2022

MONTGOMERY COUNTY HOSPITAL COLLABORATIVE **COMMUNITY HEALTH NEEDS** ASSESSMENT

Adventist HealthCare

HOLY CROSS HEALTH
A Member of Trinity Health

MedStar Health

SUBURBAN HOSPITAL
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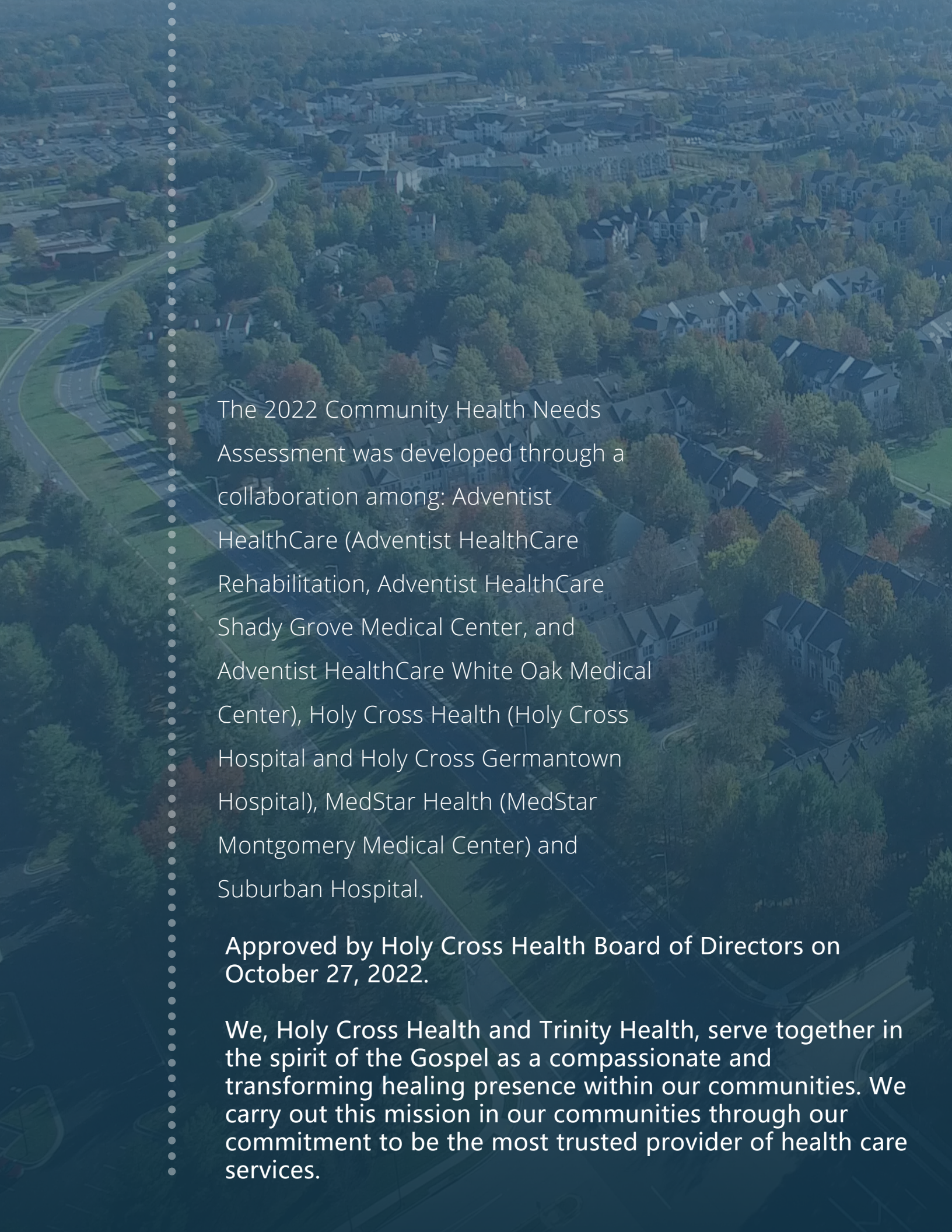

The 2022 Community Health Needs Assessment was developed through a collaboration among: Adventist HealthCare (Adventist HealthCare Rehabilitation, Adventist HealthCare Shady Grove Medical Center, and Adventist HealthCare White Oak Medical Center), Holy Cross Health (Holy Cross Hospital and Holy Cross Germantown Hospital), MedStar Health (MedStar Montgomery Medical Center) and Suburban Hospital.

Approved by Holy Cross Health Board of Directors on October 27, 2022.

We, Holy Cross Health and Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. We carry out this mission in our communities through our commitment to be the most trusted provider of health care services.

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GLOSSARY

A list of commonly used terms and acronyms is provided below as well as a list of acronyms used in this report to refer to various organizations, departments, offices, programs, data collection, and surveillance systems.

Commonly Used Terms

Age-Adjustment	Age-adjustment is a statistical process applied to rates of disease, death, injury, or other health outcomes that allows for the comparison of rates among populations having different age distributions.
Incidence	The number of newly diagnosed cases of disease occurring in a specific population during a specific time.
Risk Factor	Something that can increase the chance of developing disease.
Morbidity	The incidence of disease within a population.
Mortality	The number of deaths during a specific time.

Acronyms

ACA	Affordable Care Act
CBSA	Community Benefit Service Area
CDC	Centers for Disease Control and Prevention
MC	Montgomery County, Maryland
PGC	Prince George's County, Maryland
MCHC	Montgomery County Hospital Collaborative
PSA	Primary Service Area
SNAP	Supplemental Nutrition Assistance Program
SDOH	Social Determinants of Health
USDA	United States Department of Agriculture

In addition to the commonly used terms and acronyms provided, a list of how race and ethnicity is used in this report is provided below. Race and ethnicity are not precisely defined constructs and multiple terms can be used to define both race and/or ethnicity. For this report, the term "race" indicates one of the five categories specified in the United States Office of Management and Budget 1997 Standards, and "ethnicity" indicates Hispanic or non-Hispanic origin (VanEenwyk, 2010).

Race

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

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

Black or African American
A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

Native Hawaiian or Other Pacific Islander (NHOPI)
A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

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

Ethnicity

Hispanic or Latino	A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."
Non-Hispanic or Latino	A person not of Hispanic or Latino origin.

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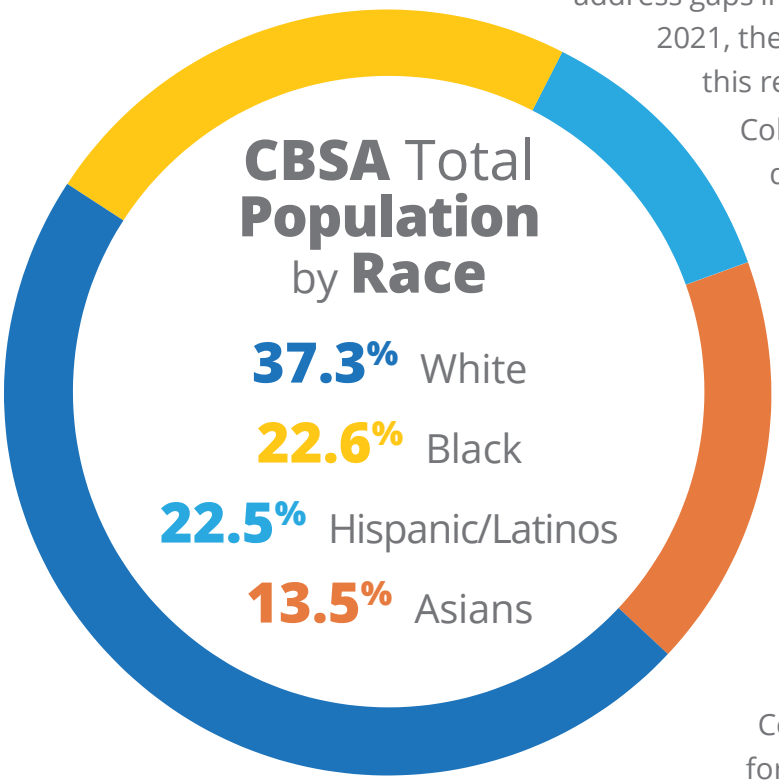
EXECUTIVE SUMMARY

In 2010, Congress enacted the Patient Protection and Affordable Care Act (The ACA) to enhance the quality of health care for all Americans through a deliberate method of comprehensive health insurance reform. Specifically, the ACA requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) and adopt an implementation strategy every three years. The CHNA and implementation strategy aim to identify the most important health issues in a defined community benefit service area (CBSA), as well as develop a plan to implement programs and services to meet identified unmet community needs.

Healthy Montgomery is Montgomery County's community health improvement process (CHIP) and dually serves as the local health improvement coalition (LHIC). Established in June 2009, Healthy Montgomery brings together County government agencies, County hospital systems, minority health programs/initiatives, advocacy groups, and other stakeholders to achieve optimal health and well-being for all Montgomery County residents.

Through the development of Healthy Montgomery, the Montgomery County hospitals (Adventist HealthCare, Holy Cross Health, MedStar Health, and Suburban Hospital) recognized the opportunity to meet as a subgroup and work together to leverage community benefit resources, identify overlapping implementation strategies, and decrease duplication of efforts. In 2015, the Montgomery County hospitals began working together to steward resources and address gaps in access to care through program mapping. In 2021, the Montgomery County hospitals (referred to in this report as the Montgomery County Hospital Collaborative [MCHC]) further advanced their dedication to collective impact by developing a joint Community Health Needs Assessment (CHNA) and Implementation Strategy.



Montgomery County ranks as one of the healthiest counties in Maryland, yet barriers to improving health and well-being persist in many pockets of our community. While the hospitals serve residents from every corner of the County and throughout the region, the MCHC narrowed its CBSA to 38 zip codes covering portions of Montgomery and Prince George's Counties where the needs and opportunities for improvement are greatest.

The 2022 MCHC CHNA relied on multiple tools and resources to understand and identify the unmet health needs of the people we serve, including:

- Federal, state, and local health surveillance data sets
- External advisory groups comprising of officers from state and local government agencies and leaders from community-based organizations, foundations, faith-based organizations, colleges, coalitions, and associations.
- A 19-question Community Health Needs Assessment Survey completed in 2021
- Community Conversations and Key Informant Interviews
- Existing needs assessments from local health initiatives, government agencies, and non-profit community health organizations

The MCHC used this information, in tandem with local public health leaders, service providers, and community advocates, to prioritize root causes of health inequities outlined in the three domains below:

1. Access to Care

- Access to mental health providers
- Access to primary care providers
- Lack of insurance

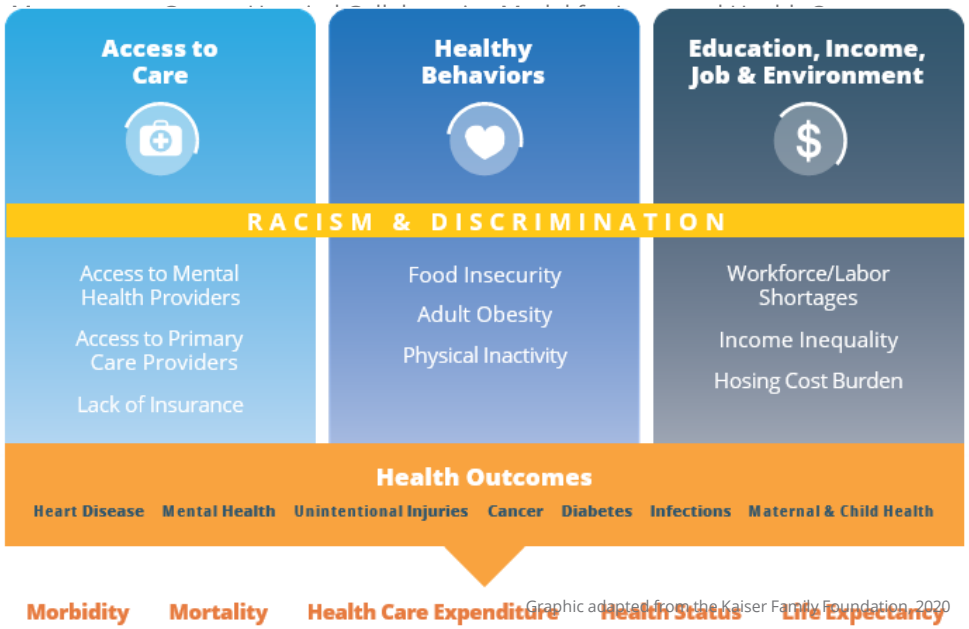
2. Healthy Behaviors

- Food insecurity
- Adult obesity
- Physical inactivity

3. Education, Income, Job & Environment

- Workforce/labor shortages
- Income inequality
- Housing cost burden

By addressing these nine root causes of health inequities, a promising impact in reducing the burden of the top health outcomes - heart disease, diabetes, mental health, cancer, maternal and child health, infections, and unintentional injuries – can be achieved.



Graphic adapted from the Kaiser Family Foundation, 2020

Next, the MCHC will develop an implementation plan that serves as a strategic roadmap to prioritize health needs. The collaborative nature of this CHNA will leverage resources, capacities, and mobilization of health improvement initiatives to cultivate a more equitable foundation for health.

For further information on how the MCHC hospitals plan to address each identified unmet health need, please reference the Multi-Year CHNA Implementation Plan.

Letter from Hospital Leadership

June 20, 2022

Dear Residents and Partners,

In Montgomery County, six hospitals are working collectively and collaboratively to reimagine health care that extends far beyond our hospital walls. In fact, caring for our community and investing in holistic approaches to improve health are a deliberate commitment.

We are setting the standard for this community commitment by creating our first joint Community Health Needs Assessment (CHNA) and Implementation Strategy. This collaborative CHNA addresses 34 zip codes served by Adventist HealthCare, Holy Cross Health, MedStar Health and Suburban Hospital, Johns Hopkins Medicine. The identified and prioritized health needs will guide the resources, program development, and collaborations required to address gaps in care, advance health equity and improve quality of life.

While Montgomery County ranks as one of the healthiest counties in Maryland, barriers to improving the well-being for many members of our community persist. Steps to address the complex social factors that influence health must incorporate both population and public health strategies. Integrating the expertise, guidance, resources and influence of partnerships beyond the healthcare environment are integral to achieving equity for all.

The data outlined in the 2022 Community Health Needs Assessment is extensive and far-reaching. We invite you to read with curiosity and excitement. The assessment process would not be possible without the critical and timely feedback of our community residents, stakeholders and thought leaders, who tirelessly shared their time to inform our prioritization, strategy model, and most importantly, how we will evaluate and track our progress. There is much more work ahead and we cannot do it without broad participation from our community!

We are stronger together.

Sincerely,

Norvell "Van" Coots, M.D.
President & CEO
Holy Cross Health

Terry Forde
President & CEO
Adventist HealthCare

Jessica Melton
President and COO
Suburban Hospital (Johns Hopkins Medicine)

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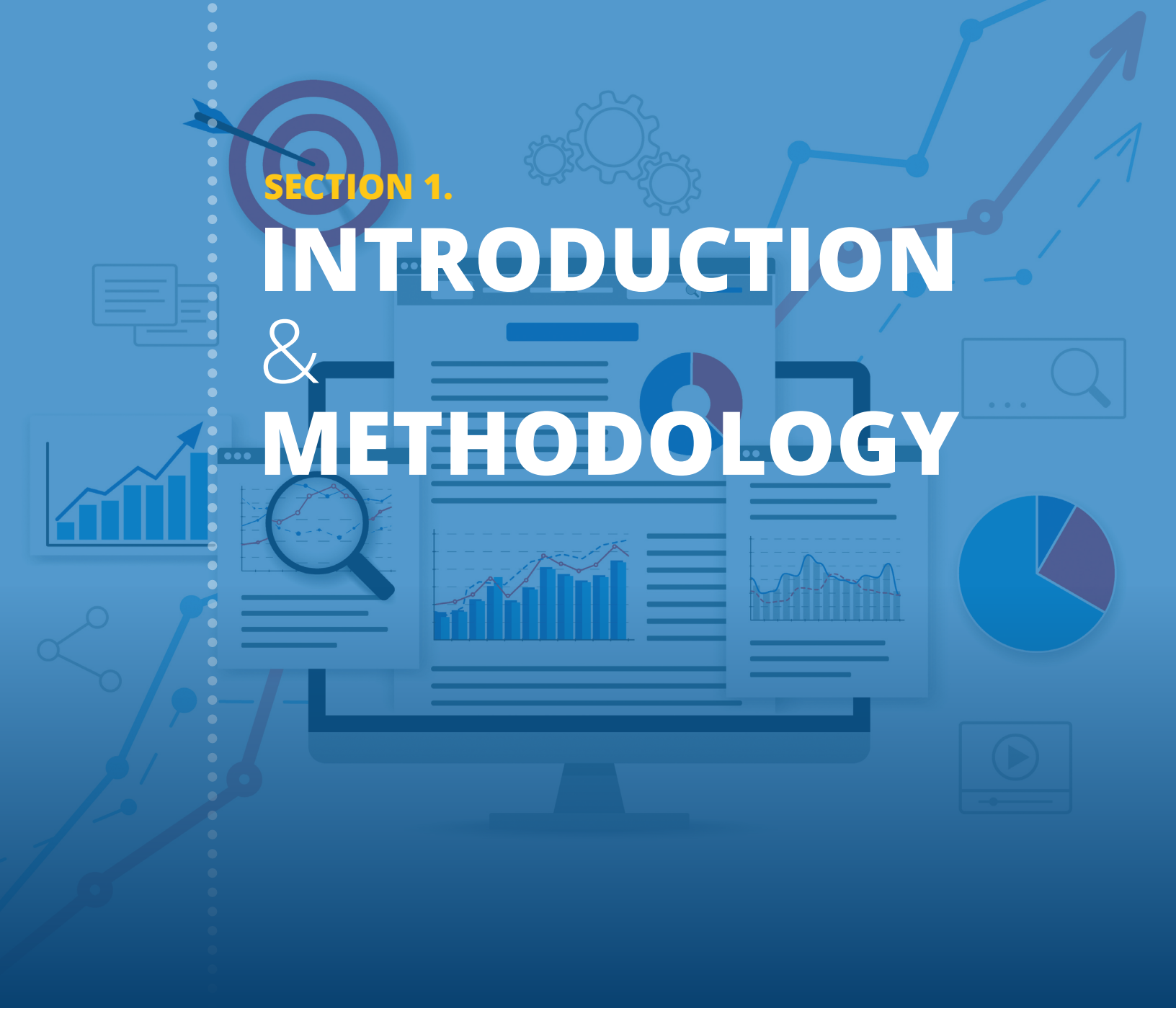


SECTION 1.

INTRODUCTION & METHODOLOGY

In 2010, Congress enacted the Patient Protection and Affordable Care Act (The ACA) to enhance the quality of health care for all Americans through a deliberate method of comprehensive health insurance reform. Specifically, the ACA requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) and adopt an implementation strategy every three years. The CHNA and implementation strategy aim to identify the most important health issues in a defined community benefit service area (CBSA), as well as develop a plan to implement programs and services to meet identified unmet community needs.

Healthy Montgomery is Montgomery County's community health improvement process (CHIP) and dually serves as the local health improvement coalition (LHIC). Established in June 2009, Healthy Montgomery brings together County government agencies, County hospital systems, minority health programs/initiatives, advocacy groups, academic institutions, community-based service providers and other stakeholders to achieve optimal health and well-being for all Montgomery County residents. Most important, Healthy Montgomery is the central catalyst to meet Affordable Care Act (ACA) requirements and local health department PHAB[1] accreditation. Healthy Montgomery centralizes data to identify priority issues among community partners, develop and implement strategies for action, as well as establish accountability to ensure measurable health improvement outcomes (NACCHO, 2022).

Through the development of Healthy Montgomery, the Montgomery County hospitals (see Figure 1) recognized the opportunity to meet as a subgroup and work together to leverage community benefit resources, identify overlapping implementation strategies, and decrease duplication of efforts. In 2015, the hospitals began working together to steward resources and address gaps in access to care through program mapping.

IIn 2021, the Montgomery County hospitals (referred to in this report as the Montgomery County Hospital Collaborative [MCHC]) further advanced their dedication to collective impact by developing a joint Community Health Needs Assessment (CHNA) and Implementation Strategy. The 2022 collaborative CHNA will serve to guide resources and program development to meet the needs of shared community and address gaps in care, health equity, and improve the quality of life for all residents. See Appendix A for a list of comprehensive services for each hospital.

Figure 1: Health System Logos

[1] The Public Health Accreditation Board (PHAB) is a nonprofit organization dedicated to advancing the continuous quality improvement of Tribal, state, local, and territorial public health departments (www.phaboard.org).

DATA SOURCES

The 2022 MCHC CHNA relied on multiple tools and resources to understand and identify the unmet health needs of the people we serve. Using the County Health Rankings model as the guide for factors that influence length and quality of life, over 100 indicators were identified and integrated to create a health profile of Montgomery and Prince George's County. In addition to gathering timely, reliable, and valid secondary health data and reports, the MCHC collected first-hand information from the community and experts in the field via our community health improvement process (Healthy Montgomery), external advisory board conversations, and key informant interviews.

HEALTHY MONTGOMERY

Serving as the Local Health Improvement Coalition (LHIC), Healthy Montgomery brings together Montgomery County government agencies, the four hospital systems, the minority health initiatives/health programs, advocacy groups, academic institutions, community-based service providers, the health insurance community, and other stakeholders to set a health priority agenda and an action plan for Montgomery County's prioritized needs. Healthy Montgomery aims to:

- Improve access to health and social services
- Achieve health equity for all residents
- Enhance the physical and social environment to support optimal health and well-being

The MCHC contributes $150,000 annually to support the infrastructure of Healthy Montgomery. In addition to providing financial support, representatives from each health system play an active role through representation on multiple Healthy Montgomery committees and planning groups, including the Healthy Montgomery Steering Committee, which is the governing body for the group (see Appendix B for a full list of steering committee members).

EXTERNAL ADVISORY GROUPS

The four health systems have convened a group of external participants representing the broad interest of the community we serve to share advice and feedback. Participants include the public health officer, the director of the Montgomery County Department of Health and Human Services, various individuals from local and state governmental agencies, and leaders from community- and faith-based organizations, foundations, colleges, coalitions, and associations. These participants are experts in a range of areas, including public health, health care, minority populations and disparities in health care, social determinants of health (SDOH), and social services. Through feedback and advice, they provide ongoing input to ensure that we have identified and responded to the most pressing community health needs. Throughout the CHNA, advisory Group members were invited to participate, particularly in the prioritization process, thought leaders discussion, and data exploration process. A comprehensive list of members of the external advisory groups is available in Appendix C.

COMMUNITY SURVEYS, CONVERSATIONS, AND KEY INFORMANT INTERVIEWS

In 2021, the MCHC widely distributed a 19-question Community Health Needs Assessment Survey centered on health status, access to care, and perceived community health needs and strengths. The survey is available in both English and in Spanish. Survey dissemination includes community events, programs, via email, listservs, social media, community partners and organizations.

Community Conversations and Key Informant Interviews were conducted in partnership with Healthy Montgomery and the Montgomery County Department of Health and Human Services oversight, participation, and support. The findings from the key informant interviews are referenced in Appendix D.

NEEDS ASSESSMENTS AND REPORTS

As available, the MCHC used a range of needs assessments and reports to identify unmet needs, especially for underserved minorities, seniors, and women and children.

- African American Health Program Annual Report FY2020
- African American Health Program Geographic Hot Spot Report 2019
- Asian American Health Initiative Annual Report FY2021
- Blueprint for Asian American Health Initiative 2020-2030
- Blueprint for Latino Health in Montgomery County 2017-2026
- CDC National Diabetes Statistics Report 2020
- Community Action Partnership, Community Needs Assessment 2019-2022
- Latino Health Initiative Annual Report FY2019
- Montgomery County Collaboration Council, Community Needs Assessment, 2020
- Montgomery County Department of Health and Human Services, Health Equity in Montgomery County 2010-2018
- Montgomery County Department of Health and Human Services, Status of Health in Montgomery County FY2018
- Montgomery County Food Council Annual Report 2020
- Prince George's County Community Health Assessment 2019
- Prince George's County Food Security Task Force Report 2021
- Prince George's County Health Department, Health Report 2018
- State of Maryland Vital Statistics Annual Report 2019
- State of Maryland, Diabetes in Maryland Action Plan
- Surveillance Report on Population Health, Health in Montgomery County 2010-2019
- Thrive Montgomery 2050
- Trinity Health System – Full Assessment Report 2021
- Trust for America's Health, The State of Obesity Report 2021
- University of Wisconsin Population Health Institute's County Health Rankings Data
- USDA Economic Research Report, Household Food Security in the US 2020

OTHER AVAILABLE DATA

The MCHC also reviewed internal patient data (i.e., emergency room utilization, patient re-admissions) and, where available, accessed publicly available data on market analyses, health

indicators, and social determinants of health. These data sets helped provide a detailed look at the community we serve by identifying potential disparities that might not surface when looking at only county or state data. In addition, members of the MCHC regularly participate in coalitions, commissions, committees, partnerships, and panels, affording a deep understanding of health opportunities and challenges resonating within the community.

INDICATORS AND MEASUREMENT LIMITATIONS

Health indicators are measures designed to summarize information about a given priority topic in population health or health system performance. These indicators can be used to describe the health of a population, health differences within a population, or to determine if a program's objectives are being met. Healthy People 2030 contains 355 core (measurable) objectives, with a smaller set of 23 Leading Health Indicators (LHIs), which communicate high-priority health issues and actions that can be taken to address them (Office of Disease Prevention and Health Promotion, 2022). The most common HP2030 LHIs are those related to birth and death, such as life expectancy, premature mortality, or adequacy of prenatal care.

At the time this report was produced, not all data was available at the zip-code level for Montgomery or Prince George's County. Therefore, county or state-level data was used to assess and analyze health needs. In addition, not all indicators were available for all races/ethnicities, so available race/ethnicity or data combining all races/ethnicities was used.

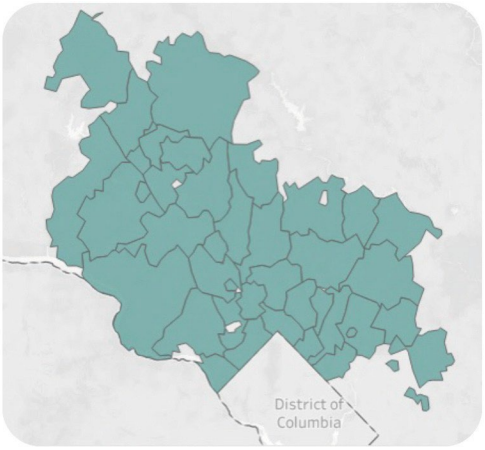
DEFINING COMMUNITIES SERVED

The MCHC serves portions of Montgomery, Prince George's, Frederick, Carol, and Howard Counties, and the District of Columbia, spanning 86 zip codes and almost 2.3 million people. However, this CHNA aims to identify and prioritize key areas and communities of focus for meaningful engagement. In order to do this, the MCHC identified zip codes in each hospital's primary service area as our collective Community Benefit Service Area (CBSA) and highlighted communities of focus within the CBSA to provide a valuable snapshot of the hospital's existing communities served and new areas of interest.

DESCRIPTION OF SERVICE AREA

The MCHC CBSA comprises 38 zip codes (see Figure 2) that span approximately 388 square miles of Montgomery County and northern Prince George's County, with a total population of 1,250,503 (Center for Applied Research and Engagement Systems, 2022). The population density for this area, estimated at 3,218 persons per square mile, is greater than Montgomery County (2,116 persons per square mile), Prince George's County (1,883 persons per square mile), and the state (620 persons per square mile). For a complete list of the zip codes comprising the MCHC CBSA, see Appendix E.

Figure 2: The MCHC Community Benefit Service Area



The MCHC CBSA serves portions of Montgomery and Prince George's Counties, two majority-minority counties[2] rich in cultural diversity. The largest populations by race/ethnicity within the service area are Non-Hispanic Whites (37.3%), Non-Hispanic Blacks (22.6%), Hispanic or Latino (22.5%), and Non-Hispanic Asian (13.5%) (see Table 1).

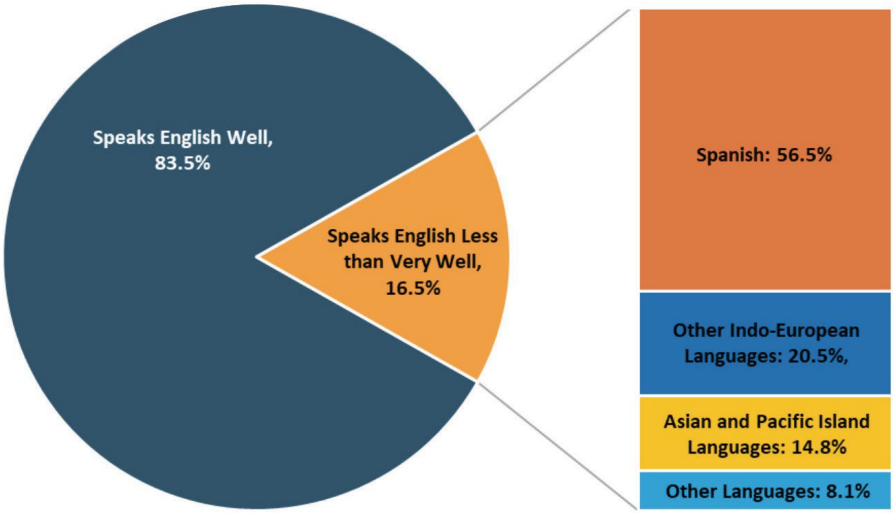
Table 1: Population by Combined Race Ethnicity

Report Area	NH White	NH Black	NH Asian	NH AIAN*	NH NHOPI*	NH Some Other Race	NH Multiple Races	Hispanic or Latino
MCHC CBSA	37.3%	22.6%	13.5%	0.1%	0.03%	0.7%	3.4%	22.5%
Frederick County, MD	72.4%	9.5%	4.4%	0.2%	0.1%	0.2%	3.3%	10.0%
Montgomery County, MD	43.1%	18.0%	14.9%	0.1%	0.04%	0.7%	3.7%	19.5%
Prince George's County, MD	12.3%	61.2%	4.2%	0.2%	0.03%	0.5%	2.7%	18.8%
Maryland	50.2%	29.4%	6.3%	0.2%	0.03%	0.4%	3.3%	10.3%
United States	60.1%	12.3%	5.6%	0.6%	0.2%	0.3%	2.8%	18.2%

Source: Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

More than 33% of the MCHC CBSA population are of foreign birth compared to 32% in Montgomery County, 23% in Prince George's County, and 15.2% in Maryland. The languages spoken in this region also reflect its diversity. However, approximately 16.5% of the CBSA population, aged 5 and older, speak English less than very well compared to 7% of the Maryland population (see Figure 3).

Figure 3: English Proficiency within the MCHC CBSA



Data Source: US Census Bureau, American Community Survey. 2016-20.

[2] A Majority-Minority County is a county where less than 50% of the population is non-Hispanic white.

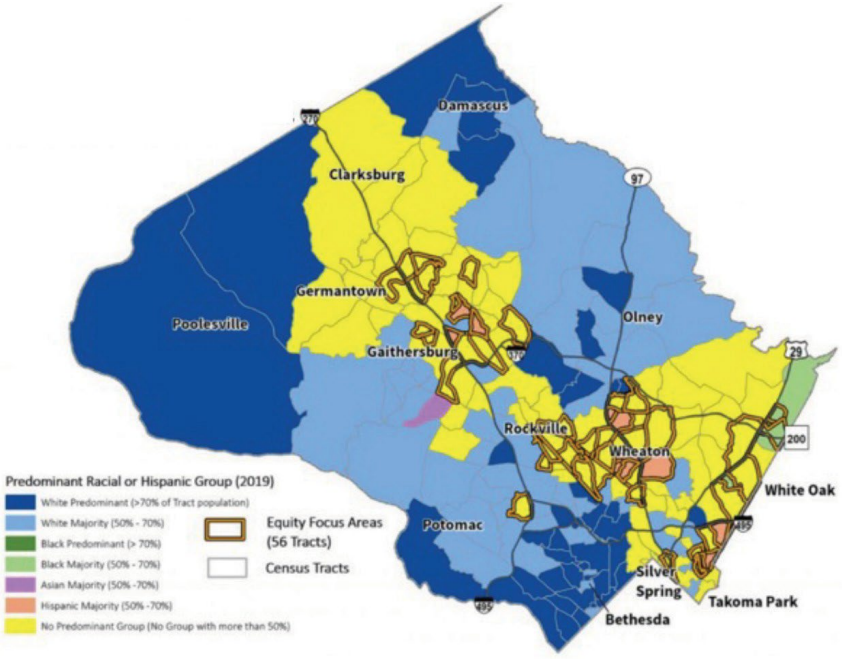
Limited English proficiency (LEP), or the inability to speak English well, creates barriers to health care access, provider communications, and health literacy/education. Spanish is the highest percentage of LEP by language spoken in the home (United States Census Bureau, 2022).

The CBSA is not only rich in diversity but also in resources. The area has over 170 private and county-run fitness and recreation facilities, roughly 75% of residents live within ½ a mile of a park, more than 240 grocery stores serve the area and more than 100 social and professional organizations per person. The average household income of $138,054 for persons in the MCHC CBSA is higher than the state average of $111,417 and the Prince George's County average of $102,593, but lower than that for Montgomery County overall ($149,437). However, despite the plethora of resources and above-average incomes, disparities exist, particularly for populations experiencing vulnerabilities.

VULNERABLE POPULATIONS

Populations experiencing vulnerability (also referred to as vulnerable populations) are groups and communities at a higher risk for poor health outcomes as a result of the barriers they experience due to structural and societal factors they face, such as systemic racism, discrimination, stigma, and poverty (Baciu, Negussie, Geller, & et al., 2017). In 2021, the Equity Data Team of Montgomery County's Planning Department developed a mapping tool to identify vulnerable populations within Montgomery County. The team identified 56 Equity Focus Areas (EFAs) by looking at demographic data at the census tract level (see Appendix F for a full list of demographic data). They focused on identifying areas with high concentrations of lower-income households, people of color, and individuals who speak English less than very well (Zorich, Mukherjee, & Blyton, 2021) (see Figure 4). Approximately one-quarter of Montgomery County's population resides in the EFAs.

Figure 4: Equity Focus Areas and Predominant Race or Hispanic Origin



Source: Research and Strategic Projects, Montgomery Planning Department, 2021.

In addition to populations residing in the EFAs, other populations experiencing vulnerabilities include low-income, racial and ethnic minorities, uninsured, seniors, pregnant women and infants, the homeless, and those with disabilities.

LOW-INCOME POPULATIONS

Low-income status and poverty are linked to poor health outcomes due to their correlation with adverse conditions such as substandard housing, homelessness, food insecurity, inadequate childcare, lack of access to health care, unsafe neighborhoods, and under-resourced schools, which adversely impact our nation's children (U.S. Department of Health and Human Services, 2022). Approximately 20.4%, or 250,418 individuals, within the MCHC CBSA, live in households with incomes below 200% of the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access, including health services, healthy food, and other necessities that contribute to poor health status (Center for Applied Research and Engagement Systems, 2022).

RACIAL ETHNIC MINORITIES

Minorities, also referred to as Black, Indigenous and People of Color, often experience higher rates of illness and death across a wide range of health conditions, including diabetes, hypertension, obesity, asthma, and heart disease, when compared to their White counterparts (Centers for Disease Control and Prevention, 2021). Although minorities experience higher rates of illness and death, it is important to note the mantra coined by Dr. Joia Crear-Perry, that "racism, not race, causes health disparities" (Chadha et al., 2020). In the CBSA, more than 40% of the population is Non-Hispanic, Non-White and 22.5% are Hispanic.

UNINSURED POPULATIONS

The lack of health insurance is considered a key driver of health status. People without insurance coverage have barriers to accessing care and often postpone or forgo health care, causing many chronic conditions to go undiagnosed or poorly treated compared to those with insurance. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected (Kaiser Family Foundation, 2022). In the CBSA, 9.1% of the total civilian non–institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is greater than the state average of 6.1%.

SENIOR POPULATIONS

The 2017-2020 State Plan on Aging for Maryland estimates that between 2015 and 2030, the population of adults aged 60 and greater will increase by 40%, from 1.2 to 1.7 million (Maryland Department of Aging, 2021). This growth reflects advances in health care and medicine, allowing individuals to live longer than ever before. A similar estimate was made by the Montgomery County Commission on Aging (2018), predicting that nearly 25% of all residents will be 60 years or greater by 2030. While this represents one of the crowning achievements of the last century, it also poses significant social and economic challenges due to the unique needs of the senior population.

According to Seniors First BC (2016), the risk for chronic illness and the need for long-term care increases directly with age, increasing seniors' vulnerability. Three main risk factors that contribute to vulnerability in older adults are:

- health status
- cognitive ability, and
- social network

Of the estimated 1,250,503 total population in the CBSA, an estimated 177,072, or 14.2%, are adults aged 65 and older. This percentage is comparable to Montgomery County and slightly higher than Prince George's County (Montgomery Planning M-NCPPC, 2018).

MATERNAL/INFANT POPULATIONS

The well-being of mothers, infants, and children can help predict future public health challenges for families, communities, and the health care system (Office of Disease Prevention and Health Promotion, 2021). Access to quality preconception (before pregnancy), prenatal (during pregnancy), postnatal (after pregnancy), and interconception (between pregnancies) care can reduce the risk of maternal/infant mortality and improve birth outcomes. Healthy birth outcomes or early detection and treatment of developmental delays and disabilities can prevent poor health outcomes, such as death and disabilities, and allow children to reach their full potential (Office of Disease Prevention and Health Promotion, 2021)

HOMELESS POPULATIONS

The definition of homelessness is broad and includes people living on the streets or other places not intended for human habitation; living in shelters; lacking a fixed, regular, and adequate nighttime residence; temporarily staying with friends and relatives; and even those at risk for homelessness (Health Quality Ontario, 2016). Montgomery County's point-in-time count for homelessness has steadily declined over the past five years, with a 35% decrease between 2017 and 2021. The issue of homelessness affects individuals of all ages. For instance, out of the 187,380 students enrolled in school during the 2019-2020 school year, 1,499, or 0.8%.

LGBTQ COMMUNITY

Disparities in health outcomes are experienced across several population groups, including racial and ethnic minorities, geographical location, and health insurance status. However, there is an increasing need for more information on other groups that are medically underserved and suffer poor health outcomes. One such group is the lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) community, also referred to as sexual minorities. Sexual minorities represent between 3 to 12% of the adult U.S. population (Mattingly, Smith, Williams, & Tai, 2020). They span all races, ethnicities, ages, socioeconomic statuses, and regions of the United States.

There is insufficient data on sexual minorities in national databases and registries. However, sexual minorities appear to have a higher prevalence of smoking, alcohol use, and obesity. In addition, surveys show that many sexual minorities underutilize and delay seeking health care.

This underutilization is often related to concerns about discrimination and stigma. The common perception of a barrier to health care access demonstrates the need for culturally competent health care providers and welcoming health care systems. Indeed, health care providers need to focus on providing a safe environment for LGBTQ+-friendly services.

POPULATIONS WITH DISABILITIES

According to Healthy People 2030, until recently, people with disabilities had been overlooked in public health surveys, data analyses, and health reports, making it challenging to raise awareness about their health status and existing disparities. Emerging data indicate that individuals with disabilities, as a group, experience health disparities in routine public health areas such as health behaviors, clinical preventive services, and chronic conditions (Office of Disease Prevention and Health Promotion, 2021).

Compared with individuals without disabilities, individuals with disabilities are:

- Less likely to receive recommended preventive health care services, such as routine teeth cleanings and cancer screenings
- At high risk for poor health outcomes such as obesity, hypertension, falls-related injuries, and mood disorders such as depression
- More likely to engage in unhealthy behaviors that put their health at risk, such as cigarette smoking and inadequate physical activity (Office of Disease Prevention and Health Promotion, 2021)

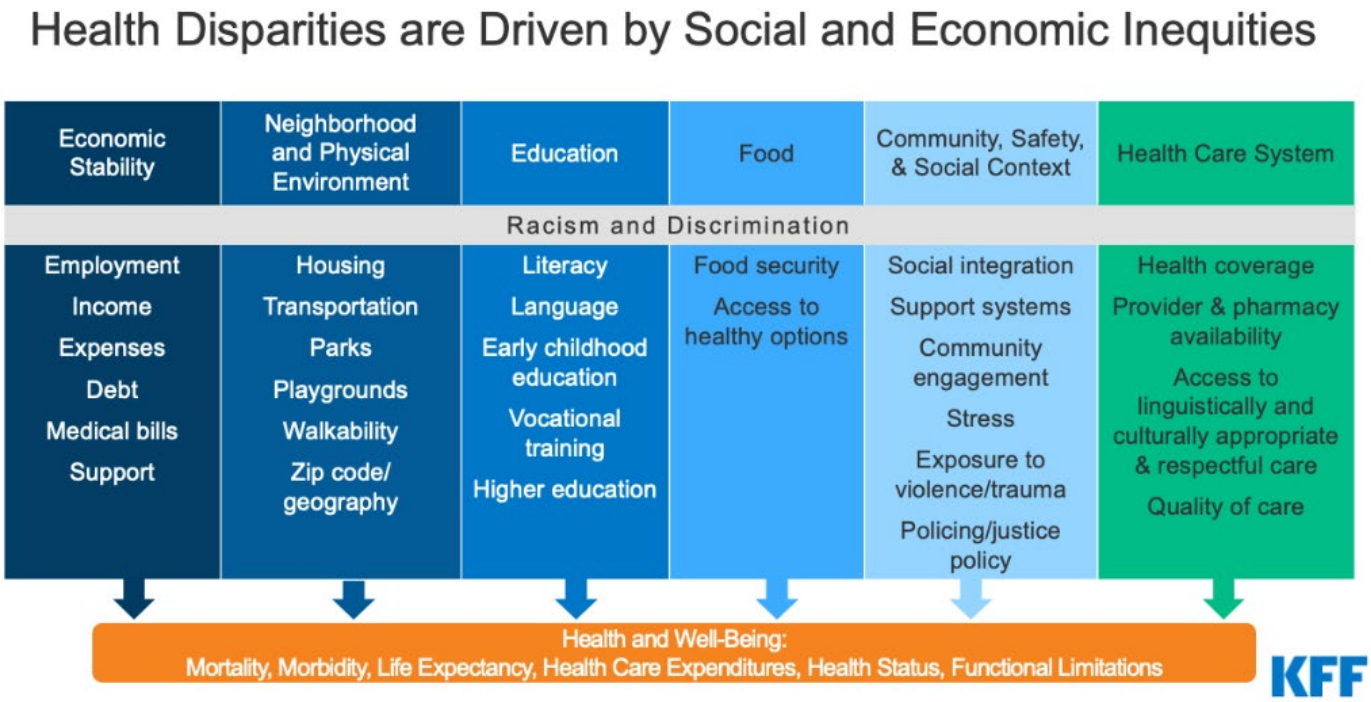
Within the CBSA, 8% (99,809) of the total civilian non–institutionalized population has one or more disabilities.

RACISM AS A PUBLIC HEALTH CRISIS

Racism is a key driver of disparities in mental and physical health outcomes. Systematic bias and structural racism cut across all social determinants of health (see Figure 5) and lead to inequities that have severe consequences (Stanley, Harris, Cormack, Waa, & Edwards, 2019). Racism and its effect on health is not a new concept. However, in the wake of protests and unrest following the killing of George Floyd[3] and many other Black people at the hands of police and the stark contrast of COVID-19 morbidity and mortality data based on race and ethnicity, a spotlight was shone on the negative impact of systemic and institutional racism on people of color, especially Black Americans (Kaur & Mitchell, 2020). In response, racism was declared a public health crisis by many states and local governments, and bills, such as Maryland's Shirley Nathan–Pulliam Health Equity Act of 2021 (SB0052), were passed to identify and address health inequities rooted in racism.

[3] The killing of George Floyd by a Minneapolis police officer on May 25, 2020, sparked days of unrest in Minneapolis and St. Paul and mass protests across the globe over the mistreatment of Black people by police. https://www.mprnews.org/crime-law-and-justice/killing-of-george-floyd

Figure 5: Health Disparities are Driven by Social and Economic Inequities



Source: Ndugga & Artiga, 2021.

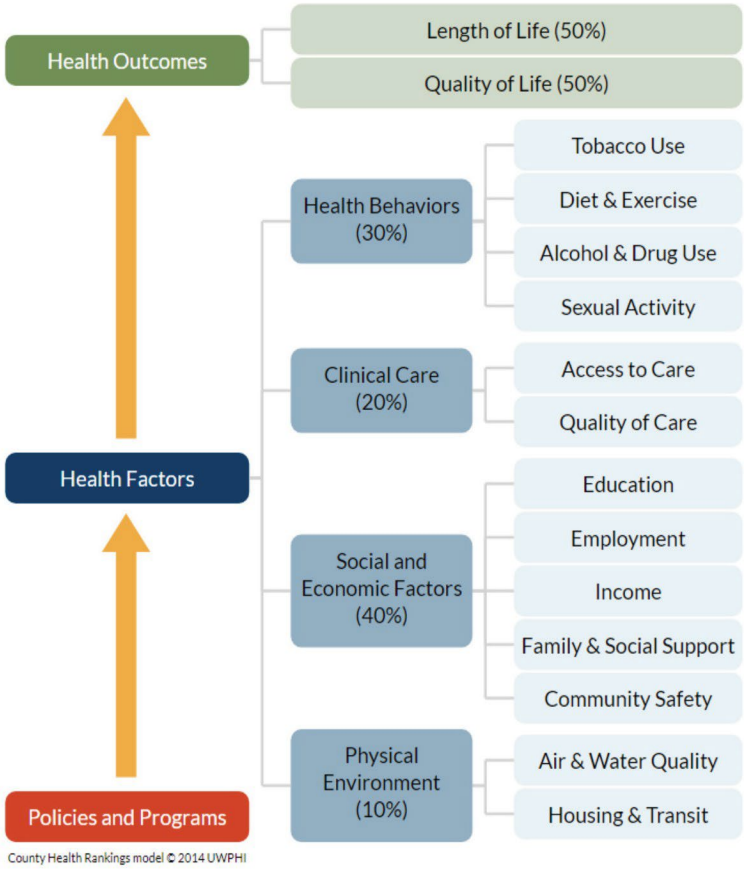
SECTION 2.

HEALTH OUTCOMES

Health outcomes measure how well and how long people live, and the foundation of these measures reflects both physical and mental well-being. Length of life measures the life expectancy of a population. High rates of premature death signal that individuals are not living as long and are not as healthy as other populations. On the other hand, quality of life tells us how satisfied people are with their health. Health outcomes represent a community's overall well-being and underscore the importance of physical, mental, social, and emotional health from birth to adulthood. Another way to look at the intersection of health outcomes and health factors is with the County Health Rankings model (see Figure 6), which aligns many factors that help stakeholders address what

drives health outcomes (University of Wisconsin Population Health Institute, 2022). When looking at the 2022 overall rankings for health outcomes for the 24 counties in Maryland, Montgomery County ranked #1 and Prince George's County ranked #12. When looking at the overall rankings for health factors, Montgomery County ranked #2 and Prince George's County ranked #17 (see Appendix G for a complete list of Maryland's County Health Rankings). In this assessment, the health factors were grouped into three categories (1) health behaviors, (2) clinical care, (3) and the socioeconomic and physical environment) and were used to create a health profile of health needs for the MCHC CBSA.

Figure 6: The County Health Rankings Model



Source: University of Wisconsin Population Health Institute, 2022.

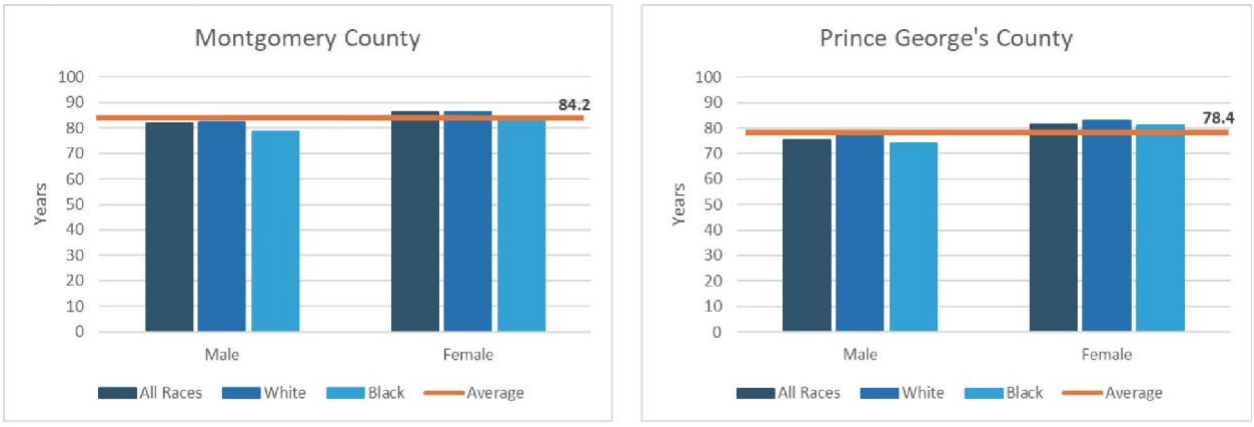
LENGTH OF LIFE

LIFE EXPECTANCY

The life expectancy at birth measures health status across all age groups and is a barometer for the overall health of a community (Tejada-Vera, Bastian, Arias, Escobedo, & Salant, 2020). In Maryland, life expectancy has remained relatively flat at 79.3 for all sexes and races since 2010. However, the life expectancy for an infant born in 2020 dropped to 77.3. In addition to the two-year decline in life expectancy, significant differences in life expectancy can be seen throughout the CBSA when comparing geographic areas (see Figure 7). A person's health is highly influenced by where they live. For instance, areas with higher SDOH needs have lower life expectancies (Holmes, Tootoo, Chosy, Bowie, & Starr, 2018). The life expectancy within the MCHC CBSA ranges from 74.7 to 96.1.

Differences in life expectancy can also be seen when comparing race and sex for both Montgomery and Prince George's County. For example, Montgomery County White males live 3.6 years longer than Black males residing in Montgomery County and 8.2 years longer than Black males residing in Prince George's County.

Figure 7: Life Expectancy by Sex and Race



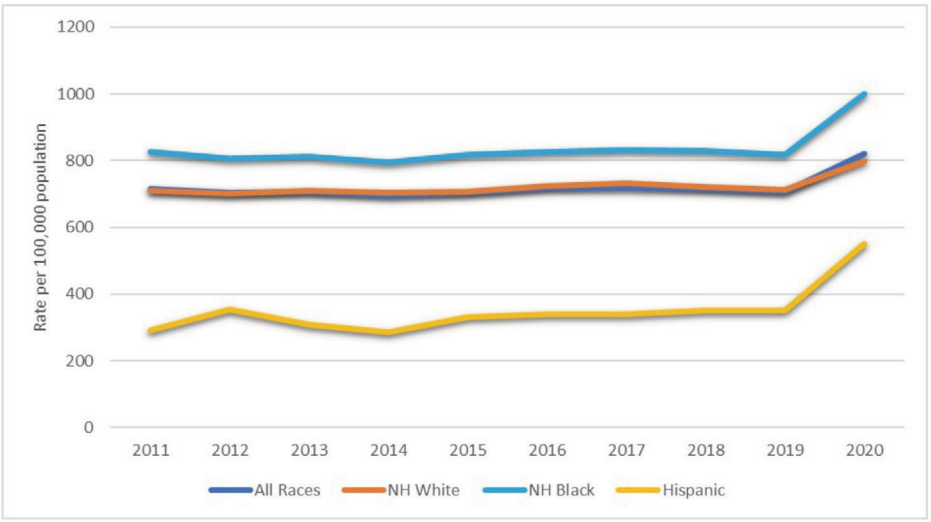
Source: Maryland Department of Vital Statistics, 2022.

MORTALITY

Mortality rate measures the frequency of death within a defined population for a specific time. It is important because it can show a particular disease's impact or indicate a country's health status, social conditions, and economic development (Kanchan, Kumar, & Unnikrishnan, 2016). For example, maternal and infant mortality rates in the United States not only tell us the total number of deaths for pregnant women and infants but also gives us a glimpse into the quality of life for these two populations (Kanchan, et al., 2016).

Age and death are strongly correlated; therefore, mortality rates are almost always adjusted for age or presented in age categories. In Maryland, the 2020 age-adjusted mortality rate was 820.5 per 100,000 population, an increase of 114.7 from the 2019 rate of 705.8. When stratifying death rates by race and ethnicity, disparities are evident (see Figure 8). For example, in 2020, for the state of Maryland, there was a 22.7% difference between the overall age-adjusted mortality rate for Non-Hispanic Blacks (1000.8) and the rate for Non-Hispanic Whites (796.8) and a 36.8% difference when the overall rate for Non-Hispanic Whites is compared to the overall rate for Hispanics (549.2) (Maryland Department of Health Vital Statistics Administration, 2022).

Figure 8: All Cause Age-Adjusted Death Rate by Race and Hispanic Origin, Maryland, 2011-2020



Source: Maryland Department of Vital Statistics, 2022.

MATERNAL MORTALITY

Maternal death is defined by the World Health Organization as, "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (Hoyert, 2021, pg. 1). It has been documented that the U.S. has the highest maternal mortality rate compared with other industrialized countries, with experts in maternal health blaming the high rate on poverty, untreated chronic conditions, and a lack of access to health care.

It is also discussed that disparities in maternal mortality are rooted in racism. Structural racism in health care and social service delivery means African American women often receive poorer quality care than White women. These stressors and the cumulative experience of racism and sexism, especially during sensitive developmental periods, trigger a chain of biological processes known as "weathering" that undermine African American women's physical and mental health. It is theorized that African American women enter pregnancies with high levels of cumulative stress that may cause their bodies to age faster than the bodies of their counterparts (Geronimus, et al., 2010).

The long-term psychological toll of racism puts African American women at higher risk for a range of medical conditions that threaten the lives of both the mother and the child. Some of these life-threatening conditions include preeclampsia (pregnancy-related high blood pressure), eclampsia (a complication of preeclampsia characterized by seizures), embolisms (blood vessel obstructions), and mental health conditions. It is also assumed that the strain placed on hospitals and health care providers during the COVID-19 pandemic may have heightened the barriers African American women already faced in accessing health care.

Despite pervasive racial disparities in maternal and infant deaths, public attention has only recently focused on this issue as a public health crisis (Taylor et al., 2019). And the full extent of the crisis is not yet known due to incomplete data. Compared with data on infant mortality, data on maternal mortality are less reliable. While the disparities in maternal mortality across race are clear within individual states, a reliable national estimate has not been possible because data across states have been inconsistent and incomplete.

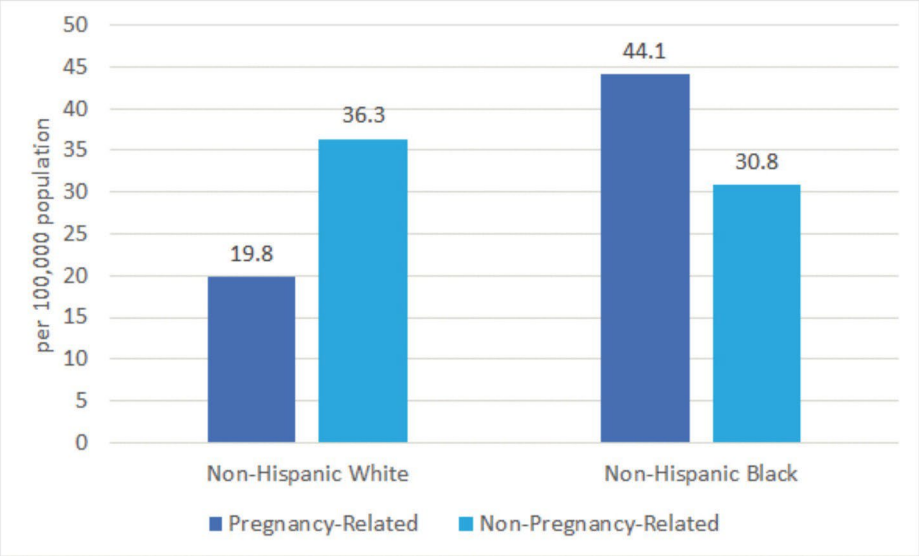
According to the report from the National Center for Health Statistics, during the first year of the coronavirus pandemic (2020), the total number of maternal deaths rose 14%, to 861 (754 in 2019) (Hoyert, 2022). The 2020 national maternal mortality rate was 23.8 deaths per 100,000 live births (an increase from 20.1 deaths per 100,000 in 2019). Maternal mortality significantly afflicts women of color. The mortality rate was highest for Non-Hispanic Black women: 55.3 deaths per 100,000 live births, compared to 19.1 deaths per 100,000 live births for Non-Hispanic White women, an almost 3 to 1 ratio. The mortality rate jumped 26% in 2020 for Black women. Hispanic women had a rate of 18.2 per 100,000 live births, which was below the overall U.S. rate, but a 44% spike from 2019. Maternal mortality rates also increased with maternal age. Rates in 2020 were

13.8 deaths per 100,000 live births for women under age 25, 22.8 for those aged 25–39, and 107.9 for those aged 40 and over. The rate for women aged 40 and over was 7.8 times higher than the rate for women under age 25.

The latest statewide data on maternal mortality based on 5-year population estimates is from 2014-2018, and the mortality rate was 18.4 per 100,000 live births (Maryland Department of Health, 2021). This rate is lower than the national average for the same timeframe (20.7 maternal deaths per 100,000 live births) but remains above the Healthy People 2030 target of 15.7 maternal deaths per 100,000 live births. In 2018, 18 pregnancy-related deaths and 20 non-pregnancy-related deaths occurred in Maryland. Ten or 56% of the 18 pregnancy-related deaths were in Non-Hispanic Black women. Among the 20 non-pregnancy-related deaths, 11 (55%) occurred among Non-Hispanic White women and 35% (7) among Non-Hispanic Black women. Of the 18 pregnancy-related deaths in Maryland, one was a resident of Montgomery County and two were Prince George's County residents (Maryland Department of Health, 2021).

When observing racial disparities in Maryland, Black women have the highest pregnancy-related maternal mortality rate (44.1) compared to any other racial or ethnic group, with hemorrhage deaths being the leading cause of death, followed by homicide and non-cardiovascular medical conditions (seizure disorders, asthma, cancer, etc.) (see Figure 9). White women have higher rates of non-pregnancy-related death, the leading cause being unintentional overdose. Most deaths in Maryland (85 percent of non-pregnancy-related deaths and 83 percent of pregnancy-related deaths) are considered preventable or potentially preventable (Maryland Department of Health, 2021).

Figure 9: Pregnancy-Related and Non-Pregnancy-Related Mortality Rates by Race/Ethnicity, Maryland, 2018



Source: Vital Statistics Administration and Maryland Maternal Mortality Review Program.

INFANT MORTALITY

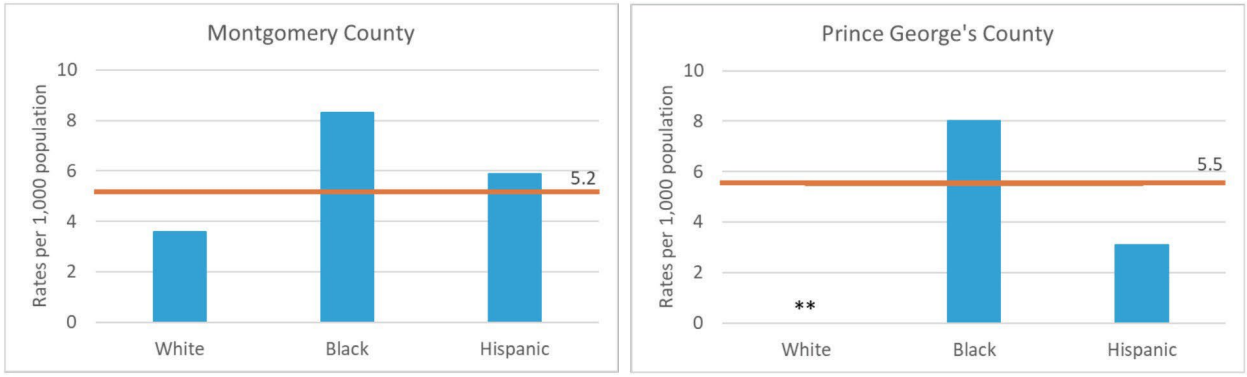
Infant mortality is defined as the death of an infant before one year of age and continues to be one of the most widely used indicators of the overall health status of a community. The main

causes of mortality in infants in the U.S. include birth defects, premature delivery (birth before 37 weeks of age), maternal complications of pregnancy, Sudden Infant Death Syndrome (SIDS), and injuries. Per the CDC, in 2019, the infant mortality rate in the United States was 5.6 deaths per 1,000 live births, which is higher than most other developed countries. Nationally, African Americans have the highest infant mortality rate of any racial or ethnic group in the United States.

Maryland's infant mortality rate in 2020 was 5.7 per 1,000 live births, a 3% decrease compared with the 2019 rate. This is the lowest infant mortality rate recorded in Maryland's history but is still higher than the national average. The infant mortality rate increased by 6% between 2019 and 2020 among Non-Hispanic Black infants and decreased by 10% among Hispanic infants during the same period. The average infant mortality rate has fallen by 6% in Maryland over the past decade, with a 7% decline in the average rate among Non-Hispanic Black infants and a 6% decline among Non-Hispanic White infants. Over the same time period, the Hispanic infant mortality rate has risen by 2% (Maryland Department of Health Vital Statistics Administration, 2022).

Montgomery County's infant mortality rate rose from 4.2 infant deaths per 1,000 births in 2019 to 5.2 infant deaths in 2020, which is higher than the Healthy People 2030 target of 5.0 per 1,000 live births. Prince George's County's infant mortality rate has decreased from 6.2 infant deaths in 2019 to 5.5 infant deaths in 2020; although still higher than the Healthy People 2030 target, the rate has experienced a steep decline from 8.0 infant deaths. Racial disparities exist in both counties, with Non-Hispanic Black infant mortality rates being significantly higher than women of other races and ethnicities (Maryland Department of Health Vital Statistics Administration, 2022) (see Figure 10).

Figure 10: Infant Mortality by Race/Ethnicity (2020)



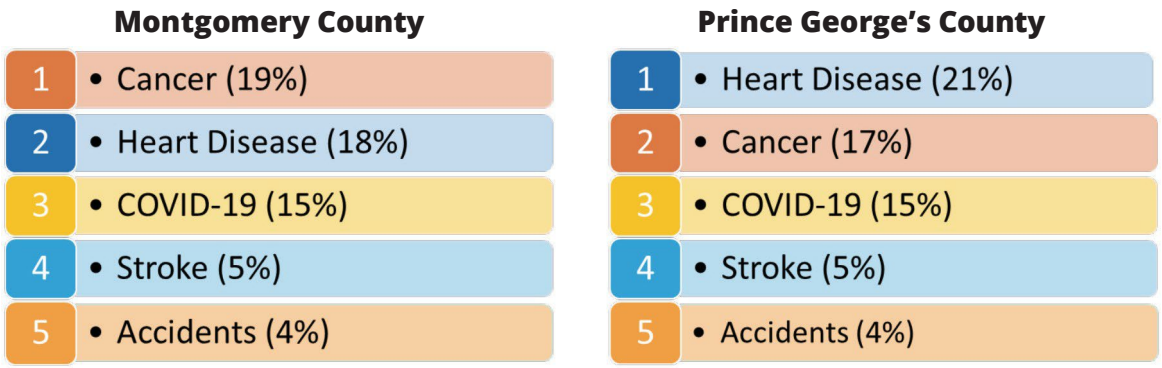
Source: Maryland Department of Health Vital Statistics Administration, 2022.
**Rates based on <5 deaths are not shown since rates based on small numbers are statistically unreliable

LEADING CAUSES OF DEATH

Nationally, COVID-19 was the third leading cause of death for most of 2020. However, in December of 2020 and the start of 2021, there was a surge of cases, briefly making COVID-19 the number one cause of death in the United States, surpassing cancer and heart disease. As of June 2021, COVID-19 was the 7th leading cause of death in the U.S (Ortaliza, Orgera, Amin, & Cox, 2021). In 2020, the most recent data available, COVID-19 was also the third leading cause of death among Marylanders.

In 2020, before the mass distribution of vaccines, COVID-19 ranked 3rd among the leading causes of death for Montgomery and Prince George's Counties and across all races. COVID-19 was the leading cause of death for Hispanics, accounting for 31% of all deaths in Montgomery County and 39% in Prince George's County (Maryland Department of Health Vital Statistics Administration, 2022) (see Figure 11).

Figure 11: Leading Causes of Death for 2020



Source: Maryland Department of Health Vital Statistics Administration, 2022.

LEADING CAUSES OF DEATH FOR CHILDREN AND YOUTH

According to Bendix (2022), car-related deaths are no longer the leading cause of death among children and youth. Nationally, for the first time, firearms were the leading cause of death among youth ages 1 to 19 in 2020, surpassing vehicle crashes, drug overdoses and cancer. More than 4,300 youth died of firearm-related injuries in 2020, an increase of 29% from 2019, with the majority associated with homicides rather than suicides and attributed to youth 14 and older.

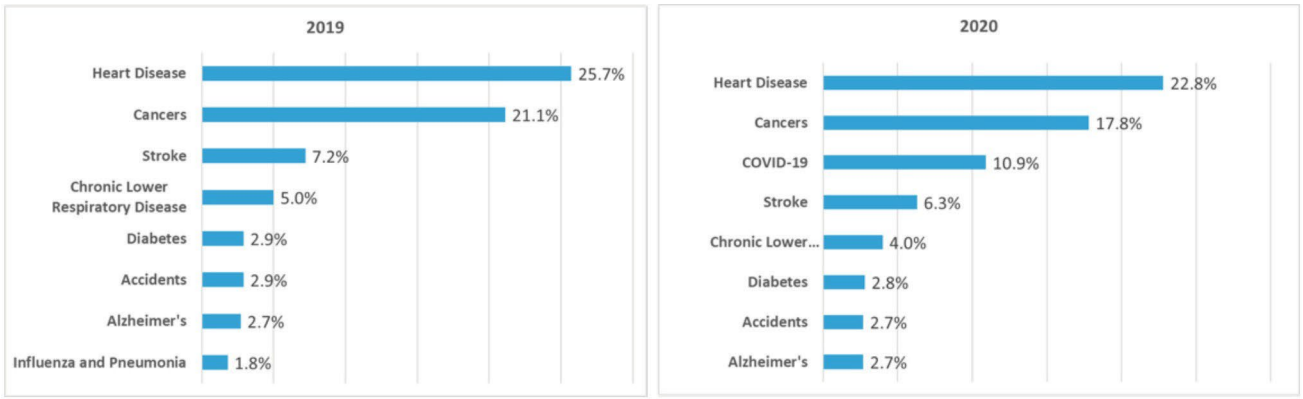
A study published by the Annals of Internal Medicine found gun ownership increased during the COVID-19 pandemic, resulting in 5 million youth under 18 becoming newly exposed to guns in the household (Miller et al., 2022). A similar study by the American Academy of Pediatrics examined the correlation between the rise of firearm acquisitions during the pandemic and high rates of youth fatal and non-fatal gun injuries (Cohen et al., 2021). It was suggested that youth confined to homes due to school closings, decreased adult supervision, and natural curiosity may have also attributed to this emerging trend. In Maryland, firearm deaths among youth rose from 59 deaths in 2019 to 73 deaths in 2020, a 24% increase (CDC, 2021).

LEADING CAUSE OF DEATH FOR 65+

A study conducted in 2007 by the World Health Organization, the World Bank, and the U.S. National Institute on Aging predicted that in a few decades, the loss of health and life worldwide would be greater from non-communicable or chronic diseases (e.g., cardiovascular disease, cancer, diabetes) than from infectious diseases, childhood diseases, and accidents combined (National Institute on Aging, 2007). This prediction was made based on a few factors: declining fertility rates and increasing life expectancy. Older persons are more likely to die from non-communicable diseases than communicable diseases, such as influenza and pneumonia; therefore, as the average age of the population shifts, mortality rates from non-communicable diseases will also increase.

Almost two decades later, the prediction seemed to still be accurate, with heart disease, cancer, and stroke being the top three leading causes of death for more than the past ten years. However, in 2020 the COVID-19 pandemic altered the prediction made in the study. A communicable disease, COVID-19, was the third leading cause of death for persons 65+ (see Figure 12).

Figure 12: Leading Cause of Death (65+) in Maryland 2019 vs. 2020



Source: Maryland Department of Health Vital Statistics Administration, 2022.

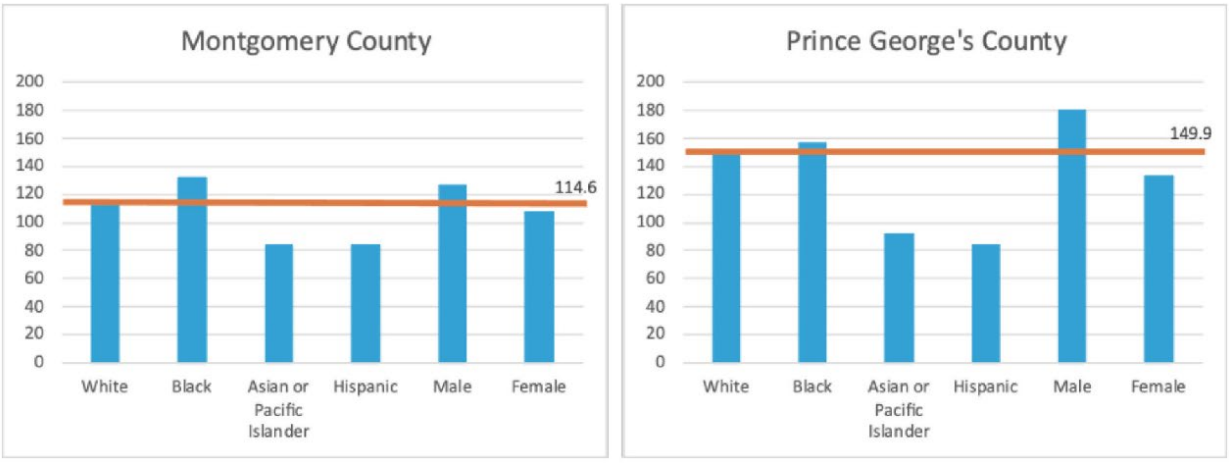
CHRONIC CONDITIONS

CANCER

Every year, more than 1.6 million people are diagnosed with cancer. Cancer is the second leading cause of death in the U.S., with approximately 600,000 associated deaths. In addition to human loss, cancer is also a burden on the nation's health care system. U.S. cancer care costs were projected to reach $208.9 billion by 2020, and lost productivity due to early death from cancer were projected to add an additional $147.6 billion (National Cancer Institute, 2022; Bradley, et al., 2008).

The age-adjusted death rates in Montgomery and Prince George's Counties are 114.6 and 149.9, respectively. Overall, African Americans/Blacks have the highest rates of cancer deaths with Hispanics having the lowest rates (see Figure 13).

Figure 13: Age-Adjusted Death Rate per 100,000 Due to Cancer by Sex, Race/Ethnicity (2019)



Source: National Cancer Institute, 2020.

The National Cancer Institute (2021) identifies 13 types of cancers as the most common cancers in the United States. This identification was based on incidence rates of 40,000 cases or more for 2021. Among these cancer types, breast cancer, with 284,200 expected cases in 2021, was labeled the most common, followed by prostate and lung cancer (National Cancer Institute, 2021). Other types of cancer in the most common list include colorectal, kidney, skin, pancreatic, and thyroid cancer. Cancer risk factors include, but are not limited to, age, alcohol use, tobacco use, a poor diet, certain hormones, and sun exposure. Although some risk factors, such as age, cannot be avoided, limiting exposure to avoidable risk factors may lower the risk of developing certain cancers.

Cancer screenings and early detection are a crucial part of cancer prevention. Unfortunately, research shows that the overall cancer screening rate is lower among Black, Hispanic, Asian, and American Indian or Alaskan Native populations than their White counterparts. In addition, data suggest that the COVID-19 pandemic contributed to decreases or delays in cancer screening, which may have exacerbated racial/ethnic disparities in cancer screening (Tong et al., 2022).

It is important to note that disparities are not limited to racial differences. The LGBTQ community, have a higher prevalence of cancer risk factors (smoking, alcohol use, etc.) that may lead to increased cancer rates in this population. However, due to data gaps, the specific rates for this population are unknown (Mattingly et al., n.d.). Populations with disabilities also experience disparities in cancer outcomes and accessing preventive and therapeutic care. Barriers to accessing care include transportation and perception of prejudice on the part of the provider. Immigrants are also at an increased risk due to risk factors experienced in their countries of origin and language and cultural barriers. Additionally, health issues and potentially carcinogenic exposures (including sun and pesticide exposure) in the migrant worker population in Maryland are an emerging public health concern.

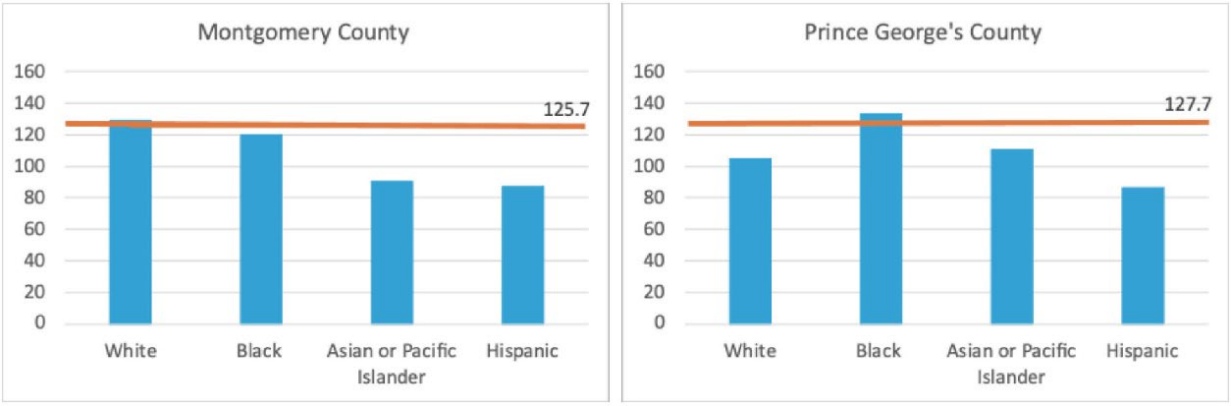
The COVID-19 pandemic's impact on cancer screenings and care could potentially impact survivorship rates for years to come, especially in populations with increased risk factors, such as people of color (Patt et al., 2020; Fernandez, 2022). During the pandemic, cancer patients experienced delays and cancellations of appointments and challenges in paying for current or future care. From March 2020 to May 2020, approximately 10 million people missed cancer screenings, and the overall rate of surgical procedures decreased by 48% compared to 2019 (Fernandez, 2022).

BREAST CANCER

Breast cancer is a disease caused by the uncontrolled growth of cells, leading to tumor formation. The most serious condition is caused by the spread of cancerous cells to other parts of the body, leading to metastatic breast cancer. Within the United States, about 12% (1 in 8) of women develop breast cancer during their lifetime. Breast cancer is also the second most common cancer among women in the United States, only second to skin cancer (National Institute of Environmental Health, 2021).

The age-adjusted incidence rate for breast cancer in Maryland is 132.2, and both Montgomery County's (125.7) and Prince George's County's (127.7) rates are lower than the state (see Figure 14).

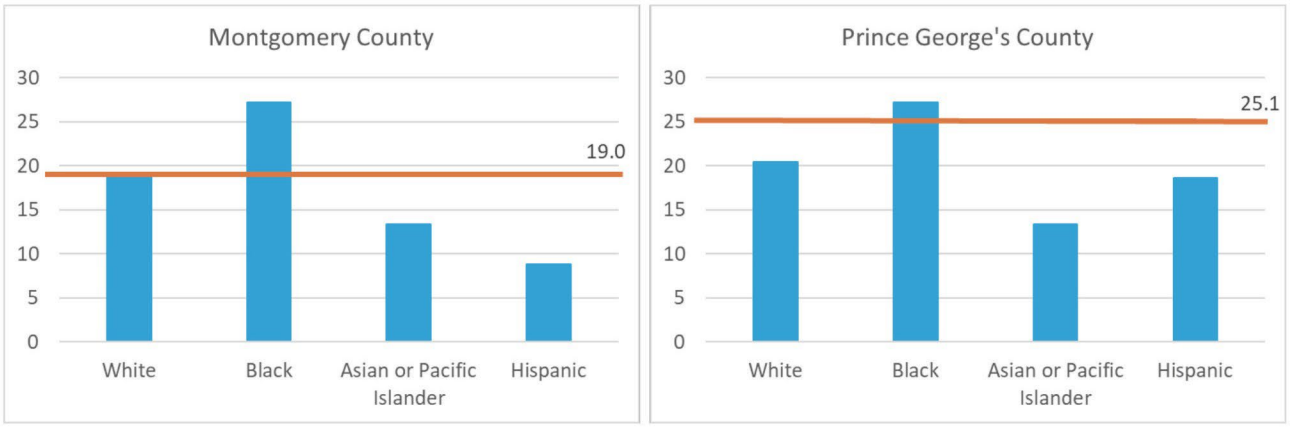
Figure 14: Age-Adjusted Incidence Rate per 100,000 Due to Breast Cancer by Race/Ethnicity (2014-2018)



Source: National Cancer Institute, 2020.

From 2015-2019, the age-adjusted death rate due to breast cancer was 21.0 in Maryland, compared to 19.0 in Montgomery County and 25.1 in Prince George's County (see Figure 15). Disparities can be seen, with the death rate for African American/Black women higher than all other races/ethnicities. In 2019, the breast cancer mortality rate was 2.7 times higher among Black female residents and 1.9 times higher among White female residents compared to Asian and Pacific Islander female residents. Data also show that although White women in Montgomery County have a higher incidence rate when compared to African American/Black women, Black women are more likely to die from the diagnosis.

Figure 15: Age-Adjusted Death Rate per 100,000 Due to Breast Cancer by Race/Ethnicity (2015-2019)



Source: National Cancer Institute, 2020.

MAMMOGRAPHY SCREENING

Regardless of ethnicity or geographic location, mammograms are important in breast cancer early detection. Mammograms are an X-ray of the breast that can be used to detect changes in the breast, such as tumors and calcifications. The procedure may be done for screening or for diagnostic purposes. A positive screening mammogram leads to further testing to determine if cancer is present. Mammograms may also be used to evaluate known cases of breast cancer.

Although mammograms do not detect all cases of breast cancer, they have been shown to increase early detection, thus reducing mortality.

The United States Preventive Services Task Force (USPSTF) recommends that women 50-74 years old and at average risk for breast cancer get a mammogram every two years. In addition, insurance plans governed by the federal ACA must cover screening mammography as a preventive benefit every 1–2 years for women age 40 and over without requiring copayments, coinsurance, or deductibles. In addition, many states require that Medicaid and public employee health plans cover screening mammography.

Healthy People 2030 national health target is to increase the proportion of females 50-74 years old who had a mammogram in the previous two years from 72.8% (2018) to 77.1%. In 2018, the most recent data available, the mammogram screening rates for both Montgomery County (77.1%) and Prince George's County (80.3%) were on a trajectory to exceed the Healthy People 2030 target (National Center for Chronic Disease Prevention and Health Promotion, 2021).

CERVICAL CANCER

Cervical cancer, when detected early, is one of the most successfully treated cancers and is found most commonly in women over the age of 30. The leading cause of cervical cancer is a long-lasting infection of certain types of human papillomavirus (HPV), a sexually transmitted infection. According to the National Cancer Institute (2022), data from 2017 to 2019 show that approximately 0.7% of women will be diagnosed with cervical cancer at some point during their lifetime. Data also show that in 2018, an estimated 295,381 women were living with cervical cancer in the United States (National Cancer Institute, 2022)

For the period 2014-2018, the age-adjusted incidence rate for the state of Maryland was 6.7 cases per 100,000, lower than the national average of 7.7. Montgomery County and Prince George's County incidence rates were 5.7 and 6.5, respectively (see Figure 16). The mortality rate was highest for Prince George's County at 2.6 per 100,000, compared to 1.3 for Montgomery County and 2.0 for the state of Maryland. The national average for the same period was 2.2 per 100,000.

Figure 16: Age-Adjusted Incidence Rate per 100,000 Due to Cervical Cancer by Race/Ethnicity (2014-2018)

Source: National Cancer Institute, 2019.
*Rates <5 events in the numerator are supressed.

The American College of Obstetricians and Gynecologists recommends that all women aged 21-29 have a Pap test every three years, while women aged 30-65 should have a Pap test and an HPV test every five years or a Pap test alone every three years. The Healthy People 2030 national health target is to increase the proportion of women (aged 21-65) who receive a cervical cancer screening to 84.3% (both Montgomery and Prince George's Counties exceed the target at 86.3% and 87.2%, respectively).

COLORECTAL

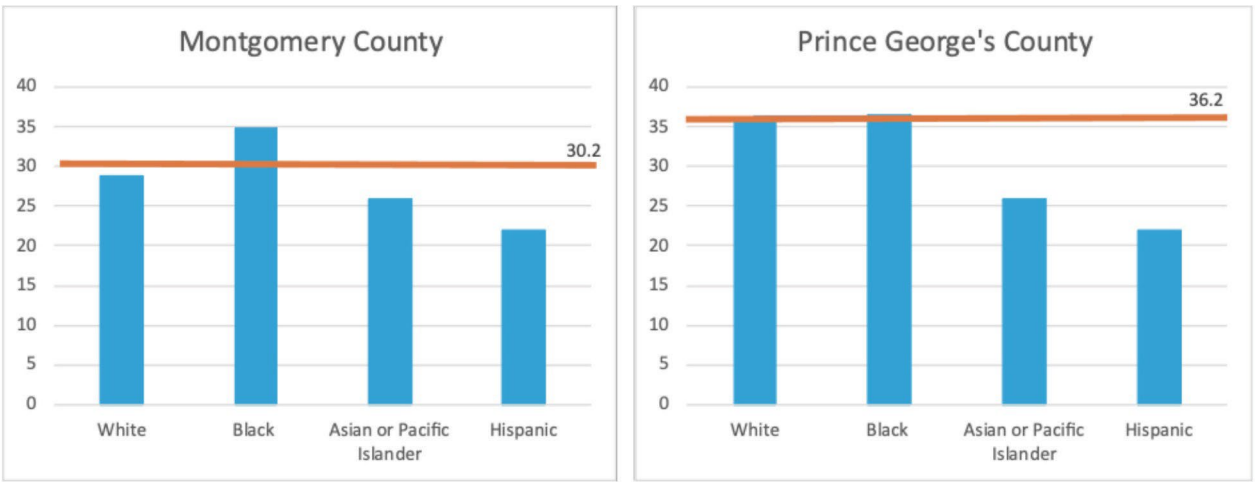
According to the CDC, colorectal cancer is one of the most diagnosed cancers. It is the third most common cancer in men and women and is also the third leading cause of cancer-related deaths in the United States. Colorectal cancer is a type of cancer that originates in the colon or rectum. It usually starts as a growth, also known as a polyp, inside the colon or rectum. Since this growth is an early indication, detecting and removing these polyps is a powerful prevention tool for colorectal cancer (National Cancer Institute, 2021). The CDC estimates that if all adults aged 50 or older had regular screening tests for colon cancer, as many as 60% of the deaths from colorectal cancer could be prevented. The risks and benefits of using different screening methods, such as stool-based tests, sigmoidoscopies, and colonoscopies, vary.

The USPSTF recommends that screening begin at age 50 and continue until age 75; however, testing may need to begin earlier or be more frequent if colorectal cancer runs in the family or if there is a previous diagnosis of inflammatory bowel disease. The Healthy People 2030 national health target is to increase the proportion of adults screened for colorectal cancer from 65.2% (2018) to 74.4%. In Montgomery and Prince George's Counties, the screening rate for adults 50+ years for colorectal cancer is 68.6% and 68.9%, respectively (CDC, 2018).

While colon cancer is mostly found in Americans over age 50, there is an increase in younger adults being diagnosed. Most recently, actor Chadwick Boseman died of the disease at age 43 after a four-year battle with colon cancer. Based on data from 2016-2018, approximately 4.1% of men and women will become diagnosed with colorectal cancer at some point in their lifetime (American Cancer Society, 2022). In 2018, an estimated 1,365,135 Americans were living with colorectal cancer.

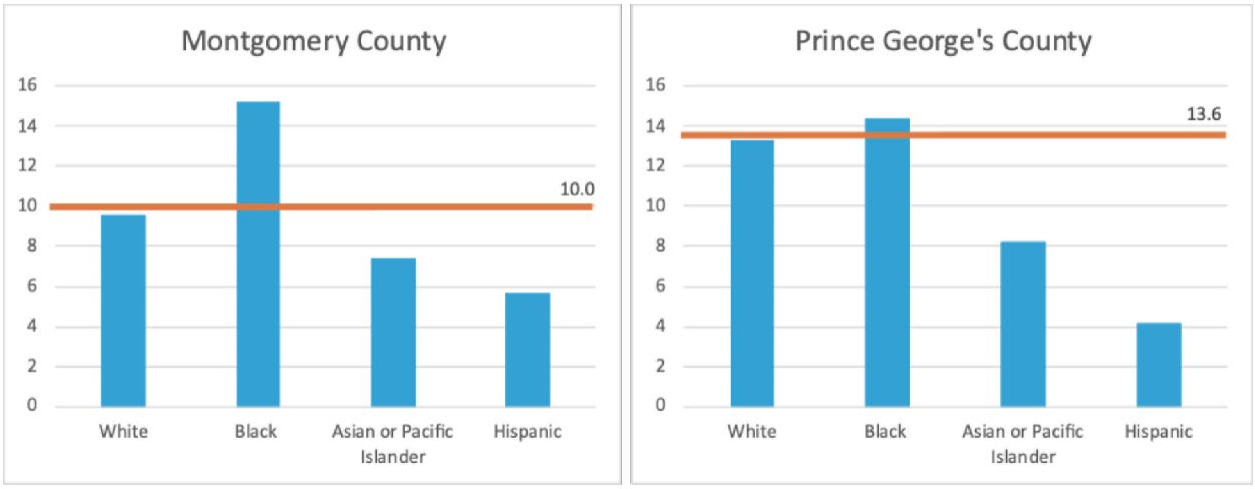
For the period 2014-2018, the age-adjusted incidence rate for colorectal cancer in the United States was 38.0 cases per 100,000. The incidence rate for the state of Maryland was 36.4, while Montgomery and Prince George's Counties had incidence rates of 30.2 and 36.2, respectively. Both incidence and death rates of colorectal cancer are slightly higher among African Americans compared to rates for Whites, Asians, and Hispanics (see Figure 17 and Figure 18).

Figure 17: Age-Adjusted Incidence Rate per 100,000 Due to Colorectal Cancer by Race/Ethnicity (2015-2018)



Source: National Cancer Institute, 2019.

Figure 18: Age-Adjusted Death Rate per 100,000 Due to Colorectal Cancer by Race/Ethnicity (2014-2018)



Source: National Cancer Institute, 2020.

LUNG

Lung cancer is caused by the uncontrolled growth of cells within the lungs leading to the creation of tumors in the lungs, mainly occurring in people over the age of 65. According to the CDC, lung cancer is the leading cause of death due to cancer in both men and women in the United States, making up almost 25% of all cancer deaths. Each year, more people die of lung cancer than colon, breast, and prostate cancers combined. Even though the duration and quantity of cigarette smoking are the leading cause of lung cancer, this cancer can also be caused by other substances such as asbestos and other forms of tobacco. Recently, lung cancer rates in the United States have been steadily decreasing due to the overall decrease in cigarette use and advancements in early lung cancer detection and treatments.

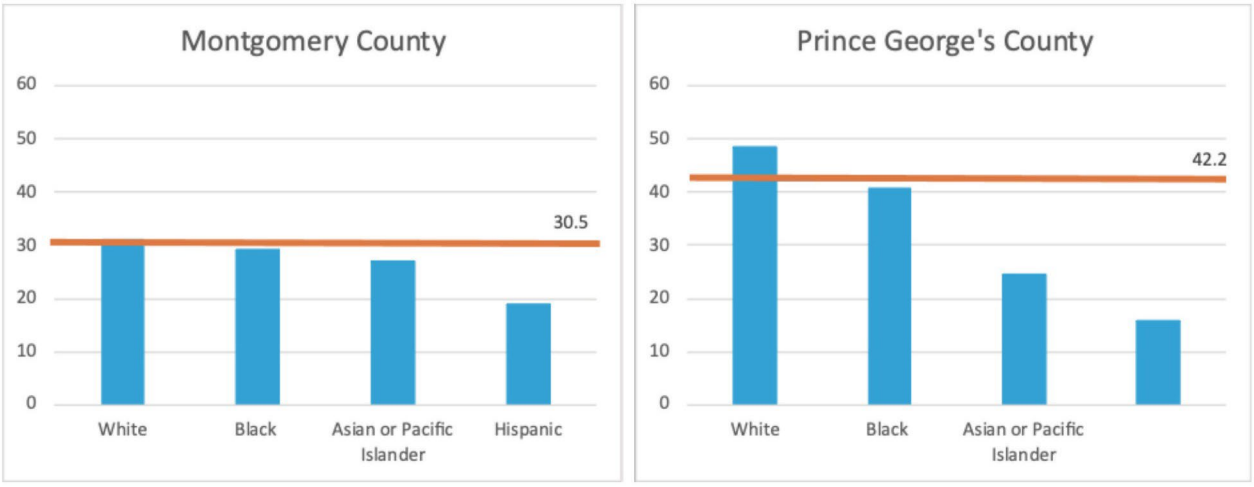
The American Cancer Society notes that nationally, the chance that a man will develop lung cancer in his lifetime is about 1 in 15; for a woman, the risk is about 1 in 17 (among both smokers and non-smokers). Black men are about 12% more likely to develop lung cancer than White men. The

rate is about 16% lower in Black women than in White women. Black and White women have lower rates than men, but the gap is closing. The lung cancer rate has been dropping over the past few decades for men and the last decade for women.

Nationally, since it was first recommended, screening rates have increased yearly. However, the national rate did not change from 2019 to 2020, likely due to COVID-19 limiting access to health care resources and the public's reticence to enter medical facilities during the pandemic. In addition, those diagnosed with lung cancer experienced additional challenges, as frequent visits to hospitals during the COVID-19 epidemic and receiving anticancer treatments with immunosuppressive properties might considerably increase the risk of infection.

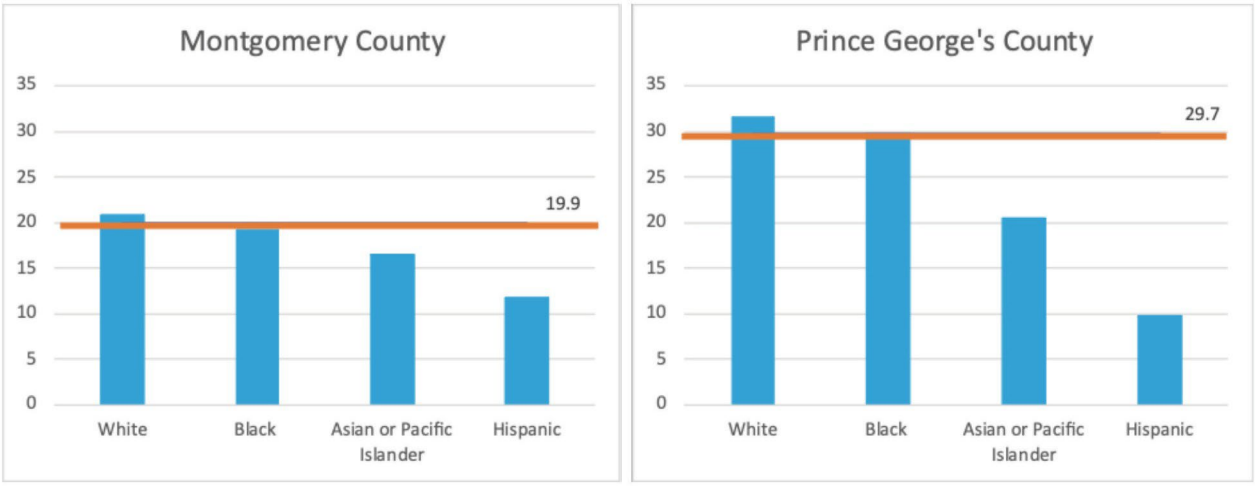
From 2014-2018, the age-adjusted lung cancer incidence rate in Montgomery County was 30.5, and 42.2 in Prince George's County (see Figure 19). Both counties fared better than the state of Maryland and the national average with rates of 55.1 and 57.3, respectively. This data is also similar to the age-adjusted mortality rates for lung cancer. Rates in Montgomery County (19.9) and Prince George's County (29.7) fare better than the state (35.3) and national (36.7) rates (see Figure 20).

Figure 19: Age-Adjusted Incidence Rate per 100,000 Due to Lung Cancer by Race/Ethnicity (2014-2018)



Source: National Cancer Institute, 2019.

Figure 20: Age-Adjusted Death Rate per 100,000 Due to Lung Cancer by Race/Ethnicity (2015-2019)



Source: National Cancer Institute, 2020.

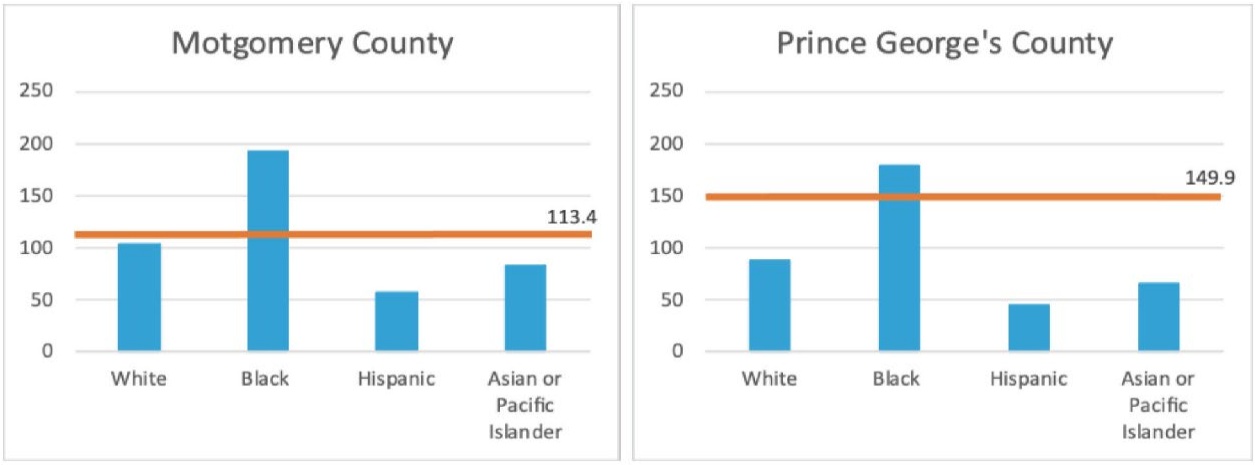
PROSTATE

Even though the exact cause of prostate cancer is unknown, the condition starts with unregulated changes in the DNA of cells leading to uncontrolled cell division and growth. The accumulation of these abnormal cells leads to the creation of tumors (Mayo Clinic Staff, 2021). Prostate cancer is the most prevalent cancer type and the second leading cause of cancer deaths among men in the United States (American Cancer Society, 2022). According to the American Cancer Society, about 1 in 7 men will be diagnosed with prostate cancer, and about 1 in 36 will die.

The age-adjusted incidence rate for the state of Maryland (2014-2018) was 128.1 cases per 100,000 men, which was higher than the national average of 106.2. Montgomery County had an incidence rate of 113.4, and Prince George's County had an incidence rate of 149.9. The incidence rate for Black or African American men is nearly 50% higher than for White men in Montgomery and Prince George's Counties (see Figure 21).

The age-adjusted prostate cancer mortality rate for the state of Maryland (2015-2019) is 20.3, Montgomery County has a rate of 14.8, and Prince George's County has a rate of 26.6. The national average is 18.9. The death rate of Black or African American men in both counties is more than 50% higher than their White counterparts (see Figure 22).

Figure 21: Age-Adjusted Incidence Rate per 100,000 Due to Prostate Cancer by Race/Ethnicity (2014-2018)



Source: National Cancer Institute, 2019.

Figure 22: Age-Adjusted Death Rate per 100,000 Due to Prostate Cancer by Race/Ethnicity (2015-2019)

Source: National Cancer Institute, 2020.
*Rates <5 events in the numerator are supressed.

SKIN

Skin cancer is the most common type of cancer in the United States. The three most common types of skin cancer are squamous cell carcinoma, basal cell carcinoma, and melanoma. Although melanoma is the least common type, it is the cause of most deaths from skin cancer (American Cancer Society, 2022). The most preventable cause of skin cancer is overexposure to ultraviolet (UV) light, either from the sun or from artificial sources like tanning beds. According to the National Cancer Institute (2022), data from 2016-2018 show that approximately 2.3 % of men and women will be diagnosed with skin cancer during their lifetime. Anyone can get skin cancer, but people with certain characteristics are at greater risk. A lighter natural skin color, skin that burns, freckles, reddens easily, or becomes painful in the sun, blue or green eyes, blond or red hair, certain types and a large number of moles, a family history of skin cancer, a personal history of skin cancer, and older age are risk factors for skin cancer.

In Maryland, the age-adjusted incidence rate for skin cancer from 2014-2018 was 24.1 cases per 100,000. The incidence rate in Montgomery County is 19.0 and 5.9 in Prince George's County. The age-adjusted death rate in 2015-2019 is 1.8 in the State, 1.4 in Montgomery County, and 0.8 in Prince George's County.

DIABETES

Diabetes is a metabolic condition that affects how the body regulates glucose levels in the blood, with three main types (Type 1, Type 2, and Gestational). Most diabetes cases in the U.S. are Type 2 Diabetes (T2D), making it the most common form of diabetes. According to the 2020 National Diabetes Statistics Report, more than 34.1 million adult Americans (about 13% of the U.S. population) have diabetes. While T2D most often develops in people over age 45, the prevalence has become more frequent in children, teens, and young adults (CDC, 2020). Additionally, 7.3 million adults aged 18 years or older are unaware they have diabetes (undiagnosed diabetes), representing 2.8% of all U.S. adults and 21.4% of all U.S. adults with diabetes. Diabetes can be a life-threatening disease that requires life-long management and is the 8th leading cause of death in the U.S. However, T2D can be prevented through healthy lifestyle choices, including proper diet and exercise (Centers for Disease Control and Prevention, 2020).

The rate of newly diagnosed diabetes (around 1.5 million newly diagnosed cases each year) has remained relatively flat from 2000 (6.2 cases per 1,000) to 2018 (6.7 per 1,000), and the rates decreased significantly between 2008 (8.4) to 2018 (6.7) (Centers for Disease Control and Prevention, 2020). Diabetes can have harmful effects on organ systems in the human body; it is a frequent cause of end-stage renal (kidney) disease, non-traumatic lower-extremity amputation, and a leading cause of blindness among working-age adults. In addition, persons with diabetes are at increased risk for ischemic heart disease, neuropathy, and stroke.

According to an article in Diabetes Care (2018), the economic costs of diabetes, after adjusting for inflation, increased 26% between 2012 and 2017. Caring for people diagnosed with diabetes accounts for 25% of health care dollars spent ($16,750 per person per year), with every $1 in $7

going to direct medical expenses (see Figure 23), with more than half directly attributed to diabetes. The estimated cost of diabetes in 2017 was $327 billion, with indirect costs, such as absenteeism, lost productivity, and premature death, estimated at $110.6 billion (Petersen, 2018).

Figure 23: The Staggering Cost of Diabetes

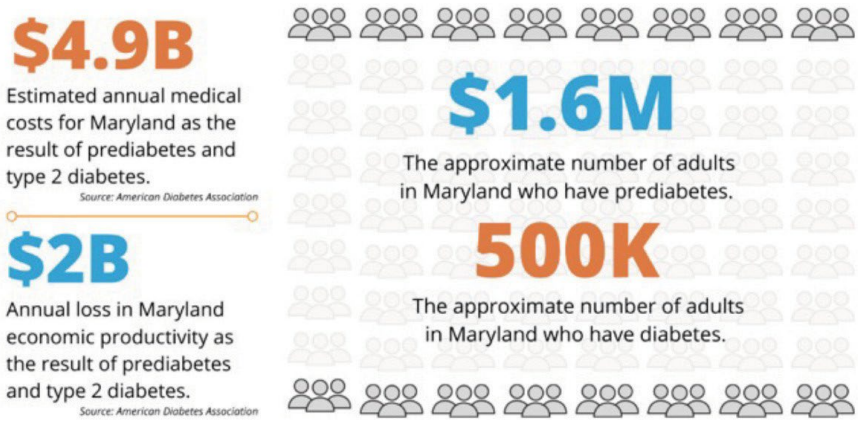
Source: American Diabetes Association, 2020.

Diabetes disproportionately affects minority populations and the elderly. Its incidence is likely to increase as minority populations grow and the U.S. population ages. Diabetes is the sixth leading cause of death in both Montgomery and Prince George's County (Maryland Department of Health Vital Statistics Administration, 2022).

The COVID-19 pandemic has had a significant impact on diabetes patients. A systemic review and meta-analysis by Mahamat-Saleh et al. (2021) found that diabetes increased the absolute risk of death from COVID-19 by 14%. In addition, another study found that decreased routine diabetes care due to the pandemic increased diabetes mortality rates by 11% (Valabhji, et al., 2022).

In Maryland, 10.5% of adults have diabetes (nearly 500,000), and 34% have prediabetes (approximately 1.6 million), resulting in an estimated annual spending of $4.9 billion (Maryland Department of Health, 2019) (see Figure 24).

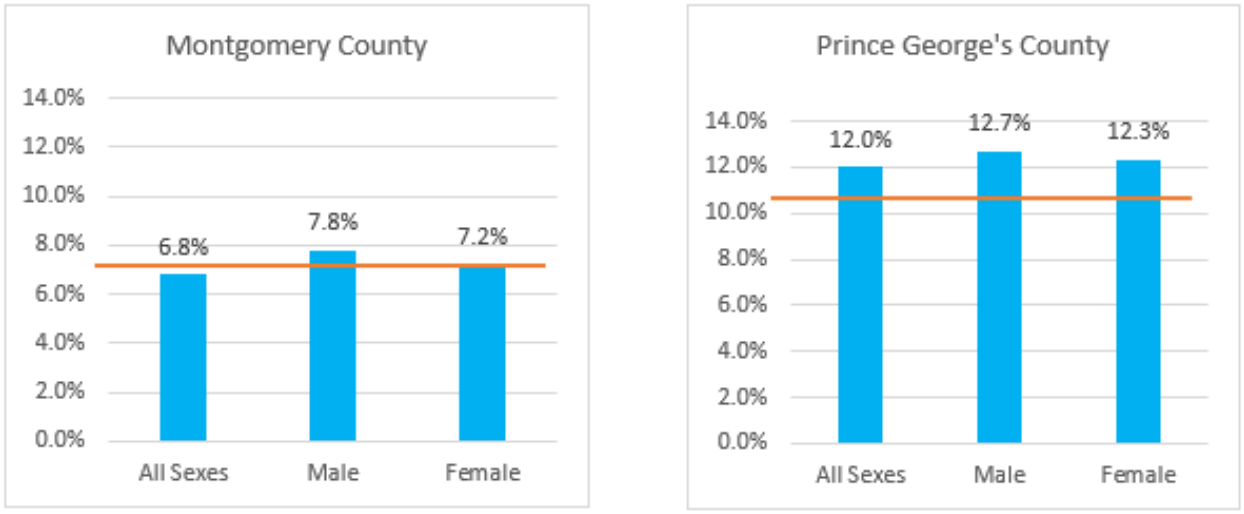
Figure 24: Diabetes Costs in Maryland



Source: Maryland Department of Health, 2019.

Within the MCHC CBSA, the crude rate of adults 18 and over ever diagnosed with diabetes was 9.0% (BRFSS, 2019). Seven percent of adults aged 20 years and older have been told that they have diabetes in Montgomery County, below both state and national levels. In Prince George's County, 12.3% of adult residents have diabetes, higher than state and national levels (BRFSS, 2019; CDC, 2019) (see Figure 25). In both Montgomery and Prince George's Counties, adult males and residents over age 65 have a higher percentage of diabetes diagnoses, and African American/Black residents are more likely to die from diabetes than White residents. Mortality rates are also higher in residents aged 65 and older and in men compared to women in both counties.

Figure 25: Percent of Adults Age 20+ Who Have Been Diagnosed with Diabetes by Sex (2019)



Source: Sparkmap, 2019.

PREDIABETES

Prediabetes is a condition in which blood glucose levels are higher than normal but not high enough for a diagnosis of diabetes. Prediabetes puts individuals at increased risk of developing type 2 diabetes, heart disease, and stroke (Centers for Disease Control and Prevention, 2021). Healthy lifestyle choices can help prevent prediabetes and its progression to type 2 diabetes. More than eighty-eight million American adults 18 years or older have prediabetes, and of those with prediabetes, nearly 85% do not even know they have it. In Maryland, 1.6 million, or 34% of the population, have prediabetes (Maryland Department of Health, 2019).

CHILDHOOD DIABETES

Diabetes prevalence is also increasing among children and youth. Approximately 210,000 children and adolescents in the U.S. younger than 20 years have been diagnosed with diabetes (including 187,000 with type 1) (CDC, 2020). The increasing frequency of type 1 and type 2 diabetes in young people is a growing clinical and public health concern. For ages 10 to 19 years, the incidence of type 2 diabetes remained stable among Non-Hispanic Whites and increased for all others, especially Non-Hispanic Blacks. Prediabetes among youth is also a rising threat – affecting 1 in 5 U.S. youths ages 12-18, with this group also having higher cholesterol and blood pressure concerns (Andes et al., 2020). Prediabetes and diabetes among youth are primarily attributed to the increasing prevalence of obesity, sedentary lifestyles, and unhealthy nutrition.

DIABETES IN THE SENIOR POPULATION

Diabetes is also prevalent in the senior population. The number of older adults with diabetes is increasing in the United States and worldwide due to increased lifespan and the increased prevalence of diabetes in the geriatric population (Milanesi & Weinreb, 2020). According to the National Diabetes Statistics Report, the prevalence of diabetes in the U.S. senior population is

nearly 26.8% for those aged 65 or higher (CDC, 2020). Diabetes is a major cause of morbidity and mortality in this population, with the latter largely attributable to macrovascular complications.

The American Geriatrics Society (AGS) guidelines for the management of diabetes in the elderly identify conditions that elderly patients with diabetes are at increased risk of having. Conditions include polypharmacy (the simultaneous use of multiple drugs to treat a single ailment or condition), depression, cognitive impairment, urinary incontinence, injurious falls, vision impairment, and pain.

CARDIOVASCULAR DISEASE

Cardiovascular disease is responsible for two of the five leading causes of death in Montgomery and Prince George's Counties. Heart disease is the leading cause of death in Prince George's County and the second leading cause in Montgomery County and stroke is the fourth leading cause of death in both counties. Together, heart disease, stroke, and other cardiovascular diseases are among the most widespread and costly health problems facing the nation today, accounting for approximately $320 billion in health care expenditures and related expenses annually (Mozaffarian, et al., 2016). Fortunately, they are also among the most preventable. The leading controllable risk factors for heart disease and stroke are high blood pressure, high cholesterol, cigarette smoking, diabetes, unhealthy diet and physical inactivity, overweight, and obesity. Maryland's age-adjusted death rate for heart disease was 168.3 deaths per 100,000 in 2020. For that same year, the death rate in Montgomery County was 97.9 deaths per 100,000 population and 139.8 per 100,000 in Prince George's County (Maryland Department of Health Vital Statistics Administration, 2022)

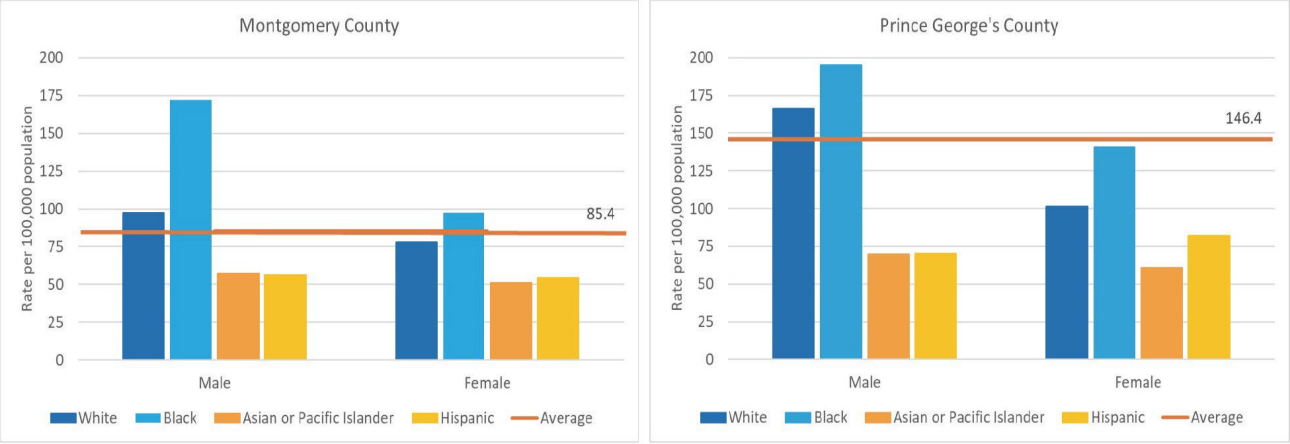
HIGH BLOOD PRESSURE AND CHOLESTEROL

High blood pressure, or hypertension (140/90 mm Hg or higher), is the number one modifiable risk factor for stroke. In addition to stroke, high blood pressure contributes to heart attacks, heart failure, kidney failure, and atherosclerosis. In the United States, nearly half of all adults (47% or 116 million) have high blood pressure; however, only about 25% of those adults have their hypertension under control (Center for Disease Control and Prevention, 2021). Hypertension is particularly prevalent in African Americans/Blacks, older adults, obese people, heavy drinkers, and women taking birth control pills (Center for Disease Control and Prevention, 2020). The hypertension prevalence rate among adults in Montgomery County is 29.8% and 37.2% in Prince George's County (Center for Disease Control and Prevention, 2020). The Healthy People 2030 national health target is to reduce the proportion of adults with high blood pressure to 27.7% (Office of Disease Prevention and Health Promotion, n.d.).

As high blood pressure is asymptomatic and frequently goes undetected, it is often called the "silent killer." In 2019, more than half a million deaths in the United States had hypertension as a primary or contributing cause (Center for Disease Control and Prevention, 2019). The hypertension death rate in Montgomery County is 85.4, and the rate in Prince George's County is 146.4. While hypertension can be controlled through lifestyle changes, including eating a heart-healthy diet, limiting alcohol, avoiding tobacco, controlling your weight, and staying physically

active, data reveals that the death rate from hypertension is higher in men compared to women. In Montgomery County, disparities can be seen in the death rates of African Americans/Blacks, and in Prince George's County, disparities can be seen in African Americans/Blacks and Hispanics (see Figure 26).

Figure 26: Hypertension Death Rate by Sex, Race/Ethnicity (2017-2019)



Source: Office of Disease Prevention and Health Promotion, 2020.

According to the CDC, about one in six adults have high blood cholesterol. High blood cholesterol, which is asymptomatic, is one of the major risk factors for heart disease and can go undetected. Lowering cholesterol levels lessens the risk of developing heart disease and reduces the chance of having a heart attack. High cholesterol prevalence is 32.7% for Prince George's County residents and 33.4% for Montgomery County residents aged 18 and older.

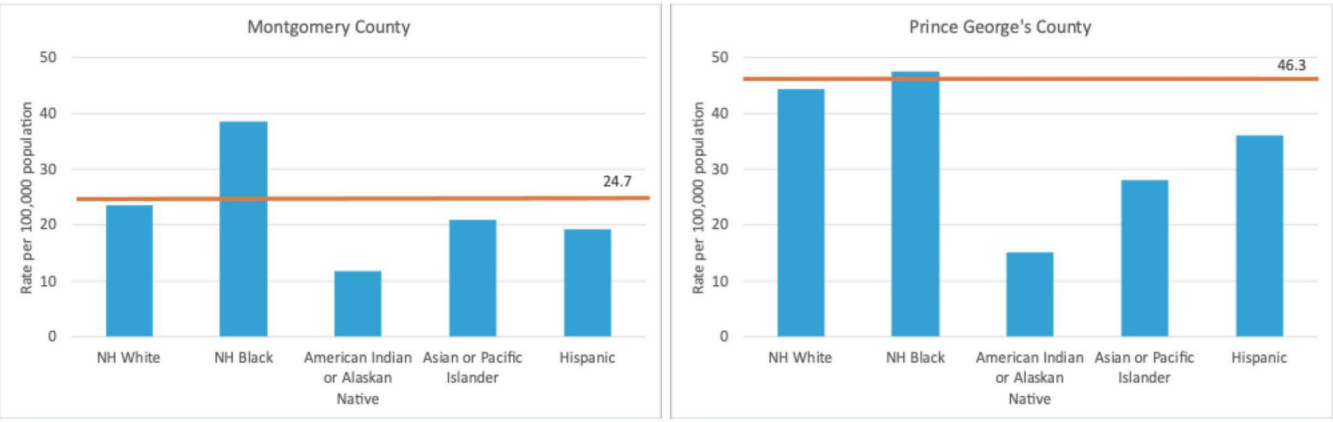
CEREBROVASCULAR DISEASE/STROKE

Cerebrovascular disease is the most common life-threatening neurological event in the U.S. It includes a variety of medical conditions that affect the system that supplies blood to the brain. The most common presentation of this disease is ischemic stroke, or mini-stroke, followed by hemorrhagic stroke.

Each year in the United States, over 795,000 people suffer a stroke, of which 610,000 are first-time events (CDC, 2017). Stroke leads to over 140,000 deaths each year, and prior to COVID-19, it was the third leading cause of death in Montgomery and Prince George's Counties. A stroke occurs when the brain is deprived of oxygen, usually when blood vessels carrying oxygen to the brain become blocked or burst. High blood pressure is the number one controllable risk factor for stroke and can be prevented through regular care and lifestyle changes.

In Maryland, the age-adjusted death rate for cerebrovascular disease increased by 8.6% from 2010 to 2019. Montgomery County's stroke death for rate was 24.7 per 100,000 population and the death rate for Prince George's County was 46.3 per 100,000 (see Figure 27) (Center for Disease Control and Prevention, 2020). The Healthy People 2030 national health goal is to reduce stroke to 33.4 deaths per 100,000 population (Office of Disease Prevention and Health Promotion, n.d.).

Figure 27: Stroke Death Rate, All Ages, 2017-2019

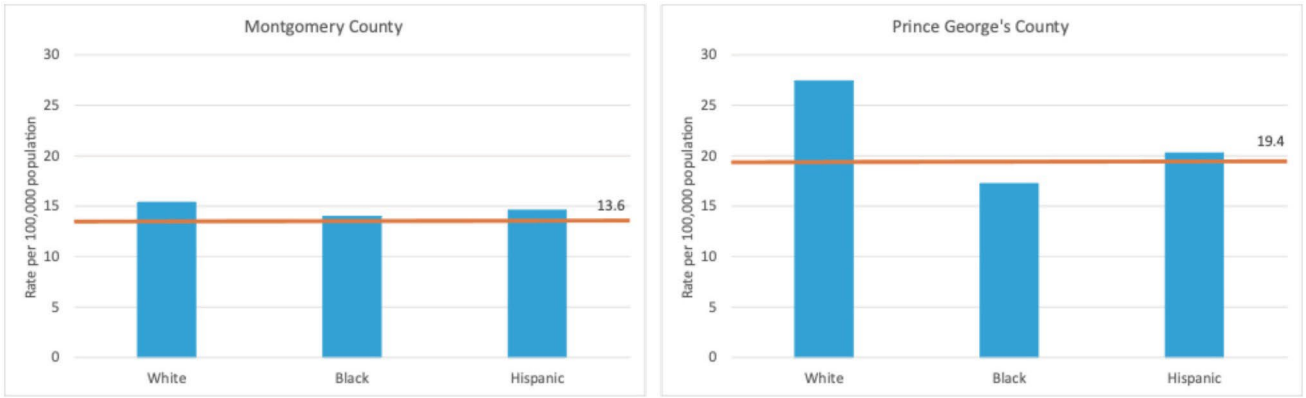


Source: Interactive Atlas of Heart Disease and Stroke.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE /CHRONIC LOWER RESPIRATORY DISEASE

Chronic lower respiratory disease (CLRD) causes airflow blockage and breathing-related issues, including chronic obstructive pulmonary disease (COPD), emphysema, bronchitis, and asthma. CLRD is a leading cause of death, with approximately 124,000 deaths yearly, and generally occurs among older adults. However, this estimate is considered low because CLRD is often cited as a contributory, not underlying, cause of death on the death certificate. In Montgomery County, 4.3% of adults have CLRD, while 4.8% of adults in Prince George's County have CLRD (National Center for Chronic Disease Prevention and Health Promotion, 2021). In 2020, Montgomery County and Prince George's County's overall age-adjusted death rates for CLRD were 13.6 and 19.4, respectively (see Figure 28) (Center for Disease Control and Prevention, National Center for Health Statistics, 2021).

Figure 28: Age-Adjusted Death Rate due to Chronic Lower Respiratory Disease by Race/Ethnicity (2020)



Source: CDC WONDER Online Database, 2021.

COPD

COPD has no known cure, with many conditions often undiagnosed (CDC, 2021). It is comprised of two main conditions, emphysema and chronic bronchitis, and patients may experience many conditions simultaneously (LiveStories, n.d). COPD slowly damages the lung air sacs causing wheezing, tightness of the chest, and shortness of breath, and can often lead to other more serious health issues if left untreated (United Health Foundation, 2020). Genetic and environmental factors,

such as exposure to tobacco smoke, air pollutants and respiratory infections, play a key role in developing COPD (CDC, 2021c). Rates of adults diagnosed with COPD have declined from 2019 to 2020. Nationally, rates have dropped from 6.5% in 2019 to 6.2% in 2020. Statewide, rates have also declined from 5.4% in 2019 to 4.8% in 2020.

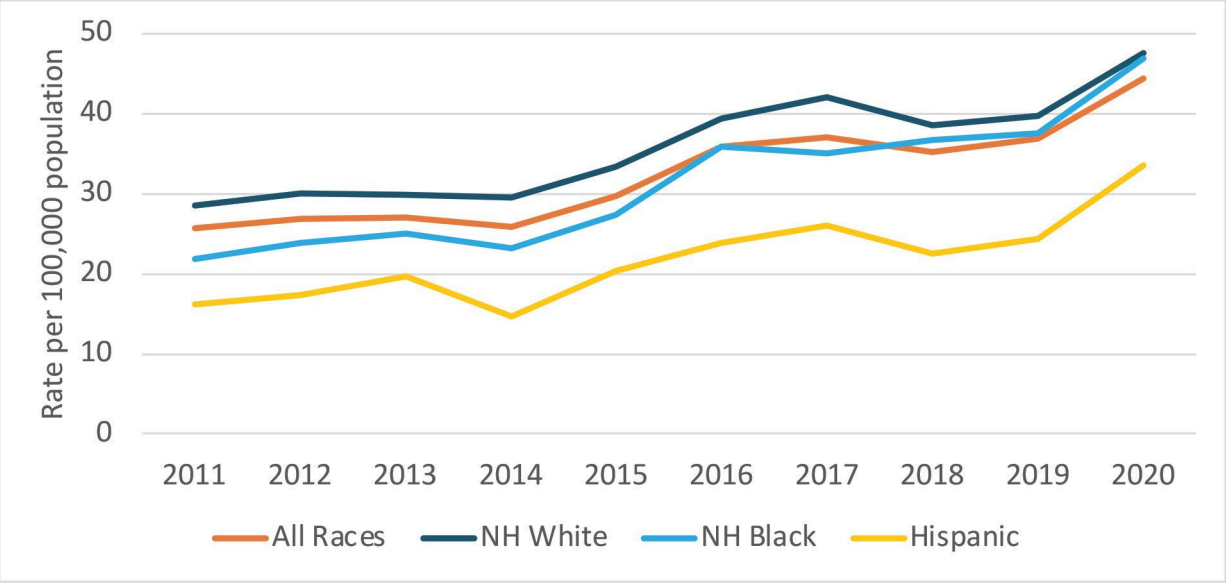
UNINTENTIONAL INJURIES (ACCIDENTS)

Injury, unlike disease, is damage to the body caused by an external force or physical trauma. It is a broad term that is first classified based on whether there is an intent to harm. Intentional injury is injury inflicted by positive, willful, and aggressive conduct. Examples include self-harm or interpersonal violence. Both intentional and unintentional injury may cause prolonged illness or death. In addition to intent, injury is also classified by several other factors, including severity, setting, activity, mechanism, and nature of the injury. There is no single comprehensive and mutually exclusive method for injury categorization. However, all classifications have merit, and often a combination is chosen (World Health Organization [WHO], 2009).

Public health practitioners have moved towards updating terminology in this area from "accident" to "injury event" to infer that these events can be studied, measured, and prevented and also to remove connotations of inevitability or lack of apparent cause. In some cases, however, the term accident is still used.

While accidents represented a small percentage (4.9%) of all Maryland deaths in 2020, the rate of increase over the last decade has been significant compared to other leading causes of death. For example, the statewide age-adjusted rate for accidents increased 73.4% from 2011 to 2020 (Figure 29). Similar rates of increase were seen among Non-Hispanic Whites (67%), with the highest percent change occurring for Non-Hispanic Blacks (113.7%) and Hispanics (106.8%) (Maryland Department of Health Vital Statistics Administration, 2022).

Figure 29 Age-Adjusted Death Rate for Accidents by Race and Ethnicity, Maryland

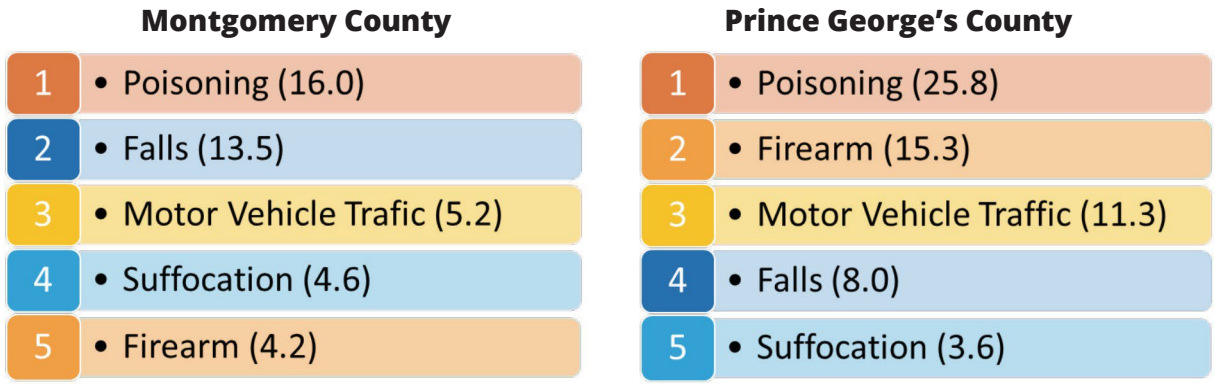


Source: Maryland Department of Health Vital Statistics Administration, 2022.

When considering the different injury types, unintentional injuries are a leading cause of death for Americans of all ages, regardless of gender, race, or economic status. Major unintentional injuries include motor vehicle collisions, drowning, fires and burns, poisonings, suffocation/aspiration, and falls caused by negligence or a mishap. According to the CDC, approximately 40 deaths per 100,000 occur each year due to unintentional injuries.

The crude death rates from unintentional injuries in Montgomery County were 48.0 per 100,000 in 2020 and 74.4 per 100,000 in Prince George's County. In 2020, the leading cause of preventable, unintentional injury in Montgomery County and Prince George's County was poisoning (see Figure 30) (Center for Disease Control and Prevention, National Center for Health Statistics, 2021).

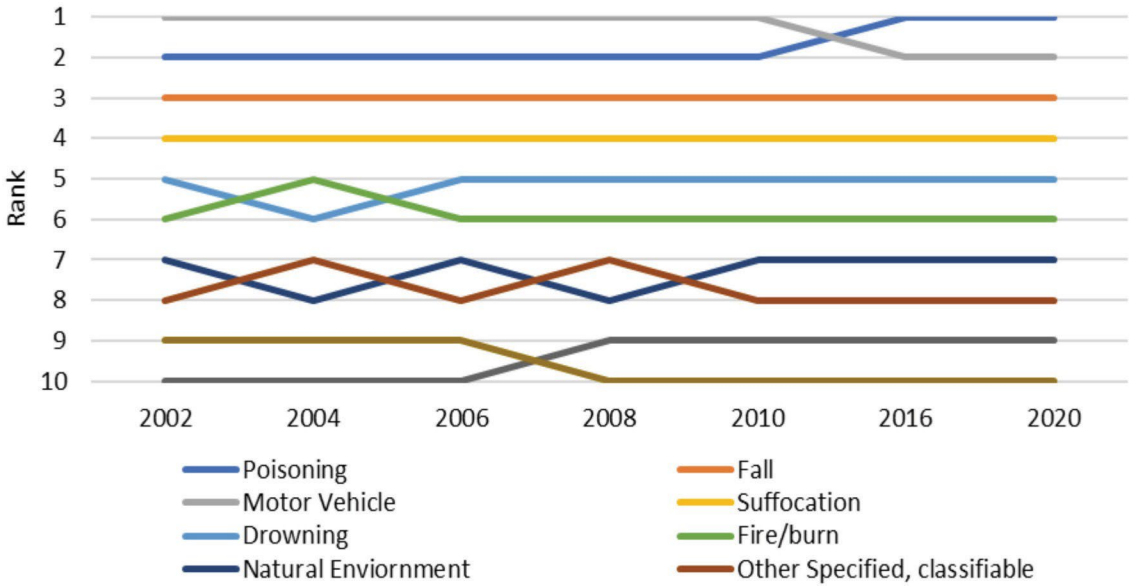
Figure 30: Crude Death Rates for Leading Causes of Death from Unintentional Injury (2020)



Source: CDC WONDER Online Database, 2021.

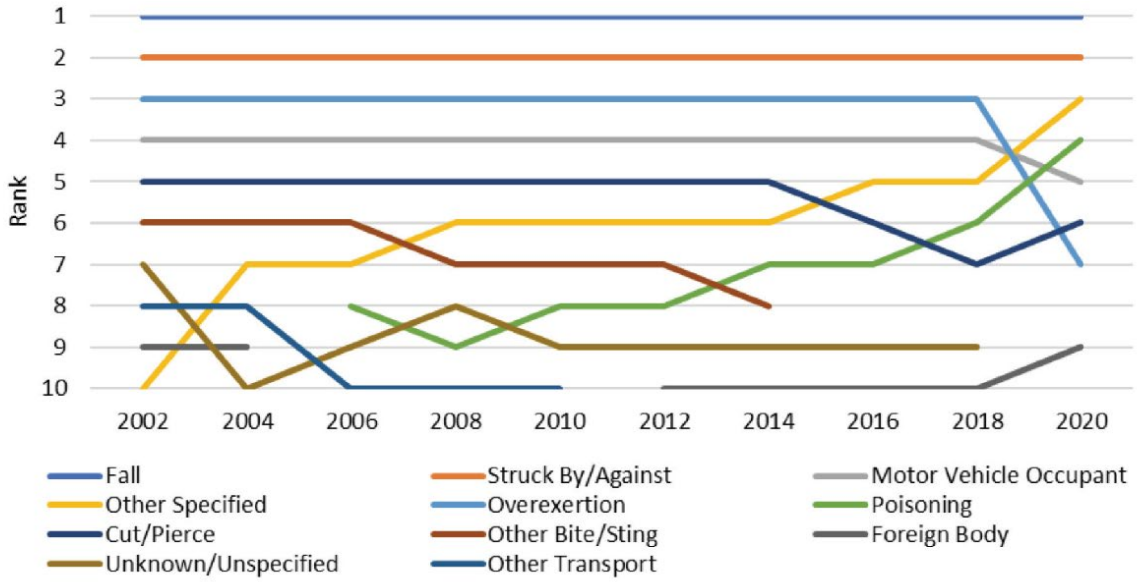
Figure 31 and Figure 32 illustrate the U.S. top 10 preventable deaths from unintentional injuries and the top 10 preventable nonfatal unintentional injuries over the last decade.

Figure 31 Top 10 Preventable Deaths from Injury in the United States (2002 – 2020)



Source: Web-based Injury Statistics Query and Reporting System (WISQARS), 2021

Figure 32: Top 10 Nonfatal Injuries in the United States (2002 - 2020)



Source: Web-based Injury Statistics Query and Reporting System (WISQARS).

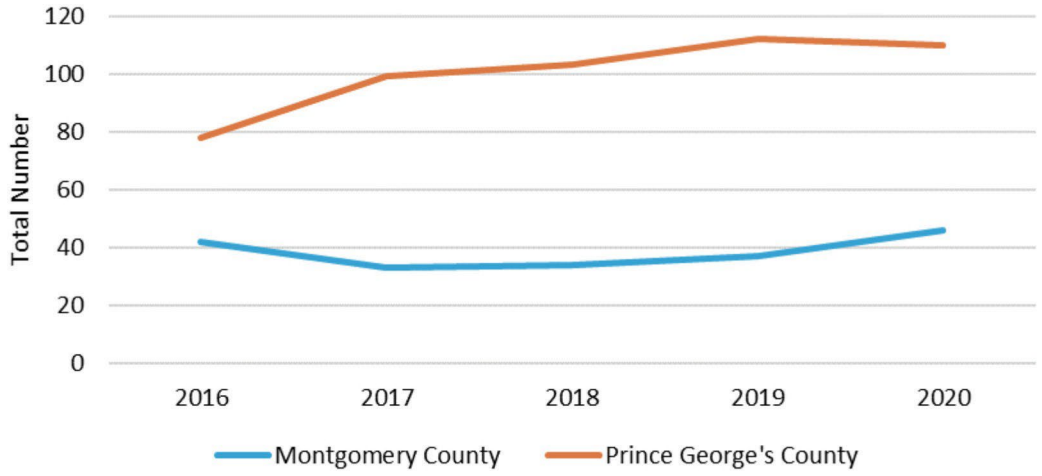
MOTOR VEHICLE ACCIDENTS

Motor vehicle collisions are the leading cause of death among people ages 5 through 34 in the United States. Many more people are injured or disabled in motor vehicle accidents each year. In addition to negative health effects, motor vehicle collisions have significant economic impacts; the costs of medical care and productivity losses resulting from motor vehicle accidents are estimated at around $100 billion per year. In Montgomery County, the age-adjusted death rate for motor vehicle traffic collisions was 5.1 per 100,000 population and the rate for Prince George's County is 11.1. In both counties, African American/Black and Hispanic rates are more than double their White counterparts (Centers for Disease Control and Prevention, 2020)

One's physical environment greatly influences the risk of suffering harm from an unintended injury; this means that existing social and environmental factors will either protect or inhibit risk. For example, pedestrian and motor vehicle fatalities are many times higher in places with lower socioeconomic status and higher exposure to traffic. A fatal crash is a metric distinct from a motor vehicle fatality.

Fatal crashes are a count of the number of incidents where at least one fatality occurred because of a motor vehicle crash, whereas fatalities are a count of the total number of persons killed in a motor vehicle crash; some fatal crashes involve more than one fatality. The driver has the highest risk of death in crashes, accounting for 61% of fatalities from crashes in 2020 (Motor Vehicle Administration, 2021). Passengers and pedestrians also have an increased risk of death, accounting for 12.4% and 22.9% of fatalities in Maryland in 2020. Overall, between 2016 and 2020, fatalities in Prince George's County have trended up, while in Montgomery County, the number has remained steady (see Figure 33).

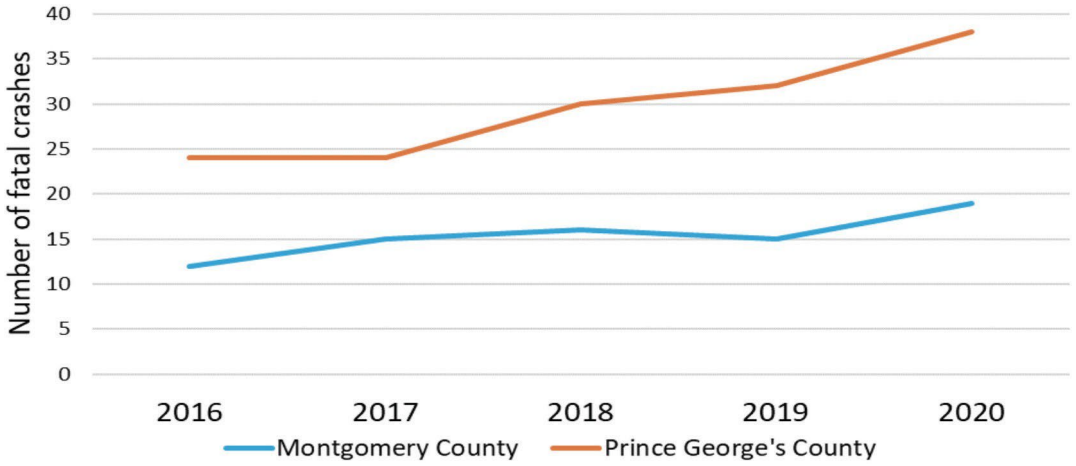
Figure 33: Number of Total Fatalities (2016-2020)



Source: Maryland Department of Transportation Motor Vehicle Administration, 2021.

After driver and passenger deaths, the highest fatality rate was among walking pedestrians. In 2018, there were 6,283 pedestrians killed in traffic crashes in the United States - a 50% increase over the past decade. In 2020 there were 131 walking pedestrian fatalities, representing 23% of fatal motor vehicle deaths in Maryland; 19 in Montgomery County and 38 in Prince George's County (Motor Vehicle Administration, 2021; Vision Zero Prince Georges, n.d.). This number represents the number of incidents where at least one pedestrian fatality occurred because of a motor vehicle crash. Injuries among pedestrians have increased between 2016 and 2020 across Montgomery and Prince George's Counties (see Figure 34).

Figure 34: Trend in Number of Total Fatalities Involving Pedestrians on Foot (2016-2020)



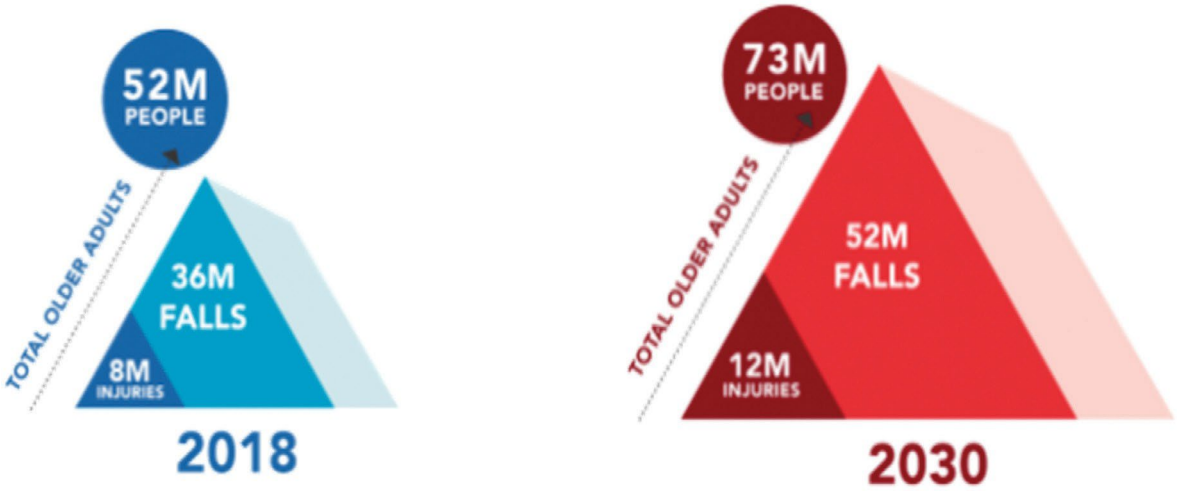
Source: Maryland Department of Transportation Motor Vehicle Administration, 2021.

FALLS

Falls, occurring most often in those aged 65 and over, are a leading cause of unintentional injury and death, and as the population ages, the number of falls each year is expected to rise (see Figure 35). Falls commonly produce bruises, hip fractures, and head trauma. These injuries can increase

the risk of early death and make it difficult for older adults to live independently. Most fatal falls occur among adults aged 65 or over but are also the leading cause of work-related injury death, especially among construction workers. Most falls are preventable. Strong, active bodies, corrected vision, medication management, and safe physical environments are all key to fall prevention.

Figure 35: Number of Older Adult Falls (2020)



Source: Centers for Disease Control and Prevention Center for Injury Prevention and Control, 2021.

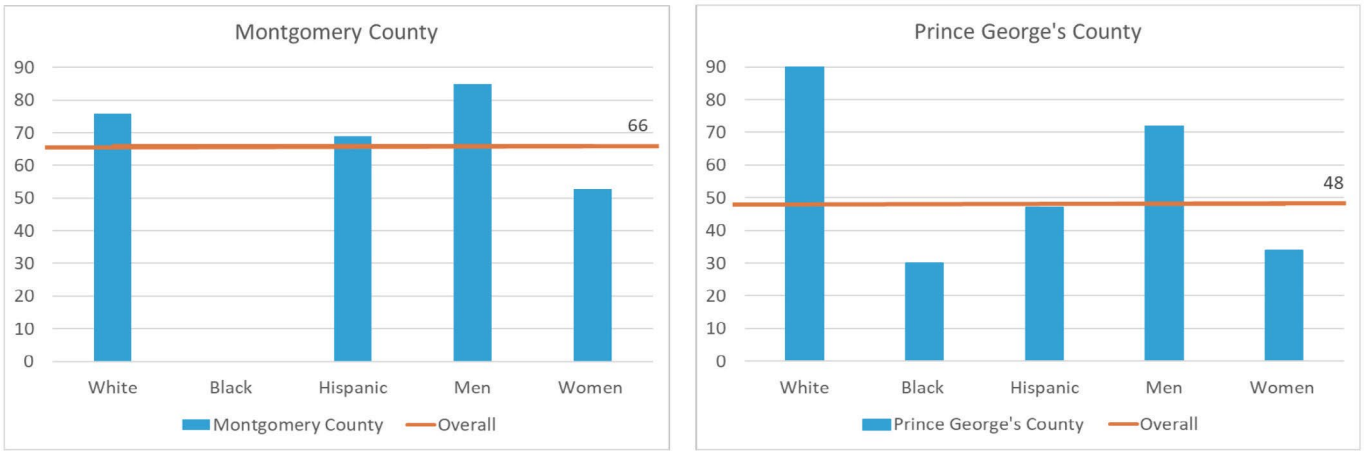
According to the CDC, in 2020, 66.1 per 100,000 Montgomery County older residents and 48 per 100,000 Prince George's County older residents died from falls. The Healthy People 2030 national health goal is to reduce fall-related deaths among older adults to 63.4 per 100,000.

While it is estimated that as many as one in four adults experience a fall, many go unreported to their health care provider. According to the CDC, falling once also increases one's risk of falling again. Falls are a threat to the health of older adults and can reduce their ability to remain independent. Serious injury, including fractured bones and head wounds, can result from a fall, sending many to the hospital. Head injuries are especially serious if the person is taking certain medicines like blood thinners. Even if no injury results from a fall, many people who fall become afraid of falling, causing them to cut down on their everyday activities. A decrease in regular activity leads to weaker bodies and an increase in falling.

The effects of falls extend beyond psychological and minor physical injuries. Falls are the most common cause of nonfatal injuries and hospital admissions for trauma. In the United States, more than one-third of adults 65 and older fall each year. Twenty to thirty percent of older adults who fall suffer from moderate to severe injuries. Falls are also very costly. The CDC estimates that each year in the U.S., about $50 billion is spent on medical costs related to non-fatal fall injuries and $754 million is spent related to fatal falls.

In Montgomery and Prince George's Counties, the 2020 overall age-adjusted rate for falls was 66.1 and 48.0, respectively. Higher rates can be seen in both counties in men compared to women and Whites compared to African Americans/Blacks and Hispanics (see Figure 36).

Figure 36: Age-Adjusted Death per 100,000 Rates (age 65+) Due to Falls (2020)



Source. CDC WONDER Online Database, 2021.

BEHAVIORAL HEALTH

Social and emotional support refers to the subjective sensation of feeling loved and cared for by those around us. Research has shown that individuals with social and emotional support experience better health outcomes compared to individuals who lack such support. In addition, it has been shown that social and emotional support have beneficial effects on recovery time post cardiac surgery, coping with cancer pain, and overall longevity.

SUBSTANCE ABUSE

Substance abuse, which is the recurrent use of alcohol and/or other drugs, can cause major health and social issues, including problems in the workplace, school, and home (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2022). Alcohol is also the third-leading preventable cause of death in the United States and contributes to 18.5% of emergency department visits and 22.1% of overdose deaths related to prescription opioids, causing an estimated 95,000 people to die from alcohol-related causes each year (NIAAA, 2022). Some of the leading causes of death are related to chronic conditions that are alcohol-associated such as liver disease, heart disease and stroke, liver cirrhosis, upper aerodigestive tract cancers, liver cancer, cardiac dysrhythmia, alcohol use disorder, breast cancer, and hypertension creating a global and economic burden. According to the National Institutes of Health, in 2010, the misuse of alcohol cost the the U.S. an estimated $249 billion (NIAAA, 2022).

BINGE OR HEAVY DRINKING

Excessive alcohol consumption, binge, or heavy drinking is a health behavior with adverse health outcomes and is associated with multiple risk factors such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes (CDC, 2022b). Binge or heavy drinking is defined as consuming five or more drinks on an occasion for men and four or more drinks on an occasion for women. More than 90% of adults

who drink excessively report binge drinking (CDC, 2022c). Nearly 17% of U.S. adults are considered binge drinkers (CDC, 2022c). In 2018, the most recent data available, the percent of adults who self-reported binge or heavy drinking over a 30-day period for Montgomery and Prince George's Counties was 13% and 14%, respectively (County Health Rankings & Roadmaps, 2021).

DRUG AND ALCOHOL-RELATED INTOXICATION DEATHS

An intoxication death is defined as a death resulting from recent ingestion or exposure to alcohol or another type of drug, including heroin, fentanyl, cocaine, prescription opioids, benzodiazepines, phencyclidine (PCP), methamphetamines, and other prescribed and non-prescribed drugs.

In 2020, Montgomery County reported 139 deaths (13.3 per 100,000 population) and Prince George's County reported 203 deaths (22.3 per 100,000 population) (Maryland Department of Health, 2021b). Both counties saw an increase in deaths when compared to 2019.

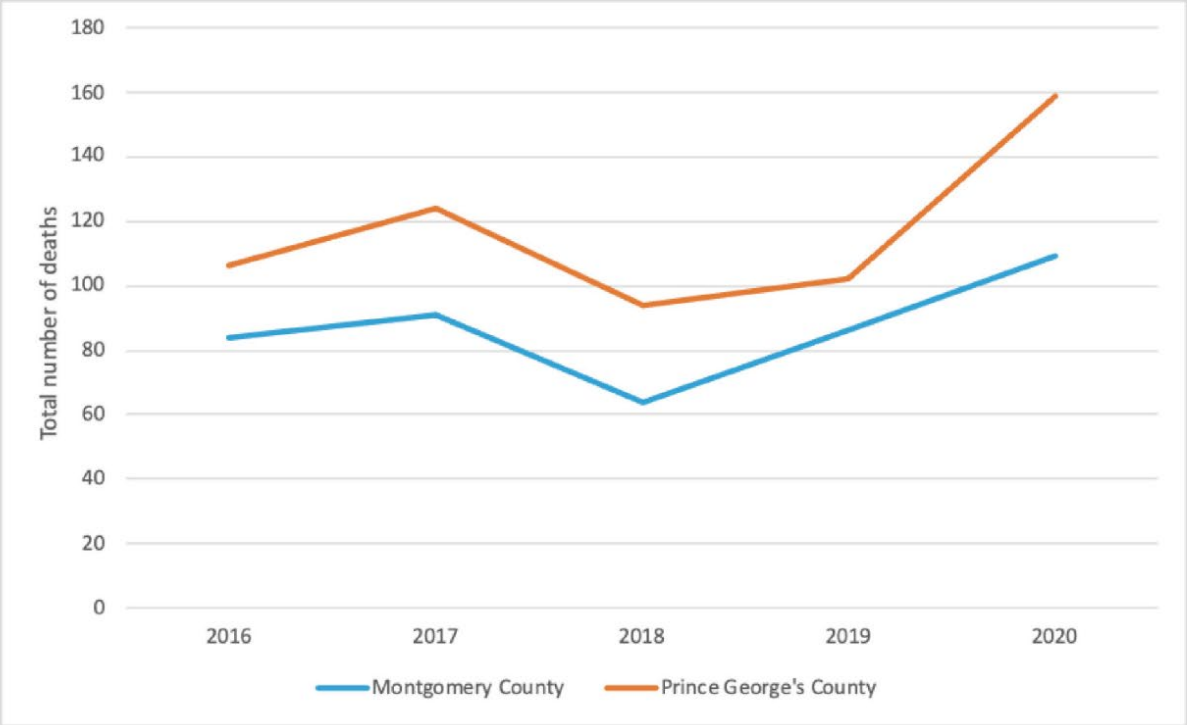
OPIOID AND PRESCRIPTION-RELATED DEATHS

Opioids include heroin and prescription medications used as pain relievers such as morphine, codeine, methadone, oxycodone, hydrocodone, fentanyl, hydromorphone, and buprenorphine (Office of Planning and Epidemiology, 2018). Overdose from prescription opioid pain relievers is a driving factor in the alarming increase in drug overdose morbidity and mortality.

Maryland, Montgomery County, and Prince George's County have seen a rise in heroin overdose over the past five years due to individuals switching to heroin after becoming addicted to prescription opioids because of its relatively low cost (Maryland Department of Health, 2016). Ninety percent of all intoxication deaths in Maryland in 2020 were opioid-related (Maryland Department of Health, 2021, p. 6). Between 2016-2020, opioid-related deaths increased 46% in Montgomery County and 127% in Prince George's County (Figure 37). In Maryland, the percent increase in deaths was 93%, with a large proportion of deaths attributed to the use of fentanyl (Maryland Department of Health, 2021b).

Fentanyl-related deaths began increasing in late 2013 due to overdoses involving nonpharmaceutical fentanyl (nonprescription fentanyl produced in clandestine laboratories and mixed with, or substituted for, heroin or other illicit substances). Nearly all fentanyl-related deaths in recent years have involved the use of nonpharmaceutical fentanyl. Fentanyl is many times more potent than heroin and greatly increases the risk of overdose death. In Maryland, fentanyl-related deaths have increased rapidly since 2013, with a 229% increase between 2015 and 2016. Deaths related to fentanyl increased sharply again in 2020, rising 22% to a 10-year high of 2,342 deaths (Maryland Department of Health, 2021, p. 7). Fentanyl-related deaths in Maryland have seen the highest increases between 2019 and 2020 among those 25-34 years (25%), those 55 and older (28%), among non-Hispanic Whites (19%) non-Hispanic Blacks (20%), and Hispanics, with rates that have nearly doubled, increasing 96% from 2019.

Figure 37: Opioid-Related Intoxication Deaths (2016 - 2020)



Source: Maryland Department of Health, 2021.

BEHAVIORAL AND MENTAL HEALTH

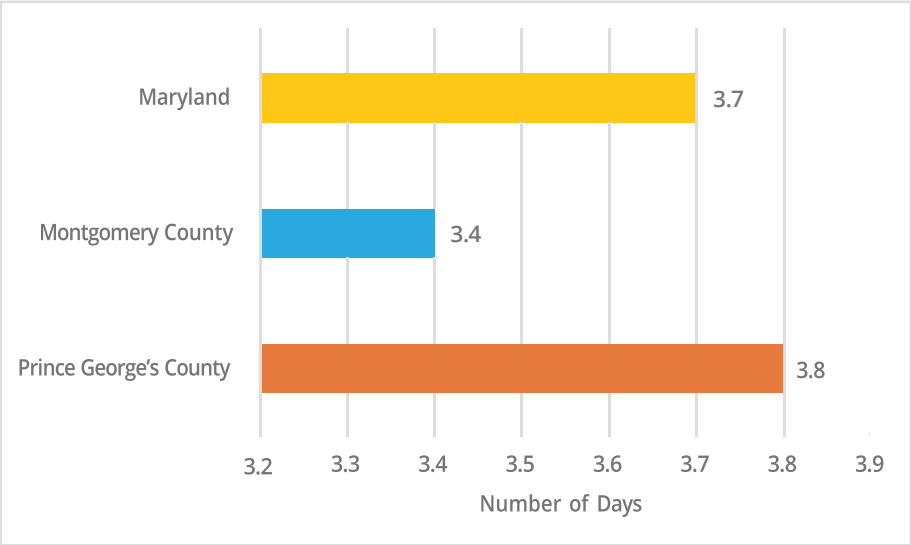
Behavioral and mental health have become prominent at the national level and described as an epidemic. One in five adults has experienced a mental illness and twelve million adults had serious thoughts of suicide in the U.S. (National Alliance for Mental Health [NAMI], 2020). Approximately one in six adolescents experience a major depressive episode (NAMI, 2020b).

In a recent study, mental health-related ER visits have exponentially increased due to the COVID-19 pandemic. This includes visits from mental health conditions, suicide attempts, drug overdoses, domestic abuse and child abuse and neglect (Holland et al., 2021). On a national level, pandemic anxiety, economic stress, social isolation, and addiction contributed to rises in cases of mental health visits to hospitals. As the impact of the COVID-19 pandemic spread across all communities, Montgomery and Prince George's counties residents faced similar risk factors affecting their mental health. In February 2021, 39.1% of adults in Maryland reported symptoms of anxiety or depression (NAMI, 2021).

Self-reported health assessments have been shown to be predictors of mortality and can be valuable for population health monitoring. Through County Health Rankings, one measure of the quality of life is to examine the number of poor mental health days, which is the average number of mentally unhealthy days reported in the past 30 days (see Figure 38). While in Montgomery County, residents reported an average of 3.4 mentally unhealthy days within the past 30 days and Prince George's County residents reported 3.8 days (CHR&R, 2021). Within the MCHC CBSA, 11.6% of adults report fourteen or more days during which their mental health was 'not good' compared

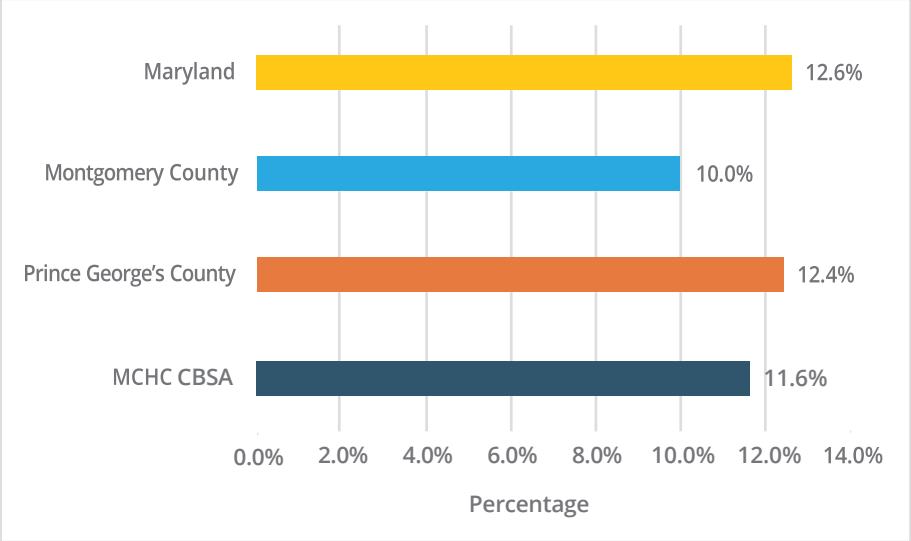
to 10.0% of those living in Montgomery County and 12.4% in Prince George's County (BRFSS, 2019) (see Figure 38).

Figure 38 Number of Poor Mental Health Days in Adults 18+ (2018)



Source: County Health Rankings & Roadmaps, 2021.

Figure 39: Percentage of Adults with Poor Mental Health (2019)



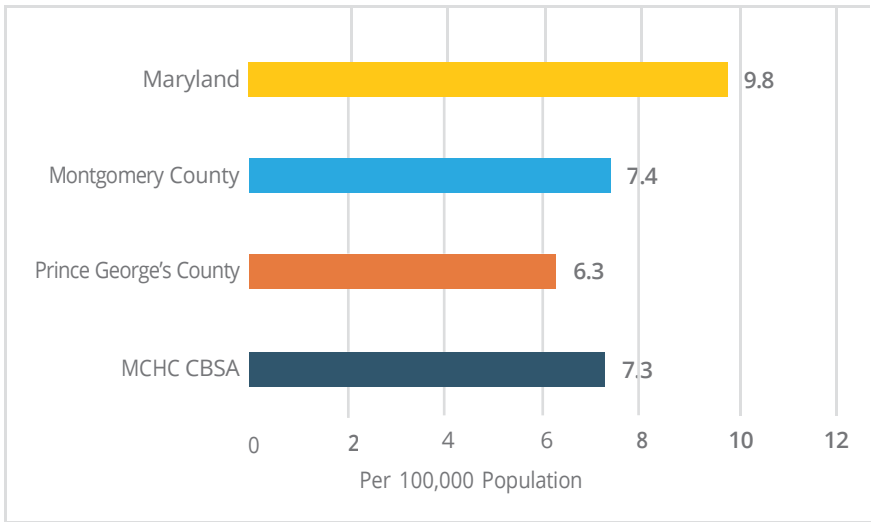
Source: Notes. Behavioral Risk Factor Surveillance System [BRFSS, Centers for Disease Control and Prevention, 2019.

Depression is a common mood disorder caused by a combination of genetic, biological, environmental, and physiological factors. Symptoms of depression include feeling hopeless, loss of interest and fatigue and can impact all aspects of a person's life, including how they think, feel, and handle daily activities. In general, there is a higher prevalence among Hispanic, White, and Black adults and affects women compared to men. It is a risk factor for dying by suicide. In 2020, 15.7% of the Maryland population was diagnosed with depression (United Health Foundation, 2021).

SUICIDE

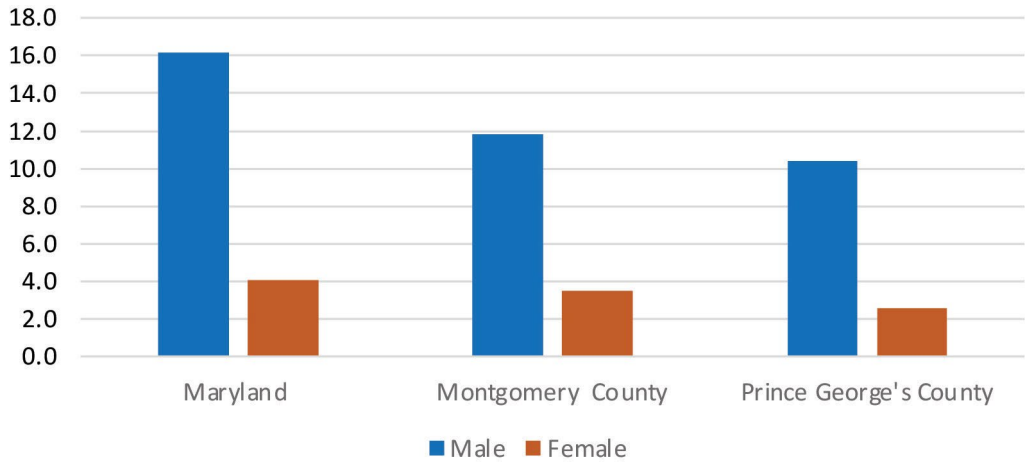
In recent years, the rate of suicide deaths has increased. For example, in Maryland, death from suicide increased 7.6% from 9.1 to 9.8 per 100,000 between 2015 and 2019. In the MCHC CBSA, there were 477 deaths from suicide with the age-adjusted death rate of 7.3 from 2016-2020. Comparing genders, a greater number of males than females died by suicide (see Figure 40).

Figure 40 Age–Adjusted Suicide Mortality (2016-2020)



Source: National Vital Statistics System, Centers for Disease Control and Prevention, 2021.

Figure 41 Suicide Mortality, Age–Adjusted Rate per 100,000 by Gender (2016-2020)

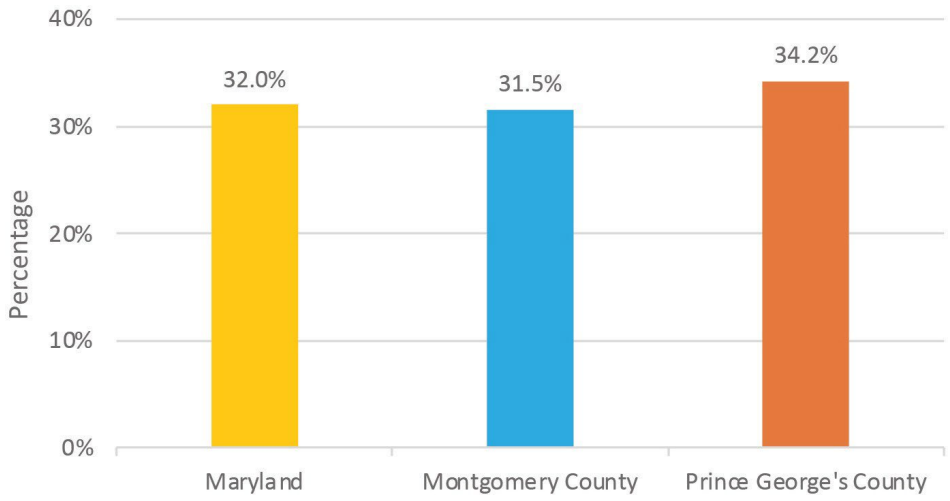


Source: National Vital Statistics System, Centers for Disease Control and Prevention, 2021.

Depression is not an adult-only problem. According to the CDC (2022f), 8 in 10 children receive treatment for depression, while the most commonly diagnosed mental disorders include anxiety, ADHD, behavior problems, and depression. Furthermore, cases of depression and anxiety have increased over the years. Suicide is the second leading cause of death among adolescents between the ages of 15 to 19 years old on the national level.

In recent years, both Prince George's and Montgomery Counties have seen a rise in middle and high school students who have stated they felt sad or hopeless. The Youth Risk Behavior Survey reported 32% of Montgomery County students and 34% of students in Prince George's County reported feeling sad or hopeless every day for two weeks or more during the past 12 months. Within the Montgomery County Public School system, crisis referrals rose from 1,804 in FY18 to 1,954 in FY19 (Yao, 2021). The number one reason for a crisis intervention referral was suicide threat. When looking at high school students who seriously considered attempting suicide, Black students in Prince George's County and White students in Montgomery County have the highest percentage (Center for Chronic Disease Prevention and Control, 2021). Interestingly, female high school students in both counties had a higher percentage of considering suicide compared to males.

Figure 42 Percentage of Students Feeling Sad or Hopeless



Source: Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS) 2018 – 2019, Maryland Department of Health CCDPC Surveys & Reports, 2021.

INFECTIOUS DISEASE

Infectious diseases are disorders that are caused by organisms such as bacteria, viruses, fungi, or parasites that are passed, directly or indirectly, from one person to another (Mayo Clinic, 2022; Department of Molecular Virology and Microbiology, n.d.). Other routes of transmission are zoonotic (exposure to an infected animal that harbors a pathogenic organism that is capable of infecting humans), consuming contaminated food or water, or being exposed to organisms in the environment. Many infectious diseases are reportable and considered to be a danger to public health. It is a requirement that local, state, and national agencies report these diseases when they are diagnosed by doctors or laboratories. Reporting allows for the collection of statistics, which helps researchers identify disease trends and track disease outbreaks. See Table 2 for a list of notifiable infectious conditions in Maryland.

Table 2 Cases of Selected Notifiable Conditions Reported in Maryland (2019)

Condition Name	Maryland	Montgomery County	Prince George's County
Amebiasis	0.4	0.6	0.9
Animal bites	174.1	91.8	132.3
Anthrax	0.1	0.4	0.1
Campylobacteriosis	14.7	16.3	6.3
Cryptosporidiosis	1.8	2	1.5
Cyclosporiasis	3.6	15.9	0.4
Dengue Fever	0.4	0.7	0.2
Giardiasis	2.9	0	4.1
Hepatitis A	1.5	1.3	1.6
Kawasaki Syndrome	0.1	0.7	0
Listeriosis	0.4	0.5	0.4
Lyme Disease	23.5	12.8	2.4
Malaria	3	5	6.5
Meningitis, Fungal	0.7	0.4	0.9
Mumps	0.3	0.8	0.3
Mycobacteriosis, Other than TB & Leprosy	13.8	23.7	12.3
Pertussis	1.7	2.9	1.2
Shiga toxin-producing E. coli (STEC)	4	6.6	3.4
Shigellosis	3.3	5.2	4.8
Strep Group B	9	6.1	8.6
Typhoid Fever – Acute	0.3	0.7	0.2
WNV Symptomatic Infections	0.1	0.2	0.3
Yersiniosis	1.6	2.7	1.2

Source: Maryland Department of Health NEDSS and PRISM databases, 2021.

TUBERCULOSIS

Tuberculosis (TB) is a bacterial disease that usually affects the lungs, although other parts of the body can also be affected. The TB bacteria are spread through the air when a person with untreated pulmonary TB coughs or sneezes. Prolonged exposure to a person with untreated TB is usually necessary for infection to occur. In 9 out of 10 exposed people, the immune system halts the spread of the infection and the infected person does not become sick or spread the disease to others. However, the bacilli remain dormant and can be activated if the immune system becomes severely weakened by HIV, diabetes, chemotherapy, cancer treatments, or other causes. A person

with TB disease is contagious until he/she has been on appropriate treatment for several days to weeks. The most effective way to stop the spread of tuberculosis is for TB patients to cover the mouth and nose when coughing and to take all TB medicine exactly as prescribed by their physician. The Healthy People 2030 national health target is to reduce tuberculosis cases to 1.4 cases per 100,000 population. Montgomery and Prince George's counties had higher rates of Tuberculosis than Maryland from 2016 -2019. Montgomery County had a decreasing trend, while Prince George's County had an increasing trend (see Table 3).

Table 3 Cases of Tuberculosis Reported in Maryland (2016 – 2019)

Location	2016	2017	2018	2019
Maryland	3.7	3.4	3.5	3.5
Montgomery County	7.2	6	6.1	5.9
Prince George's County	5.5	5.1	6.7	6.4

Source: Maryland Department of Health Prevention and Health Promotion Administration, 2021.

SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted infections (STIs) are also called sexually transmitted diseases, or STDs. STIs are usually spread by having vaginal, oral, or anal sex. An STI is an infection passed from one person to another person through sexual contact. An infection is when a bacteria, virus, or parasite enters and grows in or on your body. According to the CDC, nearly 20 million people in the United States get an STI each year. These infections affect women and men of all backgrounds and economic levels and half of all new infections are among young people 15 to 24 years old. Women often have more serious health problems from STIs than men, including infertility. Though consistently lower than Maryland and Prince George's County, the sexually transmitted infections (chlamydia, gonorrhea, and syphilis) in Montgomery County have increasing trends.

In 2020, 2.4 million cases of STDs were reported in the U.S. (CDC, 2022a). The syphilis epidemic continued to surge, driving another year of increases in congenital syphilis. Congenital syphilis (CS) is a disease that occurs when a mother with syphilis passes the infection on to her baby during pregnancy). Jurisdictions reported more than 2,100 cases of congenital syphilis, an increase of almost 15% since 2019 and a 235% increase since 2016. Gonorrhea and primary and secondary syphilis cases increased by 10% and 7% from 2019 to 2020, while reported cases of chlamydia declined 13%. However, chlamydial infections are usually asymptomatic and identified through screening. Therefore, this decline is likely due to decreases in STD screening and underdiagnosis during the pandemic rather than a reduction in new infections. The 2020 STD data also show that some racial and ethnic minority groups, gay and bisexual men, and our nation's youth continue to experience high rates of STDs.

Focused attention is needed to combat the surge in congenital syphilis, which has dramatically increased in the past five years. In 2020, nationally, there were 149 stillbirths and infant deaths,

reflecting a startling 210 percent increase since 2016. Data show that 47 states reported at least one case of congenital syphilis is 2020, compared to only 24 states in 2011. The most common missed congenital syphilis opportunity occurred when mothers did not receive timely prenatal care or syphilis testing (41%). Fueling this national trend are parallel increases in P&S syphilis (i.e., most infectious phases) among women aged 15-44 years by more than 156% from 2016 to 2020. In 2019, Montgomery County reported a case rate of 25.1 cases per 100,000 live births and Prince George's County case rate of 42.4 cases per 100,000 live births (Prevention and Health Promotion Administration, 2019). The Healthy People 2030 national health target is to reduce congenital syphilis cases to 33.9 cases per 100,000 population.

In addition to syphilis, chlamydia is also a common STI that can infect both men and women. It can cause serious, permanent damage to a woman's reproductive system, resulting in infertility. Chlamydia can also cause a potentially fatal ectopic pregnancy (pregnancy that occurs outside the uterus). Under-reporting of chlamydia is substantial because most people with chlamydia are not aware of their infections and do not seek testing. Nationally, during 2019–2020, rates of reported chlamydia decreased among both males and females, in all regions of the United States, and, except for rates among non-Hispanic persons of multiple races, among all racial/Hispanic ethnicity groups. In 2019, Montgomery County reported a case rate of 447 cases per 100,000, which is drastically lower than the Prince George's County case rate of 906.4 cases per 100,000 (see Table 4).

Table 4 Cases of Chlamydia Reported in Maryland (2016-2019)

Location	2016	2017	2018	2019
Maryland	509.6	552.1	587.2	623.9
Montgomery County	328.3	380.5	419	447
Prince George's County	740.4	806.9	881.2	906.4

Source: Maryland Department of Health Prevention and Health Promotion Administration, 2021.

The other common STI, gonorrhea, can also infect both men and women, and is the second most common notifiable STI in the U.S. in 2020. It can cause infections in the genitals, rectum, and throat. It is a very common infection, especially among young people ages 15-24 years. It is typically asymptomatic, but easy to treat. However, gonorrhea has developed resistance to antibiotics over the years, complicating treatment. Left untreated, gonorrhea can cause serious and permanent health problems in both women and men. In women, gonorrhea is a common cause of pelvic inflammatory disease. In the United States, the highest reported rates of infection are among sexually active teenagers, young adults, and African Americans. In 2019, Montgomery County reported a case rate of 79.3 cases per 100,000, which is drastically lower than the Prince George's County case rate of 240.8 cases per 100,000 (see Table 5).

Table 5 Cases of Gonorrhea Reported in Maryland (2016 – 2019)

Location	2016	2017	2018	2019
Maryland	158.3	181.4	170.5	191.5
Montgomery County	53.9	68.6	62.7	79.3
Prince George's County	200.9	219.2	222.1	240.8

Source: Maryland Department of Health Prevention and Health Promotion Administration, 2021.

According to the CDC, after reaching an all-time low in 2000, cases of primary and secondary (infectious) syphilis are on the rise in the United States, particularly among men having sex with men. New cases of primary and secondary syphilis in men having sex with men are often characterized by co-infection with HIV. In addition, syphilis can also be passed from mother to infant during pregnancy, causing a disease called congenital syphilis. Pregnant women with untreated early syphilis experience perinatal death in up to 40% of cases.

Syphilis is divided into stages (primary, secondary, latent, and tertiary), with different signs and symptoms associated with each stage. A person with primary syphilis generally has a sore or sores at the original site of infection. These sores usually occur on or around the genitals, around the anus or in the rectum, or in or around the mouth. These sores are usually (but not always) firm, round, and painless. Symptoms of secondary syphilis include skin rash, swollen lymph nodes, and fever. The signs and symptoms of primary and secondary syphilis can be mild, and they might not be noticed. During the latent stage, there are no signs or symptoms. Tertiary syphilis is associated with severe medical problems. A doctor can usually diagnose tertiary syphilis with the help of multiple tests. It can affect the heart, brain, and other organs of the body. In 2019, Montgomery County reported 8.5 per 100,000 cases of primary and secondary syphilis, which is drastically lower than the Prince George's County case rate of 18.5 per 100,000 (see Table 6).

Table 6 Cases of Syphilis Reported in Maryland (2016 – 2019)

Location	2016	2017	2018	2019
Maryland	8.5	9.5	12.2	14.3
Montgomery County	3.2	5	6.3	8.5
Prince George's County	12.1	15.7	16.8	18.5

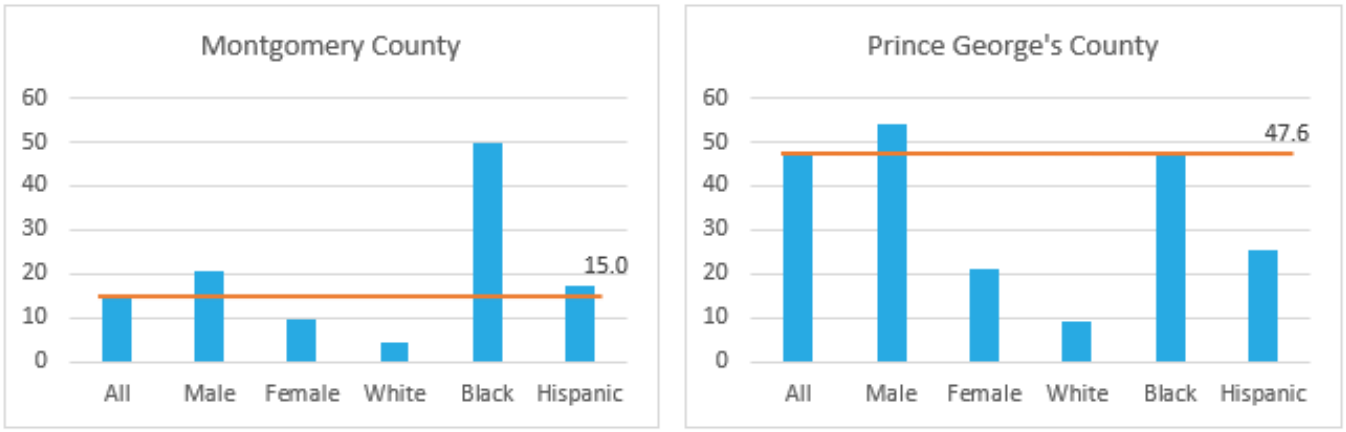
Notes. The data is from the "Cases of Selected Conditions Reported in Maryland" Maryland's Department of Health Prevention and Health Promotion Administration, 2021. https://health.maryland.gov/phpa/Pages/disease-conditions-count-rates.aspx. In the public domain.

