Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission (HSCRC or Commission) is required to collect community benefit information from individual hospitals in Maryland and compile into an annual statewide, publicly available report. The Maryland General Assembly updated §19-303 of the Health General Article in the 2020 Legislative Session (HB1169/SB0774), requiring the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments. The reporting is split into two components, a Financial Report and a Narrative Report. This reporting tool serves as the narrative report. In response to the legislation, some of the reporting questions have changed for FY 2021. Detailed reporting instructions are available here: https://hscrc.maryland.gov/Pages/init_cb.aspx

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

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

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

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

	Is this information correct?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Howard County General Hospital	◉	○	
Your hospital's ID is: 210048	◉	○	
Your hospital is part of the hospital system called Johns Hopkins Heath System	◉	○	
The primary Narrative contact at your hospital is Elizabeth Kromm	◉	○	
The primary Narrative contact email address at your hospital is ekromm@jhmi.edu	◉	○	
The primary Financial contact at your hospital is Fran Moll	◉	○	
The primary Financial email at your hospital is fmoll1@jhmi.edu	◉	○	

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

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

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

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

HCGH utilizes the Maryland SHIP metrics as well as the US Census Bureau, American Community Survey, and County Health Rankings. HCGH also uses the United Way's ALICE report to review community members above the poverty line but with financial challenges due to the high cost of living in the county. Finally, HCGH partners with the Howard County Health Department, the Horizon Foundation, the Columbia Association, and OpinionWorks to design and administer the Howard County Health Assessment Survey every two years. This Howard County-specific survey asks residents questions about a variety of health-related information such as chronic disease, physical activity, nutrition, and behavioral health.

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

HCHAS 2018 Official Final Report (3).pdf
8.7MB
application/pdf

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

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

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

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

- [ ] 21048
- [ ] 21074
- [ ] 21757
- [ ] 21771

- [ ] 21102
- [x] 21104
- [ ] 21136
- [ ] 21155
- [ ] 21157
- [ ] 21158
- [ ] 21776
- [x] 21784
- [ ] 21787
- [ ] 21791
- [x] 21797

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

- [ ] 20842
- [ ] 20871
- [ ] 21701
- [ ] 21702
- [ ] 21703
- [ ] 21704
- [ ] 21705
- [ ] 21710
- [ ] 21713
- [ ] 21714
- [ ] 21716
- [ ] 21717
- [ ] 21718
- [ ] 21719
- [ ] 21727
- [ ] 21754
- [ ] 21755
- [ ] 21757
- [ ] 21758
- [ ] 21759
- [ ] 21762
- [ ] 21769
- [ ] 21770
- [x] 21771
- [ ] 21773
- [ ] 21774
- [ ] 21775
- [ ] 21776
- [ ] 21777
- [ ] 21778
- [ ] 21780
- [ ] 21783
- [ ] 21787
- [ ] 21788
- [ ] 21790
- [ ] 21791
- [ ] 21793
- [ ] 21798

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

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

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

☐ Based on ZIP codes in your Financial Assistance Policy. Please describe.

☐ Based on ZIP codes in your global budget revenue agreement. Please describe.

☑

Based on patterns of utilization. Please describe.

HCGH selects its community benefit service area based on the geographic source of the majority of its inpatient utilization.

☐ Other. Please describe.

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

https://www.hopkinsmedicine.org/howard_county_general_hospital/services/

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

Howard County, located between Baltimore and Washington D.C., is a relatively affluent, educated and healthy community. The county is home to urban, suburban, and rural communities. Howard County continues to rank as one of the healthiest counties in the state of Maryland, according to the Robert Wood Johnson Foundation and University of Wisconsin County Health Rankings. In 2021, U.S. News and World Report ranked Howard County in the top ten healthiest counties in America. Due to these factors, Howard County is increasing in popularity for young families as well as those aging in place, and the population is growing accordingly. Howard County is inhabited by 332,317 residents. The county's population is growing more quickly than both the state and nation's populations; between 2010 and 2021 the county's population grew by over 15%. The county's population is 51% female. Between 2021 and 2045, the overall population is estimated to increase by over 11%. During the same time period, those age 50 and older will increase by 74.7%. An estimated 41% of county residents will be 50 or older by 2035. In the next 5 years alone, the 65 and older population of Howard County, currently making up about 15% of the county's population, is projected to grow by nearly 22%. As Howard County grows, it has become increasingly diverse. 56% of the county's residents are white, followed by 20.4% Black and 19.3% Asian. 7.3% of residents identify as Hispanic or Latino. 21.1% of residents are foreign-born. 24.6% of the population speaks a language other than English at home; the most common foreign languages in the county are Asian and Pacific Islander languages (Korean, Chinese, etc.). The average household size in Howard County is 2.8 persons and the average family size is 3.33 persons. Howard County overall has a high median household income, but 3.2% of all Howard County residents have an annual income that put them below the poverty level.

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

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

- (●) Yes
- ( ) No

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

This question was not displayed to the respondent.

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

06/03/2019

Q41. Please provide a link to your hospital's most recently completed CHNA.

https://www.hopkinsmedicine.org/howard_county_general_hospital/about/giving_back/chna.html

Q42. Please upload your hospital's most recently completed CHNA.

CommunityHealthNeedsAssessment_FY19.pdf
5.6MB
application/pdf

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

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

	CHNA Activities

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

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

Q45. Section II - CHNAs and Stakeholder Involvement Part 3 - Internal HCB Partners

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

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

	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:
Community Benefit staff (system level)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	Discussing and reviewing community benefits strategy
	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:
Physician(s)	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐	
	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:
Nurse(s)	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐	
	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	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐	
	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:
Hospital Advisory Board	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	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:
Other (specify) HCGH Finance Dept and Foundation	☐	☐	☐	☐	☐	☑	☑	☐	☑	☐	
	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:

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

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

Refer to the FY 2021 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is optional for FY 2021, but will be mandatory for FY 2022.

	Level of Community Engagement						Recommended Practices							
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals -- Please list the hospitals here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - K-12 -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - Colleges, Universities, Professional Schools -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Behavioral Health Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Social Service Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Post-Acute Care Facilities -- please list the facilities here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Community/Neighborhood Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

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

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

- (●) Yes
- ( ) No

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

06/03/2019

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

https://www.hopkinsmedicine.org/howard_county_general_hospital/about/giving_back/chna.html

Q222. Please upload your hospital's CHNA implementation strategy.

CommunityHealthNeedsAssessment_FY19.pdf
5.6MB
application/pdf

Q53. 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.

Q54. Please select the CHNA Priority Area Categories most relevant to your most recent CHNA. The list of categories is based on the Healthy People 2030 objectives available here. This list is not exhaustive. Please select "other" and describe any CHNA Priority Area Categories that are not captured by this list. Select all that apply even if a need was not addressed by a reported initiative.

- ☐ Health Conditions - Addiction
- ☑ Health Behaviors - Drug and Alcohol Use
- ☑ Populations - Women

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

Q56. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Q57. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q58. Section II - CHNAs and Stakeholder Involvement Part 6 - Initiatives

Q59. Please use the questions below to provide details regarding the initiatives to address the CHNA Priority Area Categories selected in the previous question.

For those hospitals completing the ***optional*** CHNA financial reporting in FY 2021, please ensure that these tie directly to line item initiatives in the financial reporting template.

For those hospitals **not** completing the ***optional*** CHNA financial template, please provide this information for as many initiatives as you deem feasible.

Please note that hospitals will be required to report on each CHNA-related initiative in FY 2022.

Q163. Please describe the initiative(s) addressing Health Conditions - Addiction.

This question was not displayed to the respondent.

Q182. Please describe the initiative(s) addressing Health Conditions - Arthritis.

This question was not displayed to the respondent.

Q183. Please describe the initiative(s) addressing Health Conditions - Blood Disorders.

This question was not displayed to the respondent.

Q184. Please describe the initiative(s) addressing Health Conditions - Cancer.

This question was not displayed to the respondent.

Q185. Please describe the initiative(s) addressing Health Conditions - Chronic Kidney Disease.

This question was not displayed to the respondent.

Q186. Please describe the initiative(s) addressing Health Conditions - Chronic Pain.

	Health Conditions - Chronic Pain Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Community Care Team (CCT)	Serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at Howard County General Hospital (HCGH) within the past year. Patients and their caregivers receive benefits from this program for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers, nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources.	In FY21, CCT had 1,236 referrals with a 66% acceptance rate. Based on an external analysis of the CCT, TCOC savings equals $1,842 per beneficiary per year post enrollment. Through care coordination efforts, enrolled patients had a positive impact on the readmission reduction payment policy: enrolled patients avoided 8 readmissions post enrollment, a favorable impact of $91,500. Additionally, there was an increase in palliative care documentation in the post-enrollment period for enrolled beneficiaries.	# of referrals and the acceptance rate; Total cost of care per beneficiary per year; Avoidable readmissions and cost impact of avoided readmissions; Palliative care documentation post-enrollment
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q187. Please describe the initiative(s) addressing Health Conditions - Dementias.

This question was not displayed to the respondent.

Q188. Please describe the initiative(s) addressing Health Conditions - Diabetes.

	Health Conditions - Diabetes Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Community Care Team (CCT)	Serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at Howard County General Hospital (HCGH) within the past year. Patients and their caregivers receive benefits from this program for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers, nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources.	In FY21, CCT had 1,236 referrals with a 66% acceptance rate. Based on an external analysis of the CCT, TCOC savings equals $1,842 per beneficiary per year post enrollment. Through care coordination efforts, enrolled patients had a positive impact on the readmission reduction payment policy: enrolled patients avoided 8 readmissions post enrollment, a favorable impact of $91,500. Additionally, there was an increase in palliative care documentation in the post-enrollment period for enrolled beneficiaries.	# of referrals and the acceptance rate; Total cost of care per beneficiary per year; Avoidable readmissions and cost impact of avoided readmissions; Palliative care documentation post-enrollment
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q189. Please describe the initiative(s) addressing Health Conditions - Foodborne Illness.

This question was not displayed to the respondent.

Q190. Please describe the initiative(s) addressing Health Conditions - Health Care-Associated Infections.

This question was not displayed to the respondent.

Q191. Please describe the initiative(s) addressing Health Conditions - Heart Disease and Stroke.

This question was not displayed to the respondent.

Q192. Please describe the initiative(s) addressing Health Conditions - Infectious Disease.

This question was not displayed to the respondent.

Q193. Please describe the initiative(s) addressing Health Conditions - Mental Health and Mental Disorders.

	Health Conditions - Mental Health and Mental Disorders Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Behavioral Health Navigator (BHN) Program	Connects patients with behavioral health issues (diagnosed mental illness and/or substance use disorder) in the Emergency Department with appropriate community-based services and providers in a timely fashion. This includes referrals and linkages to mental health treatment, substance use treatment, support groups and housing programs. The program partners with several community behavioral health organizations, such as Waystation and Grassroots. BHN services consist of a screening that identifies non-medical needs, completing referrals, assistance with scheduling post discharge mental health or drug treatment appointments, and follow up phone calls within 48 hours of discharge from the ED to ensure linkages have successfully occurred.	In FY21, even with the impact of COVID-19, HCGH BHNs screened 560 patients and assisted in connecting 72% of them to behavioral health community services.	# of participants screened; % of those screened connected to services
Initiative B	Rapid Access Program (RAP)	In conjunction with Sheppard Pratt Way Station that provides access to urgent, outpatient, psychiatric services within 48 hours of referral, this program is for adults seen in the hospital that are in need of immediate access to psychiatric intervention, regardless of insurance coverage and ability to pay. This service is intended to prevent further emotional distress and avoid decompensation which otherwise would result in accessing more acute levels of care. Patients referred to Way Station have the option of continuing with treatment or may wish to move on to a different provider once they have become stabilized.	In FY21, RAP enrolled 146 patients and had only an 8.5% 30-day all-cause readmission rate for those patients. This is a lower readmission rate than those with similar diagnoses and not enrolled in the program.	# of participants enrolled; % 30-day all-cause readmission rate
Initiative C	Community Care Team (CCT)	Serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at Howard County General Hospital (HCGH) within the past year. Patients and their caregivers receive benefits from this program for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers, nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources.	In FY21, CCT had 1,236 referrals with a 66% acceptance rate. Based on an external analysis of the CCT, TCOC savings equals $1,842 per beneficiary per year post enrollment. Through care coordination efforts, enrolled patients had a positive impact on the readmission reduction payment policy: enrolled patients avoided 8 readmissions post enrollment, a favorable impact of $91,500. Additionally, there was an increase in palliative care documentation in the post-enrollment period for enrolled beneficiaries.	# of referrals and the acceptance rate; Total cost of care per beneficiary per year; Avoidable readmissions and cost impact of avoided readmissions; Palliative care documentation post-enrollment
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q194. Please describe the initiative(s) addressing Health Conditions - Oral Conditions.

	Health Conditions - Oral Conditions Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				

Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q195. Please describe the initiative(s) addressing Health Conditions - Osteoporosis.

This question was not displayed to the respondent.

Q196. Please describe the initiative(s) addressing Health Conditions - Overweight and Obesity.

	Health Conditions - Overweight and Obesity Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Community Care Team (CCT)	Serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at Howard County General Hospital (HCGH) within the past year. Patients and their caregivers receive benefits from this program for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers, nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources.	In FY21, CCT had 1,236 referrals with a 66% acceptance rate. Based on an external analysis of the CCT, TCOC savings equals $1,842 per beneficiary per year post enrollment. Through care coordination efforts, enrolled patients had a positive impact on the readmission reduction payment policy: enrolled patients avoided 8 readmissions post enrollment, a favorable impact of $91,500. Additionally, there was an increase in palliative care documentation in the post-enrollment period for enrolled beneficiaries.	# of referrals and the acceptance rate; Total cost of care per beneficiary per year; Avoidable readmissions and cost impact of avoided readmissions; Palliative care documentation post-enrollment
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q197. Please describe the initiative(s) addressing Health Conditions - Pregnancy and Childbirth.

	Health Conditions - Pregnancy and Childbirth Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q198. Please describe the initiative(s) addressing Health Conditions - Respiratory Disease.

This question was not displayed to the respondent.

Q199. Please describe the initiative(s) addressing Health Conditions - Sensory or Communication Disorders.

This question was not displayed to the respondent.

Q200. Please describe the initiative(s) addressing Health Conditions - Sexually Transmitted Infections.

This question was not displayed to the respondent.

Q201. Please describe the initiative(s) addressing Health Behaviors - Child and Adolescent Development.

This question was not displayed to the respondent.

Q202. Please describe the initiative(s) addressing Health Behaviors - Drug and Alcohol Use.

	Health Behaviors - Drug and Alcohol Use Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Rapid Access Program (RAP)	In conjunction with Sheppard Pratt Way Station that provides access to urgent, outpatient, psychiatric services within 48 hours of referral, this program is for adults seen in the hospital that are in need of immediate access to psychiatric intervention, regardless of insurance coverage and ability to pay. This service is intended to prevent further emotional distress and avoid decompensation which otherwise would result in accessing more acute levels of care. Patients referred to Way Station have the option of continuing with treatment or may wish to move on to a different provider once they have become stabilized.	In FY21, RAP enrolled 146 patients and had only an 8.5% 30-day all-cause readmission rate for those patients. This is a lower readmission rate than those with similar diagnoses and not enrolled in the program.	# of participants enrolled; % 30-day all-cause readmission rate
Initiative B	Behavioral Health Navigator (BHN) Program	Connects patients with behavioral health issues (diagnosed mental illness and/or substance use disorder) in the Emergency Department with appropriate community-based services and providers in a timely fashion. This includes referrals and linkages to mental health treatment, substance use treatment, support groups and housing programs. The program partners with several community behavioral health organizations, such as Waystation and Grassroots. BHN services consist of a screening that identifies non-medical needs, completing referrals, assistance with scheduling post discharge mental health or drug treatment appointments, and follow up phone calls within 48 hours of discharge from the ED to ensure linkages have successfully occurred.	In FY21, even with the impact of COVID-19, HCGH BHNs screened 560 patients and assisted in connecting 72% of them to behavioral health community services.	# of participants screened; % of those screened connected to services
Initiative C	Community Care Team (CCT)	Serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at Howard County General Hospital (HCGH) within the past year. Patients and their caregivers receive benefits from this program for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers, nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources.	In FY21, CCT had 1,236 referrals with a 66% acceptance rate. Based on an external analysis of the CCT, TCOC savings equals $1,842 per beneficiary per year post enrollment. Through care coordination efforts, enrolled patients had a positive impact on the readmission reduction payment policy: enrolled patients avoided 8 readmissions post enrollment, a favorable impact of $91,500. Additionally, there was an increase in palliative care documentation in the post-enrollment period for enrolled beneficiaries.	# of referrals and the acceptance rate; Total cost of care per beneficiary per year; Avoidable readmissions and cost impact of avoided readmissions; Palliative care documentation post-enrollment
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q203. Please describe the initiative(s) addressing Health Behaviors - Emergency Preparedness.

This question was not displayed to the respondent.

Q204. Please describe the initiative(s) addressing Health Behaviors - Family Planning.

This question was not displayed to the respondent.

Q205. Please describe the initiative(s) addressing Health Behaviors - Health Communication.

	Health Behaviors - Health Communication Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Behavioral Health Navigator (BHN) Program	Connects patients with behavioral health issues (diagnosed mental illness and/or substance use disorder) in the Emergency Department with appropriate community-based services and providers in a timely fashion. This includes referrals and linkages to mental health treatment, substance use treatment, support groups and housing programs. The program partners with several community behavioral health organizations, such as Waystation and Grassroots. BHN services consist of a screening that identifies non-medical needs, completing referrals, assistance with scheduling post discharge mental health or drug treatment appointments, and follow up phone calls within 48 hours of discharge from the ED to ensure linkages have successfully occurred.	In FY21, even with the impact of COVID-19, HCGH BHNs screened 560 patients and assisted in connecting 72% of them to behavioral health community services.	# of participants screened; % of those screened connected to services
Initiative B	Rapid Access Program (RAP)	In conjunction with Sheppard Pratt Way Station that provides access to urgent, outpatient, psychiatric services within 48 hours of referral, this program is for adults seen in the hospital that are in need of immediate access to psychiatric intervention, regardless of insurance coverage and ability to pay. This service is intended to prevent further emotional distress and avoid decompensation which otherwise would result in accessing more acute levels of care. Patients referred to Way Station have the option of continuing with treatment or may wish to move on to a different provider once they have become stabilized.	In FY21, RAP enrolled 146 patients and had only an 8.5% 30-day all-cause readmission rate for those patients. This is a lower readmission rate than those with similar diagnoses and not enrolled in the program.	# of participants enrolled; % 30-day all-cause readmission rate
Initiative C	Community Care Team (CCT)	Serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at Howard County General Hospital (HCGH) within the past year. Patients and their caregivers receive benefits from this program for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers, nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources.	In FY21, CCT had 1,236 referrals with a 66% acceptance rate. Based on an external analysis of the CCT, TCOC savings equals $1,842 per beneficiary per year post enrollment. Through care coordination efforts, enrolled patients had a positive impact on the readmission reduction payment policy: enrolled patients avoided 8 readmissions post enrollment, a favorable impact of $91,500. Additionally, there was an increase in palliative care documentation in the post-enrollment period for enrolled beneficiaries.	# of referrals and the acceptance rate; Total cost of care per beneficiary per year; Avoidable readmissions and cost impact of avoided readmissions; Palliative care documentation post-enrollment
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q206. Please describe the initiative(s) addressing Health Behaviors - Injury Prevention.

This question was not displayed to the respondent.

Q207. Please describe the initiative(s) addressing Health Behaviors - Nutrition and Healthy Eating.

	Health Behaviors - Nutrition and Healthy Eating Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Community Care Team (CCT)	Serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at Howard County General Hospital (HCGH) within the past year. Patients and their caregivers receive benefits from this program for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers, nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources.	In FY21, CCT had 1,236 referrals with a 66% acceptance rate. Based on an external analysis of the CCT, TCOC savings equals $1,842 per beneficiary per year post enrollment. Through care coordination efforts, enrolled patients had a positive impact on the readmission reduction payment policy: enrolled patients avoided 8 readmissions post enrollment, a favorable impact of $91,500. Additionally, there was an increase in palliative care documentation in the post-enrollment period for enrolled beneficiaries.	# of referrals and the acceptance rate; Total cost of care per beneficiary per year; Avoidable readmissions and cost impact of avoided readmissions; Palliative care documentation post-enrollment
Initiative B				
Initiative C				
Initiative D				

Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q208. Please describe the initiative(s) addressing Health Behaviors - Physical Activity.

	Health Behaviors - Physical Activity Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Community Care Team (CCT)	Serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at Howard County General Hospital (HCGH) within the past year. Patients and their caregivers receive benefits from this program for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers, nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources.	In FY21, CCT had 1,236 referrals with a 66% acceptance rate. Based on an external analysis of the CCT, TCOC savings equals $1,842 per beneficiary per year post enrollment. Through care coordination efforts, enrolled patients had a positive impact on the readmission reduction payment policy: enrolled patients avoided 8 readmissions post enrollment, a favorable impact of $91,500. Additionally, there was an increase in palliative care documentation in the post-enrollment period for enrolled beneficiaries.	# of referrals and the acceptance rate; Total cost of care per beneficiary per year; Avoidable readmissions and cost impact of avoided readmissions; Palliative care documentation post-enrollment
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q209. Please describe the initiative(s) addressing Health Behaviors - Preventive Care.

This question was not displayed to the respondent.

Q210. Please describe the initiative(s) addressing Health Behaviors - Safe Food Handling.

This question was not displayed to the respondent.

Q211. Please describe the initiative(s) addressing Health Behaviors - Sleep.

This question was not displayed to the respondent.

Q212. Please describe the initiative(s) addressing Health Behaviors - Tobacco Use.

	Health Behaviors - Tobacco Use Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Behavioral Health Navigator (BHN) Program	Connects patients with behavioral health issues (diagnosed mental illness and/or substance use disorder) in the Emergency Department with appropriate community-based services and providers in a timely fashion. This includes referrals and linkages to mental health treatment, substance use treatment, support groups and housing programs. The program partners with several community behavioral health organizations, such as Waystation and Grassroots. BHN services consist of a screening that identifies non-medical needs, completing referrals, assistance with scheduling post discharge mental health or drug treatment appointments, and follow up phone calls within 48 hours of discharge from the ED to ensure linkages have successfully occurred.	In FY21, even with the impact of COVID-19, HCGH BHNs screened 560 patients and assisted in connecting 72% of them to behavioral health community services.	# of participants screened; % of those screened connected to services

Initiative B	Community Care Team (CCT)	Serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at Howard County General Hospital (HCGH) within the past year. Patients and their caregivers receive benefits from this program for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers, nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources.	In FY21, CCT had 1,236 referrals with a 66% acceptance rate. Based on an external analysis of the CCT, TCOC savings equals $1,842 per beneficiary per year post enrollment. Through care coordination efforts, enrolled patients had a positive impact on the readmission reduction payment policy: enrolled patients avoided 8 readmissions post enrollment, a favorable impact of $91,500. Additionally, there was an increase in palliative care documentation in the post-enrollment period for enrolled beneficiaries.	# of referrals and the acceptance rate; Total cost of care per beneficiary per year; Avoidable readmissions and cost impact of avoided readmissions; Palliative care documentation post-enrollment
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q213. Please describe the initiative(s) addressing Health Behaviors - Vaccination.

This question was not displayed to the respondent.

Q214. Please describe the initiative(s) addressing Health Behaviors - Violence Prevention.

This question was not displayed to the respondent.

Q215. Please describe the initiative(s) addressing Populations - Adolescents.

This question was not displayed to the respondent.

Q216. Please describe the initiative(s) addressing Populations - Children.

This question was not displayed to the respondent.

Q217. Please describe the initiative(s) addressing Populations - Infants.

	Populations - Infants Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A				
Initiative B				
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q218. Please describe the initiative(s) addressing Populations - LGBT.

This question was not displayed to the respondent.

Q219. Please describe the initiative(s) addressing Populations - Men.

	Populations - Men Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes

Initiative A	Community Care Team (CCT)	Serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at Howard County General Hospital (HCGH) within the past year. Patients and their caregivers receive benefits from this program for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers, nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources.	In FY21, CCT had 1,236 referrals with a 66% acceptance rate. Based on an external analysis of the CCT, TCOC savings equals $1,842 per beneficiary per year post enrollment. Through care coordination efforts, enrolled patients had a positive impact on the readmission reduction payment policy: enrolled patients avoided 8 readmissions post enrollment, a favorable impact of $91,500. Additionally, there was an increase in palliative care documentation in the post-enrollment period for enrolled beneficiaries.	# of referrals and the acceptance rate; Total cost of care per beneficiary per year; Avoidable readmissions and cost impact of avoided readmissions; Palliative care documentation post-enrollment
Initiative B	Behavioral Health Navigator (BHN) Program	Connects patients with behavioral health issues (diagnosed mental illness and/or substance use disorder) in the Emergency Department with appropriate community-based services and providers in a timely fashion. This includes referrals and linkages to mental health treatment, substance use treatment, support groups and housing programs. The program partners with several community behavioral health organizations, such as Waystation and Grassroots. BHN services consist of a screening that identifies non-medical needs, completing referrals, assistance with scheduling post discharge mental health or drug treatment appointments, and follow up phone calls within 48 hours of discharge from the ED to ensure linkages have successfully occurred.	In FY21, even with the impact of COVID-19, HCGH BHNs screened 560 patients and assisted in connecting 72% of them to behavioral health community services.	# of participants screened; % of those screened connected to services
Initiative C	Rapid Access Program (RAP)	In conjunction with Sheppard Pratt Way Station that provides access to urgent, outpatient, psychiatric services within 48 hours of referral, this program is for adults seen in the hospital that are in need of immediate access to psychiatric intervention, regardless of insurance coverage and ability to pay. This service is intended to prevent further emotional distress and avoid decompensation which otherwise would result in accessing more acute levels of care. Patients referred to Way Station have the option of continuing with treatment or may wish to move on to a different provider once they have become stabilized.	In FY21, RAP enrolled 146 patients and had only an 8.5% 30-day all-cause readmission rate for those patients. This is a lower readmission rate than those with similar diagnoses and not enrolled in the program.	# of participants enrolled; % 30-day all-cause readmission rate
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q220. Please describe the initiative(s) addressing Populations - Older Adults.

	Populations - Older Adults Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Community Care Team (CCT)	Serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at Howard County General Hospital (HCGH) within the past year. Patients and their caregivers receive benefits from this program for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers, nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources.	In FY21, CCT had 1,236 referrals with a 66% acceptance rate. Based on an external analysis of the CCT, TCOC savings equals $1,842 per beneficiary per year post enrollment. Through care coordination efforts, enrolled patients had a positive impact on the readmission reduction payment policy: enrolled patients avoided 8 readmissions post enrollment, a favorable impact of $91,500. Additionally, there was an increase in palliative care documentation in the post-enrollment period for enrolled beneficiaries.	# of referrals and the acceptance rate; Total cost of care per beneficiary per year; Avoidable readmissions and cost impact of avoided readmissions; Palliative care documentation post-enrollment
Initiative B	Behavioral Health Navigator (BHN) Program	Connects patients with behavioral health issues (diagnosed mental illness and/or substance use disorder) in the Emergency Department with appropriate community-based services and providers in a timely fashion. This includes referrals and linkages to mental health treatment, substance use treatment, support groups and housing programs. The program partners with several community behavioral health organizations, such as Waystation and Grassroots. BHN services consist of a screening that identifies non-medical needs, completing referrals, assistance with scheduling post discharge mental health or drug treatment appointments, and follow up phone calls within 48 hours of discharge from the ED to ensure linkages have successfully occurred.	In FY21, even with the impact of COVID-19, HCGH BHNs screened 560 patients and assisted in connecting 72% of them to behavioral health community services.	# of participants screened; % of those screened connected to services

Initiative C	Rapid Access Program (RAP)	In conjunction with Sheppard Pratt Way Station that provides access to urgent, outpatient, psychiatric services within 48 hours of referral, this program is for adults seen in the hospital that are in need of immediate access to psychiatric intervention, regardless of insurance coverage and ability to pay. This service is intended to prevent further emotional distress and avoid decompensation which otherwise would result in accessing more acute levels of care. Patients referred to Way Station have the option of continuing with treatment or may wish to move on to a different provider once they have become stabilized.	In FY21, RAP enrolled 146 patients and had only an 8.5% 30-day all-cause readmission rate for those patients. This is a lower readmission rate than those with similar diagnoses and not enrolled in the program.	# of participants enrolled; % 30-day all-cause readmission rate
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q221. Please describe the initiative(s) addressing Populations - Parents or Caregivers.

This question was not displayed to the respondent.

Q222. Please describe the initiative(s) addressing Populations - People with Disabilities.

This question was not displayed to the respondent.

Q223. Please describe the initiative(s) addressing Populations - Women.

	Populations - Women Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Community Care Team (CCT)	Serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at Howard County General Hospital (HCGH) within the past year. Patients and their caregivers receive benefits from this program for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers, nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources.	In FY21, CCT had 1,236 referrals with a 66% acceptance rate. Based on an external analysis of the CCT, TCOC savings equals $1,842 per beneficiary per year post enrollment. Through care coordination efforts, enrolled patients had a positive impact on the readmission reduction payment policy: enrolled patients avoided 8 readmissions post enrollment, a favorable impact of $91,500. Additionally, there was an increase in palliative care documentation in the post-enrollment period for enrolled beneficiaries.	# of referrals and the acceptance rate; Total cost of care per beneficiary per year; Avoidable readmissions and cost impact of avoided readmissions; Palliative care documentation post-enrollment
Initiative B	Behavioral Health Navigator (BHN) Program	Connects patients with behavioral health issues (diagnosed mental illness and/or substance use disorder) in the Emergency Department with appropriate community-based services and providers in a timely fashion. This includes referrals and linkages to mental health treatment, substance use treatment, support groups and housing programs. The program partners with several community behavioral health organizations, such as Waystation and Grassroots. BHN services consist of a screening that identifies non-medical needs, completing referrals, assistance with scheduling post discharge mental health or drug treatment appointments, and follow up phone calls within 48 hours of discharge from the ED to ensure linkages have successfully occurred.	In FY21, even with the impact of COVID-19, HCGH BHNs screened 560 patients and assisted in connecting 72% of them to behavioral health community services.	# of participants screened; % of those screened connected to services
Initiative C	Rapid Access Program (RAP)	In conjunction with Sheppard Pratt Way Station that provides access to urgent, outpatient, psychiatric services within 48 hours of referral, this program is for adults seen in the hospital that are in need of immediate access to psychiatric intervention, regardless of insurance coverage and ability to pay. This service is intended to prevent further emotional distress and avoid decompensation which otherwise would result in accessing more acute levels of care. Patients referred to Way Station have the option of continuing with treatment or may wish to move on to a different provider once they have become stabilized.	In FY21, RAP enrolled 146 patients and had only an 8.5% 30-day all-cause readmission rate for those patients. This is a lower readmission rate than those with similar diagnoses and not enrolled in the program.	# of participants enrolled; % 30-day all-cause readmission rate
Initiative D				
Initiative E				
Initiative F				
Initiative G				

Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q224. Please describe the initiative(s) addressing Populations - Workforce.

This question was not displayed to the respondent.

Q225. Please describe the initiative(s) addressing Settings and Systems - Community.

This question was not displayed to the respondent.

Q226. Please describe the initiative(s) addressing Settings and Systems - Environmental Health.

This question was not displayed to the respondent.

Q227. Please describe the initiative(s) addressing Settings and Systems - Global Health.

This question was not displayed to the respondent.

Q228. Please describe the initiative(s) addressing Settings and Systems - Health Care.

	Settings and Systems - Health Care Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Behavioral Health Navigator (BHN) Program	Connects patients with behavioral health issues (diagnosed mental illness and/or substance use disorder) in the Emergency Department with appropriate community-based services and providers in a timely fashion. This includes referrals and linkages to mental health treatment, substance use treatment, support groups and housing programs. The program partners with several community behavioral health organizations, such as Waystation and Grassroots. BHN services consist of a screening that identifies non-medical needs, completing referrals, assistance with scheduling post discharge mental health or drug treatment appointments, and follow up phone calls within 48 hours of discharge from the ED to ensure linkages have successfully occurred.	In FY21, even with the impact of COVID-19, HCGH BHNs screened 560 patients and assisted in connecting 72% of them to behavioral health community services.	# of participants screened; % of those screened connected to services
Initiative B	Rapid Access Program (RAP)	In conjunction with Sheppard Pratt Way Station that provides access to urgent, outpatient, psychiatric services within 48 hours of referral, this program is for adults seen in the hospital that are in need of immediate access to psychiatric intervention, regardless of insurance coverage and ability to pay. This service is intended to prevent further emotional distress and avoid decompensation which otherwise would result in accessing more acute levels of care. Patients referred to Way Station have the option of continuing with treatment or may wish to move on to a different provider once they have become stabilized.	In FY21, RAP enrolled 146 patients and had only an 8.5% 30-day all-cause readmission rate for those patients. This is a lower readmission rate than those with similar diagnoses and not enrolled in the program.	# of participants enrolled; % 30-day all-cause readmission rate
Initiative C	Community Care Team (CCT)	Serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at Howard County General Hospital (HCGH) within the past year. Patients and their caregivers receive benefits from this program for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers, nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources.	In FY21, CCT had 1,236 referrals with a 66% acceptance rate. Based on an external analysis of the CCT, TCOC savings equals $1,842 per beneficiary per year post enrollment. Through care coordination efforts, enrolled patients had a positive impact on the readmission reduction payment policy: enrolled patients avoided 8 readmissions post enrollment, a favorable impact of $91,500. Additionally, there was an increase in palliative care documentation in the post-enrollment period for enrolled beneficiaries.	# of referrals and the acceptance rate; Total cost of care per beneficiary per year; Avoidable readmissions and cost impact of avoided readmissions; Palliative care documentation post-enrollment
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q229. Please describe the initiative(s) addressing Settings and Systems - Health Insurance.

	Settings and Systems - Health Insurance Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Behavioral Health Navigator (BHN) Program	Connects patients with behavioral health issues (diagnosed mental illness and/or substance use disorder) in the Emergency Department with appropriate community-based services and providers in a timely fashion. This includes referrals and linkages to mental health treatment, substance use treatment, support groups and housing programs. The program partners with several community behavioral health organizations, such as Waystation and Grassroots. BHN services consist of a screening that identifies non-medical needs, completing referrals, assistance with scheduling post discharge mental health or drug treatment appointments, and follow up phone calls within 48 hours of discharge from the ED to ensure linkages have successfully occurred.	In FY21, even with the impact of COVID-19, HCGH BHNs screened 560 patients and assisted in connecting 72% of them to behavioral health community services.	# of participants screened; % of those screened connected to services
Initiative B	Community Care Team (CCT)	Serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at Howard County General Hospital (HCGH) within the past year. Patients and their caregivers receive benefits from this program for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers, nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources.	In FY21, CCT had 1,236 referrals with a 66% acceptance rate. Based on an external analysis of the CCT, TCOC savings equals $1,842 per beneficiary per year post enrollment. Through care coordination efforts, enrolled patients had a positive impact on the readmission reduction payment policy: enrolled patients avoided 8 readmissions post enrollment, a favorable impact of $91,500. Additionally, there was an increase in palliative care documentation in the post-enrollment period for enrolled beneficiaries.	# of referrals and the acceptance rate; Total cost of care per beneficiary per year; Avoidable readmissions and cost impact of avoided readmissions; Palliative care documentation post-enrollment
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q230. Please describe the initiative(s) addressing Settings and Systems - Health IT.

This question was not displayed to the respondent.

Q231. Please describe the initiative(s) addressing Settings and Systems - Health Policy.

This question was not displayed to the respondent.

Q232. Please describe the initiative(s) addressing Settings and Systems - Hospital and Emergency Services.

	Settings and Systems - Hospital and Emergency Services Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Behavioral Health Navigator (BHN) Program	Connects patients with behavioral health issues (diagnosed mental illness and/or substance use disorder) in the Emergency Department with appropriate community-based services and providers in a timely fashion. This includes referrals and linkages to mental health treatment, substance use treatment, support groups and housing programs. The program partners with several community behavioral health organizations, such as Waystation and Grassroots. BHN services consist of a screening that identifies non-medical needs, completing referrals, assistance with scheduling post discharge mental health or drug treatment appointments, and follow up phone calls within 48 hours of discharge from the ED to ensure linkages have successfully occurred.	In FY21, even with the impact of COVID-19, HCGH BHNs screened 560 patients and assisted in connecting 72% of them to behavioral health community services.	# of participants screened; % of those screened connected to services

Initiative B	Rapid Access Program (RAP)	In conjunction with Sheppard Pratt Way Station that provides access to urgent, outpatient, psychiatric services within 48 hours of referral, this program is for adults seen in the hospital that are in need of immediate access to psychiatric intervention, regardless of insurance coverage and ability to pay. This service is intended to prevent further emotional distress and avoid decompensation which otherwise would result in accessing more acute levels of care. Patients referred to Way Station have the option of continuing with treatment or may wish to move on to a different provider once they have become stabilized.	In FY21, RAP enrolled 146 patients and had only an 8.5% 30-day all-cause readmission rate for those patients. This is a lower readmission rate than those with similar diagnoses and not enrolled in the program.	# of participants enrolled; % 30-day all-cause readmission rate
Initiative C	Community Care Team (CCT)	Serves adult Howard County residents who have Medicare or are dually eligible with Medicaid who have had two or more encounters (inpatient, emergency or observation) at Howard County General Hospital (HCGH) within the past year. Patients and their caregivers receive benefits from this program for 30-90 days by a multi-disciplinary team that provides home-based care coordination services. Community health workers, nurses and a social worker deliver services including health education, disease-specific management, medication reconciliation, connection to and coordination with health care providers, and extensive social support and advocacy with linkages to appropriate community resources.	In FY21, CCT had 1,236 referrals with a 66% acceptance rate. Based on an external analysis of the CCT, TCOC savings equals $1,842 per beneficiary per year post enrollment. Through care coordination efforts, enrolled patients had a positive impact on the readmission reduction payment policy: enrolled patients avoided 8 readmissions post enrollment, a favorable impact of $91,500. Additionally, there was an increase in palliative care documentation in the post-enrollment period for enrolled beneficiaries.	# of referrals and the acceptance rate; Total cost of care per beneficiary per year; Avoidable readmissions and cost impact of avoided readmissions; Palliative care documentation post-enrollment
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q233. Please describe the initiative(s) addressing Settings and Systems - Housing and Homes.

This question was not displayed to the respondent.

Q234. Please describe the initiative(s) addressing Settings and Systems - Public Health Infrastructure.

This question was not displayed to the respondent.

Q235. Please describe the initiative(s) addressing Settings and Systems - Schools.

This question was not displayed to the respondent.

Q236. Please describe the initiative(s) addressing Settings and Systems - Transportation.

This question was not displayed to the respondent.

Q237. Please describe the initiative(s) addressing Settings and Systems - Workplace.

This question was not displayed to the respondent.

Q238. Please describe the initiative(s) addressing Social Determinants of Health - Economic Stability.

This question was not displayed to the respondent.

Q239. Please describe the initiative(s) addressing Social Determinants of Health - Education Access and Quality.

This question was not displayed to the respondent.

Q240. Please describe the initiative(s) addressing Social Determinants of Health - Health Care Access and Quality.

	Social Determinants of Health - Health Care Access and Quality Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes

Initiative A	Behavioral Health Navigator (BHN) Program	Connects patients with behavioral health issues (diagnosed mental illness and/or substance use disorder) in the Emergency Department with appropriate community-based services and providers in a timely fashion. This includes referrals and linkages to mental health treatment, substance use treatment, support groups and housing programs. The program partners with several community behavioral health organizations, such as Waystation and Grassroots. BHN services consist of a screening that identifies non-medical needs, completing referrals, assistance with scheduling post discharge mental health or drug treatment appointments, and follow up phone calls within 48 hours of discharge from the ED to ensure linkages have successfully occurred.	In FY21, even with the impact of COVID-19, HCGH BHNs screened 560 patients and assisted in connecting 72% of them to behavioral health community services.	# of participants screened; % of those screened connected to services
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Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q241. Please describe the initiative(s) addressing Social Determinants of Health - Neighborhood and Built Environment.

This question was not displayed to the respondent.

Q242. Please describe the initiative(s) addressing Social Determinants of Health - Social and Community Context.

	Social Determinants of Health - Social and Community Context Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Behavioral Health Navigator (BHN) Program	Connects patients with behavioral health issues (diagnosed mental illness and/or substance use disorder) in the Emergency Department with appropriate community-based services and providers in a timely fashion. This includes referrals and linkages to mental health treatment, substance use treatment, support groups and housing programs. The program partners with several community behavioral health organizations, such as Waystation and Grassroots. BHN services consist of a screening that identifies non-medical needs, completing referrals, assistance with scheduling post discharge mental health or drug treatment appointments, and follow up phone calls within 48 hours of discharge from the ED to ensure linkages have successfully occurred.	In FY21, even with the impact of COVID-19, HCGH BHNs screened 560 patients and assisted in connecting 72% of them to behavioral health community services.	# of participants screened; % of those screened connected to services

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Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q243. Please describe the initiative(s) addressing other priorities.

This question was not displayed to the respondent.

Q130. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- (●) Yes
- ( ) No

Q131.

In your most recently completed CHNA, the following community health needs were identified:
Health Conditions - Chronic Pain, Health Conditions - Diabetes, Health Conditions - Mental Health and Mental Disorders, Health Conditions - Oral Conditions, Health Conditions - Overweight and Obesity, Health Conditions - Pregnancy and Childbirth, Health Behaviors - Drug and Alcohol Use, Health Behaviors - Health Communication, Health Behaviors - Nutrition and Healthy Eating, Health Behaviors - Physical Activity, Health Behaviors - Tobacco Use, Populations - Infants, Populations - Men, Populations - Older Adults, Populations - Women, Settings and Systems - Health Care, Settings and Systems - Health Insurance, Settings and Systems - Hospital and Emergency Services, Social Determinants of Health - Health Care Access and Quality, Social Determinants of Health - Social and Community Context
Other:

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

This question was not displayed to the respondent.

Q132. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q244. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

The hospital, in conjunction with other health and community partners, conducts a Howard County Health Assessment Survey every three years. The data from this survey are stratified by race, education, income, gender, and age and that information is used to develop the Community Health Needs Assessment and Implementation Plan. Select initiatives within this plan, as well as some annual initiatives strategized each year, are designed to target and improve conditions for populations with identified disparities. Additionally, hospital leadership co-chairs the local health improvement coalition whose purpose is to work to eliminate health disparities and advance health equity.

Q245. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

- [x] Regional Partnership Catalyst Grant Program
- [ ] The Medicare Advantage Partnership Grant Program
- [x] The COVID-19 Long-Term Care Partnership Grant
- [x] The COVID-19 Community Vaccination Program
- [ ] The Population Health Workforce Support for Disadvantaged Areas Program
- [ ] Other (Describe)

Q129. If you wish, you may upload a document describing your community benefit initiatives in more detail.

Q60. Section III - CB Administration

Q61. 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

Q246. Please describe the third party audit process used.

This question was not displayed to the respondent.

Q62. Does your hospital conduct an internal audit of the community benefit narrative?

- (●) Yes
- ( ) No

Q63. Please describe the community benefit narrative audit process.

The Community Benefits report is completed by the Director of Strategic Planning, then reviewed by the VP of Population Health and Advancement. Specific sections of the report are reviewed by the Director of Population Health and the VP of Finance/CFO. Report data is also reviewed and discussed with the system Director of Strategic Initiatives in the Office of Government and Community Affairs.

Q64. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- (●) Yes
- ( ) No

Q65. Please explain:

This question was not displayed to the respondent.

Q66. Does the hospital's board review and approve the annual community benefit narrative report?

- (●) Yes
- ( ) No

Q67. Please explain:

This question was not displayed to the respondent.

Q68. Does your hospital include community benefit planning and investments in its internal strategic plan?

- (●) Yes
- ( ) No

Q69. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

Community Benefits activities are included every year in the Johns Hopkins Medicine five-year strategic plan. In FY2021, these activities were included in the category of "Make Johns Hopkins Medicine Easy" of the JHM plan, where HCGH set specific goals related to our health priorities as identified in the Community Health Needs Assessment. These health priorities are as follows: Access to Care; Behavioral Health; Healthy Aging; Healthy Weight; and Maternal/Infant Health. These priorities are integrated into HCGH's ongoing initiatives. Howard County General Hospital set the following strategic objectives for FY2021 to support these priorities: Access to Care: Expand telemedicine initiatives aimed at adding value, reducing disparities and increasing access to patients. Completion date: 6/30/21. Final status: Two projects were launched including SNF telemed with hospitalists and Anesthesia pre-op clearance. A third project was started focused on pediatric psych consults.

Q70. If available, please provide a link to your hospital's strategic plan.

https://www.hopkinsmedicine.org/strategic-plan/

Q133. Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

- [x] Diabetes - Reduce the mean BMI for Maryland residents
- [x] Opioid Use Disorder - Improve overdose mortality
- [x] Maternal and Child Health - Reduce severe maternal morbidity rate
- [ ] Maternal and Child Health - Decrease asthma-related emergency department visit rates for children aged 2-17

Q134. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Q135. ## Section IV - Physician Gaps & Subsidies

Q223. Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- ( ) No
- (●) Yes

Q218. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

	Is there a gap resulting in a subsidy?		What type of subsidy?
	Yes	No	
Allergy & Immunology	( )	( )	
Anesthesiology	(●)	( )	Physician provision of financial assistance
Cardiology	(●)	( )	Coverage of emergency department call
Dermatology	( )	( )	
Emergency Medicine	(●)	( )	Coverage of emergency department call
Endocrinology, Diabetes & Metabolism	( )	( )	
Family Practice/General Practice	( )	( )	
Geriatrics	( )	( )	
Internal Medicine	( )	( )	
Medical Genetics	( )	( )	
Neurological Surgery	( )	( )	
Neurology	( )	( )	
Obstetrics & Gynecology	(●)	( )	Physician provision of financial assistance
Oncology-Cancer	( )	( )	

Ophthamology	○	○	
Orthopedics	○	○	
Ololaryngology	◉	○	Physician provision of financial assistance
Pathology	○	○	
Pediatrics	○	○	
Physical Medicine & Rehabilitation	○	○	
Plastic Surgery	○	○	
Preventive Medicine	○	○	
Psychiatry	◉	○	Physician provision of financial assistance
Radiology	○	○	
Surgery	○	○	
Urology	○	○	
Other. (Describe) Interventional Cardiology; Vascular; Way Station Program; Hospitalist (Intern & Resident)	◉	○	Physician provision of financial assistance

Q219. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

In FY21, HCGH subsidized ED and inpatient call coverage for the following specialties: general surgery, psychiatry, anesthesiology, OB/GYN, otolaryngology, cardiology, interventional cardiology, and vascular. Payments incentivize on-call coverage responsibilities, serving both the Hospital's ED and consultation and treatment of hospital inpatients. Physicians no longer take calls unless compensated for this service. As the only hospital in the county we need to ensure our patients have access to fundamental services when needed. Additionally, people are continuing to utilize the ED for emergencies and primary care services and we need to provide that coverage. To ensure there is adequate ED coverage during unplanned volume, additional ED providers are needed to be on-call. Again, providers no longer take call unless compensated for the service.

Q139. Please attach any files containing further information and data justifying physician subsidies your hospital.

Q140. Section VI - Financial Assistance Policy (FAP)

Q141. Upload a copy of your hospital's financial assistance policy.

JHM Financial Assistance Policy 10-2021.pdf
169.3KB
application/pdf

Q220. Provide the link to your hospital's financial assistance policy.

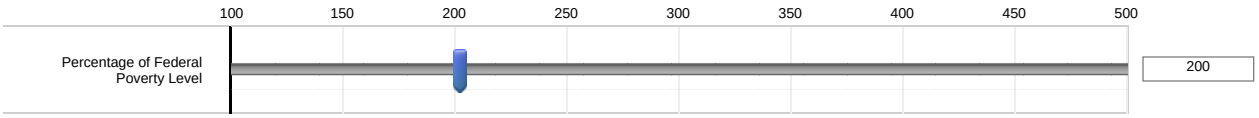
https://www.hopkinsmedicine.org/patient_care/patients-visitors/billing-insurance/_docs/pfs035-2020/PFS035.pdf

Q147. 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:

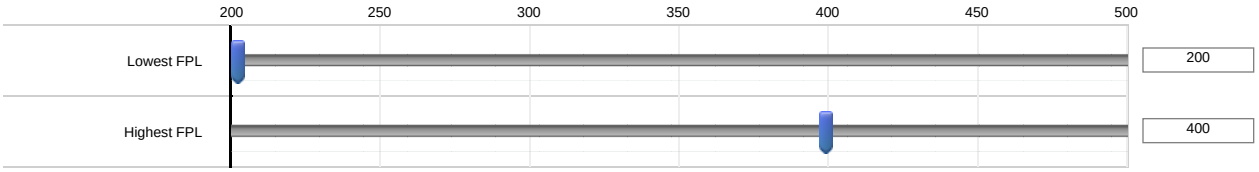
Q143. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



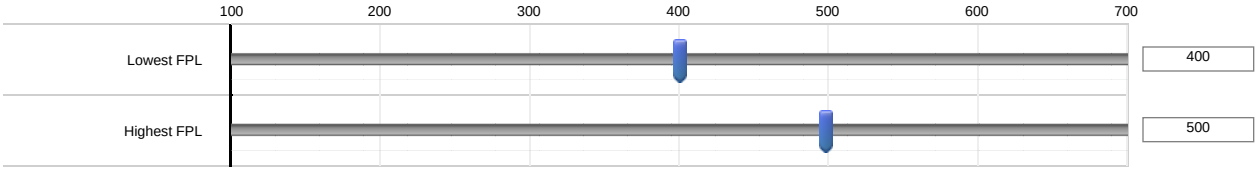
Q144. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

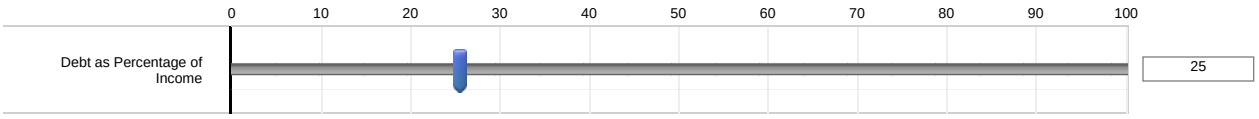


Q145. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

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



Q146. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q221. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding tax able year (select all that apply)

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

Q150. Summary & Report Submission

Q151.

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: (39.251403808594, -76.797897338867)

Source: GeoIP Estimation

2018 Howard County Health Assessment Survey

Howard County, Maryland

Final Report

OPINIONWORKS
PUBLIC SPIRITED RESEARCH

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Project Overview

The mission of this public study, known as the Howard County Health Assessment Survey (HCHAS), is to assess health-related behaviors and risk factors among the adult population of Howard County, Maryland. Results of this study enable health providers and advocates to measure progress and to know where to focus resources to help make the community healthier.

The Horizon Foundation sponsored this study, joined by the Howard County Health Department, Howard County General Hospital, and the Columbia Association. This is a biennial study, first conducted in 2012, and updated in 2014, 2016 and 2018. The survey approach and methodology are modeled after the Behavioral Risk Factor Surveillance System (BRFSS), which is conducted by Maryland and the other states under the auspices of the Centers for Disease Control and Prevention (CDC).

Survey Methodology

The study sponsors met regularly during the planning phase to discuss survey content and methodology. Final decisions over survey content were made by the sponsors. Technical aspects of the survey project, including question wording recommendations, population sampling, and telephone data collection were administered by OpinionWorks LLC of Annapolis, Maryland.

Many questions on the HCHAS were replicated from the BRFSS and other tested public health surveys so that results can be compared to other areas of Maryland and the nation, and to benefit from prior vetting of those questions. The HCHAS also included customized questions to address the local priorities of the project's sponsors, and the health environment in Howard County. In the end, these telephone interviews averaged 16.7 minutes. Field interviews for this most recent version of the HCHAS were collected from May 16 to December 12, 2018.

Prior to field interviewing, the project's sponsors notified the public about the study to encourage survey participation through a multi-media "answer the call" campaign. OpinionWorks, the survey contractor, maintained a dedicated local telephone line, named "Howard Health Survey," which appeared on residents' caller ID readouts as interview calls were made. Residents calling this number heard a voice mail greeting describing the purpose of the survey and were encouraged to leave messages if they wanted more information or wished to have their phone number removed from the calling list. Calls were returned by OpinionWorks staff to residents who had questions about the study.

During the interviewing process, a strict random respondent selection protocol was adhered to. Respondent selection within households was randomized, and all households in the County had an equal probability of being sampled. Caregivers were not allowed to answer for others; answers for all study respondents reflected their own characteristics and experience.

For analysis purposes, each interview was geo-coded and placed within one of Howard County's seven regional planning districts, with the three smallest-population districts combined into one area called "West County." Accordingly, a total of 2,002 interviews were conducted, as follows:

Regional Planning District	Interviews Conducted	Maximum Sampling Error*
West County	312	± 5.5%
Ellicott City	559	± 4.1%
Columbia	675	± 3.8%
Elkridge	214	± 6.7%
Laurel	242	± 6.3%
Howard County Total	2002	± 2.2%

*Sampling error is calculated at the 95% confidence level. This means that, in 19 out of 20 cases we can be certain that the true results would fall within this range if *every* adult resident of these areas had been interviewed.

Interviews were considered completed if the respondent proceeded through the entire interview, though respondents may have refused to answer individual questions. Interviews were conducted in English and Spanish. Both landline and mobile telephone numbers were included in the sampling frame.

Once the interviews were collected, statistical weights were applied to the sample to ensure that it was as reflective as possible of the County's population, according to the most recent data available from the United States Census Bureau. Weights were applied to the following parameters: gender, age, race and ethnicity, and geography.

A complete survey data file has been supplied by the contractor to the study sponsors, excluding identifying information for the individual respondents in order to protect their personal health information, to make possible further analysis of these health data.

The Structure of This Report

This report provides a visual representation of each question on the survey, grouped by major topic area. Those major topics are:

1. Access to Care
2. Obesity and Healthy Living
3. Behavioral Health
4. Chronic Disease
5. Children's Health
6. Other Issues

Where a question was repeated from the 2016, 2014 and/or 2012 surveys, trends from the prior survey(s) are illustrated. In cases where a question was *not* asked previously, or where question wording was significantly changed, prior data does not appear in this report.

Survey results have also been broken out for a variety of geographic, demographic, and lifestyle indicators, so that propensities can be isolated within population subgroups. On the pages that follow, subgroup numbers have been placed in tables beneath each question in cases where there are statistically-significant differences within those subgroups. Therefore, not all subgroups are listed for each question. In these tables, data cells have been highlighted in darker or lighter shades if the percentages differ significantly, in statistical terms, from the rest of Howard County's population:

- A subgroup result highlighted in a darker shade is significantly *greater than* the rest of the population.
- A subgroup result highlighted in a lighter shade is significantly *less than* the rest of the population.

The raw number of interviews collected in each subgroup is listed in parentheses below, followed by the weighted number reflecting that subgroup's proportion of the overall countywide survey sample once the results were weighted to reflect the population distribution of Howard County (raw number → weighted number). Note that the post-stratification weighting approach results in overall sample size that appears to be larger than the original sample of 2001 interviews, but that difference is simply an artifact of the weighting process.

These subgroups are:

- **Regional Planning District:** West County, which combines the less populous Cooksville, West Friendship, and Clarksville Regional Planning Districts (312 raw number → 289 weighted number); Ellicott City (559→ 582); Columbia (675 → 760); Elkridge (214 → 233); Laurel (242 → 203).
- **Gender:** Male (953 → 1009), Female (1047 → 1053).
- **Age:** 18 to 24 (78 → 234), 25 to 34 (164 → 403), 35 to 44 (439 → 375), 45 to 54 (422 → 403), 55 to 64 (376 → 313), 65 to 74 (271 → 176), 75 or older (196 → 109).
- **Race/Ethnicity:** White (1379 → 1153); Black or African-American (352 → 409); Asian (169 → 362); Hispanic (84 → 167); and Others, such as Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native (53 → 52). Note that survey participants could choose more than one of these categories to describe themselves.
- **Presence of Children under Age 18 in the Household:** Yes (824 → 928), No (1156 → 1117).
- **Columbia Association:** Yes (488 → 550), No (1431 → 1383)

- **Household Income:** Less than $50,000 per year (264 → 294), $50,000 to $99,999 per year (406 → 462), $100,000 to $149,999 per year (427 → 441), $150,000 to $199,999 per year (285 → 278), $200,000 or more per year (331 → 313).
- **Educational Attainment:** 11th Grade or less (32 → 39), High School Diploma/GED (220 → 223), Attended some college (366 → 434), 4-year college degree (581 → 603), Graduate-level work or degree (793 → 759).
- **Employment Status:** Employed for wages (1123 → 1260), Self-employed (196 → 206), Unemployed (105 → 114), Retired (436 → 277), Homemaker (92 → 87), Student (38 → 111).
- **Marital Status:** Married (1337 → 1251), Divorced or separated (201 → 172), Widowed (127 → 79), Never married (285 → 506), Member of an unmarried couple (32 → 41).
- **Body Mass Index:** Underweight (22 → 30), Normal (612 → 678), Overweight (688 → 711), Obese (559 → 536).

In many cases throughout this survey, the percentage of respondents who were not sure amounted to less than one-half percent. In those cases, where "not sure" equals or rounds to 0% of respondents, "not sure" does not appear as a response in the graphics below. In the tables contained in this report, any response amounting to less than one-half percent is displayed as *%.

It should also be noted that throughout this report, it will occasionally appear that columns of numbers do not add correctly; those minor differences (for example a column of numbers that adds to 99% or 101%) are typically due to issues of rounding.

Table of Contents

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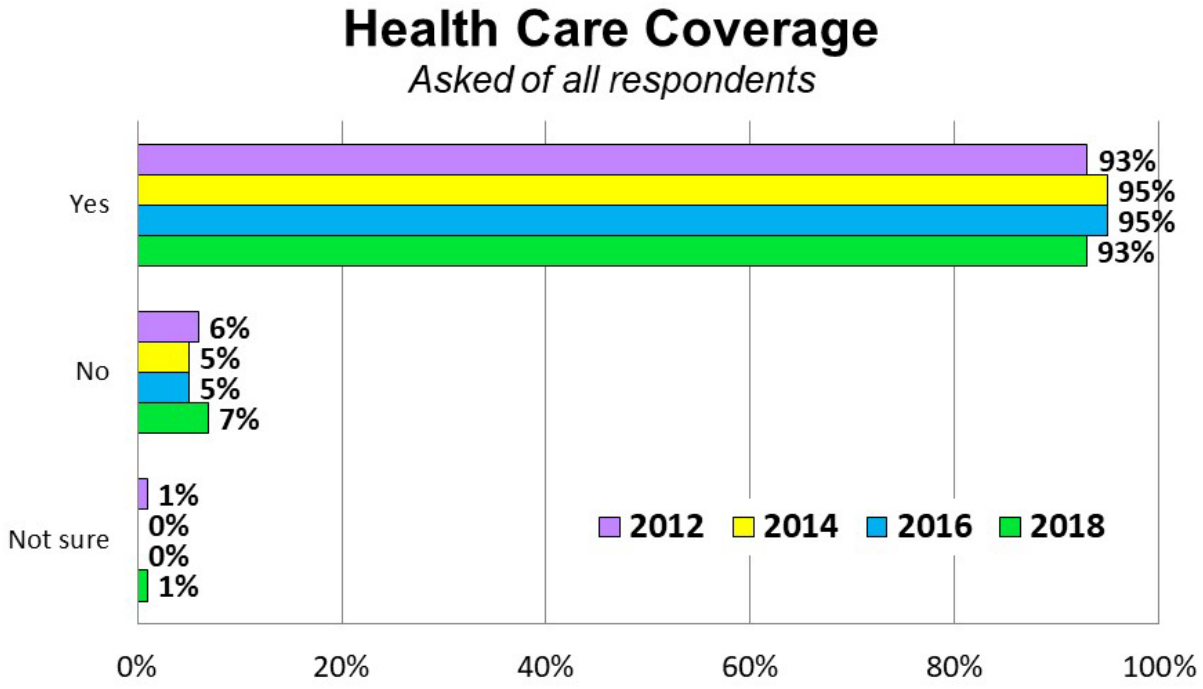
Access to Care

The Access to Care section includes the incidence of health care coverage for Howard County residents, whether residents feel they have a personal doctor or health care provider, whether cost or availability has been a barrier to seeing a primary care provider when they needed one, and where they typically go for their care. This section also addresses the incidence of mammograms, breast exams, Pap tests, cancer screenings, and dental care.

Level of Health Care Coverage for Howard County Residents

Ninety-three percent of Howard County adult residents have health care coverage in 2018. This represents a slight decrease from the levels measured in 2016 and 2014, and equals the 93% coverage measured in 2012.



Q3.1. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare or Indian Health Services?

Residents are less likely to have health care coverage if they are younger, Hispanic, lower-income, or less-educated. Data cells are highlighted if they are significantly different from the general population in statistical terms. The darker highlights indicate subgroups that are significantly higher than others in the general population, and the lighter highlights indicate cells that are lower. Note that there are cells that *appear* higher or lower than the norm, but due to the limitations of their sample size do not rise to the level of a statistically significant difference.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	93%	82%	87%	96%	95%	94%	100%	98%
No	7%	14%	13%	4%	5%	6%	-	*%
Not sure/Refused	1%	4%	-	-	-	-	-	1%

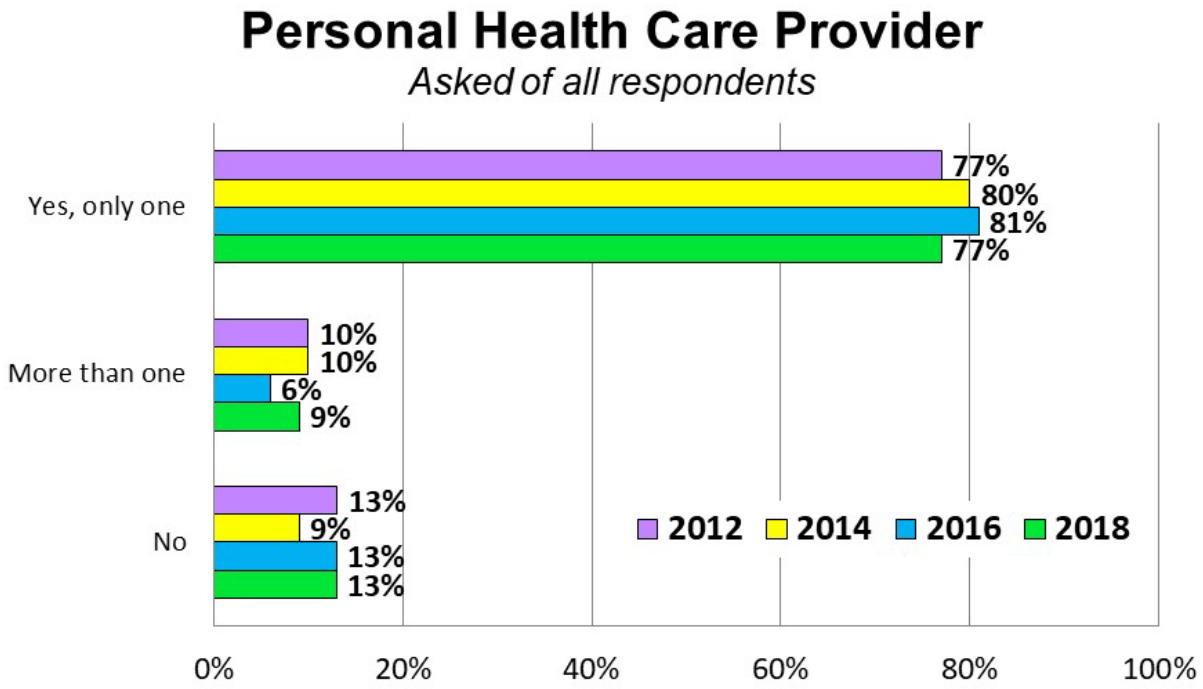
2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
Yes	93%	94%	93%	89%	82%	93%
No	7%	5%	7%	11%	16%	7%
Not sure	1%	1%	-	-	3%	-

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Yes	93%	83%	92%	93%	96%	99%
No	7%	15%	8%	6%	4%	1%
Not sure	1%	2%	-	1%	-	*%

2018 Education Breakouts	All	Less than High School	High School or GED	Some College	4-Year Degree	Post-graduate
Yes	93%	67%	84%	90%	93%	98%
No	7%	23%	15%	9%	7%	2%
Not sure	1%	11%	1%	1%	*%	-

Eighty-six percent of Howard County residents have at least one person that they think of as their personal doctor or health care provider. Of these, 77% said they have *one person* they think of as their personal doctor or health care provider, while another 9% said they have *more than one person* they think of that way.

The overall number of 86% who feel they have one or more personal health care providers is virtually unchanged from prior years. Only in 2014 was a slightly higher rate recorded.



Q3.2. Do you have one person you think of as your personal doctor or health care provider? (If No): Is there more than one, or is there no person who you think of as your personal doctor or health care provider?

Residents are less likely to have a personal doctor or health care provider if they are younger, self-employed or unemployed, or never married.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	77%	74%	63%	76%	85%	81%	87%	82%
More than one	9%	9%	9%	7%	6%	11%	10%	15%
No	13%	16%	27%	17%	8%	8%	3%	2%
Not sure/Refused	*%	1%	1%	*%	*%	*%	-	*%

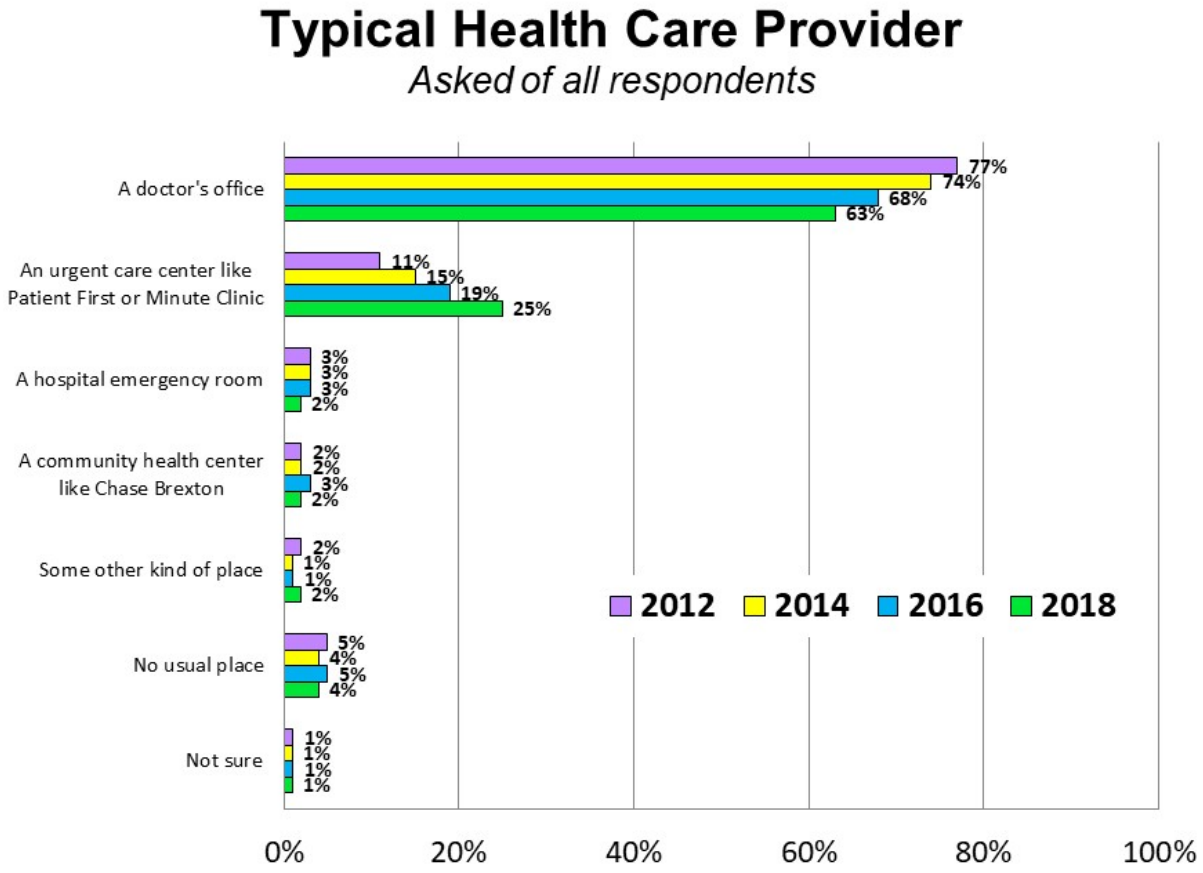
2018 Employment Status Breakouts	All	Employed	Self-Employed	Un-employed	Retired	Home-maker	Student
Yes	77%	78%	69%	70%	83%	70%	79%
More than one	9%	8%	6%	8%	12%	16%	13%
No	13%	13%	24%	22%	5%	13%	8%
Not sure/Refused	*%	*%	1%	-	-	*%	-

2018 Marital Status Breakouts	All	Married	Divorced/ Separated	Widowed	Never Married	Unmarried Couple
Yes	77%	80%	77%	84%	69%	79%
More than one	9%	8%	10%	15%	10%	3%
No	13%	12%	12%	1%	20%	19%
Not sure/ Refused	*%	*%	1%	-	1%	-

When they are sick or need medical attention, Howard County residents are most likely to go to a doctor's office. The number who would usually visit a doctor's office, however, has declined markedly since 2012, moving from 77% in 2012 to 63% in 2018.

There is a notable migration to urgent care centers, which have increased their share as the place that residents *usually* go when they are sick or need medical attention from 11% in 2012 to 25% of residents in 2018.

Two percent said a hospital emergency room is their usual site of care, 2% usually visit a community health center, and 2% said they usually visit "some other kind of place." Four percent said there is no usual place they go.



Q3.3A. When you are sick or need medical attention, to which one of the following places do you usually go?

The propensity to use urgent care centers as the usual source of care is much higher below age 45, reaching as high as 41% in the 25 to 34 age group. Among households with incomes under $50,000, there is a much higher likelihood of using hospital emergency rooms (7%) or community health centers (7%) compared to the rest of the population.

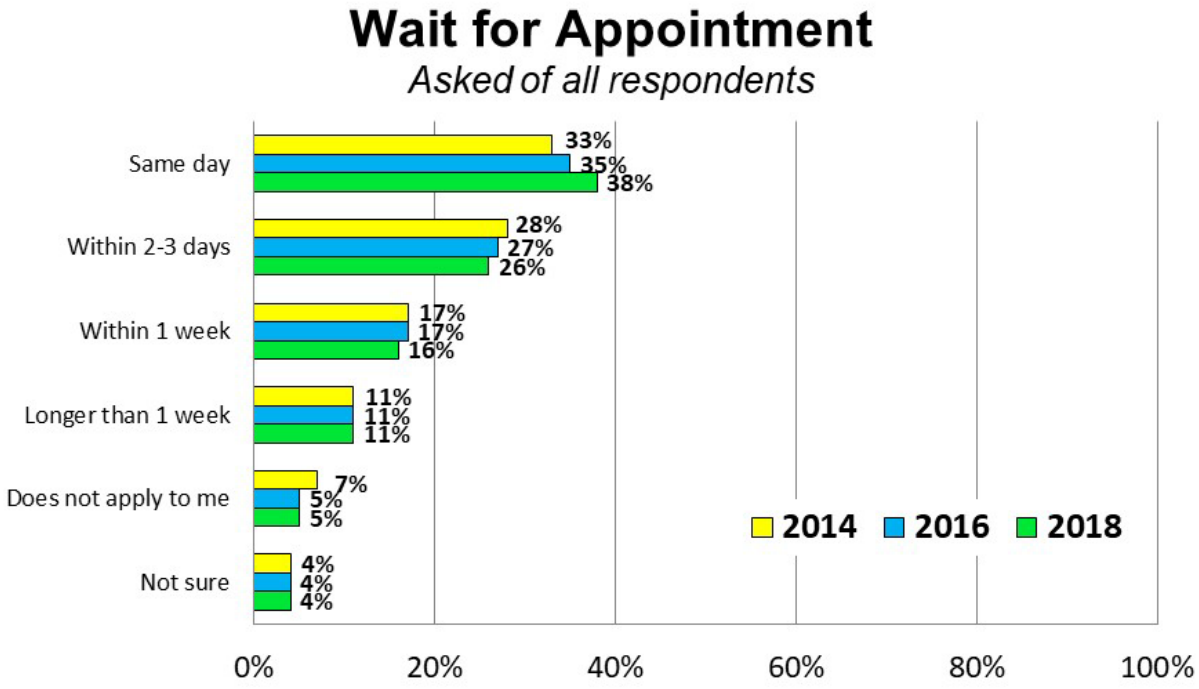
2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
A doctor's office	63%	52%	43%	57%	71%	77%	77%	80%
An urgent care center	25%	35%	41%	33%	18%	13%	11%	7%
A hospital emergency room	2%	2%	3%	2%	2%	2%	4%	4%
A community health center	2%	2%	3%	1%	2%	2%	1%	1%
Some other kind of place	2%	4%	*%	1%	2%	2%	2%	3%
No usual place	4%	4%	8%	4%	4%	2%	2%	2%
Not sure/Refused	1%	4%	1%	1%	1%	1%	3%	2%

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
A doctor's office	63%	57%	59%	64%	68%	63%
An urgent care center	25%	22%	28%	25%	24%	29%
A hospital emergency room	2%	7%	1%	2%	*%	1%
A community health center	2%	7%	2%	*%	*%	1%
Some other kind of place	2%	3%	1%	2%	1%	2%
No usual place	4%	3%	6%	5%	5%	2%
Not sure/Refused	1%	1%	3%	2%	1%	1%

2018 Marital Status Breakouts	All	Married	Divorced/ Separated	Widowed	Never Married	Unmarried Couple
A doctor's office	63%	68%	67%	78%	48%	48%
An urgent care center	25%	23%	16%	6%	35%	32%
A hospital emergency room	2%	2%	3%	2%	4%	-
A community health center	2%	1%	3%	1%	3%	-
Some other kind of place	2%	1%	2%	2%	2%	6%
No usual place	4%	3%	3%	7%	6%	14%
Not sure/Refused	1%	1%	6%	3%	1%	-

The last time they visited their primary health care provider for a medical issue they wanted resolved quickly, 38% of residents were able to see their primary health care provider within the same day, an increase from 35% in 2016 and 33% in 2014.

Another 26% were able to see their provider within two to three days. The remainder said they had to wait longer than three days.

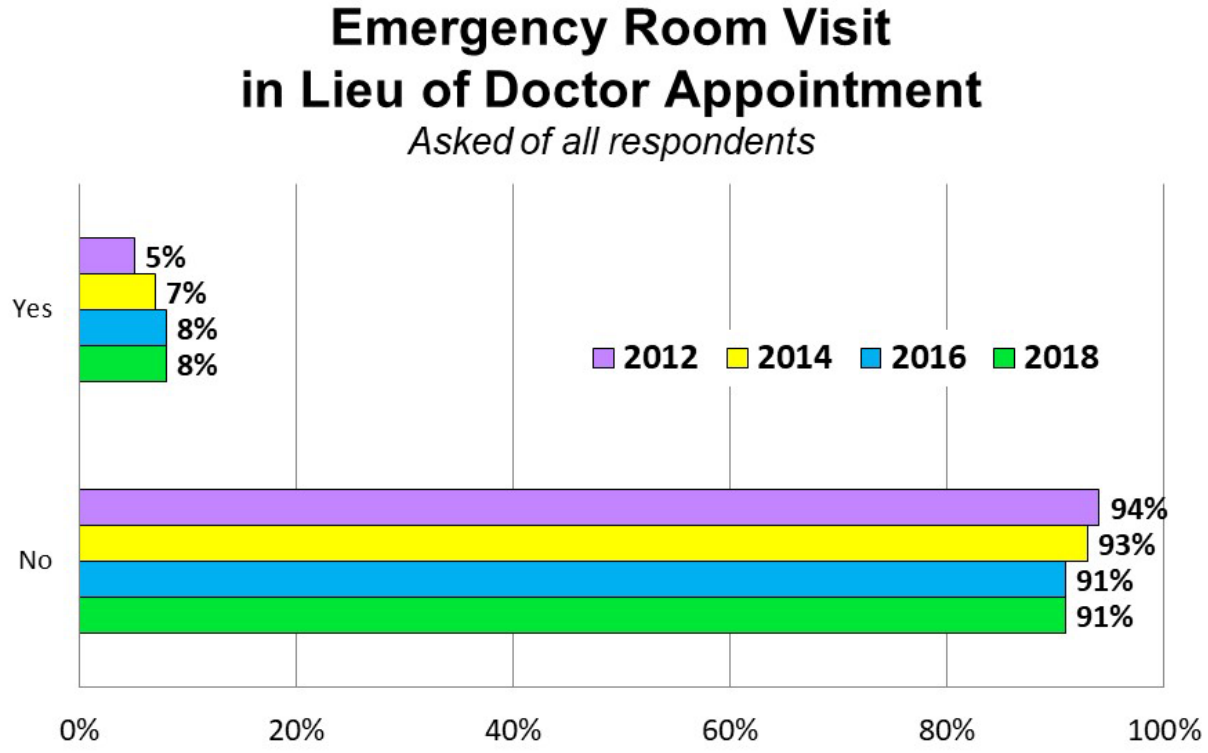


Q3.3B. Thinking about your most recent visit to your primary health care provider for a medical issue you wanted resolved quickly, how long did you have to wait between when the appointment was made and when the appointment actually occurred?
(Different answer categories in 2012 make that year's data not comparable.)

The most significant differences on this question correlate with the age of the respondent. Residents over age 55 are much more likely to be seen on the same day they experience a medical issue that they want resolved quickly.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Same day	38%	28%	37%	39%	38%	43%	40%	47%
Within 2-3 days	26%	26%	27%	27%	27%	24%	25%	20%
Within 1 week	16%	31%	14%	14%	16%	16%	10%	10%
Within 1 month	9%	12%	8%	9%	9%	7%	10%	7%
Longer than 1 month	2%	-	1%	1%	2%	4%	3%	4%
Does not apply to me	5%	2%	8%	5%	2%	4%	5%	7%
Not sure/Refused	4%	1%	4%	5%	5%	3%	6%	6%

Eight percent of residents said there was a time in the past 12 months when they needed to go to an emergency room because they could not get a timely appointment with a doctor. This measure of access is unchanged from 2016, but represents an increase of 3% from the initial measurement in 2012.



Q3.3C. Was there a time in the past 12 months when you needed to go to the emergency room because you could not get a timely appointment with a doctor?

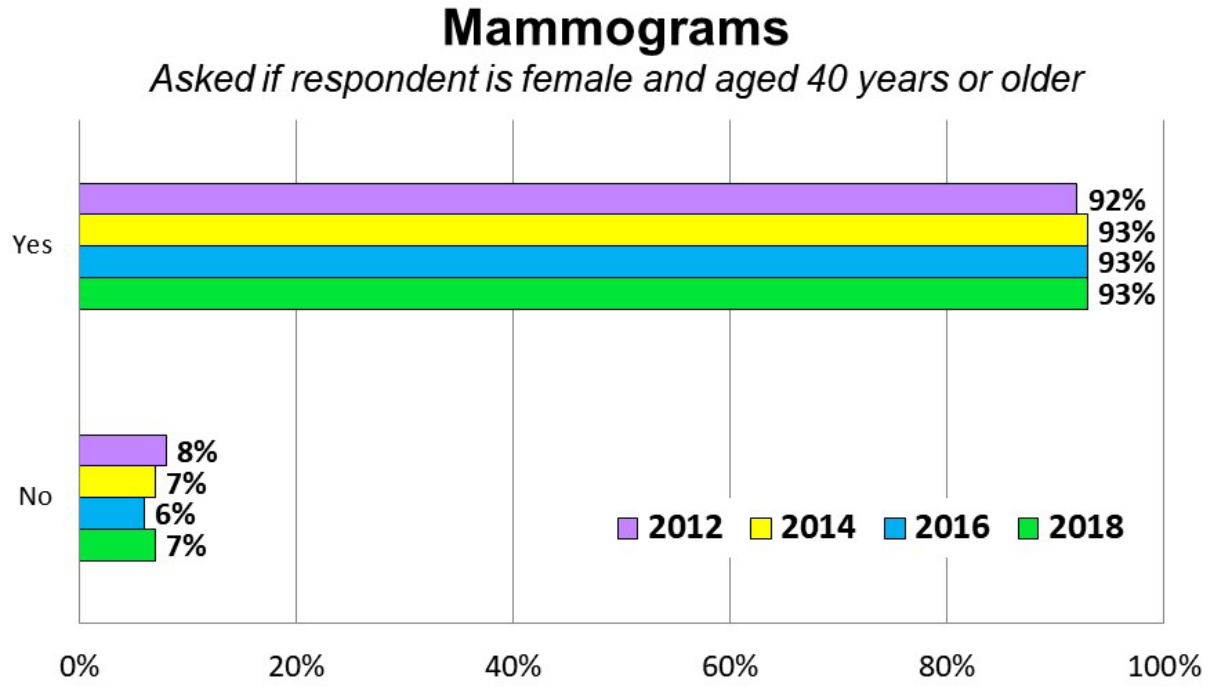
Use of an emergency room in lieu of a doctor is greater among lower income groups, as well as among residents with less than a four-year college degree.

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Yes	8%	14%	10%	6%	6%	6%
No	91%	86%	88%	94%	94%	94%
Not sure/Refused	*%	*%	2%	*%	1%	*%

2018 Education Breakouts	All	Less than High School	High School or GED	Some College	4-Year Degree	Post-graduate
Yes	8%	2%	12%	12%	8%	6%
No	91%	98%	87%	87%	91%	93%
Not sure/Refused	1%	*%	*%	1%	*%	1%

Screenings

Ninety-three percent of women over 40 in Howard County have had a mammogram. This number is virtually unchanged from the preceding surveys.



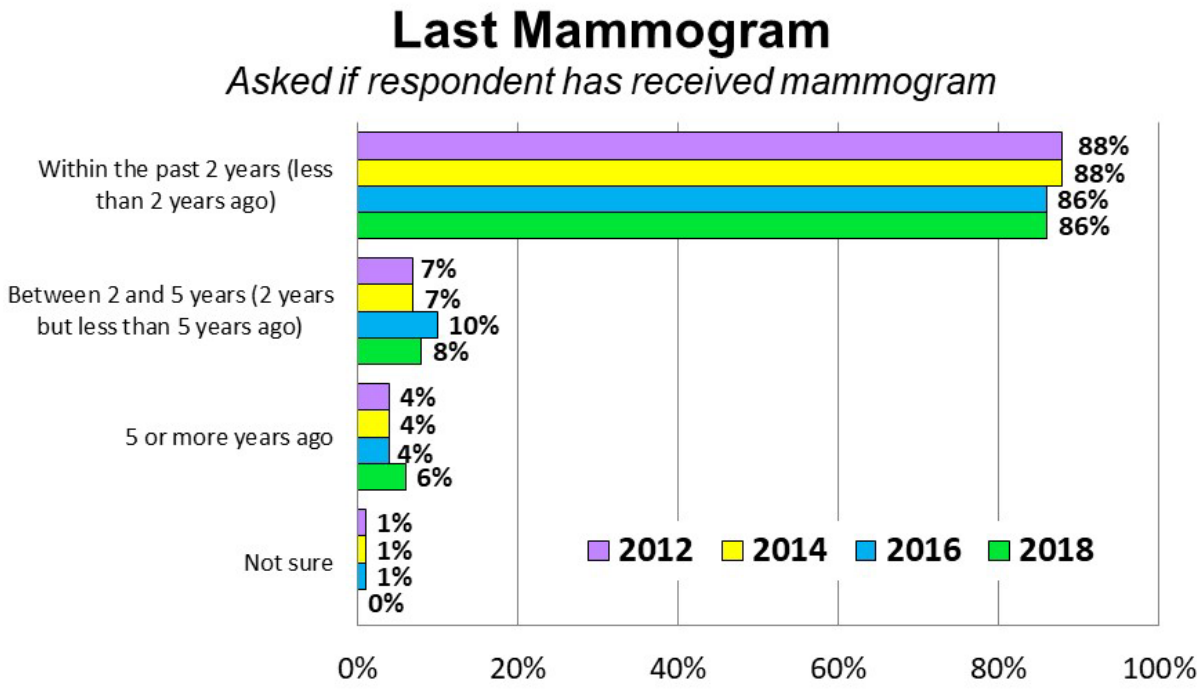
M12.1. A mammogram is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram?

Women under age 45 are less likely to have had a mammogram, as are those in households earning less than $50,000 per year. It can be noted that there were no respondents who said they could not remember in response to this question.

2018 Age Breakouts	All	40-44	45-54	55-64	65-74	75+
Yes	93%	83%	92%	95%	99%	96%
No	7%	17%	8%	5%	1%	4%

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Yes	93%	83%	91%	96%	96%	92%
No	7%	17%	9%	4%	4%	8%

Eight-six percent of the women who have had a mammogram had it within the prior two years, which is identical to the 86% recorded in 2016, and slightly less than the 88% reported in 2012 and 2014. Eight percent had their last mammogram between two and five years ago, slightly lower than the 10% in 2016. The most recent mammogram has been more than five years ago for 6% of women over age 40, which is an increase over the prior reporting periods.



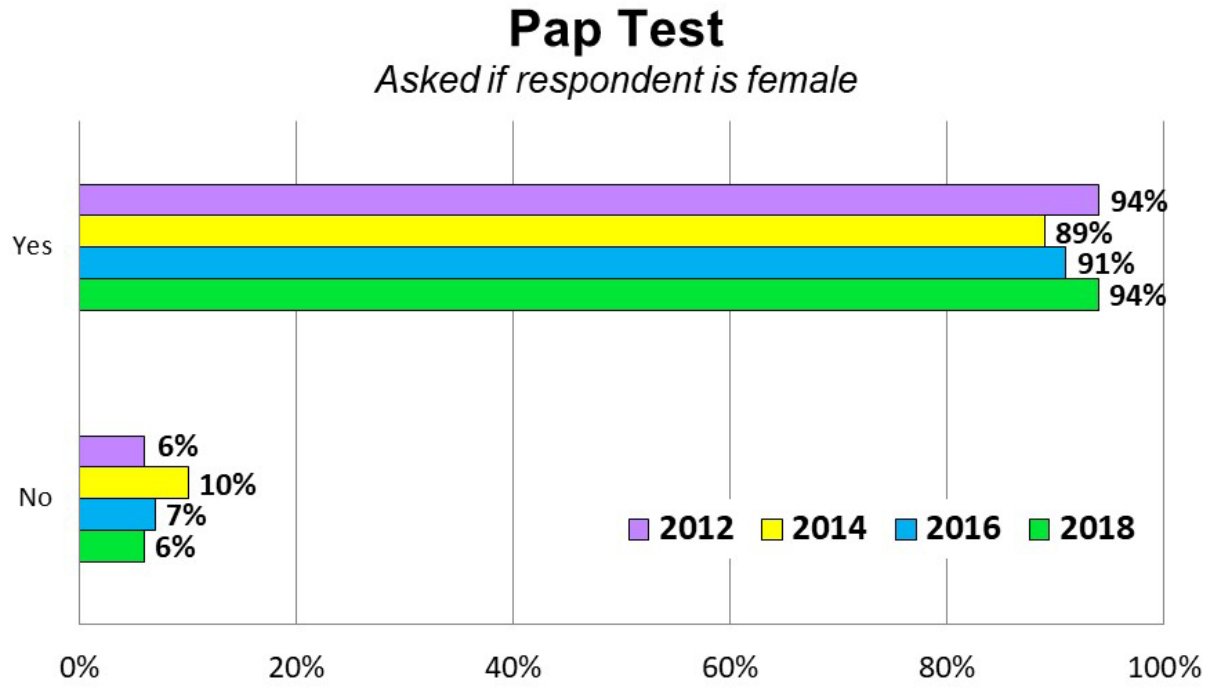
M12.2. How long has it been since you had your last mammogram?

Women under age 45 are more likely to have had a mammogram in the past two years, as are women living in the Elkridge planning area.

2018 Age Breakouts	All	40-44	45-54	55-64	65-74	75+
Within the past 2 years	86%	93%	86%	86%	87%	71%
Between 2 years and 5 years ago	8%	4%	8%	7%	7%	15%
5 or more years ago	6%	2%	7%	6%	6%	12%
Not sure/Refused	*%	-	*%	-	1%	2%

2018 Planning District Breakouts	All	West County	Ellicott City	Columbia	Elkridge	Laurel
Within the past 2 years	86%	84%	83%	86%	95%	88%
Between 2 years and 5 years ago	8%	4%	11%	7%	4%	10%
5 or more years ago	6%	11%	6%	6%	1%	2%
Not sure/Refused	*%	*%	*%	*%	-	-

Ninety-four percent of women in 2018 said they have had a Pap test, which continues the upward trend that began in 2016.



M12.5. A Pap test is a test for cancer of the cervix. Have you ever had a Pap test?

Women under age 25, those in the lowest income bracket, those that are unemployed or are students, and those who have never been married are less likely to have had a Pap test. Only a negligible number said they could not remember if they have had a Pap test.

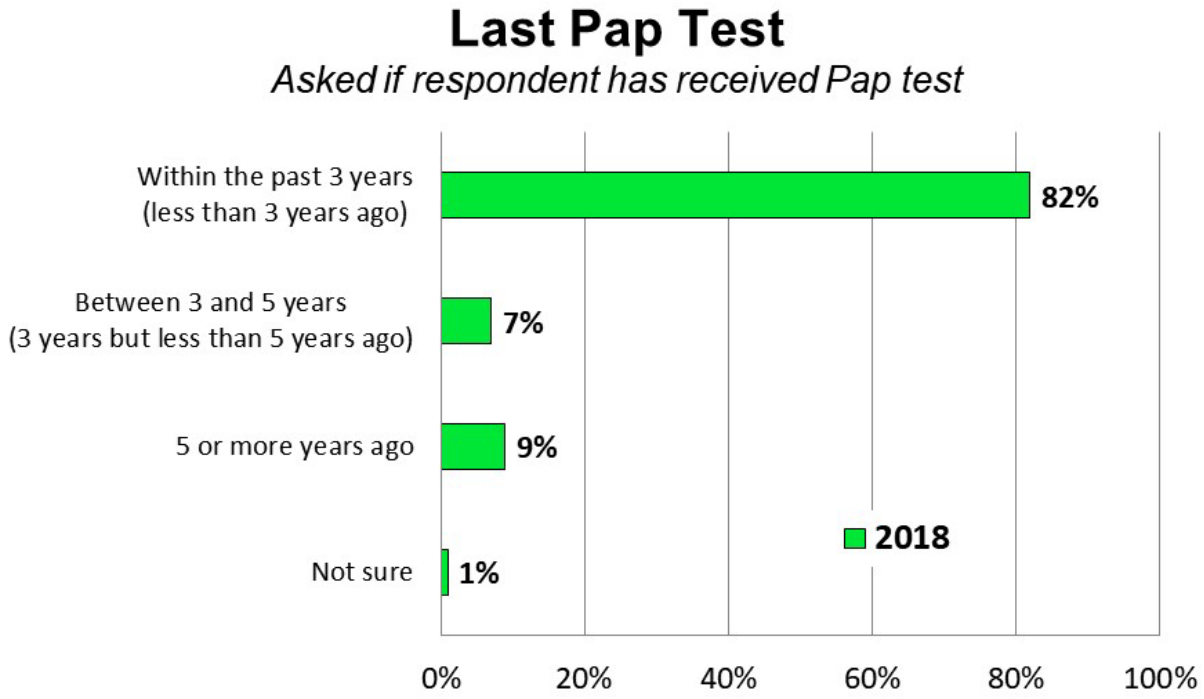
2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	94%	62%	92%	96%	95%	92%	95%	98%
No	6%	38%	8%	4%	4%	8%	5%	2%

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Yes	94%	84%	95%	94%	97%	95%
No	6%	16%	5%	5%	3%	5%

2018 Employment Status Breakouts	All	Employed	Self-Employed	Un-employed	Retired	Home-maker	Student
Yes	94%	95%	88%	82%	96%	95%	48%
No	6%	5%	12%	18%	4%	3%	52%

2018 Marital Status Breakouts	All	Married	Divorced/ Separated	Widowed	Never Married	Unmarried Couple
Yes	94%	95%	95%	94%	86%	100%
No	6%	5%	5%	6%	14%	-

Of the women who have had a Pap test, 82% said their test was within the prior three years. In prior years the answer categories were different, making the data not comparable for trend purposes.



M12.5A. When was your last Pap test?
(Different answer categories in 2018 make trend data not comparable.)

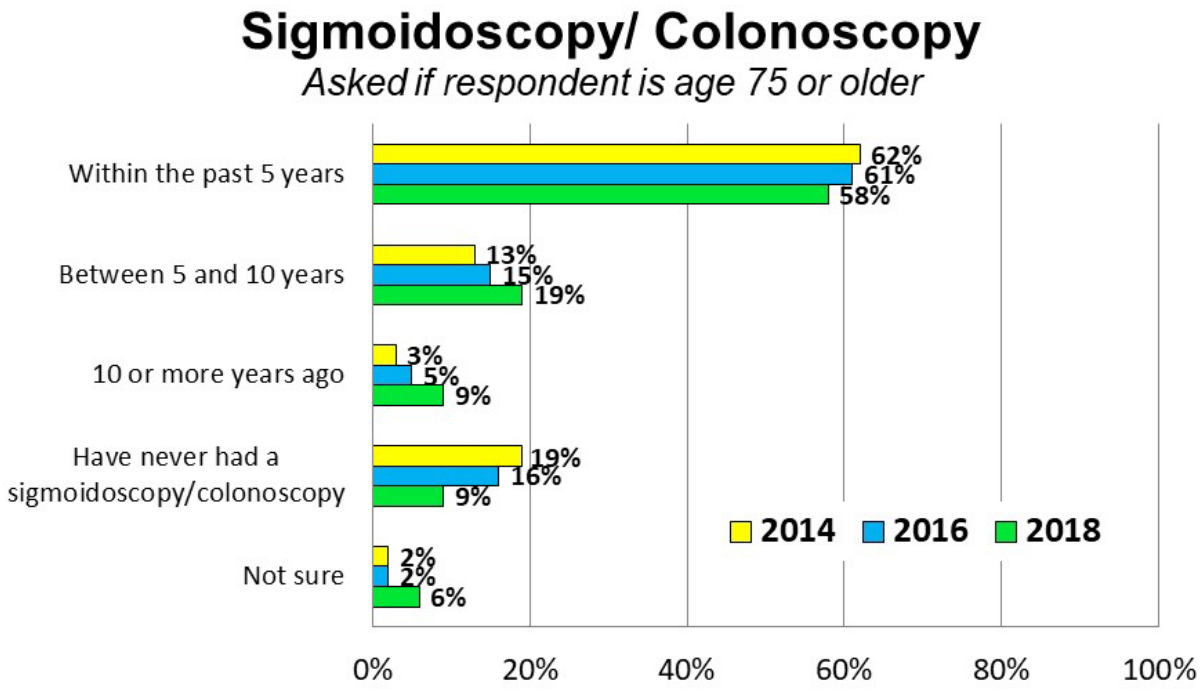
Women are less likely to have had a Pap test in the past three years if they are over age 65, have household income less than $100,000, or whose highest education level is high school.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Within the past 3 years	82%	100%	86%	93%	87%	80%	58%	46%
3 years but less than 5 years ago	7%	-	9%	4%	6%	8%	14%	7%
5 or more years ago	9%	-	5%	2%	6%	10%	23%	30%
Not sure/Refused	2%	-	-	1%	1%	2%	5%	16%

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Within the past 3 years	82%	73%	73%	87%	91%	89%
3 years but less than 5 years ago	7%	10%	12%	6%	5%	3%
5 or more years ago	9%	13%	13%	7%	3%	6%
Not sure/Refused	2%	5%	3%	-	2%	2%

2018 Education Breakouts	All	<HS	HS/GED	Some College	4-Year degree	Grad Work
Within the past 3 years	82%	50%	66%	76%	84%	88%
3 years but less than 5 years ago	7%	35%	14%	9%	6%	4%
5 or more years ago	9%	15%	15%	11%	8%	7%
Not sure/Refused	2%	-	5%	4%	1%	2%

Fifty-eight percent of residents over age 50 have had a sigmoidoscopy or colonoscopy in the last five years, down from 61% in 2016 and 62% in 2014. Different answer categories in 2012 make that year's data not comparable.

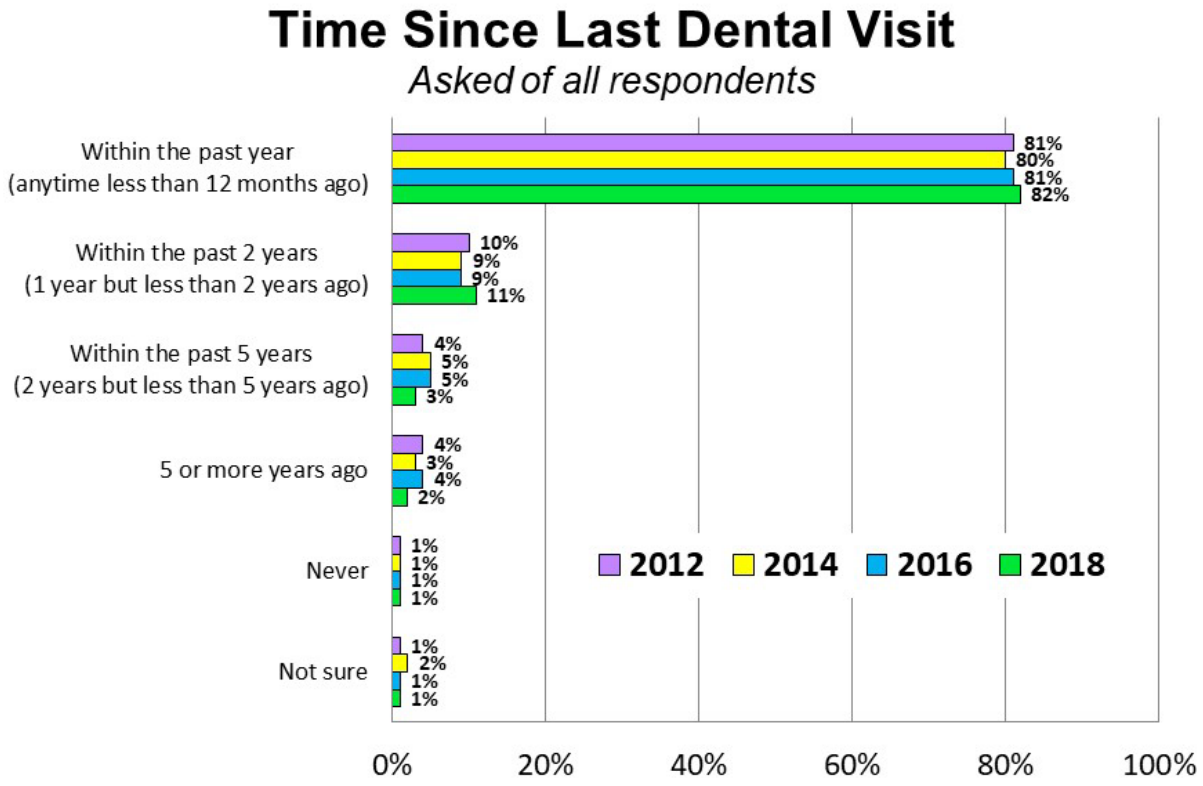


M14.3R. Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since you had your last sigmoidoscopy or colonoscopy?
(Different answer categories in 2012 make trend data not comparable; minimum age for this question raised from 50 to 75 in 2018.)

Due to small subgroup sample sizes for this question, there are no reliable statistical differences to report for this question.

Eighty-two percent of Howard County residents in the 2018 survey have visited a dentist or dental clinic within the last 12 months. This is on a par with prior reporting periods.

Eleven percent had a dental visit between one and two years ago, and 3% had their last dental visit between two and five years ago. Two percent said their most recent dental visit was more than five years ago, and 1% said they have never had a dental visit.



ORAL1. How long has it been since you last visited a dentist or a dental clinic for any reason? Include visits to dental specialists, such as orthodontists.

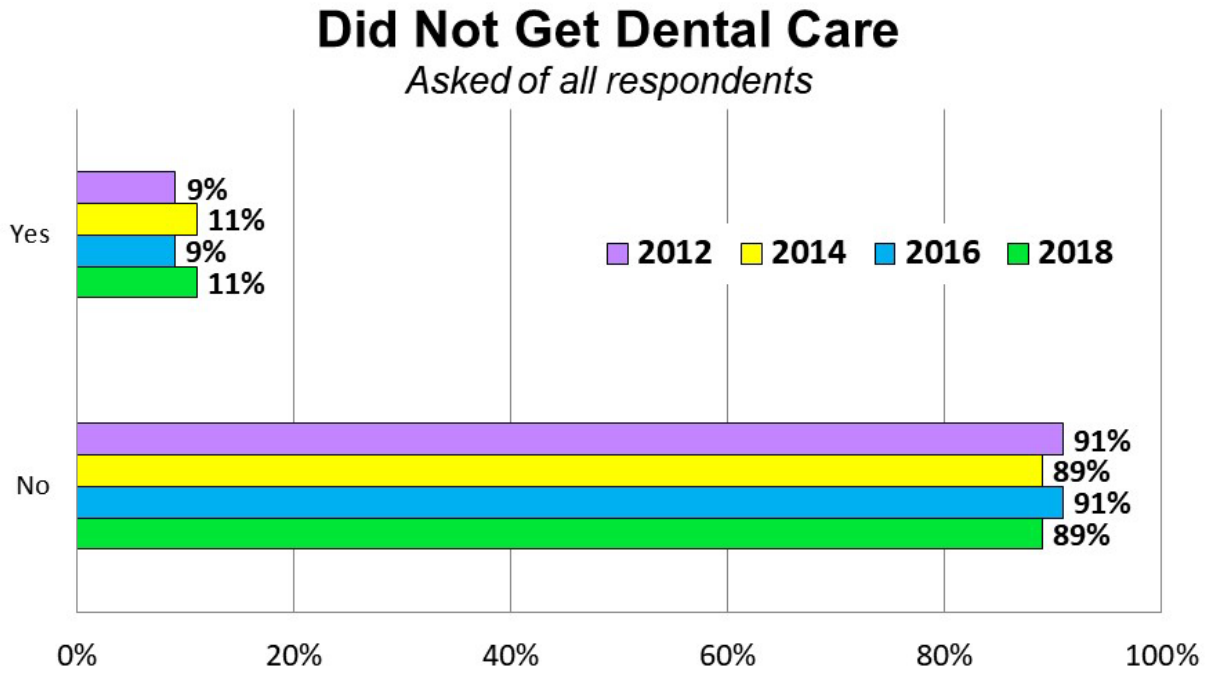
Residents are less likely to have had a dental visit in the past 12 months if they live in Elkridge, earn less than $50,000, or have less than a four-year college degree.

2018 Planning District Breakouts	All	West County	Ellicott City	Colombia	Elkridge	Laurel
Within the past year	82%	85%	87%	81%	74%	82%
1 year but less than 2 years ago	11%	10%	8%	11%	19%	10%
2 years but less than 5 years ago	3%	1%	3%	3%	2%	4%
5 or more years ago	2%	2%	1%	3%	3%	1%
Never	1%	*%	1%	2%	2%	2%
Not sure/ Refused	1%	2%	*%	*%	*%	1%

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Within the past year	82%	68%	81%	79%	89%	93%
1 year but less than 2 years ago	11%	18%	12%	14%	4%	6%
2 years but less than 5 years ago	3%	5%	3%	3%	4%	1%
5 or more years ago	2%	5%	2%	2%	2%	-
Never	1%	4%	1%	1%	1%	-
Not sure/ Refused	1%	*%	1%	-	-	-

2018 Education Breakouts	All	<HS	HS/GED	Some College	4-Year degree	Grad Work
Within the past year	82%	64%	75%	76%	82%	89%
1 year but less than 2 years ago	11%	10%	10%	16%	12%	6%
2 years but less than 5 years ago	3%	4%	4%	3%	3%	2%
5 or more years ago	2%	8%	5%	3%	1%	2%
Never	1%	1%	5%	2%	1%	1%
Not sure/ Refused	1%	13%	1%	*%	*%	*%

Eleven percent of residents said they had a dental problem in the prior 12 months where they would have liked to have seen a dentist but did not do so. This is an increase from the 9% reported in 2016, but on a par with the number reported in 2014.



ORAL2. During the last 12 months, have you had a dental problem which you would have liked to see a dentist about but you didn't see the dentist?

Residents are more likely to have put off seeing a dentist if they live in the Columbia Planning District, are younger than 35, are Hispanic, earn less than $50,000, or are self-employed or unemployed.

2018 Planning District Breakouts	All	West County	Ellicott City	Colombia	Elk Ridge	Laurel
Yes	11%	10%	5%	14%	13%	10%
No	89%	89%	95%	85%	87%	89%
Not sure/ Refused	*%	*%	*%	*%	-	1%

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	11%	16%	19%	8%	8%	6%	7%	8%
No	89%	84%	81%	92%	91%	94%	93%	91%
Not sure/ Refused	*%	-	-	-	*%	*%	-	1%

2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
Yes	11%	8%	14%	15%	24%	13%
No	89%	92%	86%	85%	76%	85%
Not sure/ Refused	*%	*%	*%	-	1%	2%

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Yes	11%	28%	12%	12%	3%	4%
No	89%	72%	88%	88%	97%	96%
Not sure/ Refused	*%	-	-	-	*%	*%

2018 Employment Status Breakouts	All	Employed	Self-Employed	Un-employed	Retired	Home-maker	Student
Yes	11%	9%	20%	19%	7%	12%	12%
No	89%	91%	79%	81%	93%	88%	88%
Not sure/Refused	*%	*%	2%	-	1%	-	-

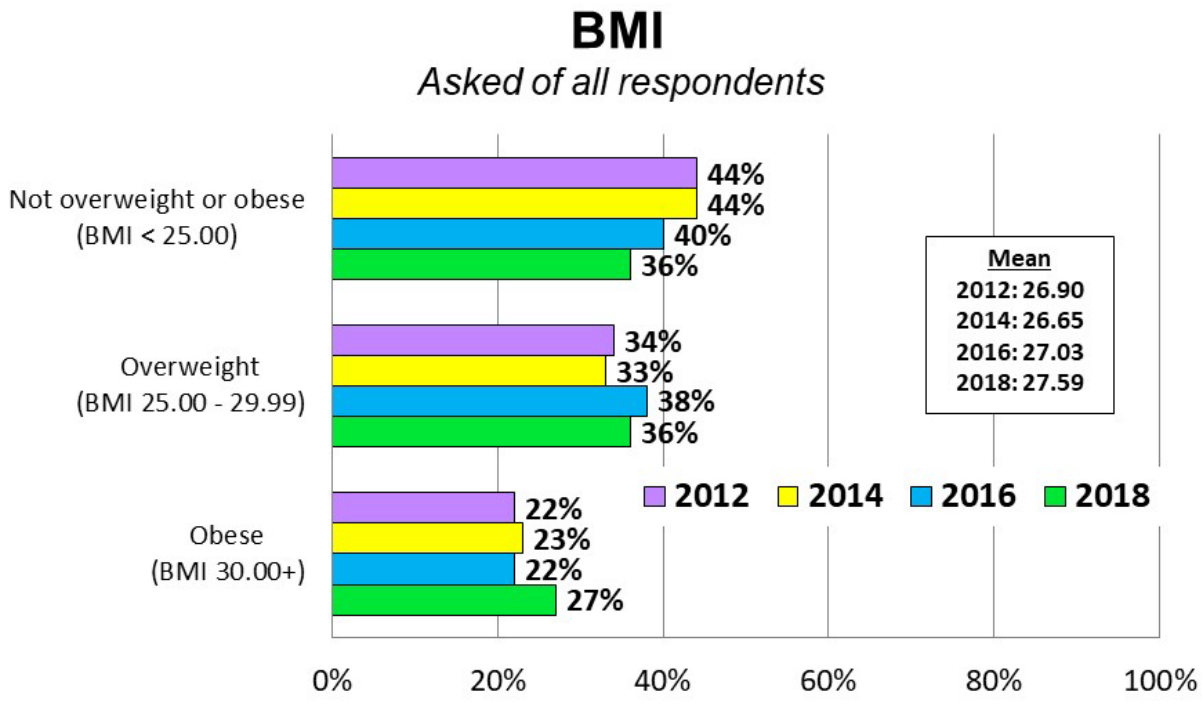
Obesity & Healthy Living

The Obesity & Healthy Living Section includes a calculated average Body Mass Index (BMI) for Howard County based on survey responses, questions about consumption of fruits and vegetables, physical activity, and consumption of sugary drinks.

Obesity

Based on survey questions about residents' height and weight, 36% of the Howard County population is overweight and 27% is obese. Taken together, 63% of the County's adult population is overweight or obese, which is up from 60% in 2016 and 56% in both 2012 and 2014.

The average BMI for the County is 27.59, which has also increased from 2014 and 2016.



Body Mass Index Calculation based on Q8.11 (weight) and Q8.12 (height).

Residents with a higher BMI live in the Elkridge or Laurel planning areas, are between the ages of 55 and 74, are African-American, earn less than $50,000, or are unemployed.

2018 Planning District Breakouts	All	West County	Ellicott City	Colombia	Elkridge	Laurel
Underweight (<18.5)	2%	3%	2%	1%	1%	1%
Normal (18.5 – 24.9)	35%	32%	43%	35%	30%	20%
Overweight (25.0 – 29.9)	36%	34%	34%	36%	36%	49%
Obese (30.0 or more)	27%	31%	21%	29%	34%	29%
Mean	27.6	27.8	26.4	27.6	29.1	29.0

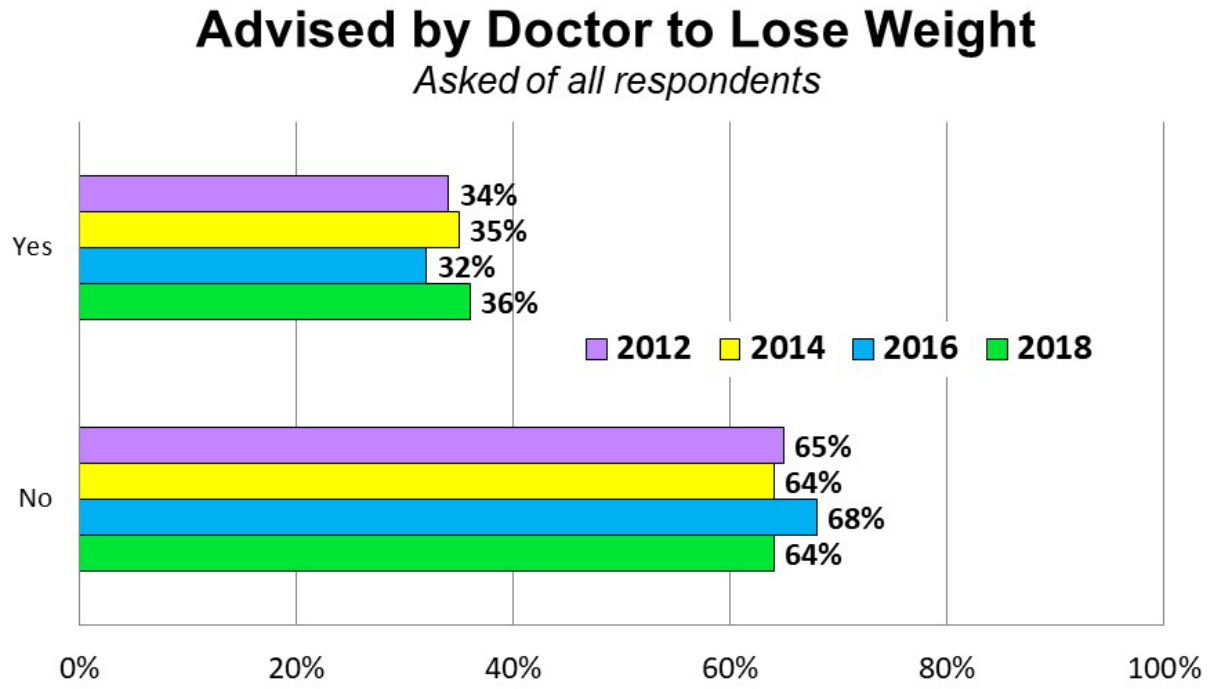
2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Underweight (<18.5)	2%	6%	1%	1%	1%	1%	2%	1%
Normal (18.5 – 24.9)	35%	56%	31%	34%	32%	27%	32%	36%
Overweight (25.0 – 29.9)	36%	23%	40%	38%	39%	39%	32%	39%
Obese (30.0 or more)	27%	15%	28%	27%	29%	34%	35%	24%
Mean	27.6	24.8	28.1	27.7	27.9	28.6	28.4	26.9

2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
Underweight (<18.5)	2%	2%	*%	2%	*%	1%
Normal (18.5 – 24.9)	35%	34%	24%	55%	26%	34%
Overweight (25.0 – 29.9)	36%	35%	43%	30%	44%	30%
Obese (30.0 or more)	27%	29%	32%	12%	30%	35%
Mean	27.6	27.8	28.6	25.1	28.3	27.6

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Underweight (<18.5)	2%	*%	1%	2%	3%	2%
Normal (18.5 – 24.9)	35%	30%	31%	36%	33%	40%
Overweight (25.0 – 29.9)	36%	33%	40%	33%	36%	37%
Obese (30.0 or more)	27%	36%	27%	30%	28%	22%
Mean	27.6	28.5	27.7	27.7	27.6	27.3

2018 Employment Status Breakouts	All	Employed	Self-Employed	Un-employed	Retired	Home-maker	Student
Underweight (<18.5)	2%	1%	1%	4%	2%	1%	8%
Normal (18.5 – 24.9)	35%	35%	37%	16%	31%	33%	53%
Overweight (25.0 – 29.9)	36%	37%	39%	36%	39%	35%	28%
Obese (30.0 or more)	27%	28%	24%	45%	29%	31%	11%
Mean	27.6	27.7	27.2	29.7	27.8	29.0	23.9

More than one-third (36%) of residents said they have been advised by a doctor to lose weight in the preceding five years. This number is higher than that reported in the three prior surveys.



Q8.12A. Have you been advised by your doctor in the last five years to lose weight?
2012 and 2014 wording: Have you ever been advised by your doctor to lose weight?

Residents are more likely to have been advised by a doctor to lose weight if they are between the ages of 55 and 74, or are divorced or part of an unmarried couple.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	36%	24%	35%	35%	38%	46%	44%	23%
No	64%	76%	65%	65%	61%	54%	55%	76%
Not sure/ Refused	*%	-	-	*%	*%	-	1%	*%

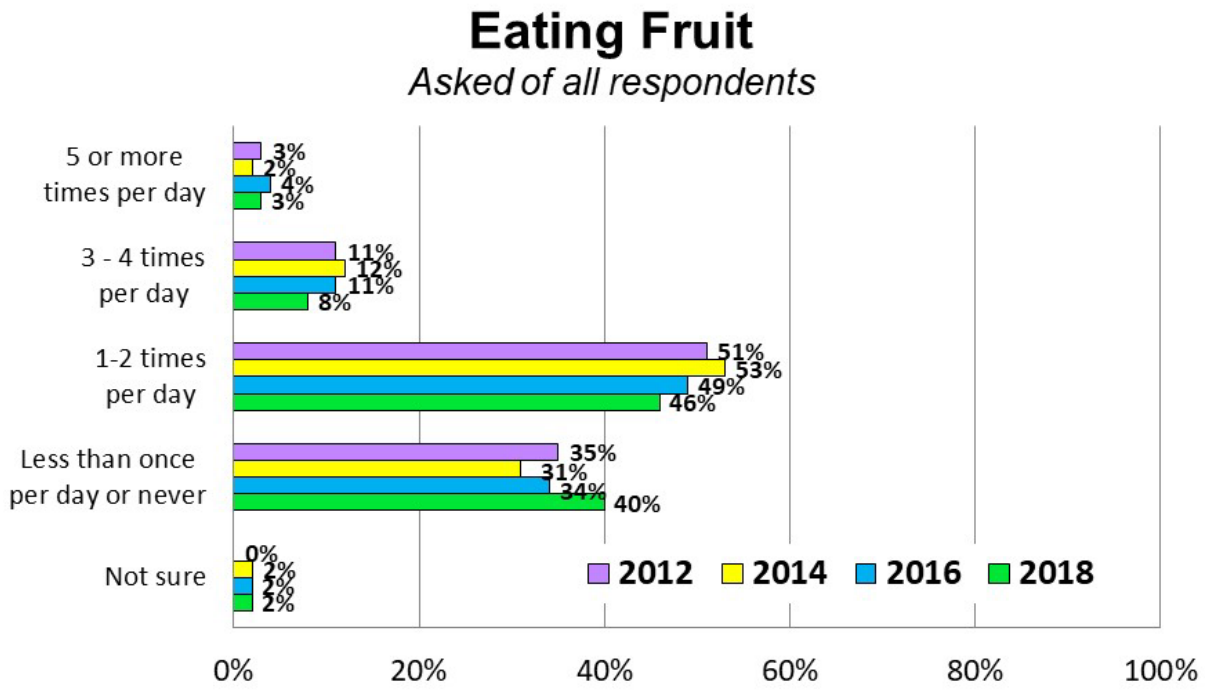
2018 Marital Status Breakouts	All	Married	Divorced	Widowed	Never Married	Unmarried Couple
Yes	36%	36%	46%	28%	31%	67%
No	64%	64%	54%	72%	69%	32%
Not sure/ Refused	*%	*%	-	-	-	2%

2018 BMI Breakouts	All	Underweight (<18.5)	Normal (18.5 – 24.9)	Overweight (25.0 – 29.9)	Obese (30.0+)
Yes	36%	13%	7%	36%	72%
No	64%	87%	93%	64%	28%
Not sure/ Refused	*%	-	-	*%	*%

Fruit and Vegetable Consumption

Fifty-seven percent of Howard County residents said they eat fruit at least once a day. Of those, 3% eat fruit five or more times a day, 8% eat it three to four times daily, and 46% eat fruit one or two times a day. Note that numbers will not always appear to add correctly due to rounding.

Daily fruit consumption by 57% of residents is significantly lower than prior reporting periods (64% in 2016, 67% in 2014 and 65% in 2012).



Q9.2R. During the past week, not counting juice, how many times did you eat fruit? Count fresh, frozen, or canned fruit.

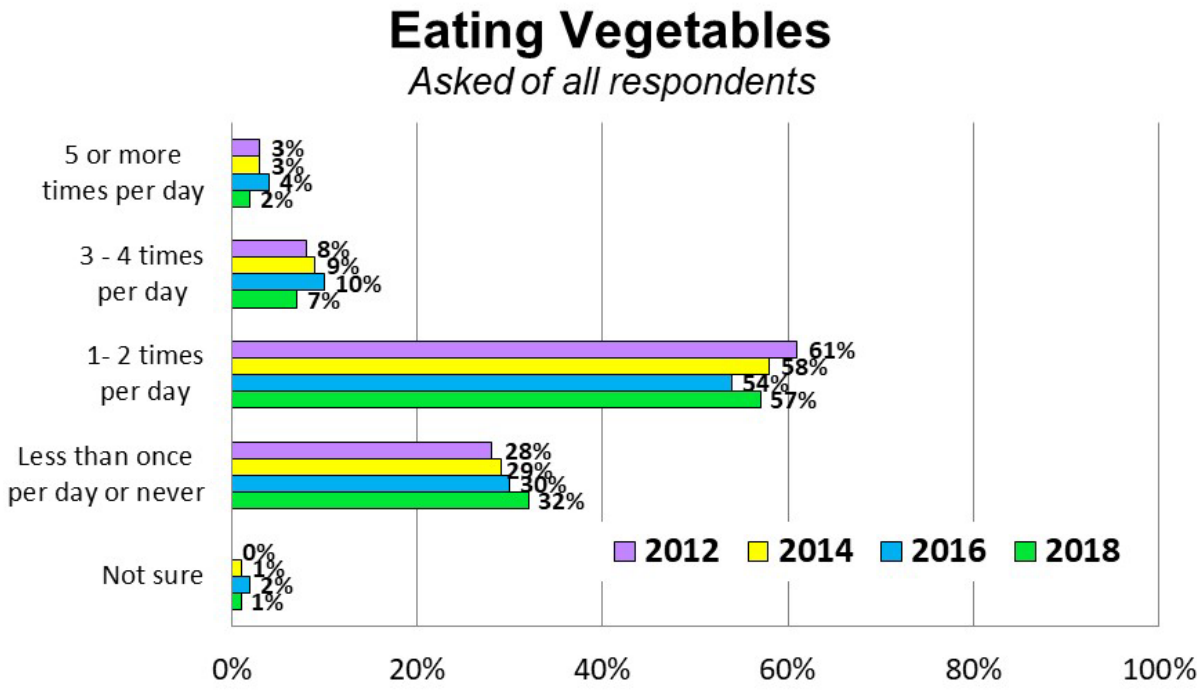
Daily fruit consumption is significantly lower in households earning less than $100,000 a year, and among residents who are divorced, widowed, never married, or part of an unmarried couple.

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
5 or more times per day	3%	2%	2%	3%	3%	3%
3 but less than 5 times per day	8%	5%	9%	8%	8%	11%
1 but less than 3 times per day	46%	42%	40%	51%	48%	51%
Total Daily	57%	50%	52%	62%	60%	64%
Less than once per day	34%	37%	40%	31%	34%	31%
Never/ Not sure	8%	14%	8%	7%	6%	5%

2018 Marital Status Breakouts	All	Married	Divorced	Widowed	Never Married	Unmarried Couple
5 or more times per day	3%	3%	2%	2%	2%	-
3 but less than 5 times per day	8%	9%	10%	7%	8%	-
1 but less than 3 times per day	46%	50%	36%	43%	41%	48%
Total Daily	57%	62%	48%	51%	51%	48%
Less than once per day	34%	31%	38%	37%	38%	50%
Never/ Not sure	8%	7%	14%	12%	11%	2%

Sixty-six percent of residents eat vegetables at least once a day. Two percent of residents eat vegetables five or more times daily, 7% eat them three or four times a day, and 57% eat vegetables one or two times daily.

Similar to the number of residents who eat fruit at least once a day, daily vegetable consumption continues to trend downward in Howard County (72% in 2012, 70% in 2014, 68% in 2016, 66% in 2018).



Q9.4R. During the past week, how many times did you eat vegetables that were not fried? Do not include rice or other grains.

African-American residents, people living in households earning less than $50,000 per year, and widowed or never married residents are less likely to eat vegetables daily.

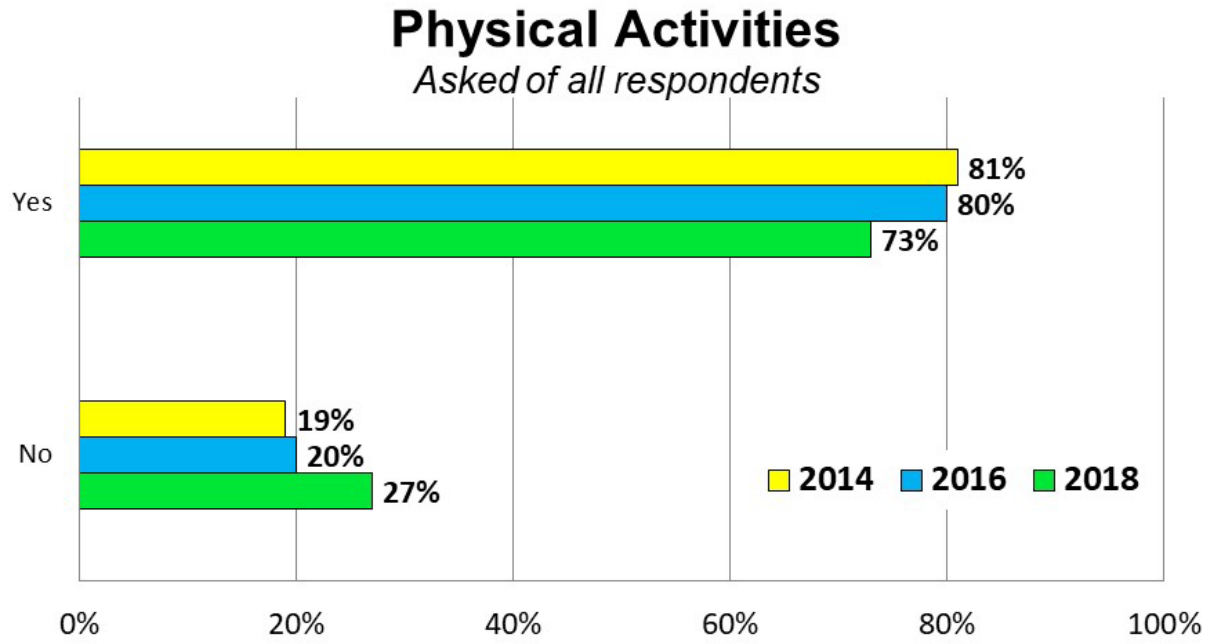
2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
5 or more times per day	2%	2%	2%	1%	2%	6%
3 but less than 5 times per day	7%	9%	7%	4%	2%	5%
1 but less than 3 times per day	57%	58%	48%	62%	57%	63%
Total Daily	66%	69%	57%	68%	61%	74%
Less than once per day	30%	28%	40%	26%	36%	23%
Never/ Not sure	3%	3%	3%	6%	2%	2%

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
5 or more times per day	2%	1%	2%	3%	3%	2%
3 but less than 5 times per day	7%	4%	6%	8%	11%	7%
1 but less than 3 times per day	57%	49%	56%	61%	55%	63%
Total Daily	66%	54%	63%	72%	69%	72%
Less than once per day	30%	40%	34%	26%	27%	26%
Never/ Not sure	3%	6%	3%	1%	2%	2%

2018 Marital Status Breakouts	All	Married	Divorced	Widowed	Never Married	Unmarried Couple
5 or more times per day	2%	3%	2%	3%	1%	-
3 but less than 5 times per day	7%	8%	6%	7%	6%	-
1 but less than 3 times per day	57%	59%	53%	45%	54%	59%
Total Daily	66%	70%	61%	56%	61%	59%
Less than once per day	30%	27%	34%	35%	36%	41%
Never/ Not sure	3%	3%	6%	9%	3%	-

Physical Activity

Seventy-three percent of residents undertook physical activities such as running, golf, swimming, yard work, or walking for exercise during the week prior to the survey. This represents a decrease from the 80% of residents in 2016 and the 81% in 2014 who said they had undertaken such physical activities. This question was not asked in 2012.



Q10.1A. During the past week, other than your regular job, did you do any physical activities or exercise such as running, golf, swimming, yard work, or walking for exercise?
(Question not asked in 2012)

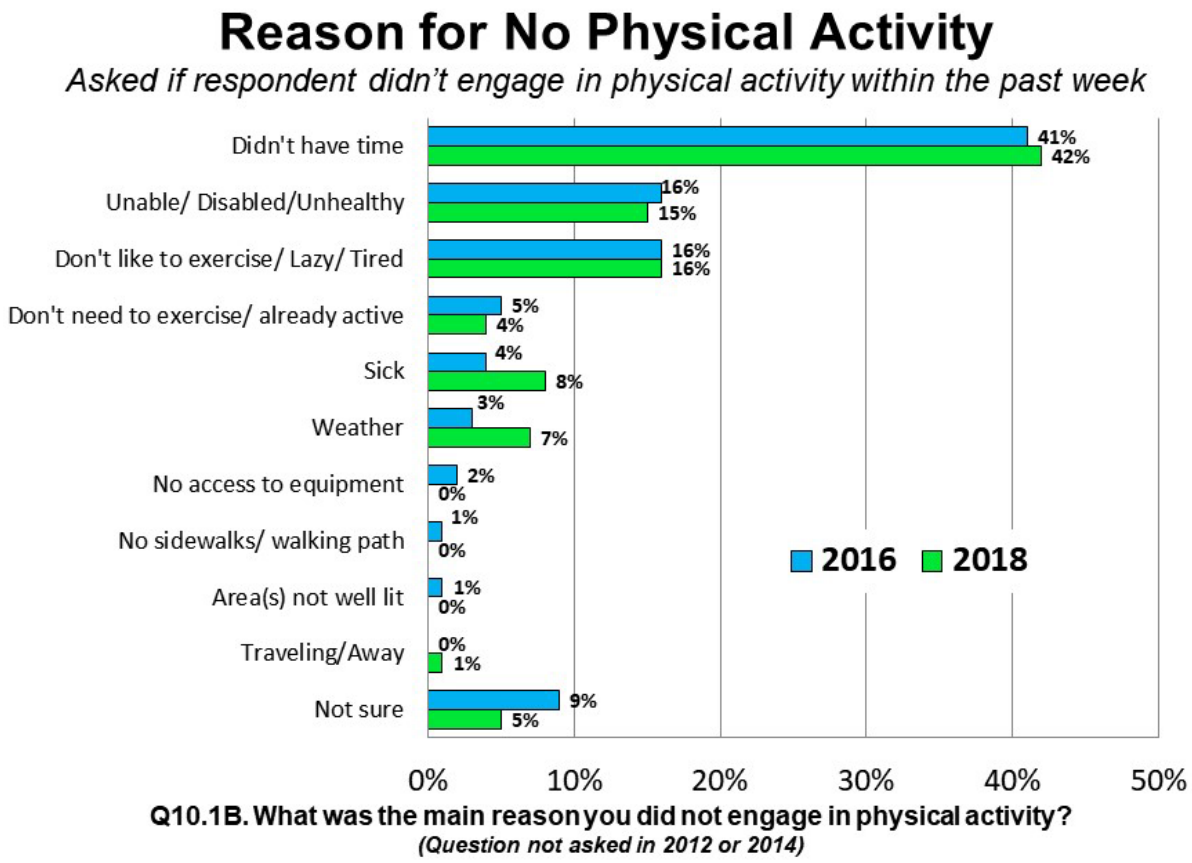
Residents are more likely to have engaged in physical activity or exercise in the past week if they are male, aged 18 to 24, or earn more than $100,000 per year.

2018 Gender Breakouts	All	Male	Female
Yes	73%	79%	67%
No	27%	21%	33%
Not sure/ Refused	*%	-	*%

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	73%	81%	73%	71%	75%	73%	67%	58%
No	27%	19%	27%	29%	25%	27%	32%	42%
Not sure/ Refused	*%	-	-	-	-	-	*%	-

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Yes	73%	62%	69%	77%	75%	83%
No	27%	38%	31%	23%	25%	17%
Not sure/ Refused	*%	-	-	-	-	-

When residents who had not engaged in physical exercise were asked what was the main reason, the largest number (42%) said it was because they felt they did not have time. The next leading responses were physically unable or disabled (15%) or residents who said they just did not like exercise or considered themselves too "lazy" or too tired (16%). Other barriers scored much lower: feeling that they do not need exercise because they are already active (4%), being sick (8%), or poor weather (7%). This question was not asked in 2012 or 2014.

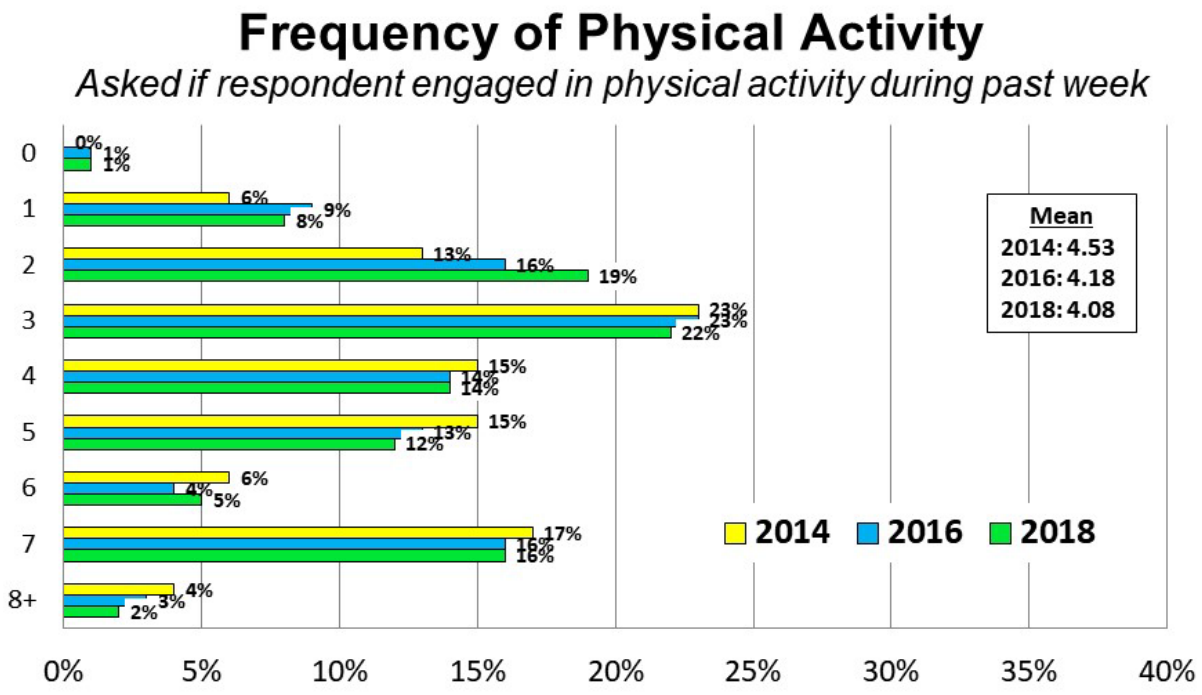


Q10.1B. What was the main reason you did not engage in physical activity?
(Question not asked in 2012 or 2014)

Barriers to physical exercise vary somewhat based on age.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Didn't have time	42%	37%	44%	68%	46%	32%	26%	9%
Don't need exercise/am active	4%	9%	-	2%	8%	2%	3%	7%
Don't like to exercise/Lazy/Tired	16%	17%	19%	5%	20%	26%	13%	16%
Weather	7%	4%	8%	10%	3%	11%	7%	2%
Unable/Disabled/Health/Old	15%	3%	11%	7%	7%	18%	38%	42%
Sick	8%	10%	17%	2%	6%	3%	6%	9%
Other	1%	-	1%	-	4%	2%	3%	3%
Not sure/ Refused	6%	19%	-	5%	5%	6%	5%	12%

Among those who said they had taken part in physical exercise during the prior week, the average (mean) number of times was 4.08. This is slightly lower than the 4.18 measured in 2016, and significantly lower than the 4.53 measured in 2014.



Q10.2A. During the past week, how many times did you take part in this activity?
(Question not asked in 2012)

While the incidence of physical activity for exercise is lower among older residents, those who do so, exercise more frequently than other age groups. That phenomenon is duplicated among lower-income residents.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
0/Never	1%	-	5%	-	*%	1%	1%	*%
1	8%	4%	11%	9%	7%	8%	9%	9%
2	19%	23%	16%	22%	21%	22%	14%	13%
3	22%	18%	26%	28%	19%	16%	21%	20%
4	14%	9%	15%	15%	14%	16%	9%	13%
5	12%	16%	9%	10%	15%	14%	12%	14%
6	5%	2%	4%	4%	4%	7%	6%	7%
7	16%	24%	14%	9%	15%	15%	22%	17%
8+	2%	-	2%	1%	4%	1%	6%	5%
Not sure/ Refused	1%	2%	-	2%	-	-	*%	2%
Mean	4.08	4.17	3.93	3.57	4.23	4.00	4.57	4.59

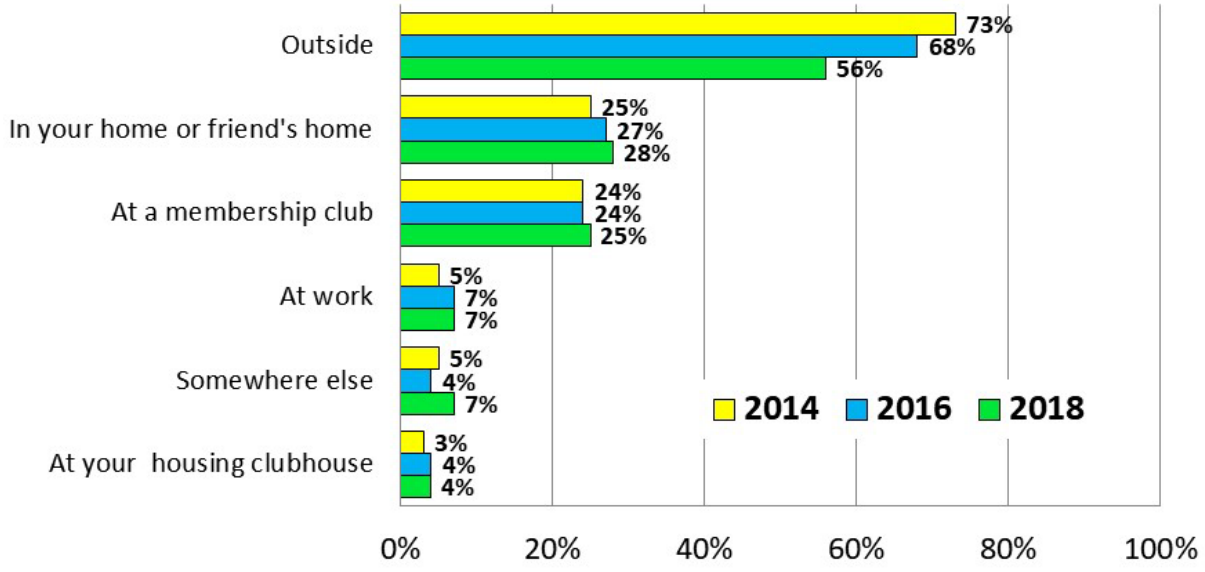
2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
0/Never	1%	3%	-	1%	-	*%
1	8%	9%	9%	9%	7%	6%
2	19%	15%	20%	22%	21%	20%
3	22%	21%	22%	20%	27%	20%
4	14%	7%	18%	11%	13%	17%
5	12%	11%	8%	16%	13%	14%
6	5%	3%	6%	3%	5%	6%
7	16%	28%	14%	15%	12%	13%
8+	2%	3%	2%	2%	3%	1%
Not sure/ Refused	1%	1%	*%	*%	-	2%
Mean	4.08	4.66	3.92	4.04	3.92	3.99

Considering *where* they did their exercise, most residents (56%) exercised outdoors, followed by at home or a friend's home (28%), at a membership club (25%), or at work (7%). The number of residents exercising outdoors in 2018 is significantly lower than in the prior two reporting periods, and may partly reflect the later time of year when many of the survey interviews were conducted in 2018.

Note that residents could choose more than one of these, so the percentages will add to more than 100%. The responses of "somewhere else" included community or recreation centers, private facilities, schools, healthcare facilities, and others.

Location of Physical Activity

Asked if respondent did engage in physical activity during past week



Q10.3A. Where did you do these activities?
(Results total more than 100% because multiple answers were accepted.)

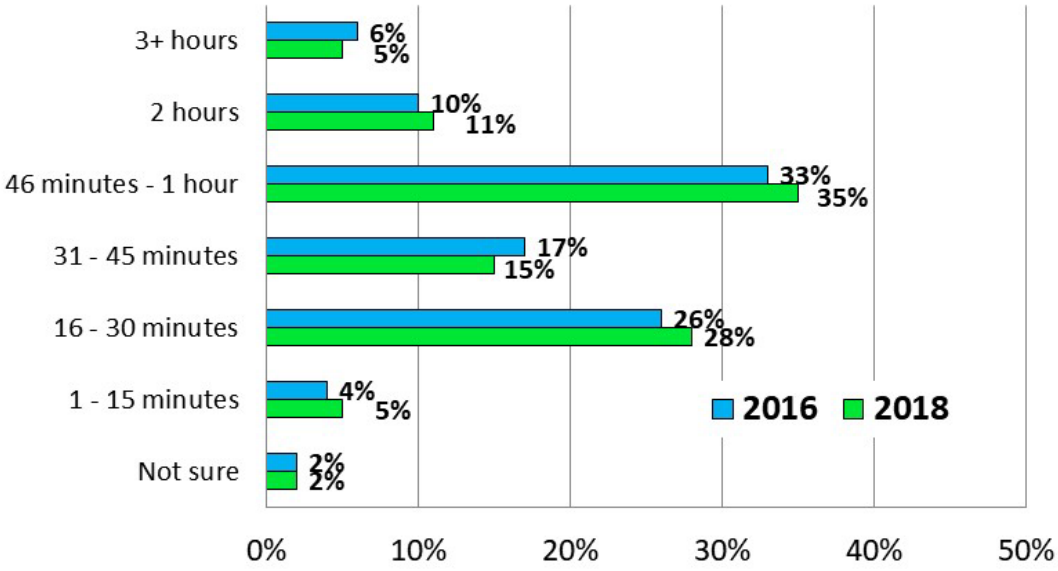
The location of physical activity varies significantly by age.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Outside	56%	41%	50%	52%	61%	67%	67%	51%
In your home or friend's home	28%	21%	28%	31%	28%	25%	24%	36%
At a membership club	25%	26%	28%	26%	28%	22%	23%	18%
At work	7%	5%	7%	10%	9%	7%	1%	5%
At your housing clubhouse	4%	6%	5%	5%	2%	4%	2%	5%
Somewhere else	18%	36%	9%	15%	14%	19%	23%	32%

On average (median), residents spent between 45 minutes and one hour on each occasion they were engaged in physical activity for exercise. This is similar to the result in 2016.

Duration of Physical Activity

Asked if respondent did engage in physical activity during past week



Q10.3B. And each time you took part in this activity, for how many minutes or hours did you usually keep at it?
(Not asked in 2012 or 2014.)

The duration of that activity varied significantly based on a person's age and household income.

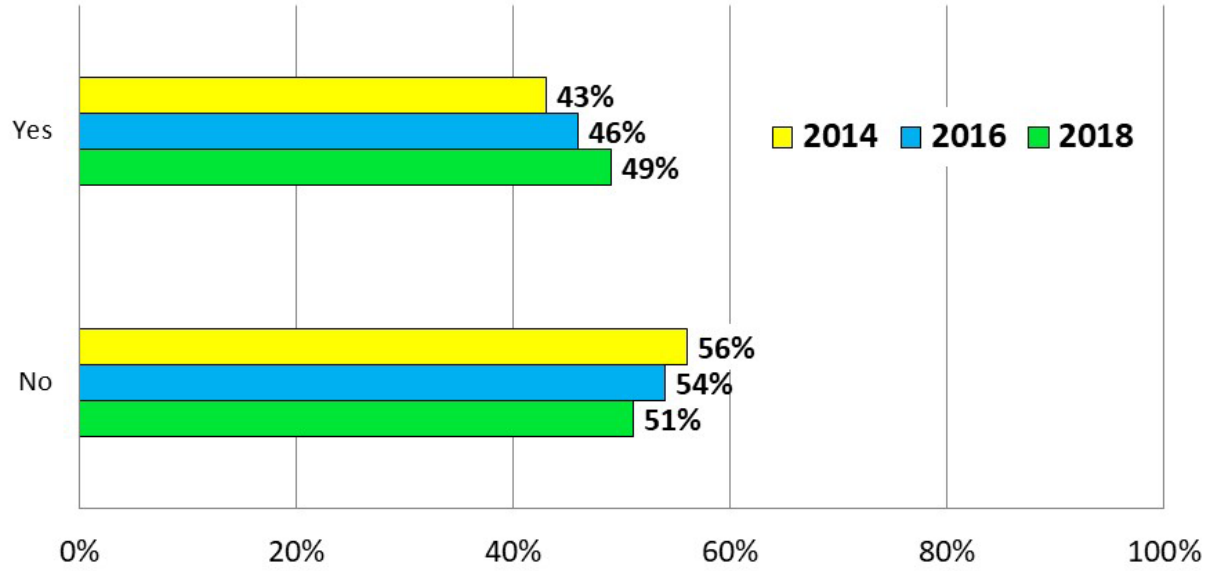
2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
1 – 15 minutes	5%	7%	5%	2%	4%	6%	8%	11%
16 – 30 minutes	28%	25%	26%	27%	32%	29%	25%	27%
31 – 45 minutes	15%	6%	9%	21%	18%	18%	15%	13%
46 minutes – 1 hour	35%	35%	39%	35%	35%	30%	34%	26%
2 hours	11%	23%	14%	8%	7%	10%	9%	9%
3+ hours	5%	4%	3%	5%	3%	7%	6%	11%
Not sure/ Refused	2%	*%	5%	2%	2%	1%	2%	4%

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
1 – 15 minutes	5%	6%	3%	9%	3%	4%
16 – 30 minutes	28%	35%	26%	26%	32%	23%
31 – 45 minutes	15%	4%	12%	14%	22%	19%
46 minutes – 1 hour	35%	35%	40%	32%	33%	37%
2 hours	11%	10%	12%	13%	7%	12%
3+ hours	5%	6%	6%	4%	3%	5%
Not sure/ Refused	2%	4%	1%	3%	*%	1%

In the week prior to the survey, 49% of residents did physical activities to strengthen their muscles such as yoga, sit-ups or push-ups, weight machines, free weights, or elastic bands. This is an increase from 46% in 2016 and 43% in 2014. This question was not asked in 2012.

Physical Activities to Strengthen Muscles

Asked of all respondents



Q10.4A. During the past week, did you do physical activities or exercises to strengthen your muscles? Count activities using your own body weight like yoga, sit-ups or push-ups, or weight machines, free weights, or elastic bands.

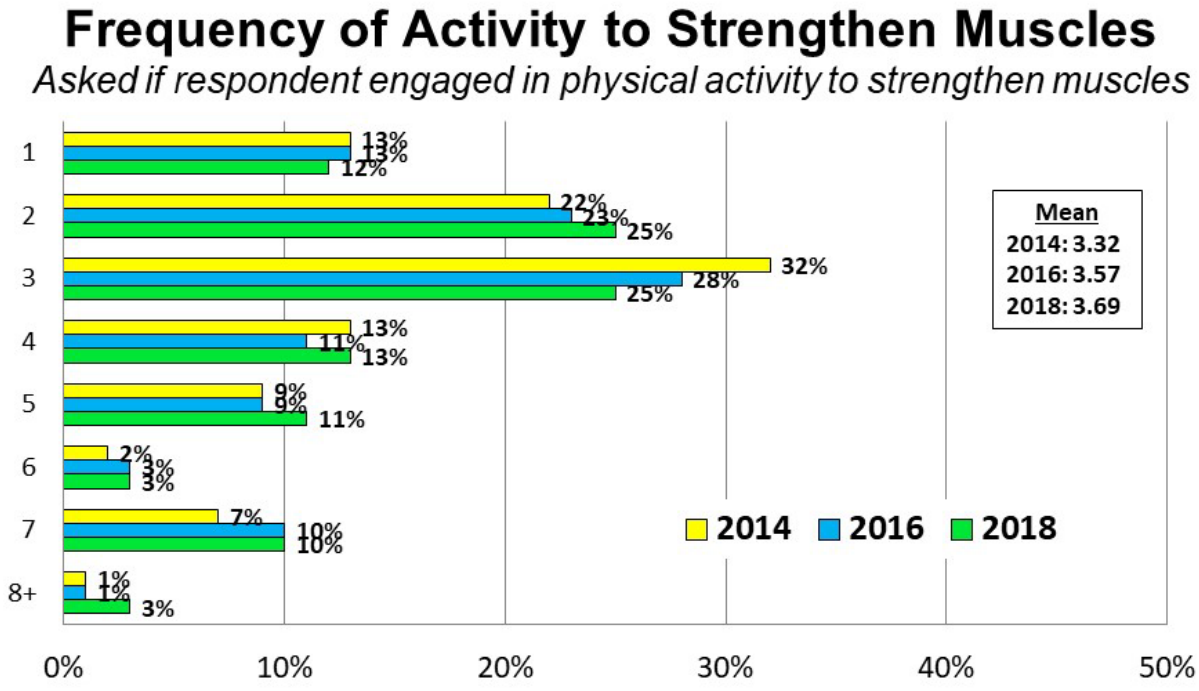
(Question not asked in 2012)

Residents are more likely to engage in physical activities or exercises to strengthen muscles if they are male, under the age of 25, or upper-income.

2018 Gender Breakouts	All	Male	Female
Yes	49%	54%	44%
No	51%	46%	56%
Not sure/ Refused	*%	*%	*%

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	49%	69%	46%	48%	50%	44%	40%	32%
No	51%	31%	54%	52%	49%	56%	59%	68%
Not sure/ Refused	*%	-	-	*%	*%	-	*%	-

Among those who said they had taken part in physical activities or exercises to strengthen their muscles during the prior week, the average (mean) number of times was 3.69, which is an increase from the 3.57 recorded in 2016 and the 3.32 recorded in 2014.



Q10.5A. During the past week, how many times did you take part in this activity?
(Question not asked in 2012)

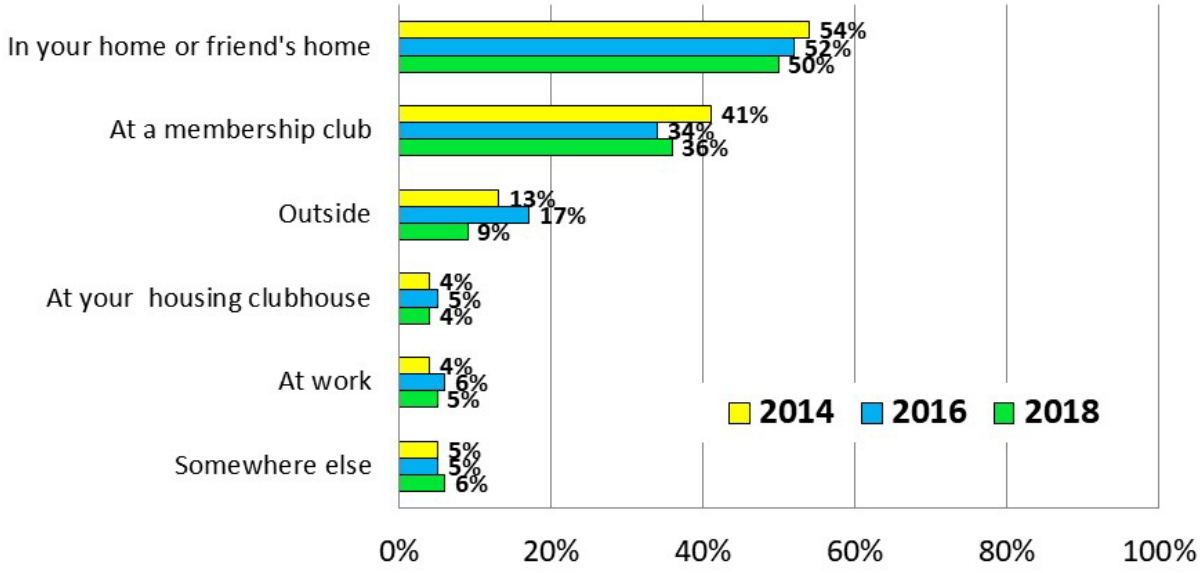
Among those who took part in these activities, the frequency was greater among the youngest and oldest participants.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
0/ Never	-	-	-	-	-	-	-	-
1	12%	9%	11%	16%	10%	14%	9%	14%
2	25%	16%	23%	27%	33%	25%	21%	17%
3	25%	25%	31%	23%	20%	24%	30%	22%
4	13%	13%	12%	13%	12%	14%	11%	14%
5	11%	18%	4%	10%	14%	10%	6%	9%
6	3%	1%	1%	4%	4%	4%	2%	-
7	10%	13%	10%	7%	6%	8%	19%	22%
8+	3%	4%	8%	1%	1%	1%	1%	-
Not sure	-	-	-	-	-	-	-	-
Mean	3.69	4.14	4.46	3.13	3.38	3.38	3.78	3.75

Residents were most likely to undertake strengthening exercises at home (50%), followed by a membership club (36%), outside (9%), at their housing clubhouse (4%), or at work (5%).

Location of Activity to Strengthen Muscles

Asked if respondent engaged in physical activity to strengthen muscles

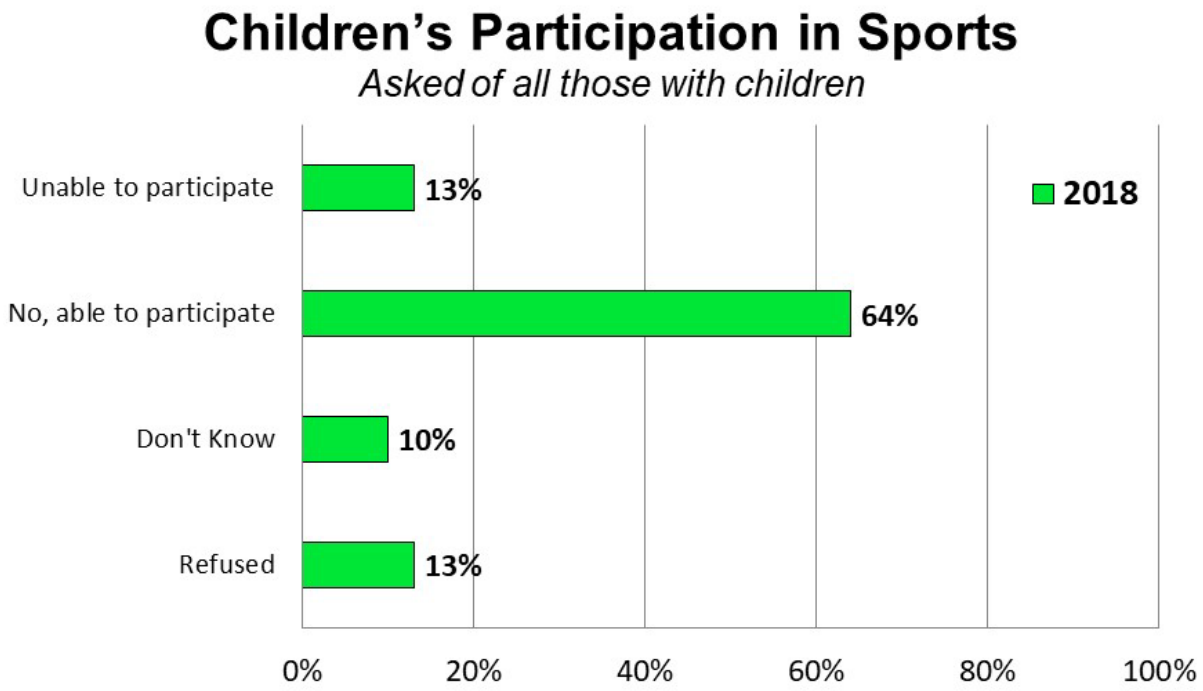


Q10.6A. Where did you do these activities?
(Results total more than 100% because multiple answers were accepted.)

Lower-income people are more likely than others to do strengthening exercises at home. Residents in the highest income group are more likely to do strengthening exercises at a membership club, while middle-income people earning between $50,000 and $100,000 are somewhat more likely than others to do them at work.

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
In your home or friend's home	50%	59%	49%	52%	50%	42%
At a membership club	36%	30%	31%	35%	35%	50%
Outside	9%	9%	7%	11%	8%	7%
At work	5%	5%	10%	5%	4%	3%
At your housing clubhouse	4%	3%	6%	6%	4%	2%
Somewhere else	11%	19%	10%	12%	12%	10%
Not sure	*%	-	*%	*%	-	-

For the first time in 2018, residents were asked whether their youngest child was unable to participate in an organized youth sporting activity. Thirteen percent said their child was unable to participate, while 64% indicated that the child was able to participate. The remainder said they did not know (10%), or chose not to give an answer (13%).

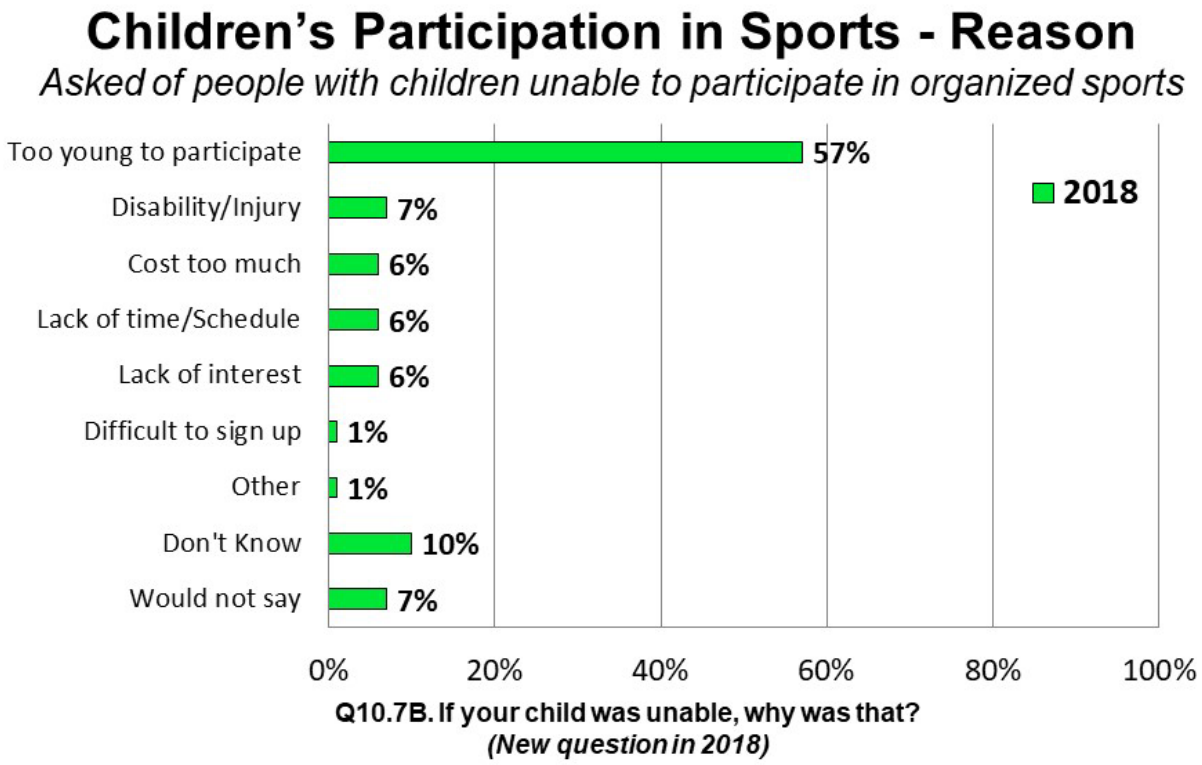


Q10.7A. In 2018 was your youngest child unable to participate in an organized youth sporting activity, such as a Rec and Parks team, soccer, or another organized youth sports team?
(New question in 2018)

Unemployed people and homemakers are more likely to have children who could not participate in organized sporting activities.

2018 Employment Status Breakouts	All	Employed	Self-Employed	Un-employed	Retired	Home-maker	Student
Unable to participate	13%	13%	11%	22%	3%	28%	6%
No, able to participate	64%	65%	71%	58%	58%	60%	59%
Don't know	10%	9%	7%	15%	17%	4%	16%
Refused to say	13%	12%	11%	6%	22%	8%	19%

The reason most often given for a child's inability to participate in organized sporting activities was that the child was too young to participate (57%). Less frequent reasons were the child's disability or injury (7%), that the activity cost too much (6%), lack of time or schedule issues (6%), and lack of interest (6%).



Due to small subgroup sample sizes for this question, there are no reliable statistical differences to report for this question.

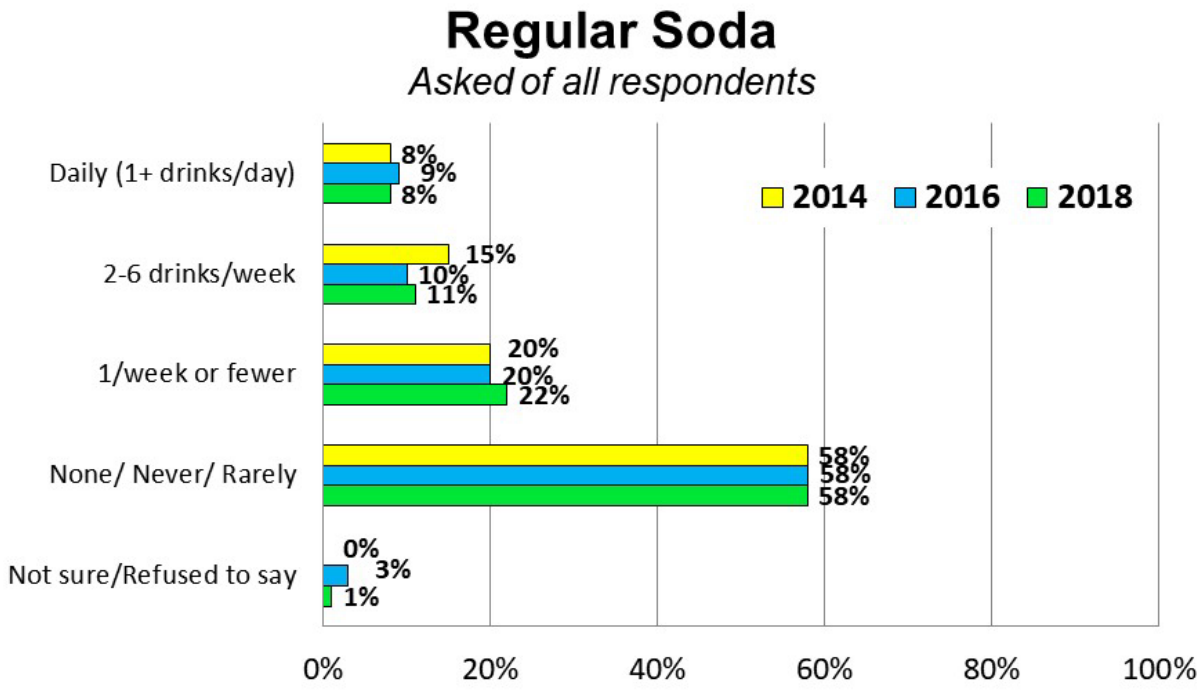
Sugary Drinks

Forty-one percent of Howard County residents consume regular soda such as Coke, Pepsi, Sprite, or Mountain Dew. This is slightly more than the 39% reported in 2016, but a decrease from the 43% reported in 2014. This number is determined by combining the responses of residents who indicated they had any measurable soda consumption.

Within that 41% total, 8% of the County's residents drink soda at least once a day, which is slightly below the 9% reported in 2016 and on a par with the 8% reported in 2014. Another 11% consume between two and six sodas a week, slightly above the 10% reported in 2016 but down from 15% in the 2014 survey. Twenty-two percent said they drink regular soda once a week or less often, a number that is only slightly higher than the 20% reported in the prior two surveys. (Note that numbers may not always appear to add correctly due to rounding.)

Fifty-eight percent of residents drink no soda at all or only rarely, which is unchanged dating back to 2014.

Different answer categories in 2012 make that year's data not comparable for this series of questions.



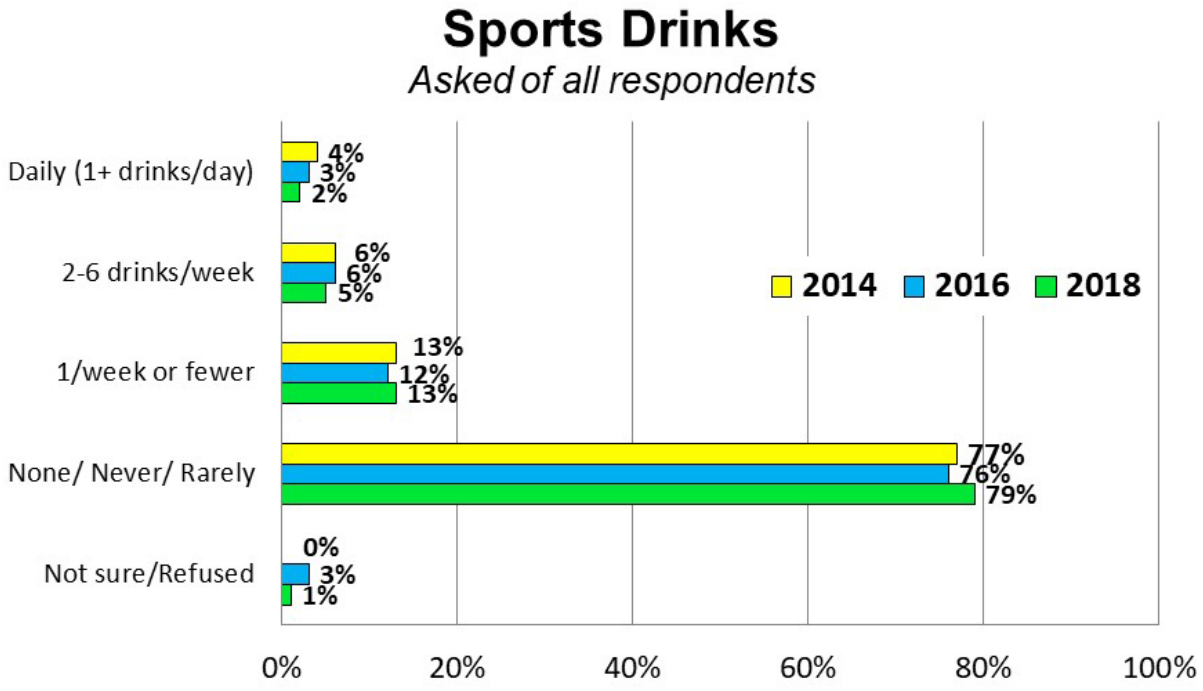
SD1. How often do you drink regular soda such as Coke Classic, Pepsi, Sprite, or Mountain Dew? Do not include diet soda or seltzer.

Residents between the ages of 18 and 24 are much more likely than other age groups to consume regular soda, as are residents who have never been married or who are in unmarried couples.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
None/ Never/ Rarely	58%	39%	54%	56%	61%	70%	66%	60%
All who consumer soda	*41%*	*61%*	*45%*	*44%*	*37%*	*29%*	*34%*	*39%*
1-3 per month	14%	18%	15%	18%	15%	7%	11%	8%
1 per week	8%	12%	9%	8%	8%	5%	5%	5%
2-6 per week	11%	21%	13%	9%	8%	8%	8%	10%
Daily	8%	10%	8%	8%	6%	8%	9%	17%
Not sure/Refused	1%	-	1%	*%	2%	1%	*%	1%

2018 Marital Status Breakouts	All	Married	Divorced	Widowed	Never Married	Unmarried Couple
None/ Never/ Rarely	58%	62%	64%	63%	47%	42%
All who consumer soda	*41%*	*37%*	*36%*	*35%*	*53%*	*58%*
1-3 per month	14%	12%	16%	6%	18%	23%
1 per week	8%	7%	6%	6%	10%	13%
2-6 per week	11%	10%	5%	8%	15%	19%
Daily	8%	7%	9%	14%	10%	3%
Not sure/Refused	1%	1%	*%	3%	-	-

Twenty percent of residents consume sports drinks like Gatorade or Powerade. This is a decrease from 21% measured in 2016 and 23% in 2014. In the 2018 survey, 2% said they drink sports drinks daily, 5% between two and six times a week, and 13% drink them once a week or less often.



SD2. How often do you drink sports drinks like Gatorade or Powerade? Do not include diet or low-calorie types.

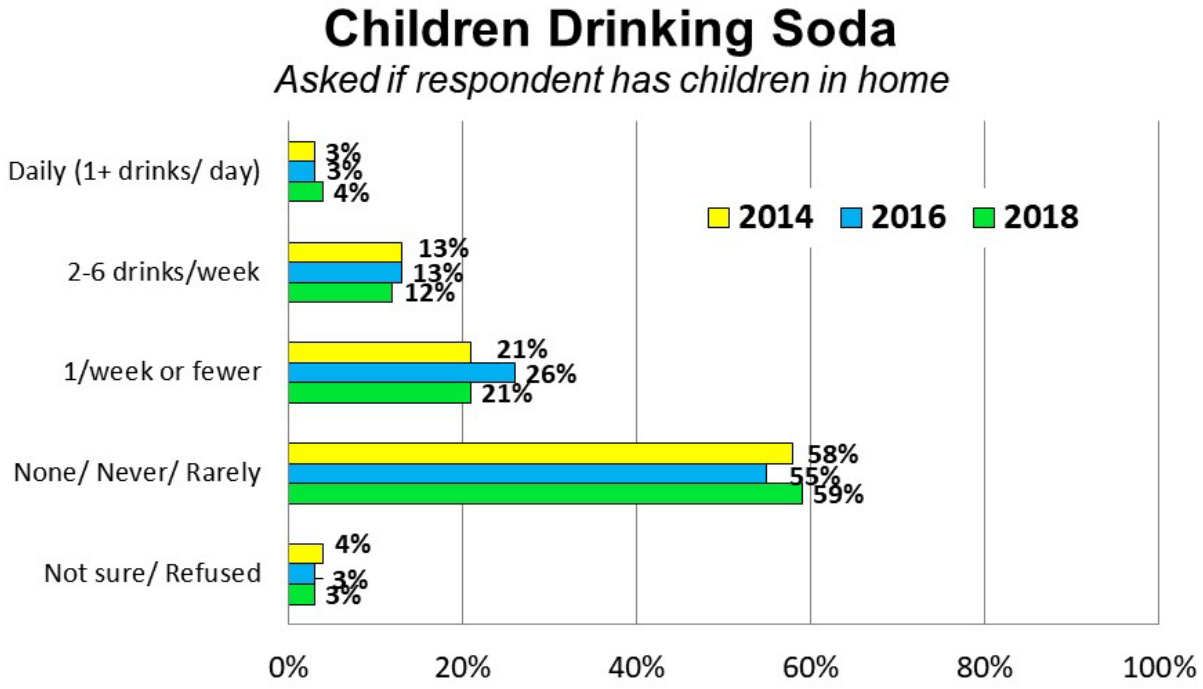
Men and residents younger than 45 are much more likely than others to drink sports drinks.

2018 Gender Breakouts	All	Male	Female
None/ Never/ Rarely	79%	69%	87%
All who consume sports drinks	20%	29%	11%
1-3 per month	8%	8%	7%
1 per week	5%	8%	2%
2-6 per week	5%	9%	1%
Daily	2%	4%	1%
Not sure/Refused	2%	2%	1%

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
None/ Never/ Rarely	79%	59%	75%	74%	83%	88%	91%	85%
All who consume sports drinks	20%	41%	23%	25%	15%	11%	9%	12%
1-3 per month	8%	17%	7%	11%	7%	3%	5%	1%
1 per week	5%	9%	8%	7%	3%	2%	*%	4%
2-6 per week	5%	12%	7%	4%	4%	3%	3%	3%
Daily	2%	3%	1%	3%	1%	3%	1%	4%
Not sure/Refused	2%	-	2%	2%	2%	2%	-	4%

Consumption of sugary drinks by children was measured by asking parents and guardians to think of their youngest child between the ages of two and 18. Thirty-seven percent said their children drink regular soda, a decrease of 6% from the 42% reported in 2016, and on a par with the 37% reported in 2014.

Four percent of parents in 2018 said their children drink soda daily, 12% drink soda two to six times per week, while 21% of children drink soda once a week or less often.

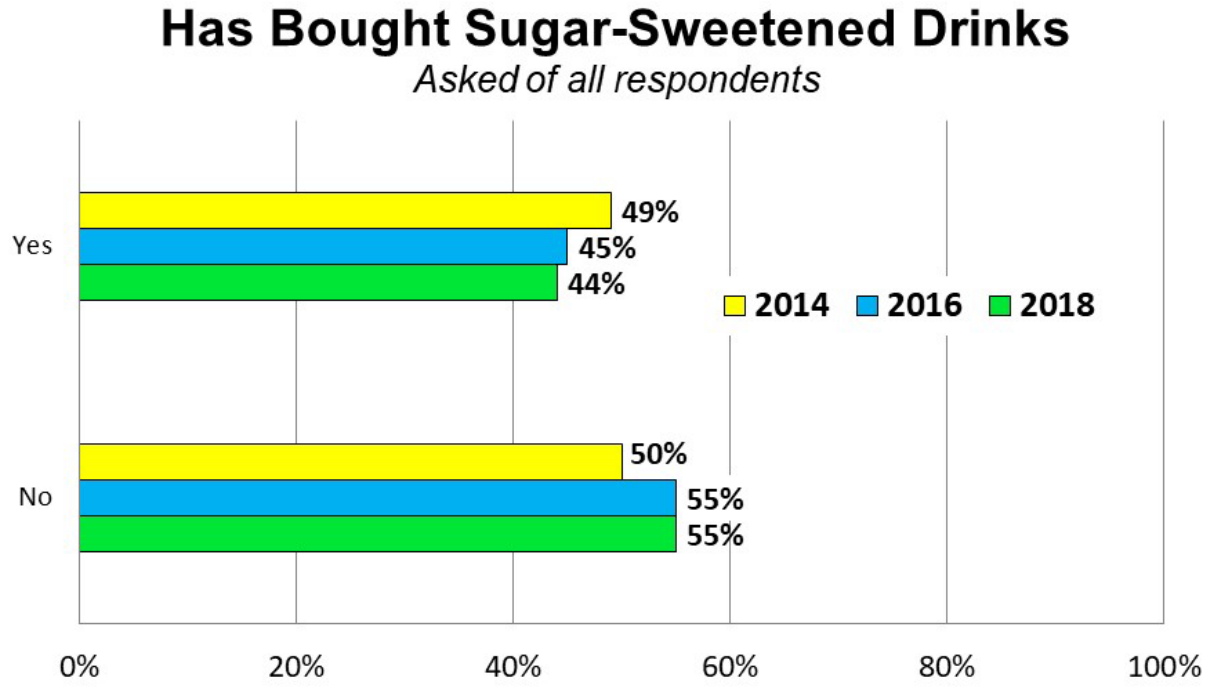


SD4. Thinking about your youngest child between the ages of 2 and 18, how often does he or she drink regular, not diet, soda like Coke Classic, Pepsi, Sprite, or Mountain Dew?

Residents who have not attended college are more likely to have children in their households who drink soda.

2018 Education Breakouts	All	<HS	HS/GED	Some College	4-Year degree	Grad Work
None/ Never/ Rarely	59%	17%	47%	57%	55%	67%
Children who consume soda	*37%*	*69%*	*45%*	*40%*	*40%*	*30%*
1-3 per month	8%	*%	9%	4%	9%	10%
1 per week	13%	28%	18%	16%	11%	11%
2-6 per week	12%	41%	14%	15%	14%	7%
Daily	4%	-	4%	6%	6%	3%
Not sure/Refused	4%	14%	8%	3%	5%	3%

Forty-four percent of residents had bought sugar sweetened beverages during the prior 30 days to drink at home, including regular soda, sports drinks like Gatorade or Powerade, fruit drinks like Capri Sun or Hawaiian Punch, energy drinks, or sweetened teas and waters. Purchasing of sugar-sweetened beverages to have at home has declined slightly from 45% in 2016, and 49% in 2014.



SD7. In the last 30 days, have you bought any of the following types of sugar sweetened beverages for your family to drink at home? Regular soda, sports drinks like Gatorade or Powerade, fruit drinks like Capri Sun or Hawaiian Punch, energy drinks, or sweetened teas and waters?

Those most likely to have purchased sugar sweetened drinks for their family are those younger than 55 or those who are African-Americans or Hispanic.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	44%	60%	46%	49%	52%	32%	24%	35%
No	55%	40%	54%	51%	48%	67%	74%	64%
Not sure/ Refused	*%	-	-	1%	*%	*%	1%	2%

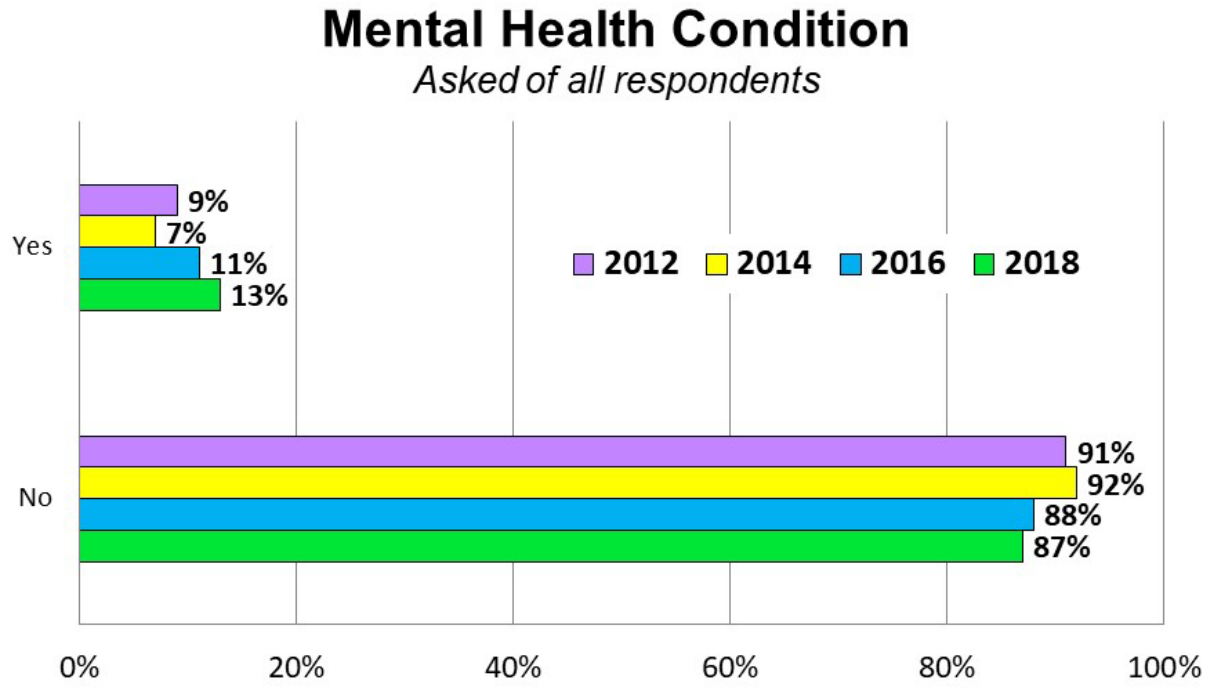
2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
Yes	44%	41%	56%	41%	60%	37%
No	55%	58%	43%	59%	39%	61%
Not sure/ Refused	*%	*%	*%	*%	1%	1%

Behavioral Health

The Behavioral Health section includes questions about residents' mental health condition, financial worry, access to mental health treatment, tobacco use, and alcohol use.

Mental Health

Thirteen percent of residents in 2018 said they are presently taking medicine or receiving treatment from a health professional for a mental health condition or emotional problem. This represents an increase from 11% reported in 2016, 7% in 2014, and 9% in 2012.



M26.9. Are you now taking medicine or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem?

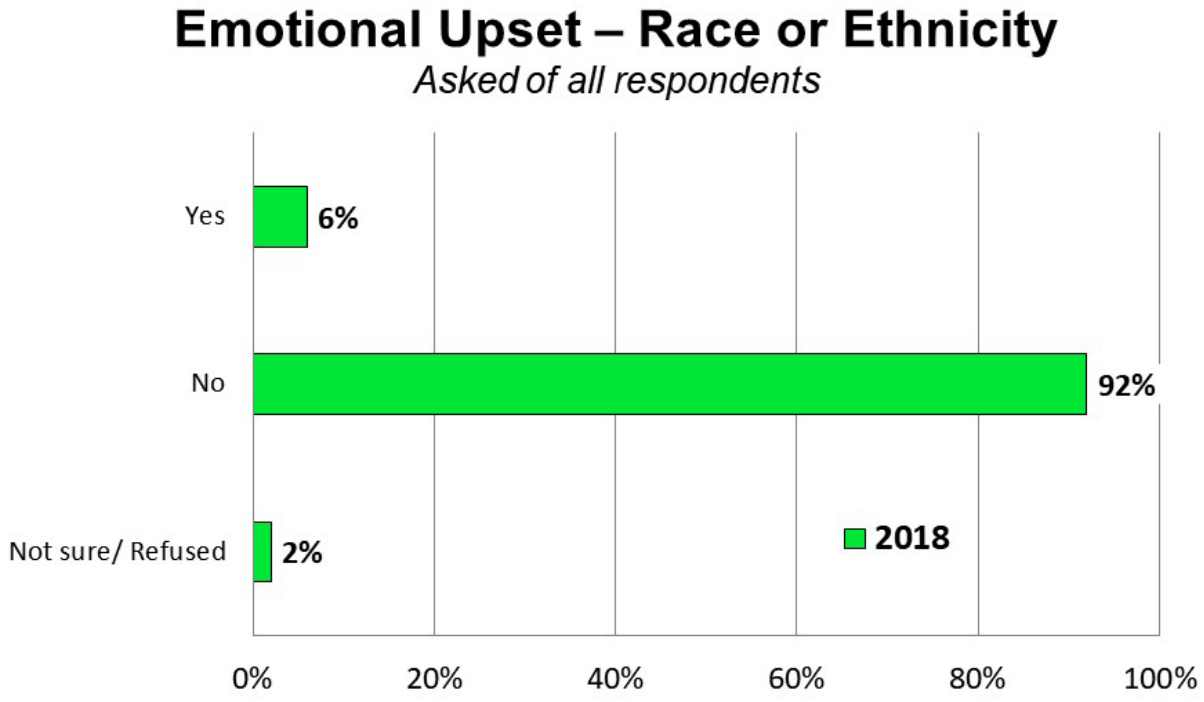
Residents are more likely to be taking medicine or receiving treatment for a mental health condition or emotional problem if they are female, earn less than $50,000, or are unemployed.

2018 Gender Breakouts	All	Male	Female
Yes	13%	7%	18%
No	87%	92%	82%
Not sure/ Refused	*%	1%	*%

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Yes	13%	20%	14%	14%	11%	11%
No	87%	80%	86%	86%	88%	89%
Not sure/ Refused	*%	*%	*%	*%	*%	*%

2018 Employment Status Breakouts	All	Employed	Self-Employed	Un-employed	Retired	Home-maker	Student
Yes	13%	11%	10%	32%	13%	13%	23%
No	87%	89%	90%	68%	85%	87%	77%
Not sure/ Refused	*%	*%	-	*%	2%	-	-

Six percent of residents said they had felt emotionally upset in the prior 30 days as a result of how they were treated based on their race or ethnicity. This question was not asked in prior years.



M28.0A. Within the past 30 days, have you felt emotionally upset, for example angry, sad, or frustrated, as a result of how you were treated based on your race or ethnicity?
(Not asked in 2012. 2014 and 2016)

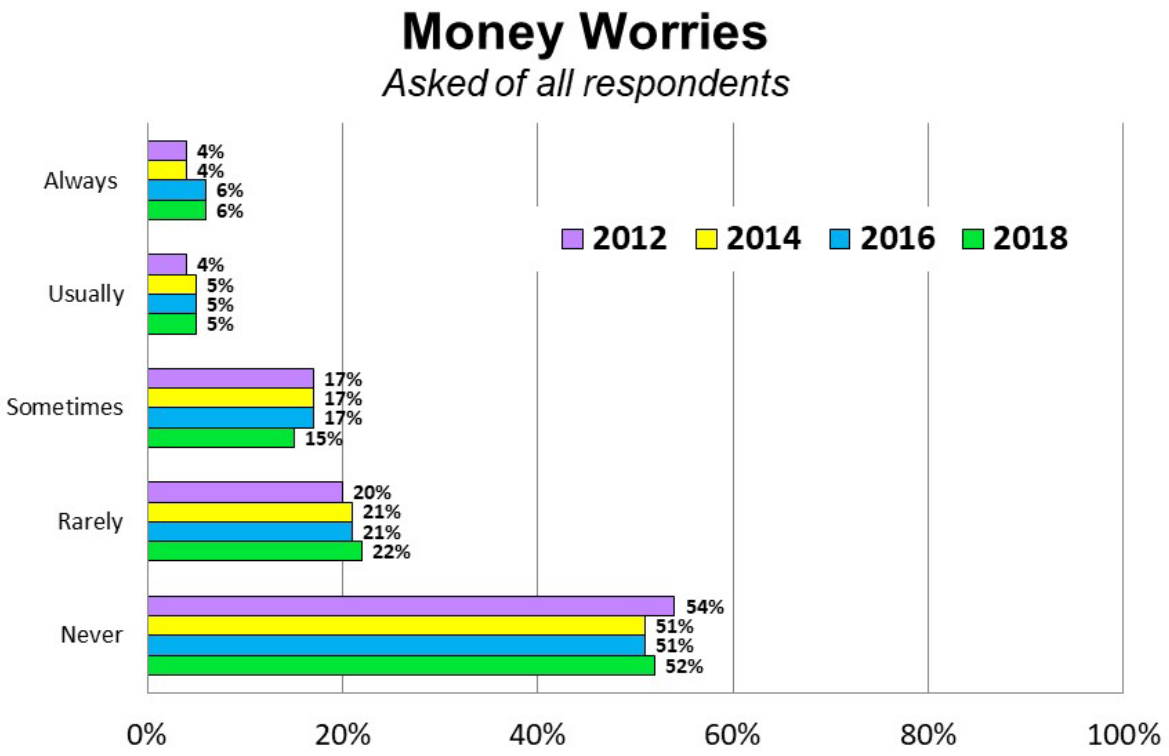
Those more likely to have felt emotionally upset due to treatment based on their race or ethnicity are African-American (15%) or members of smaller racial or ethnic groups (17%). Hispanic (9%) and Asian (8%) residents also are more likely to feel that way, although those differences do not rise to a statistically significant level. Residents with only a high school diploma are more likely to express this sentiment, as well.

2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
Yes	6%	3%	15%	8%	9%	17%
No	92%	97%	84%	89%	91%	83%
Not sure/ Refused	2%	*%	1%	4%	-	-

2018 Education Breakouts	All	Less than High School	High School or GED	Some College	4-Year Degree	Post-graduate
Yes	6%	3%	12%	7%	7%	5%
No	92%	97%	85%	93%	92%	95%
Not sure/Refused	2%	-	3%	*%	1%	*%

Twenty-six percent of Howard County residents said they were worried or stressed at least sometimes during the prior 12 months about having enough money to pay vital expenses like rent, mortgage, or food. This is down slightly from 28% in 2016 and on a par with the 26% in 2014 and 25% in 2012 who said they were worried or stressed about money.

In the current survey, 6% said they were "always" worried or stressed about money, which is identical to 2016, and up from 4% in 2014 and 2012. Another 5% said they were "usually" worried or stressed, and 15% said they worried "sometimes".



M28.1. How often in the past 12 months would you say you were worried or stressed about having enough money to pay vital expenses like your rent, mortgage, or food? Would you say you were worried or stressed---

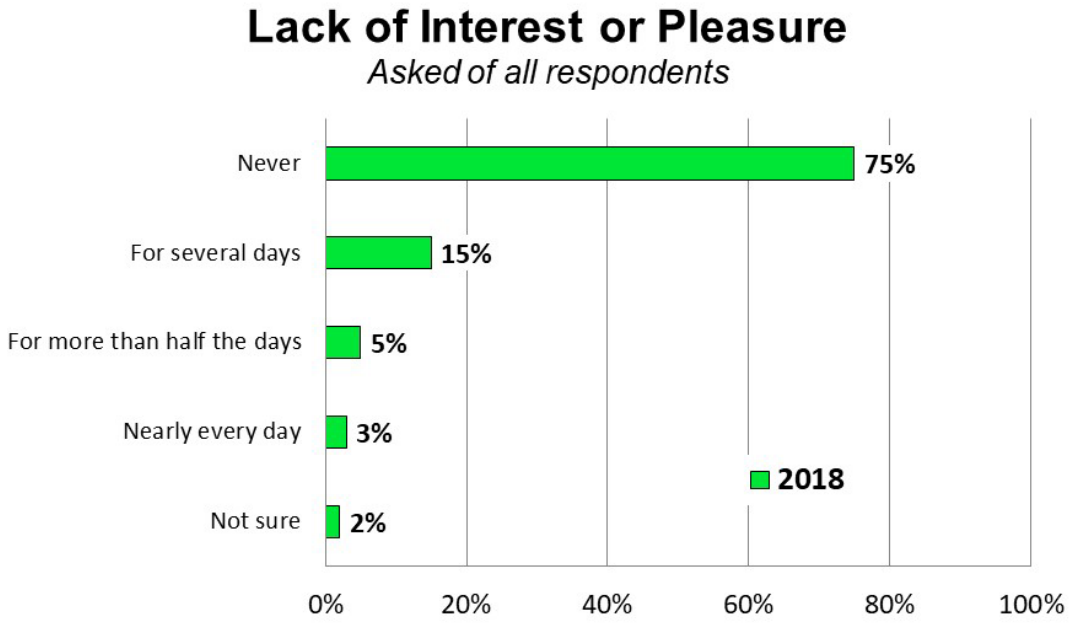
Money worries are more severe among residents who are under age 35, among African-Americans, Hispanics, or those who self-identify with a smaller racial or ethnic group, and households that earn less than $100,000.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Always	6%	7%	10%	7%	4%	4%	3%	2%
Usually	5%	8%	8%	4%	5%	3%	3%	1%
Sometimes	15%	18%	20%	14%	16%	13%	11%	9%
Rarely	22%	28%	22%	20%	23%	20%	18%	17%
Never	52%	39%	40%	54%	51%	61%	65%	71%
Not sure/ Refused	*%	-	-	*%	*%	*%	*%	1%

2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
Always	6%	4%	9%	4%	8%	4%
Usually	5%	4%	6%	2%	12%	19%
Sometimes	15%	16%	21%	9%	18%	24%
Rarely	22%	22%	23%	23%	15%	22%
Never	52%	53%	42%	61%	47%	31%
Not sure/ Refused	*%	*%	-	1%	-	-

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Always	6%	14%	10%	3%	1%	1%
Usually	5%	12%	5%	5%	2%	*%
Sometimes	15%	26%	20%	12%	14%	7%
Rarely	22%	14%	25%	26%	18%	22%
Never	52%	33%	39%	54%	64%	70%
Not sure/ Refused	*%	*%	*%	-	-	-

In 2018, Howard County residents were asked a new question about "having little interest or pleasure in doing things." Twenty-three percent said they were bothered by a lack of interest or pleasure in doing things for at least several days over the prior two weeks. Three percent said this occurred nearly every day. five percent said it happened "for more than half the days," and 15% said it happened "for several days" over those two weeks.



M28.1C. Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things? Would you say this happens...

Residents under age 25 are much more likely than others to be bothered by having little interest or pleasure in doing things. African-Americans are also more likely than others to say they are bothered by this. There is a strong relationship with household income, with residents of lower-income households much more likely than higher-income residents to feel this way.

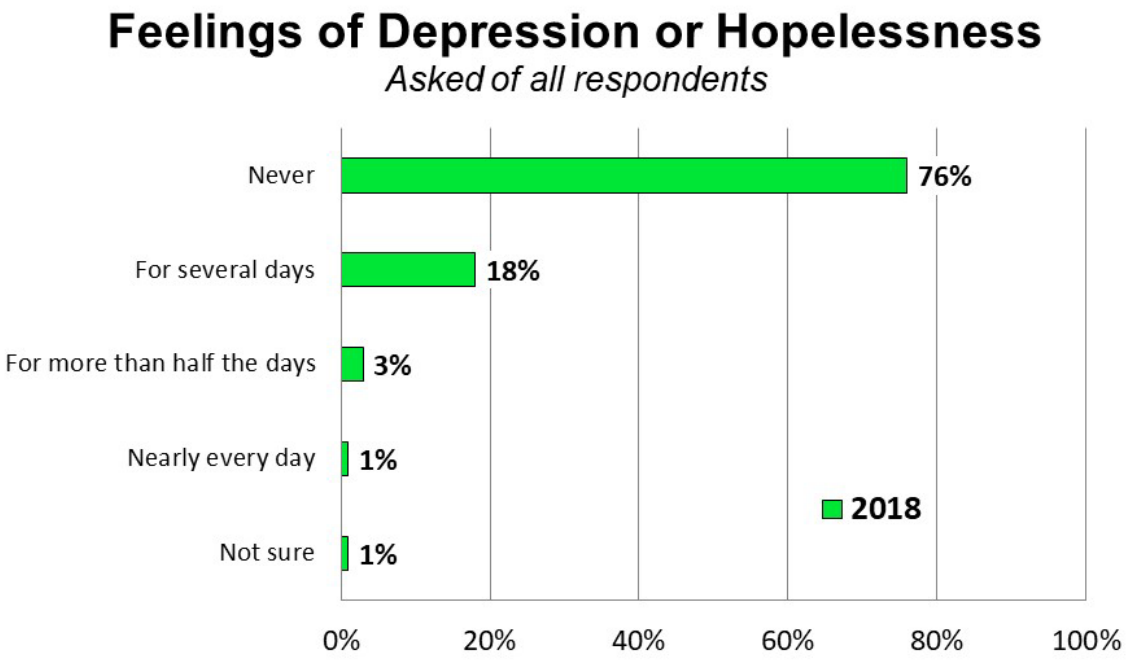
2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Never	75%	42%	70%	80%	83%	84%	82%	72%
Total bothered	*23%*	*58%*	*28%*	*19%*	*15%*	*16%*	*16%*	*18%*
For several days	15%	33%	20%	14%	12%	11%	8%	11%
More than half of days	5%	22%	5%	3%	*%	2%	3%	1%
Nearly every day	3%	2%	3%	2%	3%	4%	5%	6%
Don't know/ Refused	2%	-	2%	2%	1%	-	2%	10%

2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
Never	75%	79%	65%	72%	80%	73%
Total bothered	*23%*	*20%*	*32%*	*25%*	*20%*	*24%*
For several days	15%	12%	23%	20%	8%	14%
More than half of days	5%	4%	6%	5%	10%	5%
Nearly every day	3%	3%	3%	1%	2%	6%
Don't know/ Refused	2%	1%	2%	2%	-	3%

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Never	75%	58%	68%	74%	82%	93%
Total bothered	*23%*	*39%*	*31%*	*23%*	*17%*	*6%*
For several days	15%	24%	19%	20%	12%	5%
More than half of days	5%	10%	7%	2%	3%	*%
Nearly every day	3%	5%	5%	1%	1%	1%
Don't know/ Refused	2%	4%	1%	3%	1%	2%

In 2018, Howard County residents were asked if they had "been bothered by feeling down, depressed or hopeless" in the past two weeks. Twenty-three percent said they had felt this way for at least several days.

One percent of residents said they felt down, depressed or hopeless "nearly every day." Three percent felt that way "for more than half the days," while 18% felt that way "for several days" over the prior two weeks. Note that numbers may not always appear to add correctly due to rounding.



M28.1D. Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless? Would you say this happens...

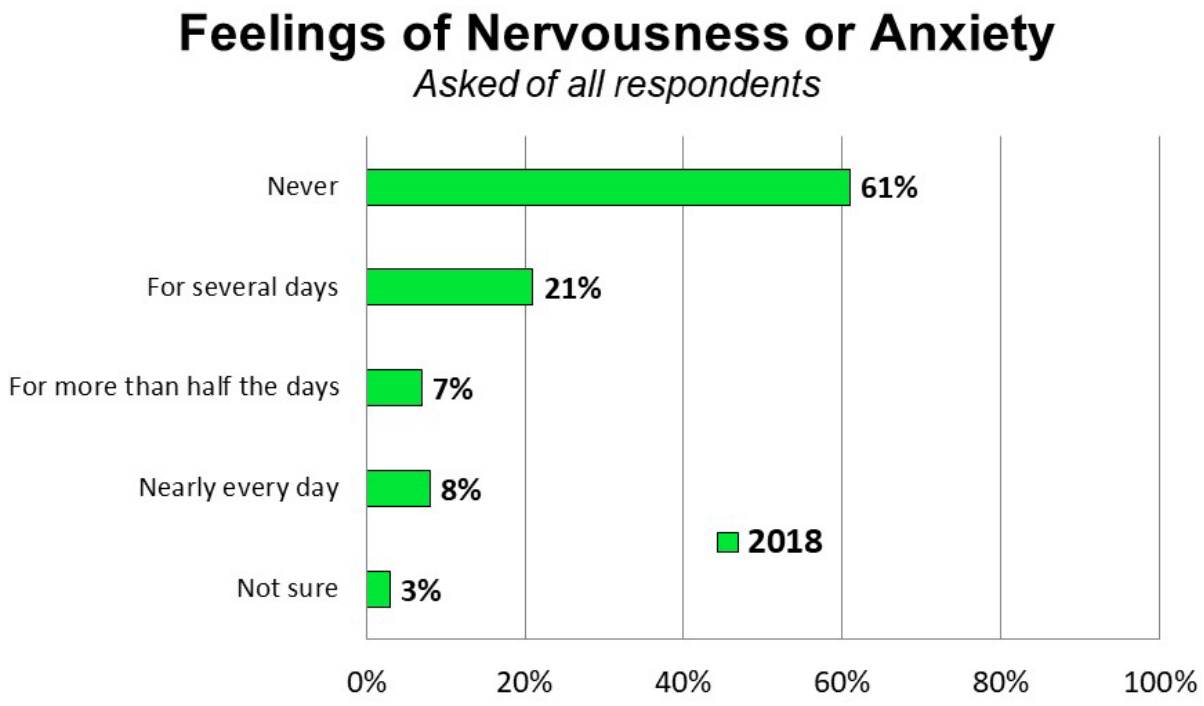
Residents under age 35 are most likely to feel depression or hopelessness at least some of the time, particularly those aged 18 to 24. Feelings of depression and hopelessness are also strongly related to household income, with those earning less than $100,000 more likely than higher-income residents to feel down, depressed or hopeless.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Never	76%	50%	71%	82%	82%	84%	81%	80%
Total bothered	*23%*	*50%*	*29%*	*18%*	*16%*	*16%*	*15%*	*16%*
For several days	18%	41%	27%	13%	12%	14%	11%	7%
More than half of days	3%	5%	2%	5%	3%	2%	2%	4%
Nearly every day	1%	4%	1%	1%	1%	1%	2%	4%
Not sure/ Refused	1%	-	-	*%	3%	-	4%	4%

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Never	76%	63%	69%	74%	86%	91%
Total bothered	*23%*	*35%*	*30%*	*25%*	*13%*	*9%*
For several days	18%	23%	25%	21%	12%	7%
More than half of days	3%	5%	5%	3%	2%	1%
Nearly every day	1%	6%	*%	1%	-	1%
Not sure/ Refused	1%	2%	1%	1%	1%	-

In 2018, Howard County residents were asked about feelings of nervousness and anxiety over the prior two weeks. Thirty-six percent of residents said they had "been bothered by feeling nervous, anxious or on edge" over the prior two weeks.

Eight percent of residents said they felt nervous, anxious or on edge "nearly every day." Seven percent felt that way "for more than half the days," while 21% felt that way "for several days" over the prior two weeks.



M28.1E. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious or on edge? Would you say this happens...

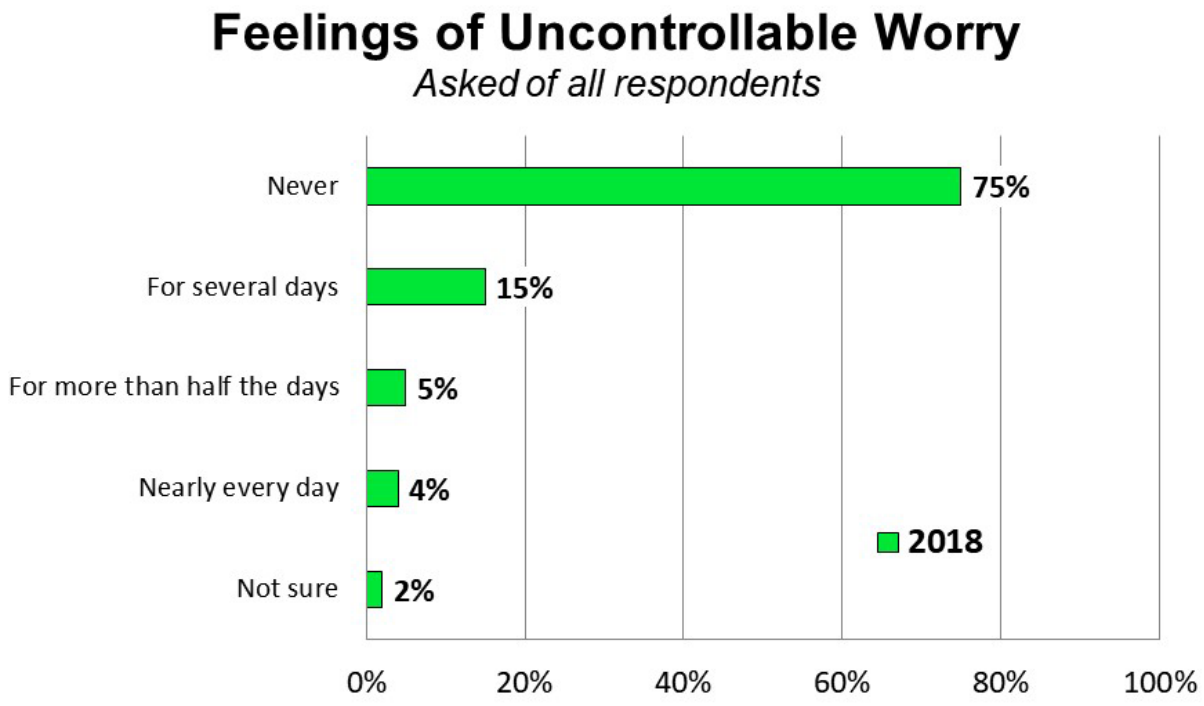
Those most likely to experience feelings of nervousness and anxiety at least some of the time were those less than age 35, particularly those aged 18 to 24. In this youngest age group, 20% said they had experienced such feelings *nearly every day*. There is also a relationship with one's level of education. Feelings of anxiety are particularly pronounced among people that have attended some college but not completed a degree, and are somewhat lower among people who have completed a four-year college degree and beyond.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Never	61%	40%	53%	62%	63%	72%	73%	72%
Total bothered	*36%*	*56%*	*46%*	*33%*	*33%*	*27%*	*21%*	*22%*
For several days	21%	28%	26%	25%	19%	16%	15%	8%
More than half of days	7%	9%	11%	6%	8%	6%	2%	1%
Nearly every day	8%	20%	9%	3%	7%	5%	4%	13%
Not sure/ Refused	3%	4%	1%	5%	3%	1%	5%	6%

2018 Education Breakouts	All	Less than High School	High School or GED	Some College	4-Year Degree	Post-graduate
Never	61%	73%	49%	51%	66%	66%
Total bothered	*36%*	*27%*	*41%*	*47%*	*33%*	*31%*
For several days	21%	6%	20%	22%	22%	22%
More than half of days	7%	*%	10%	10%	5%	6%
Nearly every day	8%	21%	10%	15%	7%	3%
Not sure/ Refused	3%	*%	10%	2%	1%	3%

Twenty-three percent of Howard County residents in 2018 said they have "been bothered by not being able to stop or control worrying" during the prior two weeks.

Four percent of residents said they experienced uncontrollable worry "nearly every day." Five percent felt that way "for more than half the days," while 15% felt that way "for several days" over the prior two weeks. Note that numbers may not always appear to add correctly due to rounding.



M28.1F. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying? Would you say this happens...

Women are twice as likely as men to be bothered by uncontrollable worrying. Six percent of women said they are bothered by this *nearly every day*. This phenomenon is also more bothersome in households earning less than $50,000 per year. Meanwhile, African-Americans are more likely that other residents to say they *never* experienced these feelings of uncontrollable worry.

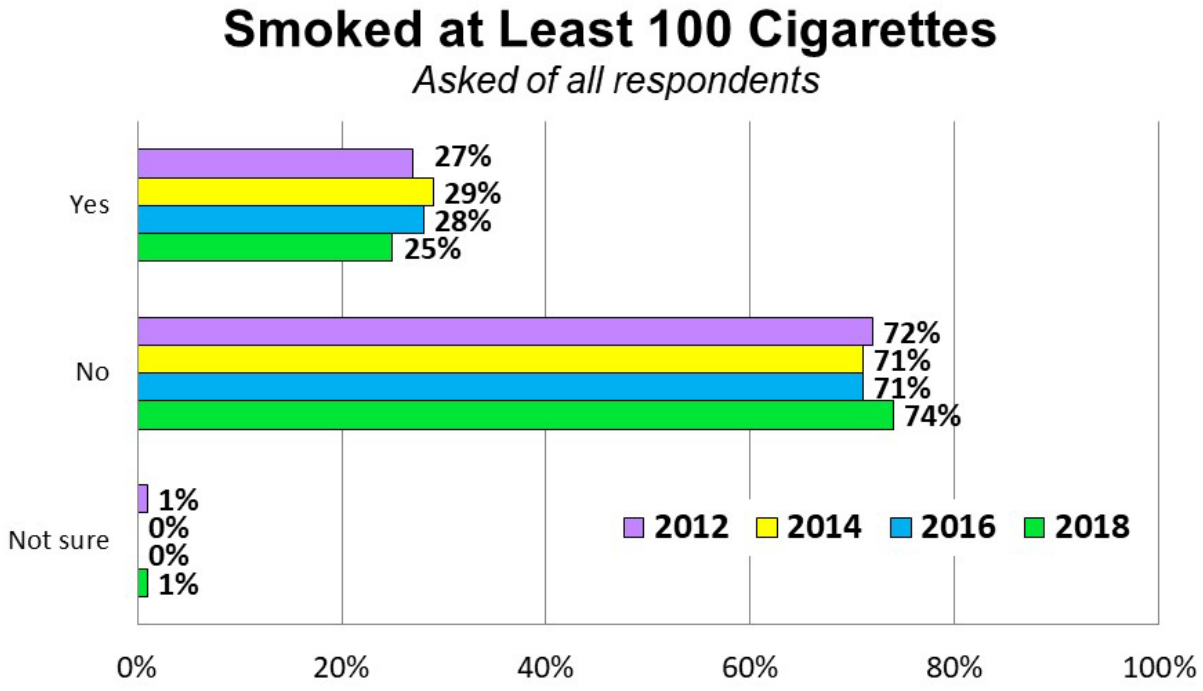
2018 Gender Breakouts	All	Male	Female
Never	75%	83%	68%
Total bothered	*23%*	*15%*	*30%*
For several days	15%	11%	18%
More than half of days	5%	3%	6%
Nearly every day	4%	1%	6%
Not sure/ Refused	2%	2%	3%

2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
Never	75%	73%	81%	69%	79%	63%
Total bothered	*23%*	*24%*	*18%*	*27%*	*21%*	*37%*
For several days	15%	17%	11%	14%	13%	22%
More than half of days	5%	4%	3%	8%	6%	5%
Nearly every day	4%	4%	4%	5%	2%	10%
Not sure/ Refused	2%	3%	1%	4%	-	-

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Never	75%	66%	77%	75%	76%	79%
Total bothered	*23%*	*33%*	*21%*	*24%*	*21%*	*19%*
For several days	15%	17%	10%	16%	18%	15%
More than half of days	5%	7%	6%	5%	2%	1%
Nearly every day	4%	9%	5%	3%	1%	3%
Not sure/ Refused	2%	2%	2%	*%	3%	1%

Tobacco

Twenty-five percent of residents said they have smoked at least 100 cigarettes in their life, a common measure of smoking behavior. This is the lowest percentage recorded in this series of surveys, down from 28% in 2016, 29% in 2014, and 27% in 2012.



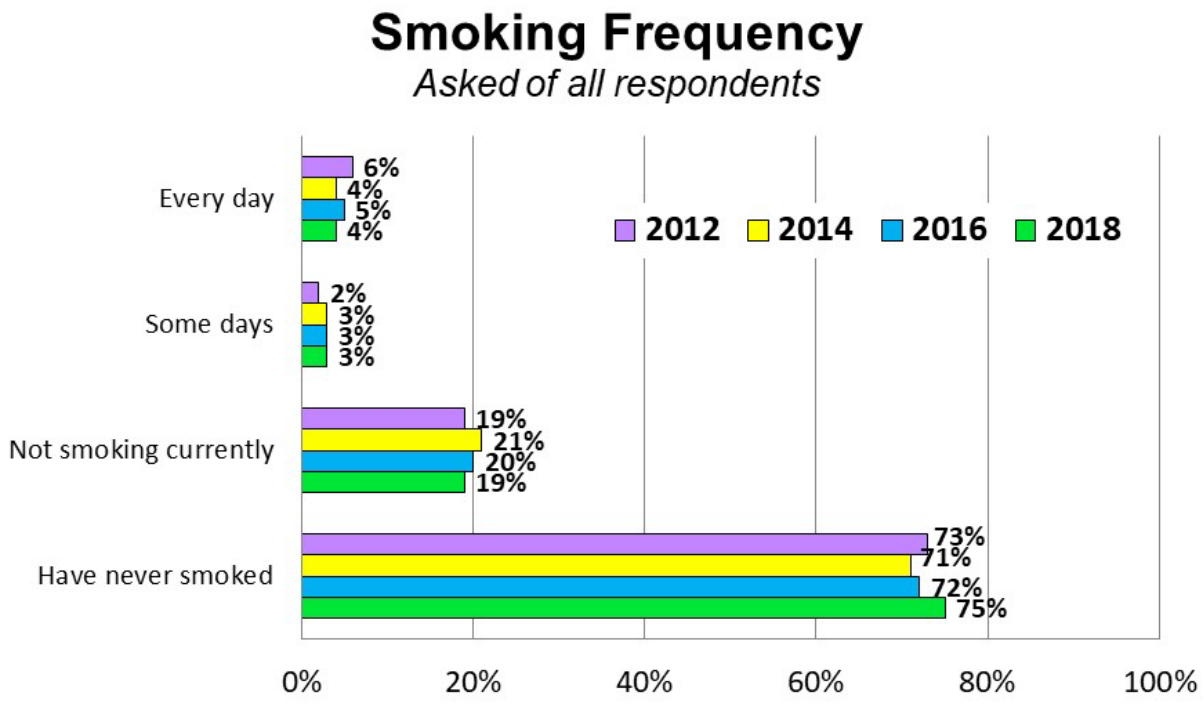
Q7.1. Have you smoked at least 100 cigarettes in your entire life?

Residents are more likely to have smoked at least 100 cigarettes in their life if they are over age 55, or are unemployed or retired.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	25%	17%	21%	25%	21%	31%	40%	42%
No	74%	81%	78%	74%	78%	69%	59%	58%
Not sure/ Refused	1%	2%	2%	*%	*%	*%	1%	*%

2018 Employment Status Breakouts	All	Employed	Self-Employed	Un-employed	Retired	Home-maker	Student
Yes	25%	22%	25%	40%	40%	23%	12%
No	74%	77%	75%	60%	59%	77%	86%
Not sure/ Refused	1%	1%	*%	-	1%	1%	2%

Four percent of Howard County residents currently smoke every day. Another 3% said they smoke "some days." The remainder of people who have smoked at least 100 cigarettes in their life said they are not smoking currently; this amounts to 19% of the County's residents. This aggregate smoking rate of 7% is slightly less than amount measured in 2016 (8%) and 2012 (8%), and on a par with that measured in 2014 (7%).



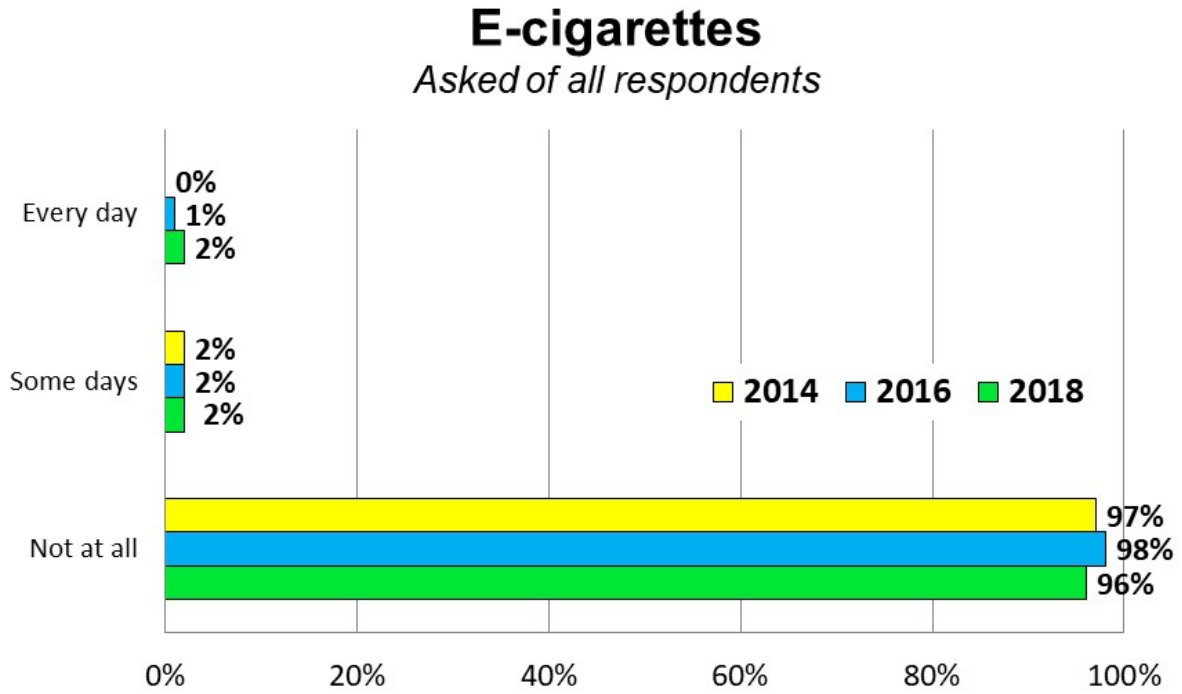
Q7.2. Do you now smoke cigarettes every day, some days, or not at all?

Older residents are more likely to have tried smoking and quit. Though the differences are not statistically significant, the current smoking rate appears higher the younger one is. In terms of employment status, unemployed residents are much more likely than others to smoke currently.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Every day	4%	3%	7%	4%	4%	5%	3%	1%
Some days	3%	7%	2%	3%	2%	1%	2%	1%
Total smoking	*7%*	*10%*	*9%*	*7%*	*6%*	*6%*	*5%*	*3%*
Not at all	19%	8%	11%	18%	15%	25%	35%	39%
Have not ever smoked/Not sure	75%	83%	79%	75%	79%	69%	60%	58%

2018 Employment Status Breakouts	All	Employed	Self-Employed	Un-employed	Retired	Home-maker	Student
Every day	4%	5%	5%	5%	2%	3%	4%
Some days	3%	2%	2%	11%	1%	4%	2%
Total smoking	*7%*	*7%*	*6%*	*16%*	*3%*	*7%*	*6%*
Not at all	19%	15%	18%	24%	37%	16%	6%
Have not ever smoked/Not sure	75%	78%	75%	60%	60%	77%	88%

Use of e-cigarettes either every day or some days amounts to 4% of the County's population in 2018. This is an increase from the 3% measured in 2016 and the 2% measured in 2014.



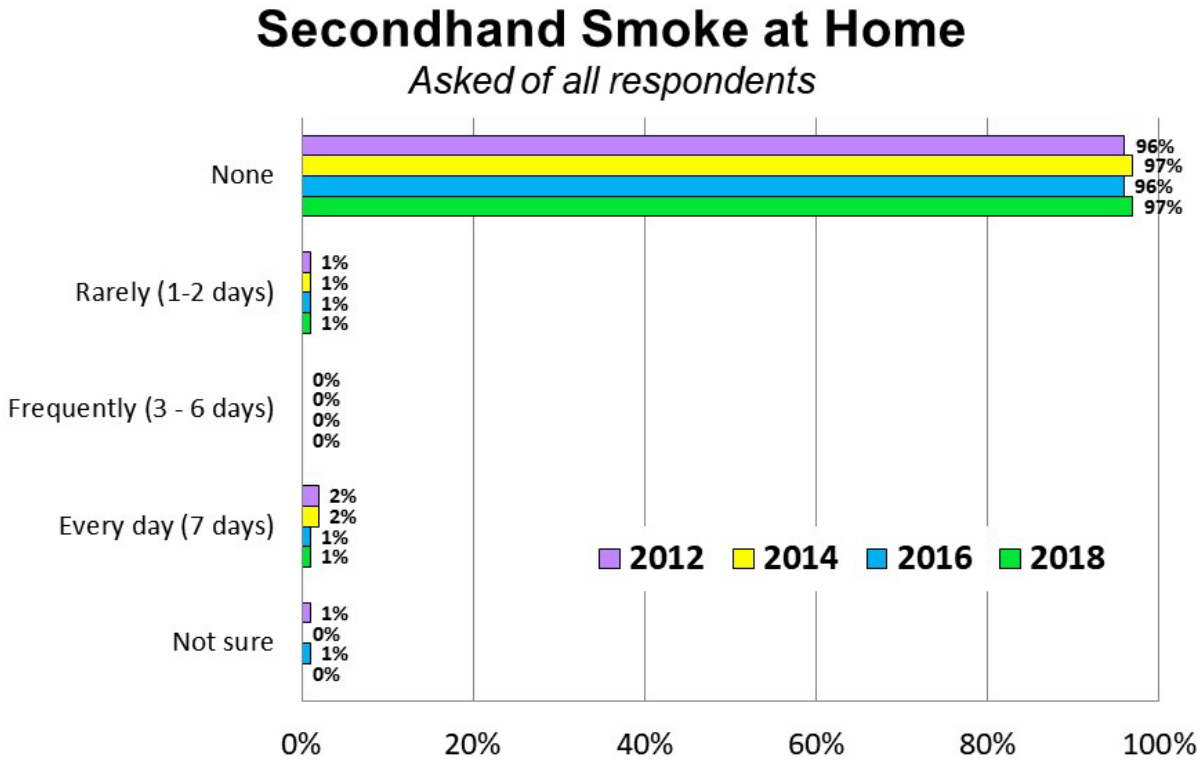
Q7.5A. Electronic cigarettes, or "e-cigarettes" and other electronic "vaping" products include electronic hookahs, or "e-hookahs," vape pens, e-cigars, and others. These products are battery powered and usually contain nicotine and flavors such as fruit, mint, or candy. Do you currently use e-cigarettes every day, some days, or not at all?
2016 wording: E-cigarettes are battery powered devices that provide inhaled doses of nicotine. Do you currently use e-cigarettes every day, some days, or not at all?

E-cigarette use is much higher among residents under age 35, and is more pronounced among those who have not completed high school or who have attended only some college.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Every day	2%	3%	5%	1%	1%	1%	-	-
Some days	2%	8%	5%	1%	1%	1%	1%	-
Total e-cigarette use	*4%*	*11%*	*9%*	*2%*	*2%*	*1%*	*1%*	**%*
Not at all	96%	89%	91%	97%	98%	99%	99%	99%
Not sure/ Refused	*%	-	-	*%	-	-	*%	1%

2018 Education Breakouts	All	Less than High School	High School or GED	Some College	4-Year Degree	Post-graduate
Every day	2%	-	1%	3%	3%	1%
Some days	2%	11%	1%	7%	1%	1%
Total e-cigarette use	*4%*	*11%*	*2%*	*10%*	*4%*	*1%*
Not at all	96%	89%	98%	90%	96%	99%
Not sure/ Refused	*%	-	-	*%	*%	*%

Ninety-seven percent of residents said that no one else had smoked inside their home while they were at home during the previous seven days. One percent said someone else smoked inside the home every day, and 1% said someone smoked in the house just one or two days during the previous week. Those numbers are virtually unchanged since first measured in 2012.

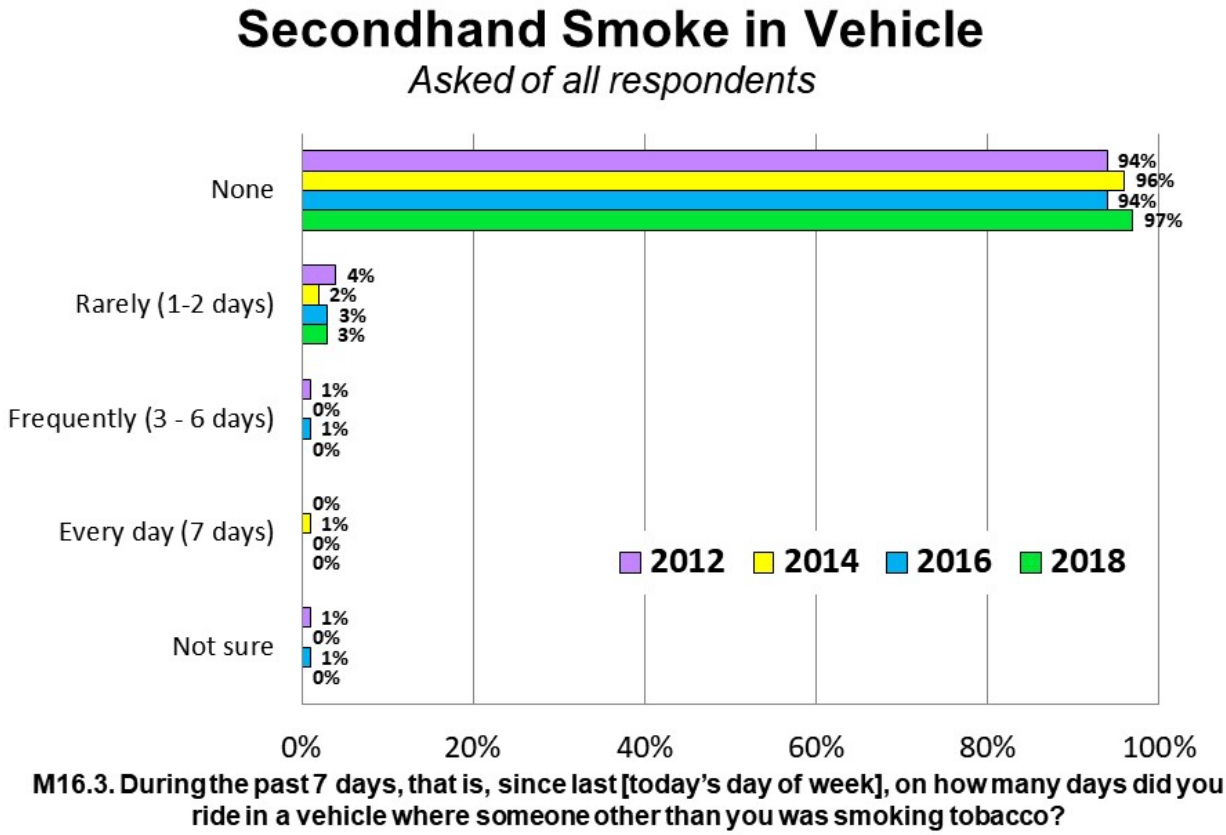


M16.2. Not counting decks, porches, or garages, during the past 7 days, that is, since last [today's day of week], on how many days did someone other than you smoke tobacco inside your home while you were at home?

The incidence of second-hand smoke at home is so low that there is little of statistical significance to note. Among residents over age 65, where smoking by others inside the home does occur, it is happening more frequently.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
None	97%	92%	97%	98%	98%	98%	96%	97%
Rarely (1-2 days)	1%	6%	2%	1%	1%	1%	*%	-
Frequently (3-6 days)	*%	-	*%	-	1%	-	*%	-
Every day (7 days)	1%	3%	*%	*%	*%	1%	2%	2%
Not sure	*%	-	-	-	1%	*%	-	1%
Mean	3.34	2.98	2.44	2.33	2.91	4.72	5.77	7.00

Ninety-seven percent of residents said that they did not ride in a vehicle during the previous week in which someone else was smoking. Three percent said they had ridden with someone who was smoking in the prior week. These numbers represent a slight improvement over prior years.



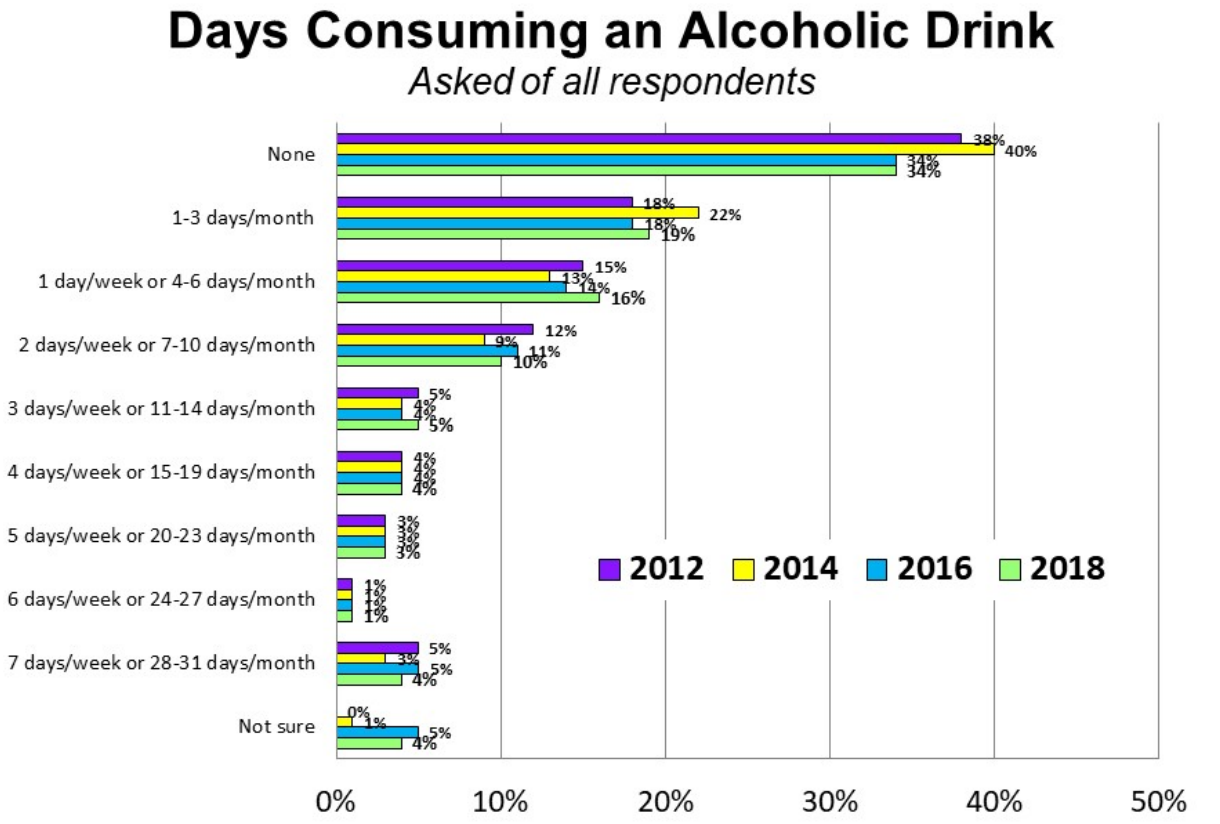
M16.3. During the past 7 days, that is, since last [today's day of week], on how many days did you ride in a vehicle where someone other than you was smoking tobacco?

Due to the low incidence of secondhand smoke in vehicles, there is nothing of significance to note in the subgroup data.

Alcohol Consumption

Thirty-four percent of residents in the 2018 survey said they consumed no alcoholic drinks in the previous 30 days, the same number as reported in 2016. This is a decline from the 40% in 2014 and 38% in 2012 who consumed no alcohol.

Four percent in 2018 said they have an alcoholic drink at least daily, compared to 5% in 2016, 3% in 2014 and 5% in 2012.



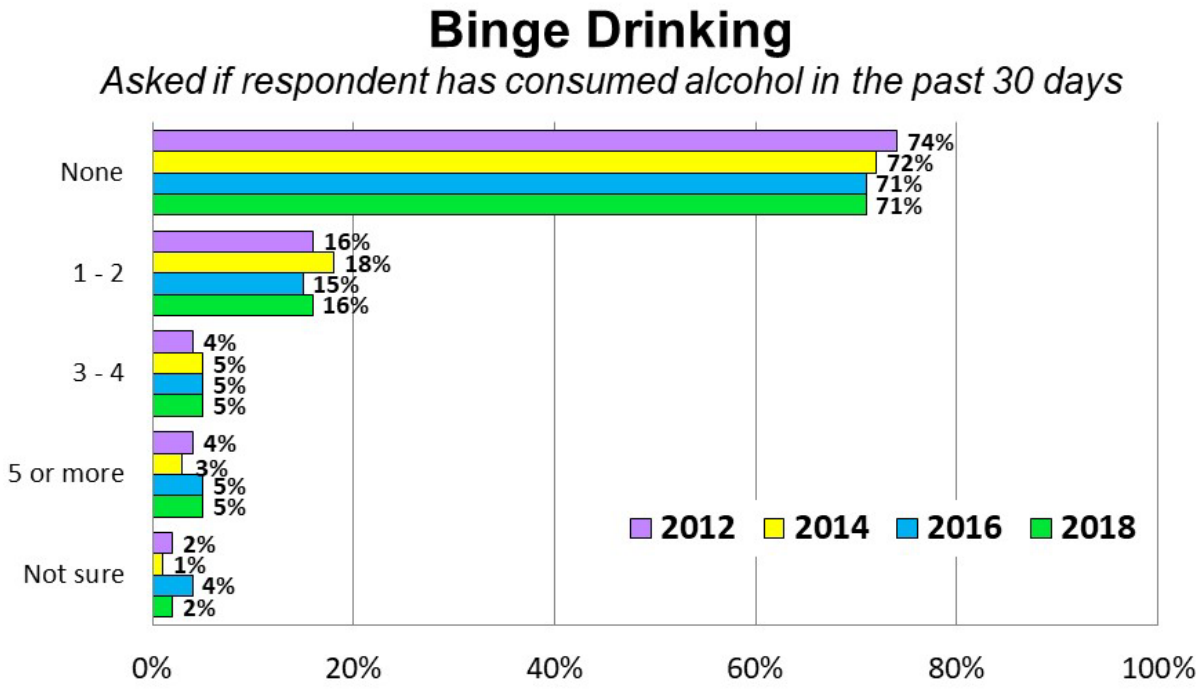
Q15.1. During the past 30 days, how many days per week or per month did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor?

There is evidence that alcohol consumption is somewhat more frequent in older residents, particularly those over the age of 55. Alcohol consumption also seems to be more common and somewhat more frequent among high-income residents.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
None	34%	44%	33%	29%	31%	32%	36%	48%
1-3 days/month	19%	24%	17%	20%	19%	17%	15%	13%
1 day/week or 4-6 days/month	16%	13%	17%	18%	19%	15%	17%	10%
2 days/week or 7-10 days/month	10%	6%	15%	12%	11%	9%	8%	4%
3 days/week or 11-14 days/month	5%	4%	4%	6%	6%	7%	4%	3%
4 days/week or 15-19 days/month	4%	2%	3%	6%	3%	6%	2%	2%
5 days/week or 20-23 days/month	3%	*%	4%	4%	3%	2%	4%	3%
6 days/week or 24-27 days/month	1%	*%	*%	1%	1%	2%	3%	3%
7 days/week or 28-31 days/month	4%	1%	3%	2%	4%	7%	7%	10%
Not sure/ Refused	4%	5%	4%	2%	4%	3%	4%	4%

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
None	34%	48%	35%	34%	25%	23%
1-3 days/month	19%	19%	17%	19%	18%	20%
1 day/week or 4-6 days/month	16%	12%	17%	17%	16%	19%
2 days/week or 7-10 days/month	10%	4%	9%	12%	12%	13%
3 days/week or 11-14 days/month	5%	3%	4%	4%	7%	10%
4 days/week or 15-19 days/month	4%	2%	3%	4%	8%	5%
5 days/week or 20-23 days/month	3%	4%	2%	3%	3%	4%
6 days/week or 24-27 days/month	1%	1%	1%	2%	3%	1%
7 days/week or 28-31 days/month	4%	4%	5%	4%	5%	4%
Not sure/ Refused	4%	4%	5%	2%	5%	1%

Of those who had had at least one alcoholic drink in the prior 30 days, 26% had engaged in at least one episode of binge drinking in the past 30 days, defined as at least five drinks on a single occasion for men, and four drinks for women. This number has climbed slightly since the initial survey in 2012. In 2018, 5% of the residents who had an alcoholic drink engaged in binge drinking at least five times during the prior month, and another 5% said they did so three or four times during the month.



Q15.3. Considering all types of alcoholic beverages, how many times during the past 30 days did you have X [CATI X = 5 for men, X = 4 for women] or more drinks on an occasion?

Binge drinking is more prevalent among residents under age 35, and those with only a high school diploma or less education.

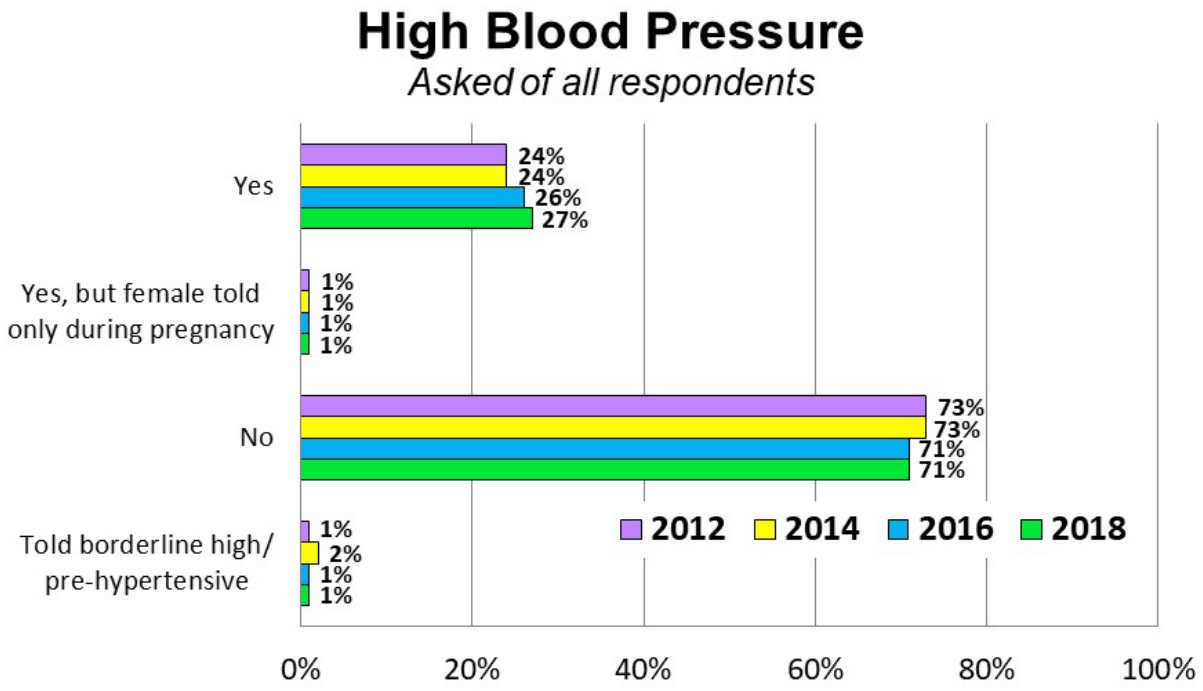
2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
None	71%	66%	52%	74%	73%	82%	82%	88%
Total binge drinking	*26%*	*34%*	*42%*	*25%*	*24%*	*18%*	*14%*	*9%*
1-2	16%	21%	29%	17%	13%	9%	9%	5%
3-4	5%	9%	6%	3%	4%	3%	3%	3%
5 or more	5%	3%	7%	6%	6%	5%	3%	1%
Not sure/ Refused	2%	-	5%	1%	4%	*%	4%	3%

2018 Education Breakouts	All	Less than High School	High School or GED	Some College	4-Year Degree	Post-graduate
None	71%	26%	57%	69%	70%	78%
Total binge drinking	*26%*	*74%*	*40%*	*29%*	*27%*	*20%*
1-2	16%	32%	22%	21%	18%	11%
3-4	5%	38%	8%	4%	4%	3%
5 or more	5%	3%	10%	4%	4%	6%
Not sure/ Refused	2%	-	2%	1%	3%	3%

Chronic Disease

The Chronic Disease section includes questions on high blood pressure, cholesterol, asthma, COPD, diabetes, health problems requiring special equipment, and in-home care.

Twenty-seven percent of Howard County residents have been told by a health professional that they have high blood pressure, a small but steady increase from the 24% measured in 2012. An additional 1% are women who were told only during pregnancy that they had high blood pressure, and 1% are residents who were told they were borderline high or pre-hypertensive.



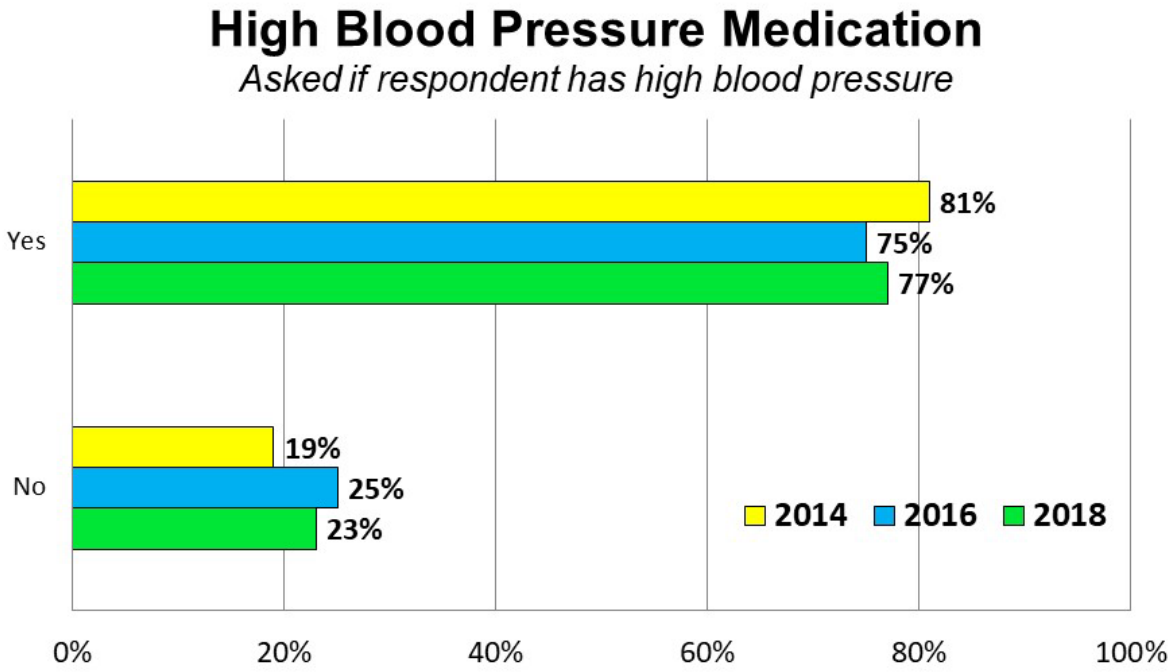
Q4.1. Have you EVER been told by a doctor, nurse, or other health professional that you have high blood pressure?

Residents are more likely to have been told by a medical professional that they have high blood pressure if they are over age 55 or if they are retired.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	27%	8%	10%	16%	28%	40%	61%	65%
Yes, but female told only during pregnancy	1%	-	1%	1%	1%	*%	1%	-
No	71%	89%	88%	83%	71%	58%	36%	33%
Told borderline high or hypertensive	1%	3%	1%	1%	*%	1%	1%	2%
Not sure / Refused	*%	-	-	-	-	-	*%	*%

2018 Employment Status Breakouts	All	Employed	Self-Employed	Un-employed	Retired	Home-maker	Student
Yes	27%	21%	30%	31%	59%	18%	2%
Yes, but female told only during pregnancy	1%	1%	*%	-	1%	-	-
No	71%	76%	70%	69%	38%	82%	96%
Told borderline high or hypertensive	1%	1%	-	-	2%	-	2%
Not sure/ Refused	*%	*%	-	-	*%	*%	-

Of those who have been told they have high blood pressure, 77% are currently taking medication to help control it, which is in the middle of the range measured since 2014. This question was not asked in 2012.



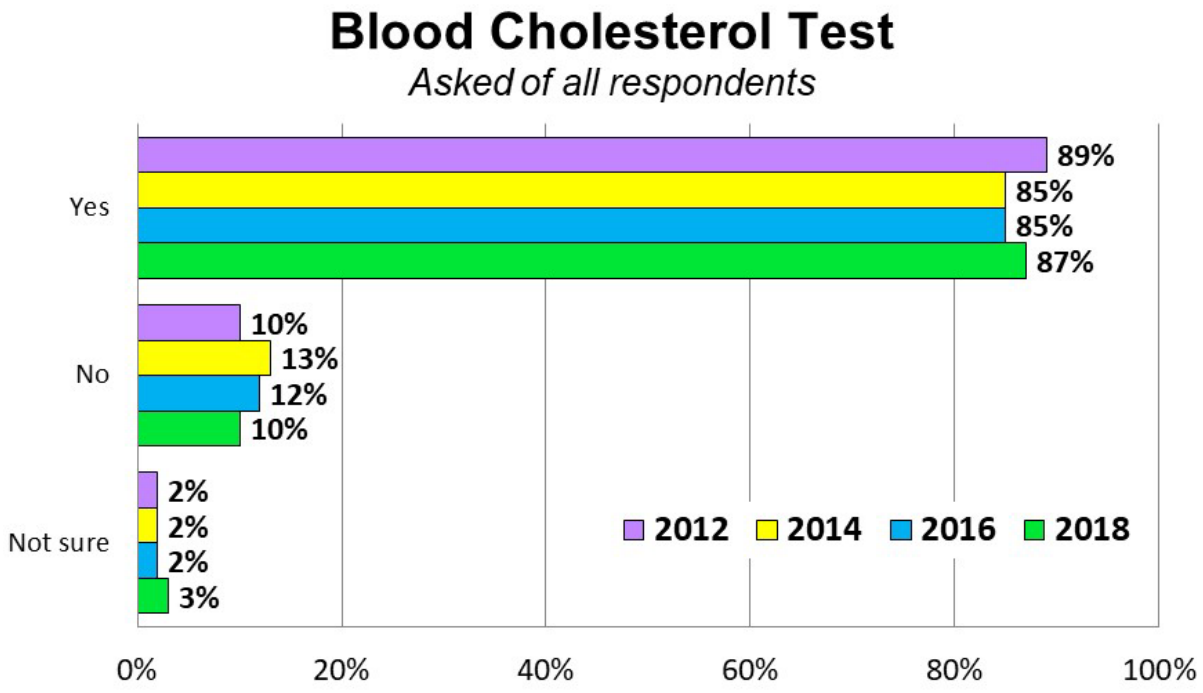
Q4.1A. Are you currently taking medication to help with your high blood pressure?
(Question not asked in 2012)

Residents who have been told they have high blood pressure are more likely to take medication the older they are, or if they are married or widowed.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	77%	16%	47%	56%	76%	82%	92%	93%
No	23%	84%	53%	44%	24%	18%	7%	7%
Not sure/Refused	*%	-	-	-	-	-	*%	-

2018 Marital Status Breakouts	All	Married	Divorced	Widowed	Never Married	Unmarried Couple
Yes	77%	80%	81%	96%	46%	70%
No	23%	20%	19%	4%	54%	30%
Not sure/Refused	*%	*%	-	-	-	-

Eighty-seven percent can remember having their blood cholesterol checked, a number that is slightly higher than the 85% measured in 2016 and 2014 but lower than the 89% measured in 2012. Ten percent said that their cholesterol has not been checked, while 3% were not sure.



Q5.1. Blood cholesterol is a fatty substance found in the blood. Have you ever had your blood cholesterol checked?

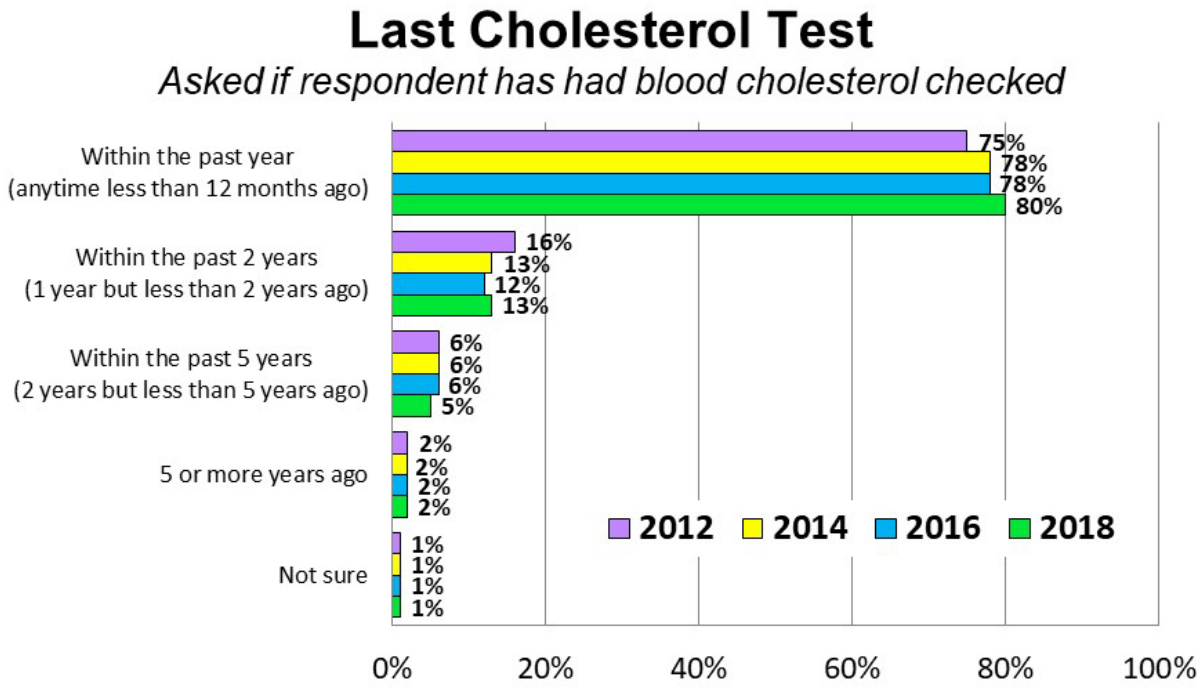
Residents are less likely to have their blood cholesterol checked if they are under age 35, or have household income under $100,000, or if they are normal weight or underweight.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	87%	60%	75%	90%	95%	97%	97%	92%
No	10%	34%	20%	6%	4%	2%	2%	4%
Not sure/Refused	3%	6%	5%	3%	2%	1%	1%	4%

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Yes	87%	80%	84%	85%	93%	94%
No	10%	17%	14%	11%	4%	4%
Not sure/Refused	3%	4%	2%	4%	3%	2%

2018 BMI Breakouts	All	Underweight (<18.5)	Normal (18.5 – 24.9)	Overweight (25.0 – 29.9)	Obese (30.0+)
Yes	87%	68%	81%	87%	92%
No	10%	23%	14%	11%	6%
Not sure/ Refused	3%	9%	5%	2%	3%

For those who could remember a cholesterol test, 80% said the test was within the past year, a number that is slightly higher than previous years. Thirteen percent said the test was between one and two years ago, 5% said it was between two and five years ago, and 2% said it was five or more years in the past.



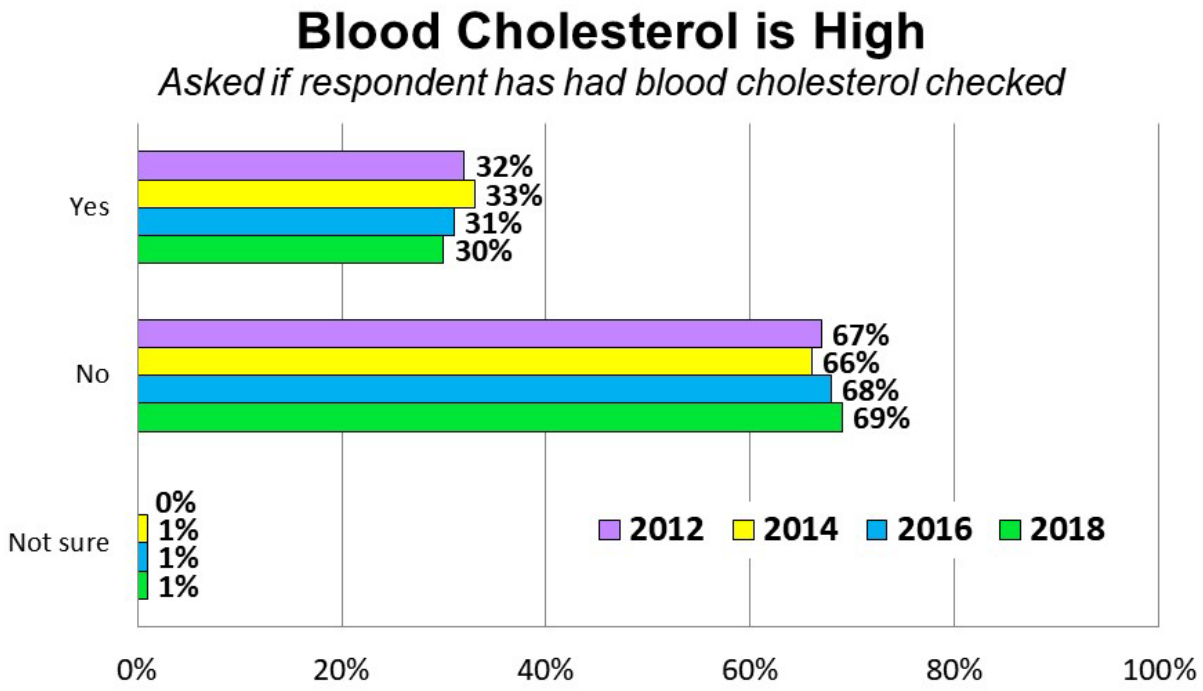
Q5.2. About how long has it been since you last had your blood cholesterol checked?

Residents age 55 or above, and those who have less than a high school education, are more likely than others to have had a blood cholesterol test in the past year.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Within the past year	80%	76%	74%	73%	77%	86%	89%	93%
1 year but less than 2 years ago	13%	19%	14%	15%	15%	8%	7%	5%
2 years but less than 5 years ago	5%	1%	8%	9%	5%	3%	2%	1%
5 or more years ago	2%	2%	3%	2%	2%	2%	1%	1%
Not sure/ Refused	1%	1%	1%	1%	1%	*%	1%	*%

2018 Education Breakouts	All	Less than High School	High School or GED	Some College	4-Year Degree	Post-graduate
Within the past year	80%	95%	81%	81%	78%	79%
1 year but less than 2 years ago	13%	5%	11%	12%	13%	13%
2 years but less than 5 years ago	5%	-	3%	3%	6%	6%
5 or more years ago	2%	-	4%	2%	2%	2%
Not sure/ Refused	1%	-	1%	1%	1%	*%

Thirty percent of those who could remember having a cholesterol test said they were told their blood cholesterol was high. This represents a slight decrease from prior years.



Q5.3. Have you ever been told by a doctor, nurse or other health professional that your blood cholesterol is high?

Residents are more likely to have been told their blood cholesterol is high if they are male, over age 55, or have no children in their household.

2018 Gender Breakouts	All	Male	Female
Yes	30%	36%	26%
No	69%	63%	73%
Not sure/ Refused	1%	1%	1%

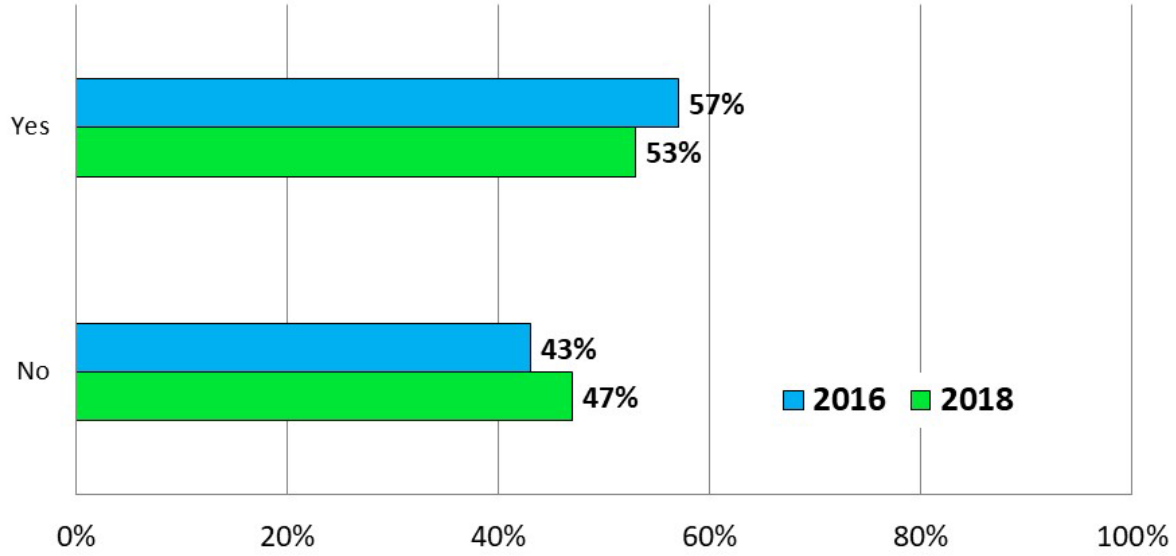
2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	30%	19%	12%	24%	29%	44%	52%	53%
No	69%	79%	87%	75%	71%	55%	45%	46%
Not sure/Refused	1%	2%	1%	1%	*%	*%	2%	1%

2018 Parent Breakouts	All	Has Children	No Children
Yes	30%	23%	37%
No	69%	76%	61%
Not sure/ Refused	1%	1%	1%

Fifty-three percent of those who have been told in the past that their blood cholesterol is high are now taking medication to help with their cholesterol. This represents a 4% decrease from 2016.

Taking Cholesterol Medicine

Asked if respondent is told that their blood cholesterol level is high



Q5.4. Are you now taking medicine to help with your cholesterol?
(Question not asked in 2012, 2014)

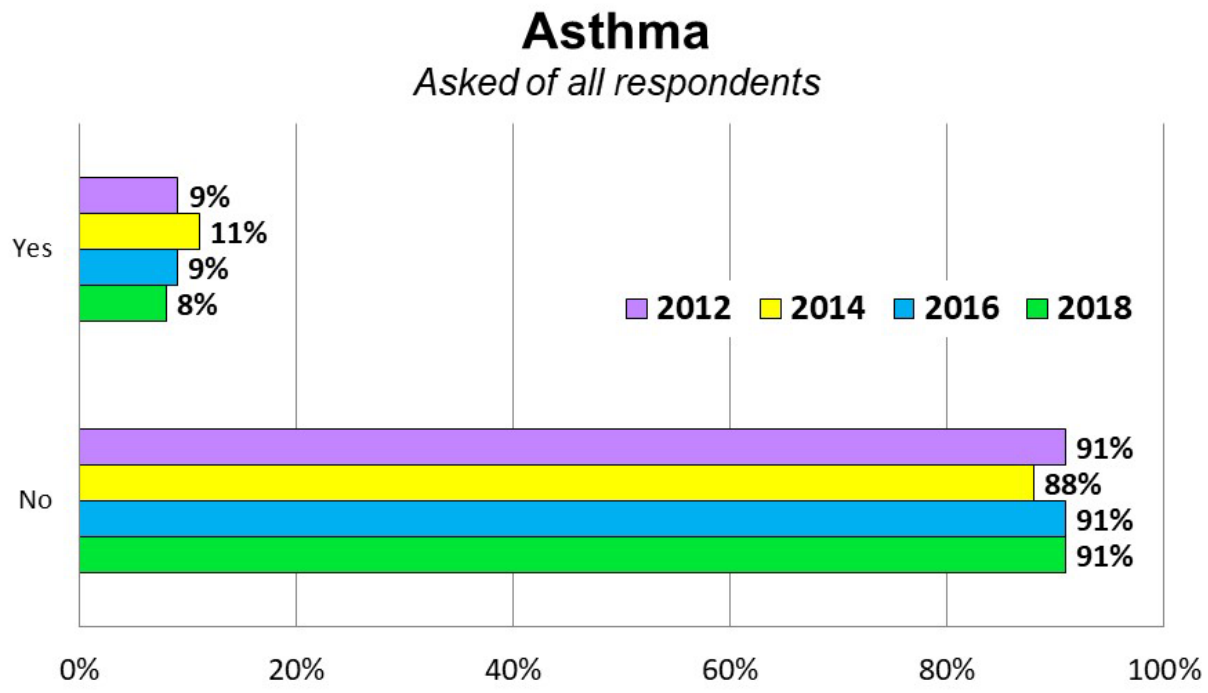
Those less likely to be taking cholesterol medication are under age 45, identify as Hispanic or Asian, or have children in their household.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	53%	11%	18%	27%	45%	66%	75%	83%
No	47%	89%	82%	73%	55%	34%	25%	15%
Not sure/Refused	*%	-	-	-	-	-	-	1%

2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
Yes	53%	56%	57%	40%	33%	66%
No	47%	44%	43%	60%	67%	34%
Not sure/Refused	*%	*%	-	-	-	-

2018 Parent Breakouts	All	Has Children	No Children
Yes	53%	34%	63%
No	47%	66%	37%
Not sure/ Refused	*%	-	*%

Eight percent of Howard County residents said they currently asthma. This represents a slight decrease from 2016 and 2014. In 2012, through a slightly different question, 9% said they had asthma.



Q6.5. Do you currently have asthma?
2012: (Have you ever been) told you have asthma? (If yes): Do you still have asthma?

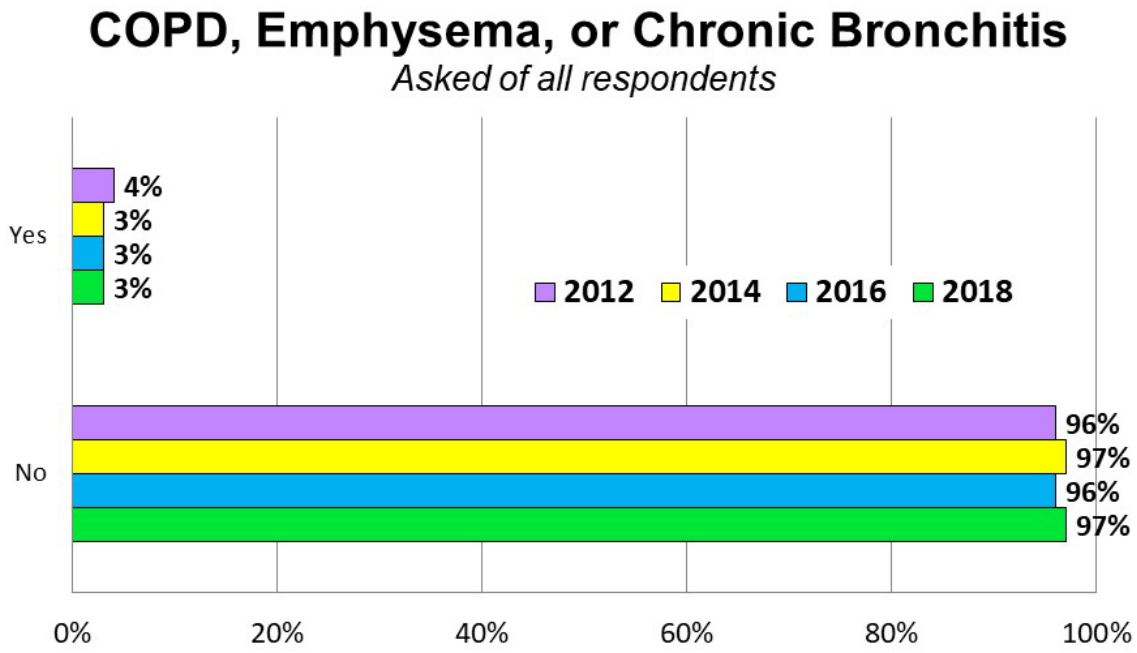
Residents are more likely to report having asthma if they are female, Hispanic, or obese.

2018 Gender Breakouts	All	Male	Female
Yes	8%	5%	11%
No	91%	94%	89%
Not sure/ Refused	1%	1%	*%

2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
Yes	8%	10%	6%	2%	22%	9%
No	91%	89%	94%	98%	78%	88%
Not sure/Refused	1%	1%	*%	*%	-	3%

2018 BMI Breakouts	All	Underweight (<18.5)	Normal (18.5 – 24.9)	Overweight (25.0 – 29.9)	Obese (30.0+)
Yes	8%	13%	4%	9%	12%
No	91%	87%	95%	91%	87%
Not sure/ Refused	1%	-	1%	-	1%

Three percent of residents said they have been told they have chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis. This number is virtually unchanged since 2012.



Q6.8. (Ever told) you have (COPD) chronic obstructive pulmonary disease, emphysema or chronic bronchitis?

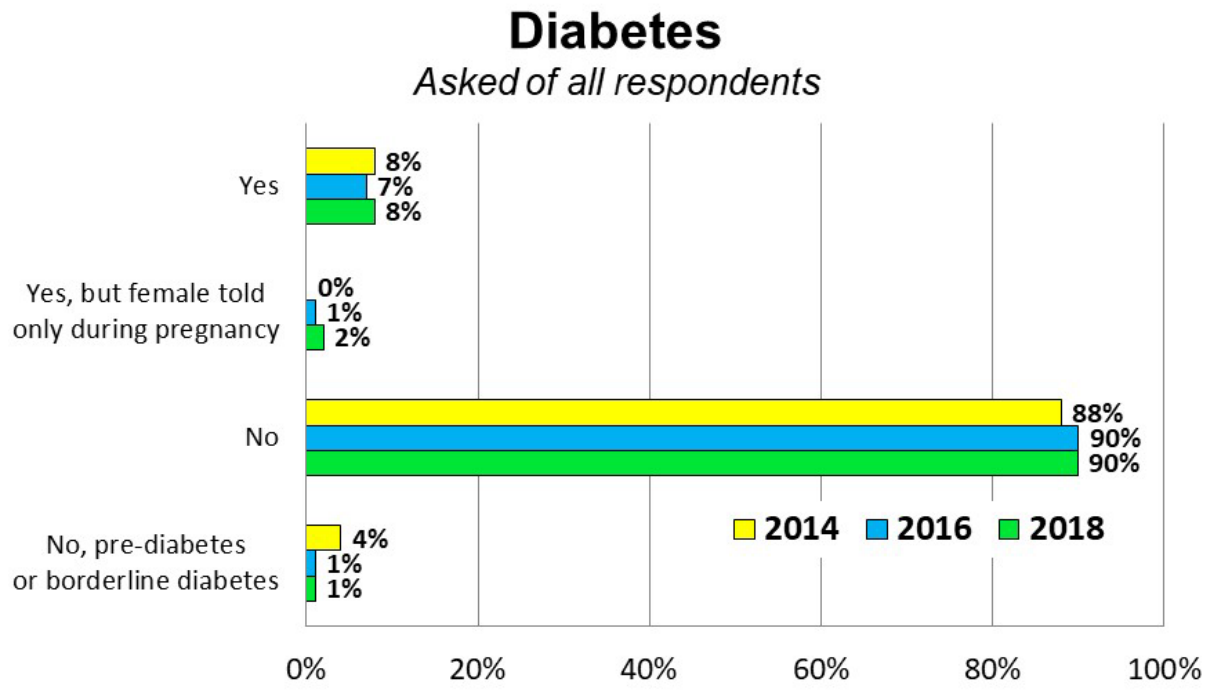
Residents are more likely to have been told they have COPD if they are age 65 or above, or if they are retired.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	3%	-	1%	1%	2%	3%	7%	11%
No	97%	100%	99%	99%	97%	96%	93%	89%
Not sure/Refused	*%	-	*%	*%	*%	*%	*%	-

2018 Employment Status Breakouts	All	Employed	Self-Employed	Un-employed	Retired	Home-maker	Student
Yes	3%	2%	1%	5%	8%	3%	-
No	97%	98%	99%	95%	92%	97%	100%
Not sure/Refused	*%	*%	*%	-	-	1%	-

Diabetes

Eight percent of residents have been told they have diabetes, up slightly from the 7% reported in 2016, and on a par with the 8% who said so in 2014. An additional 2% are women who were told only when they were pregnant that they had diabetes, and 1% volunteered that they were told they had pre-diabetes or borderline diabetes.



Q6.13. (Ever told) you have diabetes?
(2012 data for this question is not comparable.)

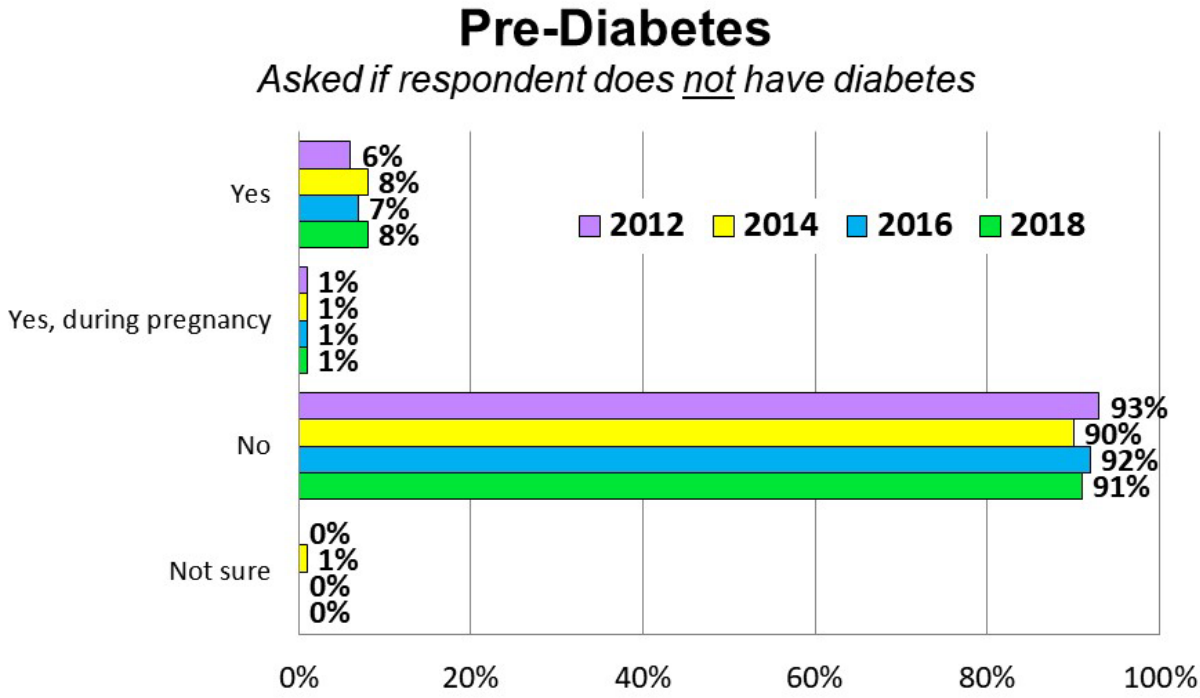
Residents are more likely to have been told they have diabetes if they are age 55 or above, have no children in the household, or are retired.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	8%	*%	2%	4%	8%	12%	23%	20%
Yes, but female told only during pregnancy	2%	*%	2%	2%	3%	1%	1%	1%
No	90%	100%	95%	94%	88%	86%	72%	76%
No, pre-diabetes or borderline diabetes	1%	*%	*%	*%	1%	1%	2%	3%
Not sure/ Refused	*%	*%	*%	*%	*%	*%	1%	*%

2018 Parent Breakouts	All	Has Children	No Children
Yes	8%	4%	11%
Yes, but female told only during pregnancy	2%	3%	1%
No	90%	93%	87%
No, pre-diabetes or borderline diabetes	1%	*%	1%
Not sure/ Refused	*%	*%	*%

2018 Employment Status Breakouts	All	Employed	Self-Employed	Un-employed	Retired	Home-maker	Student
Yes	8%	6%	5%	14%	20%	6%	1%
Yes, but female told only during pregnancy	2%	2%	1%	1%	1%	6%	1%
No	90%	92%	93%	85%	77%	87%	98%
No, pre-diabetes or borderline diabetes	1%	1%	1%	-	2%	-	-
Not sure/ Refused	*%	*%	-	-	*%	1%	-

Of those who have *not* been told they have diabetes, 8% said they have been told they have pre-diabetes or borderline diabetes. This is slightly higher than the 7% measured in 2016, on a par with the 8% measured in 2014, and less than the 6% measured in 2012. Another 1% in all reporting periods were women who said they received this diagnosis only while they were pregnant.



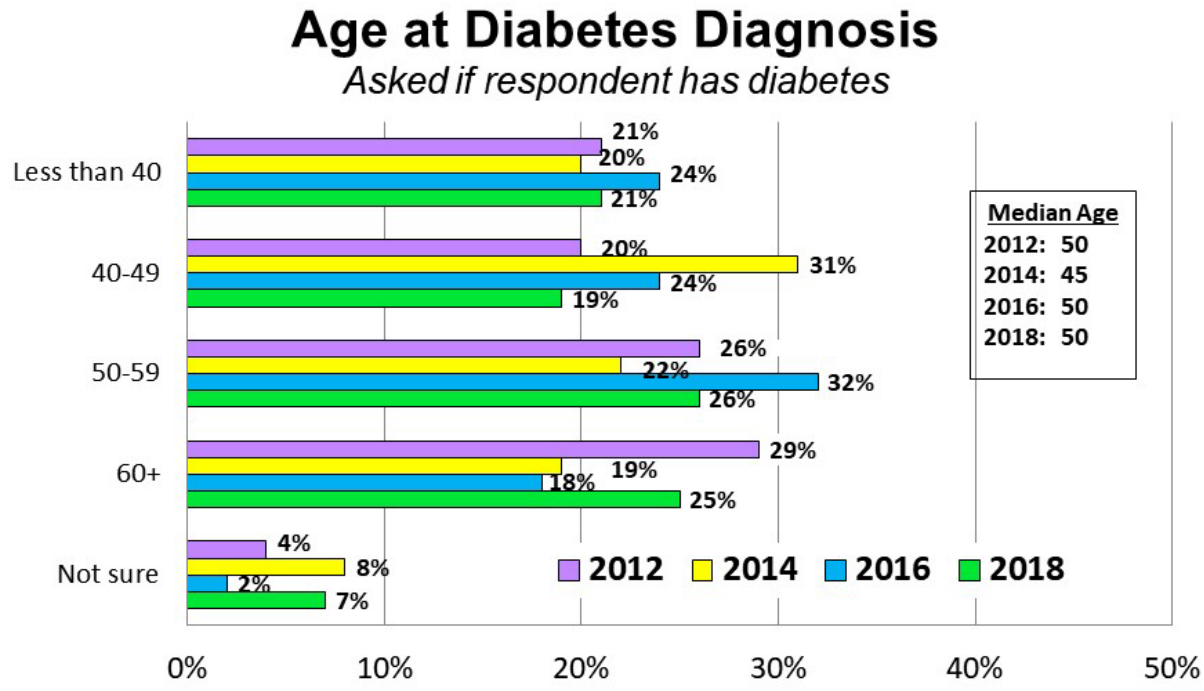
M01.2. Have you ever been told by a doctor or other health professional that you have pre-diabetes or borderline diabetes?

Residents are more likely to have been told they have pre-diabetes or borderline diabetes if they are age 55 or above, or are obese.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	8%	1%	3%	5%	10%	15%	15%	15%
Yes, during pregnancy	1%	1%	3%	1%	2%	-	-	*%
No	91%	98%	94%	93%	88%	84%	83%	84%
Not sure/ Refused	*%	-	-	*%	-	1%	1%	*%

2018 BMI Breakouts	All	Underweight (<18.5)	Normal (18.5 – 24.9)	Overweight (25.0 – 29.9)	Obese (30.0+)
Yes	8%	2%	3%	8%	13%
Yes, during pregnancy	1%	-	1%	2%	1%
No	91%	98%	95%	89%	86%
Not sure/ Refused	*%	-	*%	*%	*%

Based on their recollection, residents with diabetes were first told they had diabetes at the median age of 50. The median has consistently been age 50, with the exception of 2014 when it was somewhat lower at age 45. The relatively small sample size of people with diabetes can introduce variability into the numbers, as illustrated below.

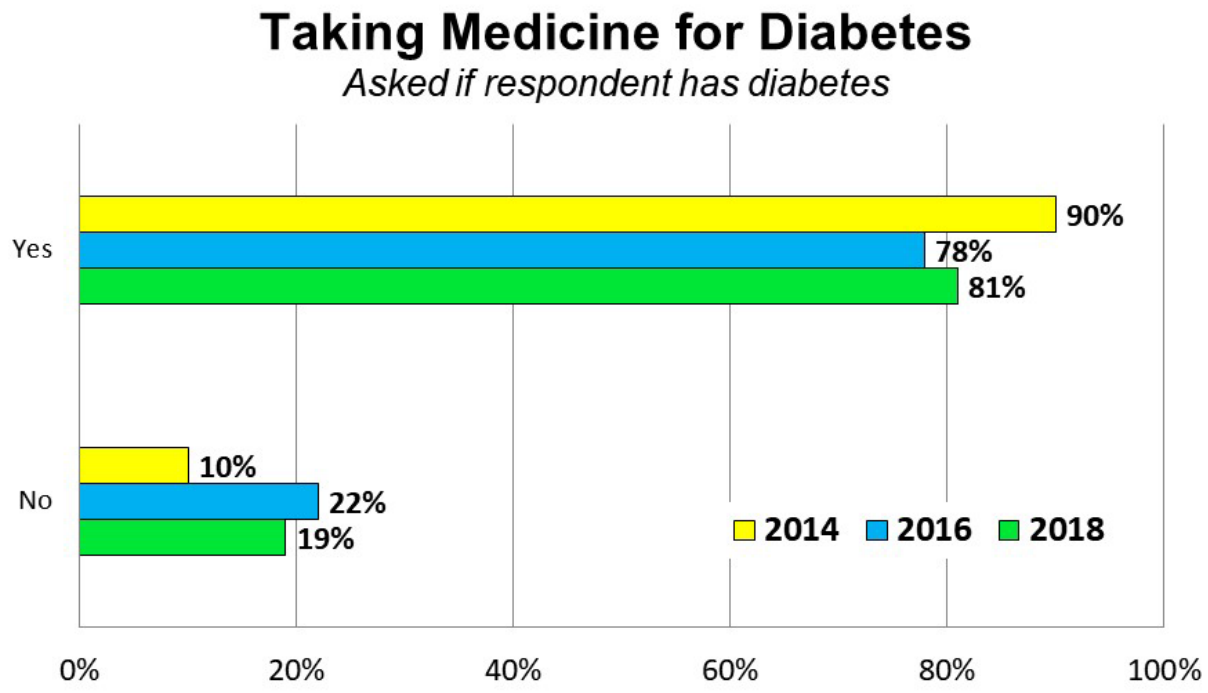


M02.1. How old were you when you were told you have diabetes?

Those earning less than $50,000 were the most likely to have been told they have diabetes prior to the age of 30, though the median age of diagnosis is near 50 for all income groups.

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Less than 30	9%	23%	6%	4%	9%	11%
30-39	12%	9%	19%	16%	-	14%
40-49	19%	14%	19%	19%	39%	13%
50-59	26%	26%	29%	23%	19%	30%
60+	25%	23%	19%	30%	26%	25%
Not sure/ Refused	8%	6%	9%	8%	8%	8%
Median age	50	50	50	51	49	51

Eighty-one percent of residents who have been told they have diabetes said they are now taking insulin or other medicine to help with the disease. This is an increase from the 78% measured in 2016 and a decrease from the 90% measured in 2014.

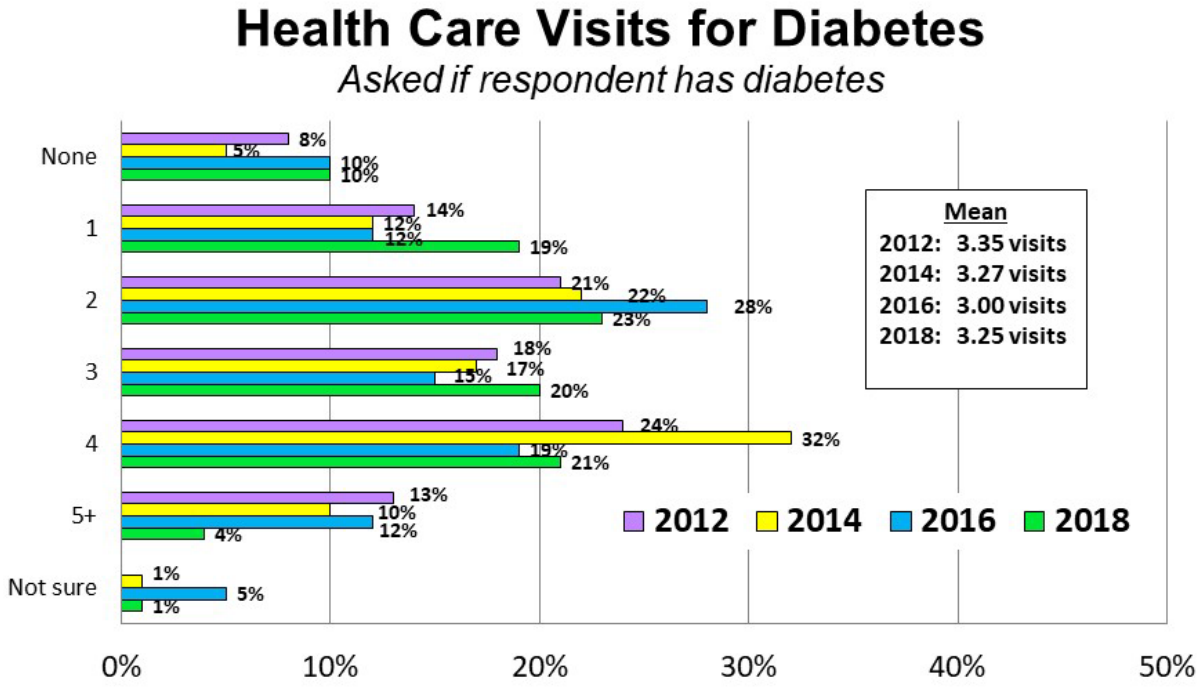


M02.2. Are you now taking insulin or other medicine to help with your diabetes?
(Question not asked in 2012.)

Those earning between $100,000 - $149,999 were more likely than others to be taking insulin or other medication to help with their diabetes.

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Yes	81%	80%	78%	91%	81%	75%
No	19%	20%	22%	9%	19%	25%
Not sure/Refused	*%	-	-	-	-	-

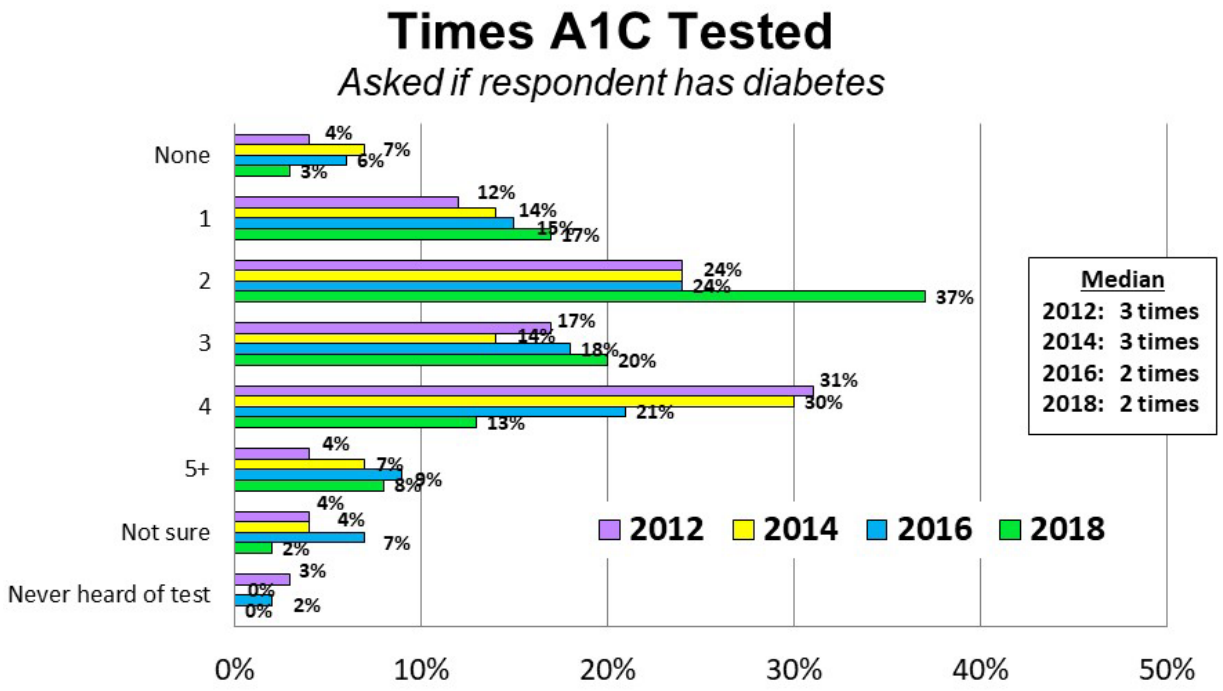
In the 2018 survey, residents with diabetes said they had seen a health professional for their diabetes an average (mean) of 3.25 times in the prior 12 months. Though there is some variability in these numbers due to a relatively small sample size of people with diabetes, this mean falls within its normal range based on past surveys.



M02.5. About how many times in the past 12 months have you seen a doctor, nurse, or other health professional for your diabetes?

Due to a small sample size, there are no statistically significant subgroup differences to note.

Residents with diabetes received the A1C test a median of two times over the prior 12 months, according to both the 2018 and 2016 surveys. In 2014 and 2012, the median was slightly higher at three times.

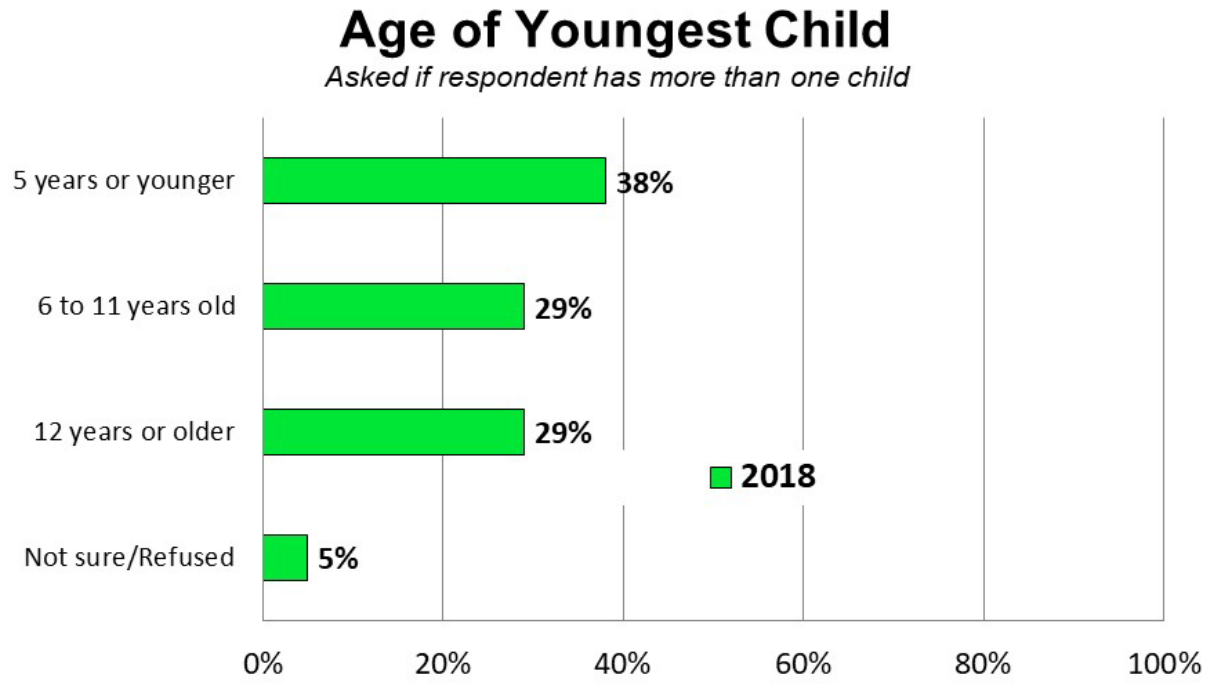


M02.6. A test for "A one C" measures the average level of blood sugar over the past three months. About how many times in the past 12 months has a doctor, nurse, or other health professional checked you for "A one C"?

Due to a small sample size, there are no statistically significant subgroup differences to note.

Children's Health

Among households with more than one child, the youngest child was 5 or younger in 38% of households, age 6 to 11 in 29% of households, and was 12 or older for 29%.



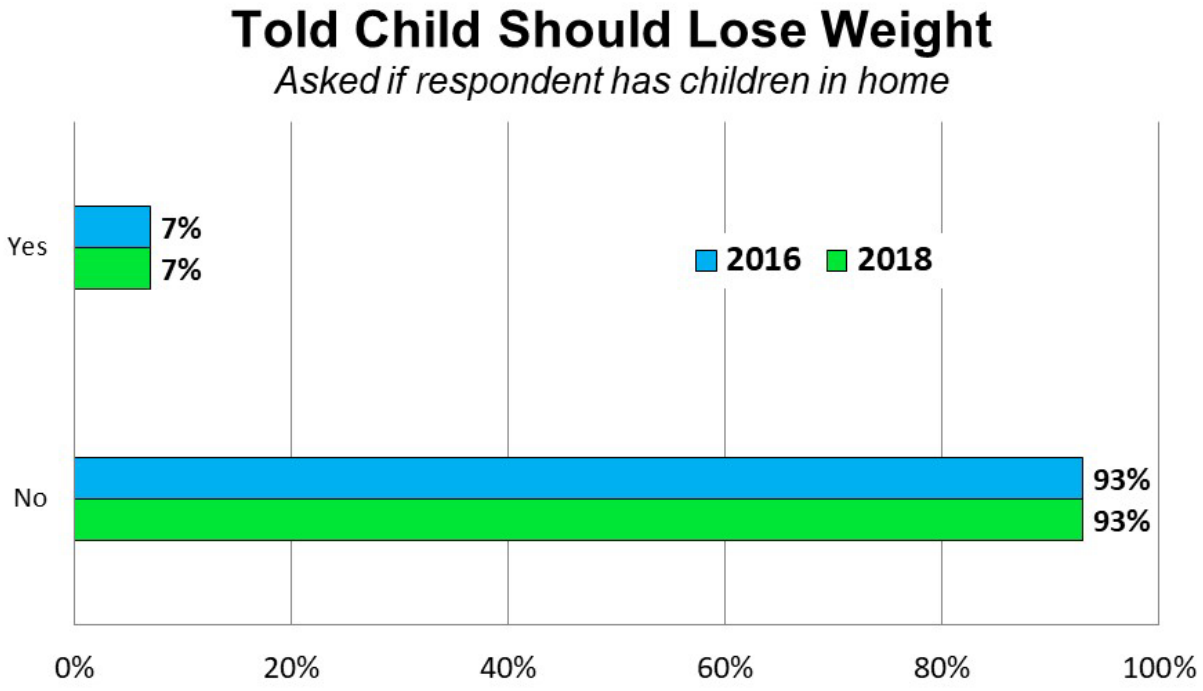
Q8.7AA. What is the age of your youngest child?
(Not asked in 2012, 2014 and 2016)

This table details the age profile of survey respondents and the children that are in their households. Progressing from youngest to oldest, this table illustrates the presence of siblings in the youngest age group, through young families and growing children, and eventually grandparents with young children in their households.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
5 years or younger	38%	3%	65%	50%	14%	2%	28%	38%
6 to 11 years old	29%	18%	21%	36%	32%	18%	32%	-
12 years or older	29%	52%	9%	12%	53%	78%	40%	62%
Not sure/Refused	4%	27%	6%	1%	1%	2%	-	-

Six questions related to children's health issues were asked in 2016 and 2018.

For those respondents with at least one child at home, 7% in 2018 said they had been told by a health care professional that their child should lose weight. This is unchanged from 2016.

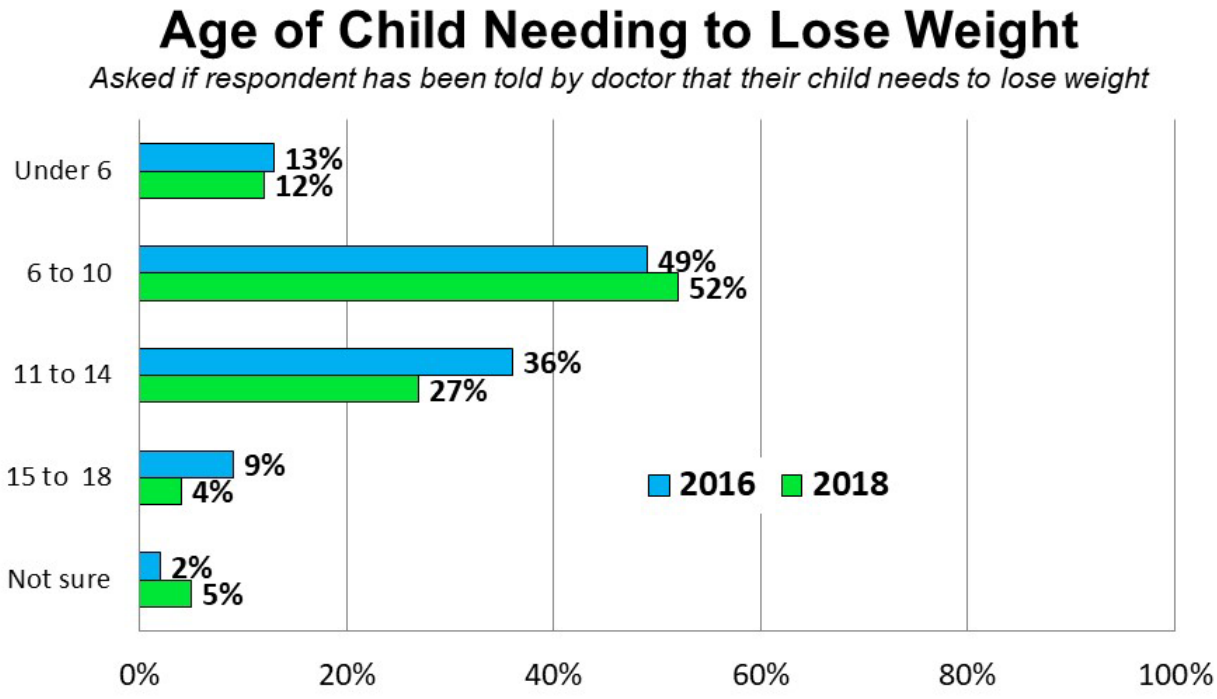


Q8.7A. Have you ever been told by a health care professional that your child should lose weight?
(Not asked in 2012 and 2014)

This is slightly more common in the Elkridge and Laurel regional planning areas. and slightly less common in Columbia.

2018 Planning District Breakouts	All	West County	Ellicott City	Columbia	Elkridge	Laurel
Yes	7%	6%	5%	4%	9%	11%
No	94%	95%	96%	91%	89%	%

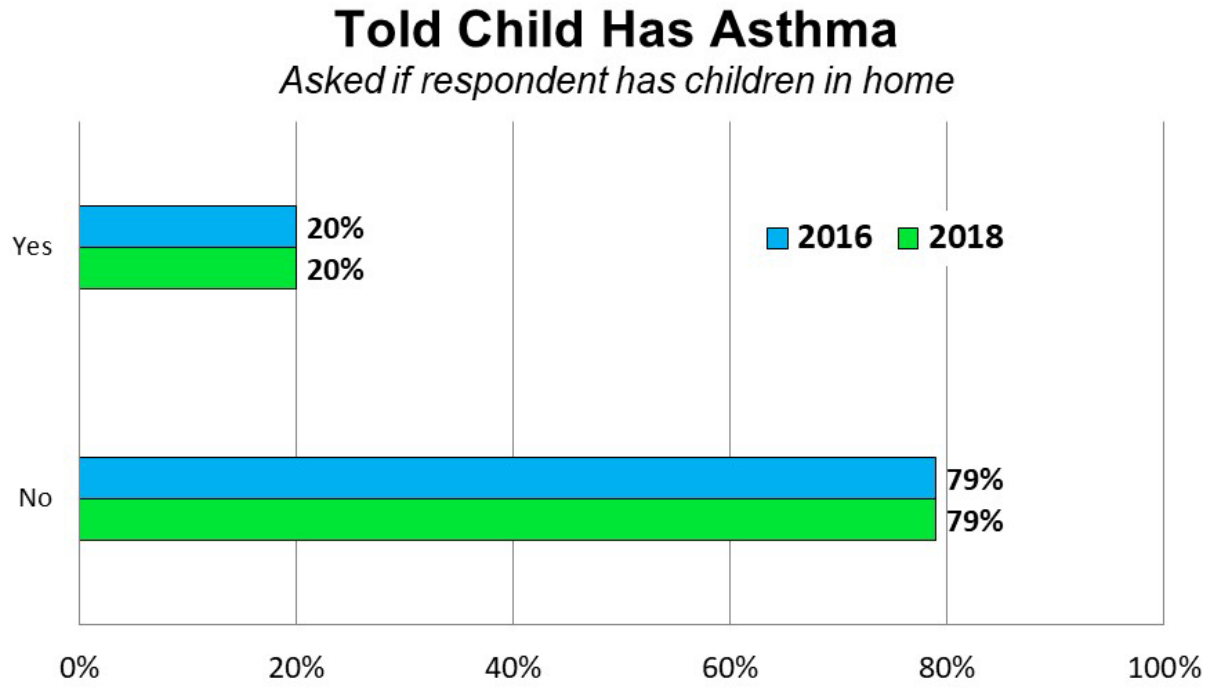
Of those children needing to lose weight, 52% were between the ages of 6 and 10, and 27% were between the ages of 11 and 14. Given a very small sample size for this question, these numbers to do represent a significant change.



Q8.7B. What age were they at the time?
(Not asked in 2012 and 2014)

The next two questions asked about chronic health conditions in children.

Twenty percent of the respondents with children said they had been told by their health care provider that a child in their household had asthma. This is unchanged from 2016.



Q8.7C. Has a doctor or other health care provider ever told you that any child in your household had asthma?
(Not asked in 2012 and 2014)

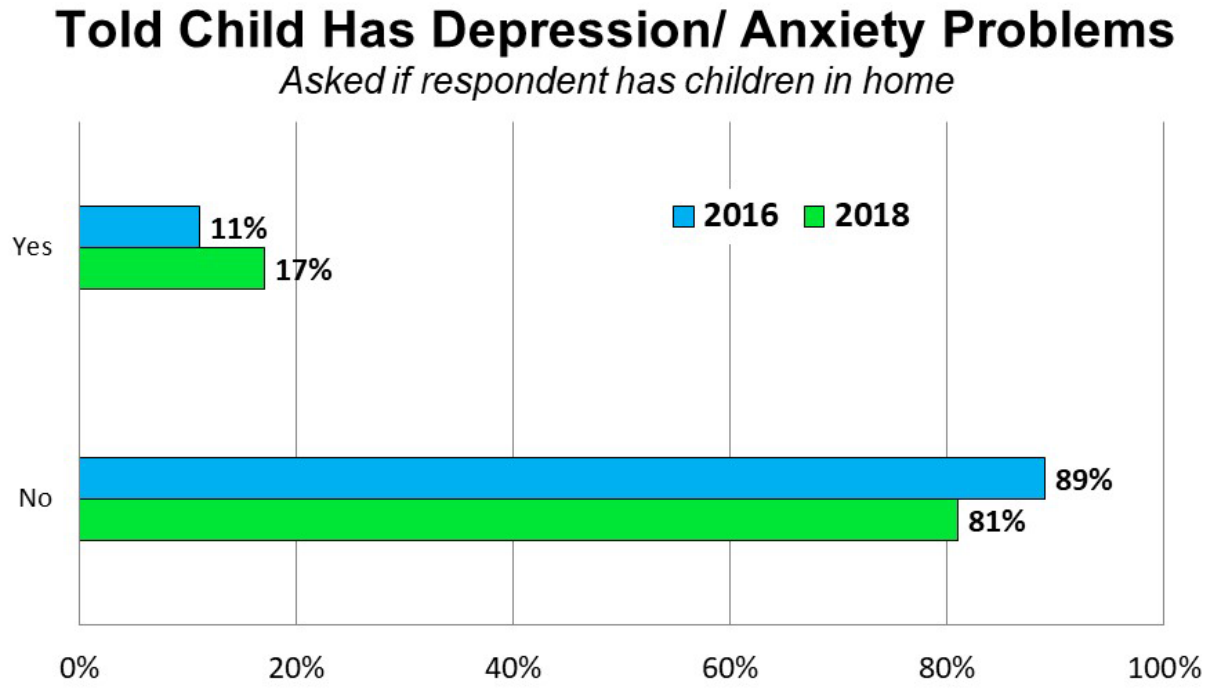
Parents and caregivers of children are more likely to have been told that their child has asthma if they were female, between the age of 18 to 24 or age 75 or more, or African-American.

2018 Gender Breakouts	All	Male	Female
Yes	20%	15%	23%
No	79%	82%	77%
Not sure/Refused	1%	3%	*%

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	20%	32%	10%	20%	21%	21%	9%	39%
No	79%	62%	87%	79%	79%	78%	91%	61%
Not sure/Refused	1%	6%	3%	*%	1%	-	-	-

2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
Yes	20%	21%	26%	16%	12%	27%
No	79%	78%	71%	84%	85%	73%
Not sure/Refused	1%	1%	2%	*%	3%	*%

Seventeen percent of the respondents with children said that their health care provider has told them that their child had depression or anxiety problems. This is a noticeable increase from the 11% reported in 2016.



Q8.7D. Has a doctor or other health care provider ever told you that any child in your household had depression/ anxiety problems?
(Not asked in 2012 and 2014)

Women are more likely to have been told that their child has depression or anxiety problems, as are parents and caregivers between the ages of 18 and 24, or between the ages of 55 and 64, or who are White. Though most differences based on educational attainment do not rise to the level of statistical significance, it appears that parents and guardians with lower education levels are more likely to be told their children are experiencing depression or anxiety problems.

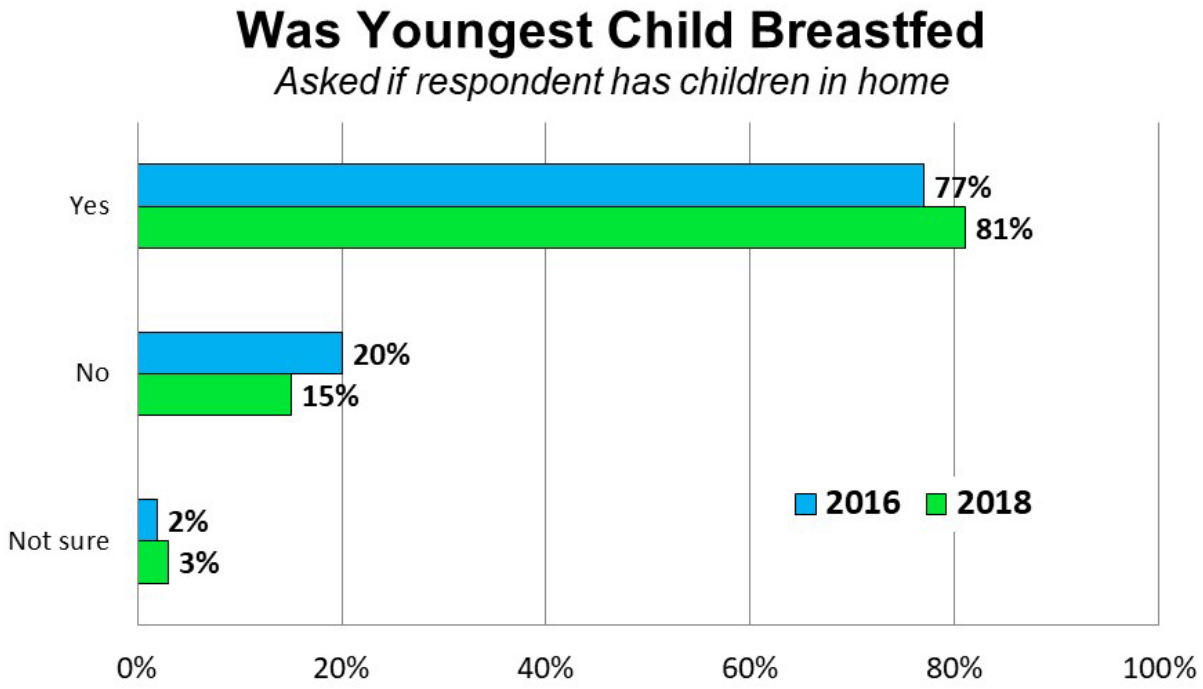
2018 Gender Breakouts	All	Male	Female
Yes	17%	13%	21%
No	81%	85%	79%
Not sure/ Refused	2%	3%	*%

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	17%	40%	9%	10%	20%	32%	26%	45%
No	81%	55%	90%	89%	80%	66%	74%	55%
Not sure/ Refused	2%	6%	1%	*%	1%	2%	-	-

2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
Yes	17%	23%	14%	7%	26%	10%
No	81%	75%	83%	92%	71%	90%
Not sure/ Refused	2%	1%	2%	*%	3%	-

2018 Education Breakouts	All	<HS	HS/GED	Some College	4-Year degree	Grad Work
Yes	17%	34%	25%	24%	15%	13%
No	81%	66%	68%	25%	85%	86%
Not sure/ Refused	2%	-	7%	2%	-	1%

The next two questions asked about breastfeeding. More than three-quarters (81%) indicated that they had breastfed their child or fed their child breastmilk. This is an increase from the 77% reported in 2016.



Q8.7F. Was your youngest child ever breastfed or fed breast milk?
(Not asked in 2012 and 2014)

Children are more likely to have been breastfed if the parent or caregiver is between the ages of 35 and 44, is Asian or identifies as "some other" race or ethnicity, or if the household earns between $100,000 and $150,000 per year.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	81%	80%	77%	87%	80%	72%	55%	39%
No	15%	7%	18%	12%	16%	25%	31%	47%
Not sure/ Refused	4%	12%	5%	1%	4%	2%	15%	13%

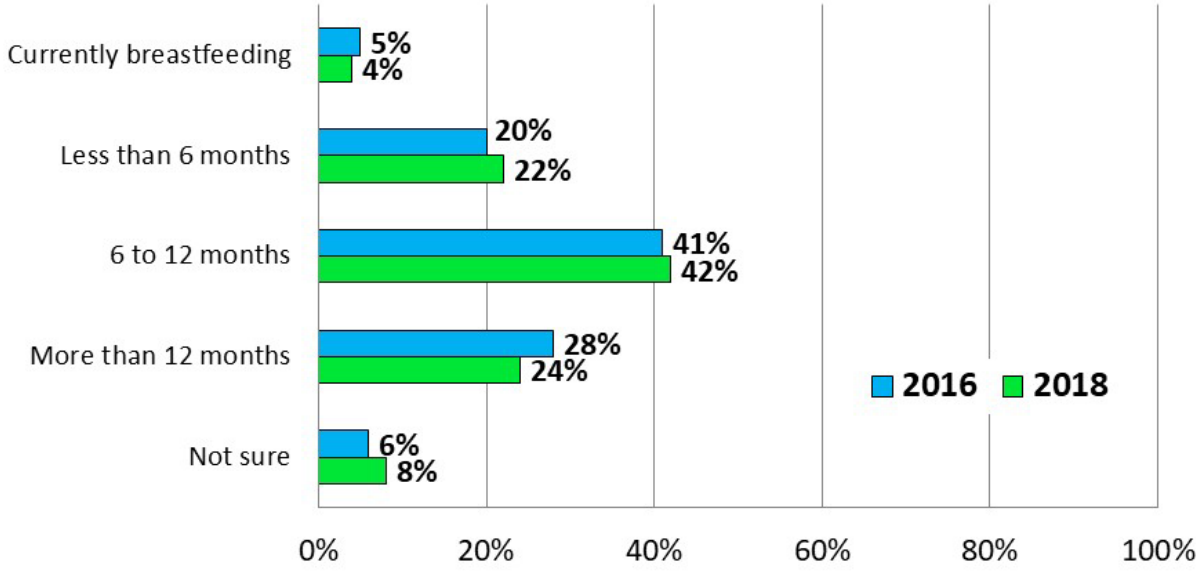
2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
Yes	81%	80%	74%	87%	75%	93%
No	15%	15%	23%	10%	14%	7%
Not sure/ Refused	4%	5%	4%	3%	11%	-

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Yes	81%	70%	76%	89%	83%	82%
No	15%	22%	20%	9%	14%	16%
Not sure/ Refused	4%	8%	4%	2%	3%	2%

Among respondents whose children were breastfed, 64% stopped breastfeeding within 12 months. Twenty-four percent continued breastfeeding beyond 12 months, which is a slight decrease from the 28% recorded in 2016.

Age When Child Stopped Breastfeeding

Asked if respondent has child that was breastfed or fed breast milk



Q8.7G. How old was [he/she] when [he/she] completely stopped breastfeeding or being fed breast milk?
(Not asked in 2012 and 2014)

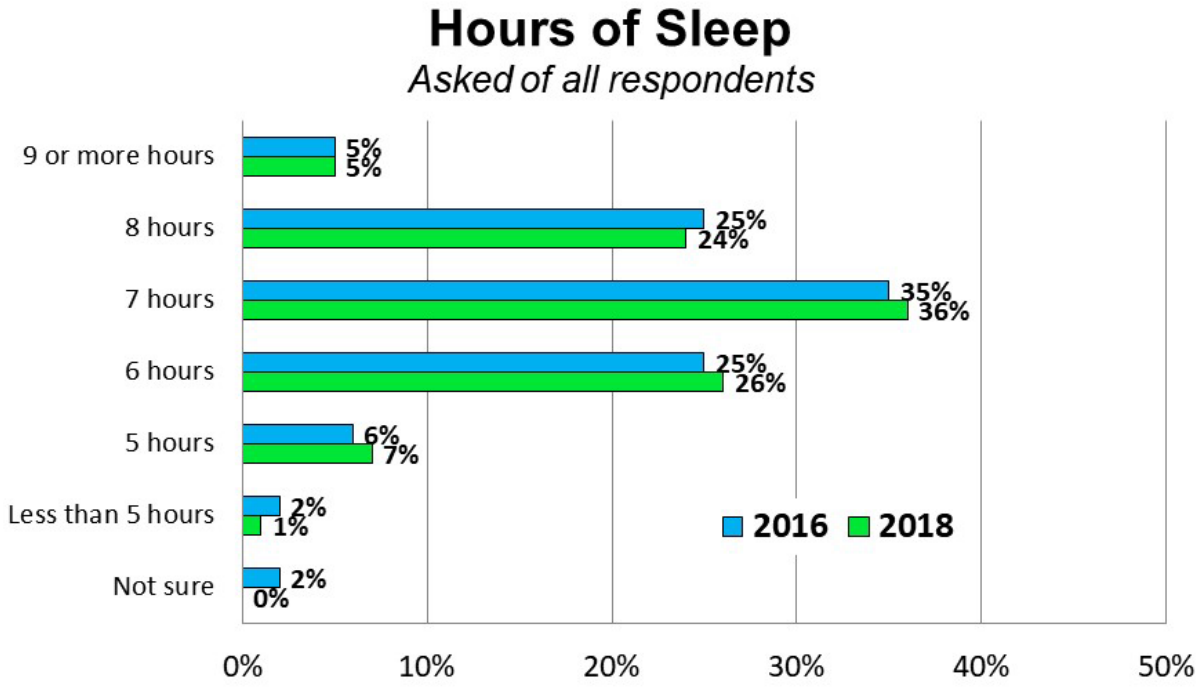
Though it does not rise to a statistically significant level, it appears that White and African-American mothers are more likely than most others to continue breastfeeding beyond 12 months. There also may be a relationship with household income, with higher-income households generally breastfeeding longer.

2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
Currently breastfeeding	4%	6%	4%	3%	*%	*%
Less than 6 months	22%	21%	23%	25%	24%	8%
6 to 12 months	42%	41%	43%	42%	54%	27%
More than 12 months	24%	25%	29%	17%	12%	65%
Not sure/ Refused	8%	8%	1%	13%	9%	*%

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Currently breastfeeding	4%	*%	6%	6%	5%	2%
Less than 6 months	22%	28%	32%	19%	18%	19%
6 to 12 months	42%	52%	28%	37%	44%	52%
More than 12 months	24%	20%	24%	27%	29%	20%
Not sure/ Refused	8%	*%	9%	11%	5%	7%

Other Issues

Thirty-six percent of Howard County residents said they typically sleep seven hours per 24-hour period, the most common sleep duration. Twenty-six percent sleep about six hours per night, while 24% sleep eight hours in a typical 24-hour period. These numbers are virtually identical to 2016.



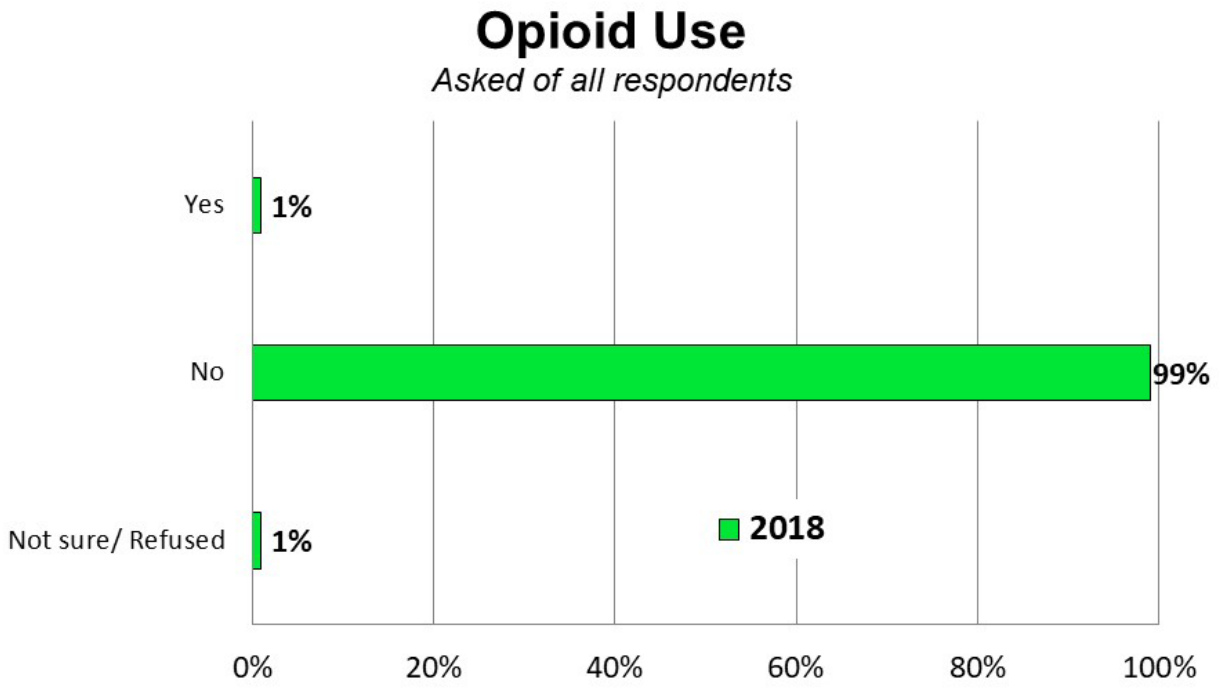
OTH2. Typically, how many hours of sleep do you get in a 24 hour period?
(Not asked in 2012 and 2014)

It appears that older residents are getting somewhat more sleep, while those who are employed are getting somewhat less.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
< 5 hours	1%	2%	1%	1%	1%	1%	1%	2%
5 hours	7%	5%	7%	10%	6%	6%	6%	3%
6 hours	26%	26%	30%	28%	26%	27%	21%	15%
7 hours	36%	35%	39%	35%	37%	37%	26%	30%
8 hours	24%	24%	20%	22%	23%	24%	35%	30%
9 or more hours	5%	8%	2%	3%	5%	4%	11%	17%
Not sure/Refused	1%	-	1%	*%	1%	1%	1%	3%

2018 Employment Breakouts	All	Employed	Self-Employed	Un-employed	Retired	Home-maker	Student
< 5 hours	1%	2%	*%	2%	2%	-	-
5 hours	7%	7%	6%	11%	4%	5%	6%
6 hours	26%	28%	28%	18%	16%	28%	31%
7 hours	36%	37%	33%	34%	29%	39%	35%
8 hours	24%	22%	27%	19%	37%	18%	21%
9 or more hours	5%	3%	5%	16%	11%	5%	7%
Not sure/Refused	*%	*%	1%	1%	2%	5%	-

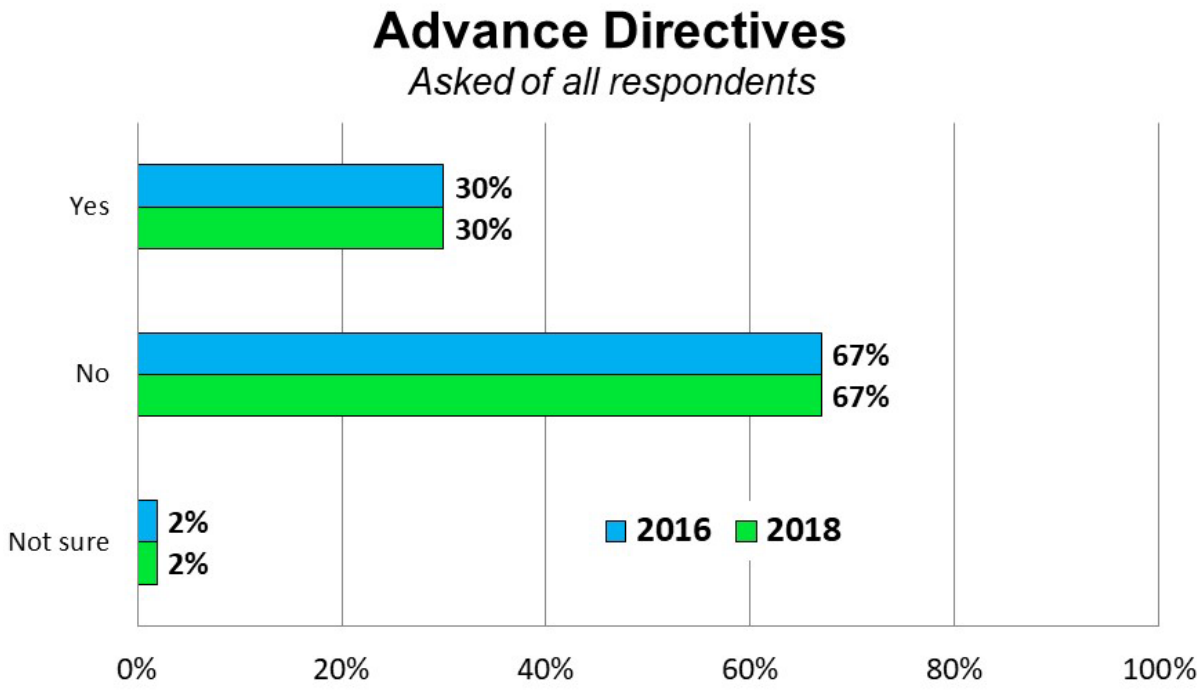
In a new question for 2018, 99% of Howard County residents said that neither they nor an immediate family member used heroin or an opioid without a prescription or more frequently than prescribed.



OTH4. In the past 12 months did you or an immediate family member use heroin or any type of opioid that you or they did not have a prescription for, or took more frequently than prescribed on one or more occasions?
(Not asked in 2012, 2014 and 2016)

Due to the very small sample size of those who acknowledge inappropriate opioid use, there are no statistically significant subgroup differences for this question.

Thirty percent of Howard County residents said they have a signed advance directive based on this description: "Advance directives are legal documents that allow you to spell out your decisions about end-of-life care ahead of time. This is not a will by which you dispose of property, but is how you communicate decisions about the type of health care you would like to receive if you are unable to speak for yourself." This is identical to the number recorded in 2016.



ACP1. Do you currently have a signed advance directive?
(Not asked in 2012 and 2014)

Residents are more likely to have an advance directive if they live in West County, are over age 55, are White, earn more than $150,000, or are widowed.

2018 Planning District Breakouts	All	West County	Ellicott City	Colombia	Elk Ridge	Laurel
Yes	30%	40%	34%	28%	23%	24%
No	67%	57%	63%	69%	73%	73%
Not sure/ Refused	3%	2%	4%	2%	4%	3%

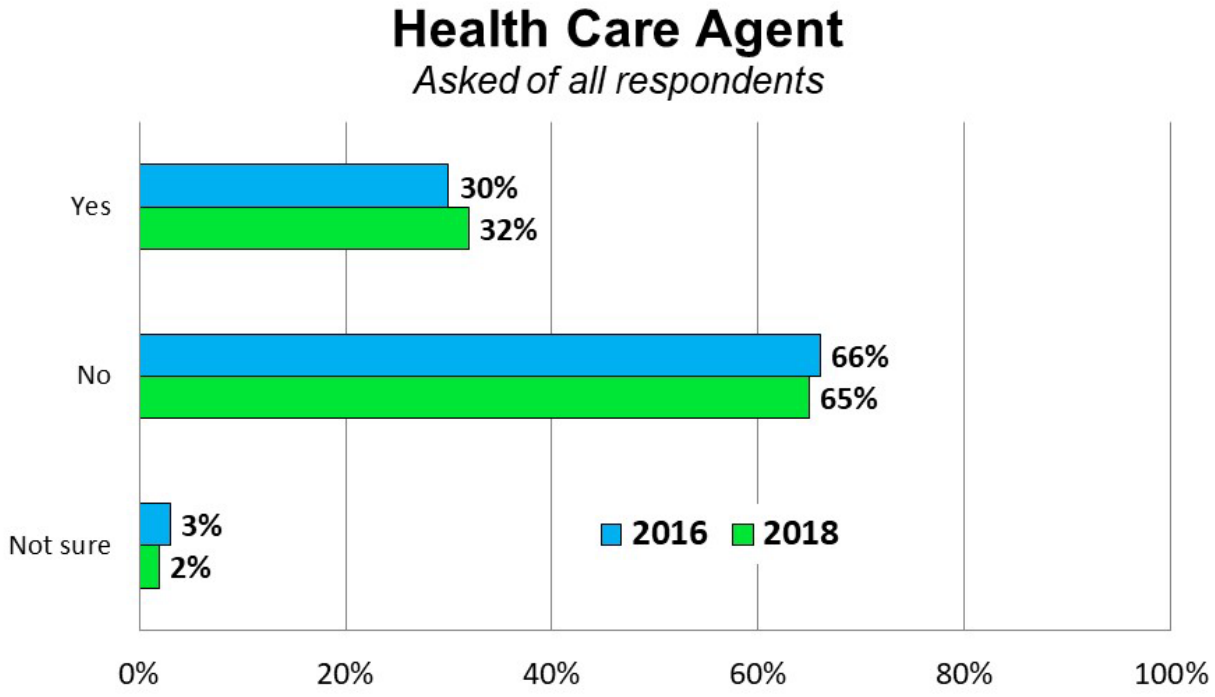
2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	30%	3%	12%	26%	34%	44%	54%	67%
No	67%	92%	84%	72%	64%	52%	44%	31%
Not sure/ Refused	3%	5%	3%	2%	2%	3%	2%	3%

2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
Yes	30%	38%	23%	15%	19%	27%
No	67%	59%	75%	82%	75%	66%
Not sure/ Refused	3%	3%	1%	3%	6%	7%

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Yes	30%	16%	26%	29%	37%	43%
No	67%	79%	72%	71%	60%	56%
Not sure/ Refused	3%	6%	2%	1%	3%	*%

2018 Marital Status Breakouts	All	Married	Divorced/ Separated	Widowed	Never Married	Unmarried Couple
Yes	30%	36%	32%	66%	11%	28%
No	67%	62%	65%	32%	85%	70%
Not sure/ Refused	3%	2%	3%	2%	5%	2%

Similarly, 32% of residents said they had designated a health care agent based on this description: "A health care agent, often called a 'proxy,' is the person you trust to act on your behalf in the event you are unable to make health care decisions or communicate your wishes. Health care agents are often named as a part of completing an advance directive." This is somewhat greater than the 30% who had selected a health care agent in 2016.



ACP2. Do you currently have a signed document naming your health care agent?
(Not asked in 2012 and 2014)

Residents are more likely to have named a health care agent if they are over age 55, are White, earn more than $200,000, or are retired.

2018 Age Breakouts	All	18-24	25-34	35-44	45-54	55-64	65-74	75+
Yes	32%	9%	16%	28%	31%	47%	52%	66%
No	65%	87%	82%	70%	66%	50%	43%	28%
Not sure/Refused	3%	4%	1%	2%	3%	2%	5%	6%

2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
Yes	32%	37%	26%	20%	21%	27%
No	65%	60%	72%	75%	78%	71%
Not sure/Refused	3%	2%	2%	5%	1%	2%

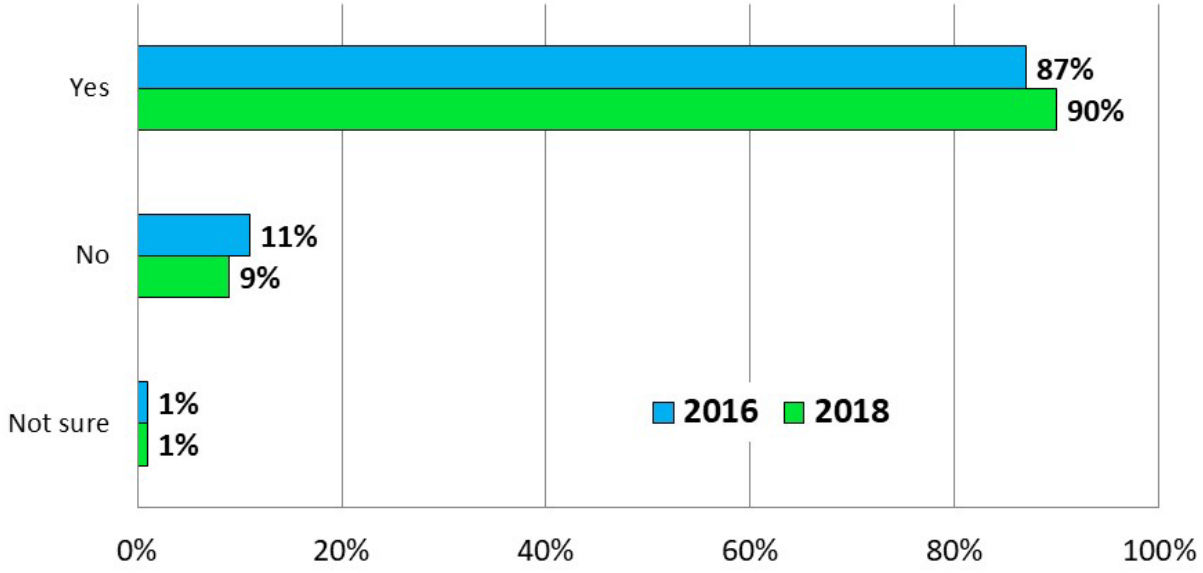
2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Yes	32%	17%	29%	32%	37%	40%
No	65%	81%	67%	66%	61%	58%
Not sure/Refused	3%	3%	3%	1%	3%	2%

2018 Employment Status Breakouts	All	Employed	Self-Employed	Un-employed	Retired	Home-maker	Student
Yes	32%	28%	37%	20%	59%	26%	9%
No	65%	70%	59%	79%	36%	67%	87%
Not sure/Refused	3%	2%	4%	1%	5%	7%	4%

Among those who have designated a health care agent, 90% said they have had a conversation with that person to communicate their care wishes, an increase from the 87% reported in 2016. Nine percent said they have not had that conversation, while the small remainder were not sure. In 2016, 11% said they had not had such a conversation.

Conversation with Agent

Asked if respondent has a signed document naming their health care agent



ACP3. Have you had a conversation with your named agent to communicate your care wishes?
(Not asked in 2012 and 2014)

These conversations are more common among White and Hispanic residents, upper-income households, and among married or divorced and separated residents.

2018 Race/ Ethnicity Breakouts	All	White	African-American	Asian	Hispanic	Other
Yes	90%	94%	83%	76%	100%	96%
No	9%	5%	16%	24%	*%	4%
Not sure/ Refused	1%	1%	1%	*%	*%	*%

2018 Income Breakouts	All	<$50,000	$50,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Yes	90%	82%	86%	88%	92%	98%
No	9%	14%	13%	11%	8%	1%
Not sure/Refused	1%	3%	1%	*%	*%	1%

2018 Marital Status Breakouts	All	Married	Divorced/ Separated	Widowed	Never Married	Unmarried Couple
Yes	90%	92%	97%	93%	70%	97%
No	9%	8%	3%	6%	24%	3%
Not sure/ Refused	1%	1%	*%	2%	6%	*%

Appendix:
2018 Survey Instrument

Hello, I am calling for the Howard County Health Department. My name is _____. We are gathering information about the health of County residents. This project is being conducted by the health department following Centers for Disease Control and Prevention guidelines. Your telephone number has been chosen randomly, and I would like to ask some questions about health and health practices.

To ensure we are speaking to a representative group of residents may I please speak to the youngest male age 18 or older who is at home right now?

IF NO: May I please speak to the youngest female in the household age 18 or older who is at home?

I will not ask for your last name, address, or other personal information that can identify you. You do not have to answer any question you do not want to, and you can end the interview at any time. Any information you give me will be confidential. If you have any questions about the survey, please call 410-280-2000.

S1. Just to confirm, do you live in Howard County?

1 Yes
2 No *(Thank and terminate.)*
9 Not sure/Refused to say *(Thank and terminate.)*

S2. In what zip code do you live? *(Record 5-digit zip.)*

20701	21042	21723
20723	21043	21737
20759	21044	21738
20763	21045	21765
20777	21046	21771
20794	21075	21784
20833	21076	21794
21029	21104	21797
21036	21150	
21041	21163	Other zip *(Specify)*

8.22 I am required to ask this question. So that we have a balanced sample, what is your gender? *(Note: Answer drives skip patterns for Q4.1, 6.1, M01.2.)*

(151)

1 Male
2 Female
3 Transgender

C03 Health Care Access (general)

3.1 Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare or Indian Health Services?

(80)

1 Yes
2 No
7 Don't know / Not sure
9 Refused

3.2 Do you have one person you think of as your personal doctor or health care provider?
If "No," ask: "Is there more than one, or is there no person who you think of as your personal doctor or health care provider?"

(81)

1 Yes, only one
2 More than one

3 No
7 Don‘t know / Not sure
9 Refused

3.3A When you are sick or need medical attention, to which one of the following places do you usually go? Would you say:

Please read:
1 A doctor's office
2 A community health center like Chase Brexton
4 A hospital emergency room
5 An urgent care center like Patient First or Minute Clinic
6 Some other kind of place
Or
8 No usual place
Do not read:
7 Don’t know / Not sure
9 Refused

3.3B Thinking about your most recent visit to your primary health care provider for a medical issue you wanted resolved quickly, how long did you have to wait between when the appointment was made and when the appointment actually occurred?

Do not read:
1 Same day
2 Within 2-3 days
3 Within 1 week
4 Within 1 month
5 Longer than 1 month
6 Does not apply to me
7 Don’t know / Not sure
9 Refused

3.3C Was there a time in the past 12 months when you needed to go to the emergency room because you could not get a timely appointment with a doctor?

1 Yes
2 No
7 Don’t know / Not sure
9 Refused

C04 Hypertension

4.1 Have you EVER been told by a doctor, nurse, or other health professional that you have high blood pressure?

(84)

Read only if necessary: By “other health professional” we mean a nurse practitioner, a physician‘s assistant, or some other licensed health professional.
If “Yes” and respondent is female, ask: “Was this only when you were pregnant?”

1 Yes
2 Yes, but female told only during pregnancy [**Go to next section]**
3 No [**Go to next section]**
4 Told borderline high or pre-hypertensive [**Go to next section]**
7 Don‘t know / Not sure [**Go to next section]**
9 Refused [**Go to next section]**

4.1A Are you currently taking medication to help with your high blood pressure?

1 Yes
2 No
7 Don't know / Not sure
9 Refused

C05 High Cholesterol

5.1 Blood cholesterol is a fatty substance found in the blood. Have you ever had your blood cholesterol checked?

(86)

1 Yes
2 No [**Go to next section]**
7 Don't know / Not sure [**Go to next section]**
9 Refused [**Go to next section]**

5.2 About how long has it been since you last had your blood cholesterol checked?

(87)

Read only if necessary:
1 Within the past year (anytime less than 12 months ago)
2 Within the past 2 years (1 year but less than 2 years ago)
3 Within the past 5 years (2 years but less than 5 years ago)
4 5 or more years ago
Do not read:
7 Don't know / Not sure
9 Refused

5.3 Have you ever been told by a doctor, nurse or other health professional that your blood cholesterol is high?

(88)

1 Yes
2 No [**Go to next section]**
7 Don't know / Not sure [**Go to next section]**
9 Refused [**Go to next section]**

5.4 Are you now taking medicine to help with your cholesterol?

1 Yes
2 No
9 Refused

C06 Chronic Health Conditions:

Now I would like to ask you some questions about general health conditions.

Has a doctor, nurse, or other health professional ever told you that you had any of the following? For each, tell me "Yes," "No," or you're "not sure."

6.5 Do you currently have asthma?

(93)

1 Yes
2 No
7 Don't know / Not sure
9 Refused

C06 COPD

6.8 (Ever told) you have (COPD) chronic obstructive pulmonary disease, emphysema (em-fiz-ZEE-muh) or chronic bronchitis (bron-KITE-us)?

(96)

1 Yes
2 No
7 Don't know / Not sure
9 Refused

C06 Diabetes

6.13 (Ever told) you have diabetes?

(101)

(If "Yes" and respondent is female, ask): "Was this only when you were pregnant?"

If respondent says pre-diabetes or borderline diabetes, use response code 4.

1 Yes
2 Yes, but female told only during pregnancy
3 No
4 No, pre-diabetes or borderline diabetes
7 Don't know / Not sure
9 Refused

M01 Pre-Diabetes

NOTE: Only asked of those not responding "Yes" (code = 1) to Core Q6.13 (Diabetes awareness question).

CATI NOTE: If Core Q6.13 = 4 (No, pre-diabetes or borderline diabetes); answer Q2 "Yes" (code = 1).

M01.2. Have you ever been told by a doctor or other health professional that you have pre-diabetes or borderline diabetes?

(246)

If "Yes" and respondent is female, ask: "Was this only when you were pregnant?"

1 Yes
2 Yes, during pregnancy
3 No
7 Don't know / Not sure
9 Refused

M02 Diabetes

To be asked following Core Q6.13; if response is "Yes" (code = 1)

M02.1. How old were you when you were told you have diabetes?

(247-248)

_ _ Code age in years **[97 = 97 and older]**
98 Don't know / Not sure
99 Refused

M02.2. Are you now taking insulin or other medicine to help with your diabetes?

(249)

1 Yes
2 No
9 Refused

M02.5. About how many times in the past 12 months have you seen a doctor, nurse, or other health professional for your diabetes?

(256-257)

_ _ Number of times **[76 = 76 or more]**
88 None
77 Don‘t know / Not sure
99 Refused

M02.6. A test for "A one C" measures the average level of blood sugar over the past three months. About how many times in the past 12 months has a doctor, nurse, or other health professional checked you for "A one C"?

(258-259)

_ _ Number of times **[76 = 76 or more]**
88 None
98 Never heard of A one C test
77 Don‘t know / Not sure
99 Refused

C07 Tobacco Use

7.1 Have you smoked at least 100 cigarettes in your entire life?

(102)

NOTE: 5 packs = 100 cigarettes
1 Yes
2 No **[Go to Q7.5A]**
7 Don‘t know / Not sure **[Go to Q7.5A]**
9 Refused **[Go to Q7.5A]**

7.2 Do you now smoke cigarettes every day, some days, or not at all?

(103)

1 Every day
2 Some days
3 Not at all
7 Don‘t know / Not sure
9 Refused

7.5A Electronic cigarettes, or “e-cigarettes” and other electronic “vaping” products include electronic hookahs, or “e-hookahs,” vape pens, e-cigars, and others. These products are battery powered and usually contain nicotine and flavors such as fruit, mint, or candy. Do you currently use e-cigarettes every day, some days, or not at all?

1 Every day
2 Some days
3 Not at all
Do not read:
7 Don‘t know / Not sure
9 Refused

C08 Demographics

8.1 What is your age?

(108-109)

_ _ Code age in years (18-97)
07 Don‘t know / Not sure
09 Refused

8.2 Are you Hispanic or Latino?

(110)

1 Yes
2 No
7 Don‘t know / Not sure
9 Refused

8.3 Which one or more of the following would you say is your race?

(111-116)

(Code all that apply)
Please read:
1 White
2 Black or African American
3 Asian
4 Native Hawaiian or Other Pacific Islander
5 American Indian or Alaska Native
Or
6 Other [specify]_____
Do not read:
7 Don‘t know / Not sure
9 Refused
11 Hispanic/Latino
12 Mixed/Multi (unspecified)
13 Middle Eastern

8.6 Are you…?

(119)

Please read:
1 Married
2 Divorced
3 Widowed
4 Separated
5 Never married
Or
6 A member of an unmarried couple
Do not read:
9 Refused

8.6A Have you ever served on active duty in the United States Armed Forces, either in the regular military or in a National Guard or military reserve unit?

1 Yes
2 No
9 Refused

8.7 How many children less than 18 years of age live in your household?

(120-121)

_ _ Number of children
88 None **[Go to Q8.8.]**
99 Refused **[Go to Q8.8.]**

8.7AA (If Q8.7 > 1): What is the age of your youngest child? (Read categories.)

1 5 years of younger
2 6 to 11 years old
3 12 years or older
Do not read:
9 Refused / Don't know

C08.7 Children's Health Issues

8.7A (If Q8.7 > 1): Have you ever been told by a health care professional that your child should lose weight?

1 Yes
2 No

8.7B (If yes): What age were they at the time? Under 6, 6 to 10, 11 to 14, or 15 to 18?

(Code all that apply; code only once for each age group even if multiple children in a single age group.)
1 Under 6
2 6 to 10
3 11 to 14
4 15 to 18
7 Don't know / Not sure
9 Refused

Has a doctor or other health care provider ever told you that any child in your household had…? **[8.7C-D]**

8.7C Asthma

1 Yes
2 No
7 Don't know/ Not sure
9 Refused

8.7D Depression/Anxiety problems

1 Yes
2 No
7 Don't know/ Not sure
9 Refused

8.7F Was your youngest child ever breastfed or fed breast milk?

1 Yes **[Go to 8.7G]**
2 No **[Go to next section]**
7 Don't know/ Not sure **[Go to next section]**
9 Refused **[Go to next section]**

8.7G (If yes): How old was [he/she] when [he/she] completely stopped breastfeeding or being fed breast milk? **(Read categories.)**

1 Currently breastfeeding
2 Less than 6 months
3 6 to 12 months
4 More than 12 months
Do not read:
7 Don't know/ Not sure
9 Refused

C08 Demographics (cont'd)

8.8 What is the highest grade or year of school you completed?

(122)

Read only if necessary:
1 Never attended school or only attended kindergarten
2 Grades 1 through 8 (Elementary)
3 Grades 9 through 11 (Some high school)
4 Grade 12 or GED (High school graduate)
5 College 1 year to 3 years (Some college or technical school)
6 College 4 years (College graduate)
7 Graduate-level work or degree (More than 4 years college)
Do not read:
9 Refused / Don't know

8.9 Are you currently…?

(123)

Please read:
1 Employed for wages
2 Self-employed
3 Out of work for more than 1 year
4 Out of work for less than 1 year
5 A Homemaker
6 A Student
7 Retired
Or
8 Unable to work
Do not read:
9 Refused

8.10 Is your annual household income from all sources—

(124-125)

1 Less than $50,000 per year (**Do not read:** $4,166 or less per month/ $961 or less per week)
2 $50,000 to $99,999 per year (**Do not read:** $8,333 – 4,167 per month/ $1,923 – 962 per week)
3 $100,000 to $149,999 per year (**Do not read:** $12,500 – 8,334 per month/ $2,884 – 1,924 per week)
4 $150,000 to $199,999 per year (**Do not read:** $12,501 – 16,666 per month/$2,885 – 3,846 per week)
5 $200,000 or more per year (**Do not read:** $16,667 or more per month/ $3,847 or more per week)
Do not read:
7 Don't know / Not sure
9 Refused
If respondent refuses at ANY income level, code 99 (Refused)

8.11 About how much do you weigh without shoes?

(126-129)

Round fractions up.

_ _ _ _ Weight
(pounds)
7777 Don‘t know / Not sure
9999 Refused

8.12 About how tall are you without shoes?

(130-133)

Round fractions down.

_ _ / _ _ Height
(ft / inches)
77/ 77 Don‘t know / Not sure
99/ 99 Refused

8.12A Have you been advised by your doctor in the last five years to lose weight?

1 Yes
2 No
7 Don’t know / Not sure
9 Refused

8.21A Which of these best describes your home?

Please read:
1 Single-family detached
2 Townhouse
3 Apartment, condo, or other multi-family building
Do not read:
7 Don‘t know / Not sure
9 Refused

8.22A (Ask only in Columbia and Ellicott City planning areas): Do you live on property subject to the Columbia Association assessment?

1 Yes
2 No
7 Don‘t know / Not sure
9 Refused

8.22B (All): Do you currently have a membership with the Columbia Association? **(If yes):** Which one?

Please read:
1 Pools only
2 Club only
3 Golf only
4 Tennis only
5 More than one, or a “package plan”
Do not read:
6 No membership
7 Don‘t know / Not sure
9 Refused

8.22C Please tell me if you strongly agree, somewhat agree, are neutral, somewhat disagree, or strongly agree with this statement. **Howard County General Hospital provides helpful information and a full network of resources to help keep you healthy.**

1 Strongly agree
2 Somewhat agree
3 Neutral
4 Somewhat disagree
5 Strongly disagree
Do not read:
7 Don't know / Not sure
9 Refused

C09 Fruits and Vegetables

These next questions are about the fruits and vegetables **you** ate or drank during the past 7 days. Please think about all forms of fruits and vegetables including cooked or raw, fresh, frozen or canned. Please think about all meals, snacks, and food consumed at home and away from home.

I will be asking how often **you** ate or drank each one: for example, once a day, twice a week, and so forth.

INTERVIEWER NOTE: If respondent responds less than once per week, put "0" times per week. If respondent gives a number without a time frame, ask: "Was that per day or per week?"

9.2R During the past week, not counting juice, how many times did you eat fruit? Count fresh, frozen, or canned fruit.

(156-158)

1 _ _ Per day
2 _ _ Per week
555 Never
777 Don't know / Not sure
999 Refused

Read only if necessary: "Your best guess is fine."

Read only if necessary: "Fruit includes apples, bananas, applesauce, oranges, grapefruit, fruit salad, watermelon, cantaloupe or musk melon, papaya, pomegranates, mangos, grapes, and berries such as blueberries and strawberries, and others."

INTERVIEWER NOTE: Do not count fruit jam, jelly, or fruit preserves. Do not include dried fruit in ready-to-eat cereals. Do include dried raisins, cran-raisins if respondent tells you - *but due to their small serving size they are not included in the prompt.*

Do include cut up fresh, frozen, or canned fruit added to yogurt, cereal, jello, and other meal items. Include culturally and geographically appropriate fruits that are not mentioned.

9.4R During the past week, how many times did you eat vegetables that were not fried? Do not include rice or other grains.

(162-164)

1 _ _ Per day
2 _ _ Per week
555 Never
777 Don't know / Not sure
999 Refused

Read only if necessary: "Your best guess is fine."

INTERVIEWER NOTE: Each time a vegetable is eaten it counts as one time.

Include all raw leafy green salads including spinach, mesclun, romaine lettuce, bok choy, dark green leafy lettuce, dandelions, komatsuna, watercress, and arugula.
Do not include iceberg (head) lettuce if specifically told type of lettuce.
Include all cooked greens including kale, collard greens, choys, turnip greens, mustard greens.

Include all forms of carrots including long or baby-cut. Include carrot-slaw (e.g. shredded carrots with or without other vegetables or fruit). Include all forms of sweet potatoes including baked, mashed, casserole, pie, or sweet potatoes fries. Include all hard-winter squash varieties including acorn, autumn cup, banana, butternut, buttercup, delicate, hubbard, kabocha, and spaghetti squash. Include all forms including soup. Include pumpkin, including pumpkin soup and pie. Do not include pumpkin bars, cake, bread or other grain-based desert-type food containing pumpkin (i.e. similar to banana bars, zucchini bars).

Include corn, peas, tomatoes, okra, beets, cauliflower, bean sprouts, avocado, cucumber, onions, peppers (red, green, yellow, orange); all cabbage including American-style cole-slaw; mushrooms, snow peas, snap peas, broad beans, string, wax-, or pole-beans. Include any form of the vegetable (raw, cooked, canned, or frozen). Do include tomato juice. Include culturally and geographically appropriate vegetables that are not mentioned.

Do not include products consumed usually as condiments including ketchup, salsa, chutney, relish. Do not include rice or other grains.

C10 Physical Activity

The next few questions are about exercise, recreation, or physical activities.

10.1A During the past week, other than your regular job, did you do any physical activities or exercise to raise your heart rate, such as running, golf, swimming, yard work, or walking for exercise?

1 Yes **[Go to Q10.2A]**
2 No **[Go to Q10.1B]**
7 Don't know / Not sure **[Go to Q10.4A]**
9 Refused **[Go to Q10.4A]**

10.1B (if no) [quota=200]: What was the main reason you did not engage in physical activity?

Do not read:
1 Didn't have time
2 No sidewalks/ walking path
3 Didn't have a safe place
4 Area(s) not well lit
5 No access to equipment
6 Another reason **(Specify.)**
7 Don't know/ Not sure
9 Refused
10 Don't need to exercise/Already active
11 Don't like exercise/Lazy/Tired
12 Weather
13 Unable/Disabled
14 Sick

[Go to Q10.4A]

10.2A (If yes in 10.1A): During the past week, how many times did you take part in this activity?
(162-164)

1 _ _ Per week
555 Never **[Go to Q10.4A]**
777 Don‘t know / Not sure
999 Refused **[Go to Q10.4A]**

10.3A Where did you do these activities? **(Code all that apply.)**

Please read:
1 Outside
2 In your home or friend’s home
3 At your housing clubhouse
4 At work
5 At a membership club
6 Or somewhere else **(Specify.)**
Do not read:
7 Don‘t know / Not sure
9 Refused
10 School/Community College
11 Community/Rec/Senior Center
12 Mall
13 Hotel/While traveling
14 Training location/Private rec center
15 Church
16 Healthcare facility/Physical therapy
17 Bowling alley

10.3B And each time you took part in this activity, for how many minutes or hours did you usually keep at it? **(Code either minutes or hours; if over one hour, round to nearest hour.)**

_ _ minutes
_ _ hour(s)
77 Don’t know/ Not sure
99 Refused

10.4A During the past week, did you do physical activities or exercises to STRENGTHEN your muscles? Count activities using your own body weight like yoga, sit-ups or push-ups, or weight machines, free weights, or elastic bands.

1 Yes **[Go to 10.5A]**
2 No **[Go to 10.7A]**
7 Don‘t know / Not sure **[Go to next section]**
9 Refused **[Go to next section]**

10.5A (If yes): During the past week, how many times did you take part in this activity?

Please read:
_ _ Per week
555 Never **[Go to 10.7A]**
777 Don‘t know / Not sure
999 Refused **[Go to 10.7A]**

10.6A Where did you do these activities? **(Code all that apply.)**

Please read:
1 Outside
2 In your home or friend's home
3 At your housing clubhouse
4 At work
5 At a membership club
6 Or somewhere else **(Specify.)**
Do not read:
7 Don't know / Not sure
9 Refused
10 School/Community College
11 Community/Rec/Senior Center
12 Mall
13 Hotel/While traveling
14 Training location/Private rec center
15 Church
16 Healthcare facility/Physical therapy
17 Bowling alley

10.7A In 2018 was your youngest child unable to participate in an organized youth sporting activity, such as a Rec and Parks team, soccer, or another organized youth sports team?

1 Yes, unable to participate
2 No, not unable
7 Don't know / Not Sure
9 Refused

10.7B If your child was unable, why was that? **(Code the 1 best response.)**

Do not read:
1 Lack of time/Did not fit schedule
2 Difficult/Did not know how to sign up
3 Cost too much
4 Lack of transportation/No way to get there
5 No one to take care of my other children
6 Too young to participate
7 Disability
8 Lack of interest
9 Other (Specify.)
77 Don't know / Not sure
99 Refused

C15 Alcohol Consumption

15.1 During the past 30 days, how many days per week or per month did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor?

(209-211)

_ _ Days per week
_ _ Days in past 30 days
777 Don't know / Not sure **[Go to next section]**
888 No drinks in past 30 days **[Go to next section]**
999 Refused **[Go to next section]**

15.3 Considering all types of alcoholic beverages, how many times during the past 30 days did you have **X [CATI X = 5 for men, X = 4 for women]** or more drinks on an occasion?

(214-215)

_ _ Number of times
77 Don‘t know / Not sure
88 None
99 Refused

Sugary Drinks

SD1 How often do you drink regular soda such as Coke Classic, Pepsi, Sprite, or Mountain Dew? Do not include diet soda or seltzer.
READ IF NEEDED: How many sodas do you drink per day, per week, or per month?

_ _ Per day
_ _ Per week
_ _ Per month
555 None / Never / Rarely
777 Don‘t know / Not sure
999 Refused

SD2 How often do you drink sports drinks like Gatorade or Powerade? Do not include diet or low-calorie types.
READ IF NEEDED: How many sports drinks do you drink per day, per week, or per month?

_ _ Per day
_ _ Per week
_ _ Per month
555 None / Never / Rarely
777 Don‘t know / Not sure
999 Refused

SD4 [Ask if number of children entered in Q8.7 > 0] Thinking about your youngest child between the ages of 2 and 18, (pause in case respondent volunteers no children) how often does he or she drink regular, not diet, soda like Coke Classic, Pepsi, Sprite, or Mountain Dew?
READ IF NEEDED: How many sodas does your youngest child between the ages of 2 and 18 drink per day, per week, or per month?

_ _ Per day
_ _ Per week
_ _ Per month
555 None / Never / Rarely
777 Don‘t know / Not sure
999 Refused

SD7 In the last 30 days, have you bought any of the following types of sugar sweetened beverages for your family to drink at home? Regular soda, sports drinks like Gatorade or Powerade, fruit drinks like Capri Sun or Hawaiian Punch, energy drinks, or sweetened teas and waters?

1 Yes
2 No
7 Don‘t know / Not Sure
9 Refused

M12 Breast/ Cervical Cancer Screening

CATI NOTE: If respondent is male, go to the next module.

The next questions are about breast and cervical cancer screening.

(Women age 40 or older):
M12.1. A mammogram is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram?

(339)

1 Yes
2 No **[Go to M12.5]**
7 Don't know / Not sure **[Go to M12.5]**
9 Refused **[Go to M12.5]**

M12.2. How long has it been since you had your last mammogram?

(340)

Read only if necessary:
(Answer categories changed from 2012.)
1 Within the past 2 years (Less than 2 years ago)
2 Between 2 and 5 years (2 years but less than 5 years ago)
3 5 or more years ago
Do not read:
7 Don't know / Not sure
9 Refused

(All women aged 21 to 65):
M12.5. A Pap test is a test for cancer of the cervix. Have you ever had a Pap test?

(343)

1 Yes
2 No **[Go to next eligible question.]**
7 Don't know / Not sure **[Go to next eligible question.]**
9 Refused **[Go to next eligible question.]**

M12.5A When was your last Pap test?

Read only if necessary:
(Revised answer options):
1 Within the past 3 years (Less than 3 years ago)
2 Between 3 and 5 years (3 years but less than 5 years ago)
3 5 or more years ago
Do not read:
7 Don't know / Not sure
9 Refused

M14 Colorectal Cancer Screening

CATI NOTE: If respondent is < 75 years of age, go to next module.

M14.3R. Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since you had your last sigmoidoscopy or colonoscopy?

(358)

Read only if necessary:
(Answer categories changed from 2012.)
1 Within the past 5 years (Less than 5 years ago)
2 Between 5 and 10 years (5 years but less than 10 years ago)
3 10 or more years ago
Do not read:
7 Don't know / Not sure
8 Have never had a sigmoidoscopy or colonoscopy
9 Refused

M16 Secondhand Smoke

The next questions are about exposure to secondhand smoke.

M16.2. Not counting decks, porches, or garages, during the past 7 days, that is, since last **[TODAY'S DAY OF WEEK],** on how many days did **someone other than you** smoke tobacco inside your home while you were at home?

(369-370)

_ _ Number of days [01-07]
00 None
77 Don't know / Not sure
99 Refused

M16.3. During the past 7 days, that is, since last **[TODAY'S DAY OF WEEK],** on how many days did you ride in a vehicle where **someone other than you** was smoking tobacco?

(371-372)

_ _ Number of days [01-07]
00 None
77 Don't know / Not sure
99 Refused

M26 Anxiety and Depression

M26.9. Are you now taking medicine or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem?

(451)

1 Yes
2 No
7 Don't know / Not sure
9 Refused

M28 Social Context

Now, I am going to ask you about several factors that can affect a person‘s health.

M28.0A Within the past 30 days, have you felt emotionally upset, for example angry, sad, or frustrated, as a result of how you were treated based on your race or ethnicity?

1 Yes
2 No
7 Don‘t know / Not sure
9 Refused

M28.1. How often in the past 12 months would you say you were worried or stressed about having enough money to pay vital expenses like your rent, mortgage, or food? Would you say you were worried or stressed…?

(464)

Please read:
1 Always
2 Usually
3 Sometimes
4 Rarely
5 Never
Do not read:
8 Not applicable
7 Don‘t know / Not sure
9 Refused

(Create Split A & B. Ask M28.1C & D of Split A. Ask M28.1E & F of Split B.)
M28.1C (Ask of Split A): Over the last 2 weeks, how often have you been bothered by having little interest or pleasure in doing things? Would you say this happens...

M28.1D (Ask of Split A): Over the last 2 weeks, how often have you been bothered by feeling down, depressed or hopeless? Would you say this happens...

M28.1E (Ask of Split B): Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious or on edge? Would you say this happens...

M28.1F (Ask of Split B): Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying? Would you say this happens...

1 Never
2 For Several Days
3 For more than half the days
4 Nearly every day
Do Not Read:
7 Don’t know / Not sure
9 Refused

Oral Health

ORAL1 How long has it been since you last visited a dentist or a dental clinic for any reason? Include visits to dental specialists, such as orthodontists.

1 Within the past year (anytime less than 12 months ago)
2 Within the past 2 years (1 year but less than 2 years ago)
3 Within the past 5 years (2 years but less than 5 years ago)
4 5 or more years ago
Do Not Read:
7 Don't know / Not sure
8 Never
9 Refused

CATI note: If ORAL1= 8 (Never), go to next section.

ORAL2 During the last 12 months, have you had a dental problem which you would have liked to see a dentist about but you didn't see the dentist?

1 Yes
2 No **[Go to next section]**
7 Don't know / Not sure **[Go to next section]**
9 Refused **[Go to next section]**

ADVANCE CARE PLANNING

ACP1 Advance directives are legal documents that allow you to spell out your decisions about end-of-life care ahead of time. This is not a will by which you dispose of property, but is how you communicate decisions about the type of health care you would like to receive if you are unable to speak for yourself. Do you currently have a signed advance directive?

1 Yes
2 No
7 Don't know/ Not sure
9 Refused

ACP2 A health care agent, often called a "proxy," is the person you trust to act on your behalf in the event you are unable to make health care decisions or communicate your wishes. Health care agents are often named as a part of completing an advance directive. Do you currently have a signed document naming your health care agent?

1 Yes **[Go to ACP3]**
2 No **[Go to next section]**
7 Don't know/ Not sure **[Go to next section]**
9 Refused **[Go to next section]**

ACP3 (If yes): Have you had a conversation with your named agent to communicate your care wishes?

1 Yes
2 No
7 Don't know/ Not sure
9 Refused

OTHER ISSUES

OTH2 Typically, how many hours of sleep do you get in a 24-hour period?

_ _ hours
77 Don't know/ Not sure
99 Refused

OTH4 As a reminder, your responses are kept confidential and not tied back to you personally. In the past 12 months did you or an immediate family member use heroin or any type of opioid that you or they did not have a prescription for, or took more frequently than prescribed on one or more occasions?

INTERVIEWER READS IF NEEDED TO DEFINE OPIOIDS: Opioids include certain painkillers, such as morphine, hydrocodone, and oxycodone; and prescription drugs such as OxyContin, Percocet, and Vicodin.

1 Yes
2 No
7 Don't know / Not sure
9 Refused

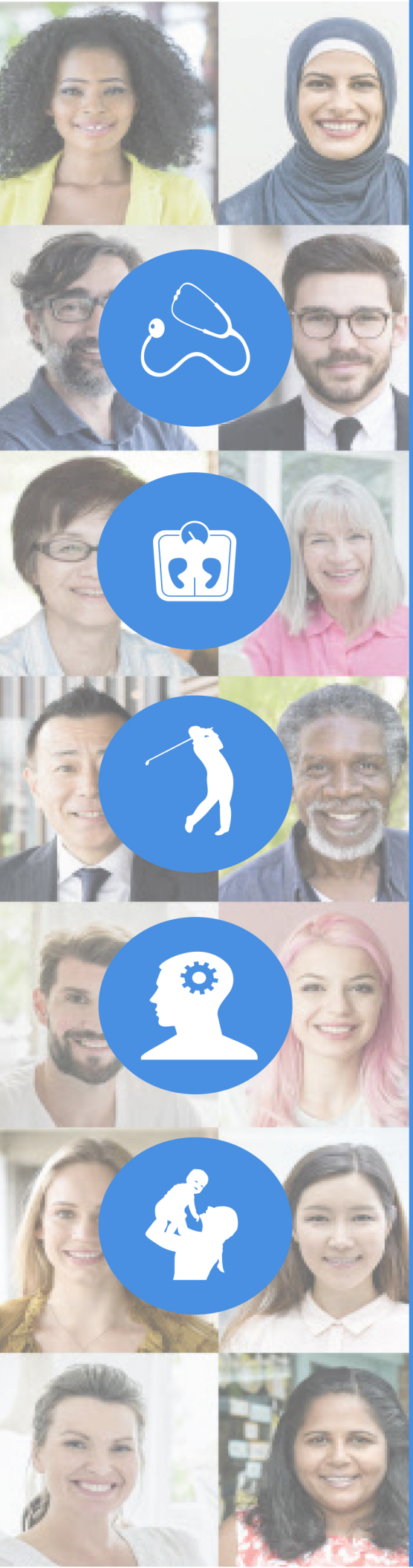
Closing Statement

Please read: That was my last question. Everyone's answers will be combined to give us information about the health practices of people in this county. Thank you very much for your time and cooperation.

Language Indicator

[INTERVIEWER: DO NOT READ THIS TO RESPONDENT.]
LANG1 In what language was this interview completed?

1 English
2 Spanish



2019

HOWARD COUNTY

COMMUNITY HEALTH NEEDS ASSESSMENT

Howard County General Hospital
And
Howard County Health Department

2019 Community Health Needs Assessment

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I. Acknowledgements

The Howard County Community Health Needs Assessment was a joint effort between the Howard County General Hospital Strategic Planning and Population Health departments and the Howard County Health Department's Policy and Planning division. It leverages the work of the Howard County Health Assessment Survey and the expertise of representatives from the Howard County Local Health Improvement Coalition.

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II. Executive Summary

Howard County General Hospital (HCGH) is a private, not-for-profit community hospital serving Howard County, Maryland and its surroundings since 1973. The hospital strives to deliver its mission, "Provide the highest quality care to improve the health of our entire community through innovation, collaboration, service excellence, diversity and a commitment to patient safety," in every patient and community interaction.

The Howard County Health Department (HCHD) is the government agency responsible for improving the health of Howard County residents. The vision of the Howard County Health Department is to create a model community in which health equity and optimal wellness are accessible for all who live, work and visit Howard County. This is achieved through the Department's mission to promote, preserve and protect the health of all in Howard County.

HCGH and HCHD both serve a community that is diverse in the demographics, life stage, and health needs of its population. Howard County has been recognized in local and national press as one of the healthiest counties in the nation, and as a whole has a highly educated and affluent population. The population is growing at a rate over double that of the state and the nation's population. The county is very diverse: 57% of county residents are white, followed by 19.5% Black and 18.9% Asian; 6.8% of residents identify as Hispanic or Latino (United States Census Bureau, 2017). Over one fifth of the residents in the county are foreign born, and one quarter of residents speak a language other than English at home (United States Census Bureau, 2017). Despite the many resources in this community, data show that there are still significant disparities in several social and economic factors affecting the population. While 5.2% of Howard County residents overall fall below the Federal Poverty Level, 10.3% of African American residents and 7.7% of Hispanic residents meet these criteria (United States Census Bureau, 2017). Additionally, 21% of the households in Howard County fall into the ALICE (Asset-Limited, Income Constrained, Employed) category, meaning that many households are categorized as working poor (United Way of Central Maryland, 2016). Housing costs in the county are quite high; 47.1% of renters in the county spend over 30% of their income on rent (United States Census Bureau, 2017).

To understand the needs of the community, HCGH and HCHD, in partnership with the Horizon Foundation, the Columbia Association, and OpinionWorks LLC, surveyed over 2,000 Howard County residents to better understand their health status by asking questions modeled after the Behavioral Risk Factors Surveillance System (BRFSS). This survey has been completed every other year since 2012 and is called the Howard County Health Assessment Survey (HCHAS). HCGH and HCHD also put out a brief community survey, which was completed by 368 residents who commented on their perceptions of greatest community health priorities, social determinants of health, and the hospital's prior Community Health Needs Assessment (CHNA). HCGH and HCHD also reviewed several state and national data sources on Howard County residents' demographics, social, economic, and health status.

Through the primary and secondary data examined, HCGH and HCHD identified five community health priority areas:

1. Access to care
2. Healthy weight
3. Healthy aging
4. Behavioral health
5. Maternal/infant health

These priority areas are similar to the areas identified in the 2016 CHNA, although maternal/infant health is a new priority for this assessment. The assessment describes specific disparities among racial/ethnic groups on metrics in each of these categories.

Using this CHNA, HCGH and HCHD have developed implementation strategies to address the health needs and health disparities in Howard County. Both organizations will build on existing programs that serve the community as well as work to develop new programs in accordance with evidence-based guidelines and practices in their respective areas.

It is important to note that these two organizations will not be able to address all health issues alone, and therefore have partnered with many other mission-driven organizations in the county to deliver programs and services to residents in need. Through these collaborative efforts, Howard County will become a healthier, more prosperous place to live for all of its residents.

III. Introduction

Federal Requirements for Not-for-Profit Hospitals

Section 501(c)(3) of the federal tax code outlines the federal requirements for nonprofit hospitals to qualify for tax-exempt status. The 2010 Patient Protection and Affordable Care Act (ACA) added four basic requirements to this code, including the development of a community health needs assessment (CHNA) every three years in order for a hospital to retain its tax-exempt status as well as an implementation strategy to meet the health needs identified in this assessment (United States Internal Revenue Service, 2018).

The purpose of a community health needs assessment is to identify the top health issues facing the community that the hospital serves and develop a collaborative plan to improve the health of its residents. The implementation strategy will help the hospital plan the best way to deliver community benefits that are targeted toward the highest priority health needs of the population.

About Howard County General Hospital

Howard County General Hospital (HCGH) is a private, not-for-profit, community health care provider, governed by a community-based board of trustees. Opened in 1973, the original 59-bed, short-stay hospital has grown into a comprehensive acute care medical center with 245 licensed beds, specializing in women's and children's services, surgery, cardiology, oncology, orthopedics, gerontology, psychiatry, emergency services and community health education. In June 1998, Howard County General Hospital joined Johns Hopkins Medicine.

Howard County General Hospital cares for its community through the collaborative efforts of a wide range of people. HCGH staff includes more than 1,800 employees. It is the second largest private employer in Howard County and employs nearly 1,000 Howard County residents. A diverse workforce, 51 percent of hospital staff are minorities. The hospital's professional staff is comprised of more than 1,000 physicians and allied health professionals, representing nearly 100 specialties and subspecialties. Ninety-five percent of the physicians are board-certified in their specialty. More than 330 volunteers contributed over 24,000 hours of service in FY 2018, working in all areas of the hospital and the community to support the hospital and its services.

In fiscal year 2018, HCGH provided services to nearly 200,000 people, including evaluation and treatment of over 78,000 patients in the emergency department. There were over 21,000 patients admitted to or observed in the hospital, over 10,500 surgeries performed, and nearly 3,400 babies delivered. In addition to the many hospital-based services, HCGH also provided outpatient services to over 52,000 patients, and reached over 30,000 people in the community through outreach, health promotion, and wellness programs.

About the Howard County Health Department

The Howard County Health Department (HCHD) is the government agency responsible for improving the health of Howard County residents. By State and County authority, HCHD is charged with enforcing specific Federal, State and County laws and regulations as well as providing public health services to Howard County. The vision of the Howard County Health Department is to create a model community in

which health equity and optimal wellness are accessible for all who live, work and visit Howard County. This is achieved through the Department's mission to promote, preserve and protect the health of all in Howard County.

HCHD is comprised of nine Bureaus, each addressing a core public health need in Howard County: Access to Healthcare, Administrative Services, Behavioral Health, Child Health, Clinical Services, Community Health, Environmental Health, Health Promotion, and Policy, Planning & Communications with approximately 200 staff in total. Each of these Bureaus work collaboratively to address needs that exist in the public health landscape of the county. The Health Department collects and analyzes community health data to identify gaps within the community, then identifies evidence-based approaches to implement creative solutions for improving the health and well-being of the community. This includes, but is not limited to, direct outreach efforts to targeted populations, leveraging strong partnerships with other County & non-profit organization, and the expansion of services offered through the Health Department.

From its founding in 1933, through today and onward, the primary focus of the Howard County Health Department has been and will continue to be ensuring the health of all in Howard County.

IV. The Community We Serve

Definition of Community Benefit Service Area

Howard County General Hospital determines its Community Benefit Service Area (CBSA) using the Maryland Health Services Cost Review Commission (HSCRC) Global Budget Revenue agreement, which identifies the top 60% of equivalent case mix-adjusted discharges (ECMADs) from the hospital as the primary service area and the top 80% as the secondary service area.

The zip codes included in the total service area are as follows: 20701, 20723, 20759, 20763, 20777, 20794, 20833, 21029, 21036, 21042, 21043, 21044, 21045, 21046, 21075, 21076, 21104, 21163, 21723, 21737, 21738, 21771, 21784, 21794, and 21797.

The zip codes included herein are primarily contained within Howard County, with a small amount of overlap in shared zip codes with Anne Arundel, Baltimore, Carroll, Frederick, Montgomery, and Prince George's Counties. As such, this report will primarily focus on Howard County data but takes our bordering counties into consideration in our implementation strategy.

Figure 1. HCGH Community Benefit Service Area, Fiscal Year 2018

Source: Johns Hopkins Medicine Business Planning and Market Analysis (2018)

Howard County Overview

Howard County, located between Baltimore and Washington D.C., is a relatively affluent, educated and healthy community. The county is home to urban, suburban, and rural communities. Howard County continues to rank as one of the healthiest counties in the state of Maryland, according to the Robert Wood Johnson Foundation and University of Wisconsin County Health Rankings (2019). Furthermore, Money Magazine has recently ranked two communities in Howard County, Columbia and Ellicott City, in the top five places to live in America due to their diversity and inclusiveness, high-quality schools, educated populace, economic opportunity, and relatively low median home price for the area (Lek, 2016; Ivry, 2018). In 2019, U.S. News and World Report ranked Howard County in the top ten healthiest counties in America. Due to these factors, Howard County is increasing in popularity for young families as well as those aging in place, and the population is growing accordingly.

Population

Howard County is inhabited by 321,113 residents (United States Census Bureau, 2017). The county's population is growing more quickly than both the state and nation's populations; between 2010 and 2017 the county's population grew by 11.8%. The county's population is 51% female (United States Census Bureau, 2017).

Table 1. Population Growth and Median Household Income

	Howard County	Maryland	USA
2010 Total Population	287,129	5,773,807	308,758,105
2017 Total Population	321,113	6,052,117	325,719,178
% Change 2010-2017	11.8%	4.8%	5.5%
Median Household Income	$115,576	$78,916	$57,652

Source: United States Census Bureau (2017)

Between 2017 and 2035, the overall population is estimated to increase by 15% (Maryland Department of Planning, 2013). During the same time period, those age 50 and older will increase by 60.7%, which is more than double the aging rate for the total county population (Maryland Department of Planning, 2013). An estimated 38% of county residents will be 50 or older by 2035 (Maryland Department of Planning, 2013). In the next 5 years alone, the 65 and older population of Howard County, currently making up 13.2% of the county's population, is projected to grow by nearly 25% (IBM Market Expert, 2018).

Ethnic/Racial Diversity

As Howard County grows, it has become increasingly diverse. 57% of the county's residents are white, followed by 19.5% Black and 18.9% Asian. 6.8% of residents identify as Hispanic or Latino (United States Census Bureau, 2017). 20.8% of residents are foreign-born (United States Census Bureau, 2017). 25.2% of the population speaks a language other than English at home (United States Census Bureau, 2017); the most common foreign languages in the county are Spanish, Korean, and Chinese (United States Census Bureau, 2015).

Table 2. Race/Ethnicity

	Howard County	Maryland	USA
White	57.3%	59.0%	76.6%
Black or African American	19.5%	30.8%	13.4%
American Indian and Alaska Native	0.4%	0.6%	1.3%
Asian	18.9%	6.7%	5.8%
Native Hawaiian and Other Pacific Islander	0.1%	0.1%	0.2%
Two or more races	3.7%	2.8%	2.7%
Hispanic or Latino	6.8%	10.1%	18.1%

Source: United States Census Bureau (2017)

Economic Characteristics

The average household size in Howard County is 2.8 persons and the average family size is 3.24 persons (United States Census Bureau, 2017). Howard County overall has a high median household income, but there is significant wealth disparity in the county depending on zip code as well as race/ethnicity. 3.3% of white Howard County residents are below the poverty level, whereas 10.3% of Black or African American residents and 7.7% of Hispanic or Latino residents meet these criteria (United States Census, Bureau, 2017).

Although 5.2% of Howard County residents fall below the Federal Poverty Level, about 21% of households fall into the ALICE category (Asset Limited, Income Constrained, Employed) according to research conducted by the United Way of Central Maryland in 2016. Four percent of Howard County residents are unemployed; therefore, most households which earn below the basic cost of living in the county have jobs (United Way of Central Maryland, 2016). From 2010 to 2016, there has been a steady decrease in households who are able to earn about the basic cost of living in Howard County from 81% to 74%, and inversely there has been an increase in ALICE households from 15% to 21% (United Way of Central Maryland, 2018). When stratified by type of household (e.g. Single or Cohabiting, Families with Children, and 65 and Over), the rates of ALICE threshold and lower incomes are approximately one-quarter of their respective demographic (United Way of Central Maryland, 2018). Across various stages in life and differing family compositions, it appears that affording basic needs is a challenge for one out of every four households in Howard County (United Way of Central Maryland, 2018). Within the county there are disparities by community and zip code, with higher percentages of ALICE households in Columbia, Elkridge, North Laurel, and Savage (United Way of Central Maryland, 2018). For a household of two adults, an infant and a preschool-aged child, a family would need to make $85,800 annually to cover expenses in Howard County (United Way of Central Maryland, 2018).

Median household income varies by race and ethnicity in Howard County. From 2013-2017, the median income in Howard County for all residents was $115,576, and White and Asian households were above

this value at $127,832 and $124,725, respectively (United States Census Bureau, 2017). Black and Hispanic households earned approximately 30% less than the County average at $90,066 and $86,435 respectively (United States Census Bureau, 2017).

Table 3. Percentages Below Poverty Level by Race/Ethnicity

	Less than 100% of the Federal Poverty Level
White	3.3%
Black or African American	10.3%
American Indian and Alaska Native	8.1%
Asian	5.5%
Native Hawaiian and Other Pacific Islander	0.0%
Two or more races	6.6%

Source: United States Census Bureau (2017)

The county is home to several major employers and is also located in close proximity to both Baltimore and Washington D.C., allowing residents to commute to both cities for work. Howard County's unemployment rate in September 2018 was 3.1% (Maryland State Department of Labor, Licensing and Regulation); the unemployment rate has steadily been decreasing from 5.6% since 2010 (United States Department of Labor, 2010-2018).

Table 4. Largest Employers in Howard County

Company Name	Product/Service	# of Employees
Johns Hopkins University Applied Physics Laboratory	R&D systems engineering	5,000
Lorien Health Systems	Nursing care	2,000
Howard County General Hospital	Medical services	1,782
Howard Community College	Higher education	1,438
Verizon	Telecommunications	1,346
Leidos	Engineering services	1,195
MICROS Systems	HQ/software development	1,092
Coastal Sunbelt Produce	Produce processing	1,050

Source: Maryland State Department of Commerce (2015) *(Excludes post offices, state and local governments, national retail and national food service; includes higher education)*

Education

Howard County has a highly educated population. Among residents 25 years and older, 95.3% are high school graduates or higher, with over 60% of the population holding a bachelor's or graduate/professional degree (United States Census Bureau, 2017).

Table 5. Educational Attainment Age 25+

	Howard County	Maryland	USA
Less than High School	2.2%	4.1%	5.4%
Some High School	2.6%	6.1%	7.2%
High School Degree	14.0%	25.1%	27.3%
Some College, no degree	14.4%	19.2%	20.8%
Associate Degree	5.6%	6.5%	8.3%
Bachelor's Degree	30.1%	21.0%	19.1%
Graduate or Professional Degree	31.1%	18.0%	11.8%

Source: United States Census Bureau (2017)

Housing

Housing costs in Howard County are lower than some neighboring communities surrounding Washington D.C., but it is still quite expensive to live in the community. The median home cost in Howard County is $438,000, compared with $282,000 in Maryland and $216,200 in the U.S (Sperling, n.d.). High housing costs are not limited to homeowners in the county; renters also face a high cost to live in the community. 47.1% of Howard County renters spend more than 30% of their income towards paying rent (United States Census Bureau, 2017). This population is vulnerable to continuing to pay a high proportion of their income towards housing in the future that results in what the American Community Survey defines as the "housing-cost burden" (United States Census Bureau, 2017).

Transportation

In 2017, there were 170,322 Howard County residents ages 16 years and over in the workforce (United States Census Bureau, 2017). 81.5% of these workers drove to work alone in a car, truck, or van, resulting in nearly 139,000 single occupant cars, trucks, or vans on the road for commuting purposes (United States Census Bureau, 2017). In addition, 6.1% of Howard County residents carpooled to work, 3.8% of residents used public transportation excluding taxis, and 0.6% walked to work (United States Census Bureau, 2017). 7% of Howard County residents worked at home (United States Census Bureau, 2017).

The average commute time for Howard County residents was 31.9 minutes one way (United States Census Bureau, 2017). This lengthy commute time reflects the fact that many residents travel outside the county, often to Baltimore or Washington, D.C., for their jobs: 57.7% of county residents commute outside the county to work (United States Census Bureau, 2017). Outside of Columbia's downtown core, the county does not offer many public transit options for residents (Regional Transportation Agency of Central Maryland, 2019).

V. Approach and Methodology

The process undertaken to assess gaps in health care services, barriers to care and effectively identifying and prioritizing the health needs of Howard County residents began with collection and analysis of multiple sources of information. The following methodologies were applied: 1) Gather primary data via a community health assessment survey; 2) Review secondary data sources to collect key health information; and 3) Engage key community stakeholders to assess community needs and provide input on areas of focus. The prior CHNA documents offered insights into trends over time in the community.

Primary Data Sources

Results of the 2018 Howard County Health Assessment Survey (HCHAS) were used as the primary data source for this CHNA. This survey has been administered every two years since 2012 and reaches 2,000 participants via land and cellular telephone. Local organizations, including the Horizon Foundation, the Howard County Health Department, Howard County General Hospital, and the Columbia Association, formed an advisory team that jointly commissioned and developed the survey. OpinionWorks, LLC provided the technical aspects of the survey, including recommendations on the precise wording of questions, population sampling, and telephone data collection.

The HCHAS advisory team modeled the survey approach, methodology, and questions after the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS). As residents across the country have been asked many of the same questions, this approach allows results from national studies to be effectively compared against Howard County results. The survey assessed health-related behaviors and risk factors among the adult population of Howard County, Maryland. Results of this study have enabled local government, health providers and stakeholders to measure progress and determine where to focus resources for improved health outcomes particularly focused on reduction of health disparities.

The 2018 HCHAS was administered from May 16th through December 12th of 2018.

Secondary Data Sources

Beyond the survey information collected directly from Howard County residents, broader statistical and demographic data was gathered from a range of secondary sources. This data included socioeconomic information, health statistics, demographics, educational levels, population growth, and more. These data, which include both quantitative and qualitative analyses, were drawn from the following sources: IBM Market Expert, the U.S. Census Bureau, and reports and websites of local, state, and federal agencies, such as the U.S. Census American Community Survey, County Health Rankings, Maryland State Health Improvement Process (SHIP), the United Way ALICE Report, and the Maryland Department of Planning.

Community Input

As a part of the CHNA development process, HCGH and HCHD solicited feedback from the community in multiple ways. HCGH and HCHD posted a short survey to their websites and social media pages, inviting any community member to provide feedback on the previous CHNA and the community health priorities

identified therein. This survey resulted in 368 respondents providing comments and feedback. Please see Appendix III for a transcript of survey questions.

Additionally, HCHD and HCGH engaged the Howard County Local Health Improvement Coalition (LHIC) to discuss the CHNA and HCHAS and provide feedback on the information gathered as well as the health priorities of the prior assessment. Howard County LHIC consists of county agencies, health organizations, businesses, nonprofits, and stakeholders representing varied populations within in Howard County. Please see Appendix II for a detailed list of LHIC active member organizations.

VI. Key Community Priorities

In reviewing the health, economic, social, and community data on Howard County residents, several key priorities rose to prominence. Taking steps to address these issues will help to make Howard County a healthier community for its residents. Throughout each of these areas, there were also notable disparities in both health outcomes and resources based on a resident's racial or ethnic background. This report will identify key disparities, while considering contributing causes, in each of the areas below to enable programmatic offerings to be more focused in specific communities with the greatest need.

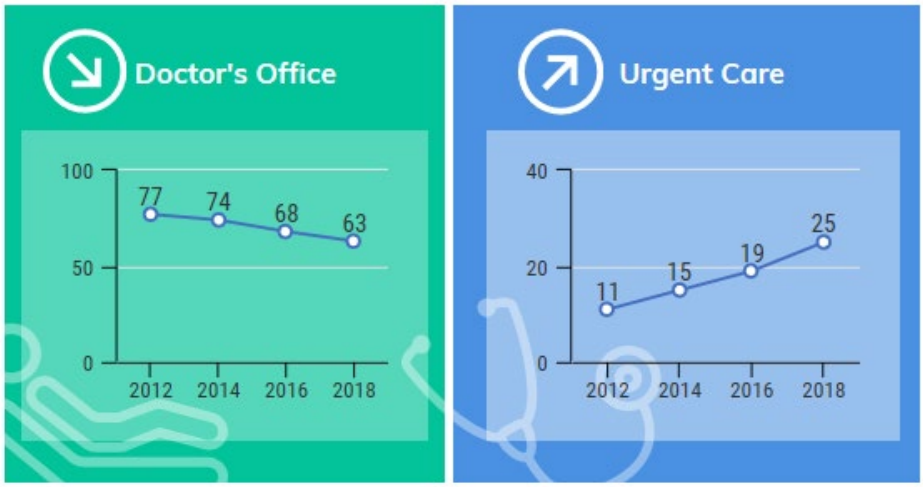
Access to Care

Accessing healthcare services in a timely, affordable, and culturally appropriate way remains a high priority for Howard County residents.

Access to Primary Care

84.9% of Howard County residents had a primary care provider, with some variation amongst different race/ethnicities (Maryland State Health Improvement Process, 2016). The highest group were Hispanic residents at 88.3% and the lowest group was Black Non-Hispanic residents at 81.6% (Maryland State Health Improvement Process, 2016). According to the Howard County Health Assessment Survey, 77% of respondents had one medical provider and 9% had more than one provider, leaving 13% of the population without a routine health care provider (Howard County Health Assessment Survey, 2018). From 2012 to 2018, there has been a decreasing trend in residents' first choice in seeking medical care at a doctor's office from 77% to 63% (Howard County Health Assessment Survey, 2018). At the same time, there has been an increase in seeking medical care at an urgent care setting as a first choice from 11% to 25% (Howard County Health Assessment Survey, 2018). Many residents do seek a primary care appointment for urgent medical needs but are not always able to be seen in a timely way. For those who could not get a doctor's appointment, 8% of residents went to the ER as a result (Howard County Health Assessment Survey, 2018).

Figure 2. First Choice Location for Seeking Medical Care (%)



Source: Howard County Health Assessment Surveys (2012-2018)

Analyses of the physician supply in Howard County indicate a shortage of 80 primary care physicians compared to the needs of the population (Johns Hopkins Medicine Business Planning and Marketing Analysis, 2017). This shortage is due to a number of factors, including population growth in the county, the increased medical needs of the aging population, and projected retirements of community physicians (Johns Hopkins Medicine Planning and Analysis, 2017).

With nearly a tenth of residents not associating with a primary care provider and the decreasing trend of primary care access, the county has a major opportunity to increase access in the primary and preventive care setting.

Health Insurance Coverage and Access to Affordable Care

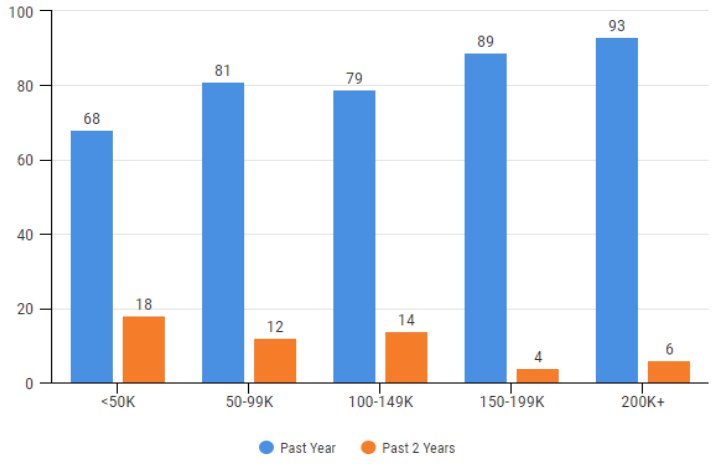
97% of Howard County residents have some form of health insurance: 84.2% with private health insurance and 25.3% with public health coverage, leaving 3% of the population uninsured (United States Census Bureau, 2017). While this insurance rate is high, residents still report challenges in finding providers that accept their insurance or are affordable. In the community survey responding to the prior CHNA, respondents reported that the three most important reasons that people in the community do not get health care are that costs are perceived as too expensive or they could not pay (76.6%), no insurance coverage (44.69%), and their insurance is not accepted (37.9%) (HCGH and HCHD, 2019). In our community survey, 29.4% of residents stated that access to insurance is a top social/environmental concern affecting their healthcare (HCGH and HCHD, 2019).

Access to Dental Care

82% of Howard County residents visited a dentist within the past year, leaving 11% having been seen within the past 2 years and 7% not having seen a dentist over 2 years (Howard County Health Assessment Survey, 2018).

In Howard County, 66.9% of resident children ages 0-20 enrolled in Medicaid received dental care in the past year (Maryland State Health Improvement Process, 2016). 61.9% of White Non-Hispanic children accessed this benefit, the lowest percentage of any of the racial/ethnic groups, with 65.2% of Black Non-Hispanics with the second lowest rate (Maryland State Health Improvement Process, 2016).

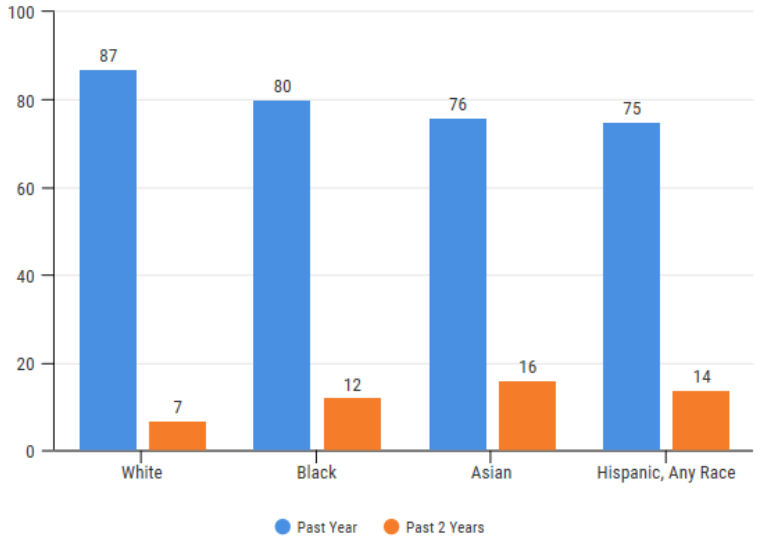
Figure 3. Dental Visit Past 2 Years by Income (%), Howard County, 2018



Source: Howard County Health Assessment Survey (2018)

The highest group to access dental services was Hispanic residents at 84.2% (Maryland State Health Improvement Process, 2016). Many dental services for children enrolled in Medicaid are free of charge through the Maryland Healthy Smiles program, so increased dental care for this population is a major opportunity (Maryland Department of Health, 2017).

Figure 4. Dental Visit Past 2 Years by Race (%), Howard County, 2018



Source: Howard County Health Assessment Survey (2018)

Access to Culturally Competent Care

For residents ages 5 and older in Howard County, 74.2% speak only English, and 25.8% of residents speak a language other than English at home (United States Census Bureau, 2017). According to Census estimates from 2012 to 2016, the most commonly spoken non-English language in Howard County was Spanish at 20.4%, followed by Hindi and related languages at 17.5%, Korean at 14.2% and Chinese at 11.4% (United States Census Bureau, 2017).

6.9% of residents speak English less than "very well"; of these residents, approximately 60% (4.1% of the total population) are those who speak an Asian and Pacific Islander language as their first (United States Census Bureau, 2017). Asian and Pacific Islanders face the largest disparity in English proficiency as compared to other groups. 38.7% of residents ages 5 and older who spoke an Asian and Pacific Island language in Howard County reported speaking English "less than well" as compared to 30.4% Spanish language speakers and 19.5% Indo-European language speakers (United States Census Bureau, 2017).

Culturally competent healthcare and language interpreter services, especially for those whose primary language is Asian and Pacific Islander in origin is needed in Howard County. The disparity for Asian and Pacific Islander speakers is nearly twice of those of Spanish language and Indo-European primary language speakers (United States Census Bureau, 2017). In Howard County, the Asian population has grown from 7.8% in 2000 to 18.8% in 2017-tied with non-Hispanic blacks (United States Census Bureau, 2017). Asians were comprised of 30% Indian in Howard County, the largest nationality within the Asian ethnic group in Howard County (United States Census Bureau, 2017).

Healthy Aging

Howard County's population is aging rapidly, and ensuring that older adults in the community live healthy and productive lives is a high priority.

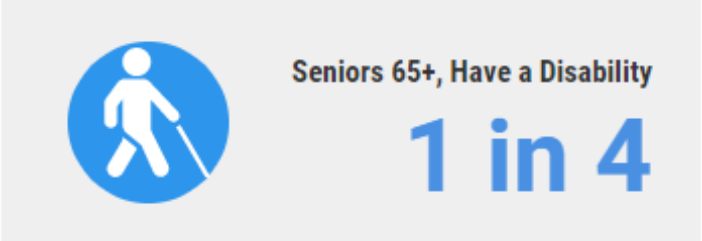
Age-Related Illness and Hospitalizations

From 2015 to 2018, residents 65 years of age and older accounted for 39% of hospital visits at Howard County General Hospital (Howard County General Hospital, 2019). The top hospital diagnoses for this population were sepsis, throat and chest pain, respiratory failure, stroke, and pneumonia (Howard County General Hospital, 2019).

For patients ages 65 and older seen in the HCGH emergency department or admitted to HCGH between 2015 and 2018, 11% had a fall as their primary reason for visit (Howard County General Hospital, 2019). Fall-related deaths in Howard County during 2014 to 2016 was 9.9 per 100,000, higher than the state average 9.4 per 100,000 people (Maryland State Health Improvement Process, 2016). The incidence of fall-related deaths has increased 27% from the 2013 to 2015 measurement period, when the death rate was 7.8 per 100,000 people (Maryland State Health Improvement Process, 2016).

The average rate of hospitalizations due to Alzheimer's and other dementias in Howard County in 2017 was 501.2 per 100,000 residents, slightly lower than the Maryland state average of 515.5 per 100,000 (Maryland State Health Improvement Process, 2017). However, when stratifying the rate based on race/ethnicity, there is a disparity for the Black Non-Hispanic population at 810.4 per 100,000, over three times greater than the lowest group, Asian/Pacific Islander Non-Hispanic residents with a rate of 253.6 per 1000,000 (Maryland State Health Improvement Process, 2017). White Non-Hispanic residents also had a relatively lower rate, nearly half compared to Black Non-Hispanics, at 457.3 per 100,000 (Maryland State Health Improvement Process, 2017). This rate has increased since the initial measurement period in 2008, when the Howard County average rate was 281.4 per 100,000 (Maryland State Health Improvement Process, 2017).

26% of Howard County Residents ages 65 years and older have a disability (United States Census Bureau, 2017).



Healthy aging can be a challenge for households with income limitations. According to ALICE data, 21% of Howard County households age 65 and over are living below the ALICE threshold and above poverty (United Way of Central Maryland, 2016). Additionally, 6% of households are living below the Federal Poverty Line (United Way of Central Maryland, 2016).

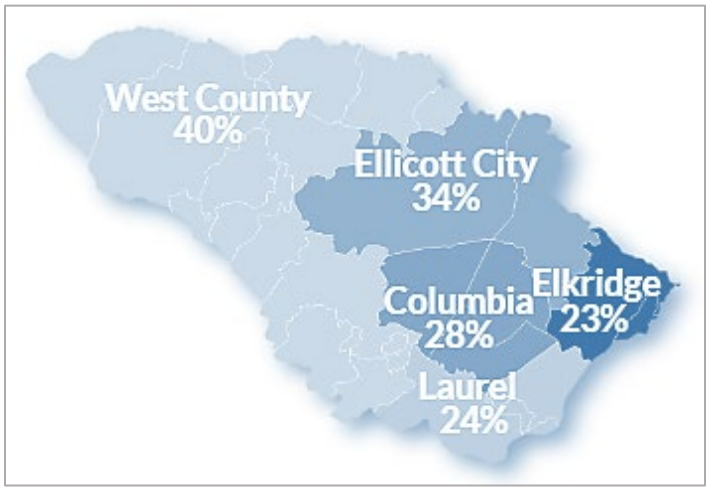
The aging population in Howard County has many complex care needs, both medically and socially, and there is a need for care coordination for those residents with chronic illnesses.

Advance Care Planning

67% of resident adults do not have an Advance Directive (Howard County Health Assessment Survey, 2018). Similarly, 65% of Howard County residents do not have a document naming a healthcare agent or proxy (Howard County Health Assessment Survey, 2018). 90% of residents who have either an advance directive or documented healthcare agent have had a conversation with their named agent on communicating their end of life wishes (Howard County Health Assessment Survey, 2018).

Naming a healthcare agent and having a plan for care preferences ensures that residents receive the care that they prefer throughout their life, but it is vital for patients nearing the end of life when many care decisions are made (Maryland Office of the Attorney General, 2019).

Figure 5. Residents with Advance Directive by County Region



Source: Howard County Health Assessment Survey (2018)

Healthy Weight

Ensuring that Howard County residents reach a healthy weight through proper nutrition and exercise is a key need and has continued to be a priority in our community.

Overweight and Obesity Rates

In 2018, 36% of Howard County residents were advised by their doctor to lose weight within the last five years, a slight increase compared to 32% in 2016 (Howard County Health Assessment Survey, 2018). 48.4% of community survey respondents stated that Overweight/Obesity was a top health priority in Howard County (HCGH and HCHD, 2019).

In 2016, Black Non-Hispanic residents had the highest rate of overweight and obesity (64.1%), compared to White Non-Hispanic and Asian/Pacific Islander residents, 54.8% and 41.3%, respectively (Maryland

State Health Improvement Process, 2016). The overweight and obesity rate had been steadily increasing from 2011 with a 54.8% prevalence to the rate in 2015 at 67.5% (Maryland Health Improvement Process, 2016). However, there was a decrease in 2016, and the rate of overweight and obesity was lowered to 54.3% (Maryland State Health Improvement Process, 2016).

In 2016, childhood obesity rates in Howard County was 6.5%, nearly half of the State average of 12.6% (Maryland State Health Improvement Process, 2016). When divided by race and ethnicity, the highest rate in Howard County was seen in Hispanic children at 11.2%, which exceeded the state goal of 10.7% (Maryland State Health Improvement Process, 2016). Black Non-Hispanic children had a slightly lower rate but still higher than the county average at 10.7% (Maryland State Health Improvement Process, 2016). White Non-Hispanic children and Asian children had a rate lower than the County average, at 4.8% and 3.2%, respectively (Maryland State Health Improvement Process, 2016). The rate of child obesity has dropped from 2014 at 7.5% (Maryland State Health Improvement Process, 2016).

High overweight and obesity rates are also correlated with chronic disease, such as diabetes and hypertension. Howard County overall performs better than the state for emergency department visits related to both diabetes and hypertension, but there is a major disparity on each of these measures for Black Non-Hispanic residents. Among this population, there were 309.8 ED visits related to diabetes per 100,000 people, which is over 2.5 times the county's rate of 119.8 visits per 100,000, and 494.5 ED visits related to hypertension per 100,000 people, also nearly 2.5 times the county rate of 203 visits per 100,000 (Maryland State Health Improvement Process, 2016).

Exercise and Nutrition

Since 2012, the rate of adult residents in Howard County who exercise or engage in physical activity that increases one's heart rate has decreased from 88% to 73% in 2018 (Howard County Health Assessment Survey, 2018). The location where people are exercising has also shifted since 2012, with a decrease in outside location (from 67% to 56% in 2018) and inversely increasing in home location (from 19% to 28% in 2018) (Howard County Health Assessment Survey, 2018). The decrease in outside location aligns with the decrease in membership club attendance of 49% residents engaging in muscle strengthening exercise onsite in 2012 versus 36% in 2018 (Howard County Health Assessment Survey, 2018).

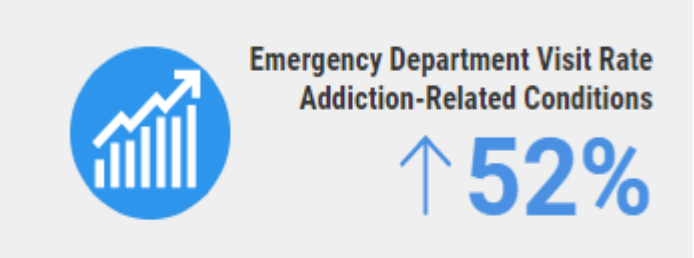
44% of Howard County residents had purchased sugar-sweetened beverages for their family to drink at home in the last 30 days (Howard County Health Assessment Survey, 2018). This represents a decrease from the initial HCHAS survey question in 2014, in which 49% of residents stated they had purchased sugar-sweetened beverages in the past 30 days. However, fruit and vegetable consumption reportedly decreased among county residents. The number of residents responding that they eat vegetables less than once per day or never increased between 2012 and 2018, from 28% to 32%, and those that eat fruit less than once per day or never also increased from 35% to 40% in the same period (Howard County Health Assessment Survey, 2018).

Behavioral Health

Mental health and substance abuse (grouped together in the category of behavioral health) are a top priority across the nation, and Howard County is no exception. Our survey showed the two most important health problems that affect the health of the community as reported by community members were Behavioral/Mental Health (52.45%) and Alcohol/Drug Addiction (50%) (HCGH and HCHD, 2019).

Emergency Department Utilization for Behavioral Health Conditions

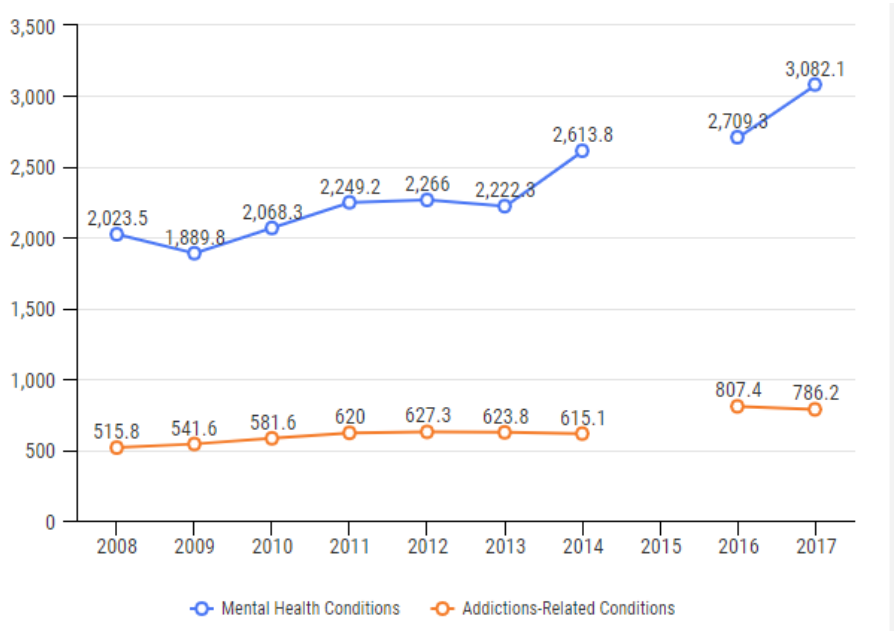
Emergency department visits due to mental health conditions has steadily increased overall in Howard County from a rate of 2023.5 per 100,000 in 2008 to 3082.1 per 100,000 in 2017 (Maryland State Health Improvement Process, 2016). When stratifying by race/ethnicity, there is a disparity in Black Non-Hispanic residents with the highest rate at 4240.1 per 100,000 which is 1.8 times greater than Hispanic residents (2384.8 per 100,000) and 1.4 times greater than White Non-Hispanic residents (3091.8 per 100,000) (Maryland State Health Improvement Process, 2016).



Emergency department visits due to addiction-related conditions has also increased by 52% since 2008, with a rate of 515.8 per 100,000 to 786.2 per 100,000 in 2017 (Maryland State Health Improvement Process, 2017). Black Non-Hispanic residents had the highest rate at 1199.8 per 100,00, a rate that is twice that of Hispanic residents (582.4 per 100,000) and 1.5 times greater than White Non-Hispanic residents (781.6 per 100,000) (Maryland State Health Improvement Process, 2017).

There has been an insufficient number of state-run psychiatric hospital beds in Maryland over the last three decades (Treatment Advocacy Center, 2016). In 1982, there were 4,390 psychiatric hospital beds available, but this was drastically reduced in 2010 to 1,058 beds and further reduced in 2016 to 950 beds. (Treatment Advocacy Center, 2016). Maryland Health Department officials have announced no plans to open psychiatric hospital beds to serve non-court-ordered inmates, emergency room involuntary patients waiting over 30 hours or community patients needing longer-term treatment. (Burton, 2018; Treatment Advocacy Center, 2016). There is a major need in both Howard County and across the state for urgent access to appointments and treatment spaces for behavioral health patients.

Figure 6. Emergency Department Utilization Rates per 100,000 for Behavioral Health Conditions, Howard County, 2008-2017



Source: Maryland State Health Improvement Process (2016) *(Data for 2015 was not available)*

Mental Health

As reported by the 2018 HCHAS, approximately a quarter of Howard County residents reported symptoms of depression and anxiety in varying degrees (Howard County Health Assessment Survey, 2018). 13% of respondents reported taking medication or receiving treatment for mental health conditions in 2018, up from 9% in 2012 (Howard County Health Assessment Survey, 2018). Additionally, 26% of respondents reported that they were usually/always or sometimes worried or stressed about vital expenses (Howard County Health Assessment Survey, 2018).

Table 6: PHQ-4 Responses to 2018 HCHAS

	Nearly every day	More than half the days	For several days	Never	Don't know/Not sure
Having little interest or pleasure in doing things	3%	5%	15%	75%	2%
Feeling down, depressed or hopeless	1%	3%	18%	76%	2%
Feeling nervous, anxious, or on edge	8%	7%	21%	61%	3%
Not being able to stop or control worrying	4%	5%	15%	75%	2%

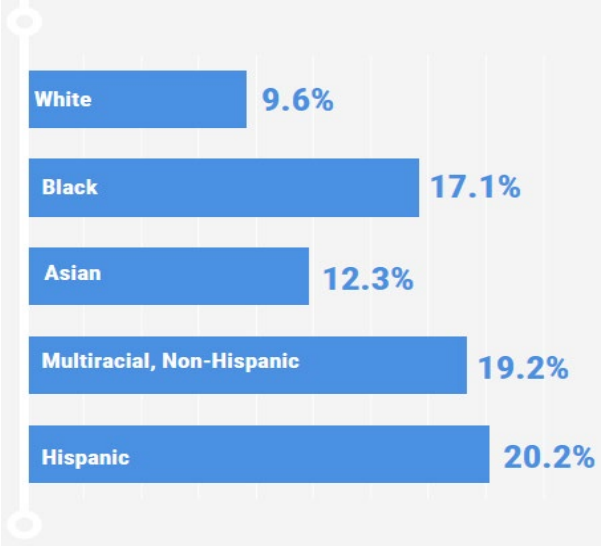
Source: Howard County Health Assessment Survey (2018)

Suicide

Twenty-three suicides occurred amongst youth ages 10-19 in Howard County between 2008 and 2017 (Maryland Vital Statistics Administration, 2008-2017). Between 2014 and 2016, suicide was the leading cause of death for youth ages 15-19 in Howard County (Maryland Vital Statistics, 2014-2016). According to self-reported data, 1 in 6 high school students and 1 in 5 middle school students in Howard County have seriously considered attempting suicide (Centers for Disease Control and Prevention, 2016).

From 2014-2016, suicide in Howard County was at a rate 7.4 per 100,000 population, lower than the state average of 9.2 per 100,000 (Maryland State Health Improvement Process, 2016). The rate has been steadily decreasing since the 2009-2011 measurement period from 9.3 per 100,000 (Maryland State Health Improvement Process, 2016). However, according to the Maryland Youth Risk Behavior Survey, the number of Howard County high school students who seriously considered attempting suicide in the year prior to being surveyed increased from 15% in 2014 to 16.2% in 2016, with a higher percentage of female students (20.5%) compared to male students (11.8%) considering suicide (Maryland Department of Health, 2016). Hispanic/Latino students had the highest reported percentage of students considering suicide at 21.9% (Maryland Department of Health, 2016). 13.8% of students reported that they made a plan about how they would attempt suicide in 2016, which was also up from 11.2% in 2014 (Maryland Department of Health, 2016).

Figure 7. Howard County high school students who made a plan about how they would attempt suicide (% by race), 2016



Source: Maryland Department of Health (2016)

Substance Abuse

In Howard County, the rate of drug-induced deaths is at 12.6 per 100,000 people, which represents a significant increase since 2007. Among white non-Hispanic residents, the rate has nearly doubled, from 10.8 deaths per 100,000 people in 2007 to 20 deaths per 100,000 people in 2016 (Maryland State Health Improvement Process, 2016). In 2017, there were 51 deaths caused by drug- and alcohol-related intoxication 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 non-prescribed drugs in 2017 (Maryland Department of Health, 2017). This was higher than the rate in 2016 (46 deaths) and has been on an overall increasing trend since 2007 (16 deaths) (Maryland Department of Health, 2017).

In 2018, there were 188 opioid related nonfatal overdoses and 38 fatal overdoses (Howard County Police Department). This total of 226 overdoses has increased by four from 2017 at 222 (Howard County Police Department, 2018).

In Howard County, 26% of residents had reported that they had 5 or more drinks for males and 4 or more drinks for females within the last 30 days (Howard County Health Assessment Survey, 2018). Of the 26% who responded, 19.2% had experienced this excess drinking five or more times in a month (Howard County Health Assessment Survey, 2018). In 2018, 71% of residents reported that they refrained from binge drinking (Howard County Health Assessment Survey, 2018). This rate of binge drinkers has increased slightly the past several years compared to 74% of respondents refraining in 2012 and 72% in 2014 (Howard County Health Assessment Survey, 2018).

Maternal and Infant Health

While Howard County overall is a healthy county for families, there are significant disparities in care for expecting mothers and the health of infants among racial/ethnic minorities.

Infant Health

In Howard County, 8.3% of live births in 2017 resulted in a low birth weight (weighing less than 2,500 grams or 5 pounds, 8 ounces), slightly lower than the Maryland state average of 8.9% (Maryland State Health Improvement Process, 2017). However, when stratifying the rate based on race/ethnicity, there is a disparity for the Black Non-Hispanic population at 12.9%, nearly 2.5 times greater than the lowest group, White Non-Hispanic residents with a rate of 5% (Maryland State Health Improvement Process, 2017). Asian/Pacific Islander residents had the second highest rate of low birth weight at 9.4% (Maryland State Health Improvement Process, 2017). The average in 2010 was 7.7% and subsequent years have shown increases in low-birthweight babies in the county (Maryland State Health Improvement Process, 2017).

Howard County also has a disparity in its preterm birth rates: the county's overall preterm birth rate was 9.7% in 2016, but the rate was 9.9% for Black women and 11.2% among Asian women. The disparity is also seen among older women: 10.7% of births among mothers aged 35-39 and 14.6% of births among mothers aged 40 and older were preterm (Howard County Health Department, 2018).

Between 2012 and 2016, the rate of Sudden Unexpected Infant Deaths (SUIDs) in Howard County was 0.63 per 1,000 live births, which was lower than the state average of 0.85 per 1,000 live births (Maryland State Health Improvement Process, 2016). However, the rate of SUIDs in Black Non-Hispanic infants was 2.23 per 1,000 live births (Maryland State Health Improvement Process, 2016). Overall, the rate has increased in Howard County as the past two measurement periods (2010 to 2014 and 2011 to 2015), SUIDs accounted for 0.29 and 0.46 per 100,000 live births, respectively (Maryland State Health Improvement Process, 2016).

Prenatal Care

In 2016, 75% of Howard County pregnant women received care beginning in the first trimester, slightly higher than the State average of 67.8% (Maryland State Health Improvement Process, 2016). When stratified by race/ethnicity, however, only 52.9% of Hispanic expectant mothers received early prenatal care, approximately 15% less than the second lowest group of Black Non-Hispanic pregnant women at 68% (Maryland State Health Improvement Process, 2016). Asian/Pacific Islander Non-Hispanic and White Non-Hispanic pregnant women had rates higher than the County average, 77% and 81%, respectively (Maryland State Health Improvement Process, 2016). The average rate of mothers who received early Prenatal Care in Howard County has steadily increased from 2013 for all races and ethnicities with a County average of 64% (Maryland State Health Improvement Process, 2016).

Other Needs

Although this assessment does not cover every health need of the community, HCGH has a full community health and wellness program addressing a broad spectrum of health conditions and wellness topics to benefit our community. The Health Department also offers many community-facing services that may not be covered in this document. More information on hospital programs can be found in the latest Community Benefit Report completed by the hospital, which is available on the hospital's website. More information on county programs may be found on the Health Department's website.

Table 7. Hospital Programs/Activities Supporting Other Key Health Needs

Health Need	Program and Description	Partners
Smoking Cessation	Quit Tobacco classes	HC Health Department
Health Screenings	Skin Cancer Screening Peripheral Artery Disease Screening Hypertension and BMI screenings	HC Health Department
Diabetes	Pre-Diabetes classes Dietary Counseling Glucose Screening	HC Health Department HC Office on Aging
Chronic Pain	Special Event Lectures (back pain, leg pain)	Various

VII. Implementation Strategy

HCGH and HCHD will work to prioritize initiatives tied to the five community health needs identified in this assessment and will monitor and evaluate progress made over the next three years. The two organizations' commitment to improving the health of the community will be evident through key strategic collaborations focused on community members facing gaps in the areas identified herein. HCGH and HCHD will also provide in-kind and financial support to organizations and initiatives that share our commitment to addressing these priorities.

HCGH's Board of Trustees and executive leadership will ensure alignment of the Hospital's strategic and clinical goals with the five community health improvement initiatives. The implementation plan identifies both hospital-specific strategies and partnership opportunities with key stakeholders that have common goals. Most collaborators are also active member of the LHIC and are already committed to building a healthier Howard County community.

The CHNA findings and corresponding implementation plan have been thoroughly reviewed by HCHD. Alignment with the mission, vision and core values of the Department was assured. The actions and initiatives outlined in the implementation strategy have been approved and adopted by each organization.

Implementation Strategy Action Items appear below.

HCGH and HCHD 2019 Community Health Needs Assessment: Implementation Strategy

Community Health Need Priority Area: Access to Care			
Goal	**Strategies**	**Metrics**	**Partners**
Increase access to care for Howard County Residents	• Participate in school-based telemedicine program for children in Title I elementary schools • Provide consultations for children who are uninsured or do not have regular access to a pediatrician	• Number of children served • Number of children served with Medicaid or uninsured • Return to class rate	• HCGH • HC Health Department • Howard County Public School System
	• Recruit additional primary care providers to practice in Howard County through the Practice Howard program	• Number of providers recruited • Number of new patients seen	• HCGH • Howard County Government • Columbia Medical Practice • Centennial Medical Group • Other community medical practices - TBD

	• Provide education on Medicare for new and existing patients	• Number of classes offered • Number of attendees	• HCGH • HC Office on Aging
	• Provide health screenings and connection to community resources to improve access to care for Hispanic population • Provide in-hospital and online patient education and information in a variety of languages through digital education programs	• Number of attendees to Latino Health Fair • Number of screenings through Journey to Better Health • Number of patients engaged	• HCGH • St. John the Evangelist Roman Catholic Church • FIRN • Priority Partners (Medicaid MCO) • HC Health Department • LHIC
	• Use the HCGH Diversity Council to develop recommendations on increasing cultural competency among providers • Increase patient and family representation on hospital committees	• Recommended interventions • Number of committees with patient/family representatives	• HCGH • Patient Family Advisory Councils
	• Provide transportation to Medicaid patients for their healthcare appointments	• Number of rides provided	• HC Health Department
	• Provide referrals to health insurance connector services so uninsured residents can sign up for coverage	• Number of residents connected to health insurance plans	• Healthcare Access Maryland • HC Health Department • LHIC

Community Health Need Priority Area: Behavioral Health			
Goal	**Strategies**	**Metrics**	**Partners**
Increase timely access to behavioral health services for residents of all ages	• Implement urgent care psychiatric stabilization services with community providers and connect eligible residents to first follow up appointment within two business days. • Establish new partnerships with community behavioral health providers to provide seamless connections to treatment from the acute,	• Number of patients referred • Connection rate	• HCGH • HC Health Department • Local Health Improvement Coalition • Way Station, Inc • Grassroots Crisis Intervention Center

	post-acute, or primary care setting • Provide linkage to care coordination and case management for behavioral health patients • Provide behavioral health navigation services in the HCGH ED		• National Alliance for Mental Illness • The Horizon Foundation • HC Drug Free • On Our Own Howard County
	• Provide Mental Health First Aid and Youth Mental Health First Aid training to community members to expand awareness	• Number of classes • Number of enrollees • Number of enrollees certified at end of course	• HCGH • HC Health Department • Grassroots • LHIC • Business community
	• Expand utilization of Peer Recovery Support Specialists for residents utilizing the emergency department for substance abuse issues	• Number of encounters • Connection rate of referrals to peers	• HCGH • HC Health Department
	• Begin offering medication-assisted treatment inductions in the emergency department for those patients willing to start a treatment regimen	• Number of encounters	• HCGH • HC Health Department • Private treatment providers?
	• Provide Opioid Overdose education and Response Training to community members	• Number of individuals trained	• HC Health Department

Community Health Need Priority Area: Healthy Aging			
Goal	**Strategies**	**Metrics**	**Partners**
Improve the health of older adults living in Howard County and provide comprehensive care coordination for those with	• Implement the Community Care Team to provide comprehensive care coordination services for chronically ill older adults with a focus on addressing social determinants of health	• Number enrolled in community care team • CCT Acceptance Rate • CCT Graduation Rate • Hospital readmissions rate • Potentially Avoidable Utilization	• HCGH • Howard County Office on Aging • HC Health Department • NeighborRide • Community Action Council

chronic conditions			• Village in Howard • Assisted Living Facilities • Home Care Providers • Primary Care Practices
	• Partner with post-acute, primary care, and specialty care providers to facilitate more effective and person-centered transitions of care	• SNF Collaborative meetings • Primary Care Forum meetings	• HCGH • Local Health Improvement Coalition • Lorien Health Systems • Gilchrist Services • Johns Hopkins Home Care • HC Health Department • Howard County Office on Aging • Johns Hopkins SNF Collaborative
	• Ensure that all older adults have identified their care wishes in the form of a completed advance care plan on file at HCGH	• Number of advance directives completed and documented in hospital EHR or CRISP • Number of patients with health care agent identified in EHR • Number of community office hours sessions offered	• HCGH • Horizon Foundation • HC Health Department
	• Provide chronic disease self-management classes for older adults to promote healthy living	• Number of classes offered • Completion rate for enrollees	• HCGH • HC Health Department

	• Implement a home-based primary care program for frail elderly patients	• Number enrolled • Hospital readmission rate	• HCGH • Johns Hopkins Home Care Group • Johns Hopkins Department of Geriatrics • Gilchrist Services

Community Health Need Priority Area: Healthy Weight			
Goal	**Strategies**	**Metrics**	**Partners**
Enable people of all ages and incomes to achieve and maintain a healthy weight	• Implement the Johns Hopkins Healthy Food and Beverage Policy to promote increasing healthy food choices throughout the hospital	• Compliance with policy • Increased discounts for healthy food options	• HCGH • Johns Hopkins Health System
	• Implement a Moveable Feast pilot to provide healthy, medically tailored meals to hospital patients with food insecurity	• Number of patients served • Evaluation of patient pre/post knowledge on nutrition	• HCGH • Moveable Feast
	• Promote healthy food choices and healthy food preparation through nutrition classes and partner events such as cooking demonstrations, community nutrition counseling, and healthy eating-centered events • Serve as pickup site for Roving Radish program	• Number of events • Number of classes • Number of Roving Radish meal kits sold • Number of subsidized meal kits	• HCGH • HC Health Department • Columbia Association • LHIC • The Horizon Foundation • Roving Radish
	• Implement faith- and community-based health initiatives focused on screenings and delivery of evidence-based classes to reduce chronic diseases closely linked to overweight and obesity	• Number of formal partnerships with congregations/faith-based organizations • Number of formal partnerships with community organizations • Number of screenings held • Number of classes held	• HCGH • HC Health Department • The Horizon Foundation • Faith-based organizations • LHIC

		• Measured weight loss for class participants	
	• Support the Howard County bike share program	• Number of bike share trips • Number of active members • Number of occasional members	• HCGH • Howard County Government • The Horizon Foundation
	• Assist in management of walking program in North Laurel and promote community exercise programs hosted by LHIC partnering organizations	• Number of events • Number of participants	• HCGH • HC Health Department • LHIC partner organizations

Community Health Need Priority Area: Maternal/Infant Health			
Goal	**Strategies**	**Metrics**	**Partners**
Improve the sudden unexpected infant death rates in Howard County	• Offer community classes to expectant parents on infant care and newborn health	• Number of classes offered • Number of participants	• HCGH • HC Health Department
	• Promote education on safe infant care to new mothers during their post-delivery hospital stay	• Number of educational videos viewed • Discharge checklists completed	• HCGH
	• Promote Health Department's Safe Sleep program • Develop partnerships with faith-based community to promote safe infant care practices to prevent SUIDs, particularly among African American population	• SUIDs rate • Number of congregations engaged	• HCGH • HC Health Department • Faith-based community
Reduce low birth weight and premature birth	• Offer childbirth classes to prospective mothers, including online courses in English and Spanish	• Number of classes offered • Number of participants	• HCGH

disparity in Howard County	• Offer prenatal information and services at the Latino Health Fair	• Number of participants	• HCGH • Community obstetricians • St. John the Evangelist Roman Catholic Church • FIRN • Priority Partners • Community Obstetricians • HC Health Department
	• Launch a prenatal support group for expectant mothers • Support the Health Department's Family Options program for pregnant teens • Promote the EMPOWER Initiative to reduce preterm deliveries in Howard County	• Number of groups offered • Number of participants	• HCGH • HC Health Department
	• Partner with faith-based communities to provide education and resources to expecting mothers, particularly to Hispanic and African American mothers	• Number of partnerships • Number of classes offered • Number of participants	• HCGH • Faith based community
	• Promote community-based services such as WIC and FQHC services to low-income expectant mothers	• Number of referrals	• HCGH • HC Health Department • WIC • Chase Brexton

VIII. Appendices

Appendix I: Howard County Health Assessment Survey Advisory Committee

The Howard County Health Assessment Survey has been conducted every 2 years beginning in 2012 through 2018. It is funded by the Columbia Association, the Horizon Foundation, Howard County General Hospital, and the Howard County Health Department. OpinionWorks LLC conducts the survey telephonically. The following individuals contributed to the development and oversight of the survey and the administration process:

Organization	Name	Title
Columbia Association	Shawni Paraska	Community Health Director
Horizon Foundation	Tiffany Callender	Program Director
	Glenn Schneider	Chief Program Officer
Howard County General Hospital	Laura Barnett	Director, Strategic Planning
	Elizabeth Edsall Kromm	Vice President, Population Health and Advancement
Howard County Health Department	Felicia Pailen	Director, Policy, Planning, and Communications
	Maura Rossman	Health Officer
Johns Hopkins Health System	Steve Arenberg	Director, Market Research
OpinionWorks, LLC	Steve Raabe	President

Appendix II: LHIC Active Member Organizations

LHIC Active Member Organizations	
AAA Physical Therapy	Howard County General Hospital
AARP® Maryland	Howard County Government
Accessible Resources for Independence	Howard County Health Department
Allergy & Asthma Network	Howard County Library System
Alzheimer's Association® Greater MD Chapter	Howard County Local Children's Board
American Diabetes Association®	Howard County MultiService Center
American Diversity Group	Howard County Office of Transportation
American Foundation for Suicide Prevention Maryland Chapter	Howard County Office of Veterans and Military Families
American Heart Association	Howard County Public School System
Association of Community Services	Howard County Recreation and Parks
BA Auto Care	Humanim
BrightStar Care®	Inquiring Minds, LLC.
Chase Brexton Health Services, Inc.	James Place, Inc.
Collaborative Counseling Center	MAC, Inc.
Columbia Association	Making Change, Inc.
Columbia Medical Practice	MD Chapter of the American Academy of Pediatrics
Columbia Rising, LLC	Maryland Coalition of Families
Community Action Council of Howard County	Maryland Hunger Solutions
Delta Sigma Theta	Maryland University of Integrative Health
Ellicott City Health and Fitness	The Bianca & Hill Group, Merrill Lynch Wealth Management
FIRN	My Life Foundation, Inc.
Giant®	NAMI Howard County
Girls on the Run of Central Maryland	Neighbor Ride
Grassroots Crisis Intervention Center	Nurturing Care at Home
HC DrugFree	One World Healthcare
HealthCare Access Maryland	PFLAG
Health Quality Innovators	Premier Health Express Urgent Care
HomeCentris Healthcare	Resolve MD
Horizon Foundation	Saint Agnes Hospital
Howard Community College	TasteWise Kids
Howard County Board of Health	The ARC of Howard County
Howard County Citizens Association	The Village in Howard
Howard County Commission on Aging	Thunder Soccer Club
Howard County Commission for Veterans and Military Families	Transition Howard County
Howard County Dental Association	UnitedHealthcare® Community Plan
Howard County Department of Community Resources and Services	United Way of Central Maryland
Howard County Department of Fire and Rescue	University of Maryland Extension
Howard County Department of Housing and Community Development	Wellness Nutritional Consultants
Howard County Department of Social Services	We Promote Health
Howard County Economic Development Authority	Winter Growth, Inc
	Y of Central Maryland

Appendix III: Howard County Community Health Needs Assessment Feedback Survey

This survey was posted by the Howard County Health Department and Howard County General Hospital on their social media sites and web pages, as well as shared with residents through email announcements. Responses were collected through SurveyMonkey. The survey was available for three weeks in February and March 2019 and received 368 responses.

Question 1: What are the three (3) most important health problems that affect the health of your community?

1. Alcohol/Drug addiction
2. Alzheimer's/Dementia
3. Behavioral health/Mental illness
4. Cancer
5. Diabetes/High blood sugar
6. Heart disease/Blood pressure
7. HIV/AIDS
8. Infant death
9. Lung disease/Asthma/COPD
10. Overweight/Obesity
11. Smoking/Tobacco use
12. Stroke
13. Don't know
14. Prefer not to answer
15. Other (please specify)

Question 2: What are the three (3) most important social/environmental problems that affect the health of your community? Please check only three.

1. Access to doctor's office
2. Access to healthy foods
3. Access to insurance
4. Child abuse/neglect
5. Domestic violence
6. Housing/homelessness
7. Lack of affordable child care
8. Lack of job opportunities
9. Limited places to exercise
10. Neighborhood safety/violence
11. Poverty
12. Race/ethnicity discrimination
13. School dropout/poor schools
14. Don't know
15. Prefer not to answer
16. Other (please specify)

Question 3: What are the three (3) most important reasons people in your community do not get health care? Please check only three.

1. Cost – too expensive/can't pay
2. Cultural/religious beliefs
3. Insurance not accepted
4. Lack of transportation
5. Language barrier
6. No doctor nearby
7. No insurance
8. Wait is too long
9. Don't know
10. Prefer not to answer
11. Other (please specify)

Question 4: Do you feel that your needs and/or the needs of the community are discussed in the Community Health Needs Assessment (2016 HCGH Community Health Needs Assessment linked)

1. Yes
2. No
3. If not, what would you add? (free text)

Question 5: Do you have any suggestions for improving the Howard County Communtiy Health Needs Assessment?

1. Yes
2. No
3. I don't know
4. If yes, please provide suggestions for improvement (free text)

Question 6: Please provide any comments on the preliminary data provided for the 2019 Howard County Community Health Needs Assessment (Preliminary data from 2019 Howard County Health Assessment Survey linked)

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HOWARD COUNTY

COMMUNITY HEALTH NEEDS ASSESSMENT

2019

Howard County General Hospital and Howard County Health Department both serve a community that is diverse in the demographics, life stage, and health needs of its population. Howard County has been recognized in local and national press as one of the healthiest counties in the nation, and as a whole has a highly educated and affluent population.

Five community health priority areas have been identified to address existing health needs and health disparities:
Access to Care
Healthy Weight
Healthy Aging
Behavioral Health
Maternal and Infant Health

Through collaborative efforts with partner organizations, Howard County will become a healthier, more prosperous place to live for all of its residents.

From: Sue Manning
To: Hilltop HCB Help Account
Cc: Elizabeth Edsall Kromm
Subject: Clarification Required - Howard County General Hospital FY 21 Community Benefit Narrative
Date: Friday, May 27, 2022 11:28:39 AM

Report This Email

Hi,
Yes, it was our intention to indicate a response of "No" in each subsidy category for which "Yes" is not selected for Question 218 on pages 29-30 of HCGH FY21 Community Benefit narrative.

Thank you,
Sue

Sue Manning, MSIE, MBA
Director, Strategic Planning
Howard County General Hospital

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Friday, May 27, 2022 10:39 AM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>; Elizabeth Edsall Kromm <ekromm@jhmi.edu>
Subject: Clarification Required - Howard County General Hospital FY 21 Community Benefit Narrative

Thank you for submitting the FY 2021 Hospital Community Benefit Narrative report for Howard County General Hospital. In reviewing the narrative, we encountered an item that requires clarification:

- For Question 218 on pages 29-30 of the attached, please confirm that your intention was to indicate a response of "No" in each subsidy category for which "Yes" is not selected.

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