2025

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

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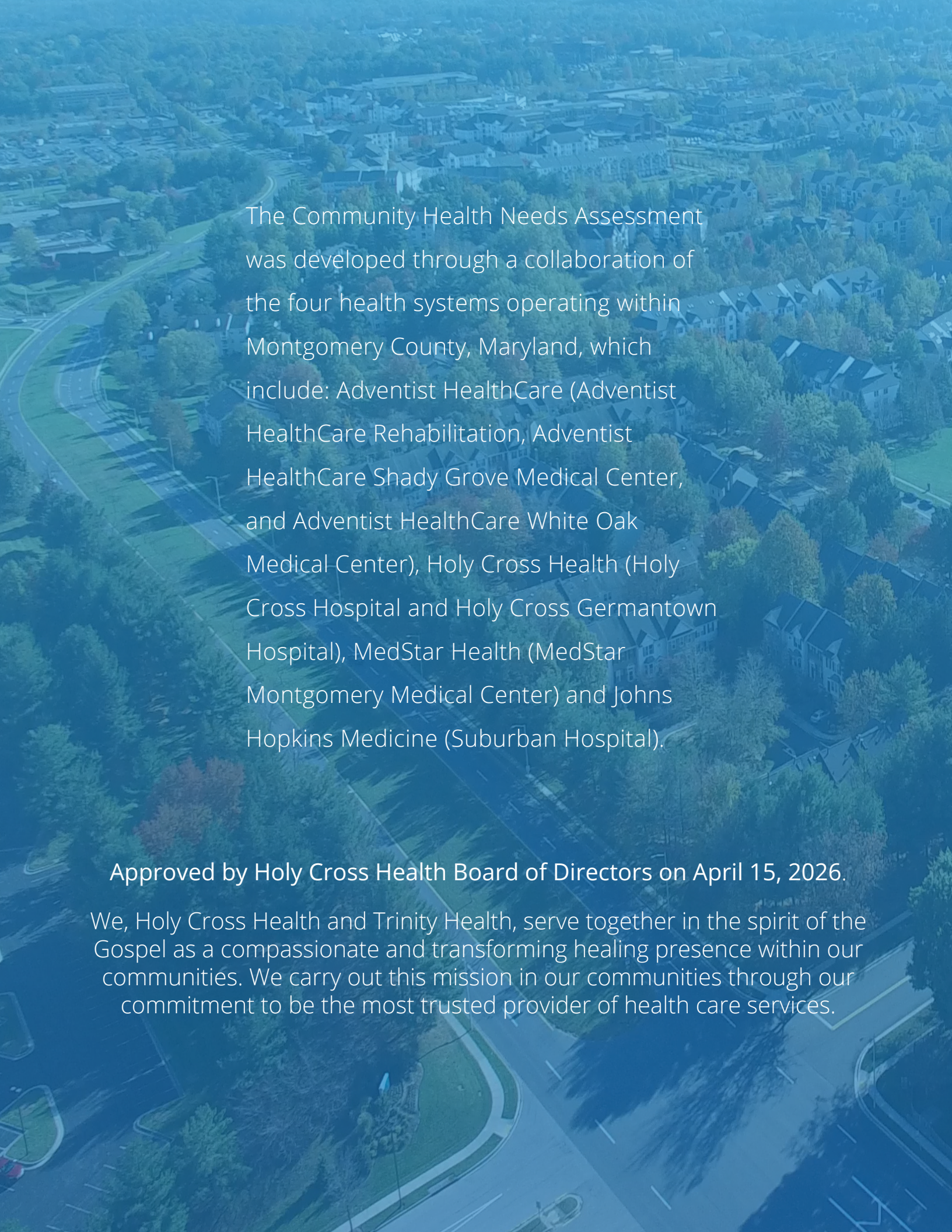


The Community Health Needs Assessment was developed through a collaboration of the four health systems operating within Montgomery County, Maryland, which include: Adventist HealthCare (Adventist HealthCare Rehabilitation, Adventist HealthCare Shady Grove Medical Center, and Adventist HealthCare White Oak Medical Center), Holy Cross Health (Holy Cross Hospital and Holy Cross Germantown Hospital), MedStar Health (MedStar Montgomery Medical Center) and Johns Hopkins Medicine (Suburban Hospital).

Approved by Holy Cross Health Board of Directors on April 15, 2026.

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.

EXECUTIVE SUMMARY

Meaningful and lasting health improvement is a necessary yet complex challenge, especially at the community level. The Montgomery County Hospital Collaborative (MCHC) Community Health Needs Assessment (CHNA) demonstrates how a collective impact approach can broaden the reach of community-centered health initiatives. By fostering strategic relationships and leveraging resources, the MCHC has deepened its commitment to health equity through intentional and inclusive community engagement.

While Montgomery County consistently ranks as one of the healthiest counties in Maryland, many residents face significant barriers to achieving positive health outcomes. These challenges are often rooted in socioeconomic disparities, which disproportionately affect racial and ethnic groups. The CHNA process exists so that data-driven, community-informed strategies can be designed to reduce disparities and barriers, ensuring that all individuals living in the MCHC Community Benefit Service Area (CBSA) can thrive.

BACKGROUND

The Patient Protection and Affordable Care Act (ACA) was enacted by Congress in 2010 to improve the quality and accessibility of health care for all Americans through comprehensive health insurance reform. One key provision of the ACA requires nonprofit hospitals to conduct a CHNA and adopt an implementation strategy every three years. This process helps hospitals identify the most pressing health issues within their defined community benefit service areas and develop a plan to implement targeted programs and services to address identified unmet community needs. By aligning hospital efforts with community priorities, the CHNA and implementation strategy serve as essential tools for advancing health equity and improving population health outcomes.

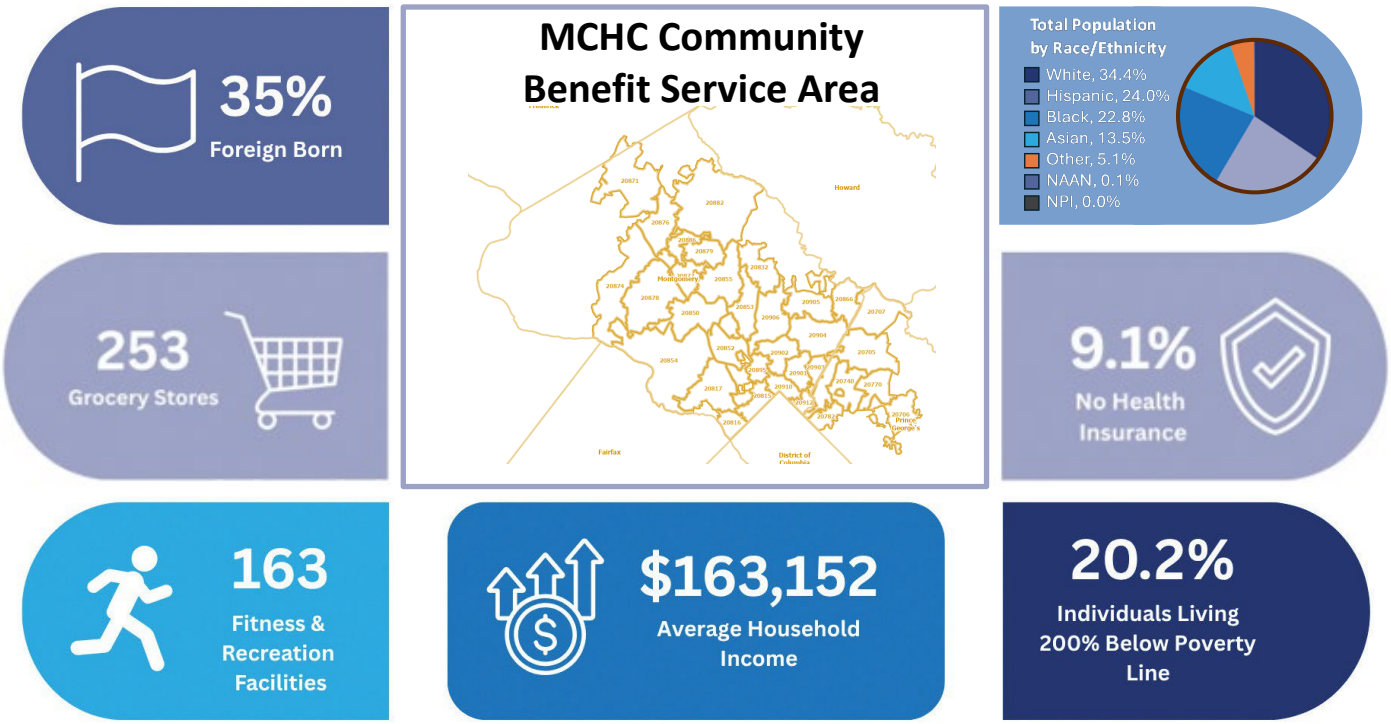
In 2021, the Montgomery County hospitals seized an opportunity to align with the collective impact model by developing a joint CHNA and Implementation Strategy, which was released in 2022. The collaborative effort was driven by their shared participation in Healthy Montgomery, Montgomery County's community health improvement process and local health improvement coalition.

Established in June 2009, Healthy Montgomery brings together County government agencies, County hospital systems, minority health programs and initiatives, advocacy groups, and other stakeholders to promote optimal health and well-being for all Montgomery County residents. Recognizing the value of collaboration, the hospitals united to leverage community benefit resources, identify overlapping implementation strategies, and reduce duplication of efforts—ultimately enhancing the effectiveness and reach of their collective health improvement initiatives.

METHODOLOGY & RESULTS

While the MCHC serves residents from multiple counties, this year's Community Benefit Service Area (CBSA) was defined by the primary service areas of the participating hospitals. As a result, the CBSA includes 38 ZIP codes spanning Montgomery and Prince George's Counties. A snapshot of demographics and resources for the MCHC CBSA can be found in Figure 1.

Figure 1. Snapshot of demographics and resources for the MCHC CBSA.



To gather comprehensive insights, the 2025 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 stakeholders, comprising officers from local government agencies and leaders from community-based organizations, foundations, churches, colleges, coalitions, and associations
- A newly formed Community Engagement Council, comprising individuals working directly with communities that face the highest needs
- A 19-question Community Health Needs Assessment Survey offered in six languages

- Community conversations, key informant interviews, and a focus group
- Existing needs assessments from local health initiatives, government agencies, and nonprofit community health organizations

The MCHC used this information, in tandem with local public health leaders, service providers and community advocates, to prioritize key focus areas for addressing health inequities, organized into three health domains (see Figure 2):

1. Easy Access to Comprehensive Care,

2. Promotion of Healthy Living and Well-being for All, and

3. Support for Essential Community Services

Addressing these priorities will help reduce the burden of health outcomes associated with heart disease, diabetes, mental health, cancer, maternal and child health, infections, and unintentional injuries.

Figure 2. Health domains prioritized by the MCHC.

EVALUATION OF PRIOR COMMUNITY HEALTH NEEDS ASSESSMENTS

As part of the CHNA process, the MCHC conducted an evaluation of the impact of its previous CHNA and Implementation Strategy. This evaluation fulfills the IRS requirement to assess the impact of actions taken in response to the previous CHNA.

The evaluation focused on priority areas identified in 2022, including access to health care, behavioral health, chronic disease prevention and management, maternal and child health, food insecurity, housing, and education. Across these domains, MCHC hospitals implemented a wide range of programs and services, such as expanding access to safety-net clinics, offering behavioral health screenings and treatment, supporting chronic disease self-management programs, and partnering with community organizations to address food and housing insecurity.

Progress was measured using key indicators such as uninsured rates, life expectancy, mental health status, diabetes prevalence, and food insecurity levels. While improvements were observed in several areas, including reduced uninsured rates in Montgomery County and expanded behavioral health services, challenges remain, particularly in addressing disparities across ZIP codes and counties. These findings informed the prioritization of focus areas in the this CHNA and reinforced the need for a coordinated, equity-driven approach to community health improvement.

NEXT STEPS

With the priority needs identified, the MCHC will develop a strategic plan to address them over the next three years. In another step towards strengthening the collective impact model, the MCHC will develop this implementation plan, or strategic roadmap, in collaboration with Montgomery County Department of Health and Human Services (DHHS) and Healthy Montgomery, who issued their most recent CHNA in 2024.

The vision is to deepen collaboration by leveraging shared experience, resources, capacities, and community input. A Health Priority Action Team, comprising community leaders with influence in change-making, will be formed for each of the three domains. Collectively, these teams will lay the groundwork for mobilizing health improvement initiatives that cultivate a more equitable foundation for health.

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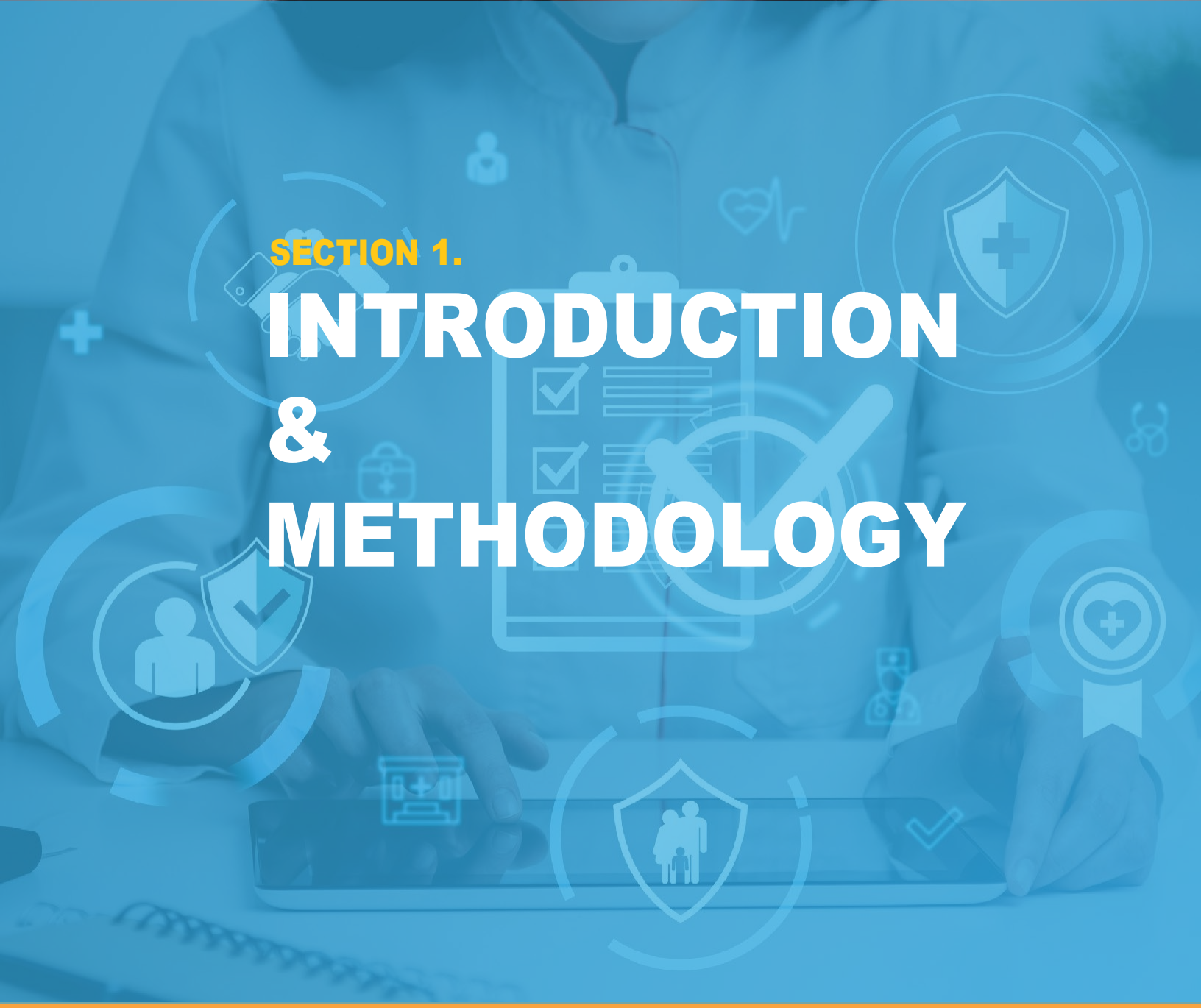


SECTION 1.

INTRODUCTION & METHODOLOGY

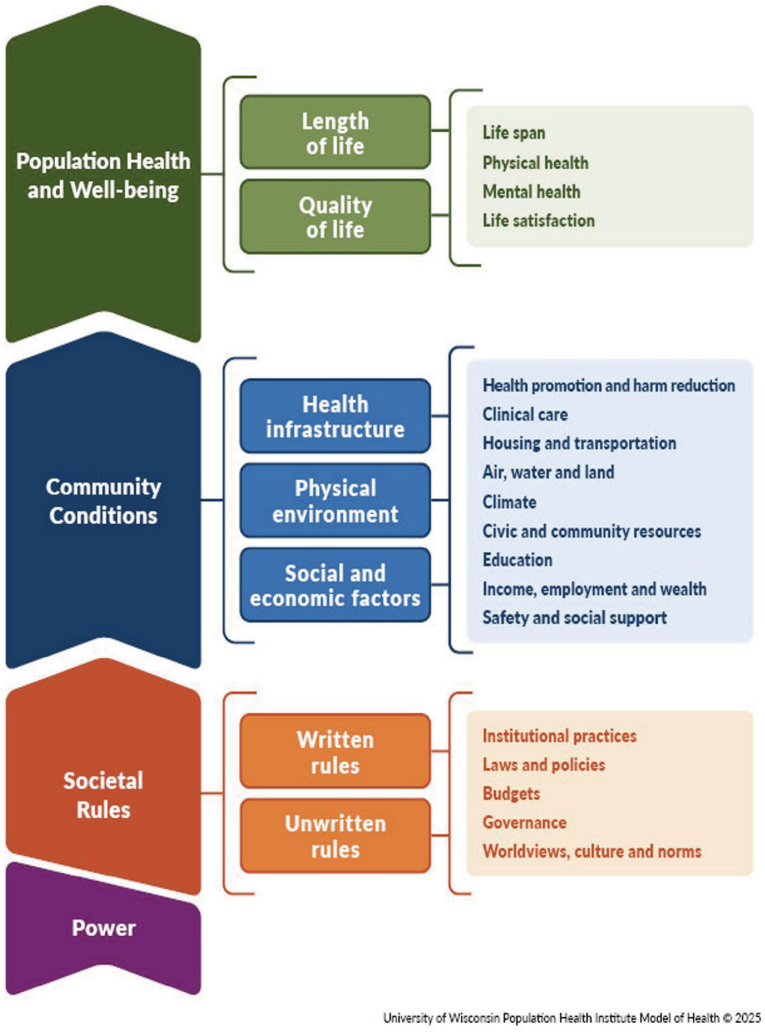
The Patient Protection and Affordable Care Act (ACA), enacted by Congress in 2010, was designed to enhance the quality and accessibility of health care for all Americans through comprehensive health insurance reform. Under the ACA, nonprofit hospitals are required to conduct a community health needs assessment (CHNA) and adopt an implementation strategy every three years. The CHNA aims to identify the most important unmet health needs within a defined community benefit service area (CBSA) and serves as the foundation for developing an implementation strategy to address those needs.

ANALYTICAL FRAMEWORK

The CHNA is structured using the County Health Rankings & Roadmaps (CHR&R) model developed by the University of Wisconsin Population Health Institute. Built on more than twenty years of research, this evidence-based framework highlights the factors that shape health outcomes and guides efforts to improve community well-being. The CHR&R model broadens our understanding of how well and how long we live by examining who and what influences our conditions and how this shapes our daily lives [1]. The model organizes determinants of health into four broad categories (see Figure 3):

1. Population Health and Well-Being
2. Community Conditions
3. Societal Rules
4. Power – ability to effect change

Figure 3. County Health Rankings & Roadmaps Model



Using this model ensures a comprehensive, systems-level approach and aligns with national best practices. This framework also guided indicator selection, ensuring a balanced analysis of upstream social determinants and downstream clinical and behavioral factors. It enables meaningful comparisons, trend analysis, and equity-focused prioritization.

DATA SOURCES & COMMUNITY ENGAGEMENT

This CHNA draws from a robust combination of quantitative and qualitative data to identify and understand unmet health needs. Guided by the CHR&R model, more than 100 indicators were reviewed to create a comprehensive health profile of Montgomery and Prince George's Counties. This integrated approach, supported by the ongoing collaboration and investment of

the MCHC, ensures a deep understanding of health inequities and identifies opportunities for targeted interventions.

HEALTHY MONTGOMERY

In Montgomery County, these efforts are coordinated through Healthy Montgomery, the County's Local Health Improvement Coalition (LHIC), which leads the Community Health Improvement Process (CHIP). Established in 2009, Healthy Montgomery brings together county government agencies, health systems, minority health programs and initiatives, advocacy groups, academic institutions, community-based service providers, and other stakeholders to achieve optimal health and well-being for all residents. The coalition plays a pivotal role in identifying community health needs, developing strategies for improvement, and promoting accountability through measurable health outcomes.

As the LHIC, Healthy Montgomery brings together stakeholders in a collaborative, ongoing effort to set a health priority agenda and action plan for Montgomery County's identified needs. The coalition has continually adapted to address emerging health issues, centralize data, improve access to health and social services, enhance physical and social environments to support optimal health and well-being, and promote health equity for all residents. Through this evolution, it has strengthened its role as the primary repository for community health data.

MONTGOMERY COUNTY HOSPITAL COLLABORATIVE

A key driver of Healthy Montgomery's progress has been the active engagement of hospitals in governance and planning. Since 2009, representatives from each health system actively participate in various committees and planning groups, including the Healthy Montgomery Steering Committee (see Appendix A), which serves as the initiatives governing body. Since the coalition's launch in 2009, hospitals have also provided consistent financial support to maintain their infrastructure—collectively contributing $150,000 annually, with each hospital contributing $25,000.

In 2015, building on Healthy Montgomery's foundational work, Montgomery County hospitals (see Figure 4) formed the Montgomery County Hospital Collaborative (MCHC) to leverage community benefit resources, align strategies, and reduce duplication. This collaboration continues to enhance coordination, program mapping, and collective impact efforts. In 2022, the MCHC developed a joint CHNA and Implementation Strategy to guide collective action, advance health equity, and improve quality of life.

Figure 4. Logos of the four health systems (six hospitals) that collaborated to develop the Montgomery County Hospital Collaborative Community Health Needs Assessment.

This CHNA integrates new data sources, comparisons to the previous CHNA, lessons learned from prior implementation strategies, and innovative approaches to meet the evolving community health needs. A summary of each hospital's comprehensive services can be found in Appendix B.

DATA SOURCES

The data process includes:

- Qualitative data – Gathering information from community members and subject matter experts through Healthy Montgomery's Community Health Improvement Process (CHIP), external advisory board discussions, and key informant interviews; and
- Quantitative data – Reviewing timely, reliable, and valid secondary health data and reports.

This dual approach—combining qualitative insights with quantitative data—strengthens the validity of findings and supports the development of targeted strategies.

ADVISORY AND COMMUNITY ENGAGEMENT GROUPS

Since 2008, the four health systems convene diverse groups of external participants representing the broad interests of the community served, providing valuable advice and feedback throughout the CHNA process. Participants include the public health officer, the director of the Montgomery County Department of Health and Human Services (DHHS), and leaders from local and state governmental agencies, community- and faith-based organizations, foundations, colleges, coalitions, and associations.

To deepen community involvement, MCHC expanded its engagement model in 2024 by forming a community advisory group. Following the International Association for Public Participation's (IAP2) Public Participation Spectrum,[1] MCHC strengthened its approach to community-centered health improvement by convening a Community Engagement Council (CEC), composed of community members from focus areas who contributed their lived experiences and insights to ensure the CHNA accurately reflected the community's needs and strengths. This group also played a crucial role in developing the distribution plan for the survey and provided input on the survey content. The formation of the CEC reflects the MCHC's commitment to elevating the public's role in shaping health priorities (see Section 5 for details about the council and their contributions).

These participants are experts in public health, health care, minority populations, health disparities, social determinants of health (SDOH), and social services. Their feedback and guidance have been instrumental in identifying, prioritizing, and responding to the most pressing community health needs. Throughout the CHNA process, advisory group members

[1] The IAP2 Spectrum outlines five levels of public participation—Inform, Consult, Involve, Collaborate, and Empower—each representing a progressively greater role for the public in shaping decisions and outcomes (https://iap2.org.au/wp-content/uploads/2020/01/2018_IAP2_Spectrum.pdf).

actively participated in key activities such as the prioritization process, thought leader discussions, and data exploration sessions.

The inclusion of these voices, particularly from underrepresented populations, enhanced the CHNA's relevance and equity focus. Their contributions provided a deeper understanding of community assets and challenges, further informing the prioritization and development of effective strategies. A comprehensive list of advisory and community engagement group members is available in Appendix C.

COMMUNITY SURVEYS, CONVERSATIONS, AND KEY INFORMANT INTERVIEWS

In 2025, a 19-question CHNA survey was widely distributed to gather insights on health status, access to care, and perceived community health needs and strengths. The survey was made available in Amharic, English, French, Mandarin, Spanish, and Vietnamese to ensure inclusivity. Dissemination followed a coordinated plan developed with input from the Community Engagement Council. This plan guided distribution through community events, programs and health fairs, email, listservs, social media, community partners, and local organizations.

Community conversations were conducted in partnership with Healthy Montgomery and with oversight, participation, and support from the Montgomery County DHHS. A total of 56 stakeholders participated in 11 key informant interviews. These conversations and interviews were originally included in the MCHC 2022 CHNA, as Montgomery County operates on a five-year CHNA cycle. The county approved its CHNA in 2024, and these qualitative insights continue to provide valuable context to complement survey data, offering a deeper understanding of the community's needs and assets. Findings from the key informant interviews are referenced in Appendix D.

Together, these qualitative and quantitative methods offer a comprehensive view of community health perceptions and priorities.

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. These include:

- African American Health Program Annual Report FY2023
- African American Health Program Health Disparities Hot Spot Report 2019
- Asian American Health Initiative Annual Report FY2023
- Blueprint for Asian American Health Initiative 2020-2030
- Blueprint for Latino Health in Montgomery County 2017-2026
- CDC National Diabetes Statistics Report 2022
- Community Action Partnership, Community Needs Assessment 2022-2025

- Healthy Montgomery Health Survey Report 2022
- Latino Health Initiative Annual Report FY2023
- Maternal and Infant Health in Montgomery County, MD 2012-2021
- Maryland Commission on Health Equity 2022 Annual Report
- Maryland Diabetes Action Plan 2022
- Maryland Vital Statistics Annual Report 2022
- Montgomery County 2023 Community Health Needs Assessment
- Montgomery County Collaboration Council, Community Needs Assessment, 2020
- Montgomery County DHHS, Health Equity Report 2013-2021
- Montgomery County DHHS, Population Health Report 2010-2019
- Montgomery County Food Council Annual Report 2022
- Prince George's County Community Health Assessment 2022
- Prince George's County Food Security Task Force Report 2021
- Thrive Montgomery 2050 Plan 2022
- Trust for America's Health, State of Obesity 2022: Better Policies for a Healthier America
- University of Wisconsin Population Health Institute's County Health Rankings Data 2023
- USDA Economic Research Report, Household Food Security in the United States 2022

These reports were selected for their relevance to priority populations and their alignment with CHNA goals. They provide both historical context and current data to inform strategic planning.

OTHER AVAILABLE DATA

The MCHC utilized a comprehensive approach to data collection by reviewing publicly accessible data on market analyses, health indicators, and SDOH. These data sets provide a nuanced understanding of the communities served, helping to identify disparities that might not emerge from examining only county- or state-level data.

Members of the MCHC also actively participate in various coalitions, commissions, committees, partnerships, and panels, ensuring ongoing engagement with community stakeholders. This consistent involvement offers critical insights into emerging health opportunities and challenges, enhancing our ability to respond proactively to evolving health needs. Furthermore, this engagement has supported the development of collaborative

strategies to address identified disparities, especially those related to behavioral health and health equity.

INDICATORS AND MEASUREMENT LIMITATIONS

The indicators used in this assessment were selected to reflect key aspects of population health and health system performance relevant to the community. These measures help describe overall health status, identify disparities, and evaluate progress toward addressing priority health needs and disparities. Indicators included those related to chronic disease prevalence, access to care, maternal child health, mental health, and SDOH, among others.

Despite their value, several limitations affect the accuracy and comprehensiveness of these indicators. A primary challenge is data timeliness—some sources reflect pre- pandemic conditions and may not capture recent shifts in health trends, particularly in mental health and SDOH. Additionally, while efforts were made to broadly distribute CHNA surveys, representation gaps may exist, especially among underserved populations or individuals with limited access to technology.

Geographic granularity also presents a limitation. County-level data, while useful, can mask disparities within specific zip codes, neighborhoods, or areas with significant socioeconomic diversity. At the time of this report, zip-code level data was not consistently available for Montgomery or Prince George's Counties, necessitating reliance on broader county or state-level data. Furthermore, not all indicators were available across all racial and ethnic groups, requiring the use of aggregated or limited race/ethnicity-specific data.

Inconsistencies in data collection and reporting practices across different organizations can affect comparability and integration. Qualitative data from community conversations and key informant interviews also have limitations, as the perspectives of individuals who may not regularly engage with healthcare systems may be underrepresented. Lastly, the limited availability of stratified data by key demographics, such as race, ethnicity, gender identity, disability status, and socioeconomic status presents challenges in accurately assessing disparities and developing targeted interventions.

These limitations highlight opportunities for improving future assessments through more inclusive data collection, enhanced granularity, and better alignment across data sources to ensure a more comprehensive understanding of community health needs.

DEFINING COMMUNITIES SERVED

The Montgomery County hospitals serve portions of Montgomery, Prince George's, Frederick, Carroll, and Howard Counties, as well as the District of Columbia. This expansive region encompasses 86 zip codes and nearly 2.3 million residents. The purpose of this CHNA is to identify and prioritize key areas and communities for meaningful engagement, focusing efforts where they are most needed. In alignment with IRS Section 501(r)(3) guidelines, the Montgomery County hospitals collectively defined a Community Benefit Service Area (CBSA) for the MCHC by identifying zip codes within each hospital's primary service area. Within this CBSA, specific communities of focus were highlighted to provide a comprehensive snapshot of the populations currently served, as well as emerging areas that may benefit from enhanced engagement and targeted health improvement strategies.

Figure 5. Geographic Boundaries of the Montgomery County Health Collaborative (MCHC) Community Benefit Service Area (CBSA) (Source: Trinity Health Data Hub, 2025).

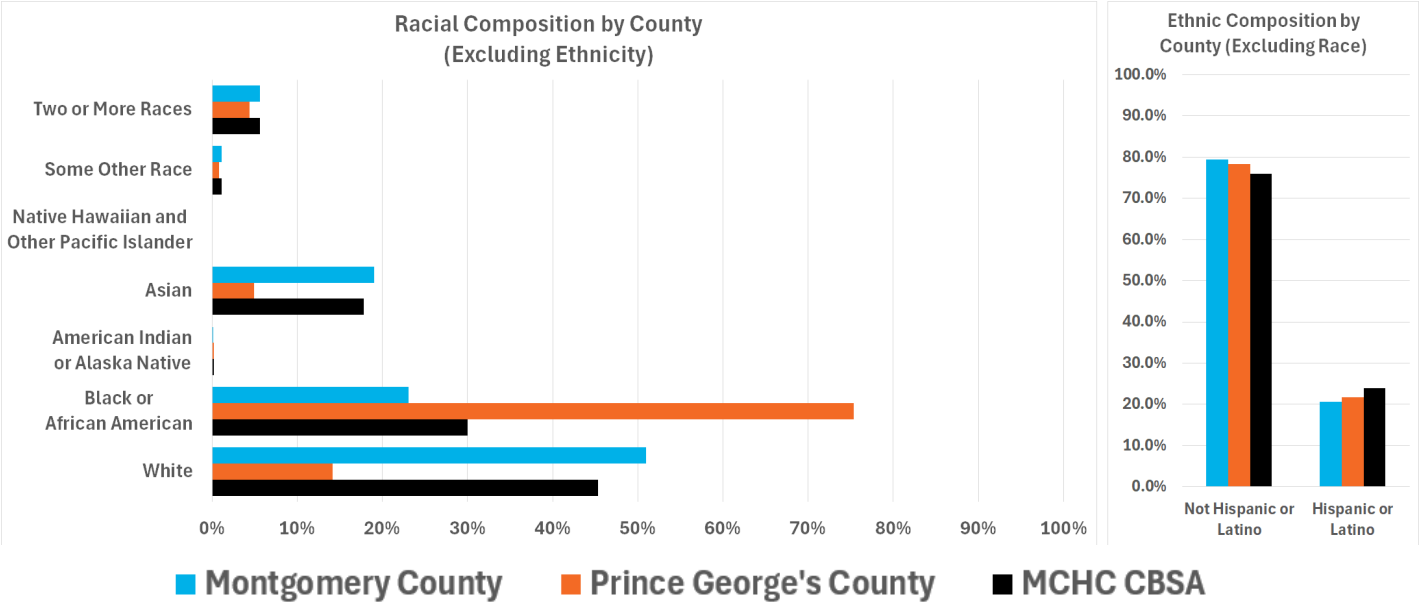
DESCRIPTION OF SERVICE AREAS

The MCHC CBSA encompasses 38 zip codes spanning approximately 388 square miles across Montgomery County and northern Prince George's County (see Figure 5). This region is home to a diverse and densely populated community of 1,281,802 [2]. The population density of the CBSA is estimated at 3,307 persons per square mile, which is a slight increase from the 2022 CHNA population density of 3,218 persons per square mile. This density remains significantly higher than that of Montgomery County (2,116), Prince George's County (1,883), and the state of Maryland (620). For a detailed list of zip codes, see Appendix E.

DEMOGRAPHIC COMPOSITION

Montgomery and Prince George's Counties are recognized for their vibrant cultural and ethnic diversity, which is clearly reflected in the demographic makeup of the service area. According to data from the US Census Bureau [2], Non-Hispanic White residents comprise 45.3% of the population, followed by Non-Hispanic Black or African American residents at 30.0%, Hispanic/Latino at 24.0%, and Non-Hispanic Asian at 17.8% (see Figure 6). This rich blend of backgrounds contributes to the dynamic social and cultural fabric of the region.

Figure 6. Population by racial and ethnic composition by county and within the MCHC CBSA.

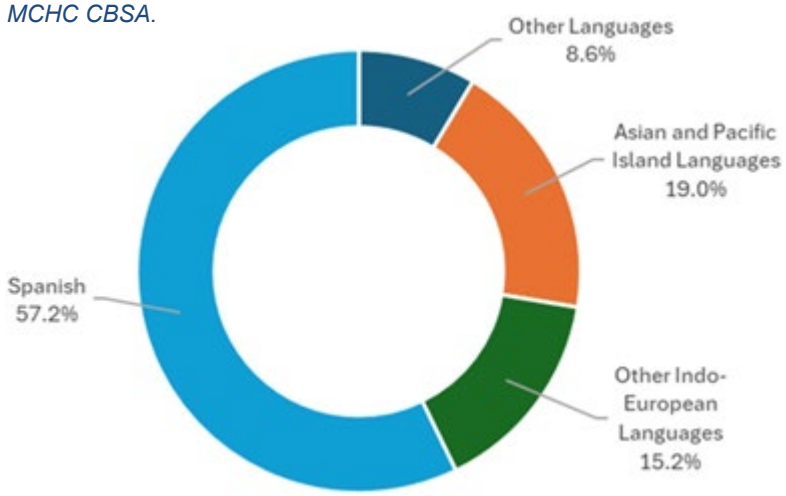


Source: US Census Bureau, American Community Survey, 2019-23

Cultural diversity is further underscored by the high proportion of foreign-born residents. Within the CBSA, 35.2% of the population is foreign-born, compared to 33.4% in Montgomery County, 24.9% in Prince George's County, and 16.2% statewide [3]. This international presence brings a wide array of languages and traditions, enriching community life while also presenting unique challenges, particularly in healthcare access and communication.

Language diversity is especially notable. Approximately 18.3% of the CBSA population ages 5 and older report speaking English less than very well, a figure that far exceeds the Maryland average of 7.8%. This level of limited English proficiency (LEP), which refers to the limited ability for individuals to speak English well because it is not their primary language, presents significant challenges and barriers in accessing healthcare. Individuals with LEP often struggle to communicate with providers, understand medical instructions, and navigate health systems. Spanish is the most commonly spoken language among LEP residents, followed by a variety of languages from Asia, the Pacific Islands, and other Indo- European regions [4] (see Figure 7.).

Figure 7. Spoken language at home among LEP residents within the MCHC CBSA.



Source: US Census Bureau, American Community Survey, 2019-23

COMMUNITY RESOURCES AND DISPARITIES

Despite the CBSA's rich resources, including over 170 fitness and recreation facilities, 240 grocery stores, and 100 social and professional organizations, significant disparities in health and economic well-being persist [5]. While approximately 75% of residents live within half a mile of a park, 18.6% of residents within the MCHC CBSA are physically inactive [6], suggesting that access alone does not guarantee utilization or improved health outcomes. However, these averages mask growing income inequality and the rising cost of living in the region.

The average household income in the MCHC CBSA is $159,305—higher than the state average of $129,642 and the Prince George's County average of $118,776, but lower than Montgomery County's overall average of $172,866 [7] However, these averages mask growing income inequality and the rising cost of living in the region.

Recent analyses have highlighted significant shifts in income distribution within Montgomery County. From 2005-2022, Montgomery County experienced a 5.4 percentage point increase in its low-income population share, the largest increase among the 11 largest jurisdictions in the Washington metropolitan area [8]. This equated to the addition of approximately 88,000 low-income residents. Concurrently, the middle-income share decreased by 5.4 percentage points, reflecting a loss of more than 26,000 middle-income residents, possibly due to a shift into a lower income group. Meanwhile, the high-income segment remained relatively stable, maintaining just over 50% of the population share. These trends indicate a widening income gap, with a growing low- income population and a diminishing middle class. These trends underscore the need for targeted interventions to address economic disparities and promote equitable health outcomes.

The Self-Sufficiency Standard, a more accurate measure of economic security than the federal poverty level, further illustrates the financial strain on working families. In 2023, a family of three in Montgomery County (one adult, one preschooler, and one school-age child) needed an annual income of $122,943 (or $55.33 per hour) to meet basic needs without public or private assistance [9]. This is more than four times the federal poverty guideline for a family of the same size. For families earning minimum wage, full-time employment is insufficient to cover essential expenses such as housing, childcare, food, and healthcare [9].

These economic pressures disproportionately affect low-income households, communities of color, and individuals with limited English proficiency—groups already facing structural barriers to care. Addressing these disparities requires a multifaceted approach that includes expanding access to affordable services, increasing culturally and linguistically appropriate care, and leveraging community strengths to support residents in achieving economic and health equity.

POPULATIONS EXPERIENCING VULNERABILITY

Populations experiencing vulnerability are groups and communities at a higher risk for poor health outcomes due to structural and societal factors such as systemic racism, discrimination, stigma, and poverty [10]. In 2021, the Equity Data Team of Montgomery County's Planning Department developed a mapping tool to identify vulnerable populations within the county. This tool identified 56 Equity Focus Areas (EFAs) by analyzing demographic data at the census tract level, focusing on areas with high concentrations of lower-income households, people of color, and individuals with Limited English Proficiency (LEP) [11].

Approximately one-quarter of Montgomery County's residents live in EFAs, all of which are located within the MCHC CBSA. Building upon this analysis, Montgomery County Planning introduced the Community Equity Index (CEI), a composite measure assessing socioeconomic conditions and disparities across neighborhoods. The CEI provides a nuanced understanding of equity and helps identify areas requiring targeted interventions [12].

In addition to populations residing in areas identified by the CEI, other vulnerable groups include individuals with low-income, racial and ethnic minorities, the uninsured, seniors, pregnant women and infants, people experiencing homelessness, and those with disabilities. Recognizing and addressing the unique needs of these populations is crucial for promoting health equity and improving overall community health outcomes.

POPULATIONS WITH LOW-INCOME STATUS

Low-income status and poverty remain significant drivers of poor health outcomes due to their correlation with adverse conditions such as substandard housing, homelessness, food insecurity, inadequate childcare, limited access to health care, unsafe neighborhoods, and under-resourced schools. Coronavirus disease (COVID-19) exacerbated these inequities, with inflation and economic instability disproportionately impacting low-income communities [13]. Approximately 20.2%, or 253,967 individuals, within the MCHC CBSA, live in households with incomes below 200% of the Federal Poverty Level (FPL) [14]. Poverty creates barriers to access, including essential health services, healthy food, and other necessities contributing to poor health status [14].

MINORITY GROUPS

Racial and ethnic minority populations continue to experience disproportionately higher rates of illness and death across various health conditions, including diabetes, hypertension, obesity, asthma, and heart disease, when compared to their White counterparts. As noted by Dr. Joia Crear-Perry, "racism, not race, causes health disparities [15]." This perspective highlights the role of systemic racism as a key driver of health inequities rather than genetic differences. In the CBSA, approximately 54.7% of the population is Non-Hispanic, Non-White, and 24.0% are Hispanic [2].

UNINSURED POPULATIONS

Lack of health insurance remains a significant barrier to achieving optimal health outcomes. People without insurance coverage face obstacles in accessing timely care, often postponing or forgoing medical attention altogether. This leads to chronic conditions remaining undiagnosed or poorly managed, increasing morbidity and mortality rates. In the CBSA, 9.1% of the total civilian non-institutionalized population are without health insurance coverage, higher than the state average of 6.2% [16]. Although Maryland has relatively lower uninsured rates, there are still several factors complicating efforts to reduce them, most notably immigrant status.

OLDER ADULT POPULATIONS

The aging population continues to grow rapidly, presenting new challenges and opportunities for health care systems. The Maryland Department of Aging projects that by 2030, the number of individuals aged 60 and older in Maryland will reach approximately 1.7 million [17]. This would represent a 40% increase from the 1.2 million seniors living in Maryland in 2015. For Montgomery County, estimates suggest that the number of older adults residing in the community will double by 2030, increasing from 205,841 in 2015 to a projected 315,666 by 2030 [18].

This substantial increase underscores the need for health care systems to adapt to the unique health needs of older adults, including managing chronic illnesses, addressing cognitive decline, and mitigating social isolation. Developing age-friendly healthcare systems and ensuring long-term care access are essential to meet the needs of this growing demographic.

MATERNAL AND INFANT POPULATIONS

The well-being of mothers, infants, and children remains a critical indicator of community health. Access to quality preconception, prenatal, postnatal, and interconception care can significantly reduce the risk of maternal and infant mortality. However, recent reports indicate that maternal mortality rates are rising nationally, particularly among Black women who experience disproportionately higher risks of severe maternal morbidity.

Locally, the MCHC CBSA continues to face significant disparities in maternal and child health. Between 2017 and 2019, 7.2% of births involved late or no prenatal care, exceeding the national average of 6.1%. Infant mortality remains a concern as well: from 2015 to 2021, the CBSA rate was 5.6 per 1,000 live births, with Prince George's County at 7.4 and Montgomery County at 5.0. Low birth weight also presents challenges. Although the CBSA average of 7.9% is below the state (8.7%) and national (8.3%) averages, disparities persist, with Non-Hispanic Black populations experiencing the highest rates, 11.6% in Prince George's County and 9.6% in Montgomery County [19].

These disparities indicate that significant work remains to be done to improve maternal and child health equity. Effective strategies must address systemic inequities, enhance access to

quality care, and prioritize outreach to populations experiencing the highest disparities.

POPULATIONS EXPERIENCING HOMELESSNESS

Homelessness continues to impact health outcomes significantly, with individuals experiencing homelessness at greater risk of mental illness, substance use disorders, and chronic disease. In 2024, Montgomery County had more than 1,100 people experiencing literal homelessness—an increase of 28% compared to 2023. This included 103 family households with minor children, a 47% increase from the previous year [20].

Economic instability, rising housing costs, and insufficient shelter capacity remain significant barriers to long-term improvement. Health care access for homeless individuals remains limited, exacerbating existing health inequities.

LGBTQ+ COMMUNITIES

The LGBTQ+ community continues to experience health disparities, including higher rates of smoking, alcohol use, mental health issues, and inadequate access to culturally competent health care. Concerns about discrimination and stigma contribute to the underutilization of health services. Current political efforts to restrict gender-affirming care and attack transgender rights further complicate efforts to improve health outcomes for LGBTQ+ populations.

POPULATIONS WITH DISABILITIES

People with disabilities continue to be an underserved population facing numerous health disparities. They are less likely to receive recommended preventive health services and are at higher risk for poor health outcomes such as obesity, hypertension, and mental health disorders. Barriers related to physical accessibility, provider bias, and inadequate insurance coverage exacerbate these disparities. Recent efforts to improve accessibility and inclusion have shown promise but remain inconsistent across health care systems.

IMPACT OF CURRENT POLITICAL AND SOCIAL CLIMATES

The broader political and social landscape continues to significantly shape health disparities across all populations, particularly those already experiencing systemic barriers to care. Ongoing legislative debates and policy shifts have introduced new challenges for underserved and marginalized groups.

Recent developments include heightened restrictions on reproductive care, the rollback of affirmative action policies, tightened immigration policies, and legislative attacks on LGBTQ+ rights, particularly transgender health care access. Addressing these structural challenges requires a multi-faceted approach to form cross-sector partnerships, and implement targeted interventions designed to improve health equity. This includes expanding culturally competent care, enhancing data collection for underrepresented groups, and actively opposing policies that exacerbate inequities, through advocacy, education, and community engagement.

SECTION 2.

POPULATION HEALTH & WELL-BEING

Population health and well-being describe the extent to which all individuals in a community can achieve their highest level of health, and whether opportunities to do so are distributed fairly across populations. The updated County Health Rankings & Roadmaps model (see Figure 3) reframes health outcomes through a broader lens, focusing not only on how long and how well people live, but also on how social, economic, and structural conditions shape these outcomes. This section reflects that shift, presenting an overview of physical and mental health in the MCHC CBSA with an emphasis on equity and community context. According to the revised model, health is created where we live, learn, work, play, and pray and it is profoundly shaped by conditions such as access to quality housing, education, transportation, living-wage employment, and social connection [1].

This assessment considers both health outcomes such as life expectancy, maternal and child health, chronic disease and behavioral health, and the conditions that influence them. Although the 2025 County Health Ranking places Montgomery County in the top three healthiest counties and Prince George's County in the top quarter, this masks wide disparities within and between communities – particularly along racial, geographic, and economic lines. To address these inequities, there is an opportunity to shift from deficit-based narratives to equity-focused strategies that invest in community strengths and infrastructure [1].

LENGTH OF LIFE

Life expectancy at birth measures health status across all age groups and is a barometer for the overall health of a community [21]. It offers a broad picture of population health; however, averages often conceal inequities. Within the MCHC CBSA, life expectancy spans from 71.8 to 96.1 years—largely influenced by SDOH such as income, education, housing stability, and access to care. In Montgomery County, for example, White residents live 3.4 years longer than Black residents, and 6.6 years longer than Black residents in Prince George's County [22].

MATERNAL AND INFANT HEALTH

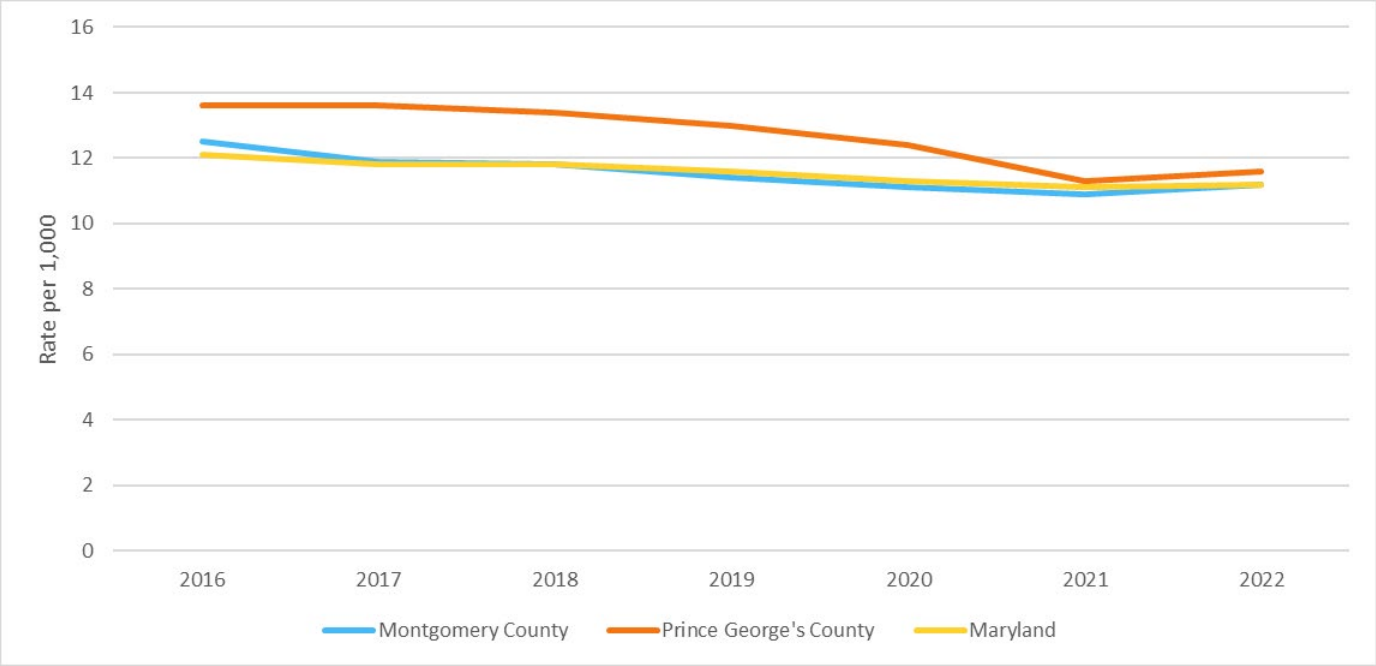
Improving the well-being of mothers, infants, and children is an important public health focus for the U.S. According to the Office of the Surgeon General, "the well-being of these populations determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system" [23]. Poor maternal and child health outcomes, such as low birth weight, preterm birth, and limited access to prenatal care, are often early indicators of broader issues like chronic disease prevalence, educational and economic disparities, and increased long-term health care costs. A mitigating strategy is to promote health across the life course, including emphasis on the importance of health from adolescence through childbearing years and beyond.

"The well-being of these populations determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system."

Maternal and infant health is an important indicator of the health and well-being of a nation. The Centers for Disease Control and Prevention (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, birth rates at the state level have been on the decline since 2016, due to several possible factors including declining marriage rates, higher economic costs, higher proportion of women joining the workforce, and changing family dynamics (see Figure 8). In 2022, Maryland had a rate of 11.2 births per 1,000 population. However, the birth rate of 11.6 in Prince George's County continues to be higher than the rates in the state and Montgomery County (11.2) [24].

Figure 8. Trends in Birth Rate by State and County, 2016-2022



Source: Maryland Department of Vital Statistics Annual Reports, 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 U.S. However, barriers to this care remain, especially for younger people, people of color, people with low incomes, linguistic minorities, and other marginalized groups.

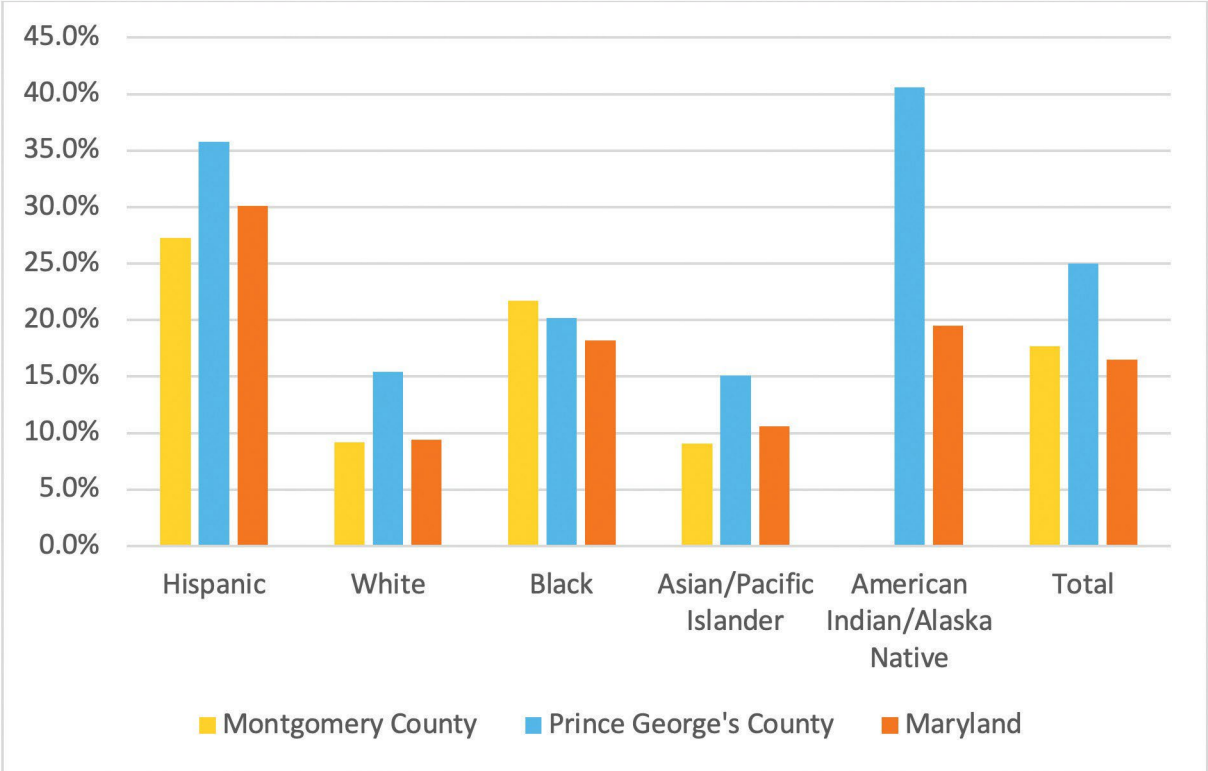
Prenatal care is critical in ensuring healthy outcomes for all. Compared with infants born to mothers who received prenatal care, infants whose mothers did not receive prenatal care are three times more likely to have a low birth weight and are five times more likely to die in infancy. Preterm births and infants with low birth weight contribute to additional complications, including an increased risk of SIDS, respiratory and gastrointestinal problems, and other long-term health complications (additional information on preterm and low birth weight infants are discussed in the next section). 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, or care in the first trimester of pregnancy, allows women and their health care providers to identify and, when possible, treat health issues and health-compromising behaviors. Increasing the number of women who receive early prenatal care can improve birth outcomes and lower health care costs by reducing the likelihood of complications during pregnancy and childbirth. Healthy People 2030 (HP2030) has a target of 80.5% of pregnant women receiving early prenatal care. In 2021 (most recent data), 65.6% of Montgomery County and 55.6% of Prince George's County women received care in the first trimester [25].

Despite the importance of prenatal care for maternal and infant health, not all individuals receive adequate or timely care. In 2023, about 1 in 6 infants (15.7% live births) were born to a woman receiving inadequate prenatal care in the U.S. [26]. Health insurance plays a critical role in accessing prenatal care, and people living in states that did not adopt 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 (29.5%), women with less than a high school degree (37%), and women of color including Hispanic women (20.1%), Black women (22.4%), and American Indian or Alaska Native women (27%). Across all races, the late or no prenatal care rate is higher in Prince George's County than in Montgomery County and the State (see Figure 9) [27].

Figure 9. Average Percentage of Inadequate Prenatal Care by Race/Ethnicity, 2021-2023



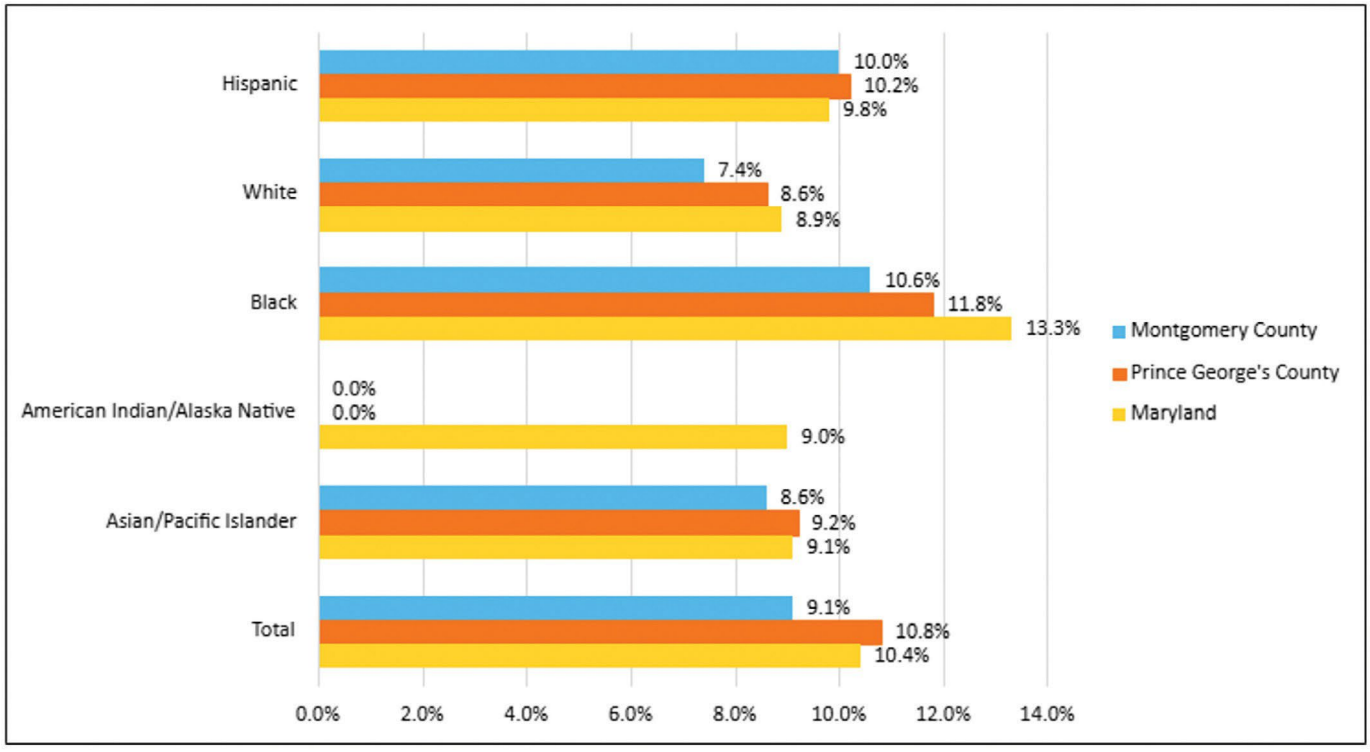
Source: National Center for Health Statistics (Final natality data), 2021-2023

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 [28]. 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 [29].

PRETERM AND LOW BIRTH WEIGHT INFANTS

Preterm birth, which refers to delivery of a live infant before 37 weeks of gestation, is a leading cause of infant mortality. These infants also have a higher risk of infections, developmental problems, and breathing problems. In 2023, the CDC estimated preterm births affected 1 of every 10 (10.4%) infants born in the U.S. Healthy People 2030 has a target of reducing preterm births to 9.4%. In 2023, 1 in 11 births (9.1%) were preterm in Montgomery County, compared to 1 in 9 births (10.9%) in Prince George's County. In 2023, the percentage of preterm births was highest among Non-Hispanic Blacks in both Prince George's County (11.8%) and Montgomery County (10.6%)28 (see Figure 10).

Figure 10. Percent Preterm Births by Race/Ethnicity, 2021-2023

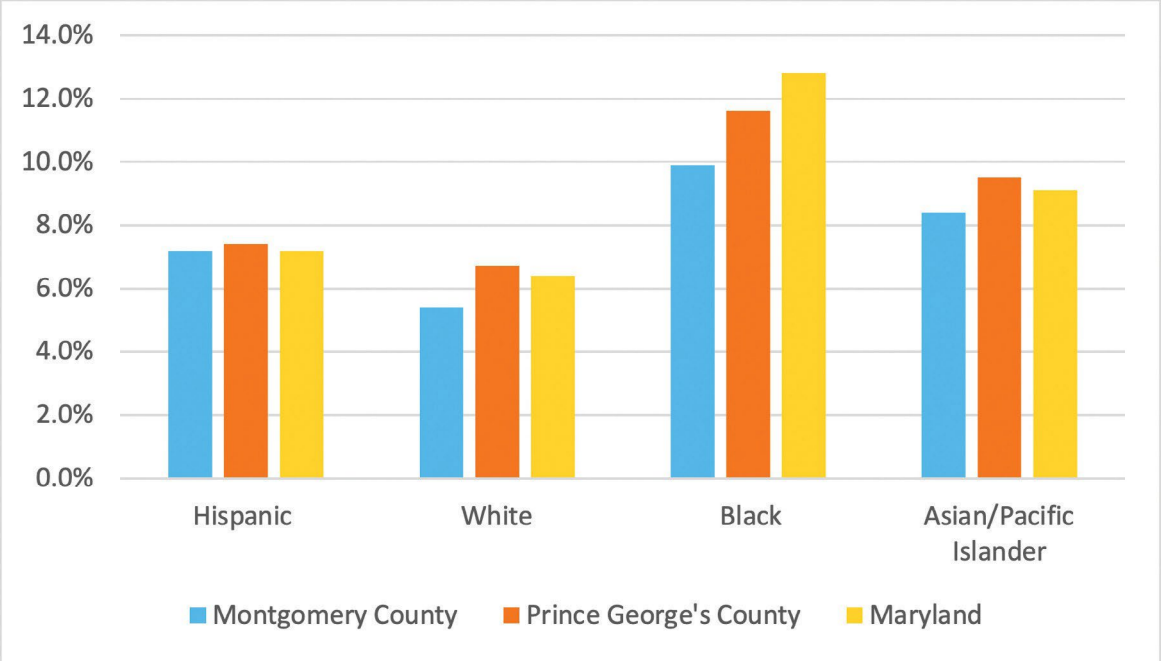


Source: National Center for Health Statistics, 2021-2023

Low birth weight (less than five pounds, eight ounces) or very low birth weight (less than three pounds, five ounces) is a common complication of infants who are born prematurely, and they are more likely than infants of normal weight to have health problems and require specialized medical care in the neonatal intensive care unit. In 2022, the CDC estimates 8.6% of all infants were born with low birth weight (LBW) while 1.4% had very low birth weight (VLBW).

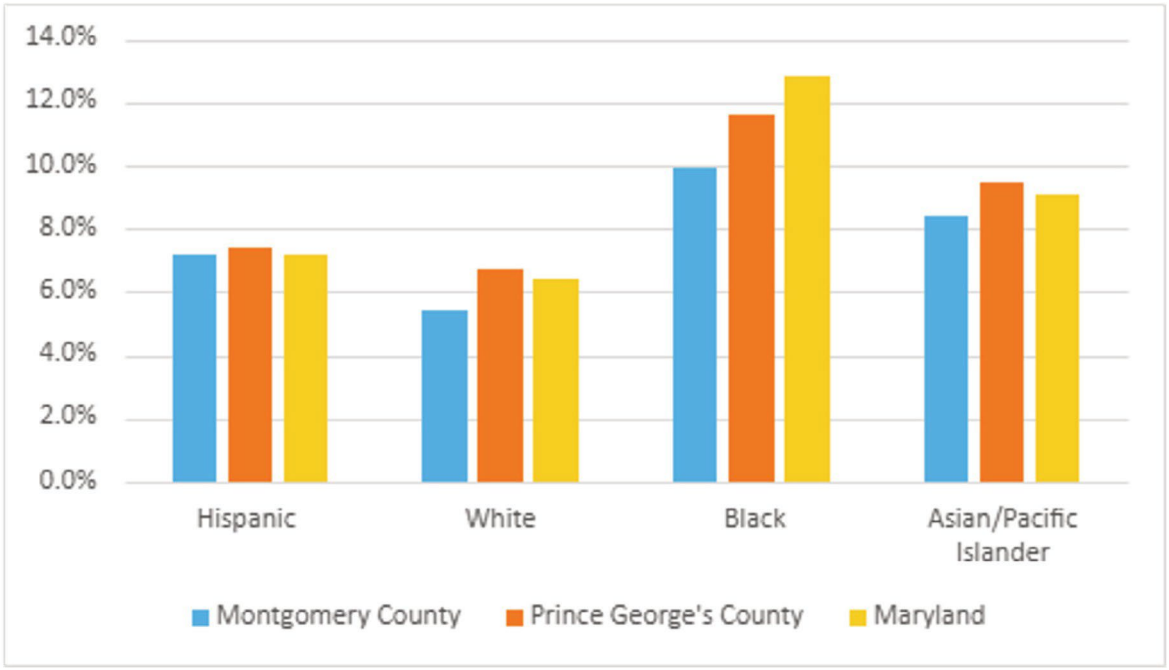
LBW and VLBW infants are typically a result of premature birth and fetal growth restriction, both of which are influenced by a mother's health and genetics. In addition to pre-term delivery, maternal risk factors include chronic health conditions, infections, complications with the placenta, inadequate weight gain during pregnancy, or previously having a LBW baby. Health behaviors such as smoking, alcohol, illicit drug use, and misuse of prescription drugs are also associated with LBW. In addition, LBW infants are more likely to suffer short-term health 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 infants have the highest percentage of LBW and VLBW when compared to any other race/ethnicity (see Figure 11 and Figure 12).

Figure 11. Percentage of Infants Born with Low Birth Weight by Race/Ethnicity, 2021-2023



Source: National Center for Health Statistics, 2021-2023

Figure 12. Percentage of Infants Born with Very Low Birth Weight by Race/Ethnicity, 2021-2023



Source National Center for Health Statistics, 2021-2023

MORTALITY

Mortality rates are important indicators of a disease's impact and a reflection of a country's social, economic, and health systems [30]. Among the most telling of these indicators are maternal and infant mortality rates, which offer insight into the overall health and quality of life for women and children in the United States. According to Vice Admiral Jerome M. Adams, former U.S. Surgeon General, "The health of our nation depends on the health of our mothers" [23]. Persistently high maternal and infant mortality rates, especially among Black women and infants, highlight systemic inequities and serve as a barometer for broader social and structural determinants of health.

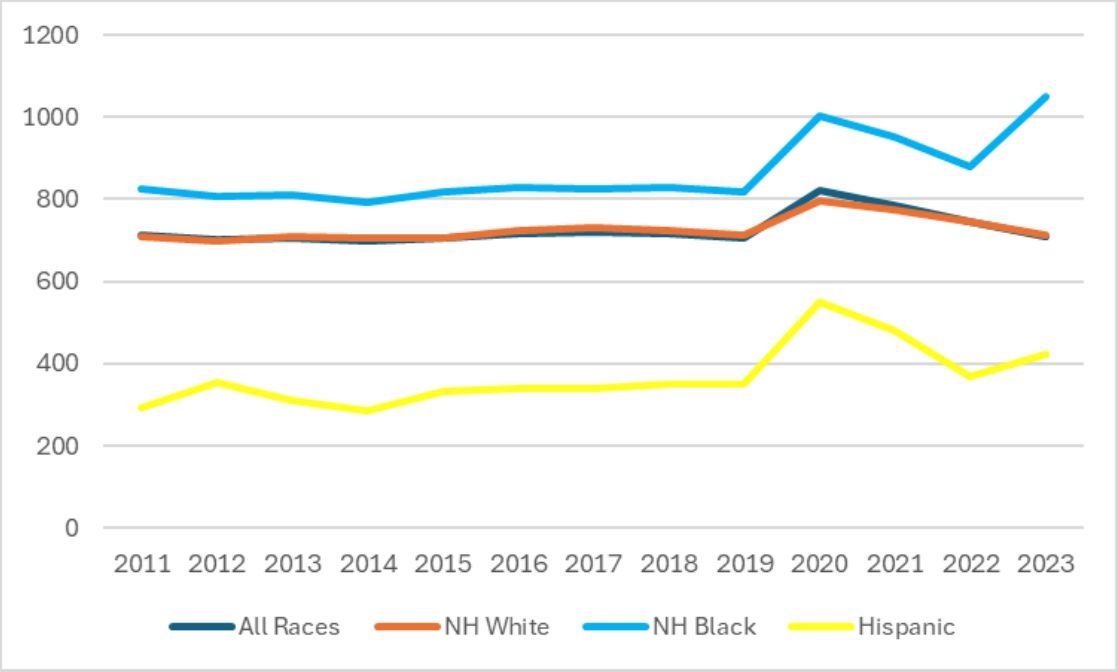
Disparities in all-cause mortality remain persistent in the U.S., particularly among Black and Hispanic residents. In 2023, non-Hispanic Black individuals had an age-adjusted mortality rate of 924.4 per 100,000, significantly higher than the rate for non-Hispanic White individuals (778.2 per 100,000) [31].

The most common causes of death (heart disease, cancer, and unintentional injuries) are

strongly linked to systemic conditions in access to health care, educational and employment opportunities, and social support [31]. Maternal mortality, gun-related deaths, and opioid overdoses further underscore how community conditions and institutional inequities intersect to produce preventable loss of life, especially for marginalized populations [32].

These national trends are mirrored at the state level. In Maryland, the age-adjusted mortality rate was 708.5 deaths per 100,000 population [24]. Mortality rates among Non-Hispanic Black residents were 1.2 times higher than those of Non-Hispanic White residents, and 2.1 times higher than among Hispanic residents [24] underscoring persistent racial and ethnic disparities. Because age is a strong predictor of mortality, these figures are typically age-adjusted to allow for fair comparisons across populations. When stratified by race and ethnicity, the data reveal stark inequities in health outcomes (see Figure 13). The following section explores leading causes of death in the CBSA and how these patterns vary by geography, race, and socioeconomic conditions.

Figure 13. All Cause Age-adjusted Death Rate by Race/Ethnicity and Hispanic Origin in Maryland, 2023



Source: Maryland Department of Vital Statistics, 2023

MATERNAL MORTALITY

The World Health Organization (WHO) defines maternal death 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” [33]. Despite medical advancements, the U.S. continues to have the highest maternal mortality rate among high-income nations, however, these rates have been declining since 2021. In 2023, the national

maternal mortality rate was 18.6 deaths per 100,000 live births (down from 32.9 deaths per 100,000 live births in 2021), with non-Hispanic Black women experiencing the highest rates at 50.3 deaths per 100,000 live births—3.5 times the rate for non-Hispanic White women(down from 69.9 deaths per 100,000 live births in 2021) [25].

Contributors to the U.S.'s high maternal mortality include systemic barriers to quality health care, untreated chronic conditions, lack of paid leave, and inadequate postpartum care [34]. These risks are exacerbated for Black women due to structural racism in health care systems, which often results in poorer quality treatment, delayed diagnoses, and dismissal of symptoms. This pattern aligns with the theory of weathering, introduced by Dr. Arline Geronimus, which describes the cumulative biological impact of chronic exposure to social, economic, and racial stressors.

Weathering accelerates aging and increases vulnerability to illness, particularly among Black women, who are more likely to face multiple, compounding stressors over their lifespans [36]. Studies using biomarkers such as allostatic load and DNA methylation patterns have provided biological evidence for this phenomenon [37]. Addressing maternal mortality, especially among Black women, requires not only clinical improvements but systemic changes that advance health equity. This includes expanding access to comprehensive maternal health services, strengthening social support systems, and improving health care practices and policies.

The latest statewide data on maternal mortality based on 5-year population estimates is from 2018-2022, and the mortality rate was 21 per 100,000 live births [38]. This rate is lower than the national average for the same timeframe (23.0 maternal deaths per 100,000 live births) but remains above the HP2030 target of 15.7 maternal deaths per 100,000 live births.

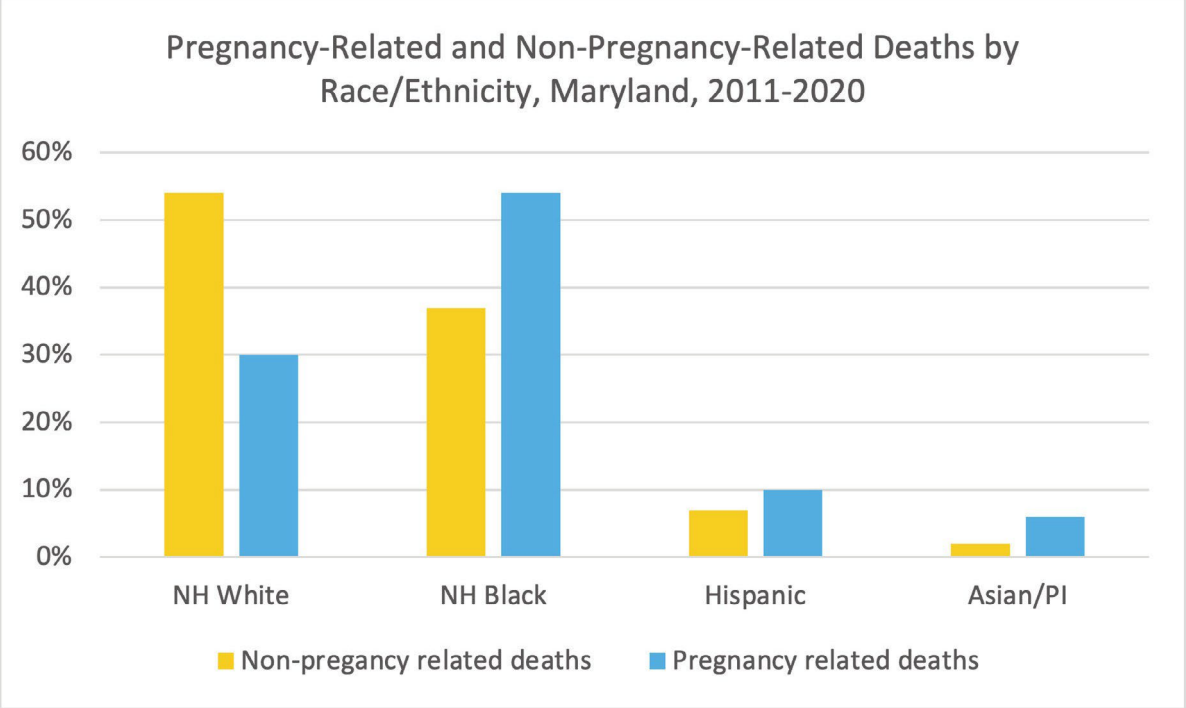
In 2020, there were 58 pregnancy-associated deaths in Maryland, with 17 deaths being pregnancy-related, 33 deaths being pregnancy-associated but not related, and eight deaths being pregnancy-associated but unable to determine relatedness. Nine of the 17 pregnancy-related deaths (53%) were among Non-Hispanic Black women, compared to 6 pregnancy-related deaths among Non-Hispanic White women (35%). Among the 41 non-pregnancy-related deaths, 18 (44%) occurred among Non-Hispanic White women and 18 (44%) among Non-Hispanic Black women. Of the 17 pregnancy-related deaths in Maryland, three were residents of Montgomery County and two were Prince George's County residents [38].

When observing racial disparities in Maryland, from 2018-2020 Black women continually had the highest pregnancy-related maternal mortality rate at 42.0 per 100,000, compared to White women at 19.2 per 100,000 for the same time period. From 2011-2020, the leading cause of pregnancy-related deaths for Non-Hispanic Black women was non-cardiovascular medical conditions (e.g., seizure disorders, asthma, cancer), followed by severe bleeding (hemorrhaging), homicide, and cardiovascular conditions. From 2018-2020 the leading causes of pregnancy-related deaths among Non-Hispanic White women were hemorrhaging and behavioral health conditions, including substance use disorders and unintentional overdoses [39]. Synthetic opioids, such as fentanyl and its analogs, have played an increasing role in

these deaths. Although fentanyl was not detected in pregnancy-associated overdose deaths prior to 2014, it became the most frequently identified opioid from 2015 onward, contributing to a growing proportion of maternal deaths linked to substance use [38]. These trends reflect broader national concerns about the intersection of maternal health, mental health, and the opioid crisis.

Most maternal deaths in Maryland (70% of non-pregnancy-related deaths and 78% of pregnancy-related deaths) are considered preventable (see Figure 14).

Figure 14. Pregnancy-related and Non-Pregnancy-related Mortality Rates by Race/Ethnicity in Maryland, 2011-2020



Source: Maryland Department of 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 gestation), maternal complications of pregnancy, sudden infant death syndrome (SIDS), and unintentional injuries. Per the CDC, in 2022, the infant mortality rate in the U.S. 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/ethnic group in the U.S.

Maryland's infant mortality rate in 2023 was 5.7 per 1,000 live births. In 2023, the highest infant mortality rate was among infants born to non-Hispanic black women (9.0). The infant mortality rate among non-Hispanic Black women was 1.9 times higher than the rate among Hispanic

women (4.8), and 2.4 times higher than the rate among non-Hispanic White women42. By race and Hispanic origin, in 2023, SIDS was the leading cause of death among infants born to non-Hispanic Black women (21.9%). Congenital malformations were the leading cause of death among infants born to Hispanic women (33.3%) and non-Hispanic white women (25.5%).

Montgomery County's average infant mortality rate decreased from 4.9infant deaths per 1,000 births from 2014-2018 to 4.5 infant deaths from 2019-2023, which is lower than the HP2030 target of 5.0 per 1,000 live births. Prince George's County's average infant mortality rate has decreased from 7.9 infant deaths from 2014-2018 to 7.1 infant deaths from 2019-2023. Racial disparities exist in both counties, with Non-Hispanic Black infant mortality rates being significantly higher than women of other races and ethnicities [40].

CHILDREN AND YOUTH MORTALITY

Since 2020, gun-related deaths continue to be the leading cause of death for children ages 1-17, with the gun-related death rates rising by 106% since 2013 [41]. According to the Johns Hopkins Center for Gun Violence Solutions, this crisis disproportionately impacts Black children and teens. In 2022, Black youth in this age group had a gun-related death rate 18 times higher than that of White youth in the same age group. More than half (55%) of deaths among older Black teens ages 15-17 were caused by firearms. The rate of gun suicide among older Black teens and emerging adults ages 15-19 rose sharply surpassing the gun suicide rate among White teens for the first time – 24% year-over-year from 2021-2022. Black male teens and young adults ages 15-34, despite comprising only 2% of the total U.S. population, accounted for 34% of all gun homicides in 2022, with a gun homicide rate 24 times higher than that of White males in the same age group [41].

In Maryland, accidents (unintentional injuries) were the leading cause of death for children ages 1-17 in 2023, followed by assault (homicide), malignant neoplasms (cancer), and congenital malformations. When expanding the age range for young adults aged 20-24, the statewide leading causes of death were accidents (with the majority due to drug overdoses and motor vehicle crashes), assault (homicide) and intentional self-harm (suicide).

In 2022, injury-related causes were the leading drivers of mortality among youth and young adults ages 15–24 in both Montgomery County and Prince George's County. Montgomery County reported 78 total deaths in this age group, with unintentional injuries, including overdoses, as the leading cause (37.2%, n = 29), followed by suicide (20.5%, n = 16) and homicide (15.4%, n = 12). Prince George's County experienced a higher mortality burden, with 131 total deaths among individuals ages 15–24. Assault (homicide) was the leading cause of death (37.4%, n = 49), followed by unintentional injuries (29.8%, n = 39). These contrasting patterns underscore the need for county-specific prevention strategies focused on violence prevention, overdose prevention, and youth mental health.

These patterns show that while unintentional injuries are the leading cause of death statewide for those ages 15-24, homicide disproportionately affects young people in Prince George's

County, particularly young Black males, and suicide remains a pressing concern in Montgomery County.

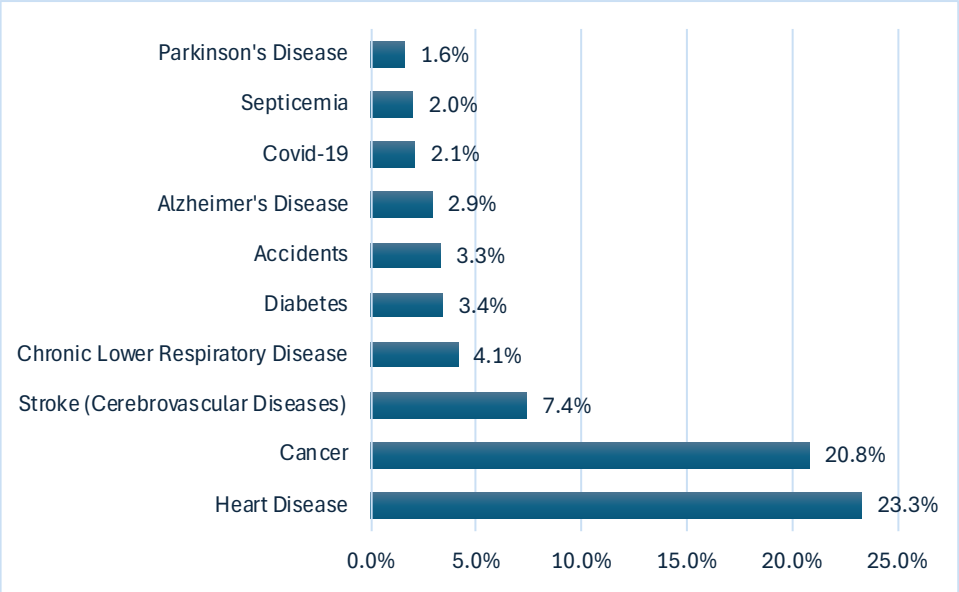
Addressing these trends requires a multifaceted approach that includes trauma-informed care, firearm safety, overdose prevention, and culturally tailored mental health supports [42].

OLDER ADULT MORTALITY

According to Healthy People 2030, almost a quarter of the U.S. population will be age 65 or older by 2060. Older adults are at higher risk for chronic health problems like diabetes, osteoporosis, and Alzheimer's disease. In addition, 1 in 4 older adults fall each year, and falls are a leading cause of injury for this age group. Physical activity can help older adults prevent both chronic disease and fall-related injuries.

In Maryland, the top two causes of death for older adults (ages 65 and older) in 2023 were heart disease and cancer, followed by cerebrovascular diseases, chronic lower respiratory diseases and diabetes (see Figure 15) [43].

Figure 15. Leading Causes of Death Among Older Adults, Ages 65+



Source: Maryland Vital Statistics Administration, 2023

In Montgomery County, the top causes of death for individuals aged 65 and older align closely with state trends, with heart disease and cancer being the most prevalent. Alzheimer's disease ranks higher in Montgomery County compared to the state average, reflecting the county's aging population, while stroke and chronic lower respiratory diseases remain significant causes of mortality in this age group.

Prince George's County exhibits a higher mortality rate from heart disease among residents ages 65 and older compared to the state average. Cancer remains the second leading cause of death, followed by stroke and diabetes, which are more prevalent in this county than

statewide. The impact of COVID-19 also remains significant among older adults in Prince George's County.

The data highlight notable disparities in health outcomes among older adults across Maryland counties. Prince George's County's elevated rates of heart disease and diabetes-related deaths may be influenced by socioeconomic factors, access to health care, and the prevalence of chronic conditions. In contrast, Montgomery County's higher incidence of Alzheimer's disease-related deaths could be attributed to its larger elderly population and longer life expectancy. These disparities underscore the need for targeted public health interventions, including chronic disease management programs, improved access to health care services, and community-based initiatives tailored to the specific needs of each county's aging population [24].

QUALITY OF LIFE

Quality of life reflects not only how long people live but also how well they live, encompassing physical health, mental well-being, and the ability to participate fully in work, family, and community life. Across the MCHC Community Benefit Service Area, Montgomery County, and Prince George's County, quality of life is influenced by the burden of chronic disease, the leading causes of death, and mental health challenges that affect residents of all ages. Examining these conditions, such as cancers, diabetes, and other illnesses that drive disparities in health outcomes, provides insight into how disease impacts daily life, limits opportunity, and underscores the need for prevention, treatment, and support strategies tailored to the diverse communities we serve.

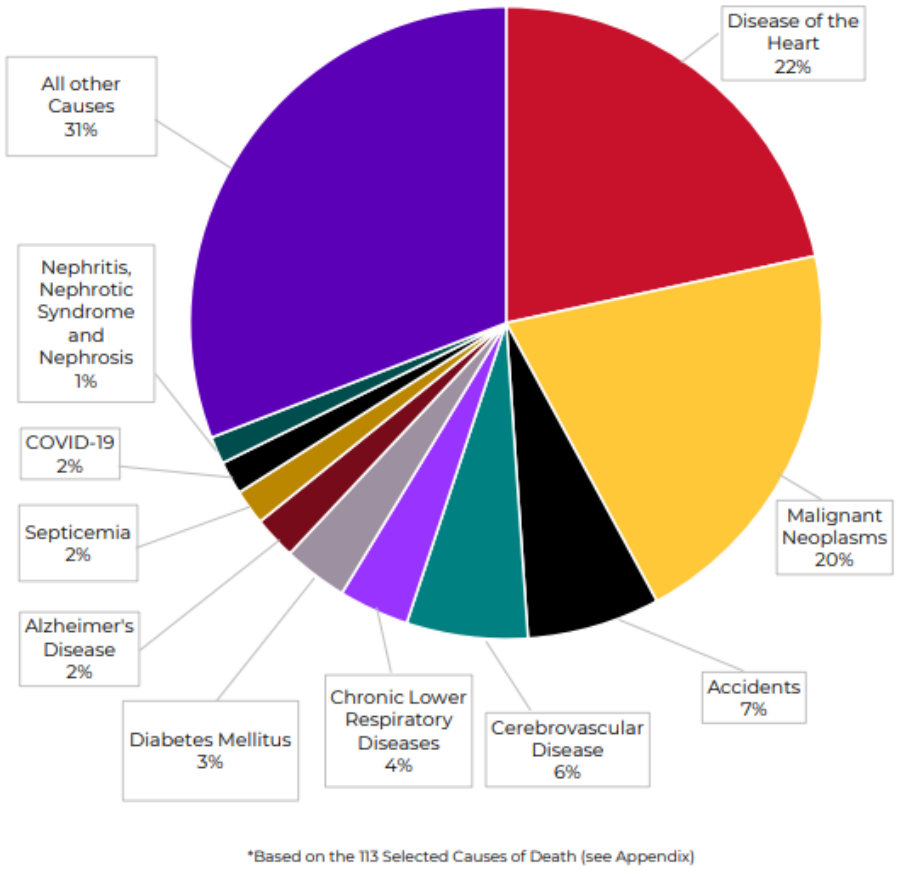
CHRONIC CONDITIONS

Chronic conditions are a central driver of health outcomes and overall quality of life. They account for the majority of preventable illness, disability, and premature death, and their impact extends well beyond individual health to influence families, communities, and the health care system. The leading causes of death reflect the prevalence of underlying chronic conditions that shape the health of residents. Understanding these conditions, their risk factors, and their disproportionate impact on vulnerable populations is essential to identifying opportunities for prevention, early intervention, and improved management.

LEADING CAUSES OF DEATH

Following national trends, the age-adjusted leading causes of death in Maryland in 2023 were heart disease (149.7 per 100,000 population), cancer (137.8 per 100,000 population), and accidents (53.6 per 100,000 population). A closer look at Montgomery and Prince George's Counties reveals similar patterns, with cancer and heart disease ranking highest (see Figure 16 and Table 1).

Figure 16. Percent Distribution for 10 Leading Causes of Death, Maryland, 2023*



Source: Maryland Vital Statistics Annual Report, 2023

Table 1. Leading Causes of Death in Maryland and by County (Age-Adjusted), 2023

Maryland		Montgomery County		Prince George's County	
CAUSE OF DEATH	DEATH RATE	CAUSE OF DEATH	DEATH RATE	CAUSE OF DEATH	DEATH RATE
Diseases of the Heart	149.7	Malignant Neoplasms	101.0	Disease of the Heart	139.9
Malignant Neoplasms	137.8	Diseases of the Heart	92.7	Malignant Neoplasms	127.6
Accidents	53.6	Cerebrovascular Diseases	35.9	Accidents	51.2
Cerebrovascular Diseases	43.4	Accidents	30.6	Cerebrovascular Diseases	44.7
Chronic Lower Respiratory Diseases	24.1	Diabetes	13.8	Diabetes	31.4

Source: Maryland Department of Health Vital Statistics Administration, 2023

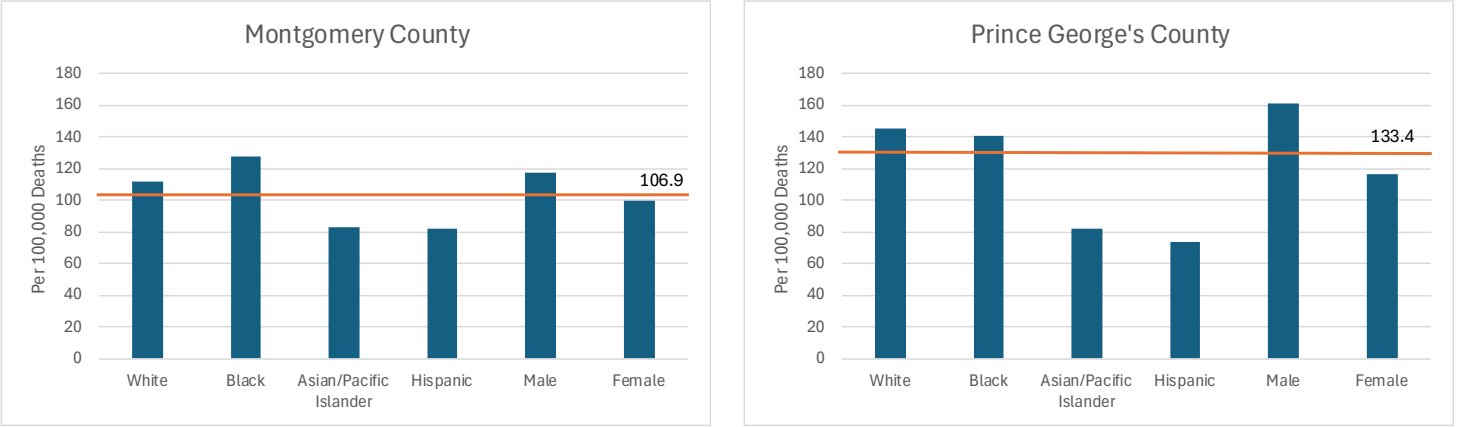
CANCER

In 2022, more than 1.8 million people nationwide were diagnosed with cancer, the 2nd leading cause of death in the U.S. Despite declining rates in recent decades, over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care. Interventions to

promote evidence-based cancer screenings, such as screenings for lung, breast, cervical, and colorectal cancer, can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer. In the US, the cancer mortality rate is higher among men than women (171.5 per 100,000 men and 126.3 per 100,000 women). When comparing groups based on race/ethnicity and sex, cancer mortality is highest in non-Hispanic Black men (203.6 per 100,000) and lowest in non-Hispanic Asian/Pacific Islander women (83.1 per 100,000). 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 $222.2 billion by 2025, and $245.6 billion by 2030 [44]. Healthy People 2023 national health target is to reduce the overall cancer death rate to 122.7 cancer deaths per 100,000 population.

For the period 2018-2022, the age-adjusted death rates in Montgomery and Prince George's Counties are 106.9 and 133.4 deaths per 100,000, respectively. Overall, those who are White have the highest rates of cancer deaths followed by Black/African American individuals (see Figure 17).

Figure 17. Age-adjusted Death Rate per 100,000 Due to Cancer by Sex and Race/Ethnicity, 2022



Source: National Cancer Institute, 2022

The National Cancer Institute identifies 13 types of cancers as the most common cancers in the U.S. based on incidence rates of 40,000 cases or more in 2024. Among these cancer types, breast cancer, with 310,720 confirmed cases in 2024, was the most common, followed by prostate and lung cancer [45] [46]. Other common types of cancer include colorectal, kidney, skin, pancreatic, and thyroid cancer. Cancer risk factors include, but are not limited to, age, alcohol use, tobacco use, 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/Alaskan Native populations than their White counterparts [47].

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 [47]. Populations with disabilities and immigrant populations also experience disparities in cancer outcomes and accessing preventive and therapeutic care. Among populations with disabilities, barriers to accessing care include transportation and perception of prejudice on the part of the provider. Immigrants are at an increased risk due to factors experienced in their countries of origin, 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.

BREAST CANCER

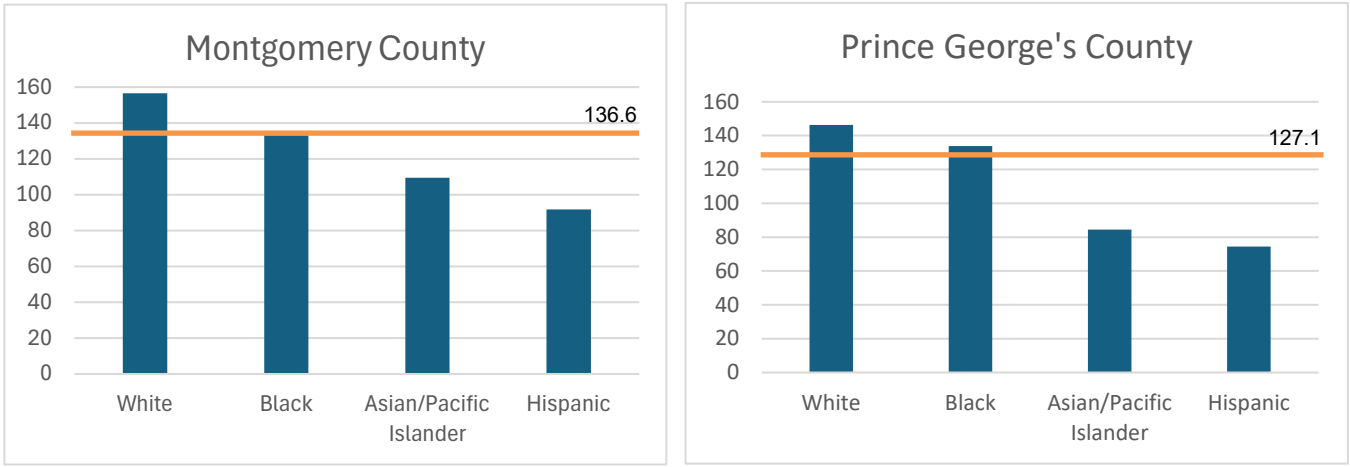
Breast cancer is a disease caused by the uncontrolled growth of cells in the breast tissue, leading to tumor formation. Breast cancer mainly occurs in middle-aged and older women. The median age at the time of breast cancer diagnosis is 62. This means half of the women who developed breast cancer are 62 years of age or younger when they are diagnosed. A very small number of women diagnosed with breast cancer are younger than 45. In the U.S., about 13% of women (1 in 8) develop breast cancer during their lifetime. Breast cancer is one of the most common cancers among women in the U.S., making up 30% of female cancer cases each year, only second to skin cancer [48].

In recent years, incidence rates have increased by 1% per year. The rise in incidence rates is a little steeper in women younger than 50 (1.4%). This is thought to be due to risk factors of having excess body weight, not having children, or having a first child after age 30. The increasing trend also could be attributed to reflect post-pandemic “catch-up” mammography and diagnosis. Nationwide, breast cancer age-adjusted incidence rate is 129.8 cases per 100,000, with Black women having 5% lower breast cancer incidence than White women, but 38% higher mortality, largely due to later diagnosis and less access to high-quality screening and treatment.

For the period 2017-2021, the age-adjusted incidence rate for breast cancer in Maryland is 135.5 cases per 100,000, with Montgomery County having a rate higher than the state at 136.6 cases per 100,000 and Prince George’s County having a rate lower than the state at 127.1 cases per 100,000 (see

Figure 18). Racial disparities exist on the state and county level, mirroring national disparities of breast cancer incidence.

Figure 18. Age-adjusted Incidence Rate per 100,000 Due to Breast Cancer by Race/Ethnicity, 2017-2021



Source: National Cancer Institute, 2021

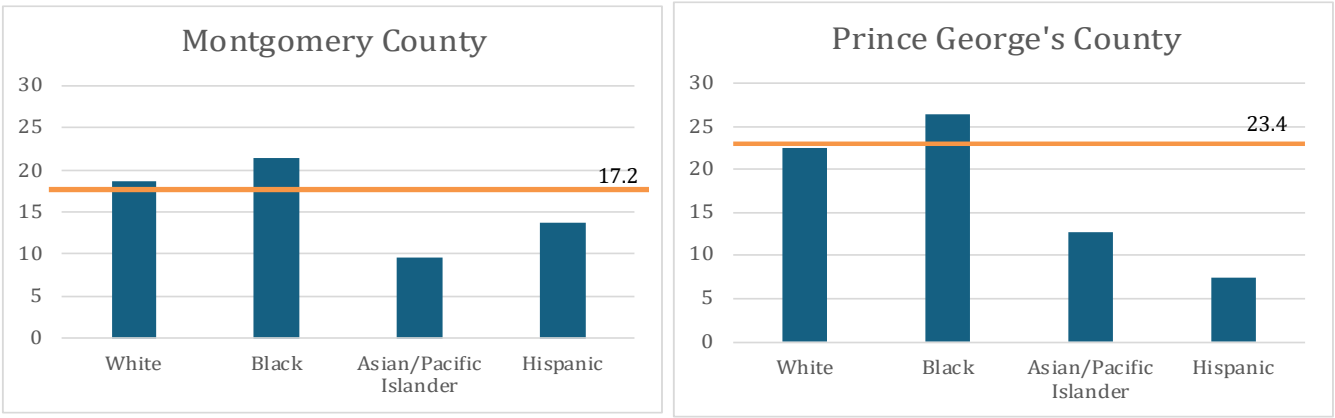
Breast cancer is the second leading cause of cancer death in women (only lung cancer kills more women each year). The chance that any woman will die from breast cancer is about 1 in 43 (about 2.3%). Breast cancer death rates have been decreasing steadily since 1989, for an overall decline of 44% through 2022. The decrease in death rates is believed to be the result of finding breast cancer earlier through screening and increased awareness, as well as better treatments. Some variations in breast cancer can be seen in racial and ethnic groups, specifically in Black women who have the highest death rate from breast cancer. At every age, Black women are more likely to die from breast cancer than any other race or ethnic group, for every stage of breast cancer. Healthy People 2030 national target is to reduce the breast cancer death rate to 15.3 deaths per 100,000 females, with the US age-adjusted death rate at 19.3 deaths per 100,000 females.

From 2018-2022, the age-adjusted death rate due to breast cancer was 20.0 per 100,000 in Maryland, compared to 17.2 in Montgomery County and 23.4 in Prince George's County (see Figure 19). Although White women have a higher incidence rate when compared to Black/African American women, Black/African American women are more likely to die from the diagnosis.

Regardless of ethnicity or geographic location, mammograms are important for early detection of breast cancer. Mammograms are a type of X-ray 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.

Figure 19. Age-adjusted Death Rate per 100,000 Due to Breast Cancer by Race/Ethnicity, 2018-2022



Source: National Cancer Institute, 2022

As of 2024, the U.S. Preventive Services Task Force (USPSTF) now recommends that all women get screened for breast cancer every other year, starting at age 40 and continuing through age 74, (a change from the previous range of women 50-74 years old and at average risk for breast cancer get a mammogram every two years). USPSTF provides specific guidance for Black women, who are 40 percent more likely to die from breast cancer than White women and too often get aggressive cancers at young ages. “Ensuring Black women start screening at 40 is an important first step, yet it is not enough to improve these inequities. It’s important that patients receive equitable and appropriate follow-up after screening and effective treatment of breast cancer. We are urgently calling for more evidence to better understand whether Black women could potentially be helped by different screening strategies.” [49]

HP2030 national health target is to increase the proportion of females ages 50-74 who had a breast cancer screening in the previous two years to 80.3%. Using the 2022 Maryland Behavioral Risk Factor Surveillance System (BRFSS) data, the mammogram screening rate in Maryland for those age 40+ and having a mammogram in the last two years is 75.6%, in Montgomery County that rate is 77.7% and in Prince George’s County, the rate is 75.2%. The mammogram screening rate for women 50+ and having a mammogram in the last two years in Maryland is 83.2%, with Montgomery County having a rate of 85.2% and Prince George’s County having a rate of 82.4% exceeding the HP2030 target [47].

CERVICAL CANCER

Cervical cancer, when detected early, is one of the most successfully treated cancers and is most frequently diagnosed in women between the ages of 35 and 44, with the average age being 50. The leading cause of cervical cancer is a long-lasting infection of certain types of human papillomavirus (HPV), a sexually transmitted infection.

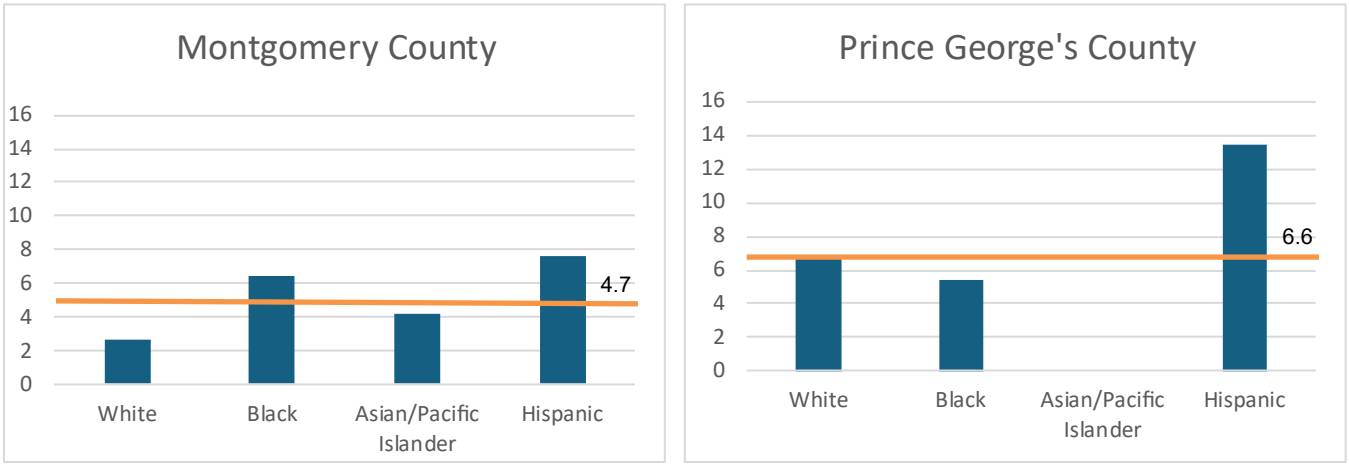
Cervical cancer incidence rates decreased by more than half from the mid-1970s to the mid-2000s, largely because of the increased use of screening, and have stabilized over the past decade. However, in women ages 30 to 44, rates have increased 1.7% each year from 2012 to 2019. In contrast, rates declined 11% each year for women ages 20 to 24, confirming that HPV

vaccination is effectively preventing early-stage cancer [50]. The American Cancer Society's estimates for cervical cancer in the United States for 2025 are about 13,360 new cases of invasive cervical cancer will be diagnosed and about 4,320 women will die from cervical cancer.

According to the National Cancer Institute (NCI), data from 2018-2021 show that approximately 0.6% of women will be diagnosed with cervical cancer at some point during their lifetime. Additionally, as of 2022, NCI estimates 297,908 women were living with cervical cancer in the U.S [51].

Racial disparities in cervical cancer remain substantial across the U.S., with non-Hispanic Black women experiencing over 22% higher incidence [52] and about 55% [52] higher mortality compared to non-Hispanic White women. From 2017-2021, the age-adjusted incidence rate of cervical cancer in Maryland, 6.4 cases per 100,000 women, was lower than the national rate of 7.5 cases per 100,000 women. Montgomery County and Prince George's County incidence rates were also lower at 4.7 and 6.6 per 100,000 women, respectively, with racial disparities occurring in both counties (see Figure 20).

Figure 20. Age-adjusted Incidence Rate per 100,000 Due to Cervical Cancer by Race/Ethnicity, 2017-2021



Source: National Cancer Institute, 2022. **Rates <5 events in the numerator are suppressed.*

The mortality rate was highest for Prince George's County at 2.2 deaths per 100,000, compared to 1.3 deaths per 100,000 for Montgomery County and 2.0 deaths per 100,000 for Maryland.

The American College of Obstetricians and Gynecologists recommends that all women ages 21-29 have a Pap test every three years, while women ages 30-65 have the following options for testing: 1) a Pap test and HPV test every five years, 2) a Pap test alone every three years, or 3) an HPV test alone every 5 years. The HP2030 national health target is to increase the proportion of women ages 21-65 who receive a cervical cancer screening (Pap test or HPV test) to 79.2%. Maryland has a cervical cancer screening rate for women 18 and older of 59.2% (Montgomery and Prince George's Counties are slightly below the target at 79.1% and

83.9%, respectively [48].

COLORECTAL CANCER

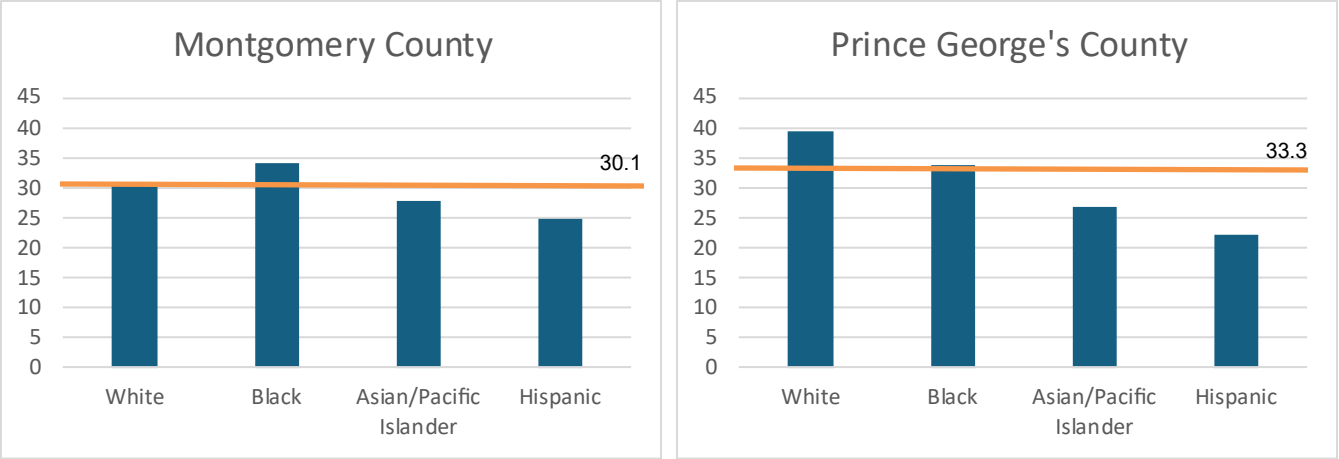
According to the CDC, colorectal cancer is the fourth most common cancer in men and women and the fourth leading cause of cancer-related deaths in the United. This type of cancer usually starts as a growth originating in the colon or rectum. This growth is known as a polyp. Since polyps are an early indication, detecting and removing them is a powerful prevention tool for colorectal cancer [51].

Based on data from 2016-2018, approximately 4.1% of men and women will be diagnosed with colorectal cancer at some point in their lifetime [53]. In 2021, an estimated 1.3 million Americans were living with colorectal cancer. Colorectal Cancer incidence in the US is highest in people who are Alaska Native (88.5 cases per 100,000), followed by those who are American Indian (46.0 cases per 100,000) or Black (41.7 cases per 100,000) when compared with those who are White (35.7 cases per 100,000). The rate of older adults being diagnosed with colon or rectal cancer has dropped overall since the mid-1980s due to increased screening and changing lifestyle-related risk factors. However, in people younger than 50 years of age, rates have increased by 2.4% per year from 2012 to 2021. The reason why colorectal cancer is increasing in younger adults is unknown. Experts are studying possible connections to diet and obesity, lack of physical activity, tobacco or alcohol use, and exposure to chemicals.

Due to the increase in young adults being affected by colorectal cancer, the USPSTF changed their screening recommendations in 2021, lowering the recommended screening age to begin at age 45 for those at average risk for the disease (the screening age historically began at 50). The HP2030 national health target is to increase the proportion of adults screened for colorectal cancer to 72.8%. In the US, 66.9% of adults 45-75 have at least one recommended colorectal cancer screening test, compared to 71.8% in Maryland. In Montgomery and Prince George's Counties, the screening rate for adults ages 45 and older is 69.7% and 67.7%, respectively [53].

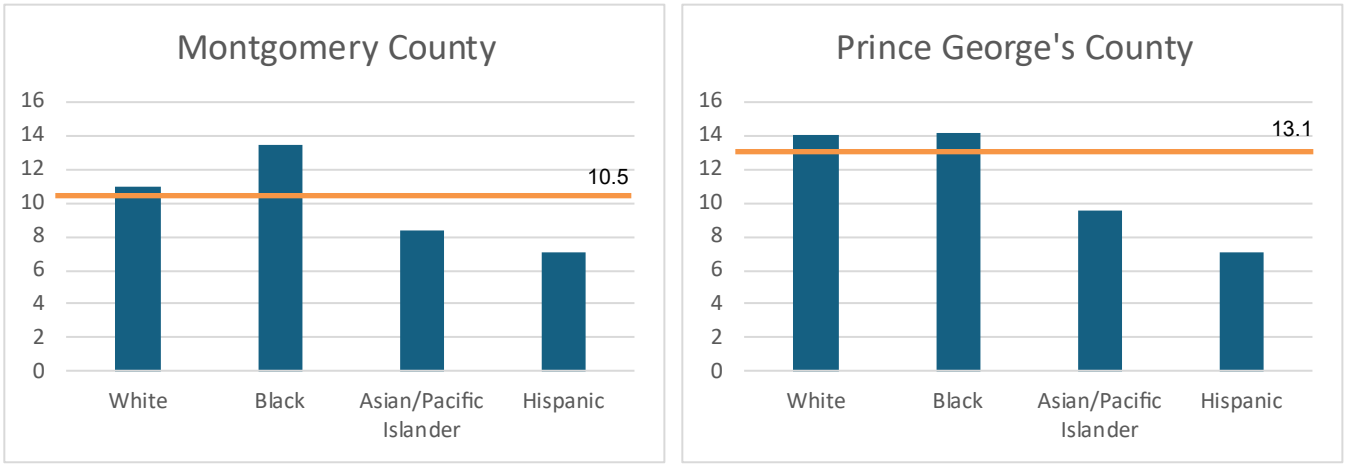
From 2017-2021, the age-adjusted incidence rate for colorectal cancer in the U.S. was 36.4 cases per 100,000. The incidence rate for the state of Maryland was 35.2, while Montgomery and Prince George's Counties had incidence rates of 30.1 and 33.3, respectively. Both incidence and death rates of colorectal cancer are slightly higher among African American populations in Montgomery County compared to rates among White, Asian, and Hispanic populations (see Figure 21 and Figure 22). In Prince George's County, the incidence rate for White individuals is higher than that of Black individuals, however, the mortality rate for the Black population in Prince George's County is still higher than that of the White population. The Healthy People 2030 target is to reduce the colorectal cancer death rate to 8.9 deaths per 100,000 population.

Figure 21. Age-adjusted Incidence Rate per 100,000 Due to Colorectal Cancer by Race/Ethnicity, 2017-2021



Source: National Cancer Institute, 2021

Figure 22. Age-adjusted Death Rate per 100,000 Due to Colorectal Cancer by Race/Ethnicity, 2018-2022



Source: National Cancer Institute, 2022

LUNG CANCER

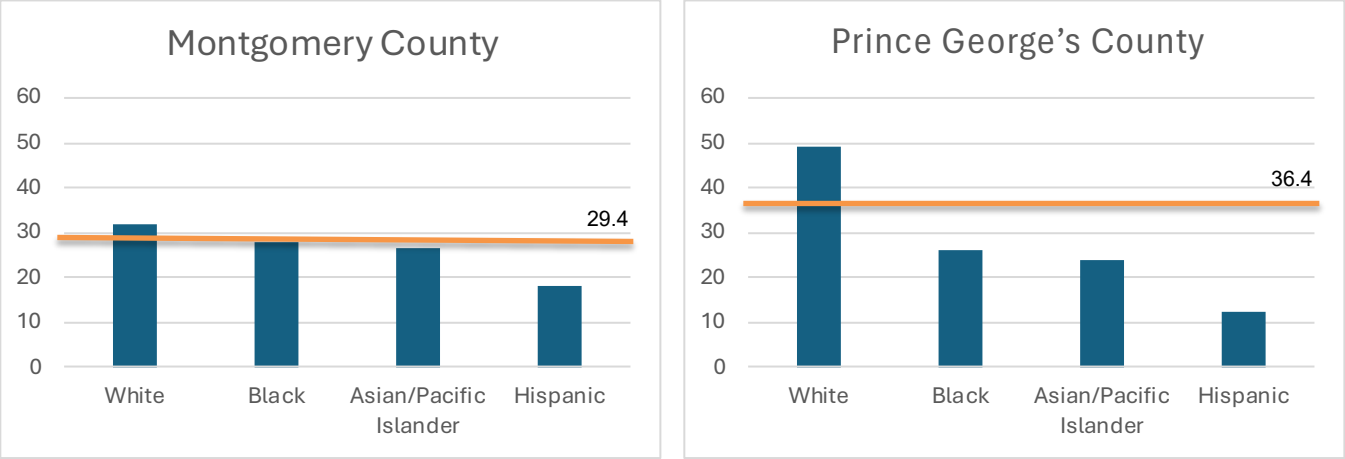
Lung cancer is caused by the uncontrolled growth of cells within the lungs, mainly occurring in people older than age 65. According to the CDC, lung cancer is the second most common cancer in both men and women in the US. The number of new lung cancer cases continues to decrease, partly because more people are quitting smoking (or not starting). The number of deaths from lung cancer continues to drop as well, due to fewer people smoking and advances in early detection and treatment. Nationwide, Black men are about 12% more likely to develop lung cancer than White men, while the rate is about 16% lower in Black women than in White women. The American Cancer Society (ACS) notes that, nationally, the probability that a man will develop lung cancer in his lifetime is about 1 in 17; for a woman, the risk is about 1 in 18 (among both smokers and non-smokers).

National lung cancer screening rates have increased annually since they were first recommended, except for 2019-2020, likely due to COVID-19 limiting access to health care

resources and the public's reticence to enter medical facilities during the pandemic55.

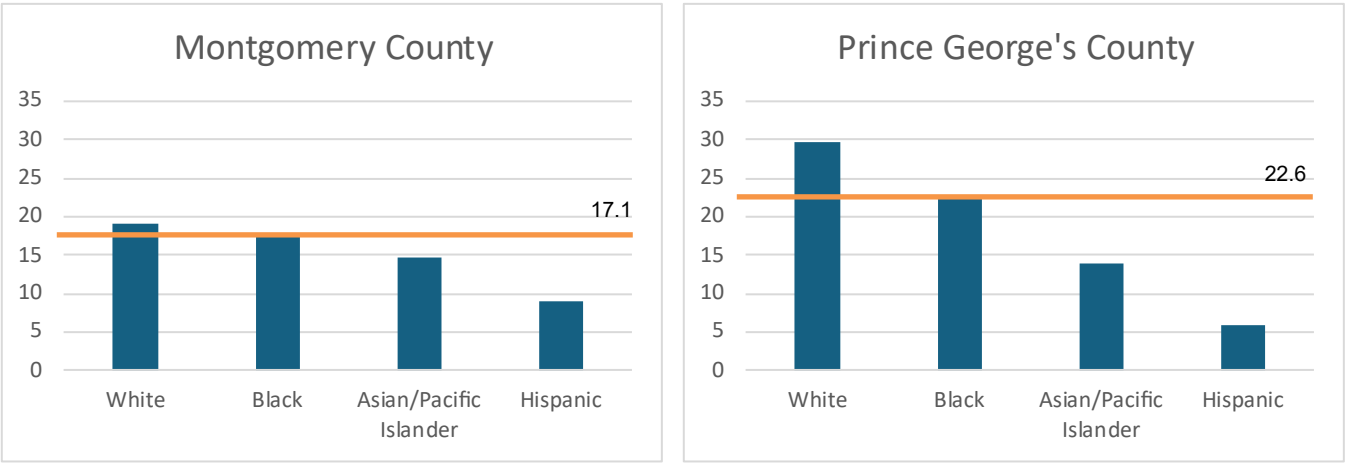
Locally, lung cancer incidence and death rates have trended continue to decrease. From 2017-2021, the age-adjusted lung cancer incidence rate in Montgomery County was 29.4 cases per 100,000, and 36.4 cases per 100,000 in Prince George's County (see Figure 23), an improvement over the Maryland incidence rate of 50.0 cases per 100,000. This data is also similar to the age-adjusted mortality rates for lung cancer. Rates in Montgomery County (17.1 deaths per 100,000) and Prince George's County (22.6 deaths per 100,000) fared better than the state death rates (29.9 deaths per 100,000) (see Figure 24). Healthy People 2030 targets to reduce the lung cancer death rate to 25.1 deaths per 100,000.

Figure 23. Age-adjusted Incidence Rate per 100,000 Due to Lung Cancer by Race/Ethnicity, 2017-2021



Source: National Cancer Institute, 2021

Figure 24. Age-adjusted Death Rate per 100,000 Due to Lung Cancer by Race/Ethnicity, 2018-2022



Source: National Cancer Institute, 2022

Lung cancer screening can help prevent deaths from lung cancer in people at high risk, mostly in current and former smokers but screening rates in this population remain very low. Increasing knowledge about screening recommendations, among both health care providers and people at risk for lung cancer, can help prevent deaths. Increasing knowledge about

tobacco initiation and cessation can also help prevent lung cancer deaths. There are numerous screening tests to diagnosis lung cancer, including X-ray, MRI, and CT scans. The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 (previously 55 to 80) years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.

While changes in the guidelines have increased the number of women and Black individuals in the US who are considered high risk, a very small percentage of eligible individuals are screened due to access, cost, stigma, or general lack of awareness. When comparing the White and Black population, Blacks are diagnosed with lung cancer at a younger age and have a higher risk of developing and dying from lung cancer, yet they smoke fewer cigarettes.

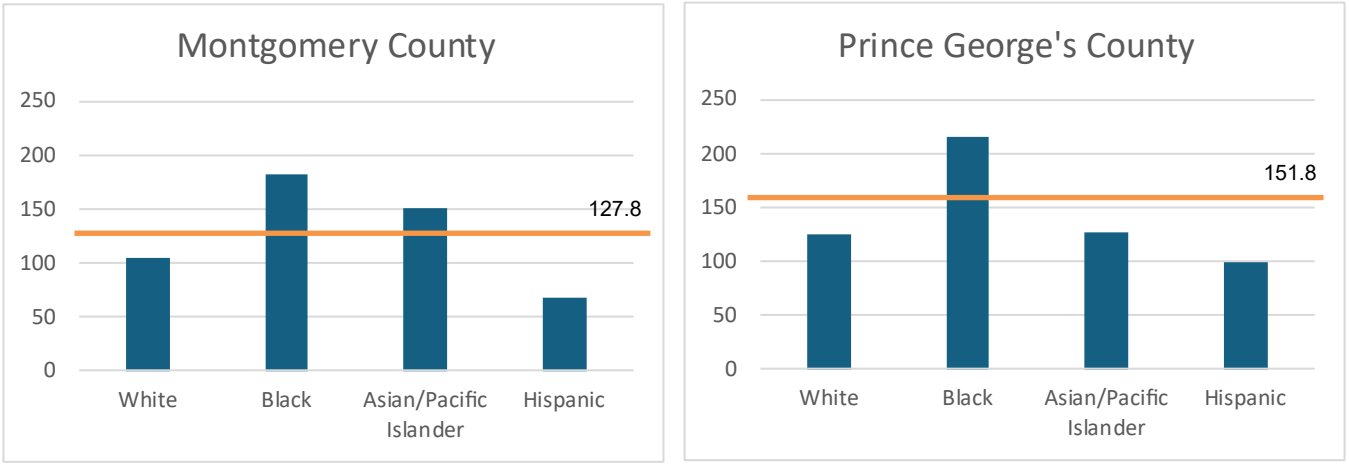
Healthy People 2030 targets to increase the proportion of adults screened for lung cancer to 7.5%. In 2023, 13.6% of Montgomery County residents and 12.1% of Prince George's County residents had a scan done to check or screen for lung cancer.

PROSTATE CANCER

According to the American Cancer Society (ACS), prostate cancer is second only to skin cancer as the most common cancer among men in the United States and the second-leading cause of cancer death in American men, behind only lung cancer [54]. According to the ACS, about 1 in 8 men will be diagnosed with prostate cancer, and about 1 in 44 will die.

About 6 in 10 prostate cancers are diagnosed in men who are 65 or older, and it is rare in men under 40. The average age of men when they are first diagnosed is 67. Prostate cancer risk is also higher in African American men and in Caribbean men of African ancestry than in men of other races. From 2017-2021, Montgomery County had an incidence rate of 127.8 cases per 100,000, and Prince George's County had an incidence rate of 151.8 cases per 100,000. The incidence rate for Black/African American men is approximately 40% higher than for White men in Montgomery and Prince George's Counties (see Figure 25).

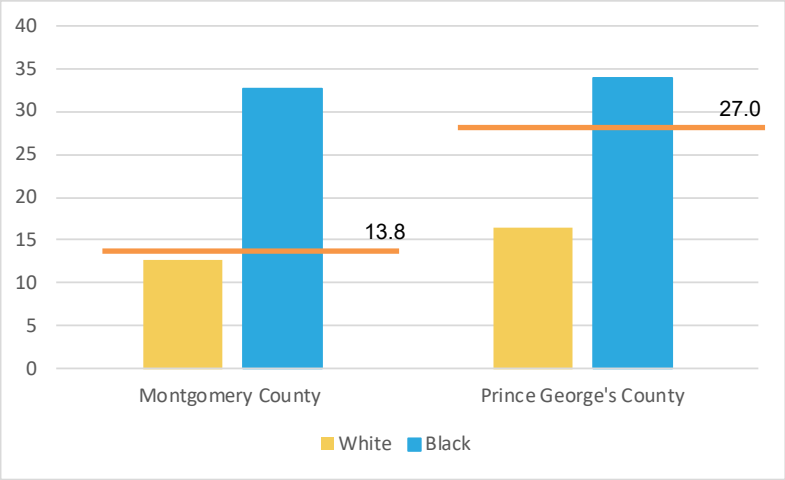
Figure 25. Age-adjusted Incidence Rate per 100,000 Due to Prostate Cancer by Race/Ethnicity, 2017-2021



Source: National Cancer Institute, 2021

Prostate cancer can be a serious disease, but most men diagnosed with prostate cancer do not die from it. In fact, more than 3.5 million men in the United States who have been diagnosed with prostate cancer are still alive today. The prostate cancer death rate declined by about half from 1993 to 2022, most likely due to earlier detection and advances in treatment. In recent years, the decline in the death rate has slowed, likely reflecting the rise in cancers being found at an advanced stage. The age-adjusted prostate cancer mortality rate from 2018-2022 for the state of Maryland is 19.9 deaths per 100,000, Montgomery County had a rate of 13.8 deaths per 100,000, and Prince George's County has a rate of 27.0 deaths per 100,000.

Figure 26. Age-adjusted Death Rate per 100,000 Due to Prostate Cancer by Race/Ethnicity, 2018-2022



Source: Source: National Cancer Institute, 2022
**Rates <5 events in the numerator are suppressed.*

Healthy People 2030's target is to reduce prostate cancer deaths to 16.9 deaths per 100,000. The death rate of Black/African American men in both counties is more than 50% higher than their White counterparts (see Figure 26).

SKIN CANCER

Skin cancer is the most common type of cancer in the U.S. 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 [47]. The most preventable cause of skin cancer is overexposure to ultraviolet (UV) light, either from the sun or from artificial sources like tanning beds. While everyone can get skin cancer, individuals with certain characteristics are at greater risk. This includes those with 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 who are older.

Based on recent data from the National Cancer Institute's State Cancer Profiles (2017-2021), melanoma skin cancer incidence rates are generally rising in Maryland and across the region, with many Maryland counties exceeding the national average of 22.7 per 100,000. Maryland and Montgomery County have significantly higher age-adjusted melanoma incidence rates 24.5 and 21.2 per 100,000, respectively, when compared to Prince George's County's rate of 5.5 per 100,000. While Montgomery County shows a slight upward trend in cases, Prince George's County has experienced a downward trend in recent years [46].

CHRONIC LOWER RESPIRATORY DISEASE & COPD

Chronic lower respiratory disease (CLRD) affects the lungs and lower airways, causing breathing-related issues, including chronic obstructive pulmonary disease (COPD), emphysema, bronchitis, and asthma. CLRD resulted in over 145,000 deaths in the US in 2023 and ranks as the 5th leading cause of death in the US, generally occurring among older adults. However, this estimate is considered low because CLRD is often cited as a contributory, not underlying, cause on death certificates. In Maryland, CLRD was the 5th leading cause of death in 2023. The age-adjusted mortality rate was 24.1 deaths per 100,000 population, with mortality rates higher in men than women, and in Whites compared to all other racial/ethnic groups. In 2023, Montgomery and Prince George's Counties' age-adjusted death rates for CLRD were 11.7 and 16.8 deaths per 100,000, respectively [55].

COPD has no known cure, with many conditions often undiagnosed, comprised of two main conditions, emphysema and chronic bronchitis, and patients may experience many conditions simultaneously [56]. Chronic obstructive pulmonary disease, or COPD, is a term which refers to a large group of lung diseases characterized by obstruction of air flow that interferes with normal breathing. Emphysema and chronic bronchitis are the most important conditions that compose COPD and they frequently coexist. Although there is no cure for COPD, smoking cessation, medications, and therapy or surgery can help individuals manage their symptoms. In the United States, COPD affects more than 14 million adults, and many others do not know they have it. More than half of those diagnosed are women.

Rates are higher than average in American Indian and Alaska Native communities and in rural areas. COPD is a major cause of disability, and it is the sixth leading cause of death in the United States, according to the Centers for Disease Control and Prevention. Genetic and environmental factors, such as exposure to tobacco smoke, air pollutants and respiratory infections, play a key role in developing COPD [56]. In 2023, 5.0% of Marylanders have been diagnosed with COPD, with the worst outcomes for residents living in rural communities, having lower incomes and education levels. On the county level, 2.7% of Montgomery County residents have been told they have COPD, compared to 5.2% of Prince George's County residents.

DIABETES

Diabetes mellitus is a chronic disease and metabolic disorder resulting in elevated blood glucose levels. It is categorized as type 1 or type 2 diabetes, gestational diabetes, and other specific types due to other causes. Uncontrolled blood glucose levels over a long period of time can affect multiple organ systems, including the nervous system, kidneys, eyes, heart, and blood vessels. Diabetes is a major cause of morbidity and mortality in the United States. Most diabetes cases in the U.S. are type 2 Diabetes (T2D), making it the most common form of diabetes. According to the 2021 National Diabetes Statistics Report, more than 38.4 million Americans of all ages (11.6% of the U.S. population) have diabetes65 , diagnosed and undiagnosed. 8.7 million adults ages 18 years or older have undiagnosed diabetes,

representing 3.4% of all U.S. adults and 22.8% of all U.S. adults with diabetes. Diabetes is currently listed as the eighth leading cause of death in the U.S. (28.4 deaths per 100,000 population).

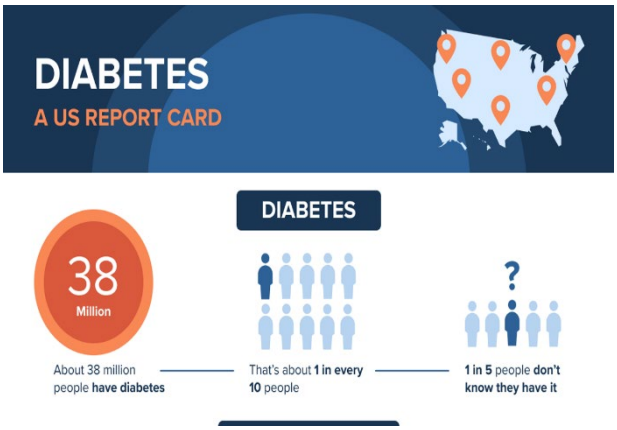


Figure 27: CDC, A Report Card: Diabetes in the United States, 2021

There are approximately 1.2 million newly diagnosed cases of diabetes each year, mainly in adults over 45. Diabetes disproportionately affects minority populations and older adults, and the incidence is likely to increase as minority populations grow and the U.S. population ages. Among adults 18 years and older, diabetes incidence is higher in American Indian/Alaska Native, Black and Hispanic adults and those with less than a high school education. People with diabetes are at higher risk of serious health conditions, such as stroke, blindness, kidney disease, heart disease, and nerve damage/amputation. Adults can lower their risk of developing diabetes through weight loss, increasing physical activity, and portion control.

The total estimated cost of diagnosed diabetes in the U.S. in 2022 is $412.9 billion, including $306.6 billion in direct medical costs and $106.3 billion in indirect costs attributable to diabetes, such as reduced employment due to disability, presenteeism, and lost productivity due to premature death. People diagnosed with diabetes, on average, have medical expenditures 2.6 times higher than what would be expected without diabetes.

According to an article in Diabetes Care, the economic costs of diabetes, after adjusting for inflation, increased 14% between 2012 and 2021 [57]. Despite this, the growth from 2017 to 2022 was minimal, increasing by 1%. The direct and indirect medical costs associated with diabetes increased 14% from 2012-2017, costing approximately $16,022, but has since plateaued to $16,191 in 2022. As of 2022, every $1 in $4 goes towards diabetes, making up 61% of costs. The estimated cost of diabetes in 2017 was $327 billion, with indirect costs estimated at $110.6 billion67. Since then, the costs have risen significantly, reaching $412.9 billion in 2022, and although indirect costs remained relatively the same at $106.3 billion, the direct medical costs increased to $306.6 billion.

Statewide, 10.9% of the population (or nearly 600,000 residents) have been told they have diabetes. In Montgomery County, 8.4% of the population is affected (over 75,00 residents), compared to 12.4% of the residents in Prince George's County (nearly 100,000 residents).

In Maryland, diabetes was the 6th leading cause of death in 2023 with an age-adjusted mortality rate of 23.0 per 100,000 population. African American/Blacks in Maryland had an age-adjusted death rate of 35.7 deaths per 100,000, nearly twice as high as their White counterparts, and 2.5 times higher than their Hispanic/Latino counterparts.

Diabetes is the 5th leading cause of death in both Montgomery and Prince George's Counties

[40]. Montgomery County age-adjusted death rate for diabetes was 13.8 deaths per 100,000, compared to 31.4 deaths per 100,000 in Prince George's County. Healthy People 2030 national target is to reduce the death rate for adults (18 and older) with diabetes to 13.7 deaths per 100,000.

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 [58]. There are usually no signs when an individual has prediabetes, which is why 81% of the population do not know they have it. Approximately 34% of adults have prediabetes (n = approximately 84.1 million), resulting in an estimated annual spend of $6 billion [58]. Healthy lifestyle choices can help prevent prediabetes and its progression to type 2 diabetes, however, risk factors such as family history, over age 45, obesity, high blood pressure can put a person at higher risk.

As of 2021, more than 98 million American adults ages 18 or older have prediabetes (one in three adults). In Maryland, 1.8 million, or 38% of adults, have prediabetes [59], however nearly 8 out of 10 Marylanders don't know that they do. Healthy People 2030 national target is to reduce the percent of adults who are unaware they have prediabetes to 33.2%.

CHILDHOOD DIABETES

Diabetes prevalence is also increasing among children and youth. Approximately 352,000 children and adolescents in the U.S. younger than age 20 have been diagnosed with diabetes (including 304,000 individuals with type 1 diabetes) [60]. Prediabetes and diabetes among youth are primarily attributed to the increasing prevalence of obesity, sedentary lifestyles, and unhealthy nutrition. Researchers believe if the rate of new diagnoses continue to stay the same, by 2060, for youth less than 20 years, type 1 diabetes cases would remain the same, and Type 2 cases would increase about 70%. However, if new cases continue to increase, Type 1 cases would increase about 65%, and type 2 cases would increase about 700%.

The increasing frequency of type 1 and type 2 diabetes in young people is a growing clinical and public health concern. For children under the age of 20, the incidence of type 2 diabetes increased for all racial groups from 2002-2018, especially among Asian, Pacific Islander, Hispanic and Non-Hispanic Black populations. Prediabetes among youth is also a rising threat, affecting 1 in 5 U.S. youth ages 12-18, with this group also having higher cholesterol and blood pressure concerns [60]. Prediabetes and diabetes among youth are primarily attributed to the increasing prevalence of obesity, sedentary lifestyles, and unhealthy nutrition.

DIABETES IN OLDER ADULTS

Diabetes is also prevalent in the senior population. The number of older adults with diabetes is increasing in the U.S. and worldwide due to increased lifespan and the increased prevalence diabetes in the geriatric population [61]. According to the National Diabetes Statistics Report,

the prevalence of diabetes in the U.S. older adult population is nearly 29.2% (16.5 million) for those ages 65 or older 74. Diabetes is a major cause of morbidity and mortality in this population, with the latter largely attributable to macrovascular complications.

The American Geriatrics Society provides guidelines for the management of diabetes in older adults and identifies conditions that this population are at increased risk of having if they have diabetes. Conditions include polypharmacy (the simultaneous use of multiple drugs to treat a single ailment or condition), depression, cognitive impairment, urinary incontinence, fall-related injuries, vision impairment, and pain.

OBESITY

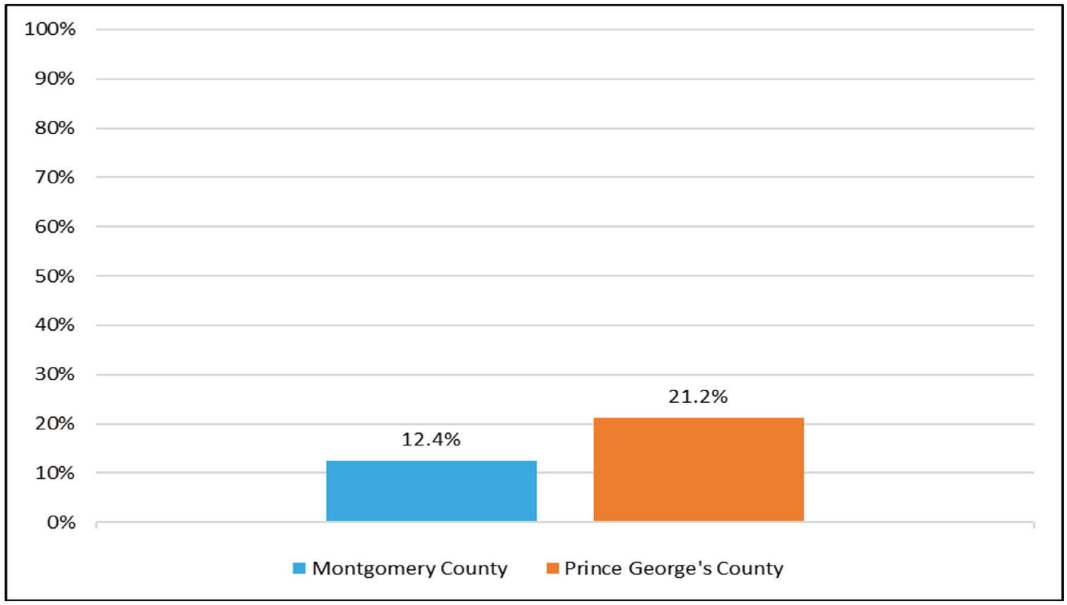
Obesity is a critical indicator of population health and well-being, reflecting the intersection of lifestyle, environment, and access to resources. Nationally, obesity rates have risen steadily over the past two decades, with prevalence doubling among adults and tripling among children (CDC, 2023). Obesity significantly increases the risk of chronic conditions such as cardiovascular disease, type 2 diabetes, hypertension and various cancers. Adults are classified as obese when their Body Mass Index (BMI) is 30.0 or higher, and as overweight when their BMI falls between 25.0 and 29.9 (NIH, 2022). As part of its national health objectives, Healthy People 2030 (HP2030) aims to reduce the proportion of adults ages 20 and older who are classified as obese to 36% (U.S. Department of Health and Human Services, 2020).

OBESITY IN ADOLESCENTS AND YOUTH

Obesity among children and adolescents is a growing public health concern, with long-term implications for health and well-being. Youth with obesity are more likely to develop chronic conditions such as diabetes and heart disease, and they face heightened risk of social stigma, bullying and persistent weight challenges into adulthood. Childhood obesity is shaped by multiple factors, including nutrition, physical activity, genetics, medication use, and the built environment.

In Montgomery County, 12.4% of high school students are considered obese, compared to 21.2% in Prince George's County (see Figure 28). The HP2030 target is to reduce the proportion of children and adolescents with obesity to 15.5%. These disparities highlight the need for targeted strategies that improve access to healthy foods, create safe environments for physical activity, and address structural inequities in community conditions.

Figure 28. Percent of Overall Obesity Among High School Students by County, 2022-2023

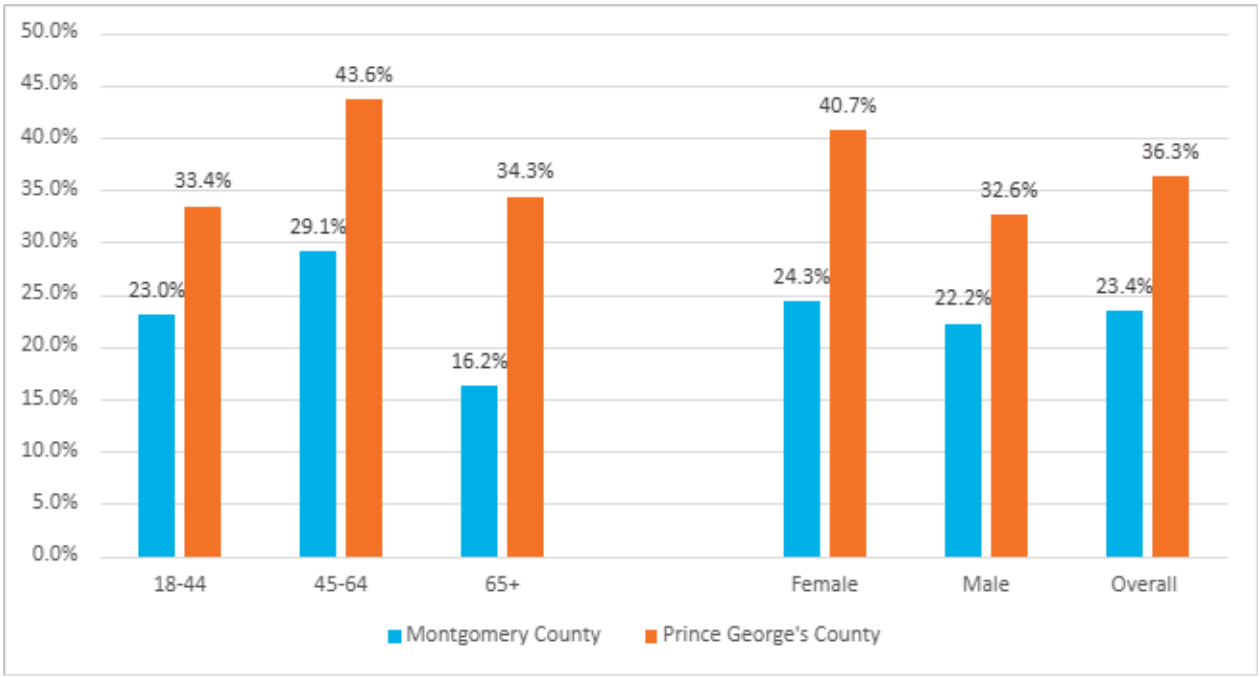


Source: Youth Behavior Risk Survey 2022-2023, Maryland Department of Health, 2023

OBESITY IN ADULTS

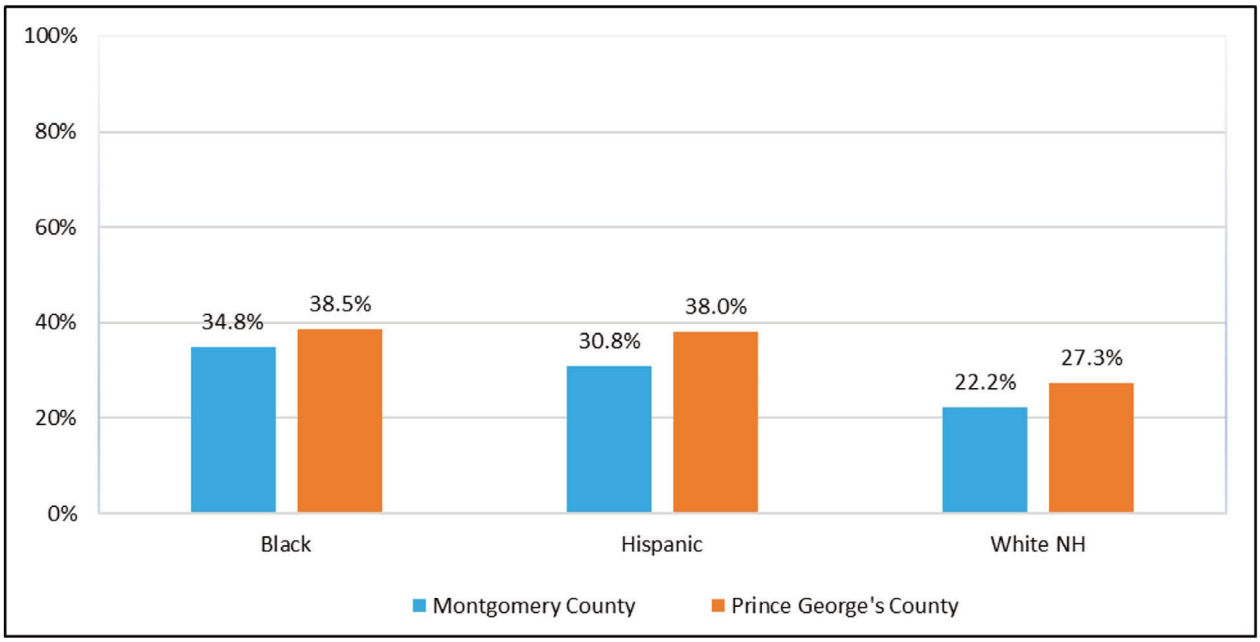
Adult obesity remains a persistent challenge for Maryland and the MCHC community benefit service area (MCHC CBSA). Across the MCHC CBSA, 27.7% of adults are considered obese. This rate is lower in Montgomery County (23.4%) but significantly higher in Prince George's County (36.3%) (see Figure 29). Disparities are especially pronounced among non-White female residents aged 45-64, with Black and Hispanic women in Prince George's County experiencing the highest prevalence compared to their counterparts in Montgomery County (see Figure 30) [62].

Figure 29. Percent of Obesity Among Adults by Age and Gender, 2022



Source: Behavioral Risk Factor Surveillance System, Maryland Department of Health, 2022

Figure 30. Percent of Adults Who are Overweight or Obese by Race/Ethnicity, 2022



Source: Behavioral Risk Factor Surveillance System, Maryland Department of Health, 2022

These differences reflect the influences of social determinants of health, including income, neighborhood environment, food access, and opportunities for physical activity, on weight status.

CARDIOVASCULAR DISEASE

Cardiovascular (heart) disease is a term that encompasses a variety of different diseases affecting the heart and is the leading cause of death in the United States, accounting for 25.4% of total deaths. The most common type in the United States is coronary artery disease, which can cause heart attack, angina, heart failure, and arrhythmias. Coronary artery disease occurs when plaque builds up in the arteries that supply blood to the heart and the arteries narrow (atherosclerosis). Moreover, it is important to note that heart disease is the number one killer of women in the United States.

Heart disease can result in poor quality of life, disability, and death, however, it can often be prevented by controlling risk factors like high blood pressure, high cholesterol, smoking, diabetes, unhealthy diet and physical inactivity, and obesity. Making sure people who experience a cardiovascular emergency, such as a stroke, heart attack, or cardiac arrest, receive timely, evidence-based treatment can significantly reduce their risk of long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

One in 3 U.S. adults received care for a cardiovascular risk factor or condition in 2020. Annual inflation-adjusted (2022 US dollars) health care costs of cardiovascular risk factors are projected to triple between 2020 and 2050, from $400 billion to $1344 billion. For

cardiovascular conditions, annual health care costs are projected to almost quadruple, from $393 billion to $1490 billion, and productivity losses are projected to increase by 54%, from $234 billion to $361 billion. Stroke is projected to account for the largest absolute increase in costs. Large relative increases among the Asian American population (497%) and Hispanic American population (489%) reflect the projected increases in the size of these populations.

Cardiovascular disease is the leading cause of death in both Montgomery and Prince George's Counties, while stroke is the third leading cause of death in both counties. Maryland's age-adjusted crude death rate for heart disease was 186.5 deaths per 100,000 in 2023. For that same year, the crude death rate in Montgomery County was 125.1 deaths per 100,000 population and 154 per 100,000 in Prince George's County33. This was consistently higher than the rates seen in 2020.

HIGH BLOOD PRESSURE AND CHOLESTEROL

High blood pressure, or hypertension, is the number one modifiable risk factor for stroke. It also contributes heart attacks, heart failure, kidney failure, and atherosclerosis [63]. In the U.S., nearly half of all adults (48.1%) have high blood pressure, yet only about 25% of those adults have their hypertension under control [64]. Hypertension is particularly prevalent in Black/African Americans, older adults, those with obesity, heavy drinkers, and women taking birth control pills [64]. The hypertension prevalence rate among adults in Montgomery County is 27.7% and 35.5% in Prince George's County [59]. The HP2030 national health target is to reduce the proportion of adults with high blood pressure to 41.9% [65].

High blood pressure is often known as the "silent killer" because it is asymptomatic and frequently goes undetected. In 2023, over 660,000 deaths in the U.S. were associated with high blood pressure as a primary or contributing cause [64]. In 2023, the mortality rate for essential hypertension and hypertensive renal disease in the US was 12.7 per 100,000; in Montgomery and Prince George's Counties, it was 8.0 and 13.8 per 100,000, respectively. While hypertension can be controlled through lifestyle changes, including eating a heart-healthy diet, limiting alcohol, avoiding tobacco, maintaining a healthy weight, and staying physically active, data reveal that the death rate from hypertension is higher in men compared to women.

According to the CDC, about 1 in 10 adults have high blood cholesterol. High blood cholesterol, which is also asymptomatic and tends to go undetected, is one of the major risk factors for heart disease. Lowering cholesterol levels lessens the risk of developing heart disease and reduces the risk of heart attack. In 2023, high cholesterol prevalence is 34.3% for Prince George's County residents and 39.2% for Montgomery County residents ages 18 and older.

CEREBROVASCULAR DISEASE AND STROKE

Stroke is the third leading cause of death in the United States. Of the more than 700,000

people affected every year, about 500,000 of these are first attacks and 200,000 are recurrent. About 25 percent of people who recover from their first stroke will have another stroke within five years. Stroke is also a leading cause of serious long-term disability, with an estimated 5.4 million stroke survivors currently alive today. Stroke-related costs in the United States totaled nearly $56.2 billion between 2019 and 2020, including health care services, medications, and lost work productivity [67].

The most recent prevalence statistics from the American Heart Association estimate that 5,4 million people have experienced stroke. Risk of having a first stroke is nearly twice as high for non-Hispanic Black adults as for White adults and non-Hispanic Black adults and Pacific Islander adults have the highest rates of death from stroke [67]. The Healthy People 2030 national health goal is to reduce stroke to 33.4 deaths per 100,000 population.

Although strokes are more common in older adults, 10-14% of all strokes occur in younger adults under 50, affecting women more than men, and Black and Hispanic young adults more than their white counterparts. Young adults have many of the same stroke risk factors as the general population, but they also experience unique risks, including migraines, oral contraceptive use, recreational drugs, pregnancy, and the postpartum period.

In Maryland, cerebrovascular disease was the fourth leading cause of death in 2023, with an age-adjusted rate of 43.4 deaths per 100,000; Black or African American Marylanders experienced the highest rate at 53.4 per 100,000, though this has been declining. Montgomery County reported a cerebrovascular disease death rate of 35.9 per 100,000 in 2023, compared with 44.7 per 100,000 in Prince George's County [24]. Healthy People 2030 emphasizes improving cardiovascular health and reducing deaths from heart disease and stroke, noting that many cases can be prevented by controlling major risk factors such as high blood pressure and high cholesterol. The Healthy People 2030 national goal for stroke mortality is to reduce stroke deaths to 33.4 per 100,000 population [67].

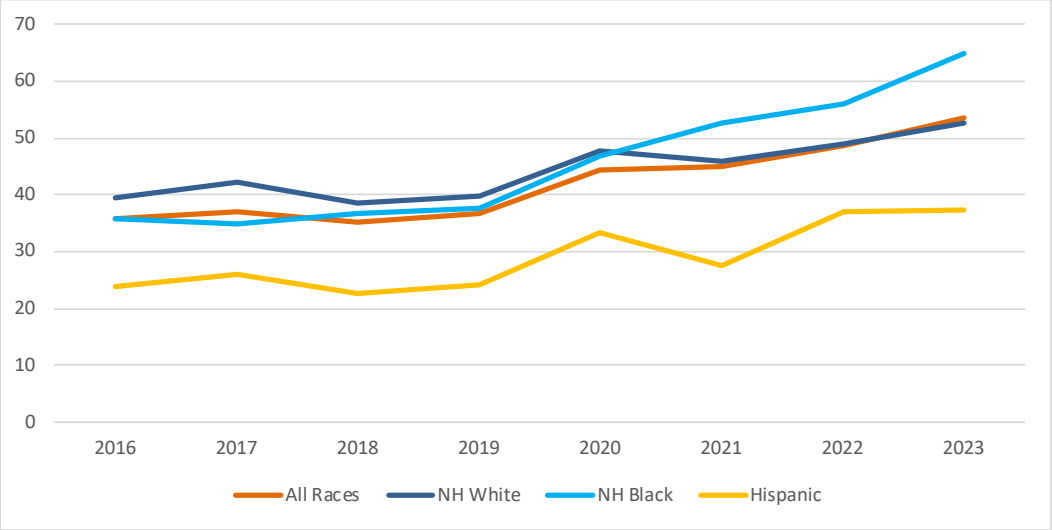
UNINTENTIONAL INJURIES

Unintentional injuries are injuries caused by events without intent to harm and are often preventable. They remain a major public health concern in Maryland, where they were the third leading cause of death in 2023, with an age-adjusted death rate of 53.6 per 100,000. Rates have been rising across racial and ethnic groups, with the largest increases seen among Black and Hispanic residents (see Figure 31). In Montgomery and Prince George's Counties, unintentional injury patterns mirror statewide trends: in 2023, the age-adjusted death rate was 30.6 per 100,000 in Montgomery County and 51.2 per 100,000 in Prince George's County. The most common causes also differ locally, falls were the leading cause of preventable unintentional injury deaths in Montgomery County, while poisoning (including overdoses) was the leading cause in Prince George's County [55].

Healthy People 2030 emphasizes that most unintentional injuries can be prevented, setting a national target to reduce unintentional injury deaths to 43.2 per 100,000 population. Local

prevention efforts in both counties focus on addressing the leading contributors, particularly fall prevention, overdose prevention, and broader safety strategies that reduce avoidable harm.

Figure 31. Age-Adjusted Death Rate (per 100,000 population) for Unintentional Injury by Race/Ethnicity in Maryland, 2016-2023



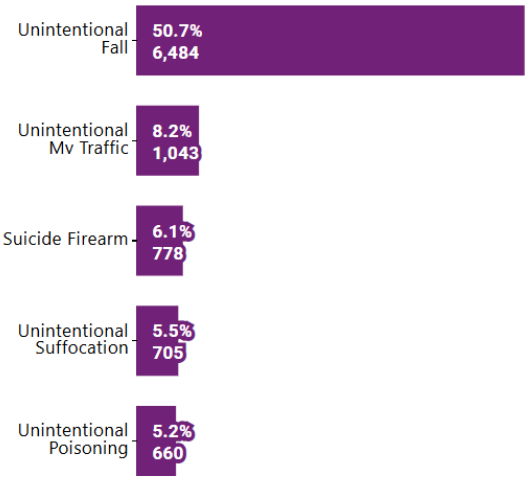
Source: Maryland Vital Statistics Administration, 2023

FALLS

More than 14 million adults ages 65 and older—about one in four—fall each year in the United States, making falls the leading cause of injury in older adults (see Figure 32). About 37% of those who fall sustain an injury requiring medical care or restricting activity, resulting in millions of fall-related injuries annually. Falls can cause serious harm, including fractures and head injuries, and often go unreported. As the population ages, the number of falls is expected to rise.

Falling once increases the likelihood of falling again, and fear of another fall can reduce activity, weakening the body and raising risk further. Most falls are preventable through strengthening, vision care, medication review, and safer home environments. Fall-related deaths among older adults continue to increase each year, underscoring the importance of screening for fall risk and addressing modifiable factors such as medications, poor balance, and unsafe surroundings.

Figure 32. Unintentional Deaths due to Fall among Persons Aged 65+ Years, 2014 to 2023, Maryland.



Source: National Center for Injury Prevention and Control, CDC

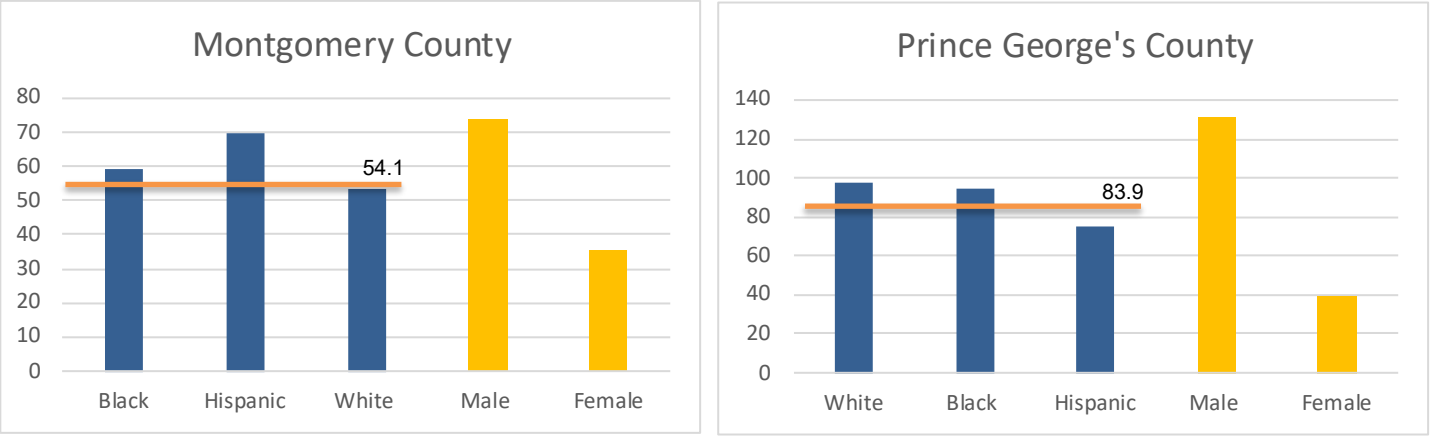
The effects of falls extend beyond psychological and physical injuries. Falls are the most common cause of nonfatal injuries and hospital admissions for trauma. The financial toll for

older adult falls is expected to increase as the population ages. In 2020, non-fatal older adult falls totaled about $80 billion in health care costs. The cost of treating injuries caused by falls among older adults is projected to increase to over $101 billion by 2030.

In Montgomery and Prince George's Counties, the 2023 overall crude death rates for falls were 54.1 and 83.9, respectively. Higher rates can be seen in men compared to women in both counties; however, the death rate for White individuals in Prince George's County was higher compared to Black/African American and Hispanic populations whose crude rate was found to be higher in Montgomery County (see Figure 33).

While the HP2030 national health goal is to reduce fall-related deaths among older adults to 63.4 per 100,000, there were 104 deaths per 100,000 in Montgomery County older residents and 64 deaths per 100,000 in Prince George's County older residents due to falls in 2023 [55].

Figure 33. Fall-related Death Rates per 100,000 for Ages 65+ by Race/Ethnicity and Gender, 2023



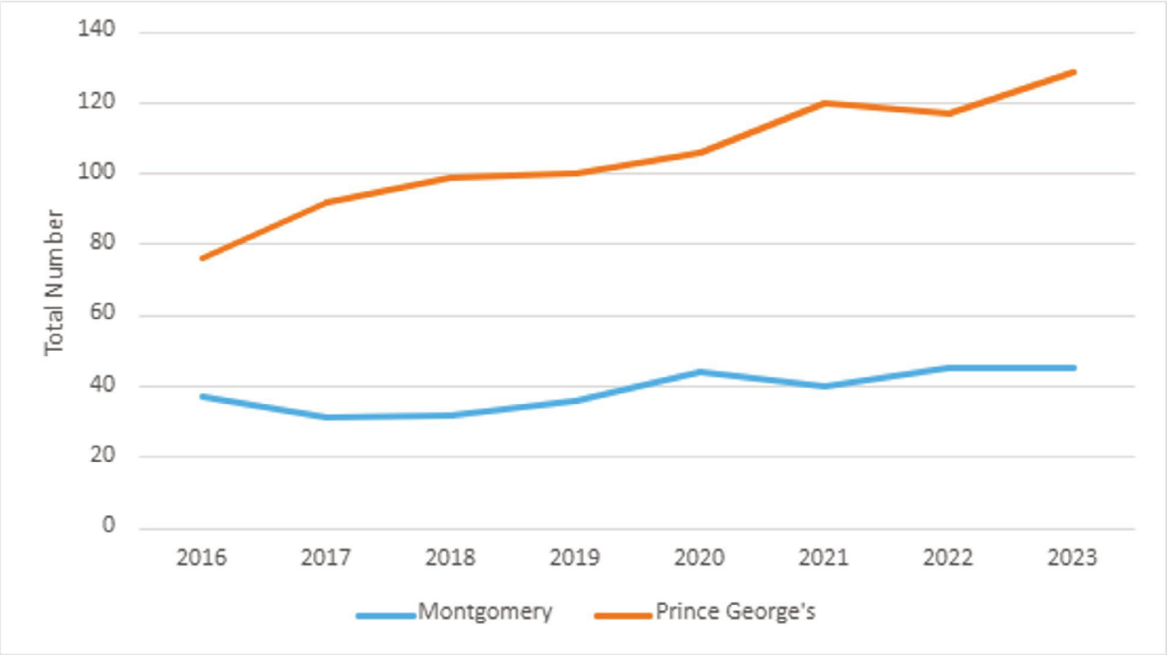
Source: CDC WONDER Online Database, 2023

MOTOR VEHICLE COLLISIONS

Motor vehicle collisions are the leading cause of death among people ages 5-34 in the U.S, however, 2023 marks the second consecutive year of decrease in deaths. In addition to negative health effects, motor vehicle collisions have significant economic impacts; the costs of total motor-vehicle injury (including medical care, productivity losses, employer costs, etc.) are estimated at around $513.8 billion per year. In 2023, the crude death rate for motor vehicle traffic collisions was 6.3 deaths per 100,000 population in Montgomery County and 14.5 deaths per 100,000 population in Prince George's County; Healthy People 2030's national target is to reduce deaths from motor vehicle crashes to 10.1 deaths per 100,000.

Fatal crashes are the number of incidents where at least one fatality occurred as a result of a motor vehicle crash, whereas fatalities are 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 62% of fatalities from crashes in 2022 [68]. Passengers and pedestrians also have an increased risk of death, accounting for 11.6% and 23.3% of fatalities in Maryland in 2022. Overall, between 2016-2023, fatalities in Prince George's County have trended up, while in Montgomery County, the number has remained steady (see Figure 34).

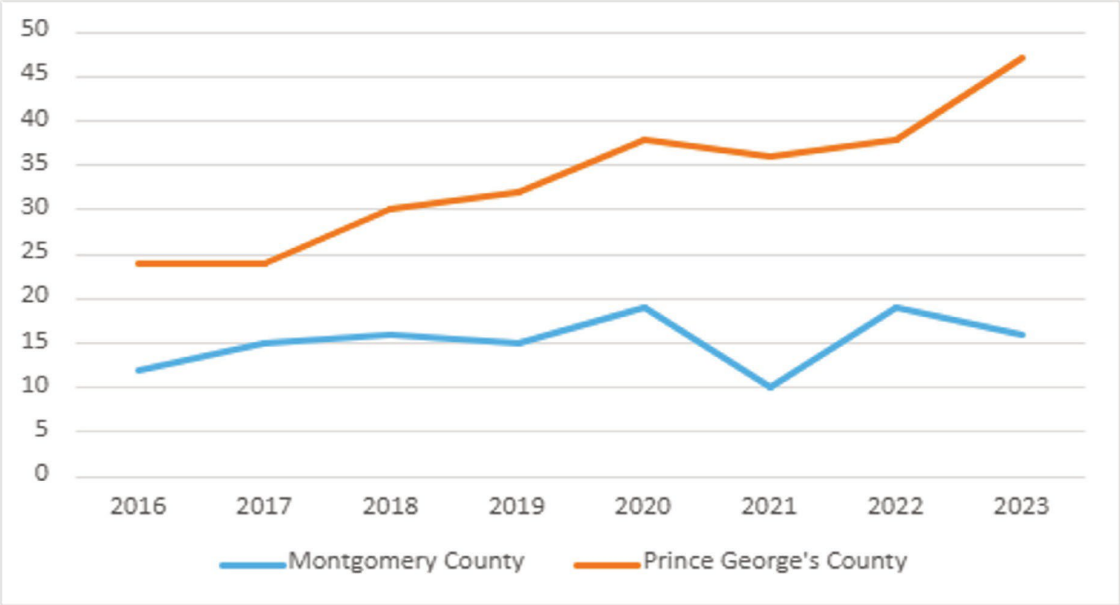
Figure 34. Number of Total Fatalities, 2016-2023



Source: Maryland Department of Transportation Motor Vehicle Administration, 2023

After driver and passenger deaths, the highest fatality rate was among pedestrians. According to the CDC more than 8,000 motor vehicle-related pedestrian fatalities occurred in the U.S. in 2022 [69]. In Maryland, there were 157 walking pedestrian fatalities in 2023, a 19.8% increase from 2020. Pedestrian fatalities involving motor vehicles in Montgomery County and Prince George's County were 16 and 47, respectively [68]. Fatalities among pedestrians from a motor vehicle have increased between 2016-2023 across Montgomery and Prince George's Counties (see Figure 35).

Figure 35. Trend in Number of Total Fatalities Involving Pedestrians, 2016-2023



Source: Maryland Department of Transportation Motor Vehicle Administration, 2023

BEHAVIORAL AND MENTAL HEALTH

Behavioral health refers to a state of mental, emotional, and social well-being or behaviors and actions that affect wellness. Behavioral health is a key component of overall health. The term is also used to describe the support systems that promote well-being, prevent mental distress, and provide access to treatments and services for mental health conditions. Behavioral health is an umbrella term that refers to the following topics:

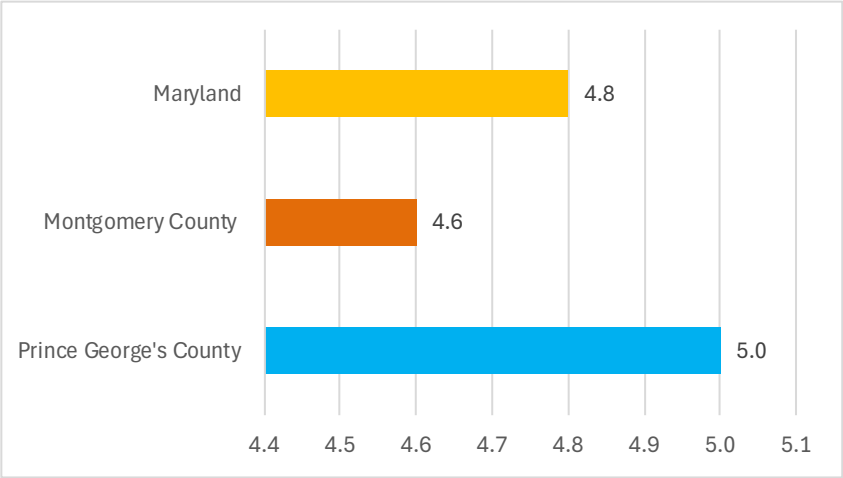
- Mental health (i.e., well-being, mental distress, mental health conditions)
- Suicidal thoughts or suicide attempts
- Substance use or substance use disorders

Improving behavioral outcomes means addressing factors at multiple levels, including social determinants of health; supporting the environments where we live, work, learn, and play.

MENTAL HEALTH

Mental health is a key part of overall well-being, shaping how people handle stress, relate to others, and function in daily life. Nationally, nearly 23% of U.S. adults reported a mental illness in 2023, reflecting growing behavioral health needs across communities [70]. In Montgomery County, residents reported an average of 4.6 mentally unhealthy days in the past 30 days in 2022, slightly better than Prince George's County at 5.0 days (see Figure 36) [71].

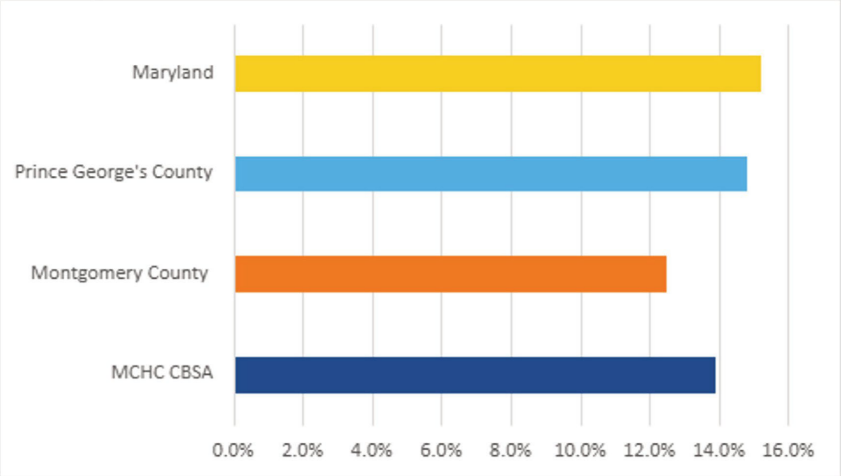
Figure 36. Number of Reported Poor Mental Health Days Experienced by Adults, 2022



Source: County Health Rankings & Roadmaps, 2025

Within the broader MCHC region, 13.9% of adults reported 14 or more mentally unhealthy days in 2022, compared with 12.5% in Montgomery County and 14.8% in Prince George's County(see Figure 37)., underscoring local variation in mental health needs [19]. Social support, stable environments, and access to care remain protective factors that help residents thrive.

Figure 37. Percentage of Adults Reporting Poor Mental Health, 2022

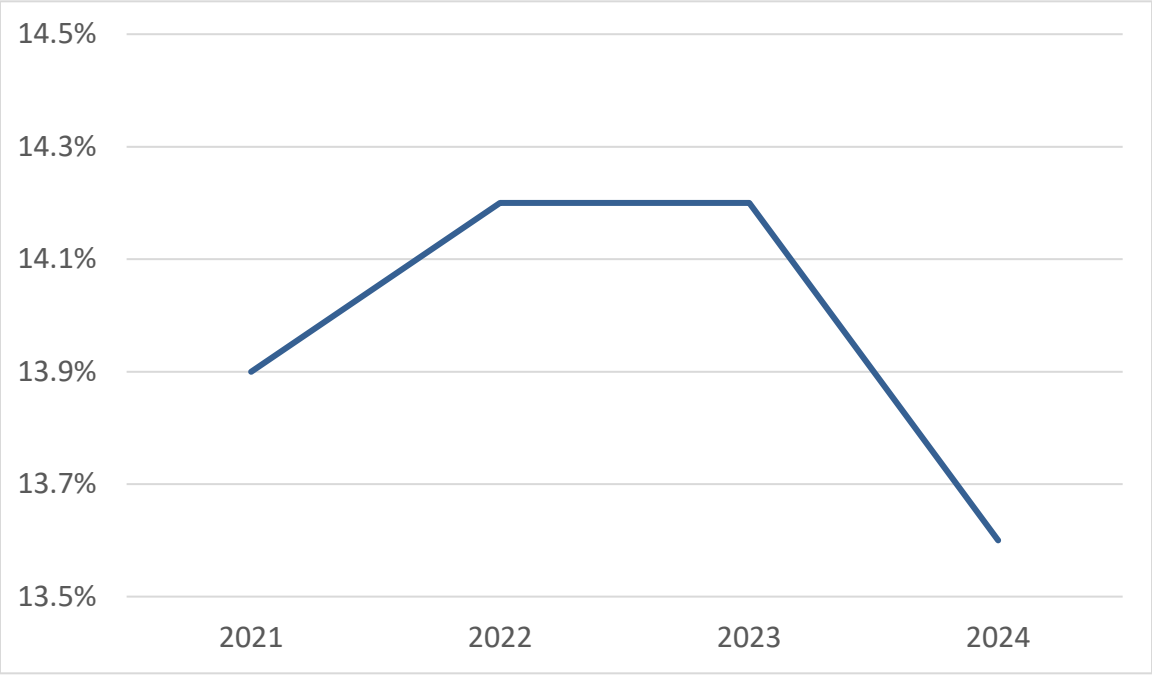


Source: Trinity Health Data Hub

DEPRESSION AND SUICIDE

Depression is a common mood disorder shaped by genetic, biological, environmental, and psychological factors. It affects how people think, feel, and manage daily activities, and is more frequently reported among Hispanic, White, and Black adults, as well as women. In 2023, 17.4% of Maryland adults had been diagnosed with depression [72]. In Montgomery County, 13.6% of adults purchased medications to treat anxiety or depression in 2024, down from 14.2% in 2022 and 2023 [73]. Because depression is also a major risk factor for suicide, these patterns underscore the importance of early identification, effective treatment, and strong community supports to promote mental well-being (see **Error! Reference source not found.**).

Figure 38. Percent of Montgomery County Adults Purchasing Medications for Anxiety or Depression by Year

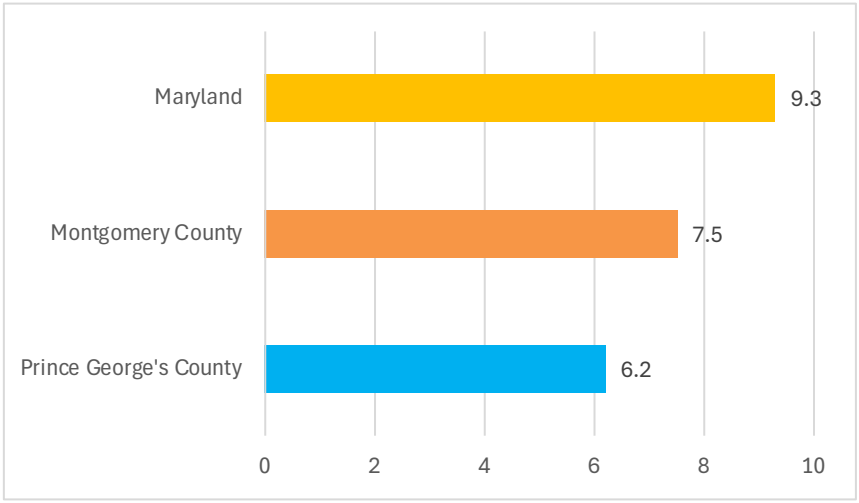


Source: Healthy Montgomery, 2025

Suicide remains a serious public health issue in the U.S., with over 49,000 deaths in 2023, about one every 11 minutes [74]. Nationally, 12.8 million adults seriously considered suicide, 3.7 million made a plan, and 1.5 million attempted suicides [75]. Rates are highest among non-Hispanic American Indian/Alaska Native and non-Hispanic White individuals, and men die by suicide at roughly four times the rate of women, most often involving firearms.

National suicide trends have risen by 37% since 2000 [74]. In contrast, Maryland saw a 4% decline in suicide mortality between 2020 and 2022 [76]. Within the MCHC region, there were 486 deaths from suicide between 2019–2023, with an age-adjusted rate of 7.7 deaths per 100,000, consistent with national goals to reduce suicide mortality [19]. The age-adjusted suicide mortality rates were 7.5 deaths per 100,000 in Montgomery County and 6.2 per 100,000 in Prince George's County (see Figure 39), both below the Healthy People 2030 national target of 12.8. While these counties experience comparatively lower rates, each death represents profound community loss. Sustaining progress will require ongoing investments in early intervention, culturally responsive care, and community-based prevention supports.

Figure 39. Age-adjusted Suicide mortality rate, 2023



Source: Maryland Vital Statistics Administration

YOUTH MENTAL HEALTH

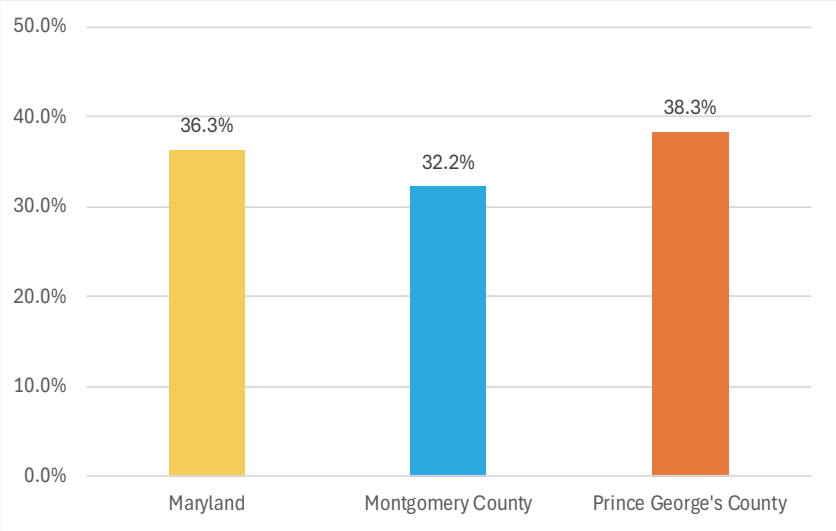
Youth mental health is a growing concern locally and nationally as adolescents face increasing academic, social, and digital pressures. Nationally, nearly 1 in 3 U.S. youth ages 12–17 had a mental, emotional, developmental, or behavioral condition in 2022–2023, compared with 21% in Maryland [76]. Many young people also experience symptoms of anxiety, depression, trauma, and stress, with the highest burden falling on LGBTQ+ youth, youth of color, and youth from low-income households.

Local survey data reflect these trends: During the 2022–2023 school year, 32.2% of Montgomery County high school students and 38.3% of Prince George's County students reported feeling sad or hopeless for at least two consecutive weeks (see Figure 40). At the

same time, Montgomery County Public Schools documented 1,283 crisis referrals in FY 2022, most involving middle school students, with suicide threats being the leading cause.

Suicidal ideation among youth remains especially concerning. Nationally, 20% of high school students seriously considered suicide, and 9% attempted suicide in 2023 [77]. Locally, 14.6% of Montgomery County high school students and 16.8% in Prince George's County seriously considered attempting suicide in 2022–2023. Actual suicide attempts were reported by 6.0% of Montgomery County students and 10.4% of Prince George's County students, with higher rates among Hispanic youth in Montgomery County and Asian youth in Prince George's County. Female students in both counties reported higher rates of suicide attempts than males [78].

Figure 40. Percentage of Students Feeling Sad or Hopeless, 2022-2023



Source: YRBS/YTS 2022-2023 and Maryland Department of Health CCDPC Surveys & Reports, 2023

INFECTIOUS DISEASE

Infectious diseases are disorders caused by organisms such as bacteria, viruses, fungi, or parasites that are directly or indirectly passed from one person to another96. 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 reported 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 for a list of notifiable infectious conditions in Maryland [79].

Table 2. Cases of Selected Notifiable Conditions Reported in Maryland, 2023

Condition Name	Maryland	Montgomery County	Prince George's County
Amebiasis	0.26	0.66	0.11
Animal bites	164.6	89.8	120.96
Anthrax	0.1	0	0
Campylobacteriosis	20.86	24.75	13.72
Cryptosporidiosis	2.62	2.27	2.32
Cyclosporiasis	1.39	3.59	0.32
Dengue Fever	0.4	0.66	0.21
Giardiasis	3.62	1.8	2.74
Hepatitis A	0.28	0.28	0.32
Kawasaki Syndrome	0.02	0.09	0
Listeriosis	0.28	0.38	0.11
Lyme Disease	39.85	13.7	8.44
Malaria	4.5	6.14	13.51
Meningitis, Fungal	0.37	0.19	0.42
Mumps	0.11	0.28	0
Mycobacteriosis, Other than TB & Leprosy	13.04	21.35	12.24
Pertussis	0.34	0.57	0.11
Shiga toxin-producing E. coli (STEC)	7.25	13.79	7.81
Shigellosis	5.63	9.07	8.34
Strep Group B	9.19	5.76	7.6
Typhoid Fever – Acute	0.24	0.28	0.32
WNV Symptomatic Infections	0.19	0.38	0.11
Yersiniosis	3.48	6.05	2.22

Source: Maryland Department of Health NEDSS and PRISM databases, 2023

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 nine 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 in appropriate treatment for several days to weeks. The most effective way to stop the spread of tuberculosis is for TB patients to cover their mouth and nose when coughing and to take all TB medicine exactly as prescribed by their physician. The HP2030 national health target is to

reduce tuberculosis cases to 1.4 cases per 100,000 population. Between 2021-2025, Montgomery County had an increasing trend in new cases, while Prince George's County cases have fluctuated (Table 3).

Table 3. Cases of Tuberculosis Reported in Maryland, 2021-2024

Location	2021	2022	2023	2024
Maryland	3.2	2.6	3.3	3.5
Montgomery County	4.7	4.7	6.2	6.2
Prince George's County	5.7	4.0	4.9	4.7

Source: Maryland Department of Health Prevention and Health Promotion Administration, 2025

INFLUENZA AND PNEUMONIA

Influenza (flu) is a contagious disease caused by the influenza virus. The flu can cause severe illness and life-threatening complications, particularly in older adults, young children, pregnant women, and people with certain health conditions such as heart or respiratory conditions.

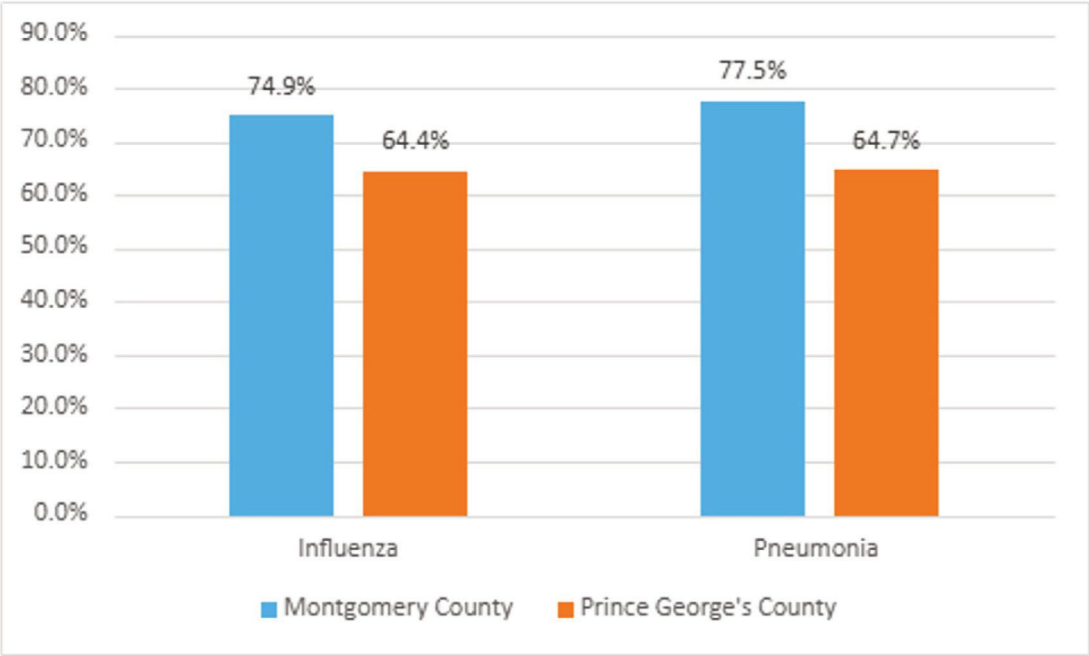
The CDC estimates that, on average, 5%-20% of the population in the U.S. gets the flu and more than 200,000 people are hospitalized each year. While flu seasons can vary in severity, during most seasons, adults ages 65 and older bear the greatest burden of severe flu and have the highest flu-related mortality. The seasonal influenza vaccine can prevent serious illness and death. The CDC recommends annual vaccinations to prevent the spread of influenza.

The flu can lead to pneumonia and can be dangerous for those with heart or respiratory conditions. 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. It is the leading cause of vaccine-preventable death and illness in the U.S., and flu kills about one out of every 20 people who develop the disease.

According to the Maryland Vital Statistics Administration [24], death rates of influenza and pneumonia declined as there were 9.3 deaths per 100,000 in 2022. In 2022, Montgomery County's death rate for influenza and pneumonia was 7.0 deaths per 100,000 and Prince George's County's death rate was 8.7 deaths per 100,000 [80].

As people age, the immune system does not respond to infections as well as it once did. Therefore, it is important for older adults to stay current on recommended vaccines and boosters. The pneumococcal vaccine is very effective at preventing severe disease, hospitalization, and death. The CDC recommends the current vaccine for adults ages 65 and older and for children ages two and older who are at high risk for disease. In 2023, 74.9% of Montgomery County and 64.4% percent of Prince George's County residents ages 65 and older received a flu vaccination in the past year (see Figure 41).

Figure 41. Percent of Adults Ages 65+ Vaccinated for Influenza and Pneumonia, 2023



Source: Maryland Behavioral Health Risk Surveillance System, 2023

CORONAVIRUS DISEASE

COVID-19 is an infectious disease caused by the coronavirus 2 (SARS-CoV-2) and is a member of a large family of viruses that causes respiratory disease. The first known human cases of SARS-CoV-2 virus were in 2019 and spread from person to person through droplets released when an infected person coughed, sneezed, or talked. It also spreads when a person touches a surface with the virus on it and then touches their mouth, nose, or eyes [81].

The COVID-19 outbreak was declared a worldwide pandemic in 2020 by the World Health Organization (WHO) and Centers for Disease Control (CDC). These organizations issued recommendations for preventing and treating COVID-19. Most people infected with the virus experienced mild to moderate respiratory illness and recovered without requiring special treatment. However, some became seriously ill and required hospitalization. Older adults and those with underlying medical conditions such as cardiovascular disease, diabetes, chronic respiratory disease, or cancer were more likely to become severely ill. Other factors that contributed to the pandemic include discrimination, access to care, location, beliefs about medical care, and/or type of work.

As of March 2025, Maryland had reported over 1.5 million COVID-19 cases and nearly 20,000 deaths. Strikingly, nearly 95% of those deaths occurred among residents aged 50 and older, a group that accounted for only one-third of total cases. This disproportionate impact highlights the heightened vulnerability of older adults to severe outcomes, underscoring the importance of targeted protections and health interventions for aging populations during public health emergencies.

Some counties within the state were highly affected more than others, with the two counties

most affected being Montgomery and Prince George's counties. These two counties had the highest number of cases, but the second and third in fatalities (see Table 4 and Table 5).

Table 4. COVID-19 Statistics in Maryland by County

County	Cases	Deaths	*
Allegany	25,011	(431)	3*
Anne Arundel	131,141	(1,425)	17*
Baltimore	190,237	(3,175)	49*
Baltimore City	165,978	(2,116)	36*
Calvert	16,318	(198)	2*
Caroline	7,993	(99)	2*
Carroll	30,497	(548)	8*
Cecil	22,730	(310)	4*
Charles	43,456	(460)	3*
Dorchester	10,753	(133)	1*
Frederick	63,834	(726)	10*
Garrett	8,429	(132)	1*
Harford	55,234	(762)	13*
Howard	73,373	(536)	8*
Kent	4,366	(84)	3*
Montgomery	271,030	(2,690)	56*
Prince George's	252,995	(2,558)	51*
Queen Anne's	9,602	(143)	2*
St. Mary's	27,291	(287)	1*
Somerset	6,745	(87)	1*
Talbot	8,079	(134)	4*
Washington	42,931	(717)	6*
Wicomico	27,510	(398)	1*
Worcester	11,769	(204)	1*
Data not available	0	(24)	0*

Source: Maryland Department of Health, Covid-19 Database
Parenthesis () = Confirmed death, laboratory-confirmed positive COVID-19 test result
Asterisk * = Probable death, death certificate lists COVID-19 as the cause of death but not yet confirmed by a laboratory test
NH = Non-Hispanic

Table 5. COVID-19 Statistics in Maryland by Age/Gender

Age/Gender	Cases	Deaths	
0-9	148,648	(17)	1*
10-19	170,491	(21)	1*
20-29	238,738	(92)	1*
30-39	246,288	(257)	11*
40-49	206,752	(623)	5*
50-59	202,303	(1,506)	42*
60-69	149,343	(3,042)	43*
70-79	88,558	(4,544)	61*
80+	56,181	(8,273)	118*
Data not available	0	(2)	0*
Female	825,408	(8,807)	132*
Male	681,894	(9,570)	151*
Unknown Gender	0	(0)	0*

Source: Maryland Department of Health, Covid-19 Database

At the onset of the COVID-19 pandemic, nationally, American Indian and Alaska Native people, non-Hispanic Black people and Hispanic people had higher rates of infection and COVID-19 deaths compared with those of non-Hispanic white people. Black and Hispanic people in the United States also had higher chances of needing care in the hospital for COVID-19.

By 2021, the rate of infection and death for non-Hispanic white people had risen and closed the gap between the groups. By April 2024, non-Hispanic white people had the highest rate of death compared with that of other race and ethnicities. In Maryland, racial and ethnic disparities mirror what was observed nationally (see Table 6).

Table 6. COVID-19 Statistics in Maryland by Race/Ethnicity

Race/Ethnicity	Cases	Deaths	
African American (NH)	516,315	(5,843)	105*
Asian (NH)	64,791	(580)	12*
White (NH)	605,545	(10,620)	144*
Hispanic	181,538	(1,124)	20*
Other (NH)	74,778	(197)	2*
Data not available	64,335	(13)	0*

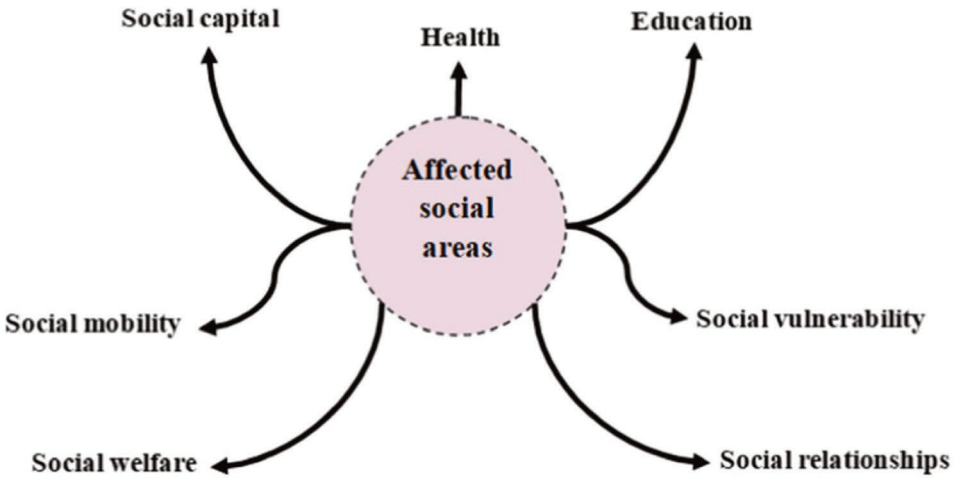
Source: Maryland Department of Health, Covid-19 Database

The U.S. Food and Drug Administration (FDA) authorized antiviral medications to treat mild to moderate COVID-19 in people who were more likely to become very ill, as they target specific

parts of the virus to stop it from multiplying in the body once a person is infected, helping to prevent severe illness and death. The two approved vaccines, Pfizer-BioNTech and the Moderna COVID-19, were given emergency approval by the FDA and were developed based on previous studies of SARS-CoV, Middle East respiratory syndrome coronavirus (MERS-CoV), and other viruses105. Since approval, more than 13 billion COVID-19 vaccine doses have been administered globally. In Maryland, about 7.2 million vaccine doses were administered with 78.1% of the population ages 18 and older received at least one dose [82].

COVID-19 required individuals and families to change many aspects of their everyday lives, causing a variety of social disruptions due to the many unknown situations communities encountered at the time. The pandemic also affected a wide range of health and quality-of-life outcomes and intensified the impact of social determinants of health (SDOH) on minority communities109. Based on a study that was published by the National Library of Medicine, COVID-19 negatively affected seven major social areas: health, social vulnerability, education, social capital, social relationships, social mobility, and social welfare [83] (see Figure 42).

Figure 42. Social Areas Affected by COVID-19



Source: Impacts of COVD-19, Natural Hazards, 2023

SEPSIS

Septicemia or sepsis is the body's response to infection. Sepsis is a serious and relatively common disorder and has become the leading cause of death worldwide, surpassing cancer and coronary disease [84]. Sepsis and septic shock can result from infections such as pneumonia, influenza, or urinary tract infections (UTIs). According to the Sepsis Alliance [84], 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. Older adults are particularly vulnerable because they often delay treatment and do not recognize the symptoms of infections. For example, UTIs can be treated quickly and effectively with antibiotics. However, more than 50% of sepsis cases among older adults are caused by a UTI because the infections go undiagnosed [84].

SECTION 3.

COMMUNITY CONDITIONS

Social and economic factors, or social determinants of health (SDOH), such as education, income, housing, food insecurity, and transportation has a major impact on a person's health, well-being, and quality of life. These conditions shape daily choices and long-term opportunities, influencing access to healthcare, the ability to live in a safe and affordable home, and the capacity to access nutritious food or reliable transportation. For example, employment provides paid work, which offers income and benefits such as health insurance, paid sick leave, and financial stability.

These resources, in turn, influence where people live, the care they receive, and their resilience during a crisis. As employment, income and assets increase or decrease for individuals, families and communities, so do opportunities to lead healthy, fulfilling lives.

According to the 2025 County Health Rankings Report, community conditions encompass where we live, learn, work, play, and pray. Shaped by social, economic, and physical factors, they play a critical role in determining health outcomes and life expectancy. When these conditions are unfavorable or inequitably distributed, they limit opportunities for people to thrive and contribute to persistent health disparities across populations.

Unfortunately, persistent poor health and health inequities continue to exist across the country due to a system of intertwined causes and the complexities of SDOH, creating barriers that prevent many individuals from reaching their fullest potential to be healthy and thrive. These gaps disproportionately harm racialized groups, women, LGBTQ+ communities, low-income individuals, and people of color [1].

Community conditions that support health and well-being are often distributed unfairly and 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.

Additionally, poor physical environments affect the ability of individuals, families and community members to live long, healthy lives. Clean air and safe water are necessary for good health. Air pollution is associated with increased asthma rates and lung diseases as well as 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 risk of cancer.

Stable, affordable housing can provide safer environments for families to live, learn, grow, and form social bonds. However, housing is often the single largest expense for individuals or families, and the housing cost burden can force them to choose between paying for other essentials such as utilities, food, transportation, or medical care.

Addressing the root causes of health disparities through equitable community conditions is essential to ensuring that everyone has the opportunity to live a healthy, fulfilling life.

HEALTH INFRASTRUCTURE

A strong foundation of health infrastructure is essential to creating communities where everyone has the opportunity to live a long and healthy life. Health infrastructure goes beyond clinical settings, encompassing the systems, services, and supports that enable timely, high-quality, and culturally responsive care. This includes primary and specialty care, behavioral health services, and safety-net programs like the Supplemental Nutrition Assistance Program (SNAP), which play a vital role in closing access gaps.

In the MCHC CBSA, the availability, affordability, and capacity of health services shape how residents engage with the health care system and ultimately influence outcomes across the lifespan. This section explores the health care and support systems in place, examining both

their strengths and the areas where strategic investments are needed to meet growing and evolving community needs. Strengthening these systems is key to building resilient communities equipped to meet future health challenges.

HEALTH PROMOTION AND HARM REDUCTION

Health promotion and harm reduction are about more than encouraging healthy habits—they're about making it easier for people to live well and avoid preventable harm. These strategies blend education, prevention services, and connections to care to address behaviors like tobacco and substance use, physical inactivity, and risky sexual activity. The ability to make healthy choices depends not just on personal motivation but also on access, opportunity, and the environments we live in. Communities that have been historically marginalized often face greater barriers, from food deserts to higher rates of chronic disease. The following sections explore how these approaches play out across preventive health and healthcare, behavioral health and lifestyle, sexual and reproductive health, and substance use and related mortality.

PREVENTIVE HEALTH & HEALTHCARE ACCESS

Strong communities prioritize prevention, keeping people healthy and addressing risks before they turn into serious illnesses. Access to preventive services and resources, such as vaccinations, nutritious food, and safe spaces for physical activity, plays a critical role in overall health. Yet these opportunities are not distributed evenly. Barriers like limited access to healthy foods, poor food environments, and lack of nearby exercise facilities can make healthy living harder, especially for communities already facing higher rates of food insecurity. Even something as routine as getting a flu shot can be a challenge when cost, transportation, or trust in the healthcare system stand in the way. Understanding where these gaps exist helps us target efforts to strengthen prevention and improve access for everyone.

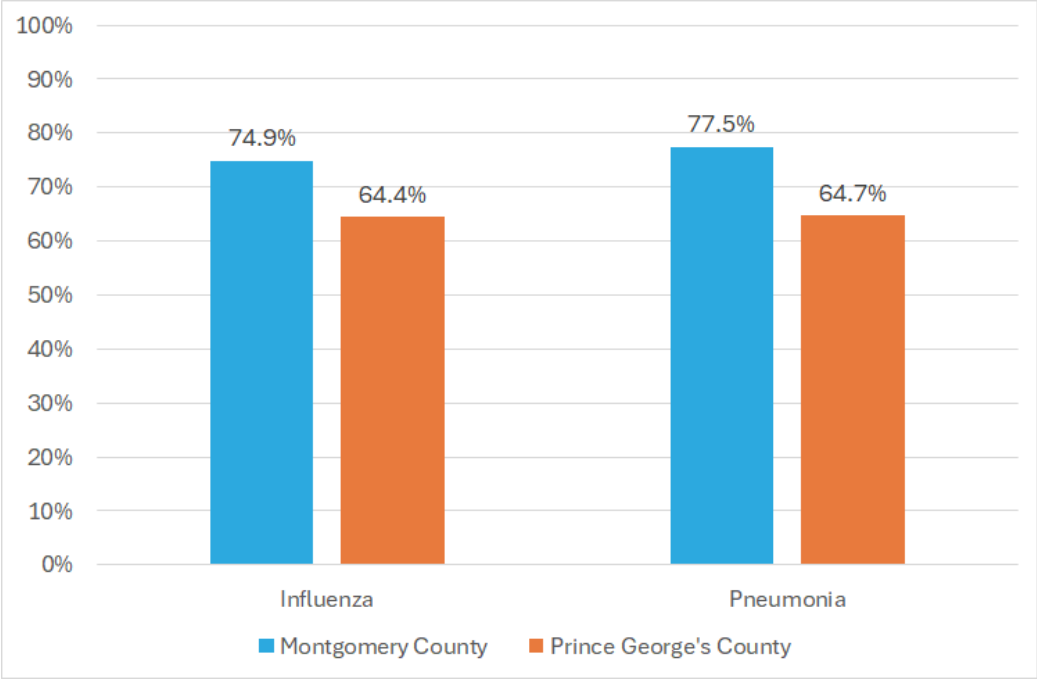
VACCINES

Influenza and pneumonia are serious respiratory illnesses that contribute to substantial morbidity and mortality each year in the United States. These diseases disproportionately affect older adults and individuals with chronic health conditions, often leading to severe complications and hospitalizations. Vaccination remains one of the most effective strategies for preventing illness, reducing transmission, and lowering the risk of life-threatening outcomes. Promoting widespread access to and uptake of influenza and pneumococcal vaccines is essential to safeguarding public health, especially among high-risk populations.

In 2023, flu vaccination rates among older adults varied across the region, highlighting both progress and areas for improvement in preventive care. In Montgomery County, 74.9% of residents aged 65 and older received a flu vaccination within the past year, compared to 64.4% in Prince George's County (see Figure 43). Pneumonia vaccination rates showed a similar pattern, with 77.5% of older adults in Montgomery County reporting they had received

the vaccine, compared to 64.7% in Prince George's County. While these figures reflect a majority of older adults taking advantage of these critical preventive measures, the gap between counties, and the fact that roughly one in four seniors in Montgomery and more than one in three in Prince George's remain unvaccinated, underscores the need for continued outreach, education, and access. Targeted efforts to increase vaccination rates among older adults can help reduce the burden of vaccine-preventable illnesses and protect those most vulnerable to severe outcomes.

Figure 43. Percent of Adults Ages 65 and Older Vaccinated for Influenza and Pneumonia, 2023



Source: Maryland Behavioral Health Risk Surveillance System, 2023.

ACCESS TO EXERCISE AND PHYSICAL ACTIVITY

Just like vaccines, regular physical activity is a cornerstone of preventive health. When paired with a balanced diet, it helps manage weight and lowers the risk of chronic conditions like heart disease, type 2 diabetes, stroke, and certain cancers. But physical activity isn't just about physical health, it also supports mental and emotional well-being by reducing anxiety and depression, improving mood, and helping regulate sleep. These benefits apply across all age groups, making access to safe and supportive environments for exercise an essential part of a healthy community.

Recreation and Fitness Facilities

Access to recreation and fitness facilities plays a big role in encouraging physical activity and promoting healthier lifestyles. In the MCHC CBSA, there are 172 establishments primarily focused on fitness and recreational sports, places where people can engage in activities like swimming, skating, racquet sports, and other forms of exercise [19]. When we look at the number of recreation and fitness facilities per 100,000 residents, Montgomery County leads with 14.8, followed by the broader MCHC CBSA region at 13.4. Prince George's County trails behind at 5.6, while the Maryland state average sits at 11.3 [19].

Beyond indoor facilities, access to outdoor spaces also matters. Having a park within walking distance makes it easier for people to stay active. In the MCHC CBSA, 74.3% of residents live within a 10-minute walk of a park (see Figure 44). Montgomery County is slightly higher at 77.1%, while Prince George's County is at 66.2%. The statewide average is much lower at 48.3% [19]. These numbers show that while some areas are doing well in providing access to physical activity spaces, others still have room to grow, especially when it comes to equitable access across communities.

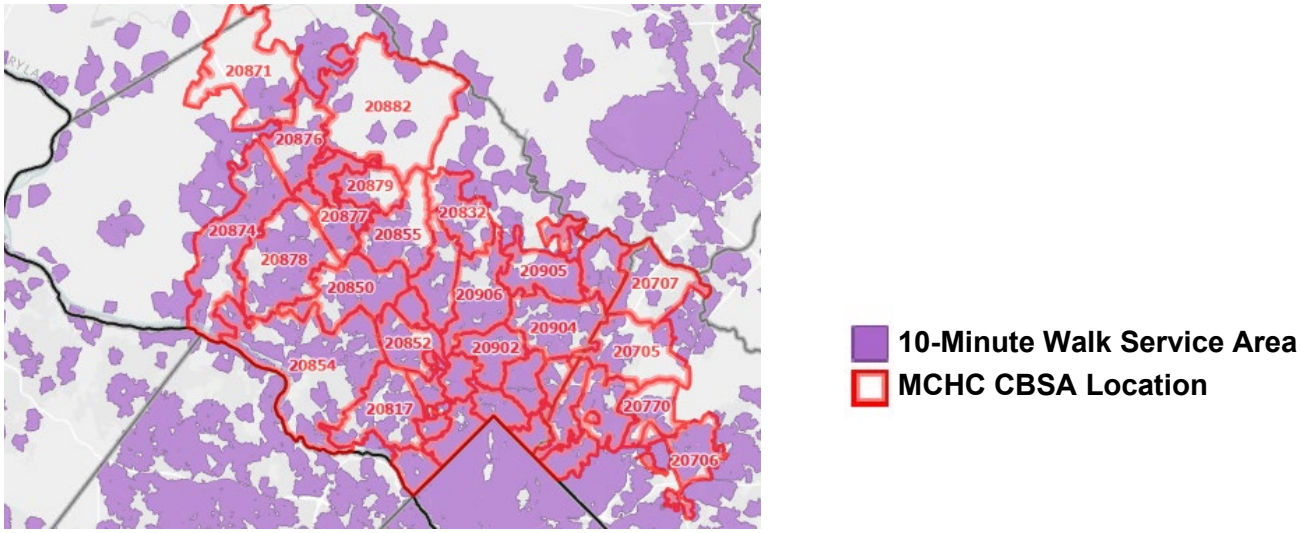


Figure 44. Population Within a 10-Minute Walk of a Park
SOURCE: TRUST FOR PUBLIC LAND. 2020.

Adolescent and Youth Physical Activity

Access to recreation and fitness facilities plays a crucial role in promoting physical activity among youth. When safe, convenient spaces are available, adolescents are more likely to engage in regular exercise, which supports both physical and mental health.

According to the CDC, adolescents 6-17 years old should engage in at least 60 minutes of moderate-to-vigorous physical activity daily. This activity should include both aerobic and muscle-strengthening activities at least three days per week. Regular physical activity helps teens build strong hearts, muscles, and bones. It also supports mental health by boosting focus and reducing feelings of stress and depression [85].

In 2022, 55.0% of male and 33.3% of female high school students in Montgomery County were physically active at least five days during the past week. This resulted in a net increase of 3.6% among males and a 1.3% decrease among females from the previous year. In Prince George's County, 34.1% of male and 17.4% of female high school students met the same activity threshold, reflecting net increases of 2.1% and 1.6%, respectively [86]. This resulted in a net increase of 2.1% in males and a net increase of 1.6% in females from the previous year.

Overall, 44.3% of Montgomery County and 25.8% of Prince George's County high school students were physically active at least five days during the past week, compared to the Maryland state average of 39.5% [86]. The net increase of 1% in Montgomery County and

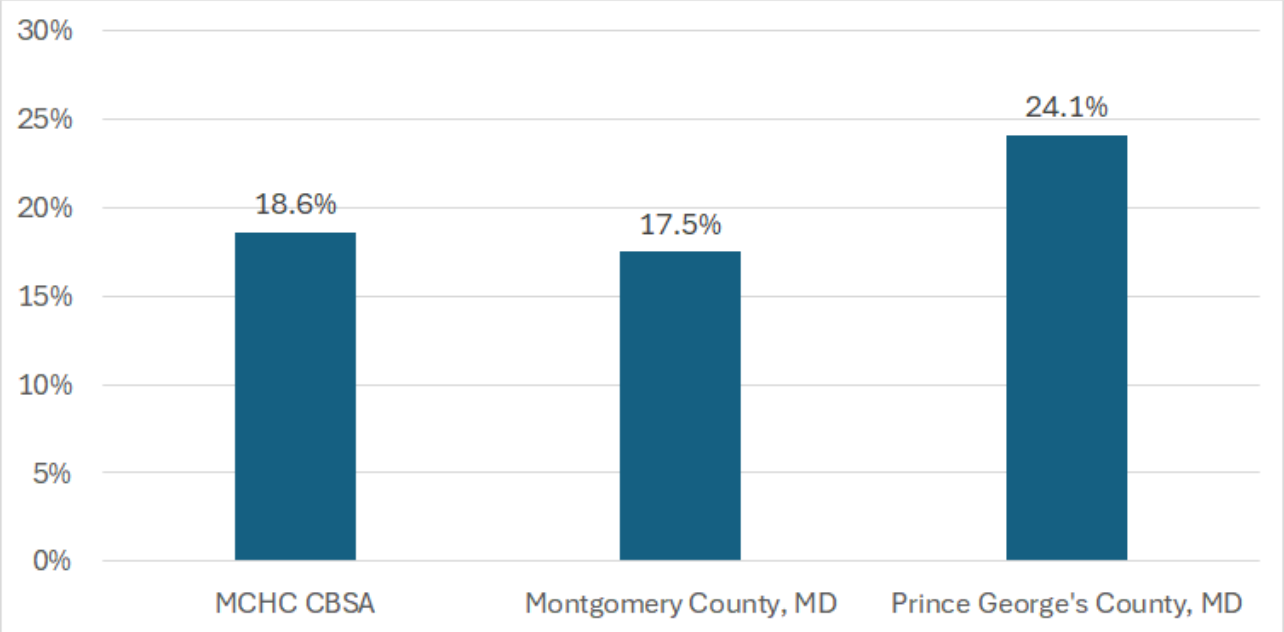
0.3% in Prince George's County suggests that more high school students are engaging in physical activity, contributing to improved health outcomes.

Adult Physical Activity

Building on the importance of physical activity among youth, it is equally vital to promote regular exercise among adults to support long-term health and well-being. The American College of Sports Medicine recommends that active adults engage in physical activity of moderate intensity at least 150-300 minutes a week or 75-150 minutes a week of vigorous intensity152. Unfortunately, only 25%% of adults and 16.6% of adolescents in the U.S. engage in the recommended amount of physical activity [85].

Encouragingly, the percentage of physically active adults in Montgomery County (62.5%) and Prince George's County (54.0%) is higher than the national average [86]. However, within the MCHC CBSA, 18.6% of adults aged 18 and older reported that, in the past month, they did not engage in any physical activities or exercises outside of their regular job, such as running, calisthenics, golf, gardening, or walking for exercise [19] (see Figure 45). This underscores the need for continued efforts to reduce inactivity and promote accessible opportunities for physical activity across the region.

Figure 45. Adults Age 18+ with No Leisure-Time Physical Activity (Crude), 2021



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2021.

For older adults, regular activity supports independence, mobility, and mental well-being. The CDC advises adults aged 65+ to aim for at least 150 minutes of moderate-intensity activity per week, along with muscle-strengthening exercises twice weekly and balance-improving activities. Despite these proven benefits, an estimated 28% of adults aged 50 and older remain physically inactive [87]. Creating age-friendly environments and offering tailored programs can help older residents stay active, engaged, and connected within their communities.

LIFESTYLE BEHAVIORS AND SUBSTANCE-RELATED HARM

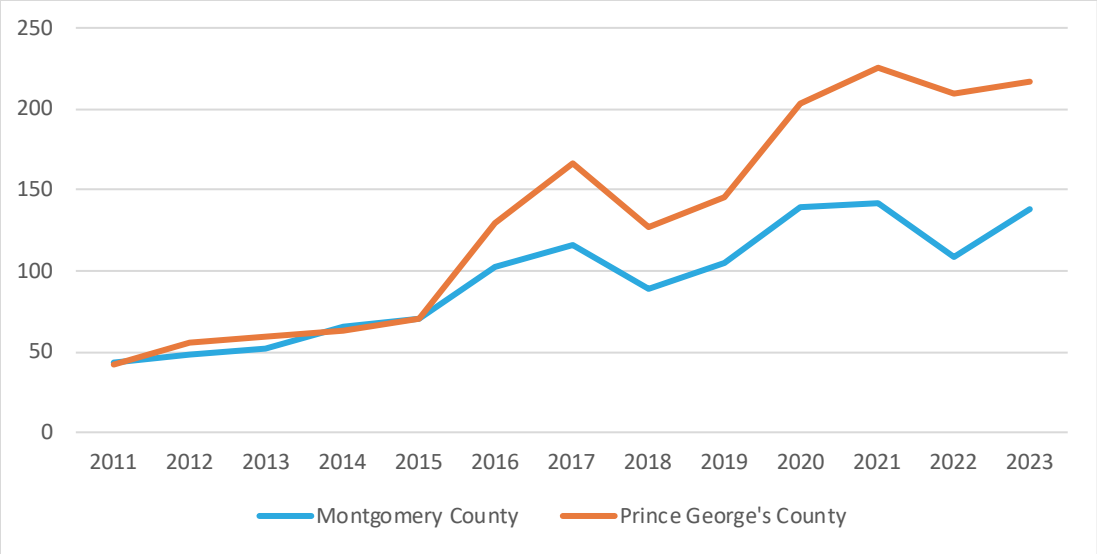
While physical activity and access to recreational opportunities are key protective factors for health, lifestyle behaviors can also increase risk for chronic disease, injury, and premature death. Substance use, tobacco consumption, and alcohol misuse remain leading contributors to preventable illness and mortality nationwide. These behaviors do not occur in isolation—they are influenced by the same social and environmental conditions that shape opportunities for physical activity, nutrition, and preventive care. The following section examines the impact of substance use and related harms on community health, highlighting patterns, disparities, and prevention opportunities.

SUBSTANCE USE, ALCOHOL AND RELATED HARMS

Substance use disorder (SUD), the recurrent misuse of alcohol and/or other drugs, continues to have a profound impact on health and safety in Maryland. In 2023, Maryland recorded 2,513 unintentional drug- and alcohol-related intoxication deaths, reflecting a slight decrease from 2022 but a 274.4% increase since 2011 [88]. The rise has been driven largely by synthetic opioids, particularly fentanyl, which was involved in 85% of all intoxication deaths in 2023. Opioids overall accounted for 90% of these deaths, while prescription opioids were implicated in 13%, and alcohol in 10% [88].

At the county level, Montgomery County reported 138 intoxication deaths, and Prince George's County reported 217 deaths in 2023. These figures represent a 213.6% and 416.7% increase, respectively, from 2011 [88]. While both counties started with nearly identical numbers, the gap between them has widened, growing from just 2 deaths in 2011 to 79 in 2023 (see Figure 46), underscoring the disproportionate impact in Prince George's County and the need for tailored prevention and treatment strategies.

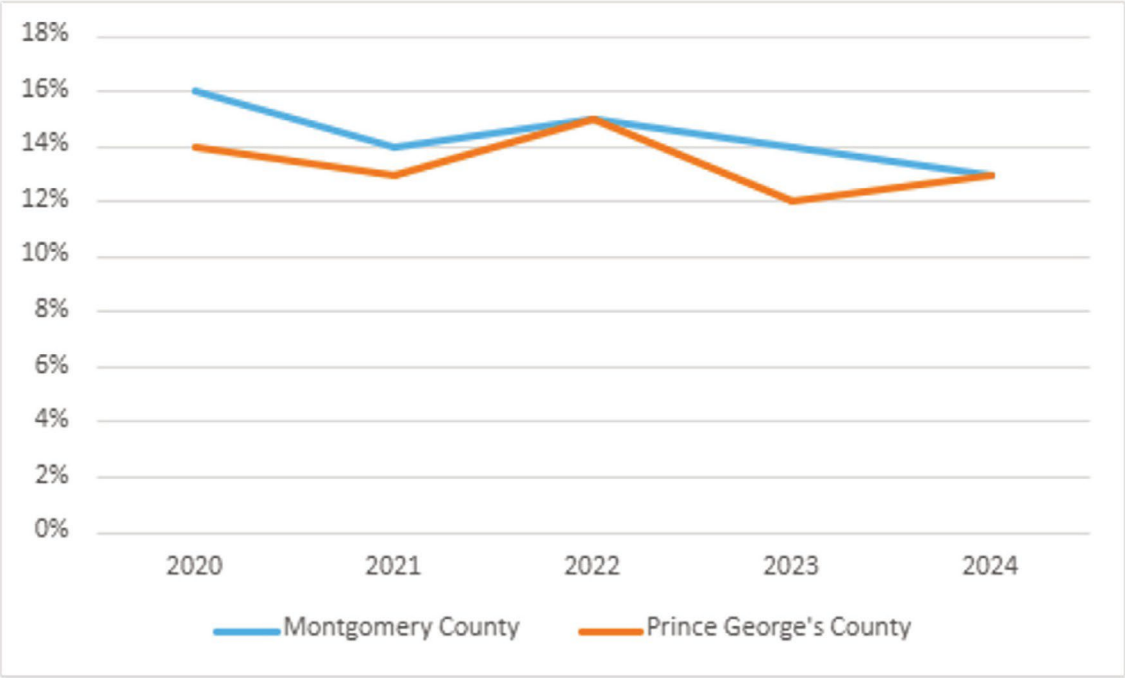
Figure 46. Total Number of Unintentional Drug- and Alcohol-related Intoxication Deaths by County, 2011-2023



Source: Maryland Department of Health, 2024. Data for 2023 and 2024 are preliminary as of 06/10/2024 and are subject to change until finalized by the Vital Statistics Administration.

Excessive alcohol use, through binge or heavy drinking, remains a significant health risk, contributing to chronic disease, injury, violence, and premature death [89]. Binge drinking is defined as consuming five or more drinks on a single occasion for men and four or more for women; heavy drinking is 15 or more drinks per week for men and eight or more for women. More than 90% of adults who drink excessively report binge drinking, and nearly 17% of U.S. adults are considered binge drinkers [90]. In 2024, 13% of adults in both Montgomery and Prince George's Counties, reported binge drinking in the past 30 days, a gradual decrease over the past five years and lower than the national average but still a rate that warrants attention (see Figure 47).

Figure 47. Percent of Adults Who Binge or Heavily Drink, 2020-2024



Source: County Healthy Rankings, 2024

Opioids, ranging from heroin to prescription pain relievers such as oxycodone, morphine, and fentanyl, remain the primary driver of intoxication deaths. The affordability and potency of fentanyl have fueled its widespread sue, often mixed with or substituted for heroin and other illicit drugs. Nearly all recent fentanyl-related deaths have involved nonpharmaceutical fentanyl produced in clandestine laboratories. Between 2019-2023, opioid-related deaths rose by 23.3% in Montgomery County and 71.6% in Prince George's County, despite a brief dip in 2022 [91].

Demographic shifts in the epidemic are also notable: fentanyl-related deaths in Maryland from 2017-2022 declined among residents under 25 (-18.7%) but increased among those 55 and older (+62.6%), non-Hispanic Black residents (+56.0%) and Hispanic residents (+157.9%) [88]. These trends highlight the urgency of prevention, harm reduction, and treatment strategies that are responsive to the changing face of the crisis.

TOBACCO USE

Tobacco use remains the leading cause of preventable disease and death in the United States, resulting in more than 490,000 deaths annually and imposing substantial economic costs through health care spending and lost productivity [92]. Cigarette smoking is responsible for nearly 30% of all cancer deaths nationwide and almost 90% of lung cancer deaths, with total annual costs exceeding $600 billion, including approximately $240 billion in health care expenditures and $372 billion in lost productivity [92]. These impacts underscore the continued importance of tobacco prevention and cessation strategies for community health planning in Montgomery County and Prince George's County.

In Maryland, lung and bronchus cancer remains the leading cause of cancer death for both men and women, accounting for 22.6% of all cancer deaths [93]. While overall adult smoking prevalence is lower among Black adults nationally compared to White adults, Black or African American residents in Maryland experience lung cancer mortality rates comparable to White residents, reflecting persistent health inequities [93]. This disparity is partly attributed to the disproportionately high use of menthol cigarettes, which are used by approximately 91% of Black smokers in Maryland compared with 40% of White smokers [93]. Menthol cigarettes make smoking easier to initiate, increase nicotine dependence, and reduce cessation success, contributing to higher disease burden despite lower smoking prevalence.

Policy measures play an important role in reducing tobacco use. In 2024, Maryland increased its cigarette excise tax from $3.75 to $5.00 per pack, making it the second-highest cigarette tax in the nation, behind New York [94]. While such policies have contributed to long-term declines in cigarette smoking, the growing use of e-cigarettes, particularly among youth and young adults, continues to shift the tobacco landscape. For Montgomery County and Prince George's County, sustained prevention, equitable tobacco-control policies, and targeted cessation support, especially in communities disproportionately affected by menthol products, remain critical priorities for reducing tobacco-related illness and mortality.

Smoking in Montgomery and Prince George's Counties

According to the Maryland 2023 Chronic Disease Burden Tables, 10.5% of Maryland adults reported smoking every day or some days. Rates were significantly lower in Montgomery County (5.2%) and Prince George's County (7.9%) compared to the state. In 2020, the most recent year for which data is available, the MCHC CBSA had a rate of 9.6%, slightly below the state average [19].

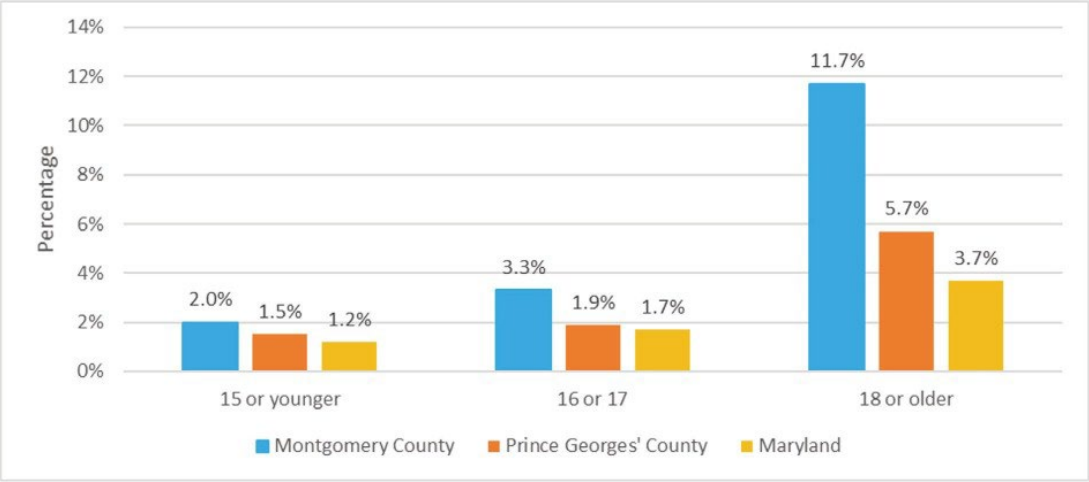
These adult smoking trends underscore the importance of addressing tobacco use early in life. Youth initiation remains a critical concern, as nearly nine in ten adults who smoke daily report trying their first cigarette before age 18, and most who ever smoke begin before age 26 [95]. In response, Maryland enacted Tobacco 21 in 2019, raising the minimum legal sales age for all tobacco products, including e-cigarettes, to 21 [96]. However, despite this policy shift, e-cigarettes have emerged as the most commonly used tobacco product among youth. National survey data estimate that more than 1.6 million middle and high school students currently use e-cigarettes, exposing

them to significant risks such as nicotine addiction and toxic substances including heavy metals and diacetyl, a flavoring chemical linked to serious lung disease [97], [98].

While combustible cigarettes remain the most lethal tobacco product, the rapid rise of vaping has significantly reshaped tobacco use patterns, particularly among adolescents and young adults. Since 2019, e-cigarette use has increased among youth nationally and regionally, often serving as a gateway to sustained nicotine dependence [97]. This trend is especially concerning given persistent misperceptions among adolescents that vaping is less harmful than smoking, despite growing evidence of respiratory, cardiovascular, and neurodevelopmental harms associated with nicotine exposure during adolescence [99].

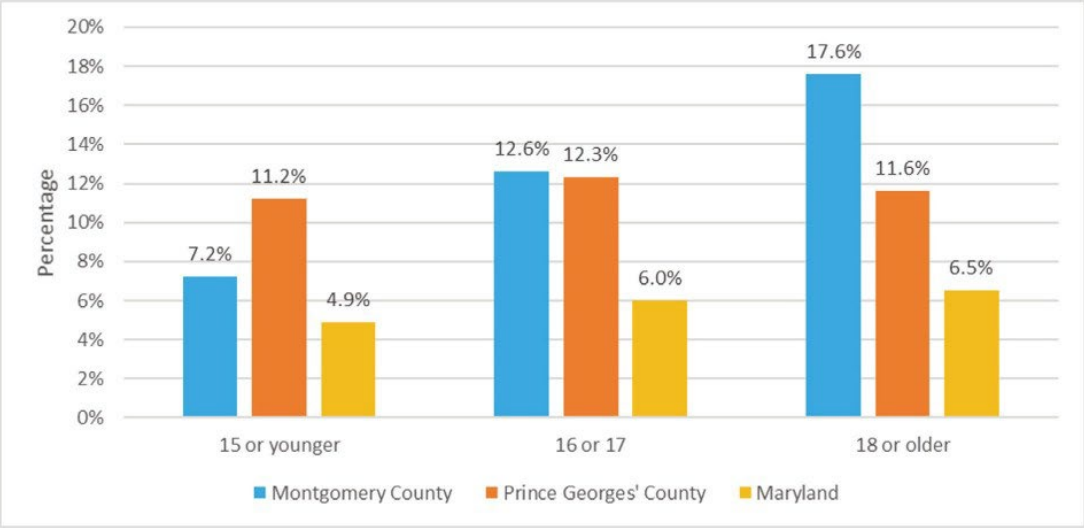
Local data further illustrate how these patterns differ by age and geography. Between 2022 and 2023, high school students ages 18 and older in Montgomery County were twice as likely as their peers in Prince George's County to report cigarette smoking in the past 30 days [100] (see Figure 48). In contrast, younger students in Prince George's County were more likely to report using electronic vapor products (see Figure 49), reflecting a shift toward vaping as the primary mode of tobacco initiation among adolescents [100]. Together, these findings suggest that while traditional cigarette use persists among older teens, vaping increasingly represents the entry point for nicotine use among younger youth, underscoring the need for prevention strategies that address both conventional tobacco products and emerging nicotine delivery systems.

Figure 48. Percent of High School Students Who Smoked a Cigarette in the Past 30 Days, 2022–2023



Source: Youth Risk Behavior Survey/Youth Tobacco Survey, CDC, 2023

Figure 49. Percent of High School Students Who Used an Electronic Vapor Product in the Past 30 Days, 2022-2023



Source: Youth Risk Behavior Survey/Youth Tobacco Survey, CDC, 2023

These contrasting patterns emphasize that tobacco use is not only a health risk but also an equity issue in Montgomery and Prince George's Counties. Black residents face a disproportionate burden from menthol-related lung cancer mortality, while youth in both counties are increasingly targeted by e-cigarette marketing and access. Addressing these disparities requires age-specific and culturally responsive prevention strategies, stronger community-based education, and policies that limit youth access to high-risk tobacco products. Without such targeted interventions, the counties risk deepening inequities in tobacco-related disease and death.

SEXUAL & REPRODUCTIVE HEALTH

Sexual and reproductive health outcomes, including rates of sexually transmitted infections (STIs) and teen births, are key indicators of health equity. These outcomes reflect not only personal behaviors, but also structural factors such as access to comprehensive education, culturally responsive preventive care, and affordable reproductive health services. In both Montgomery and Prince George's Counties, persistent disparities highlight how systemic barriers and social determinants influence who is most affected.

Rising STI rates signal gaps in prevention and treatment, while teen birth trends underscore the role of opportunity, family support, and community context. Examining these outcomes side by side provides a deeper understanding of inequities and helps identify where targeted action can improve health for adolescents, young adults, and families across the region.

TEEN BIRTHS

Adolescent birth rates are an important community health indicator, shaped not only by personal behaviors but also by access to education, reproductive health care, and economic stability. Nationally, teen birth rates have declined dramatically over the past several decades, dropping by 78% from 1991 to 2022 [101]. In 2022, the U.S. teen birth rate reached a historic low of 13.5 births per 1,000 females aged 15–19, reflecting substantial progress but also underscoring the

importance of sustained prevention efforts [102].

Maryland has followed similar trends. The statewide teen birth rate fell from 17.5 per 1,000 in 2012 to 10.5 in 2022 [103]. Both Montgomery and Prince George's Counties experienced declines, though disparities persist. In 2022, Montgomery County reported a rate of 5.1 per 1,000, compared to Prince George's County at 13.9 per 1,000—more than twice as high [103], [104]. Prince George's County remains among the highest in the state, despite overall improvement.

Racial and ethnic disparities are also evident. Across Maryland and nationally, Hispanic and Black adolescents continue to experience higher teen birth rates compared to White and Asian peers [105], [103]. These differences are driven by structural factors such as inequitable access to comprehensive sexual health education, contraception, affordable reproductive health care, and the broader social and economic conditions that shape opportunity.

Reducing teen births has far-reaching benefits. Lower rates are associated with improved health outcomes for mothers and infants, higher educational attainment for young parents, greater economic stability for families, and stronger community well-being overall [106]. The continued decline in teen birth rates demonstrates progress, but persistent racial and geographic disparities highlight the need for targeted strategies that ensure equitable access to reproductive health care and support services for adolescents in both Montgomery and Prince George's Counties.

SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted infections (STIs) are infections spread primarily through sexual contact, including chlamydia, gonorrhea, syphilis and HIV. The CDC estimates that in 2018, nearly 68 million people in the U.S. were living with a sexually transmitted infection, about 20% of the population on any given day. Almost half of all new infections, 26 million in 2018, occurred among adolescents and young adults, reflecting the disproportionate impact on younger populations.

These infections affect people of all backgrounds, but young people, racial and ethnic minorities, and those with limited access to preventive care are disproportionately impacted. The overall economic burden was nearly $16 billion to the health care system, underscoring how inequities in education, prevention, and access to care contribute to both health and financial costs.

CHLAMYDIA

Chlamydia remains the most commonly reported sexually transmitted infection in the U.S., with more than 1.6 million cases reported in 2023. Nationally, rates showed only minor increases from 2022 to 2023, 1.3% for men and 1.7% for women—suggesting relative stability. However, it's important to note that chlamydial infections are often asymptomatic and typically identified through screening, meaning reported decline since 2019 likely reflects reduced screening and underdiagnosis during the COVID-19 pandemic, rather than a true drop in new infections.

In Maryland, the statewide chlamydia rate increased from 509.6 per 100,000 in 2018 to 623.9 in 2022, indicating a growing public health concern. Montgomery County, by contrast, has experienced a steady decline dropping from 419.0 per 100,000 in 2018 to 338.6 in 2022, with a

slight increase to 421.6 in 2023. Meanwhile, Prince George's County continues to report significantly higher rates, with 805.5 cases per 100,000 in 2023, among the highest in the state, despite a downward trend since its peak in 2019 (see Table 7).

Table 7. Cases of Chlamydia Reported in Maryland, 2018-2022

Location	2018	2019	2020	2022
Maryland	509.6	552.1	587.2	623.9
Montgomery County	419	447	362.6	338.6
Prince George's County	881.3	906.4	766.7	665.9

Source: Maryland Department of Health Prevention and Health Promotion Administration, 2024

GONORRHEA

Gonorrhea was the second most commonly reported sexually transmitted infection in the U.S. in 2023. After years of steady increases, national rates have begun to decline, with a 9.2% decrease from 2021 to 2022 and an additional 7.7% decrease between 2022 and 2023. Gonorrhea most commonly affects youth ages 15–24 and can infect the genitals, rectum, and throat. While typically asymptomatic and treatable, rising antibiotic resistance has complicated treatment. Left untreated, gonorrhea can cause serious and permanent health consequences, including pelvic inflammatory disease and infertility in women.

In Maryland, gonorrhea rates have fluctuated over time, peaking at 199 cases per 100,000 in 2019, dropping during the COVID-19 pandemic to 169.8 in 2020, and rebounding to 181.1 in 2022. At the local level, Montgomery County reported a rate of 116.3 cases per 100,000 in 2023, significantly lower than Prince George's County's 298.7 cases per 100,000 (see Table 8). This disparity has been consistent over time, with Prince George's County experiencing a much higher burden of disease than both Montgomery County and the state average.

Table 8. Cases of Gonorrhea Reported in Maryland, 2018-2022

Location	2018	2019	2020	2022
Maryland	191.5	199	169.8	181.1
Montgomery County	62.7	79.3	89	79
Prince George's County	222.1	240.9	249.2	238.2

Source: Maryland Department of Health Prevention and Health Promotion Administration, 2024

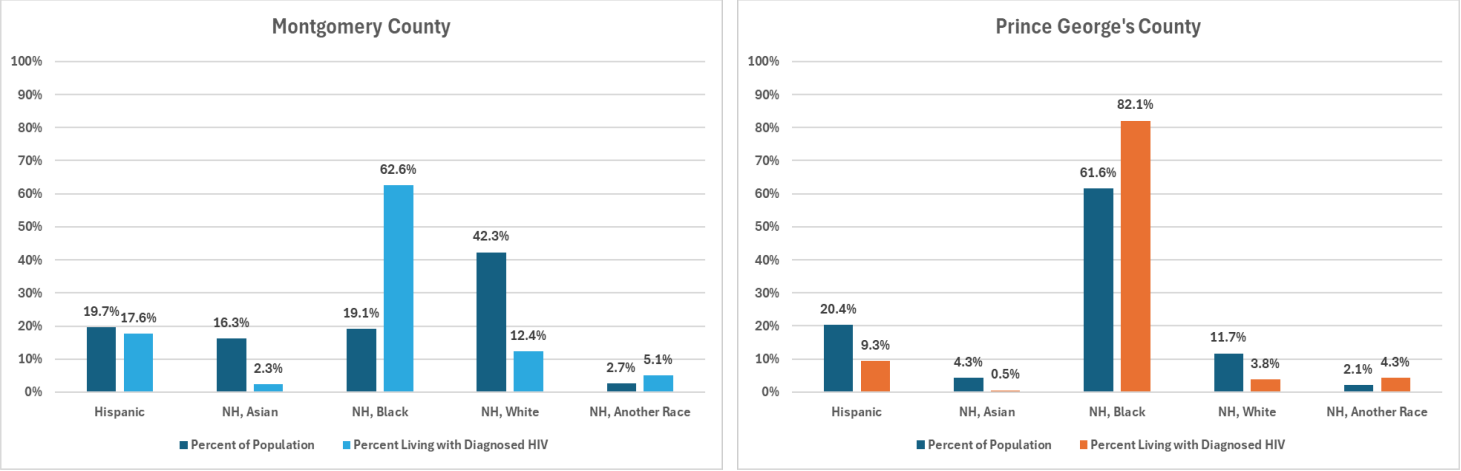
HIV/AIDS

Human immunodeficiency virus (HIV) attacks a person's immune system by destroying CD4 cells, which are critical for fighting off infections and diseases [107]. If left untreated, HIV infection can progress to acquired immunodeficiency syndrome (AIDS), the most severe stage of the disease. HIV is primarily transmitted through sexual contact, exposure to certain body fluids, and needle or syringe use. While HIV affects people of all races, ethnicities, genders, and sexual orientations, the highest risk is among men who have sex with men, particularly Black men who have sex with men and young people under the age 30.

In Maryland, new HIV diagnoses declined steadily until 2019 but have since plateaued, underscoring the need for sustained prevention and treatment efforts. Prince George's County continues to carry the highest burden in the state, reporting more than twice the number of new HIV cases as Montgomery County. In both counties, Black and Hispanic residents experience higher rates of HIV diagnoses compared to White residents.

Significant racial and ethnic disparities exist in the prevalence of diagnosed HIV among individuals aged 13 and older. Non-Hispanic Black residents are disproportionately affected, representing 62.6% of HIV diagnoses in Montgomery County and 82.1% in Prince George's County, despite comprising only 19.1% and 61.6% of their respective populations. Conversely, Non-Hispanic White and Asian populations are consistently underrepresented in HIV diagnoses relative to their population shares (see Figure 50). Hispanic residents show moderate underrepresentation, particularly in Prince George's County. These disparities highlight the need for targeted HIV prevention, education, and treatment efforts that address systemic inequities and improve access to care for disproportionately impacted communities.

Figure 50. Percent of Population Aged 13+ Living with Diagnosed HIV vs. Percent of Total Population, by Race/Ethnicity and County.



Source: Maryland Department of Health. *Montgomery County and Prince George's County HIV Progress Reports, 2023.*

HIV prevention has advanced significantly with the introduction of pre-exposure prophylaxis (PrEP), a daily medication that reduces the risk of acquiring HIV through sex by about 99% when taken consistently. Despite its effectiveness, PrEP uptake remains low among those who could benefit the most, particularly Black and Hispanic men who have sex with men and young adults under 30. Expanding access to PrEP, along with HIV testing and culturally responsive education, is a central strategy of the federal *Ending the HIV Epidemic* initiative, which includes both Montgomery and Prince George's Counties as priority jurisdictions. Addressing gaps in PrEP awareness and utilization is essential to reducing new HIV diagnoses and eliminating disparities in the region.

Although HIV can be effectively managed with antiretroviral therapy, which reduces transmission and allows people to live long, healthy lives, there is still no cure. These persistent disparities highlight the need for culturally tailored prevention, testing, and treatment strategies, particularly in communities of color and among young adults in Prince George's County.

SYPHILIS

After reaching a historic low in 2000, cases of primary and secondary syphilis have risen steadily in the United States, particularly among men who have sex with men, many of whom are co-infected with HIV. Syphilis can also be transmitted from mother to infant during pregnancy, leading to congenital syphilis, a condition associated with severe outcomes such as stillbirth, infant death, and lifelong complications.

Nationally, congenital syphilis has become one of the fastest-growing public health crises. In 2023, there were 3,882 reported cases, including 279 stillbirths and infant deaths, a 47% increase from the previous year. Most cases stemmed from missed opportunities for timely prenatal care or syphilis testing, and women of reproductive age (15–44 years) have experienced sharp increases in syphilis rates in the past decade.

In Maryland, primary and secondary syphilis rates have mirrored national trends. The statewide rate in 2023 was 14.2 per 100,000, higher than Montgomery County (6.1 per 100,000) but lower than Prince George's County (15.5 per 100,000). Congenital syphilis has also risen in both counties: Montgomery County reported 42.6 cases per 100,000 live births in 2023, a nearly 70% increase since 2019, while Prince George's County reported 99.9 per 100,000, reflecting a 136% increase [108].

Table 7. Cases of Syphilis Reported in Maryland, 2018-2022

Location	2018	2019	2020	2022
Maryland	**12.2**	**14.3**	**14.4**	**12.7**
Montgomery County	**6.3**	**8.5**	**7.2**	**8.6**
Prince George's County	**16.8**	**18.5**	**17.9**	**11.7**

Source: Maryland's Department of Health Prevention and Health Promotion Administration 2022 Annual Maryland STI Report, 2024

Racial and ethnic disparities remain pronounced. Nationally, Black and Hispanic infants are disproportionately affected by congenital syphilis, reflecting inequities in access to prenatal care, timely testing, and treatment. These inequities are mirrored locally, where Prince George's County's higher burden points to structural barriers that exacerbate disparities. Early detection and treatment of syphilis remain critical, as untreated infection can progress through stages with increasingly severe consequences for the heart, brain, and other organs. Strengthening access to prenatal care, screening, and timely treatment is essential to reversing these rising trends.

Sexually transmitted infections, HIV, and teen births together reflect deep inequities in prevention, education, and access to care. Across Montgomery and Prince George's Counties, young people, racial and ethnic minorities, and individuals with limited access to health care carry a disproportionate burden of chlamydia, gonorrhea, syphilis, HIV, and adolescent pregnancies.

Prince George's County consistently reports higher rates of both STIs and teen births than

Montgomery County, underscoring the influence of structural barriers such as poverty, gaps in health insurance, and limited access to culturally responsive services. The sharp rise in congenital syphilis, persistent racial disparities in HIV diagnoses, and disproportionate teen birth rates among Black and Hispanic youth highlight how missed opportunities—such as delayed prenatal care, reduced screening, and limited PrEP utilization, compound inequities.

Addressing these inequities requires a multi-faceted approach:

- Expanding access to comprehensive and culturally responsive sexual health education,
- Strengthening routine screening and early treatment for STIs,
- Ensuring equitable access to contraception and prenatal care,
- Scaling up prevention tools like PrEP,
- Providing wraparound supports for adolescent parents to improve long-term health and socioeconomic outcomes.

By centering these strategies in communities most affected, Montgomery and Prince George's Counties can reduce preventable infections, narrow racial and ethnic gaps, and foster healthier futures for adolescents, families, and the broader community.

HEALTHY FOOD ACCESS AND FOOD SECURITY

Food access is not only a matter of individual choice but a reflection of the health infrastructure that surrounds communities. Grocery stores, farmers markets, food pantries, transportation networks, and public nutrition programs together form the systems that determine whether residents can obtain healthy food. When these systems fail, communities face food insecurity, poor diet quality, and health inequities.

The World Health Organization identifies access to safe and adequate food as a basic human right, yet in 2024 the USDA reported that more than 47 million Americans were unable to reliably meet their food needs. For some households, this means disrupted eating patterns and reduced food intake; for others, coping strategies such as eating less varied diets or depending on food assistance programs. These outcomes underscore that food systems must be viewed as essential health infrastructure, no less critical than clinics, hospitals, or clean water.

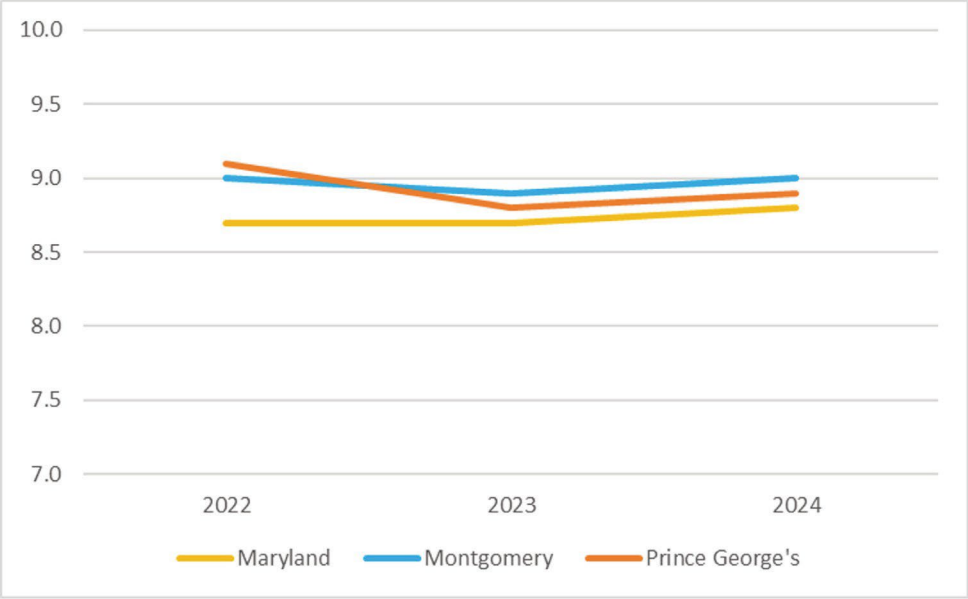
FOOD ENVIRONMENT INDEX

The County Health Rankings measure of the food environment accounts for both proximity to healthy foods and the ability to afford them. This measure includes access to healthy food by considering the distance an individual lives from a grocery store or supermarket 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.

From 2022 to 2024, the Food Environment Index remained relatively stable across Maryland,

Montgomery County, and Prince George's County. Both counties consistently outperformed the state average, reflecting stronger local food environments. While Prince George's County held a slight lead over Montgomery County in 2022 and 2023, Montgomery County surpassed it in 2024. These trends highlight the relative strength of food access in both counties compared to the broader state context, with Montgomery County showing a modest upward shift in the most recent year (see Figure 51).

Figure 51. Food Environment Index, 2022-2024



Source: County Health Rankings & Roadmaps, 2024

FOOD DESERTS

Food deserts represent a structural barrier within the food system, where residents lack reasonable access to affordable, nutritious foods. According to the USDA, about 19 million people, roughly 6% of the U.S. population, lived in food deserts in 2015 [109]. The definition varies by geography: in urban areas, residents must live more than one mile from a supermarket, while in rural areas the threshold is more than 10 miles. Rural communities, while making up 63% of U.S. counties, account for 87% of the counties with the highest rates of food insecurity.

Households in food deserts often encounter an oversupply of convenience stores and small retailers, which provide lower-quality, less varied, and more expensive food options compared to suburban supermarkets. Limited transportation further compounds barriers, particularly for people with disabilities, residents in rural areas, and minority populations.

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

- Low-income (LI): poverty rate ≥20% or median family income ≤80% of the statewide or metropolitan area median.
- Low-access (LA): at least 500 people or 33% of the tract's population live more than one

mile (urban) or ten miles (rural) from the nearest supermarket.

Local trends show diverging experiences. Between 2015 and 2019, the number of low-income, low-access (LILA) tracts in Montgomery County declined from five to three, suggesting modest improvements in food access. By contrast, Prince George's County saw an increase from 20 to 25 tracts, highlighting persistent structural barriers to healthy food access (see Table 9 and Table 10).

Table 9. Total Food Desert LILA Census Tracts Montgomery County, 2015 & 2019

Census Tract	2015	2019	Status
24031700310	✓	✓	Unchanged
24031700818	✓	✓	Unchanged
24031700819	✓	✗	Removed
24031703215	✓	✗	Removed
24031703220	✓	✗	Removed
24031703301	✗	✓	Added

Source: U.S. Federal Agriculture Service Economic Research Service, 2015-2019

Table 10. Food Desert LILA Census Tracts Prince George's County, 2015 & 2019

Census Tract	2015	2019	Status
24033800206	✓	✗	Removed
24033800412	✓	✓	Unchanged
24033801104	✓	✗	Removed
24033801312	✓	✗	Removed
24033801406	✓	✗	Removed
24033801704	✓	✗	Removed
24033801708	✓	✗	Removed
24033801904	✓	✗	Removed
24033801906	✓	✗	Removed
24033802001	✓	✗	Removed
24033802201	✓	✗	Removed
24033802404	✓	✗	Removed

Census Tract	2015	2019	Status
24033802804	✓	✗	Removed
24033803605	✓	✗	Removed
24038800601	✗	✓	Added
20438800704	✗	✓	Added
20438801406	✗	✓	Added
20438801409	✗	✓	Added
20438801704	✗	✓	Added
20438801708	✗	✓	Added
20438802001	✗	✓	Added
20438802201	✗	✓	Added

Source: U.S. Federal Agriculture Service Economic Research Service, 2015-2019

POVERTY AND FOOD INSECURITY

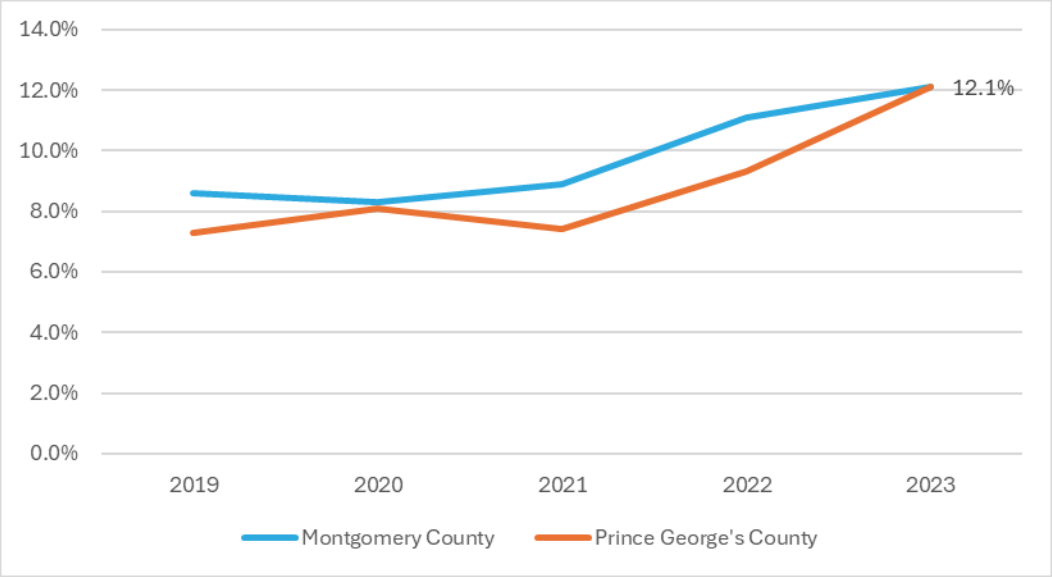
Food insecurity is both an economic and social indicator of community health and a reflection of weaknesses in local infrastructure. The USDA defines food insecurity as the lack of consistent access to enough food for an active, healthy life. It can be temporary or long-term and is closely tied to poverty and unemployment, which are strong predictors of hunger in the U.S. At the root of most food insecurity is financial instability and the difficult trade-offs households face between purchasing nutritious food and covering other essentials such as housing, health care, or transportation [110].

From 2019 to 2023, food insecurity among the overall population rose markedly in both Montgomery and Prince George's Counties. Montgomery County experienced a steady increase from just over 8% in 2019 to 12.1% in 2023, while Prince George's County saw a slight dip mid-period before rising sharply to match Montgomery County at 12.1% in 2023 (see Figure 52). This convergence at a higher rate underscores a growing regional challenge and highlights the urgent need for coordinated food access strategies and community-based support systems.

Food insecurity disproportionately affects communities of color, low-income households, and people living with disabilities. Across the District of Columbia, Maryland, and Virginia region, of those experiencing food insecurity, 42% were Black/African American, 24% were Hispanic, and 18% were White [111]. People living with disabilities face more than double the rate of food insecurity compared to adults without disabilities, due to higher medical costs, reduced workforce participation, and mobility barriers to food access. Education level is also a strong predictor: nearly 27% of adults without a high school diploma experience food insecurity compared to just 5% of

college graduates [111].

Figure 52. Food Insecurity among the Overall Population by County, 2019-2023



Source: Map the Meal Gap, Feeding America, 2025

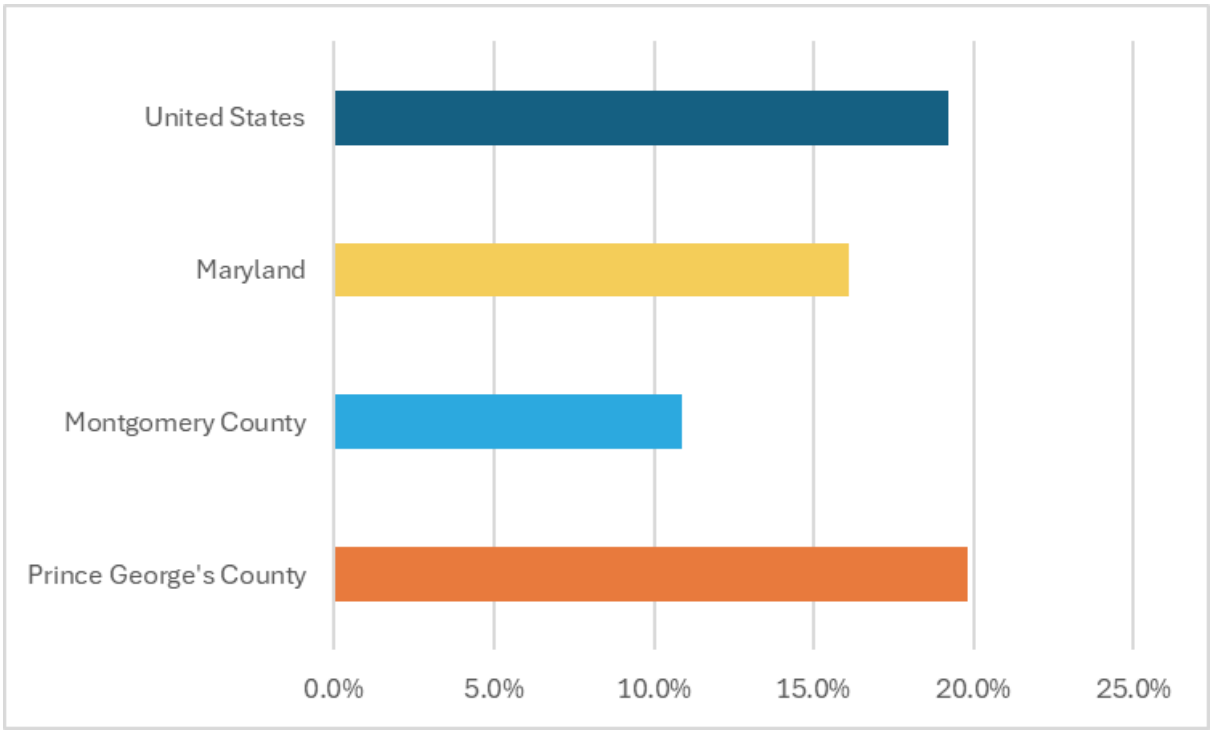
The Capital Area Food Bank Hunger Report 2024 highlights how the pandemic reshaped food insecurity. While long-standing food-insecure households remain vulnerable, new groups have emerged, including older adults, single mothers, immigrants, and multigenerational families. These households are more likely to be employed but face eviction risk, lack English proficiency, or have limited knowledge of public benefits. They are also less likely to access programs such as SNAP or school meal assistance, often due to misinformation or perceived ineligibility. Latino households were particularly overrepresented among the newly food insecure, reflecting the disproportionate economic impact of job loss and reduced hours in industries with high Latino labor participation [111].

Local response has been critical. Both Montgomery and Prince George's Counties strengthened food security infrastructure through expanded food distributions, partnerships with the Capital Area Food Bank, and community-based efforts such as Manna Food Center, the UpCounty Hub, and local food security task forces. These programs complement federal nutrition benefits by addressing immediate needs, providing culturally appropriate food options, and supporting long-term food system resilience.

While these local efforts have strengthened food security infrastructure, they are not equally felt across all populations, especially among children, who remain disproportionately affected by food insecurity. Children remain among the most vulnerable to food insecurity, and local data show stark differences across jurisdictions. In Prince George's County, nearly one in five children (19.8%) live in food-insecure households, a rate slightly higher than the national average of 19.2%. Maryland's statewide rate is lower at 16.1%, while Montgomery County reports the lowest level in the region at 10.9% (see Figure 53). These disparities highlight the importance of targeted strategies, particularly in Prince George's County, where food insecurity threatens not only children's

immediate well-being but also their long-term health and educational outcomes. The 2022 Maryland Youth Risk Behavior Survey further underscores this gap: in Prince George's County, 26% of high school students and 21% of middle school students reported food insecurity, compared to 7.8% and 10.8% in Montgomery County [100].

Figure 53. Percent of Children That Are Food Insecure in the United States, Maryland, Montgomery County, and Prince George's County.



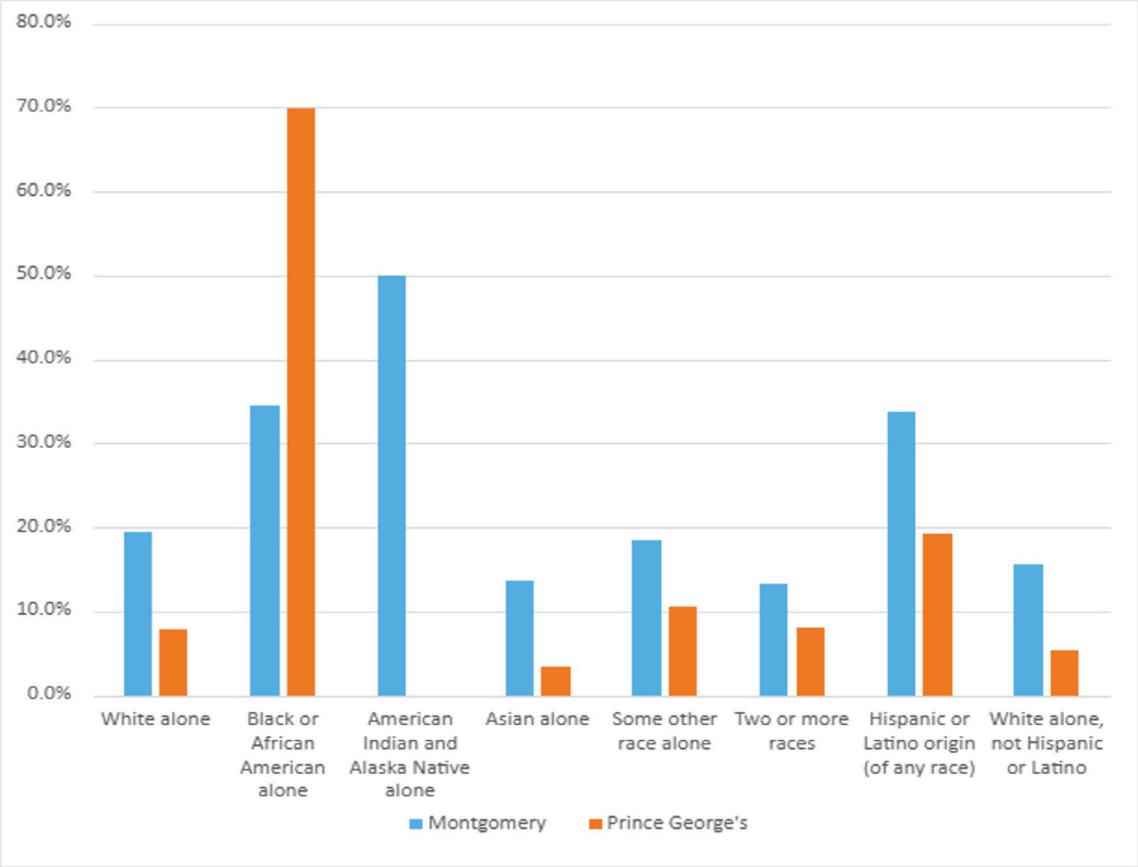
Source: Feeding America Research, 2022

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

These local disparities underscore the critical role of federal nutrition programs in bridging gaps and supporting vulnerable populations, especially children. SNAP is the largest federal nutrition assistance program and a cornerstone in the fight against hunger. In Maryland, approximately one in nine residents, about 670,866 individuals, relied on SNAP benefits each month in FY2023 [113]. Statewide, SNAP benefits play a crucial role in supporting vulnerable populations. Over 62% of SNAP participants are families with children, nearly 38% are families with members who are elderly or disabled, and more than 34% are in working families [114]. However, participation is uneven, with many eligible households not enrolled due to barriers such as stigma, immigration fears, misinformation about eligibility, lengthy application processes, and low benefit levels.

Local data show that in Montgomery County, American Indian/Alaska Natives are most likely to receive SNAP benefits, followed by Black/African Americans and Hispanic/Latino households. In Prince George's County, Black/African Americans make up the largest share of participants (see Figure 54). Despite these participation levels, a significant proportion of eligible families, including immigrants and seniors, remain unenrolled.

Figure 54. Percent Households Receiving SNAP Benefits by Race/Ethnicity and by County, 2023



Source: U.S. Census Bureau, American Community Survey Office, 2023

Both Montgomery and Prince George's Counties' health and human service agencies, in partnership with nonprofits, have launched SNAP outreach and enrollment assistance programs to address the gaps. Programs include multilingual application support, benefits navigation at food pantries, and partnerships with trusted organizations to build awareness and reduce stigma.

The health implications of underutilization are significant. Research shows that access to SNAP reduces hospital admissions by 14% and nursing home admissions by 23% among older adults, with each $10 increase in monthly benefits linked to reduced hospital stays [115]. Yet nearly half of dual-eligible older adults in Maryland are not enrolled, underscoring the urgent need for outreach.

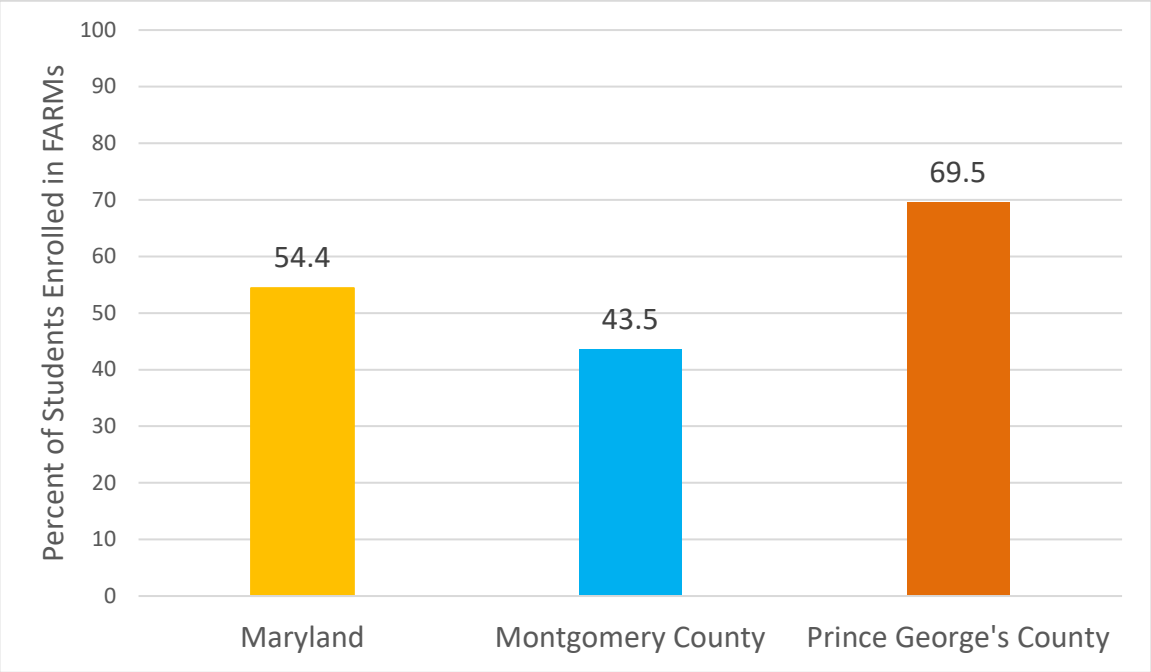
FREE AND REDUCED-PRICE MEAL PROGRAMS

Federal child nutrition programs, including the National School Lunch Program (NSLP), School Breakfast Program, and summer meals programs, play a critical role in addressing child food insecurity. These programs ensure millions of children have reliable access to healthy meals during the school year and summer months.

Participation in Free and Reduced-Price Meal (FARM) programs varies considerably across Maryland, reflecting underlying economic conditions and geographic disparities (Figure 55). Statewide, more than half of public school students rely on school-based meal assistance,

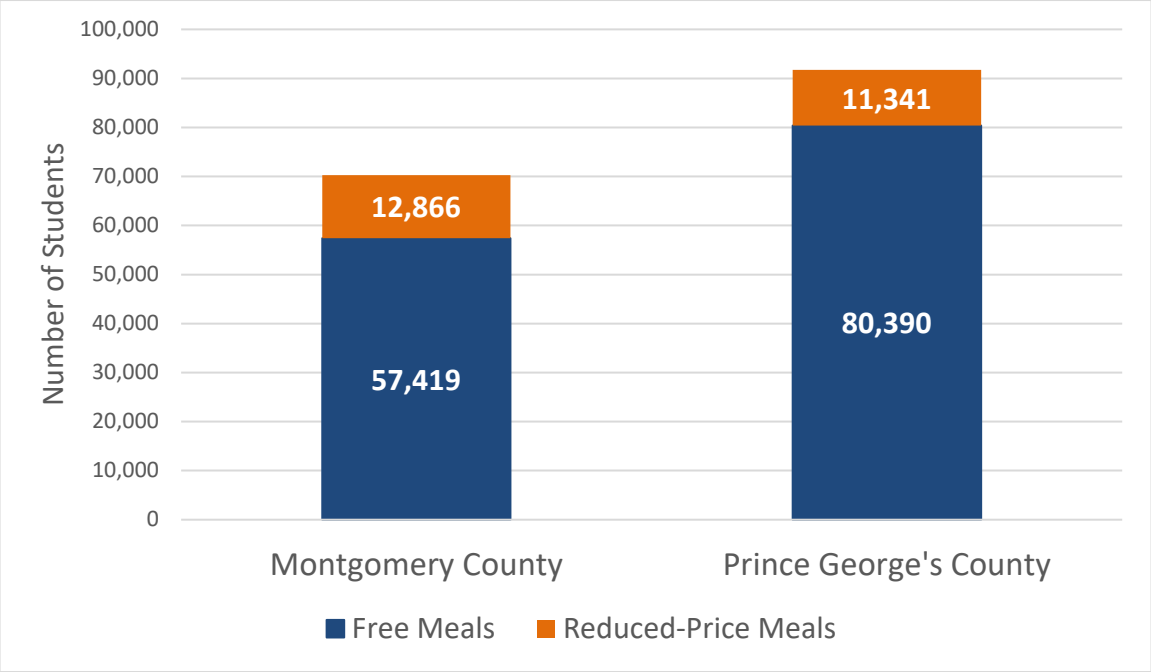
signaling widespread economic need [116]. Enrollment in Montgomery County is substantially lower than the state average, consistent with higher median household incomes. In contrast, Prince George's County shows markedly higher participation, highlighting persistent structural and economic challenges faced by many families. Together, these patterns underscore the strong relationship between place, income, and child food security.

Figure 55: Free and Reduced-Price Meal (FARM) Enrollment Rates, 2022–2023



Source: Maryland State Department of Education, 2023

Figure 56: Students Receiving FARMs by Type (2022-2023)



Source: Maryland State Department of Education, 2023

Both counties have expanded food access through universal free breakfast in high-need schools, summer meal distribution sites, and weekend backpack programs in partnership with local food banks. These strategies not only fill nutritional gaps but also reduce stigma by making participation seamless and equitable across school communities.

By ensuring children receive daily meals, FARMs not only address immediate nutritional needs but also support long-term educational outcomes, physical health, and overall well-being. However, disparities in participation and outreach highlight the need for consistent efforts to reduce stigma, expand access during out-of-school times, and ensure immigrant families are informed of eligibility.

Taken together, poverty and food insecurity create cascading impacts on health across Montgomery and Prince George's Counties. While both counties perform relatively well on food environment indicators, structural inequities mean that low-income households, communities of color, children, seniors, and immigrant families remain disproportionately affected. Food insecurity contributes directly to chronic disease, poor maternal and child health outcomes, and diminished educational attainment. Strengthening participation in programs like SNAP and FARMs, alongside local initiatives such as Manna Food Center, Capital Area Food Bank partnerships, and county food security coalitions, is essential to reducing disparities and ensuring equitable access to healthy food as a foundation for community health.

ACCESS TO HEALTH CARE AND CLINICAL CARE

Access to affordable, high-quality, and timely health care is essential for preventing illness, detecting conditions early, and supporting longer, healthier lives. Advances in clinical care, such as vaccines, surgical innovations, preventative screenings, telehealth, and care coordination, have significantly improved life expectancy and overall health outcomes. These innovations continue to evolve, enhancing the quality and accessibility of care across diverse populations and geographic regions. A broader understanding of health care systems helps explain why some communities experience better outcomes than others, underscoring the importance of continued investment in innovation and infrastructure.

Despite these advancements, approximately 25.6 million Americans remain uninsured and face persistent barriers to care. Challenges such as provider shortages, high out-of-pocket costs, language barriers, and transportation limitations disproportionately affect marginalized groups, leading to delayed diagnoses, poorer health outcomes, and higher mortality rates. Access to care also varies widely by income, race, ethnicity, and location. Addressing these disparities is critical to achieving equitable health outcomes and ensuring that all individuals, regardless of background, can benefit from the progress made in clinical care.

ACCESS TO HEALTH INSURANCE

Access to health care is essential for achieving and maintaining good health. The 2025 County Health Rankings model emphasizes that access to care, including its quality, timeliness, and affordability, accounts for approximately 20% of health outcomes. Comprehensive systems that deliver safe, effective, and culturally responsive care are critical to ensuring individuals receive the

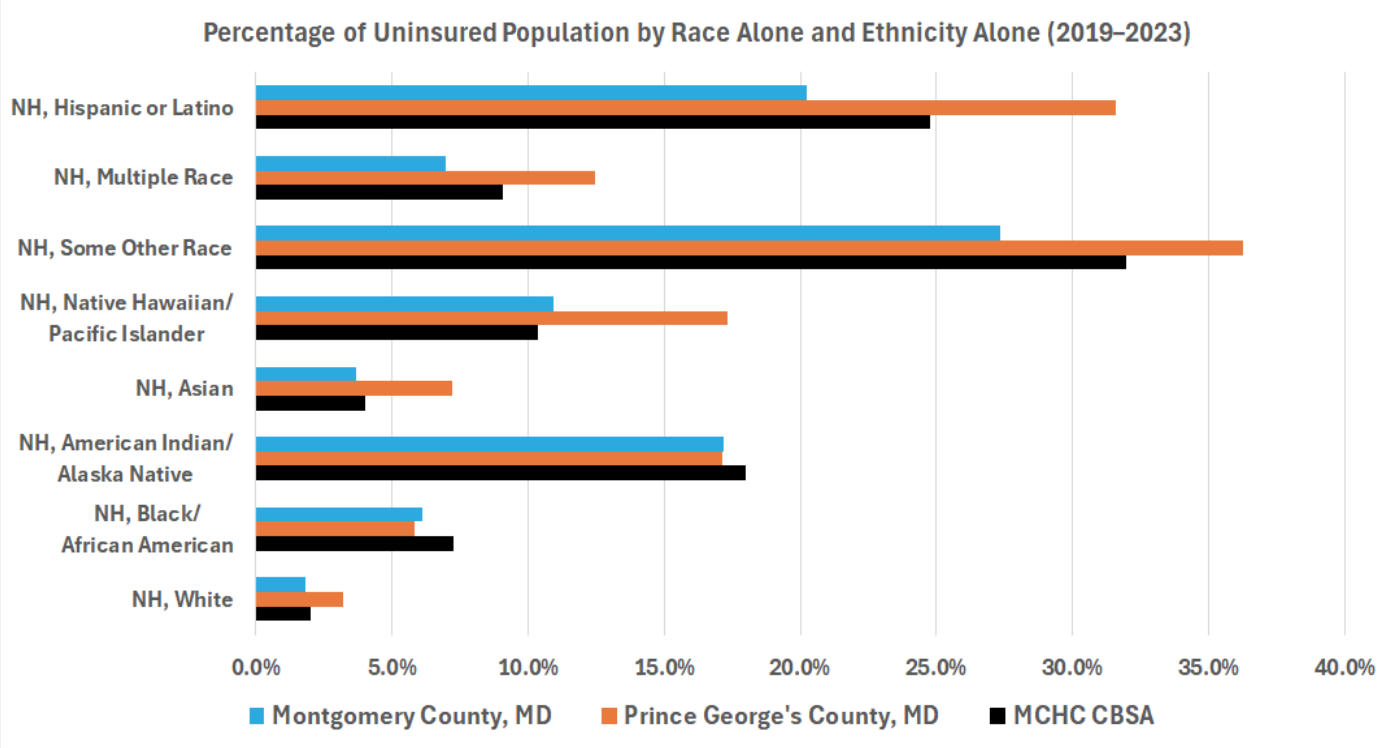
right care at the right time. As of 2025, about 11% of Americans under age 65 remain uninsured [117]. Lack of insurance is a major barrier to accessing preventive services, medications, and timely treatment, often resulting in worse health outcomes and higher costs.

Lack of insurance is a major barrier to preventive services, medications, and timely treatment, often resulting in worse health outcomes and higher costs. The U.S. spends more on healthcare than any other country in the Organization for Economic Co-operation and Development (OECD),[2] yet ranks 31st in life expectancy at birth among the 38 member nations [118]. These disparities reflect both the high cost of health care and the systemic challenges of access, particularly for uninsured and underinsured populations.

UNINSURED

Maryland has made significant progress in expanding health insurance coverage through the Affordable Care Act and the Maryland Health Benefit Exchange (MHBE) [119]. Between 2011 and 2023, uninsured rates fell across most demographic groups: from 12.2% to 5.1% among African American/Black residents, from 31.4% to 19.8% among Hispanic residents (see Figure 57), and from 21.0% to 10.5% among youth [120], [121]. During the 2023 open enrollment period, MHBE enrollment reached a record 182,166 individuals, with Montgomery County enrollment increasing by 2.1% and Prince George's County by 1.5% [122].

Figure 57. Percentage of the uninsured population in Maryland by race alone and ethnicity alone from 2019 to 2023.



Source: U.S. Census Bureau, American Community Survey, 2019–2023

[2] The Organization for Economic Co-operation and Development (OECD) is an international organization that promotes policies aimed at improving the economic and social well-being of people around the world. It provides a platform for governments to collaborate, share data, and develop best practices on a wide range of issues including economic policy, education, environmental sustainability, and development.

While 9.1% of the MCHC CBSA population remains uninsured [121], all hospitals in the region provide emergency care regardless of ability to pay and offer financial assistance programs [122]. Maryland's global budget system[3] also helps support coverage for uninsured inpatients.

Despite this progress, coverage gaps remain. Within the MCHC CBSA, 8.9% of residents remain uninsured compared to 7.2% in Montgomery County, 9.8% in Prince George's County and 6.5% statewide [19]. Men, Black/African Americans, and Hispanic/Latinos have some of the lowest insured rates across both counties, highlighting a need for targeted outreach and support [124]. Children are also impacted by coverage gaps. In 2023, approximately 6.5% of children over age six in Prince George's County were uninsured, nearly twice the rate observed among children in Montgomery County [124]. Although younger children generally experience higher insurance due to public programs, meaningful geographic disparities persist across age groups [125].

The consequences of being uninsured are significant. Adults without insurance are more likely to experience late-stage cancer diagnoses, higher cancer mortality, and unmanaged chronic conditions that lead to avoidable emergency department visits [126]. In Maryland, 8.9% of adults reported needing a doctor but not being able to afford a visit in the past year, with the highest burden among Hispanic residents, women, young adults, and households earning less than $25,000 annually [127]. For children, lack of insurance increases risks of missed immunizations, untreated illnesses, and poorer academic performance [128]. Medicaid and the Children's Health Insurance Program (CHIP) provide critical safety nets for children and families offering coverage for preventive, dental, vision, prescription, and behavioral health services [129].

MEDICAID

Medicaid is the largest public health insurance program in the United States, covering one in five Americans and serving as the primary source of long-term care coverage. It plays a pivotal role in the health system by reducing barriers to care for low-income individuals and families, pregnant women, people with disabilities, and others facing complex health needs. By financing nearly one-fifth of all personal health care spending, Medicaid not only improves access to care but also supports hospitals, community health centers, and the broader health care workforce.

The program's importance was underscored during the COVID-19 pandemic, when enrollment and spending rose sharply in response to increased need. Nationally, Medicaid spending grew by 9.2% in 2020, reflecting the program's role as a vital safety net during times of crisis. Each state administers its own program, tailoring eligibility and benefits to meet resident needs [130]. In Maryland, Medicaid offers little to no out-of-pocket costs for a wide range of services, including preventive and specialty care, mental health treatment, and prescription coverage. This comprehensive scope of benefits ensures that enrollees can access physician-recommended care

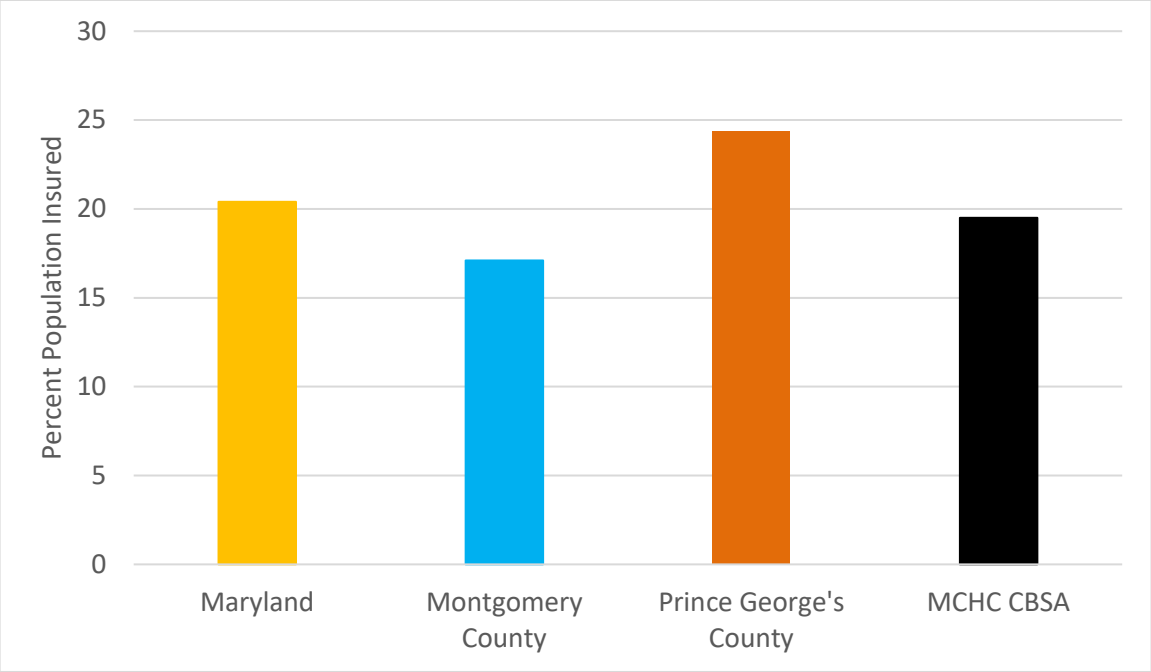
[3] Maryland's global budget system is a unique hospital payment model in which hospitals receive a fixed annual revenue amount to cover all inpatient and outpatient services, regardless of the volume of care provided. This approach incentivizes hospitals to focus on preventive care, reduce unnecessary admissions, and improve efficiency. Overseen by the Health Services Cost Review Commission (HSCRC), the model ensures equitable pricing across all payers and supports financial stability for hospitals while promoting better health outcomes for patients

without significant financial burden.

As of 2023, approximately 1.5 million Maryland residents, more than one in five, were enrolled in Medicaid [129]. Enrollment is particularly high among vulnerable groups such as children, pregnant women, and individuals with disabilities. The program's impact is evident in the percentage of enrollees within the MCHC CBSA (19.5%), Montgomery County (17.1%) and Prince George's County (24.4%), where Medicaid coverage helps reduce health disparities by ensuring access to prenatal care, chronic disease management, and behavioral health services [19] (see Figure 58). Medicaid's reach into these communities is especially critical for low-income households and residents who would otherwise remain uninsured.

Medicaid remains central to efforts to improve health equity in Maryland. By offering comprehensive, affordable coverage to those most at risk of poor health outcomes, the program reduces disparities in access, strengthens community health infrastructure, and protects families from the financial burden of health care costs.

Figure 58. Percentage of Insured Population Receiving Medicaid, 2015-2023



Source: U.S. Census Bureau, 2023

ACCESS TO CLINICIANS

Access to clinicians, including primary care providers, dentists, and mental health professionals, is fundamental to achieving positive health outcomes. Having a usual source of care ensures that individuals receive timely checkups, screenings, and treatment, reducing the risk of preventable complications and improving health outcomes. Clinical care goes beyond treating illness, primary care providers coordinate preventive and chronic care, dentists address oral health needs closely tied to overall health, and mental health professionals provide essential support for behavioral and emotional well-being.

Communities with sufficient access to clinicians experience lower rates of preventable hospitalizations, reduced mortality, and stronger population health. Yet shortages and uneven distribution of providers across Montgomery and Prince George's Counties highlight persistent gaps in access that disproportionately affect low-income, minority, and immigrant populations.

PRIMARY CARE

Having a usual place for checkups, screenings, and ongoing treatment is a key driver of timely care and prevention of avoidable complications [131]. The Healthy People 2030 national health target aims to increase the proportion of people with a usual primary care provider to 84.0%. In Maryland, 83.5% of residents report having a personal doctor or health care provider, with slightly lower rates in Prince George's County (79.2%) and Montgomery County (78.5%) [132]. However, in Montgomery County, disparities exist within the county. For example, in the Germantown/Gaithersburg/Poolesville Primary Care Service Area (PCSA), 71.0% of residents report having a personal doctor or health care provider, compared to 77.8% in Olney/Damascus and 79.4% in Rockville/Washington [132].

A strong supply of PCPs is associated with lower rates of low-weight births, reduced mortality, and decreased health system costs [133], [134]. The MCHC CBSA has one PCP for every 780.1 residents slightly higher than Montgomery County (592.1), but lower than both Prince George's County (1,368.0) and the state (847.1) [19]. Within Prince George's County, the Inner Beltway and South County regions are particularly affected by physician shortages. These imbalances highlight the need for targeted strategies to address workforce distribution and increase access to primary care in underserved areas.

DENTAL CARE

Oral health is closely linked to overall health, with periodontal disease and untreated infections tied to diabetes, cardiovascular disease, and Alzheimer's. Dentists play a critical role in diagnosing oral diseases, creating treatment plans, and managing oral trauma, providing essential preventive and restorative care, yet many communities, especially rural and low-income areas, struggle with inadequate supply. In the MCHC CBSA, (1.3%) of residents don't have access to a dentist and 84.3% of the population are underserved [19]. Results are similar in Montgomery County (1.5% of residents don't have access and 84.3% are underserved) and Prince George's County (3.1% of residents don't have access and 79.8% are underserved). However, both counties have better access than the state where 13.3% of residents don't have access and 79.8% are underserved. Medicaid acceptance among dentists remains limited, exacerbating disparities for low-income households [19].

MENTAL HEALTH

Just as oral health is essential to overall well-being, mental health is a foundational component of holistic care. Yet access to mental health services remains one of the most pressing challenges in the healthcare system, as the demand for providers continues to far exceed supply demand for

mental health providers far outpaces supply [135]. Nationally, one in five adults experience mental illness each year, but only 26.4% of the need for mental health professionals is being met with over 122 million people living in designated Mental Health Professional Shortage Areas [135], [136].

Mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, substance abuse treatment professionals, and advanced practice psychiatric nurses, play a vital role in assessment, diagnosis, treatment, and therapeutic interventions [137]. The variety of specialists reflects the complexity and breadth of mental health services needed to address diverse patient needs. Strengthening this workforce is essential for improving mental health outcomes and ensuring comprehensive, coordinated care.

Despite growing demand, disparities persist in access to mental health services. Rural communities, low-income populations, and communities with higher proportions of Black/African American or Hispanic residents face disproportionate barriers to care [138]. These disparities are compounded by cultural stigma, lack of insurance, and uneven provider distribution. In Montgomery and Prince George's Counties, residents frequently encounter long wait times, limited provider availability, and a shortage of culturally and linguistically responsive services [139]. Expanding the mental health workforce, improving geographic distribution and reducing financial and cultural barriers are critical steps toward ensuring equitable access [140].

EMERGENCY DEPARTMENT UTILIZATION

The shortage of clinicians, including primary care, dental and mental health providers, directly impacts how residents use emergency departments (EDs). When outpatient services are unavailable, unaffordable, or inaccessible, many individuals turn to the ED for conditions that could otherwise be prevented or managed in community. While emergency services are essential for acute conditions such as heart attacks, stroke, sepsis, and major trauma, high reliance on EDs for routine or preventable care signals gaps in the broader health care system [141].

In 2023, the rate of residents accessing ED services was highest in Prince George's County (14.9%) compared to Montgomery County (13.4%), both exceeding the state rate of 8.6%. Chronic conditions, such as diabetes, high blood pressure, and asthma contribute significantly to ED utilization, with asthma alone accounting for nearly 55,000 ED visits statewide [142].

The shortage of mental health providers places further strain on emergency services. In Maryland, there were more than 210,000 ED visits for mental health disorders in 2023, including various disorders such as anxiety, mood disorders, and schizophrenia[126]. Substance abuse issues similarly drive emergency visits, with 100,000 visits for substance-related disorders in 2023[126]. Similarly, lack of access to affordable dental care contributes to rising ED utilization, with 52,631 outpatient dental visits recorded statewide that year [142].

These trends highlight the need for stronger outpatient infrastructure. Expanding preventive care, improving access to mental health services, and increasing availability of dental providers are essential strategies to reduce avoidable ED visits. Ensuring that residents can access timely and

comprehensive outpatient care will not only alleviate pressure on emergency services but also improve health outcomes across the community.

PREVENTABLE HOSPITAL STAYS

Preventable hospital stays reflect gaps in access to timely, high-quality outpatient care and place significant strain on patients and the health care system. Across Maryland, preventable hospitalizations—largely driven by chronic conditions such as heart failure, diabetes, and chronic obstructive pulmonary disease—remain an important indicator of health system performance and equity [143], [142]. While Maryland's global budget model has helped reduce avoidable utilization and readmissions statewide, disparities persist across communities and payer groups [144].

In Montgomery County and Prince George's County, uneven access to primary, dental, and behavioral health care continues to contribute to preventable hospital use. Uninsured and underinsured residents, disproportionately Black/African American, Hispanic, and low-income, face higher risks of delayed treatment and avoidable hospitalizations. These challenges are more pronounced in Prince George's County and in underserved areas of Montgomery County, where workforce shortages and structural barriers limit access to consistent outpatient care.

Reducing preventable hospital stays in both counties will require continued investment in primary care and chronic disease management, strengthened Medicaid networks, and expanded access to culturally responsive care. Addressing these gaps is essential to advancing health equity, improving outcomes, and reducing unnecessary hospital utilization [143], [144].

PHYSICAL ENVIRONMENT

Where people live, their homes, neighborhoods, and transportation systems, shapes their health in profound ways. The physical environment includes housing quality, access to safe drinking water, exposure to pollutants, and reliable transportation. These conditions can either protect health or reinforce inequities. For example, high housing cost burdens and overcrowded living conditions can contribute to stress, limit access to healthy food, and increase the risk of chronic disease.

Meanwhile, poor air quality and unreliable transportation can act as silent barriers to care, employment, and community engagement. This section examines how the physical environment across the MCHC CBSA supports or constrains the health and well-being of its residents, identifying place-based disparities and opportunities to create healthier living environments for all.

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 opportunities to thrive. Where one resides can determine how long or how well one lives, and those in substandard neighborhoods

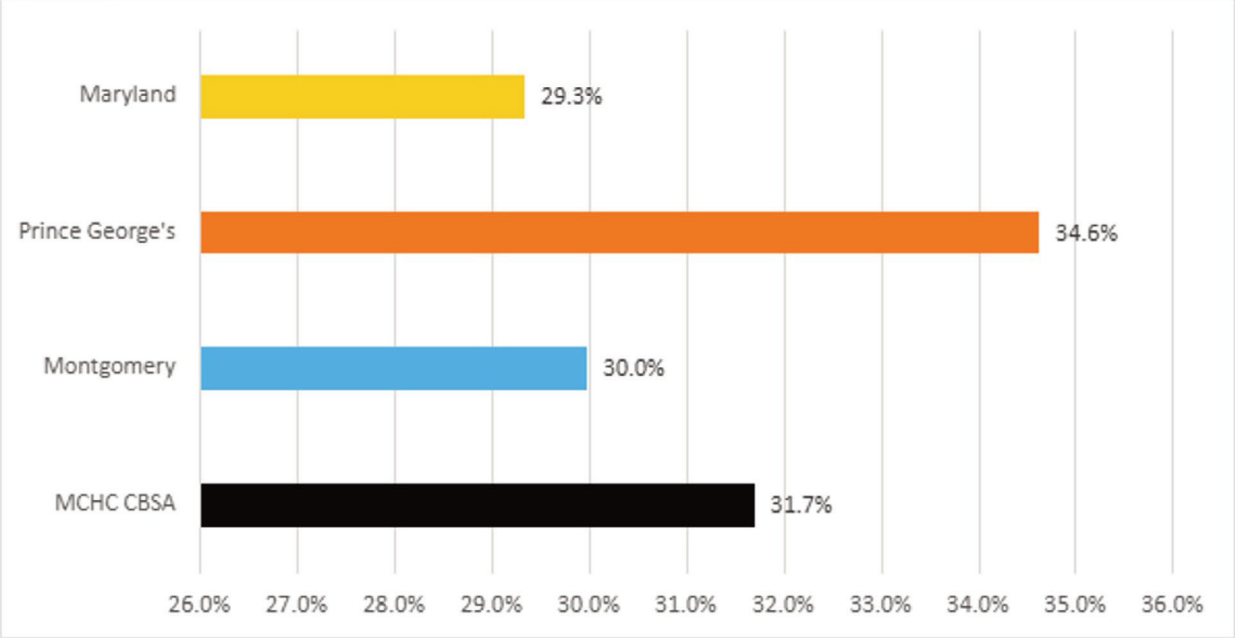
lack access to healthy foods, quality schools, stable housing, good jobs with fair pay, and safe places to exercise and play. Quality housing is an important determinant to overall health and well-being. However, many individuals experience housing issues such as a high-cost burden, one or more substandard living conditions as well as overcrowding, which furthers the risk of other health challenges.

HOUSING COST BURDEN

The high cost of living affects residents' access to safe, healthy housing. High housing costs can create 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.

In the MCHC CBSA, which encompasses 457,620 total households, 152,338 or 33.3% of households live in a cost-burdened home. In Maryland, 29.3% of residents experience high housing costs compared to 30.0% in Montgomery County, and 34.6% in Prince George's County (see Figure 59). While this represents a very slight downward trend compared to 2015-2019, the HP2030 national health target is to reduce the proportion of families that spend more than 30% of their income on housing to 25.5% [19].

Figure 59. Housing Cost Burden by State and County, 2019-2023



Source: American Community Survey, U.S. Census Bureau, 2023

The U.S. Department of Housing and Urban Development (HUD) administers the Housing Choice Voucher Program to assist very low-income families, older adults, and individuals with disabilities in accessing safe and affordable housing in the private market [145].

In high-income jurisdictions like Montgomery County, HUD adjusts income limits to reflect local economic conditions. Although HUD typically defines "low income" as 80% of the Area Median Income (AMI), in Montgomery County, the low-income threshold has been capped at approximately 63% of AMI due to federal policy constraints [146].

As a result, to be eligible for a Housing Choice Voucher in Montgomery County, a family of four must earn less than $97,461 per year, a figure significantly below the county's actual median income for a family of four ($163,900) [147]. This discrepancy underscores the need for expanded housing support and affordability measures in the region.

SUBSTANDARD HOUSING

Substandard housing conditions pose an ongoing challenge to community health in both Montgomery County and Prince George's County. Substandard housing is defined as households experiencing one or more of the following conditions: overcrowding, high housing cost burden, lack of complete kitchen facilities, or lack of complete plumbing facilities. These conditions are associated with increased exposure to environmental hazards such as mold, pests, and lead, as well as higher risks of chronic and infectious disease.

Based on American Community Survey data analyzed through HUD's Comprehensive Housing Affordability Strategy (CHAS), approximately 30.9% of housing units statewide experience at least one substandard housing condition. Rates are higher within the MCHC CBSA (34.5%), driven in large part by Prince George's County (37.4%), compared with 32.2% in Montgomery County [19]. These patterns reflect the combined effects of housing affordability pressures and uneven access to safe, adequate housing.

Overcrowding—defined as more than one person per room—is a particularly acute concern in Prince George's County. In 2023, nearly 29% of housing units in Prince George's County were overcrowded, compared with 6.6% in Montgomery County [148]. Overcrowding has been linked to increased communicable disease transmission, higher injury risk, and worse outcomes for residents with chronic conditions. The stark contrast between counties highlights how rising housing costs and limited housing supply disproportionately affect lower-income households and communities of color.

Together, these data underscore the importance of expanding access to affordable, safe housing and addressing overcrowding as part of broader health equity efforts in Montgomery County and Prince George's County.

BROADBAND 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.

In 2023, the Federal Communications Commission (FCC) reported that broadband access is

extremely high in Montgomery and Prince George's Counties (both 99.7%), and the MCHC CBSA (99.9%). The report shows an increase in access compared to 2020, indicating that recent infrastructure efforts in increasing broadband access have been successful [19].

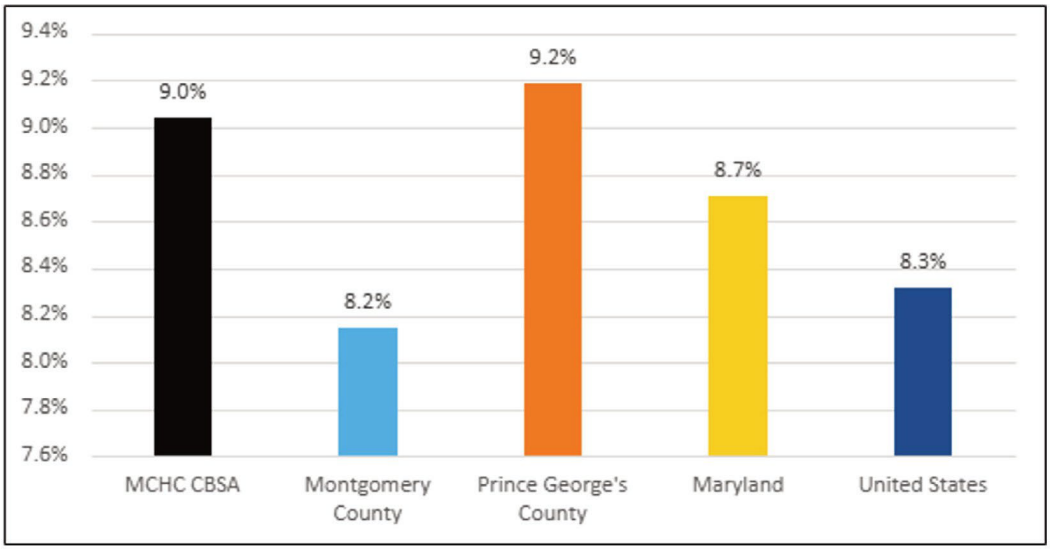
TRANSPORTATION

Transportation access plays a critical role in connecting residents to health care, employment, food, and recreational opportunities that support healthy living. In Montgomery County and Prince George's County, extensive public transportation systems, including Metrorail, Metrobus, MARC trains, local bus networks, and subsidized transportation for older adults and individuals with disabilities, provide important mobility options. However, service availability and frequency are closely tied to ridership patterns, leaving residents in lower-density or underserved areas with limited access to essential services.

Lack of safe, reliable, and affordable transportation remains a significant barrier for many residents, particularly older adults, people with disabilities, and low-income households. Transportation challenges, including long travel distances, high costs, lack of vehicle access, and inadequate infrastructure, can impede access to medical appointments, routine care, and prescription medications. Vehicle ownership is a key determinant of mobility; households without a car make fewer than half as many daily trips as those with vehicle access, limiting their ability to reach healthcare facilities and other necessities.

According to the 2019–2023 American Community Survey, 8.7% of Maryland households do not have access to a motor vehicle, while 9.0% of households in the MCHC Core-Based Statistical Area lack a vehicle and must rely on public transportation, walking, or other means to meet daily needs (see Figure 60). These transportation barriers reinforce health inequities and highlight the importance of transportation planning as part of broader strategies to improve access to care and advance health equity in Montgomery County and Prince George's County.

Figure 60. Percent of Households with No Motor Vehicle, 2019-2023



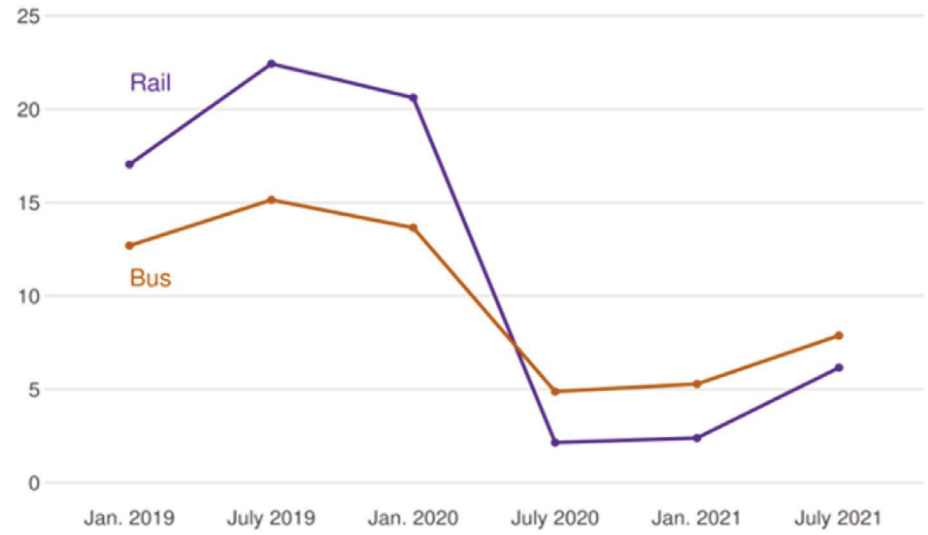
Source: American Community Survey 2019-2023, U.S. Census Bureau

However, transportation programming that currently exists has income or geographic requirements and is 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, and Ride on Programs as well as Metro Access, 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 for 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 their destination than those 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 and time constraints can serve as an added barrier to those needing to utilize public transportation. In the MCHC CBSA, 9.8% of the population uses public transit to commute to work, down significantly from 15.3% in the 2018-2022 ACS [19]. Bus and rail ridership have not reverted to pre-pandemic numbers, creating barriers such as decreased rail and bus frequency and increased prices for those who rely on public transportation (see Figure 61).

Figure 61. Millions of Total Capital Regional Monthly Transit Rides, January 2019-July 2021



Source: National Transit Database 2021. Notes: Total unliked rides. Includes Washington Metropolitan Area Transit Authority, Montgomery County, Maryland, City of Fairfax, Fairfax County, VA, Potomac and Rappahannock Transportation Commission, City of Alexandria, Virginia Railway Express, Arlington County, Virginia, Loudoun County, Prince George's County, Maryland, Martz Group, National Coach Works of Virginia, DDOT - Progressive Transportation Services Administration, Maryland Transit Administration.

SOCIAL & ECONOMIC FACTORS

The social and economic context in which people are born, grow, live, work, and age profoundly influences health outcomes. Factors such as educational attainment, employment opportunities, income, and social support all shape a person's ability to thrive. These

influences are not evenly distributed; historic and ongoing systems of discrimination have created deep inequities, particularly affecting communities of color and those with lower incomes. In the MCHC CBSA, these structural barriers result in persistent income gaps, food insecurity, educational disparities, and labor force challenges. This section unpacks how social and economic conditions drive community health, while also highlighting the resilience and assets within communities that can be harnessed to promote equity and opportunity.

EDUCATION

Education is a key social determinant of health that shapes economic opportunity, environmental stability, and long-term well-being. Higher levels of educational attainment are associated with better employment prospects, higher incomes, stable housing, and improved access to nutritious food and health care [149], [150]. Education also supports health literacy, critical thinking, and problem-solving skills, enabling individuals to navigate health information, make informed care decisions, and engage in preventive health behaviors [149].

Across Montgomery County and Prince George's County, educational attainment varies substantially and mirrors broader health and economic inequities. Within the MCHC service area, 55.4% of adults ages 25 and older have earned a bachelor's degree or higher, exceeding the Maryland average (42.7%) and Prince George's County (36.0%), but remaining below Montgomery County (60.3%) [19]. These differences are meaningful, as higher educational attainment has been consistently linked to better health outcomes, including lower rates of chronic disease, higher life expectancy, and healthier behaviors.

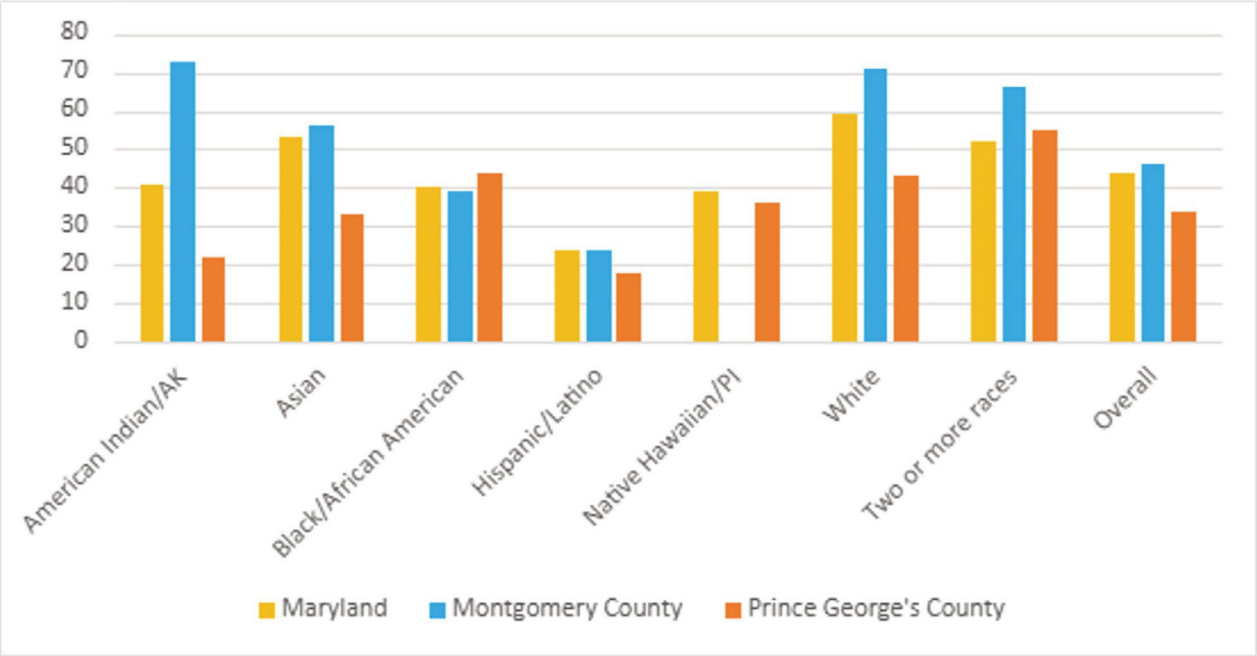
Conversely, individuals with lower levels of education experience higher rates of chronic conditions and poorer overall health, driven by economic instability, environmental stressors, and limited access to care. Understanding educational attainment patterns in Montgomery County and Prince George's County is essential for identifying health disparities and informing strategies to promote equity and opportunity.

KINDERGARTEN READINESS

Kindergarten readiness and health are linked to a child's future educational success, as a strong foundation in both areas leads to better academic performance, social-emotional development, and overall well-being. In addition, academic performance at younger ages is a predictor of high school graduation rates, which are strongly correlated with higher life expectancies and improved quality of life.

For the 2023-2024 school year 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 Black/African American had the highest rates of readiness. Montgomery County had the highest rates of students entering kindergarten ready to learn (46%) and Prince George's County had the lowest rate (34%) in the state [151] (see Figure 62).

Figure 62. Percent of Kindergarten Students Demonstrating Readiness, 2023-2024



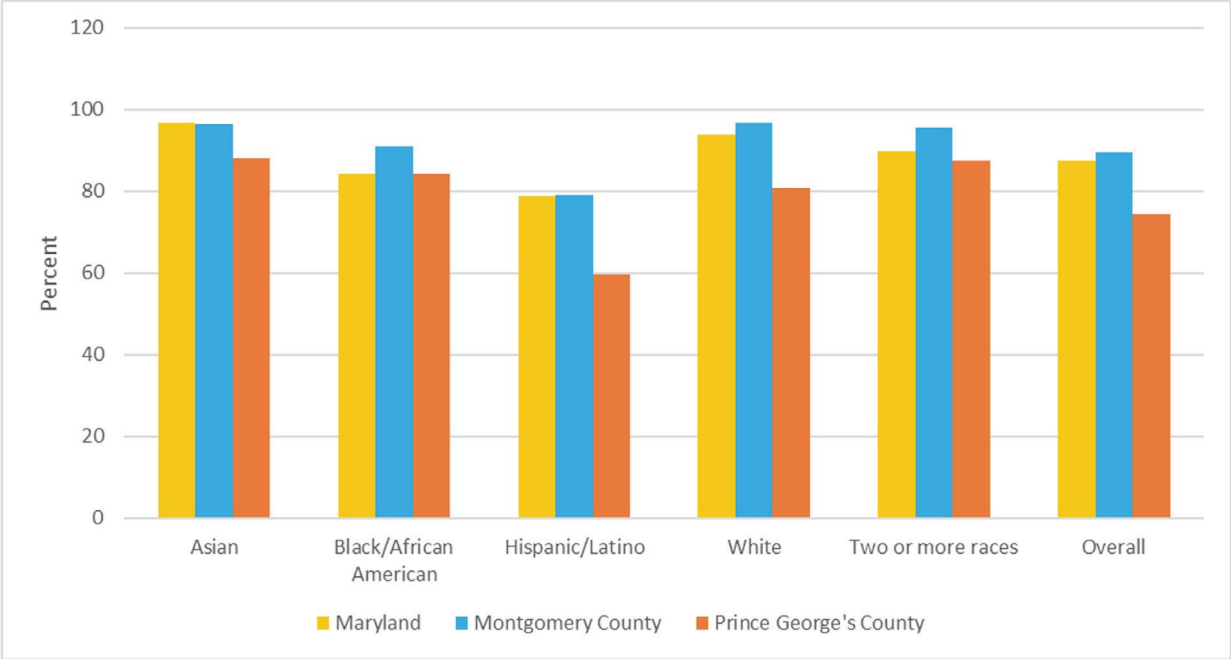
Source: Maryland State Department of Education, 2024

HIGH SCHOOL GRADUATION

Individuals who do not finish high school are statistically more likely to lack the basic skills needed to navigate an increasingly complex job market and society, leading to lower earning potential, limited employment prospects, and other challenges. Also, those who drop out of high school may lack foundational skills in areas like reading, writing, math, and critical thinking, which are essential for success in the workforce and daily life.

In Maryland, the four-year high school graduation rate reached 88% in 2024, the highest it has been since 2017 [152]. Notably, from 2023 to 2024 the graduation rate for Hispanic students rose 7% and 10% for multilingual learners [153]. In Montgomery County the graduation rate was even higher for the class of 2024 at 91.4%, rising 2.2% from 2023 [154]. This included a 6.6% increase for Hispanic students and a 12% increase for multilingual learners. For 2024, Prince George's County graduation rate was at 80.02%, 5.6% higher than the year before [155]. This included a 12% rise in Hispanic graduation rates to 71.3% and a 14.6% jump for multilingual learners to 66.9% in 2024 (see Figure 63).

Figure 63. Percent of Four-Year High School Graduation Rate, 2024



Source: Maryland Department of Education, 2024

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 and incarceration risks.

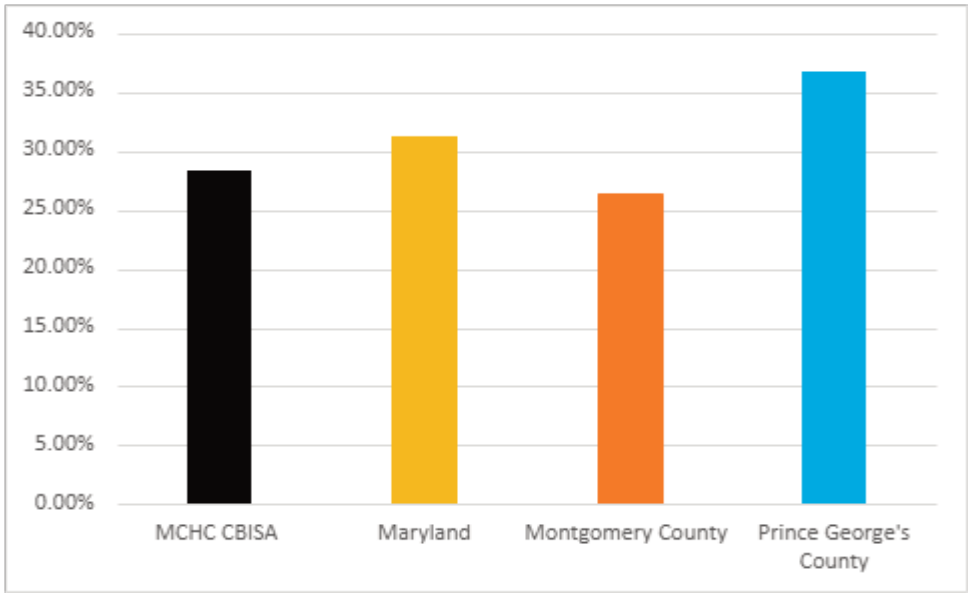
The population of people aged 25 years and older with no high school diploma varies in both counties, with about 8.8% of the population in Montgomery County and more than 13% of the population in Prince George's County. Altogether, in the MCHC CHNA 11.3% of the population age 25 years and older do not have their high school diploma, compared to 10.6% and 8.9% nationally and at the state, respectively [19]. The 2024 Maryland State Report Card reported the percentage of youth dropouts in Montgomery County was 5.14% and 14.57% in Prince George's County [156].

CHRONIC ABSENTEEISM

Chronic absences (missing 15 or more school days) can jeopardize students' academic proficiency, social engagement, and opportunities for long-term success. Missing school means missing valuable instructional time and poses serious implications for a student's overall academic success and well-being.

According to the Maryland Board of Education, chronic absences have gradually declined since 2022, indicating progress but still above the pre-pandemic levels of around 19% in 2018-2019 [157]. During the 2022-2023 school year, 28.3% of students (approximately 106,461 children) in the MCHC CHNA were chronically absent. In comparison, the absentee rate was 26.4% in Montgomery County and 36.7% in Prince George's County. The statewide average was 31.3% [19] (see Figure 64).

Figure 64. Students Absent from 10% or More School Days During the School Year, 2022-2023

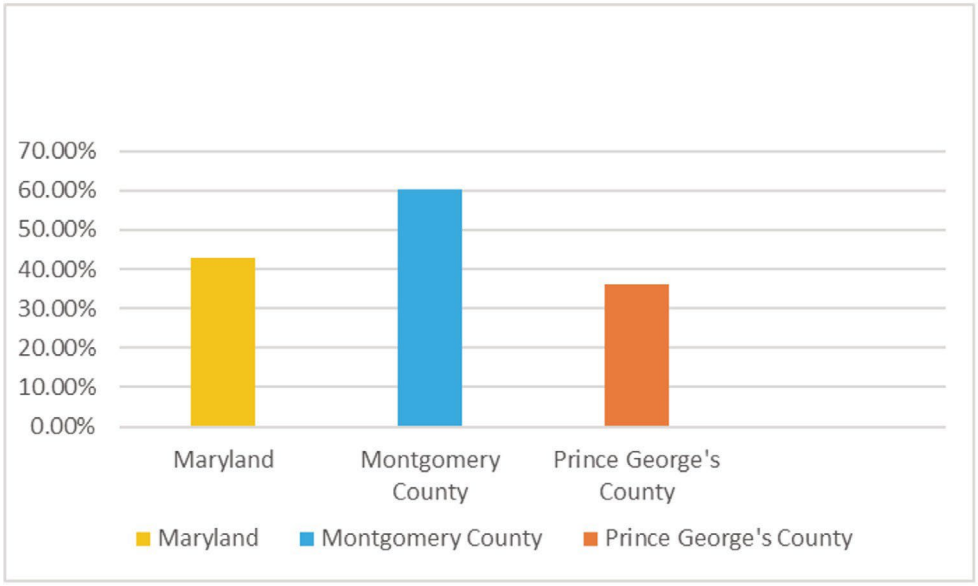


Source: Notes: U.S. Census Bureau, American Community Survey Office, 2022-2023

COLLEGE

Higher education levels are relatively higher in Montgomery County and Prince George's County. About 60% of Montgomery County residents hold a bachelor's degree or higher, and a little more than 35% of Prince George's County residents hold a bachelor's degree or higher (see Figure 65).

Figure 65. Percent of Residents Age 25+ with Bachelor's Degree or Higher, 2019-2023



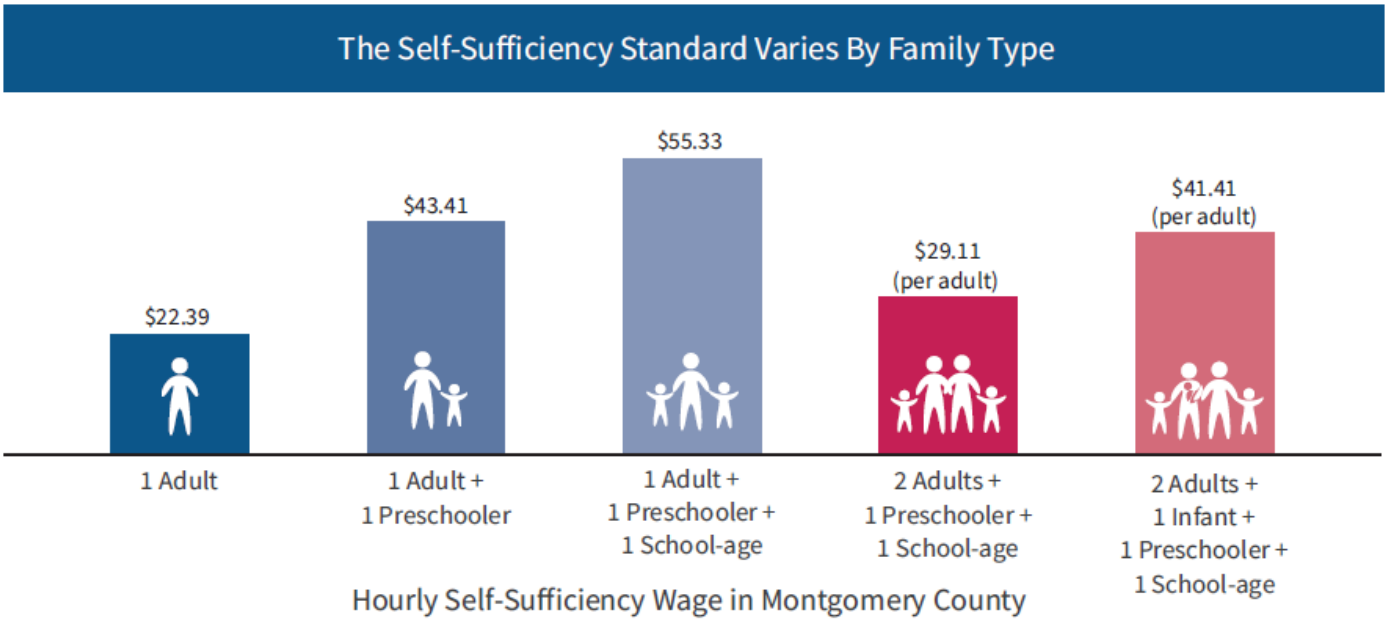
Source: U.S. Census Bureau American Community Survey, 2019 -2023

INCOME

Montgomery County is an affluent community in aggregate. The median household income of $128,733 is significantly higher than the statewide median household income of $109,530. However, 45% of households in the County earn less than $100,000 in a community where the

self-sufficiency standard for a family of four requires an annual income of $99,756. The self-sufficiency standard is the income required for an individual or family to meet basic needs without public subsidies or private/informal assistance. According to the Self-Sufficiency Standard for Maryland 2023, this varies by family composition and location. A single parent with one infant would need an income of $90,293, and one adult living in Montgomery County would need $46,571, or $22.39 per hour, $4.74 more than the Minimum Wage of $17.65 per hour (see Figure 66). In Prince George's County, the median household income in 2023 was $97,171, which is lower than the statewide median, but still an increase from $93,833 in 2022 [158].

Figure 66. Hourly Self-Sufficiency Wage in Montgomery County by Family Type, 2023.



Source: Self-Sufficiency Standard Montgomery County, Maryland

LABOR AND WORKFORCE

A healthy workforce is crucial for a robust economy because it directly impacts productivity, reduces health care costs, and boosts overall economic growth, as highlighted by the U.S. HHS (2024). Healthy employees are more likely to be present and focused on work, leading to higher output and efficiency. It also translates to lower health care expenses for both employers and the government, freeing up resources for other essential areas.

In 2023, the U.S. workforce expanded to 167.8 million, up from 161 million in 2021 [159]. This total includes both employed individuals and those who are unemployed but actively seeking work. However, it does not account for those who have exited the workforce, such as retirees or discouraged job seekers who have stopped looking for employment.

LABOR SHORTAGES

The COVID-19 pandemic significantly disrupted the U.S. labor market, leading to a notable increase in the unemployment rate and a surge in voluntary job departures, commonly referred to as the "Great Resignation." In 2021, more than 47 million American workers quit

their jobs, seeking better work-life balance, higher pay, or more supportive company cultures. This trend, an average monthly quit rate of about 3%, resulted in a substantial number of unfilled positions across various states, including Maryland [160].

As of January 2025, the U.S. job quits rate stood at 2.1%, reflecting a decrease from the peak levels observed during the Great Resignation. In Maryland, the labor market has shown resilience. The state's unemployment rate remained steady at 3.1% in December 2024, significantly lower than the national average of 4.1%. Throughout 2024, Maryland added over 38,000 jobs, achieving a 1.4% employment growth rate and in May 2024, the state reported approximately 184,000 job openings, indicating ongoing challenges in filling vacant positions [159]. Overall, while the immediate impacts of the Great Resignation have subsided, Maryland continues to experience a dynamic labor market characterized by low unemployment and a substantial number of job openings.

There is great uncertainty about the impact of layoffs and decreases in federal employment opportunities on the regional employment market. Maryland hospitals continue to face significant nursing shortages, a challenge that has intensified in recent years. The 2024 Maryland Nurse Workforce Projections report, commissioned by the Maryland Hospital Association, estimates a current shortage of approximately 5,000 full-time equivalent (FTE) registered nurses (RNs) in the state. This means the RN supply meets only about 91% of the demand for services at a national average level of care [161].

The distribution of these shortages varies across the state. According to the Maryland Board of Nursing Annual Report, in 2024 Montgomery County had a high number of employed RNs of 5,204. However, these areas also experience significant demand, contributing to high vacancy rates.

UNEMPLOYMENT

Unemployment serves as a crucial indicator of the local economy, reflecting the balance between job availability and the workforce's skill set. High unemployment not only imposes economic hardships but also affects access to employer-provided health insurance and places additional strain on public support systems.

The COVID-19 pandemic in 2020 led to unprecedented unemployment rates nationwide, with certain demographics experiencing more severe impacts. The pandemic's impact on local businesses led to increased unemployment rates in both Montgomery and Prince George's Counties. In Montgomery County, the unemployment rate rose from 2.9% in 2019 to 6.1% in 2020, then decreased to 5.1% in 2021, and further to 2.9% in 2022. In Prince George's County, the rate increased from 3.5% in 2019 to 7.8% in 2020, then declined to 6.8% in 2021, and further to 3.3% in 2022. These data demonstrate a significant recovery from the peak unemployment rates experienced during the pandemic [160].

By September 2024, Montgomery County's unemployment rate had risen slightly to 2.6%, up from 1.7% in September 2023, indicating a modest increase over the year [158]. In Prince George's County, the unemployment rate was 3.3% in 2023, reflecting continued

improvement from previous years [162].

Overall, while both counties experienced significant unemployment rate increases during the pandemic, recent data indicate a substantial recovery, with unemployment rates approaching pre-pandemic levels. However, in the fourth quarter of 2024, the unemployment rate for Black/African American individuals was 5.8%, higher than the overall rate of 3.9% for all races [159]. Gender disparities were also evident.

In February 2025, the unemployment rate for women stood at 4.1%, slightly above the 3.9% rate for men. However, these overall rates mask significant variations among different racial and ethnic groups. For instance, the unemployment rate for Black/African American women was notably higher compared to their White counterparts [159]. These statistics underscore the persistent and complex nature of unemployment disparities across different demographics. Addressing these inequities requires targeted policies and interventions aimed at supporting the most affected communities.

SECTION 4.

SOCIETAL RULES & POWER

Community health is shaped not only by medical care, but by the policies, systems, and power structures that determine access to opportunity and resources. Consistent with the University of Wisconsin County Health Rankings model, this section examines how societal rules, such as health care access, education funding, labor protections, housing policy, and environmental regulation, shape health outcomes in Montgomery County and Prince George's County. Drawing on local data, peer-reviewed research, and public policy analysis, this assessment highlights how upstream decisions influence disparities and identifies opportunities to advance health equity across the region.

ACCESS TO HEALTH CARE

Access to health care is a core driver of community health and a key policy lever in Maryland. The state's early adoption of Medicaid expansion under the Affordable Care Act in 2014 significantly increased insurance coverage, particularly for low-income adults in Montgomery County and Prince George's County. Following expansion, Maryland's uninsured rate declined from approximately 12% in 2010 to about 6% by 2021, among the lowest in the country [163], [164]. Both counties experienced similar gains, though coverage gaps persist among immigrant populations and residents facing affordability barriers.

By 2022, more than 1.1 million Maryland residents were enrolled in Medicaid or the Children's Health Insurance Program, including tens of thousands of residents in Montgomery County and Prince George's County [164]. Expanded coverage has improved access to preventive care, chronic disease management, and maternal health services. National evidence shows that Medicaid expansion is associated with reduced mortality, fewer preventable hospitalizations, and improved self-reported health among low-income adults [165]. Local data also indicate declining emergency department use among uninsured patients in Prince George's County following coverage expansion [142].

Maryland has continued to strengthen access through targeted policy innovations. In 2022, the state extended Medicaid postpartum coverage from 60 days to 12 months, ensuring continuity of care during a high-risk period for maternal complications [164]. This policy is particularly relevant in Montgomery County and Prince George's County, where Medicaid covers a substantial share of births and maternal health disparities persist.

These policy choices illustrate how state-level decisions shape local health outcomes. Continued monitoring of coverage, access to preventive services, and avoidable utilization will be critical for evaluating progress and identifying remaining gaps in both counties.

SOCIAL & ECONOMIC CONDITIONS

Social and economic conditions are shaped by decisions about who receives public investment, what protections are guaranteed, and whose needs are prioritized in policy-making. Under the County Health Rankings & Roadmaps model, these conditions—education, employment, income, food security, housing, and transportation—are understood not as individual circumstances, but as outcomes of systems of power and policy choices that influence health long before someone enters a clinic.

In Montgomery County and Prince George's County, these societal rules have produced markedly different opportunities and health outcomes across communities, often aligning with racial, economic, and geographic lines.

EDUCATION POLICY AND OPPORTUNITY

Educational attainment is a powerful determinant of long-term health, and disparities in educational

opportunity reflect structural policy decisions about school funding, staffing, and resource allocation. In Montgomery County and Prince George's County, differences in school investment and outcomes mirror broader economic and racial inequities shaped by state and local policy. Montgomery County Public Schools have historically benefited from a stronger local tax base, enabling higher per-pupil spending and more robust academic supports. Prince George's County, which serves a higher-need student population, has faced persistent resource constraints despite sustained enrollment growth and academic demand.

Maryland's *Blueprint for the Future* represents a deliberate policy intervention to rebalance educational opportunity by directing additional funding to high-poverty schools, expanding early childhood education, reducing class sizes, and increasing teacher pay [166]. These investments are especially consequential for Prince George's County, where graduation rates and postsecondary attainment have lagged behind Montgomery County [166]. Because educational attainment influences income stability, health literacy, and stress exposure across the life course, education policy functions as a long-term health intervention affecting chronic disease risk, mental health, and life expectancy [150].

LABOR, WAGES, AND SOCIAL SUPPORT POLICIES

Labor and wage policies determine whether work provides stability or perpetuates vulnerability. Statewide decisions, such as Maryland's increase to a $15 minimum wage, reflect recognition that income is a health intervention, not just an economic one. However, the benefits of these policies vary locally. Montgomery County's higher cost of living and Prince George's County's higher share of essential and public-sector workers mean that wage adequacy, job security, and exposure to layoffs are experienced unevenly. These structural factors affect residents' ability to afford housing, food, transportation, and medical care, directly shaping chronic disease risk and mental health.

Labor and wage policies shape residents' ability to achieve economic stability. Maryland's statewide increase to a $15 minimum wage reflects recognition that income adequacy supports health by improving access to housing, food, and medical care [167]. However, the benefits of wage policy vary locally. Montgomery County's higher cost of living means that even full-time employment may not protect households from cost burden, while Prince George's County residents are more likely to work in public sector and essential roles where wages have been slower to rise and job security is more vulnerable [168].

Recent federal workforce reductions under the Trump administration illustrate how federal policy decisions can quickly affect local economic security. Thousands of federal employees and contractors in Maryland, many residing in Montgomery County and Prince George's County, were laid off or furloughed as part of large-scale federal spending cuts and agency restructuring [169], [170]. These layoffs disrupted household incomes, increased food and housing insecurity, and placed additional strain on local safety net systems. Research consistently links job loss and income volatility to worsened mental health, delayed medical care, and poorer chronic disease outcomes [150].

INCOME, POVERTY, AND COST BURDEN

Income, poverty, and household cost burden are not simply economic outcomes; they reflect long-standing societal rules that shape who bears the costs of living and who benefits from growth. In Montgomery County and Prince George's County, differences in income stability and material hardship are the result of decades of policy decisions related to taxation, land use, infrastructure investment, and labor markets. These structural factors strongly influence health by determining residents' ability to afford housing, transportation, food, and health care.

TAX POLICY AND LOCAL REVENUE CAPACITY

Local tax structures have played a central role in shaping economic opportunity between the two counties. Montgomery County has historically benefited from higher property values, a larger commercial tax base, and concentrated federal and professional employment, generating greater per-capita public revenue. This has enabled sustained investment in schools, public services, transportation infrastructure, and amenities that further reinforce income growth and neighborhood stability. In contrast, Prince George's County has relied more heavily on residential property taxes while serving a population with lower median household income, placing proportionally greater financial pressure on households with lower median incomes, limiting fiscal flexibility and increasing household cost burden [168], [169]. These revenue disparities contribute to differences in public investment that affect long-term economic and health outcomes.

LAND-USE DECISIONS AND HOUSING COST PRESSURE

Land-use and zoning policies have further structured income and cost burden across the region. Exclusionary zoning practices in Montgomery County, such as minimum lot sizes and restrictions on multifamily housing, limited the supply of affordable housing for decades, preserving wealth in some communities while pushing lower-income households to fewer available areas. Prince George's County absorbed a greater share of the region's affordable and multifamily housing without commensurate investment in transit access or job density, increasing transportation costs and household cost burden [170], [171]. These decisions have contributed to higher rates of housing instability, overcrowding, and financial strain, particularly among renter households.

HISTORIC DISINVESTMENT AND UNEQUAL INFRASTRUCTURE

Patterns of historic disinvestment have further shaped income inequality and material hardship. Prince George's County experienced delayed transit expansion, fewer early commercial anchors, and land-use decisions that concentrated industrial uses and highway infrastructure in residential areas. Combined with discriminatory lending and redlining practices that limited homeownership and wealth accumulation for Black residents, these policies constrained long-term household economic security even among employed residents [171], [172]. Montgomery County, by contrast, benefited earlier from transit-oriented development and federal office siting, accelerating income growth and reducing exposure to severe cost burden for many households.

FOOD ACCESS AND NUTRITIONAL SECURITY

Food security reflects eligibility rules, benefit adequacy, and local investment in food access. SNAP policy decisions during and after the COVID-19 pandemic illustrate how federal rules translate into local health outcomes. Enhanced benefits significantly reduced food insecurity across the region; when those benefits ended, food hardship increased sharply, particularly in Prince George's County, which has a higher concentration of SNAP participants [176].

Federal layoffs further strained food systems by increasing demand for nutrition assistance and charitable food programs among newly unemployed households. Food insecurity directly affects chronic disease risk, child development, and mental health, making federal and state nutrition policy a critical component of community health in both counties [177].

TRANSPORTATION ACCESS & MOBILITY

Transportation policy shapes residents' ability to access employment, education, health care, and healthy food. Historic investment patterns prioritized high-density corridors, leaving many residents in lower-density or disinvested areas reliant on infrequent transit service. Households without access to a private vehicle, more common among low-income residents, face longer travel times to work and medical appointments, reinforcing health and economic inequities [178].

Pandemic-era ridership declines and subsequent federal funding uncertainty reduced service frequency and increased costs, disproportionately affecting residents displaced by federal layoffs and those already facing economic instability [170].

STRUCTURAL INEQUITY AND POWER

Across all social and economic domains, disparities in Montgomery County and Prince George's County reflect who has had influence over public decisions and who has been excluded from them. Policies that expand access, such as increased school funding, wage protections, housing stabilization, and nutrition assistance, represent efforts to rebalance power and improve health equity. Tracking these policy impacts through indicators such as graduation rates, food insecurity, housing stability, and avoidable health care use allows not only the assessment of conditions, but also the effectiveness of societal rules in promoting community well-being.

SECTION 5.

COMMUNITY INPUT

The Montgomery County Hospital Collaborative (MCHC) was intentional in seeking input from the community through the formation of a Community Engagement Council. This group of residents was assembled by leveraging existing stakeholder relationships among hospitals and was guided by the Public Participation Spectrum model, which outlines levels of public involvement [179]. The CEC aligned with the model's "Collaborate" level, aiming to partner with the public in decision-making, including identifying alternatives and preferred solutions [179].

In the summer of 2024, the MCHC engaged known community leaders to help identify individuals committed to their communities, including faith-based groups, older adults, geographically isolated residents, and people living with disabilities. Recruitment focused on individuals living or working in zip codes identified by the Community Equity Index (CEI). Ten individuals were invited to join the CEC, which met weekly over seven weeks from October to November 2024. Their primary task

was to develop a Community Engagement Plan (CEP) to guide efforts in gathering meaningful insights on health concerns, service gaps, and community resources from a broad and representative population.

During the seven-week period, the CEC strategized on stakeholder outreach, engagement activities, incentives, communication methods, and sustaining long-term involvement. Key outcomes included recommendations for survey languages, preferred delivery methods (e.g., in-person vs. virtual), and accessibility considerations. The resulting CEP positioned MCHC to successfully implement community survey and focus group activities from January through March 2025.

Building on a 2022 survey, the 2025 version was enhanced by the CEC's lived experience and feedback, including simplified language and expanded focus on barriers and health issues. To ensure accessibility, the survey was available electronically and on paper in English, Spanish, Mandarin, Vietnamese, French, and Amharic. MCHC used diverse community channels—such as safety-net clinics, newsletters, community classes, and CEC-identified stakeholders—to reach underserved, low-income, and minority populations (see Appendix H for the full list).

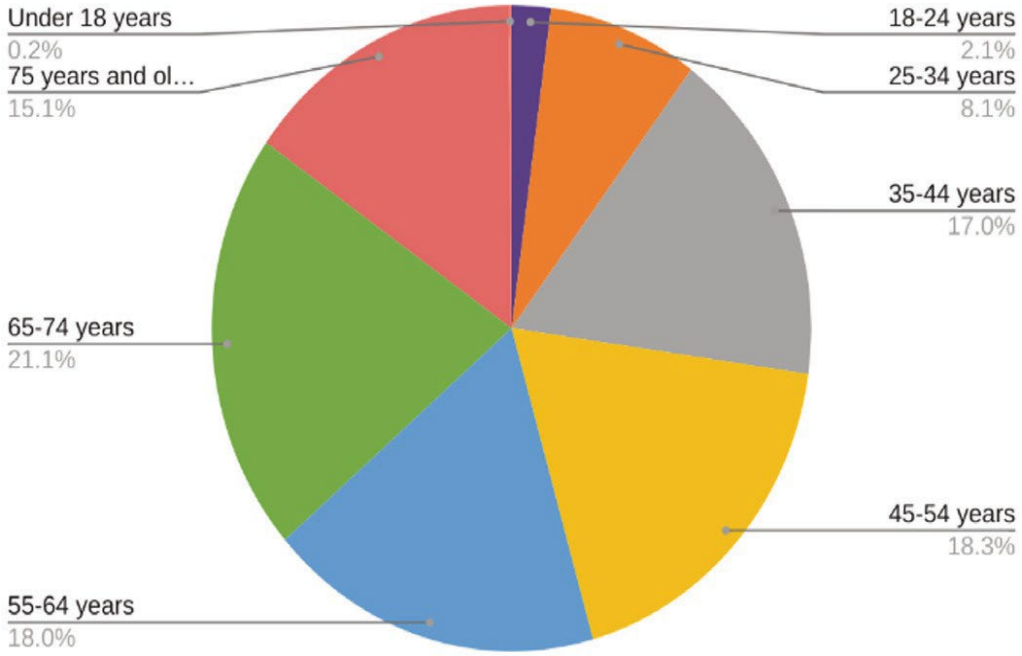
A total of 715 individuals responded to the survey, with 616 meeting the inclusion criteria as adults residing in the MCHC CBSA (Appendix E). This marked a 26.2% increase in eligible responses compared to 2022, a result largely attributed to the CEC's contributions. The following section presents key findings from the survey and focus groups, offering deeper insight into the health concerns, service gaps, and priorities identified by community members.

DEMOGRAPHICS

The 2025 community survey captured a diverse cross-section of residents. Most respondents identified as Non-Hispanic White (56.3%), women (78%), and heterosexual or straight (83%). Geographically, 72.5% of respondents reported living in one of Montgomery County's four major cities: Silver Spring (38%), Rockville (14%), Gaithersburg (12%), and Bethesda (9%). Only 1% of responses came from residents of the eight zip codes in Prince George's County, highlighting a continued need for targeted outreach in that area.

Age distribution in 2025 was more balanced than in the previous survey. While older adults (65+) continued to represent a significant portion of respondents, their share declined from 48% in 2022 to 35.2% in 2025. This shift reflects broader engagement across age groups, particularly among younger adults ages 25 to 43, whose participation doubled—from 4% in 2022 to 8% in 2025. The most represented age group in 2025 was 65–74 (21.1%), followed closely by those ages 45–54 (18.3%) and 55–64 (18.0%), indicating strong participation across middle and older age ranges (see Figure 67).

Figure 67. Age Distribution of 2025 CHNA Survey Respondents

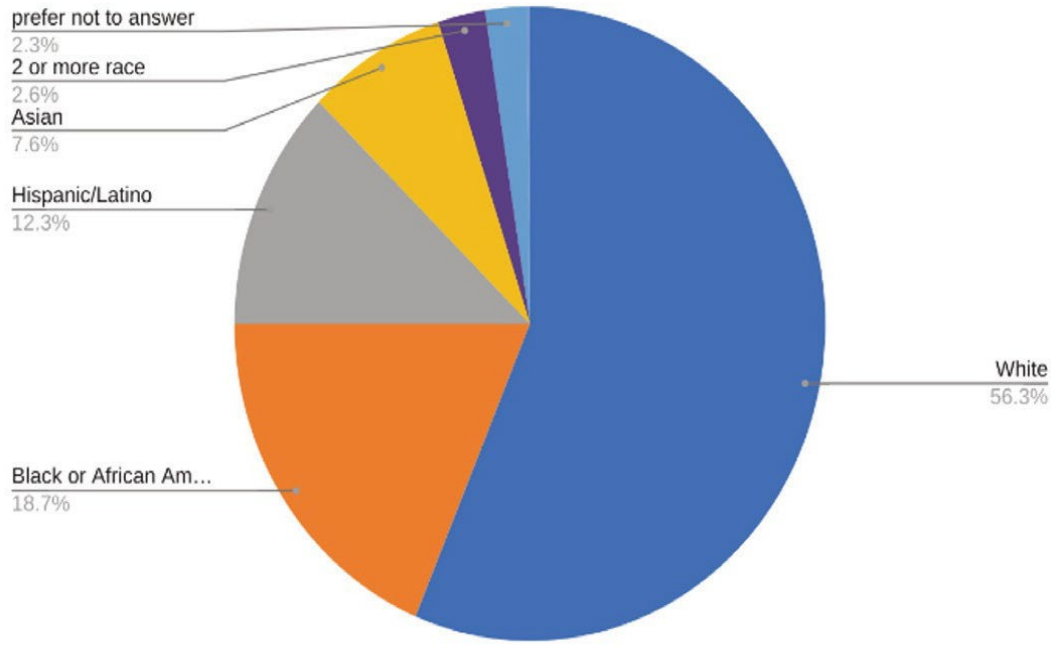


In addition to age diversity, respondents demonstrated high levels of educational attainment. Nearly all (95.5%) had completed high school, and 78.6% held a bachelor's, graduate, or professional degree. While this is higher than the county average, the survey still reflects a broad range of lived experiences and perspectives across educational backgrounds, ensuring that the findings are both informed and representative of the community.

The 2025 survey also showed meaningful progress in capturing the racial and ethnic diversity of Montgomery County. In total, 41.4% of respondents identified as part of a racial or ethnic minority group, an increase from 37% in 2022 and a step toward better alignment with the county's demographic profile. African American/Black respondents represented 18.7% of the sample, up from 14% in 2022, making them the second-largest racial group after Non-Hispanic Whites. Hispanic/Latino (12.3%) and Asian (8%) respondents participated at similar rates to the previous survey, maintaining consistent representation. Meanwhile, Non-Hispanic White participation declined from 63% in 2022 to 56.3% in 2025 (see Figure 68), reflecting a more balanced distribution across racial groups.

These shifts suggest that outreach and engagement strategies, particularly those informed by the Community Engagement Council, were more effective in reaching historically underrepresented populations. As a result, the 2025 survey offers a more inclusive and accurate reflection of the county's racial and ethnic makeup, strengthening the validity of the findings and their relevance to community health planning.

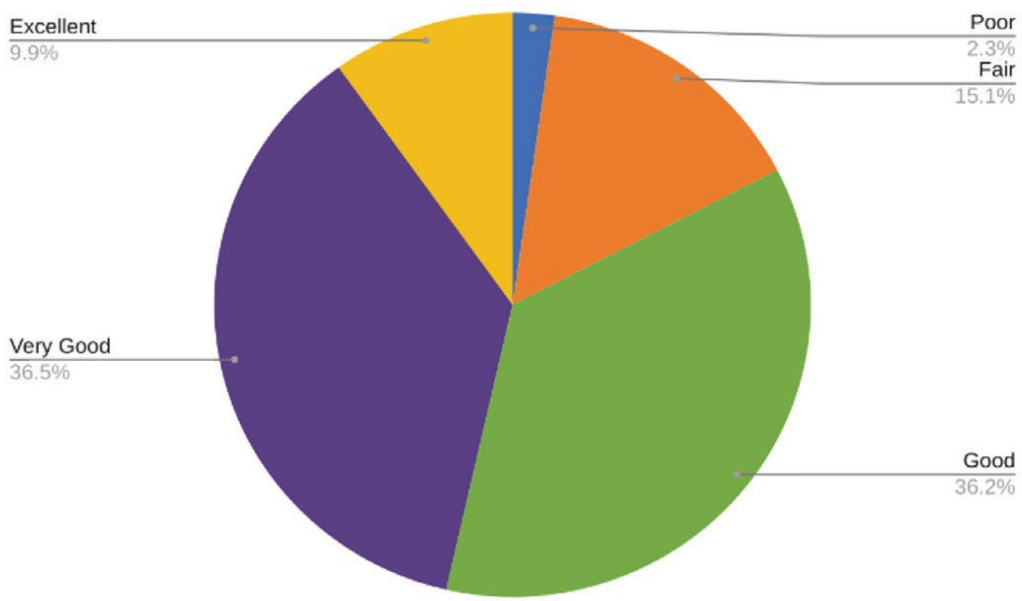
Figure 68. Race and Ethnicity of 2025 CHNA Survey Respondents



HEALTH STATUS

Survey respondents were asked to rate their general health on a scale ranging from “Poor” to “Excellent.” Their responses offer valuable insight into how community members perceive their overall well-being. Figure 69 illustrates the distribution of self-reported health status, revealing a range of experiences across the population, from those reporting excellent health to those facing more significant health challenges. This data provides important context for understanding community needs and identifying areas for targeted health interventions.

Figure 69. Self-Reported General Health Status of Survey Respondents



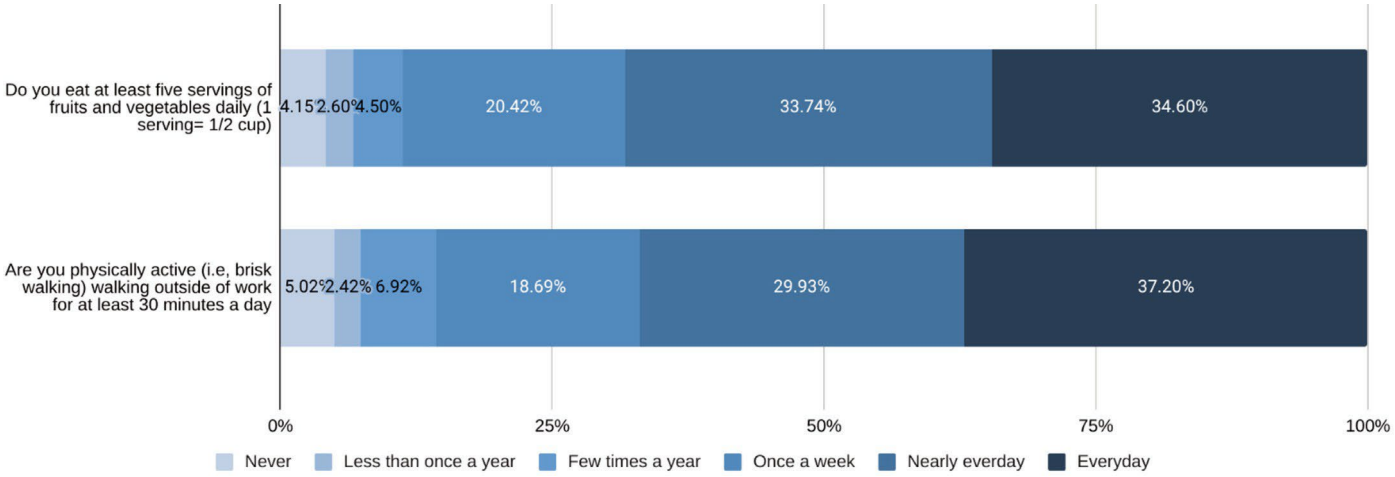
FREQUENCY OF HEALTHY BEHAVIORS

Survey responses revealed meaningful patterns in how residents approach everyday health habits. A large majority (88.8%) reported consuming at least five servings of fruits and vegetables either daily, nearly every day, or once a week (see Figure 70). However, 11.3% indicated they eat this amount only a few times a year, less than once a year, or never, highlighting gaps in consistent nutrition.

Racial and ethnic differences were notable. While White respondents were most likely to report regular intake, 4.7% said they never consume five servings of fruits and vegetables. Among Hispanic respondents, that figure rose to 8%, suggesting potential barriers to access or awareness.

Physical activity followed a similar pattern. Most respondents (85.8%) reported engaging in at least 30 minutes of exercise daily, nearly every day, or weekly. Yet 14.4% said they exercise only a few times a year or not at all. Black (8.9%) and Hispanic (8%) respondents were more likely to report never exercising, compared to White (2.9%) and Asian (6.4%) respondents. These disparities underscore the need for culturally responsive health promotion and equitable access to resources that support healthy lifestyles.

Figure 70. Frequency of Healthy Behaviors (n=578)



FREQUENCY OF UNHEALTHY BEHAVIORS

Understanding the behaviors and experiences that influence health outcomes is essential to identifying community needs. In addition to questions about nutrition and physical activity, the 2025 survey explored behaviors that pose health risks, such as substance use and distracted driving, as well as mental health challenges and barriers to accessing care. These insights help illuminate the lived realities of residents and highlight areas where targeted interventions may be most needed.

SUBSTANCE USE

Most respondents reported low engagement in behaviors that negatively impact health. A large majority indicated they never misuse prescription drugs (92%), use tobacco products (91.9%), use

recreational or illicit drugs (89.6%), or consume five or more alcoholic beverages in one sitting (82.7%).

However, racial and ethnic differences revealed important nuances. Among Asian respondents, 10.6% reported misusing prescription drugs weekly or more often—significantly higher than Black (3.5%), Hispanic (2.7%), and White (1.5%) respondents. Tobacco use was also more prevalent among Asian respondents, with 4.3% reporting use nearly every day or weekly. In contrast, 92% of Black respondents reported never using tobacco. Hispanic respondents showed moderate use, with 8% reporting use less than once a year and 5.3% a few times a month.

Recreational drug use was relatively consistent across groups, though Asian respondents reported the highest rate of monthly use (6.4%). White respondents had the highest rate of daily use (2%), followed closely by Black (1.8%) and Hispanic (1.3%) respondents.

Alcohol consumption patterns were similar across groups, with 73.9% of respondents reporting they never drink five or more alcoholic beverages in one sitting. White respondents had the highest rate of daily heavy drinking (1.2%), while Asian and Hispanic respondents reported no daily use.

DISTRACTED DRIVING

Texting while driving emerged as a concerning behavior across all racial groups. While 69.9% of respondents reported they “never” or “rarely” text while driving, nearly one in ten (9.3%) admitted to doing so “every day” or “nearly every day.” Black respondents had the highest rate of frequent texting while driving (5%), followed by Hispanic (2.7%), White (2.6%), and Asian (2.1%) respondents. These findings suggest a need for continued education and intervention around distracted driving.

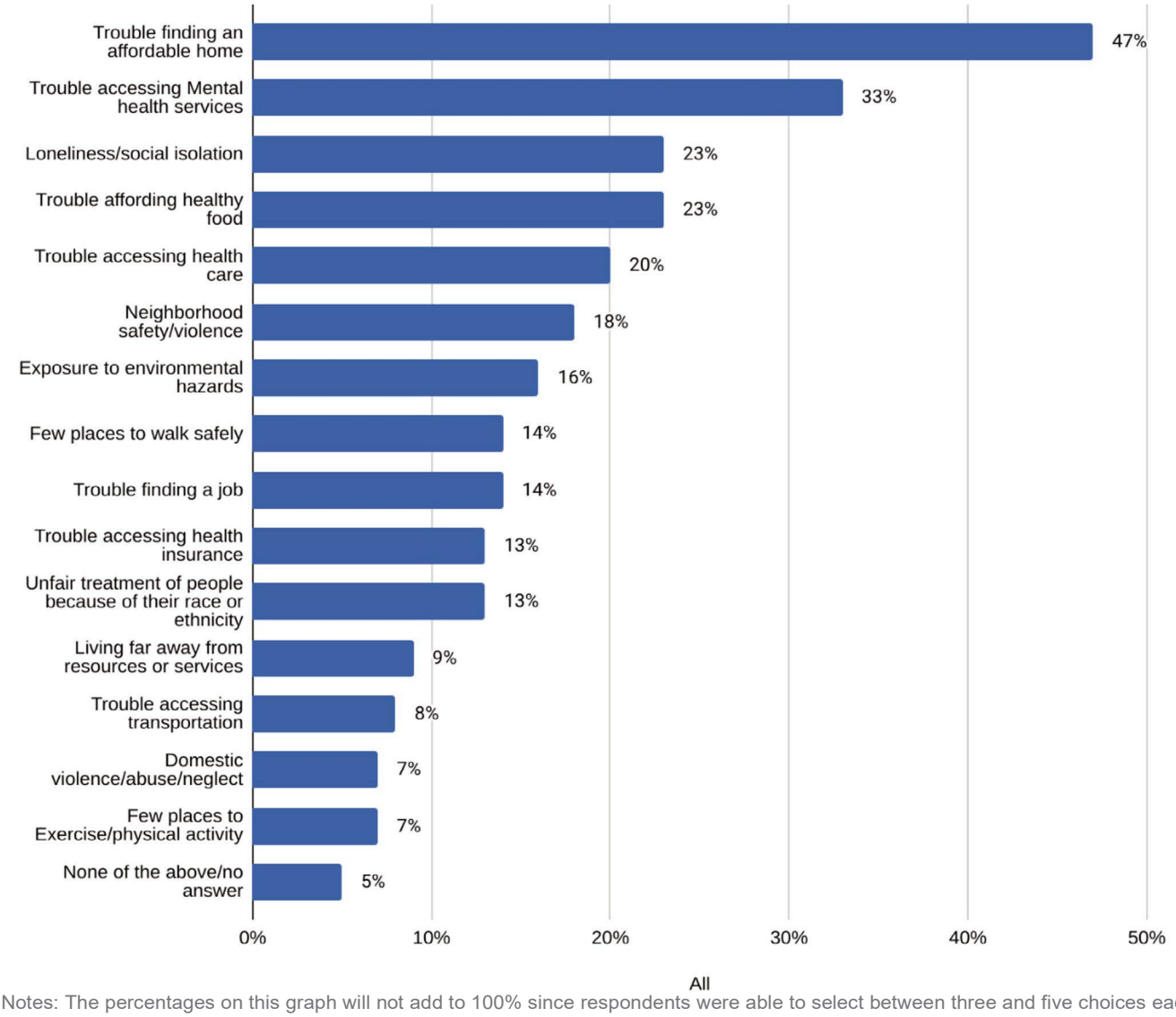
NEEDS & HEALTH PRIORITIES

This section explores the intersection of individual health concerns and the broader social and environmental factors that shape well-being across the community. Drawing from survey responses and demographic analysis, the findings reveal how issues such as housing affordability, access to care, and emotional well-being vary across racial, ethnic, and age groups. These insights provide a nuanced understanding of community needs and help identify opportunities for targeted interventions and equitable resource distribution.

SOCIAL AND ENVIRONMENTAL CONCERNS

When asked to identify the top social and environmental challenges impacting their community, nearly half of survey respondents cited “Trouble finding an affordable home” (see Figure 71) This concern was consistently ranked highest across all racial and ethnic groups, underscoring its widespread impact.

Figure 71. Top Social/Environmental Health Concerns Impacting the Community (n=616)



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

While affordable housing was a universal concern, other priorities varied by group:

- Asian respondents: Top concerns included affordable housing (34%), healthy food access (26%), and environmental hazards (26%). Access to health care and safe walking spaces were also notable (23% each).
- Black/African American respondents: Affordable housing (46%) was followed by healthy food access (34%) and unfair treatment due to race or ethnicity (26%).
- Hispanic/Latino respondents: Affordable housing (37%), healthy food access (28%), and access to health care (28%) were top concerns.
- White respondents: Affordable housing (52%), mental health access, and social isolation (23%) were most frequently selected.

In summary, affordable housing emerged as the only concern shared across all racial/ethnic

groups. Healthy food access was a top issue for Asian, Black, and Hispanic respondents, while mental health access and social isolation were primarily concerns among White respondents.

HEALTH PRIORITIES

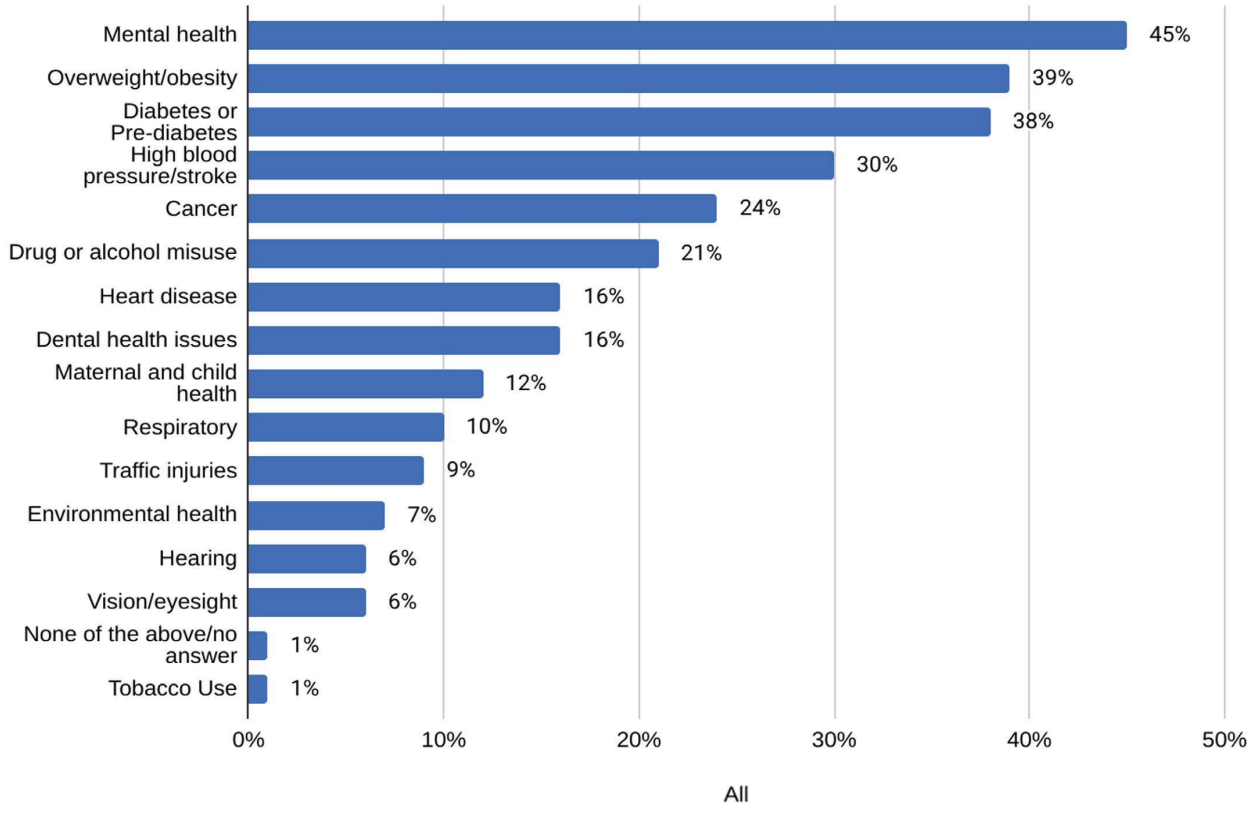
When respondents were asked to list the "top three health issues', nearly 45% selected mental health, regardless of age (see Figure 72). However, significant disparities emerged when examining responses by race and age:

- White respondents prioritized mental health at a notably higher rate (52%) compared to Black/African American respondents (26%).
- Younger adults (ages 35–44) were more likely to prioritize mental health (55%) than older adults (75+, 28%).

Other key findings include:

- Overweight/Obesity was the second most common concern overall, especially among White respondents (44%).
- Diabetes/Pre-Diabetes ranked third overall, with Black/African American respondents identifying it as their top concern (50%).
- High blood pressure/stroke was the second highest priority among Black respondents (48%) and third among Asian respondents (32%).
- Dental health was a top three concern for 36% of Hispanic/Latino respondents.

Figure 72. Top Health Issues in the Community (n=616)



BARRIERS TO HEALTH CARE

When asked about barriers to accessing health care, 30% of respondents reported having none. Among those who did face challenges, the most frequently cited barriers were cost (52%) and difficulty getting a medical appointment (39%).

Racial and ethnic differences revealed additional insights:

- Only African American/Black and White respondents selected “None” among their top three barriers.
- Hispanic/Latino respondents identified transportation as their third most common barrier.
- Asian respondents cited difficulty obtaining health insurance.
- Language differences were a more significant barrier for Hispanic respondents, who reported this issue at a rate 18% higher than the overall average.

INSURANCE STATUS

Most respondents (95%) reported having some form of health insurance. However, coverage varied by race and ethnicity. Hispanic respondents had the lowest rate of coverage, with 21% reporting they were uninsured. In comparison, nearly all White respondents (99.7%) had insurance, followed by Black (95.7%) and Asian (97.8%) respondents. These disparities point to ongoing challenges in ensuring equitable access to coverage across all communities.

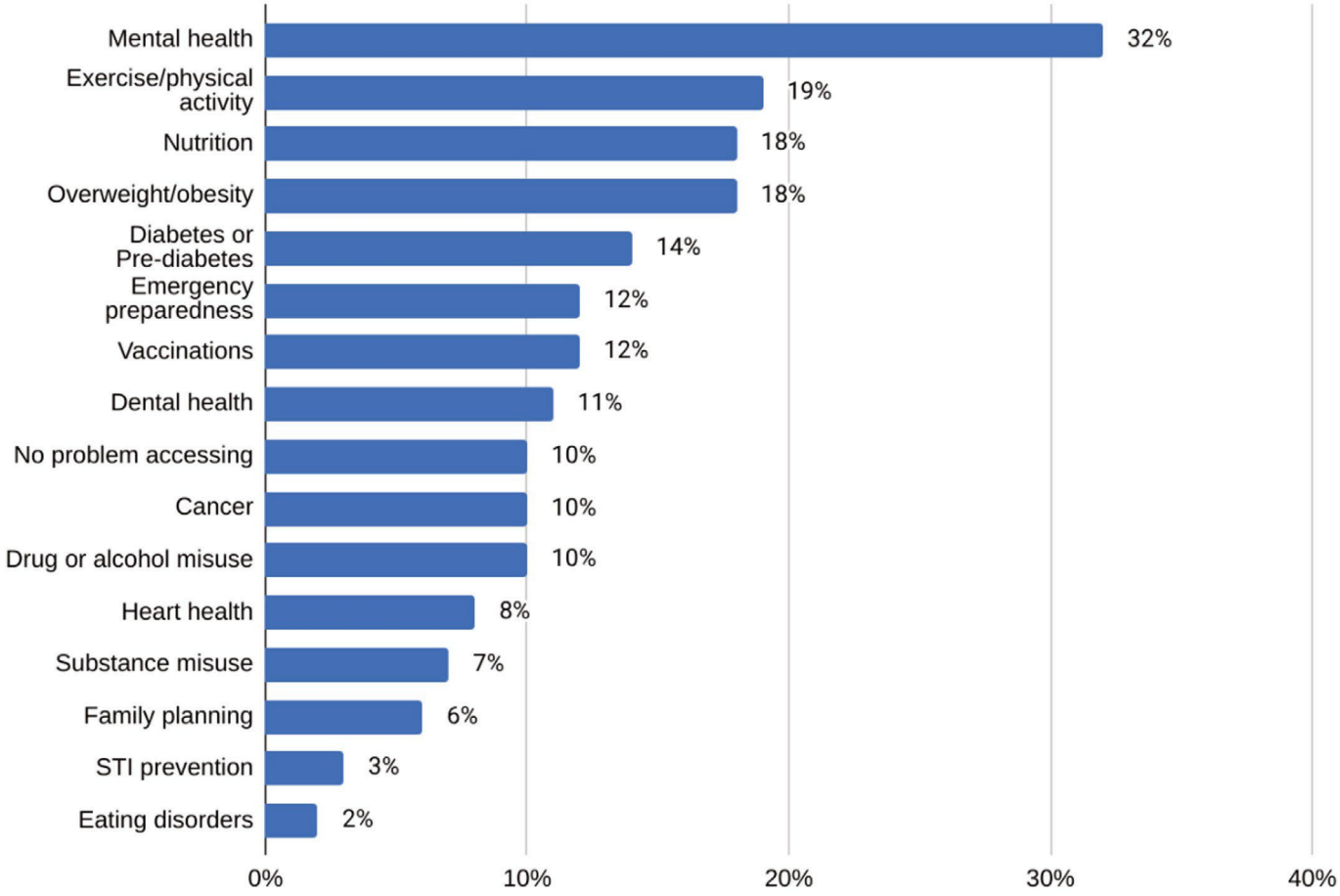
COMMUNITY IDENTIFIED PRIORITIES

To better understand which health prevention services are most needed, survey respondents were asked to select the top three services they believed would benefit their communities (see Figure 73). The most frequently selected priority was mental and behavioral health services (32%), followed by exercise and physical activity programs (19%), nutrition education (18%), and support for overweight/obesity (18%).

These findings are critical because they reflect a community-driven call for upstream intervention services that can prevent illness before it begins and promote long-term wellness. The strong emphasis on mental health prevention aligns with broader concerns about emotional well-being and access to care, as seen throughout the CHNA. Similarly, the prioritization of physical activity, nutrition, and weight management highlights the community’s awareness of chronic disease risk factors and the need for accessible, culturally relevant lifestyle support.

These priorities offer a clear direction for future programming and investment. By aligning services with the needs identified by residents themselves, health systems and community partners can build trust, improve engagement, and foster a culture of prevention. This approach not only supports better health outcomes but also strengthens the foundation for a more equitable and responsive public health infrastructure.

Figure 73. Top Community-Identified Health Priorities



EXPERIENCES OF DISRESPECT AND DISCRIMINATION

To better understand how social dynamics and interpersonal treatment affect health and well-being, the community survey asked respondents to reflect on how frequently they experience certain behaviors from others. Using a scale ranging from “Never” to “Nearly Every Day,” participants rated how often they felt disrespected, stereotyped, or unsafe due to others’ actions.

The results reveal stark disparities across racial and ethnic groups:

- Black (37.2%) and Hispanic/Latino (36%) respondents reported being treated with less courtesy or respect than others “a few times a month,” more than double the rate of White respondents (15.7%). Asian respondents also reported this experience at elevated levels (23.4%).
- Poorer service in restaurants or stores was reported by 28.3% of Black and 22.7% of Hispanic/Latino respondents at least a few times a month, compared to 12.8% of Asian and just 4.1% of White respondents.
- Perceptions of being viewed as unintelligent were common among Black (34.5%),

Hispanic/Latino (28%), and Asian (19.2%) respondents, compared to 13.1% of White respondents.

- When asked how often "people act as if they are afraid of you," Black respondents were more than seven times more likely than White respondents to report this behavior occurring "a few times a month" (24.8% vs. 3.5%). Hispanic/Latino respondents (16%) and Asian respondents (4.3%) also reported this experience, though at lower rates.
- Feelings of being threatened or harassed were most frequently reported by Hispanic/Latino respondents, with 12% experiencing this weekly or daily, and 17.3% a few times a month. Among Black respondents, 6.2% reported weekly or daily harassment, and 15% at least a few times a month. These rates were significantly higher than those reported by Asian respondents (4.3%).

These findings are deeply important because they highlight how interpersonal discrimination and microaggressions, even when subtle or routine, can have a cumulative impact on mental health, stress levels, and trust in institutions. Experiences of disrespect, fear, and exclusion are not just social issues; they are public health concerns. They shape how individuals engage with health systems, access care, and feel safe in their communities.

Understanding these lived experiences is essential for designing trauma-informed, culturally responsive health services and for fostering environments where all residents feel valued and respected. These insights call for intentional efforts to address bias, improve customer service across sectors, and build inclusive spaces that promote dignity and belonging.

SECTION 6.

CONCLUSION & COMMITMENT TO ACTION

RESPONSE TO FINDINGS

Primary data collection is a critical component of a needs assessment. However, for meaningful impact to be made, the identified unmet needs must be prioritized to reflect the feasibility of change based on the capacities of the stakeholders. This process was conducted via a brief electronic survey shared with over 50 internal and external hospital leaders, the Community Engagement Council, and other MCHC external stakeholders. Appendix I lists the organizations

represented in the prioritization process; some organizations had multiple individuals respond.

These individuals were asked to consider their experiences working in and with the community while reviewing the barriers identified during the primary data collection process and select what they believed the top three were in each of three categories. Each of the 50 respondents were also asked to rank (low, moderate, or high) the seriousness, the ease to address, and the impact of each of their responses.

CONCLUSION

The findings from this CHNA reaffirm a core truth: health is not only shaped in hospitals and clinics, but in the day-to-day conditions of people's lives – where they live, work, learn, play, and pray. While Montgomery and Prince George's Counties are rich in assets, stark disparities persist, especially along racial, geographic, and economic lines.

The CHNA was designed to highlight both local and state data and community voices. Its findings reflect a multitude of deep and intersecting challenges including barriers to care, chronic conditions, and the structural and systemic inequities that underlie them. These inequities are not accidental; they are shaped by societal rules, governance practices, and power structures that influence who has access to opportunity, safety, and health.

In response, the assessment findings have been organized into three priority domains (see Figure 74) that despite the challenges noted, take a positive and forward-looking approach and will anchor the collective response. The MCHC will address these priorities collaboratively with Montgomery County DHHS through the development of a shared implementation plan.

- **Easy Access to Comprehensive Care**: While both counties have a strong health care infrastructure, persistent gaps remain, particularly in behavioral health, maternal health, and care coordination for low-income and uninsured populations. Transportation, provider shortages, cultural responsiveness, and affordability continue to be major barriers.
- **Promotion of Healthy Living and Well-being for All**: Preventable conditions like diabetes, hypertension, asthma, and depression continue to burden residents, particularly within Black/African American, Hispanic/Latino, and immigrant communities. Opportunities exist to expand prevention, promote wellness across the life span, and strengthen community-based support for mental and physical health.
- **Support for Essential Community Services**: Housing instability and food insecurity profoundly shape health outcomes. These challenges are tied to both policy and history and include intergenerational poverty, under-resourced schools, environmental injustice, and unequal political representation.

Figure 74. Health Domains Prioritized by the MCHC

As the COVID-19 pandemic magnified these disparities in 2022, the rapidly changing political landscape and policy changes of late 2024 into 2025 continue to underscore the need for more resilient systems, inclusive policymaking, and stronger community safety nets. Yet, within this complex landscape, there are numerous strengths to build on, long-standing and trusted community-based organizations, inter-agency collaboration, and residents who are ready to lead and co-create change. Each of these community assets has been active and present in this second collaborative needs assessment, evidenced by the intentional inclusion of the Public Participation Spectrum Model to advance the inclusion and authentic voice of the community and the commitment to address the needs collaboratively with Montgomery County DHHS.

COMMITMENT TO ACTION

MCHC, in collaboration with Montgomery County DHHS, will develop a joint Implementation Strategy rooted in equity, aligned with these priority areas, and informed by the lived experiences and wisdom of community members. During the next three years, our shared commitment will focus on:

- Access to care, including maternal and behavioral health, through coordinated, culturally responsive services.
- Prevention and wellness by supporting youth development, healthy aging, and chronic disease management through both clinical and community-based approaches.
- Addressing social and structural drivers of health by:
- Leveraging cross-sector partnerships;
- Supporting policy reform and advocacy at the local and state level;

- Advancing equitable resource distribution through tools such as equity impact assessments;
- Creating pathways to housing stability, food security, economic mobility, and safe environments.

This CHNA is not simply a report – it is a roadmap for systems change. It reflects where we've been, where the gaps remain, and how we can work differently to build trust, shift power, and close disparities. Our success depends not just on what we do, but how we do it – with transparency, accountability, and in partnership with the communities most impacted by inequities. Together, we have the opportunity and the responsibility to build a healthier, more just future for all who live in our community.

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Acknowledgements

Ronna Borenstein-Levy, Principal Consultant, Levy Strategic Communications

Julie Trocchio, Patient and Family Advisory Council Co-Chair, Suburban Hospital, Johns Hopkins Medicine

Leslie Ford Weber, Associate Director, Maryland Government Affairs, Government, Community & Economic Partnerships, Johns Hopkins University & Medicine

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-adjusted	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. Mortality rates are the frequency of death within a defined population during a specific time.

ACRONYMS

ACA	Patient Protection and Affordable Care Act
ACS	American Cancer Society
AHEAD	All-Payer Health Equity Approaches and Development Model
BMI	Body Mass Index
CBSA	Community Benefit Service Area
CDC	Centers for Disease Control and Prevention
CEC	Community Engagement Council
CEP	Community Engagement Plan
CEI	Community Equity Index
CHIP	Children's Health Insurance Plan
CHNA	Community Health Needs Assessment
CLRD	Chronic lower respiratory disease
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus Disease
DHHS	Montgomery County Department of Health and Human Services
EBT	Electronic Benefit Transfer
ED	Emergency Department
EFA	Equity Focus Area
FARMS	Free and Reduced-Price Meals
FCC	Federal Communications Commission
FDA	U.S. Food and Drug Administration
FPL	Federal Poverty Level
FTE	Full-time Equivalent
FY	Fiscal Year

HHS	U.S. Department of Health and Human Services
HP2030	Healthy People 2023
HPV	Human Papillomavirus
HUD	U.S. Department of Housing and Urban Development
LBW	Low Birth Weight
LEP	Limited English Proficiency
LHI	Leading Health Indicators
LHIC	Local Health Improvement Coalition
LILA	Low Income (LI), Low Access (LA)
MCHC	Montgomery County Hospital Collaborative
MDE	Maryland Department of the Environment
MERS-CoV	Middle East Respiratory Syndrome Coronavirus
MHBE	Maryland Health Benefit Exchange
NCI	National Cancer Institute
NIH	National Institutes of Health
NSLP	National School Lunch Program
NYTS	National Youth Tobacco Survey
OECD	Organization for Economic Co-operation and Development
ORESJ	Office of Racial Equity and Social Justice
PCP	Primary Care Provider
PCSA	Primary Care Service Area
RN	Registered Nurse
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SDOH	Social Determinants of Health
SIDS	Sudden Infant Death Syndrome
SNAP	Supplemental Nutrition Assistance Program
T2D	Type 2 Diabetes
U.S.	United States
USDA	U.S. Department of Agriculture
USPSTF	U.S. Preventive Services Task Force
VLBW	Very Low Birthweight
WHO	World Health Organization
YRBS/YTS	Youth Risk Behavior Survey/Youth Tobacco Survey

In addition to the commonly used terms and acronyms provided, a list of how race and ethnicity are 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 U.S. Equal Employment Opportunity Commission 2024 and “ethnicity” indicates Hispanic or non-Hispanic origin.

RACE

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

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 / African American
A person having origins in any of the black racial groups of Africa.

Native Hawaiian / Other Pacific Islander
A person having origins in any of the 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 / Latino
A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

Non-Hispanic / Latino
A person not of Hispanic or Latino origin.

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APPENDICES

APPENDIX A HEALTHY MONTGOMERY STEERING COMMITTEE

CO-CHAIRS

Montgomery County DHHS	Dr. Kisha Davis, Montgomery County Health Officer
Primary Care Coalition	Leslie Graham, President & Chief Executive Officer

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	Susan Emery, 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
Manna Food Center	Patricia Rios, Board Member
MedStar Health, MedStar Montgomery Medical Center	Dairy Marroquin, Program Manager, Community Health
Montgomery County Collaboration Council	Jade-Ann Rennie, Program Manager, Public 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 Public Safety	Anthony Scott, EMIHS Quality Management Battalion Chief
Montgomery County Public Schools	Dr. Christina Chester, Director, Division of Psychological Services
Montgomery County Recreation	Judi-Lei Hernandez, Recreation Specialist
Montgomery Parks	Cristina Sassaki, Parks Planner Coordinator/Urban Designer
Primary Care Coalition	Leslie Graham, President & Chief Executive Officer
Suburban Hospital, Johns Hopkins Medicine	Monique Sanfuentes, Administrative Director, Community Affairs & Population Health

APPENDIX B LISTING OF COMPREHENSIVE SERVICES BY HOSPITAL

ADVENTIST HEALTHCARE

Founded in 1907, Adventist HealthCare is a faith-based, non-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 is recognized as a trusted choice for exceptional care particularly in the areas of heart, stroke, cancer, 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 and nine outpatient centers
- Two community cancer centers
- Nine imaging centers
- Mental health services
- Home care services
- Sports performance services
- Community outreach

Adventist HealthCare also promotes collaboration through the Adventist HealthCare Physician Alliance, our clinically integrated network of over 2,400 health care providers who work together to advance the quality of care and improve patient outcomes throughout the region.

For more information about our specialties, services and locations, please visit AdventistHealthCare.com

HOLY CROSS HEALTH

Holy Cross Health is a Catholic, not-for-profit health system serving more than 160,000 individuals each year from Maryland's two largest counties — Montgomery and Prince George's. Our vibrant and diverse community is always on the move, and Holy Cross Health is right there with it – evolving as a forward-thinking health system committed to helping our community members achieve better health and quality of life.

With hospitals, primary and specialty care sites, and wellness programs, Holy Cross Health is accessible throughout the region for individuals regardless of where they are on their journey to better health. For more than 60 years, Holy Cross Health has been a trusted steward of our

diverse community's well-being – rooted in compassion and committed to every individual, regardless of their ability to pay.

Our dedicated team includes more than 3,400 employees, 1,800 community-based physicians, and nearly 200 volunteers, all working together to deliver personalized, high-quality care. In just the last five fiscal years, Holy Cross Health has provided more than $280 million in community benefits, including more than $165 million in financial assistance.

Each day, our colleagues go above and beyond to move people's lives forward, providing a continuum of quality care that spans prevention, primary and specialty care, chronic disease management, inpatient care, at home services, and support groups. By making care more accessible and coordinated, we help ensure our community receives the right care, at the right time, in the right place. The Holy Cross Health system includes:

As one of the largest hospitals in Maryland, Holy Cross Hospital is proud to be home to the nation's first and region's only Seniors Emergency Center. We provide a wide range of advanced specialties and services, including:

- 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 is the first hospital in the nation to be located on a community college campus, made stronger through an innovative educational partnership. We provide high quality medical, surgical, obstetric, emergency, and behavioral health services to the county's fastest-growing region. Our specialties and services include:

- 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.

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. Suburban Hospital is one of just 12 hospitals in Maryland, and the first in Montgomery County, with a Magnet designation for excellence in nursing.

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 Johns Hopkins Cardiothoracic Surgery at Suburban.
- 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), a 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) in 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 $37.8 million in community benefit contributions in FY 2024, including 2,383 community health improvement programs, biometric screenings, wellness classes and community building activities that served 75,619 individuals in Montgomery County.

Please visit https://www.hopkinsmedicine.org/suburban_hospital/ for a detailed list of our

specialties and services.

MEDSTAR HEALTH, MEDSTAR MONTGOMERY MEDICAL CENTER

The MedStar Health system functions as a unified alliance of hospitals, physicians, outpatient centers, and other healthcare entities working together under a shared mission to provide high-quality, patient-first care across the Baltimore–Washington, D.C. region.

MedStar Montgomery Medical Center is a 138-bed, nonprofit acute care hospital located in Olney, Maryland, within the northeastern corner of Montgomery County. As part of the MedStar Health system, it has been serving the community for over 100 years, offering high-quality, compassionate, and personalized care in a welcoming environment. MedStar Montgomery Medical Center provides a broad range of health care specialties, advanced technologies, and treatments not traditionally found at community hospitals.

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

MedStar Montgomery is also dedicated to addressing health inequities by ensuring an inclusive experience, delivering high-quality and safe care equitably, and supporting those who face social barriers to living their healthiest life possible.

For a detailed list of our programs, services, and providers, visit https://www.medstarhealth.org/locations/medstar-montgomery-medical-center

APPENDIX C ADVISORY & COMMUNITY ENGAGEMENT GROUPS

ADVISORY GROUP

Cornerstone Montgomery	Cari Guthrie - President & CEO
Healthcare Initiative Foundation	Lynn Arndt, Interim Executive Director
Interfaith Works	Courtney Hall, CEO
Montgomery County Council	Gabe Albornoz, Councilmember-At-Large Beth Shuman, Chief of Staff
Montgomery County Health Department	Susan Chang, Intern
Montgomery County Department of Health and Human Services	Dr. Nina Ashford, Chief of Public Health Services Dr. Kisha Davis, Montgomery County Health Officer Julia Mandible, Special Assistant Sean O'Donnell, Deputy Public Health Services
Primary Care Coalition	Liza Greenberg, RN, MPH, Director, Workforce Capacity

COMMUNITY ENGAGEMENT GROUP

American Diversity Group	Bhavya Kandipalli
Babies Born Healthy	Kathy Awkard
Community Member	Keisha Miller
Greater Stonegate Village	Kendell Matthews
Griswold Home Care	Erin Pickerell
Inwood House	Eunice Wye
Leadership Montgomery	Miranto "Mira" Ravelomanantsoa
Western Upper Montgomery County (WUMCO) Help	Heather Witt

APPENDIX D SUMMARY OF HEALTHY MONTGOMERY KEY INFORMANT INTERVIEWS

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 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 54 stakeholders participated in the 11 KIIs. The participants of the KIIs represented the diversity of the communities they served. 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, a member of Johns Hopkins Medicine, Medstar Montgomery Medical Center, Holy Cross Health, representatives from the Montgomery Cares Clinics, and Montgomery County Boards, Committees and Commissions (Racial Equity and Social Justice Advisory Committee, Fire and Emergency Services Commission, and Board of Participants) noted that certain services or needs are greater in some zip codes as compared to others.

Community Conversation Identified Health Needs, Barriers, and Issues

Health behaviors were discussed by stakeholders as issues, 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. 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 of low-income community residents, especially because 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 suicidal 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. Intimate partner sexual violence, including physical abuse, was a health issue described by participants. Participants cited additional barriers to intimate partner sexual violence that 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. 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 that there is an increased 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. Participants identified Alzheimer's or other dementia as an increasing memory care issue for the older adult population of Montgomery County. Of note there was a need for more in-home care for older adults with Alzheimer's or other dementias. One participant shared 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". Food security and access to healthy foods was an issue discussed by many participants in 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 reveals 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.

Social, economic, and demographic factors were discussed by community stakeholders as issues, 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. Participants shared that some residents may be underemployed (limited hours or pay to support needs) or have lost their jobs due to the COVID-19 pandemic, which is contributing to poorer health outcomes in the community. Stakeholders cited that 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”, one participated 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 and stakeholders stated having difficulties navigating government/accessing services. Other factors of need cited by community stakeholders included wrap-around services and navigation support to help individuals access human services and racism as a health issue.

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. More mobile health care services were discussed as a need by community stakeholders. Access to specialty care health services was a need identified by stakeholders. One participant cited from their experience a growing number of younger adults with renal failure noting, there are “no clinics” to send patients to for hemodialysis, especially if they are uninsured or undocumented. These patients may end up “hospital hopping” to receive care, which in the long run is not good for continuity of patient care or for hospital resources. Dental care associated with costs, and the need to travel for oral health care, was a barrier identified by community stakeholders. 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.

Participants also cited that many existing mental health facilities do not have enough space for patients to keep up with the demand for treatment. Community stakeholders emphasized the need for more health care staff to support patients with healthy living. Of note were the need for more health navigators, community health educators, and care managers. Participants stated that 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. 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 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.

Community stakeholders discussed **physical and built environment** issues, 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 include both homelessness and the availability of affordable housing. Participants noted that housing insecurity (e.g., overcrowding, landlords who operate poorly maintained properties) has critical implications related to health care (e.g., medications that require refrigeration) and safety (e.g., domestic abuse, family stress, etc.).

Discrimination in the right to adequate housing was cited by stakeholders as a barrier experienced in the community. Community stakeholders stated that there is a need for more rental assistance programs and supportive and permanent housing in Montgomery County. 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. Community stakeholders shared that transportation is 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. 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.

APPENDIX E MCHC COMMUNITY BENEFIT SERVICE AREA

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 FACTORS THAT DRIVE HEALTH OUTCOMES IN MONTGOMERY & PRINCE GEORGE'S COUNTIES

County Health Rankings & Roadmaps

Compare Counties

Select from all counties or choose based on demographic, social and economic indicators.

Select year: 2024

Select | Additional

		Montgomery, MD	Prince George's, MD	Maryland	----------
		Remove Location ☐	Remove Location ☐	Remove Location ☐	Add Location ☐
Health Outcomes					
Length of Life		Montgomery, MD	Prince George's, MD	Maryland	—
Premature Death	~	4,600	8,100	7,900	
Quality of Life		Montgomery, MD	Prince George's, MD	Maryland	—
Poor or Fair Health		11%	16%	13%	
Poor Physical Health Days		2.6	3.0	2.8	
Poor Mental Health Days		4.4	4.5	4.4	
Low Birthweight		7%	10%	9%	
Health Factors					
Health Behaviors		Montgomery, MD	Prince George's, MD	Maryland	—
Adult Smoking		9%	11%	10%	
Adult Obesity		25%	40%	34%	
Food Environment Index		8.8	8.9	8.8	
Physical Inactivity		17%	24%	21%	
Access to Exercise Opportunities		100%	98%	92%	
Excessive Drinking		13%	13%	15%	

Alcohol-Impaired Driving Deaths	~	24%	32%	29%	
Sexually Transmitted Infections	~				
Teen Births		9	17	13	
Clinical Care		Montgomery, MD	Prince George's, MD	Maryland	—
Uninsured	~	7%	11%	7%	
Primary Care Physicians	~	740:1	2,020:1	1,180:1	
Dentists	~	790:1	1,580:1	1,240:1	
Mental Health Providers		250:1	460:1	290:1	
Preventable Hospital Stays	~	1,533	3,076	2,508	
Mammography Screening	~	43%	39%	43%	
Flu Vaccinations	~	56%	40%	51%	
Social & Economic Factors		Montgomery, MD	Prince George's, MD	Maryland	—
High School Completion		91%	87%	91%	
Some College		78%	64%	71%	
Unemployment	~	2.9%	3.5%	3.2%	
Children in Poverty	~	10%	14%	12%	
Income Inequality		4.6	3.9	4.6	
Children in Single-Parent Households		20%	33%	26%	
Social Associations		9.0	7.7	8.8	
Injury Deaths		46	64	92	
Physical Environment		Montgomery, MD	Prince George's, MD	Maryland	—
Air Pollution - Particulate Matter	~	6.1	7.2	7.4	
Drinking Water Violations		No	No		
Severe Housing Problems		17%	19%	15%	
Driving Alone to Work		57%	62%	68%	
Long Commute - Driving Alone		52%	61%	49%	

Note: Blank values reflect unreliable or missing data.

APPENDIX G COMMUNITY INPUT SURVEY DISTRIBUTION CHANNELS

A Wider Circle
Achieving the Dream
ADRA International
Adventist Comm Services
African American Health Program
African American Health Program
African Community Center
Age Friendly Montgomery
Allen Chapel AME Church
Alpha Phi Alpha Fraternity
American Diversity Group
American Diversity Group
ARC of Montgomery County
Arts on the Block
Asian American Health Program
Lyttonsville Neighborhood - Silver Spring, MD
Black Physicians Healthcare Network (PPHN)
Building Communities Today
Caribbean Help Center Inc
Carroll Avenue Community Center
CASA de Maryland
CenterPointe Counseling
Centro Nia
Charles E. Smith Life Communities
Chi Center, Inc.
Christ Kingdom Church
City of Gaithersburg
Clifton Park Baptist Church
Colesville Baptist Church
Colesville Council of Community Congregations (C4)
Community Bridges
Community Cheer
Community Farm Share
Community Member - Shirleeta Jackson
Community Multi Services, Inc.
Cornerstone Montgomery
Cross Community
Crossroads Community Food Network
Difference Makers
Disability Partnerships Project
East County Regional Service Center
East County Village
Eastern Montgomery Emergency Assistance Network (EMEAN)
Education Market Association
Educational Sustainability Mobilization
EmpowerMoms Doulas
Ethiopian Community Development
Ethiopian Community Center
EveryMind
Fair Access Committee
First Baptist Church Glenarden
Forcey Bible Church
Fox Chapel ES
Friendship Heights Village Center
Gaithersburg HELP
Gaithersburg/Germantown Chamber of Commerce
Generation Hope
Germantown Elementary
Gigi Montgomery County
Gilchrist Immigrant Resource Center
Girls on the Run of Montgomery County
Global Communities
Good Hope Community Center
Greater Stonegate Village
Gwendolyn Coffield Community Center
Habitat For Humanity Metro Maryland
Habitat for Humanity Metro MD
Healthcare Initiative Foundation

Hebron Association Community
Holiday Park Senior Center
Holy Cross Health Center Aspen Hill
Homestead Hustle and Healing
Housing Opportunities Commission
Housing Opportunities Commission - Georgian Court Apartments
Hughes United Methodist Church
Humanity & Inclusion U.S.
Huntley's Inc.
Identity, Inc.
Impact Silver Spring
Integrated Community Services
Interfaith Works
Inwood House
Jewish Social Services Agency (JSSA)
Kingdom Fellowship AME Church
Latin American Youth Center
Latino Community of Maryland, Inc
Latino Economic Development Center
Latino Health Initiative
Leadership Montgomery
Leisure World of Maryland - Social Services
Leveling the Playing Field
Linkages to Learning
Long Branch Community Center
Manna Food Center
Mansfield Kaseman Health Clinic
Maple Community Association, Inc
Maryland Vietnamese Mutual Association
Mary's Center
MedStar Montgomery Medical Center Patient Family Advisory Council - Community Member
Mercy Health Clinic
Mid-County United Ministries
Mindoula
Ministries United Silver Springs
Mobile Medical, Inc.
Montgomery County Cancer Coalition
Montgomery County Coalition for the Homeless
Montgomery County Crisis Center
Montgomery County DHHS Services to Prevent Homelessness
Montgomery County Food Council
Montgomery County Health Officer
Montgomery County Hospital Collaborative Community Engagement Council
Montgomery County Police Department - Latino Services
Montgomery County Public Schools Medical Officers
Montgomery County Recreation
Montgomery Hills Baptist Church
Montgomery Village Foundation
Mosaic Silver Spring
Mount Jezreel Baptist Church
Mt. Calvary Baptist Church
Muslim Community Center
National Alliance on Mental Illness
National Association Deaf
National Black Child Development, Inc.
NeighborWorks Capital
Nourish Now
Olney Home for Life
Operation Home Village
Parenting Encouragement Program
People Community Baptist Church
Pilgrim Baptist Church
Potomac Conservancy
Primary Care Coalition
Prince George's County Health Department
Pro Bono Counseling

Program of All-Inclusive Care for the Elderly (PACE)

Proyecto Salud

Rainbow Community Development

Rebuilding Together Montgomery County

Redeemer's Community Development

Represent Women

Round Oak Missionary Baptist Church

Scotland Community

Shephard's Table, Inc.

Silver Spring Welcome Center

SLK Health Services Corporation (PG)

SOAR! (Support Our Aging Religious)

Spanish Speaking Community

St Michael the Archangel Catholic Church

Sunflower Bakery

Symbral Foundation

Takoma East Silver Spring

Takoma Park Baptist Church

TESS Community Action Center

The Center for Workforce Inclusion

The Civic Circle

The First Baptist Church of Silver Spring

Tivoli Community Association

TSC Alliance

Western Upper Montgomery County (WUMCO)

YMCA of Metropolitan Washington

APPENDIX H KEY STAKEHOLDERS & INFORMANTS FOR PRIORITIZATION PROCESS

- A Wider Circle
- Adventist HealthCare
- Age Friendly Montgomery County
- American Diversity Group
- Charles E. Smith Life Communities
- Community Farm Share
- Community Member
- Eastern Montgomery Emergency Assistance Network
- EveryMind
- EveryMind Linkages to Learning Program
- Fair Access for the Western County
- Girls on the Run of Montgomery County, MD
- Greater Stonegate Village
- Griswold Home Care
- Healthcare Initiative Foundation
- Holy Cross Health
- Holy Cross Health Network
- Interfaith Works
- Mary's Center for Maternal and Child Care, Inc.
- Muslim Community Center (MCC) Medical Clinic
- MedStar Health
- MedStar Montgomery Medical Center
- Montgomery County DHHS
- Montgomery County Recreation
- Primary Care Coalition
- Retired Community Member, formerly with CHEER
- Suburban Hospital
- Trinity Health PACE
- Village of Friendship Heights
- Washington Metro Oasis
- Wholistic Birth Project
- Western Upper Montgomery County (WUMCO) Help, Inc.

APPENDIX I EVALUATION OF PRIOR CHNAS

ACCESS TO HEALTH CARE SERVICES

CHNA IMPACT	CHNA BASELINE 2022	TARGET	ACTUAL/CURRENT (MCHC CBSA)α 2025	ACTUAL/ CURRENT (MC) 2025	ACTUAL/ CURRENT (PGC) 2025
Uninsured rate (%)	MCHC CBSA: 9.6% MC: 7.1% PGC: 10.1%	0%†	9.1%	6.8%	11.2%

PROGRAMS AND SERVICES

Adventist HealthCare: Provide financial support to several safety-net clinics within the CBSA through grants and sponsorships; Partner with the safety-net clinics to provide in-kind lab and imaging services for uninsured patients; Provide support to uninsured patients by assisting with enrollment to publicly funded programs and hospital charity care programs.

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, Elevate for Medicaid Emergency Medicaid program, Social Care Hub referrals.

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; Provide support to uninsured patients by assisting with enrollment to publicly funded programs and hospital charity care programs.

Suburban Hospital: MobileMed/NIH Heart Clinic at Suburban Hospital, MobileMed/NIH Endocrine Clinic at Suburban Hospital, Certified Diabetes Education for under/uninsured patients.

AGING AND OLDER ADULTS

CHNA IMPACT	CHNA BASELINE 2022	TARGET	ACTUAL/ CURRENT (CBSA)α 2025	ACTUAL/ CURRENT (MC) 2025	ACTUAL/ CURRENT (PGC) 2025
Life expectancy	MCHC CBSA: N/A MC: 84.2 PGC: 78.4	79.8††	82.3	83.5	77.9
Decrease death rate due to falls in older adults (per 100,000)	MCHC CBSA: N/A MC: 84.2 PGC: 44.0	47.0†	N/A	8.4	5.4

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; Host and offer age-friendly senior wellness virtual and in-person health education programs, dementia-friendly seminars, and fall prevention workshops; Partner with local skilled nursing facilities to improve transitions of care and quality between hospitals and nursing home; Expansion of Center for Successful Aging.

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

BEHAVIORAL HEALTH

CHNA IMPACT	CHNA BASELINE 2022	TARGET	ACTUAL/ CURRENT (CBSA)α 2025	ACTUAL/ CURRENT (MC) 2025	ACTUAL/ CURRENT (PGC) 2025
Decrease percentage of adults with poor mental health	**MCHC CBSA:11.6% MC: 10.0% PGC: 12.4%**	**16.8%Δ**	**15.0%**	**13.4%**	**15.2%**

PROGRAMS AND SERVICES

Adventist HealthCare: Counseling, Therapy and Medication Management Services; Substance Abuse Treatment through Intensive Outpatient and Structured Outpatient Programs; Inpatient Psychiatric Care; Partial Hospitalization Program; Lourie Center for Children's Social & Emotional Wellness; Ridge School Special Education Day School; The Manor (assisted living facility for adults with chronic and severe mental illness who are unable to live independently); 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 A Resilient Person); Behavioral Health Internships; Mental Health First Aid; Forensic Medical Unit at Shady Grove Medical Center; Grants and Sponsorships Addressing Access to Care for Behavioral Health.

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, Offer Mental Health First Aid Trainings to faith communities.

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; Provide sponsorships to organizations addressing access to care for Behavioral health.

Suburban Hospital: Concerned Persons Program, Addiction Treatment Center, Support to Parents Encouragement Program with their Critical Topics in Parenting Series, Village Ambassador Alliance, Monthly Health Webinars, Engaged as a member of Nexus Montgomery Regional partnership, Charles E. Smith Life Communities Symposium-Embracing Calm: Navigating Anxiety in the Senior Years, National Alliance on Mental Illness-NAMI in the Lobby, Annual Tara McMahon Behavioral Health Symposium: Understanding the Growing Mental Health Crisis in our Community; Conduct Screenings through Brief Interventions and Referral to Treatment (SBIRT) Program in the Emergency Room, supported by Peer Recovery Coaches.

MCHC Joint Program: Behavioral health community health education partnership with EveryMind.

CHRONIC DISEASE: CANCER

	CHNA BASELINE 2022	TARGET	ACTUAL/ CURRENT (CBSA)α 2025	ACTUAL/ CURRENT (MC) 2023-2025	ACTUAL/ CURRENT (PGC) 2023-2025
	MCHC CBSA: 118.7 MC: 114.6 PGC: 149.9	147.4††	137.3	134	149.7

PROGRAMS AND SERVICES

Adventist HealthCare: Classes, Support Groups and Workshops for Patients, Family Members, and Caregivers (e.g. Navigating the New Normal Support Group, Gentle Yoga with Meditation, Mindfulness, Nutritional Management of Side Effects for Treatment, Ask a Dietician, etc.); Annual Breast Cancer Survivorship Event; Webinars, Health Education Events, and Screening, Awareness and Health Risk Assessment Campaigns.

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; Annual Breast Cancer and You educational seminar, focused on early prevention and detection, host community educational tables focused on cancer prevention awareness.

Suburban Hospital: American Lung Association's Better Breathers Club, American Lung Association's Freedom from Smoking Program, Referrals to the MD Quitline, Colorectal Cancer Awareness Education, Talk & Walk for Breast Cancer Survivors, Yoga for Cancer Survivors, Prostate Cancer Support Group, Prostate Cancer Symposium, HPV education.

CHRONIC DISEASE: CARDIOVASCULAR HEALTH

CHNA IMPACT	CHNA BASELINE 2022	TARGET	ACTUAL/ CURRENT (CBSA)α 2025	ACTUAL/ CURRENT (MC) 2023-2025	ACTUAL/ CURRENT (PGC) 2023-2025
Decrease heart disease mortality (per 100,000)	MCHC CBSA: N/A MC: 97.9 PGC: 181.3	166.3††	67.2	63.8	79.9

PROGRAMS AND SERVICES

Adventist HealthCare: Community Health Screenings and Lectures; Webinars, Health Education Events, and Screening, Awareness and Health Risk Assessment Campaigns; Grants and Sponsorships Addressing Chronic Disease Prevention & Management.

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, Pilates and Strength Training, Senior Shape Exercise Programs including several classes that focus on Aerobics, Weight Training, Flexible Strength and Stability Ball, Blood pressure screenings, Health Education Seminars/Webinars, Women's and Men's Health Symposia, MobileMed/NIH Heart Clinic at Suburban Hospital, HeartWell clinic at Friendship Heights Village Center, Heart Failure Education.

CHRONIC DISEASE: DIABETES

CHNA IMPACT	CHNA BASELINE 2022	TARGET	ACTUAL/ CURRENT (CBSA)α 2025	ACTUAL/ CURRENT (MC) 2025	ACTUAL/ CURRENT (PGC) 2025
Decrease percentage of adults with Diabetes	**MCHC CBSA: 9.0% MC: 7.2% PGC: 12.3%**	**10.2%◊**	**9.90%**	**9.1%**	**13.0%**

PROGRAMS AND SERVICES

Adventist HealthCare: Diabetes Education Classes and Support Groups (Nutrition, Gestational Diabetes); Tailored one-on-one Diabetes Education and Support for High-Risk Patients in our Clinically Integrated Network in English and Spanish; Community Health Screenings & Lectures; Integrative Medicine Programs; Food & Nutrition Classes; Grants and Sponsorships Addressing Chronic Disease Prevention & Management.

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 Self-Management support 3-part series and Spanish Diabetes Self-Management support class.

Suburban Hospital: Pre-Diabetes: Laying the Foundation, Thrive 365 Education and Support Group Meetings in English, Diabetes A-Z Management, Breakthrough T1D, formally JDRF Type 1 Support Group, Health Education Webinars, MobileMed/NIH Endocrine Clinic at Suburban Hospital, Certified Diabetes Education counseling for under/uninsured patients.

CHRONIC DISEASE: OBESITY

CHNA IMPACT	CHNA BASELINE 2022	TARGET	ACTUAL/ CURRENT (CBSA)α	ACTUAL/ CURRENT (MC) 2025	ACTUAL/ CURRENT (PGC) 2025
Decrease the percent of adults who are overweight or obese	**MCHC CBSA: N/A MC: 56.4% PGC: 71.2%**	**64.3%††**	**N/A**	**61.5%**	**76.1%**

PROGRAMS AND SERVICES

Adventist HealthCare: Community Health Screenings and Lectures; Grants and Sponsorships Addressing Chronic Disease Prevention & Management

Holy Cross Health: BMI assessments and diagnosis of obesity for health center patients, Implementation of Kids Fit program.

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.

Suburban Hospital: Senior Shape Exercise Programs, Health Partner of Girls on the Run Montgomery County, Health Education Seminars/Webinars on nutrition and exercise.

EDUCATION

CHNA IMPACT	CHNA BASELINE 2022	TARGET	ACTUAL/ CURRENT (CBSA)α	ACTUAL/ CURRENT (MC) 2024	ACTUAL/ CURRENT (PGC) 2023
Increase percentage of students who graduate high school in 4 years	**MCHC CBSA: 88.7% MC: 87.2% PGC: 91.4%**	**95.0%†**	**N/A**	**91.8%**	**74.4%**

PROGRAMS AND SERVICES

Adventist HealthCare: Education & Workforce Development (Medical Careers Program, Stepping Stones, Clinical Shadowing, Internships & Fellowships); Grants and Sponsorships Addressing Educational Inequities

MedStar Montgomery: High School Students shadowing Program and CNA Clinical Placements for High School students, Internships and Fellowships with Healthcare Professional Developments.

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

FOOD INSECURITY

CHNA IMPACT	CHNA BASELINE 2022	TARGET	ACTUAL/ CURRENT (CBSA)α 2025	ACTUAL/ CURRENT (MC) 2025	ACTUAL/ CURRENT (PGC) 2025
2022: Reduce percent of population that experienced food insecurity at some point in a year **2025: Reduce household food insecurity and hunger**	**MCHC CBSA: 7.6% MC: 8.6% PGC: 7.3%**	**6.0%†**	**10.7%**	**11.1%**	**9.3%**

PROGRAMS AND SERVICES

Adventist HealthCare: Hungry Harvest Rx; Food is Medicine Program for Food Insecure Youth; Grants and Sponsorships Addressing Food Access

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 Find Help 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; host food drives to support local food pantries.

Suburban Hospital: Provide financial support to Manna Food, Nourishing Now

INFECTIOUS DISEASE

CHNA IMPACT	CHNA BASELINE 2022	TARGET	ACTUAL/ CURRENT (CBSA)α	ACTUAL/ CURRENT (MC) 2023	ACTUAL/ CURRENT (PGC) 2023
Septicemia Age-Adjusted Death Rate	**MCHC CBSA: N/A MC: 8.6 PGC: N/A**	**N/A**	**N/A**	**13**	**14.5**
Influenza & Pneumonia Age-Adjusted Death Rate	**MCHC CBSA: N/A MC: 8.4 PGC: 10.3**	**N/A**	**N/A**	**10.2**	**10.2**

PROGRAMS AND SERVICES

Suburban Hospital: Health Education seminars, Knots for Shots: Flu Vaccination Initiative.

MATERNAL AND CHILD HEALTH

CHNA IMPACT	CHNA BASELINE 2022	TARGET	ACTUAL/ CURRENT (CBSA)α 2025	ACTUAL/ CURRENT (MC) 2021-2025	ACTUAL/ CURRENT (PGC) 2021-2025
Decrease infant mortality rate (per 1,000 births)	**MCHC CBSA: N/A MC: 5.2 PGC: 5.5**	**6.3††**	**5.6**	**5.0**	**7.4**

PROGRAMS AND SERVICES

Adventist HealthCare: Parent and Family Education Support Groups (Childbirth and Infant Care Classes, Breastfeeding Education Support & Togetherness - B.E.S.T., Discovering Motherhood, Perinatal Loss Support Group, Gestational Diabetes Education Class); 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, infant feeding, childbirth education and infant care educational classes.

Suburban Hospital: Safe Sitter Babysitting Program, Health Partner of Girls on the Run Montgomery County, community contributions to Bethesda Chevy Chase YMCA and Parent Encouragement Program

HOUSING

CHNA IMPACT	CHNA BASELINE 2022	TARGET	ACTUAL/ CURRENT (CBSA)α 2025	ACTUAL/ CURRENT (MC) 2025	ACTUAL/ CURRENT (PGC) 2025
Reduce the proportion of families that spend more than 30% of income on housing	**MCHC CBSA: 33.7% MC: 32.1% PGC: 36.7%**	**34.6%†**	**31.7%**	**30.0%**	**34.6%**

PROGRAMS AND SERVICES

Adventist HealthCare: Grants and Sponsorships Addressing Housing and Homelessness.

Holy Cross Health: Pathways to Independent Employment Program.

MedStar Montgomery: Provide grant funding and sponsorships to community organizations addressing housing cost burden.

UNINTENTIONAL INJURY

CHNA IMPACT	CHNA BASELINE 2022	TARGET	ACTUAL/ CURRENT (CBSA)α	ACTUAL/ CURRENT (MC) 2023	ACTUAL/ CURRENT (PGC) 2023
Accidents/Unintentional Injury Deaths (per 100,000)	**MCHC CBSA: N/A MC: 33.4 PGC: 32.9**	**36.4†**	**N/A**	**35.7**	**52.8**

PROGRAMS AND SERVICES

Adventist HealthCare: Grants and Sponsorships Addressing Safely Aging in Place.

Suburban Hospital: Senior Shape Exercise Program including 21 classes that focus on Aerobics, Weight Training, Flexible Strength and Stability, Tai Chi, Intermediate Taiji, Pilates and Strength Training.

OTHER

CHNA IMPACT	CHNA BASELINE	TARGET	ACTUAL/CURRENT (CBSA)α
Number of grants and sponsorships awarded to community organizations addressing CHNA priority areas	**MCHC CBSA: N/A MC: 79 PGC: 25**	**N/A**	**2025: TBD 2024: 43 Grants & 44 Sponsorships 2023: 37 Grants & 41 Sponsorships 2022: 25 Grants & 39 Sponsorships**

PROGRAMS AND SERVICES

Adventist HealthCare: Community Partnership Fund (CPF).

MedStar Montgomery: Community Sponsorships Program.

Suburban Hospital: Community Giving Program.

α Refers to the current collaborative CHNA
* Indicator measurement changed which prevents comparison
+ Provided Target value from Healthy People 2030
Δ Median or mean value for all counties in the state
†† MD SHIP Target
◊ Represents the 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

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, and we hope the collaborative nature of the 2025 MCHC CHNA Report is valued as an enhanced asset. As members of the community, we invite you to submit questions and feedback on this CNHA. To request a print copy of the report or to submit your comment, please contact:

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HOLY CROSS HEALTH
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SUBURBAN HOSPITAL
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