HIV/AIDS

Human immunodeficiency virus (HIV) attacks one's immune system by destroying CD4 cells that help in fighting off infections and diseases (CDC, 2020b). HIV infection can progressively worsen in stages until it becomes Acquired Immunodeficiency Syndrome (AIDS), the most severe phase of

HIV infection. HIV can be transmitted through sexual behaviors and needle/syringe use. HIV/AIDS affects people of all races, ethnicities, genders, and sexual orientations. However, the most at-risk population is men who have sex with men, particularly Black men who have sex with men and young people under 30. In Maryland, HIV diagnosis are down, as of 2019. When comparing the two counties, Prince George's County has more than two times the number of new HIV cases than Montgomery County (see Figure 43) (CDC, 2021d). Prince George's County is the highest in new HIV diagnosis in the state. Four people are diagnosed with HIV in Prince George's County every week and two people in Maryland every day. While HIV can be controlled through treatment, to date, there is no cure (Prevention and Health Promotion Administration, 2021b).

Figure 43 HIV Diagnosis by Race & Ethnicity and Gender (2019)



Source: Centers for Disease Control and Prevention, National Center for HIV, Viral Hepatitis, STD, and TB Prevention, 2019.

INFLUENZA/PNEUMONIA

Influenza is a contagious disease caused by the influenza virus. The flu can cause severe illness and life-threatening complications, particularly in older people, young children, pregnant women, and people with certain health conditions. It can lead to pneumonia and can be dangerous for people with heart or breathing conditions.

The CDC estimates that in the United States, 5% to 20% of the population on average gets the flu and more than 200,000 people are hospitalized each year. While flu seasons can vary in severity, during most seasons, people 65 years and older bear the greatest burden of severe flu disease and have the highest flu-related mortality. The seasonal influenza vaccine can prevent serious illness and death. The CDC recommends annual vaccinations to prevent the spread of influenza. According to the Maryland Vital Statistics Administration (2019a), in 2019, influenza and pneumonia were the 9th leading cause of death in the state at 11.4 deaths per 100,000. In 2019, Montgomery County's death rate for influenza and pneumonia was 8.4 deaths per 100,000. Prince George's County death rate was 10.3 deaths per 100,000.

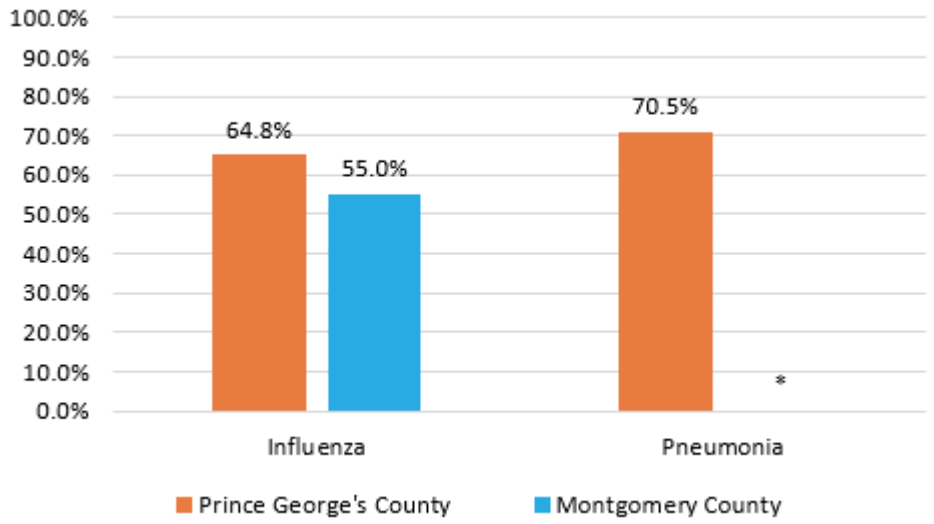
Pneumococcal pneumonia is a serious condition characterized by high fever, cough, shortness of breath, and meningitis. It is a contagious disease and can be spread by respiratory secretions from

coughing or sneezing. Pneumococcal pneumonia is the leading cause of vaccine-preventable death and illness in the United States--it kills about 1 out of every 20 people who develop the disease. The pneumococcal vaccine is very effective at preventing severe disease, hospitalization, and death. The CDC recommends the current vaccine for adults ages 65 years and older and for children ages 2 and older who are at high risk for disease.

PERCENT VACCINATED ADULTS 65+

As we age, the immune system does not respond to infections as well as it once had. Therefore, it is important for older adults to stay up to date on recommended vaccines and boosters. Influenza is an entirely preventable infection whose risk is mitigated by vaccination. In 2019, 55% of Montgomery County and 64.8% of Prince George's County residents 65+ received an influenza vaccination in the past year (see Figure 44).

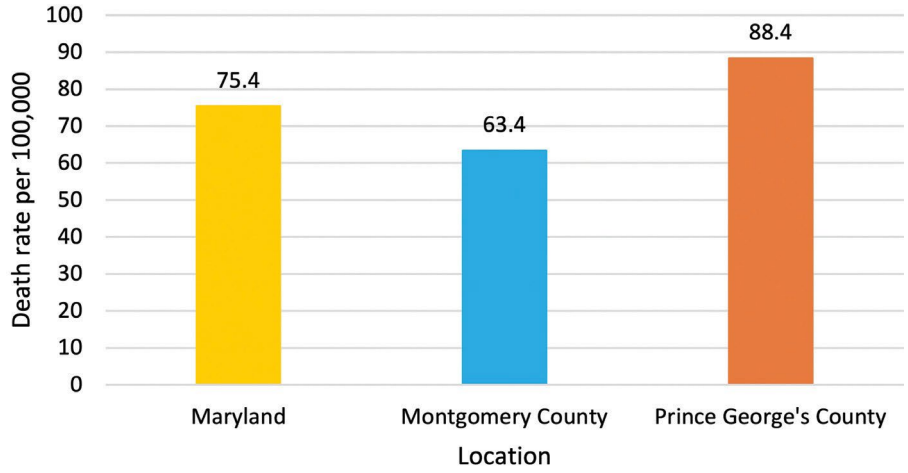
Figure 44 Percent of Vaccinated Adults 65+ for Influenza and Pneumonia (2019)



Source: Maryland Behavioral Health Risk Surveillance System, 2019.
*Insufficient or missing data.

In 2020, Prince George's County had the highest influenza and pneumonia death rate for individuals 65+ at 88.4 per 100,000 population when compared to Montgomery County (63.4) and the state of Maryland (75.4) (see Figure 45) (CDC, 2021).

Figure 45 Influenza/Pneumonia Death Rates per 100,000 for Individuals 65+ (2020)



Source: CDC WONDER Online Database, Centers for Disease Control and Prevention, 2021.

COVID-19

The first case of COVID-19 was reported on December 1, 2019, and the cause was a then-new coronavirus later named SARS-CoV-2. SARS-CoV-2 may have originated in an animal and changed (mutated), allowing it to cause illness in humans. In the past, several infectious disease outbreaks have been traced to viruses originating in birds, pigs, bats and other animals. Research continues, and more studies may reveal how and why the coronavirus evolved to cause pandemic disease. As of now, researchers know that the coronavirus is spread through droplets and virus particles released into the air when an infected person breathes, talks, laughs, sings, coughs or sneezes. Larger droplets may fall to the ground in a few seconds, but tiny infectious particles can linger in the air and accumulate in indoor places, especially where many people are gathered and there is poor ventilation. Therefore mask-wearing, hand hygiene and physical distancing are essential to preventing COVID-19.

In addition to hygiene-based prevention, immunizations are also a crucial part of the prevention process. The prioritization of immunization among seniors has risen since 2019, with the worldwide pandemic that ravaged the nation starting in early 2020. As of April 2022, 86.7% and 75.9% of Montgomery and Prince George's residents, respectively, have been fully vaccinated against the SARS-CoV-2 virus. Over 90% of adults 65+ in both Montgomery and Prince George's Counties have been fully vaccinated.

SEPSIS

Septicemia or sepsis is the body's response to infection. Sepsis is a serious and relatively common disorder and represents the leading cause of death worldwide, surpassing cancer and coronary disease (Faculty of Medicine, 2020). Sepsis and septic shock can result from an infection such as pneumonia, influenza, or urinary tract infections (UTIs). According to the Sepsis Alliance (2022), one-third of people who develop sepsis die worldwide. Many who do survive are left with life-changing effects, such as post-traumatic stress disorder (PTSD), chronic pain and fatigue, organ dysfunction, and/or amputations. Although sepsis does not discriminate, those at higher risk include people with chronic conditions (such as diabetes and cancer), compromised immune systems, and pneumonia

(Johns Hopkins Medicine, n.d.). Older adults are particularly vulnerable because they often delay treatment and do not recognize the symptoms of infections. For example, urinary tract infections (UTIs) can be treated quickly and effectively with antibiotics. However, over 50% of sepsis cases among older adults are caused by a UTI because the infections go undiagnosed (Sepsis Alliance, 2021).

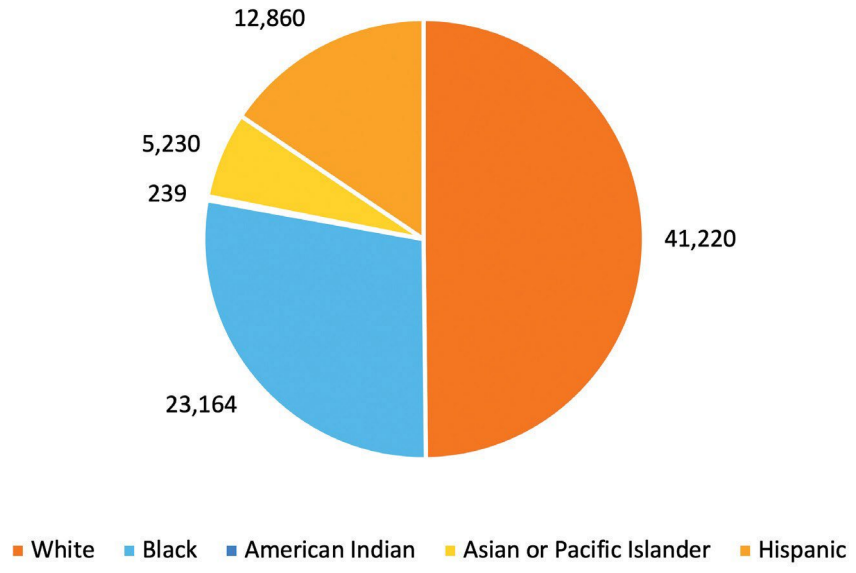
MATERNAL AND INFANT HEALTH

Improving the well-being of mothers, infants, and children is an important public health goal for the United States. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system. Pregnancy can provide an opportunity to identify existing health risks in women and to prevent future health problems for women and their children.

Maternal and infant health is an important indicator of the health and well-being of a nation. The CDC contends that the factors that affect the health of a population also typically impact the mortality rate of infants. This makes understanding infant mortality and the risk factors surrounding it especially valuable for public health research and practice. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy), prenatal (during pregnancy), postnatal (after pregnancy), and interconception (between pregnancies) care.

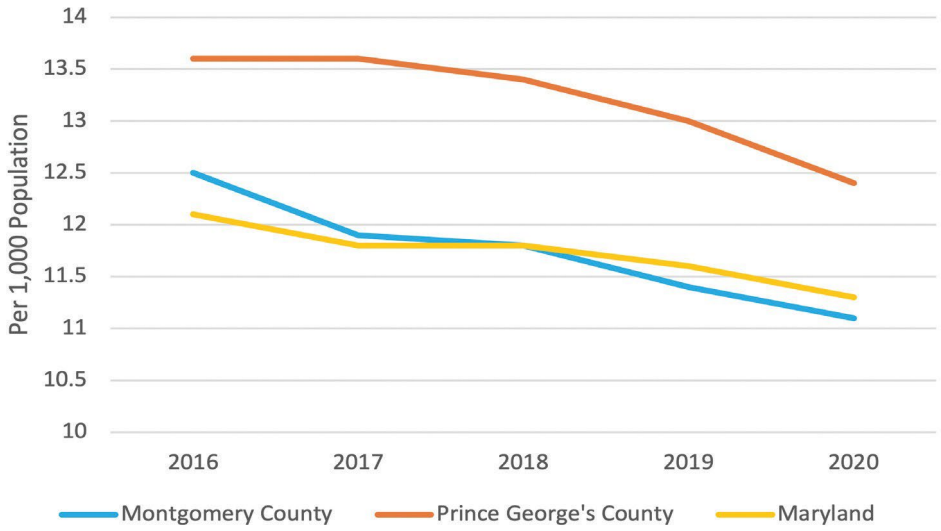
According to data from the Maryland Department of Health Vital Statistics, the birth rates at the state level have been on the decline since 2016 (see Figure 47). In 2020, Maryland had a rate of 11.3 births per 1,000 population. However, Prince George's County birth rate of 12.4 continues to be higher than the state and Montgomery County (11.1).

Figure 46 Number of Births by Race/Ethnicity in Maryland (2019)



Maryland Department of Health Vital Statistics Administration, 2019.

Figure 47 Trends in Birth Rate by State and County (2016-2020)



Source: National Center for Health Statistics, 2022.

PRENATAL CARE

Prenatal care is a well-established determinant for the optimal health of the mother and infant and it is believed up to half of pregnancy-related infant deaths can be prevented through early prenatal care, including nutrition and behavior education. Prenatal care is the most routine source of care, pregnancy education, and support for expectant parents in the United States. However, barriers to this care remain, especially for younger people, people of color, people with low incomes, linguistic minorities, and other marginalized groups.

Prenatal care is critical in ensuring healthy outcomes for all. Compared with infants born to mothers who received prenatal care, infants whose mothers did not receive prenatal care are three times more likely to have a low birth weight—defined by the World Health Organization as a weight of less than 5.5 pounds—and are five times more likely to die in infancy. Low weight and preterm birth in infants contribute to additional complications, including an increased risk of sudden infant death syndrome (SIDS), respiratory and gastrointestinal problems, and other long-term health complications. Women who do not receive prenatal care are also three to four times more likely to die from pregnancy-related complications than those who do receive care.

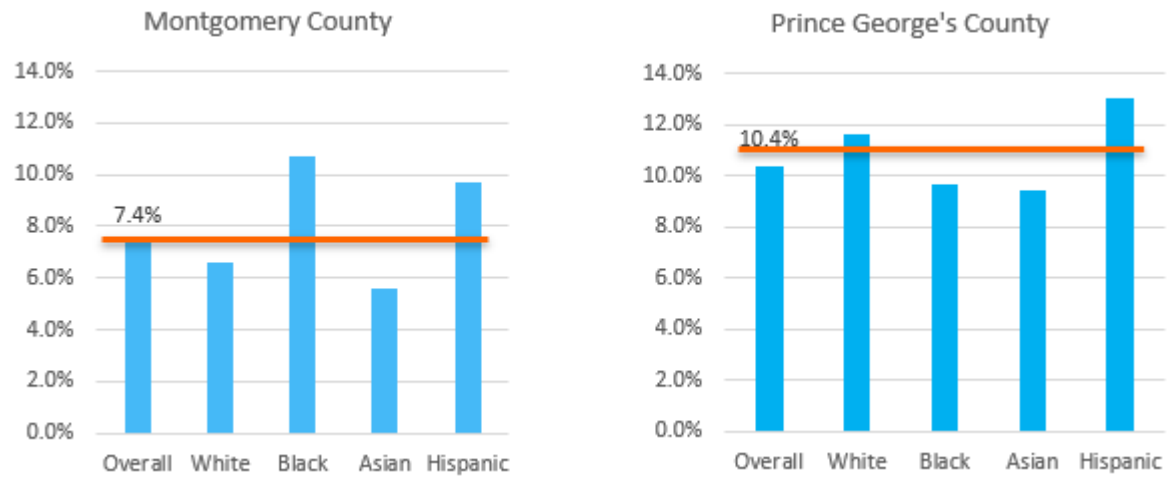
Early prenatal care (i.e., care in the first trimester of pregnancy) allows women and their health care providers to identify and, when possible, treat or correct health problems and health-compromising behaviors. Increasing the number of women who receive prenatal care, and who do so early in their pregnancies can improve birth outcomes and lower health care costs by reducing the likelihood of complications during pregnancy and childbirth. Healthy People 2030 has a target of 80.5% of pregnant women receiving early and adequate prenatal care; 70.2% of Montgomery County and 59.4% of Prince George's County women received care in the first trimester (Vital Statistics Administration, 2020).

Despite the importance of prenatal care for maternal and infant health, not all people receive adequate or timely care (prenatal care after the 7th month of pregnancy). In 2016, nearly 1 in 4

women in the U.S. started care late or received fewer than the medically recommended number of visits (Osterman & Martin, 2018). Health insurance plays a critical role in accessing prenatal care, and people living in states that refused the ACA's Medicaid expansion are more likely to remain uninsured and therefore struggle to access prenatal care. Nationally, the share of women receiving inadequate care is higher for women under age 20 (37%), women with less than a high school degree (37%), and women of color—including Hispanic women (29%), Black women (34%), American Indian or Alaska Native women (41%), and Native Hawaiian or other Pacific Islander women (50%). Across all races, the rate of women receiving late or no prenatal care is higher in Prince George's County than in Montgomery County and the State (see Figure 48).

Barriers to care have both structural and individual dimensions. Structural barriers include high service costs, poor transportation options to and from care settings, long wait times, a lack of childcare for other children, and unwelcoming provider attitudes. Individual dimensions include fear or distrust of medical providers and procedures, lack of health insurance, lack of social support, and mental health conditions—such as depression—that make seeking care difficult (Taylor et al., 2019).

Figure 48 Percent of women who receive late or no prenatal care

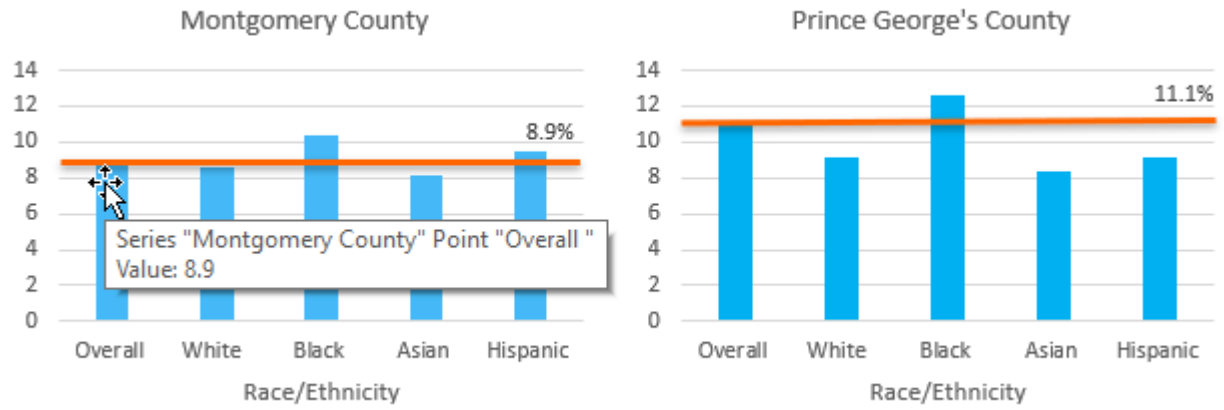


Source: Maryland Department of Health, Vital Statistics Administration, 2019.

PRETERM AND LOW BIRTH WEIGHT

Preterm birth, which refers to when an infant is born before 37 weeks of pregnancy, is a leading cause of infant mortality. These infants also have a higher risk of infections, developmental problems, and breathing problems. In 2020, the CDC estimated preterm births affected 1 of every 10 infants born in the United States. Healthy People 2030 has a target of reducing preterm births to 9.4%. In 2020, the percentage of preterm births was highest among Hispanics in Montgomery County (10.5%) and Non-Hispanic Blacks in Prince George's County (11.3%) (see Figure 49).

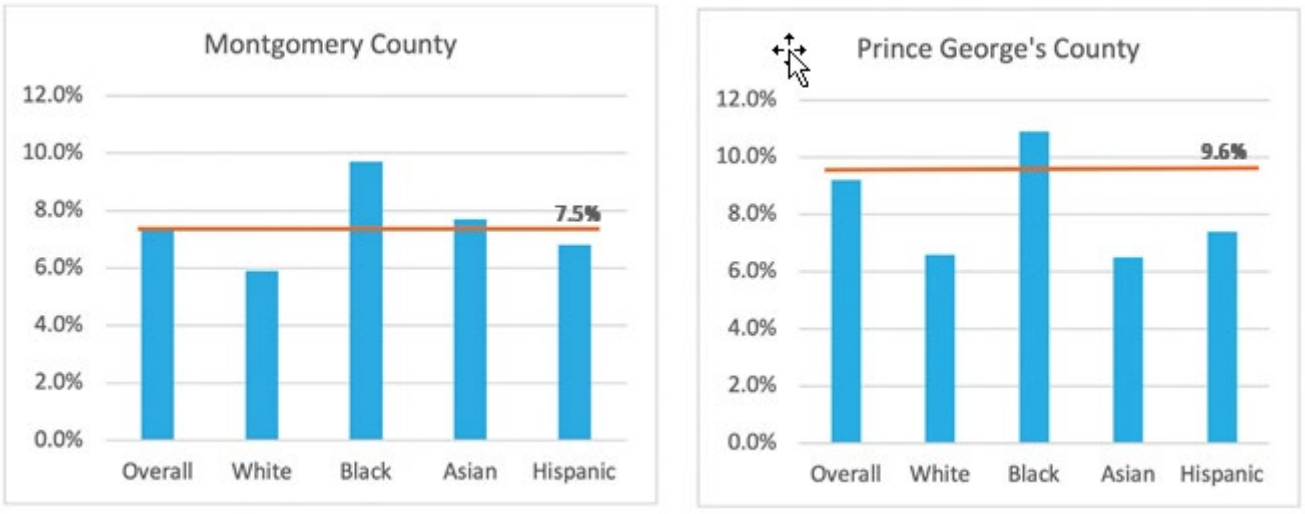
Figure 49 Percent preterm births by county and race



Source: Maryland Department of Health, Vital Statistics Administration, 2019.

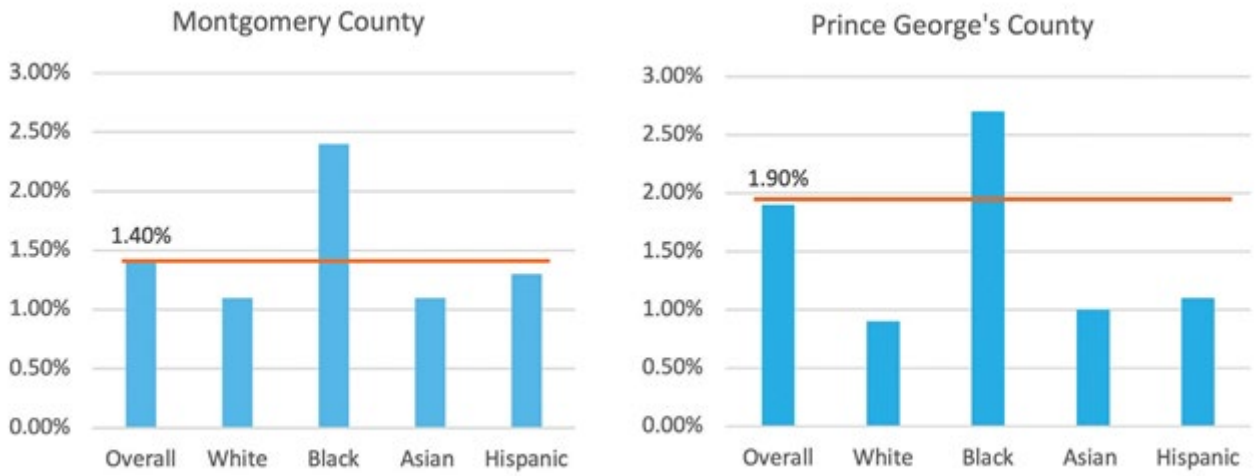
Low birthweight (less than 5 lbs. 8 oz.) or very low birthweight (less than 3 lbs. 5 oz.) is a common complication of infants who are born prematurely, and these babies are more likely than babies of normal weight to have health problems and require specialized medical care in the neonatal intensive care unit. In 2020, the CDC estimates 8.2% of all infants were born with low birthweight while 1.3% had very low birth weight. Low birth weight and very low birth weight is typically caused by premature birth and fetal growth restriction, both of which are influenced by a mother's health and genetics. In addition to preterm delivery, maternal risk factors include chronic health conditions, infections, complications with the placenta, inadequate weight gain during pregnancy, or previously having a low birth weight baby. Lifestyle choices such as smoking, alcohol, street drugs, and abusing prescriptions are also associated with low birth weight. In addition, low birthweight babies are more likely to suffer short-term effects, including respiratory distress syndrome or bleeding in the brain, and are also more likely to develop diabetes, high blood pressure, metabolic syndrome, or obesity later in life. Across both counties and the state of Maryland, Black babies have the highest percentage of low and very low birth weight when compared to any other race and ethnicity (see Figures 50 and 51).

Figure 50 Percent of Babies born with Low Birth Weight by Race/Ethnicity



Source: Maryland Department of Health Vital Statistics Administration, 2019.

Figure 51 Percent of babies born with Very Low Birth Weight by Race



Source: Maryland Department of Health Vital Statistics Administration, 2019.

SECTION 3.

SOCIOECONOMIC & PHYSICAL ENVIRONMENT

Social and economic factors, such as income, education, employment, community safety, and social supports can significantly affect how well and how long we live. These factors affect our ability to make healthy choices, afford medical care and housing, manage stress, and more. For example, employment provides income that shapes choices about housing, education, childcare, food, medical care, and more. In contrast, unemployment limits these choices and the ability to accumulate savings and assets that can help cushion in times of economic distress. Social and economic factors are not commonly considered when it comes to health; yet strategies to improve these factors can have an even greater impact on health over time than those traditionally associated with health improvement.

Across the nation, there are meaningful differences in social and economic opportunities for residents in communities that have been cut off from investments or have experienced discrimination. These gaps disproportionately affect people of color – especially children and youth (CHR&R, 2022). Per County Health Rankings & Roadmap, the physical environment is where individuals live, learn, work, and play. People interact with their physical environment through the air they breathe, the water they drink, houses they live in, and the transportation they access to travel to work and school. Poor physical environment can affect our ability and that of our families and neighbors to live long and healthy lives. Clean air and safe water are necessary for good health. Air pollution is associated with increased asthma rates and lung diseases and an increase in the risk of premature death from heart or lung disease. Water contaminated with chemicals, pesticides, or other contaminants can lead to illness, infection, and increased risks of cancer. Stable, affordable housing can provide a safe environment for families to live, learn, grow, and form social bonds.

However, housing is often the single largest expense for a family and when too much of a paycheck goes to paying the rent or mortgage, the housing cost burden can force people to choose between paying for other essentials such as utilities, food, transportation, or medical care.

Our collective health and well-being depend on opportunity for everyone. Yet, across and within counties, there are stark differences in the opportunities to live in safe, affordable homes, especially for people with low incomes and people of color. These differences emerge from discrimination and institutional racism in the form of long-standing, deep-rooted, and unfair systems, policies, and practices such as redlining, restrictive zoning rules, and predatory bank lending practices that reinforce residential segregation and barriers to opportunity. It is important to dig into the data to understand how factors related to the physical environment are playing out in Montgomery and Prince George's County.

EDUCATION

Education gives people the tools needed to lead fulfilling lives, thrive personally, and contribute to their communities. In addition, education makes it more likely a person can access quality health care, find employment that pays a living wage, and live in a safe, non-polluted environment — all factors that affect well-being. People who live in lower socioeconomic conditions are at greater risk for a host of health issues, including higher rates of disease, mental illness, and premature death. Access to quality education early in life, high school graduation, and a college education can provide opportunities for people to shift their socioeconomic status, reducing the likelihood of adverse health outcomes. Because of this, understanding how education impacts the health of communities is vital for public health professionals fighting to end health inequity.

People who have access to quality education throughout their lives tend to stay healthier than people who don't. Not only does education give individuals a chance at upward mobility, which places them in better financial circumstances to access quality health care, it also keeps them better informed about how to take care of their health. For example, an individual with a college degree

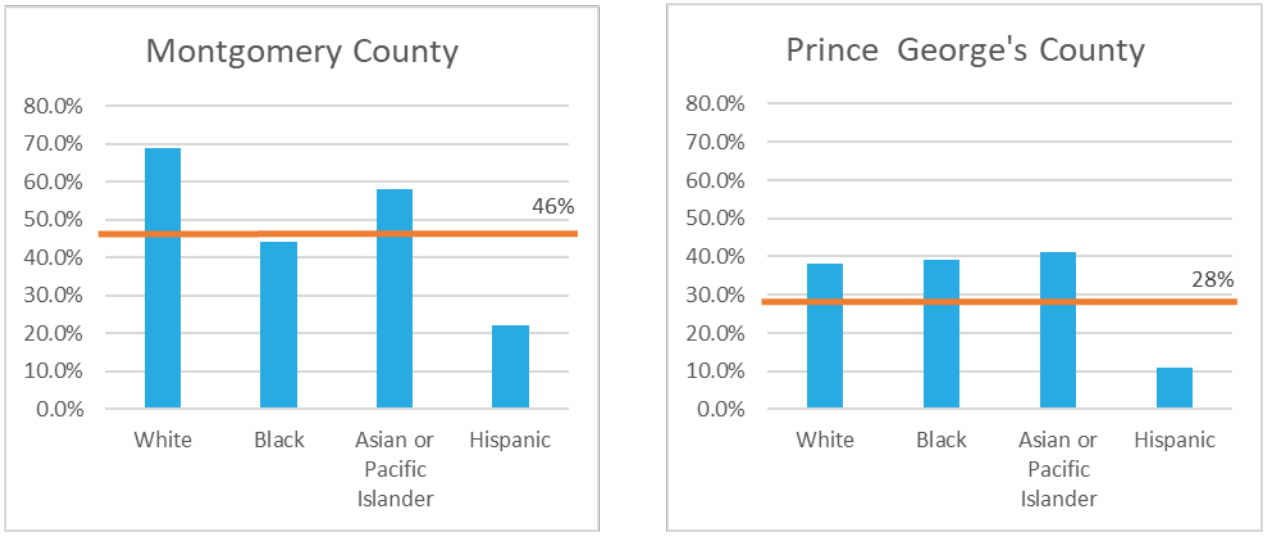
may have better skills to evaluate conflicting or complex information they read on the internet about how to care for their prediabetes. In addition, someone with less formal education may be less prepared to decide between reliable and unreliable information.

Less education is linked to lower income, which is linked to poorer health. Numerous studies show that people in lower socioeconomic situations experience more obesity, asthma, diabetes, heart disease, and other health problems than people in better financial circumstances. Additionally, a recent study also shows higher education helps individuals secure higher paying work with fewer safety risks. Ultimately, more highly educated people have greater economic resources to afford things like better housing far away from environmental toxins and expert doctors trained in the most effective techniques.

KINDERGARTEN READINESS

Kindergarten readiness is strongly linked to later school success, which is predictive of adult health. Full readiness to learn is defined as consistently demonstrating skills, knowledge, and behaviors that are needed to successfully engage in the kindergarten curriculum. For the 2021-2022 school year in Maryland, Montgomery County had the highest rates of students entering kindergarten ready to learn (46%) and Prince George's County had the lowest rate (28%) (see Figure 52). In Maryland students identifying as White and Asian had the highest rates of readiness. In Montgomery County, students identifying as White and two or more races had the highest rates of readiness. In Prince George's County, students identifying as two or more races and Asian had the highest rates of readiness.

Figure 52 Percent of Kindergarten Students Demonstrating Readiness (2020-2021)



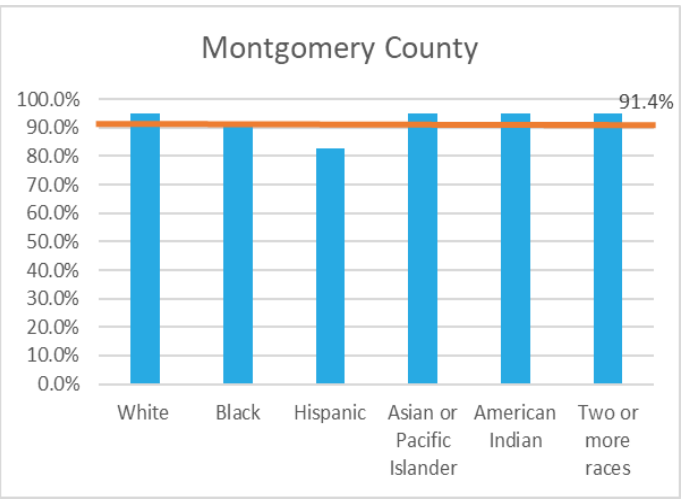
Source: Maryland State Department of Education, 2022.

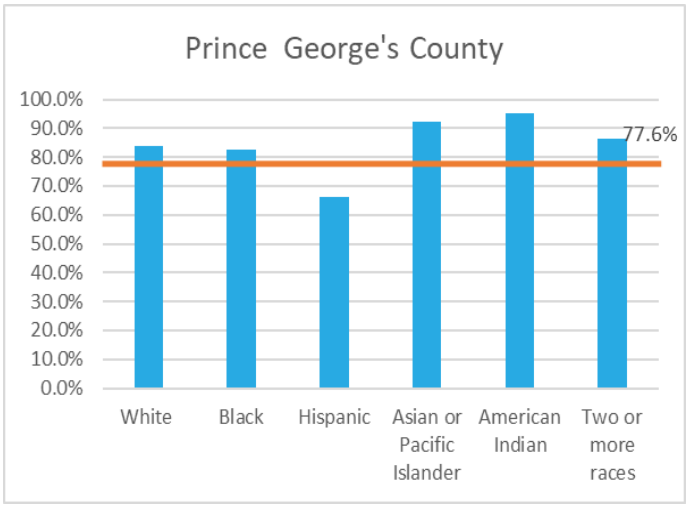
HIGH SCHOOL GRADUATION

Individuals who do not finish high school are more likely than people who finish high school to lack the basic skills required to function in an increasingly complicated job market and society. Adults with limited education levels are more likely to be unemployed, on government assistance,

or involved in crime (Healthy Communities Institute, 2019). In 2021, Montgomery County's 4-year high school graduation rate was 91.4%, which is higher than the state of Maryland (87.2%) and Prince George's County (77.6%) (see Figure 43). The Healthy People 2030 national health target is to increase the proportion of high school students who graduate in 4 years to 90.7%. Asian students in Maryland and Montgomery County had the highest graduation rates. In Prince George's County, students who identify as American Indian/Alaska Native had the highest graduation rate, followed by Asian students. Hispanic/Latino students had the lowest graduation rate across both jurisdictions.

Figure 53 Percent of 4-Year High School Graduation Rate (2021)





Source: Maryland Department of Education, 2021.

Graduating high school is an important personal achievement and is essential for an individual's social and economic advancement. According to the Office of Disease Prevention and Health Promotion, high school graduation leads to lower rates of health problems as well as risk for incarceration.

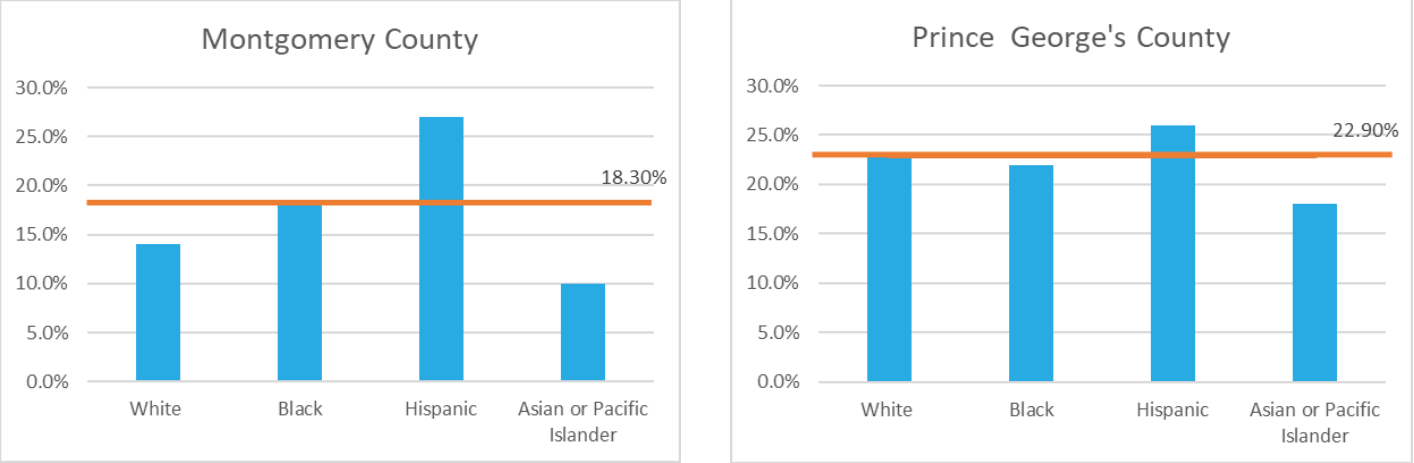
In 2015-2019 the population of people 25 years old and over with no high school diploma varied in both counties, with about 9% of the population in Montgomery County and more than 13% of the population in Prince George's County. Altogether, the MCHC CHNA area has a low percentage at 11.29% compared to 12% nationally, but higher than the state rate of 9.80% (United States Census Bureau, n.d).

The 2021 Maryland State Report Card reports the percent of youth dropouts in Montgomery County was 4.47%. Prince George's County's percentage of youth dropouts was 15.36% in 2021. When comparing the two counties, Prince George's County has the highest rate of youth dropouts at 5.20%.

CHRONIC ABSENTEEISM

Chronic absence (missing 15 or more school days) can jeopardize students' academic proficiency, social engagement, and opportunities for long-term success. Compared to the national rate of 15.9%, the MCHC CBSA area chronic absence rate was 19.0% for the 2017-2018 school year (U.S. Department of Education, n.d.). Prince George's County chronic absenteeism rate was 22.9%, compared to Montgomery County at 18.3% (see Figure 54).

Figure 54 Percent of Students Absent 15 or more School Days (2017-2018)

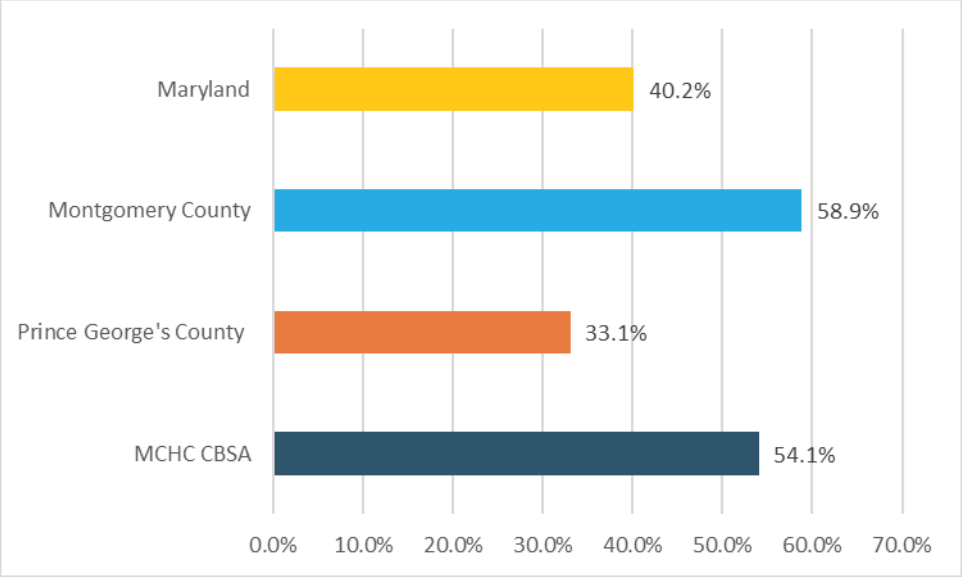


Source: U.S. Department of Education, n.d.

COLLEGE

Montgomery County and Prince George's County enjoy relatively high education levels. More than half of Montgomery County residents hold a bachelor's degree or higher, and a little more than 30% of Prince George's County residents hold a bachelor's degree or higher. Altogether, more than 54% of residents in the MCHC CBSA area had a bachelor's degree or higher (see Figure 55).

Figure 55 Percent of Residents Age 25+ with Bachelor's Degree or Higher (2015-2019)

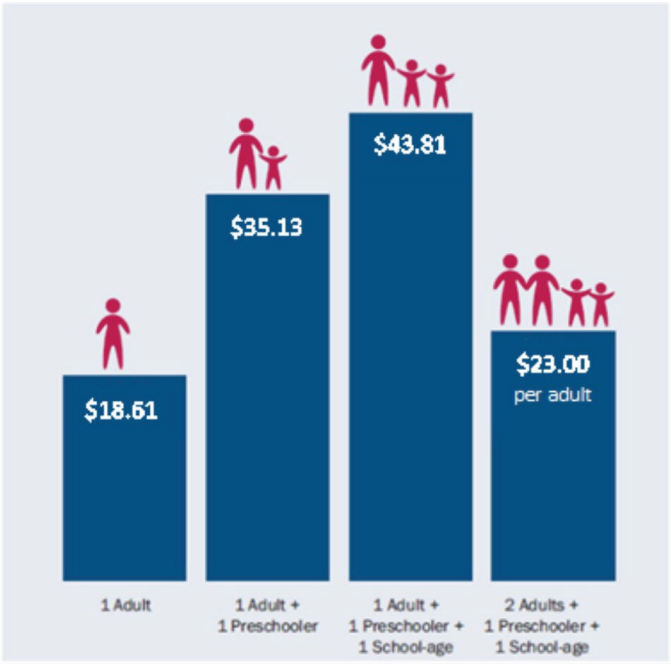


Source: US Census Bureau, American Community Survey, 2015-19.

INCOME

Montgomery County is an affluent community in aggregate. The median household income is $111,812 compared to the statewide median household income of $87,063. However, 45% of households earn less than $100,000 in a community where the self-sufficiency standard for a family of four (income needed to meet basic needs without public subsidies or private/informal assistance) requires an annual income of $99,756. A single parent with one infant would need to make $77,215, and one adult living in Montgomery County would need to make $39,303—or $18.61 per hour, $3.61 more than the Minimum Wage of $15.65 per hour (see Figure 56). In Prince George's County, the median household income is $86,994, slightly lower than the state, and 40.4% of households earn less than $75,000 in a community with a self-sufficiency standard of $79,712 for a family of four. A single parent with one infant would need to make $62,890, and one adult would need to make $34,458—or $16.32 per hour (University of Washington Center for Women's Welfare, 2019).

Figure 56 Hourly Wage to be Self-Sufficient in Montgomery County by Family Type



Source: Self-Sufficiency Standard Montgomery County, Maryland

LABOR/WORKFORCE

The health and well-being of the U.S. workforce is central to the strength of the economy (DHHS, 2022). A strong, healthy workforce is needed for the delivery of high-quality goods and services and can be impacted by recessions and a large number of people entering or leaving the workforce, for example, women joining the workforce or baby boomers retiring.

In 2021, there were 161 million people in the workforce, down from 165 million people in 2019 (US Bureau of Labor Statistics, 2022) and over half of the workforce are men. The total workforce consists of the number of people who are currently employed plus the number of people who are unemployed and seeking employment. The workforce does not include individuals who have left the workforce, such as retirees or the discouraged jobless who have been able to find employment and are no longer looking for work.

Unemployment

A key indicator of the local economy is the unemployment rate. Unemployment occurs when local businesses cannot supply enough jobs for local employees or when the labor force cannot supply appropriate skills to employers (Healthy Communities Institute, 2019). During periods of unemployment, individuals are likely to experience severe economic strain and mental stress. Unemployment is also related to access to health care, as many individuals receive health insurance through their employer. A high unemployment rate strains financial support systems as unemployed persons qualify for unemployment benefits and food stamp programs.

In 2020, the coronavirus pandemic set record highs for unemployment rates across the country. However, the pandemic affected some communities more than others. For instance, immigrants, young adults, those with less education, and low-wage workers saw higher rates of unemployment during the pandemic. Women also saw a disproportionate rate of unemployment when compared to men (U.S. Bureau of Labor Statistics, 2022). In the first year of the pandemic, women accounted for 54% of unemployment rates even though they make up less than half of the U.S. workforce. However, disparities cannot only be seen between sexes, but also between race/ethnicity. Hispanic and Black women accounted for 46% of the unemployment rate for women but represent less than one-third of the female US labor force, collectively.

The global pandemic and its effect on local businesses caused a rise in the unemployment across rates in both counties. Montgomery County's rate went from 2.9% in 2019 to 6.2% in 2020, and 5.5% in 2021. In Prince George's County, the rate rose from 3.7% in 2019 to 8.0% in 2020 and 7.5% in 2021 (Maryland, 2022). In February 2022, the unemployment rate was 4.2% within the MCHC CBSA, 3.9% in Montgomery County, 5.3% in Prince George's County, and 4.4% for the state (U.S. Bureau of Labor Statistics, 2022); showing improvement from what was reported in previous years.

Labor Shortages

The pandemic not only caused a disruption in the unemployment rate, but also in the number of people leaving employment—also known as the Great Resignation. In 2021, more than 47 million workers quit their jobs. Many participants of the Great Resignation were in search of a better

work-life balance, more pay, or a strong company culture (Kochhar and Bennett, 2021). As a result of the Great Resignation, 7.6% of Maryland's jobs, or about 220,000 positions, are currently unfilled. In general, due to the availability of jobs at many federal agencies and contractors, Maryland generally enjoys low unemployment compared to the U.S. In November of 2021, Maryland had fewer than 169,000 unemployed persons, making it difficult to fill the 220,000 vacant positions (Fritz, 2022).

Maryland hospitals have been particularly affected by the nursing shortages that were exacerbated during the Great Resignation. The 2022 State of Maryland's Health Care Workforce Report (MHA, 2022) found that one of every four nursing positions is vacant. Maryland is currently short 5,000 full-time registered nurses and 4,000 licensed practical nurses with the most populated areas, like Montgomery and Prince George's Counties, experiencing the highest vacancy rates. According to the report, hospitals could see numbers two to three times higher than current shortages if a solution is not found to attract and maintain nurses in the field.

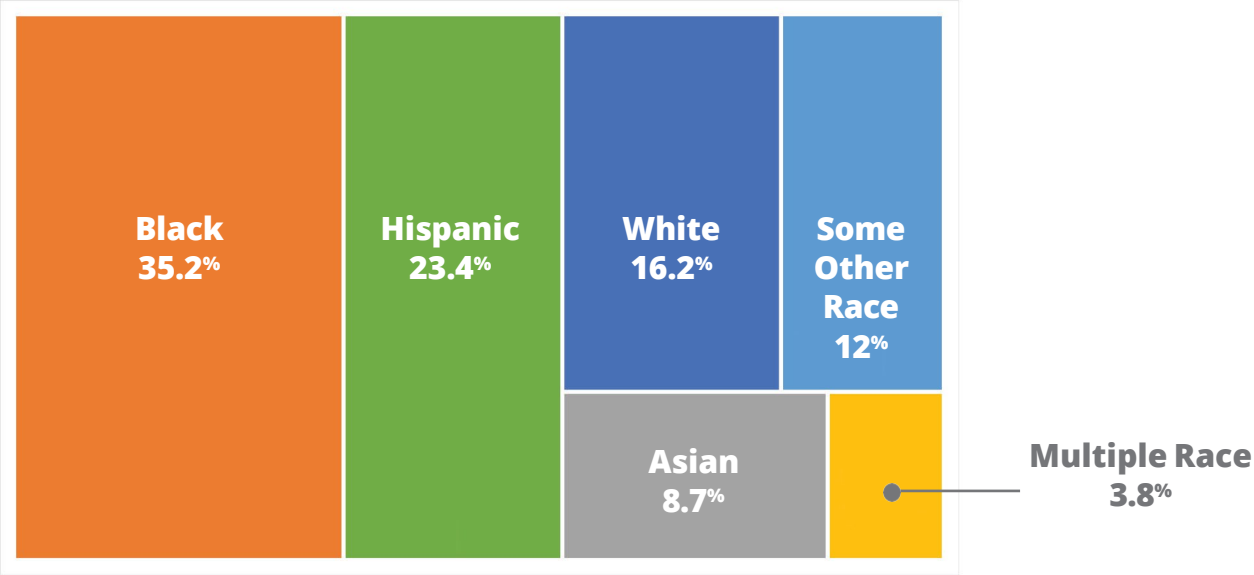
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

According to the Center on Budget and Policy Priorities, in 2019, one in nine people in the U.S. have used the Supplemental Nutrition Assistance Program (SNAP or food stamps), the nation's largest nutrition assistance program. SNAP recipients receive funds monthly, which are loaded on an electronic benefit transfer card that they can use to purchase food and beverages from participating retailers. SNAP benefits vary depending on the need of the participant, but the average Maryland SNAP benefit for each member of a household was $128 per month in fiscal year 2019 (or $1.29 per meal per person). In Maryland, 10% of the state's population receive SNAP benefits, with more than 62% of SNAP participants being families with children, almost 38% are families with members who are elderly or disabled, and more than 34% are in working families (Hall & Nchako, 2022).

SNAP has been proven effective in helping low-income households buy food, reducing food insecurity by 30%, reducing child poverty by 28%, creating economic activity (every $1 in SNAP, generates $1.80 in economic growth), and reducing health care costs. However, the program is underutilized due to stigma, immigration fears, lack of information/misinformation about eligibility, lack of knowledge about how to apply, the lengthy application process, frequent recertification requirements, and low benefit amount.

In the MCHC CBSA, an estimated 29,164 (6.7%) households receive SNAP benefits, with Black or African Americans and Hispanic/Latino households making up the highest populations to receive SNAP benefits (see Figure 57).

Figure 57 Households Receiving SNAP Benefits by Race/Ethnicity by MCHC CBSA, Total



Notes: U.S. Census Bureau, American Community Survey Office, 2020.

Underutilization is not only limited to SNAP use. The Capital Area Food Bank Hunger Report 2021 also notes that food insecure individuals exhibited low engagement with public benefits and social services. Of the nearly 2,000 Greater Washington Area residents surveyed, only 23% of local households that the United States Department of Agriculture (USDA) would classify as food insecure receive SNAP, and 15% receive free and reduced-price school meals. These numbers shift from state to state in the region, with DC households reporting the highest rates of SNAP enrollment. Nearly 1 in 5 households surveyed are not receiving any government benefits, with the highest reasons being they do not believe themselves to be eligible, are unaware of food assistance programs, and do not understand the application process.

A closer look at local government benefits utilization patterns shows higher utilization rates in Black and White households compared to Asian and Hispanic households. One potential reason for this trend is the higher percentage of immigrants in Asian and Hispanic households, who may either not qualify for these programs or experience barriers of risk, low trust, or low awareness of government agencies. When considering the fast growth rates among Asian and Latino populations, these trends of low utilization strongly suggest prioritizing support and outreach to these groups. It is estimated that 28% of Montgomery County residents and 34% of Prince George's County residents are food insecure and ineligible for state or federal nutrition assistance (Feeding America, 2017).

Nationally, about 4.8 million older adults (aged 60+) are enrolled in SNAP. Yet this figure represents less than half of the eligible population; approximately three out of five seniors who qualify to receive SNAP are missing out on benefits—an estimated 5 million people in all (McGovern, 2021). Older adults may not be aware that they are eligible, or may feel stigma about receiving food assistance, putting this group at increased risk of food insecurity, and having harmful impacts on their health and well-being.

The Benefits Data Trust 2017 study examined the association between both hospital and nursing home utilization. Researchers studied 54,000 Maryland seniors on Medicaid and Medicare (dual eligible). Individual-level medical claims data were cross-matched against the SNAP enrollment data and used to analyze the impact of receiving the benefit on health care utilization and costs. The study found that:

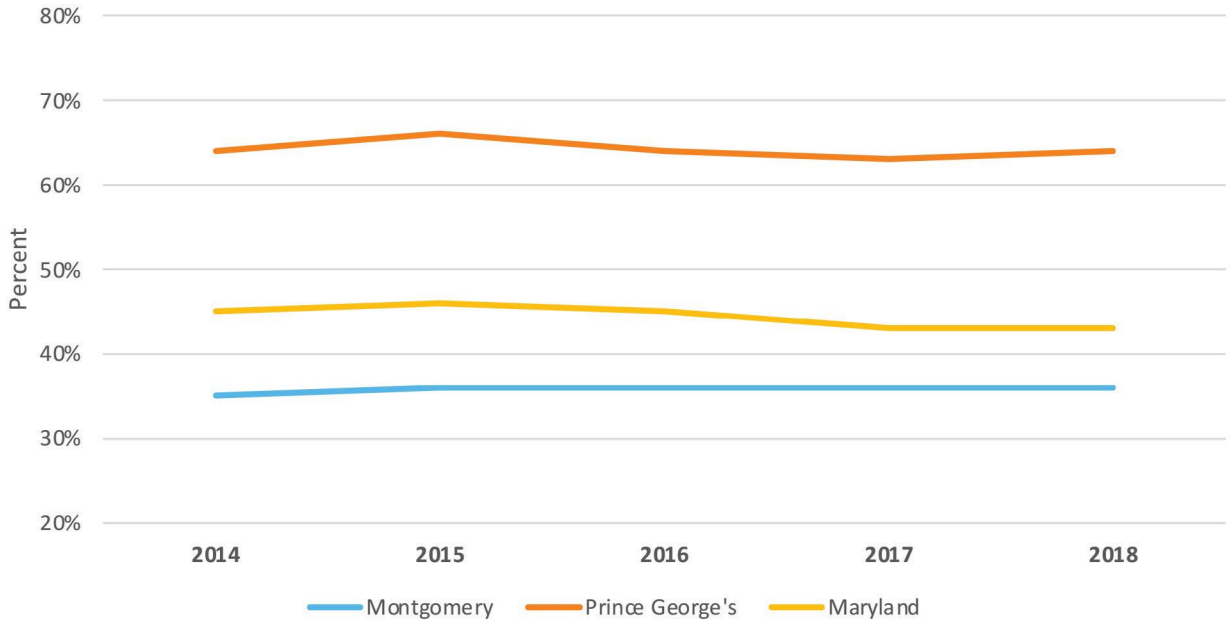
- Although they qualify, 49 percent of seniors on Medicaid are not enrolled in SNAP.
- The average annual income for an older dual eligible was just $5,860.
- Access to SNAP reduces a senior's likelihood of admission into a hospital by 14% and a nursing home by 23%.
- Every $10 increase in monthly SNAP benefits further reduced the odds of additional days in the hospital and shortened nursing home length of stay.
- Increased access to SNAP delivers $2,100 in annual health care savings per senior enrolled.

CHILDREN ELIGIBLE FOR FREE AND REDUCED-PRICE MEAL PROGRAMS (FARMS)

Federal child nutrition programs—including the National School Lunch Program, the School Breakfast Program, and the summer meals programs—together form the nation's second-largest nutrition-assistance effort. These programs ensure that millions of American schoolchildren are eating healthy meals on a regular basis. The child nutrition programs are federally funded and operate in public and private schools, daycare centers, after-school programs, and residential child-care centers. Even when schools closed due to the pandemic nationwide, the School Lunch Program alone served 3.2 billion meals in FY 2020, with an average of 22.4 million children participating in the program. For millions of children, child nutrition programs help address food insecurity, an important social determinant of health. With school closures limiting access to these programs, many families were at increased risk of lacking consistent access to nutritious food.

The number of children and youth eligible for free/reduced-price meals at public schools typically reflects the income and poverty levels of the surrounding neighborhoods, with nearly 47% of all Maryland students receiving free and reduced school meals. In Montgomery County during the 2021-2022 school year, 51,944 students received free lunch, and 11,020 students received reduced-price lunch. Nearly 40% of the county's student population is enrolled in the free/reduced-price meal program. In Prince George's County, 71,151 students are enrolled in free lunch, and 8,436 students are enrolled in reduced-price lunch. Nearly 67% of the county's student population is enrolled in free/reduced-price lunches. The percentage of Montgomery County students receiving free and reduced meals has been historically lower than the state average. Conversely, the percentage of Prince George's County students has remained higher than the state average (see Figure 58).

Figure 58 Percent of Students Receiving Free & Reduced School Meals (2014-2018)



Source: Maryland Center on Economic Progress.

HOUSING AND TRANSIT

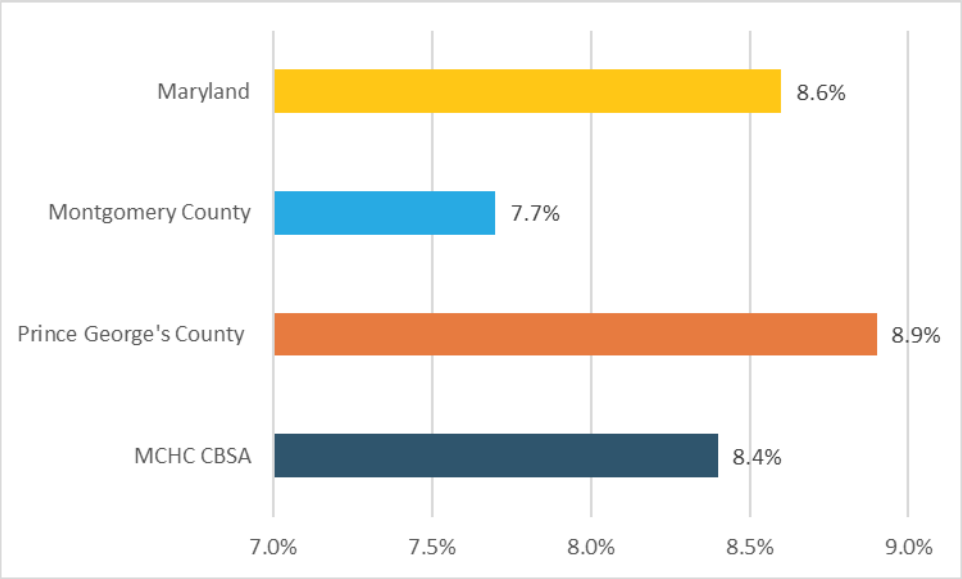
TRANSPORTATION

Transportation plays an integral part in accessing health care and other resources that promote healthy living, such as parks and recreation facilities; Therefore, barriers to transportation limit this access and can have a negative effect on health. Montgomery and Prince George's Counties have a vast network of public transportation options that range from metro rail, bus and train transport, including subsidized services for seniors and people with disabilities. However, ridership dictates the number and location of stops, leaving many residents in less populated areas with limited access to county services and resources. A lack of reliable and safe transportation remains a burden for many residents in Montgomery and Prince George's Counties, especially for seniors, people with disabilities, and people with limited income. Transportation burdens include the need to travel long distances, lack of a vehicle, transportation costs, and inadequate infrastructure. A lack of transportation also causes barriers in accessing medical health appointments, obtaining routine care as well as filling prescriptions.

Since vehicle ownership is directly related to the ability to travel, it creates a disparity between vehicle owners and those who do not own their own vehicles. In general, people living in a household without a vehicle make fewer than half the number of needed trips compared to those with a vehicle. This limits their access to essential local services such as supermarkets, post offices, doctors' offices, and hospitals. Most households with above-average incomes own a vehicle, while only half of low-income households own a vehicle. According to the 2015-2019 American

Community Survey, 9.0% of Maryland residents reported not having a motor vehicle. On a county level, 7.7% of residents in Montgomery County and 8.9% of residents in Prince George's County do not have access to a motor vehicle and must rely on public transportation or walking in high traffic areas (see Figure 59).

Figure 59 Percent of Households with No Motor Vehicle (2015-2019)



Source: American Community Survey 2015-2019, US. Census.

However, transportation programming that does exist has inome or geographic requirements or are available to older adults or those with a disability. Some examples of transportation resources in Montgomery and Prince George's counties include county government resources such as Call-N-Ride, Same-Day Access, Ride on Programs as well as MetroAccess, a reduced fare program specific to the Washington Metropolitan Area. In addition, there are services offered by nonprofit organizations such as Villages, Village Rides, Connect-A-Ride, and Senior Rides. However, there remains a gap for reliable transportation services to youth, young adults, adults with children as well as working adults.

Those with access to public transit may take up to twice as long to reach the destination than it would with access to a private vehicle, with trips taking longer in areas with infrequent transit service. In some cases, the time it takes to get to and from the transit stop can exceed the overall expected trip time. The extra planning time, and time constraints can serve as an added barrier to those needing to utilize public transportation. In the MCHC CBSA, 15.3% of the population uses public transit to commute to work.

HOUSING

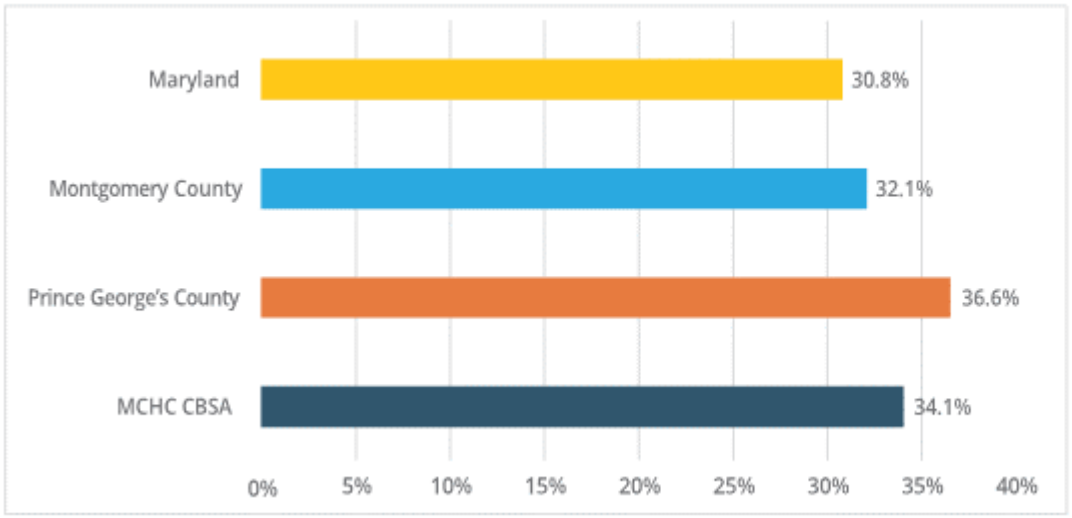
The home environment, which consists of living conditions and surrounding neighborhoods, has an impact on health status. Substandard neighborhoods and living conditions such as overcrowding, have been linked to poor health outcomes and can lead to an increased risk of cardiovascular disease, mental health issues, and unfavorable birth outcomes. Unfortunately, in many communities, there are persistent barriers to health and opportunity to thrive. Where one

resides can determine how long or how well one lives, and those in substandard neighborhoods lack access to healthy foods, quality schools, stable housing, good jobs with fair pay, and safe places to exercise and play.

Quality housing is an important determinant to overall health and wellbeing. However, many individuals experience several housing issues such as a high-cost burden, one or more substandard living conditions as well as overcrowding which furthers the risk of other health challenges. The high cost of living affects residents' access to safe, healthy housing. Paying a high rent can create a financial hardship, especially for those with a limited income, leaving little money for other expenses such as food, transportation, medical services, and savings. A housing cost burden is defined as the percentage of households (homeowners and renters) where housing costs are 30% or more of the total household income.

Collectively in the MCHC CBSA, which encompasses 435,433 total households, 146,834 or 33.7% of the population live in a cost-burdened home (US Census Bureau, 2020). Most recently, 31.4% of Maryland residents experience high housing costs; however, in Montgomery County, 32.1% of people live in homes that exceed 30% of their income, while 36.7% of Prince George's County residents experience housing cost burden (see Figure 60). The Healthy People 2030 national health target is to reduce the proportion of families that spend more than 30% of income on housing to 25.5%.

Figure 60 Housing Cost Burden 30% (2015-2019)



Source: American Community Survey, US Census Bureau, 2022.

SEVERE HOUSING COST BURDEN

Housing cost burden not only measures housing affordability but the data also aids in the development of programs to meet the needs of people at different economic levels, such as those with severe housing cost burden who spend more than 50% of their income on housing expenses. Spending a high percentage of household income on housing can create financial hardship, especially for lower-income homeowners. With a limited income, high monthly housing costs may not leave enough money for other expenses, such as food, transportation, and medical care.

The Housing and Urban Development's (HUD) Housing Choice Voucher Program provides very low-income families, the elderly, and the disabled housing vouchers for safe, sanitary, private market housing that they otherwise would not be able to afford. 95680

In Maryland, to be eligible for HUD, a family of four needs to make less than $68,000 per year, 71% of the self-sufficiency rate for the same size family and 60% of the median income of Montgomery County.

SEVERE HOUSING PROBLEMS/SUBSTANDARD HOUSING

Housing units where the quality of living or housing conditions are considered substandard is another challenge that can contribute to poor health outcomes. This can include households with at least 1 of the 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. Residents who do not have a complete kitchen (a sink with a faucet, a stove or range, or a refrigerator) in their home are more likely to depend on unhealthy convenience foods. A lack of plumbing facilities, such as hot and cold running water, a flush toilet, or a bathtub or shower, increases the risk of infectious disease. Research has found that young children who live in crowded housing conditions are at increased risk of food insecurity, which may impede their academic performance. In areas where housing costs are high, low-income residents may be forced into substandard living conditions with an increased exposure to mold and mildew growth, pest infestation, and lead or other environmental hazards.

According to the American Community Survey (2015-2019), Maryland has 31.5% of housing units that have one or more substandard conditions (US Census Bureau, n.d.). In the MCHC CBSA, 34.7% of housing units meet the criteria for substandard housing (32.5% in Montgomery County and 37.8% in Prince George's County).

Overcrowding, or units with more than one occupant per room, goes hand-in-hand with low-paying essential jobs. People forced by poverty into overcrowded homes are much more likely to be people of color, due to historic patterns of discriminatory housing, education and banking policies that segregated neighborhoods and made it more difficult for Non-White families to amass wealth.

Overcrowding has been associated with increased communicable disease transmission and increased accidents. In the age of COVID-19, people of color also are more likely to live in overcrowded households and suffer chronic conditions, such as diabetes or high blood pressure, that can worsen COVID-19 outcomes. The average household size is measured by dividing the number of persons in households by the number of households. Collectively in Maryland, there are on average 2.67 members living in one household. However, there is a slightly higher average in Montgomery County with 2.76 people per household and 2.86 average household size in Prince George's County. In the MCHC CBSA, 7.5% of housing units are overcrowded. In Prince George's County, 22% of housing units are considered overcrowded, compared to 5.4% of housing units in Montgomery County (US Census Bureau, n.d.).

BROADBAND ACCESS

The 21st century has placed an ever-increasing reliance on internet access. The County Health Rankings & Roadmaps measures broadband access as the percentage of households with broadband internet connection. This indicator is important because access to reliable, high-speed broadband internet improves access to education, employment, and health care opportunities and is associated with increased economic development.

Researchers at the University of Chicago found that one of the factors most consistently associated with a high risk of death due to COVID-19 in the U.S. was the lack of internet access, whether broadband, dial-up, or cellular (Paykin, Halpern, Martinez-Cardoso, & Kolak, 2022). This was regardless of other demographic risk factors like socioeconomic status, education, age, disability, rent burden, health insurance coverage, or immigration status. The study authors estimated that for every additional 1 percent of residents in a county who have internet access, between 2.4 and six deaths per 100,000 people could be prevented, depending on the makeup of the region. The findings held more surprises. The trend held true not just in rural areas with sparse internet access, but also in urban areas, where most homes can be wired for broadband internet. That is, residents living in areas where internet access is available, but unable to be accessed, are also at increased risk of dying from COVID-19. The COVID-19 pandemic has revealed that the ability to get online might be a matter of life or death.

More than a quarter of Americans still don't have home broadband internet, and the proportion without access is twice as high for those without any college education and those who earn less than $30,000 a year. These inequities were not created by chance. In the U.S., private internet service providers developed the infrastructure for broadband internet access where it was profitable. Consequently, many of the country's most marginalized communities have the fewest, most expensive, and lowest-quality choices when it comes to an internet service provider. Having broadband internet access means having access to education and financial stability, which on their own contribute to our well-being. Broadband internet performs as a gateway to information and services, and the Federal Communications Commission (FCC) is now framing broadband internet access as a "super" determinant of health. In December of 2020, the FCC reported that broadband access has remained extremely high in Montgomery County (99%) and Prince George's County (97.7%), including the MCHC CBSA (99.3%).

SECTION 4.

HEALTH BEHAVIORS

The County Health Rankings & Roadmaps states that health behaviors are actions individuals take that affect their health. They include actions that lead to improved health, such as eating well and being physically active, and actions that increase one's risk of disease, such as tobacco use, excessive alcohol intake, and risky sexual behavior.

Many of the leading causes of death and disease are attributed to unhealthy behaviors. For example, poor nutrition and low levels of physical activity are associated with higher risk of cardiovascular disease, type 2 diabetes, and obesity. Tobacco use is associated with heart disease, cancer, and poor pregnancy outcomes if the mother smokes during pregnancy. Excessive alcohol use is associated with injuries, certain types of cancers, and cirrhosis.

It is important to consider that not everyone has the means and opportunity to make healthy decisions. Policies and programs put in place have marginalized some population groups and communities, keeping them from the support and resources necessary to thrive. Addressing health behaviors requires strategies to encourage individuals to engage in healthy behaviors, as well as ensuring that they can access nutritious foods, safe spaces to be physically active, and support to make healthy choices.

TOBACCO USE

Tobacco use is the leading cause of preventable death and disease in the United States, killing more than 480,000 people each year. Nearly 40 million U.S. adults smoke cigarettes, and about 4.7 million middle and high school students use at least one type of tobacco product, e-cigarettes included. Almost 30% of all cancer deaths in the United States are linked to smoking. Approximately 90% and 80% of lung cancer deaths among men and women, respectively, are due to smoking. Lung and bronchus cancers are the leading causes of cancer deaths in Maryland among both men and women. Maryland's Black or African American adults die from lung and bronchus cancer at the same rates as White adults even though they have lower smoking rates. This difference may be attributed to high menthol cigarette use and limited access to care in African American communities (Mattingly et al., n.d.).

The Healthy People 2030 national health target is to reduce current cigarette smoking in adults to 5.0%. In addition to the direct damage to health, tobacco use also causes a major financial burden on the nation. Smoking costs the U.S. billions each year, with the total annual economic cost of smoking being more than $300 billion, including more than $225 billion in direct medical care for adults and more than $156 billion in lost productivity due to premature death and exposure to secondhand smoke (U.S. Department of Health and Human Services, 2014).

Both Montgomery and Prince George's Counties have lower rates of tobacco use when compared to the state and national rates. About 9% of Montgomery County adults and more than 13% of Prince George's County adults report smoking at least 100 cigarettes in a lifetime and are current smokers.

Per the CDC, cigarette smoking is responsible for more than 480,000 deaths per year in the United States, including more than 41,000 deaths resulting from secondhand smoke exposure. This is about one in five deaths annually, or 1,300 deaths every day.

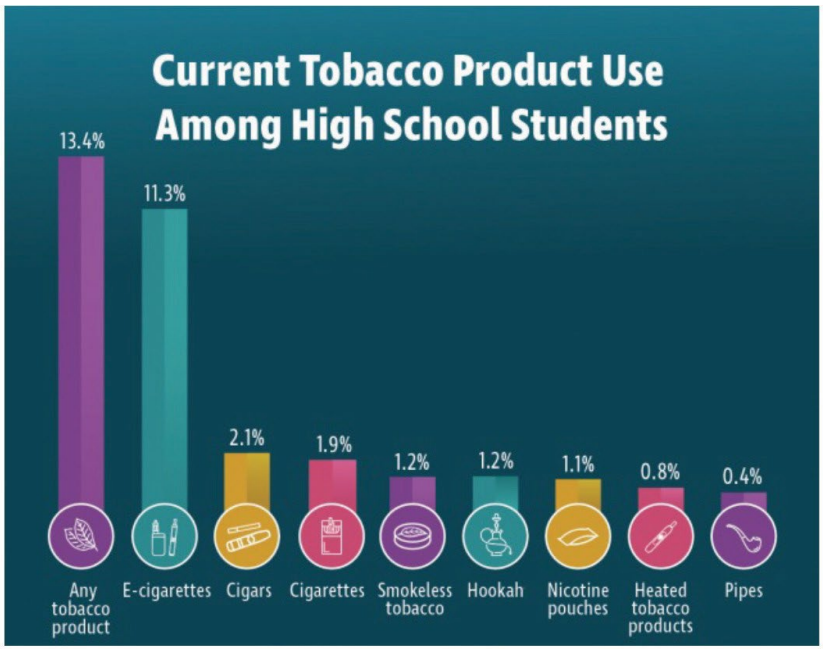
YOUTH SMOKING

The CDC estimates that 9 out of 10 adults who smoke cigarettes daily first try smoking by the age of 18, and 99% first try by age 26. Each day in the U.S., about 1,600 youth smoke their first cigarette, and nearly 200 youth become regular, daily smokers. If smoking among U.S. youth continues at the current rate, 5.6 million of U.S. youth are expected to die prematurely from a smoking-related illness. This represents about 1 in every 13 Americans aged 17 years or younger

who are alive today. In 2019, the state of Maryland joined 17 other states and the District of Columbia to pass Tobacco 21, a law that increases the minimum legal sale age for any tobacco product to 21. The law is intended to cut down on the access that teenagers have to cigarettes and other tobacco and nicotine products, including e-cigarettes.

Use of cigarettes and cigars decreased significantly among youth from 2000 to 2018, but electronic smoking device (ESD) use increased dramatically, causing a reversal of the nearly 20 years of progress (Mattingly et al, n.d.). Many youths are unaware of the potentially serious side effects of electronic vapor products such as e-cigarettes, vapes, electronic nicotine delivery systems, and similar devices. These devices typically deliver nicotine, flavorings, and other additives to users through an inhaled aerosol. Electronic vapor products are usually flavored and are of particular concern due to

Figure 61 Current Tobacco Product Use Among High School Students (2021)



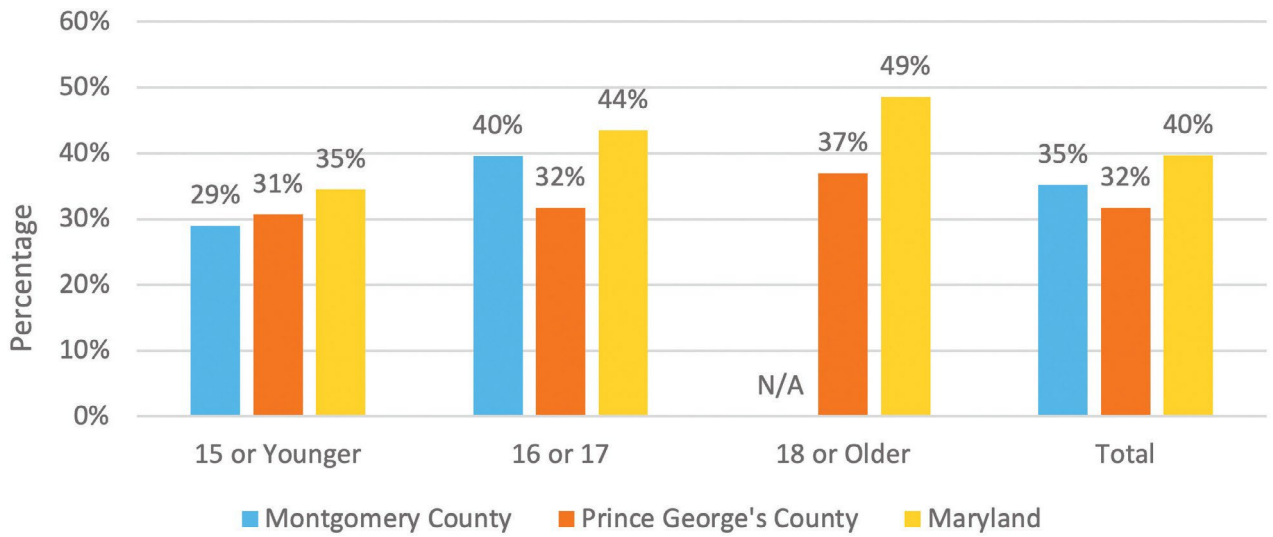
Source: Centers for Disease Control and Prevention, 2022.

their high nicotine content and nicotine's harmful effects on the developing adolescent brain. Additionally, the aerosol emissions can contain heavy metals such as nickel, lead and tin, and flavoring such as diacetyl, a chemical linked with lung disease.

Flavored tobacco products are more appealing to youth. In 2021, 80.2% of high school students and 74.6% of middle school students in the U.S. who used tobacco products in the past 30 days reported using a flavored tobacco product during that time. Also, in 2021, 85.8% of high school students and 79.2% of middle school students in the U.S. who used e-cigarettes in the past 30 days reported using a flavored e-cigarette during that time (CDC, 2022f).

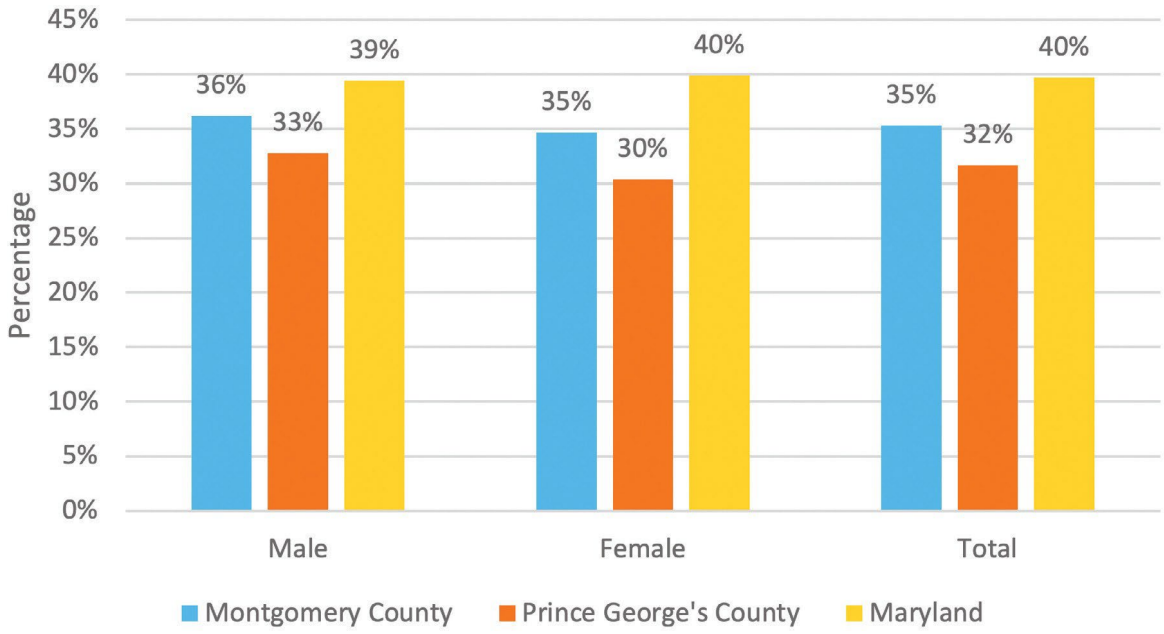
Figures 62 and 63 depict the popularity of e-cigarettes among high school students. The percentage of high school students aged 16 or 17 reporting ever using electronic vapor products between 2018-2019, was higher in Montgomery County than in Prince George's County. Males in Montgomery County and Prince George's County and females in Maryland have higher rates of high school students who have ever used electronic vapor products. Among high school students who ever used electronic vapor products, White students in Maryland and Montgomery County and Hispanic students in Prince George's County have the highest rates compared to any other race or ethnicity.

Figure 62: Percent of High School Students Who Ever Used Electronic Vapor Product by Age (2018-2019)



Source: Youth Risk Behavior Survey/Youth Tobacco Survey, Center for Chronic Disease Prevention and Control, 2021.

Figure 63 Percent of High School Students Who Ever Used Electronic Vapor Product by Gender (2018-2019)



Source: Youth Risk Behavior Survey/Youth Tobacco Survey, Center for Chronic Disease Prevention and Control, 2021.

DIET AND EXERCISE

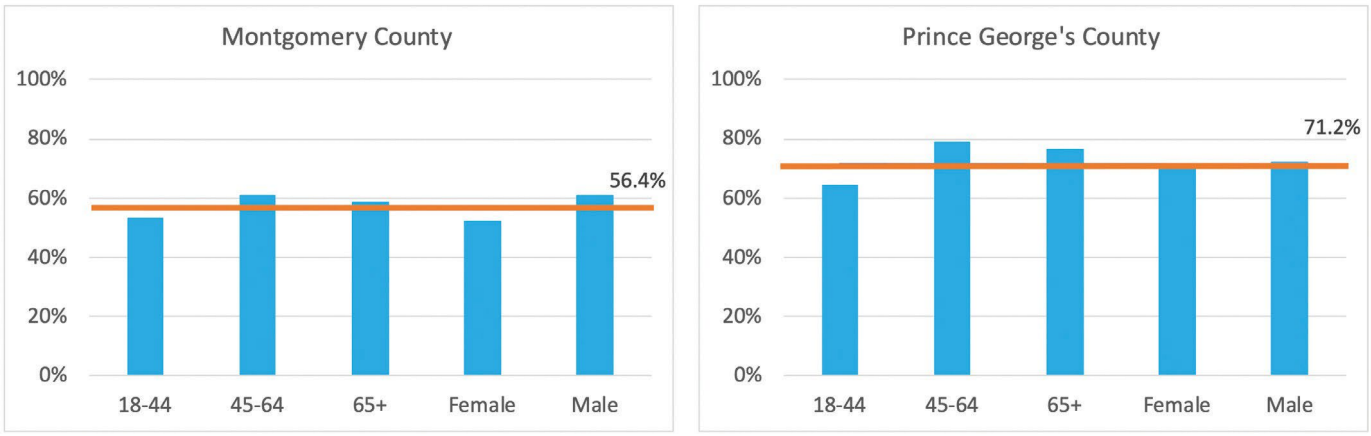
Obesity is an indicator of the overall health and lifestyle of a community. During the past twenty years, obesity rates have continually increased in the United States, doubling for adults and tripling for children. Obesity increases the risk of many diseases and health conditions, including heart disease, type 2 diabetes, cancer, hypertension, stroke, liver and gallbladder disease, respiratory problems, and osteoarthritis. An adult is classified as obese if their Body Mass Index

(BMI) is 30.0 and greater or overweight if the BMI is 25.0 to 29.9. The Healthy People 2030 national health target is to reduce the proportion of adults aged 20 and older who are obese to 36%. The 2019 Behavioral Risk Factor Surveillance System estimates that 30% of the US adult population is obese.

ADULT OBESITY

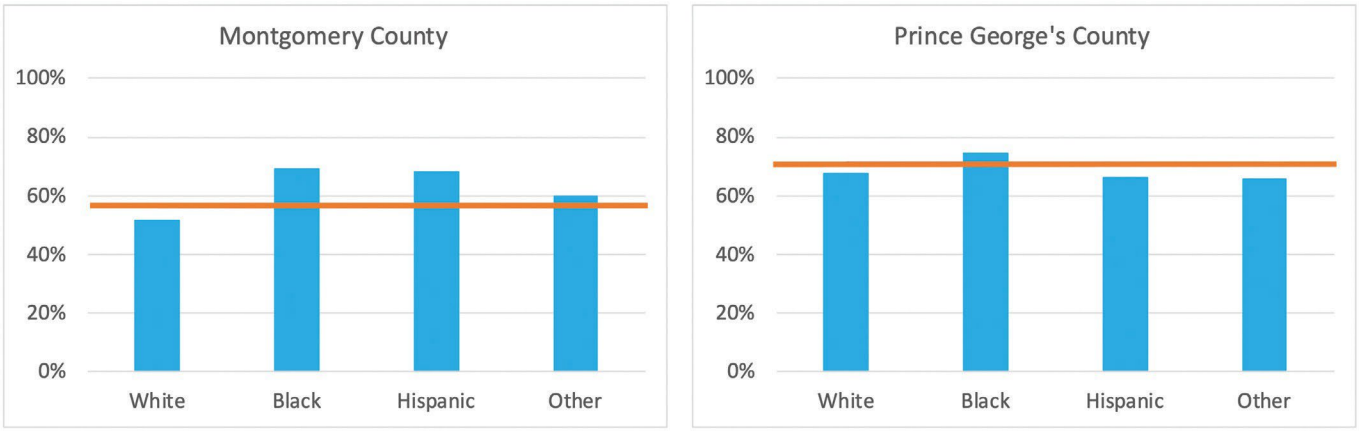
The rates of adults who are either obese or overweight in the state of Maryland are also concerning. In Maryland and the MCHC CBSA, 32.1% and 31.1% of adults age 18 and older are considered obese, respectively. In comparison, 56.4% of Montgomery County residents and 71.2% of Prince George's County residents are overweight or obese. Obesity affects all populations, regardless of age, sex, race, ethnicity, and socioeconomic status; however, disparities do exist (see Figures 64 and 65).

Figure 64 Percent of Adults Who are Overweight or Obese by Age and Gender (2019)



Source: Behavioral Risk Factor Surveillance System, Maryland Department of Health, 2019.

Figure 65 Percent of Adults Who are Overweight or Obese by Race and Ethnicity (2019)



Source: Behavioral Risk Factor Surveillance System, Maryland Department of Health, 2019.

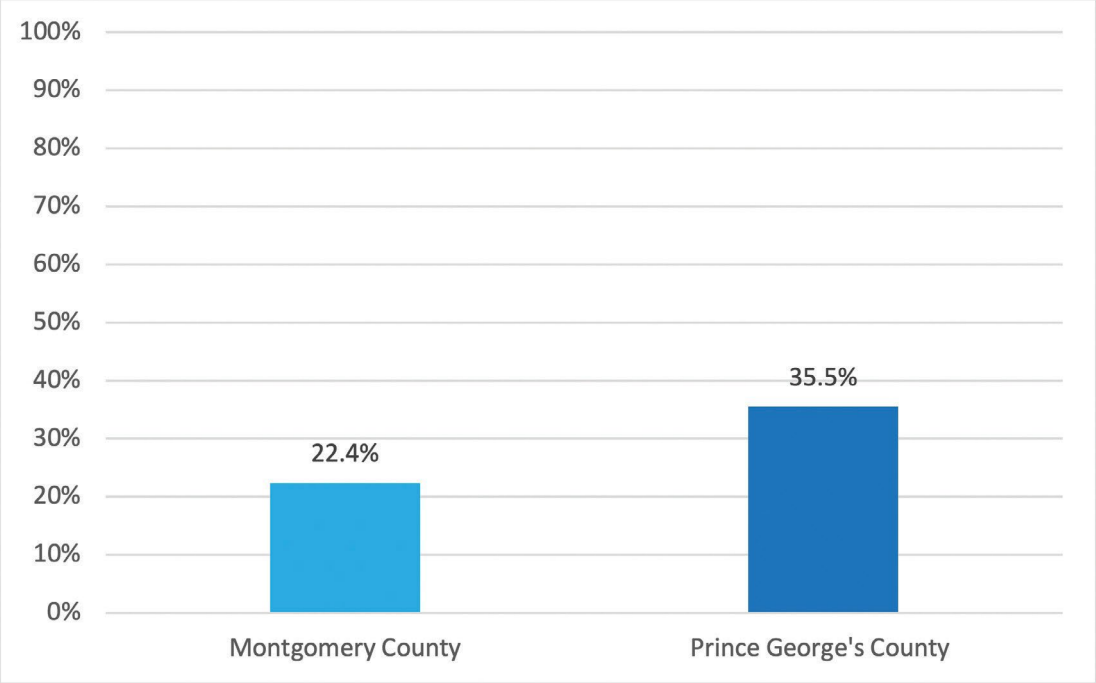
An important preventive tool to reduce obesity is the promotion of healthy eating and an active lifestyle. Eating a balanced diet and being physically active can help maintain a healthy weight and reduce risk factors associated with many chronic diseases, including cancer, diabetes and obesity. Unhealthy food intake and insufficient exercise have economic impacts for individuals and

communities. Current estimates for obesity-related health care costs in the U.S. range from $147 billion to nearly $210 billion annually, and productivity losses due to obesity-related job absenteeism cost an additional $4 billion each year (Levi et al., 2013). Inadequate physical activity results in $117 million annually in additional health care costs (CDC, 2020b).

ADOLESCENT/YOUTH OBESITY

Many children and adolescents in the United States are considered obese. In addition to being at a higher risk of diseases and health conditions in their youth (and more severe as adults), children with obesity are also more likely to be bullied and to have obesity as adults. Contributing factors to childhood obesity include dietary patterns, physical inactivity, genetics, medication use, and the physical and social environment. In Montgomery County, 22.4% of high school students are obese or overweight, and 35.5% of Prince George's County high school students are obese or overweight (see Figure 66). The Healthy People 2030 target is to reduce the proportion of children and adolescents with obesity to 15.5%.

Figure 66 Percent of Overall High School Students Who are Obese or Overweight (2018-2019)



Notes. Youth Behavior Risk Survey 2018-2019, Centers for Disease Control and Prevention, 2021.

OBESITY AND COVID-19 PANDEMIC

Emerging data suggest that one of the indirect effects of the pandemic was weight gain. National self-reported survey data showed weight gain was common across youth and adults. A survey conducted by the Harris Poll in 2021 found that 42% of adults in the United States reported undesired weight gain since the start of the pandemic. The average reported weight gain was 29 pounds (American Psychological Association, 2021). Younger adults ages 18 to 42 (Gen Z and Millennials), parents, essential workers, and Latinos were disproportionately likely to report weight gain (of any amount), while adults aged 25 to 42 (Millennials), essential workers, parents, men, and

Blacks reported the largest number of pounds gained (American Psychological Association, 2021b). Social determinants of health (SDOH) have always been connected with obesity, and COVID-19's interaction with SDOH has intensified certain effects on choices, behaviors, and health, including obesity. During the pandemic, the following factors influenced unhealthy weight gain:

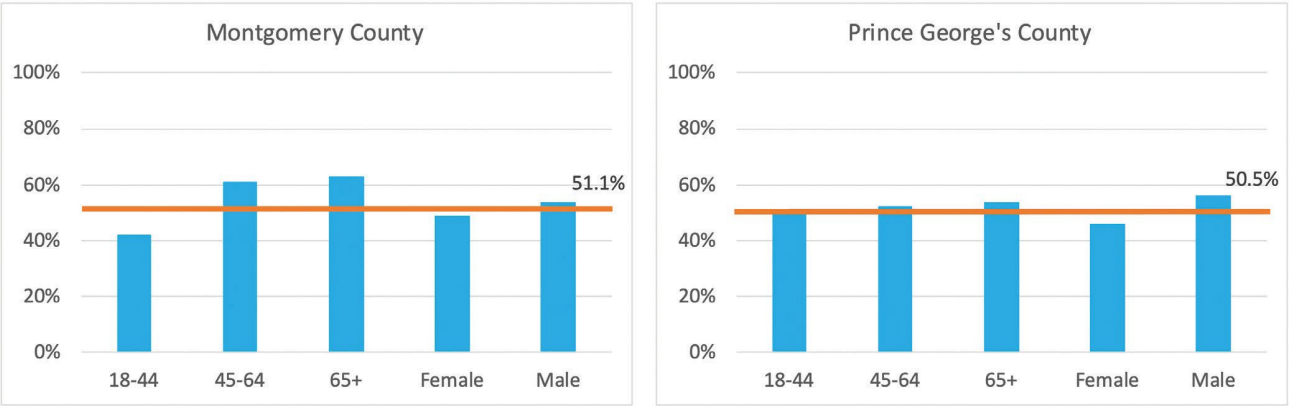
- Closing of farmer's markets reduced access to fresh produce
- Job loss/reduced hours meant a reduction in income to purchase healthy food
- Childcare and school closing reduced access to nutritious lunches for children
- Reduction in physical activity due to gyms, community centers, and recreation facility closures
- Increased sedentary behavior and work from home mandates reduced activity levels
- Increased stress levels due to mental distress and social isolation and subsequent "comfort eating" habits

PHYSICAL ACTIVITY

Similar to eating a balanced diet, regular physical activity reduces the risk of multiple chronic diseases and helps maintain a healthy weight and reduce body fat. Active individuals reduce their risk of many serious health conditions, including obesity, heart disease, diabetes, stroke, colon cancer, and high blood pressure. Physical activity also reduces symptoms of anxiety and depression, improves mood and feelings of well-being, and promotes healthy sleep patterns.

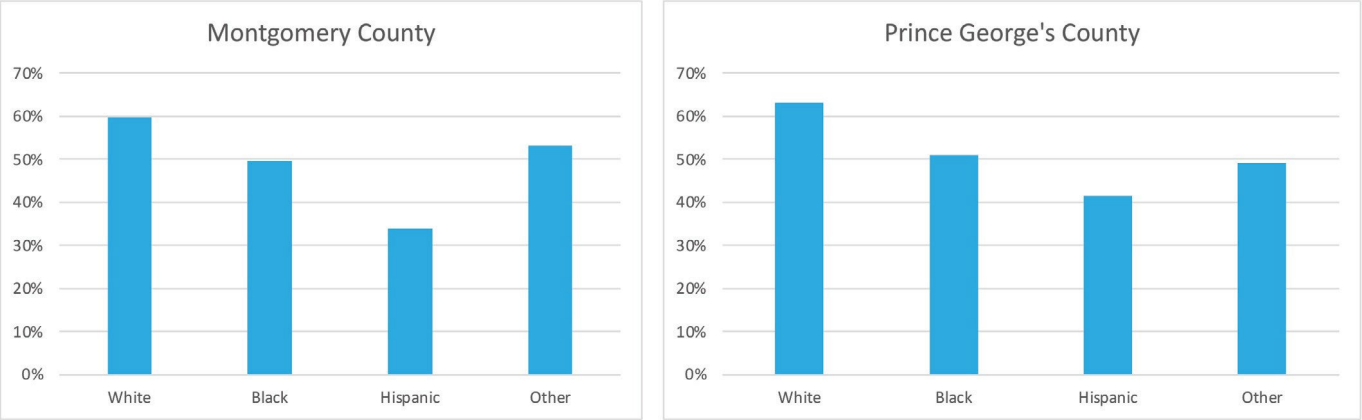
The American College of Sports Medicine (ACSM) recommends that active adults perform physical activity three to five times each week for 20 to 60 minutes at a time to improve cardiovascular fitness and body composition. Unfortunately, only 25% of adults or 1 in 5 adolescents in the United States engage in the recommended amount of physical activity (U.S. Department of Health and Human Services, 2018). However, the percentage of physically active adults in Montgomery County (51.1%) and Prince George's County (50.5%) is higher than the national average (see Figures 67 and 68).

Figure 67 Percent of Adults Who Participated in at Least 150 Minutes or 75 Minutes of Moderate or Vigorous Physical Activity by Age and Gender (2019)



Source: Behavioral Risk Factor Surveillance System, Maryland Department of Health, 2019.

Figure 68 Percent of Adults Who Participated in at Least 150 Minutes of Physical Activity or 75 Minutes of Moderate or Vigorous Physical Activity by Race and Ethnicity (2019)



Source: Behavioral Risk Factor Surveillance System, Maryland Department of Health, 2019.

Proximity to exercise opportunities, such as parks and recreation facilities, has been linked to an increase in physical activity among residents. The role of the built environment is important for encouraging physical activity. Individuals who live closer to sidewalks, parks, and gyms are more likely to exercise. One hundred percent (100%) of Montgomery County residents, and 98.3% of Prince George's County residents live reasonably close to a location for physical activity.

ADOLESCENT/YOUTH PHYSICAL ACTIVITY

Adolescents need at least 60 minutes of physical activity a day, including muscle-strengthening activities at least 3 days a week. Physical activity improves heart, muscle, bone, and mental health in adolescents. In Montgomery County, 45.9% of male high school students and 29.7% of female high school students were physically active at least five days of the past week. In Prince George's County, 29.6% of high school males and 18.9% of females were physically active at least five days of the past week (Maryland Department of Health, 2019).

OLDER ADULTS PHYSICAL ACTIVITY

Physical activity is an important activity for older adults. Regular activity can assist adults in maintaining or growing muscle strength needed for routine activities of daily living that are needed to remain independent. In addition, physical activity also decreases the risk for cardiovascular disease, stroke, diabetes, and some types of cancer. It has also been shown to improve mental, emotional, and psychological health as well as decrease isolation and improve social well-being (CDC, 2022). It is estimated that about 28% of older Americans aged 50 and older are inactive.

According to the Division of Nutrition, Physical Activity, and Obesity at the CDC, adults aged 65 and older need:

- At least 150 minutes a week (for example, 30 minutes a day, 5 days a week) of moderate intensity activity such as brisk walking. Or they need 75 minutes a week of vigorous-intensity activity such as hiking, jogging, or running.
- At least 2 days a week of activities that strengthen muscles.
- Activities to improve balance such as standing on one foot about 3 days a week.

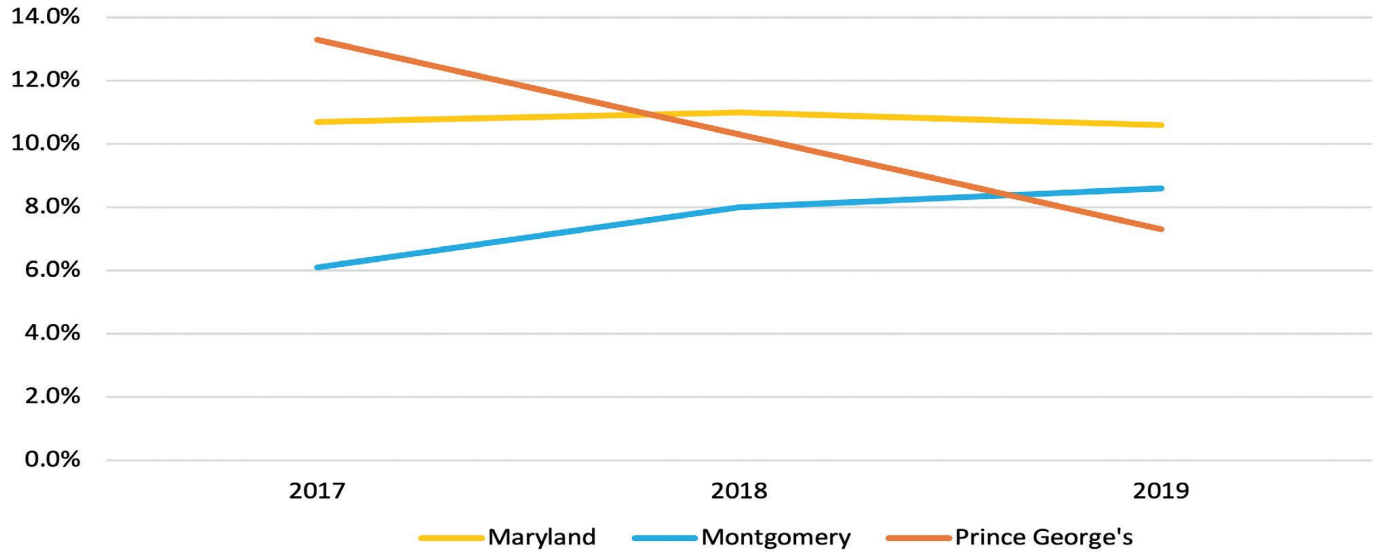
FOOD INSECURITY

Food insecurity is an economic and social indicator of the health of a community. The USDA defines food insecurity as a lack of consistent access to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Food insecurity can be temporary or long-term. Poverty and unemployment are frequently predictors of food insecurity in the United States, and hunger is a potential consequence. Any discussion of food insecurity must come with the acknowledgment that this issue does not exist in a vacuum. It has many contributing factors and is most often an indicator of other individual and societal barriers. At the root of most food insecurity is financial instability and its numerous related challenges—namely, the forced trade-offs between nutritious food and other necessities. Other common and interconnected issues include unemployment, low availability of affordable housing, race/ethnicity, disability status, social isolation, and transportation hurdles that make it difficult to travel to work or a distant grocery store.

The USDA Economic Research Service (2022) now divides food insecurity into the following two categories:

- Low food security: "Reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake." These food-insecure households obtained enough food to avoid substantially disrupting their eating patterns or reducing food intake by using a variety of coping strategies, such as eating less varied diets, participating in Federal food assistance programs, or getting food from community food pantries. Approximately 6.6% (8.6 million) of U.S. households had low food security in 2020.
- Very low food security: "Reports of multiple indications of disrupted eating patterns and reduced food intake." In these food-insecure households, normal eating patterns of one or more household members were disrupted and food intake was reduced at times during the year because they had insufficient money or other resources for food and affected 3.9 % (5.1 million) of U.S. households at some time during 2020.

Figure 69 Food Insecurity Rate (2017-2019)



Source: Feeding America, 2021.

Pre-pandemic data demonstrate a reduction in the food insecurity rate in Prince George's County compared to an increase in Montgomery County. However, both counties have rates that are lower than those for the state of Maryland of 10.6% (see Figure 69). Due to the pandemic, Feeding America (2021b) projects 2020 data to show drastic adjustments in the food insecurity rate. The report projects Montgomery County rates to increase to 11.1% and Prince George's County rates to increase to 10.3%. Nationally, food insecurity rates had been at their lowest in 20 years pre-pandemic (35.2 million). However, the current climate is likely to reverse those figures, with 2021 food insecurity rates estimated to hover around 42 million people.

Similar to other social determinants of health, food insecurity is also more prevalent in low-income communities. Communities of color, especially Black and Hispanic communities, experience hunger, poverty, and unemployment at much higher rates than White people. This is because of long-standing racial injustice that leads to barriers in education, employment, housing, and more. According to USDA data, 19.1% of Black households and 15.6% of Hispanic households experienced food insecurity in 2019. White Americans fell below the national average, with 7.9% experiencing food insecurity (Silva, 2020).

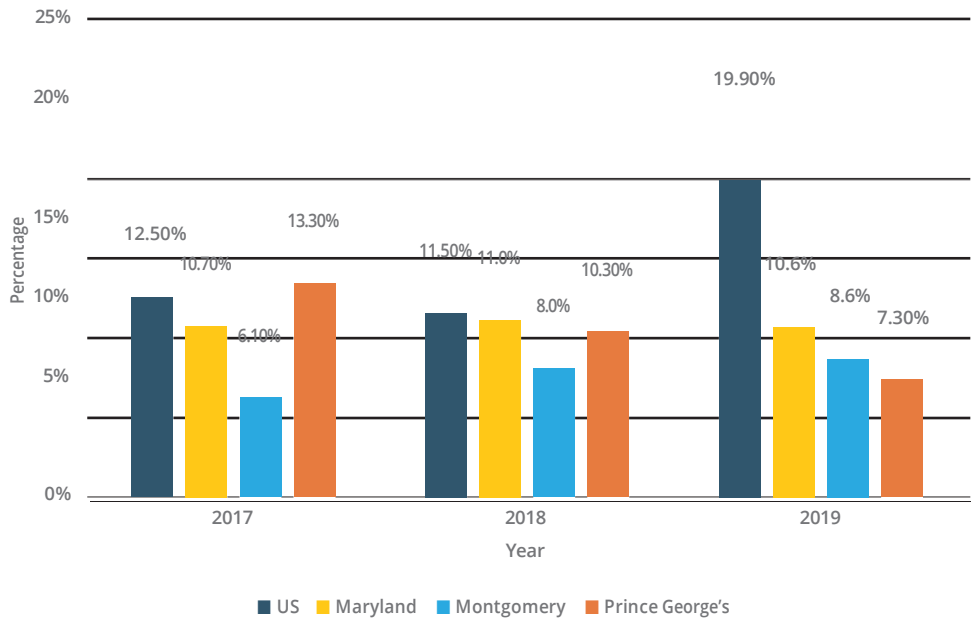
People living with a disability and people living with chronic conditions are more likely to experience hunger and lower incomes. Living with a disability or chronic condition may lead to higher medical costs, prevent people from working regularly, or simply make grocery shopping more difficult. Adults who have a disability and are not in the work force experience more than two times the rate of food insecurity as adults who do not have a disability. For those without a high school degree, the food insecurity rate is nearly 27%, in comparison to college graduates who have a food insecurity rate of 5%.

The Capital Area Food Bank (CAFB) Hunger Report 2021 notes that since the start of the pandemic, the data around persons in the U.S. who only become food insecure is staggering and has reached unprecedented levels. Across several socioeconomic dimensions, those who are newly food insecure are markedly different from those who were experiencing food insecurity before the pandemic. Those newer to food insecurity are more likely to be older adults, children, immigrants (e.g., Hispanic, West Africans and newly-arrived Afghans), single mothers, and grand-families or multigenerational households. They tend to be employed, live in larger households with more children, fall into more severe levels of food insecurity, and tend to be facing eviction. They are less likely to have a fluent English speaker in the household, know more than one place to access free food, and understand the process of applying for government benefits. The newly food insecure population is also far less likely to be receiving benefits from the public sector. The report suggests that even programs that were targeted to those most affected by the pandemic did not benefit the newly food insecure as much as it did those who were already food insecure, mainly due to those newer to food insecurity were more likely to say they did not believe they were eligible. The overrepresentation of Hispanics among the newly food insecure can be explained in part by the concentration of Latino laborers in industries that were hit particularly hard by the pandemic. Latinos exhibited higher rates of lost full-time employment and reduced hours at work due to the pandemic.

CHILDHOOD FOOD INSECURITY

Food insecurity has the potential to be harmful to individuals of any age, but it can be especially devastating to children. Food insecure children are at an increased risk of obesity and linked to childhood developmental problems, mental health issues, and poorer school performance. Health consequences among food insecure children include increased illness and higher associated health costs. In non-pandemic times, households with children were nearly 1.5 times more likely to experience food insecurity than households without children. Figure 70 displays child food insecurity rates prior to the pandemic. In the summer of 2021 (during the pandemic), an analysis by the Brookings Institution found that 27.5% of households with children were food insecure — meaning 13.9 million children lived in a household characterized by child food insecurity. A separate analysis by researchers at Northwestern found insecurity has more than tripled among households with children to 29.5%.

Figure 70 Child Food Insecurity Rate (2017-2019)



Source: Feeding America Research, 2018.

The fall 2018 Maryland Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS) was approved to add two CDC-approved food insecurity questions for Maryland High and Middle School students.

- During the past 12 months, how often was your family worried that your food would run out before you got money to buy more?
- During the past 12 months, how often did the food your family bought not last and they did not have money to get more?

Food insecurity was most prevalent in Prince George's County (40.7% for High School students, 34.4% for Middle School students) and least prevalent in Montgomery County (21.9% for High School students, 18.4% for Middle Schools students). Overwhelmingly, Black and Hispanic/Latino high school students in Montgomery and Prince George's Counties attested to having a greater risk of food insecurity as compared to their White peers.

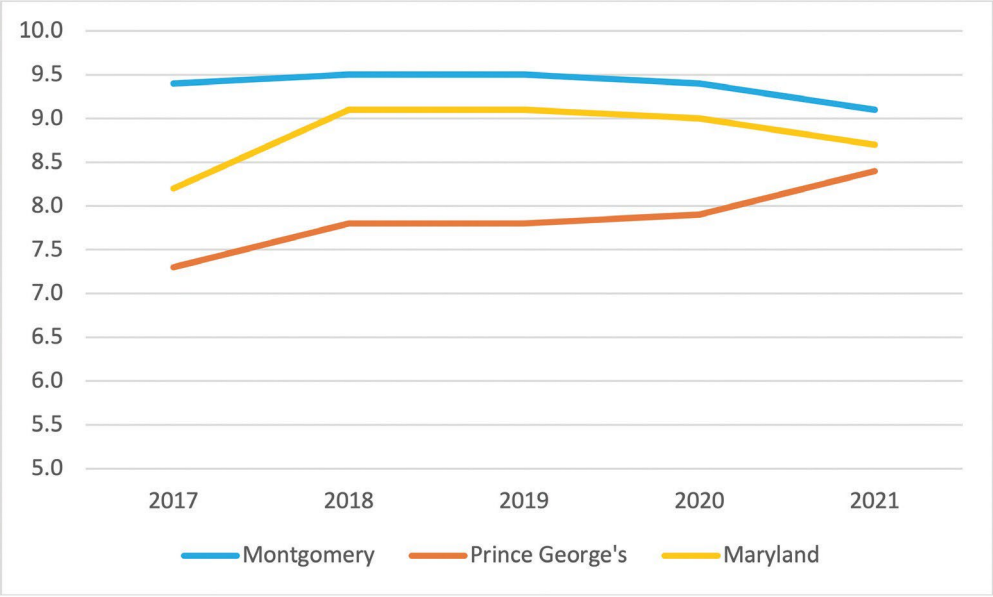
ACCESS TO HEALTHY FOODS

Food access refers to the ability to source good, quality food—food that's filling and adequate for our individual needs. For many, this means having access to fresh and minimally processed foods that are good for the physical and environmental health of the community. Access to food is determined by space and money and determines one's food security and quality. The World Health Organization considers access to safe and adequate food a basic individual right—but still, as of 2020, over 37 million Americans were unable to acquire enough food to meet their needs or uncertain of where their next meal might come from. For about a third of these households, access to food was so limited that their eating patterns were disrupted, and food intake was reduced (Silva, 2020). The rest were able to obtain enough food to avoid completely disrupting their eating patterns but had to cope by eating less varied diets or utilizing food assistance programs.

FOOD ENVIRONMENT INDEX

The County Health Rankings measure of the food environment accounts for both proximity to healthy foods and income. This measure includes access to healthy foods by considering the distance an individual lives from a grocery store or supermarket, locations for healthy food purchases in most communities, and the inability to access healthy food because of cost barriers. The Food Environment Index ranges from a scale of 0 (worst) to 10 (best) and equally weighs two indicators of the food environment: limited access to healthy foods and food insecurity. In 2021, the average food environment index value (median) for Maryland counties was 8.7 and most counties fell between about 6.6 and 9.2. Over the past two years, the food environment index for Montgomery County has been trending down while the food index for Prince George's County has been trending higher (see figure 71).

Figure 71 Food Environment Index (2017-2021)



Source: County Health Rankings & Roadmaps, 2021.

FOOD DESERTS

According to a 2015 USDA report, about 19 million people, or roughly 6% of the population, lived in a food desert without access to affordable, healthy food (Coleman-Jensen, Rabbitt, Gregory, & Singh, 2016,). The definition of a food desert can change depending on where you live. In urban settings, you need to live more than a mile away from a supermarket to be considered inside a food desert. For rural areas, it's greater than 10 miles. Rural areas are slightly more likely to be food deserts than urban areas. According to Feeding America, while rural areas make up just 63% of counties in the country, they make up 87% of counties with the highest rates of food insecurity.

People who live in food deserts are often more likely to experience food insecurity because affordable, healthy food is harder to obtain where they live, as these neighborhoods may have limited access to full-service supermarkets or grocery stores. On the other hand, these communities have an overabundance of convenience stores and small independent stores that provide unhealthy food options. These stores often carry foods that are of a lower quality and have less variety. Furthermore, groceries sold in food deserts can cost significantly more than groceries sold in suburban markets, meaning people in low-income communities impacted by food insecurity often pay more money for their food. Access to healthy foods is also affected by lack of transportation resources to utilize better food options, or the distance is too consuming. Those with disabilities, residents in rural areas, and some minority groups often face lack of transportation issues to obtain healthy food.

Census tracts qualify as food deserts if they meet low-income and low-access thresholds:

- low-income (LI): poverty rate of 20% or greater, or median family income at or below 80% of the statewide or metropolitan area median family income
- low-access (LA): a low-income tract with at least 500 people or 33% of the tract's population living more than 1 mile (urban areas) or more than 10 miles (rural areas) from the nearest

supermarket or grocery store.

From 2015-2019, the number of LILA census tracts in Montgomery County decreased from five to three while in Prince George's County they increased from 20 to 25 (see Table 7 and Table 8).

Table 7: Total Food Desert (LILA) Census Tracts Montgomery County (2015 & 2019)

	Year	
	2015	2019
	24031700310	24031700310
	24031700818	24031700818
	24031700819	24031703301
	24031703215	
	24031703220	
Total LILA Census Tracts	**5**	**3**

Source: Economic Research Service, United States Federal Agriculture Service, 2015-2019.

Table 8: Total Food Desert (LILA) Census Tracts Prince George's County (2015 & 2019)

	Year	
	2015	2019
	24033800206	24033800412
	24033800412	24033800601
	24033801104	24033800704
	24033801312	24033801406
	24033801406	24033801409
	24033801704	24033801704
	24033801708	24033801708
	24033801904	24033802001
	24033801906	24033802201
	24033802001	24033802404
	24033802201	24033802405
	24033802404	24033802700
	24033802804	24033802803
	24033803605	24033802804
	24033806706	24033802805
	24033807000	24033803100
	24033807200	24033803524
	24033807301	24033803606
	24033807404	24033803608
	24033807407	24033803610
		24033806706
		24033806711
		24033807301
		24033807404
		24033807407
Total LILA Census Tracks	**20**	**25**

Source: Economic Research Service, United States Federal Agriculture Service, 2015-2019.

FOOD APARTHEID

The term “food desert” is becoming viewed as an inaccurate and misleading term that pulls focus from the underlying root causes of the lack of access to healthy food in communities. The term implies the lack of healthy and affordable food is naturally occurring in “desert” barren landscapes. On the contrary, these communities are often the direct result of systematic racism and discrimination, as well as oppression in the form of zoning codes, lending practices, systemic disinvestment, and other discriminatory policies. Many groups are now using the term “food apartheid” to correctly highlight how racist policies shaped these areas and led to limited access to healthy food. Apartheid is a system of institutional racial segregation and discrimination, and these areas are food apartheids because they too are created by racially discriminatory policies. Using the term “apartheid” focuses the examination on the intersectional root causes that created low-income and low food access areas, and more importantly, points towards working for structural change to address these root causes.

SECTION 5.

HEALTH CARE / CLINICAL CARE

According to County Health Rankings, access to affordable, quality, and timely health care can help prevent diseases and detect issues sooner, enabling individuals to live longer, and healthier lives. While part of a larger context, looking at clinical care helps us understand why some communities can be healthier than others.

Advances in clinical care over the last century, including breakthroughs in vaccines, surgical procedures like transplants and chemotherapy, and preventive screenings, have contributed significantly to increases in life expectancy. Care continues to evolve, with promising advances in fields like tele-health and care coordination leading to improved quality and availability of clinical care.

Despite the advances in clinical care, many individuals do not have access to a provider. Nearly 30 million Americans remain without health insurance, generally considered the first barrier to receiving quality health care. Others do not access health services because of high deductible costs, language barriers, distance to a provider, or lack of specialists in their geographic area or health network. Those without regular access to quality providers and care are often diagnosed at later, less treatable stages of disease than those with insurance and, overall, have worse health outcomes, lower quality of life, and higher mortality rates. Health care access and quality also vary widely both by place, race, ethnicity, and income.

HEALTH INSURANCE

Access to health care is essential to achieving and maintaining good health. Because detection and prevention are pivotal to improved health outcomes, access to health care allows individuals to live longer, healthier lives. According to the County Health Rankings model, access to health care accounts for 20% of an individual's health outcomes. The model stresses the importance of not just access to care but to the quality of available health care. High-quality health care is timely, safe, effective, and affordable–the right care for the right person at the right time.

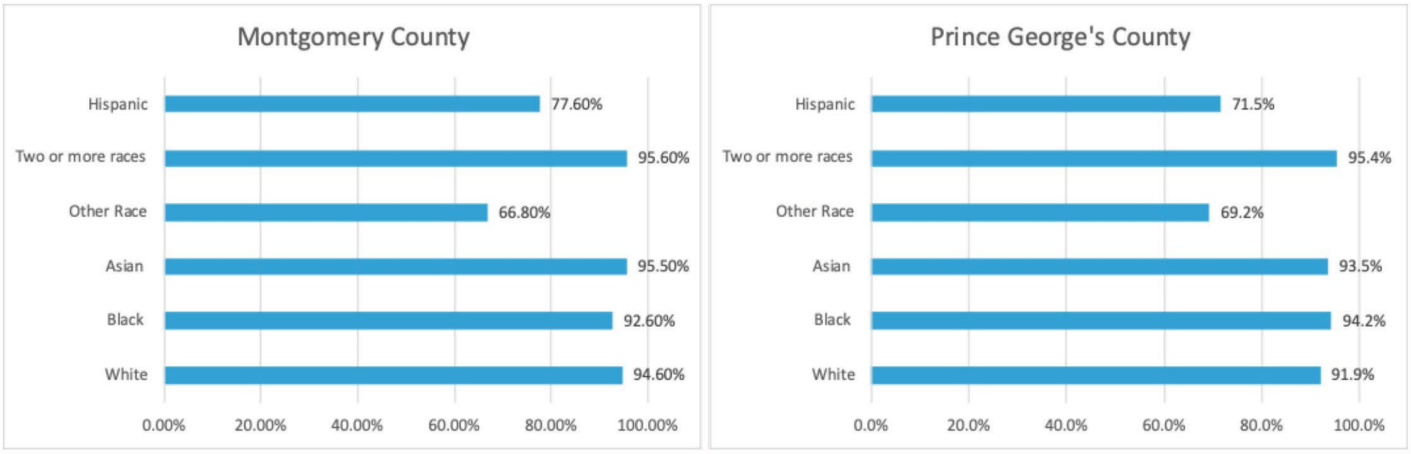
Health insurance is a resource that covers part or all expenses of an individual's need for health care. The amount paid on behalf of the individual is associated with his or her level of risk to the insurer, which can be public, e.g., Medicare, or private. According to Healthy People 2030, 1 in 10 Americans do not have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Delaying medical care can negatively impact health and increase the cost of care, including out of pocket expenses. People who cannot access the care they need may have more preventable complications, hospitalizations, emotional stress, and higher expenses.

The Patient Protection and Affordable Care Act (ACA or commonly known as Obamacare) was signed into law by President Obama on March 23, 2010. The ACA significantly changed the health care system in the U.S. by reducing the amount individuals and families paid for uncompensated care. The act requires every American to have health insurance and provides assistance to those who cannot afford a plan. In response, Maryland established the Maryland Health Benefit Exchange (MHBE), and recently marked ten years of providing a marketplace for Marylanders to explore health insurance plans, compare rates, and determine program eligibility. The MHBE has benefited communities that historically lacked health insurance coverage. From 2011 to 2019, Black Marylanders have seen uninsured rates drop from 12.2% to 5.8%, Hispanic Marylanders have seen a drop from 31.4% to 21.4%, and Young Adult Marylanders have seen a decrease from 21% to 12%. During the 2021 open enrollment period, MHBE had a 4.5% increase in enrollees, the largest in the history of the program. Both Montgomery and Prince George's Counties saw enrollment gains from 2020 to 2021 (2.6% and 1.8%, respectively).

In response to the COVID-19 pandemic, Maryland leadership launched a special enrollment to assist those in need of health insurance obtain the coverage needed. Over 200,000 Marylanders were enrolled during this period, with 63% enrolling in Medicaid. Demographically, nearly 70,000 young adults, 60,000 Blacks, and over 25,000 Latinos could obtain coverage they may not have received otherwise.

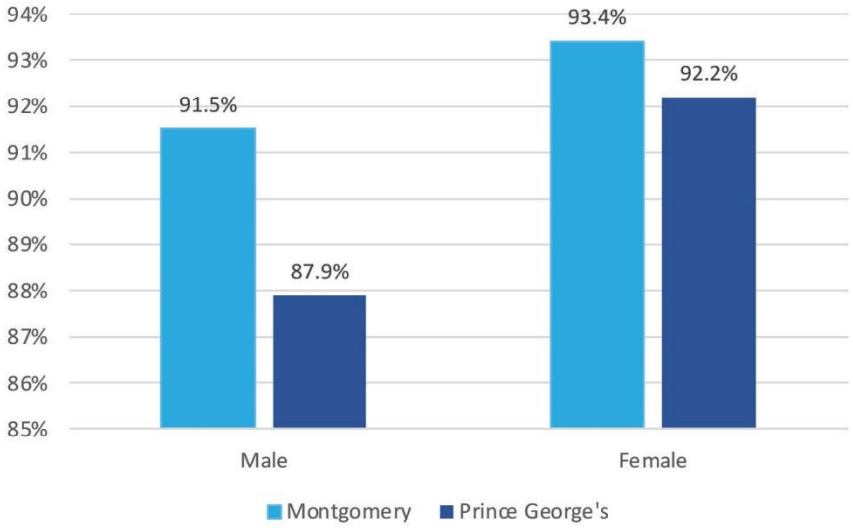
Persons who benefit from having health insurance coverage also benefit from better health outcomes. In 2019, Keisler-Starkey and Bunch (2020) found that 92% of Americans had public or private health insurance for all or part of the year, which is closely aligned with the MCHC CBSA insured rate of 90.9% (US Census Bureau, n.d.). Montgomery County's insured rate is 92.3%, and Prince George's County's insured rate is 89.9%. See Figures 72 and 73 for a breakdown of insurance coverage based on race, ethnicity, and gender. The Healthy People 2030 target is to increase the proportion of people with health insurance under age 65 to 92.1%. Men, Blacks, and Hispanics have some of the lowest insured rates in both counties.

Figure 72 Percentage Health Insurance Coverage by Race/Ethnicity (2019)



Source: United States Census Bureau, n.d..

Figure 73 Percentage Health Insurance Coverage by Gender (2019)



Source: United States Census Bureau, n.d..

The United States spends more on health care than any other country in the Organization for Economic Co-operation and Development (OECD) yet provides fewer resources and ranks 29th for life expectancy at birth of the 38 member nations. The high cost of health care in the U.S. is a major barrier to accessing health care, along with inadequate or no insurance coverage and lack of culturally competent care. Lack of access to health care has long been associated with increased preventable hospitalizations and missed opportunities to prevent disease and manage chronic conditions, all of which can lead to worse and more expensive health outcomes. Meanwhile, U.S. health care costs are projected to continue trending upward for the next 30 years. Currently, the average American spends more than $11,000 a year on health care (America's Health Rankings, n.d.).

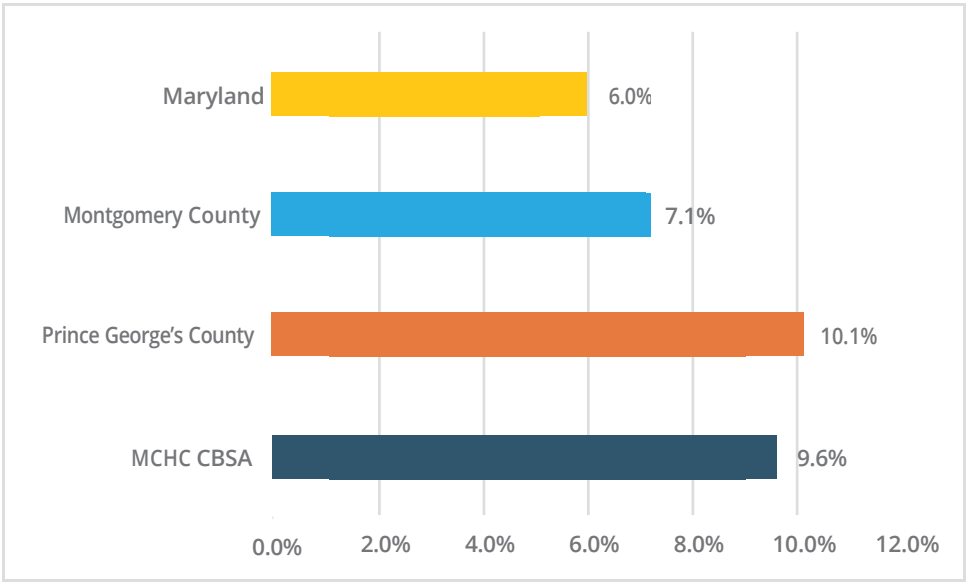
Adults who are uninsured are more likely to have problems paying medical bills compared with adults who have health insurance. Even among insured adults, those enrolled in high-deductible health plans are nearly twice as likely to delay or entirely forgo care due to cost compared with adults enrolled in traditional health plans. In Maryland, 8.7% of adults report a time in the past 12 months when they needed a doctor but could not go because of cost (America's Health Ranking, n.d). This group tends to be Hispanic, female, aged 18-44, have less than high school education, and earns less than $25,000.

UNINSURED

Lack of insurance is a primary barrier to health care access, including regular primary care, specialty care, and other health services that contribute to poor health status. Access to affordable health insurance represents only one barrier to access care. Availability, affordability, and language also prevent Montgomery and Prince George's Counties residents from accessing quality health care. Compared with insured adults, uninsured adults have more health disadvantages, including worse health outcomes and higher rates of mortality and premature death, higher rates of cancer mortality and greater risk of a late-stage cancer diagnosis, inadequate access to quality care, including preventive services, and expensive medical bills due to undiagnosed or untreated chronic conditions, and more emergency room visits.

While the ACA has assisted many in obtaining insurance coverage, as of 2019, there were still 6.1% of Marylanders who are not covered by private or public health insurance, primarily due to cost or ineligibility (America's Health Ranking, n.d.). Within the MCHC CBSA, 9.1% of the population is uninsured – 10% in Prince George's County and 7% in Montgomery County; the rate was 6% in Maryland in 2019 (see Figure 74).

Figure 74 Percentage of population without health insurance (2019)



Source: United States Census Bureau, n.d..

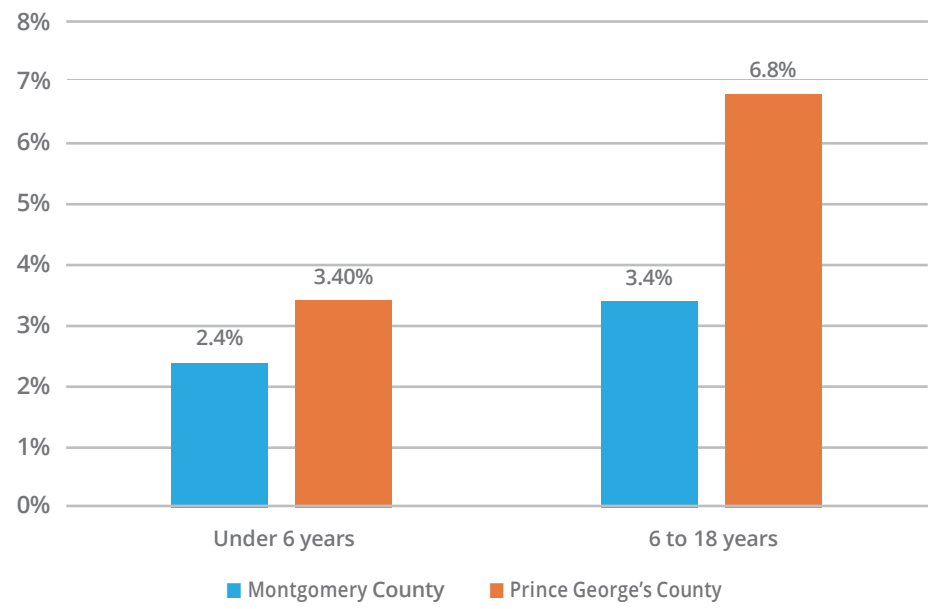
UNINSURED CHILDREN

Health insurance for children is particularly important. To stay healthy, children require regular checkups, dental and vision care, and medical attention for illness and injury. Children with health insurance are more likely to have better health throughout their childhood and adolescence. They are more likely to receive required immunizations, fall ill less frequently, obtain necessary treatment when they do get sick, and perform better at school. Having health insurance lowers barriers to accessing care, which is likely to prevent the development of more serious illnesses. This is not only of benefit to the child but also helps lower overall family health costs. In 2019, nearly 7% of children older than six years old residing in Prince George's County were not covered by insurance- the rate was half that for the same age range in Montgomery County. For children younger than six years old, less were uninsured and the coverage between counties was closer (see Figure 75).

In Maryland, there are two public insurance programs that cover children ages 0-19. Medicaid covers the entire age range for youth whose family earns up to a percentage of the federal poverty level. The Children's Health Insurance Plan, or CHIP, supports children whose families earn too much for Medicaid but otherwise remain uninsured.

Maryland Children's Health Insurance Program provides coverage for many important medical services. CHIP covers preventive care like doctor's visits and immunizations, as well as emergency care and mental health services. CHIP also covers x-rays and laboratory tests, dental care, vision care, transportation to medical appointments, prescription medication, and substance use treatments. The services covered by CHIP often come with a small copayment, whereas those enrolled in Medicaid will have more services covered and will not have to pay for these treatments.

Figure 75 Percentage of Uninsured Children by Age (2019)



Source: United States Census Bureau, n.d..

MEDICAID

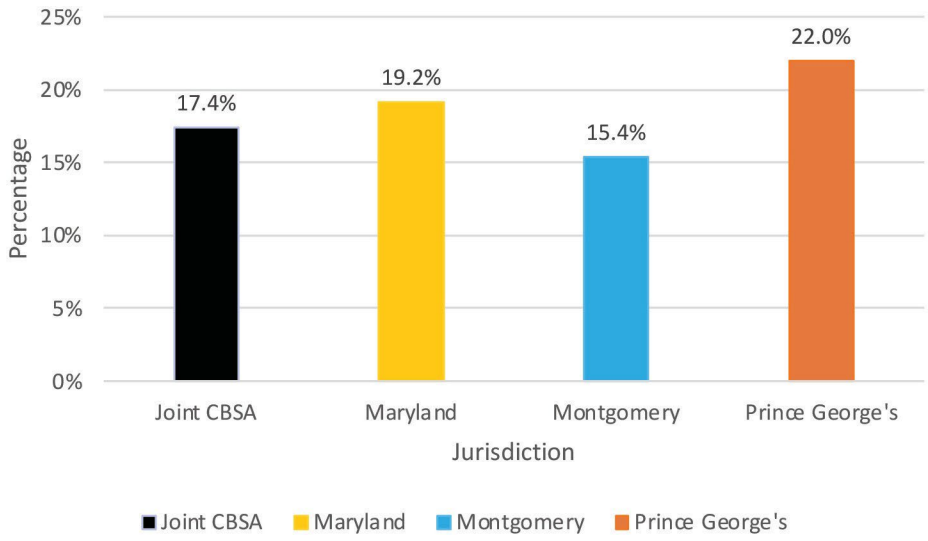
Medicaid is the nation's public health insurance program for people with low income. The Medicaid program covers 1 in 5 Americans, including many with complex and costly needs for care (US Census Bureau, n.d.). The program is the principal source of long-term care coverage for Americans. The vast majority of Medicaid enrollees lack access to other affordable health insurance. Medicaid covers a broad array of health services and limits enrollee out-of-pocket costs. Medicaid finances nearly a fifth of all personal health care spending in the U.S., providing significant financing for hospitals, community health centers, physicians, nursing homes, and jobs in the health care sector.

As with so many aspects of American life, the COVID-19 pandemic had a dramatic impact on the nation's health sector in 2020, driving a 9.7% growth in total national health care spending, bringing spending to $4.1 trillion according to the 2020 National Health Expenditures (NHE) Report, prepared by the Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS). Medicaid spending grew faster in 2020, increasing 9.2% to $671.2 billion compared to 3.0% growth in 2019, primarily driven by increased enrollment due to the pandemic. Maryland Medicaid spending from October 1, 2019, to September 30, 2020, was nearly $12 million (Kaiser Family Foundation, n.d.-c).

Each state runs its own Medicaid program, which means eligibility varies depending on residence. The intended beneficiaries of Maryland's Medicaid are vulnerable populations, including pregnant women, individuals with disabilities, and low-income individuals. Those enrolled pay little to no

cost for this health care benefit. In addition to reducing the barriers to health care previously mentioned, Medicaid opens the doors for these individuals to access services such as physician-recommended specialty care, substance use disorder treatment, mental health physician and facility treatment, transportation to health care visits, dental care for individuals under the age of 21, and prescription coverage. According to the American Community Survey (2015-2019), 1.01 million Marylanders are enrolled in Medicaid (US Census Bureau, n.d.). Figure 76 illustrates Medicaid coverage by jurisdiction.

Figure 76 Percentage of Insured Population Receiving Medicaid (2015-2019)



Source: United States Census Bureau, n.d..

ACCESS TO CLINICIANS

People with a usual source of care (typically a primary care provider) are more likely to receive routine checkups and screenings and are more likely to know where to go for treatment in acute situations. Not having a usual source of care or a usual place to go when sick or needing health advice can cause a delay in necessary care, leading to an increased risk of complications. The Healthy People 2030 national health target is to increase the proportion of people with a usual primary care provider to 84.0%. In Maryland, 83.2% of the population report they have one provider they think of as a personal doctor or health care provider (Office of Population Health Improvement, 2021). On a jurisdiction level, 78.0% of Montgomery County and 78.9% of Prince George's County residents identified a primary care provider.

Health care providers are fundamental when it comes to clinical care. Having a regular health care provider allows the patient and provider to build a stable, long-term relationship that is associated with several benefits, including better care of chronic conditions. Increased physician density is found to be associated with a decreased mortality rate from cardiovascular, cancer and respiratory conditions. The United States is currently facing a shortage of physicians due to the

nation's growing health care needs. Primary care physicians provide direct patient care and counsel patients on the appropriate use of specialists and advanced treatment options. They are typically the patient's first point of contact with the health care system and provide critical preventive care, disease management and referrals to specialists. Having a sufficient supply of primary care physicians in a community has numerous benefits, including lower rates of low birthweight births, lower all-cause mortality and longer life spans, reductions in health system costs, and reductions in health disparities.

The number of primary care physicians per 100,000 population changes due to evolving state populations, physician retirement, new physicians entering the system, and physicians changing states and/or specialties. The Health Resources & Services Administration has estimated that, as of 2021, an additional 14,860 primary medical care providers are necessary to meet current U.S. health care needs. Projections for primary care shortages by 2034 range from 17,800 to 48,000 physicians, mainly due to population growth and aging (America's Health Rankings, n.d.).

In addition to general primary care, dental care is also an important component of a healthy community. Oral health provides a window into general health. Many underlying health conditions, such as eating disorders, diabetes, and immune disorders, have close connections to oral health. Dentists diagnose oral diseases, create treatment plans, promote oral health and disease prevention, perform surgical procedures, and manage oral trauma. Oral infections and periodontal (gum) disease are associated with diabetes, heart disease, respiratory disease, cancer, and Alzheimer's disease. Despite projections of steady growth in the number of working dentists, the Health Resources and Services Administration has identified many areas and populations that have an inadequate supply of dentists to meet current or future needs. Some of the most significant oral health disparities are in rural communities. Disparities in oral health care contribute to higher rates of dental caries and edentulism (having no natural teeth) in rural populations compared with urban populations. Contributing factors to these disparities include an inadequate supply of dentists, higher uninsurance rates and fewer dentists accepting Medicaid patients, patient difficulty in traveling to a dentist, poverty, lack of a fluoridated community water supply, and a growing population of older adults.

In addition to primary care physicians and dentists, there is also a demand for mental health professionals. Mental health providers offer essential care to adults and children who have a mental or behavioral disorder by offering services such as assessment, diagnosis, treatment, medication and therapeutic interventions. The mental health workforce includes a broad array of professionals, including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, professionals treating alcohol and other drug abuse and advanced practice nurses specializing in mental health care.

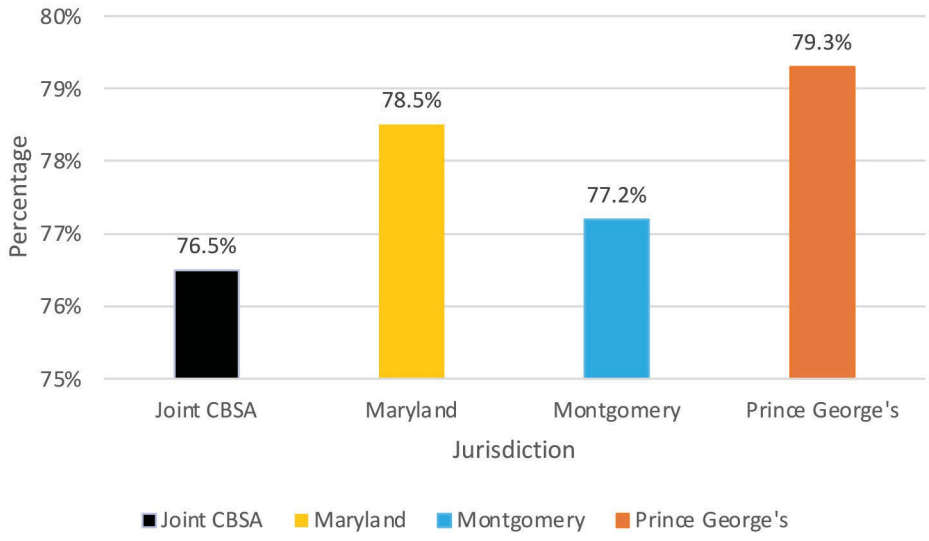
According to the National Institutes of Mental Health, in 2019, about one in five Americans experienced some form of mental illness (not including substance abuse disorders), but only 44.8% of adults with any mental illness and 65.5% with a serious mental illness reported receiving

treatment in the past year. An analysis by the Kaiser Family Foundation found that more than 119 million Americans live in mental health shortage areas, and only 26.9% of the need is being met. The National Council for Mental Wellbeing reported that 77% of counties in the United States are experiencing a severe shortage of mental health providers. The demand for mental health professionals is projected to increase during and after the COVID-19 pandemic. Populations identified with limited access to mental health care include, rural communities, which are less likely to have a mental health treatment facility than metropolitan counties, communities with a higher percentage of Black or Hispanic individuals, and low-income communities

RECENT PRIMARY CARE VISIT

Accessing preventive health care services, such as getting routine physical checkups, receiving recommended vaccinations on appropriate schedules, and checking blood pressure and cholesterol and maintaining them at health levels, can reduce morbidity and mortality from chronic diseases. The 2018 Behavioral Risk Factor Surveillance System measured adults 18 and older with one or more visits to a doctor for routine checkups within the past one year. While there is a shortage of providers in Prince George's County compared to Montgomery County, the percentage of Prince George's County adults reporting a recent routine PCP visit was notably higher compared to both Montgomery County and the state (see Figure 77).

Figure 77 Percentage of Adults with Recent Primary Care Visit (2019)



Source: Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System, 2019.

Access to emergency services is essential for emergency care-sensitive conditions such as acute myocardial infarction (heart attack), stroke, sepsis, and major trauma. People without health insurance are more likely to be in poor health than the insured. Lack of health insurance can result in increased visits to the emergency department and decreased routine care visits with a primary care provider. The rate of individuals accessing emergency department services in 2017 was

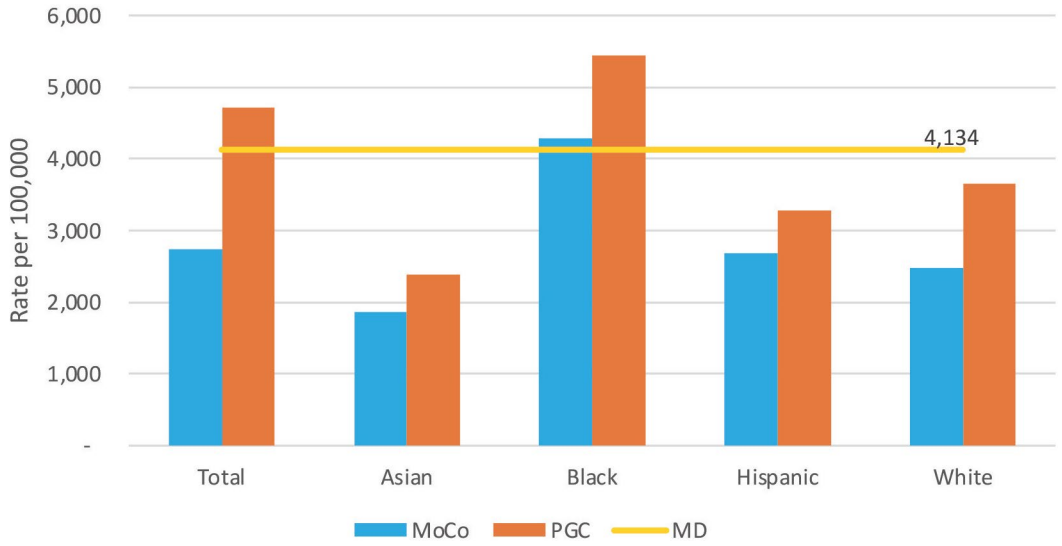
highest in Prince George's County (14.9%) compared to Montgomery County (13.4%). Both were higher than the state rate of 8.6% (Open Data Portal, 2020a). Diabetes can lead to blindness, heart and blood vessel disease, stroke, kidney failure, amputations, nerve damage, pregnancy complications and birth defects. When uncontrolled, complications arise and lead to an increase in emergency department visits. In Maryland, there were 12,907 emergency department visits for primary diagnosis of diabetes (Open Data Portal, 2020b). Similarly, high blood pressure drives emergency department visits. In Maryland, 30% of all deaths in 2017 were attributed to heart disease and stroke. Heart disease and stroke can be prevented by control of high blood pressure (Open Data Portal, 2020c). Due to the shortage of mental health providers, individuals often have nowhere to turn but the emergency department, placing a heavy burden on the health care system. In Maryland, there were 207,650 mental health disorder-related emergency department visits in 2014. Examples of disorders included in this figure are adjustment disorders, anxiety disorders, attention deficit disorders, disruptive behavior disorders, mood disorders, personality disorders, schizophrenia and other psychotic disorders, suicide and intentional self-inflicted injury and miscellaneous mental disorders (Open Data Portal, 2020d). Substance abuse problems also place a heavy burden on the health care system, particularly when persons in crisis utilize emergency departments instead of other sources of care when available. In Maryland, there were 96,991 emergency department visits for substance-related disorders from 2012-2014 (Open Data Portal, 2020e). Asthma is a chronic health condition that causes very serious breathing problems. When properly controlled through close outpatient medical supervision, individuals and families can manage their asthma without costly emergency intervention. In 2017, there were nearly 50,000 emergency department visits related to asthma (Open Data Portal, 2020f). The utilization of dental services in emergency departments has steadily risen over the last decade. Dental emergency department visits are growing as a percentage of all emergency department visits throughout the United States. In 2014, there were 52,631 outpatient dental visits in emergency departments in Maryland (Open Data Portal, 2020g).

PREVENTABLE HOSPITAL STAYS

Some hospital admissions related to chronic conditions or acute illnesses can be prevented through adequate management and treatment in outpatient settings. The number of preventable hospital stays reflects the overuse of the hospital as a primary source of care and the accessibility and quality of primary care for outpatient services. Preventable hospitalizations place financial burdens on patients, insurance providers, and hospitals. In 2017, $33.7 billion in hospital costs were attributed to preventable hospitalizations, of which the majority were for chronic conditions, such as heart failure, diabetes, and chronic obstructive pulmonary disease. Populations that experience higher rates of preventable hospitalizations include, Black adults compared with Asian/Pacific Islander adults, adults ages 65 and older, who have a rate of preventable hospitalization more than 12 times that of those ages 18-44, and adults from lower-income communities compared with those from higher-income communities.

Preventable hospital stays, as measured by County Health Rankings & Roadmap (n.d.), is the rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. The average number of preventable hospital stays in Maryland in 2018 was 4,134 per 100,000 Medicare population (see Figure 78). Populations with highest preventable hospital stays in Maryland tend to be Black, followed by American Indian/Alaska Native and White.

Figure 78 Preventable Hospital Stays by Race (2018)



Source: County Health Rankings & Roadmaps, 2018.

Since 2014, Maryland hospitals have been funded under a global budget system, or fixed annual revenue cap, that is adjusted for inflation, quality performance, reductions in potentially avoidable utilization, market shifts, and demographic growth. Under this system, hospitals are incentivized to transition services to the most appropriate setting. If the transition results in cost savings via improved health care delivery (e.g., reduced avoidable utilization, readmissions, hospital-acquired infections), the hospitals may retain the difference. By the end of 2018, the Medicare readmission rate in Maryland was 15.4%, which was below the national rate of 15.4%. The readmission rates in Maryland continue to improve. The most recent 12 months of data (through September 2019) reported Maryland's Medicare readmission rate at 15.1%, compared to the national rate of 15.5%. Racial and socioeconomic differences in readmission rates are well documented and have been a source of significant concern among health care providers and regulators for years. In 2018, the readmission rate for Black individuals was 2.6% points higher than for White individuals, and the rate for Medicaid enrollees was 3.4 points higher than for other patients (Maryland Health Services Cost Review Commission [HSCRC], 2020).

SECTION 6.

COMMUNITY INPUT

The Montgomery County Hospital Collaborative (MCHC) was deliberate in seeking input from the community for the 2022 Community Health Needs Assessment (CHNA). To achieve this goal, a questionnaire was designed to understand the health priorities, barriers to care, and health behavior prevalence in the MCHC defined Community Benefit Service Area (CBSA). Due to COVID-19 restrictions and to help widen our reach, the questionnaire was made available electronically in both English and Spanish. In an effort to reach community stakeholders, the medically underserved, low-income, and minority populations, a questionnaire was distributed via various channels, including community classes, hospital's community newsletters, vaccination and safety-net clinics, and through community partners. For a complete list of distribution channels, please see Appendix H.

A total of 580 individuals responded to the questionnaire, but only 488 responses met the inclusion criteria for the analysis: adults who reside in the 2022 CHNA CBSA. This section of the report will highlight findings from the 488 respondents. The findings from the community input survey will be compared against secondary level data and used in the prioritization process.

DEMOGRAPHICS

Overall, survey respondents self-identified as non-Hispanic white (63%), women (82%), over the age of 55 (65%), heterosexual or straight (89%), with a bachelor's degree or higher (85%). Exactly 70% of respondents reported living in one of the four major cities in Montgomery County: Silver Spring (26%), Rockville (22%), Bethesda (15%), and Gaithersburg (7%).

Ethnic and racial minorities accounted for 38% of the responses (n=488). African Americans/Blacks (14%) were the second most common group to participate in the survey. Latinos/Hispanics accounted for 13% of respondents and Asians for 7%. The Latino/Hispanic respondents most often reported their race as white (53%), other (27%), or preferred not to answer (11%). Survey respondents belonged to various age groups, with the majority (65%) of respondents being adults over 65. Respondents were asked to share their highest level of education completed. 98% completed high school and 81% a combination of a bachelor's and/or Post Graduate degree. Respondents' demographic information is illustrated by age, race, and ethnicity in Figures 79 and 80.

Figure 79 Respondents' Age Distribution

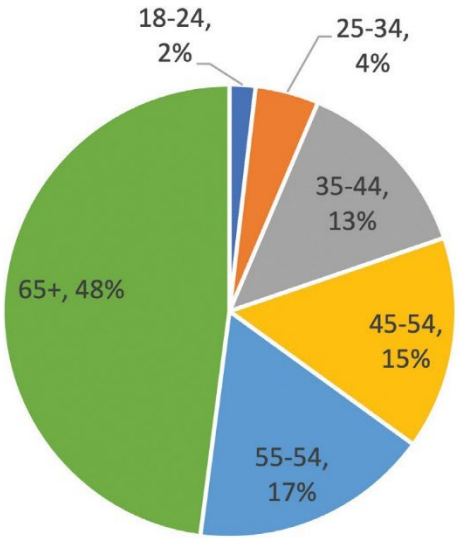
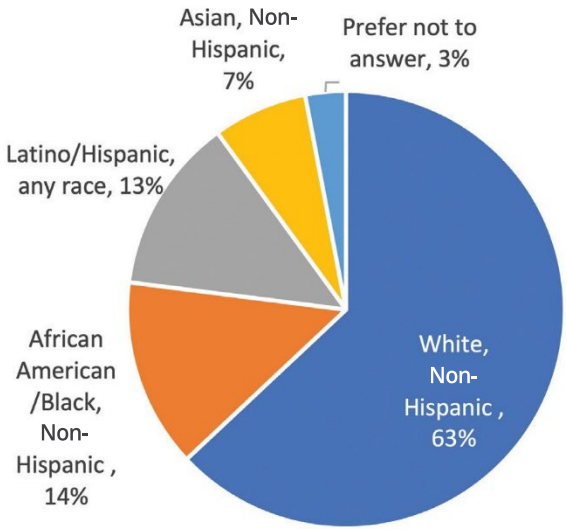


Figure 80 Respondents' Race/Ethnicity Distribution

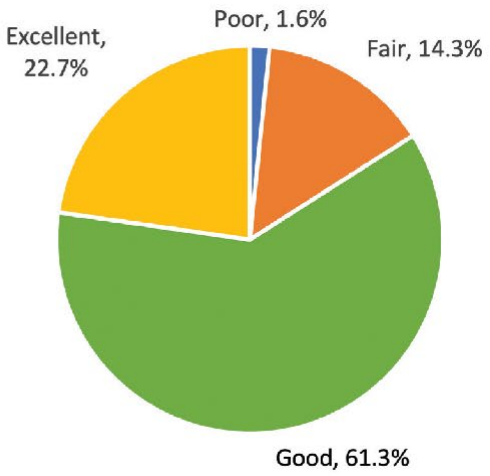


RESPONDENTS' HEALTH

HEALTH STATUS

Respondents were asked to rate their general health on a scale from "Poor" to "Excellent." Out of 488 responses, 22.7% rated their health as "excellent," 61.1% rated their health as "good," 14.3% rated their health as "fair," and 1.6% rated their health as "poor" (see Figure 81).

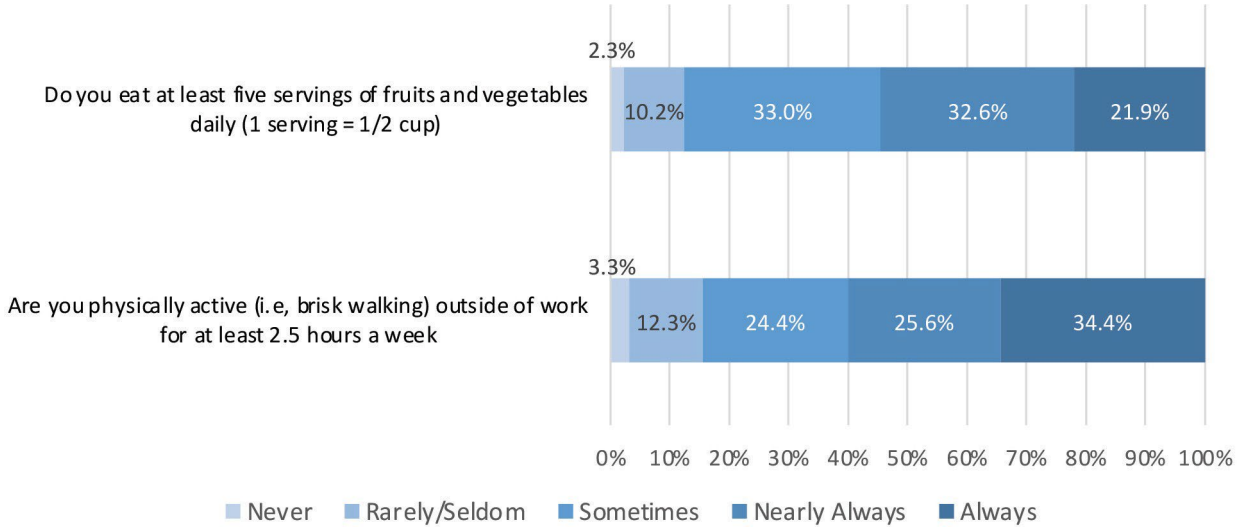
Figure 81 Self-Rated General Health



HEALTHY BEHAVIORS

When asked about the frequency of their healthy behaviors, 54.5% of respondents said they "always" or "nearly" always eat at least five servings of fruits and vegetables daily, 33% said they did so "sometimes," and 12.5% said they did so "rarely" or "never." A slightly higher percentage, 60%, of respondents said they were "always" or "nearly always" physically active outside of work for at least 2.5 hours a week; 24% reported doing so "sometimes," and 15.6% said they did so "rarely" or "never."

Figure 82 Frequency of Healthy Behaviors (n=488)



When asked about the frequency of their unhealthy behaviors, over 90% of respondents said they "never" or "rarely/seldom" overuse prescription drugs (92.1%), use illicit drugs (96.5%), or use tobacco products (95.2%). Comparatively, more people reported that they text while driving, consume more than five alcoholic drinks a week, or feel stressed/anxious/depressed/ emotionally overwhelmed. Around 11.9% of respondents reported "sometimes" texting while driving, while 1.8% reported doing so "always" or "nearly always."

Alcohol consumption of more than five drinks per week similarly had 12.1% report "sometimes," though 9.2% (nearly 1 in 10) respondents reported drinking that amount "always" or "nearly always." More than 1/3 (37.9%) of respondents reported feeling stressed, anxious, depressed, and/or emotionally overwhelmed. Around 1/5 (20.5%) reported feeling this way "always" or "nearly always."

PERCEIVED BARRIERS TO HEALTH CARE

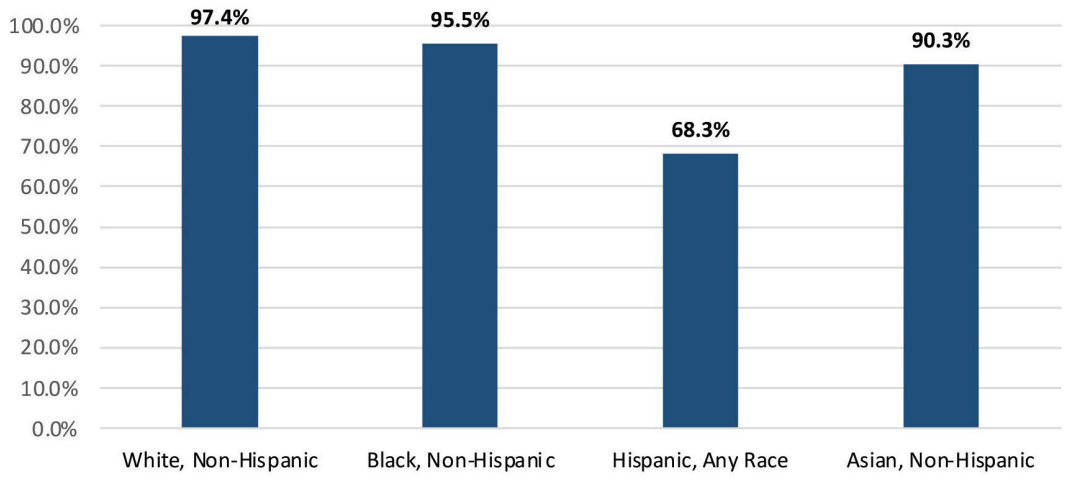
Respondents were asked to select barriers keeping them from seeking health care. More than half of total respondents (57.8%) said they had no barriers keeping them from seeking care. If barriers were present, "lack of available appointments" (20%) and "cost" (19.5%) were noted as the top two reasons. However, when the data for barriers to health care was stratified by race/ethnicity, the following observations were noted:

- All race/ethnicity categories except Hispanics predominantly chose "none" when asked their top (three) barriers to seeking health care
- Hispanic respondents cited "cost" (41.3%) as their top barrier. Additionally, the number of different barriers selected per person were also higher among Hispanic respondents.

INSURANCE STATUS

When it came to insurance status, 90% of respondents stated they had some sort of insurance, and 10% either did not have insurance or did not know their insurance type. Insurance status was noticeably lower among Latino/Hispanic respondents of any race (see Figure 83). Only 68.3% of Hispanic respondents had some form of insurance. In comparison, 97.4% of White or Caucasian respondents, 95.5% of Black or African American respondents, and 90.3% of Asian respondents had some form of insurance.

Figure 83 Percent of Respondents with Any Form of Health Insurance (n=468)

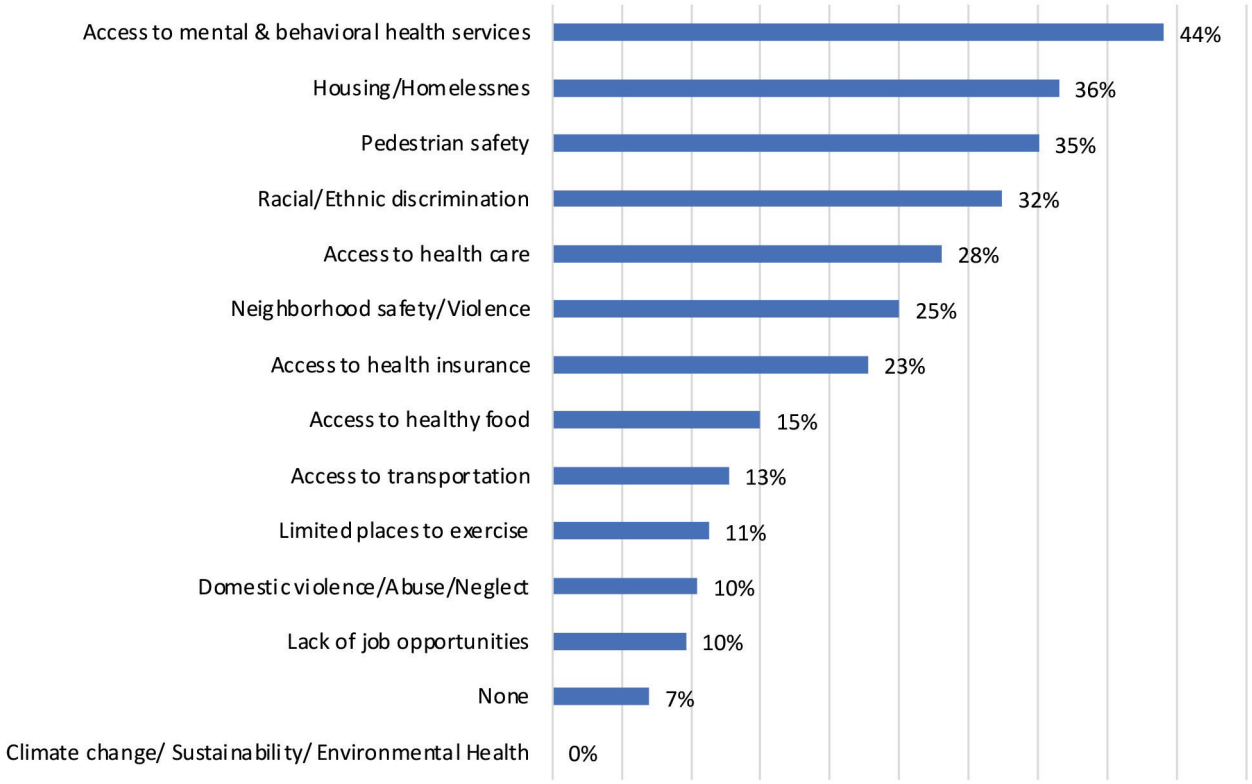


RESPONDENTS' HEALTH PRIORITIES & NEEDS

SOCIAL/ENVIRONMENTAL CONCERNS

When asked to rank the most important social and environmental problems affecting their community, 44.1% of respondents chose "access to mental & behavioral health services," around 1 in 3 chose "housing/homelessness," "pedestrian safety," and "racial/ethnic discrimination."

Figure 84 Most Important Social/Environmental Problems Affecting Community



Notes: The percentages on this graph will not add to 100% since respondents were able to select between three and five choices each.

When broken down by race/ethnicity, respondents' chosen priorities were different compared to the total sample size (n=488).

- Non-Hispanic White respondents most commonly chose "access to mental and behavioral health services" as one of their top three social/environmental community problem (48.7%).
- Non-Hispanic Black respondents most commonly chose "racial/ethnic discrimination" (50%), comparatively it was the 4th most chosen among Non-Hispanic White and the 6th most chosen among Asian respondents.
- Hispanic respondents most commonly chose "access to health insurance" (50.8%), comparatively it was the 7th most chosen among Non-Hispanic White respondents, the 8th most chosen among Non-Hispanic Black respondents, and the 5th most chosen among Asian respondents.

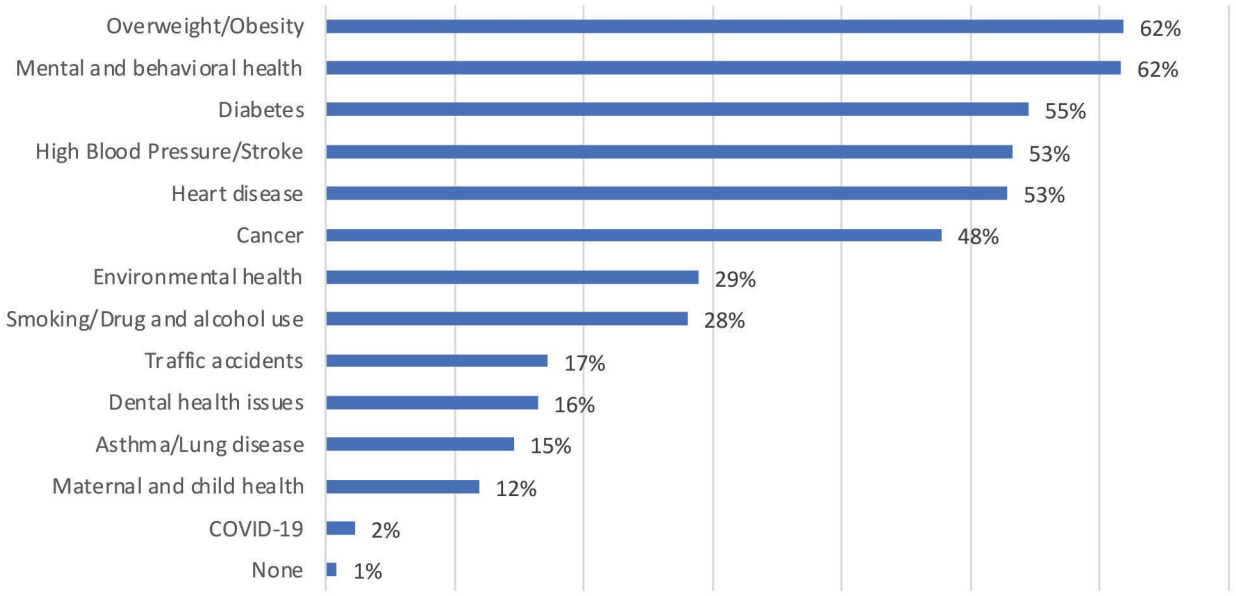
- Asian respondents most commonly chose “pedestrian safety” (38.7%), comparatively it was the 3rd most chosen among Non-Hispanic White respondents, the 4th most chosen among Non-Hispanic Black respondents, and the 6th most chosen among Hispanic respondents.

In summary, when comparing the top five social and environmental problems chosen most frequently by the four racial/ethnic groups, only “access to mental and behavioral health services” appeared in all four groups. Other problems that appeared in three out of four racial/ethnic groups (White, Black, and Asian) were “racial/ethnic discrimination” and “pedestrian safety.” Interestingly, the top three most chosen problems among Hispanic respondents all related to health care (access to health insurance, access to health care, and access to mental and behavioral health services).

HEALTH PRIORITIES

When respondents were asked to list the “top five most important health issues present in their communities,” nearly 62% selected “overweight/obesity” and “mental and behavioral health.” Slightly more than half chose “diabetes,” “high blood pressure/stroke,” and “heart disease.”

Figure 85 Most Important Health Issues in Community (n=488)



Responses to “most important health issues affecting their communities” also differed by race/ethnicity, though less drastically.

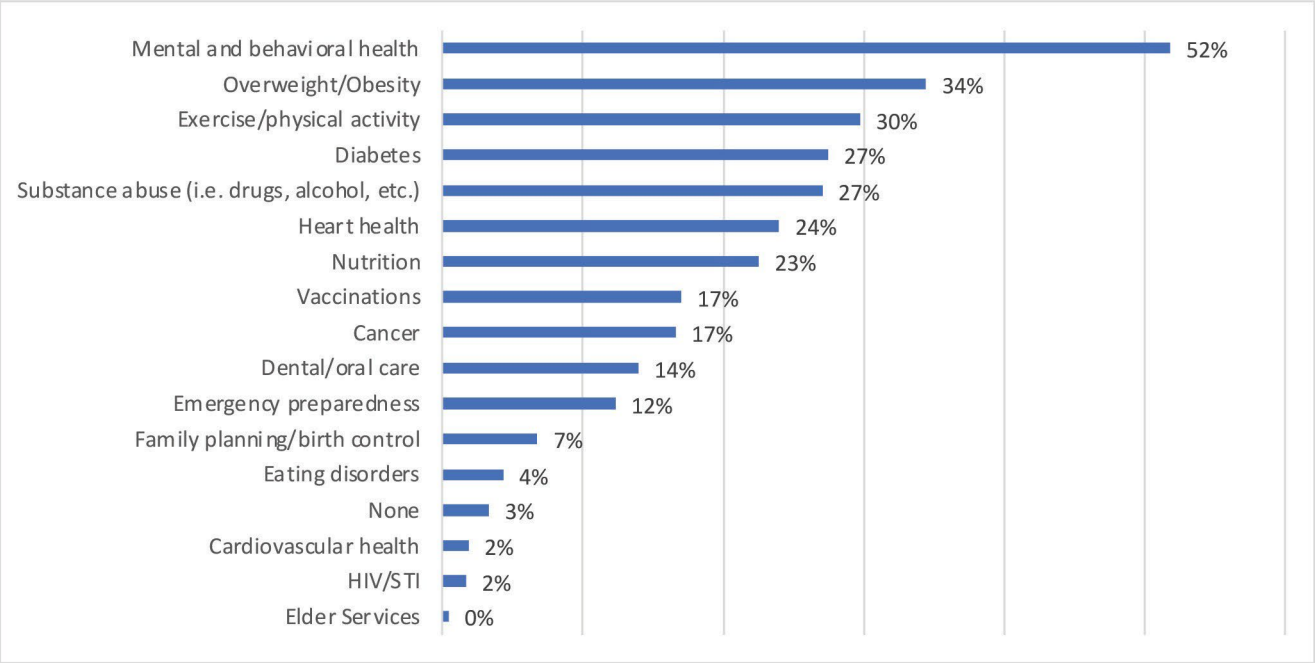
- The most frequently chosen health issue among Non-Hispanic White respondents was “mental and behavioral health” (66%), compared to being the 6th most chosen among Non-Hispanic Black respondents, the 3rd most chosen among Hispanic/Latino respondents, and the 4th most chosen among Asian respondents.
- Among Non-Hispanic Black respondents, the most chosen health issue was a tie between “diabetes” and “high blood pressure/stroke” (both 72.7%). In comparison, “diabetes” was the 6th most chosen among Non-Hispanic White respondents, the 2nd most chosen among

- Hispanic respondents, and the 3rd most chosen among Asian respondents. “High blood pressure/stroke” was the 5th most chosen among Non-Hispanic White respondents, the 5th most chosen among Hispanic/Latino respondents, and the 2nd most chosen among Asian respondents.
- Among Hispanic/Latino respondents, the most chosen was “overweight/obesity” (76.2%), compared to being the 2nd most chosen among Non-Hispanic White respondents, the 3rd most chosen among Non-Hispanic Black respondents, and the 5th most chosen among Asian respondents.
- Among Asian respondents, the most chosen was “heart disease” (71%), compared to being the 4th most chosen among Non-Hispanic White, Non-Hispanic Black, and Hispanic/Latino respondents.

PERCEIVED COMMUNITY NEEDS

To understand what health prevention services community members felt were needed in their community, respondents were asked to select their top three “health prevention services needed in your community.” Figure 86 lists the top prevention services selected by respondents. “Mental and behavioral health” services (51.8%) were most commonly selected as a needed service, followed by “overweight/obesity” (34.4%), and “exercise/physical activity” (29.7%).

Figure 86 Most Selected Health Prevention Services Needed in Community (n=488)



PERCEIVED TREATMENT

The community survey also asked respondents about other people’s behavior towards them. On a scale of “never,” “less than once a year,” “few times a year,” “a few times a month,” “at least once a week,” and “almost every day,” respondents were asked to rate the frequency of the described

behavior. The graphs below show the percentage of respondents who answered "a few times a month" or more often ("at least once a week" or "almost every day") to the suggested behavior.

Black respondents reported that they are "treated with less courtesy or respect" than others at least "a few times a month" at 3 times the amount Non-Hispanic White respondents did so (36.4% vs 12%). Around 23.8% of Hispanic respondents of any race and 22.6% of Asians respondents reported experiencing this behavior "a few times a month" to "almost every day."

Around 1 in 5 (20%) of Black, Hispanic, and Asian respondents reported receiving "poorer service than other people at restaurants or stores" "at least a few times a month" to "almost every day," compared to only 3.2% of Non-Hispanic White respondents.

More than 1/4 (25.8%) of Black respondents and 1/5 (22.2%) of Hispanic respondents reported that "people act as they think you are not smart" at least "a few times a month" or more often. Around 16% of Asian respondents reported this behavior toward them at this frequency, compared to 7.8% of Non-Hispanic White respondents.

When asked how often "people act as if they are afraid of you," around 1/4 (24.2%) of Black respondents answered "a few times a month" or more often, around 10.5 times more than the proportion of Non-Hispanic White respondents answered the same (2.3%). Around 8% of Hispanic respondents and 3.2% of Asian respondents reported this behavior at least "a few times a month" or more.

Non-Hispanic Blacks (16.7%) were twice as likely to feel threatened or harassed compared to Hispanic/Latinos (9.5%) and almost three times as likely as Asians (6.5%). A small percentage of Non-Hispanic Whites reported feeling "threatened or harassed" a few times a year or more.

When asked how often respondents felt "followed around in stores," approximately a quarter of Hispanic/Latinos (25.4%) and Non-Hispanic Blacks (22.7%) respondents expressed it happens to them "a few times a year or more."

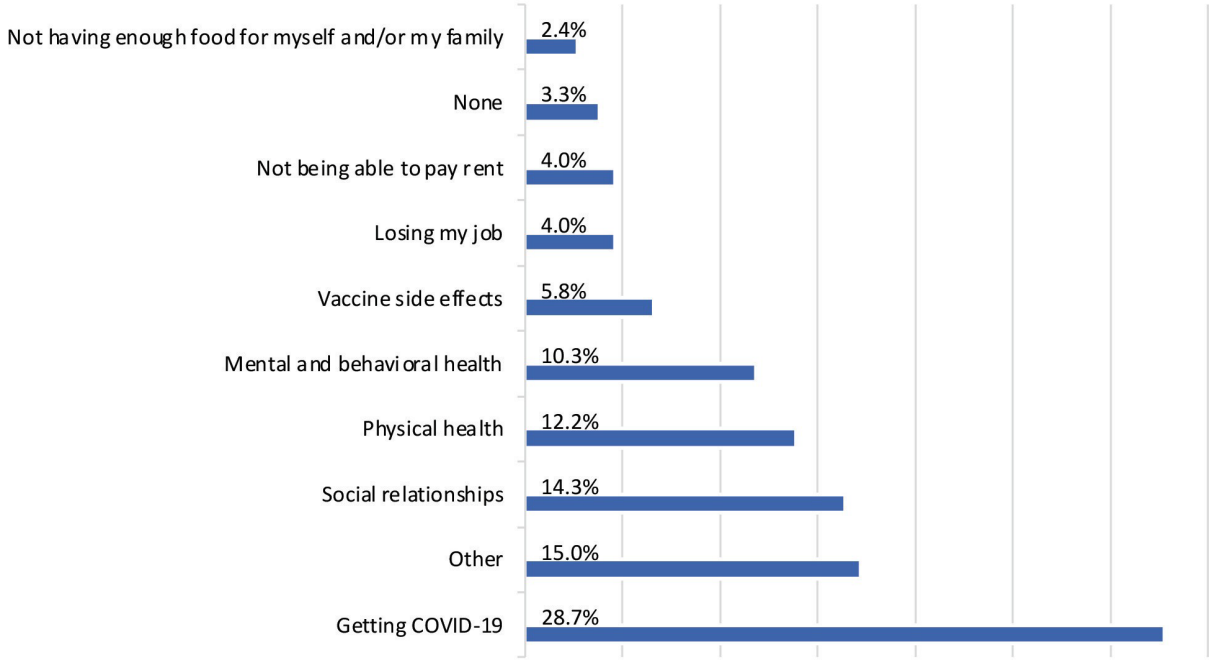
In general, those who reported feeling mistreated "a few times a year or more" were asked to list the main reason for these experiences. For Non-Hispanic Whites, the difference in experience was attributed to their age and gender; Non-Hispanic Blacks & Asians (48.5%) attributed the difference to their race (68.2%), and Hispanic/Latinos attributed the difference to their Ancestry/National Origins (38.1%) and race (20.6%).

COVID-19

This survey was distributed a year after the COVID-19 pandemic started to help understand lasting and emerging concerns related to the pandemic. A year into the pandemic, respondents (n=488) listed "getting COVID-19" as a top concern, followed by "other" (15%), social relationships (14%), and physical health (12%) (respondents were able to select more than one concern). Those who selected "other" as their response cited "concern for their kids or a family member getting COVID-19" and vulnerability from exposure to unvaccinated individuals (at the time, vaccines were not widely available, and there was a lot of vaccine hesitancy present in the community). When the list

of concerns was stratified by race and ethnicity, Latino/Hispanic respondents labeled “mental & behavioral health” and “not being able to pay rent” as a second and third concern, respectively. Non-Hispanic Blacks and Asians noted their “physical and mental health” as their second and third concerns. For Non-Hispanic Whites “social connections” and “physical health” were among the top three concerns. Across all four racial and ethnic group, “getting COVID-19” was the main concern.

Figure 87 Respondents’ COVID-19 Related Concerns (n =488)



SECTION 7.

RESPONSE TO FINDINGS & CONCLUSION

The MCHC CHNA used a systematic data collection and analysis process to identify key health needs and issues that persist in our community. In addition to using the highest quality data available from private and public sources, the MCHC CHNA was pro-active in engaging a broad and diverse level of stakeholders at key stages of the assessment via surveys and community conversations.

RESPONSE TO FINDINGS

A fundamental component of a community health needs assessment, as described by the Catholic Health Association, is the prioritization of the identified needs. To effectively achieve this goal, the MCHC engaged local public health leaders, service providers, and community advocates to

participate in the priority-setting process (see Appendix I for a list of community stakeholders invited to partake in this process). Three criteria were used to prioritize the needs identified from the primary and secondary data analysis: severity (high level of seriousness or urgency in the community), feasibility (could realistically improve in the next three years), and outcome (potential impact on the greatest number of people identified). Using the criteria, their professional expertise and experience, our stakeholders informed nine health factors as top unmet needs:

1. Access to Care

- Access to mental health providers
- Access to primary care providers
- Lack of insurance

2. Healthy Behaviors

- Food insecurity
- Adult obesity
- Physical inactivity

3. Education, Income, Job & Environment

- Workforce/labor shortages
- Income inequality
- Housing cost burden

These nine health factors are recognized as root causes that impact a person's health, well-being, and quality of life. By addressing these root causes, meaningful changes can be made to decrease risk for the top health outcomes in our community: heart disease, diabetes, mental health, cancer, maternal and child health, infections, and unintentional injuries (see Figure 88).

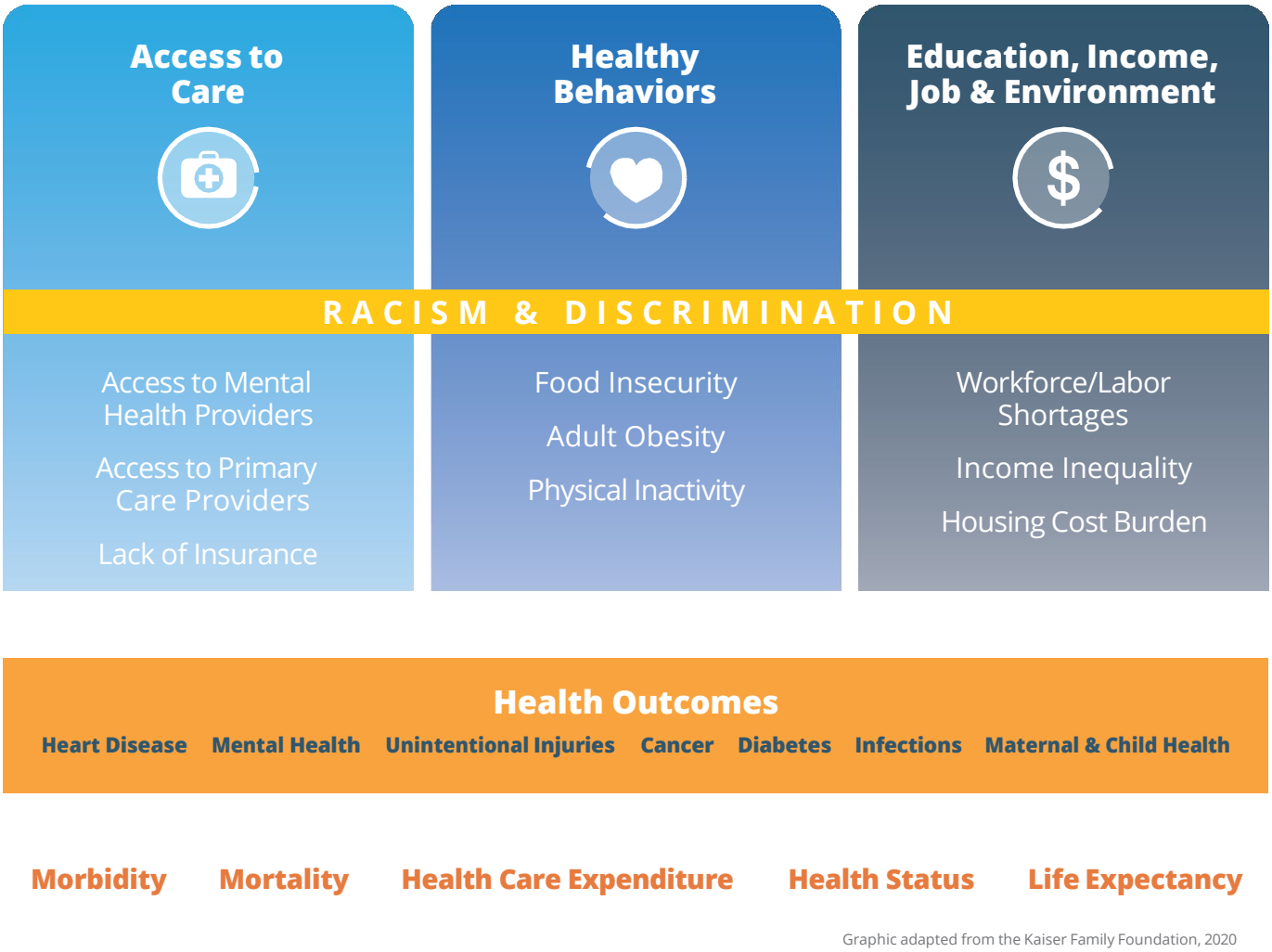
Through a multi-sectoral collaboration, the MCHC will seek to address these top health factors in a collaborative implementation strategy, while paying particular attention to the most vulnerable populations in our communities. Appendix K provides a list of existing resources within the community currently available to meet the identified community health needs.

CONCLUSION

The 2022 MCHC CHNA is an initial collaborative assessment that will serve as a starting point for ongoing evaluation of collaborative improvement efforts. Progress on identified health priorities based on measurements from the individual hospital's CHNA's from previous years can be found in Appendix J. The MCHC will work diligently over the next three years to ensure that the valuable information attained from the 2022 CHNA is an indispensable tool to measure and evaluate meaningful health impact in the communities we serve. The implementation plan, created in response to the findings of this report, will provide strategies to reduce and prevent health inequities, so all members of our community have the opportunity to achieve optimal health.

The 2022 MCHC CHNA report marks a monumental step towards systemic change needed to maximize impact and advance health equity through collective action. In addition to guiding our implementation plan, we hope this report provides residents, partners, and community groups with valuable information for community-based planning.

Figure 88. The Montgomery County Hospital Collaborative Model for Improved Health Outcomes.



Graphic adapted from the Kaiser Family Foundation, 2020

For further information on how the hospitals of the MCHC plan to address each identified unmet need, please review our Multi-Year CHNA Implementation Plan.

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APPENDIX

APPENDIX A LISTING OF COMPREHENSIVE SERVICES BY HOSPITAL

Adventist HealthCare

Founded in 1907, Adventist HealthCare is a faith-based, not-for-profit organization of dedicated professionals who work together to improve the health of people and communities through the ministry of physical, mental and spiritual healing. This total well-being approach has been so successful in helping our community achieve the best health outcomes that Adventist HealthCare has grown to become a comprehensive health system and are seen as leaders, particularly in the areas of heart, orthopedics, maternity and mental health.

Adventist HealthCare is headquartered in Montgomery County, Maryland, and supports the Washington, D.C., metro area through:

- Three acute care hospitals
- Two rehabilitation hospitals
- Two community cancer centers
- Mental health services
- Home care services
- Imaging centers
- Urgent care centers
- Community outreach

Adventist HealthCare also promotes collaboration through the One Health Quality Alliance, our clinically integrated network of over 1,700 health care providers who work together to improve both the quality of care and patient outcomes throughout the region.

For a detailed list of our specialties and services, please visit AdventistHealthCare.com

Holy Cross Health

Holy Cross Health is a Catholic, not-for-profit health system that serves more than 160,000 individuals each year from Maryland's two largest counties — Montgomery and Prince

George's counties. Our community is vibrant, active and diverse, where life is always moving. Holy Cross Health is continuously advancing, too, as a forward-thinking health system committed to helping our community members address their individual needs and goals to achieve a better quality of life. From hospitals and primary care sites to specialty care and wellness programs, Holy Cross Health is accessible throughout the region to meet individuals on their path to good health.

Holy Cross Health has been a steward of our diverse community's health for more than 55 years, earning the trust of area residents. Our team of more than 3,000 employees, 2,069 community-based physicians, and 167 volunteers works proactively each day to meet the needs of every individual we touch. And our mission and values mean that we uphold this commitment for every person, without regard for the ability to pay. During the last five fiscal years, Holy Cross Health has provided more than $287 million in community benefit, including more than $174 million in financial assistance.

Each day, Holy Cross Health colleagues work hard to move people's lives forward, by providing a continuum of quality care that touches individuals in many ways — from prevention to primary care, to chronic disease management, to inpatient care, to care at home and support groups, making the right level of care more accessible and more coordinated. The Holy Cross Health system includes:

- **Holy Cross Hospital**, one of the largest hospitals in Maryland and home to the nation's first and region's only Seniors Emergency Center.

  Specialties and Services:

  - Cardiac services
  - Cancer institute
  - Dialysis services
  - Emergency center
  - Home-based services
  - Hospitalists and intensivists
  - Medical imaging services
  - Neurosciences
  - Pain management center
  - Palliative care
  - Pediatric services
  - Physical medicine and rehabilitation program
  - Senior services
  - Sleep center

- **Holy Cross Germantown Hospital**, the first hospital in the nation to be located on a community college campus and enhanced by an educational partnership, offering high-quality medical, surgical, obstetric, emergency and behavioral health services to the fastest-growing region in the county.

  Specialties and Services:

  - Surgical services
  - Maternity services
  - Behavioral health services
  - Emergency department
  - Intensive care medical/surgical units
  - Imaging and diagnostics

- **Holy Cross Health Network**, which operates Holy Cross Health Centers in Aspen Hill, Gaithersburg, Germantown and Silver Spring; provides primary care at Holy Cross Health Partners at Asbury Methodist Village and in Kensington; offers a wide range of innovative health and wellness programs; and leads partner relationships.
- **Holy Cross Health Foundation** is a not-for-profit organization devoted to raising philanthropic funds to support the mission of Holy Cross Health and to improve the health of the community.

MedStar Health, MedStar Montgomery Medical Center

MedStar Health operates 10 hospitals across Baltimore, central Maryland, Washington, D.C., and southern Maryland. Our facilities offer a full range of health care services and are recognized both regionally and nationally for excellence in medical care.

MedStar Montgomery Medical Center is a not-for-profit, acute care community hospital serving Montgomery County, Maryland. For 100 years, MedStar Montgomery Medical Center has served as a medical care provider and community health resource offering high-quality, personalized care. MedStar Montgomery Medical Center provides a broad range of health care specialties, advanced technologies, and treatments not traditionally found at community hospitals— including cutting-edge care in obstetrics, orthopedics, breast health, and oncology. MedStar Health is the region's largest non-profit and most trusted integrated

health care delivery system, giving patients access to the latest in modern medicine and medical technology within a community hospital setting.

Clinical specialties:

- Bariatric Surgery
- Breast Health
- Gastroenterology
- Non-Surgical Weight Loss
- Orthopedics
- Pulmonology
- Behavioral Health & Psychiatry
- Cardiology p Geriatrics p Oncology
- Physical Therapy & Rehabilitation
- Women's Health

For a detailed list of our programs, services, and providers, visit MedStarHealth.org

Suburban Hospital, Johns Hopkins Medicine

Suburban Hospital is a community-based, not-for-profit hospital serving Montgomery County and the surrounding area since 1943. The hospital provides all major services except obstetrics. The hospital is one of nine regional trauma centers in Maryland and is the state-designated Level II Trauma Center for Montgomery County, with a fully equipped and elevated helipad.

Primary services include:

- Radiation and surgical oncology a part of the Johns Hopkins Kimmel Cancer Center in the National Capital Region and recognized by the American College of Surgeons Commission on Cancer.
- Cardiac surgery including elective and emergency angioplasty and inpatient, diagnostic, and rehabilitation services through the Johns Hopkins Medicine Structural Heart Disease Program at Suburban Hospital.
- Treatment for multiple brain and nervous system conditions—including brain tumors,

movement disorders and general neurosurgical care—provided by Johns Hopkins neurosurgical team.

- Home to inpatient and outpatient behavioral health programs, and an Addiction Treatment Center, offering day treatment programs to adolescents and adults.

- A 24-hour stroke team, as well as state-of-the-art diagnostic pathology and radiology departments.
- A full-service Emergency Department treating more than 40,000 patients annually and includes the Shaw Family Pediatric Emergency Center exclusively for children and adolescents.
- Inpatient Diabetes Management Service (IDMS), which is a special diabetes clinical consultation service designed to promote better glycemic (blood sugar levels) control and reduce hypoglycemia (low blood sugar) and glucose-related safety challenges in hospitalized patients. Suburban Hospital also offers the Diabetes Self-Management Training (DSMT) which a certified diabetes educator meets one on one with individuals living with diabetes to improve their health outcomes.
- An extensive community health and wellness program that invested more than $33.6 million in community benefit contributions in FY 2021, including 5,612 community health improvement programs, biometric screenings, wellness classes and community building activities that served 52,049 individuals in Montgomery County.
- Suburban Hospital achieved Magnet designation in recognition of its nursing excellence from the American Nurses Credentialing Center, becoming the first and only hospital in Montgomery County with this distinct recognition.

For a detailed list of our specialties and services, please visit https://www.hopkinsmedicine.org/suburban_hospital/

APPENDIX B HEALTHY MONTGOMERY STEERING COMMITTEE MEMBERS

STEERING COMMITTEE

CO-CHAIRS

Manna Food Center	Jackie DeCarlo, Chief Executive Officer
Montgomery County DHHS	Christopher Rogers, Policy & Strategy Officer of Public Health Services

MEMBERS

Adventist HealthCare	Gina Maxham, Director, Community Benefit & Engagement
African American Health Program	Jacquelyn Williams, Co-Chair, African American Health Program Steering Committee
Asian American Health Initiative	Nguyen Nguyen, Chair, Asian American Health Initiative Steering Committee
Commission on Health	Crystal DeVance-Wilson, Commissioner
EveryMind	Kathy McCallum, President, Board of Directors
Holy Cross Health	Kimberley McBride, Vice President, Community Health
Latino Health Initiative	Dr. Olivia Carter-Pokras, Latino Health Initiative Steering Committee
MedStar Health, MedStar Montgomery Medical Center	Diana Saladini, Director, Population Health
Montgomery County Department of Planning	Amy Lindsey, Senior Planner
Montgomery County Department of Transportation	Samuel Oji, Chief, Enhanced Mobility and Senior Services Section
Montgomery County Collaboration	Jade-Ann Rennie, Program Manager, Public Health
Montgomery County Public Schools	Victoria Thompson, Coordinator, Student Health Care Services
Montgomery County Recreation	Stephanie McKay, Recreation Specialist
Montgomery Parks	Cristina Sassaki, Parks Planner Coordinator/Urban Designer
Primary Care Coalition of Montgomery County	Leslie Graham, President & Chief Executive Officer
Suburban Hospital	Monique Sanfuentes, Administrative Director, Community Affairs & Population Health
UnitedHealth care Community Plan MCO	Lynn Mejia, Bilingual Community Development Specialist

APPENDIX C HOSPITAL ADVISORY GROUPS AND EXTERNAL REVIEW COMMITTEES

MEMBERS

Addiction Treatment Center – Suburban Hospital	Beth Kane Davidson, Department Director ATC
Adventist HealthCare	Nicolas Cacciabeve, MD, Pathologist
Adventist HealthCare Behavioral Health & Wellness Services	Marissa C. Leslie, MD, Medical Director
Adventist HealthCare	Terry Forde, President & CEO
American University	Anastasia Snelling, Ph.D., Department Chair, Health Studies
AQUAS, Inc.	Carmen Larsen, President
Asian American Health Initiative	Sanjana Qusem, Program Manager
Bethesda NEWtrition & Wellness Solutions	Diana Rapalo, Nurse Practitioner
Bethesda NEWtrition & Wellness Solutions	Rose Oshinsky, Diabetes Nurse Educator
Bradley Hills Village	Betsy Carrier, Treasurer
Cancer Center – Suburban Hospital	Jamie Borns, Nurse Care Coordinator Oncology
Chesapeake Conference of Seventh-day Adventists	Rick Remmers, President
Chevy Chase Trust	Stacy Murchison, Chief Marketing Officer
City of Gaithersburg	Mary Armbruster, Senior Program Coordinator
City of Gaithersburg	Maureen Herndon, Division Manager
Columbia Union Conference of Seventh-day Adventist	David E. Weigley, President
Columbia Union Conference of Seventh-day Adventists	Emmaneul Asiedu, CFO/Treasurer
Community Physician	Michael Smith, M.D., Radiologist and brother of Alpha Phi Alpha Fraternity, Montgomery County Chapter
Cross Community	Ben Wikner, Executive Director and Pastor
Events DC	Henry Mosley, CFO
EveryMind	Karishma Sheth, Chief Program Officer
Everymind- Linkages to Learning	Reina Guerrero, Community School Coordinator
Community Advocate	Karin Bertozzi
Gaithersburg Chamber of Commerce	Marilyn Balcombe, President and CEO
Girls on the Run, Montgomery County	Elizabeth McGlynn, Executive Director
GT Health	Gerti Tashko, MD
Healthcare Initiative Foundation	Crystal Townsend, President & CEO
Healthy Montgomery/ DHHS Office	Felicia Hugee, Planning Specialist

Holy Cross Health Center-Aspen Hill	Jacqueline Williams-Hubbard, Director
Housing Opportunities Commission	Marsha Batista, Resident Counselor III
Impact Silver Spring	Michael Rubin, Interim Executive Director
Kamehameha Schools	Janet Devinney, Director-Orivate Equity & Venture Capital
Latino Health Initiative	Paola Fernan-Zagarra, Planning and Quality Assurance Manager
Laurel Medical Associates	Darryl Hill, MD
Leisure World of Maryland Corporation	Susan Montgomery, Director of Social Services
Lerch Early & Brewer	Paul Alpuche Jr., Attorney
MC Chapter of National PanHellenic Council	Bertha Ballew, President
MedStar Health, MedStar Montgomery Medical Center	Debbie Otani, Cancer Nurse Navigator
MedStar Health, MedStar Montgomery Medical Center	Lynda Suh, Director, Quality and Risk
MedStar Health, MedStar Montgomery Medical Center	Ngozi Wexler, MD, VP, Medical Affairs
MedStar Health, MedStar Montgomery Medical Center	Deana Cho, Social Worker, Center for Successful Aging
MedStar Health, MedStar Montgomery Medical Center	Lisa King, Patient Family Advisory Council Member
Millian United Methodist Church	Edith Williams, Community Representative
Mindoula	Danielle Dennis, Readmissions Reduction Case Manager
Montgomery College	Karla Silvestre, Director of Community Engagement
Montgomery County Department of Health and Human Services	James Bridgers, PhD, Acting Health Officer & Chief
Montgomery County Department of Health and Human Services	Christopher Rogers, PhD, Policy & Strategy Officer of Public Health Services
Montgomery County Government	Ken Hartman, Director of Strategic Partnerships at Montgomery County Government
Montgomery County Police 2nd District	Officer Dana Stroman, Community Services Officer
Montgomery County Public Schools	Ana Schmitz, Community School Coordinator
Montgomery County Recreation	Amanda DeFilippo, Manager III
Olney Home for Life	Audrey Partington, Chair, Outreach
Olney Theater	Debbie Ellinghaus, Community Representative
Pastoral Care – Suburban Hospital	Philip Ridley, Director
Primary Care Coalition	Mary Jane Joseph, Project Manager
Resident of Montgomery County	Belle O'Brien, Community Advocate
Seventh-day Adventists	Charles Tapp, President

Southern Asian Seventh-day Adventist Church	Franklin David, Senior Pastor
Suburban Hospital	Jeanmarie Gallagher, Manager Cardiac Rehabilitation
Suburban Hospital	Fayyaz Hashmi, MD, Clinical Associate – Cardiac Surgery
Suburban Hospital	Carolyn Wu, MD, Cardiology
Suburban Hospital	Mihail "Misha" Zilbermint, MD, MBA, Endocrinologist
Summit Leadership Solutions	James Boyle, President & CEO
The RJ Clarke Group LLC	Robert Clarke, Principal
United Way of the National Capital Area	Ian Gordan, Vice President, Community Impact
University of Maryland	Stephen B. Thomas, PhD, Professor, Department of Health Policy & Management and Director, Maryland Center for Health Equity
USACS East	Brett Gamma, MD, Medical Director
Washington Adventist University	Cheryl Kisunzu, Provost
YMCA of Metropolitan Washington	Carla Larrick, Vice President of Operations
National Institutes of Health	Meg Whelpley, Nurse Practitioner
Patient & Family Advisory Committee, Suburban Hospital	Elsie Durland, Community Advocate
Patient & Family Advisory Committee, Suburban Hospital	Jacqueline Beale, Community Advocate
JDRF (Juvenile Diabetes Research Foundation)	Barbara Kahl, Community Advocate

APPENDIX D HEALTHY MONTGOMERY KEY INFORMANT INTERVIEW SUMMARY

Community Health Improvement Process
2021-2022 Community Health Needs Assessment
Community Conversation with *Key Informants*

Introduction

The purpose of the key informant interview (KII) component of the Community Health Needs Assessment (CHNA) was to gather thoughts and perspectives from key Montgomery County stakeholders on the local environment, to identify the most pressing needs of the community, and to prioritize significant health needs of the Montgomery County community over the next several years. A total of 56 stakeholders participated in the 11 KIIs. The KIIs included stakeholders from the following County entities: organizations primarily serving Asian Americans, organizations primarily serving Latino/a or Hispanic Individuals, organizations primarily serving Black, African or African Americans, Faith Leaders, Adventist HealthCare, Suburban Hospital, Medstar Health, Holy Cross Hospital, and Montgomery County Boards, Committees and Commissions (Racial Equity and Social Justice Advisory Committee, Fire and Emergency Services Commission, and Board of Social Services).

The participants of the KIIs represented the diversity of the communities they served. Participants noted that certain services or needs are greater in some zip codes as compared to others. Notable health issues, concerns, barriers or needs of the communities served were identified by participants as inadequate housing, increasing homelessness among low-income individuals, lack of advance care planning among older adults, expensive medication, human trafficking, and domestic violence. Participants emphasized the need for an integrated approach to solving the health care needs in the community that provided resources and client/patient education.

Health Issues, Concerns, Barriers or Needs of the Community

Health behaviors were discussed by stakeholders as issues, concerns, barriers, or needs affecting the health of the community. Teen pregnancy was stated as a health concern in the community. Participants shared concerns over increases in the number of pregnant teens that are engaging in substance use (marijuana). Further, use of opioids, specifically fentanyl, and alcohol use disorders are increasing health concerns in Montgomery County. One participant stated from their experience that calls to 911 involving alcohol use disorders have increased during the pandemic.

Intimate partner sexual violence, including physical abuse, was a health issue described by participants. Participants cited additional barriers to intimate partner sexual violence are related to culture (such as beliefs about divorce or having both parents for the children, even in the face of violence) and economic need (individuals perceived inability to leave abusers due to financial dependence). Multiple families residing in one dwelling, often related to economic insecurity, presents a heightened risk factor related to intimate partner sexual violence, cited one participant.

Social, economic, and demographic factors were discussed by stakeholders as issues, concerns, barriers, or needs affecting the health of the community. Participants felt that economic stability,

specifically financial insecurity among low-income community members was a barrier that affected the health of individuals served. Transportation was referenced by many participants as a barrier to medical appointments, especially for low-income individuals seeking primary care, though in some areas participants mentioned, clients do live near clinics that serve this population.

Food security and access to healthy foods was an issue discussed by many participants across the interviews. Stakeholders shared those individuals in the communities they serve, specifically those with chronic conditions or low-income, experience barriers associated with affordable healthy food options based on dietary preferences. One stakeholder commented that individuals' feedback on their organization's current nutritional resources reveal that these services are inadequate. Feedback results showed that individuals who are referred to nutritional counseling or support find that these services do not meet their needs.

Some residents have no health insurance or limited health insurance benefits. Participants shared concerns for the availability of health insurance that impacts one's ability to pay co-payments for mental health and wellness visits.

Participants emphasized concerns around employment as a health barrier. Some community residents may be underemployed (limited hours or pay to support needs) or have lost their job due to the COVID-19 pandemic. Those most impacted by employment concerns are the working poor, which includes:

- Women
- Part-time workers
- Service workers
- Young workers
- Unrelated individuals (people who live together but are not blood relatives)

Participants also noted that as stakeholders, they too can find it difficult to navigate information on the availability of additional resources to support their clients and patients. "We're blessed. Montgomery County has an incredible amount of resources and information available, except, there is so much, you can get overwhelmed going on the MontgomeryCounty.gov website", as one participant stated. Participants agreed that assistance with the navigation of county resources and services would be helpful to them. One participant felt that low-income individuals fear completing government assistance applications due to undocumented status. Other low-income individuals, stakeholders stated, have difficulties navigating government/accessing services.

Clinical care factors were discussed as issues, concerns, barriers, or needs for access to affordable, quality, and timely health care that can help prevent diseases and detect issues sooner. Access to specialty care health services was a need identified by stakeholders. One participant cited from their experience a growing increase of younger adults with renal failure noting, there is "no clinics" to send patients to for hemodialysis, especially if they are uninsured or undocumented. These patients may end up "hospital hopping" in order to receive care, which in the long run is not good for continuity of patient care or for hospital resources. The other specialty care needs within the community include barriers dental care associated with costs, and the need to travel to this care. Participants expressed that even if families get the money to pay for dental care and find a dentist, they are often spread out so far that individuals must take multiple buses to get there or rely on someone giving them a ride.

Participants discussed insufficient fiscal and human resources support to meet the mental health needs of the communities. For example, mental health facilities lacked support for those needing

behavioral health care, making it challenging to place those in need of substance use treatment/detox and assistance with a mental health condition. Also, participants cited that many existing facilities do not have enough space for patients to keep up with the demand of treatment needs.

Post-hospital discharge support services for individuals who are uninsured, underinsured, or homeless was a concern mentioned by participants. One participant shared concern around there not being enough facilities to meet the safe hospital discharge needs of the older adult population. Access to a primary care provider was also cited as a barrier to health care services for individuals who are uninsured or underinsured. The unaffordable cost of prescription medications was another barrier experienced by and concern for the uninsured and underinsured communities. One participant shared that some patients come to the emergency room because they have run out of their maintenance prescriptions for conditions like diabetes or hypertension.

Participants discussed **physical and built environment** issues, concerns, barriers, or needs that affect where individuals live, learn, work, and play. Stakeholders emphasized housing affecting health as a concern for Montgomery County communities. Housing concerns includes both homelessness and the availability of affordable housing. Housing insecurity (e.g., overcrowding, landlords who operate poorly maintained properties) participants noted has critical implications related to health care (e.g., medications that require refrigeration) and safety (e.g., domestic abuse, family stress, etc.).

Access to transportation was discussed by many participants as a barrier that impacts the ability to access health services, which can affect one's health if one cannot get routine care. Having limited transportation options, one participant noted, can also be a source of stress.

Internet access to find information about available support services was discussed as a barrier.

Environmental conditions and climate change concerns are issues discussed by stakeholders across the key informant interviews. Some examples provided are general concerns about air quality, radon levels in homes, mold in housing, health issues related to lead paint, unmaintained air conditioning units that could lead to Legionnaires' disease, and safe environments for animals.

Stakeholders across all interviews discussed several **quality of life** issues, concerns, barriers, or needs that represent the lack of health of people in the community. Participants shared an overall concern for patients who decided to delay their annual preventive health care screenings due to the COVID-19 pandemic. Preventable conditions like obesity, hypertension and diabetes were listed as health concerns. Several participants felt that these conditions are more prevalent among minority communities, specifically Blacks and Latinos. One participant cited that obesity can also be impacted by mental health and other co-morbidities, so a "one-size-fits-all approach to address obesity does not work." Another participant mentioned from their experience there is an increase incidence of younger adults presenting to the hospital emergency room with diabetic ketoacidosis and heart disease.

Breast cancer was stated as a health issue that adversely affects the quality of life for women in Montgomery County communities. One participant cited concerns for late-stage breast cancer diagnosis for individuals that have delayed preventive screenings due to the COVID-19 pandemic.

Stakeholders identified mental and behavioral health concerns affecting the community they serve. Participants discussed that community members are impacted by depression, mania, bipolar, schizophrenia, and other chronic mental health concerns. Participants shared concerns for the overall mental health for low-income community residents, especially as a result of the COVID-19

pandemic. Participants further expressed concern that youth and adolescents are dealing with mental and behavioral health issues including depression, anxiety, and suicide ideation. One participant shared that mental health conditions among pregnant teens is a growing issue in the community they serve. Participants stated that trauma and grief in low-income individuals is an issue affecting the health of the community they serve. One participant shared from their own experience that mental health-related calls to 911 have increased during the COVID-19 pandemic.

Participants identified Alzheimer's or other dementia as an increasing memory care issue for the older adult population of Montgomery County. Of note was a need for more in-home care for older adults with Alzheimer's or other dementias. One participant shared those older adults like to stay in their homes, so when a medical emergency arises, they may delay seeking care for fear they will not return home and will be placed in a nursing home or other assisted living facility. Participants voiced concern that familial support may not be readily available for aging adults as this community was described by one participant as being "a very transient area".

Resources to Support Healthy Living

Stakeholders across the KIIs shared their thoughts on resources that currently exist and would like to see in the community that can help people live a healthy life. These resources support several health issues, concerns, needs, and barriers identified in the previous section, including behavioral health, mental health, substance use, food security, housing, and dental care.

Clinical Care Resources

- A "middle level" facility, for example a step-down from a skilled nursing facility, that can address mental and behavioral health needs of the community by providing daily counseling and a more holistic care approach.
- Montgomery County Restoration Center to support behavioral health and substance use.
- Suicide prevention groups within schools to provide resources to youth
- Montgomery County should continue existing programs that support mental health, especially for minority populations, like African American Health Program, the Latino Health Initiative, and the Asian American Health initiative. These programs were described as "good programs, and we would like to see those continue."
- Ancillary behavioral health services including Vesta and Cornerstone Montgomery
- Specialized resources/services and safe spaces for individuals to be able to come forward and report when they are experiencing traumas and being targeted by law enforcement.
- Avery Road and Maryland treatment services for mental health
- Medical respite homes for the homeless
- Mobile units bringing dental care to communities
- Offering family and nursing care, which sends nurses to patients' home to conduct safety checks and connect to community resources.
- Resources to make medication freely available to clients

Social, Economic, and Demographic Resources

- Maximize the use of local services within the Montgomery County cities are good as these agencies and programs often work together to provide more tailored and holistic support to the community. These types of initiatives could serve as models for county-level programs.

- Integration of social services into medical care services: eligibility and support services, especially to help food security, foster care programs, and leveraging county resources with existing HHS funded programs
- Interfaith Works Program
- Community wrap-around services that offer food and shelter resources
- Homeless shelters
- Homeless programs to connect individuals to temporary housing, for example hotels
- United US and Info Montgomery are websites used to look up existing resources to address social determinants of health.
- Expanded online health and human services repositories to look up and identify resources quickly.
- Case managers to connect individuals to social services
- Neighborhood networks to strengthen partnerships between health care and community-based organizations.
- Living wages

Quality of Life

- Public awareness of intimate partner sexual violence community resources available
- Specialized training/capacity building, such as trauma-informed interpretation (as opposed to mere translation)
- Building a trusting relationship between a client/patient (or potential clients/patients) and provider so that those who need services feel safe seeking help if/when needed.

Health Behaviors

- Culturally appropriate health education and resources tailored to the Black and Latino populations to address diabetes and obesity.
- Chronic disease self-management education to understand the disease process and to promote healthier eating based on dietary preferences.
- Health education for pregnant teens about the dangers engaging in substance use (marijuana) poses to the baby.
- Maximize the use of technology platforms such as WhatsApp and YouTube to provide tailored health information to special populations.

Built Environment

- Enhance the built environment with more grocery stores in the County in order to support a healthy lifestyle
- Enhance the built environment with more parks and greenspaces in the County in order to support a healthy lifestyle

** The 2021-2022 Community Health Needs Assessment Community Conversation with Key Informants was prepared by Healthy Montgomery staff.*

APPENDIX E MCHC CBSA ZIP CODES

ZIP CODE	CITY
20705	BELTSVILLE
20706	LANHAM
20707	LAUREL
20740	COLLEGE PARK
20742	COLLEGE PARK
20770	GREENBELT
20782	HYATTSVILLE
20783	HYATTSVILLE
20814	BETHESDA
20815	CHEVY CHASE
20816	BETHESDA
20817	BETHESDA
20832	OLNEY
20850	ROCKVILLE
20851	ROCKVILLE
20852	ROCKVILLE
20853	ROCKVILLE
20854	POTOMAC
20855	DERWOOD
20866	BURTONSVILLE
20871	CLARKSBURG
20874	GERMANTOWN
20876	GERMANTOWN
20877	GAITHERSBURG
20878	GAITHERSBURG
20879	GAITHERSBURG
20882	GAITHERSBURG
20886	MONTGOMERY VILLAGE
20895	KENSINGTON
20899	GAITHERSBURG
20901	SILVER SPRING
20902	SILVER SPRING
20903	SILVER SPRING
20904	SILVER SPRING
20905	SILVER SPRING
20906	SILVER SPRING
20910	SILVER SPRING
20912	TAKOMA PARK

APPENDIX F DEMOGRAPHICS OF EQUITY FOCUS AREAS (2018)

Montgomery County, Md	% of Equity Focus Areas	% of Area Outside of EFAs	% of County
POPULATION			
Total population	*275,873*	*764,260*	*1,040,133*
% of County's population	26.5%	73.5%	
Population living in households	274,447	756,839	1,031,286
Age Distribution			
Total population	*275,873*	*764,260*	*1,040,133*
0-4 years	7.7%	5.9%	6.4%
5-17 years	16.8%	17.1%	17.0%
18-34 years	26.1%	19.0%	21.0%
35-44 years	15.3%	13.2%	14.0%
45-64 years	23.7%	28.7%	27.0%
65 years and older	10.5%	16.1%	14.6%
Race and Hispanic Origin Combined [1]			
Total population	*275,873*	*764,260*	*1,040,133*
Not Hispanic	64.8%	86.5%	80.7%
White	22.0%	52.6%	44.5%
Black	25.7%	14.8%	17.7%
Asian or Pacific Islander	13.6%	15.0%	14.6%
Other race	3.5%	4.1%	3.9%
Hispanic or Latino [1]	35.2%	13.5%	19.3%
Language Spoken at Home			
Population 5 years and over	*254,609*	*718,824*	*973,433*
Speak language other than English	57.8%	34.6%	40.6%
Speak English less than "very well"	24.0%	10.5%	14.0%
Educational Attainment			
Persons 25 years and older	*182,898*	*531,597*	*714,495*
Less than high school diploma	17.5%	5.7%	8.7%
High school graduate, some college or associate	42.7%	28.6%	32.3%
Bachelor's degree	21.4%	29.1%	27.1%
Graduate or professional degree	18.5%	36.5%	31.9%
Residence 1 Year Ago			
Population 1 year and over	*271,567*	*756,455*	*1,028,022*
Same house	81.9%	86.8%	85.5%
Different house in U.S.	16.4%	11.5%	12.8%
Abroad	1.8%	1.6%	1.7%
LABOR FORCE			
Class of Worker [2]			
Civilian employed population 16 years and over	*150,339*	*405,924*	*556,263*
Private wage and salary	77.7%	70.6%	72.5%
Government	16.7%	23.0%	21.3%
Self-employed in own not incorporated business	5.5%	6.2%	6.0%

Source: Research and Strategic Projects, Montgomery Planning Department, M-NCPPC (March 2021).

Equity Focus Areas & Area Outside of EFAs (2018)

Montgomery County, Md	% of Equity Focus Areas	% of Area Outside of EFAs	% of County
Occupation			
Civilian employed population 16 years and over	*150,339*	*405,924*	*556,263*
Management, business, science, and arts	38.0%	62.9%	56.2%
Service	24.8%	12.0%	15.5%
Sales and office	18.5%	16.7%	17.2%
Natural resources, construction, and maintenance	10.6%	4.0%	5.8%
Production, transportation, and material moving	8.0%	4.3%	5.3%
Work Trip			
Workers 16 years and over	*147,143*	*401,371*	*548,514*
Drove	75.0%	75.2%	75.1%
Alone	61.8%	66.6%	65.3%
Carpool	13.2%	8.6%	9.8%
Public transportation	18.6%	13.8%	15.1%
Walked and other means	3.5%	3.8%	3.7%
Worked at home	3.0%	7.3%	6.1%
Average travel time to work (minutes)	34.3	37.3	34.6
Work Location			
Workers 16 years and over	*147,143*	*401,371*	*548,514*
In County	62.3%	60.8%	61.2%
Outside County, in Maryland	12.3%	10.4%	10.9%
In another state	25.3%	28.9%	27.9%
HOUSEHOLD INCOME			
2018 Household Income Distribution			
Households	*94,019*	*276,208*	*370,227*
Under $25,000	13.3%	7.9%	9.3%
$25,000 to $49,999	19.9%	9.9%	12.4%
$50,000 to $74,999	18.8%	11.5%	13.4%
$75,000 to $99,999	14.7%	11.1%	12.0%
$100,000 to 149,999	18.0%	19.7%	19.3%
$150,000 to 199,999	8.7%	13.7%	12.4%
$200,000+	6.7%	26.3%	21.3%
2018 average household income	$89,950	$163,368	$144,723
People whose income is below the poverty level	11.9%	5.1%	6.9%

Source: Research and Strategic Projects, Montgomery Planning Department, M-NCPPC (March 2021).

Equity Focus Areas & Area Outside of EFAs (2018)

Montgomery County, Md	% of Equity Focus Areas	% of Area Outside of EFAs	% of County
HOUSING			
Housing units	*99,578*	*288,676*	*388,254*
% of County's housing units	25.7%	74.4%	
Households	94,019	276,208	370,227
Average Household Size	2.92	2.74	2.79
Housing Units in Structure			
Housing units	*99,578*	*288,676*	*388,254*
1-unit, detached	29.1%	53.8%	47.4%
1-unit, attached	19.6%	17.9%	18.4%
2 to 4 units	2.7%	1.5%	1.8%
5 to 9 units	10.4%	3.3%	5.1%
10 to 19 units	20.0%	5.7%	9.4%
20 to 49 units	3.5%	2.6%	2.8%
50 or more units	14.4%	15.1%	14.9%
Mobile homes, RV	0.2%	0.1%	0.2%
Households by Type			
Households	*94,019*	*276,208*	*370,227*
Family households	66.7%	71.0%	69.9%
Families with children under 18	34.2%	32.4%	32.8%
Nonfamily households	33.3%	29.0%	30.1%
Householder living alone	26.4%	24.3%	24.8%
Households by Tenure			
Households	*94,019*	*276,208*	*370,227*
Owner-occupied	46.0%	72.0%	65.4%
Renter-occupied	54.0%	28.0%	34.6%
Owner-Occupied Housing Value (2018 dollars)			
Owner-occupied households	*43,280*	*198,983*	*242,263*
less than $300,000	38.7%	15.5%	19.6%
$300,000 to $399,999	29.7%	15.2%	17.8%
$400,000 to $499,999	20.2%	15.7%	16.5%
$500,000 to $749,999	10.2%	27.6%	24.5%
$750,000 to $999,999	0.8%	14.0%	11.7%
$1,000,000 or more	0.5%	12.0%	9.9%
Average housing value	$344,664	$628,725	$561,998
Selected Monthly Owner Costs			
Households with a mortgage	*31,862*	*147,310*	*179,172*
Less than $1,500	21.2%	11.1%	12.9%
$1,500 to $1,999	29.6%	15.4%	17.9%
$2,000 to $2,499	22.3%	18.3%	19.0%
$2,500 to $2,999	14.7%	16.4%	16.1%
$3,00 to $3,999	9.8%	20.3%	18.4%
$4,000 or more	2.4%	18.5%	15.6%
Average monthly mortgage cost	$2,136	$2,983	$2,844

Source: Research and Strategic Projects, Montgomery Planning Department, M-NCPPC (March 2021).

Equity Focus Areas & Area Outside of EFAs (2018)

Montgomery County, Md	% of Equity Focus Areas	% of Area Outside of EFAs	% of County
Gross Rent (including utilities)			
Households paying rent	*49,824*	*74,623*	*124,447*
Less than $1,000	9.2%	8.8%	9.0%
$1,000 to $1,499	29.7%	18.6%	23.0%
$1,500 to $1,999	44.7%	32.2%	37.2%
$2,000 to $2,499	12.7%	22.5%	18.6%
$2,500 or more	3.8%	17.9%	12.3%
Average monthly rent	$1,591	$2,787	$1,769
Households Spending More Than 35% of Income on Housing Costs			
Households	*94,019*	*276,208*	*370,227*
Homeowners with a mortgage	25.9%	19.2%	20.4%
Renters	44.2%	38.5%	41.3%
Households with Available Vehicles			
Households	*94,019*	*276,208*	*370,227*
No vehicles available	11.3%	6.4%	7.6%
1 vehicle	39.4%	31.7%	33.6%
2 vehicles	34.2%	41.8%	39.8%
3 or more vehicles	15.2%	20.2%	18.9%

Note: The profile is derived from the aggregation of U.S. Census Block Groups from the 2018 American Community Survey, 5-year estimates.

[1] *Those of Hispanic origin may be of any race.* [2] *Unpaid family workers are not shown.*

** Data reliabilty was judged on a scale of good, fair, caution, or poor. The majority of reported estimates are judged as "good" the highest level of reliability with the exception of mobile homes rates as "poor".*

Source: 2018 American Community Survey, 5-year estimates, U.S. Census Bureau; compiled by Research & Strategic Projects, Montgomery County Planning Department, M-NCPPC (March 2021).

Source: Research and Strategic Projects, Montgomery Planning Department, M-NCPPC (March 2021).

APPENDIX G FACTORS THAT DRIVE HEALTH OUTCOMES FOR MONTGOMERY AND PRINCE GEORGE'S COUNTIES

County Health Rankings & Roadmaps
Building a Culture of Health, County by County

Robert Wood Johnson Foundation

The 2022 Rankings include deaths attributable to COVID-19 from 2020. See our FAQs for more information on COVID-specific data.

Compare Counties

2022 Rankings

	Maryland	Prince George's (PG), MD X	Montgomery (MO), MD X PEER COUNTY
Health Outcomes			
Length of Life			
Premature death	7,500	7,500	4,300
Quality of Life			
Poor or fair health**	14%	17%	13%
Poor physical health days**	3.2	3.5	2.9
Poor mental health days**	4.0	4.1	3.6
Low birthweight	9%	9%	7%
Health Factors			
Health Behaviors			
Adult smoking**	13%	13%	9%
Adult obesity**	32%	37%	25%
Food environment index**	8.7	9.1	9.0
Physical inactivity**	23%	27%	19%
Access to exercise opportunities	88%	97%	99%
Excessive drinking**	16%	15%	15%
Alcohol-impaired driving deaths	28%	31%	22%
Sexually transmitted infections**	624.9	908.6	447.2
Teen births	15	20	10
Clinical Care			
Uninsured	7%	10%	8%
Primary care physicians	1,120:1	1,890:1	720:1
Dentists	1,260:1	1,570:1	800:1
Mental health providers	330:1	550:1	280:1
Preventable hospital stays	3,568	3,855	2,185
Mammography screening	42%	38%	41%
Flu vaccinations	51%	40%	54%
Social & Economic Factors			
High school completion	91%	87%	91%
Some college	71%	63%	78%
Unemployment**	6.8%	8.2%	6.3%

Children in poverty	11%	13%	8%
Income inequality	4.5	3.8	4.5
Children in single-parent households	26%	33%	20%
Social associations	9.0	8.0	8.8
Violent crime**	459	423	173
Injury deaths	88	62	43
Physical Environment			
Air pollution - particulate matter	7.4	6.3	8.7
Drinking water violations		No	No
Severe housing problems	16%	19%	17%
Driving alone to work	72%	66%	63%
Long commute - driving alone	50%	61%	54%

** Compare across states with caution
^ This measure should not be compared across states
Note: Blank values reflect unreliable or missing data

APPENDIX H COMMUNITY INPUT SURVEY DISTRIBUTION CHANNELS

Artistry	Thought Leaders (Behavioral Health, Cancer, Heart, Diabetes, Infections, and Injuries)
The FitSolution	WellWorks
Community Ministries of Rockville	BCC Chamber – Health & Wellness Workgroup
AAHP	PFAC
PG County Health Department	Village Ambassadors
HCH Senior Source	Barrington Apartments – vaccine clinics
Montgomery County Stroke Association	Montgomery County Food Council
Capital Digestive Care	Bethesda Beat
Life Insurance for Diabetics	SH – Community Health Improvement Council
Maryland Metro Ostomy Association	EveryMind
GKV	Girls of the Run
Maryland Physicians Care	Neighborhood Patches
Very Vegelicious	Regional Service Newsletter
Kensington Lions Club	Latino Health Initiative
The Michael and Mauritia Patch Foundation	InterStaff Communication
Organo Gold	BCC Rotary Club
White Oak Physical Therapy	YMCA
Columbia Lighthouse for the Blind	Greater Bethesda Chamber of Commerce
Montgomery Hospice	Scotland Community
Safe Places	Safe Kids MoCo
Mont Co - Energy Program	Transamerica
Fitness for Less Gym	Center for Vein Restoration
Montgomery County Cancer Crusade	Schrier Physical Therapy
Foot and Ankle Specialists	Giant Food
Senior Life Insurance Company	Montgomery County Police Department
MC DHHS - Dental	Holistic Acupuncture and Physical Therapy
MC Fire & Rescue	Bemer Microcirculation
MC Library - Gaithersburg	Jewish Council for The Aging
Primary Care Coalition	Germantown and Women's Imaging Center, Community Radiology Associates
Scion Dental - Smile Program	Capital Women's Care
Family Services, Inc	Potomac Valley Associates
Gold's Gym - Germantown	Waters Landing Elem School
Mobile Eye Care	Montgomery College, Germantown

Healing Our Village	Southern Management
African Women's Cancer Awareness Association	Margaret Schweinhaut
Prevention of Blindness Society	Bauer Park Apartments
Commission on Indian Affairs	Langley Park Community Center
Mt. Jezreel Baptist Church	MarComm Department - external and internal
Hunter Memorial AME Church	Germantown Baptist Church
First Baptist Church of Glenarden	Bethel World Outreach Church
Taking Effective Action, Inc	Washington Adventist University
First United Methodist Church	Matsunaga Elem School
Clifton Park Baptist Church	

APPENDIX I PRIORITIZATION PROCESS KEY STAKEHOLDERS/INFORMANTS LIST

Area	Organization
Minority Health Initiatives	African American Health Program
	Latino Health Initiative
	National Pan-Hellenic Council
Healthy Montgomery Steering Committee (LHIC)	Manna Food Center
	Montgomery County DHHS
	Commision on Health
	Latino Health Initiative
	Primary Care Coalition of Montgomery County
	Montgomery County Department of Planning
	Ronald D. Paul Cos., Inc.
	Montgomery County Recreation
	United Healthcare Community Plan MCO
	Asian American Health Initiative
	Montgomery County Department of Transportation
	Montgomery County Collaborative
	Montgomery Parks
	African American Health Program
Social Services	CASA de Maryland
	CHEER
	Gaithersburg HELP
	St. Ann's Center for CYF (PGC)
	United Way (PGC)
	Taking Effective Action, Inc (PGC)
	Prince George's County Health Department
	Langley Park Civic Association (PGC)
	Gilchrist Immigrant Resource Center
County Government	City of Gaithersburg
	City of New Carrollton (PGC)
	Gaithersburg/Germantown Chamber of Commerce
	Prince George's County County Council
	Bethesda Chevy Chase Regional Services Center
Behavioral & Mental Health	EveryMind
	Mindoula
	CentrePointe Counseling (PGC)

Faith-based Organizations	Faith Community leader
	Millian United Methodist Church
	Cross Community
	National Wesleyan Church (PGC)
	Zion Church Greenbelt (PGC)
	Metropolitan Seventh-Day Adventist Church (PGC)
	Kingdom Fellowship
	SHABACH! Ministries (PGC)
Community Clinics	Holy Cross Health Center- Aspen Hill
	Mary's Center
	Mary's Center
	Mary's Center
	Mary's Center
	La Clinica del Pueblo (PGC)
	Primary Care Coalition
	CCI (PGC)
Housing	Maple Ridge Apartments (PGC)
	MC DHHS/End and Prevent Homelessness
	MCCH or County Housing Services
Youth	Identity
	MCPS
	YMCA of Metropolitan Washington
Food	Manna
	Homestead Hustle and Healing
	La Sirenita Restaurant (PGC)
	PGC Food Equity Council
Older Adults	Leisure World of Maryland Corporation
	County Office of Aging
	Suburban's Parent and Family Advisory Council
	Prince George's County Advisory Committee on Aging
	Bradley Hills Village
	Potomac Community Village
	Friendship Heights Village
	PGC Parks & Recreation
	OASIS
Other	Olney Theater
	MC Department of Recreation
	ElevateHER
	University of Maryland, School of Public Health (Director, Maryland Center for Health Equity)
	Healthcare Initiative Foundation
	American Mega Laudromat (PGC)
	Coco Cabana (PGC)
	PGHAC (LHIC) - Healthy Eating Active Living Workgroup
	PGHAC (LHIC) - HEAL
	PGHAC (LHIC) - Health Equity Workgroup
	PGHAC (LHIC) - Behavioral Health

APPENDIX J EVALUATION OF PREVIOUS CHNAS

ACCESS TO HEALTH CARE SERVICES

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA)[α]	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Uninsured rate (%)	7.1%	0%†	9.6%	7.1%	10.1%

PROGRAMS AND SERVICES

Holy Cross Health: Operate four health centers for the un/underinsured in geographically accessible locations; Implement plan to link uninsured Maternity Partnership patients to primary care services at HC Health Centers to create a medical home for the whole family

Medstar Montgomery: Provide financial support to two safety-net clinics within the CBSA, including Holy Cross Health Center Aspen Hill and Proyecto Salud Clinic Olney; Assist patients in need of Insurance through screenings, referrals and linkage to community resources through hospital-based programs and Community Health Advocate program.

Suburban Hospital: MobileMed/NIH Heart Clinic at Suburban Hospital, MobileMed/NIH Endocrine Clinic at Suburban Hospital

BEHAVIORAL HEALTH

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA)[α]	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Decrease percentage of adults with poor mental health	16.8%	16.8%Δ	11.6%	10.0%	12.4%
ER visits for behavioral health conditions (per 100,000)	752.0	3152.6††	N/A	1376.4	1955.6
Decrease suicide rate (per 100,000)	6.8	9.0††	7.3	7.4	6.3

PROGRAMS AND SERVICES

Adventist HealthCare: Behavioral Health Support Groups & Workshops (Overcoming Winter Blues, Tools for Effective Communication, How to Stop Avoiding Issues and Become a Stronger Communicator, Grief & Loss, Becoming Resilient Person); Behavioral Health Education (partnership with MC Hospitals & EveryMind, Inc.); Behavioral Health Internships; Mental Health First Aid; Forensic Medical Unit at Shady Grove Medical Center.

Holy Cross Health: Behavioral health screenings with links to treatment at the HCH Health Centers; Provide behavioral health services and links to treatment through the Nexus Montgomery Crisis House, ACT Teams, and behavioral health Integration; Offer Stanford University's Chronic Pain Self-Management Program; Collaborate with community partners to address behavioral health in the community

MedStar Montgomery: Conduct Screenings through Brief Interventions and Referral to Treatment (SBIRT) Program in the Emergency Room, supported by Peer Recovery Coaches; Mindoula Behavioral Health Program; Engage as a member of Nexus Montgomery Regional partnership by centralizing crisis services ecosystem, expanding mobile crisis delivery, and offering same day access services; Behavioral Health Education (Partnership with MC Hospitals and EveryMind, Inc.).

Suburban Hospital: Concerned Persons Program, Addiction Treatment Center, Widowed Persons Social Group, Support to Parents Encouragement Program with their Critical Topics in Parenting Series, Village Ambassodar Alliance, Monthly Health Webinars, Men's Helth Symposium: Brain-Gut Health, Engaged as a member of Nexus Montgomery Regional partnership, Charles E. Smith Life Communities Symposium- COVID-19 Pandemic: Mental Health Effects on Older Adults and their Health Care Providers.

CHRONIC DISEASE: DIABETES

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA)[α]	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Decrease percentage of adults with Diabetes	13.5%	10.2%◊	9.00%	7.2%	12.3%
Decrease ER Visits for Diabetes (per 100,000)	280.5	186.3††	N/A	444.4	229.2

PROGRAMS AND SERVICES

Adventist HealthCare: NEXUS Montgomery Regional Partnership Catalyst Diabetes Project; Community Health Screenings & Lectures; Integrative Medicine Programs; Food & Nutrition Classes

Holy Cross Health: Provide care management, education and nutrition counseling at HC Health Centers for high-risk patients; Expand diabetes programming (English and Spanish) with Nexus Montgomery Regional Partnership Catalyst Diabetes Project (NMRP) (DPP and DSMT metric); Offer Stanford University's Diabetes Self-Management Program in English and Spanish

MedStar Montgomery: Host and provide access to healthy lifestyle educational programs, wellness activities, community screenings and support groups; Diabetes Support Group, Pre-Diabetes Support Group.

Suburban Hospital: Pre-Diabetes: Laying the Foundation, Thrive 365 Education and Support Group Meetings in English and Spanish, Diabetes A-Z Management, JDRF Type 1 Support Group, Baltimore Metropolitan Diabetes Regional Partnership, Health Education Webinars, MobileMed/NIH Endocrine Clinic at Suburban Hospital.

CHRONIC DISEASE: CANCER

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA)[α]	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Decrease cancer mortality rate (per 100,000)	134.1	147.4††	118.7	114.6	149.9
Increase percent of colorectal cancer screening for adults 50+	72.9%	73%◊	N/A	68.6%	68.9%
Decrease colorectal cancer mortality (per 100,000 men)	11.7	14.5†	N/A	10.0	13.6
Increase percent of women who have a Pap in past 3 years	83.0%	93.0%†	N/A	86.3%	87.2%
Decrease prostate cancer incidence (per 100,000)	159.3	135.0◊	N/A	113.4	149.9
Decrease Prostate Cancer Mortality (per 100,000 men)	18.8	21.8†	N/A	14.8	26.6
Decrease breast cancer mortality (per 100,000 women)	20.1	20.7†	N/A	19.0	25.1

PROGRAMS AND SERVICES

Adventist HealthCare: Navigating Cancer (First Step Workshop,Young Women with Breast Cancer Monthly Support Group, Newly Diagnosed: Navigating the New Normal Support Group); Mind, Body, Spirit (Gentle Yoga with Meditation, Gentle Hatha Yoga, Mindfulness for Self-Care, Mindfulness Based Stress Reduction); Eating Well (Nutritional Management of Side Effects for Treatment, Ask a Dietitian, Cooking with Patty and Nick, Healthy Eating After Treatment, and Good Nutrition for Cancer Care).

Holy Cross Health: Provide access to mammogram services for uninsured and underinsured women; Provide outreach and education on cancer prevention in Montgomery and Prince George's County through an equitable lens; Provide outreach and education on tobacco-free living; Provide HC Health Center referrals for breast, colonoscopies, and obesity and tobacco cessation referrals and/or counseling to eligible health center patients

MedStar Montgomery: Gentle Flow Yoga for Cancer Patients.

Suburban Hospital: American Lung Association's Better Breathers Club, American Lung Association's Freedom from Smoking Program, Roundtable: African Americans & Colorectal Cancer, Roundtable: Young Adults & Colon Cancer, Talk & Walk for Breast Cancer Survivors, Yoga for Cancer Survivors, Prostate Cancer Support Group, Prostate Cancer Symposium, Annual Living with Breast Cancer Symposium.

CHRONIC DISEASE: CARDIOVASCULAR HEALTH

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA)[α]	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Decrease heart disease mortality (per 100,000)	136.4	166.3††	N/A	97.9	181.3
Decrease stroke (cerebrovascular) mortality (per 100,000)	30.1	34.8†	N/A	41.8	46.8
Decrease percentage of high blood pressure prevalence in adults	21.6%	26.9%†	N/A	29.8%	37.2%

PROGRAMS AND SERVICES

Adventist HealthCare: Community Health Screenings and Lectures; Faith Community Health Network

Holy Cross Health: Implement care management team at HC Health Centers for high-risk patients; Provide community fitness classes for adults and older adults aged 55+; Offer Stanford University's Chronic Disease Self-Management Program

MedStar Montgomery: Host and provide access to healthy lifestyle education programs, wellness activities, community screenings, and support groups; Annual Wine Women and Heart Health webinar; Senior Strength and Balance Fitness class; Gentle Flow Yoga for Seniors.

Suburban Hospital: Yoga from the Heart, Senior Shape Exercise Program including several classes that focus on Aerobics, Weight Training, Flexible Strenght and Stability Ball, Dine, Learn & Move, Cocina, Meuvete & Aprende, Blood pressure screenings, Health Education Webinars, Women's Health Symposium, MobileMed/NIH Heart Clinic at Suburban Hospital, Nutrition Counseling

CHRONIC DISEASE: OBESITY

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA)[α]	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Decrease the percent of adults who are overweight or obese	55.2%	64.3%††	N/A	56.4%	71.2%
Decrease percent of adolescents who are overweight or obese* (previously obese only)	13.7%	10.7%††	N/A	22.4%	35.5%
Decrease percent of adolescents with no physical activity	23.2%	18%Δ	N/A	20.20%	30.50%

PROGRAMS AND SERVICES

Adventist HealthCare: Community Health Screenings and Lectures; Faith Community Health Network

Holy Cross Health: BMI assessments and diagnosis of obesity for health center patients

MedStar Montgomery: Host and provide access to healthy lifestyle education programs, wellness activities, community screenings, and support groups; Senior Strength and Balance fitness class; Gentle flow Yoga for Seniors.

INFECTIONS

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA)[a]	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Septicemia Age-Adjusted Death Rate	10.3	N/A	N/A	8.6	N/A
Influenza & Pneumonia Age-Adjusted Death Rate	12.5	N/A	N/A	8.4	10.3

PROGRAMS AND SERVICES

Suburban Hosptial: COVID-19 community testing, COVID-19 community vaccination clinics, Health Education webinars, Knots for Shots: Flu Vaccination Initiative.

UNINTENTIONAL INJURY

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA)[a]	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Accidents/Unintentional Injury Deaths (per 100,000)	36.2	36.4†	N/A	33.4	32.9

PROGRAMS AND SERVICES

Suburban Hospital: Senior Shape Exercise Program including 18 classes that focus on Aerobics, Weight Training, Flexible Strenght and Stability, Tai Chi, Intermediate Taiji, Pilates for Seniors with Core.

DISABILITY AND REHABILITATION SERVICES

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA)[a]	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Traumatic brain injury-related ED visits (MD)	39,721	N/A	N/A	N/A	N/A

PROGRAMS AND SERVICES

Adventist HealthCare: Disability & Rehab Support Groups (Brain Injury Support Group - available in English & Spanish, Amputee Support Group, Stroke Support Group); Athletic Trainer Program/Student Athlete Concussion Program.

AGING AND OLDER ADULTS/SENIORS

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA)[a]	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Life expectancy	79.2	79.8††	N/A	84.2	78.4
Decrease death rate due to falls in older adults (per 100,000)	47.2	47.0†	N/A	66.1	44.0

PROGRAMS AND SERVICES

Holy Cross Health: Provide physical and social activity programs for seniors 55+; Provide evidence-based memory programs for seniors 55+

MedStar Montgomery: Host and offer age-friendly senior wellness services, health education programs, and online/in-person senior exercise programs; Partner with local skilled nursing facilities to improve transitions of care and quality between hospitals and nursing homes; Expansion of Center for Successful Aging.

Suburban Hospital: Metro Washington Oasis Lifelong Learning for Active Older Adults & Village Ambassador Alliance.

MATERNAL/INFANT/CHILD HEALTH

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA)[α]	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Decrease infant mortality rate (per 1,000 births)	5.5	6.3††	N/A	5.2	5.5
Increase percent of mothers receiving early prenatal care	63.1%	66.9%††	N/A	70.2%	59.4%
Reduce percentage preterm births	8.6%	9.4%†	N/A	8.9%	11.1%
Decrease percentage of low birth weight infants	8.2%	8%††	7.9%	7.5%	9.6%
Decrease percentage of very low birth weight infants	1.3%	1.4%†	N/A	1.4%	1.9%

PROGRAMS AND SERVICES

Adventist HealthCare: Parent and Family Education Support Groups (Breastfeeding Education Support & Togetherness - B.E.S.T., Discovering Motherhood, Navigating Fatherhood, Perinatal Loss Support Group); Warm Line (Lactation Support with International Board Certified Lactation Consultant); Maternity Partnership/Prenatal Care Program.

Holy Cross Health: Provide prenatal care to 60% of Montgomery County Maternity Partnership patients; Provide perinatal education, baby care programs, and support services to expecting and new families in Montgomery & Prince George's County; Provide Early Care and Education Program to decrease costs to government; Increase educational achievement (and therefore greater earning power); and increase opportunity in adulthood; Increase the number of programs focusing on healthy birth outcomes for women of color (morbidity and mortality)

MedStar Montgomery: Breastfeeding support group, Babysitting CPR Course.

Suburban Hospital: Safe Sitter Babysitting Program, Health Partner of Girls on the Run Montgomery County, Bethesda Chevy Chase YMCA and Parents Encouragement Program.

FOOD ACCESS/FOOD INSECURITY

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA)[α]	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Reduce percent of population that experienced food insecurity at some point in a year	7.9%	6.0%†	7.6%	8.6%	7.3%

PROGRAMS AND SERVICES

Adventist HealthCare: Hungry Harvest Rx

Holy Cross Health: Increase availability and access to healthy and/or culturally appropriate food

MedStar Montgomery: Provide social needs screenings for food insecurity through Community Health Advocate program and Aunt Bertha social needs screening tool; Pop-up food pantries in collaboration with Manna Food Center and local community organizations; Sponsor Manna Food Center Smart Sacks program.

HOUSING AND HOMELESSNESS

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA)α	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Reduce the proportion of families that spend more than 30% of income on housing	**34.6%**	**34.6%†**	**33.7%**	**32.1%**	**36.7%**

PROGRAMS AND SERVICES

Holy Cross Health: Pathways to Independent Employment Program.

EDUCATION

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA)α	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Increase percentage of students who graduate high school in 4 years	**79.0%**	**95.0%††**	**88.7%**	**87.2%**	**91.4%**

PROGRAMS AND SERVICES

Adventist HealthCare: Education & Workforce Development (Medical Careers Program, Stepping Stones, Clinical Shadowing, Internships & Fellowships).

Suburban Hospital: Medical Exploring Program for high school students interested in healthcare careers, Clinical Shadowing, Internships and Fellowship with Healthcare Professional Development.

OTHER

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/ CURRENT (CBSA)α	ACTUAL/ CURRENT (MC)	ACTUAL/ CURRENT (PGC)
Number of grants and sponsorships awarded to community organizations addressing CHNA priority areas	**27***	**N/A**	**N/A**	**79**	**25**

PROGRAMS AND SERVICES

Adventist HealthCare: Community Partnership Fund (CPF).

Notes:
α Refers to the current collaborative CHNA
* Indicator measurement changed which prevents comparison
+ Provided Target value from Healthy People 2020
Δ Median or mean value for all counties in the state
†† MD SHIP Target
◊ Representsthe top 50th percentile of all MD counties
^Number of cases (state level)
N/A = not available
Rates are age-adjusted per 100,000 population unless otherwise noted

APPENDIX K COMMUNITY ASSETS & RESOURCES

List of available community or social needs resources based on the priority areas identified by the findings of the 2022 MCHC CHNA. This is not a comprehensive list of available resources and will not be updated beyond the published date of the 2022 MCHC CHNA. For a larger and more up to date list of community resources, please refer to organizations that specialize in organizing and verifying social needs programs, such as 211 or the Findhelp Network.

Health Care/Clinical: Access to mental health services; access to primary care physicians; lack of insurance

Montgomery Cares by: Primary Care Coalition (PCC)

Montgomery Cares provides basic medical services for people who do not have, and cannot get, insurance. If you have Montgomery Cares, the program pays part of the cost of your health services, but you may also have to pay something.

Services provided:

- Medical checkups
- Sick visits to diagnose and treat illness
- Age-appropriate screenings and preventive health services
- Behavior health care
- Some medicines
- Vaccinations/Immunization

Eligibility: Must be a resident of Montgomery County. Must be unable to get health insurance. This program helps people who are older than 17 years old. This program helps people with income at or below 250% of federal poverty guidelines.

Address: 2424 Reedie Drive, Suite 125, Wheaton-Glenmont, MD 20902

Phone: 301-962-6173

Outpatient Mental Health Clinic (OMHC) by: Vesta, Inc.

Vesta, Inc. offers the Outpatient Mental Health Clinic (OMHC) to provide therapy and medication management to clients who are experiencing mental health symptoms. The team of therapists and psychiatric nurse practitioners assist the client in the development of a customized plan to meet the individual's goals and needs.

This program provides:

- Diagnostic evaluation
- Individual and group therapy
- Medication management
- Substance use assessment and
- Services for co-occurring disorders

Interested clients can complete the referral form and submit it with a copy of your ID and your insurance card. Vesta, Inc. accepts Maryland Medicaid and Medicare.

8737 Colesville Road, 700, Silver Spring, MD 20910

Phone: 240-296-5860 ext. 6

Child and Adolescent Mental Health Program by: Montgomery County Department of Health and Human Services - Silver Spring

The Department of Health and Human Services (DHHS) Silver Spring Center offers the Child and Adolescent Mental Health Program. This program provides family-focused, outpatient mental health services to children, adolescents, and their families to help address severe emotional, behavioral, substance abuse, and victimization issues. We are also able to provide all services in Spanish for Spanish speaking clients. Services include:

- Mental health screening & assessment
- Diagnostic evaluation
- Family, individual and group psychotherapy
- Clinical case management
- Drug and alcohol assessment and education
- Behavioral and medication management
- Follow up services
- Outreach treatment and support services in the selected school sites

The Department of Health and Human Services accepts Medical Assistance (Medicaid) and we offer a sliding scale to individuals with no health insurance.

Eligibility: This program helps people who are 5 to 18 years old.

Address: 8818 Georgia Avenue, Silver Spring, MD 20910

Phone: 240-777-0311; 240-777-1450

Mental Health by: Children's National Health System

The Children's National Health System's Mental Health program provides comprehensive services for a variety of issues and conditions. Mental health specialists draw upon the latest research and expertise when designing a care plan for your child.

This program provides:

- Emergency consultation
- Medical psychology
- Tele-psychiatry
- Evaluation
- Counseling
- Inpatient psychiatry
- Outpatient clinics

Children's National Health System accepts Medicaid and offers Financial Assistance for those who are eligible. Services may vary based on location. Please call your nearest location to determine which services are offered. Please call 800-787-0021 anytime between 9:00 a.m. and 4:00 p.m. Monday through Friday to speak with a representative about financial assistance options and insurance.

Eligibility: This program helps children and adolescents struggling with mental health issues.

Address: 6833 4th Street Northwest, Washington, DC 20012

Phone: 202-729-3300

Adult Behavioral Health Program by: Montgomery County Department of Health and Human Services

The Adult Mental Health Program provides outpatient mental health services to low-income residents of Montgomery County who are experiencing serious mental illness and who are unable to access the public mental health system due to lack of public benefits or their immigration status or income. We seek to improve the mental health of clients and to assist them in increasing their adaptive functioning in the community.

Services include:

- Individual and group psychotherapy
- Office-based case management
- Psychiatric medication monitoring

We also serve in special situations, such as those discharged from a psychiatric hospital or incarceration, those involved with other health and human service agencies, or those who have experienced treatment failures in the public mental health system. Most staff members are bilingual in either Spanish and English or Vietnamese and English. Translation services are available via the Language Line.

Adult Behavioral Health accepts Maryland Medical Assistance and Medicare. We also offer a sliding fee scale to uninsured patients; however, clients are not turned away due to inability to pay.

Call Access to Behavioral Health Services to apply to the program. The Adult Mental Health Program does not accept walk-ins or direct referrals.

Eligibility: This program helps people who are older than 17 years old. Must be a Montgomery County resident. Must have a serious mental illness. Must not have private insurance. Must be low-income. Must not be able to find services elsewhere in the public mental health system.

Address, 11002 Veirs Mill Road, Suite 705, Silver Spring, MD 20902

Phone: 240-777-1770

Maryland Children's Health Program (MCHP) by: Maryland Department of Health (MDH)

Maryland Department of Health (MDH) operates the Maryland Children's Health Program (MCHP) to give full health benefits to children up to age 19.

This program provides:

- Doctor Visits (well and sick care)
- Hospital Care
- Work and Tests
- Dental Care
- Vision Care
- Immunizations (shots)
- Prescription Medicines
- Transportation to Medical Appointments
- Mental Health Services
- Substance Abuse Treatment

If you or your child is found eligible for MCHP, you can select an Managed Care Organization right away. MCHP Premium requires a small monthly premium per family based on income. Enrollment is year round. You can enroll in Medicaid/MCHP at any time if you qualify.

Eligibility: This program helps people who are younger than 19 years old. Must not be insured. This program helps people with income at or below 211% of federal poverty guidelines.

Address: 8630 Fenton Street, 10th floor, Silver Spring, MD 20910

Phone: 855-642-8572; 240-777-3066

Maryland Medicaid by: Maryland Department of Health (MDH)

Medicaid pays the medical bills of eligible individuals. It is administered by the State and pays medical bills with Federal and State funds.

This program provides:

- Health insurance

You can apply for Medicaid at any time and eligible applicants can enroll year-round. Individuals who receive Supplemental Security Income (SSI) are automatically eligible and do not need to apply.

Eligibility: Must meet income eligibility requirements.

Address: 401 Hungerford Drive, 5th Floor, Rockville, MD 20850

Phone: 855-642-8572; 240-777-4513

Employed Individuals with Disabilities (EID) by: Maryland Department of Health (MDH)

The Employed Individuals with Disabilities Program provides Medical Assistance (also called Medicaid) to working Marylanders with disabilities.

This program provides:

- Covers most medical services for individuals who have no other health insurance
- Saves individuals with Medicare $1,000 - $12,000 a year
- Pays for some services that the other insurance does not cover

The monthly premium amount depends on income. People who sign up for EID almost always save much more than they pay for premiums. Apply on your own or with help from other agencies. To apply on your own, complete the EID Application, gather the supporting documents you have available, enclose the supporting documents, and mail in. To get free assistance in filling out the application, contact Center For Independent Living closest to you.

Eligibility: Applicant must be at least 18 years old but not yet 65 years old. Applicant must be U.S. citizen or qualified alien. Applicant must have a disability that meets Social Securitys medical criteria. Applicant must be working for pay. Applicants must have assets under the $10,000 limit if you are unmarried. The limit is $15,000 if you are married.

Address: 12301 Old Columbia Pike, Suite 101, Silver Spring, MD 20904

Phone: 410-767-7090; 301-277-2839

Holy Cross Health Centers by: Holy Cross Health

Holy Cross Health Centers are primary care medical centers providing affordably priced health care services to children and adults who face financial barriers to accessing care.

Services provided:

- Physical exams
- Lab work
- Vaccinations
- Disease management
- Social service referrals
- Behavioral health services
- Post-hospital and emergency room discharge follow-up care
- Health education
- On site pharmacy

Holy Cross Health Centers provide services to uninsured children and adults for an adjusted fee based on financial need, and to community members enrolled in Maryland Medicaid/Maryland Children's Health Program.

Eligibility: Anyone can access this program.

Addresses:
Silver Spring - 8630 Fenton St, Silver Spring, MD 20910; (240) 777-0311

Aspen Hill – 13415 Connecticut Ave #100, Silver Spring, MD 20906; (301) 557-1950

Gaithersburg - 220 Perry Pkwy #5, Gaithersburg, MD 20877; (301) 557-1832

Mobile Medical Care - Primary Care by: Mobile Medical Care Inc

Mobile Medical Care provides all of its patients with a full array of primary care services. These services fill critical gaps in care delivery in underserved areas.

Services include:

- Physical exams
- Screenings
- Labs
- Vaccinations
- Medications
- Integrated behavioral health (including counseling)
- Arrangements for diagnostic testing
- Referrals to specialty care, if necessary

MobileMed accepts Montgomery Care, Medicare, and most Medicaid.

Address: 3820 Aspen Hill Road, Aspen Hill, MD 20906

Phone: 301-493-2400

Affordable Health Care by: Mary's Center

Federally Qualified Health Center (FQHC) that delivers affordable, accessible, quality, and value-based primary health care to everyone in our community regardless of their ability to pay. Our work helps to deliver care to the nation's most vulnerable individuals and families, including people experiencing homelessness, agricultural workers, residents of public housing, and the nation's veterans.

Services provided include:

- High quality, culturally competent, comprehensive primary care
- Connections to pharmacy, mental health, substance use disorder, and oral health services
- Diagnostic assessments & treatment planning
- Individual and family therapy
- Medication evaluation and management by Board-Certified Psychiatrists
- Community support/case management
- Supportive services such as health education, translation, and transportation
- Primary pediatric care
- Prevention and treatment of illness and injury
- Vaccinations

FQHCs accept Medicaid, Medicare, and provide a sliding-scale fee structure for those who do not have insurance or are underinsured.

Due to COVID-19 many of our offices are not taking in-person appointments but will be offering virtual visits. Please call us and we will schedule the appropriate appointment for your needs.

Eligibility: Anyone can access this program.

Address: 344 University Boulevard West, Silver Spring, MD 20901

Phone: 844-796-2797

General Medical Services by: Catholic Charities Archdiocese of Washington

We provide low-cost, patient-centered primary care services and specialty services on-site, including minor surgery, Gynecology, Cardiology, Pulmonology, Dermatology, Orthopedics, Acupuncture and referrals to other specialty services including Physical Therapy.

Services provided:

- Primary care
- Minor surgery services
- Cardiology
- Pulmonology p Dermatology p Orthopedics
- Reproductive health services
- Acupuncture
- Referrals to specialty services

We welcome people of all ages who are low-income and uninsured, or covered by DC Alliance, Medstar and Amerihealth.

Medical Clinics in D.C. and Silver Spring remain open but are restricted to patients who have been pre-screened. Patients with flu-like symptoms should leave their phone number, and a doctor will contact them. Telemedicine appointments are offered for sick patients.

Address: 12247 Georgia Avenue, Silver Spring, MD 20902

Phone: 301-857-9144

Health Care by: Community Clinic, Inc. (CCI) - Silver Spring

Community Clinic, as your Primary Care Home, will identify and address your physical & behavioral health needs. We utilize a team-based patient-centered approach to care for adults and children.

Services include:

- Routine visits (adult and pediatric)
- Common laboratory tests
- Acute and chronic care p Routine immunizations p Vaccinations
- Diabetes education
- Nutrition counseling
- Referral to specialists

Community Clinic accepts Medicaid and Medicare. If you do not have health insurance, call (240) 839-5810 and a team member will help you explore your coverage options. You may also be eligible for our sliding fee scale discount.

Address: 8630 Fenton Street, 12th floor, Silver Spring, MD 20910

Phone: 301-585-1250

Affordable Health care by: Neighborhood Health At The Casey Clinic

Federally Qualified Health Center (FQHC) that delivers affordable, accessible, quality, and value-based primary health care to everyone in our community regardless of their ability to pay. Our work helps to deliver care to the nation's most vulnerable individuals and families, including people experiencing homelessness, agricultural workers, residents of public housing, and the nation's veterans.

Services provided include:

- High quality, culturally competent, comprehensive primary care
- Supportive services such as health education, translation, and transportation
- Connections to pharmacy, mental health, substance use disorder, and oral health services

FQHCs accept Medicaid, Medicare, and provide a sliding-scale fee structure for those who do not have insurance or are underinsured.

Eligibility: Anyone can access this program.

Address: 1200 North Howard Street, Alexandria, VA 22304

Phone: 615-227-3000

Primary Care by: MedStar Montgomery Medical Center

MedStar Montgomery Medical Center offers primary care services to those in need in the community. Primary Care Physicians focus on the interactions of all your body systems and know how to help you with just about every complaint you may have: from asthma to arthritis, headaches to high blood pressure, and dizziness to diabetes.

Primary care services may include:

- Preventive medicine
- Sick care and injuries
- Chronic medical condition management
- Urgent medical care
- Annual and sports physicals
- School forms
- Immunizations, including flu shots
- Preoperative consults
- Health promotion and education
- Nurse phone line available 8 hours/day to speak live with an RN regarding medical concerns, advice, and appointments

MedStar Montgomery Medical Center offers financial assistance to those in need based on income and household size. This program also accepts Medicaid and Medicare.

Address: 18109 Prince Philip Drive, Olney, MD 20832

Phone: 301-774-8881

Mansfield Kaseman Health Clinic by: Community Reach of Montgomery County

Mansfield Kaseman Health Clinic delivers health care and education to medically uninsured and Maryland Medicaid insured adult residents of Montgomery County.

This program provides:

- Health education
- Lab services
- Pharmacy
- Primary care
- Specialty care

Mansfield Kaseman Health Clinic accepts adults who are low-income, uninsured, and those insured with Maryland Medicaid. Primary care and specialists in endocrinology, gastroenterology, gynecology, internal medicine, podiatry, and pulmonology are available to our patients. Lab work available onsite.

Eligibility: This program helps people who are older than 17 years old.

8 West Middle Lane, Rockville, MD 20850

Phone: 301-917-6800

Women's Health by: MedStar Health

Women's Health Centers provide comprehensive medical care that focuses on the health and well-being of women of all ages. MedStar Health has a commitment to investing in state-of-the-art-facilities that provide women with every possible treatment option available in health care today - no matter if you are delivering a baby or undergoing minimally invasive gynecologic surgery.

Specific services include:

- Childbirth and parenting education classes
- Fibroid treatments
- Genetic counseling
- Gynecology treatments and surgery
- Incontinence and pelvic surgery
- Lactation services p Labor and delivery p Mammography
- Maternity services, including fertility services and obstetrics
- Menopause
- Osteoporosis treatments
- Pediatric and adolescent gynecology
- Preconception counseling
- Pregnancy Planning
- Recommended health screenings for women of all ages
- Urogynecology treatments

MedStar Health is committed to ensuring that uninsured patients and underinsured patients meeting medical hardship criteria within the communities served who lack financial resources have access to emergency and medically necessary hospital services. Facilities can assist with enrollment in publicly-funded entitlement programs, referrals to State or Federal Insurance Exchange Navigator resources, and consideration of funding that may be available from other charitable organizations. Please call 800-280-9006 for support with financial assistance.

Address: 18101 Prince Philip Drive, Suite 5100, Olney, MD 20832

Phone: 301-570-7424

Primary Adult Health care by: Proyecto Salud Clinic

Proyecto Salud Clinic provides high quality, culturally competent, and affordable primary health care services to adults living in Montgomery County.

Primary care services may include:

- Preventive activities such as flu vaccination
- Nutritional education
- Pap smears
- Referrals for mammograms and colonoscopies

Proyecto Salud Clinic provides a sliding scale fee for uninsured individuals.

Eligibility: Must live in Montgomery county.

11002 Veirs Mill Road, Suite 700, Silver Spring, MD 20902

Phone: 301-962-6173

Adult Primary Care by: Mercy Health Clinic Inc

Mercy Health Clinic (MHC) provides quality care, free to reduced cost for individuals who are uninsured or have Medicaid. All patients are seen by a board-certified physician or nurse practitioner.

Services offered:

- Primary preventive care
- Diagnosis and treatment of general acute and chronic medical problems
- Management of chronic medical conditions, such as hypertension and diabetes
- Referrals for professional consultation, including to on-site dental clinic and behavioral health specialists
- Access to off-site specialty care, including surgical procedures when possible
- Patient navigation to assist with mammography and other areas

When scheduling your appointment via phone or email, include name, date of birth and phone number. Email service is currently for primary and specialty care patients. If your card has lapsed, you must call for any inquiries.

Due to COVID-19, MHC is not currently processing eligibility applications, but they are still accepting new patients. The clinic will be serving most patients via telemedicine.

Eligibility: This program helps people who are older than 17 years old. This program helps people with income at or below 250% of federal poverty guidelines. Must be a resident of Montgomery County. Must be uninsured or have Medicaid.

Address: 7 Metropolitan Court, Suite 1, Gaithersburg, MD 20878

Phone: 240-773-0300

Care for Kids by: Montgomery County Department of Health and Human Services - Juvenile Assessment Center

Care for Kids is a health care program that provides access to health care services for uninsured children in Montgomery County. Pediatric care includes:

- Well child visits
- Sick visits

- Prescription medicines
- Optometry
- Dental

The program is funded through Montgomery County and administered by the Primary Care Coalition. Most services offered by Care for Kids are low cost or discounted, although some do have a small fee or co-pay.

Families may have a co-payment of up to $20 per visit with a health care provider. There is a $5 co-pay for all prescription medications. Other fees and co-pays may be charged for lab work, radiology and some specialty care visits. Patients are informed of any fee before they go to their appointment.

The required documents are needed for this program:

- Proof of residence in Montgomery County
- Proof of family income
- Proof of child's identity: birth certificate, passport, school ID or report card

Eligibility: Child must be uninsured and not eligible for MCHP or MCHP Premium. Child must be a Montgomery County resident. This program helps people who are younger than 19 years old. This program helps people with income at or below 250% of federal poverty guidelines.

Address: 8513 Piney Branch Road, Silver Spring, MD 20901

Phone: 240-773-8260

Medical Visits by: FiveMedicine

With FiveMedicine, you can have access to health care anywhere and see an online health care provider in minutes.

Services provided:

- Virtual doctor visits

FiveMedicine treats over 55 routine medical conditions including common cold, allergies, constipation, cough, diarrhea, ear problems, pink eye, respiratory problems, sore throat, UTI, fever, flu, headache, nausea, vomiting, and more.

Services can be provided on a sliding fee scale.

Address: 724 Maiden Choice Lane, Suite 304, Catonsville, MD 21228

Phone: 207-719-2530

Health Care Services by: CCACC Pan Asian Volunteer Health Clinic

Pan Asian provides a variety of health care services, ranging from basic care to management of chronic conditions. Our services are provided by practicing doctors and nurses, and we're always seeking to expand our services in order to better serve our patients.

We offer the following services:

- Basic health care (family doctor services)
- LabCorp-provided inspections, lab testing, and radiology examinations

- Free or low-cost prescription drugs
- Free or low-cost routine blood tests
- Chronic disease management including asthma and diabetes
- Pain Management
- Diabetic Retinopathy
- Fecal Immunochemical Test (FIT)
- Hepatitis B screening, treatment, and treatment referral
- Mammogram screenings
- Mental health services
- Woman's Wellness
- Patient followup care
- Specialist referrals
- Public education and community outreach Documents Required: ID; Utility Bills

Eligibility: Must be a resident of Montgomery County AND Must not have any insurance (including any commercial insurances, Medicaid, or Medicare). This program helps people with income at or below 250% of federal poverty guidelines.

Address: 9318 Gaither Road, Suite 205, Gaithersburg, MD 20877

Phone: 240-393-5950

Primary Care by: Patient First

Patient First provides a full range of preventive, primary, and urgent care services. When specialty care is required, patients are referred to outside physicians in the appropriate specialty.

Patient First accepts Medicare and offers a discounted self-pay program for uninsured patients.

No appointments are necessary.

Eligibility: This program helps people who are older than 7 years old.

Address: 8206 Georgia Avenue, Silver Spring, MD 20910

Phone: 301-960-4682

OB/GYN Clinics by: Holy Cross Health

The Obstetric/Gynecologic (OB/GYN) Clinic at Holy Cross Hospital and the OB Clinic at Holy Cross Germantown Hospital offer maternity care and services to patients in need, regardless of their ability to pay.

These clinics provide:

- Maternity care
- Routine obstetrical care
- Specialized care for high-risk pregnancies
- Prenatal care

- Post-delivery care
- Gynecological services and counseling

Address: 1500 Forest Glen Road, Silver Spring, MD 20910

Phone: 301-754-8200

Primary Medical Care by: La Clinica del Pueblo

At La Clinica del Pueblo, we are dedicated to providing high quality health care, putting you and your health first. Your primary care doctor is a key member of your health care team and helps coordinate patient care all in one place.

Services:

- Prenatal care
- Pediatrics
- Adolescent medicine
- Adult medicine
- Geriatrics
- Medical evaluations p Reproductive health p Health education
- Immunization
- Lab testing
- Diagnose and treat
- Referrals to outside specialist
- Onsite language and document interpretation

We also provide Care Management and Care Coordination for our patients, and offer Insurance Enrollment and Support.

La Clinica del Pueblo accepts Medicare.

If you are not eligible for coverage on other programs, we offer affordable health care to uninsured patients on a sliding fee scale based on a patient's income and family size. No patient is ever denied services because of his or her ability to pay.

Address: 2970 Belcrest Center Drive, #301, Hyattsville, MD 20782

Phone: 240-714-5247

Primary Care by: Maryland Physicians Care (MPC)

Maryland Physicians Care is a Medicaid company providing high-quality health care to individuals and families. The program's doctors serve as key members of your health care team and help coordinate patient care all in one place.

Services Include:

- Primary Care

- Urgent Care
- Pregnancy & New Mother Benefits
- Specialists Care
- Pharmacy Coverage
- Primary Mental Health Services
- Vision
- Dental Care

Eligibility: Must have Medicaid.

Address: 1201 Winterson Road, 4th floor, Linthicum Heights, MD 21090

Phone: 800-953-8854

THRIVE Program - Ryan White Services by: University of Maryland Center for Infectious Diseases

The THRIVE Program specializes in preventing, treating and managing a range of illnesses, including Hepatitis C and Human Immunodeficiency Virus (HIV).

This program provides:

- Outpatient ambulatory health services (primary care and HIV specialty care)
- Medical case management (clinic and community based)
- Mental health care
- Substance abuse outpatient (treatment for opioid use disorder, including Suboxone® prescriptions)
- Medical nutritional therapy (nutritionist consults, Ensure®)
- Food bank/home delivered meals
- Other professional services (legal services)
- Transportation (tokens for public transportation)
- Health insurance premium cost sharing (assistance with copays)
- Emergency financial assistance (medications)

Eligibility: Must be HIV positive. This program helps people with income at or below 500% of federal poverty guidelines. Must have lack of insurance coverage for needed services Must live in Baltimore or the 6 surrounding counties (for Part A Services) and/or in the state of Maryland (for Part B Services)

Address: 827 Linden Avenue, Armory Building, Suite B, Baltimore, MD 21201

Phone: 410-225-8369

Socioeconomic & Physical Environment: housing cost burden; income inequality; workforce/labor shortages

Housing Choice Voucher Program (HCV) by: Housing Opportunities Commission Of Montgomery County (HOC)

The Housing Choice Voucher Program a rent subsidy for very low-income households (single or family), the elderly, and the disabled to afford safe and quality affordable housing in Montgomery County. Participants who receive vouchers search for their own housing, and the housing subsidy is paid to the landlord directly by the HOC.

The subsidy amount is based on a payment standard set by HOC and the client's household information so that the client pays no more than 40% of their income on housing.

Eligibility: Family's gross annual income may not exceed 50% of the local median family income. This program helps people who are older than 17 years old. Must be a US Citizen or have eligible immigration status.

Address: 10400 Detrick Avenue, Kensington, MD 20895

Phone: 240-627-9400

Section 8 Housing Choice Vouchers by: Housing Opportunities Commission of Montgomery County

Montgomery County Housing Authority administers Housing Choice Vouchers to very low-income families, the elderly, and the disabled. HCVP is a U.S. Department of Housing and Urban Development (HUD) program created to give vulnerable families access to decent, safe, sanitary, and affordable housing in the private market.

People may apply online. Kiosks are available at HOC offices and public libraries in Montgomery County. To speak with a Customer Service Representative, please call 311 during business hours.

Eligibility: Must meet annual income guidelines.

Address: 10400 Detrick Avenue, Kensington, MD 20895

Phone: 240-773-9000

U.S. Department of Housing and Urban Development - VA Supportive Housing (HUD-VASH)

The HUD-VASH is a collaborative program between HUD and the VA that combines HUD housing vouchers with VA supportive services to help Veterans who are homeless and their families find and sustain permanent housing.

This program provides:

- HUD Housing vouchers
- Case management

Through public housing authorities, HUD provides rental assistance vouchers for privately owned housing to Veterans who are eligible for VA health care services and are experiencing homelessness. VA case managers may connect these Veterans with support services such as health care, mental health treatment and substance use counseling to help them in their recovery process and with their ability to maintain housing in the community.

To apply for HUD-VASH, please contact your local VA Medical Center (VAMC) and ask for a Homeless Coordinator. Veterans can contact the HUD-VASH program directly, or obtain a referral

from a case manager in another VA program, from a community program, or other referral sources. You can also call the National Call Center for Homeless Veterans at 1-877-4AID-VET (877-424-3838).

Eligibility: Must not be a sex offender. Must be enrolled or eligible for VA Health System benefits. This program serves homeless veterans and their families. Must have need or vulnerability requiring case management services in order to obtain and sustain independent community housing.

Address: 50 Irving Street Northwest, Washington, DC 20422

Phone: 877-424-3838; 202-745-8000

Section 8 Housing Choice Vouchers by: Rockville Housing Authority

Rockville Housing Authority administers Housing Choice Vouchers for very low-income families, the elderly, and the disabled. HCVP is a U.S. Department of Housing and Urban Development (HUD) program that gives vulnerable families access to decent, safe, sanitary, and affordable housing in the private market.

To be considered for the Housing Choice Voucher Program, a household must be on RHE's Housing Choice Voucher Program Wait List. RHE does not accept new applications when the Wait List is closed. Please periodically check both this Web site and Rockville Reports, the City of Rockville's monthly newspaper to determine when the wait list will be open again for new applications

A program participant's share of the rent is determined by formula (approximately 30% of household income).

Eligibility: Must meet income limits.

Address: 1300 Piccard Drive, Suite 203, Rockville, MD 20850

Phone: 301-424-6265

Emergency Rental Assistance Program by: Maryland Department of Housing and Community Development

The Maryland Department of Housing and Community Development will administer federal emergency rental funding either direc t to local jurisdictions through the Maryland Eviction Partnership Program to support local rental assistance efforts or to property managem ent on behalf of tenants residing in affordable rental properties that received federal or state financing through the Assisted Housing Relief Program.

Call the Maryland Emergency Rental Assistance Call Center at 877-546-5595 apply online.

Address: 2 North Charles Street, Suite 450, Baltimore, MD 21201

Phone: 877-546-5595; 410-209-5800

Montgomery County Workforce Program by: Latin American Youth Center (LAYC)

Our Montgomery County Workforce Program provides aid and support to out-of-school, unemployed, and disconnected youth. We offer a wide variety or services and classes to prepare our clients to enter the workforce.

Our program offers:

- Job readiness training
- GED Classes
- Career exploration services
- Certifications
- Internships
- Job placement and support

Participants of our Montgomery County workforce programs receive job placement and follow-up support. This may include updating a resume, cover letter, receiving targeted coaching on navigating a workplace situation and self-advocacy.

Eligibility: This program helps people who are 16 to 24 years old.

Address: 8700 Georgia Avenue, Suite 500, Silver Spring, MD 20910

Phone: 301-495-0441 ext. 226

YouthBuild USA by: YouthBuild International

YouthBuild is a non-residential, community-based alternative education program that provides classroom instruction and occupational skills training in construction and other in-demand occupations.

In the course of their full-time enrollment, they:

- Achieve their high school equivalency credentials or high school diplomas in a caring individualized context
- Obtain job skills and earn a stipend, wage, or living allowance for building affordable, increasingly green housing for homeless and low income people in their communities
- Gain industry-recognized certifications in preparation for productive careers (in addition to construction, some train for jobs in health care, technology, or customer service)
- Solve personal problems with counseling support, addressing urgent needs for housing or child care, record expungement, or other problems
- Give back and lead through participation in community service and advocating for their communities on the local and national levels.
- Transition into post-program placements, in college, registered apprenticeships, other postsecondary opportunities, and employment, with support of a transition coordinator and mentors

Low-income young people who have left high school without a diploma enroll full-time in YouthBuild Programs for about 10 months. They spend at least 50% of their time, usually alternate weeks, in caring academic classrooms, and at least 40% in hands-on job training building affordable housing or other community assets. A strong emphasis is placed on creating a safe and caring community of adults and peers committed to each other's success.

Eligibility: This program helps people who are 16 to 24 years old. The program serves youth who have dropped out of high school and who have been in the justice system, are aging out of foster care or are otherwise at-risk of failing to reach key educational and career milestones.

Address: 3014 14th Street NW, Washington, DC 20009

Phone: 202-319-0141

Job Skills and Training by: Job Corps

Job Corps provides hands-on career technical training in high-growth industries and can also help individuals get a GED or high school diploma if they don't already have one.

This program provides:

- Skill training and career development
- Job placement
- Optional residential for students

Eligibility: This program helps people who are 16 to 34 years old. Must be in need of job skills. Must be income eligible. Must be a U.S. citizen, is a legal U.S. resident, or is a resident of a U.S. territory and/or is authorized to work in the United States. Must make suitable arrangements for the care of any dependent children for the proposed period of enrollment. The student may not be eligible if they have certain criminal convictions or require court supervision. Must not exhibit behavioral problems that could keep them or others from experiencing Job Corps' full benefits. Must not use drugs illegally.

Address: 200 Constitution Avenue NW, Ste. N4463, Washington, DC 20210

Phone: 800-733-5627; 202-693-3000

Employment Programs by: Catholic Charities Archdiocese of Washington

We provide support and guidance for young adults and adults with developmental disabilities who have little to no work history entering the workforce. Through adaptive programming, a dedicated staff, open partnerships with businesses, families and community members, we find new opportunities for our consumers to grow, share and develop as independent adults.

Our services include:

- Intake: All participants must be referred by either the DC Office of Rehabilitation Services Administration (RSA), the Maryland Division of Rehabilitation Services (DORS) or the Maryland Developmental Disabilities Administration (DDA).
- Assessment of strengths and interests
- Skills development
- Job placement
- Continued support throughout employment
- More education

We do accept walk-ins. We have offices throughout Washington, DC, and Maryland. Please call your nearest office to get started today!

Address: 1010 Grandin Avenue, Rockville, MD 20851

Phone: 301-251-2860 ext.208

Refugee Employment Services by: Lutheran Social Services of the National Capital Area (LSS/NCA)

Upon arrival, every refugee adult is matched with a LSS/NCA Job Developer to help them secure work as quickly as possible. Job Developers meet our new neighbors to assess their skills and interests in order to match them with an appropriate first job in our country.

Services include:

- Job placement
- Orientation workshops
- Vocational trainings
- Help looking for jobs

After a placement is made, the Job Developers will remain in contact with the client for a minimum of 90 days to ensure the match is successful.

Newcomers may also participate in employment orientation workshops and vocational training, so that they may succeed in the American workforce. Pre-employment workshops address topics specific to the United States, including how to locate jobs, the application process, interview techniques, and American workplace culture. Job Developers assist clients to create resumes and cover letters.

With the strength and support of community members, LSS/NCA has helped thousands of refugees build careers in a variety of professions from health care workers to commercial drivers. Clients are eligible to return for employment services for up to five years.

Address: 4406 Georgia Ave NW, Washington, DC 20011

Phone: 202-723-3000

Adult Services - Employment & Meaningful Day by: The Arc Montgomery County

Employment Services provides adults with disabilities the opportunity to gain independence and contribute to their community by obtaining and maintaining gainful employment. Our employment process includes discovering a person's skills and interests, career counseling, resume building, developing a customized employment plan, job coaching and follow-along services to ensure job stability.

Eligibility: This program serves adults with intellectual and developmental disabilities. Individuals must apply with the Maryland Developmental Disabilities Administration to receive a Medicaid waiver.

Address: 7362 Calhoun Place, Derwood, MD 20855

Phone: 301-984-5777

PDGRS - Vocational Program by: Partnership Development Group (PDG)

Our Evidenced-Based Supported Employment (EBSE) program delivers individualized vocational services to those with mental illnesses. The moment a participant expresses a desire to work, the job search begins. The individual will work with an employment specialist to develop a personalized vocational plan. The whole treatment team will work together using an integrated approach to identify and address specific barriers to employment. This cohesive method facilitates the individual's long term success in the workforce.

Our specialized vocational staff provides workforce reentry training with:

- Job development and application assistance
- Interview and interpersonal skills
- On-site coaching and job retention
- Evidence-based supported employment services

The EBSE program also promotes long term stability by providing ongoing, uninterrupted job coaching and community support services after the individual has gained employment. Once employed, PDG delivers job coaching services for at least 90 days – during the critical adjustment period – thereby increasing the probability of job retention.

Address: 7529 Standish Place, Suite 103, Rockville, MD 20855

Phone: 410-863-7213

Vocational Services by: Sheppard Pratt Health System

Sheppard Pratt helps individuals with varying disabilities be work-ready through supported employment.

Services include:

- Individual placement and support
- Skill assessment
- Job training
- Job placement
- Ongoing job training as needed for job retention and personal growth

Sheppard Pratt works closely with the client and the employer to resolve any concerns that may arise. Please call your nearest office for more information.

Eligibility: This program serves adults with disabilities.

Address: 620 East Diamond Avenue, Gaithersburg, MD 20877

Phone: 301-840-3292

Career Gateway by: Jewish Council for the Aging (JCA)

The Jewish Council for the Aging (JCA) provides the Career Gateway Program for Seniors living in the capital region and parts of Virginia.

This program provides:

- Interview coaching
- Skills assessment
- Online job search training

The program fee is listed as $75 but scholarships are available for anyone who needs one and no one is turned away.

Eligibility: This program helps people who are older than 49 years old.

Address: 12320 Parklawn Drive, Rockville, MD 20852

Phone: 301-255-4215

English and Adult Education - Computer Literacy by: CASA de Maryland

CASA's computer literacy class is a free class for residents of the Long Branch community. Students learn how to perform basic tasks such as explore the internet, send emails and create MS Word documents. They also learn how to effectively utilize their smartphones to access resources and perform everyday life tasks.

This program provides:

- Computer classes
- Skills & training

Three 9 week sessions are offered per year: Fall (9/6/16 to 11/3/16), Winter (1/17/17 to 3/16/17), and Spring (4/4/17 to 6/1/17) at our Pine Ridge Community Center. Students can register for classes that meet Tuesday and Thursday evening OR for classes meet on Saturday from 9:00 am to 1:00 pm.

Address: 2729 University Boulevard West, Silver Spring, MD 20902

Phone: 301-445-3139; 240-491-5772

Health Behaviors: food insecurity; adult obesity; physical inactivity

Food Bank by: MANNA Food Center

MANNA Food Center provides Food Pantries where anyone in need can obtain food to meet nourishment needs. Manna is temporarily waiving income requirements to provide food to any Montgomery County resident impacted by the COVID-19 crisis.

This program provides:

- Box of pantry staples (e.g. beans, pasta, canned vegetables, canned fruits)
- Box of fresh fruits and vegetables
- Bag of frozen meat

Manna needs to receive your call by 3:00 pm the day before you would like to receive food so your order will be prepared. Manna Food Center has waived all income requirements due to extraordinary circumstances resulting from the COVID-19 crisis. Manna Food Center does not ask about your immigration status and we do not report any of your personal information to the government.

Eligibility: Any resident of Montgomery County can access this program.

Address: 12901 Georgia Avenue, Silver Spring, MD 20906

Phone: 301-424-1130

Refugee Resettlement by: International Rescue Committee (IRC) - Silver Spring

The International Rescue Committee provides opportunities for refugees, asylees, victims of human trafficking, survivors of torture, and other immigrants to thrive in America. The IRC ensures that refugees receive a variety of support to address basic needs.

This program provides:

- A furnished home
- Help with rent
- Health care
- Nutritious, affordable food
- English language classes
- Help building job, computer, and financial literacy skills

- Education for their children
- Social services and community support
- Legal services towards residency and citizenship

Refugees are greeted and welcomed at the airport by IRC case workers and volunteers to ensure their transition is as comfortable as possible.

Eligibility: This program serves refugees.

Address: 8719 Colesville Road, 3rd Floor, Silver Spring, MD 20910

Phone: 301-562-8633

Groceries 2 Go! by: Up 2 Us Foundation

The Groceries 2 Go! program regularly provides free boxes of produce for curbside pickup to individuals and families in need at locations throughout the community. This service supplies critical nutrition to hungry people.

This program provides:

- Food to meet basic nutritional needs

To find out where and when the next Groceries 2 Go! distribution will take place, please visit the Facebook page. Please note, food is distributed at these events until supplies run out -on a first-come, first-served basis.

Eligibility: Anyone can access this program.

Address: 11160 Veirs Mill Road, Unit 164, Silver Spring, MD 20902

Phone: 202-440-3781

Hughes Mid County Consolidation Hub by: Hughes United Methodist Church

Hughes United Methodist Church has partnered with the Montgomery County Department of Health and Human Services to create the Hughes Mid County Consolidation Hub. The Hub is committed to provide food and essential item access to those impacted by the pandemic.

This program provides:

- Drive-in food distributions
- Walk-in food distributions
- Diaper distributions

Food distributions occur every Tuesday at 10:30AM. Diaper distributions are monthly and by appointment only. Appointments can be requested online or by calling HUMC.

Address: 10700 Georgia Avenue, Silver Spring, MD 20902

Phone: 301-949-8383

Food Pantry by: Luther Rice Memorial Baptist Church

Luther Rice Memorial Baptist Church addresses the needs of low-income individuals and households that lack a reliable access to affordable, nutritious food and may experience hunger on a regular basis.

This program provides:

- Nutritious foods

Address: 801 University Boulevard West, Silver Spring, MD 20901

Phone: 301-593-1130

Social Services by: Ayuda

The Social Services program offers holistic services in a culturally sensitive environment to low-income immigrant victims of crime, domestic violence/sexual assault/stalking, and human trafficking. The program serves both women and men from all over the world.

Domestic Violence and Sexual Assault services include the following:

- Help clients secure emergency and transitional shelter, food, clothing, medical and mental health care for themselves and their children
- Provide individual and group therapy for immigrant residents who have experienced domestic violence and/or sexual assault (DC and VA only)
- Provide case management

Ayuda provides comprehensive case management for trafficked persons. Social service staff assists clients with emergency and transitional housing needs, obtaining food and clothing, and providing referrals for medical and mental health needs. Ayuda's team also assists clients to enhance their education and life skills by helping clients enroll in English language courses, computer courses, GED courses and job training programs.

The Children and Youth services provide case management to neglected and vulnerable immigrant children in Fairfax, Virginia. Ayuda offers comprehensive case management, including:

- Connecting with educational resources, after school programs and activities
- Obtaining basic needs such as food, shelter, and clothing
- Social services to neglected and vulnerable immigrant children

Please call the appropriate office depending on your state of residence to receive services:

- Washington, D.C.: 202-387-4848
- Virginia: 703-444-7009
- Maryland: 240-594-0600

Eligibility: Human Trafficking Survivor Foreign born. Low income. Victim/survivor of domestic violence, sexual assault and/or stalking.

Address: 8757 Georgia Avenue, Suite 800, Silver Spring, MD 20910

Phone: 240-594-0600

Food Pantry by: Allen Chapel African Methodist Episcopal Church

Allen Chapel African Methodists Episcopal Church's food pantry serves everyone from low income families, single parents, senior citizens, unemployed individuals, disabled veterans, working poor, and anyone else that comes to the pantry. No one is turned away.

This program provides:

- Food to meet basic nutritional needs

This program is provided every second and fourth Saturday of the month from 8:00 a.m. to 10:00 a.m.

Proof of residency is required (must live in Maryland). Bring a government issued ID to confirm residency.

Eligibility: Anyone can access this program. Must prove that you live in Maryland with photo ID.

Address: 2518 Fairland Road, Silver Spring, MD 20904

Phone: 301-404-2688; 301-879-9232

Food Outreach by: Celestial Manna Inc

Celestial Manna provides quality food items to households experiencing food insecurity. This program supplies critical nutrition to hungry individuals and families.

This program provides:

- Food to meet basic nutritional needs

Please fill out the online form if you are in need of food. Please describe your situation and number of children, adults, and seniors in your family.

Eligibility: Anyone can access this program.

Address: 7800 Suthard Drive, Rockville, MD 20879

Phone: 301-915-7538

Basic Needs Assistance by: Bethesda Help

Bethesda Help offers immediate short-term assistance to residents of southern Montgomery County, Maryland, who are in financial crisis. This program offers help in several areas and is designed to keep families in crisis from slipping into homelessness or food insecurity.

This program provides:

- Help pay rent (for those facing eviction)
- Help pay utilities (for those about to have their utilities disconnected)
- Prescription assistance (for those with a verified physician's prescription)
- Emergency food deliveries to households in crisis (grocery bags containing a three-day supply of food for each member of the household)
- Referrals to additional resources

Please call to request services. If you are requesting food services, you must call on an odd day of the month (1,3,5, etc.) if your home address ends in an odd number. If your home address ends in an even number, you must call on an even day of the month (2,4,6, etc.).

Eligibility: This program serves individuals within a 25 mile radius bounded by the District of Columbia on the south; Falls Road, Montrose Road, and Randolph Road on the north; Veirs Mill Road, Georgia Avenue, and 16th Street on the east; and the Potomac River on the west.

Address: PO Box 34094, Bethesda, MD 20827

Phone: 301-365-2022

Homeless Veterans Program by: Vietnam Veterans of America

The Homeless Veterans Program provides medical exams, haircuts, clean clothes, food and a safe night's sleep through several short and long-term initiatives, multiple times throughout the year, to homeless veterans.

This program provides:

- Temporary shelter
- Emergency food
- Clothing
- Disease screening
- Personal hygiene

Eligibility: This program helps people who are older than 17 years old. This program serves Veterans.

Address: 8719 Colesville Rd, Suite 100, Silver Spring, MD 20910

Phone: 301-585-4000

Food Pantry by: EduCare Support Services

EduCare Support Services provides a food pantry for low-income individuals and families in the community who need support meeting their basic needs.

This program provides:

- Healthy food

Once per calendar month, participants may receive a three-day supply of food, measured by family size. Participants may select which food items they want with a choice pantry service model.

To receive services, please call EduCare's main office during regular business hours. They need to receive your call by 3:00 pm the day before you would like to receive food so that your order can be ready.

Eligibility: Must be a Montgomery County resident. Income must fall below what is necessary to be self-sufficient.

Address: 7001 New Hampshire Avenue, Takoma Park, MD 20912

Phone: 240-450-2092

WIC Centers by: Community Clinic, Inc. (CCI) Health & Wellness Services

Women, Infant and Children Supplemental Food Program is a nutrition program that provides health education, healthy foods, breastfeeding support, and other services free of charge to pregnant and postpartum women, infants and children who qualify in Montgomery and Prince Georges Counties. Our staff can assist clients in applying for WIC and accessing its services.

Services provided:

- Nutritional counseling and education
- Supplemental foods
- Breastfeeding promotion and support
- Referrals for health care

CCI Health & Wellness Services' WIC clinics in Maryland are currently closed due to the COVID-19 (Coronavirus) outbreak. We are able to assist you via phone. Please call your local WIC office at 301-762-9426 if you need any assistance.

If you are on Medicaid, TANF, or SNAP, you meet the income eligibility guidelines for WIC.

Eligibility: This program helps people with income at or below 185% of federal poverty guidelines. WIC serves pregnant, breastfeeding, and postpartum women, infants, and children (under 5 years old). Fathers, parents, step-parents, guardians, and foster parents of infants and children under the age of 5 can apply for their children. Must be a resident of Montgomery or Prince Georges county.

Address: 2730 University Boulevard West, Suite LL10, Wheaton-Glenmont, MD 20902

Phone: 301-762-9426; 301-933-6680

Supplemental Nutrition Assistance Program (SNAP) Outreach by: Montgomery County Food Council

Montgomery County Food Council provides an outreach team to help individuals prescreen for SNAP eligibility and assist with the SNAP application process.

This program provides:

- Assistance applying for SNAP
- Help navigating the system

Eligibility: This program serves U.S. citizens, lawful permanent residents (5 years), lawful permanent resident for any period of time with a disability, refugees or asylum seeker with refugee or asylee status. OR a U.S. citizen under 18, regardless of parent's citizenship status, and students considered "half-time" by educational institutions.

Address: 4825 Cordell Avenue, Suite 204, Bethesda, MD 20814

Phone: 301-818-3614; 240-630-0774

SHARE Food Network by: Catholic Charities Archdiocese of Washington

SHARE Food Network is a sustainable, social enterprise of Catholic Charities that provides nutritious groceries at a reduced cost. Everyone is welcome to purchase without application, qualification, identification, or documentation. Everyone receives the same, fresh, high-quality food.

Monthly value packages cost just $22 and include $40-$50 worth of basic and healthy groceries, typically made up of 4-5 pounds of frozen protein products, 1-3 grocery items, and 8-9 pounds of fresh produce.

Each customer is asked to document at least two hours of service to their community each month before buying.

To receive services, please call the main program line or find the SHARE site closest to you on the program website.

Eligibility: Anyone can access this program.

Address: 3222 Hubbard Road, Hyattsville, MD 20785

Phone: 301-864-3115

Diabetes Prevention Program by: Holy Cross Health

The Diabetes Prevention Program can help individuals reduce the risk of developing Type 2 diabetes and help them adopt and maintain a healthy lifestyle to reduce your chances of developing diabetes.

This program lasts for one year. To learn more about the program, please call.

Eligibility: Must have Medicare or Maryland Medicaid. This program helps people who are older than 17 years old. Must be overweight. Must NOT be diagnosed with type 1 or type 2 diabetes. Must not be pregnant.

Address: 3720 Farragut Avenue, 2nd Fl, Kensington, MD 20895

Phone: 301-557-1231; 301-949-4242

CONTACT INFORMATION

We are grateful to the scholars, hospital staff, advocacy leaders, partners, and stakeholders who have expressed appreciation for easy access to previous CHNAs to reference comprehensive data on local community health status, needs, and issues. We hope the collaborative nature of the 2022 MCHC CHNA is valued as an *enhanced* asset. We invite all members of the community to submit questions and feedback regarding this collective assessment.

To request a print copy of this report, or to submit your comment, please contact:

Adventist HealthCare
Gina Maxham, MPH
ourcommunity@adventisthealthcare.com

Holy Cross Health
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DriverM@holycrosshealth.org

Suburban Hospital, Johns Hopkins Medicine
Monique Sanfuentes, MA, MBA
MSanfuentes@jhu.edu

MedStar Health, MedStar Montgomery Medical Center
Diana Saladini, MA
Diana.Saladini@medstar.net

An electronic version of this Community Health Needs Assessment is publicly available at:

Adventist HealthCare website:
https://www.adventisthealth care.com/about/community/health-needs-assessment/

Holy Cross Health website:
https://www.holycrosshealth.org/about-us/community-involvement/community-benefit-planning/community-health-needs-assessment

Suburban Hospital, Johns Hopkins Medicine website:
https://www.hopkinsmedicine.org/about/community_health/suburban-hospital/community_commitment/needs_assessment.html

MedStar Health, MedStar Montgomery Medical Center website:
https://www.medstarhealth.org/locations/medstar-montgomery-medical-center/community-health

Adventist HealthCare

HOLY CROSS HEALTH
A Member of Trinity Health

MedStar Health

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE