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 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. In response to the legislation, some of the reporting questions have changed for FY 2021. Detailed reporting instructions are available here: https://hscrc.maryland.gov/Pages/init_cb.aspx

In this reporting tool, responses are mandatory unless specifically marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

For technical assistance, contact HCBHelp@hilltop.umbc.edu.

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

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

	Is this information correct? Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: TidalHealth McCready Pavilion	◉	○	TidalHealth McCready Pavilion located in Crisfield, Maryland is now a Freestanding Medical Facility and is no longer a designated hospital. It is currently a department of TidalHealth Peninsula Regional.
Your hospital's ID is: 210045	◉	○	TidalHealth McCready is a department of TidalHealth Peninsula Regional. The HSCRC will continue to use the now defunct CMS Certification ID 210045.
Your hospital is part of the hospital system called TidalHealth	◉	○	
The primary Narrative contact at your hospital is Henry Nyce	○	◉	Katherine Rodgers, MPH Director of Community Health Initiatives Population Health Management
The primary Narrative contact email address at your hospital is henry.nyce@tidalhealth.org	○	◉	katherine.rodgers@tidalhealth.org 410-912-5826
The primary Financial contact at your hospital is Cindy Sapp	◉	○	
The primary Financial email at your hospital is cindy.sapp@tidalhealth.org	◉	○	

Q4. 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.

Q5. Please select the community health statistics that your hospital uses in its community benefit efforts.

- ☑ Median household income
- ☑ Percentage below federal poverty line (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

Q6. Please describe any other community health statistics that your hospital uses in its community benefit efforts.

TidalHealth McCready Pavilion uses combined primary and secondary health statistics to provide an understanding of the health status, health disparity, quality of life and risks factors to provide insight into the needs of our community. Specific health indexes that are reviewed include an index of disparity, health equity index, food insecurity index and mental health index, In addition, we tract households without a vehicle, racial ethnicity diversity and extensively rely on the ALICE report as a way to define and identify households and geographic regions that struggle with basic health and household necessities but do not qualify for Federal Assistance.

Q7. Attach any files containing community health statistics that your hospital uses in its community benefit efforts.

CHNA Secondary Data Analysis 10.01.21.pdf
6.2MB
application/pdf

Q8. Section I - General Info Part 2 - Community Benefit Service Area

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.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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.

- [x] 21817
- [x] 21821
- [ ] 21822
- [x] 21824
- [ ] 21836
- [x] 21838
- [ ] 21851
- [x] 21853
- [ ] 21857
- [ ] 21866
- [ ] 21867
- [x] 21871
- [ ] 21890

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.

TidalHealth McCready Pavilion identities its service area based on facility utilization history.

- [ ] Other. Please describe.

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

https://www.tidalhealth.org/about-us/mission-values

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

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

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

- (●) Yes
- ( ) No

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

This question was not displayed to the respondent.

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

05/16/2022

Q41. Please provide a link to your hospital's most recently completed CHNA. Please provide the entire CHNA, not just an Executive Summary.

https://www.tidalhealth.org/community-outreach-partners/community-health-research-data

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

Final_TidalHealth CHNA.pdf
15MB
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 your most recent CHNA development.

	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 exp 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)	☐	☐	☐	☐	☐	☐	☑	☑	☐	☑	The Board of Trustees receives a copy and a presentation Community Health Needs Assessment to ask questions, revi approve. There are periodic updates to action plans, key perfo indicators, partnerships and progress.
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	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 exp below:
Population Health Staff (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Community Benefit staff (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Community Benefit staff (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☑	Those identified in the preceding positions such as nurses, workers, health educators, patient advocates, community health care coordinators, behavioral specialists continue to have inpu health needs of our community working closely with the Com Benefit/Population Health Staff.
	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 exp below:
Physician(s)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Nurse(s)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Social Workers	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Other (specify) Behavioral Health, Marketing, Planning, Diabetes Department, Emergency Department, Cardiac Rehab, Pediatric Endocrinology, Employee Health and Wellness, Oncology, Women's and Children's, Patient Care Management	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	We relied upon the knowledge of these participants in each o divisions as they brought their own unique experiences and con to the process.
	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 exp below:

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)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	The Board of Trustees receives a copy of the Community Benefits Implementation Plan along with an educational session which includes a narrative, financial data, and an explanation of how the Hospital is addressing identified critical health needs in the community through the CHNA. Following discussion and any required or modified changes, the Board will accept the Community Benefit Implementation Plan through the passing of a resolution. Several times throughout the year, updates to the plan may be provided to the Board of Trustees along with discussion on progress, challenges and what could be done to better improve outreach.
Clinical Leadership (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Clinical Leadership (system level)	☐	☐	☐	☐	☐	☐	☑	☑	☑	☐	
Population Health Staff (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Population Health Staff (system level)	☐	☐	☑	☑	☑	☐	☑	☑	☑	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Community Benefit staff (system level)	☐	☐	☑	☑	☑	☐	☑	☑	☑	☐	
Physician(s)	☐	☐	☐	☐	☐	☐	☐	☑	☑	☑	Has oversight, provides guidance over the initiatives and helps to direc the overall community benefit efforts.
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 2022 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is mandatory for FY 2022.

	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

	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:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Local Health Department -- Please list the Local Health Departments here: Wicomico County Health Department, Somerset County Health Department	☑	☑	☑	☑	☐	☑	☑	☑	☐	☑	☑	☑	☑	☑
Local Health Improvement Coalition -- Please list the LHICs here: Wicomico County LHIC, Somerset County LHIC, Sussex County Health Coalition	☑	☑	☑	☑	☐	☑	☑	☑	☐	☑	☑	☑	☑	☑
Maryland Department of Health	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other State Agencies -- Please list the agencies here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Local Govt. Organizations -- Please list the organizations here: Wicomico County Council	☑	☑	☐	☐	☐	☐	☐	☑	☐	☑	☐	☐	☐	☐
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: Somerset County 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: niversity of Maryland Eastern Shore, Salisbury University	☑	☑	☐	☐	☐	☐	☐	☑	☐	☑	☐	☐	☐	☐
	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: Recovery Resource Center, Inc.	☑	☑	☐	☐	☐	☐	☐	☑	☐	☑	☐	☐	☐	☐
	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: Maintaining Active Citizens (MAC), Somerset 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: Deers Head Hospital Center	☑	☑	☐	☐	☐	☐	☐	☑	☐	☑	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Community/Neighborhood Organizations -- Please list the organizations here: Rebirth, empower immigrants, low-income workers, HOPE Inc. Help and Outreach Point of Entry	☑	☑	☐	☐	☐	☐	☐	☑	☐	☑	☐	☐	☐	☐

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

Q49. Section II - CHNAs and Stakeholder Involvement Part 5 - Follow-up

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

- (●) Yes
- ( ) No

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

11/07/2019

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

https://www.tidalhealth.org/community-outreach-partners/community-health-research-data

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

Implementation Strategy Community Benefit 2019.pdf
3.3MB
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.

TidalHealth McCready Pavilion has a preliminary draft of the 2022 Community Benefit Implementation Strategy / CHIP which will be finalized this winter, as we continue to work with our partners Wicomico and Somerset County Health Departments. As we transition to the new plan some of the health strategies and initiatives shall continue as there will be overlap from the previous implementation plan. TidalHealth and partners will be concentrating on the following community benefit healthcare themes moving forward as identified in the new 2022 CHNA; Access to health services, Health equity within our communities, Chronic disease management, Behavioral Health and overall Wellness. In addition, Katherine Rodgers, TidalHealth's Director of Community Health Initiatives co-chairs the Wicomico County LHIC. Both Somerset and Wicomico County LHICs have approved the 2022 CHIP. This implementation plan goes before TidalHealth's Board in January. TidalHealth, Somerset County Health Department (SCHD) and Wicomico County Health Department (WiCHD) worked collaboratively to develop this Community Health Improvement Plan and Implementation Strategy in response to the 2022 Community Health Needs Assessment. The collaborative approach reduces duplication of resources and provides a more comprehensive approach to addressing health improvement. For purposes of this report, the three leading organizations: TidalHealth, SCHD, and WiCHD will collectively be referred to as "the Partnership." A community health improvement plan (or CHIP) is a long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process. Health and other governmental education and human service agencies, in collaboration with community partners, use this plan to set priorities, coordinate and target resources. At the heart of this plan are the fundamental goals and actions that will enable communities to improve health and environment, implement policies to support healthy lifestyles, increase access to health services, and strengthen safety net systems that foster more effective and equitable delivery of health services. Conduent HCI worked with the Partnership as a leadership committee to create a joint framework that serves both the needs of nonprofit hospital and health department partners, as well as the entire service area encompassing the Lower Eastern Shore of Maryland and Sussex County, Delaware. Please note the Community Benefit Stategic Implementation/ CHIP is a living document adapted in response to everchanging citizens, community and stakeholders needs. Any list(s) of partners included is not exhaustive. The Partnership welcomes any organizations and stakeholders involved in priority-centered work to join the Teams efforts. Below we have attached a preliminary draft that is being worked on and will be finalized this Winter.

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

Prelim Implementation_Strategy_Community_Benefit_2022.pdf
949.9KB
application/pdf

Q57. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- ○ Yes
- ◉ No

Q58.

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

- ☐ Health Conditions - Addiction
- ☐ Health Conditions - Arthritis
- ☑ Health Conditions - Blood Disorders
- ☐ Health Conditions - Cancer
- ☐ Health Conditions - Chronic Kidney Disease
- ☐ Health Conditions - Chronic Pain
- ☐ Health Conditions - Dementias
- ☐ Health Conditions - Diabetes
- ☑ Health Conditions - Foodborne Illness
- ☑ Health Conditions - Health Care-Associated Infections
- ☐ Health Conditions - Heart Disease and Stroke
- ☐ Health Conditions - Infectious Disease
- ☐ Health Conditions - Mental Health and Mental Disorders
- ☐ Health Conditions - Oral Conditions
- ☐ Health Conditions - Osteoporosis
- ☐ Health Conditions - Overweight and Obesity
- ☐ Health Conditions - Pregnancy and Childbirth
- ☐ Health Conditions - Respiratory Disease
- ☑ Health Conditions - Sensory or Communication Disorders
- ☑ Health Conditions - Sexually Transmitted Infections
- ☐ Health Behaviors - Child and Adolescent Development
- ☐ Health Behaviors - Drug and Alcohol Use
- ☐ Health Behaviors - Emergency Preparedness
- ☑ Health Behaviors - Family Planning
- ☐ Health Behaviors - Health Communication
- ☐ Health Behaviors - Injury Prevention
- ☐ Health Behaviors - Nutrition and Healthy Eating
- ☐ Health Behaviors - Physical Activity
- ☐ Health Behaviors - Preventive Care
- ☑ Health Behaviors - Safe Food Handling
- ☑ Health Behaviors - Sleep
- ☐ Health Behaviors - Tobacco Use
- ☐ Health Behaviors - Vaccination
- ☑ Health Behaviors - Violence Prevention
- ☐ Populations - Adolescents
- ☐ Populations - Children
- ☐ Populations - Infants
- ☐ Populations – LGBT
- ☑ Populations - Men
- ☑ Populations - Older Adults
- ☐ Populations - Parents or Caregivers
- ☐ Populations - People with Disabilities
- ☐ Populations - Women
- ☐ Populations - Workforce
- ☐ Other Social Determinants of Health
- ☐ Settings and Systems - Community
- ☑ Settings and Systems - Environmental Health
- ☐ Settings and Systems - Global Health
- ☐ Settings and Systems - Health Care
- ☐ Settings and Systems - Health Insurance
- ☐ Settings and Systems - Health IT
- ☐ Settings and Systems - Health Policy
- ☐ Settings and Systems - Hospital and Emergency Services
- ☐ Settings and Systems - Housing and Homes
- ☑ Settings and Systems - Public Health Infrastructure
- ☐ Settings and Systems - Schools
- ☐ Settings and Systems - Transportation
- ☐ Settings and Systems - Workplace
- ☐ Social Determinants of Health - Economic Stability
- ☐ Social Determinants of Health - Education Access and Quality
- ☐ Social Determinants of Health - Health Care Access and Quality
- ☐ Social Determinants of Health - Neighborhood and Built Environment
- ☐ Social Determinants of Health - Social and Community Context
- ☐ Other (specify)

Q59. Why were these needs unaddressed?

TidalHealth McCready Pavilion relied upon our most recent CHNA primary and secondary data analysis on input from all of our key partners, key stakeholder interviews, community member surveys and data analytics to prioritize a handful of critical community health needs. From this we developed a Strategic Community Benefits Implementation document that will drive tactics, initiatives, partnerships, resources and key performance indicators. Based upon Hospital resources and the aftermath of COVID it is not possible to address all issues, however, we listened to our partners and the community on what was needed and best matched that to TidalHealth and our Partnership core skill competencies.

Q60. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

TidalHealth McCready Pavilion uses data from the Community Health Needs Assessment and data from its Epic EHR stratified by race, ethnicity, age, language and gender to identify significant health disparities in the patient population. The Population Health division in partnership with community-based organizations, managed care organizations, the local health improvement coalitions, and local health departments, has initiatives underway to address disparities and health issues prioritized and included in the CHNA and Community Health Improvement Plan. From Fall 2020 through Spring 2022, TidalHealth participated in the Institute for Healthcare Improvement (IHI) Pursuing Equity Learning Collaborative to advance efforts to address disparities and advance health equity. TidalHealth formed a Diversity, Equity, and Inclusion task force to lead and inform efforts based on the framework and tools learned via the collaborative. The group identified disparities and pushed for additional grant funding to launch new equity initiatives. TidalHealth was awarded a grant through the Maryland Community Health Resources Commission's new Pathways to Health Equity Program. The program, Rural Equity and Access to Community Health (REACH), launched in May 2022 and is a collaborative, regional project to prevent and reduce disparities particularly among Black/African American residents of the Lower Eastern Shore with diabetes and/or hypertension. REACH involves multi-level, cross-sector approaches to address disparities and improve population health. At the individual level, the project includes increased care coordination and follow-up for high risk patients with diabetes and/or hypertension who have been discharged from the hospital. Community health workers are deployed to screen and address social determinants of health (SDOH). At the community-level, TidalHealth works with community partners to increase access to evidence-based chronic disease prevention and management or healthy lifestyle programming in underserved communities. At the system level, TidalHealth and community partners are working on developing a regional platform and standardized processes for SDOH screening and referrals. In fiscal 2022, TidalHealth was also awarded a grant from the Rural Maryland Council to address disparities and SDOH factors impacting residents with asthma, COPD, or other obstructive lung disease. The program, EXHALE, involved community health workers of TidalHealth screening and addressing SDOH factors of eligible participants and working with local nonprofit community-based organizations Chesapeake Housing Mission and Habitat for Humanity to complete home repairs to improve health and quality of life of grant program participants.

Q61. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

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

Q62. If you wish, you may upload a document describing your community benefit initiatives in more detail.

Community Benefit Narrative.docx
30.8KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q63. Section III - CB Administration

Q64. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

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

Q65. Please describe the third party audit process used.

This question was not displayed to the respondent.

Q66. Does your hospital conduct an internal audit of the community benefit narrative?

- (●) Yes
- ( ) No

Q67. Please describe the community benefit narrative audit process.

Both the worksheet and the narrative component of the Community Benefits Report is reviewed by the Finance Department and the Strategy, Planning and Business Development Department. Upon completion of their review, the Vice President of Population Health and the Director of Community Health Initiatives evaluates and provides additional input to the narrative component. Following review/audit by these three departments, the Report is forwarded to the Executive Staff for final review.

Q68. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- ( ) Yes
- (●) No

Q69. Please explain:

Due to timing the Board does not have an opportunity to approve the Community Benefit Financial Spreadsheet. However, the Board does review and approve the CHNA, in addition to receiving updates and presentations throughout the year regarding Community Health Initiatives within the CBSA. The very nature of our many community benefit partnerships with schools, local colleges, county health departments and faith-based institutions, creates overlap and awareness with our local Board members as to community benefit efforts.

Q70. Does the hospital's board review and approve the annual community benefit narrative report?

- ○ Yes
- ◉ No

Q71. Please explain:

Due to the timing the Board does not have an opportunity to review the narrative, however, the Board does receive narrative updates throughout the year regarding our Community Health Initiatives and the partners we are working with.

Q72. Does your hospital include community benefit planning and investments in its internal strategic plan?

- ◉ Yes
- ○ No

Q73. Please describe how community benefit planning and investments were included in your hospital's internal strategic plan during the fiscal year.

TidalHealth has an overarching Strategic Plan with three major strategic themes; Access to Care, Effectiveness and Engagement which guides TidalHealth Peninsula Regional's Implementation Strategy for the CHNA (Community Health Needs Assessment). Access to Care: providing access to the underserved through sites and services that will achieve health equity, prevent, and manage diseases and address the distinctive needs identified in the CHNA. Effectiveness: we are a high value care delivery team that embraces enhancing the processes that lead to access, effectiveness and efficiencies, eliminating fragmentation and optimizing care delivery to improve the health of the communities we serve. Engagement of not just our Team at TidalHealth but partnering with the local County Health Departments, Schools, Colleges, Faith Based Organizations, Behavioral Health Providers, Addiction Centers, and the community at large establishing programs that bring energy, hope and resources to those most in need. Community Benefit planning and initiatives are layered throughout the TidalHealth System as all of our major service lines participate in community benefits based upon their service line strengths fulfilling our mission statement to improve the health of the communities we serve

Q74. If available, please provide a link to your hospital's strategic plan.

https://www.tidalhealth.org/about-us/mission-values

Q75. Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

- ☑ Diabetes - Reduce the mean BMI for Maryland residents

  TidalHealth's Community Health Implementation Plan (CHIP) aligns with the SIHIS goals for diabetes. Diabetes is explicitly named as a priority issue for the 2019 CHNA and is included within the category of Chronic Disease and Wellness for the 2022 CHNA. Goals, objectives, strategies, and activities are established and underway to prevent and reduce diabetes. These initiatives include expansion of evidence-based healthy lifestyle programming such as Chronic Disease Self-Management, Diabetes Self-Management, National Diabetes Prevention Program, and other community-based health eating and physical activity programs such as Sustainable Change and Lifestyle Enhancement (SCALE) program in Somerset and Wicomico County. Mobile health screenings include diabetes risk assessments, education, and referral to PCPs for follow-up care and recommendations.

- ☑

Opioid Use Disorder - Improve overdose mortality

TidalHealth’s Community Health Implementation Plan (CHIP) aligns with the SIHIS goals for addressing opioid use disorder and improving overdose mortality. Behavioral Health was identified as a priority area in the 2019 and 2022 CHNAs. Goals, objectives, strategies and activities are established and underway to address substance use disorder and mental health conditions. The 2019 and draft 2022 CHIP included goals and activities specifically to reduce the instances of opioid-related deaths. TidalHealth works in partnership with Somerset and Wicomico County Health Departments on collaborative initiatives such as Narcan expansion program(s), educational messaging, Opioid Intervention Teams, Community Outreach Addictions Team, informational campaigns.

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

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

TidalHealth’s community benefit activities align with the SIHIS goals for decreasing asthma-related emergency department visit rates for youth ages 12-17. TidalHealth was the recipient of a grant from the Rural Maryland Council to support the EXHALE program. TidalHealth matched the $125,000 grant funds to support a project using community health workers (CHWs) to identify, educate and address asthma triggers or trigger-promoting conditions in Lower Eastern Shore homes that negatively affect breathing. The CHWs were trained to provide family-focused asthma education under the guidance of a certified asthma educator. The CHWs conducted home, health and social determinants of health assessments and linked participants to appropriate community-based resources and/or organizations to provide necessary home repairs to improve health outcomes.

- [ ] None of the Above

Q76. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Q77. Section IV - Physician Gaps & Subsidies

Q78. Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- (●) No
- ( ) Yes

Q79. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

This question was not displayed to the respondent.

Q80. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

This question was not displayed to the respondent.

Q81. Please attach any files containing further information and data justifying physician subsidies at your hospital.

This question was not displayed to the respondent.

Q82. Section VI - Financial Assistance Policy (FAP)

Q83. Upload a copy of your hospital's financial assistance policy.

Financial Assistance Policy.pdf
415.2KB
application/pdf

Q84. Provide the link to your hospital's financial assistance policy.

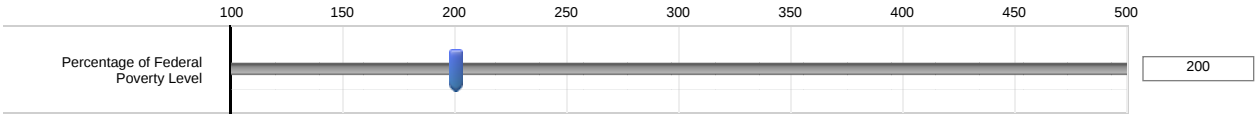
https://www.tidalhealth.org/medical-care/financial-admin-services/billing/tidalhealth-financial-assistance

Q85. 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: [ ]

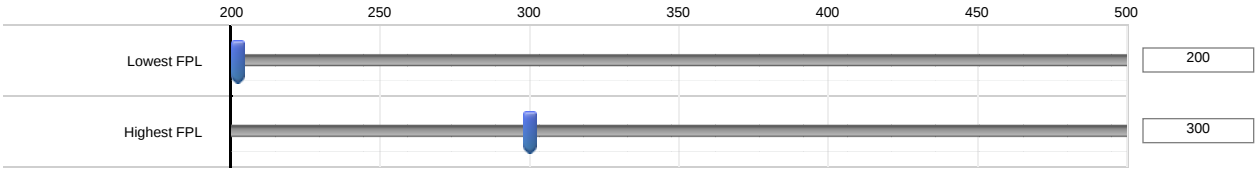
Q86. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



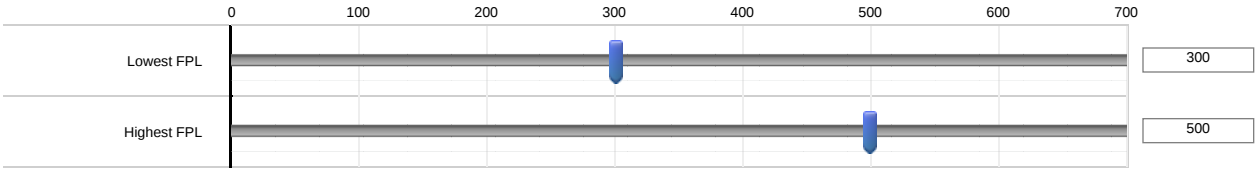
Q87. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

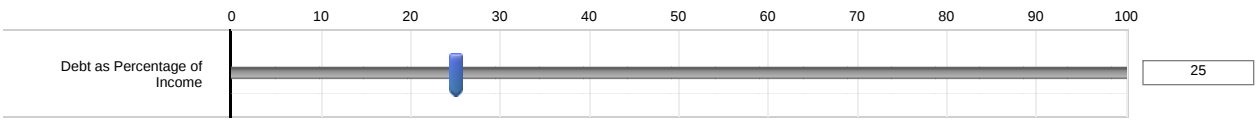


Q88. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health 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.



Q89. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q90. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding taxable year (select all that apply)

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

Q91. Summary & Report Submission

Q92.

Attention Hospital Staff! IMPORTANT!

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

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

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

Location Data

Location: (38.3792, -75.6307)

Source: GeoIP Estimation

Tidalhealth and Somerset & Wicomico Health Departments CHNA

Secondary Data Analysis

Presentation to
Wicomico County Local Health Improvement Coalition

October 1, 2021

Agenda

- Secondary Data Overview
  - Demographics
  - Social Determinants of Health
  - SocioNeeds Index and Food Insecurity Index
  - Data Analysis
    - Data Scoring and IoD Methodology
    - Findings
- Q & A

Comprehensive Data Components

Demographic Data	• Economic, Education, Poverty, Language • HCI's Indices to identify zip codes with the greatest need
Secondary Data Scoring	• Systematic methodology to score and rank indicators and topic areas to identify those with the greatest need
Index of Disparity	• Review subpopulation data within indicators for disparities (among race/ethnicity, gender)

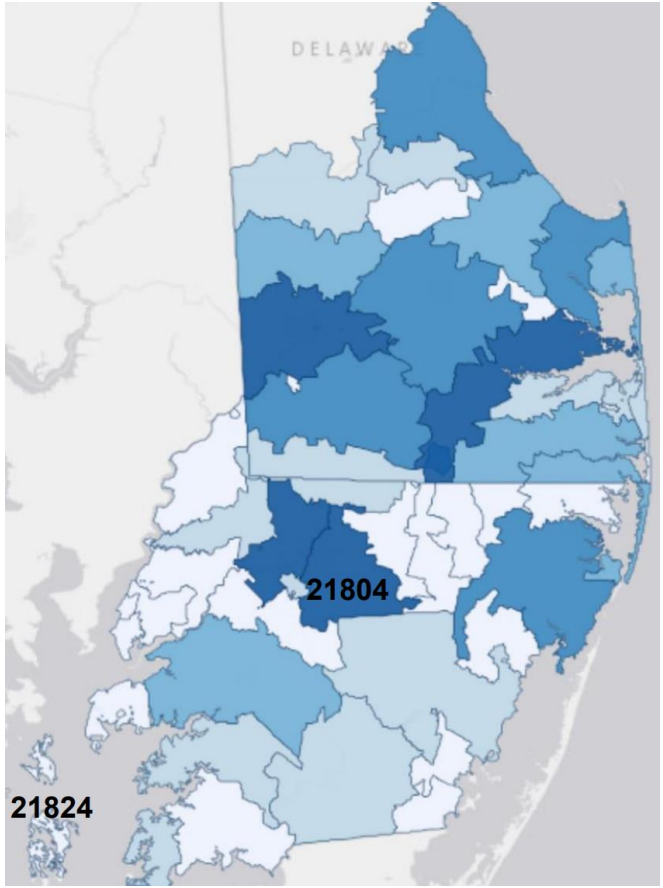
Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Demographics

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

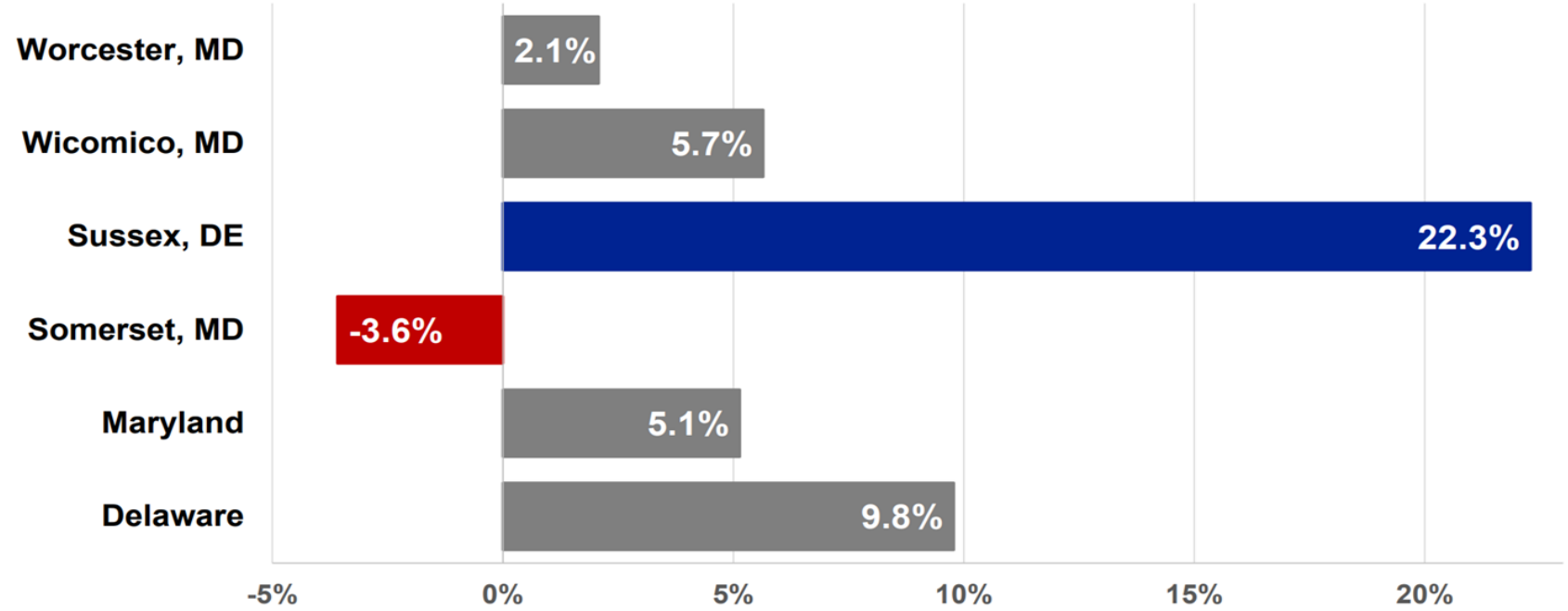
Population Distribution

- Total Collaborative Service Area Population (2021): 423,437
  - Largest Zip Code by population: 21804 (Wicomico)
  - Smallest Zip Code by population: 21824 (Somerset)



Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

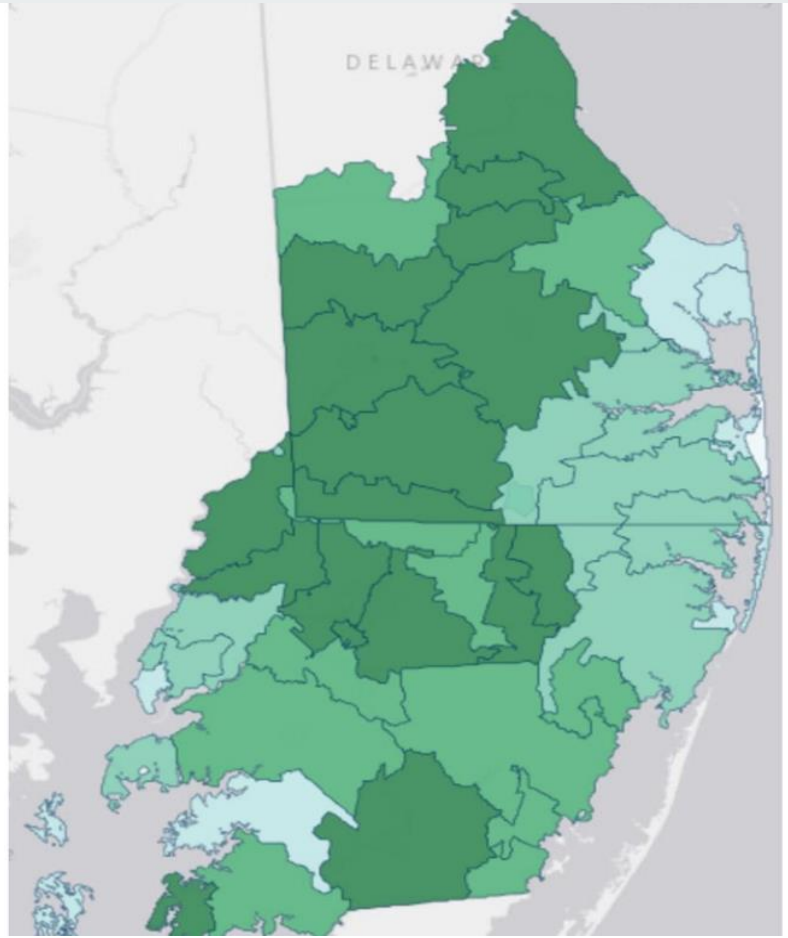
Somerset County's population has decreased from 2010-2021. The population of Sussex, DE has increased 22.3% over the same time period.



Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Population by Age Group: Percent Population <18

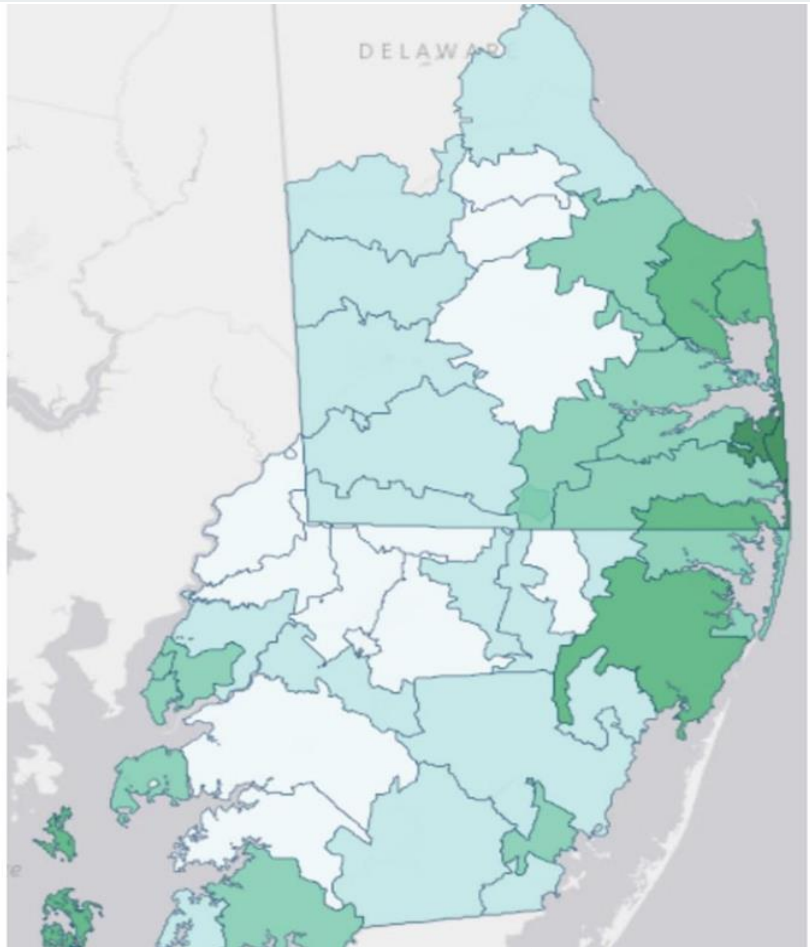
- Wicomico County has the largest % population <18 (22.1%)
- Worcester County has the smallest (16.8%)



Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

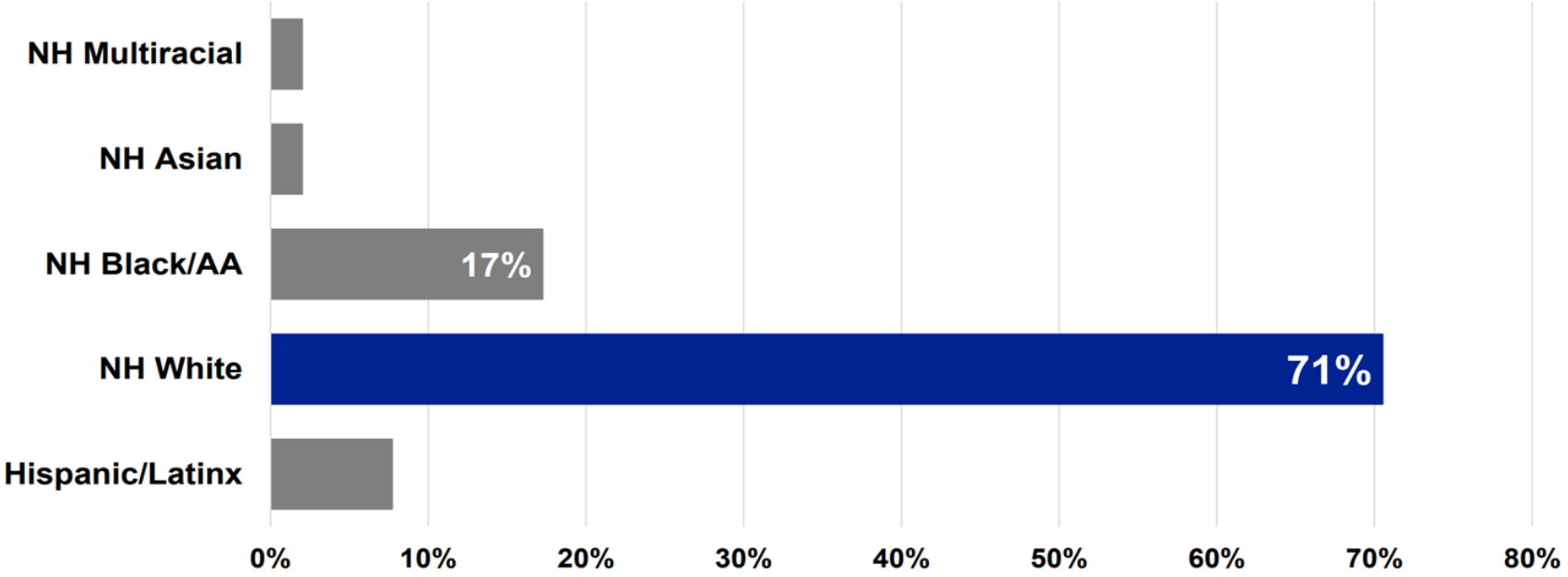
Population by Age Group: Percent Population 65+

- Worcester County has the largest % population over 65 (29.1%)
- Wicomico County has the smallest (17%)



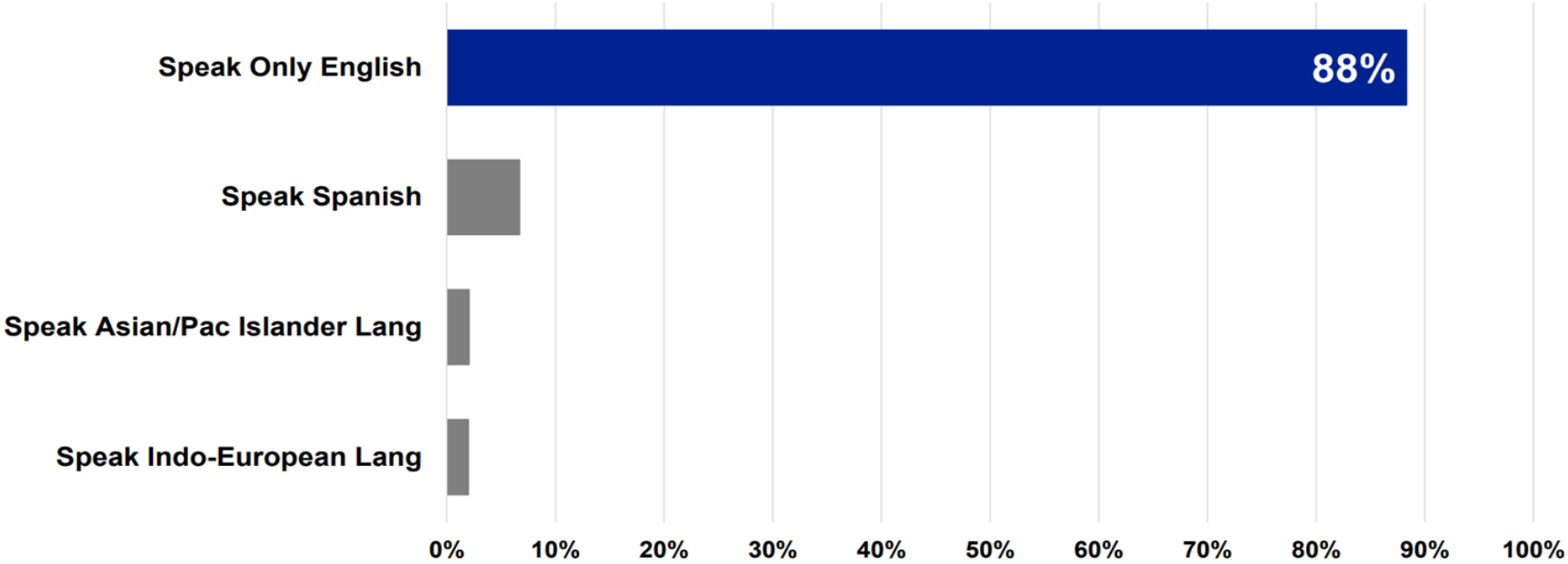
Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

The Collaborative Service Area is majority White (Non-Hispanic/Latinx).



Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

The Majority of the Population (5+) Speak Only English at Home.



Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

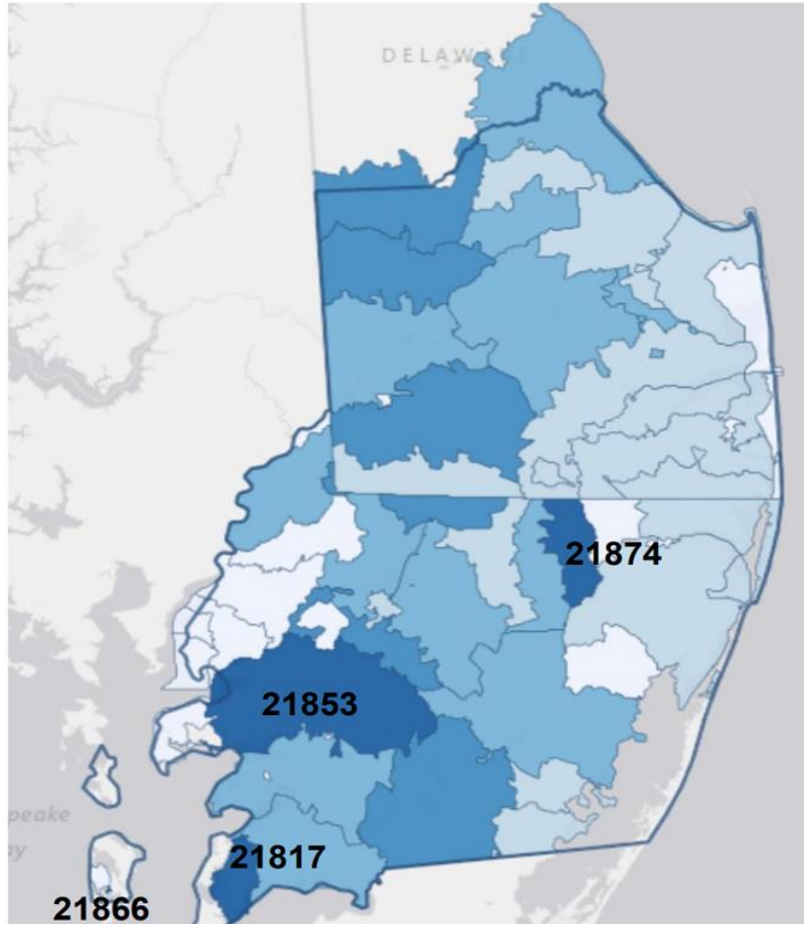
Social Determinants of Health

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

High Poverty Rate is both a Cause and a Consequence of Poor Economics

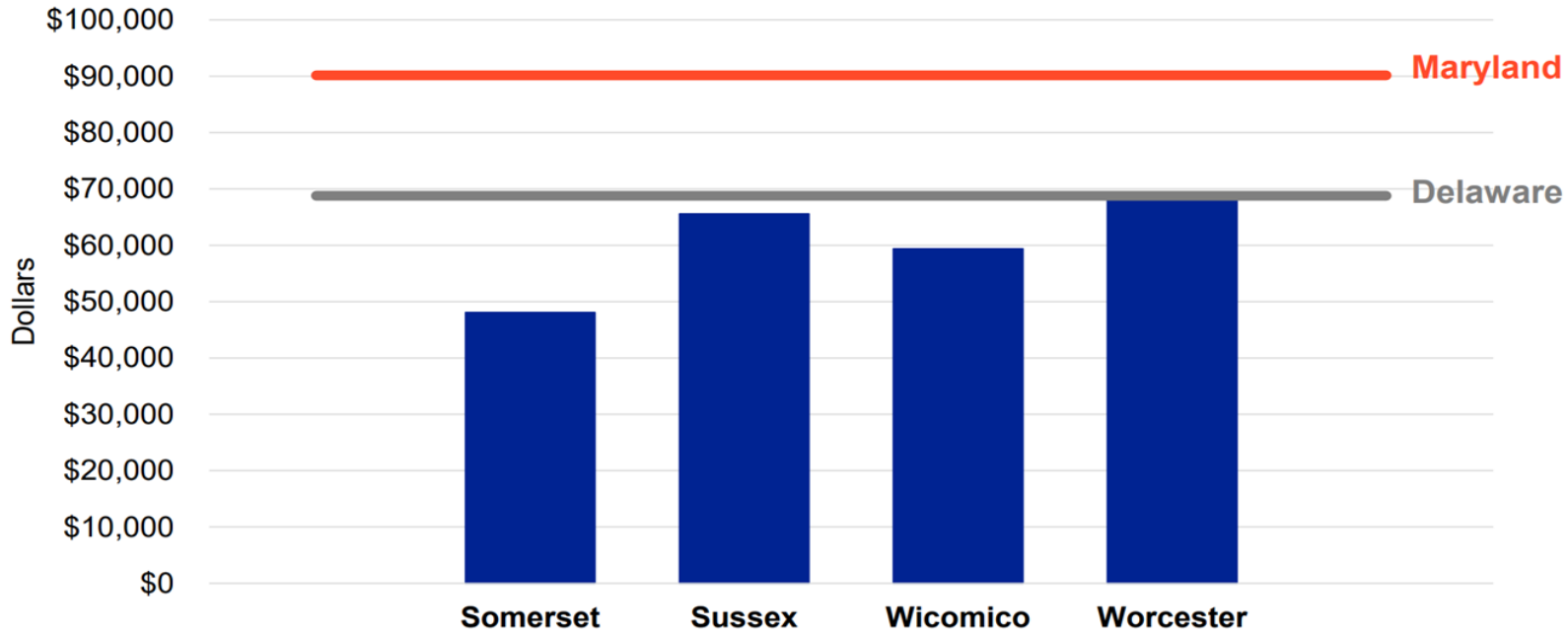
Percentage of Families Living Below Poverty

- MD: 6.1%
- DE: 7.9%
- Sussex: 7.4%
- Somerset: **17%**
- Wicomico: 8.6%
- Worcester: 6.3%



Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

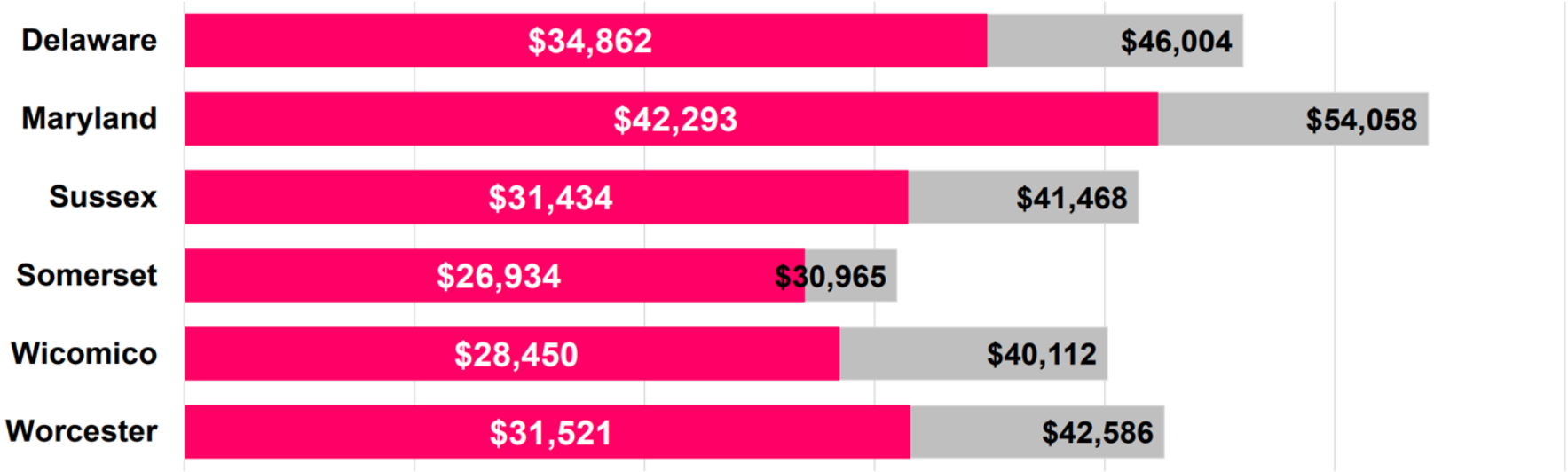
Residents of Somerset and Wicomico have Median Household Incomes below $60,000. This is lower than Maryland and Delaware overall Median Household Incomes.



Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

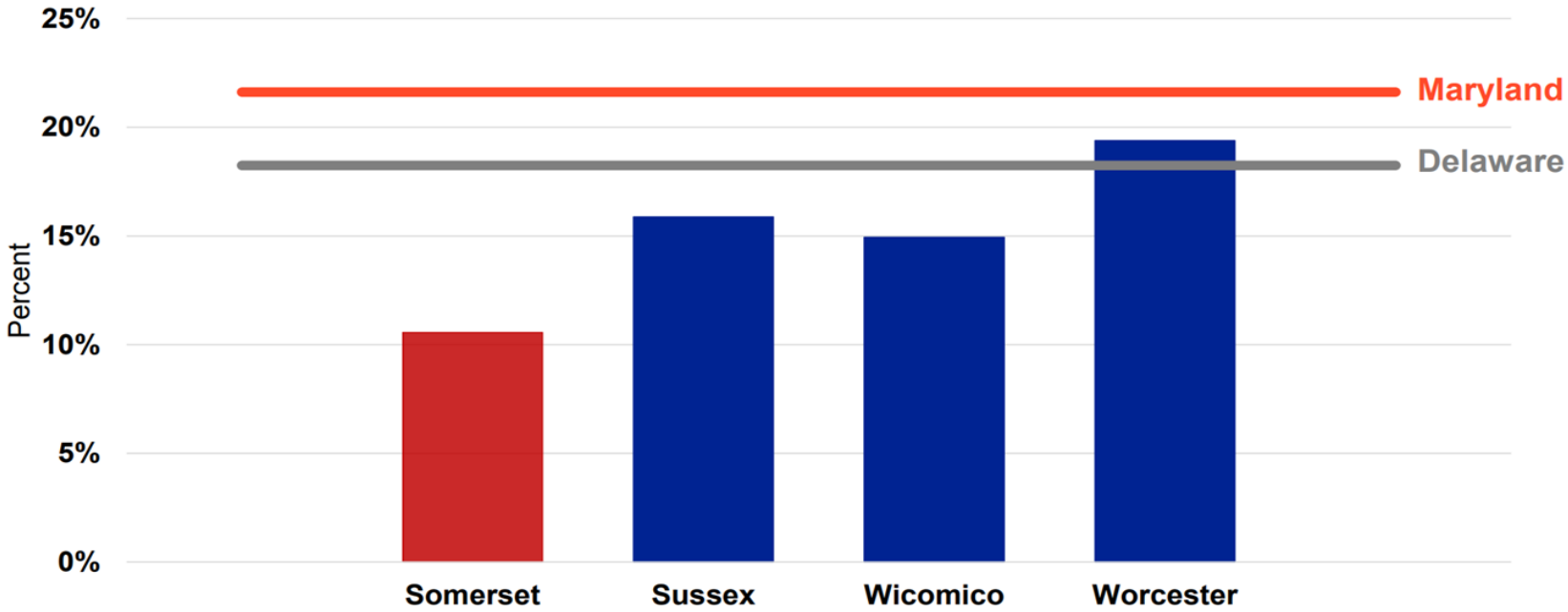
Working women living in the Collaborative Service Area make less than their **male** counterparts. Wicomico has the largest wage gap (70.9%). Somerset has the smallest wage gap (87%)

Although data is not available by race/ethnicity from this source, national trends suggest that this wage gap persists (and is worsened) by race/ethnicity of women.



Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

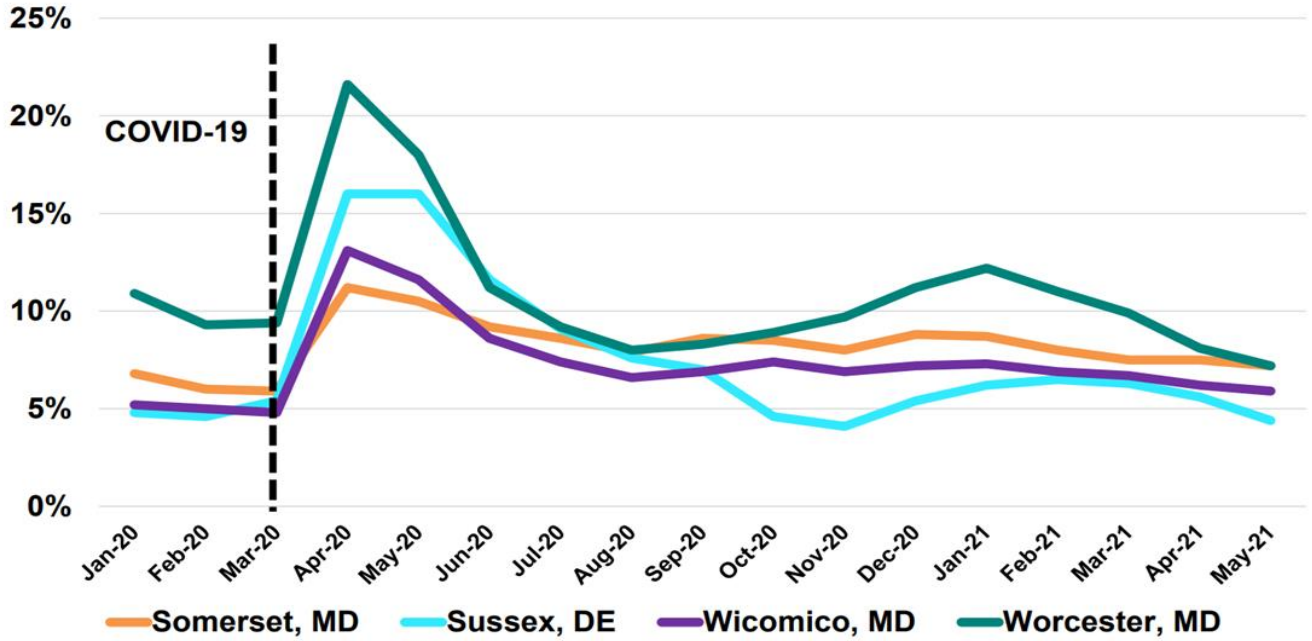
Somerset has the lowest Percent of Population 25+ with a Bachelor's Degree.



Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Unemployment Rate is a Key Indicator of the Local Economy

Unemployment rates (population 16+) rose after the start of the COVID-19 pandemic. Rates have dropped since the beginning of the pandemic and are close to pre-pandemic rates.



Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

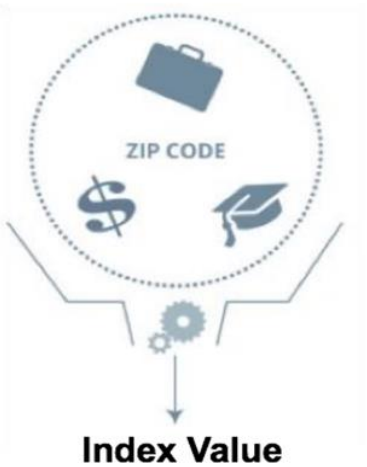
SocioNeeds Index and Food Insecurity Index

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

SocioNeeds Index – Can We Estimate How a Person's Zip Code Affects Their Health?

CONDUENT

Income
Poverty
Unemployment
Occupation
Education
Language



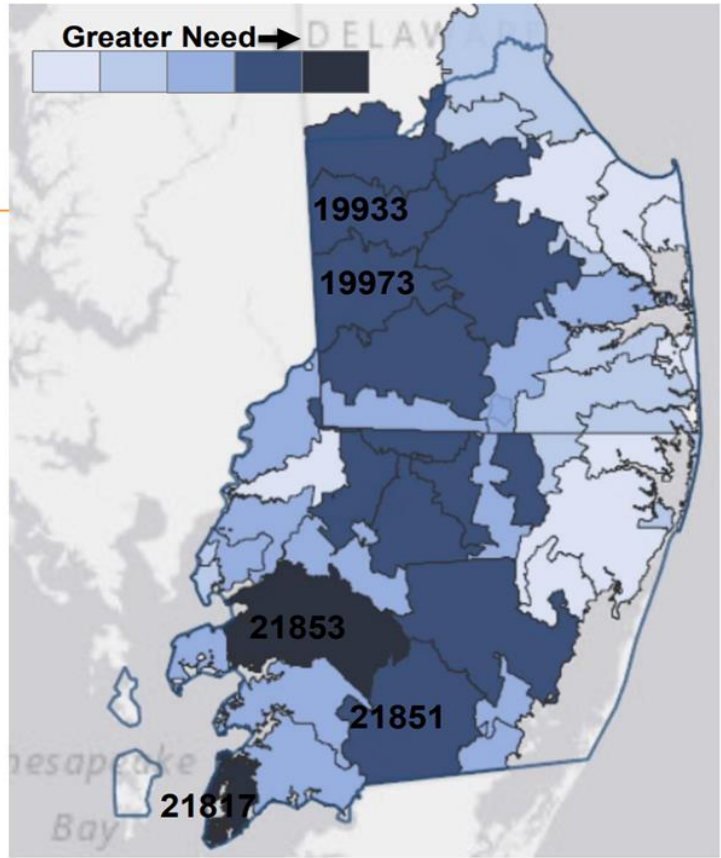
This index incorporates estimates for six different social and economic determinants of health that are associated with poor health outcomes. The indicators were standardized and averaged to create one composite index value for each zip code. Zip codes with higher values are estimated to have higher socioeconomic need, which is correlated with poorer health.

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

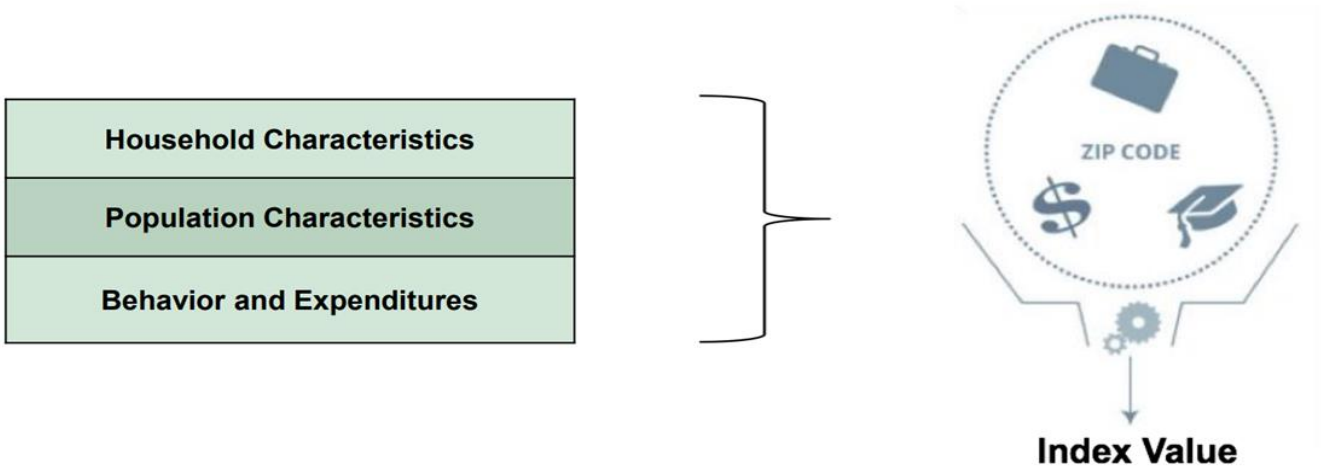
Your Zip Code May be the Most Important Factor in Determining Life-Long Health

In high SNI zip codes, residents are expected to experience greater burdens related to preventable health issues. Below are the highest need zip codes for the Collaborative Service Area

Zip Code	Rank	SNI Value	County
21853	5	90.2	Somerset
21817	5	88.6	Somerset
19933	4	76.0	Sussex
21851	4	73.1	Worcester
19973	4	69.5	Sussex



Food Insecurity Index: Assessing Food Accessibility and Economic Hardship



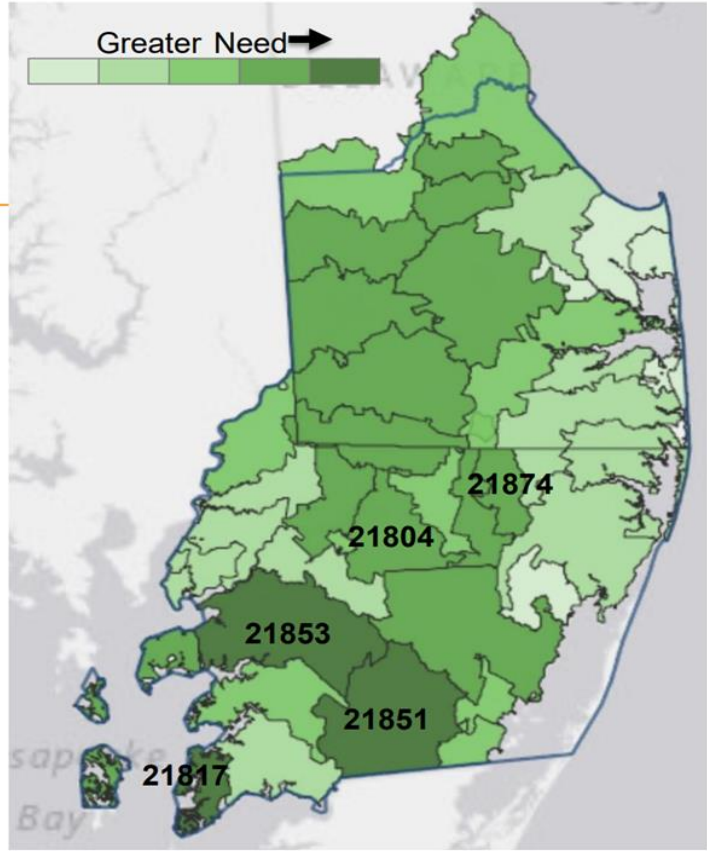
This index incorporates estimates of indicators for three topic areas that are associated with social and economic burden. The indicators were standardized and averaged to create one composite index value for each zip code. Zip codes with higher values are estimated to experience higher social and economic burden.

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Food Insecurity

In high FII zip codes, residents are expected to experience greater social and economic hardships. Below are the highest need zip codes for the Collaborative Service Area

Zip Code	Rank	FII Value	County
21817	5	89.1	Somerset
21851	5	86.5	Worcester
21853	5	86.4	Somerset
21874	4	72.0	Wicomico
21804	4	69.4	Wicomico



Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Data Analysis: *Secondary Data*

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Secondary Data Methodology

COLLECTED DATA FROM OVER 25 SECONDARY DATA SOURCES INCLUDING THE AMERICAN COMMUNITY SURVEY AND CDC

OVER 200 DEMOGRAPHIC, SOCIAL, ECONOMIC, AND HEALTH INDICATORS

INDICATORS MAINTAINED FROM MOST RECENTLY AVAILABLE DATA BY CONDUENT, HEALTHY COMMUNITIES INSTITUTE

INDICATORS MEASURED AT THE COUNTY-LEVEL.

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Data Sources

- American Community Survey
- Annie E. Casey Foundation
- CDC - PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- County Health Rankings
- Feeding America
- Healthy Communities Institute
- Maryland Behavioral Risk Factor Surveillance System
- Maryland Department of Health
- Maryland Department of the Environment
- Maryland Governor's Office for Children
- Maryland Governor's Office of Crime Control & Prevention
- Maryland State Board of Elections
- Maryland State Department of Education
- Maryland Youth Risk Behavior Survey/Youth Tobacco Survey
- National Cancer Institute
- National Center for Education Statistics
- National Environmental Public Health Tracking Network
- U.S. Bureau of Labor Statistics
- U.S. Census - County Business Patterns
- U.S. Census Bureau - Small Area Health Insurance Estimates
- U.S. Department of Agriculture - Food Environment Atlas
- United For ALICE
- Delaware Department of Health and Social Services, Division of Public Health
- Delaware Office of the State Election Commissioner
- Delaware School Survey
- Delaware Youth Risk Behavior Survey
- Behavioral Risk Factor Surveillance System

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Topic Areas

We leveraged the HCI database, with over 200 indicators in both health and quality of life topic areas for the Secondary Data Analysis of Sussex, Somerset, Wicomico, and Worcester Counties

Quality of Life	Health	
Economy	Mental Health & Mental Disorders	Respiratory Diseases
Community	Sexually Transmitted Infections	Children's Health
Environmental Health	Maternal, Fetal & Infant Health	Immunizations & Infectious Diseases
Health	Prevention & Safety	Cancer
Education	Older Adults	Women's Health
	Wellness & Lifestyle	Men's Health
	Diabetes	Tobacco Use
	Alcohol & Drug Use	Heart Disease & Stroke
	Health Care Access & Quality	Physical Activity
	Adolescent Health	Nutrition & Healthy Eating

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Methodology

Data Scoring is done in 3 stages:

- MD & DE Counties
- US Counties
- MD & DE State Value
- US Value
- HP 2030
- Trend

Comparisons

- Quantitatively score all possible comparisons

Score range:

Good → Bad

0 1 2 3

Indicators

- Summarize comparison scores for each indicator

Topics

- Summarize indicator scores by topic area

Indicator Score

↓

Topic Score

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Index of Disparity: Methodology
Assessing Health Disparities

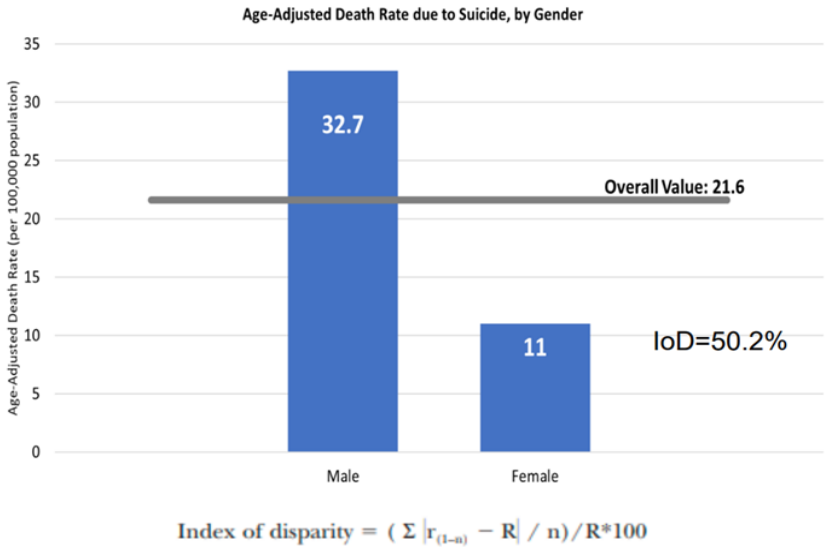
Index of Disparity (IoD): Identifies large disparities based on how far each subgroup (by race/ethnicity or gender) is from the overall county value.

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Index of Disparity (IoD): Example

- Provides a % value, which is a summary of how different each subgroup is from the overall value
  - % based on absolute differences from the overall value for each breakout category in each subgroup.

- For this analysis, high disparities were identified based on most recent period of measure for each indicator and IoD values were shown overtime.



Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Data Scoring and Index of Disparity Findings

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

County Level Analysis:

Secondary Data Scoring Results

Somerset, MD

Health and Quality of Life Topics	Score
Diabetes	2.25
Weight Status	2.23
Wellness & Lifestyle	2.07
Economy	2.02
Maternal, Fetal & Infant Health	2.01
Prevention & Safety	1.97
Sexually Transmitted Infections	1.90
Heart Disease & Stroke	1.87
Respiratory Diseases	1.86
Older Adults	1.81
Education	1.80
Immunizations & Infectious Diseases	1.78
Other Conditions	1.77
Environmental Health	1.76
Physical Activity	1.73
Tobacco Use	1.70

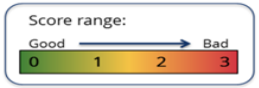
Sussex, DE

Health and Quality of Life Topics	Score
Other Conditions	1.93
Prevention & Safety	1.86
Heart Disease & Stroke	1.78
Alcohol & Drug Use	1.72
Oral Health	1.69
Wellness & Lifestyle	1.67
Health Care Access & Quality	1.59
Adolescent Health	1.53
Physical Activity	1.47
Older Adults	1.47
Community	1.39
Environmental Health	1.34
Mental Health & Mental Disorders	1.32
Respiratory Diseases	1.30
Education	1.28
Children's Health	1.27

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

County Level Analysis:

Secondary Data Scoring Results



Wicomico, MD

Health and Quality of Life Topics	Score
Diabetes	2.07
Sexually Transmitted Infections	1.98
Wellness & Lifestyle	1.91
Cancer	1.86
Other Conditions	1.85
Prevention & Safety	1.85
Education	1.83
Older Adults	1.82
Oral Health	1.80
Weight Status	1.80
Heart Disease & Stroke	1.79
Community	1.77
Physical Activity	1.75
Mental Health & Mental Disorders	1.73
Environmental Health	1.71
Respiratory Diseases	1.68

Worcester, MD

Health and Quality of Life Topics	Score
Alcohol & Drug Use	1.93
Other Conditions	1.91
Oral Health	1.68
Children's Health	1.66
Heart Disease & Stroke	1.65
Women's Health	1.64
Cancer	1.63
Prevention & Safety	1.62
Environmental Health	1.53
Economy	1.49
Community	1.47
Older Adults	1.47
Diabetes	1.43
Maternal, Fetal & Infant Health	1.42
Physical Activity	1.42
Adolescent Health	1.40

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Collaborative Service Area

Secondary Data Analysis-Topic Areas

Data Scoring Results Collaborative Service Area
Older Adults/Other Conditions
Prevention & Safety
Heart Disease & Stroke
Physical Activity
Wellness and Lifestyle
Oral Health
Diabetes

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Indicators of Interest

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

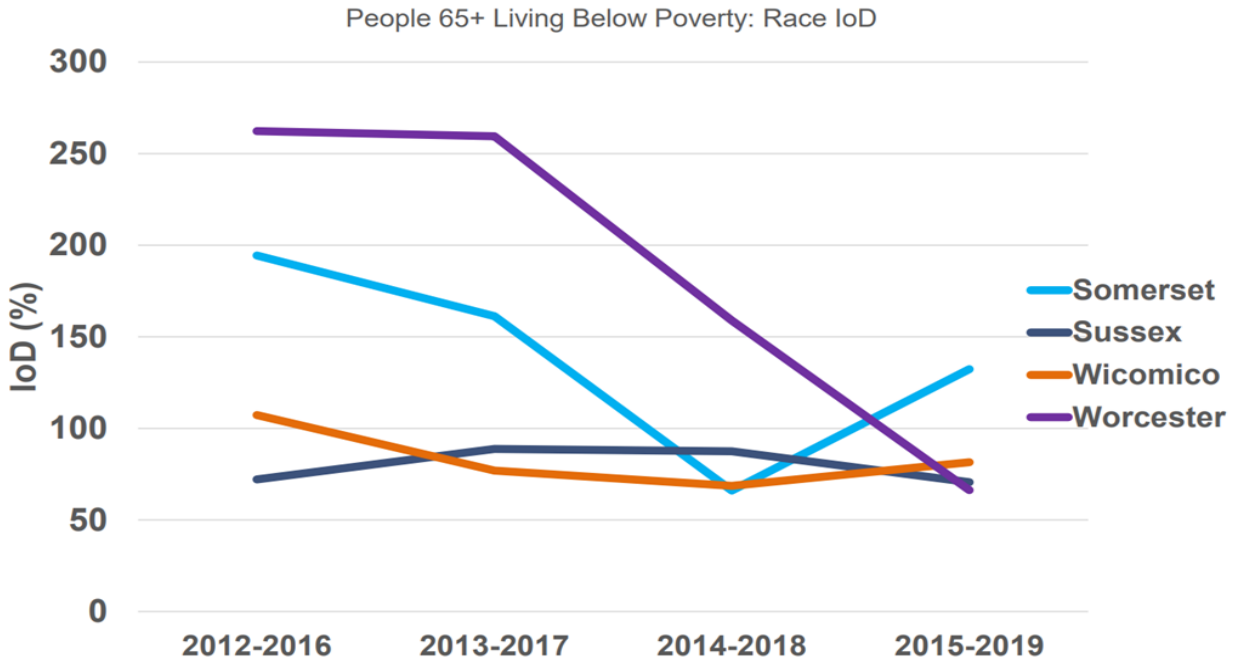
Older Adults/Other Conditions
Indicators of Interest

INDICATORS	SOMERSET	SUSSEX	WICOMICO	WORCESTER
Chronic Kidney Disease: Medicare Population (%)	2.78	1.58	2.78	1.73
Hypertension: Medicare Population (%)	2.78	2.42	2.38	2.23
Stroke: Medicare Population (%)	2.48	2.03	2.28	1.83
Atrial Fibrillation: Medicare Population (%)	2.18	2.31	2.23	2.53
Hyperlipidemia: Medicare Population (%)	2.08	2.33	2.53	2.40
Adults with Arthritis (%)	1.88	1.92	1.58	2.18
Adults with Kidney Disease (%)	1.88	1.92	1.13	2.03
Rheumatoid Arthritis or Osteoarthritis: Medicare Population (%)	1.43	2.08	1.88	2.18

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Index of Disparity: People 65+ Living Below Poverty

- IoD values for Race/Ethnicity were much higher than Gender IoD for this indicator.
- Worcester County saw a decrease in IoD values overtime while Wicomico and Sussex remained relatively stable.



Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Prevention & Safety
Indicators of Interest

INDICATORS	SOMERSET	SUSSEX	WICOMICO	WORCESTER
Severe Housing Problems (%)	2.53	0.75	2.28	1.93
Pedestrian Injuries (injuries/100,000 population)	2.23	(unavailable)	1.63	1.98
Death Rate due to Drug Poisoning (deaths/100,000 population)	1.63	2.42	1.78	1.53
Age-Adjusted Death Rate due to Unintentional Injuries (deaths/100,000 population)	1.50	2.42	1.55	1.05

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Heart Disease & Stroke
Indicators of Interest

INDICATORS	SOMERSET	SUSSEX	WICOMICO	WORCESTER
Atrial Fibrillation: Medicare Population (%)	2.18	2.31	2.23	2.53
Hyperlipidemia: Medicare Population (%)	2.08	2.33	2.53	2.40
Hypertension: Medicare Population (%)	2.78	2.42	2.38	2.23
Age-Adjusted ER Rate due to Hypertension (ER visits/100,000 pop)	2.23	(unavailable)	2.23	2.08
Adults who Experienced a Stroke (%)	2.03	1.92	1.58	1.88
Stroke: Medicare Population (%)	2.48	2.03	2.28	1.83
Age-Adjusted Hospitalization Rate due to Heart Attack (hospitalizations/10,000 pop 35+)	1.80	(unavailable)	1.95	1.80
High Blood Pressure Prevalence (%)	2.13	2.17	2.13	1.08

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

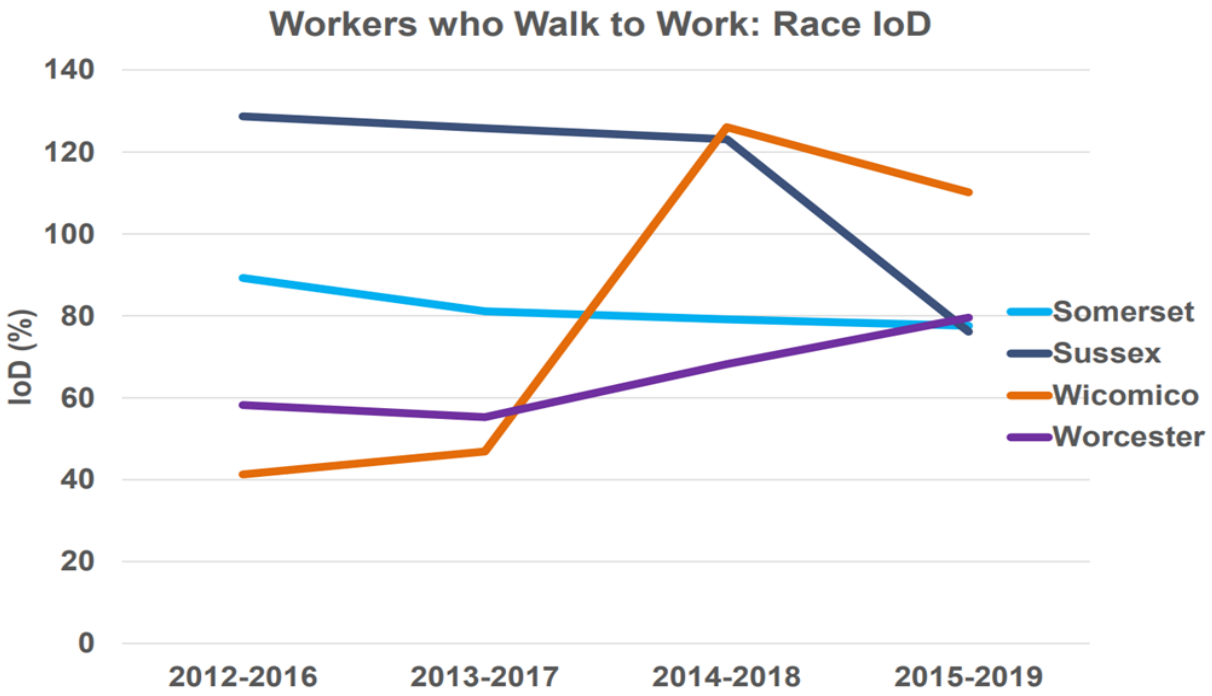
Physical Activity
Indicators of Interest

INDICATORS	SOMERSET	SUSSEX	WICOMICO	WORCESTER
Adults with a Healthy Weight (%)	2.45	(unavailable)	2.05	1.30
Food Environment Index	2.28	0.97	1.98	1.78
Access to Exercise Opportunities (%)	2.25	1.83	1.80	1.20
Adults Who Are Obese (%)	2.18	1.72	2.15	1.15
Low-Income and Low Access to a Grocery Store (%)	2.10	1.50	1.95	1.35
Adolescents who are Obese (%)	1.98	(unavailable)	1.95	1.78
Households with No Car and Low Access to a Grocery Store (%)	1.95	1.67	1.50	1.50
WIC Certified Stores (stores/1,000 pop)	1.95	1.33	1.95	1.50
People 65+ with Low Access to a Grocery Store (%)	1.35	1.67	1.80	1.95
Workers who Walk to Work* (%)	0.23	2.75	1.93	2.03

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Index of Disparity: Workers who Walk to Work

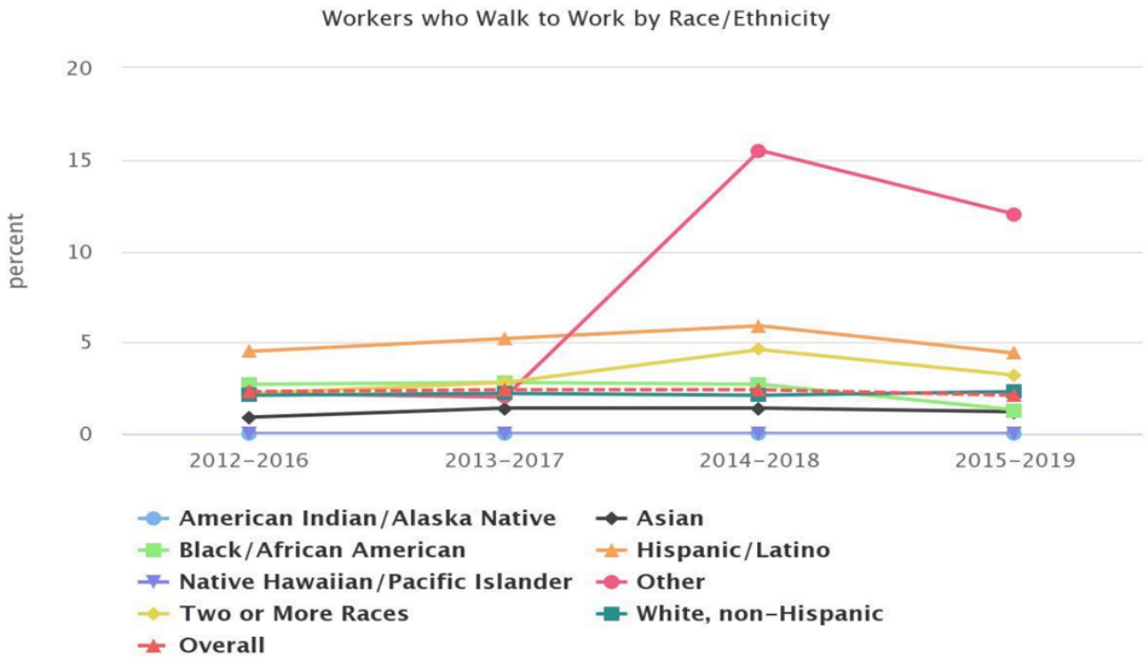
- IoD values for Race/Ethnicity were much higher than Gender IoD for this indicator.
- Wicomico and Worcester values have increased overtime.
- Sussex and Somerset values have decreased.



Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Wicomico County: Workers who Walk to Work

- Hispanic/Latino and Two or more races consistently have more workers who walk to work than the overall average.
- Increase in percentage for Other Race could contribute to increase in IoD



Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Wellness & Lifestyle
Indicators of Interest

INDICATORS	SOMERSET	SUSSEX	WICOMICO	WORCESTER
Insufficient Sleep (%)	2.48	1.25	2.03	0.93
Frequent Physical Distress (%)	2.25	1.83	1.95	1.65
Self-Reported General Health Assessment: Good or Better (%)	2.05	2.17	2.00	0.60
Life Expectancy (years)	1.95	1.17	1.95	0.90
Poor Physical Health: 14+ Days (%)	1.95	1.92	1.80	1.35
Self-Reported Good Physical Health (%)	1.93	(unavailable)	1.65	1.95
Average Life Expectancy (years)	1.85	(unavailable)	1.98	1.13

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Oral Health
Indicators of Interest

INDICATORS	SOMERSET	SUSSEX	WICOMICO	WORCESTER
Adults who Visited a Dentist (%)	2.30	1.58	2.30	1.15
Adults with No Tooth Extractions (%)	2.30	(unavailable)	1.60	2.05
Oral Cavity and Pharynx Cancer Incidence Rate (cases/100,000 pop)	2.10	1.19	2.53	2.23
Adults 65+ with Total Tooth Loss (%)	2.03	1.75	1.58	1.13
Age-Adjusted ER Visit Rate due to Dental Problems (ER visits/100,000 pop)	1.98	(unavailable)	1.98	1.98
Children who Visited a Dentist (%)	0.53	(unavailable)	1.78	1.48
Dentist Rate (dentists/100,000 pop)	0.45	2.22	0.85	1.73

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Diabetes
Indicators of Interest

INDICATORS	SOMERSET	SUSSEX	WICOMICO	WORCESTER
Adults with Diabetes (%)	2.30	2.22	1.85	2.18
Diabetes: Medicare Population (%)	2.28	0.58	1.98	0.90
Age-Adjusted ER Rate due to Diabetes (ER Visits/100,000 pop)	2.23	(unavailable)	2.48	2.03
Age-Adjusted Death Rate due to Diabetes (Deaths/100,000 pop)	2.18	0.61	1.95	0.60

Conduent Healthy Communities Institute. (September 2021). Secondary Data Analysis.

Questions?

TIDALHEALTH AND SOMERSET COUNTY & WICOMICO COUNTY HEALTH DEPARTMENTS

2022 CHNA Report

TidalHealth™

Public Health
Prevent. Promote. Protect.
Wicomico County
Health Department

Public Health
Prevent. Promote. Protect.
Somerset County
Health Department

TABLE OF CONTENTS

SECTION 1

INTRODUCTION & PURPOSE

TidalHealth, Somerset County Health Department (SCHD), and Wicomico County Health Department (WiCHD) are pleased to partner and present the 2022 Community Health Needs Assessment (CHNA). For purposes of this report the three leading organizations: TidalHealth, SCHD, and WiCHD will collectively be referred to as "The Partnership".

This CHNA report provides an overview of the process and methods used to identify and prioritize significant health needs for a four-county region served by the above-mentioned organizations. This report serves to meet TidalHealth's requirement to complete a CHNA as a non-profit hospital. Somerset County utilizes this report for strategic planning purposes, and Wicomico County as an accredited health department by the Public Health Accreditation Board (PHAB).

The purpose of this CHNA is to offer a deeper understanding of the health needs across the region and guide the planning efforts to address needs in actionable ways and with community engagement. Findings from this report will be used to identify and develop efforts to address disparities, improve health outcomes, and focus on social determinants of health to improve the health and quality of life of residents in the community.

This report includes a description of:

- The community and methods used to obtain, analyze and synthesize primary and secondary data;
- The significant health needs in the community, taking into account the needs of uninsured, low-income, and marginalized groups;
- The process and criteria used in identifying certain health needs as significant and prioritizing those significant community needs.

ACKNOWLEDGEMENTS

The development of this CHNA was a collective effort that included hospital and health department employees, community-serving organizations, and community members from within areas of focus that provided input and knowledge of issues and solutions and those who share our commitment to improve health and quality of life.

HOSPITAL AND HEALTH DEPARTMENT LEADERSHIP

Kathryn Fiddler, TidalHealth Vice President of Population Health

Christopher Hall, TidalHealth Vice President/Chief Business Officer of Strategy and Business Development

Katherine Rodgers, TidalHealth Director of Community Health Initiatives

Allie O'Leary, TidalHealth Population Health Analyst

Danielle Weber, SCHD Health Officer

Sharon Lynch, SCHD Preventive Health Service & Communication Director

Lori Brewster, WiCHD Health Officer

Lisa Renegar, WiCHD Health Planner

Kelly Ward, WiCHD Special Assistant to the Health Officer & Deputy PIO

Christina Gray, WiCHD Epidemiologist

TIDALHEALTH

TidalHealth's mission is stated simply: Improve the health of the communities we serve. This concept is straightforward, but accomplishing that mission is a complex task in a rapidly changing healthcare and dynamic social environment. This is our mission despite the complexities of recruiting and retaining qualified healthcare professionals, adopting and implementing new clinical knowledge and techniques, and acquiring sophisticated emerging technologies to provide care and comply with an increasingly complex clinical and regulatory environment. The well-being of each patient is the center of all those activities. We have served our community and become a trusted healthcare resource for the entire region.

In 2020, nearly 5,000 healthcare providers from across the region joined under one name and became Better Together.

TidalHealth was formed when the former Peninsula Regional Medical Center, Nanticoke Memorial Hospital in Seaford, DE, and McCready Memorial Hospital in Crisfield, MD, united to improve the health of the communities we serve. Combined, TidalHealth is the recipient of more than 150 national awards, recognitions, and certifications.

Today, TidalHealth Peninsula Regional, TidalHealth Nanticoke and TidalHealth McCready Pavilion all share a rich history of care.

TidalHealth Peninsula Regional, a 266-bed acute care facility celebrating 125 years of service in 2022, is the largest and most experienced healthcare provider in the region. As the sole tertiary hospital on the Delmarva Peninsula, the hospital provides emergency and trauma care, a broad range of acute specialty and subspecialty services, subacute, outpatient, diagnostic, and community health services. Our community-based services are provided by a network of family medicine and specialty care practices across the Delmarva Peninsula through private office sites, health pavilions in Delaware, and a mobile van service to extend the reach across rural communities. Our physicians, staff and volunteers provide care to over 500,000 patients each year. The Salisbury hospital's primary service area (PSA) is Wicomico County, Worcester County, and Somerset County. This Tri-County Region represents nearly 80% of the patients discharged from TidalHealth Peninsula Regional.

TidalHealth Nanticoke is a 99-bed nationally recognized community hospital reaching a 70-year milestone of service in 2022. The hospital provides specialty and subspecialty services, outpatient, diagnostic, and community health services. Each year, TidalHealth Nanticoke cares for more than 5,500 admitted patients, 35,000 people in the emergency department, and provides more than 105,000 outpatient tests and procedures. The Seaford hospital's primary service area (PSA) includes the cities of Seaford, Laurel, Bridgeville and Georgetown in the state of Delaware. These four cities encompass 80% of patients discharged from TidalHealth Nanticoke.

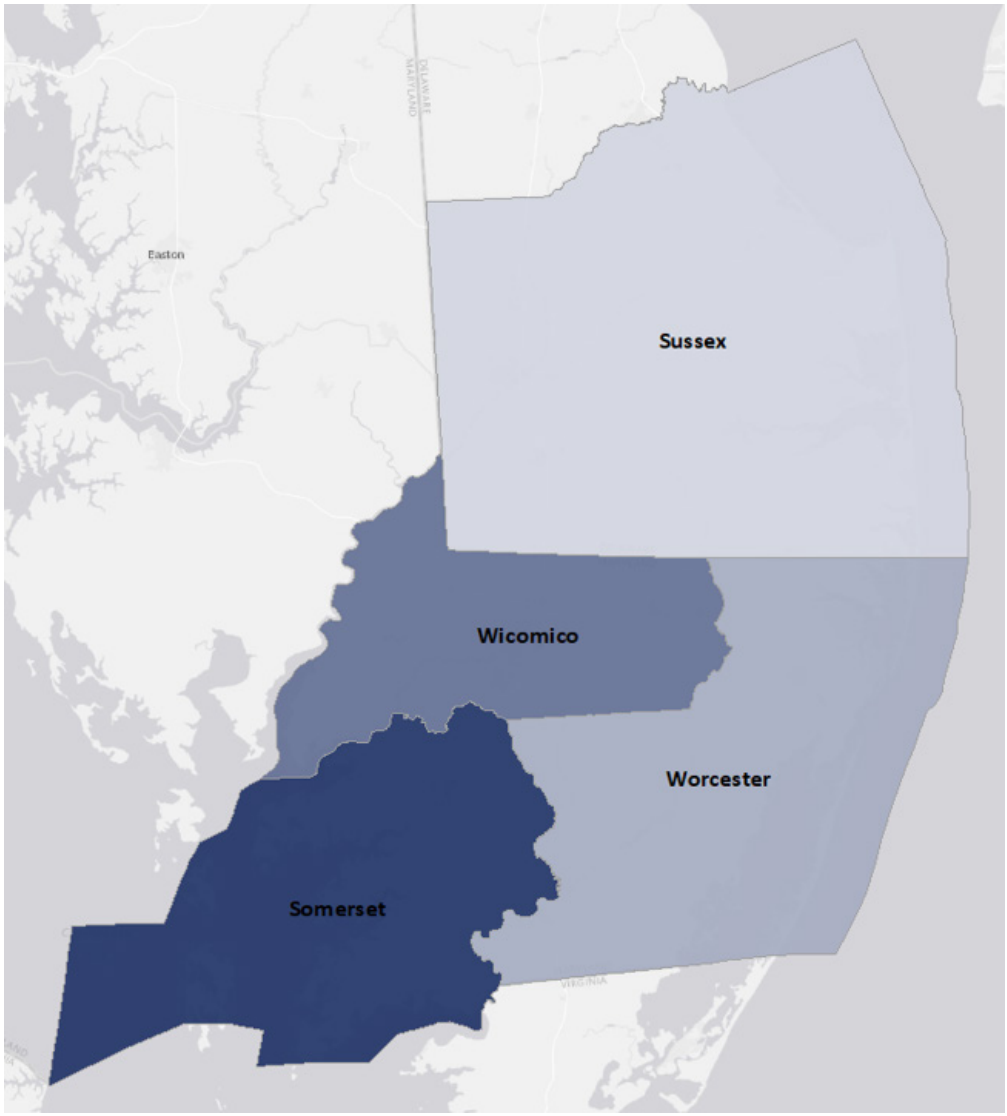
Mission
To improve the health of the communities we serve

Vision
To achieve world-class health and wellness for our families, friends and neighbors

1.1 SERVICE AREA

TidalHealth Peninsula Regional's service area is Somerset, Wicomico, and Worcester counties in Maryland; also known as the Tri-County Region. TidalHealth Nanticoke's service area is Sussex County, Delaware. TidalHealth, SCHD, and WiCHD collaborated for this CHNA to focus on the combined service area made up of the following four counties: Somerset, Wicomico, and Worcester counties in Maryland and Sussex County in Delaware. Together these counties include 66 zip codes, and census tracts therein. For purposes of this report, we will refer to this combined service area as the Tri-County Region and Sussex County, DE.

FIGURE 1. TRI-COUNTY AND SUSSEX, DE SERVICE AREA



SOMERSET HEALTH DEPARTMENT

The Somerset Health Department is led by Health Officer Danielle Weber, MS, RN. Approximately 70 employees serve the public in the following departments: Behavioral Health, Community Health, Emergency Preparedness, Environmental Health, Medical Assistance Transportation, Preventive Health Services and Communication, Tri-County Alliance of the Homeless, Vital Records, and our Wellness and Recovery Center.

Mission
To serve the public by preventing illness, promoting wellness, and protecting the health of our community

Vision
Healthy People in Healthy Communities

WICOMICO HEALTH DEPARTMENT

The Wicomico County Health Department is led by Health Officer Lori Brewster. Wicomico Health has over 200 employees and 8 major divisions, including: Administration, Behavioral Health, Case Management, Community Health Services, Dental, Environmental Health, Local Behavioral Health Authority, and Prevention and Health Communications. WiCHD has expanded over the years to meet the changing needs of the community and to continually work towards protecting the health and environment of Wicomico County. The behavioral health programs are fully accredited by CARF International (Commission on Accreditation of Rehabilitation Facilities). This achievement is an indication of the organization's dedication and commitment to continually improve services, encourage feedback, and serve the community to improve the quality of the lives of persons served. Additionally, since 2016, WiCHD has been accredited through the Public Health Accreditation Board (PHAB). PHAB sets standards against which governmental public health departments can continuously improve the quality of their services and performance.

Mission
To maximize the health and wellness of all members of the community through collaborative efforts

Vision
Healthy People in Healthy Communities

1.2 CONSULTANTS

The Partnership commissioned Conduent Healthy Communities Institute (HCI) to support report preparation for its 2022 CHNA. HCI works with clients across the nation to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems, and implementing performance evaluation processes. The following HCI team members were involved in the development of this report: Ashley Wendt, MPH – Public Health Consultant, Dari Goldman, MPH - Senior Project Specialist, Emily Hummel, MPH - Senior Account Manager, and Margaret Mysz, MPH – Research Associate. To learn more about Conduent HCI, please visit https://www.conduent.com/claims-and-administration/community-health-solutions/.

COMMUNITY HEALTH NEEDS ASSESSMENT: At a Glance

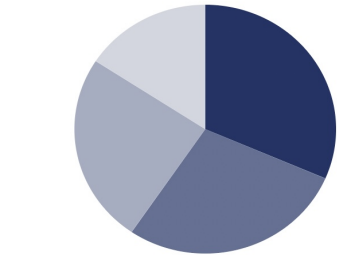
Community Input

Community Survey (n=774)

Key Informants (n=14)

Focus Groups (n=26)

Most Important Community Health Issues



- Alcohol and Drug Use (50.1%)
- Mental Health and Mental Disorders (44.6%)
- Access to Affordable Health Care Services (39.3%)
- Weight Status (25.1%)

Secondary Data

- Other Conditions/ Older Adults
- Prevention & Safety
- Heart Disease & Stroke
- Oral Health
- Wellness & Lifestyle

Prioritized Health Needs

Access and Health Equity

- Cultural / language barriers
- Health Literacy
- Lack of knowledge / ability to navigate healthcare system

Behavioral Health

44.6% of survey respondents identified Mental Health & Mental Disorders as a priority.

Chronic Disease and Wellness

- Diabetes
- Cancer
- Heart Disease & Stroke
- Nutrition & Healthy Eating

Health Equity

Health equity focuses on the fair and just distribution of health determinants, outcomes, and resources across communities.

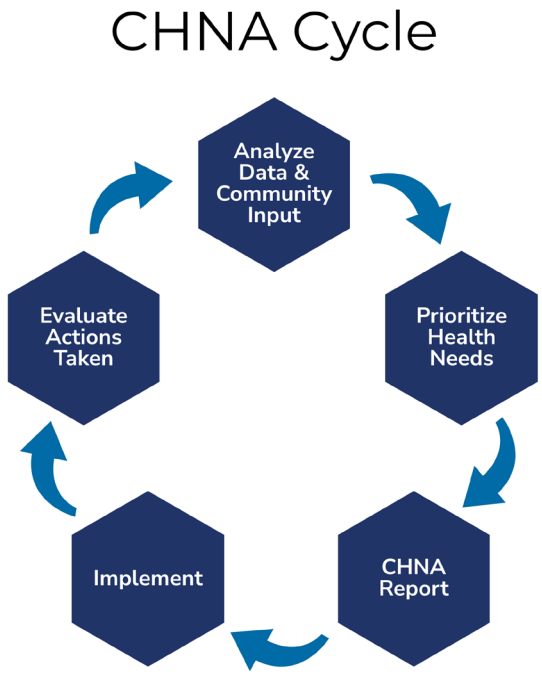
- Systemic racism
- Poverty
- Gender discrimination

Poorer health outcomes for groups such as Black, Indigenous, People of Color, individuals living below the poverty level, and LGBTQ+ communities.

SECTION 2

LOOK BACK:
EVALUATION OF PROGRESS SINCE PRIOR CHNA

The CHNA process should be viewed as a three-year cycle. An important part of that cycle is revisiting the progress made on priority topics from previous CHNAs. By reviewing the actions taken to address priority areas and evaluating the impact of these actions in the community, an organization can better focus and target its efforts during the next CHNA cycle.



2.1 PRIORITY HEALTH NEEDS FROM PRECEDING CHNA

Behavioral Health

Diabetes

Cancer

The Partnership built upon efforts from the previous 2019 CHNA to focus on communities and populations who disproportionally experience the prioritized health challenges identified above. Of the activities or programs implemented, the most notable are below. You can see more details in the 2019-2022 Implementation Strategy Plan/CHIP in the Appendix or on https://www.wicomicohealth.org/wp-content/uploads/2021/11/2019-2022-CHIP-CBP_FY22-Update-10.28.2021.pdf.

2.1.1 BEHAVIORAL HEALTH

1. Community Outreach Addictions Team (COAT): This program has been recognized by NACCHO (National Association of County and City Health Officials) as a Promising Practice. COAT hires peer support workers, individuals who have been successfully in the recovery process, to help others struggling with addiction, with the goal of linking individuals to treatment services. The program works closely with TidalHealth Peninsula Regional as well as local law enforcement. This program has proven to be an invaluable resource to the community in providing linkage to treatment and other support services to community members dealing with alcohol and substance issues. During Fiscal Year 2021, COAT served 421 individuals, linking 236 to treatment.
2. Wicomico County Opioid Intervention Team and Somerset County Opioid United Team: In accordance with the 2017 Executive Order 01.01.2017.01 issued by Governor Larry Hogan, WiCHD and SCHD each continue to coordinate a local Opioid Intervention Team (OIT) in their respective counties. Both teams include private and public partners and have the goal to identify and address opioid related needs in the community by following the state's three-pronged approach of addressing the opioid epidemic in the areas of prevention, treatment, and enforcement. The teams work collaboratively to address policy, develop education, and raise community awareness in the fight against opioid use and opioid overdoses.
3. Program to Encourage Active and Rewarding Lives (PEARLS): TidalHealth offers all patients the opportunity to participate in PEARLS. PEARLS is a one-on-one evidence-based program designed to reduce depression in physically impaired and socially isolated individuals. The program is offered in six to eight sessions over a 19-week period by a certified PEARLS Counselor. It is a participant driven program with psychiatric supervision/clinical oversight and consultation offered through MAC, Inc.
4. Salisbury-Wicomico Integrated First-Care Team: This innovative partnership to establish a mobile integrated health and community paramedicine program is proven to improve care coordination and health outcomes, reduce hospitalizations and readmissions as well as increase the use of preventive and primary care services. TidalHealth in partnership with Salisbury Fire Department enrolls patients who have utilized the 9-1-1- system more than five times in six months. The multidisciplinary team meets patients in their home, provides home assessments and connection to primary care and support for social determinants of health such as food, shelter, clothing, work-force connections, and healthcare support.
5. Smith Island Primary Care and Telemedicine Access: This initiative supports a multidisciplinary team including a medical assistant, pharmacist, nurse practitioner, and physician who travel to the remote, isolated island community to provide health screenings, primary and secondary preventive services and health education and outreach. The team goes to Smith Island twice monthly during spring, summer, and fall months.

2.1.2 DIABETES

1. Chronic Disease Self-Management (CDSM) Classes: TidalHealth partnered with local non-profit, MAC, Inc. to expand access to evidence-based CDSME class throughout the community.

2. TidalHealth Community Wellness Program expansion: The Community Wellness Program has expanded beyond mobile health screenings via the Wagner Wellness Van to also include community health workers (CHWs) integrated as part of a mobile multidisciplinary care coordination team. CHWs screen for social determinants of health and work with the nurse-led team to promote chronic disease self-management.
3. Sustainable Change and Lifestyle Enhancement (SCALE): SCHD collaborated with WiCHD to implement a free, evidence-based weight loss, nutrition, and physical activity program in Somerset and Wicomico Counties. This evidence-based weight loss, nutrition, and physical activity program is for women ages 18 to 55 and their children ages 7 to 17. In a group setting, health coaches guide participants through healthy eating and physical activity education and activities to achieve sustained weight loss and healthy lifestyle habits. The program also includes special group exercise, cooking demonstrations, grocery store tours, etc. From Fiscal Year 2020 to 2021, 82 adults enrolled in the program. Due to COVID-19, classes were held virtually.

2.1.3 CANCER

1. TidalHealth Community Wellness Program and Cancer Institute: The Community Wellness Program of the Population Health Management division of TidalHealth works in coordination with the TidalHealth Richard A. Henson Cancer Institute and local health departments to promote early detection and screening for cancer. Teams provide screening for lung cancer, colon cancer, and breast cancer. Outreach is done through events within the community as well as using electronic medical records detection in providers' offices.

2.2 COMMUNITY FEEDBACK FROM PRECEDING CHNA & IMPLEMENTATION PLAN

The 2019 Community Health Needs Assessment Report and Implementation Strategies were made available to the public via the TidalHealth website at https://www.tidalhealth.org/community-outreach-partners/community-health-research-data. The reports are also available at the front desk at TidalHealth Peninsula Regional for patients and visitors who would like a copy.

A final review of the report was completed by the Wicomico Local Health Improvement Coalition and the Healthy Somerset Local Health Improvement Coalition. Wicomico County Health Department has a phone number and email listed on their website to request additional information or provide feedback at https://www.wicomicohealth.org/planning/reports-and-plans/. Somerset County Health Department also made the report available on their site at www.somersethealth.org. No comments had been received on the preceding CHNA at the time this report was written. The report is widely used by local health improvement coalitions, community-based organizations focused on health initiatives, Salisbury University, University of Maryland Eastern Shore, and others to understand the needs of the community and develop interventions to meet those needs.

SECTION 3

DEMOGRAPHICS

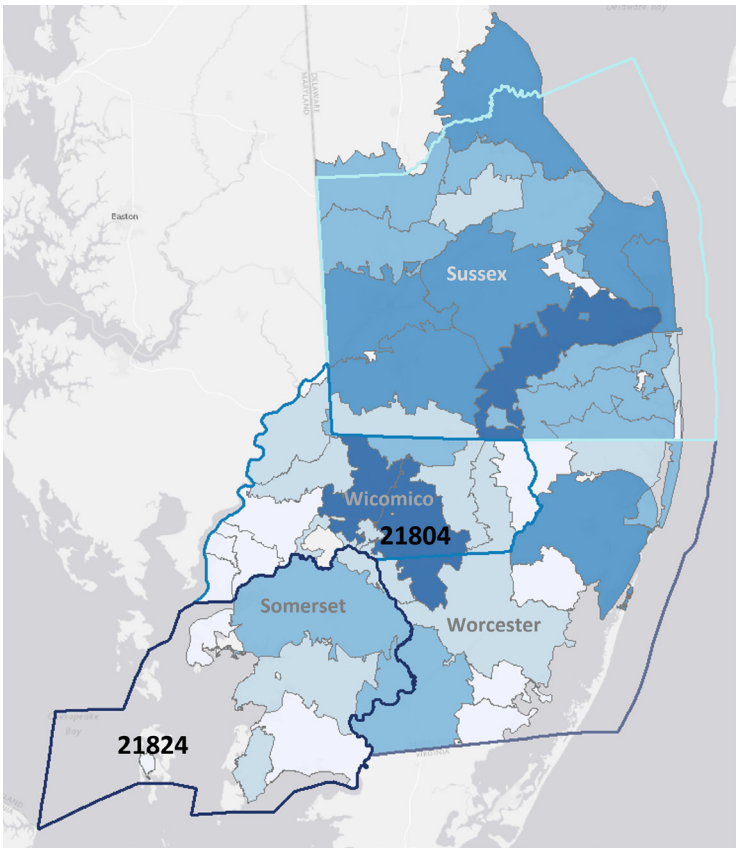
The following section explores the demographic profile of the Tri-County Region and Sussex County, DE. The demographics of a community significantly impact its health profile. Different race/ethnicity, age, and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts. All demographic estimates are sourced from Claritas Pop-Facts® (2021 population estimates) and American Community Survey one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

3.1 DEMOGRAPHIC PROFILE

3.1.1. POPULATION

The Tri-County Region and Sussex County, DE has an estimated population size of 423,437 in 2021. The largest county is Sussex County, with a population of 241,079 in 2021. The smallest county is Somerset County with a population of 25,521 in 2021. Figure 2 shows population size by zip code. The darkest blue regions represent zip codes with the largest population. The most populated zip code is 21804 in Wicomico County and the least populated is 21824 in Somerset County.

FIGURE 2: TRI-COUNTY REGION AND SUSSEX, DE POPULATION SIZE BY ZIP CODE



3.1.2 AGE

The figures below show the population by age group for zip codes within the Tri-County Region and Sussex County, DE. As shown in Figure 3, zip codes within western Sussex County and Wicomico County have a high percentage of the population that is under 18. In contrast, as shown in Figure 4, most of the population over 65 is located in eastern Sussex County and northern Worcester County.

According to the Maryland Department of Planning[1] and the Delaware Population Consortium[2], the percentage of persons aged 65 and older is projected to increase in both states. Maryland projects that older adults will make up 21% of the state's population by 2040 (from 12% in 2010). Delaware projects that older adults will make up nearly 25% of the state's population by 2040 (from 14% in 2010). As aging brings a higher risk of chronic diseases such as dementia, heart disease and diabetes, this change will impact the health and public health systems that should be considered in long-term planning.

1. "Department of Planning Maryland State Data Center." Maryland State Data Center, Department of Planning, Dec. 2020, https://planning.maryland.gov/MSDC/Pages/s3_projection.aspx

2. https://stateplanning.delaware.gov/demography/documents/dpc/DPC2021v0.pdf

FIGURE 3: PERCENT POPULATION UNDER 18, BY ZIP CODE

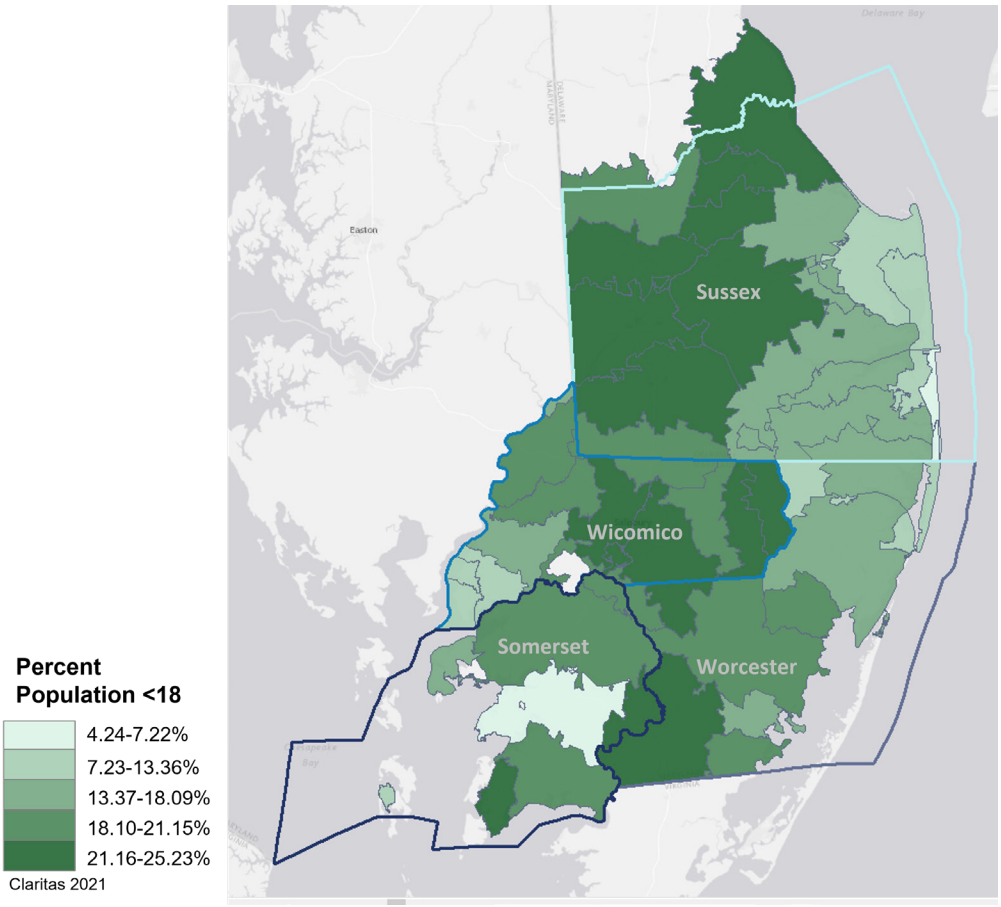
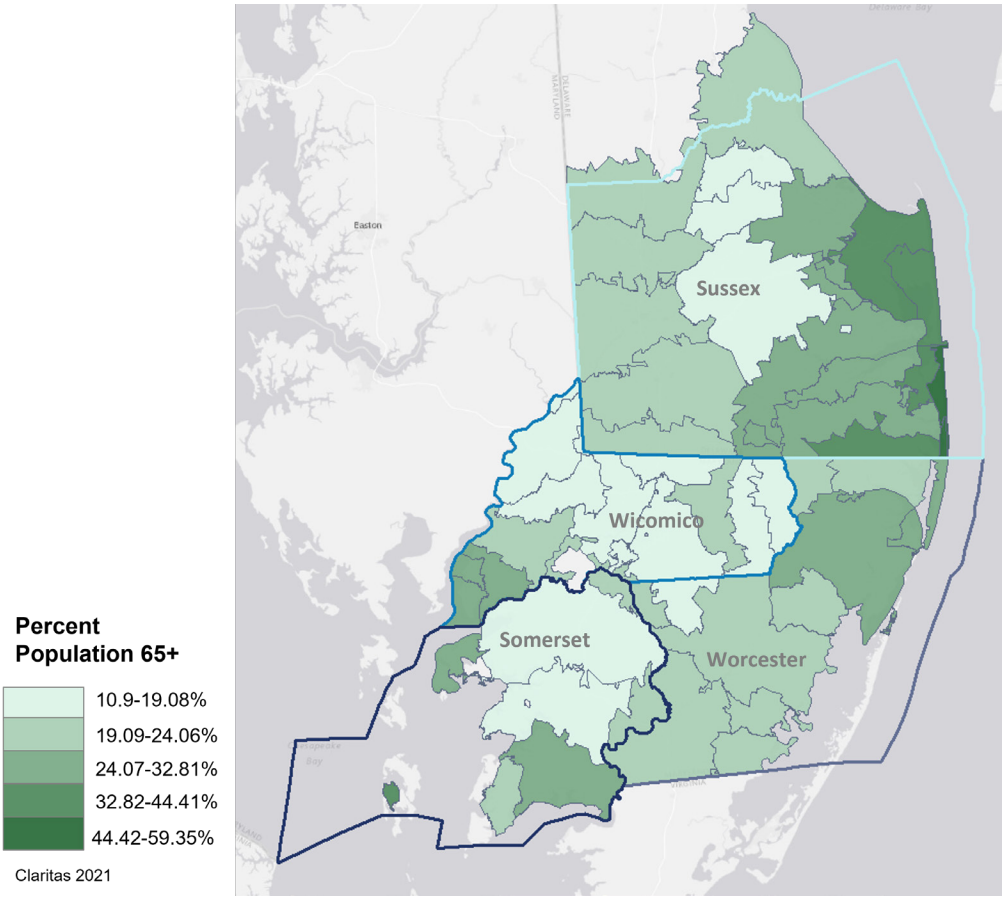


FIGURE 4: PERCENT POPULATION OVER 65, BY ZIP CODE



3.1.3 RACE AND ETHNICITY

Race and ethnicity contribute to the opportunities individuals and communities have in order to be healthy. Figures 5 and 6 show the population by race and by ethnicity of each of the four counties. All four counties are majority Non-Hispanic White with Worcester County having the highest proportion identifying as Non-Hispanic White (82.9%) and Somerset having the lowest proportion identifying as Non-Hispanic White (53.1%). Hispanics or Latinos compose between 3.9% and 9.8% of each county's population; Sussex County has the highest proportions of Hispanic or Latino populations at 9.8%. The proportion of Non-Hispanic Asian individuals in each county ranges from 1.0% in Somerset to 3.3% in Wicomico. The Non-Hispanic Black or African American population composes between 13.1% of the population in Worcester to 42.6% in Somerset. The proportion of the population identifying as two or more races also ranges from 1.9% in Worcester to 2.9% in Wicomico.

FIGURE 5: POPULATION BY RACE

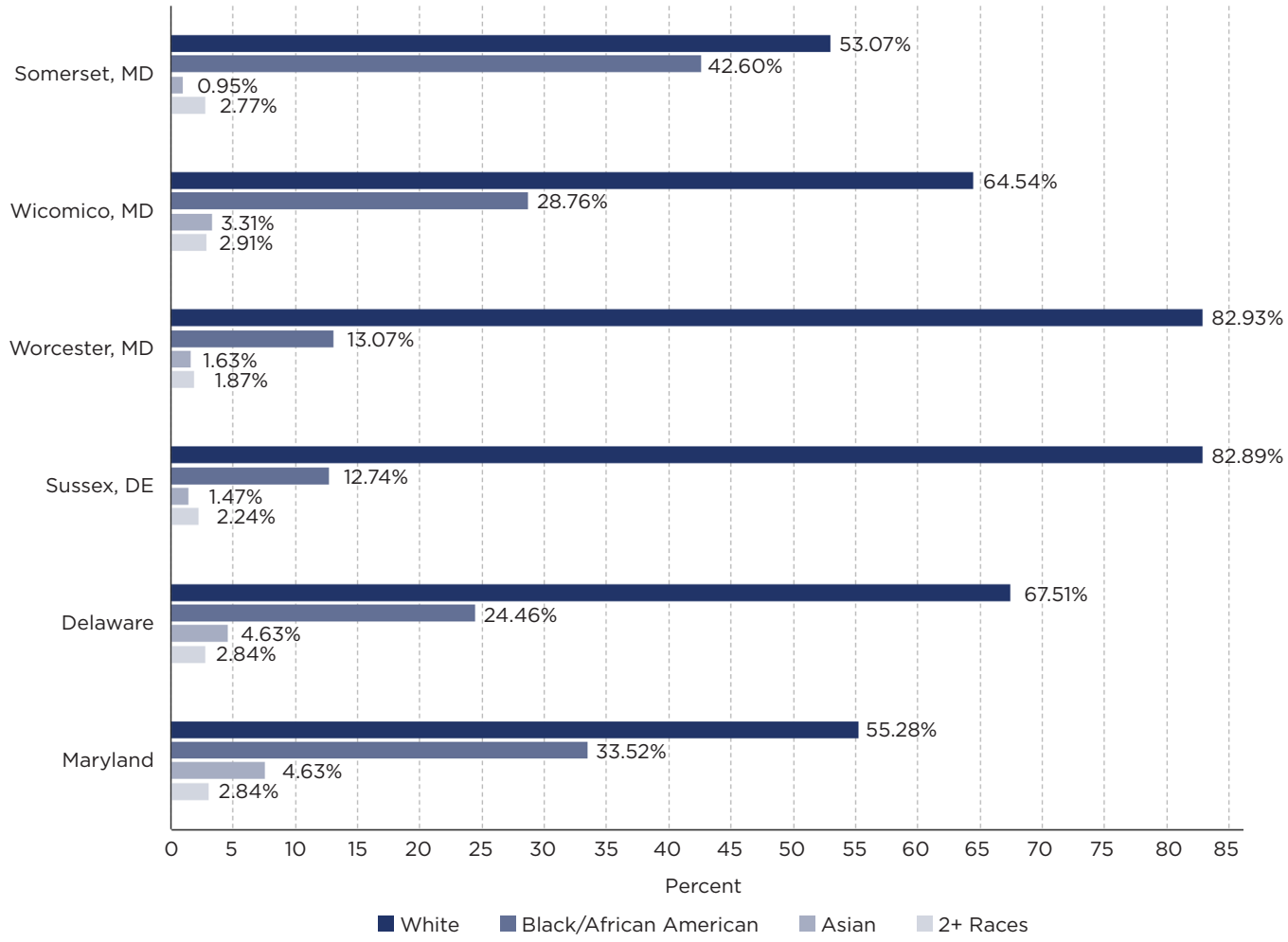
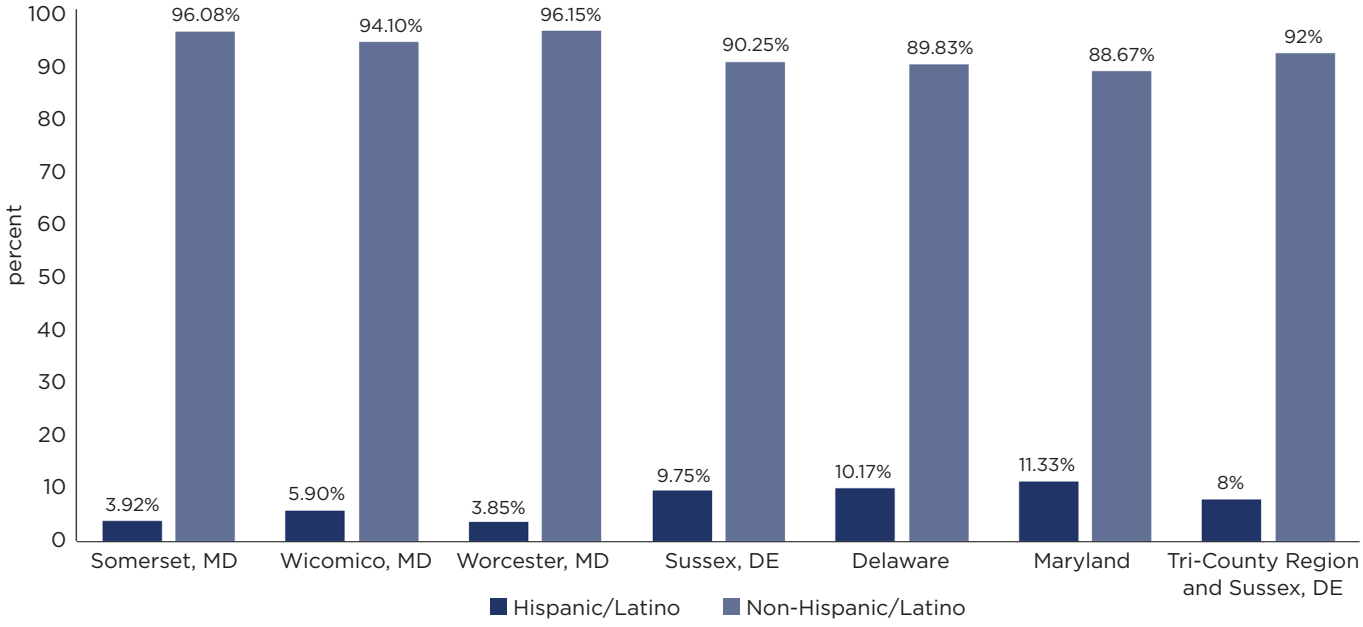


FIGURE 6: POPULATION BY ETHNICITY

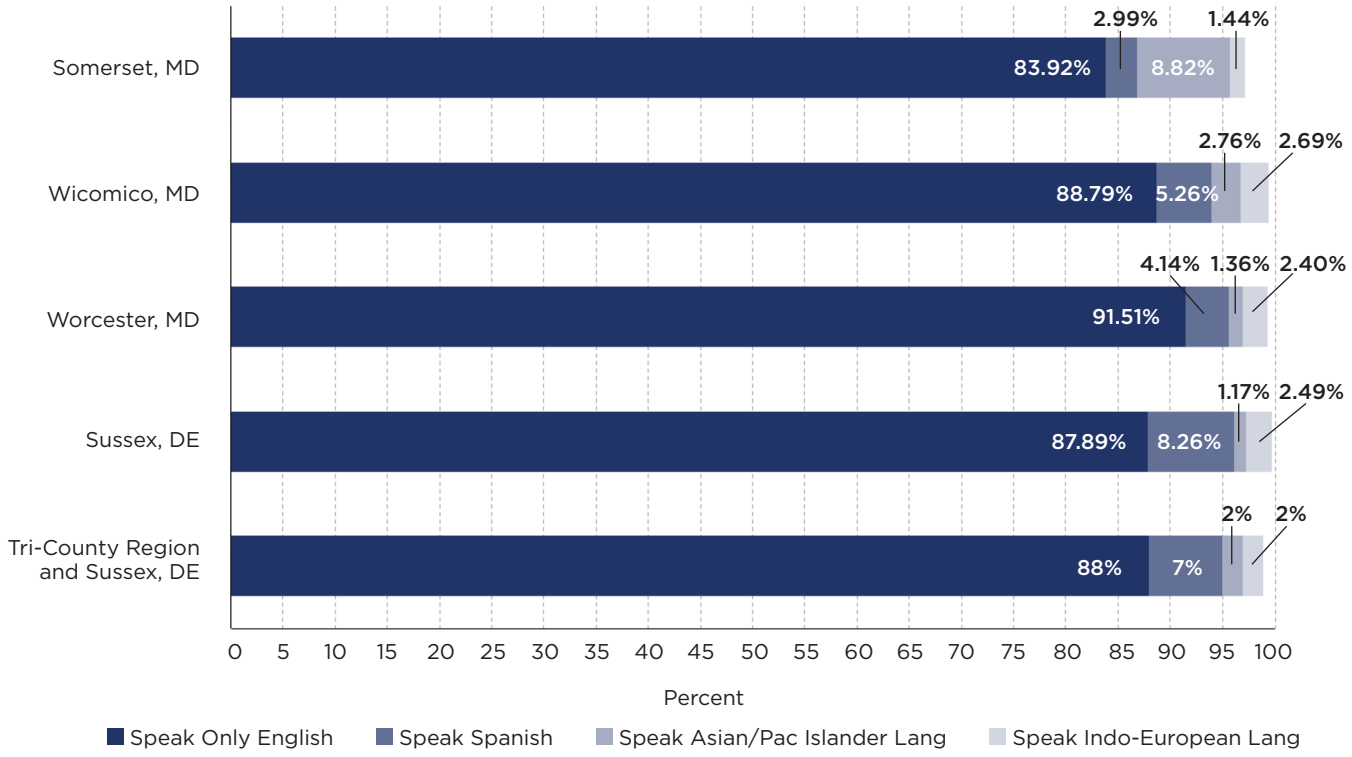


3.1.4 LANGUAGE AND IMMIGRATION

Understanding countries of origin and languages spoken at home can help inform the cultural and linguistic context for the health and public health system. About 11.7% of the Tri-County Region and Sussex County, DE population ages five and older speak a language other than English at home, which is lower than Delaware and Maryland state averages of 14.8% and 19.6%, respectively. The most common languages spoken at home for the service area is English (88.3%) and Spanish (6.7%).

Figure 7 below shows the percentage of the population five and older in each county and languages spoken at home. Somerset, MD, has the lowest percentage of the population five and older who speak only English at home (83.9%) and the largest percent of the population who speak an Asian or Pacific Islander language at home (8.8%). Sussex County, DE, has the highest percent of the population that speaks Spanish at home (8.3%) compared to the counties within the Tri-County Region and Sussex County, DE.

FIGURE 7. LANGUAGE SPOKEN AT HOME



SECTION 4

SOCIAL & ECONOMIC DETERMINANTS OF HEALTH

This section explores the economic, environmental, and social determinants of health of the Tri-County Region and Sussex County, DE and its 66 zip codes. Social determinants are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. It should be noted that county-level data can sometimes mask what could be going on at the zip code level in many communities. While indicators may be strong at the county level, zip code level analysis can reveal disparities.

4.1 INCOME

Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one's ability to work.

Figure 8 shows the Median Household Income of each county compared to both Maryland and Delaware state values. As shown, all counties are below Maryland's median household income of $90,160. Worcester, MD, has the highest median household income of $68,939. Somerset, MD, has the lowest median household income of $48,094.

FIGURE 8: MEDIAN HOUSEHOLD INCOME

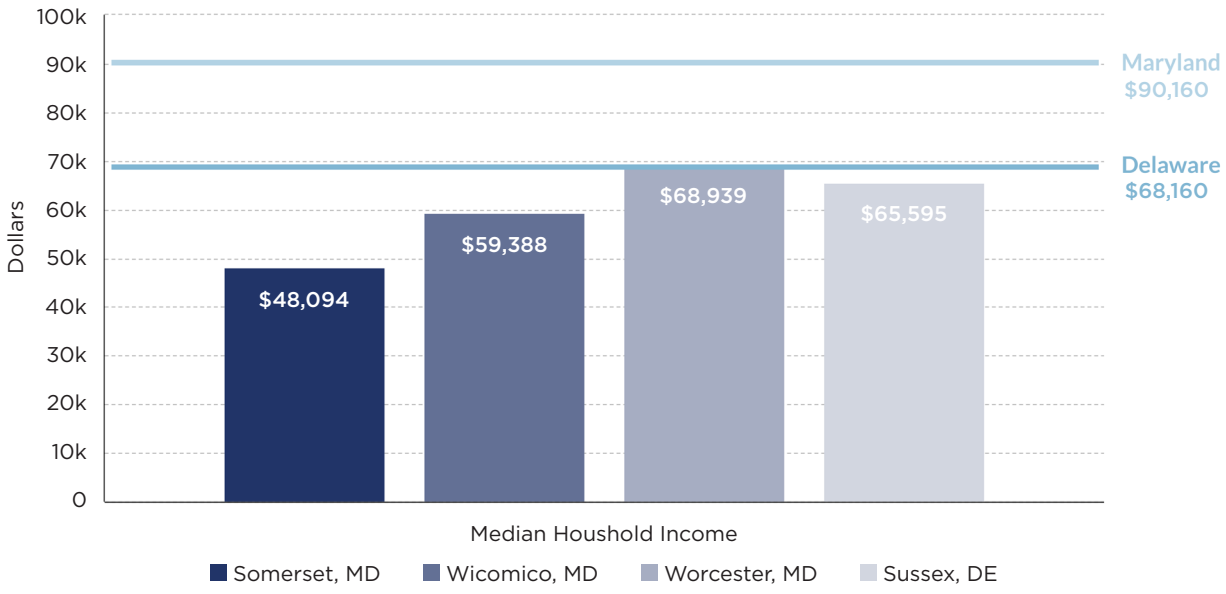


Figure 9 and Figure 10 below show the Median Household Incomes for each county by race and ethnicity, respectively. As shown, there is variation in median income by race and ethnicity for the Tri-County Region and Sussex County, DE. For all counties, Black or African American households have the lowest median household incomes than other racial groups. In Worcester, MD, Black or African American households make only 57% of the overall county median household income ($39,778 compared to $68,939). In general, Non-Hispanic/Latino households have higher median incomes than Hispanic/Latino households.

FIGURE 9: MEDIAN HOUSEHOLD INCOME BY RACE

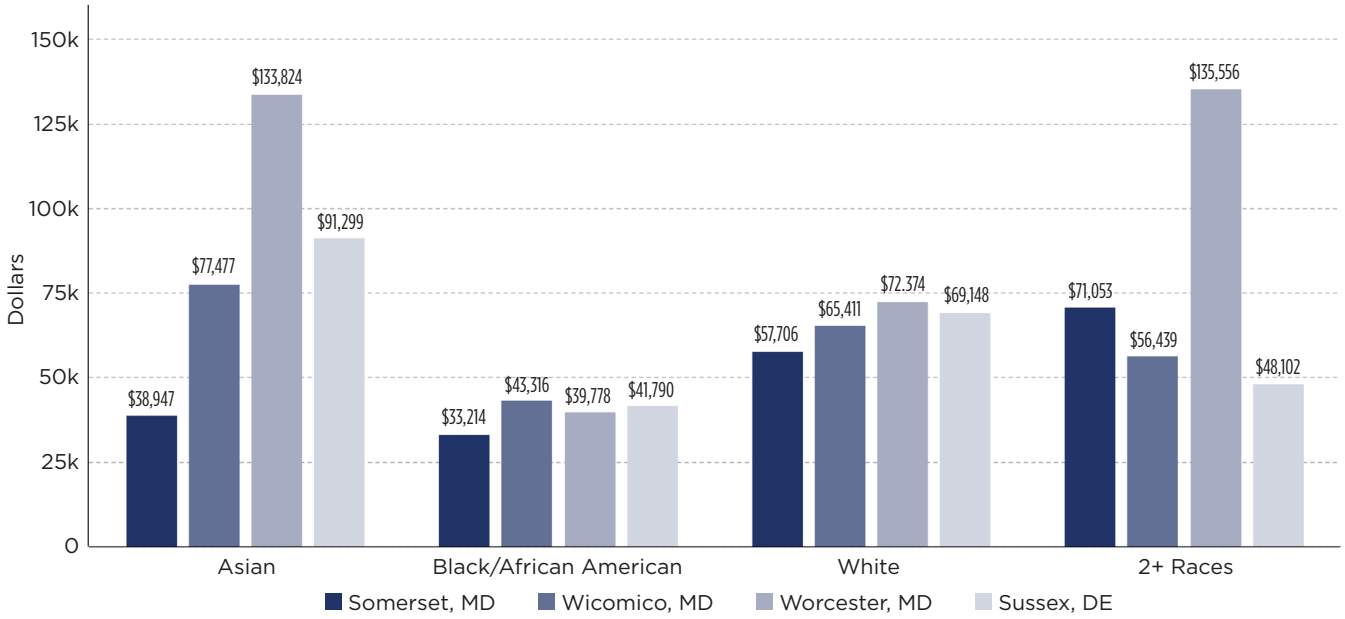
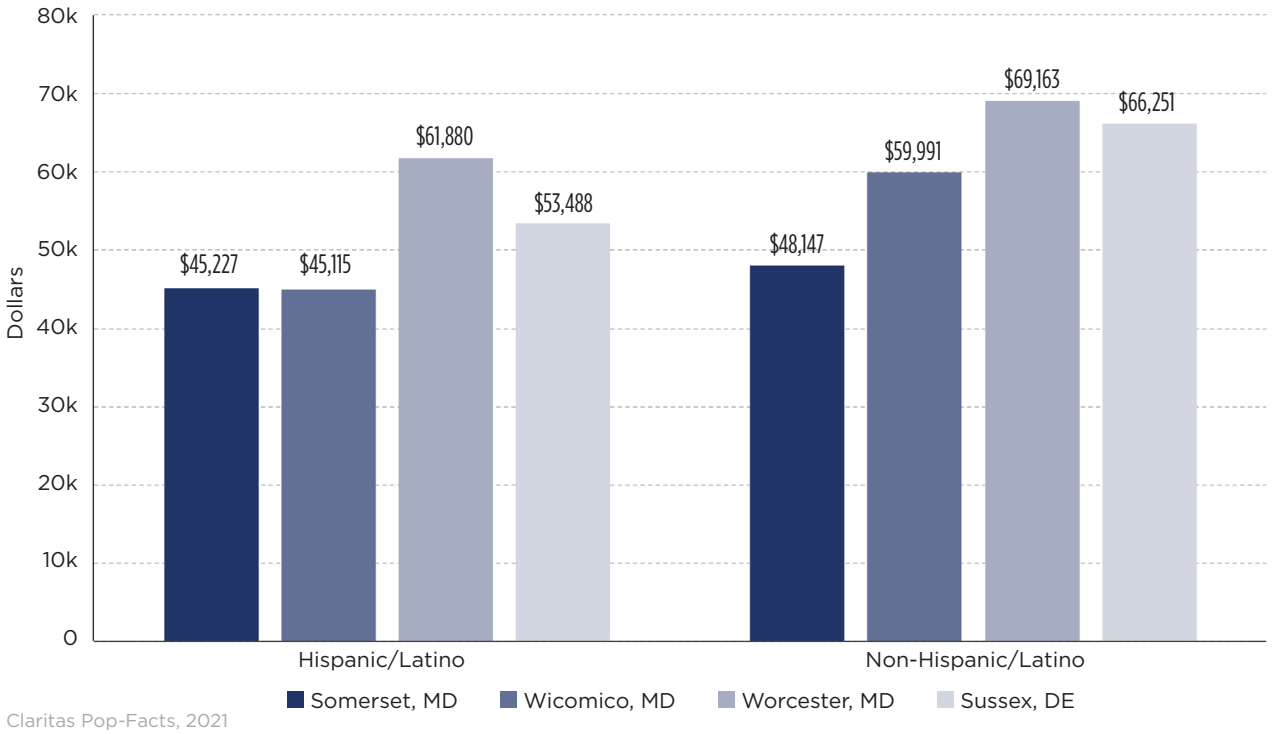


FIGURE 10: MEDIAN HOUSEHOLD INCOME BY ETHNICITY



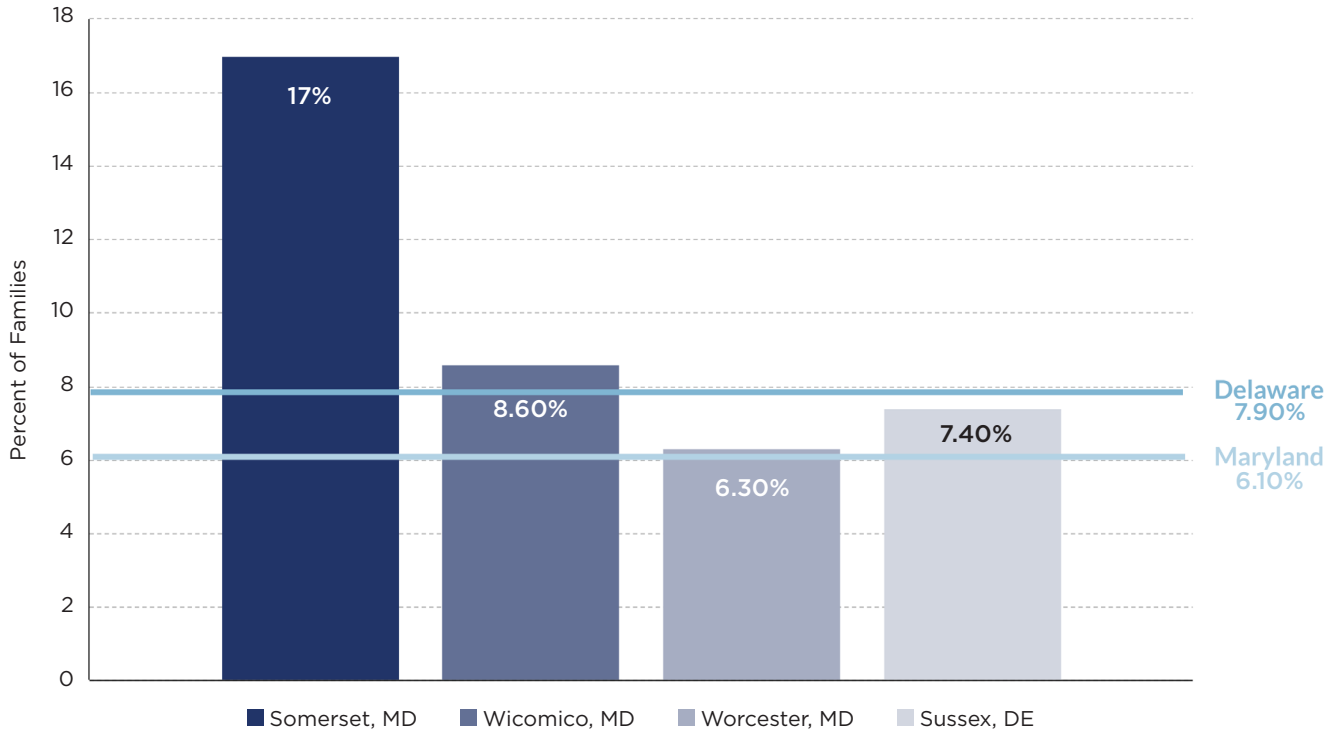
Claritas Pop-Facts, 2021

4.2 POVERTY

Federal poverty thresholds are set every year by the U.S. Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to healthcare, healthy food, stable housing, and opportunities for physical activity. These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.

