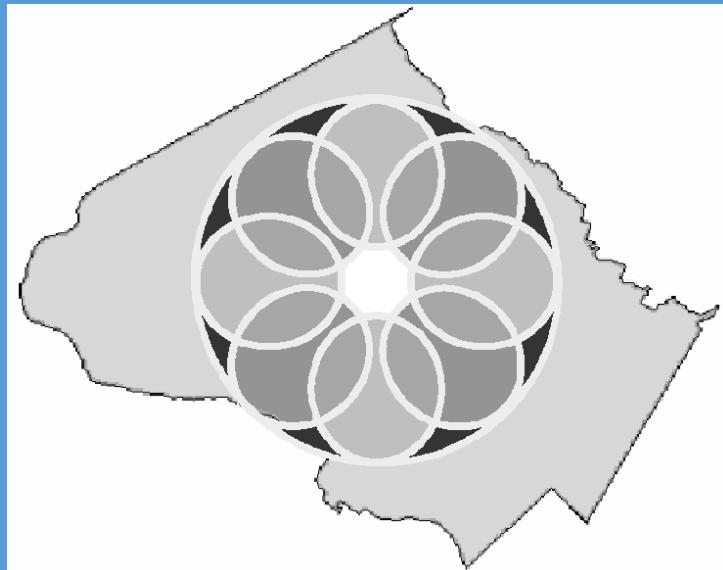


2016 COMMUNITY HEALTH NEEDS ASSESSMENT



HEALTHY MONTGOMERY



HEALTHY MONTGOMERY 2016 COMMUNITY HEALTH NEEDS ASSESSMENT

May 30, 2016

FRONT MATTER SECTION

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Susan DeFrancesco provided facilitation support to the Community Conversations, summarized the Community Conversation findings, led the information gathering for the Community Resources, Hospital Alignment and Evidence-Based Strategies sections of the Report, and led and coordinated the report writing.

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Executive Summary

Healthy Montgomery is the community health improvement process for Montgomery County, Maryland. Launched in June 2009, it is an ongoing effort that brings together County government agencies, elected officials, the four County hospital systems, minority health initiatives/program, advocacy groups, academic institutions, community-based service providers, the health insurance community, and other stakeholders to achieve optimal health and well-being for all Montgomery County residents. It follows a five-stage process that includes data collection, needs assessment, priority-setting, strategic action planning, and the implementation and evaluation of collaborative efforts designed to improve access to health and social services, achieve health equity, and enhance the physical and social environment to support optimal health and well-being and reduce unhealthful behaviors.

The cross-sector Healthy Montgomery Steering Committee (HMSC) informs, advises, and ensures implementation of the community health improvement process. Building on efforts that increase access, promote healthy behaviors, and achieve health equity, the HMSC has identified six priority health areas: obesity, cardiovascular health, diabetes, cancers, behavioral health, and maternal and infant health. Healthy Montgomery Work Groups comprised of subject-matter experts and public and private service providers developed action plans for obesity and behavioral health. The Eat Well Be Active Partnership and the Behavioral Health Task Force (BHTF) are two Healthy Montgomery entities that were formed to carry out the work of the Obesity and Behavioral Health Action Plans, respectively. Work is currently underway to implement the action plans and to find additional support for implementation. (The Action Plans and other information about the Eat Well Be Active Partnership and BHTF can be found on the Healthy Montgomery website at www.healthymontgomery.org).

Healthy Montgomery has 37 Healthy Montgomery Core Measures that represent the six Healthy Montgomery priority areas, provide a distinct set of cross-cutting measures that support more than one priority area, and include measures that capture key social determinants of health in Montgomery County. The 37 measures are used to provide an overall quantitative snapshot of the Healthy Montgomery community health improvement efforts. A Measurement and Evaluation Subcommittee of the HMSC tracks the core measures as well as develops and tracks performance measures. It also identifies measurement and evaluation approaches for Healthy Montgomery action planning and implementation.

With the compilation of this Community Health Needs Assessment (CHNA), Healthy Montgomery is currently entering its second cycle in the community health improvement process. The work moves forward into the 2016-2019 cycle in the context of a supportive health care climate created by the 2010 Patient Protection and Affordable Care Act (Affordable Care Act), with its emphasis on preventive services and enhanced access to health insurance and health care services. Healthy Montgomery also continues its work within a framework that acknowledges the importance of addressing health equity and the underlying social, economic, and environmental factors that influence health outcomes.

HMSC members also recognize the potential for effective collective impact and strive to incorporate the collective impact framework within Healthy Montgomery. Collective impact requires multiple sectors to commit to a common agenda, share a common measurement system, conduct mutually reinforcing activities, and engage in continuous communication. It also requires the support of a backbone

organization.¹ The HMSC also frames its work within the goals of the Triple Aim which are to simultaneously improve the patient experience of care, improve the health of populations, and reduce the per capita cost of health care.²

The purpose of this 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 2016-2019 cycle. The content and format of the 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 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. Community resources are compiled in the Report to provide information about existing programs and services provided by County government agencies and other public and private organizations. Hospital services and programs are also included in the Report revealing the alignment or potential for alignment of efforts across the County's four hospital systems. These hospital resources can also be considered in conjunction with the other community resources from other sectors. The Report includes evidence-based strategies to address the covered topic areas. Finding synergy and potential alignment for collective impact can be accomplished by using the information and data compiled in the Report to identify vulnerable populations and areas of focus, recognize the potential for leveraging existing community resources, build upon existing or potential alignment with hospital CHNA efforts, and employ evidence-based strategies. Preliminary ideas for actionable, aligned strategies are also included in the Report.

This Report also includes information and data gathered on underlying conditions or determinants of health— that is, the social, economic, and environmental factors that influence health outcomes and health equity. These underlying factors create an important context for considering the other Report sections which describe the six Healthy Montgomery priority health issues – obesity, cardiovascular health, diabetes, cancers, maternal and infant health, and behavioral health – as well as the emerging health issue of heroin and other opioid misuse.

Key Findings

The Report's Key Findings document an abundance of health care and social service resources in Montgomery County but there is also a need for much greater coordination and alignment to make them more effective and accessible. The findings also reveal the need to increase accessibility to these services by addressing barriers such as affordability, cultural and linguistic barriers, and transportation barriers, especially those that challenge seniors and people with disabilities.

Community residents call for better promotion of available resources as well as targeted outreach to communities using community gathering places (e.g., retail sites, schools, churches, libraries, and community centers) as strategies for increasing access. Report findings also reveal the opportunity to enhance the *infoMONTGOMERY* database as well as the ongoing activities and outreach of the County's Minority Health Initiatives and Program to improve promotion of County resources in a way that is culturally and linguistically competent and effective in reaching those most in need. In addition, the County's hospital systems have implemented evidence-based strategies that integrate health literacy

¹ Kania J, Kramer M (2011). Collective Impact. *Stanford Social Innovation Review*, 9(1): 36-41

² Berwick DM, Nolan TW, Whittington J. (2008). The triple aim: care, health, and cost. *Health Affairs* 27(3):759-69.

and equity into the care and services they provide through cultural- and language-appropriate methods. The use of peer support and community health navigators and community health workers is also encouraged and highlighted among the Report findings to improve connectivity and accessibility to resources and services.

The need for a cross-sector response to address issues such as transportation, housing, and employment and other underlying determinants of health is a consistent finding in the Report. Community residents described a healthy community as one that provides safe places to walk, bicycle and be physically active; access to healthy, affordable food; well-paying jobs; affordable housing; high-quality education; crime-free neighborhoods; reliable and affordable public transportation; and access to preventive services, health care, and social services.

Approaching community health improvement in this way requires an intentionally aligned collective response from a range of sectors (e.g., health, transportation, planning, housing, education, recreation, environment, and police) that routinely and consistently embed health considerations into their decision-making processes. The need to engage community members in decisions affecting health is also included among the findings of the Report.

The Report findings emphasize the way in which improving the underlying conditions that affect health can influence many risk factors that cut across the Healthy Montgomery health issue areas. For example, a community purposely designed to support healthy eating (e.g. healthy vending in workplaces and schools, affordable farmers' markets, community gardens), encourage physical activity (e.g., accessible, affordable and safe places to be physically active), promote safer and more connected communities that prevent injury, violence and crime (e.g., designing safer environments, fostering economic growth) and provide safe shared spaces for people to interact (e.g., parks, community centers) addresses risk factors associated with obesity, cardiovascular disease, diabetes and cancers. It also fosters healthy relationships and positive mental health among community residents, and positively impacts the health of a pregnant mother.

Additionally, another Report finding that cuts across health issue areas is the need to provide and promote preventive services (including screenings for obesity, cardiovascular disease, diabetes, cancers, suicide, depression, and substance abuse) and targeted messages about prevention. Another specific preventive service need identified is access to affordable dental care. Evidence-based strategies confirm the importance of using public-private partnerships to implement community preventive oral health services to adults and children, especially those at risk. The Report findings reveal a number of efforts to provide affordable and free dental services to low-income residents that can be leveraged and promoted more effectively.

The Report also reveals opportunities for involvement in addressing the emerging issue of heroin and prescription drug misuse in the County. The findings describe existing cross-sector collaborative efforts in the County that can be leveraged to effectively employ evidence-based strategies to address the issue.

Finally, the Report findings reveal the need and possibility for additional sectors to become involved in the work of Healthy Montgomery as HMSC members. The Montgomery County Police Department collaborates with municipal police departments to raise public awareness about the issue of opioid misuse and safe disposal of unwanted prescription drugs. This finding reveals an opportunity for Healthy Montgomery to engage the County Police Department as a Healthy Montgomery partner to enhance cross-sector collaboration to address opioid misuse as well as other priority health issues. In addition, the findings reflect a scarcity of information about resources provided by County businesses, as the

business sector is not yet represented on the HMSC. Cross-sector evidence-based public health strategies encourage the involvement of the business sector.

Next Steps

This Report provides information and data as well as a framework needed for the Healthy Montgomery priority-setting process.

Once specific strategies are identified by key stakeholders, a rapid process will take place through 2016 to develop and complete targeted action/implementation plans with an evaluation component. These plans will identify partner organizations and describe the activities each organization will undertake to actualize the strategies prioritized by Healthy Montgomery.

Relevant content from this Report along with the adopted implementation and evaluation plans will be incorporated into the Healthy Montgomery Community Health Improvement Plan for 2016-2019, providing an aligned, targeted, evidence-based improvement plan that can be implemented and measured for impact within the three-year timeframe.

I. Introduction

Healthy Montgomery Background and History

Healthy Montgomery is the community health improvement process for Montgomery County, Maryland, a collaborative, ongoing effort that brings together County government agencies, elected officials, the four County hospital systems, minority health initiatives/program, advocacy groups, academic institutions, community-based service providers, the health insurance community, and other stakeholders to improve the health and well-being of all Montgomery County residents. It includes data collection, needs assessment, priority-setting, strategic action planning, and the implementation and evaluation of collaborative efforts designed to improve health outcomes and achieve health equity.

Healthy Montgomery is guided by the Healthy Montgomery Steering Committee (HMSC) which also serves as the local health improvement coalition (LHIC) for the Maryland Department of Health and Mental Hygiene's State Health Improvement Process (MD SHIP). The multi-sector HMSC includes representatives from all four County hospital systems, elected officials, the County's Department of Health and Human Services and other public agencies and private organizations that represent diverse constituencies and that serve vulnerable populations disproportionately affected by poor health and well-being outcomes.³ The HMSC informs, advises, and ensures implementation of the community health improvement process. As a collaborative process, budgetary and policy-making coordination and support from all the Healthy Montgomery partners including the Office of the Montgomery County Executive is critical to the ongoing success of the initiative.

³ HMSC members are listed on the Healthy Montgomery website at www.healthymontgomery.org.

The HMSC was nationally recognized in May 2014, when Healthy Montgomery was identified, by the University of Kentucky, as a “highly successful collaborative partnership” involving hospitals, public health departments and other stakeholders focused on improving the health of the communities they jointly serve. The final report, *Improving Community Health through Hospital-Public Health Collaboration*, funded in part by the Robert Wood Johnson Foundation, was released in November 2014.⁴

The HMSC has established a set of goals and objectives for Healthy Montgomery. The goals are to:

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

Healthy Montgomery’s objectives are to:

- Establish a comprehensive set of indicators related to health and well-being 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;
- Identify and prioritize health and social needs in the County as a whole and in the diverse communities within the County;
- 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
- Coordinate and leverage resources to support the community health improvement process infrastructure and improvement projects.

The Healthy Montgomery community health improvement process is based on five phases intended to occur within a three-year cycle:

- Phase 1: Compiling of available quantitative data, community resources, and evidence-based strategies;
- Phase 2: Collection of qualitative data and development of a comprehensive community health needs assessment;
- Phase 3: Setting of health priorities and development of action plans to address identified priorities
- Phase 4: Planning for Action; and
- Phase 5: Implementing, monitoring and evaluation as well as preplanning for the next cycle.

This process is based upon nationally recognized community health improvement process models such as the National Association of County and City Health Officials’ (NACCHO’s) planning initiative, Mobilizing for Action through Planning and Partnerships (MAPP) and the Community Health



⁴ L. Prybil, F. Douglas Scutchfield, R. Killian, A. Kelly, G. Mays, A. Carman, S. Levey, A. McGeorge, D. W. Fardo, *Improving Community Health through Hospital-Public Health Collaboration: Insights and Lessons Learned from Successful Partnerships*. Commonwealth Center for Governance Studies and the University of Kentucky College of Public Health. November 2014. Accessed at: <http://www.aha.org/content/14/141204-hospubhealthpart-report.pdf>

Improvement Partners (CHIP) Model of Collaboration employed by the community health improvement process in San Diego, California.⁵

Healthy Montgomery 2009 Launch and 2011 Prioritization

Healthy Montgomery was launched in June 2009 with a comprehensive scan of all existing and past planning processes. Past assessment, planning, and evaluation processes that related to health and well-being focus and social determinants of health across a multitude of sectors, populations, and communities within Montgomery County were compiled. An environmental scan was also conducted that included the key data sources and past planning, assessment and evaluation reports on Montgomery County. By 2010, the focus was on establishing a core set of indicators that could be examined through a comprehensive needs assessment. Approximately 100 indicators were identified and released at the launch of the Healthy Montgomery website early in 2011. This information was compiled into a Community Health Needs Assessment (CHNA), which was used by the HMSC in a priority-setting process conducted later in 2011. The priority-setting process resulted in the selection of six Healthy Montgomery priority areas: obesity, cardiovascular health, diabetes, cancers, behavioral health, and maternal and infant health. In addition to selecting these six broad priorities for action, the HMSC identified three overarching themes (lenses) to be addressed in the action planning -- lack of access, health inequities, and unhealthy behaviors. As limited resources could not support work on all priority areas, the HMSC decided to focus initially on behavioral health and obesity. In 2012, the HMSC established two work groups charged with developing behavioral health and obesity action plans.

Healthy Montgomery: Six Priority Areas for Community Health Improvement



⁵ National Association of County and City Health Officials. *Mobilizing for Action through Planning and Partnerships (MAPP)*. Accessed at: <http://www.naccho.org/programs/public-health-infrastructure/mapp>; Community Health Improvement Partners. *Case for Collaboration Handbook*. Accessed at: <http://www.sdchip.org/media/CaseforCollaborationHandbook.pdf>

Obesity Action Planning and Implementation

The Healthy Montgomery Obesity Action Planning Work Group included representatives from governmental and community-based organizations with subject-matter expertise in obesity, nutrition, physical activity, and community settings (schools, hospitals, health care providers, and recreational facilities). Many of the members worked in organizations that advocate for and provide health and social services to vulnerable populations disproportionately affected by poor obesity outcomes. The Work Group analyzed existing data bases to create indicator tables focused on obesity; created an inventory of resources; reviewed the status of related activities, programs, services, and policies; and identified gaps in resources, data, and coordination of activities. In March 2014, the HMSC approved the Healthy Montgomery Obesity Action Plan, which recommends the following actionable strategies, developed by the Work Group, to prevent and reduce obesity among County residents:

- Establish a broad-based, collaborative, County-wide partnership to address gaps in existing obesity prevention and reduction programming and policy, reduce redundancies and make the best use of finite resources, with a focus on children and populations most at risk; and
- Build upon existing data sources to establish a reliable and valid data system for monitoring the effectiveness of obesity prevention and reduction programs and policies, especially among children and high-risk populations.

To implement the Action Plan, a county-wide collaborative partnership, later named the Eat Well Be Active (EWBA) Partnership, was launched in May, 2014. The Partnership's initial focus is on limited-income families with children, and on prevention, starting with selected communities considered to be at high risk for obesity in order to pilot intervention efforts. The pilot community selected by the Partnership is Long Branch/Takoma Park. The Partnership formed four place-based work groups to develop localized strategies for obesity prevention – schools, community, health care, and home/child care. Work plans were developed for implementation of the following strategies:

- **Schools** – Promote the formation of school wellness councils in Montgomery County Public Schools (MCPS) Title I schools to advance local implementation of the MCPS school district-wide wellness policy and promote healthy food and physical activity policies and practices within local schools.
- **Community** - Enhance *infoMONTGOMERY* to serve as an asset map and inventory that lists resources related to: physical activity, healthy eating, and nutrition education and counseling. Share the information with service providers, nonprofit organizations, residents and others. Increase utilization by community residents (e.g., use of passport/coupons).
- **Health Care** - Disseminate screening questions for health care providers to use to assess the risk of sedentary behavior and increase awareness of the importance of physical activity, and provide age and culturally appropriate educational materials and local resources to share with patients --“Physical Activity as a Vital Sign” (PAVS).
- **Home/ Child Care** - Provide educational materials and training to child care providers to facilitate compliance with a new Maryland law that promotes breastfeeding, limits screen time, and promotes healthier drinks.

In June 2015, the work plans were reviewed and approved by the HMSC. In March 2016, a multi-year Transforming Communities Initiative Grant was awarded to the Institute for Public Health Innovation (IPHI) by Trinity Health. The grant was submitted as a collaborative effort by Healthy Montgomery partners including IPHI, the Montgomery County Department of Health and Human Services (DHHS) and Holy Cross Health. The grant will be used to implement and evaluate the strategies developed by the Partnership work groups. Early in 2016, the Partnership also received a small donation from the Kaiser Foundation Health Plan of the Mid-Atlantic States to fund a grant writer who is currently working with

the Partnership's Coordinating Committee to pursue additional support to staff and sustain the Partnership.

Also, as a step toward implementing the strategy of enhancing existing data sources to effectively monitor and evaluate obesity prevention and reduction programs and policies among children, the MCPS and the DHHS have collaborated to begin collecting aggregated County-wide weight status estimates on MCPS entering kindergartners who are healthy weight, overweight, and obese.

Behavioral Health Action Planning and Implementation

The Behavioral Health Action Planning Work Group was comprised of individuals who have subject-matter expertise in mental health and substance abuse as well as experience in providing behavioral health-related services and advocating for vulnerable populations disproportionately affected by poor behavioral health outcomes. The Work Group analyzed existing data bases to create indicator tables focusing on behavioral health, created an inventory of resources, reviewed the status of related activities, programs, services, and policies, and identified gaps in resources, data and coordination of activities. In March 2014, the HMSC approved the Behavioral Health Action Plan Report, which contains the following strategies developed by the Work Group, to impact behavioral health outcomes in the County:

- Consider ways in which *infoMONTGOMERY* can be enhanced to create an accessible Web-based basic information, communications, and linkage system through which consumers, their families, providers and other social service agency or referral source personnel can easily gain clear, basic information about treatment options, the full range of available services, payment mechanisms, and how to access services;
- Establish protocols to facilitate safe and appropriate transfer of clients from institutional settings (e.g., hospitals, emergency rooms, correctional facilities, schools, universities) to community behavioral health organizations, primary care organizations and crisis centers;
- Initiate a process to explore the creation of a coordinated system of care or other formal partnership-based business agreement to meet the needs of individuals with more serious behavioral health conditions who live in Montgomery County.

The Behavioral Health Task Force (BHTF) was launched in November 2014 to carry out the strategies defined in the Healthy Montgomery Behavioral Health Action Plan. BHTF membership includes public and private behavioral health service providers (including mental health and substance abuse) from throughout Montgomery County who treat adults and children in institutional and community settings. Also represented are the County's Minority Health Initiatives/Program, the four County hospital systems, County boards, committees, and commissions, academia, family and consumer advocates, and Montgomery County emergency services, police, and corrections.

Three BHTF Subcommittees were formed – *infoMONTGOMERY* Subcommittee, Policies and Protocols Subcommittee and Coordinated Care Subcommittee -- and over the course of a year, developed recommendations for implementation of each of the three strategies. In February 2016, the HMSC adopted the recommendations of the BHTF which include:

***infoMONTGOMERY* Subcommittee Recommendations:**

1. Create an accurate, relevant, and updated inventory of behavioral health services in the County through *infoMONTGOMERY*.
2. Enhance *infoMONTGOMERY* to improve the usability and accessibility of the information provided and its accessibility to vulnerable populations including people with disabilities, youth, seniors and people of diverse ethnicities, cultures and languages.

3. Inform consumers and professionals (e.g., consumers, caregivers, case managers, social workers, school counselors, therapists, physicians, hospitals, and other service providers) about *infomONTGOMERY*, as the gateway to behavioral health resources, using a deliberate, coordinated, and long-term outreach campaign, including targeted outreach to culturally and linguistically diverse populations in the County.

Policies and Protocols Subcommittee Recommendations:

1. Establish and fund an Integrated Care Consortium.
2. Establish a process and assign a high priority to the identification of specific measures that will alleviate the problem of insufficient and inadequate housing for persons with behavioral health problems.
3. Identify and implement specific measures that will reduce the barrier that transportation presents in access to care, housing, and supportive services for persons with behavioral health problems.

Coordinated Care Subcommittee Recommendations:

1. Identify funding for a study to create guidelines for a County-wide care coordination system (the study would be overseen by the Integrated Care Consortium, if formed).
2. Create and implement a pilot for a formalized, coordinated system of care addressing behavioral health (substance abuse and mental health), medical, and social needs of 300 adult consumers (18 years and older) who have a mental health diagnosis and *one* of the following – chronic homelessness as defined by the federal Department of Housing and Urban Development (HUD); minimal or no supports; multiple acute hospitalizations and/or emergency department (ED) visits; and/or multiple incarcerations.
3. Implement a Hub and Pathways Model for Care Management of Behavioral Health consumers.

The Montgomery County Collaboration Council for Children, Youth and Families is currently working on the implementation of the *infomONTGOMERY* Subcommittee recommendations. The other BHTF recommendations will be implemented when additional funding is obtained or efforts are aligned with existing initiatives.

Measurement and Evaluation

In 2013, the HMSC reconvened the Healthy Montgomery Data Project Team, a multi-sector collaborative of local data experts, which had developed the original core set of Healthy Montgomery indicators in 2011. In preparation for the 2015 community health needs assessment, the Data Project Team was charged with evaluating all the existing Healthy Montgomery indicators, scanning any newly available or updated indicators, and identifying an updated set of community indicators, including the establishment of a Healthy Montgomery Core Measure Set. At the conclusion of its work in 2014, the Data Project Team had identified 37 core measures that represent the six Healthy Montgomery priority areas, provide a distinct set of cross-cutting measures that support more than one priority area, and include measures that capture key social determinants of health in Montgomery County. The Core Measure set also aligns with the Healthy Montgomery hospital partners' Community Health Needs Assessments and related Implementation Plans. The 37 measures provide a quantitative snapshot of the Healthy Montgomery community health improvement efforts. Data related to those measures are included in this Report.

In 2014, the HMSC also convened the Measurement and Evaluation Subcommittee to identify measurement and evaluation approaches for Healthy Montgomery action planning and implementation. The Measurement and Evaluation Subcommittee includes members of the HMSC and their designated

representatives. It has assisted the Eat Well Be Active Partnership and the Behavioral Health Task Force in the development of driver diagrams and logic models for the purpose of measuring the impact of their implementation efforts. The Subcommittee also tracks the Healthy Montgomery core measures and develops and tracks performance measures. Currently, Subcommittee members are working on a report that will develop a common language for the types of data used in Healthy Montgomery, the uses of the data, and the subgroups that can be measured with available data sources, including sub-County geographies.

Healthy Montgomery Framework

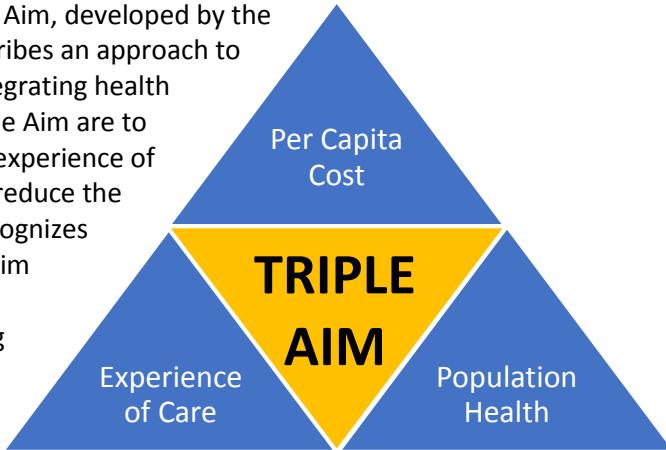
From the inception of the Healthy Montgomery work, the HMSC and the Healthy Montgomery work groups adopted an approach to the work that acknowledges the importance of addressing health equity and the underlying social, economic, and environmental factors that influence health outcomes. As noted above, health equity is prominent in Healthy Montgomery's goals and objectives. In this 2016 CHNA Report, there is a deliberate effort to continue to emphasize and further define those underlying factors of health and well-being, providing an informed context and framework for the priority-setting and action planning work ahead.

As the Healthy Montgomery work evolved in its first cycle, HMSC members also became aware of, and made a commitment to two additional approaches that will continue to frame the work as the new 2016-2019 cycle begins. One approach focuses on the effectiveness of collective impact. The collective impact approach is based on the concept that addressing complex health problems requires more than a single solution. It involves multiple sectors committing to a common agenda for solving a specific problem community-wide. Collective impact has five conditions that produce alignment and can lead to a powerful impact: a common agenda, shared measurement system, mutually reinforcing activities, continuous communication, and a backbone support organization.⁶



⁶ Kania J, Kramer M (2011). Collective Impact. *Stanford Social Innovation Review*, 9(1): 36-41

The second framework for action is the Triple Aim, developed by the Institute for Healthcare Improvement. It describes an approach to optimizing health system performance by integrating health care and population health. The goals of Triple Aim are to simultaneously work to: improve the patient experience of care, improve the health of populations, and reduce the per capita cost of health care.⁷ The HMSC recognizes that strategic application of the three Triple Aim goals across these six Healthy Montgomery priority areas, in the context of the underlying factors that determine health outcomes, can improve the health and well-being of the County's residents.



The Healthy Montgomery work is also conducted within the context of the requirements of the 2010 Patient Protection and Affordable Care Act (Affordable Care Act). Healthy Montgomery's hospital partners, active members and funders of the Healthy Montgomery community health improvement process, are currently required by the Act to conduct a community health needs assessment, including implementation plans on actionable strategies, every three years. They are also required by the Internal Revenue Service and the state of Maryland to submit an annual Community Benefit Report in order to maintain their non-profit status. DHHS provides, to each of the hospital systems, the Healthy Montgomery core measures, compiled locally using primary and secondary service area zip codes to reflect each of the hospital's Community Benefit Service Area for inclusion in the hospitals' CHNAs. The hospital partners, as a result of their participation in Healthy Montgomery, have formed a hospital work group that is committed to working with the HMSC toward a more aligned and joint effort at community health assessment.

Changes in Health Care Climate

There have also been notable changes in the health care climate, since the inception of the Healthy Montgomery work, related to passage of the Affordable Care Act and, in Maryland in particular, the work of the Maryland Health Services Cost Review Commission (HSCRC).

The nation's Affordable Care Act, when it passed in 2010, required states to establish and operate a health insurance exchange by 2014, or to participate in a federal exchange. In response, Maryland created the Maryland Health Connection, a marketplace for Maryland residents to enroll in health insurance plans. As required by the Affordable Care Act and Maryland law, consumer assistance organizations, or Connector Entities, were launched in 2013 to provide health coverage education, and eligibility and enrollment assistance⁸. In spite of the technical challenges in the first year of the program, there was a significant decrease in the rate of the uninsured in Maryland. The enrollment website (MarylandHealthConnection.gov) continues to improve in 2016 -- it is more mobile-friendly, has a streamlined application process, and has the ability to rate the quality of plans⁹. Marylanders also have more options in selecting dental coverage. While these enhancements are improvements to the

⁷ Berwick DM, Nolan TW, Whittington J. (2008). The triple aim: care, health, and cost. *Health Affairs* 27(3):759-69.

⁸ Maryland Health Benefit Exchange, Connector Entities, Accessed at: <http://www.marylandhbe.com/connectors-acses/connector-entities/>

⁹ 2015 Maryland Health Benefit Exchange Annual Report. Accessed at: <http://www.marylandhbe.com/wp-content/uploads/2015/11/MHBE-AnnualReport2015-Web.pdf>

enrollment system, these changes will most likely require more in-person interactions between consumers and those assisting with enrollment. Currently there are 1,500 trained experts (navigators, brokers, consumer assistance workers) statewide that provide free in-person assistance with enrollment⁴.

The Maryland Health Services Cost Review Commission (HSCRC) is an independent State agency that was formed in 1971 to regulate hospital rates paid by Medicaid and Medicare as well as all private insurers.¹⁰ Building on the possibilities this unique “all payer” system affords, in 2014 Maryland received one of the first State Innovation Model (SIM) grants from the federal Centers for Medicare and Medicaid Services. The goal of the grant is to modernize the all-payer system to enhance patient care, improve health outcomes, and lower costs. The modernization effort operates in conjunction with a number of other endeavors currently underway in Maryland, including efforts to strengthen primary care and coordinate hospital care with community care; map and track preventable disease and health costs; develop public-private coalitions for improved health outcomes; and establish regional partnerships. Built on decades of innovation and equity in health care payment and delivery, the model modernizes the “all payer” rate setting system. The goal is to attain a health care system that enhances patient care, improves health outcomes, and lowers costs.¹¹

The HSCRC also established the system for hospitals to report their community benefits activities. The narrative requirement of the Community Benefits Report component is intended to assist hospitals in critically reviewing their community benefit programs. Examination of the effectiveness of major program initiatives enables hospitals to better determine which programs are achieving the desired results and which are not.¹² With the FY2015 Narrative Requirements, there is an increased focus on:

- Collaboration with community partners in assessment of needs
- Partnerships in delivery
- Data supported initiatives
- Reach to target population
- Evaluation of outcomes—data supported
- Improvement of population health¹³

II. CHNA Purpose and Framework

The purpose of this CHNA Report is to identify 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 2016-2019 cycle. The information and data compiled for this assessment include the following sources:

- **Qualitative data**, gathered from County residents through a series of community conversations, are reported in the ***From the Community Conversations*** subsection of each of the Key Findings

¹⁰ See <http://www.hscrc.state.md.us/hscrc-stakeholders.cfm> and other tabs at this page. All of the tabs other than “HSCRC Home” relate to the modernization effort.

¹¹ Maryland Health Services and Cost Review Commission. Accessed at: <http://www.hscrc.state.md.us/hscrc-stakeholders.cfm>

¹² *Maryland Hospital Community Benefit Report: FY 2014*. Accessed at:

http://www.hscrc.state.md.us/documents/HSCRC_Initiatives/CommunityBenefits/cbr-fy14/FY14-MD-Hospital-Community-Benefits-Report.pdf

¹³ *HSCRC Community Benefits Reporting*. Presentation to the HMSC on March 2, 2015.

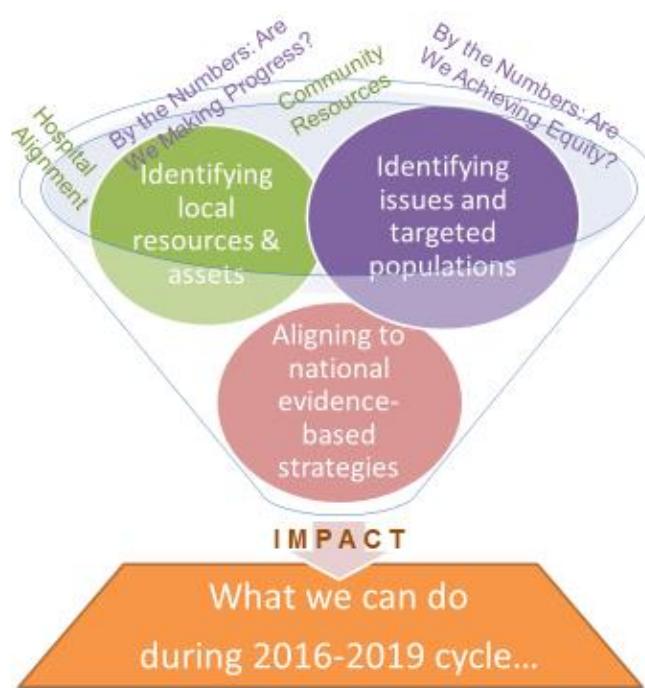
sections of the Report. The data are organized by the themes that emerged across the 15 public conversation sessions when residents were asked about assets and challenges to community health and well-being and about their ideas for strategies for improvement.

- In the **quantitative data** presented in the ***By the Numbers: Are We Making Progress?*** and ***By the Numbers: Are We Achieving Equity?*** subsections, Healthy Montgomery population-based public health data and trends describe socio-economic, access, clinical care, health and well-being status, health and well-being outcome characteristics; data are assessed against state and national benchmarks as well as evaluated for reducing health and well-being inequities among diverse populations in the County.
- **Hospital services and programs** targeted to specific populations are included in the ***Hospital Alignment*** subsections of the Report, primarily in table form, revealing the alignment or potential for alignment of efforts across the County's four hospital systems and in conjunction with the other community resources listed from other sectors.
- In the ***Community Resources*** subsection of the Key Findings sections of the Report, **existing programs and services** provided by County government agencies and other public and private organizations are compiled and organized by various sectors.
- In the ***What Works*** subsections of the Report, **nationally recognized evidence-based strategies** are provided relevant to the section topic area.

Finding synergy and potential alignment can be accomplished by: identifying targeted vulnerable populations and areas of focus from the community conversations and the population health data and trends; recognizing the potential for leveraging existing community resources; building upon existing or potential alignment with hospital CHNA efforts; and employing evidence-based strategies. Strategic review of the information and data compiled in this Report allows for the development of actionable ideas to consider for prioritization, action planning, and implementation. Based on the available

information in this Report, preliminary ideas for actions to consider for inclusion in the final Community Health Improvement Plan are included in the Report's Key Findings under the ***What We Can Do*** subsections of the Report.

This Report framework not only encourages the alignment of existing resources and the use of targeted, evidence-based strategies to impact community health but also emphasizes the underlying social,



economic and environmental factors that influence health and well-being outcomes and health equity. The Report's Key Findings, presented in the format described above, present data and information on the six Healthy Montgomery priority health areas (obesity, cardiovascular disease, diabetes, cancers,

behavioral health and maternal and infant health), the emerging health issue of heroin and other opioid misuse, and also on key underlying factors that affect health – equity, access to health care and health insurance, and healthy and safe community environments.

Using this Report

This Report provides needed information and data as well as a framework for approaching the Healthy Montgomery priority-setting process. It can also be used to inform the action planning that will culminate in Healthy Montgomery's Community Health Improvement Plan for 2016-2019, providing an aligned, targeted, evidence-based action plan that can be implemented and measured for impact within the three-year timeframe for this cycle.

III. Information Gathering for the CHNA

Qualitative Data Collection (Community Conversations)

Montgomery County residents had the opportunity to participate in the CHNA process by attending one of 15 public community conversations held at venues throughout the County from May 21, 2015 to October 10, 2015 (see Appendix I for community conversation meeting dates, number of participants, and hosting organizations). The purpose of the community conversations was to obtain the perspectives of a broad sample of County residents regarding health and well-being in the County. A total of 367 individuals participated in the community conversations. They represented diverse races/ethnicities (29% of the 300 participants who responded to a demographic survey were African American, 26% were non-Hispanic White, 22% were Asian, 15% were Hispanic/Latino; 8% responded as other, mixed race or did not provide an answer)¹⁴ and several distinct communities (including people with disabilities, seniors, youth, people experiencing homelessness, and the faith-based community). In addition, community conversations were held at County Regional Service Centers (Mid County, East County, Bethesda/Chevy Chase, and Up County) to attain geographic diversity. One of the community conversations was conducted in Mandarin, one in Korean, and another in Spanish; the remaining 12 conversations were conducted in English. (Additional socio-demographic information describing the community conversation participants can be found in Appendix II).

The input gathered from residents at the community conversations is a critical component of this Report. The input provides residents' perspectives regarding assets and challenges that affect health, as described in their own words and based on their personal experiences. In some cases, the residents' input supports the quantitative data findings and provides additional context. In other cases, the information gathered from residents describes additional issues and concerns that may be important to consider and respond to as the community health improvement process continues. It is important to note, however, that the information gathered from the community conversations is not generalizable to all residents in the County.

¹⁴ Percentages were rounded and therefore do not equal 100%.

The CHNA Advisory Committee was formed to help develop and guide the community conversation process and played a prominent role in helping to organize and, in some cases, host the community conversations. The Committee, which includes representatives from the four County hospital systems, the County's Minority Health Initiatives and Program, County public health and social agencies, and other community safety net service providers, met regularly to plan the community conversation process and monitor progress. CHNA Advisory Committee members, along with the hosting organization and Healthy Montgomery partners, helped to promote the community conversations to residents through web postings, emails, flyers, announcements at meetings and word-of-mouth.

The community conversations were facilitated discussions that ranged from one to two hours in length, depending upon the circumstances and the participants. Experienced facilitators, identified by Healthy Montgomery staff and the County's minority health Initiatives and program, were hired to lead the community conversations using a facilitator's guide that was developed with input from the CHNA Advisory Committee.

While the community conversations were structured and facilitated, the format encouraged a supportive environment for natural discussion and enabled the facilitators to make allowances for specific group dynamics. Each conversation started by welcoming the participants and providing an overview of the CHNA process, and explaining the purpose of the community conversation. After establishing group ground rules, the facilitator began the conversation with a discussion about the group's understanding of health and well-being. Participants were encouraged to think in terms of the broader community and not their personal health. Participants were then asked to identify community assets (i.e., services, activities, and other characteristics of their community) supportive of a healthy community and a sense of well-being. The facilitator then asked participants to identify challenges to health and well-being. Finally, participants were asked to identify practical steps to improve the health and well-being of their communities. When possible, participants prioritized their suggestions for improvement via voting.

For large community conversations, there were table breakout sessions for each aspect of the discussion and responses were recorded at the tables and then reported out to the larger group. Notes from the large group discussions and table breakout sessions were recorded on flip charts by staff who assisted the facilitator. Participants were also asked to complete an anonymous demographic form and were given the opportunity to record final thoughts or feedback about the conversation on a second form.

The facilitators, using flip chart notes from the community conversations, compiled a summary report listing the assets, challenges, and strategies for improvement identified by the community conversation participants. Facilitator reports were mined to identify key themes that emerged across the conversations in terms of the assets, challenges, and strategies for improvement. Key theme areas identified are: Community Resources and Services, Health and Health Care, Transportation, Housing, Access to Healthy Food, Parks and Recreation, Education, Business/Economy, Public Safety, Equity, and County Governance and Community Advocacy. (Appendix III provides a table that offers a visual summary of the key themes discussed either as an asset, challenge, or strategy for improvement across the community conversations).

These findings from the community conversations are included in the "From the Community Conversations" subsections of each of the Key Findings sections of this Report. Findings relevant to each section's topic area are categorized under the themes noted above as well as by assets, challenges and strategies for improvement. The community conversation themes, which identify issue areas for community health improvement, provided a standardized framework for organizing information gathering required for the other Report sections. Summary reports from each of the 2015 Healthy

Montgomery Community Conversations are available on the Healthy Montgomery website at:
<http://www.healthymontgomery.org/index.php?module=Tiles&controller=index&action=display&alias=chnacommunityconversations>.

Quantitative Data Collection

"A common set of health status metrics can facilitate comparisons across populations, promote collaboration between organizations conducting assessments, assist in establishing a shared understanding of the factors that influence health, and help to galvanize residents to work collaboratively to improve community health."

- U.S. Centers for Disease Control and Prevention

Population health measures play a critical role in community health needs assessments¹⁵ by providing a common set of measures that can be benchmarked, compared with and across select population groups, and monitored over time to evaluate progress. Key measures include those that describe health status, health outcomes, clinical care, risk behaviors, protective factors, and social determinants of health.

The quantitative findings in this report are based on the results of a process where Healthy Montgomery devised its 37 Healthy Montgomery Core Measures Set. These measures provide the quantitative snapshot of the Healthy Montgomery community health improvement efforts.

Background

In May 2013, the Healthy Montgomery Steering Committee approved the reconvening of the Healthy Montgomery Data Project Team to accomplish the following:

- Review and establish indicator selection criteria for 2013 environmental scan process;
- Using established criteria, review existing indicators on Healthy Montgomery and identify any indicators that are no longer a high-priority for inclusion going forward (proposed deletions);
- Using established criteria, conduct a review of new community indicators and/or data sources that became available since the 2009-2010 selection process that should be considered for inclusion for the 2014 needs assessment (proposed additions); and
- Draft and submit a candidate set of indicators (measures) for review and consideration by the Healthy Montgomery Steering Committee by December 2013.

In July 2013 the Healthy Montgomery Data Project Team convened its multi-sector collaborative of local data experts and began its process to evaluate all Healthy Montgomery Community Dashboard Indicators available on the www.HealthyMontgomery.org website, and scan all new and updated indicators that had become available since the 2009-2010 inaugural process that established the Healthy

¹⁵ U.S. Centers for Disease Control and Prevention. *Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants*, Atlanta, GA: Office of Surveillance, Epidemiology, and Laboratory Services, 2013. Accessed at <http://stacks.cdc.gov/view/cdc/20707> on November 30, 2015.

Montgomery Community Dashboard Indicators. This process ultimately identified an updated set of community indicators, which included the establishment of the Healthy Montgomery Core Measures Set.

Healthy Montgomery Core Measures Set

Healthy Montgomery Core Measures Set

Behavioral Health

- Adolescent and Adult Illicit drug Use in Past Month
- Adults with Any Mental Illness in Past year
- ER Visits for Behavioral Health Conditions
- Suicide

Cancers

- Colorectal screening
- Pap in past 3 years
- Prostate cancer incidence
- Breast cancer mortality

Cardiovascular Health

- Heart disease mortality
- Stroke mortality
- High blood pressure prevalence

Cross-Cutting Measures

- Adults who have had a routine check-up
- Persons without health insurance
- Adults in Good Physical Health
- Adults in Good Mental Health
- Students in Good General Health
- Students ever feeling sad or hopeless in past year
- Adults who smoke
- Students current cigarette use
- Adults engaging in moderate physical activity
- Adult fruit and vegetable consumption
- Adults who are overweight or obese
- Students with no participation in physical activity
- Students who drank no soda or pop in the past week
- Students who are overweight or obese

Diabetes

- Adults with diabetes
- ER visits for diabetes

Maternal & Infant Health

- Mothers who received early prenatal care
- Infant mortality
- Babies with low birthweight

Obesity

See Highlighted Cross-Cutting Measures

Context Measures (SDOH)

- Families Living Below Poverty Level
- Residents 5+ years old that report speaking English "not very well"
- Students ever receiving free and reduced-price meals (FARMS)
- Adults with Adequate Social and Emotional Support

- Students who could talk to adult besides a parent
- Student participation in extracurricular activities
- High School Completion Rate

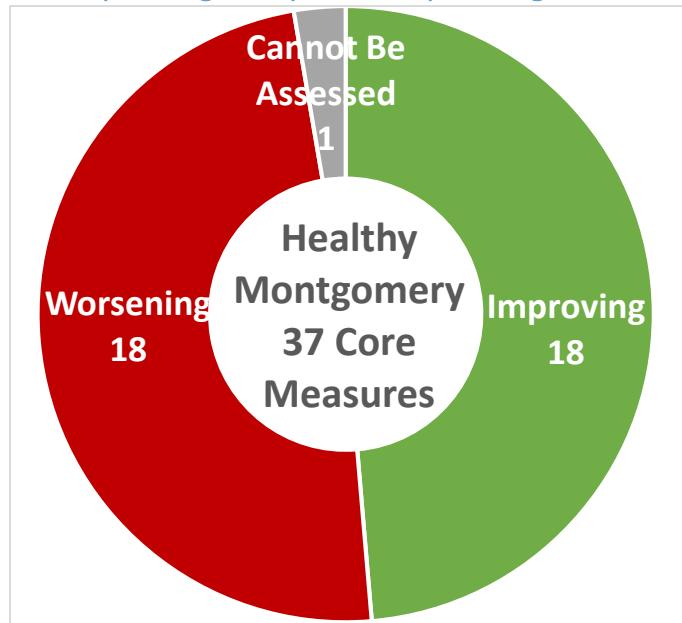
At the conclusion of its process, the Healthy Montgomery Data Project Team identified 37 measures that accomplished the following:

- Represented the six Healthy Montgomery priority areas identified in the 2011 priority-setting process, provided a distinct set of cross-cutting measures within the Healthy Montgomery Core Measures Set that supported more than one priority area, and included measures that captured key social determinants of health in Montgomery County;
- Aligned with Montgomery County's six not-for-profit hospital's individual Community Health Needs Assessments (CHNAs) and related Implementation Plans (IPs);
- Illustrated areas where Montgomery County both needs to make improvements and has actionable strategies within our community sectors to achieve positive impacts;
- Highlighted areas where there are known disparities and/or inequities that can be reduced and/or eliminated; and

- Included metrics that are part of the Maryland State Health Improvement Process (MD SHIP), Robert Wood Johnson's County Health Rankings (RWJF CHR), and the national Healthy People 2020 benchmarks (HP2020).

On the Healthy Montgomery website, www.healthymontgomery.org, all 37 Healthy Montgomery core measures are presented in detail. This online resource provides detailed documentation on each measure as well as the most recent data for subgroup comparisons and benchmarking to state and federal efforts (including MD SHIP Goals, HP2020 Targets). (The diagram above summarizes the Core Measures Set).

Healthy Montgomery Summary of Progress, 2009-2015



This section summarizes results from the Healthy Montgomery Core Measures Set, the scorecard for the Healthy Montgomery initiative's progress during its inaugural cycle 2009-2015.

Are We Making Progress?

Among the 37 Healthy Montgomery Core Measures half (18) are improving and half (18) are worsening. One measure could not be assessed since it has had no further updates after its baseline result.

All 10 measures that were also Maryland SHIP measures have already met Maryland SHIP 2017 goals.

Of the 16 measures that could be

benchmarked with Healthy People 2020, 9 had already met their Healthy People 2020 targets, while 7 did not meet their HP2020 targets. Please see Appendix IV, Healthy Montgomery Core Measures: 2016 Results, for more data details on progress for each measure as well as its state and national benchmarking results.

Are We Achieving Equity?

Detailed data summaries are provided in Appendix V, Summary of Results from Healthy Montgomery Core Measures, where specific differences between groups by gender, age, and race/ethnicity are provided for each of the 37 core measures.

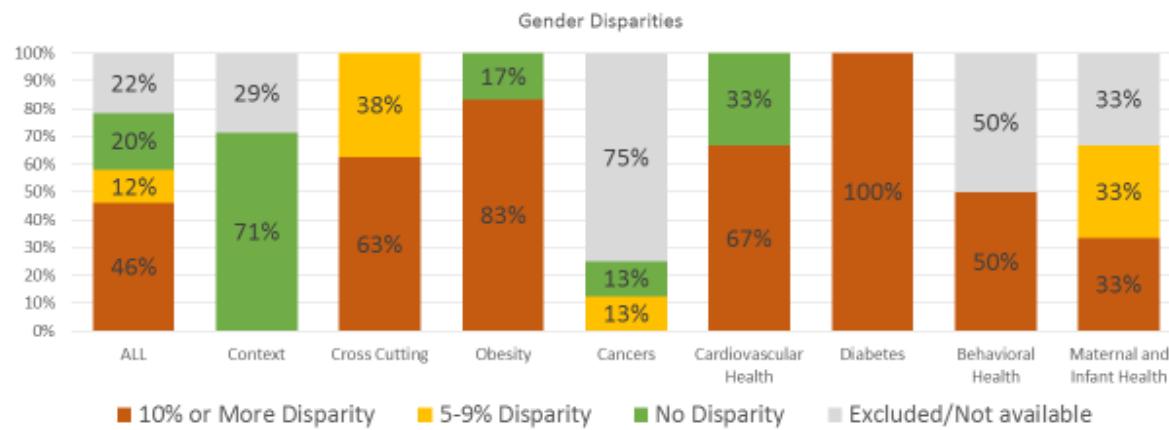
In the figure below the number at the top of each race/ethnicity column reflects the total number of core measures that reported results for that sub group. The proportion of those counts is reflected in the percent widening, narrowing or showing no change. Of the 34 measures that could evaluate differences across racial/ethnic subgroups, 32 measures had results for Black/African American residents. Results showed Black/African American residents experiencing a widening disparity 38% of the time, the highest proportion of measures across all racial/ethnic groups. Black/African American residents also had the highest proportion of core measures with results that showed their disparity was narrowing at 63%.

Progress Made by Healthy Montgomery Core Measures to Narrow Racial/Ethnic Disparities



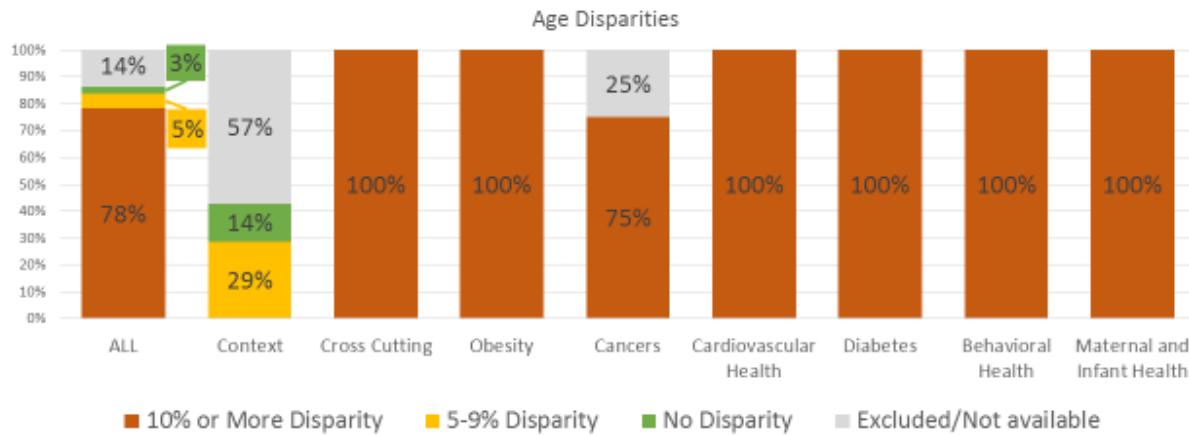
Differences were also noted by gender. - Almost half of the 37 core measures identified gender-related disparities. The largest gender specific differences were in diabetes, obesity, cardiovascular health and behavioral health (mental health and substance abuse).

Percent of Healthy Montgomery Core Measures with Gender-Related Disparities



Across all core measures, with the exception of community context measures (where only 3 out of the 7 measures are designed to measure person-level characteristics) all key areas of Healthy Montgomery showed most, if not all, measures with an age-related disparity.

Percent of Healthy Montgomery Core Measures with Age-Related Disparities



Progress by Healthy Montgomery Priority Areas

The table below provides a summary of progress for each Healthy Montgomery Priority Area. Only one measure – the percent of students who described their health as very good or excellent – could not be assessed since it was not collected in the Fall 2014 after its baseline was measured in the Spring 2013 using the Maryland Youth Tobacco and Risk Behavior Survey. Detailed findings on all Healthy Montgomery Core Measures in this section can be found in Appendices V and VI.

The table below illustrates in each Healthy Montgomery Priority Area that progress and further improvement is needed. Best progress was among context (5 out of 7 measures) and cross-cutting (excluding obesity-related measures) (also 5 out of 7 measures). Worst progress was among behavioral health (0 out its 3 measures) and diabetes (0 out of 2 measures).

Priority Area	Improving Measures (18)	Worsening Measures (18)
Context	Percent of families below federal poverty level Percent of adults with needed social/emotional support Percent of students comfortable seeking help from adults besides parents Percent of adults with at least a high school diploma/GED Percent of population 5+ years that report not speaking English only and speaking English less than very well	Percent of students participating in any extracurricular activities Percent of students currently receiving FARDS
Cross-cutting	Percent of adults with routine checkup in past 2 years Percent of residents without health insurance coverage Percent of adults with 2 or fewer poor mental health days last month Percent of adults that currently smoke Percent of students that currently smoke	Percent of adults with 2 or fewer poor physical health days last month Percent of students who felt sad/hopeless daily for 2+ weeks in the past year that they stopped doing usual activities
Cross-cutting (Obesity)	Percent of adults doing recommended aerobic activity Percent of students that drank no soda or pop in the past week	Percent of adults consuming 5+ servings of fruits and vegetables daily Percent of overweight or obese adults Percent of students with no physical activity in the past week Percent of overweight or obese students
Behavioral Health		Suicide rate (age-adjusted) Behavioral health emergency room visit rate (age-adjusted) Percent of adults with major depressive episode in past year Percent of adolescents and adults with Illicit drug use in the past month

Priority Area	Improving Measures (18)	Worsening Measures (18)
Cancers	Prostate cancer incidence rate (age-adjusted)	Percent of adults 50+ years with recommended colorectal screenings (fecal occult blood test, colonoscopy, or sigmoidoscopy)
	Female breast cancer mortality rate (age-adjusted)	Percent of women with pap smear in past 3 years
Cardiovascular Health	Heart disease mortality rate (age-adjusted)	Percent of adults told they have high blood pressure by doctor
	Stroke mortality rate (age-adjusted)	
Diabetes		Percent of adults ever being diagnosed with diabetes (excluding gestational diabetes)
		Diabetes-related emergency room visit rate (age-adjusted)
Maternal and Infant Health	Infant mortality rate	Percent of births with mothers receiving first trimester prenatal care
	Percent of births with low birthweight	

Major Healthy Montgomery Data Sources

Appendix VI (Healthy Montgomery Major Data Sources) summarizes the major data sources used to compile the updated set of measures that are tracked in the Healthy Montgomery Core Measures Set. Details included are the data source acronym; periodicity of data collection; availability of standardized population attributes for subgroup reporting and comparisons (gender, age, race, ethnicity, income, educational attainment); and reportable geographies (national, state, county, zip code, census tract, census block, school enrollment area, and other).

Integrating Data into Key Findings

By The Numbers: Are We Achieving Progress?

As part of the Key Findings summary presented for each Healthy Montgomery priority area, data have been compiled to summarize the trends observed for any related Healthy Montgomery Core Measures. Trends, assessment on progress, and comparisons to state and national benchmarks are summarized. More details on specific measurements and their interpretation are provided in Appendix V (Summary of Results from Healthy Montgomery Core Measures) of this report.

Progress was assessed by considering the percent change over time, that is, the difference from the baseline year to the most current value, divided by the baseline value, and reported as a percent (multiplied by 100). The percent changes are computed to quantify the size of the change or difference over the reporting period.

Progress results also ascribe whether the change constitutes an increase, decrease, or no change. Based on the desired direction of the measure, the change is described as improving, worsening, or no change.

Measures with only baseline data will not have any progress to report but could have information on differences within comparable subgroups.

Benchmarking provides comparisons to the goals, targets, and rankings from each applicable measure in the Maryland State Health Improvement Process (MD SHIP) 2017 Goals¹⁶, Healthy People 2020 (HP2020) Targets,¹⁷ and Robert Wood Johnson Foundation County Health Rankings (CHR) for Maryland¹⁸ wherever appropriate comparisons can be made with measures comparable to those used in the Healthy Montgomery Core Measures Set.

By The Numbers: Are We Achieving Equity?

In addition to noting progress for the measures overall, a summary is also provided that describes the extent of disparities – or differences – between comparison groups. This section describes differences noted by:

- Gender (male, female)
- Age (infants, children, adolescents, young adults, adults, older adults)
- Race (American Indian/Alaska Native, Asian or Pacific Islander, Black or African American, and White)
- Hispanic Origin (Not Hispanic/Latino and Hispanic/Latino)

Percent differences and disparity ratios were computed to characterize differences between groups.

Disparity ratios were computed across comparison groups based on identifying the sub-group with the best result and dividing its result value into the result value of the other subgroup results. For measures where **smallest** value is the **best** value, ratios will be larger than one (e.g. 1.56, 12.4, 128) when a disparity is present. For measures where the **largest** value is the **best** value, ratios will be smaller than one when a disparity is present (e.g. 0.12, 0.40, 0.93). When the disparity ratio equals or approximates one (0.99, 1.02, 1.00), there is no disparity - the groups are relatively the same (equal).

The disparity ratio values with more than one measurement period were additionally assessed to see if there were changes in the disparity ratios over time that increase (widen the gap) or decrease (narrow the gap) the size of the disparities noted. Inequities – or differences between groups that are inherently unfair rather than biologically driven – are noted in all areas where present.

In addition to the summary scorecard, to facilitate the summary of the more detailed interpretations of the results by subgroups, benchmark comparisons, and overall progress, Appendix V (Summary of Results from Healthy Montgomery Core Measures) provides detailed indications of progress, explanations behind disparity flags, and interprets benchmark comparisons where appropriate.

Community Resources

Another important part of the information gathering for the CHNA included cataloguing existing resources or assets (e.g., programs and services) provided by Healthy Montgomery partners including

¹⁶Maryland Department of Health and Mental Hygiene. Maryland State Health Improvement Process. Accessed at: <http://dhmh.maryland.gov/ship/Pages/home.aspx>

¹⁷ U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. 2020 Topics and Objectives. Accessed at: <https://www.healthypeople.gov/2020/topics-objectives>

¹⁸ County Health Rankings and Roadmaps. Accessed at: <http://www.countyhealthrankings.org/app/maryland/2015/overview>

County government agencies and other public and private organizations, related to the six Healthy Montgomery priority areas. Documenting community resources identifies opportunities to leverage and align existing resources to improve community health and uncovers resource gaps.

Cataloguing the existing community resources was accomplished primarily by surveying HMSC members. Members were asked to complete a survey on behalf of the organization they represent. (HMSC members representing the County's hospital systems received a separate survey discussed below.) The survey asked the members to list the existing resource, note which of the six priority health issue areas the resource impacts, and report on any efforts to measure health impact (the information gathered on measuring impact is not included in the Report but will be available for use during the upcoming action planning stage of the community health improvement process). The survey also asked HMSC members to identify emerging health issues, not included among the six Healthy Montgomery priority areas, for possible inclusion in the CHNA report. They also listed any resources their organization provides to address the emerging issue.

The survey responses were categorized by the six Healthy Montgomery priority areas and emerging issues identified. Healthy Montgomery staff used the compiled information to create templates for each of the six priority areas. Each template listed the resources and the evidence-based strategies addressing the related priority areas (see the discussion below regarding evidence-based strategies). The templates were sent to content area experts involved in Healthy Montgomery either as a HMSC member, a CHNA Advisory Committee member, or a member of a Healthy Montgomery work group. The experts were asked to align listed resources to appropriate evidence-based strategies and to also add any Community resources not already listed. This process identified those Community programs and services that are evidence-based but also identified some additional Community resources related to the six Healthy Montgomery priority areas and emerging issues.

The compilation of resources used in this Report is quite extensive but not exhaustive because the information, for the most part, was obtained from the HMSC members and some additional partners. It is important to note that, because the business sector is not currently represented on the HMSC, the community resources collected for the Report that pertain to that sector are minimal and largely incomplete.



As noted elsewhere, Healthy Montgomery partners were surveyed and asked to identify emerging health issues for possible inclusion in the CHNA report – issues not included among the six Healthy Montgomery priority areas. Several emerging issues were reported: heroin and other opioid misuse, oral health, health literacy, and health care for the uninsured. The issues of oral health, health literacy, and health care for the uninsured are included in the Underlying Factors – Health and Health Care of this Report. A section devoted to heroin and other opioid misuse is included within the Behavioral Health Key Findings section. These sections are noted with the symbol used here to denote each contains content related to an identified emerging issue.

To gather information related to community resources for the Heroin and Other Opioid Misuse section, Healthy Montgomery staff worked with content area experts in the Montgomery County Department of Health and Human Services. They provided reports and other resources from which information about related community resources and evidence-based strategies could be obtained. The *infoMONTGOMERY* database was also queried to identify additional information.

It was also necessary to conduct additional research to identify community resources for the Underlying Factors Key Findings Sections of the Report. The *infoMONTGOMERY* database, the County's operating

budget website¹⁹, and an Internet search were used to identify community resources relevant to those sections of the Report.

The community resources are listed in the *Community Resources* subsections of each of the Key Findings sections of this Report. They are categorized by the following sectors: State and Local Government; Early Learning Centers, Schools, Colleges and Universities; Health Care Systems, Insurers and Clinicians; Businesses and Employers; and Community, Non-profit and Faith Based Organizations. These categories reflect the way in which the National Prevention Strategies organizes its recommended prevention strategies and is used in this Report both to categorize the *Community Resources* subsections of the Report's Key Findings and present the evidence-based strategies listed in the *What Works* subsections of each of the Key Findings sections.

Alignment with Hospital CHNA and Implementation Plans

Identifying and highlighting the potential for aligning the Healthy Montgomery work with the community health initiatives of the County hospital systems is an important objective of the CHNA process. Therefore, the Healthy Montgomery hospital partners were queried several times to provide information about their programs and services. Initially, to gather information on the community resources related to the six Healthy Montgomery priority health issue areas provided by the hospitals, a survey was sent to Healthy Montgomery's hospital partners. Similar to the survey sent to other HMSC members (described above), the survey asked the hospitals to list resources related to the six priority areas and efforts to measure health impact. Additionally, the hospitals were asked to identify the target population for the resources and note if the resources are included in their hospital's community benefits implementation plan. The information provided was categorized by the priority issue area, and then compiled into the Report.

The community resources information collected from the hospitals is found in the *Hospital Alignment* subsection of the Key Findings sections of the Report. Most often the resources are presented in table form, showing the ways in which the programs and services are aligned or have the potential to be aligned across hospital systems and in conjunction with the other community resources listed from other sectors.

An additional request for information was made of the hospitals for the Key Findings Section, Underlying Factors – Health and Health Care. In that case, a matrix listing evidence-based strategies for addressing access to health care, health literacy issues, and coordinated care was sent to the hospitals with the request that they list their hospital programs and services consistent with those strategies. Those resources are also presented in table form in the *Hospital Alignment* subsection of that Key Findings section of the Report.

Evidence-Based Strategies

Knowing what works to improve community health is central to the Healthy Montgomery priority-setting process and action planning. Therefore, evidence-based strategies are included among the Key Findings of this Report relevant to the six Healthy Montgomery priority areas, Heroin and Opioid Misuse, and the underlying determinants of health (e.g., issues of equity, access to care, the built environment). Consideration of these evidence-based strategies, within the context of the information gathered from County residents, the Healthy Montgomery core measures data measuring progress, and the existing

¹⁹ Office of Management and Budget. Montgomery County, MD. <https://reports.data.montgomerycountymd.gov/omb>

community resources and hospital community health initiatives, allowed for the generation of preliminary ideas for action listed in the *What We Can Do* subsections of the Report's Key Findings sections.

The evidence-based strategies contained in the Report come from several nationally recognized sources including the U.S. Surgeon General's *National Prevention Strategy*²⁰, the Centers for Disease Control and Prevention's (CDC's) *Guide to Community Preventive Services* (the *Community Guide*)²¹, and the U.S. Preventive Services Task Force's *Guide to Clinical Preventive Services*.²² These were selected because of their broad acceptance as nationally-recognized sources for evidence-based strategies and because their recommendations are cross-sector, reflecting the diverse sectors represented by the HMSC members. In addition, the *National Prevention Strategy*'s "four strategic directions," meant to provide "a strong foundation for all of our nation's prevention efforts" are concerned with issues of equity, healthy and safe communities, empowering people, and access to health care and preventive services and are consistent with this Report's focus on the underlying determinants of health.

Several additional sources of evidence-based strategies were used for some of the topic areas in order to acknowledge existing national and state -level prevention efforts and also to provide targeted recommendations on certain topics. Recommendations from the *Maryland Comprehensive Cancer Control Plan*, a publication of the Maryland Department of Health and Mental Hygiene, are included in the Obesity and Cancer Key Findings sections of the Report. In the Underlying Factors – Equity section the U.S. Interagency Council on Homelessness's *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* and the *Montgomery County Ten Year Plan to End Homelessness* are referenced.

In the Underlying Factors – Health and Health Care Key Findings section, the U.S. Department of Health and Human Services' *National Action Plan to Improve Health Literacy*²³ and *National Culturally and Linguistically Appropriate Services in Health and Health Care*²⁴ (CLAS standards) provide additional recommendations on the topic of health literacy. For the Heroin and Other Opioid Misuse Key Findings section of the Report, several additional publications provide targeted recommendations including: the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration's (SAMHSA's), *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*²⁵ and *Opioid Overdose Prevention Toolkit*²⁶, and from the Johns Hopkins Bloomberg School of Public Health, *The Prescription Opioid Epidemic: An Evidence-Based Approach*.²⁷

²⁰ U.S. Surgeon General, U.S. Department of Health and Human Services. *National Prevention Strategy*. Accessed at: <http://www.surgeongeneral.gov/priorities/prevention/strategy/index.html>

²¹ Centers for Disease Control and Prevention. *Guide to Community Preventive Services*. Accessed at: <http://www.thecommunityguide.org/>

²² U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services*. Accessed at: <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/index.html>

²³ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *National Action Plan to Improve Health Literacy*. Accessed at: <http://health.gov/communication/initiatives/health-literacy-action-plan.asp>

²⁴ U.S. Department of Health and Human Services, Office of Minority Health. *National Culturally and Linguistically Appropriate Services in Health and Health Care* Accessed at: <https://www.thinkculturalhealth.hhs.gov/content/clas.asp>

²⁵ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*. Accessed at: http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf

²⁶ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. *Opioid Overdose Prevention Toolkit*. Accessed at: <http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2016/SMA16-4742>

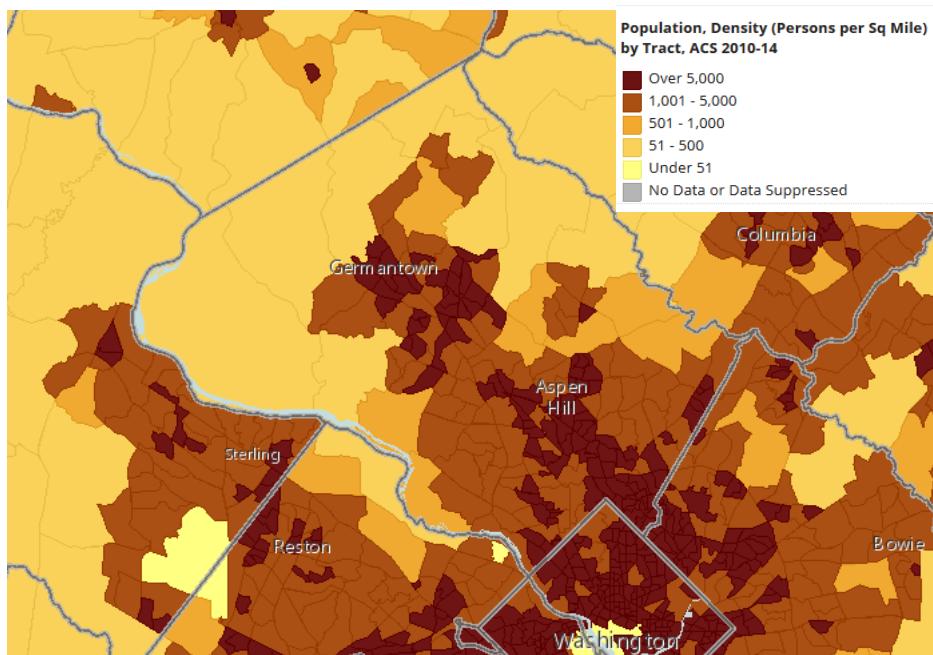
²⁷ Johns Hopkins Bloomberg School of Public Health. *The Prescription Opioid Epidemic: An Evidence-Based Approach*. Accessed at: <http://www.jhsph.edu/research/centers-and-institutes/center-for-drug-safety-and-effectiveness/opioid-epidemic-town-hall-2015/2015-prescription-opioid-epidemic-report.pdf>

IV. Overview of Montgomery County

Socio-Demographics

Montgomery County is the largest jurisdiction in Maryland, spanning 492.92 square miles.²⁸ It is located on the northern border of our Nation's capital. The County has nineteen municipalities. Since 1948, it has had a home rule charter form of government with a County Executive and County Council.²⁹

The County is also the most populous in the State with an estimated population of 1,040,116 in 2015.³⁰ It is home to 17.2% of Maryland's total population.³¹ Suburbanization has contributed to a high population density of nearly 2,000 people per square mile, about 22 times greater than the national average of 88.93, with the greatest concentration of people residing in the Gaithersburg, Rockville,



North Bethesda, and Silver Spring areas.³² Although the overall percent population change for the County has slowly declined since 2010, the Department of Planning anticipates population growth to 1,075,000 by 2020 and 1,141,000 by 2030.^{33,34} A growing elderly population has yielded a decline in the proportion of residents ages 25 to 54 years and an increase in residents between the age of 65 to 74 years, and those

85 years and over; the median age, however, remains unchanged at 38.6 years.³⁵ Overall, the number of children under 19 years has decreased slightly.³⁵

The County is also one of the most highly educated counties in the United States, and is second to Howard County which ranks highest in the state.³⁶ Of the County population 25 years and over, an

²⁸ Community Commons, ACS 2010-2014. Accessed at: <http://www.communitycommons.org>

²⁹ Maryland Manual On-Line. Accessed at: <http://msa.maryland.gov/msa/mdmanual/36loc/mo/html/mo.html>

³⁰ U. S. Census Bureau. Quick Facts. Accessed at: <http://www.census.gov/quickfacts/table/PST045215/24031>

³¹ U.S. Census Bureau. American Community Survey 2014. *Demographic and Housing Estimates*. Accessed at: http://planning.maryland.gov/msdc/American_Community_Survey/2014ACS.shtml

³² Community Commons, ACS 2010-2014. Accessed at: <http://www.communitycommons.org>

³³ U.S. Census Bureau. American Community Survey 2010-2014. Accessed at:

http://planning.maryland.gov/MSDC/American_Community_Survey/2010-2014ACS.shtml

³⁴ Maryland Department of Planning. Accessed at: http://planning.maryland.gov/msdc/S3_Projection.shtml

³⁵ U.S. Census Bureau. American Community Survey 2014. Accessed at:

http://planning.maryland.gov/msdc/American_Community_Survey/2014ACS.shtml

estimated 90.9% are high school graduates or higher, 58.5% have earned a bachelor's degree or higher, and 31.6% have a graduate or professional degree.³⁷

Montgomery County is one of the most affluent counties in the United States, and the second most affluent county in the State.³⁸ The County's high economic performance in economic growth and stability is attributed to several factors including its accessibility to neighboring jurisdictions and increases payroll employment (1.1% increase in employees working in the County), and resident employment (0.7% increase in employed residents).³⁹ Increased sale of existing homes, residential construction, and per capita personal income, combined with a declining unemployment rate, suggest continued economic growth and stability.³⁹ However, while none of the cities in the County rank highest (very poorly) on the Community Needs Index (CNI), areas with a CNI ranking from mild to second highest indicate vulnerable populations with urgent needs to be addressed in specific geographic communities. Residents facing substantial economic challenge are mostly residing in the Gaithersburg, Rockville, Germantown, Burtonsville, Montgomery Village, Silver Spring, Takoma Park areas.⁴⁰ Based on the 2012 self-sufficiency standard for Maryland, the annual income required for a family of three to live in the County without financial assistance is \$77,933 (2012).⁴¹

Since 2010, the unemployment rate has declined from 5.2% to an estimated 4.7% of the civilian labor force unemployed in 2014.⁴² The percentage of people who are private wage and salary workers (72%) and the percent of residents receiving private health insurance coverage (75%) demonstrate the presence of many private-sector employers.⁴³ Proximity to many employers and businesses allows for a mean commute time of 34.3 minutes.⁴⁴

Overall, single female-headed households make up 12% of householders in the County and 21% of families living under the Federal Poverty Level (FPL).⁴⁵ Generally, the percent of County residents experiencing poverty has been significantly less than the state and the nation since 1997.⁴⁶ However, there are many people in Montgomery County with complex needs such as children experiencing

³⁶ U.S. Census Bureau. 2014 American Community Survey 1-Year Estimates. All County Comparison. Accessed at: http://planning.maryland.gov/msdc/American_Community_Survey/2014/comparison/All_Cnty_Comparison_ACS2014.xlsx

³⁷ U.S. Census Bureau. 2014 American Community Survey 1-Year Estimates. *Selected Social Characteristics in Maryland*. Accessed at: http://planning.maryland.gov/msdc/American_Community_Survey/2014ACS.shtml

³⁸ Maryland Department of Planning, Planning Data and Analysis. U.S. Census Bureau, 2010 – 2014 American Community Survey. Accessed at: http://planning.maryland.gov/msdc/American_Community_Survey/2010-2014/Maps/MHHinc_2010_2014.pdf

³⁹ Montgomery County Maryland. Comprehensive Annual Financial Report FY 2015. Accessed at: www.montgomerycountymd.gov/finance/resources/files/data/financial/cafr/FY2015_CAFR.pdf

⁴⁰ Truven Health Analytics, 2015; Insurance Coverage Estimates, 2015; The Nielson Company, 2015; and Community Need Index, 2015. Dignity Health 2016. Accessed at: <http://cni.chw-interactive.org/>

⁴¹ The Self-Sufficiency Standard for Maryland 2012. Accessed at: http://www.montgomeryplanning.org/research/housing/rental_housing_study/documents/MD12-SSS-Final-Print-012412.pdf

⁴² U.S. Census Bureau. American Community Survey 2010 and 2014. Accessed at: http://planning.maryland.gov/msdc/American_Community_Survey/2010ACS.shtml and http://planning.maryland.gov/msdc/American_Community_Survey/2014ACS.shtml

⁴³ U.S. Census Bureau. American Community Survey 2014. Accessed at: http://planning.maryland.gov/msdc/American_Community_Survey/2014ACS.shtml

⁴⁴ U.S. Census Bureau. American Community Survey 2014. Accessed at: http://planning.maryland.gov/msdc/American_Community_Survey/2014ACS.shtml

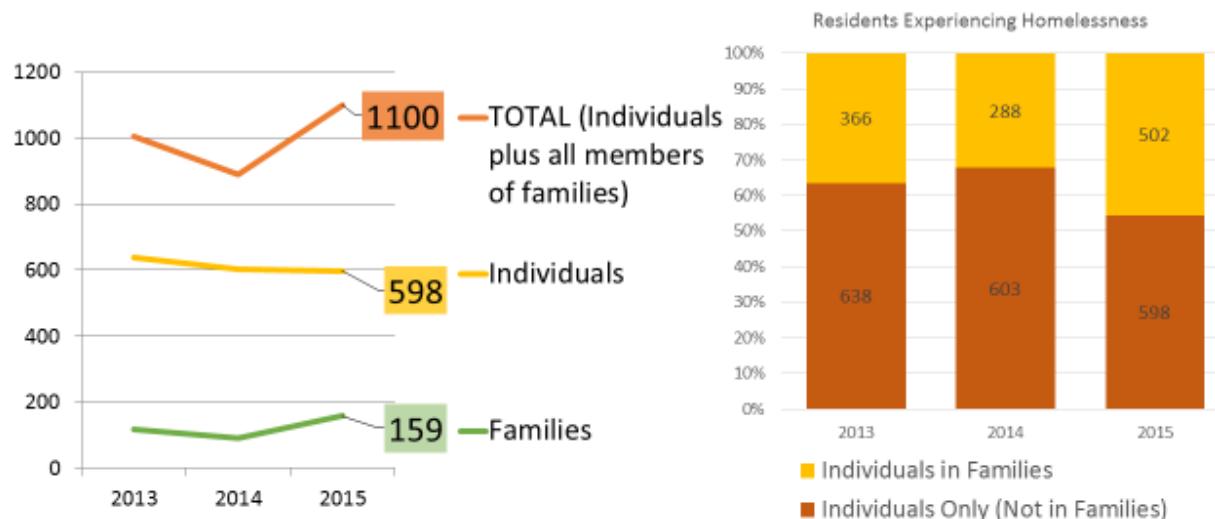
⁴⁵ U.S. Census Bureau. American Community Survey 2014. Accessed at: http://planning.maryland.gov/msdc/American_Community_Survey/2014ACS.shtml

⁴⁶ US Census Bureau, Small Area Income and Poverty Estimates. Accessed at: http://www.census.gov/did/www/saipe/data/interactive/saipe.html?s_appName=saipe&map_yearSelector=2014&map_geoSelector=mhi_c&s_county=24031&s_state=24&s_measures=5_17_fam_snc&menu=trends&s_inclStTot=y&s_USStOnly=n&s_inclStTot=y#view=Mapping

poverty, residents experiencing income inequality, residents with severe housing problems, and residents with a disability.⁴⁷ Further, indicators of need, such as the significant change in percentage of people with food stamp/Supplemental Nutrition Assistance Program (SNAP) benefits and public assistance, have increased since 2010.⁴⁸

With respect to home ownership, almost two-thirds of homes in the County are owner-occupied, while the rest are renter occupied, both with average household size ranging from 2-3 people and a median of 6.3 rooms per unit.⁴⁹ Housing units without a mortgage have a higher monthly rent-to-income ratio compared to those with a mortgage.⁵⁰

Residents Experiencing Homelessness, Montgomery County, 2013-2015



In 2015, a total of 1,100 residents experiencing homelessness were counted- 598 individuals and 502 individuals in families experiencing homelessness. This total number is a 10% increase from 2013 where 1004 residents were identified as experiencing homelessness. Individuals experiencing homelessness (that were not in families that experience homelessness) has decreased by 6% in the past two years while the individuals in families experiencing homelessness has increased in that same time period by 37%. The overall change observed since 2013 is largely due to an increase in homeless families with multiple members, particularly children. Children in homeless families comprise the category that experienced the greatest change, increasing 39% since 2013. The homeless population, both individuals and families, bears a large burden of chronic substance abuse, mental health issues, co-occurring disorders, and chronic health conditions and disabilities. Of those with children, 20% of families cited

⁴⁷ 2016 County Health Rankings Maryland Data. Accessed at: <http://www.countyhealthrankings.org/rankings/data/MD>

⁴⁸ U.S. Census Bureau. American Community Survey 2014. Accessed at:

http://planning.maryland.gov/msdc/American_Community_Survey/2014ACS.shtml

⁴⁹ U.S. Census Bureau. American Community Survey 2014. Accessed at:

http://planning.maryland.gov/msdc/American_Community_Survey/2014ACS.shtml

⁵⁰ U.S. Census Bureau. American Community Survey 2014. Accessed at:

http://planning.maryland.gov/msdc/American_Community_Survey/2014ACS.shtml

domestic violence as the cause for homelessness (with others attributing a variety of socio-economic causes of homelessness).⁵¹

The 2014 population distribution in the County is 54.4% White (with 45.8% non-Hispanic White), 18.7% Hispanic/Latino (Mexican, Puerto Rican, Cuban, other), 17.9% Black/African American, 14.7% Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, other), 0.3% American Indian and Alaskan Natives, and a small but new population of Native Hawaiian and Other Pacific Islanders (0.1%).⁵² The percent change by race is greatest for people who identify as Black/African American, American Indian and Alaskan Native, Asian, and those who identify as two or more races.⁵³ Recent in-migration of other multiple ethnic groups identifying as non-white contributed to a 112.4% change in the total population between 2010-2014.⁵⁴ Of current residents, almost one-third were born outside of the United States.⁵⁵ Overall, County migration trends have shifted between 2010-2014, resulting in a statistically significant increase in in-migration of foreign born residents mostly from Asia, Latin America, and Africa.⁵⁶

There are many diverse languages spoken by people in the County including Spanish or Spanish Creole, Chinese, French Patois or French Cajun, Korean, Vietnamese, and Hindi. Increasing numbers of residents, including those who speak other languages, have indicated increasing English language fluency and speaking ability; the population of people who speak English less “than very well” has decreased significantly since 2010.⁵⁷

Summary Measures of Health

Montgomery County is ranked as the healthiest county in Maryland, according to the 2016 County Health “Health Outcomes” Rankings.⁵⁸ This ranking is based on an equal weighting of health outcomes and health factors. Montgomery County ranks first for health outcomes (mortality), and second for health factors (morbidity) when compared to other counties in the state. Since 2010, the County’s status

⁵¹ Montgomery County Interagency Commission on Homelessness Annual Report. 2015.

<https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwiawMWfnaXMAhWHZj4KHU7hAwEQFggdMAA&url=https%3A%2F%2Fwww.montgomerycountymd.gov%2FHHS-Program%2FResources%2FFiles%2FSNH%2FICH%2F2015%2520Annual%2520ICH%2520Report%2520-%2520Final.pdf&usg=AFQjCNGDqv4ZGNp4c15bx5yLGdP32U3Bqg&sig2=UOwHRYZQzspwUVQdNMiaRw>

⁵² U.S. Census Bureau. American Community Survey 2014. Accessed at:

http://planning.maryland.gov/msdc/American_Community_Survey/2014ACS.shtml

⁵³ Maryland State Data Center. Department of Planning. Table 6B: Change in Total Population by Race for Maryland's Jurisdictions, 2010-2014. Accessed at:

http://www.mdp.state.md.us/msdc/pop_estimate/estimate_10to14/HighlightSection/table6b.pdf

⁵⁴ Maryland State Data Center. Department of Planning. Table 3B: Total Population Change for Minorities and Non-Minorities for Maryland's Jurisdictions 2010-2014. Accessed at:

http://www.mdp.state.md.us/msdc/pop_estimate/estimate_10to14/HighlightSection/table3b.pdf

⁵⁵ U.S. Census Bureau. American Community Survey 2014. Accessed at:

http://planning.maryland.gov/msdc/American_Community_Survey/2014ACS.shtml

⁵⁶ U.S. Census Bureau. American Community Survey 2014. Accessed at:

http://planning.maryland.gov/msdc/American_Community_Survey/2014ACS.shtml

⁵⁷ U.S. Census Bureau. American Community Survey 2014. Accessed at:

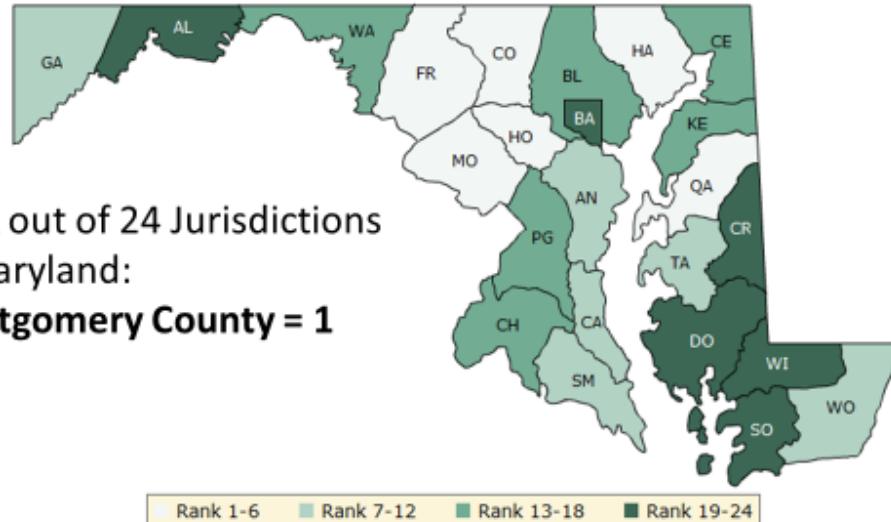
http://planning.maryland.gov/msdc/American_Community_Survey/2014ACS.shtml

⁵⁸ County Health Rankings. 2016. Accessed at:

http://www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2016_MD.pdf

has remained consistently high, ranking between 1 and 3 for all health outcomes and health factor sub-rankings.⁵⁹

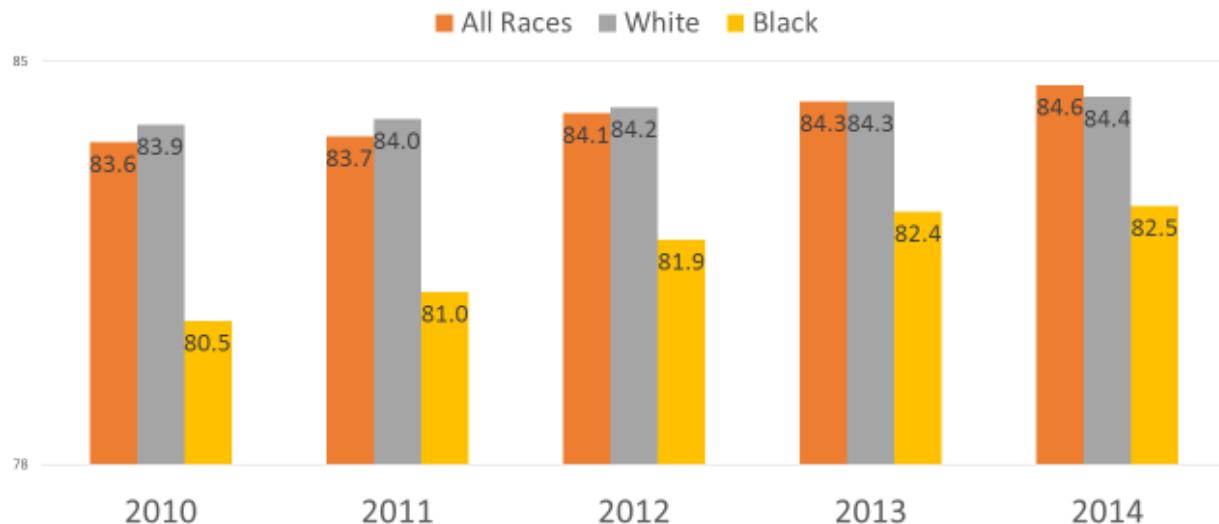
2016 County Health Rankings, Health Outcomes Map: *Maryland*



Rank out of 24 Jurisdictions
in Maryland:
Montgomery County = 1

Compared to the state, life expectancies in Montgomery County are almost 4 years higher for all races.⁶⁰ Life expectancy in the County for women continues to be ranked one of the highest in the United States. In general, life expectancy has increased for both males and females since 1985. However, Black/African

Life Expectancy at Birth By Race: Montgomery County, MD 2010-2014



⁵⁹ County Health Rankings. Montgomery County, Maryland. 2016. Accessed at:

<http://www.countyhealthrankings.org/app/maryland/2016/rankings/montgomery/county/outcomes/overall/snapshot>

⁶⁰ Maryland Vital Statistics Report. 2014. Accessed at: http://dhmh.maryland.gov/vsa/Documents/14annual_revised.pdf

American residents continue to experience lower life expectancy compared to all races.⁶¹

As seen in Table 1. below, all cancers combined, heart disease, stroke, chronic lower respiratory disease, and unintentional injuries rank among the top 5 leading causes of death for all County residents across sex, all ages, and racial/ethnic backgrounds.⁶²

While all cancers combined rank as the first leading cause of death among Asian/Pacific Islanders, Black/African Americans, and Hispanic residents, diseases of the heart are the leading cause of death among the Non-Hispanic White population.

For males and females between ages 18 and 34 years, unintentional injuries rank highest, followed by suicide. Similarly, among males and females between ages 35 and 64 years, unintentional injuries are the third leading cause of death, followed by suicide.

The majority of deaths attributable to unintentional injuries occur in the male population, however unintentional injuries are the fourth leading cause of death for all Hispanic White Females and the third leading cause for Non-Hispanic White Females ages 35 to 64 years.

Septicemia and influenza/pneumonia rank in the top 5 causes only among Asian/Pacific Islanders, with the majority of those deaths occurring among people over age 65 years.

More detailed rankings for specific subpopulations by gender, age, and race/ethnicity can be found in Appendix VII (Montgomery County Leading Causes of Death by Gender, Age, and Race/Ethnicity).

⁶¹ Institute for Health Metrics and Evaluation (IHME), US County Profile: Montgomery County, Maryland. Seattle, WA: IHME, 2015. Accessed at:

http://www.healthdata.org/sites/default/files/files/county_profiles/US/County_Report_Montgomery_County_Maryland.pdf

⁶² Healthy Montgomery 2012-2014 Mortality Data. Deaths by 52 Cause Categories and Combine Mortality Data. Crude Rates and Frequencies for Total Population. Age Group (0-17, 18-34, 35-64, 65+). Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology.

Table 1. Leading Causes of Death by Race/Ethnicity, all Montgomery County, Maryland Residents, 2012-2014 Combined

Causes of death that are shaded represent Healthy Montgomery Priority Areas					
Population= 3,051,833 TOTAL POP	N = 17,217 Total	N= 1,300 A/PI	N= 2,546 Black	N = 13,285 White	N= 892 Hispanic
1	All Cancers Combined (n=4,144)	All Cancers Combined (n= 403)	All Cancers Combined (n= 636)	Heart Disease (n= 3,170)	All Cancers Combined (n=231)
2	Heart Disease (n=3,983)	Heart Disease (n=255)	Heart Disease (n=543)	All Cancers Combined (n=3,085)	Heart Disease (n=135)
3	Cerebrovascular Disease (n=893)	Stroke (n= 89)	Stroke (n= 114)	Cerebrovascular Disease (n=686)	Unintentional Injuries (n=63)
4	Chronic Lower Resp. Dis. (n= 599)	Influenza & Pneumonia (n= 40)	Diabetes Mellitus (n=113)	Chronic Lower Resp. Dis. (n=525)	Stroke (n=51)
5	Unintentional Injuries (n=557)	Septicemia (n= 39)	Unintentional Injuries (n=75)	Unintentional Injuries (n=442)	Diabetes Mellitus (n=36)

Population= 1,470,818 ALL MALES	N = 8,162 Total	N= 650 A/PI	N= 1,244 Black	N= 6,223 White	N= 443 Hispanic
1	Heart Disease (n=2,003)	All Cancers Combined (n=193)	All Cancers Combined (n= 300)	Heart Disease (n=1,563)	All Cancers Combined (n=107)
2	All Cancers Combined (n=1,964)	Heart Disease (n= 144)	Heart Disease (n=289)	All Cancers Combined (n=1,463)	Heart Disease (n=74)
3	Unintentional Injuries (n=348)	Stroke (n= 39)	Unintentional Injuries (n=58)	Unintentional Injuries (n=226)	Unintentional Injuries (n=42)
4	Cerebrovascular Disease (n=342)	Unintentional Injuries (n= 22)	Diabetes Mellitus (n=50)	Stroke (n= 252)	Stroke (n=26)
5	Chronic Lower Resp. Dis. (n=257)	Influenza & Pneumonia (n= 21)	Stroke (n=49)	Chronic Lower Resp. Dis. (n=224)	Diabetes Mellitus (n=19)

Population= 1,581,015 ALL FEMALES	N = 9,055 Total	N= 650 A/PI	N= 1,302 Black	N= 7,062 White	N= 449 Hispanic
1	All Cancers Combined (n=2,180)	All Cancers Combined (n= 210)	All Cancers Combined (n=336)	All Cancers Combined (n=1,622)	All Cancers Combined (n=124)
2	Heart Disease (n=1,980)	Heart Disease (n= 111)	Heart Disease (n=254)	Heart Disease (n= 1,607)	Heart Disease (n= 61)
3	Stroke (n=551)	Stroke (n= 50)	Stroke (n=65)	Stroke (n= 434)	Stroke (n=25)
4	Chronic Lower Resp. Dis. (n=342)	Diabetes Mellitus (n= 25)	Diabetes Mellitus (n=63)	Chronic Lower Resp. Dis. (n= 301)	Unintentional Injuries (n = 21)
5	Alzheimer's Disease (n=308)	Septicemia (n= 21)	Influenza & Pneumonia (n=34)	Alzheimer's Disease (n= 260)	Septicemia (n = 18)

Leading causes of death by gender and race/ethnicity for infants, children, adults and older adults can be found in Appendix VII.

HEALTHY MONTGOMERY 2016 COMMUNITY HEALTH NEEDS ASSESSMENT

May 30, 2016

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Preface

The Key Findings of this Report are organized in a way that intentionally presents the Underlying Factors sections first. These sections describe those underlying, upstream conditions – that is, the social, economic, and environmental factors – that are the primary determinants of health. Differences in these underlying conditions, in which we live, learn, work, and play (often called social determinants of health) are among the root causes of inequities in health.¹ These underlying factors create an important context when considering the six Healthy Montgomery priority health issues – obesity, cardiovascular health, diabetes, cancers, maternal and infant health, and behavioral health -- and the emerging health issue of heroin and other opioid misuse, described in other Report sections. Taking these underlying factors into account, when addressing specific health issues, can help to ensure that an improvement in health outcomes will be achieved across all populations – for everyone.

Each Section of the Key Findings is arranged in the following format:

- **Overview** provides a brief introduction to the topic;
- **What We Can Do** offers preliminary ideas for actions to consider, based on the available information in the Report, for inclusion in the final Community Health Improvement Plan;
- **From the Community Conversations** includes results from the 15 public conversation sessions during which residents were asked about assets and challenges to community health and well-being and about strategies for improvement;
- **By the Numbers: Are We Making Progress?** and **By the Numbers: Are We Achieving Equity?** provide results on the progress made by the Healthy Montgomery Core Measures in terms of changes over time, benchmark comparisons, and measures of disparities/inequities across comparison groups;
- **Hospital Alignment** tables show the hospital services and programs targeted to specific populations;
- **Community Resources** are a compilation of resources in the County primarily gathered from Healthy Montgomery partners; and
- **What Works** provides evidence-based strategies.

This consistent format organizes the information and data collected in a way intended to facilitate recognition of the potential for alignment of efforts in the topic areas and identification of any unifying elements across topic areas.

It is important to note that information collected for the Community Resources section of the Report is quite extensive but not exhaustive. Healthy Montgomery partners, put an enormous effort into providing much of the information for this section. However, this collection method, as well as limited staff time to provide additional information about County resources, narrowed the reach of the information gathering efforts. It also limited the depth of the reporting. That is, the information gathered does not provide the number of people served by the programs or services, the quality and sustainability of the resources, or any gaps in the services and programming. It is expected that more

¹ The World Health Organization defines social determinants of health as: “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life...These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.” Accessed at: http://www.who.int/social_determinants/en/

detailed information regarding community resources will need to be collected at the action planning stage of the community health improvement process. It is also notable that this information gathering approach also resulted in a scarcity of information about resources from the business sector which is not yet represented on the Healthy Montgomery Steering Committee.

The contents of this Report provide a context and the information needed for the Healthy Montgomery priority-setting process. It is intended to inform that decision-making process as well as the action planning that will follow. The data and information gathering that was conducted to compile this Report should be considered a dynamic process that will evolve during the upcoming stages of the community health improvement process.

Summary of Key Findings

The abundance of resources in Montgomery County – health care services as well as social service programs provided by government agencies and community-based organizations – is remarkable and evident in the report findings. These resources include services and programming addressing specific health issues and targeting specific populations at risk for poor health. Also reflected in the findings, however, is the need for greater coordination and alignment of resources and services. Specifically, the integration of primary care and behavioral health services and greater coordination of health care and social services are identified needs.

Evidence-based strategies noted in the Report emphasize the need to address the issue of access to health care and services to improve health outcomes. Improved coordination of services could increase access, but the findings also reveal the need to increase accessibility by addressing other barriers including affordability, cultural and linguistic barriers, and transportation. The Affordable Care Act (ACA) has made insurance and preventive health care services more affordable. However, navigating the ACA enrollment process, understanding the coverage selected, and utilizing services successfully are still challenges for some residents, especially residents of diverse cultures and languages. Cultural and linguistic diversity, according to the findings, affects access to many of the County's resources and health care services. Community conversation participants suggested that better promotion of available resources, as well as targeted outreach to communities using community gathering places (e.g., retail sites, schools, churches, libraries, and community centers), could increase access. Similarly, evidence-based recommendations encourage efforts to develop and disseminate, in an array of settings and programs, health resource information that is accurate, accessible, and actionable. Opportunities exist to improve the promotion of County resources in a way that is culturally and linguistically competent and effective in reaching those most in need. These opportunities include leveraging the current efforts to enhance the *infoMONTGOMERY* database as well as the ongoing activities and outreach of the County's Minority Health Initiatives and Program.

In addition, the findings reveal that the County's hospital systems have implemented evidence-based strategies that integrate health literacy and equity into the care and services they provide through cultural- and language-appropriate methods. The use of peer support and community health navigators and community health workers is also encouraged and highlighted in the Report as effective in improving connectivity and accessibility to resources and services. This growing practice among the

County's hospital systems and other County health service providers can be utilized and enhanced to promote access and integrated care.

Transportation is also identified, as a barrier to accessing health care and resources that promote health (e.g. access to places to be physically active), especially for seniors, people with disabilities, and people of limited income. The need for a cross-sector response to address transportation needs and other underlying determinants of health is a consistent finding in the Report. Community conversation participants spoke of health and well-being largely in terms of the social, economic, and environmental factors that affect their lives. They described a healthy community as one that provides safe places to walk, bicycle and be physically active; access to healthy affordable food; well-paying jobs, affordable housing; high-quality education; crime-free neighborhoods; reliable and affordable public transportation; and access to preventive services, health care, and social services. Evidence-based recommendations for approaching community health improvement in this way require that professionals from a range of sectors (e.g., health, transportation, planning, education, recreation, environment, and law enforcement) routinely and consistently embed health considerations into their decision-making processes. The need to engage community members in decisions affecting health is also included among the findings both as an evidence-based way to ensure that community health needs are adequately identified and addressed and as a suggested strategy for community health improvement shared by community conversation participants.

The Report findings also emphasize that improving the underlying conditions that affect health can influence many risk factors that cut across the Healthy Montgomery health issue areas. For example, a community purposely designed to support healthy eating (e.g. healthy vending in workplaces and schools, affordable farmers' markets, community gardens); encourage physical activity (e.g., accessible, affordable and safe places to be physically active); promote safer and more connected communities that prevent injury, violence and crime (e.g., designing safer environments, fostering economic growth); and provide safe shared spaces for people to interact (e.g., parks, community centers) addresses risk factors associated with obesity, cardiovascular disease, diabetes and cancers as well as fosters positive mental health among community residents and can promote the health of pregnant mothers. Cross-sector involvement in the design of a safe and healthy community allows for concurrently targeting all County residents where they live, work, play, learn, and receive services.

Another finding that cuts across Healthy Montgomery priority health issue areas is the need to provide and promote preventive services. The need for more screening and other preventive services and targeted messages about prevention was articulated during the community conversations. Also included among the Report findings are evidence-based strategies that promote screenings for obesity; cardiovascular disease; diabetes; cancers; behavioral health problems such as suicide, depression, and substance abuse (including prescription drug misuse); and screenings for pregnant mothers. Evidence-based strategies also call for informing community members about the range of preventive services they should receive and the benefits of preventive services. Access to affordable dental care was identified as a specific preventive service need. Evidence-based strategies confirm the importance of using public-private partnerships to implement community preventive oral health services to adults and children, especially those at high risk. The Report findings reveal many efforts to provide affordable and free dental services to low-income residents that can be leveraged and promoted more effectively.

The Report findings also reveal the opportunity for involvement in addressing heroin and prescription drug misuse. Evidence-based strategies for addressing this growing problem include: increasing adult and youth awareness about heroin and prescription drug misuse and about proper storage and disposal of prescription drugs; encouraging persons at risk and family members and others to learn how to prevent and manage opioid overdose; ensuring ready access to naloxone (a medication used to reverse an opioid overdose in an emergency situation); educating prescribers and pharmacists about how to prevent, identify, and treat opioid addiction; and promoting the use of the state Prescription Drug Monitoring Program. The findings describe existing cross-sector collaborative efforts in the County that can be utilized to effectively address the issue. The Montgomery County Police Department is working with local police departments to raise public awareness about the issue and provide programs for safe disposal of unwanted prescription drugs. This finding reveals an opportunity for Healthy Montgomery to engage the County Police Department as a Healthy Montgomery partner in cross-sector collaboration across all health issue areas.

Additionally, the findings reveal a scarcity of information about resources provided by County businesses, identifying the business sector as another needed Healthy Montgomery partner for effective cross-sector collaboration.

Acronyms Used in the Report

Community Resources

The following is a compilation of all the acronyms used in the *Community Resources* subsections of the Key Findings to represent those agencies and organizations that provide the resources listed. These acronyms and agencies/organizations are also listed within the subsections.

Adventist HealthCare (AHC)
Affordable Care Act (ACA)
African American Health Program (AAHP)
African Immigrant and Refugee Foundation (AIRF)
ARC of Montgomery County (ARC)
Asian American Health Initiative (AAHI)
Aspire Counseling (AC)
Association of Vietnamese Americans (AVA)
A Wider Circle (WC)
Bethesda Cares (BC)
Bladder Cancer Advocacy (BCA)
Boys & Girls Club (BGC)
CASA of Maryland (CASAMD)
Catholic Charities, Archdiocese of Washington (CCAW)
Catholic Charities McCarrick Medical Clinic (CCMMC)
Children's National Health System (CN)
Circle of Rights (CR)
City of Rockville (CR)
Community Clinic, Inc. (CCI)
Community Connections (CommC)
Community Ministry of Montgomery County (CMMC)
Community Ministries of Rockville (CMR)
Conflict Resolution Center of Montgomery County (CRCMC)
Cornerstone Montgomery (CM)
Court Appointed Special Advocates of Montgomery County (CASA)
Family Services, Inc. (FSI)
Gaithersburg City Police (GPD)
Germantown Hardknocks Youth Foundation (GHYF)
Gilchrist Center for Cultural Diversity (GC)
Healthy Montgomery (HM)

Heroin Action Coalition of Maryland (HAC)
Holy Cross Health (HCH)
Hope Connections for Cancer Support (HC)
Housing Opportunities Commission (HOC)
Identity, Inc. (II)
Impact Silver Spring (ISS)
Independence Now (IN)
Interagency Commission on Homelessness (ICH)
Interfaith Works (IFW)
Islamic Center of Maryland (ICM)
Islamic Society of the Washington Area (ISWA)
Keeping It SAFE (KS)
Korean Community Service Center of Greater Washington (KCSC)
Latino Health Initiative (LHI)
Literacy Council of Montgomery County (LCMC)
Lourie Center for Children's Social & Emotional Wellness (LC)
Manna Food (MF)
Many Voices for Smart Choices (MVSC)
Mary's Center (MC)
Maryland Department of Health and Mental Hygiene (DHMH)
Maryland Department of Transportation (MDOT)
Maryland Family Network (MFN)
Maryland National Capital Park and Planning Commission (MNCPPC)
Maryland State Government (MSG)
MedStar Montgomery Medical Center (MMMS)
Mental Health Association of Montgomery County (MHA)
Montgomery Coalition for Adult English Literacy (MCAEL)
Montgomery County Alcohol and Other Drug Abuse Advisory Council (AODAAC)
Montgomery County Cancer Crusade (MCCC)

**Healthy Montgomery
Community Health Needs Assessment**

Key Findings

Montgomery County Child Care Resource and Referral Center (CCRRC)
Montgomery County Coalition for the Homeless (MCCH)
Montgomery County Collaboration Council for Children, Youth and Families (CC)
Montgomery County Commission on Health (COH)
Montgomery County Commission on People with Disabilities (COPD)
Montgomery County Council (MCC)
Montgomery County Department of Correction and Rehabilitation (DCR)
Montgomery County Department of Economic Development (DED)
Montgomery County Department of Environmental Protection (DEP)
Montgomery County Department of Health and Human Services (DHHS)
Montgomery County Department of Housing and Community Affairs (DHCA)
Montgomery County Department of Liquor Control (DLC)
Montgomery County Department of Transportation (DOT)
Montgomery County Federation of Families for Children's Mental Health (FFCMH)
Montgomery County Food Council (MCFC)
Montgomery County Government (MCG)
Montgomery County Interagency Coalition on Adolescent Pregnancy (ICAP)
Montgomery County Office of Agriculture (MCOA)
Montgomery County Public Library (MCPL)
Montgomery County Recreation (MCR)
Montgomery County Police Department (MCPD)
Montgomery County Prevention Planning Workgroup Committee (PPWC)

Montgomery County Public Schools (MCPS)
Montgomery County Public Schools Parent Academy (MCPA)
Montgomery County State Attorney (MCSA)
Montgomery Heroin Action Coalition (MHAC)
Nathan's Ridge (NR)
National Alliance on Mental Illness, Montgomery County (NAMI)
National Cancer Institute (NCI)
Oakdale Emory United Methodist Church (OEUMC)
On Our Own of Montgomery County (OOOMC)
Passion for Learning (PL)
Pharmacist Education and Advocacy Council of Maryland (PEAC)
Primary Care Coalition (PCC)
Proyecto Salud (PS)
Rebuilding Together Montgomery County (RTMC)
Recovery Oriented Systems of Care (ROSC)
Rockville City Police (RCP)
Rockville Housing Enterprises (RHE))
Senior Connection of Montgomery County (SC)
Shady Grove Medical Center (SGMC)
Silver Spring Wellness and Recovery Center (SSWRC)
Spanish Catholic Center (SCC)
Street Outreach Network (SON)
Suburban Hospital (SH)
Tree House Child Assessment Center of Montgomery County (TH)
University of Maryland Extension (UME)
Vesta (Vesta)
Walter Reed Military Medical Center (WR)
Washington Adventist Hospital (ACH-WAH)
Washington Metropolitan Area Transit Authority (WMATA)
Washington Youth Foundation (WYF)
Women, Infants and Children (WIC)

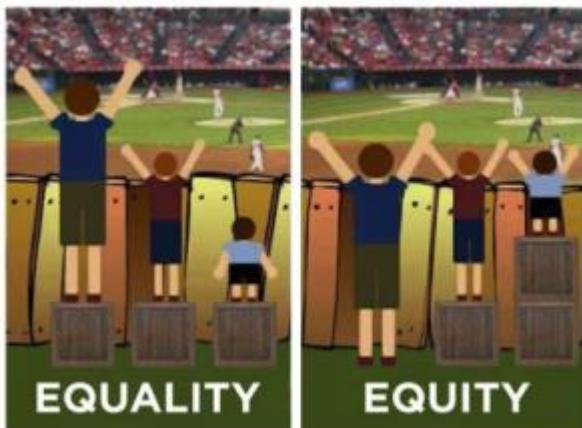
What Works – Sources of Evidence-Based Strategies

The following is a compilation of all the acronyms used in the *What Works* subsections of the Key Findings to represent the sources of the evidence-based strategies listed. These acronyms and resources are also listed within the subsections.

- *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA Clinical Guidelines)
- *Community Guide*, Centers for Disease Control and Prevention (CG)
- *Guide to Clinical Preventive Services*, U.S. Preventive Services Task Force (CPS)
- Healthy Montgomery Behavioral Health Task Force (BHTF)
- Healthy Montgomery Eat Well Be Active Partnership (EWBA)
- *Maryland Comprehensive Cancer Control Plan 2011-2015*, Maryland Department of Health and Mental Hygiene (MCCCP)
- *Montgomery County Ten Year Plan to End Homelessness*, Montgomery County Continuum of Care (MCCoC)
- *National Action Plan to Improve Health Literacy*, U.S. Department of Health and Human Services (NAP)
- *National Culturally and Linguistically Appropriate Services in Health and Health Care* (National CLAS Standards), U.S. Department of Health and Human Services
- *National Prevention Strategy*, Surgeon General, U.S. Department of Health and Human Services (NPS)
- *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*, U.S. Interagency Council on Homelessness (USICH)
- *The Prescription Opioid Epidemic: An Evidence-Based Approach*, Johns Hopkins Bloomberg School of Public Health (JHSPH)
- *SAMHSA Opioid Overdose Prevention Toolkit*, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)

Introduction

Health begins where County residents live, learn, work, and play. That is, their health is affected by the social, economic, and environmental conditions they experience in these settings. For example, health and well-being are influenced by social and economic opportunities (e.g., safe and affordable housing, affordable healthy food, employment that pays a fair wage), the quality of neighborhood schools, the safety of streets and workplaces, the availability and affordability of community resources, the nature of social interactions and relationships, and the cleanliness of a community's air and water.



Unjust differences in these underlying conditions of health (often called social determinants of health) can put specific populations at a disadvantage and create health inequity. These "socially produced" health differences or disparities are often avoidable.² According to *Healthy People 2020*, 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 healthcare disparities."³

Highlighting the importance of addressing the underlying conditions that affect health, one of *Healthy People 2020*'s four overarching goals for the decade, is to "create social and physical environments that promote good health for all."⁴ A companion report to *Healthy People 2020*, *Healthy People 2020: An Opportunity to Address Social Determinants of Health in the U.S.* emphasizes the importance of collective action to achieve that goal. In that document, the Secretary's Advisory Committee notes that *Healthy People 2020*'s 10-year goals and objectives can be achieved "only if many sectors of our society—such as transportation, housing, agriculture, commerce, and education, in addition to medical care—become broadly and deeply engaged in promoting health."⁵ (See Figure. 1 below for U.S. Department of Health and Human Services' social determinants of health framework)

Montgomery County is ranked as the healthiest County in Maryland, yet health disparities among County residents are described in the data findings throughout this Report. Additionally, in the findings from the community conversations held throughout the County, residents describe barriers to good

² The World Health Organization. A Conceptual Framework for Action on the Social Determinants of Health: Social Determinants of Health Discussion Paper 2. Accessed at:

http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

³ U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. *Healthy People 2020: Disparities*. Accessed at: <https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>

⁴ U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. *Healthy People 2020: Social Determinants of Health*. Accessed at: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

⁵ Secretary's Advisory Committee on National Health Promotion and Disease Prevention. *Healthy People 2020: An Opportunity to Address Social Determinants of Health in the U.S.*

<https://www.healthypeople.gov/sites/default/files/SocietalDeterminantsHealth.pdf>

health that inequitably affect specific population groups. Also, compiled in this Report, are many of the existing programs and services in the County that address health disparities.

Issues related to health disparities are discussed in the Underlying Factors sections of this Report's Key Findings. They are presented within the context of three broad topic areas: Equity, Health and Health

Care, and Healthy and Safe Communities. (It is important to note that although these sections are presented separately, their contents are interrelated.) These Underlying Factors Report sections offer a health equity frame for the Healthy Montgomery work ahead.

*Healthy People 2020 defines health disparity as:
“a particular type of health difference that is closely linked with economic, social or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, or mental health; cognitive, sensory or physical disability, geographic location; or other characteristics historically linked to discrimination or exclusion.”*

*U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020: Disparities. Accessed at:
<https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>*

provides affordable health insurance coverage for many County residents but cumbersome and confusing application processes can affect access, especially for residents from culturally and linguistically diverse communities. Transportation barriers affect access to health care and preventive services, especially for seniors and people with disabilities. For residents with co-occurring conditions (e.g., medical and behavioral health conditions), primary and behavioral health services that are not

The **Underlying Factors-Equity** section provides information and data related specifically to unfair differences in community settings that affect health outcomes. Social and economic factors are included such as income level, educational attainment, and employment status. Economic disadvantage can result in an inability to buy needed goods and services. It can be associated with living in unstable or substandard housing, unsafe neighborhoods, having limited educational opportunities, and relying upon public transportation to access basic needs and employment. Social and economic disadvantage can also be the result of factors such as race, ethnicity, gender, and disability.⁶ In this section of the Report, the needs of and resources available to individuals with disabilities, veterans, seniors, children, immigrants, and people experiencing homelessness are highlighted. Also included are issues of social isolation, discrimination, the reliability and affordability of public transportation, and meaningful involvement by communities in the decision-making and policymaking processes affecting health.

The **Underlying Factors - Health and Health Care** section of the Report's Key Findings compiles information and data related to issues of access to health insurance and health care, integrated health care, and health literacy – all factors affecting health outcomes. Health insurance, health care and preventive services are not equally accessible to all County residents because of structural, social, and economic barriers.

The Patient Protection and Affordable Care Act (ACA)

⁶ Centers for Disease Control and Prevention. *Social Determinants of Health: Know What Affects Health*. Accessed at: <http://www.cdc.gov/socialdeterminants/>; Braverman P. What are health disparities and health equity? We need to be clear. *Public Health Reports*, 2014, Suppl. 2, Vol. 129. Accessed at: <http://www.publichealthreports.org/issueopen.cfm?articleID=3074>

integrated or coordinated can present a major challenge to accessing all the services needed to maintain good health. Many County public and private organizations provide affordable or free health care and preventive services that target populations such as seniors, people with disabilities, and residents from cultural and linguistically diverse communities. But inadequate promotion of available health care and preventive services, especially to residents in diverse communities, also affects accessibility. Health care services that are respectful of and responsive to cultural and linguistic needs can make services and care more understandable and accessible.

Figure 1. HHS Social Determinants of Health (SDOH) Framework.
(<https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>)



The **Underlying Factors – Healthy and Safe Communities** section of the Report's Key Findings provides information and data related to the natural environment (e.g., water, air, and atmosphere) and the built environment (physical components that people create or modify such as buildings, public spaces, transportation systems). Issues such as housing, places to be physically active, public safety, and transportation networks are included in this section. The natural and physical environment can affect health and safety directly (e.g., clean water and air, safe and affordable housing) but can also influence

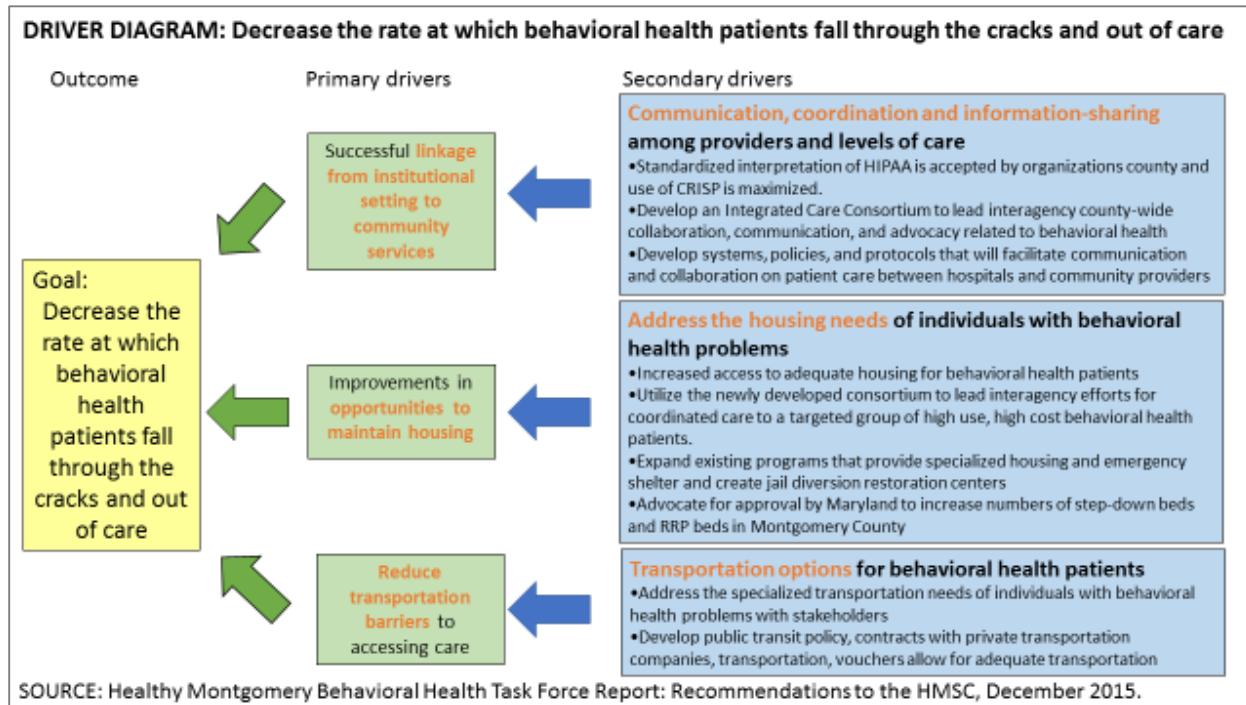
community residents' health-related choices (e.g., affordable and reliable transportation networks can facilitate access to places to purchase healthy food and be physically active). A healthy and safe community can help make healthy choices easy, affordable, and universally available.⁷

The cross-sector collaborative approach of the community health improvement process provides a promising opportunity for Healthy Montgomery to effectively impact health inequities in the County. By maximizing existing efforts in the County to address health disparities-, Healthy Montgomery can work to create social and physical environments that provide an equal opportunity for all County residents to reach their full health potential regardless of their level of income, education, ethnicity, or race.

During the Healthy Montgomery action planning and implementation planning, many of these underlying factors (root causes) that drive outcomes will be mapped into driver diagrams as primary and secondary drivers. These factors impact desired health and well-being outcomes, as seen in the behavioral health driver diagram below (See Figure 2.).

⁷ Centers for Disease Control and Prevention. CDC's Built Environment and Health Initiative. Accessed at: http://www.cdc.gov/nceh/information/built_environment.htm; U.S. Surgeon General, National Prevention Strategy. Strategic Directions and Priorities. Accessed at: <http://www.surgeongeneral.gov/priorities/prevention/strategy/intro-strategic-directions-priorities.pdf>

Figure 2 Healthy Montgomery Behavioral Health Task Force Driver Diagram on Behavioral Health Patients that Fall through the Cracks and Out of Care.



Key Findings: Underlying Factors - Equity

May 30, 2016

Overview

This **Underlying Factors-Equity** section provides information and data related specifically to unfair differences in community settings that affect health outcomes. Social and economic factors such as income level, educational attainment, and employment status are included. Economic disadvantage can result in an inability to buy needed goods and services. It can be associated with living in unstable or substandard housing and unsafe neighborhoods, having limited educational opportunities, and relying upon public transportation to access basic needs and employment.

Social and economic disadvantage can also be the result of factors such as race, ethnicity, gender, and disability.⁸ In this section of the Report, the needs of and resources available to individuals with disabilities, veterans, seniors, children, immigrants, and people experiencing homelessness are highlighted. Also included are issues of social isolation, discrimination, the reliability and affordability of public transportation, and meaningful involvement by communities in the decision-making and policymaking processes affecting health.

What We Can Do

Leverage/Enhance Existing Efforts:

- **Identify and help connect County residents to key resources (National Prevention Strategy) based on the existing efforts of:**
 - Montgomery County Collaboration Council for Children, Youth and Families (*infoMONTGOMERY*),
 - Montgomery County Department of Health and Human Services
 - Montgomery County Government 311 Information and Services Resource
 - Leadership Institute for Equity and the Elimination of Disparities (LIEED)
 - Montgomery County Department of Transportation
 - Other County non-profit organizations and government agencies serving immigrants, diverse communities, and low-income communities
- **Implement processes to ensure that County residents are actively engaged in decisions that affect health; empower individuals and their families to develop and participate in health protection and health promotion programs through neighborhood associations, labor unions, volunteer/service projects, or community coalitions; and improve coordination, collaboration, and opportunities for engaging community leaders and members in prevention (National Prevention Strategy) based on the existing efforts of:**
 - Impact Silver Spring
 - Montgomery County Department of Health and Human Services

⁸ Centers for Disease Control and Prevention. *Social Determinants of Health: Know What Affects Health*. Accessed at: <http://www.cdc.gov/socialdeterminants/>; Braverman P. What are health disparities and health equity? We need to be clear. *Public Health Reports*, 2014, Suppl. 2, Vol. 129. Accessed at: <http://www.publichealthreports.org/issueopen.cfm?articleID=3074>

- Leadership Institute for Equity and the Elimination of Disparities (LIEED)
- Other County non-profit organizations and government agencies serving immigrants, diverse communities, and low-income communities
- **Provide input, guidance, and technical assistance to local health department programs in assessing health impacts and conducting comprehensive health improvement planning (National Prevention Strategy); use data to identify populations at greatest risk and work with communities to implement policies and programs that address highest priority needs (National Prevention Strategy); improve coordination, collaboration, and opportunities for engaging community leaders and members in prevention (National Prevention Strategy); and conduct comprehensive community health needs assessments and develop state and community health improvement plans (National Prevention Strategy) based on the existing efforts of:**
 - Healthy Montgomery
 - Other County non-profit organizations and government agencies serving immigrants, diverse communities, and low-income communities
- **Support the Montgomery County Ten Year Strategic Plan to End Homelessness including the efforts to develop a comprehensive, systemic response to end homelessness that includes the capacity to quickly identify and engage people at risk of and experiencing homelessness; intervene to prevent the loss of housing and divert people from entering the homelessness services system; and, when homelessness does occur, provide immediate access to shelter and crisis services, without barriers to entry, while permanent stable housing and appropriate supports are being secured, and quickly connect people to housing assistance and services (tailored to their unique needs and strengths) to help them achieve and maintain stable housing (Opening Doors: Federal Strategic Plan to Prevent and End Homelessness) (Montgomery County Ten Year Plan to End Homelessness) based on the existing efforts of:**
 - Montgomery County Continuum of Care
 - Montgomery County Interagency Commission on Homelessness

Initiate Efforts:

- **Establish and sustain a Health in All Policies (HiAP) model that brings together professionals from a range of sectors (e.g., transportation, health, environment, labor, education, and housing) with community representatives to ensure that community health needs are identified and that needs and barriers are addressed (National Prevention Strategy) and implements processes to ensure that County residents are actively engaged in decisions that affect health (National Prevention Strategy). Partners to include:**
 - Maryland National Capital Park and Planning Commission
 - Montgomery County Recreation
 - Montgomery County Public Schools
 - Montgomery County Department of Transportation
 - Montgomery County Department of Environmental Protection
 - Montgomery County Police Department

- Montgomery County Department of Health and Human Services
- Montgomery County Department of Housing and Community Affairs
- Montgomery County Department of Corrections and Rehabilitation

National Prevention Strategy, Surgeon General, U.S. Department of Health and Human Services
Opening Doors: Federal Strategic Plan to Prevent and End Homelessness, U.S. Interagency Council on Homelessness
Montgomery County Ten Year Plan to End Homelessness, Montgomery County Continuum of Care

Information Gathered on Equity

A. From the Community Conversations

1. Community Resources and Services

Assets

- Many County services and resources including: government facilities, libraries, senior centers, and the Silver Spring Civic Center, responsive County government staff
- Government and non-profit services and programs such as pro-bono legal services; consumer protection services; disability and aging services; 311 information service (bilingual line); the online Disability Network; installation of home safety devices for seniors; Jewish Community Center services; social service programming targeting immigrants; the County's sister city program; Spanish-speaking service providers; and the Senior Village concept to assist seniors aging in place
- County's boards and commissions
- Funding for services
- Many cultural and community events

Challenges

- Cumbersome processes, difficulty navigating the system, prohibitive requirements, and long waiting lists are challenges to accessing services
- Lack of privacy within service systems is a challenge for people experiencing homelessness

Strategies for Improvement

- Promote services through the use of local newspapers, grocery stores, places of worship, restaurants, regional service centers, health fairs, and libraries
- Partner with minority groups and immigrant populations to provide consistent and directed outreach into communities in need of the information
- Promote resources and services among people with disabilities by creating a calendar of health events targeting and accessible to people with disabilities; create a hotline or website

- to link people newly diagnosed with disabilities to services; organize a large community resource fair to highlight programs and services for people with disabilities; and make the County website accessible to people using screen readers
- Coordinate services, including providing health care in combination with social services
- Maintain, restore, or increase funding for services for immigrants, refugees, low-income families, people with disabilities, foster children, seniors, people experiencing homelessness and single parents
- Provide affordable child care and adult daycare, public nursing homes, more home visiting programs, peer support groups, comprehensive care for children in foster care, more adult English classes, a greater variety of classes at community centers, additional community centers, more low-cost summer camps, and student service learning projects that involve assisting people with disabilities
- Leverage the Senior Village concept to increase services to seniors
- Revise income support measurements for seniors so that more residents can use the services at senior day care centers
- Improve communication with seniors by hiring bilingual staff at senior apartments that predominantly house one ethnic population
- Review rules and regulations for receiving services, especially at homeless shelters, to determine if they are working effectively and make sense
- Provide more places to access Wi-Fi and more financial assistance for people experiencing homelessness
- Connect health organizations and service organizations with homeless shelters

2. Transportation

Assets

-
- Transportation network for seniors, including subsidized taxi services and bus rides for seniors

Challenges

-
- Unreliability and poor quality of public transportation, limited services areas and times available, lack of affordability
 - Lack of public transportation to access County services and resources
 - Unreliability of Metro Access
 - Bus drivers who do not enforce Americans with Disabilities Act (ADA) seating requirements
 - Lack of adequate designated parking spaces for people with disabilities
 - Absent bus shelters and benches, infrequency of buses
 - High tolls on the Intercounty Connector (ICC)

Strategies for Improvement

-
- Increase the reliability and affordability of public transportation to increase access to services and programs
 - Address limited public transportation service areas and times that service is available
 - Extend free hours on Metro Bus and Ride On for seniors and provide a “transportation volunteer” to help seniors identify the most inexpensive way to travel

- Provide more designated parking spaces for people with disabilities and seniors and enforce proper use of designated spaces

3. Housing

Assets

-
- Homeless shelters

Challenges

-
- Lack of affordable housing
 - Lack of high quality housing options for low-income residents and seniors
 - Limited housing options for people with disabilities and people experiencing homelessness

Strategies for Improvement

-
- Provide more affordable, high-quality housing options for low-income residents, including low-cost rentals
 - Address gentrification, overcrowded housing conditions, and the displacement of residents to build or renovate low-income housing
 - Provide more housing programs for seniors, refugees, people with disabilities and people experiencing homelessness
 - Provide alternative housing and extended hours at homeless shelters to address homelessness
 - “Put a face” on homelessness to encourage greater involvement in addressing the issue

4. Education

Assets

-
- High-quality public schools
 - Family services programs in the schools improve quality of life and communication between parents and children
 - Many options for higher education in the region
 - Montgomery College is a strong community college system that serves many County residents

Challenges

-
- Racial achievement gap exists in the schools
 - Extracurricular activities such as sports are unaffordable for some families
 - Postsecondary options for students with disabilities are limited

Strategies for Improvement

-
- Provide low-cost after-school programs and day care in elementary schools to enable parents to stay employed
 - Reduce standardized testing (e.g., create an awareness among administrators, drop out of Partnership for Assessment of Readiness for College and Careers (PARCC) as a state) to reduce student stress

- Provide more school counselors, more time to relax, and give more attention to the ideas of the Student Member of the Board of Education
- Promote more involvement of parents in schools (e.g., involving parents as teachers)
- Provide education on good parenting
- Pay more attention to the unique needs of the County's diverse student population (e.g., more integrated supports, expansion of summer programming)
- Increase access to educational resources for adults

5. Business/Economy

Assets

-
- Strong and stable economy

Challenges

-
- A high cost of living (housing, food, transportation)
 - High taxes including property taxes
 - Long hours at work and low wages cause stress
 - The high cost of complying with the Americans with Disabilities Act (ADA) is a challenge for employers and businesses

Strategies for Improvement

-
- Provide higher-paying jobs in the County
 - Provide employment opportunities, including at the professional level and for new immigrants
 - Provide greater access to job readiness programs and training programs and apprenticeships that lead to certification and licensing
 - Increase job opportunities for people with disabilities to promote self-sufficiency
 - Provide low-cost after-school programs and day care in every elementary school so that parents can stay employed
 - Create an accessibility designation for County restaurants businesses and other organizations to support their efforts related to accessibility
 - Create a vibrant business community in the County; market the East County to attract new business opportunities and jobs so that people can live where they work
 - Enforce the minimum wage law

6. Equity

Assets

-
- County's population is diverse

Challenges

-
- Increase in population strains the County's aging infrastructure (e.g., roads and public transit system)
 - Racism, and the isolation of racial and ethnic minorities, are challenges to good health
 - Teens are affected by racial stereotyping and lack of equal opportunity
 - Inconsistent commitment on the part of County officials to address health disparities

- Institutional and personal prejudices toward people with disabilities persist

Strategies for Improvement

- Provide teens with more open-mindedness and support to improve their self-image
- Provide programming to raise public awareness about disabilities
- Hold public dialogue on the impact of racial and health disparities in the Healthy Montgomery work
- Avoid segregation of housing, schools, and resources

7. County Governance and Community Advocacy

Strategies for Improvement

- Engage the community more to collaboratively address health issues
- Invite County decision-makers to meet with members of the community so the decision-makers can learn about pressing issues from community members and play a more active role in community initiatives
- Promote more participation by minorities in policymaking
- Increase community advocacy so that community voices can be heard
- Advocacy by community members for the needs of their communities, including the need for more funding and improved services
- Leverage County Commissions, such as the Commission on People with Disabilities, to effectively voice community concerns and inform County decision-making
- Improve survey methods to better represent the needs of specific populations
- Encourage more community leaders and role models
- Engage the faith-based community to assist community leaders

B. By the Numbers: Are We Making Progress?

Within the 37 Healthy Montgomery Core Measures Set, there were 34 measures that enabled reporting within specific racial and ethnic subgroups in Montgomery County. Among those 34 measures, the number of measures with trends (more than one estimate over time) varied (from 26 to 32) for specific subgroups: 31 White (including non-Hispanic White), 32 Black (including non-Hispanic Black), 26 Asian or Pacific Islander, and 31 Hispanic measures. The chart below provides a snapshot of the percent of measures with trend data that demonstrated a narrowing of disparities, widening of disparities, or had no change because the subgroup had the best result over time.

Black and African American subpopulations exhibited the greatest percent of applicable Core Measures with disparities narrowing (63%) when compared to other racial/ethnic subgroups, followed by the Hispanic subgroup (55%). The Black and African American subgroup (including the non-Hispanic Black) also had the largest percent of measures with widening disparities (38%) as well, followed by the Hispanic subgroup (32%).

Progress Made by Healthy Montgomery Core Measures to Narrow Racial/Ethnic Disparities

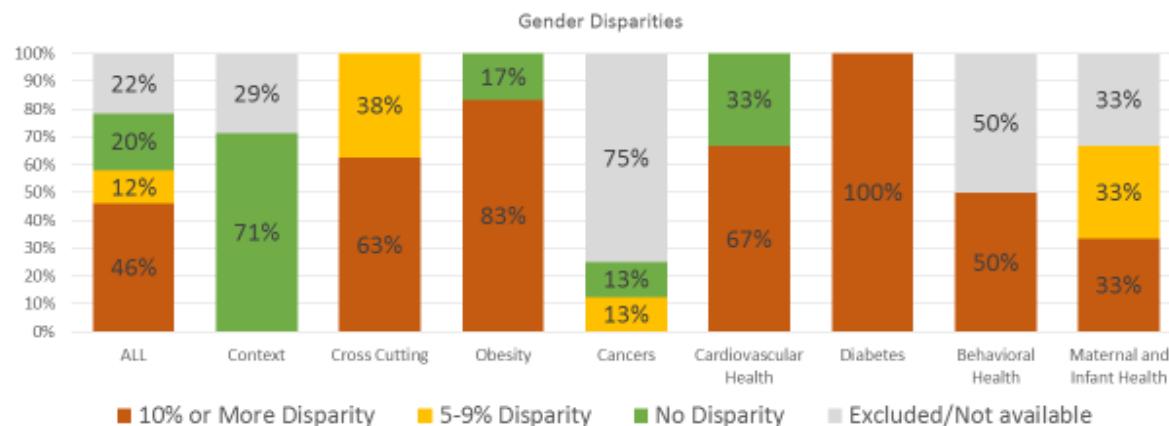


C. By the Numbers: Are We Achieving Equity?

The ability to report disparities by gender, age, and race varied based on the availability of these subgroup estimates within each of the Healthy Montgomery 37 Core Measures. Below is a summary of the disparity status for all measures, context measures, and cross-cutting measures that apply to multiple priority areas (excluding obesity), followed by each Healthy Montgomery priority area (obesity, cancers, cardiovascular health, diabetes, behavioral health, and maternal and infant health).

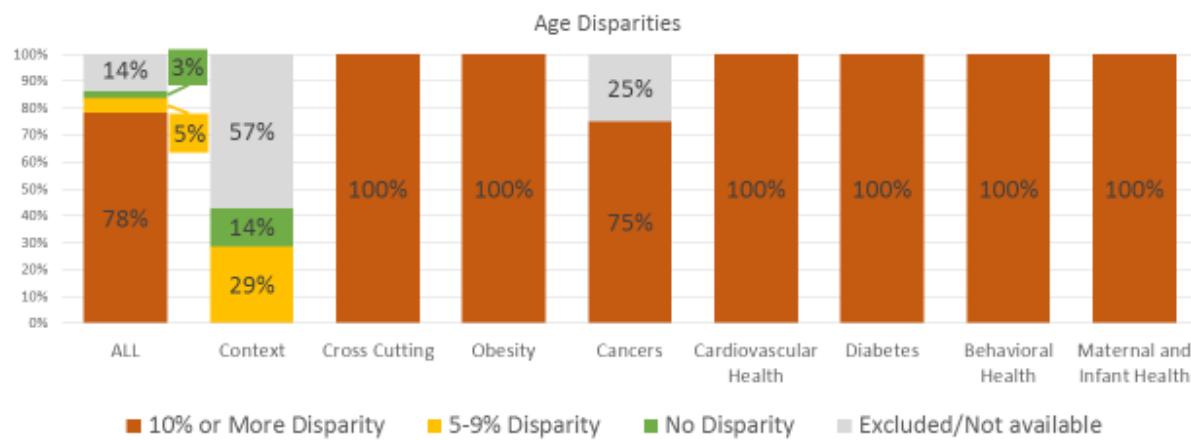
Gender-related disparities vary widely across Healthy Montgomery priority areas.

Percent of Healthy Montgomery Core Measures with Gender-Related Disparities



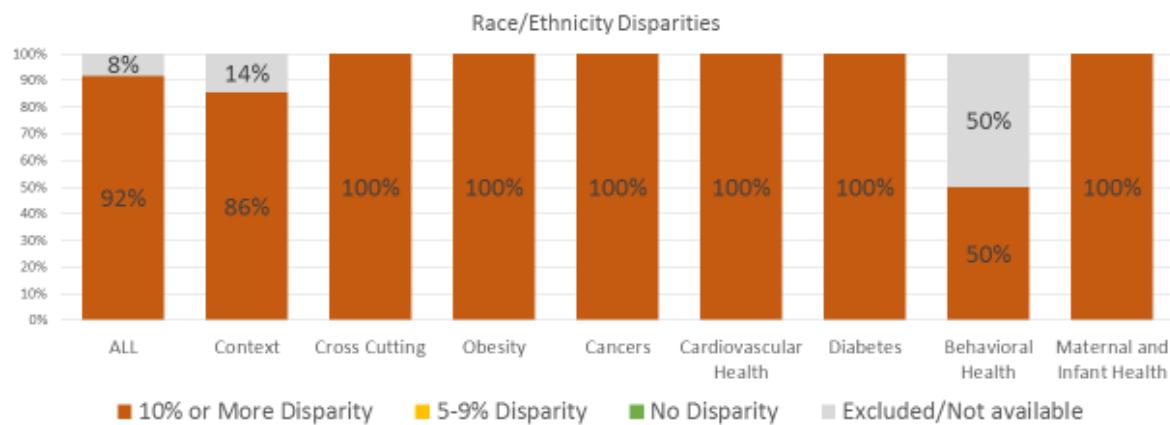
Age matters when addressing priorities in Montgomery County. Over three-quarters of the core measures depicted age-related disparities- that is, all measures in cross cutting, obesity, cardiovascular health, diabetes, behavioral health, and maternal and infant health.

Percent of Healthy Montgomery Core Measures with Age-Related Disparities



All Healthy Montgomery priority areas include opportunities to reduce or eliminate racial/ethnic disparities.

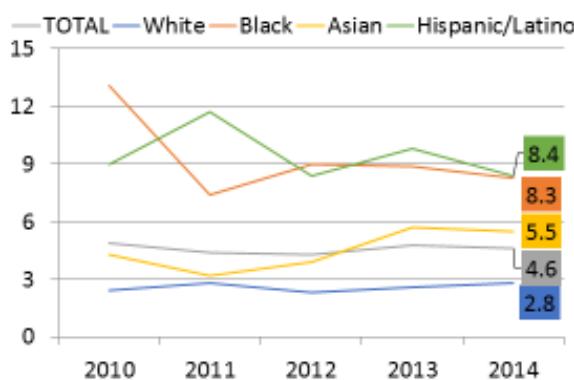
Percent of Healthy Montgomery Core Measures with Race/Ethnicity-Related Disparities



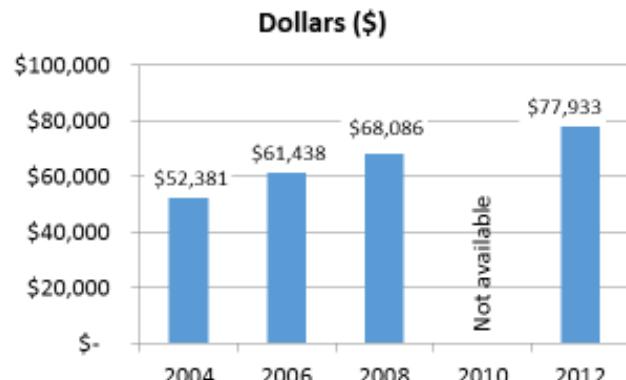
The percent of families living in poverty has declined over the past five years, most notably among Black and African American families.

Economic stability

Percent of families living in poverty, 2010-2014, Montgomery County



Self-sufficiency standard wage for family of three, Montgomery County, select years



The cost of living in Montgomery County continues to rise as described by the self-sufficiency standard increasing each year measured, through 2012.

Education

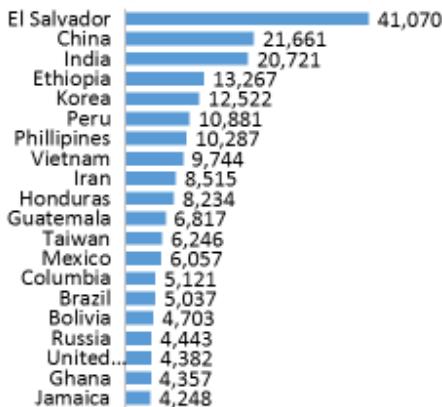
ADULTS 25+ WITH AT LEAST A HIGH SCHOOL DIPLOMA



Social and Community Context



Top 20 Country of Origin Responses among Foreign-born County Residents



1 in 3 of our residents speak a language other than English at home

Language	Population	%
English Only	564,386	60.9
1 Spanish or Spanish Creole	144,106	15.6
2 Chinese	36,290	3.9
3 African	28,451	3.1
4 French	21,695	2.3
5 Korean	13,444	1.5
6 Vietnamese	11,047	1.2
7 Persian	10,514	1.1
8 Other Indic Languages	9,541	1.0
9 Tagalog	9,327	1.0
10 Other Asian Languages	8,825	1.0

D. Hospital Alignment

Throughout many of this Report's Key Findings sections, there is evidence of our County hospital systems' efforts to provide health care services and community-based programming that address health-related disparities and inequities and ensure that all County residents have opportunities for good health.

Each hospital's community health benefit plan identifies and documents community health needs and the hospital's efforts to address those needs. The hospital systems' financial support of, and active involvement in, Healthy Montgomery are also central to their efforts to improve community health.

To further promote its commitment to addressing health disparities and promoting health equity, Healthy Montgomery partner Adventist HealthCare has created a Center for Health Equity and Wellness that works to improve the health of communities served by AHC by raising awareness of community health needs and local disparities, improving access to culturally appropriate care, and providing wellness outreach and education. A team of health educators, clinical care coordinators, nurses, patient navigators, and public health researchers and interns work together to ensure the delivery of population-based care and promote health equity in the communities we serve. As part of the Center's mission, it researches local health disparities and outcomes and produces annual reports on health care equity and community health needs.

E. Community Resources

(Note: The acronyms following each entry below represent the agencies and organizations that provide the resource listed; a list of the agencies and organizations represented by the acronyms can be found at the end of the section).

1. State and Local Government

Connecting Individuals and Families to Services

- Montgomery County Information and Referral Hotline 311 connect residents with County services (MCG)
- Children, Youth and Family Service's ChildLink is an information and referral service for families with young children; callers may receive simple referrals, consultation on child development or parenting issues, or linkages and follow up for families presenting more complex or at-risk situations which require early intervention services (DHHS)
- Interagency Commission on Homelessness provides Crisis Hotlines services to residents experiencing homelessness including 24-hour Adult Protective Services; 24-hour Abused Persons Program; 24-hour Child Abuse and Neglect; 24-hour crisis outreach unit Crisis Center; confidential Veterans Crisis & Suicide Line; 24-hour Victim Assistance/Sexual Assault and access to Behavioral Health and Substance Abuse and Mental Health Services (ICH)

- Homeless Resource Day is a one-day, one-stop opportunity for individuals and families experiencing homelessness or at risk of homelessness to access services, resources and information (DHHS)
- Aging and Disability Resource Unit assists seniors, persons with disabilities, and their families in defining service needs, locating required services, and facilitating the application process to access services (DHHS)
- Children Fleeing Violence Program assists immigrant children and families, offering navigation services to enroll children in MCPS, Care for Kids Program, and referrals to legal and human services (LHI)

Accessing Basic Needs - Housing

- Montgomery County Continuum of Care is a collaboration of public and private groups working to prevent and end homelessness in the County through implementation of the County's Ten Year Plan to End Homelessness (MCCoC)
- Design for Life Montgomery Tax Incentive Program provides tax credits to builders and homeowners for including features in new and existing residential housing that improve accessibility for persons of all ages, including seniors and those with disabilities (DHHS)
- Senior Group Home Subsidy / Household-Related Public Assistance Programs pays a portion of the cost for clients to live in licensed senior group homes in Montgomery County (DHHS)
- Rental Assistance Program / Housing Expense Assistance assist individuals with rental costs for households who meet eligibility criteria; the Handicapped Rental Assistance program helps low-income individuals with disabilities with rental expenses in licensed care facilities (DHHS)
- Emergency Eviction Prevention/Housing Expense Assistance provides crisis intervention assistance to qualified individuals and families, including financial assistance and/or shelter to families and adults who are homeless or at high risk of losing housing (DHHS)
- Utility Assistance Program helps low-income residents pay their heating costs and electric bills (DHHS)
- City of Rockville provides emergency assistance, housing counseling, moderately priced dwelling unit rental program, and Step Teen program to Rockville residents (CR)
- Montgomery County Department of Housing and Community Affairs provides Moderately Priced Dwelling Units and Rental Program for eligible households (DHCA)
- Rockville Housing Enterprises provides safe, affordable public housing; provides vouchers for rental units in the private market (RHE)
- Interagency Commission on Homelessness provides a range of temporary and permanent housing options to persons experiencing homelessness and helps them rapidly exit homelessness; crisis response system also provides emergency shelter, overflow shelter and transitional housing options (ICH)
- Interagency Commission on Homelessness provides financial assistance to address housing emergencies in order to prevent homelessness (ICH)
- Montgomery County Council, in collaboration with the Montgomery County Coalition for the Homeless and Bethesda Cares, created a coordinated system that ends veteran homelessness by moving veterans from homelessness to permanent housing (MCC) (MCCH) (BC)

Accessing Basic Needs – Social Services and Wellness Programs

- Takoma East Silver Spring (TESS) Community Service Center is a Neighborhood Opportunity Network site that provides information and referrals, social service assistance, interpretation and translation, education, Volunteer Income Tax Assistance (VITA) and legal services for County residents (DHHS)
- Child Welfare Services provides protective, rehabilitative, and supportive services for children who are maltreated and for their families (DHHS)
- My Turn Program provides resources, support, and programmatic/financial assistance to families with children with developmental disabilities ages 3 to 13 years (DHHS)
- Senior Care Assistance/Subsidy Program provides funds to supplement the cost of Adult Day Care, medications, personal care, transportation for medical appointments, home delivered meals, over the counter medications, medical insurance co-payments, durable and disposable medical supplies, eyeglasses, dentures, medical and dental care not covered by insurance, a lifeline system, or other possible needs not covered by other resources (DHHS)
- Assessment and Continuing Case Management Services includes multi-disciplinary assessments, care planning, and case management services to frail seniors and adults with disabilities to remedy and prevent abuse, neglect, self-neglect, exploitation, or inappropriate institutionalization (DHHS)
- Autism Waiver Service Coordination provides service coordination to children diagnosed with severe autism, ages birth through 21 years, who are currently enrolled in the autism waiver program (DHHS)
- Community Support Network for People with Disabilities provides services that enable the individual to remain in their home or in the least restrictive environment, and provides general support, guidance and assistance to clients who have developmental disabilities and their families; also provides financial assistance to State-funded providers who serve adults with developmental disabilities (DHHS)
- Therapeutic Recreation programs are specifically designed for individuals with disabilities (MCR)
- Information and reading materials for people with disabilities, family members, and service providers; multi-cultural library services (MCPL)
- Respite Care program provides temporary care of frail seniors, adults and children with disabilities, and children with severe behaviors and/or medical issues to give relief to families and other primary caregivers (DHHS)
- Senior health, wellness, and fitness classes are delivered throughout the county (MCR)
- Mobile Recreation is designed to improve wellbeing and reduce barriers to health by targeting school communities with high FARMS rates; combines structured physical activity and play with the Summer Food Service Program (MCR) (MCPS)
- Summer Teen Programs is a community partnership that provides a wide variety of outreach and programming for disconnected children and children in economically challenged communities (MCR)
- Maryland's Child Care Subsidy Program helps limited-income families pay for child care while parents work or attend school or job training (MSG)
- WIC provides supplemental food to nursing, pregnant women, and children 5 years old and under at various County locations (WIC)

Empowering Individuals, Families, and Communities

- Equity Initiative improves the Montgomery County Department of Health and Human Services' capacity to serve the community and fulfill its mission to eliminate inequities in health and human services, including child welfare, juvenile justice, behavioral health services, and employment and housing assistance; adopts and integrates equity in all of its work (DHHS)
- Leadership Institute for Equity and the Elimination of Disparities (LIEED) addresses social determinants of health with the goal of eliminating disparities and achieving equity among County residents by providing strategic leadership and coordination, serving as a capacity builder, acting as a resource partner and collaborator, promoting effective community engagement, promoting innovation and support linkages/opportunities, and supporting community advocacy (DHHS)
- Through "Be the One that Makes a Difference" videos and photo novels, outreach and education is provided to Asian-American residents at health fairs and cultural celebrations (AAHI)
- Asian American Leadership, Empowerment and Development for Youth and Family Program provides after school enrichment programs and mentoring to students at four middle schools and two high schools (AAHI)
- Maryland Multicultural Youth Center provides case management, GED preparation, job readiness development, and after school programs to high risk youth (DHHS)
- Youth Opportunity Centers (in Takoma Park and Gaithersburg) provide individually-tailored gang intervention and prevention action plans that may include intensive case management, mental health counseling, GED preparation, workforce development, tattoo removal, relocation assistance, engagement activities, and life-skills oriented group sessions (DHHS)
- Education Program and Workforce Development Program provides educational and career goal guidance, academic support and job-related services to low-income disadvantaged youth (DHHS)
- Ombudsman Services investigates and resolves complaints made by residents, staff, and family members in nursing homes and assisted living facilities for seniors and people with disabilities (DHHS)
- Customized Employment Public Interim Program provides supported employment for adults with developmental disabilities (DHHS)
- Montgomery Moving Forward Initiative is a partnership of Montgomery County Department of Economic Development, MCPS, Montgomery College, the non-profit community and the private sector that assists unemployed and underemployed residents gain employment in the health and wellness industry (DED)
- Montgomery County Department of Housing and Community Affairs Power Hour Program provides homework and reading assistance and tutoring after school and during the summer to increase academic proficiency of low-income Germantown youth (DHCA)
- Office of Community Partnerships strengthens relationships between the Montgomery county government and residents, with special focus on underserved and emerging community and neighbors in need (DHHS)
- Department of Housing and Community Affairs handles disputes between landlords and tenants and gives information on tenant rights (DHCA)
- City of Rockville Regional Youth Services Bureau Program provides culturally competent, culturally responsive youth counseling, youth development groups and informational workshops for parents to youth and their families living or attending school in Rockville (CR)

Transportation

- Connect-A-Ride program provides information and referral for older adults and adults with disabilities about transportation options, including public, private and volunteer transportation services; Call'N'Ride provides transportation for low-income seniors and people with disabilities (DHHS)
- Medicaid Transportation Program provides non-emergency transportation to persons who have Medical Assistance (MTP)
- Kids Ride Free Program provides free rides year-round on weekdays between 2pm and 8pm on County Ride On buses and certain Metro bus routes to youth ages 18 and under (older if still in high school) who are County residents (DOT)
- User-side subsidy program (Call-n-Ride) that provides travel options for low-income elderly and people with disabilities, and information on public private transportation programs available to seniors and persons with disabilities (DOT)
- RIDE ON buses are free to senior citizens and people with disabilities at scheduled times during the week; at other times a discounted fare is offered; all buses are wheel chair accessible (DOT)
- Washington Metropolitan Area Transit Authority provides MetroAccess, a shared-ride, door-to-door paratransit service for people whose disability prevents them from using bus or rail (WMATA)

2. Early Learning Centers, Schools, Colleges and Universities

Accessing Basic Needs

- Family Services' Linkages to Learning program is a community school partnership in 29 public schools providing comprehensive behavioral health or social wraparound services to mitigate the effects of poverty and reduce non-academic barriers to learning (FSI) (MHA) (MCPS) (DHHS)
- Child Find assists families with young children; provides free screening for children who may be delayed in their speech, motor, or cognitive development (MCPS)
- High School-Based Wellness Centers (at Watkins Mill, Northwood, and Gaithersburg High Schools Wheaton High School center will open in FY2017) provide school-based, culturally-based, positive youth development services such as after school activities, job readiness, academic support, trauma-informed mental health services, parent support groups, leadership development, truancy reduction, substance abuse treatment, and other health related services (DHHS) (MCPS)
- Head Start Child Developmental Program serves eligible 3 and 4 year-old children of low-income families, providing comprehensive educational, social, medical, dental, mental health, and nutrition services (MCPS)
- School-based pre-kindergarten program is provided for low-income 4 year-old children in the County; transportation and lunch are provided for children; also provides parent involvement, social services, and health services (MCPS)
- The National School Lunch Program provides nutritionally balanced low-cost or free breakfast, school lunch, after school snack, suppers, Saturday meals and summer food service (MCPS)

Empowering Individuals, Families, and Communities

- YMCA's Linkages to Learning program is a school-based/school-linked service delivery system that is designed to enable at-risk children and adolescents to reach optimal physical and mental health, achieve academic success, and become socially secure in their communities (YMCA) (MHA) (MCPS) (DHHS)
- Discovery Station Early Head Start serves low-income families with children from birth to three years old and pregnant women who reside in the Up County area; activities occur in the home and in the Family Services Discovery Station Child Development Center, with group activities on a regularly scheduled basis; emphasis is placed on child development and extensive support services for families (FSI)
- The Lourie Center for Children's Social & Emotional Wellness Early Head Start Program provides comprehensive, year-round, child and family development services to low-income families with children, prenatal to three years old (LC)
- Infants and Toddlers Program offers early intervention services to assist families address their children's developmental and special needs; serves families with children between birth and the start of the school year following the fourth birthday (MCPS) (DHHS)
- Dare to Be You is a ten-week prevention program provided at various MCPS elementary schools to help families with preschoolers improve parent and child interactions (FSI) (MCPS)
- IMPACT Silver Spring program examines the impact of race, class, and culture on the growing achievement gap in the public schools and has implemented a pilot program at a local elementary school to engage minority and immigrant parents (ISS) (MCPS)
- Parent Educators conduct parent group seminars in the Preschool Education Program which provides special education services for children with educational disabilities (MCPS)
- The WINGS Mentor Program provides additional support to gifted/learning disabled students and highly able students who are not succeeding in the regular education classroom (MCPS)
- The Hispanic Hotline minimizes language barriers between school staff and monolingual Spanish speaking parents of the community in situations related to school issues affecting their children (MCPS)
- Students can apply for Dr. Paul L. Vance Scholarship if they are graduating from MCPS, financially disadvantaged, and show academic promise (MCPS)
- Blair Ewing Center School Program is an alternative school program serving students in grades 9-12 who are not achieving in their home schools; provides effective educational supports and services to address academic, social, emotional and physical health (MCPS)
- Kennedy Cluster Watkins Mill Cluster Project is a multi-agency effort providing a collaborative service model that works to improve school performance by breaking down institutional barriers, reducing educational and social disparities and addresses issues associated with the impact of poverty (MCPS)
- ARC of Montgomery County provides after-school and summer programming for adolescents ages 9 to 18 with intellectual and developmental disabilities (ARC)
- Excel Beyond the Bell in seven County middle schools increases positive outcomes for youth by providing students, at no cost, with access to after-school recreational and social programming, academic support, hot nutritional meals, and bus transportation home (CC) (MCR)(MCPS)
- Kensington Wheaton Youth Services offer services to help families overcome obstacles which thwart the efforts of students to learn and grow; includes mental health tutoring, educational workshops and after-school programs (MCPS) (MHA) (DHHS)

- Passion for Learning provides a Young Writers Program and a Communication and Technology Program in County schools for low-income students ages 11 through 14 (PL)
- African and Immigrant Refugee Foundation Catching Up Program assists African immigrant children to succeed academically and to thrive emotionally by providing after school clubs for middle and high school students (AIRF)
- Catholic Charities Community Companions Program offers after school programs, in-home support, and respite care and camps for children with disabilities in the County (CCAW)

3. Community, Non-profit, and Faith Based Organizations

Connecting Individuals and Families to Services

- *infoMONTGOMERY* is a collaborative effort of public and private agencies to provide detailed information about health, education and human service resources throughout the County to link individuals and families with services that can help (CC)
- Gilchrist Center for Cultural Diversity provides an information and referral system to County services for immigrants (GC)
- Child Care Resource and Referral Center works with parents, child care providers, businesses, and community members to help promote the availability of quality child care services in the County (CCRRC)
- Maryland Family Network offers referrals to licensed child care providers for individuals looking for child care; offers training, mentoring, coaching, and advocates quality child care (MFN)

Accessing Basic Needs - Housing

- Montgomery County Coalition for the Homeless participates in the 10,000 Homes Campaign, a national effort to house the most vulnerable homeless individuals and families; two new permanent supportive housing programs serve 30 medically-vulnerable households (MCCH)
- Rebuilding Together Montgomery County helps homeowners whose failing health or fixed income does not allow them to cover the extraordinary costs of home repair (RTMC)
- Housing Opportunities Commission provides affordable housing and supportive services (e.g., Mortgage Purchase Program, Housing Choice Voucher Program) for low- and moderate-income families and individuals throughout the County (HOC)
- Interfaith Works provides services across the housing continuum of care to help people in crisis lift themselves out of poverty (IFW)
- Community Ministries of Rockville provides case management services to low-income seniors who are Rockville residents to avoid premature institutionalization (CMR)
- Community Ministries of Rockville provides permanent, affordable housing for men and women experiencing homelessness who have completed an addiction program but are unable to live independently (CMR)

Accessing Basic Needs - Social Services

- Mental Health Association's Serving Together program assists veterans, service members and their families, to access the local services they need (MHA)
- Mary's Center provides health care, family literacy and social services to individuals whose needs go unmet by the public and private systems (MC)

- Islamic Society of the Washington Area provides social services for low-income Muslim families including domestic violence prevention programming, referrals, family counseling, and temporary shelter (ISWA)
- Korean Community Service Center of Greater Washington provides no-cost comprehensive services to Korean-American families and new immigrants (KCSC)
- Spanish Catholic Center provides job training programs, English classes, a food pantry, case management services, and family support services (SCC)
- Manna Food provides food distribution centers located across Montgomery County (MF)
- A Wider Circle provides furniture and basic needs support to individuals and families living in poverty (WC)
- Friendly Visitor offers friendship and emotion support to seniors that are home-bound, isolated and lonely (MHA)

Empowering Individuals, Families, and Communities

- Healthy Montgomery strives to attain optimal health and well-being for all residents through an ongoing effort that brings together County government agencies, County hospital systems, minority health program/initiatives, advocacy groups, academic institutions, community-based service providers, the health insurance community, and other stakeholders to improve the health and well-being of all Montgomery County residents; includes data collection, needs assessment, priority-setting, strategic action planning, and the implementation and evaluation of collaborative efforts (HM)
- Family Service Inc.'s Healthy Families Montgomery is a voluntary home visiting service for first-time parents; begins before the baby is born and continues weekly for at least six months and up to five years; emphasis is on health care, child development, parenting education and support, and family self-sufficiency (FSI)
- Impact Silver Spring supports and empowers community members to work collaboratively across lines of race, class, and culture on challenging community issues; provides leadership development to community leaders and diversity awareness training (ISS)
- Collaboration Council's youth enrichment program addresses the needs of immigrant families with a focus on writing, reading fluency, comprehension, and English language learning; Disproportionate Minority Contact Reduction Initiative works toward ensuring that the local juvenile justice system responds with fair and equitable treatment for all youth, regardless of race and ethnicity (CC)
- Association of Vietnamese Americans helps refugees and immigrants of all backgrounds secure housing, find jobs, and study for U.S citizenship tests (AVA)
- Washington Youth Foundation provides education, leadership development training, mentoring, community engagement opportunities, parent education and outreach campaigns for Asian American immigrant families (WYF)
- Identity, Inc. provides positive youth development programs for Latino youth (II)
- Montgomery Coalition for Adult English Literacy provides opportunities for high-quality English language and literacy instruction in the County (MCAEL)
- Boys & Girls Clubs provide youth with a positive and safe place to go and a way to grow in a safe and caring environment (BGC)
- 4-H Clubs teach life skills in a supportive setting for all girls and boys to mature into competent, caring, and responsible adults (UME)
- N*Common provides clinical mental health services to low-income and uninsured Spanish and French speaking immigrants who are newly arrived to the U.S. and dealing with trauma,

- loss, and trying to adults to life in the U.S. (MHA)Independence Now provides peer counseling, advocacy, independent living skills training for people with disabilities (IN)
- Literacy Council provides individual reading and writing tutoring for adults in English for Speakers of Other Languages (ESOL) programs (LCMC)
 - Community Ministries of Rockville Language Outreach program offers a family-centered approach to language skills development for residents who are non-English speakers struggling with language and cultural barriers; offers citizenship classes (CMR)
 - Gilchrist Center for Cultural Diversity offers services to immigrants including ESOL classes, citizenship and civic classes, multilingual computer classes, seminars on small business development, and cultural programs (GC)
 - CASA of Maryland provides English classes, citizenship classes, vocational skills training, financial literacy workshops, legal services, a family engagement initiative that builds parenting skills, and employment placement for Latino and immigrant populations (CASAMD)
 - A Wider Circle provides job preparedness support and educational workshops to individuals and families living in poverty (WC)
 - Various community organizations provide emergency assistance for residents in crisis including food assistance and financial assistance to make home and utility payments: Bethesda Help, Damascus Help, Eastern Montgomery Emergency Assistance Network, Inc., Faith Connections, Gaithersburg HELP, Inc., Mid-County United Ministries, Olney HELP, Salvation Army, Share Food Network Program, Upper Montgomery Assistance Network, Western Upper Montgomery County Help, Inc.

Transportation

- Senior Connection of Montgomery County helps adults ages 62 and up in the County to maintain their independence, primarily by providing them transportation services (SC)
-

African Immigrant and Refugee Foundation (AIRF)
ARC of Montgomery County (ARC)
Asian American Health Initiative (AAHI)
Association of Vietnamese Americans (AVA)
A Wider Circle (WC)
Bethesda Cares (BC)
Boys & Girls Club (BGC)
CASA of Maryland (CASAMD)
Catholic Charities, Archdiocese of Washington (CCAW)
City of Rockville (CR)
Community Ministries of Rockville (CMR)
Family Services, Inc. (FSI)
Gilchrist Center for Cultural Diversity (GC)
Healthy Montgomery (HM)
Housing Opportunities Commission (HOC)
Identity, Inc. (II)
Impact Silver Spring (ISS)

Independence Now (IN)
Interagency Commission on Homelessness (ICH)
Interfaith Works (IFW)
Islamic Society of the Washington Area (ISWA)
Korean Community Service Center of Greater Washington (KCSC)
Latino Health Initiative (LHI)
Literacy Council of Montgomery County (LCMC)
Lourie Center for Children's Social & Emotional Wellness (LC)
Manna Food (MF)
Mary's Center (MC)
Maryland Family Network (MFN)
Maryland State Government (MSG)
Mental Health Association (MHA)
Montgomery Coalition for Adult English Literacy (MCAEL)
Montgomery County Child Care Resource and Referral Center (CCRRRC)

**Healthy Montgomery
Community Health Needs Assessment**

Montgomery County Coalition for the Homeless (MCCH)
Montgomery County Collaboration Council for Children, Youth and Families (CC)
Montgomery County Council (MCC)
Montgomery County Department of Economic Development (DED)
Montgomery County Department of Health and Human Services (DHHS)
Montgomery County Department of Housing and Community Affairs (DHCA)
Montgomery County Department of Transportation (DOT)
Montgomery County Government (MCG)

Key Findings: Underlying Factors - Equity

Montgomery County Public Library (MCPL)
Montgomery County Recreation (MCR)
Montgomery County Public Schools (MCPS)
Passion for Learning (PL)
Rebuilding Together Montgomery County (RTMC)
Rockville Housing Enterprises (RHE))
Senior Connection of Montgomery County (SC)
Spanish Catholic Center (SCC)
University of Maryland Extension (UME)
Washington Metropolitan Transit Authority (WMTA)
Washington Youth Foundation (WYF)
Women, Infants and Children (WIC)

F. What Works

(Note: The acronyms following each entry below represent the source for the evidence-based strategy listed; a list of the acronyms and the source they represent can be found at the end of the section).

1. State and Local Government

- Implement tenant-based rental assistance programs that provide vouchers or direct cash assistance to provide low-income families with more housing options than they could afford by themselves (allows families to move to safer neighborhoods and reduce exposure to crimes against person and property and decreases neighborhood social disorder) (CG)
- Use data to identify populations at greatest risk and work with communities to implement policies and programs that address highest priority needs (NPS)
- Improve coordination, collaboration, and opportunities for engaging community leaders and members in prevention (NPS)
- Improve privacy-protected health data collection for underserved populations to help improve programs and policies for these populations (NPS)
- Provide early childhood home visitation programs (by nurses, social workers, paraprofessionals, community peers) to reduce child maltreatment among high-risk families (CG)
- Provide therapeutic foster care for adolescents ages 12-18 with a history of chronic delinquency based on sufficient evidence of effectiveness in preventing violence among this population (CG)
- Conduct comprehensive community health needs assessments and develop state and community health improvement plans (NPS)
- Develop a comprehensive, systemic response to end homelessness that includes the capacity to quickly identify and engage people at risk of and experiencing homelessness; intervene to prevent the loss of housing and divert people from entering the homelessness services system; and, when homelessness does occur, provide immediate access to shelter and crisis services, without barriers to entry, while permanent stable housing and appropriate supports are being secured, and quickly connect people to housing assistance and services (tailored to their unique needs and strengths) to help them achieve and maintain stable housing (USICH) (MCCoC)

2. Early Learning Centers, Schools, Colleges and Universities

- Provide center-based early childhood education programs (ECE) to improve educational outcomes that are associated with long-term health and improved social- and health-related outcomes (CG)
- Provide full-day kindergarten programs to improve the health prospects of low-income and racial and ethnic minority children to improve reading and mathematics achievement—two determinants of long-term academic and health-related outcomes (CG)
- Provide high school completion programs for students at high risk for non-completion (CG)
- Provide three types of out-of-school time academic programs - reading-focused, math-focused, and general programs that do not focus on a specific subject (CG)
- Provide input, guidance, and technical assistance to local health departments in assessing health impacts and conducting comprehensive health improvement planning (NPS)

3. Community, Non-profit, and Faith Based Organizations

- Bring together professionals from a range of sectors (e.g., transportation, health, environment, labor, education, and housing) with community representatives to ensure that community health needs are identified and that needs and barriers are addressed (NPS)
- Implement processes to ensure that people are actively engaged in decisions that affect health (NPS)
- Empower individuals and their families to develop and participate in health protection and health promotion programs through neighborhood associations, labor unions, volunteer/service projects, or community coalitions (NPS)
- Identify and help connect people to key resources (e.g., for health care, education, and safe playgrounds) (NPS)
- Support and expand continuing and adult education programs (e.g., English language instruction, computer skills, health literacy training) (NPS)

4. Health Care Systems, Insurers and Clinicians

- Train and hire more qualified staff from underrepresented racial and ethnic minorities and people with disabilities (NPS)
- Partner with state, tribal, local, and territorial governments, business leaders, and community-based organizations to conduct comprehensive community health needs assessments and develop community health improvement plans (NPS)

Community Guide, Centers for Disease Control and Prevention (CG)

National Prevention Strategy, Surgeon General, U.S. Department of Health and Human Services (NPS)

Opening Doors: Federal Strategic Plan to Prevent and End Homelessness, U.S. Interagency Council on Homelessness (USICH)

Montgomery County Ten Year Plan to End Homelessness, Montgomery County Continuum of Care (MCCoC)

Key Findings: Underlying Factors – Health and Health Care



EMERGING ISSUE

Healthy Montgomery partners were surveyed and asked to identify emerging health issues for possible inclusion in the CHNA report – issues not included among the six Healthy Montgomery priority areas. Please note that the issues of oral health, health literacy and health care for the uninsured are included in the Underlying Factors – Health and Health Care section of this Report. The findings in this section reveal the needs related to those issues as well as the many existing resources and efforts addressing them, including efforts by Healthy Montgomery partners.

Overview

This **Underlying Factors - Health and Health Care** section of the Report compiles information and data related to issues of access to health insurance and health care, integrated health care, and health literacy – all factors which affect health outcomes. Health insurance, health care and preventive services are not equally accessible to all County residents because of structural, social, and economic barriers. The ACA provides affordable health insurance coverage for many County residents but its cumbersome and confusing application processes can affect access, especially for residents from culturally and linguistically diverse communities. Transportation barriers affect access to health care and preventive services, especially for vulnerable populations such as seniors and people with disabilities. For residents with co-occurring conditions (e.g., medical and behavioral health conditions), primary and behavioral health services that are not integrated or coordinated can present a major challenge to accessing all the services needed to maintain good health.

Many County public and private organizations provide affordable or free health care and preventive services that target populations such as seniors, people with disabilities and residents from cultural and linguistically diverse communities. But inadequate promotion of available health care and preventive services, especially to residents in communities with predominantly minority populations, also affects accessibility. Health care services that are respectful of and responsive to cultural and linguistic needs can make services and care more understandable and accessible.

What We Can Do

Leverage/Enhance Existing Efforts:

- To expand public-private partnerships to implement community preventive oral health services to adults and children, especially those at risk (National Prevention Strategy) and provide school-based sealant delivery programs to prevent dental caries (tooth decay) among children 5 to 16 years of age (Community Guide)⁹ based on existing efforts of:
 - Montgomery County Department of Health and Human Services (on-site and mobile dental services for children and adults)
 - Community dental clinics in the County
 - Montgomery County Minority Health Initiatives/ Program
 - Montgomery County Community Safety-Net Clinics
 - Montgomery County Public Schools

⁹ Several strategies are integrated here: offer preventive services (e.g., mental health services, oral care, vision, and hearing screenings) for all children, especially those at risk (National Prevention Strategy); expand public-private partnerships to implement community preventive services (e.g., school-based oral health programs, community-based diabetes prevention programs) (National Prevention Strategy) and provide school-based sealant delivery programs to prevent dental caries (tooth decay) among children (5 to 16 years of age) (Community Guide)

- **To develop and disseminate, in diverse settings and programs, health and safety information and information about health resources and services that is accurate, accessible, and actionable (National Prevention Strategy) and inform County residents about the range of preventive services they should receive and the benefits of preventive services (National Prevention Strategy) ¹⁰ based on the existing efforts of:**
 - Montgomery County Collaboration Council for Children, Youth and Families
 - Montgomery County Department of Health and Human Services
 - Montgomery County Minority Health Initiatives/Program
 - Montgomery County hospital systems
 - Montgomery County Community Safety-Net Clinics
 - Montgomery County Public Schools
- **To support use of retail sites, schools, churches, and community centers for the provision of evidence-based preventive services (National Prevention Strategy) and expand public-private partnerships to implement community preventive services (National Prevention Strategy) based on the existing efforts of:**
 - Montgomery County Department of Health and Human Services
 - Montgomery County Minority Health Initiatives/Program
 - Montgomery County hospital systems
 - Montgomery County Community Safety-Net Clinics
 - Montgomery County Public Schools
- **To increase the dissemination and use of evidence-based health literacy practices and interventions (National Action Plan to Improve Health Literacy) based on the existing efforts of:**
 - Montgomery County Department of Health and Human Services
 - Montgomery County Minority Health Initiatives/Program
 - Montgomery County hospital systems,
 - Montgomery County Community Safety-Net Clinics
 - Montgomery County Public Schools
 - Primary Care Coalition of Montgomery County
 - University of Maryland Extension
 - Consumer Health First (formerly Maryland Women's Coalition for Health Care Reform)
- **To foster collaboration among community-based organizations, the education and faith-based sectors, businesses, and clinicians to identify underserved groups and implement programs to improve access to preventive services, including access issues related to public transportation (National Prevention Strategy) ¹¹ based on the existing efforts of:**
 - Montgomery County Department of Health and Human Services

¹⁰ Several strategies are integrated here: offer accurate, accessible, and actionable health information in diverse settings and programs (National Prevention Strategy); develop and disseminate health and safety information that is accurate, accessible, and actionable (National Action Plan to Improve Health Literacy), and inform people about the range of preventive services they should receive and the benefits of preventive services (National Prevention Strategy)

¹¹ Access issues related to public transportation, as identified in the community conversations, were added to the following National Prevention Strategy recommendation: foster collaboration among community-based organizations, the education and faith-based sectors, businesses, and clinicians to identify underserved groups and implement programs to improve access to preventive services.

- Montgomery County Minority Health Initiatives/Program
- Montgomery County hospital systems
- Montgomery County Community Safety-Net Clinics
- Montgomery County Department of Transportation
- Interfaith Works
- To establish or enhance patient reminder systems for preventive services (e.g., mailing cards, sending e-mails, or making phone calls when a patient is due for a preventive health service) as well as clinical systems (e.g., electronic health records with reminders or cues, chart stickers, vital signs stamps, medical record flow sheets) (National Prevention Strategy) based on the existing efforts of:
 - The Montgomery County Department of Health and Human Services
 - Montgomery County Minority Health Initiatives/Program
 - Montgomery County hospital systems
 - Montgomery County Community Safety-Net Clinics

Community Guide, Centers for Disease Control and Prevention

National Action Plan to Improve Health Literacy, U.S. Department of Health and Human Services

National Prevention Strategy, Surgeon General, U.S. Department of Health and Human Services

Information Gathered on Health and Health Care

A. From the Community Conversations

1. Health Insurance Coverage

Assets

-
- Increased accessibility to health insurance coverage through the ACA

Challenges

-
- Implementation challenges related to the ACA

Strategies for Improvement

-
- Provide more assistance to residents and health care providers to effectively navigate ACA enrollment and coverage, and promote utilization
 - Provide reasonably priced secondary insurance with comprehensive health coverage
 - Recruit more minority health navigators to address language barriers
 - Make navigation system more user-friendly and efficient

2. Health Care Access

Assets

- Increased eligibility for Medicare/Medicaid
- Care provided for the uninsured
- County community-based health clinics that provide low-cost, quality health care

Challenges

- High cost of health care
- High hospital fees
- High prescription drug costs
- Difficulty finding physicians for specific health conditions when transitioning to Medicare
- Lack of full-service hospitals in some parts of the County

Strategies for Improvement

- Increase reliability and affordability of public transportation to increase access to services and programs
- Promote County services more effectively
- Increase use of mobile health care units
- Provide more clinical services for the growing County population
- Provide more low-cost specialty care, especially for residents on Medicaid
- Increase the number of providers who accept Medicaid and Medicare, especially specialists
- Increase hospital outreach programs that are free or affordable to address diabetes and other health conditions
- Increase access to health screenings
- Increase access to low-cost vaccines
- Make the cost of prescription drugs more affordable

3. Health Literacy

Assets

- Health information available on the Internet
- Media attention on health and wellness
- Spanish-speaking health care providers
- Health clinics and workshops for low-income, Korean-speaking residents

Challenges

- Lack of health literacy regarding disease management
- Lack of culturally and linguistically appropriate mental health outreach and resources for the Asian community specifically addressing high suicide rates
- Language and cultural barriers that keep people from seeking health care

Strategies for Improvement

- Translate health messages for culturally and linguistically diverse communities, especially those addressing mental health issues
- Strategically target health messages and outreach to diverse populations

- Partner with community groups, community organizations, churches, libraries and other community gathering places to promote health messages
- Use community health promoters to convey prevention messages
- Increase the knowledge of health care providers to more appropriately serve people with disabilities
- Increase diversity among health care providers
- Address generational and gender differences, especially in diverse cultures, that create barriers to accessing health information
- Engage communities in a dialogue about health

4. Health Care Services and Preventive Services

Assets

- Top notch health care practitioners and facilities
- County efforts to provide health care services to diverse populations
- Community clinics and County hospitals
- Urgent care centers
- County asthma and diabetes programs
- Health events targeting specific communities and populations (including the transgender population) including local health screenings
- Community health educators
- On-call nurses at senior centers
- Montgomery County Care for Kids program
- Domestic violence and child abuse services
- Suicide prevention groups for students
- School-based health care
- Grocery stores offering vaccines

Challenges

- Difficulty finding providers that accept Medicare and Medicaid, especially specialists who accept Medicaid
- Insufficient mental and behavioral health services
- Lack of coordination of health care services, especially for people with multiple health issues
- Lack of affordable dental care
- Increased number of prescriptions written, unnecessary medical tests, and over-medication
- Lack of teen suicide prevention services and programs addressing teen alcohol abuse and DUI
- Lack of knowledge and outreach among nail salon workers
- Generational differences and cultural gender-specific roles that affect access to health information
- Lack of knowledge among health care providers to appropriately serve people with disabilities

Strategies for Improvement

- Increase mental health services for children and adults and promote mental health awareness, especially in culturally and linguistically diverse communities

- Improve coordination of health care services, especially for residents with multiple health issues
- Improve integration of health care services and social services
- Provide affordable dental care for low-income families and free dental care for low-income pregnant women
- Increase the availability of health and wellness services for seniors
- Increase investment in and promotion of preventive health care and health messaging focused on prevention
- Provide programs addressing teenage alcohol abuse
- Integrate mental health services with treatment for disabilities
- Increase awareness and skill among health care providers about caring for people with disabilities
- Leverage the state medical license authority to mandate regular training of medical providers on how to best address the spectrum of disabilities
- Offer incentives for practitioners to treat people with disabilities, especially those who are unable to afford treatment
- Provide tax incentives to health care facilities to increase the accessibility of the facilities
- Institute a faster identification program for people with new diagnoses of disability
- Control deer population to prevent Lyme disease

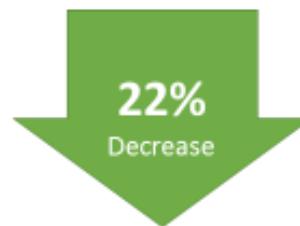
B. By the Numbers: Are We Making Progress?

The percent of residents with no health insurance coverage is improving but has not reached the Healthy People 2020 target of 0%.

Percent Uninsured

- The percent of residents without health insurance coverage has decreased by 22% from its 12.5% baseline in 2010 to 9.7% in 2014. A 9.7-point-reduction is needed to meet the Healthy People 2020 Target

From 12.5% in 2010...



22%
Decrease

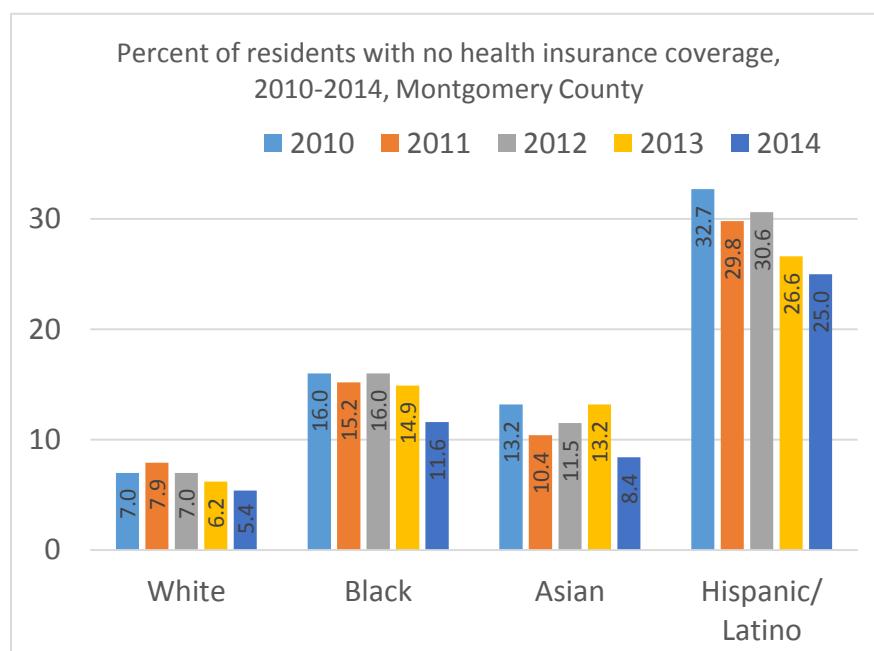
TARGET= 0%



Adults 19-25 years are 6 times more likely to lack health insurance than older adults 65+ years.
Montgomery County ranked 13th among 24 Maryland jurisdictions for the percent of population uninsured in RWJF County Health Rankings.

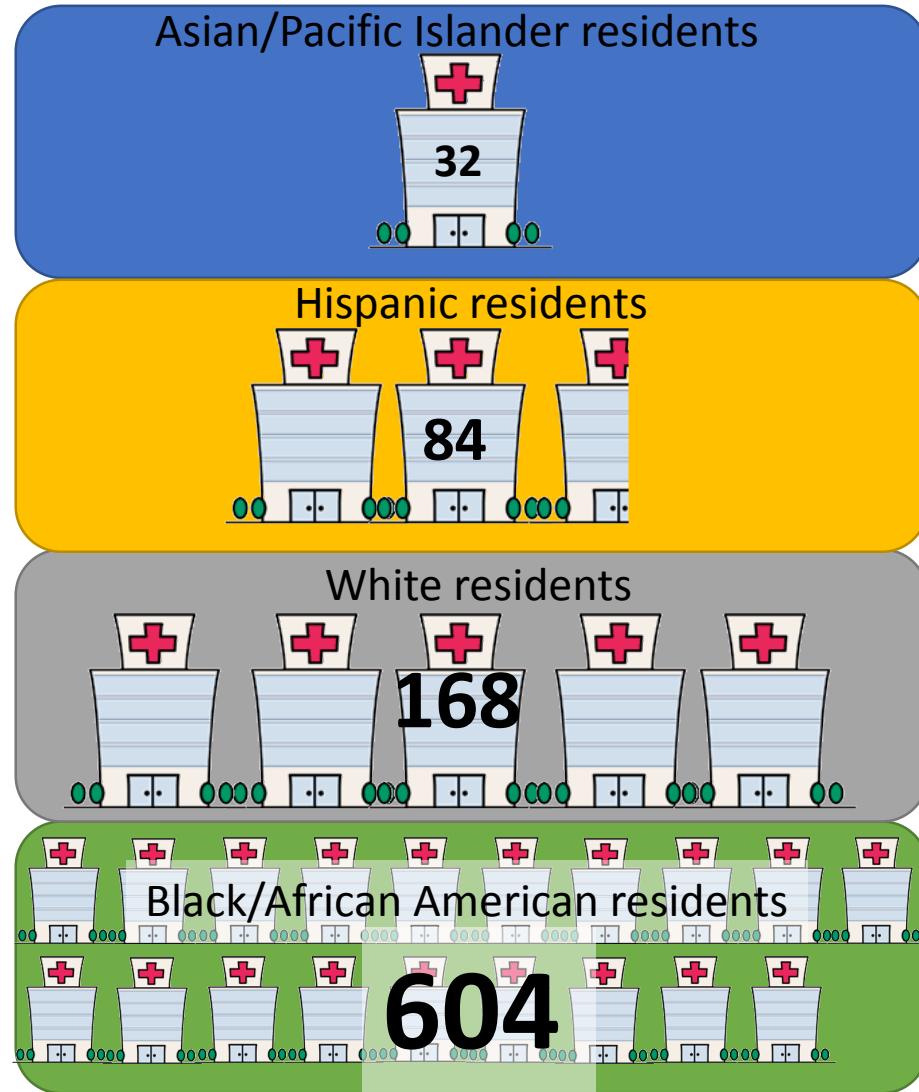
C. By the Numbers: Are We Achieving Equity?

Hispanic residents are almost 5 times more likely to be uninsured than White residents.



The rate of uninsured residents has decreased 19% from 2010 (32.7%) to 2014 (25%) among Hispanics; Hispanic residents are 4.6 times more likely to not have health insurance than White residents (essentially the same as in 2010).

Dental Care-Related ER Visits



In 2014:

- Non-Hispanic Black residents were almost 20 times more likely than Non-Hispanic Asian residents to visit ER for dental care (green box below)
- Non-Hispanic White residents were 5 times more likely than Non-Hispanic Asian residents (gray box below)
- Hispanics were 2.6 times more likely than Non-Hispanic Asian residents (yellow box below)
- Black disparity gap with Asian/Pacific Islander residents has widened by 7% from 2010 to 2014

Non-Hispanic Black residents dental care-related emergency room visits were almost 20 times higher (604 visits per 100,000 population) than non-Hispanic Asian residents (32) in 2014.

While this rate is below the Maryland State Health Improvement Process (SHIP) 2017 Goal of 792, the rate has increased – in the wrong direction by 26% – from 478 in 2010 to 604 in 2014.

The only other racial/ethnic subgroup that has worsened more in that same time period is non-Hispanic white residents whose dental care-related ER visits increased 30% from 129 visits per 100,000 population in 2010 to 168 in 2014.

D. Hospital Alignment

	Adventist HealthCare	Holy Cross Health	MedStar Montgomery Medical Center	Suburban Hospital
Health Care Coverage	<ul style="list-style-type: none"> Quality Improvement Organization Partnership- partners w/Medicare Quality Innovation Network, Virginia Quality Care Center; provides coordinated care for Medicare beneficiaries, improves care delivery, improves health and reduces growth in costs for Medicare beneficiaries. Washington Adventist Health (WAH) Population health services offered under the Global Budget Revenue (GBR) model maintains high quality healthcare while containing healthcare costs; treats patients beyond the hospital. Walgreens 340b Drug Program- offers 30 days of medication prior to discharge; WAH subsidizes medications based on financial status. Prescription Produce Program provides prescription for healthy food. 	<ul style="list-style-type: none"> Population Health ACA Enrollment Task Force facilitates ACA health insurance enrollment for patients and community members; task force includes members from financial counseling, DECO, patient registration, Faith Community Nursing, Community Health Workers and Linking Individuals to Community Services (LINCS) coordinator ED-PC connect program reduces/eliminates out-of-pocket costs for unnecessary ED utilization by educating patients on primary care and referring uninsured and Medicaid recipients to Holy Cross Health Centers 	<ul style="list-style-type: none"> Patient Financial Assistance Program facilitates ACA enrollment assistance to patients and community members who reside within the hospital service area ED-PC Connect Program and Patient Navigation Program reduce/eliminate out-of-pocket costs for certain preventive services and educate and encourage enrollees to access these services 	<ul style="list-style-type: none"> Suburban Hospital and Patient Access facilitate health ACA health insurance enrollment Suburban Hospital, Community Health & Wellness Department, Cancer Patient Nurse Navigators, and HeartWell Program reduce/eliminate out-of-pocket costs for certain preventive services and educate and encourage enrollees to access these services
Health Care Access	<ul style="list-style-type: none"> See You in 7 Program- Transitional Care Team, Emergency Department U- Turn Team and Case Management Team ensure acute follow up appointment 7 days after discharge. WAH provides preventive (e.g. blood pressure) screenings at local barber shops and beauty salons Outpatient care management 	<ul style="list-style-type: none"> Holy Cross Health Centers inform patients about the benefits of preventive services and offer clinical preventive services, LINCS and Community Health Workers inform patients about the benefits of preventive services and refer community members to clinical preventive services offered at Holy Cross Health 	<ul style="list-style-type: none"> ED-PC Connect program and Women's Health Improvement Program inform patients about the benefits of preventive services and offer clinical preventive services Case Management Transitional Care Program expands the use of community health workers and home visiting programs 	<ul style="list-style-type: none"> Suburban Hospital, Community Health & Wellness Department, Cancer Patient Nurse Navigators, and HeartWell Program inform patients about the benefits of preventive services and offer clinical preventive services Suburban Hospital, Mobile Med/NIH Heart Clinic @ Suburban Hospital, Mobile Med/NIH Endocrine Clinic @

	Adventist HealthCare	Holy Cross Health	MedStar Montgomery Medical Center	Suburban Hospital
	<p>program in partnership with Family Services Inc. Community Health Workers facilitates transition from hospital to home; monitors patients for 30 days after discharge, meetings 6 times a month.</p> <ul style="list-style-type: none"> • High Risk Discharge Program in which RNs set a time to carry out a home visit within 48-72 hours of discharge to provide safety check, medication education, discharge instructions, follow up appointments and chronic disease management. • Established Center for Health Equity and Wellness to promote health equity throughout all AHC entities • AHC is participating in the American Hospital Association's Pledge for Equity, promoting diversity in leadership 	<p>Centers</p> <ul style="list-style-type: none"> • Holy Cross Health Centers have expanded hours of operation and offer services in convenient locations • Holy Cross Health expands the use of home visiting programs • Holy Cross Health provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs • Holy Cross Health has established culturally and linguistically appropriate goals, policies, and management accountability, and infused them throughout planning and operations • Holy Cross Health has established leadership support and diversity among managers and board members 	<ul style="list-style-type: none"> • MedStar Health/MedStar Montgomery Medical Center provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs • MedStar Health/MedStar Montgomery Medical Center has established culturally and linguistically appropriate goals, policies, and management accountability, and infused them throughout planning and operations • MedStar Health/MedStar Montgomery Medical Center has established leadership support and diversity among managers and board members 	<p>Suburban Hospital establish patient and clinical reminder systems for preventive services</p> <ul style="list-style-type: none"> • Suburban Hospital, Mobile Med/NIH Heart Clinic @ Suburban Hospital, Mobile Med/NIH Endocrine Clinic @ Suburban Hospital have expanded hours of operation and, offer services in convenient locations • Care Coordination and Transition expands the use of community health workers and home visiting programs • Suburban Hospital, Mobile Med/NIH Heart Clinic @ Suburban Hospital, Mobile Med/NIH Endocrine Clinic @ Suburban Hospital provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs • Suburban Hospital has established culturally and linguistically appropriate goals, policies, and management accountability, and infused them throughout planning and operations • Suburban Hospital and the Community Benefit Advisory Council has established leadership support and diversity among managers and board members
Coordinated/ Integrated Care	<ul style="list-style-type: none"> • Both Shady Grove Medical Center and (SGMC) and WAH have implemented an electronic medical record • Population Health Team and 	<ul style="list-style-type: none"> • Holy Cross Health uses certified electronic health records and personal health records • Holy Cross Health has adopted medical home or team-based care 	<ul style="list-style-type: none"> • MedStar Health/ MedStar Montgomery Medical Center uses certified electronic health records and personal health records • MedStar Health/ MedStar 	<ul style="list-style-type: none"> • Suburban Hospital uses certified electronic health records and personal health records • Suburban Hospital, Partnership with safety-net clinics and Cross-

	Adventist HealthCare	Holy Cross Health	MedStar Montgomery Medical Center	Suburban Hospital
	<p>Readmission Review Team conduct readmission review of patients to aid in readmission prevention</p> <ul style="list-style-type: none"> • Population Health Team & Emergency Department (ED) - develop comprehensive plans for frequent ED users; meet social needs, connect to community resources and transportation to follow up appointments. • Center for Health Equity and Wellness, CareLink, Community Clinics Incorporated (CCI), Walgreens 340b Drug Program, MCPS EMS Partnership, Housing and Homeless Initiative, Churches and Faith Community Nurses Program connect patients with numerous community resources. • AHC partners with Family Services Inc., community health workers, nurses, physicians, churches, non-profit Structured Employment Economic Development Corporation (SEEDCO), and CCI to examine the wellbeing of patients after release and connect them with community resources. 	<p>models</p> <ul style="list-style-type: none"> • Holy Cross Health creates linkages and connects patients to community resources, family support and education programs through their LINCS program, Community Health Workers, Faith Community Nurses and other community-based programs • Holy Cross Health facilitates coordination among diverse care providers. 	<p>Montgomery Medical Center has adopted medical home or team-based care models</p> <ul style="list-style-type: none"> • ED-PC Connect Program and Community Outreach Program creates linkages and connects patients to community resources, family support and education programs • ED-PC Connect Program and MedStar Health/ MedStar Montgomery Medical Center facilitate coordination among diverse care providers. 	<p>Continuum Collaborative have adopted medical home or team-based care models</p> <ul style="list-style-type: none"> • Suburban Hospital, Social Workers, Community Health & Wellness and Care Coordination & Transition facilitate coordination among diverse care providers
Health Literacy	<ul style="list-style-type: none"> • During cultural competency trainings, providers are encouraged to use the teach-back method to assess patient understanding. • Faith Community Nurses Program targets faith community members promoting healthy living through health education, screenings, prevention practices and supportive programs tracking 	<ul style="list-style-type: none"> • Holy Cross Health uses proven methods of checking and confirming patient understanding of health promotion and disease prevention • Holy Cross Health uses alternative communication methods and tools to support traditional written and oral communication • Holy Cross Health refers patients to adult education and English- 	<ul style="list-style-type: none"> • MedStar Health/ MedStar Montgomery Medical Center uses proven methods of checking and confirming patient understanding of health promotion and disease prevention • MedStar Health/ MedStar Montgomery Medical Center uses alternative communication methods and tools to support 	<ul style="list-style-type: none"> • Suburban Hospital, Nursing Councils and Community Health & Wellness use proven methods of checking and confirming patient understanding of health promotion and disease prevention • Patient Family Advisory Council and Community Benefit Advisory Council involves consumers in planning, developing, disseminating and evaluating health and safety

	Adventist HealthCare	Holy Cross Health	MedStar Montgomery Medical Center	Suburban Hospital
	<p>health and progress.</p> <ul style="list-style-type: none"> • Through Remote Patient Monitoring Program tele scales and blood pressure cuffs evaluate signs and symptoms of congestive heart failure patients; data is sent to a dashboard where it is monitored by a nurse. • WAH works with Community Clinics Incorporated (CCI) volunteers who use software to identify uninsured patients by their electronic health record and screen them for benefits. • Adventist HealthCare Center for Health Equity and Wellness offers health education, community needs assessments and a tobacco cessation program. • Qualified Bilingual Staff program and other methods for language interpretation 	<p>language instruction programs to help enhance understanding of health promotion and disease prevention messages</p> <ul style="list-style-type: none"> • Holy Cross Health communicates with patients in an appropriate manner so that patients can understand and act on their advice and directions 	<p>traditional written and oral communication</p> <ul style="list-style-type: none"> • MedStar Health/ MedStar Montgomery Medical Center and Community Outreach Program refers patients to adult education and English-language instruction programs to help enhance understanding of health promotion and disease prevention messages • MedStar Health/ MedStar Montgomery Medical Center communicates with patients in an appropriate manner so that patients can understand and act on their advice and directions 	<p>information</p> <ul style="list-style-type: none"> • Patient education on iPads and Smart TVs uses alternative communication methods and tools to support traditional written and oral communication • Partnership with Montgomery County Minority Health Initiatives/Program refers patients to adult education and English-language instruction programs to help enhance understanding of health promotion and disease prevention messages • Suburban Hospital, Nursing Council and Patient Advisory Council communicate with patients in an appropriate manner so that patients can understand and act on their advice and directions

E. Community Resources

(Note: The acronyms following each entry below represent the agencies and organizations that provide the resource listed; a list of the agencies and organizations represented by the acronyms can be found at the end of the section).

1. State and Local Government

Assistance Accessing Services

- 311 is Montgomery County government's telephone number for accessing government programs and services; customer Service representatives use a state-of-the-art database of information and services; the database can also be searched online; language interpretation services are available as is TTY for people who are hearing impaired (MCG)
- Montgomery County's Maryland Health Benefit Exchange (MHBE) Connector Entity program works to expand access to health insurance coverage for County residents under the ACA; Connector Entity personnel (navigators) provide eligibility determination and/or enrollment support within Maryland Health Connection (the state's online health insurance enrollment portal); navigators help enroll all eligible, uninsured and under-insured individuals into health coverage options, including private health insurance carriers, Qualified Health Plans Medicaid, and the Maryland Children's Health Program ; a team of outreach partners assist with expanding health literacy throughout Montgomery County as well as prepare applicants for the enrollment process; the Department of Health and Human Services serves as the Connector Entity for Montgomery County (DHHS)
- The Office of Eligibility & Support Services serves low-income families and individuals facing significant challenges in meeting basic needs including food, shelter and medical coverage. The program determines eligibility for: Temporary Cash Assistance (TCA), Temporary Disability Assistance Program, Refugee Cash Assistance, and Supplement Nutrition Assistance Program (SNAP); manages a required employment program for applicants and recipients of TCA; assists with health insurance enrollment under the ACA and includes the following programs Community Medical Assistance; Maryland Children's Health Program, Medical Assistance for Families and Children, and Refugee Medical Assistance. It also offers health coverage through Montgomery Cares (for uninsured low-income residents in the County) and Care for Kids, Senior Dental and The Maternity Partnership Program (for uninsured, undocumented pregnant women in Montgomery County) (DHHS)

Legislation to Enhance Health Care Access

- County law requires companies to provide or approve leave time in order for their employees to seek assistance from Montgomery County's Maryland Health Benefit Exchange (MHBE) Connector Entity personnel (MCC)
- County law encourages companies seeking County contracts to document the provision of health insurance coverage to its employees; documentation of such coverage will favorably impact the company's score during the contract review process; the Department of Health and Human Services will review and certify that the company has met the criteria for documented insurance coverage of its employees (MCC)

Primary Care

- The Montgomery Cares safety-net clinic program (public-private partnership administered by the Primary Care Coalition and composed of 12 independent clinics, including four hospital systems, and DHHS) provides primary and preventive health care services, prescriptions, specialty care, limited behavioral health and oral health services for low-income, uninsured adults who may not qualify for Medicaid due to immigration status (DHHS) (PCC)¹²
- Care for Kids (public-private partnership administered by the Primary Care Coalition) provides access to health care services for uninsured children in the County; pediatric care includes well child visits, sick visits, prescription medicines, optometry, dental, and other limited specialty care services. Pediatric health care providers include Kaiser Permanente, Community Clinic, Inc., Catholic Charities McCarrick Medical Clinic, DHHS School-Based Health and Wellness Centers, Mary's Center for Maternal and Child Care, and two private physician practices (DHHS) (PCC)
- On-site medical care and dental services are provided at the County's three year-round emergency shelters by Mobile Med (medical contractor) and The Mobile Dentist (dental contractor) (DHHS)
- DHHS Public Health Services/Health Care for the Uninsured conduct discharge planning for patients experiencing homelessness in collaboration with all six local hospitals (DHHS)
- DHHS Public Health Services/Health Care for the Uninsured provide on-site nurse case management services to individuals who previously experienced homelessness and are living in permanent supportive housing (DHHS)

Dental Services

- Dental Services/HIV Dental Program provides dental services to promote oral health in six dental clinics; services are provided to income-eligible Montgomery County children, pregnant women, adults, seniors, and HIV-positive clients (DHHS)
- General dental care is provided to maternity patients of all ages who are enrolled in nurse case management services under the Montgomery County Maternity Partnership Program (DHHS)
- Dental Services for children provides general dental care, including preventive, restorative, and emergency dental services to children age 3 through 18 years of age who are enrolled in the Care for Kids program and are uninsured or do not have dental insurance (DHHS)
- Dental Services for adults, provides general dental care, including preventive, restorative and emergency dental services are provided to adults 19 years and older at reduced rates (DHHS)
- On-site medical care and dental services are provided at the County's three year-round emergency shelters by Mobile Med (medical contractor) and The Mobile Dentist (dental contractor) (DHHS)

¹² Montgomery Cares Clinics include: Holy Cross Health (various locations), Mobile Med (various locations), CCACC-Pan Asian Volunteer Health Clinic, Community Clinic, Inc. (various locations), Mercy Health Clinic, Proyecto Salud (various locations), Mansfield Kaseman Health Clinic, Care for Your Health, Catholic Charities McCarrick Medical Center, Mary's Center Clinic, Muslim Community Center Medical Clinic, and the People's Community Wellness Center.

Services for Special Populations

- Nurse monitoring services are provided to more than 2,000 senior and clients with disabilities receiving services through the State's Medicaid waiver program, Community First Choice (DHHS)
- Children with Special Health Care Needs Coordination Program assists low income, uninsured families with obtaining special medical care for their children with chronic medical conditions or disabilities by linking them to needed services (DHHS)
- Refugee and Asylee Health Program provides refugees and asylees with a comprehensive health assessment/screening for STD/HIV/AIDS, tuberculosis, measles, mumps, rubella, varicella, Hepatitis B, syphilis, stool testing, lead screening and other communicable diseases; also ensures that migrant workers have access to county health care services (DHHS)
- Childhood Lead Poisoning program, in collaboration with the Maryland Department of Environment, offers home visitation, environmental home inspections, and health education to families of severely lead-poisoned children (DHHS)
- Autism Waiver Service Coordination provides service coordination to children diagnosed with severe autism, ages birth - 21 years, who are currently enrolled in the autism waiver program (DHHS)

Communicable Disease Control

- Tuberculosis Services Program includes testing persons for exposure to Tuberculosis (TB), treating active cases, identifying persons at risk of developing TB, performing contact studies to determine who may have been exposed to an infectious person, and medication therapy; special programs are provided to high-risk populations such as the people experiencing homelessness, addicted persons, incarcerated persons, and persons living in high-density areas of foreign-born populations (DHHS)
- STD/HIV Testing Program provides testing and treatment for Sexually Transmitted Diseases (STDs) for County residents; free, anonymous and confidential HIV testing is open to all and includes pre-test counseling and post-test counseling (DHHS)
- The Rabies Program provides consultation to medical providers and County residents regarding potential human exposure to animal bites and other possible exposures; dispenses both rabies vaccine and rabies immune globulin, when appropriate, to County residents (DHHS)

Minority Health Initiatives/Program, LIEED

- The African American Health Program (AAHP) mission is to eliminate health disparities and improve the number and quality of years of life for African Americans and people of African descent in Montgomery County; focuses on health and wellness targeting infant mortality, HIV/AIDS, diabetes, oral health, cardiovascular disease and cancer; provides outreach, health education, support groups and nurse case management services; the program is staffed by Registered Nurses, Nutritionist, Diabetes Educators, Health Educators and Community Health Outreach Workers (AAHP)
- The Montgomery County Latino Health Initiative (LHI) is committed to improving the quality of life for Latinos living in Montgomery County by contributing to the development and implementation of an integrated, coordinated, culturally and linguistically competent health wellness system that supports, values, and respects Latino families and communities;

programs include the Health Promoter Program, "Vias de la Salud," designed to improve the health and well-being of the low income Latino community of Montgomery County; the Latino Asthma Management Program increases the knowledge of Latino parents of children with asthma regarding the condition and its management, and increases awareness and use of pediatric clinical services; and the Welcome Back Center which provides a comprehensive, integrated and coordinated approach to effectively address the needs and decrease the challenges and barriers that foreign-trained nurses encounter in Maryland while obtaining their nursing licenses (LHI)

- Asian American Health Initiative (AAHI) identifies the health care needs of the Asian American community, develops culturally competent health care services, and implements health education programs that are accessible and available for all Asian Americans in Montgomery County; provides education and awareness about Hepatitis B, cancer (breast, cervical, colorectal, and prostate), diabetes, osteoporosis, and tobacco control (among other topics) through seminars, health events, and community outreach; a conducts on-site osteoporosis screenings at community events and provides referrals to community services (such as cancer screenings) to eligible Montgomery County residents; has also developed a Patient Navigators Program to provide culturally and linguistically appropriate services and interventions to Asian Americans (AAHI)
- The Leadership Institute for Equity and the Elimination of Disparities (LIEED) seeks ways to enhance the practice, policy and infrastructure of DHHS to best serve racially, linguistically and ethnically diverse communities, including emerging populations; LIEED provides strategic leadership and coordination on systemic issues impacting health and wellness, works on specific projects related to addressing health disparities and equity, engages racial/ethnic minority communities in a manner that promotes and fosters trust, improves DHHS's ability to deliver culturally and linguistically appropriate services, and cultivates an organizational culture that promotes fairness and opportunity (DHHS)

2. Early Learning Centers, Schools, Colleges and Universities

- School Health Services include first aid/emergency care, medication and treatment administration, hearing and vision screenings, case management of students with chronic health conditions, health promotion/education, and linking students to health care providers and other resources; School Community Health Nurses (RNs) and School Health Room Technicians (Certified Nursing Assistants) provide a public health presence in schools to prevent and contain communicable diseases, assure that students are appropriately immunized, and respond to school and community wide emergencies; also provide specialized programs including Head Start Health Services, School-Based Health and Wellness Centers, Teen Pregnancy Prevention and Parenting Program and the School Health Services Center at the MCPS International Student Office (DHHS) (MCPS)
- School-Based Health and Wellness Centers (SBHWC) operate in twelve County schools providing comprehensive health, mental health, social services, case management and health promotion; services are free or cost a nominal amount for students enrolled in the SBHWC; students eligible for enrollment include students who attend the school, their uninsured siblings, and children enrolled in the County's Care for Kids Program who live in the zip code served by the school (for elementary school students) or are assigned to the Wellness Center site (for high school students); each site is staffed with a school nurse,

- certified nursing assistant, a site coordinator, a nurse practitioner, a pediatrician, a case manager, and a licensed mental health counselor or therapist (DHHS) (MCPS)
- Social Workers in MCPS implement the Head Start Family and Community Partnership Performance Standard to promote service integration (MCPS)

3. Health Care Systems, Insurers and Clinicians

- Insurers of non-grandfathered ACA plans provide coverage, at no cost to the enrollees, for an oral health risk assessment for young children, developmental screening for children under age 3 and surveillance throughout childhood, hearing screenings for all newborns, and vision screening for all children (ACA)
- Community Ministries of Rockville's Mansfield Kaseman Health Clinic provides quality healthcare and healthcare education to low-income, uninsured County residents and to homeless women (CMR)
- Proyecto Salud Clinic serves Montgomery County's uninsured immigrant community; its mission is to outreach to the language minority community of Montgomery County and to improve the health status of this community through health services, health education, and disease prevention (PS)
- The Montgomery Cares safety-net clinic program (public-private partnership administered by the Primary Care Coalition and composed of 12 independent clinics, four hospital systems, and the Montgomery County Department of Health and Human Services) provides primary and preventive health care services, specialty care, and limited behavioral health and dental services for low-income, uninsured adults who, because of immigration status, may not qualify for Medicaid (DHHS) (PCC)
- DHHS Public Health Services/Health Care for the Uninsured conduct discharge planning for homeless patients in collaboration with all six local hospitals (DHHS)
- Several dental clinics in Montgomery County and Greater Metropolitan Area provide dental care at reduced rates for low income adults and children including the Howard University College of Dentistry, Mary's Center Dental Clinic, the Muslim Community Center and the Catholic Charities McCarrick Dental Clinic
- The Commission on People with Disabilities and the Commission on Health work to increase health prevention strategies for secondary illnesses in people with physical, developmental, cognitive, psychiatric and sensory disabilities; includes ensuring equitable access to health promoting venues and increasing recreational programming to better engage people with disabilities in health promoting activities (COPD) (COH)

[Note: Hospital programs and services are provided in the Hospital Alignment Subsection D above]

4. Community, Non-profit, and Faith Based Organizations

- *infoMONTGOMERY* is a collaborative effort of public and private agencies to provide detailed information about health, education and human service resources throughout Montgomery County to link individuals and families with services that can help (CC)
- Pathways to Services connects callers with community resources to assist children with emotional and/or behavioral needs (CC)

- Family Navigation program provides peer assistance program in which selected experienced parents assist families to navigate available programs and effectively advocate for their child with intensive behavioral health needs (CC)
- "Health Home" consumers involved in Psychiatric Rehabilitation Programs are offered care coordination and whole-person integrated behavioral and somatic wellness services (FSI)
- CareLink Transitions involves partnership with area hospitals with services geared toward preventing unnecessary hospital readmissions for patients through case management and coordinated care (FSI)
- Identity Inc., provides HIV prevention services to high-risk Latinos youth age 14 to 21 at two Youth Opportunity Centers (Takoma Park and Gaithersburg), a mobile unit, and the Montgomery County Correctional Facility (II)
- Community Ministry of Montgomery County provides shelter for women, healthcare and healthcare education, short term financial assistance, case management services, and language outreach (CMMC)
- Mary's Center provides health care, family literacy and social services to individuals whose needs go unmet by the public and private systems (MC)

Affordable Care Act (ACA)

African American Health Program (AAHP)

Asian American Health Initiative (AAHI)

Catholic Charities McCarrick Medical Center (CMMC)

Community Ministries of Rockville, Inc. (CMR)

Community Ministry of Montgomery County (CMMC)

Family Services, Inc. (FSI)

Identity Inc. (II)

Latino Health Initiative (LHI)

Mary's Center (MC)

Montgomery County Collaboration Council for Children, Youth and Families (CC)

Montgomery County Commission on Health (COH)

Montgomery County Commission on People with Disabilities (COPD)

Montgomery County Council (MCC)

Montgomery County Public Schools (MCPS)

Primary Care Coalition (PCC)

Proyecto Salud (PS)

F. What Works

(Note: The acronyms following each entry below represent the source for the evidence-based strategy listed; a list of the acronyms and the source they represent can be found at the end of the section).

1. Community, Non-profit, and Faith Based Organizations

- Inform people about the range of preventive services they should receive and the benefits of preventive services (NPS)
- Support use of retail sites, schools, churches, and community centers for the provision of evidence-based preventive services (NPS)
- Expand public-private partnerships to implement community preventive services (e.g., school-based oral health programs, community-based diabetes prevention programs) (NPS)
- Support community health workers, patient navigators, patient support groups, and health coaches (NPS)

- Help ensure that prevention strategies are culturally, linguistically, and age appropriate, and that they match people's health literacy skills (NPS)
- Provide Internet access and skill-building courses to help residents find reliable health information and services (NPS)
- Offer accurate, accessible, and actionable health information in diverse settings and programs (NPS)
- Develop and disseminate health and safety information that is accurate, accessible, and actionable (NAP)
- Increase the dissemination and use of evidence-based health literacy practices and interventions (NAP)
- Support and expand local efforts to provide adult education, English language instruction, and culturally and linguistically appropriate health information services in the community (NAP)

2. Health Care Systems, Insurers and Clinicians

- Use proven methods of checking and confirming patient understanding of health promotion and disease prevention (e.g., teach-back method) (NPS)
- Involve consumers in planning, developing, implementing, disseminating, and evaluating health and safety information (NPS)
- Use alternative communication methods and tools (e.g., mobile phone applications, personal health records, credible health websites) to support more traditional written and oral communication (NPS)
- Refer patients to adult education and English-language instruction programs to help enhance understanding of health promotion and disease prevention messages (NPS)
- Inform patients about the benefits of preventive services and offer recommended clinical preventive services, including the ABCS, as a routine part of care (NPS)
- Adopt and use certified electronic health records and personal health records (NPS)
- Adopt medical home or team-based care models (NPS)
- Reduce or eliminate client out-of-pocket costs for certain preventive services, as required for most health plans by the ACA, and educate and encourage enrollees to access these services (NPS)
- Establish patient (e.g., mailing cards, sending e-mails, or making phone calls when a patient is due for a preventive health service) and clinical (e.g., electronic health records with reminders or cues, chart stickers, vital signs stamps, medical record flow sheets) reminder systems for preventive services (NPS)
- Expand hours of operation, provide child care, offer services in convenient locations (e.g., near workplaces), or use community or retail sites to provide preventive services (NPS)
- Create linkages with and connect patients to community resources (e.g., tobacco quit lines), family support, and education programs (NPS)
- Facilitate coordination among diverse care providers (e.g., clinical care, behavioral health, community health workers, complementary and alternative medicine) (NPS)
- Expand the use of community health workers and home visiting programs (NPS)
- Communicate with patients in an appropriate manner so that patients can understand and act on their advice and directions (NPS)

- Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs (CLAS) (NAP)
- Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations (CLAS) (NPS)
- Establish leadership support and diversity among managers and board members (CLAS)

3. Businesses and Employers

- Provide interventions that promote seasonal influenza vaccinations among health-care and non-healthcare workers (e.g., on-site, reduced cost, and actively promoted vaccinations) (CG)
- Assess health risks with feedback combined with health education programs (CG)
- Offer health coverage that provides employees and their families with access to a range of clinical preventive services with no or reduced out-of-pocket costs (NPS)
- Provide incentives for employees and their families to access clinical preventive services, consistent with existing law (NPS)
- Give employees time off to access clinical preventive services (NPS)
- Provide employees with on-site clinical preventive services (including preventive screenings) and comprehensive wellness programs, consistent with existing law (NPS)
- Provide easy-to-use employee information about clinical preventive services covered under the ACA (NPS)
- Offer accurate, accessible, and actionable health information in diverse settings and programs (NPS)
- Develop and disseminate health and safety information that is accurate, accessible, and actionable (NAP)
- Partner with local resources such as libraries and literacy programs to enhance employees' ability to identify and use reliable health information (NPS)
- Use media to promote health (e.g., television, Internet, social networking) (NPS)

4. Early Learning Centers, Schools, Colleges and Universities

- Incorporate health education into coursework (e.g., by embedding health-related tasks, skills, and examples into lesson plans) (NPS)
- Incorporate accurate, standards-based, and developmentally appropriate health and science information and curricula in child care and education through the university level (NAP)
- Increase the dissemination and use of evidence-based health literacy practices and interventions (NAP)
- Develop and disseminate health and safety information that is accurate, accessible, and actionable (NAP)
- Train providers (e.g., doctors, nurses, dentists, allied health professionals) to use health information technology and offer patients recommended clinical preventive services as a routine part of their health care (NPS)
- Promote the use of evidence-based preventive services within health services (e.g., school health program) (NPS)
- Implement and maintain school-based health centers (SBHCs) in low-income communities, to improve educational and health outcomes (including the delivery of vaccinations and

- other recommended preventive services, asthma morbidity, emergency department and hospital admissions, contraceptive use among females, prenatal care and birth weight, and other health risk behaviors) (CG)
- Offer preventive services (e.g., mental health services, oral care, vision, and hearing screenings) for all children, especially those at risk (NPS)
 - Provide school-based sealant delivery programs to prevent dental caries (tooth decay) among children (5 to 16 years of age) (CG)
 - Support and expand local efforts to provide adult education, English language instructions, and culturally and linguistically appropriate health information services in the community (NAP)
 - Increase basic research and the development, implementation, and evaluation of practices and interventions to improve health literacy (NAP)
 - Conduct outreach to increase diversity (e.g., racial/ethnic, income, disability) in health care and public health careers (NPS)
 - Integrate appropriate core public health competencies into relevant curricula (e.g., nursing, medicine, dentistry, allied health, pharmacy, social work, education) and train professionals to collaborate across sectors to promote health and wellness (NPS)

5. State and Local Government

- Offer accurate, accessible, and actionable health information in diverse settings and programs (NPS)
- Develop and disseminate health and safety information that is accurate, accessible, and actionable (NAP)
- Support and expand local efforts to provide adult education, English language instructions, and culturally and linguistically appropriate health information services in the community (NAP)
- Increase delivery of clinical preventive services, including ABCS, by Medicaid and Children's Health Insurance Program (CHIP) providers (NPS)
- Foster collaboration among community-based organizations, the education and faith-based sectors, businesses, and clinicians to identify underserved groups and implement programs to improve access to preventive services (NPS)
- Create interoperable systems to exchange clinical, public health and community data, streamline eligibility requirements, and expedite enrollment processes to facilitate access to clinical preventive services and other social services (NPS)
- Expand the use of community health workers and home visiting programs (NPS)

Community Guide, Centers for Disease Control and Prevention (CG)

National Action Plan to Improve Health Literacy, U.S. Department of Health and Human Services (NAP)

National Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards), U.S. Department of Health and Human Services

National Prevention Strategy, Surgeon General, U.S. Department of Health and Human Services (NPS)

Key Findings: Underlying Factors – Healthy and Safe Communities

Overview

This **Underlying Factors – Healthy and Safe Communities** section of the Report provides information and data related to the natural environment (e.g., water, air, atmosphere) and the built environment (physical components that people create or modify such as buildings, public spaces, transportation systems). Issues such as housing, places to be physically active, public safety, and transportation networks are included in this section. The natural and physical environment can affect health and safety directly (e.g., clean water and air, safe and affordable housing) but can also influence community residents' health-related choices (e.g., affordable and reliable transportation networks can facilitate access to places to purchase healthy food and be physically active). A healthy and safe community can help make healthy choices easy, affordable, and universally available.¹³

What We Can Do

Leverage/Enhance Existing Efforts:

- Promote safer and more connected communities that prevent injury, violence and crime (e.g., by designing safer environments, fostering economic growth, crime prevention through environmental design) and provide safe shared spaces for County residents to interact (e.g., parks, community centers) in community development plans, which can foster healthy relationships and positive mental health among community residents (**National Prevention Strategy**)¹⁴ based on the existing efforts of:
 - Maryland National Capital Park and Planning Commission
- Participate in the national voluntary accreditation of health departments (**National Prevention Strategy**) based on the existing efforts of:
 - Montgomery County Department of Health and Human Services

¹³ Centers for Disease Control and Prevention. CDC's Built Environment and Health Initiative. Accessed at: http://www.cdc.gov/nceh/information/built_environment.htm; U.S. Surgeon General, National Prevention Strategy. Strategic Directions and Priorities. Accessed at: <http://www.surgeongeneral.gov/priorities/prevention/strategy/intro-strategic-directions-priorities.pdf>

¹⁴ Three National Prevention Strategy recommendations are integrated here: promote safer and more connected communities that prevent injury and violence (e.g., by designing safer environments, fostering economic growth); implement policies to support modifications to the physical environment to deter crime (e.g., crime prevention through environmental design) and include safe shared spaces for people to interact (e.g., parks, community centers) in community development plans, which can foster healthy relationships and positive mental health among community residents.

Initiate Efforts:

- Establish and sustain a Health in All Policies (HiAP) model to include health criteria as a component of decision-making (**National Prevention Strategy**) based on the existing efforts of:
 - Maryland National Capital Park and Planning Commission
 - Montgomery County Recreation
 - Montgomery County Public Schools
 - Montgomery County Department of Transportation
 - Montgomery County Department of Environmental Protection
 - Montgomery County Police Department
 - Montgomery County Department of Health and Human Services
 - Montgomery County Department of Housing and Community Affairs
 - Montgomery County Department of Corrections and Rehabilitation

National Prevention Strategy, Surgeon General, U.S. Department of Health and Human Services

Information Gathered on Healthy and Safe Communities

A. From the Community Conversations

1. Transportation

Assets

-
- Improved pedestrian safety
 - Excellent road system
 - Well-maintained bicycle paths
 - Bike lanes
 - Bike share program
 - Inter-County Connector (ICC)
 - Red light/speed cameras

Challenges

-
- Bicyclists are at risk for injury and would benefit from increased off-road bicycle trails
 - Traffic congestion (and the long commutes resulting from the congestion) causes poor air quality, stress, safety concerns, and limited time for healthy recreational activities

Strategies for Improvement

-
- Continue County efforts to address dangerous conditions for pedestrians (e.g., complicated intersections, driver texting and phone use, lots of traffic); increased signage, speed and red

- light cameras, crosswalks and lights for pedestrians are needed as is the enforcement of laws prohibiting drinking and phone use while driving
- Ease traffic congestion by lowering tolls on the Inter County Connector and scheduling construction projects at times less disruptive to traffic

2. Health and Health Care

Challenges

- Traffic congestion causes poor air quality

Strategies for Improvement

- Check the quality of the drinking water in the area
- Enforce air quality regulations

3. Access to Healthy Food

Assets

- Healthier options and better food labeling in grocery stores and restaurants
- Farmer's markets
- Soda removal from schools
- Healthier options in vending machines
- Regulation prohibiting restaurants from using trans fats

Challenges

- High cost of healthy food; unhealthy food is inexpensive
- Too few farmers' markets
- Too many fast food restaurants

Strategies for Improvement

- Provide greater access to affordable, healthy food including more community gardens and partnerships with local farms to provide affordable food
- Provide incentives to restaurants to offer healthy food and buy food from local farmers
- Regulate food prices

4. Physical Activity and Recreation

Assets

- Parks, trails, recreation centers
- Availability of pools, tennis courts, soccer fields, golf courses, playgrounds
- School tracks open to the public
- Shopping malls open to the public for walking

Challenges

- Places to be active are not within walking distance
- Limited fitness options for seniors who cannot drive to senior or recreation centers
- Community centers close early

Strategies for Improvement

- Need more places to be active that are in walking distance
- Need more parks and exercise facilities in the community that are accessible to seniors and people with disabilities

5. Education

Asset

- Public schools are accessible to people with disabilities

Challenge

- Gang activity in schools

Strategies for Improvement

- Increase security in the schools to prevent violence, theft and drugs and lower gang involvement (e.g., more police personnel, more security cameras)
- Provide more effective regulations/consequences to prevent bullying

6. Public Safety

Assets

- County police presence
- County fire and rescue services

Challenges

- Unsafe neighborhoods
- Drugs

Strategies for Improvement

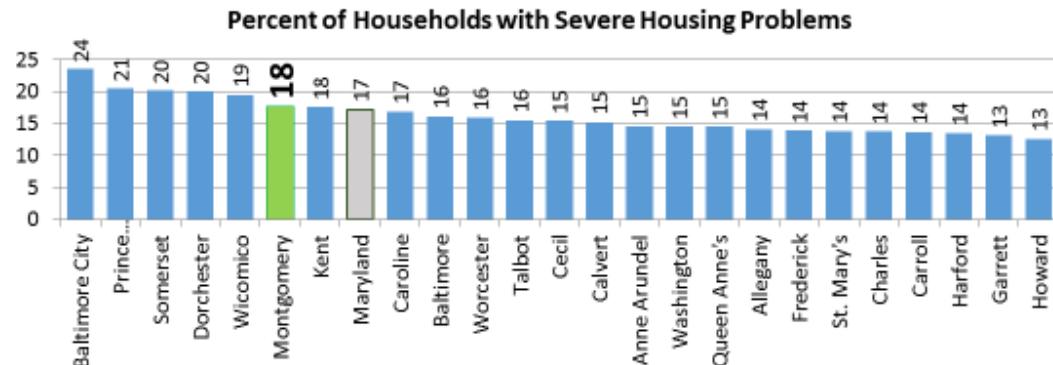
- Increase crime prevention and police presence to address unsafe neighborhoods and drugs
- Provide better lighting and emergency call boxes in parks
- Increase communication between police and the community
- Enforce underage drinking laws

B. By the Numbers: Are We Making Progress?

Neighborhood and built environment



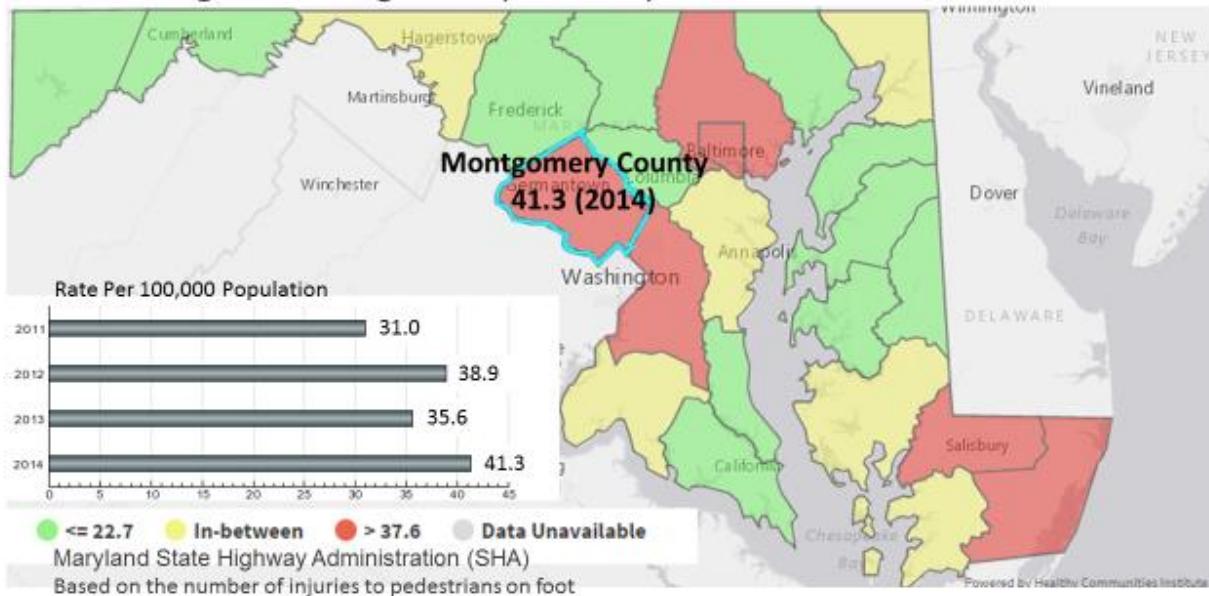
Percentage of households with at least 1 of 4 housing problems: overcrowding, **high housing costs***, or lack of kitchen or plumbing facilities



* Top housing problem in Montgomery County

C. By the Numbers: Are We Achieving Equity?

Pedestrian Injury Rate (Per 100,000) on Public Roads is Worsening in Montgomery County



D. Hospital Alignment

Throughout many of this Report's Key Findings sections, there is evidence of our County hospital systems' efforts to provide health care services and community-based programming that contribute to improving the health and safety of the County's communities.

Each hospital's community health benefit plan identifies and documents community health needs and the hospital's efforts to address those needs. The hospital systems' financial support of and active involvement in Healthy Montgomery are also central to their efforts to improve community health.

E. Community Resources

(Note: The acronyms following each entry below represent the agencies and organizations that provide the resource listed; a list of the agencies and organizations represented by the acronyms can be found at the end of the section).

1. State and Local Government

Public Safety

- Community Services Officer, in each of the six police districts, provides community outreach and community relations including addressing day- to-day citizen questions, maintaining station web site, providing community presentations, attending neighborhood/homeowner association meetings and assisting with Neighborhood Watch, CRIMEREPORTS.com, and National Night Out events (MCPD)
- Young Latino residents under the supervision of the Department of Correction and Rehabilitation are referred to the Latin American Youth Center for GED programming and other services (MCPD)
- Pre-release and Re-entry Services partners with Future Link to provide youth coaches, self-advocacy education, and other academic, vocational and career supports to assist vulnerable yet motivated young adults successfully transition into adulthood (MCPD)
- Clinical Assessment and Transition Services (CATS) is comprised of two components: assessment and post-booking diversion services within 24 hours of booking to inmates with behavioral health issues upon entry into the MC Detention Center, and discharge planning for inmates who are being released from the Correctional Facilities by assessing inmates' behavioral health needs and coordinating access to services in the community (DHHS)
- Projects for Assistance in Transition from Homelessness (PATH) is a federal/state program that targets re-entry mentally-ill individuals in the criminal justice system (DCR)
- Trauma Services provides integrated services to domestic violence victims and offenders, sexual assault victims, and victims of general crime including counseling and psychiatric care as well as a variety of specialty services; programming for domestic violence also includes information and referral, crisis intervention, safety planning, and placement in emergency shelter; services are also provided for victims of sexual assault (DHHS)

- Child Welfare Services provides protective, rehabilitative, and support services for children who are maltreated and for their families; the program also provides supportive and financial help to relatives, foster parents, and adoptive parents as well as kinship care, foster care, and adoption; In-home Services provide social services to families with children who are at risk of removal from home due to neglect or abuse (DHHS)
- Positive Youth Development program focuses on positive youth development, gang prevention and intervention for those youth who are at-risk of gang involvement and those already involved in gang activity, as well as youth and their families who may have been involved or exposed to violence; works closely with the Police Department, MCPS, State Attorney's Office, Recreation, other DHHS divisions, libraries, and other community groups to address gang and youth violence issues throughout the County (DHHS)
- Abused Persons Program supports a therapist in Trauma Services to expand clinical service capacity and address waitlists for victims of domestic violence (DHHS)
- Assessment and Continuing Case Management Services provides multi-disciplinary assessments, care planning, and case management services to frail seniors and adults with disabilities to remedy and prevent abuse, neglect, self-neglect, exploitation, or inappropriate institutionalization; includes Adult Protective Services, Adult Evaluation and Review Services , Statewide Evaluation and Planning Services, Social Services to Adults, and the Public Guardianship Program (DHHS)
- Children Fleeing Violence activities respond to children and families recently arriving in the County; offers navigation services to enroll children in MCPS, in the Maryland Children Health Program or Care for Kids Programs, and makes referrals to legal and human services (LHI)

Access to Healthy Food and Physical Activity/Recreation

- Four indoor aquatic centers with exercise rooms, seven outdoor pools, and twenty Community Centers with gyms/fitness centers are provided throughout the County (MCR)
- A Health and Wellness Zone encompasses 2 community centers, ice rink, golf course, ballfields, fitness stations, trails, tennis and basketball courts and a farmers market (MNCPPC)
- Maryland National Capital Park and Planning Commission (MNCPPC) builds community gardens (MNCPPC)
- Safe Routes to Play makes it easier to access parks and recreational facilities (MNCPPC)
- Master plans include land use plans that recommend mix of land use to reduce automobile dependency; recommendations also increase walkability and transit accessibility (MNCPPC)
- MNCPPC implements functional and master plans on a site-by-site basis; ensures implementation of goals of transit-oriented, pedestrian-friendly development are implemented; also reviews plans for environmental protection (MNCPPC)
- Functional plans address county-wide planning issues such as Bicycle Master Plan (MNCPPC)

Environmental Health

- Montgomery County mandates that most single-family homes be tested for radon prior to being sold (MCC)
- Montgomery County bans the use of pesticides on County-owned and private lawns; County's Department of Parks can continue to use pesticides on playing fields as part

- of an integrated pest management program but will maintain fields without pesticide use by 2020 (MCC)
- Montgomery County bans smoking in common indoor areas of multi-unit residential dwellings; within 25 feet of a playground area on privately owned property that has a primary purpose of serving residents of more than one dwelling unit (MCC)
 - Montgomery County prohibits use of electronic cigarettes in certain public places; restricts the sale of certain liquid nicotine in retail outlets unless the nicotine is in a child-resistant container; restricts the accessibility of certain tobacco products in retail settings; and prohibits the use of electronic cigarettes by minors (MCC)
 - Household Hazardous Waste (HHW) Program pays for young offenders doing alternative community service to bulk and mix good paint for donation to non-profits and harden unusable paint for disposal in the HHW area (DEP)

Transportation

- The County's RIDE ON bus system consisting of 335 County owned and operated buses which complement the service provided by the other transit providers in the County; all buses are wheelchair accessible (DOT)
- Washington Metropolitan Area Transit Authority provides Metrorail, a rail transit system that provides service to the County (WMATA)
- Washington Metropolitan Area Transit Authority provides Metrobus, a bus transit system that provides service to the County (WMATA)
- Maryland Department of Transportation MARC Train Service is a commuter rail system that provides service to the County (MDOT)
- Maryland Department of Transportation Commuter Bus Service provides service to the County (MDOT)

2. Early Learning Centers, Schools, Colleges and Universities

Public Safety

- Second Step Program is a classroom-based social-skills program for children aged 4-14 years implemented by school counselors. The program builds on cognitive behavioral intervention models (MCPS)
- Positive Behavioral Interventions and Supports (PBIS) Coaches coordinate a plan to create safer and more effective schools by building a better environment through positive disciplinary practices (MCPS)
- Sexual Harassment and Assault Prevention Planning (SHAPP) Grant (MCPS)
- School Resource Officers serve as liaisons between the County and local police departments and high schools; primary function is to enhance safety and security of the learning environment for students, staff and the school community (MCPD) (GPD) (RCP) (MCSO) (MCPS)

3. Community, Non-profit, and Faith Based Organizations

Public Safety

- Germantown Hardknocks Youth Foundation Gang Prevention Curriculum provides gang prevention curriculum that generates measurable improvements in youth self-esteem, goal setting abilities and attitudes toward learning (GHYF)
- Voices VS Violence (VVV) works to ensure safe lives for youth and families by bringing together diverse segments of the community to foster attitudes and behaviors that prevent and reduce violence in our homes, families, schools, communities, and workplaces (MHA)
- The Conflict Resolution Center of Montgomery County provides workshops on conflict prevention and resolution skills to members of community and church groups, service organizations, government agencies, and nonprofit organizations (CRCMC)
- Collaboration Council's Evening Reporting Center is an alternative to secure detention for youth who have been charged with an offense that warrants detention or close supervision prior to their adjudicatory hearing; provides necessary structure, support, pro-social asset building and academic help to lead to successful outcomes for youth (CC)
- Tree House Child Assessment Center coordinates a timely, thorough, and multidisciplinary response to children who may have suffered physical abuse, sexual abuse, or neglect in a safe, neutral, culturally sensitive, and child-focused setting (TH)
- Court Appointed Special Advocates of Montgomery County provides advocacy for the timely placement of abused and neglected children in safe, permanent homes and for the highest quality of their care while they are under the court's jurisdiction (CASA)
- Framework for Families provides services to families with children birth to 18 years of age, referred by Child Welfare Services who are at low to moderate risk for child maltreatment; includes short-term family skills training and resources and referrals to community services (FSI)

Housing

- Montgomery County Coalition for the Homeless participates in the 10,000 Homes Campaign, a national effort to house the most vulnerable homeless individuals and families; two new permanent supportive housing programs serve 30 medically-vulnerable households (MCCH)
-

Court Appointed Special Advocates of Montgomery County (CASA)
Conflict Resolution Center of Montgomery County (CRCMC)
Gaithersburg City Police (GPD)
Germantown Hardknocks Youth Foundation (GHYF)
Latino Health Initiative (LHI)
Maryland Department of Transportation (MDOT)
Maryland National Capital Park and Planning Commission (MNCPPC)
Montgomery County Collaboration Council for Children, Youth and Families (CC)
Montgomery County Council (MCC)

Montgomery County Department of Correction and Rehabilitation (DCR)
Montgomery County Department of Health and Human Services (DHHS)
Montgomery County Department of Environmental Protection (DEP)
Montgomery County Recreation (MCR)
Montgomery County Police Department (MCPD)
Montgomery County Public Schools (MCPS)
Rockville City Police (RCP)
Tree House Child Assessment Center of Montgomery County (TH)
Washington Metropolitan Area Transit Authority (WMATA)

F. What Works

(Note: The acronyms following each entry below represent the source for the evidence-based strategy listed; a list of the acronyms and the source they represent can be found at the end of the section).

1. Community, Non-profit, and Faith Based Organizations

- Convene diverse partners and promote strong cross-sector participation in planning, implementing, and evaluating community health efforts (NPS)
- Provide home-based, multi-trigger, multicomponent environmental asthma control intervention for children and adolescents with asthma (CG)
- Promote safer and more connected communities that prevent injury and violence (e.g., by designing safer environments, fostering economic growth) (NPS)
- Build public awareness about preventing falls, promote fall prevention programs in home and community settings, and educate older adults on how to prevent falls (NPS)
- Implement programs that assist juveniles and adults who are re-entering their communities following incarceration that support their returning to school, securing employment, and leading healthy lifestyles (NPS)

2. Health Care Systems, Insurers and Clinicians

- Support integration of prevention and public health skills into health care professional training and cross train health care practitioners to implement prevention strategies (NPS)
- Increase the use of certified electronic health records to identify populations at risk and develop policies and programs (NPS)
- Include occupational and environmental risk assessment in patient medical history-taking (NPS)
- Home-based, multi-trigger, multicomponent environmental asthma control intervention for children and adolescents with asthma (CG)

3. Businesses and Employers

- Ensure that homes and workplaces are healthy, including eliminating safety hazards (e.g., trip hazards, unsafe stairs), ensuring that buildings are free of water intrusion, indoor environmental pollutants (e.g., radon, mold, tobacco smoke), and pests, and performing regular maintenance of heating and cooling systems (NPS)
- Adopt practices to increase physical activity and reduce pollution (e.g., workplace flexibility, rideshare and vanpool programs, park-and-ride incentives, travel demand management initiatives, and telecommuting options) (NPS)
- Identify and implement green building siting, design, construction, operations, and maintenance solutions that over time will improve the environment and health (NPS)
- Adhere to best practices to promote safety and health, including participatory approaches to hazard identification and remediation as well as supervisory and worker training (NPS)
- Implement and enforce safety policies for all drivers (e.g., seat belts or restraint use, zero tolerance for distracted driving) (NPS)

- Implement comprehensive workplace injury prevention programs that include management commitment, employee participation, hazard identification and remediation, worker training, and evaluation (NPS)
- Expand and improve occupational injury and illness reporting systems (NPS)

4. Early Learning Centers, Schools, Colleges and Universities

- Include training on assessing health impact within fields related to community planning and development (e.g., urban planning, architecture and design, transportation, civil engineering, agriculture) and encourage innovation in designing livable, sustainable communities (NPS)
- Implement policies and practices that promote healthy and safe environments (e.g., improving indoor air quality; addressing mold problems; reducing exposure to pesticides and lead; ensuring that drinking water sources are free from bacteria and other toxins; implementing and enforcing tobacco free policies) (NPS)
- Develop and implement local strategies to reduce health, psychosocial, and environmental conditions that affect school attendance and chronic absenteeism (NPS)
- Provide universal, school-based programs to reduce violence that teach all students about violence prevention (e.g., emotional self-awareness, emotional control, self-esteem, positive social skills, social problem solving, conflict resolution, or team work) (CG)
- Encourage youth to use seat belts, bicycle helmets, and motorcycle helmets, and not drive while distracted or under the influence of alcohol or drugs (NPS)
- Collect and report statistics on crimes that occur and result in injuries on or around campuses and issue timely warnings to campus communities about crimes that may threaten safety and health (NPS)
- Implement policies, practices, and environmental design features to reduce school violence and crime (e.g., classroom management practices, cooperative learning techniques, student monitoring and supervision, limiting and monitoring access to buildings and grounds, performing timely maintenance) (NPS)

5. State and Local Government

- Create healthy environments that support people's ability to make healthy choices (e.g., smoke-free buildings, attractive stairwells, cafeterias with healthy options) (NPS)
- Include safe shared spaces for people to interact (e.g., parks, community centers) in community development plans, which can foster healthy relationships and positive mental health among community residents (NPS)
- Design safe neighborhoods that encourage physical activity (e.g., include sidewalks, bike lanes, adequate lighting, multi-use trails, walkways, and parks) (NPS) (CG)
- Implement policies to support modifications to the physical environment to deter crime (e.g., crime prevention through environmental design) (NPS)
- Facilitate collaboration among diverse sectors (e.g., planning, housing, transportation, energy, education, environmental regulation, agriculture, business associations, labor organizations, health and public health) when making decisions likely to have a significant effect on health (NPS)
- Include health criteria as a component of decision making (e.g., policy making, land use and transportation planning) (NPS)

- Promote the use of interoperable systems to support data-driven prevention decisions and implement evidence-based prevention policies and programs, such as those listed in the Guide to Community Preventive Services (NPS)
- Strengthen and enforce housing and sanitary code requirements and ensure rapid remediation or alternative housing options (NPS)
- Participate in national voluntary accreditation of health departments (NPS)
- Provide community water fluoridation to reduce dental caries (tooth decay) across populations (CG)
- Strengthen and enforce transportation safety policies and programs (e.g., primary seat belt laws, child safety and booster seat laws, graduated driver licensing systems for young drivers, motorcycle helmet use laws, ignition interlock policies) (NPS)
- Implement traffic engineering strategies (e.g., sidewalks and pedestrian safety medians) that allow pedestrians, bicyclists, motorists, and public transportation users to safely move along and across streets (NPS)
- Implement countermeasures for impaired driving (e.g., alcohol sobriety checkpoints) and enhance enforcement of speeding and other safety regulations (NPS)
- Adopt dram shop liability as an effective means of preventing and reducing alcohol-related harms -- owner or server of a retail alcohol establishment where a customer recently consumed alcoholic beverages to be held legally responsible for the harms inflicted by that customer (CG)
- Increase the unit price of alcohol by raising taxes to reduce excessive alcohol consumption and related harms (CG)
- Maintain existing limits on the days of sale on which alcoholic beverages are sold to prevent excessive alcohol consumption and related harms (CG)
- Maintain limits on hours of alcohol sale in on-premises settings to reduce excessive alcohol consumption and related harms (CG)
- Use regulatory authority (e.g., through licensing and zoning) to limit alcohol outlet density for the purpose of discouraging excessive alcohol consumption and related harms (CG)
- Enhanced enforcement of laws prohibiting sale of alcohol to minors to limit underage alcohol purchases (CG)
- Maintain and enforce the age 21 minimum legal drinking age (e.g., increasing the frequency of retailer compliance checks) (NPS)
- Implement per se drug impairment laws (presence of any illegal drug in one's system), train law enforcement personnel to identify drugged drivers, and develop standard screening methodologies to detect the presence of drugs (NPS)
- Develop systems to increase access to trauma care (NPS)
- Provide home-based, multi-trigger, multicomponent environmental asthma control intervention for children and adolescents with asthma (CG)

Community Guide, Centers for Disease Control and Prevention (CG)

National Prevention Strategy, Surgeon General, U.S. Department of Health and Human Services (NPS)

Key Findings: Healthy Montgomery Priorities

Key Findings: Obesity and Related Chronic Conditions

Includes Cardiovascular Health, Diabetes, and Cancers

Obesity increases the risk of several debilitating and sometimes deadly diseases, including heart disease, diabetes, and some cancers. This is because body weight is closely related to some of the risk factors for these diseases. Policies and practices aimed at the prevention and control of obesity can also, in effect, reduce the risk of these disease conditions. Recognizing the important relationship among these four Healthy Montgomery priority health issue areas -- obesity, cardiovascular health, diabetes, and cancers – and the potential to address them in a concerted way, the key findings for all four topic areas are integrated into this one section of the Report, as presented below.

Overview - Obesity

Obesity is a complex health issue that results from a combination of causes and contributing factors found in the environment in which people live, work, learn, and play. Community, home, child care, school, health care, and workplace settings can all influence peoples' daily behaviors and either enable or discourage healthy eating and active living.

Evidence-based strategies that prevent and reduce obesity include practices and policies that make nutritious foods and drinks accessible and affordable and that provide safe, affordable opportunities to be physically active. Providing people with the knowledge they need to make healthy food and beverage choices and the ability to prepare and cook healthy foods at home is also important to promote a healthy weight as is assessing physical activity levels and providing education, counseling and referral.¹⁵

Disparities in obesity prevalence exist within some population groups requiring that prevention strategies also focus on the social, economic, and political factors that create health inequity.¹⁶

Overview – Cardiovascular Health

Cardiovascular disease refers to several types of heart and artery-related conditions. The most common type is coronary artery disease which is caused by plaque (made up of deposits of cholesterol and other substances) building up in the walls of the arteries that supply blood to the heart and other body parts. Plaque build-up (called atherosclerosis) can narrow artery walls, making it hard for blood to flow to the heart and throughout the body. If a blood clot forms, it can stop the blood flow. This can cause a heart attack or stroke. Other types of heart disease include: heart failure, also called congestive heart failure, a chronic, progressive condition that occurs when a weakened heart isn't adequately pumping oxygen and nutrient rich-blood to the body's cells; arrhythmia which is an abnormal rhythm of the heart – the

¹⁵ National Prevention Strategy, Accessed at: <http://www.surgeongeneral.gov/priorities/prevention/strategy/active-living.pdf>; <http://www.surgeongeneral.gov/priorities/prevention/strategy/healthy-eating.pdf>

¹⁶ Centers for Disease Prevention and Control. Accessed at: <http://www.cdc.gov/obesity/adult/causes.html>; <http://www.cdc.gov/obesity/data/adult.html>

heart beats too slowly, too fast, or irregularly; and heart valve disease when the heart's valves function abnormally and affect the flow of blood.¹⁷

Several health conditions as well as a person's lifestyle and family history can increase the risk for cardiovascular disease. Three key risk factors are: high blood pressure, high cholesterol, and smoking. Diabetes can also increase the risk for cardiovascular disease. Eating a healthy diet, getting enough physical activity, maintaining a healthy weight, not smoking, and limiting alcohol use can keep blood pressure, cholesterol, and blood sugar at normal levels, and lower the risk for cardiovascular disease. Screening for cardiovascular disease and its risk factors is important. Treatment includes lifestyle changes and medications, when necessary.¹⁸

For most races and ethnicities in the U.S., heart disease is the leading cause of death. However, some groups are more likely to be affected than others. African Americans have the highest rate of high blood pressure of all population groups, and they tend to develop it earlier in life than others. Also, African Americans, compared to whites, are nearly twice as likely to have a first stroke. Individuals with low incomes are much more likely to suffer from high blood pressure, high cholesterol, heart attack, and stroke than their high-income peers.¹⁹

Many people with risks for cardiovascular disease and stroke—such as high blood pressure and high cholesterol—do not always know that they have these conditions or how to effectively control them to prevent a heart attack or stroke. Other barriers to prevention and treatment include:

- Access to convenient, consistent, and affordable monitoring of blood pressure and cholesterol
- Inadequate time with health care professionals to ask important questions and receive personalized advice
- Medication expense, side effects, and habits about daily use
- Lack of continuity of clinical care across varied providers and systems
- Lack of implementation of community-based strategies for healthier lifestyle choices

Overview – Diabetes

Diabetes is a disease that involves problems with the hormone insulin. Insulin in the blood helps carry glucose to the body's cells. When insulin levels are too low, or the insulin produced by the body is not working the way it should, too much glucose stays in the blood and causes damage to nerves, blood vessels, and organs. Over time, diabetes can cause serious complications including heart disease, stroke, vision loss, kidney failure, and nerve damage. There are several types of diabetes including Type 1 and Type 2 diabetes, gestational diabetes, and other less common types resulting from specific genetic

¹⁷ Centers for Disease Control and Prevention. Accessed at: http://www.cdc.gov/heartdisease/coronary_ad.htm American Heart Association. Accessed at: http://www.heart.org/HEARTORG/Caregiver/Resources/WhatisCardiovascularDisease/What-is-Cardiovascular-Disease_UCM_301852_Article.jsp#.VsTUYXnfPcs;

¹⁸ Centers for Disease Control and Prevention. Accessed at:
http://www.cdc.gov/heartdisease/risk_factors.htm http://www.cdc.gov/heartdisease/materials_for_patients.htm

¹⁹ Million Hearts, Centers for Disease Control and Prevention. Accessed at:
<http://millionhearts.hhs.gov/learn-prevent/risks.html>

syndromes, surgery, drugs, malnutrition, infections, and other illnesses.²⁰

Type 2 diabetes accounts for about 90% to 95% of all diagnosed cases of diabetes and affects both adults and children. Risk factors for Type 2 diabetes include older age, obesity, family history of diabetes, prior history of gestational diabetes, impaired glucose tolerance, physical inactivity, and race/ethnicity. African Americans, Hispanic/Latino Americans, American Indians, and some Asian Americans and Pacific Islanders are at particularly high risk for Type 2 diabetes. Often, many people with Type 2 diabetes do not know that they have the disease until they develop the health complications associated with it. Risk factors are not as well defined for Type 1 diabetes but autoimmune, genetic, and environmental factors play a role in the development of the disease. Type 1 diabetes most often affects young people but can also develop in adults.²¹

Gestational diabetes can develop during pregnancy. Overweight or obese women are at greater risk of developing gestational diabetes. Most often, gestational diabetes goes away after the baby is born. However, having gestational diabetes puts the mother more at risk for developing Type 2 diabetes later in life. Babies born to mothers with gestational diabetes are also more likely to develop obesity and type 2 diabetes. Gestational diabetes occurs more frequently in African Americans, Hispanic/Latino Americans, American Indians, and people with a family history of diabetes.²²

Treatment for diabetes includes making healthy food choices, being physically active, and controlling blood pressure and cholesterol levels. In addition, some people require medication, insulin, or both to keep glucose levels under control. People with diabetes often need a comprehensive team of health care providers including cardiologists for cardiovascular care, nephrologists for kidney care, endocrinologists for conditions related to hormone imbalance, ophthalmologists for eye examinations, podiatrists for foot care, and dietitians and diabetes educators who teach the skills necessary for self-management of the disease.²³

Overview – Cancers

There are more than 100 kinds of cancers, a term generally used to describe diseases in which abnormal cells grow out of control and invade other tissues in the body. There are many possible causes of cancer – risk factors differ based on cancer type and may include genetic factors, certain types of infections, environmental exposures to different kinds of chemicals and radiation, and lifestyle factors such as

²⁰ National Institute of Diabetes and Digestive and Kidney Diseases. Accessed at: <http://www.niddk.nih.gov/health-information/health-topics/Diabetes/your-guide-diabetes/Pages/index.aspx>; Centers for Disease Control and Prevention. Accessed at: <http://www.cdc.gov/diabetes/basics/diabetes.html>

²¹ Centers for Disease Control and Prevention. Accessed at: <http://www.cdc.gov/diabetes/basics/diabetes.html>
American Heart Association. Accessed at:

https://www.heart.org/HEARTORG/Conditions/Diabetes/UnderstandYourRiskforDiabetes/Understand-Your-Risk-for-Diabetes_UCM_002034_Article.jsp

²² Centers for Disease Control and Prevention. Accessed at: <http://www.cdc.gov/diabetes/basics/diabetes.html>

²³ Centers for Disease Control and Prevention. Accessed at: <http://www.cdc.gov/diabetes/basics/diabetes.html>

tobacco use, diet, and physical activity. The risk of developing cancer increases with age; 3 out of every 4 people diagnosed with cancer are 55 years and older.²⁴

Most cancers are related to how we live; lifestyle factors (smoking, diet, obesity, and lack of exercise) are thought to contribute to 2/3 of cancer-related deaths. Less than 10 percent of all cancers may be related to environmental exposures.²⁵

The risk of cancer is greater for some individuals because of their socio-economic status (SES) – that is, their social, economic, and work status. For example, SES can affect affordability and accessibility to preventive health care such as screenings. People with low income may live in a community environment that does not provide access to healthy food or places to be physically active, may not have adequate transportation to access the health care they need, and may have jobs that put them at risk of exposure to carcinogens. Also, language and cultural barriers to health care for some racial and ethnic minorities may also put them at greater risk of cancer.²⁶

The number of new cancer cases can be reduced by screening for cancers (e.g., cervical, colorectal, prostate, lung and breast cancers). Cancer risk can be lowered by vaccines (e.g., human papillomavirus (HPV) vaccine can help prevent cervical cancer; hepatitis B vaccine can lower liver cancer risk) and by the practice of health behaviors such as avoiding tobacco, limiting alcohol use, protecting the skin from the sun, eating a diet rich in fruits and vegetables, being physically active, and keeping a healthy weight.²⁷

What We Can Do to Impact Obesity

Active Living and Healthy Eating

Leverage/Enhance Existing Efforts:

- **Develop and distribute an inventory of physical activity, healthy eating, nutrition education, and nutrition counseling resources and encourage resource use (Healthy Montgomery Eat Well Be Active Partnership)** based on the existing efforts of:
 - Healthy Montgomery Eat Well Be Active Partnership
 - Montgomery County Recreation

²⁴ Cancer Facts and Figures, 2015. American Cancer Society. Accessed at:

<http://www.cancer.org/acs/groups/content/@editorial/documents/document/acspc-044552.pdf> Maryland Comprehensive Cancer Control Plan, Maryland Department of Health and Mental Hygiene. Accessed at:

<http://phpa.dhmh.maryland.gov/cancer/cancerplan/Pages/publications.aspx>

2014 Cancer Report of the Cigarette Restitution Fund Program, Maryland Department of Health and Mental Hygiene. Accessed at: http://phpa.dhmh.maryland.gov/cancer/SiteAssets/SitePages/surv_data-reports/2014%20CRF%20Cancer%20Report.pdf

²⁵ Maryland Comprehensive Cancer Control Plan, Maryland Department of Health and Mental Hygiene. Accessed at:

<http://phpa.dhmh.maryland.gov/cancer/cancerplan/Pages/publications.aspx>; 2014 Cancer Report of the Cigarette Restitution Fund Program, Maryland Department of Health and Mental Hygiene. Accessed at:

http://phpa.dhmh.maryland.gov/cancer/SiteAssets/SitePages/surv_data-reports/2014%20CRF%20Cancer%20Report.pdf

²⁶ Centers for Disease Control and Prevention. Accessed at:

http://www.cdc.gov/cancer/healthdisparities/basic_info/challenges.htm

http://www.cdc.gov/cancer/healthdisparities/basic_info/index.htm

²⁷ Centers for Disease Control and Prevention. Accessed at: <http://www.cdc.gov/cancer/dcpc/prevention/index.htm>

- **Promote the formation of local school wellness councils (Healthy Montgomery Eat Well Be Active Partnership) based on the existing efforts of:**
 - Healthy Montgomery Eat Well Be Active Partnership
 - Montgomery County Public Schools

Initiate Efforts:

- **Establish and sustain a Health in All Policies (HiAP) model and consider health impacts when making transportation or land use decisions (National Prevention Strategy). Partners to include:**
 - Maryland National Capital Park and Planning Commission
 - Montgomery County Recreation
 - Montgomery County Public Schools
 - Montgomery County Department of Transportation
 - Montgomery County Department of Environmental Protection
 - Montgomery County Police Department
 - Montgomery County Department of Health and Human Services
 - Montgomery County Department of Housing and Community Affairs
 - Montgomery County Department of Corrections and Rehabilitation

Active Living

Leverage/Enhance Existing Efforts:

- **Use urban design and land use policies and practices that encourage physical activity (e.g., include sidewalks, bike lanes, adequate lighting, multi-use trails, walkways, and parks) (National Prevention Strategy) (Community Guide) based on the existing efforts of:**
 - Maryland National Capital Park and Planning Commission
- **Increase access to places for physical activity combined with informational outreach activities (Community Guide) based on the existing efforts of:**
 - Maryland National Capital Park and Planning Commission
 - Montgomery County Recreation
- **Incorporate Physical Activity as a Vital Sign in clinic settings (Healthy Montgomery Eat Well Be Active Partnership) based on the existing efforts of:**
 - Healthy Montgomery Eat Well Be Active Partnership
 - Community Clinic, Inc.
- **Limit screen time in child care centers (Healthy Montgomery Eat Well Be Active Partnership) based on the existing efforts of:**
 - Healthy Montgomery Eat Well Be Active Partnership

Initiate Efforts:

- **Provide point-of-decision prompts that encourage use of stairs (Community Guide)**
Partners to include:
 - Healthy Montgomery Eat Well Be Active Partnership
 - Montgomery County Government
 - Montgomery County Public Schools
 - Montgomery County hospital systems
 - Montgomery County businesses and community organizations
- **Ensure the availability of transportation to safe, accessible, and affordable places for physical activity (National Prevention Strategy)** Partners to include:
 - Montgomery County Department of Transportation
 - Montgomery County Recreation
 - Maryland National Capital Park and Planning Commission
 - State and local government

Healthy Eating

Leverage/Enhance Existing Efforts:

- **Promote healthier drinks in child care centers (Healthy Montgomery Eat Well Be Active Partnership)** based on the existing efforts of:
 - Healthy Montgomery Eat Well Be Active Partnership
 - Head Start
- **Assess local community needs and expand programs (e.g., community gardens, farmers' markets) that bring healthy foods, especially locally grown fruits and vegetables, to schools, businesses, and high-risk communities (National Prevention Strategy) (Maryland Comprehensive Cancer Control Plan)** based on the existing efforts of:
 - Montgomery County Food Council
 - Maryland National Capital Park and Planning Commission
 - Montgomery County Public Schools
- **Encourage the use of grants, zoning regulations, and other incentives to attract full-service grocery stores, supermarkets, and farmers' markets to underserved neighborhoods, and the use of zoning codes and disincentives to discourage a disproportionately high availability of unhealthy foods, especially around schools (National Prevention Strategy)** based on the existing efforts of:
 - Montgomery County Food Council
 - Maryland National Capital Park and Planning Commission
- **Encourage businesses to provide nutrition information to customers (e.g., on menus), make healthy options and appropriate portion sizes the default, and limit marketing of unhealthy food to children and youth (National Prevention Strategy)** based on the existing efforts of:
 - Montgomery County Council

- **Implement culturally and linguistically appropriate social supports for breastfeeding (i.e., marketing campaigns and breastfeeding peer support programs); promote the use of maternity care practices that empower new mothers to breastfeed, such as the Baby-Friendly Hospital standards, and promote breastfeeding in child care centers (National Prevention Strategy)** based on the existing efforts of:
 - Montgomery County hospital systems
 - Maternity Partnership Program
 - Montgomery County Minority Health Initiatives and Program
 - Healthy Montgomery Eat Well Be Active Partnership
- **Encourage businesses and employers to adopt lactation policies that provide space and break time for breastfeeding employees (in accordance with the Affordable Care Act) and offer lactation management services and support (e.g., breastfeeding peer support programs) (National Prevention Strategy)** based on the existing efforts of:
 - Montgomery County Department of Health and Human Services
 - Montgomery County hospital systems
 - Montgomery County Government

What MORE We Can Do to Impact Cardiovascular Health

(also refer to Obesity WWCD section above)

Leverage/Enhance Existing Efforts:

- **Reduce patient out-of-pocket costs for medications to control high blood pressure and high cholesterol when combined with additional interventions aimed at improving patient-provider interaction and patient knowledge, such as team-based care with medication counseling and patient education (Community Guide)** based on the existing efforts of:
 - Primary Care Coalition (MedBank and Community Pharmacy)
- **Offer team-based care to improve blood pressure control (e.g., nurses and pharmacists working in collaboration with primary care providers, patients, and other professionals) (Community Guide)** based on the existing efforts of:
 - Montgomery County hospital systems
 - Montgomery Cares clinics and the County Safety-Net Clinics
 - Montgomery County Department of Health and Human Services
 - Montgomery County Minority Health Initiatives and Program

- **Screen adults in the general population aged 18 years or older for high blood pressure (if high blood pressure is confirmed pharmacological and non-pharmacological therapies should be recommended); screen men 35 and older for lipid disorder (cholesterol, dyslipidemia); screen men 20-35 that are at increased risk for coronary heart disease (CHD); and screen women 20 and older at increased risk for CHD (Guide to Clinical Preventive Services)²⁸ based on the existing efforts of:**
 - Montgomery County hospital systems
 - Montgomery Cares clinics and the County Safety-Net Clinics
 - Montgomery County Department of Health and Human Services
 - Montgomery County Minority Health Initiatives and Program
- **Prescribe aspirin as a preventive medication for the prevention of cardiovascular disease for men age 45-79 and women age 55-79 when potential cardiovascular benefit outweighs potential harm of gastrointestinal hemorrhage (Guide to Clinical Preventive Services) based on the existing efforts of:**
 - Montgomery County hospital systems
 - Montgomery Cares clinics and the County Safety-Net Clinics

What MORE We Can Do to Impact Diabetes (also refer to Obesity WWCD section above)

Leverage/Enhance Existing Efforts:

- **Implement diabetes self-management education (DSME) interventions in community gathering places to improve glycemic control for persons with type 2 diabetes (Community Guide) based on the existing efforts of:**
 - Montgomery County hospital systems
 - Montgomery County Minority Health Initiatives and Program
 - School Health Rooms/School-Based Health and Wellness Centers (Montgomery County Department of Health and Human Services, Montgomery County Public Schools)
- **Offer combined diet and physical activity promotion programs for County residents at increased risk of type 2 diabetes to reduce new-onset diabetes; programs commonly include a weight loss goal, individual or group sessions (or both) about diet and exercise, meetings with a trained diet or exercise counselor (or both), and individually tailored diet or exercise plans (or both) (Community Guide) based on the existing efforts of:**

²⁸ Two strategies recommended by the Guide to Clinical Preventive Services are integrated here: Screen adults in the general population aged 18 years or older for High Blood Pressure (hypertension). If hypertension is confirmed pharmacological and non-pharmacological therapies should be recommended screen men 35 and older for lipid disorder (cholesterol, dyslipidemia), screen men 20-35 that are at increased risk for coronary heart disease (CHD); screen women 20 and older at increased risk for CHD should be screened

- Montgomery County hospital systems
- Montgomery County Minority Health Initiatives and Program
- Montgomery Cares Clinics, and the County Safety Net Clinics
- **Screen for abnormal blood glucose in adults aged 40 to 70 years who are overweight or obese with referral to intensive behavioral counseling interventions to promote a healthful diet and physical activity (Guide to Clinical Preventive Services)** based on the existing efforts of:
 - Montgomery County primary care providers
 - Montgomery County hospital systems
- **Screen for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation (Guide to Clinical Preventive Services)** based on the existing efforts of:
 - Montgomery County primary care providers, obstetricians, gynecologists,
 - Montgomery County hospital systems
 - Maternity Partnership Program (Montgomery County Department of Health and Humans Services)

What MORE We Can Do to Impact Cancers (also refer to Obesity WWCD section above)

Leverage/Enhance Existing Efforts:

- **Reduce client out-of-pocket costs and structural barriers** (i.e., non-economic burdens or obstacles that make it difficult for people to access cancer screening) to increase access to preventive cancer screenings (including breast, colorectal, prostate, lung, skin and cervical cancer). Costs can be reduced through a variety of approaches, including vouchers, reimbursements, reduction in co-pays, or adjustments in federal or state insurance coverage. Interventions designed to reduce structural barriers include: reducing time or distance between service delivery settings and target populations; modifying hours of service to meet client needs; offering services in alternative or non-clinical settings (e.g., mobile mammography vans at worksites or in residential communities); eliminating or simplifying administrative procedures and other obstacles (e.g., scheduling assistance, patient navigators, transportation, dependent care, translation services, limiting the number of clinic visits) (**Community Guide**)²⁹ based on the existing efforts of:
 - Breast Health Quality Consortium (Primary Care Coalition)
 - Montgomery County hospital systems
 - Montgomery Cares
 - Montgomery County Minority Health Initiatives and Program
 - Montgomery County Commission on People with Disabilities
 - Montgomery County Commission on Health

²⁹ Two Community Guide strategies are integrated here: reduce structural barriers (i.e., non-economic burdens or obstacles that make it difficult for people to access cancer screening) to increase screening for breast and colorectal cancers (by mammography and fecal occult blood test, respectively); and reduce client out-of-pocket costs for breast cancer screening to minimize or remove economic barriers that make it difficult for clients to access cancer screening services.

- Cigarette Restitution Fund Cancer Crusade Coalition
- Women's Cancer Control Program (Montgomery County Department of Health and Human Services)
- **Offer group and one-on-one education about preventive cancer screenings (including breast, colorectal, prostate, lung, skin and cervical cancer) that conveys information on indications for, benefits of, and ways to overcome barriers to screening with the goal of informing, encouraging, and motivating participants to seek recommended screening (group education can be given by health professionals or trained laypeople to a variety of groups, in different settings, and by different types of educators with different backgrounds and styles; one-on-one education can be delivered by healthcare workers or other health professionals, lay health advisors, or volunteers and are conducted by telephone or in person in medical, community, worksite or household settings) (Community Guide)³⁰ based on the existing efforts of:**
 - Montgomery County hospital systems
 - Montgomery County Minority Health Initiatives and Program
 - Proyecto Salud
 - Community Radiology Associates
 - Women's Cancer Control Program (Montgomery County Department of Health and Human Services)
- **Implement evidence-based recommendations for tobacco use treatment (including electronic cigarette and cigar/cigarillo use in adolescents and adults), provide information to patients on the health effects of tobacco use and secondhand smoke exposure, and reduce or eliminate out-of-pocket costs for cessation therapies (National Prevention Strategy)³¹ based on the existing efforts of:**
 - Montgomery County Department of Health and Human Services (Cigarette Restitution Fund Tobacco Program)
 - Montgomery County hospital systems
 - Montgomery County Minority Health Initiatives and Program
- **Support workplace initiatives among other County employers and businesses that encourage continued breastfeeding after return to work (Maryland Comprehensive Cancer Control Plan) based on the existing efforts of:**
 - Montgomery County Department of Health and Human Services
 - Montgomery County hospital systems
- **Screen annually for lung cancer with low-dose computed tomography (LDCT) in adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years (Guide to Clinical Preventive Services) based on the existing efforts of:**

³⁰ Two Community Guide strategies are integrated here: offer group education to increase breast cancer screening that conveys information on indications for, benefits of, and ways to overcome barriers to screening; and provide one-on-one education to increase screening for breast, colorectal, and cervical cancers that delivers information to individuals about indications for, benefits of, and ways to overcome barriers to cancer screening.

³¹ Two National Prevention Strategy recommendations are integrated here: implement evidence-based recommendations for tobacco use treatment and provide information to patients on the health effects of tobacco use and secondhand smoke exposure; and reduce or eliminate patient out-of-pocket costs for cessation therapies.

- Montgomery County hospital systems
- County's broader primary care provider community

Initiate Efforts:

- **Provide multicomponent community-wide interventions to prevent skin cancer using combinations of individual-directed strategies, mass media campaigns, and environmental and policy changes across multiple settings within a defined geographic area in an integrated effort to influence UV-protective behaviors; usually delivered with a defined theme, name, logo, and set of messages (Community Guide)** Partners to include:
 - Montgomery County Government
 - Montgomery County Department of Health and Human Services
 - Montgomery County Public Schools
 - Montgomery County hospital systems
- **Provide prevention strategies, mass media campaigns, and environmental and policy changes to promote radon testing in homes as well as mitigation when radon levels exceed normal limits (Maryland Comprehensive Cancer Control Plan)** Partners to include:
 - Montgomery County Government
 - Montgomery County Department of Health and Human Services
 - Montgomery County Public Schools
 - Montgomery County hospital systems

Community Guide, Centers for Disease Control and Prevention
Guide to Clinical Preventive Services, U.S. Preventive Services Task Force

Healthy Montgomery Eat Well Be Active Partnership

Maryland Comprehensive Cancer Control Plan 2011-2015, Maryland Department of Health and Mental Hygiene

National Prevention Strategy, Surgeon General, U.S. Department of Health and Human Services

Information Gathered on Obesity, Cardiovascular Health, Diabetes, and Cancers

A. From the Community Conversations

1. Health and Health Care

Assets

- Increased accessibility to health insurance coverage through the ACA
- Increased eligibility for Medicaid
- Care provided for the uninsured
- County community-based health clinics provide low-cost, quality health care
- Top notch health care practitioners and facilities
- County efforts to provide health care services to diverse populations
- Community clinics and County hospitals
- Health events targeting specific communities and populations including local health screenings

Challenges

- High cost of health care
- High hospital fees
- High prescription drug costs
- Language and cultural barriers that keep people from seeking health care
- Lack of coordination of health care services, especially for people with multiple health issue
- Difficulty finding physicians for specific health conditions when transitioning to Medicare
- Lack of health literacy regarding disease management

Strategies for Improvement

- Provide more assistance to residents and health care providers to effectively navigate ACA enrollment and coverage, and promote utilization
- Improve coordination of health care services, especially for residents with multiple health issues
- Improve integration of health care services and social services
- Increase access to health screenings
- Increase access to low-cost vaccines
- Increase use of mobile health care units
- Promote County services more effectively
- Provide more clinical services for the growing population
- Provide more low-cost specialty care, especially for residents on Medicaid and Medicare
- Increase the number of providers who accept Medicaid and Medicare, especially specialists
- Increase hospital outreach programs that are free or affordable to address diabetes and other health conditions
- Make the cost of prescription drugs more affordable
- Translate health messages for culturally and linguistically diverse communities
- Strategically target health messages and outreach to diverse populations
- Partner with community groups, community organizations, churches, libraries and other community gathering places to promote health messages
- Use community health promoters to convey prevention messages
- Increase investment in and promotion of preventive health care and health messaging focused on prevention

2. Transportation

Assets

- Improved pedestrian safety

- Well-maintained bicycle paths
- Bike lanes
- Bike share program

Challenges

- Bicyclists are at risk for injury and would benefit from increased off-road bicycle trails
- Unreliability and poor quality of public transportation, limited services areas and times available, lack of affordability
- Lack of public transportation to access County services and resources

Strategies for Improvement

- Increase reliability and affordability of public transportation to increase access to services and programs
- Continue County efforts to address dangerous conditions for pedestrians (e.g., complicated intersections, driver texting and phone use, lots of traffic); increased signage, speed and red light cameras, crosswalks and lights for pedestrians are needed as is the enforcement of laws prohibiting drinking and phone use while driving
- Provide more off-road bicycle trails

3. Access to Healthy Food

Assets

- Healthier options and better food labeling in grocery stores and restaurants
- Farmer's markets
- Healthier options in vending machines
- Regulation prohibiting restaurants from using trans fats
- WIC/SNAP benefits, food banks, food stamps provided for residents in need
- Healthy school lunches

Challenges

- High cost of healthy food; unhealthy food is inexpensive
- Inadequate food stamp allotment
- Too few farmers' markets
- Too many fast food restaurants
- Unhealthy school lunches

Strategies for Improvement

- Increase food stamp allotment
- Provide greater access to affordable, healthy food including more community gardens and partnerships with local farms to provide affordable food
- Provide incentives to restaurants to offer healthy food and buy food from local farmers
- Regulate food prices
- Work with students to offer healthier school lunches
- Provide food in homeless shelters that caters to people who have diabetes

4. Parks and Recreation

Assets

- Parks, trails, recreation centers
- Availability of pools, tennis courts, soccer fields, golf courses, playgrounds
- School tracks open to the public
- Shopping malls open to the public for walking

Challenges

- Places to be active are not within walking distance
- Community centers close early
- Extracurricular activities such as sports are unaffordable for some families

Strategies for Improvement

- Provide more places to be active that are in walking distance
- Increase promotion and coordination of parks and recreation services and programs to increase use
- Make it easier to access recreation services and programs, especially among populations of diverse cultures and languages
- Offer more physical activity opportunities in schools

B. By the Numbers: Are We Making Progress?

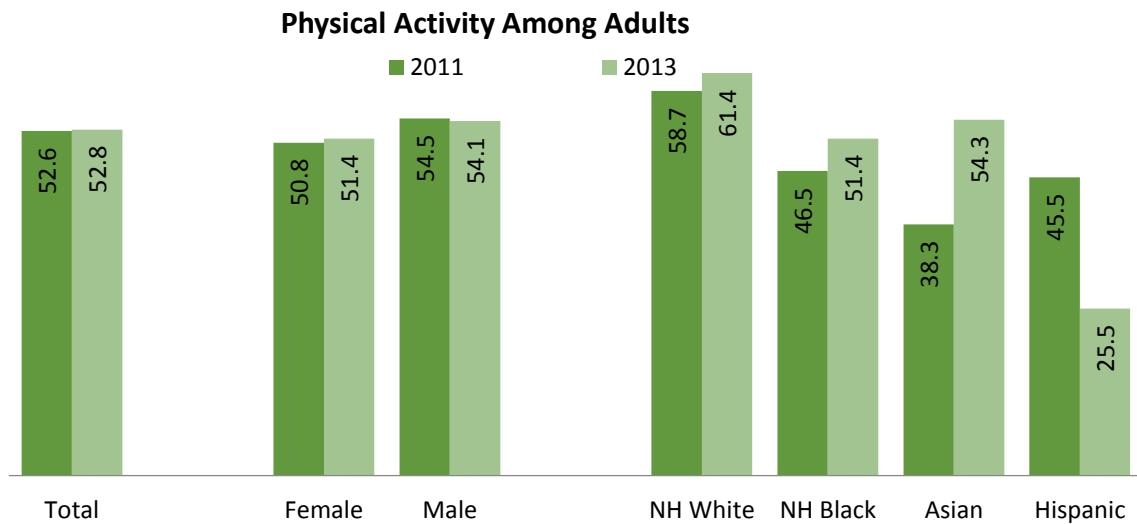
1. By the Numbers: Are We Making Progress on Obesity?

High School Students with No Physical Activity in Past Week

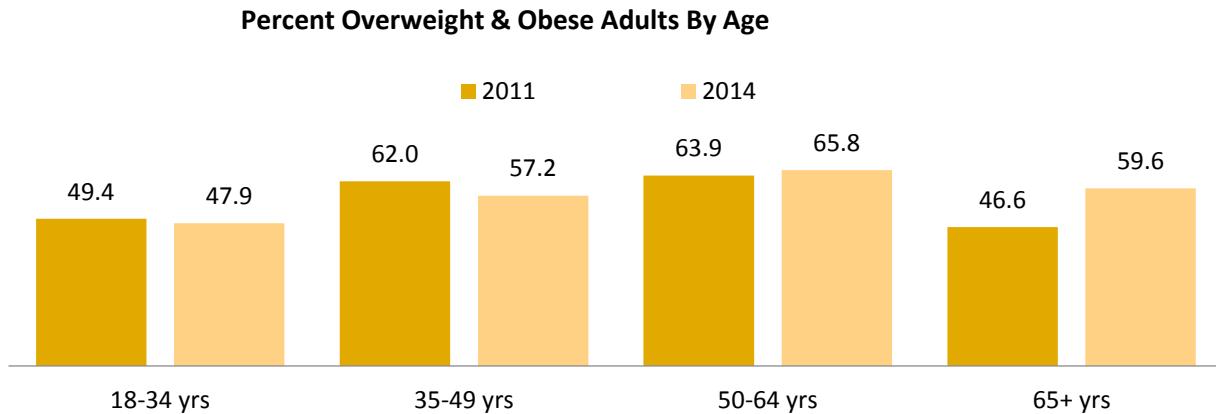
- One out of every 6 high school students had no physical activity in the past week (no days in past week where they had at least 60 minutes of physical activity).



About half of adults are meeting recommended minimum duration and intensity of physical activity each week either with 150 minutes of moderate activity or 75 minutes of vigorous physical activity.



None of the differences between 2011 and 2013 were statistically significant.



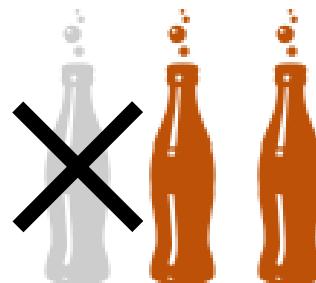
None of the differences between 2011 and 2014 were statistically significant.

Between 2011 and 2014, about 57% of adults reported being overweight or obese. While the percent of overweight/obese residents declined slightly among adults 18-49 years, it has increased among adults 50 years and older- with a 28%-increase among older adults 65+ years.



Only one-third of Montgomery County adults report eating five or more servings of fruits and vegetables daily.

Two out every three high school students in fall 2014 consumed soda or pop in the past week.



2. By the Numbers: Are We Making Progress on Cardiovascular Health?

- **Heart disease mortality** improved by 19% from 2006-2008 baseline of 136.4 to 2012-2014 update of 110.8



- **High blood pressure prevalence** worsened by 28% from 21.6% baseline in 2011 to 27.7 in 2013.

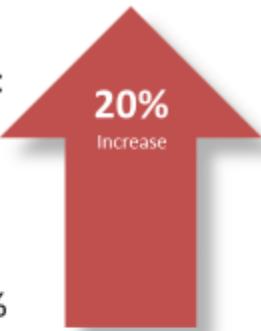


- **Stroke mortality** improved by 16% from 2006-2008 baseline of 30.1 to 2012-2014 update of 25.3

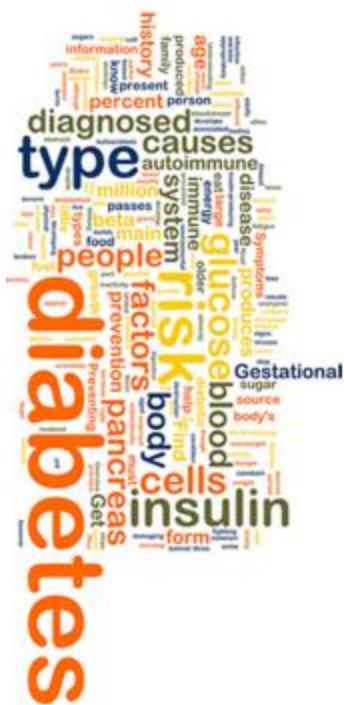


By the Numbers: Are We Making Progress on Diabetes?

- Diabetes -related emergency room visit (primary diagnosis only) rate (age-adjusted, per 100,000 population) has increased by over 20% from 2008-2010 (81.9) to 2011-2013 (98.4), but still meets the Maryland SHIP 2017 Target of 186.3

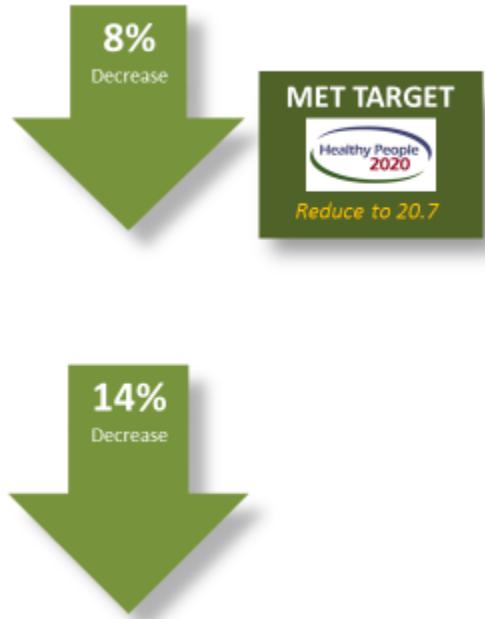


- 7.0 percent of County adults report ever being diagnosed with diabetes in 2014 (excluding diagnoses during pregnancy).
- Prevalance has increased 37% from the 2011 revised baseline of 5.1%



3. By the Numbers: Are We Making Progress on Cancers?

- Breast Cancer mortality decreased by 8% from 2006-2008 baseline of 19.8 deaths per 100,000 female population to 2012-2014 update of 18.3.
- Prostate cancer incidence decreased by 14% from 2004-2008 baseline of 159.3 deaths per 100,000 male population to 2008-2012 update of 137.

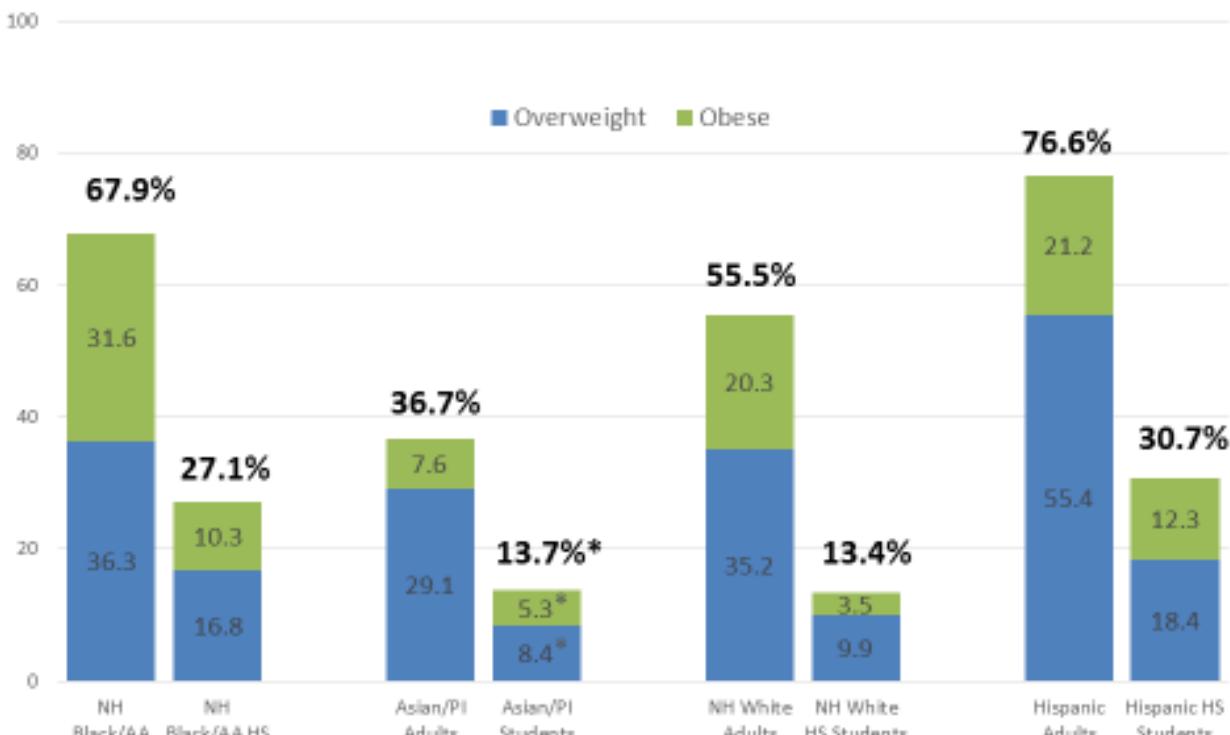


C. By the Numbers: Are We Achieving Equity?

1. By the Numbers: Are We Achieving Equity in Obesity?

In 2014, 68% of NH Black adults, 77% of Hispanic adults, 56% of NH White adults, and 37% of Asian Adults self-reported height and weight that resulted in body-mass indices (BMIs) indicating overweight or obese weight status (BMI of 25.0 or higher).

Overweight & Obese Weight Status Among Adults (2014 MD BRFSS) & High School Students (Fall 2014 MD YRBS) By Race/Ethnicity

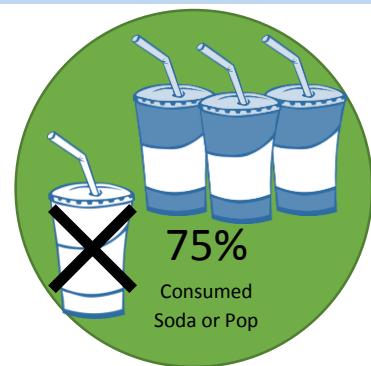


*Data are from Spring 2013, no Asian subgroup provided on the Fall 2014 YRBS results released by MD DHMH.

In the fall of 2014, almost one-third (30.7%) of Hispanic high school (HS) students were overweight or obese, which is 2.3 times more than Non-Hispanic White high school students (13.4%); Non-Hispanic Black students (27.1%) are 2 times more likely to be overweight or obese than Non-Hispanic White HS students. 13.7 % Asian HS students were overweight or obese in spring 2013- no Asian subgroups were reported in fall 2014 results.

Only one out of every four Hispanic high school students reported NO soda or pop in the past week in the fall of 2014.

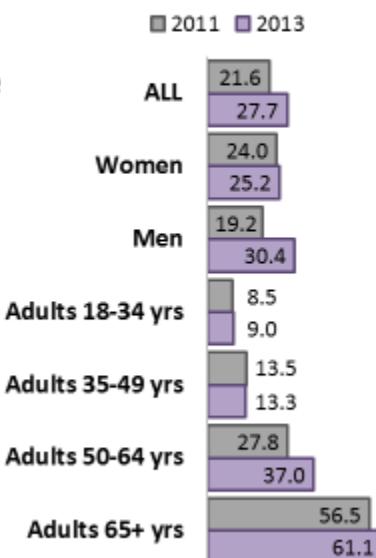
Hispanic High School Students



2. By the Numbers: Are We Achieving Equity in Cardiovascular Health?

High Blood Pressure Prevalence

- Older adults 65+ yrs are 6 times more likely to have high blood pressure than young adults 18-34 yrs**

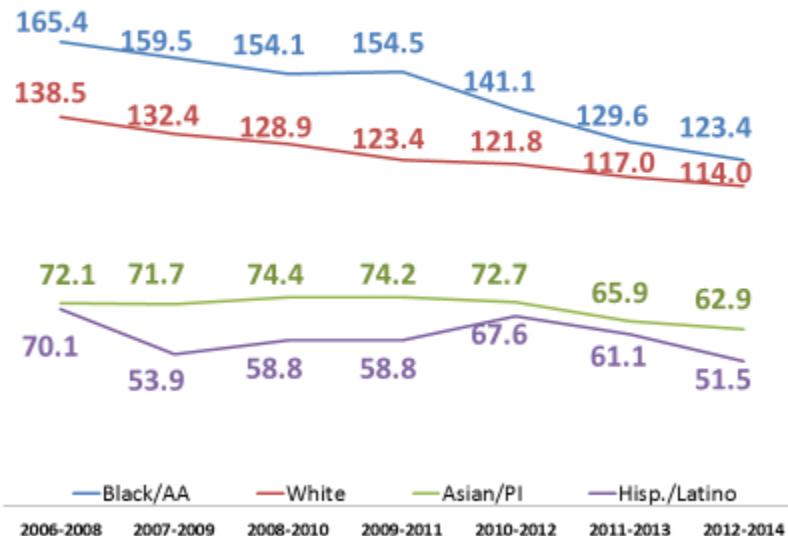


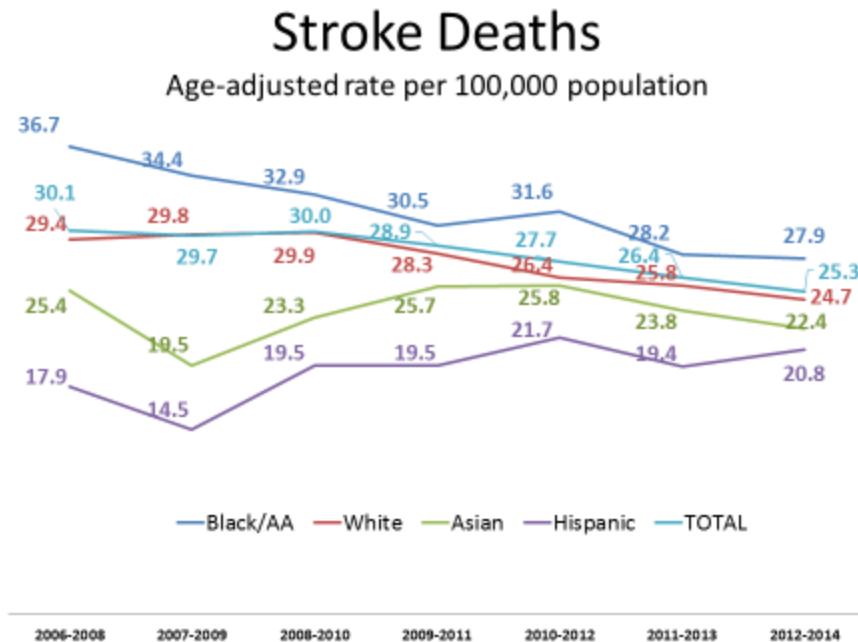
Black/African American residents are about 2.4 times more likely than Hispanic residents to die from heart disease.

Black/ African American death rates decreased by 25%, the largest improvement among racial/ethnic sub groups; however, the disparity between Black and Hispanic rates did not narrow.

Heart Disease Deaths

Age-adjusted rate per 100,000 population





Black residents are 34% more likely than Hispanic residents to die from a stroke.

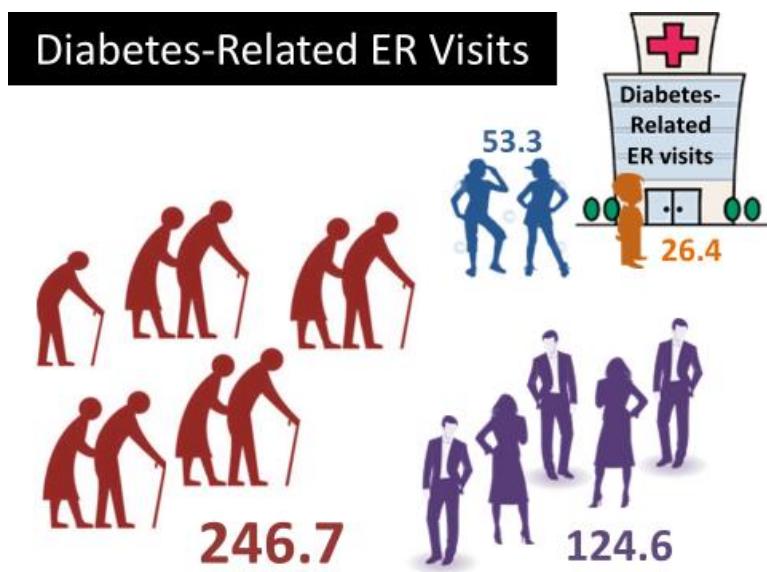
Disparities between Hispanic rates and rates of other race groups are improving over time (narrowing) – however, this is at least partly due to Hispanic rates worsening (increasing) by 16% between 2007-2009 (14.5) and 2012-2014 (20.8).

3. By the Numbers: Are We Achieving Equity in Diabetes?

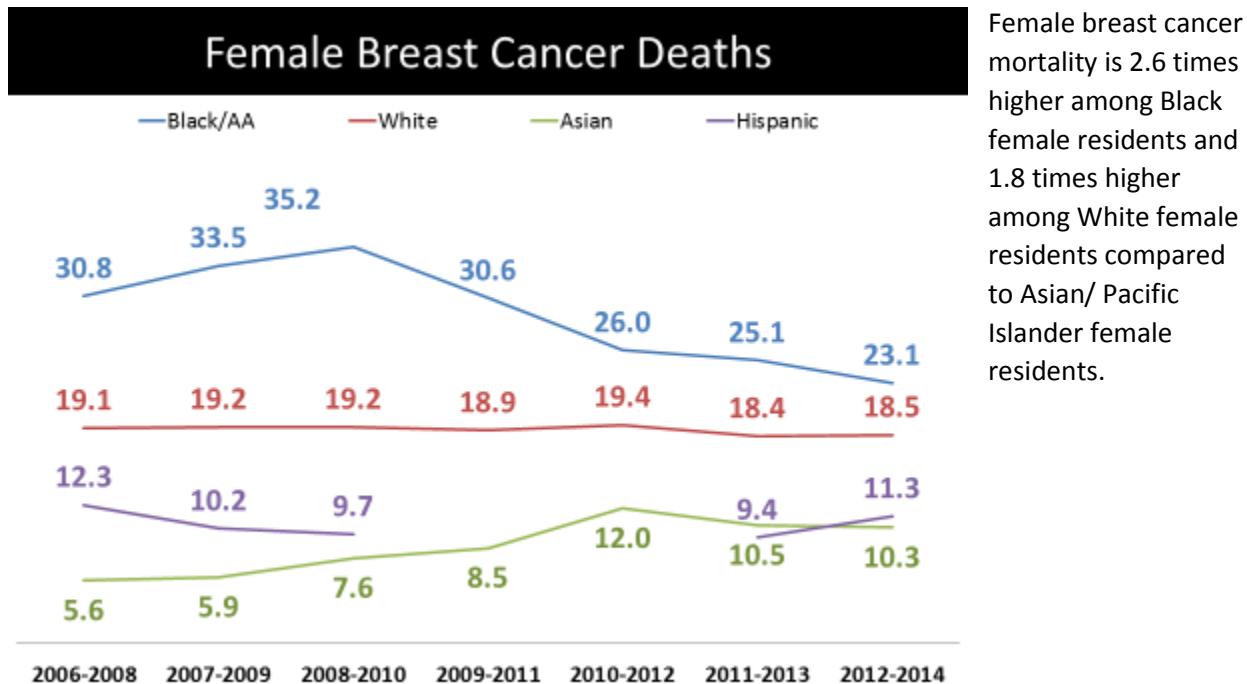
Visits to the ER with a primary diagnosis increases by age- children have the lowest rates while older adults have the highest. In 2011-2013, adult age groups have multi-fold increases in their rates compared to the rate for **children** under 18 years (26.4):

- **Older adults** (65+) have **9** times more visits (246.7 visits per 100,000 population)
- **Adults** (35-64) are **5** times more likely (124.6); and
- **Young adults** 18-34 are **2** times more likely (53.3)

Disparities by age are **narrowing** but primarily because ER visits among children have **increased by 28%** from 2008-2010 to 2011-2013.



4. By the Numbers: Are We Achieving Equity in Cancers?



D. Hospital Alignment

1. Obesity

Activity	Target Populations					
	Children	Adults	Families	Seniors	Low-Income	Neighborhood
Health and Wellness Education, including healthy eating and physical activity	<ul style="list-style-type: none"> • Healthy cooking classes (SH) • Kids Fit (HCH) 	<ul style="list-style-type: none"> • Individual and group nutrition counseling; health education on exercise and nutrition (AHC) • Breastfeeding Support Groups, Breastfeeding Education Support and Togetherness (B.E.S.T) and Hecho de Pecho (Spanish language breastfeeding support group); Warm Line (free breastfeeding support via phone with a certified lactation consultant) (AHC) • Shady Grove Medical Center has Baby-Friendly designation (AHC) • Nutrition Programs and Lectures (HCH) • Breastfeeding Support Groups and Classes (HCH) • Healthy eating and educational events held throughout the year (MMMC) • Breastfeeding Support Groups (MMMC) 	<ul style="list-style-type: none"> • Individual and group nutrition counseling; health education on exercise and nutrition (AHC) • Kids Shape (HCH) • Individual nutrition counseling (SH) 	<ul style="list-style-type: none"> • Healthy eating and educational events held throughout the year (MMMC) • Individual and group nutrition counseling; health education on exercise and nutrition (AHC) • Nutrition Programs and Lectures (HCH) • Individual Nutrition Counseling, Healthy Choices, Healthy Weight nutrition classes, Dine and Learn Program (SH) 	<ul style="list-style-type: none"> • Healthy eating and educational events held throughout the year (MMMC) 	<ul style="list-style-type: none"> • Community Health Workers (HCH) • Kids Fit (HCH) • Kids Shape (HCH)

Activity	Target Populations						
	Children	Adults	Families	Seniors	Low-Income	Neighborhood	
		<ul style="list-style-type: none"> Individual Nutrition Counseling, Healthy Choices, Healthy Weight nutrition classes, Dine and Learn Program (SH) 					
Physical Activity Programming	<ul style="list-style-type: none"> Kids Fit; (HCH) Support to Girls On the Run Montgomery County: after school program promoting healthy habits and an active lifestyle (3rd-8th grades) (SH) 	<ul style="list-style-type: none"> Mall walking program (SH) Fitness and Movement Classes (HCH) 	<ul style="list-style-type: none"> Kids Shape (HCH) 	<ul style="list-style-type: none"> Senior Fit (HCH) Senior Exercise Program (55 and older); Tai Chi and yoga classes (MMMC) Mall walking program, Senior Shape exercise classes, Pilates, Tai Chi, Zumba Gold (SH) 	<ul style="list-style-type: none"> Kids Fit; Kids Shape (HCH) 	<ul style="list-style-type: none"> Kids Fit; Kids Shape; Senior Fit (HCH) 	
Screenings	<ul style="list-style-type: none"> BMI, body composition and waist circumference (SH) 	<ul style="list-style-type: none"> BMI, Body Fat Analysis and Waist to hip ratio screenings (AHC) Obesity Screenings (Body Fat Analysis) (HCH) BMI, body composition and waist circumference (SH) 		<ul style="list-style-type: none"> BMI, Body Fat Analysis and Waist to hip ratio screenings (AHC) BMI, body composition and waist circumference (SH) 	<ul style="list-style-type: none"> Discounted Clinical Heart Health Screenings and packages include glucose screenings, A1c tests, and body fat analyses (AHC) 		

2. Cardiovascular Health

Activity	Target Populations					
	Children	Adults	Families	Seniors	Low-Income	Neighborhood
Education and Awareness		<ul style="list-style-type: none"> Love Your Sweetheart is an annual collection of community events focused on cardiovascular health (e.g. education, awareness, and screenings) (AHC) Support groups ranging from broad (e.g. healthy lifestyles, mended hearts, etc.) to targeted (women and heart disease, congestive heart failure, etc.) (AHC) Annual Heart Health Day, outreach and education on cardiovascular health conducted by community health workers, To Your Health! Heath Education and Screening Day (HCH) Dare to C.A.R.E- Event held twice a year- Free educational and vascular screening event, offered to participants who are age 50 or older, smoke, have diabetes, high blood pressure, or high cholesterol, and who are at greater risk. (MMMC) Wine Women and Heart Health Celebrate Your heart -is an annual educational event where women come and learn about signs and 		<ul style="list-style-type: none"> HeartWell program-increases awareness about heart disease prevention, symptom recognition and management of heart disease, medications, blood pressure monitoring, diet and lifestyle enhancements, Senior Shape Exercise Program (SH) 	<ul style="list-style-type: none"> Annual Heart Health Day (HCH) To Your Health! Heath Education and Screening Day (HCH) 	<ul style="list-style-type: none"> Outreach and education on cardiovascular health conducted by community health workers (HCH)

Activity	Target Populations					
	Children	Adults	Families	Seniors	Low-Income	Neighborhood
		<p>symptoms of heart disease and ways to reduce risks. (MMMC)</p> <ul style="list-style-type: none"> Dine and Learn Program, monthly community, health seminars, Heart Smarts classes for heart healthy living, nutrition counseling, cooking classes and CPR classes (SH) 				
Screenings		<ul style="list-style-type: none"> Multiple blood pressure screenings weekly at health fairs, senior centers, houses of faith, etc.(AHC) To Your Health! Heath Education and Screening Day, weekly blood pressure screenings (HCH) “Free Blood Pressure, Glucose and Cholesterol screenings.” (MMMC) Blood pressure and cholesterol screenings (SH) 		<ul style="list-style-type: none"> Multiple blood pressure screenings weekly at health fairs, senior centers, houses of faith, etc. (AHC) Weekly blood pressure screenings (HCH) Free Blood Pressure, Glucose and Cholesterol screenings at local churches and Senior Recreation Centers. (MMMC) Blood pressure and cholesterol screenings at health fairs for vulnerable families and seniors (SH) Bi-weekly and monthly blood pressure screenings at several community and senior centers, mall walking, HeartWell program-increases awareness about heart disease 	<ul style="list-style-type: none"> Discounted Clinical Heart Health Screenings and packages are offered including glucose screenings, A1c tests, and body fat analyses (AHC) Blood Pressure Screenings (HCH) To Your Health! Heath Education and Screening Day (HCH) Free Blood Pressure, Glucose and Cholesterol screenings at local churches and Senior Recreation Centers. (MMMC) Blood pressure and cholesterol screenings at health fairs for vulnerable families and seniors (SH) 	<ul style="list-style-type: none"> Free Blood Pressure, Glucose and Cholesterol screenings at local churches and senior centers in the Aspen Hill Bel Pre Area, residents of zip code 20906. (MMMC)

Activity	Target Populations					
	Children	Adults	Families	Seniors	Low-Income	Neighborhood
				prevention, symptom recognition and management of heart disease, medications, blood pressure monitoring, diet and lifestyle enhancements, (SH)		
Health Care		<ul style="list-style-type: none"> • Chronic Disease Self-Management Program (HCH) • NIH Heart Center at Suburban Hospital specializes in cardiac diagnostics, surgery and angioplasty (SH) 		<ul style="list-style-type: none"> • HeartWell program-increases awareness about heart disease prevention, symptom recognition and management of heart disease, medications, blood pressure monitoring, diet and lifestyle enhancements (SH) 	<ul style="list-style-type: none"> • Care offered at Health Centers in Silver Spring, