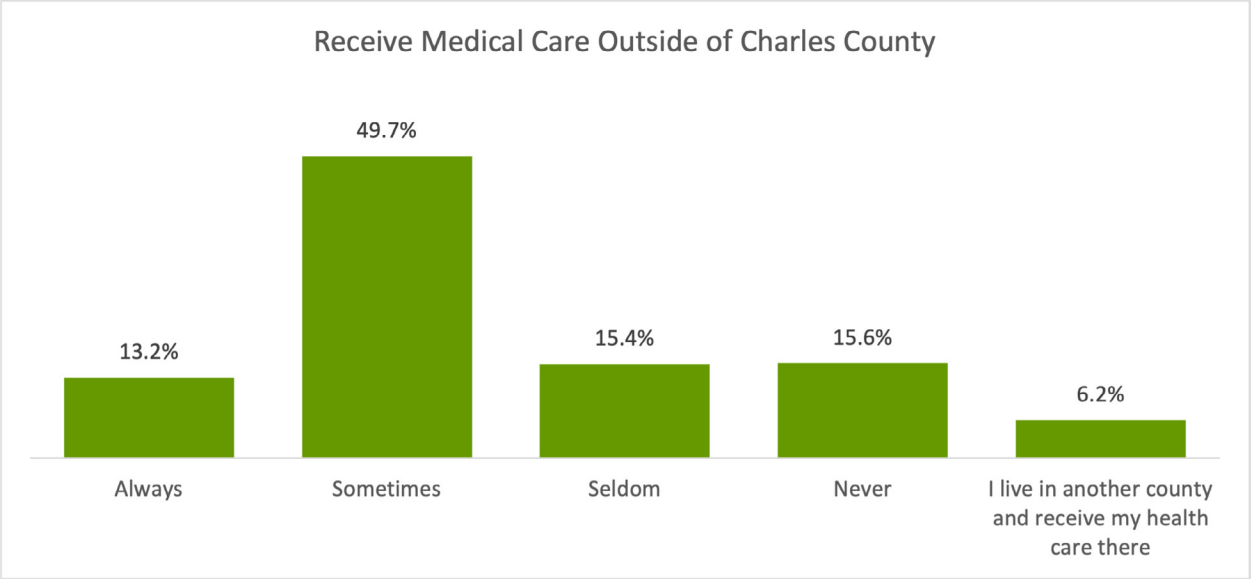


61.3% of survey respondents were able to see a doctor when needed. This percentage is a decrease from 75.3% reported in the 2021 survey. Just under 5% of respondents reported that they were seldom or never able to see a doctor when needed. This is an increase from 1.9% reported in 2021. If participants were unable to see a doctor when needed, the most common reasons were that there were no available appointments (41.3%), that it was too expensive/could not afford it (3.8%), or the doctor/provider was too far away (3.8%). The percentage of respondents who reported they were unable to see a provider when needed because there were no available appointments saw a 41% increase since the 2021 needs assessment survey when the percentage was 29.3%. However, 55.5% of survey respondents reported that they were able to see a doctor/provider when they needed one.





When asked if they receive medical care outside of Charles County, almost 16% of respondents reported that they never receive care outside of Charles County. This is a decrease from 22% reported in the 2021 survey. Almost half of respondents reported that they sometimes receive medical care outside of Charles County. The largest increase since the 2021 survey was in those who reported they always receive medical care outside of Charles County. 13.2% of respondents reported always receiving care outside of the county, compared to 5.8% in 2021.



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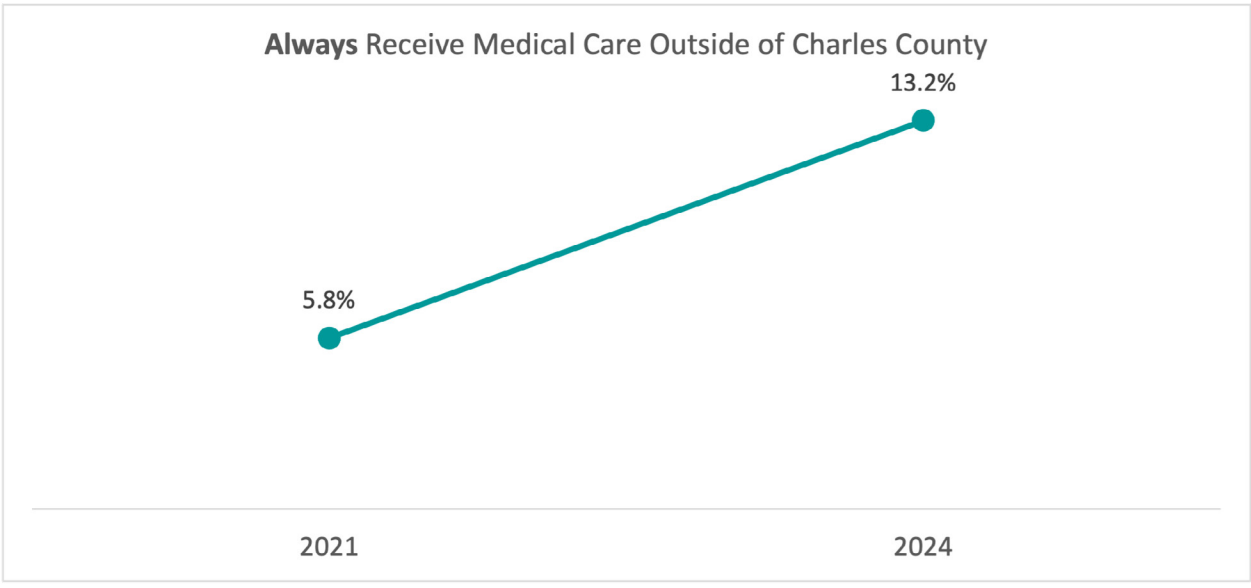
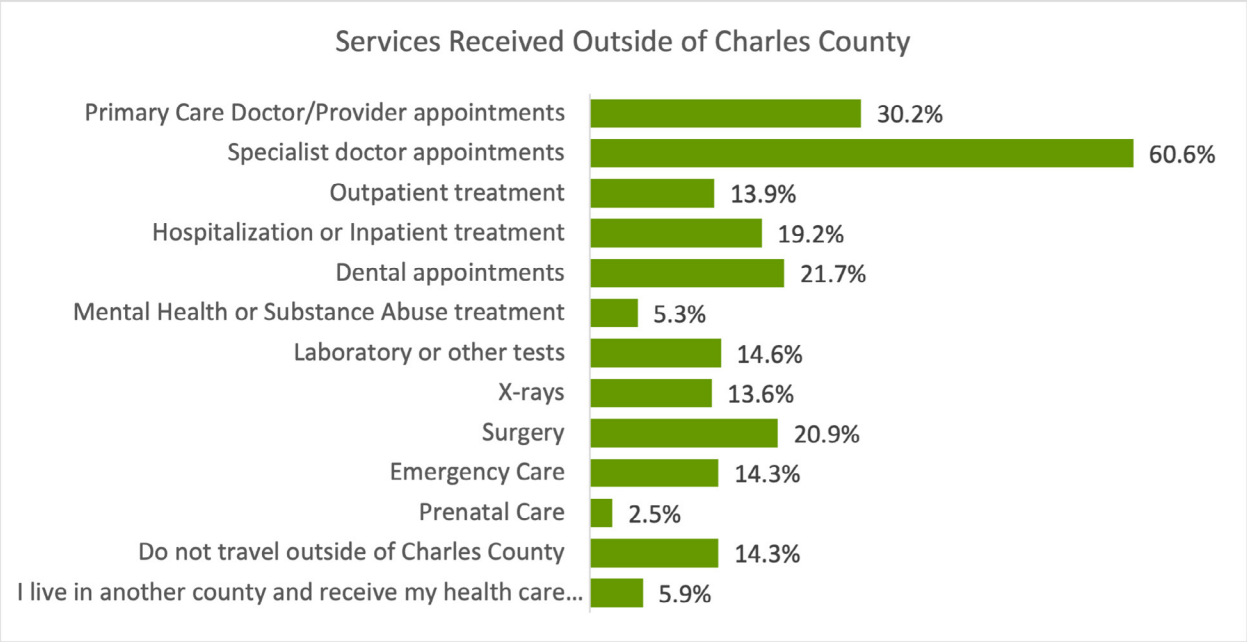
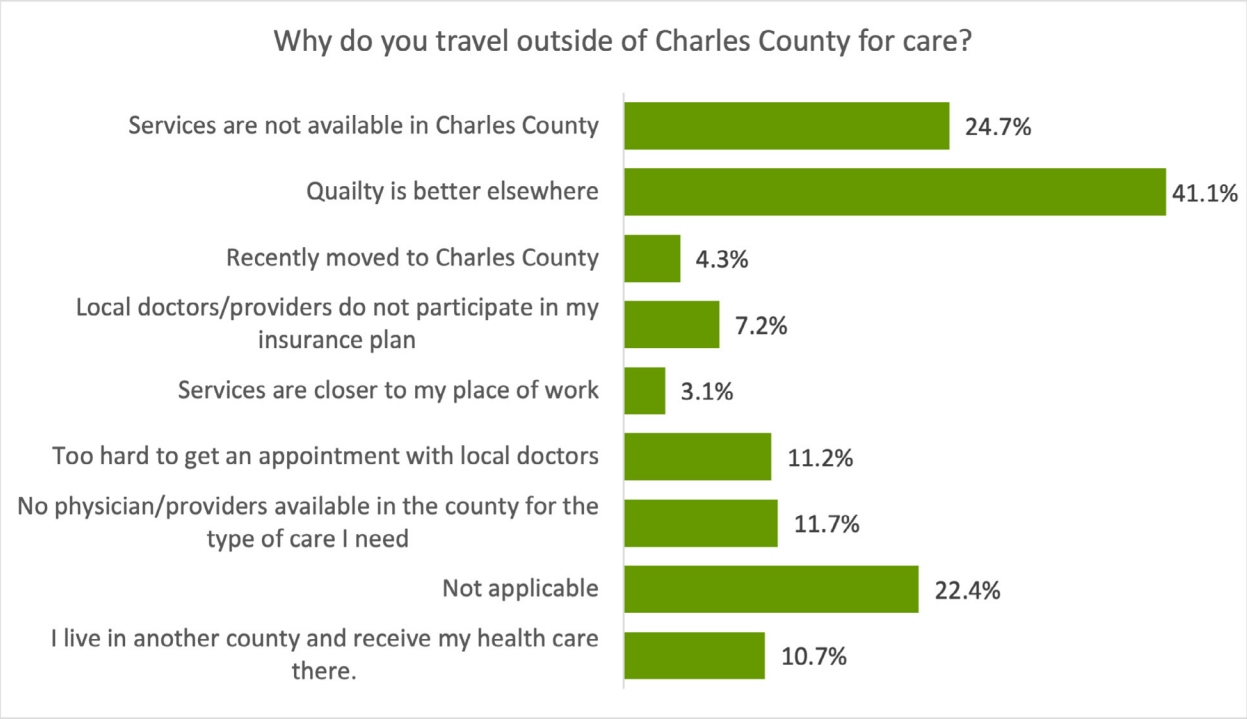


Participants were asked what medical services they receive outside of Charles County. They were asked to check all services that were applicable. The most common services that people receive outside of Charles County are specialist doctor appointments (60.6%), Primary Care Doctor/Provider appointments (30.2%), Dental appointments (21.7%), and Surgeries (20.9%). These were the most common responses reported in the 2021 survey as well.

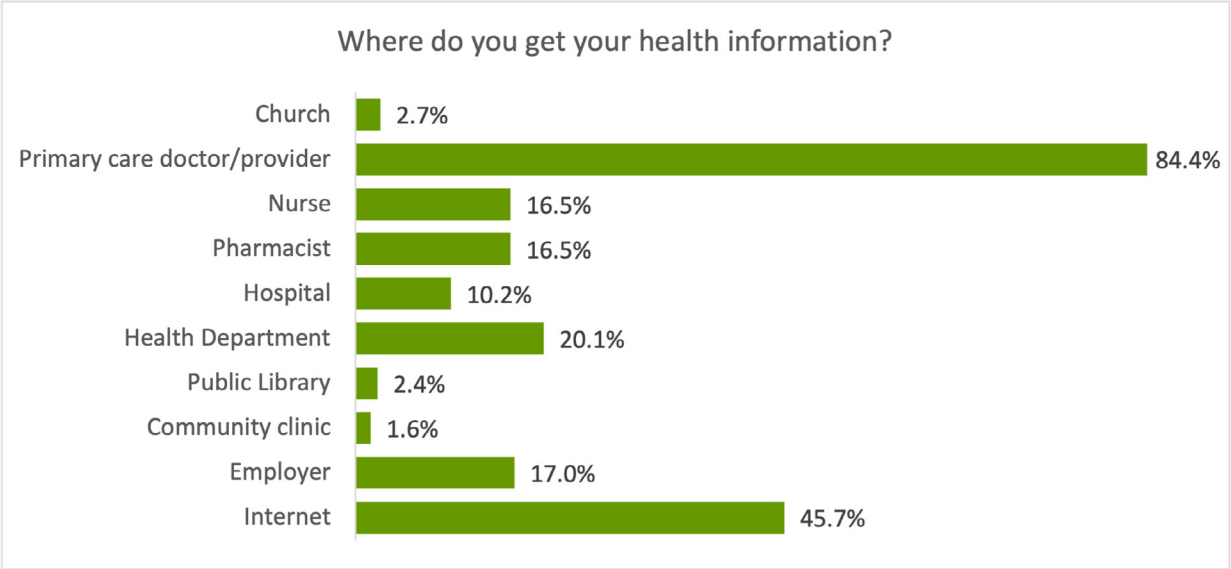
The percentage of respondents who reported receiving primary care services outside of Charles County increased to 30.2% from 19.0% reported in the 2021 survey.



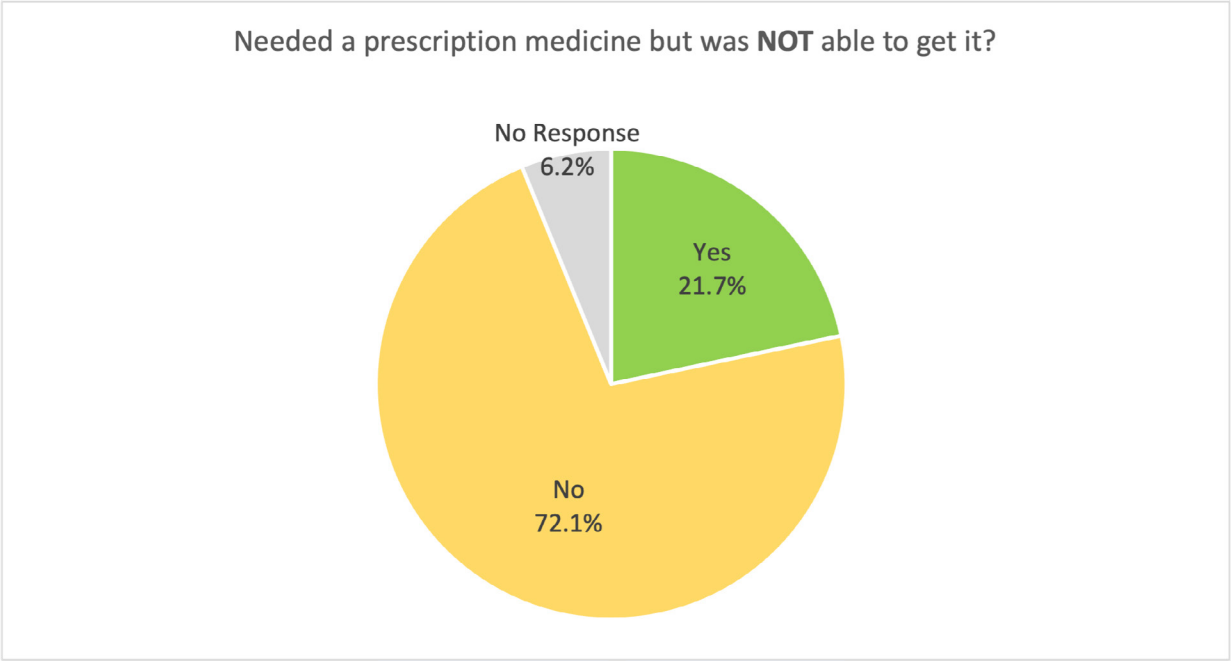
Participants were also asked why they choose to receive those medical services outside of Charles County. The most common responses were that quality is better elsewhere (41.1%) and that those services are not available in Charles County (24.7%). These were also the most common responses in the 2021 survey. The percentage of respondents that reported quality is better elsewhere increase from the 2021 survey from 37.1% to 41.1%.



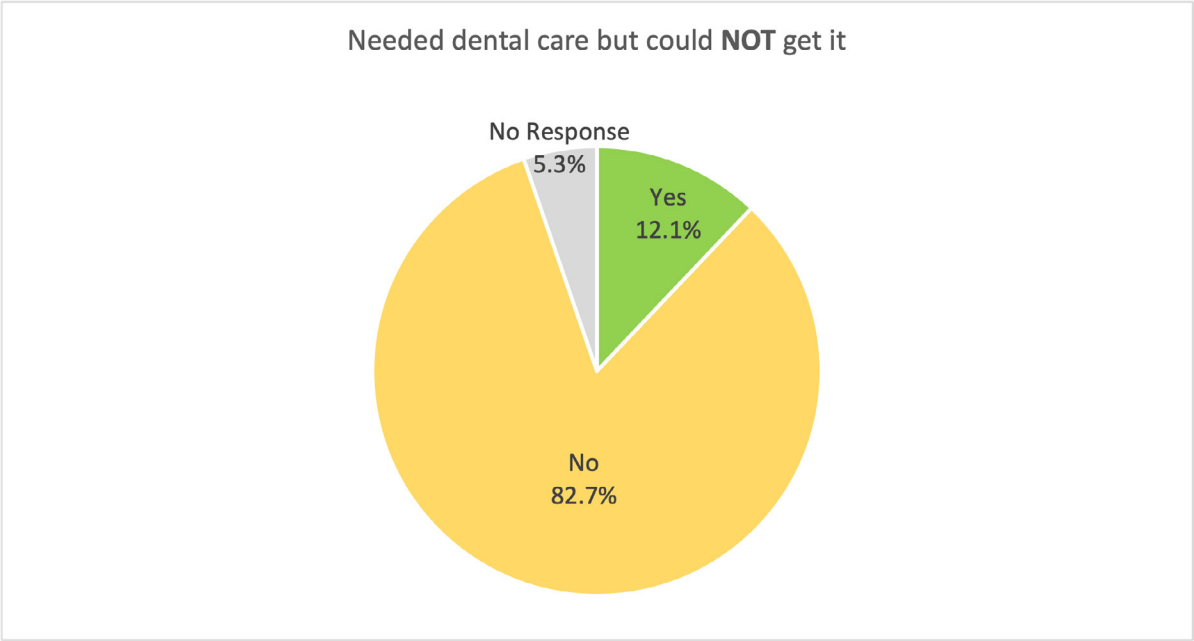
There are various sources in which individuals can get health information. The majority of survey respondents reported getting their health information from a Primary Care doctor/provider (84.4%). The second highest response was the Internet at 45.7% of responses. The percentage of respondents who reported receiving health information from the health department increased from 16.0% in 2021 to 20.1% in 2024.



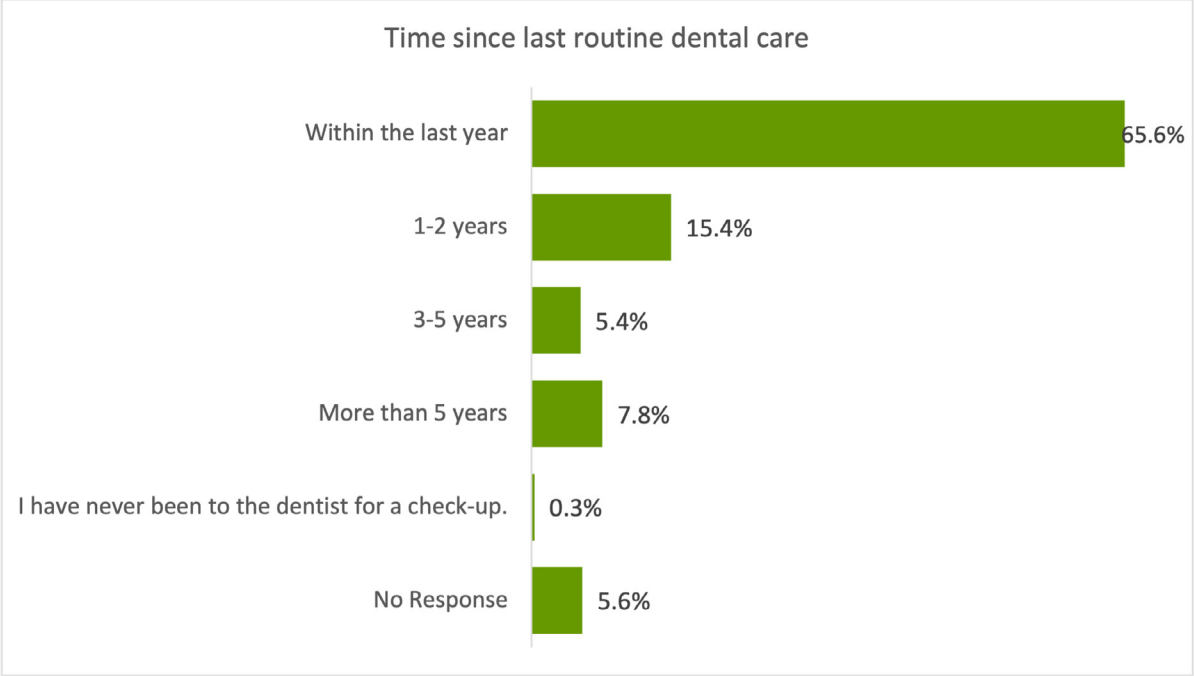
Various questions were asked to determine specific barriers in the county around access to care. The first question for respondents was in the last year, did they need a prescription medicine but were not able to get it? Almost 22% of respondents reported that in the last year they needed prescription medicine but were unable to get it.



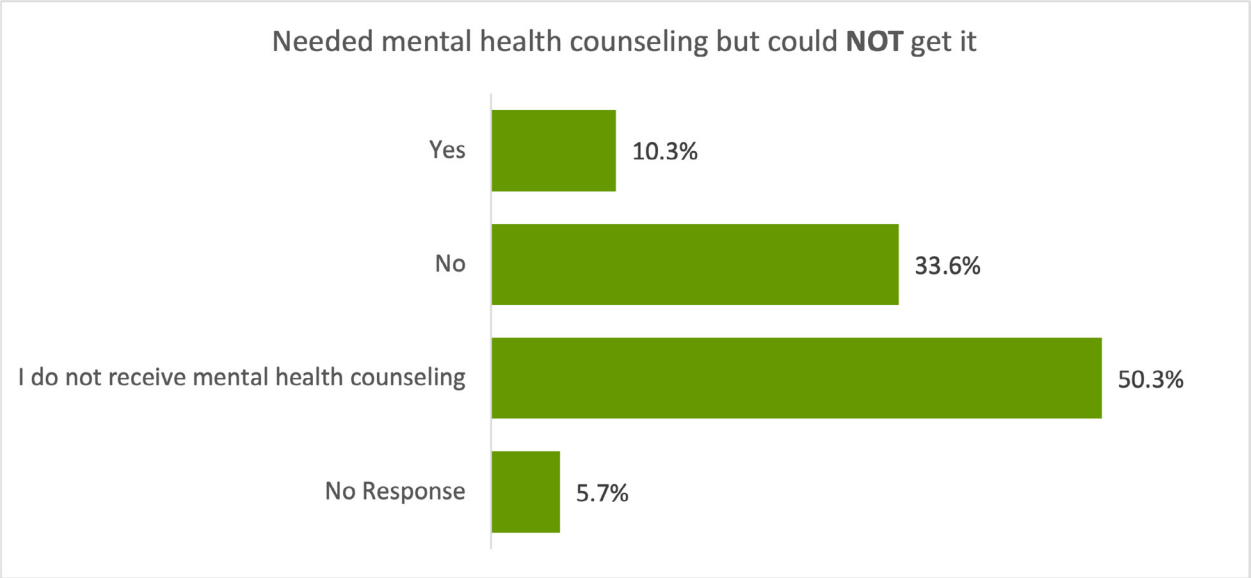
Access to care questions regarding oral health were also asked. The majority of survey respondents reported that in the last year they were able to receive dental care if they needed it (82.7%). Around 12% of respondents reported that in the last year they needed dental care but could not get it.



65.6% of survey respondents reported having routine dental care within the last year. However, over 10% of respondents reported not having routine dental care in over 3 years (13.2%). Only 0.3% of respondents have never been to the dentist for a check-up.



Survey participants were also asked in the last year if they needed mental health counseling but were unable to get it. About half of respondents reported that they do not receive mental health counseling. 33.6% of respondents reported they were able to receive mental health counseling when they needed it, and 10.3% reported they were not able to receive mental health counseling when they needed it.



Short Survey Responses:

17.3% of the short survey participants reported that access to healthcare and no health insurance is a big health problem in Charles County. This condition scored somewhere in the middle of the health conditions listed on the survey (10th highest).

The most commonly cited barriers to needed health care were care is too expensive/can't afford it (56.6%) and lack of health insurance (41.0%). Over 20% of respondents also identified transportation and not being able to get an appointment with their doctor as barriers to needed health care as well. Under "Other", several respondents explained that there is an issue trying to get in to see a provider. Respondents expressed that there's not enough health care providers, no available appointments for months, hard to find new doctors when needed, not enough doctor's offices, hard to get appointments, not enough specialist providers, hard to find a primary care doctor they like, providers not accepting new patients, and lack of providers that take Medicaid in the psychiatric department. Other barriers were distrust of health care providers, no time off from work, poverty, lack of education, unreliable services, overcrowded ER facility, insurance is not accepted, limited eye doctors, and no prevention.

Barriers to getting health care:	Response Count (N)	Response Percent (%)
Couldn't get an appointment with my doctor	265	22.3%
Doctor is too far away from my home	135	11.4%
Local doctors are not on insurance plan	225	18.9%
No health insurance	487	41.0%
No transportation	262	22.0%
Service is not available in my own county	128	10.8%
Too expensive/Can't afford it	673	56.6%
Other	121	10.1%
No Response	5	0.4%

43.2% of short survey respondents felt that there are many or some resources available for access to care for children and adults. 33.1% felt that there are many or some resources available for access to care in rural Charles County. 41.3% felt that there are many or some resources available to address access to needed prescriptions.

Recommendations surrounding Access to Care included:

- Affordable healthcare/insurance
  - — Many respondents expressed the need for lower health care costs and more affordable health care. Better insurance policies and lower costs for health insurance were also noted.
- Public Transportation
  - — Recommendations for more VanGo stops, partnering with Uber or Lyft to provide transportation to appointments, provide rides to the hospital, and creating a transportation program were all mentioned by respondents.
- Increase the number of doctors, hospitals/facilities, and provider hours.
  - — Many short survey respondents expressed the need to expand the hospital to meet the county population, addition of weekend or holiday hours, increase the number of doctors in the county, build more doctor's offices, and add more primary care doctors.
- Other access to care ideas and recommendations from short survey respondents included the addition of mobile health services in the community and the need for better providers in the county (ENTs, providers in Indian Head, and more reputable doctors).

Focus Groups:

Access to care was also seen as a major barrier to healthcare services in Charles County among focus group participants. Across the six focus groups, participants mentioned there is a lack of facilities in the county and inpatient beds. A lack of proximity to services was also expressed as a barrier. Many of the perceived barriers in the community that were mentioned were related to mental health services. In the Healthcare Consumers and Community Leaders focus group, participants stated that there is a lack of psychiatrists in the county and that there needs to be more education on how to access mental health services. Focus group members within the Partnerships for a Healthier Charles County Coalition also stated that behavioral health practitioners are limited in Charles County. Among the school nurses, many agreed that there was a lack of mental health providers and services for youth, and too much screen time. Also related to mental health, participants mentioned that there is a lack of behavioral health prescribers in Charles County and trouble with the school systems filling their school psychiatrist positions. Lastly, barriers of commercial insurance and behavioral health services were identified. Focus group participants stated that those with public insurance have access to community-based services and case management. If those services can be offered through Medicaid, they should also be available for those with commercial insurance. It was also mentioned that most people develop behavioral health conditions in childhood or adolescence, yet if they have commercial insurance, they have limited options when it comes to accessing services. Other barriers mentioned among participants related to access to care included the need for a bigger hospital, more specialists in the county, long wait-times, health literacy, the lack of health care centers and urgent care centers, and the care for Drug Affected Newborns (DAN) babies that is not offered in the county. Those patients currently must travel outside of the county to receive those services and parents may not be able to make that trip.

Conclusions:

Progress From the Last Needs Assessment Report

Data from the Fiscal Year 2024 Charles County Community Health Needs Assessment Report was examined against the baseline Fiscal Year 2021 needs assessment data. The previous needs assessment data was used to develop the FY2022-2024 Charles County Health Improvement Plan objectives. An update on the status of the Charles County health priority objectives is discussed below.

There were 2 objectives within the Charles County Health Improvement Plan that reached the anticipated goals. These measures were focused on Physician Recruitment and Retention.

There were 5 health objectives that did not reach their expected goals. 3 of those 5 objectives did not see any progress, and data moved in the opposite direction. 2 out of the 5 objectives saw some progress but did not reach the goals set.

For 3 of the long-term objectives, updated information is unknown. Objective fulfillment cannot be established. All 3 objectives were based on measures within the Maryland Department of Health's State Health Improvement Process. All measures related to emergency department visit rates have not been updated since 2017. This is what was used in the last needs assessment report.

Access to Care Objectives

1. *Physician Recruitment and Retention*

   2 out of 2 Objectives Fulfilled:

   - *Establish 3 medical practices within Charles County that will provide health care to the underserved population, with particular emphasis on mental health/psychiatry and primary care.*

     Update: The University of Maryland Charles Regional Medical Group has established a primary care practice in Bryans Road, MD. They have also opened a Behavioral Health practice in La Plata, MD.

     Other organizations who have opened practices within Charles County in the last 3 years include a new Greater Baden Medical Center practice in Bryans Road, MD and the Alpas Wellness Maryland Recover Center in La Plata, MD, focusing on behavioral health.

   - *Reduce the Charles County preventable hospital stay rate from 5,108 per 100,000 Medicare enrollees to 4852.6 (5% reduction) per 100,000 Medicare enrollees.*

     Update: In the 2023 County Health Rankings Report, the 2020 Charles County preventable hospital stay rate was 2,635 per 100,000 Medicare enrollees. This was below the goal of 5,108 per 100,000 Medicare enrollees.

2. *Social Determinants of Health:*

   0 out of 1 Objective Fulfilled:

   - *Decrease the percentage of Charles County residents who report that they were unable to see a doctor in the past 12 months due to cost from 8.6% to 8.2% (5% reduction).*

   Update: Unfortunately, this objective moved in the opposite direction. 8.8% of Charles

County BRFSS respondents reported that they were unable to see a doctor in the last year due to cost. This is an increase from 8.6% reported in the last needs assessment report.

Behavioral Health Objectives:

1 Objective Not Fulfilled, 1 Objective Fulfillment Unknown

3. *Mental Health:*

    - *Reduce the Charles County mental health emergency department visit rate from 2,817.6 per 100,000 to 2,676.7 per 100,000 (5% reduction).*

    Update: This data measure has not been updated by the Maryland Department of Health's State Health Improvement Process. Therefore, we cannot evaluate the progress on this objective. The 2017 measure that was used to create this objective is still the most recent year displayed at https://health.maryland.gov/pophealth/Pages/SHIP-Lite-Home.aspx.

4. *Substance Use Disorders:*

    - *Reduce the Charles County drug-induced death rate from 27 per 100,000 to 25 per 100,000.*

    Update: The 2019-2021 Charles County drug-induced death rate was 26.8 per 100,000 population. This is a small reduction from the metric reported in the last needs assessment report, but it is still higher than the anticipated goal of 25 per 100,000.

Disease Prevention and Management Objectives:

5. *Obesity:*

    0 out of 2 Objectives Fulfilled:

    - *Increase the percentage of Charles County adults who are at a healthy weight from 28.2% to 29.6%.*

      Update: This objective moved in the opposite direction. The percentage of Charles County adults who are at a healthy weight decreased from 28.2% in 2019 to 23.2% in 2021.

    - *Maintain the percentage of Charles County high school students who are obese at 14.6%*

      Update: This objective moved in the opposite direction. There was an increase in the percentage of Charles County high school students who were obese. The percentage went from 14.6% in 2018-2019 to 15.5% in 2021-2022.

6. *Diabetes:*

    Objective Fulfillment Unknown

    - *Reduce the Charles County diabetes emergency department visit rate from 245 per 100,000 to the Maryland rate of 232.75 per 100,000.*

      Update: This data measure has not been updated by the Maryland Department of Health's State Health Improvement Process. Therefore, we cannot evaluate the progress on this objective. The 2017 measure that was used to create this objective is still the most recent year displayed at https://health.maryland.gov/pophealth/Pages/SHIP-Lite-Home.aspx.

7. Major Cardiovascular Disease:

Objective Fulfillment Unknown

- *Reduce the Charles County hypertension emergency department visit rate from 469.9 per 100,000 to 446.4 per 100,000.*

  Update: This data measure has not been updated by the Maryland Department of Health's State Health Improvement Process. Therefore, we cannot evaluate the progress on this objective. The 2017 measure that was used to create this objective is still the most recent year displayed at https://health.maryland.gov/pophealth/Pages/SHIP-Lite-Home.aspx.

8. Infectious Diseases:

0 of 1 Objective Fulfilled

- *Increase the percentage of Charles County residents who receive a flu vaccination from 45.6% to the Maryland percentage of 49.6%.*

  Update: The 2020 percentage of Charles County who received a flu vaccination was 48%. This was an increase from 45.6% reported in the last needs assessment report; however, it did not reach our lofty goal of 49.6%.

Next Steps

The data presented in this report will be used by the University of Maryland Charles Regional Medical Center, the Charles County Department of Health, and all other participating agencies of the Partnerships for a Healthier Charles County to undertake health prioritization and to create the county health improvement plan.

After a thorough analysis of all quantitative data on the health of Charles County and of the qualitative data gathered from the community, a list of health priorities will be developed to help guide future endeavors to improve the health of Charles County.

The Steering Committee of the Partnerships for a Healthier Charles County will use the National Association of City and County Health Officials (NACCHO) recommended Hanlon Method for health prioritization. The Hanlon Method for Prioritizing Health Problems is a well-respected technique which objectively takes into consideration explicitly defined criteria and feasibility factors. Though a complex method, the Hanlon Method is advantageous when the desired outcome is an objective list of health priorities based on baseline data and numerical values.

Once the health priorities are established, the action teams of the Partnerships for a Healthier Charles County will be restructured to address the current needs of the county. From there, the teams will develop 3-year action or work plans for Fiscal Years 2025-2027 using the SMARTIE template. SMARTIE stands for Strategic, Measurable, Ambitious, Realistic, Time-bound, Inclusive, and Equitable.

A SMARTIE goal is:

- Specific — It reflects some important dimension of what an organization seeks to accomplish.
- Measurable — It includes a standard or benchmark to be met.

- Achievable or Ambitious — It is challenging to the degree that accomplishment would mean significant progress or even a “stretch” for the organization.
- Relevant or Realistic — It isn’t overly challenging or reflective of too little thought to resources or execution.
- Timebound — It includes a clear deadline.
- Inclusion is an opportunity to bring traditionally excluded individuals and groups into processes, activities, decisions, and policy making in a way that shares power. While diversity is about who is present at the table, inclusion is about who is empowered to make decisions or participate in a meaningful way.
- Equity means including an element of fairness or justice to address systemic injustice, inequity, or oppression.

CHARLES COUNTY

Community Health Improvement Plan

Long-Term Objectives FY2025-2027

UM CHARLES REGIONAL MEDICAL CENTER

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Charles County health improvement plan FY2025-FY2027

Overview of the Needs Assessment Process:

From July 2023 to February 2024, the University of Maryland Charles Regional Medical Center, the Charles County Department of Health, and the Partnerships for a Healthier Charles County undertook a comprehensive assessment of the health needs of Charles County, Maryland.

To provide a comprehensive assessment of the health needs of the county, a four-method plan was developed, which included 5 different sources of data: a long online survey of Charles County residents' perceptions of health and health behaviors, a short paper survey on health perceptions throughout the county, focus groups with community members and leaders, and a quantitative data analysis of secondary, published data. Data collection occurred between July 2023 and December 2023.

The use of multiple data collection methods strengthened the validity of the assessment's findings as well as ensuring that Charles County residents had an opportunity to participate in the assessment process and to provide recommendations and suggestions for programming to address their communities.

Six focus groups were conducted with the participation of community members from various backgrounds. The goal of each focus group was to gain feedback, gather insights, and obtain opinions and perceptions of the current health status in Charles County. The six focus groups included: the Charles County school nurses, members of the Partnerships for a Healthier Charles County Local Health Improvement Coalition, Charles County Access to Care Coalition members, Healthcare Consumers and Community Leaders, Chronic Disease Prevention and Management Coalition members, and Charles County Overdose Fatality Review Team members.

The biggest issues to emerge from the focus groups included:

- Behavioral Health Services and Resources
- Transportation
- Access to Care
- Specialty Services
- Obesity/Overweight
- Cost of Living (health care costs, housing, food, inflation)

755 people completed the 51-question online survey between July 1, 2023 and December 31, 2023. It was designed using Survey Monkey, and a link was provided on the University of Maryland Charles Regional Medical Center website and the Charles County Department of Health website. The first set of questions gathered demographic information for all participants. A second set of questions asked people about their own health status and their access to needed health care. A third set of questions asked participants about their risk factors for health conditions (for example, fruit and vegetable intake, physical activity level, alcohol/tobacco use) to determine if they are at risk for certain health conditions and chronic diseases. The fourth set of questions asked participants about their perceptions of the state of health and health conditions within Charles County. A fifth set of questions asked participants perceptions of improvements within the county to improve health. Lastly, survey respondents were given the opportunity to comment on

the state of health in the county and provide suggestions on how to improve the health status of Charles County.

Most of the respondents were from Charles County (85.4%). The second largest percentage is from St. Mary's County (5.6%). Only 5.68% of respondents reported living outside of Southern Maryland (Charles, Calvert, St Mary's, or Prince George's). Approximately 67.15% of the respondents were between the ages of 45-74 years. The highest percentage was in the 45-54-year age group (25.66%). The overwhelming majority of the respondents were assigned female at birth (79.52%).

This report represents a more diverse group of respondents. Minorities made up 47.16% of the total surveyed population. This is a large increase from 26% reported in the last needs assessment report. African Americans comprised 41.49% of the respondents. This is an increase from 22% in the FY21 needs assessment report. Approximately 4.47% of the survey respondents self-identified as Hispanic.

The survey participants were a highly educated group with 91.16% reporting having had some college education. Just over half of the group had completed an undergraduate degree or higher (59.12%). Most of the participants were employed and working full-time.

Individuals from all income levels were represented in the surveyed population. Individuals who reported a household income of $180,000 or more per year represented 19.49% of the respondents. Individuals with a household income less than $60,000 made up one-sixth of the 2023 survey (15.4%). This represents all individuals responding that their household income was either $0-$29,999 or $30,000-$59,999.

Nearly all the survey participants (96.32%) reported having health insurance. Most of the participants also reported having dental insurance (84.72%), though this percentage is smaller than those reporting health insurance. Many of the respondents also had vision insurance (74.62%). Only 1.5% of the survey population reported having no type of insurance.

The top 5 serious health issues for Charles County residents were affordable housing, obesity, crime, drug use, and affordable healthcare. Social determinants of health, such as housing and crime, have come to the forefront during this needs assessment.

The protective health behaviors that Charles County residents were displaying included: always wearing a seat belt, washing hands after using the bathroom or making food, practicing safe sex, getting a flu shot, and following road safety rules.

Some risk factors that Charles County residents possessed that may lead to chronic disease included: not participating in physical activity each day, not eating enough fruits and vegetables, not performing self-exams for cancer, not getting enough sleep at night, and not using sunscreen regularly.

The online survey participants were also asked about access to health care. 84.9% have had a routine doctor's visit in the past 12 months. 93.37% receive their routine health care in a primary care physician or provider's office.

64.94% were always able to see a doctor when needed. If they were unable to see the doctor when needed, the most common reasons were that there were no available appointments (41.3%) or that it was too expensive, and they could not afford it (3.75%).

78.26% travel outside of Charles County for medical care at some point. Only 13.18% reported

that they always travel outside the county for care. The most common medical services that people receive outside of Charles County are specialist doctor appointments (60.62%), dental appointments (21.68%), primary care doctor appointments (30.24%), and surgeries (20.94%). The most common responses among participants were that the quality is better elsewhere (41.12%) and services are not available in Charles County (24.67%).

A short 5-question survey was developed to distribute throughout the county for additional qualitative data from July 1, 2023, through December 31, 2023. A total of 1,189 surveys were completed throughout the community. Short survey data collection was performed at various community events throughout the county.

Emphasis was given to the collection of data among the county's vulnerable populations, including the medically underserved, the homeless, and the geographically isolated. An ongoing survey collection was conducted at the Charles County Department of Health and the University of Maryland Charles Regional Medical Center. Short surveys were collected during blood drives at the University of Maryland Charles Regional Medical Center (CRMC), the Red Cross Blood Drive, and church Blood Drives. CRMC also coordinated with the Charles County Department of Health to distribute surveys at the Charles County Fair. The Charles County Department of Health conducted survey collection at all community outreach events attended from July to December 2023. Emphasis was given to the western region of the county, that is more geographically isolated. Surveys collection was conducted at Fruit and Vegetable distribution sites and at the Nanjemoy Heritage Day. The community was also surveyed at large events such as the Charles County Fair, blood drives, Charles County Government Wellness Fair and Rodeo, Recovery Day, food drives, and other community outreach events.

The biggest health problems identified by the short community survey included: obesity, drug and alcohol use, mental health, heart disease, cancer, and high blood pressure/stroke. Common themes for recommendations included access to care, mental health, transportation, substance use, and outreach.

The most cited barriers to needed health care were care is too expensive/can't afford it (56.6%) and lack of health insurance (41.0%). Over 20% of respondents also identified transportation and not being able to get an appointment with their doctor as barriers to needed health care as well. Under "Other", several respondents explained that there is an issue trying to get in to see a provider. Respondents expressed that there are not enough health care providers, no available appointments for months, hard to find new doctors when needed, not enough doctor's offices, hard to get appointments, not enough specialist providers, hard to find a primary care doctor they like, providers not accepting new patients, and lack of providers that take Medicaid in the psychiatric department. Other barriers were distrust of health care providers, no time off from work, poverty, lack of education, unreliable services, overcrowded ER facility, insurance is not accepted, limited eye doctors, and no prevention.

Short survey participants were asked if sufficient services are available to address the health conditions in Charles County. Many of the respondents answered that they did not know, or they left it blank. This leads us to believe that additional outreach and awareness campaigns are needed to educate people on available services in Charles County.

There were very few survey respondents who believed there were no services available for the listed health conditions. Of those who did answer, there were no services available in the county, Mental Health, Traffic Safety/Injuries, and Access to healthcare in rural Charles County had the most responses.

Quantitative data was analyzed for various health topics, including: mortality, population and demographic data, natality, infant mortality, social determinants of health, heart disease, stroke, hypertension, access to health care/health un-insurance, cancer, asthma, injuries, diabetes, food, physical activity, obesity, arthritis, dementia/Alzheimer's disease, infectious disease, environmental health, sexually transmitted diseases, HIV/AIDS, mental health, dental health, substance use, disabilities, violence, social determinants of health, and tobacco use.

The current assessment findings are an update from the Fiscal Year 2021 community health needs assessment report and health improvement plan. 25% of the objectives outlined in the Charles County Health Improvement Plan reached their anticipated goals in the given time frame.

Thanks to the work of the Partnerships for a Healthier Charles County and its teams, the Charles County Health Improvement Plan objectives have been met for:

- Preventable Hospital Stay Rate decreased
- Number of medical practices increased

Charles County Health Improvement Plan objectives that were not met include:

- Percentage of residents who did not see a doctor in the last year due to cost increased
- Percentage of Charles County residents who received a flu vaccination increased but did not reach goal
- Drug-induced death rate decreased but did not reach goal
- Childhood obesity percentage increased
- Adult obesity percentage increased

3 Charles County Health Improvement Plan objectives where updated data was not available: mental health, hypertension, and diabetes emergency department visit rates.

The data from this community health needs assessment will be used to develop the next Charles County health improvement plan and subsequent action plans. They provide the county with measurable outcomes and benchmarks for 3-year program implementation.

Charles County Health Prioritization Process:

After a thorough analysis of all quantitative data on the health of Charles County and of the qualitative data gathered from the community, a list of health priorities will be developed to help guide future endeavors to improve the health of Charles County.

The Steering Committee of the Partnerships for a Healthier Charles County has chosen to use the National Association of City and County Health Officials (NACCHO) recommended the Hanlon Method for health prioritization. The Hanlon Method for Prioritizing Health Problems is a well-respected technique, which objectively takes into consideration explicitly defined criteria and feasibility factors. Though a complex method, the Hanlon Method is advantageous when the desired outcome is an objective list of health priorities based on baseline data and numerical values.

A list of health problems is identified using the health data section of the community health needs assessment report. Then, using a scale of O to 10, each health problem is rated on the following criteria: size of the health problem, magnitude of the health problem, and effectiveness of potential interventions. The table below represents the numerical rating system for rating health problems against the criteria.

The Hanlon Method: Sample Criteria Rating

Rating	Size of Health Problem *(% of population w/health problem)*	Seriousness of Health Problem	Effectiveness of Interventions
9 or 10	>25% (STDs)	Very serious (e.g. HIV/AIDS)	80% - 100% effective (e.g. vaccination program)
7 or 8	10% - 24.9%	Relatively Serious	60% - 80% effective
5 or 6	1% - 9.9%	Serious	40% - 60% effective
3 or 4	.1% - .9%	Moderately Serious	20% - 40% effective
1 or 2	.01% - .09%	Relatively Not Serious	5% - 20% effective
0	< .01% (Meningococcal Meningitis)	Not Serious (teen acne)	<5% effective (access to care)

The size of the problem is based on the baseline data collected on the county population through the community health needs assessment. If more than one data measure is available for a particular health topic, an average of the percentages is calculated to determine the size of the problem. Prevalence data is used whenever available; however, mortality data is used as a proxy measure when reliable prevalence sources are not available.

The seriousness of the problem is determined by asking a series of questions regarding the status of the health problem in the community. A score is determined based on the number of questions with an answer of “yes.”

The seriousness of the problem questions included:

- Does it require immediate attention?
- Is there a public demand?
- What is the economic impact?

• What is the impact on quality of life?

• Is there a high hospitalization rate?

• Is the disparity between the county rate and state and national rates?

• Do racial/age/gender/ethnic disparities exist?

The effectiveness of the interventions is determined using the Centers for Disease Control and Prevention's (CDC) Guide to Community Preventive Services. The guide gives examples of evidence-based strategies that have been implemented to address each health problem. Systematic reviews are conducted on all available interventions, and they rank the evidence-based strategies as: recommended, not recommended, or insufficient evidence. The basis of the rankings is presented below.

Recommended:

The systematic review of available studies provides strong or sufficient evidence that the intervention is effective.

> The categories of "strong" and "sufficient" evidence reflect the Task Force's degree of confidence that an intervention has beneficial effects. They do not directly relate to the expected magnitude of benefits. The categorization is based on several factors, such as study design, number of studies, and consistency of the effect across studies.

Recommended Against:

The systematic review of available studies provides strong or sufficient evidence that the intervention is harmful or not effective.

Insufficient Evidence:

The available studies do not provide sufficient evidence to determine if the intervention is, or is not, effective. This does **NOT** mean that the intervention does not work. It means that additional research is needed to determine whether or not the intervention is effective.

Task Force findings may include a rationale statement that explains why they made a recommendation or arrived at other conclusions.

To determine the effectiveness of interventions, the percentage of available interventions that received a recommended score from the CDC's Guide to Community Preventive Services is calculated. Information is available in the guide for all health problems on the list.

Based on the three criteria rankings assigned to each health problem in Step 1 of the Hanlon Method, the priority scores are calculated using the following formula:

$$D= [A+ (2 \times B)] \times C$$

Where: D= Priority Score

A= Size of the health problem ranking

B= Seriousness of the health problem ranking

C= Effectiveness of the Intervention ranking

*Note: The seriousness of the health problem is multiplied by two because, according to the Hanlon technique, it is weighted as being twice as important as the size of the health problem.

Based on the priority scores calculated in Step 2 of the Hanlon Method, ranks are assigned to each health problem, with the highest priority score receiving the rank of 1, the next high priority score receiving a rank of 2, and so on. The table below represents the results of the Hanlon Method ranking and priority scoring.

Health Problem:	Size (A)	Seriousness (B)	Effectiveness of Intervention (C)	Priority Score (A+2B)C	Rank
Heart Disease	10	9	10	280	1
Diabetes	7	9	9	225	6
Asthma/Lung Diseases	8	7	7	154	11
Cancer	9	7.9	6	148.8	13
Mental Health	7	9.6	9	235.8	4
Tobacco Use/Smoking	8	6	5	100	16
Infectious Disease	7	6.5	10	200	8
Environmental health	7	5.3	7	123.2	14
Injuries	5	6.1	7	120.4	15
Hypertension/Stroke	10	9	10	280	1
Obesity/Nutrition/Physical activity	10	9.5	7	203	7
Dental health	6	6.9	5	99	17
Access to Care	9	8.8	7	186.2	9
Infant Mortality	4	6.5	10	170	10
STI/HIV/AIDS	5	9.3	7	151.2	12
Substance Use Disorders	10	9.6	8	233.6	5
Social Determinants of Health	10	9.8	8	236.8	3

Based on the priority score from the Hanlon Method, the health priorities chosen include:

1. Chronic Disease Prevention and Management

- Major Cardiovascular Disease (Heart Disease, Hypertension, and Stroke)
- Diabetes Prevalence
- Obesity and Nutrition/Physical Activity
- Food Insecurity

2. Behavioral Health

- Substance Use Disorders

- Mental Health

3. Access to Care

- Social Determinants of Health (transportation, health literacy}
- Recruit and retain a healthcare and public health workforce.

Charles County health improvement plan long-term objectives FY2025-2027

Priority One: Chronic Disease Prevention and Management

Obesity

1. Maintain or improve the percentage of Charles County adults who are at a healthy weight at/from 23.2% (combat yearly increases).
   Source: Maryland Behavioral Risk Factor Surveillance System
2. Maintain the percentage of Charles County high school students who are obese at 15.5% (combat yearly increases).
   Source: Maryland Youth Risk Behavior Survey

Food Insecurity

1. Lower the percentage of Charles County residents who do not have a reliable source of food from 7% to 5%.
   Source: Robert Wood Johnson Foundation County Health Rankings

Diabetes

1. Reduce the Charles County diabetes death rate from 41.5 per 100,000 to 39.4 per 100,000 (5% decrease).
   Source: Maryland Vital Statistics Report

Major Cardiovascular Disease

1. Increase the percentage of Charles County residents with diagnosed hypertension who are taking medication to control it from 68.2% to 71.6% (5% increase).
   Source: Maryland Behavioral Risk Factor Surveillance System
2. Reduce the Charles County heart disease death rate from 165.7 per 100,000 to 155 per 100,000.
   Source: Maryland Vital Statistics Report

Priority Two: Access to Care

Social Determinants of Health

1. Decrease the percentage of Charles County residents who report that they were unable to see a doctor in the past 12 months due to cost from 8.8% to 8.4% (5% reduction).
   Source: Maryland Behavioral Risk Factor Surveillance System

Recruit and Retain a Healthcare and Public Health Workforce

1. Increase the proportion of persons with a usual primary care provider from 87.7% to 90%.
   Source: Maryland Behavioral Risk Factor Surveillance System

Priority Three: Behavioral Health

Mental Health

1. Reduce the percentage of Charles County high school students who felt sad or hopeless most days for more than 2 weeks in the last 12 months from 38.6% to 35% (10% decrease).
   Source: Maryland Youth Risk Behavior Survey

2. Decrease the percentage of Charles County adults who report having 3-5 days in the last month when their mental health was not good from 14.1% to 13.4% (5% decrease).
   Source: Maryland Behavioral Risk Factor Surveillance System

Substance Use Disorders

1. Reduce the Charles County drug-induced death rate from 26.8 per 100,000 to 25 per 100,000.
   Source: County Health Rankings

Strategy: *Recruit and Retain a Healthcare and Public Healthcare Workforce*	Enhance county capacity to recruit and retain healthcare and public healthcare workforce.			
Long Term or Outcome Objective:	Increase the proportion of persons with usual primary care providers from 87.7% to 90%.			
Activity/Key Action Steps	**Measures**	**Key Partners**	**Timeline**	**Comments**
Recruit additional healthcare providers and specialists to the county.	• Charles County Population to Primary Care Provider Ratio Source: County Health Rankings • The number of Primary Care Practices and Behavioral Health Practices started in Charles County. • The number of media campaigns initiated.	University of Maryland Charles Regional Medical Center Charles County Department of Health Medstar Kaiser NDG	July 1, 2024 – June 30, 2027	
Provide support to present Primary Care Practices in Charles County by providing resources through offering Care Transition Organization services.	• The number of individuals assisted through care transition services. • Number of county practices educated on resources.	University of Maryland Charles Regional Medical Center	July 1, 2024- June 30, 2027	
Develop video series to promote careers in healthcare for use on social media	• Number of videos posted to promote careers in healthcare.	NDG UMMS	July 1, 2024- June 30, 2027	
Internship and training for students pursuing a healthcare career.	• Number of students interned. • Number of colleges	University of Maryland Charles Regional Medical Center Charles County Department of Health NDG	July 1, 2024- June 30, 2027	

Strategy: Social Determinants of Health	Decrease the social determinants of health and barriers to healthcare access for Charles County Residents.			
Long-Term or Outcome Objective:	Decrease the percentage of Charles County residents who report that they could not see a doctor in the past 12 months due to cost from 8.8% to 8.4% (5% reduction). Source: Maryland Behavioral Risk Factor Surveillance System			
Activity/Key Action Steps	**Measure**	**Key Partners**	**Timeline**	**Comments**
Attend community events and programs to provide information on available county health services.	• Number of encounters per community event • Number of agencies attending community events	University of Maryland Charles Regional Medical Center Charles County Department of Health	July 1, 2024 – June 30, 2027	
Increase the county's capacity to implement evidence-based community health worker models which can provide culturally competent, individualized case management, patient navigation, and health education.	• Number of Community Health Worker models created, developed, or planned. • Number of new certified community health workers employe	University of Maryland Charles Regional Medical Center Charles County Health Department Charles County Board of Education College of Southern Maryland	July 1, 2024-June 30, 2027	
Engage community health stakeholders in the bimonthly Access to Care meetings to share and gather information on services available.	• Number of meetings held. • The number of new members recruited.	Charles County Health Department University of Marland Charles Regional Medical Center Health Partners Lifestyles Charles County Sheriff's Office Charles County Board of Education	July 1, 2024 – June 30, 2027	

Strategy:	**<u>Community Education and Outreach</u>: Engage and educate all segments of the community on behavioral health to promote resources, to reduce stigma, and to increase awareness.**			
Long Term or Outcome Objective:	1. Reduce the percentage of Charles County high school students who felt sad or hopeless most days for more than 2 weeks in the last 12 months from 38.6% to 35% (10% decrease). Source: Maryland Your Risk Behavior Survey 2. Decrease the percentage of Charles County adults who report having 3-5 days in the last month when their mental health was not good from 14.1% to 13.4% (5% decrease). Source: Maryland Behavioral Risk Factor Surveillance System			
Activity/Key Action Steps	**Measures**	**Key Partners**	**Timeline**	**Comments**
Expand the Mental Health First Aid training in the Charles County Public Schools and in the general community.	• Number of Mental Health First Aid Trainings Conducted • Number of people educated on Mental Health First Aid • Number of agencies represented at trainings	Charles County Public Schools Local Behavioral Health Authority Charles County Department of Health	July 1, 2024-June 30, 2027	
Promote and create behavioral health campaigns in Charles County to increase knowledge and reduce stigma.	• Number of media campaigns initiated • Number of community events where the campaigns were promoted • Number of county residents who were educated on the campaigns • Number of UMMS Webinars on Mental Health and Behavioral Health promoted to the community	Charles County Department of Health University of Maryland Charles Regional Medical Center All Behavioral Health Team members	July 1, 2024-June 30, 2027	
Expand Crisis Intervention Training	• Number of partners recruited • Number of people trained • Number of crisis intervention teams established	Charles County Department of Health Local Behavioral Health Authority Charles County Sheriff's Office La Plata Police Department Southern Maryland Criminal Justice Academy	July 1, 2024-June 30, 2027	

Strategy:	**Increase county capacity to provide services and treatment for opioid use and overdose.**			
Long Term or Outcome Objective:	Reduce the Charles County drug-induced death rate from 26.8 per 100,000 to 25 per 100,000.			
Activity/Key Action Steps	**Measure**	**Key Partners**	**Timeline**	**Comments**
Train county agencies and community members on Naloxone distribution and educate on replacing Narcan kits after expiration.	• Number of trainings held • Total Number of individuals trained • Number of agencies trained on Naloxone administration • Number of law enforcement officers trained • Number of Naloxone kits distributed • Number of Naloxone kids replaced	Charles County Department of Health Local Behavioral Health Authority University of Maryland Charles Regional Medical Center Charles County Department of Emergency Services Charles County Sheriff's Office La Plata Police Department	July 1, 2024-June 30, 2027	
Educate the community on the risks and dangers of using opioids and heroin.	• Number of media campaigns developed and initiated • Number of adults educated on opioid risks • Number of presentations given • Number of youth educated on the dangers of opioid use • Number of community events held on opioids	Charles County Department of Health Local Behavioral Health Authority University of Maryland Charles Regional Medical Center Maryland Coalition for Families Charles County Public Schools	July 1, 2024-June 30, 2027	
Promote and expand the Charles County Sheriff's Office Prescription Take Back Program.	• Number of flyers created • Number of Take Back days conducted • Number of flyers distributed in the community • Number of new boxes installed at CCSO locations • Number of pounds of medication disposed each year	Charles County Department of Health Local Behavioral Health Authority University of Maryland Charles Regional Medical Center Charles County Sheriff's Office	July 1, 2024-June 30, 2027	
Establish a Charles County Harm Reduction Program.	• Number of syringe services programs developed • Number of community events attended to spread the word. • Number of people educated • Number of wound care kits distributed • Number of Narcan kits distributed • Number of Fentanyl test strips distributed • Number of Xylazine test strips distributed.	Charles County Department of Health	July 1, 2024-June 30, 2027	
Promote the Charles County Sheriff's Office HOPE trailer to teach parents about the potential for drug and opioid use among children and adolescents.	• Number of parents educated using the HOPE trailer • Number of events where the HOPE trailer is in attendance	Charles County Department of Health Charles County Sheriff's Office	July 1, 2024-June 30, 2027	

Strategy for *Adult Obesity*	Create a community of wellness through community engagement and evidence-based programming for adults			
Long Term or Outcome Objective:	Maintain or improve the percentage of Charles County adults who are at a healthy weight at/from 23.2% (combat yearly increases). Source: Maryland Behavioral Risk Factor Surveillance System			
Activity/Key Action Steps	**Measures**	**Key Partners**	**Timeline**	**Comments**
Offer Stanford University's Chronic Disease Self-Management (CDSMP), Diabetes Self-Management (DSMP)	Number of evidence-based programs offered Number of participants enrolled	Charles County Department of Health (CCDOH), University of Maryland Charles Regional Medical Center (UMCRMC), Office on Aging	Classes will be offered quarterly	
Offer the CDC's Diabetes Prevention Program (DPP) in the county	Number of Participants enrolled in DPP programs Number of participants losing 4-7% of their initial body weight Number of participants reported a reduction in HgA1c	CCDOH serves as the lead agency for the DPP. They will develop the schedule, coordinate and facilitate cohorts. All LHIC members will assist with advertising and referrals.	FY25-FY27	
Maintain a TOPS chapter	Number of members	CCDOH	Meetings are held every Tuesday	
Physical activity opportunities will be offered to adults in Charles County. Includes; Walk with Ease, classes offered at the senior centers, sessions offered to DPP and TOPS participants, sessions offered to parents in teen court, monthly community walks, etc.	Number of opportunities offered	CCDOH, Parks, Recreation and Tourism, Charles County Senior Centers, CCSO	FY25-FY27	

Strategy: *Childhood Obesity*	Create a community of wellness through community engagement for children and their families			
Long Term or Outcome Objective:	Maintain the percentage of Charles County high school students who are obese at 15.5% (combat yearly increases). Source: Maryland Youth Risk Behavior Survey			
Activity/Key Action Steps	**Measure**	**Key Partners**	**Timeline**	**Comments**
Educate children and their families on the importance of physical activity and good nutrition	Number of social media posts Number of views	All LHIC Members	FY25-FY27	
Offer a family obesity program (MEND/CATCH)	Number of cohorts held Number of participants	CCDOH, Charles County Parks, Recreation and Tourism	FY25-FY27	
Offer physical activity programs to r children/youth in Charles County	Number of opportunities offered	CCSO, CCPS, CCDOH		

Strategy: *Food Security*	Create community awareness of food insecurity through data collection and evidence-based interventions.			
Long Term or Outcome Objective:	Lower the percentage of Charles County residents who do not have a reliable source of food from 7% to 5%. Source: Robert Wood Johnson Foundation County Health Rankings			
Activity/Key Action Steps	**Measure**	**Key Partners**	**Timeline**	**Comments**
Offer food demonstrations to address food security issues for families. Demonstrations will include; how to chop, cook and prepare fresh fruits and vegetables, how to flavor food without sodium, how to prepare quick affordable foods, how to choose healthier cooking ingredients, how to shop affordably, etc.	Number of food demonstrations held Number of participants	CCDOH, UM Extension, Office on Aging	FY25-FY27	
Provide healthy food options to citizens in Charles County. Includes; community school food pantries, backpack program, summer lunch program, Southern Maryland Food Bank, FMNP for Seniors, seed libraries, Christ Church refrigerator pantry, Lifestyles purple donation boxes.	Number of families served Number of opportunities held	CCDOH, UMCRMC, Office on Aging, CCPS, Steam Onward, Southern Maryland Food Bank, CCPS, Charles County Food Pantries	FY25-FY27	

Strategy: *Diabetes*	Increase capacity of Charles County diabetes and prediabetes self-management programs.			
Long Term or Outcome Objective:	Reduce the Charles County diabetes death rate from 41.5 per 100,000 to 39.4 per 100,000 (5% decrease). Source: Maryland Vital Statistics Report			
Activity/Key Action Steps	**Measure**	**Key Partners**	**Timeline**	**Comments**
Promotion of the University of Maryland Charles Regional Medical Center's efforts to provide diabetes education.	Number of new patients receiving diabetes education Number of workshops held for under or uninsured patients Number of diabetes support group meetings held	UMCRMC is the lead agency. LHIC partners will share posts relating to diabetes and make referrals to the Diabetes Center.	FY25-FY27	
Participate in outreach events and educational visits in the area of diabetes	Number of opportunities	CCDOH, UM CRMC, Office on Aging	FY25-FY27	
Offer the CDC's Diabetes Prevention Program (DPP) in the county	Number of Participants enrolled in DPP programs Number of participants losing 4-7% of their initial body weight Number of participants reported a reduction in HgA1c	CCDOH serves as the lead agency for the DPP. They will develop the schedule, coordinate and facilitate cohorts. Office on Aging, Health Partners and UMCRMC will assist with referrals.	FY25-FY27	

Strategy: *Major Cardiovascular Disease*	Provide evidence-based programs that will teach citizens to self-monitor their condition.			
Long Term or Outcome Objective:	1. Increase the percentage of Charles County residents with diagnosed hypertension who are taking medication to control it from 68.2% to 71.6% (5% increase). Source: Maryland Behavioral Risk Factor Surveillance System 2. Reduce the Charles County heart disease death rate from 165.7 per 100,000 to 155 per 100,000. Source:			
	Maryland Vital Statistics Report			
Activity/Key Action Steps	**Measure**	**Key Partners**	**Timeline**	**Comments**
Offer Healthy Hearts Start at Home Blood Pressure Self-Monitoring Program to eligible participants.	Number of participants Number of program completers	CCDOH	FY25-FY27	
Provide Tobacco Education and Cessation	Number of opportunities Number of citizens receiving education and/or cessation assistance	CCDOH	FY25-FY27	
Offer Stanford's Hypertension module	Number of programs held Number of participants	CCDOH, UMCRMC, Senior Centers	Quarterly	

University of Maryland Charles Regional Medical Center FY24 Initiatives

Number of workshops: 7

Average participants per workshop: 11.7
Number of participants: 70
Participants with attendance data: 69
DPRP-Attend-Qual. Participants: 20 of 69 (29%)
DPRP-Qual. Participants: 19 of 70 (27%)
Number who are caregivers: 0 of 0

A1c	Count	Pre	Post	Decrease
No A1c	30			
One A1c	37	6.0		
Two A1c's	3	6.2	6.1	0.1

ACL Gender Long	Count	Percent
No answer	70	100%

Age	Count	Percent
0-44	10	14%
44-49	4	6%
50-54	7	10%
55-59	10	14%
60-64	11	16%
65-69	12	17%
70-74	8	11%
75-79	5	7%
80-84	2	3%
85-89	1	1%

Attended Group Session	Count	Percent
1	62	90%
2	60	87%
3	61	88%
4	59	86%
5	59	86%
6	62	90%
7	62	90%
8	59	86%
9	57	83%
10	57	83%
11	55	80%
12	59	86%
13	48	70%
14	59	86%
15	51	74%
16	52	75%
17	48	70%
18	46	67%
19	46	67%
20	38	55%
21	35	51%
22	19	28%
23	9	13%
24	5	7%

CDC Gender	Count	Percent
Female	51	84%
Male	10	16%
Unknown	9	

Chronic Condition	Count	Percent

Hypertension	38	93%
Diabetes	9	22%

Completers	Count	Percent
No	50	71%
Yes	20	29%

Condition Count	Count	Percent
One chronic condition	35	50%
No chronic conditions	29	41%
Multiple chronic conditions	6	9%

Disabilities	Count	Percent
Diff. walking or climbing stairs	11	16%
Hearing impaired	7	10%
Diff. remembering	6	9%
Diff. with errands	6	9%
Visually impaired	3	4%
Diff. dressing	3	4%

Disability Count	Count	Percent
No disabilities	47	73%
One disability	9	14%
Multiple disabilities	8	12%
Unknown	6	

Education	Count	Percent
Completed College	30	45%
Some College	22	33%
Completed High School	12	18%

Some High School	2	3%
Unknown	4	

Ethnicity/Race	Count	Percent
Black or African American	40	59%
White/Caucasian	25	37%
American Indian or AK Native	2	3%
Asian or Asian American	2	3%
Hispanic/Latino	2	3%
Unknown	2	

GDM	Count	Percent
No	55	79%
Yes	1	1%

Gender	Count	Percent
Female	56	80%
Male	14	20%

How Did You Hear	Count	Percent
Media: poster/flyer, etc.	12	21%
Doctor/Health Care Provider	11	19%
Friends or family	9	16%
Other: mail	7	12%
Organization	4	7%
Social media	4	7%
Other: community outreach events	2	4%
Media: billboard	1	2%
Other	7	12%

Insurance	Count	Percent
Medicare	12	39%
Carefirst BlueCross BlueShield	10	32%
BlueCross	4	13%
TriCare	3	10%
Aetna	3	10%
Kaiser Permanente	3	10%
Cigna	2	6%
No Insurance	1	3%
Medicare Part B ("Regular" Medicare)	1	3%
Medicaid FFS (Fee For Service)	1	3%
Unknown	39	

Last Group Session Attended	Count	Percent
1	0	0%
2	0	0%
3	1	1%
4	0	0%
5	0	0%
6	0	0%
7	0	0%
8	0	0%
9	0	0%
10	0	0%
11	1	1%
12	1	1%
13	1	1%
14	1	1%
15	7	10%

16	2	3%
17	1	1%
18	3	4%
19	11	16%
20	3	4%
21	17	25%
22	11	16%
23	4	6%
24	5	7%

Minutes of Activity for DPRP-Qual. Participants	Count	Percent
0-19 Minutes	0	0%
30-74 Minutes	1	5%
75-149 Minutes	8	42%
150+ Minutes	10	53%

Number of Group Sessions Attended	Count	Percent
1	0	0%
2	0	0%
3	1	1%
4	0	0%
5	0	0%
6	1	1%
7	1	1%
8	0	0%
9	4	6%
10	3	4%
11	1	1%
12	5	7%
13	2	3%

14	3	4%
15	0	0%
16	5	7%
17	3	4%
18	6	9%
19	13	19%
20	3	4%
21	5	7%
22	7	10%
23	2	3%
24	4	6%

Organization	Count	Percent
Charles County Department of Health	70	100%

Participant County	Count	Percent
Charles, MD	70	100%

Participant Funding	Count	Percent
Prevention Link	10	100%
None	60	

Payment Source	Count	Percent
Not reported	70	100%

Percent Weight Change For DPRP-Qual. Participants	Count	Percent
7.00%+ Loss	4	21%
5.00%-6.99% Loss	2	11%
3.00%-4.99% Loss	5	26%

1.00%-2.99% Loss	5	26%
0.99% Loss-0.99% Gain	3	16%
1.00%-2.99% Gain	0	0%
3.00%-4.99% Gain	0	0%
5.00%-6.99% Gain	0	0%
7.00%+ Gain	0	0%
Average Weight Loss Percent		4.46%

Prediabetes	Count	Percent
Yes	45	85%
No	8	15%
Unknown	17	

Served in Military	Count	Percent
No	70	100%

Type of Test	Count	Percent
A1C	40	57%
Risk Test	30	43%
Fasting Glucose	2	3%

Workshop Funding	Count	Percent
None	70	

Diabetes Self-Management (DSMP)
July 1, 2023 - June 30, 2024

Number of workshops: 1

Average participants per workshop: 8.0
Number of participants: 8
Participants with attendance data: 8
Completers: 7 of 8 (88%)
Number who are caregivers: 2 of 5 (40%)
May 7, 24—Indian Head Senior Center

A1c	Count	Pre	Post	Decrease
No A1c	8			
One A1c	0	0		
Two A1c's	0	0	0	0

ACL Gender	Count	Percent	Bar
Woman	6	86%	
Man	1	14%	
Unknown	1		

ACL Gender Long	Count	Percent	Bar
Straight	6	75%	
Noanswer	2	25%	

Age	Count	Percent	Bar
0-44	1	14%	
60-64	1	14%	
70-74	2	29%	
80-84	1	14%	
85-89	2	29%	
Unknown	1		

Caregiver	Count	Percent	Bar
No	3	60%	
Yes	2	40%	
Unknown	3		

Chronic Condition	Count	Percent	Bar
Diabetes	4	57%	
Obesity	4	57%	
Hypertension	4	57%	
Cancer	2	29%	
Arthritis	2	29%	
Chronic Pain	1	14%	
Kidney Disease	1	14%	

Completers	Count	Percent	Bar
Yes	7	88%	
No	1	12%	

Condition Count	Count	Percent	Bar
Multiple chronic conditions	6	75%	
No chronic conditions	1	12%	
One chronic condition	1	12%	

Disabilities	Count	Percent	Bar
Diff. remembering	1	12%	
Hearing impaired	1	12%	
Visually impaired	1	12%	
Diff. walking or climbing stairs	1	12%	
Diff. with errands	1	12%	

Disability Count	Count	Percent	Bar
No disabilities	4	57%	
One disability	2	29%	
Multiple disabilities	1	14%	
Unknown	1		

Education	Count	Percent	Bar
Some College	4	57%	
Completed High School	2	29%	
Completed College	1	14%	
Unknown	1		

Ethnicity/Race	Count	Percent	Bar
Black or African American	5	71%	
White/Caucasian	2	29%	
Unknown	1		

Impacted by COVID-19	Count	Percent	Bar
No	8	100%	

Lives Alone	Count	Percent	Bar
Yes	4	57%	
No	3	43%	
Unknown	1		

Number of Group Sessions Attended	Count	Percent	Bar
1	0	0%	
2	0	0%	
3	1	12%	

4	3	38%	
5	0	0%	
6	4	50%	

Organization	Count	Percent	Bar
Charles County Department of Community Services, Aging & Human Services Division	8	100%	

Participant County	Count	Percent	Bar
Charles	7	88%	
Charles, MD, MD	1	12%	

Participant Funding	Count	Percent	Bar
None	8		

Payment Source	Count	Percent	Bar
Not reported	8	100%	

Referred	Count	Percent	Bar
No	4	67%	
Yes	2	33%	
Unknown	2		

Served in Military	Count	Percent	Bar
No	6	86%	
Yes	1	14%	
Unknown	1		

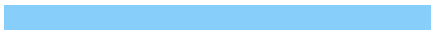
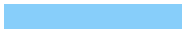
Virtual Workshop	Count	Percent	Bar
No	8	100%	

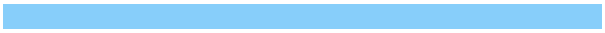
Workshop Funding	Count	Percent	Bar
None	8		

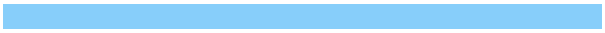
Felt welcomed	Count	Percent	Bar
Strongly Agree (1)	7	100%	
Average Value	1		

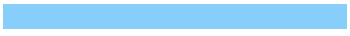
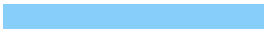
Teaching was shared	Count	Percent	Bar
Strongly Agree (1)	6	86%	
Average Value	1		

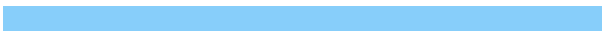
Leaders were prepared	Count	Percent	Bar
Strongly Agree (1)	7	100%	
Average Value	1		

I have more self-confidence	Count	Percent	Bar
Strongly Agree (1)	5	71%	
Agree (2)	2	29%	
Average Value	1.3		

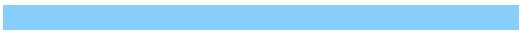
Book was helpful	Count	Percent	Bar
Strongly Agree (1)	7	100%	
Average Value	1		

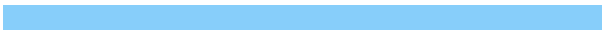
Learned action plans	Count	Percent	Bar
Strongly Agree (1)	7	100%	
Average Value	1		

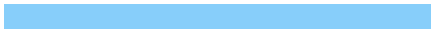
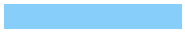
Better manage symptoms	Count	Percent	Bar
Strongly Agree (1)	4	57%	
Agree (2)	3	43%	
Average Value	1.4		

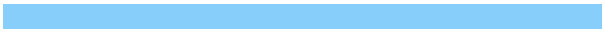
Site was conducive	Count	Percent	Bar
Strongly Agree (1)	7	100%	
Average Value	1		

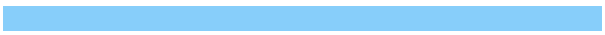
Part. valued contributions	Count	Percent	Bar

Strongly Agree (1)	6	86%	
Agree (2)	1	14%	
Average Value	1.1		

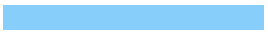
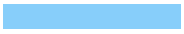
Leaders managed group	Count	Percent	Bar
Strongly Agree (1)	7	100%	
Average Value	1		

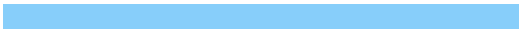
Leaders valued contributions	Count	Percent	Bar
Strongly Agree (1)	5	71%	
Agree (2)	2	29%	
Average Value	1.3		

Leaders got along	Count	Percent	Bar
Strongly Agree (1)	7	100%	
Average Value	1		

Valued break time	Count	Percent	Bar
Strongly Agree (1)	7	100%	
Average Value	1		

Noticed participants missing	Count	Percent	Bar
Strongly Agree (1)	1	14%	

Agree (2)	3	43%	
Disagree (3)	1	14%	
Strongly Disagree (4)	2	29%	
Average Value	2.6		

Feel more motivated	Count	Percent	Bar
Strongly Agree (1)	6	86%	
Agree (2)	1	14%	
Average Value	1.1		

Chronic Disease Self-Management (CDSMP)
July 1, 2023 - June 30, 2024

Number of workshops: 2

Average participants per workshop: 9.5
Number of participants: 19
Participants with attendance data: 19
Completers: 14 of 19 (74%)
Number who are caregivers: 2 of 16 (12%)

Jul 10, 23—Charles Regional Medical Center - Kent Building
Oct 30, 23—University of Maryland Charles Regional Medical Center

A1c	Count	Pre	Post	Decrease
No A1c	19			
One A1c	0	0		
Two A1c's	0	0	0	0

ACL Gender	Count	Percent	Bar
Woman	7	78%	
Man	2	22%	
Unknown	10		

ACL Gender Long	Count	Percent	Bar
No answer	10	53%	
Straight	9	47%	

Age	Count	Percent	Bar
55-59	2	11%	
60-64	3	17%	
65-69	1	6%	
70-74	3	17%	
75-79	7	39%	

80-84	2	11%	
Unknown	1		

Caregiver	Count	Percent	Bar
No	14	88%	
Yes	2	12%	
Unknown	3		

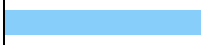
CDC Gender	Count	Percent	Bar
Female	7	70%	
Male	3	30%	
Unknown	9		

Chronic Condition	Count	Percent	Bar
Hypertension	13	76%	
Chronic Pain	10	59%	
Arthritis	9	53%	
Obesity	7	41%	
Osteoporosis	7	41%	
Cancer	6	35%	
Diabetes	6	35%	
Heart Disease	4	24%	
Lung Disease	4	24%	
Stroke	2	12%	
Other	2	12%	

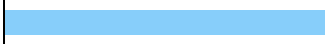
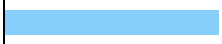
Completers	Count	Percent	Bar
Yes	14	74%	
No	5	26%	

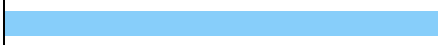
Condition Count	Count	Percent	Bar

Multiple chronic conditions	16	84%	
No chronic conditions	2	11%	
One chronic condition	1	5%	

Disabilities	Count	Percent	Bar
Diff. walking or climbing stairs	6	32%	
Diff. dressing	2	11%	
Diff. remembering	2	11%	
Hearing impaired	1	5%	
Visually impaired	1	5%	
Diff. with errands	1	5%	

Disability Count	Count	Percent	Bar
No disabilities	9	53%	
Multiple disabilities	5	29%	
One disability	3	18%	
Unknown	2		

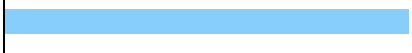
Education	Count	Percent	Bar
Completed College	9	53%	
Some College	6	35%	
Completed High School	2	12%	
Unknown	2		

Ethnicity/Race	Count	Percent	Bar
Black or African American	13	72%	
White/Caucasian	5	28%	
Unknown	1		

GDM	Count	Percent	Bar
No	7	37%	

Gender	Count	Percent	Bar
Female	7	70%	
Male	3	30%	
Unknown	9		

Impacted by COVID-19	Count	Percent	Bar
No	19	100%	

Insurance	Count	Percent	Bar
Medicare Part B ("Regular" Medicare)	6	67%	
BC/BS	5	56%	
AARP	1	11%	
United	1	11%	
Veterans Health	1	11%	
Other	1	11%	
Unknown	10		

Lives Alone	Count	Percent	Bar
Yes	9	50%	
No	9	50%	
Unknown	1		

Number of Group Sessions Attended	Count	Percent	Bar
1	1	5%	
2	2	11%	
3	2	11%	

4	4	21%	
5	3	16%	
6	7	37%	

Organization	Count	Percent	Bar
Charles County Department of Community Services, Aging & Human Services Division	19	100%	

Participant County	Count	Percent	Bar
Charles	17	89%	
Charles, MD, MD	1	5%	
Calvert	1	5%	

Participant Funding	Count	Percent	Bar
None	19		

Payment Source	Count	Percent	Bar
Not reported	19	100%	

Referred	Count	Percent	Bar
No	13	76%	
Yes	4	24%	
Unknown	2		

Served in Military	Count	Percent	Bar
No	15	83%	
Yes	3	17%	
Unknown	1		

Virtual Workshop	Count	Percent	Bar
No	10	53%	
Yes	9	47%	

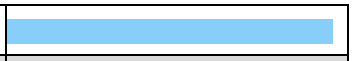
Workshop Funding	Count	Percent	Bar
None	19		

Felt welcomed	Count	Percent	Bar
Strongly Agree (1)	11	85%	
Agree (2)	2	15%	
Average Value	1.2		

Teaching was shared	Count	Percent	Bar
Strongly Agree (1)	11	85%	
Agree (2)	2	15%	
Average Value	1.2		

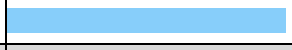
Leaders were prepared	Count	Percent	Bar
Strongly Agree (1)	9	69%	
Agree (2)	3	23%	
Average Value	1.2		

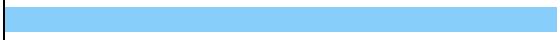
I have more self-confidence	Count	Percent	Bar
Strongly Agree (1)	6	46%	

Agree (2)	7	54%	
Average Value	1.5		

Book was helpful	Count	Percent	Bar
Strongly Agree (1)	10	77%	
Agree (2)	3	23%	
Average Value	1.2		

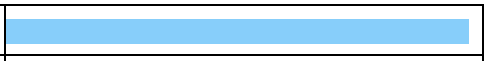
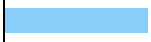
Learned action plans	Count	Percent	Bar
Strongly Agree (1)	6	46%	
Agree (2)	7	54%	
Average Value	1.5		

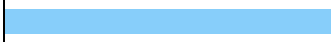
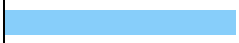
Better manage symptoms	Count	Percent	Bar
Strongly Agree (1)	7	54%	
Agree (2)	6	46%	
Average Value	1.5		

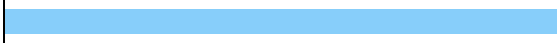
Site was conducive	Count	Percent	Bar
Strongly Agree (1)	12	92%	
Agree (2)	1	8%	
Average Value	1.1		

Part. valued contributions	Count	Percent	Bar
Strongly Agree (1)	8	62%	
Agree (2)	5	38%	
Average Value	1.4		

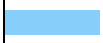
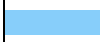
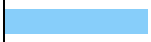
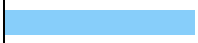
Leaders managed group	Count	Percent	Bar

Strongly Agree (1)	10	77%	
Agree (2)	3	23%	
Average Value	1.2		

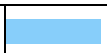
Leaders valued contributions	Count	Percent	Bar
Strongly Agree (1)	7	54%	
Agree (2)	5	38%	
Disagree (3)	1	8%	
Average Value	1.5		

Leaders got along	Count	Percent	Bar
Strongly Agree (1)	12	92%	
Agree (2)	1	8%	
Average Value	1.1		

Valued break time	Count	Percent	Bar
Strongly Agree (1)	10	77%	
Agree (2)	2	15%	
Average Value	1.2		

Noticed participants missing	Count	Percent	Bar
Strongly Agree (1)	2	15%	
Agree (2)	2	15%	
Disagree (3)	3	23%	
Strongly Disagree (4)	4	31%	
Average Value	2.8		

Feel more motivated	Count	Percent	Bar
Strongly Agree (1)	11	85%	

Agree (2)	2	15%	
Average Value	1.2		

Living Well with Hypertension (BP)
July 1, 2023 - June 30, 2024

Number of workshops: 5

Average participants per workshop: 9.4
Number of participants: 47
Participants with attendance data: 34
Completers: 34 of 34 (100%)
Number who are caregivers: 13 of 42 (31%)

Sep 25, 23—Charles County Department of Health
Jan 25, 24—Charles County Department of Health
Mar 5, 24—Charles County Department of Health
May 1, 24—Charles County Department of Health
May 30, 24—Charles County Department of Health

A1c	Count	Pre	Post	Decrease
No A1c	47			
One A1c	0	0		
Two A1c's	0	0	0	0

ACL Gender Long	Count	Percent	Bar
No answer	47	100%	

Age	Count	Percent	Bar
0-44	2	5%	
44-49	1	2%	
50-54	2	5%	
55-59	7	16%	
60-64	10	23%	
65-69	7	16%	
70-74	8	18%	
75-79	5	11%	

80-84	2	5%	
Unknown	3		

Caregiver	Count	Percent	Bar
No	29	69%	
Yes	13	31%	
Unknown	5		

Chronic Condition	Count	Percent	Bar
Hypertension	38	88%	
Arthritis	11	26%	
Diabetes	9	21%	
Chronic Pain	7	16%	
Cancer	6	14%	
Lung Disease	5	12%	
Stroke	1	2%	
Heart Disease	1	2%	
Other	19	44%	

Completers	Count	Percent	Bar
Yes	34	72%	
No	13	28%	

Condition Count	Count	Percent	Bar
Multiple chronic conditions	30	64%	
One chronic condition	13	28%	
No chronic conditions	4	9%	

Disabilities	Count	Percent	Bar
Diff. walking or climbing stairs	12	26%	
Diff. remembering	7	15%	

Visually impaired	3	6%	
Diff. with errands	2	4%	
Diff. dressing	2	4%	
Hearing impaired	1	2%	

Disability Count	Count	Percent	Bar
No disabilities	29	64%	
One disability	10	22%	
Multiple disabilities	6	13%	
Unknown	2		

Education	Count	Percent	Bar
Completed College	18	43%	
Some College	17	40%	
Completed High School	6	14%	
Some High School	1	2%	
Unknown	5		

Ethnicity/Race	Count	Percent	Bar
Black or African American	32	70%	
White/Caucasian	14	30%	
Hispanic/Latino	2	4%	
American Indian or AK Native	2	4%	
Unknown	1		

GDM	Count	Percent	Bar
No	39	83%	

Gender	Count	Percent	Bar
Female	39	85%	

Male	7	15%	
Unknown	1		

Impacted by COVID-19	Count	Percent	Bar
No	47	100%	

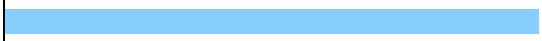
Insurance	Count	Percent	Bar
Medicare Part B ("Regular" Medicare)	21	88%	
Medicaid	6	25%	
Aetna	1	4%	
Kaiser	1	4%	
Other	1	4%	
Unknown	23		

Lives Alone	Count	Percent	Bar
No	29	67%	
Yes	14	33%	
Unknown	4		

Number of Group Sessions Attended	Count	Percent	Bar
1	34	100%	

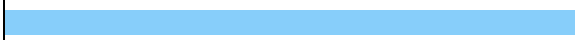
Organization	Count	Percent	Bar
Charles County Department of	47	100%	

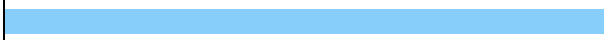
Community Services, Aging & Human Services Division			

Participant County	Count	Percent	Bar
Charles	42	89%	
Saint Marys	2	4%	
Charles, MD, MD	2	4%	
Prince Georges	1	2%	

Participant Funding	Count	Percent	Bar
None	47		

Payment Source	Count	Percent	Bar
Not reported	47	100%	

Referred	Count	Percent	Bar
No	36	95%	
Yes	2	5%	
Unknown	9		

Served in Military	Count	Percent	Bar
No	1	100%	
Unknown	46		

Virtual Workshop	Count	Percent	Bar

No	37	100%	
Unknown	10		

Workshop Funding	Count	Percent	Bar
None	47		

Felt welcomed	Count	Percent	Bar
Strongly Agree (1)	35	92%	
Agree (2)	3	8%	
Average Value	1.1		

Facilitator was prepared	Count	Percent	Bar
Strongly Agree (1)	33	87%	
Agree (2)	5	13%	
Average Value	1.1		

I know more now	Count	Percent	Bar
Strongly Agree (1)	30	79%	
Agree (2)	8	21%	
Average Value	1.2		

The materials were helpful	Count	Percent	Bar
Strongly Agree (1)	33	87%	
Agree (2)	5	13%	
Average Value	1.1		

I know how to manage my health	Count	Percent	Bar
Strongly Agree (1)	32	84%	

Agree (2)	6	16%	
Average Value	1.2		

It's important to manage my care	Count	Percent	Bar
Strongly Agree (1)	37	97%	
Agree (2)	1	3%	
Average Value	1.0		

The site was helpful	Count	Percent	Bar
Strongly Agree (1)	27	71%	
Agree (2)	10	26%	
Average Value	1.3		

I would recomment the workshop	Count	Percent	Bar
Strongly Agree (1)	33	87%	
Agree (2)	5	13%	
Average Value	1.1		

Participants valued my opinions	Count	Percent	Bar
Strongly Agree (1)	33	87%	
Agree (2)	5	13%	
Average Value	1.1		

Facilitator managed the group	Count	Percent	Bar
Strongly Agree (1)	32	84%	
Agree (2)	3	8%	
Average Value	1.1		

Facilitators valued my opinions	Count	Percent	Bar
Strongly Agree (1)	30	79%	
Agree (2)	5	13%	
Average Value	1.1		

My health wont interfere	Count	Percent	Bar
Strongly Agree (1)	21	55%	
Agree (2)	14	37%	
Average Value	1.4		

Talking to participants helped	Count	Percent	Bar
Strongly Agree (1)	26	68%	
Agree (2)	9	24%	
Average Value	1.3		

I'm more motivated	Count	Percent	Bar
Strongly Agree (1)	32	84%	
Agree (2)	3	8%	
Average Value	1.1		

Building Better Caregivers (BBC)
July 1, 2023 - June 30, 2024

Number of workshops: 1

Average participants per workshop: 8.0
Number of participants: 8
Participants with attendance data: 8
Completers: 8 of 8 (100%)
Number who are caregivers: 4 of 6 (67%)

Jan 23, 24—Charles County Department of Health

A1c	Count	Pre	Post	Decrease
No A1c	8			
One A1c	0	0		
Two A1c's	0	0	0	0

ACL Gender	Count	Percent	Bar
Woman	4	67%	
Man	2	33%	
Unknown	2		

ACL Gender Long	Count	Percent	Bar
Straight	5	62%	
No answer	3	38%	

Age	Count	Percent	Bar
44-49	1	14%	
60-64	2	29%	
65-69	3	43%	
80-84	1	14%	
Unknown	1		

Caregiver	Count	Percent	Bar
Yes	4	67%	
No	2	33%	
Unknown	2		

Chronic Condition	Count	Percent	Bar
Arthritis	2	50%	
Hypertension	2	50%	
Chronic Pain	2	50%	
Osteoporosis	2	50%	
Lung Disease	1	25%	
Cancer	1	25%	
Diabetes	1	25%	
Heart Disease	1	25%	
Obesity	1	25%	

Completers	Count	Percent	Bar
Yes	8	100%	

Condition Count	Count	Percent	Bar
No chronic conditions	4	50%	
Multiple chronic conditions	3	38%	
One chronic condition	1	12%	

Disabilities	Count	Percent	Bar
Diff. remembering	2	25%	
Hearing impaired	1	12%	

Disability Count	Count	Percent	Bar
No disabilities	5	71%	
One disability	1	14%	

Multiple disabilities	1	14%	
Unknown	1		

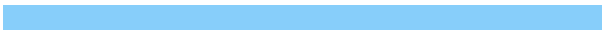
Education	Count	Percent	Bar
Completed High School	5	71%	
Some College	1	14%	
Completed College	1	14%	
Unknown	1		

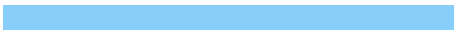
Ethnicity/Race	Count	Percent	Bar
White/Caucasian	5	83%	
Black or African American	1	17%	
Unknown	2		

Impacted by COVID-19	Count	Percent	Bar
No	8	100%	

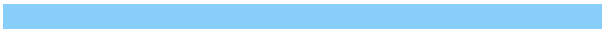
Lives Alone	Count	Percent	Bar
No	6	86%	
Yes	1	14%	
Unknown	1		

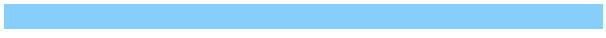
Number of Group Sessions Attended	Count	Percent	Bar
1	0	0%	
2	0	0%	
3	0	0%	
4	1	12%	
5	2	25%	
6	5	62%	

Organization	Count	Percent	Bar
Charles County Department of Community Services, Aging & Human Services Division	8	100%	

Participant County	Count	Percent	Bar
Charles	6	75%	
Saint Marys	1	12%	
Charles, MD, MD	1	12%	

Participant Funding	Count	Percent	Bar
None	8		

Payment Source	Count	Percent	Bar
Not reported	8	100%	

Referred	Count	Percent	Bar
No	7	100%	
Unknown	1		

Served in Military	Count	Percent	Bar
No	5	71%	
Yes	2	29%	
Unknown	1		

Virtual Workshop	Count	Percent	Bar
No	8	100%	

Workshop Funding	Count	Percent	Bar
None	8		

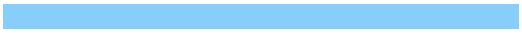
Felt welcomed	Count	Percent	Bar
Strongly Agree (1)	7	100%	
Average Value	1		

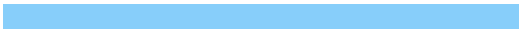
Teaching was shared	Count	Percent	Bar
Strongly Agree (1)	7	100%	
Average Value	1		

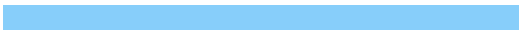
Leaders were prepared	Count	Percent	Bar
Strongly Agree (1)	7	100%	
Average Value	1		

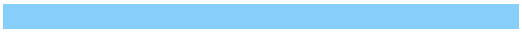
I have more self-confidence	Count	Percent	Bar
Strongly Agree (1)	6	86%	

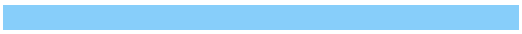
Average Value	1		

Book was helpful	Count	Percent	Bar
Strongly Agree (1)	6	86%	
Agree (2)	1	14%	
Average Value	1.1		

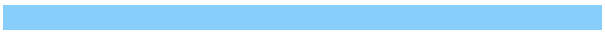
Learned action plans	Count	Percent	Bar
Strongly Agree (1)	6	86%	
Agree (2)	1	14%	
Average Value	1.1		

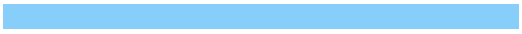
Better manage symptoms	Count	Percent	Bar
Strongly Agree (1)	6	86%	
Average Value	1		

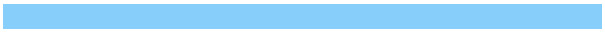
Site was conducive	Count	Percent	Bar
Strongly Agree (1)	6	86%	
Average Value	1		

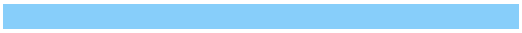
Part. valued contributions	Count	Percent	Bar
Strongly Agree (1)	6	86%	
Disagree (3)	1	14%	
Average Value	1.3		

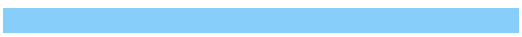
Leaders managed group	Count	Percent	Bar

Strongly Agree (1)	7	100%	
Average Value	1		

Leaders valued contributions	Count	Percent	Bar
Strongly Agree (1)	6	86%	
Disagree (3)	1	14%	
Average Value	1.3		

Leaders got along	Count	Percent	Bar
Strongly Agree (1)	7	100%	
Average Value	1		

Valued break time	Count	Percent	Bar
Strongly Agree (1)	6	86%	
Agree (2)	1	14%	
Average Value	1.1		

Noticed participants missing	Count	Percent	Bar
Agree (2)	1	14%	
Strongly Disagree (4)	6	86%	
Average Value	3.7		

Feel more motivated	Count	Percent	Bar

Strongly Agree (1)	6	86%	
Strongly Disagree (4)	1	14%	
Average Value	1.4		

Mobile Integrated Healthcare: The Charles County Department of Health, the University of Maryland Charles Regional Medical Center, and the Charles County Department of Emergency Services, collectively implement the Charles County Mobile Integrated Healthcare project to address the health/social determinants leading to repeated use of emergent care.

The Mobile Integrated Healthcare (MIH) Team includes a paramedic employed by Emergency Services and a registered nurse and community health worker, employed by the health department. The MIH team has offices at both the Charles County Department of Health and the Charles County Department of Emergency Services. During the initial visit, the MIH team assesses the patient's vital signs, reviews discharge paperwork, evaluates compliance with discharge instructions, completes a medication evaluation/reconciliation, conducts an environmental scan of the home for safety issues, and provides health education and chronic disease self-management information when appropriate. After the initial visit, the community health worker provides the high touch needed to keep the patients engaging in this program and out of the emergency department.

Enrollment:
- Must be:
  - 18 years of age, or older (and)
  - Charles County resident (and)
  - 1 or more chronic health conditions

ALL 3 MUST APPLY

Criteria for Hospital and Emergency Medical Services Inclusion:
- 3 or more visits to the ED in 3 months
- 3 or more calls to EMS in 3 months

Criteria for Primary Care Clinic Inclusion: Must display one or more
- 2 missed appointments/no-show's to scheduled appointments (and/or)
- Have not followed up with recommended specialists/agencies pertaining to health needs (and/or)
- Poor medication adherence

Criteria for Office on Aging Inclusion:
- Individuals on the Senior Care Waiting List with Chronic Conditions and Lower Acuity Levels

Initial Visits:
- Medical history review
- Individual concerns regarding health conditions
- Social and Emotional Health Questionnaire
- Physical Assessment
  - Vital signs

- Respiratory/Neuro/Integumentary/GI/GU

Cardiovascular/Musculoskeletal/Pain Assessments

- Immunization history review
- Assessment of ADL's
- Medication reconciliation
  - Ability to safely dispose of unused/unwanted medications
  - Carbon copied lists for convenience
- Thorough Home Safety Assessments
  - Ability to address safety needs with little to no cost to patient
- Smoke detectors / Carbon Monoxide detectors
- Individualized "To-Do" lists for patients
- Recognize needs for IDT discussions where applicable
- File of Life
- Personalized binders with accessible educational materials/references for client's health conditions
  - Zone Sheets; BP, FSBS, weight charts

Follow-up after Initial Visit:

- Contact appropriate resources
  - Maryland Access Point line, dental, mental health
  - Schedule appointments
- Arrange transportation when necessary
  - Contact staff for MA Transportation Forms to be completed
- Send "needs list" to providers offices regarding needs of patient
  - Refill requests, referrals, requests, etc.
- Insurance companies
  - Coverage specifications
  - Case Manager access
- Schedule for home safety modifications when applicable

Discharge Process:

- First month:
  - MIH is "hands-on," doing tasks for clients/family and informing them before and after tasks are completed (i.e.- appointment scheduling, etc.)
- Second month:
  - Clients/family are encouraged to take initiative in completing necessary tasks to manage healthcare needs, reflecting level of involvement from MIH in the first month
- Third month - onward:
  - MIH monitors the ability of client/family to manage healthcare needs independently and provides assistance/guidance when needed
  - Discharge (successful/unsuccessful)
- Self-manages, or remains non-compliant

From May 1, 2023 to April 30, 2024, the Charles County MIH program served a total of 34 new clients in addition to their other active client base (N=17). That brings the total number of MIH participants to 232 clients since program inception. Some clients have remained in the program. Many have been

successfully discharged. A few have been discharged due to non-compliance, but we hope that they have gained information and been connected to services that they previously did not have.

1. Decrease the percentage of ED visits and 911 system calls among participants by 25%.

The program tracks the number of ED visits and inpatient admissions by program participants, as a reduction in hospital use is a key outcome measure to document program impact. At the time of data analysis, there were 212 clients with 3 months pre and post data for evaluation. In the 3 months prior to MIH participation, these 212 patients had a total of 377 visits to the CRMC emergency department. After MIH, the number of ED visits among participants 3 months post dropped 60% to a total of 152 ED visits. The number of inpatient admissions dropped 61% from a total of 134 inpatient admissions 3 months prior to MIH to 53 inpatient admissions 3 months after MIH enrollment. The number of 30-day readmissions dropped from 27 to 9 (67% reduction).

From May 1, 2023, to April 30, 20234, there were a total of 23 ED visits, 6 inpatient admissions, and 0 30-day readmissions among MIH active participants. The average number of ED visits per MIH client was 0.67 visits. Year 7 totals saw a reduction from Year 6 utilization, which included 72 ED visits, 11 inpatient hospitalizations, and 4 30-day readmissions among MIH active clients.

Among the 34 new clients during the time period May 1, 2023 to April 30, 2024, ED visits decreased from 71 3-months pre MIH enrollment to 21 3-months post MIH enrollment. Inpatient hospitalizations decreased from 12 pre to 7 post MIH enrollment. There were no 30-day readmissions among the MIH clients 3-months pre MIH enrollment and 0 in the 3-months post MIH enrollment.

22 of the 34 new clients saw improvement in ED and hospital admission utilization from 3-months pre to 3-months post intervention (65%).

From May 1, 2023 to April 30, 2024, the number of EMS calls among MIH participants was 32 calls. This is a small reduction from the Year 6 total of 36 calls among MIH clients.

EMS call volume reduced by 49% from pre and post MIH participation. Looking at the data for 214 MIH clients, they had 398 9-1-1 calls in the 3 months prior to their MIH enrollment date. There have been 206 calls to 911 from MIHealth participants 3 months after MIH enrollment.

101 out of 203 MIHealth saw a reduction in EMS utilization after enrollment (50%). Several other MIH clients either had no EMS call utilization before and after enrollment or their call volume remained the same.

From May 1, 2023 to April 30, 2024, there were 34 new MIH clients with EMS call volume data. This group had 51 calls to 911 in the 3-months prior to MIH enrollment. They had 32 calls in the 3-months post MIH enrollment. This is a 37% reduction in call volume. 16 of these MIH clients saw an improvement in their call volume pre to post enrollment (47%). It is important to note that 8 of the 34 MIH clients had no 911 call volume pre or post MIH enrollment, so there was no change to report.

Health Professional Shortage Areas/ Medically Underserved Populations and Areas:

Health Professional Shortage Areas (HPSA):

There is 1 federally designated health professional shortage area in Charles County for dental health. The dental health HPSA is for Greater Baden Medical Services in Bryans Road and La Plata in Charles County. This HPSA was updated on September 11, 2021. The HPSA score is 26, the highest score you can get for dental health. Scores range from 1 to 26 for dental. The higher the score is, the greater the priority.

There is a federally designated mental health professional shortage area for the entire county. This was last updated on August 27, 2021. Charles County received a score of 11 out of 25. HPSA Scores are developed for use by the National Health Service Corps in determining priorities for assignment of clinicians. Scores range from 1 to 25 for primary care and mental health, 1 to 26 for dental. The higher the score is, the greater the priority. An additional HPSA was identified for Greater Baden Medical Services located in Bryan's Road and La Plata for Charles County. The Greater Baden HPSA score is 23 for mental health.

There is a federally designated primary care professional shortage area for the Medicaid eligible population. Charles County received a score of 16 out of 25. HRSA estimates that 9.46 full-time equivalent (FTE) practitioners are needed in the Health Professional Shortage Area (HPSA) so that it will achieve the population to practitioner target ratio. This HPSA was last updated on 4/5/2022. There is also a second primary care HPSA identified for Greater Baden Medical Services located in Bryan's Road and La Plata for Charles County. The Greater Baden HPSA score is 22 for primary care. HPSA Scores are developed for use by the National Health Service Corps in determining priorities for assignment of clinicians. Scores range from 1 to 25 for primary care and mental health, 1 to 26 for dental. The higher the score is, the greater the priority.

Medically Underserved Populations and Areas:

Medically Underserved Areas/Populations (MUA/MUP) are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty and/or high elderly population.

There are 6 population/areas in Charles County with MUA/MUP designation.

There is one medically underserved population (MUP) in Charles County. An MUP is a group of people who face economic, cultural, or linguistic barriers to health care. In Charles County, the MUP is located in the Brandywine Service Area. This population is a government MUP, which means it was designated at the request of a State Governor based to documented unusual local conditions and barriers to accessing personal health services. This designation has been in place since 1992 and was last updated on February 1, 1994.

The Index of Medical Underservice (IMU) score. The lowest score (highest need) is 0; and the highest score (lowest need) is 100. The Brandywine MUP received a 0 IMU score. That means the need for medical services in this region is of the highest priority.

In addition to the MUP, there are 5 medically underserved areas (MUA) in Charles County. Medically Underserved Areas may be a whole county or a group of contiguous counties, groups of county or civil

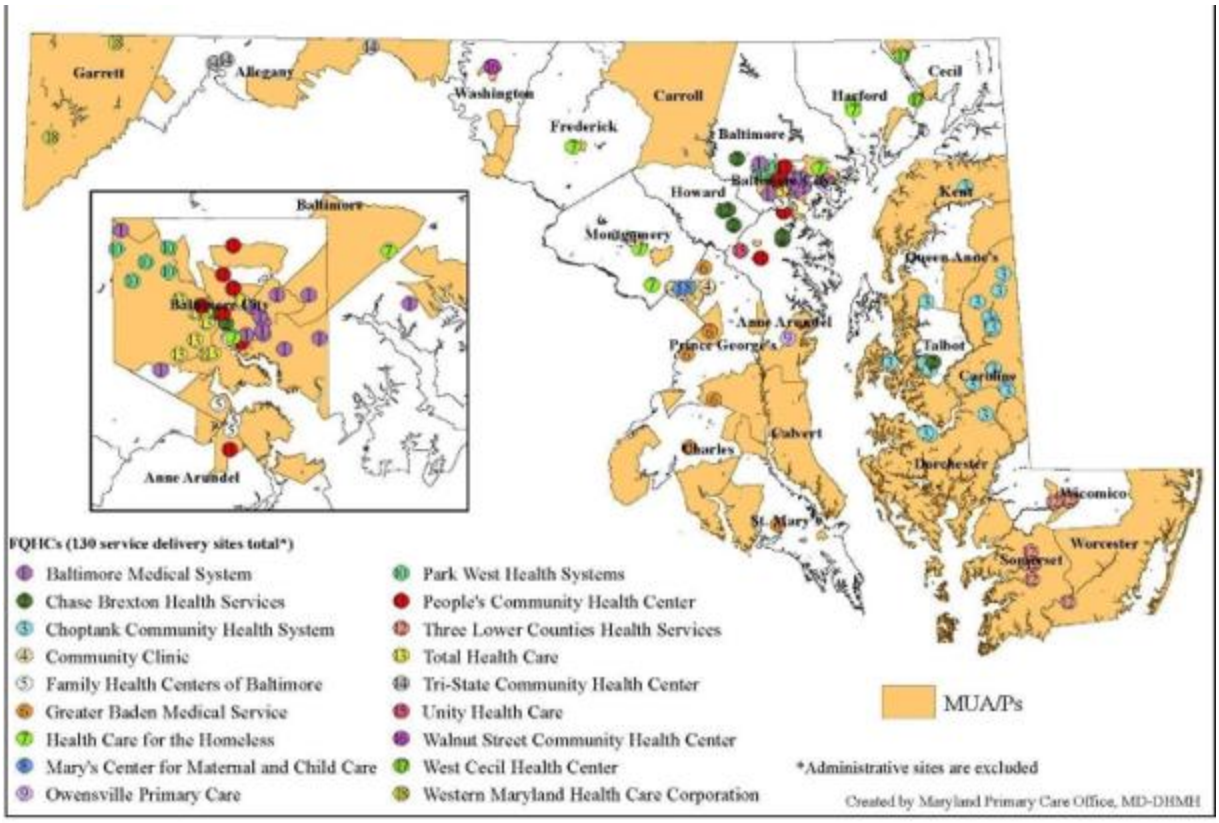
divisions or a group of urban census tracts in which residents have a shortage of personal health services. Those areas include:

- **Medically Underserved Area (MUA)**: Score 52.0
- District 4, Allens Fresh
- District 5, Thompkinsville
- District 9, Hughesville
- **Medically Underserved Area**: Score 61.3
- District 10, Marbury
- District 3, Nanjemoy

The IMU scale for Medically Underserved Areas is from 0 to 100, where 0 represents completely underserved and 100 represents best served or least underserved. Under the established criteria, each service area found to have an IMU of 62.0 or less qualifies for designation as an MUA.

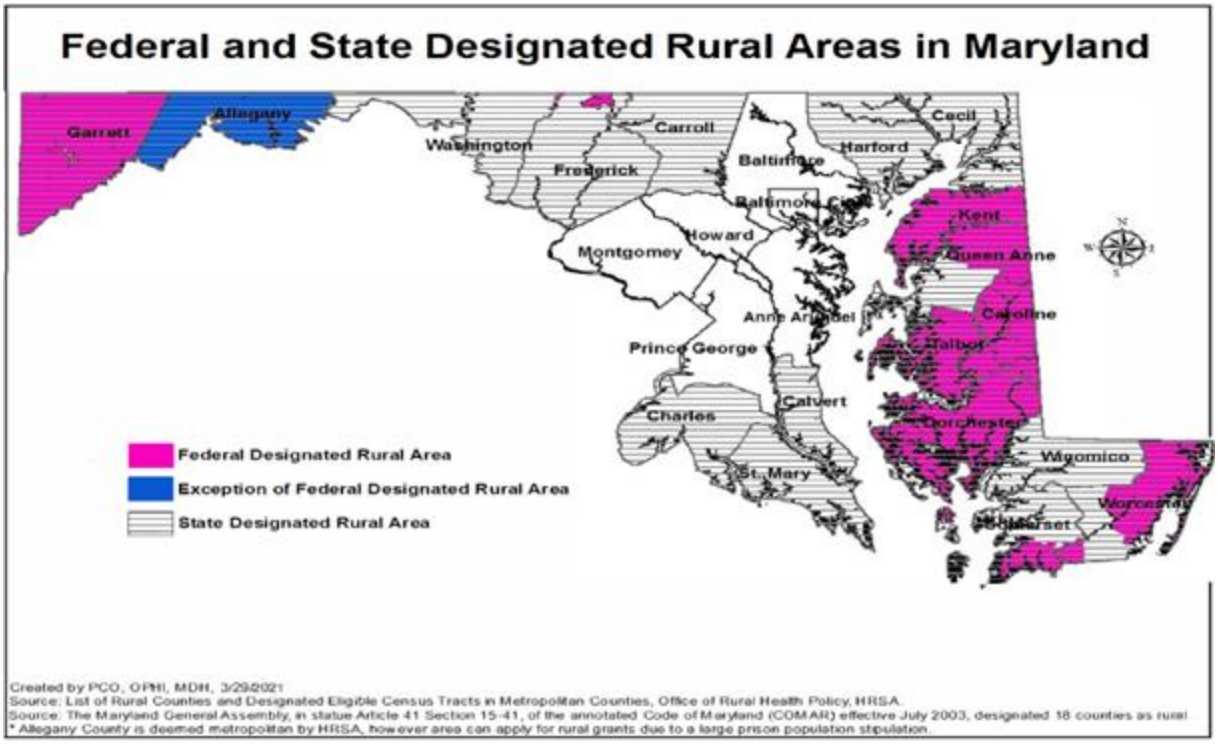
The IMU involves four variables - ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. The value of each of these variables for the service area is converted to a weighted value, according to established criteria. The four values are summed to obtain the area's IMU score.

The Allens Fresh/Thompkinsville/Hughesville areas received an IMU score of 52.0. The Marbury/Nanjemoy areas received an IMU score of 61.3, which is close to the 62 cut off for MUA designation. These designations have been in place since 1994.



Rural Health Designation:

Charles County no longer holds a federal designation as a rural area. All Southern Maryland counties have lost their rural designation. However, Charles County has hold a state rural designation.



Availability of Health Services:

Maryland Primary Care Needs Assessment 2021:

The 2021 Maryland Primary Care Office Needs Assessment was based on the integration of two health data tracking methods: Prevention Quality Indicators (PQIs) and the State Health Improvement Process (SHIP) measures.

Based on this Needs Assessment findings, the Primary Care Office (PCO) will prioritize in the following ways:

• For any competing requests from stakeholders for shortage analyses, workforce development, or technical assistance, the PCO will give priority first to those that pertain to areas of the state with greatest need as demonstrated by the results of the analyses of PQI and SHIP indicators for jurisdictions within the Bottom Quartile.

• The PCO will continue to pursue shortage analyses in all parts of the state, with priority given to the areas of greater need in the state before proceeding to others.

• The PCO will also continue to monitor health status and health care access in Maryland and will update the PCO Needs Assessment per HRSA grant requirements.

A quartile ranking was used to order the PQI, and SHIP indicator results by Maryland jurisdictions. The Health Indicator Rankings by Jurisdiction matrix can be found in Appendix A, Table 1. The information in this matrix was compiled from data from the Maryland Vital Statistics Administration, and the SHIP. The matrix focuses on 49 indicators and ranks those indicators at the jurisdictional level. Charles County is ranked 14th out of the 24 jurisdictions. This is an improvement from the 2016 needs assessment when Charles County was ranked 16th in the state. Charles County has remained in the third quartile.

Chart 1: Quartile Rankings by Jurisdiction Based on PQI & SHIP Indicators, 2021 PCO Needs Assessment*

2021 Jurisdictions	Rate	Rankings	Quartile
Montgomery County	221	1	First Quartile (Best)
Howard County	227	2	
Frederick County	279	3	
Queen Anne's County	284	4	
Talbot County* (↑ from 11)	308	5	
Carroll County	324	6	
Calvert County	366	7	Second Quartile
Anne Arundel	387	8	
Harford County* (↓ from 6)	409	9	
Caroline County* (↑ from 15)	424	10	
Kent County* (↑ from 19)	430	11	
Prince George's County* (↑ from 13)	432	12	
Garrett County* (↓ from 8)	438	13	Third Quartile
Charles County	439	14	
Worcester County* (↓ from 10)	469	15	
Somerset County	491	16	
Cecil County* (↓ from 12)	492	17	
Baltimore County	508	18	
Saint Mary's County* (↓ from 14)	515	19	Fourth Quartile (Worst)
Washington County	536	20	
Wicomico County	566	21	
Dorchester County	587	22	
Allegany	602	23	
Baltimore City	718	24	

*Quartile ranking changed from the 2016 Needs Assessment.

Data on the 49 health indicators is listed below for each county. Health indicators where Charles County scored favorably: Diabetes with long term complications, COPD or asthma in older adults, students entering kindergarten ready to learn, and children with elevated blood levels. Health indicators where Charles County scored the lowest in the state: Chlamydia infection rate, domestic violence, affordable housing, children receiving dental care in the last year, emergency department visits for hypertension, annual flu vaccinations, early prenatal care, and adults who are at a healthy weight.

Table 1: Health Indicator Rankings by Jurisdiction, Maryland, 2021 (PQI and SHIP)

Prevention Quality Indictors (PQI) & State Health Improvement Process (SHIP) Rankings by Jurisdiction																									
	Jurisdictions	Allegany	Anne Arundel	Baltimore City	Baltimore County	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince Georges	Queen Annes	Saint Marys	Somerset	Talbot	Washington	Wicomico	Worcester
Indicators/Tables																									
PQI Data																									
2. Diabetes with short-term complications		20	7	24	12	17	14	4	10	16	18	5	11	6	2	21	3	9	1	13	19	8	22	23	15
3. Diabetes with long-term complications		23	9	24	21	19	22	10	18	4	15	8	12	14	3	20	2	16	11	13	5	7	17	6	1
4. Chronic Obstructive Pulmonary Disease (COPD) or asthma in older adults		23	14	24	21	11	7	10	19	3	15	6	12	17	1	9	2	8	5	20	16	4	22	13	18
5. Hypertension		22	8	23	21	9	2	10	8	11	19	6	12	15	3	1	13	17	4	14	20	5	18	16	7
6. Heart failure		22	10	24	21	16	3	14	4	8	18	5	2	15	6	11	1	13	7	17	19	9	12	20	23
7. Community Acquired Bacterial pneumonia		20	8	21	13	3	19	22	18	6	24	9	7	11	2	10	1	4	5	16	14	15	23	12	17
8. Urinary tract infection		17	14	24	23	5	1	22	15	7	19	9	10	18	3	8	11	13	6	12	16	2	4	20	21
9. Uncontrolled diabetes without complications		20	11	24	16	12	5	4	13	6	22	3	8	10	9	23	7	17	1	14	19	2	15	18	21
10. Asthma in younger adults		19	5	24	21	4	14	10	22	8	16	11	9	20	12	3	7	15	2	18	13	1	23	17	6
11. Lower extremity amputations among admissions for diabetes		23	11	24	21	7	3	8	12	4	10	5	20	13	2	22	1	6	19	15	18	9	17	14	16
SHIP Data																									
Healthy Beginnings																									
12. Infant Death Rate			2	9	6	7				11		5		1	4		3	8		7	13		10	11	12
13. Babies With Low Birth Weight		3	10	20	14	10	8	4	8	19	7	5	18	6	11	17	9	15	12	2	21	7	13	16	1
14. Sudden Unexpected Infant Death Rate (SUIDs)			2	5	3				5					4			1	3					4		
15. Teen Birth Rate		21	11	23	9	3	15	2	17	14	20	4	16	6	1	5	8	18	7	6	13	10	22	19	12
16. Early Prenatal Care		8	17	20	19	9	16	1	7	21	6	3	5	8	14	2	18	22	11	12	10	13	15	15	4
17. Students Entering Kindergarten Ready to Learn		14	8	13	9	7	10	3	12	14	11	6	2	10	6	1	9	16	8	12	4	10	15	9	5
18. High School Graduation Rate		13	14	21	11	2	20		9	1	18	4	5	12	6	9	10	19		3	16	15	7	17	8
19. Children Receiving Blood Lead Screening		1	10	6	4	22	5	17	14	8	11	10	19	12	13	21	3	9	15	16	2	7	20	13	18
Healthy Living																									
20. Adults Who are a Healthy Weight		9	6	13	11	3	15	14	12	21	20	8	16	4	5	1	2	23	19	22		10	18	17	7
21. Adolescents Who Have Obesity (2018)		18	7	21	9	6	15	3	8	12	22	4	19	6	1	17	2	16	5	11	23	14	13	20	10
22. Adults Who Currently Smoke		19	10	16	4	14	17	7	18	6	20	5	13	8		3	1	2	8	15	21	8	11	9	12
23. Public High School Students Currently Using Tobacco (2018)		18	7	4	5	14	16	11	17	4	19	8	21	6	2	22	3	1	20	12	9	13	10	11	15
24. HIV Incidence Rate		6	11	19	13	7	1	4	5	14	17	9	2	12	8	5	16	18		7			10	15	3

Table 1: Health Indicator Rankings by Jurisdiction, Maryland, 2021 (PQI and SHIP)

Prevention Quality Indictors (PQI) & State Health Improvement Process (SHIP) Rankings by Jurisdiction																									
	Jurisdictions	Allegany	Anne Arundel	Baltimore City	Baltimore County	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince Georges	Queen Annes	Saint Marys	Somerset	Talbot	Washington	Wicomico	Worcester
25. Chlamydia Infection Rate		14	15	24	18	6	7	4	8	21	19	10	3	9	11	1	13	23	2	12	22	5	16	20	17
26. Life Expectancy		19	6	21	12	7	17	10	18	11	18	4	13	10	2	9	1	9	5	8	20	3	15	16	14
27. Increase Physical Activity		19	9	17	10	1	20	22	11	18	23	2	21	14	3	16	5	8	7	12	15	4	10	13	6
Healthy Communities																									
28. Child Maltreatment Rate		21	9	20	10	6	17	4	18	8	22	3	23	16	1	15	2	11		5	14	7	12	13	19
29. Suicide Rate			8	4	5		17	9				6		7	3		2	1					10		
30. Domestic Violence		19	16	21	24	11	5	7	12	20	18	15	8	14	17	6	4	3	9	23	10	1	2	22	13
31. Children with Elevated Blood Levels		6	2	7	3	3	5	3	3	2	8	3	1	2	3	1	2	4	2	3	1	4	3	4	2
32. Fall-Related Death Rate			3	6	10			9				4		7	5		1	2					8		
33. Pedestrian Injury Rate on Public Roads			7	15	12			1	6	5		3		4	2		10	11			14		8	9	13
34. Affordable Housing (needs more recent data)		1	24	3	9	14	6	21	5	20	10	17	12	13	23	11	19	16	18	15	4	22	7	2	8
Access to Healthcare																									
35. Adolescents who Received a Wellness Checkup in the Last Year		15	9	12	8	21	4	20	17	13	7	11	23	16	5	19	1	3	14	22	4	2	18	6	10
36. Children Receiving Dental Care in the Last Year		22	14	13	11	18	4	20	16	23	9	5	10	17	7	3	2	8	6	21	1	1	19	15	12
37. Persons with a Usual Primary Care Provider		19	14	16	8	10	20	1	13	17	3	12	7	15	9	2	22	21	5	23	18	4	6	11	10
38. Uninsured ED Visits*		5	18	16	17	6	11	3	5	15	7	20	10	1	12	2	21	22	8	4	13	9	14	19	13
Quality Preventative Care																									
39. Age Adjusted Cancer Mortality Rate		15	9	24	17	13	18	7	22	10	21	8	5	14	2	6	1	11	4	16	20	3	12	23	19
40. Emergency Department Visit Rate Due to Diabetes*		13	6	24	8	12	17	3	11	10	22	5	21	7	1	16	2	9	4	15	20	19	14	23	18
41. Emergency Department Visit Rate Due to Hypertension*		18	5	23	11	12	14	1	6	20	24	4	8	13	2	17	3	10	7	21	19	15	9	22	16
42. Drug-Induced Death Rate		15	8	17	13	11		10	16	5		7		9	3		1	2		4			12	6	14
43. Emergency Department Visits Related To Mental Health Conditions*		10	15	22	12	6	18	13	21	4	23	8	20	7	9	24	2	1	16	17	3	19	14	5	11
44. Hospitalization Rate Related to Alzheimer's or Other Dementias*		23	13	24	22	7	15	9	17	10	11	14	4	12	16	8	5	20	2	21	3	1	19	18	6
45. Annual Season Influenza Vaccinations		22	14	18	11	7	23	5	12	20	4	16	24	13	8	15	3	19	2	21	1	6	17	9	10
46. Emergency Department Visit Rate Due to Asthma		19	5	24	13	9	10	3	17	16	23	4	11	8	2	21	1	6	7	14	22	15	12	20	18
47. Age-Adjusted Mortality Rate From Heart Disease		20	5	22	12	13	15	10	17	8	19	7	18	9	2	6	1	11	8	4	23	3	14	21	16
48. Emergency Department Visits For Addictions-Related		18	15	24	16	6	5	4	21	7	23	3	2	14	1	17	11	8	10	9	12	20	22	13	19

Table 1: Health Indicator Rankings by Jurisdiction, Maryland, 2021 (PQI and SHIP)

Prevention Quality Indictors (PQI) & State Health Improvement Process (SHIP) Rankings by Jurisdiction																									
	Jurisdictions	Allegany	Anne Arundel	Baltimore City	Baltimore County	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garrett	Harford	Howard	Kent	Montgomery	Prince Georges	Queen Annes	Saint Marys	Somerset	Talbot	Washington	Wicomico	Worcester
49. Emergency Department Visit Rate For Dental Care		13	6	20	7	10	15	3	18	9	23	4	14	8	1	17	2	5	9	11	19	16	12	22	21

Top Quartile (Best)
Second Quartile
Third Quartile
Bottom Quartile (Worst)
No Data Available/Sample Size Too Small

Created by PCO, OPHI, MDH 1/14/21
Source: HSCRC, 2019. Data results after application of AHRQ PQI 2020 methodology.
* Includes only Maryland Residents.

The following table displays the healthcare provider ratios for Charles County zip code and the county as a whole.

County/Neighborhoods by Census Tracts		Resident Civilian Population[1,2]	Primary Care FTE[3, 5]	Primary Care Provider to Population Ratio[6]	Mental Health FTE[4, 5]	Mental Health Provider to Population Ratio[6]
Charles County	Nanjemoy (850400)	3,562	0.0	0 : 3,562	0.0	0 : 3,562
	Welcome (850500)	2,884	0.0	0 : 2,884	0.0	0 : 2,884
	La Plata (850600, 850904, 851001, 851002)	26,422	18.9	1 : 1,400	0.0	0 : 26,422
	Waldorf (850706, 850708, 850709, 850710, 850711, 850712, 850713, 850801, 850802, 850901, 850902, 850905, 850906, 851500)	80,964	52.8	1 : 1,533	1.0	1 : 80,964
	Port Tobacco/Charlotte Hall (851100, 851301, 851302)	12,381	0.0	0 : 12,381	0.0	0 : 12,381
	Newburg (851200)	4,960	0.0	0 : 4,960	0.0	0 : 4,960
	Hughesville (851400)	8,692	0.0	0 : 8,692	0.0	0 : 8,692
Charles County	**Whole County**	**163,257**	**73.7**	**1 : 2,216**	**1.0**	**1 : 163,257**
	Bryans Road (850101, 850102)	8,038	1.0	1 : 8,038	0.0	0 : 8,038
	Indian Head/Marbury (850201, 850202, 850300)	7,432	1.0	1 : 7,432	0.0	0 : 7,432

[1] **Annual Estimates of Resident Population in 2019.**

[2] **Annual Estimates of Resident Population in 2018.**

[3] Primary Care FTE: Includes family practice, general practice, internal medicine, obstetric and gynecology and pediatric.

[4] **Mental Health FTE: Only includes psychiatrists**

[5] Excluded FTE: Physicians solely working at hospitals, non-acute care facilities, or providing academia or research services.

[6] Blue font indicates possible eligibility for a Mental Health or Primary Care Geographic HPSA based on provider to population ratio factors below:

Primary Care Geographic HPSA

- If FTE = 0, then population should be at least 500
- FTE > 0, then provider: population ratio should be at least 1:3,500 and include a minimum population of 20,000 unless a full county.

Mental Health Geographic HPSA

- If FTE = 0, then population should be at least 3,000
- If FTE > 0, then provider: population ratio should be 1:30,000 for only psychs and include a minimum population of 20,000 unless a full county.

Source: U.S. Census Bureau, Population Division, https://www.census.gov/data/tables/time-series/demo/popest/2010s-counties-total.html; Health Resources and Services Administration (HRSA), HPSA Find, https://data.hrsa.gov/tools/shortage-area/hpsa-find

The report also identified safety net providers for each county. For Charles County, 3 organizations were identified.

CHARLES COUNTY SAFETY NET SITES														
Site Type	**Site Name**	**Site Address**	**Telephone Number**	**Web Address**	**Location Type**	**Type Description**	**Contact Name**	**Migrant Health**	**Homeless**	**Medical**	**Dental**	**Mental Health**	**Vision**	**Substance Use**
FQHC	Greater Baden Medical Services at La Plata	6 Garrett Ave La Plata, MD 20646-5959	301-539-5100	www.gbms.org	Permanent	Service Delivery Site	Unknown	Yes	No	Yes	Yes	Yes	No	Yes
Hospital	University of Maryland Charles Regional Medical Center	5 Garrett Avenue, La Plata, MD 20646	301-609-4000	https://www.umms.org/charles	Permanent	Service Delivery Site	Unknown	No	Yes	Yes	Unknown	Yes	No	Yes
LHD	Charles County Health Department	4545 Crain Hwy, White Plains, MD 20695	301-609-6900	https://charlescountyhealth.org/	Permanent	Administra-tive/Service Delivery Site	Unknown	Unknown	Unknown	Yes	Yes	Yes	Unknown	Yes

FQHC - Federally Qualified Health Center
LHD - Local Health Department
SBHC - School Based Health Center

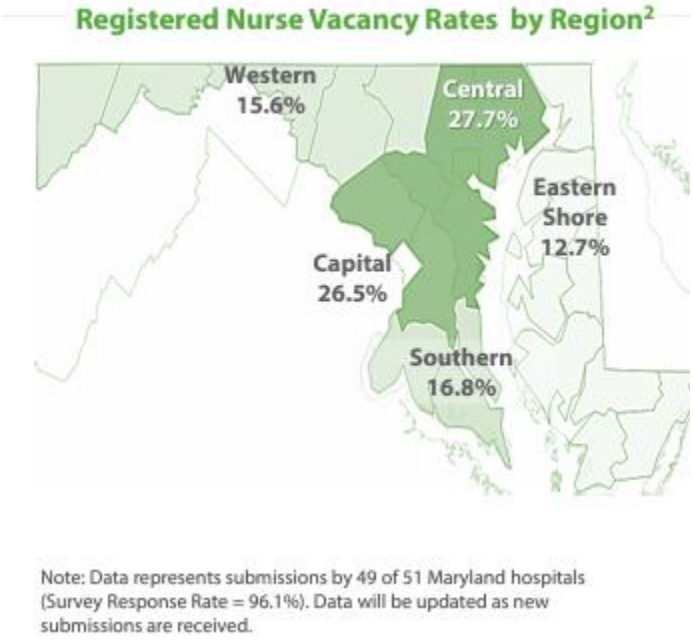
Sources:
1. 2019 Program Awardee Data
https://data.hrsa.gov/tools/data-reporting/program-data?type=AWARDEE&state=MD, 2/8/21
2. Health Resources and Services Administration, accessed 2/1/2021
http://datawarehouse.hrsa.gov/tools/hdwreports/reports.aspx
3. Maryland Hosptial Association, accessed 3/22/2021
https://www.mhaonline.org/about-mha/member-hospitals
4. University of Maryland Charles Regional Medical Center, accessed 3/24/21
https://www.umms.org/charles
5. Charles County Health Department, accessed 3/24/21
https://charlescountyhealth.org/

Maryland Hospital Association 2022 State of Maryland's Health Care Workforce Report:

The 2022 State of Maryland's Health Care Workforce Report looked at the healthcare professions with high vacancy rates. Nursing positions were at the top of the list. They were higher than the overall Maryland vacancy rate of 21.2%.

Top 10 Hospital Occupations by Vacancy Rate[2] (as of 12/31/2021)	
Licensed Practical (Vocational) Nurses	**37.7%**
Registered Nurses	**25.4%**
Respiratory Therapists	**23.7%**
Nursing Assistive Personnel	**22.9%**
Overall Vacancy Rate	**21.2%**
Nurse Practitioners	21.0%
Surgical Technicians	20.5%
Pharmacy Technicians	19.0%
Sterile Processing Technicians	17.2%
Laboratory Technicians	17.1%
Radiology Technicians	16.9%

Southern Maryland has a registered nurse vacancy rate of 16.8%. This is the third highest in the state.



Note: Data represents submissions by 49 of 51 Maryland hospitals (Survey Response Rate = 96.1%). Data will be updated as new submissions are received.

Maryland Health Workforce Study Phase 2 Report, January 2014:

In January 2014, the Maryland Health Care Commission (MHCC) released a second report detailing Phase 2 of the Maryland Health Workforce Study. This study assessed health workforce distribution and the adequacy of supply. Using funding from the Robert Wood Johnson Foundation, the MHCC was able to study the Maryland healthcare workforce on the state and jurisdictional level. Phase II presents estimates of current supply and demand for health professions designated by MHCC has high priority in supporting Maryland's transition to health reform, and for which data were readily available for estimating supply and demand. These professions included primary care specialties and psychiatrists. Current supply estimates were also presented for psychologists, social workers, counselors, physician assistants, pharmacists, registered nurses, and dentists.
Demand modeling: Estimates of the current demand for healthcare providers were developed using the IHS Healthcare Demand Micro-simulation Model. The major components of this model include: 1. A population database that contains characteristics and health risk factors for a representative sample of the population in each Maryland count; 2. Equations that relate a person's characteristics to his or her demand for healthcare services by care delivery setting; and 3. Staffing patterns that convert demand for healthcare services to demand for full time equivalent (FTE) providers.
This report has not been updated since 2014.

In Charles County, the primary care FTE demand is greater than the primary care FTE supply (7.4 vs. 6.1). There is an 18% shortfall in the demand for primary care services. Charles County falls in the up to 20% shortage area for primary care physician supply.

Map 1: Maryland County-Level Adequacy of FTE Primary Care Physician Supply

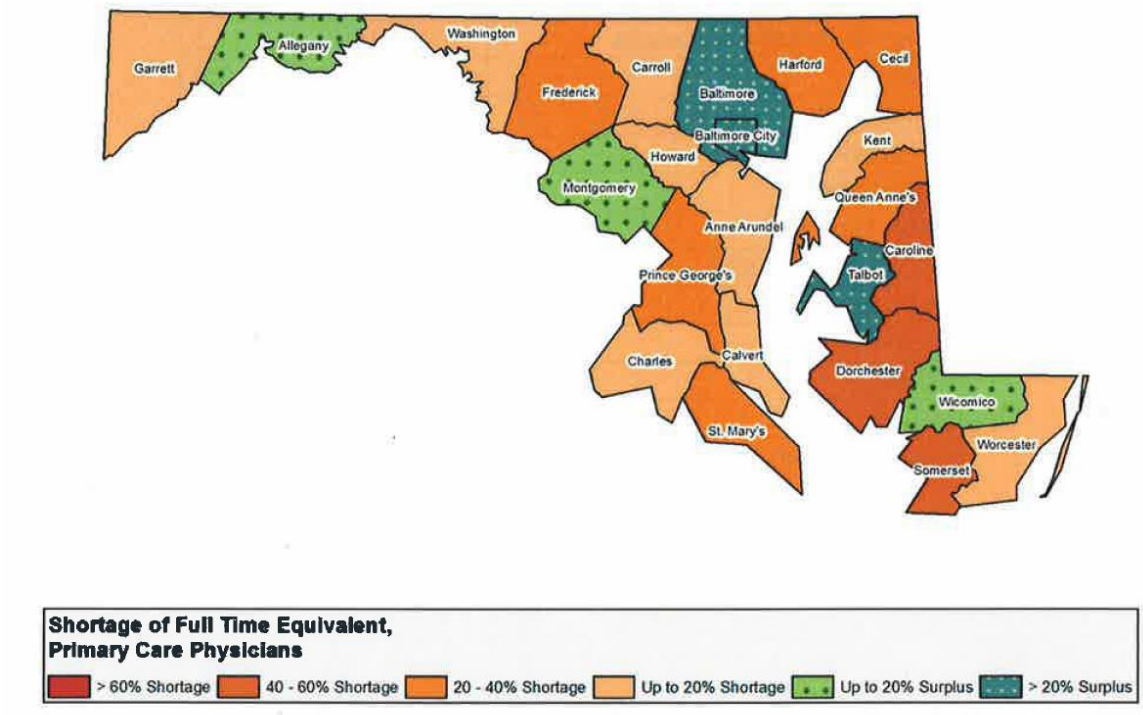


Exhibit 3: Adequacy of Supply for Primary Care Physicians by County, 2012

County	Total FTEs			FTEs/10,000 Population	
	FTE Demand	FTE Supply	Supply - Demand	FTE Demand	FTE Supply
Allegany	57	63	6	7.6	8.5
Anne Arundel	407	379	(28)	7.4	6.9
Baltimore City	464	817	353	7.5	13.1
Baltimore County	621	788	167	7.6	9.6
Calvert	66	56	(10)	7.5	6.2
Caroline	25	14	(11)	7.5	4.2
Carroll	125	103	(22)	7.5	6.2
Cecil	75	60	(15)	7.5	5.9
Charles	111	91	(20)	7.4	6.1
Dorchester	25	14	(11)	7.9	4.1
Frederick	176	140	(36)	7.4	5.8
Garrett	23	20	(3)	7.7	6.6
Harford	186	142	(44)	7.5	5.7
Howard	218	197	(21)	7.3	6.6
Kent	16	16	0	8.0	7.9
Montgomery	729	833	104	7.2	8.3
Prince George's	637	471	(166)	7.2	5.3
Queen Anne's	37	25	(12)	7.6	5.1
St. Mary's	80	53	(27)	7.3	4.9
Somerset	19	8	(11)	7.3	2.9
Talbot	31	42	11	8.1	11.0
Washington	112	111	(1)	7.5	7.4
Wicomico	75	81	6	7.5	8.0
Worcester	42	41	(1)	8.0	7.9
Total	**4,357**	**4,565**	**208**	**7.4**	**7.8**

Note: Primary care specialties include general and family practice, general internal medicine, geriatrics, and general pediatrics.

The supply versus demand for pediatric services in Charles County is similar.

Exhibit 4: Adequacy of Supply for Pediatricians by County, 2012

County	Total FTEs			FTEs/10,000 Children	
	FTE Demand	FTE Supply	Supply - Demand	FTE Demand	FTE Supply
Allegany	10	11	1	7.0	7.9
Anne Arundel	87	85	(2)	7.1	6.9
Baltimore County	125	185	60	7.1	10.4
Baltimore City	99	168	69	7.3	12.3
Calvert	15	13	(2)	7.0	6.1
Caroline	6	1	(5)	7.0	0.9
Carroll	26	21	(5)	6.9	5.4
Cecil	16	9	(7)	7.0	3.9
Charles	26	26	0	7.1	7.0
Dorchester	5	1	(4)	7.1	1.9
Frederick	40	34	(6)	7.0	5.9
Garrett	4	-	(4)	6.9	-
Harford	40	40	0	7.0	7.0
Howard	51	52	1	7.1	7.2
Kent	2	1	(1)	7.0	2.6
Montgomery	163	234	71	7.1	10.1
Prince George's	148	104	(44)	7.2	5.1
Queen Anne's	7	6	(1)	6.9	5.7
St. Mary's	19	12	(7)	7.0	4.3
Somerset	3	2	(1)	7.1	3.6
Talbot	5	9	4	7.0	13.4
Washington	23	21	(2)	7.0	6.5
Wicomico	16	26	10	7.1	11.1
Worcester	7	-	(7)	7.0	-
Total	**943**	**1,061**	**118**	**7.1**	**8.0**

The FTE per 10,000 supply rates for professional counselors, social workers, and psychologists in Charles County is much lower than the rates for Maryland. The Charles County FTE rate for physician assistants is the only rate that came close to the Maryland state supply rate.

Exhibit 6: Supply of Selected Health Professions by County, 2012

County	Professional Counselors		Social Workers		Psychologists		Physician Assistants	
	FTEs	FTE/ 10,000	FTEs	FTE/ 10,000	FTEs	FTE/ 10,000	FTEs	FTE/ 10,000
Allegany	267	36.1	222	29.9	27	3.6	27	3.6
Anne Arundel	684	12.4	833	15.1	144	2.6	162	2.9
Baltimore City	2,132	34.3	4,030	64.9	405	6.5	570	9.2
Baltimore County	1,294	15.8	2,124	26.0	357	4.4	330	4.0
Calvert	118	13.2	128	14.2	8	0.8	20	2.2
Caroline	17	5.2	61	18.6	-	-	1	0.3
Carroll	277	16.5	315	18.8	48	2.9	52	3.1
Cecil	97	9.5	175	17.2	25	2.4	23	2.3
Charles	193	12.8	126	8.4	14	0.9	49	3.2
Dorchester	79	24.3	150	45.9	5	1.4	3	0.8
Frederick	320	13.3	530	22.1	56	2.3	62	2.6
Garrett	53	17.6	73	24.3	1	0.2	5	1.5
Harford	351	14.1	355	14.3	46	1.9	63	2.5
Howard	407	13.6	667	22.3	181	6.0	40	1.3
Kent	41	20.1	52	25.5	8	3.7	3	1.5
Montgomery	1,200	11.9	2,927	29.1	754	7.5	300	3.0
Prince George's	833	9.4	913	10.4	129	1.5	154	1.7
Queen Anne's	29	5.9	70	14.4	9	1.7	3	0.5
St. Mary's	105	40.0	115	43.8	18	1.6	22	8.4
Somerset	45	4.1	79	7.2	-	-	4	0.3
Talbot	62	16.3	167	43.8	7	1.8	11	2.8
Washington	273	18.3	435	29.1	18	1.2	65	4.4
Wicomico	193	19.1	334	33.2	20	1.9	72	7.1
Worcester	67	12.9	106	20.6	5	0.9	11	2.1
Total	**9,131**	**15.5**	**14,982**	**25.5**	**2,278**	**3.9**	**2,045**	**3.5**

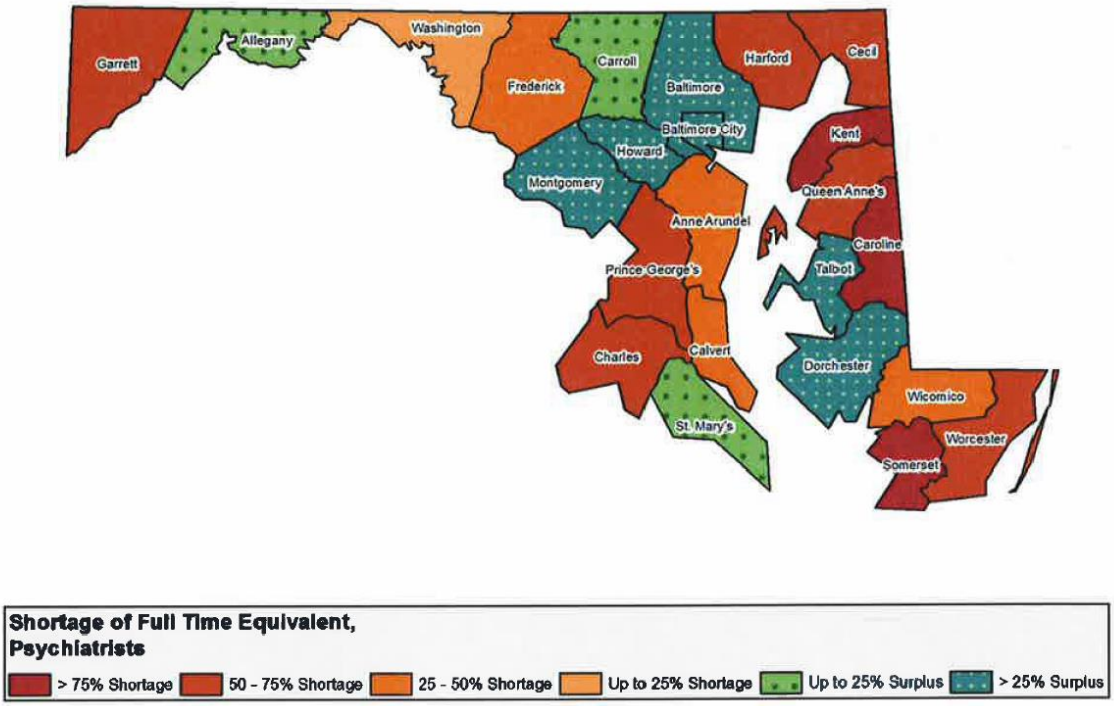
Note: These are professions for which only FTE supply analysis was possible at this time.

The demand for psychiatrists in Charles County is much higher than the county supply for psychiatry. Charles County has a shortage between 50-75% of full time equivalent psychiatrists.

Exhibit 5: Adequacy of Supply for Psychiatrists by County, 2012

County	Total FTEs			FTEs/10,000 Population	
	FTE Demand	FTE Supply	Supply - Demand	FTE Demand	FTE Supply
Allegany	10	10	0	1.3	1.4
Anne Arundel	74	41	(33)	1.3	0.7
Baltimore City	94	233	139	1.5	3.7
Baltimore County	113	242	129	1.4	3.0
Calvert	12	6	(6)	1.3	0.7
Caroline	4	-	(4)	1.3	-
Carroll	22	26	4	1.3	1.6
Cecil	13	6	(7)	1.3	0.6
Charles	22	6	(16)	1.5	0.4
Dorchester	5	8	3	1.4	2.5
Frederick	32	18	(14)	1.3	0.8
Garrett	4	2	(2)	1.3	0.5
Harford	33	15	(18)	1.3	0.6
Howard	40	64	24	1.3	2.1
Kent	3	-	(3)	1.4	-
Montgomery	134	214	80	1.3	2.1
Prince George's	135	47	(88)	1.5	0.5
Queen Anne's	6	3	(3)	1.3	0.6
St. Mary's	14	5	(9)	1.3	0.4
Somerset	4	1	(3)	1.5	0.3
Talbot	5	8	3	1.3	2.2
Washington	20	18	(2)	1.3	1.2
Wicomico	14	8	(6)	1.4	0.8
Worcester	7	2	(5)	1.3	0.5
Total	**820**	**983**	**163**	**1.4**	**1.7**

Map 2: Maryland county-Level Adequacy of FTE Psychiatrist Supply



2019-2020 Maryland Physician Workforce Profile:

The current state of the physician workforce in Maryland is present below in the following three charts. The data is based on the American Medical Association's Masterfile and is compiled each year into the State Physician Workforce Data Report. The results for Maryland from the 2019-2020 State Physician Workforce Data Report state that there are 23,791 active physicians and 7,075 primary care physicians practicing in Maryland.

Maryland Physician Workforce Profile

2019-2020

State Population:	6,045,680	Total Female Physicians:	9,984
Population ≤ age 24	1,861,822	Total MD or DO Students:	1,939
Total Active Physicians:	23,791	Total Residents:	3,031
Primary Care Physicians:	7,075		

For additional data, including maps and tables, please see the 2021 State Physician Workforce Data Report online at www.aamc.org/workforce

		MD	MD Rank	State Median
Physician Supply	Active Physicians per 100,000 Population, 2020	393.5	2	272.0
	Total Active Patient Care Physicians per 100,000 Population, 2020	309.4	6	239.8
	Active Primary Care Physicians per 100,000 Population, 2020	117.0	7	94.7
	Active Patient Care Primary Care Physicians per 100,000 Population, 2020	98.0	9	84.5
	Active General Surgeons per 100,000 Population, 2020	9.2	14	7.7
	Active Patient Care General Surgeons per 100,000 Population, 2020	7.3	17	7.0
	Percentage of Active Physicians Who Are Female, 2020	42.0%	4	36.1%
	Percentage of Active Physicians Who Are International Medical Graduates (IMGs), 2020	27.0%	9	19.7%
	Percentage of Active Physicians Who Are Age 60 or Older, 2020	35.8%	13	32.9%
	Percent of Active Physicians Who Identify as Asian, 2020	20.5%	9	13.7%
	Percent of Active Physicians Who Identify as Black or African American, 2020	12.3%	2	3.8%
	Percent of Active Physicians Who Identify as Hispanic, Latino or of Spanish Origin, 2020	3.3%	22	3.2%
	Percent of Active Physicians Who Identify as American Indian or Alaska Native, 2020	0.3%	40	0.4%
	Percent of Active Physicians Who Identify as Native Hawaiian or Other Pacific Islander, 2020	0.2%	18	0.1%
	Percent of Active Physicians Who Identify as Other Race/Ethnicity, 2020	1.6%	19	1.4%
	Percent of Active Physicians Who Identify as White, 2020	50.6%	46	67.3%
Undergraduate Medical Education (UME)	MD and DO Student Enrollment per 100,000 Population, AY 2019-2020 & 2020-2021	32.1	28	38.6
	Student Enrollment at Public MD and DO Schools per 100,000 Population, AY 2019-2020 & 2020-2021	22.3	19	21.5
	Percentage Change in Student Enrollment at MD and DO Schools, 2010-2020	0.1%	44	31.2%
	Percentage of MD Students Matriculating In-State, AY 2020-2021	24.8%	42	67.6%
Graduate Medical Education (GME)	Total Residents/Fellows in ACGME Programs per 100,000 Population as of December 31, 2019	50.1	12	32.7
	Total Residents/Fellows in Primary Care ACGME Programs per 100,000 Population as of Dec. 31, 2019	16.4	15	12.7
	Percentage of Residents in ACGME Programs Who Are IMGs as of December 31, 2019	24.7%	14	19.2%
	Ratio of Residents and Fellows (GME) to Medical Students (UME), AY 2019-2020 & 2020-2021	1.6	6	1.0
	Percent Change in Residents and Fellows in ACGME-Accredited Programs, 2010-2020	5.2%	48	24.4%
Retention	Percentage of Physicians Retained in State from Undergraduate Medical Education (UME), 2020	21.6%	40	39.7%
	Percentage of Physicians Retained in State from Public UME, 2020	24.1%	40	43.7%
	Percentage of Physicians Retained in State from Graduate Medical Education (GME), 2020	37.6%	43	45.1%
	Percentage of Physicians Retained in State from UME and GME Combined, 2020	52.6%	43	69.7%

State Rank: How the state ranks compared to the other 49. Rank of 1 goes to the state with the highest value for the category.
State Median: The value in the middle of the 50 states, with 25 states above the median and 25 states below (excludes the District of Columbia and Puerto Rico).
Due to changes in the Census data tables, population data was only available for ages ≤ 24, compared to ages ≤ 21 in previous reports.
* Data not shown, for states with less than 10 physicians.
--- Indicated that category is not applicable because some states do not have data on this
N.R. = "Not Ranked"

Source: 2021 State Physician Workforce Data Report.Population estimates as of July 1, 2019 are from the U.S. Census Bureau (Release date: December 2019).

The specialty with the highest people to physician ratios was pediatric cardiology. Females make up 42.0% of all specialists. Additionally, 35.8% of specialists in Maryland are 60 years of age and older.

Maryland Physician Workforce Profile

Specialty	Total Active Physicians	People Per Physician	Female		Age 60 or Older	
			Number	Percent	Number	Percent
All Specialties	23,791	254	9,984	42.0	8,507	35.8
Allergy & Immunology	215	28,119	98	45.6	105	48.8
Anatomic/Clinical Pathology	384	15,744	160	41.7	211	54.9
Anesthesiology	974	6,207	342	35.1	374	38.4
Cardiovascular Disease	561	10,777	105	18.8	310	55.3
Child & Adolescent Psychiatry**	334	5,574	213	64.0	102	30.5
Clinical Cardiac Electrophisiology	54	111,957	*	*	*	*
Critical Care Medicine	410	14,746	126	30.8	57	13.9
Dermatology	307	19,693	166	54.1	106	34.5
Emergency Medicine	939	6,438	346	36.8	199	21.2
Endocrinology, Diabetes & Metabolism	301	20,085	177	58.8	103	34.2
Family Medicine/General Practice	1,627	3,716	899	55.3	569	35.0
Gastroenterology	391	15,462	104	26.6	167	42.7
General Surgery	555	10,893	135	24.3	226	40.7
Geriatric Medicine***	181	7,553	89	49.2	57	31.5
Hematology & Oncology	541	11,175	205	37.9	194	35.9
Infectious Disease	498	12,140	209	42.0	164	32.9
Internal Medicine	3,537	1,709	1,432	40.5	1,360	38.5
Internal Medicine/Pediatrics	119	50,804	81	68.1	*	*
Interventional Cardiology	61	99,110	*	*	*	*
Neonatal-Perinatal Medicine	131	46,150	91	69.5	52	39.7
Nephrology	279	21,669	102	36.6	86	30.8
Neurological Surgery	124	48,755	13	10.5	42	33.9
Neurology	458	13,200	151	33.0	217	47.4
Neuroradiology	105	57,578	25	23.8	12	11.4
Obstetrics & Gynecology	1,073	5,634	723	67.4	349	32.5
Ophthalmology	577	10,478	196	34.0	218	37.8
Orthopedic Surgery	403	15,002	28	6.9	187	46.4
Otolaryngology	240	25,190	64	26.7	85	35.4
Pain Medicine & Pain Management	152	39,774	38	25.0	17	11.2
Pediatric Anesthesiology & Anesthesia	57	106,065	33	57.9	*	*
Pediatric Cardiology	50	120,914	20	40.0	15	30.0
Pediatric Critica Care Medicine	64	94,464	44	68.8	*	*
Pediatric Hematology & Oncology	135	44,783	72	53.3	34	25.2
Pediatrics**	1,591	1,170	1,058	66.7	627	39.5
Physical Medicine & Rehabilitation	252	23,991	96	38.4	77	30.6
Plastic Surgery	182	33,218	37	20.3	77	42.3
Preventive Medicine	395	15,306	174	44.1	219	55.4
Psychiatry	1,111	5,442	490	44.1	599	53.9
Pulmonary Disease	121	49,964	16	13.2	108	89.3
Radiation Oncology	134	45,117	56	41.8	36	26.9
Radiology & Diagnostic Radiology	628	9,627	222	35.5	274	43.6
Rheumatology	220	27,480	110	50.0	80	36.4
Sports Medicine	56	107,959	18	32.1	*	*
Sports Medicine Orthopedic Surgery	64	94,464	*	*	11	17.2
Thoracic Surgery	100	60,457	*	*	46	46.0
Urology	240	25,190	26	10.8	84	35.0
Vascular & Interventional Radiology	76	79,548	13	17.1	*	*
Vascular Surgery	114	53,032	23	20.2	29	25.4

Sources: AMA Physician Masterfile (December 31, 2020), Population estimates as of July 1, 2019 are from the U.S. Census Bureau (Release date: December 2019)

* Counts and percentages for specialties with fewer than 10 physicians are not shown

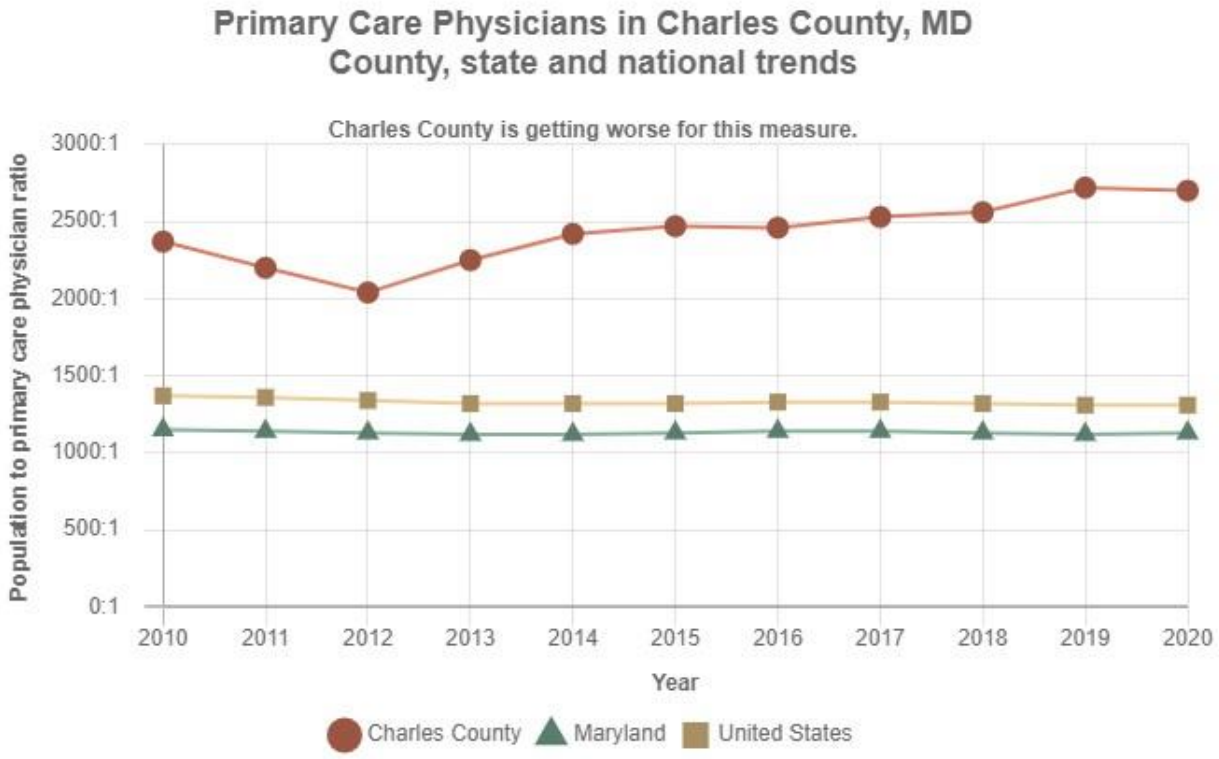
** Only those 24 years or younger are included in People Per Physician

*** Only those 60 years or older are included in People Per Physician

Primary Care Physicians and Mental Health Provider Ratios:

Access to care requires not only financial coverage, but also, access to providers. While high rates of specialist physicians have been shown to be associated with higher, and perhaps unnecessary utilization, sufficient availability of primary care physicians is essential for preventive and primary care, and when needed, referrals to appropriate specialty care. Using data from the Area Health Resource File and the American Medical Association, the County Health Rankings were able to provide 2020 primary care physician ratios for all United States counties. For 2020, the Charles County primary care physician ratio was 2700:1. Primary Care Physicians (PCP) is the ratio of the population to total primary care physicians.

Primary care physicians include non-federal, practicing physicians (M.D.'s and D.O.'s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. The 2020 Charles County PCP ratio is more than twice as high as the Maryland state ratio of 1130:1. The Charles County PCP ratio has gotten worse since the last needs assessment report when the ratio was 2530:1.



Notes:
The data in this table reflect the average population served by a single primary care physician.

The 2022 ratio of population to primary care providers other than physicians for Charles County was 1030:1. This was higher than the Maryland other primary care provider ratio of 770:1 and the national ratio of 810:1.

The 2022 ratio of population to mental health providers for Charles County was 520:1. This was higher than the Maryland mental health provider ratio of 310:1 and the national ratio of 340:1.

UNIVERSITY of MARYLAND MEDICAL SYSTEM **Revenue Cycle Services**	**PAGE:** **1 OF 14**	**POLICY NO:** **RCS - 01**
	EFFECTIVE DATE: 09/18/19	**REVISION DATE(S):** 07/01/24
SUBJECT: UMMS Financial Assistance Policy		

KEY WORDS:
Financial Assistance, Financial Hardship, Financial Clearance, Medical Assistance

OBJECTIVE/BACKGROUND:
The purpose of the following policy statement is to describe the financial assistance application process, how applications are reviewed and determinations of eligibility are made, eligibility criteria for financial assistance programs (including presumptive eligibility and financial hardship assistance), financial clearance of patients with medically unique or humanitarian needs, how UMMS notifies patients of the availability financial assistance availability, the appeal process, and extraordinary collection actions.

APPLICABILITY:
This policy applies to all team members, vendors, and agents [volunteers, medical team members] of any of the following University of Maryland Medical System member organizations:

University of Maryland Medical Center (UMMC)
UM Midtown Campus (MTC)
UM Rehabilitation & Orthopaedic Institute (UMROI)
UM St. Joseph Medical Center (UMSJMC)
UM Baltimore Washington Medical Center (UMBWMC)
UM Shore Regional Health (UMSRH)
UM Shore Medical Center at Dorchester (UMSMCD)
UM Shore Medical Center at Easton (UMSME)
UM Charles Regional Medical Center (UMCRMC)
UM Upper Chesapeake Health (UCHS)
UM Capital Region Health (UMCRH)
UM Physician Networks (UMPN)
UMMS Outpatient Rx Weinberg
UMMC Pharmacy at Redwood
UMMS Pharmacy Services
UMMC Mid-Town Campus Pharmacy
UMMC Pharmacy at Capital Region
UMMC Pharmacy at Baltimore Washington

DEFINITIONS:

Federal Poverty Level	A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits.
Financial Hardship	Instances in which member organization charges incurred at UMMS member organizations for medically necessary treatment by a family household over a twelve (12) month period that exceeds 25% of that family's annual income.
MDH Limits	Refers to the income eligibility limits for reduced cost care, set by Maryland Department of Health (MDH) office of Medical Assistance Planning. The State of Maryland accepted the Federal Medicaid expansion on January 1, 2014 vs the Federal Poverty Levels, under the Affordable Care Act, which expanded the eligible income limits for Maryland Medicaid. UMMS adopted these new limits for the reduced cost care sliding scale, as set forth in Attachment A.
Medical Debt	Out-of-pocket expenses, including co-payments, coinsurance, and deductibles, incurred at UMMS member organizations for medically necessary treatment.
Presumptive Eligibility	Instances in which information provided by the patient or through other sources provides sufficient evidence that the patient is eligible for financial assistance, but there is no financial assistance form on file.

POLICY:

The University of Maryland Medical System ("UMMS") is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergent and medically necessary care based on their individual financial situation.

It is the policy of the University of Maryland Medical System ("UMMS") member organizations to provide financial assistance which meets or exceeds the requirements set forth by the State of Maryland for patients who meet specified financial criteria and request such assistance.

I. **Free Care -** Those with income up to 200% of the income eligibility limits established by the Maryland Department of Health are eligible for free care.

II. **Reduced Cost Care -** Those between 200% and 300% of the income eligibility limits established by the Maryland Department of Health are eligible for discounts on a sliding scale, as set forth in Attachment A.

III. **Financial Hardship -** Those who otherwise do not qualify for financial assistance under the primary guidelines of this policy, but for whom their medical debt incurred at all UMMS member organizations exceeds 25% of the Family Annual Household Income, are eligible for financial hardship assistance.

Payment plans are also available to all patients. Plan terms may be modified at the request of the patient. Additional information on payment plans is available in the UMMS Payment Plan Policy. UMMS retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent/urgent services, financial assistance applications will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

PROCEDURE:

I. How To Apply for Financial Assistance

For any episode of care, the financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill for the care is sent. Patients may voluntarily apply for financial assistance before or after receiving healthcare services, or they may be identified as potential candidates for financial assistance during the financial clearance process or a presumptive financial assistance eligibility screening.

Financial clearance is a process that determines a patient's ability and likelihood to pay. When possible effort will be made to provide financial clearance prior to date of service. During the financial clearance process, patients who indicate they are unemployed and have no insurance coverage will be required to submit a financial assistance application before receiving non-emergency medical care (unless they meet presumptive financial assistance eligibility criteria).

There will be one application process for all UMMS member organizations. UMMS will accept the Faculty Physicians, Inc.'s (FPI) completed financial assistance applications (and application requirements) in determining eligibility for the UMMS Financial Assistance program. Patients are required to provide a completed financial assistance application (with all required information and documentation), unless they meet the criteria for presumptive eligibility. To facilitate this process, each applicant must provide information about

family size and income. Oral submission of needed information will be accepted, where appropriate. UMMS will provide the financial assistance application to all patients regardless of health insurance status to all patients, including uninsured patients, and the application will be readily available on the UMMS website and by request.

Supporting Documentation for Financial Assistance Applications

To help applicants complete the process, required and suggested documentation will be clearly listed on the financial assistance application, including:

- A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return); proof of disability income (if applicable), proof of social security income (if applicable).
- If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.
- A copy of their most recent pay stubs (if employed) or other evidence of income.
- A Medical Assistance Notice of Determination (if applicable).
- Copy of their Mortgage or Rent bill (if applicable), or written documentation of their current living/housing situation.
- If a patient submits both a copy of their most recent Federal Income Tax Return and a copy of their most recent pay stubs (or other evidence of income), and only one of the two documents indicates eligibility for financial assistance, the most recent document will dictate eligibility.

Financial assistance may not be denied based on the omission of information or documentation that is not specifically required in this policy or on the financial assistance application, and UMMS reserves the right to offer financial assistance to patients that have not provided all supporting documentation.

- If a patient submits a financial assistance application without the information or documentation required for a final determination of eligibility, a written request for the missing information or documentation will be sent to the patient.
- This written request will also contain the contact information (including telephone number and physical location) of the office or department that can provide information about financial assistance and assistance with the application process.
- The patient will have thirty (30) days from the date this written request is provided to submit the required information or documentation to be considered for eligibility. If no the information is not received within the 30 days, a letter will be sent notifying the patient that the case is now closed for lack of the required documentation.
- The patient may re-apply for financial assistance and initiate a new case by submitting the missing information or documentation

II. Reviewing and Determining Eligibility of Financial Assistance Applications

There are designated team members who will be responsible for taking financial assistance applications. These team members can be financial counselors, patient financial receivable coordinators, customer service representatives, or third party agencies working as an extension of the central business office. To help applicants complete the process, UMMS will provide the financial assistance application that will let them know what paperwork is required for a final determination of eligibility. Where possible, designated team

members will consult via phone or meet with patients who request financial assistance to determine if they meet preliminary criteria for assistance.

Preliminary data will be entered into a third party data exchange system which will allow the designated team member to track the application and determine eligibility for financial assistance. Designated team members will:

- Determine whether the patient has health insurance. Patients who have access to other medical coverage (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for financial assistance.
- If the patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the designated team member and recommendations shall be made to Senior Leadership.
- Complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage. To facilitate this process each applicant must provide information about family size and income.
- Determine whether the patient is presumptively eligible for free or reduced-cost care.
- Determine whether uninsured patients are eligible for public or private health insurance. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

To the extent practicable, the designated team members will offer assistance to uninsured patients if the patient chooses to apply for public or private health insurance, determine whether the patient is eligible for other public programs that may assist with health care costs, and use information available to UMMS to determine whether the patient is qualified for free or reduced-cost care under the UMMS Financial Assistance policy.

Within two business days of receipt of a patient's request for financial assistance or an application for medical assistance, UMMS must make a determination of probable eligibility. The determination of probable eligibility is subject to change, based on the receipt of supporting documentation.

If the patient's financial assistance application is determined to be complete and appropriate, the designated team member will recommend the patient's level of eligibility and forward for a second and final approval. UMMS will provide final determination the patient's eligibility within 14 days after the patient submits a completed application for financial assistance and suspend any billing or collections actions while eligibility is being determined.

If a Financial Assistance Application is Approved

Once a patient is approved for financial assistance, financial assistance coverage is effective for the month of determination and a year prior to the determination.

- A letter of final determination will be submitted to each patient who has formally requested financial assistance, which includes (if applicable): the assistance for which the individual is eligible and the basis for the determination.
- UMMS may decide to extend the financial assistance eligibility period further into the past or the future on a case-by-case basis.

- Financial assistance is generally applicable to all emergency and other medically necessary care provided by each UMMS member organization (See Exclusions for more information).
- If additional healthcare services are provided beyond the eligibility period, patients must reapply for financial assistance.
- If the patient is determined to be eligible for reduced-cost care, and has already received a statement for eligible healthcare services rendered during the financial assistance coverage period, the patient will also be provided with a billing statement that indicates the amount the patient owes for the care after financial assistance is applied.
- If a patient made payments for healthcare services prior to receiving approval for financial assistance, they may be eligible for a refund. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. If the amount that the patient is determined able to pay is less than the amount of the patient payment, the resulting credit balance will be issued to the patient as a refund if the amount exceeds the patient's determined responsibility by $5.00 or more. This includes determinations of eligibility for financial assistance within 240 days after the initial bill was provided.

If there are changes to the patient's income, assets, expenses or family status, the patient is expected to notify the Financial Assistance Department at 410-821-4140. To facilitate this process, and ensure that patients have the opportunity to be re-evaluated for eligibility for financial assistance within 240 days of the initial statement, UMMS will notify patients that if their income has changed, they should contact the Financial Assistance Program Department on each statement.

If a Financial Assistance Application is Not Approved

If a patient is determined to be ineligible for financial assistance prior to receiving a service (for that service), all efforts to collect co-pays, deductibles, or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.

- If the patient is determined to be ineligible for financial assistance, and they applied in order to obtain financial clearance for non-emergent or non-urgent hospital based services, the designated team member will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.
- A clinician may appeal this decision and request reconsideration by the Financial Clearance Executive Committee on a case-by case basis.
- For emergent or urgent services, financial assistance applications will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.
- Patients who are ineligible for financial assistance will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.
- The patient may appeal the decision, please see the Appeals section for more information.
- For any episode of care, the financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill for the care is sent.

III. Eligibility Criteria

UMMS will offer financial assistance when a review of a patient's individual financial circumstances has been conducted and documented. UMMS will not use a patient's citizenship or immigration status as an eligibility

requirement for financial assistance; or withhold financial assistance or deny a patient's application for financial assistance on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, or on the basis of disability.

The following criteria will be applied in assessing a patient's eligibility for financial assistance, presumptive eligibility for financial assistance, and eligibility for financial hardship assistance.

Financial Assistance Eligibility

UMMS will refer to the MDH household income thresholds to determine eligibility for financial assistance and the level of free or reduced cost care to award to eligible patients. UMMS will calculate a patient's family (household) income at time of service. To account for any changes in financial circumstance, UMMS will recalculate family (household) income within 240 days after the initial hospital bill is provided.

UMMS may consider household monetary assets in determining eligibility for free and reduced-cost care under the financial assistance policy in addition to income-based criteria. Monetary assets shall be adjusted annually for inflation in accordance with the Consumer Price Index. The following monetary assets that are convertible to cash shall be excluded:

- At a minimum, the first $10,000 of monetary assets.
- A safe harbor equity of $150,000 in a primary residence.
- Retirement assets that the Internal Revenue Service has granted preferential tax treatment as a retirement account, including deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred-compensation plans.
- One motor vehicle used for the transportation needs of the patient or any family member of the patient;
- Any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act.
- Prepaid higher education funds in a Maryland 529 Program account.

In determining the family income of a patient, UMMS shall apply a definition of household size that consists of the patient and, at a minimum, a spouse (regardless of whether the patient and spouse expect to file a joint federal or State tax return), biological children, adopted children, or stepchildren, and anyone for whom the patient claims a personal exemption in a federal or State tax return. For a patient who is a child, the household size shall consist of the child and biological parents, adopted parents, or stepparents or guardians, biological siblings, adopted siblings, or stepsiblings, and anyone for whom the patient's parents or guardians claim a personal exemption in a federal or State tax return.

Patients may be deemed ineligible for financial assistance:

- If they have insurance coverage (e.g., HMO, PPO, or Workers Compensation, Medicaid, or other insurance programs), that denies access to UMMS due to insurance plan restrictions/limits.
- If they refuse to be screened for other assistance programs prior to submitting an application for financial assistance.
- If they refuse to divulge information pertaining to a pending legal liability claim.

Financial assistance generally applies to all emergency and other medically necessary care provided by each UMMS member organization; however, the following exclusions may apply:

- Services provided by healthcare providers not affiliated with UMMS member organizations (e.g., durable medical equipment, home health services).
- Services denied by a patient's insurance program or policy (e.g., HMO, PPO, or Workers Compensation). Exceptions may be made on a case by case basis considering medical and programmatic implications.
- Cosmetic or other non-medically necessary services.
- Patient convenience items, meals, and lodging.
- Supervised Living accommodations and meals while a patient is in the Day Program.
- Third Party Liability claims (Auto Accident, Workers Compensation, Bodily Injury, or other legal claim) until all means of payment are exhausted.

Financial assistance for professional charges awarded under this policy applies to the UM Physician Network (UMPN). Patients who wish to pursue financial assistance for non-UM Physician Network charges must contact the physician or provider group directly. A list of providers delivering medically necessary care in each UMMS hospital can be obtained on the website of each UMMS entity. This list specifies which such as providers do not participate in the UMMS Financial Assistance Policy.

Presumptive Financial Assistance Eligibility

In the event there is no evidence to support a patient's eligibility for financial assistance, UMMS reserves the right to determine presumptive financial assistance eligibility for all hospital accounts. To determine presumptive eligibility for financial assistance, UMMS may use outside agencies or information to estimate income which can be used to assess the patient's eligibility for financial assistance eligibility. Due to the inherent nature of presumptive circumstances, UMMS will award free care to patients deemed presumptively eligible for financial assistance. Presumptive eligibility for financial assistance shall only cover the patient's specific date of service. UM Physician Network provider groups will offer financial assistance on a physician balance based on a determination of eligibility on a hospital balance.

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

a. Active Medical Assistance pharmacy coverage
b. Specified Low Income Medicare (SLMB) coverage
c. Primary Adult Care (PAC) coverage
d. Homelessness
e. Patient currently has Medical Assistance coverage
f. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
g. Medical Assistance spend down amounts
h. Eligibility for other state or local assistance programs, such as:
    i) Supplemental Nutrition Assistance Program
    ii) State Energy Assistance Program
    iii) Special Supplemental Food Program for Women, Infants, and Children
    iv) Any other social service program as determined by MD DHMH and Health Services Cost Review Commission (HSCRC).

i. Patient is deceased with no known estate
j. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
k. Non-US Citizens deemed non-compliant
l. Non-Eligible Medical Assistance services for Medical Assistance eligible patients
m. Patients that are determined to meet Medical Assistance eligibility criteria outside the timely claim filing and/or application period
n. Patients that were determined to meet Medical Assistance eligibility criteria and in-between their new Non-Governmental Health Insurance coverage's activation waiting period
o. Unidentified patients (Doe accounts that we have exhausted all efforts to locate and/or ID)
p. Bankruptcy, by law, as mandated by the federal courts
q. Eligibility in certain UMMS clinical programs (including: St. Clare Outreach Program, UMMS Maternity Program, UMSJMC Hernia Program).

Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered for presumptive financial assistance until the Maryland Medicaid Psych program has been billed.

Financial Hardship Assistance Eligibility

Financial hardship assistance is available for patients who otherwise do not qualify for financial assistance under the primary guidelines of this policy, but for whom medical debt for medically necessary treatment over a twelve (12) month period exceeds 25% of that family's annual income.

- The amount of uninsured medical costs incurred at all UMMS member organizations will be considered in determining a patient's eligibility (including any accounts having gone to bad debt, except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses.
- For the patients who are eligible for reduced-cost care under the financial assistance criteria and also meet the criteria for financial hardship assistance criteria, UMMS will grant the total eligible reduction in charges.
- To calculate household income, UMMS will use the same criteria outlined in the Financial Assistance Eligibility section of this policy to calculate assets, household income, and family size.
- Once a patient is approved for financial hardship assistance, coverage will be effective for the month of the first qualifying date of service and a year prior to the determination. UMMS may decide to extend the financial hardship eligibility period further into the past or the future on a case-by-case basis.
- Financial hardship assistance will cover the patient and the eligible family members living in the household for the approved reduced cost and eligibility period for medically necessary care and will remain eligible for reduced-cost medically necessary care when seeking subsequent care at the same member organization during the 12–month period beginning on the date on which the reduced-cost medically necessary care was initially received. To avoid an unnecessary duplication of UMMS' determination of eligibility for free and reduced-cost care, the patient or eligible family members shall inform UMMS of the patient's or family member's eligibility for the reduced-cost medically necessary care.

All other eligibility, ineligibility, and procedures for primary financial assistance criteria apply to financial hardship assistance criteria, unless otherwise stated above.

IV. Appealing a Determination of Eligibility for Financial Assistance

Patients whose financial assistance applications are denied have the option to appeal the decision. Appeals can be initiated verbally or written. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.

If a patient wishes to make an appeal, UMMS will:

- Notify the patient that the Health Education and Advocacy Unit is available to assist them or their authorized representative in filing and mediating a reconsideration request.
- Provide the address, phone number, facsimile number, e-mail address, mailing address, and website of the Health Education and Advocacy Unit: Office of the Attorney General, Health Education and Advocacy Unit | 200 St. Paul Place, 16th Floor, Baltimore, MD 21202 | Phone: (410) 528-1840 | Toll-free in Maryland 1-877-261-8807 | Fax: (410) 576-6571 | Email: heau@oag.state.md.us
- Document appeals within the third party data and workflow tool for review by the next level of management above the representative who denied the original application.
- Submit a letter of final determination to each patient who has formally submitted an appeal.

Provider Driven Financial Clearance and Reconsideration

Where there is a compelling educational, medical, and/or humanitarian benefit, UMMS clinical team members may request financial clearance of patients that are not otherwise able or likely to pay for their healthcare services. Clinical team members must submit appropriate justification in advance of the patient receiving services. UMMS Revenue Cycle central billing office will evaluate the patient's eligibility for Medical Assistance and financial assistance. A Financial Clearance Executive Committee at the member organization level, comprised of clinical and financial leadership, will request the information submitted by the requesting clinical and the central billing office and make the final determination on whether to grant financial clearance on a case-by-case basis.

If financially cleared, patients are still responsible to complete the financial assistance application process, and may be subject to presumptive eligibility screening, as outlined in this policy.

V. Notice of Availability of Financial Assistance

UMMS will advise patients, patient's families, and authorized representatives of the availability of financial assistance using posted notices and the Patient Billing and Financial Assistance Information Sheet. The Patient Billing and Financial Assistance Information Sheet notifies the patient of the availability of financial assistance and payment plans, includes a description of UMMS Financial Assistance Policy, explains how to apply for financial assistance, and includes a description of the patient's rights and obligations with regard to hospital billing and collection under the law.

- UMMS will post notices of financial assistance availability in each UMMS hospital's emergency room (if any), admissions areas, key patient access areas, and the hospital billing office. Notice of availability will also be sent to the patient with patient statements.

- The Patient Billing and Financial Assistance Information Sheet will be provided at preadmission and before discharge for each hospital encounter, with each hospital statement, and it will be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas.
- The Financial Assistance Policy and the Financial Assistance Application will also be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas.
- The Financial Assistance Policy, the Patient Billing and Financial Assistance Information Sheet, and the Financial Assistance Application will also be conspicuously posted on the UMMS website (www.umms.org).

Patient Billing and Financial Assistance Information Sheet Content

In addition to the content referenced above, the Patient Billing and Financial Assistance Information Sheet will include:

- The website and physical location(s) where patients can obtain copies of the financial assistance policy and financial assistance application form
- Instructions on how to obtain a free copy of the financial assistance policy and financial assistance application form by mail.
- A statement of the availability of translations of the financial assistance documents.
- Contact information for UMMS Hospital Billing Customer Service Department, which is available to assist the patient, the patient's family, or the patient's authorized representative understand their statement, understand the patient's rights and obligations regarding the statement, learn how to apply for free or reduced cost care, or learn how to apply for Maryland Medical Assistance, or any other programs that may help pay their medical bills.
- Contact information for the Maryland Medical Assistance Program.
- A notification that physician charges are not included in the hospital statement and are billed separately.
- A notification informing patients of the right to request and receive a written estimate of the total charges for hospital nonemergency services, procedures, and supplies that reasonably are expected to be provided for professional services by the hospital.
- A notification that a patients who are eligible for free or reduced care may not be charged more than AGB for emergency or other medically necessary care.
- A section that informs the patient of their ability to make a formal complaint with the HSCRC and the Office of the Attorney General of Maryland.
- A section for the patient to initial to indicate that they have been made aware of UMMS Financial Assistance Policy

The Patient Billing and Financial Assistance Information Sheet will be written in plain language, as specified by the Requirements for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r), and will be made available in the patient's preferred language. It will also include a section that allows for patients to initial that they have been made aware of the financial assistance policy.

VI. Extraordinary Collection Actions

Account balances that have not been paid may be transferred to Bad Debt (deemed uncompensated care) and referred to an outside collection agency or to UMMS's attorney for legal and/or collection activity. Third party agencies and/or attorneys are jointly and severally responsible for meeting the debt collection requirements listed in this policy, and in the UMMS Credits and Collections Policy. Collection activities taken on behalf of UMMS by a collection agency or UMMS' attorney may include the following Extraordinary Collection Actions (ECAs):

- Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus. UMMS will not report adverse information to a consumer reporting agency regarding a patient who was uninsured or eligible for free or reduced-cost care at the time of service. UMMS will not report to a consumer reporting agency until at least 180 days after the initial statement was provided. Prior to reporting to a consumer reporting agency, UMMS will determines whether the patient is eligible for free or reduced-cost care. UMMS will not report adverse information about a patient to a consumer reporting agency if UMMS was notified in accordance with federal law by the patient or an insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days, or if UMMS has completed a requested reconsideration of the denial of free or reduced-cost care that was appropriately completed by the patient within the immediately preceding 60 days.
- Commencing a civil action against the individual. UMMS will not hold a spouse or another individual liable for the debt owed on a hospital bill of an individual who is at least 18 years old. UMMS will not file a civil action to collect debt until at least 180 days of after the initial bill was provided. Prior to filing the civil action, UMMS will determines whether the patient is eligible for free or reduced-cost care. UMMS will not file a civil action to collect debt if UMMS was notified in accordance with federal law by the patient or an insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days. UMMS will not file a civil action to collect debt if UMMS has completed a requested reconsideration of the denial of free or reduced-cost care that was appropriately completed by the patient within the immediately preceding 60 days.
- Attaching or seizing an individual's bank account or any other personal property.
- Garnishing an individual's wage. UMMS will not request a garnishment of wages or file an action that would result in an attachment of wages against a patient if the patient is eligible for free or reduced-cost care.

ECAs may be taken on accounts that have not been disputed or are not on a payment arrangement. ECAs will occur no earlier than 180 days from submission of first post-discharge bill to the patient and will be preceded by a written notice 45 days prior to commencement of the ECA. This written notice will be accompanied by an application for financial assistance (and instructions for completing the application) and a notice of availability of a payment plan to satisfy the medical debt, and the Patient Billing and Financial Assistance Information Sheet. The written notice will include the following information:

- Specified contact and procedural information.
    - The name and telephone number for UMMS,
    - The name and telephone number for the debt collector (if applicable)
    - The contact information for the UMMS Financial Assistance Department (or third party agency acting on behalf of UMMS), authorized to modify the terms of a payment plan (if applicable)
    - Telephone number and internet address of the Health Education Advocacy Unit in the Office of the Attorney General, available to assist patients experiencing medical debt.

- The amount required to satisfy the debt (including any past due payments, penalties, or fees, if applicable)
- Identification of ECAs that UMMS (or its collection agency, attorney, or other authorized party) intends to utilize in order to obtain payment for the care, and state a deadline after which such ECAs may be initiated.
- A deadline after which such ECA(s) may be initiated that is no earlier than 45 days after the date that the written notice is provided.
- A statement recommending that the patient seek debt counseling services,
- An explanation of the UMMS Financial Assistance Policy, and a notification of availability of financial assistance for eligible individuals
- And any other information as prescribed by the HSCRC

Written notice and accompanying documentation will be sent to the patient by certified mail and first class mail, in the patient's preferred language, or another language, as specified. The written notice will be in simplified language of at least 10 point type.

In addition to the written notification, UMMS (and/or its collection agency or attorney) will make reasonable efforts to orally communicate the availability of financial assistance to the patient and tell the patient how he or she may obtain assistance with the application process. A presumptive eligibility review will occur prior to any ECA being taken. Finally, no ECA will be initiated until approval has been obtained from the UMMS Revenue Cycle Services leadership.

If a patient is determined to be eligible for financial assistance, UMMS (and/or its collection agency or attorney) will take all reasonably available measures to reverse any ECAs taken against the patient to obtain payment for care rendered during the financial assistance eligibility window. Such reasonably available measures will include measures to vacate any judgment against the patient, lift levies or liens on the patient's property, and remove from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau. All ECAs will cease once the patient is approved for financial assistance and all the patient responsible balances are paid.

UMMS will not engage in the following ECAs:

- Selling debt to another party.
- Charge interest on bills incurred by patients before a court judgement is obtained
- Requesting a lien against a patient's primary residence. In some cases, Local, State, or Federal judicial protocols may mandate that a lien is placed, but UMMS will not force the sale or foreclosure of a patient's primary residence.
- Request the issuance of or take action causing a court to issue a body attachment or an arrest warrant against a patient.
- Make a claim against the estate of a deceased patient if the deceased patient was known by UMMS to be eligible for free care or if the value of the estate after tax obligations are fulfilled is less than half of the debt owned. However, UMMS may offer the family of the deceased patient the ability to apply for financial assistance.
- Require payment of medical debt prior to providing medically necessary care.

ATTACHMENTS:

ATTACHMENT A: Sliding Scale – Reduced Cost of Care

2024 Federal Poverty Limits (FPL) Annual Income Eligibility Limit Guidelines							
House-hold (HH) Size	1	2	3	4	5	6	See UMMS Charity Thresholds below
Income Limit (up to Max)	$15,060	$20,440	$25,820	$31,200	$36,580	$41,960	

2024 Maryland Dept of Health (MDH) Annual Income Eligibility Limit Guidelines							
House-hold (HH) Size	1	2	3	4	5	6	See UMMS Charity Thresholds below
Income Limit (up to Max)	$20,784	$28,224	$35,640	$43,056	$50,496	$57,912	

UMMS Financial Assistance Charity Income Thresholds							
If your total annual household (HH) income level is at or below:							You are eligible for the following level of charity at UMMS:
House-hold (HH) Size	1	2	3	4	5	6	
Income Limit (up to Max)	$41,568	$56,448	$71,280	$86,112	$100,992	$115,824	**100% Charity** (Equals Up to 200% of MDH Annual Income limits)
Income Limit (up to Max)	$43,646	$59,270	$74,844	$90,418	$106,042	$121,615	**90% Charity** (Equals Up to 210% of MDH Annual Income limits)
Income Limit (up to Max)	$45,725	$62,093	$78,408	$94,723	$111,091	$127,406	80% Charity (Equals Up to 220% of MDH Annual Income limits)
Income Limit (up to Max)	$47,803	$64,915	$81,972	$99,029	$116,141	$133,198	**70% Charity** (Equals Up to 230% of MDH Annual Income limits)
Income Limit (up to Max)	$49,882	$67,738	$85,536	$103,334	$121,190	$138,989	60% Charity (Equals Up to 240% of MDH Annual Income limits)
Income Limit (up to Max)	$51,960	$70,560	$89,100	$107,640	$126,240	$144,780	**50% Charity** (Equals Up to 250% of MDH Annual Income limits)
Income Limit (up to Max)	$54,038	$73,382	$92,664	$111,946	$131,290	$150,571	**40% Charity** (Equals Up to 260% of MDH Annual Income limits)
Income Limit (up to Max)	$56,117	$76,205	$96,228	$116,251	$136,339	$156,362	**30% Charity** (Equals Up to 270% of MDH Annual Income limits)
Income Limit (up to Max)	$58,195	$79,027	$99,792	$120,557	$141,389	$162,154	**20% Charity** (Equals Up to 280% of MDH Annual Income limits)
Income Limit (up to Max)	$60,274	$81,850	$103,356	$124,862	$146,438	$167,945	**10% Charity** (Equals Up to 290% of MDH Annual Income limits)

*All discounts stated above shall be applied to the amount the patient is personally responsible for paying after insurance reimbursements.
*Amounts billed to patients who qualify for Reduced-Cost of Care on a sliding scale (or for Financial Hardship Assistance) will be less than the amounts generally billed to those with insurance (AGB), which in Maryland is the charge established by the Health Services Cost Review Commission (HSCRC). UMMS determines AGB by using the amount Medicare would allow for the care (including the amount the beneficiary would be personally responsible for paying, which is the HSCRC amount; this is known as the "prospective Medicare method".

Effective 7/1/24

RELATED POLICIES:
UMMS Credit & Collections Policy
UMMS Payment Plan Policy

POLICY OWNER:
UMMS Revenue Cycle Services

APPROVED:
Executive Compliance Committee Approved Initial Policy: 09/18/19
Executive Compliance Committee Approved Revisions: 10/19/2020, 11/07/22

Federal Poverty Level and Maryland Department of Health Annual Income Eligibility Limit Updated: 07/01/20, 07/01/21, 07/01/22, 07/01/23, 07/01/24

This policy was approved by the UMMS Executive Compliance Committee (ECC) Board on October 19, 2020. This policy was adopted for:

- UM St. Joseph Medical Center (UMSJMC) effective June 1, 2013.
- UM Midtown Campus (MTC) effective September 22, 2014.
- UM Baltimore Washington Medical Center (UMBWMC) effective July 1, 2016.
- UM Shore Regional Health (UMSRH) effective September 1, 2017.
- UM Charles Regional Medical Center (UMCRMC) effective December 2, 2018.
- UM Upper Chesapeake Health (UCHS) effective July 1, 2019
- UM Capital Region Health (UMCRH) effective September 18, 2019