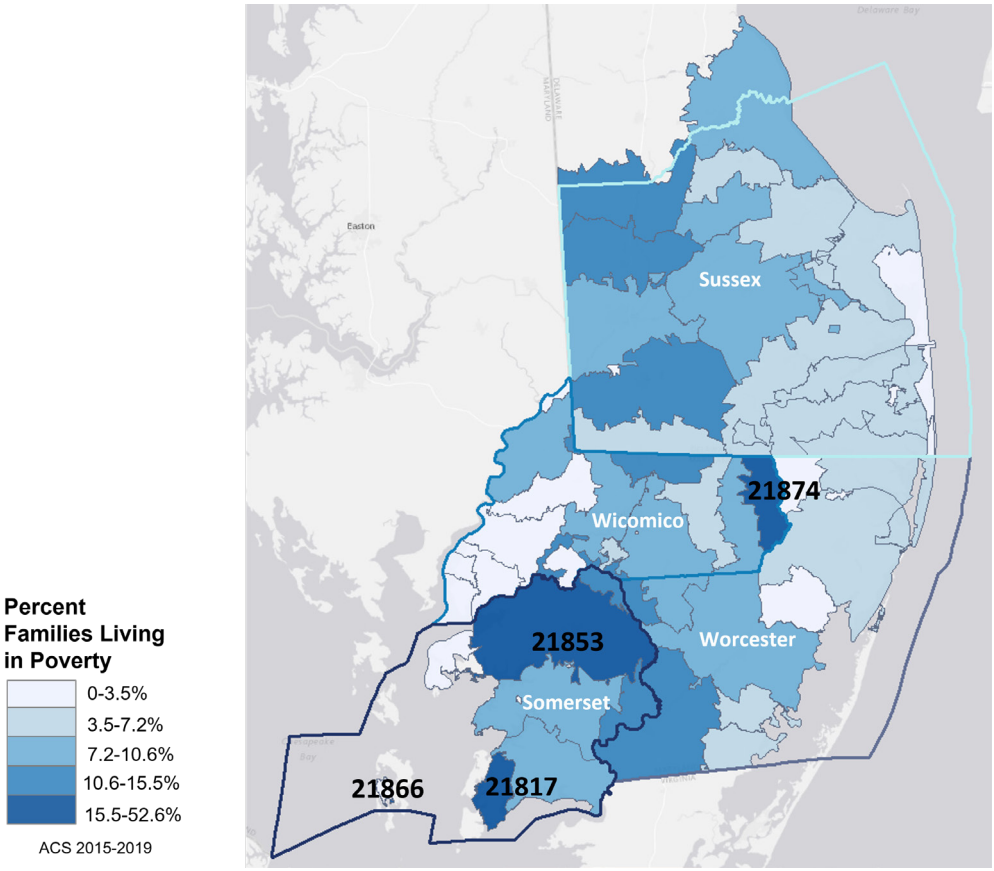
Figure 11 shows the Percentage of Families Living Below Poverty Level by county while Figure 12 shows the Percentage of Families Living Below Poverty Level by zip code. Overall, Somerset, MD, has the highest percentage of families living below poverty (17%) while Worcester, MD, has the lowest percentage (6.3%). In Figure 12 below, the four zip codes with the highest percentage of families living below poverty are seen in the darkest blue color. These zip codes are 21817, 21866, and 21853 in Somerset, MD, and 21874 in Wicomico, MD.

FIGURE 11: FAMILIES LIVING BELOW POVERTY LEVEL BY COUNTY



ACS, 2015-2019

FIGURE 12: FAMILIES LIVING BELOW POVERTY BY ZIP CODE



4.3 EMPLOYMENT

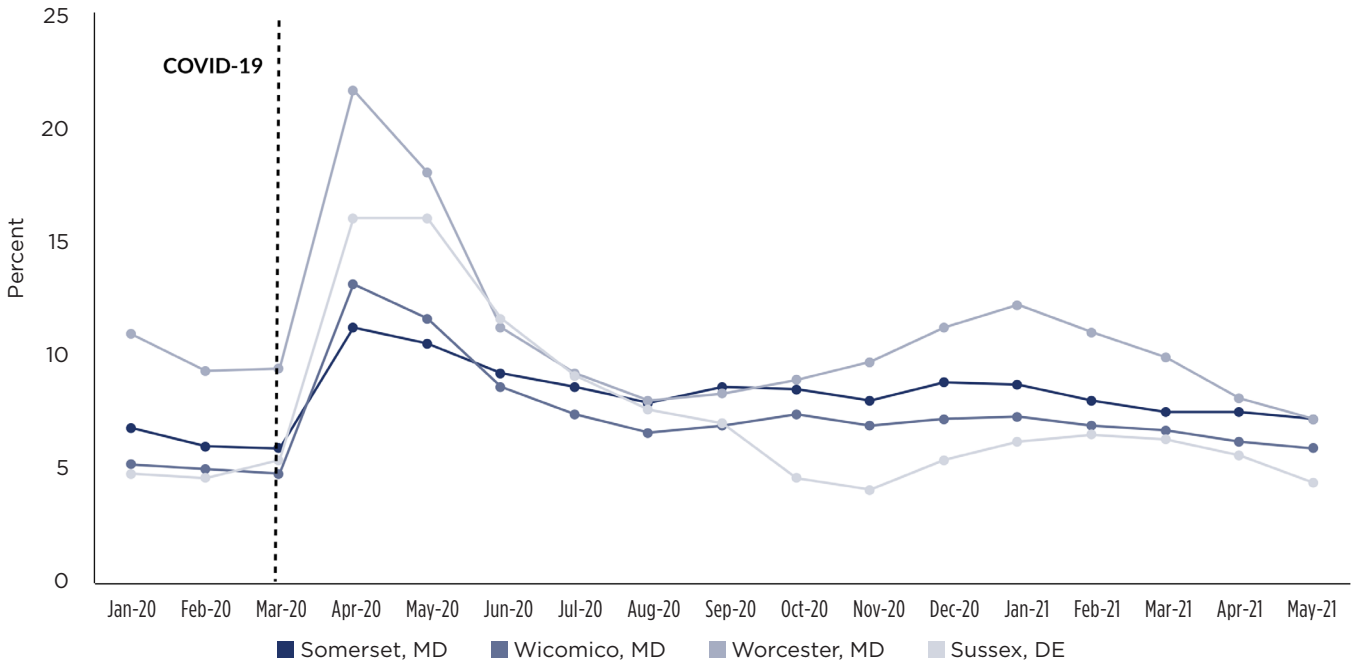
A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to healthcare, work environment, and health behaviors and outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes.

Unemployment and underemployment can limit access to health insurance coverage and preventive care services. Underemployment is described as involuntary part-time employment, poverty-wage employment, and insecure employment.

Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are examples of ways employment can lead to poorer health.

Figure 13 shows the Unemployment Rate, according to the U.S. Bureau of Labor Statistics (2021), for each county within the Tri-County Region and Sussex County, DE from October 2019 to May 2021. Noted in the chart is when COVID-19 stay-at-home orders began (around March 2020). Unemployment rates rose after the start of the pandemic and have dropped since, but unemployment will continue to be an issue as the economy recovers.

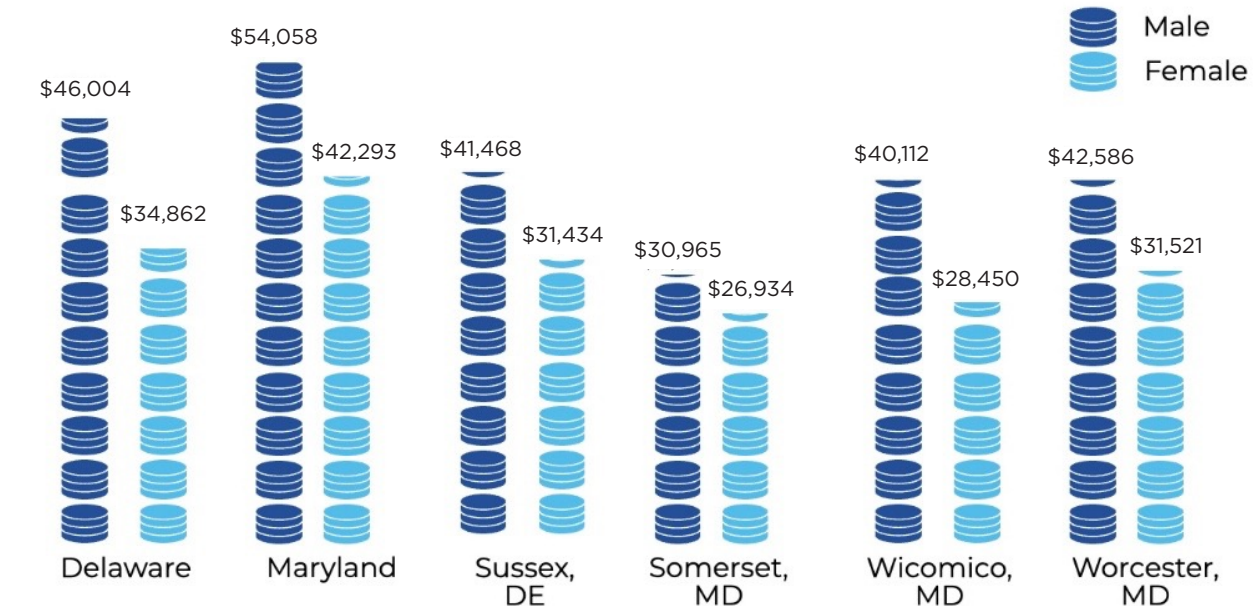
FIGURE 13. UNEMPLOYMENT RATE (POPULATION 16+)



U.S. Bureau of Labor Statistics

Employment and wage potential can be limited based on an individual's education status, gender identity, race/ethnicity, and sexual orientation. As shown in Figure 14, there is a wage gap between women and men in the Tri-County Region and Sussex County, DE. Wicomico, MD, has the largest wage gap, with women earning 70.9% of their male counterparts. Somerset, MD, has the smallest wage gap, with women earning 87% of their male counterparts. Although the data is not available by race/ethnicity for each county, national trends suggest that this wage gap persists and is most likely worsened by racial or ethnic identity.

FIGURE 14. WAGE GAPS FOR WORKING WOMEN



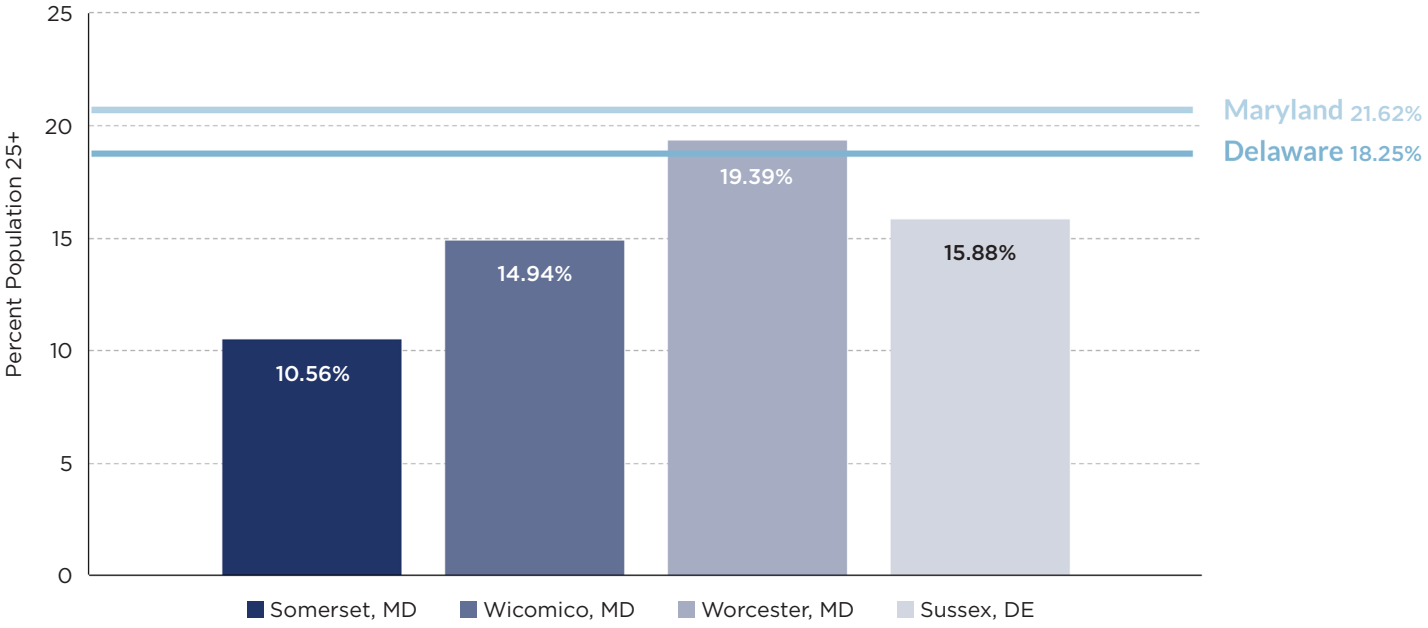
ACS, 2015-2019

4.4 EDUCATION

Education is an important indicator of health and well-being across the lifespan. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. People with higher levels of education are likely to live longer, experience better health outcomes, and practice health-promoting behaviors.

Figure 15 shows the Percent of the Population 25 and Older who have a Bachelor's Degree for each county compared to both Maryland and Delaware state. Somerset, MD, has the lowest percentage of the population 25 and older with a bachelor's degree (10.6%), while Worcester, MD, has the highest percentage at 19.4%.

FIGURE 15. POPULATION 25+ WITH A BACHELOR'S DEGREE

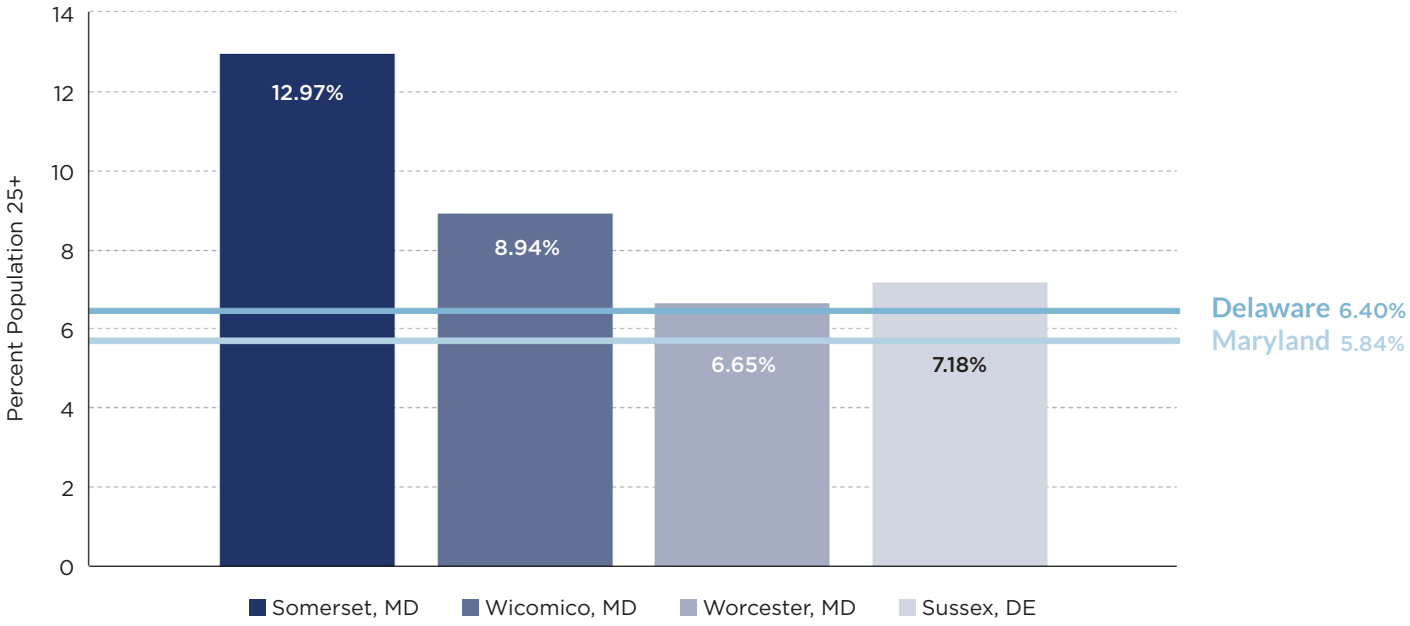


Claritas Pop-Facts, 2021

Another indicator related to education is on-time high school graduation. A high school diploma is a requirement for many employment opportunities and for higher education. Not graduating high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty.

Figure 16 shows the Percent of the Population 25 and Older who have some High School Education but No Diploma. Somerset, MD, has the highest percentage of the population 25 and older without a high school diploma (13.0%) compared to other counties within the Tri-County Region and Sussex County, DE.

FIGURE 16. POPULATION 25+ WITH SOME HIGH SCHOOL EDUCATION, NO DIPLOMA



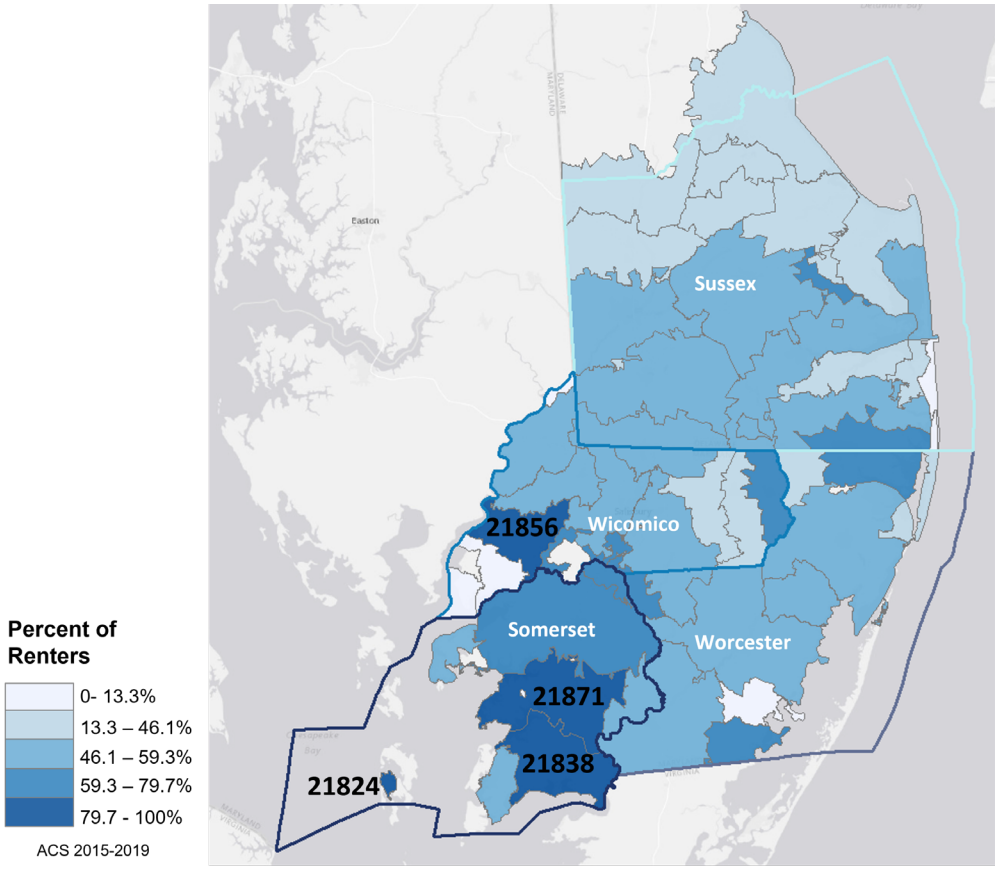
Claritas Pop-Facts, 2021

4.5 HOUSING

Safe, stable, and affordable housing provides a critical foundation for health and well-being. Exposure to health hazards and toxins in the home can cause significant damage to an individual or family's health. When families must spend a large part of their income on housing, they may not have enough money to pay for things like healthy food or healthcare. This is linked to increased stress, mental health problems, and an increased risk of disease.

As shown in Figure 17, many renters living within Wicomico and Somerset counties spend 30% or more of their household income on rent. In some zip codes, such as 21824, 21838, 21856, 21864, and 21853, this is estimated to be over three-quarters of renters. As indicated by the primary data collected during the CHNA process, housing costs and affordability may have been impacted by COVID-19 in these communities. Therefore, the Percent of Renters Spending 30% or More of their Household Income on Rent may have increased since 2019 for all communities.

FIGURE 17. RENTERS SPENDING 30% OR MORE OF HOUSEHOLD INCOME ON RENT BY ZIP CODE



SECTION 5

DISPARITIES AND HEALTH EQUITY

Identifying disparities by race/ethnicity, gender, age, and geography helps to inform and focus priorities and strategies. Understanding disparities also helps us better understand root causes that impact health in a community and inform action towards health equity. Health equity focuses on the fair distribution of health determinants, outcomes and resources across communities. National trends have shown that systemic racism, poverty, and gender discrimination have led to poorer health outcomes for groups such as Black, Indigenous, or People of Color, individuals living below the poverty level, and LGBTQ+ communities.

Primary and secondary data revealed significant community health disparities based on race/ethnicity, particularly among the Black and Hispanic communities. The assessment also found zip codes with disparities related to health and social determinants of health. It is important to note that while much of the data is presented to show differences and disparities of data by population groups, differences within each population group can be as great as differences between different groups. For instance, Asian or Asian and Pacific Islander encompasses individuals from over 40 different countries with very different languages, cultures, and history in the United States. Information and themes captured through focus groups, key informant interviews, and a community survey have been shared to provide a more comprehensive and nuanced understanding of each community's experiences. This report includes information drawn from all aspects including both quantitative and qualitative data, analysis of health and social determinants collected through interviews, focus group discussions, and an online community survey. The HCI team used a variety of methodologies to analyze data and provide findings that can inform decision-makers and advocates working toward creating more equity, access, and quality within healthcare.

5.1 DISPARITIES BY RACE AND ETHNICITY

Community health disparities were assessed in both the primary and secondary data collection processes. Table 1 below identifies notable secondary data health indicators with a statistically significant disparity for any of the counties within the Tri-County Region and Sussex County, DE. A complete list can be found in Appendix A.

TABLE 1. INDICATORS WITH SIGNIFICANT RACE/ETHNIC DISPARITIES

HEALTH INDICATOR	GROUP(S) NEGATIVELY IMPACTED
People 65+ Living Below Poverty Level	Black/African American, Hispanic/ Latino, Other Race
Workers who Walk to Work	Black/African American, Hispanic/ Latino
Families Living Below Poverty Level	Black/African American, Hispanic/ Latino, Two or More Races, Other Race, American Indian/Alaskan Native
Teen Birth Rate: 15-19	Black/African American
Children Living Below Poverty	Hispanic/Latino, Other Race, Two or More Races

The indicators listed in Table 1 above show a statistically significant difference for race or ethnic groups according to the Index of Disparity analysis. Black or African American and Hispanic/Latino populations were identified as the most negatively impacted groups. Both groups show significant disparities in four of the five listed indicators. These disparities will be considered during implementation planning to improve overall health and wellbeing in the Tri-County Region and Sussex County, DE.

Focus groups and key informant interviews identified the following groups as those struggling more with social determinants of health and potentially experiencing worse health outcomes: families living on a low income, Black or African American populations, Hispanic/Latino populations, Haitian population, and immigrant populations. Additionally, older adults and children were identified as groups challenged with accessing healthcare services and providers. Specifically, a lack of pediatric and specialty care providers was frequently mentioned. Transportation was consistently raised as a major barrier to accessing services for these populations, especially in rural regions.

5.2 INDEX OF DISPARITY (IOD)

The Index of Disparity (IoD)[3] identified large disparities based on how far each subgroup (by race/ethnicity or gender) is from the overall county value. For this analysis, indicators with a high disparity were identified and, when available, IoD values were tracked over time to show if progress has been made to address those disparities. These findings are shown alongside relevant secondary data throughout this report. For more information about IoD methodology, see the Index of Disparity section in Appendix A.

3. Pearcy, Jeffrey, and Kenneth Keppel. *A Summary Measure of Health Disparity*. Public Health Reports, June 2002.

5.3 GEOGRAPHIC DISPARITIES

Geographic disparities were identified using the Health Equity Index and Food Insecurity Index. These indices have been developed by Conduent Healthy Communities Institute to easily identify areas of high socioeconomic need or food insecurity. Conduent's Health Equity Index estimates areas of highest socioeconomic need correlated with poor health outcomes. Conduent's Food Insecurity Index estimates areas of low food accessibility correlated with social and economic hardship. For both indices, counties, zip codes, and census tracts with populations

over 300 are assigned index values ranging from zero to 100, where higher values are estimated to highest need, critical to targeting prevention and outreach activities.

5.3.1 HEALTH EQUITY INDEX

Conduent's Health Equity Index (HEI) estimates areas of highest socioeconomic need correlated with poor health outcomes. In the HEI, zip codes are ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 18. According to the 2021 index, the following zip codes had the highest level of socioeconomic need (as indicated by the darkest shades of blue): 21853 (Somerset, MD) and 21817 (Somerset, MD). Table 2 provides the index values for each top need zip code. See Appendix A for more detailed methodology for the calculation of Health Equity Index values.

FIGURE 18: HEALTH EQUITY INDEX

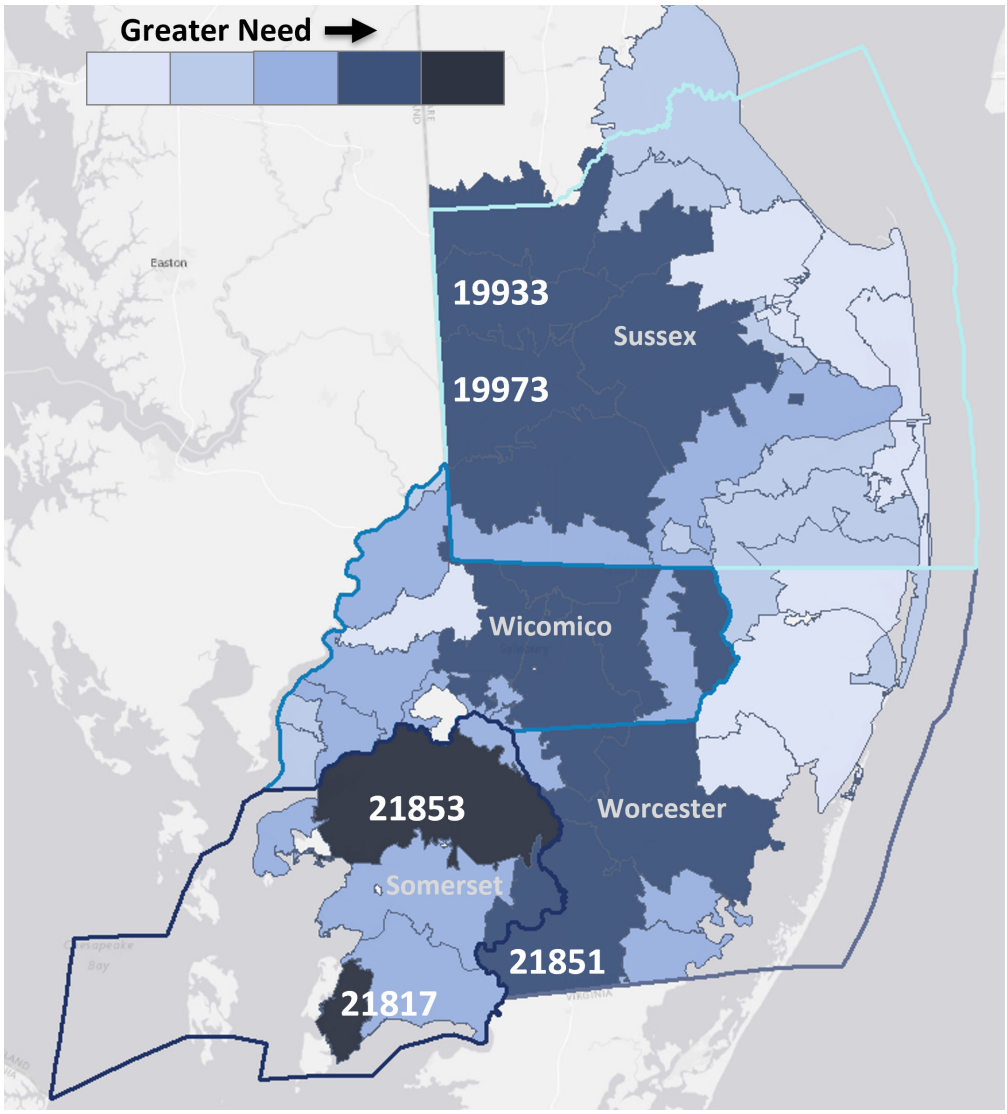


TABLE 2. HEALTH EQUITY INDEX VALUES BY ZIP CODE

ZIP CODE	RANK	HEI VALUE	COUNTY
21853	5	90.2	Somerset, MD
21817	5	88.6	Somerset, MD
19933	4	76.0	Sussex, DE
21851	4	73.1	Worcester, MD
19973	4	69.5	Sussex, DE

5.3.2 FOOD INSECURITY INDEX

Conduent's Food Insecurity Index (FII) estimates areas of low food accessibility correlated with social and economic hardship. In this index, zip codes are ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 19. According to the 2020 FII, the following zip codes have the highest level of food insecurity (as indicated by the darkest shades of green): 21817 (Somerset, MD), 21851 (Worcester, MD), and 21853 (Somerset, MD). Table 3 provides the index values for high needs zip codes. See Appendix A for a more detailed FII methodology.

FIGURE 19. FOOD INSECURITY INDEX

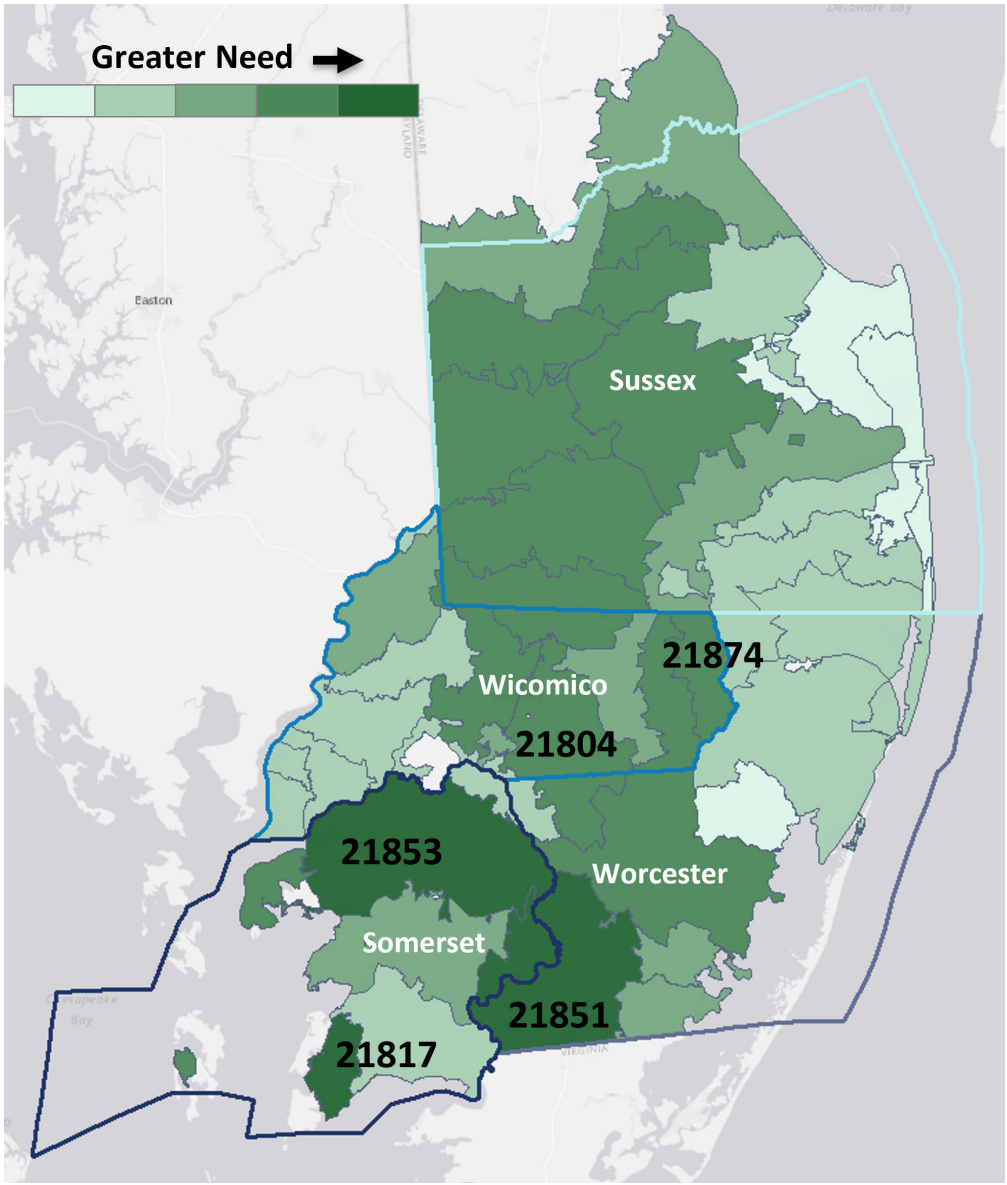


TABLE 3. FOOD INSECURITY INDEX VALUES BY ZIP CODE

ZIP CODE	RANK	FII VALUE	COUNTY
21817	5	89.1	Somerset, MD
21851	5	86.5	Worcester, MD
21851	5	86.4	Somerset, MD
21874	4	72.0	Wicomico, MD
21804	4	69.4	Wicomico, MD

5.4 FUTURE CONSIDERATIONS

While identifying barriers and disparities are critical components in assessing the needs of a community, it is also important to understand the social determinants of health and other upstream factors that influence a community's health as well. The challenges and barriers faced by a community must be balanced by identifying practical, community-driven solutions. Together, these factors come together to inform and focus strategies to positively impact a community's health. The following outlines opportunities for on-going work as well as potential for future impact.

The Partnership and a coalition of community-based stakeholders was awarded $1.2 million through the Maryland Community Health Resources Commission Pathways to Health Equity grant to support the Rural Equity and Access to Community Health (REACH) project. The project is a two-year pilot with the potential for another five years of funding to become a sustainable Health Equity Resource Community as defined by the Maryland Health Equity Resource Act approved during the 2021 state legislative session. This new funding ensures resources for local communities to address health disparities, improve health outcomes, expand access to primary care and prevention services, and help reduce healthcare costs. The REACH Project will specifically address disparities in diabetes and hypertension experienced by the Black and Haitian population on the Lower Eastern Shore. Key interventions will occur at the individual, community and system levels and include expansion of mobile integrated health, connections with primary care, expansion of culturally and linguistically appropriate evidence-based diabetes programming and deployment of community health workers.

SECTION 6

METHODOLOGY AND KEY FINDINGS

6.1 OVERVIEW

The Partnership combined primary and secondary data to inform its Community Health Needs Assessment (CHNA). The CHNA provides an understanding of the health status, quality of life, and risk factors of a community through findings from secondary data analysis and qualitative data collection. The themes and strengths provide insights about what topics and issues community members feel are important, how they perceive their quality of life, and what assets they believe can be used to improve health. Findings from both primary and secondary data helped to inform the top community health needs. Each type of data was analyzed using a defined methodology. Primary data was obtained through a community survey, focus groups, and key informant interviews. Secondary data are health indicator data that have been collected by other sources, such as national and state level government entities, and made available for analysis.

6.2 SECONDARY DATA FINDINGS

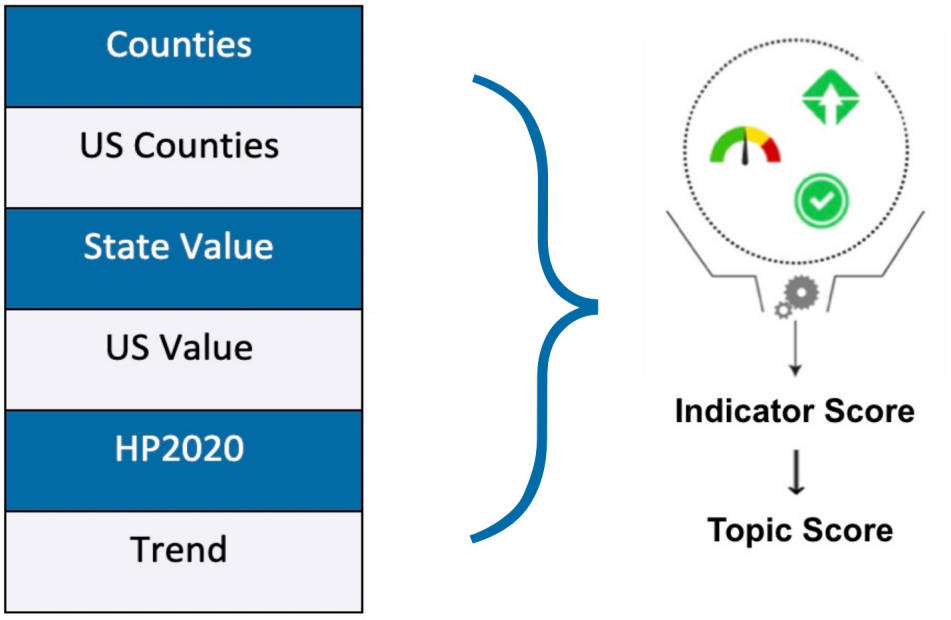


TABLE 4: SECONDARY DATA SCORING RESULTS (WEIGHTED)

Health and Quality of Life Topics	Score
Other Conditions	1.90
Prevention & Safety	1.84
Heart Disease & Stroke	1.78
Oral Health	1.71
Wellness & Lifestyle	1.70
Alcohol & Drug Use	1.63
Older Adults	1.58
Physical Activity	1.55
Health Care Access & Quality	1.51
Community	1.51
Adolescent Health	1.49
Environmental Health	1.48
Diabetes	1.47
Mental Health & Mental Disorders	1.43

Secondary data used for this assessment were collected and analyzed with the Conduent Healthy Communities Institute (HCI) Community Dashboard — a web-based community health platform developed by Conduent Community Health Solutions. The Community Dashboard brings data, local resources, and a wealth of information to one accessible, user-friendly location. It includes over 250 community indicators covering more than 25 topics in the areas of health, determinants of health, and quality of life. The data are primarily derived from state and national public secondary data sources. The value for each of these indicators is compared to other communities, nationally or locally set targets, and to previous time periods.

HCI's Data Scoring Tool was used to systematically summarize multiple comparisons across the Community Dashboard and rank indicators based on highest need. This was done separately for each county within the Tri-County Region and Sussex County, DE. For each indicator, the county value was compared to a distribution of either Maryland or Delaware counties, US counties, state and national values, Healthy People 2030, and significant trends. Each indicator was then given a score based on the available comparisons. These scores range from 0 to 3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected from other communities, and changes in methodology over time. These indicators were grouped into topic areas for a higher-level ranking of community health needs.

A weighted analysis of the results was performed to determine the top health needs for the entire Tri-County Region and Sussex County, DE service area. The weighted analysis was conducted using the individual county results and the total population of each county as compared to the combined population of the service area.

Table 4 shows the health and quality of life weighted topic scoring results. Topics that score close to or above a 1.50 are considered high need. Health topic areas with fewer than three indicators were considered a data gap. Data gaps were

specifically assessed as a part of the key informant interviews to ensure that, where the secondary data fell short, primary data could provide a more accurate picture of that particular health topic area.

The analysis of national, state, and local indicators that contributed to the CHNA can be reviewed in full in Appendix A.

6.3 PRIMARY DATA COLLECTION & ANALYSIS

To ensure the perspectives of community members were considered, input was collected from all four counties in the Tri-County Region and Sussex County, DE. Primary data used in this assessment consisted of an online community survey, focus groups, and key informant interviews. The findings from this data expanded upon information gathered from the secondary data analysis to inform this Community Health Needs Assessment.

As the assessment was conducted during the COVID-19 pandemic, primary data collection methods were managed in a way to maintain social distancing and protect the safety of participants by eliminating in-person data collection.

To help inform an assessment of community assets, community members were asked to list and describe resources available in the community. Although not reflective of every resource available in the community, the list can help The Partnership to expand and support existing programs and resources. This resource list is available in Appendix C.

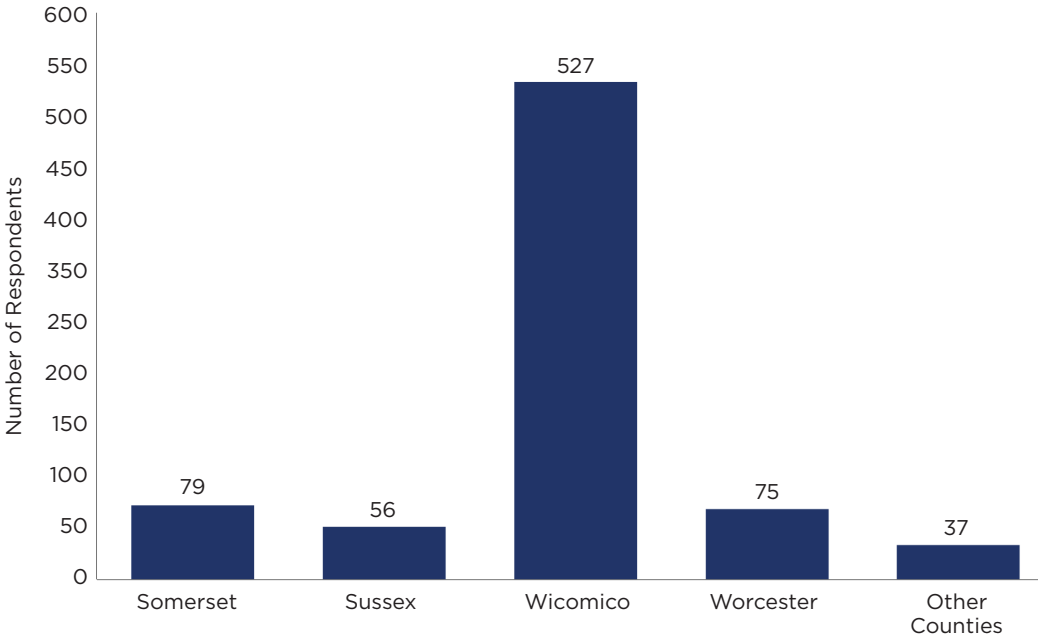
6.3.1 COMMUNITY SURVEY

Community input was collected via an online community survey available in English and Spanish, as well as paper copies available in Arabic, Creole, Korean, and Portuguese, from August 2021 through November 2021. The survey consisted of 45 questions related to top health needs in the community, individuals' perception of their overall health, individuals' access to healthcare services, as well as social and economic determinants of health. The survey was shared via health departments' websites, social media, email distribution, and other local community partners. Paper copies were also distributed at several community outreach events, local libraries, and directly to patients at TidalHealth via Community Health Workers or Care Coordination Specialists. A total of 774 responses were collected.

Demographics of Community Survey Respondents

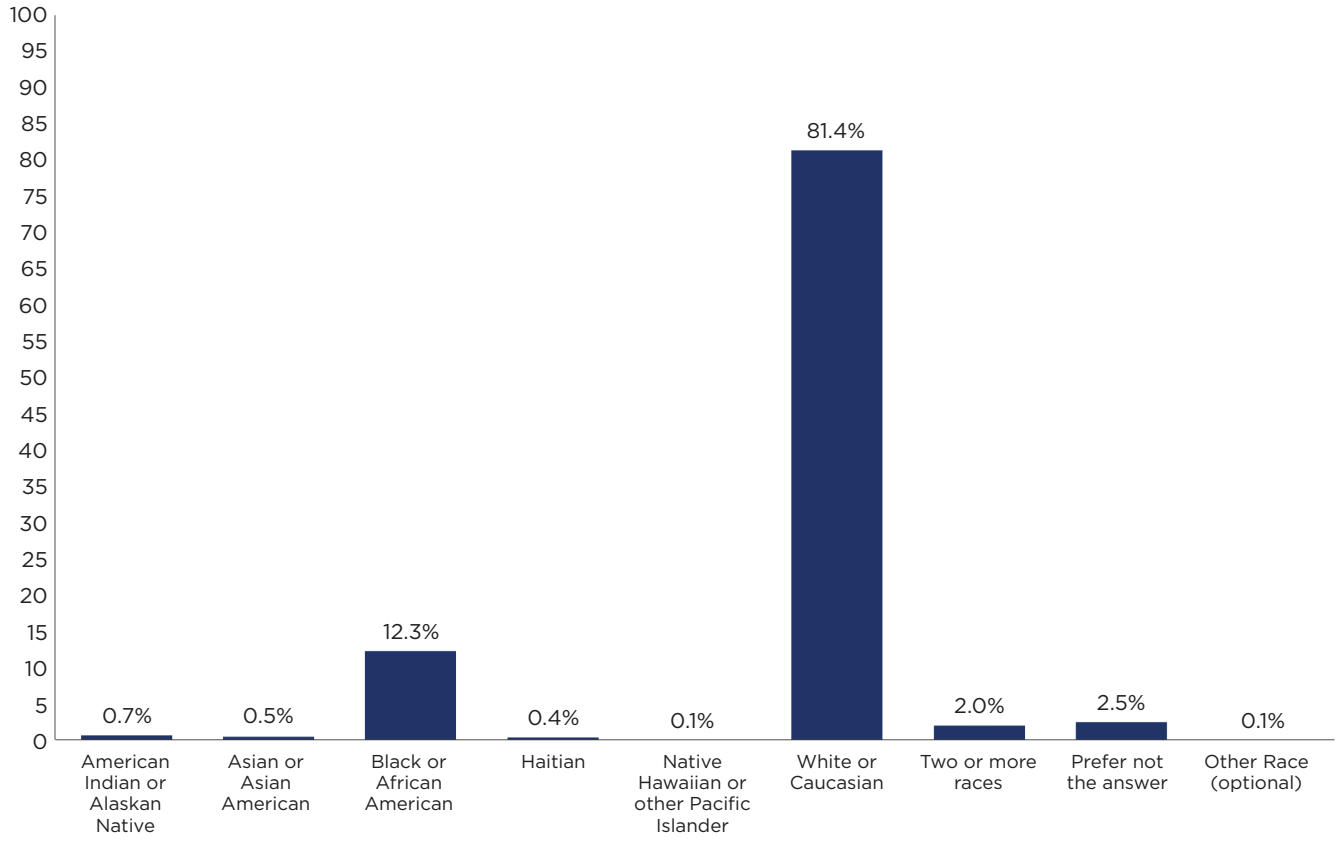
As seen in Figure 20, a majority of survey respondents reported being from Wicomico County, even though it does not have the largest population of the Tri-County Region and Sussex County, DE. This is something to consider in future assessments.

FIGURE 20: RESPONDENTS COUNTY OF RESIDENCE



As shown in Figure 21, White or Caucasian community members comprised the largest percentage of survey respondents at 81.4%, followed by Black/African American community members at 12.3%.

FIGURE 21: RESPONDENTS RACE



Only 1.4% of survey respondents identified as Hispanic/Latino, while the majority, 92.4% identified as Non-Hispanic/Latino (Figure 22).

FIGURE 22: RESPONDENTS ETHNICITY

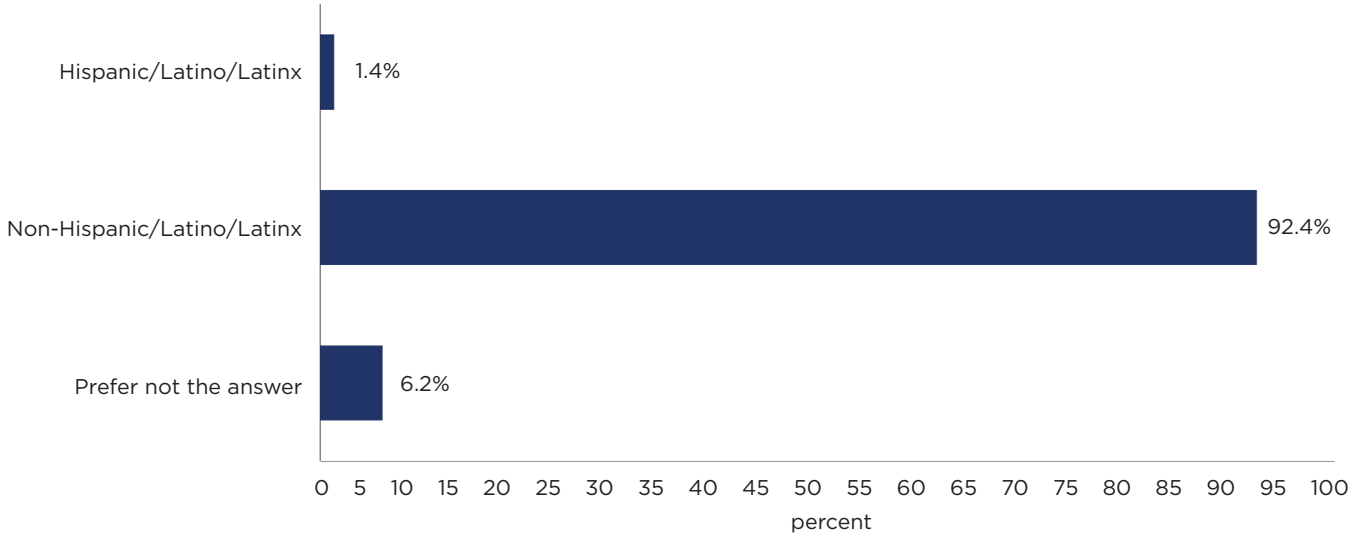
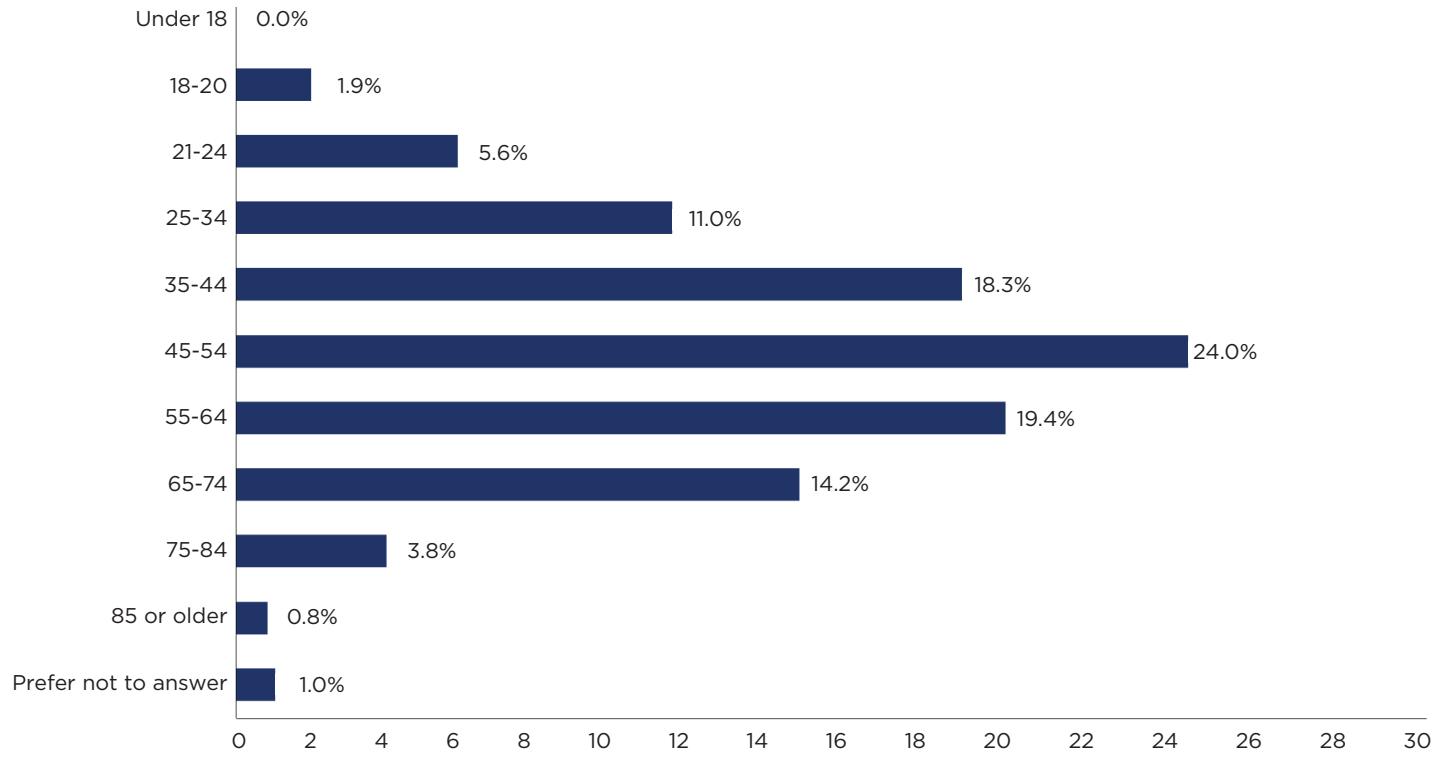


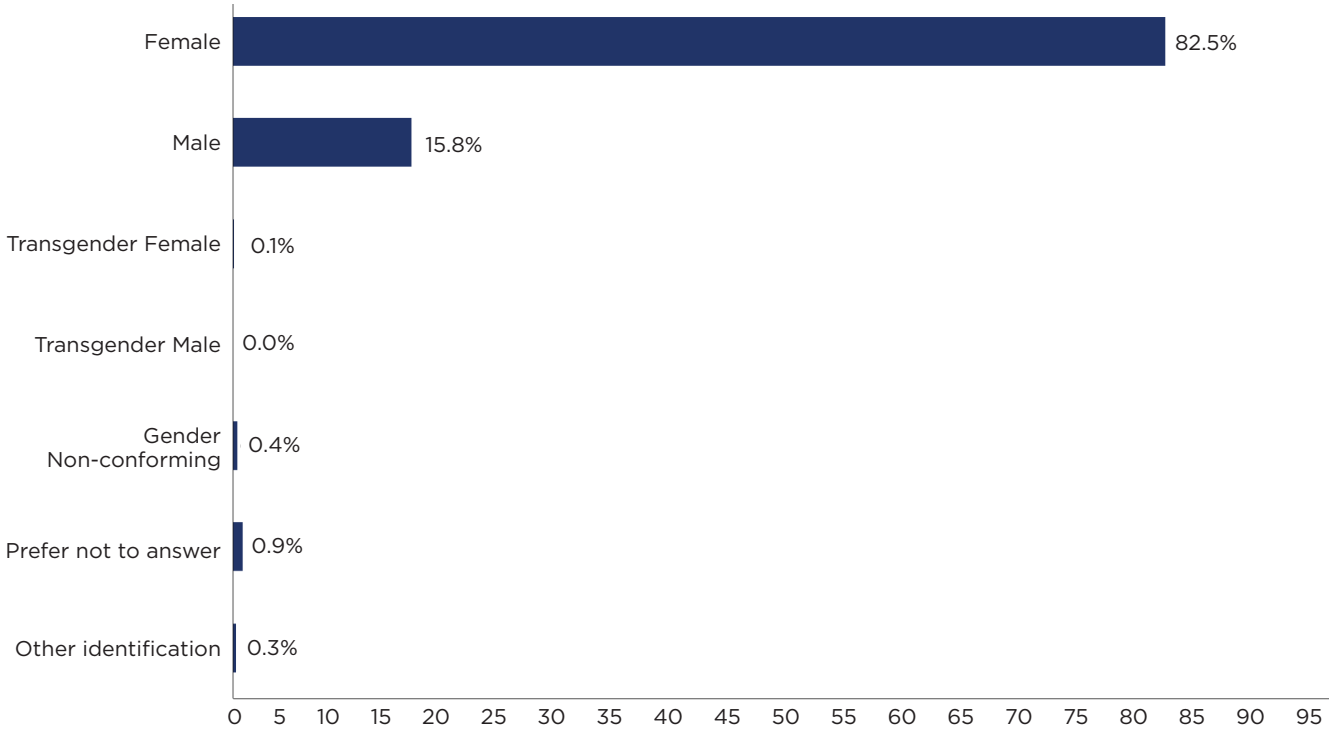
Figure 23 shows the age breakdown of survey respondents. The 35-44 and 45-54 age groups comprised the largest portions of survey respondents, at 19.4% and 24.0% respectively.

FIGURE 23: RESPONDENTS AGE



The majority of survey respondents identified as female at 82.5%. An additional 15.8% identified as male, and the remaining 1.7% as other (transgender, non-conforming or prefer not to answer), as shown in Figure 24.

FIGURE 24: RESPONDENTS GENDER

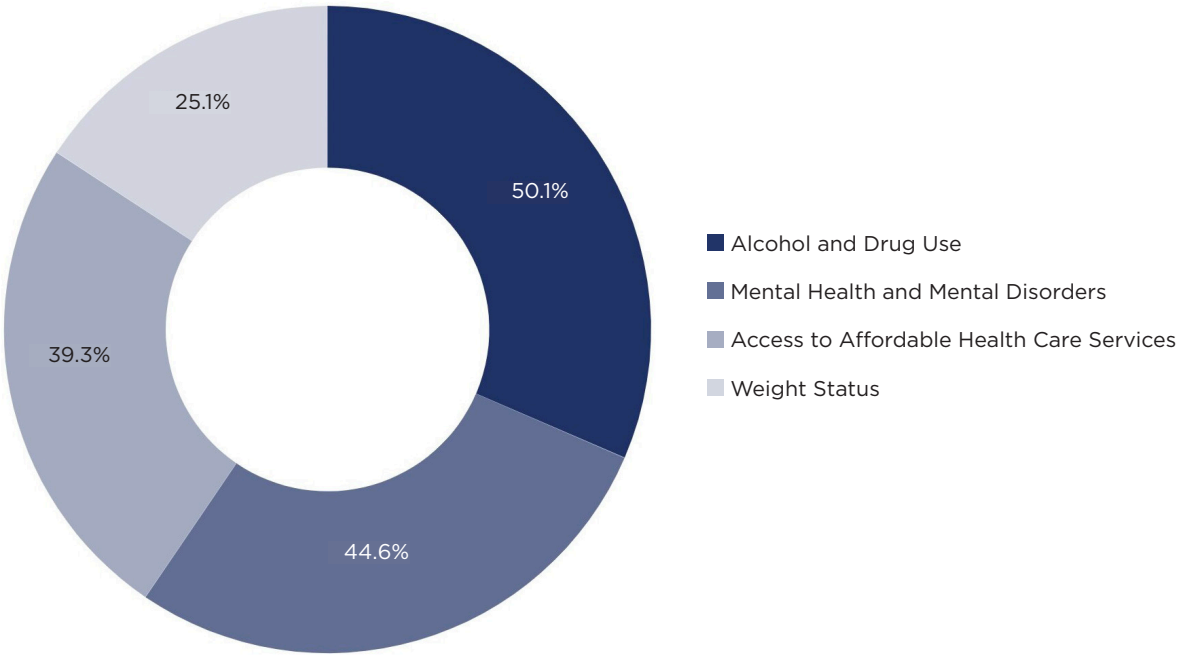


6.3.2 COMMUNITY SURVEY ANALYSIS RESULTS

In the survey, participants were asked about important health issues in the community, and which were the most important quality of life issues to address in the Tri-County Region and Sussex County, DE. The top responses for these questions are shown in Figures 25 and 26 below. Additionally, questions were included to get feedback about the impact of COVID-19 on the community, which is included in the "COVID-19 Impact Snapshot" section of this report.

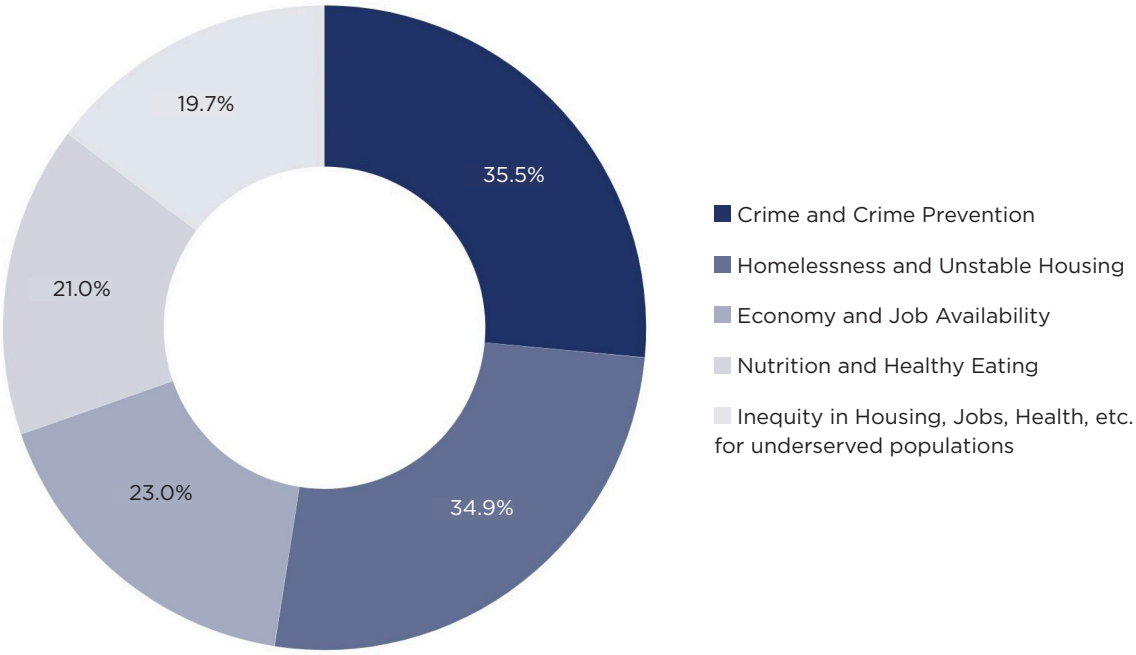
As shown in Figure 25, the "Most Important Community Health Issues" were Alcohol and Drug Use (50.1% of respondents), Mental Health and Mental Disorders (44.6%), Access to Affordable Healthcare Services (39.3%), and Weight Status (25.1%).

FIGURE 25. MOST IMPORTANT COMMUNITY HEALTH ISSUES



As shown in Figure 26 below, Crime and Crime Prevention was ranked by survey respondents as the most urgent quality of life issue needing to be addressed (35.5% of survey respondents), followed by Homelessness and Unstable Housing (34.9%), Economy and Job Availability (23.0%), Nutrition and Health Eating (21.0%) and Inequity in Housing, Jobs, Health, etc. for underserved populations (19.7%).

FIGURE 26: MOST IMPORTANT QUALITY OF LIFE ISSUES TO ADDRESS



6.3.3 QUALITATIVE DATA (FOCUS GROUPS & KEY INFORMANT INTERVIEWS)

The Partnership conducted key informant interviews and focus groups to gain deeper insights about perceptions, attitudes, experiences, or beliefs held by community members about their health and the health of their community. It is important to note that the information collected in an individual focus group or interview is not necessarily representative of other groups.

Focus Groups

The project team developed a focus group guide made up of a series of questions and prompts about the health and well-being of residents in the Tri-County Region and Sussex County, DE. The guide can be found in Appendix B. All participants volunteered. Advertisement was done via social media, press releases and posters with QR codes. $10 local gift cards were offered as an incentive. Participants could sign up through an online registration form or by phone. Community members were asked to speak to barriers and assets to their health and access to healthcare. Four virtual focus groups were hosted in the following counties: Somerset, Wicomico, Worcester, MD, and Sussex, DE, during October and November 2021. A total of 26 participants took part in the four focus groups, which each lasted approximately 30 - 45 minutes. Facilitators implemented techniques to ensure that everyone was able to participate in the discussions.

Key Informant Interviews

HCI consultants conducted key informant interviews to collect community input. Interviewees who were asked to participate were recognized as having expertise in public health, special knowledge of community health needs, and/or represented the broad interest of the community served by the hospitals and health departments, and/or could speak to the needs of medically underserved or vulnerable populations.

A total of 14 key informant interviews were conducted during August 2021-October 2021. You can see the key informant organizations represented below in Table 5. These organizations are also current or potential community partners for the hospitals and health departments leading this assessment. Each interview included an interviewer and notetaker and lasted approximately 30 – 60 minutes. During the interviews, questions were asked to learn about the interviewee's background and organization, biggest health needs and barriers of concern in the community, as well as the impact of health issues on vulnerable populations. A list of the questions asked during the interviews can be found in Appendix B.

TABLE 5. KEY INFORMANT ORGANIZATIONS & POPULATION SERVED

KEY INFORMANT ORGANIZATION	POPULATION SERVED
Chesapeake Healthcare	Tri-County Region
Deer's Head Hospital Center	Tri-County Region
HOPE, Inc.	Tri-County Region
MAC, Inc	Tri-County Region
Rebirth, Inc.	Wicomico County and surrounding region
Recovery Resource Center	Wicomico County
Salisbury University	Wicomico County
Somerset County Department of Social Services	Somerset County
Somerset County Health Department	Somerset County
Somerset County Schools	Somerset County
Sussex County Coalition	Sussex, DE
University of Maryland Eastern Shore (UMES)	Tri-County Region and Sussex, DE
Wicomico County Council	Wicomico County
Wicomico County Health Department	Wicomico County

6.3.4 QUALITATIVE DATA ANALYSIS RESULTS

Transcripts from the focus groups and key informant interviews were uploaded to the web-based qualitative data analysis tool, Dedoose[4]. Transcript text was coded using a pre-designed codebook, organized by themes, and analyzed for significant observations. The frequency with which a health topic was discussed was used to assess the relative importance of that health and/or social need to determine the most pressing health needs of the community. The findings from the qualitative analysis were combined with the findings from other data sources and incorporated into the Data Synthesis, Top Health Needs, and COVID-19 sections of this report.

4. Dedoose Version 8.0.35, web application for managing, analyzing and presenting qualitative and mixed method research data (2018). Los Angeles, CA: Socio-Cultural Research Consultants, LLC www.dedoose.com

Themes Across Qualitative Data

Figure 27 below summarizes the main themes and topics that trended across all or almost all focus group conversations and key informant interviews.

FIGURE 27: WORD CLOUD THEMES FROM QUALITATIVE DATA

6.3.5 DATA CONSIDERATIONS

A key part of any data collection and analysis process is recognizing potential limitations within the data considered. All forms of data have their own strengths and limitations. Each data source for this CHNA process was evaluated based on these strengths and limitations during data synthesis and should be kept in mind when reviewing this report. For both quantitative and qualitative data, immense efforts were made to include as wide a range of secondary data indicators, community survey respondents, focus group participants, and key informant experts as possible.

While data collection efforts aimed to include a wide range of secondary data indicators and community member voices, some limitations of the data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and health-related areas, within each topic there is a varying scope and depth of secondary data indicators and primary data findings.

Secondary data were limited to availability of data, with some health topic areas having a robust set of indicators while others were more limited. The Index of Disparity, used to analyze disparities for the secondary data, is also limited by data availability from data sources. Some secondary data sources do not include subpopulation data and others only display values for a select number of racial/ethnic groups.

For the primary data, the breadth of findings is dependent upon who was selected to be a key informant or who self-selected to participate in the community focus groups. Additionally, the community survey was a convenience sample, which means results may be vulnerable to selection bias and make the findings less generalizable. Findings from the survey were shown to have a majority of respondents who identified as White, Non-Hispanic, and/or Female. This is a limitation to consider in future assessments, specifically in targeting the qualitative data collection to better include a true representation of the Tri-County Region and Sussex County, DE.

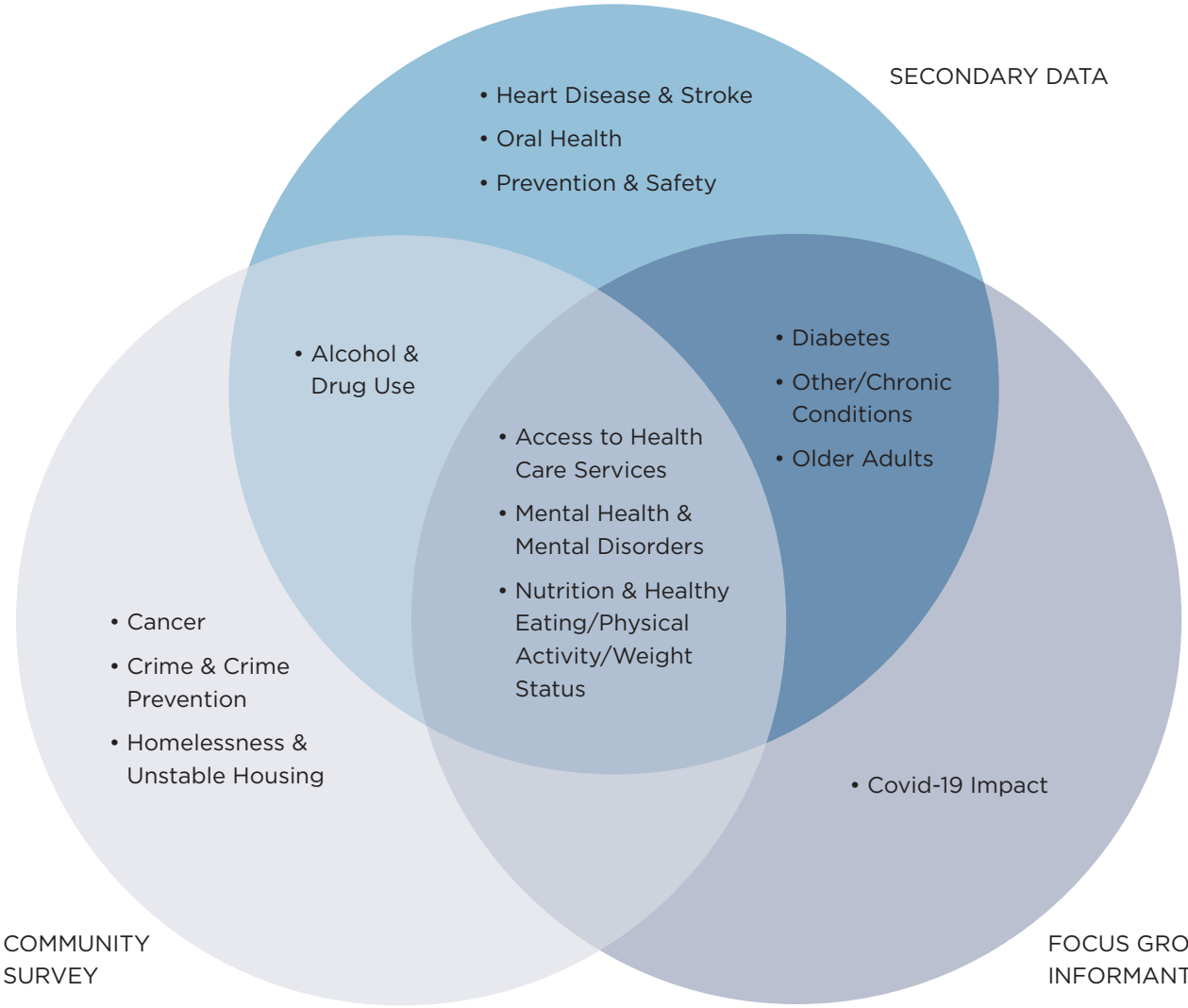
SECTION 7

DATA SYNTHESIS AND PRIORITIZATION

7.1 DATA SYNTHESIS

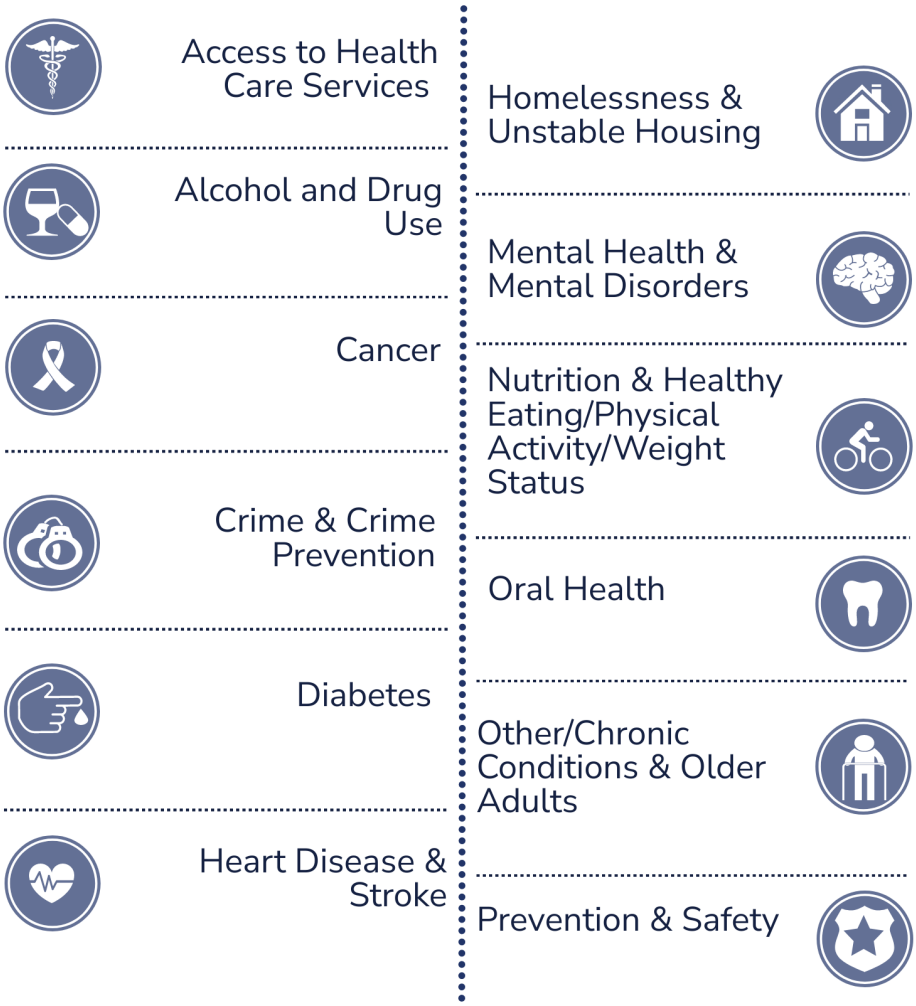
Primary and secondary data were collected, analyzed, and synthesized to identify the significant community health needs in the Tri-County Region and Sussex County, DE. The top health needs identified from data sources were analyzed for areas of overlap.

FIGURE 28: DATA SYNTHESIS VENN DIAGRAM



Primary data from the community survey, focus groups, and key informant interviews as well as secondary data findings identified 12 areas of greater need. Figure 29 shows the final 12 significant health needs, listed in alphabetical order, that were included for prioritization based on the synthesis of all forms of data collected for CHNA.

FIGURE 29. DATA SYNTHESIS RESULTS



PRIORITIZATION

To better target activities to address the most pressing health needs in the community, The Partnership convened a group of hospital and health department leaders and colleagues to participate in a presentation of data on significant health needs facilitated by HCI. Following the presentation and question session, participants were given access to an online link to complete a scoring exercise to rank the significant health needs based on a set of criteria. The presentation and prioritization session were conducted virtually to maintain social distancing and safety guidelines related to the COVID-19 pandemic.

The participants reviewed the scoring results of the significant community needs and determined prioritized health needs based on the same set of criteria used in the scoring exercise.

7.2.1 PARTICIPANTS

The following hospital and health department leaders took part in the prioritization session:

- Allie O'Leary, Data Analyst, TidalHealth
- Chris Hall, Vice President/Chief Business Officer, TidalHealth
- Christina Gray, Epidemiologist, Wicomico County Health Department
- Danielle Weber, Health Officer, Somerset County Health Department
- Henry Nyce, Manager of Strategic Planning, TidalHealth
- James Trumble, VP Clinical Integration, TidalHealth
- Kathryn Fiddler, Vice President Population Health, TidalHealth
- Katherine Rodgers, Director of Community Health Initiatives, TidalHealth
- Kelly Ward, Special Assistant to the Health Officer & Deputy PIO, Wicomico County Health Department
- Lisa Renegar, Health Planner, Wicomico County Health Department
- Logan Becker, Planning Analyst, TidalHealth
- Lori Brewster, Health Officer, Wicomico County Health Department
- Sharon Lynch, Preventive Services and Communications Director, Somerset County Health Department

7.2.2 PROCESS

On January 24, 2022, the above-mentioned joined together for the prioritization meeting hosted by HCI. During this meeting, the group reviewed and discussed the results of HCI's primary and secondary data analyses leading to the preliminary significant health needs discussed in detail in the data synthesis portion of this report. From there, participants were given three days to access an online link to score each of the significant health needs by how well they met the following criteria:

1. Magnitude of the Issue
   - How many people in the community are or will be impacted?
   - How does the identified need impact health and quality of life?
   - Has the need changed over time?
2. Ability to Impact
   - Can actionable and measurable goals be defined to address the health need? Are those goals achievable in a reasonable time frame?
   - Does the hospital or health system have the expertise or resources to address the identified health need?
   - Can the need be addressed in collaboration with community partners? Are organizations already addressing the health issue?

The group also agreed that root causes, disparities, and social determinants of health would be considered for all health topics resulting from prioritization.

Participants scored each health area against each criterion on a scale from 1-3 with 1 meaning it did not meet the given criterion, 2 meaning it met the criterion, and 3 meaning it strongly met the criterion. In addition to considering the data presented by HCI in the presentation and on the health topic note sheet, participants were encouraged to use their own judgment and knowledge of the community in considering how well a health topic met the criteria.

Completion of the online exercise resulted in a numerical score for each health need that correlated with how well that particular need met the criteria for prioritization. HCI downloaded the online results, calculated the scores, and then ranked the significant health needs according to their topic scores, with the highest scoring health need receiving the highest priority ranking.

7.2.3 SIGNIFICANT HEALTH NEEDS PRIORITIZATION

The aggregate ranking can be seen in the list below. The Partnership reviewed the scoring results of the significant community needs and determined prioritized health needs based on the same set of criteria used in the scoring exercise.

1. Diabetes (2.8)
2. Mental Health & Mental Disorders (2.7)
3. Alcohol & Drug Use (2.6)
4. Nutrition & Health Eating / Physical Activity / Weight Status (2.6)
5. Access to Healthcare Services (2.5)
6. Cancer (2.5)
7. Other/Chronic Conditions & Older Adults (2.4)
8. Heart Disease & Stroke (2.4)
9. Homelessness & Unstable Housing (2.0)
10. Prevention & Safety (1.8)
11. Oral Health (1.7)
12. Crime & Crime Prevention (1.6)

The group decided to combine Access to Healthcare Services with some of the underlying disparities and social determinants of health into the broader priority area of Access and Health Equity. Similarly, and as was done in the past CHNA cycle, they decided on combining the health areas of Mental Health & Mental Disorders with Alcohol & Drug Use into the broader category of Behavioral Health. Finally, the group combined Chronic Disease topics of Cancer, Diabetes, Heart Disease & Stroke with Nutrition & Healthy Eating/Physical Activity/Weight Status, as well as Other/Chronic Conditions & Older Adults into a comprehensive topic area of Chronic Disease and Wellness. The results of the prioritization session were presented to the Wicomico LHIC where they reviewed and approved the priority areas at their February 4, 2022, meeting. The three priority health areas that will be considered for subsequent implementation planning are:

PRIORITIZED HEALTH NEEDS
Access and Health Equity
Behavioral Health
Chronic Disease and Wellness

A deeper dive into the primary data and secondary data indicators for each of these three priority topic areas is provided later in this report. This information highlights how each issue became a high priority health need for The Partnership. Most of these health topic areas are consistent with the priority areas that emerged from the previous CHNA process. TidalHealth, SCHD, and WiCHD plan to build upon these efforts and continue to address these health needs in their upcoming Implementation Strategies and Community Health Improvement Plans.

SECTION 8

PRIORITIZED SIGNIFICANT HEALTH NEEDS

The following section provides detailed descriptions of the three prioritized health needs. This also includes health issues, the population groups with greater needs, and factors that contribute to those needs.

8.1 PRIORITIZED HEALTH TOPIC #1: ACCESS AND HEALTH EQUITY

Access and Health Equity

Secondary Data Score: **1.51** (Access to Health Care)

Key Themes from Community Input

- Access to Health Services was ranked by survey respondents as the **third most pressing** health issue **(39.3%)**
- Lack of provider availability/specialty providers
- Barriers include: transportation, language, education, cost, knowledge of healthcare system
- **20%** of survey respondents disagree or strongly disagree that individuals in my community can access healthcare services regardless of race, gender, sexual orientation, immigration status, etc.

Warning Indicators

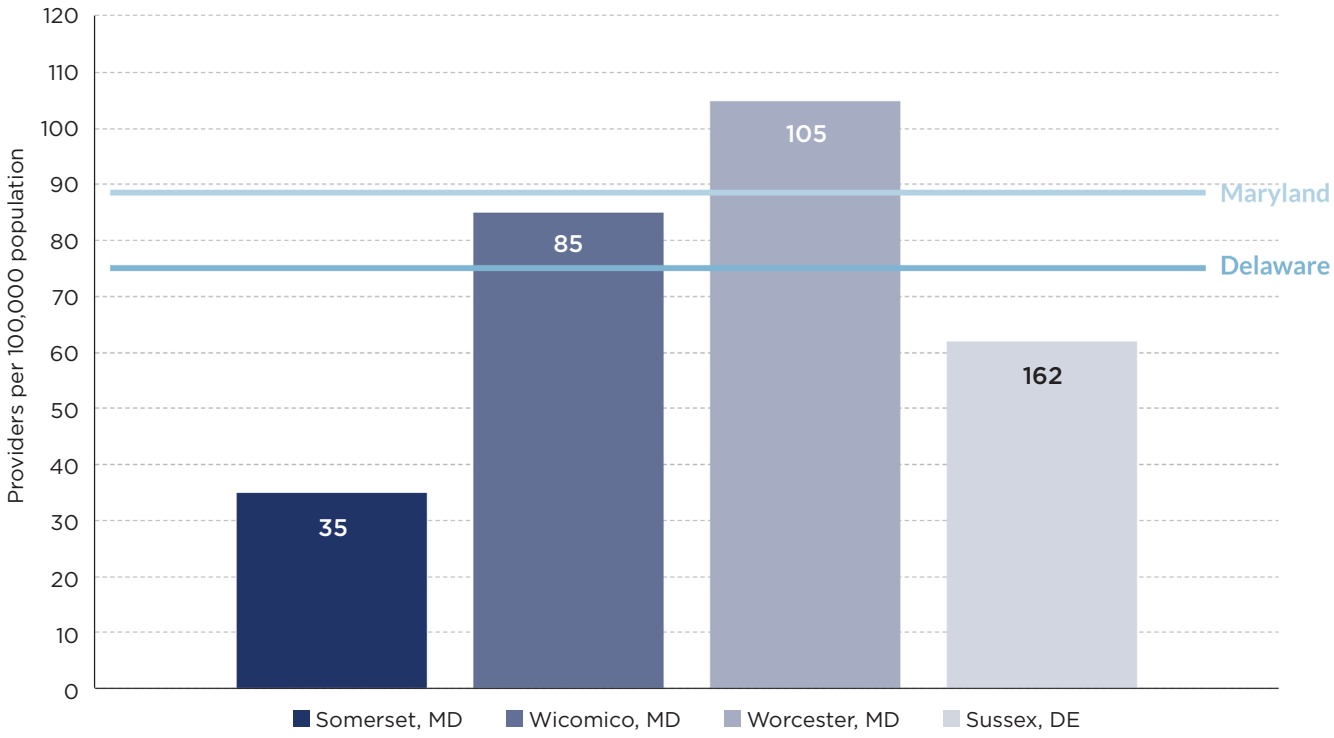
- Adults with Health Insurance
- Adults Unable to Afford to See a Doctor
- Dentist Rate
- Primary Provider Rate

SECONDARY DATA

The secondary data analysis for Healthcare Access and Quality resulted in a topic score of 1.51 on a scale of 0 to 3, indicating need slightly above average. Some notable indicators that fall within this topic area are seen in the charts below. All counties within the Tri-County Region and Sussex County, DE are below their state average for Primary Care Provider Rates, Non-Physician Provider Rates, and Adults with Health Insurance (Figures 30, 31, and 32). Somerset, MD, is also

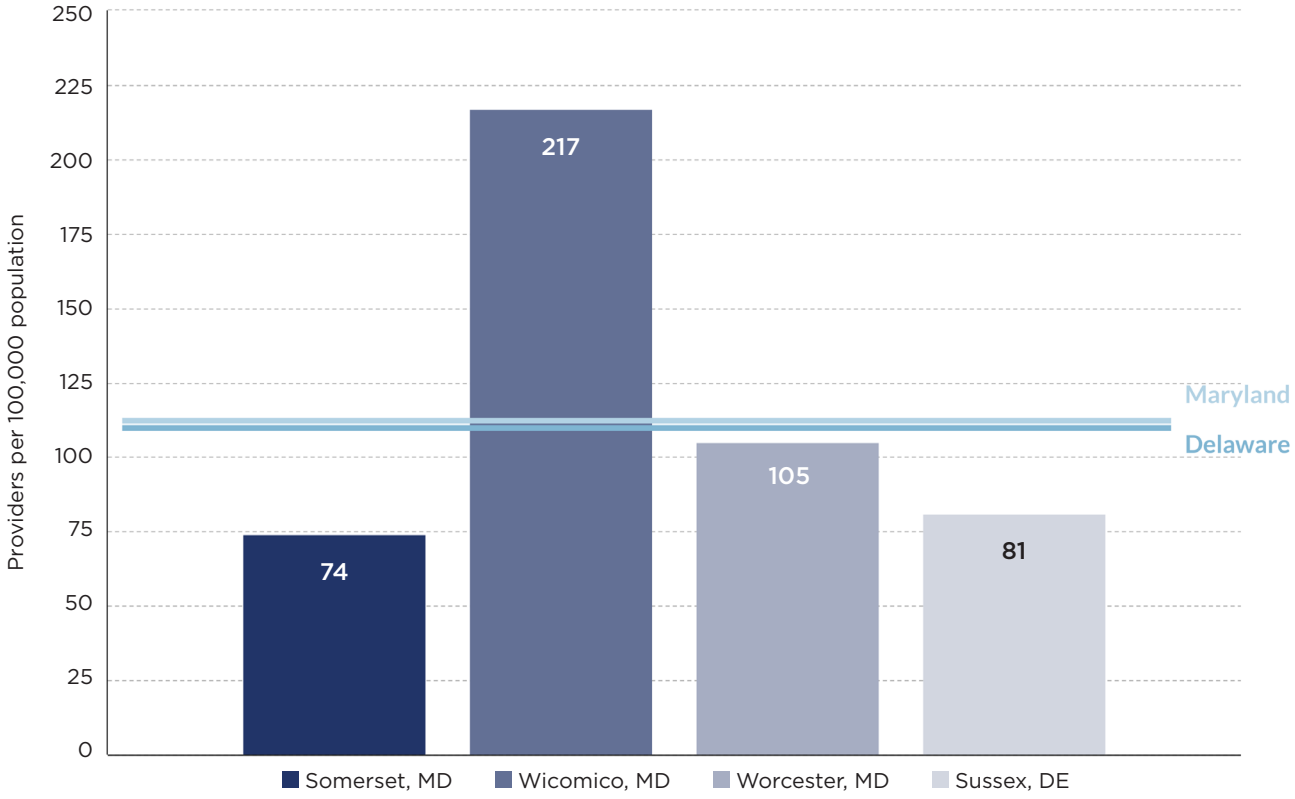
within the worst quartile for all Maryland counties for primary care provider rates and Wicomico, MD, has seen a significant decrease in primary care provider rates between 2011 and 2018. All counties have seen a significant increase in health insurance rates since 2010. All counties except Wicomico, MD, are below their state averages for non-physician provider rates in 2020 (Figure 31). A full list of indicators that fall within this topic can be found in the Secondary Data Methodology in Appendix A.

FIGURE 30: PRIMARY CARE PROVIDER RATE (COUNTY HEALTH RANKINGS, 2018)



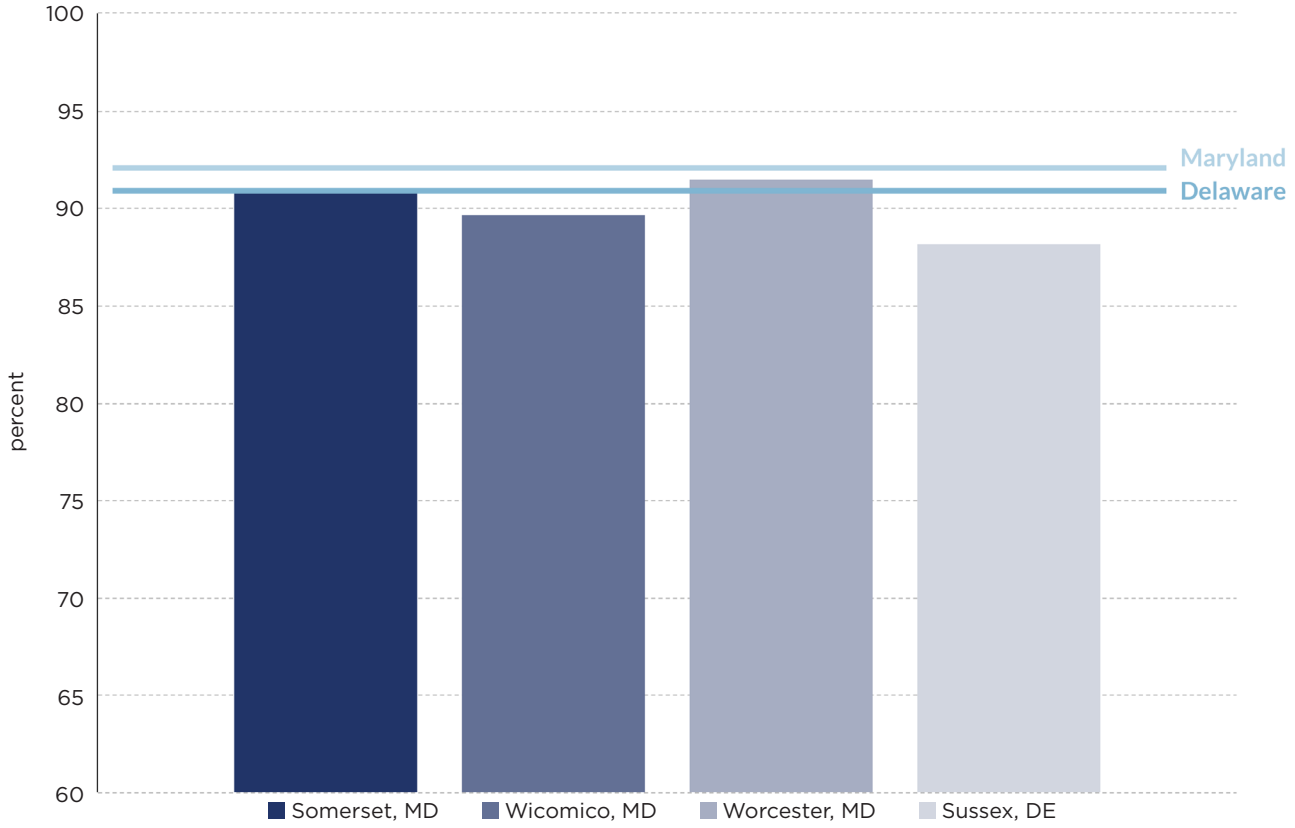
County Health Rankings, 2018

FIGURE 31: NON-PHYSICIAN PROVIDER RATE (COUNTY HEALTH RANKINGS, 2020)



County Health Rankings, 2020

FIGURE 32: ADULTS WITH HEALTH INSURANCE: 18-64 (SMALL AREA HEALTH INSURANCE ESTIMATES, 2019)



Small Area Health Insurance Estimates, 2019

Access to Care can be affected by many factors, including poverty rates. As shown in Table 1 above in the Disparities section of this report, families identifying as Black or African American, Hispanic/Latino, Two or More Races, Other Race, and American Indian/Alaskan Native have the highest poverty rates. These disparities not only affect quality of health but can also affect access to quality healthcare services.

PRIMARY DATA

ACCESS TO CARE

Access to Care was a top health need identified from the community survey, focus groups, and key informant interviews. The general cost of care, populations that are uninsured or underinsured, and the impact of unemployment were mentioned as underlying causes. Recent health facility closings and delays due to COVID-19 were also mentioned as barriers to accessing care. The need for improved/increased cultural competency, as well as offering services in languages spoken in some of the minority populations of the community, were subjects that surfaced in the primary data as well. Additionally, transportation was listed as a major barrier to accessing services, as well as a general lack of providers, especially in the more rural areas. Many participants spoke about the lack of specialists making access for those in need of specialist health services very difficult.

> Getting to the doctor is a challenge for many. And there is a shortage of healthcare providers. Specifically, a major shortage of specialty and/or pediatric providers.
> -Key informant

HEALTH EQUITY

Inequities related to accessing healthcare or social services were mentioned throughout the focus groups and key informant interviews. Participants specifically spoke about families living on low incomes, people from racial or ethnic minority groups, immigrant populations, and older adults being more at risk for negative health outcomes due to lack of equitable access. Health literacy, cultural or language barriers, and lack of knowledge or ability to navigate the healthcare system were all brought up as topics of concern affecting those who are at increased risk for poor health.

> Socioeconomics plays a major role in the level of health for individuals. The poorer communities simply do not have equitable access or resources to seek appropriate care when needed.
> -Key informant

The community survey respondents also listed inequities in housing, jobs, and health for populations that have historically been underserved as top contributors impacting quality of life in the community.

8.2 PRIORITIZED HEALTH TOPIC #2: BEHAVIORAL HEALTH

Behavioral Health

Secondary Data Score: **1.63** (Alcohol & Drug Use) **1.43** (Mental Health & Mental Disorders)

Key Themes from Community Input

- Alcohol and Drug Use was the top ranked health need from the community survey
- **44.6%** of survey respondents ranked Mental Health & Mental Disorders as the most pressing health issue
- Top reasons for not seeking mental health services or alcohol/substance use treatment services included: wait is too long, cost - too expensive/can't pay, office/service/program has limited access or is closed due to COVID-19
- Stress, anxiety, co-occurring substance abuse, behavioral health problems all are contributing factors to mental health issues
- Need for more mental health services, providers, and resources

Warning Indicators

- Frequent Mental Distress
- Poor Mental Health Days
- Self-Reported Mental Health: Good or Better
- Age-Adjusted Death Rate due to Drug Use
- Alcohol Impaired Driving Deaths
- Death Rate due to Drug Poisoning

SECONDARY DATA

The secondary data analysis for Mental Health & Mental Disorders and Alcohol & Drug Use resulted in topic scores of 1.43 and 1.63, respectively. These topic areas were combined into one priority, Behavioral Health, given the relationship between mental health and substance use disorders.

MENTAL HEALTH AND MENTAL DISORDERS

Secondary data scoring presented Mental Health & Mental Disorders as slightly below average, with a topic score of 1.43. Wicomico, MD, and Somerset, MD, had higher individual scores for this topic area (1.73 and 1.61, respectively), which could indicate a greater need for mental health services or interventions in these counties.

It is important to note that Mental Health can be affected by a variety of socioeconomic factors including income, social support, socioeconomic status, gender identity, disability status, and stress caused by structural racism and other systemic barriers. Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. Based on the MHI, in 2021, zip codes are ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 33. The following zip codes are estimated to have the highest need (as indicated by the darkest shades of purple): 21817 (Somerset, MD), 21853 (Somerset, MD), 21851 (Worcester, MD), and 21801 (Wicomico, MD). Table 6 provides the index values for high needs zip codes. See Appendix A for more detailed MHI methodology.

FIGURE 33: MENTAL HEALTH INDEX BY ZIP CODE

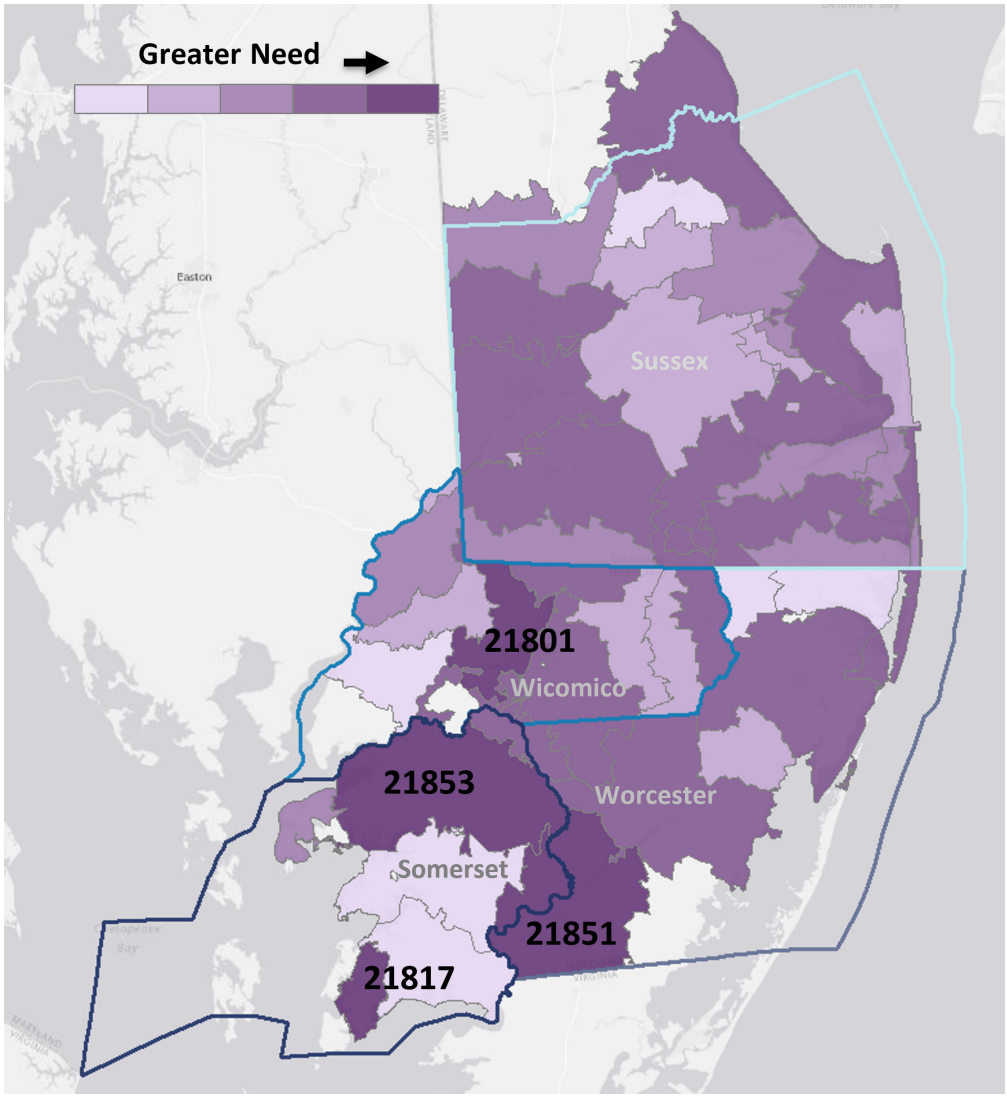


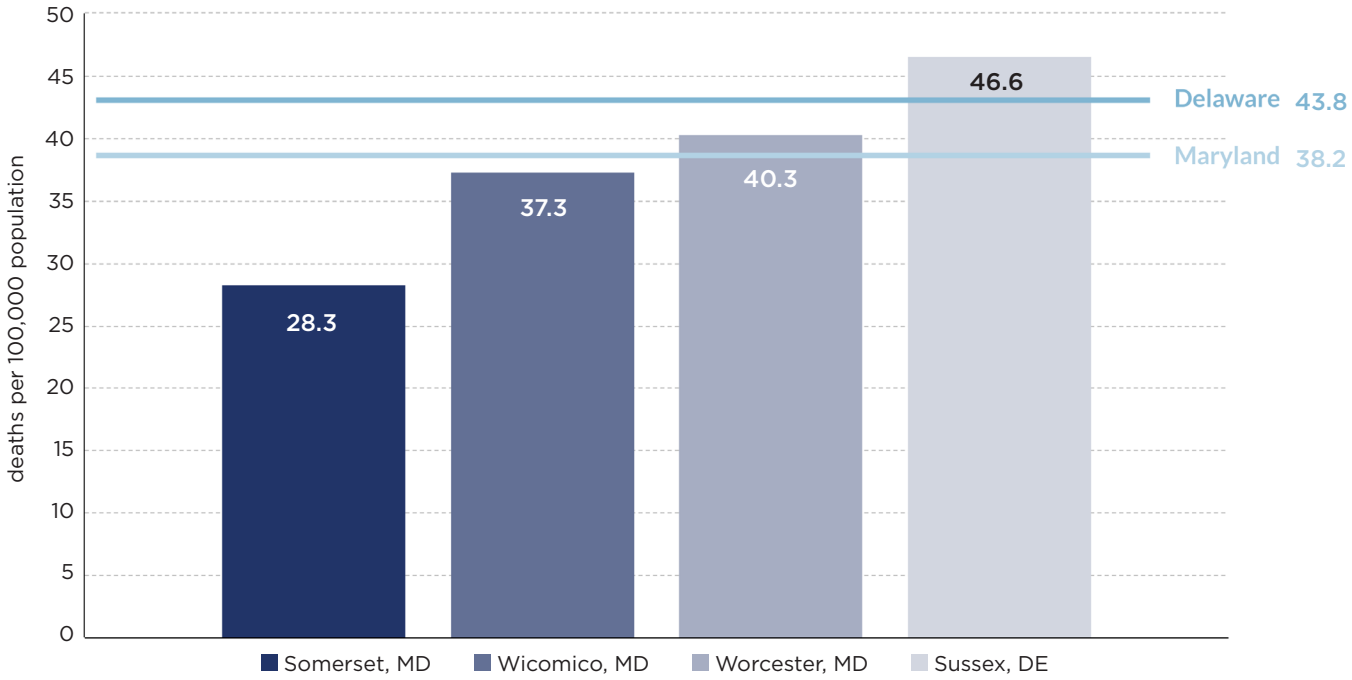
TABLE 6. FOOD INSECURITY INDEX VALUES BY ZIP CODE

ZIP CODE	RANK	MHI VALUE	COUNTY
21817	5	95.3	Somerset, MD
21853	5	95.8	Somerset, MD
21851	5	93.6	Worcester, MD
21801	5	93.2	Wicomico, MD

ALCOHOL & DRUG USE

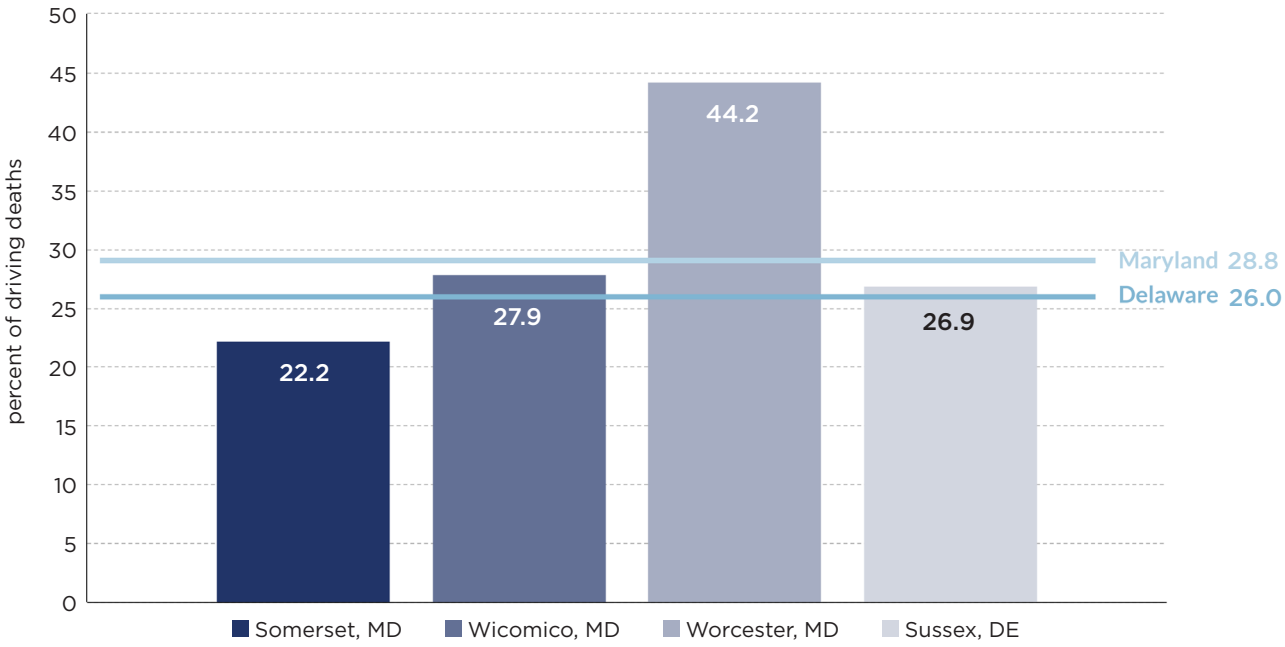
Secondary data scoring presented Alcohol & Drug Use as above average, with a topic score of 1.63. There are concerning data around age-adjusted drug and opioid-involved overdose deaths, alcohol-impaired driving deaths, and death rate due to drug poisonings. Both Worcester, MD, and Sussex, DE, have higher Age-Adjusted Drug and Opioid-Involved Overdose Death rates than their respective state values (Figure 34). All counties also have higher Age-Adjusted Drug and Opioid-Involved Overdose Death Rates than the U.S. value of 22.8 deaths/100,000 population. Additionally, both Worcester, MD, and Sussex, DE, have higher Alcohol-Impaired Driving Deaths than their respective state values (Figure 35). Worcester, MD, has also seen a non-significant increase in Alcohol-Impaired Driving Deaths between 2008-2012 and 2015-2019 and is among the worst quartile of all MD and U.S. counties. Lastly, as shown in Figure 36, all counties within the Tri-County Region and Sussex County, DE saw a significant increase for the Death Rate Due to Drug Poisoning between 2004-2010 and 2017-2019.

FIGURE 34: AGE-ADJUSTED DRUG AND OPIOID-INVOLVED OVERDOSE DEATH RATES (CENTERS FOR DISEASE CONTROL AND PREVENTION, 2017-2019)



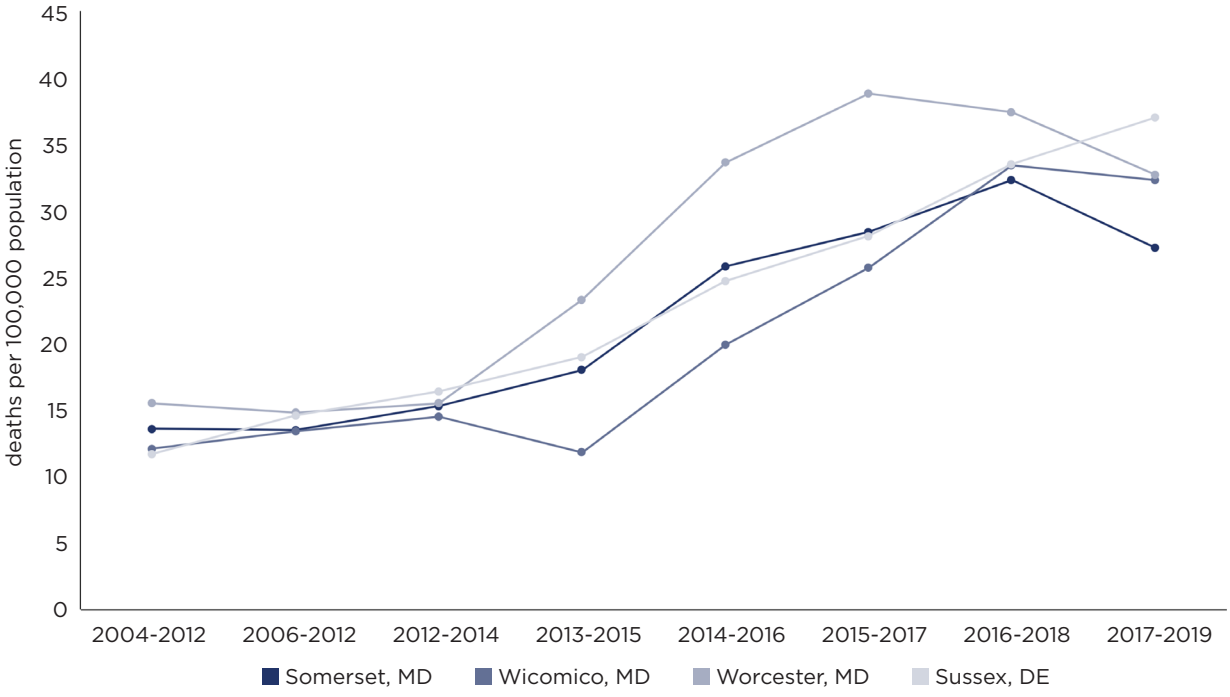
Centers for Disease Control and Prevention, 2017-2019

FIGURE 35: ALCOHOL-IMPAIRED DRIVING DEATHS (COUNTY HEALTH RANKINGS, 2015-2019)



County Health Rankings, 2015-2019

FIGURE 36: DEATH RATE DUE TO DRUG POISONING (COUNTY HEALTH RANKINGS, 2004-2019)



County Health Rankings, 2004-2019

PRIMARY DATA

MENTAL HEALTH AND MENTAL DISORDERS

Mental Health and Mental Disorders was a top health need from the community survey, focus groups, and key informant interviews. In the community survey it was ranked as the second most pressing health need in the community.

Mental health resources, and the availability of mental health providers were frequently cited as disproportionate to community need. Focus group and key informant participants mentioned stigma associated with mental health or mental disorders being a limitation for people in need to seek help or treatment. Overall cost, lack of mental health providers and resources, and navigation and/or knowledge about available services were all mentioned as barriers also.

Participants emphasized the impact of anxiety and stress that some community members were experiencing due to COVID-19. Social isolation was a topic that was discussed during these conversations, specifically mentioning the impact on youth and older adults. Separation from school routines and social networks are greatly impacting mental health for these groups.

> Mental health is a real struggle before/during/after the pandemic. There are more people in need of mental health resources now than we've ever seen before.
>
> -Key informant

ALCOHOL AND DRUG USE

Alcohol and Drug Use was the top ranked health need from the community survey. Focus group participants mentioned alcoholism and drug addictions frequently coincide with or are a result of mental health issues. Key informants pointed out that low-income and impoverished neighborhoods typically deal with more stressors while drugs are simultaneously more accessible in those areas. Participants mentioned the opioid epidemic still affecting their community, specifically the issue of opioid overdoses. Additionally, they spoke about unintentional overdoses due to lacing certain drugs with fentanyl.

> There is a need for more outreach, education, and prevention efforts in schools and among youth. Need more protective factors in place as youth are getting older.
>
> -Key informant

8.3 PRIORITIZED HEALTH TOPIC #3: CHRONIC DISEASE AND WELLNESS

Chronic Disease and Wellness

Secondary Data Score:

1.47 (Diabetes)

1.78 (Heart Disease & Stroke) **1.90** (Other Conditions)

1.58 (Older Adults) **1.55** (Physical Activity)

Key Themes from Community Input

- Weight status ranked by survey respondents as the **4th most pressing** health issue
- **12.6%** of survey respondents strongly agree that we have good parks and recreational facilities
- Lack of nutrition education and lack of access to healthy foods, grocery stores, farmers markets cited as leading factors
- **28.4%** of survey respondents disagree/strongly disagree that affordable healthy food options are easy to purchase at nearby grocery stores or farmer's markets
- Prevalent Cancers include: Breast Cancer, Colon Cancer, Colorectal Cancer, Lung Cancer, Prostate Cancer

Warning Indicators

- Adults with Diabetes
- Diabetes: Medicare Population
- Age-Adjusted ER Rate due to Diabetes
- Age-Adjusted Death Rate due to Diabetes
- Atrial Fibrillation: Medicare Population
- Hyperlipidemia: Medicare Population
- Hypertension: Medicare Population
- Adults who Experienced a Stroke
- Stroke: Medicare Population
- High Blood Pressure Prevalence
- Chronic Kidney Disease: Medicare Population
- Hypertension: Medicare Population
- Adults with Arthritis
- Adults with Kidney Disease
- Hyperlipidemia: Medicare Population
- People 65+ Living Below Poverty
- Adults with a Healthy Weight
- Workers who Walk to Work
- Adults who are Obese
- Households with No Car and Low Access to a Grocery Store

SECONDARY DATA

The Chronic Disease and Wellness topic area encompasses five different topic areas: Diabetes, Cancer, Heart Disease & Stroke, Nutrition & Healthy Eating/ Physical Activity/Weight Status, and Other Conditions/Older Adults. The decision to combine these topic areas was based on how access to healthy foods, nutrition resources, and exercise opportunities can affect one's chronic disease status. This is of particular concern for older adults within the Tri-County Region and Sussex, DE.

Figure 37 shows the Percent of Adults with Diabetes by Zip Code. The darkest blue color indicates a higher percentage of adults with diabetes within that zip code. Compared to the Food Insecurity Index map (Figure 19), there is some overlap between zip codes with higher Food Insecurity Index values and diabetes rates. This overlap can be easily seen in 21817 (Somerset, MD) and 21851 (Wicomico, MD) along with some zip codes within western Sussex, DE. These general trends can also be seen for Adults Who Experienced a Stroke and Poor Physical Health Days (Figure 38 and Figure 39, respectively). The Percent of Adults with Cancer is higher for zip codes in western Sussex (Figure 40), which does not overlap with general trends seen in either the Food Insecurity Index or Health Equity Index. This could indicate different factors at play that affect cancer incidence, such as the higher population of older adults that reside in the most affected zip codes.

FIGURE 37: PERCENT OF ADULTS WITH DIABETES, BY ZIP CODE

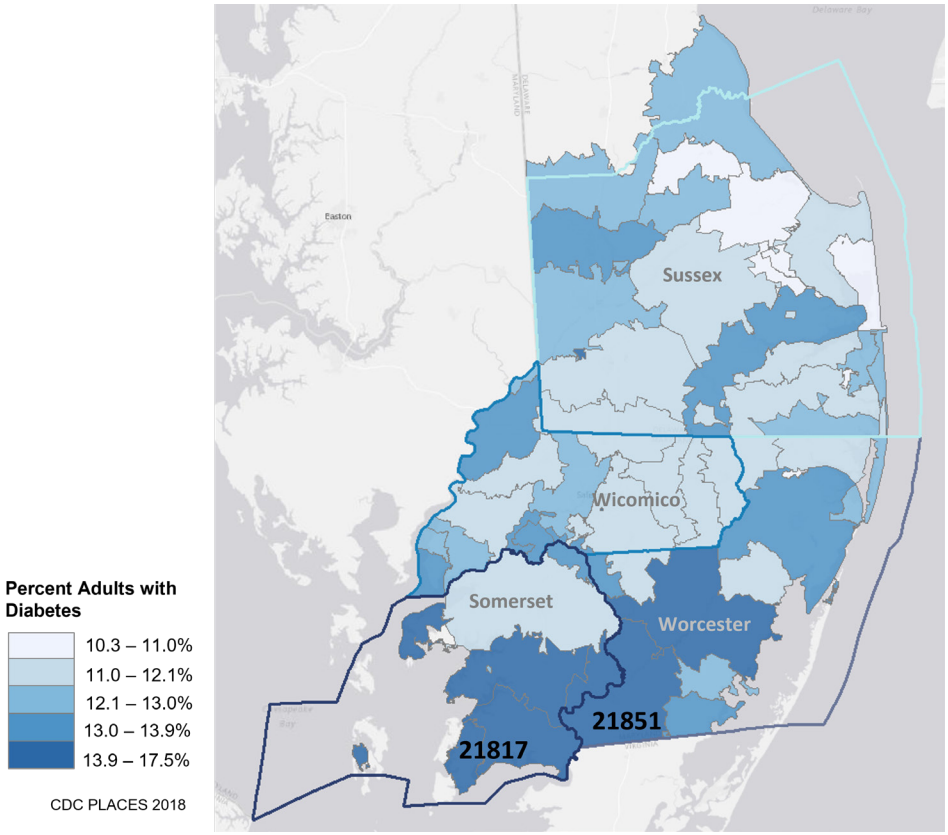


FIGURE 38: ADULTS WHO EXPERIENCED A STROKE, BY ZIP CODE

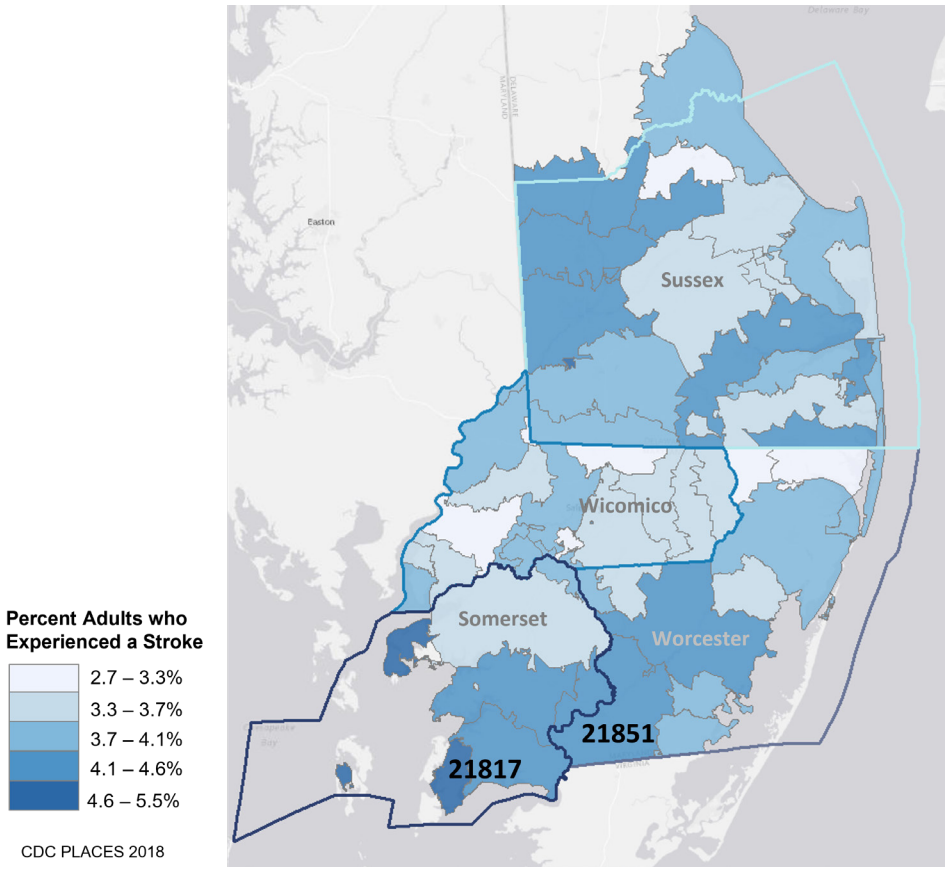


FIGURE 39: POOR PHYSICAL HEALTH DAYS: 14+ DAYS

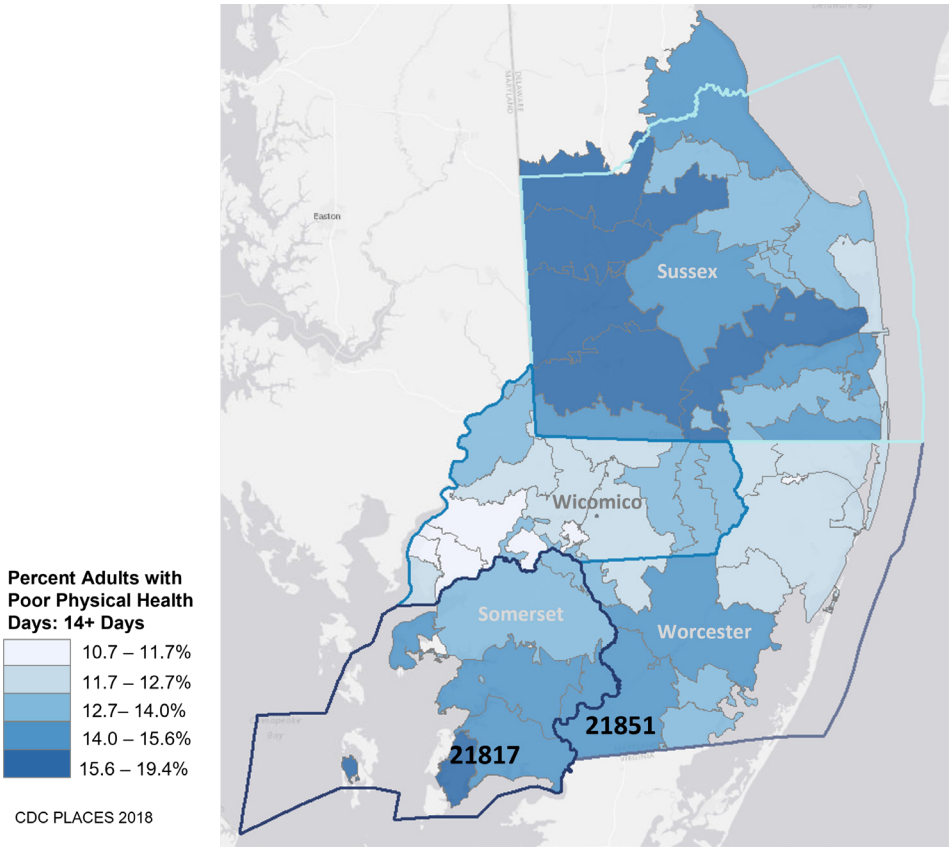
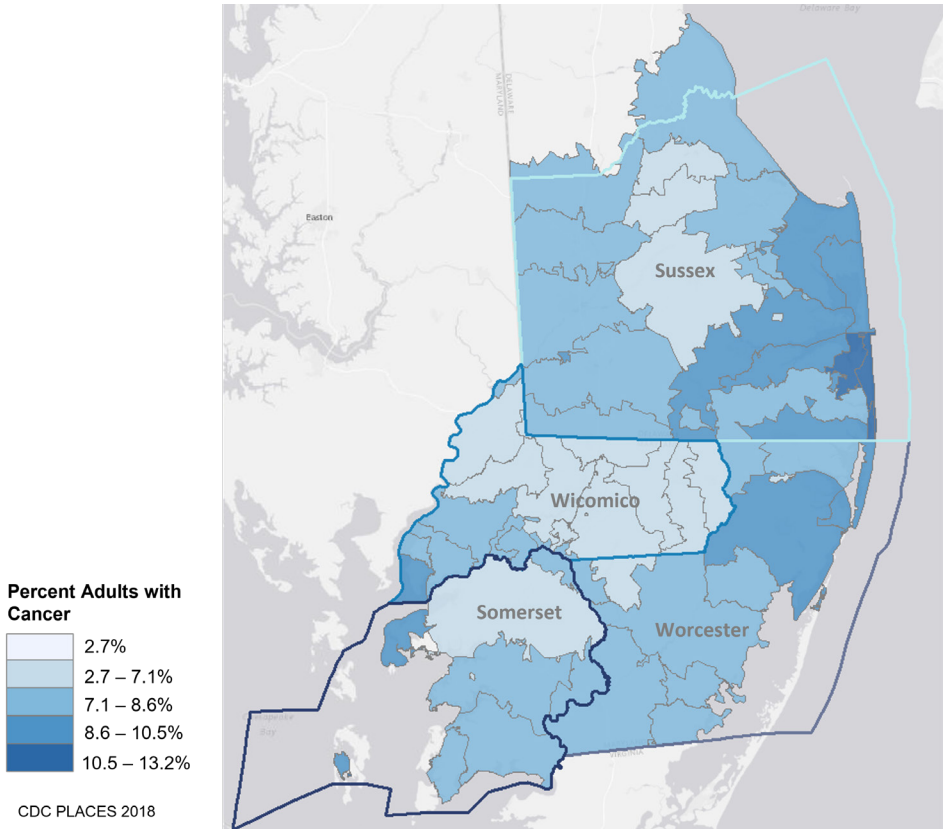
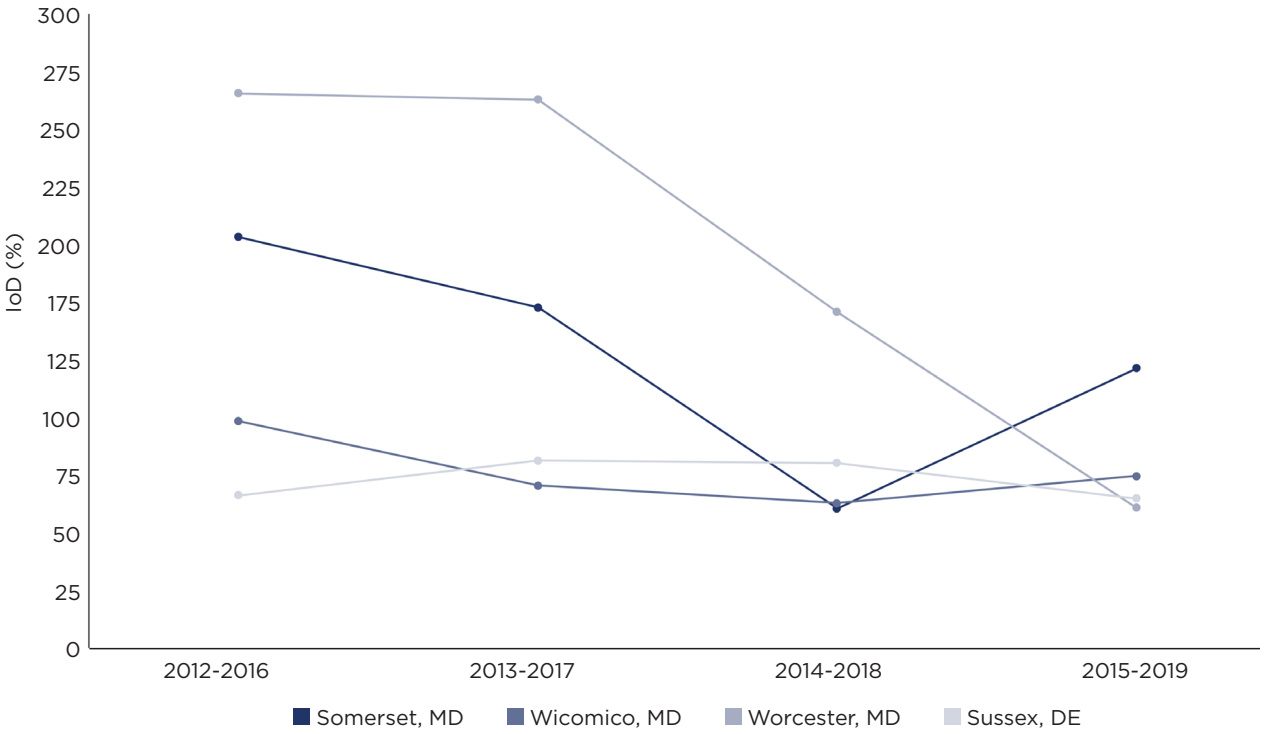


FIGURE 40: ADULTS WITH CANCER, BY ZIP CODE



People 65+ Living Below Poverty Level was identified as having a high disparity through the Index of Disparity (IoD) analysis. Of note, the IoD values for race/ethnicity were much higher than gender for this indicator. This could mean that differences seen by race/ethnicity is a greater contributor to disparities than gender for people 65+ living below poverty level. Figure 41 below shows the IoD value for race/ethnicity for each county for this indicator. As shown, Worcester, MD, saw a decrease in IoD values over time while Wicomico, MD, and Sussex, DE, remained stable over the same time period. These changes could indicate that there has not been much progress in addressing racial or ethnic disparities among older adults in poverty over these time periods. Older adults identifying as Black/African American, Hispanic/Latino, or Other Race have the highest poverty rates compared to other groups. Addressing disparities amongst older adults living in poverty could improve the overall health of the community, as disparate poverty levels can contribute to lack of healthcare access and higher rates of chronic disease, impacting cost of care for all.

FIGURE 41: INDEX OF DISPARITY BY RACE/ETHNICITY FOR PEOPLE 65+ LIVING BELOW POVERTY LEVEL (AMERICAN COMMUNITY SURVEY, 2015-2019)



ACS, 2015-2019

PRIMARY DATA

Chronic diseases were all mentioned as common health issues in the focus groups and key informant interviews. Some participants referred to the three health issues of Diabetes, Cancer, and Heart Disease as “the trifecta” citing them as the most common health issues affecting their community. Additionally, Nutrition & Healthy Eating, specifically Access to Healthy Foods, was mentioned in almost every key informant interview. Similarly, Physical Activity and Weight Status were cited frequently when discussing overall health and wellness, and commonly co-

occurring with chronic conditions like Diabetes and Hypertension. Community survey respondents also ranked Nutrition & Healthy Eating as a top quality of life issue. Focus groups cited lower-income or impoverished areas having less access to healthy foods and being less likely to lead healthy lifestyles. Also mentioned was economic status, worsened by COVID-19, causing added stress and financial hardship which tend to exacerbate unhealthy habits.

> People want a quick fix, not a lifestyle change. Stress plays so much into our ability to be healthy.
> -Key informant

Another theme from primary data was older adults being more negatively impacted by topics previously mentioned such as: Access to Care, Social Isolation, Ability to Navigate the Healthcare System, and COVID-19. Additionally, this group is seen as more at risk and having worse health outcomes when it comes to issues like Mental Health, Hypertension, and certain Cancers. Older adults' ability to manage chronic disease via frequent doctor visits and/or medication management was made more challenging by the impacts of COVID-19.

> During COVID, the elderly population's challenge with lack of transportation, services out their area, providers speaking above their head. . . all worsened.
> -Focus Group Participant

SECTION 9

NON-PRIORITIZED SIGNIFICANT HEALTH NEEDS

The following significant health needs, presented in alphabetical order, emerged from a review of the primary and secondary data. However, The Partnership will not focus directly on these topics in their Implementation Strategy/Community Health Improvement Plans. Several of the non-prioritized needs are related to the three primary priority areas, and implementation of activities under those priorities will have an indirect impact on many of these needs.

Key themes from community input are included where relevant for each non-prioritized health need along with the secondary data score and warning indicators.

9.1 NON-PRIORITIZED HEALTH NEED #1: HOMELESSNESS & UNSTABLE HOUSING

Homelessness & Unstable Housing

Key Themes from Community Input

- Ranked by respondents as the **2nd most pressing** quality of life issue
- **48.8%** of respondents **disagreed or strongly disagreed** that there are affordable places to live
- **8.5%** of respondents reported their current housing situation does not meet their needs

9.2 NON-PRIORITIZED HEALTH NEED #2: PREVENTION & SAFETY

Prevention & Safety

Secondary Data Score: **1.84**

Warning Indicators

- Severe Housing Problems
- Pedestrian Injuries
- Death Rate due to Drug Poisoning
- Age-Adjusted Death Rate due to Unintentional Injuries

9.3 NON-PRIORITIZED HEALTH NEED #3: ORAL HEALTH

Oral Health

Secondary Data Score: **1.71**

Warning Indicators

- Adults who Visited a Dentist
- Adults with No Tooth Extractions
- Oral Cavity and Pharynx Cancer Incidence
- Adults 65+ with Total Tooth Loss
- Age-Adjusted ER Visit Rate due to Dental Problems

9.4 NON-PRIORITIZED HEALTH NEED #4: CRIME & CRIME PREVENTION

Crime & Crime Prevention

Key Themes from Community Input

- Ranked by survey respondents as the **top most pressing** quality of life issue
- Subjects in this category included: robberies, shootings, and other violent crimes

SECTION 10

OTHER FINDINGS

Critical components in assessing the needs of a community are identifying barriers to and disparities in healthcare. Additionally, the identification of these will help inform and focus strategies for addressing prioritized health needs. We previously covered disparities in the Disparities and Health Equity section of this report. The following identifies barriers as they pertain to the Tri-County Region and Sussex County, DE.

10.1 BARRIERS TO CARE

Community health barriers were identified as part of the primary data collection. Community survey respondents, focus group participants, and key informants were asked to identify any barriers to healthcare observed or experienced in the community.

10.1.1 TRANSPORTATION

Transportation was identified through this assessment as a major barrier to accessing health and social services in the Tri-County Region and Sussex County, DE. The geographic region is particularly rural which exacerbates the issues of access to healthcare providers and services, especially for low-income populations and older adults who already experience barriers to access. Focus group and key informant participants stressed how important an issue transportation is across the region. They specifically spoke about the lack of public transit options available. Additionally, 47.8% of community survey respondents disagreed or strongly disagreed that transportation is easily accessible if they needed it.

10.1.2 COST, HEALTH LITERACY, CULTURAL/LANGUAGE BARRIERS

In general, accessing affordable healthcare was a common problem that was discussed due to several identified barriers. For community survey respondents that did not receive the care they needed, 30.6% selected cost as a barrier to seeking the care they needed, while 59.9% selected cost as a barrier to seeking dental or oral health services. Focus group participants and key informants were concerned that low-income community members do not have access to affordable healthcare providers or medications for certain disease management. Key informants added that even when health insurance or services may be available, health literacy issues and cultural/language barriers make seeking or continuing to seek care difficult, especially for older adults and immigrant populations.

SECTION 11

COVID-19 IMPACT SNAPSHOT

11.1 INTRODUCTION

At the time that The Partnership began its collaborative CHA/CHNA process, they were in the midst of dealing with the novel coronavirus (COVID-19) pandemic.

The process for conducting the assessment remained fundamentally the same. However, there were some adjustments made during the primary data collection to ensure the health and safety of those participating.

11.2 PANDEMIC OVERVIEW

On March 13, 2020, a U.S. national emergency was declared over the novel coronavirus outbreak first reported in the Wuhan Province of China in December 2019. Officially named COVID-19 by the World Health Organization (WHO) in February, WHO declared COVID-19 a pandemic on March 11, 2020. Later that month, stay-at-home orders were placed by the Maryland and Delaware Governors and unemployment rates soared as companies were impacted and began mass layoffs.

Vaccinations were available to select groups of individuals starting in December 2020 and became more widely available to all adults in early 2021. Despite availability of vaccinations, new cases, hospitalizations, and deaths continue to occur throughout Maryland, Delaware, the U.S., and worldwide. Upon completion of this report in April 2022, the pandemic was still very much a health crisis across the United States and in most countries.

Community Insights

The CHNA project team researched additional sources of secondary data and gathered primary data to provide a snapshot of the impact of COVID-19 on the Tri-County Region and Sussex, DE. Findings are reported below.

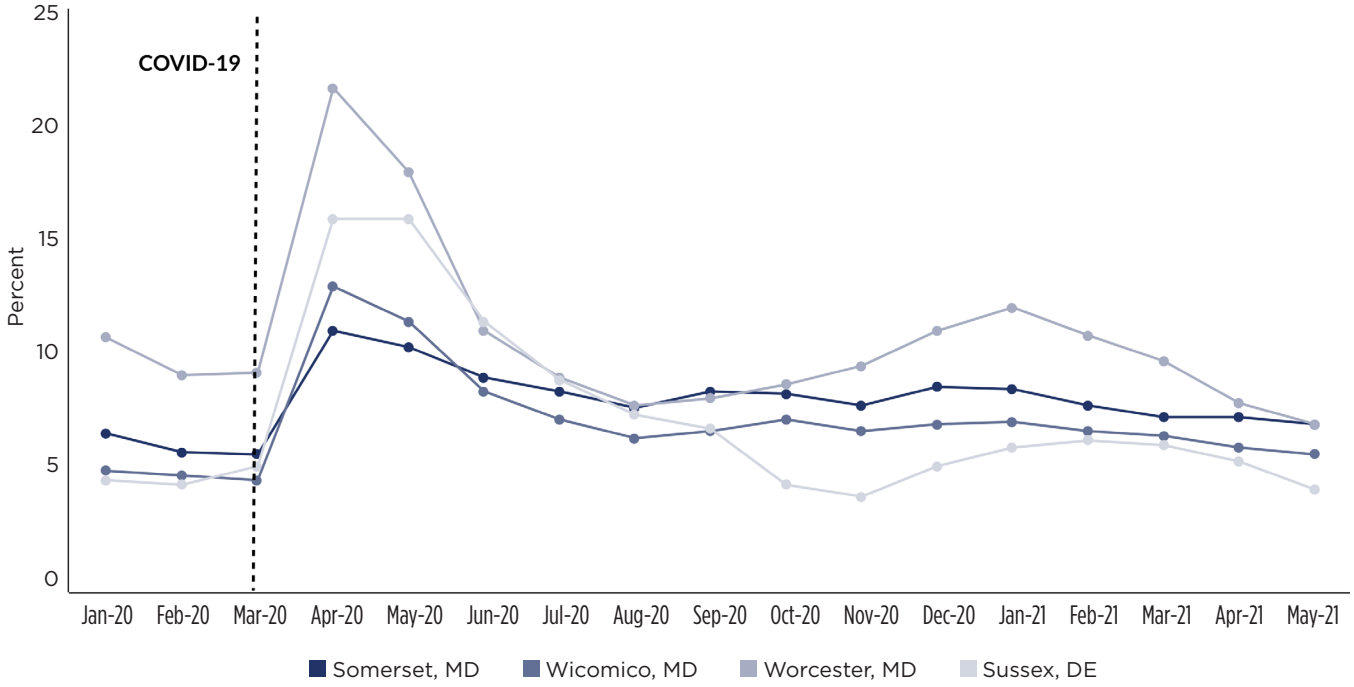
11.3 COVID-19 CASES AND DEATHS IN THE TRI-COUNTY REGION OF MARYLAND AND SUSSEX COUNTY, DELAWARE

For current cases and deaths due to COVID-19 visit the Maryland Department of Health https://coronavirus.maryland.gov.

11.4 UNEMPLOYMENT RATES

As expected, unemployment rates rose in April 2020 for all counties when stay-at-home orders were first in place. Illustrated in Figure 42 below, as counties began slowly reopening some businesses in May 2020, the unemployment rate gradually began to go down. As of mid-2021, unemployment rates have stabilized for the Tri-County Region and Sussex County, DE. When unemployment rates rise, there is a potential impact on health insurance coverage and healthcare access if jobs are lost include employer-sponsored healthcare.

FIGURE 42: UNEMPLOYMENT RATE (POPULATION 16+)



U.S. Bureau of Labor Statistics

11.5 COMMUNITY FEEDBACK

The community survey, focus groups, and key informant interviews were used to capture insights and perspectives of the health needs of the Tri-County Region and Sussex County, DE. Included in these primary data collection tools were questions specific to COVID-19. Survey respondents were specifically asked about the biggest challenges their households were currently facing due to COVID-19. This question had the following answers from respondents:

- 55.5% Reported not knowing when the pandemic will end
- 42.0% Reported feeling nervous or anxious
- 27.6% Reported feeling alone/isolated
- 20.5% Reported challenges for my children attending school

Additionally, the information highlighted below summarizes insights from the focus groups and key informant interviews regarding the impact of COVID-19 on their community.

TABLE 7. COVID-19 PRIMARY DATA INSIGHTS

FOCUS GROUP INSIGHTS	KEY INFORMANT INSIGHTS
Parents concerned and stressed with children attending school, possibly getting sick, or schools closing; lack of chilcare services available or open	Local health departments and health services organizations experiencing burden with staffing shortages and in-turn negatively affects community need
Low-income families struggling to keep their homes and/or losing employment	Financial impact on local community has been significant
Patients whoe need routine healthcare or lab work are unable to get it; general access to care being worsened by closures or delays	Problems with testing coordination and availability; schools/students heavily affected
Misinformation; vaccination hesitancy/ confusion; conflicting information around vaccinations from healthcare professionals, especially for immigrant populations and older adults	Technology gap in immigrant communities specifically; lack of clear communication; hesitancy to trust/get vaccination

11.6 SIGNIFICANT HEALTH NEEDS AND COVID-19 IMPACT

Each of the three prioritized health needs appeared to worsen throughout the duration of the COVID-19 pandemic according to information gathered through primary data as discussed in the Prioritized Health Needs section of this report.

11.6.1 COVID-19 IMPACT SNAPSHOT DATA SOURCES

As local, state, and national data are updated and become available, these data can continue to help inform approaches to meeting existing and developing needs related to the pandemic. Recommended data sources for the Tri-County Region in MD and Sussex County, DE, are included here:

National Data Sources

Data from the following national websites are updated regularly and may provide additional information into the impact of COVID-19:

- United States National Response to COVID-19 https://www.usa.gov/coronavirus
- Centers for Disease Control and Prevention: https://www.cdc.gov/
- U.S. Department of Health and Human Services: https://www.hhs.gov/
- Centers for Medicare and Medicaid: https://www.cms.gov/
- U.S. Department of Labor: https://www.dol.gov/coronavirus
- Johns Hopkins Coronavirus Resource Center: https://coronavirus.jhu.edu/us-map
- National Association of County and City Health Officials: https://www.naccho.org/
- Feeding America (The Impact of the Coronavirus on Food Insecurity): https://www.feedingamerica.org/

Maryland and Delaware State Data Sources

Data from the following websites are updated regularly and may provide additional information into the impact of COVID-19:

- Maryland Department of Health: https://health.maryland.gov
- Somerset County Health Department: https://somersethealth.org/
- Wicomico County Health Department: https://www.wicomicohealth.org/

SECTION 12

CONCLUSION

This collaborative Community Health Needs Assessment (CHNA) provided a comprehensive picture of health in the Tri-County Region and Sussex County, DE. This report helps meet IRS requirements of TidalHealth as a non-profit health system and is part of the essential services of local public health departments based on standards by the Public Health Accreditation Board.

This assessment was completed through a collaborative effort that integrated the CHNA process of the two TidalHealth hospitals and the two local health departments in Somerset County and Wicomico County. This group partnered with Conduent Healthy Communities Institute to conduct this 2022 CHNA.

This process was used to determine the 12 significant health needs in the Tri-County Region and Sussex, DE. The prioritization process identified three top health needs: Access and Health Equity, Behavioral Health (including Mental Health and Alcohol & Drug Use), and Chronic Disease and Wellness (including Diabetes, Cancer, Heart Disease and Stroke, Nutrition & Healthy Eating/Physical Activity/Weight Status, and Other Conditions/Older Adults).

The findings in this report will be used to guide the development of the TidalHealth hospitals' Implementation Strategy Plans as well as the health departments' Community Health Improvement Plans (CHIP), which will outline strategies to address identified priorities and improve the health of the community.

SECTION 13

APPENDICES SUMMARY

A SECONDARY DATA METHODOLOGY AND DATA SCORING TABLES, SOCIONEEDS INDEX® SUITE METHODOLOGIES

A detailed overview of the Conduent HCI Data Scoring methodology and indicator scoring results from the secondary data analysis. This section also includes the Index of Disparity methodology and the methodologies for the Health Equity Index, Food Insecurity Index, and Mental Health Index.

B PRIMARY DATA ASSESSMENT TOOLS (COMMUNITY INPUT)

Quantitative and qualitative community feedback data collection tools that were vital in capturing community feedback during this collaborative CHNA:

- Community Survey
- Focus Group Guide
- Key Informant Interview Questions

C COMMUNITY RESOURCES/POTENTIAL COMMUNITY PARTNERS

This document highlights existing resources that organizations are currently using and available widely in the community. Additionally, this lists potential community partners who were identified in the qualitative data collection process for this CHNA.

D 2019-2022 IMPLEMENTATION STRATEGY PLAN/CHIP

This document is the strategic plan shared by TidalHealth and Somerset & Wicomico County Health Departments as their actionable plan following their previous CHNA.

APPENDIX A

SECONDARY DATA METHODOLOGY

SECONDARY DATA SOURCES

The main source for the secondary data, or data that has been previously collected, is the TidalHealth Community Health Research and Data platform, a publicly available data platform that is maintained by the partnership and Conduent Healthy Communities Institute.

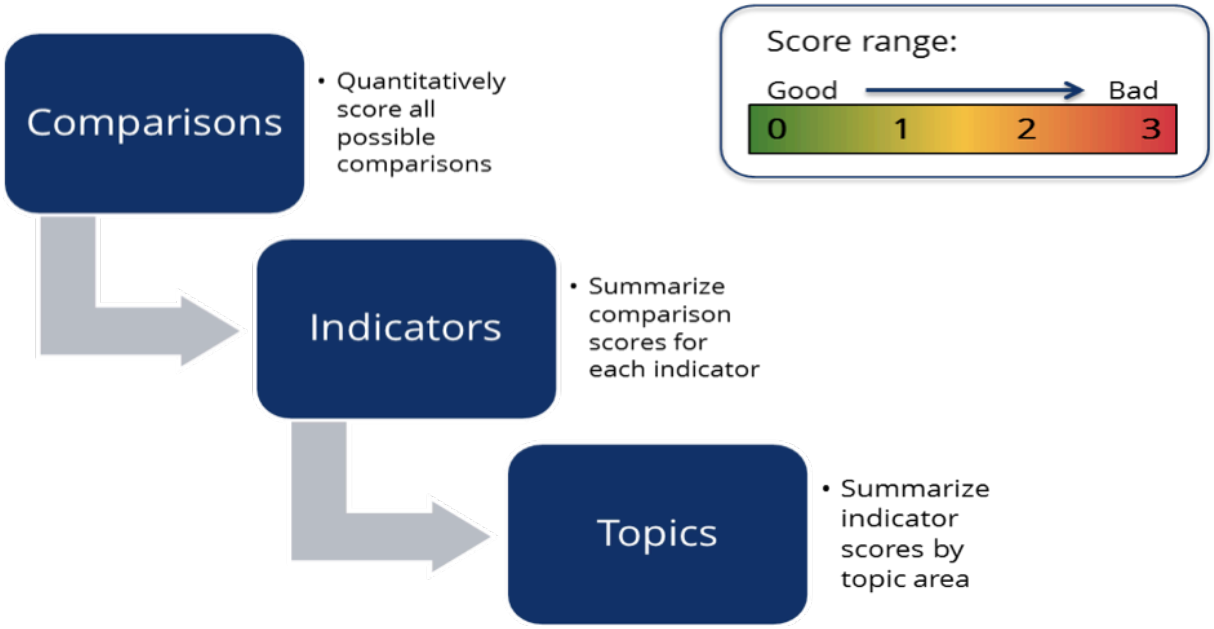
The following is a list of both local and national sources for which data is maintained for the Tri-County Region and Sussex County, DE on the community health research and data platform.

- American Community Survey
- Annie E. Casey Foundation
- CDC — PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- County Health Rankings
- Feeding America
- Healthy Communities Institute
- Maryland Behavioral Risk Factor Surveillance System
- Maryland Department of Health
- Maryland Department of the Environment
- Maryland Governor's Office for Children
- Maryland Governor's Office of Crime Control & Prevention
- Maryland State Board of Elections
- Maryland State Department of Education
- Maryland Youth Risk Behavior Survey/Youth Tobacco Survey
- National Cancer Institute
- National Center for Education Statistics
- National Environmental Public Health Tracking Network
- U.S. Bureau of Labor Statistics
- U.S. Census — County Business Patterns
- U.S. Census Bureau — Small Area Health Insurance Estimates
- U.S. Department of Agriculture — Food Environment Atlas
- United For ALICE
- Delaware Department of Health and Social Services, Division of Public Health
- Delaware Office of the State Election Commissioner
- Delaware School Survey
- Delaware Youth Risk Behavior Survey
- Behavioral Risk Factor Surveillance System

SECONDARY DATA SCORING

SECONDARY DATA SCORING DETAILED METHODOLOGY

Data Scoring is done in three stages:



For each indicator, each county within the Tri-County Region and Sussex County, DE is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time.

Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic.

Comparison to a Distribution of County Values: Within State and Nation

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. A distribution is created by taking all county values within the state or nation, ordering them from low to high, and dividing them into three groups (green, yellow, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

Comparison to Values: State, National, and Targets

The county is compared to the state value, the national value, and target values. Targets values include the nation-wide Healthy People 2030 (HP2030) goals. Healthy People 2030 goals are national objectives for improving the health of the nation set by the Department of Health and Human Services' (DHHS) Healthy People Initiative. For all value comparisons, the scoring depends on whether the county value is better or worse than the comparison value, as well as how close the county value is to the target value.

Trend Over Time

The Mann-Kendall statistical test for trend was used to assess whether the county value is increasing over time or decreasing over time, and whether the trend is statistically significant. The trend comparison uses the four most recent comparable values for the county, and statistical significance is determined at the 90% confidence level. For each indicator with values available for four time periods, scoring was determined by direction of the trend and statistical significance.

Missing Values

Indicator scores are calculated using the comparison scores, availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators on the community dashboard, it will be included in the indicator score. After exclusion of comparison types with inadequate availability, all missing comparisons are substituted with a neutral score for the purposes of calculating the indicator's weighted average. When information is unknown due to lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

Indicator Scoring

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated and the indicator is excluded from the data scoring results.

Topic Scoring

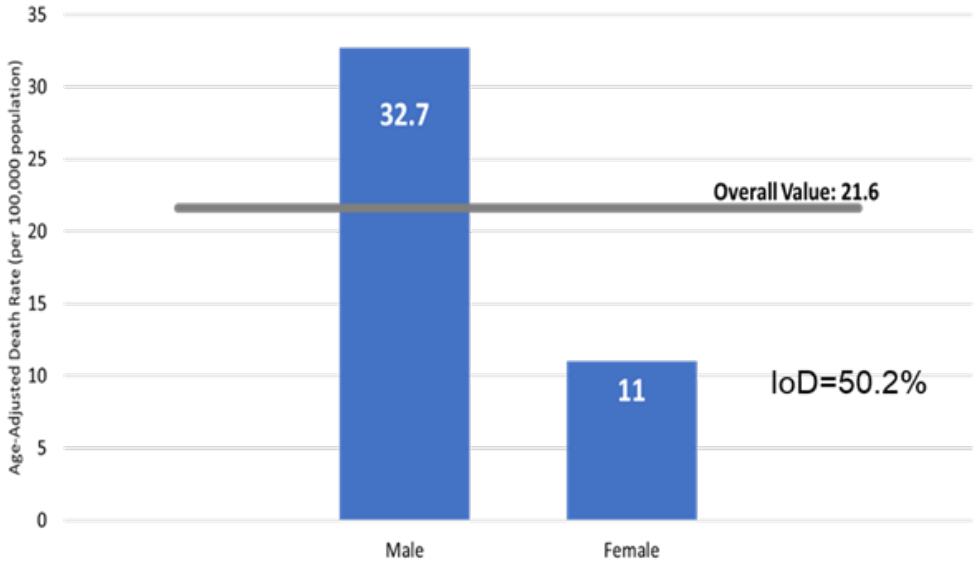
Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. Resulting scores range from 0-3, where a higher score indicates a greater level of need as evidenced by the data. A topic score is only calculated if it includes at least three indicators.

INDEX OF DISPARITY

The Index of Disparity (IoD) identified large disparities based on how far each subgroup (by race/ethnicity or gender) is from the overall county value. This analysis provides a percent value, based on the absolute difference from the overall value for each breakout category in a subgroup, which is a summary of how different each subgroup is from the overall value. For example, Figure 1A shows an example of Age-Adjusted Death Rate due to Suicide by Gender. Most often, gender (the subgroup) has two breakout categories: male and female. First, the IoD sums

the absolute difference between the male value and the overall county value and the difference between the female value and the overall value, divided by the overall county value to get a percent. In this case, the IoD is 50.2% for gender. This would be completed for race/ethnicity, which typically has more breakout categories available. Finally, those IoD values for gender and race/ethnicity can be compared to see where disparities may exist, and which groups are driving those disparities. When available, the IoD value can be used to show if progress has been made in addressing disparities over time.

FIGURE 1A. EXAMPLE OF IOD CALCULATION: AGE-ADJUSTED DEATH RATE DUE TO SUICIDE, BY GENDER



$$\text{Index of disparity} = (\Sigma |r_{(1-n)} - R| / n)/R*100$$

For this analysis, indicators with a high disparity were identified. This means that the IoD values for either race or gender for the indicator were in the top twenty-five percent of all index values for all available indicators. IoD values were tracked over time, when available, for indicators within the top health needs identified with the Data Scoring Tool. These findings are shown alongside relevant secondary data throughout this report.

HEALTH EQUITY INDEX

Every community can be described by various social and economic factors that can contribute to disparities in health outcomes. Conduent HCI's Health Equity Index (formerly SocioNeeds Index) considers validated indicators related to income, employment, education, and household environment to identify areas at highest risk for experiencing health inequities.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic needs correlated with preventable hospitalizations and premature death.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Health Equity Index, with darker coloring associated with higher relative need.

FOOD INSECURITY INDEX

Every community can be described by various health, social, and economic factors that can contribute to disparities in outcomes and opportunities to thrive. Conduent HCI's Food Insecurity Index considers validated indicators related to income, household environment, and wellbeing to identify areas at highest risk for experiencing food insecurity.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest food insecurity, which is correlated with household and community measures of food-related financial stress such as Medicaid and SNAP enrollment.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Food Insecurity Index, with darker coloring associated with higher relative need.

MENTAL HEALTH INDEX

Every community can be described by various health, social, and economic factors that can contribute to disparities in mental health outcomes. Conduent HCI's Mental Health Index considers validated indicators related to access to care, physical health status, transportation, employment, and household environment to identify areas at highest risk for experiencing poor mental health.

How is the index value calculated?

The national index value (from 0 to 100) is calculated for each zip code, census tract, and county in the U.S. Communities with the highest index values are estimated to have the highest socioeconomic and health needs correlated with self-reported poor mental health.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the Mental Health Index, with darker coloring associated with higher relative need.

COLLABORATIVE SERVICE AREA TOPICS

COLLABORATIVE SERVICE AREA WEIGHTED ANALYSYS: TOPIC SCORES

Top 10 Health Needs	*wt avg*
Other Conditions	**1.90**
Prevention & Safety	**1.84**
Heart Disease & Stroke	**1.78**
Oral Health	**1.71**
Wellness & Lifestyle	**1.70**
Alcohol & Drug Use	**1.63**
Older Adults	**1.58**
Physical Activity	**1.55**
Adolescent Health	**1.49**
Diabetes	**1.47**
Mental Health & Mental Disorders	**1.43**

Top Quality of Life Topics	wt avg
Community	**1.51**
Health Care Access & Quality	**1.51**
Environmental Health	**1.48**
Education	**1.43**
Economy	**1.42**

WEIGHTED TOPICS: FULL LIST

Health and Quality of Life Topics	**wt avg**
Other Conditions	**1.90**
Prevention & Safety	**1.84**
Heart Disease & Stroke	**1.78**
Oral Health	**1.71**
Wellness & Lifestyle	**1.70**
Alcohol & Drug Use	**1.63**
Older Adults	**1.58**
Physical Activity	**1.55**
Health Care Access & Quality	**1.51**
Community	**1.51**
Adolescent Health	**1.49**
Environmental Health	**1.48**
Diabetes	**1.47**
Mental Health & Mental Disorders	**1.43**
Respiratory Diseases	**1.43**
Education	**1.43**
Economy	**1.42**
Children's Health	**1.41**
Immunizations & Infectious Diseases	**1.40**
Cancer	**1.40**
Sexually Transmitted Infections	**1.37**
Women's Health	**1.33**
Weight Status	**0.73**
Maternal, Fetal & Infant Health	**0.66**
Tobacco Use	**0.65**

SOMERSET DATA SCORING

SOMERSET SOURCES

Key	Source
1	American Community Survey
2	Annie E. Casey Foundation
3	CDC - PLACES
4	Centers for Disease Control and Prevention
5	Centers for Medicare & Medicaid Services
6	County Health Rankings
7	Feeding America
8	Healthy Communities Institute
9	Maryland Behavioral Risk Factor Surveillance System
10	Maryland Department of Health
11	Maryland Department of the Environment
12	Maryland Governor's Office for Children
13	Maryland Governor's Office of Crime Control & Prevention
14	Maryland State Board of Elections
15	Maryland State Department of Education
16	Maryland Youth Risk Behavior Survey/Youth Tobacco Survey
17	National Cancer Institute
18	National Center for Education Statistics
19	National Environmental Public Health Tracking Network
20	U.S. Bureau of Labor Statistics
21	U.S. Census - County Business Patterns
22	U.S. Census Bureau - Small Area Health Insurance Estimates
23	U.S. Department of Agriculture - Food Environment Atlas
24	United For ALICE

SOMERSET TOPICS

Health and Quality of Life Topics	Score
Diabetes	2.25
Weight Status	2.23
Wellness & Lifestyle	2.07
Economy	2.02
Maternal, Fetal & Infant Health	2.01
Prevention & Safety	1.97
Sexually Transmitted Infections	1.90
Heart Disease & Stroke	1.87
Respiratory Diseases	1.86
Older Adults	1.81
Education	1.80
Immunizations & Infectious Diseases	1.78
Other Conditions	1.77
Environmental Health	1.76
Physical Activity	1.73
Tobacco Use	1.70
Oral Health	1.67
Community	1.66
Women's Health	1.62
Cancer	1.62
Mental Health & Mental Disorders	1.61
Adolescent Health	1.57
Children's Health	1.27
Health Care Access & Quality	1.27
Alcohol & Drug Use	1.23

SOMERSET COUNTY INDICATORS

SCORE	ADOLESCENT HEALTH	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.98	Adolescents who are Obese	*percent*	18.8		12.6		*2016*		10
1.58	Adolescents who Use Tobacco	*percent*	22		23		*2016*		10
1.58	Teens who Smoke Cigarettes: High School Students	*percent*	9.7		5		*2018*		16
1.45	Teen Birth Rate: 15-19	*live births/ 1,000 females aged 15-19*	15.8		13.9	16.7	*2019*		10
1.28	Adolescents who have had a Routine Checkup: Medicaid Population	*percent*	59.3		54.6		*2017*		10

SCORE	ALCOHOL & DRUG USE	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.38	Liquor Store Density	*stores/ 100,000 population*	23.4		20.5	10.5	*2019*		21
1.63	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	27.2		38.3	21	*2017-2019*		6
1.28	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	28.3		38.2	22.8	*2017-2019*		4
1.25	Age-Adjusted ER Rate due to Alcohol/Substance Abuse	*ER visits/ 100,000 population*	1538.3		2017		*2017*		10
0.83	Adults who Binge Drink	*percent*	10.8		15.4	16	*2014*	Black (22.1) White (6.7) Hisp (37.9)	9
0.68	Age-Adjusted Death Rate due to Drug Use	*deaths/ 100,000 population*	0		12.1	12.7	*2008-2010*		10
0.55	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	22.2	28.3	28.8	27	*2015-2019*		6

SCORE	CANCER	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.63	Breast Cancer Incidence Rate	*cases/ 100,000 females*	141.7		132.9	125.9	*2013-2017*		17
2.50	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	187.7	122.7	155.1	155.5	*2013-2017*		17
2.35	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	68.2	25.1	37.2	38.5	*2013-2017*		17
2.25	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	38.1	16.9	26.7		*2005-2009*		17
2.13	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	44.1		36.4	38.4	*2013-2017*		17
2.10	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	13.8		11.1	11.8	*2013-2017*		17
2.03	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	79.7		56.4	58.3	*2013-2017*		17
1.95	Mammogram in Past 2 Years: 50+	*percent*	58.5		66.3		*2016*		9
1.88	Cervical Cancer Screening: 21-65	*Percent*	82.5			84.7	*2018*		3
1.80	Colon Cancer Screening	*percent*	64.3	74.4		66.4	*2018*		3
1.60	Mammogram in Past 2 Years: 50-74	*percent*	72.5	77.1		74.8	*2018*		3
1.38	Pap Test in Past 3 Years	*percent*	69.8		70.3		*2018*		9
1.08	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	107.3		124.7	104.5	*2013-2017*		17
0.98	Adults with Cancer	*percent*	6.7			6.9	*2018*		3
0.93	Cancer: Medicare Population	*percent*	8.2		9.2	8.4	*2018*		5
0.93	Colon Cancer Screening: Sigmoidoscopy or Colonoscopy	*percent*	84.4		75.7		*2018*		9
0.30	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	19.3	15.3	24.5	22.6	*2006-2010*		17
0.30	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	12.1	8.9	14.2	14.5	*2011-2015*		17

SCORE	CHILDREN'S HEALTH	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.40	Child Food Insecurity Rate	*percent*	27.9		16.1	15.2	*2018*		7
1.95	Projected Child Food Insecurity Rate	*percent*	37.2				*2020*		7
1.30	Children with Health Insurance	*percent*	96.5		96.8		*2018*		22
1.28	Child Abuse Rate	*cases/ 1,000 children*	6.2		5.7		*2018*		12
1.20	Children with Low Access to a Grocery Store	*percent*	2.6				*2015*		23
0.78	Blood Lead Levels in Children	*percent*	0		0.2		*2019*		11
0.75	Food Insecure Children Likely Ineligible for Assistance	*percent*	1		32	25	*2018*		7
0.53	Children who Visited a Dentist	*percent*	71.5		63.7		*2017*		10

SCORE	COMMUNITY	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.35	People Living Below Poverty Level	*percent*	21.7	8	9.2	13.4	*2015-2019*		1
2.28	Children Living Below Poverty Level	*percent*	33.4		12.1	18.5	*2015-2019*		1
2.28	Homeownership	*percent*	48.7		60.2	56.2	*2015-2019*		1
2.28	Households without a Vehicle	*percent*	11.6		9	8.6	*2015-2019*		1
2.28	Median Household Income	*dollars*	37803		84805	62843	*2015-2019*		1
2.28	People 25+ with a Bachelor's Degree or Higher	*percent*	14.4		40.2	32.1	*2015-2019*	an (4.5) AIAN (6.1) NHPI (100) Mult	1
2.28	Per Capita Income	*dollars*	18772		42122	34103	*2015-2019*		1
2.28	Single-Parent Households	*percent*	35.6		26.4	25.5	*2015-2019*		1
2.25	Households with an Internet Subscription	*percent*	74.2		86.7	83	*2015-2019*		1
2.23	Pedestrian Injuries	*injuries/ 100,000 population*	92.6		53.5		*2017*		10
2.03	Persons with an Internet Subscription	*percent*	77.8		89.4	86.2	*2015-2019*		1
2.00	Workers Commuting by Public Transportation	*percent*	0.8	5.3	8.4	5	*2015-2019*		1
1.98	People 25+ with a High School Degree or Higher	*percent*	81.3		90.2	88	*2015-2019*		1
1.95	Households with No Car and Low Access to a Grocery Store	*percent*	5				*2015*		23
1.95	Households with One or More Types of Computing Devices	*percent*	83.4		92.4	90.3	*2015-2019*		1

1.93	Violent Crime Rate	*crimes/ 100,000 population*	414.4			394	*2017*		13
1.83	Voter Registration	*percent*	60.3		83.6		*2016*		14
1.68	People 65+ Living Alone	*percent*	27.1		26	26.1	*2015-2019*		1
1.28	Child Abuse Rate	*cases/ 1,000 children*	6.2		5.7		*2018*		12
1.08	Persons with Health Insurance	*percent*	92.5	92.1	93.1		*2018*		22
1.05	Mean Travel Time to Work	*minutes*	24.4		33.2	26.9	*2015-2019*		1
1.03	Domestic Violence Offense Rate	*offenses/ 100,000 population*	420.6		537.1		*2017*		10
0.98	Workers who Drive Alone to Work	*percent*	78		73.9	76.3	*2015-2019*		1
0.93	Solo Drivers with a Long Commute	*percent*	34.3		50.2	37	*2015-2019*		6
0.78	Social Associations	*membership associations/ 10,000 population*	11.3		9	9.3	*2018*		6
0.55	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	22.2	28.3	28.8	27	*2015-2019*		6
0.48	Youth not in School or Working	*percent*	0		1.9	1.9	*2015-2019*		1
0.23	Workers who Walk to Work	*percent*	6.5		2.3	2.7	*2015-2019*	ɜ (3.1) Asian (7.1) NHPI (0) Mult (0)	1

SCORE	**DIABETES**	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.30	Adults with Diabetes	*percent*	20.1		11.1	10.9	*2018*		9
2.28	Diabetes: Medicare Population	*percent*	34		29.6	27	*2018*		5
2.23	Age-Adjusted ER Rate due to Diabetes	*ER Visits/ 100,000 population*	381		243.7		*2017*		10
2.18	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	25.2		19.9	21.2	*2010-2012*		10

SCORE	**ECONOMY**	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.78	Households with Cash Public Assistance Income	*percent*	4.6		2.2	2.4	*2015-2019*		1
2.53	Renters Spending 30% or More of Household Income on Rent	*percent*	67.4		49.7	49.6	*2015-2019*		1
2.53	Severe Housing Problems	*percent*	24.5		16.2	18	*2013-2017*		6
2.40	Child Food Insecurity Rate	*percent*	27.9		16.1	15.2	*2018*		7
2.40	Food Insecurity Rate	*percent*	16.6		11	11.5	*2018*		7
2.40	People Living 200% Above Poverty Level	*percent*	51.6		78.4	69.1	*2015-2019*		1
2.35	People Living Below Poverty Level	*percent*	21.7	8	9.2	13.4	*2015-2019*		1
2.28	Children Living Below Poverty Level	*percent*	33.4		12.1	18.5	*2015-2019*		1
2.28	Families Living Below Poverty Level	*percent*	17		6.1	9.5	*2015-2019*	sian (59.2) AIAN (0) NHPI (0) Mult (	1
2.28	Homeowner Vacancy Rate	*percent*	3.5		1.7	1.6	*2015-2019*		1
2.28	Homeownership	*percent*	48.7		60.2	56.2	*2015-2019*		1
2.28	Median Household Income	*dollars*	37803		84805	62843	*2015-2019*		1
2.28	Per Capita Income	*dollars*	18772		42122	34103	*2015-2019*		1
2.28	Unemployed Workers in Civilian Labor Force	*percent*	7.5		5.9	5.7	*Apr-21*		20
2.13	Persons with Disability Living in Poverty (5-year)	*percent*	30.3		20.9	26.1	*2015-2019*		1
2.10	Low-Income and Low Access to a Grocery Store	*percent*	12				*2015*		23
2.08	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	42.5		61		*2018*		24
2.08	Households that are Below the Federal Poverty Level	*percent*	20.2		9		*2018*		24
1.98	People 65+ Living Below Poverty Level	*percent*	9.6		7.7	9.3	*2015-2019*	ɨ.1) White (7.9) NHPI (0) Mult (0) H	1
1.95	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	37.3		30		*2018*		24
1.95	Projected Child Food Insecurity Rate	*percent*	37.2				*2020*		7
1.95	Projected Food Insecurity Rate	*percent*	21.9				*2020*		7
1.95	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		23
1.73	Overcrowded Households	*percent of households*	1.6		2.3		*2015-2019*		1
1.68	Students Eligible for the Free Lunch Program	*percent*	56.8				*2019-2020*		18
1.63	SNAP Certified Stores	*stores/ 1,000 population*	0.7				*2017*		23
0.78	Affordable Housing	*percent*	86.2		48.1		*2016*		10
0.75	Food Insecure Children Likely Ineligible for Assistance	*percent*	1		32	25	*2018*		7
0.48	Youth not in School or Working	*percent*	0		1.9	1.9	*2015-2019*		1

SCORE	**EDUCATION**	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.33	3rd Grade Students Proficient in Math	*percent*	17.4		42.5		*2019*		2
2.30	High School Graduation	*percent*	82.4	90.7	86.8		*2020*		15
2.28	People 25+ with a Bachelor's Degree or Higher	*percent*	14.4		40.2	32.1	*2015-2019*	an (4.5) AIAN (6.1) NHPI (100) Mult	1
2.08	3rd Grade Students Proficient in Reading	*percent*	23.6		41.2		*2019*		2
1.98	People 25+ with a High School Degree or Higher	*percent*	81.3		90.2	88	*2015-2019*		1
1.95	8th Grade Students Proficient in Reading	*percent*	37.1		45.1		*2019*		2
1.08	8th Grade Students Proficient in Math	*percent*	17.4		12.5		*2019*		2
1.08	School Readiness at Kindergarten Entry	*percent*	60		47		*2019-2020*		15
1.08	Student-to-Teacher Ratio	*students/ teacher*	12.9				*2019-2020*		18

SCORE	**ENVIRONMENTAL HEALTH**	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.55	Adults with Asthma	*percent*	23.6		14.9	14.9	*2019*		9
2.53	Severe Housing Problems	*percent*	24.5		16.2	18	*2013-2017*		6
2.38	Liquor Store Density	*stores/ 100,000 population*	23.4		20.5	10.5	*2019*		21
2.28	Food Environment Index		6.5		8.7	7.8	*2021*		6
2.25	Access to Exercise Opportunities	*percent*	61		92.6	84	*2020*		6
2.23	Age-Adjusted ER Rate due to Asthma	*ER visits/ 10,000 population*	122.9		68.4		*2017*		10
2.18	Adults with Current Asthma	*percent*	11			9.2	*2018*		3
2.18	Daily Dose of UV Irradiance	*Joule per square meter*	2700		2499		*2015*		19

2.10	Low-Income and Low Access to a Grocery Store	*percent*	12				*2015*	23
1.95	Households with No Car and Low Access to a Grocery Store	*percent*	5				*2015*	23
1.95	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.80	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0				*2016*	23
1.73	Overcrowded Households	*percent of households*	1.6		2.3		*2015-2019*	1
1.65	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*	23
1.65	People with Low Access to a Grocery Store	*percent*	22.7				*2015*	23
1.63	Months of Mild Drought or Worse	*months per year*	4				*2016*	19
1.63	Number of Extreme Heat Days	*days*	26				*2016*	19
1.63	Number of Extreme Heat Events	*events*	7				*2016*	19
1.63	Number of Extreme Precipitation Days	*days*	31				*2016*	19
1.63	SNAP Certified Stores	*stores/ 1,000 population*	0.7				*2017*	23
1.35	People 65+ with Low Access to a Grocery Store	*percent*	1.9				*2015*	23
1.20	Children with Low Access to a Grocery Store	*percent*	2.6				*2015*	23
1.05	Farmers Market Density	*markets/ 1,000 population*	0.1				*2018*	23
0.93	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.4				*2016*	23
0.78	Asthma: Medicare Population	*percent*	4.2		5.4	5	*2018*	5
0.78	Blood Lead Levels in Children	*percent*	0		0.2		*2019*	11

SCORE	**HEALTH CARE ACCESS & QUALITY**	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.30	Adults who Visited a Dentist	*percent*	52		66.3	67.6	*2018*		9
1.90	Primary Care Provider Rate	*providers/ 100,000 population*	35.1		88.6		*2018*		6
1.75	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	74.2		115.1		*2020*		6
1.70	Adults who have had a Routine Checkup	*percent*	85.7		88.2	83.6	*2016*		9
1.30	Children with Health Insurance	*percent*	96.5		96.8		*2018*		22
1.28	Adolescents who have had a Routine Checkup: Medicaid Population	*percent*	59.3		54.6		*2017*		10
1.28	People with a Usual Primary Care Provider	*percent*	87.5	84	84.8		*2016*		10
1.20	Adults with Health Insurance: 18-64	*percent*	91.1		91.7		*2018*		22
1.70	Adults who have had a Routine Checkup	*percent*	85.7		88.2	83.6	*2016*		9
1.08	Persons with Health Insurance	*percent*	92.5	92.1	93.1		*2018*		22
1.08	Uninsured Emergency Department Visits	*percent*	6.4		8.6		*2017*		10
0.75	Mental Health Provider Rate	*providers/ 100,000 population*	292.8		274.9		*2020*		6
0.68	Adults Unable to Afford to See a Doctor	*percent*	6.7		10.1	13.1	*2014*	Black (5) White (5.7) Other (85.1)	9
0.53	Children who Visited a Dentist	*percent*	71.5		63.7		*2017*		10
0.45	Dentist Rate	*dentists/ 100,000 population*	210.8		79.4		*2019*		6

SCORE	**HEART DISEASE & STROKE**	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.78	Hypertension: Medicare Population	*percent*	68.5		61.2	57.2	*2018*		5
2.48	Stroke: Medicare Population	*percent*	4.8		4.5	3.8	*2018*		5
2.23	Age-Adjusted ER Rate due to Hypertension	*ER Visits/ 100,000 population*	460.4		351.2		*2017*		10
2.18	Atrial Fibrillation: Medicare Population	*percent*	9		8.2	8.4	*2018*		5
2.13	High Blood Pressure Prevalence	*percent*	48.3	27.7	32.2	32.3	*2019*		9
2.08	Hyperlipidemia: Medicare Population	*percent*	53.9		51.9	47.7	*2018*		5
2.05	High Cholesterol Prevalence	*percent*	38.4		31.3	33.1	*2019*		9
2.03	Adults who Experienced a Stroke	*percent*	4.5			3.4	*2018*		3
1.83	Heart Failure: Medicare Population	*percent*	14.1		12.6	14	*2018*		5
1.80	Age-Adjusted Hospitalization Rate due to Heart Attack	*hospitalizations/ 10,000 population 35+ years*	28.5		23.9		*2014*		19
1.75	Age-Adjusted Death Rate due to Heart Disease	*deaths/ 100,000 population*	284.9		161.9	723.5	*2017-2019*		10
1.73	Adults who Experienced Coronary Heart Disease	*percent*	8.2			6.8	*2018*		3
1.73	Adults who Have Taken Medications for High Blood Pressure	*percent*	76.9			75.8	*2017*		3
1.73	Cholesterol Test History	*percent*	80.8			81.5	*2017*		3
1.68	Ischemic Heart Disease: Medicare Population	*percent*	27.7		26.4	26.8	*2018*		5
1.43	High Cholesterol Prevalence: Adults 18+	*percent*	35.3			34.1	*2017*		3
1.18	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	36.9		45.9		*2016*		19
0.88	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	28.5	33.4	36.5	37	*2011-2013*		10

SCORE	**IMMUNIZATIONS & INFECTIOUS DISEASES**	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	100		7.3	2.8	*44386*		8
2.30	Gonorrhea Incidence Rate	*cases/ 100,000 population*	266.2		170.3	179.1	*2018*		10
2.30	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	113.2	11.1	16.5		*2019*		10
2.20	Chlamydia Incidence Rate	*cases/ 100,000 population*	721.5		586.3	539.9	*2018*		10
2.10	Adults with Influenza Vaccination	*percent*	29.5		41.7		*2014*		10
2.08	HIV Diagnosis Rate	*cases/ 100,000 population*	26.5		22.1		*2016*		10
2.03	Adults 65+ with Influenza Vaccination	*percent*	61.7		68.7	64	*2019*		9
2.00	Adults 65+ with Pneumonia Vaccination	*percent*	70.1		76.6	73.3	*2019*		9

1.73	Adults Fully Vaccinated Against COVID-19	*percent*	39.8				*10-Jun-21*	4
1.73	Overcrowded Households	*percent of households*	1.6		2.3		*2015-2019*	1
1.00	Syphilis Incidence Rate	*cases/ 100,000 population*	7.7		12.2	10.8	*2018*	10
0.63	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0	1.4	3.5	2.8	*2018*	10
0.48	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	0.6		1.2	6.1	*9-Jul-21*	8

SCORE	**MATERNAL, FETAL & INFANT HEALTH**	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.53	Infant Mortality Rate	*deaths/ 1,000 live births*	18.3	5	6.4	5.8	*2014-2018*		10
2.45	Babies with Low Birth Weight	*percent*	10.7		8.7	8.3	*2019*		10
2.38	Preterm Births	*percent*	12.4	9.4	10.3	10	*2019*		10
2.33	Sudden Unexpected Infant Death Rate	*deaths/ 1,000 live births*	3.4		1	0.9	*2011-2015*		10
1.45	Teen Birth Rate: 15-19	*live births/ 1,000 females aged 15-19*	15.8		13.9	16.7	*2019*		10
0.93	Perinatal Deaths	*per 1,000 live births plus fetal deaths of 28 or more weeks gestation*	0		6.2		*2018*		10

SCORE	**MENTAL HEALTH & MENTAL DISORDERS**	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.33	Self-Reported Good Mental Health	*percent*	56.8		70.2		*2019*		9
2.25	Frequent Mental Distress	*percent*	15.7		11.4	13	*2018*		6
2.10	Poor Mental Health: Average Number of Days	*days*	4.6		3.7	4.1	*2018*		6
2.05	Self-Reported General Health Assessment: Good or Better	*percent*	72.7		85.8	82	*2019*		9
1.43	Depression: Medicare Population	*percent*	16.7		18	18.4	*2018*		5
1.33	Age-Adjusted Hospitalization Rate Related to Alzheimer's and Other Dementias	*hospitalizations/ 100,000 population*	365.1		515.5		*2017*		10
1.25	Age-Adjusted ER Rate due to Mental Health	*ER Visits/ 100,000 population*	3265.9		3796.7		*2016*		10
1.03	Alzheimer's Disease or Dementia: Medicare Population	*percent*	10		11.3	10.8	*2018*		5
0.75	Mental Health Provider Rate	*providers/ 100,000 population*	292.8		274.9		*2020*		6

SCORE	**OLDER ADULTS**	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.78	Chronic Kidney Disease: Medicare Population	*percent*	31.7		25.1	24.5	*2018*		5
2.78	Hypertension: Medicare Population	*percent*	68.5		61.2	57.2	*2018*		5
2.53	COPD: Medicare Population	*percent*	15.2		10.2	11.5	*2018*		5
2.48	Stroke: Medicare Population	*percent*	4.8		4.5	3.8	*2018*		5
2.28	Diabetes: Medicare Population	*percent*	34		29.6	27	*2018*		5
2.18	Atrial Fibrillation: Medicare Population	*percent*	9		8.2	8.4	*2018*		5
2.08	Hyperlipidemia: Medicare Population	*percent*	53.9		51.9	47.7	*2018*		5
2.03	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	28.2			32.4	*2018*		3
2.03	Adults 65+ with Influenza Vaccination	*percent*	61.7		68.7	64	*2019*		9
2.03	Adults 65+ with Total Tooth Loss	*percent*	18.8			13.5	*2018*		3
2.00	Adults 65+ with Pneumonia Vaccination	*percent*	70.1		76.6	73.3	*2019*		9
1.98	People 65+ Living Below Poverty Level	*percent*	9.6		7.7	9.3	*2015-2019*	.1) White (7.9) NHPI (0) Mult (0) H	1
1.88	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	26.7			28.4	*2018*		3
1.88	Adults with Arthritis	*percent*	32.3			25.8	*2018*		3
1.83	Heart Failure: Medicare Population	*percent*	14.1		12.6	14	*2018*		5
1.68	Ischemic Heart Disease: Medicare Population	*percent*	27.7		26.4	26.8	*2018*		5
1.68	People 65+ Living Alone	*percent*	27.1		26	26.1	*2015-2019*		1
1.43	Depression: Medicare Population	*percent*	16.7		18	18.4	*2018*		5
1.43	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	33.3		34.6	33.5	*2018*		5
1.35	People 65+ with Low Access to a Grocery Store	*percent*	1.9				*2015*		23
1.33	Age-Adjusted Hospitalization Rate Related to Alzheimer's and Other Dementias	*hospitalizations/ 100,000 population*	365.1		515.5		*2017*		10
1.03	Alzheimer's Disease or Dementia: Medicare Population	*percent*	10		11.3	10.8	*2018*		5
0.93	Cancer: Medicare Population	*percent*	8.2		9.2	8.4	*2018*		5
0.88	Osteoporosis: Medicare Population	*percent*	4.8		6.4	6.6	*2018*		5
0.78	Asthma: Medicare Population	*percent*	4.2		5.4	5	*2018*		5

SCORE	**ORAL HEALTH**	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.30	Adults who Visited a Dentist	*percent*	52		66.3	67.6	*2018*		9
2.30	Adults with No Tooth Extractions	*percent*	45.5		60.3	58.9	*2018*		9
2.10	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	13.8		11.1	11.8	*2013-2017*		17
2.03	Adults 65+ with Total Tooth Loss	*percent*	18.8			13.5	*2018*		3
1.98	Age-Adjusted ER Visit Rate due to Dental Problems	*ER Visits/ 100,000 population*	982.2		362.7		*2017*		10
0.53	Children who Visited a Dentist	*percent*	71.5		63.7		*2017*		10
0.45	Dentist Rate	*dentists/ 100,000 population*	210.8		79.4		*2019*		6

SCORE	OTHER CONDITIONS	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.78	Chronic Kidney Disease: Medicare Population	*percent*	31.7		25.1	24.5	*2018*		5
1.88	Adults with Arthritis	*percent*	32.3			25.8	*2018*		3
1.88	Adults with Kidney Disease	*Percent of adults*	3.5			3.1	*2018*		3
1.43	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	33.3		34.6	33.5	*2018*		5
0.88	Osteoporosis: Medicare Population	*percent*	4.8		6.4	6.6	*2018*		5

SCORE	PHYSICAL ACTIVITY	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.45	Adults with a Healthy Weight	*percent*	20.2		35.1	35.2	*2014*		10
2.30	Adults who are Overweight or Obese	*percent*	89.6		66.1	66.7	*2019*		9
2.28	Food Environment Index		6.5		8.7	7.8	*2021*		6
2.25	Access to Exercise Opportunities	*percent*	61		92.6	84	*2020*		6
2.18	Adults Who Are Obese	*percent*	66.7		32.1	32.1	*2019*		9
2.10	Low-Income and Low Access to a Grocery Store	*percent*	12				*2015*		23
1.98	Adolescents who are Obese	*percent*	18.8		12.6		*2016*		10
1.95	Households with No Car and Low Access to a Grocery Store	*percent*	5				*2015*		23
1.95	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		23
1.88	Adults Engaging in Regular Physical Activity	*percent*	39.2	28.4	51.8		*2019*		9
1.80	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0				*2016*		23
1.65	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*		23
1.65	People with Low Access to a Grocery Store	*percent*	22.7				*2015*		23
1.63	SNAP Certified Stores	*stores/ 1,000 population*	0.7				*2017*		23
1.35	People 65+ with Low Access to a Grocery Store	*percent*	1.9				*2015*		23
1.20	Children with Low Access to a Grocery Store	*percent*	2.6				*2015*		23
1.05	Farmers Market Density	*markets/ 1,000 population*	0.1				*2018*		23
0.93	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.4				*2016*		23
0.23	Workers who Walk to Work	*percent*	6.5		2.3	2.7	*2015-2019*	e (3.1) Asian (7.1) NHPI (0) Mult (0)	1

SCORE	PREVENTION & SAFETY	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.53	Severe Housing Problems	*percent*	24.5		16.2	18	*2013-2017*		6
2.23	Pedestrian Injuries	*injuries/ 100,000 population*	92.6		53.5		*2017*		10
1.63	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	27.2		38.3	21	*2017-2019*		6
1.50	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	33.7	43.2	26.6	39.7	*2012-2014*		10

SCORE	RESPIRATORY DISEASES	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.55	Adults with Asthma	*percent*	23.6		14.9	14.9	*2019*		9
2.53	COPD: Medicare Population	*percent*	15.2		10.2	11.5	*2018*		5
2.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	100		7.3	2.8	*9-Jul-21*		8
2.35	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	68.2	25.1	37.2	38.5	*2013-2017*		17
2.23	Age-Adjusted ER Rate due to Asthma	*ER visits/ 10,000 population*	122.9		68.4		*2017*		10
2.18	Adults with Current Asthma	*percent*	11			9.2	*2018*		3
2.10	Adults with Influenza Vaccination	*percent*	29.5		41.7		*2014*		10
2.03	Adults 65+ with Influenza Vaccination	*percent*	61.7		68.7	64	*2019*		9
2.03	Adults with COPD	*Percent of adults*	9.3			6.9	*2018*		3
2.03	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	79.7		56.4	58.3	*2013-2017*		17
2.00	Adults 65+ with Pneumonia Vaccination	*percent*	70.1		76.6	73.3	*2019*		9
1.93	Adults who Smoke	*percent*	16.9	5	13.1	16	*2019*		9
1.58	Adolescents who Use Tobacco	*percent*	22		23		*2016*		10
1.58	Teens who Smoke Cigarettes: High School Students	*percent*	9.7		5		*2018*		16
0.78	Asthma: Medicare Population	*percent*	4.2		5.4	5	*2018*		5
0.63	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0	1.4	3.5	2.8	*2018*		10
0.48	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	0.6		1.2	6.1	*9-Jul-21*		8

SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.30	Gonorrhea Incidence Rate	*cases/ 100,000 population*	266.2		170.3	179.1	*2018*		10
2.20	Chlamydia Incidence Rate	*cases/ 100,000 population*	721.5		586.3	539.9	*2018*		10
2.08	HIV Diagnosis Rate	*cases/ 100,000 population*	26.5		22.1		*2016*		10
1.00	Syphilis Incidence Rate	*cases/ 100,000 population*	7.7		12.2	10.8	*2018*		10

SCORE	TOBACCO USE	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.93	Adults who Smoke	*percent*	16.9	5	13.1	16	*2019*		9
1.58	Adolescents who Use Tobacco	*percent*	22		23		*2016*		10
1.58	Teens who Smoke Cigarettes: High School Students	*percent*	9.7		5		*2018*		16

SCORE	WEIGHT STATUS	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.45	Adults with a Healthy Weight	*percent*	20.2		35.1	35.2	*2014*		10
2.30	Adults who are Overweight or Obese	*percent*	89.6		66.1	66.7	*2019*		9
2.18	Adults Who Are Obese	*percent*	66.7		32.1	32.1	*2019*		9
1.98	Adolescents who are Obese	*percent*	18.8		12.6		*2016*		10

SCORE	WELLNESS & LIFESTYLE	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.48	Insufficient Sleep	*percent*	41.8	31.4	37.7	35	*2018*		6
2.25	Frequent Physical Distress	*percent*	14.8		10.1	11	*2018*		6
2.05	Self-Reported General Health Assessment: Good or Better	*percent*	72.7		85.8	82	*2019*		9
1.95	Life Expectancy	*years*	75.5		79.2	79.2	*2017-2019*		6
1.95	Poor Physical Health: 14+ Days	*percent*	16.1		9		*2016*		9
1.93	Self-Reported Good Physical Health	*percent*	68.8		76.4		*2019*		9
1.85	Average Life Expectancy	*years*	75.5		79.2		*2017-2019*		10

SCORE	WOMEN'S HEALTH	UNITS	SOMERSET COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.63	Breast Cancer Incidence Rate	*cases/ 100,000 females*	141.7		132.9	125.9	*2013-2017*		17
1.95	Mammogram in Past 2 Years: 50+	*percent*	58.5		66.3		*2016*		9
1.88	Cervical Cancer Screening: 21-65	*Percent*	82.5			84.7	*2018*		3
1.60	Mammogram in Past 2 Years: 50-74	*percent*	72.5	77.1		74.8	*2018*		3
1.38	Pap Test in Past 3 Years	*percent*	69.8		70.3		*2018*		9
0.30	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	19.3	15.3	24.5	22.6	*2006-2010*		17

SUSSEX DATA SCORING

SUSSEX SOURCES

Key	Source
1	American Community Survey
2	American Lung Association
3	Behavioral Risk Factor Surveillance System
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	County Health Rankings
8	Delaware Department of Health and Social Services, Division of Public Health
9	Delaware Office of the State Election Commissioner
10	Delaware School Survey
11	Delaware Youth Risk Behavior Survey
12	Feeding America
13	Healthy Communities Institute
14	National Cancer Institute
15	National Center for Education Statistics
16	National Environmental Public Health Tracking Network
17	U.S. Bureau of Labor Statistics
18	U.S. Census - County Business Patterns
19	U.S. Census Bureau - Small Area Health Insurance Estimates
20	U.S. Department of Agriculture - Food Environment Atlas
21	U.S. Environmental Protection Agency
22	United For ALICE

SUSSEX TOPICS

Health and Quality of Life Topics	Score
Other Conditions	1.93
Prevention & Safety	1.86
Heart Disease & Stroke	1.78
Alcohol & Drug Use	1.72
Oral Health	1.69
Wellness & Lifestyle	1.67
Health Care Access & Quality	1.59
Adolescent Health	1.53
Physical Activity	1.47
Older Adults	1.47
Community	1.39
Environmental Health	1.34
Mental Health & Mental Disorders	1.32
Respiratory Diseases	1.30
Education	1.28
Children's Health	1.27
Immunizations & Infectious Diseases	1.27
Economy	1.23
Diabetes	1.14
Cancer	1.13
Sexually Transmitted Infections	1.13
Women's Health	1.12

SUSSEX COUNTY INDICATORS

SCORE	ADOLESCENT HEALTH	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.97	Teens who Use Illicit Drugs	*percent*	7		5		*2019*		10
1.83	Teens who Use Alcohol: 11th Graders	*percent*	33		24		*2019*		10
1.69	Teens who Smoke: 11th Graders	*percent*	5		3		*2019*		10
1.67	Teen Birth Rate: 15-19	*live births/ 1,000 females aged 15-19*	25.6		18.2	19.1	*2015-2019*	Black (42.9) White (14.5)	8
1.47	Teens who Use Marijuana: 11th Graders	*percent*	24		24		*2019*		10
1.31	Teens who Engage in Regular Physical Activity: High School Students	*percent*	45.2		43.6		*2017*		11
0.75	Teens who are Sexually Active	*percent*	44.8		45.4		*2017*		11

SCORE	ALCOHOL & DRUG USE	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.42	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	37		40.4	21	*2017-2019*		7
1.97	Teens who Use Illicit Drugs	*percent*	7		5		*2019*		10
1.92	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	46.6		43.8	22.8	*2017-2019*		5
1.86	Liquor Store Density	*stores/ 100,000 population*	27.3		26.8	10.5	*2019*		18
1.83	Teens who Use Alcohol: 11th Graders	*percent*	33		24		*2019*		10
1.47	Teens who Use Marijuana: 11th Graders	*percent*	24		24		*2019*		10
1.22	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	26.9	28.3	26	27	*2015-2019*		7
1.06	Adults who Binge Drink	*percent*	14.8		17.2	16.8	*2019*		3

SCORE	CANCER	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.58	Cancer: Medicare Population	*percent*	9.4		9.1	8.4	*2018*		6
2.08	Adults with Cancer	*percent*	9.7			6.9	*2018*		4
1.69	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	67.6		66.9	58.3	*2013-2017*		14
1.61	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22	15.3	21.4	20.1	*2013-2017*		14
1.33	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	44.4	25.1	43.2	38.5	*2013-2017*		14
1.33	Mammogram in Past 2 Years: 50+	*percent*	80		78.9		*2018*		3
1.25	Cervical Cancer Screening: 21-65	*Percent*	85.5			84.7	*2018*		4
1.19	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	12.2		12.6	11.8	*2013-2017*		14
1.17	Breast Cancer Incidence Rate	*cases/ 100,000 females*	124		134.7	125.9	*2013-2017*		14
1.11	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	161.6	122.7	164.8	155.5	*2013-2017*		14
1.06	Mammogram in Past 2 Years: 50-74	*percent*	77.6	77.1		74.8	*2018*		4
1.03	Pap Test in Past 3 Years	*percent*	84.3		83		*2018*		3
0.94	Colon Cancer Screening	*percent*	70	74.4		66.4	*2018*		4
0.75	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	105.6		124.5	104.5	*2013-2017*		14
0.44	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	11.7	8.9	13.3	13.7	*2013-2017*		14
0.42	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	35.3		37.9	38.4	*2013-2017*		14
0.36	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.2		7.8	7.6	*2013-2017*		14
0.00	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	13.7	16.9	17.2	19	*2013-2017*		14

SCORE	CHILDREN'S HEALTH	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.72	Children with Health Insurance	*percent*	95.4		96.4		*2018*		19
1.50	Child Food Insecurity Rate	*percent*	17.9		19	15.2	*2018*		12
1.33	Projected Child Food Insecurity Rate	*percent*	28				*2020*		12
1.25	Children with Asthma: Grades 6,7,8	*percent*	19.8		22		*2015*		11
1.17	Children with Low Access to a Grocery Store	*percent*	2.7				*2015*		20
0.67	Food Insecure Children Likely Ineligible for Assistance	*percent*	3		21	25	*2018*		12

SCORE	COMMUNITY	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.75	Workers who Walk to Work	*percent*	1.1		2.1	2.7	*2015-2019*	Asian (1.9) AIAN (4) NHPI (0) Mult ((	1
2.50	Workers Commuting by Public Transportation	*percent*	0.4	5.3	2.5	5	*2015-2019*	) Asian (1.2) AIAN (2) NHPI (0) Mult (	1
2.25	Solo Drivers with a Long Commute	*percent*	37.4		35.1	37	*2015-2019*		7
2.03	Children Living Below Poverty Level	*percent*	20.6		17.5	18.5	*2015-2019*		1
2.03	Youth not in School or Working	*percent*	2.2		1.9	1.9	*2015-2019*		1
1.75	Persons with an Internet Subscription	*percent*	83.6		87.7	86.2	*2015-2019*		1
1.69	Workers who Drive Alone to Work	*percent*	83.1		80.9	76.3	*2015-2019*		1
1.67	Households with an Internet Subscription	*percent*	81.4		85.2	83	*2015-2019*		1
1.67	Households with No Car and Low Access to a Grocery Store	*percent*	2.4				*2015*		20
1.67	Households with One or More Types of Computing Devices	*percent*	89.4		91.6	90.3	*2015-2019*		1
1.64	Mean Travel Time to Work	*minutes*	26.4		26.3	26.9	*2015-2019*		1
1.64	Social Associations	*membership associations/ 10,000 population*	10.2		10.4	9.3	*2018*		7
1.58	Homeownership	*percent*	53.3		59.7	56.2	*2015-2019*		1
1.25	People 25+ with a Bachelor's Degree or Higher	*percent*	28.3		32	32.1	*2015-2019*		1
1.22	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	26.9	28.3	26	27	*2015-2019*		7
1.17	Voter Turnout: Presidential Election	*percent*	71.3		68.8		*2020*		9
1.08	People 25+ with a High School Degree or Higher	*percent*	88.1		90	88	*2015-2019*		1
0.86	Single-Parent Households	*percent*	24.7		27.9	25.5	*2015-2019*		1
0.83	Violent Crime Rate	*crimes/ 100,000 population*	406.1		499	386.5	*2014-2016*		7
0.81	Age-Adjusted Death Rate due to Homicide	*deaths/ 100,000 population*	3.3	5.5	7	5.8	*2014-2018*		8
0.75	Median Household Income	*dollars*	63162		68287	62843	*2015-2019*		1
0.58	Per Capita Income	*dollars*	35491		35450	34103	*2015-2019*		1
0.50	People Living Below Poverty Level	*percent*	11.3	8	11.8	13.4	*2015-2019*	an (4.2) AIAN (19.5) NHPI (0) Mult (2	1
0.36	Households without a Vehicle	*percent*	3.9		6	8.6	*2015-2019*		1
0.36	People 65+ Living Alone	*percent*	20.3		23.2	26.1	*2015-2019*		1

SCORE	DIABETES	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.22	Adults with Diabetes	*percent*	14.7		12.8	10.7	*2019*		3
0.61	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	16.6		18.6	21.2	*2014-2018*		8
0.58	Diabetes: Medicare Population	*percent*	26.9		28.8	27	*2018*		6

SCORE	ECONOMY	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.25	Renters Spending 30% or More of Household Income on Rent	*percent*	50		49.1	49.6	*2015-2019*		1
2.03	Children Living Below Poverty Level	*percent*	20.6		17.5	18.5	*2015-2019*		1
2.03	Youth not in School or Working	*percent*	2.2		1.9	1.9	*2015-2019*		1
1.97	Overcrowded Households	*percent of households*	2.4		1.8		*2015-2019*		1
1.92	Homeowner Vacancy Rate	*percent*	2.5		1.8	1.6	*2015-2019*		1
1.67	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	33.4		31.8		*2016*		22
1.64	SNAP Certified Stores	*stores/ 1,000 population*	0.9				*2017*		20
1.58	Homeownership	*percent*	53.3		59.7	56.2	*2015-2019*		1
1.58	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	26.5		25.1	26.5	*2019*		1
1.53	Students Eligible for the Free Lunch Program	*percent*	41.3		37.6	42.6	*2015-2016*		15
1.50	Child Food Insecurity Rate	*percent*	17.9		19	15.2	*2018*		12
1.50	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	56.8		57.1		*2016*		22
1.50	Low-Income and Low Access to a Grocery Store	*percent*	4.6				*2015*		20
1.33	Projected Child Food Insecurity Rate	*percent*	28				*2020*		12
1.33	Projected Food Insecurity Rate	*percent*	16.6				*2020*		12
1.33	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		20
1.03	Unemployed Workers in Civilian Labor Force	*percent*	5.6		6.1	5.7	*Apr-21*		17
1.00	Food Insecurity Rate	*percent*	10.9		12.6	11.5	*2018*		12
1.00	Households that are Below the Federal Poverty Level	*percent*	9.8		11.1		*2016*		22
0.75	Median Household Income	*dollars*	63162		68287	62843	*2015-2019*		1
0.75	People Living 200% Above Poverty Level	*percent*	72.8		73.8	69.1	*2015-2019*		1
0.75	Severe Housing Problems	*percent*	14.3		14.3	18	*2013-2017*		7
0.69	Persons with Disability Living in Poverty (5-year)	*percent*	21.6		22.2	26.1	*2015-2019*		1
0.67	Food Insecure Children Likely Ineligible for Assistance	*percent*	3		21	25	*2018*		12
0.58	Families Living Below Poverty Level	*percent*	7.4		7.9	9.5	*2015-2019*	ian (2) AIAN (30.5) NHPI (0) Mult (18	1
0.58	Per Capita Income	*dollars*	35491		35450	34103	*2015-2019*		1
0.50	People Living Below Poverty Level	*percent*	11.3	8	11.8	13.4	*2015-2019*	an (4.2) AIAN (19.5) NHPI (0) Mult (2	1
0.36	People 65+ Living Below Poverty Level	*percent*	5.8		6.6	9.3	*2015-2019*	sian (4.2) AIAN (14.2) NHPI (0) Mult	1
0.25	Households with Cash Public Assistance Income	*percent*	1.9		2.2	2.4	*2015-2019*		1

SCORE	EDUCATION	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.50	Student-to-Teacher Ratio	*students/ teacher*	14.5				*2019-2020*		15
1.25	People 25+ with a Bachelor's Degree or Higher	*percent*	28.3		32	32.1	*2015-2019*		1
1.08	People 25+ with a High School Degree or Higher	*percent*	88.1		90	88	*2015-2019*		1

SCORE	ENVIRONMENTAL HEALTH	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.97	Overcrowded Households	*percent of households*	2.4		1.8		*2015-2019*		1
1.86	Liquor Store Density	*stores/ 100,000 population*	27.3		26.8	10.5	*2019*		18
1.83	Access to Exercise Opportunities	*percent*	74		86.5	84	*2020*		7
1.81	Daily Dose of UV Irradiance	*Joule per square meter*	2595		2505		*2015*		16
1.67	Households with No Car and Low Access to a Grocery Store	*percent*	2.4				*2015*		20
1.67	People 65+ with Low Access to a Grocery Store	*percent*	3.5				*2015*		20
1.64	Months of Mild Drought or Worse	*months per year*	5				*2016*		16
1.64	SNAP Certified Stores	*stores/ 1,000 population*	0.9				*2017*		20
1.50	Low-Income and Low Access to a Grocery Store	*percent*	4.6				*2015*		20
1.36	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.7				*2016*		20
1.36	Number of Extreme Heat Days	*days*	26				*2016*		16
1.36	Number of Extreme Heat Events	*events*	4				*2016*		16
1.36	Number of Extreme Precipitation Days	*days*	36				*2016*		16
1.33	People with Low Access to a Grocery Store	*percent*	14				*2015*		20
1.33	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		20
1.25	Children with Asthma: Grades 6,7,8	*percent*	19.8		22		*2015*		11
1.19	Annual Ozone Air Quality		3				*2017-2019*		2
1.17	Children with Low Access to a Grocery Store	*percent*	2.7				*2015*		20
1.17	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*		20
1.17	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*		20
1.08	PBT Released	*pounds*	261.5				*2019*		21
1.00	Annual Particle Pollution		1				*2017-2019*		2
1.00	Farmers Market Density	*markets/ 1,000 population*	0.1				*2018*		20
0.97	Food Environment Index		8.3		7.8	7.8	*2021*		7
0.89	Adults with Current Asthma	*percent*	8.5		9.8	9.7	*2019*		3
0.86	Asthma: Medicare Population	*percent*	4.5		5.2	5	*2018*		6
0.75	Severe Housing Problems	*percent*	14.3		14.3	18	*2013-2017*		7

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.22	Dentist Rate	*dentists/ 100,000 population*	24.3		49		*2019*		7
2.17	Primary Care Provider Rate	*providers/ 100,000 population*	61.9		75		*2018*		7
1.72	Children with Health Insurance	*percent*	95.4		96.4		*2018*		19
1.58	Adults who Visited a Dentist	*percent*	63.2		66.5	67.6	*2018*		3
1.44	Adults with Health Insurance: 18-64	*percent*	89.3		92		*2018*		19
1.33	Mental Health Provider Rate	*providers/ 100,000 population*	197.7		282.2		*2020*		7
1.33	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	81.1		132.9		*2020*		7
0.92	Adults who have had a Routine Checkup	*percent*	82.4			76.7	*2018*		4

SCORE	HEART DISEASE & STROKE	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.47	Ischemic Heart Disease: Medicare Population	*percent*	31.4		28.4	26.8	*2018*		6
2.42	Hypertension: Medicare Population	*percent*	65.2		63	57.2	*2018*		6
2.33	Hyperlipidemia: Medicare Population	*percent*	67.8		61.1	47.7	*2018*		6
2.31	Atrial Fibrillation: Medicare Population	*percent*	10.2		9.4	8.4	*2018*		6
2.17	High Blood Pressure Prevalence	*percent*	41.4	27.7	36.4	32.3	*2019*		3
2.08	Adults who Experienced Coronary Heart Disease	*percent*	9.9			6.8	*2018*		4
2.08	High Cholesterol Prevalence	*percent*	40.3		35.4	33.1	*2019*		3
2.03	Stroke: Medicare Population	*percent*	4.8		4.7	3.8	*2018*		6
1.92	Adults who Experienced a Stroke	*percent*	4.5			3.4	*2018*		4
1.92	High Cholesterol Prevalence: Adults 18+	*percent*	38.3			34.1	*2017*		4
1.72	Age-Adjusted Death Rate due to Heart Disease	*deaths/ 100,000 population*	166.1		159.4	165.9	*2014-2018*		8
1.36	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	34.7	33.4	41.7	37.2	*2014-2018*		8
1.36	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	37.6		33.2		*2018*		16
0.92	Adults who Have Taken Medications for High Blood Pressure	*percent*	81.6			75.8	*2017*		4
0.92	Cholesterol Test History	*percent*	84.7			81.5	*2017*		4
0.53	Heart Failure: Medicare Population	*percent*	11.2		11.5	14	*2018*		6

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.33	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	44.3	11.1	22.1		*2018*		8
2.06	Tuberculosis Incidence Rate	*cases/ 100,000 population*	2.1	1.4	1.8		*2020*		8
1.97	Overcrowded Households	*percent of households*	2.4		1.8		*2015-2019*		1
1.72	Syphilis Incidence Rate	*cases/ 100,000 population*	6.8		6.1	8.7	*2016*		8
1.56	Adults 65+ with Influenza Vaccination	*percent*	63.4		63.4	64	*2019*		3
1.25	Adults Fully Vaccinated Against COVID-19	*percent*	56.9				*10-Jun-21*		5
1.00	HIV Incidence Rate	*cases/ 100,000 population*	7.7		12.4		*2016*		8
0.94	Adults 65+ with Pneumonia Vaccination	*percent*	78.7		75.3	73.3	*2019*		3
0.89	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	9.5		13.6	14.6	*2014-2018*		8
0.89	Chlamydia Incidence Rate	*cases/ 100,000 population*	446.5		622.4	539.9	*2018*		8
0.89	Gonorrhea Incidence Rate	*cases/ 100,000 population*	132.2		174.3	179.1	*2018*		8
0.69	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	2.4		2.4	6.1	*09-Jul-21*		13
0.36	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		0	2.8	*09-Jul-21*		13

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.17	Self-Reported General Health Assessment: Good or Better	*percent*	79.1		81.3	82	*2019*		3
1.75	Depression: Medicare Population	*percent*	17.3		18.1	18.4	*2018*		6
1.67	Poor Mental Health: Average Number of Days	*days*	4.3		4.2	4.1	*2018*		7
1.50	Frequent Mental Distress	*percent*	13.8		13.1	13	*2018*		7
1.33	Mental Health Provider Rate	*providers/ 100,000 population*	197.7		282.2		*2020*		7
1.25	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	12.6	12.8	12	13.6	*2014-2018*		8
0.92	Poor Mental Health: 14+ Days	*percent*	12.2			12.7	*2018*		4
0.89	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	22		25.3	29.4	*2014-2018*		8
0.36	Alzheimer's Disease or Dementia: Medicare Population	*percent*	8.3		9.3	10.8	*2018*		6

SCORE	OLDER ADULTS	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.58	Cancer: Medicare Population	*percent*	9.4		9.1	8.4	*2018*		6
2.47	Ischemic Heart Disease: Medicare Population	*percent*	31.4		28.4	26.8	*2018*		6
2.42	Hypertension: Medicare Population	*percent*	65.2		63	57.2	*2018*		6
2.33	Hyperlipidemia: Medicare Population	*percent*	67.8		61.1	47.7	*2018*		6
2.31	Atrial Fibrillation: Medicare Population	*percent*	10.2		9.4	8.4	*2018*		6
2.14	Osteoporosis: Medicare Population	*percent*	6.7		6.1	6.6	*2018*		6
2.08	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	35.4		34.7	33.5	*2018*		6
2.03	Stroke: Medicare Population	*percent*	4.8		4.7	3.8	*2018*		6
1.92	Adults with Arthritis	*percent*	33			25.8	*2018*		4
1.75	Adults 65+ with Total Tooth Loss	*percent*	17.1			13.5	*2018*		4
1.75	Depression: Medicare Population	*percent*	17.3		18.1	18.4	*2018*		6
1.67	People 65+ with Low Access to a Grocery Store	*percent*	3.5				*2015*		20
1.58	Chronic Kidney Disease: Medicare Population	*percent*	24		25.2	24.5	*2018*		6
1.56	Adults 65+ with Influenza Vaccination	*percent*	63.4		63.4	64	*2019*		3
1.33	COPD: Medicare Population	*percent*	11.2		10.5	11.5	*2018*		6
1.08	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	33.7			32.4	*2018*		4
0.94	Adults 65+ with Pneumonia Vaccination	*percent*	78.7		75.3	73.3	*2019*		3
0.92	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	34.5			28.4	*2018*		4
0.89	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	22		25.3	29.4	*2014-2018*		8
0.86	Asthma: Medicare Population	*percent*	4.5		5.2	5	*2018*		6
0.58	Diabetes: Medicare Population	*percent*	26.9		28.8	27	*2018*		6
0.53	Heart Failure: Medicare Population	*percent*	11.2		11.5	14	*2018*		6
0.36	Alzheimer's Disease or Dementia: Medicare Population	*percent*	8.3		9.3	10.8	*2018*		6
0.36	People 65+ Living Alone	*percent*	20.3		23.2	26.1	*2015-2019*		1
0.36	People 65+ Living Below Poverty Level	*percent*	5.8		6.6	9.3	*2015-2019*	sian (4.2) AIAN (14.2) NHPI (0) Mult	1

SCORE	ORAL HEALTH	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.22	Dentist Rate	*dentists/ 100,000 population*	24.3		49		*2019*		7
1.75	Adults 65+ with Total Tooth Loss	*percent*	17.1			13.5	*2018*		4
1.58	Adults who Visited a Dentist	*percent*	63.2		66.5	67.6	*2018*		3
1.19	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	12.2		12.6	11.8	*2013-2017*		14

SCORE	OTHER CONDITIONS	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.14	Osteoporosis: Medicare Population	*percent*	6.7		6.1	6.6	*2018*		6
2.08	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	35.4		34.7	33.5	*2018*		6
1.92	Adults with Arthritis	*percent*	33			25.8	*2018*		4
1.92	Adults with Kidney Disease	*Percent of adults*	3.7			3.1	*2018*		4
1.58	Chronic Kidney Disease: Medicare Population	*percent*	24		25.2	24.5	*2018*		6

SCORE	PHYSICAL ACTIVITY	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.75	Workers who Walk to Work	*percent*	1.1		2.1	2.7	*2015-2019*	Asian (1.9) AIAN (4) NHPI (0) Mult ((	1
1.83	Access to Exercise Opportunities	*percent*	74		86.5	84	*2020*		7
1.72	Adults Who Are Obese	*percent*	35.3		34.4	32.1	*2019*		3
1.67	Households with No Car and Low Access to a Grocery Store	*percent*	2.4				*2015*		20
1.67	People 65+ with Low Access to a Grocery Store	*percent*	3.5				*2015*		20
1.64	SNAP Certified Stores	*stores/ 1,000 population*	0.9				*2017*		20
1.50	Low-Income and Low Access to a Grocery Store	*percent*	4.6				*2015*		20
1.44	Adults who are Overweight or Obese	*percent*	70.4		68.9	66.7	*2019*		3
1.36	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.7				*2016*		20
1.33	People with Low Access to a Grocery Store	*percent*	14				*2015*		20
1.33	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		20
1.31	Teens who Engage in Regular Physical Activity: High School Students	*percent*	45.2		43.6		*2017*		11
1.17	Children with Low Access to a Grocery Store	*percent*	2.7				*2015*		20
1.17	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*		20
1.17	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*		20
1.00	Farmers Market Density	*markets/ 1,000 population*	0.1				*2018*		20
0.97	Food Environment Index		8.3		7.8	7.8	*2021*		7

SCORE	PREVENTION & SAFETY	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.42	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	58.8	43.2	55.2	45.7	*2014-2018*		8
2.42	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	37		40.4	21	*2017-2019*		7
0.75	Severe Housing Problems	*percent*	14.3		14.3	18	*2013-2017*		7

SCORE	RESPIRATORY DISEASES	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.06	Tuberculosis Incidence Rate	*cases/ 100,000 population*	2.1	1.4	1.8		*2020*		8
2.03	Adults who Smoke	*percent*	18.8	5	15.9	16	*2019*		3
1.92	Adults with COPD	*Percent of adults*	9.7			6.9	*2018*		4
1.69	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	67.6		66.9	58.3	*2013-2017*		14
1.69	Teens who Smoke: 11th Graders	*percent*	5		3		*2019*		10
1.56	Adults 65+ with Influenza Vaccination	*percent*	63.4		63.4	64	*2019*		3
1.33	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	44.4	25.1	43.2	38.5	*2013-2017*		14
1.33	COPD: Medicare Population	*percent*	11.2		10.5	11.5	*2018*		6
1.25	Children with Asthma: Grades 6,7,8	*percent*	19.8		22		*2015*		11
0.94	Adults 65+ with Pneumonia Vaccination	*percent*	78.7		75.3	73.3	*2019*		3
0.89	Adults with Current Asthma	*percent*	8.5		9.8	9.7	*2019*		3
0.89	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	9.5		13.6	14.6	*2014-2018*		8
0.86	Asthma: Medicare Population	*percent*	4.5		5.2	5	*2018*		6
0.69	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	2.4		2.4	6.1	*09-Jul-21*		13
0.36	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		0	2.8	*09-Jul-21*		13

SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.72	Syphilis Incidence Rate	*cases/ 100,000 population*	6.8		6.1	8.7	*2016*		8
1.00	HIV Incidence Rate	*cases/ 100,000 population*	7.7		12.4		*2016*		8
0.89	Chlamydia Incidence Rate	*cases/ 100,000 population*	446.5		622.4	539.9	*2018*		8
0.89	Gonorrhea Incidence Rate	*cases/ 100,000 population*	132.2		174.3	179.1	*2018*		8

SCORE	WELLNESS & LIFESTYLE	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.17	Self-Reported General Health Assessment: Good or Better	*percent*	79.1		81.3	82	*2019*		3
1.92	Poor Physical Health: 14+ Days	*percent*	15.5			12.5	*2018*		4
1.83	Frequent Physical Distress	*percent*	13.3		11.3	11	*2018*		7
1.25	Insufficient Sleep	*percent*	35.7	31.4	36.5	35	*2018*		7
1.17	Life Expectancy	*years*	78.7		78.5	79.2	*2017-2019*		7

SCORE	WOMEN'S HEALTH	UNITS	SUSSEX COUNTY	HP2030	DE	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.61	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22	15.3	21.4	20.1	*2013-2017*		14
1.33	Mammogram in Past 2 Years: 50+	*percent*	80		78.9		*2018*		3
1.25	Cervical Cancer Screening: 21-65	*Percent*	85.5			84.7	*2018*		4
1.17	Breast Cancer Incidence Rate	*cases/ 100,000 females*	124		134.7	125.9	*2013-2017*		14
1.06	Mammogram in Past 2 Years: 50-74	*percent*	77.6	77.1		74.8	*2018*		4
1.03	Pap Test in Past 3 Years	*percent*	84.3		83		*2018*		3
0.36	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.2		7.8	7.6	*2013-2017*		14

WICOMICO DATA SCORING

WICOMICO SOURCES

Key	Sources
1	American Community Survey
2	Annie E. Casey Foundation
3	CDC - PLACES
4	Centers for Disease Control and Prevention
5	Centers for Medicare & Medicaid Services
6	County Health Rankings
7	Feeding America
8	Healthy Communities Institute
9	Maryland Behavioral Risk Factor Surveillance System
10	Maryland Department of Health
11	Maryland Department of the Environment
12	Maryland Governor's Office for Children
13	Maryland Governor's Office of Crime Control & Prevention
14	Maryland State Board of Elections
15	Maryland State Department of Education
16	Maryland Youth Risk Behavior Survey/Youth Tobacco Survey
17	National Cancer Institute
18	National Center for Education Statistics
19	National Environmental Public Health Tracking Network
20	U.S. Bureau of Labor Statistics
21	U.S. Census - County Business Patterns
22	U.S. Census Bureau - Small Area Health Insurance Estimates
23	U.S. Department of Agriculture - Food Environment Atlas
24	U.S. Environmental Protection Agency
25	United For ALICE

WICOMICO TOPICS

Health and Quality of Life Topics	Score
Diabetes	2.07
Sexually Transmitted Infections	1.98
Wellness & Lifestyle	1.91
Cancer	1.86
Other Conditions	1.85
Prevention & Safety	1.85
Education	1.83
Older Adults	1.82
Oral Health	1.80
Weight Status	1.80
Heart Disease & Stroke	1.79
Community	1.77
Physical Activity	1.75
Mental Health & Mental Disorders	1.73
Environmental Health	1.71
Respiratory Diseases	1.68
Immunizations & Infectious Diseases	1.67
Economy	1.67
Children's Health	1.62
Women's Health	1.61
Tobacco Use	1.58
Maternal, Fetal & Infant Health	1.47
Health Care Access & Quality	1.45
Adolescent Health	1.42
Alcohol & Drug Use	1.36

WICOMICO COUNTY INDICATORS

SCORE	ADOLESCENT HEALTH	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.95	Adolescents who are Obese	*percent*	16.1		12.6		*2016*		10
1.48	Adolescents who have had a Routine Checkup: Medicaid Population	*percent*	56.2		54.6		*2017*		10
1.45	Teen Birth Rate: 15-19	*live births/ 1,000 females aged 15-19*	15.9		13.9	16.7	*2019*	Black (33.4) White (8) Hisp (33.8)	10
1.43	Teens who Smoke Cigarettes: High School Students	*percent*	6.9		5		*2018*		16
0.78	Adolescents who Use Tobacco	*percent*	16.1		23		*2016*		10

SCORE	ALCOHOL & DRUG USE	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.10	Age-Adjusted Death Rate due to Drug Use	*deaths/ 100,000 population*	30.5		30.9	20.3	*2015-2017*		10
1.78	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	32.3		38.3	21	*2017-2019*		6
1.58	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	37.3		38.2	22.8	*2017-2019*		4
1.50	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	27.9	28.3	28.8	27	*2015-2019*		6
1.38	Age-Adjusted ER Rate due to Alcohol/Substance Abuse	*ER visits/ 100,000 population*	1643.3		2017		*2017*		10
0.70	Adults who Binge Drink	*percent*	11.9		14.8	16.8	*2019*		9
0.48	Liquor Store Density	*stores/ 100,000 population*	5.8		20.5	10.5	*2019*		21

SCORE	CANCER	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.78	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	79.3		56.4	58.3	*2013-2017*		17
2.60	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	19.4	8.9	13.7	13.7	*2013-2017*		17
2.60	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	27.6	16.9	20	19	*2013-2017*		17
2.53	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	15.3		11.1	11.8	*2013-2017*		17
2.50	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	197.7	122.7	155.1	155.5	*2013-2017*		17
2.38	Breast Cancer Incidence Rate	*cases/ 100,000 females*	142.6		132.9	125.9	*2013-2017*		17
2.28	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	140		124.7	104.5	*2013-2017*	Black (242.7) White (115.1)	17
2.23	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	8.7		6.6	7.6	*2013-2017*		17
1.95	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	52.6	25.1	37.2	38.5	*2013-2017*		17
1.73	Cervical Cancer Screening: 21-65	*Percent*	84			84.7	*2018*		3
1.70	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	21.4	15.3	21.7	20.1	*2013-2017*		17
1.68	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	40.7		36.4	38.4	*2013-2017*		17
1.63	Cancer: Medicare Population	*percent*	8.7		9.2	8.4	*2018*		5
1.20	Colon Cancer Screening: Sigmoidoscopy or Colonoscopy	*percent*	77.8		75.7		*2018*		9
1.20	Pap Test in Past 3 Years	*percent*	75.6		70.3		*2018*		9
1.15	Colon Cancer Screening	*percent*	67.6	74.4		66.4	*2018*		3
1.13	Adults with Cancer	*percent*	6.9			6.9	*2018*		3
1.08	Mammogram in Past 2 Years: 50+	*percent*	89		82		*2018*		9
0.95	Mammogram in Past 2 Years: 50-74	*percent*	78.2	77.1		74.8	*2018*		3

SCORE	CHILDREN'S HEALTH	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.10	Child Food Insecurity Rate	*percent*	20.4		16.1	15.2	*2018*		7
1.93	Child Abuse Rate	*cases/ 1,000 children*	6.3		5.7		*2018*		12
1.80	Children with Low Access to a Grocery Store	*percent*	6.4				*2015*		23
1.78	Blood Lead Levels in Children	*percent*	0.3		0.2		*2019*		11
1.78	Children who Visited a Dentist	*percent*	60		63.7		*2017*		10
1.65	Projected Child Food Insecurity Rate	*percent*	30.4				*2020*		7
1.50	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.4		1.7		*2014*		19
1.30	Children with Health Insurance	*percent*	96.2		96.8		*2018*		22
0.75	Food Insecure Children Likely Ineligible for Assistance	*percent*	9		32	25	*2018*		7

SCORE	COMMUNITY	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.63	Homeownership	*percent*	51.4		60.2	56.2	*2015-2019*		1
2.33	Violent Crime Rate	*crimes/ 100,000 population*	492.6			394	*2017*		13
2.28	Single-Parent Households	*percent*	29.9		26.4	25.5	*2015-2019*		1
2.20	People Living Below Poverty Level	*percent*	15.4	8	9.2	13.4	*2015-2019*	Black (20.7) White (11.9) Asian (3.8) AIAN (0) NHPI (0) Mult (31.1) Other (40.3) Hisp (30)	1
2.15	Workers Commuting by Public Transportation	*percent*	0.7	5.3	8.4	5	*2015-2019*	Black (2.3) White (0.2) Asian (0) AIAN (0) NHPI (0) Mult (0) Other (0.3) Hisp (0.6)	1
2.10	Domestic Violence Offense Rate	*offenses/ 100,000 population*	708.3		537.1		*2017*		10
2.08	People 25+ with a High School Degree or Higher	*percent*	87.2		90.2	88	*2015-2019*		1
2.03	Households without a Vehicle	*percent*	8.5		9	8.6	*2015-2019*		1
1.98	Children Living Below Poverty Level	*percent*	19.6		12.1	18.5	*2015-2019*	Black (26.1) White (8.9) Asian (2.1) AIAN (0) Mult (40) Other (70.5) Hisp (45.1)	1
1.98	Per Capita Income	*dollars*	28080		42122	34103	*2015-2019*	Black (20762) White (32635) Asian (27998) AIAN (13415) NHPI (117757) Mult (14601) Other (17198) Hisp (16352)	1
1.93	Child Abuse Rate	*cases/ 1,000 children*	6.3		5.7		*2018*		12

1.93	People 25+ with a Bachelor's Degree or Higher	*percent*	27.2		40.2	32.1	*2015-2019*		1
1.93	Workers who Walk to Work	*percent*	2.1		2.3	2.7	*2015-2019*	Black (1.3) White (2.3) Asian (1.2) AIAN (0) NHPI (0) Mult (3.2) Other (12) Hisp (4.4)	1
1.83	Voter Registration	*percent*	74.7		83.6		*2016*		14
1.78	Social Associations	*membership associations/ 10,000 population*	9.1		9	9.3	*2018*		6
1.73	Persons with an Internet Subscription	*percent*	82.4		89.4	86.2	*2015-2019*		1
1.65	Households with an Internet Subscription	*percent*	80.9		86.7	83	*2015-2019*		1
1.65	Households with One or More Types of Computing Devices	*percent*	89.5		92.4	90.3	*2015-2019*		1
1.63	Pedestrian Injuries	*injuries/ 100,000 population*	40.8		53.5		*2017*		10
1.63	Persons with Health Insurance	*percent*	92.1	92.1	93.1		*2018*		22
1.58	Age-Adjusted Death Rate due to Homicide	*deaths/ 100,000 population*	7.1	5.5	8.4	5.6	*2008-2010*		10
1.58	Median Household Income	*dollars*	56956		84805	62843	*2015-2019*		1
1.58	Workers who Drive Alone to Work	*percent*	82.5		73.9	76.3	*2015-2019*		1
1.53	People 65+ Living Alone	*percent*	26.8		26	26.1	*2015-2019*		1
1.50	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	27.9	28.3	28.8	27	*2015-2019*		6
1.50	Households with No Car and Low Access to a Grocery Store	*percent*	2.4				*2015*		23
0.88	Mean Travel Time to Work	*minutes*	21.9		33.2	26.9	*2015-2019*		1
0.88	Solo Drivers with a Long Commute	*percent*	25.8		50.2	37	*2015-2019*		6
0.78	Youth not in School or Working	*percent*	1.4		1.9	1.9	*2015-2019*		1

SCORE	**DIABETES**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.48	Age-Adjusted ER Rate due to Diabetes	*ER Visits/ 100,000 population*	530.9		243.7		*2017*		10
1.98	Diabetes: Medicare Population	*percent*	31		29.6	27	*2018*		5
1.95	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	21.7		20.1	21.5	*2017-2019*		10
1.85	Adults with Diabetes	*percent*	10.9		10	10.7	*2019*		9

SCORE	**ECONOMY**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.63	Homeownership	*percent*	51.4		60.2	56.2	*2015-2019*		1
2.28	Severe Housing Problems	*percent*	20		16.2	18	*2013-2017*		6
2.23	Renters Spending 30% or More of Household Income on Rent	*percent*	54.3		49.7	49.6	*2015-2019*		1
2.20	People Living Below Poverty Level	*percent*	15.4	8	9.2	13.4	*2015-2019*	Black (20.7) White (11.9) Asian (3.8) AIAN (0) NHPI (0) Mult (31.1) Other (40.3) Hisp (30)	1
2.10	Child Food Insecurity Rate	*percent*	20.4		16.1	15.2	*2018*		7
2.10	Food Insecurity Rate	*percent*	13.3		11	11.5	*2018*		7
2.08	Overcrowded Households	*percent of households*	2.9		2.3		*2015-2019*		1
1.98	Children Living Below Poverty Level	*percent*	19.6		12.1	18.5	*2015-2019*	Black (26.1) White (8.9) Asian (2.1) AIAN (0) Mult (40) Other (70.5) Hisp (45.1)	1
1.98	Per Capita Income	*dollars*	28080		42122	34103	*2015-2019*	Black (20762) White (32635) Asian (27998) AIAN (13415) NHPI (117757) Mult (14601) Other (17198) Hisp (16352)	1
1.95	Low-Income and Low Access to a Grocery Store	*percent*	8.9				*2015*		23
1.95	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		23
1.83	Households that are Below the Federal Poverty Level	*percent*	13.4		9		*2018*		25
1.83	Households with Cash Public Assistance Income	*percent*	2.5		2.2	2.4	*2015-2019*		1
1.83	People Living 200% Above Poverty Level	*percent*	65.2		78.4	69.1	*2015-2019*		1
1.80	Projected Food Insecurity Rate	*percent*	18.8				*2020*		7
1.80	Students Eligible for the Free Lunch Program	*percent*	49.7				*2019-2020*		18
1.78	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	56.5		61		*2018*		25
1.78	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	30		30		*2018*		25
1.73	Unemployed Workers in Civilian Labor Force	*percent*	6.2		5.9	5.7	*Apr-21*		20
1.65	Projected Child Food Insecurity Rate	*percent*	30.4				*2020*		7
1.63	Persons with Disability Living in Poverty (5-year)	*percent*	23.1		20.9	26.1	*2015-2019*		1
1.58	Median Household Income	*dollars*	56956		84805	62843	*2015-2019*		1
1.48	People 65+ Living Below Poverty Level	*percent*	7.8		7.7	9.3	*2015-2019*	Black (15) White (6.1) Asian (0) AIAN (0) Mult (10.1) Other (20.9) Hisp (20.2)	1
1.28	Families Living Below Poverty Level	*percent*	8.6		6.1	9.5	*2015-2019*	Black (15.8) White (5.1) Asian (3.4) AIAN (0) NHPI (0) Mult (8.2) Other (57.8) Hisp (25.8)	1
1.23	SNAP Certified Stores	*stores/ 1,000 population*	0.9				*2017*		23
0.78	Affordable Housing	*percent*	88.4		48.1		*2016*		10
0.78	Youth not in School or Working	*percent*	1.4		1.9	1.9	*2015-2019*		1
0.75	Food Insecure Children Likely Ineligible for Assistance	*percent*	9		32	25	*2018*		7
0.63	Homeowner Vacancy Rate	*percent*	1.2		1.7	1.6	*2015-2019*		1
0.48	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	19.7		26	26.5	*2019*		1

SCORE	**EDUCATION**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.08	People 25+ with a High School Degree or Higher	*percent*	87.2		90.2	88	*2015-2019*		1

2.08	School Readiness at Kindergarten Entry	*percent*	41		47		*2019-2020*		15
1.93	3rd Grade Students Proficient in Math	*percent*	38.2		42.5		*2019*		2
1.93	8th Grade Students Proficient in Math	*percent*	10.9		12.5		*2019*		2
1.93	High School Graduation	*percent*	83.9	90.7	86.8		*2020*		15
1.93	People 25+ with a Bachelor's Degree or Higher	*percent*	27.2		40.2	32.1	*2015-2019*		1
1.83	8th Grade Students Proficient in Reading	*percent*	34.9		45.1		*2019*		2
1.68	3rd Grade Students Proficient in Reading	*percent*	33		41.2		*2019*		2
1.08	Student-to-Teacher Ratio	*students/ teacher*	13.3				*2019-2020*		18

SCORE	**ENVIRONMENTAL HEALTH**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.28	Severe Housing Problems	*percent*	20		16.2	18	*2013-2017*		6
2.23	Age-Adjusted ER Rate due to Asthma	*ER visits/ 10,000 population*	102.9		68.4		*2017*		10
2.18	Daily Dose of UV Irradiance	*Joule per square meter*	2653		2499		*2015*		19
2.08	Overcrowded Households	*percent of households*	2.9		2.3		*2015-2019*		1
1.98	Food Environment Index		7.4		8.7	7.8	*2021*		6
1.95	Grocery Store Density	*stores/ 1,000 population*	0.1				*2016*		23
1.95	Low-Income and Low Access to a Grocery Store	*percent*	8.9				*2015*		23
1.95	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		23
1.88	Adults with Current Asthma	*percent*	10.4			9.2	*2018*		3
1.85	Adults with Asthma	*percent*	15.2		14.9	14.9	*2019*		9
1.80	Access to Exercise Opportunities	*percent*	77.2		92.6	84	*2020*		6
1.80	Children with Low Access to a Grocery Store	*percent*	6.4				*2015*		23
1.80	People 65+ with Low Access to a Grocery Store	*percent*	4				*2015*		23
1.80	People with Low Access to a Grocery Store	*percent*	26.7				*2015*		23
1.78	Blood Lead Levels in Children	*percent*	0.3		0.2		*2019*		11
1.68	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.8				*2016*		23
1.65	Farmers Market Density	*markets/ 1,000 population*	0				*2018*		23
1.63	Months of Mild Drought or Worse	*months per year*	5				*2016*		19
1.63	Number of Extreme Precipitation Days	*days*	43				*2016*		19
1.53	Asthma: Medicare Population	*percent*	5.2		5.4	5	*2018*		5
1.50	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.4		1.7		*2014*		19
1.50	Households with No Car and Low Access to a Grocery Store	*percent*	2.4				*2015*		23
1.50	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*		23
1.38	Number of Extreme Heat Days	*days*	20				*2016*		19
1.38	Number of Extreme Heat Events	*events*	4				*2016*		19
1.38	PBT Released	*pounds*	0				*2018*		24
1.23	SNAP Certified Stores	*stores/ 1,000 population*	0.9				*2017*		23
0.48	Liquor Store Density	*stores/ 100,000 population*	5.8		20.5	10.5	*2019*		21

SCORE	**HEALTH CARE ACCESS & QUALITY**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.30	Adults who Visited a Dentist	*percent*	56.3		66.3	67.6	*2018*		9
2.23	Adults Unable to Afford to See a Doctor	*percent*	16.1		11.4		*2019*		9
1.78	Children who Visited a Dentist	*percent*	60		63.7		*2017*		10
1.70	Primary Care Provider Rate	*providers/ 100,000 population*	62		88.6		*2018*		6
1.68	Adults who have had a Routine Checkup	*percent*	87		90		*2019*		9
1.63	Persons with Health Insurance	*percent*	92.1	92.1	93.1		*2018*		22
1.60	Adults with Health Insurance: 18-64	*percent*	90.5		91.7		*2018*		22
1.48	Adolescents who have had a Routine Checkup: Medicaid Population	*percent*	56.2		54.6		*2017*		10
1.38	Uninsured Emergency Department Visits	*percent*	8.3		8.6		*2017*		10
1.30	Children with Health Insurance	*percent*	96.2		96.8		*2018*		22
1.30	People with a Usual Primary Care Provider	*percent*	85.1	84	84.8		*2016*		10
1.68	Adults who have had a Routine Checkup	*percent*	87		90		*2019*		9
0.85	Dentist Rate	*dentists/ 100,000 population*	83		79.4		*2019*		6
0.45	Mental Health Provider Rate	*providers/ 100,000 population*	345.5		274.9		*2020*		6
0.45	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	217.2		115.1		*2020*		6

SCORE	**HEART DISEASE & STROKE**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.63	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	64.6	33.4	40.7	37.2	*2017-2019*		10
2.53	Hyperlipidemia: Medicare Population	*percent*	59.2		51.9	47.7	*2018*		5
2.38	Hypertension: Medicare Population	*percent*	66.9		61.2	57.2	*2018*		5
2.28	Stroke: Medicare Population	*percent*	5		4.5	3.8	*2018*		5
2.23	Age-Adjusted ER Rate due to Hypertension	*ER Visits/ 100,000 population*	743.3		351.2		*2017*		10
2.23	Atrial Fibrillation: Medicare Population	*percent*	9.2		8.2	8.4	*2018*		5
2.13	High Blood Pressure Prevalence	*percent*	38.2	27.7	32.2	32.3	*2019*		9
1.95	Age-Adjusted Hospitalization Rate due to Heart Attack	*hospitalizations/ 10,000 population 35+ years*	29.4		23.9		*2014*		19
1.75	Age-Adjusted Death Rate due to Heart Disease	*deaths/ 100,000 population*	232.2		161.9	723.5	*2017-2019*		10
1.58	Adults who Experienced a Stroke	*percent*	3.7			3.4	*2018*		3
1.58	Adults who Have Taken Medications for High Blood Pressure	*percent*	77.6			75.8	*2017*		3
1.58	High Cholesterol Prevalence: Adults 18+	*percent*	35.7			34.1	*2017*		3

1.43	Adults who Experienced Coronary Heart Disease	*percent*	7			6.8	*2018*	3
1.43	Cholesterol Test History	*percent*	82.6			81.5	*2017*	3
1.38	Heart Failure: Medicare Population	*percent*	13.2		12.6	14	*2018*	5
1.38	Ischemic Heart Disease: Medicare Population	*percent*	26.7		26.4	26.8	*2018*	5
0.93	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	33.1		43.9		*2018*	19
0.90	High Cholesterol Prevalence	*percent*	30		31.3	33.1	*2019*	9

SCORE	**IMMUNIZATIONS & INFECTIOUS DISEASES**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.55	Gonorrhea Incidence Rate	*cases/ 100,000 population*	377		170.3	179.1	*2018*		10
2.45	Chlamydia Incidence Rate	*cases/ 100,000 population*	811.3		586.3	539.9	*2018*		10
2.30	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	39.4	11.1	16.5		*2019*		10
2.23	Adults with Influenza Vaccination	*percent*	34.3		41.7		*2014*		10
2.08	Overcrowded Households	*percent of households*	2.9		2.3		*2015-2019*		1
1.78	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	1.6		1.2	6.1	*9-Jul-21*		8
1.78	HIV Diagnosis Rate	*cases/ 100,000 population*	18.5		20.4		*2017*		10
1.73	Adults Fully Vaccinated Against COVID-19	*percent*	47.6				*10-Jun-21*		4
1.70	Adults 65+ with Pneumonia Vaccination	*percent*	74.8		76.6	73.3	*2019*		9
1.43	Adults 65+ with Influenza Vaccination	*percent*	67.7		68.7	64	*2019*		9
1.13	Syphilis Incidence Rate	*cases/ 100,000 population*	4.9		12.2	10.8	*2018*		10
1.08	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.9	1.4	3.5	2.8	*2018*		10
0.70	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	8.3		16	15.2	*2012-2014*		10
0.48	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		7.3	2.8	*9-Jul-21*		8

SCORE	**MATERNAL, FETAL & INFANT HEALTH**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.40	Infant Mortality Rate	*deaths/ 1,000 live births*	8.8	5	6.4	5.8	*2014-2018*		10
1.83	Perinatal Deaths	*per 1,000 live births plus fetal deaths of 28 or more weeks gestation*	7.9		6.3		*2019*	Black (0) White (8.1) Hisp (0)	10
1.70	Babies with Low Birth Weight	*percent*	9		8.7	8.3	*2019*		10
1.45	Teen Birth Rate: 15-19	*live births/ 1,000 females aged 15-19*	15.9		13.9	16.7	*2019*	Black (33.4) White (8) Hisp (33.8)	10
0.98	Preterm Births	*percent*	9.2	9.4	10.3	10	*2019*		10
0.45	Sudden Unexpected Infant Death Rate	*deaths/ 1,000 live births*	0.8		1	0.9	*2011-2015*		10

SCORE	**MENTAL HEALTH & MENTAL DISORDERS**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.25	Poor Mental Health: Average Number of Days	*days*	4.8		3.7	4.1	*2018*		6
2.03	Depression: Medicare Population	*percent*	18.5		18	18.4	*2018*		5
2.00	Self-Reported General Health Assessment: Good or Better	*percent*	78.8		85.8	82	*2019*		9
1.98	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	12.2	12.8	9.2	12.7	*2012-2014*		10
1.95	Frequent Mental Distress	*percent*	14.6		11.4	13	*2018*		6
1.80	Age-Adjusted Hospitalization Rate Related to Alzheimer's and Other Dementias	*hospitalizations/ 100,000 population*	543.9		515.5		*2017*		10
1.80	Poor Mental Health: 14+ Days	*percent*	11.1		9.7		*2016*		9
1.80	Self-Reported Good Mental Health	*percent*	63.6		70.2		*2019*		9
1.78	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11		11.3	10.8	*2018*		5
1.15	Age-Adjusted ER Rate due to Mental Health	*ER Visits/ 100,000 population*	2863.5		3796.7		*2016*		10
0.45	Mental Health Provider Rate	*providers/ 100,000 population*	345.5		274.9		*2020*		6

SCORE	**OLDER ADULTS**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.78	Chronic Kidney Disease: Medicare Population	*percent*	31.1		25.1	24.5	*2018*		5
2.53	Hyperlipidemia: Medicare Population	*percent*	59.2		51.9	47.7	*2018*		5
2.38	Hypertension: Medicare Population	*percent*	66.9		61.2	57.2	*2018*		5
2.28	Stroke: Medicare Population	*percent*	5		4.5	3.8	*2018*		5
2.23	Atrial Fibrillation: Medicare Population	*percent*	9.2		8.2	8.4	*2018*		5
2.23	COPD: Medicare Population	*percent*	12.7		10.2	11.5	*2018*		5
2.03	Depression: Medicare Population	*percent*	18.5		18	18.4	*2018*		5
2.00	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	8.6		8.5	8.5	*2012-2014*		10
1.98	Diabetes: Medicare Population	*percent*	31		29.6	27	*2018*		5
1.88	Osteoporosis: Medicare Population	*percent*	6.4		6.4	6.6	*2018*		5
1.88	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	33.8		34.6	33.5	*2018*		5
1.80	Age-Adjusted Hospitalization Rate Related to Alzheimer's and Other Dementias	*hospitalizations/ 100,000 population*	543.9		515.5		*2017*		10
1.80	People 65+ with Low Access to a Grocery Store	*percent*	4				*2015*		23
1.78	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11		11.3	10.8	*2018*		5
1.70	Adults 65+ with Pneumonia Vaccination	*percent*	74.8		76.6	73.3	*2019*		9
1.63	Cancer: Medicare Population	*percent*	8.7		9.2	8.4	*2018*		5
1.58	Adults 65+ with Total Tooth Loss	*percent*	14.8			13.5	*2018*		3
1.58	Adults with Arthritis	*percent*	28.6			25.8	*2018*		3
1.53	Asthma: Medicare Population	*percent*	5.2		5.4	5	*2018*		5
1.53	People 65+ Living Alone	*percent*	26.8		26	26.1	*2015-2019*		1

1.48	People 65+ Living Below Poverty Level	*percent*	7.8		7.7	9.3	*2015-2019*	Black (15) White (6.1) Asian (0) AIAN (0) Mult (10.1) Other (20.9) Hisp (20.2)	1
1.43	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	32.6			32.4	*2018*		3
1.43	Adults 65+ with Influenza Vaccination	*percent*	67.7		68.7	64	*2019*		9
1.38	Heart Failure: Medicare Population	*percent*	13.2		12.6	14	*2018*		5
1.38	Ischemic Heart Disease: Medicare Population	*percent*	26.7		26.4	26.8	*2018*		5
1.13	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	32.7			28.4	*2018*		3

SCORE	**ORAL HEALTH**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.53	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	15.3		11.1	11.8	*2013-2017*		17
2.30	Adults who Visited a Dentist	*percent*	56.3		66.3	67.6	*2018*		9
1.98	Age-Adjusted ER Visit Rate due to Dental Problems	*ER Visits/ 100,000 population*	1346.1		362.7		*2017*		10
1.78	Children who Visited a Dentist	*percent*	60		63.7		*2017*		10
1.60	Adults with No Tooth Extractions	*percent*	54.9		60.3	58.9	*2018*		9
1.58	Adults 65+ with Total Tooth Loss	*percent*	14.8			13.5	*2018*		3
0.85	Dentist Rate	*dentists/ 100,000 population*	83		79.4		*2019*		6

SCORE	**OTHER CONDITIONS**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.78	Chronic Kidney Disease: Medicare Population	*percent*	31.1		25.1	24.5	*2018*		5
1.88	Osteoporosis: Medicare Population	*percent*	6.4		6.4	6.6	*2018*		5
1.88	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	33.8		34.6	33.5	*2018*		5
1.58	Adults with Arthritis	*percent*	28.6			25.8	*2018*		3
1.13	Adults with Kidney Disease	*Percent of adults*	3			3.1	*2018*		3

SCORE	**PHYSICAL ACTIVITY**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.15	Adults Who Are Obese	*percent*	37.5		32.1	32.1	*2019*		9
2.05	Adults with a Healthy Weight	*percent*	31.3		35.1	35.2	*2014*		10
1.98	Food Environment Index		7.4		8.7	7.8	*2021*		6
1.95	Adolescents who are Obese	*percent*	16.1		12.6		*2016*		10
1.95	Grocery Store Density	*stores/ 1,000 population*	0.1				*2016*		23
1.95	Low-Income and Low Access to a Grocery Store	*percent*	8.9				*2015*		23
1.95	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		23
1.93	Workers who Walk to Work	*percent*	2.1		2.3	2.7	*2015-2019*	Black (1.3) White (2.3) Asian (1.2) AIAN (0) NHPI (0) Mult (3.2) Other (12) Hisp (4.4)	1
1.80	Access to Exercise Opportunities	*percent*	77.2		92.6	84	*2020*		6
1.80	Children with Low Access to a Grocery Store	*percent*	6.4				*2015*		23
1.80	People 65+ with Low Access to a Grocery Store	*percent*	4				*2015*		23
1.80	People with Low Access to a Grocery Store	*percent*	26.7				*2015*		23
1.68	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.8				*2016*		23
1.65	Farmers Market Density	*markets/ 1,000 population*	0				*2018*		23
1.50	Households with No Car and Low Access to a Grocery Store	*percent*	2.4				*2015*		23
1.50	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*		23
1.45	Adults Engaging in Regular Physical Activity	*percent*	50.5	28.4	51.8		*2019*		9
1.23	SNAP Certified Stores	*stores/ 1,000 population*	0.9				*2017*		23
1.05	Adults who are Overweight or Obese	*percent*	66.7		66.1	66.7	*2019*		9

SCORE	**PREVENTION & SAFETY**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.28	Severe Housing Problems	*percent*	20		16.2	18	*2013-2017*		6
2.00	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	8.6		8.5	8.5	*2012-2014*		10
1.78	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	32.3		38.3	21	*2017-2019*		6
1.63	Pedestrian Injuries	*injuries/ 100,000 population*	40.8		53.5		*2017*		10
1.55	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	40.2	43.2	36.4	48.9	*2017-2019*		10

SCORE	**RESPIRATORY DISEASES**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.78	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	79.3		56.4	58.3	*2013-2017*		17
2.53	Adults who Smoke	*percent*	21.1	5	13.1	16	*2019*		9
2.23	Adults with Influenza Vaccination	*percent*	34.3		41.7		*2014*		10
2.23	Age-Adjusted ER Rate due to Asthma	*ER visits/ 10,000 population*	102.9		68.4		*2017*		10
2.23	COPD: Medicare Population	*percent*	12.7		10.2	11.5	*2018*		5
1.95	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	52.6	25.1	37.2	38.5	*2013-2017*		17
1.88	Adults with Current Asthma	*percent*	10.4			9.2	*2018*		3
1.85	Adults with Asthma	*percent*	15.2		14.9	14.9	*2019*		9
1.78	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	1.6		1.2	6.1	*9-Jul-21*		8
1.73	Adults with COPD	*Percent of adults*	7.8			6.9	*2018*		3
1.70	Adults 65+ with Pneumonia Vaccination	*percent*	74.8		76.6	73.3	*2019*		9
1.53	Asthma: Medicare Population	*percent*	5.2		5.4	5	*2018*		5
1.43	Adults 65+ with Influenza Vaccination	*percent*	67.7		68.7	64	*2019*		9

1.43	Teens who Smoke Cigarettes: High School Students	*percent*	6.9		5		*2018*		16
1.08	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.9	1.4	3.5	2.8	*2018*		10
0.78	Adolescents who Use Tobacco	*percent*	16.1		23		*2016*		10
0.70	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	8.3		16	15.2	*2012-2014*		10
0.48	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		7.3	2.8	*9-Jul-21*		8

SCORE	**SEXUALLY TRANSMITTED INFECTIONS**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.55	Gonorrhea Incidence Rate	*cases/ 100,000 population*	377		170.3	179.1	*2018*		10
2.45	Chlamydia Incidence Rate	*cases/ 100,000 population*	811.3		586.3	539.9	*2018*		10
1.78	HIV Diagnosis Rate	*cases/ 100,000 population*	18.5		20.4		*2017*		10
1.13	Syphilis Incidence Rate	*cases/ 100,000 population*	4.9		12.2	10.8	*2018*		10

SCORE	**TOBACCO USE**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.53	Adults who Smoke	*percent*	21.1	5	13.1	16	*2019*		9
1.43	Teens who Smoke Cigarettes: High School Students	*percent*	6.9		5		*2018*		16
0.78	Adolescents who Use Tobacco	*percent*	16.1		23		*2016*		10

SCORE	**WEIGHT STATUS**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.15	Adults Who Are Obese	*percent*	37.5		32.1	32.1	*2019*		9
2.05	Adults with a Healthy Weight	*percent*	31.3		35.1	35.2	*2014*		10
1.95	Adolescents who are Obese	*percent*	16.1		12.6		*2016*		10
1.05	Adults who are Overweight or Obese	*percent*	66.7		66.1	66.7	*2019*		9

SCORE	**WELLNESS & LIFESTYLE**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.03	Insufficient Sleep	*percent*	39.4	31.4	37.7	35	*2018*		6
2.00	Self-Reported General Health Assessment: Good or Better	*percent*	78.8		85.8	82	*2019*		9
1.98	Average Life Expectancy	*years*	76.6		79.2		*2017-2019*		10
1.95	Frequent Physical Distress	*percent*	12.2		10.1	11	*2018*		6
1.95	Life Expectancy	*years*	76.7		79.2	79.2	*2017-2019*		6
1.80	Poor Physical Health: 14+ Days	*percent*	11.3		9		*2016*		9
1.65	Self-Reported Good Physical Health	*percent*	73.8		76.4		*2019*		9

SCORE	**WOMEN'S HEALTH**	UNITS	WICOMICO COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.38	Breast Cancer Incidence Rate	*cases/ 100,000 females*	142.6		132.9	125.9	*2013-2017*		17
2.23	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	8.7		6.6	7.6	*2013-2017*		17
1.73	Cervical Cancer Screening: 21-65	*Percent*	84			84.7	*2018*		3
1.70	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	21.4	15.3	21.7	20.1	*2013-2017*		17
1.20	Pap Test in Past 3 Years	*percent*	75.6		70.3		*2018*		9
1.08	Mammogram in Past 2 Years: 50+	*percent*	89		82		*2018*		9
0.95	Mammogram in Past 2 Years: 50-74	*percent*	78.2	77.1		74.8	*2018*		3

WORCESTER DATA SCORING

WORCESTER SOURCES

Key	Source
1	American Community Survey
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	County Health Rankings
8	Feeding America
9	Healthy Communities Institute
10	Maryland Behavioral Risk Factor Surveillance System
11	Maryland Department of Health
12	Maryland Department of the Environment
13	Maryland Governor's Office for Children
14	Maryland Governor's Office of Crime Control & Prevention
15	Maryland State Board of Elections
16	Maryland State Department of Education
17	Maryland Youth Risk Behavior Survey/Youth Tobacco Survey
18	National Cancer Institute
19	National Center for Education Statistics
20	National Environmental Public Health Tracking Network
21	U.S. Bureau of Labor Statistics
22	U.S. Census - County Business Patterns
23	U.S. Census Bureau - Small Area Health Insurance Estimates
24	U.S. Department of Agriculture - Food Environment Atlas
25	United For ALICE

WORCESTER TOPICS

Health and Quality of Life Topics	Score
Alcohol & Drug Use	1.93
Other Conditions	1.91
Oral Health	1.68
Children's Health	1.66
Heart Disease & Stroke	1.65
Women's Health	1.64
Cancer	1.63
Prevention & Safety	1.62
Environmental Health	1.53
Economy	1.49
Community	1.47
Older Adults	1.47
Diabetes	1.43
Maternal, Fetal & Infant Health	1.42
Physical Activity	1.42
Adolescent Health	1.40
Health Care Access & Quality	1.36
Tobacco Use	1.31
Respiratory Diseases	1.30
Mental Health & Mental Disorders	1.29
Immunizations & Infectious Diseases	1.28
Weight Status	1.23
Wellness & Lifestyle	1.22
Education	1.13
Sexually Transmitted Infections	1.00

WORCESTER COUNTY INDICATORS

SCORE	ADOLESCENT HEALTH	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.78	Adolescents who are Obese	*percent*	13.6		12.6		*2016*		11
1.68	Adolescents who have had a Routine Checkup: Medicaid Population	*percent*	53		54.6		*2017*		11
1.43	Teens who Smoke Cigarettes: High School Students	*percent*	7.7		5		*2018*		17
1.15	Teen Birth Rate: 15-19	*births/ 1,000 females aged 1!*	14		13.9	16.7	*2019*	Black (42) White (6.9)	11
0.98	Adolescents who Use Tobacco	*percent*	18.4		23		*2016*		11

SCORE	ALCOHOL & DRUG USE	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.45	Age-Adjusted Death Rate due to Drug Use	*deaths/ 100,000 population*	48.7		30.9	20.3	*2015-2017*		11
2.35	Alcohol-Impaired Driving Deaths	*driving deaths with alcohol in*	44.2	28.3	28.8	27	*2015-2019*		7
2.13	Liquor Store Density	*stores/ 100,000 population*	24.9		20.5	10.5	*2019*		22
1.80	Age-Adjusted ER Rate due to Alcohol/Substance Abuse	*ER visits/ 100,000 population*	1977.1		2017		*2017*		11
1.73	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*)eaths per 100,000 populatio*	40.3		38.2	22.8	*2017-2019*		5
1.53	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	32.7		38.3	21	*2017-2019*		7
1.50	Adults who Binge Drink	*percent*	17.2		14.8	16.8	*2019*		10

SCORE	CANCER	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.55	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	15.2	8.9	13.7	13.7	*2013-2017*		18
2.40	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	12.1		6.6	7.6	*2013-2017*		18
2.23	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	13.2		11.1	11.8	*2013-2017*		18
2.18	Adults with Cancer	*percent*	9.6			6.9	*2018*		4
2.08	Breast Cancer Incidence Rate	*cases/ 100,000 females*	135.8		132.9	125.9	*2013-2017*		18
1.83	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	121.3		124.7	104.5	*2013-2017*		18
1.65	Cancer: Medicare Population	*percent*	9		9.2	8.4	*2018*		6
1.65	Mammogram in Past 2 Years: 50+	*percent*	77.1		82		*2018*		10
1.60	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	19.7	16.9	20	19	*2013-2017*		18
1.60	Mammogram in Past 2 Years: 50-74	*percent*	73.7	77.1		74.8	*2018*		4
1.48	Pap Test in Past 3 Years	*percent*	71.6		70.3		*2018*		10
1.40	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	164.5	122.7	155.1	155.5	*2013-2017*		18
1.35	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	41.9	25.1	37.2	38.5	*2013-2017*		18
1.35	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	37.5		36.4	38.4	*2013-2017*		18
1.20	Colon Cancer Screening: Sigmoidoscopy or Colonoscopy	*percent*	79.9		75.7		*2018*		10
1.15	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	19.9	15.3	21.7	20.1	*2013-2017*		18
1.13	Cervical Cancer Screening: 21-65	*Percent*	85.7			84.7	*2018*		4
1.13	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	62		56.4	58.3	*2013-2017*		18
1.00	Colon Cancer Screening	*percent*	70.2	74.4		66.4	*2018*		4

SCORE	CHILDREN'S HEALTH	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.25	Child Food Insecurity Rate	*percent*	22.3		16.1	15.2	*2018*		8
1.95	Child Abuse Rate	*cases/ 1,000 children*	13.5		5.7		*2018*		13
1.95	Projected Child Food Insecurity Rate	*percent*	34.8				*2020*		8
1.63	Blood Lead Levels in Children	*percent*	0.2		0.2		*2019*		12
1.48	Children who Visited a Dentist	*percent*	62.7		63.7		*2017*		11
1.35	Children with Low Access to a Grocery Store	*percent*	3.4				*2015*		24
1.35	Food Insecure Children Likely Ineligible for Assistance	*percent*	25		32	25	*2018*		8
1.30	Children with Health Insurance	*percent*	96.2		96.8		*2018*		23

SCORE	COMMUNITY	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.35	Alcohol-Impaired Driving Deaths	*driving deaths with alcohol in*	44.2	28.3	28.8	27	*2015-2019*		7
2.28	Homeownership	*percent*	29.4		60.2	56.2	*2015-2019*		1
2.13	Single-Parent Households	*percent*	29.2		26.4	25.5	*2015-2019*		1
2.03	Workers who Walk to Work	*percent*	2.2		2.3	2.7	*2015-2019*	Black (0.3) White (2.5) Asian (0) AIAN (0) NHPI (0) Mult (5.3) Other (0) Hisp (0.1)	1
1.98	Pedestrian Injuries	*injuries/ 100,000 population*	81.3		53.5		*2017*		11
1.98	Youth not in School or Working	*percent*	2.1		1.9	1.9	*2015-2019*		1
1.95	Child Abuse Rate	*cases/ 1,000 children*	13.5		5.7		*2018*		13
1.78	Workers who Drive Alone to Work	*percent*	80.8		73.9	76.3	*2015-2019*		1
1.68	Domestic Violence Offense Rate	*offenses/ 100,000 population*	543.6		537.1		*2017*		11
1.65	Households with One or More Types of Computing Devices	*percent*	88.5		92.4	90.3	*2015-2019*		1
1.65	People 25+ with a Bachelor's Degree or Higher	*percent*	29		40.2	32.1	*2015-2019*		1
1.60	Workers Commuting by Public Transportation	*percent*	2.5	5.3	8.4	5	*2015-2019*	Black (8.8) White (1.2) Asian (9.5) AIAN (0) NHPI (0) Mult (3.6) Other (0) Hisp (6.5)	1
1.58	Persons with an Internet Subscription	*percent*	87.8		89.4	86.2	*2015-2019*		1
1.50	Households with No Car and Low Access to a Grocery Store	*percent*	2.1				*2015*		24
1.48	People 65+ Living Alone	*percent*	26		26	26.1	*2015-2019*		1
1.35	Households with an Internet Subscription	*percent*	83.1		86.7	83	*2015-2019*		1
1.35	Violent Crime Rate	*crimes/ 100,000 population*	344.3			394	*2017*		14
1.33	Persons with Health Insurance	*percent*	93	92.1	93.1		*2018*		23
1.18	Mean Travel Time to Work	*minutes*	24.8		33.2	26.9	*2015-2019*		1
1.13	Median Household Income	*dollars*	63499		84805	62843	*2015-2019*		1
1.08	Children Living Below Poverty Level	*percent*	13.1		12.1	18.5	*2015-2019*		1
1.08	Households without a Vehicle	*percent*	6.7		9	8.6	*2015-2019*		1
1.08	Voter Registration	*percent*	89.6		83.6		*2016*		15
1.00	People Living Below Poverty Level	*percent*	9	8	9.2	13.4	*2015-2019*		1

0.83	People 25+ with a High School Degree or Higher	*percent*	91.3		90.2	88	*2015-2019*		1
0.83	Per Capita Income	*dollars*	38080		42122	34103	*2015-2019*		1
0.73	Social Associations	*ship associations/ 10,000 po*	17.4		9	9.3	*2018*		7
0.63	Solo Drivers with a Long Commute	*percent*	30		50.2	37	*2015-2019*		7

SCORE	DIABETES	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.18	Adults with Diabetes	*percent*	11.8		10	10.7	*2019*		10
2.03	Age-Adjusted ER Rate due to Diabetes	*ER Visits/ 100,000 population*	310.5		243.7		*2017*		11
0.90	Diabetes: Medicare Population	*percent*	26.3		29.6	27	*2018*		6
0.60	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	14.5		19.2	21.1	*2012-2014*		11

SCORE	ECONOMY	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.53	Homeowner Vacancy Rate	*percent*	3.4		1.7	1.6	*2015-2019*		1
2.28	Homeownership	*percent*	29.4		60.2	56.2	*2015-2019*		1
2.25	Child Food Insecurity Rate	*percent*	22.3		16.1	15.2	*2018*		8
2.10	Food Insecurity Rate	*percent*	13.3		11	11.5	*2018*		8
2.08	Renters Spending 30% or More of Household Income on Rent	*percent*	50.1		49.7	49.6	*2015-2019*		1
2.03	Unemployed Workers in Civilian Labor Force	*percent*	8.1		5.9	5.7	*Apr-21*		21
1.98	Youth not in School or Working	*percent*	2.1		1.9	1.9	*2015-2019*		1
1.95	Projected Child Food Insecurity Rate	*percent*	34.8				*2020*		8
1.93	Severe Housing Problems	*percent*	17		16.2	18	*2013-2017*		7
1.80	Projected Food Insecurity Rate	*percent*	20.1				*2020*		8
1.78	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	60.5		61		*2018*		25
1.78	Households that are Below the Federal Poverty Level	*percent*	9.7		9		*2018*		25
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.2				*2016*		24
1.48	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	29.8		30		*2018*		25
1.35	Food Insecure Children Likely Ineligible for Assistance	*percent*	25		32	25	*2018*		8
1.35	Low-Income and Low Access to a Grocery Store	*percent*	4.3				*2015*		24
1.33	Overcrowded Households	*percent of households*	1.2		2.3		*2015-2019*		1
1.33	SNAP Certified Stores	*stores/ 1,000 population*	1				*2017*		24
1.23	People Living 200% Above Poverty Level	*percent*	74.8		78.4	69.1	*2015-2019*		1
1.13	Median Household Income	*dollars*	63499		84805	62843	*2015-2019*		1
1.08	Children Living Below Poverty Level	*percent*	13.1		12.1	18.5	*2015-2019*		1
1.08	Families Living Below Poverty Level	*percent*	6.3		6.1	9.5	*2015-2019*	Black (14.9) White (5) Asian (2.5) AIAN (0) NHPI (0) Mult (18.1) Other (0) Hisp (9.1)	1
1.08	Households with Cash Public Assistance Income	*percent*	2		2.2	2.4	*2015-2019*		1
1.00	People Living Below Poverty Level	*percent*	9	8	9.2	13.4	*2015-2019*		1
0.98	Students Eligible for the Free Lunch Program	*percent*	36.2				*2019-2020*		19
0.93	Persons with Disability Living in Poverty (5-year)	*percent*	19.9		20.9	26.1	*2015-2019*		1
0.83	Per Capita Income	*dollars*	38080		42122	34103	*2015-2019*		1
0.68	Affordable Housing	*percent*	62.5		48.1		*2016*		11
0.48	People 65+ Living Below Poverty Level	*percent*	5.6		7.7	9.3	*2015-2019*		1

SCORE	EDUCATION	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.65	People 25+ with a Bachelor's Degree or Higher	*percent*	29		40.2	32.1	*2015-2019*		1
1.43	Student-to-Teacher Ratio	*students/ teacher*	11.9				*2019-2020*		19
1.18	3rd Grade Students Proficient in Reading	*percent*	60.8		41.2		*2019*		3
1.18	8th Grade Students Proficient in Math	*percent*	31.8		12.5		*2019*		3
1.08	School Readiness at Kindergarten Entry	*percent*	66		47		*2019-2020*		16
1.05	8th Grade Students Proficient in Reading	*percent*	63.1		45.1		*2019*		3
0.93	3rd Grade Students Proficient in Math	*percent*	69.3		42.5		*2019*		3
0.83	People 25+ with a High School Degree or Higher	*percent*	91.3		90.2	88	*2015-2019*		1
0.80	High School Graduation	*percent*	94.6	90.7	86.8		*2020*		16

SCORE	ENVIRONMENTAL HEALTH	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.18	Daily Dose of UV Irradiance	*Joule per square meter*	2675		2499		*2015*		20
2.13	Liquor Store Density	*stores/ 100,000 population*	24.9		20.5	10.5	*2019*		22
2.08	Age-Adjusted ER Rate due to Asthma	*ER visits/ 10,000 population*	79.1		68.4		*2017*		11
1.95	People 65+ with Low Access to a Grocery Store	*percent*	5.8				*2015*		24
1.93	Severe Housing Problems	*percent*	17		16.2	18	*2013-2017*		7
1.83	Fast Food Restaurant Density	*estaurants/ 1,000 populatior*	1.6				*2016*		24
1.78	Food Environment Index		7.8		8.7	7.8	*2021*		7
1.63	Blood Lead Levels in Children	*percent*	0.2		0.2		*2019*		12
1.63	Months of Mild Drought or Worse	*months per year*	5				*2016*		20
1.63	Number of Extreme Precipitation Days	*days*	40				*2016*		20
1.50	Households with No Car and Low Access to a Grocery Store	*percent*	2.1				*2015*		24
1.50	People with Low Access to a Grocery Store	*percent*	20.7				*2015*		24
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.2				*2016*		24
1.45	Adults with Asthma	*percent*	15.3		15.2	14.7	*2018*		10
1.43	Adults with Current Asthma	*percent*	9.5			9.2	*2018*		4
1.38	Number of Extreme Heat Days	*days*	24				*2016*		20
1.35	Annual Ozone Air Quality		4				*2008-2010*		2
1.35	Children with Low Access to a Grocery Store	*percent*	3.4				*2015*		24

1.35	Low-Income and Low Access to a Grocery Store	*percent*	4.3				*2015*	24
1.33	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*	24
1.33	Overcrowded Households	*percent of households*	1.2		2.3		*2015-2019*	1
1.33	SNAP Certified Stores	*stores/ 1,000 population*	1				*2017*	24
1.20	Access to Exercise Opportunities	*percent*	89.6		92.6	84	*2020*	7
1.20	Farmers Market Density	*markets/ 1,000 population*	0.1				*2018*	24
1.05	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.2				*2016*	24
0.63	Asthma: Medicare Population	*percent*	3.9		5.4	5	*2018*	6

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.20	Adults Unable to Afford to See a Doctor	*percent*	14.1		9.9	12	*2016*		10
2.00	People with a Usual Primary Care Provider	*percent*	78.3	84	84.8		*2016*		11
1.73	Dentist Rate	*dentists/ 100,000 population*	57.4		79.4		*2019*		7
1.68	Adolescents who have had a Routine Checkup: Medicaid Population	*percent*	53		54.6		*2017*		11
1.48	Children who Visited a Dentist	*percent*	62.7		63.7		*2017*		11
1.33	Persons with Health Insurance	*percent*	93	92.1	93.1		*2018*		23
1.30	Children with Health Insurance	*percent*	96.2		96.8		*2018*		23
1.15	Adults who Visited a Dentist	*percent*	69.2		66.3	67.6	*2018*		10
1.15	Adults with Health Insurance: 18-64	*percent*	91.9		91.7		*2018*		23
1.15	Primary Care Provider Rate	*roviders/ 100,000 populatior*	84.9		88.6		*2018*		7
1.13	Adults who have had a Routine Checkup	*percent*	89.7		90		*2019*		10
1.08	Uninsured Emergency Department Visits	*percent*	6.4		8.6		*2017*		11
1.05	Non-Physician Primary Care Provider Rate	*roviders/ 100,000 populatior*	105.2		115.1		*2020*		7
1.13	Adults who have had a Routine Checkup	*percent*	89.7		90		*2019*		10
0.90	Mental Health Provider Rate	*roviders/ 100,000 populatior*	248.7		274.9		*2020*		7

SCORE	HEART DISEASE & STROKE	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.53	Atrial Fibrillation: Medicare Population	*percent*	10.4		8.2	8.4	*2018*		6
2.40	Hyperlipidemia: Medicare Population	*percent*	59.4		51.9	47.7	*2018*		6
2.23	Hypertension: Medicare Population	*percent*	66.3		61.2	57.2	*2018*		6
2.18	High Cholesterol Prevalence: Adults 18+	*percent*	41.1			34.1	*2017*		4
2.08	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	44.3	33.4	40.7	37.2	*2017-2019*		11
2.08	Age-Adjusted ER Rate due to Hypertension	*ER Visits/ 100,000 population*	417.2		351.2		*2017*		11
2.03	Adults who Experienced Coronary Heart Disease	*percent*	8.8			6.8	*2018*		4
1.88	Adults who Experienced a Stroke	*percent*	4.2			3.4	*2018*		4
1.83	Stroke: Medicare Population	*percent*	4.4		4.5	3.8	*2018*		6
1.80	Age-Adjusted Hospitalization Rate due to Heart Attack	*zations/ 10,000 population 3*	28.5		23.9		*2014*		20
1.68	Age-Adjusted Death Rate due to Heart Disease	*deaths/ 100,000 population*	185.9		161.9	723.5	*2017-2019*		11
1.60	High Cholesterol Prevalence	*percent*	33.1		31.3	33.1	*2019*		10
1.08	High Blood Pressure Prevalence	*percent*	30.9	27.7	32.2	32.3	*2019*		10
0.98	Adults who Have Taken Medications for High Blood Pressure	*percent*	82.5			75.8	*2017*		4
0.98	Cholesterol Test History	*percent*	87.4			81.5	*2017*		4
0.93	Age-Adjusted Death Rate due to Heart Attack	*hs/ 100,000 population 35+ y*	32.5		43.9		*2018*		20
0.78	Heart Failure: Medicare Population	*percent*	11.9		12.6	14	*2018*		6
0.68	Ischemic Heart Disease: Medicare Population	*percent*	24.4		26.4	26.8	*2018*		6

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.30	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	57.2	11.1	16.5		*2019*		11
2.00	Adults 65+ with Pneumonia Vaccination	*percent*	72		76.6	73.3	*2019*		10
1.58	Adults 65+ with Influenza Vaccination	*percent*	67		68.7	64	*2019*		10
1.53	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	3		1.2	6.1	*9-Jul-21*		9
1.43	Adults Fully Vaccinated Against COVID-19	*percent*	61.2				*Jun-21*		5
1.38	Adults with Influenza Vaccination	*percent*	42.6		41.7		*2014*		11
1.33	Overcrowded Households	*percent of households*	1.2		2.3		*2015-2019*		1
1.10	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	13.3		16	15.2	*2012-2014*		11
1.10	Chlamydia Incidence Rate	*cases/ 100,000 population*	381.1		586.3	539.9	*2018*		11
1.05	HIV Diagnosis Rate	*cases/ 100,000 population*	4.4		20.4		*2017*		11
1.00	Gonorrhea Incidence Rate	*cases/ 100,000 population*	118		170.3	179.1	*2018*		11
0.85	Syphilis Incidence Rate	*cases/ 100,000 population*	3.9		12.2	10.8	*2018*		11
0.63	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0	1.4	3.5	2.8	*2018*		11
0.60	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		7.3	2.8	*9-Jul-21*		9

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.53	Infant Mortality Rate	*deaths/ 1,000 live births*	9.9	5	6.4	5.8	*2014-2018*		11
2.18	Sudden Unexpected Infant Death Rate	*deaths/ 1,000 live births*	2		1	0.9	*2011-2015*		11
1.35	Babies with Low Birth Weight	*percent*	7.9		8.7	8.3	*2019*		11
1.15	Teen Birth Rate: 15-19	*births/ 1,000 females aged 1!*	14		13.9	16.7	*2019*	Black (42) White (6.9)	11
0.93	Perinatal Deaths	*; plus fetal deaths of 28 or mc*	0		6.2		*2018*		11
0.38	Preterm Births	*percent*	5.6	9.4	10.3	10	*2019*		11

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.08	Self-Reported Good Mental Health	*percent*	60.3		70.2		*2019*		10
1.73	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	12	12.8	9	12.5	*2011-2013*		11
1.65	Age-Adjusted ER Rate due to Mental Health	*ER Visits/ 100,000 population*	3657		3796.7		*2016*		11

1.50	Frequent Mental Distress	*percent*	13		11.4	13	*2018*	7
1.33	Age-Adjusted Hospitalization Rate Related to Alzheimer's and Other Dementias	*ɔitalizations/ 100,000 popula*	407.7		515.5		*2017*	11
1.20	Poor Mental Health: Average Number of Days	*days*	4		3.7	4.1	*2018*	7
1.13	Alzheimer's Disease or Dementia: Medicare Population	*percent*	9.2		11.3	10.8	*2018*	6
1.05	Poor Mental Health: 14+ Days	*percent*	6.9		9.7		*2016*	10
0.98	Depression: Medicare Population	*percent*	14.5		18	18.4	*2018*	6
0.90	Mental Health Provider Rate	*roviders/ 100,000 populatior*	248.7		274.9		*2020*	7
0.60	Self-Reported General Health Assessment: Good or Better	*percent*	90.4		85.8	82	*2019*	10

SCORE	**OLDER ADULTS**	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.53	Atrial Fibrillation: Medicare Population	*percent*	10.4		8.2	8.4	*2018*		6
2.40	Hyperlipidemia: Medicare Population	*percent*	59.4		51.9	47.7	*2018*		6
2.23	Hypertension: Medicare Population	*percent*	66.3		61.2	57.2	*2018*		6
2.18	Adults with Arthritis	*percent*	39.4			25.8	*2018*		4
2.18	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	35.1		34.6	33.5	*2018*		6
2.00	Adults 65+ with Pneumonia Vaccination	*percent*	72		76.6	73.3	*2019*		10
1.95	People 65+ with Low Access to a Grocery Store	*percent*	5.8				*2015*		24
1.83	Stroke: Medicare Population	*percent*	4.4		4.5	3.8	*2018*		6
1.73	Chronic Kidney Disease: Medicare Population	*percent*	23.5		25.1	24.5	*2018*		6
1.65	Cancer: Medicare Population	*percent*	9		9.2	8.4	*2018*		6
1.58	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	31.3			32.4	*2018*		4
1.58	Adults 65+ with Influenza Vaccination	*percent*	67		68.7	64	*2019*		10
1.48	People 65+ Living Alone	*percent*	26		26	26.1	*2015-2019*		1
1.43	Osteoporosis: Medicare Population	*percent*	5.6		6.4	6.6	*2018*		6
1.33	Age-Adjusted Hospitalization Rate Related to Alzheimer's and Other Dementias	*ɔitalizations/ 100,000 popula*	407.7		515.5		*2017*		11
1.13	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	33.1			28.4	*2018*		4
1.13	Adults 65+ with Total Tooth Loss	*percent*	11.2			13.5	*2018*		4
1.13	Alzheimer's Disease or Dementia: Medicare Population	*percent*	9.2		11.3	10.8	*2018*		6
0.98	Depression: Medicare Population	*percent*	14.5		18	18.4	*2018*		6
0.90	Diabetes: Medicare Population	*percent*	26.3		29.6	27	*2018*		6
0.88	COPD: Medicare Population	*percent*	9.7		10.2	11.5	*2018*		6
0.78	Heart Failure: Medicare Population	*percent*	11.9		12.6	14	*2018*		6
0.68	Ischemic Heart Disease: Medicare Population	*percent*	24.4		26.4	26.8	*2018*		6
0.63	Asthma: Medicare Population	*percent*	3.9		5.4	5	*2018*		6
0.48	People 65+ Living Below Poverty Level	*percent*	5.6		7.7	9.3	*2015-2019*		1

SCORE	**ORAL HEALTH**	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.23	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	13.2		11.1	11.8	*2013-2017*		18
2.05	Adults with No Tooth Extractions	*percent*	52.1		60.3	58.9	*2018*		10
1.98	Age-Adjusted ER Visit Rate due to Dental Problems	*ER Visits/ 100,000 population*	1051.9		362.7		*2017*		11
1.73	Dentist Rate	*dentists/ 100,000 population*	57.4		79.4		*2019*		7
1.48	Children who Visited a Dentist	*percent*	62.7		63.7		*2017*		11
1.15	Adults who Visited a Dentist	*percent*	69.2		66.3	67.6	*2018*		10
1.13	Adults 65+ with Total Tooth Loss	*percent*	11.2			13.5	*2018*		4

SCORE	**OTHER CONDITIONS**	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.18	Adults with Arthritis	*percent*	39.4			25.8	*2018*		4
2.18	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	35.1		34.6	33.5	*2018*		6
2.03	Adults with Kidney Disease	*Percent of adults*	3.6			3.1	*2018*		4
1.73	Chronic Kidney Disease: Medicare Population	*percent*	23.5		25.1	24.5	*2018*		6
1.43	Osteoporosis: Medicare Population	*percent*	5.6		6.4	6.6	*2018*		6

SCORE	**PHYSICAL ACTIVITY**	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.03	Workers who Walk to Work	*percent*	2.2		2.3	2.7	*2015-2019*	Black (0.3) White (2.5) Asian (0) AIAN (0) NHPI (0) Mult (5.3) Other (0) Hisp (0.1)	1
1.95	People 65+ with Low Access to a Grocery Store	*percent*	5.8				*2015*		24
1.83	Fast Food Restaurant Density	*estaurants/ 1,000 populatior*	1.6				*2016*		24
1.78	Adolescents who are Obese	*percent*	13.6		12.6		*2016*		11
1.78	Food Environment Index		7.8		8.7	7.8	*2021*		7
1.50	Households with No Car and Low Access to a Grocery Store	*percent*	2.1				*2015*		24
1.50	People with Low Access to a Grocery Store	*percent*	20.7				*2015*		24
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.2				*2016*		24
1.35	Children with Low Access to a Grocery Store	*percent*	3.4				*2015*		24
1.35	Low-Income and Low Access to a Grocery Store	*percent*	4.3				*2015*		24
1.33	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*		24
1.33	SNAP Certified Stores	*stores/ 1,000 population*	1				*2017*		24
1.30	Adults with a Healthy Weight	*percent*	36.2		35.1	35.2	*2014*		11
1.20	Access to Exercise Opportunities	*percent*	89.6		92.6	84	*2020*		7
1.20	Farmers Market Density	*markets/ 1,000 population*	0.1				*2018*		24
1.15	Adults Engaging in Regular Physical Activity	*percent*	54.7	28.4	51.8		*2019*		10

1.15	Adults Who Are Obese	*percent*	31.3		32.1	32.1	*2019*		10
1.05	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.2				*2016*		24
0.70	Adults who are Overweight or Obese	*percent*	54.2		66.1	66.7	*2019*		10

SCORE	**PREVENTION & SAFETY**	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.98	Pedestrian Injuries	*injuries/ 100,000 population*	81.3		53.5		*2017*		11
1.93	Severe Housing Problems	*percent*	17		16.2	18	*2013-2017*		7
1.53	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	32.7		38.3	21	*2017-2019*		7
1.05	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	36.1	43.2	36.4	48.9	*2017-2019*		11

SCORE	**RESPIRATORY DISEASES**	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.08	Age-Adjusted ER Rate due to Asthma	*ER visits/ 10,000 population*	79.1		68.4		*2017*		11
2.00	Adults 65+ with Pneumonia Vaccination	*percent*	72		76.6	73.3	*2019*		10
1.73	Adults with COPD	*Percent of adults*	8.5			6.9	*2018*		4
1.58	Adults 65+ with Influenza Vaccination	*percent*	67		68.7	64	*2019*		10
1.53	Adults who Smoke	*percent*	15.5	5	13.1	16	*2019*		10
1.53	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	3		1.2	6.1	*9-Jul-21*		9
1.45	Adults with Asthma	*percent*	15.3		15.2	14.7	*2018*		10
1.43	Adults with Current Asthma	*percent*	9.5			9.2	*2018*		4
1.43	Teens who Smoke Cigarettes: High School Students	*percent*	7.7		5		*2018*		17
1.38	Adults with Influenza Vaccination	*percent*	42.6		41.7		*2014*		11
1.35	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	41.9	25.1	37.2	38.5	*2013-2017*		18
1.13	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	62		56.4	58.3	*2013-2017*		18
1.10	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	13.3		16	15.2	*2012-2014*		11
0.98	Adolescents who Use Tobacco	*percent*	18.4		23		*2016*		11
0.88	COPD: Medicare Population	*percent*	9.7		10.2	11.5	*2018*		6
0.63	Asthma: Medicare Population	*percent*	3.9		5.4	5	*2018*		6
0.63	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0	1.4	3.5	2.8	*2018*		11
0.60	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		7.3	2.8	*9-Jul-21*		9

SCORE	**SEXUALLY TRANSMITTED INFECTIONS**	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.10	Chlamydia Incidence Rate	*cases/ 100,000 population*	381.1		586.3	539.9	*2018*		11
1.05	HIV Diagnosis Rate	*cases/ 100,000 population*	4.4		20.4		*2017*		11
1.00	Gonorrhea Incidence Rate	*cases/ 100,000 population*	118		170.3	179.1	*2018*		11
0.85	Syphilis Incidence Rate	*cases/ 100,000 population*	3.9		12.2	10.8	*2018*		11

SCORE	**TOBACCO USE**	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.53	Adults who Smoke	*percent*	15.5	5	13.1	16	*2019*		10
1.43	Teens who Smoke Cigarettes: High School Students	*percent*	7.7		5		*2018*		17
0.98	Adolescents who Use Tobacco	*percent*	18.4		23		*2016*		11

SCORE	**WEIGHT STATUS**	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.78	Adolescents who are Obese	*percent*	13.6		12.6		*2016*		11
1.30	Adults with a Healthy Weight	*percent*	36.2		35.1	35.2	*2014*		11
1.15	Adults Who Are Obese	*percent*	31.3		32.1	32.1	*2019*		10
0.70	Adults who are Overweight or Obese	*percent*	54.2		66.1	66.7	*2019*		10

SCORE	**WELLNESS & LIFESTYLE**	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
1.95	Self-Reported Good Physical Health	*percent*	66.7		76.4		*2019*		10
1.65	Frequent Physical Distress	*percent*	11.3		10.1	11	*2018*		7
1.35	Poor Physical Health: 14+ Days	*percent*	8.6		9		*2016*		10
1.13	Average Life Expectancy	*years*	79.6		79.2		*2017-2019*		11
0.93	Insufficient Sleep	*percent*	33.7	31.4	37.7	35	*2018*		7
0.90	Life Expectancy	*years*	79.7		79.2	79.2	*2017-2019*		7
0.60	Self-Reported General Health Assessment: Good or Better	*percent*	90.4		85.8	82	*2019*		10

SCORE	**WOMEN'S HEALTH**	UNITS	WORCESTER COUNTY	HP2030	MD	U.S.	MEASUREMENT PERIOD	HIGH DISPARITY*	Source
2.40	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	12.1		6.6	7.6	*2013-2017*		18
2.08	Breast Cancer Incidence Rate	*cases/ 100,000 females*	135.8		132.9	125.9	*2013-2017*		18
1.65	Mammogram in Past 2 Years: 50+	*percent*	77.1		82		*2018*		10
1.60	Mammogram in Past 2 Years: 50-74	*percent*	73.7	77.1		74.8	*2018*		4
1.48	Pap Test in Past 3 Years	*percent*	71.6		70.3		*2018*		10
1.15	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	19.9	15.3	21.7	20.1	*2013-2017*		18
1.13	Cervical Cancer Screening: 21-65	*Percent*	85.7			84.7	*2018*		4

APPENDIX B

PRIMARY DATA ASSESSMENT TOOLS (COMMUNITY INPUT)

KEY INFORMANT INTERVIEW QUESTIONS

1. **To begin, could you please tell us a little about the organization you work for and the geographic location it serves?**

2. **COVID-19 has significantly impacted everyone's lives. Through that lens, what have you seen as the biggest challenges in *[Somerset, Wicomico, Worcester, Sussex]* County during the pandemic?**

3. **Now, we would appreciate your perspective on the current health needs or issues faced by people living in *[Somerset, Wicomico, Worcester, Sussex]* County. In your opinion, what are the top health issues affecting residents of your community?**

4. **What do you think are the leading factors that contribute to these health issues?**

5. **Which groups (or populations) in your community seem to struggle the most with the health issues that you've identified?**
    a. *Are there specific challenges that impact low-income, under-served/uninsured, racial or ethnic groups, age or gender groups in the community?*
    b. *How does it impact their lives?*

6. **What geographic parts of the county/community have greater health or social need?**
    a. *Which neighborhoods in your community need additional support services or outreach?*

7. **What do you think needs to be done to better address these health needs you've identified?**

8. **What barriers or challenges might prevent someone in the community from accessing health care or social services?**

9. **Could you tell us about some of the strengths and resources in your community that address these issues, such as groups, partnerships/initiatives, services, or programs?**
    a. *What services or programs could potentially have an impact on the needs that you've identified, if not yet in place?*

10. **Is there anything additional that should be considered for assessing the needs of the community?**

COMMUNITY SURVEY TOOLS

TidalHealth and Somerset & Wicomico Health Depts. Community Health Survey 2021

Welcome to this collaborative effort for the TidalHealth and Somerset & Wicomico Health Departments community health survey. The information collected in this survey will allow community organizations across the counties of Somerset, Wicomico, and Worcester, MD and Sussex, DE to better understand the health needs in your community. The knowledge gained will be used to implement programs that will benefit everyone in the community. We can better understand community needs by gathering the voices of community members like you to tell us about the issues that you feel are most important.

REMINDER: You must be 18 years old or older to complete this survey. We estimate that it will take 10 minutes to complete. Survey results will be available and shared broadly in the community within the next year. The responses that you provide will remain anonymous and not attributed to you personally in any way. Your participation in this survey is completely voluntary. If you have any questions, please contact Kat Rodgers by email at katherine.rodgers@tidalhealth.org. Thank you very much for your input and your time!

TidalHealth and Somerset & Wicomico Health Depts. Community Health Survey 2021

Demographic Information

Please answer a few questions about yourself so that we can see how different types of people feel about local health issues.

* 1. In what zip code do you live? Please write in your five-digit zip code in the box below.

2. Are you of Hispanic or Latino origin or descent? Select one.

- ◯ Hispanic/Latino/Latinx
- ◯ Non-Hispanic/Latino/Latinx
- ◯ Prefer not to answer

3. Which of the following best describes you? Select one.

- ◯ American Indian or Alaskan Native
- ◯ Asian or Asian American
- ◯ Black or African American
- ◯ Haitian
- ◯ Native Hawaiian or other Pacific Islander
- ◯ White or Caucasian
- ◯ Two or more races
- ◯ Prefer not to answer
- ◯ Other Race (optional): If you feel comfortable doing so, please indicate what other race you most identity with:

4. What is your age? Select one.

- ◯ Under 18
- ◯ 18-20
- ◯ 21-24
- ◯ 25-34
- ◯ 35-44
- ◯ 45-54
- ◯ 55-64
- ◯ 65-74
- ◯ 75-84
- ◯ 85 or older
- ◯ Prefer not to answer

5. To which gender identity do you most identify? Select one.

- ◯ Female
- ◯ Male
- ◯ Transgender Female
- ◯ Transgender Male
- ◯ Gender Non-conforming
- ◯ Prefer not to answer
- ◯ Other identification (optional): If you feel comfortable doing so, please indicate what other gender identity you most identity with:

6. What is the highest level of education you have completed? Select one.

- ◯ Did not attend school
- ◯ Less than 9th Grade
- ◯ Some High School, No Diploma
- ◯ High School Graduate, Diploma or the equivalent (GED)
- ◯ Associate Degree
- ◯ Bachelor's Degree
- ◯ Master's Degree
- ◯ Professional Degree
- ◯ Doctorate Degree

7. How much total combined money did all members of your household earn in the previous year? Select one.

- ◯ Less than $15,000
- ◯ $15,000 to $24,999
- ◯ $25,000 to $34,999
- ◯ $35,000 to $49,999
- ◯ $50,000 to $74,999
- ◯ $75,000 to $99,999
- ◯ $100,000 to $124,999
- ◯ $125,000 to $149,999
- ◯ $150,000 to $199,999
- ◯ $200,000 to $249,999
- ◯ $250,000 to $499,999
- ◯ $500,000 or more
- ◯ Prefer not to answer

8. What language do you mainly speak at home? Select one.

- ◯ Arabic
- ◯ Creole
- ◯ English
- ◯ French
- ◯ Korean
- ◯ Spanish
- ◯ Vietnamese
- ◯ Some other language (please specify)

9. Do you identify with any of the following statements? Select all that apply.

- [ ] I have a disability
- [ ] I am active duty Military
- [ ] I am retired Military
- [ ] I am a Veteran
- [ ] I am an immigrant or refugee
- [ ] Prefer not to answer
- [ ] I do not identify with any of these

10. Including yourself, how many people currently live in your household?

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ More than 4

TidalHealth and Somerset & Wicomico Health Depts. Community Health Survey 2021

Community Health

In this survey, "community" refers to the major areas where you live, shop, play, work, and get services.

* 11. How would you rate your community as a healthy place to live? Select one.

- ◯ Very Unhealthy
- ◯ Unhealthy
- ◯ Somewhat Healthy
- ◯ Healthy
- ◯ Very Healthy

* 12. In the following list, what do you think are the three most important “health problems” in your community? (Those problems that have the greatest impact on overall community health.) Select up to 3.

- [ ] Access to Affordable Health Care Services (doctors available nearby, wait times, services available nearby, takes insurance)
- [ ] Adolescent Health
- [ ] Alcohol and Drug Use
- [ ] Auto Immune Diseases (multiple sclerosis, Crohn's disease, etc.)
- [ ] Cancer
- [ ] Children's Health
- [ ] Chronic Pain
- [ ] Diabetes
- [ ] Family planning services (birth control)
- [ ] Heart Disease and Stroke
- [ ] Injury and Violence
- [ ] Maternal and Infant Health
- [ ] Mental Health and Mental Disorders (anxiety, depression, suicide)
- [ ] Nutrition and Healthy Eating
- [ ] Older Adults (hearing/vision loss, arthritis, etc.)
- [ ] Oral Health and Access to Dentistry Services (dentists available nearby)
- [ ] Physical Activity
- [ ] Quality of Health Care Services Available
- [ ] Respiratory/Lung Diseases (asthma, COPD, etc.)
- [ ] Sexually transmitted diseases/infections (STDs/STIs)
- [ ] Tobacco Use (including e-cigarettes, chewing tobacco, etc.)
- [ ] Weight Status (Individuals who are Overweight or Obese)
- [ ] Women’s Health (ex: mammogram, pap exam)
- [ ] Other (please specify)

* 13. In your opinion, which of the following would you most like to see addressed in your community? Select up to 3.

- [ ] Access to higher education (2-year or 4-year degrees)
- [ ] Air and water quality
- [ ] Bike lanes
- [ ] Crime and Crime Prevention (robberies, shootings, other violent crimes)
- [ ] Disability accessible sidewalks and other structures
- [ ] Discrimination or inequity based on race/ethnicity, gender, age, sex.
- [ ] Domestic Violence and Abuse (intimate partner, family, or child abuse)
- [ ] Economy and job availability
- [ ] Education and schools (Pre-K to 12th grade)
- [ ] Emergency Preparedness
- [ ] Inequity in jobs, health, housing, etc. for underserved populations
- [ ] Food insecurity or hunger
- [ ] Homelessness and unstable housing
- [ ] Injury Prevention (traffic safety, drownings, bicycling and pedestrian accidents)
- [ ] Nutrition and Healthy Eating (restaurants, stores, or markets)
- [ ] Parks and walking paths
- [ ] Senior services (over 65)
- [ ] Social isolation/feeling lonely
- [ ] Support for families with children (childcare, parenting support)
- [ ] Transportation
- [ ] Other (please specify)

14. Below are some statements about health care services in your community. Please rate how much you agree or disagree with each statement. Select an option for your response in each row below.

	Strongly Agree	Agree	Feel Neutral	Disagree	Strongly Disagree
I am connected to a primary care doctor or health clinic that I am happy with.	○	○	○	○	○
I can access the health care services that I need within a reasonable time frame and distance from my home or work.	○	○	○	○	○
I know where to find the health care resources or information I need when I need them.	○	○	○	○	○
There are good quality health care services in my community.	○	○	○	○	○
There are affordable health care services in my community.	○	○	○	○	○
Individuals in my community can access healthcare services regardless of race, gender, sexual orientation, immigration status, etc.	○	○	○	○	○

* 15. How would you rate your own personal health in the past 12 months? Select one.

- ○ Very Unhealthy
- ○ Unhealthy
- ○ Somewhat Healthy
- ○ Healthy
- ○ Very Healthy

16. Do you currently have a health insurance plan/health coverage? Select one.

- ○ Yes
- ○ No
- ○ I don't know

TidalHealth and Somerset & Wicomico Health Depts. Community Health Survey 2021

Community Health

* 17. Which type(s) of health plan(s) do you use to pay for your health care services? Select all that apply.

- [ ] Medicaid
- [ ] Medicare
- [ ] Insurance through an employer (HMO/PPO) - either my own or partner/spouse/parent
- [ ] Insurance through the Health Insurance Marketplace/Obama Care/Affordable Care Act (ACA)
- [ ] Private Insurance I pay for myself (HMO/PPO)
- [ ] Indian Health Services
- [ ] Veteran's Administration
- [ ] COBRA
- [ ] I pay out of pocket/cash
- [ ] Other (please specify)

18. In the past 12 months, was there a time that you needed health care services but did not get the care that you needed? Select one.

- ◯ Yes
- ◯ No, I got the services I needed
- ◯ Does not apply, I did not need health care services in the past year

TidalHealth and Somerset & Wicomico Health Depts. Community Health Survey 2021

Community Health

* 19. Select the top reason(s) that you did not receive the health care services that you needed in the past 12 months. Select all that apply.

- [ ] Cost - too expensive/can't pay
- [ ] No insurance
- [ ] Lack of transportation
- [ ] Language barrier
- [ ] Hours of operation did not fit my schedule
- [ ] Wait is too long
- [ ] No doctor is nearby
- [ ] Office/service/program has limited access or is closed due to COVID-19
- [ ] Insurance not accepted
- [ ] Cultural/religious reasons
- [ ] Other (please specify)

20. In the past 12 months, was there a time that you needed dental or oral health services but did not get the care that you needed? Select one.

- ◯ Yes
- ◯ No, I got the services I needed
- ◯ Does not apply, I did not need dental/oral health services in the past year

TidalHealth and Somerset & Wicomico Health Depts. Community Health Survey 2021

Community Health

* 21. Select the top reason(s) that you did not receive the dental or oral health services that you needed in the past 12 months. Select all that apply.

- ☐ Cost - too expensive/can't pay
- ☐ No insurance
- ☐ Lack of transportation
- ☐ Language barrier
- ☐ Hours of operation did not fit my schedule
- ☐ Wait is too long
- ☐ No doctor is nearby
- ☐ Office/service/program has limited access or is closed due to COVID-19
- ☐ Insurance not accepted
- ☐ Cultural/religious reasons
- ☐ Other (please specify)

22. In the past 12 months, was there a time that you needed or considered seeking mental health services or alcohol/substance abuse treatment but did not get services? Select one.

- ◯ Yes
- ◯ No, I got the services I needed
- ◯ Does not apply, I did not need services in the past year

TidalHealth and Somerset & Wicomico Health Depts. Community Health Survey 2021

Community Health

* 23. Select the top reason(s) that you did not receive mental health services or alcohol/substance use treatment. Select all that apply.

- [ ] Cost - too expensive/can't pay
- [ ] No insurance
- [ ] Lack of transportation
- [ ] Hours of operation did not fit my schedule
- [ ] Language barrier
- [ ] Wait is too long
- [ ] Other (please specify)
- [ ] No doctor is nearby
- [ ] Office/service/program has limited access or is closed due to COVID-19
- [ ] I did not know how treatment would work
- [ ] I worried that others would judge me
- [ ] Cultural/religious reasons

24. In the past 12 months, did you go to a hospital Emergency Department (ED)? Select one.

- ○ Yes
- ○ No, I have not gone to a hospital ED in the past 12 months

TidalHealth and Somerset & Wicomico Health Depts. Community Health Survey 2021

Community Health

25. Please select the number of times you have gone to the ED in the past 12 months. Select one.

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6 or more

* 26. What were the main reasons that you went to the Emergency Department (ED) instead of a doctor's office or clinic? Select all that apply.

- [ ] After clinic hours/weekend
- [ ] I do not have a regular doctor/clinic
- [ ] I do not have health insurance
- [ ] Concerns about cost or co-pays
- [ ] Other (please specify)
- [ ] Emergency/Life-threatening situation
- [ ] Long wait for an appointment with my regular doctor
- [ ] Needed food, shelter, or other resources

TidalHealth and Somerset & Wicomico Health Depts. Community Health Survey 2021

Employment and Education

* 27. Below are some statements about employment and education in your community. Please rate how much you agree or disagree with each statement. Select an option for your response in each row below.

	Strongly Agree	Agree	Feel Neutral	Disagree	Strongly Disagree
There are plenty of jobs available for those who are over 18 years old.	○	○	○	○	○
There are plenty of jobs available for those who are 14 to 18 years old.	○	○	○	○	○
There are job trainings or employment resources for those who need them.	○	○	○	○	○
There are resources for individuals in my community to start a business (financing, training, real estate, etc.).	○	○	○	○	○
Childcare (daycare/pre-school) resources are affordable and available for those who need them.	○	○	○	○	○
The K-12 schools in my community are well funded and provide good quality education.	○	○	○	○	○
Our local University/Community College provides quality education at an affordable cost.	○	○	○	○	○

28. Which is your current employment status? Select one.

- ○ Employed, working full-time
- ○ Employed, working part-time
- ○ Home-maker
- ○ Out of work, looking for work
- ○ Out of work, but NOT currently looking for work
- ○ Unable to work
- ○ A student
- ○ Retired

TidalHealth and Somerset & Wicomico Health Depts. Community Health Survey 2021

Employment and Education

29. What is the main reason(s) you are not working? Select any that apply.

- ☐ Sick or disabled, not able to work
- ☐ Cannot find work
- ☐ Care giver for a family member
- ☐ Need more training
- ☐ Furloughed or temporarily unemployed
- ☐ Other (please specify)

TidalHealth and Somerset & Wicomico Health Depts. Community Health Survey 2021

Housing and Transportation

30. Below are some statements about housing, transportation, and safety in your community. Please rate how much you agree or disagree with each statement. Select an option for your response in each row below.

	Strongly Agree	Agree	Feel Neutral	Disagree	Strongly Disagree
There are affordable places to live in my community.	○	○	○	○	○
Streets in my community are typically clean and buildings are well maintained.	○	○	○	○	○
I feel safe in my own neighborhood.	○	○	○	○	○
Crime is not a major issue in my neighborhood.	○	○	○	○	○
There is a feeling of trust in Law Enforcement in my community.	○	○	○	○	○
Transportation is easy to get to if I need it.	○	○	○	○	○

31. What transportation do you use most often to go places? Select one.

- ◯ Drive my own car
- ◯ Walk
- ◯ Ride a motorcycle or scooter
- ◯ Ride a bicycle
- ◯ Someone drives me
- ◯ Other (please specify)
- ◯ Use medical transportation/specialty van transport
- ◯ Take a taxi or ride share service (Uber/Lyft)
- ◯ Take a bus
- ◯ Hitchhike

* 32. Which of the following categories best reflects your current living situation? Select one.

- ◯ Live alone in a home (house, apartment, condo, trailer, etc.)
- ◯ Live in a home with another person such as a partner, sibling(s), or roommate(s)
- ◯ Live in single-family home that includes a spouse or partner AND a child/children under age 25
- ◯ Live in a multi-generational home (home includes grandparents or adult children age 25+)
- ◯ Multi-family home (more than one family lives in the home)
- ◯ Other (please specify)
- ◯ Live in an assisted living facility or adult foster care (such as nursing home)
- ◯ Temporarily staying with a relative or friend
- ◯ Staying in a shelter or are homeless (living on the street)
- ◯ Living in a tent, recreational vehicle (RV), or couch-surfing

33. Does your current housing situation meet your needs? Select one.

- ◯ Yes
- ◯ No

TidalHealth and Somerset & Wicomico Health Depts. Community Health Survey 2021

Housing and Transportation

34. What issues do you have with your current housing situation? Select all that apply.

- [ ] Too small /crowded, problems with other people
- [ ] Unsafe, high crime
- [ ] Too run down or unhealthy environment (ex. mold, lead)
- [ ] Rent/facility is too expensive
- [ ] Mortgage is too expensive
- [ ] Other (please specify)
- [ ] Too far from town/services
- [ ] Current housing is temporary, need permanent housing
- [ ] Need supportive and/or assisted living
- [ ] None of the above

35. In the past 2 years, was there a time when you (and your family) were living on the street, in a car, or in a temporary shelter? Select one.

- ◯ Yes, 1 or 2 times in the past 2 years
- ◯ Yes, 3 or more times in the past 2 years
- ◯ No

36. In the past 12 months, has the utility company shut off your service for not paying your bills? Select one.

- ◯ Yes
- ◯ No
- ◯ Does not apply - I do not pay utility bills

37. Are you worried or concerned that in the next 2 months you (and your family) may not have stable housing that you own, rent, or stay in as part of a household? Select one.

- ◯ Yes
- ◯ No

TidalHealth and Somerset & Wicomico Health Depts. Community Health Survey 2021

Access to Healthy Food and Community Resources

38. Below are some statements about access to food and resources in your community. Please rate how much you agree or disagree with each statement. Select an option for your response in each row below.

	Strongly Agree	Agree	Feel Neutral	Disagree	Strongly Disagree
We have good parks and recreational facilities	○	○	○	○	○
There are good sidewalks or trails for walking safely	○	○	○	○	○
It is easy for people to get around regardless of abilities	○	○	○	○	○
The air and water quality are good in my community	○	○	○	○	○
Affordable healthy food options are easy to purchase at nearby grocery stores or farmer's markets	○	○	○	○	○
Local restaurants serve healthy food options	○	○	○	○	○
In my neighborhood it is easy to grow/harvest and eat fresh food from a home garden	○	○	○	○	○

39. In the past 12 months, did you worry about whether your food would run out before you got money to buy more? Select one.

- ○ Often
- ○ Sometimes
- ○ Never

40. In the past 12 months, was there a time when the food that you bought just did not last, and you did not have money to get more? Select one.

- ○ Often
- ○ Sometimes
- ○ Never

41. In the past 12 months, did you or someone living in your home receive emergency food from a church, a food pantry, or a food bank, or eat in a soup kitchen? Select one.

- ◯ Often
- ◯ Sometimes
- ◯ Never

TidalHealth and Somerset & Wicomico Health Depts. Community Health Survey 2021

COVID-19

During this time, we understand that COVID-19 has impacted everyone's lives, directly and indirectly. We would like to know how these events have impacted you and your household to better understand how our community has been affected overall.

REMINDER: This is an anonymous survey. If you or anyone in your household has questions or concerns related to COVID-19, information is available at www.wicomicohealth.org.

* 42. We know the COVID-19 pandemic is challenging in many ways. Please select from the following list the issues that are the biggest challenge for your household right now. Select all that apply.

- ☐ Access to basic medical care
- ☐ Access to emergency medical services
- ☐ Access to prescription medications
- ☐ A shortage of food
- ☐ A shortage of healthy food
- ☐ A shortage of sanitation and cleaning supplies (e.g., toilet paper, disinfectants, etc.)
- ☐ Challenges for my children attending school (in person or virtually)
- ☐ Experience housing challenges or homelessness
- ☐ Feeling alone/isolated, not being able to socialize with other people
- ☐ Feeling nervous, anxious, or on edge
- ☐ Household members not getting along
- ☐ Household member(s) have or have had COVID-19 or COVID-like symptoms (fever, shortness of breath, dry cough)
- ☐ Lack of technology to communicate with people outside of my household, access virtual school, or work remotely from home (e.g. internet access, computer, tablet, etc.)
- ☐ Lack of skills to use technology to communicate, access virtual school, or work remotely from home
- ☐ Not being able to exercise
- ☐ Not knowing when the pandemic will end/not feeling in control
- ☐ Options for childcare services/lack of childcare support
- ☐ Unable to find work
- ☐ None of the following apply
- ☐ Other (please specify)

43. What is your COVID-19 Vaccine status?

- ○ I am vaccinated
- ○ I plan to get vaccinated
- ○ I do not plan to get vaccinated

TidalHealth and Somerset & Wicomico Health Depts. Community Health Survey 2021

COVID-19

44. If you are planning to get vaccinated, have any of the following contributed to the delay? Select all that apply.

- ☐ I have just not scheduled my appointment
- ☐ Uncertain about the safety or side-effects of the vaccine
- ☐ Challenges getting a vaccine appointment
- ☐ Not able to take off work for an appointment
- ☐ Other (please specify)
- ☐ Lack of transportation
- ☐ Language barrier
- ☐ No vaccine site is nearby
- ☐ Wait is too long

45. If you do not plan to get vaccinated, help us understand why:

- ☐ I do not believe the vaccine is safe for me
- ☐ I have a pre-existing condition that makes me ineligible
- ☐ Cultural or religious reasons
- ☐ Other (please specify)

TidalHealth and Somerset & Wicomico Health Depts. Community Health Survey 2021

Thank You

Thank you for taking the time to participate in this community survey. Your feedback and insight are vital as we work to improve and address issues impacting our community's health.

APPENDIX C

COMMUNITY RESOURCES AND POTENTIAL COMMUNITY PARTNERS

Christian Shelter – Salisbury, MD

Diakonia - Ocean City, MD

La Red Health Center – Sussex, DE

Lower Shore Vulnerable Populations Task Force – Salisbury, MD

Salisbury Urban Ministries – Salisbury, MD

Chesapeake Healthcare

Deer's Head Hospital Center

HOPE, Inc.

MAC, Inc.

Rebirth, Inc.

Recovery Resource Center

Salisbury University

Somerset County Schools

Sussex County Coalition

University of Maryland Eastern Shore (UMES)

Wicomico County Council

APPENDIX D

2019-2020 IMPLEMENTATION STRATEGY PLAN/CHIP

2019 – 2022
Implementation Strategy Plan
for TidalHealth Peninsula Regional

Community Health Improvement Plan
for Somerset County Health Department and Wicomico County Health Department

Fiscal Year 2022 Plan Update

Public Health
Prevent. Promote. Protect.
Somerset County Health Department

Public Health
Prevent. Promote. Protect.
Wicomico County Health Department

TidalHealth™

2019 – 2022 Implementation Strategy Plan
for TidalHealth Peninsula Regional
and
Community Health Improvement Plan
for Somerset County Health Department and
Wicomico County Health Department

Fiscal Year 2022 Plan Update

The 2019 – 2022 plan has been updated for Fiscal Year 2022 (July 1, 2021 – June 30, 2022).

- Several program activities and evaluation measures have been updated.
- A summary of FY20 and FY21 progress is provided in Appendices A and B.
- The document reflects the name change of Peninsula Regional Medical Center (PRMC) to TidalHealth Peninsula Regional. In January 2020, PRMC was re-branded to reflect the merge with McCready Health in Crisfield and Nanticoke Memorial in Seaford.
- The internal team staff members identified for TidalHealth Peninsula Regional, Somerset County Health Department, and Wicomico County Health Department has been updated to reflect staff changes.

Introduction

TidalHealth Peninsula Regional, in partnership with Somerset County Health Department (SCHD), and Wicomico County Health Department (WiCHD) is pleased to share their Implementation Strategy Plan, which follows the development of the 2019 Community Health Needs Assessment (CHNA). In accordance with requirements in the Affordable Care Act and IRS 990 Schedule H requirements, this plan was approved by the TidalHealth Peninsula Regional Board of Directors on November 7, 2019. This document also serves as the Community Health Improvement Plan for the health departments and was approved by the Somerset Local Health Improvement Coalition (LHIC) on November 12, 2019, and approved by the Wicomico LHIC on December 6, 2019.

After a thorough review of the health status in our community through the Community Health Needs Assessment (CHNA), we identified areas that we could address using our resources, expertise, and community partners.

The following are the prioritized health needs that will be addressed:

- Behavioral Health (Mental Health and Mental Disorders as well as Substance Abuse)
- Diabetes
- Cancer (Focus Areas: Breast, Colorectal, Cervical, Lung, Skin)

Each priority area selected, will also address access to care when possible and appropriate.

This Implementation Strategy summarizes the plans for TidalHealth Peninsula Regional, SCHD, and WiCHD to develop and/or collaborate on community benefit programs that address the prioritized health needs identified in the 2019 CHNA.

TidalHealth Peninsula Regional provides additional support for community benefit activities in the community that lay outside the scope of the programs and activities outlined in this Implementation Strategy. However, those additional activities will not be explored in detail in this document.

Additionally, this document includes the significant health needs that the partnership will not be addressing and why.

TidalHealth Peninsula Regional, SCHD, and WiCHD

TidalHealth Peninsula Regional is the 8th largest hospital in Maryland with 288 acute care beds, and the region's largest, most advanced tertiary care facility, which has been meeting the healthcare needs of

Delmarva Peninsula residents since 1897. Its 3,300 physicians, staff, and volunteers provide safe, compassionate, and affordable care designed to exceed the expectations of the nearly 500,000 patients who rely on the Medical Center team each year for inpatient, outpatient, diagnostic, sub-acute and emergency/trauma services. It is the region's oldest healthcare institution with the most experienced team of healthcare professionals. It also infuses over $500 million annually into its regional economy, and is the recipient of over 125 national awards, recognitions, and certifications in the past half-decade for the care it offers patients and the outcomes they experience.

Somerset County Health Department's (SCHD) mission is "Dedicated to serving the Public by preventing illness, promoting wellness and protecting the health of our community." The Health Department continues to evolve with the changes in the healthcare system and is currently in the planning stage of the Public Health Accreditation process.

Wicomico County Health Department's (WiCHD) mission is "To maximize the health and wellness of all members of the community through collaborative efforts." The public health department, accredited by the Public Health Accreditation Board on March 8, 2016, has expanded over the years to meet changing needs of the community and continually works toward protecting the health and environment of the people of Wicomico County.

TidalHealth Peninsula Regional, SCHD, and WiCHD service areas are jointly defined by Somerset, Wicomico, and Worcester counties in the state of Maryland. These three counties are referred to as the Tri-County Service Area. Additionally, the service area includes the 43 zip codes and associated census places and census tracts within those three counties.

Community Health Needs Assessment

In December 2018, TidalHealth Peninsula Regional, SCHD, and WiCHD published their 2019 Community Health Needs Assessment (CHNA). The CHNA Report provides an overview of significant health needs in the Tri-County Service Area. This CHNA report was developed to provide an overview of the health needs in the Tri-County Service Area, including Somerset, Wicomico, and Worcester counties in Maryland. TidalHealth Peninsula Regional, SCHD, and WiCHD partnered with Conduent Healthy Communities Institute (HCI) to conduct the CHNA. The goal of this report is to offer a meaningful understanding of the greatest health needs across the Tri-County Service Area, as well as to guide planning efforts to address those needs. Special attention has been given to identify health disparities, needs of vulnerable populations, unmet health needs or gaps in services, and input from the community.

The CHNA findings are drawn from an analysis of an extensive set of secondary data (over 100 indicators from national and state data sources) and in-depth primary data from community health leaders and organizations that serve the community at large, as well as non-health professionals and community members. The main source for the secondary data, or data that has been previously collected, is the TidalHealth Creating Healthy Communities platform, a publicly available data platform that is embedded on the main TidalHealth Peninsula Regional website. That platform can be found here: https://www.tidalhealth.org/community-outreach-partners/community-health-research-data/creating-healthy-communities.

Priorities

On October 24, 2018, TidalHealth Peninsula Regional, SCHD and WiCHD came together to prioritize the significant health needs in a session facilitated by Conduent HCI consultants. Using a prioritization matrix, participants voted on the most critical needs while considering the following criteria:

- Importance of problem to the community
- Alignment with Maryland SHIP 2017 objectives
- Opportunity for partnership
- Addresses disparities of subgroups
- Existing resources/programs to address the problem

The following three topics were selected as the top priorities:

- Behavioral Health (Mental Health and Mental Disorders as well as Substance Abuse)
- Diabetes
- Cancer (Focus Areas: Breast, Colorectal, Cervical, Skin)

Each priority area selected, will also address access to care when possible and appropriate.

No one organization can address all the health needs identified in its community. TidalHealth Peninsula Regional, SCHD, and WiCHD are committed to serving the community by adhering to their mission, and using their skills, expertise, and resources to provide a range of community

benefit programs. This Implementation Strategy does not include specific plans to address other significant health needs including: Older Adults & Aging, and Oral Health.

These needs were not selected because they did not meet the prioritization criteria as strongly as the selected topics. TidalHealth Peninsula Regional, SCHD, and WiCHD have other programs in these areas, but they are not the focus of this report.

Implementation Strategy Design Process

In April 2018, TidalHealth Peninsula Regional contracted with Conduent HCI to facilitate the Implementation Strategy process. TidalHealth Peninsula Regional, SCHD, and WiCHD assembled an internal team and created an inventory of existing programs in the chosen priority areas. Conduent HCI reviewed the inventory for those with an evidence base and those most applicable for community benefit. Conduent HCI also conducted research into additional evidence-based programs for consideration by the internal team. As a result, TidalHealth Peninsula Regional, SCHD, and WiCHD are committed to a portfolio of new and existing programs to create positive change for the prioritized health needs of their community.

TidalHealth Peninsula Regional, SCHD, and WiCHD Internal Team

Stakeholder	Organization/Title
Chris Hall	TidalHealth, Vice President, Strategy & Business Development
Kathryn Fiddler	TidalHealth, Vice President, Population Health Management
Henry Nyce	TidalHealth, Manager, Planning and Business Development
Logan Becker	TidalHealth, Planning Analyst
Allie O'Leary	TidalHealth, Population Health Data Analyst
Kat Rodgers	TidalHealth, Director, Community Health Initiatives
Lori Brewster	WiCHD Health Officer
Lisa Renegar	WiCHD, Health Planner, Office of Planning
Danielle Weber	SCHD Health Officer
Sharon Lynch	SCHD, Preventive Services & Communications Supervisor

Priority Areas

Behavioral Health

Goal 1: Address behavioral issues in the Tri-County Service Area by reducing the instances of opioid-related deaths.

Strategies:

- Collaboratively address the opioid crisis in the Tri-County Service Area with an emphasis on prevention, treatment, resources, and enforcement.
- Provide peer support for people who have overdosed or sought help for opioid addiction issues.

Goal 2: Address behavioral health issues in the Tri-County Service Area by prioritizing programs and services for seniors suffering with minor to major depression.

Strategies:

- Address depression in adults 50 years or older through skill building, problem solving, and socialization activities.

Objectives and Anticipated Impact for Goal 1:

- Work collaboratively to address policy, develop education, and raise community awareness in the fight against opioid use and continue to reduce instances of heroin overdose each year.
    - **Evaluation Measures for Somerset County Opioid United Team**
        - # of individuals exposed to opioid related messaging through an advertising "campaign." Target - 7,000
        - # of individuals attending community events held in schools. Target - 600
        - # of individuals attending educational/training events held in the community. Target - 1500
        - # of additional officer hours dedicated to opioid related calls and initiative. Target - 480
        - % of overdose cases shared by Law Enforcement with the Health Department. Target - 100%
        - # of individuals referred to Peer Recovery Support Specialists (PRSS) from Law Enforcement. Target – 30
        - # of resource cards given to Law Enforcement Officers to disseminate to overdose patients, families, friends, and the community. 2000
        - # of individuals referred to PRSS from Emergency Department. Target – 20
        - # of individuals referred to PRSS from Law Enforcement. Target – 30.

        - # of individuals referred to treatment by PRSS. Target -25.
        - # of Individuals referred to treatment by PRSS who were admitted to treatment. Target - 15
    - **Evaluation Measures for Wicomico County Opioid Intervention Team**
        - # of OIT meetings held. Target- 25
        - # of community events where Opioid Coordinator was present and providing education to the community. Target- 10
        - # of Local Overdose Fatality Review Team (LOFRT) meetings attended- Target-10
        - # of individuals who attend CE (continuing education) trainings planned by OIT Coordinator- Target- 100
        - # of individuals exposed to messaging via tv, radio, or social media – Target- 60,000
        - # of times the OIT Educational Trailer is deployed in FY21 Target-10
        - # of Medication Disposal Bags provided to community members. Target-150
        - #of individuals provided education via OIT trailer- Target- 500
        - # of first responders who attended dinner and received education- Target-75

- Utilizing the Community Outreach Addictions Team (C.O.A.T.), contact and provide linkage to treatment and other support services to community members dealing with substance abuse issues.
    - **Evaluation Measures**
        - # of contact attempts
        - # of opioid users contacted
        - # linked to treatment
        - % of those who receive treatment and remain in recovery for 6 months and beyond
- # supported through navigation services (increase access to insurance, primary care physicians, and social service benefits)Reduce avoidable or preventable Emergency Department (ED) Utilization
    - **Evaluation Measures for SWIFT**
        - # of patients served
        - Pre/Post analysis of hospital utilization for recipients of SWIFT

Objectives and Anticipated Impact for Goal 2:

- Reduce the instances of depression in older adults through outreach and access to an evidence-based intervention program. Increase percent of program participants with a significant reduction of depression above the 2018 baseline of 50%
    - **Evaluation Measures**
        - # of community members enrolled
        - % of enrollees with reduction in level of depression maintained over 12 months

        - % of enrollees achieving remission of depression symptoms for at least 6 months
        -
- Increase Access to Care for Smith Island.
    - **Evaluation Measures for Smith Island:**
        - # patients served
        - # Medication refills
        - # of telehealth visits
        - # Office visits
        - # labs
        - # community BP
        - Pre/Post analysis of ED utilization for residents of Smith Island.

Recommended Policy Change:

- Align and integrate prevention and treatment efforts among public and private agencies.
- Design communications that help people understand detection, management, and decreased stigma of mental illness and their associated risk factors.

TidalHealth Peninsula Regional Resource Contributions:

- TidalHealth Peninsula Regional staff
- Data Collection
- Vehicles/Transportation
- Phone Service
- Staff training and materials as needed

Alignment Opportunities:

- TidalHealth Peninsula Regional as part of a regional partnership with Atlantic General Hospital in Worcester County, Worcester County Health Department, and SCHD and WiCHD are collaborating with the Maryland Health Service Cost Review Commission to develop a regional approach to behavioral health. The planning for the crisis stabilization center began in fiscal 2021. A 23-hour center will be located in Salisbury and an additional site will be located in Berlin with limited hours.
- The health departments and hospitals are also collaborating on a "Hub and Spoke" grant focusing on primary care offices that assist patients in initiating medication assisted treatment. This grant award continues through September 2024. WiCHD Strategic Plan 2017-2022, Priority #1: Improve community health and wellness by focusing on priority areas identified in collaboration with the Local Health Improvement Coalition: chronic disease and behavioral health. Increasing access to care will be addressed in the priority areas.

Programs to Address Behavioral Health

1. **Community Outreach Addictions Team (C.O.A.T.)**

TidalHealth Peninsula Regional and WiCHD will build off the successful efforts that were included for this program in their 2016 Implementation Strategy Plan

Activities:

- Train peer support specialists
- Provide phone and in-person support for people who have overdosed or who struggle with opioid addiction, as well as other substance abuse issues
- Provide connections to resources including treatment options
- Provide peer outreach to high risk areas of the community
- Maintain ongoing communications about metrics between TidalHealth Peninsula Regional and C.O.A.T. team
- Evaluate expansion to Somerset County
- Collaborate with TidalHealth Peninsula Regional to meet with any patient, 24/7, who has overdosed; C.O.A.T. will address barriers to treatment, such as insurance, transportation, etc.

Program Owner:

- Wicomico County Health Department

Program Collaborators:

- TidalHealth Peninsula Regional
- Somerset County Health Department
- Hudson Health Services, Inc.
- Lower Shore Clinic, Inc.
- Wicomico County Sheriff's Department
- Tri-County community Primary Care Physicians
- Law Enforcement
- EMS
- Office of the State's Attorney General
- Numerous other community providers assist with resources and access to program services

2. Wicomico County Opioid Intervention Team and Somerset County Opioid United Team

Activities:

- Bring awareness, education, and resources to the community to work toward reducing the stigma associated with addiction and substance use disorders.
- Provide OIT partners and stakeholders with continuing education opportunities, which include Harm Reduction focused trainings, with the ability to obtain continuing education credits.
- Target awareness activities and campaigns for the community, which will include a community event.

- Participation in drug awareness coalitions and other community meetings that seek to address the opioid epidemic.
- Provide education to the general community via the OIT educational trailer. This is a mock teenage bedroom set up to show possible red flags for unhealthy behavior and/or substance use.
- Coordinate and host first responder dinner to help address compassion fatigue among the first responder population.
- Work with community partners to coordinate the Go Purple Substance Misuse Awareness Campaign

Program Owners:

- Wicomico County Health Department
- Somerset County Health Department

Program Collaborators:

- TidalHealth Peninsula Regional
- Wicomico County Health Department
- Somerset County Health Department
- Wicomico County Executive's Office
- Wicomico County Department of Emergency Services
- Wicomico County State's Attorney
- Wicomico County Sheriff's Office
- Maryland State Police Barrack E
- Fruitland Police Department
- Salisbury Police Department
- Natural Resource Police
- Pittsville Police Department
- Delmar Police Department
- Hudson Health Services, Inc.
- Maryland Coalition of Families
- Clarion Call Restoration Ministries
- MAC, Inc.
- Peninsula Addictions and Mental Health
- J. David Collins and Associates
- Second Wind, Inc.
- Focus Point Behavioral Health
- United Way of the Lower Eastern Shore
- SonRise Church 8
- Recovery Resource Center
- City of Salisbury Fire Department
- High Intensity Drug Trafficking Area (HIDTA) Program
- Eastern Shore Psychological Center
- Wor-Wic Community College
- Salisbury University

- Wicomico County Public Schools/Board of Education
- BNJ Health Services
- St. James AME Methodist Church
- Department of Social Services
- Department of Parole and Probation
- Sante Group/Mobile Crisis
- Life Crisis Center
- Community Behavioral Health
- Deer's Head Hospital Center
- Comcast Spotlight
- Lower Shore Clinic, Inc.
- DKH Recovery House
- Somerset County Emergency Services
- Crisfield Police Department
- Somerset County Sheriff's Office
- McCready Health
- Somerset County Department of Social Services
- Princess Anne Police Department
- Department Parole & Probation
- Crisfield Drug Free Community
- University of Maryland Eastern Shore
- Somerset Circuit Court
- Somerset Recovery Court
- Somerset County Public Schools

3. **Program to Encourage Active and Rewarding Lives (PEARLS)**

Activities:

- Raise awareness of this free program through targeted outreach to clinicians caring for older adults, as well as senior centers and other local organizations serving older community members
- Provide engaging and impactful curriculum in an easy-to-learn approach through flexible one-on-one visits at locations convenient for the community member being served

Program Owner:

- TidalHealth Peninsula Regional

Program Collaborators:

- MAC, Inc.

4. **SWIFT**

Activities:

- SWIFT–a mobile integrated health team makes home-based visits to individuals utilizing 911 at least five times over a six-month period for non-life-threatening medical reasons. The team provides physical, mental, and safety assessments, and screens for social determinants of health. Based on their assessment, patients are referred for appropriate care interventions such as primary care providers, medical specialists, in-home providers, financial and social resources, as well as other community resources as necessary.
- Update for FY2022 – The SWIFT program is expanding to a wider radius in Wicomico County outside of Salisbury. Additionally, an expanded model for SWIFT launched August 2021 in which a TidalHealth nurse practitioner and fire department paramedic respond in real time to low acuity 911 calls.
- TidalHealth is partnering with Salisbury University to distribute Narcan and provide Narcan training through the Community Wellness and SWIFT programs.

Program Owner:

- TidalHealth Peninsula Regional Program

Collaborators:

- City of Salisbury
- Wicomico County Health Department

5. Smith Island Primary Care and Telemedicine Access
Activities:

- TidalHealth provides primary care in person and via telemedicine to residents of Smith Island. A nurse practitioner and/or physician, pharmacist and other health care providers and educators travel to the island by boat throughout the year. A medical assistant is a resident of the island and provides health outreach and education as well as coordinates in person and telemedicine visits with the providers.

Diabetes

Goal: Improve health of people with diabetes or pre-diabetes in the Tri-County Service Area.

Strategies:

- Offer Evidence-Based Chronic Disease Self-Management Classes (CDSM) throughout the Tri-County Service Area.
- Expand access to diabetes screening, education, and resources throughout the TriCounty Service Area through the TidalHealth mobile Community Wellness program.
- Provide a free evidenced-based weight loss, nutrition, and physical activity program for women and children in Wicomico and Somerset counties.

Objectives and Anticipated Impact:

- By December 2020, increase the number of 6-week educational classes with identified diabetes patients and their supporting caregivers from 26 to 52 per year.
    - **Evaluation Measures:**
        - # of 6-week classes
        - # of people reached
        - Class completion rate
        - % knowledge change

- By partnering with other community stakeholders, the Community Wellness Program will increase access to diabetes screening, education, and connection to community resources. This program, which includes the Wagner Wellness Van outreach, provides health outreach events that are both large-scale and small-scale, and can be aimed toward the general public or a targeted population or geographic area.
    - **Evaluation Measures:**
        - # of screenings provided
        - Number of A1C's checked
        - # of community members referred for diabetes education
        - # of community members referred to their PCP

- Starting in September 2019 and ending in December 2021 SCALE's expected outcomes include: 80% of adult participants will report weight loss of at least 5% of their total body weight from baseline; demonstrated behavior change and improved health status
    - **Evaluation Measures:**
        - % of adults with weight loss of at least 5% of their baseline body weight
        - % knowledge change
        - % reporting improved health status
        - # of adults enrolled in SCALE program
        - # of adults diagnosed as overweight or obese
        - # of adults diagnosed as overweight or obese with improved BMI or weight loss
        - # of adults with an increase in healthy lifestyle choices.

Recommended Policy Changes:

- Increase access to fresh fruits and vegetables through community-based initiatives.
- Increase active time in early childcare care sites and schools including physical education.

TidalHealth Peninsula Regional System Resource Contributions:

- Staff
- Data
- Marketing materials
- Training materials
- Mobile van

- Phone service
- Staff training and materials as needed

Alignment Opportunities:

- WiCHD Strategic Plan 2017-2022, Priority #1: Improve community health and wellness by focusing on priority areas identified in collaboration with the Local Health Improvement Coalition: chronic disease and behavioral health.

Programs to Address Diabetes

1. **Chronic Disease Self-Management (CDSM) Classes**

TidalHealth Peninsula Regional will build off the successful efforts that were included for this program in its 2016 Implementation Strategy Plan

Activities:

- Target and identify patients who have diabetes and their caregivers through self-referral or provider referral
- Train Community Peer Trainers and TidalHealth Peninsula Regional Community Health Workers to conduct classes
- Offer classes in English, Spanish and American Sign Language
- Explore the possibility to offer classes in Haitian-Creole, Korean and Mandarin languages, based on availability of peer trainers in these languages
- Offer 6-week classes at least weekly
- Educate participants on diabetes self-management and have them set and track personal goals weekly and share goals with their providers
- Partner with MAC, Inc. to collect data on pre and post A1C values
- Connect with the statewide Health Information Exchange to make referrals between providers office and Mac, Inc for all CDSM classes

Program Owners:

- MAC, Inc.

Program Collaborators:

- TidalHealth Peninsula Regional

2. **TidalHealth Community Wellness Program expansion**

TidalHealth Peninsula Regional and WiCHD will build off the successful efforts that were included for this program in its 2016 Implementation Strategy Plan

Activities:

- Outreach to communities utilizing a Nurse Practitioner (NP) to provide primary care services.
- Provide screenings for diabetes (other screenings provided as well).

- Identify need for and make referrals to community resources for health education programs.
- Ensure those people identified as diabetic or pre-diabetic are referred for primary care follow up.
- Track rate of successful PCP follow up for all referrals.
- Identify barriers to accessing PCP follow up and work towards future solutions.
- Connect individuals with additional social and economic needs to a community health worker to address SDOH and self-management education.

Program Owners:

- TidalHealth Peninsula Regional

Program Collaborators:

- Wicomico, Somerset and Worcester County Health Departments
- HOPE
- HALO
- Salisbury Urban Ministries
- St. James AME
- St. Peter's Lutheran
- Resource and Recovery Center
- Atlantic Club
- Marion Pharmacy
- MAC, Inc
- National Kidney Foundation
- Wicomico County Schools
- Maryland Food Bank
- Various other community and faith-based organizations

3. Sustainable Change and Lifestyle Enhancement (SCALE)

Activities:

- Target outreach to overweight women of child bearing age (up to age 55) and overweight children ages 7 – 17
- Offer education and activities to encourage healthier eating and physical activity
- Provide support through cooking demonstrations, grocery store tours, walks and better access to fresh, healthy food

Program Owners:

- Wicomico County Health Department
- Somerset County Health Department

Program Collaborators:

- TidalHealth Peninsula Regional
- YMCA

- University of Maryland Eastern Shore
- Wicomico County Detention Center
- HOPE
- Community Health Providers

Cancer

Goal: Improve cancer prevention, and early detection and intervention/treatment of cancer to provide the best possible outcomes in the Tri-County Area for colorectal, breast, cervical, lung and skin cancer in the Tri-County Area.

Strategies:

- Partner with WiCHD and SCHD to expand cancer screening
- Utilize cancer rate data to identify neighborhoods with high cancer incidence rates for targeted education and screening activities
- Collaborate with local school district(s) and colleges/universities to integrate skin cancer prevention education within student health curricula

Objectives and Anticipated Impact:

- Working in partnership with the WiCHD and SCHD offer additional cancer prevention programs and screening options for underserved community members, and connect those that need it to treatment
- Increase knowledge of at-risk activities for cancer, importance of healthy behaviors in prevention of cancer and importance of screening activities
    - **Evaluation Measures:**
        - # of individuals reached with cancer screening
        - # of individuals reached with prevention education
        - # of screenings conducted
        - % follow up post positive screening
        - # of patients connected to treatment
        - # events participated in

Recommended Policy Changes:

- Design culturally competent communications that help people understand the importance of screening for early detection
- Engage communities with health disparities to modify risky behaviors and to access resources for prevention

TidalHealth Peninsula Regional System Resource Contributions:
Providers for screening

Programs in Support of the Strategies

1. **TidalHealth Community Wellness Program and Cancer Institute**

Activities

- Increase knowledge in terms of cancer prevention and healthy lifestyle (American Cancer Society handout, etc.)
- Skin cancer screening
- Education
- Referral for cancer screenings

Program Owner:

- TidalHealth Peninsula Regional

Program Collaborators:

- Wicomico County Health Department
- Somerset County Health Department

Alignment Opportunities

- WiCHD Strategic Plan 2017-2022, Priority #1: Improve community health and wellness by focusing on priority areas identified in collaboration with the Local Health Improvement Coalition: chronic disease and behavioral health

APPENDIX A

FY 2020 Progress in Addressing Priority Areas				
BEHAVIORAL HEALTH PRIORITY AREA **Goal:** Address behavioral issues in the Tri-County Service Area by reducing the instances of opioid related deaths **Goal:** Address behavioral issues in the Tri-County Service Area by targeting seniors suffering with minor to major depression **Strategies:** • Collaboratively address the opioid crisis in the Tri-County Service Area with an emphasis on prevention, treatment, resources, and enforcement • Provide peer support for people who have overdosed or sought help for opioid addiction issues • Address depression in adults 50 years or older through skill building, problem solving, and socialization activities				
Program Owner	**Program**	**Activities**	**Objectives** • Evaluation Measures	**FY 2020 Evaluation Data**
WiCHD	C.O.A.T.	• Train peer support specialists • Provide phone and in-person support for people who have overdosed or who struggle with opioid addiction, as well as other substance abuse issues • Provide connections to resources including treatment options • Provide peer outreach to high risk areas of the community • Maintain ongoing communications about metrics between PRMC and C.O.A.T. team •Evaluate expansion to Somerset County	**Contact and provide linkage to treatment and other support services to community members dealing with substance abuse issues** • of contact attempts • # of opioid users contacted • # linked to treatment • % of those who receive treatment and remain in recovery for 6 months and beyond • # supported through navigation services (increase access to insurance, primary care physicians, and social service benefits)	• 1,413 Contact Attempts • 240 served* • 119 linked to treatment* •6 month follow-up data to be reported in FY21** •260 Navigation Services * * *Data for the categories marked, do not include data from July 1, 2019 - December 31, 2019 due to a change in data collection and data operationalization.* ***This measure assesses progress of individuals served the prior fiscal year. Data collection began January 2020. Six months of data will be reported in the FY21 report.*

SCHD WiCHD	Opioid Teams	• Bring awareness, education, and resources to the community to work toward eliminating opioid abuse • Target awareness activities and campaigns to the community and schools • Participation in drug awareness coalitions • Narcan training for community members • Develop and implement an OIT educational trailer for parents, guardians, and adults This is a mock teenage bedroom set up to show possible red flags for unhealthy behavior and/or substance use • Coordinate and host first responder dinner to help address compassion fatigue • Work with community partners to coordinate the Go Purple Awareness Campaign	**Work collaboratively to address policy, develop education, and raise community awareness in the fight against opioid use and continue to reduce instances of heroin overdose each year** • Monthly data from ED visits on opioid overdoses collected and reported to the count • # of individuals Narcan trained • # of individuals exposed to educational messaging • # of prescription drug deactivation bags distributed in the community • # of educational/training events • # of OIT meetings held • # of informational campaigns • # of schools with Go Purple Clubs • # of school based educational Go Purple events	Data is for Somerset and Wicomico Counties • 131 ED visits • 140 Salisbury Fire Dept. Overdose Calls • 319 Narcan Trained • 333,930 exposed to educational messaging • 350 deactivation bags distributed • 66 educational/training events • 37 meetings held • 14 informational campaigns • 8 Go Purple School Clubs • 26 School Go Purple Events
Tidal Health (contracts with MAC)	PEARLS	• Raise awareness of this free program through targeted outreach to clinicians caring for older adults, as well as senior centers and other local organizations serving older community members • Provide engaging and impactful curriculum in an easy-to-learn approach through flexible one-on-one	**Reduce the instances of depression in older adults through outreach and access to an evidence-based intervention program. Increase percent of program participants with a significant reduction of depression above the 2018 baseline of 50%** • # of community members enrolled • % of enrollees with reduction in level of depression maintained over 12 months	• 128 participants enrolled • 38 Active (in-person) • 17 Active (completed and follow-up) • 1 Active (screened out) • 34 Inactive (completed) • 39 Disenrolled or dropped out • 79% enrollees achieved reduction in level of depression • 65% of enrollees achieved remission of depressive symptoms for at least 6 months

		visits at locations convenient for the community member being served	• % of enrollees achieving remission of depression symptoms for at least 6 months	
Tidal Health	ER Utilization Reduction & Access Improvement Wagner Wellness Van; SWIFT; and Smith Island Telemedicine	• Mobile unit conducts home-based visits to individuals utilizing 911 at least five times over a six-month period for non-life-threatening medical reasons. •The team provides physical, mental, and safety assessments, and screens for social determinants of health. •Based on their assessment, patients are referred for appropriate care interventions such as primary care providers, medical specialists, in-home providers, financial and social resources, as well as other community resources as necessary.	**Reduce emergency department utilization of high end users as well as increase access for Smith Island** • # of patients • # refills • # telehealth visits (office, lab and community) • # SWIFT patients served	Smith Island Telemedicine: • Total patients: 184 • Medication refills: 18 • Telehealth visits: 46 • Office: 32 • Lab: 14 • Community BP: 27 SWIFT: • 112 SWIFT Patients served
DIABETES PRIORITY AREA **Goal:** Improve health of people with diabetes or pre-diabetes in the Tri-County Service Area **Strategies:** ● Offer Evidence-Based Chronic Disease Self-Management Classes (CDSM) throughout the Tri-County Service Area ● Expand access to diabetes screening, education, and resources throughout the Tri-County Service Area with the Wagner Wellness Van mobile clinic services ● Provide a free evidenced-based weight loss, nutrition, and physical activity program for women and children in Wicomico and Somerset Counties				
Program Owner	**Program**	**Activities**	**Objectives** • Evaluation Measures	**FY 2020 Evaluation Data**

Tidal Health (contracts with MAC)	CDSM Classes	• Target and identify patients who have diabetes and their caregivers through self-referral or provider referral • Train Community Peer Trainers and PRMC Community Health Workers to conduct classes • Offer classes in English, Spanish and American Sign Language • Explore the possibility to offer classes in Haitian-Creole, Korean and Mandarin languages, based on availability of peer trainers in these languages. • Offer 6-week classes at least weekly • Educate participants on diabetes self-management and have them set and track personal goals weekly and share goals with their providers • Partner with MAC, Inc. to collect data on pre and post A1C values • Connect with the Statewide Health Information Exchange to make referrals between providers and MAC, Inc. for all CDSM classes	**By December 2020, increase the number of 6-week educational classes with identified diabetes patients and their supporting caregivers from 26 to 52 per year** • # of 6-week classes • # of people reached • Class completion rate • % knowledge change	• 14 workshops completed • 105 people reached • 71% completion rate
Tidal Health	Wagner Wellness Van Expansion	• Outreach to communities utilizing a Nurse Practitioner (NP) to provide primary care ser Provide screenings for	**By partnering with other community stakeholders, the Community Wellness Program will increase access to diabetes screening, education, and connection to community resources. This program,**	• 690 screenings • 138 outings • Screening events: 37 • 1,097 patients reached • 150 Diabetes Screenings

		diabetes (other screenings provided as well) • Identify need for and make referrals to community resources for health education programs • Ensure those people identified as diabetic or pre-diabetic are referred for primary care follow up • Track rate of successful PCP follow up for all referrals • Identify barriers to accessing PCP follow up and work towards future solutions	**which includes the Wagner Wellness Van outreach, provides health outreach events that are both large-scale and small-scale, and can be aimed toward the general public or a targeted population or geographic area.** • # of screenings provided • Number of A1C's checked • # of community members referred for diabetes education • # of community members referred to their PCP	• 9 A1cs • 7 referred to PCP **Please note that every patient seen in outreach is offered the pre-diabetes risk assessment. If their score is 5 or above, they are given education by the nurses. If the score is very high (8 or above), they are given education, referred to PCP, and/or finger stick glucose or A1c is performed.*
SCHD WiCHD	SCALE	• Target outreach to overweight women of child bearing age (up to age 55) and overweight children ages 7 – 17 • Offer education and activities to encourage healthier eating and physical activity • Provide support through cooking demonstrations, grocery store tours, walks and better access to fresh, healthy food	**Starting in September 2019 and ending in June 2021 SCALE's expected outcomes include: 80% of adult participants will report weight loss of at least 5% of their total body weight from baseline; 20% of adults participants will report a drop-in hemoglobin A1C by 0.2 point or more; 20% of adult participants will report a decrease in blood pressure (diastolic and systolic) by 5 points or more; demonstrated behavior change and improved health status** • % of adults with weight loss of at least 5% of their baseline body weight • % of adults with a drop in A1C levels by 0.2 point or more. • % of adults reporting decrease in blood pressure by 5 points or more • % knowledge change • % reporting improved health status	Data is for Somerset and Wicomico Counties • 50 adults enrolled • 22 Somerset • 28 Wicomico • 18 adults completed program • 11 Somerset • 7 Wicomico • 10 children enrolled • 1 Somerset • 9 Wicomico • 1 child completed program (Somerset) • 26% reported weight loss of at least 5% of body weight • 26% Somerset • 0% Wicomico • % unknown for drop in A1C levels • % unknown for decrease in blood pressure • % adults demonstrated behavior change • 100% Somerset • unknown Wicomico • % unknown for improved health status

CANCER PRIORITY AREA

Goal: Improve cancer prevention, and early detection and intervention/treatment of cancer to provide the best possible outcomes in the Tri-County Area for colorectal, breast, cervical, lung and skin cancer in the Tri-County Area.

Strategies:

- Partner with WiCHD and SCHD to expand cancer screening
- Utilize cancer rate data to identify neighborhoods with high cancer incidence rates for targeted education and screening activities
- Collaborate with local school district(s) and colleges/universities to integrate skin cancer prevention education within student health curricula

Program Owner	**Program**	**Activities**	**Objectives** • Evaluation Measures	**FY 2020 Evaluation Data**
Tidal Health	Wagner Wellness Van Expansion	• Clinical breast exams • Skin cancer screening • Education • Referral for cancer screenings	**Working in partnership with the WiCHD and SCHD offer additional cancer prevention programs and screening options for low income community members, and connect those that need it to treatment** **Increase knowledge of at-risk activities for cancer, importance of healthy behaviors in prevention of cancer and importance of screening activities** • # of screenings conducted • % follow up post positive screening • # of patients connected to treatment • % knowledge increase of cancer prevention	Two cancer screening events in the tri-county area. 1) Westover event to reach Haitian/Creole population. Partnered with Somerset Health Department by having the BCCP booth next to TidalHealth. There were trust issues at first with not wanting to do the breast exam on the van, but we worked through that and were able to connect them that day with BCCP. 2) Salisbury – Primarily Hispanic population. We had hoped to do an oral cancer screening event on the van, but have not been able to do this because of COVID. We are focusing/prioritizing communities/populations in Somerset County with our cancer screening efforts because of the disproportionately high prevalence of cancer. We have resumed lung cancer screenings at the hospital and would like to outreach to the community about this service. We typically have skin cancer screening events four times a year, but these have been on hold because of COVID. As we start to get the van back out into the communities, we are hoping to resume these screenings.

APPENDIX B

FY 2021 Progress in Addressing Priority Areas				
BEHAVIORAL HEALTH PRIORITY AREA **Goal:** Address behavioral issues in the Tri-County Service Area by reducing the instances of opioid related deaths **Goal:** Address behavioral issues in the Tri-County Service Area by targeting seniors suffering with minor to major depression **Strategies:** • Collaboratively address the opioid crisis in the Tri-County Service Area with an emphasis on prevention, treatment, resources, and enforcement • Provide peer support for people who have overdosed or sought help for opioid addiction issues • Address depression in adults 50 years or older through skill building, problem solving, and socialization activities				
Program Owner	**Program**	**Activities**	**Objectives** • Evaluation Measures	**FY 2021 Evaluation Data**
WiCHD	C.O.A.T.	• Train peer support specialists • Provide phone and in-person support for people who have overdosed or who struggle with opioid addiction, as well as other substance abuse issues • Provide connections to resources including treatment options • Provide peer outreach to high risk areas of the community • Maintain ongoing communications about metrics between PRMC and C.O.A.T. team •Evaluate expansion to Somerset County	**Contact and provide linkage to treatment and other support services to community members dealing with substance abuse issues** • of contact attempts • # of opioid users contacted • # linked to treatment • % of those who receive treatment and remain in recovery for 6 months and beyond • # supported through navigation services (increase access to insurance, primary care physicians, and social service benefits)	• 421 served • 176 served with history of Opioid Disorder • 236 Wicomico Residents linked to treatment • 42 non-residents linked to treatment •Attempted contact with 234 for 6 month follow-up. Made contact with 56. Of those contacted, 45 or 80.3% remained in recovery. • 261 Navigation Services provided to 171 individuals

SCHD WiCHD	Opioid Teams	• Bring awareness, education, and resources to the community to work toward eliminating opioid abuse • Target awareness activities and campaigns to the community and schools • Participation in drug awareness coalitions • Narcan training for community members • Develop and implement an OIT educational trailer for parents, guardians, and adults This is a mock teenage bedroom set up to show possible red flags for unhealthy behavior and/or substance use • Coordinate and host first responder dinner to help address compassion fatigue • Work with community partners to coordinate the Go Purple Awareness Campaign	**Work collaboratively to address policy, develop education, and raise community awareness in the fight against opioid use and continue to reduce instances of heroin overdose each year.** *Evaluation Measures for Somerset County Opioid United Team (SCOUT):* • # of individuals exposed to opioid related messaging through an advertising "campaign." Target - 7,000 • # of individuals attending community events held in schools. Target - 600 • # of individuals attending educational/training events held in the community. Target - 1500 • # of additional officer hours dedicated to opioid related calls and initiative. Target - 480 • % of overdose cases shared by Law Enforcement with the Health Department. Target - 100% *Evaluation Measures for Wicomico County Opioid Intervention Team (OIT)*: • # of OIT meetings held. Target- 25 • # of community events where Opioid Coordinator was present and providing education to the community. Target- 10 • # of Local Overdose Fatality Review Team (LOFRT) meetings attended- Target- 10 • # of individuals who attend CE (continuing education) trainings planned by OIT Coordinator- Target- 100 • # of individuals exposed to messaging via tv, radio, or social media – Target- 60,000	***Somerset County Opioid United Team (SCOUT):*** • 306,389 individuals exposed to opioid related messaging (Shore Birds stadium 50,000 fans, Clear Channel Billboard 106,389 impressions, The Voice radio station 150,000 listeners.) • Due to COVID-19 no community events at schools were held in FY21 • Due to COVID-19 no education/training events were held in the community in FY21. However, bags were provided that advertised Somerset OIT grant with educational information to the increasing food pantries that popped up due to COVID-19. • 368.75 additional officer hours dedicated to opioid related calls and initiatives were funded by this grant. • 100 overdose cases shared by Law Enforcement with the Health Department. ***Wicomico County Opioid Intervention Team (OIT)*:** • 15 OIT Meetings held. COVID-19 impacted the # of meetings held. • 16 community events were held. 14 of these were Narcan trainings. • 11 Local Overdose Fatality Review Team meetings held. • 70 individuals attended CE trainings. • 76,103 post reaches were made via Facebook, 15,000 resource mailers were sent to residences in Wicomico County which included SUD resources, and 76.11k impressions were made by utilizing digital advertising. • OIT trailer was only deployed at 1 event in FY21 due to COVID restrictions. • 60 Medication bags provided. • 100 provided education via OIT trailer. Efforts impacted by COVID-19.

			• # of times the OIT Educational Trailer is deployed in FY21 Target-10 • # of Medication Disposal Bags provided to community members. Target- 150 • #of individuals provided education via OIT trailer- Target- 500 • # of first responders who attended dinner and received education- Target-75	• Appreciation dinner not held due to COVID-19. 24 appreciation baskets sent to each local agency in lieu of dinner.
Tidal Health (contracts with MAC)	PEARLS	• Raise awareness of this free program through targeted outreach to clinicians caring for older adults, as well as senior centers and other local organizations serving older community members • Provide engaging and impactful curriculum in an easy-to-learn approach through flexible one-on-one visits at locations convenient for the community member being served	**Reduce the instances of depression in older adults through outreach and access to an evidence-based intervention program. Increase percent of program participants with a significant reduction of depression above the 2018 baseline of 50%** • # of community members enrolled • % of enrollees with reduction in level of depression maintained over 12 months • % of enrollees achieving remission of depression symptoms for at least 6 months	• 143 enrolled • 141 screened • 71 with 6 or more sessions • 51% total remission of depressive symptoms • 59% achieved a response
Tidal Health	ER Utilization Reduction & Access Improvement Wagner Wellness Van; SWIFT; and Smith Island Telemedicine	• Mobile unit conducts home-based visits to individuals utilizing 911 at least five times over a six-month period for non-life-threatening medical reasons. •The team provides physical, mental, and safety assessments, and screens for social determinants of health.	**Reduce emergency department utilization of high end users as well as increase access for Smith Island** *Evaluation Measures for Smith Island Telemedicine:* • # patients served • # Medication refills • # of telehealth visits • # Office visits • # labs • # community BP *Evaluation Measures for SWIFT*	• Labs 126 • Telehealth 32 • Office 68 • Med refill 42 • Bp 48 • COVID-19 test 55 (most were health department issued) • Flu shots 58 • Pneumonia 3

		•Based on their assessment, patients are referred for appropriate care interventions such as primary care providers, medical specialists, in-home providers, financial and social resources, as well as other community resources as necessary.	• # patients served	
DIABETES PRIORITY AREA **Goal:** Improve health of people with diabetes or pre-diabetes in the Tri-County Service Area **Strategies:** ● Offer Evidence-Based Chronic Disease Self-Management Classes (CDSM) throughout the Tri-County Service Area ● Expand access to diabetes screening, education, and resources throughout the Tri-County Service Area with the Wagner Wellness Van mobile clinic services ● Provide a free evidenced-based weight loss, nutrition, and physical activity program for women and children in Wicomico and Somerset Counties				
Program Owner	**Program**	**Activities**	**Objectives** • Evaluation Measures	**FY 2021 Evaluation Data**
Tidal Health (contracts with MAC)	CDSM Classes	• Target and identify patients who have diabetes and their caregivers through self-referral or provider referral • Train Community Peer Trainers and PRMC Community Health Workers to conduct classes • Offer classes in English, Spanish and American Sign Language • Explore the possibility to offer classes in Haitian-Creole, Korean and Mandarin	**By December 2020, increase the number of 6-week educational classes with identified diabetes patients and their supporting caregivers from 26 to 52 per year** • # of 6-week classes • # of people reached • Class completion rate • % knowledge change	• 13 Workshops • 94 enrolled • 79 completed • 92% completed

		languages, based on availability of peer trainers in these languages • Offer 6-week classes at least weekly • Educate participants on diabetes self-management and have them set and track personal goals weekly and share goals with their providers • Partner with MAC, Inc. to collect data on pre and post A1C values • Connect with the statewide Health Information Exchange to make referrals between providers office and Mac, Inc for all CDSM classes		
Tidal Health	Wagner Wellness Van Expansion	• Outreach to communities utilizing a Nurse Practitioner (NP) to provide primary care ser Provide screenings for diabetes (other screenings provided as well) • Identify need for and make referrals to community resources for health education programs • Ensure those people identified as diabetic or pre-diabetic are referred for primary care follow up • Track rate of successful PCP follow up for all referrals	**By partnering with other community stakeholders, the Community Wellness Program will increase access to diabetes screening, education, and connection to community resources. This program, which includes the Wagner Wellness Van outreach, provides health outreach events that are both large-scale and small-scale, and can be aimed toward the general public or a targeted population or geographic area.** • # of screenings provided • Number of A1C's checked • # of community members referred for diabetes education	• No A1cs were done due to licensing constraints during the pandemic emergency. We did refer 11 people to their PCP for elevated blood pressures during this time.

		• Identify barriers to accessing PCP follow up and work towards future solutions	• # of community members referred to their PCP	
SCHD WiCHD	SCALE	• Target outreach to overweight women of child bearing age (up to age 55) and overweight children ages 7 – 17 • Offer education and activities to encourage healthier eating and physical activity • Provide support through cooking demonstrations, grocery store tours, walks and better access to fresh, healthy food	**Starting in September 2019 and ending in June 2021 SCALE's expected outcomes include: 80% of adult participants will report weight loss of at least 5% of their total body weight from baseline; 20% of adults participants will report a drop-in hemoglobin A1C by 0.2 point or more; 20% of adult participants will report a decrease in blood pressure (diastolic and systolic) by 5 points or more; demonstrated behavior change and improved health status** • % of adults with weight loss of at least 5% of their baseline body weight • % knowledge change • % reporting improved health status • # of adults enrolled in SCALE program • # of adults diagnosed as overweight or obese • # of adults diagnosed as overweight or obese with improved BMI or weight loss • # of adults with an increase in healthy lifestyle choices.	*Due to COVID-19, the grant has been extended to December 2021. Both counties held classes virtually due to COVID-19. ***Somerset County Classes:*** • 14 Adults enrolled • 57% reported at least 5% weight loss from baseline • 100% demonstrated knowledge change • 85% reported improved health status • 10 individuals diagnosed as overweight or obese; 2 had improved BMI after class • 9 individuals had increase in healthy lifestyle choices ***Wicomico County Classes:*** • 8 Adults enrolled • 95% reported at least 5% weight loss from baseline • 100% demonstrated knowledge change • 50% reported improved health status • 7 individuals diagnosed as overweight or obese; 7 had improved BMI after class

CANCER PRIORITY AREA

Goal: Improve cancer prevention, and early detection and intervention/treatment of cancer to provide the best possible outcomes in the Tri-County Area for colorectal, breast, cervical, lung and skin cancer in the Tri-County Area.

Strategies:

- Partner with WiCHD and SCHD to expand cancer screening
- Utilize cancer rate data to identify neighborhoods with high cancer incidence rates for targeted education and screening activities
- Collaborate with local school district(s) and colleges/universities to integrate skin cancer prevention education within student health curricula

Program Owner	**Program**	**Activities**	**Objectives** • Evaluation Measures	**FY 2021 Evaluation Data**
Tidal Health	Wagner Wellness Van Expansion	• Clinical breast exams • Skin cancer screening • Education • Referral for cancer screenings	**Working in partnership with the WiCHD and SCHD offer additional cancer prevention programs and screening options for low income community members, and connect those that need it to treatment** **Increase knowledge of at-risk activities for cancer, importance of healthy behaviors in prevention of cancer and importance of screening activities** • # of screenings conducted • % follow up post positive screening • # of patients connected to treatment • % knowledge increase of cancer prevention	We did not do any screening events with the cancer program during this time period because of the pandemic; however, we did provide the American Cancer Society screening handout to thousands of individuals who came to the COVID vaccination clinics.

2019 – 2021
Implementation Strategy Plan
for Peninsula Regional Medical Center

Community Health Improvement Plan
for Somerset County Health Department and
Wicomico County Health Department

2019 – 2021 Implementation Strategy Plan
for Peninsula Regional Medical Center
and
Community Health Improvement Plan
for Somerset County Health Department and Wicomico County Health Department

Introduction

Peninsula Regional Medical Center (PRMC), in partnership with Somerset County Health Department (SCHD) and Wicomico County Health Department (WiCHD), is pleased to share our Implementation Strategy Plan, which follows the development of the 2019 Community Health Needs Assessment (CHNA). In accordance with requirements in the Affordable Care Act and IRS 990 Schedule H requirements, this plan was approved by the Board of Trustees of PRMC on November 7, 2019. This document also serves as the Community Health Improvement Plan for the health departments and was approved by the Somerset Local Health Improvement Coalition (LHIC) on November 12, 2019, and approved by the Wicomico LHIC on December 6, 2019.

After a thorough review of the health status in our community through the CHNA, we identified areas that we could address using our resources, expertise, and community partners.

The following are the prioritized health needs that will be addressed:

- Behavioral Health (Mental Health and Mental Disorders as well as Substance Abuse)
- Diabetes
- Cancer (Focus Areas: Breast, Colorectal, Cervical, Lung, Skin)

This Implementation Strategy summarizes the plans for PRMC, SCHD, and WiCHD to develop and/or collaborate on community benefit programs that address the prioritized health needs identified in the 2019 CHNA.

PRMC provides additional support for community benefit activities in the community that lie outside the scope of the programs and activities outlined in this Implementation Strategy. However, those additional activities will not be explored in detail in this document.

Additionally, this document includes the significant health needs that the partnership will not be addressing and why.

PRMC, SCHD, and WiCHD

PRMC is the 10th largest hospital in Maryland with 266 acute care beds, and the region's largest, most advanced tertiary care facility, which has been meeting the healthcare needs of Delmarva Peninsula residents since 1897. Its 3,300 physicians, staff, and volunteers provide

safe, compassionate, and affordable care designed to exceed the expectations of the nearly 500,000 patients who rely on the Medical Center team each year for inpatient, outpatient, diagnostic, sub-acute and emergency/trauma services. It is the region's oldest healthcare institution with the most experienced team of healthcare professionals. It also infuses over $500 million annually into its regional economy, and is the recipient of over 125 national awards, recognitions, and certifications in the past half-decade for the care it offers patients and the outcomes they experience.

SCHD's mission is "Dedicated to serving the Public by preventing illness, promoting wellness and protecting the health of our community." The Health Department continues to evolve with the changes in the healthcare system and is currently in the planning stage of the Public Health Accreditation process.

WiCHD's mission is "To maximize the health and wellness of all members of the community through collaborative efforts." The public health department, accredited by the Public Health Accreditation Board on March 8, 2016, has expanded over the years to meet changing needs of the community and continually works toward protecting the health and environment of the people of Wicomico County.

PRMC, SCHD, and WiCHD service areas are jointly defined by Somerset, Wicomico, and Worcester counties in the state of Maryland. These three counties are referred to as the Tri-County service area. Additionally, the service area includes the 43 zip codes and associated census places and census tracts within those three counties.

Community Health Needs Assessment

In December 2018, PRMC, SCHD, and WiCHD published their 2019 CHNA. The CHNA Report provides an overview of significant health needs in the Tri-County service area. This CHNA report was developed to provide an overview of the health needs in the Tri-County service area, including Somerset, Wicomico, and Worcester counties in Maryland. PRMC, SCHD, and WiCHD partnered with Conduent Healthy Communities Institute (HCI) to conduct the CHNA. The goal of this report is to offer a meaningful understanding of the greatest health needs across the Tri-County service area, as well as to guide planning efforts to address those needs. Special attention has been given to identify health disparities, needs of vulnerable populations, unmet health needs or gaps in services, and input from the community.

The CHNA findings are drawn from an analysis of an extensive set of secondary data (over 100 indicators from national and state data sources) and in-depth primary data from community health leaders and organizations that serve the community at large, as well as non-health professionals and community members. The main source for the secondary data, or data that has been previously collected, is the Peninsula Regional Medical Center Creating Healthy Communities platform, a publicly available data platform that is embedded on the main PRMC website. That platform can be found here: https://www.peninsula.org/community/creating-healthy-communities.

Priorities

On October 24, 2018, PRMC, SCHD and WiCHD came together to prioritize the significant health needs in a session facilitated by Conduent HCI consultants. Using a prioritization matrix, participants voted on the most critical needs while considering the following criteria:

- Importance of problem to the community
- Alignment with Maryland State Health Improvement Process (SHIP) 2017 objectives
- Opportunity for partnership
- Addresses disparities of subgroups
- Existing resources/programs to address the problem

The following three topics were selected as the top priorities:

- Behavioral Health (Mental Health and Mental Disorders as well as Substance Abuse)
- Diabetes
- Cancer (Focus Areas: Breast, Colorectal, Cervical, Skin)

No one organization can address all the health needs identified in its community. PRMC, SCHD, and WiCHD are committed to serving the community by adhering to their mission, and using their skills, expertise, and resources to provide a range of community benefit programs. This Implementation Strategy does not include specific plans to address other significant health needs including: Access to Health Services, Older Adults & Aging, and Oral Health.

These needs were not selected because they did not meet the prioritization criteria as strongly as the selected topics. PRMC, SCHD, and WiCHD have other programs in these areas, but they are not the focus of this report.

Implementation Strategy Design Process

In April 2018, PRMC contracted with Conduent HCI to facilitate the Implementation Strategy process. PRMC, SCHD, and WiCHD assembled an internal team and created an inventory of existing programs in the chosen priority areas. Conduent HCI reviewed the inventory for those with an evidence base and those most applicable for community benefit. Conduent HCI also conducted research into additional evidence-based programs for consideration by the internal team. As a result, PRMC, SCHD, and WiCHD are committed to a portfolio of new and existing programs to create positive change for the prioritized health needs of their community.

PRMC, SCHD, and WiCHD Internal Team

Stakeholder	Organization/Title
Chris Hall	PRMC, Vice President, Strategy
Kathryn Fiddler	PRMC, Vice President, Population Health

Henry Nyce	PRMC, Data Analyst
Logan Becker	PRMC, Planning Analyst
Rachel Blades	PRMC, Data Analyst, Population Health
Stephanie Elliott	PRMC, Director, Community Health Initiatives
Lori Brewster	WiCHD, SCHD Health Officer
Lisa Renegar	WiCHD, Health Planner, Office of Planning
Danielle Weber	SCHD, Administrative Deputy Health Officer

Priority Areas

Behavioral Health

Goal: Address behavioral issues in the Tri-County service area by reducing the instances of opioid-related deaths

Goal: Address behavioral issues in the Tri-County service area by targeting seniors suffering with minor to major depression

Strategies:

- Collaboratively address the opioid crisis in the Tri-County service area with an emphasis on prevention, treatment, resources, and enforcement
- Provide peer support for people who have overdosed or sought help for opioid addiction issues
- Address depression in adults 50 years or older through skill building, problem solving, and socialization activities

Objectives and Anticipated Impact:

- Work collaboratively to address policy, develop education, and raise community awareness in the fight against opioid use and continue to reduce instances of heroin overdose each year
    - **Evaluation Measures**
        - Monthly data from ED visits on opioid overdoses collected and reported to the county
        - # of individuals Narcan trained
        - # of individuals exposed to educational messaging
        - # of prescription drug deactivation bags distributed in the community

        - # of educational/training events
        - # of OIT meetings held
        - # of informational campaigns
        - # of schools with Go Purple Clubs
        - # of school-based educational Go Purple events

- Utilizing the Community Outreach Addictions Team (C.O.A.T.), contact and provide linkage to treatment and other support services to community members dealing with substance abuse issues
    - **Evaluation Measures**
        - # of contact attempts
        - # of opioid users contacted
        - # linked to treatment
        - % of those who receive treatment and remain in recovery for 6 months and beyond
        - # supported through navigation services (increased access to insurance, primary care physicians, and social service benefits)

- Reduce the instances of depression in older adults through outreach and access to an evidence-based intervention program. Increase percent of program participants with a significant reduction of depression above the 2018 baseline of 50%
    - **Evaluation Measures**
        - # of community members enrolled
        - % of enrollees with reduction in level of depression maintained over 12 months
        - % of enrollees achieving remission of depression symptoms for at least 6 months

Recommended Policy Change:

- Align and integrate prevention and treatment efforts among public and private agencies
- Design communications that help people understand detection, management, and decreased stigma of mental illness and their associated risk factors

PRMC System Resource Contributions:

- PRMC staff
- Data Collection
- Vehicles/Transportation
- Phone Service
- Staff training and materials as needed

Alignment Opportunities:

- PRMC, as part of a regional partnership with Atlantic General Hospital in Worcester County, SCHD and WiCHD, are collaborating with the Maryland Health Service Cost Review Commission to develop a regional approach to behavioral health for FY 2021. Work in these three areas will be incorporated into this Tri-County Regional Partnership and updated in this document in 2021
- WiCHD Strategic Plan 2017-2022, Priority #1: Improve community health and wellness by focusing on priority areas identified in collaboration with the Local Health Improvement Coalition: chronic disease and behavioral health

PRMC and WiCHD will build off the successful efforts that were included for this program in their 2016 Implementation Strategy Plan

Activities:

- Train peer support specialists
- Provide phone and in-person support for people who have overdosed or who struggle with opioid addiction, as well as other substance abuse issues
- Provide connections to resources including treatment options
- Provide peer outreach to high-risk areas of the community
- Maintain ongoing communications about metrics between PRMC and C.O.A.T. team
- Evaluate expansion to Somerset County

Program Owner:

- Wicomico County Health Department

Program Collaborators:

- PRMC
- Somerset County Health Department
- Hudson Health Services, Inc.
- Lower Shore Clinic, Inc.
- Wicomico County Sheriff's Department
- Tri-County community Primary Care Physicians
- Law Enforcement
- EMS
- Office of the State's Attorney General
- Numerous other community providers assist with resources and access to program services

1. Wicomico County Opioid Intervention Team and Somerset County Opioid United Team

Activities:

- Bring awareness, education, and resources to the community to work toward eliminating opioid abuse
- Target awareness activities and campaigns to the community and schools
- Participation in drug awareness coalitions
- Narcan training for community members
- Develop and implement an Opioid Intervention Team educational trailer for parents, guardians, and adults. This is a mock teenage bedroom set up to show possible red flags for unhealthy behavior and/or substance use
- Coordinate and host first responder dinner to help address compassion fatigue
- Work with community partners to coordinate the Go Purple Awareness Campaign

Program Owners:

- Wicomico County Health Department
- Somerset County Health Department

Program Collaborators:

- PRMC
- Wicomico County Executive's Office
- Wicomico County Department of Emergency Services
- Wicomico County State's Attorney
- Wicomico County Sheriff's Office
- Maryland State Police Barrack E
- Fruitland Police Department
- Salisbury Police Department
- Maryland Natural Resources Police
- Pittsville Police Department
- Delmar Police Department
- Hudson Health Services, Inc.
- Maryland Coalition of Families
- Clarion Call Restoration Ministries
- MAC, Inc.
- Peninsula Addictions and Mental Health
- J. David Collins and Associates
- Second Wind, Inc.
- Focus Point Behavioral Health
- United Way of the Lower Eastern Shore
- SonRise Church
- Recovery Resource Center

- City of Salisbury Fire Department
- High Intensity Drug Trafficking Area (HIDTA) Program
- Eastern Shore Psychological Center
- Wor-Wic Community College
- Salisbury University
- Wicomico County Public Schools/Board of Education
- BNJ Health Services
- St. James AME Methodist Church
- Department of Social Services
- Department of Parole and Probation
- Sante Group/Mobile Crisis
- Life Crisis Center
- Community Behavioral Health
- Deer's Head Hospital Center
- Comcast Spotlight
- Lower Shore Clinic, Inc.
- DKH Recovery House
- Somerset County Emergency Services
- Crisfield Police Department
- Somerset County Sheriff's Office
- McCready Health
- Somerset County Department of Social Services
- Princess Anne Police Department
- Department Parole & Probation
- Crisfield Drug Free Community
- University of Maryland Eastern Shore
- Somerset Circuit Court
- Somerset Recovery Court
- Somerset County Public Schools

2. Program to Encourage Active and Rewarding Lives (PEARLS)

Activities:

- Raise awareness of this free program through targeted outreach to clinicians caring for older adults, as well as senior centers and other local organizations serving older community members
- Provide engaging and impactful curriculum in an easy-to-learn approach through flexible one-on-one visits at locations convenient for the community member being served

Program Owner:

- PRMC

Program Collaborators:

- MAC, Inc.

3. ER Utilization Reduction and Access Improvement

Activities:

- SWIFT–a mobile integrated health team makes home-based visits to individuals utilizing 911 at least five times over a six-month period for non-life-threatening medical reasons. The team provides physical, mental, and safety assessments, and screens for social determinants of health. Based on their assessment, patients are referred for appropriate care interventions such as primary care providers, medical specialists, in home providers, financial and social resources, as well as other community resources as necessary.

Program Owner:

- PRMC

Program Collaborators:

- City of Salisbury
- Wicomico County Health Department

Diabetes

Goal: Improve health of people with diabetes or pre-diabetes in the Tri-County service area

Strategies:

- Offer Evidence-Based Chronic Disease Self-Management Classes (CDSM) throughout the Tri-County service area
- Expand access to diabetes screening, education, and resources throughout the Tri-County service area with the Wagner Wellness Van mobile clinic services
- Provide a free evidence-based weight loss, nutrition, and physical activity program for women and children in Wicomico and Somerset Counties

Objectives and Anticipated Impact:

- By December 2020, increase the number of 6-week educational classes with identified diabetes patients and their supporting caregivers from 26 to 52 per year
    - **Evaluation Measures:**
        - # of 6-week classes
        - # of people reached
        - Class completion rate
        - % knowledge change

- By partnering with other community stakeholders, the Community Wellness Program will increase access to diabetes screening, education, and connection to community resources. This program, which includes the Wagner Wellness Van outreach, provides health outreach events that are both large-scale and small-scale, and can be aimed toward the general public or a targeted population or geographic area.
    - **Evaluation Measures:**
        - # of screenings provided
        - Number of A1C's checked
        - # of community members referred for diabetes education
        - # of community members referred to their PCP

- Starting in September 2019 and ending in June 2021 SCALE's expected outcomes include: 80% of adult participants will report weight loss of at least 5% of their total body weight from baseline; 20% of adults participants will report a drop-in hemoglobin A1C by 0.2 point or more; 20% of adult participants will report a decrease in blood pressure (diastolic and systolic) by 5 points or more; demonstrated behavior change and improved health status
    - **Evaluation Measures:**
        - Weight loss
        - A1C levels
        - BP rate
        - % knowledge change
        - % participants reporting improved health status

Recommended Policy Changes:

- Increase access to fresh fruits and vegetables through community-based initiatives
- Increase active time in early childcare care site and schools including physical education

PRMC System Resource Contributions:

- Staff
- Data
- Marketing materials
- Training materials
- Mobile van
- Phone service
- Staff training and materials as needed

Alignment Opportunities:

- WiCHD Strategic Plan 2017-2022, Priority #1: Improve community health and wellness by focusing on priority areas identified in collaboration with the Local Health Improvement Coalition: chronic disease and behavioral health

Programs to Address Diabetes

1. Chronic Disease Self-Management (CDSM) Classes

PRMC will build off the successful efforts that were included for this program in its 2016 Implementation Strategy Plan

Activities:

- Target and identify patients who have diabetes and their caregivers through self-referral or provider referral
- Train Community Peer Trainers and PRMC Community Health Workers to conduct classes
- Offer classes in English, Spanish and American Sign Language
- Explore the possibility to offer classes in Haitian-Creole, Korean and Mandarin languages, based on availability of peer trainers in these languages
- Offer 6-week classes at least weekly
- Educate participants on diabetes self-management and have them set and track personal goals weekly and share goals with their providers
- Partner with MAC, Inc. to collect data on pre and post A1C values
- Connect with the statewide Health Information Exchange to make referrals between providers' office and MAC, Inc. for all CDSM classes

Program Owners:

- MAC, Inc.

Program Collaborators:

- PRMC

2. Wagner Wellness Van Expansion

PRMC and WiCHD will build off the successful efforts that were included for this program in its 2016 Implementation Strategy Plan

Activities:

- Outreach to communities utilizing a Nurse Practitioner (NP) to provide primary care services
- Provide screenings for diabetes (other screenings provided as well)
- Identify need for and make referrals to community resources for health education programs
- Ensure those people identified as diabetic or pre-diabetic are referred for primary care follow up
- Track rate of successful PCP follow up for all referrals
- Identify barriers to accessing PCP follow up and work towards future solutions

Program Owners:

- PRMC

Program Collaborators:

- Wicomico, Somerset and Worcester County Health Departments
- HOPE
- HALO
- Salisbury Urban Ministries
- St. James AME
- St. Peter's Lutheran
- Resource and Recovery Center
- Atlantic Club
- Marion Pharmacy
- MAC, Inc.
- National Kidney Foundation
- Wicomico County Schools
- Maryland Food Bank
- Various other community and faith-based organizations

3. Sustainable Change and Lifestyle Enhancement (SCALE)

Activities:

- Target outreach to overweight women of child-bearing age (up to age 55) and overweight children ages 7 – 17
- Offer education and activities to encourage healthier eating and physical activity
- Provide support through cooking demonstrations, grocery store tours, walks and better access to fresh, healthy food

Program Owners:

- Wicomico County Health Department
- Somerset County Health Department

Program Collaborators:

- PRMC
- YMCA
- University of Maryland Eastern Shore
- Wicomico County Detention Center
- HOPE
- Community Health Providers

Cancer

Goal: Improve cancer prevention, and early detection and intervention/treatment of cancer to provide the best possible outcomes in the Tri-County Area for colorectal, breast, cervical, lung and skin cancer.

Strategies:

- Partner with WiCHD and SCHD to expand cancer screening
- Utilize cancer rate data to identify neighborhoods with high cancer incidence rates for targeted education and screening activities
- Collaborate with local school district(s) and colleges/universities to integrate skin cancer prevention education within student health curricula

Objectives and Anticipated Impact:

- Working in partnership with the WiCHD and SCHD, offer additional cancer prevention programs and screening options for low-income community members, and connect those who need it to treatment
- Increase knowledge of at-risk activities for cancer, importance of healthy behaviors in prevention of cancer and importance of screening activities
    - **Evaluation Measures:**
        - # of screenings conducted
        - % follow up post positive screening
        - # of patients connected to treatment
        - % knowledge increase of cancer prevention

Recommended Policy Changes:

- Design culturally competent communications that help people understand the importance of screening for early detection
- Engage communities with health disparities to modify risky behaviors and to access resources for prevention

PRMC System Resource Contributions:
Providers for screening

Programs in Support of the Strategies

1. **Wagner Wellness Van expansion**

Activities

- Clinical breast exams
- Skin cancer screening
- Education
- Referral for cancer screenings

Program Owner:

- PRMC

Program Collaborators:

- Wicomico County Health Department
- Somerset County Health Department

Alignment Opportunities

- WiCHD Strategic Plan 2017-2022, Priority #1: Improve community health and wellness by focusing on priority areas identified in collaboration with the Local Health Improvement Coalition: chronic disease and behavioral health

Community Health Improvement Plan Strategies and Indicators: 2023-2025

Executive Summary: IDEAS INTO ACTION

TidalHealth, Somerset County Health Department (SCHD) and Wicomico County Health Department (WiCHD) worked collaboratively to develop this Community Health Improvement Plan and Implementation Strategy in response to the 2022 Community Health Needs Assessment. The collaborative approach reduces duplication of resources and provides a more comprehensive approach to addressing health improvement. For purposes of this report, the three leading organizations: TidalHealth, SCHD, and WiCHD will collectively be referred to as "the Partnership."

A community health improvement plan (or CHIP) is a long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process. Health and other governmental education and human service agencies, in collaboration with community partners, use this plan to set priorities, coordinate and target resources. At the heart of this plan are the fundamental goals and actions that will enable communities to improve health and environment, implement policies to support healthy lifestyles, increase access to health services, and strengthen safety net systems that foster more effective and equitable delivery of health services.

Conduent HCI worked with the Partnership as a leadership committee to create a joint framework that serves both the needs of nonprofit hospital and health department partners, as well as the entire service area encompassing the Lower Eastern Shore of Maryland and Sussex County, Delaware.

2022 Maryland Statewide Integrated Health Improvement Strategy (SIHIS)

In 2019, the State of Maryland collaborated with the Center for Medicare and Medicaid Innovation (CMMI) to establish the domains of health care quality and delivery that the State could impact under the Total Cost of Care (TCOC) Model. The collaboration also included an agreed-upon process and timeline by which the State would submit proposed goals, measures, milestones, and targets to CMMI. As a result of the collaboration with CMMI, the State entered into a Memorandum of Understanding (MOU) that required Maryland to provide a proposal for the Statewide Integrated Health Improvement Strategy (SIHIS) to CMMI by December 31, 2020. The SIHIS aligns statewide efforts across three domains that are interrelated and, if addressed successfully, have the potential to make significant improvement in not just Maryland's healthcare system, but in the health outcomes of Marylanders.

The top health priorities identified for the Maryland SIHIS were:

1. Hospital Quality
2. Care Transformation Across the System
3. Total Population Health Diabetes
4. Total Population Health Opioid Use Disorder
5. Total Population Health Maternal and Child Health

The interconnectedness of Maryland's greatest health challenges, along with the overall consistency of health priorities identified in the CHNA assessment, indicates many opportunities for collaboration between a wide variety of partners at and between the state and local level, including physical and behavioral health organizations and sectors beyond health. It is our hope that this framework will serve as a foundation for such collaboration.

To view the full 2021 Statewide Integrated Health Improvement Strategy, please visit: https://hscrc.maryland.gov/Documents/Modernization/Statewide%20Integrated%20Health%20Improvement%20Strategy/SIHIS%202021%20Annual%20Report%20FINAL%20w%20appendix.pdf

2022 Delaware Statewide Integrated Health Improvement Plan (SHIP)

The State Health Assessment (SHA), State Health Improvement Plan (SHIP), and the Division of Public Health's organizational strategic plan are prerequisites for State Health Departments that pursue National Public Health Accreditation Board Accreditation (PHAB).
The State Health Department's SHIP addresses the needs of all citizens in the state. The SHIP is a long-term, systematic plan to address issues identified in the SHA. The purpose of the SHIP is to describe how the health department and the community it serves will work together to improve the health of the population in their jurisdiction. The community, stakeholders, and partners can use a solid SHIP to set priorities, direct the use of resources, and develop and implement projects, programs, and policies.
The Evidence-based and Promising Strategies across SHIP priority areas for 2020 include:

- Chronic Disease
- Maternal and Child Health
- Substance Use Disorder
- Mental Health

Hospital Internal Revenue Services (IRS) Requirements

Certain hospitals as set forth in the Section 501(r) regulations are required to complete a CHNA and corresponding implementation strategy at least once every three years in accordance with regulations promulgated by the Internal Revenue Service pursuant to the Patient Protection and Affordable Care Act (ACA), 2010. The partnership collaborating on this CHIP framework adopted the most recent CHNA in April 2022 in accordance with requirements in the Affordable Care Act and IRS 990 Schedule H requirements.

Public Health Accreditation Board (PHAB) Accreditation Requirements

PHAB accreditation is a process that supports health departments to improve and strengthen quality, accountability and performance. One of the standards to receive and maintain PHAB accreditation includes participating in or leading a collaborative process that results in a comprehensive community health assessment. For local health departments, the community health assessment assesses the health of residents within the jurisdiction it serves. A local health department's assessment may also assess the health of residents within a larger region, but the submitted assessment will include details that address the requirements specific to the jurisdiction applying for accreditation.

Please note the CHIP/IS is a living document adapted in response to everchanging citizens, community and stakeholder needs. Any list(s) of partners included is not exhaustive. The Partnership welcomes any organizations and stakeholders involved in priority-centered work to join our efforts.

COMMUNITY HEALTH IMPROVEMENT PLAN

At-a-Glance

THE PARTNERSHIP

ACCESS AND HEALTH EQUITY

GOAL 1.1: Increase equitable access to healthcare.

OBJECTIVES:

1. By June 2025, increase insurance coverage for all populations, especially groups experiencing disparities in health coverage.
2. By December 2023, implement best practices and standardization of social determinants of health screening and closed-loop, bidirectional referrals across multiple sectors and community-based partners.
3. By June 2025, expand the diversity of the community health worker workforce within health systems, public health and adjacent sectors.

GOAL 1.2: Provide education and promote awareness of health equity, including policy recommendations.

OBJECTIVES:

4. By June 2023, Develop and adopt a Health Equity Framework among the Partnership organizations.
5. By June 2024, complete environmental scan for community organizations to assess health literacy policies and resources in place.
6. By June 2023, increase engagement of diverse community members in local health coalitions.
7. By June 2025, local health equity committees present at least one policy recommendation related to Health In All Policies (HiAP) to local health improvement coalitions.

BEHAVIORAL HEALTH

GOAL 2: Improve behavioral health through prevention, treatment, and recovery.

OBJECTIVES:

1. By June 2025, reduce suicide rates in the service area.
2. By June 2025, reduce and prevent opioid misuse and overdoses.
3. By June 2025, strengthen the integrated care model by collaborating with local healthcare providers.
4. By June 2025, decrease the proportion of adults reporting excessive poor mental health days.

COMMUNITY HEALTH IMPROVEMENT PLAN

At-a-Glance

CHRONIC DISEASE AND WELLNESS

GOAL 3.1: Reduce the prevalence and mortality from chronic diseases in the partnership area.

OBJECTIVES:

1. By June 2025, reduce prevalence of diabetes.
2. By June 2025, reduce the rate of hospital encounters including ED visits, admissions and readmissions for diabetes and hypertension among adults.
3. By June 2025, increase the proportion of adults who get evidence-based preventative health care including screenings.

GOAL 3.2: Promote and support healthy lifestyles and wellness in the service area to reduce risk of chronic disease.

OBJECTIVES:

4. By 2025, increase the proportion of people at a healthy weight.
5. By 2025, increase the proportion of residents achieving the recommended physical activity levels.

THE PARTNERSHIP

TidalHealth's Overview of Community Benefits Initiatives

TidalHealth uses data from the Community Health Needs Assessment and data from its Epic EHR stratified by race, ethnicity, age, language and gender to identify significant health disparities in the patient population. The Population Health division in partnership with community-based organizations, managed care organizations, the local health improvement coalitions, and local health departments, has initiatives underway to address disparities and health issues prioritized and included in the CHNA and Community Health Improvement Plan.

TidalHealth was awarded a grant through the Maryland Community Health Resources Commission's new Pathways to Health Equity Program to enhance and expand efforts to address health disparities and advance health equity. The program, Rural Equity and Access to Community Health (REACH), launched in May 2022 and is a collaborative, regional project to prevent and reduce disparities particularly among Black/African American residents of the Lower Eastern Shore with diabetes and/or hypertension.

REACH involves multi-level, cross-sector approaches to address disparities and improve population health. At the individual level, the project includes increased care coordination and follow-up for high risk patients with diabetes and/or hypertension who have been discharged from the hospital. Community health workers are deployed to screen and address social determinants of health (SDOH).

At the community-level, TidalHealth works with community partners to increase access to evidence-based chronic disease prevention and management or healthy lifestyle programming in underserved communities.

At the system level, TidalHealth and community partners are working on developing a regional platform and standardized processes for SDOH screening and referrals.

In fiscal 2022, TidalHealth was also awarded a grant from the Rural Maryland Council to address disparities and SDOH factors impacting residents with asthma, COPD, or other obstructive lung disease. The program, EXHALE, involved community health workers of TidalHealth screening and addressing SDOH factors of eligible participants and working with local nonprofit community-based organizations Chesapeake Housing Mission and Habitat for Humanity to complete home repairs to improve health and quality of life of grant program participants.

Additionally, the following initiatives continued in fiscal 2022 to reduce health disparities:

Initiatives to address chronic disease:
TidalHealth Peninsula Regional and MAC, Inc., the area agency on aging, has an ongoing collaboration to address chronic disease management in the community. MAC, Inc. offers a variety of classes, events, activities, and meals for the senior populations of the area. The programs run by MAC include Chronic Disease Self-Management, Stepping on Falls Prevention, Healthy Living with Hypertension, and other exercise and nutrition classes.

TidalHealth has six team members in Population Health trained to conduct the Chronic Disease Self-Management Education programs, which includes chronic conditions, diabetes, and chronic pain. These programs were developed by Stanford University in 1990 and have gone through rigorous random controlled trials to show efficacy and evidence of health improvement among participants.

Participants learn to cope with the fatigue, frustration and pain that accompany chronic disease, and exercises for improving strength and endurance, all which have been shown to improve health and decrease the number of hospital stays. The Stepping on Falls prevention program builds skills and exercises to reduce falls and increase self-confidence and behavioral change to reduce risk of falling. Strength and balance exercises are taught by physical therapists.

Other programs that MAC, Inc. offers include Chronic Pain Self-Management, Diabetes Prevention, Diabetes Self-Management and Walking with Ease. These programs have a similar format to the Chronic Disease Self-Management Program. Many participants are enrolled in multiple evidence-based programs through MAC.

A substantial number of participants in these programs have comorbidities such as diabetes, chronic pain, heart disease, stroke, hypertension, etc. The evidence-based programs offered by MAC, Inc. are essential to improving the health of the communities we serve and are a good first step in helping people become more educated about their health. This collaboration between MAC, Inc.and TidalHealth Peninsula Regional is a community benefit that has multiple touch points that affect the overall health of our senior and older adult community in the Tri-County area.

Initiatives to address access and disparities caused by social determinants of health:
The Community Wellness Program of TidalHealth utilizes a mobile, multidisciplinary community health team to identify and outreach to vulnerable and at-risk populations in Wicomico, Worcester, and Somerset counties.

The Wellness team hosted screening events in all three counties, several days a week including at local migrant camps, Haitian community centers, schools, Smith Island, shelters, and churches. The strong commitment and trust built by the team proved significant in TidalHealth's ability to improve trust in hard-to-reach communities and improve access to primary and secondary prevention as well as screenings for social determinants of health (SDOH).

Smith Island Telehealth
TidalHealth supports primary care, health education, prevention, and telehealth to the approximately 300 residents of the remote Smith Island in Somerset County. Without this partnership, Smith Island would have no direct access to health care. A team of providers including a physician, nurse practitioner and pharmacist, visit the island on average every other week. New primary care provider appointments are offered to community members without a PCP. Telehealth acute visits occur through a nurse practitioner at TidalHealth. A medical assistant resides on the island to provide ongoing support for chronic disease prevention and management, medication management, referrals and follow-up post discharge and ED visits.TidalHealth partnered with the Maryland Department of Health and National Guard to provide COVID testing and vaccinations to residents on the island in fiscal 2021.

SWIFT
SWIFT is a mobile integrated health initiative in partnership with the City of Salisbury and the Wicomico County Health Department. The program reduces unnecessary use of the 911 EMS system and health system emergency department by addressing medical and psychosocial needs of those identified as high utilizers of EMS and/or the ED. An interdisciplinary team including a nurse practitioner, registered nurse, paramedic, community health worker and social

worker work together to address underlying conditions or social determinants of health contributing to excessive calls to 911 and visits to the ED. The team connects the program participants to primary care, behavioral health, chronic disease prevention and management, medication management, and social determinants of health needs such as housing, transportation, food, utility assistance and other services. The program saves lives by taking a team approach to support participants in achieving their own goals for better quality of life. The team builds trust with participants over time by showing up, meeting them where they are, and helping them get the support they need to stay well. New for the program in fiscal 2022 was the addition of the Minor Definitive Care Now (MDCN) model which included a paramedic-NP team responding to low acuity 911 calls and providing care at home. This model avoids unnecessary transports and ED visits.

Remote Patient Monitoring
The Remote Patient Monitoring Program at TidalHealth helps Medicare patients with chronic conditions like diabetes, COPD, CHF, or respiratory failure adhere to protocols, medications, and medical instructions. Equipment is rented to the patient free of charge after discharge from the hospital for 60 days. During the 60-day period, healthcare workers help to educate the patient on monitoring their vitals, medications, etc. To reduce readmission rates to the hospital and increase patient/caregiver engagement. After the 60-day period, patients are encouraged to purchase their own monitoring equipment which then can be used in the future for self-monitoring.

COAT
The COAT program stands for Community Outreach Addictions Team. This program helps people who have entered the Emergency Department for substance abuse issues, behavioral health or socialization issues, high utilization of the ED due to drugs or alcohol, and/or social determinants of health associated with these themes. The COAT Team consists of peer support specialists who are in recovery from substance abuse disorder and are on call for the ED to be a navigator for these patients while they are being treated in the ED for the substance. The navigators are there for support and to also provide information about resources to substance abuse counseling, community resources, or social resources that the patient may need. The COAT Team helps people from any area that come to the ED, but the program is mostly helping people from Somerset, Worcester, or Wicomico counties. The COAT Team also tries to maintain contact with the patient post-ED visit to keep the lines of communication open in case the patient needs any other sort of counseling or help with their current social determinants of health.

Opioid Intervention Team and Somerset County Opioid United Team (OIT and SCOUT)
The Opioid Intervention Team and Somerset County Opioid United Team are programs that target the populations of Wicomico and Somerset Counties who are struggling with addiction and their families and friends. The teams consist of several community partners and stakeholders that bring awareness of the harms of opioid and other substances that affect not only the user, but also affect the family and friends of these users. Educational seminars are conducted at local schools, and clubs are formed at these schools to help bring education to other students about the dangers of substance abuse and the toll it takes on family and friends. There is also a substantial awareness campaign during Opioid Awareness Month in Somerset and Wicomico Counties. The teams meet with local businesses and local government to set up opioid awareness campaigns that provide education to residents. Secure prescription drug drop boxes are located around Wicomico and Somerset counties as well as at TidalHealth Peninsula Regional to have residents safely dispose of their unwanted or expired opioids and limit the inappropriate use of these drugs in the community. The teams also educate

and train community members on how to properly administer Narcan, the medicine used to treat someone with an opioid overdose. The overarching strategy of these teams is to combat the current opioid epidemic affecting the local community and engage the community in helping reduce opioid use by increasing awareness.

PEARLS
PEARLS stands for Programs to Encourage Active and Rewarding Lives. This program, run by MAC Inc., the Agency on Aging, is an evidence-based program that helps residents aged 60 and over combat depression from loss or feelings of isolation. The program provides one-on-one counseling sessions to participants who may feel depressed, frustrated, restless, or anxious from due to events in their life. As one ages, there are losses such as loss of health, loved ones, and/or independence. A grieving widow who lost their spouse of forty years may feel depressed and lonely now that their partner is gone. Another older gentleman may feel frustration at not being able to be as independent as he once was at a younger age. PEARLS helps counsel the patient and provide guidance on how to manage their feelings. Especially during the COVID-19 epidemic, many older residents in the Tri-County area are feeling lonely, due to the restrictions on nursing homes and families not being able to get together with older family members. COVID-19 affects older populations worse than younger people, and by the advice of healthcare officials, many families are having to keep their distance. With help from MAC, Inc., these older adults can talk to a counselor and improve their quality of life.

Adult Diabetes Support Group
The Adult Diabetes Support Group is a program geared towards adults with diabetes and their caregivers. The program helps to provide support, networking, education, fellowship and to promote community unity to these adults with diabetes and their caregivers. The program will continue into FY 2022 with in-person meetings.

Kids and Teens Diabetes Support Group
The Kids and Teens Diabetes Support Group is a program geared towards kids, teens, and their caregivers. The program helps to provide support, networking, education, fellowship and to promote community unity to these kids, teens, and their caregivers. The program started in FY 2021 with the Diabetes and Nutrition team at TidalHealth Peninsula Regional and then transitioned into a local “home grown” community-based support group.

Nutrition and Diabetes Education Community Education Presentations
Nutrition and Diabetes Education Department provides community presentations and educational opportunities to increase awareness and efficacy among participants to understand the risks of diabetes, prediabetes and how to better manage the conditions. A member of the Nutrition and Diabetes Education team was the Preceptor for a local college’s Dietetic Internship Program to educate on the importance of diabetes education in the Tri-County Area.

TRIBE
TRIBE stands for Tri-County Behavioral Health Engagement. This newly formed collaboration is a regional partnership between TidalHealth Peninsula Regional, Atlantic General Hospital and nine behavioral health community partner agencies in Somerset, Wicomico, and Worcester counties. The immediate goal is to design behavioral health crisis stabilization centers or behavioral health urgent care centers within the Tri-County area. The primary objectives of this program are to reduce ED utilization, hospital admissions to both TidalHealth Peninsula Regional and Atlantic General Hospital and readmissions for individuals experiencing behavioral

health issues in the Tri-County area. TRIBE met throughout the year to discuss and identify gaps and fragmentation of services in the area with the goal of providing more seamless and “real time” behavioral health urgent care and behavioral health care services.

Healing Seated Yoga
A program through which cancer patients and their caregivers practice yoga. Studies have indicated that yoga can complement cancer treatment and it is useful in helping heal the body and spirit. The goal is to help the patient and their caregivers reduce stress, lower fatigue, improve daily living activities and improve sleep.

What’s Cooking
The What’s Cooking program teaches cancer patients and their caregivers how to modify their diets to help build strength to withstand the effect of cancer treatments. This educational class stresses the importance of limiting sugar, alcohol, and salt. A Registered Dietician leads the class and teaches cancer patients and their caregivers how to prepare healthy food dishes using fruits, vegetables, beans, and healthy grains. The Registered Dietician also has topics of discussion during these sessions and the participants can taste test the dishes and ask questions.

Tai Chi for Better Balance
The Tai Chi for Better Balance program improves physical strength, balance, circulation, stress levels and ambulation among cancer patients. The program is led by an instructor who teaches hour long classes for a variety of patient levels. Tai Chi classes are offered in many hospitals and cancer centers. The classes help support recovery and ambulation, which is critical for cancer patients in their battle.

Prostate Cancer Support Group
This program meets bi-monthly for patients and their caregivers who have been affected by prostate cancer. The goal of this support group is to provide emotional support to families of prostate cancer patients in addition to helping loved ones adjust to supporting their family member who has prostate cancer. It has improved psychological wellbeing of patients, reduced anxiety and depression, and overall improved the quality of life for these patients going through prostate cancer.

Cancer Thriving and Surviving
This class is for current cancer patients and their caregivers to educate about the difficulties associated with cancer diagnosis and cancer treatment. Cancer patients and their families are provided with the tools needed to live a healthier life.

Cancer Survivor Caregiver Support Group
This program gathers survivors, current cancer patients and caregivers from past and present to offer support and connect with each other. The weekly support group’s focuses are to educate, network and enjoy fellowship with past and present cancer patients and their caregivers. This network can provide advice about current and future difficulties that current cancer patients and their caregivers may face.

Food Distribution

This program is used to provide clean, nutritious food to nourish patients in their fight against cancer. A share of organic vegetables is provided to cancer patients and cancer survivors. During the months of May-October, vegetables are primarily provided from the Healing Rose Garden. During the months of December-April or during periods of low vegetable production, vegetables are purchased by a local organization to provide for cancer patients. This program is especially valuable for cancer patients who have food insecurities or come from a poorer quality of life and cannot afford these nutritious foods. These wholesome, clean food helps to overcome food insecurity and get cancer patients healthier.

Wagner Wellness Van Expansion

The Wagner Wellness Van helps to provide health outreach events that are both large-scale and small-scale that are aimed at the public or a targeted population or geographic area. The Wagner Wellness Van partnered with both the Somerset County Health Department and the Wicomico County Health Departments to increase access to diabetes screening, education, and connection to other community resources. The Wagner Wellness Van also offered additional cancer prevention programs and screenings options for low-income community members and connected those that needed it to treatment. The Wagner Wellness Van is vitally important for reaching communities that otherwise could not afford or would not seek healthcare.

How TidalHealth measures and evaluates initiatives to address disparities: TidalHealth optimizes several data analytics tools and platforms to track and reduce health disparities among the communities it serves. The following tools support analysis of the disparities in priority chronic conditions such as CHF, COPD, Diabetes, Hypertension, Cancer as well as behavioral health conditions and create a stronger understanding of the specific populations in terms of geography, zip codes, race, ethnicity, age, gender most affected by these conditions as well as the social determinants of health that may be exacerbating poor health outcomes in certain communities.

Below is a summary of the tools TidalHealth uses to implement, improve, monitor and evaluate strategies and interventions:

Community Health Needs Assessment and Community Health Improvement Plan: To ensure that our health system resources are put to the best use, TidalHealth conducts research into our community's health needs. TidalHealth partners with Conduent Healthy Communities Institute to discover what the most pressing health challenges are in Somerset, Wicomico and Worcester counties of Maryland. Conduent's specialized team analyzes secondary and primary qualitative and quantitative data to develop the triannual Community Health Needs Assessment and accompanying Community Health Improvement Plan. The Local Health Improvement Coalitions work with TidalHealth to identify the top health priorities and health disparities to address based on the data presented in the CHNA. The CHIP includes the strategies to address the identified priorities.

Epic EMR – Healthy Planet Dashboard: TidalHealth optimizes its Epic EMR software module, Healthy Planet, to build a suite of reports and dashboards that compiles and aggregates patient record data in terms of demographics and quality health indicators. Reports generated from the platform allow the healthcare system to better manage patient populations, coordinate care and monitor cost and health indicators.

Lightbeam Health Solutions: TidalHealth as a Care Transformation Organization and as part of the Peninsula Regional Clinically Integrated Network uses Lightbeam Health Solutions analytics platform to analyze, track and reduce health disparities among the Medicare population served. The platform supports our team's ability to close care gaps and improve quality of care as well as coordinate care for high risk and high-cost patients.

CRISP: The Chesapeake Regional Information System, I.e. the designated Health Information Exchange in Maryland and D.C. provides reporting services for analytics for the health care community to improve patient outcomes and reduce cost of care. Our data analysts use this suite of reports to drill down into health care utilization and health care disparity data to better understand trends and assist with strategic planning for reducing admissions and readmissions as well as ED utilization among our patient populations.

Manual tracking mechanisms for new programs: TidalHealth is employing several new and innovative strategies to address health disparities. When new programs are being implemented, we initially capture data through manual data entry while we work with our IT solutions to build reports into our electronic systems.

ADMINISTRATIVE POLICY MANUAL

Subject: Financial Assistance / Uncompensated Care

Effective Date:	August 1981
Approved by:	President/CEO and Senior Vice President of Finance/CFO
Responsible Parties:	Senior Executive Director of Patient Financial Services
Revised Date:	12/86, 6/88, 3/90, 3/91, 7/93, 7/94, 8/98, 12/05, 8/08, 5/10, 10/10, 12/14, 7/16, 11/16, 7/17, 7/18, 7/19, 7/20, 9/20, 7/21
Reviewed Date:	8/83, 12/85, 2/88, 6/92, 8/95, 7/96, 9/97, 6/00, 6/01, 10/02, 10/04, 12/11, 12/12, 12/13
Date Approved by Board:	
Key Words:	Financial Assistance, Federal Poverty Guidelines, Charity Care, Uncompensated

POLICY

In accordance with state and federal guidelines, TidalHealth will provide emergency and medically necessary free and/or reduced-cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of their medical bill. A patient's payment shall not exceed the amount generally billed (AGB). All hospital regulated services (which includes emergency and medically necessary care) at TidalHealth Peninsula Regional will be charged consistently as established by the Health Services Cost Review Commission (HSCRC) which equates to the amounts generally billed (AGB) method. All patients seen by a TidalHealth Provider or in an unregulated area at TidalHealth Peninsula Regional or all services at TidalHealth Nanticoke Hospital will be charged the fee schedule plus the standard mark-up which is the AGB for TidalHealth. Self-pay patients, for all services not regulated by the HSCRC, will receive a discount to reduce charges to the amount TidalHealth would be reimbursed by Medicare which is the prospective method. For self-pay patients, the amount billed will not exceed the Medicare fee schedule for all unregulated services.

TidalHealth may use outsource vendors to provide patient collection and/or pre-collection services. Vendors act in accordance with TidalHealth policies and wherever policy notates employee, financial services department, or other such wording – vendor and/or vendor employees are included without such notation.

Definitions:

a. Elective Care: Care that can be postponed without harm to the patient or that is not medically necessary. An appropriate clinical or physician representative will be contacted for consultation in determining the patient status.
b. Medical Necessity: Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, resulting in illness or infirmity, threatening to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.

c. Immediate Family: Anyone for whom the patient claims a personal exemption in a federal or State tax return. A spouse, regardless of whether the patient and spouse expect to file a joint federal or State tax return, biological children, adopted children, or step-children. If the patient is a child, the household size is anyone for whom the patient's parents or guardians claim a personal exemption in a federal of State tax return. Biological parents, adopted parents, or stepparents or guardians, biological siblings, adopted siblings, or stepsiblings.
d. Liquid Assets: Cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, rental properties etc. The availability of liquid assets plus annual income may be considered in relation to the current poverty guidelines published in the Federal Register.
e. Medical Debt: Out of pocket expenses, including copayments, coinsurance and deductibles, for medical costs for medical costs billed by TidalHealth.
f. Extraordinary Collection Actions (ECA): Any legal action and/or reporting the debt to a consumer reporting agency.

TidalHealth will provide free medically necessary care to patients with family income at or below 200% of the federal poverty level. Patients qualifying for financial assistance based on income at or below 200% of the federal poverty level have no cost for their care and therefore pay less than AGB.

TidalHealth will provide reduced-cost medically necessary care to low-income patients with family income between 200% and 300% of the Federal poverty level.

TidalHealth will provide reduced-cost medically necessary care to low-income patients with family income between 301% and 500% of the Federal poverty level who have a medical hardship as defined by Maryland Law. Medical hardship is medical debt, incurred by a family over a 12-month period that exceeds 25% of the family income.

Other healthcare fees and professional fees that are not provided by TidalHealth are not included in this policy. Pre-planned service may only be considered for financial assistance when the service is medically necessary. As an example, cosmetic surgery is excluded. Inpatient, outpatient, emergency services, and services rendered by TidalHealth are eligible.

TidalHealth's financial assistance is provided only to bills related to services provided at TidalHealth or at a TidalHealth site including services provided by physicians employed by TidalHealth. To determine if your physician's services are covered by the TidalHealth financial assistance program, please see the roster of providers that deliver emergency and other medically necessary care, indicating which providers are covered under the policy and which are not. The list of providers is updated quarterly and available on the TidalHealth website. If you prefer, you may contact any financial counselor or patient accounting representative by calling (410) 912-4974, or in person at TidalHealth Peninsula Regional or TidalHealth Nanticoke.

PROCEDURE

If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies. In the event that the patient has applied for and kept all necessary appointments and third party assistance is not available, TidalHealth will provide care at reduced or zero cost. When no third party assistance is available to cover the total bill and the patient indicates that they have insufficient funds, Financial Assistance (FA) will be offered. The Uniform Financial Assistance application, Financial Assistance Policy, Patient Collection Practice Policy, and plain language summary, can be obtained by one of the following ways:

a. Available free of charge and upon request by calling (410) 543-7436 or (877) 729-7762.
b. Are located in the registration areas.
c. Downloaded from the TidalHealth website:
https://www.tidalhealth.org/patientforms
https://www.tidalhealth.org/patientbills
d. The plain language summary is inserted in the Admission packet and with all patient statements.
e. Annual notification in the local newspaper.
f. The application is available in English, Spanish, and Creole. No other language constitutes a group that is 5% or more, or more than 1,000 residents (whichever is less) of the population in our primary service area (Worcester, Wicomico and Somerset Counties) for Maryland based on U.S. Census data. For Delaware, the hospital population considered was 5%.
g. For patients who have difficulty in filling out an application, the information can be taken orally by calling (410) 912-6957 or in person at the Financial Counselor's Office located in the Frank B. Hanna Outpatient Center.

Signs will be posted in various locations throughout TidalHealth to inform patients where to call or apply for Financial Assistance.

TidalHealth Peninsula Regional – Emergency Department, Frank B. Hanna Outpatient Center, Cardiac Rehab, Wound Care, L&D Waiting Area, Hospital Cancer Center, and Same Day Surgery Waiting Area.

TidalHealth McCready Pavilion – Lab and Radiology Waiting Area, Emergency Department, Clinic, and Physical Therapy.

TidalHealth Nanticoke – Outpatient Registration, Emergency Department, Mears Building, Wound Care and Cardiac Rehab Entrance, and Cancer Center.

The patient's income will be compared to current Federal Poverty Guidelines (on file with the Collection Coordinator). The Collection Coordinator representative will consult with the patient as needed to make assessment of eligibility.

a. If the application is received within 240 days of the first post-discharge billing statement, and the account is with a collection agency, the agency will be notified to suspend all Extraordinary Collection Actions (ECA) until the application and all appeal rights have been processed.

b. If the application is incomplete, all ECA efforts will remain on hold for a reasonable amount of time and assistance will be provided to the patient in order to get the application completed. If there is not a phone contact to call, a written notice that describes the additional information and/or documentation required will be mailed which includes a phone contact to call for assistance.

c. Preliminary eligibility will be made within 2 business days based upon receipt of sufficient information to determine probable eligibility. A letter will be mailed to patients notifying them of their eligibility status. Following preliminary approval, patients must submit a completed application and any supporting documentation requested (if not done previously). TidalHealth Patient Financial Services determines final approval for Financial Assistance. Upon final approval, a financial assistance discount will be applied to the patient's responsibility.

d. Patients who are beneficiaries/recipients of certain means-tested social services programs are deemed to have presumptive eligibility at 100% and are FA eligible without the completion of an application or submission of supporting documentation. It is the responsibility of the patient to notify TidalHealth that they are in a means-tested program. This information may also be obtained from an outsourced vendor or other means available to TidalHealth. Programs included are patients that:

   - Live in a household with children enrolled in the free and reduced-cost meal program.
   - Receive benefits through the federal Supplemental Nutrition Assistance Program.
   - Receive benefits through the State's Energy Assistance Program.
   - Receive benefits through the federal Special Supplemental Food Program for Women, Infants, and Children.
   - Receive benefits from any other social service program as determined by the Department and the Commission.

e. A patient that has qualified for Maryland Medical Assistance is deemed to automatically qualify for Financial Assistance (FA) at 100%. The amount due from a patient on these accounts may be written off to FA with verification of Medicaid eligibility. Standard documentation requirements are waived.

f. TidalHealth may automatically approve Financial Assistance for accounts ready to be sent to a collection agency that are identified as Poverty based on the propensity to pay score.

g. If the application is ineligible, normal dunning processes will resume, which includes notifying the agency if applicable to proceed with ECA efforts. A copy of TidalHealth's Collections Policy may be obtained by calling (410) 543-7436 or (877) 729-7762 and is available on the website listed above.

h. The patient may request reconsideration by submitting a letter to the Senior Executive Director of Revenue Cycle at 100 East Carroll Street, Salisbury, Maryland 21801-5493 indicating the reason for the request.

i. Only income and family size will be considered in approving applications for FA unless one of the following three scenarios occurs:
   - The amount requested is greater than $50,000
   - The tax return shows a significant amount of interest income, or the patient states they have been living off of their savings accounts
   - Documentation indicates significant wealth

j. If one of the above three scenarios are applicable, liquid assets may be considered including:
   - Checking and savings accounts
   - Stocks and bonds
   - CD's
   - Money market or any other financial accounts for the past three months
   - Last year's tax return
   - A credit report may also be reviewed

The following assets are excluded:

- The first $10,000 of monetary assets
- Up to $150,000 in a primary residence
- Certain retirement benefits such as a 401-K where the IRS has granted preferential tax treatment as a retirement account including but not limited to deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans where the patient potentially could be required to pay taxes and/or penalties by cashing in the benefit.
- 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 or Delaware 529 Program account.

If the balance due is sufficient to warrant it and the assets are suitable, a lien may be placed on the assets for the amount of the bill. Collection efforts will consist of placement of the lien which will result in payment to TidalHealth upon sale or transfer of the asset. Refer to the TidalHealth Collection policy on filing liens.

k. If TidalHealth has reason to believe the information is unreliable or incorrect, or obtained under duress, or through the use of coercive practices, FA may be denied.

l. We do not request or provide waivers, written or oral, expressing patient does not wish to apply for assistance.

m. In accordance with state and federal guidelines, staff training records regarding this policy are maintained by the TidalHealth Training Coordinator.

Collection Coordinator

a. If eligible, and under $2,500, the account will be written off to FA when the "Request for Financial Assistance" form is finalized. A copy is retained in the patient's electronic file. If eligible, and the balance is $2,500 or above, the Collection Coordinator will obtain the appropriate adjustment signature(s).

b. TidalHealth will review only those accounts where the patient or guarantor inquire about FA, based on mailing in an application, or in the normal working of the account there is indication that the patient may be eligible. Any patient/customer service representative, financial counselor, or collection representative may begin the application process.

c. Once a request has been approved, service eight months before the approval and twelve months after the approval may be included in the adjustment. All encounters included with the application must reference the original encounter number where the electronic image of the application is stored. Service dates outside this twenty month window may be included if approved by a Supervisor, Manager, or Director. Any amount exceeding $5 that has already been collected from the patient or guarantor for approved dates of service shall be refunded to the patient if the determination is made within two years of the date of care.

d. TidalHealth will communicate with the patient using the method preferred by the patient including electronic communications, telephone or mail.

_____
Steven Leonard
President/CEO

_____
Bruce Ritchie
Senior Vice President of Finance/CFO

TidalHealth™

PLAIN LANGUAGE SUMMARY

Financial Assistance Policy

It is the intention of TidalHealth to make available to all patients the highest quality of medical care possible within the resources available. If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies, or, if no help is available, to render care at a reduced or zero cost for emergency and medically necessary care.

Patients requiring elective services may, through consultation with their physician, have their procedure postponed until such time as the patient is able to make full payment or meet the established deposit. Elective procedure patients who, according to their diagnosis and/or their physician, cannot have their procedure postponed will be helped with obtaining assistance from agencies. If no assistance is available, and the patient requests, the account will be reviewed for possible financial assistance.

TidalHealth physician charges are not included in the hospital bill and are billed separately, with the exception of self-pay balances. Self-pay balances for TidalHealth services will appear on the same statement. Physician charges outside of TidalHealth are not included in the hospital bill and will be billed separately. Physician charges outside of TidalHealth are not covered by TidalHealth's financial assistance policy. A list of providers that deliver emergency and other medically necessary care at TidalHealth is provided on the website at www.tidalhealth.org/find-a-doctor.

In the event that the patient has applied for and kept all necessary appointments and third party assistance is not available, the patient may be eligible for financial assistance.

Eligibility Determination Process

1. Interview patient and/or family.
2. Obtain annual gross income.
3. Determine eligibility *(preliminary eligibility within 2 business days).*
4. Screen for possible referral to external charitable programs.
5. If the patient and/or family refuse to disclose financial resources or cooperate, the patient will be subject to standard collection efforts. No Extraordinary Collection Actions (ECA) will be taken for at least 120 days from the first post-discharge billing statement.
6. All applications received within 240 days of the first post-discharge billing statement will be reviewed. ECA actions will be suspended until the application has been processed.
7. The determination of eligibility *(approval or denial)* shall be made in a timely manner.

How to Apply

- Applications can be taken orally by calling (410) 912-6957 between 8:00 a.m. and 5:00 p.m., Monday through Friday
- In person at TidalHealth Peninsula Regional, 100 East Carroll Street, Salisbury, Maryland at the Financial Counselor's office (located in the Frank B. Hanna Outpatient Center lobby) between 8:00 a.m. and 4:00 p.m., Monday through Friday or the Registration Office of TidalHealth Nanticoke, 801 Middleford Road, Seaford, Delaware, between 8:00 a.m. and 4:00 p.m. Monday through Friday.
- Mailing a request for an application to TidalHealth Peninsula Regional, PO Box 2498, Salisbury, MD 21802-2498
- On the internet at:
  https://www.tidalhealth.org/patientforms
  https://www.tidalhealth.org/patientbills
- Applications are available in English, Spanish, and Creole.

Qualifications

TidalHealth compares the patient's income to the Federal Poverty Guidelines. In order to process your application we require the following information:

- An independent third party to verify your household income (one of the following)
  a. Recent pay stub showing current and year-to-date earnings
  b. Most recent tax return showing your Adjusted Gross Income or W-2 form
  c. Written documentation of Social Security benefits, SSI disability, VA benefits, etc.
  d. If no income, a letter from an independent source such as a clergy or neighbor verifying no income
- Completed application

This information, and any information obtained from external sources, is used to determine your eligibility for financial assistance. The more information provided, the easier it is for us to determine your financial need. TidalHealth may request a credit report to support a patient's application for assistance.

Need Assistance?

If, at any time, you have questions about obtaining financial assistance, your medical bill, your rights and obligations with regard to the bill, or applying for the Medical Assistance Program, please contact the TidalHealth Financial Services Department at (877) 729-7762. You can obtain a copy of the TidalHealth Financial Assistance Policy at www.tidalhealth.org/financialassistance.

Medical Assistance Program

To find out if you are eligible for Maryland Medical Assistance or other public assistance, please apply at your local Department of Social Services (DSS) office, or you may visit mmcp.dhmh.maryland.gov for information about the various Medicaid programs available. You may apply online for Maryland Medicaid at marylandhealthconnection.gov. If you are applying for assistance for a child, or are pregnant, you may apply for the Maryland Children's Health Program (MCHP). If you are only applying for assistance with paying your Medicare premiums, co-payments, or deductibles, you may apply at your local Department of Social Services (DSS) for the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) Program. QMB/SLMB applications may be filed by mail or in person. For more information, if you are a Maryland resident, you may call the Department of Health and Mental Hygiene's Recipient Relations Hotline at 1 (800) 492-5231 or (410) 767-5800.

Delaware residents may obtain information online at dhss.delaware.gov or apply online at assist.dhss.delaware.gov. If you are a Delaware resident, call (302) 571-4900. Virginia residents may obtain information at dmas.Virginia.gov. To receive an application, call your local DSS office or the Area Agency on Aging, (AAA).

Patients' Rights and Obligations

Rights:

- Prompt notification of their preliminary eligibility determination for financial assistance.
- Guidance from TidalHealth on how to apply for financial assistance and other programs which may help them with the payment of their medical bill.
- Receipt of financial assistance for all services not payable by another program that meet the qualifications of TidalHealth's Financial Assistance Policy.
- TidalHealth will provide emergency and medically necessary free and/or reduced-cost care to patients who lack health care coverage or whose health care coverage does not pay the full cost of their medical bill.

Obligations:

- Submit complete and accurate information on the Uniform Financial Assistance Application in use in the state of Maryland.
- Attach supporting documentation and return the form to TidalHealth Peninsula Regional in a timely manner.
- Make payment in full or establish a payment plan for services not qualified under TidalHealth's Financial Assistance Policy.

Cómo hacer la solicitud

- Llame al (410) 912-6957 o (877) 729-7762 entre las 8:00 a.m. y las 4:00 p.m., de lunes a viernes
- Acuda en persona a la oficina del consejero financiero (Localizado en el vestibulo Frank B. Hanna del Centro de attencion de Pacientes Externos) entre las 8:00 a.m. y las 4:00 p.m., de lunes a viernes
- A través de Internet, visite www.tidalhealth.org. Haga clic en Patients & Visitors (Pacientes y vistantes), luego en Patient Financial Services (Servicios financieros para pacientes) y después en Billing Information (Información de facturación)

Date: 5/16 (effective 11/01/16)
Reviewed:
Revised: 7/17, 7/18, 7/19, 7/20, 9/20, 7/21

From:	Henry Nyce
To:	Hilltop HCB Help Account
Cc:	Katherine Rodgers; Laren MacMillan; Rachel Webster; Gregory Mann; Chris Hall
Subject:	Clarification Required TidalHealth Peninsula Regional, TidalHealth McCready Pavilion - Strategy
Date:	Thursday, March 9, 2023 8:46:47 AM

Thank You,

We continually update the content of our TidalHealth website, please see the attached link to the page that outlines
our Mission, Vision, Guiding Values and Strategic Plan.

TidalHealth has three Strategic Themes which govern: TidalHealth Peninsula Regional, TidalHealth Nanticoke, TidalHealth Medical Partners and TidalHealth McCready Pavilion.

https://www.tidalhealth.org/about-us/mission-values

If you have any additional questions please feel free to call me Henry Nyce at 410-543-7404 or 302-515-4934.

Question:
Hilltop HCB Help

Thank you for submitting the FY 2022 Hospital Community Benefit Narrative report for TidalHealth McCready Pavilion and TidalHealth Peninsula Regional. In reviewing the narratives, we noted that for Question 74 on page 14 the links provided to your hospitals' strategic plans were actually links to a page with the mission statement and guiding values. Please provide a link to the strategic plans for your hospitals.

Henry Nyce
Manager of Planning & Business Dev.
Strategy & Business Development

TidalHealth
100 East Carroll Street
Salisbury, MD 21801

O 410-543-7404
F 410-543-7144

Please note, my e-mail has changed to:
Henry.nyce@TidalHealth.org

From: Hilltop HCB Help Account
To: katherine.rodgers@tidalhealth.org; Hilltop HCB Help Account
Subject: Clarification Required - FY 22 TidalHealth McCready Pavilion and Peninsula Regional Narratives
Date: Wednesday, March 8, 2023 1:43:56 PM
Attachments: TidalHealth McCready Pavilion_HCBNarrative_FY2022_20221215.pdf
TidalHealth Peninsula Regional_HCBNarrative_FY2022_20221215.pdf

---

Thank you for submitting the FY 2022 Hospital Community Benefit Narrative report for TidalHealth McCready Pavilion and TidalHealth Peninsula Regional. In reviewing the narratives, we noted that for Question 74 on page 14 the links provided to your hospitals' strategic plans were actually links to a page with the mission statement and guiding values. Please provide a link to the strategic plans for your hospitals.