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2023

COMMUNITY HEALTH NEEDS ASSESSMENT

DHHS
MONTGOMERY COUNTY
Department of Health and Human Services

Healthy Montgomery
Montgomery County, Maryland

2023

COMMUNITY HEALTH NEEDS ASSESSMENT

of Montgomery County, Maryland

Conducted on behalf of

Healthy Montgomery, Montgomery County's Community Health Improvement Process

Marc Elrich, County Executive

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NOVEMBER 2023

Montgomery County, Maryland, Department of Health and Human Services, Healthy Montgomery. 2023 Community Health Needs Assessment of Montgomery County, Maryland. Rockville, Maryland. 2023.

OFFICIAL SUPPORTERS OF THE CHNA

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HOLY CROSS HEALTH
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MedStar Health

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MONTGOMERY COUNTY
Department of Health and Human Services

MONTGOMERY COUNTY MARYLAND 1776

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Acknowledgments

This report was prepared by Montgomery County Department of Health and Human Services (DHHS), Public Health Services. Many organizations, individuals and residents contributed input on the health issues, needs, barriers, and conditions impacting their communities or the communities they serve to make this project possible. We gratefully acknowledge the contributions of these participants, all of whom confidentially and openly shared with us deep personal challenges and experiences impacting them and their communities. We hope that the contents of this report accurately represent their voices.

Funding for this Community Health Needs Assessment was provided in part by the Montgomery County hospital systems: Adventist HealthCare, Holy Cross Health, MedStar Montgomery Medical Center, and Suburban Hospital, a member of Johns Hopkins Medicine as members of Healthy Montgomery.

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- Healthy Montgomery Steering Committee
- Community Health Needs Assessment Advisory Taskforce

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The data included in the report reflect a continued need for action planning and robust strategies to continue to make Montgomery County the healthiest county in Maryland

MESSAGE FROM: the County Executive

On behalf of the residents of Montgomery County, I am pleased to present the Healthy Montgomery 2023 Community Health Needs Assessment (CHNA) report.

While I am pleased that the data in this report reflect that Montgomery County has healthier outcomes compared to the state of Maryland across a range of indicators, the data included in the report shows a continued need for actionplanning and robust strategies to keep Montgomery County the healthiest county in Maryland. Finding synergy and potential alignment for collective impact can be accomplished by using the information and data compiled in the CHNA report to identify vulnerable populations and areas of focus, recognizing the potential for leveraging existing community resources, building upon existing or potential alignment with community partner CHNA efforts, and employing evidence-based strategies.

The data included in this report will help further guide the County's public health-related efforts to address the health needs of our County and prioritize relevant strategies to address the most prevalent health concerns within Montgomery County.

I would like to thank the Department of Health and Human Services staff, the Healthy Montgomery Steering Committee, County agencies, partner organizations, and our dedicated and engaged residents for their input into the CHNA report and their tireless commitment to promoting health and wellness throughout our community.

Sincerely,

Marc Elrich

MESSAGE FROM: the Department of Health and Human Services Director

I am pleased to present the Healthy Montgomery 2023 Community Health Needs Assessment (CHNA) report. The 2023 CHNA is the third time a needs assessment has been completed by Healthy Montgomery. The current CHNA is a result of collaboration with our interdepartmental and community partners to review progress collectively made on our previous plan and to chart a new course towards community health improvement for the upcoming years.

While Montgomery County has again been ranked as the healthiest county in Maryland in the 2023 annual *County Health Rankings*, we recognize there are still persistent health outcomes that can be improved and health disparities that should be addressed. Responding to the health needs of the community, especially the most vulnerable among us, is core to achieving our mission to promote and ensure the health and safety of the residents of Montgomery County and to build individual and family strength and self-sufficiency. Through the CHNA process, we seek to gain an understanding of these needs to develop holistic approaches to address them.

The overarching goal of the CHNA is to research and analyze current health needs in the county to determine if current programs and services available are meeting the needs of our community, and to determine if there are opportunities for improvement through alignment between the Department of Health and Human Services, other County Departments and agencies, and community partners to achieve the greatest collective impact to benefit residents. Through the CHNA process we seek to gain an understanding of these needs in order to develop holistic approaches to address them through Healthy Montgomery's upcoming Community Health Improvement Plan. This can be accomplished by using the data in the CHNA to identify areas of focus and opportunities, leverage community partner efforts and prioritize and employ evidence-based public health strategies and resources to achieve the greatest impact on the most prevalent health issues affecting our community. This approach also strengthens and advances DHHS' commitment to equity as expressed in our department's equity principles and standards.

I would like to thank Healthy Montgomery and its steering committee, the leadership and staff of Public Health Services, colleagues across Montgomery County Government departments, the local hospitals and other community partner organizations as well as community residents who all provided their input to create the CHNA report.

Sincerely,

James C. Bridgers, Jr., Ph.D., M.B.A.

MESSAGE FROM: the County Health Officer

The Department of Health and Human Services public health programs that serve our community are dedicated to protecting and promoting the health and safety of County residents by monitoring health trends and implementing intervention strategies to contain or prevent disease; fostering public-private partnerships that remove barriers to access to services; developing and implementing programs and strategies to address health needs, and rigorously evaluating the effectiveness of those initiatives.

The purpose of the Community Health Needs Assessment process is to examine the overall health needs of the residents of Montgomery County and identify existing synergies and potential for alignment among the Healthy Montgomery partners for use in the priority setting, action planning, and implementation processes that will take place during the 2023 Community Health Improvement Process (CHIP). The content and format of this CHNA report serve that purpose. Qualitative data gathered from county residents, through a series of community conversations, are reported among the Key Findings and offer residents' perspectives on the assets and challenges in the community that affect health outcomes and include their strategies for improvement. Quantitative public health data and trends, based on the Healthy Montgomery Core Measure Set, describe health outcomes and health inequity among diverse populations in the county.

The data from our qualitative and quantitative research in this CHNA furthers our understanding of the root causes of disparate outcomes and fuels our efforts to continue our successful programs and develop new and effective ones that respond to the health needs of our diverse community. This CHNA report is also a vehicle to share information on our county's health status with our internal and external partners, policy makers and county residents. We hope the CHNA research data will be used by our community partners to inform the development and enhancement of their own programs and to guide their work towards elimination of health disparities in our community.

Sincerely,

Kisha N. Davis

Kisha N. Davis, M.D., M.P.H., FAAFP

MESSAGE FROM: Public Health Services Acting Chief

Dear Community Members, Community Partners, and Friends,

I am pleased to share with you the Montgomery County Department of Health and Human Services' (DHHS) 2023 Community Health Needs Assessment (CHNA) report.

The purpose of the CHNA Report is to identify existing synergies and potential for alignment among the Healthy Montgomery partners for use in the priority setting, action planning, and implementation processes that will take place during the upcoming Community Health Improvement Process (CHIP). Qualitative data gathered from County residents through a series of community conversations, are reported among the Key Findings and offer residents' perspectives on the assets and challenges in the County that affect health outcomes and include their strategies for improvement. Quantitative public health data and trends, based on the Healthy Montgomery Core Measure Set, describe health outcomes and health inequity among diverse populations in the County.

Many health needs were identified through the assessment including the need for increased access to behavioral health, primary and specialty care, oral health, preventive health care and social services as well as better transportation to access medical care among many other needs detailed in the report. We recognize that many County residents experience health disparities and negative health outcomes, and we are committed to addressing these inequities by working together across sectors to achieve health equity for all.

The data from the CHNA report will strengthen our ability to more effectively devise collaborative strategies to identify and address the needs of the vulnerable populations in the community and leverage community resources to identify or create new approaches to promoting health equity.

While the CHNA report positively reflects that Montgomery County has healthier outcomes compared to the state of Maryland, across a range of indicators, the data also reflects the continued need for a proactive plan to further improve the health of County residents. The data from the CHNA report will serve to further guide the County's public health work to prioritize evidence-based strategies to address the most prevalent health concerns within the County.

Many thanks to our dedicated Public Health Services and DHHS staff, Healthy Montgomery, community partners, residents, and other County agencies for their input into the CHNA report and for their dedication to improving and promoting health and wellness in our community.

Sincerely,

Christopher Rogers

Christopher K. Rogers, Ph.D., M.P.H.

MESSAGE FROM:
The Healthy Montgomery Steering Committee Co-Chair on Behalf of Healthy Montgomery

Dear Montgomery County Community Members and Partners,

On behalf of the Healthy Montgomery Steering Committee, I am delighted by the release of the Montgomery County Department of Health and Human Services (DHHS) 2023 Community Health Needs Assessment (CHNA) report.

Healthy Montgomery is the designated Local Health Improvement Coalition (LHIC) for Montgomery County, one of 22 LHICs in the State of Maryland. Each LHIC works to determine and address the specific public health priorities of their jurisdiction.

The Healthy Montgomery Steering Committee includes representation from public agencies, community-based organizations and other stakeholders. The Steering Committee oversees the community health improvement process, which includes community health needs assessment, priority-setting, strategic action planning, and implementation monitoring.

For the first time, this CHNA includes specific data and residents' perspectives on health needs for populations such as:

- Montgomery County's large Agricultural Reserve,
- Our growing aged population,
- Our communities of color,
- Our immigrant residents, and
- Our LGBTQ+ communities.

The 2023 CHNA reflects community member and stakeholder perspectives on the county's most pressing health needs and identifies seventeen specific health priorities. The richness of the data is impressive, made more so given the data and community input was obtained during the pandemic. The 2023 CHNA also includes a look at the needs revealed by the COVID-19 pandemic.

The Healthy Montgomery Steering Committee welcomes all readers to this 2023 CHNA report. This report serves as a strong base from which we, as a community, can proceed with priority setting and action planning.

I am grateful to serve this community through this initiative and it is my hope that you find the report beneficial.

Sincerely,

Leslie Graham, MSHA
Co-Chair Healthy Montgomery Steering Committee
President & CEO, Primary Care Coalition

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Welcome To Our 2023 Community Health Needs Assessment (CHNA) Report

REPORT SUMMARY

Purpose

According to the U.S. Centers for Disease Control and Prevention (CDC), a community health needs assessment (CHNA), also referred to as a community health assessment (CHA), is a state, tribal, local or territorial health assessment that identifies key health needs and issues through a systematic, comprehensive data collection and analysis. The guiding principles of a CHNA include the use of multisector collaborations with stakeholders, a demographic assessment to identify and define the community, conduct a quantitative and qualitative analysis of current health issues, and an appraisal of current efforts and resources to address health care issues. The goal of a CHNA is to develop strategies to address the community's health needs and social determinants of health issues. The CHNA provides research and information to create a Community Health Improvement Plan (CHIP).

This CHNA report details the health and socioeconomic needs of the Montgomery County community as shared from the perspectives of community members and stakeholders.

Definition of Community

A community is a group of people who share an identity-forming narrative.[1] The term embodies a group of people who share a story so important to them that it defines an aspect of who they are. It conveys a sense of togetherness and positivity and speaks both of solidarity and homeliness. Community is about people. People live in multiple communities. With formal and informal institutions, communities are nested within each other.[2] In *The Art of Community: Seven Principles for Belonging*, Vogl defines community as "a group of individuals who share a mutual concern for one another's welfare."[3] To successfully grow a community, one must understand shared values, membership identity, moral proscriptions, and insider understanding.[4]

Definition of Health and Health Equity

The World Health Organization defines health as a state of "complete physical, mental and social well-being and not merely the absence of disease or infirmity".[5] The CDC endorses this definition.[6] Researchers have called for a more inclusive definition of health that works for more people in recent years. The Robert Wood Johnson Foundation's (RWJF) County Health Rankings & Roadmaps defines health as "living long and well. It is where we live, work, learn, and play. It is opportunity—for all of us—to strive and thrive".[7]

It is impossible to discuss health without mentioning health equity. RWJF defines health equity as everyone having a fair and just

opportunity to be as healthy as possible. Achieving health equity means removing obstacles to health such as poverty and discrimination and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[8] Healthy People defines health equity as the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

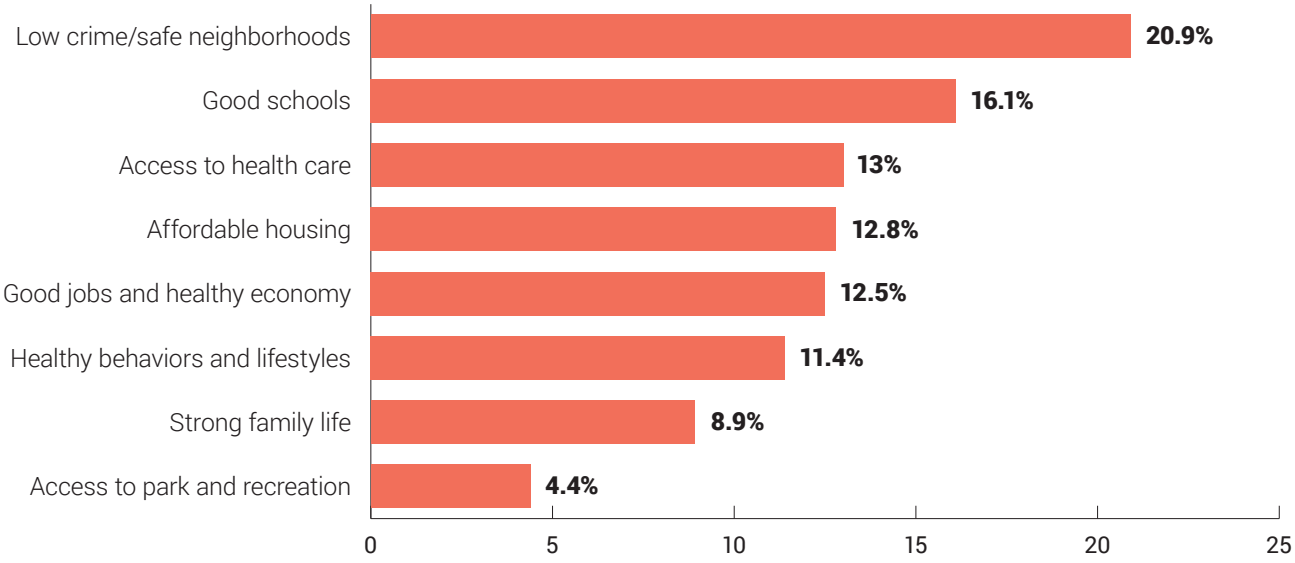
Healthy People 2030 sets data-driven national objectives to improve health and well-being over the next decade.[9] Social determinants of health have a major impact on people's health and well-being and are a key focus of Healthy People. Healthy Montgomery set 2023 goals that are consistent with leading health indicators from Healthy People 2020 and the Maryland Department of Health's State Health Improvement Process across core measures and topic areas that include behavioral health, chronic disease, infectious disease, injury, and maternal and infant health.[10] This includes baseline and proposed measures.

Defining "Healthy Community"

CDC defines a healthy community as "one in which local groups from all parts of the community work together to prevent disease and make healthy living options accessible. Working at the community level to promote healthy living brings the greatest health benefits to the greatest number of people. It also helps to reduce health gaps caused by differences in income, education, race and ethnicity, location and other factors that can affect health. Healthy communities commonly have high vaccination rates to protect citizens from diseases and easy access to medical care and healthy food; are designed for healthy living at home, work, and school; and provide good mental health resources. Often, this also means it is safe and easy to walk, bike, and play in parks and community spaces."[11]

As stated in the Community Tool Box from the Center for Community Health and Development at the University of Kansas, "A healthy community is one in which all systems work well (and work together), and in which all citizens enjoy a good quality of life. This means that the health of the community is affected by the social determinants of health and development – the factors that influence individual and community health and development."[12]

FIGURE 1. **Most Important Factors that Make Up a Healthy Community**



Based on the 2022 community health needs survey, Montgomery County residents selected low crime/safe neighborhoods, good schools, access to health care and affordable housing as the most important factors that make up a healthy community (Figure 1).

Assessment Process and Methods

PUBLIC HEALTH SERVICES (PHS) FOUR LENSES

PHS is guided by its 2020 strategic plan which is broadly conceptualized through four "lenses." PHS' four "lenses" are in alignment with Department of Health and Human Services' Roadmap of 2016-2019. DHHS' Roadmap has four strategic foci that guide development of goals and objectives for the Department and its Service Areas. These four "lenses" require that PHS:

- Develop and implement strategies that are evidence-based and data driven;
- Effectively address the social determinants of health and root causes that impact health;
- Promote access to care for all county residents and implement a Health-in-All-Policies approach through strong collaborative relationships; and
- Ensure equity in planning, policy, health promotion and practice, and an equity focused workforce that delivers equitable services.

Table 1 below provides a crosswalk between the DHHS Roadmap of 2016-19, which had four foci (shown below), and the PHS Strategic Plan's four "lenses" and current goals/objectives.

TABLE 1. Crosswalk between the DHHS Roadmap and the PHS Strategic Plan's Four Lenses.

DHHS ROADMAP		PUBLIC HEALTH SERVICES' FOUR LENSES
Effective and Equitable Service Delivery	⟷	**Evidence-based and data-driven strategies** are employed to develop new initiatives, scale up pilot projects, and enhance service delivery in a targeted manner within geographic or population parameters.
Service Delivery Transformation	⟷	**Social Determinants:** An integrated, technology-enhanced service delivery system which leverages opportunities to deliver "wrap-around" health and social services in a manner that addresses the social determinants and root causes of poor health.
Strong, Collaborative Relationships	⟷	Public Health assumes a leadership role in Healthy Montgomery, a multi-sector county-wide effort that engages governmental, non- profit, and private sectors to collectively impact health and well-being of the county's residents. PHS' strategic goals employ a Health-in-All-Policies approach through **collaborative relationships**.
Capable and Engaged Workforce	⟷	The **PHS workforce** is actively engaged in equity-focused training, planning, developing, and evaluating program performance to promote racial equity and ensure **equitable service delivery**.

CONCEPTUAL FRAMEWORK

The qualitative and quantitative assessment was guided by the Robert Wood Johnson Foundation's County Health Rankings Model.[13] In this model, interrelated individual, environmental and community modifiable health factors and health policies and community programs influence health outcomes (length of life and quality of life). This conceptual model was selected for this CHNA because it details the importance of the impact that modifiable health factors have on population health outcomes. The County Health Rankings Model divides health factors into four components: health behaviors, clinical care, social and economic factors, and physical (built) environment. To capture the impact demographics have on health outcomes, we add a demographic category to the social and economic factors domain. Each component also comprises one or more subcomponents, which are defined by one or more indicators from numerous data sources.

QUALITATIVE OVERVIEW

The purpose of the qualitative component of the CHNA was to gather thoughts and perspectives from community members and key community

stakeholders on the local environment, to identify the most pressing needs of the community, and to prioritize significant health needs of the Montgomery County community over the next several years. The qualitative component of the CHNA used a Community-Based Participatory Research (CBPR) approach in that our unit of analysis for this CHNA were the geographic and demographic communities throughout Montgomery County, which we broke down into subpopulations to detect disparities in health outcomes between groups. In addition, we facilitated collaborative partnerships with the CHNA Advisory Committee, community members, patients, and families around assessing and addressing community needs. The focus groups were with community members and the key informant interviews were with health care experts, social-service organizations, and medical personnel in group interviews that helped guide the focus of the prioritized needs, strategies selected to address them, and the implementation and evaluation of the intervention. Data analysis and theme development was guided by Rapid Identification of Themes from Audio (RITA) method.

QUANTITATIVE OVERVIEW

Assessment and surveillance make up one of the foundational public health services and serve as a cornerstone of a CHNA. The quantitative component of the CHNA used primary and secondary data to assess and monitor population health. In 2022, DHHS contracted with Westat to implement a mail-in survey assessing community health needs for adults aged 18 and older living in the county. The primary quantitative data collection was designed to assess community health needs and complement findings from the secondary quantitative data collection findings from vital records and hospitalization data, as well as qualitative data collected from key informant interviews and focus groups meetings. Findings from the mail-in survey and the secondary quantitative data analysis of the Healthy Montgomery core measures and other health indicators are summarized and publicly available on the Healthy Montgomery website and the DHHS website.[14,15] The Office of Health Planning and Epidemiology also reviewed community health indicators of interest and compared the most recent available data between Montgomery County and the state of Maryland.

Identifying Significant Health Needs

Analysis of primary and secondary data was conducted to identify and categorize into themes the significant health needs of Montgomery County. The Healthy Montgomery team first met to review available quantitative and qualitative data and to categorize it into ***a priori*** themes using the conceptual frame as a guide. The CHNA Advisory Committee also met to validate and identify new ***a priori*** themes used to categorize the qualitative and quantitative data. Additionally, an inductive approach was undertaken by the Healthy Montgomery team to derive meaning and create themes from data without any preconceptions or without an idea of what themes would emerge, and thus allow themes to be determined by the data – to emerge from the data.

LIST OF SIGNIFICANT HEALTH NEEDS

The following significant health needs were identified using the ***a priori*** and emerging themes. The significant health needs are listed in alphabetical order.

- Access to Behavioral Health, and Substance Use Disorder Services
- Access to Human Services' Needs, Such as Education, Income, Housing, Employment, Food, and Personal Social Services
- Access to Parks, Public Spaces, Wellness, and Recreation
- Access to Quality Dental Health Services
- Access to Quality Primary Care Health Services
- Access to Specialty and Extended Care
- Access to Technology
- Access to Transportation

- Active Living and Healthy and Nutritious Eating
- Cultural and Language Competence
- Environmental Health
- Health and Human Services' System Navigation
- Injury and Disease Prevention and Management
- Maternal and Early Childhood Health
- Pedestrian Safety
- Safe and Violence-Free Environment
- Social Associations and Community Connectiveness
- Waste Management

Organization of This Report

The Montgomery County CHNA is organized into 16 sections. Prior to outlining findings, readers gain a better understanding of the Montgomery County community and the population served.

The subsequent section of the report presents the list of significant health needs. The thematic list of significant health needs emerged from an analysis of all the primary and secondary data collected from the participants.

The next sections present results from a subgroup analysis of the primary and secondary data. This report is purposeful in sharing the lived experiences of health care and describing the health status of key Montgomery County subgroups, some of which are disproportionately impacted groups of individuals. Presenting subgroup analyses allows readers and users of the CHNA to gain deeper

insights into the unique health needs, issues, and challenges of specific communities across Montgomery County's diverse population.

The report concludes with a list of potential resources that meet the health needs of community members. The report is organized in a practical way for the reader to gain a full understanding of the structure and significant health needs of Montgomery County, while also finding relevant resources for health topics.

Conclusion

This CHNA report details the health and socioeconomic needs of the Montgomery County community as shared from the perspectives of community members and stakeholders. This CHNA is part of a collaborative partnership between the Healthy Montgomery Steering Committee, CHNA Advisory Committee, Montgomery County Government, and community stakeholders. This CHNA report provides an overall examination of the health disparities and health inequities being experienced by community members living throughout Montgomery County. Available at the end of this report is a list of Montgomery County resources available to potentially meet significant health needs. This report provides an inclusive profile to guide Healthy Montgomery in identifying priorities as part of the community health improvement cycle.

INTRODUCTION AND PURPOSE

Developed in 2001, the National Association of County and City Health Officials (NACCHO's) Mobilizing for Action through Planning and Partnerships (MAPP) framework is now one of the most widely used and reputable community health improvement (CHI) frameworks in the field. MAPP is a community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them.

The following report provides a structure for communities to assess their most pressing population health issues and align resources across sectors for strategic action. It emphasizes the integral role of broad stakeholders and community engagement; the need for policy, systems, and environmental change; and alignment of community resources toward shared goals. The process results in a CHNA and a CHIP.[16] Montgomery County's CHNA follows the MAPP framework. It serves as a foundation for collaboration, priority setting, planning, program development, funding applications, coordination of resources, and new ways to collaboratively use assets and resources to improve population health.[17]

FINDINGS – MONTGOMERY COUNTY

Significant Health Needs

This section distinguishes the most pressing community health needs based on the data collected. Primary and secondary qualitative and quantitative data were analyzed to identify significant health needs for Montgomery County. We categorized the significant health needs based on the ***a priori*** and emerging themes. Where qualitative interviews were observed to have the same subthemes coming out, repeatedly as a health need, issue, or barrier, then the subtheme was elevated and reported in the table below each of the significant health needs. Quantitative indicators from primary data/survey that were mostly reported by respondents as health needs, issues, or barriers were elevated and reported in the table below each of the significant health needs. The quantitative indicators from secondary data that performed poorly when compared to state benchmarks are also listed in the table below each of the significant health needs. Data to support the quantitative indicators in this section are derived from Tables 13-18 of this report, the Population Health Surveillance Report (2010-2019), the 2022 Health Survey Report, and the Healthy Montgomery Core Measures (see Appendix for access to full reports). To identify which subpopulations are experiencing one or more significant health needs, see subgroup findings in the subsequent sections of this report. The significant health needs are listed below in alphabetical order. The list of significant health needs will be used to inform the prioritization process which is a key step in the health planning process, enabling the identification of priority problems to intervene in a given community at a given time.

Access to Behavioral Health and Substance-Use Disorder Services

Good mental health is vital for achieving optimal health. Substance use disorders, depressive disorders, feeling socially isolated and associated stigmas can have a negative consequence on health, sometimes resulting in suicide.[2] Access to mental, behavioral, and substance use services can have profound positive effects for a person's emotional, psychological, and social well-being and is key to a healthy community.

> "Access to mental health care is critical, we have lost so many family members.

QUALITATIVE THEMES	QUANTITATIVE INDICATORS	MONTGOMERY COUNTY	TREND DIRECTION OVER TIME	LATEST YEAR OF DATA
SUBSTANCE USE DISORDER				
• Excessive alcohol use • Marijuana addiction and use • Drug use and addiction • Use of opioids, specifically fentanyl	Drug induced mortality[1]	14.3 / 100,000	Increasing	2020
	Substance use disorder related to ER visit rate[1]	414.82 / 100,000	Decreasing	2020
MENTAL/BEHAVIORAL HEALTH				
• Depression • Anxiety • Stress • Suicides among youth • Loneliness and social isolation • Stigma preventing seeking mental health services	Mental health ER visits per 100,000[1]	994 / 100,000	Decreasing	2020
	Age-adjusted average number of mentally unhealthy days reported in past 30 days[2]	4	–	2020
	Age-adjusted average number of physically unhealthy days reported in past 30 days[2]	2	–	2020
	Suicide mortality[3]	7.2 / 100,000	Fluctuating	2020
	Suicide-related hospitalization[3]	45.8 / 100,000	Decreasing	2019
	Suicide-related ER visits[3]	356.4 / 100,000	Decreasing	2019

[1] *https://health.gov/healthypeople/priority-areas/social-determinants-health*
[2] *https://www.mentalhealth.gov/basics/what-is-mental-health*

MENTAL/BEHAVIORAL HEALTH CARE				
• Lack of mental health insurance and substance use benefits • Lack of mental health providers to meet the needs of the community • Mental health facilities not accepting new patients	Portion of the county that falls within a Health Professional Shortage Area[1]	Gaithersburg, Germantown, Southeast Montgomery, Central Kensington, Wheaton	–	2022
	Ratio of Population to Mental Health Providers[1]	260:1	–	2022
RECOMMENDATIONS FROM COMMUNITY				
• Need more affordable drug rehabilitation programs • Need more affordable alcohol rehabilitation programs	–	–	–	–

The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.

1. Data Source: ***Healthy Montgomery Core Measures***

2. Data Source: ***https://www.countyhealthrankings.org/explore-health-rankings/maryland/montgomery?year=2023***

3. Data Source: ***Maryland Department of Health MD-IBIS – Maryland's Public Heath Data Resource***

Access to Human Services' Needs, Such as Education, Income, Housing, Employment, Food, and Personal Social Services

Access to education, income, housing, employment, food, and personal social services such as in-home supportive services are vital for achieving optimal health. Research has demonstrated that the social determinants of health contribute to a wide range of health disparities and inequalities resulting in poorer health outcomes.[1] Without access to good human services to meet basic needs, communities cannot experience thriving and healthy lives.

QUALITATIVE THEMES	QUANTITATIVE INDICATORS	MONTGOMERY COUNTY	TREND DIRECTION OVER TIME	LATEST YEAR OF DATA
HOUSING				
• High cost of living in the area • High cost of rental housing • Unsafe housing conditions • Limited availability of affordable, low or moderately, priced housing • Increasing number of people who are experiencing homelessness • Housing overcrowding • Homeownership opportunities and information	Percentage of households with overcrowding or high housing costs[1]	17%	Increasing	2019
	Percentage of households that spend 50% of or more of their household income on housing[1]	14%	–	2021
EMPLOYMENT				
• Need more employment supports and services	Unemployment rate[1]	5.5%	Decreasing	2021
INCOME				
• Low wages/income necessary to meet basic needs • Income inequality and poverty • Not enough money to buy healthy foods to eat	Median household income defined by Census[1]	$112,400	Increasing	2021
	Percentage of children under age 18 in poverty[1]	11%	Increasing	2021
	Percentage of population that is low income and does not live close to a grocery store[1]	2%	Stable	2019

[1] *https://health.gov/healthypeople/priority-areas/social-determinants-health*

EDUCATION				
• High costs of college/higher education	Percent of individuals with college degree or higher[1]	59.8%	Stable	2021
	Percentage of population not having high school diploma[1]	8.64%	Stable	2020
DEMOGRAPHICS				
• Fear of reprisal keeping immigrants from accessing necessary social services	–	–	–	–
RECOMMENDATIONS FROM COMMUNITY				
• Need more investment in early childhood education • Need more access to stores and markets to buy healthy foods • Need more accessible homeless shelters • Need more financial literacy education classes and workshops • In-home services that help older adults • Offer legal assistance	– 			

The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.

1. Data Source: ***https://www.countyhealthrankings.org/explore-health-rankings/maryland/montgomery?year=2023***

[1] ***https://health.gov/healthypeople/priority-areas/social-determinants-health***

Access to Parks, Public Spaces, Wellness, and Recreation

Access to parks, public spaces, wellness, and recreation affords an environment where people are more likely to engage in physical activity. Inequitable access to structures in the built environment like parks and recreational facilities are associated with higher prevalence of chronic diseases in communities.[34] Considerations for critical access to places that promote wellness such as parks, public spaces, and recreation, encourages community residents to participate in physical activity.

QUALITATIVE THEMES	QUANTITATIVE INDICATORS	MONTGOMERY COUNTY	TREND DIRECTION OVER TIME	LATEST YEAR OF DATA
WELLNESS AND PHYSICAL ACTIVITY				
• Physical inactivity	Age-adjusted average number of physically unhealthy days reported in past 30 days[1]	2	Decreasing	2020
	Percentage of adults reporting body mass index (BMI) of 30 or more[1]	26.5%	Decreasing	2021
	Percentage of adults 20 and older with no reported leisure-time physical activity[1]	17.6%	Increasing	2021
ACCESS				
• Lack of publicly accessible and low-cost or free fitness centers, gyms, and sports fields	Percentage of population that is low income and does not live close to a grocery store[1]	2%	Stable	2019
	Percentage of population with adequate access to locations for physical activity[1]	100%	Stable	2022

RECOMMENDATIONS FROM COMMUNITY				
• Need for more outdoor exercise equipment in parks and/or playgrounds • Need more low-cost or free community organized youth recreational activities • More green spaces needed • Need more activities for children with special needs • More accessible parks needed	–	–	–	–

The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.

1. Data Source: ***https://www.countyhealthrankings.org/explore-health-rankings/maryland/montgomery?year=2023***

There are limitations in the measurements of access to locations for physical activity, including parks and recreational facilities. The calculation of access to parks could be overestimated as it does not account for potential barriers to access parklands, such as limited entrance locations and comp lex street networks. Also, the recreational facilities include locations that may charge users for fees, which could also lead to overestimation in access to physical activity opportunities. Please visit the **County Health Rankings & Roadmaps website** *for more details about the data and methodology.*

Access to Quality Dental Health Services

Regular dental care is an important aspect of optimal health. Disparities in oral health reflect unequal opportunities to be healthy, impacting a person's ability to thrive.[5] Trouble accessing appropriate dental care for routine teeth cleanings, to seal teeth, to prevent tooth decay, or to treat dental caries and other oral diseases is associated with poor health outcomes.[6] Increasing the number of dental providers is critical to expanding access to dental care. When communities have access to dental care, the residents are more likely to experience good physical, emotional, psychological, and social well-being.

QUALITATIVE THEMES	QUANTITATIVE INDICATORS	MONTGOMERY COUNTY	TREND DIRECTION OVER TIME	LATEST YEAR OF DATA
ACCESS				
• Long travel time to dental care services	Portion of the county that falls within a Health Professional Shortage Area (HPSA)[1]	Gaithersburg, Germantown, Southeast Montgomery, Central Kensington, Wheaton	–	2022
	Ratio of population to dentists[1]	790:1	–	2021
COST				
• Lack of access to affordable dental care • High cost of dental care	Ratio of population to dentists[1]	790:1	–	2021
RECOMMENDATIONS FROM COMMUNITY				
• Need more mobile dental services	–	–	–	–

The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.

1. Data Source: ***https://www.countyhealthrankings.org/explore-health-rankings/maryland/montgomery?year=2023***

[5] ***https://www.cdc.gov/oralhealth/oral_health_disparities/index.htm***
[6] ***https://www.cdc.gov/nchs/fastats/dental.htm***

Access to Quality Primary Care Health Services

Primary care services are the first line of defense to prevent and treat common diseases and injuries in a community. Primary care resources include community health clinics, mobile health clinics, medications, primary care providers, and similar. Determinants that integrate supply and demand-side factors and enabling the operationalization of access to care include health insurance, transportation, health literacy, language and culture, and similar. Communities where individuals have limited access to care are more likely to experience poorer quality of life and length of life.

QUALITATIVE THEMES	QUANTITATIVE INDICATORS	MONTGOMERY COUNTY	TREND DIRECTION OVER TIME	LATEST YEAR OF DATA
ACCESS				
• Long wait times for health care services • Lack of access to health care services • Lack of access to an urgent care center • Lack of access to home health care services • Lack of access to health insurance • Barriers to prevention-related health care seeking and engagement • Poor proximity and availability of health care facilities • Limited hours of operation for health care services • Limited benefit health insurance plans • Need more access to medications • Health literacy barriers • Lack of transportation affecting access to primary care	Percent of individuals without health insurance[1]	7%	Decreasing	2020
	Population/PCP ratio[2]	720:1	–	2020
	Portion of the county that falls within a Health Professional Shortage Area (HPSA)[1]	Gaithersburg, Germantown, Southeast Montgomery, Central Kensington, Wheaton	–	2022
	Language/cultural barrier[3]	4.7%	–	2022
	Transportation barrier[3]	4.5%	–	2022
	Length of time since last visited a doctor or healthcare provider[3]	5 or more years ago: 5.8% Within the past 2-5 years: 17.8% Within the past year: 76.4%	–	2022

ACCESS continued				
	Percentage of persons who identify that they have a personal doctor or healthcare provider[3]	75.9%	–	2022
	Percentage of individuals without a PCP[3]	24.1%	–	2022
COST				
• High cost of health care (out-of-pocket costs) • High cost of prescription drugs	Amount of Medicare spending per enrollee	$9,764	–	2021
RECOMMENDATIONS FROM COMMUNITY				
• Need more free mobile health clinics • Need more free or low-cost community health clinics • Need more access to primary care providers • Need more holistic - mind, body, and spirit - health care • Need better patient-provider relationships	–	–	–	–

The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.

1. Data Source: ***https://www.countyhealthrankings.org/explore-health-rankings/maryland/montgomery?year=2023***

2. Data Source: ***Population Health Report (2010-2019)***

3. Data Source: ***Health Survey Report, 2022***

> There are not enough doctors... to meet the size of the population.

Access to Specialty and Extended Care

Specialty care is an extension of primary care and includes medical care services to treat specific health care problems. Specialty care, when needed, generally follows primary care. Types of specialty care services include dialysis, obstetrics, gynecology, cardiology, and diabetes. Without access to specialists such as an endocrinologist, diabetes nurse specialist, or cardiologist, community residents are often left to manage their chronic illnesses on their own. In addition to specialty care, extended care refers to medical services and treatment in the community that supports physical health and wellbeing and extends beyond primary care services, such as urgent care clinics, home health care, and the like.

> "The medical specialty services are at least 8-14 miles away from the Poolesville area.

QUALITATIVE THEMES	QUANTITATIVE INDICATORS	MONTGOMERY COUNTY	TREND DIRECTION OVER TIME	LATEST YEAR OF DATA
ACCESS				
• Need more access to affordable urgent care clinics • Lack of access to home health care services for older adults • Lack of access to home health care services for people with disabilities • Lack of transportation affecting access to specialty care	Percent of individuals without health insurance[1]	7%	Decreasing	2020
	Percent of community health survey respondents that indicate transportation to health care is a barrier[1]	4.5%	–	2022
RECOMMENDATIONS FROM COMMUNITY				
• Need more specialty medical care services	–	–	–	–

The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.

1. *Data Source:* ***https://www.countyhealthrankings.org/explore-health-rankings/maryland/montgomery?year=2023***

Access to Technology

"Digital divide" is a phrase that describes the gap between communities that have access to reliable technology, such as internet service, computers, and cell phones, and communities who do not. The digital divide impacts access to health care. Lack of access to technology has been called a social determinant of health (SDOH) and deepens health disparities.[7] Increasing persons digital literacy and access is necessary to addressing health inequities and disparities leading to improvements in physical, emotional, psychological, and social well-being.

QUALITATIVE THEMES	QUANTITATIVE INDICATORS	MONTGOMERY COUNTY	TREND DIRECTION OVER TIME	LATEST YEAR OF DATA
ACCESS				
• Lack of internet access • High cost of internet service • Lack of cell phone access • Lack of computer access	Percent of households with broadband internet connection[1]	94%	–	2021
LITERACY				
• Lack of computer literacy	–	–	–	–

The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.

1. *Data Source:* ***https://www.countyhealthrankings.org/explore-health-rankings/maryland/montgomery?year=2023***

[7] ***https://www.ahrq.gov/sdoh/data-analytics/sdoh-tech-poverty.html***

Access to Transportation

> I go to [Doctors name]. And if I don't count on friends and neighbors and family, I can't get there; and take taxis, they are pretty expensive.

Transportation among communities is critical for accessing health care services. There is growing concern among community residents that individuals will become increasingly transportation disadvantaged when attempting to access health care services. Transportation barriers have been associated with poorer health care access, missed or delayed medical appointments, and lower health status.[8] In addition, transportation barriers impact social health by limiting one's access to healthy food, employment, or personal activities of daily living.[24] Expanding access to transportation can improve health and health equity by improving physical, emotional, psychological, and social well-being.

QUALITATIVE THEMES	QUANTITATIVE INDICATORS	MONTGOMERY COUNTY	TREND DIRECTION OVER TIME	LATEST YEAR OF DATA
ACCESS				
• Lack of transportation affecting access to healthcare, such as medical appointments for primary care or specialty care • Proximity to public transportation is a barrier to accessing health and human services • Long travel distance to health and human services	Percent of population living in a Census block within a quarter of a mile to a fixed transit stop[1]	54.9%	–	2019
	Percent of community health survey respondents that indicate transportation to health care is a barrier[2]	4.5%	–	2022
COST				
• High cost of transportation	–	–	–	–
RECOMMENDATIONS FROM COMMUNITY				
• Need more convenient public transportation routes in neighborhoods • Need more convenient public bus stops • Need more transportation options to access community resources and services	–	–	–	–

The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.

1. Data Source: ***https://www.countyhealthrankings.org/explore-health-rankings/maryland/montgomery?year=2023***

2. Data Source: ***Health Survey Report, 2022***

Active Living and Healthy and Nutritious Eating

Regular physical activity and healthy and nutritious eating is vital for overall health and well-being and disease prevention. Physical inactivity and unhealthy eating are associated with lower health status, including an increased likelihood of developing a chronic disease.[9] Communities experiencing high social vulnerability are more likely to have challenges getting convenient, affordable, and reliable healthy foods and are often saturated with fast-food establishments serving unhealthy foods. The importance of engaging in regular physical activity and healthy and nutritious eating are key factors for a thriving community.

QUALITATIVE THEMES	QUANTITATIVE INDICATORS	MONTGOMERY COUNTY	TREND DIRECTION OVER TIME	LATEST YEAR OF DATA
ACCESS				
• Lack of healthy food eating • Culturally inappropriate food solutions • Availability of affordable healthy and nutritious foods at primary and secondary schools • High cost of healthy foods	Percentage of children in public schools eligible for free or reduced-price lunch[1]	37%	Increasing	2021
PHYSICAL ACTIVITY, CHRONIC CONDITIONS, AND BEHAVIORAL HEALTH				
• Physical inactivity	Diabetes mortality rate[2]	15 / 100,000	Increasing	2020
	Diabetes ER visit rate[2]	329 / 100,000	Decreasing	2020
	Percent of adults who are overweight or obese[2]	58%	Fluctuating	2020
	Percent of adults with high blood pressure[2]	24.1%	Fluctuating	2019

PHYSICAL ACTIVITY, CHRONIC CONDITIONS, AND BEHAVIORAL HEALTH continued				
	Length of time since adults last had blood cholesterol checked[3]	5 or more years ago: 7.1% Within the past 2-5 years: 18.9% Within the past year: 66.4% Never: 7.6%	–	2022
	Percentage of residents aged 20 years and older with no reported leisure-time physical activity[3]	17.6%	Increasing	2022
	No physical activity in the last month[3]	23.5%	Increasing	2022
	Percentage of adults who indicate they smoke, how often[3]	Within the past 5-10 years: 3.9% Within the past year: 5.5% Some days: 2.3% Every day: 2.6%	Increasing	2022
	Percentage of adults who ever used e-cigarettes or electronic vaping products[3]	10.2%	Increasing	2022

RECOMMENDATIONS FROM COMMUNITY

- Need more virtual/online physical activity programs
- Need more expanded access to healthy foods at food banks
- Need more grocery or variety stores that sell healthy foods
- Need more education about healthy foods and healthy eating
- Need healthier low-cost "speed of service" (i.e., fast-food) food options

–

The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.

1. Data Source: ***https://www.countyhealthrankings.org/explore-health-rankings/maryland/montgomery?year=2023***

2. Data Source: ***Healthy Montgomery Core Measures***

3. Data Source: ***Health Survey Report, 2022***

[9] ***https://www.cdc.gov/healthyweight/index.html***

Cultural and Language Competence

Cultural and language competence refers to the ability of those bringing health and human services to the community, including health care providers and human services professionals, to deliver services that meet an individual's social, cultural, and language needs. Cultural and language barriers to health care and human services contributes to lower quality, reduces that uptake of needed services that can improve well-being, and exacerbates health disparities. Bilingual, bicultural personnel, professional interpreters, concise and plain language health and human services information, and the like, are important structures of care that may lead to improved health care and a more satisfying experience for patients and their providers.

> "Create an atmosphere where people of different languages and of different ethnicities feel comfortable enough to seek guidance, who feel understood and who also feel like they can almost see themselves in the people they need help from.

QUALITATIVE THEMES	QUANTITATIVE INDICATORS	MONTGOMERY COUNTY	TREND DIRECTION OVER TIME	LATEST YEAR OF DATA
CULTURAL COMPETENCY				
• Lack of bilingual and culturally competent mental health providers • Lack of bilingual and culturally competent health care providers • Lack of interpreters and language translation services in the health and human services professions • COVID-19 communication and engagement efforts with people from culturally and linguistically diverse communities • Culturally and linguistically appropriate health care services available throughout the community	Race/Ethnicity[1]	58.4% White, 20.7% Black or African American alone, 16.2% Asian alone, 20.3% Hispanic or Latino	–	2020
	Percentage of population not having a high school diploma[2]	8.64%	–	2020
	Percentage of population having language barriers[2]	4.7%	–	2022
	Language spoken at home other than English[2]	41.5%	Increasing	2021

RECOMMENDATIONS FROM COMMUNITY				
• Need more bilingual and culturally competent human services providers • Need more bilingual and culturally competent community health workers • Need more culturally and linguistically tailored, concise and plain language health and human services information	–	–	–	–

The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.

1. *Data Source: data.census.gov*
2. *Data Source:* ***https://www.countyhealthrankings.org/explore-health-rankings/maryland/montgomery?year=2023***

Environmental Health

Environmental health focuses on the environmental conditions that affect our health and well-being. Environmental hazards, such as air pollution, water pollution, radon in the home, crowding, and other factors or conditions in the environment can increase the risk of human injury, disease, or death. Efforts to reduce and manage environmental hazards in the community can have positive effects on the physical, emotional, psychological, and social well-being of residents living in these communities.

QUALITATIVE THEMES	QUANTITATIVE INDICATORS	MONTGOMERY COUNTY	TREND DIRECTION OVER TIME	LATEST YEAR OF DATA
ENVIRONMENTAL HEALTH				
• Air pollution • Water pollution • Environmental hazards in home • Housing overcrowding	Lead poisoning in children aged 0-6[1]	Blood Lead Level 5-9 ug/dL: 112 Blood Lead Level >=10 ug/dL: 32	Decreasing	2018
	Reports of health-related drinking water violations in a community within the county[1]	None	Stable	2021
	Average daily density of fine particulate matter in micrograms per cubic meter (PM 2.5)[1]	6.1	–	2019
	Percentage of unhealthy days/ year[2]	0	–	2022
	Water quality indicators[1]	See Table 34 of Population Health Surveillance Report	–	2019

ENVIRONMENTAL HEALTH continued				
	Radon[1]	Highest radon levels in the following zip codes: 20854, 20905, 20882, 20872, 20871, 20838, 20939, and 20842	–	2016

The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.

1. Data Source: ***Population Health Report (2010-2019)***

2. Data Source: ***https://www.countyhealthrankings.org/explore-health-rankings/maryland/montgomery?year=2023***

Health and Human Services' System Navigation

Help in navigating health care and human services' systems and obtaining support services is necessary to improve health outcomes. Challenges in navigating the complex U.S. health care system may result in access barriers and has been associated with health disparities and may increase social vulnerabilities in communities. Navigation services can improve health and social care access, address issues related to distrust between communities and health and human services professionals and reduce cultural and language barriers leading to improved physical, emotional, psychological, and social well-being.[10]

QUALITATIVE THEMES	QUANTITATIVE INDICATORS
ACCESS	
• Challenges navigating the health care system • Challenges navigating government services • Lack of a centralized institution that directs and coordinates health and human services	No quantitative indicators used or identified for this health need.
AWARENESS	
• Lack of awareness about the availability of health and human services • Lack of information about the availability of health and human services • Information about the availability of health and human services is not in plain language	No quantitative indicators used or identified for this health need.
RECOMMENDATIONS FROM COMMUNITY	
• More collaboration among health and human services providers • Need for more linguistically and culturally appropriate information about where to go for help to get health and human services • Need more help applying for health and human services programs	No quantitative indicators used or identified for this health need.
The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.	

[10] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4121958/*

Injury and Disease Prevention and Management

Prevention aims to reduce risks or threats to health. Injury and disease are the unfortunate result of challenges and barriers impacting access to health care. When individuals do experience an injury or are diagnosed with a disease, managing the illness can improve quality of life while reducing health care costs for the patient and health care system by preventing or minimizing effects of the disease or injury. Prevention efforts and management strategies targeted to common injuries such as motor vehicle accidents or firearm incidents or diseases such as diabetes or obesity are important for community health improvement.

QUALITATIVE THEMES	QUANTITATIVE INDICATORS	MONTGOMERY COUNTY	TREND DIRECTION OVER TIME	LATEST YEAR OF DATA
HEALTH BEHAVIOR	Injury mortality age adjusted rate[1]	64.7 / 100,000	Increasing	2019
• Smoking	Injury related ER visit rate[1]	3573 / 100,000	Decreasing	2019
	Motor vehicle deaths age adjusted rate[1]	5.6 / 100,000	Fluctuating	2019
PERCEPTIONS	Motor vehicle related hospitalization[1]	35.8 / 100,000	Fluctuating	2019
• COVID-19 vaccine apprehension, stigma, and fear • Prevention-related health needs associated with not going for regular physical checkups	Fall mortality age adjusted rate[1]	10.4 / 100,000	Fluctuating	2020
	Fall related hospitalization rate[1]	189.2 / 100,000	Decreasing	2020
	Firearm mortality[1]	3.6 / 100,000	Increasing	2019
CHRONIC CONDITIONS	Firearm related hospitalization rate[1]	2.7 / 100,000	Increasing	2019
• Heart disease • Diabetes • Cancer • Obesity • Stress	Heart disease mortality rate[1]	110.6 / 100,000	Increasing	2020
	Heart disease related ER visit rate[1]	1244 / 100,000	Increasing	2020

RECOMMENDATIONS FROM COMMUNITY				
	Cerebrovascular disease (including stroke) mortality rate[1]	25.3 / 100,000	Increasing	2019
• Offer more smoking cessation classes • Focus on prevention in health education • Offer more chronic disease support service	Cerebrovascular disease related ER visit rate[1]	29.2 / 100,000	Increasing	2019
	Chronic lower respiratory disease (including COPD) mortality rate[1]	14.2 / 100,000	Fluctuating	2020
	Chronic lower respiratory disease related ER visit rate[1]	473 / 100,000	Increasing	2020
	Cancer incidence (overall, lung and bronchus, colon and rectum, female breast, prostate, melanoma of skin)[1]	Overall: 369.5 / 100,000 Lung and bronchus: 28.3 / 100,000 Colon and rectum: 31.3 / 100,000 Female breast: 112.2 / 100,000 Prostate: 110.5 / 100,000 Melanoma of skin: 18.5 / 100,000	See Population Health Surveillance Report starting on page 81	2016
	Diabetes mortality rate[1]	15 / 100,000	Increasing	2020
	Diabetes related ER visit rate[1]	329 / 100,000	Increasing	2020
	Infectious diseases (Campylobacteriosis, Vibriosis, Pertussis, Salmonellosis, Legionellosis, Rabies, Lyme Disease, Shiga Toxin producing E. coli)[1]	Campylobacteriosis: 16.3 / 100,000 Vibriosis: 1.3 / 100,000 Pertussis: 2.9 / 100,000 Salmonellosis: 14 / 100,000 Legionellosis: 2.5 / 100,000 Rabies: 2.4 / 100,000 Lyme Disease: 12.8 / 100,000 Shiga Toxin producing E.coli: 6.6 / 100,000	See Population Health Surveillance Report starting on page 92	2019

Percent of Adults overweight or obese[2]	58%	Increasing	2020
Tuberculosis incidence[1]	5.4 per 100,000	Increasing	2020
Sexually transmitted infections (Chlamydia, Gonorrhea, Syphilis, HIV) incidence[1]	Chlamydia: 362.9/100,000 Gonorrhea: 89/100,000 Syphilis: 7.2/100,000 HIV: 9.7/100,000	Increasing	2020; 2021 for HIV
Alzheimer's disease mortality[3]	11.8 / 100,000	–	2020
Influenza & pneumonia mortality[3]	9.04 / 100,000	–	2019
COVID-19[4]	See COVID-19 Surveillance Report and Health Survey Report	–	2022
Length of time since adults last had blood cholesterol checked[4]	5 or more years ago: 7.1% Within the past 2-5 years: 18.9% Within the past year: 66.4% Never: 7.6%	–	2022
Percentage of adults who indicate they smoke, how often[4]	Within the past 5-10 years: 3.9% Within the past year: 5.5% Some days: 2.3% Everyday: 2.6%	–	2022
Percentage of adults who ever use e-cigarettes or electronic vaping products[4]	10.2%	–	2022

The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.

