Q1.
Introduction:

COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) Community Benefit Report, required under §19-303 of the Health General Article, Maryland Annotated Code, is the Commission's method of implementing a law that addresses the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals.

The Commission developed a two-part community benefit reporting system that includes an inventory spreadsheet that collects financial and quantitative information and a narrative report to strengthen and supplement the inventory spreadsheet. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulatory environment. This reporting tool serves as the narrative report. The instructions and process for completing the inventory spreadsheet remain the same as in prior years. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

The Commission moved to an online reporting format beginning with the FY 2018 reports. In this new template, responses are now mandatory unless marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

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

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

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

	Is this information correct?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: UM Capitol Region Health	◉	○	
Your hospital's ID is: 210003	◉	○	
Your hospital is part of the hospital system called University of Maryland Medical System.	◉	○	

Q4. The next two questions ask about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

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

To gain a clearer understanding of the current and future health and human services needs among residents, the level of unmet need, and the resources being allocated to health, the Prince George's County Council, acting as the County Board of Health, contracted with the RAND Corporation in 2019 to complete a health and human services needs assessment in its pursuit of a Health in All Policies approach to policymaking. This assessment builds on the 2009 RAND assessment and other County reports to more deeply examine the drivers of health influencing health outcomes. The findings are based on original analyses of primary and secondary data, as well as synthesis of existing studies, proposed operating budgets, and promising practices from other relevant communities and regions across the country.

Q6. (Optional) Please attach any files containing community health statistics that your hospital uses in its community benefit efforts.

RAND_RRA647-1.pdf
7.5MB
application/pdf

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

Q8. Please select the county or counties located in your hospital's CBSA.

- [ ] Allegany County
- [x] Anne Arundel County
- [ ] Baltimore City
- [ ] Baltimore County
- [ ] Calvert County
- [ ] Charles County
- [ ] Dorchester County
- [ ] Frederick County
- [ ] Garrett County
- [ ] Harford County
- [x] Prince George's County
- [ ] Queen Anne's County
- [ ] Somerset County
- [ ] St. Mary's County
- [ ] Talbot County

☐ Caroline County	☑ Howard County	☐ Washington County
☐ Carroll County	☐ Kent County	☐ Wicomico County
☐ Cecil County	☑ Montgomery County	☐ Worcester County

Q9. Please check all Allegany County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

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

☐ 20701	☐ 20776	☐ 21062	☐ 21146
☐ 20711	☐ 20778	☐ 21076	☐ 21225
☐ 20714	☐ 20779	☐ 21077	☐ 21226
☑ 20724	☐ 20794	☐ 21090	☐ 21240
☐ 20733	☐ 21012	☐ 21106	☐ 21401
☐ 20736	☐ 21032	☐ 21108	☐ 21402
☐ 20751	☐ 21035	☐ 21113	☐ 21403
☐ 20754	☐ 21037	☐ 21114	☐ 21404
☐ 20755	☐ 21054	☐ 21122	☐ 21405
☐ 20758	☐ 21056	☐ 21123	☐ 21409
☐ 20764	☐ 21060	☐ 21140	☐ 21411
☐ 20765	☐ 21061	☐ 21144	☐ 21412

Q11. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

- [ ] 20701
- [x] 20723
- [ ] 20759
- [ ] 20763
- [ ] 20777
- [ ] 20794
- [ ] 20833
- [ ] 21029
- [ ] 21036
- [ ] 21041
- [ ] 21042
- [ ] 21043
- [ ] 21044
- [ ] 21045
- [ ] 21046
- [ ] 21075
- [ ] 21076
- [ ] 21104
- [ ] 21150
- [ ] 21163
- [ ] 21723
- [ ] 21737
- [ ] 21738
- [ ] 21765
- [ ] 21771
- [ ] 21784
- [ ] 21794

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

This question was not displayed to the respondent.

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

- [ ] 20058
- [ ] 20207
- [ ] 20707
- [ ] 20777
- [ ] 20783
- [ ] 20787
- [ ] 20810
- [ ] 20811
- [ ] 20812
- [ ] 20814
- [ ] 20815
- [ ] 20816
- [ ] 20817
- [ ] 20818
- [ ] 20824
- [ ] 20825
- [ ] 20827
- [ ] 20830
- [ ] 20832
- [ ] 20833
- [ ] 20837
- [ ] 20838
- [ ] 20839
- [ ] 20841
- [ ] 20842
- [ ] 20847
- [ ] 20848
- [ ] 20849
- [ ] 20850
- [ ] 20851
- [ ] 20852
- [ ] 20853
- [ ] 20854
- [ ] 20855
- [ ] 20857
- [ ] 20859
- [ ] 20860
- [ ] 20861
- [ ] 20862
- [ ] 20866
- [ ] 20868
- [ ] 20871
- [ ] 20872
- [ ] 20874
- [ ] 20875
- [ ] 20876
- [ ] 20877
- [ ] 20878
- [ ] 20879
- [ ] 20880
- [ ] 20882
- [ ] 20883
- [ ] 20884
- [ ] 20885
- [ ] 20886
- [ ] 20889
- [ ] 20891
- [ ] 20892
- [ ] 20894
- [ ] 20895
- [ ] 20896
- [ ] 20898
- [ ] 20899
- [ ] 20901
- [ ] 20902
- [ ] 20903
- [x] 20904
- [ ] 20905
- [ ] 20906
- [ ] 20907
- [ ] 20910
- [ ] 20911
- [ ] 20912
- [ ] 20913
- [ ] 20914
- [ ] 20915
- [ ] 20916
- [ ] 20918
- [ ] 20993
- [ ] 21770
- [ ] 21771
- [ ] 21797

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

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

Q26. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q33. How did your hospital identify its CBSA?

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

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

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

  UM Prince George's Hospital Center and UM Laurel Medical Center primary and secondary service areas, based on Patient Care analyst data.

- [x] Other. Please describe.

  The CBSA also, includes zip codes/geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside, based on the SocioNeeds Index, updated for 2019. The 2019 SocioNeeds Index, created by Conduent Healthy Communities Institute, is a measure of socioeconomic need that is correlated with poor health outcomes. The SocioNeeds Index is calculated by Conduent Healthy Communities Institute using data from Claritas

Q34. (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

Portions of Prince George's County Maryland boarder the District of Columbia- wards 7 and 8. Data provided based on Patient Care Analyst indicate portions of the district that boarder PGC are also included in both our primary and secondary service areas.These zip codes include: 20019, 20020, 20032, 20002.

Q35. Section I - General Info Part 3 - Other Hospital Info

Q36. Provide a link to your hospital's mission statement.

https://www.umms.org/capital/about/mission-vision-values

Q37. Is your hospital an academic medical center?

- ○ Yes
- ◉ No

Q38. (Optional) Is there any other information about your hospital that you would like to provide?

UNIVERSITY OF MARYLAND CAPITAL REGION HEALTH University of Maryland Capital Region Health (formerly Dimensions Healthcare System), is the largest not-for-profit provider of healthcare services in Prince George's County , Maryland. UM Capital includes University of Mary land Prince George's Hospital Center, Cheverly, MD; University of Maryland Laurel Medical Center, Laurel, Maryland; and University of Maryland Bowie Health Center, Bowie, Maryland. University of Maryland Capital Region Health is wholly owned by the University of Mary land Medical System. Leadership: Chairman, UM Capital Board of Directors – Judge Alexander Williams President & CEO (Interim), UM Capital Region Health, Senior Vice President and Chief Medical Officer – Dr. Joseph L. Wright, MD, MPH, FAAP Senior Vice President Strategic Planning & Business Development - Jeffrey L. Johnson, MBA, FACHE Chief Nurse Officer – Katie Boston-Leary, PHD, MBA, MHA Senior Vice President Clinical Integration and Ambulatory Services - Tiffany Sullivan, MPH UNIVERSITY OF MARYLAND PRINCE GEORGE'S HOSPITAL CENTER: Located in Cheverly, Maryland, University of Maryland Prince George's Hospital Center (UM PGHC) is a private not-for-profit acute care teaching hospital and regional referral center which has been providing quality healthcare services to the southern Maryland region since 1944. Over the past 70 years, University of Maryland Prince George's Hospital Center has grown to become the region's major tertiary care center and one of its largest employers. UM PGHC is a member of the University of Maryland Capital Region Health (UM Capital), formerly Dimensions Healthcare System. Location: 3001 Hospital Drive, Cheverly , Maryland 20785 Facility type: Acute care teaching hospital and regional referral center Specialty services: A comprehensive range of inpatient and outpatient medical and surgical services including: • Emergency and trauma services (designated Level II regional trauma center for southern Maryland) • Critical care services • Cardiovascular Care Center (comprehensive cardiac care – only program of its kind in the County) o Open-heart surgery o Two cardiac catheterization labs (diagnostic & therapeutic cardiac caths, cardiac stenting) o 10 bed CCU and 66 telemetry beds o Cardiac diagnostic evaluation center o Cardiac rehabilitation • Laboratory and pathology testing • Medical and surgical services (virtually all adult specialties performed) • Maternal and child health o Labor and delivery postpartum units o Perinatal diagnostic center o Diabetes and pregnancy program o Neonatal intensive care unit (designated Level III, regional center for Prince George's County) o Inpatient pediatric unit o Chronic pediatric inpatient unit and outpatient program Other specialty services: • Ambulatory and outpatient services o Surgical short-stay center o Special procedures o Diabetes treatment center o Mt. Washington Pediatric Hospital at UM Prince George's Hospital Center o University of Maryland Bowie Health Center o University of Maryland Capital Region Surgery Center (a freestanding ambulatory surgery center located on the University of Maryland Bowie Health Center campus) o University of Maryland, Capital Region Health Medical Group; Bowie, Cheverly, Suitland and Laurel Maryland. o • Behavioral health services o Inpatient psychiatric unit for adults o Hospital-based sexual assault center o Partial hospitalization program o Emergency psychiatric services • Domestic Violence and Sexual Assault Center • Graduate medical education, internal medicine and f amily medicine residency programs Facilities: • The Surgical Services and Critical Care Center Pavilion houses a 24 bed intensive care unit, 10 operating suites, a 15 bay Post Anesthesia Care Unit, 11 private room Short Stay Center, two state-of -the-art cardiac catheterization labs with 10 Transcare bays and 2 endoscopy suites with 9 recovery bay s. • The UM PGHC Emergency Department includes 15 acute care rooms, 4 hall area beds, a 4 bed resuscitation area, 2 isolation rooms, 2 dedicated trauma rooms, an 8 bed ambulatory emergency area, with 2 minor trauma/suture rooms and a designated ENT room, point-of -care testing, a 16-bed distinct observation unit and a blood bank. • UM PGHC also has a licensed, freestanding emergency department, located on the Bowie Health Center campus. The emergency department includes 27 beds, including two cardiac rooms, 2 suture rooms and an isolation room. The department also has a stat lab, and radiology services, including CT and ultrasound. UNIVERSITY OF MARYLAND LAUREL MEDICAL CENTER: Effective January 1, 2019 the Laurel facility transitioned from a full service hospital to a not-for-profit, free standing medical facility serving residents of Prince George's County and portions of Anne Arundel, Howard, and Montgomery counties. The Laurel Medical Center is now under UM Prince George's Hospital's CMS Certification Number (CCN). Leadership: Site Executive & Vice President Medical Affairs, UM LRH (Interim) – Trudy Hall, M.D. Location: 7300 Van Dusen Road, Laurel, Maryland 20707 Facility type: Free-standing Medical Facility Services: University of Maryland Laurel Medical Center provides a comprehensive range of outpatient services including: Behavioral Health Services (outpatient partial hospitalization program) Emergency Services (24- hour emergency care) Observation care (24-48 hour length of stay) Wound Care & Hyperbaric Medicine Center (wound treatment and healing services) Facilities: The emergency services has 27 total rooms (ambulatory care) that includes one resuscitation/trauma room; 4 behavioral health rooms, 4 isolation rooms and 3 more that can be converted to negative pressure isolation rooms; POC (Point of Care) lab, and blood bank located in the main lab. Surgical services houses 2 operating suites and 2 procedure rooms/endoscopy suites.

Q39. (Optional) Please upload any supplemental information that you would like to provide.

Q40. Section II - CHNA Part 1 - Timing & Format

Q41.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- ◉ Yes
- ○ No

Q42. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q43. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

06/1/2019

Q44. Please provide a link to your hospital's most recently completed CHNA.

https://www.umms.org/capital/-/media/files/um-capital/community/community-health-assessment-2019.pdf?
upd=20190702140715&la=en&hash=894B8FCED4641B36B25846EF26B995663AA51186

Q45. Did you make your CHNA available in other formats, languages, or media?

- (●) Yes
- ( ) No

Q46. Please describe the other formats in which you made your CHNA available.

Printed copies are provided on demand.

Q47. Section II - CHNA Part 2 - Internal Participants

Q48. Please use the table below to tell us about the internal participants involved in your most recent CHNA.

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

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

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

Q49. Section II - CHNA Part 2 - External Participants

Q50. Please use the table below to tell us about the external participants involved in your most recent CHNA.

	CHNA Activities									
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here: Doctor's Community Hospital, Fort Washington Medical Center, Medstar Southern Maryland Hospital Center	[ ]	[x]	[x]	[x]	[x]	[x]	[x]	[x]	[ ]	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Department -- Please list the Local Health Departments here: Prince George's County Health Department	[ ]	[x]	[x]	[x]	[x]	[x]	[x]	[x]	[ ]	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Improvement Coalition -- Please list the LHICs here: Prince George's Health Action Coalition	[ ]	[ ]	[ ]	[ ]	[x]	[x]	[x]	[ ]	[ ]	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Health	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[x]	[ ]	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Human Resources	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[x]	[ ]	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Organization	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Natural Resources	☐	☐	☐	☐	☐	☐	☐	☑	☐	
Maryland Department of the Environment	☐	☐	☐	☐	☐	☐	☐	☑	☐	
Maryland Department of Transportation	☐	☐	☐	☐	☐	☐	☐	☑	☐	
Maryland Department of Education	☐	☐	☐	☐	☐	☐	☐	☑	☐	
Area Agency on Aging -- Please list the agencies here: Prince George's County Area Agency on Aging	☐	☐	☐	☐	☑	☑	☑	☐	☐	
Local Govt. Organizations -- Please list the organizations here: Totally Linked Care (TLC) MarylandSeventh Judicial Circuit of Maryland, Prince George's Department of Family Services, Division on Aging City of Berwyn Heights City of Brentwood Town of Comar Manor City of Mount Rainier Prince George's Healthcare Alliance Prince George's Health Department Family Health Services Prince George's Health Department Behavioral Health Prince George's Department of Corrections Maryland Dental Action Coalition Prince George's Parks and Recreation Prince George's Department of Social Services MD-National Capital Park and Planning Commission Prince George's County Planning Department Maryland General Assembly Prince George's County Health Connect	☐	☐	☐	☐	☑	☑	☑	☐	☐	
Faith-Based Organizations	☐	☐	☐	☐	☑	☑	☑	☐	☐	
School - K-12 -- Please list the schools here: Prince George's County Public Schools	☐	☐	☐	☐	☑	☑	☑	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Colleges and/or Universities -- Please list the schools here: University of Maryland, Bowie State University				✔	✔	✔	✔			
School of Public Health -- Please list the schools here: University of Maryland School of Public Health				✔	✔	✔	✔			
School - Medical School -- Please list the schools here:	✔									
School - Nursing School -- Please list the schools here:	✔									
School - Dental School -- Please list the schools here:	✔									
School - Pharmacy School -- Please list the schools here:	✔									
Behavioral Health Organizations -- Please list the organizations here: Prince George's County Health Department					✔	✔	✔			
Social Service Organizations -- Please list the organizations here: Friends of the Earth,Independence Now						✔	✔			
Post-Acute Care Facilities -- please list the facilities here:	✔									
Community/Neighborhood Organizations -- Please list the organizations here:	✔									

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Consumer/Public Advocacy Organizations -- Please list the organizations here: Laurel Advocacy and Referral Services,African Women's Cancer Awareness Association, La Clinica del Pueblo,Hope Connections for Cancer Support	☐	☐	☑	☐	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other -- If any other people or organizations were involved, please list them here: Marys Center, Giant Food, MGM National Harbor, NAMI Prince George's County,Pregnancy Center Konterra Realty, LLC The Bridge center at Adam's House, Langely Park Multi-Service Center CCI Health & Wellness Services Gerald Family Care, PC	☐	☐	☐	☐	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q51. Section II - CHNA Part 3 - Follow-up

Q52. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

- (●) Yes
- ( ) No

Q53. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

06/25/2019

Q54. Please provide a link to your hospital's CHNA implementation strategy.

Q55. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q56. Please select the health needs identified in your most recent CHNA. Select all that apply even if a need was not addressed by a reported initiative.

- [x] Access to Health Services: Health Insurance
- [x] Access to Health Services: Practicing PCPs
- [x] Access to Health Services: Regular PCP Visits
- [x] Access to Health Services: ED Wait Times
- [ ] Access to Health Services: Outpatient Services
- [x] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [x] Behavioral Health, including Mental Health and/or Substance Abuse
- [x] Cancer
- [ ] Children's Health
- [x] Chronic Kidney Disease
- [x] Community Unity
- [ ] Dementias, Including Alzheimer's Disease
- [x] Diabetes
- [x] Environmental Health
- [ ] Family Planning
- [x] Food Safety
- [ ] Global Health
- [x] Health Communication and Health Information Technology
- [x] Health Literacy
- [x] Health-Related Quality of Life & Well-Being
- [x] Heart Disease and Stroke
- [x] HIV
- [x] Immunization and Infectious Diseases
- [x] Injury Prevention
- [x] Lesbian, Gay, Bisexual, and Transgender Health
- [x] Maternal & Infant Health
- [x] Nutrition and Weight Status
- [x] Oral Health
- [x] Physical Activity
- [x] Respiratory Diseases
- [x] Sexually Transmitted Diseases
- [ ] Sleep Health
- [x] Telehealth
- [x] Tobacco Use
- [x] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [x] Housing & Homelessness
- [ ] Transportation
- [ ] Unemployment & Poverty
- [x] Other Social Determinants of Health

☐ Disability and Health ☑ Older Adults ☐ Other (specify)

☑ Educational and Community-Based Programs

Q57. Please describe how the needs and priorities identified in your most recent CHNA compare with those identified in your previous CHNA.

> In 2016, the first inclusive CHA was completed. The Prince George's County Health Department and Hospitals agreed to again work collaboratively to update the 2016 CHNA in 2019. All four hospitals and the Health Department appointed staff to facilitate the 2019 CHA process. The core team began meeting in September 2018 and included leadership from the Prince George's Healthcare Action Coalition during the data review and prioritization process. The Health Department staff led the CHNA process for a second time, in developing the data collection tools and analyzing the results with input from the hospital representatives. In 2019, The process again included: •A community resident survey available in English, Spanish, and French distributed by the hospitals and health department; •Secondary data analyses that included the county demographics and population description through socioeconomic indicators, and a comprehensive health indicator profile; •Hospital Service Profiles to detail the residents served by the core team; •A community expert survey and key informant interviews; •A prioritization process that included the Core Team and Prince George's Healthcare Action Coalition leadership. After initially reviewing the data collection results (the data reviewed is available in the Prioritization Process section of the CHNA), the Core Team determined that the priorities selected in the 2016 CHNA should remain the 2019 priorities based on the community and expert input in the process that focused on these areas, the challenges remaining in the county from the population and health indicators, and acknowledgment that it is realistic for such substantial priorities to require more than three years to show improvement, as a result of the investment of long-term resources to improve the health & well-being of our communities. The 2019 priorities will continue to be: • Social determinants of health • Behavioral health, • Obesity and metabolic syndrome

Q58. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

> In 2019, UM Capital Region Health again completed a joint Community Health Needs Assessment (CHNA) for Fiscal Years 2020- 2023 in collaboration with other area hospitals (Doctor's Community Hospital, Fort Washington Medical Center, MedStar Southern Maryland Hospital Center). The joint community health needs assessment process was led by the Prince George's County Health Department. The CHNA stakeholders engaged in a collaborative process to conduct a comprehensive community health needs assessment process in Prince George's County, Maryland that complies with the CHNA requirements as set forth by the Internal Revenue Code and Public Health Department certification requirements. The process involves the collection and analysis of valid data (quantitative and qualitative) to ascertain residents' health status, identify trends in health problems, as well as the social and economic determinants impacting the health of Prince George's County residents. A written report of the community health needs assessment process and findings was prepared and presented in May of 2019. The report included recommendations and key findings that were not much different than what was found to be the priorities in the 2016 CHNA. Drivers of Poor Health Outcomes Include • Social determinants of health drive many of our health disparities. o Poverty, food insecurity, access to healthy food, affordable housing, employment, lack of educational attainment, inadequate financial resources, access to care, and a disparate built environment result in poorer health outcomes o Growth in the county, while benefiting some, may harm others. For example, in just 3 years the income needed for an efficiency rental has grown by over $13,000. However, the median renter household income has grown by only $3,000, potentially making affordable housing less attainable for some residents. o Education was a consistent concern for residents and key informants; resident surveys ranked good schools as the third most important aspect of a healthy community. There is notable disparity in high school graduation rates, with only 66% of Hispanic students graduating compared to 85% and higher for other groups. o Resources available in communities with greater needs continue to be perceived as lower quality, such as healthcare and fresh food. • Access to health insurance through the Affordable Care Act has not helped everyone. o Many residents still lack health insurance (some have not enrolled, some are not eligible). o Those with health insurance struggle to afford healthcare (such as co-pays, high premiums, and deductibles) and prescriptions, and difficulty accessing care due to transportation challenges. • Residents lack knowledge of or how to use available resources. o The healthcare system is challenging to navigate, and providers and support services need more coordination. o There are services available, but they are perceived as underutilized because residents do not know how to locate or use them. o Low literacy and low health literacy contribute to poor outcomes. • The county does not have enough healthcare providers to serve the residents. o There is a lack of behavioral health providers, dentists, specialists, and primary care providers (also noted in the 2015 Primary Healthcare Strategic Plan for the county3). While there has been some growth in providers, it has struggled to keep pace with the population growth and has been unable address deficits. • There is a perception that the county lacks quality healthcare providers. o Surrounding jurisdictions are perceived to have better quality providers; residents with resources are perceived as often traveling outside the county for healthcare needs. o There is a lack of culturally competent and bilingual providers. • Lack of ability to access healthcare providers o There are limited transportation options available, and the supply does not meet the need. There is also a lack of transportation for urgent but nonemergency needs that cannot be scheduled in advance. o The distribution of providers is uneven in the county; some areas have a high geographic concentration of providers, while other areas have very few or no providers available nearby. • Disparities in health outcomes are complicated o Even though Black, non-Hispanic residents are more likely to be screened for cancer, they still have higher cancer mortality rates. The infant mortality rate for Black, non-Hispanic residents is significantly higher compared to other race/ethnic groups. It is challenging to determine how elements such as stress, culture, structural racism, and implicit bias contribute to health disparities along with the social determinants of health, healthcare access, and healthcare utilization, for example.

Q59. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q60. Section III - CB Administration Part 1 - Internal Participants

Q61. Please use the table below to tell us about how internal staff members were involved in your hospital's community benefit activities during the fiscal year.

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

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

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

Q62. Section III - CB Administration Part 1 - External Participants

Q63. Please use the table below to tell us about the external participants involved in your hospital's community benefit activities during the fiscal year.

	Activities									
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here: Totally Linking Care Maryland - Doctors Community Hospital, Fort Washington Medical Center, Medstar Southern Maryland Medical Center, Calvert Memorial Medical Center	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Local Health Department -- Please list the Local Health Departments here: Prince George's County Health Department	☐	☑	☐	☑	☐	☑	☑	☑	☐	
Local Health Improvement Coalition -- Please list the LHICs here: Prince George's Healthcare Action Coalition; Healthy Eating Active Living Workgroup Health Equity Committee; Health in All Policies & Healthy Literacy Work Group Behavioral Health Committee PGC's Health Department's Populations Experiencing Vulnerabilities Committee PGC Health Department's Community Care Coalition Committee Meeting	☐	☑	☑	☑	☐	☐	☑	☑	☐	
Maryland Department of Health	☐	☐	☑	☐	☐	☐	☐	☐	☐	
Maryland Department of Human Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Natural Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of the Environment	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Transportation	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Education	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Area Agency on Aging -- Please list the agencies here: Prince George County Area Agency on Aging	☐	☑	☑	☐	☐	☐	☑	☑	☐	
Local Govt. Organizations -- Please list the organizations here: Maryland National Capital Parks and Planning, Prince George's County Economic Development Corporation, Prince George's County Health Department, Prince George's County Department of Social Services, Prince George's County Public Schools, Prince George's County Fire/EMS, City of Bowie, City of Laurel,City of Hyattsville,	☐	☑	☑	☑	☑	☐	☑	☐	☐	
Faith-Based Organizations	☐	☐	☐	☐	☐	☐	☑	☐	☐	
School - K-12 -- Please list the schools here: Bladensburg High School, Laurel High School, Fairmont Heights High School, Port Towns Elementary School, Nicholas Orem Middle School	☐	☐	☐	☐	☐	☐	☑	☐	☐	
School - Colleges and/or Universities -- Please list the schools here: University of Maryland, Bowie State University , Prince George's Community College	☐	☐	☐	☐	☐	☐	☑	☐	☐	
School of Public Health -- Please list the schools here: University of Maryland School of Public Health	☐	☑	☑	☑	☐	☐	☑	☑	☐	

Organization	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Medical School -- Please list the schools here: Ross University School of Medicine	☐	☐	☐	☐	☐	☐	☑	☐	☐	
School - Nursing School -- Please list the schools here: Bowie State University , Prince George's Community College, University of Maryland, Trinity Washington University	☐	☐	☐	☐	☐	☐	☑	☐	☐	
School - Dental School -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
School - Pharmacy School -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Behavioral Health Organizations -- Please list the organizations here: Prince George's County Health Department Behavioral Health	☐	☑	☑	☑	☐	☐	☑	☑	☐	
Social Service Organizations -- Please list the organizations here: March of Dimes, Access to Wholistic and Productive Living Institute, United Communities Against Poverty, Laurel Advocacy and Referral Services, Salvation Army, La Union Multi-Service Center, Capital Area Food Bank, Mission of Love Charities, Greater Baden Medical Services;Elaine Ellis Health Center; Mary's Center; La Clinica Del Pueblo	☐	☑	☑	☑	☑	☐	☑	☑	☐	
Post-Acute Care Facilities -- please list the facilities here: Prince George's County Skilled Nursing and Assisted Living Facilities	☐	☐	☐	☐	☐	☐	☑	☐	☐	Partnerships related to community health education and external care coordination as it relates to population health.
Community/Neighborhood Organizations -- Please list the organizations here: Giant Nutrition Services, Access to Wholistic and Productive Living Institute, Victoria Falls Community Association	☐	☑	☑	☐	☐	☐	☑	☑	☐	
Consumer/Public Advocacy Organizations -- Please list the organizations here: Breast Care for Washington; Hope Connections for Cancer; United Community Ministries	☐	☐	☐	☐	☐	☐	☑	☐	☐	
Other -- If any other people or organizations were involved, please list them here: Amerigroup, Avanath Capital Management LLC. Nbc4 Washington News Outlet	☐	☑	☐	☐	☐	☐	☑	☑	☐	

N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q64. Section III - CB Administration Part 2 - Process & Governance

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

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

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

- (●) Yes
- ( ) No

Q67. Please describe the community benefit narrative audit process.

The Community Benefit Narrative is prepared by the Director of Community Health and reviewed by the VP of Women's, Infants & Community Health at UM Capital Region Health. The narrative and financial spreadsheet is then submitted to the UM Capital, Chief Financial Officer for review and approval, and the University of Maryland Medical System Senior Vice President of Government, Regulatory and Community Health. In addition, it is also shared and reviewed internally with our Executive Council. The Narrative is then presented to the Board of Directors for review and approval. Once approved by the Board, the Narrative is final and approved for submission.

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

- (●) Yes
- ( ) No

Q69. Please explain:

This question was not displayed to the respondent.

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

- (●) Yes
- ( ) No

Q71. Please explain:

This question was not displayed to the respondent.

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

- (●) Yes
- ( ) No

Q73. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

UM Capital recently published a 3 year strategic plan; outlining five strategic goals that will guide our way forward in improving the health status of Prince George's County residents and our surrounding communities. GOAL #1 Cultural Transformation and Exceptional Quality, Safety, and Patient Experience. Create a culture of excellence to drive significant improvements in quality, safety, and patient experience. GOAL #2 Leader in Innovation and Integrated Care Delivery. Advance the health of Prince George's County communities, transforming care delivery through partnerships and investing in community health and wellness. GOAL #3 Access to Care and Market Leading Clinical Programs. Expand access to preventive and comprehensive healthcare services, resulting in the "right care in the right place at the right time" and select relationships with the UM SOM. GOAL#4 Engaged Physicians and Employees Build a highly engaged and talented workforce and a core team of physician partners to work in concert to achieve a culture of excellence. GOAL #5 Strong Financial Performance Operate in an efficient and effective manner to achieve sustained positive performance under Maryland's Global Budget Revenue model. The Community Health Implementation Plan has been integrated into Goal #2- Theme 2;Committment to Community by demonstrating innovation and integrated care delivery; implementing community health implementation and health equity strategy and enhancing and expanding community, academic and public/private partnerships. Additionally,UM Capital began implementing an organizational Annual Operating Plan in Fiscal Year 2019 with the goal of providing the institution with a set of guiding performance indicators. The FY 20/21 Annual Operating Plan includes 5 different Pillars of strategic performance improvement: 1.) Quality 2.) Integration 3.) Market 4.) Workforce and 5.) Finance. Each pillar consists of an executive leader and contains a specific set of performance metrics. The implementation of the FY 20-23 community health implementation plan is housed within the Integration pillar. This pillar is under the leadership of the Vice President of Business and Strategic Development for Women's, Infant, Community and Population Health. Furthermore, the development of the FY 20-23 community health implementation plan included a committee of physicians, nurses, and administrators, from a steering body, to determine the internal community health priorities, strategies, and tactics. This was done to ensure priorities aligned with the Annual Operating Plan for UM Capital as well as the University of Maryland Medical System strategic initiatives.

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

Q75. (Optional) Is there any other information about your hospital's community benefit administration and external collaboration that you would like to provide?

Q76. (Optional) Please attach any files containing information regarding your hospital's community benefit administration and external collaboration.

PGHAC HiAP Summary Report (Final Draft) 6.29.2020.docx (1).pdf
657.4KB
application/pdf

Q77. Based on the implementation strategy developed through the CHNA process, please describe *three* ongoing, multi-year programs and initiatives undertaken by your hospital to address community health needs during the fiscal year.

Q78. Section IV - CB Initiatives Part 1 - Initiative 1

Q79. Name of initiative.

Domestic Violence and Sexual Assault (DV/SAC)

Q80. Does this initiative address a community health need that was identified in your most recently completed CHNA?

- (●) Yes
- ( ) No

Q81. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Practicing PCPs, Access to Health Services: Regular PCP Visits, Access to Health Services: ED Wait Times, Adolescent Health, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Chronic Kidney Disease, Community Unity, Diabetes, Educational and Community-Based Programs, Environmental Health, Food Safety, Health Communication and Health Information Technology, Health Literacy, Health-Related Quality of Life & Well-Being, Heart Disease and Stroke, HIV, Immunization and Infectious Diseases, Injury Prevention, Lesbian, Gay, Bisexual, and Transgender Health, Maternal & Infant Health, Nutrition and Weight Status, Older Adults, Oral Health, Physical Activity, Respiratory Diseases, Sexually Transmitted Diseases, Telehealth, Tobacco Use, Violence Prevention, Housing & Homelessness, Other Social Determinants of Health
Other:

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

- [ ] Access to Health Services: Health Insurance
- [ ] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [x] Heart Disease and Stroke
- [x] HIV
- [x] Immunization and Infectious Diseases
- [x] Injury Prevention

- [ ] Access to Health Services: Outpatient Services
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [x] Behavioral Health, including Mental Health and/or Substance Abuse
- [ ] Cancer
- [ ] Children's Health
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, including Alzheimer's Disease
- [ ] Diabetes
- [ ] Disability and Health
- [x] Educational and Community-Based Programs
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [ ] Health Literacy
- [x] Health-Related Quality of Life & Well-Being
- [x] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [ ] Nutrition and Weight Status
- [ ] Older Adults
- [ ] Oral Health
- [ ] Physical Activity
- [ ] Respiratory Diseases
- [x] Sexually Transmitted Diseases
- [ ] Sleep Health
- [ ] Telehealth
- [ ] Tobacco Use
- [x] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [x] Housing & Homelessness
- [ ] Transportation
- [ ] Unemployment & Poverty
- [x] Other Social Determinants of Health
- [x] Other (specify) Human Trafficking Survivors of Trauma, Sexual Abuse

Q82. When did this initiative begin?

For more than 45 years the Domestic Violence and Sexual Assault Center has existed as the certified rape crisis center for Prince George's County. In 2011 we became a hospital based domestic violence program and instituted a screening and consultation process for all patients

Q83. Does this initiative have an anticipated end date?

- (●) No, the initiative has no anticipated end date.
- ( ) The initiative will end on a specific end date. Please specify the date.
- ( ) The initiative will end when a community or population health measure reaches a target value. Please describe.
- ( ) The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- ( ) The initiative will end when external grant money to support the initiative runs out. Please explain.
- ( ) The initiative will end when a contract or agreement with a partner expires. Please explain.
- ( ) Other. Please explain.

Q84. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

The target population includes all Prince George's County residences, specifically targeting undeserved populations such as immigrants and refugees, mentally and physically disabled, and persons who identify as LGBTQ. In addition, the Domestic Violence and Sexual Assault program focuses on providing trauma informed care; targeting survivors of trauma (physical & emotional) victims of human trafficking, sexual abuse as well as those who subsequently are at an increased risk of contracting HIV.

Q85. Enter the estimated number of people this initiative targets.

909,308

Q86. How many people did this initiative reach during the fiscal year?

3,945

Q87. What category(ies) of intervention best fits this initiative? Select all that apply.

- [x] Chronic condition-based intervention: treatment intervention
- [x] Chronic condition-based intervention: prevention intervention
- [x] Acute condition-based intervention: treatment intervention
- [x] Acute condition-based intervention: prevention intervention
- [ ] Condition-agnostic treatment intervention
- [x] Social determinants of health intervention
- [x] Community engagement intervention
- [ ] Other. Please specify.

Q88. Did you work with other individuals, groups, or organizations to deliver this initiative?

- (●) Yes. Please describe who was involved in this initiative.

•Prince George's County Family Justice Center
•Maryland National Capital Park Police
•Prince George's County Sherriff's Department
•Prince George's County Police
•University of Maryland College Park CARE Center
•Bowie State University Wellness Center
•Prince George's County Community College
•Joint Base Andrews Air Force Base
•Prince George's County Department of Social Services Child Advocacy Center
•Prince George's County Department of Housing and Community Development

- ( ) No.

Q89. Please describe the primary objective of the initiative.

The objective of DV/SAC is to provide trauma informed medical/forensic examinations, crisis response, and therapeutic care to survivors of sexual and domestic violence and exploitation. In addition, DV/SAC provides resources and education that promote a safer community.

Q90. Please describe how the initiative is delivered.

•Crisis Counselors operate and respond via a 24/7 hotline. •Respond with Victim Advocates and Crisis Counselors who provide medical accompaniment to navigate through the medical treatment and forensic exams, as well as conduct case management, safety planning, and accompany to court proceedings. •Provide Forensic Nurse Examiners (FNE) who have specialized training and are certified to collect evidence for criminal cases and provide critical medical treatment to victims of sexual and domestic violence •Participate in awareness events at Health Fairs, Schools, Churches, and other community activities •Engage in Community partnerships such as the Prince George's County Family Justice Center where we are equipped to perform forensic exams, provide an on-site crisis intervention and trauma therapy, and co-facilitate trauma empowerment groups. •Conduct Individual and group counseling sessions by licensed social workers and mental health counselors •Offer Bi-lingual screening and consultations at the hospital for patient safety and further consultation to provide safety planning, assistance with legal referral and support in court appearances. •Provide case management and life skills training to survivors. •Partner with HIV Program at Health Fairs and other events to also screen for possible victims of domestic and sexual violence and human trafficking.

Q91. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters: 3,945
- [ ] Other process/implementation measures (e.g. number of items distributed)
- [ ] Surveys of participants
- [ ] Biophysical health indicators
- [ ] Assessment of environmental change
- [ ] Impact on policy change
- [ ] Effects on healthcare utilization or cost
- [ ] Assessment of workforce development
- [ ] Other

Q92. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

•Counseling clients report reduced trauma symptoms and better quality of life. •Clients report feeling better informed about their rights as a victim. •Clients report feeling more safe as a result of advocacy support and receiving information regarding their medical condition, the judicial process, and resources that are available. •Participants and attendees of community education events and professional training report having learned more about the law, victim's rights, how trauma impacts a victim's responses. •Attendees report learning new information that they would use in appropriate circumstances such as techniques for bystander intervention, recognizing signs of abuse, and understanding and respecting the importance of consent.

Q93. Please describe how the outcome(s) of the initiative addresses community health needs.

This initiative addresses community health needs by responding to a broad spectrum of needs as it relates to Trauma by adopting a holistic approach, providing education, prevention and treatment for survivors of trauma. Components of the initiative include, identifying victims of Domestic Violence, Violence prevention, Survivors of Trauma, Human Trafficking, Sexual Abuse and the impact it has on one's behaviors. In addition, the 2019 CHNA has indicated in 2017 Prince George's County had the second highest rate of HIV diagnoses (41.90 per 100,000 population) in the State after Baltimore City. The initiative works in partnership with the UM Capital HIV/HEP C Program to identify individuals who are at an increased risk of contracting HIV due to risky sexual behaviors. In addition, due to the complexities of the Domestic Violence and Sexual assault program and the level of outreach required to reach those who are at risk, there is a great deal of partnership and community collaborations required to reach those most in need(as outlined above). Thus, this initiative demonstrates the success of community partnerships and the impact meaningful collaborations can have on the communities we serve, as recommended in both the 2016 and 2019 CHNA Statistics reported in the 2019 CHNA as it relates to Domestic Violence/Violence: There were 2,949 violent crimes (includes homicide, rape, robbery, and aggravated assault) in 2017, and 93 residents in the county died by homicide (MD Vital Statistics). In 2017, there were 1,711 reports of domestic violence in the county, and from July 2016 to June 2017 there were 5 domestic violence-related deaths. (Maryland Network Against Domestic Violence). The county's age-adjusted death rate due to homicide in 2017 was 11.6, compared to the state overall at 10.2 and the U.S. at 6.0 per 100,000 population. The county's violent crime rate in 2017 was 385.3, below the state rate of 481.9 per 100,000.

Q94. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

Hospital: 350,000 Grant Funds: 864,347

Q95. (Optional) Supplemental information for this initiative.

Q96. Section IV - CB Initiatives Part 2 - Initiative 2

Q97. Name of initiative.

Mama & Baby Mobile Health Program

Q98. Does this initiative address a need identified in your most recently completed CHNA?

- (●) Yes
- ( ) No

Q99. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Practicing PCPs, Access to Health Services: Regular PCP Visits, Access to Health Services: ED Wait Times, Adolescent Health, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Chronic Kidney Disease, Community Unity, Diabetes, Educational and Community-Based Programs, Environmental Health, Food Safety, Health Communication and Health Information Technology, Health Literacy, Health-Related Quality of Life & Well-Being, Heart Disease and Stroke, HIV, Immunization and Infectious Diseases, Injury Prevention, Lesbian, Gay, Bisexual, and Transgender Health, Maternal & Infant Health, Nutrition and Weight Status, Older Adults, Oral Health, Physical Activity, Respiratory Diseases, Sexually Transmitted Diseases, Telehealth, Tobacco Use, Violence Prevention, Housing & Homelessness, Other Social Determinants of Health
Other:

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

- [x] Access to Health Services: Health Insurance
- [x] Access to Health Services: Practicing PCPs
- [x] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Access to Health Services: Outpatient Services
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Behavioral Health, including Mental Health and/or Substance Abuse
- [ ] Cancer
- [ ] Children's Health
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, including Alzheimer's Disease
- [ ] Diabetes
- [ ] Disability and Health
- [x] Educational and Community-Based Programs
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [ ] Health Literacy
- [ ] Health-Related Quality of Life & Well-Being
- [ ] Heart Disease and Stroke
- [x] HIV
- [x] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [x] Maternal and Infant Health
- [x] Nutrition and Weight Status
- [ ] Older Adults
- [ ] Oral Health
- [ ] Physical Activity
- [ ] Respiratory Diseases
- [x] Sexually Transmitted Diseases
- [ ] Sleep Health
- [x] Telehealth
- [x] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Housing & Homelessness
- [ ] Transportation
- [ ] Unemployment & Poverty
- [x] Other Social Determinants of Health
- [ ] Other (specify)

Q100. When did this initiative begin?

The partnership agreement was executed in winter of 2016 and programming launched in the summer 2017.

Q101. Does this initiative have an anticipated end date?

- ( ) No, the initiative does not have an anticipated end date.
- ( ) The initiative will end on a specific end date. Please specify the date.
- ( ) The initiative will end when a community or population health measure reaches a target value. Please describe.
- ( ) The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- ( ) The initiative will end when external grant money to support the initiative runs out. Please explain.
- ( ) The initiative will end when a contract or agreement with a partner expires. Please explain.
- (•)

Other. Please explain.

UM Capital Region Health signed a three-year partnership agreement to provide health services in Prince George’s County through the Mama & Baby Mobile Unit; a traveling mobile health unit owned by the March of Dimes. March of Dimes executed an addendum in December of 2019; awarding UM Capital with an additional funding commitment to expand access and services into specific Washington DC communities; wards 7 & 8. Funding has been committed annually for the next three years --Fall of 2020-2023.

Q102. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

Communities in Prince George's County with poverty rate at 16% or higher based on Community health needs assessment data and input from community partners. The following communities are also home to relatively large proportions of uninsured women and children according the US Census Bureau 2015 data report. Target areas include: Lahnam (20706), laurel/Beltsville (20707,20787), Fort Washington (20744), Hyattsville/Langley Park (20783,20784,20785). Disparities in Maternal/Fetal and Infant Health exist in Prince George's County: Mothers who received early pre-natal care is at 53.1% in Prince George's compared to 62.2% in Maryland and 77.1% in U.S.; infant Mortality in Prince George's is 8.9/deaths per 1,000 live births compared to 6.7 in Maryland and 5.9 in U.S. Beginning fall of 2020, the mobile bus program will begin targeting uninsured and under-insured women who reside in Wards 7 & 8. The recent closures of the maternity wards of two hospitals on the east side of the city have only added to the urgency of addressing high-risk pregnancies in low-income neighborhoods. These communities border the Prince George's County line and consist of the highest rates of preterm birth (ward 7; 13.4% and ward 8; 13.8%) and infant mortality (ward 7; 10.9% and ward 8; 18.0%) in the district.

Q103. Enter the estimated number of people this initiative targets.

89,000

Q104. How many people did this initiative reach during the fiscal year?

570

Q105. What category(ies) of intervention best fits this initiative? Select all that apply.

- [ ] Chronic condition-based intervention: treatment intervention
- [ ] Chronic condition-based intervention: prevention intervention
- [x] Acute condition-based intervention: treatment intervention
- [x] Acute condition-based intervention: prevention intervention
- [ ] Condition-agnostic treatment intervention
- [x] Social determinants of health intervention
- [ ] Community engagement intervention
- [ ] Other. Please specify.

Q106. Did you work with other individuals, groups, or organizations to deliver this initiative?

- (●) Yes. Please describe who was involved in this initiative.

March of Dimes & the UM Capital Region Health Medical Group as well as a host of community organizations. Key partnering organizations include: Prince George's Community College, Prince George's County Health Department, Laurel Advocacy & Referral Services, La Union Multi-Service Center, United Communities Against Poverty/ Shepherd's Cove, Southern Management Corporation & Oak Ridge Apartments/Townhomes,Crossroads Farmer's Market, Laurel Municipal Center. Maryland National Capital Parking & Planning Commission (Parks & Recreation) and Prince George's Community College as well as a host of churches and community organizations who request the mobile unit's participation in various health screening events throughout the year.

- ( ) No.

Q107. Please describe the primary objective of the initiative.

The Mama & Baby Mobile Unit serves as a healthcare access point for under-insured, uninsured and under-served women and children. The Mama & Baby Mobile Unit provides basic, uncomplicated maternal and child health services through partnerships with local community based organizations, shelters, food pantries, faith institutions, schools and institutions of higher learning.

Q108. Please describe how the initiative is delivered.

The mobile health services team consists of a variety of providers including a team of Midwifes, Family Medicine and Ob/Gyn Providers. Prince George's County partnering organizations also work in collaboration with the mobile health unit to provide community health workers and health insurance navigators to assist patients with aspects related to social determinants of health. The bus midwives manage low-risk patients using protocols developed consistent with recommendations of the American College of Obstetricians and Gynecologists (ACOG), which allow a minimum number of visits in the schedules for prenatal care. This approach accommodates a variety of life challenges the women must overcome to attend regular prenatal care appointments and minimizes the some of the barriers these women may face. For women who are at high and medium risk the bus staff follows the pregnancy management guidelines of the America College of Obstetricians and Gynecologist (ACOG) related to those specific populations. The staff will also employ ACOG's well women visit guidelines. Patients will be routinely screened for HIV per the preventive health guidelines from the Centers of Disease Control and Prevention. Postpartum care will follow ACOG guidelines and address breastfeeding support, level of available social support, depression, physical activity, contraception etc, in addition to the patients overall health. Every attempt will be made to link women to a full range of supportive services provided by the bus's partners so that they and their infants will attain optimal health outcomes.

Q109. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters: 570
- [x] Other process/implementation measures (e.g. number of items distributed): Proportion of uninsured patients who are assisted to apply for insurance. Proportion of patients who are screened for depression screening. Proportion of patients who smoke, who are linked to tobacco cessation services. Proportion of patients who receive HIV Testing and counseling Proportion of patients who receive recommended preventiveflu vaccines, mammograms, diabetes and hypertension screenings. Proportions of patients who receive an annual well woman visits. Proportions of patients who are screened for domestic violence Proportion of patients with social support needs Number of women served Proportion of patients referred to dental care Proportion of Infants and children receiving well child visits Proportion of patients who return for follow-up visits
- [ ] Surveys of participants
- [ ] Biophysical health indicators
- [ ] Assessment of environmental change
- [ ] Impact on policy change
- [ ] Effects on healthcare utilization or cost
- [ ] Assessment of workforce development
- [ ] Other

Q110. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

570 patients seen on mobile unit: 85% received preventive screenings (Flu, Bp,breast exams, birth control, preconception counseling and diabetes) 28% received depression and domestic violence screenings 17% received HIV testing 11% received well women exams 12% were referred to insurance services 7% to social service referral services 9% received referrals to dental services 17% completed referrals 31% returned for follow-up visits

Q111. Please describe how the outcome(s) of the initiative addresses community health needs.

Key findings from the CHNA indicate significant concerns with Maternal and infant health indicators in Prince George's County. The infant mortality rate in the 2016 CHNA for Prince George's county was reported at 6.9% In the 2019 CHNA it is reported at 8.2; an increase of approximately 19%. The Healthy People (HP) 2020 Goal is 6.3% and the MD State Health Improvement Plan (SHIP) Goal is 6.0%. The percent of low birth weight infants in Prince George's county was reported at 9.2% in the 2016 CHNA compared to the 2019 CHNA that was even higher at 9.8%. The Healthy People 2020 goal is 7.8% and the MD SHIP goal is 8.0% . In addition, the percent of low birth weight infants of black non-Hispanic race has also increased from 11.0% in the 2016 CHNA to 12.1 in the 2019 CHNA. Our UM Capital Community Health Implementation Plan includes specific Maternal and Infant Health Long term goals supporting Maryland SHIP and Healthy People 2020.

Q112. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

March of Dimes Grant funds:$50,000 Hospital funds:209,405.

Q113. (Optional) Supplemental information for this initiative.

Q114. Section IV - CB Initiatives Part 3 - Initiative 3

Q115. Name of initiative.

HIV Testing Program

Q116. Does this initiative address a need identified in your most recently completed CHNA?

- (•) Yes
- ( ) No

Q117. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Access to Health Services: Practicing PCPs, Access to Health Services: Regular PCP Visits, Access to Health Services: ED Wait Times, Adolescent Health, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Chronic Kidney Disease, Community Unity, Diabetes, Educational and Community-Based Programs, Environmental Health, Food Safety, Health Communication and Health Information Technology, Health Literacy, Health-Related Quality of Life & Well-Being, Heart Disease and Stroke, HIV, Immunization and Infectious Diseases, Injury Prevention, Lesbian, Gay, Bisexual, and Transgender Health, Maternal & Infant Health, Nutrition and Weight Status, Older Adults, Oral Health, Physical Activity, Respiratory Diseases, Sexually Transmitted Diseases, Telehealth, Tobacco Use, Violence Prevention, Housing & Homelessness, Other Social Determinants of Health
Other:

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

- [ ] Access to Health Services: Health Insurance
- [ ] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Access to Health Services: Outpatient Services
- [x] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [x] Behavioral Health, including Mental Health and/or Substance Abuse
- [ ] Cancer
- [ ] Children's Health
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, including Alzheimer's Disease
- [ ] Diabetes
- [ ] Disability and Health
- [x] Educational and Community-Based Programs
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [ ] Health Literacy
- [x] Health-Related Quality of Life & Well-Being
- [ ] Heart Disease and Stroke
- [x] HIV
- [x] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [x] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [ ] Nutrition and Weight Status
- [ ] Older Adults
- [ ] Oral Health
- [ ] Physical Activity
- [ ] Respiratory Diseases
- [x] Sexually Transmitted Diseases
- [ ] Sleep Health
- [ ] Telehealth
- [ ] Tobacco Use
- [x] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Housing & Homelessness
- [ ] Transportation
- [ ] Unemployment & Poverty
- [x] Other Social Determinants of Health
- [ ] Other (specify)

Q118. When did this initiative begin?

The State funded Rapid HIV Testing program began in 2008. The Gilead Sciences HIV Grant program began in 2018

Q119. Does this initiative have an anticipated end date?

- ◯ No, the initiative does not have an anticipated end date.
- ◯ The initiative will end on a specific end date. Please specify the date.
- ◯ The initiative will end when a community or population health measure reaches a target value. Please describe.
- ◯ The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- ◯ The initiative will end when external grant money to support the initiative runs out. Please explain.
- ◯ The initiative will end when a contract or agreement with a partner expires. Please explain.
- ◉ Other. Please explain.

Funding will continue as long as grants are re-awarded.The State funded program is funded annually at the start of the calendar year.Funding for the Gilead Sciences grant is reviewed annually and was again awarded for FY20.

Q120. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

The Gilead Grant targets all UM Prince George's Emergency Department patients, providing Opt out testing to patients between the ages of 17-84. The State funded rapid HIV testing targets all Prince George's County residents and is provided both internally and externally (in the community)

Q121. Enter the estimated number of people this initiative targets.

909,308

Q122. How many people did this initiative reach during the fiscal year?

The Gilead Grant reached 3210. The State program reached 1439

Q123. What category(ies) of intervention best fits this initiative? Select all that apply.

- [x] Chronic condition-based intervention: treatment intervention
- [x] Chronic condition-based intervention: prevention intervention
- [ ] Acute condition-based intervention: treatment intervention
- [ ] Acute condition-based intervention: prevention intervention
- [ ] Condition-agnostic treatment intervention
- [ ] Social determinants of health intervention
- [ ] Community engagement intervention
- [ ] Other. Please specify.

Q124. Did you work with other individuals, groups, or organizations to deliver this initiative?

- (•) Yes. Please describe who was involved in this initiative.

  Prince George’s County Health Department,
  AIDS Healthcare Foundation,
  La Clinica del pueblo,
  Prince George’s Community College,
  Access to Wholistic and Productive Living Institute,
  Us Helping US,
  Heart to Hand

- ( ) No.

Q125. Please describe the primary objective of the initiative.

The primary objective for both programs is to reduce the number of newly diagnosed HIV and HEP C and link to care the positive cases by developing best practice algorithms, normalizing testing, and establishing community partnerships for linkages to care. The primary objective for the Gilead focused program is to screen and test patients for HIV and HEPC and link the positives to care as well as provide education for those who are not positive so that they remain negative. The primary objective for the State is to reduce the transmission of HIV and help Marylander's with HIV live longer, healthier lives.

Q126. Please describe how the initiative is delivered.

The Gilead Grant screens patients in the emergency department and provides free testing and counseling for HIV and HEPC. In addition linkages to care are provided for positive patients. The State Rapid HIV Testing program can be provided anywhere in Prince George's county. The program will service any individual that presents for testing at the hospital. The program also provides free testing at health fairs and community events. Both programs continued testing amid the pandemic however, experienced some impact to testing due to decreased numbers of walk-in participants, those individuals isolated due to Covid 19 precautionary protocols and cancellation of community events.

Q127. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters: 4,649
- [ ] Other process/implementation measures (e.g. number of items distributed)
- [ ] Surveys of participants
- [ ] Biophysical health indicators
- [ ] Assessment of environmental change
- [ ] Impact on policy change
- [ ] Effects on healthcare utilization or cost
- [ ] Assessment of workforce development
- [ ] Other

Q128. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

Gilead Grant Sciences - 3210 screened, 43 individuals have identified positive for HIV and 69 were identified as positive HEP C; 17 out of the the 43 who tested positive have been linked to care for HIV and of the 69 HEP C positive patients, 26 were linked to care State Funded Program- 1439 screened, 7 have tested positive for HIV, 6 have been linked to care.

Q129. Please describe how the outcome(s) of the initiative addresses community health needs.

In 2017, Prince George’s County had the second highest rate of HIV diagnoses (41.9 per 100,000 populations) in the state after Baltimore City. In terms of the number of new cases, the county had the highest number of actual cases in the state and 320. Followed by Baltimore City with 231. The rate of HIV diagnoses in other Maryland counties range from 0.0 (Somerset and Talbot counties) to 44.7 per 100,000 population (Baltimore City). The state overall had a rate of 20.4 per 100,000 population and the U.S. had a rate of 11.8 per 100,000.

Q130. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

Gilead Grant: 288,633.00 State Funded Rapid HIV Testing: 50,000 Annually

Q131. (Optional) Supplemental information for this initiative.

Q132. Section IV - CB Initiatives Part 4 - Other Initiative Info

Q133. Additional information about initiatives.

Q134. (Optional) If you wish, you may upload a document describing your community benefit initiatives in more detail, or provide descriptions of additional initiatives your hospital undertook during the fiscal year. These need not be multi-year, ongoing initiatives.

COVID 19 Outreach Summary.Final.pdf
409KB
application/pdf

Q135. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- ○ Yes
- ◉ No

Q136.

In your most recently completed CHNA, the following community health needs were identified:

Access to Health Services: Health Insurance, Access to Health Services: Practicing PCPs, Access to Health Services: Regular PCP Visits, Access to Health Services: ED Wait Times, Adolescent Health, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Chronic Kidney Disease, Community Unity, Diabetes, Educational and Community-Based Programs, Environmental Health, Food Safety, Health Communication and Health Information Technology, Health Literacy, Health-Related Quality of Life & Well-Being, Heart Disease and Stroke, HIV, Immunization and Infectious Diseases, Injury Prevention, Lesbian, Gay, Bisexual, and Transgender Health, Maternal & Infant Health, Nutrition and Weight Status, Older Adults, Oral Health, Physical Activity, Respiratory Diseases, Sexually Transmitted Diseases, Telehealth, Tobacco Use, Violence Prevention, Housing & Homelessness, Other Social Determinants of Health
Other:

Using the checkboxes below, select the needs that appear in the list above that were NOT addressed by your community benefit initiatives.

- [ ] Access to Health Services: Health Insurance
- [ ] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Access to Health Services: Outpatient Services
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Behavioral Health, including Mental Health and/or Substance Abuse
- [ ] Cancer
- [ ] Children's Health
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, including Alzheimer's Disease
- [ ] Diabetes
- [ ] Disability and Health
- [ ] Educational and Community-Based Programs
- [x] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [ ] Health Literacy
- [ ] Health-Related Quality of Life & Well-Being
- [ ] Heart Disease and Stroke
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [ ] Nutrition and Weight Status
- [ ] Older Adults
- [x] Oral Health
- [ ] Physical Activity
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health
- [ ] Telehealth
- [ ] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [x] Housing & Homelessness
- [ ] Transportation
- [ ] Unemployment & Poverty
- [ ] Other Social Determinants of Health
- [ ] Other (specify)

Q137. Why were these needs unaddressed?

Environmental Health- In FY20 this institution primarily focused its efforts and resources on the environmental and safety needs of its facilities. Oral Health-The Dental provider for the institution left the organization in FY18. Dental Health was not selected as a priority for the institution at this time. Housing and Homelessness was not selected as a priority, nor were resources allocated to address this need, at this time.

Q138. Do any of the hospital's community benefit operations/activities align with the State Health Improvement Process (SHIP)? Specifically, do any activities or initiatives correspond to a SHIP measure within the following categories?

See the SHIP website for more information and a list of the measures:
https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx

	Select Yes or No	
	Yes	No
Healthy Beginnings - includes measures such as babies with low birth weight, early prenatal care, and teen birth rate	◉	○
Healthy Living - includes measures such as adolescents who use tobacco products and life expectancy	◉	○
Healthy Communities - includes measures such as domestic violence and suicide rate	◉	○
Access to Health Care - includes measures such as adolescents who received a wellness checkup in the last year and persons with a usual primary care provider	◉	○
Quality Preventive Care - includes measures such as annual season influenza vaccinations and emergency department visit rate due to asthma	◉	○

Q139. (Optional) Did your hospital's initiatives in FY 2018 address other, non-SHIP, state health goals? If so, tell us about them below.

Q140. Section V - Physician Gaps & Subsidies

Q141. As required under HG §19-303, please select all of the gaps in physician availability in your hospital's CBSA. Select all that apply.

- ☐ No gaps
- ☑ Primary care
- ☑ Mental health
- ☑ Substance abuse/detoxification
- ☑ Internal medicine
- ☑ Dermatology
- ☑ Dental
- ☑ Neurosurgery/neurology
- ☑ General surgery
- ☑ Orthopedic specialties
- ☐ Obstetrics
- ☐ Otolaryngology
- ☑ Other. Please specify. Endocrinology

Q142. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand.

Hospital-Based Physicians	UM PGHC's emergency departments, and other specialties including intensive care, anesthesia, cardiology, endocrinology, internal medicine, neurology, orthopedics,pathology, physical medicine and radiology, are staffed by Hospital-based physicians, with whom the hospital has exclusive contracts, seeking guaranteed levels of compensation through hospital provided subsidies
Non-Resident House Staff and Hospitalists	The subsidies cover gaps in physician services due to lack of adequate community providers who practice within the hospital. Additionally the hospital supports a disproportionate share of underinsured or uninsured patients.
Coverage of Emergency Department Call	The subsidies cover gaps in physician income that are the outcome of UM PGHC's disproportionate share of underinsured or uninsured patients
Physician Provision of Financial Assistance	The provision of physician reimbursement subsidies to cover free or discounted care through the Hospital's FAP is consistent, appropriate and essential to the execution of the Hospital's mission, vision, and values, and is consistent with its tax-exempt, charitable status.
Physician Recruitment to Meet Community Need	The UM PGHC physician subsidies also include expenses incurred for ongoing physician recruitment consistent UM Capital Region Health's Medical Staff Development Plan.
Other (provide detail of any subsidy not listed above)	
Other (provide detail of any subsidy not listed above)	
Other (provide detail of any subsidy not listed above)	

Q143. (Optional) Is there any other information about physician gaps that you would like to provide?

2019 RAND assessment findings as it relates to physician gaps in Prince George's County: In comparing physician to population ratios across jurisdictions, Prince George's County had a much smaller supply of primary care physicians compared to Baltimore, Howard, and Montgomery Counties in 2017. This was also observed for all medical specialties, surgical specialties, and hospital-based physician specialties and also true when compared to rates across the entire United States. Primary Care Health Professional Shortage Areas (HPSA) are the most common type of HPSA in Prince George's County. All districts in the County have at least some communities within those districts, which are experiencing primary care shortages. Shortages are most often observed in the communities neighboring Washington, D.C. District 7 (Includes the areas of District Heights, Bradbury/Boulevard Heights, Capitol Heights, Hillcrest Heights, Marlow Heights, Seat Pleasant, Suitland and Morningside) is the only district that is completely designated as a geographic primary care shortage area. District 2 (Includes Adelphi, Avondale, Brentwood, Carole Highlands, Chillum, Green Meadows, Hyattsville, Langley Park, Lewisdale, Mount Rainier and North Brentwood) is completely designated as a primary care shortage area due to its large Medicaid-insured population. Furthermore, the Prince George's County Health Department prepared the 2019 Prince George's County Community Health Needs Assessment. Key findings from the 2019 and previous 2016 county-wide report indicated many drivers of poor health outcomes, including inadequate supply of providers to serve the number of residents. While there has been some growth in providers, it has struggled to keep pace with the population growth and has been unable address deficits and the trend is worsening. Provider to Resident ratios: • Primary Care: 2016 Assessment: 1,860;1 2019 Assessment: 1,910:1

Q144. (Optional) Please attach any files containing further information regarding physician gaps at your hospital.

Q145. Section VI - Financial Assistance Policy (FAP)

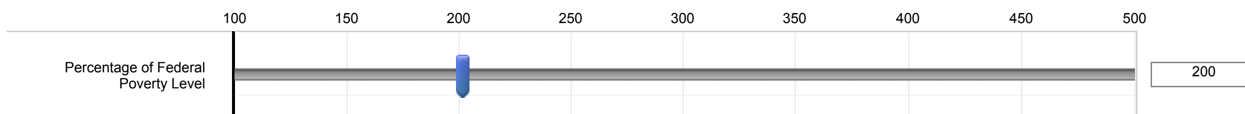
Q146. Upload a copy of your hospital's financial assistance policy.

English UMMS Financial Assistance Policy 10 19.pdf
911.6KB
application/pdf

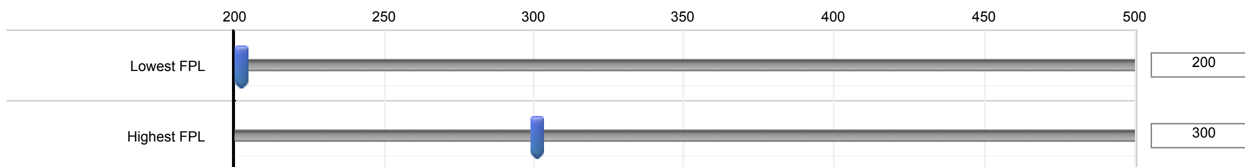
Q147. Upload a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e).

1-136_What You Should Know As A Patient - Final 2.pdf
234.8KB
application/pdf

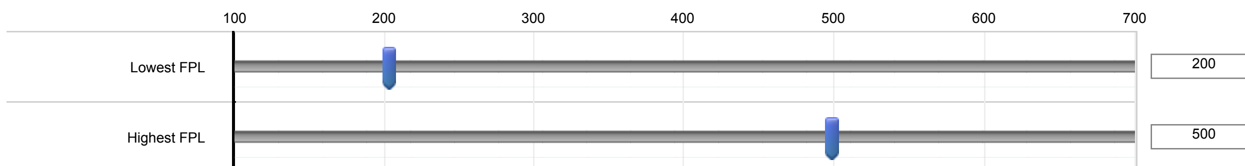
Q148. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL). Please select the percentage of FPL below which your hospital's FAP offers free care.



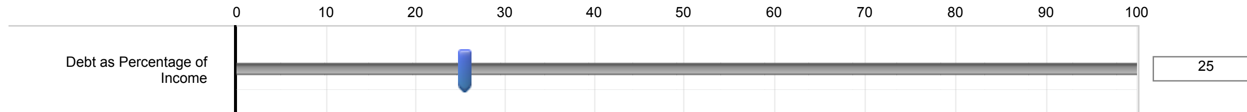
Q149. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level. Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care.



Q150. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income. Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care for financial hardship. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q151. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q152. Has your FAP changed within the last year? If so, please describe the change.

- (●) No, the FAP has not changed.
- ( ) Yes, the FAP has changed. Please describe:

Q153. (Optional) Is there any other information about your hospital's FAP that you would like to provide?

Medical Financial Hardship Assistance is available for patients who otherwise do not qualify for Financial Assistance under the primary guidelines of the UMMS FAP, but for whom: 1) Their medical debt incurred exceeds 25% of the Family Annual Household Income, which is creating Medical Financial Hardship Additionally, UMMS/UM Capital uses the Maryland Poverty Level verses the Federal Poverty Level due to the fact that the MPL guidelines are more generous to the patient.

Q154. (Optional) Please attach any files containing further information about your hospital's FAP.

Q155. Summary & Report Submission

Q156.

Attention Hospital Staff! IMPORTANT!

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

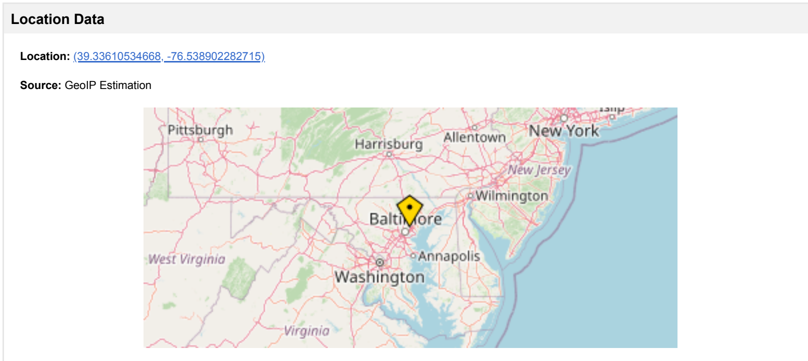
We strongly urge you to contact us at hcbhelp@hilltop.umbc.edu to request a copy of your answers. We will happily send you a pdf copy of your narrative that you can share with your leadership, Board, or other interested parties. If you need to make any corrections or change any of your answers, you can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

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

Location Data

Location: (39.33610534668, -76.538902282715)

Source: GeoIP Estimation



From:	Hilltop HCB Help Account
To:	kimberly.davidson@umm.edu; djacobs@umm.edu
Cc:	Hilltop HCB Help Account
Subject:	HCB Narrative Report Clarification Request - UM Capital
Date:	Thursday, May 27, 2021 8:27:40 AM
Attachments:	UM_Capital_Region_HCBNarrative_FY2020_20210331.pdf

Thank you for submitting the FY 2020 Hospital Community Benefit Narrative report for the University of Maryland Capital Region Health. In reviewing the narrative, we encountered a few items that require clarification:

- In Question 33 on page 4 of the attached, it was indicated CBSA identification was done in part based on ZIP codes in your Financial Assistance Policy, however no further description was provided. Please describe how ZIP codes were used to identify your hospital's CBSA.
- In Question 54 on page 11, no link was provided to your hospital's CHNA implementation strategy. Please provide a link.
- In Question 63 beginning on page 14, no response was provided regarding whether "School – Dental School" or "School – Pharmacy School" were involved in your hospital's community benefit activities. Please clarify.
- In Question 81 on page 18, it was reported that the "Domestic Violence and Sexual Assault (DV/SAC)" initiative addressed the community need of "Heart Disease and Stroke." If this is correct, please provide an explanation of how this need was addressed by this initiative.
- In Question 81 on page 19, where you selected the CHNA-identified needs addressed by the Domestic Violence and Sexual Assault (DV/SAC) initiative you selected Other: Human Trafficking Survivors of Trauma, Sexual Abuse as a need even though it was not selected in Question 56 on page 11 as a need identified in the CHNA. Please confirm whether these should have been selected for question 56.
- In Question 119 on page 26, there is a separate option that can be selected if the HIV Testing Program initiative will operate until grant funds are no longer awarded. Please clarify whether this option is appropriate for this initiative.
- In response to Question 130 on page 27, you only list the amount of grant funds used for the HIV Testing Program initiative. Please provide the amount of hospital funds that were used for this initiative.
- In response to Question 136 on page 28, you responded that the need Housing & Homelessness was not addressed by your hospital's initiatives. However, in Question 81 on page 19, it was reported that the Domestic Violence and Sexual Assault (DV/SAC) initiative addressed this need. Please clarify which of these selections is correct.

Please provide your clarifying answers as a response to this message.

UM Capital Region FY20 Community Benefit Report Clarifying Questions/Answers- June 2021

- In Question 33 on page 4 of the attached, it was indicated CBSA identification was done in part based on ZIP codes in your Financial Assistance Policy, however no further description was provided. Please describe how ZIP codes were used to identify your hospital's CBSA.

  Patient analysis data was used to identify the top zip codes of patients served, who qualify for financial assistance.

- In Question 54 on page 11, no link was provided to your hospital's CHNA implementation strategy. Please provide a link.
  Community Health Implementation Plan

  https://www.umms.org/capital/community/community-health-needs-assessment

Note: Both hyperlinks are active. The Community Health Implementation Plan can be found on the same page as the Community Health Needs Assessment.

- In Question 63 beginning on page 14, no response was provided regarding whether "School – Dental School" or "School – Pharmacy School" were involved in your hospital's community benefit activities. Please clarify.

  Dental School- N/A

  Pharmacy School- N/A

- In Question 81 on page 18, it was reported that the "Domestic Violence and Sexual Assault (DV/SAC)" initiative addressed the community need of "Heart Disease and Stroke." If this is correct, please provide an explanation of how this need was addressed by this initiative.

  Some victims of domestic violence and sexual abuse/assault suffer from other chronic disease aliments, including heart related conditions that are often a result of stress. The DV/SAC program seeks to treat victims by addressing the holistic needs of the patient's entire state of health.

- In Question 81 on page 19, where you selected the CHNA-identified needs addressed by the Domestic Violence and Sexual Assault (DV/SAC) initiative you selected Other: Human Trafficking Survivors of Trauma, Sexual Abuse as a need even though it was not selected in Question 56 on page 11 as a need identified in the CHNA. Please confirm whether these should have been selected for question 56.

  Human Trafficking, Survivors of Trauma and *Sexual Abuse* should be added to Q56 under the "Other" category.

- In Question 119 on page 26, there is a separate option that can be selected if the HIV Testing Program initiative will operate until grant funds are no longer awarded. Please clarify whether this option is appropriate for this initiative.

  The external grant money option can be selected. The same explanation as stated in the narrative applies:

  "Funding will continue as long as both grants are re-awarded. The state funded program is funded annually at the start of the calendar year. Funding from the Gilead Sciences grant is reviewed annually and was again awarded for FY20."

- In response to Question 130 on page 27, you only list the amount of grant funds used for the HIV Testing Program initiative. Please provide the amount of hospital funds that were used for this initiative.

  Thank you for asking this question. This initiative is primarily supported through grant funding: Gilead Sciences Grant $288,633.00 and the State Funded Rapid HIV Testing: $50,000. However, upon a second review, it was reported that the hospital contributed a total of $29,568 to support personnel costs for program expansion in FY 20.

- In response to Question 136 on page 28, you responded that the need Housing & Homelessness was not addressed by your hospital's initiatives. However, in Question 81 on page 19, it was reported that the Domestic Violence and Sexual Assault (DV/SAC) initiative addressed this need. Please clarify which of these selections is correct.

  Uncheck "housing and homelessness" as a need addressed in Q81. While our DV/SAC program will refer to shelters, as needed, our hospital system has not allocated the appropriate level of resources to prioritize housing and homelessness initiatives at this time.

PGHAC Health Equity Workgroup Health in All Policies (HiAP) Subcommittee Implementation Report

June 2020

Acknowledgements

Prince George's Healthcare Action Coalition Health Equity Workgroup and Health in All Policies (HiAP) Subcommittee

Prince George's County Health Department, Office of Planning

Stacey Little, PhD, MPH, MSW, Vice President of Business and Strategic Development -Women Infant, and Community Health, University of Maryland Medical Systems/UM Capital Region Health, Co-chair, HiAP Subcommittee, Health Equity Workgroup

Surayyah Khan, Intern, University of Maryland Medical Systems/UM Capital Region Health

Natalie S. Burke, President and CEO, CommonHealth Action

To all Transformative Change-Our Role in Achieving Health Equity in Prince George's County Part 1 and 2 Forum participants

Thanks to all organizations that participated in the Health Equity evaluation survey

For more information on the PGHAC and the Health Equity workgroup, please email pghac@co.pg.md.us

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Health in All Policies (HiAP) is a transformative collaborative approach to eradicating health gaps and improving health outcomes by integrating health considerations in all policies that impact all residents in those communities. Local and state government policies and agency guidance are developed with a health lens and consider key decision-making approaches that address health equity and eradicate health disparities.

WHAT IS HEALTH IN ALL POLICY?

The World Health Organization (WHO) defines Health in All Policy as an "approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts to improve population health and health equity."[1] WHO further asserts HiAP has several guiding principles which include:

[1] https://www.paho.org/hq/dmdocuments/2014/2014.01-WHO-HiAP-FrameworkCountryAction.pdf

- **legitimacy** grounded in the rights and obligations conferred by national and international law
- **accountability** of governments towards their people
- **transparency** of policy-making and access to information
- **participation** of wider society in the development and implementation of government policies and programs
- **sustainability** in order that policies aimed at meeting the needs of present generations do not compromise the needs of future generations.
- **collaboration** across sectors and levels of government in support of policies that promote health, equity, and sustainability.

The WHO asserts, "Health and health equity are values in their own right, and are also important prerequisites for achieving many other societal goals. Many of the determinants of health and health inequities in populations have social, environmental, and economic origins that extend beyond the direct influence of the health sector and health policies. Thus, public policies in all sectors and at different levels of governance can have a significant impact on population health and health equity."[2] The American State and Territorial Health Organization (ASTHO) provides a thorough review of key features and elements needed to have a successful HiAP integrated implementation practice.[3] These elements are listed below:

- ***Defining mutually beneficial goals***
    - HiAP requires the health sector to listen to how health policies might impact its partner agency's goal or bottom line. Health agencies are responsible for providing information to partners about the benefits and risks of participation in a HiAP initiative
    - The Collaboration Multiplier (provided through CDC)[4] is a useful tool that helps partners determine what other partners should be at the table

Cross-sector collaboration

- A framework which encompasses a range of models from private-public **partnerships** to shared values to collective impact.

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[2] https://www.paho.org/hq/dmdocuments/2014/2014.01-WHO-HiAP-FrameworkCountryAction.pdf

[3] https://www.astho.org/HiAP/Framework/#:~:text=Key%20Elements%20of%20HIAP%20Practice,-%E2%80%A2&text=Defining%20mutually%20beneficial%20goals.&text=Cross%2Dsector%20collaboration.&text=Engaging%20stakeholders.&text=Opportunity%20for%20policy%20change.

[4] https://www.preventioninstitute.org/tools/collaboration-multiplier

Engaging stakeholders

- Stakeholders are people who are impacted by HiAP work and could include state, local, or federal agencies, community members, nonprofit leaders, faith-based organizations, academic institutions, or businesses.
- Stakeholders can provide background information about issues, bring new solutions to light, and "ground-truth".
- The Policy Consensus Initiative defines four levels of interaction with stakeholders: inform, consult, engage, and collaborate.

Opportunity for policy change

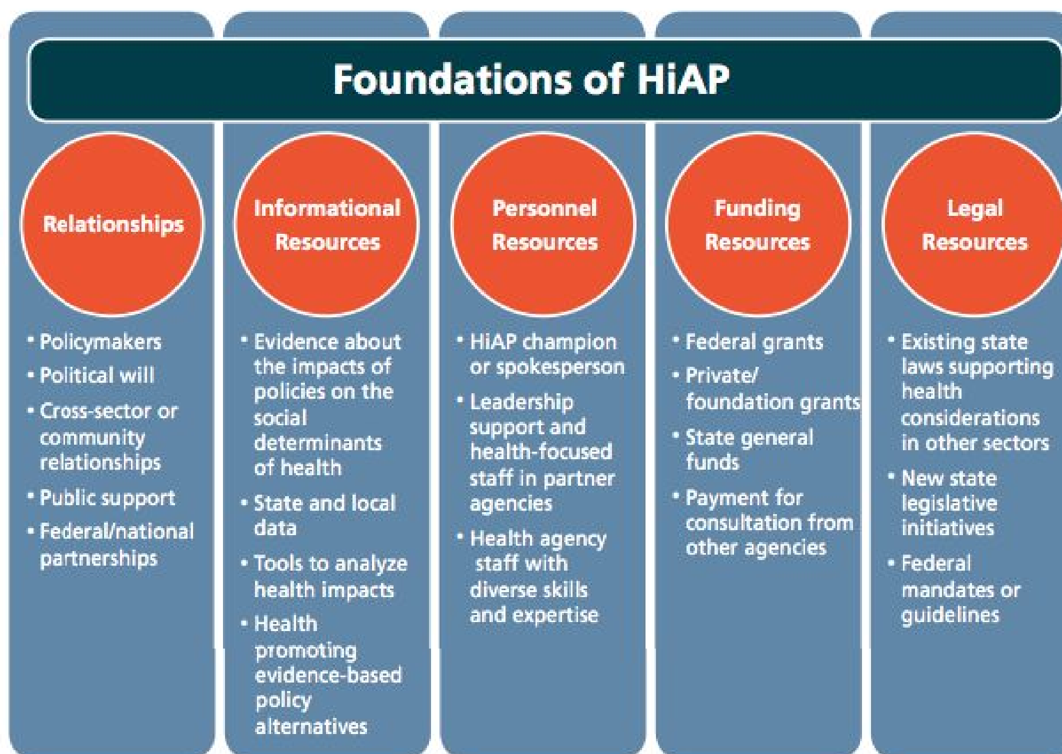
- Three critical components must be aligned for policy change to occur: problems, policies, and politics.
- Problems refer to the current issues in the field and must be clearly defined, widely understood, and evidence-based.
- Federal agencies, national policy organizations, and local groups can provide information about promising policy strategies to practitioners and policymakers.

Promote health and equity.

- HiAP addresses the social determinants of health that are the key drivers of health outcomes and health inequities.
- HiAP strives to embed and institutionalize considerations of health, equity, and sustainability as a standard part of decision-making processes across multiple sectors.

These elements are further described in the ASTHO Framework for State Health Leadership graphic below:[5]

[5] https://www.astho.org/HiAP/Framework/#:~:text=Key%20Elements%20of%20HIAP%20Practice,-%E2%80%A2&text=Defining%20mutually%20beneficial%20goals.&text=Cross%2Dsector%20collaboration.&text=Engaging%20stakeholders.&text=Opportunity%20for%20policy%20change.



HiAP MATTERS

According to the American Public Health Association, "Health in All Policies is a response to a variety of complex and often inextricably linked problems such as the chronic illness epidemic, growing inequality and health inequities, rising healthcare costs, an aging population, climate change and related threats to our natural resources, and the lack of efficient strategies for achieving governmental goals with shrinking resources."[6] With increasing demands on resources to support local and state health systems and a public health infrastructure, cooperation and collaboration is needed to effectively address the health needs of communities and innovatively problem-solve key issues that fuel health inequity. This requires collaborative multi-agency efforts that include typical health focused entities and those focusing on other key systems that support community life and social systems such as transportation, housing, education, recreation, social services, finance, and land development.

6 https://www.apha.org/-/media/files/pdf/factsheets/health_inall_policies_guide_169pages.ashx?la=en&hash=641B94AF624D7440F836238F0551A5FF0DE4872A

HiAP provides a framework in which to legitimately assess and review policies, practices and systems that promote health inequity and drive health disparity. Through the process of assessing local and state policies one can begin to unpack and discern what are the drivers of health inequity so that new policies and approaches can be implemented to promote health equity.

WHAT IS HEALTH EQUITY?

Equity is the absence of unfair differences among groups of people, whether those groups differ socially, economically, demographically or geographically. "Health equity" or "equity in health" implies that all persons should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.[7] According to the American Public Health Association, "health inequities are differences in health "that are a result of systemic, avoidable and unjust social and economic policies and practices that create barriers to opportunity."[8] These health differences are often realized in chronic disease rates and death caused by disease, lack access to healthcare, and under insurance. Many researchers suggest that the drivers of these disparities are social determinants of health. Social determinants are lack of food access, limited transportation, uninsured and underinsured, poor housing or homelessness, poor education and unemployment.

SOCIAL DETERMINANTS OF HEALTH DRIVERS OF HEALTH INEQUITIES

Any strategy to reduce or eliminate health inequities requires a thorough assessment of local, state and national policies that impact the social, environmental, and physical circumstances of individuals. Over the past 20 years, researchers have been theorizing and researching the impact of social determinants of health (SDOH) as drivers of health inequities throughout the world. The World Health Organization's Commission on the Social Determinants of Health has defined SDOH as "the conditions in which people are born, grow, live, work and age" and "the fundamental drivers of these conditions."[9] These

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[7] https://www.who.int/topics/health_equity/en/

[8] https://www.apha.org/-/media/files/pdf/factsheets/health_inall_policies_guide_169pages.ashx?la=en&hash=641B94AF624D7440F836238F0551A5FF0DE4872A

[9] Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. *Public Health Rep*. 2014;129 Suppl 2(Suppl 2):19-31. doi:10.1177/00333549141291S206

fundamental drivers are often social and economic factors that people experience by virtue of where they live, the financial resources they have, the impact of structural racism and discrimination and their access to food, clean water and educational experiences.[10] Disparity-reducing policy interventions must be targeted at improving life circumstances and creating equity in systems that support our communities such as education, housing, employment, community development, job development, and community/urban planning to promote healthy choices in homes, neighborhoods, schools, and workplaces. [11] As public health experts and professionals we should be constantly striving to work upstream to uncover the drivers of disparity and health inequity. Below is a parable that exemplifies public health efforts in action.

Fishing Parable

A man was fishing in the river when he noticed someone was drowning. He pulled them out and attempted to resuscitate them. Shortly afterwards, he noticed another person in the river and saved them too. He then noticed another, and another and another. Soon he was exhausted and realized he would not be able save all of the drowning people. He went further upstream to find out why all these people were falling into the river. On arriving further upstream, he discovered a broken bridge was causing people to fall into the river. He decided he would fix the bridge and stop others from falling in

[10] https://www.nationalacademies.org/news/2017/01/new-report-identifies-root-causes-of-health-inequity-in-the-us-outlines-solutions-for-communities-to-advance-health-equity

[11] Thornton RL, Glover CM, Cené CW, Glik DC, Henderson JA, Williams DR. Evaluating Strategies For Reducing Health Disparities By Addressing The Social Determinants Of Health. *Health Aff (Millwood)*. 2016;35(8):1416-1423. doi:10.1377/hlthaff.2015.1357

> rather than fishing them out one by one, or letting them drown when he wasn't there to save them. The aim of public health is simply to work upstream, or fix the bridge. Health systems, by their nature, are mainly focused on helping those who are drowning, or ill. When framed in this way, preventing illness before it occurs seems vital.[12]

Multiple resources are needed to develop state and national approaches to implementing systematic change. Long-term financing strategies are required to scale up effective interventions for implementation at the local, state, and national levels.[13] Factors that impede our abilities to improve the public's health is often fueled by the lack of community, local and state resources, siloed approaches to public health solutions, and public health approaches that are absent of community input and integration.

HiAP SUBCOMMITTEE PURPOSE

The Prince George's Healthcare Action Coalition Health Equity Workgroup's Health in All Policies (HiAP) sub-committee's primary objective is to Promote and Advocate for Health Equity for all individuals within Prince George's County. Health in All Policies (HiAP) is a collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people. HiAP recognizes that health is created by a multitude of factors beyond healthcare and, in many cases, beyond the scope of traditional public health activities. Our committee is made up of representatives of government agencies, nonprofit organizations and advocates from multiple sectors such as health, transportation, education, recreation, built environment and planning.

The HiAP subcommittee is a part of the larger Prince George's Healthcare Action Coalition's Health (PGHAC) Equity Workgroup. PGHAC is a collaboration of over 300 members representing 200 agencies, organizations, and communities that conducts the Community Health Needs Assessment (CHNA) and develops and implements the Community Health Improvement Plan (CHIP). The CHNA collected and analyzed data about health needs from a variety of sources across the county. The four health priorities that emerged were behavioral health, cancer, metabolic conditions, and cancer. The CHIP uses a policy, systems, and environments framework to address health needs. In order to address long-term change within this framework, the PGHAC formed work groups that focus on

[12] https://upstreamthinking.wordpress.com/upstream-story/

[13] Thornton RL, Glover CM, Cené CW, Glik DC, Henderson JA, Williams DR. Evaluating Strategies For Reducing Health Disparities By Addressing The Social Determinants Of Health. *Health Aff (Millwood)*. 2016;35(8):1416-1423. doi:10.1377/hlthaff.2015.1357

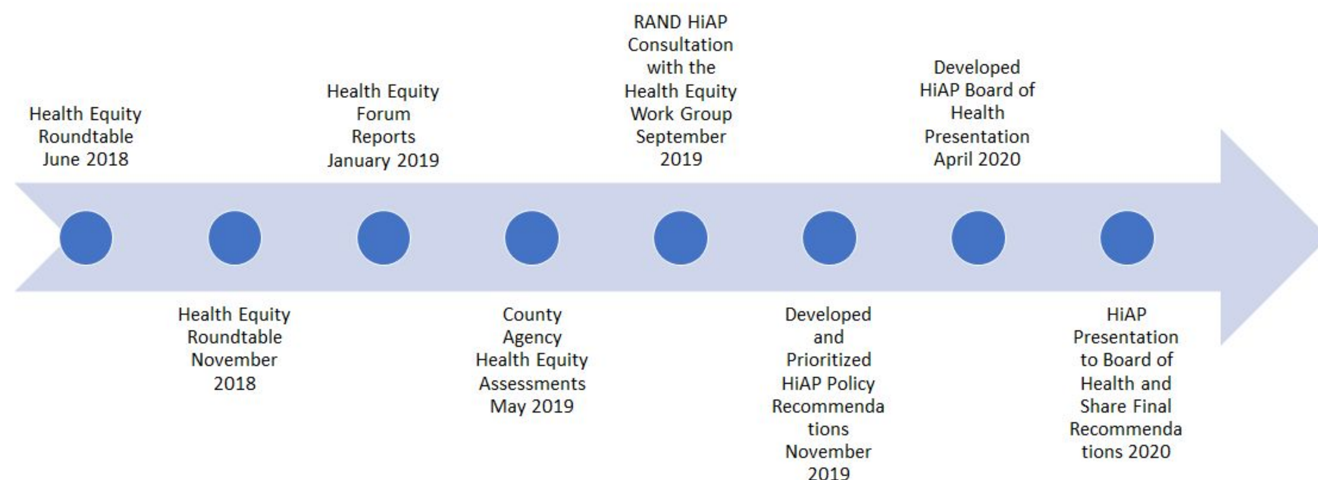
population health improvement and health equity. The coalition envisions a county that elevates and invests in the health and well-being of all residents and engages community members to share in the responsibility of creating the conditions that foster a healthier county.

HiAP SUBCOMMITTEE GOALS AND OBJECTIVES

- Promote and Advocate for Health Equity by developing HiAP (Health in All Policies) guidance for county agencies to include health considerations and an equity lens in their policies and work plans.
- Promote and Advocate for Health Equity by providing resources and data to assist agencies and community-based organizations with operationalizing Health in All Policies and/or Health Equity within their organizations.
- Engage the Healthcare System to Advance Health Equity by promoting Health Literacy through health care providers.
- Promote Health Equity within communities by advocating for community-based organizations CBO's to incorporate health equity into the foundation of their organizations through education, training, and accountability.

HEALTH EQUITY WORKGROUP AND HiAP SUBCOMMITTEE TIMELINE

The Health Equity Workgroup and HiAP Subcommittee developed a work plan and adhered to an implementation timeline over the past year and a half. Table 1 timeline outlines each of the subcommittee's planned tasks.



BRIEF DESCRIPTIONS OF THE HEALTH EQUITY WORKGROUP AND HiAP SUBCOMMITTEE INITIATIVES

As indicated in Table 1, the Health Equity Workgroup and HiAP Subcommittee has engaged in ongoing efforts to build the understanding of HiAP and Prince George's County's need to adopt and implement HiAP principles and practices. Below are brief descriptions of activities outlined in the timeline.

Health Equity Integration Organizational Self Assessments

- Provided through the PGHAC Equity Workgroup Data and Assessment subcommittee, 15 Prince George's County agencies have completed a Health Equity Assessment.
- The assessment was scored with a maximum of 45 points, with higher scores equating to higher levels of current health equity implementation.
  - Agencies and institutions with the highest current levels of health equity incorporation were the Community Ministry of Prince George's County, Doctors Community, Hospital's Case Management Division, and the Prince George's County Healthcare Alliance.
- Responses to the root causes of health inequities.
  - Over three-quarters, (77.8%) of agencies reported that they "currently always" or "almost always" collaborate with other agencies and businesses in the development of policies and initiatives to address the root causes of health inequities.
  - Only one-third (33%) of the agencies reported "currently always" or "almost always" dedicating resources or reviewing policies and procedures to address the root causes of health inequities.
  - The potential for growth exists across each of these areas, as the majority of agencies reported continuing their efforts at the same level or more in the near future.

Case Study Results

After reviewing and assessing the organizational self-assessment data, he PGCHAC Health Equity Workgroup thought it prudent to conduct case studies with two agencies. The case studies provided the workgroup with snapshot examples of how our county's agencies interpreted the implementation of health equity and to what degree health equity practices were integrated into those agencies. Below are summaries of the two case studies that were conducted.

Prince George's County: Case Studies

Community Ministry of Prince George's County (CMPGC): http://www.cmpgc.com

- **Background:**
    - Community Ministry of Prince George's County (CMPGC) is an interfaith, 501(c)(3) non-profit organization committed to help address human service needs, close the educational achievement gap, and reduce health inequities that exist in various communities.
    - **Aim:** It's aim is to alleviate homelessness, hunger, health disparities, and other circumstances that put families and children at risk of living in poverty.
        - Recently, Community Ministries has shifted from crisis response to prevention to help address health inequities in Prince George's County, Maryland.
        - CMPGC assisted Prince George's County Health Department with recruiting churches to help institute smoking cessation community programs.

How does CMPGC Address Health Inequities?

- **Health Equity Initiatives:**
    - Providing rent and transportation assistance to those who are on the cusp of homelessness.
        - Applicants are carefully screened, as funds are intended for those who need temporary assistance in order to get back on their feet. Applicants are asked to work with the ***Step-Up program*** for budgeting support after they are given monetary assistance.
- **Health Equity Strategies**
    - Working with undergraduate University of Maryland (UMD) students to provide education and use current communication strategies.
        - Ex: UMD students assist with creating content for the Community Ministry's Instagram account
    - Producing written content at the 8th-10th grade reading level, and utilizing varied distribution channels such as health fairs, e-mail distribution lists, and interim reports for education and outreach.

- Training staff and volunteers on effective community engagement in order to understand the community's needs. Providing quality customer service enables staff to build strong relationships with community members, and thus serve as a trusted community resource for health information.
- Staying abreast of the community's needs requires a strong professional network. CMPGC works closely with community advisory groups, church leaders, and researchers at Johns Hopkins University and the University of Maryland.
- CMPGC also capitalizes on their internal assets. Along with ongoing and solicited input from board members and staff members, CMPGC has an annual review where they evaluate how they have impacted the community and determine appropriate strategies for the coming years

- **Challenges:**
  - **CMPGC does not have enough resources to meet the needs of all of those in the County.** Over the years they have implemented several strategies that allow for their resources to have a larger impact. This work has taught them that:
    - Coordination and collaboration with others are paramount. In order to do this effectively, strong relationships with other entities must be built prior to responding to organizational requests.
    - To verify resources individuals are receiving from social services in order to avoid service duplication.
    - Intervening early (i.e. prior to a crisis) often allows for more cost-effective strategies, so it is important that people know how to find you and other providers.
    - Hiring consultants as opposed to employees allows for more variation and flexibility in an organization's staffing structure throughout the fiscal year. This is useful when relying on grant funds to implement programmatic priorities.
    - Working alongside a coalition is an effective strategy to extend services provided.

- County agencies should better leverage non-profit agencies, who may be more embedded and trusted in the community

Doctor's Community Hospital: http://www.dcweb.org

- **Background:**
  - Doctors Community Hospital (DCH) was founded in 1975 and is a leading healthcare provider in Prince George's County. Delivering high-quality and compassionate care, and continuously striving for excellence in service and clinical quality to distinguish us with our patients and other customers.
    - Recent Awards/Accomplishments: ·The Joint Commission's top performer on key quality core measures for three consecutive years, Medicare's highest ranking hospital in Prince George's County, Leapfrog Hospital Safety Grade of 'B' – the highest rated hospital in Prince George's County

- **Health Equity Initiatives**
  - **Diabetes on the Road Program:** Provided diabetes screenings and education at locations throughout the county. The target audiences were people who had diabetes/prediabetes and their caregivers.
    - In 2019, the program had 1,002 encounters with participants who had abnormal A1C screenings receiving calls from a diabetes educator. Also, about 80 percent of screening results were sent to patients' healthcare providers for follow-up care.
    - Partnership w/ Prince George's County Health Department
  - **Susan Denision Mona Center:** This multi-service center provided medical, dentistry, legal and social services in an underserved area of Prince George's County.
    - Partnership w/ Catholic Charities of the Archdiocese of Washington and the University of Maryland School of Public Health
    - With DCH managing primary care services, it cared for about 2,000 people in 2018
    - The Center also developed an Urban Farm with the crops used to feed those in need of meals
    - **Totally Linking Care in Maryland (TLC-MD):** This grant-funded program was free to the community, and it coordinated the care of

people who were discharged from acute settings, had multiple chronic diseases and needed services from a team of medical professionals. Also guided patients to additional resources available in the community.

- Partnered w/ with seven hospitals and other providers in three counties

- **Wellness on Wheels:** mobile health clinic travelled throughout the county and provided free screenings and medication education
  - Support of Carrollton Enterprises and other donors
  - In 2018, it had about 10,000 visits at 50+ locations.

- **Health Equity Strategies**
  - Leaders served on various boards and coalitions: Prince George's Healthcare Action Coalition, Prince George's County Taskforce, Catholic Charities, the Rotary, Maryland Chamber of Commerce, Business Roundtable, Maryland Hospital Association's Health Equity Taskforce, etc.
  - DCH managed the grant-funded Cancer Prevention, Education, Screening and Treatment (CPEST) program, which offered no cost colorectal and breast health services to qualified Prince George's County residents.
  - The hospital provided numerous free support groups: breast cancer, grief, diabetes, lymphedema, stroke, heart disease, etc.
  - **Social Work Department:**
    - This team consisted of 24 members – six social workers, thirteen nurse case managers, four transitional care nurses and one transitional care nurse practitioner.
    - Four of the transitional care registered nurses assisted discharged patients who had multiple comorbidities and required care from various specialists.
    - Case managers, social workers, transitional care nurses and a nurse practitioner helped patients schedule appointments and access needed services.
  - **Transitional Care Clinic:**

            - Free resource was offered to high-risk discharged patients who had multiple comorbid conditions or immobility. Transitional care patients were evaluated and treated by a multidisciplinary team (providers, social workers and pharmacists) to help minimize disruptions to the transition of care.
            - Providers also performed home health visits that included coaching and support for high-risk and immobile patients.
            - The clinic provided care Tuesdays to Thursdays from 10 a.m. – 4p.m. Nurse practitioners cared for patients in the community Mondays to Fridays from 8:30 a.m. to 5 p.m.
    - All DCH team members were required to participate in annual core competency training based on their clinical or non-clinical areas of responsibility. Specific to case management and social work employees, their health inequities-related training included the following with some resulting in continuing education credits:
        - 40 training hours every two years focused on numerous patient care topics such as dementia, ethics in older adults, addiction in older adults, ethical dilemmas, complicated/uncomplicated grief, etc.
        - This education was provided by several providers, approved by the Maryland Board of Social Work and paid through Doctors Community Hospital's education reimbursement program.
    - All other DCH employees learned about health inequities and the social determinants of health through annual training, guest speakers and/or internal communications.
- **Challenges**
    - Accurately capturing population shifts based on the results of the above efforts given changes in the market.
        - For example, the hospital experienced an increase in emergency department visits instead of a decline.
            - Contributing factors may have included:
                - the closing of emergency departments at Laurel Hospital and Providence Hospital.

        - DCH was a designated stroke treatment center; and it was the only in-network hospital for Kaiser Permanente in Prince George's County.
    - These shifts may mean that more people were brought to DCH by ambulance or self-selected via personal transportation. Thus, it was challenging to accurately reflect the full impact of DCH's initiatives on overall population health
- **Patient Compliance with Providers Orders:**
    - Hindered by social determinants of health. ·
        - Some of these factors could include: transportation, literacy, food insecurity, etc.
        - These determinants often pose obstacles that prevent many people from consistently managing their health, which can result in declining health and repeated visits to the emergency department.
        - Advancing current tactics and encouraging more community-based collaboration may contribute to additional successes.

Health Equity Forums

https://drive.google.com/file/d/1ObNUNw7FXjaswjSlO9gwk8w0WblopxAL/view?usp=sharing

The PGHAC and the PGCHD hosted two one-day forums on health equity in Prince George's County. The meetings engaged key stakeholders in conversations relevant to their roles, responsibilities, and interests. Data was collected and aggregated; recommendations include:

- **Transformative Change - Our Role in Achieving Health Equity in Prince George's County**

On Thursday, June 7th, 2018, the Prince George's Healthcare Action Coalition and the Prince George's County Health Department (PGCHD) hosted a one-day meeting, "Transformative Change – Our Role in Achieving Health Equity for Prince George's County', to engage County elected officials, agency leadership, health provider organizations, and academic partners in a conversation about how policies and plans affect health equity. This meeting aimed to build a common language, shared framework, and policy agenda to identify changes needed to integrate Health in All Policies (HiAP) with an intentional focus on equity and inclusion.

Capturing the essence of the conversations that transpired on that day, this report documents the first steps to building a roadmap for the County and its stakeholders. Our vision is a Prince George's County where everyone has equitable access to achieve their full health and wellness potential, regardless of race, color, religion, country of origin, immigration status, class, age, disability, sexual orientation, gender or gender identity.

Link to the report below:

Health Equity Forum: Transformative Change, June 2018

- **Transformative Change - Our Role in Achieving Health Equity in Prince George's County (Part 2)**

On Thursday, November 29, 2018, the Prince George's Healthcare Action Coalition (PGHAC) and the Prince George's County Health Department (PGCHD) hosted a one-day health equity forum, *Transformative Change – Our Role in Achieving Health Equity in Prince George's County*. The second of its kind, this forum engaged stakeholders from different sectors in the county in conversation about the intersections of health equity through presentations, facilitated panel discussions, and interactive group activity.

Link to the report below:

Health Equity Forum: Transformative Change, November 2018

Data Assessment from the Health Equity Forums

Data gathered from both forums was assessed and recommendations were aggregated by themes. Below are the recommendations by theme provided by participants who attended either the June 7th or November 29th forums.

Improve Interagency Collaboration

- Prince George's County Health Department should prioritize collaboration with the Department of Social Services to improve the navigation of health and social services to improve their overall quality of life.
- Create a single health and social services application for all needs between the Health Department and the Department of Social Services.

- Consider how to utilize Prince George's County's assets to support efforts to promote health equity and HiAP, such as increased engagement with the University of Maryland Medical System and School of Public Health.

Encourage Truth-Telling

- Disseminate data and research findings to elected officials and constituents.
- Engage and provide guidance to legislators and policy-makers on health equity initiatives.
- Engage community members impacted by inequity in policy discussions and decision-making.
- Engage in transactional conversations that emphasize the long-term benefits and value of applying the equity lens.
- Publicly claim ownership of our work towards health equity to promote accountability.

Strengthen Prince George's County's Non-Profit Sector

- Support non-profit organizations in translating policy into practice.
- Encourage agency self-assessments to determine whether organizations are addressing what their communities need or want.

Invest in the Future

- Educate youth and promote civic engagement.
- Recruit and mentor future leaders so that they are prepared to serve.
- Develop a long-term change strategy that engages multiple agencies, organizations and community stakeholders.

Promote Perspective Transformation

- Engage in constructive discomfort. Evaluate yourself and your agency to identify implicit biases, prejudicial tendencies and inequity in structures, policies, and programs around you.
- Cultivate and nurture youth so that they can bravely act to address inequity. Bring community voices to the planning table and actively engage in respectful listening.

- Educate clinical providers on how implicit bias directly affects how they provide health care. Provide training to clinical providers on how to care for people with varying experiences, abilities, and limitations.
- Value the insights of community health workers, recognize the critical role that they play in care teams, and acknowledge their contribution to improving patient care.

Institutionalize the Equity Lens

- HiAP Manager and Coordinators should have backgrounds and experience in health and urban planning. Such individuals can translate HiAP into planning, practice and policy and participate in cross-sector meetings throughout Prince George's County.
- Integrate equity into existing and new policies and strategic planning processes rather than creating separate plans to address it.
- Consider successful initiatives in other states as models for next steps.

Final Recommendations

The HiAP subcommittee conducted a structured process with its members to prioritize recommendations.. Key Work Group priorities were used as levers to assist each member in making decisions. Committee members reviewed each recommendation and selected one recommendation in each thematic category that most closely met all of the key priority levers. Priority levers are as follows:

- Aligns with Action Plan and Other Key County Initiatives
- Achievable (Complete in a Reasonable Amount of Time)
- Reasonable (Within Our Purview)
- Policy Implications (Something PGCO HD Can Give Legs)

Improve Interagency Collaboration

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Encourage Truth-Telling

- Disseminate data and research findings to elected officials and constituents.

- Engage and provide guidance to legislators and policy-makers on health equity initiatives.

Strengthen Prince George's County's Non-Profit Sector

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CONCLUSION

This summary document provides an introductory review of HiAP and the meaning of health equity and social determinants of health. Most importantly, the document provides a the chronological review of the PGHAC Health Equity Work Group and HiAP Subcommittee's efforts over the past two years to increase community awareness specifically among state agencies and community based organizations that have a role in impacting the quality of life experienced by individuals residing in Prince George's County. , Specifically, representatives from the following state agencies engaged in one or both of the health equity forums: Department of Social Services, Public Safety, Department of Transportation, Department of the Environment, Department of Education, Department of Employment, Department of Housing and the Health Department, Federally Qualified Health Centers, human service and philanthropic organizations, health systems and community health centers.

A HiAP approach requires the use of an equity lens in the consideration of policy and program development and how those policies and efforts are impacting the lives of

individuals and communities ability to thrive economically, socially, and intellectually. The prudent assessment, engagement, collaboration, consensus and collective systematic implementation of thoughtful approaches that are guided by the principles of HiAP and with the intention of improving the lives of everyone but particularly those individuals who are disproportionately impacted by complex historical social and economic factors also known as social determinants. Findings from the multiple data gathering efforts were assessed, summarized and key learnings guided the PGHAC Health Equity Group's development and prioritization of key County specific HiAP recommendations that we strongly believe will drive the integration of a HiAP approach to improving the health and wellness of all Prince George's County Residents.

HiAP RESOURCES AND TOOLS

- On May 4th, 2017, Maryland Governor Larry Hogan signed into law the **University of Maryland School of Public Health, Center for Health Equity Workgroup on Health in All Policies.** The legislation was introduced by a group of Maryland lawmakers including Senator Shirley Nathan-Pulliam, who is a member of the Education, Health and Environmental Affairs Committee. The Universityof Maryland School of Public Health, Center for HEalth Equity is led by Dr. Stephen B. Thomas

  Links to workgroup reports are below:

  Read the Senate Bill 340: University of Maryland School of Public Health, Center for Health Equity — Workgroup on Health in All Policies: January 2018 Report.

  Read the Senate Bill 340: University of Maryland School of Public Health, Center for Health Equity — Workgroup on Health in All Policies: January 2019 Report

- *Health in All Policies: A Guide for State and Local Governments* was created by the Public Health Institute, the California Department of Public Health, and the American Public Health Association. Document can be found at the link below:

  https://www.apha.org/~/media/files/pdf/factsheets/hiapguide_4pager_final.ashx

- The link below provides a national and regional listing of significant HiAP models, toolkits, tip sheets, and effective approaches.

  https://www.cdc.gov/policy/hiap/resources/resources-list.html

- Below is a link to the Association for State and Territorial Health Organizations (ASTHO) fact sheet on Health in All Policies.

  https://astho.org/Programs/Health-in-All-Policies/Environmental-Health-in-All-Policies/Health-in-All-Policies-introduction/

- September 2013 Institute of Medicine Roundtable Report on Health in All Policies as a pathway to population health improvement. See link below:

  https://nam.edu/wp-content/uploads/2015/06/BPH-HiAP.pdf

COVID-19 – UM Capital Region Health, Community Health Outreach Efforts

Food Insecurity Donations

Mission of Love Charities Inc., $12,000
Food pantry located in Capital Heights Maryland, supporting low income, homeless and immigrant families. •located in current food desert •Items include perishables and produce •Families can fill one shopping cart per visit, once a week •Pantry is open 7 days a week and every other Saturday
"The *funding you provided to our organization has helped us fill a significant gap in services during this time. We are truly grateful for your generous donation*" *Deborah Martinez- CEO, Mission of Love Inc. Prince George's County Maryland*

Capital Area Food Bank $20,000
Supporting existing food distributions through the existing partnership networks as well as Pop-up distributions in locations that are food insecure and lack existing partnership networks. • Provided 1 truck load of food • Distribution (existing) sites as well as pop-up locations in Prince George's County (including weekends) as the need arises. • All distributions occur in food deserts • Family of 4 receives 1 box of food • Each box contains various non-perishable food items ($50 value)

COVID Family Supportive Program

The Family Support Service Program provides compassionate individual and family supportive services to families, caregivers, and loved-ones of individuals receiving medical care in the hospital as a result of COVID19. The program helps individuals cope with the specialized care needs of patients with COVID19 which restricts visits and interaction of the patient with visitors.

Coping kits will be issued to all families of individuals who have been tested for coronavirus absent of a positive result. The kit will include stress relieving exercise, self-soothing methods (i.e., meditation and self-guided imagery), tip sheets, fact sheets, information about the COVID19 Family Supportive Services Program, and visitor policy.

Diaper Distribution & Donations

In response to community need and in collaboration with Amerigroup and the UM Capital Office of Philanthropy, a Diaper Donation drive was conducted to provide adult and infant diapers to communities that have been financially impacted by COVID-19. These communities include:

- Hyattsville
- Bladensburg
- Colmar Manor
- Suitland

Diapers, gift cards, as well as monetary donations were collected. We have partnered with Amerigroup as well as Port Towns Elementary and Nicholas Orem Middle School (Title 1), who will receive the donations.

UM Capital in collaboration with the DC Diaper Bank will serve as a diaper distribution site at our Suitland ambulatory medical location. UM Capital will distribute diapers to at least 100 families a month through our Friday no-contact diaper distribution program.

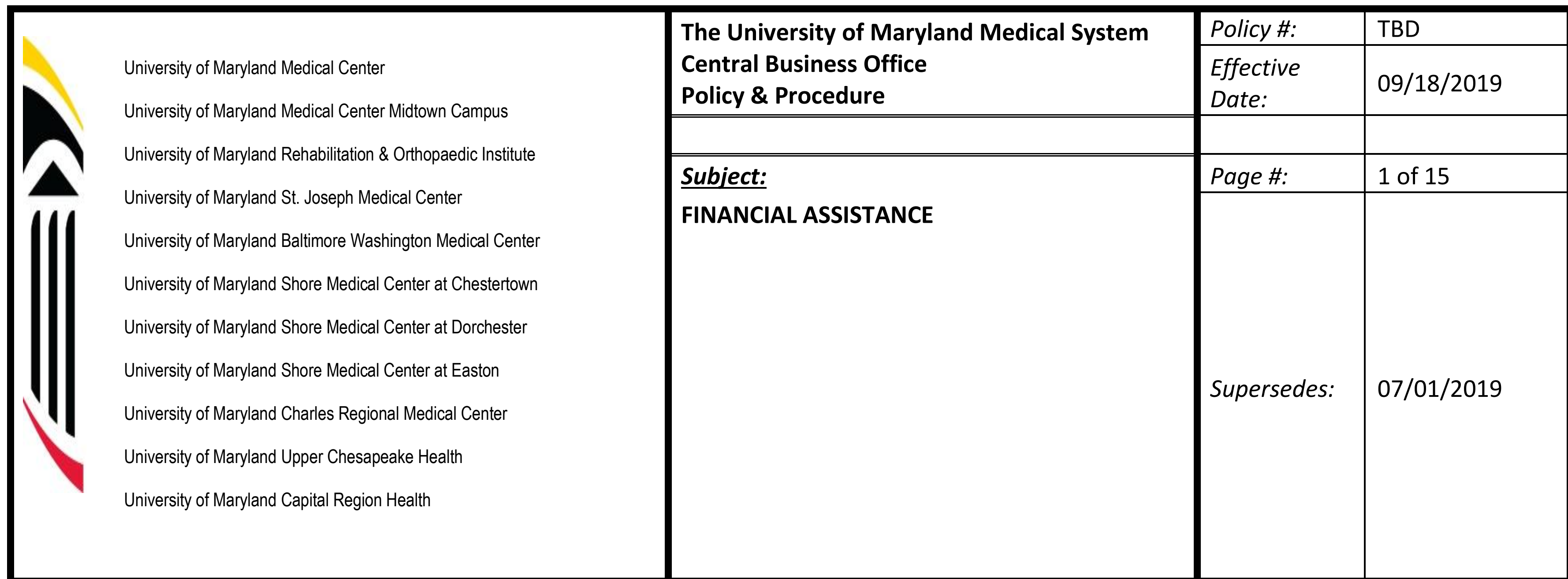
COVID Outreach Response Totals

Total costs: 40,000

Total number of diapers donation: 40,050

Pounds of food funded: 40,000lbs

Total number of families served: 10,000

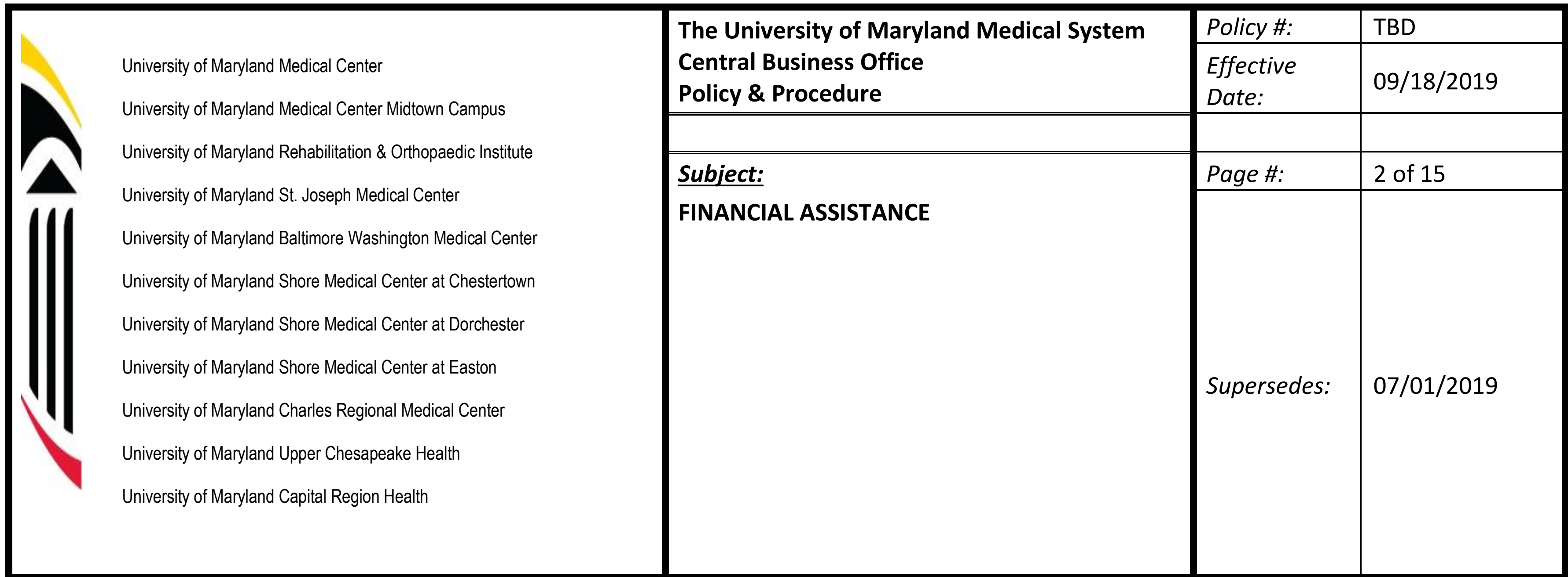


University of Maryland Medical Center University of Maryland Medical Center Midtown Campus University of Maryland Rehabilitation & Orthopaedic Institute University of Maryland St. Joseph Medical Center University of Maryland Baltimore Washington Medical Center University of Maryland Shore Medical Center at Chestertown University of Maryland Shore Medical Center at Dorchester University of Maryland Shore Medical Center at Easton University of Maryland Charles Regional Medical Center University of Maryland Upper Chesapeake Health University of Maryland Capital Region Health	**The University of Maryland Medical System Central Business Office Policy & Procedure**	*Policy #:*	TBD
		Effective Date:	09/18/2019
	Subject: **FINANCIAL ASSISTANCE**	*Page #:*	1 of 15
		Supersedes:	07/01/2019

POLICY

This policy applies to the following hospital facilities of the University of Maryland Medical System ("UMMS hospitals"):

- University of Maryland Medical Center (UMMC)
- University of Maryland Medical Center Midtown Campus (MTC)
- University of Maryland Rehabilitation & Orthopaedic Institute (UMROI)
- University of Maryland St. Joseph Medical Center (UMSJMC)
- University of Maryland Baltimore Washington Medical Center (UMBWMC)
- University of Maryland Shore Medical Center at Chestertown (UMSMCC)
- University of Maryland Shore Medical Center at Dorchester (UMSMCD)
- University of Maryland Shore Medical Center at Easton (UMSME)
- University of Maryland Charles Regional Medical Center (UMCRMC)
- University of Maryland Upper Chesapeake Health (UCHS)
- University of Maryland Capital Region Health (UM Capital)



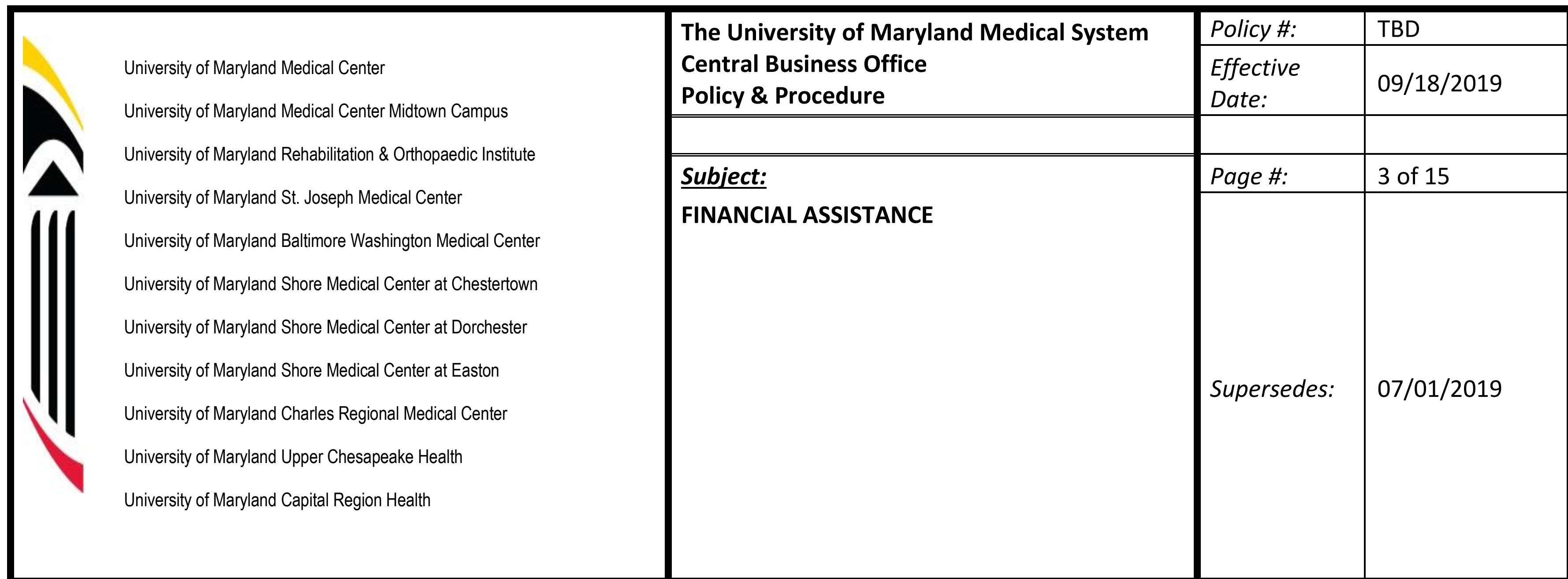
The University of Maryland Medical System ("UMMS") is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergent and medically necessary care based on their individual financial situation.

It is the policy of the UMMS hospitals to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance should be made, the criteria for eligibility, and the steps for processing applications.

UMMS will post notices of financial assistance availability in each UMMS hospital's emergency room (if any) and admissions areas, as well as the Billing Office. Notice of availability will also be sent to the patient with patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge, and it (along with this policy and the Financial Assistance Application) will be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas. This policy, the Patient Billing and Financial Assistance Information Sheet, and the Financial Assistance Application will also be conspicuously posted on the UMMS website (www.umms.org).

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financial Assistance Applications may be offered to patients whose accounts are with a collection agency.

UMMS retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent/urgent services, applications to the Financial Clearance Program will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.



This policy was adopted for University of Maryland St. Joseph Medical Center (UMSJMC) effective June 1, 2013.

This policy was adopted for University of Maryland Medical Center Midtown Campus (MTC) effective September 22, 2014.

This policy was adopted for University of Maryland Baltimore Washington Medical Center (UMBWMC) effective July 1, 2016.

This policy was adopted for University of Maryland Shore Medical Center at Chestertown (UMSMCC) effective September 1, 2017.

This policy was adopted for University of Maryland Shore Medical Center at Dorchester (UMSMCD) effective September 1, 2017.

This policy was adopted for University of Maryland Shore Medical Center at Easton (UMSMCE) effective September 1, 2017.

This policy was adopted for University of Maryland Charles Regional Medical Center (UMCRMC) effective December 2, 2018.

This policy was adopted for University of Maryland Upper Chesapeake Health (UCHS) effective July 1, 2019

This policy was adopted for University of Maryland Capital Region Health (UM Capital) effective September 18, 2019

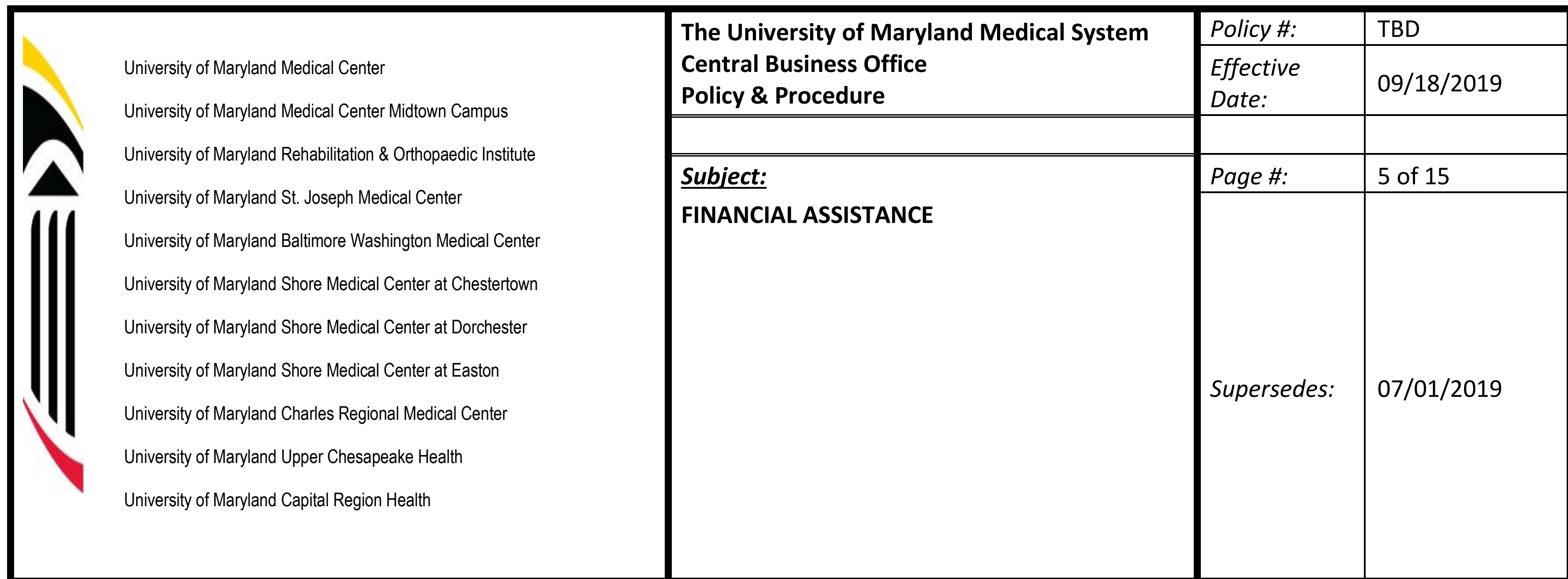
PROGRAM ELIGIBILITY

Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate for those who do not have the means to pay for medically necessary care, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital hospitals strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

Specific exclusions to coverage under the Financial Assistance Program:

The Financial Assistance Program generally applies to all emergency and other medically necessary care provided by each UMMS hospital, as well as certain entities related to such hospitals listed in Attachment B. However, the Financial Assistance Program does not apply to any of the following:

1. Services provided by healthcare providers not affiliated with UMMS hospitals (e.g., durable medical equipment, home health services).
2. Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, or Workers Compensation), are not eligible for the Financial Assistance Program.
   a. Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications.
3. Cosmetic or other non-medically necessary services.
4. Patient convenience items.
5. Patient meals and lodging.
6. Physician charges related to the date of service are excluded from this UMMS financial assistance policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly.
   a. A list of providers, other than the UMMS hospital itself, delivering medically necessary care in each UMMS hospital that specifies which such as providers are not covered by this policy (as well as certain such providers that are covered) may be obtained on the website of each UMMS Entity.



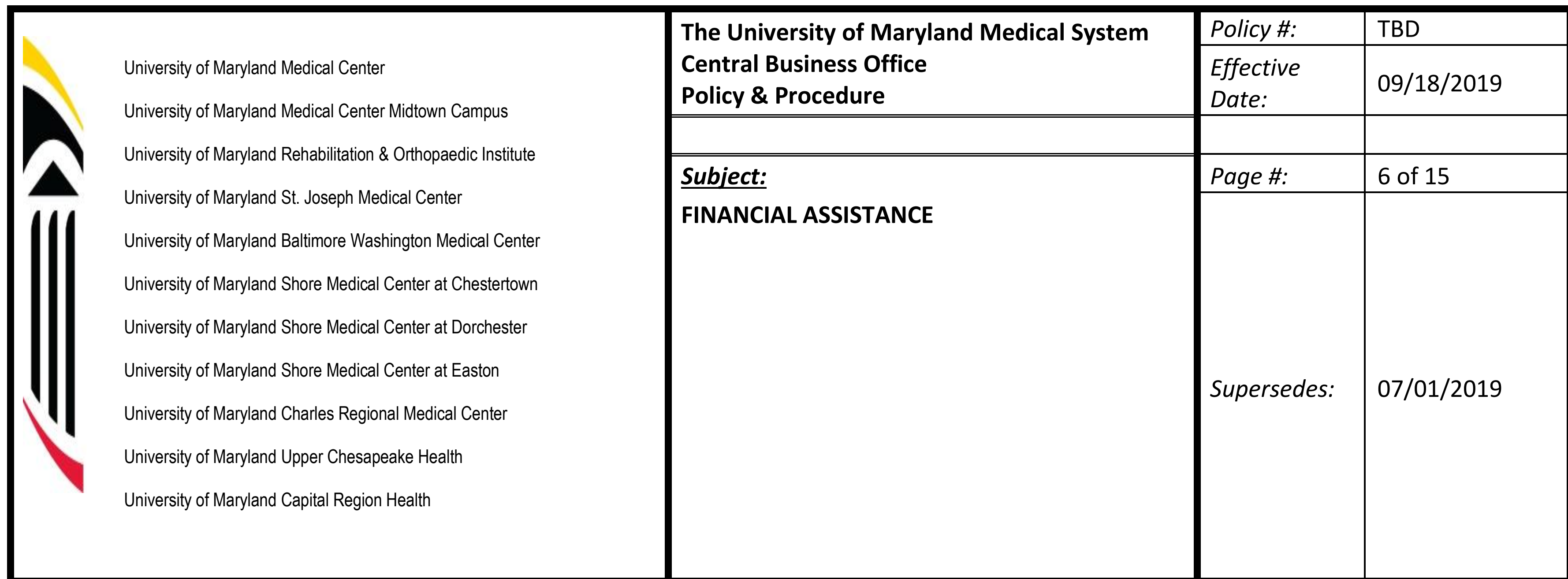
Patients may be ineligible for Financial Assistance for the following reasons:

1. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to the Medical Center due to insurance plan restrictions/limits.
2. Refusal to be screened for other assistance programs prior to submitting an application to the Financial Clearance Program.
3. Refusal to divulge information pertaining to a pending legal liability claim.
4. Foreign-nationals traveling to the United States seeking elective, non-emergent medical care.

Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.

Unless they meet Presumptive Financial Assistance Eligibility criteria, patients shall be required to submit a complete Financial Assistance Application (with all required information and documentation) and determined to be eligible for financial assistance in order to obtain financial assistance. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application before receiving non-emergency medical care unless they meet Presumptive Financial Assistance Eligibility criteria. If the patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor/Coordinator and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

Those with income up to 200% of Maryland State Department of Health and Mental Hygiene Medical Assistance Planning Administration Income Eligibility Limits for a Reduced Cost of Care (“MD DHMH”) are eligible for free care. Those between 200% to 300% of MD DHMH are eligible for discounts on a sliding scale, as set forth in Attachment A.



Presumptive Financial Assistance

Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. There is adequate information provided by the patient or through other sources, which provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, UMMS reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

a. Active Medical Assistance pharmacy coverage
b. Specified Low Income Medicare (SLMB) coverage
c. Primary Adult Care (PAC) coverage
d. Homelessness
e. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
f. Medical Assistance spend down amounts
g. Eligibility for other state or local assistance programs
h. Patient is deceased with no known estate

i. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program

j. Non-US Citizens deemed non-compliant

k. Non-Eligible Medical Assistance services for Medical Assistance eligible patients

l. Unidentified patients (Doe accounts that we have exhausted all efforts to locate and/or ID)

m. Bankruptcy, by law, as mandated by the federal courts

n. St. Clare Outreach Program eligible patients

o. UMSJMC Maternity Program eligible patients

p. UMSJMC Hernia Program eligible patients

Specific services or criteria that are ineligible for Presumptive Financial Assistance include:

a. Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive financial assistance program until the Maryland Medicaid Psych program has been billed.

PROCEDURES

1. There are designated persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Service Representatives, etc.

2. When possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

   a. Staff will complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage.

   b. Preliminary data will be entered into a third party data exchange system to determine probably eligibility. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.

   c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance. Determination of Probable Eligibility will be provided within two business days following a patient’s request for charity care services, application for medical assistance, or both.

   d. If a patient submits a Financial Assistance Application without the information or documentation required for a final determination of eligibility, a written request for the missing information or documentation will be sent to the patient. This written request will also contain the contact information (including telephone number and physical location) of the office or department that can provide information about the Financial Assistance Program and assistance with the application process.

   e. The patient will have thirty (30) days from the date this written request is provided to submit the required information or documentation to be considered for eligibility. If no data is received within the 30 days, a letter will be sent notifying the patient that the case is now closed for lack of the required documentation. The patient may re-apply to the program and initiate a new case by submitting the missing information or documentation 30 days after the date of the written request for missing information/documentation.

   f. For any episode of care, the Financial Assistance Application process will be open up to at least 240 days after the first post-discharge patient bill for the care is sent.

   g. Individual notice regarding the hospital's Financial Assistance Policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

3. There will be one application process for UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital. The patient is required to provide a completed Financial Assistance Application orally or in writing. In addition, the following may be required:

   a. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return); proof of disability income (if applicable), proof of social security income (if applicable). If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc ...

   b. A copy of their most recent pay stubs (if employed) or other evidence of income.

   c. A Medical Assistance Notice of Determination (if applicable).

   d. Copy of their Mortgage or Rent bill (if applicable), or written documentation of their current living/housing situation.

If a patient submits both a copy of their most recent Federal Income Tax Return and a copy of their most recent pay stubs (or other evidence of income), and only one of the two documents indicates eligibility for financial assistance, the most recent document will dictate eligibility. Oral submission of needed information will be accepted, where appropriate.

4. In addition to qualifying for Financial Assistance based on income, a patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses based on the Financial Hardship criteria discussed below. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on UMMS guidelines.

   a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Coordinator will recommend the patient's level of eligibility and forward for a second and final approval.

i) If the patient does qualify for Financial Assistance, the Financial Coordinator will notify clinical staff who may then schedule the patient for the appropriate hospital-based service.

ii) If the patient does not qualify for Financial Assistance, the Financial Coordinator will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.

(1) A decision that the patient may not be scheduled for hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Clinical Chair.

5. Once a patient is approved for Financial Assistance, Financial Assistance coverage is effective for the month of determination and a year prior to the determination. However, an UMMS hospital may decide to extend the Financial Assistance eligibility period further into the past or the future on a case-by-case basis. If additional healthcare services are provided beyond the eligibility period, patients must reapply to the program for clearance. In addition, changes to the patient's income, assets, expenses or family status are expected to be communicated to the Financial Assistance Program Department. All Extraordinary Collections Action activities, as defined below, will be terminated once the patient is approved for financial assistance and all the patient responsible balances are paid.

6. Account balances that have not been paid may be transferred to Bad Debt (deemed uncompensated care) and referred to an outside collection agency or to the UMMS hospital's attorney for legal and/or collection activity. Collection activities taken on behalf of the hospital by a collection agency or the hospital's attorney may include the following Extraordinary Collection Actions (ECAs):

a. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

b. Commencing a civil action against the individual.

c. Placing a lien on an individual's property. A lien will be placed by the Court on primary residences within Baltimore City. The hospital will not pursue foreclosure of a primary residence but my maintain its position as a secured creditor if a property is otherwise foreclosed upon.

d. Attaching or seizing an individual's bank account or any other personal property.

e. Garnishing an individual's wage.

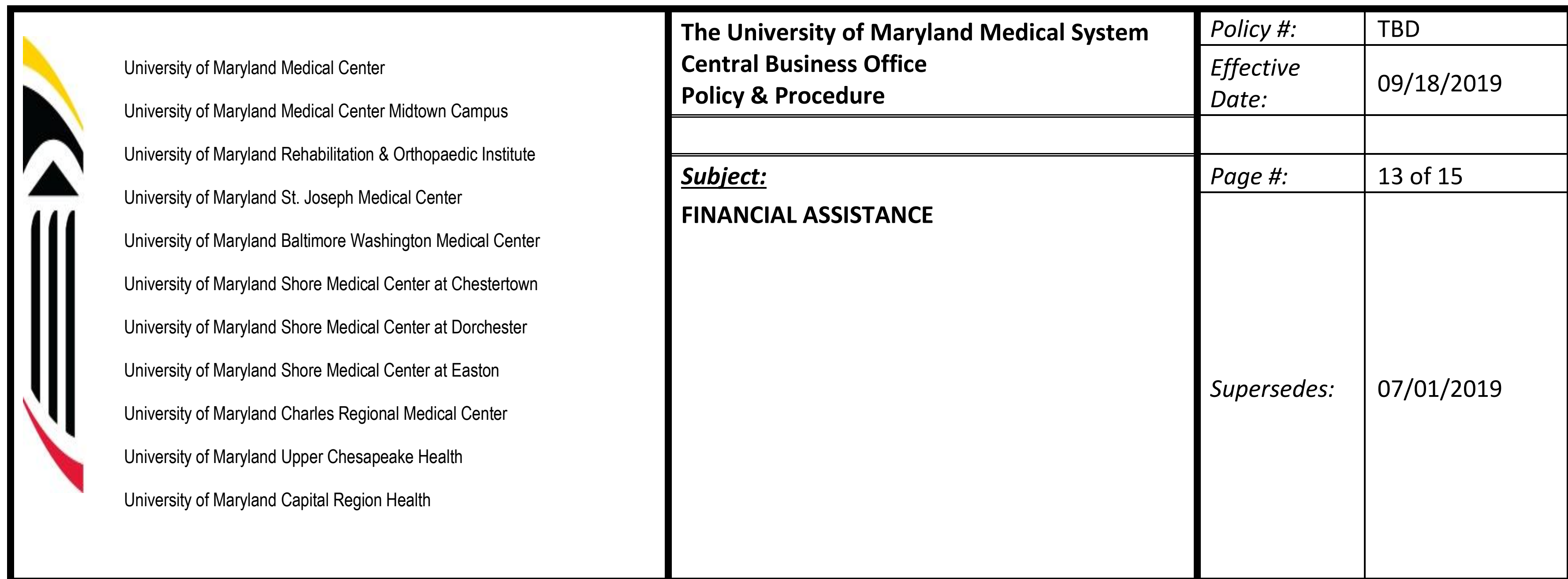
7. ECAs may be taken on accounts that have not been disputed or are not on a payment arrangement. ECAs will occur no earlier than 120 days from submission of first post-discharge bill to the patient and will be preceded by a written notice 30 days prior to commencement of the ECA. This written notice will indicate that financial assistance is available for eligible individuals, identify the ECAs that the hospital (or its collection agency, attorney, or other authorized party) intends to obtain payment for the care, and state a deadline after which such ECAs may be initiated. It will also include a Patient Billing and Financial Assistance Information Sheet. In addition, the hospital will make reasonable efforts to orally communicate the availability of financial assistance to the patient and tell the patient how he or she may obtain assistance with the application process. A presumptive eligibility review will occur prior to any ECA being taken. Finally, no ECA will be initiated until approval has been obtained from the CBO Revenue Cycle.

8. If prior to receiving a service, a patient is determined to be ineligible for financial assistance for that service, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.

9. A letter of final determination will be submitted to each patient who has formally submitted an application. The letter will notify the patient in writing of the eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for the determination. If the patient is determined to be eligible for assistance other than free care, the patient will also be provided with a billing statement that indicates the amount the patient owes for the care after financial assistance is applied.

10. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. Refunds will be issued back to the patient for credit balances, due to patient payments, resulting from approved financial assistance on considered balance(s). Payments received for care rendered during the financial assistance eligibility window will be refunded, if the amount exceeds the patient's determined responsibility by $5.00 or more.

11. If a patient is determined to be eligible for financial assistance, the hospital (and/or its collection agency or attorney) will take all reasonably available measures to reverse any ECAs taken against the patient to obtain payment for care rendered during the financial assistance eligibility window. Such reasonably available measures will include measures to vacate any judgment against the patient, lift levies or liens on the patient's property, and remove from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.
12. Patients who have access to other medical coverage (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for the Financial Assistance Program.
13. The Financial Assistance Program will accept the Faculty Physicians, Inc.'s (FPI) completed financial assistance applications in determining eligibility for the UMMS Financial Assistance program. This includes accepting FPI's application requirements.
14. The Financial Assistance Program will accept all other UMMS hospital's completed financial assistance applications in determining eligibility for the program. This includes accepting each facility's application format.
15. The Financial Assistance Program does not cover Supervised Living Accommodations and meals while a patient is in the Day Program.
16. Where there is a compelling educational and/or humanitarian benefit, Clinical staff may request that the Financial Clearance Executive Committee consider exceptions to the Financial Assistance Program guidelines, on a case-by-case basis, for Financial Assistance approval.
    a. Faculty requesting Financial Clearance/Assistance on an exception basis must submit appropriate justification to the Financial Clearance Executive Committee in advance of the patient receiving services.
    b. The Chief Medical Officer will notify the attending physician and the Financial Assistance staff of the Financial Clearance Executive Committee determination.



Financial Hardship

The amount of uninsured medical costs incurred at either, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital will be considered in determining a patient's eligibility for the Financial Assistance Program. The following guidelines are outlined as a separate, supplemental determination of Financial Assistance, known as Financial Hardship. Financial Hardship will be offered to all patients who apply for Financial Assistance and are determined to be eligible.

Medical Financial Hardship Assistance is available for patients who otherwise do not qualify for Financial Assistance under the primary guidelines of this policy, but for whom:

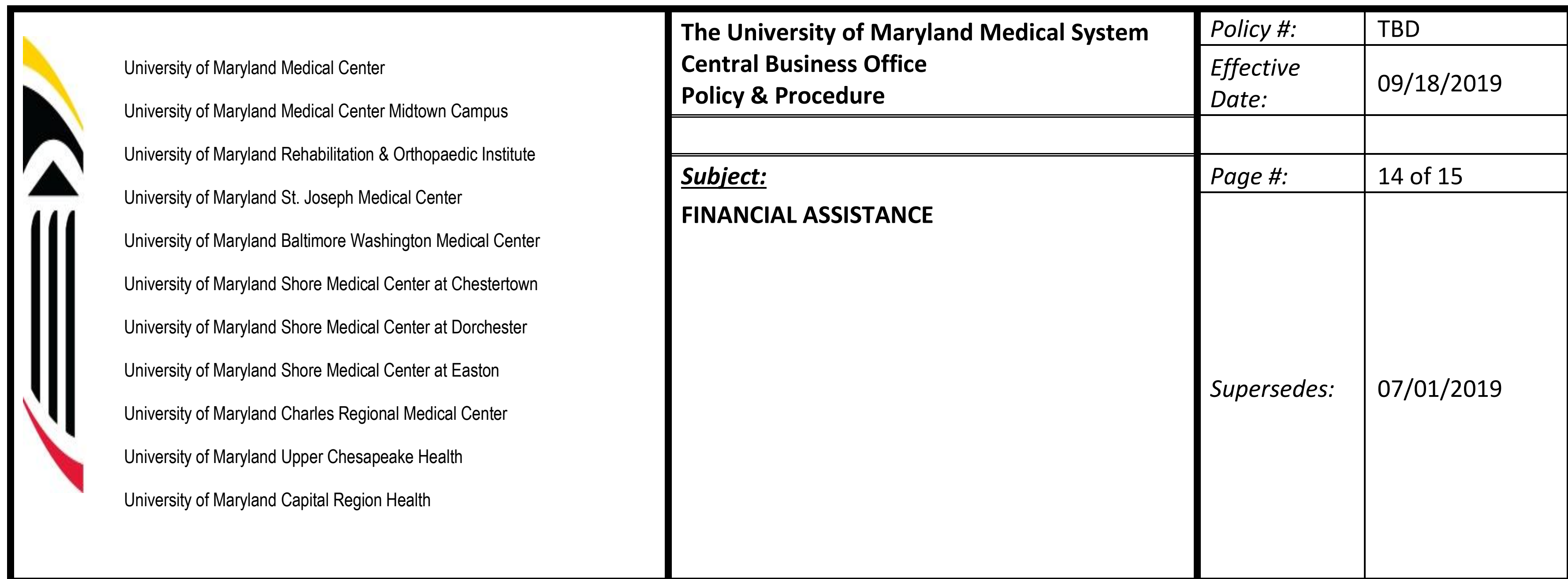
1) Their medical debt incurred at UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital exceeds 25% of the Family Annual Household Income, which is creating Medical Financial Hardship.

For the patients who are eligible for both, the Reduced Cost Care under the primary Financial Assistance criteria and also under the Financial Hardship Assistance criteria, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital will grant the reduction in charges, which is balance owed that is greater than 25% of the total annual household income.

Financial Hardship is defined as facility charges incurred at UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital for medically necessary treatment by a family household over a twelve (12) month period that exceeds 25% of that family's annual income.

Medical Debt is defined as out of pocket expenses for the facility charges incurred at UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and/or UM Capital for medically necessary treatment.

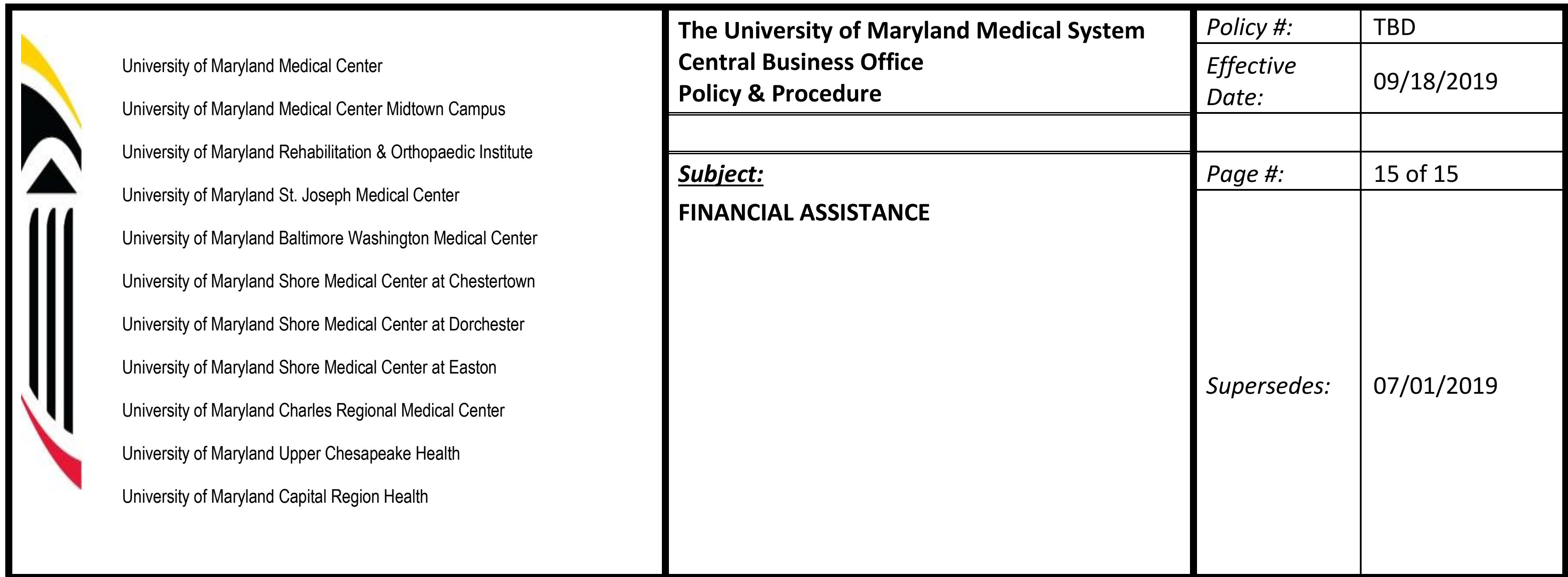
Once a patient is approved for Financial Hardship Assistance, coverage will be effective for the month of the first qualifying date of service and a year prior to the determination. However, an UMMS hospital may decide to extend the Financial Hardship eligibility period further into the past or the future on a case-by-case basis according to their spell of illness/episode of care. It will cover the patient and the eligible family members living in the household for the approved reduced cost and eligibility period for medically necessary care.



All other eligibility, ineligibility, and procedures for the primary Financial Assistance program criteria apply for the Financial Hardship Assistance criteria, unless otherwise stated above.

Appeals

- Patients whose financial assistance applications are denied have the option to appeal the decision.
- Appeals can be initiated verbally or written.
- Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.
- Appeals are documented within the third party data and workflow tool. They are then reviewed by the next level of management above the representative who denied the original application.
- If the first level of appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.
- The escalation can progress up to the Chief Financial Officer who will render a final decision.
- A letter of final determination will be submitted to each patient who has formally submitted an appeal.



University of Maryland Medical Center
University of Maryland Medical Center Midtown Campus
University of Maryland Rehabilitation & Orthopaedic Institute
University of Maryland St. Joseph Medical Center
University of Maryland Baltimore Washington Medical Center
University of Maryland Shore Medical Center at Chestertown
University of Maryland Shore Medical Center at Dorchester
University of Maryland Shore Medical Center at Easton
University of Maryland Charles Regional Medical Center
University of Maryland Upper Chesapeake Health
University of Maryland Capital Region Health

The University of Maryland Medical System
Central Business Office
Policy & Procedure

Subject:

FINANCIAL ASSISTANCE

Policy #:	TBD
Effective Date:	09/18/2019
Page #:	15 of 15
Supersedes:	07/01/2019

ATTACHMENT A

Sliding Scale – Reduced Cost of Care

MD DHMH 2019 Income Elig Limit Guidelines		**Income Level Up to 200% Pt Resp 0%**	**S L I**	**Income Level Pt Resp 10%**	**Income Level Pt Resp 20%**	**Income Level Pt Resp 30%**	**Income Level Pt Resp 40%**	**Income Level Pt Resp 50%**	**Income Level Pt Resp 60%**	**Income Level Pt Resp 70%**	**Income Level Pt Resp 80%**	**Income Level Pt Resp 90%**
HH	**100% MD DHMH**	**100% Charity**	**D**	**90% Charity**	**80% Charity**	**70% Charity**	**60% Charity**	**50% Charity**	**40% Charity**	**30% Charity**	**20% Charity**	**10% Charity**
Size	Max	**Max**	**I**	Max	Max	Max	Max	Max	Max	Max	Max	Max
1	**$17,244**	**$34,488**	**N**	$36,212	$37,937	$39,661	$41,386	$43,110	$44,834	$46,559	$48,283	$51,731
2	**$23,364**	**$46,728**	**G**	$49,064	$51,401	$53,737	$56,074	$58,410	$60,746	$63,083	$65,419	$70,091
3	**$29,448**	**$58,896**		$61,841	$64,786	$67,730	$70,675	$73,620	$76,565	$79,510	$82,454	$88,343
4	**$35,532**	**$71,064**	**S**	$74,617	$78,170	$81,724	$85,277	$88,830	$92,383	$95,936	$99,490	$106,595
5	**$41,652**	**$83,304**	**C**	$87,469	$91,634	$95,800	$99,965	$104,130	$108,295	$112,460	$116,626	$124,955
6	**$47,748**	**$95,496**	**A**	$100,271	$105,046	$109,820	$114,595	$119,370	$124,145	$128,920	$133,694	$143,243

*All discounts stated above shall be applied to the amount the patient is personally responsible for paying after insurance reimbursements.
*Amounts billed to patients who qualify for Reduced-Cost of Care on a sliding scale (or for Financial Hardship Assistance) will be less than the amounts generally billed to those with insurance (AGB), which in Maryland is the charge established by the Health Services Cost Review Commission (HSCRC). UMMS determines AGB by using the amount Medicare would allow for the care (including the amount the beneficiary would be personally responsible for paying, which is the HSCRC amount; this is known as the "prospective Medicare method".
Effective 7/1/19

Information given will be appropriate to your age, understanding and language. If you have vision, speech, hearing and/or other impairments, you will receive additional aids to ensure your care needs are met.

- Make an advance directive and appoint someone to make healthcare decisions for you, if you are unable. If you do not have an advance directive, we can provide you with information and help you complete one.
- Be involved in your discharge plan. You can expect to be told in a timely manner of your discharge, transfer to another facility or transfer to another level of care. Before your discharge, you can expect to receive information about follow-up care that you may need.
- Receive detailed information about your hospital and physician charges.
- Expect that all communication and records about your care are confidential, unless disclosure is permitted by law.
- See or get a copy of your medical records, request an amendment to your medical record and/or request a list of people to whom your personal health information was disclosed by contacting the medical records department.
- Give or refuse consent for recordings, photographs, films or other images to be produced or used for internal or external purposes other than identification, diagnosis or treatment. You have the right to withdraw consent up until a reasonable time before the item is used.
- Discuss an ethical issue related to your care (see Healthcare Decisions section).
- Spiritual services (see Pastoral Care section).
- Voice your concerns about the care you receive. If you have a problem or complaint, you may talk with your doctor, nurse manager or a department manager (see Complaints/Grievances section).

Your Responsibilities Are to:

- Provide complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer when it is required.
- Provide the hospital or your doctor with a copy of your advance directive if you have one.
- Provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products and any other matters that pertain to your health, such as perceived safety risks.
- Communicate in a direct and honest manner with doctors, nurses and other hospital staff members about matters or conditions that concern your health.
- Follow instructions regarding your care and treatment. If you leave the hospital against the advice of your doctor, the hospital and doctors will not be responsible for any medical consequences that may occur.
- Inform the staff of your whereabouts and probable return time if you leave the patient unit/ancillary department.
- Ask questions when you do not understand information or instructions. If you believe you cannot follow through with your treatment plan, you are responsible for telling your doctor. You are responsible for outcomes, if you do not follow the care, treatment and service plan.
- Actively participate in your pain management plan and to keep your doctors and nurses informed of the effectiveness of your treatment.
- Leave valuables at home and bring only necessary items for your hospital stay.
- Treat all hospital staff, other patients and visitors with courtesy and respect; abide by all hospital rules and safety regulations; and be mindful of noise levels, privacy and number of visitors/guests.
- Accept accountability for your financial obligations for health care provided and to pay your bills in a timely manner.
- Keep appointments and be on time, and to call your healthcare provider if you are unable to do so.
- ***SPEAK UP™**: Be an active member of your healthcare team and help us make your health care safer.
- Speak-up if you have questions or concerns. If you still don't understand, ask again.
- Pay attention to your care. Always make sure you're getting the right treatments and medicines by the right healthcare professionals. Don't assume anything.
- Educate yourself about your condition. Learn about the medical tests and your treatment plan.
- Ask a trusted family member or friend to be your advocate (advisor or supporter).
- Know what medicines you take and why you take them. Medicine errors are the most common healthcare mistakes.
- Use a facility, clinic, surgery center or healthcare facility that has been carefully checked out.
- Participate in all decisions about your treatment. You are the center of the healthcare team.

*Speak Up is a Joint Commission Patient Safety Program Initiative

Healthcare Decisions

UM Capital Region Health recognizes and respects the rights of patients with decision-making capacity to participate in decisions about their medical treatment. Making healthcare decisions can be very complex and difficult, especially when the patient does not have the capacity to do so on their own. Family members may have difficulty making these healthcare decisions for the patient as well.

The Ethics Committee is available to assist patients, families and facility staff in determining the most appropriate plan of care. A family member, physician or a healthcare team member can request an ethics consultation at UM Prince George's Hospital Center by calling (301) 618-2740 or at UM Laurel Medical Center by calling patient relations at 240-456-4764.

Advance Directives

Advance directive decisions can include:

- the right to accept or refuse care,
- the right to make oral or written declarations,
- a living will,
- a durable power of attorney for healthcare decisions, and/or
- organ donation wishes.

If you would like information about advance directives, ask any member of the healthcare team.

If you have an advance directive, please give a copy to staff so that all members of the healthcare team will be aware of your wishes. You can review, revise or withdraw your advance directive at any time. Your advance directive will be honored in accordance with the law.

Pastoral Care

Patients and family members often turn to their faith for emotional support in a time of illness or grief. We work with the community faith system to provide support to patients and family who desire pastoral care. Please ask your caregiver if you would like to request a pastoral care visit.

Chapel/Meditation Room

At UM Laurel Medical Center, there is a chapel available to patients and their families for prayer, meditation and reflection. UM Prince George's Hospital Center has a meditation room for this same purpose. These rooms are unattended and provide a quiet place for patients and their families to pray.

Support Groups

We offer a number of support groups. Please visit www.umcapitalregion.org for additional information.

Corporate Compliance

UM Capital Region Health is committed to excellence. Our services are provided in accordance with applicable laws and regulations. Staff is continually educated and practice according to legal and ethical standards while providing quality healthcare services to patients and family members.

If you have any concerns, please contact Corporate Compliance via the Compliance Hotline at (877) 631-0015.

Safety and Security

Everyone has a role in making health care safe. Therefore, every staff member will display picture identification and every patient must wear their ID band until they are discharged.

You, as the patient, play a vital role in making your care safe by becoming an active, involved and informed member of your healthcare team.

We encourage you to notify us if you have concerns about your safety. To report a concern at UM Prince George's Hospital Center call 301-618-3360; at UM Bowie Health Center call 301-809-2024; at UM Laurel Medical Center call Security through the Operator at 301-725-4300.

Patient Property and Valuables

For your own protection, you should not bring items of value to the facility and we request that you send any personal property home. Neither UM Capital Region Health nor any of its facilities will accept responsibility for patient property or valuables.

Smoking

To provide a healthy environment, UM Capital Region Health is a smoke-free campus. You must refrain from smoking on all facility property.

If you wish to stop smoking, a free smoking cessation program is offered. The program is four weeks in length (one group session per week for 1½ hours). Day and evening sessions are available. To participate, you must be 18 years old and a Maryland resident. For more information, you can call (301) 618-6363.

Follow-up Phone Call

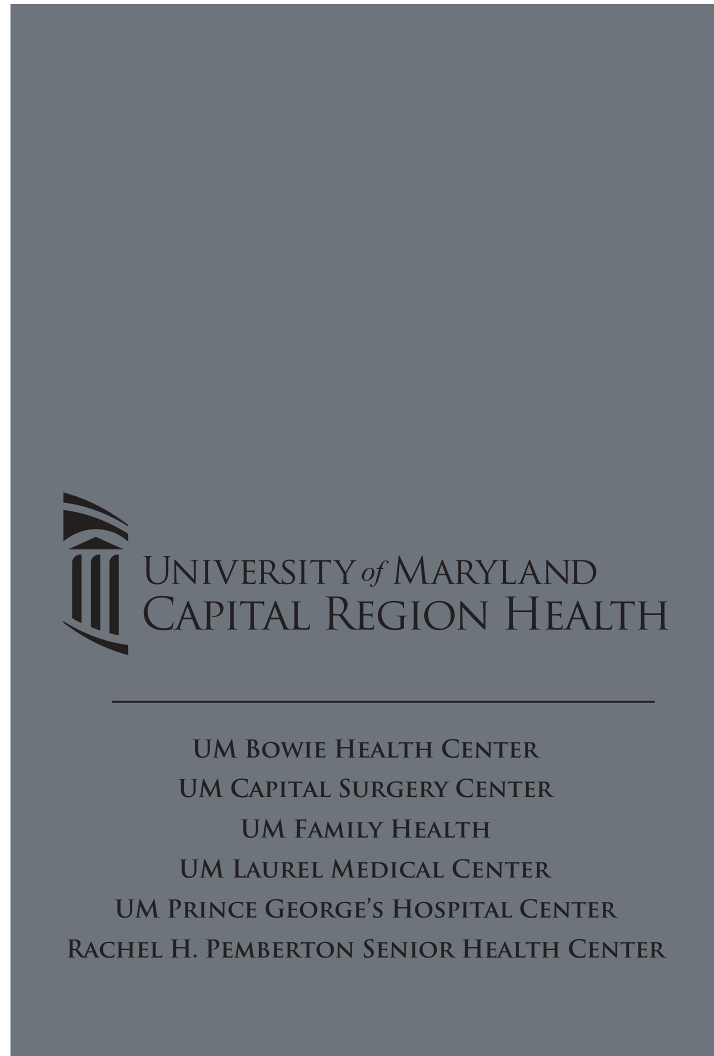
Upon leaving the hospital, you may receive a follow-up phone call to see how you are doing. It is our goal to be your healthcare provider of choice. Feel free to share your concerns or suggestions with us during this call.

Copy of your Medical Record

If you need a copy of your medical record, you can request a copy by visiting the medical records department.

1-136 4/19

WHAT YOU SHOULD KNOW AS A PATIENT



Access to Care

Each patient has the right to quality care, treatment, service or accommodations that are available or medically necessary without consideration of race, color, religion, sex, national origin, age, handicap or source of payment.

Interpretive Services

A patient and/or his/her companion with hearing, language, speech, vision, or other cognitive impairments, will be offered assistance to ensure effective communication and access to healthcare services at no charge.

If you need assistance or have questions about available accommodations, you may ask any staff member for assistance. If you or a visitor believes you have been unable to use the facility's full array of services, we encourage you to contact a patient representative.

Patient Representative

A patient representative is available to meet with patients and families, who have questions and concerns about their stay, to facilitate problem resolution and to assist with special needs. To contact the patient representative at UM Prince George's Hospital Center, call (301) 618-3857. For UM Laurel Medical Center, call (240) 456-4764. For UM Bowie Health Center and UM Capital Surgery Center, call (301) 809-2035.

Visitors / Patient Guests

Patients and families are welcomed as essential members of the healthcare team, helping to ensure quality and safety. All guests designated by the patient or their "partner in care", when appropriate, will have full and equal visitation privileges that are no more restrictive than those that immediate family members enjoy. Your guests' visitation privileges will be consistent with your preferences and will not be denied on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity or disability.

A patient has the right to withdraw or deny visitation at any time and there may be times that it is necessary to restrict patient visitors, such as in the case of a justified clinical restriction. The decision to restrict or limit the presence of visitors, as well as the reason for the decision, will be explained to the patient and/or their partner in care. UM Capital Region Health's visitation policies are aimed at protecting the health and safety of all patients.

Complaints / Grievances

- Complaint: A verbal expression of dissatisfaction or allegation of hospital wrong doing from a patient/patient representative or visitor which can be successfully resolved by staff present at the time of the complaint.
- Grievance: Formal or informal written complaint a grievance is also a verbal complaint that is made by a patient/patient representative regarding the patient's care that is not successfully resolved at the time by staff.

UM Capital Region Health endeavors to meet its patients' expectations for care and services in a timely, reasonable and consistent manner. Patients, their immediate family members and/or their representatives have the right to submit a complaint or grievance regarding their experience. Should you have a complaint about your care, please ask to speak with the manager/supervisor of the department or area involved. Our healthcare staff will seek to resolve your issues to your satisfaction as soon as possible. Please note that resolution is defined by the patient/family member and may include a meeting with all involved parties.

If you have a complaint pertaining to the following UM Capital Region Health facilities: **UM Bowie Health Center; UM Capital Surgery Center; Family Health and Wellness Center; UM Prince George's Hospital;** and/or **Rachel H. Pemberton Senior Health Center** that has not been resolved by the healthcare staff at the time of your complaint and you wish to file a grievance, you may do so by telephone, letter or e-mail, at the following:

UM Capital Region Health/UM Prince George's Hospital Center
Attn: Patient Relations
3001 Hospital Drive Cheverly, MD 20785
Phone: (301) 618-3857

UM Laurel Medical Center
Attn: Patient Relations Department
7300 Van Dusen Road Laurel, MD 20707
Phone: (240) 456-4764

UM Bowie Health Center
Attn: Patient Relations
15001 Health Center Drive Bowie, MD 20716
Phone: (301)809-2035

Or by email at UMCapital-Complaints@umm.edu

UM Capital Region Health's complaint/grievance process is as follows:

If, in your judgment as a patient/family member, the issue has not been resolved by the manager or supervisor to your satisfaction, please ask to speak with a patient relations coordinator. After hours, and on weekends and holidays, dial the hospital operator, at "0," and ask to speak with the nursing administrative supervisor, who will seek resolution of your issues. Filing a grievance will not subject you to any form of adverse action or jeopardize your future access to care at any UM Capital Region Health facility. Your grievance will be reviewed and investigated and you will receive a written response. The written response will include steps taken on your behalf to investigate the grievance, results of the grievance process, the date of completion and the appropriate hospital contact person.

If you are dissatisfied with any facility's report or outcome at the conclusion of your complaint/grievance investigation, you may contact one of the following agencies directly:

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Hospital
Center Bland Bryant Building
55 Wade Avenue
Catonsville, MD 21228
Phone: (410) 402-8000 or (877) 402-8218
E-mail: ohcq.web@dhmh.state.md.us

Patient safety concerns can be reported to the Joint Commission:

The Joint Commission
Office of Quality and Patient Safety
One Renaissance Blvd, Oakbrook Terrace, IL 60181
complaint@jointcommission.org
800.994.6610 telephone; 630.792.5636 fax
www.jointcommission.org, using the "Report a Patient Safety Event" link in the "Action Center" on the left

For Medicare discharge and appeal rights:

KePro
5201 West Kennedy Blvd. Suite 900
Tampa, FL 33609
(844) 455-8708
TTY (855) 843-4776

For mental and behavioral health services:

Maryland Disability Law Center
1500 Union Avenue, Suite 2000
Baltimore, MD 21211
Phone: (800) 233-7201
TTY: (410) 235-5387
Fax: (410) 727-6389
Email: feedback@mdlclaw.org

For medication concerns:

Maryland Board of Pharmacy 4201 Patterson Avenue
Baltimore, MD 21215
Phone: (410) 764-4755 or (800) 542-4964
TTY: (800) 735-2258
Fax: (410) 358-6207
Email: DMHM.MDBOP@Maryland.gov

Note: This patient grievance process excludes account and billing issues. These issues should be referred to Patient Financial Services at (301) 618-3100.

Financial Information

Your insurance information will be verified at each visit in order to bill your insurance company for payment on your behalf. Payment of all known deductibles, co-payments and non-covered services will be required at the time service is rendered.

You may receive a bill from UM Capital Region Health for facility fees and from individual physicians for professional fees.

If you are unable to pay your bill, you may call (301) 618-3250 for information about applying for Medical Assistance. If you need financial assistance, you may qualify for UM Capital's Financial Assistance program or arrange a payment plan for your facility fees. You may call (301) 618-3250 for help with applying for financial assistance.

There may be services provided by physicians or other providers that are not covered by the hospital's Financial Assistance. Services provided at one of the UM Capital Region Healths may be considered for Financial Assistance. You may call (301) 618-2273 if you have any questions.

If you have questions regarding your bill, call the Business Office at (301) 618-3100.

For concerns about payment or lack of payment by your health insurance plan, you may file a complaint directly to:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health / Appeals and Grievances
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: (410) 468-2000 or (800) 492-6116
TTY: (800) 735-2258
Fax: (410) 468-2270 or (410) 468-2260

Patient Rights and Responsibilities

As a patient at any UM Capital Region Health facility, we encourage you to speak openly with your healthcare team, to take part in your treatment choices and to assist in the safety of your care by being well informed and involved. Since we believe that you are a partner in your care, we want you to know your rights, as well as your responsibilities, during your stay at any of our facilities. We invite you and your family to join us as active members of your care team.

You Have the Right to:

- Receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.
- Receive care in a safe environment free from all forms of abuse, neglect or mistreatment.
- Be called by your proper name and to be in an environment that maintains dignity and adds to a positive self-image.
- Know the names of your doctors, nurses and all healthcare team members directing and/or providing your care.
- Have a family member or person of your choice, as well as your own doctor, notified promptly of your admission to the hospital.
- Have someone remain with you for emotional support during your hospital stay, unless your visitor's presence compromises your or others' rights, safety or health.
- Deny visitation at any time (see Visitors/Patient Guests section for additional information).
- Have your doctor inform you about your diagnosis and possible prognosis, the benefits and risks of treatment, and the expected and unexpected outcomes of treatment. You have the right to give written informed consent before any non-emergency procedure begins.
- Have your pain assessed and to be involved in decisions about treating your pain.
- Be free from restraints and seclusion in any form that is not medically required.
- Expect full consideration of your privacy and confidentiality in care discussions, exams and treatments. You may ask for an escort during any type of exam.
- Access protective and advocacy services in cases of abuse or neglect. The hospital will provide a list of these resources.
- Be free from neglect, exploitation and abuse that could occur while the patient is receiving care, treatment and services.
- Have your family and friends, with your permission, participate in decisions about your care, your treatment and services, including the right to refuse treatment to the extent permitted by law.
- Give or withhold informed consent for care.
- Have your end of life wishes honored to include forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services, in accordance with the law and regulations.
- Agree or refuse to take part in medical research studies. You may withdraw from a study at any time without impacting your quality of care.
- Communication that you can understand. The hospital will provide, at no cost to you, sign language and foreign language interpreters as needed.

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Assessing Health and Human Services Needs to Support an Integrated *Health in All Policies* Plan for Prince George's County, Maryland

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Preface

Prince George's County is at a critical crossroads with respect to its future health and well-being. Over the past decade, the County has seen a demographic shift (e.g., growing populations of seniors and immigrants) and tremendous changes in the health care landscape through hospital mergers and acquisitions. During this time, the Prince George's County Council has pursued an active approach to health promotion, including considering legislation to promote healthy behaviors. Currently, there are widespread discussions regarding the social determinants of health and recognition of the multiple sectors and factors influencing health. Thus, Prince George's County is now poised to pursue new approaches to promoting and budgeting for a more holistic approach to health and well-being.

To gain a clearer understanding of the current and future health and human services needs among residents, the level of unmet need, and the resources being allocated to health, the Prince George's County Council, acting as the County Board of Health, contracted with the RAND Corporation in 2019 to complete a health and human services needs assessment in its pursuit of a *Health in All Policies* approach to policymaking. This assessment builds on the 2009 RAND assessment and other County reports to more deeply examine the drivers of health influencing health outcomes. The findings are based on original analyses of primary and secondary data, as well as synthesis of existing studies, proposed operating budgets, and promising practices from other relevant communities and regions across the country. This report should be of interest to County policymakers, stakeholders, and residents, as well as those who have a general interest in a *Health in All Policies* approach to population health and well-being.

This research was sponsored by the Prince George's County Council, acting as the County Board of Health, and conducted within RAND Social and Economic Well-Being. Ashley Kranz and Anita Chandra led this research study. Questions about the report can be directed to akranz@rand.org and chandra@rand.org. RAND Social and Economic Well-Being is a division of the RAND Corporation that seeks to actively improve the health and social and economic well-being of populations and communities throughout the world. This research was conducted in the Community Health and Environmental Policy Program within RAND Social and Economic Well-Being. The program focuses on such topics as infrastructure, science and technology, community design, community health promotion, migration and population dynamics, transportation, energy, and climate and the environment, as well as other policy concerns that are influenced by the natural and built environments, technology, and community organizations and institutions that affect well-being. For more information, email chep@rand.org.

Abstract

With evolving demographics and a changing health care landscape, the Prince George's County Council, acting as the County Board of Health, is considering its future policy approaches and resource allocations related to health and well-being.

To inform this path forward, this assessment builds on a RAND 2009 assessment and other County health reports to use primary and secondary data to describe both the health needs of County residents *and* drivers of health within the County, inclusive of the social, economic, built, natural, and health service environments. This report uniquely integrates these findings, analysis of budget documents, and review of promising practices from other communities, to situate recommendations in a *Health in All Policies* framework to foster aligned and integrated planning and budgeting across the County to promote health and well-being.

There is a shared interest of leaders and residents to embrace a holistic strategy for health and well-being in the County. Health services (inclusive of clinical care and health programs) are provided across many sectors in the County including human services, criminal justice, and schools. Yet, drivers of health largely exist outside of health care alone. While most adults in the County reported having good to excellent health, there are persistent challenges related to behavioral health, obesity, and cancer. Additionally, the drivers of health situated in the built, natural, and social environments, are unevenly distributed throughout the County and contribute to health equity challenges. Findings suggest two problems: (1) inefficient uses of the health care system, highlighting a need to rebalance investments in health care use and drivers of health, and (2) challenges in navigating health and human services and inequities in drivers of health across communities, signaling broader concerns related to residents' access to health and human services that influence health and well-being outcomes.

There are several paths forward for Prince George's County to pursue a more integrated policy approach to influence health and well-being outcomes. Recommendations are offered related to (1) creating a *Health in All Policies* system, (2) aligning investments, and (3) implementing new measurement and data systems.

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Note to Readers

As of June 2020, more than 7 million cases and 400,000 deaths due to the Coronavirus Disease-2019 (COVID-19) have been confirmed globally (Johns Hopkins University, 2020). In the United States (US), the pandemic has led to more than 110,000 deaths, mass shutdowns, and significant economic consequences (Johns Hopkins University, 2020). COVID-19 has disproportionately affected people of color and racial and ethnic minorities, in terms of cases, deaths, and economic upheaval (NYC Health, 2020; Parker, Horowitz, & Brown, 2020). Prince George's County, which is predominantly composed of Black residents, accounts for more than one-in-four COVID-19 cases in Maryland (Maryland Department of Health, 2020). As of this writing, the County has reported the highest rate of COVID-19 cases (The New York Times, 2020) and the highest number of unemployment claims across all counties in Maryland (Fulginiti & Melser, 2020). The significant impacts of COVID-19 on Black and Hispanic/Latino residents has not simply been a result of the pandemic, but due to years of cumulative stress, trauma, lack of access to services and resources and ultimately, systemic racism. This context has been further amplified with other experiences of brutality and marginalization, most recently in the death of George Floyd at the hands of Minneapolis police in May 2020. The interconnection of the pandemic and police brutality has sharpened a national conversation about systems and policies, including how communities fund public safety, education, and health.

This report describes key findings from data collection and analyses conducted during the summer and fall of 2019 for a health and human services needs assessment conducted for Prince George's County, Maryland. The motivation of the report was to articulate a new path for the County in implementing a *Health in All Policies* approach to policymaking. While the timing of report-writing preceded the COVID-19 pandemic and the increased global attention to the Black Lives Matter movement and systemic racism, the report's framework, data, and recommendations are even more resonant in light of recent events. Current calls for reallocation of policing resources, new examinations of the cumulative impacts of racism on health, and general awareness of how history and institutions affect the well-being of communities further underscore the value of a holistic approach to health and well-being. This report provides an important and timely framework to aid policy makers and other stakeholders in their efforts to dismantle systemic barriers and address the upstream drivers of health.

Executive Summary

Overview

Prince George's County is at a critical crossroads with respect to its future health and well-being. Over the past decade, the demographics of the County have been evolving with a steadily growing number of seniors, Hispanic, and foreign-born residents. Additionally, the County's health care landscape has changed through hospital mergers and acquisitions and will continue to evolve with the expected 2021 opening of the University of Maryland Capital Region Medical Center. During this time, the Prince George's County Council has pursued an active approach to health promotion, convening health care providers in the community and considering legislation to promote healthy behaviors. Along with these developments in the County, broader societal changes are happening including national discussions regarding the increasing burden of chronic diseases, rising health care expenditures, and growing attention to the role of social determinants of health (SDOH). In this context, Prince George's County is poised to consider and pursue new approaches to promoting and budgeting for health.

This health and human services needs assessment is intended to assist the Prince George's County Council, acting as the County Board of Health, in their pursuit of *Health in All Policies*, an approach that aligns county funding, across departments and services, with needs and desired health outcomes. To inform these decisions, there is strong recognition of the need to not only understand the health needs of residents captured in prior health assessments, but to combine that with a more holistic analysis of the historical and systemic factors that influence health and well-being over generations. The aims of this assessment are to

1. Describe the health of County residents
2. Describe drivers of health within the County, inclusive of the social, economic, built, natural, and health service environments
3. Offer recommendations to foster aligned and integrated planning and budgeting across the County to promote health and well-being.

This report adds to a rich foundation of analyses, in particular the 2019 Community Health Needs Assessment led by Prince George's County Health Department (Prince George's County Health Department, 2019b). We situate this report by highlighting the key features of this report that distinguish it from existing work (Figure E.1). Key contributions of this report include its holistic examination of drivers of health, broad assessment of health care providers, and recommendations to support future integrated health planning in the County.

By offering a deep dive into drivers of health (e.g., social, economic, natural, built, and health service environments) along with health and well-being, we seek to provide integrated information to inform the County's pursuit of a *Health in All Policies* approach to policymaking. Our recommendations are particularly focused on policy actions that involve cross-government department strategies, associated data, and financial alignment. With these recommendations, we provide examples used in other jurisdictions to help the County understand how these approaches have been practically implemented in other settings.

Figure E.1.
Key Features of This Report

Provides broad review of health influences from the social, economic, built, and natural environments
Offers insight into role of schools and human services departments in promoting health
Utilizes health care discharge data from both Maryland and District of Columbia (DC), highlighting key role of care provision from providers in DC
Examines health care provision outside of traditional health care providers, including schools, fire/EMS and corrections
Situates recommendations via *Health in All Policies*, inclusive of budget alignment and legislative action levers
Establishes a foundation for future integrated health planning for the County

This report is organized around a framework that can be used by the County to implement *Health in All Policies*, which is defined as a "collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people" (Centers for Disease Control and Prevention, 2016). The framework emphasizes the interconnectedness of health and well-being, systemic factors that influence health over generations, drivers of health, and health systems (Figure E.2), and illustrates how health and well-being cannot be considered independently from historical and systemic inequities and drivers of health that shape opportunities and environments. As articulated in this framework, *health and well-being* are downstream outcomes and are described by quality of life, physical, mental and behavioral health, healthy behaviors, and community engagement (given links between *connection to community* and *health outcomes*) (Nelson, Sloan, & Chandra, 2019). While health and well-being are influenced by genetic composition, health and well-being are largely affected by upstream factors and drivers in the broader environment.

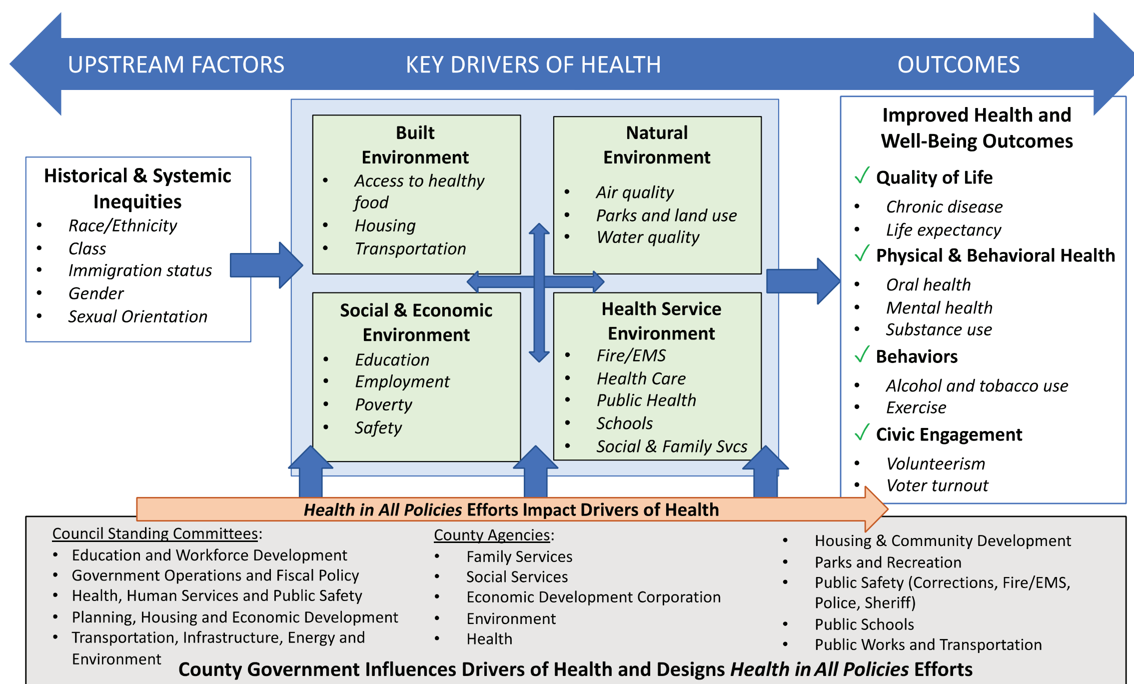
Approach

To describe the health and human services needs of County residents, we relied on both primary and secondary data. Primary data collection involved obtaining input via a Town Hall meeting; online survey of residents conducted after the Town Hall meeting; three focus groups composed of adult residents; one focus group composed of adolescents and young adults; and 23 interviews with individuals from organizations knowledgeable about the health and human services needs of County residents. The study team combined notes from all sessions, reviewed notes, and categorized key themes from the work.

In addition, county and sub-county secondary data were collected from a variety of public and proprietary sources to describe the current and historical health and human services needs of County residents. Data were obtained from numerous county agencies (e.g., Departments of Health, Corrections, Family Services, Social Services), public sources (e.g., American Community Survey, Behavioral Risk Factor Surveillance Survey), and proprietary sources (e.g., Maryland Healthcare Services Cost Review Commission and the District of Columbia Hospital Association). Together, these data describe drivers of health impacting County residents, the health systems serving County residents, and the health and well-being of County residents.

Finally, to inform our recommendations, we reviewed Prince George's County's operating budgets from fiscal year (FY) 2007 to 2019 and proposed operating budget from FY2020 determine where funding was allocated across county departments. We also reviewed promising practices from other communities and regions in the United States, highlighting those with similar challenges that Prince George's County faces with respect to integration of health and human services, such as data systems, financing, and related policy interventions.

Figure E.2.
Improving Health and Well-Being Through an Integrated *Health in All Policies* Approach



NOTES: Bulleted items in italics are examples only. Our framework was informed by the Bay Area Regional Health Inequities Initiative's Public Health Framework for Reducing Health Inequities (Bay Area Regional Health Inequities Initiative, 2019), and modified specifically for Prince George's County.

Key Findings

In the text below and in Figure E.3, we summarize key findings related to the health and well-being and the drivers of health impacting health and well-being of County residents.

Health and Well-Being

We observed positive findings and improvements in the health and well-being of Prince George's County residents for numerous indicators. The County has a lower rate of years of potential life lost, a measure of premature death, than the state average, and most adults in the County (83.9 percent) described their health as "good," "very good," or "excellent." Positive metrics of well-being include a 17.8 percentage point increase in voter turnout in 2018 compared to the last non-presidential general election and stakeholders expressing a high interest in volunteer opportunities.

Figure E.3.
Key Findings from This Assessment

KEY FINDINGS

Inefficient uses of the health care system remain despite improvements.

- One in four emergency calls for medical services were for non-urgent needs.
- EDs continue to be used for preventable issues, such as asthma and dental care.

Highlights need to rebalance investments in health care use and drivers of health.

Residents encounter challenges in navigating health and human services.

- There is a lack of health insurance for some groups, including noncitizen immigrants, and insufficient funding to support the needs of these groups.
- Transportation barriers hinder residents obtaining health and human services.
- Residents are often unaware of available services and resources or may not know how to access or navigate known services and resources.
- Shortages of primary care providers, behavioral health providers, and dentists impact access, as does the cultural competency of providers.

Offers insight into why some residents may use costly and inefficient emergency services when primary care is a better option.

Spending on health and human services is low.

- Estimated County spending on health and human services departments is $39 per person, about one-third to one-seventh the per-person spending of surrounding Maryland counties.

Inefficient health services use signals a broader concern for access to health and human services that contributes to inequities in health and well-being.

Systemic inequities in drivers of health place some communities farther behind in building healthy futures.

- Districts are differentially impacted by drivers of health and thus encounter different health challenges.
  - District 2 has high rates of uninsurance and is predominantly Hispanic, a population with a teen birth rate more than double the County rate.
  - District 3 has the highest poverty rate and numerous community "hot spots" of low-income individuals with poor access to healthy food.
  - District 7 is predominantly Black, has low health literacy and the highest ED visit rates for adults and children in the County.

We also identified opportunities for improvement. As has been highlighted in the prior health assessments of Prince George's County, Prince George's County has high rates of incidence and mortality for select cancers. These data reflect stakeholder concerns about **men's health**, as prostate cancer incidence and mortality rates are considerably higher in Prince George's County than rates observed across Maryland or the United States. Additionally, stakeholders emphasized the need for resources and education to **promote healthy behaviors** like exercise and healthy eating. This is essential to address the **high rates of obesity** among county residents, which is concerning because it increases the risk of worse health, including poor birth outcomes, cancer, and cardiovascular disease. Stakeholders also expressed concerns about the **mental and behavioral health of children** and adolescents in the County. In analysis of secondary data, we observed high rates of bullying and suicidality among middle school students, with almost one in four reporting bullying at school and almost one in four reporting seriously thinking about attempting suicide. Finally, there are widespread concerns about **inequity in health and well-being**. High rates of many chronic diseases and unhealthy behaviors were more likely to be reported by among racial/ethnic minorities. Additionally, birth outcomes, including low birthweight and mortality, were significantly higher among Black infants than White infants.

Drivers of Health

Health Service Environment

The health care delivery system in Prince George's County includes more than just hospitals and other traditional medical providers. Collaboration across multiple agencies is a growing and important part of health care delivery in Prince George's County. In examining health care services offered to County residents, we find challenges related to access to care and system confusion indicated by use of emergency services for non-urgent needs. Stakeholders expressed concern about **access to care**, frequently related to access to primary care and mental and behavioral health services. The primary care needs of the County are well-documented and nearly all districts have some communities designated as shortage areas. It is possible that lack of access to primary care may be driving some of the racial/ethnic inequities observed in utilization of the ED for potentially preventable conditions. For example, rates of asthma-related ED visits and inpatient hospitalizations were more than four times higher for Black and Hispanic children compared to White children. Although few communities in the County are designated as mental health shortage areas, stakeholders mentioned challenges in **accessing mental and behavioral health services** for children and adolescents, individuals with severe mental illness, and reentering populations. County rates of adult ED visits for mental and behavioral health conditions were more than double that of visits for heart disease and nearly four times greater than the rates of visits for diabetes. Additionally, there is **system confusion** as evidenced by use of inappropriate health care systems. One example of this is the amount of calls for non-urgent medical services received by EMS. The majority of 911 calls for EMS (80.3 percent) resulted in the provision of medical services, and about one in four of these calls were considered to be for non-urgent medical services. Because EMS agencies provide an entry way into EDs, these are also a key entity of the health care system for helping to reduce the number of ED visits that are treatable outside EDs.

Social and Economic Environments

The County has experienced some positive trends when it comes to the social and economic environments, but still faces higher rates of poor social and economic drivers that influence health than neighboring counties. The percentage of residents who are **unemployed** or **"working poor"** has declined since 2014 yet remains higher than that seen in neighboring counties. Stakeholders noted that County residents, who face underemployment, may experience negative impacts to their physical and mental health due to psychological stress and difficult trade-offs that are needed to seek out care when it competes with employment schedules or because of lack of insurance. Although the County offers services to promote employment, stakeholders noted that many residents are unaware of these programs. This relates to broader comments we heard regarding **unmet need for social services**, but quantifying unmet need is challenging because individuals in need may not interact with the County and therefore may be uncounted. Improvements were observed for school and **public safety**, with fewer high school students reporting sexual dating violence and a lower violent crime rate. However, self-reported data from middle school students suggests safety concerns, as one in four County middle school students reported carrying a weapon to school and two in three County middle school students reported having been in a physical fight.

Built and Natural Environments

Features of the built and natural environments either increase health risk or serve to motivate health-promoting behaviors, and thus, may contribute to any health disparities that exist across the County. In the United States, spatial patterning of built and natural environment features has been influenced by historical patterns of discriminatory practices, and thus, this context is important when thinking about upstream drivers of health inequities in the County. In particular, households in District 2, where more than half of residents are Hispanic, experience more **overcrowding** than elsewhere in the County and housing structures in Districts 2, 3, and 5 have a higher potential for exposure to lead than other districts in the County, due to the age of these structures. Although the proportion of children in the County with concerning **blood lead** levels is low, a notable trend is that it appears to be on the rise over the last five to six years. Additionally, residents expressed concern about **access to healthy food** and **physical activity opportunities** and quantitative data support this concern. The density of fitness and recreation centers in the county is lower than the state of Maryland, on average, and "food deserts" exist throughout the county. Mixed-use neighborhoods with dense street connections can promote active transport and serve as a means of increasing access to physical activity opportunities. The majority of highly walkable neighborhoods in the county exist in Districts 2, 3, 5, and 7. Although, it should be noted that even within these districts, there exist pockets of "food deserts" and low walkability.

Exploring Prince George's County Budget for Health

Tracking the alignment of dollars across departments that contribute to health is a key first step in being able to understand the true accounting of *health return on investment*. Prince George's County's health and human services departments are majority grant-funded and, relative to Howard, Montgomery, Anne Arundel, and Baltimore Counties in Maryland, have the lowest general fund-approved health spending, as of FY2018, even after adjusting for population size. A broad array of departments within the executive branch of the County government contribute to residents' health and health care utilization. Thus, budget allocations outside the health and human services departments are also influencing health outcomes, such as emer-

gency medical services from the Fire/EMS Department, health care offered by Department of Corrections, public safety supported by the Police Department, and environmental efforts from the Department of the Environment. This preliminary budget review can be enhanced by a comprehensive review of spending on health and drivers of health across departments, which requires detailed budget information to understand when and where funds are having an impact on health. Moving forward, this detail can come from a second level of coding, which includes extensive review of the time spent by government staff as well as health-related objectives and outcomes of programs and other services.

Recommendations

The findings from this assessment offer many paths forward for Prince George's County, particularly as the County pursues a more integrated approach to influencing health and well-being outcomes. Building a *Health in All Policies* system does not happen in one step, but rather through many strategies and phases. In order to make progress, however, it is useful to consider a few first steps. Figure E.4 presents initial steps to consider. Allocating funding to support these efforts is important to ensure staff time and resources are available to pursue this work.

Figure E.4.
Getting Started with *Health in All Policies*

√ County Council acting as the Board of Health

- o Require a more detailed County inventory (government and ideally, nongovernment) of the places and programs in which health services (e.g., health education, health promotion, clinical services) are being provided and who is receiving these services (in order to measure and reduce inequities).
- o Align information about what is being spent on these health services and information on reach, effectiveness, and impact overall on reducing inequities.
- o Require all nongovernmental organizations receiving County funding to identify their role(s) in promoting health and well-being and reducing inequities.

√ County Departments within the Executive Branch

- o Centralize data on drivers of health with information on health services and health outcomes, including requiring common reporting on drivers by each County agency.
- o Update the County website to coordinate information on what influences health across sectors. Offer resources organized by the health drivers to better support populations with health issues in more integrated ways ("one stop").

Below, we provide a high-level overview of the recommendations for implementing a comprehensive *Health in All Policies* approach and include examples of how other communities have implemented similar approaches. Full details about these approaches are provided in the final chapter of this report. We organize findings into three categories: (1) creating a *Health in All Policies* system, (2) aligning investments, and (3) implementing new measurement and data systems. *We use the acronyms LB and EB to help delineate primary roles for the County Board of Health (LB) versus activities of the Office of the County Executive (EB).*

1. Create a Health in All Policies system

1.1 Develop a coordinated *Health in All Policies* system that creates guidelines for governance (LB)

A key issue noted in this assessment was the challenge of connecting and coordinating residents across departments that address health and human services needs. In order for *Health in All Policies* to most effectively work, there is often a structure that defines a shared set of health goals across departments, a clarity on how information is shared to achieve those goals, and accountability across departments on how health will be integrated into policy design and development. These governance guidelines can ensure a more coordinated approach to integrated planning for health and are fundamental when making decisions about health-resource allocations. Examples of successful integration from other communities that can inform the County's next steps include efforts in integrated governance and health promotion in San Diego (Live Well San Diego, 2014) and Seattle & King County in Washington state (King County, 2010, 2013).

1.2 Create a strategic plan for all health and human services departments (EB)

While Prince George's County has a robust Community Health Needs Assessment led by the County Health Department, there is no such comparable assessment from Social Services or Family Services. Developing a comparable assessment and strategic plan for those departments can be used to organize investments, data, and programmatic decisions across health and human services. Further, it is key for moving towards *Health in All Policies* to have actions that bring in departments beyond health and human services, such as Police, Corrections and Fire/EMS. Montgomery County, Maryland offers an example for integration, having merged four county departments (Social Services, Public Health, Family Resources and Addictions, and Victims and Mental Health Services) into a single department and unified electronic records to better allocate resources based on client need and capacity (Hencoski, Ahluwalia, Seling, & Buckland, 2017).

1.3 Implement policies that promote health equity, including design and economic environment decisions (LB)

Stakeholders highlighted concerns related to the design of the physical and built environments. Across these topics, stakeholders recommended policies around enhancing walkability and environmentally friendly communities; implementing health equity guidelines with new economic investment; and harnessing whole community approaches to place-based investment. Examples for community design come from the Vermont Department of Health, which produced a guide to help towns design health communities (Vermont Agency of Transportation, 2019). Examples of using equity lenses on community investment and policy decisions include Multnomah County, Oregon, which developed the Equity and Empowerment Lens, a tool to ensure policies, programs, and processes are equitable for all populations within the communities (Multnomah County Health Department, 2012). Finally, place-based investment is a popular strategy in Prince George's County and elsewhere. In 2016, Detroit launched a public-private partnership to promote neighborhood revitalization and improve walkability. This effort pools funds for park improvements, streetscape improvements, commercial corridor development, and affordable single-family home stabilization (Invest Detroit, 2019b).

1.4 Improve the delivery and coordination of health services, including better screening for social needs (EB)

There was general agreement across stakeholders and in our data that while there are efforts to coordinate some health services, there is a need to do more, including helping residents access services, particularly within underserved populations and for mental and behavioral health needs. Seattle & King County in Washington state offers an example for promoting coordination via data integration, in which they aggregate medical, mental and behavioral health, social service, and health assessment data to provide clinical decisionmakers with a holistic view of a patient's risk factors, health outcomes, and service utilization (Washington State Department of Health and Human Services, 2014). Expanded screening is essential, but should be accompanied by funding to support the delivery of needed services.

1.5 Improve the accessibility, clarity, and usability of health and human services promoting resources and related civic engagement opportunities among County residents (EB)

With only 52 percent of County residents having above-average health literacy, combined with stakeholders noting residents' confusion and lack of knowledge about County resources, the County has the opportunity to strengthen its outreach and communication efforts. In considering how to address these issues, the County can learn from efforts intended to improve health literacy. For example, the Horowitz Center for Health Literacy at the University of Maryland School of Public Health is developing a framework for "community health literacy," which emphasizes the variety of sources of and channels for information and communication and the interconnectedness of people and organizations (Horowitz Center for Health Literacy, 2019a). Beyond health literacy, local governments are increasingly using multiple channels of communication (e.g., text messaging, online apps, and social media) to improve residents' knowledge of and use of services. Using a variety of communication channels is essential for ensuring messages reach the correct populations. For example, communicating volunteer opportunities to seniors necessitates a different communication strategy than communicating about service availability to young adults.

2. Align Investments

2.1 Break down silos between funding streams for health and human services, particularly in ways that can better leverage and coordinate grant funding (LB)

Prince George's County's health and human services departments are majority grant-funded, and Prince George's County has the lowest general fund approved health spending, as of FY2018, relative to Howard, Montgomery, Anne Arundel, and Baltimore Counties in Maryland. Trying to fund initiatives that encourage innovation or advance a *Health in All Policies* approach may be difficult with some grant restrictions. Moreover, grants are time-limited and the efforts they supported may cease when the grant ends if they are not supported by other funding streams. To break down funding silos, other communities have blended external grants and donations into a single fund to provide long-term and flexible support, blended finances for select populations across agencies (e.g., Virginia pools funds for services for at-risk youth), created a well-being trust, and levied taxes to support funding for select populations (e.g., Florida counties can levy taxes to support children's services) (Stafford County, 2019; Trust for America's Health, 2018).

2.2 Engage the nontraditional health sector to participate in "health mapping" and analysis (LB and EB)

To move toward a full *Health in All Policies* approach that links sectors and data systems that inform and influence health and well-being outcomes, sectors beyond the Health Department should be engaged. One approach to this is organizing budgets using a common health framework. For example, "health mapping" is an approach that can include coding all agency or department budgets for those programs that influence health outcomes or have health as part of an objective or mission, in order to capture a true accounting of health spending. This approach has been used for federal coding of *Health in All Policies* and can be used at the County level. In Appendix D, we offer a four-step process with templates that could be used to support pursuing an integrated *Health in All Policies* approach to global health budgeting. Another approach used in Massachusetts mandates that health impact assessments be conducted for every transportation project, thus engaging agency officials from transportation, health and human services, energy and environment, and public health (Massachusetts Department of Transportation, 2011).

Additionally, Vermont created a workgroup that conducted a series of health impact assessments, focused on midstream and upstream determinants and drivers of health, which were then used to develop policy recommendations (Vermont Department of Health, 2018a).

2.3 Better coordinate the nongovernmental organizations that address health and human service needs in the County and employ high-capacity nonprofits strategically (EB and LB)

There are a large number of nongovernmental organizations operating throughout the County and helping to address residents' health and well-being. Stakeholders emphasized the important role these organizations play and also expressed concern that many of these organizations are often too small to support ongoing and large-scale efforts. To better utilize these community partners, the County can look to examples of multi-stakeholder strategic partnerships throughout the country.

3. Implement New Measurement and Data Systems

3.1 Identify data gaps and implement systems to address gaps (EB)

In analyzing quantitative data for this report, we encountered two main challenges. First, there were limitations in the granularity of data at the sub-County level. Data analysis only at the County-level will mask the experiences of some residents. Second, there were limitations in information that offer insight about broader health and well-being; thus, there remains a need for more detailed information about primary care access and use, prevalence of stress and behavioral health conditions, health literacy, and other indicators of well-being). A *single*, shared data system that allows joint or dual entry of information so that departments have a common operating picture of health needs may facilitate coordination of services and offer a clearer picture of the role of drivers of health in impacting the health and well-being of County residents. Examples of this include an effort in Massachusetts to implement a two-way electronic referral system where clinical providers can send referrals to community-based organizations for assistance with out-of-scope health needs (Commonwealth of Massachusetts Department of Public Health, 2015). The experience of Massachusetts may be relevant to the County as it develops a bidirectional referral system to connect clinicians and community-based organizations with funding from the CDC.

3.2 Improve structures that support health and well-being data transparency and stewardship (LB)

Stakeholders noted that the County's existing performance monitoring systems are disproportionately focused on administrative outputs, as opposed to outcomes of health and well-being. Relatedly, stakeholders indicated that information on the overall health and well-being of County residents was often not publicly available or easily accessible. Enhanced performance monitoring systems have been implemented in other communities to better describe and publicize the health and well-being of residents. For example, Santa Monica, California reports traditional health outputs and outcomes in physical, social, and emotional health in addition to broader well-being measures of community cohesion, the quality of the natural and built environments, and economic opportunity (City of Santa Monica, 2020). Additionally, Allegheny County has an office dedicated to the measurement and the tracking of key indicators of population health and well-being. The Office of Data Analysis, Research and Evaluation (DARE) is a joint endeavor from the Allegheny County Health Department, the Allegheny County Jail, the City of Pittsburgh, the Pittsburgh Bureau of Police, and Pittsburgh Public Schools (Allegheny County Department of Human Services, 2019). Information is conveyed to the public through its website, which offers maps and interactive and customizable dashboards to illustrate drivers of health and health outcomes, covering a variety of topics related to mental and behavioral health, child health, crime and justice, and education.

Limitations

This assessment should be considered in the context of its limitations. Few datasets enabled concurrent examination of health and drivers of health at a granular level. Therefore, we were unable to fully characterize how health behaviors, access to care, and health outcomes vary within the County. This data gap highlights the need for data sources that enable measurement of key drivers of health and health outcomes in a way that allows examination at a subcounty level and among specific subpopulations. Relatedly, more detailed and granular data need to be collected to fully measure several key areas of interest, including: use of outpatient health care; child health; and well-being. In addition, the qualitative data are a sample and do not necessarily capture opinions from all relevant stakeholders. We attempted to obtain feedback from a diverse and representative set of stakeholders, however, the views expressed by participants in interviews, focus groups, and the town hall meeting may represent the views of more engaged residents and may not be representative of all County residents. Moreover, while the town hall meeting featured a Spanish translator and a sign language interpreter, interviews and focus groups were conducted in English. Additionally, some populations are notoriously hard-to-reach, including individuals experiencing homelessness and undocumented immigrants.

Conclusions and Next Steps

With evolving demographics and a changing health care landscape, the Prince George's County Council, acting as the County Board of Health, is considering its future policy approach and resource allocations related to health and well-being. One of the most significant bright spots of this assessment process is the shared interest of leaders and residents to embrace a more integrated and holistic strategy for promoting health and well-being and addressing inequities in the County. This shared interest provides an excellent foundation for implementing and sustaining a strategic plan that can be executed.

As summarized in the recommendations, Prince George's County has opportunities to create a more cohesive governance structure focused on *Health in All Policies* and a robust budgeting process that codes, categorizes, and aligns funding against a shared health framework. This approach can be enhanced by a centralized and integrated data system that enables measurement of access and use of services, disease management, and indicators of quality of life and well-being that track real progress towards a thriving County. Given the motivations for this work came through legislative branch, the County has opportunities to leverage this interest via traditional legislative tools, such as spending policies. Building on a review of these data and recommendations, the next steps for the County are to determine what is structurally and financially possible to implement and what actions will bolster the County's goal of reducing inequities and promoting overall health and well-being.

Acknowledgments

We extend our appreciation to all individuals who shared their thoughts on the health and human services needs of Prince George's County, in particular all key informants, focus group participants, and town hall attendees. We thank the Prince George's County Council, acting as the Board of Health, and all staff for hosting a town hall meeting focused on health and human services needs of County residents. We also thank the numerous County agencies that provided data for this report, helped us to understand and analyze these data, and reviewed the report. We offer our gratitude to Dr. Yolandra Hancock and Dr. Terrence M. Fullum for offering guidance on this work. We thank our formal reviewers, Lori Simon-Rusinowitz of the University of Maryland School of Public Health and Laurie Martin of the RAND Corporation. Finally, we extend our deepest appreciation to County Council Administrator Robert J. Williams Jr., County Council Deputy Administrator William Hunt, and policy analysts Anya Makarova and Joseph Hamlin for their leadership and help with all aspects of this report, including facilitating connections to key informants.

Abbreviations

ACS	American Community Survey
ATSDR	Agency for Toxic Substances and Disease Registry
BLS	Bureau of Labor Statistics
BRFSS	Behavioral risk factor surveillance system
CBP3	Community-based public-private partnership
CDC	Centers for Disease Control and Prevention
CHNA	community health needs assessment
COPD	Chronic obstructive pulmonary disease
DFS	Department of Family Services
DSS	Department of Social Services
EB	Executive Branch
ED	Emergency department
EMS	Emergency medical services
EPA	Environmental Protection Agency
ERS	Economic Research Service of the U.S. Department of Agriculture
FQHCs	Federally Qualified Health Centers
FTE	Full time equivalent
FY	fiscal year
HPSA	Health Professional Shortage Area
HRSA	Health Resources & Services Administration
HUD	U.S. Department of Housing and Urban Development
LAUS	Bureau of Labor Statistics Local Area Unemployment Statistics.

LB	Legislative Branch
MCHP	Maryland Children's Health Program
MDs	Medical Doctors
M-NCPPC	Maryland-National Capital Parks and Planning Commission
NP	Nurse Practitioner
PA	Physician assistant
PGCPS	Prince George's County Public Schools
PRAMS	Pregnancy Risk Assessment Monitoring System
RN	Registered Nurse
RWJF	Robert Wood Johnson Foundation
SDOH	Social determinants of health
SNAP	Supplemental Nutrition Assistance Program
SVI	Social Vulnerability Index
TNI	Transforming Neighborhoods Initiative
UMMS	University of Maryland Medical System
USDA	United States Department of Agriculture
YRBS/YTS	Maryland Youth Risk Behavior Survey and Youth Tobacco Survey
ZCTA	ZIP Code Tabulation Area

1. Introduction

Overview

Prince George's County is at a critical crossroads with respect to its future health and well-being. Over the past decade, the demographics of the County have been evolving with a steadily growing number of seniors, Hispanic, and foreign-born residents. Additionally, the County's health care landscape has changed through hospital mergers and acquisitions and will continue to evolve with the expected 2021 opening of the University of Maryland Capital Region Medical Center. During this time, the Prince George's County Council has pursued an active approach to health promotion, convening health care providers in the community and considering legislation to promote healthy behaviors. Along with these developments in the county, broader societal changes are happening. At a time when there are national discussions of topics such as the increasing burden of chronic diseases, rising health care expenditures, and increasing attention to the role of social determinants of health (SDOH), Prince George's County is poised to consider and pursue new approaches to promoting and budgeting for health.

With this context, the Prince George's County Council, acting as the County Board of Health, is considering its future policy approach and resource allocation for health in the County. To do so, there is strong recognition of the need to not only understand the health needs of residents captured in prior health assessments, but to combine that with a more holistic analysis of the environmental and service influences on health and well-being and to outline the relative roles of government departments within the executive branch, nonprofit organizations, and other service providers. In particular, there is a need to understand the full extent of the health issues in the County as well as where and how health is being influenced in order to inform recommendations for how the County proceeds with more aligned and integrated planning and budgeting for health. The term "integrated" is used to describe the removal of silos across departments and funding streams and to reflect a coordinated approach to health and well-being.

This health and human services needs assessment is intended to assist the Prince George's County Board of Health in its consideration of an integrated *Health in All Policies* approach, which is an approach that aligns county funding across departments and services, with needs and desired health outcomes. The aims of this work are to

1. Describe the health of County residents
2. Describe drivers of health within the County, inclusive of the social, economic, built, natural, and health service environments
3. Offer recommendations to foster aligned and integrated planning and budgeting across the County to promote health and well-being

As this report stems from interests of the County's legislative branch, we provide attention to potential policy actions that can focus on cross-government strategy, engaging both the legislative and executive branches of government, and associated policy and financial alignment. In the remaining parts of this chapter, we describe key findings and progress since the 2009 County-wide health needs assessment conducted by RAND, *Assessing Health and Health Care in Prince George's County* (Lurie et al., 2009). We then summarize the unique contributions of this report. We briefly offer a framework for how the County can organize its future integrated health planning, then outline the study methods used, and the roadmap for the rest of the report.

County Context Over the Last Decade

As noted earlier, the RAND Corporation, working with the Prince George's County Council, developed a report titled, *Assessing Health and Health Care in Prince George's County* in 2009. At the time, the County was facing challenges of fiscal constraints and demographic transitions, with net out-migration of White residents with higher incomes. The 2009 report principally emphasized issues of health care access and capacity given concerns at the time of the financial viability of Prince George's Hospital Center and the adequacy of the region's health care workforce. The report's findings led to recommendations to strengthen health care infrastructure in the County, including the primary care and the safety net.

Since the 2009 report, there have been changes to the County health care delivery landscape and even greater engagement from the Board of Health in promoting health. As has been the trend across the United States, the hospital mergers and acquisitions have changed the County's health care landscape (National Institute for Health Care Management Foundation, 2020). In 2019, Anne Arundel Medical Center and Doctors Community Health System merged to create Luminis Health and Adventist HealthCare acquired Fort Washington Medical Center. Additionally, following years of effort to transfer Prince George's County hospital system from County ownership and address its struggling financial situation, the University of Maryland Medical System took ownership of the system in 2017. This merger led to the construction of a new hospital, to replace Prince George's Hospital Center in Cheverly, Maryland. The new hospital, called the University of Maryland Capital Region Medical Center, is being built in Largo, Maryland and expected to open in 2021. Moreover, the health care delivery landscape was affected by changes at the state-level, including the introduction of the Maryland All-Payer Model in 2014, which introduced a new all-payer, annual global budget payment structure for hospitals throughout the state. Evaluations of the model found reduced hospital admissions, potentially avoidable hospitalizations, and total expenditures (Centers for Medicare & Medicaid Services, 2019). CMS approved the extension of the model through 2023 and the expansion of it to include additional parts of the health care system (e.g., mental health, long-term care, primary care).

As the health care delivery landscape has evolved, the Prince George's County Council has pursued an active approach to health promotion. This includes serving as a convener of health care providers in the community, providing oversight of hospital mergers, and monitoring access to health care services. Additionally, several pieces of legislation have been proposed to promote healthy eating, some of which has passed, including offering healthy options in vending machines (proposed in 2016, proposed and passed in 2017), adding warning labels to beverages with added sugar (proposed in 2017), and requiring nutritional labeling for food services (proposed in 2015). Numerous bills focused on creating "food truck hubs" to improve access to healthy foods in areas with limited options have been passed annually since 2015. Moreover, the Board of Health has pursued innovative partnerships to promote the health of residents. In 2015, the Board of Health engaged in an innovative partnership with several local churches to promote weight loss over a 3-month period. This collaboration was motivated by research suggesting that regular church attendance was associated with a greater risk of obesity (Feinstein, Liu, Ning, Fitchett, & Lloyd-Jones, 2012). In 2018, the Board of Health collaborated with Clinical Pharmacy Associates, Inc. to launch a pilot project connecting about 200 seniors in the County with clinical pharmacists to deliver care virtually, an approach known as "telepharmacy" (Council News, 2018). With a history of engagement in health promotion and at the cusp of a new hospital, the Board of Health is poised to pursue new approaches to promoting and budgeting for health.

The past decade has also seen great attention to the health and health care needs of County residents. Key studies are highlighted in Figure 1.1. These prior studies were conducted by County departments and outside partners and serve to highlight the health and health care needs of residents and in some cases, to provide recommendations for resource allocation and planning. The studies cover a range of topics, including community health, health care workforce, health equity, immigrant health, maternal and infant health, and opioid overdoses. Nearly all studies have highlighted racial/ethnic disparities in health outcomes. Overall, the past research and discussion surrounding the health of Prince George's County residents underscore three themes:

1. There exists a high demand, yet low supply of primary care providers in the County. The dynamic is further exacerbated by transportation challenges experienced by some within the county to obtain health care services.
2. Social determinants of health play a key role in influencing health outcomes for County residents.
3. Bolstering existing nonprofit capacities by encouraging collaborations can increase the ability of the County to serve the health needs of residents.

Figure 1.1.
Examples of Key Reports Highlighting the Health Needs of County Residents

Community health needs assessments

- *Prince George's County Community Health Assessment* from the Prince George's County Health Department (2016; 2019b).

Healthcare and health

- *Assessing Health and Health Care in Prince George's County* from the RAND Corporation (2009).
- *Transforming Health in Prince George's County, Maryland: A Public Health Impact Study* from the University of Maryland School of Public Health (2012).
- *Prince George's County Primary Healthcare Strategic Plan* from the County (2014).
- *Prince George's County Behavioral Health System Needs Assessment, Gap Analysis, and Action Plan* from Health Management Associates (2015).
- *The Healthcare Landscape in Prince George's County: Opportunities for Improvement* from Regional Primary Care Coalition (2018).

Health equity

- *Transformative Change: Our Role in Achieving Health Equity for Prince George's County* from the Prince George's Healthcare Action Coalition (2018).
- *Uneven opportunities: How conditions for wellness vary across the Metropolitan Washington Region* from the VCU Center on Society and Health for the Metropolitan Washington Council of Governments (2018).

Immigrant health

- *Partnering for Health Equity: Strategies, Partnerships and Recommendations for Immigrants' Health in Prince George's County* from La Clínica Del Pueblo (2018).

Maternal and infant health

- *Maternal and Infant Health Report* from the County Health Department (2019c).

Substance abuse

- *Opioid Overdose Report* from the County Health Department (2018a).

Contributions of This Report

This report adds to a rich foundation of analyses, in particular the 2019 Community Health Needs Assessment led by Prince George's County Health Department (Prince George's County Health Department, 2019b). To accomplish our goal of conducting a holistic analysis of the broad environmental and service influences on health and well-being in the County necessarily requires some redundancy with other reports, particularly those which have focused on health outcomes. For example, similar to other reports, this report uses secondary data to describe county demographics, self-reported health outcomes, and health care utilization, and primary data to describe priorities articulated by residents and community leaders. While this information will be familiar to readers well-versed on the health needs of residents, its inclusion is an important component in describing the relative contributions of broader environmental and

service influences on health and well-being and in informing recommendations related to an integrated *Health in All Policies* approach (see next section).

In Figure 1.2, we situate this report with the 2019 Community Health Needs Assessment and other recent reports, by highlighting the key features of this report that distinguish it from existing work. As noted in the table, key contributions of this report include its holistic examination of drivers of health, broad assessment of health care providers, and recommendations to support future integrated health planning in the County. By offering a broad overview of drivers of health (e.g., social, economic, natural, built, and health service environments) along with health and well-being, we seek to provide integrated information to inform the County's movement toward a *Health in All Policies* approach to policymaking. Because each driver of health could warrant its own lengthy reporting examining its relationship to health and well-being, in this report we focus on describing the wide variety of drivers of health and note opportunities for future exploration. Our recommendations are particularly focused on policy actions that involve cross-government department strategies, associated data, and financial alignment. With these recommendations, we provide examples used in other jurisdictions to help the County understand how these approaches have been practically implemented in other settings.

Figure 1.2.
Key Features of This Report

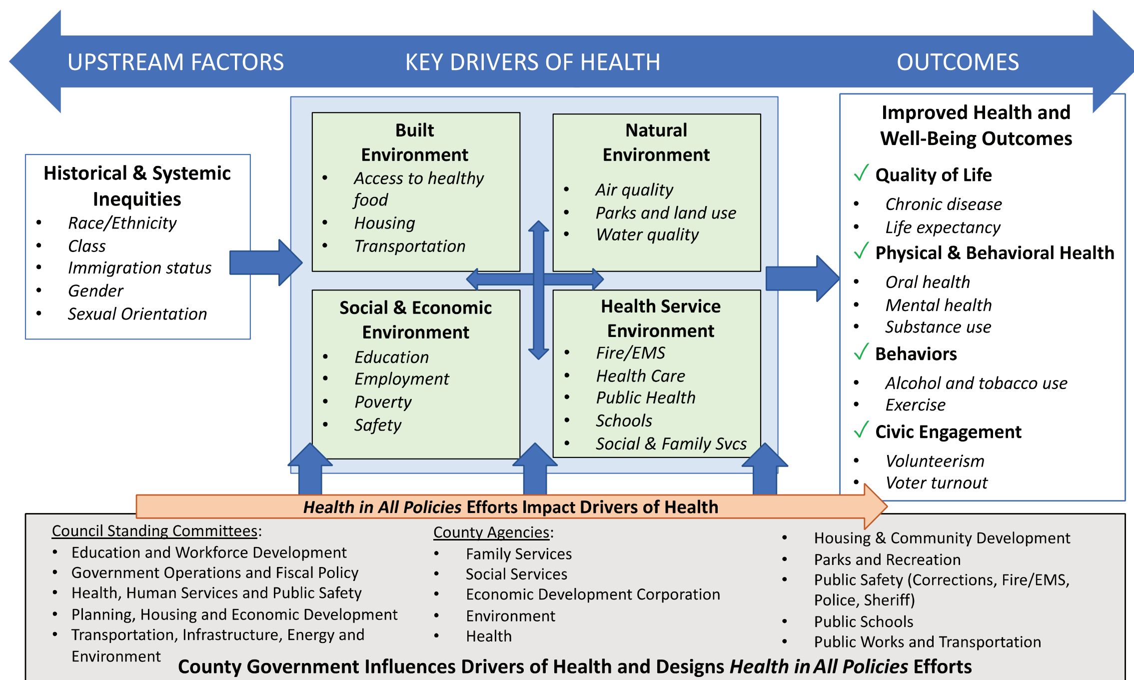
Key Features of This Report
Provides broad review of health influences, from the social, economic, built, and natural environments.
Offers insight into role of schools and human services departments in promoting health.
Utilizes health care discharge data from both Maryland and District of Columbia (DC), highlighting key role of care provision from providers in DC.
Examines health care provision outside of traditional health care providers, including schools, fire/EMS, and corrections.
Situates recommendations via *Health in All Policies*, inclusive of budget alignment and legislative action levers.
Establishes a foundation for future integrated health planning for the County.

Framework for Understanding Health and Human Services Needs

As noted earlier, this report is organized by a framework that can be used by the County to implement *Health in All Policies*. The framework emphasizes the interconnectedness of health and well-being, systemic factors that influence health over generations, drivers of health, and health systems (Figure 1.3). First introduced outside of the United States (U.S.) (Melkas, 2013), *Health in All Policies* in the U.S. was adopted by the Centers for Disease Control and Prevention (CDC), and defined as a "collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people" (Centers for Disease Control and Prevention, 2016). *Health in All Policies* requires interagency collaboration and thoughtful consideration of health equity (Rudolph, Caplan, Ben-Moshe, & Dillon, 2013).

Our framework (Figure 1.3) illustrates how health and well-being cannot be considered independently from historical and systemic inequities and drivers of health that shape opportunities and environments. As articulated in this framework, *health and well-being* are downstream outcomes and are described by quality of life, physical and behavioral health, healthy behaviors, and civic engagement (given links between *connection to community* and *health outcomes*) (Nelson et al., 2019). While health and well-being are influenced by genetic composition, health and well-being are largely affected by upstream factors and drivers in the broader environment.

Figure 1.3.
Improving Health and Well-Being through an Integrated *Health in All Policies* Approach



NOTES: Bulleted items in italics are examples only. Our framework was informed by the Bay Area Regional Health Inequities Initiative's Public Health Framework for Reducing Health Inequities (Bay Area Regional Health Inequities Initiative, 2019), and modified specifically for Prince George's County.

In the figure, *drivers of health* describe the conditions that influence health, namely the social, economic, natural, built, and health service environments, which influence health at both individual and community levels (Centers for Disease Control and Prevention, 2018). While the health care system is widely recognized as impacting health, public health systems are essential for promoting both individual- and community-level health by conducting health promotion activities and engaging in disease surveillance. In addition, the social, built, and natural environments also play a key role in health and well-being due to the associated consequences related to access, lifestyle, and choices. For example, studies report that food insecurity, lack of stable housing, low income status, and limited education are associated with poor health outcomes (Leonard, Hughes, Donegan, Santillan, & Pruitt, 2018; Vásquez-Vera et al., 2017; Walker, Gebregziabher, Martin-Harris, & Egede, 2014).

In this framework, we also name the *government departments* in Prince George's County and *standing committees* in the County Council that influence these drivers of health. It should be noted that while this framework explicitly names these government departments and committees, nongovernmental organizations are a key part of influencing health and the drivers of health.

Finally, we use the term "upstream" to describe the macro-level factors that affect health and well-being (Bharmal, Derose, Felician, & Weden, 2015). *Historical and systemic inequities*, inclusive of systemic racism and bias against historically marginalized groups, influence drivers of health (e.g., living conditions, educational and economic opportunities, access to social and health services) and ultimately shape the downstream outcomes of health and well-being. In addition to these inequities impacting health via drivers of health, research indicates that accumulated stress, or allostatic load, such as due to racial trauma, may have direct impacts on health (Chandra, Cahill, Yeung, & Ross, 2018). Throughout this framework and assessment, we emphasize the role of equity across the key drivers of health, recognizing that equal provision of services will not lead to equal outcomes when individuals and communities have varying levels of need. While equality suggests that all people receive the same amount of resources, equity emphasizes fairness as proportionate to need and history. Understanding equity, particularly within a society with a long history of systemic and structural racism and bias against marginalized groups, is imperative for implementing fair health and human services policy, and is a tenet emphasized by the U.S. Department of Health and Human Services (Secretary's Advisory Committee for Healthy People 2030, (2018)).

Approach

To describe the health and human services needs of County residents, we relied on both primary and secondary data. Primary data collection involved obtaining input via

- One Town Hall meeting attended by approximately 70 residents during June 2019 at the Prince George's County Administration Building in Upper Marlboro. An online survey was also used to capture comments from residents who were unable to attend this meeting.
- Three focus groups composed of 24 residents. These groups were distributed geographically in the North, Central, and South regions of the County and included residents who were recruited by council members with the goal of being demographically representative of each district.
- One focus group composed of 12 adolescents and young adults living in the County.
- Interviews with 23 organizations addressing the health and human services needs of County residents, including 15 government agencies and 8 nonprofit organizations serving County residents.

The Town Hall meeting, interviews, and focus groups offered an opportunity for residents and employees of County departments and nongovernmental organizations to share their perspectives and subjective experiences. A full description of how primary data was collected and analyzed, including the protocols for the focus groups and interviews, is available in Appendix A. Briefly, comprehensive notes were taken and augmented by audio recordings. To identify key themes, notes from all primary data collection activities were combined, then the

study team reviewed notes and categorized key themes from the work. Findings from residents and organizational leaders were analyzed together and are presented together as findings from stakeholders. Themes were identified as priority based on the level of comment obtained across stakeholders (e.g., frequency, relative importance), and reviewed by at least two study team members to ensure the team agreed on that priority identification. We describe these findings as responses from "stakeholders," which is inclusive of both residents and employees of County departments and nongovernmental organizations, to emphasize the key role that all respondents play in improving the County overall health and well-being.

In addition, we collected county and sub-county secondary data from a variety of public and proprietary sources to describe the current and historical health and human services needs of County residents. Data were obtained from numerous County departments (e.g., Departments of Corrections, Family Services, Social Services), public sources (e.g., American Community Survey, Behavioral Risk Factor Surveillance Survey), and proprietary sources (e.g., Maryland Healthcare Services Cost Review Commission and the District of Columbia Hospital Association). The data sources used in this report and some details on quantitative analysis are described in each chapter the data appear as well as comprehensively described in Appendix B. Indicators included in this report were selected based on data availability with attention to reflecting all areas of our framework and also to highlight indicators that have not previously been included in prior reports related to health needs in Prince George's County. Together, these data describe drivers of health affecting County residents, including the social and economic environment, built environment, natural environment, and health service environment, as well as the overall health and well-being of County residents. Our goal was to obtain and analyze longitudinal data to describe trends over time, make comparisons between Prince George's County residents and residents of nearby counties (Baltimore County, Howard County, and Montgomery County) and the state of Maryland, and to make comparisons within the County (e.g., examine data at the neighborhood or other sub-county level). With such a large number of data sources providing diverse information in this report, it is nearly impossible to present information uniformly across chapters. For example, some data sources report information stratified by race and Hispanic ethnicity, yet others do not. There is value in presenting trends over time, across counties, and within the County, however not all data sources enable these types of analyses, and for some data sources, this information has been presented in other reports. Therefore, we begin each chapter with a summary of the data sources to be presented and an overview of how the data will be presented to guide the reader.

In order to inform the recommendations at the end of the report, we also reviewed promising practices from other communities and regions in the United States, particularly focused on some of the challenges that Prince George's County faces with respect to integration of health and human services, such as governance, data systems, and investment alignment. We also reviewed Prince George's proposed operating budgets to describe where funding has been allocated to health and specifically drivers of health across County departments.

Organization of the Report

Given the decisions that the County has to make and, in the context, described above, it is important that this report serves as a foundational document to examine

- What is really driving these health outcomes?
- Where services are coming from and where there could be gaps or misalignment?
- What the County should do first to move more effectively toward a *Health in All Policies* approach to policymaking?

The report is organized as follows:

- Chapter Two offers a profile of the population, documenting trends, comparisons to other counties, and comparisons within the County.
- Chapter Three describes health and well-being outcomes for County residents.
- Chapters Four - Six describe what may be driving those outcomes, describing the roles of the health care, social and economic, and built and natural environments. Where relevant, we provide findings by populations that have special needs, such as pregnant women, seniors, and people experiencing homelessness.
- Chapter Seven provides several exemplars illustrating the linkages of drivers of health and health outcomes for two populations receiving significant attention given emergent and chronic needs: children and foreign-born noncitizens. *In Chapters Three - Seven, we offer next steps regarding data limitations and future data analyses.*
- Chapter Eight offers an overview of key trends in health budgeting in the County.
- Chapter Nine concludes with a summary of findings and recommendations to implement *Health in All Policies* effectively. These recommendations are based on findings from primary and secondary data, review of budget documents, and an environmental scan of promising practices utilized by other jurisdictions.

While the County Board of Health is the key audience for this report, it is also likely to be highly informative to organizations within and outside the County government focused on addressing the health and human services needs of residents. Additionally, other communities considering a *Health in All Policies* approach are likely to find the last chapter and the examples of different strategies informative.

2. Demographic Profile

Background

Despite improvements in health outcomes in the U.S. over the last two decades, inequities remain. For example, the life expectancy for Black persons is nearly four years less than that of whites (Cunningham et al., 2017). Further, disparities remain in the prevalence of cardiovascular disease, the leading cause of death in the United States, and its risk factors, for Black and Hispanic individuals compared to Whites (Mensah, Mokdad, Ford, Greenlund, & Croft, 2005). Thus, understanding the demographic characteristics of Prince George's County residents, including distributions across age, race/ethnicity, sex, and so forth is critical to a baseline assessment of health and well-being in the County.

Key data used in this chapter comes from the American Community Survey (ACS). Longitudinal county-level information is derived from annual surveys (2009-2018). To examine sub-county characteristics (e.g., across districts), information is derived from pooled surveys (2014 to 2018).

Population demographics Over Time

Table 2.1 below describes the demographics of Prince George's County from 2009 to 2018. The population aged 65 years or older increased about 4 percent over the ten years. The percentage of Hispanic residents has increased over 6 percent, the largest percent change across all race/ethnicity groups. The percentage of foreign-born residents and households with limited English speaking also increased. The prevalence of female-headed, single parent households with children under the age of 18 decreased by 3 percent.

Table 2.1.
Demographics of Prince George's County Over Time, 2009–2018

	Year									
	2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Age										
Younger than 18 years	24.7	23.7	23.5	23.1	22.7	22.7	22.5	22.4	22.3	22.2
Aged 18 - 39 years	31.7	33.3	33.3	33.4	32.7	32.5	32.3	32.4	31.8	31.5
Aged 40 - 64 years	34.1	33.5	33.4	33.3	33.7	33.5	33.5	32.9	33.2	33.0
Aged 65 years or older	9.4	9.5	9.8	10.3	10.8	11.3	11.7	12.3	12.8	13.3
Sex										
Female	51.9	52.0	51.9	52.0	51.9	51.8	51.8	51.9	51.8	51.9
Male	48.1	48.0	48.1	48.0	48.1	48.2	48.2	48.1	48.2	48.1
Race/Ethnicity										
White	16.9	14.9	15.2	14.7	14.3	14.1	13.8	13.0	12.6	12.3
Black	63.6	63.6	63.3	62.6	62.8	62.1	61.6	62.0	62.0	61.3
American Indian and Alaska Native	0.2	0.2	0.3	0.2	0.3	0.2	0.2	0.2	0.2	0.2
Asian	3.9	4.1	4.1	4.2	4.3	4.4	4.3	4.2	4.3	4.1
Native Hawaiian and Other Pacific Islander	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.2	0.1	0.3	0.2	0.4	0.2	0.5	0.3	0.4	0.6
Two or more races	1.7	2.1	1.6	2.4	1.7	2.2	2.3	2.5	2.0	2.6
Hispanic	13.5	15.0	15.2	15.7	16.2	16.9	17.2	17.8	18.5	19.1
Place of Birth										
Foreign born	18.1	19.9	21.0	20.8	20.6	21.8	22.8	22.2	22.6	23.6
English Proficiency										
Households limited English Speaking	*	*	*	*	*	*	*	5.8	6.1	6.9
Household composition										
Single person with no own children <18 years	18.4	21.1	20.1	22.2	21.8	22.4	21.3	22.3	23.9	19.7
Single parent with own children <18 years	20.0	21.4	21.0	20.3	20.5	19.2	17.0	18.3	15.4	17.0
Female householder, no husband present with own children <18	15.7	16.2	16.8	15.8	16.0	14.3	12.5	13.4	11.3	12.7
Marital status										
Age 15+ married	37.0	34.3	34.7	33.3	34.2	34.5	35.5	33.4	35.2	36.6

SOURCE: U.S. Census Bureau, 2019.
NOTES: Data in table were obtained from the American Community Survey 1-Year Summary Files, 2009-2018. In this table and throughout the report, we use the term "Hispanic" to describe persons who identify as Hispanic, Latino, and Latina. This term describes a person from Cuba, Mexico, Puerto Rico, South or Central America, or other Spanish culture or origin. *Indicates not available.

Population Demographics Compared to Neighboring Jurisdictions

Compared to the state overall, Prince George's County has a higher percentage of residents who are Hispanic (17.9 percent vs. 9.8 percent) and a higher percentage of households with limited English proficiency (5.5 percent vs. 3.2 percent). When compared to nearby counties of Baltimore, Howard, and Montgomery, the population of Prince George's County is younger (only 12.3 percent of residents are aged 65 or older), more likely to be Black, and less likely to be married (Table 2.2).

Table 2.2.
Demographics, by County and State, Pooled 2014–2018

	Prince George's County	Baltimore County	Howard County	Montgomery County	Maryland
Age					
Younger than 18 years	22.5	21.6	24.5	23.4	22.4
Aged 18 - 39 years	31.9	29.2	27.1	28.0	29.4
Aged 40 - 64 years	33.4	32.7	35.4	34.0	33.6
Aged 65 years or older	12.3	16.5	13.0	14.6	14.6
Sex					
Female	51.8	52.6	51.1	51.7	51.5
Male	48.2	47.4	48.9	48.3	48.5
Race/Ethnicity					
White	13.0	58.1	53.1	44.5	51.4
Black	62.0	27.9	18.2	17.7	29.3
American Indian and Alaska Native	0.2	0.2	0.2	0.1	0.2
Asian	4.1	5.9	17.7	14.6	6.2
Native Hawaiian and Other Pacific Islander	0.0	0.0	0.0	0.0	0.0
Other	0.4	0.2	0.5	0.5	0.3
Two or more races	2.3	2.3	3.6	3.3	2.8
Hispanic	17.9	5.3	6.7	19.3	9.8
Place of Birth					
Foreign born	22.4	12.4	21.1	32.3	15.1
English Proficiency					
Households limited English speaking	5.5	2.6	3.1	6.7	3.2
Household composition					
Single person with no own children <18 years	21.8	15.3	8.7	11.1	14.6
Single parent with own children <18 years	17.2	14.1	9.8	10.9	13.6
Female householder, no husband present with own children <18	12.7	10.7	7.8	8.0	10.2
Marital status					
Age 15+ married	35.3	43.4	55.0	49.7	44.3

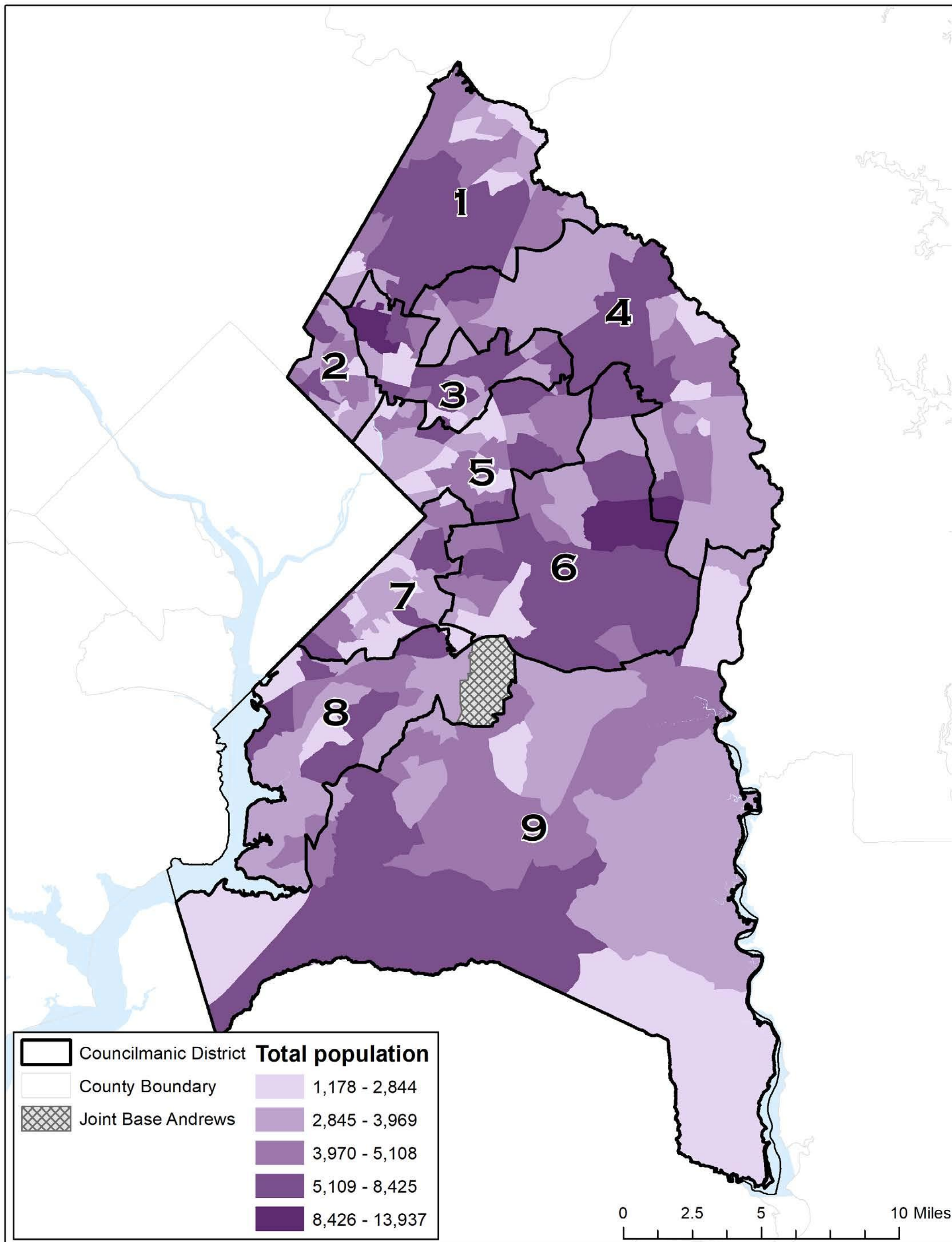
SOURCE: U.S. Census Bureau, 2019.
NOTES: Data in table were obtained from the American Community Survey 5-Year Summary File, 2014-2018.

Population Demographics Compared Across County Districts

We also used the ACS data to examine the County's nine councilmanic districts. Figure 2.1 illustrates where people live in the County, by census tract. The population is similar across districts, with an average of about 100,700 residents per district. Most districts have more than 100,000 residents, with only Districts 2, 7, and 8 having slightly fewer than 100,000 residents.

About 23 percent of the County population is younger than 18 years, and about 12 percent is aged 65 years or older. This age distribution is similar across districts, with District 8 having a slightly higher proportion of adults aged 65 years or older (15.4 percent) (Table 2.3). Residents of Prince George's County are predominantly Black (62.3 percent) and 17.4 percent of residents are Hispanic. Additionally, more than one in five residents were born outside the United States. While residents of the County are predominantly Black, there is evidence of segregation by racial and ethnic groups. Black residents are highly concentrated in Districts 5, 6, 7, 8, and 9, where they make up more than 70% of each district's population. Fewer than 50% of residents are Black in Districts 1, 2, and 3. In District 2, more than 50% of residents are Hispanic. In District 2, nearly half the residents are born outside the United States and 21.8 percent of households report a limited ability to speak English.

Figure 2.1.
Map Illustrating Distribution of Population throughout Prince George's County, Pooled 2014–2018



SOURCE: U.S. Census Bureau, 2019.
NOTES: Rates provided for the civilian noninstitutionalized population. Data in table were obtained from the American Community Survey 5-Year Summary File, 2014–2018.

Table 2.3.
Demographics of Prince George's County, by District, Pooled 2014–2018

	County Councilmanic Districts									
	PG	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Age										
Younger than 18 years	22.5	23.2	24.7	21.4	22.2	25.2	21.4	22.8	20.4	20.9
Aged 18 - 39 years	31.9	32.3	37.8	42.2	28.1	30.0	28.8	32.3	30.5	25.6
Aged 40 - 64 years	33.4	33.2	28.8	27.0	36.6	32.0	37.1	32.5	33.7	38.8
Aged 65 years or older	12.3	11.4	8.7	9.3	13.0	12.8	12.7	12.5	15.4	14.6
Sex										
Female	51.8	50.7	48.5	49.9	52.6	52.9	53.8	54.0	52.6	51.7
Male	48.2	49.3	51.5	50.1	47.4	47.1	46.2	46.0	47.4	48.3
Race/Ethnicity										
White	13.0	22.2	9.2	21.8	27.6	6.2	4.7	3.2	8.0	12.1
Black	62.0	43.6	33.3	40.5	51.7	70.3	87.0	86.9	71.0	74.9
American Indian and Alaska Native	0.2	0.3	0.2	0.3	0.1	0.2	0.1	0.1	0.2	0.3
Asian	4.1	9.1	3.3	6.9	6.2	2.1	1.5	0.6	4.6	2.6
Native Hawaiian and Other Pacific Islander	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0
Other	0.4	0.5	0.4	0.4	0.5	0.3	0.5	0.2	0.3	0.5
Two or more races	2.3	2.6	1.4	2.9	3.3	1.8	2.1	1.5	2.2	2.8
Hispanic	17.9	21.6	52.2	27.2	10.5	19.1	4.1	7.4	13.6	6.7
Place of Birth										
Foreign born	22.4	32.9	48.2	33.4	20.0	24.0	11.5	8.5	14.9	8.6
English Proficiency										
Households limited English Speaking	5.5	6.6	21.8	9.5	3.1	5.0	1.0	1.6	3.7	0.8
Household composition										
Single person with no own children <18 years	21.8	17.4	24.7	20.7	16.6	25.7	22.4	29.4	23.9	17.1
Single parent with own children <18 years	17.2	13.9	22.4	15.9	13.8	19.9	17.0	28.8	15.9	10.1
Female householder, no husband present with own children <18	12.7	9.7	12.1	11.2	10.8	15.5	14.0	23.3	11.5	7.4
Marital status										
Age 15+ married	35.3	39.2	28.5	30.2	42.6	33.1	36.6	24.0	36.0	45.8

SOURCE: U.S. Census Bureau, 2019.
NOTES: Individuals are civilian noninstitutionalized. Data in table were obtained from the American Community Survey 5-Year Summary File, 2014-2018.

Summary

Prince George's County is diverse, with some demographic patterns varying regionally. Within the County, demographics have remained relatively unchanged. However, the percentage of foreign-born residents has increased since 2009. Compared to other nearby counties, Prince George's County has a higher percentage population of Hispanic residents (17.9 percent). Within the County, there is notable segregation by racial and ethnic groups. County residents are predominantly Black and compose more than 70% of the population in Districts 5, 6, 7, 8, and 9. Fewer than 50% of residents are Black in Districts 1, 2, and 3. In District 2, more than 50% of residents are Hispanic. Notable demographic characteristics for each district are highlighted below:

- District 1 has a higher proportion of White (22.2 percent), Asian (9.1 percent), and foreign-born (32.9 percent) residents than the County average (13.0 percent, 4.1 percent, and 22.4 percent, respectively).
- District 2 has a very high proportion of foreign-born (48.2 percent) residents and the highest proportion of Hispanic residents (52.2 percent) compared to all other districts.
- District 3 has a higher proportion of White (21.8 percent) and Hispanic (27.2 percent) residents than the County average (13.0 percent, 17.9 percent, respectively).
- District 4 has a higher proportion of White (27.6 percent) residents than the County average (13.0 percent).
- Districts 5 through 9 have predominantly Black residents, with the proportion of this group ranging between 71 percent and 87 percent of the district population for these five districts.
- Districts 8 and 9 also have a higher proportion of 65 years and older residents than other districts (15.4 percent and 14.6 percent, respectively, versus 12.3 percent for the County average).

3. Health and Well-being

Background

In this chapter, we describe the health and well-being of County residents. Health is the term broadly used to describe physical and mental health outcomes. Well-being encompasses a variety of factors that are part of a full and safe life, such as participation in healthy behaviors, activities related to health promotion, and civic engagement. As illustrated in our conceptual framework (Figure 1.3), health and well-being are largely influenced by the social, economic, built, natural, and health service environments, as well as by historical and systemic inequities.

Before discussing the roles of those drivers of health, here in this chapter we first describe health and well-being among County residents. As will be noted in this chapter, the information on health and well-being is currently limited, which informs a recommendation for the County going forward as it pursues *Health in All Policies* (see Chapter Nine). When feasible, we sought to examine inequities in health outcomes, including by race/ethnicity and socioeconomic characteristics.

Key data used in this chapter include information from Robert Wood Johnson Foundation's (RWJF) County Health Rankings, CDC WONDER, the CDC Behavior Risk Factor Surveillance System (BRFSS), the Maryland Youth Risk Behavior Survey & Youth Tobacco Survey (YRBS/YTS), the Maryland Cancer Prevention, Education, Screening and Treatment data, and the Pregnancy Risk Assessment Monitoring System (PRAMS), among other vital statistics.

We begin this chapter by describing Prince George's County's relative rankings within RWJF's County Health Rankings, which provide a high-level summary of health and well-being in the County. Next, we summarize indicators of health outcomes, focusing on the following topics:

- Life expectancy
- Leading causes of death
- Health status and chronic conditions
- Cancer screening, incidence, and mortality
- Disability
- Mental health

- Substance use disorder
- Sexual health
- Maternal and infant health

After that, we summarize indicators of well-being, inclusive of

- Health literacy
- Health behaviors
- Civic engagement

We end the chapter by sharing key themes that emerged during our stakeholder discussions related to health and well-being and synthesizing the available primary and secondary data.

County Health Rankings

RWJF began the County Health Rankings project in 2010 to monitor county health performance across the United States. Health indicators and social determinants are aggregated to rank counties within each state based on (1) health outcomes and (2) health factors. The health outcomes ranking is based on indices measuring length of life and quality of life. Length of life metrics include premature death, measured as years of potential life lost, life expectancy, and various mortality rates. Quality of life metrics "refer to how healthy people feel while alive" and include indicators of poor or fair health, poor physical health days, poor mental health days, low birthweight, frequent physical distress, frequent mental distress, diabetes prevalence, and HIV prevalence (County Health Rankings, 2019c). As illustrated by Table 3.1, Prince George's County ranked 11th of 24 counties in Maryland for health outcomes in 2019.

Table 3.1.
County Health Rankings by Health Outcomes, Length of Life, and Quality of Life, 2019

Health Outcomes		Length of Life		Quality of Life	
Rank	**County**	**Rank**	**County**	**Rank**	**County**
1	Montgomery	1	Montgomery	1	Montgomery
2	Howard	2	Howard	2	St. Mary's
3	Frederick	3	Frederick	3	Howard
4	Carroll	4	Carroll	4	Carroll
5	St. Mary's	5	Talbot	5	Calvert
6	Calvert	6	Harford	6	Queen Anne's
7	Queen Anne's	7	St. Mary's	7	Frederick
8	Anne Arundel	8	Anne Arundel	8	Anne Arundel
9	Talbot	9	Calvert	9	Talbot
10	Harford	**10**	**Prince George's**	10	Worcester
11	**Prince George's**	11	Queen Anne's	11	Harford
12	Charles	12	Kent	12	Baltimore
13	Baltimore	13	Charles	13	Charles
14	Kent	14	Garrett	**14**	**Prince George's**
15	Garrett	15	Baltimore	15	Cecil
16	Worcester	16	Washington	16	Washington
17	Washington	17	Caroline	17	Garrett
18	Cecil	18	Wicomico	18	Wicomico
19	Wicomico	19	Allegany	19	Kent
20	Allegany	20	Cecil	20	Allegany
21	Caroline	21	Dorchester	21	Caroline
22	Dorchester	22	Worcester	22	Dorchester
23	Somerset	23	Somerset	23	Somerset
24	Baltimore City	24	Baltimore City	24	Baltimore City

SOURCE: RWJF County Health Rankings, 2019.
NOTES: Possible ranking out of 24 counties in Maryland.

RWJF also ranks counties on "health factors," which are based on measures related to health behaviors, clinical care, social and economic factors, and the physical environment. Health behaviors are "actions individuals take that affect their health" and includes metrics on physical activity and actions related to chronic disease such as smoking, alcohol intake, and risky sexual behavior. Clinical care assesses a county's accessibility to affordable and quality health care. Subsequent chapters in this report focused on drivers of health will further describe the measures related to social and economic factors and the physical environment. In Table 3.2, we illustrate the County's rankings for health factors, health behaviors, and clinical care over time.

In 2019, Prince George's County was ranked as follows: health factors = 16th, health behaviors = 11th, and clinical care = 24th. Currently, Prince George's County is ranked last in the state for clinical care. This is primarily due to the County having the highest uninsurance rate in Maryland in 2019. These results are also driven by low rates of mammography screenings (36 percent screened in 2019) and low rates of flu vaccinations (37 percent vaccinated in 2019) in the County. Comparatively, the state-wide average rate for mammography screenings is 42 percent and the average rate for flu vaccinations is 48 percent.

Table 3.2.
County Health Rankings for Health Factors, Prince George's County 2010–2019

Year	Health Factors Rank	Health Behaviors Rank	Clinical Care Rank
2010	14	12	21
2011	18	12	22
2012	17	10	17
2013	17	9	20
2014	14	8	21
2015	15	9	23
2016	16	11	23
2017	16	11	23
2018	16	10	22
2019	16	11	24

SOURCE: RWJF County Health Rankings, 2019.
NOTES: Possible ranking out of 24 counties in Maryland.

Health outcomes

In the following section, we describe health outcomes of residents in Prince George's County. Some of this information has been presented elsewhere, including the 2019 Prince George's County Community Health Assessment (Prince George's County Health Department, 2019b). However, presenting similar information here, in a report focused on exploring the broad drivers of health, facilitates further connection between health and well-being and the drivers of health. To augment redundant information, we focus on comparisons across jurisdictions and comparisons within the County (e.g., across districts and across additional subgroups). This section includes discussion of the following health outcomes:

- Life expectancy
- Leading causes of death
- Health status and chronic conditions
- Cancer screening, incidence, and mortality
- Disability
- Mental health
- Substance use disorder
- Sexual health
- Maternal and infant health.

Life Expectancy

Years of potential life lost (YPLL) is used to measure premature death. Compared to mortality, it emphasizes deaths that could have been prevented. As illustrated in Table 3.3, Prince George's County has a lower overall rate of YPLL than the state and Baltimore County. However, both Howard and Montgomery counties have considerably lower rates of YPLL. Within Prince George's County, the YPLL rate was greater for Black residents than White and Hispanic residents.

Table 3.3.
Years of Potential Life Lost Rate per 100,000 by Jurisdiction and Race/Ethnicity, Pooled 2015–2017

	Prince George's County	Baltimore County	Howard County	Montgomery County	Maryland
YPLL Rate	6,862	7,783	4,222	4,099	7,067
YPLL Rate by Race/Ethnicity					
Black (B)	7,964	8,991	5,573	5,800	*
Hispanic (H)	3,964	3,863	2,728	3,397	*
White (W)	6,535	7,973	4,379	4,137	*
YPLL Ratio					
B:W Ratio	1.2	1.1	1.3	1.4	*
H:W Ratio	0.6	0.5	0.6	0.8	*

SOURCE: RWJF County Health Rankings, 2019.
NOTES: Raw data obtained from the National Center for Health Statistics Mortality Files 2015-2017. Table presents years of potential life lost before age 75 per 100,000 population (age-adjusted). YPLL, Years of Potential Life Lost. *Data not available.

Leading Causes of Death

In Table 3.4, we present the notable leading causes of death in Prince George's County in 2017, derived from the Centers for Disease Control and Prevention (CDC) WONDER Online Database. Compared to Maryland, the mortality rates in Prince George's County were higher for heart disease, cancer, stroke, diabetes, nephritis, septicemia, hypertension, and homicides. Within Prince George's County, heart disease and cancer were the primary causes of death in 2017. Additional exploration of mortality rates by race/ethnicity are presented in the 2019 Prince George's County Community Health Needs Assessment (Prince George's County Health Department, 2019b).

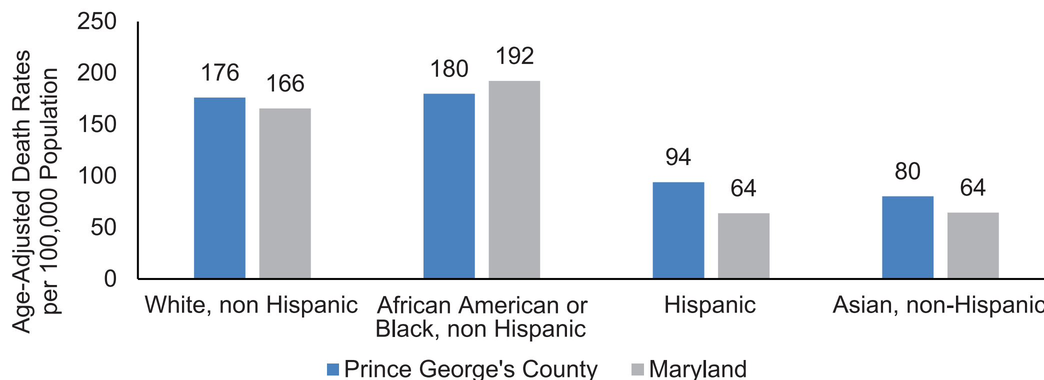
Table 3.4.
Leading Causes of Death, Rates per 100,000 Population, 2017

	Prince George's County	Maryland
All causes	712.5	718.1
Heart disease	167.5	164.5
Cancer	155.7	151.5
Stroke	46.7	40.2
Accidents	30.6	36.9
Diabetes	28.6	20.3
Chronic lower respiratory diseases	21.9	29.9
Nephritis	14.9	11.9
Alzheimer's disease	16.0	17.1
Septicemia	13.5	12.5
Hypertension	14.0	8.3
Influenza and pneumonia	14.0	14.0
Homicide	10.4	10.2
Liver disease	6.1	6.6
Suicide	6.5	9.8
Perinatal conditions	7.0	4.8

SOURCE: Centers for Disease Control and Prevention, 2019b.
NOTES: Data was accessed from CDC WONDER in 2019 and represents 2017. Rates are age-adjusted and presented per 100,000 population.

In the figures below, we describe mortality rates by race/ethnicity for the top two leading causes of death in the County: heart disease and cancer. Mortality rates for heart disease in the County were highest for Black residents (180 per 100,000) and White residents (176 per 100,000). The rates for White, Hispanic, and Asian residents were higher than the state rates for each of the aforementioned racial/ethnic group.

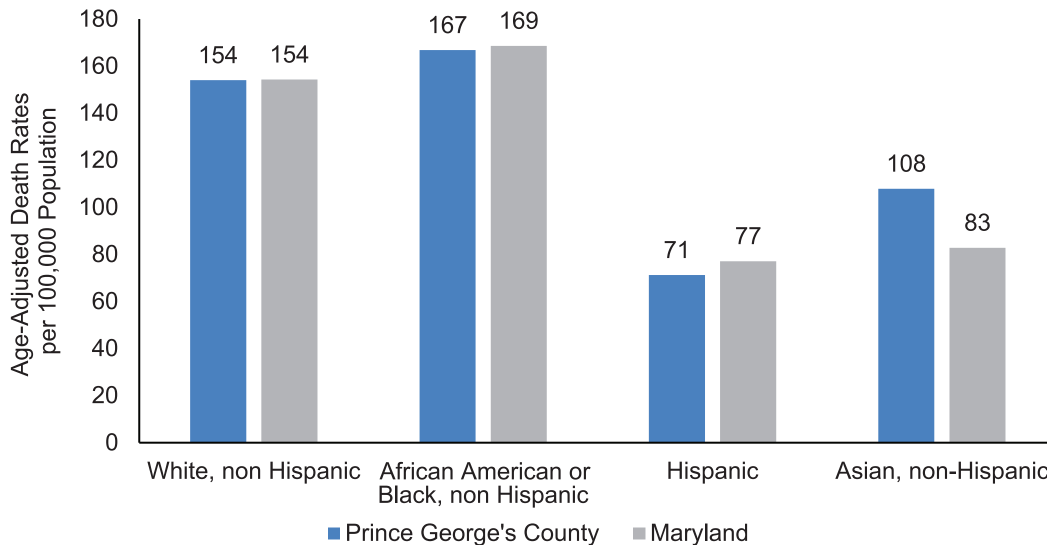
Figure 3.1.
Mortality Rates per 100,000 Population for Heart Disease, by Race/Ethnicity, 2017



SOURCE: Centers for Disease Control and Prevention, 2019b.
NOTES: Data was accessed from CDC WONDER in 2019 and represents 2017. Rates are age-adjusted and presented per 100,000 population.

Figure 3.2 presents mortality rates for malignant cancer by race/ethnicity in Prince George's County and Maryland. Mortality rates for malignant cancer in the County were highest for Black residents (167 per 100,000) and White residents (154 per 100,000). The rate for Asian residents was higher in the County (108 per 100,000) than the state rate (83 per 100,000).

Figure 3.2.
Mortality Rates per 100,000 Population for Malignant Cancer by Race/Ethnicity, 2017



SOURCE: Centers for Disease Control and Prevention, 2019b.
NOTES: Data was accessed from CDC WONDER in 2019 and represents 2017. Rates are age-adjusted and presented per 100,000 population.

Health Status and Chronic Conditions

Health conditions are considered chronic if they are long lasting, generally lasting at least three months and often more than one year. Chronic health conditions may require ongoing medical care, medication, and limit usual activities. Engaging in healthy behaviors (e.g., healthy diet, exercise, and not smoking) can prevent many chronic conditions (National Center for Chronic Disease Prevention and Health Promotion, 2019). Drivers of health, such as those that are part of the built environment (e.g., walkability, parks, food deserts) affect these healthy behaviors and therefore have an impact on the development of chronic conditions.

Below, we present self-reported information about adults' health status on chronic conditions from the BRFSS. We examine the chronic conditions described in Figure 3.3. Of note, we describe the prevalence of mental health and substance use disorders within their own sections later in this chapter. We compare rates in Prince George's County to nearby jurisdictions and also compare rates within Prince George's County by subgroup. Specifically, we compare rates across demographic categories: age group, sex, race/ethnicity. Additionally, we compare rates across socioeconomic characteristics (educational attainment and household income) and having a personal doctor. We offer these comparisons across socioeconomic characteristics because research suggests that adults with more education are healthier than adults with less education, and adults with higher incomes are healthier than adults with lower incomes

(Ettner, 1996; Zimmerman, Woolf, & Haley, 2015). Further, we present results stratified for adults with and without a personal doctor because access to primary health care and having a medical home is a known challenge in the County Assessment (Prince George's County Health Department, 2019b).

Figure 3.3.
Descriptions of Chronic Conditions

Condition	Description	Prevention & Treatment
Arthritis	• Inflammation of joint tissue, causing pain and stiffness. • **Prevalence:** About 23 percent of adults in the United States have diagnosed arthritis, with prevalence increasing in older age.*	• Healthy diet and regular exercise can help prevent arthritis, but may be unavoidable. • Medications, physical therapy, or surgery can reduce symptoms.
Asthma	• Chronic disease of the lungs causing inflammation of the airways, making it difficult to breathe. • **Prevalence:** About 8 percent of adults and 8 percent of children in the United States currently have asthma.*	• Cannot be prevented. • Symptoms are managed with inhalers and oral steroids.
Cardiovascular disease	• Describes group of conditions related to the heart and blood vessels (e.g., heart attack, stroke, hypertension). • **Prevalence:** Leading cause of death in the United States. About 47 percent of adults have risk factors for it.	• Prevention and treatment include avoiding risk factors of smoking, unhealthy diet, and lack of exercise. • Medication can also be prescribed.
COPD	• Chronic obstructive pulmonary disease refers to inflammatory diseases that cause obstructed airflow from the lungs and can damage lung tissue. • **Prevalence:** About 13 percent of adults in the United States.**	• Inhalers and oral steroids can help with symptom management.
Diabetes	• Group of diseases that cause too much sugar to enter the blood stream. • **Prevalence:** About 15 percent of adults in the United States.***	• Type I is not preventable. • Type II prevention (and treatment) includes exercise, weight management, and a healthy diet. • Treatments for both include insulin intake and blood sugar monitoring.
High cholesterol	• High amounts of LDL cholesterol can reduce blood flow and increase risk of cardiovascular disease. • **Prevalence:** About 12 percent of adults in the United States.***	• Prevention and treatment include healthy diet (avoiding saturated fats), regular exercise, avoiding smoking and alcohol. • Medication can also be prescribed.
Hypertension	• High blood pressure above 130/80, which increases risk of heart attack and stroke. • **Prevalence:** About 33 percent of adults in the United States.***	• Prevention and treatment include healthy diet (avoiding saturated fats), regular exercise, avoiding smoking and alcohol. • Medication can also be prescribed.

NOTES: *Prevalence estimates from the National Health Interview Survey. **Prevalence estimates from the BRFSS. ***Prevalence estimates from the National Health and Nutrition Examination Survey.

In 2017, County adults had similar self-rated health as other jurisdictions and the state (Table 3.5). However, County adults had higher rates of cardiovascular disease and diabetes than the state and nearby counties.

Table 3.5.
Self-Reported Health Status for Adults, by Jurisdiction, 2017

Measure	Prince George's County	Baltimore County	Howard County	Montgomery County	Maryland
Self-rated health: Excellent, very good, or good	83.8	83.8	93.8	86.5	84.9
Diagnosed arthritis	23.4	23.5	19.4	16.1	22.9
Diagnosed asthma	9.6	11	8.7	6.6	9.7
Diagnosed COPD	6.1	6.9	3.2	3.2	5.3
Diagnosed hypertension	31.9	32.1	24.5	25.3	30.6
Diagnosed cardiovascular disease	8.7	6.8	4.4	3.8	7.0
Diagnosed diabetes	12.3	9.1	7.3	7.5	9.6
Diagnosed high cholesterol	27.6	27.4	29.5	31.9	29.0

SOURCE: 2017 BRFSS.
NOTES: All rates are age-adjusted unless otherwise indicated. *Indicates crude rate. Diagnosed hypertension excludes borderline hypertension and women diagnosed only during pregnancy. Diagnosed cardiovascular disease includes coronary heart disease, heart attack, and stroke. Diagnosed diabetes women diagnosed only during pregnancy. COPD, chronic obstructive pulmonary disease.

In 2017, more than half of adults aged 65 years and older in the County reported having arthritis and high cholesterol and 70 percent had hypertension (Table 3.6). Adults without a personal doctor were less likely to rate their health as excellent, very good or good.

Table 3.6.
Self-Reported Health Status for Adults in Prince George's County, 2017

	Self-rated health: excellent, very good, or good	Diagnosed Arthritis	Diagnosed Asthma	Diagnosed COPD
Overall	83.8	23.4	9.6	6.1
Demographics				
Age group*				
18 - 64	86.5	17.6	9.4	4.2
65 and older	71.2	55.4	9.8	16.3
Sex				
Female	83.8	26.7	12.6	6.0
Male	84.1	20.2	5.8	6.4
Race				
White, non-Hispanic	90.0	23.0	9.1	NA
Black, non-Hispanic	86.2	23.4	11.1	5.1
Hispanic	71.3	29.6	NA	NA
Socioeconomic characteristics				
Educational attainment				
Above high school	89.2	20.7	11.3	4.3
High school or less	75.7	28.4	7.7	10.0
Household income				
$50k and above	93.6	23.2	12.6	2.6
Below $50k	71.0	25.1	8.5	10.5
Has a personal doctor				
Has a personal doctor	86.9	24.0	11.7	5.9
No personal doctor	73.1	22.3	NA	NA

SOURCE: 2017 BRFSS.
NOTES: All rates are age-adjusted unless otherwise indicated. *Indicates crude rate. NA, indicates the rate was not available due to small sample size. COPD, chronic obstructive pulmonary disease.

In 2017, Black and Hispanic adults reported higher rates of hypertension and diabetes than White adults (Table 3.7). Adults without a personal doctor had lower rates of diagnosed hypertension and diagnosed high cholesterol than adults with a personal doctor, however, rather than reflecting better health, this may be reflecting lack of a diagnosis due to poor access to medical care. For example, undiagnosed hypertension has been identified as a problem among immigrants in the United States with poor access to health care (Zallman et al., 2013).

Table 3.7.
Self-Reported Health Status for Adults in Prince George's County, 2017

	Diagnosed Hypertension	Diagnosed Cardiovascular Disease	Diagnosed Diabetes	Diagnosed High Cholesterol
Overall	31.9	8.7	12.3	27.6
Demographics				
Age group*				
18 - 64	25.0	5.9	9.4	24.8
65 and older	70.0	22.9	28.7	51.3
Sex				
Female	31.1	7.3	12.0	29.3
Male	32.8	10.6	13.0	26.1
Race				
White, non-Hispanic	28.3	9.5	10.5	36.0
Black, non-Hispanic	34.2	7.3	13.6	26.1
Hispanic	34.6	18.4	16.7	31.3
Socioeconomic characteristics				
Educational attainment				
Above high school	30.5	7.1	12.3	26.0
High school or less	35.2	11.3	12.8	31.0
Household income				
$50k and above	32.9	7.0	10.7	26.7
Below $50k	30.8	10.7	15.3	29.1
Has a personal doctor				
Has a personal doctor	32.5	7.8	13.0	28.9
No personal doctor	27.5	NA	NA	23.1

SOURCE: 2017 BRFSS.
NOTES: All rates are age-adjusted unless otherwise indicated. *Indicates crude rate. NA, indicates the rate was not available due to small sample size. Diagnosed hypertension excludes borderline hypertension and women diagnosed only during pregnancy. Diagnosed cardiovascular disease includes coronary heart disease, heart attack, and stroke. Diagnosed diabetes women diagnosed only during pregnancy.

Cancer Screening, Incidence, and Mortality

In this section, we describe rates of cancer screening, incidence, and mortality. Cancer screening can facilitate early diagnosis of cancer, which is important because cancers that are detected earlier may be easier to treat and therefore have lower mortality. Despite the benefits of early detection, barriers to cancer screening persist, including lack of a usual medical provider, lack of insurance, inaccurate perception of cancer risk, and general fear of a cancer diagnosis (Guessous et al., 2010; Young & Severson, 2005). Known behavioral risk factors for cancer include smoking, excessive drinking, lack of exercise, and obesity (National Cancer Institute, 2019).

Below, we present self-reported information about cancer screening for adults using the 2016 BRFSS, the most recent version of the survey to capture information about cancer screening. We compare screening rates in Prince George's County to nearby jurisdictions and also compare rates within Prince George's County by subgroup. Specifically, we compare rates by race/ethnicity, socioeconomic characteristics (educational attainment and household income), and having a personal doctor. Then, we use data from the Maryland Cancer Prevention, Education, Screening and Treatment Program to describe cancer incidence and mortality by site, over time, and by jurisdiction.

Cancer screening

In 2016, Prince George's County had slightly higher cancer screening rates compared to the state for prostate, colorectal, and breast cancers, and slightly lower screening rate for cervical cancer (Table 3.8).

Table 3.8.
Self-Reported Cancer Screening for Adults in Prince George's County, 2016

	Prince George's County	Baltimore County	Howard County	Montgomery County	Maryland
Mammogram in last 2 years, women aged 50 and older*	82.8	76.3	85.2	77.6	79.2
Pap smear in last 3 years, women aged 21 - 65*	77.2	80.0	76.4	82.9	80.6
Colorectal cancer screening, men and women aged 50 - 75	70.5	71.2	67.7	70.2	69.7
PSA test in last 2 years, men aged 40 and older	41.4	39.5	37.7	37.2	38.1

SOURCE: Maryland Department of Health Query System, 2017.
NOTES: All rates are age-adjusted unless otherwise indicated. PSA, Prostate-Specific Antigen test. *Indicates crude rate.

Table 3.9 compares cancer screening rates for subgroups within Prince George's County. Black men and women had higher rates of cancer screening than White residents. Rates of cancer screening were lower among populations with less education, lower household incomes, and those without a personal doctor.

Table 3.9.
Self-Reported Cancer Screening for Adults in Prince George's County, 2016

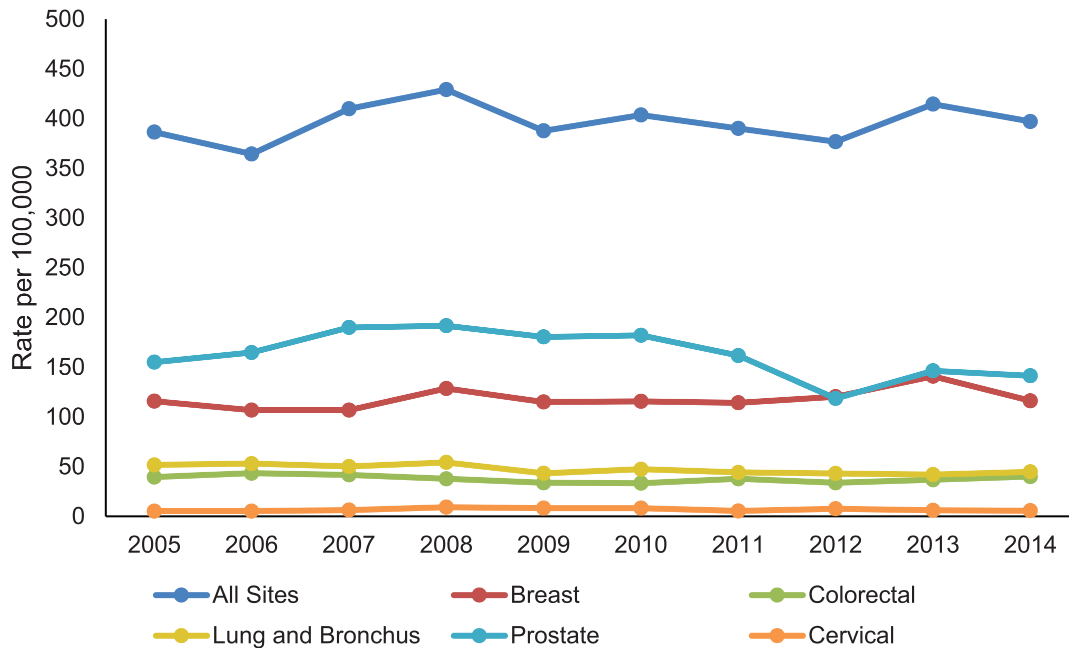
	Mammogram in last 2 years, women aged 50 and older*	Pap smear in last 3 years, women aged 21 - 65*	Colorectal cancer screening, men and women aged 50 - 75	PSA test in last 2 years, men aged 40 and older
Overall	82.8	77.2	70.5	41.4
Demographics				
Race				
White, non-Hispanic	67.9	68.6	66.1	36.7
Black, non-Hispanic	89.6	83.0	72.2	45.6
Hispanic	NA	67.9	NA	NA
Socioeconomic characteristics				
Educational attainment				
Above high school	83.4	80.7	74.0	42.5
High school or less	81.2	70.1	62.5	39.6
Household income				
$50k and above	83.0	84.9	77.0	45.3
Below $50k	80.8	68.1	55.9	33.9
Has a personal doctor				
Has a personal doctor	83.1	79.9	74.8	46.2
No personal doctor	NA	58.2	23.9	NA

SOURCE: 2016 BRFSS.
NOTES: All rates are age-adjusted unless otherwise indicated. *Indicates crude rate. NA, indicates the rate was not available due to small sample size. PSA, Prostate-Specific Antigen test.

Cancer incidence

Figure 3.4 illustrates cancer incidence over time in Prince George's County by site of where the cancer developed. Of note, age-adjusted rates of prostate cancer in Prince George's County reached a low of 118.5 per 100,000 in 2012, however, rates increased to 141.3 per 100,000 in 2014. Additionally, breast cancer incidence declined from in 140.9 per 100,000 in 2013 to 116.2 per 100,000 in 2014.

Figure 3.4.
Cancer Age-Adjusted Incidence Rates per 100,000 by Site, Prince George's County, 2005–2014



SOURCE: Maryland Cancer Prevention, Education, Screening and Treatment Program, 2017.
NOTES: 2006 incidence rates are lower than actual due to case underreporting.

When comparing cancer incidence in Prince George's County to Maryland and the United States (Table 3.10), we find that overall rates were comparatively lower in Prince George's County (396.5 per 100,000). However, incidence of prostate cancer was considerably higher in Prince George's County (149.2 per 100,000) than rates observed in Maryland (125.4 per 100,000) or the United States (116.1 per 100,000).

Table 3.10.
Cancer Age-Adjusted Incidence Rates per 100,000 Population by Site, 2010–2014

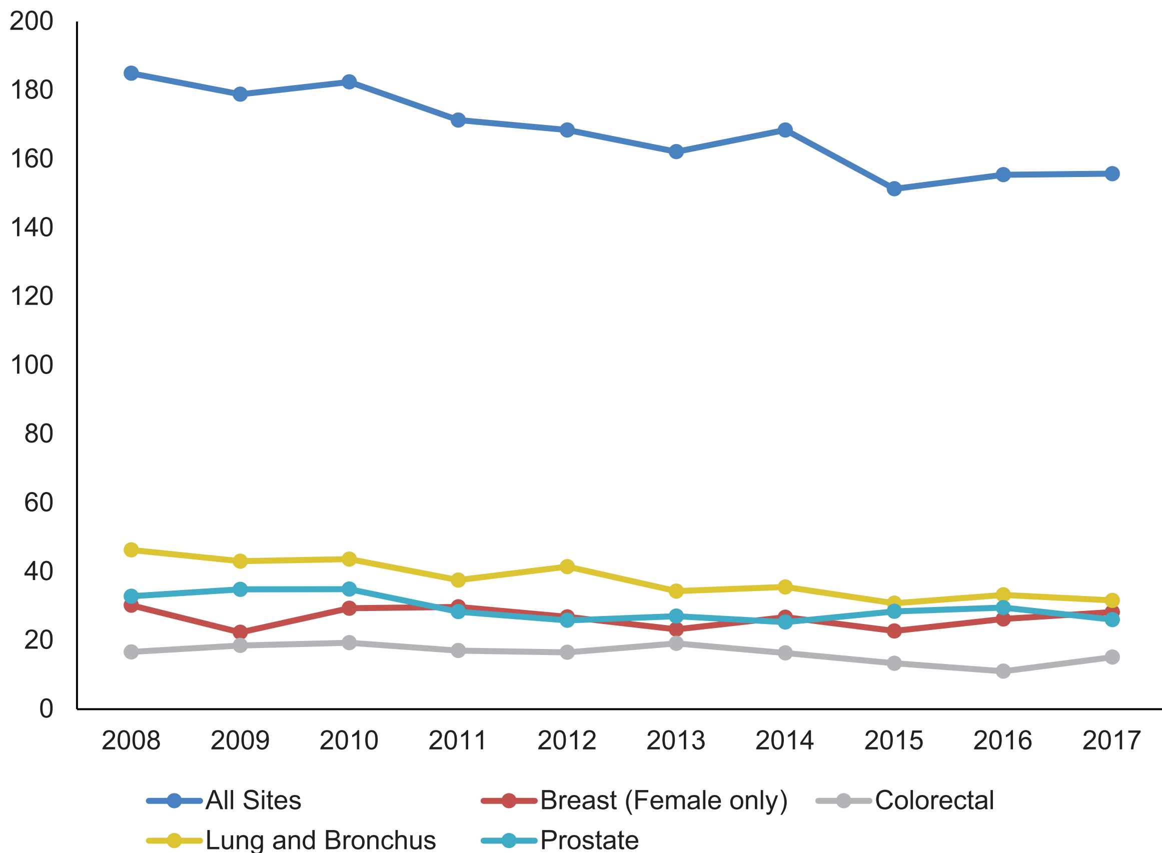
Site	Prince George's	Maryland	United States	HP 2020 Goal
All Sites	396.5	443.4	454.9	*
Breast (Female)	121.7	129.2	124.1	*
Colorectal	36.3	36.7	40.0	39.9
Male	42.8	41.8	46.0	*
Female	31.6	32.7	34.9	*
Lung and Bronchus	44.2	56.6	61.5	*
Male	52.7	64.6	73.0	*
Female	38.0	50.7	52.9	*
Prostate	149.2	125.4	116.1	*
Cervical	6.6	6.4	7.6	7.2

SOURCE: Maryland Cancer Prevention, Education, Screening, and Treatment Program, 2017.
NOTES: Raw data obtained from National Center for Health Statistics CDC WONDER Online Database. HP 2020 Goal, indicates the Healthy People 2020 goal which serves as a federal benchmark for improving health. *No HP 2020 goal specified.

Cancer mortality

Figure 3.5 illustrates cancer mortality rates over time in Prince George's County by site of where the cancer developed. Of note, the breast cancer mortality rate increased from 22.7 per 100,000 in 2015 to 25.8 in 2017. Higher cancer mortality rates could be driven by poorer access to timely health care, which leads to delays in diagnosis and treatment.

Figure 3.5.
Cancer Age-Adjusted Mortality Rates per 100,000 by Site, Prince George's County, 2008–2017



SOURCE: Maryland Cancer Prevention, Education, Screening, and Treatment Program, 2017.
NOTES: Raw data obtained from National Center for Health Statistics WONDER Online Database. Cervical cancer statistics not included due to insufficient numbers.

When comparing cancer mortality rates in Prince George's County to Maryland and the United States (Table 3.11), we find that mortality rates for breast cancer, cervical cancer, and prostate cancer are higher in Prince George's County than in Maryland and the United States.

Table 3.11.
Cancer Age-Adjusted Mortality Rates per 100,000 by Site and Sex, Pooled 2015–2017

Site	Prince George's	Maryland	United States	HP 2020 Goal
All Sites	154.1	154.3	155.5	161.4
Breast (Female)	25.8	21.5	20.1	20.7
Colorectal	13.2	13.19	13.9	14.5
Male	16.5	16.3	16.5	*
Female	10.9	12.0	11.9	*
Lung and Bronchus	31.9	37.0	38.5	45.5
Male	38.0	44.1	46.8	*
Female	27.3	31.8	32.0	*
Prostate	27.9	20.3	20.3	21.8
Cervical	2.6	1.9	1.9	2.2

SOURCE: Maryland Cancer Prevention, Education, Screening, and Treatment Program, 2017.
NOTES: HP 2020 Goal, indicates the Healthy People 2020 goal which serves as a federal benchmark for improving health. *No HP 2020 goal specified.

Disability

The CDC defines disability as "any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions)" (Centers for Disease Control and Prevention, 2019). This expansive definition identifies a broad group of individuals with diverse health needs. Research suggests that individuals with disabilities encounter unique barriers to health care, including inadequate accommodations such as those for patients who are deaf, offices that are inaccessible or lack adaptive equipment, and providers' misconceptions about people with disabilities (Drainoni et al., 2006).

Below, we present self-reported information about the disability status of adults from the BRFSS. We compare rates in Prince George's County to nearby jurisdictions and also compare rates within Prince George's County by subgroup. Specifically, we compare rates by demographics, socioeconomic characteristics, and having a personal doctor.

In 2017, nearly one in four adults in Prince George's County reported having one or more disabilities (Table 3.12). Adults most commonly reported mobility disabilities (13.2 percent) and cognitive disabilities (8.5 percent). Women were more likely than men to report having any disability, and men were more likely to report having a hearing disability. Disabilities were more common among adults with less education and adults in households with incomes less than $50,000. The County had higher rates of adults with disabilities compared to the state and neighboring counties, driven primarily by having higher rates of adults with mobility disabilities.

Table 3.12.
Self-Reported Disability Status for Adults, by Jurisdiction, 2017

	Prince George's County	Baltimore County	Howard County	Montgomery County	Maryland
Has one or more disabilities	24.0	21.3	14.8	16.4	21.7
Type of disability					
Vision	5.0	3.0	NA	2.5	3.6
Cognitive	8.5	10.6	NA	5.8	8.9
Mobility	13.2	10.8	6.5	7.2	10.6
Self-Care	4.3	3.7	NA	1.7	3.0
Independent living	6.0	6.9	NA	3.5	5.7
Hearing	4.9	3.2	3.5	4.8	4.8

SOURCE: Maryland Department of Health Dataset Query System, 2017.
NOTES: All rates are age-adjusted unless otherwise indicated.

Table 3.13 compares disability rates for subgroups within Prince George's County. Hispanic adults reported the highest rate of disabilities overall (42.1 percent) and had the highest rate of mobility disabilities (27.1 percent). Reporting a mobility disability was more common among adults who were less educated and lived in lower income households.

Table 3.13.
Self-Reported Disability Status for Adults in Prince George's County, 2017

	Has one or more disabilities	Type of Disability					
		Vision	Cognitive	Mobility	Self-Care	Independent living	Hearing
Overall	24.0	5.0	8.5	13.2	4.3	6.0	4.9
Demographics							
Age group*							
18-64	21.6	4.5	8.9	10.5	3.3	4.8	4.4
65 and older	36.1	NA	5.2	26.7	NA	12	7.2
Sex							
Female	26.8	NA	12.2	16.1	NA	6.5	2.5
Male	20.8	NA	NA	9.8	NA	5.3	7.2
Race							
White, non-Hispanic	23.8	NA	11.3	7.9	NA	NA	NA
Black, non-Hispanic	20.5	NA	7.0	11.3	3.5	4.4	2.1
Hispanic	42.1	NA	NA	27.1	NA	18.9	NA
Socioeconomic characteristics							
Educational attainment							
Above high school	16.3	NA	4.3	9.1	NA	4.5	3.3
High school or less	36.8	9.7	13.9	20.1	7.1	7.8	NA
Household income							
$50k and above	13.9	NA	NA	7.5	NA	NA	NA
Below $50k	37.2	NA	13.0	21.5	7.3	9.1	NA

SOURCE: Maryland Department of Health Dataset Query System, 2017.
NOTES: All rates are age-adjusted unless otherwise indicated. *Indicates crude rate. NA, indicates the rate was not available due to small sample size.

Mental Health

Mental health is the term used to describe overall psychological well-being. It is key to overall health as it affects personal relationships, response to stress, and decision-making. Mental health conditions can be diagnosed (e.g., depression, anxiety, bipolar disorder, or schizophrenia) and may be acute or chronic. Additionally, mental health conditions are common, as more than half of individuals will be diagnosed with one during their lifetime (Kessler et al., 2007) and one in 25 Americans has a serious mental illness (Bose et al., 2016).

Below, we present self-reported information about adult mental health from the BRFSS. We compare rates in Prince George's County to nearby jurisdictions and also compare rates within Prince George's County by subgroup. Specifically, we compare rates by demographics, socioeconomic characteristics, and having a personal doctor. Additionally, we present self-reported information on bullying experiences and suicidality among adolescents and teens from the Youth Tobacco and Risk Behavior Survey. We use this survey to present trends over time in the County and to compare rates in the County and the state. Information about health care utilization related to mental health, including emergency department visits and hospitalizations, is included in the next chapter.

In 2017, self-reported indicators of the mental health burden for adults in Prince George's County were lower than compared to the state and nearby counties; that is, fewer adults in the County reported being diagnosed with depressive disorder than in other nearby counties or the state (Table 3.14).

Table 3.14.
Self-Reported Mental Health for Adults, by Jurisdiction, 2017

Measure	Prince George's County	Baltimore County	Howard County	Montgomery County	Maryland
Diagnosed depressive disorder	10.1	19.3	14.3	16.8	17.9
Reported days of "not good" mental health past 30 days					
8 to 29 days	8.8	9.1	7.5	10.1	10.1
30 days	3.9	6.2	NA	3.0	5.4

SOURCE: Maryland Department of Health Dataset Query System, 2017.
NOTES: All rates are age-adjusted unless otherwise indicated. NA, indicates the rate was not available due to small sample size.

When examining the self-reported mental health of adults by subgroup within the County, White and Hispanic adults were more likely to report more days of "not good" mental health (Table 3.15). Additionally, rates of diagnosed depressive disorder were higher among individuals with household incomes less than $50,000.

Table 3.15.
Self-Reported Mental Health for Adults in Prince George's County, 2017

	Diagnosed depressive disorder	Reported days of "not good" mental health past 30 days	
		8 to 29 days	30 days
Overall	10.1	8.8	3.9
Demographics			
Age group*			
18-64	9.6	8.7	4.1
65 and older	13.0	8.8	NA
Sex			
Female	14.0	11.0	3.2
Male	5.8	6.6	4.7
Race			
White, non-Hispanic	19.0	17.1	NA
Black, non-Hispanic	9.0	8.9	3.5
Hispanic	17.7	NA	NA
Socioeconomic characteristics			
Educational attainment			
Above high school	10.6	9.5	3.6
High school or less	10.4	8.1	NA
Household income			
$50k and above	6.6	7.5	NA
Below $50k	16.1	10.2	NA

SOURCE: 2017 BRFSS.
NOTES: All rates are age-adjusted unless otherwise indicated. *Indicates crude rate. NA, indicates the rate was not available due to small sample size.

In 2016, the rates of students seriously considering suicide were 23.5 percent for middle school students and 17.7 percent for high school students in the County (Table 3.16). These rates were higher than the state average and higher than the County rates in 2014. Almost one in three high school students reported feeling sad or hopeless frequently, which was slightly higher than the state average in that same year (29.9 percent) and higher than the County rate in 2014 (26.8 percent). Regarding bullying, almost one in four middle school students in the County reported being bullied on school property; comparatively, bullying was reported by fewer high school students (14.5 percent). Rates of reported bullying were lower in the County than the state averages.

Table 3.16.
Percentage of Middle School and High School Students Reporting Bullying and Suicidality, Prince George's County and Maryland, 2013–2016

	2013		2014		2016	
	PG	MD	PG	MD	PG	MD
Suicidality						
Middle School						
Tried to kill themselves	+	+	+	+	11.5	8.5
Seriously thought about killing themselves	24.7	19.1	22.5	17.6	23.5	21.3
High School						
Seriously considered attempting suicide	17	16	14.7	15.9	17.7	17.3
Felt sad or hopeless frequently	29.8	27	27.3	26.8	31.5	29.9
Bullying						
Middle School						
Been bullied on school property	36.6	43	37	40.9	24.1	28.2
Been electronically bullied	14.7	19.4	16	19.7	13.3	15.4
High School						
Been bullied on school property	15.9	19.6	17.7	17.7	14.5	18.2
Been electronically bullied	10.7	14.0	9.9	13.8	10.5	14.1

SOURCE: Maryland Department of Health, 2017.
NOTES: Data obtained from the YRBS/YTS. + Indicates data unavailable.

Substance Use Disorder

Substance use disorder refers to the dependence on drugs or alcohol that leads to clinical and functional impairments. Individuals dependent on drugs or alcohol experience health problems and often struggle to meet basic responsibilities at school, work, or home. Thus, families, as well as individuals, experience negative consequences. In 2017, more than one in ten Americans aged 12 years and older used an illicit drug in the past month (National Center for Health Statistics, 2018). Co-occurring mental illness and substance use disorders are common, with 9.2 million U.S. adults diagnosed with both in 2018 (Substance Abuse and Mental Health Services Administration, 2019).

Below, we present self-reported information about various forms of substance use. First, we summarize findings on binge drinking by adults, using BRFSS data. We compare rates in Prince George's County to nearby jurisdictions and also compare rates within Prince George's County by subgroup. Then, we use data from the Maryland Department of Health to describe drug and alcohol-related intoxication deaths over time in the County and state by type of drug. Additionally, we use data from the Prince George's County Fire and Emergency Medical Services (EMS) Department counts of EMS responses for overdoses and use of Naloxone to reverse opioid overdoses, specifically. Information about health care utilization related to substance use, including emergency department visits and hospitalizations, is included in the next chapter on health care services.

In 2017, 12.8 percent of adults in Prince George's County reported binge drinking, which is lower than the rates in nearby counties and the state (Table 3.17). Rates of binge drinking were higher for men and higher for White and Hispanic adults compared to Black adults. Rates of binge drinking were higher among more educated adults and adults with higher incomes (Table 3.18).

Table 3.17.
Self-Reported Binge Drinking by Adults, by Jurisdiction, 2017

	Prince George's	Baltimore County	Howard County	Montgomery County	Maryland
Binge drinking	12.8	17.8	17.4	14.2	16.4

SOURCE: 2017 BRFSS.
NOTES: All rates are age-adjusted unless otherwise indicated. Binge drinking is defined as drinking 5 or more drinks on an occasion for men or 4 or more drinks on an occasion for women.

Table 3.18.
Self-Reported Binge Drinking by Adults in Prince George's County, 2017

	Binge drinking
Overall	12.8
Demographics	
Age group*	
18-64	14.6
65 and older	NA
Sex	
Female	9.7
Male	16.2
Race	
White, non-Hispanic	17.3
Black, non-Hispanic	10.9
Hispanic	19.5
Socioeconomic characteristics	
Educational attainment	
Above high school	14.1
High school or less	12.5
Household income	
$50k and above	15.1
Below $50k	13.0
Has a personal doctor	
Has a personal doctor	13.2
No personal doctor	15.1

SOURCE: 2017 BRFSS.
NOTES: All rates are age-adjusted unless otherwise indicated. Binge drinking is defined as drinking 5 or more drinks on an occasion for men or 4 or more drinks on an occasion for women. +Other categories of physical activity include highly active, active, and insufficiently active. *Indicates crude rate. NA, indicates the rate was not available due to small sample size.

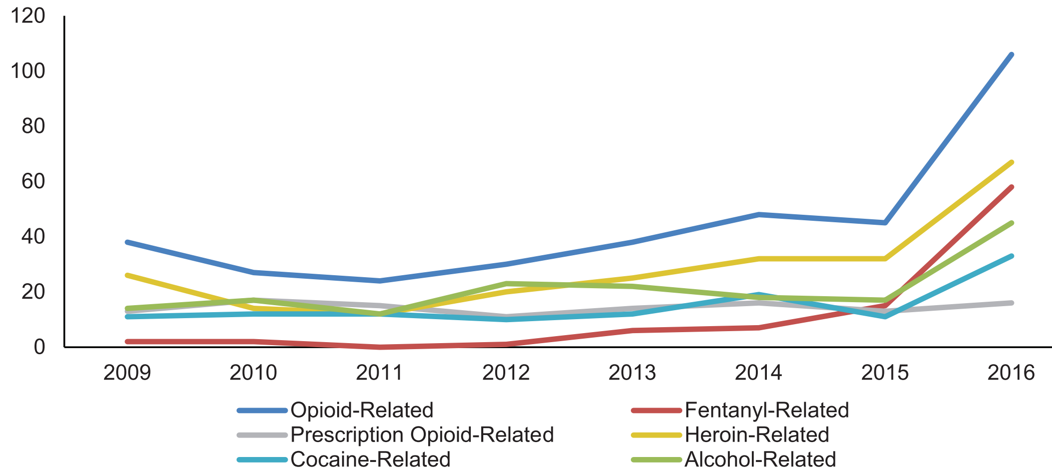
Drug and alcohol-related intoxication deaths are increasing in Prince George's County and in Maryland (Table 3.19). Drug and alcohol-related intoxication deaths in Prince George's County increased from 53 in 2007 to 167 in 2017, representing an increase of 215 percent (Figure 3.6). Opioid-related intoxication deaths are a leading cause of overall intoxication deaths. Opioid-related intoxication deaths increased from 27 in 2007 to 124 in 2017, representing an increase of 359 percent. Fentanyl-related intoxication deaths (fentanyl is a deadly opioid synthetic) were relatively rare before 2015 (accounting for fewer than 10 deaths per year) but increased to 103 deaths in 2017.

Table 3.19.
Drug and Alcohol-Related Intoxication Deaths in Prince George's County and in the Entire State of Maryland, 2007–2018 and up to March 2019

	Drug and Alcohol-Related		Opioid-Related		Fentanyl-Related		Heroin-Related	
	PG	MD	PG	MD	PG	MD	PG	MD
2007	53	815	27	628	1	26	20	399
2008	58	694	33	523	0	25	24	289
2009	59	731	38	570	2	27	26	360
2010	43	649	27	504	2	39	14	238
2011	42	671	24	529	0	26	12	247
2012	56	799	30	648	1	29	20	392
2013	59	858	38	729	6	58	25	464
2014	63	1,041	48	888	7	186	32	578
2015	70	1,259	45	1,089	15	340	32	748
2016	129	2,089	106	1,856	58	1,119	67	1,212
2017	167	2,282	124	2,009	103	1,594	52	1,078
2018*	127	2,420	94	2,144	75	1,888	44	831
2019 YTD*	21	577	14	515	14	474	7	188

SOURCE: Maryland Department of Health, 2019b.
NOTES: Includes deaths that were the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, cocaine, prescription opioids, benzodiazepines, and other prescribed and unprescribed drugs. Includes only deaths for which the manner of death was classified as accidental or undetermined. *Counts for 2018 and 2019 are not complete.

Figure 3.6.
Drug and Alcohol-Related Intoxication Deaths in Prince George's County, Maryland, 2007–2017



SOURCE: Maryland Department of Health, 2019b.
NOTES: Includes deaths that were the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, cocaine, prescription opioids, benzodiazepines, and other prescribed and unprescribed drugs. Includes only deaths for which the manner of death was classified as accidental or undetermined.

The number of EMS responses for overdoses declined slightly from 1,054 in 2017 to 1,004 in 2018 (Table 3.20). This decline was primarily driven by a decline in District 6, a district that reported 36 fewer EMS responses for overdoses from 2017 to 2018.

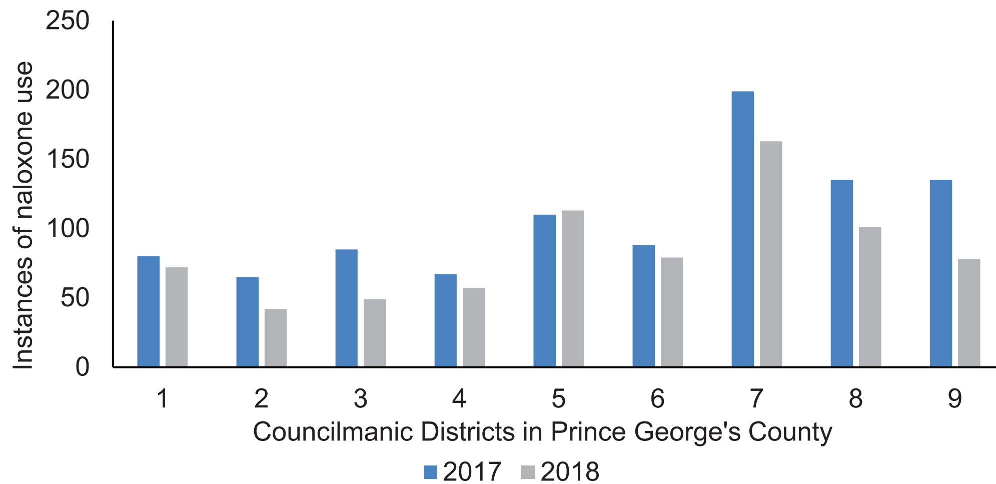
Table 3.20.
EMS Responses for Overdoses in Prince George's County, by District and Year

	County Councilmanic Districts									
	PG	1	2	3	4	5	6	7	8	9
2017	1,054	106	85	145	93	111	127	168	119	94
2018	1,004	90	105	132	84	122	91	151	125	104

SOURCE: Prince George's County Fire and Emergency Medical Services Department, 2019.
NOTES: Data was provided by the Fire and Emergency Medical Services Department and is not available publicly.

Naloxone is used to reverse an opioid overdose. Use of naloxone by the Prince George's County Fire and EMS Department declined from 974 in 2017 to 754 in 2018. All districts experienced a decline in use of naloxone by the Fire and EMS Department, except District 5, which had a slight increase from 110 in 2017 to 113 in 2018 (Figure 3.7).

Figure 3.7.
Naloxone Use in Prince George's County, by District and Year



SOURCE: Prince George's County Fire and Emergency Medical Services Department, 2019.
NOTES: Data was provided by the Fire and Emergency Medical Services Department and is not available publicly.

Sexual health

The numbers of cases of chlamydia, gonorrhea and syphilis in Prince George's County have increased over time (Table 3.21). Chlamydia is the most common bacterial sexually transmitted infection in the United States. and Prince George's County. Chlamydia can cause negative outcomes, including tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain (Genuis & Genuis, 2004). Across Maryland, the highest rates of chlamydia per 100,000 population were observed in Baltimore City (1,189), Somerset (877.1), and Prince George's (742.5) (Table 3.22).

Table 3.21.
Number of Sexually Transmitted Infections, Prince George's County, 2015–2018

	2015	2016	2017	2018
Chlamydia	6,153	6,752	7,365	8,013
Gonorrhea	1,282	1,832	2,001	2,020
Syphilis*	81	110	143	153

SOURCE: Infectious Disease Bureau, Prevention and Health Promotion Administration, Maryland Department of Health.
NOTE: *Includes both Primary and Secondary Syphilis.

Table 3.22.
Chlamydia Infections by County, 2016

	Prince George's County	Baltimore County	Howard County	Montgomery County	Maryland
# Chlamydia Cases	6,753	4,190	948	3,428	30,658
Chlamydia Rate Per 100,000	742.5	504.1	302.5	329.6	510.4

SOURCE: RWJF County Health Rankings, 2019.
NOTES: Raw data obtained from the 2016 National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Number of newly diagnosed chlamydia cases per 100,000 population.

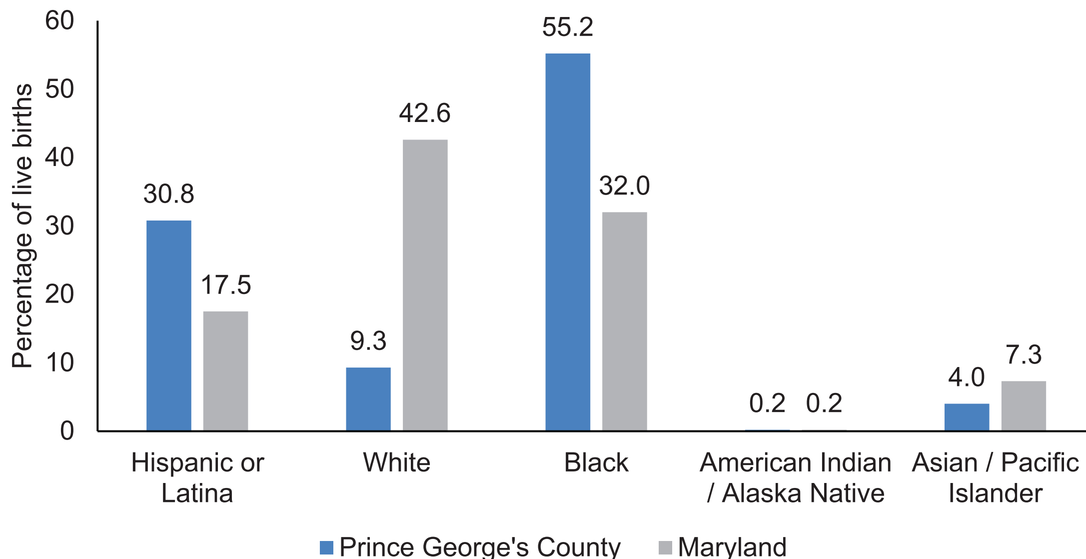
Maternal and Infant Health

There is a strong link between maternal health and perinatal health outcomes (Bhutta, Lassi, Blanc, & Donnay, 2010). For example, pregnant women who smoke or have inadequate nutrition have a higher risk of having infants with cognitive, behavioral, and physical health challenges (Bell et al., 2018). In 2019, the Prince George's County Health Department published a comprehensive report on maternal and infant health (Prince George's County Health Department, 2019c). As described in that report, reproductive-age women (15-44 years) comprise over one-fifth of County residents. Racial/ethnic disparities exist throughout the County for rates of pre-term deliveries, low birthweight infants, infant mortality, and maternal risk factors (e.g., obesity, diabetes, hypertension). Our findings below echo the important findings of the County's report and provide additional information about health care access and utilization and summarize findings from the PRAMS.

Births and Birth Outcomes

As reported by the Maryland Vital Statistics Administration, in 2018 there were 12,160 live births in the County. Almost one in four births (22.5 percent) were to women aged 35 years and older. As illustrated by Figure 3.8, the majority of births in the County were to Black, non-Hispanic mothers (55.2 percent).

Figure 3.8.
Percentage of Live Births by Race/Ethnicity, 2018



SOURCE: Maryland Vital Statistics Administration, 2019.
NOTES: All race categories exclude Hispanics. Percentages will not total 100 percent since data with missing information on ethnicity are not shown.

In 2019 in Prince George's County, 1.2 percent of births in the County were to mothers less than 18 years of age (Maryland Vital Statistics Administration, 2019). When examining pooled data from 2011–2017, the teen birth rate in Prince George's County was higher than rates in nearby counties and the state (Table 3.23). The teen birth rate in Prince George's County varied greatly by race/ethnicity: 56 per 1,000 for Hispanic or Latina women, 21 per 1,000 for Black women, and 6 per 1,000 for White women.

Table 3.23.
Teen Birth Rates (TBR) per 1,000, by Jurisdiction and Race/Ethnicity, Pooled 2011–2017

	Prince George's	Baltimore	Howard	Montgomery	Maryland
Overall	24	15	7	12	19
Black (B)	21	21	13	15	*
Hispanic	56	38	30	35	*
White (W)	6	10	3	3	*
B : W TBR Ratio	3.2	2.1	4	5.6	*
H : W TBR Ratio	8.7	3.7	9.6	12.8	*

SOURCE: RWJF County Health Rankings, 2019.
NOTES: Raw data obtained from 2011-2017 National Center for Health Statistics Natality files. Includes number of births per 1,000 female population ages 15-19. *Data not available.

In 2018, nearly 10 percent of infants in Prince George's County were born at a low birthweight, which was higher than the rate of nearby counties and the state (Table 3.24). Within the county, low birthweight was more common for Black infants compared to White infants (2.11 low birthweight ratio) and for Hispanic infants compared to White infants (1.36 low birthweight ratio).

Table 3.24.
Percentage Low Birthweight (LBW) Infants by County and Race/Ethnicity, 2018

	Prince George's	Baltimore	Howard	Montgomery	Maryland
Overall	9.7	9.5	9.3	7.4	8.9
White (W)	5.5	7.6	7.3	5.9	6.8
Black (B)	11.6	13.1	13.3	9.4	12.5
Hispanic (H)	7.5	5.7	8.2	6.6	6.9
B : W LBW Ratio	2.11	1.72	1.82	1.59	1.84
H : W LBW Ratio	1.36	0.75	1.12	1.12	1.01

SOURCE: Maryland Vital Statistics Administration, 2019.
NOTES: All race categories exclude Hispanics or Latinas. Low birthweight is less than <2500 grams. *Percentages based on <5 events in the numerator are not presented since percentages based on small numbers are unstable.

Infant Deaths

Infant mortality rates in Maryland and Prince George's County have declined over time. In Prince George's County, the infant mortality rate declined from 8.7 per 1,000 live births during 2009 to 2013 to 7.9 per 1,000 live births during 2014 to 2018 (Table 3.25). However, the infant mortality rates in Maryland and Prince George's County are still higher than the Healthy People 2020 goal of 6.0 per 1,000 live births.

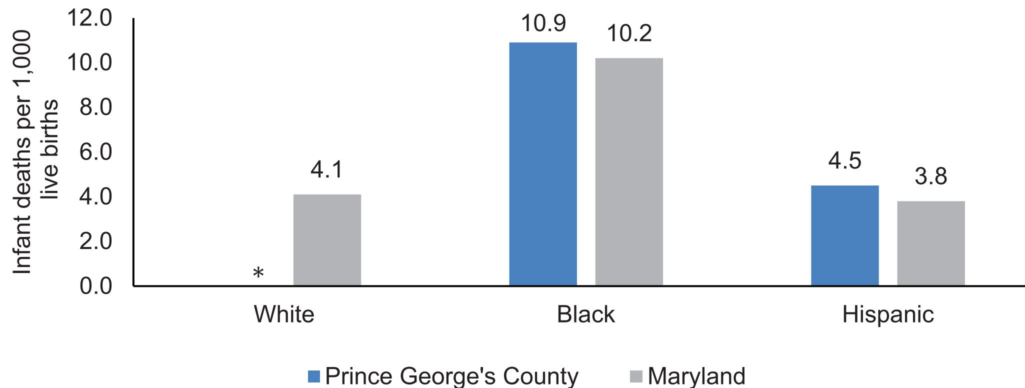
Table 3.25.
Infant Mortality Rates per 1,000 Live Births, 2009–2018

	2009 - 2013	2014 - 2018	% Change
Maryland	6.7	6.4	-4.1%
Prince George's	8.7	7.9	-9.0%

SOURCE: Maryland Vital Statistics Administration, 2018.

Large racial/ethnic differences were observed in infant mortality rates within Prince George's County (Figure 3.9). In 2017, the infant mortality rate was 12.0 per 1,000 live births for Black mothers, 5.0 per 1,000 live births for Hispanic or Latina mothers, and fewer than 5 births total for White mothers in Prince George's County.

Figure 3.9.
Infant Mortality Rates per 1,000 Live Births by Race/Ethnicity, 2018



SOURCE: Maryland Vital Statistics Administration, 2019.
NOTES: *Rates based on <5 deaths are not shown since rates based on small numbers are statistically unreliable.

Well-Being

Well-being encompasses the factors that describe a full and safe life, including health literacy, participation in healthy behaviors, and civic engagement. Well-being is influenced by the social, economic, built, natural, and health service environments. For example, access to safe and walkable areas makes it easier to engage in exercise. Additionally, living close to stores that sell affordable and healthy food makes it easier to maintain a healthy diet. Below, we use several data sources to describe residents' health literacy, participation in healthy and unhealthy behaviors, and civic engagement. As noted earlier, well-being data are currently limited, a point for County consideration as it implements *Health in All Policies* in the future.

Health Literacy

Health literacy refers to "the **degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions**" (U.S. Department of Health and Human Services, 2010). Using information from the Health Literacy Component of the 2003 National Assessment of Adult Literacy, we examined within-County variation of the percentage of adults with above basic health literacy. Performance levels of health literacy, created by the National Research Council, include: below basic, basic, intermediate, and proficient. Adults with above basic health literacy (intermediate or proficient) should be able to read a pamphlet and understand two reasons why a person without symptoms should be tested for a disease. Adults should also be able to read a one-page article about a medical condition and explain how the disease could be asymptomatic (Kutner, Greenberg, Jin, & Paulsen, 2006). About half of adults in Prince George's County

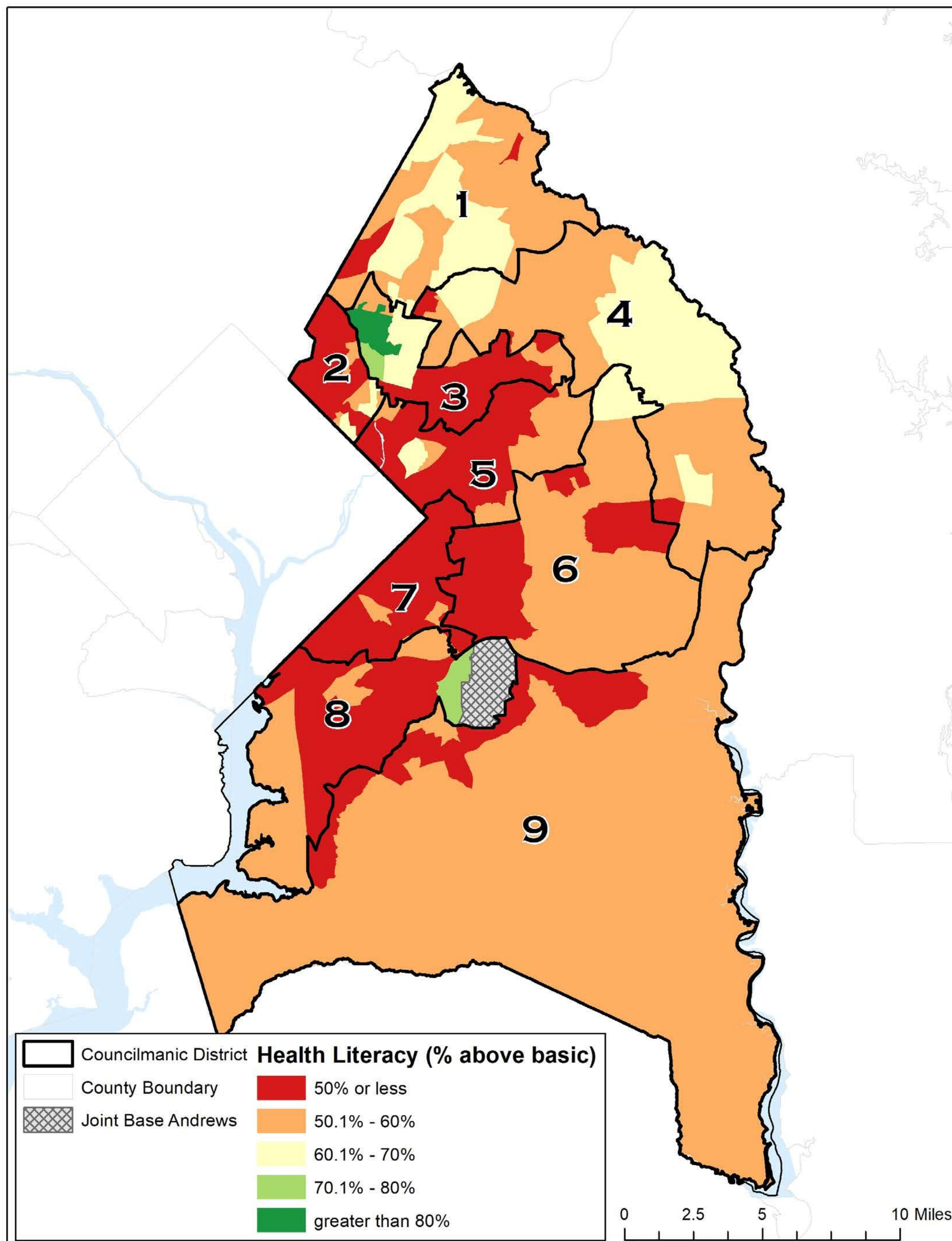
(51.7 percent) were predicted to have above basic health literacy (Table 3.26). The percentage of adults predicted to have above basic health literacy varied by district and within district, with some of the highest rates of health literacy observed in Districts 4 and 1 (Figure 3.10).

Table 3.26.
Percentage of Adults with Above Basic Health Literacy in Prince George's County, by District

	Councilmanic Districts									
	PG	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
% having above "basic" estimated health literacy	51.7	55.6	45.3	54.4	59.2	47.7	51.7	46.8	50.1	52.4

SOURCE: U.S. Census Bureau, 2019.
NOTES: Estimated probability of having above basic health literacy (i.e., intermediate or proficient) using data from the American Community Survey 5-Year Summary File, 2014–2018, and the Health Literacy Component of the 2003 National Assessment of Adult Literacy, an in-person assessment of English language literacy among a nationally representative sample of U.S. adults aged 18 and older. Full methods describing the modeling approach are included in the 2010 report by Lurie and colleagues (Lurie et al., 2010) and available online (http://healthliteracymap.unc.edu).

Figure 3.10.
Percentage of Adults with Above Basic Health Literacy in Prince George's County, by Census Tract, Pooled 2014–2018



SOURCE: U.S. Census Bureau, 2017.
NOTES: Estimated probability of having above basic health literacy (i.e., intermediate or proficient) using pooled data from the 2014–2018 American Community Survey and the Health Literacy Component of the 2003 National Assessment of Adult Literacy, an in-person assessment of English language literacy among a nationally representative sample of U.S. adults aged 18 and older. Full methods describing the modeling approach are included in the 2010 report by Lurie and colleagues (Lurie et al., 2010) and available online (http://healthliteracymap.unc.edu).

Health Behaviors

Unhealthy behaviors, such as smoking, lack of exercise, and poor diet, contribute to poor health outcomes. For example, studies suggest that insufficient sleep is associated with negative outcomes, such as increased risk for obesity, diabetes, high blood pressure, coronary heart disease, and stroke (Liu et al., 2016). Relatedly, engagement in healthy behaviors can help to prevent poor health outcomes. For example, a healthy diet is associated with a lower risk of cancer (Grosso et al., 2017).

Below, we present self-reported information about adults' participation in healthy and unhealthy behaviors. We compare rates in Prince George's County to nearby jurisdictions and also compare rates within Prince George's County by subgroup. Additionally, we present self-reported information on healthy and unhealthy behaviors of adolescents and teens from the Youth Tobacco and Risk Behavior Survey. We use this survey to present trends over time in the County and to compare rates in the County and the state.

Health Behaviors Among Adults

In 2016, 41.8 percent of adults in Prince George's County reported insufficient sleep, which was greater than the state average of 35.6 percent (Table 3.27). Fewer adults in the County reported daily smoking (5.5 percent), compared to the state average (9.5 percent). Physical activity and diet are strong predictors of healthy weight. In 2017, almost three of four adults reported a BMI classified as overweight or obese. Half of adults in the County reported meeting aerobic recommendations of at least 150 minutes of light/moderate or 75 minutes of vigorous aerobic physical activity per week. In 2017, daily self-reported fruit-and-vegetable consumption among County adults was lower than the state average and lower than rates in Howard and Montgomery counties, and the obesity rate was considerably higher among County adults.

Table 3.27.
Self-Reported Health Behaviors for Adults, by Jurisdiction, 2017

	Prince George's County	Baltimore County	Howard County	Montgomery County	Maryland
Insufficient sleep*	41.8	34.1	29	31.9	35.6
Tobacco use					
Smoke daily	5.5	10.1	NA	4.9	9.5
Healthy weight					
Obese (BMI 30.0+	42.8	29.8	24.5	20.3	31.6
Physical activity					
Inactive**	25.3	27.3	19.7	23.4	27.3
Healthy eating					
Consumed fruit one or more times per day	63.2	62.0	71.9	73.7	65.4
Consumed vegetables one or more times per day	77.6	75.6	87.0	81.7	81.2

SOURCE: 2017 BRFSS.
NOTES: All rates are age-adjusted unless otherwise indicated. *Insufficient sleep was defined as the percentage of adults who report fewer than 7 hours of sleep on average as reported in 2016. **Other categories of physical activity include highly active, active, and insufficiently active.

Rates of cigarette smoking every day and inactivity were higher among adults with less education and lower household incomes (Table 3.28). Rates of obesity were considerably higher among Black adults and among adults with less education. Daily vegetable consumption was higher among adults with more education, higher household incomes, and among those reporting a personal doctor.

Table 3.28.
Self-Reported Unhealthy Behaviors Among Adults, by Jurisdiction, 2017

	Daily smoker	Obese	Inactive*
Overall	5.5	42.8	25.3
Demographics			
Age group**			
18-64	6.0	42.8	22.5
65 and older	3.2	41.5	39.6
Sex			
Female	3.7	45.2	24.7
Male	7.0	40.8	25.5
Race			
White, non-Hispanic	9.1	30.9	21.8
Black, non-Hispanic	5.3	47.7	25.7
Hispanic	NA	34.5	26.1
Socioeconomic characteristics			
Educational attainment			
Above high school	4.1	38.7	20.4
High school or less	8.8	51.2	34.8
Household income			
$50k and above	5.4	47.5	18.9
Below $50k	6.0	42.2	31.9
Has a personal doctor			
Has a personal doctor	6.0	43.8	23.9
No personal doctor	NA	36.9	26.2

SOURCE: 2017 BRFSS.
NOTES: All rates are age-adjusted unless otherwise indicated. Insufficient sleep variable not available by subgroup. *Other categories of physical activity include highly active, active, and insufficiently active. **Indicates crude rate. NA, indicates the rate was not available due to small sample size.

Table 3.29.
Self-Reported Healthy Eating by Adults, by Jurisdiction, 2017

	Consumed fruit one or more times per day	Consumed vegetables one or more times per day
Overall	63.2	77.6
Demographics		
Age group*		
18-64	62.2	77.0
65 and older	67.8	82.4
Sex		
Female	64.9	84.6
Male	60.8	69.6
Race		
White, non-Hispanic	64.0	85.2
Black, non-Hispanic	60.2	78.0
Hispanic	64.8	65.9
Socioeconomic characteristics		
Educational attainment		
Above high school	64.7	83.2
High school or less	58.2	65.9
Household income		
$50k and above	61.5	79.2
Below $50k	65.7	72.4
Has a personal doctor		
Has a personal doctor	62.0	81.1
No personal doctor	65.4	69.3

SOURCE: 2017 BRFSS.
NOTES: All rates are age-adjusted unless otherwise indicated. *Indicates crude rate.

Living closer to parks and recreational centers may make it easier and more convenient to exercise. Using this measure of proximity to parks and other recreational facilities, we find that nearly all County residents (98 percent) have adequate access to locations for exercise opportunities (Table 3.30). This measure, however, is likely an overestimate of access to exercise opportunities in the County because it does not account for transportation barriers, which may hinder the accessibility of these locations for some, as well as safety barriers, which may also discourage individuals from engagement.

Table 3.30.
Percentage of Population with Adequate Access to Locations for Exercise Opportunities, 2018

	Prince George's	Baltimore	Howard	Montgomery	Maryland
Percentage	98	96	97	100	92

SOURCE: RWJF County Health Rankings, 2019.
NOTES: Raw data obtained from 2010 U.S. Census and 2018 ArcGIS Business Analyst. Individuals are considered to have access to exercise opportunities if they reside in a census block that is within a half mile of a park or an urban census block that is within one mile of a recreational facility, or a rural census block that is within three miles of a recreational facility.

Health Behaviors Among Youth

The adolescent and teenage years are an important time for developing healthy habits. In 2016, the obesity rate among high school students was 16.4 percent (Table 3.31). Few high school students reported frequently and recently eating fruits or drinking 100 percent fruit juices (17.3 percent) or eating vegetables (10.7 percent). Compared to the state average, high school students in the County were more likely to be obese and less likely to report frequent and recent physical activity.

Table 3.31.
Self-Reported Physical Activity, Prince George's County and Maryland, 2016

Measure	Prince George's County	Maryland
Healthy weight		
High school students who are obese	16.4	12.6
Physical activity		
High school students reporting they were physically active frequently and recently	25.0	35.2
Healthy eating		
Ate fruits or drank 100% fruit juices frequently and recently	17.3	15.8
Ate vegetables frequently and recently	10.7	12.0

SOURCE: Maryland Department of Health, 2017.
NOTES: Data obtained from the YRBS/YTS.

The percentage of high school students in Prince George's County reporting drinking alcohol, smoking, and using an electronic vapor product declined from 2014 to 2016 (Table 3.32). In 2016, 17 percent of County high school students reported drinking alcohol, which was lower than the state rate of 25.5 percent in 2017. Similarly, fewer high school students in the County compared to the state reported using cigarettes, cigars, or smokeless tobacco in the past month than the state (10.9 percent and 14.4 percent). Slightly fewer County students reported ever using an electronic vapor product than the state average (32.6 percent and 35.3 percent).

Table 3.32.
Percentage of High School Students Reporting Alcohol and Tobacco Use, Prince George's County and the State of Maryland, 2013–2016

	2013		2014		2016	
	PG	MD	PG	MD	PG	MD
Alcohol use						
Had at least one drink of alcohol on one or more of the past 30 days	23.2	31.2	19.0	26.1	17.0	25.5
Tobacco use						
Used cigarettes, cigars, or smokeless tobacco in past 30 days	13.3	16.9	13.3	16.4	10.9	14.4
Currently used cigarettes, cigars, or smokeless, electronic vapor products	+	+	23.0	+	16.6	+
Ever used an electronic vapor product*	+	+	35.0	37.6	32.6	35.3
Currently use an electronic vapor product	+	+	14.9	20.0	9.0	13.3

SOURCE: Maryland Department of Health, 2017.
NOTES: Data obtained from the YRBS/YTS. + Indicates data unavailable.

Civic Engagement

As reflected in our framework (Figure 1.3), civic engagement is positively associated with overall well-being. Further, civic engagement is associated with health outcomes, including chronic disease prevalence and community health advocacy (Nelson et al., 2019). The RWJF County Health Rankings uses a count of membership associations as a proxy for social support. In 2016, Prince George's County was ranked 19 of 24 counties in Maryland on the number of membership associations per 10,000. As described in Table 3.33, the rate of membership associations in the County was lower than nearby counties and the state.

Table 3.33.
Number of Membership Associations per 10,000 Population as a Measure of Social Associations, 2016

	Prince George's	Baltimore	Howard	Montgomery	Maryland
# of membership associations	735	697	286	931	5,422
Rate per 10,000	8.1	8.4	9.0	8.9	9.0

SOURCE: RWJF County Health Rankings, 2019.
NOTES: Raw data using data obtained from the 2016 U.S. Census Bureau's County Business Patterns. Associations include membership organizations such as civil organizations, bowling centers, golf clubs, fitness centers, or sports, religious, political, labor, business, and professional organizations.

Civic engagement can also be measured by examining vote participating in elections. More than half of registered voters turned out for the 2017 general election, which was slightly less than the statewide rate of 59.1 percent and much higher than the County's 2014 voter turnout rate of 38.0 percent (Table 3.34).

Table 3.34.
Voter Turnout, 2010–2018

	Prince George's County	Maryland
General Election	Percent	Percent
2010	42.0	50.4
2012*	68.6	73.5
2014	38.0	44.7
2016*	68.5	72.0
2018	55.8	59.1

SOURCE: Maryland State Board of Elections, 2019.
NOTES: *Indicates presidential election.

Stakeholder Insights

In stakeholder discussions, the need for holistic health that incorporates a broader concept of health and well-being emerged. For example, stakeholders noted that improving housing and transportation can help improve connectedness to County services, which in turn can promote health and well-being. As noted earlier, residents and community leaders are seeking more support in promoting healthy lives, including health education and opportunities to promote well-being and healthy eating. Residents also noted interest in volunteerism, a key component of civic engagement and health (Nelson et al., 2019). In this section, we summarize themes related to health management and promotion in the County, health concerns for specific groups and issues, and community interest in civic engagement as part of overall well-being.

Health Management and Promotion

In the areas of health management and promotion, there was support for more health management tools, resources to promote health, and better communication and coordination about County services that support health. There were also concerns expressed for specific health conditions, such as mental and behavioral health, and concern about particular populations, such as pregnant women.

There was interest in **health self-management tools**, which stakeholders felt can be useful for promoting health, but are often inaccessible due to issues of health literacy challenges that impede the use of technology. Although a number of disease self-management tools exist, such as smartphone applications, residents shared that they often do not understand how to use them due to low health literacy or lack of understanding of the use of technology. Residents felt that educational opportunities about the use of self-management tools are often limited. The County has a number of community partners that can assist with promoting the use of such tools, including faculty at the University of Maryland School of Public Health, but it was conveyed that those services were underutilized.

As for **resources to promote health**, many stakeholders expressed a need for materials related to exercise and healthy eating. Some stakeholders shared that schools have a great deal of expertise yet are underutilized in promoting health education about healthy eating and exercise. This was particularly important for many stakeholders given the importance of establishing healthy behaviors early in life. Participants noted that lack of recess at school,

limited school gym spaces, and few places to exercise in the community contribute to the problems of childhood obesity. In addition, one participant noted that there are few options for younger children to engage in outdoor recreational activities in the community. As a result, children may spend time on relatively sedentary activities within the home, such as playing video games and watching television. The school was noted as an ideal environment for initiating approaches to address obesity. One mechanism is through the school lunch program. School lunches are perceived as offering limited healthy food options for children. Healthy meals should be accompanied by education about healthy eating behaviors in order to be most effective. Stakeholders remarked:

> *[A] fourth grader eats the same crap I ate 40 years ago for lunch. The high schools have a lot of junk and processed food. We need them to get hooked on better foods.*

> *They keep building and buying townhouses without yards for kids to play in. They're playing video games inside, and it's contributing to obesity.*

> *Our children spend 2000 hours a year in school and even more hours for our educators and support staff! What an opportunity to capitalize on creating healthy environments for all including our families in Prince George's.*

Health education, particularly for healthy eating and exercise, was also noted as a concern for adults. Many stakeholders noted that there are few educational activities available that promote healthy eating. Grocery store tours and cooking classes, offered through the local community college, were thought to be helpful activities that could encourage residents to learn about healthy eating. In addition, it was noted that these classes can train enrolled students about how to operate a healthy food establishment, which may subsequently encourage them to stay in the area and invest in the development of healthy eating establishments.

One of the challenges with health management and services is the concern that **communication about County services** is limited. Residents felt that Prince George's County offers many human services that promote health through both agencies as nonprofits, such as exercise and recreational programs. However, there is a lack of information communicated to residents about such resources. There was a desire to be better informed about County services across a number of domains, including about health care resources and recreational programs. Residents shared a perception that public information officers do not communicate well with each other, so often information is not disseminated well throughout the county. Residents also felt that the County website could be improved to be more user-friendly and to better inform individuals about services.

> *I went to a county council meeting where organizations were providing information and requesting funding. I didn't know about a lot of these programs. Why don't they coordinate what these programs are doing?*

One participant noted several examples of social media partnerships that have improved communication about county services. For example, Seat Pleasant partnered with Microsoft to get city services faster. Capitol Heights also had a web application that allows residents to find meetings and learn about crime, as well as to get updates about other relevant issues. Communication is essential to helping seniors stay connected with human services. Information about

County programs is often disseminated through social media. Seniors may be less likely to have an online presence and instead use other forms of communication, such as the newspaper, radio or television.

Health Concerns for Specific Populations and Issues

There were also populations and health issues of greatest concern with respect to health management and promotion.

Stakeholders brought up concerns about **maternal and infant health.** The 2019 Maternal and Infant Health Report from the Prince George's County Health Department (Prince George's County Health Department, 2019c) offers important insights into this topics, including:

- Compared to 2013, more mothers were obese, had diabetes, and had hypertension in 2017.
- The number of births to women aged 35 and older is increasing, from 17 percent of births in 2010 to 22 percent of births in 2017.
- Rates of newborns being breastfed increased from 82 percent in 2013 to 88 percent in 2017.

Additionally, residents and stakeholders reported a need for maternal and postpartum health services, including access to reproductive services and comfortable spaces for breastfeeding. One participant noted the lack of lactation consultants in the County. In addition, in County and other public buildings, there are few places available for breastfeeding for either visitors or employees. Of note, the 2010 Patient Protection and Affordable Care Act requires employers to provide a place, other than a bathroom, for employees to breastfeed. Additionally, the need for more accessible childcare was a concern raised by stakeholders as parents often have to obtain care for children outside of the County.

Additionally, **men's health**, such as the prevalence of chronic disease and cancer and early mortality among men, especially Black, was mentioned as a concern. Residents expressed a desire for more education and screening initiatives that specifically target men. As compared to women, men were noted to be a harder population for outreach because of lack of engagement in a number of outlets, such as the church, that traditionally encourage health promotion. Residents noted a need for engagement of community-based organizations to help provide outreach to men for diseases such as prostate and colon cancers.

> *I could call eight of my mom's friends who are still alive. I have fewer men to call because they're not staying around.*

In the area of health issues, stakeholders were particularly concerned about **mental and behavioral health**, including among people experiencing homelessness. In data provided by DSS about people experiencing homelessness, the top barriers to permanent housing for single adults were severe mental illness and physical disability and for families they were domestic violence and severe mental illness. Stakeholders noted that many people experiencing homelessness with mental and behavioral health needs have migrated from Washington, D.C. to areas in Prince George's County such as Lanham, Cheverly, and District Heights – but it was perceived that Washington, D.C. has better resources available to assist people experiencing homelessness who have mental and behavioral health needs. Moreover, stakeholders noted that many of these individuals commonly have **co-occurring substance use disorders and**

co-morbid physical health conditions. Stakeholders indicated that cost is a barrier to getting care for these individuals. Additionally, one stakeholder described a perspective about the high needs of this population:

> *Many of these patients have high needs, like co-occurring drug addictions, victims of acute disease processes, untreated health. Also,[there is a] large anti-social population and forensic population.*

Civic Engagement

A resounding theme, particularly from residents in focus groups, was the interest in civic engagement. Residents would like to be engaged in the improvement of human service needs through volunteerism. Residents recognize the sense of "village life" and community as a very positive aspect of Prince George's County, which attracted them to live in the area. Because of this, a number of people expressed a desire to support the community through volunteerism. Volunteerism is viewed as a means for residents to contribute to the County and to help progress many of the county's initiatives. In addition to the civic engagement associated with volunteerism, it is also thought to be a means to transition into paid positions at an organization. One participant expressed concern about the County's shift towards "anti-volunteerism." This is thought to be due to legal concerns that make agencies and organizations less interested in relying on volunteers. A need for more investment on how to use volunteers more effectively was cited. Examples of effective volunteer efforts include the Bowie Seniors Program, which residents feel could be expanded to give seniors more involvement.

> *Can't just say 'have more volunteers' It's a lot of work. I think the county, if they can find experts who have looked at volunteerism, they can look at the county and tell them how to incorporate volunteers in an efficient way.*

Among **seniors**, there was interest in having County services that **foster engagement to reduce isolation and improve health**. Stakeholders explained that isolation can lead to depression which in turn leads to adverse health outcomes among seniors, yet they hoped a *Health in All Policies* approach to meeting human needs can help seniors maintain independence and stay connected with other individuals. Issues raised included the need to better understand senior needs comprehensively, have more transportation options to services, provide better supports to age in place, improve communication about senior services, and augment funding to support these services. Stakeholders noted that there are a number of programs that are offered by Prince George's County departments to help seniors avoid social isolation. For example, there are senior centers run by the Department of Parks and Recreation that offer senior activity programs and provide balanced meals for seniors. However, getting to these programs can be challenging due to barriers to transportation, such as limited options for assisted transportation and difficulty reaching access points for bus routes. The County provides transportation to senior centers, but one stakeholder thought that this list is not regularly updated.

> *Many seniors can't get to centers because [the Department of Public Works and Transportation] says they are "full" but then the van shows up with just 3 or 4 people on board. If someone dies, they don't update the list…Need to get people off the waitlist.*

Additional programming currently offered throughout the County includes a speaker series that utilizes senior expertise and programs run by the Department of Family Services to support seniors with dementia. For example, the Dementia Friendly American Initiative

in Prince George's County offers "memory cafes," which are social programs for those living with dementia and their caregivers, and other special services for seniors. Many of these programs are supported by nonprofit organizations. However, because there are fewer nonprofits in the South County, per one stakeholder, this is a barrier to offering some supportive services for seniors in that area.

Summary

An understanding of residents' health and well-being, as well as inequities in health and well-being, is needed to better understand the role of drivers of health in shaping these outcomes. A summary of the current status of health and well-being, and how this differs across key socioeconomic and demographic characteristics, also informs policy strategies to promote health and well-being.

Highlighting Key Unmet Needs

- Persistent health challenges remain for cancer, behavioral health, and conditions related to obesity. Reported risk factors for these diseases (e.g., obesity, tobacco use, lack of exercise, unhealthy diet) are more common among adults with less education.
- Large inequities for infant outcomes were observed, with Black infants having the highest rates of low birthweight and infant mortality.
- Concerns about substance abuse in District 7, where more than one in four residents are Black, which had the highest rates of EMS responses for overdoses and naloxone use in 2018.
- Challenge to fully measure well-being with existing data sources, which are more focused on the presence or absence of disease.

In this chapter, we observed positive findings and improvements in the health and well-being of Prince George's County residents for numerous indicators. The County has a lower rate of years of potential life lost, a measure of premature death, than the state average (pooled data for 2015–2017) and in 2017 most adults in the County (83.9 percent) described their health as "good," "very good," or "excellent." Although County level rates of voter turnout are consistently lower than the state average, the County experienced a 17.8 percentage point increase in voter turnout in 2018 compared to the last non-presidential general election. Additionally, stakeholders expressed strong community engagement, as noted by a high interest in volunteer opportunities.

We also identified opportunities to improve the health and well-being of residents, several of which were also highlighted in the prior health assessments of Prince George's County, Maryland.

- High rates of incidence and mortality for select cancers were observed. These data reflect stakeholder concerns about men's health, as prostate cancer incidence and mortality rates are considerably higher in Prince George's County than rates observed across Maryland or the United States.

- Obesity was common for both adults and youth in the County, which is concerning because it increases risk of worse health, including poor birth outcomes, cancer, and cardiovascular disease.
- Prevalence of chronic diseases and health behaviors varied across race/ethnicity and across socioeconomic characteristics – with worse health and unhealthy behaviors more likely to be reported by racial/ethnic minorities and among individuals with less education and lower household incomes.
- Nearly one in four adults in the County reported having a disability, which was primarily driven by reporting of mobility disabilities and primarily by older adults.

Stakeholders emphasized the need for resources and education to promote healthy behaviors like exercise and healthy eating. Thus, the County can consider its role in improving the accessibility, clarity and usability of health-promoting resources. It was noted that schools are an important place for these efforts to occur because of the importance of introducing healthy habits earlier. These concerns are supported by data, as few high school students reported eating vegetables often.

Finally, residents and stakeholders expressed concerns about mental health, and specifically that of children and adolescents in the County. In analysis of secondary data, we observed high rates of bullying and suicidality among middle school students, with almost one in four reporting bullying at school and almost one in four reporting seriously thinking about attempting suicide. These findings highlight the importance of delivering health care services in nontraditional settings, like schools, in order to help residents get the care they need.

Next Steps in Data Collection and Analysis

While there are important insights from the available health and well-being data, there are limitations that the County should consider as it pursues *Health in All Policies*. More information is needed on measures of well-being, such as resident life appraisal, engagement in daily stress management, participation in emotional health-promoting activities (and not just mental health disorder management), connection to nature, and sense of place as well as community measures of collective stress, social cohesion, trauma experience, and other aspects of environmental and economic well-being. There are some communities in the United States. pursuing more data collection to capture community well-being, referenced in Chapter Nine, which can be useful for County planning.

4. Drivers of Health: Health Care Service Environment

Overview

Timely receipt of high-quality health care services is integral to the health and well-being of a community. A high functioning health care system enables individuals to obtain screening and preventive services to reduce the risk of poor health outcomes, treatment to address ongoing health conditions, and care for emergencies and urgent needs. Access to health care services is influenced by cost, insurance, overall provider supply, and supply of providers willing to see a patient, which may depend on insurance type, insurance status, age, and other factors (Agency for Healthcare Research and Quality, 2016). Upstream factors, including historic and systemic racism and bias, influence access and use of health care services. While some racial/ethnic disparities have narrowed over time, access to care remains challenging for many groups, including Black and Hispanic individuals and people living in poverty (Agency for Healthcare Research and Quality, 2016). Poor access to health care services may lead to inappropriate and costly use of care (e.g., use of emergency departments [EDs] for non-urgent needs) and poor health outcomes (e.g., delayed diagnosis of a condition).

In Prince George's County, health care services are delivered and coordinated by a mix of traditional health care providers (i.e., hospitals and medical offices), first responders, public safety agencies, schools, and health and human services agencies. This chapter describes the types of health care providers serving Prince George's County, their roles, and the services provided.

Key data used in this chapter describe access to care, utilization, and the health care workforce. Key datasets used to describe access to care include: BRFSS and YRBS/YTS. Key datasets used to describe utilization were obtained from the Maryland Health Services Cost Commission and DC Hospital Association. Key datasets used to describe the health care workforce include: Area Health Resources Files and data from the Health Resources Services Administration (HRSA), County Department of Fire and EMS, and the Maryland Health Care Commission

This chapter covers

- Office-based care
- Hospital based health care, including emergency department care and inpatient hospital care
- Health care offered via other settings (e.g., EMS, school-based, hospice).

Office-Based Health Care

Office-based health care describes the medical, dental, and mental health services that residents received outside of hospitals. We describe access to health care by analyzing self-reported barriers to health care from the 2016 and 2017 BRFSS, supply measures related to the health-care workforce, and highlight areas impacted by health professional shortages.

Access to Primary and Secondary Medical Care Services

In 2017, 21.5 percent of adults in the County reported having their last routine checkup more than one year ago and 13.7 percent reported having missed needed care due to cost (Table 4.1). In 2017, fewer County adults reporting having a routine checkup more than one year ago compared to neighboring counties and the state average. However, the County had a higher percentage of adults reporting cost as a barrier to health care in the past year compared to neighboring counties and the state average.

Table 4.1.
Barriers to Health Care Access and Utilization for Adults, by Jurisdiction, 2017

	Prince George's County	Baltimore County	Howard County	Montgomery County	Maryland
Last routine checkup more than one year ago	21.5	28.6	26.7	31.2	28.5
Unable to see doctor due to cost in past year	13.7	11.3	9.4	11.7	10.9

SOURCE: Maryland Department of Health Query System, 2017.
NOTES: Data from the BRFSS. All rates are age-adjusted unless otherwise indicated. *Indicates crude rate. NA, indicates the rate was not available due to small sample size.

In examining barriers to access and utilization among subgroups within the County, we observe that White and Hispanic adults were more likely to report having a routine checkup more than one year ago. This pattern also was observed among adults with household incomes less than $50,000 and those reporting no personal doctor. More Hispanic adults reported cost as a barrier to medical care than Black adults. Adults with less education were more likely to report cost as a barrier to medical care.

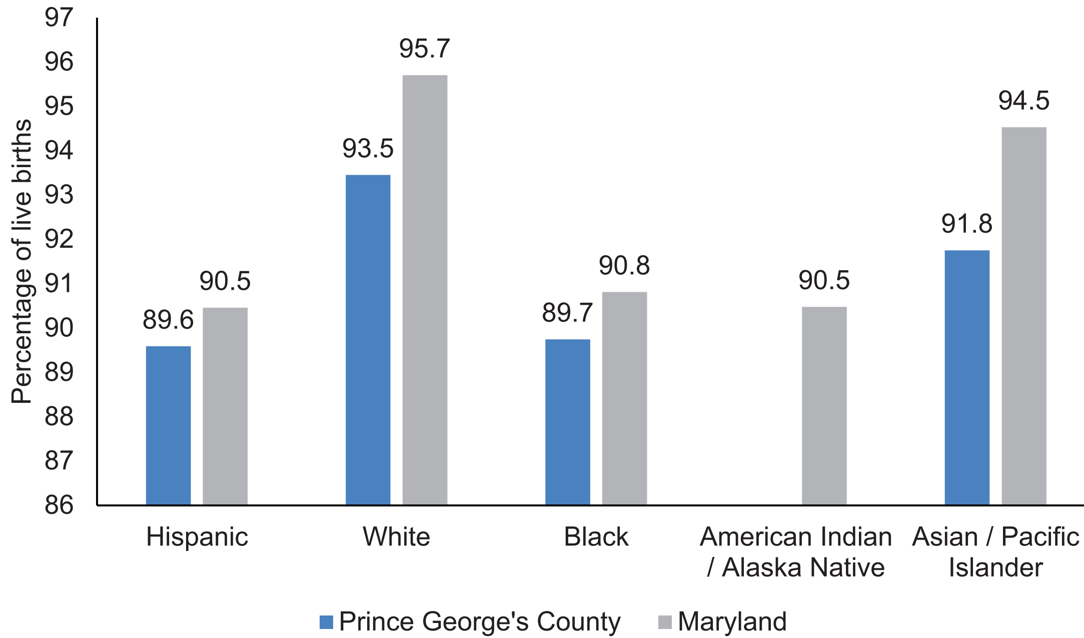
Table 4.2.
Barriers to Health Care Access and Utilization for Adults in Prince George's County, 2017

	Last routine checkup more than one year ago	Unable to see doctor due to cost in past year
Overall	21.5	13.7
Demographics		
Age group*		
18-64	23.3	15.2
65 and older	10.8	5.7
Sex		
Female	17.1	15.6
Male	25.3	11.5
Race		
White, non-Hispanic	27.2	NA
Black, non-Hispanic	18.6	9.7
Hispanic	29.1	24.6
Socioeconomic characteristics		
Educational attainment		
Above high school	21.5	7.9
High school or less	22.2	22.8
Household income		
$50k and above	19.0	NA
Below $50k	27.4	28.1
Has a personal doctor		
Has a personal doctor	14.2	8.7
No personal doctor	45.9	27.1

SOURCE: Maryland Department of Health Query System, 2017.
NOTES: Data from the BRFSS. All rates are age-adjusted unless otherwise indicated. *Indicates crude rate. NA, indicates the rate was not available due to small sample size or other reason.

We examine racial/ethnic disparities in receipt of prenatal care to better understand access to care for pregnant women. In 2018, most live births in Prince George's County were to Black mothers (Prince George's County Health Department, 2019c), however these mothers were less likely to receive no or late prenatal care compared to White mothers (Figure 4.1).

Figure 4.1.
Percentage of Live Births Receiving Timely Prenatal Care, by Race/Ethnicity, 2018



SOURCE: Maryland Vital Statistics Administration, 2019.
NOTES: All race categories exclude Hispanics or Latinas. Timely prenatal care was calculated by subtracting the percentage of live births with late or no prenatal care from 100. Late/No prenatal care is pregnancy-related care beginning in the 3rd trimester (7-9 months) or when no pregnancy-related care was received at all.

We examined the supply of health care providers in the County by first examining physician to population ratios. From 2013 to 2017 (the most recent year of data available), there were declines in the number of general internal medicine physicians and pediatricians per 100,000 population (Table 4.3). There were smaller declines in the physician to population ratio for select medical and surgical specialties. During this period, the County experienced growth in the numbers of family practice physicians and general surgeons.

Table 4.3.
Physician Counts and Rate per 100,000 for Prince George's County, 2013–2017

	Count					Rate per 100,000				
	2013	2014	2015	2016	2017	2013	2014	2015	2016	2017
Primary Care										
Family Practice	174	182	181	181	184	1.96	2.01	1.99	1.99	2.02
General Internal Medicine	293	288	290	288	287	3.29	3.18	3.19	3.17	3.14
Pediatrics	123	118	117	119	121	1.38	1.31	1.29	1.31	1.33
Medical Specialties										
Allergy & Immunology	10	12	12	10	12	0.11	0.13	0.13	0.11	0.13
Cardiovascular Disease	40	40	41	38	41	0.45	0.44	0.45	0.42	0.45
Dermatology	22	21	20	21	22	0.25	0.23	0.22	0.23	0.24
Gastroenterology	24	24	23	23	23	0.27	0.27	0.25	0.25	0.25
Pulmonary Disease	13	13	13	14	14	0.15	0.14	0.14	0.15	0.15
Psychiatry	46	49	49	49	47	0.52	0.54	0.54	0.54	0.52
Pediatric Subspecialties	21	19	19	20	20	0.24	0.21	0.21	0.22	0.22
Surgical Specialties										
General	51	54	59	57	59	0.57	0.60	0.65	0.63	0.65
Neurological	6	4	4	4	4	0.07	0.04	0.04	0.04	0.04
Ophthalmology	33	32	34	34	35	0.37	0.35	0.37	0.37	0.38
Orthopedic	42	39	35	38	36	0.47	0.43	0.39	0.42	0.39
Otolaryngology	12	10	10	9	9	0.14	0.11	0.11	0.10	0.10
Plastic	8	8	8	8	9	0.09	0.09	0.09	0.09	0.10
Thoracic	5	6	6	7	6	0.06	0.07	0.07	0.08	0.07
Hospital-based										
Anesthesiology	57	54	53	52	50	0.64	0.60	0.58	0.57	0.55
Emergency Medicine	58	60	57	61	62	0.65	0.66	0.63	0.67	0.68
Pathology	13	13	12	12	15	0.15	0.14	0.13	0.13	0.16
Physical Medicine / Rehabilitation	22	23	25	23	25	0.25	0.25	0.28	0.25	0.27

SOURCE: Area Health Resources File, 2019.
NOTES: Raw data derived from the American Medical Association Master File. Provides counts of non-federal medical doctors (MDs). FTE, full time equivalent.

In comparing physician to population ratios across jurisdictions, Prince George's County had a much smaller supply of primary care physicians compared to Baltimore, Howard, and Montgomery Counties in 2017 (Table 4.5). This was also observed for all medical specialties, surgical specialties, and hospital-based physician specialties and also true when compared to rates across the entire United States.

Table 4.5.
Physician FTE Rate per 100,000, by Jurisdiction, 2017

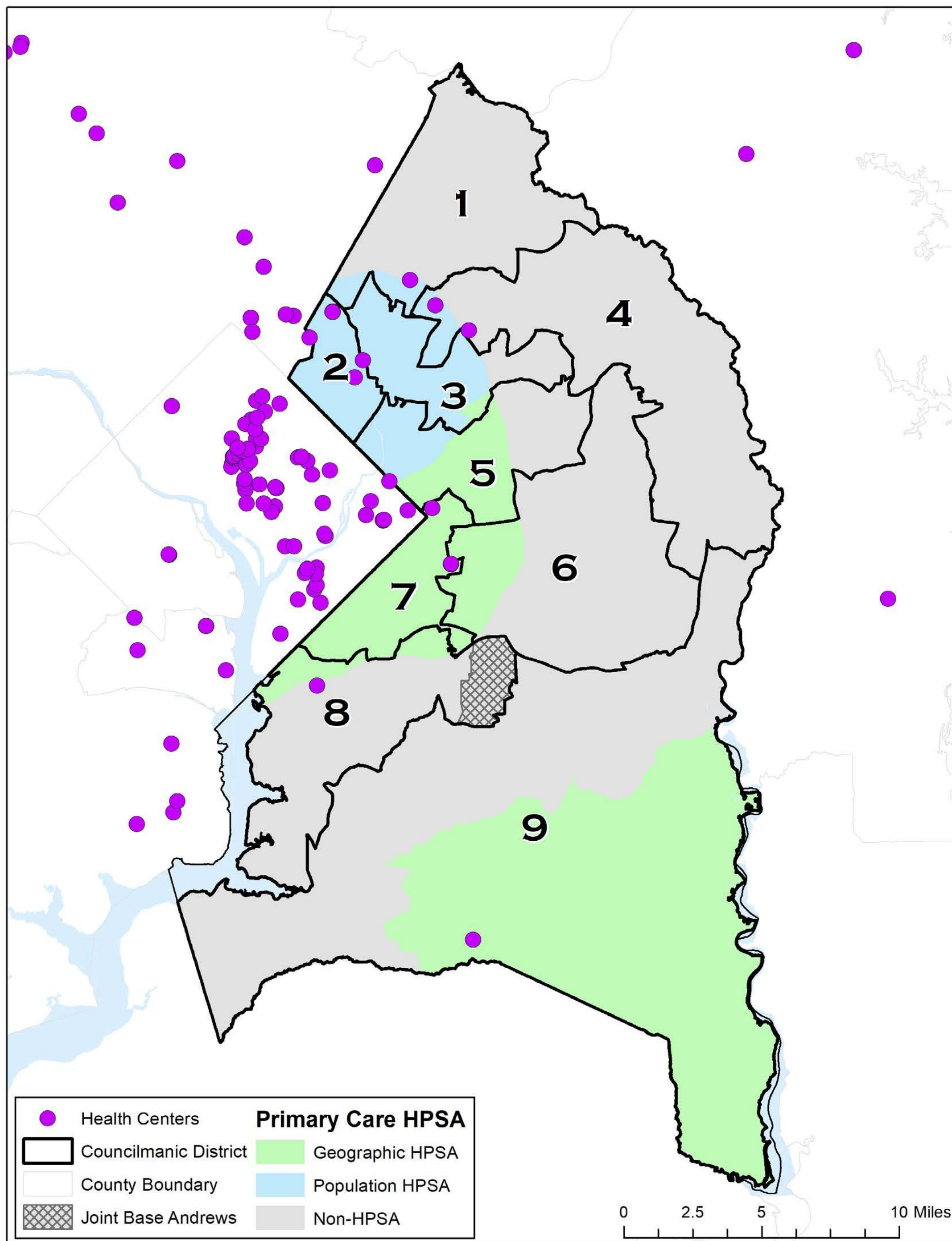
	Prince George's County	Baltimore County	Howard County	Montgomery County	United States
Primary Care					
Family Practice	2.02	2.09	4.24	3.01	3.05
General Internal Medicine	3.14	7.68	11.80	8.47	3.65
Pediatrics	1.33	2.50	5.33	4.55	1.83
Medical Specialties					
Allergy & Immunology	0.13	0.24	0.44	0.77	0.14
Cardiovascular Disease	0.45	1.12	1.43	1.48	0.70
Dermatology	0.24	0.54	0.53	0.99	0.38
Gastroenterology	0.25	0.75	1.28	0.94	0.45
Pulmonary Disease	0.15	0.63	1.28	0.80	0.40
Psychiatry	0.52	2.68	3.80	3.16	1.19
Pediatric Subspecialties	0.22	0.78	2.15	2.05	0.83
Surgical Specialties					
General	0.65	1.67	1.87	1.72	1.20
Neurological	0.04	0.32	0.09	0.37	0.20
Ophthalmology	0.38	1.17	1.06	1.76	0.58
Orthopedic	0.39	1.45	1.00	1.51	0.81
Otolaryngology	0.10	0.61	0.31	0.75	0.32
Plastic	0.10	0.43	0.25	0.60	0.25
Thoracic	0.07	0.19	0.28	0.21	0.14
Hospital-based					
Anesthesiology	0.55	2.38	4.48	2.57	1.41
Emergency Medicine	0.68	1.23	2.90	2.09	1.29
Pathology	0.16	0.53	1.00	1.60	0.54
Physical Medicine / Rehabilitation	0.27	0.69	0.53	0.71	0.35

SOURCE: Area Health Resources File, 2019.
NOTES: Raw data derived from the American Medical Association Master File. Provides counts of non-federal medical doctors (MDs). Counts are of full time equivalent (FTE) physicians. FTE is considered to be working eight hours per day, five days per week. Working 20 hours per week is considered 0.5 FTE.

Not well reflected in these data is the fact that more health care is now delivered by nonphysicians, including nurse practitioners (NPs) and physician assistants (PAs). For example, a national study of adults with private health insurance found that medical office visits to primary care physicians declined by 18 percent, while visits to NPs and PAs increased by 129 percent during 2012 to 2016 (Frost & Hargraves, 2018). Additionally, there are more options for receiving health care services outside the traditional medical office. For example, more Americans are receiving care in retail clinics (often located in retail pharmacies and drug stores) (Mehrotra & Lave, 2012). These clinics often offer immediate walk-in appointments, extended hours, and list prices, which can make them easier to access for many people (Levine & Linder, 2016).

HRSA designates communities, using census tracts, as having health care provider shortages in primary care, dental health, or mental health. HRSA uses a variety of information to identify health professional shortage areas (HPSAs). Shortages may be identified due to geography (e.g., lack of providers nearby) and population (e.g., lack of providers to serve specific populations, such as Medicaid enrollees) or based on facility (e.g., large health care facilities report few available providers) (Health Resources & Services Administration, 2019b). Primary care HPSAs are the most common type of HPSA in Prince George's County. These shortage areas, along with the locations of service sites of Federally Qualified Health Centers (FQHCs), are illustrated in Figure 4.2. All districts in the County have at least some communities within those districts, which are experiencing primary care shortages. Shortages are most often observed in the communities neighboring Washington, D.C. District 7 is the only district that is completely designated as a geographic primary care shortage area. District 2 is completely designated as a primary care shortage area due to its large Medicaid-insured population.

Figure 4.2.
Primary Care Health Professional Shortage Areas in Prince George's County, 2018



SOURCE: Health Resources & Services Administration, 2019c.
NOTES: HPSA, health professional shortage areas. health. HPSAs are identified based geography (e.g., lack of providers nearby) and population (e.g., lack of providers to serve specific populations, such as Medicaid enrollees) or based on facility (e.g., large health care facilities report few available providers). "Geographic HPSA" identified areas with few providers. "Population HPSA" identified areas with underserved populations.

Access to Behavioral and Mental Health Providers

As noted in the prior chapter, mental health affects overall health and disproportionally impacts some subgroups, including Hispanic adults and individuals in lower income households. As illustrated in Table 4.5, the rate of psychiatrists per 100,000 population is much lower in Prince George's County than in neighboring jurisdictions. In 2017, Prince George's County had 0.52 FTE psychiatrists compared to 2.68 in Baltimore County, 3.80 in Howard County, and 3.16 in Montgomery County. Although the number of psychiatrists declined in the County in recent years (Table 4.4), the number of mental health providers in the County increased. Mental health providers encompass a variety of providers, including licensed clinical social workers, counselors, and marriage and family therapists. The ratio of the county population to mental health providers improved, from 1,151 to 1 in 2014 to 806 to 1 in 2018 (Table 4.6). Throughout all counties in Maryland, this ratio ranges from 2,770 to 1 to 230 to 1. Several hospitals in the County offer inpatient psychiatric care. As of fiscal year 2019, there were 67 licensed acute care psychiatric beds in the County, spread across three hospitals (Table 4.7). Few census tracts in the County are designated mental health professional shortage areas (Figure 4.3). These designations are driven by the large number of Medicaid-eligible residents in these communities.

Table 4.6.
Ratio of Population to Mental Health Providers in Prince George's County, 2014–2018

Year	Total mental health providers	Ratio of the population to mental health providers
2014	773	1,151:1
2015	854	1,059:1
2016	936	972:1
2017	1,025	886:1
2018	1,133	806:1

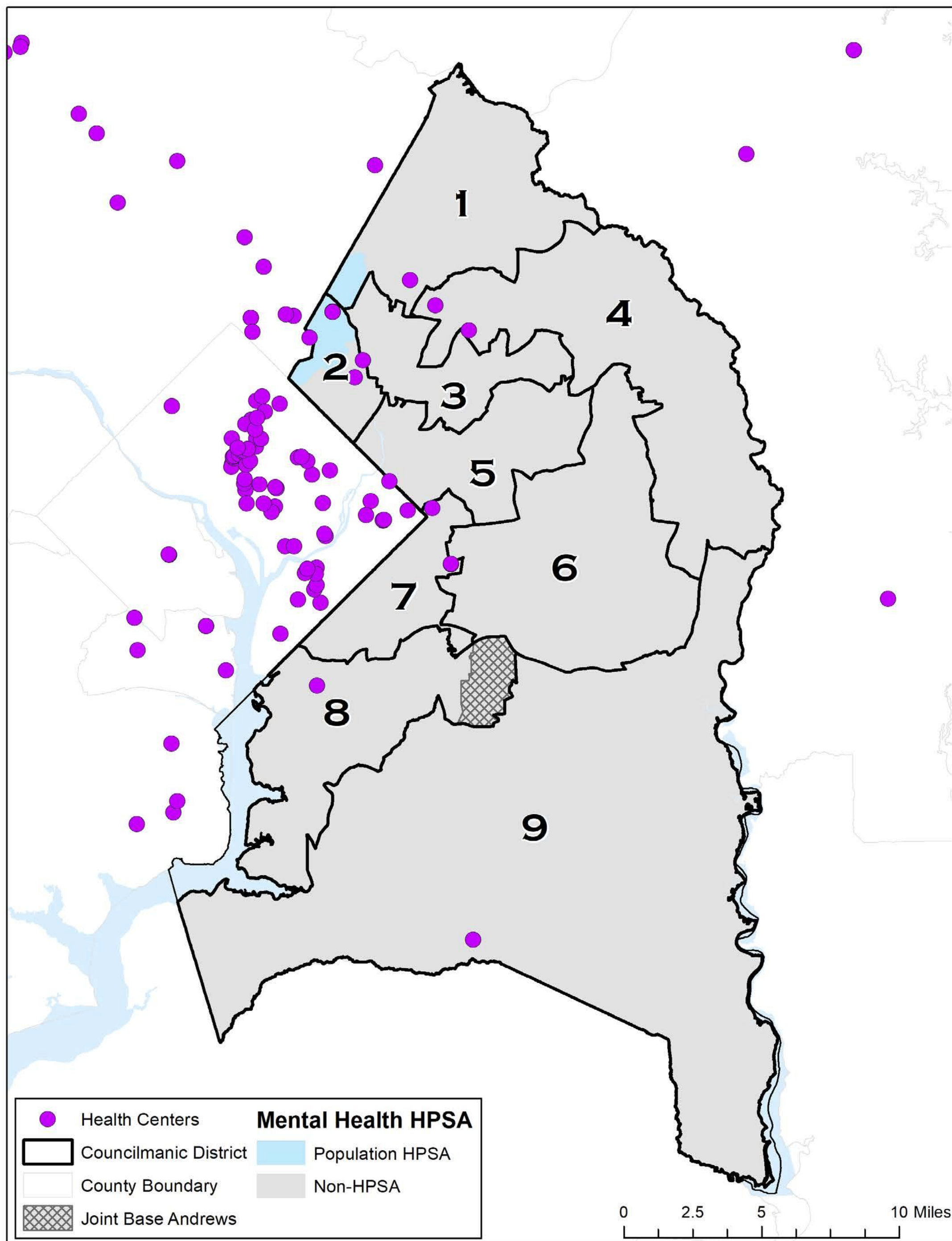
SOURCE: RWJF County Health Rankings, 2019.
NOTES: Raw data obtained from CMS, National Provider Identification file 2013-2018. Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and mental health providers that treat alcohol and other drug abuse, as well as advanced practice nurses specializing in mental health care.

Table 4.7.
License Acute Care Psychiatrics Beds by Hospital in Prince George's County, 2015–2019

	2015	2016	2017	2018	2019
MedStar Southern Maryland Hospital Center	25	25	25	25	25
UM Laurel Regional Hospital	14	9	18	16	10
UM Prince George's Hospital Center	28	28	28	28	32
Total	67	62	71	69	67

SOURCE: Maryland Health Care Commission, 2019.
NOTES: Data from annual reports on licensed acute care beds by hospital and service. Acute care beds generally accommodate hospital days of 30 days or less. Data presented for each fiscal year.

Figure 4.3.
Mental Health Professional Shortage Areas in Prince George's County, 2018



SOURCE: Health Resources & Services Administration, 2019c.
NOTES: HPSA, health professional shortage areas. HPSAs are identified based on geography (e.g., lack of providers nearby) and population (e.g., lack of providers to serve specific populations, such as Medicaid enrollees) or based on facility (e.g., large health care facilities report few available providers). "Population HPSA" identified areas with underserved populations.

Access to Dental Care

Poor oral health can cause pain, problems sleeping, and embarrassment (American Dental Association Health Policy Institute, 2015). Fewer than two-thirds of adults in the County reported visiting a dentist in the past year and 10 percent of adults reported having received their last dental exam more than five years ago (Table 4.8). In 2016, about half of adults in the County reported having no permanent teeth removed, which is an indicator of good oral health. Fewer adults visited a dentist in the past year in the County (65 percent) than the state overall (68 percent) and compared to nearby counties.

Table 4.8.
Self-Reported Use of Dental Care and Oral Health for Adults in Prince George's County, 2016

	Prince George's County	Baltimore County	Howard County	Montgomery County	Maryland
Visited dentist in past year	64.9	66.2	75.4	75.0	68.1
Last visited dentist 5+ years ago	7.7	9.1	5.4	3.8	8.1
No permanent teeth removed	53.1	58.4	67.9	64.7	58.6

SOURCE: BRFSS, 2016.
NOTES: All rates are age-adjusted unless otherwise indicated.

In examining use of dental care and oral health for subgroups within the County (Table 4.9), we find that Hispanic adults were least likely to have a dental visit in the last year and more likely to be missing permanent teeth. Income, educational attainment, and having a personal doctor were all associated with higher rates of having visited a dentist in the past year and having no permanent teeth removed.

Table 4.9.
Self-Reported Use of Dental Care and Oral Health for Adults in Prince George's County, 2016

	Visited dentist in past year	Last visited dentist 5+ years ago	No permanent teeth removed
Overall	64.9	7.7	53.1
Demographics			
Age group*			
18-64	65.0	7.4	58.9
65 and older	66.2	8.7	21.2
Sex			
Female	68.4	6.4	51.3
Male	60.9	9.2	54.9
Race			
White, non-Hispanic	69.1	9.9	64.7
Black, non-Hispanic	69.0	7.4	55.5
Hispanic	50.9	NA	47.3
Socioeconomic characteristics			
Educational attainment			
Above high school	70.4	6.4	61.4
High school or less	56.1	10.1	39.5
Household income			
$50k and above	72.9	3.6	62.5
Below $50k	53.5	14.0	45.3
Has a personal doctor			
Has a personal doctor	70.2	5.3	54.9
No personal doctor	40.3	18.4	47.8

SOURCE: 2016 BRFSS.
NOTES: All rates are age-adjusted unless otherwise indicated. *Indicates crude rate. NA, indicates the rate was not available due to small sample size.

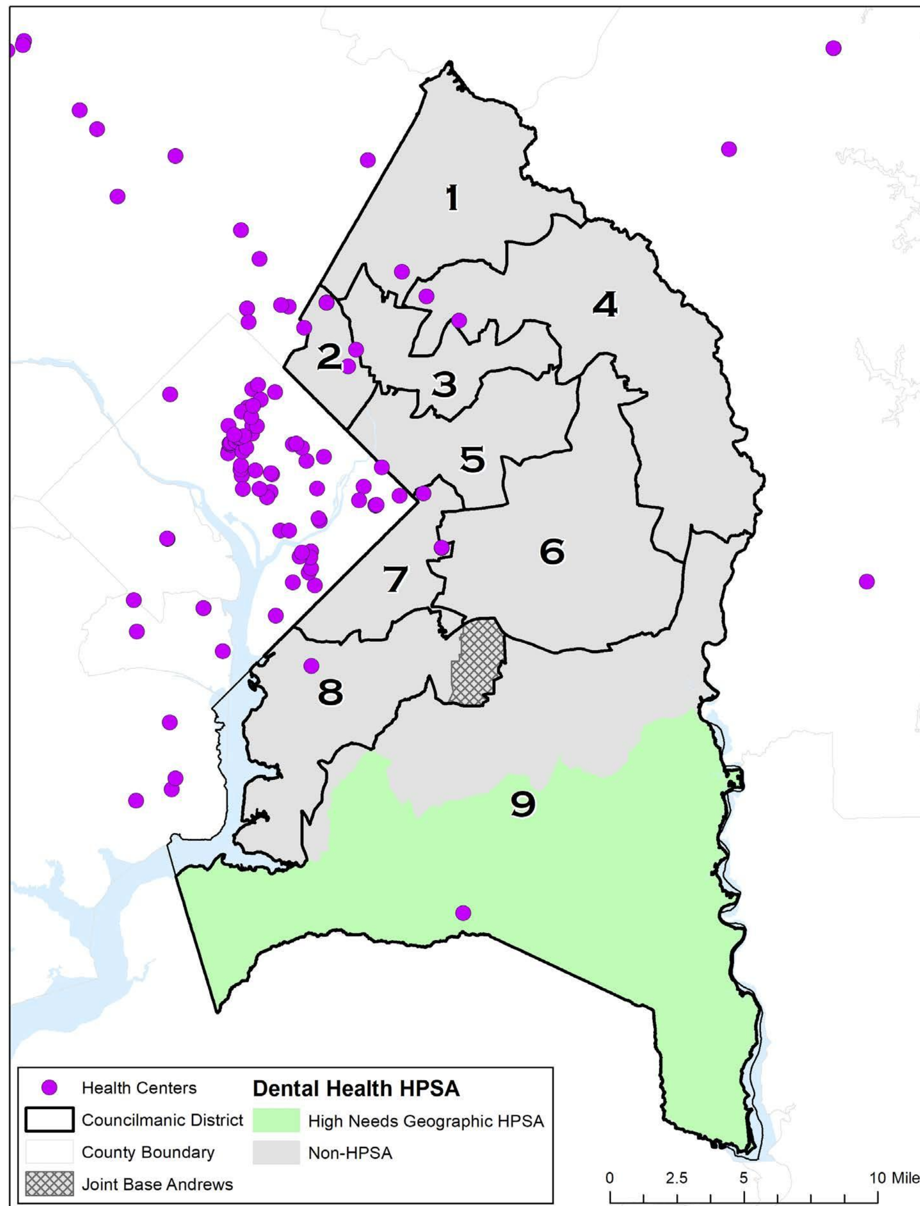
The number of dentists in the County has grown. The ratio of the County population to dentists improved, from 1,712 to 1 in 2013 to 1,645 to 1 in 2017 (Table 4.10). When examining dental health professional shortage areas (Figure 4.4), only District 9 has communities with this designation. This region, however, was flagged as having unusually high needs.

Table 4.10.
Ratio of Population to Dentists in Prince George's County, 2013–2017

Year	Total dentists	Ratio of the population to dentists
2013	520	1,712:1
2014	539	1,678:1
2015	542	1,678:1
2016	550	1,651:1
2017	555	1,645:1

SOURCE: RWJF County Health Rankings, 2019.
NOTES: Raw data obtained from the 2013-2017 Area Health Resources File and the National Provider Identification file.

Figure 4.4.
Dental Health Professional Shortage Areas in Prince George's County, 2018



SOURCE: Health Resources & Services Administration, 2019c.
NOTES: HPSA, health professional shortage areas. HPSAs are identified based on geography (e.g., lack of providers nearby) and population (e.g., lack of providers to serve specific populations, such as Medicaid enrollees) or based on facility (e.g., large health care facilities report few available providers). "High Needs Geographic HPSA" identified areas with few providers and population with high needs.

Hospital-Based Health Care

Emergency Departments (EDs)

EDs offer care to the critically ill and injured. Importantly, EDs are the only part of the U.S. health care system required to screen and stabilize all patients, regardless of insurance status or ability to pay. Thus, EDs frequently provide non-emergency care to individuals living in poverty. Prior research suggests that nearly half of all hospital-associated health care services in the United States. are delivered in EDs and that EDs are increasingly responsible for referrals for inpatient care (Marcozzi, Carr, Liferidge, Baehr, & Browne, 2018; Morganti et al., 2013). The results below describe the common reasons for ED visits for adults and children overall, by race/ethnicity, and by geography. We present age-adjusted rates per 100,000 population.

In 2017, adult county residents made 32,315 visits per 100,000 population to the 16 EDs serving county residents in Maryland and DC. The majority of visits were made to the 11 EDs in Maryland, with fewer visits made to EDs in DC (Table 4.11). More ED visits were made to Doctors Community Hospital, located in Lanham, Maryland, MedStar Southern Maryland Hospital Center, located in Clinton, MD, and University of Maryland Prince George's Hospital Center, located in Cheverly, Maryland. Children made 34,244 visits per 100,000 population to 11 EDs in Maryland and D.C.. About 44 percent of ED visits for children were to Children's National Medical Center in D.C.

Table 4.11.
Percentage of ED Visits by Hospital for Adults and Children, 2017

	Location	% for Adults	% for Children
Doctors Community Hospital*	MD	16.3	8.2
MedStar Southern Maryland Hospital Center*	MD	11.9	5.5
University of Maryland (UM) Prince George's Hospital Center*	MD	11.3	6.4
Fort Washington Medical Center*	MD	10.4	5.3
UM Bowie Health Center*	MD	9.8	7.7
Washington Adventist Hospital	MD	6.5	4.2
Laurel Medical Center*	MD	5.6	3.4
Holy Cross Hospital	MD	5.1	5.6
MedStar Washington Hospital Center	DC	4.3	0
Anne Arundel Medical Center	MD	4	3.9
George Washington University	DC	2.4	0
Providence Hospital	DC	2.3	0
Howard County General Hospital	MD	1.3	1.5
Charles Regional Medical Center	MD	1.2	0
Howard University Hospital	DC	1.2	0
MedStar Georgetown University Hospital	DC	1.1	0
Children's National Medical Center	DC	0	44.3

SOURCE: 2017 Maryland data was obtained from the Maryland Health Services Cost Review Commission. 2017 DC data was obtained from the DC Hospital Association.
NOTES: Includes 2017 ED discharges in Maryland and DC for Prince George's County residents. Adults are aged 18 years and older. Children are younger than 18 years. *Located in Prince George's County.

The most common reasons for ED visits for adults and children are listed in Tables 4.12 and 4.13. For adults, most ED visits were due to sprains and strains (6.1 percent). For children, most ED visits were due to upper respiratory infections (11.7 percent).

Table 4.12.
Most Common Reasons for ED Visits for Adults, Percentage of all ED visits, 2017

	Percentage
Sprains and strains	6.1
Chest pain	6.0
Abdominal pain	4.9
Back pain	4.8
Superficial injury or contusion	3.5

SOURCE: 2017 Maryland data was obtained from the Maryland Health Services Cost Review Commission. 2017 DC data was obtained from the DC Hospital Association.
NOTES: Includes 2017 ED discharges in Maryland and DC for Prince George's County residents. Adults are aged 18 years and older. Reasons are Clinical Classifications Software (CCS) codes which group related diagnoses and procedures into meaningful categories.

Table 4.13.
Most Common Reasons for ED Visits for Children, Percentage of all ED visits, 2017

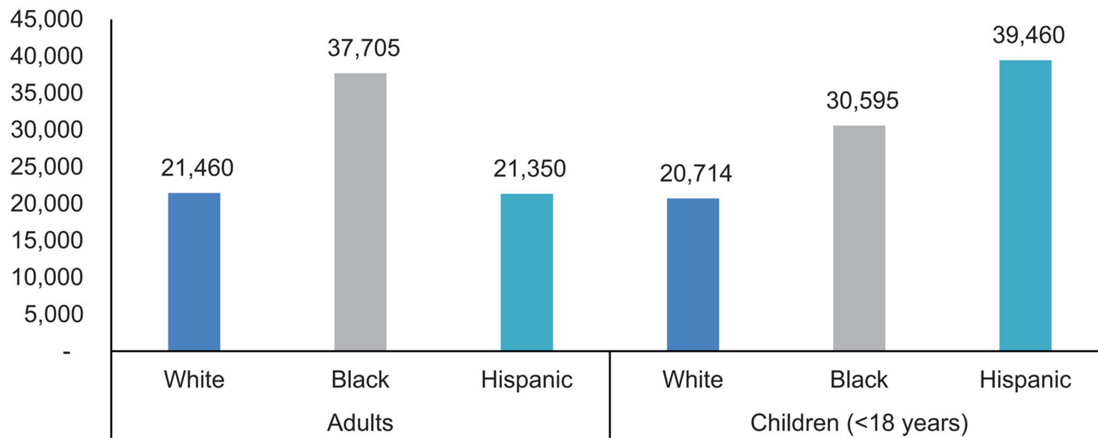
	Percentage
Upper respiratory infections	11.7
Viral infections	4.8
Injuries due to external causes	4.6
Superficial injury or contusion	4.3
Ear infections and related conditions	3.9

SOURCE: 2017 Maryland data was obtained from the Maryland Health Services Cost Review Commission. 2017 DC data was obtained from the DC Hospital Association.
NOTES: Includes 2017 ED discharges in Maryland and DC for Prince George's County residents. Children are younger than 18 years. Reasons are CCS codes which group related diagnoses and procedures into meaningful categories.

Variation in ED visits by race/ethnicity

Rates of ED visits varied across racial/ethnic groups. ED visit rates among adults were greatest for Black adults (37,705 per 100,000) and, among children, were greatest for Hispanic children (39,460 per 100,000) (Figure 4.5).

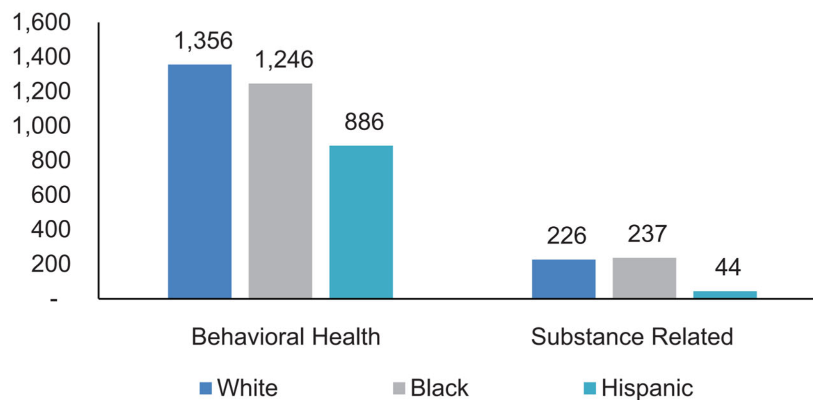
Figure 4.5.
Rates of ED Visits for Adults and Children per 100,000 Population, by Race and Ethnicity, 2017



SOURCE: 2017 Maryland data was obtained from the Maryland Health Services Cost Review Commission. 2017 DC data was obtained from the DC Hospital Association.
NOTES: Includes 2017 ED discharges in Maryland and DC for Prince George's County residents. Adults are aged 18 years and older. Children are younger than 18 years. Rates are age-adjusted and presented as rates per 100,000 population.

When examining ED visit rates for adults by race and ethnicity for mental and behavioral health conditions (Figure 4.6), high rates were observed for White adults (1,356 visits per 100,000) and Black adults (1,246 visits per 100,000). High ED visit rates for substance-related conditions were also observed for White adults (226 visits per 100,000) and Black adults (237 visits per 100,000). ED visit rates for Hispanic adults were considerably lower for mental and behavioral health conditions (886 visits per 100,000) and substance-related conditions (44 visits per 100,000).

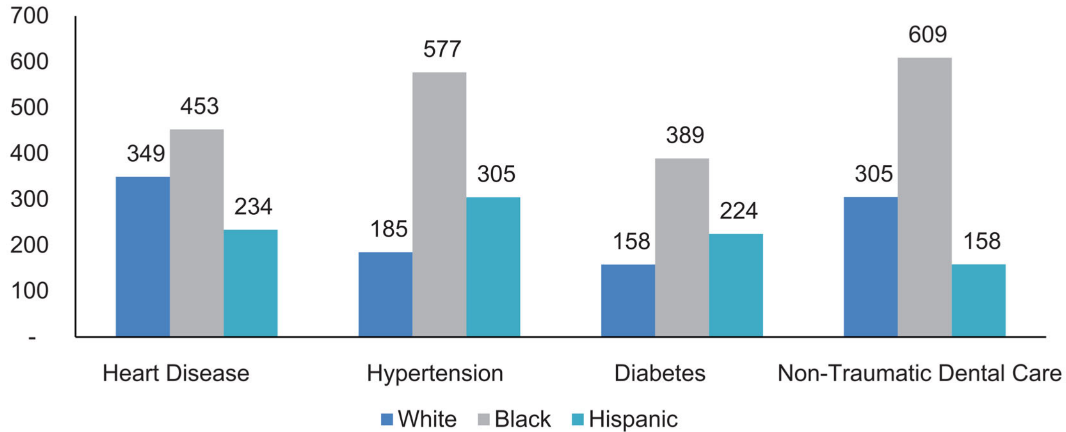
Figure 4.6.
Rates of ED Visits for Mental and Behavioral Health Conditions and Substance-Related Conditions for Adults per 100,000 Population, by Race and Ethnicity, 2017



SOURCE: 2017 Maryland data was obtained from the Maryland Health Services Cost Review Commission. 2017 DC data was obtained from the DC Hospital Association.
NOTES: Includes 2017 ED discharges in Maryland and DC for Prince George's County residents aged 18 years and older. Rates are age-adjusted and presented as rates per 100,000 population.

When examining ED visit rates for adults by race and ethnicity for chronic conditions (Figure 4.7), Black adults had the highest ED visit rates for heart disease, hypertension, diabetes, and non-traumatic dental care. For Black adults, ED visits rates for hypertension were 577 per 100,000 and 609 per 100,000 for non-traumatic dental care.

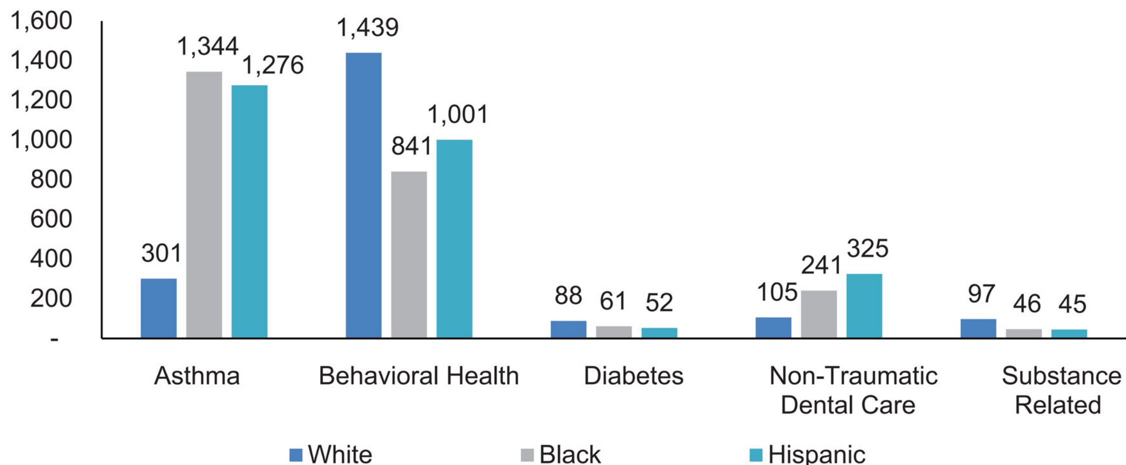
Figure 4.7.
Rates of ED Visits for Chronic Conditions for Adults per 100,000 Population, by Race and Ethnicity and by Condition, 2017



SOURCE: 2017 Maryland data was obtained from the Maryland Health Services Cost Review Commission. 2017 DC data was obtained from the DC Hospital Association.
NOTES: Includes 2017 ED discharges in Maryland and DC for Prince George's County residents aged 18 years and older. Rates are age-adjusted and presented as rates per 100,000 population. Non-traumatic dental care identifies conditions that can be prevented or best treated in a traditional dental office. It is an indicator of poor access to a usual source of dental care.

Rates of ED visits for asthma were more than four times higher for Black and Hispanic children than White children (Figure 4.8). Rates of ED visits for mental and behavioral health conditions were highest among White children (1,429 per 100,000) and lower among Hispanic (1,001 per 100,000) and Black children (841 per 100,000). Rates of ED visits for non-traumatic dental care were highest for Hispanic children (325 per 100,000) followed by Black children (241 per 100,000), and White children (105 per 100,000).

Figure 4.8.
Rates of ED Visits for Children per 100,000 Population, by Race and Ethnicity and by Condition, 2017



SOURCE: 2017 Maryland data was obtained from the Maryland Health Services Cost Review Commission. 2017 DC data was obtained from the DC Hospital Association.
NOTES: Includes 2017 ED discharges in Maryland and DC for Prince George's County residents aged younger than 18 years. Rates are age-adjusted and presented as rates per 100,000 population.

Geographic variation in ED visits

Rates of ED visits per 100,000 population for adults were greatest in Districts 5 and 7 (Table 4.14). District 7 also had the greatest rates of ED visits for diabetes, heart disease, and hypertension for adults. District 5 had the greatest rates of ED visits for mental and behavioral health and substance-related conditions for adults. Behavioral health conditions were responsible for 1,178 ED visits per 100,000 population, in 2017. Additionally, non-traumatic dental care, which is an indicator for poor access to a usual source of dental care, was responsible for 467 ED visits per 100,000 population, which was a higher rate than for diabetes, heart disease, hypertension, or asthma. Additional maps illustrating rates of ED visits for select conditions by patient ZIP code and age group are included in Appendix C.

Table 4.14.
Rates of ED Visits for Adults per 100,000 Population, by District and Condition, 2017

	County Councilmanic Districts									
	PG	1	2	3	4	5	6	7	8	9
All ED visits	32,315	28,443	28,420	30,260	30,708	39,625	33,477	40,224	33,734	30,739
Mental and behavioral health	1,178	1,398	1,289	1,103	1,096	1,668	1,025	1,280	960	993
Substance related	194	168	129	149	163	344	195	301	184	164
Diabetes	321	230	336	339	288	372	315	458	337	268
Heart disease	405	361	305	338	469	413	417	509	462	359
Hypertension	464	409	505	386	396	492	504	626	484	427
Non-traumatic dental care	467	393	277	440	385	587	483	697	577	477
Asthma	416	293	321	350	346	559	427	617	613	339

SOURCE: 2017 Maryland data was obtained from the Maryland Health Services Cost Review Commission. 2017 DC data was obtained from the DC Hospital Association.
NOTES: Includes 2017 ED discharges in Maryland and DC for Prince George's County residents aged 18 years and older. Rates are age-adjusted and presented as rates per 100,000 population. Non-traumatic dental care identifies conditions that can be prevented or best treated in a traditional dental office. It is an indicator of poor access to a usual source of dental care.

Rates of ED visits for children were greatest in District 7 (Table 4.15). District 7 had the greatest rates of ED visits for mental and behavioral health conditions, substance related conditions, and asthma for children. Asthma was responsible for 1,250 per 100,000 ED visits for children. Asthma is best managed in primary care settings, but children who visit EDs for care often lack a usual medical provider or may not have adequate access to needed medications, often having expired prescriptions, missing inhalers, or lack inhalers in all settings (e.g., home, school, sports) (L. Johnson, H., Chambers, & Dexheimer, 2016). Mental and behavioral health conditions were responsible for 936 per 100,000 ED visits for children. The highest rates of ED visits for non-traumatic dental care were observed in Districts 2, 3, 7, and 8.

Table 4.15.
Rates of ED Visits for Children per 100,000 Population, by District and Condition, 2017

	County Councilmanic Districts									
	PG	1	2	3	4	5	6	7	8	9
All ED visits	34,244	29,418	37,464	37,549	28,360	37,527	31,278	41,761	38,296	27,571
Asthma	1,250	790	988	1,107	918	1,318	1,405	1,865	1,863	1,136
Mental and behavioral health	936	1,015	940	869	973	948	931	1,075	982	720
Diabetes	59	72	37	46	41	65	62	72	103	45
Non-traumatic dental care	274	224	329	361	193	282	248	331	325	168
Substance related	49	48	61	47	40	50	59	70	43	33

SOURCE: 2017 Maryland data was obtained from the Maryland Health Services Cost Review Commission. 2017 DC data was obtained from the DC Hospital Association.
NOTES: Includes 2017 ED discharges in Maryland and DC for Prince George's County residents aged younger than 18 years. Rates are age-adjusted and presented as rates per 100,000 population. Non-traumatic dental care identifies conditions that can be prevented or best treated in a traditional dental office. It is an indicator of poor access to a usual source of dental care.

Inpatient Hospitals

Inpatient hospital care is defined as involving an overnight stay at the hospital and therefore tends to include more serious and costly care. In fiscal year 2019, there were five hospitals operating a total of 686 licensed acute care beds (Table 4.16). Acute care beds generally accommodate hospital stays of 30 days or less. UM Prince George's Hospital Center operated the most beds (238), followed by Doctors Community Hospital (190) and MedStar Southern Maryland Hospital Center (176). The total number of licensed acute care beds in the County has declined from 836 in 2009 to 686 in 2019.

Table 4.16.
Licensed Acute Care Beds by Hospital in Prince George's County, 2009–2019

	Doctors Community Hospital	Fort Washington Medical Center	MedStar Southern Maryland Hospital Center	UM Laurel Regional Hospital	UM Prince George's Hospital Center	Total
2009	195	43	255	97	246	836
2010	190	43	246	95	254	828
2011	195	42	235	87	244	803
2012	219	41	238	83	242	823
2013	207	31	239	77	224	778
2014	198	33	227	78	214	750
2015	182	31	207	74	215	709
2016	163	34	208	60	237	702
2017	190	32	192	63	233	710
2018	210	32	182	61	230	715
2019	190	27	176	55	238	686

SOURCE: Maryland Health Care Commission, 2019.
NOTES: Data presented for each fiscal year and obtained from annual reports on licensed acute care beds by hospital and service. Acute care beds generally accommodate hospital stays of 30 days or less. In 2017 the University of Maryland Medical System (UMMS) acquired Dimensions Health System, representing two acute care general hospitals, Laurel Regional Hospital and Prince George's Hospital Center. Dimensions Health System was renamed to University of Maryland Capital Regional Health and the two hospitals were renamed University of Maryland Laurel Regional Medical Center and University of Maryland Prince George's Medical Center, and joined UMMS.

Inpatient Utilization

The results below describe the common reasons for inpatient hospitalizations for adults and children overall, by race/ethnicity, and by geography. Information is presented on County residents who received care in Maryland or in D.C. We present age-adjusted rates per 100,000 population.

In 2017, adult County residents had 10,603 hospital discharges per 100,000 population to the 12 hospitals serving County residents in Maryland and DC. Table 4.13 describes the percentage of inpatient hospitalizations by hospital for adults and children, sorted by percentage of hospitalizations for adults. Most hospitalizations occurred at Holy Cross Hospital, located in Silver Spring, Maryland, Prince George's Hospital Center, located in Cheverly, Maryland, and Doctors Community Hospital, located in Lanham, Maryland (Table 4.17). Children had 2,582 hospital discharges per 100,000 population to nine hospital EDs in Maryland and D.C. The majority of hospital discharges for children (69 percent) were to Children's National Medical Center in D.C.

Table 4.17.
Percentage of Inpatient Hospitalizations by Hospital for Adults and Children, 2017

	Location	% for Adults	% for Children
Holy Cross Hospital	MD	12.0	6.2
University of Maryland (UM) Prince George's Hospital Center*	MD	11.9	4.8
Doctors Community Hospital*	MD	11.5	0
MedStar Washington Hospital Center	DC	10.6	0
MedStar Southern Maryland Hospital Center*	MD	10.5	2.1
Washington Adventist Hospital	MD	6.6	2.7
Anne Arundel Medical Center	MD	6.1	2
MedStar Georgetown University Hospital	DC	3.6	1.9
Laurel Medical Center*	MD	3.0	0
George Washington University	DC	3.0	0
Fort Washington Medical Center*	MD	2.4	0
Providence Hospital	DC	2.1	0
Johns Hopkins Hospital	MD	2.0	3.4
Howard County General Hospital	MD	1.6	0
Suburban Hospital	MD	1.5	0
University of Maryland Medical Center	MD	1.3	1.1
United Medical Center	DC	1.2	0
Sibley Memorial Hospital	DC	1.0	0
Children's National Medical Center	DC	0	69

SOURCE: 2017 Maryland data was obtained from the Maryland Health Services Cost Review Commission. 2017 DC data was obtained from the DC Hospital Association.
NOTES: Includes 2017 inpatient hospital discharges in Maryland and DC for Prince George's County residents. Adults are aged 18 years and older. Children are younger than 18 years. Rates are age-adjusted and presented as rates per 100,000 population. *Indicates location in Prince George's County.

The most common reasons for hospitalizations for adults and children are listed in Tables 4.18 and 4.19. For adults, most hospitalizations were due to septicemia (6.2 percent), a serious bloodstream infection. For children, most ED visits were due to mood disorders (6.6 percent).

Table 4.18.
Most Common Reasons for Hospitalizations for Adults, Percentage of all Hospitalizations, 2017

	Percentage
Septicemia (except in labor)	6.2
Hypertension with complications	5.2
Other complications of birth	3.6
Acute cerebrovascular disease	2.8
Osteoarthritis	2.6

SOURCE: 2017 Maryland data was obtained from the Maryland Health Services Cost Review Commission. 2017 DC data was obtained from the DC Hospital Association.
NOTES: Includes 2017 inpatient hospital discharges in Maryland and DC for Prince George's County residents. Adults are aged 18 years and older. Reasons are CCS codes which group related diagnoses and procedures into meaningful categories.

Table 4.19.
Most Common Reasons for Hospitalizations for Children, Percentage of all Hospitalizations in 2017

	Percentage
Mood disorders	6.6
Asthma	6.3
Pneumonia	4.5
Acute bronchitis	4.1
Sickle cell anemia	3.9

SOURCE: 2017 Maryland data was obtained from the Maryland Health Services Cost Review Commission. 2017 DC data was obtained from the DC Hospital Association.
NOTES: Includes 2017 inpatient hospital discharges in Maryland and DC for Prince George's County residents. Children are younger than 18 years. Reasons are CCS codes which group related diagnoses and procedures into meaningful categories.

Variation in Hospitalization by Race/Ethnicity

During 2017, rates of hospitalizations were highest for Black adults (11,163 per 100,000) and for Hispanic children (3,690 per 100,000) (Figure 4.9). Hispanic children were hospitalized at a rate nearly double their White and Black counterparts. Maps illustrating rates of hospitalizations for select conditions by patient ZIP code and age group are available in Appendix D.

When examining rates of hospitalizations of adults by race and ethnicity (Figure 4.10), Black adults had the highest rates of inpatient hospitalizations for conditions associated with metabolic syndrome, including heart disease (1,208 per 100,000), hypertension (679 per 100,000), and diabetes (290 per 100,000). Hospitalization rates per 100,000 for mental and behavioral health