1. *Data Source:* ***Population Health Report (2010-2019)***
2. *Data Source:* ***Maryland Department of Health MD-IBIS – Maryland's Public Heath Data Resource***
3. *Data Source:* ***https://www.countyhealthrankings.org/explore-health-rankings/maryland/montgomery?year=2023***
4. *Data Source:* ***Health Survey Report, 2022***

Maternal and Early Childhood Health

Maternal and early childhood health encompasses the health of women of childbearing age from pre-pregnancy to pregnancy, labor, delivery, and the postpartum period, and the health of the child prior to birth up to adolescence.[11] Supporting the health and well-being of during pregnancy, childbirth, and the postnatal period has important implications for the quality of life for both mother and child. In addition, improving the availability, accessibility and utilization of family and reproductive health services, such as family planning services, can help individuals determine the preferred number and spacing of children and choose the appropriate means to achieve this preference, increase the likelihood that a baby will be born healthy, and improve their health even if they choose not to have children.[12]

> "Women of color are overly sedated instead of given pain medication... I never knew I would ever be in a position to experience all the things that I had read about health care disparities, and how different racial demographics are treated in medicine.

QUALITATIVE THEMES	QUANTITATIVE INDICATORS	MONTGOMERY COUNTY	TREND DIRECTION OVER TIME	LATEST YEAR OF DATA
• Better access to family planning services and information needed	Birth rate[1]	11.1 Births / 1,000	Decreasing	2020
	Infant mortality rate[1]	5.2 / 1,000	Decreasing	2020
	Teen birth rate[1]	8.0 Births / 1,000	Decreasing	2020
	Percentage births among women aged 35-44[1]	33.2%	Increasing	2020
	Percentage of births to unmarried women[1]	28.7%	Increasing	2020
	Percentage of births to women without a high school education[1]	12.9%	Decreasing	2020
	Percentage of plurality births[1]	2.9%	Decreasing	2020

	Percentage of births with late or no prenatal care[1]	6.2%	Decreasing	2020
	Percentage of preterm births[1]	9%	Fluctuating	2020
	Percentage of Low weight births and very low weight births[1]	7.3%	Increasing	2020
	Tobacco use during pregnancy[1]	0.9%	–	2020

The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.

1. Data Source: ***Population Health Report (2010-2019)***

Pedestrian Safety

Pedestrian safety requires that people have safe places to walk and play. Pedestrian safety is a shared responsibility between all members in the community. A community's focus on pedestrian safety can reduce unintended injuries among its residents. In addition, communities that promote a safe and comfortable environment for walking can motivate its residents to engage in physical activity.

QUALITATIVE THEMES	QUANTITATIVE INDICATORS
MOBILITY	
• Maintenance of greenery on roadways and sidewalks • Potholes	No quantitative indicators used or identified for this health need.
RECOMMENDATIONS FROM COMMUNITY	
• Need more safe and accessible sidewalks • Need more walking trails	No quantitative indicators used or identified for this health need.

The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.

Safe and Violence-Free Environment

When people feel safe from hurt or harm in their community and home, they experience improved physical, emotional, psychological, and social well-being. The importance of community safety can reduce unintentional and intentional injuries.[13] Efforts to prevent violent acts in neighborhoods and homes that affect health and quality of life are important to the well-being of the community.

QUALITATIVE THEMES	QUANTITATIVE INDICATORS	MONTGOMERY COUNTY	TREND DIRECTION OVER TIME	LATEST YEAR OF DATA
• Discrimination • Intensive police presence in community • Drug use • Intimate partner violence • Gang activity • Vandalism • Crime	Firearm mortality[1]	10.4 / 100,000	Increasing	2019
	Firearm-related hospitalization[1]	3.3 / 100,000	Fluctuating	2020
	Homicide deaths per 100,000[1]	2	Stable	2020
	Reported violent crime offenses per 100,000[1]	421.46 / 100,000	–	2020

The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.

1. Data Source: ***https://www.countyhealthrankings.org/explore-health-rankings/maryland/montgomery?year=2023***

[11] ***https://www.cdc.gov/reproductivehealth/maternalinfanthealth/index.html***

[12] ***https://www.cdc.gov/reproductivehealth/contraception/qfp.htm***

[13] ***https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/social-economic-factors/community-safety?***

Social Associations and Community Connectiveness

Social associations and community connectiveness refer to the ability of individuals in a community to "have relationships that create a sense of belonging and being cared for, valued, and supported."[14] Social associations and community connectedness, or the lack thereof, is a SDOH. Minimal relationships between and among individuals and social groups within a community are associated with increased morbidity and lower life expectancy.[15] Increasing opportunities for social associations and community connectiveness may improve health status and health outcomes.

QUALITATIVE THEMES	QUANTITATIVE INDICATORS	MONTGOMERY COUNTY	TREND DIRECTION OVER TIME	LATEST YEAR OF DATA
• Social isolation **RECOMMENDATIONS FROM COMMUNITY** • Need for a social atmosphere that respects diversity • Need for more senior centers offering social gatherings • Need more family support services • Promoting stronger social connectedness	Percentage of population that is low income and does not live close to a grocery store[1]	2%	Stable	2019
	Percentage of population with adequate access to locations for physical activity[1]	100%	Stable	2022
	Percentage of adults reporting binge or heavy drinking[1]	10.1%	Decreasing	2021
	Age-adjusted average number of physically unhealthy days reported in past 30 days[1]	2	Decreasing	2020
	Age-adjusted average number of mentally unhealthy days reported in past 30 days[1]	4	Increasing	2020

The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.

1. Data Source: ***https://www.countyhealthrankings.org/explore-health-rankings/maryland/montgomery?year=2023***

[14] ***https://www.cdc.gov/chronicdisease/healthequity/sdoh-and-chronic-disease/nccdphp-and-social-determinants-of-health/social-connectedness.htm***

[15] ***https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model/health-factors/social-economic-factors/family-and-social-support/social-associations?year=2022***

Waste Management

Managing the constant accumulation of waste from households, agriculture, and businesses through collection, source reduction, product reuse and recycling, treatment, and disposal is important for the health of the community and environment. Keeping neighborhoods and parks free of waste may help to promote health and build resilience within communities.

QUALITATIVE THEMES	QUANTITATIVE INDICATORS
• Cleaner neighborhoods and parks	No quantitative indicators used or identified for this health need.
The Trend Direction Over Time column indicates whether the value of an indicator has increased, decreased, or stayed the same over time. If a trend cannot be determined due to limited data, a hyphen (-) is included in the field.	

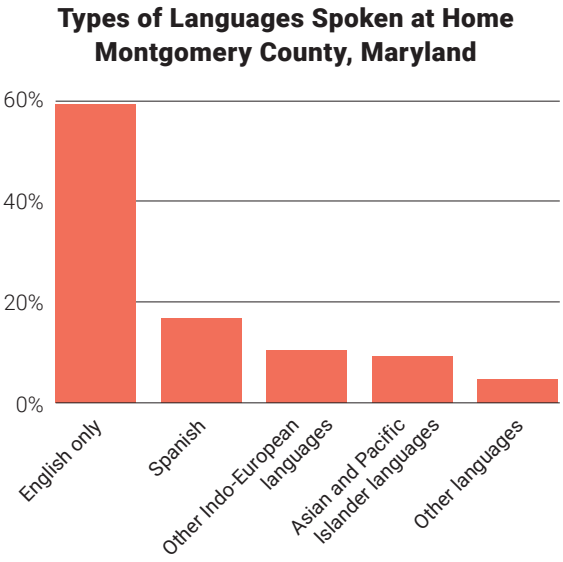
MONTGOMERY COUNTY – THE COMMUNITY SERVED

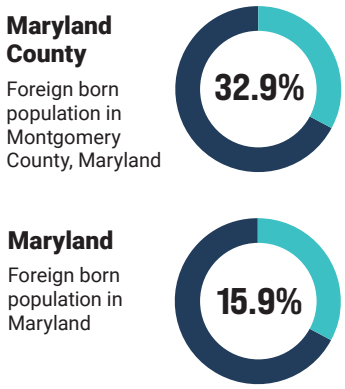
Population

Montgomery County is the most diverse county in Maryland with a large and diverse foreign-born population. The county has a diverse population made up of a majority of persons of color, many of whom are foreign born. Fifty-six percent of residents identify as Hispanic or non-white.[35] As shown in Figure 3, about one-third (32.9 percent) of the county's residents are foreign-born, which is more than double the rate in Maryland (15.9 percent).[36] Over forty percent (43.7 percent) of county residents speak a language other than English at home, as compared to 20.4 percent of Maryland residents.[37] The largest ethnic groups are from El Salvador, mainland China, India, and Ethiopia. The County has more immigrants from Ethiopia than any other county in the United States.[38]

The median age in Montgomery County is 40 years old, which compares to the median age in Maryland of 39.3.[39] However, unprecedented growth is expected in the senior population. As the large cohort of the baby boom generation age, (generation born between 1946-1964), the county's 65 and plus population is expected to double from 120,000 in 2010 to 244,000 by 2040.[40] By 2040, one in five residents in Montgomery County will be 65 and older, and one out of three will be 55 and older. [41]

FIGURE 3. **Montgomery County Population Characteristics**





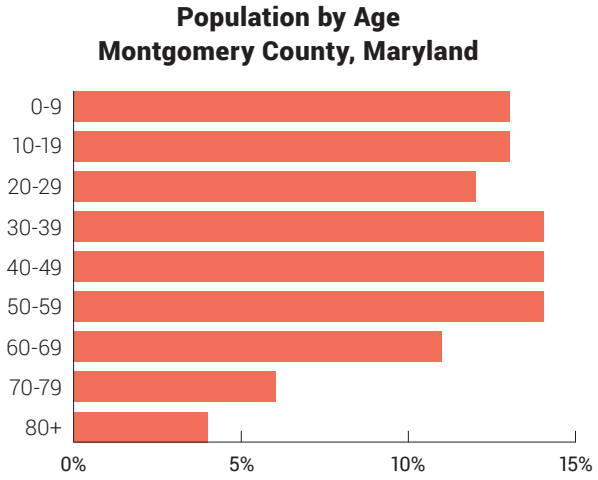
Largest Ethnic Groups
Montgomery County, Maryland

El Salvador, China, India, and Ethiopia

Data Sources: Montgomery County Council District Profiles 2022
Census data: ACS 2020 5-year; Montgomery County Food Security Plan 2017

FIGURE 3.1

Montgomery County Population by Age



Data Sources: Montgomery County Trends: A Look at People, Housing and Jobs, January 2019 Census data: ACS 2020 5-year

Median Age
Montgomery County, Maryland

40

Aging Population

By 2040, one in five County residents will be 65 and older

Over the decades, Montgomery County has shifted from predominately households of married-couples-with-children to a broader mix of household types including single parent, couples with no children under 18, singles, and unrelated cohabitation.[42] In 2016-2020, married-couple households made up 54.5 percent of households in the county, cohabitating couples made up 4.7 percent of households and 40.8 percent of households were male or female households with no spouse or partner present.[43]

Vulnerable Populations

Vulnerable populations are groups and communities at a higher risk for poor health because of the barriers they experience to social, economic, political, and environmental resources, as well as limitations due to illness or disability.[44] This includes youth, older adults, persons with disabilities, the LGBTQ+ population and people experiencing homelessness.

FIGURE 3.2

Percent Population Estimates by Selected Characteristics Montgomery County, Maryland and U.S., 2015-2019

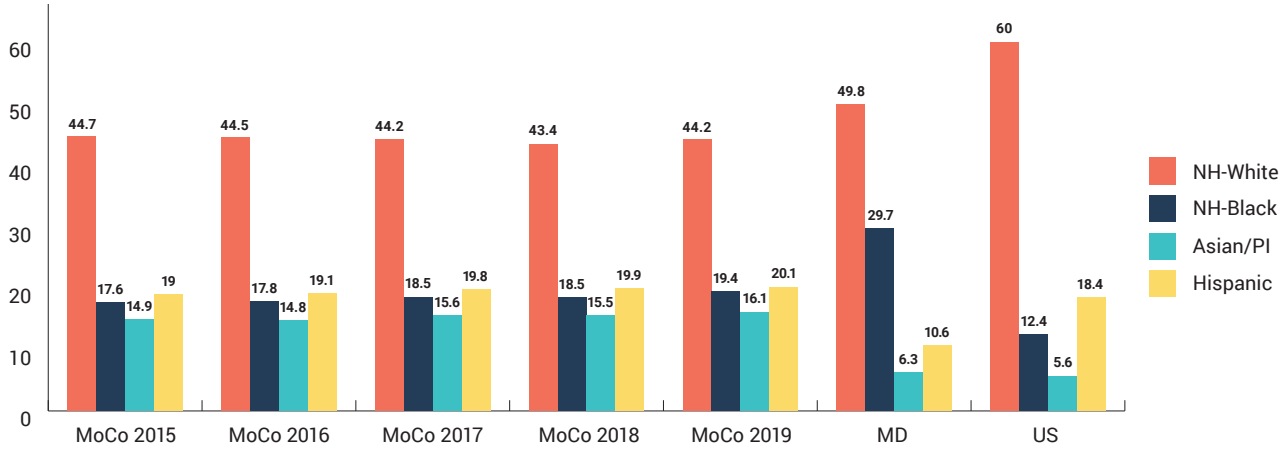


FIGURE 3.3 **Montgomery County Mix of Household Types**

Data Source: 2016-2020 American Community Survey

PERSONS WITH DISABILITIES

In Montgomery County 8.7 percent of residents reported a disability.[45] The likelihood of having a disability varied by age, from 3.3 percent of people under 18 years old, to 6.7 percent of people 18 to 64 years old, and to 23.8 percent of those 65 and over].[46] About one quarter of residents aged 65 or older have a disability—a rate that rises to 37 percent among older adult residents living in poverty.[47] The unemployment rate is higher for those who have a disability. In 2018, the unemployment rate for those 18-64 years old who reported a disability was over three times that of those who did not report a disability (11.1 percent compared to 3.5 percent).[48] Families with a disabled member are nearly two to three times more likely to be food insecure than those without a disabled member.[49]

OLDER ADULTS

The U.S population will be older and more racially and ethnically diverse in the decades to come.[50] This is also true for Montgomery County, as the 65 and older population is forecast to reach 20 percent of the total population in 2040.[51] According to the 2021 ACS one-year estimates, Asian residents make up the largest minority group among County residents age 60 or older.[52]

Additionally, 35.2 percent of residents who are age 60 and older speak a language other than English at home, with 18.6 percent of residents age 60 or older speaking English less than "very well".[53]

Almost eight percent of the county's older adults live in poverty, with 3.5 percent of older adults living between 100 and 150 percent of the poverty line.[54]

YOUTH

Twenty-three percent of the population in Montgomery County are below 18 years of age.[55] The leading causes of death for ages 5- to 17-year-old residents is accidents (16.2 percent) and the leading cause of hospitalization for this age group is mental health (53.9 percent).[56] Disparities exist in the younger residents including in those experiencing poverty and in adolescent birth rate. In 2016-2020, an estimated 7.9 percent of children under 18 were below the poverty level.[57] Children living in poverty are more likely to be Black (14.1 percent), Hispanic or Latino (11.7 percent), and Asian (5.6 percent) then non-Hispanic white (2 percent).[58] The adolescent birth rate has been declining over the past ten years, however the birth rate has consistently been higher in the Hispanic population (31/1,000) as compared with the Non-Hispanic White population (1.5/1,000).[59]

LGBTQ+

LGBTQ+ is an abbreviation for lesbian, gay, bisexual, transgender, queer, and/or questioning. The 'plus' is used to signify all the gender identities and sexual orientations that are not specifically covered by the other five initials. The umbrella acronym LGBTQ+ groups together comprise distinct populations, to include subpopulations based on race, ethnicity,

socioeconomic status, age, and other factors, with their own concerns and considerations. Although county-level data is limited for this population, the County is working to address social issues and unforeseen barriers faced by this community.

Health disparities exist between LGBTQ+ people and non-LGBTQ+ people. LGBTQ+ youth are disproportionately at risk for substance use disorder, risky sexual behaviors, bullying and harassment in schools, and violence.[60] Young black gay and bisexual men and transgender women are at significantly higher risk of acquiring HIV/AIDS.[61]

Social Determinants of Health and Health Inequities

While Montgomery County is ranked among the healthiest counties in Maryland, social determinants of health contribute to racial and ethnic inequities across zip codes in the county.[62] For example, residents in Bethesda, Chevy Chase, and Potomac have greater length of life compared to those living in Montgomery Village, Silver Spring, and Poolesville.[63] In order to assess potential racial and social inequities in the county, Montgomery Planning Department developed the Equity Focus Areas Analysis tool to identify areas that have high concentrations of lower-income households, people of color, and individuals who may speak English less than very well.[64] These communities may not have equitable access to resources or opportunities, and by developing this data-driven tool to identify and map these areas in the county, they can better understand existing conditions and direct planning efforts. Approximately 25 percent of the county population is living in an Equity Focus Area, areas primarily found along the I-270 Corridor, the Route 29 Corridor and the eastern part of Down County. Compared to the county overall, the population in Equity Focus areas are younger, have lower educational attainment and are more likely to be Hispanic.[65]

Social Determinants of Health
conditions in the environment where people are **born**, **live**, **work**, **play** and **worship** that impact **health and quality of life** (examples: transportation, housing, health care access, employment)

EDUCATION, INCOME AND EMPLOYMENT

Montgomery County continues to be one of the most highly educated counties in the United States, and this characteristic correlates to relatively high incomes.[66] Sixty percent of county residents hold a bachelor's degree or higher as compared to 42.5 percent of Maryland residents.[67] The median household income in Montgomery County is higher when compared to Maryland as a whole.

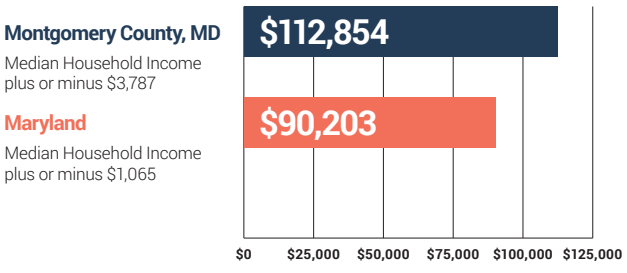
FIGURE 3.4 **Montgomery County Median Household Income**

Median Income by Types of Families
in Montgomery County, Maryland

MEASURE	VALUE
Families	$133,556
Married - Couple Families	$156,330
Nonfamily households	$68,931

** A nonfamily household consists of a householder living alone (a one-person household) or where the householder shares the home exclusively with people to whom he/she is not related*

Data Source: 2021 American Community Survey 1-Year Estimates



Data Source: 2021 American Community Survey 1-Year Estimates

Incomes vary greatly across subpopulations and places in the county.[68] For example, the median household income of residents in the 20816-zip code is $202,309 and the median household income for residents in the 20903-zip code is $67,883. Foreign born, Black, and Hispanic residents tend to be disproportionately represented in the lower income grouping in Montgomery County.[69]

Montgomery County also has a lower poverty rate as compared with the state of Maryland, with 8.6 percent of county residents living in poverty as compared to 10.3 percent of all residents in Maryland living in poverty.[70] Montgomery County has one of the biggest employer bases in Maryland.[51] About a quarter of county residents work for the government (local, state and federal level) while over half (56.5 percent) of county residents work for private companies.[51]

Due to the COVID-19 pandemic and efforts to limit the spread, the unemployment rate soared in the United States in the spring of 2020 to a record high of 14.7 percent.[71] In May 2020, Montgomery County's unemployment rate also reflected the national trend reaching 9.8 percent.[72] The unemployment rate steadily declined throughout the rest of the year to reach 5.5 percent in 2021, however not returning to pre-pandemic unemployment rate of 2.9 percent in 2019.[73]

FOOD INSECURITY

Food insecurity is the state of being without consistent, reliable access to enough affordable, nutritious food. As with unemployment, food insecurity rose in Montgomery County due to the COVID-19 pandemic. In 2021, food insecurity affected 30 percent of the Montgomery County residents.[74] Nearly 13.9 percent of the county's children are estimated to be food insecure, representing 33,000 children.[75] Food insecurity is estimated to be most prominent in certain areas in East County, Silver Spring, Aspen Hill, Wheaton, Gaithersburg, and Germantown.[56] Additionally, during the 2021-2022 school year, more than one third (39.5 percent) of Montgomery County Public Schools' students received free and reduced-price meals.[76] To end food insecurity for county youth, the County created the Office of Food Systems Resilience. The office will serve as a liaison to County government and help bolster food access in the county.

HOUSING

The Point-in-Time survey is a "snapshot" count of

TABLE 2. Households and Individuals Experiencing Homelessness Identified During the Point in Time Count

CATEGORY	2017	2018	2019	2020	2021	2022	PERCENT CHANGE 2018-2022	PERCENT CHANGE 2021-2022
Total Number Counted	894	840	647	670	577	581	-31%	0%
Total Individuals	616	568	441	487	480	408	-28%	-15%
Total Number of Families	86	85	61	61	29	56	-34%	93%
Total Persons in Families	278	272	206	183	97	173	-36%	78%
Total Adults in Families	107	92	76	70	34	70	-24%	106%
Total Children in Families	171	280	130	113	63	103	-63%	63%
Reproduced from https://www.montgomerycountymd.gov/Homelessness/Numbers.html								

those experiencing homelessness on a single night during the last two weeks of January. Table 2 below provides a comparison of the past six years, showing in 2022, there were 581 residents experiencing homelessness in Montgomery County.[77] The County aims to end homelessness for all populations by 2025.[78]

Lack of affordable housing, in addition to poverty and unemployment, can contribute to homelessness. According to a 2020 Montgomery County Housing Needs Assessment, the income needed to afford the median-priced home is rising faster than the median household income. In 2018, the household income required to afford the median home was $125,621, which is above the 2018 median household income of $108,188.[79] There is demand for housing across all income levels, with a particularly growing need for affordably priced housing.[80]

Boards, Committees and Commissions

In Montgomery County, there are more than 75 Boards, Committees and Commissions (BCC) appointed by the County Executive and confirmed by the County Council.[81] Sixteen of these boards, committees and commissions are related to the work of the Department of Health and Human Services. Participation in boards, committees, and commissions by the public provides a valuable service to the community by presenting the concerns and viewpoints of County residents on a variety of issues to County government. A few of the 80 Boards, Committees and Commissions are described below.

FIRE AND EMERGENCY SERVICES COMMISSION

The Fire and Emergency Services Commission makes recommendations to, and advises, the Fire Chief, County Executive and County Council on any matter relating to fire, rescue, and emergency medical services, including how the County can achieve and maintain effective, efficient, and equitable fire, rescue, and emergency medical services county-wide.

POLICE ADVISORY COMMISSION

The Policing Advisory Commission's mission is to advise the County Council on policing matters and recommend policies, programs, legislation, or regulations with regards to policing.

INTERAGENCY COMMISSION ON HOMELESSNESS

The Interagency Commission on Homelessness (ICH) works to promote efforts to prevent and end homelessness in Montgomery County. The ICH acts on behalf of county residents experiencing homelessness to provide advice, counsel, and recommendations to the County Executive and County Council. The ICH's responsibilities involve matters influencing provisions of services, County government policies and procedures, development and implementation of state and federal laws, and other issues affecting the lives, rights, and welfare of people experiencing homelessness in Montgomery County.

BOARD OF SOCIAL SERVICES

The Board of Social Services advises the County and State health and human services officials on matters relating to local social services programs.

RACIAL EQUITY AND SOCIAL JUSTICE ADVISORY COMMITTEE

The Racial Equity and Social Justice Advisory Committee (RESJAC) works to increase the understanding of racial equity and social justice in the county. The Committee also advises County Council, the Executive, and County agencies about racial equity and social justice in the county, and recommends policies, programs, legislation, or regulations necessary to reduce racial and social justice inequity.

The following sections provide quantitative and qualitative findings for selected sub-populations throughout Montgomery County.

RACIAL AND ETHNIC COMMUNITIES OF MONTGOMERY COUNTY

Asian American and Pacific Islander Community

COMMUNITY CONVERSATION IDENTIFIED HEALTH NEEDS, BARRIERS, AND ISSUES

Community members that identify with the Asian American and Pacific Islander (AAPI) community were invited to participate in a series of focus groups and a key informant interview to share their perspectives on the health needs, barriers, and issues affecting their community. Participants were asked to share their perspectives on the biggest health needs in their community, the challenges, or barriers to being healthy in their community, and the most important or urgent health issues or challenges to address to improve the health of their community. Using the County Health Rankings Model conceptual domains to report the thematic analysis, Table 3 presents the health needs, barriers, and issues that participants of the AAPI community identified through their qualitative interviews.

TABLE 3. Asian American and Pacific Islander Community Conversation Identified Health Needs, Barriers, and Issues

CONCEPTUAL DOMAINS	THEMES	SUBTHEMES
HEALTH BEHAVIORS	Tobacco Use	Social pressure to smoke tobacco
		Need for more tobacco cessation classes in common languages of the AAPI community
	Alcohol Use	Social pressure related to excessive alcohol use
	Mental Health	Depression
		Anxiety
		Post-traumatic stress disorder (PTSD)
		Stress caused by difficulties in native countries
		Suicides among AAPI youth

HEALTH BEHAVIORS	Mental Health	Elevated levels of loneliness and social isolation, specifically during the COVID-19 pandemic
		Stigma preventing seeking mental health services
	Diet	Need more low sodium food options at restaurants
	Chronic Health Conditions	Hepatitis
		Chronic liver disease
	COVID-19	COVID-19 vaccine apprehension, stigma, and fear of adverse side effects
	Health Seeking Behavior	Prevention-related health needs associated with not going for regular physical checkups

CLINICAL CARE	Cultural & Language Barriers in Health Care	Lack of AAPI bilingual and culturally competent mental health providers
		Lack of AAPI bilingual and culturally competent health care providers
		Limited English proficiency among AAPI individuals
		Lack of AAPI interpreters and language translation services in health care facilities
	Barriers in Accessing Health Care	Need more access to free medications for low-income community members
		Need more free mobile health clinics
		Need more free or low-cost community health clinics
		Not enough facilities that combine health and human services in a single location to deliver services
		Lack of senior centers in the community offering health promotion services
		Lack of access to affordable dental care
		Lack of traditional Chinese medicine services
		Uninsured AAPI individuals
		Health insurance system too complicated to understand

CLINICAL CARE	System Navigation	Complicated health care referral system
		Lack of collaboration among different health care providers
		Challenges in navigating the health care system
		Lack of language appropriate information about the availability of culturally appropriate primary care and specialty care
	Financial Barriers to Health Care	High cost of health care
		High cost of dental care
	Timeliness and Efficiency of Care	Long time from diagnosis to the completion of treatment care
		Long wait times for medications/prescriptions

SOCIAL, ECONOMIC, AND DEMOGRAPHIC FACTORS	Cultural & Language Barriers in the Community	Need more language appropriate call centers, virtual seminars and workshops to provide information on human services and health care benefit programs
		Information about the availability of health care resources is not distributed equally among different racial and ethnic groups
		Lack of knowledge about where to get linguistically and culturally appropriate health prevention and health promotion materials
		Lack of knowledge about the availability of language and cultural appropriate human services
		Many AAPI community members are unaware of community health clinics
		Need more AAPI bilingual staff in local government and community-based organizations

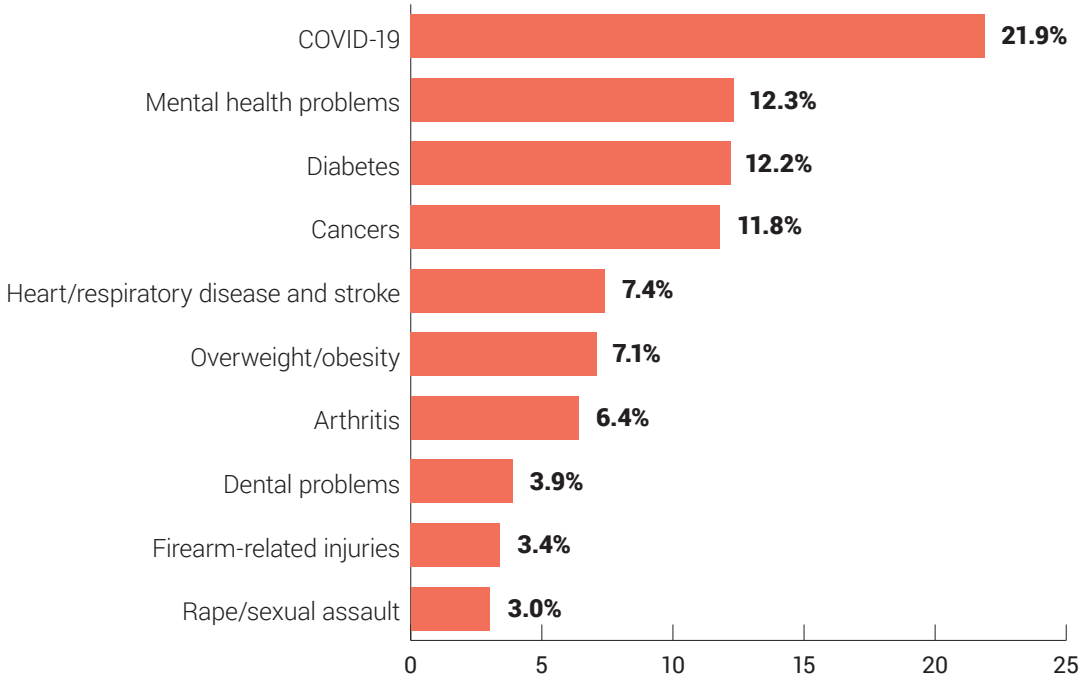
SOCIAL, ECONOMIC, AND DEMOGRAPHIC FACTORS	Community Safety	Concerns and anxiety about community safety caused by AAPI hate crimes and discrimination
		AAPI culture does not encourage speaking out against discrimination and other forms of suffering
		Need for a social atmosphere that respects diversity
	Employment Instability	Availability of employment agencies to increase opportunities for unemployed individuals is limited
	Income Assistance	Lack of accessible financial assistance resources for low-income families
	Social Support	Lack of senior centers in the community offering health promotion and communal gathering
		Lack of support for older adults' health and independence in their homes and communities
	Technology Literacy	Lack of knowledge about how to use computers

PHYSICAL AND BUILT ENVIRONMENT	Housing Instability	Need to expand rental assistance eligibility guidelines
		Need to reform housing voucher program application
		More accessible homes for seniors
	Transportation Access Barriers	Lack of transportation to accessing health care, such as medical appointments for preventative care
		Need more convenient public transportation
		Need a better application method for applying for public transportation passes
	Transportation Access Barriers	Lack of transportation for accessing health care, such as medical appointments for preventative care
	Pedestrian Safety	Need more safe sidewalks with streetlights for walking
	Health Equipment for Public Use	Need for more outdoor exercise equipment in parks and/or playgrounds

COMMUNITY HEALTH NEEDS SURVEY

Based on the data from the 2022 community health needs survey, Asian residents identified COVID-19, mental health, diabetes, cancer, heart/respiratory disease, and stroke as the most important health problems they face (Figure 4). Neighborhood safety/violence, availability/access to insurance, and race/ethnicity discrimination were the top social/environmental problems that affect health (Figure 5). Lack of exercise, drug use, and poor eating habits were the most important risky behaviors that impact health (Figure 6). A third of residents reported cost as the top reason for not getting care, followed by no insurance and long wait times (Figure 7). Fifteen percent of those that responded to the survey indicated that they needed financial assistance because of COVID-19, and 13 percent needed help getting health care (Figure 8).

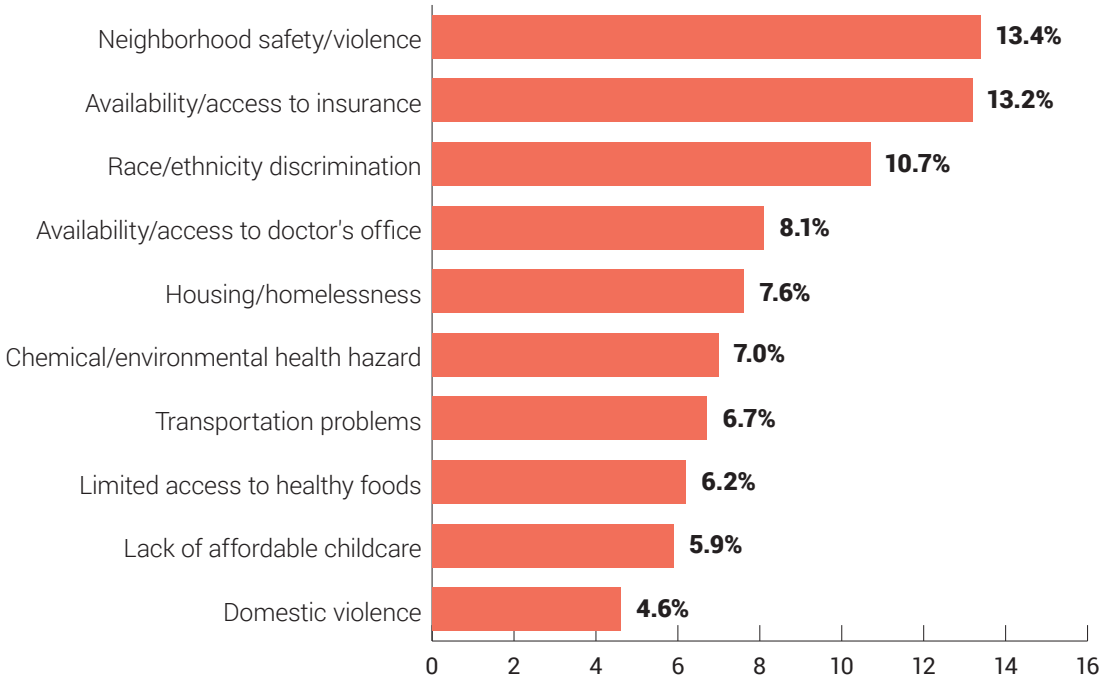
FIGURE 4. **Asian American and Pacific Islander Community Most Important Health Problems**



(N = 170) Asian American and Pacific Islander residents that completed the survey identified COVID-19, mental health problems, and diabetes as the top three most important health problems for them.

FIGURE 5.

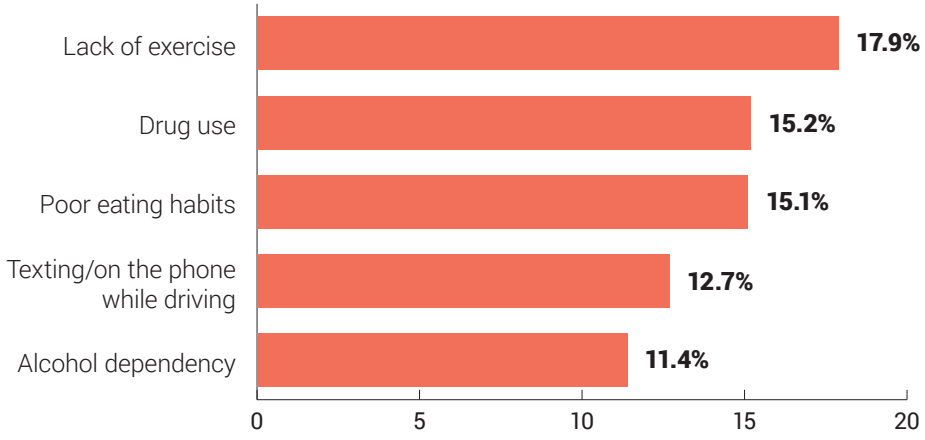
Asian American and Pacific Islander Community Most Important Social/Environmental Problems



(N = 170) Asian American and Pacific Islander residents that completed the survey identified neighborhood safety/violence, availability/access to insurance, and race/ethnicity discrimination as the top three most important social/environmental problems for them.

FIGURE 6.

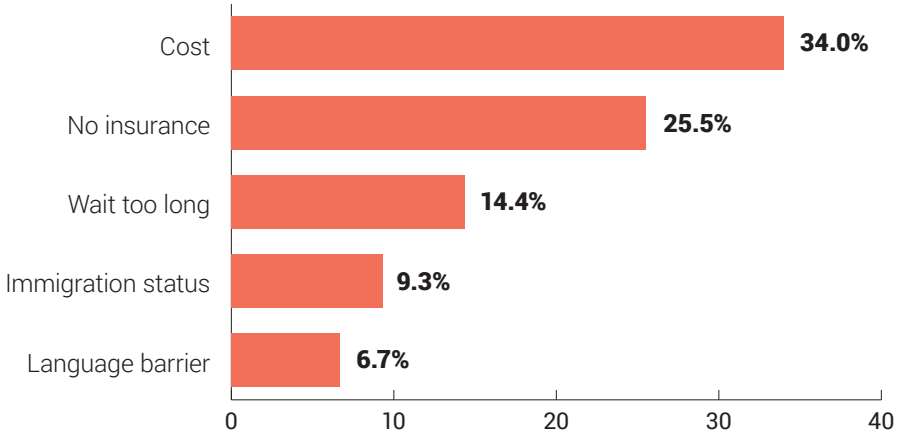
Asian American and Pacific Islander Community Risk Factors that Impact Health Behaviors and Outcomes



(N = 170) Asian American and Pacific Islander residents that completed the survey identified lack of exercise, drug abuse, and poor eating habits as the top three most important risk factors that impact health behaviors and outcomes for them.

FIGURE 7.

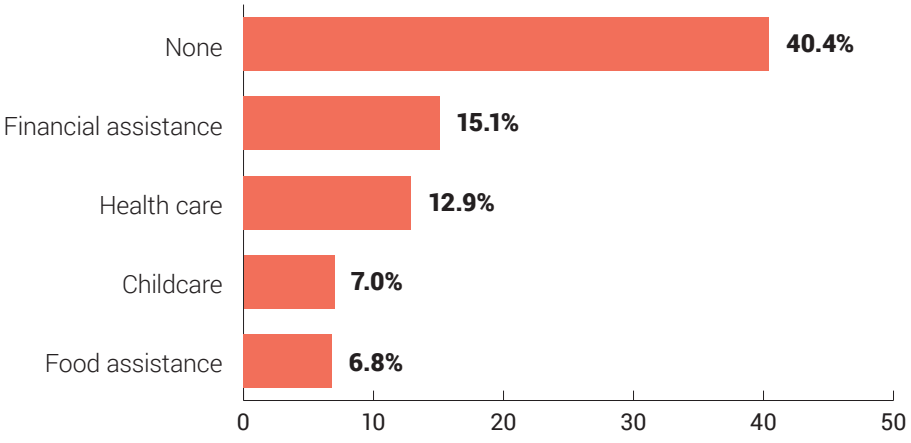
Asian American and Pacific Islander Community Top Reasons for Not Getting Care



(N = 170) Asian American and Pacific Islander residents that completed the survey identified cost, no insurance, and wait too long as the top three most important reasons that one does not get health care.

FIGURE 8.

Asian American and Pacific Islander Community Assistance Needed as a Result of COVID-19



(N = 170) Asian American and Pacific Islander residents that completed the survey identified financial assistance, health care, and childcare as the top three needs as a result of COVID-19.

Black/African American/ African Diaspora Community

COMMUNITY CONVERSATION IDENTIFIED HEALTH NEEDS, BARRIERS, AND ISSUES

Community members that identify as Black, African American, African Diaspora were invited to participate in a series of focus groups and a key informant interview to share their perspectives on the health needs, barriers, and issues affecting their community. Participants were asked to share their perspectives on the biggest health needs in their community, the challenges or barriers to being healthy in their community, and the most important or urgent health issues or challenges to address to improve the health of their community. Using the County Health Rankings Model conceptual domains to report the thematic analysis, Table 4 presents the health needs, barriers, and issues that participants of the Black, African American, African Diaspora community identified through their qualitative interviews.

TABLE 4. Black/African American/African Diaspora Community Conversation Identified Health Needs, Barriers, and Issues

CONCEPTUAL DOMAINS	THEMES	SUBTHEMES
HEALTH BEHAVIORS	Chronic Health Conditions	High blood pressure
		Stress
		Diabetes
		Obesity
		Cancer
		Chronic kidney disease
	Substance Use Disorder	Marijuana addiction and use, among adults and youth
		Drug use leading to overdoses
		High-risk substance use among youth
		Self-medication among Black, African American, or African Diaspora men
	Tobacco Use	Smoking
	Alcohol Use	Excessive drinking
	Exercise	Physical inactivity

HEALTH BEHAVIORS	Diet	Lack of healthy food eating
		Junk food consumption
		Negative health effects of fast food
		Need more nutrition information on healthy eating habits
	Food Insecurity	Need more subsidies to improve access to healthy foods
		Limited access to enough healthy foods in many areas throughout the county
		Costs of healthy foods are unaffordable for many individuals
		Limited access to Women, Infants, and Children (WIC)

SOCIAL, ECONOMIC, AND DEMOGRAPHIC FACTORS	Immigration Challenges	Immigrants and recently arrived asylum seekers fear of retribution preventing seeking of necessary social services
		Immigrants and recently arrived asylum seekers fear of non-eligibility preventing seeking of necessary social services
	Economic Insecurity	Need more job centers that provide training and career coaching to help improve earning potential
		Lack of employment support
		Cost of living in Montgomery County is higher than other counties
		Cost of living in Montgomery County is increasing fast
		Need more financial literacy education classes and workshops
		Need for higher minimum wage
		Blacks, African Americans, or Africans of the Diaspora living below the poverty line
		Low income affecting resource consumption to meet basic family needs

SOCIAL, ECONOMIC, AND DEMOGRAPHIC FACTORS	Education Insecurity	Low educational attainment beyond high school diploma
		Need more investment in early childhood education
	Service Needs of Children & Youth	Lack of access to safe and affordable childcare for children under age 5
		Need more affordable afterschool programs
		Need more low-cost or free community organized youth recreational activities
	Cultural & Language Barriers in the Community	Need for more linguistically and culturally appropriate trusted sources and community-based organizations to provide accurate and current information on where to go for help to get health and human services at a low cost
		Need a multi-pronged approach (placed-based; social media; text message; 1:1 conversations) to provide rapid information to help access culturally appropriate community resources and services
	Cultural & Language Barriers in the Community	Need a "Black Book" catalog of cultural businesses
	Community Safety	Car break-ins
		Intensive police presence in community
		Heavy police patrol in some public parks
	Technology Literacy	Lack of computer literacy
	Social Issues	Lack of social connectedness
		Need more in-person or virtual seminars dealing with helping individuals to improve various social issues
	Discrimination	Racial disparities negatively affect quality of life for Blacks, African Americans, and Africans of the Diaspora
		Racism
		Classism

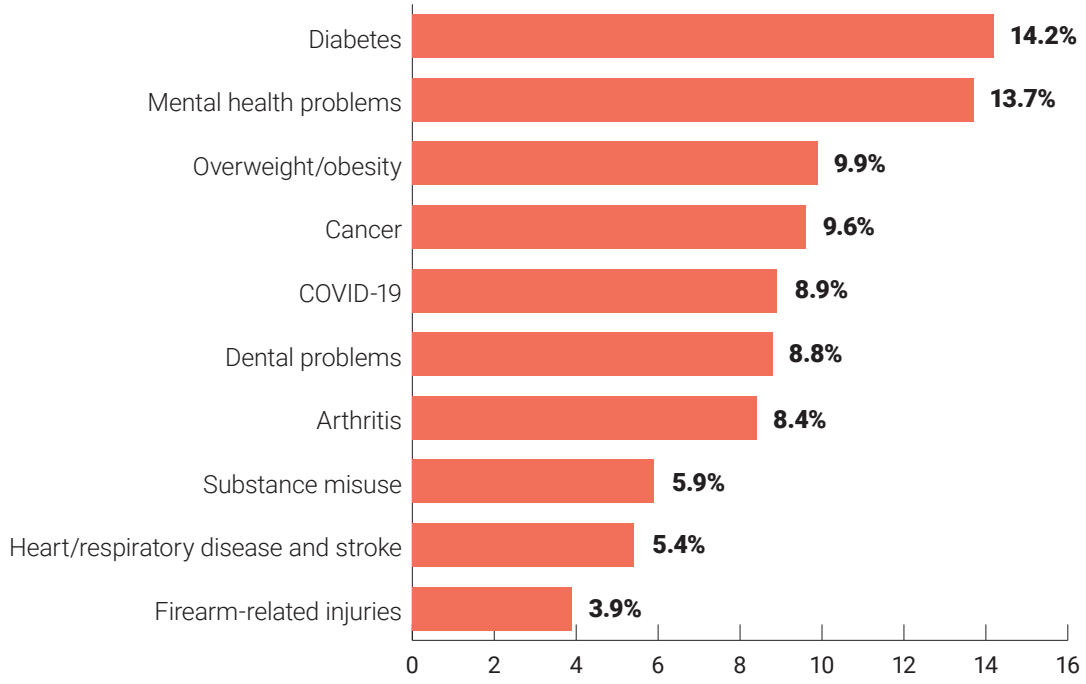
PHYSICAL AND BUILT ENVIRONMENT	Challenges in Public Parks	Drug use in some public parks
		Litter/trash left in parks by users
		Lack of access to community centers and sports fields are not readily available to community members.
	Housing Instability	Negative effects of low-income housing
		Rent and housing in general is too expensive, and is affected by race as seen by differences within zip codes
		Limited availability of low or moderately priced housing
		Increasing costs of home insurance due to natural disasters
	Pedestrian Safety	Need more sidewalks
		Need more bike lanes
	Transportation Access Barriers	Need more public transportation to access community resources and services

COMMUNITY HEALTH NEEDS SURVEY

Based on the data from the 2022 community health needs survey, Black, African Americans, or African Diaspora residents identified diabetes as the top health problem that affects them and their community, followed by mental health, overweight/obesity, and cancer (Figure 9). Availability/access to insurance, housing/homelessness, and race/ethnicity discrimination were the top social/environmental problems that affect health (Figure 10). Lack of exercise, poor eating habits and substance use were the most important risky behaviors that impact health (Figure 11). A third of residents reported cost as the top reason for not getting care, followed by no insurance and immigration status (Figure 12). Eighteen percent of those that responded to the survey indicated that they needed food assistance because of COVID-19, and 17 percent needed financial assistance (Figure 13).

FIGURE 9.

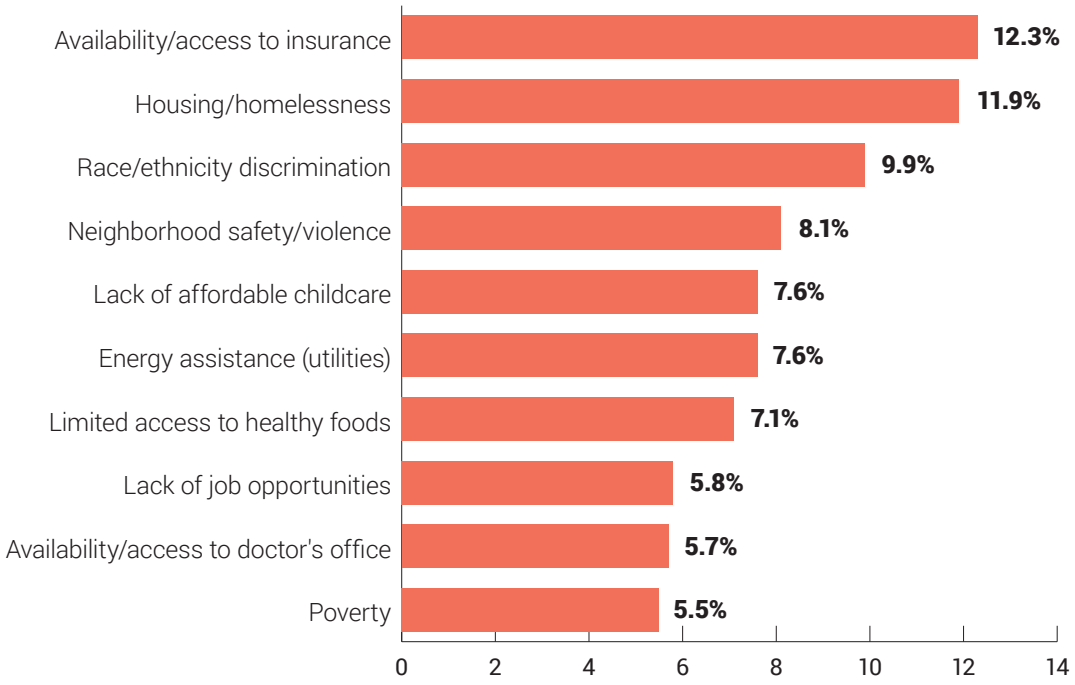
Black/African American/African Diaspora Community Most Important Health Problems



(N = 196) Black/African American/African Diaspora residents that completed the survey identified diabetes, mental health problems, and overweight/obesity as the top three most important health problems for them.

FIGURE 10.

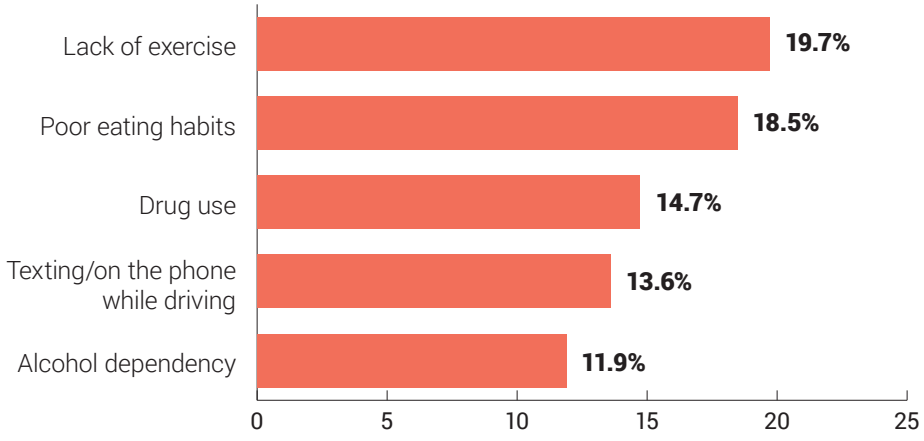
Black/African American/African Diaspora Community Most Important Social/Environmental Problems



(N = 196) Black/African American/African Diaspora residents that completed the survey identified availability/access to insurance, housing/homelessness, and race/ethnicity discrimination as the top three most important social/environmental problems for them.

FIGURE 11.

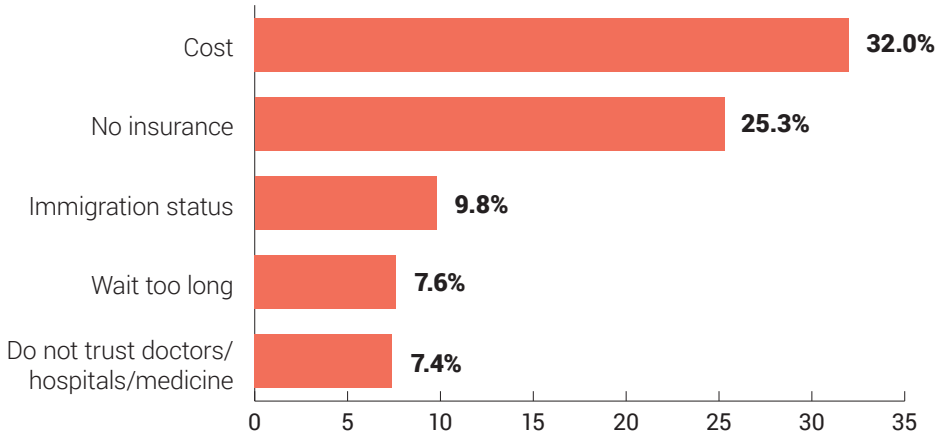
Black/African American/African Diaspora Community Risk Factors that Impact Health Behaviors and Outcomes



(N = 196) Black/African American/African Diaspora residents that completed the survey identified lack of exercise, poor eating habits, and drug abuse as the top three most important risk factors that impact health behaviors and outcomes for them.

FIGURE 12.

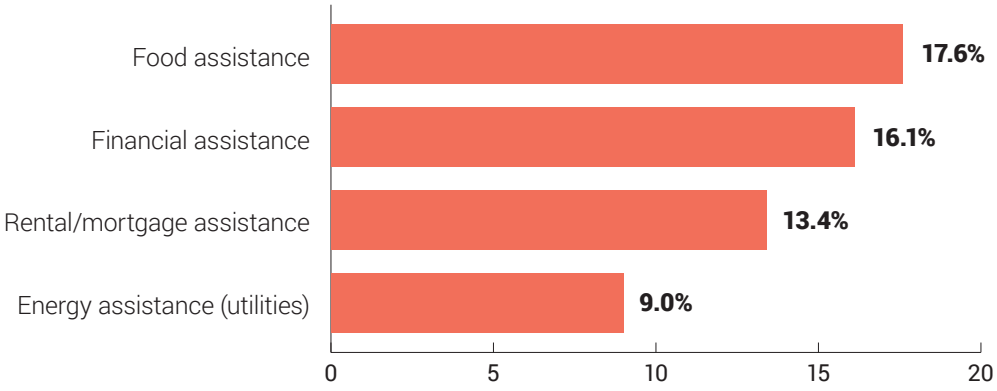
Black/African American/African Diaspora Community Top Reasons for Not Getting Care



(N = 196) Black/African American/African Diaspora residents that completed the survey identified as cost, no insurance, and immigration status as the top three most important reasons for not getting care.

FIGURE 13.

Black/African American/African Diaspora Community Community Assistance Needed as a Result of COVID-19



(N = 196) Black/African American/African Diaspora residents that completed the survey identified food assistance, financial assistance, and rental/mortgage assistance as the top three most important needs for them as a result of COVID-19.

FIGURE 14

Percent of NH Black Preterm Births and NH Black Births with Late/ No Prenatal Care, 2016-2020

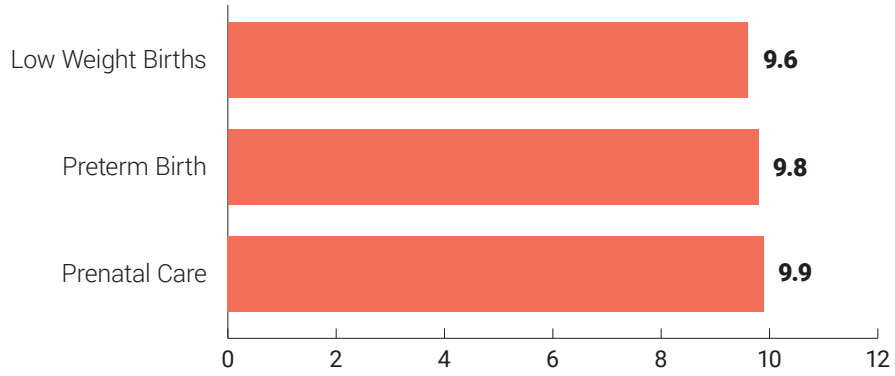
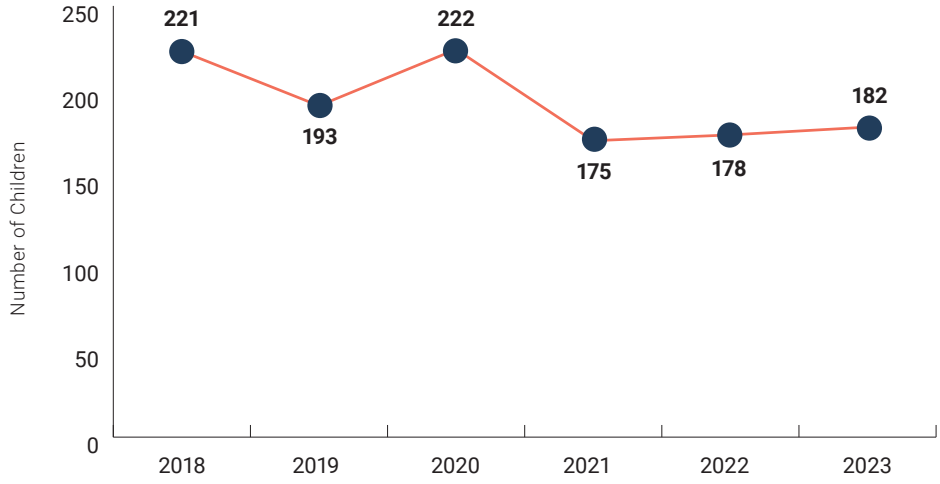


FIGURE 15

Black/African American/African Diaspora Community Youth Entering Foster Care Rates for Montgomery County 2018-2023



Hispanic or Latino Community

COMMUNITY CONVERSATION IDENTIFIED HEALTH NEEDS, BARRIERS, AND ISSUES

Community members that identify with the Hispanic or Latino community were invited to participate in a series of focus groups and a key informant interview to share their perspectives on the health needs, barriers, and issues affecting their community. Participants were asked to share their perspectives on the biggest health needs in their community, the challenges or barriers to being healthy in their community, and the most important or urgent health issues or challenges to address to improve the health of their community. Using the County Health Rankings Model conceptual domains to report the thematic analysis, Table 5 presents the health needs, barriers, and issues that participants of the Hispanic or Latino community identified through their qualitative interviews.

TABLE 5. Hispanic or Latino Community Conversation Identified Health Needs, Barriers, and Issues

CONCEPTUAL DOMAINS	THEMES	SUBTHEMES
HEALTH BEHAVIORS	Mental Health	Concerns around low self-esteem negative impacts on mental health
		Concerns around low self-worth negative impacts on mental health
		Depression, among adults and youth
		Poor social-emotional well-being of youth
		Suicide attempts
		Rape consequences
		Anxiety
		Panic attacks
		Fear of dying
	Abusive & Neglectful Behavior	Domestic violence
		Elder abuse
		Child abuse
		Child neglect
	Substance Use Disorder	Excessive drinking
		Marijuana addiction and use, among adults and youth

HEALTH BEHAVIORS	Chronic Health Conditions	Obesity
		Diabetes, among adults and youth
		Cancer
		High blood pressure
		Respiratory diseases
	Health Seeking Behavior	Undocumented people do not go to community clinics for fear of deportation
		Immigration status barriers to health care seeking and engagement
	COVID-19	Long COVID or Post-COVID conditions
	Victimization of Youth	Online sexual predators
	Oral Health	Oral hygiene
	Food Insecurity	Need more food assistance sites that provide healthy, nutritious, and fresh foods
		Need more healthy and nutritious foods at primary and secondary schools
		Buying healthy food is expensive
		Need more community gardens that provide access to healthy and nutritious foods

CLINICAL CARE	Communication Challenges Surrounding COVID-19	COVID-19 guidelines cause confusion
		Need more information to aid limited English proficiency individuals with accessing COVID-19 vaccines in their communities
		Information on how and where to go to get the COVID-19 vaccine is confusing
		Difficulty getting the COVID-19 vaccine and following up with the second doses due to inflexible service hours
		Difficulty of registering for COVID-19 vaccinations and following up with the second doses due to lack of digital literacy

CLINICAL CARE	Health Education and Promotion Challenges	Need more health education programs
		Need more effective use of media for health promotion to reach the Hispanic or Latino communities
		Need more Peer Health Workers / Community Health Workers that serve the Hispanic or Latino communities
	Barriers in Accessing Health Care	Limited office hours impacting access to health care
		Poor availability/proximity of health care facilities in communities where a high proportion of Hispanics or Latinos live
		Need more access to affordable dental care
		Need more access to mental health care
		Lack of access to health care, especially for newly arrived immigrants
		Need more access to prenatal care
		Need better access to family planning care
		Need more access to affordable emergency health care
		Lack of interpreters for patients with limited English proficiency
		Legal obstacles to U.S. immigration status impacting access to health care
	Barriers in Accessing Addiction Treatment	Need more affordable alcohol rehabilitation programs
		Need more affordable drug rehabilitation programs
	Cultural & Language Barriers in Health Care	Lack of culturally competent health care providers who speak Spanish and understand the Hispanic or Latino communities
		Lack of culturally competent mental health providers who speak Spanish and understand the Hispanic or Latino communities

CLINICAL CARE	Financial Barriers to Health Care	Lack of access to health care insurance, especially for newly arrived immigrants
		Limited access to health care due to low-income levels among some Hispanic or Latino individuals
		High cost of health care
		High cost of dental care
		Need more financial emergency assistance for medical expenses
	Discrimination in Health Care	Health care providers' discrimination towards limited-English proficiency Hispanics or Latinos
		Health systems discrimination towards Hispanic or Latino individuals with or without legal U.S. citizenship documents
	Barriers to Exchanging Health Information	Need more language appropriate health information provided in non-electronic formats
		Lack of knowledge about where to go to get health care services
		Need more concise and plain language health information available in the top languages spoken in Montgomery County

SOCIAL, ECONOMIC, AND DEMOGRAPHIC FACTORS	Economic Insecurity	Expensive cost of living in Montgomery County
		Minimum wage workers need to choose what necessities to pay first
	Access to Clothing	Need more financial emergency assistance for clothing
	Employment and Labor Relations Issues	Lack of access to jobs due to Public Charge Rule concerns
		Need more information and awareness about workers' rights
		Need more employment opportunities for undocumented immigrants
	Family & Social Support	Need an increase in family integration and strengthening services
	Service Needs of Children & Youth	Need more activities for children with special needs

SOCIAL, ECONOMIC, AND DEMOGRAPHIC FACTORS	Barriers to Exchanging Human Services Information	Lack of information and awareness where to find resources
		Information about the availability of health and human services is confusing because it is not in plain language
		Information provided by County government offices can sometimes be incomplete or incorrect
		Need a single place to find all resources for health and human services
	Cultural & Language Barriers in the Community	Need for more linguistically and culturally appropriate information about where to go for help to get health and human services
		Need more culturally competent human services providers who speak Spanish and understand the Hispanic or Latino community
		Lack of interpreters is a barrier to accessing human services
		Lack of responsiveness by the health care system to the social needs of the Hispanic or Latino populations
	Challenges in Navigating the Human Services System	Need more in-person guidance and assistance to help with completing entire processes to apply for and receive social services
		Need more help with scheduling initial and follow-up appointments
		Lack of a centralized institution that directs and coordinates health and human services
		Need more collaboration between organizations and people for more effective referrals
	Help Seeking Barriers	Limited English proficiency people feel intimidated and do not ask for help
		Limited English proficiency people fear being discriminated against so they do not seek resources
		People not seeking services for fear of deportation

SOCIAL, ECONOMIC, AND DEMOGRAPHIC FACTORS	Immigration Challenges	Social systems discriminate against Hispanic or Latino individuals with or without legal U.S. citizenship documents
		Need more legal assistance to help complete U.S. citizenship and immigration documents
		Need more information about health and human services that do not require U.S. citizenship and immigration documents
		Lack of access to government health and human services' benefits due to Public Charge Rule concerns
	Community Safety	Not many bilingual county police officers
		Need faster police response time
		Need more police patrolling high crime areas
		Need more awareness on specific telephone number to send complaints about police officers
		Concerns of orientation of youth to join gangs
		Noisy neighborhoods
	Technology Literacy	Lack of computer literacy
	Education Insecurity	Need more affordable colleges that Hispanic or Latino individuals qualify for

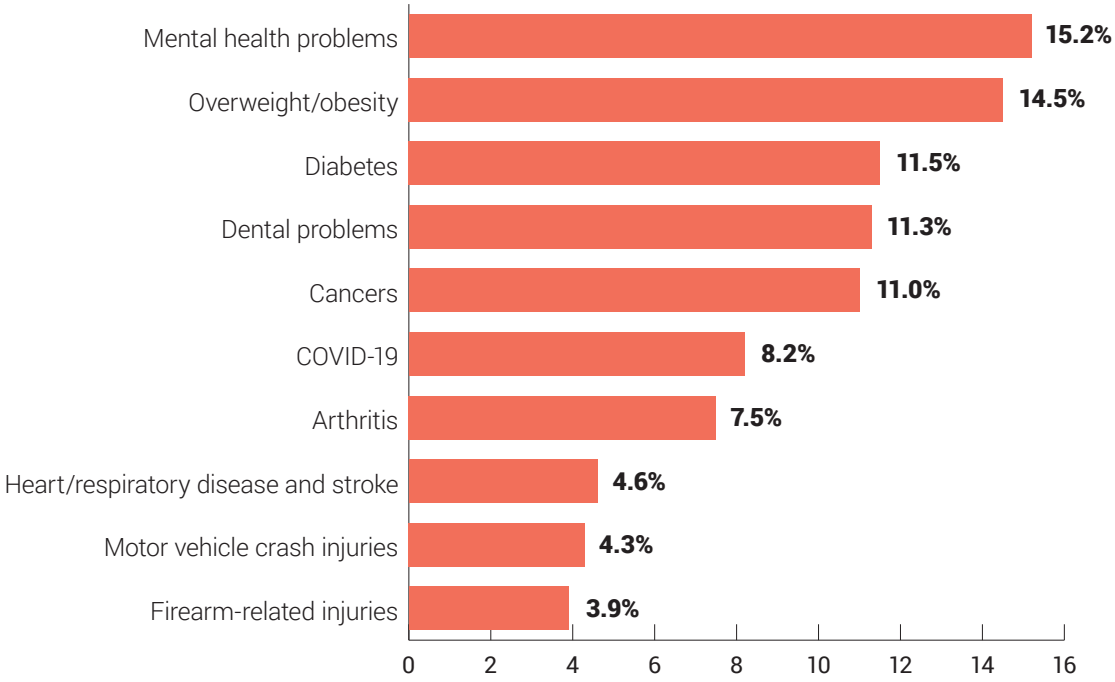
PHYSICAL AND BUILT ENVIRONMENT	Transportation Access Barriers	High cost of transportation
	Housing Instability	High cost of renting apartments
		Rental prices rising too fast
		Services in some apartment complexes are very bad
		Animal infestation (rats, bed bugs) in some apartment complexes
		Mold in some apartment complexes
		Apartment complexes not fixing things in a timely manner
		Need more rental assistance programs

PHYSICAL AND BUILT ENVIRONMENT	Housing Instability	Need more county-funded rental assistance programs that people qualify for
		Need more financial emergency assistance for housing
		Need more shelters for individuals experiencing homelessness
	Residential Segregation	Neighborhood foreclosures negative impact on racial residential segregation
	Digital Divide	Lack of access to smartphones
		Lack of access to the internet
	Survivors of Domestic Violence Safe Housing Access Challenges	Need more safe houses and shelters for individuals experiencing domestic violence
		Need less eligibility requirements for safe houses and shelters for individuals experiencing domestic violence
		Need easier access to safe houses and shelters for individuals experiencing domestic violence
	Invest in Community Infrastructure	Need more infrastructure development and investments in low-income areas

COMMUNITY HEALTH NEEDS SURVEY

Based on the data from the 2022 community health needs survey, Hispanic residents identified mental health as the top health problem that affect them and their community, followed by overweight/obesity, diabetes, and dental problems (Figure 16). Availability/access to insurance, limited access to healthy foods, race/ethnicity discrimination and lack of affordable childcare were the top social/environmental problems that affect health (Figure 17). Poor eating habits, drug use, and lack of exercise were the most important risky behaviors that impact health (Figure 18). A third of residents reported cost as the top reason for not getting care, followed by no insurance and immigration status (Figure 19). Twenty percent of those that responded to the survey indicated that they needed financial assistance because of COVID-19, and 13% needed food assistance (Figure 20).

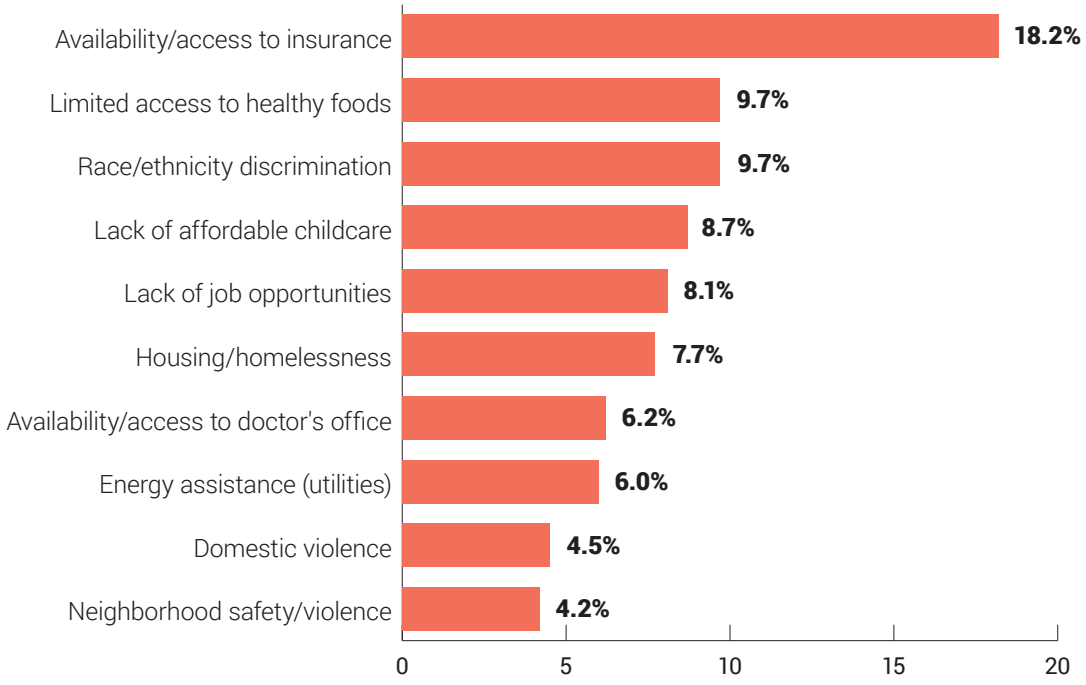
FIGURE 16. **Hispanic or Latino Community Most Important Health Problems**



(N = 112) Hispanic or Latino residents that completed the survey identified availability/access to insurance, limited access to healthy foods, and race/ethnicity discrimination as the top three most important social/environmental problems for them.

FIGURE 17.

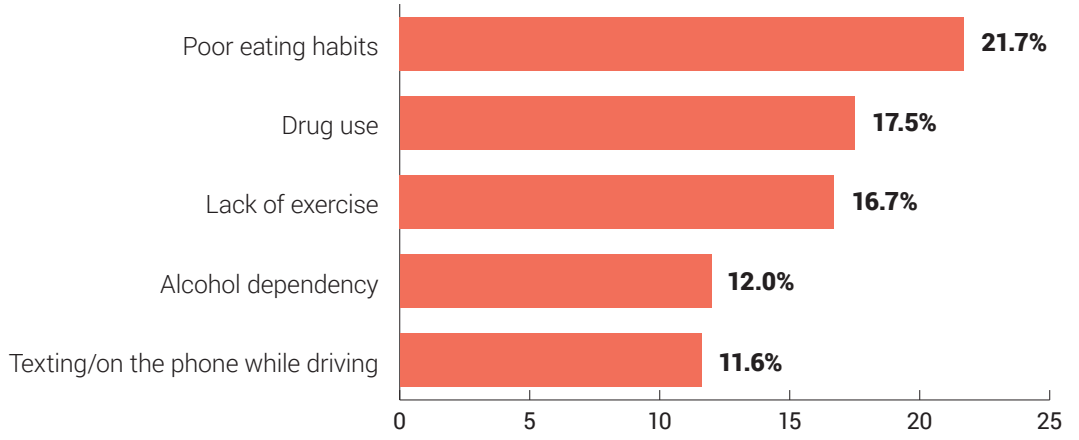
Hispanic or Latino Community Most Important Social/ Environmental Problems



(N = 112) Hispanic or Latino residents that completed the survey identified availability/access to insurance, limited access to healthy foods, and race/ethnicity discrimination as the top three most important social/environmental problems for them.

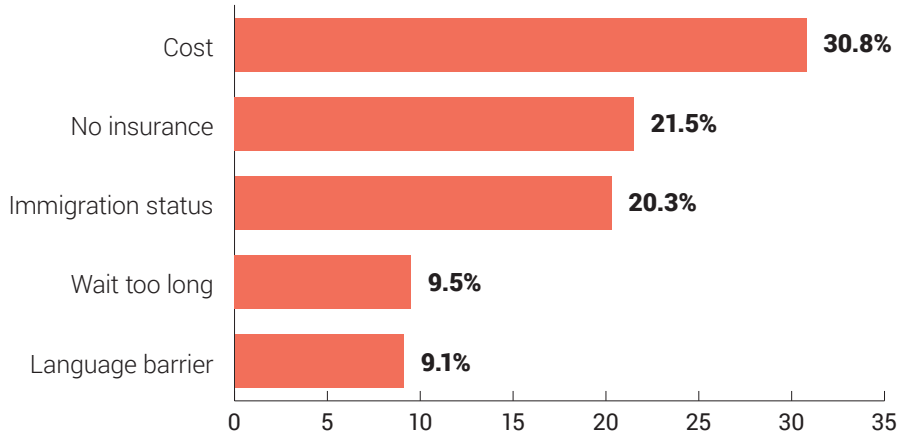
FIGURE 18.

Hispanic or Latino Community Risk factors that Impact Health Behaviors and Outcomes



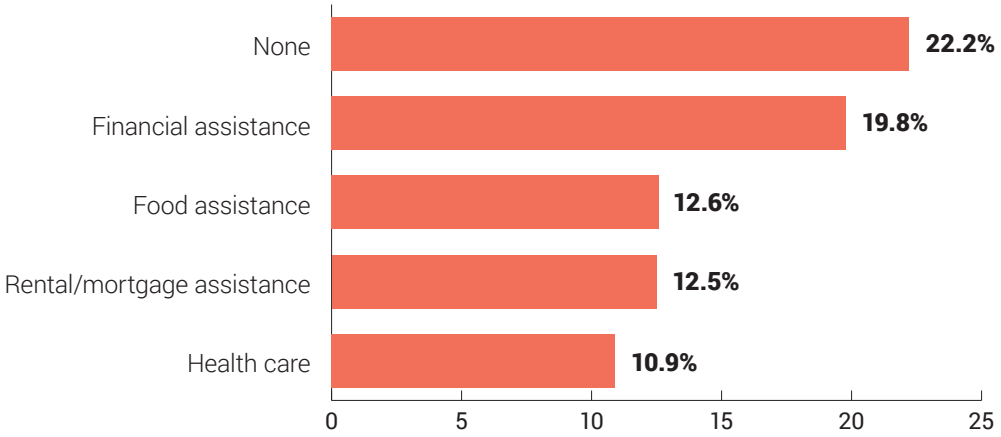
(N = 112) Hispanic or Latino residents that completed the survey identified poor eating habits, drug abuse, and lack of exercise as the top three most important risk factors that impact health behaviors and outcomes for them.

FIGURE 19. **Hispanic or Latino Community Top Reasons for Not Getting Care**



(N = 112) Hispanic or Latino residents that completed the survey identified cost, no insurance, and immigration status as the top three reasons for not getting care for them.

FIGURE 20. **Hispanic or Latino Community Assistance Needed as a Result of COVID-19**



(N = 112) Hispanic or Latino residents that completed the survey identified financial assistance, food assistance, and rental/mortgage assistance as the top three most important needs for them as a result of COVID-19.

SPECIAL POPULATIONS OF MONTGOMERY COUNTY

Agricultural Reserves Community

Population Characteristics for Agricultural Reserves

ZIP CODE	TOTAL POPULATION (2020)	PEOPLE OF COLOR (%)	MEDIAN AGE	LESS THAN HIGH SCHOOL DIPLOMA (%)	UNEMPLOYMENT RATE	PEOPLE OF DISABILITY STATUS (%)	UNINSURED (%)	MEDIAN HOUSEHOLD INCOME ($)	HOUSEHOLDS SPENDING ≥ 35% OF INCOME ON HOUSING COSTS– MORTGAGED (%)	HOUSEHOLDS SPENDING ≥ 35% OF INCOME ON HOUSING COSTS– RENTERS (%)
20832	25,427	40.97	41.3	5.16	2.9	9.3	2.91	139,007	18.6	37.9
20833	7,746	33.55	45.7	3.34	3.6	5.5	3.23	178,017	22.1	28.3
20837	6,129	22.25	44.4	5.14	4.5	10.6	1.8	151,667	4.8	34.2
20838	377	16.18	45	0	0	9	10.61	135,714	21.1	-
20839	139	33.81	28.2	0	0	5	0	188,833	23.3	-
20841	11,692	65.69	39.7	8.01	4.8	7	3.32	171,598	22.3	61
20842	1,467	21.13	47.2	6.34	2.4	17.9	5.07	128,542	19.8	25.4
20871	18,961	66.51	36	3.63	3.8	4.9	3.54	136,414	18.5	26.1
20872	12,790	30.59	41.8	4.93	3	8.7	2.1	121,896	18.9	23.5
20874	60,258	67.49	36.4	9.67	4	10.2	6.35	98,007	18.6	37.7
20876	31,703	72.86	34.1	9.82	4.8	7.4	7.16	106,061	19.5	42.7
20879	26,343	70.53	35.3	10.04	6.4	9.2	11.75	89,163	18.1	44.4
20882	14,441	29.55	45.8	3.07	4	8.6	2.02	140,428	18	20

Note: Data includes zip codes 20832, 20871, and 20882 that crossover into other areas of Montgomery County that lie outside of the designated boundaries of the Agricultural Reserves

COMMUNITY CONVERSATION IDENTIFIED HEALTH NEEDS, BARRIERS, AND ISSUES

Community members that live within the Agricultural Reserve area of the county were invited to participate in a focus group to share their perspectives on the health needs, barriers, and issues affecting their community. Participants were asked to share their perspectives on the biggest health needs in their community, the challenges or barriers to being healthy in their community, and the most important or urgent health issues or challenges to address to improve the health of their community. Using the County Health Rankings Model conceptual domains to report the thematic analysis, Table 6 presents the health needs, barriers, and issues that participants of the Agricultural Reserve community identified through their qualitative interviews.

TABLE 6. Agricultural Reserve Community Conversation Identified Health Needs, Barriers, and Issues

CONCEPTUAL DOMAINS	THEMES	SUBTHEMES
HEALTH OUTCOMES	Quality of Life	Poor behavioral and mental health
		Poorer health outcomes affecting elderly, Hispanics/Latinos, Blacks, and low-income individuals the most
	Length of Life	Premature deaths associated with access to health care
		Length of life associated with access to health care
HEALTH BEHAVIORS	Chronic Diseases	High blood pressure
		Prediabetes or diabetes
	Mental Health	Social isolation
	Diet	Need more education about healthy foods and healthy eating
	Food Insecurity	Need more grocery stores that sell healthy foods
		Need more variety stores that sell non-processed foods
		Hunger, especially among children

CLINICAL CARE	Barriers in Accessing Care	Need more access to health care services
		Need more primary care doctors
		Need more specialty medical care services
		Need access to urgent or emergency health care services
		Need more access to dental care
		Need more access to facilitated telemedicine
		Need more health care services for low-income individuals
	Financial Barriers to Health Care	Lack of access to health insurance for farmers
		Lack of access to health insurance for low-income individuals
		Need more medical providers that accept the prevalent health insurances in the Agricultural Reserves area
	Health Education and Promotion Challenges	Need more health education

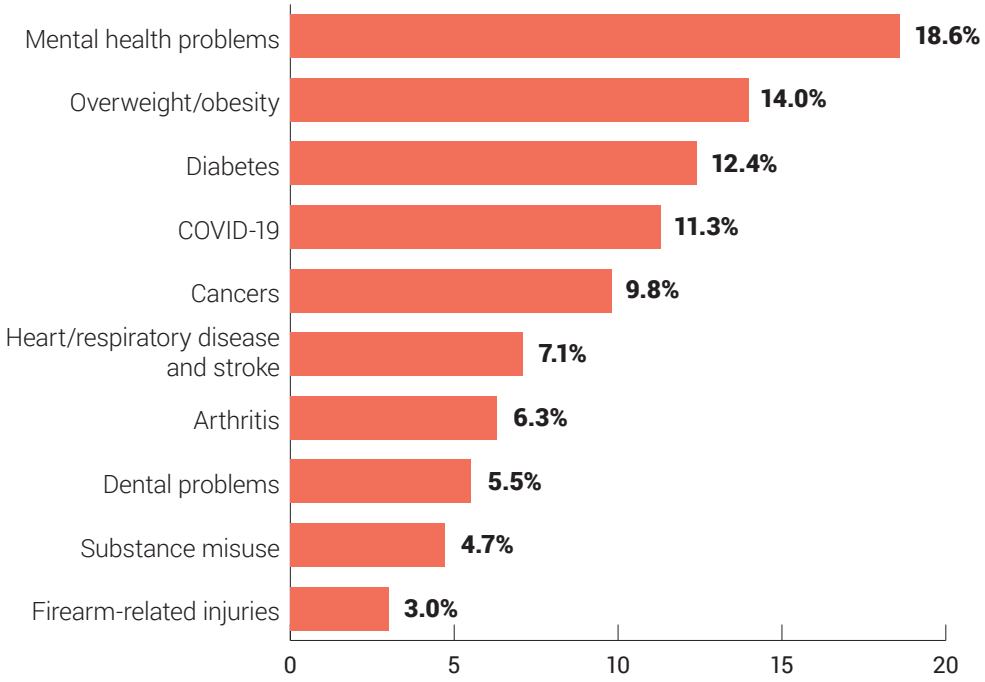
SOCIAL, ECONOMIC, AND DEMOGRAPHIC FACTORS	Social Issues	Need stronger community connectedness
	Economic Insecurity	High cost of living in the area
		Incomes and wages are not equal to the cost of living in the area
	Challenges in Navigating the Human Services System	Hard for people to find the health and human services they need
		Need more County government services that help people apply for health and human services programs

PHYSICAL AND BUILT ENVIRONMENT	Transportation Access Barriers	Lack of public buses/metro lines
		Need more on demand public transit services
		Need to expand fixed bus routes to other parts, the more rural parts, of the Agricultural Reserves (e.g., Dickerson or Barnesville)
		Infrequent schedules of public buses
		Long commute to medical appointments for people using public transportation
		Need more non-emergency transportation services for people who need assistance getting to and from medical appointments in other parts of the county
		Public buses that pickup in Agricultural Reserves do not drop off in areas where most of the medical specialty care providers are (e.g., Germantown, Shady Grove, Key West Highway)
		Long travel distance to supportive human services
	Environmental Hazards	Health concerns over the emission of pollutants from the incinerator, power plant and nuclear engineering facility located in the Agricultural Reserves
		Dust on unpaved and gravel roads contains asbestos
	Housing Instability	High cost of rental housing
		High cost of leases prohibiting business investment
		Unsafe housing conditions, especially among those who are living on farms, living on the "back roads" of the area, or individuals who are low-income
		Poor housing infrastructure
	Community Infrastructure Investment	Need more parks
		Need access to a community center (physical space for community to use) to provide access to health and human services
		Need a senior center that provides health and human services programs (e.g., exercise activities or nutrition education classes)

COMMUNITY HEALTH NEEDS SURVEY

The 2022 community health needs survey identified residents living in the Agricultural Reserve by zip code. Residents living in the Agricultural Reserve identified mental health, overweight/obesity, diabetes, COVID-19, and cancer as the most important health problems they face (Figure 21). Availability/access to insurance, neighborhood safety/violence, race/ethnicity discrimination, and housing/homelessness were the top social/environmental problems that affected health (Figure 22). Poor eating habits, lack of exercise, and texting/on the phone while driving were the most important risky behaviors that impact health (Figure 23). A third of residents reported cost as the top reason for not getting care, followed by no insurance and immigration status (Figure 24). Seventeen percent of those that responded to the survey indicated that they needed financial assistance because of COVID-19, and 10% needed help getting health care (Figure 25).

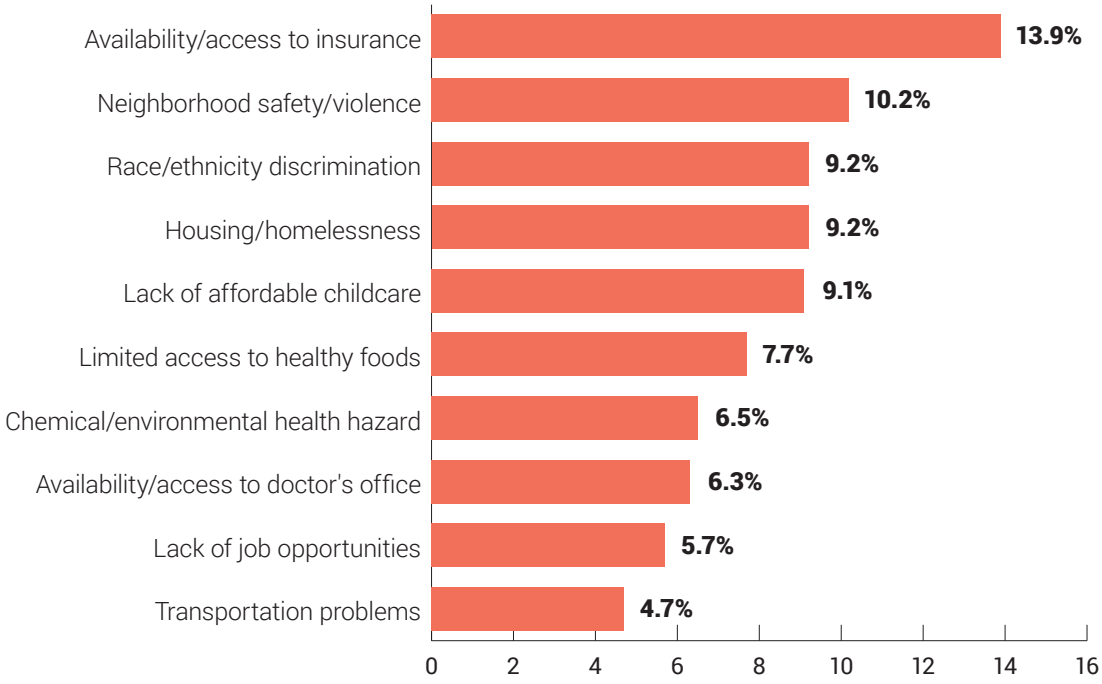
FIGURE 21. **Agricultural Reserve Community Most Important Health Problems**



(N = 244)

FIGURE 22.

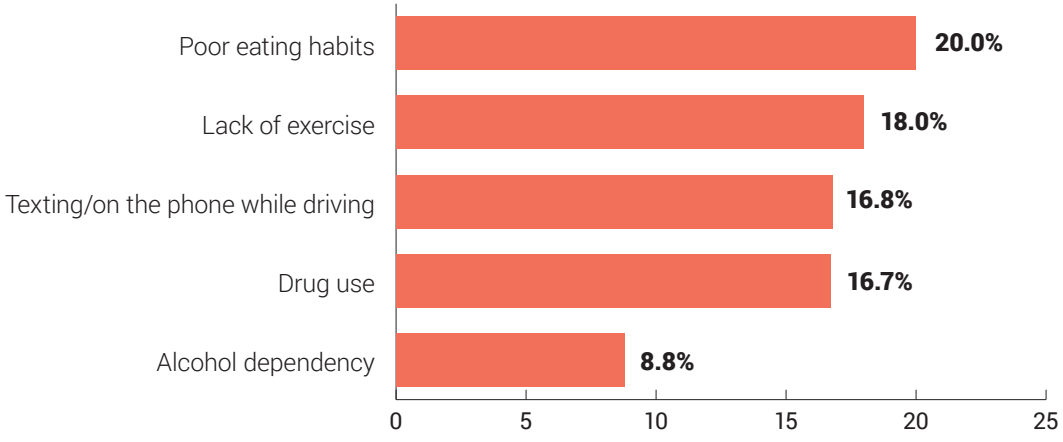
Agricultural Reserve Community Most Important Social/ Environmental Problems



(N = 244)

FIGURE 23.

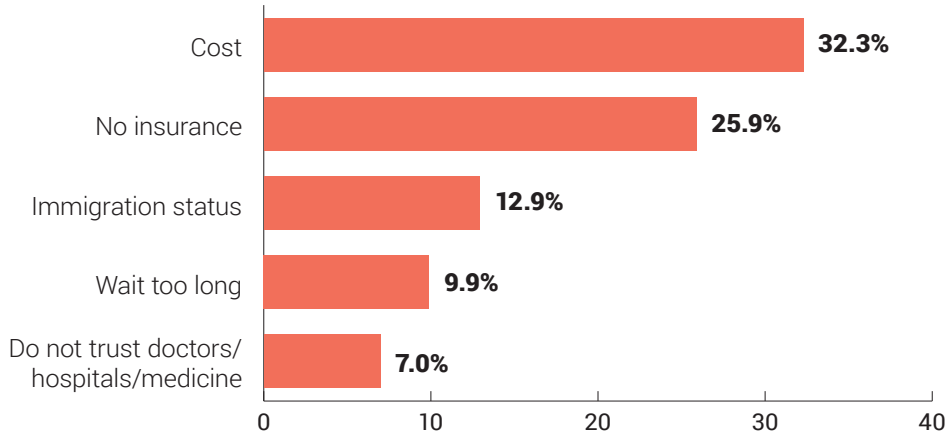
Agricultural Reserve Community Most Important Risk factors that Impact Health Behaviors and Outcomes



(N = 244)

FIGURE 24.

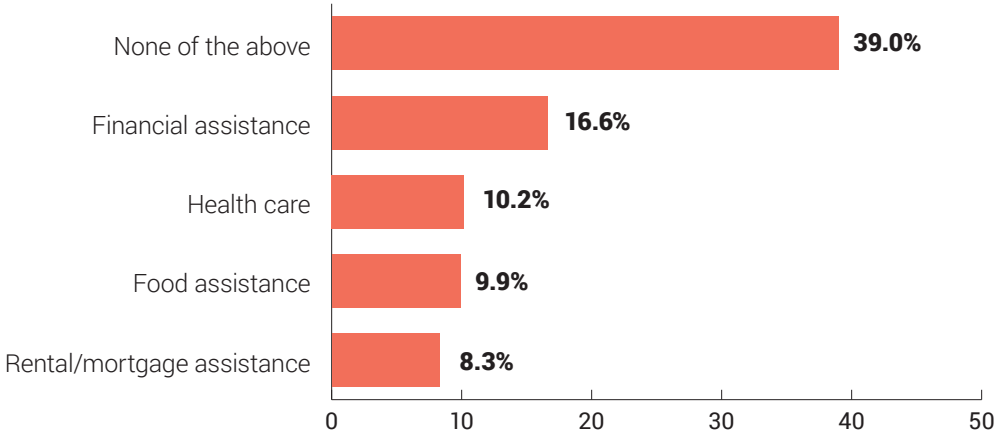
Agricultural Reserve Community Top Reasons for Not Getting Care



(N = 244)

FIGURE 25.

Agricultural Reserve Community Assistance Needed as a Result of COVID-19



(N = 244)

Community Members with Disabilities

COMMUNITY CONVERSATION IDENTIFIED HEALTH NEEDS, BARRIERS, AND ISSUES

Community members who identified that they have a disability were invited to participate in a focus group to share their perspectives on the health needs, barriers, and issues affecting their community. Participants were asked to share their perspectives on the biggest health needs in their community, the challenges or barriers to being healthy in their community, and the most important or urgent health issues or challenges to address to improve the health of their community. Using the County Health Rankings Model conceptual domains to report the thematic analysis, Table 7 presents the health needs, barriers, and issues that participants with disabilities identified through their qualitative interview.

TABLE 7. Community Members with Disabilities Community Conversation Identified Health Needs, Barriers, and Issues

CONCEPTUAL DOMAINS	THEMES	SUBTHEMES
HEALTH BEHAVIORS	Diet	Physical inactivity
		Need more virtual/online physical activity programs of various levels for people with disabilities
		Lack of healthy food eating
	Tobacco Use	Smoking
	Mental Health	Stress
		Elevated levels of loneliness and social isolation, specifically during the COVID-19 pandemic
CLINICAL CARE	COVID-19	Concerns over the spread of COVID-19 variants
	Barriers in Accessing Health Care	Access to doctors
		Need more access to home health care services
		Access to medication
	Financial Barriers to Health Care	Access to health insurance
		Concerns over health insurance companies denying claims
		High cost of prescription drugs

SOCIAL, ECONOMIC, AND DEMOGRAPHIC FACTORS	Issues of Social Associations	Getting to know neighbors (especially those with disabilities)
		Disability inclusion
		Need more social groups for people with disabilities
	Barriers to Healthy Eating	Limited time available for food preparation and cooking
		Cooking-related challenges faced by people with disabilities
	Economic Insecurity	Need more paid employment opportunities for people with disabilities
		Need more job placement services for people with disabilities
		Long term financial planning literacy is needed
	Challenges in Navigating the Human Services System	Hard for people with disabilities to find the health and human services they need
		Need more resources and advocates that help people with disabilities apply for health and human services programs
PHYSICAL AND BUILT ENVIRONMENT	Pedestrian Safety	Need more Americans with Disabilities Act compliant accessible sidewalks
		Limited sidewalks impacting ability to get to doctor's appointments
		Limited sidewalks impacting ability to get to pharmacy
	Transportation Access Barriers	Challenges with access to transportation for people with disabilities
	Housing Instability	Need more accessible housing for people with disabilities
		Need more affordable housing
		Need more safe housing

Immigrant Community

COMMUNITY CONVERSATION IDENTIFIED HEALTH NEEDS, BARRIERS, AND ISSUES

Community members that identify with the immigrant community were invited to participate in a focus group to share their perspectives on the health needs, barriers, and issues affecting their community. Immigrant was defined as having arrived in the United States within the past 10 years. Participants were asked to share their perspectives on the biggest health needs in their community, the challenges or barriers to being healthy in their community, and the most important or urgent health issues or challenges to address to improve the health of their community. Using the County Health Rankings Model conceptual domains to report the thematic analysis, Table 8 presents the health needs, barriers, and issues that participants of the immigrant community identified through their qualitative interview.

TABLE 8. Immigrant Community Conversation Identified Health Needs, Barriers, and Issues

CONCEPTUAL DOMAINS	THEMES	SUBTHEMES
HEALTH BEHAVIORS	Exercise	Physical inactivity
		Need more free memberships to gyms for low-income residents
	Diet	Lack of healthy food eating
	Food Insecurity	Use of food banks to supplement families' nutritional needs
	Chronic Health Conditions	Diabetes
		Stress
		High blood pressure
		High cholesterol
	Health Seeking Behavior	Use of emergency room due to poor access to community-based primary care services
		Prevention-related health needs associated with not going for regular physical checkups (especially for men)
	Mental Health	Depression
		Anxiety

CLINCAL CARE	Financial Barriers to Health Care	High out-of-pocket costs in outpatient and primary care settings
		High insurance premiums as deterrent for health coverage enrollment
	Barriers in Accessing Health Care	Need more mobile health care services
		Need more mobile dental clinic services
		Need more mental health care and services
		Poor availability/proximity of health care facilities
		Need more community health centers in neighborhoods where high proportions of immigrants live
		Need more access to eye care
	Cultural & Language Barriers in Health care	Lack of bilingual and culturally competent health care providers characteristic of the Montgomery County immigrant community
		Lack of bilingual and culturally competent mental health providers characteristic of the Montgomery County immigrant community
	Barriers to Exchanging Health Information	Lack of relevant information on mental health

SOCIAL, ECONOMIC, AND DEMOGRAPHIC FACTORS	Economic Insecurity	Low wages/income
		High cost of living in Montgomery County
		Need more employment opportunities for adult immigrants
	Cultural & Language Barriers in the Community	Need for more linguistically and culturally appropriate County information on where to go to for help to get health and human services
	Social Associations	Need more inclusive socialization activities for children with disabilities

SOCIAL, ECONOMIC, AND DEMOGRAPHIC FACTORS	Community Safety	Intensive police presence in community
		Heavy police patrol in some public parks
		Vandalism

PHYSICAL AND BUILT ENVIRONMENT	Pedestrian Safety	Need more accessible sidewalks to encourage walking
		Need more walking trails
	Housing Instability	Need more affordable rental housing
		Need more home ownership opportunities
	Transportation Access Barriers	Lack of public bus routes to and from medical facilities (hospitals and community clinics)
	Digital Divide	High cost of internet service

Older Adults' Community

COMMUNITY CONVERSATION IDENTIFIED HEALTH NEEDS, BARRIERS, AND ISSUES

Residents aged 60 and older were invited to participate in a focus group to share their perspectives on the health needs, barriers, and issues affecting their community. Participants were asked to share their perspectives on the biggest health needs in their community, the challenges or barriers to being healthy in their community, and the most important or urgent health issues or challenges to address to improve the health of their community. Using the County Health Rankings Model conceptual domains to report the thematic analysis, Table 9 presents the health needs, barriers, and issues that participants of the older adult community identified through their qualitative interview.

TABLE 9. Older Adults' Community Conversation Identified Health Needs, Barriers, and Issues

CONCEPTUAL DOMAINS	THEMES	SUBTHEMES
HEALTH BEHAVIORS	Physical Activity	Need more water aerobic exercise classes for older adults
		Need more online exercise classes for older adults
		Need more outdoor activities for older adults
	Mental Health	Social isolation
	Food Insecurity	Need more access to grocery stores that are convenient to get to
		Need more access to farmer's markets that are convenient to get to
		Need more access to a variety of stores to buy basic necessities
	Healthy Eating Education	Processed food consumption
		Need more classes about healthy foods and healthy eating

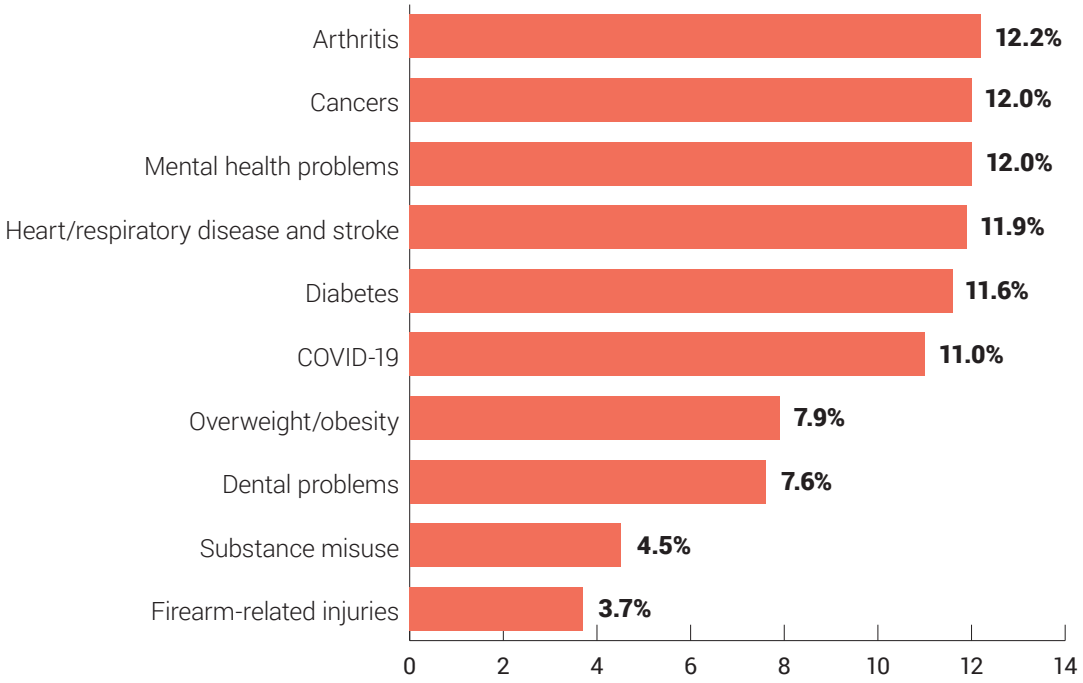
CLINICAL CARE	Financial Barriers to Health Care	Misunderstanding of Medicare insurance could lead to unnecessarily services and high out-of-pocket costs
		Medicare premiums increasing rapidly
		High out-of-pocket costs associated with concern over the increasing number of concierge doctors offering primary care services
		High cost of prescription drugs
	Barriers in Accessing Care	Need more community health care clinics in rural parts of Montgomery County (e.g., Poolesville)
		Need an urgent care center in rural parts of Montgomery County (e.g., Poolesville)
		Need more primary care doctors that accept Medicare
	Health Education Challenges	Need to improve Medicare related health care information for older adults
	Issues of Medication Prescribing	Polypharmacy in older adults
SOCIAL, ECONOMIC, AND DEMOGRAPHIC FACTORS	Challenges in Navigating the Human Services System	Online client/patient pre-appointment forms are too lengthy and very difficult for seniors to complete
	Social Associations	Need more free or low-cost activities for older adults living in senior housing complexes
PHYSICAL AND BUILT ENVIRONMENT	Transportation Access Barriers	Need more transportation options that enable seniors to attend medical appointments
		Need more transportation funding to connect older adults who live in areas without senior centers to areas with senior centers
		Need more convenient public transportation routes (e.g., in Upcounty region) that connect seniors to personal activities of daily living

PHYSICAL AND BUILT ENVIRONMENT	Transportation Access Barriers	Need more convenient public bus stops (e.g., in Upcounty region) in areas where a high proportion of seniors live
		Long travel distance to personal activities of daily living (e.g., to grocery stores in some communities throughout Eastern Montgomery and Upcounty regions)
	Pedestrian Safety	Need more accessible sidewalks (e.g., in some communities throughout Eastern Montgomery and Upcounty regions)
		Need more walking trails
	Vegetation Control for Safety	Overgrown tree branches or brush block common areas for walking
	Land-Use Planning	Need more green spaces (e.g., in and around some communities throughout the Bethesda-Chevy Chase Region)

COMMUNITY HEALTH NEEDS SURVEY

The 2022 community health needs survey included many respondents who live in the county and who are 65 years and older. Residents 65 years and older identified arthritis, cancer, mental health, and heart/respiratory disease and stroke as the most important health problems they face (Figure 26). Neighborhood safety/violence, housing/homelessness, race/ethnicity discrimination and lack of affordable childcare were the top social/environmental problems that affect health (Figure 27). Lack of exercise, texting/on the phone while driving and drug use were the most important risky behaviors that impact health (Figure 28). A third of residents reported cost as the top reason for not getting care, followed by no insurance and long wait times (Figure 29). Ten percent of those that responded to the survey indicated that they needed financial assistance because of COVID-19, and 7% needed food assistance (Figure 30).

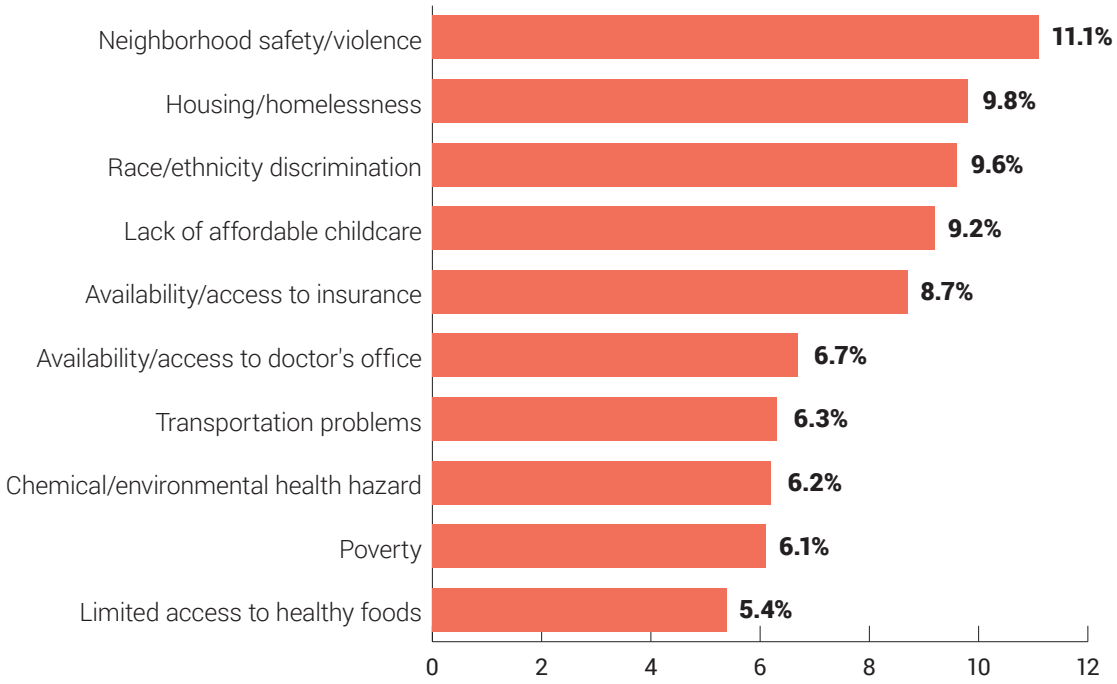
FIGURE 26. **Older Adults' Community Most Important Health Problems**



(N = 594)

FIGURE 27.

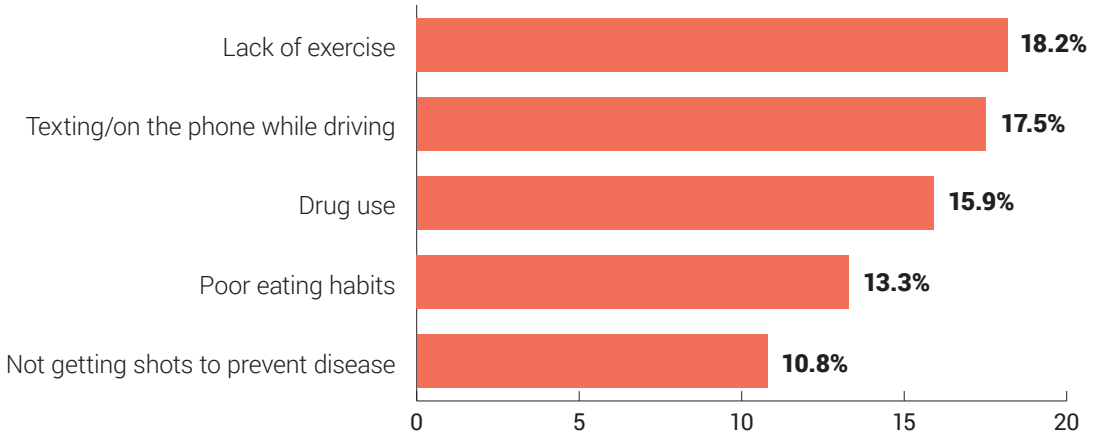
Older Adults' Community Most Important Social/Environmental Problems



(N = 594)

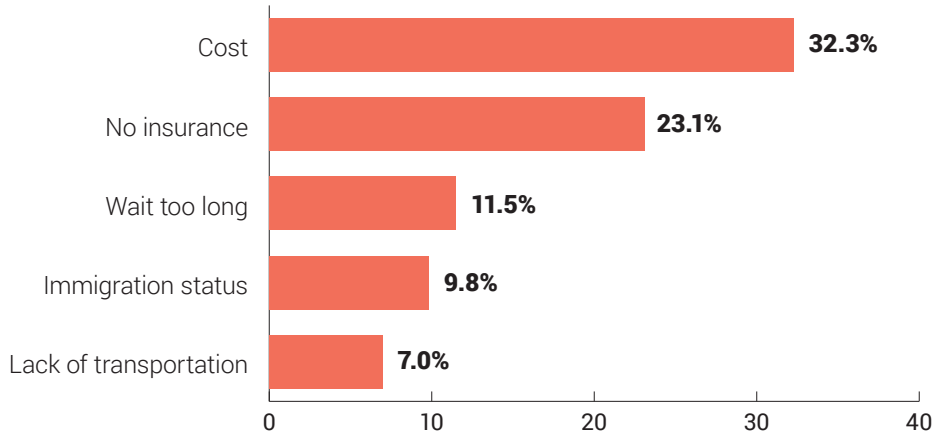
FIGURE 28.

Older Adults' Community Most Important Risk factors that Impact Health Behaviors and Outcomes



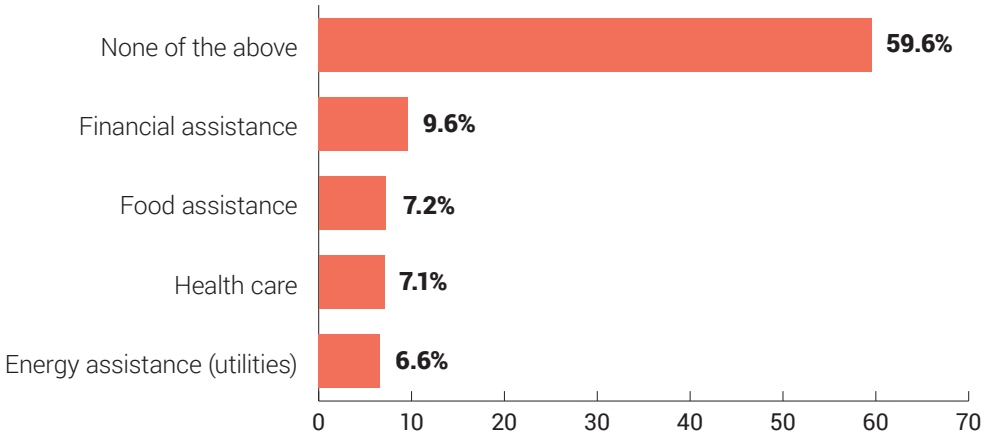
(N = 594)

FIGURE 29. **Older Adults' Community Top Reasons for Not Getting Care**



(N = 594)

FIGURE 30. **Older Adults' Community Assistance Needed as a Result of COVID-19**



(N = 594)

Uninsured, Low-Income Community

COMMUNITY CONVERSATION IDENTIFIED HEALTH NEEDS, BARRIERS, AND ISSUES

Community members with household incomes at or below 250 percent of the federal poverty level or who report being uninsured were invited to participate in a focus group to share their perspectives on the health needs, barriers, and issues affecting their community. Participants were asked to share their perspectives on the biggest health needs in their community, the challenges or barriers to being healthy in their community, and the most important or urgent health issues or challenges to address to improve the health of their community. Using the County Health Rankings Model conceptual domains to report the thematic analysis, Table 10 presents the health needs, barriers, and issues that participants of the uninsured, low-income community identified through their qualitative interview.

TABLE 10. Uninsured, Low-Income Community Conversation Identified Health Needs, Barriers, and Issues

CONCEPTUAL DOMAINS	THEMES	SUBTHEMES
HEALTH BEHAVIORS	Substance Use Disorders	Drug use
	Tobacco Use	Smoking
	Alcohol Use	Excessive drinking
	Food Insecurity	Access to healthy foods for individuals who panhandle
		Single-parent households having challenges affording healthy foods
CLINICAL CARE	Communication Barriers in Health Care	Need better patient-provider relationships
	Financial Barriers to Health Care	Lack of access to public health insurance
		High out-of-pocket costs for health care services
	Barriers in Accessing Health Care	Long travel distance to health care services for uninsured people
		Long wait times for medical appointments

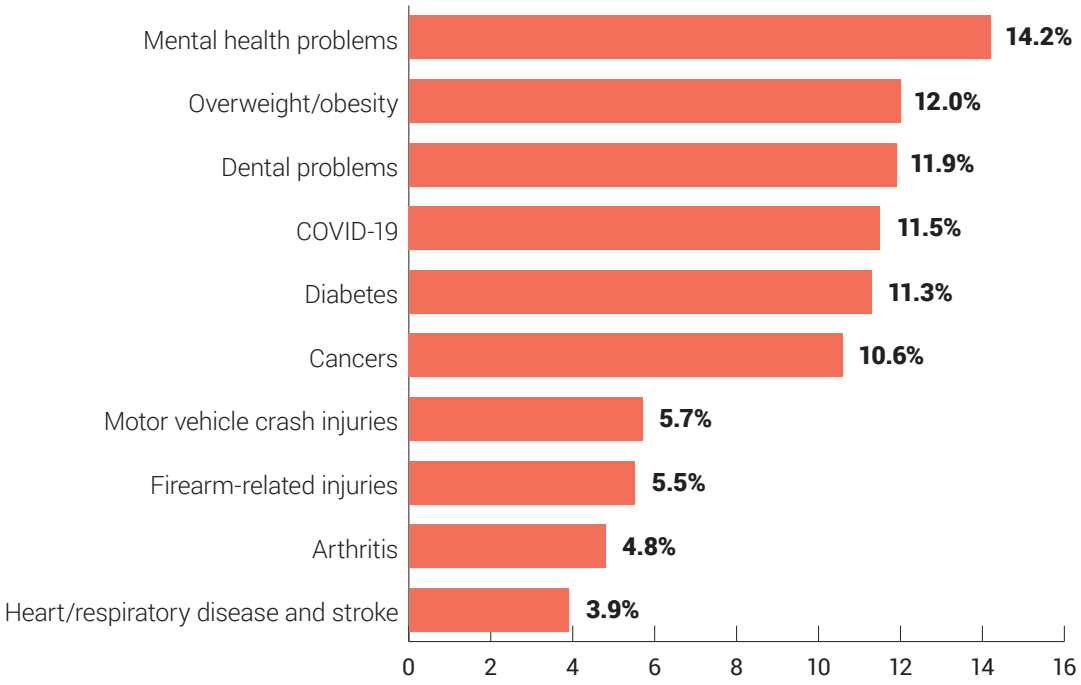
SOCIAL, ECONOMIC, AND DEMOGRAPHIC FACTORS	Social Associations	Need better social connectedness among individuals living in low-income housing complexes
	Education Insecurity	High costs of college/higher education
		Need more information and help with understanding the process to apply to college

PHYSICAL AND BUILT ENVIRONMENT	Housing Instability	Apartment complexes not fixing things in a timely manner
		Availability of housing for individuals who panhandle
		Increasing number of people who are experiencing homelessness
		Need longer hours for homeless shelters to be open
		Need more available homeless shelters
	Pedestrian Safety	Need more speed bumps and humps in neighborhoods
		Potholes on roadways increasing risk of car collision involving injury to drivers or pedestrians
	Transportation Access Barriers	Long distance to access a public bus or metro
		Need more convenient public transportation routes in neighborhoods
		Need more convenient public bus stops in areas where a high proportion of low-income individuals live
		Lack of transportation options to attend medical appointments

COMMUNITY HEALTH NEEDS SURVEY

Data from self-identified uninsured residents were analyzed from the 2022 community health needs survey. Uninsured residents identified mental health, overweight/obesity, dental problems, COVID-19, and diabetes as the most important health problems they face (Figure 31). Availability/access to insurance, lack of job opportunities, limited access to healthy foods and race/ethnicity discrimination were the top social/environmental problems that affect health (Figure 32). Substance use/addiction, poor eating habits, and lack of exercise were the most important risky behaviors that impact health (Figure 33). A third of residents reported cost as the top reason for not getting care, followed by no insurance and immigration status (Figure 34). Twenty-three percent of those that responded to the survey indicated that they needed financial assistance because of COVID-19, and 14 percent needed food assistance (Figure 35).

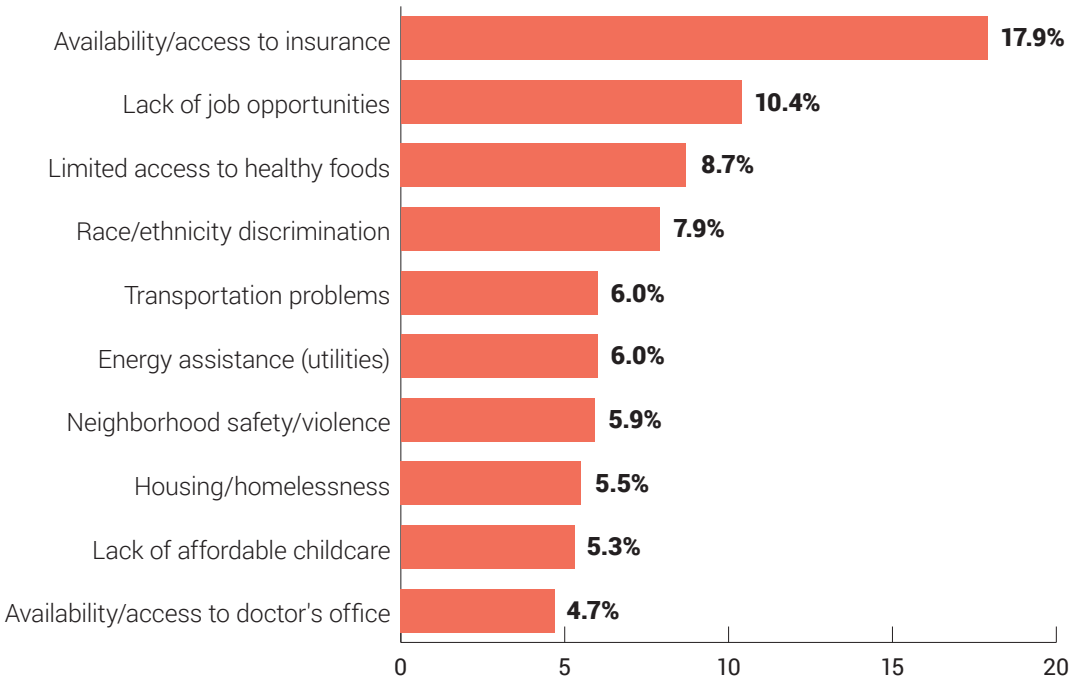
FIGURE 31. **Uninsured, Low-Income Community Most Important Health Problems**



(N = 88)

FIGURE 32.

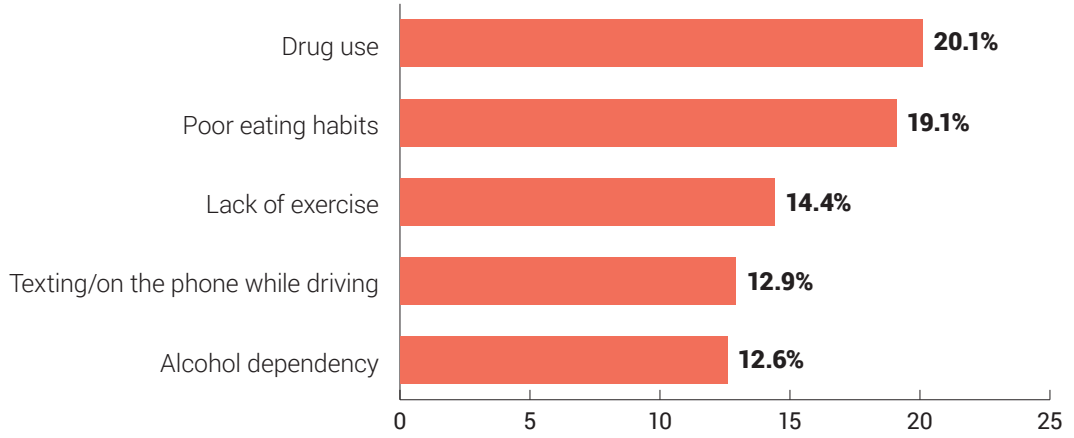
Uninsured, Low-Income Community Most Important Social/ Environmental Problems



(N = 88)

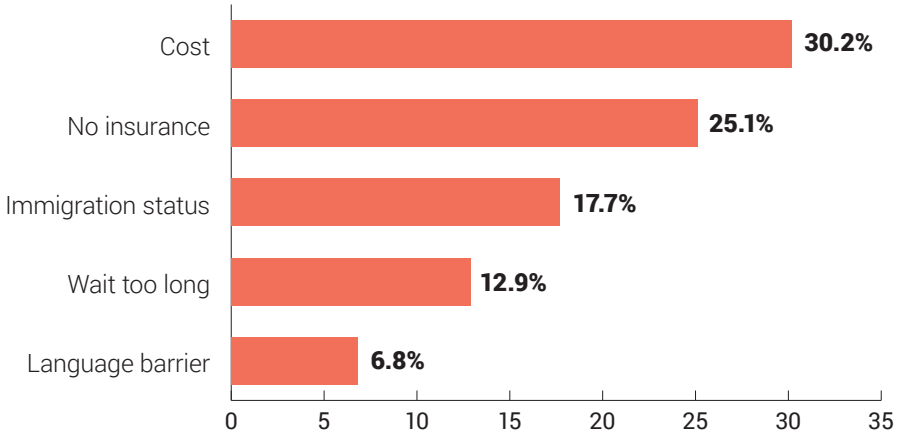
FIGURE 33.

Uninsured, Low-Income Community Risk factors that Impact Health Behaviors and Outcomes



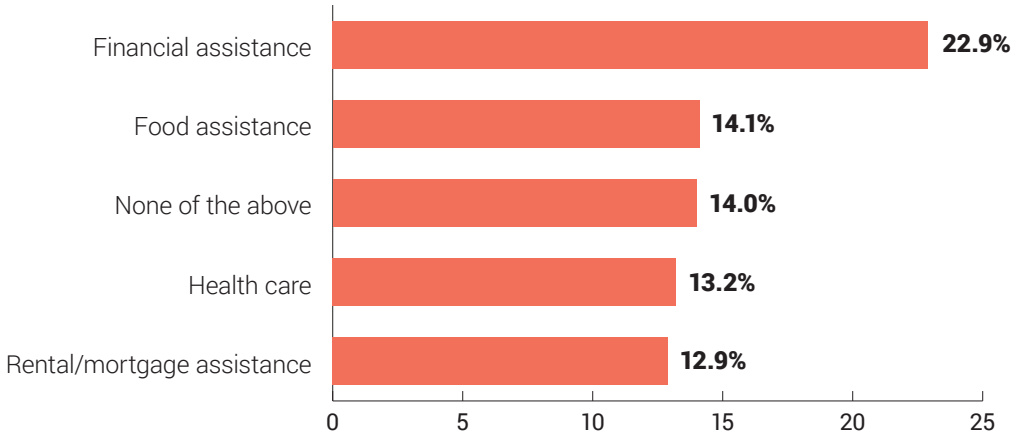
(N = 88)

FIGURE 34. **Uninsured, Low-Income Community Top Reasons for Not Getting Care**



(N = 88)

FIGURE 35. **Uninsured, Low-Income Community Assistance Needed as a Result of COVID-19**



(N = 88)

Youth Community

COMMUNITY CONVERSATION IDENTIFIED HEALTH NEEDS, BARRIERS, AND ISSUES

Residents ages 17 and younger were invited to participate in a focus group to share their perspectives on the health needs, barriers, and issues affecting their community. Participants were asked to share their perspectives on the biggest health needs in their community, the challenges or barriers to being healthy in their community, and the most important or urgent health issues or challenges to address to improve the health of their community. Using the County Health Rankings Model conceptual domains to report the thematic analysis, Table 11 presents the health needs, barriers, and issues that youth participants identified through their qualitative interview.

TABLE 11. Youth Community Conversation Identified Health Needs, Barriers, and Issues

CONCEPTUAL DOMAINS	THEMES	SUBTHEMES
HEALTH BEHAVIORS	Tobacco Use	E-cigarette "vape" use among youth
	Substance Use Disorder	Drug use
	Hygiene Practices	Lack of appropriate personal hygiene
	Physical Activity	Need more gyms and other community resources for youth to engage in exercise
	Diet	Too many unhealthy fast-food restaurants in the community
		Lack of knowledge about healthy eating
		Need better access to healthy and affordable school meals
	Food Insecurity	Not enough money to buy healthy foods to eat
		Need larger portions (two or three) of bag food per family size at food distribution sites
	Injuries	Youth sports injuries
	Chronic Health Conditions	Heart diseases
		Stress

HEALTH BEHAVIORS	Health Seeking Behavior	Prevention-related health needs associated with not going to regular physical checkups
		Adults working multiple jobs is a time barrier to health care seeking and engagement
	COVID-19	COVID-19 vaccine hesitancy associated with lack of information and mistrust
CLINICAL CARE	Barriers in Accessing Health Care	Lack of access to medical care for people without insurance
		Lack of access to urgent care for people without insurance
		Need increased access to preventive care (e.g., childhood immunizations)
		Need increased access to physical therapy for youth to overcome their sports injuries
		Lack of access to dental care
		Need more access to elderly care for low-income individuals
		Need improvements to heart health care
	Financial Barriers to Health Care	High cost of health care
		High cost of dental care
		Lack of access to health insurance (specifically for low-income individuals and newly arrived immigrants)
	Health Education and Promotion Challenges	Need more school-based health education (e.g., on preventive measures and quitting vaping)
		Lack of information sharing and support towards making healthy choices
	Barriers to Exchanging Health Information	Lack of awareness on how and where to go to receive preventive health care services

SOCIAL, ECONOMIC, AND DEMOGRAPHIC FACTORS	Education Insecurity	High cost of a college education
		Some scholarships do not allow students to apply if they are not citizens in the U.S.
		Adults working multiple jobs is a time barrier to pursuing a college education
	Community Safety	Gang activity
		Violent crime
		Drug use
		Drug dealing

PHYSICAL AND BUILT ENVIRONMENT	Environmental Hazards	Presence of water pollution
	Waste Management	Need cleaner neighborhoods

LGBTQ+ Community

COMMUNITY CONVERSATION IDENTIFIED HEALTH NEEDS, BARRIERS, AND ISSUES

Community members that identify with the LGBTQ+ community were invited to participate in a focus group to share their perspectives on the health needs, barriers, and issues affecting their community. Participants were asked to share their perspectives on the biggest health needs in their community, the challenges or barriers to being healthy in their community, and the most important or urgent health issues or challenges to address to improve the health of their community. Using the County Health Rankings Model conceptual domains to report the thematic analysis, Table 12 presents the health needs, barriers, and issues that participants of the LGBTQ+ community identified through their qualitative interview.

TABLE 12. LGBTQ+ Community Conversation Identified Health Needs, Barriers, and Issues

CONCEPTUAL DOMAINS	THEMES	SUBTHEMES
CLINICAL CARE	Barriers in Accessing Health Care	Lack of culturally competent care for LGBTQ+ community (includes care sensitive to gender identity, nonconforming, and nonbinary individuals)
		Burden of traveling distance to out of county medical services that provide gender affirming care to LGBTQ+ individuals
		Lack of health care insurances that participate with in-network and out-of-network providers that offer gender-affirming care
	Barriers in Accessing Behavioral Health Services	Need more inclusive and accepting mental health and substance use recovery programs for members of the LGBTQ+ community
		Lack of support groups for individuals undergoing hormone therapy
	Financial Barriers to Health Care	High out-of-pocket costs for medical visits
		High out-of-pocket costs for medications
		High out-of-pocket costs for hormone replacement therapy
	Health Education and Promotion Challenges	Burden of educating providers about familiarity and comfort caring for the LGBTQ+ community

CLINICAL CARE	Cultural Barriers in Health care	Lack of health care practitioners who deliver LGBTQ+ culturally appropriate care and gender-affirming care
		Lack of mental health practitioners who deliver LGBTQ+ culturally appropriate care and gender-affirming care
SOCIAL, ECONOMIC, AND DEMOGRAPHIC FACTORS	Barriers to Exchanging Health Information	Need more information on the Montgomery County website about LBGTQIA+ affirming health and human services and programs
	Challenges in Navigating the Human Services System	Need telephonic or video- based navigation services to help locate LGBTQ+ friendly services in Montgomery County
	Legal Assistance	Lack of legal support services for the LGBTQ+ community
	Issues of Social Associations	Need more LGBTQ+ friendly and respectful neighborhoods and communities in Montgomery County
PHYSICAL AND BUILT ENVIRONMENT	Housing Instability	Need more homeless shelters or supportive housing for LGBTQ+ individuals (especially youth)
	Transportation Access Barriers	Need more gender-affirming care health centers located near metro and bus lines
		Lack of transportation to out-of-county medical services that provide gender-affirming care to LGBTQ+ individuals

COMMUNITY HEALTH NEEDS SURVEY – SELECT RESULTS FROM MONTGOMERY COUNTY'S LGBTQ+ COMMUNITY SURVEY

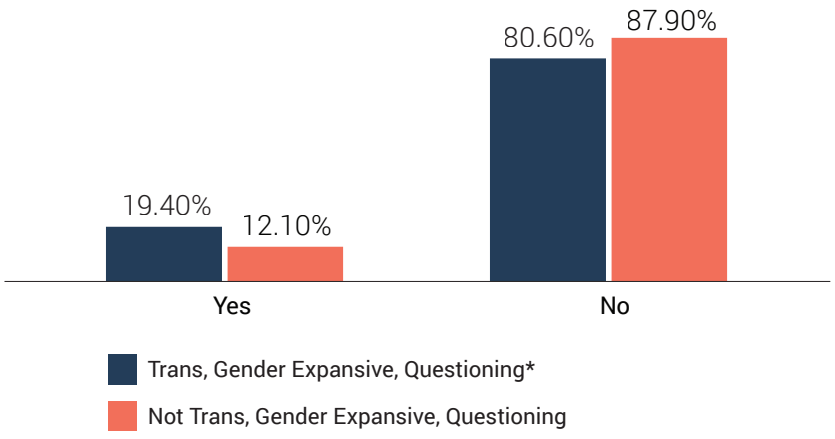
In the summer of 2022, Montgomery County launched the first-ever survey of Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ+) residents. The Montgomery County LGBTQ+ Community Survey was distributed to participants via online platforms, websites, affinity group email lists, and in-person at the Pride in the Plaza event. The survey collected anonymous information about health and wellness, access to resources and services, experiences of discrimination and other aspects of LGBTQ+ residents' life and experience in Montgomery County. The data were collected through the online survey platform, Cognito Forms.

Results in this section include LGBTQ+ participants' experiences with housing, health care, gender affirmation, sexual health, and law enforcement. Our primary variable of interest for reporting were participants who identified as trans, gender-expansive, or questioning compared to participants who did not. The results included a total of 842 respondents and do not include respondents who identified as heterosexual, cis-gender, and not falling under the gender expansive umbrella. Of those surveyed, 38 percent of respondents identified as gender expansive and unsure/questioning. The youngest respondent was 11 years old and the oldest was 84 years old.

Housing

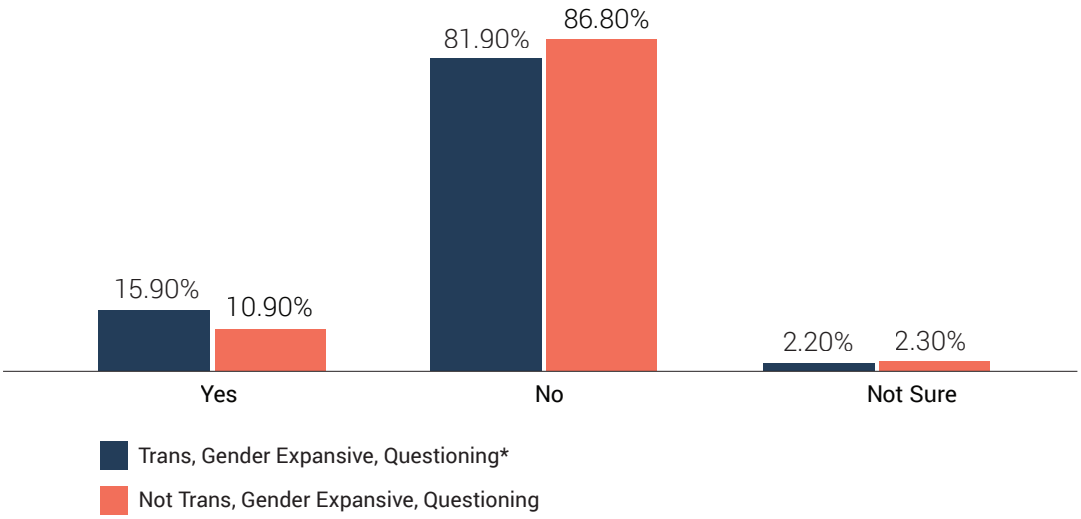
Approximately 19 percent of respondents identifying as trans, gender expansive and questioning indicated they had difficulty finding or staying housed within the past year, while 12.1 percent of respondents identifying as not trans, gender expansive and questioning indicated housing difficulty within the past year (Figure 36).

FIGURE 36. **LGBTQ+: Difficulty Finding Housing or Staying Housed**



About 16 percent of respondents identifying as trans, gender expansive, and questioning reported experiencing homelessness, compared to 10.9 percent of respondents not identifying as trans, gender expansive and questioning (Figure 37) reporting ever experiencing homelessness.

FIGURE 37. **LGBTQ+: Ever Experienced Homelessness**



Health Care

Twenty percent of all respondents indicated they do not have a primary care provider (Figure 38). Of those respondents that have a primary care provider, about 80 percent have a primary care provider located in Montgomery County (Figure 39).

FIGURE 38. **LGBTQ+: Access to Primary Care Provider or Office**

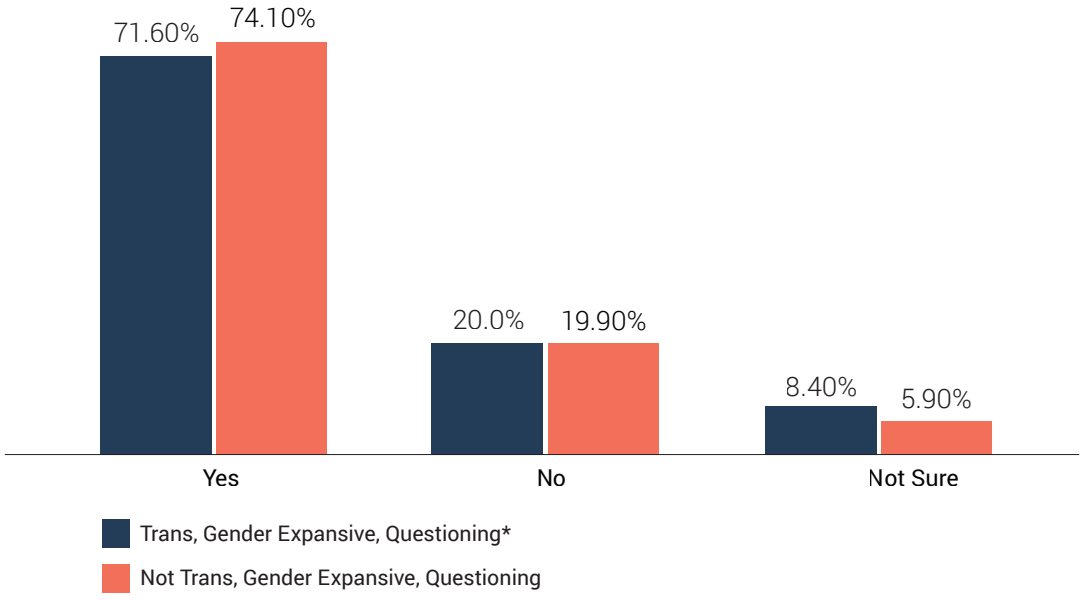
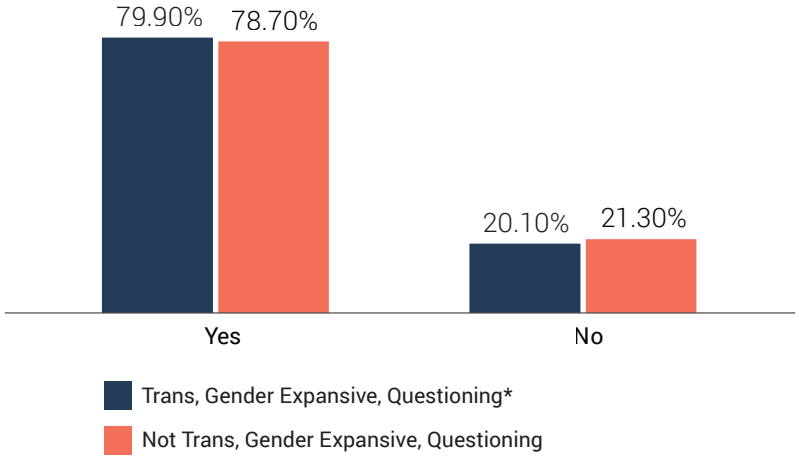
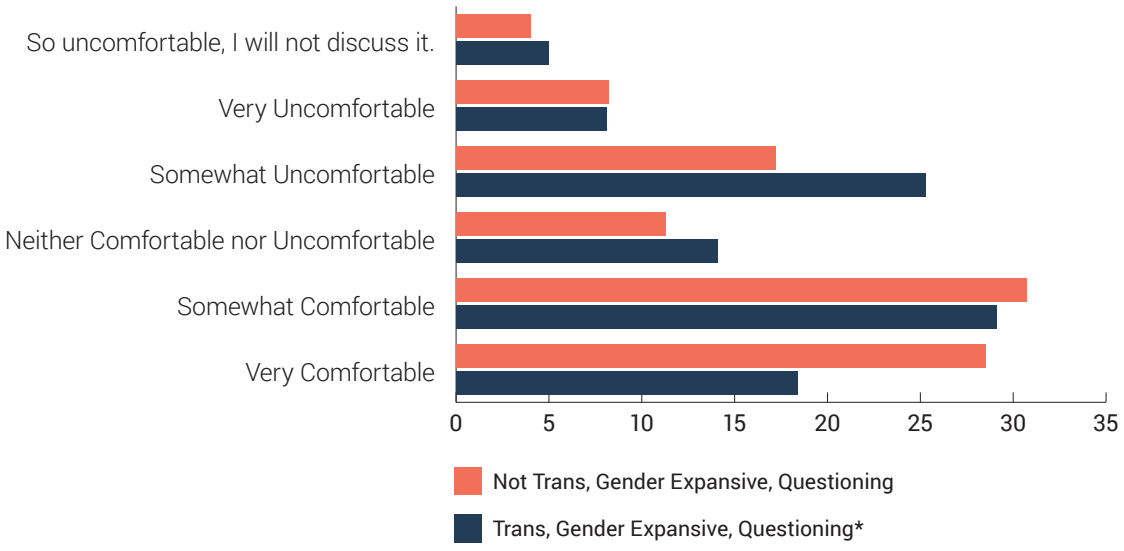


FIGURE 39. **LGBTQ+: Primary Care Provider or Office Located in Montgomery County**



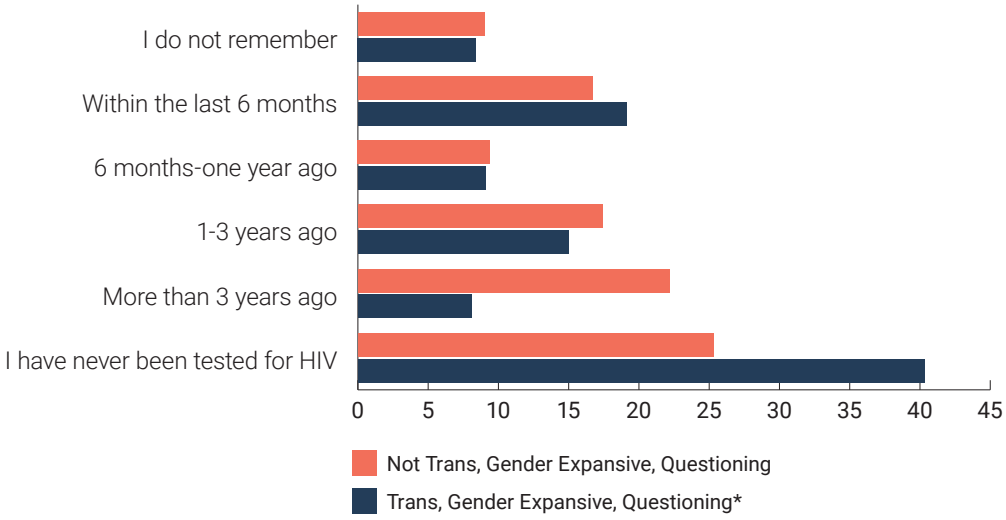
How comfortable do you feel discussing your sexual health with a health care provider? Approximately 38 percent of respondents identifying as trans, gender expansive, and questioning indicated they feel uncomfortable discussing sexual health with a health care provider (this includes the responses: somewhat uncomfortable, very uncomfortable and so uncomfortable, I won't discuss it; (Figure 40). This value was higher than for respondents identifying as not trans, gender expansive, and questioning, with 29.4 percent indicating they felt uncomfortable discussing sexual health with a health care provider.

FIGURE 40. **LGBTQ+: Comfortability Discussing Sexual Health with Health care Provider**



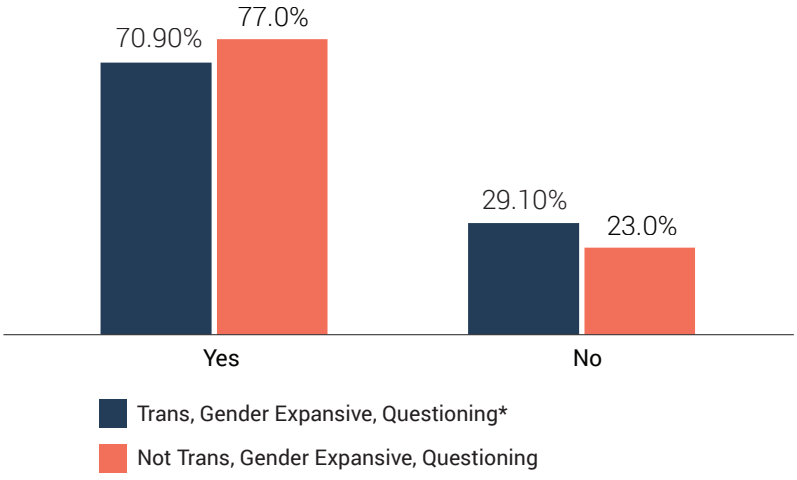
The last time I got tested for HIV was: An estimated 40% of respondents identifying as trans, gender expansive, and questioning report never having been tested for HIV, compared to 25.3% of respondents identifying as not trans, gender expansive, and questioning (Figure 41).

FIGURE 41. **LGBTQ+: Most Recent HIV Test**



Have you heard of PrEP, the HIV prevention medication? Approximately 30% of respondents identifying as trans, gender expansive, and questioning indicated they have not heard of PrEP (Figure 42).

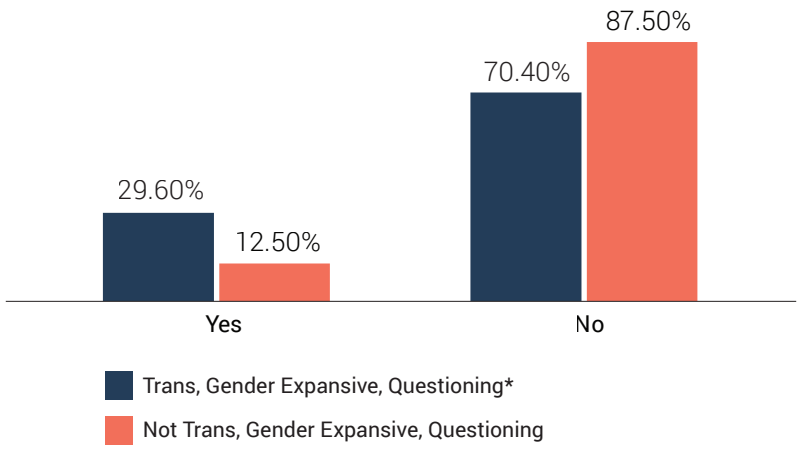
FIGURE 42. **LGBTQ+: PrEP Awareness**



Within the past year, respondents were asked if any of the following occurred at a medical visit:

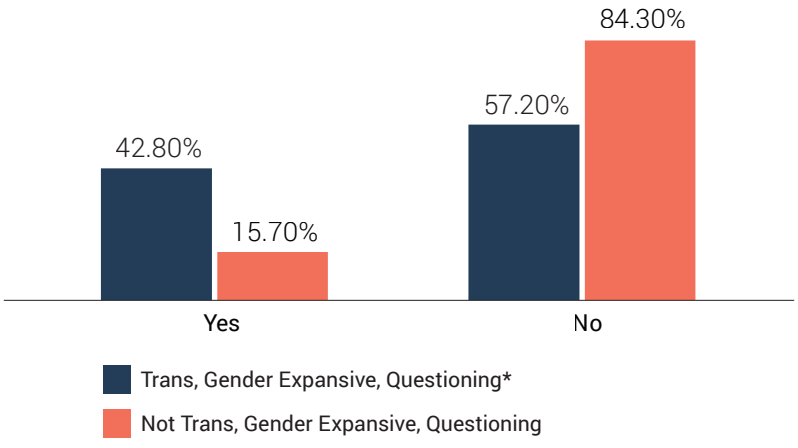
A provider was visibly uncomfortable because of my actual or perceived sexual orientation or gender identity: About 30% of respondents identifying as trans, gender expansive, and questioning indicated yes, a provider was visibly uncomfortable because of actual or perceived sexual orientation or gender identity (Figure 43), as compared to 12.5% of respondents identifying as not trans, gender expansive, and questioning who perceived a provider was visibly uncomfortable.

FIGURE 43. **LGBTQ+: Provider Comfortability with Actual or Perceived Sexual Orientation or Gender Identity**



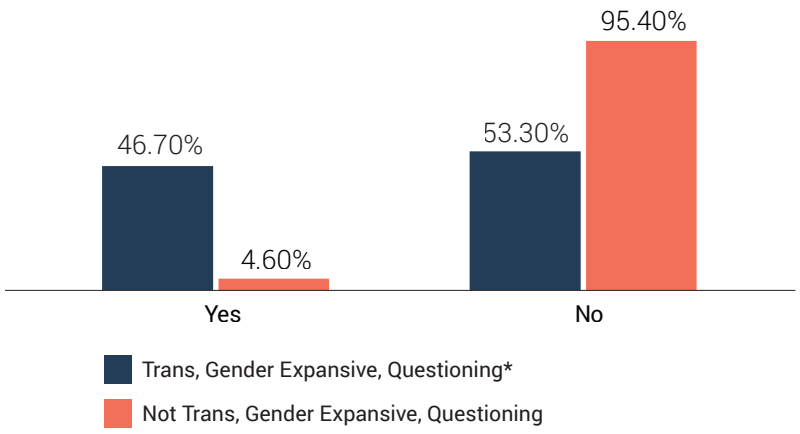
I had to teach the doctor about my sexual orientation or gender identity to receive appropriate care: An estimated 43% of respondents identifying as trans, gender expansive, and questioning had to teach the doctor about their sexual orientation or gender identity to receive appropriate care (Figure 44).

FIGURE 44. **LGBTQ+: Teaching Doctors about Sexual Orientation or Gender Identity**



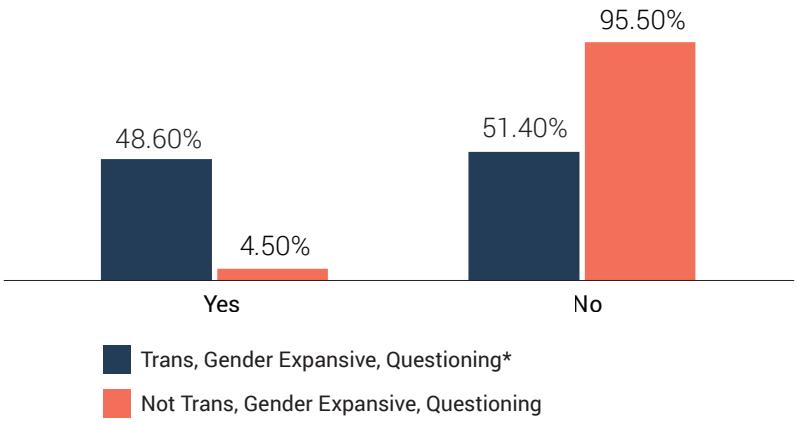
A provider misgendered me or used the wrong name: About half (46.7%) of respondents identifying as trans, gender expansive, and questioning were misgendered or called the wrong name by a provider within the past year (Figure 45).

FIGURE 45. **LGBTQ+: Provider Misgendered Individual or Used the Wrong Name**



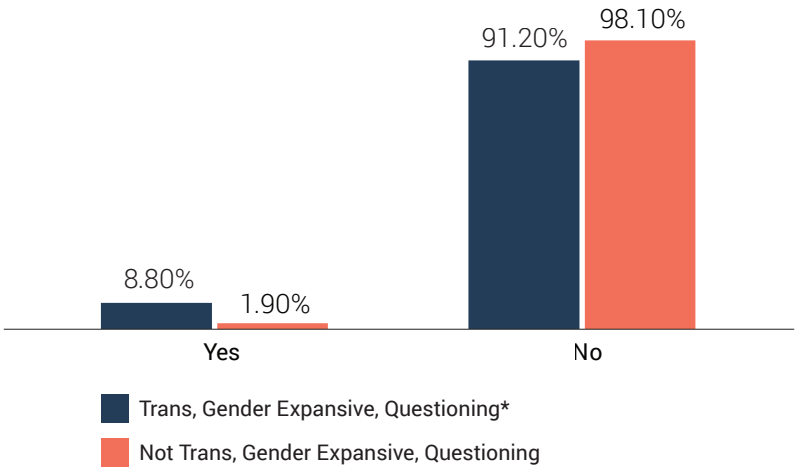
Office staff misgendered me or used the wrong name: About half (48.6%) of respondents identifying as trans, gender expansive, and questioning were misgendered or called the wrong name by office staff in the past year (Figure 46).

FIGURE 46. **LGBTQ+: Office Staff Misgendered Individual or Used the Wrong Name**



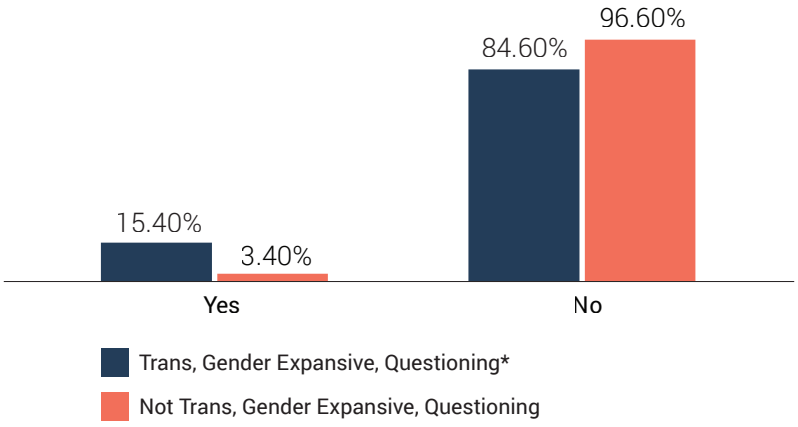
A provider refused to see me: Nearly 10% of respondents identifying as trans, gender expansive, and questioning indicated a provider refused to see them within the past year. Only about 2% of respondents identifying as not trans, gender expansive and questioning had a provider refuse to see them in the past year (Figure 47).

FIGURE 47. **LGBTQ+: Provider Refused to See Individual**



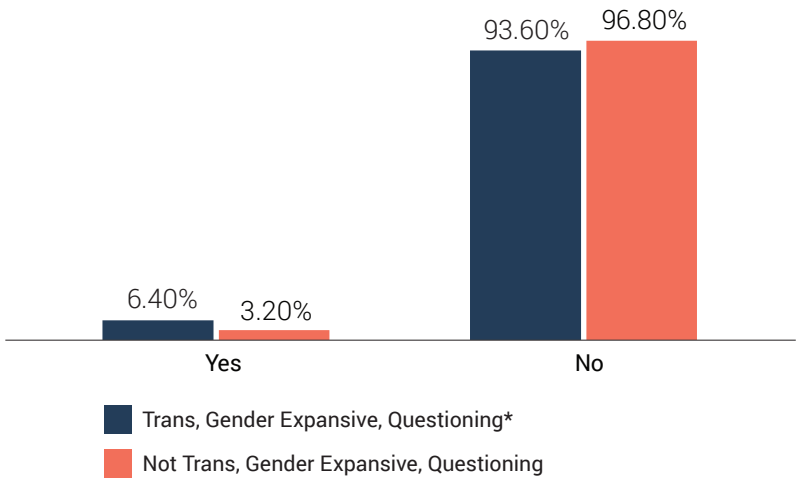
A provider refused to give me gender-affirming medical care (such as gender-affirming hormone therapy or support letters for surgery): Approximately 15% of respondents identifying as trans, gender expansive, and questioning had a provider refuse to provide them gender affirming care within the past year (Figure 48).

FIGURE 48. **LGBTQ+: Provider Refused to Give Gender-Affirming Medical Care**



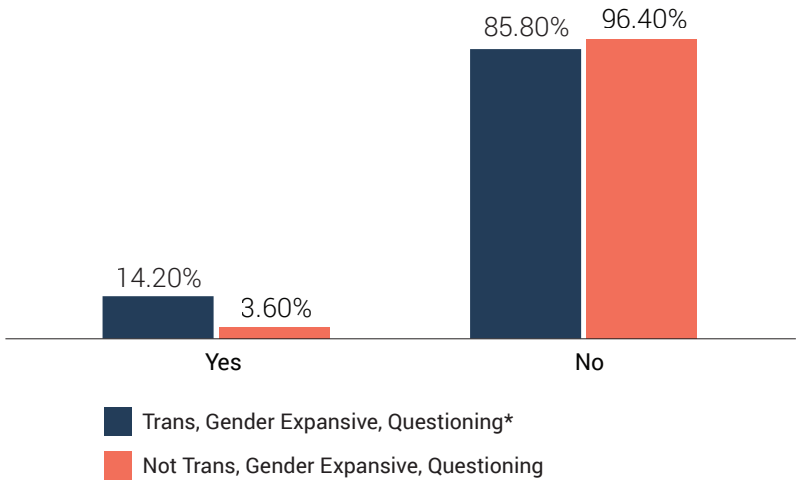
A provider was physically abusive when treating me: An estimated 6% of respondents identifying as trans, gender expansive, and questioning indicated a provider was physically abusive when treating them in the past year (Figure 49).

FIGURE 49. **LGBTQ+: Provider Physical Abusive When Treating Individual**



A provider used harsh or abusive language when treating me: Fourteen percent of respondents identifying as trans, gender expansive, and questioning indicated a provider used harsh or abusive language with them in the past year (Figure 50), as compared to 3.6% for respondents identifying as not trans, gender expansive, and questioning.

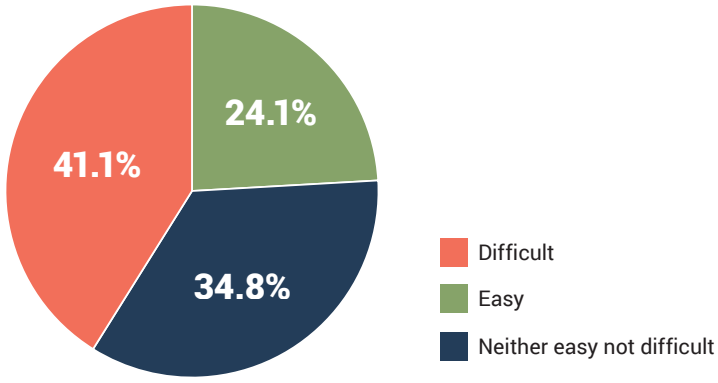
FIGURE 50. **LGBTQ+: Provider Used Harsh Language When Treating Individual**



The following information applies to only those respondents identifying as trans, gender expansive, and questioning.

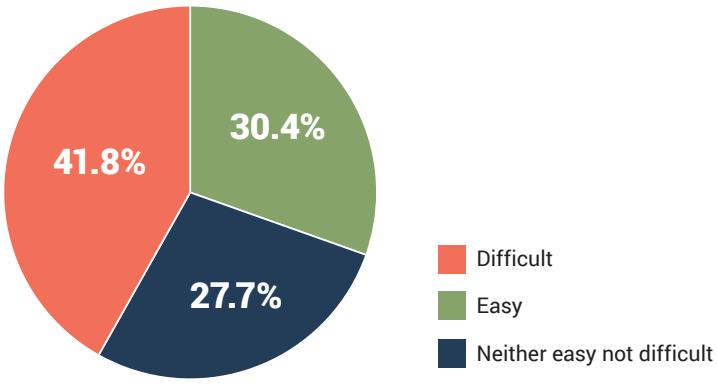
Approximately 41% of respondents indicated it was difficult finding a medical provider to support gender-affirming medical care (Figure 51).

FIGURE 51. **LGBTQ+: Difficulty Finding a Medical Provider to Support Gender-Affirming Medical Care**



An estimated 42% of respondents indicated it was difficult finding gender affirming mental health support (Figure 52).

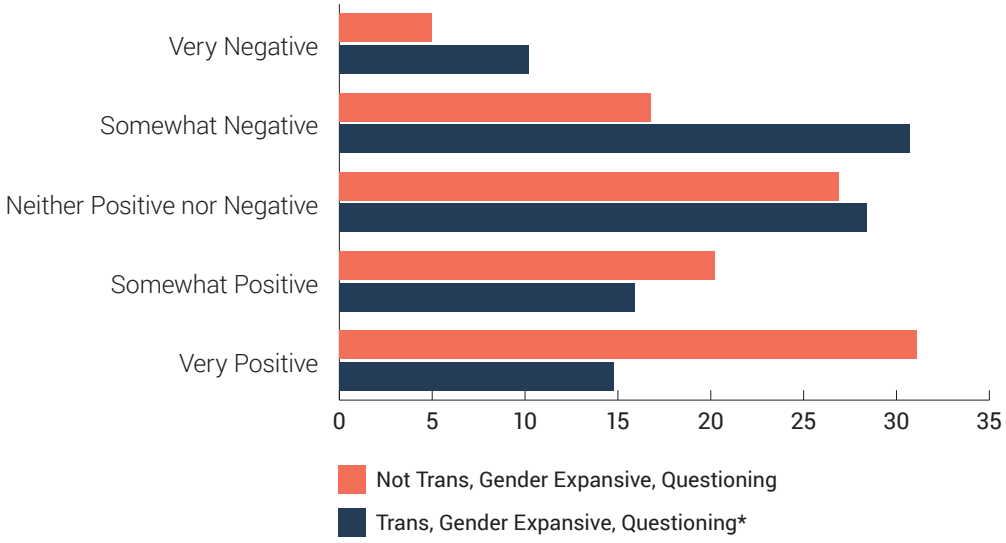
FIGURE 52. **LGBTQ+: Difficulty Finding Gender Affirming Mental Health Support**



Community Safety.

In the past year, your experience with any interaction with law enforcement in Montgomery County: Approximately 41% of respondents identifying as trans, gender expansive, and questioning indicated their experience with law enforcement was negative (including the responses of somewhat negative and very negative), as compared to 21.8% of respondents identifying as not trans, gender expansive, and questioning (Figure 53).

FIGURE 53. **LGBTQ+: Experience with Law Enforcement in Montgomery County**



PERSPECTIVES FROM COMMUNITY STAKEHOLDERS

The purpose of the key informant interview (KII) component of the CHNA was to gather thoughts and perspectives from key Montgomery County stakeholders on the local environment, to identify the most pressing needs of the community, and to prioritize significant health needs of the Montgomery County community over the next several years. A total of 54 stakeholders participated in the 11 KIIs.

The participants of the KIIs represented the diversity of the communities they served. The KIIs included stakeholders from the following county entities: organizations primarily serving Asian Americans, organizations primarily serving Latino/a or Hispanic Individuals, organizations primarily serving Black, African or African Americans, Faith Leaders, Adventist HealthCare, Suburban Hospital, a member of Johns Hopkins Medicine, Medstar Montgomery Medical Center, Holy Cross Health, representatives from the Montgomery Cares Clinics, and Montgomery County Boards, Committees and Commissions (Racial Equity and Social Justice Advisory Committee, Fire and Emergency Services Commission, and Board of

Participants noted that certain services or needs are greater in some zip codes as compared to others.

Community Conversation Identified Health Needs, Barriers, and Issues

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

Stakeholders identified mental and behavioral health concerns affecting the community they serve. Participants discussed that community members are impacted by depression, mania, bipolar, schizophrenia, and other chronic mental health concerns. Participants shared concerns for the overall mental health of low-income community residents, especially because of the COVID-19 pandemic. Participants further expressed concern that youth and adolescents are dealing with mental and behavioral health issues including depression, anxiety, and suicidal ideation. One participant shared that mental health conditions among pregnant teens is a growing issue in the community they serve. Participants stated that trauma and

grief in low-income individuals is an issue affecting the health of the community they serve. One participant shared from their own experience that mental health-related calls to 911 have increased during the COVID-19 pandemic.

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

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

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

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

described by one participant as being "a very transient area".

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

Social, economic, and demographic factors were discussed by community stakeholders as issues, barriers, or needs affecting the health of the community. Participants felt that economic stability, specifically financial insecurity among low-income community members was a barrier that affected the health of individuals served.

Participants shared that some residents may be underemployed (limited hours or pay to support needs) or have lost their job due to the COVID-19 pandemic, which is contributing to poorer health outcomes in the community. Stakeholders cited that those most impacted by employment concerns are the working poor, which includes:

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

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

Other factors of need cited by community stakeholders included wrap-around services and navigation support to help individuals access human services and racism as a health issue.

Clinical care factors were discussed as issues, concerns, barriers, or needs for access to affordable, quality, and timely health care that can help prevent diseases and detect issues sooner. More mobile health care services were discussed as a need by community stakeholders. Access to specialty care health services was a need identified by stakeholders. One participant cited from their experience a growing number of younger adults with renal failure noting, there are "no clinics" to send patients to for hemodialysis, especially if they are uninsured or undocumented. These patients may end up "hospital hopping" to receive care, which in the long run is not good for continuity of patient care or for hospital resources.

> "We're blessed. Montgomery County has an incredible amount of resources and information available, **except**, there is so much, you can get overwhelmed going on the www.montgomerycountymd.gov website

Dental care associated with costs, and the need to travel for oral health care, was a barrier identified by community stakeholders. Participants expressed that even if families get the money to pay for dental care and find a dentist, they are often spread out so far that individuals must take multiple buses to get there or rely on someone giving them a ride.

Participants discussed insufficient fiscal and human resources support to meet the mental health needs of the communities. For example, mental health facilities lacked support for those needing behavioral health care, making it challenging to place those in need of substance use treatment/detox and assistance with a mental health condition. Participants also cited that many existing mental health facilities do not have enough space for patients to keep up with the demand for treatment.

Community stakeholders emphasized the need for more health care staff to support patients with healthy living. Of note were the need for more health navigators, community health educators, and care managers.

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

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

Community stakeholders discussed **physical and built environment** issues, barriers, or needs that affect where individuals live, learn, work, and play. Stakeholders emphasized housing affecting health as a concern for Montgomery County communities. Housing concerns include both homelessness and the availability of affordable housing. Participants noted that housing insecurity (e.g., overcrowding, landlords who operate poorly maintained properties) has critical implications related to health care (e.g., medications that require refrigeration) and safety (e.g., domestic abuse, family stress, etc.). Discrimination in the right to adequate housing was cited by stakeholders as a barrier experienced in the community. Community stakeholders stated that there is a need for more rental assistance programs and supportive and permanent housing in Montgomery County.

Access to transportation was discussed by many participants as a barrier that impacts the ability to access health services, which can affect one's health if one cannot get routine care. Community stakeholders shared that transportation is a barrier to medical appointments, especially for low-income individuals seeking primary care, though in some areas participants mentioned, clients do live near clinics that serve this population. Having limited transportation options, one participant noted, can also be a source of stress.

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

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

REGIONS OF MONTGOMERY COUNTY

Montgomery County has five regions: Bethesda-Chevy Chase, Eastern Montgomery, Mid-County, Silver Spring, and Upcounty (Figure 52).[82] The regions differ in population density and racial diversity (Figure 54). As noted in Figure 54, Montgomery County's regions are increasingly racially diverse with high proportions of People of Color.

FIGURE 54. **Service Regions & Zip Codes in Montgomery County**

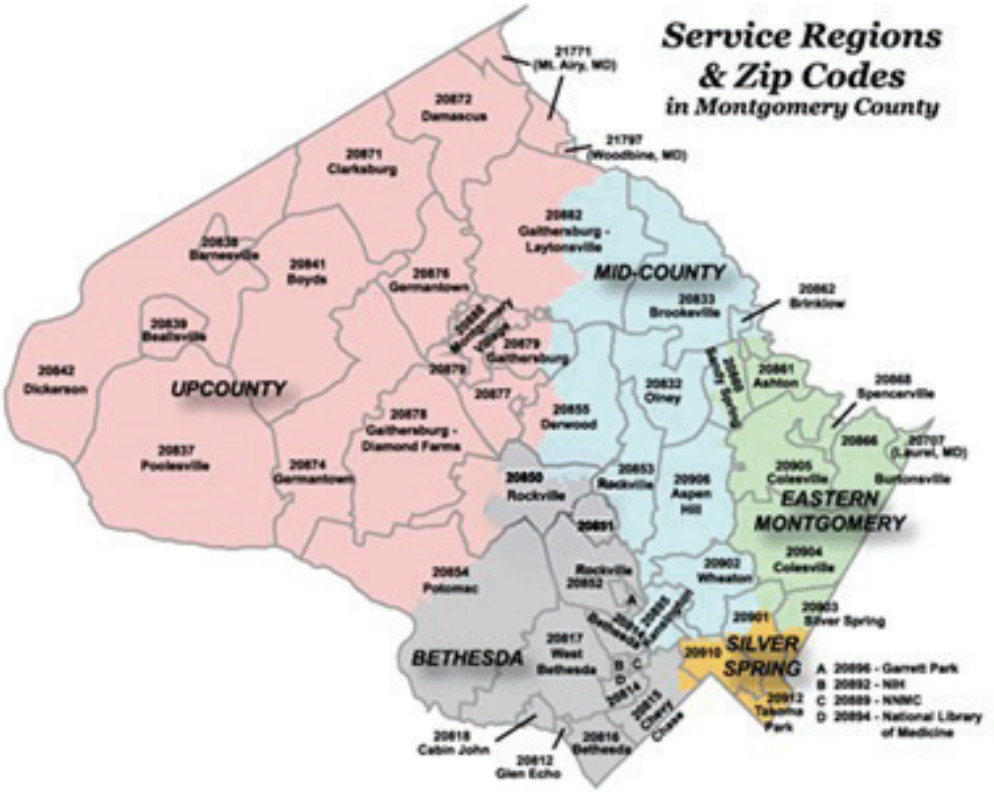
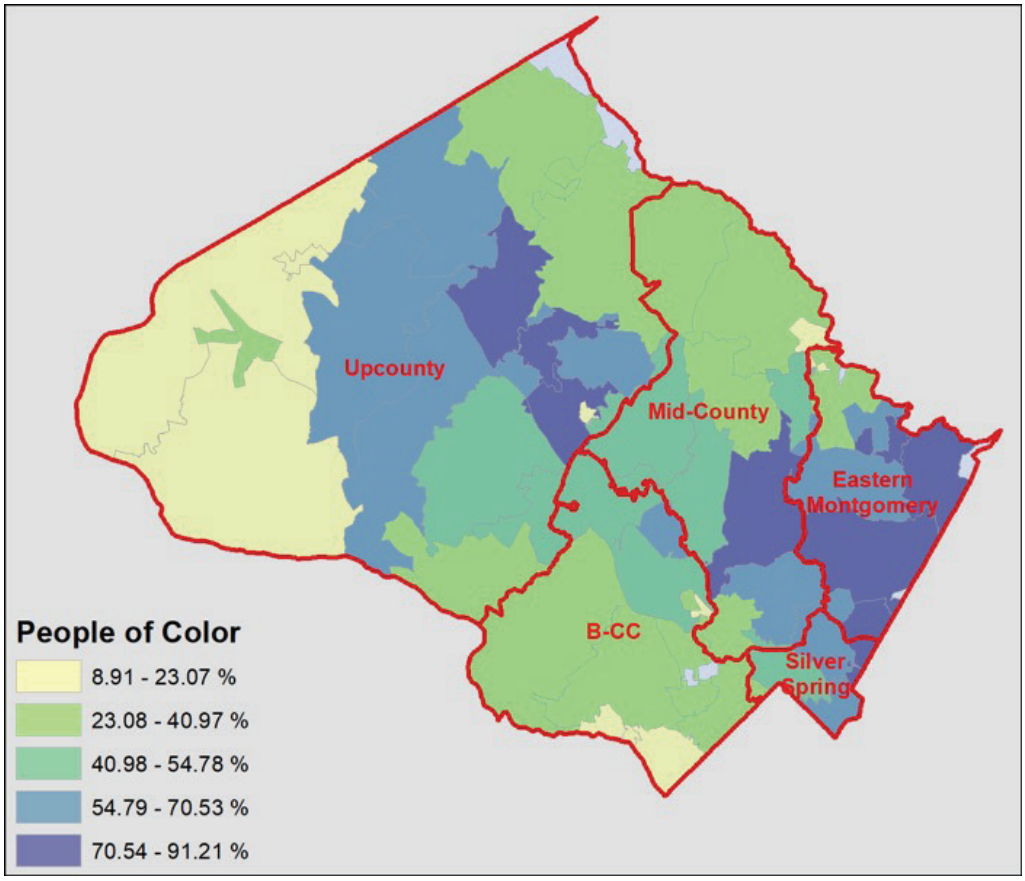


FIGURE 55. **People of Color by Montgomery County Regions**



Social Vulnerability Index (SVI)

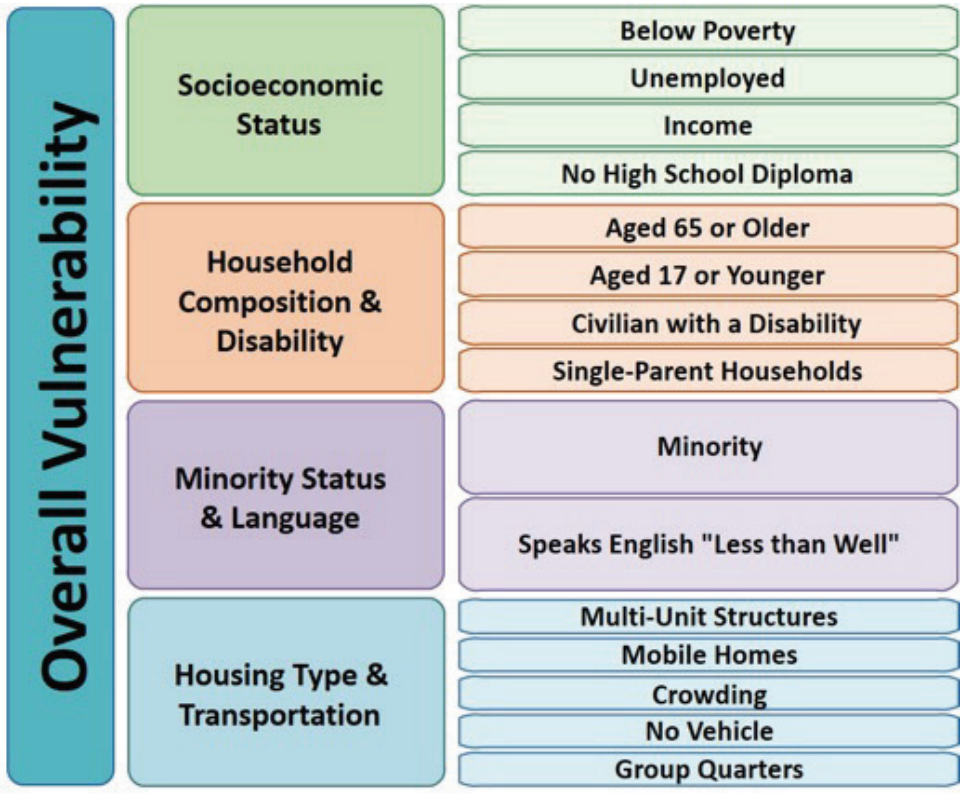
This section of the CHNA report presents the Centers for Disease Control and Prevention (CDC) Agency for Toxic Substances and Disease Registry (ATSDR) Social Vulnerability Index (CDC/ATSDR SVI) results across zip codes within Montgomery County regions overlayed with Montgomery County's Equity Focus Areas (EFA).

The ATSDR defines social vulnerability as the factors that pose potential negative effects on communities caused by external stresses on human health. These include natural or human-caused disasters, or disease outbreaks. The CDC/ATSDR SVI uses U.S. Census data to determine the social vulnerability of every census tract. The index is scored from 0 (lowest vulnerability) to 1 (highest vulnerability).

The CDC/ATSDR SVI uses 15 U.S. census variables to help local officials identify communities that may need support before, during, or after disasters (atsdr.cdc.gov). The 15 U.S. census variables are grouped into four related themes, as well as an overall ranking (Figure 54).[83]

FIGURE 56.

Centers for Disease Control and Prevention, Agency for Toxic Substances and Disease Registry, Social Vulnerability Index 15 U.S. Census Variables



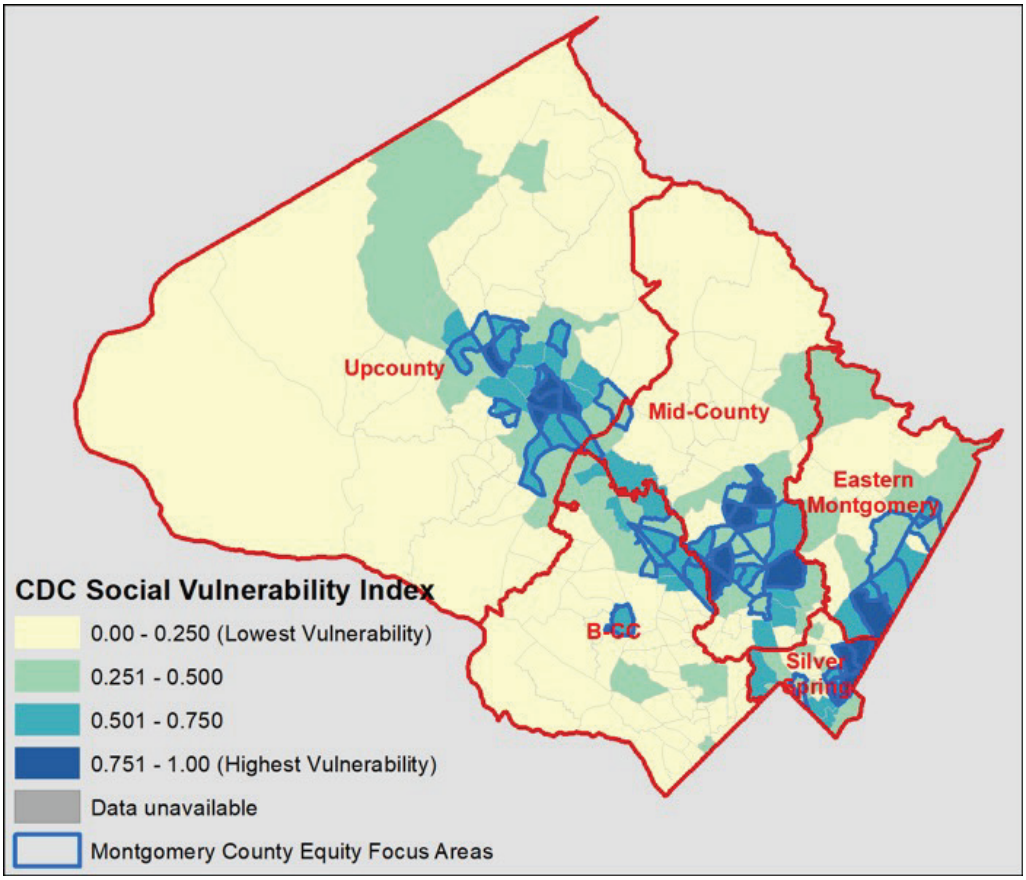
The EFA is an analytical model to identify marginalized populations in Montgomery County. The EFA is a tool for analysis of racial equity and social justice issues such as access to opportunities and resources, employment, transportation, health, housing and government services.[84] The EFA are the result of analysis of three core equity variables to define the highest concentration of vulnerable populations. EFA are derived from high concentrations of low-income households, people of color, and people speaking English less than very well. The EFA provides groundwork for equity analysis to support ongoing and future planning efforts.

The ATSDR's Geospatial Research, Analysis and Services Program (GRASP) created databases to help emergency response planners and public health officials identify and map communities. In the event of an emergency or natural disaster, the CDC SVI databases and maps can be used to estimate the number of needed supplies like food, water, medicine; help decide how many emergency personnel are needed to assist; plan the best way to evacuate people; and identify communities that may need continued support to recover from an emergency or natural disaster.

Social vulnerability also has a profound impact on individuals' health-related behaviors and health outcomes. Previous studies have examined the relationship between residential county social vulnerability and a range of health outcomes, for example chronic diseases such as obesity, among U.S. adults. Research has demonstrated that people living in communities with mid-low, mid-high, and highest SVI quartiles have higher odds of experiencing poor health outcomes, for example physical inactivity or obesity.

Figure 55 provides SVI indexes for Montgomery County regions. Identifying zip codes across regions of Montgomery County that has an SVI score indicative of moderate to high level of vulnerability may help public health officials and emergency response planners target resources that meet the needs of socially vulnerable populations in emergency response and recovery efforts. In addition, identifying zip codes across regions of Montgomery County with moderate to high social vulnerability may help guide community-based health promotion initiatives that target disparities impacting health outcomes. Reducing social vulnerability can minimize the impacts of stressors and or disasters, decreasing human suffering and economic loss.

FIGURE 57. **Social Vulnerability Indexes for Montgomery County Regions**



Findings for Each Region

BETHESDA-CHEVY CHASE REGION

Description of Community Served.

Population Characteristics for Bethesda-Chevy Chase Region

ZIP CODE	TOTAL POPULATION (2020)	PEOPLE OF COLOR (%)	MEDIAN AGE	LESS THAN HIGH SCHOOL DIPLOMA (%)	UNEMPLOYMENT RATE	PEOPLE OF DISABILITY STATUS (%)	UNINSURED (%)	MEDIAN HOUSEHOLD INCOME ($)	HOUSEHOLDS SPENDING ≥ 35% OF INCOME ON HOUSING COSTS–MORTGAGED (%)	HOUSEHOLDS SPENDING ≥ 35% OF INCOME ON HOUSING COSTS–RENTERS (%)
20812	323	14.55	44.6	3.3	1.8	5.9	1.86	141,250	34.8	22.2
20814	29,632	29.74	39.3	2.13	2.5	7	2.35	137,962	21.4	30.2
20815	30,908	25.03	47.2	1.83	2.3	8.4	2.17	163,016	13.8	44.2
20816	16,661	20.57	44.2	1.8	5.7	7.8	1.22	202,309	14.5	43.3
20817	38,131	35.43	45.1	2.18	3.9	6.8	2.15	206,592	18.5	29
20818	2,072	23.07	49.1	0.64	1.1	9.8	0.78	181,471	26.7	0
20850	53,522	52.62	40.4	5.41	4.3	9	4.68	114,691	23.7	35.1
20851	14,519	66.46	37.9	17.97	4.5	8	13.13	92,561	24.8	49.9
20852	47,338	49.36	38.4	6.52	3.1	9.2	5.34	105,645	18.9	33.5
20854	49,196	38.46	47.5	3	3.1	8.1	1.43	210,639	20.1	26.6
20896	792	9.34	53.1	0	4.3	6.9	0.51	203,750	15	100
20879	26,343	70.53	35.3	10.04	6.4	9.2	11.75	89,163	18.1	44.4
20882	14,441	29.55	45.8	3.07	4	8.6	2.02	140,428	18	20

No data available for zip codes 20889, 20892, and 20894

Social Vulnerability Index.

Bethesda-Chevy Chase Region Social Vulnerability Index by Zip Code

ZIP CODE	OVERALL	SOCIOECONOMIC	HOUSEHOLD COMPOSITION & DISABILITY	MINORITY STATUS & LANGUAGE	HOUSING TYPE & TRANSPORTATION
20812	0.11	0.11	0.44	0.47	0.06
20814	0.27	0.02	0.24	0.31	0.84
20815	0.12	0.11	0.35	0.25	0.19
20816	0.01	0.00	0.23	0.28	0.03
20817	0.14	0.06	0.40	0.52	0.14
20818	0.11	0.11	0.44	0.47	0.06
20850	0.48	0.51	0.13	0.83	0.42
20851	0.33	0.47	0.09	0.87	0.17
20852	0.40	0.16	0.34	0.78	0.54
20854	0.16	0.04	0.18	0.54	0.34
20889	0.27	0.02	0.24	0.31	0.84
20892	0.23	0.06	0.27	0.54	0.45
20894	0.27	0.02	0.24	0.31	0.84
20896	0.03	0.01	0.25	0.40	0.05

SVI COMMUNITIES OF CONCERN

Bethesda-Chevy Chase region (B-CC) zip code 20850 has the highest overall social vulnerability with .48 index, followed by zip code 20852 with .40 social vulnerability index. Zip code 20850 has a relatively high socioeconomic vulnerability compared to all other B-CC zip codes with .51 index. Zip code 20851 has the second highest socioeconomic vulnerability with .47 index. B-CC zip codes 20812 and 20818 have greater household composition and disability vulnerabilities compared to all other B-CC zip codes with .44 index, respectively. B-CC zip code 20817 has the second highest household composition and disability vulnerability with .40 index. Minority status and language vulnerability is the highest in B-CC zip code 20851 with .87 index. B-CC zip code 20850 has the next highest minority status and language vulnerability compared to the remaining zip codes with .83 index. The highest housing type and transportation vulnerabilities are found in B-CC zip codes 20814, 20889, and 20894, with each zip code demonstrating .84 index, respectively. B-CC zip code 20852 has the next highest housing type and transportation vulnerability with .54 index.

Community Conversation Identified Health Needs, Barriers, and Issues.

Community members who participated in the community conversation discussed two main **health behavior** issues in the Bethesda-Chevy Chase region. Participants shared concerns around increased social isolation for people in their community because of the COVID-19 pandemic. One participant stated that the social isolation may be contributing to partner violence or child abuse. One participant expressed concern that social isolation among older adults prior to the COVID-19 pandemic and throughout the COVID-19 pandemic is an issue in the Bethesda-Chevy Chase region. How to reach out to seniors experiencing social isolation in the community to identify them is a continued concern that was mentioned by one participant. Participants also shared their concern that social isolation could be having a poor effect on individuals' mental health and their ability to get mental health care.

Participants identified adults experiencing food insecurity as an additional health behavior issue pertaining to older adults.

Social, economic, and demographic health issues expressed by participants centered around concerns for older adults not having help with fixing issues in their home.

Participants discussed several **physical and built environmental** factors that are health needs, barriers, or issues in the Bethesda-Chevy Chase region. Stable, affordable housing in the Bethesda-Chevy Chase region was mentioned as a health issue by the participants.

Air pollution was an important health issue cited by the participants. Participants cited three main causes of air pollution in the Bethesda-Chevy Chase region. First, living in immediate proximity to the Capital beltway, Interstate 495, participants felt has increased the air pollution in the region due to the heavy traffic. Participants cited the contribution of rapid construction development due to Capital Beltway expansions and houses being torn down as a health issue in their community. Rapid construction development one participant stated has been contributing to loss of the Bethesda-Chevy Chase region's tree canopy which contributes to the air pollution in the area. Thirdly, one participant noted that increased airplane traffic over the Bethesda-Chevy Chase community has contributed to increasing air pollution in the region. Airplane traffic over the Bethesda-Chevy Chase region one participant stated also has contributed to noise pollution and increased stress levels among community members.

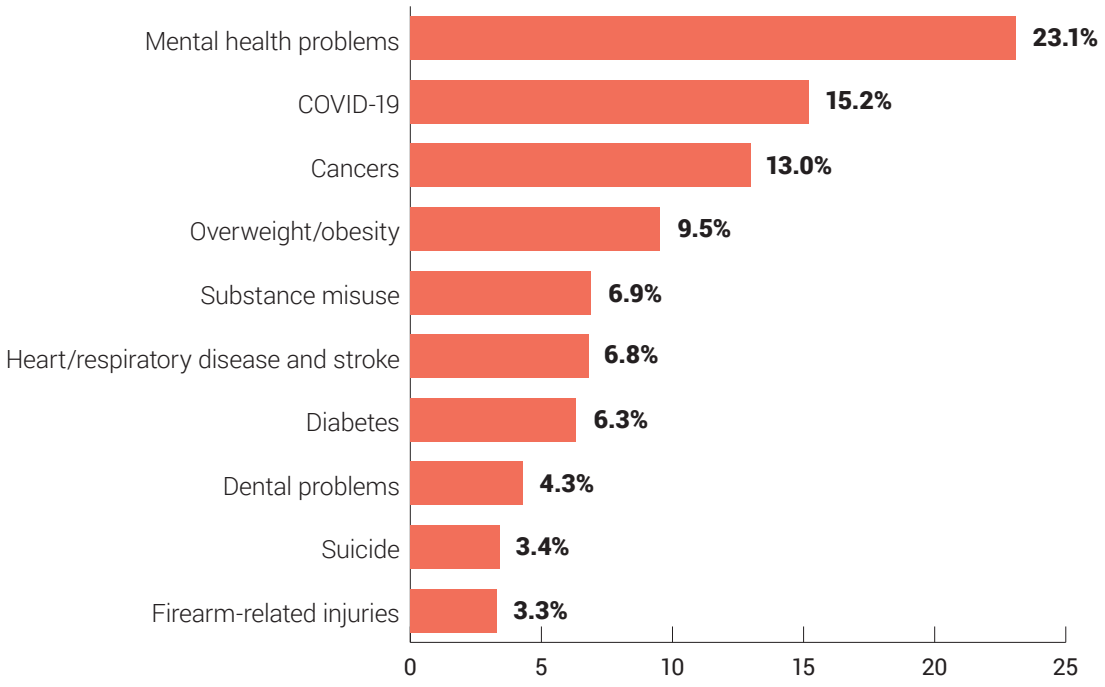
Another physical and built environmental issue in the Bethesda-Chevy Chase region that was mentioned by the participants were inaccessible sidewalks and street crossings that negatively

impact health. One participant shared that the burgeon of highway and housing construction development in the community has placed limitations on the walkability of the neighborhood and reduced running/walking/biking paths. Another participant shared pedestrian accidents while crossing the road is a health issue in the community. Participants shared concerns about kids and/or small children walking or playing outside because some crosswalks are not well-lit, and some residential streets have fast speed limits.

Community Health Needs Survey.

Based on the data from the 2022 community health needs survey, Bethesda-Chevy Chase residents identified mental health, COVID-19, cancer, overweight/obesity, and substance misuse as the most important health problems they face (Figure 58). Availability/access to insurance, housing/homelessness, lack of affordable childcare and transportation problems were the top social/environmental problems that affect health (Figure 59). Texting/on the phone while driving, lack of exercise and alcohol dependency were the most important risky behaviors that impact health (Figure 60). A third of residents reported cost as the top reason for not getting care, followed by no insurance and long wait times (Figure 61). Approximately 10% of those that responded to the survey indicated that they needed financial assistance because of COVID-19, and 8.1% needed health care assistance (Figure 62).

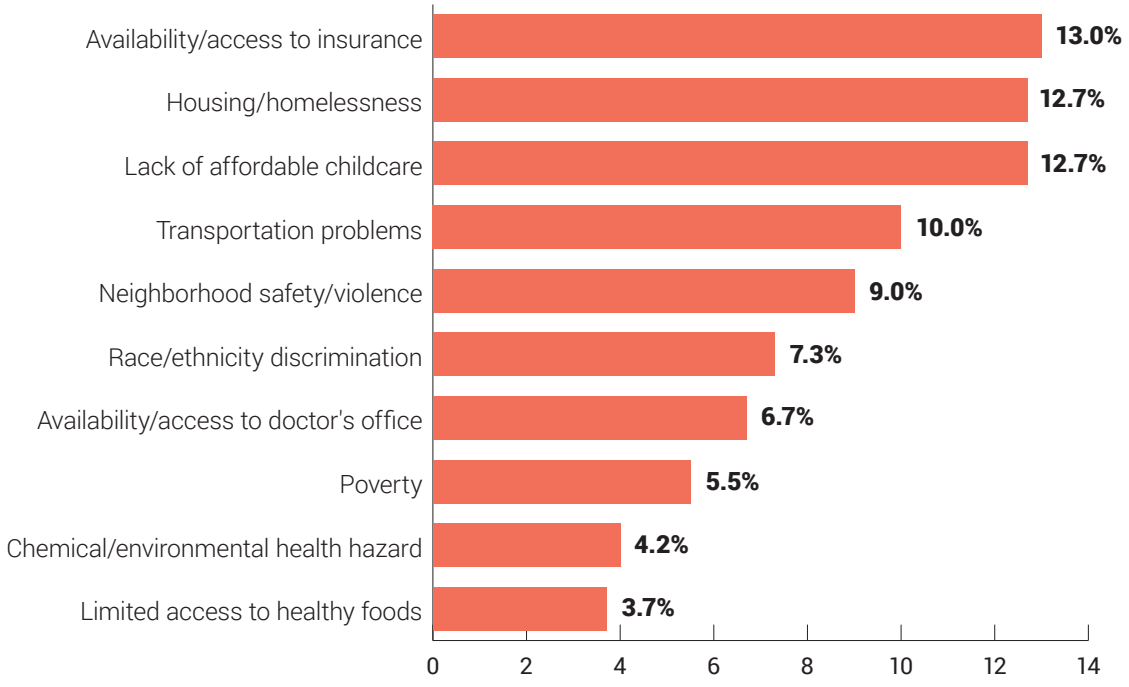
FIGURE 58. **Bethesda-Chevy Chase Region Most Important Health Problems**



(N = 357)

FIGURE 59.

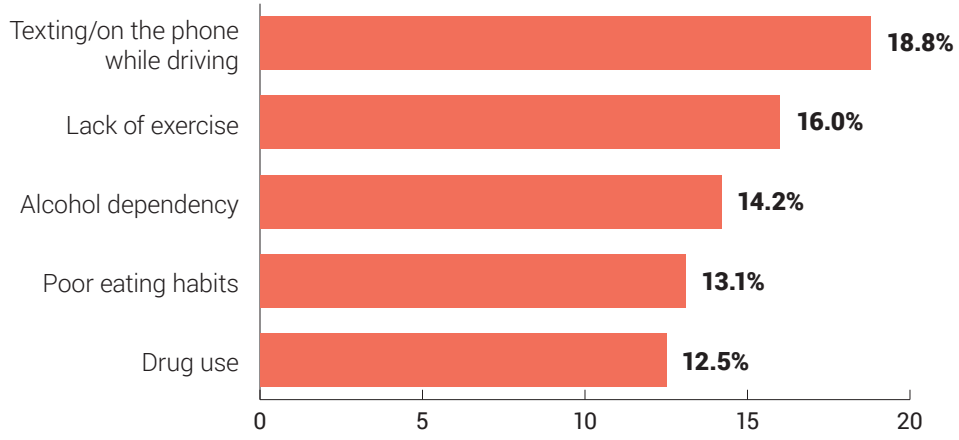
Bethesda-Chevy Chase Region Most Important Social/Environmental Problems



(N = 357)

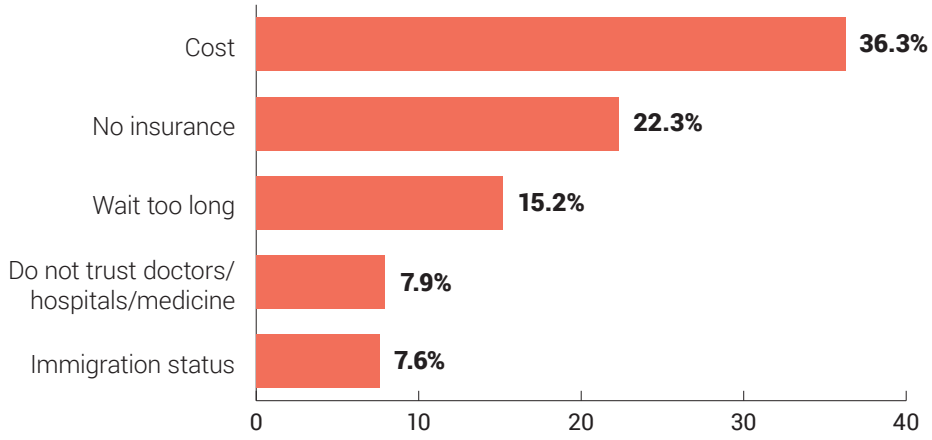
FIGURE 60.

Bethesda-Chevy Chase Region Risk factors that Impact Health Behaviors and Outcomes



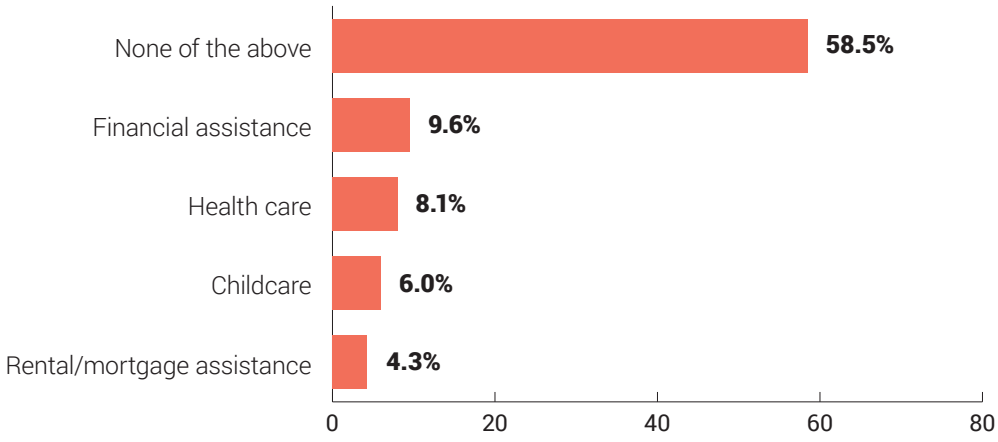
(N = 357)

FIGURE 61. **Bethesda-Chevy Chase Region Top Reasons for Not Getting Care**



(N = 357)

FIGURE 62. **Bethesda-Chevy Chase Region Assistance Needed as a Result of COVID-19**



(N = 357)

EASTERN MONTGOMERY REGION

Description of Community Served.

Population Characteristics for Eastern Montgomery Region

ZIP CODE	TOTAL POPULATION (2020)	PEOPLE OF COLOR (%)	MEDIAN AGE	LESS THAN HIGH SCHOOL DIPLOMA (%)	UNEMPLOYMENT RATE	PEOPLE OF DISABILITY STATUS (%)	UNINSURED (%)	MEDIAN HOUSEHOLD INCOME ($)	HOUSEHOLDS SPENDING ≥ 35% OF INCOME ON HOUSING COSTS–MORTGAGED (%)	HOUSEHOLDS SPENDING ≥ 35% OF INCOME ON HOUSING COSTS–RENTERS (%)
20861	2,015	28.04	48.5	1.55	0.7	9.4	1.64	158,497	4.3	0
20866	16,974	81.99	38.2	8.26	3.7	6.1	4.33	114,195	16.2	42.8
20868	539	72.54	39	21.86	0	0	6.68	-	21.8	100
20903	26,951	91.21	32.7	34.88	7.3	6.9	24.38	67,883	32.6	45.5
20904	55,856	80.85	39.8	9.61	6.3	10.2	6.93	85,000	21.1	54
20905	18,590	59.3	42.4	5.34	6.6	6.9	1.9	130,811	26.6	44.9

Social Vulnerability Index.

Eastern Montgomery Region Social Vulnerability Index by Zip Code

ZIP CODE	OVERALL	SOCIOECONOMIC	HOUSEHOLD COMPOSITION & DISABILITY	MINORITY STATUS & LANGUAGE	HOUSING TYPE & TRANSPORTATION
20861	0.38	0.08	0.77	0.61	0.47
20866	0.46	0.37	0.41	0.86	0.39
20868	0.21	0.26	0.21	0.76	0.09
20903	0.87	0.80	0.47	0.97	0.86
20904	0.56	0.43	0.51	0.87	0.68
20905	0.38	0.26	0.77	0.87	0.47

SVI COMMUNITIES OF CONCERN

Eastern Montgomery zip code 20903 has the highest overall social vulnerability with .87 index, followed by zip code 20904 with .56 social vulnerability index. Zip code 20903 has a relatively high socioeconomic vulnerability compared to all other Eastern Montgomery zip codes with .80 index. Zip code 20904 has the second highest socioeconomic vulnerability with .43 index. Eastern Montgomery zip codes 20861 and 20905 have greater household composition and disability vulnerabilities compared to all other Eastern Montgomery zip codes with .77 index, respectively. Eastern Montgomery zip code 20904 has the second highest household composition and disability vulnerability with .51 index. Minority status and language vulnerability is the highest in Eastern Montgomery zip code 20903 with .97 index. Eastern Montgomery zip codes 20904 and 20905 have the next highest minority status and language vulnerabilities compared to the remaining zip codes with .87 index, respectively. The highest housing type and transportation vulnerability is found in Eastern Montgomery zip code 20903 with .86 index. Eastern Montgomery zip code 20904 has the next highest housing type and transportation vulnerability with .68 index.

Community Conversation Identified Health Needs, Barriers, and Issues.

Community members in the Eastern Montgomery region discussed several **health behaviors** needs, barriers, and issues affecting the health of their community. Healthy food access was a key need and issue of the Eastern Montgomery region. The participants agreed that the availability of healthy low-cost "speed of service" (i.e., fast-food) food options was very limited, and in some neighborhoods not available, in the Eastern Montgomery region. Participants also stated that outside of a few grocery stores that have an organic aisle, the availability of grocery stores whose primary focus is to sell natural and organic foods is "nonexistent" in the Eastern Montgomery region. This had a direct adverse impact on how

easy residents can physically reach healthy retail food establishments according to participants. Residents must travel outside of the Eastern Montgomery region to access retail food establishments that emphasize the sale of natural and organic foods, participants also stated.

The participants identified the availability of indoor and outdoor physical fitness activities and locations as a health need and barrier to healthy living. The participants emphasized that these physical fitness activities should also be affordable.

Community members identified obesity and mental health as issues affecting the health of their community. One participant emphasized that there is stigma around seeking out mental health support for youth in the community.

Clinical care factors were discussed as needs, barriers, and issues affecting the health of the Eastern Montgomery community. Community members identified lack of access to health insurance as a need in the Eastern Montgomery region. Participants felt that populations having issues the most with accessing health insurance included youth, single parents, older adults, those with language or literacy differences, and those who were resource limited (i.e., the working poor and moderate-income residents, those unstably housed).

Participants also shared that there were few mental health providers in their community which limits access to mental health care.

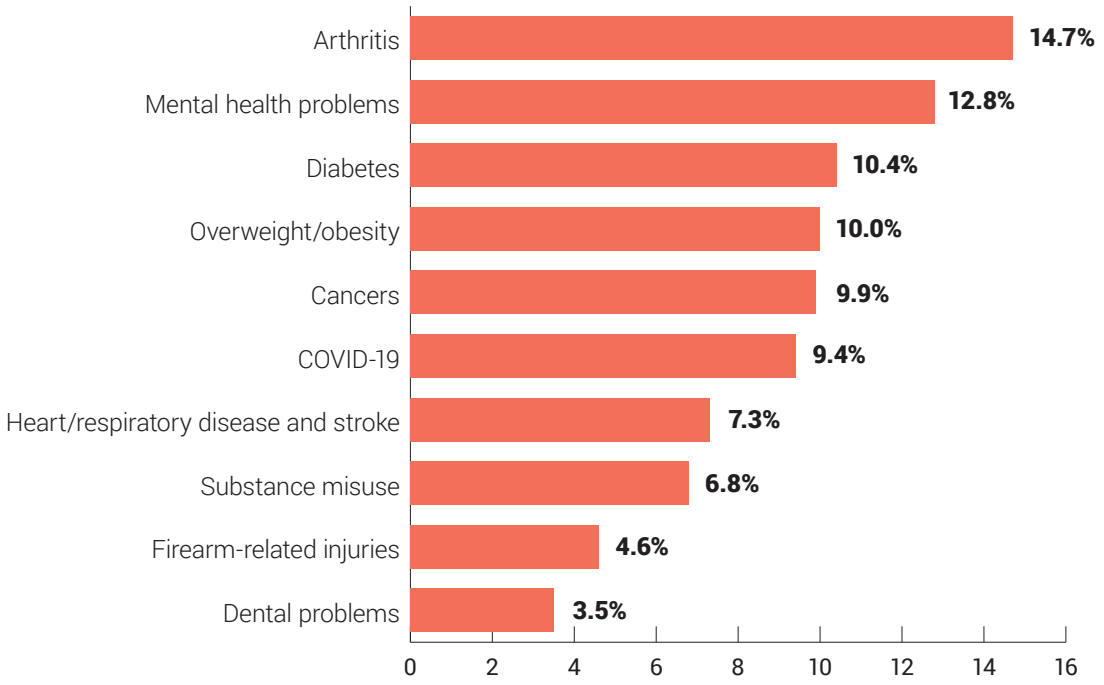
Community members discussed two **physical and built environmental** factors that are health needs, barriers, or issues in the Eastern Montgomery region. According to participants, limited walkability of the neighborhoods are contributors to increases in obesity among people living in the Eastern Montgomery region.

Access to technology was also identified as a community need. Participants shared that due to COVID-19, education and medical care shifted to virtual formats, so being able to communicate via technology was something needed for all Eastern Montgomery community members to properly engage with others and the services they may need to utilize. One participant noted that students in some neighborhoods of the Eastern Montgomery region are having challenges getting access to the Internet, and even did not have a computer or device that could connect to the Internet.

Community Health Needs Survey.

Based on data from the 2022 community health needs survey, Eastern Montgomery residents identified arthritis, mental health, diabetes, overweight/obesity, and cancer as the most important health problems they face (Figure 63). Availability/access to insurance, neighborhood safety/violence, and housing/homelessness were the top social/environmental problems that affect health (Figure 64). Lack of exercise, poor eating habits, substance use/addiction and texting/on the phone while driving were the most important risky behaviors that impact health (Figure 65). A third of residents reported cost as the top reason for not getting care, followed by no insurance and long wait times (Figure 66). Approximately 15% of those that responded to the survey indicated that they needed rental/mortgage assistance because of COVID-19, and 12.2% needed food assistance (Figure 67).

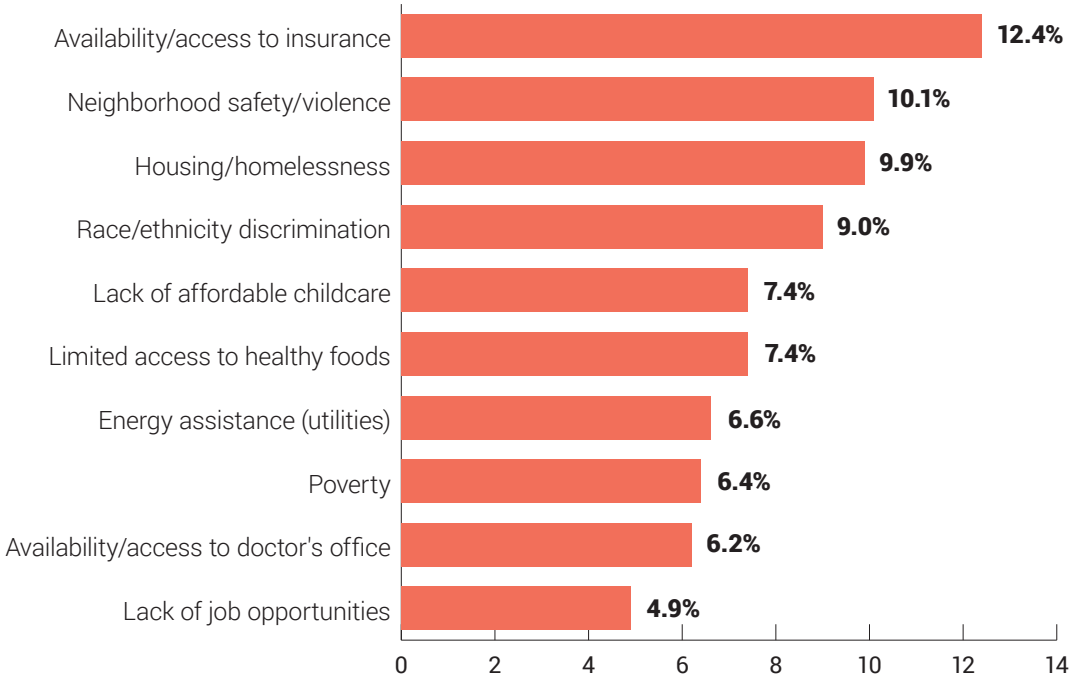
FIGURE 63. **Eastern Montgomery Region Community Most Important Health Problems**



(N = 117)

FIGURE 64.

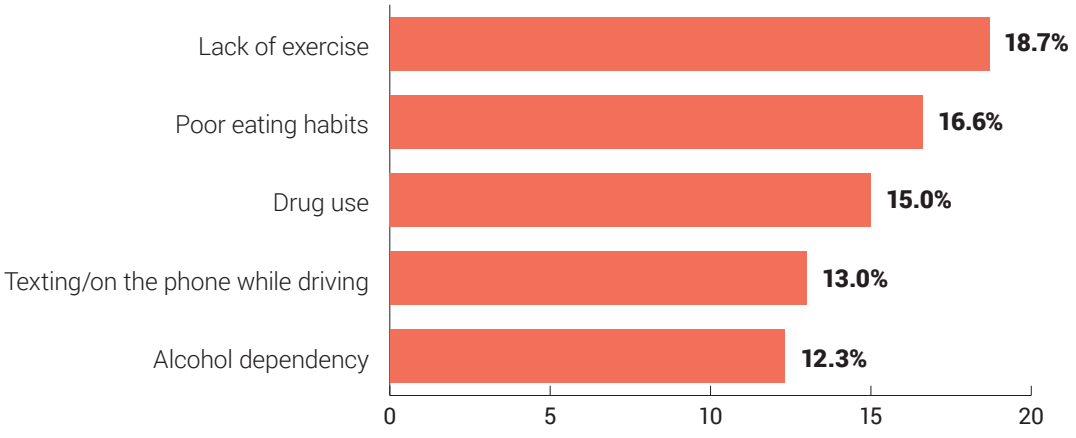
Eastern Montgomery Region Community Most Important Social/ Environmental Problems



(N = 117)

FIGURE 65.

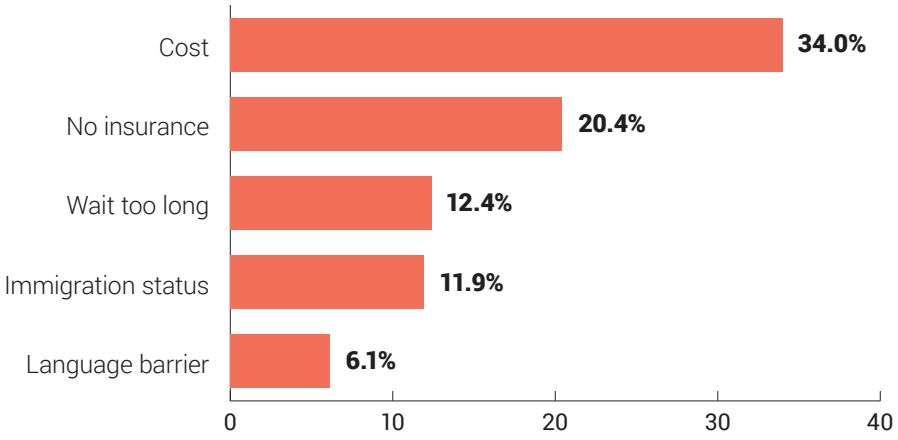
Eastern Montgomery Region Community Risk Factors that Impact Health Behaviors and Outcomes



(N = 117)

FIGURE 66.

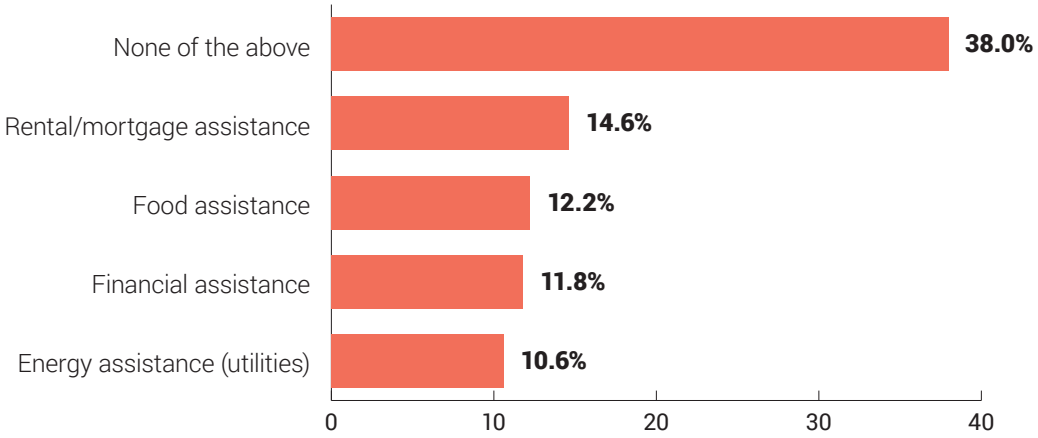
Eastern Montgomery Region Community Top Reasons for Not Getting Care



(N = 117)

FIGURE 67.

Eastern Montgomery Region Community Assistance Needed as a Result of COVID-19



(N = 117)

MID-COUNTY REGION

Description of Community Served

Population Characteristics for Mid-County Region

ZIP CODE	TOTAL POPULATION (2020)	PEOPLE OF COLOR (%)	MEDIAN AGE	LESS THAN HIGH SCHOOL DIPLOMA (%)	UNEMPLOYMENT RATE	PEOPLE OF DISABILITY STATUS (%)	UNINSURED (%)	MEDIAN HOUSEHOLD INCOME ($)	HOUSEHOLDS SPENDING ≥ 35% OF INCOME ON HOUSING COSTS–MORTGAGED (%)	HOUSEHOLDS SPENDING ≥ 35% OF INCOME ON HOUSING COSTS–RENTERS (%)
20832	25,427	40.97	41.3	5.16	2.9	9.3	2.91	139,007	18.6	37.9
20833	7,746	33.55	45.7	3.34	3.6	5.5	3.23	178,017	22.1	28.3
20853	31,510	50.47	40.4	10.87	4.7	9.9	6.04	120,821	28.2	31.9
20855	15,955	49.9	42.1	4.89	2.6	8	5.56	137,028	20.1	33.5
20860	2,890	54.78	39.9	18.19	11.2	9.3	0.82	106,772	21.5	40.8
20862	359	8.91	63.5	0	7.6	29	0	155,694	11.1	--
20895	18,930	28.64	42.8	2.77	2.5	8.8	1.7	149,934	13.5	34.5
20902	52,752	66.82	37.2	16.41	5.5	7.6	13.47	94,211	23.7	41.5
20906	70,441	73.98	40.2	15.44	6.9	10.7	11.78	78,611	25.7	52.4

Social Vulnerability Index

Mid-County Region Social Vulnerability Index by Zip Code

ZIP CODE	OVERALL	SOCIOECONOMIC	HOUSEHOLD COMPOSITION & DISABILITY	MINORITY STATUS & LANGUAGE	HOUSING TYPE & TRANSPORTATION
20832	0.23	0.12	0.28	0.76	0.43
20833	0.38	0.23	0.77	0.64	0.47
20853	0.77	0.69	0.40	0.93	0.81
20855	0.53	0.49	0.36	0.88	0.86
20860	0.38	0.08	0.77	0.61	0.47
20862	0.38	0.23	0.77	0.65	0.47
20895	0.62	0.45	0.65	0.84	0.73
20902	0.40	0.50	0.48	0.90	0.56
20906	0.77	0.67	0.41	0.93	0.79

SVI COMMUNITIES OF CONCERN

Mid-County zip codes 20853 and 20906 have the highest levels of overall social vulnerability with .77 index, respectively, followed by zip code 20895 with .62 social vulnerability index. Zip code 20853 has a relatively high socioeconomic vulnerability compared to all other Mid-County zip codes with .69 index. Zip code 20906 has the second highest socioeconomic vulnerability with .67 index. Mid-County zip codes 20833, 20860, and 20862 have greater household composition and disability vulnerabilities compared to all other Mid-County zip codes with .77 index, respectively. Mid-County zip code 20895 has the next highest household composition and disability vulnerability with .65 index. Minority status and language vulnerability is the highest in Mid-County zip codes 20853 and 20906 with .93 index, respectively. Mid-County zip code 20902 has the next highest minority status and language vulnerability compared to the remaining zip codes with .90 index. The highest housing type and transportation vulnerability is found in Mid-County zip code 20855 with .86 index. Mid-County zip code 20853 has the next highest housing type and transportation vulnerability with .81 index.

Community Conversation Identified Health Needs, Barriers, and Issues.

Participants of the Mid-County focus group identified several **health behaviors** that impact the health of their community. According to participants, challenges to being healthy in their communities were impacted by the differences in views of people about health related to COVID-19 preventive measures, such as adhering to mask

and social distancing requirements as well as the apprehension people feel around the vaccine in terms of adverse side effects. One participant mentioned an increase in alcohol consumption as a health issue in his neighborhood and believes the issue has gotten worse since the start of the COVID-19 pandemic.

The increasing prevalence of obesity in the Mid-County was a health issue identified by participants. Other chronic diseases such as diabetes and high blood pressure that are prevalent in Hispanic/Latinos and African Americans populations were discussed as health issues. Participants suggested that there is a lack of nutrition education for people with pre-diabetes, diabetes, and high blood pressure.

> "I think we need to work with cultural expectations or at least approach that with more culturally awareness". "...It is also cultural humility, how to approach people, how to understand where they are coming from..."

Food insecurity was a topic that Mid-County community members felt was of great importance, mostly in COVID-19 times. Participants shared that food insecurity was one of the biggest factors that affected their community, particularly the larger Hispanic/Latino community and other low-income families. Participants agreed that the big demand "speaks to the need and issues surrounding insecurity of food as a whole." Participants pointed out concerns that reflect the extent to which Montgomery County food banks' operations are organized in ways that meet the constraints and preferences of the community. Of greatest concern were hours of operation. Participants also mentioned the need for more food bank locations. One newcomer to Montgomery County from Philadelphia, stated that finding food banks was difficult.

Participants questioned the prevalence of unhealthy and culturally inappropriate food options both in food banks and in the community. Cultural expectations and awareness were also questioned when referring to the content of food boxes, "I think we need to work with cultural expectations or at least approach that with more cultural awareness". "...It is also cultural humility, how to approach people, how to understand where they are coming from..."

According to participants interviewed, the quality of food and the heavy presence of fast-food chains in Mid-County, are some of the problems that individuals are facing, who are "too busy," have lower health literacy about nutrition, or simply have competing basic needs to fulfill with extremely low wages and salaries. Participants mentioned the difficult position people are put in when they must choose between paying their rent or mortgage and being able to afford good, healthy food, when there is a cheaper option right around the corner at "McDonald's." Participants thought this had to do with a person's health literacy in health prevention.

One of the issues mentioned by participants is the number of fast-food chains that sell food that is

> ...it is too easy to find bad food around here. The one thing that I found awful from the health point of view in this community, is that there isn't a gateway for improving health in the community.

affordable but is unhealthy considering that African American and Hispanic/Latinos both have prevalent conditions of hypertension and diabetes. "...it is too easy to find bad food around here. The one thing that I found awful from the health point of view in this community, is that there isn't a gateway for improving health in the community."

Another issue mentioned by a few participants was related to access to quality foods in school provided breakfasts and lunches. Participants felt that this issue has a bigger impact on low-income communities. One participant brought up a concern about school lunches that had been distributed throughout the community during the COVID-19 pandemic. The participant questioned the quality of the food, stating, "[I] heard from a bunch of students (...) it is only cold lunches (...) with a sad plastic wrapping, soggy, with mystery meats and sad cheese. This makes kids not want to eat and I know they are hungry, but it is just not appealing to them." This same participant explained that it is "not right to feed children low quality food simply because they are hungry, and that there should be a way to feed children healthy and appealing food."

Community members emphasized several **clinical care** factors as key needs, barriers, and issues that affect the health of the Mid-County region. Access to health care was a common issue described by the participants. Several participants addressed the fact that as a working-class neighborhood, lots of families lack the benefits of paid health insurance. One participant stated, "Many people in Wheaton are self-employed, trade people, painters, tile workers, construction; they don't have employer insurance." Another participant stated, "My immediate community is largely the working class, many of my neighbors don't have the benefits of an employer or paid health plan, and some will go to the public route..."

The cost of health services was also a barrier to health care that was brought up by several participants, concluding that "health care is not affordable in this country" and that "health care needs to be a right." The rising out-of-pocket costs of health care and the need for more preventive care was a barrier mentioned by one participant. This participant stated, "You cannot even afford to be sick, you can't walk into a hospital, (...) you will be broke forever. That is the best push I've seen for preventive medicine".

Access to hospice care was another issue brought up by a participant. The participant stated, "there is a hole in the safety net in between hospice, rehab, and death and it falls on the family to have to find a way to pay for it."

Several of the participants discussed issues of access to COVID-19 vaccination, as well as

COVID-19 vaccine hesitancy. Participants cited factors like clinic hours, appointment times and locations, and vaccination slots presented huge barriers for community members in accessing COVID-19 vaccination services. One participant stated, "…many people are working multiple jobs and have heavy hours, so they don't have access to appointments they need to get to." "[Community members] feel that they cannot get to the locations to get the vaccine. It is not only the vaccine, but it also is an issue of accessing vaccination sites." A newcomer to Montgomery County stated, she experienced several barriers to getting services and information. The individual further explained that "finding where to go for the COVID-19 vaccine was difficult." For a few of the participants the health issue is "the great deal of dissatisfaction, a great deal of concern among a lot of the population, as to the safety of the vaccine, and the necessity of the vaccines…" despite efforts to reinforce people's sense of security and confidence in it.

Community members emphasized several needs, barriers, and issues that affect **social, economic, and demographic** health of the Mid-County region. Participants cited isolation from the community and confinement at home as a health matter that is an issue for some residents in their community, especially during the COVID-19 pandemic.

Several participants mentioned a meaningful presence of retired people and variety of professionals, whom despite the gap in income levels may have the same needs, they may not qualify for human services' programs or may not have access to human services' programs. Specifically, participants mentioned transportation to services and seniors who are living independently in their own homes. "I live in the Lake Hill area community and what I see is an aging population, there is a senior community of 10,000 seniors…" "…you may have a person that is retired and making a higher income and they do not qualify to meet the services, but they still need the services…" "…we need to be able to provide services for everyone regardless of income level."

Participants agreed on the need for greater collaboration between the Montgomery County government—DHHS, County Executive's office, County Council, or County committees—and private sector partners to disperse health information. Of specific note was dispersing health information regarding accessing COVID-19 vaccines. One participant stated, "I feel that each part of the county was decentralized, and when people wanted to get the vaccine

the health department had their doses, and they do not have control over the other agencies like CVS, and Holy Cross, so you have to sign up separately for each site to try to get your vaccine, and I was waiting for someone to take charge…"

For most of the participants, one of the biggest problems is the lack of information about the resources that are available from the County. Participants agreed that there is an awareness problem in the county when it comes to available resources and how to get them. Although there may be a lot of resources available in the county, "the information is scattered and incomplete, so people just don't know about it," exclaimed one participant. Community members explained that residents either do not know what is available, or they are not sure how to get those services. Not being able to get preventive care creates several kinds of problems the participants noted, for example when individuals "do not get the basic needs of health care that people take for granted."

Community members in the Mid-County region shared that, "people should know where they can get food, where affordable housing is; they should know where to get resources for preventive and health care." Participants shared a lack of community awareness of the existence of mobile clinics or free clinics, which they attributed to the lack of information about the resources offered by the County.

Participants shared that it is important to have in mind the literacy levels that people have in their own languages. Participants shared that "sometimes the information that is sent to them is too long and too saturated." A few participants addressed that the Spanish language is "taken for granted" when individuals are from Central and Latin America, but when designing resources, it is important to take into consideration, not only the language, but also the level of literacy, and dialects. All participants agreed that it is important and inclusive to offer health prevention and health promotion materials in "eight of the most prevalent languages spoken in the county;" "Not just in Spanish."

A few participants brought attention to bullying problems that children have with other children in the community. One participant expressed that there is a problem of security and safety in recreational areas such as parks and playgrounds.

Community members discussed several **physical and built environmental** factors that are health needs, barriers, or issues in the Mid-County region. Specifically, participants expressed that some populations, like older adults and people that do not have cars, have issues with transportation, such as they cannot afford to use the public transportation in that area. One participant explained, "… transportation is something that definitely needs to be made widely available to people who have different income levels, to start to close the gap as far as health needs for all individuals."

The lack of crosswalks into some of the parks in the Mid-County region, for example on Georgia Avenue and the Parkway, was an issue mentioned by some participants. "There is a sidewalk on Georgia Avenue, but I don't feel that anyone really feels safe on that road". The participant cites lots of pedestrian deaths over the last three years. "People don't go to the crossing lines, so they cross where it is more convenient for them…" Other things participants identified as issues in the Mid-County community were not enough sidewalks for

pedestrians and bike lanes for cyclists, and stormwater drainage issues.

All participants agreed that Montgomery County is the most expensive county to live in and is one of the highest selling markets in Maryland. Participants agreed that not only is housing very expensive, but so is health care and public transportation, specifically, the Metro. Affordable housing is an issue for many people unscored the participants, and the participants believed that there is a need to address affordability in the county, not only for homeowners but also renters.

Most of the participants believed that affordable housing is critical for an area that "should be a fairly modest neighborhood." They considered the cost of houses for sale and rental prices "ridiculous", given that rental houses are offered between $2,000 to $2,300 a month from Aspen Hill to Takoma Park, and in the Wheaton area houses are priced at a half million dollars. One of the participants, who has lived in the Mid-County area for the last 17 years, said "I could not afford to live in this neighborhood" if he were not already there due to skyrocketing home prices.

Participants mentioned issues with new communities that are trying to build some

affordable housing. Some participants described issues about the use of space to build more apartments in Wheaton areas, which they describe as not necessarily affordable. According to some participants, the problem with affordable housing is that builders are allowed "to cheat with equitable units" that usually do not look like the rest of the units offered in those buildings. These affordable housing units, which one participant referred to as a "bargain basement down hole," are often significantly smaller and different than other units offered within the same complex—the difference in quality and appearance is very marked.

Participants shared that the lack of affordable housing has resulted in many immigrant families that relocate to the Mid-County region having difficulty in keeping their home, especially during COVID-19 pandemic. This the participants felt, has caused an increase in multi-family homes so that the people living in the home can keep up with payments while still being able to afford their other bills. One participant stated that people "would not have to do that if we gave them the resources, gave them the means and made sure that developers provided not only 12% of a building, but 40% closer to 50% for people who need to live in an affordable way."

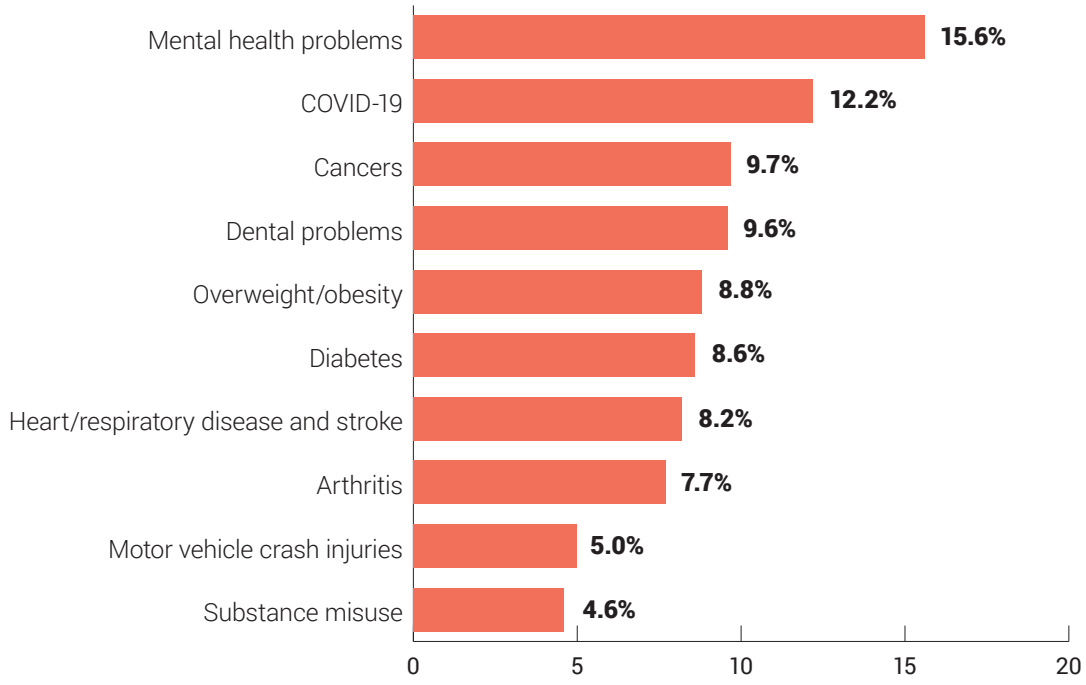
The concern about the lack of access to technology, specifically among the large community of immigrants that lived in the Mid-County area, which may prevent them from

registering and participating in services was discussed as a barrier. "…[they] do not have the access in the technical aspect to have computers, they may not have cell phones with technology to allow them register for certain services or to be able to have the resources (…) there should be a way to reach these individuals that cannot register for services when libraries are not open."

Community Health Needs Survey.

Based on data from the 2022 community health needs survey, Mid-County residents identified mental health, COVID-19, cancer, and dental problems as the most important health problems they face (Figure 68). Availability/access to insurance, housing/homelessness, and neighborhood safety/violence were the top social/environmental problems that affect health (Figure 69). Poor eating habits, texting/on the phone while driving, alcohol dependency, lack of exercise, and drug use/misuse were the most important risky behaviors that impact health (Figure 70). Nearly a third of residents reported cost as the top reason for not getting care, followed by no insurance and immigration status (Figure 71). Approximately 13% of those that responded to the survey indicated that they needed financial assistance because of COVID-19, and 12.9% needed food assistance (Figure 72).

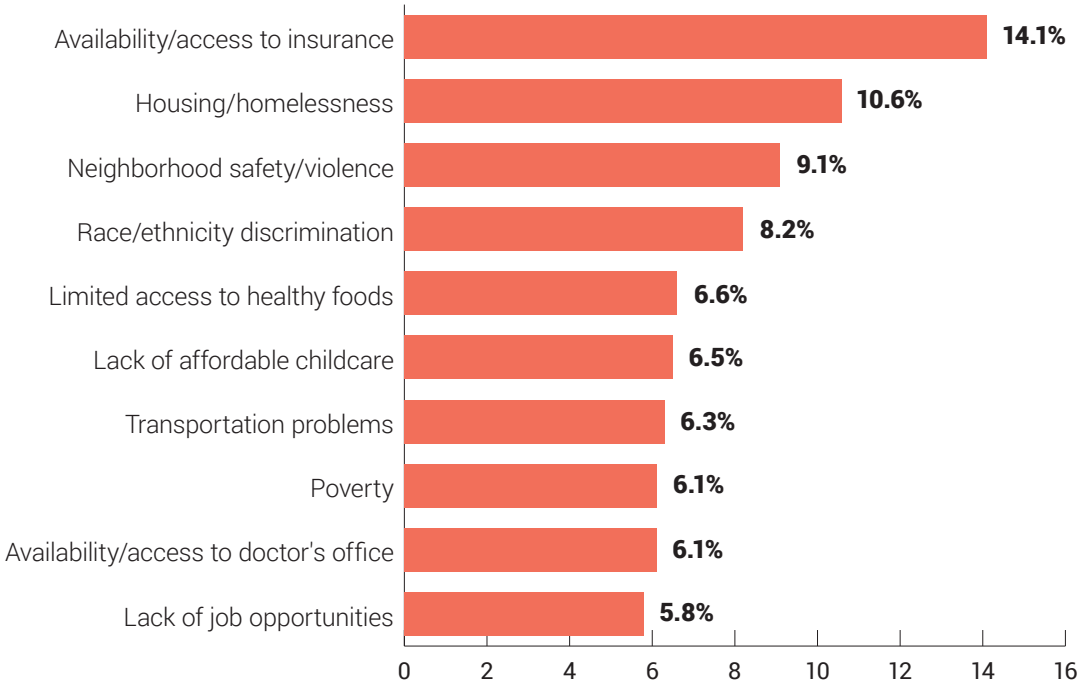
FIGURE 68. **Mid-County Region Community Most Important Health Problems**



(N = 310)

FIGURE 69.

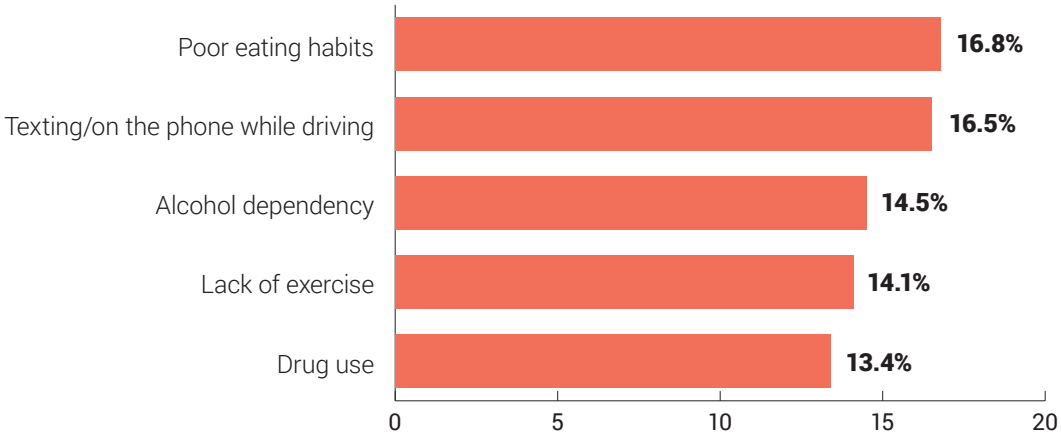
Mid-County Region Community Most Important Social/ Environmental Problems



(N = 310)

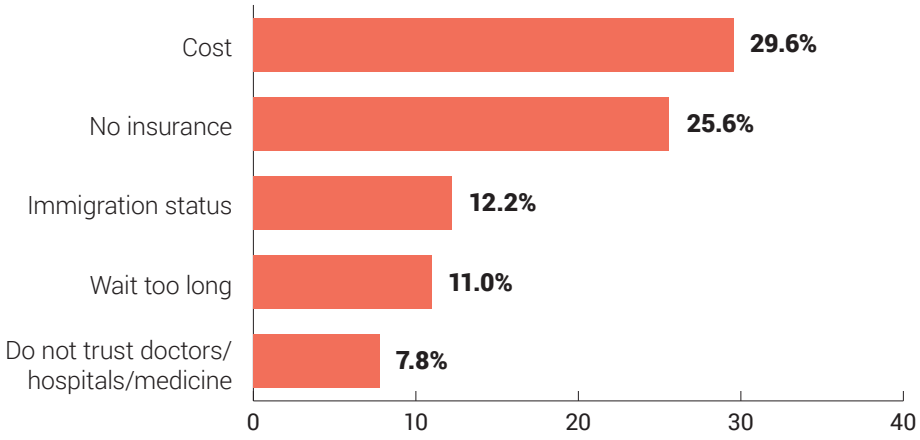
FIGURE 70.

Mid-County Region Community Risk Factors that Impact Health Behaviors and Outcomes



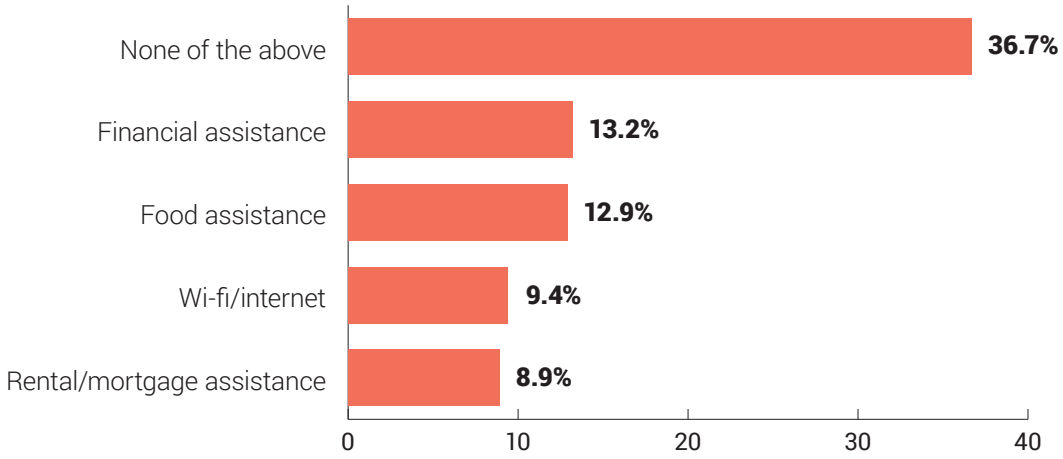
(N = 310)

FIGURE 71. **Mid-County Region Community Top Reasons for Not Getting Care**



(N = 310)

FIGURE 72. **Mid-County Region Community Assistance Needed as a Result of COVID-19**



(N = 310)

SILVER SPRING REGION

Description of Community Served.

Population Characteristics for Silver Spring Region

ZIP CODE	TOTAL POPULATION (2020)	PEOPLE OF COLOR (%)	MEDIAN AGE	LESS THAN HIGH SCHOOL DIPLOMA (%)	UNEMPLOYMENT RATE	PEOPLE OF DISABILITY STATUS (%)	UNINSURED (%)	MEDIAN HOUSEHOLD INCOME ($)	HOUSEHOLDS SPENDING ≥ 35% OF INCOME ON HOUSING COSTS–MORTGAGED (%)	HOUSEHOLDS SPENDING ≥ 35% OF INCOME ON HOUSING COSTS–RENTERS (%)
20901	36,802	59.92	38.2	9.24	5.8	7.5	8.48	112,689	12.4	43.8
20910	43,729	52.5	34.9	5.51	3.9	8.2	4.86	97,944	13.2	38.5
20912	25,118	65.46	36.4	15.9	6.6	5.8	13.33	68,662	16.7	42.9

Social Vulnerability Index.

Silver Spring Region Social Vulnerability Index by Zip Code

ZIP CODE	OVERALL	SOCIOECONOMIC	HOUSEHOLD COMPOSITION & DISABILITY	MINORITY STATUS & LANGUAGE	HOUSING TYPE & TRANSPORTATION
20901	0.68	0.52	0.48	0.86	0.81
20910	0.62	0.45	0.65	0.80	0.87
20912	0.61	0.36	0.46	0.80	0.82

SVI COMMUNITIES OF CONCERN.

Silver Spring region zip code 20901 has the highest overall social vulnerability with .68 index, followed by zip code 20910 with .62 social vulnerability index. Zip code 20901 has a relatively high socioeconomic vulnerability compared to all other Silver Spring region zip codes with .52 index. Zip code 20910 has the second highest socioeconomic vulnerability with .45 index. Silver Spring region zip code 20910 has greater household composition and disability vulnerability compared to all other zip codes in the region with .65 index. Silver Spring region zip code 20901 has the second highest household composition and disability vulnerability with .48 index. Minority status and language vulnerability is the highest in Silver Spring region zip code 20901 with .86 index. Silver Spring region zip codes 20910 and 20912 has high minority status and language vulnerabilities of .80 index, respectively. The highest housing type and transportation vulnerability is found in Silver Spring region zip code 20910 with .87 index. Silver Spring region zip code 20912 has the next highest housing type and transportation vulnerability with .82 index.

Community Conversation Identified Health Needs, Barriers, and Issues.

Access to healthy foods of preference in the Silver Spring region was a **health behavior** need mentioned by community members. One participant described the lack of vegetarian restaurants or "health-conscious stores to go and shop."

A significant topic of discussion for the Silver Spring region community members were **clinical care** health issues, needs, and barriers. Participants shared that in the Silver Spring area there is a lack of access to doctors and challenges finding a new doctor, specifically primary care. One participant specifically underscored that in the Olney area the availability of doctors, "at least reasonably quickly," even for those who have insurance is an issue, and that there's "not enough doctors…to meet the size of the population." This participant went on to seemingly call for a balance between the availability of doctors to nurse practitioners, stating, "some people are happy with nurse practitioner, but I'm not." Additionally, the availability of doctors who accept Medicaid was an issue raised during the discussion.

One participant felt that "Montgomery County government should do more…to try to attract more [private practice general internist] doctors to [the Silver Spring area]." Another participant emphasized the role of the government in incentivizing internists to accept lower income people as their patients. Another participant expressed the need for medical providers who practice precision or individualized medicine, holistic medicine, or alternative medicine. Access to mental health care services was raised as a need by one participant.

> "Montgomery County Government should do more…to try to attract more [private practice general internist] doctors to [the Silver Spring area].

Participants shared concern over the increasing number of concierge doctors offering primary care services in the Silver Spring region. One participant shared that community members are "very… concerned…upset…disgusted…angry, the doctors they had been with, in many cases, many years are suddenly, are basically demanding these payments if they want to stick with them. Doctors are limiting their practice… I'm very concerned that…the way things are headed…at least in this area, probably just in Montgomery County in general…if you want real access to a doctor, you're going to have to pay

thousands of dollars extra in addition to insurance. If you want sort of access to a doctor, then it's still going to cost you thousands of dollars in insurance." On the other hand, the participant further stated that some community members are "going to = Doctors Name =…and of course they're not doing that [offering concierge medicine] …you're like just a number."

Another participant expressed the need for more doctors and health care administrators who are educated on, understand and "take seriously" the needs of women of color. For example, the participant stated that from personal experience and studies that she has read, "women of color are overly sedated instead of given pain medication… I never knew I would ever be in a position to experience all the things that I had read about health care disparities, and how different racial demographics are treated in medicine."

Community members discussed several needs, barriers, and issues that affect the **social, economic, and demographic** health of the Silver Spring region. Economic issues leading to poverty were mentioned several times because of "how foundational it is as it affects ability to take care of yourself and your family" as stated by one participant. Participants also expressed those members of their community, "need access to good paying jobs to be able to take care of themselves and their health." Another participant shared that "[Silver Spring] used to be the place where immigrants go to take advantage of the jobs/ability to make living."

The public education system was identified by one participant as a social, economic, and demographic health issue in the Silver Spring region. The participant explained: "schools declined in quality overtime…The expectations kept just getting lower and lower…I think it's impacted the community, in that the…expectations of the school has declined so much that I don't think a lot of the kids are getting the education that they really deserve and need…There's clearly a lowers expectations I think… largely in the Eastern side of the county than there are in the Down-County/Western-side, and that's not fair to anybody. I think every child has the potential to perform very well and cutting the requirements doesn't really help anybody." Another participant stated that the schools in the region are "very congested."

Public safety and crime in the Silver Spring neighborhood was raised as a social and economic issue by participants. One participant expressed concerns regarding the County's emergency dispatch system, citing, "I've had times where I've been on hold waiting for 911 to answer. I've been on hold for over four minutes. And I know that they're working in the state to be able to have 911 be able to track the location of your cell phone if you are calling from your cell phone. But if you're nonresponsive, my concern is they wouldn't be able to reach you."

Participants mentioned the lack of in-person assistance as a barrier to accessing governmental health programs, especially for individuals who have limited English proficiency, those who have a lower reading level, persons who have low technological literacy, and people who do not have a cell phone. One participant stated, "The process for signing up for Medicaid and then renewing it is near impossible. It took me…probably five months of writing to the County, and to going on the website to figure out how it's done. It's very illogical and very user-unfriendly as well. And…I didn't have a cell phone. And Montgomery County has changed everything where you can't even access the bus schedule without having a cell phone. So, if you're stuck in the position where you don't have access to those things you don't belong in the County anymore, you don't have any rights. There were times when I called the County for help, where I was told, 'well you don't have a cell phone we can't get in contact with you to help you.' I think that attitudes have changed a little bit more."

Community members discussed two key **physical and built environmental** factors that are health needs, barriers, or issues in the Silver Spring region. Participants voiced concern that the Silver Spring

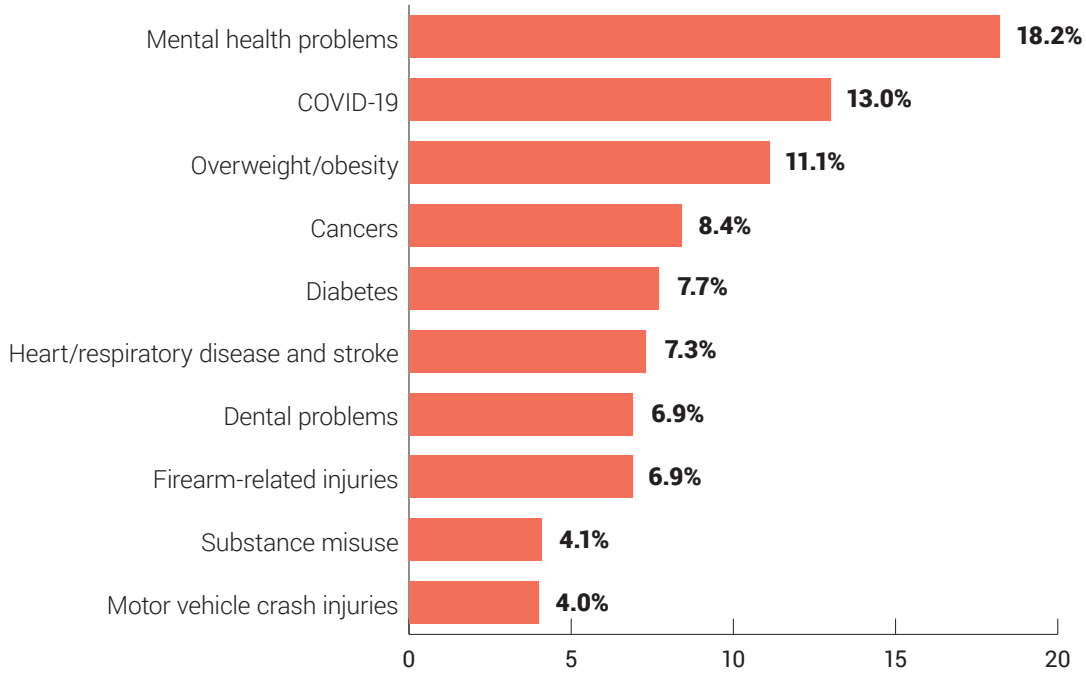
region is "dense and becoming more and more congested." One participant stated that road traffic congestion is a common problem in the Silver Spring region. Another participant stated that "every time you turn around there's a new building being constructed," which increases congestion in the area. The participant further explained that there are not enough trees in the Silver Spring area due to the increasing number of buildings being constructed.

Additionally, housing as a physical and built environment issue was discussed by participants. Specifically, community members underscored the need for more affordable housing, with one participant citing, "we don't have rent control" in the area. Related, participants discussed that there is a significant homeless population in the Silver Spring area and that there is a need for this group of individuals to receive more services. One area of need underscored by the participants is housing access for people who are experiencing homelessness. One participant stated, "without having housing we just really can't even begin to address the health care disparities we have."

Community Health Needs Survey.

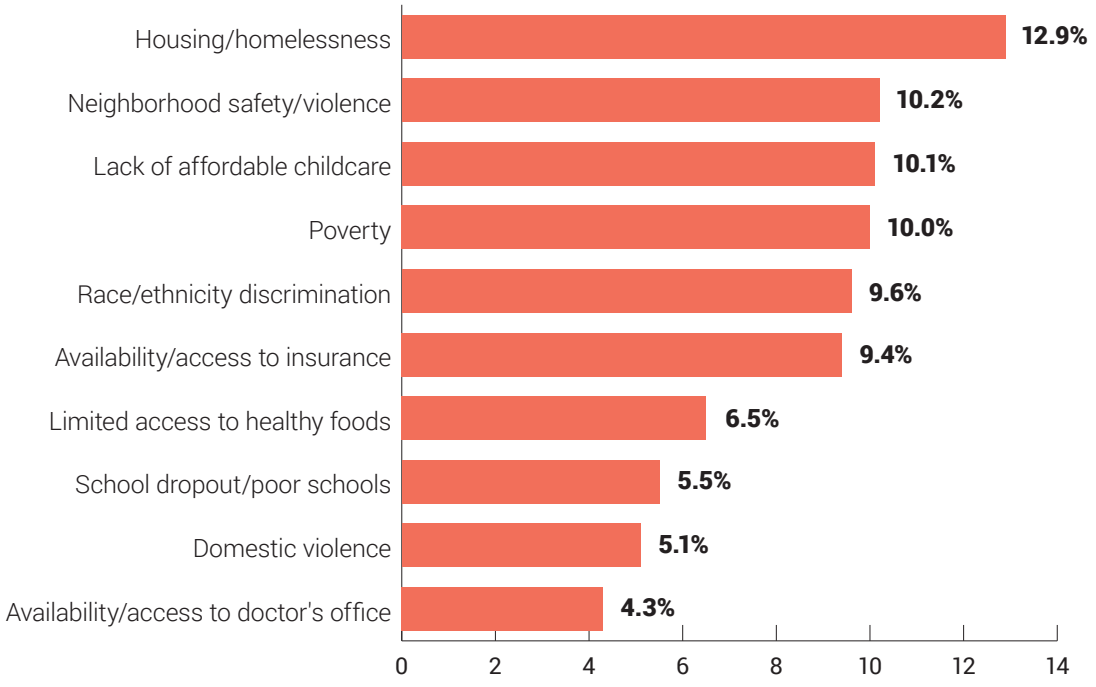
Based on the data from the 2022 community health needs survey, Silver Spring residents identified mental health, COVID-19, and overweight/obesity as the most important health problems they face (Figure 73). Housing/homelessness, neighborhood safety/violence, lack of affordable childcare and poverty were the top social/environmental problems that affect health (Figure 74). Poor eating habits, lack of exercise, texting/on the phone while driving, and substance use/misuse were the most important risky behaviors that impact health (Figure 75). A third of residents reported cost as the top reason for not getting care, followed by no insurance and immigration status (Figure 76). Approximately 14% of those that responded to the survey indicated that they needed financial assistance because of COVID-19, 12% needed rental/mortgage assistance, 11.8% needed health care assistance, and 8.7% needed food assistance (Figure 77).

FIGURE 73. **Silver Spring Region Most Important Health Problems**



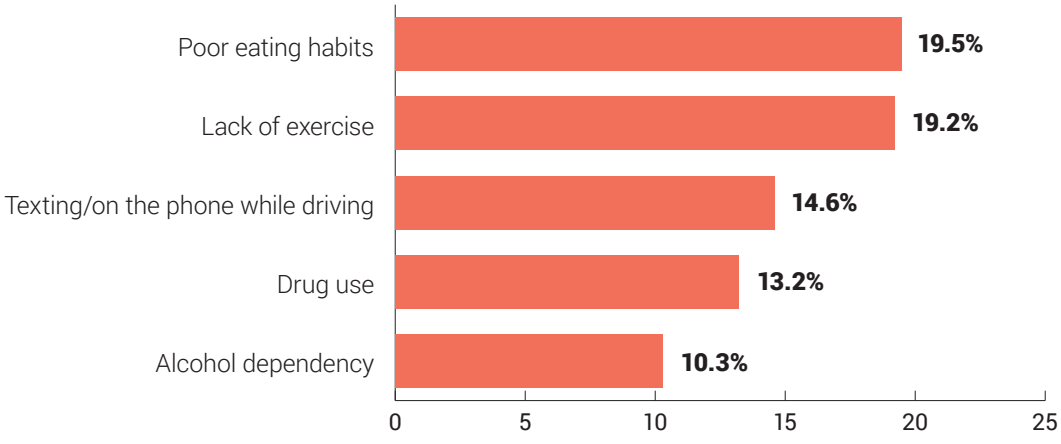
(N = 190)

FIGURE 74. **Silver Spring Region Most Important Social/Environmental Problems**



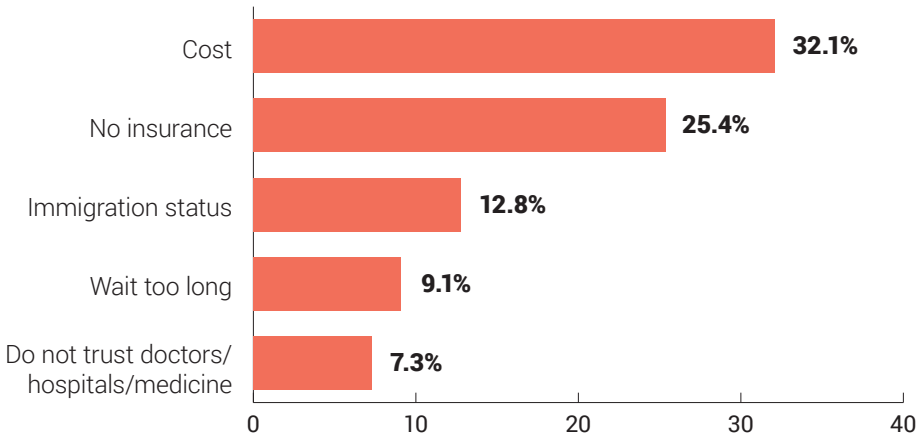
(N = 190)

FIGURE 75. **Silver Spring Region Risk factors that Impact Health Behaviors and Outcomes**



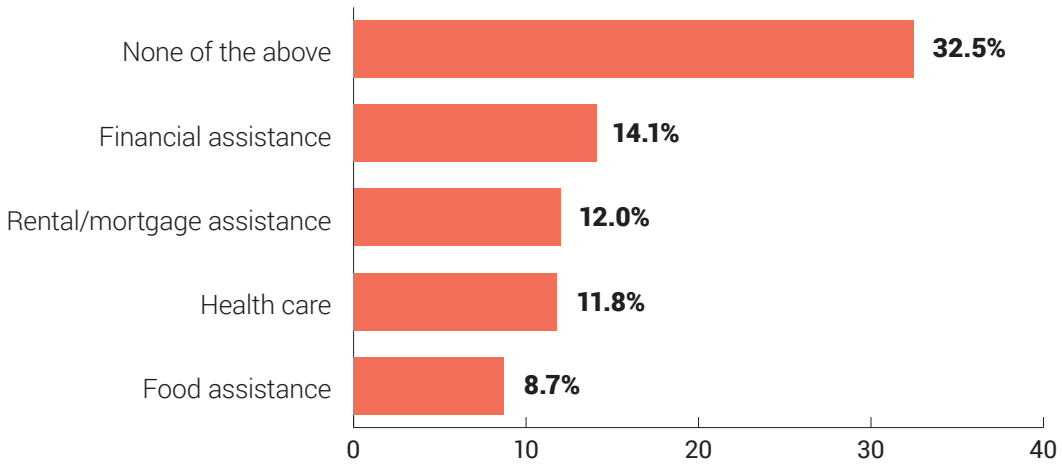
(N = 190)

FIGURE 76. **Silver Spring Region Top Reasons for Not Getting Care**



(N = 190)

FIGURE 77. **Silver Spring Region Assistance Needed as a Result of COVID-19**



(N = 190)

UPCOUNTY REGION

Description of Community Served.

Population Characteristics for Upcounty Region

ZIP CODE	TOTAL POPULATION (2020)	PEOPLE OF COLOR (%)	MEDIAN AGE	LESS THAN HIGH SCHOOL DIPLOMA (%)	UNEMPLOYMENT RATE	PEOPLE OF DISABILITY STATUS (%)	UNINSURED (%)	MEDIAN HOUSEHOLD INCOME ($)	HOUSEHOLDS SPENDING ≥ 35% OF INCOME ON HOUSING COSTS–MORTGAGED (%)	HOUSEHOLDS SPENDING ≥ 35% OF INCOME ON HOUSING COSTS–RENTERS (%)
20837	6,129	22.25	44.4	5.14	4.5	10.6	1.8	151,667	4.8	34.2
20838	377	16.18	45	0	0	9	10.61	135,714	21.1	--
20839	139	33.81	28.2	0	0	5	0	188,833	23.3	--
20841	11,692	65.69	39.7	8.01	4.8	7	3.32	171,598	22.3	61
20842	1,467	21.13	47.2	6.34	2.4	17.9	5.07	128,542	19.8	25.4
20871	18,961	66.51	36	3.63	3.8	4.9	3.54	136,414	18.5	26.1
20872	12,790	30.59	41.8	4.93	3	8.7	2.1	121,896	18.9	23.5
20874	60,258	67.49	36.4	9.67	4	10.2	6.35	98,007	18.6	37.7
20876	31,703	72.86	34.1	9.82	4.8	7.4	7.16	106,061	19.5	42.7
20877	37,948	77.54	37.8	18.64	6.5	11.7	15.4	75,531	27.7	45.8
20878	63,576	53.83	41.1	4.66	4.2	6.4	4.53	127,957	17.9	35.5
20879	26,343	70.53	35.3	10.04	6.4	9.2	11.75	89,163	18.1	44.4
20880	530	20.19	53.1	5.42	3.6	14.7	3.58	130,536	19.4	63.2
20882	14,441	29.55	45.8	3.07	4	8.6	2.02	140,428	18	20
20886	34,887	73.29	37.5	11.95	5.8	9.3	10.86	85,578	19.9	56
20899	284	83.8	44.9	4.41	0	21.5	8.8	37,279	0	48.9

Social Vulnerability Index.

Upcounty Region Social Vulnerability Index by Zip Code

ZIP CODE	OVERALL	SOCIOECONOMIC	HOUSEHOLD COMPOSITION & DISABILITY	MINORITY STATUS & LANGUAGE	HOUSING TYPE & TRANSPORTATION
20837	0.08	0.12	0.19	0.58	0.05
20838	0.04	0.10	0.08	0.34	0.08
20839	0.04	0.10	0.08	0.34	0.08
20841	0.15	0.08	0.30	0.84	0.18
20842	0.08	0.12	0.19	0.58	0.08
20871	0.18	0.16	0.22	0.82	0.09
20872	0.37	0.23	0.22	0.71	0.56
20874	0.79	0.76	0.45	0.88	0.71
20876	0.21	0.14	0.15	0.74	0.24
20877	0.88	0.60	0.61	0.88	0.99
20878	0.24	0.07	0.47	0.78	0.46
20879	0.69	0.55	0.56	0.90	0.85
20880	0.80	0.65	0.61	0.94	0.93
20882	0.21	0.17	0.22	0.74	0.24
20886	0.77	0.66	0.56	0.95	0.87
20899	0.51	0.28	0.19	0.87	0.72

SVI COMMUNITIES OF CONCERN.

Upcounty zip code 20877 has the highest overall social vulnerability with a .88 index, followed by zip code 20880 with a .80 social vulnerability index. Zip code 20874 has a relatively high socioeconomic vulnerability compared to all other Upcounty zip codes with a .76 index. Zip code 20886 has the second highest socioeconomic vulnerability with a .66 index. Upcounty zip codes 20877 and 20880 have greater household composition and disability vulnerabilities compared to all other Upcounty zip codes with a .61 index score, respectively. Upcounty zip codes 20879 and 20886 have the next highest household composition and disability vulnerabilities with .56 index, respectively. Minority status and language vulnerability is the highest in Upcounty zip code 20886 with a .95 index. Upcounty zip code 20880 has the next highest minority status and language vulnerability compared to the remaining zip codes with a .94 index. The highest housing type and transportation vulnerability is found in Upcounty zip code 20877 with a .99 index. Upcounty zip code 20880 has the next highest housing type and transportation vulnerability with a .93 index.

Community Conversation Identified Health Needs, Barriers, and Issues.

Upcounty community members shared their views on health needs, barriers, or issues associated with the COVID-19 pandemic. The COVID-19 pandemic has created more social isolation and has "led to desperation, depression, and lack of self-preservation of health" according to one participant. Older adults are experiencing "more" social isolation according to another participant. Another participant shared that people in their community with chronic diseases who are experiencing social isolation have challenges accessing mental health services, specifically for depression and anxiety.

One participant cited that early in the COVID-19

pandemic, when the vaccine became available, there were access challenges for certain racial and ethnic groups. COVID-19 vaccine hesitancy among certain racial and ethnic groups one participant shared has led to lower vaccination rates in these groups of people. Language barriers that led people of certain racial and ethnic groups not trusting the COVID-19 vaccine has resulted in lower rates in these groups of people according to one participant. The lack of technology access or the inability to effectively operate technology to schedule a vaccine appointment has created challenges with certain racial and ethnic groups not having adequate access to the COVID-19 vaccine, according to another participant.

Participants of the Upcounty focus group identified several **health behaviors** that impact the health of their community. Poor mental health was one health issue described by the participants of the Upcounty region. One participant expressed concern that poor police-community relations in some areas of the Upcounty region are associated with poor mental health. Further, participants expressed concern for the mental health of the youth in the Upcounty region and voiced the need for more mental health professionals in schools and in the community to provide services to the youth population.

Access to facilities that promote health were identified as issues in the Upcounty region. Access

to affordable geographically located fitness clubs that can help promote exercise and healthy lifestyles was an issue shared by participants. Participants shared that there is a need in the Upcounty region for more recreational centers that promote health for youth. Another participant shared that to promote exercise and healthy living, there is a need for an indoor swimming pool that is open year-round in the western part of the Upcounty region.

Participants shared that there is limited access to grocery stores in the western and northern parts of Upcounty that sell a variety of healthy foods. For example, foods that are labeled as all-natural, organic, or free from hydrogenated fats and artificial colors, flavors, and preservatives. As a result, one participant shared that they travel as far as Frederick County to buy these types of healthy foods.

A topic that received much discussion by the Upcounty region community members were **clinical care** health issues, needs, and barriers. Access to routine medical services, particularly specialty services on a regular basis for people with chronic conditions, was an issue identified by community members. Of particular concern was related to accessible health care for individuals who live in the Poolesville, Dickerson, Barnesville, Boyds, and Beallsville areas of the Upcounty region. Participants shared that "the medical specialty services are at least 8-14 miles away from the Poolesville area" of the Upcounty region, and this especially impacts older people who need these services on a frequent basis. Likewise, another participant explained that residents often must travel to Germantown or Gaithersburg for medical care due to the limited availability of health care providers in certain areas of the Upcounty region, such as Clarksburg. One participant expressed length of life concerns regarding the impact of the inability to get to routine medical services has had on lower life expectancy rates of people who live in the western areas of the Upcounty region specifically the Poolesville zip code of 20837 as compared to other parts of Montgomery County.

Another clinical care issue mentioned by participants was limited access to health care for people who are employed or workers who recently lost their health benefits. According to one participant, even though residents in the western and northern areas of the Upcounty region have employer-sponsored health care coverage, they also must travel to Germantown or Gaithersburg for medical care due to the limited availability of health care providers in their area of the Upcounty region. Another participant spoke on the limited access to health care and outreach and awareness to people who recently lost their job and are unable to afford COBRA health insurance or health care coverage through the Maryland Health Connection.

Similarly, participants called for the need for free clinics and more community health centers for people who are unemployed or low-income so that this population of people do not have to use the emergency room. Another participant expressed concern for the affordability of health care for people who work part-time, as well as accommodations in the hours of operation of medical appointments for families with multiple children. Similarly, one participant cited the need for community health centers that offer health care services on a sliding fee scale for people who may be underinsured or

> "Create an atmosphere where people of different languages and of different ethnicities feel comfortable enough to seek guidance, feel understood and also feel like they can almost see themselves in the people they need help from.

employed but have no health care coverage.

Participants shared that there is a need for more culturally competent health care workers to "create an atmosphere where people of different languages and of different ethnicities feel comfortable enough to seek guidance, feel understood and also feel like they can almost see themselves in the people they need help from."

Participants cited difficulty in finding information about the availability of health care providers that deliver medical or mental health care. One participant underscored that there is a lack of places in the western and northern parts of Upcounty where residents can go to get information on County-sponsored services to address health care needs. The issue of limited knowledge of what public services are available and where people can get public services for their health care needs, another participant shared, affects people of minority and immigrant communities and older adults. Another participant shared that there is a need for more accessible culturally competent information on the availability of health care services for people that may need assistance. Participants explained that not everyone has the ability (access and/or skills) to access digital health information, so other mechanisms of communicating health information and the availability of government-sponsored health care services to community members are needed.

Community members in the Upcounty region shared several needs, barriers, and challenges related to the **physical and built environment**. Participants seemed to agree that the public transportation system in their community adversely affects the health of residents. One participant described the public transportation system in the Upcounty region as "very sporadic." One participant stated, "without public transportation, which we have almost none out here, although we have a bus that doesn't really go to many places people need to go." Another participant stated, "It's one bus line. It only goes in the morning and afternoon; it's limited on the weekend…we have a lot of shortcomings in terms of getting, especially older people and people who can't drive or can't afford a car to medical services."

Another participant shared that while some older adult housing communities provide trips "once a week to medical appointments with a confined time frame," it is difficult for seniors to schedule appointments and "a lot of people refuse or don't go" to their medical appointments because of this. Another participant expressed that some parts of the Upcounty region, such as Germantown, can use more accessible public transportation options for medical appointments that are in other regions for Montgomery County, stating, "I go to [Doctors name]. And if I don't count on friends and neighbors and family I can't get there; and take taxis, they are pretty expensive."

Another participant shared that time and distance on public transportation to other regions within Montgomery County is a challenge when residents in the Upcounty region are seeking to access services in other parts of the county, for example health care services. One more participant shared that in the northern communities of the Upcounty region there are safety concerns with bus stops being "right off the edge of a busy road." This participant further explained that in the northern communities of the Upcounty region there is the lack of benches to sit on at the bus stops which creates a barrier for people who depend on public transportation to travel to medical appointments.

Participants expressed the need for more affordable housing to promote healthy living in the Upcounty region. The higher prevalence of poverty in the Upcounty region compared to other regions within Montgomery County impacts cost of living and adequate housing according to many of the participants interviewed. One participant exclaimed, "when they say affordable housing it's based on the income from Washington, DC…People who are trying to get appropriate and decent housing…in a

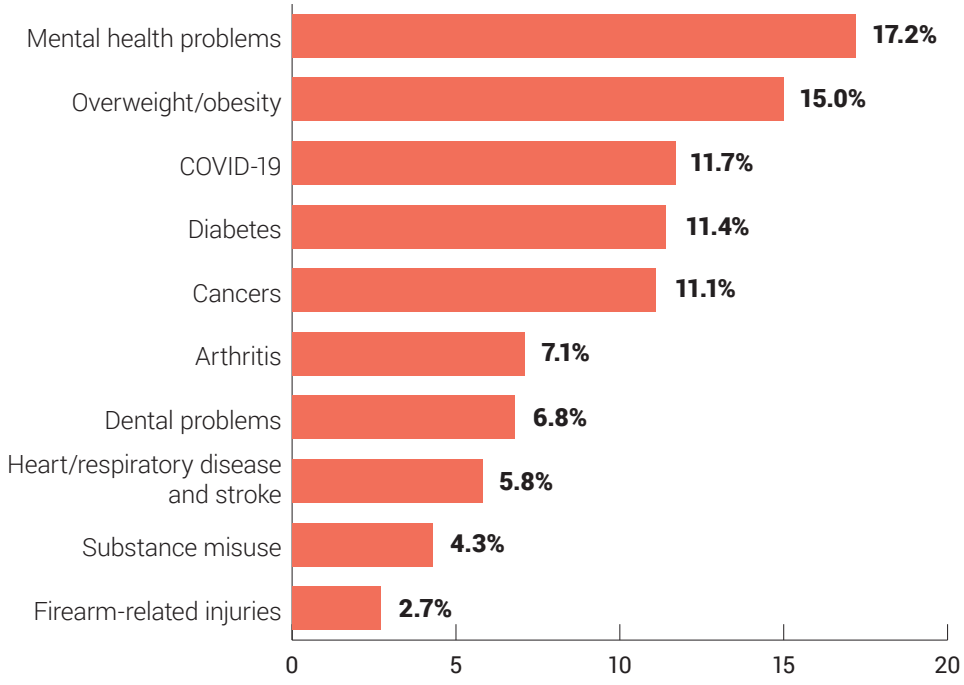
decent school district…they still can't afford it, two jobs, three jobs, many family members in the house, and they still can't afford it, and it's still like a dream. The dream is to own, but here it's just a dream to have decent house, an apartment to live in, especially when you have children." Expensive rental housing costs are impacting older adults' ability to afford and pay their medical bills, medications, and food according to one participant.

Community members shared those physical barriers in the Upcounty region, like lack of streetlights, and sidewalks inhibit walkability. These barriers present mobility challenges and reduce opportunities for activity, which can affect physical and mental health. One participant expressed concern over roadway vegetation control with regard to safety, stating that specifically in their community of Germantown, there are unusually low tree branches or brush that block motorists' ability to see people on the sidewalks.

Community Health Needs Survey.

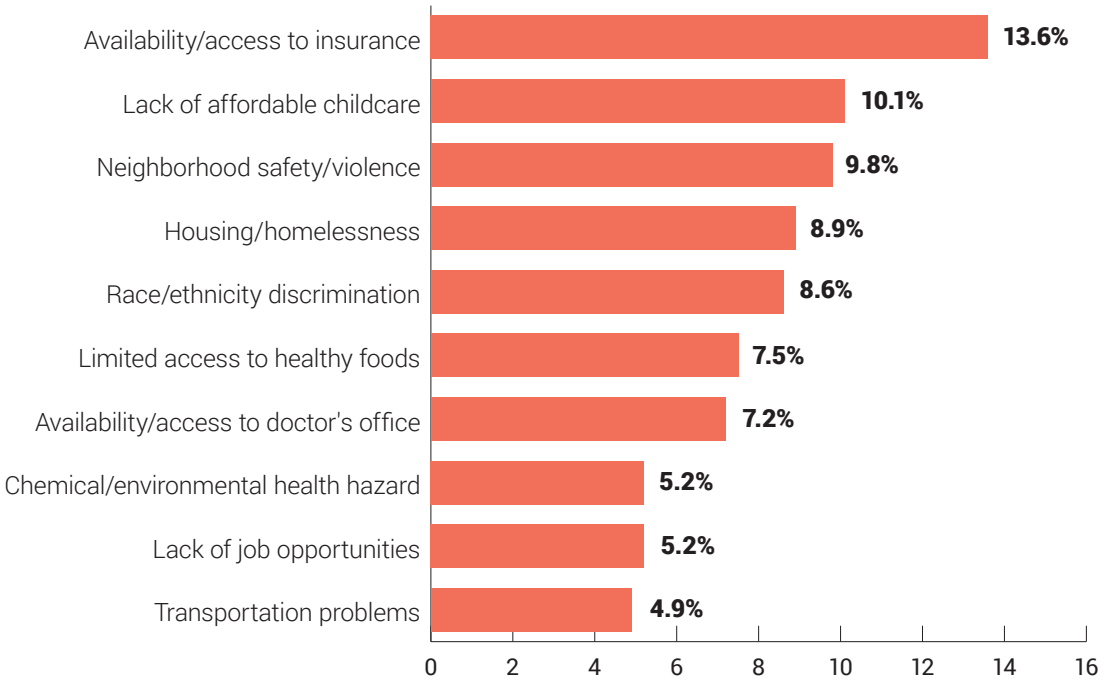
Based on data from the 2022 community health needs survey, Upcounty residents identified mental health, overweight/obesity, COVID-19, diabetes, and cancer as the most important health problems they face (Figure 78). Availability/access to insurance, lack of affordable childcare, and neighborhood safety/violence were the top social/environmental problems that affect health (Figure 79). Poor eating habits, lack of exercise, substance use/misuse, and texting/on the phone while driving were the most important risky behaviors that impact health (Figure 80). A third of residents reported cost as the top reason for not getting care, followed by no insurance and immigration status (Figure 81). Approximately 14% of those that responded to the survey indicated that they needed financial assistance because of COVID-19 (Figure 82). In addition, 10.2% needed food assistance and 10.1% needed assistance with health care (Figure 82).

FIGURE 78. **Upcounty Region Most Important Health Problems**



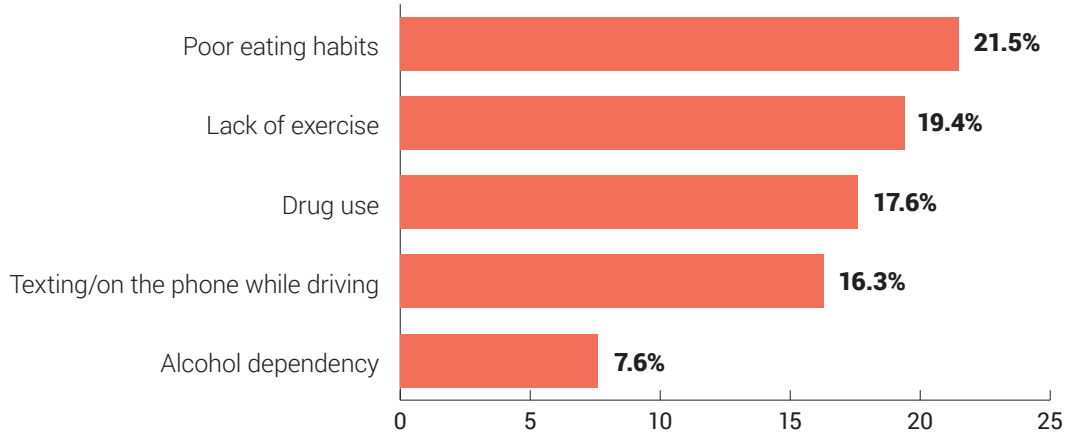
(N = 378)

FIGURE 79. **Upcounty Region Most Important Social/Environmental Problems**



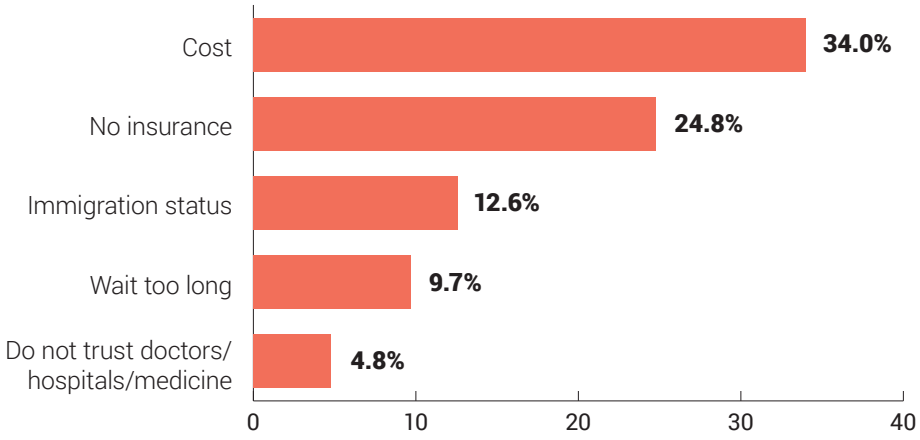
(N = 378)

FIGURE 80. **Upcounty Region Risk Factors that Impact Health Behaviors and Outcomes**



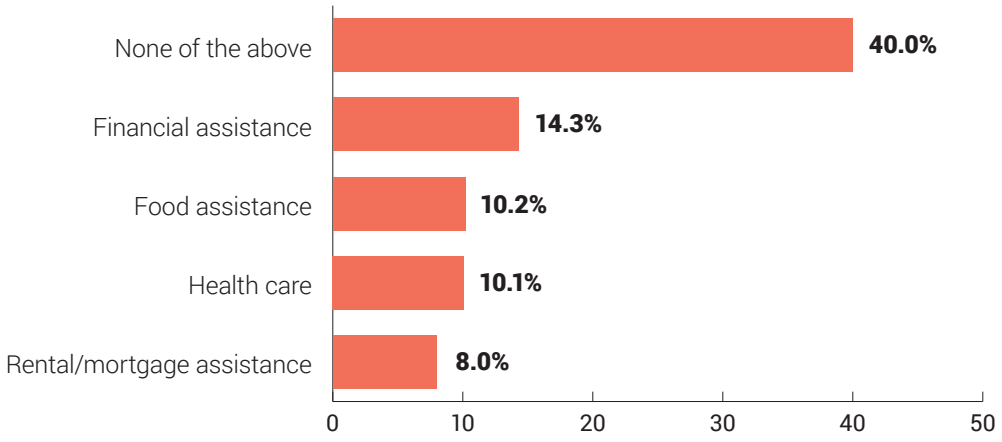
(N = 378)

FIGURE 81. **Upcounty Region Top Reasons for Not Getting Care**



(N = 378)

FIGURE 82. **Upcounty Region Assistance Needed as a Result of COVID-19**



(N = 378)

RESULTS OF SECONDARY DATA ANALYSIS

Secondary Data

While Montgomery County may rank as the healthiest Maryland county, there are many troubling trends that point to disparities in outcomes for several subpopulations ranging from disease specific outcomes to economic and quality of life outcomes and could pertain to health conditions such as asthma, diabetes, hypertension, mortality, and morbidity rates stratified by age, sex, race, and ethnic subpopulations. It is important to track and study the impact of poverty and wealth on life expectancy rates and other indicators such as transit-oriented development. The data in tables 13-18 show several trends, including increases in sexually transmitted infections, tuberculosis rates, substance use (e.g., opioid use and overdoses), utilization of emergency rooms for management of chronic diseases (e.g., diabetes) and controlling the spread of infectious disease. Numerous gaps and disparities in outcomes remain, including infant mortality, and mortality associated with chronic diseases, such as diabetes, heart disease, and cancer as well as communicable diseases.

TABLE 13. Length of Life

DOMAIN/ CONSTRUCT	INDICATOR	DEFINITIONS	MONTGOMERY COUNTY	MARYLAND	TREND	INEQUITY WITHIN RACES/ ETHNICITIES?	SOURCE YEAR(S) OF DATA
Length of Life	**EARLY LIFE**						
	Infant Mortality	Infant deaths per 1,000 live births	5.2	5.7	Decreasing	Black>Hispanic >White (Statistically Significant)	2020
	Child Mortality	Deaths among children under age 18 per 100,000	40	50	--	Black>White (Statistically Significant)	2017-2020
	Life Expectancy	Life expectancy at birth in years	84.6	77.3	Increasing	--	2020

TABLE 13.	Length of Life						
Length of Life	**OVERALL**						
	Age-Adjusted Mortality	Age-adjusted deaths under 75 years old per 100,000	500.5	735.6	--	Black>White (Statistically Significant)	2020
	Years of Potential Life Lost	Age-adjusted years of potential life lost before age 75 per 100,000	4300 (4200-4500)	7500 (7500-7600)	Fluctuating	--	2018-2020
Length of Life	**CHRONIC DISEASE**						
	Stroke Mortality	Deaths per 100,000	25.4	40.9	--	Black>White (Statistically Significant)	2020
	Chronic Liver Disease Mortality	Deaths per 100,000	5.22	9.5	--	--	2020
	Diabetes Mortality	Deaths per 100,000	12	20.8	Increasing	Black>White (Statistically Significant)	2020
	Heart Disease Mortality	Deaths per 100,000	100.4	163.7	Decreasing	Black>White (Statistically Significant)	2020
	Hypertension Mortality	Deaths per 100,000	6.95	10.5	--	--	2020
Length of Life	**CANCER AND KIDNEY DISEASE**						
	Cancer Mortality	Deaths per 100,000	111.3	148.8	--	Black>White (Statistically Significant)	2020
	Kidney Disease Mortality	Deaths per 100,000	7.73	9.9	--	--	2020

TABLE 13.	Length of Life						
Length of Life	**INTENTIONAL AND UNINTENTIONAL INJURIES**						
	Suicide Mortality	Deaths per 100,000	7.2	9.2	Increasing	No	2020
	Unintentional Injury Mortality	Deaths per 100,000	26.42	44.4	Increasing	No	2020
Length of Life	**OTHER**						
	Alzheimer's Mortality	Deaths per 100,000	11.8	15.8	Decreasing	No	2020
	Influenza and Pneumonia Mortality	Deaths per 100,000	9.04	12.3	Decreasing	No	2020
	Influenza Mortality	Deaths per 100,000	1.1	--	--	--	2020
	Pneumonia Mortality	Deaths per 100,000	8.8	--	--	--	2020

TABLE 14. Quality of Life

DOMAIN/ CONSTRUCT	INDICATOR	DEFINITIONS	MONTGOMERY COUNTY	MARYLAND	TREND	INEQUITY WITHIN RACES/ ETHNICITIES?	SOURCE YEAR(S) OF DATA
Quality of Life	Hospitalizations	Total hospitalizations per 100,000	5889.8	--	Decreasing	--	2019
	CHRONIC DISEASE						
	Diabetes Prevalence	Percentage age 18 and older with diagnosed diabetes	8.2	11	--	Black>White (Statistically Significant)	2020
	Low Birth Weight	Percentage of live births with birthweight below 2500 grams	7.0	9.0	Fluctuating	Black>White (Statistically Significant)	2014-2020
	HIV Prevalence	Persons aged 13 or older with a(n) Human Immunodeficiency Virus (HIV) infection per 100,000	439	655	Decreasing	Black>White (Statistically Significant)	2020
	Percentage with Disability	Percentage of total civilian noninstitutionalized population with a disability	15.9 (13.5-18.3)	19.8 (18.8-20.9)	--	Black>White (Statistically Significant)	2020
Quality of Life	**BEHAVIORAL HEALTH**						
	Mental Health Hospitalizations	Mental health hospitalizations per 100,000	1302	2255.6	Decreasing	Black>White (Statistically Significant)	2019
	Poor Mental Health Days	Age-adjusted average number of mentally unhealthy days reported in past 30 days	4.0 (3.8-4.1)	4.1 (3.9-4.3)	--	--	2020

TABLE 14.	Quality of Life						
	Poor Physical Health Days	Age-adjusted average number of physically unhealthy days reported in past 30 days	2.0 (1.9-2.2)	2.5 (2.3-2.6)	--	--	2020
Quality of Life	**CANCER**						
	Cancer Female Breast	Age-adjusted incidence per 100,000	125.7 (121.7, 129.7)	132.2 (130.5, 133.9)	Stable	No	2014-2018
	Cancer Colon and Rectum	Age-adjusted incidence per 100,000	28.2 (26.4, 30.1)	32.8 (32.0, 33.7)	Decreasing	Black>White (Statistically Significant)	2014-2018
	Cancer Lung and Bronchus	Age-adjusted incidence per 100,000	29.5 (27.6, 31.4)	50.9 (49.9, 51.9)	Decreasing	Black>White (Statistically Significant)	2014-2018
	Cancer Prostate	Age-adjusted incidence per 100,000	113.4 (109.4, 117.4)	128.1 (126.4, 129.9)	Stable	Black>White (Statistically Significant)	2014-2018
	Cancer Female Cervical	Age-adjusted incidence per 100,000	5.7 (4.8, 6.6)	6.7 (6.3, 7.1)	Decreasing	--	2014-2018
	Cancer Female Breast (Late Stage)	Age-adjusted incidence per 100,000	41.8 (39.5, 44.2)	44.4 (43.4, 45.4)	--	--	2014-2018
	Cancer Colon and Rectum (Late Stage)	Age-adjusted incidence per 100,000	14.1 (13.1, 15.1)	20.4 (19.9, 20.9)	--	--	2014-2018
	Cancer Lung and Bronchus (Late Stage)	Age-adjusted incidence per 100,000	20.3 (19.2, 21.5)	36.3 (35.7, 36.9)	--	--	2014-2018
	Cancer Prostate (Late Stage)	Age-adjusted incidence per 100,000	18.0 (16.5, 19.7)	20.6 (19.9, 21.3)	--	--	2014-2018
	Cancer Female Cervical (Late Stage)	Age-adjusted incidence per 100,000	2.4 (1.9, 3.0)	3.1 (2.8, 3.4)	--	--	2014-2018
	Cancer Female Breast	Age-adjusted mortality per 100,000	19.0 (17.5, 20.5)	21.0 (20.4, 21.7)	Stable	Black>White (Statistically Significant)	2015-2019
	Cancer Colon and Rectum	Age-adjusted mortality per 100,000	10.0 (9.3, 10.9)	13.4 (13.1, 13.8)	Stable	Black>White (Statistically Significant)	2015-2019

TABLE 14.	Quality of Life						
Quality of Life	Cancer Lung and Bronchus	Age-adjusted mortality per 100,000	19.9 (18.8, 21.1)	35.2 (34.6, 35.9)	Decreasing	--	2015-2019
	Cancer Prostate	Age-adjusted mortality per 100,000	14.8 (13.4, 16.4)	20.3 (19.6, 21.1)	Decreasing	Black>White (Statistically Significant)	2015-2019
	Cancer Female Cervical	Age-adjusted mortality per 100,000	1.3 (0.9, 1.8)	2.0 (1.8, 2.2)	Decreasing	--	2015-2019

TABLE 15. Health Behaviors

DOMAIN/ CONSTRUCT	INDICATOR	DEFINITIONS	MONTGOMERY COUNTY	MARYLAND	TREND	INEQUITY WITHIN RACES/ ETHNICITIES?	SOURCE YEAR(S) OF DATA
Health Behaviors	Excessive Drinking	Percentage of adults reporting binge or heavy drinking	14	15	--	--	2020
	Drug Overdose Deaths	Age-adjusted deaths per 100,000	12 (11-14)	41 (40-42)	Increasing	--	2018-2020
	Adult Obesity Prevalence	Percentage of adults reporting BMI of 30 or more	22	31	--	Black>White (Statistically Significant)	2020
	Youth Obesity Prevalence	Percentage of age 17 and younger reporting BMI of 30 or more	8.6	12.8	--	--	2019
	Physical Inactivity	Percentage 20 and older with no reported leisure-time physical activity	17 (15-18)	21 (20-22)	--	--	2020
	Limited Access to Healthy Food	Percentage of population that is low income and does not live close to a grocery store	2	4	--	--	2019
	Access to Exercise	Percentage of population with adequate access to locations for physical activity	100	92	--	--	2022 & 2020
	Chlamydia Incidence Rate	Number of newly diagnosed chlamydia cases per 100,000	362.9	535.9	Increasing	Black>White (Statistically Significant)	2020

TABLE 15. Health Behaviors

Health Behaviors	Tuberculosis Incidence Rate	Estimated number of new and relapsed Tuberculosis cases arising in a given year/100,000	5.4	2.4	Decreasing	Hispanic>White (Statistically Significant)	2020
	Teen Birth Rate	Number of births per 1,000 females aged 15-19	10	15	Decreasing	Black>White (Statistically Significant)	2014-2020
	Adult Smoking Prevalence	Percentage of adults who are current smokers	7.4	13.5	--	--	--
	Youth Smoking Prevalence	Percentage of teens who are current smokers	3.7	5	--	--	--

TABLE 16. Clinical Care

DOMAIN/ CONSTRUCT	INDICATOR	DEFINITIONS	MONTGOMERY COUNTY	MARYLAND	TREND	INEQUITY WITHIN RACES/ ETHNICITIES?	SOURCE YEAR(S) OF DATA
Clinical Care	Health Care Costs	Amount of Medicare spending per enrollee	$9,501.84	$11,377	Increasing	--	2019
	HPSA Primary Care	Portion of the county that falls within a Health Professional Shortage Area	5	50	--	--	--
	HPSA Dental Health	Portion of the county that falls within a Health Professional Shortage Area	3	45	--	--	--
	HPSA Mental Health	Portion of the county that falls within a Health Professional Shortage Area	3	48	--	--	--

TABLE 16.	Clinical Care						
	Primary Care Providers	Number per 100,000	720:1	1130:1	--	--	2020
	Psychiatry Providers	Number per 100,000	--	20.4	--	--	2018
	Mental Health Providers	Number per 100,000	260:1	310:1	--	--	2022
	Dentists	Number per 100,000	790:1	1260:1	--	--	2021
	Health Care Employment	Percent of work force employed in health care profession		13	--	--	2020
	Flu Vaccinations	Percentage of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination	59	55	Increasing	--	2020
Clinical Care	Emergency Department Visits	Total ER visits per 100,000	20324	--	Increasing	--	2019
	Preventable Hospital Stays	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	1498	2653	Decreasing	--	2020

TABLE 17. Social, Economic, and Demographic Factors

DOMAIN/ CONSTRUCT	INDICATOR	DEFINITIONS	MONTGOMERY COUNTY	MARYLAND	TREND	INEQUITY WITHIN RACES/ ETHNICITIES?	SOURCE YEAR(S) OF DATA
Social, Economic, and Demographic Factors	Homicides	Deaths per 100,000	2	9	Increasing	--	2014-2020
	Violent Crimes	Reported violent crime offenses per 100,000	1835	3285	Fluctuating	--	2019-2020
	Injury Deaths	Number of deaths due to injury per 100,000	43	88	Increasing	--	2016-2020
	Motor Vehicle Crash Deaths	Deaths per 100,000	5	9	Increasing	Hispanic> Black>White (Statistically Significant)	2014-2020
	Did Not Graduate High School	Percent of population over age 25 without a high school diploma	9.8	9.6	Decreasing	--	2019
	Some College	Percentage aged 18 and older with some postsecondary education	77	--	--	--	--
	High School/ GED Graduation	Percentage of population graduating high school/GED	91	91	--	--	2017-2021
	Unemployed	Percentage of population 16 and older unemployed	5.5	5.8	--	--	2021
	Children with Single Parents	Percentage of children living in a household headed by a single parent	20	26	--	--	2017-2021
	Free and Reduced Lunch	Percentage of children in public schools eligible for free or reduced-price lunch	37	45	Stable	--	2020-2021

TABLE 17. Social, Economic, and Demographic Factors

Social, Economic, and Demographic Factors	Children in Poverty	Percentage of children under age 18 in poverty	11	14	Fluctuating	--	2021
	Median Household Income	Median household income	$112,400	$90,100	--	--	2021
	Uninsured Adults	Percentage of population under age 65 without health insurance	9(8-10)	8(8-8)	Decreasing	--	2020
	Uninsured Children	Percentage of children under age 19 without health insurance	3 (2-4)	3(3-4)	Decreasing	--	2020

TABLE 18. Physical and Built Environment

DOMAIN/ CONSTRUCT	INDICATOR	DEFINITIONS	MONTGOMERY COUNTY	MARYLAND	TREND	INEQUITY WITHIN RACES/ ETHNICITIES?	SOURCE YEAR(S) OF DATA
Physical and Built Environment	Drinking Water Violations	Reports whether there was a health-related drinking water violation in a community within the county	None	N/A	--	--	--
	Air Pollution-Particulate Matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	6.1	7.4	--	--	2019
	Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities	17	16	--	--	2015-2019

TABLE 18.	Physical and Built Environment						
Physical and Built Environment	Severe Housing Cost Burden	Percentage of households that spend 50% or more of their household income on housing	14	14	--	--	2017-2021
	Broadband Access	Percentage of households with broadband internet connection	94	90	--	--	2017-2021
	Traffic Volume	Average traffic volume per meter of major roadways in the county	963	695	--	--	2019
	Public Transit Proximity	Percentage of population living in a Census block within a quarter of a mile to a fixed transit stop	74.8	--	--	--	--

Community Health Needs Survey: COVID-19 Data

Data from the 2022 community health needs survey shows that residents needed financial assistance, food assistance and health care assistance the most because of COVID-19.

AREAS NEED ASSISTANCE	OVERALL WEIGHTED PERCENTAGE
Health care	8.42 (5.06-11.77)*
Financial assistance	12.75 (8.38-17.12)*
Energy assistance (utilities)	6.01 (3.08-8.94)
Food assistance	9.32 (5.44-13.20)*
Wi-Fi/internet	4.96 (1.83-8.09)
Housing/shelter	2.66 (0.82-4.49)
Translation/interpretation services	1.44 (0-3.09)
Childcare	3.73 (1.84-5.62)
Rental/mortgage assistance	8.30 (5.44-11.15)
None of the above	42.42 (38.19-46.65)

* Top 3 (other than none of the above). 95% Confidence Intervals are included in parentheses.

Additional data related to the COVID-19 pandemic can be found in the report, *Health Survey in Montgomery County, MD, 2022*,[85] as well as the *COVID-19 Surveillance Report in Montgomery County, MD.*[86]

Oral Health Capacity and Demand Environmental Scan

The purpose of the CHNA's Oral Health Capacity and Demand Environmental Scan Survey was to obtain information regarding oral health services available to Montgomery County residents, capture information on potential integrated (medical and dental) services, identify characteristics of dental providers and patient populations, and identify needs, barriers, and issues in oral health services.

Data Collection

METHODS

The survey questions were developed by the Department of Health and Human Services Public Health Dental Services based on existing dental environmental scans given by other national organizations. Additional questions were developed based on the specific needs and concerns of County residents, staff, and administrators. The questions were refined by a survey workgroup comprised of Health Promotion staff. Approval of the final version of the survey was provided by the Healthy Montgomery Steering Committee.

Data collection and a quantitative analysis of survey responses was conducted via the SurveyMonkey web-based program. Instructions for completing the questionnaire were included on SurveyMonkey.

DATA SOURCES AND TARGET SAMPLE SIZE

The respondent target population was local public and private dental offices and dental clinics that provide oral health services in Montgomery County.

The online survey was emailed to all licensed dentists in the county from a list of email addresses provided by the Maryland State Board of Dental Examiners. The survey link was also distributed to Montgomery County licensed dentists who are members of the Southern Maryland Dental Society via its online newsletter. Additionally, questionnaires were distributed to the target population on the Montgomery County web site via news releases and on the front page as well as via email with an introduction that included a link to the survey. The survey was also shared weekly on the Healthy Montgomery Twitter page. The entire survey sample size was estimated to be over 1,200.

SURVEY DESIGN AND IMPLEMENTATION

The survey included multiple choice items and open-ended questions for individualized, narrative responses. The questions were divided into five sections: 1) Patient Population; 2) Facility; 3) Clinical Care and Utilization; 4) Workforce; and 5) Request for Participation and Contact Information for a future meeting with the County to identify collaborative initiatives to increase access to oral health preventive and specialty care for uninsured and underinsured Montgomery County residents.

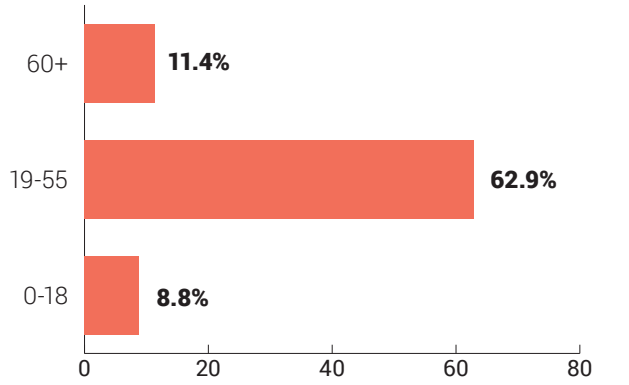
Data Analysis

Data was electronically collected and analyzed by the SurveyMonkey web-based program. A quantitative analysis of survey responses was conducted and were reported using descriptive statistics.

Results

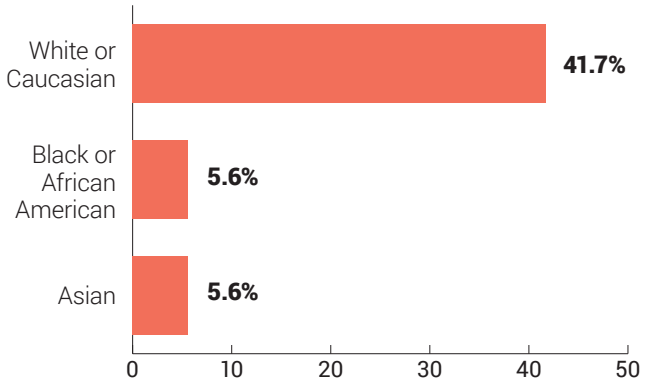
The online survey remained open for 57 days and collected 40 responses from local public and private dental offices, and dental clinics that provide oral health services. Based on the 40 responses, 88.9 percent indicated that their office provides services in Montgomery County. The predominant patient age group served were adults 19-59 (62.9 percent) (Figure 83) and the predominant patient race were White or Caucasian (41.7 percent) (Figure 84). The survey question asked dental providers to provide an estimate of the percentages of Hispanic patients seen in the practice. Overall, 77.8 percent of all dental providers that responded to this question reported an estimate ranging between 10 percent to 40 percent of Hispanic patients (Figure 85). Dental providers responding were less likely to serve uninsured or Medicaid (adults or children) patients (Figure 86). Approximately 11 percent of respondents reported that their dental practice offered a sliding fee scale based off patient income for uninsured or underinsured individuals (Figure 87). Further, the cost of care was reported as the most prominent barrier to accessing dental care, and the second most prominent barrier was the ability to find a dentist that accepts the patients' insurance (Figure 88). Approximately 13 percent offered transportation services to address patient barriers accessing dental services (Figure 89). Lastly, the survey asked about additional health care services provided, 76.5 percent of the responding dental clinics reported that their clinic provides both dental and health care services (Figure 90). According to responses, 85.3 percent provide glucose screening (Figure 91) and 64.7 percent provide blood pressure screening (Figure 92).

FIGURE 83. **Predominant Patient Age Group of Dental Provider Survey Respondents.**



**Predominant defined as equal or greater than 50%*

FIGURE 84. **Predominant Patient Race of Dental Provider Survey Respondents.**



**Predominant defined as equal or greater than 50%*

FIGURE 85.

Self-Reported Percentage of Hispanic Dental Patients

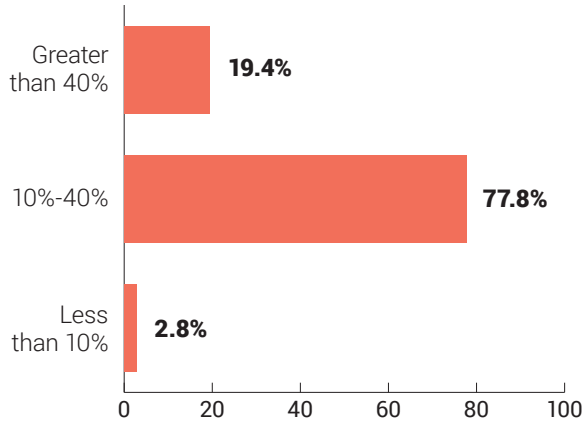


FIGURE 86.

Patient Insurance Payers of Dental Provider Survey Respondents

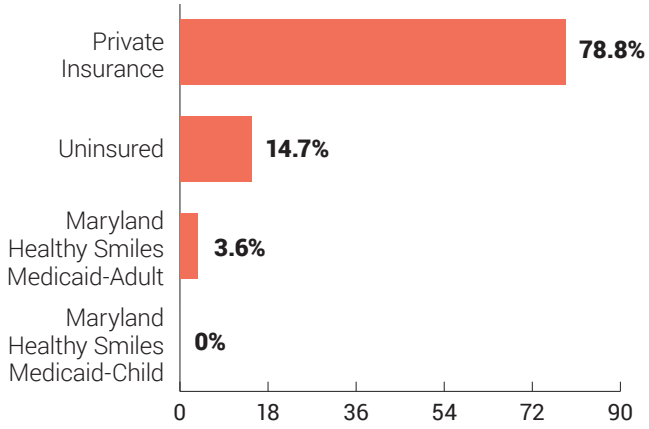
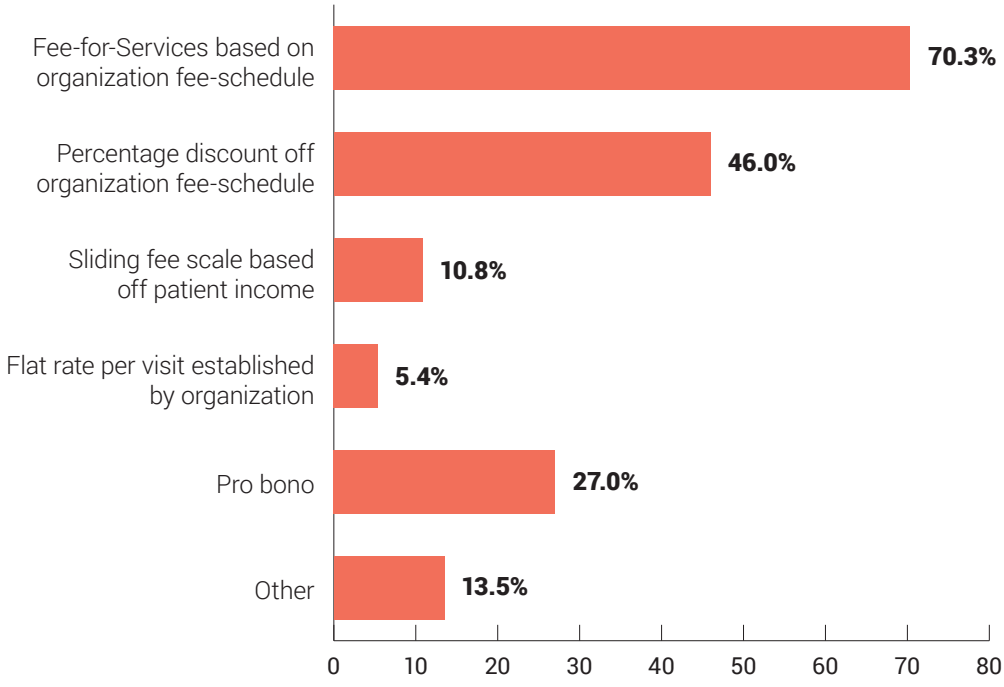


FIGURE 87.

Facility Fee/Billing Structure for Uninsured and Underinsured (inadequate dental insurance to cover services) Dental Patients.



**Other includes: in-house flat fee for uninsured; preferred provider organization fee schedule, in-house member discount plan; in office insurance plan; pro bono work for non-profits upon referral/will adjust fee if patient needs treatment*

FIGURE 88.

Patient Barriers to Regularly Access Dental Care

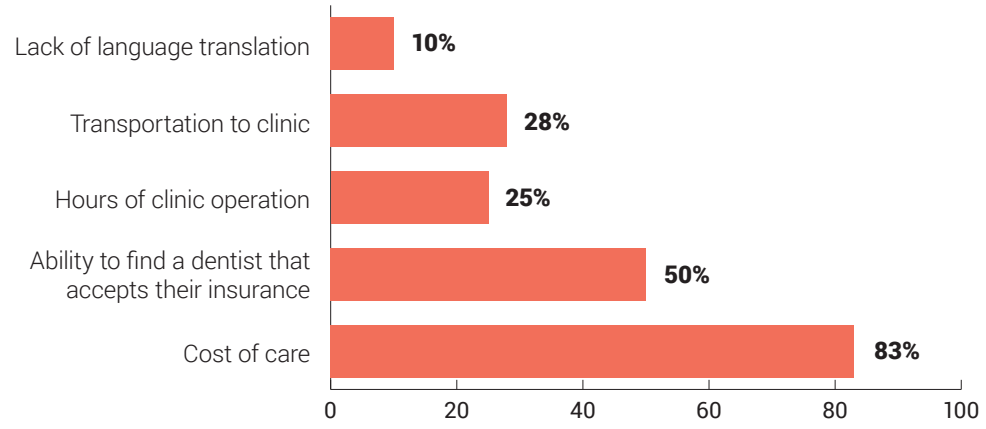
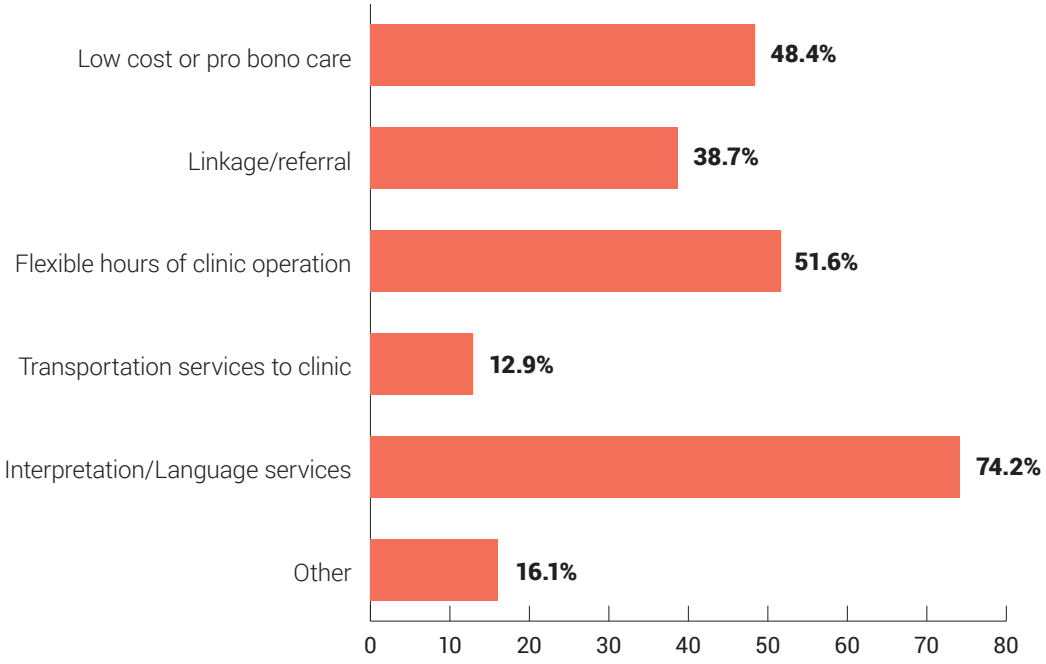


FIGURE 89.

Dental Provider Efforts to Address Patient Barriers to Accessing Dental Care



**Other includes: monthly payment plans, full range of services in one convenient location, savings plan, and portable dental services for those that cannot visit the office.*

FIGURE 90. **Dental Provider Provides Both Dental and Health Care Services**

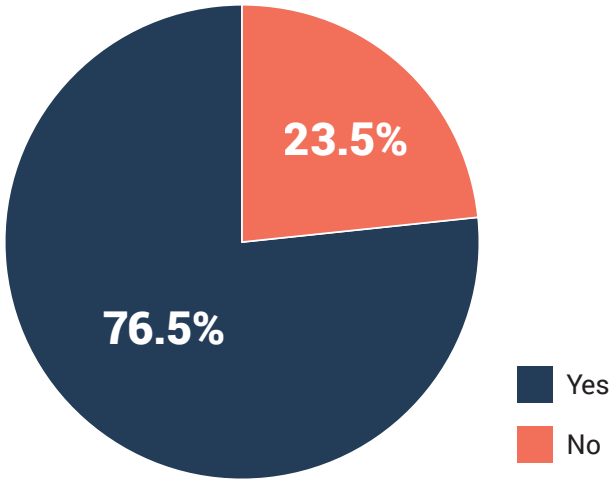


FIGURE 91. **Dental Provider Provides Glucose Screening**

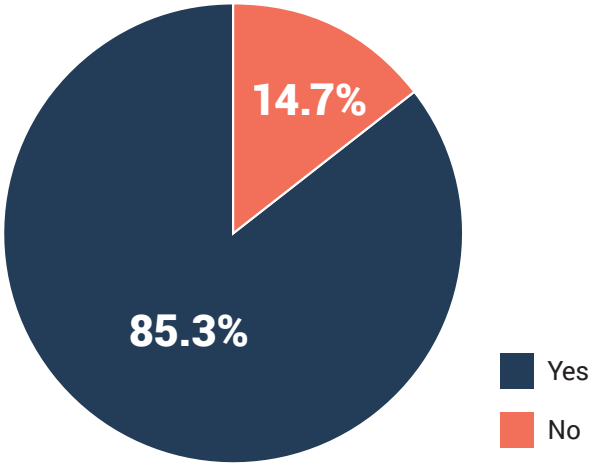
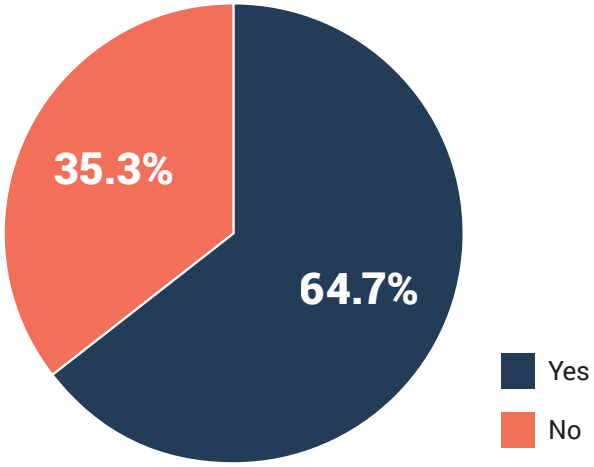


FIGURE 92. **Dental Provider Provides Blood Pressure Screening**



AVAILABLE RESOURCES TO POTENTIALLY MEET SIGNIFICANT HEALTH NEEDS

To assist in addressing the significant health needs of Montgomery County, the following resource list can be used to find programs, services, and organizations to improve health outcomes in these areas (Table 19). The resource list is organized by the service organization, the Montgomery County region and zip code where the organization is physically located. The resource list also includes the website and population served.

TABLE 19. Resources Potentially Available to Meet Significant Health Needs

ORGANIZATION SPECIALTY, NAME AND WEBSITE *Note: Please refer to the organization website for full address and locations*	ORGANIZATION LOCATION BY REGION	ORGANIZATION ZIP CODE	TARGET POPULATION(S) (IF APPLICABLE)
HEALTH BEHAVIORS			
Weight Management/Healthy Eating/Dietician Services			
AAHP's Weight Management Program	B-CC	20852	All age groups
Maryland Bariatrics	B-CC	20850	Adults 18+
Mercy Health Clinic - Gaithersburg	Upcounty	20878	13 and up
NavaRX Maryland Weight Loss Clinic	B-CC	20817	Adults 18+
Ama tu Vida Campaign – Latino Health Initiative	Silver Spring	20910	Visit the website to learn more and see upcoming events.
Latino Youth Wellness Programs	Silver Spring	20910	
Food Resources			
Community Gardens by Montgomery Parks	Upcounty	20841	All age groups
MANNA Food Center- Food Bank	Upcounty	20874	All age groups
Choice Food Pantry by Catholic Charities Archdiocese of Washington	Mid-County	20902	All age groups

HEALTH BEHAVIORS			
Food Pantry by Forcey Bible Church	Eastern Montgomery	20904	All age groups
WIC PROGRAMS: Community Clinic, Inc. (CCI) Health & Wellness Services	Upcounty	20877	Pregnant people/children 0 - 5ys
Supplemental Nutrition Assistance Program (SNAP)	B-CC	20850	All age groups
Celestial Manna	Mid- County	20855	All age groups
Food Giveaway Events	B-CC	20850	All age groups
Montgomery County Food Council	B-CC	20814	All age groups
Montgomery County Maryland Food Assistance	B-CC	20850	All age groups
Catholic Charities Center	Mid-County	20902	All age groups
Substance Use Disorder (SUD) Treatment			
Adventist Behavioral Health and Wellness Services	B-CC	20852	Ages 13 +
Another Way	Silver Spring	20901	Adults 18+
Born Free Wellness Center	Upcounty	20877	Adults 18+
Drug Court	B-CC	20850	Adults 18+
Family Services - The Landing	Upcounty	20877	Youth, ages 12-17
MedStar Montgomery Medical Center - Addiction and Mental Health Center	Mid-County	20832	All age groups
Montgomery Wellness Hub	Upcounty	20879	All age groups
Sandstone Care	B-CC	20852	All age groups
Suburban Hospital Addiction Treatment Center	B-CC	20852	All age groups
Second Chance Addiction Care	B-CC, Mid-County	20817, 20827, 20854, 20859	Adults 18+
Ryan Rehabilitation	Mid-County, Upcounty	20895, 20886	All age groups
Positive Recovery Services	Upcounty	20874, 20875, 20876, 20879	Adults 18+
Newport Academy	B-CC	20852, 20850	Youth, ages 13-18
Maryland Wellness and Recovery	Washington DC	20587	Adults 18+
Kolmac Outpatient Recovery Center	Silver Spring	20901	Adults 18+

HEALTH BEHAVIORS			
Fresh Start Recovery Center	Upcounty	20877, 20878, 20879, 20884, 20885, 20899	Adults 18+
The Freedom Center	Upcounty	20877, 20878, 20879, 20884, 20885, 20899	Adults 18+
Embark at Cabin John	B-CC	20817, 20818	Youth and young adults, ages 14-25
DA Wynne and Associates	Silver Spring	20901	Adults 18+
Physical Activity Resources			
Suburban Hospital, a Member of Johns Hopkins Medicine, Senior Shape Program	All regions	All zip codes	Ages 50+
Montgomery County Recreation	Mid-County	20906	
Holy Cross Hospital - Senior Fit and Exercise	Upcounty, Mid-County, Eastern Montgomery, Silver Spring, B-CC	20877, 20853, 20904, 20874, 20910, 20901, 20866, 20906, 20850, 20876, 20905, 20902	
Ama tu Vida Campaign – Latino Health Initiative	Silver Spring	20910	Visit the website to learn more and see upcoming events.
African American Health Initiative – Walking Club and Online Exercise	B-CC	20852	Visit the website to learn more and access resources.
CLINICAL CARE			
Cardiovascular Health			
Johns Hopkins Community Physicians—Heart Care, Rockville; Bethesda; Silver Spring; Chevy Chase	B-CC, Silver Spring	20850, 20817, 20910, 20815	Adults 18+
Adventist Medical Group – Cardiovascular Specialists	B-CC	20850	Adults 18+
Montgomery Cardiology, LLC.	B-CC	20850	Adults 18+
Montgomery Cares Mobile Medical/NIH Heart Clinic	B-CC	20814	All age groups
MedStar Health: Cardiology Associates at Olney	Mid- County	20832	Adults 18+
Capital Cardiac Care	Upcounty	20878	Adults 18+
Hausner Cardiology Center	B-CC	20815	All age groups
Advanced Cardiology Care	B-CC, Silver Spring, Mid-County	20852, 20901, 20902	

HEALTH BEHAVIORS			
Dental Services			
Montgomery Care for Kids	B-CC, Silver Spring, Upcounty	20852, 20910, 20874	Children younger than 18
Maternity Partnership	B-CC, Silver Spring, Upcounty	20852, 20910, 20874	Pregnant people
Senior Dental	B-CC, Silver Spring, Upcounty	20852, 20910, 20874	Seniors, age 60+
Adult Dental Program	B-CC, Silver Spring, Upcounty	20852, 20910, 20874, 20878	Adults 19-59
Catholic Charities Dental Clinic	Silver Spring	20902	All age groups
Muslim Community Dental Clinic	Silver Spring	20905	Adults 18+
CCI Dental Clinic	Upcounty, Silver Spring	20877, 20770, 20910	All age groups
Mary's Center Dental Clinic	Silver Spring	20901	All age groups
Mental Health Services			
Cornerstone Montgomery	All regions	All zip codes	All ages
Second Chance Counseling Services, LLC	Upcounty	20874	All age groups
Behavioral Health Family Support Group	B-CC	20850	All age groups
Green Ridge Behavioral Health	Upcounty	20879	Teens and up
Primary Care Coalition (PCC)	Silver Spring	20910	Adults 18+
Mary's Center		20901	All age groups
Sheppard Pratt Health system at Gaithersburg	Upcounty	20877	Teens and UP
Healthy Mothers Healthy Babies	Upcounty	20877	Pre or postpartum depression diagnosis
Adventist Healthcare in Rockville (Acute Inpatient Services)	B-CC	20850	Teens and up
Adventist Healthcare in Rockville (Intensive Outpatient)	B-CC	20850	Teens and up
Mercy Health Clinic - Gaithersburg	Upcounty	20878	13 and up
EveryMind Mental Health Wellness	B-CC	20851	All age groups
The Lourie Center for Children's Social & Emotional Wellness	B-CC	20852	Birth to 12 years-old and families
The Steven A. Cohen Military Family Clinic at Easter Seals	Silver Spring	20910	All age groups
CCI Health Services	Upcounty	20877	Ages 6+
JSSA	B-CC	20852	All age groups
Montgomery Cares – several locations, click link to see all	All regions	All zip codes	All age groups

HEALTH BEHAVIORS			
Diabetes			
Suburban Hospital, a member of Johns Hopkins Medicine	All regions	All zip codes	All age groups
Medstar Montgomery Medical Center @ Olney	Mid- County	20832	All age groups
Healthy Montgomery - Type 2 Diabetes Prevention	B-CC	20850	All age groups
Diabetes Education Program at Adventist HealthCare Germantown	B-CC	20850	All age groups
Diabetes Education Program at Adventist HealthCare Gaithersburg	Upcounty	20878	All age groups
Adventist Medical Group - Primary Care & Endocrinology	B-CC	20850	All age groups
CCI health and Wellness Services—Gaithersburg	Upcounty	20877	All age groups
New Life New U Holistic Diabetic Care	B-CC	20817	All age groups
Mercy Health Clinic - Gaithersburg	Upcounty	20878	All age groups
Holy Cross Health - Germantown	Upcounty	20886	Adults 18+
African American Health Program	B-CC	20852	Adults 18+
Cancer Care			
The Sidney Kimmel Comprehensive Cancer Center at Suburban Hospital	All regions	All zip codes	All age groups
Cornerstone Montgomery	All regions	All zip codes	All age groups
Medstar Montgomery Medical Center @ Olney	Mid- County	20832	All age groups
Medstar Georgetown Cancer Institute at Montgomery Med Center	Mid- County	20832	All age groups
Adventist Health Care	Upcounty	20878	All age groups
Hope Connections for Cancer Support	Upcounty	20874	Adults 18+
Shady Grove Adventist Aquilino Cancer Center	B-CC	20850	All age groups
Adventist HealthCare White Oak Medical Center	Eastern Montgomery	20904	All age groups
MC Govt-Breast and Cervical Cancer Screening	B-CC	20852	All age groups
Regional Cancer Care Associate	B-CC	20850	All age groups
Holy Cross Health - Germantown	Upcounty	20876	All age groups
Holy Cross Health - Silver Spring		20910	All age groups
Montgomery County DHHS Cancer Crusade Program	B-CC	20852	Adults 18+
Montgomery County DHHS Women's Cancer Control Program (Colorectal Screening)	B-CC	20852	

HEALTH BEHAVIORS			
Maternal and Child Health			
Maternal Wellness Services	B-CC	20814	Pregnant people/children 0 - 5 yrs
Rockville Women's Center	B-CC	20852	
Community Clinic Inc. (CCI) WIC Main Office	Silver Spring	20910	
Babies Born Healthy - DHHS (African American Women only)	Eastern Montgomery, Mid-County	20903, 20904, 20906	
Teen Pregnancy Support Program	B-CC	20850	Teenage parents
SMILE Program (AAHP)	B-CC	20852	
Aspire Counseling: Healthy Mothers, Healthy Babies	Upcounty	20877	Counseling for prenatal and postpartum depression
Shady Grove Pregnancy Center	Upcounty	20877	Pregnant people
Healthy Families Montgomery	Upcounty	20877	First time parents - early intervention and parenting support
Sanctuaries for Life (SFL) Program-Catholic Charities	Mid-County	20902	Pregnancy support program that builds a network of medical, emotional and spiritual assistance
Mary's Center	Silver Spring	20901	Medical, dental, behavioral health, and WIC assistance
Asthma Management Program, Child Respiratory Health	Silver Spring	20910	Spanish program for parents and caregivers
HIV & STI Services			
African American Health Program	B-CC	20852	All age groups
MCC Dept of Health and Human Services - Silver Spring	Mid-County	20902	All age groups
MCC Dept of Health and Human Services - Silver Spring - HIV	Mid-County	20902	All age groups
MedStar Health STD Treatment Center - Germantown	Upcounty	20876	All age groups
Mary's Center	Silver Spring	20901	All age groups

HEALTH BEHAVIORS			
COVID-19			
COVID-19 tests in Montgomery County	B-CC, Upcounty, Mid-County, Eastern Montgomery, Silver Spring	20853, 20910, 20815, 20814, 20872, 20817, 20879, 20874, 20816, 20901, 20837, 20866, 20895, 20832,20878, 20850, 20851, 20902, 20904	
Community Assistance & Resources	Upcounty	20877	All age groups
Independence Now	Eastern Montgomery	20904	All age groups, vulnerable populations
Mary's Center	Silver Spring	20901	All age groups
Primary Care for Medicaid and Uninsured			
Comprehensive Primary Care	B-CC, Upcounty, Silver Spring	20850, 20814, 20910, 20815, 20876	All age groups
Community Family Medicine	B-CC	20852	All age groups
Black Physicians & Healthcare Network (BPHN)	All regions	All zip codes	All age groups
Mary's Center	Silver Spring	20901	All age groups
Montgomery Cares – several locations, click link to see all	All regions	All zip codes	All age groups
Care for Kids	Silver Spring	20901	Birth to 18
Primary Care Coalition	Silver Spring	20910	All age groups, uninsured
Health and Human Services System Navigation			
Emergency Eviction Prevention	Silver Spring, B-CC, Upcounty	20850, 20910, 20874	All ages at risk of homelessness
Department of Human Services (DHS)	All regions	All zip codes	All ages
African American Health Program	All regions	All zip codes	

HEALTH BEHAVIORS			
Asian American Health Initiative (AAHI)	All regions	All zip codes	301) 760 – 4991 – Chinese Navigation (301) 760 – 4992 – Vietnamese Navigation (301) 760 – 4571 – Hindi Navigation (301) 760 – 7058 – Korean Navigation (301) 760 – 7051 – For other languages press 0 to speak with the operator
The Latino Health Initiative	All regions	All zip codes	
Montgomery County HIV/STI	All regions	All zip codes	
Colorectal Cancer Screening	B-CC	20852	
Women's Cancer Control Program	B-CC	20852	Provides colorectal screenings
Aging and Disability			
Montgomery County DHHS Aging and Disability Unit	B-CC	20850	
Montgomery County's Dementia Friendly Initiative	All regions	All zip codes	
Senior Housing	All regions	All zip codes	
Montgomery County DHHS Senior Services	All regions	All zip codes	
Montgomery County Police - Keeping Seniors Safe Program	All regions	All zip codes	
Independence Now	Eastern Montgomery	20904	
LGBTQ+ Resources			
CCI Health Services	Upcounty	20877	
Empodérate	All regions	20010, 20783	
LGBTQ+ Resources for MCPS students, staff and parents	All regions	20850	
Mary's Center	Eastern Montgomery	20901	LGBTQ+
MoCo Pride Youth	All regions	All zip codes	MoCo Pride Youth is a county-wide, MCPS affinity group for LGBTQ+ students.

HEALTH BEHAVIORS			
PFLAG DC	All regions	20056	Support groups for family members, friends, partners, and loved ones of LGBTQ+ people.
Planned Parenthood	Eastern Montgomery	20886	Gender-affirming hormone care via Telehealth. STI testing and treatment, birth control, safer sex supplies, HIV testing, PrEP/PEP, abortion, and other reproductive health services.
Queer MoCo Community	All regions	All zip codes	Moderated Facebook group for queer people living in Montgomery County.
Trans Latinx DMV	All regions	All zip codes	Trans-Latinx DMV
Trans Lifeline	All regions	All zip codes	Peer support hotline run by trans people.
Trans Maryland	All regions	All zip codes	Statewide advocacy and support group for trans people.
Trevor Project - 1-800-488-7386 | text "start" to 678.678	All regions	All zip codes	24/7 crisis hotline for LGBTQ+ and questioning youth and young adults
SOCIAL AND ECONOMIC FACTORS			
Employment Assistance			
People-4-People Employment Assistance Program	Eastern Montgomery	20905	All age groups
Worksource Montgomery	Mid-County, Eastern Montgomery, Upcounty	20902, 20874, 20904, 20841	All age groups
JSSA Employment Services	B-CC, Mid-County	20852, 20850, 20902	Adults with disabilities
Work Opportunities Unlimited - Ticket to Work Program	Mid-County	20902	Adults receiving SSI or SSDI
The Arc Montgomery County	Mid-County	20855	Adults with disabilities
Interfaith Works: Employment Program	B-CC	20850	Adults
TransCen Employment and Support Services	B-CC	20852	All ages with disabilities

SOCIAL AND ECONOMIC FACTORS			
Mary's Center - Job Training	Silver Spring	20901	All age groups
Youth Services			
Yes to Youth	All regions	All zip codes	
Montgomery County Recreation	Mid-County	20906	
Montgomery County Parks	All regions	All zip codes	
Latino Youth Wellness Programs	Silver Spring	20910	
Safe and Violence Free Environment			
The Tree House - CAC of Montgomery County, MD	Mid-County	20855	Children and families, any ages
Montgomery County Family Justice Center Foundation	Upcounty	20849	Children and families, any ages
MoCo Students for Change	All regions	All zip codes	Youth
Pedestrian Safety			
Montgomery County Department of Transportation	All regions	All zip codes	
Pedestrian Safety at School	All regions	All zip codes	
Community Connectiveness			
Aging and Disability Resource Unit	All regions	20850	Seniors, people with disabilities, and caregivers.
Community Connections	Washington, DC	20003	All ages
Maryland Community Connection	Lanham	20706	Adults with developmental disabilities
Montgomery Parks	Mid-County	20902	All ages
Senior Connection	Mid-County	20906	Ages 60+

SOCIAL AND ECONOMIC FACTORS			
Cultural and Language Competence			
Minority Health and Health Disparities	Silver Spring, B-CC, UpCounty	20850, 20910, 20874	
Culturally and Linguistically Appropriate Services (CLAS)	All regions	All zip codes	Health care agencies
Limited English Proficiency (LEP)	Silver Spring, B-CC, UpCounty	20850, 20910, 20874	Assistance for those with limited English proficiency
Asian American Health Initiative Resource Library	All regions	All zip codes	
PHYSICAL ENVIRONMENT			
Transportation			
Montgomery County Department of Transportation	B-CC	20850	Seniors
Senior Ride (SNR. Connection - Silver Spring MD)	Mid-County	20906	Seniors
Jewish Council for the Aging - Connect A Ride	Mid-County	20853	All age groups
SB Medical Transportation	Mid-County	20902	Transportation across the county for people in nursing homes, assisted living facilities, and hospitals
Rockville Senior Service Bus and Transportation	B-CC	20850	Seniors
Montgomery County Bikeshare	All regions	All zip codes	Adults 18+
Montgomery County Ride On	B-CC	20850	Bus routes available throughout the county
Housing and Utility Assistance			
Montgomery County Dept of Health and Human Serv. - Mid County (Utility Assistance)	B-CC	20850	Adults 18+
Office of Home Energy Prog. - Statewide	B-CC	20850	Adults 18+
Bethesda Help- Neighbors Helping Neighbors in Need	Mid-County, B-CC	20827	All age groups
Catholic Charities - Silver Spring MD	Mid-County	20902	All age groups
Montgomery County Coalition for the Homeless: Laytonsville Haven	Upcounty, B-CC	20882, 20850	All age groups

PHYSICAL ENVIRONMENT			
Interfaith Works: Empowerment Center and Housing Coalition	All regions	All zip codes	All age groups
Community Reach of Montgomery County - Rockville Emergency Assistance	B-CC, Mid-County	20850, 20851, 20852, 20853, 20854, 20855	All age groups, need referral from Department of Health and Human Services
Mary's Center - Energy Assistance Program	Silver Spring	20901	All age groups
Adventist Community Services	Mid-County	20902	All age groups
Environmental Health			
Montgomery Parks	All regions	All zip codes	
Montgomery County Government Environmental Health	All regions	All zip codes	
Montgomery Department of Environmental Protection	All regions	All zip codes	All age groups
Waste Management			
Department of Environmental Protection	All regions	All zip codes	
Bulk Waste Rockville	Mid-County	20855	
Maryland.gov	All regions	All zip codes	
Access To Technology			
Montgomery Connects	All regions	All zip codes	All ages
Montgomery County Public Libraries	B-CC, Upcounty, Mid-County, Eastern Montgomery, Silver Spring	20853, 20910, 20815, 20814, 20872, 20817, 20879, 20874, 20816, 20901, 20837, 20866, 20895, 20832,20878, 20850, 20851, 20902, 20904	

Note: The chart is meant to serve as a guide for any community member or provider to find services or resources for the identified health priorities. This list is for informational purposes only and is not an endorsement, nor is it inclusive.

APPENDIX

Overview of Montgomery County Government

Montgomery County is located on the northern border of Washington D.C. and the eastern border of Virginia. The county is the fifth largest jurisdiction in Maryland by total area and the most populous County in the state, with over 1 million residents. The county has a diverse population made up of a majority of persons of color, many of whom are foreign born. Montgomery County continues to rank among the healthiest, wealthiest, and most highly educated counties in Maryland. However, income and health outcomes vary across subpopulations and zip codes across the county. Over time, Montgomery County is expected to become more diverse and to see continued growth in the older population. With an aging and increasingly diverse population, addressing health disparities remains critical.

DHHS Overview

The Department of Health and Human Services (DHHS) promotes and ensures the health and safety of Montgomery County residents and supports individual and family strength and self-sufficiency. DHHS serves more than 100,000 customers per year and provides critical support services directly and through a network of community-based partners to address physical and behavioral health, economic and housing security, and other health and human services needs of county residents.

DHHS uses an equity lens to develop and implement programs that are accessible and delivered by culturally competent professionals, offering the highest level of client-centric care and support, maximizing staffing resources, and responding to changing needs. DHHS offers a "no wrong door" approach to service delivery. Our programs and policies are based on sound principles of accountability and commitment to innovative approaches, collaboration and systems integration, fiscal responsibility and the pursuit of strategic funding opportunities. DHHS places emphasis on the following County Priority Outcomes: Thriving Youth and Families; A Greener County; An Affordable, Welcoming County for a Lifetime; Safe Neighborhoods; and an Effective, Sustainable Government.

DHHS has an operating budget of $421,855,068 with over 1840 full-time employees and more than 120 programs within its five service areas and administration and support services. There are two distinct divisions, DHHS Service Areas and Programs and Public Health Services. The service areas are Aging and Disability Services, Behavioral Health and Crisis Services, Children Youth and Family Services, Public Health Services, and Services to End and Prevent Homelessness. Administration and support services include the Office of Community Affairs which oversees the Community Action Agency and three minority health programs, the Office of the Chief Operating Officer, and the Director's Office.

DHHS SERVICE AREAS AND PROGRAM DESCRIPTIONS:

Aging and Disability Services: The mission of Aging and Disability Services (ADS) is to affirm the dignity and value of seniors, persons with disabilities, and their families by offering a wide

range of information, home and community-based support services, protections, and opportunities, which promote choice, independence, and inclusion. Programs in ADS include Adult Foster Care, Aging & Disability Resource Unit, Area Agency on Aging, Assessment & Continuing Care Management Services, Community Provider Support, Community Support Network for People with Disabilities (CSN), Home Care Services, Medicaid Funded Long-Term Care Service, Medicaid Funded Long-Term Care Service, and Respite Care.

Behavioral Health and Crisis Services: The mission of Behavioral Health and Crisis Services (BHCS) is to promote the behavioral health and well-being of Montgomery County residents. BHCS works to promote mental wellness, prevent substance use and suicide, and to ensure access to a comprehensive treatment and recovery system of effective services and support for children, youth and families, adults, and seniors in crisis or with behavioral health needs. BHCS is committed to ensuring culturally and linguistically competent care and the use of evidence-based or best practices along a continuum of care. BHCS works with the State's Behavioral Health Administration, DHHS service areas, County agencies, and the community to provide strength-based and integrated services to persons in need. Programs in BHCS include: Administrative Office of Behavioral Health and Crisis Services, Local Behavioral Health Authority, 24-Hour Crisis Center, Trauma Services, Outpatient Behavioral Health Services for children and adolescents, Access to Behavioral Health Services, Adult Behavioral Health Services, Adult Forensic Services, Treatment Services, and Specialty Behavioral Health Services.

Children, Youth and Family Services: The mission of Children, Youth and Family Services (CYF) is to promote opportunities for children to grow up safe, healthy, ready for school, and for families and individuals to achieve well-being and self-sufficiency. This mission is realized through the provision of protection, prevention, intervention, and treatment services for children and their families, and through education, support, and financial assistance for parents, caretakers, and individuals. These services work to build on the strengths of both the individual and the community in addressing issues of child development, abuse, neglect, health, and economic security. Programs in CYF include: Child Welfare Services, Linkages to Learning, Child & Adolescent School and Community Based Services, Positive Youth Development, Early Childhood Services, Office of Eligibility and Support Services, and Child Care Subsidies.

Services to End and Prevent Homelessness: The mission of Services to End and Prevent Homelessness (SEPH) is to make homelessness a

rare, brief, and non-recurring event by operating from a Housing First philosophy. SEPH provides a continuum of services including housing stabilization, homeless diversion, and permanent housing; and employs evidence-based and promising practices. The mission cannot be achieved without collaborating with public and private partners through the Interagency Commission on Homelessness. Special needs populations include veterans, both individuals and families, persons with behavioral health challenges, individuals with developmental disabilities, transitioning youth, and seniors with disabilities experiencing or at risk of homelessness. Programs in SEPH include: Homeless Services for Single Adults, Homeless Services for Families, Eviction Prevention, Healthcare for the Homeless, Rapid Rehousing, the Housing Initiative Program, the Interagency Commission on Homelessness, Coordinated Entry, and Permanent Supportive Housing.

Administration and Support Services: This unit provides leadership and administration to DHHS and includes the Offices of the Director, and the Chief Operating Officer. Other areas of focus are:

- **Office of Community Affairs** leads the development of equitable and inclusive health and human services systems that are responsive to racial/ethnic and economically disinvested communities. The area takes a global view of equity and inclusion that transcends the mandate of individual service units and offices to ultimately drive for systems change.
- **Community Action Agency (CAA)**, whose mission is to advance social and economic mobility among communities through services, partnerships, and advocacy using an equity lens. The CAA manages the federal and state Head Start and Community Services Block Grant (CSBG) funding, which includes the Takoma-East Silver Spring (TESS) Community Action Center, Volunteer Income Tax Assistance

(VITA), the Community Action Board, and its Community Advocacy Institute. CAA staff and volunteers join with 30+ partners to deliver critical services that strengthen the social and economic assets of low-income communities.

- **Minority Health Programs**: The African American Health Program (AAHP), the Latino Health Initiative (LHI), and the Asian American Health Initiative (AAHI) support Department-wide efforts to eliminate health and other disparities and achieve equity while continuing their population-targeted programs and services. The programs' knowledge, expertise, and experiences in racially, ethnically, and linguistically diverse communities helps inform department-wide programs, policy, and budget decisions.
- **Equity and Language Access**: This focus area leads an organizational change effort by engaging in systematic planning, implementation, and evaluation of activities that help the Department understand, define, and adopt equity as an operating value that guides how staff work with customers, colleagues, and the community to promote health, safety, and self-sufficiency. Limited English Proficiency (LEP) is a key barrier to equitable access to services. This program oversees the implementation of key components of the comprehensive Department-wide LEP policy and implementation plan to fulfill an essential systemic strategy to create equitable access to services.

Public Health Services: Public Health Services (PHS) programs protect and promote the health and safety of residents by monitoring health status and implementing strategies to contain or prevent disease; fostering public-private partnerships which increase access to health services and developing and implementing programs and strategies to address health needs; providing community health education and evaluating the effectiveness of programs and strategies; and licensing and inspecting facilities and institutions affecting public health and safety.

Public Health Services Divisions and Programs

Cancer & Tobacco Prevention: The Tobacco Use Prevention and Cessation Program and the Cancer Prevention, Education, Screening, and Treatment Program are programs funded through the State Cigarette Restitution Fund and offer outreach, screenings, education, and treatment activities via coalitions of community-based organizations, hospitals, and other partners to implement tobacco-control programs and elimination of cancer disparities.

Communicable Disease and Epidemiology: This program investigates, diagnoses, and surveils, and in some cases, provides medical services to Montgomery County residents. Tuberculosis Control and Sexually Transmitted infections programs test, diagnose, and treat residents with the illnesses, and HIV Medical and Dental Services

manage cases and provide medical care for those who are HIV positive and have limited insurance. The Disease Control Program tracks and manages cases of rabies exposures in the county. Additionally, ongoing surveillance of COVID-19 is a function of Communicable Disease and Epidemiology.

Public Health Emergency Preparedness and Response Program: This program is responsible for the planning, readiness, and response activities related to public health emergencies and bio-terrorism threats in collaboration with other departments, hospitals, state, and federal agencies.

Maternal and Child Health Programs: Provides preventive health access services to uninsured and underinsured residents including nurse case management and home visits to targeted populations such as pregnant women, pregnant, and parenting teens, children up to one year of age, and at-risk infants, as well as care coordination and referrals.

Dental Services: This program provides dental services to income-eligible Montgomery County residents to promote oral health. The five clinics offer prevention, assessments, emergency, and targeted dental services to children, pregnant women, adults, and seniors.

Health Care for the Uninsured: Through public-private partnerships, this program provides health care services for low-income, uninsured children and adults as well as care coordination for uninsured children with chronic conditions.

Health Planning and Epidemiology: This program is responsible for data collection and analysis to support the community health needs assessment, evaluations, and for the surveillance and investigation of outbreaks. The program also develops and maintains statistics and population data for DHHS.

Healthy Montgomery: Healthy Montgomery is Montgomery County's community health improvement process bringing together public and private partners including hospitals, academia, and non-profits to achieve optimal health for residents. Top priority areas are obesity, behavioral health, diabetes, cardiovascular disease, cancer, and maternal and infant health.

Food Security Plan: The Food Security Plan is a five-year strategic plan to reduce food insecurity in the county and increase access to nutritious food for vulnerable groups and residents in need. The plan is an integral part of the Healthy Montgomery initiative, and the program collaborates with community-based organizations and county agencies to research, develop, and implement strategies to remove barriers to access and to improve the quality of food assistance services in the county.

Licensure and Regulatory Services: The program is responsible for licensing, inspecting, and enforcing compliance with county, state, and federal regulations for facilities that care for children, the elderly and those with mental illness, as well as food service facilities, pools, businesses, and other enterprises requiring a license.

School Health Services: Nurses and health room technicians provide services in all Montgomery County Public Schools. They also staff the School Based Health and Wellness Centers to provide health services to students including emergency services, medication and treatment, referrals for medical and mental health, lead and vision screenings, and immunizations.

Healthy Montgomery Overview

In June 2008, DHHS and the Montgomery County Collaboration Council for Children, Youth and Families sponsored a meeting that brought together organizations in the county that provide services to improve the health and well-being of Montgomery County residents. The purpose of the meeting was to evaluate how the local public health system delivers essential public health services to the community. Attendees collectively assessed how well the ten essential public health functions are carried out in the county and identified several areas needing improvement. Montgomery County initiated Healthy Montgomery to address these needs.

Healthy Montgomery works to improve the health and well-being of Montgomery County residents by:

- Improving access to health and social services;
- Achieving health equity for all residents; and
- Enhancing the physical and social environment to support optimal health and well-being and reduce unhealthful behaviors.

Healthy Montgomery objectives are:

- To establish a comprehensive set of indicators related to health processes, health outcomes and social determinants of health in Montgomery County that incorporates a wide variety of county and sub-county information resources and utilizes methods appropriate to their collection, analysis, and application;
- To identify and prioritize health needs in the County as a whole and in the diverse communities within Montgomery County;
- To foster projects to achieve health equity by addressing health and well-being needs, improving health outcomes and reducing demographic, geographic, and socioeconomic disparities in health and well-being; and to coordinate and leverage resources to support the community health improvement process infrastructure and improvement projects.

Healthy Montgomery is guided by the Healthy Montgomery Steering Committee which is comprised of community stakeholders who represent various sectors and communities in Montgomery County.

PURPOSE

The purpose of Healthy Montgomery is to provide ongoing sustainable and community-driven approaches that identify and address key priority areas for the health and well-being of Montgomery County community members. The Healthy Montgomery Steering Committee provides insights into community needs and offers strategies to address those needs.

FUNCTION

Healthy Montgomery's process is based upon nationally recognized community health improvement process models such as the National Association of County and City Health Officials' planning initiative and Mobilizing for Action through Planning and Partnerships. The community health improvement process is based on five phases.

- Phase 1: Compile quantitative data, qualitative data, community resources, and strategies
- Phase 2: Develop a comprehensive community health needs assessment
- Phase 3: Set health priorities and develop action plans to address identified priorities

- Phase 4: Plan for action
- Phase 5: Implement, monitor, evaluate, and preplan for the next cycle

HEALTHY MONTGOMERY EFFORTS TO-DATE

Progress made on Assessing and Monitoring Community Health Data

Six priority areas and 37 core measures were identified since Healthy Montgomery's inception in 2009 with resources allocated to address them. As population dynamics change over time, Healthy Montgomery measures progress and re-evaluates and updates community health indicators on an ongoing basis to ensure that interventions address the most prevalent health risks and are targeted towards those who are most vulnerable.

The four overarching lenses proposed by the County Health Officer include data, access, social determinants of health and equity. Public Health Services reviewed county level health data for the original 37 core measures and 56 additional measures from the recently released population surveillance status of the health report using criteria that include secular trends, disparities among race/ethnicity population subgroups, and state and national level benchmarks including Heathy People 2020. A need index score was generated for each measure. Progress made towards goals were calculated using methods from Healthy People 2020. Four community priority areas were generated after the data review to include maternal and infant health, chronic disease, infectious disease, and behavioral health with 25 proposed measures. Advisory groups, formed across the four priority areas, reviewed appropriate measures and proposed county-specific goals to measure progress with the community health needs assessment. This systematic data-driven approach successfully informs and re-aligns Healthy Montgomery to work towards improving the health of all county residents. The CHNA workgroup, Chronic Disease Coalition and other community stakeholders including the Minority Health Initiatives and Programs continue to work together, review new data across disease burdens, and evaluate resources allocated to address them.

Appendix I provides links to population health data and surveillance reports to support Healthy Montgomery's work and to monitor progress towards achieving core measures.

Healthy Montgomery's website features a data dashboard that highlights trends over time across all core measures tracked. All data activities meet current standards and measures outlined by the Public Health Accreditation Board. The DHHS Health Planning and Epidemiology staff also provides data support and technical assistance to local hospital partners, county agencies, and other community stakeholders.

Healthy Montgomery convened two public data workshops on Envisioning Equity in Montgomery County using Data. The activity was supported by the Robert Wood Johnson Foundation's Data Across Sectors for Health. Members attended to discuss ways to share data across sectors to improve community health. The network served as a resource hub with useful information on health data, community health improvement, and data sharing best practices.

Accomplishments as Local Health Improvement Coalition

Healthy Montgomery serves as Montgomery County's Local Health Improvement Coalition (LHIC) and has regularly participated in information gathering and technical assistance activities convened by the Maryland Department of Health (MDH). Healthy Montgomery staff participated in operations and needs interviews coordinated by the MDH Office of Population Health Improvement and Primary Care Office, and most recently attended webinars and other technical assistance sessions coordinated by the University of Maryland School of Public Health. The DHHS Office of Health Planning and Epidemiology also submitted data gaps and needs to be considered moving forward.

The Montgomery County Food Security Plan is an essential component of the Healthy Montgomery initiative, and since its inception in 2017, it has continuously engaged low-income residents and community partners that serve them in the design and implementation of food assistance programs that meet the needs of our most vulnerable groups. We strive to serve children, older adults and persons with disabilities and others experiencing barriers to access such as unhoused persons and those with limited English proficiency. There is a robust network of partnerships with schools, social services agencies, clinics, civic groups, senior centers, faith-based organizations, and community leaders across the county to provide services to those in need. The program supports the work of over 100 food assistance partners that provide culturally appropriate food, offer weekly distributions of produce and staples as well as diapers and other hygiene needs, and include home delivery services. In the last two years, eight service consolidation hubs were created in priority zip codes to serve our most vulnerable residents with weekly food and diapers. The Hubs also offer a case management component to connect participants to health, mental health, benefit services, and other social programs.

An accomplishment of the LHIC included efforts related to Health in All Policies (HiAP). According to the American Public Health Association, HiAP is a collaborative approach to improve the health of all people by incorporating health considerations into decision-making across sectors and policy areas. In Montgomery County, HiAP activities began in 2017 and first assisted in the development of the CHIP, creating a workplan, website, and completing an environmental scan. HiAP work has evolved since its initial efforts and currently, HiAP projects are focused on equitable transportation, where a workgroup was formed to strategize improvements for nonemergency medical needs. Future efforts may include offering technical assistance resources and creating a toolkit.

CHNA Advisory Committee

The CHNA Advisory Committee was formed to provide input and guidance to the CHNA process. The CHNA Advisory Committee is comprised of representatives from community health organizations, County agencies, social-service organizations, medical personnel, racial, and ethnic serving institutions, and community members. The CHNA Advisory Committee was tasked with ensuring that the CHNA process and activities are consistent with national best practices and guidance. The committee provided expertise and access to key assets and resources. The committee provides regular updates to the Healthy Montgomery Steering Committee. The CHNA Advisory Committee maintained active engagement throughout the CHNA process.

Office of Health Planning and Epidemiology, Public Health Services Published Data Reports Since 2016

Health Survey Report, 2022

The report summarizes findings from the 2022 community health needs survey, including demographics of respondents, health and health related priorities, access to health care, impact from COVID-19 and health status and health related behaviors. The County's Department of Health and Human Services worked with Rockville-based Westat to design a mail-in survey to assess community health needs for Montgomery County residents aged 18 and older. The report is the first primary quantitative data collected to assess community health needs and will complement findings from other secondary quantitative data and qualitative data collected from key informant interviews and focus groups meetings.

Health in Montgomery County, 2010-2019, A Surveillance Report on Population Health, Montgomery County, Maryland

This report offers a comprehensive view of Montgomery County's community health status and highlights how the health of county residents compares to state and national benchmarks. The data included help guide the County's public health related efforts to address the health needs of the community and prioritize relevant strategies to address the most prevalent health concerns within Montgomery County.

Health Equity in Montgomery County, MD–Healthy Montgomery Core Indicators 2010-2018

This report includes information and data on maternal and infant health, behavioral health, chronic disease, infectious disease, and injury in the county. The report addresses population subgroups on race/ethnicity and geographic areas for Healthy Montgomery Core Measures, evaluating health equity from the perspectives of current disparity and change of disparity over time, using data from 2010 to 2018. The report highlights where and how disparities exist and how they have changed over time.

Health in Montgomery County, 2008-2016, A Surveillance Report on Population Health, Montgomery County, Maryland

This report offers a comprehensive view of Montgomery County's community health status and highlights how the health of county residents compares to state and national benchmarks. The data included help guide the county's public health related efforts to address the health needs of the county and prioritize relevant strategies to address the most prevalent health concerns within Montgomery County.

Coronavirus Disease 2019 (COVID-19) in Montgomery County Surveillance Report

This report offers information and data on COVID-19 Epidemiology Surveillance and DHHS Programs' Efforts and Responses to the pandemic.

Report on Infectious Disease, 2013-2017, Montgomery County, Maryland

This is the first Report on Infectious Disease for Montgomery County that includes information and data on infectious diseases in the county, as well as the roles the Department of Health and Human Services (DHHS) programs play in combating infectious diseases through disease surveillance, prevention, and control. The report highlights where Montgomery County stands in comparison to state and the nation on infectious disease.

Maternal and Infant Health in Montgomery County, MD, 2008-2017

This is the first report on Maternal and Infant Health for Montgomery County. The report includes information and data on maternal and infant health topics in the county and identifies the Department of Health and Human Services (DHHS) role in providing education and services to reduce adverse pregnancy-related outcomes and improve maternal and infant health among county residents. The report highlights where Montgomery County stands in comparison to the state and the nation on maternal and infant health topics.

Healthy Montgomery 2023 Goals and Core Measures

This report highlights federal and state community health standards and sets community health goals for the county. It includes baseline and proposed measures across core topic areas that include maternal and infant health, behavioral health, chronic disease, infectious disease, and injury.

The Zip Code Ranking Project

This report uses a modified algorithm to rank zip codes within Montgomery County that include length of life, quality of life, health behaviors, clinical care, socioeconomic factors, and the physical environment. The report helps inform program development and resource allocation moving forward.

Hospital Community Benefits Report, 2019

This report highlights information and data across hospital community benefit service areas in the county across core topic areas that include maternal and infant health, behavioral health, chronic disease, infectious disease, and injury.

Hospital Community Benefits Report, 2017

This report highlights information and data across hospital community benefit service areas in the county across core topic areas that include maternal and infant health, behavioral health, chronic disease, infectious disease, and injury.

Hospital Community Benefits Report, 2016

This report highlights information and data across hospital community benefit service areas in the county across core topic areas that include maternal and infant health, behavioral health, chronic disease, infectious disease, and injury.

CHNA METHODS AND PROCESSES

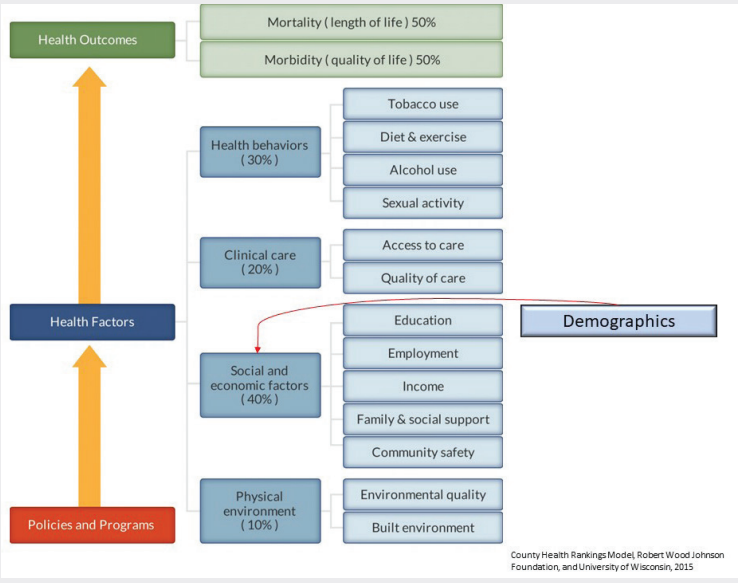
Conceptual Overview

Robert Wood Johnson's (RWJ) County Health Rankings Model was used to identify, organize, and conceptualize the data used to conduct the CHNA.[33] The model is a widely use population health tool to identify factors and associated indicators across the four domains, health behaviors, clinical care, social and economic factors, and physical (built) environment, that significantly impact health outcomes. To capture the impact demographics have on health outcomes, we added a demographic category to the social and economic factors domain. The rankings use more than 30 measures that help communities understand how healthy their residents are today (health outcomes) and what will impact their health in the future (health factors).

Health is dependent on many factors, some which are under an individual's control and others which are not. Data shows that health is dependent on things such as a healthy physical environment, like access to affordable housing and safe drinking water, in addition to social and economic factors like income, quality education, and community safety. Many times, the choices that individuals make for their health depend solely on what options exist in the environment in which they live. Figure 2 shows the County Health Rankings framework, which **provides data, evidence, guidance, and examples to build awareness of the multiple factors that influence health**.

Healthy Montgomery uses the metrics identified in RWJ's County Health Rankings model to determine health needs of Montgomery County community

FIGURE 2. **County Health Rankings Framework with added Demographic Category**



members. In using this model, Healthy Montgomery examines health outcomes and priorities through multiple lenses for community members. While Montgomery County continues to be one of the healthiest counties in the state of Maryland, there are still many environmental and social factors that must be considered to fully advance health equity in Montgomery County. This CHNA report presents results of the health factors that impact health equity as identified by community members and stakeholders.

To further guide the overall process of conducting the CHNA, a defined set of quantitative and qualitative data collection and analytic stages were developed.

Data Used in the CHNA

The CHNA collected and used data from primary and secondary sources. Primary data included both qualitative interviews and quantitative surveys. The advantages of using both primary qualitative and quantitative data were to compare and contrast results and gain much deeper insights into the health needs of the Montgomery County community. Primary data included key informant group interviews with 54 health care experts, community or social-service providers, faith leaders, and medical personnel. Additionally, 252 residents participated in focus groups. Forty Montgomery dental providers responded to the oral health capacity and demand environmental scan survey. For the environmental scan of organizational resources, 31 stakeholder groups shared health and social resources in Montgomery County.

Additionally, 9,000 surveys were mailed in 2022 to Montgomery County residents in English and Spanish using address-based sampling. Of these, Department of Health and Human Services received 1374 completed surveys from residents 18 years and older that serve as a primary data source for the CHNA.

Secondary data sources used include vital records, inpatient and outpatient hospitalization, disease registry, surveys, area health resources file, and Census data. Vital records including births and deaths are provided by the Vital Statistics Administration of the Maryland Department of Health. Hospitalization data including inpatient and outpatient visits are provided by the Maryland Health Services Cost Review Commission. Cancer incidence data are provided by the Maryland

Cancer Registry, whereas data on infectious diseases are provided by the Infectious Disease Bureau of Maryland Department of Health.

Other data sources including Behavioral Risk Factor Surveillance System (BRFSS) data and Youth Risk Behavior Survey (YRBS) data are provided by the Cancer and Chronic Disease Bureau of the Maryland Department of Health. Information on prevalence estimates of certain behavioral health topics is from the National Survey on Drug Use and Health (NSDUH) of Substance Abuse and Mental Health Services Administration (SAMHSA). Vaccination coverage estimates are from the National Immunization Survey (NIS) of the CDC. Area Health Resource File (AHRF) is from the U.S. Department of Health and Human Service's Health Resources & Services Administration (HRSA). Data on population estimates are derived from the American Community Survey (ACS) of the U.S. Census Bureau. Data is presented using the CDC's Agency for Toxic Substances and Disease Registry (ATSDR) Social Vulnerability Index (CDC/ATSDR SVI) results across zip codes within Montgomery County regions overlayed with Montgomery County's Equity Focus Areas (EFA).

Healthy Montgomery core measures and secondary data were updated up until 2020. The core measures are also compared with indicators from State Health Improvement Process (SHIP) and federal Healthy People 2020 and Healthy People 2030 goals, along with the Robert Wood Johnson Foundation County Health Rankings. Healthy Montgomery has 25 core measures across health topic areas that include behavioral health, maternal and infant health, chronic disease, infectious disease, and injury.

Data Analysis

Primary and secondary data were analyzed to identify the most pressing needs of the Montgomery County community. Analysis of the data resulted in the categorized list of significant health needs. Where qualitative interviews were observed to have the same subthemes coming out, repeatedly as a health need, issue, or barrier, then the subtheme was elevated and reported in the

table for each of the significant health needs. Quantitative indicators from primary data/survey that were mostly reported by respondents as health needs, issues, or barriers were elevated and reported in the table for each of the significant health needs. The quantitative indicators from secondary data that performed poorly when compared to state benchmarks are also listed in the table for all of the significant health needs.

QUALITATIVE

To guide the data collection and analytic stages, we used the rapid identification of themes from audio recordings (RITA) methodology. One advantage of using RITA to code and analyze the data was that we bypassed costly and time-consuming transcription. Identification of themes and subthemes was done while listening to prespecified time segments of the audio recordings. The codebook was created according to the conceptual framework. Deductive or a priori themes and subthemes came from the conceptual framework. Inductive or in vivo themes and subthemes were identified and recorded using the conceptual framework as they emerged from the data. Inter-rater reliability was achieved by having two independent observers code each qualitative interview to measure the extent of agreement. If the two coders agreed perfectly on an item, then the theme or subtheme was maintained. If the two coders disagreed on an item, then both of the individuals met to discuss where their codes diverged and then agreed upon final themes and subthemes to maintain. All final themes and subthemes identified using the conceptual framework through the data analysis for all subpopulation groups is presented in this CHNA report.

QUANTITATIVE

To assess and monitor population health as part of the community health needs assessment, DHHS' Health Planning and Epidemiology (HPE) analyzes vital records and hospitalization data as they become available to produce age-adjusted rates following standard methodology from the CDC and Prevention. Additional information on methodology in analyzing population health data can be found in the most recent population health surveillance report.[34]

In 2022, DHHS contracted with Westat, a research services agency, to implement a mail-in survey assessing community health needs for adults aged 18 and older living in the county. This was the first primary quantitative data collected in the county by HPE on behalf of Healthy Montgomery to assess community health needs and complement findings from the secondary quantitative data and qualitative data collected. Survey results were analyzed using standard procedures in SAS for surveys, specifically the jackknife method of variance estimation that were validated by Westat and University of Maryland School of Public Health.

Primary survey quantitative data results for some subgroups are not available due to missing data or small sample size and therefore will not be reported on in the respective proceeding sections. Where subgroup analysis of primary survey data is not available, the report provides qualitative data subgroup results only.

LIST OF TABLES AND FIGURES

Tables

Figures

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References for the significant health need charts are listed under each respective chart from pages 21 to 47

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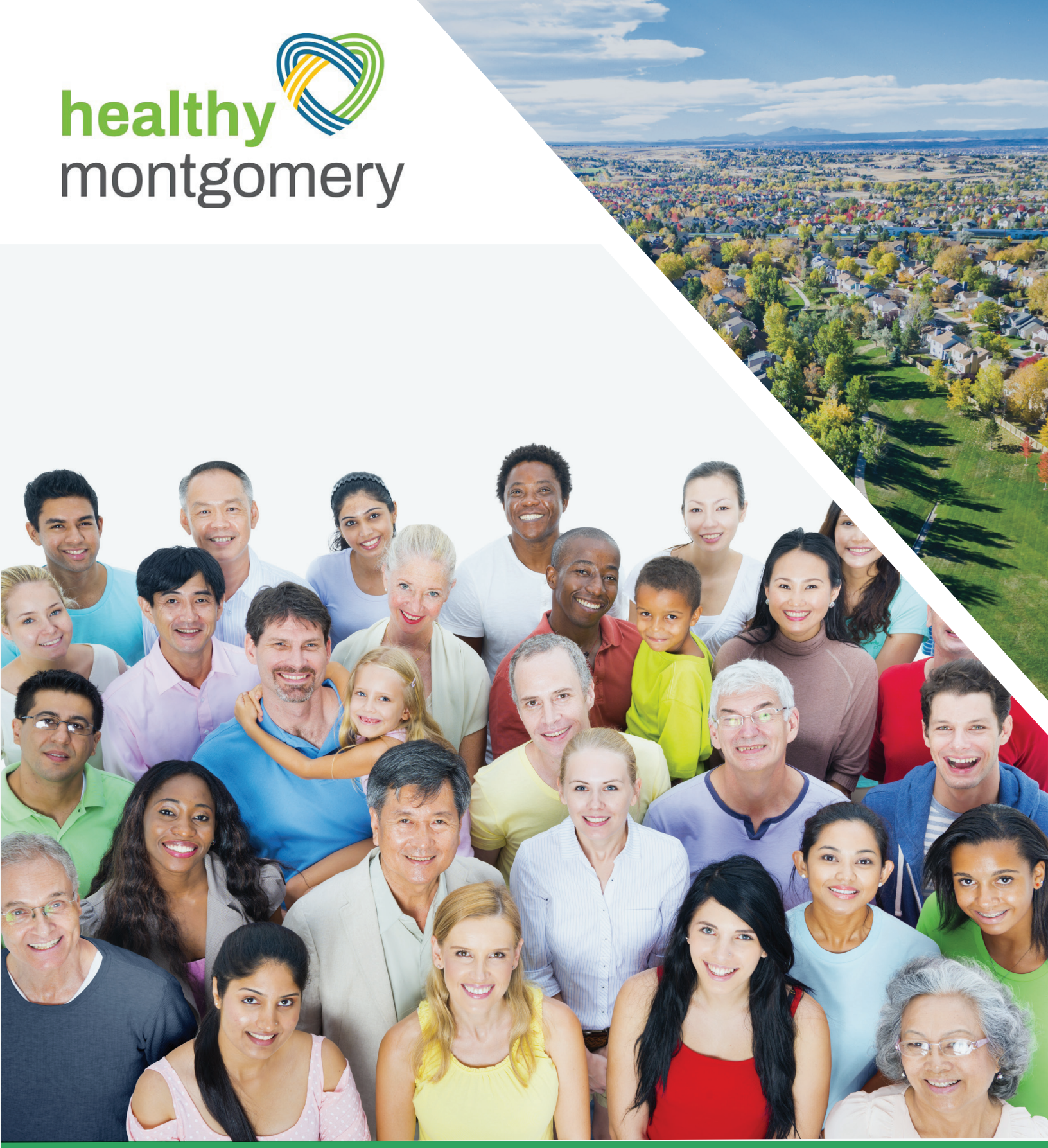
healthy montgomery



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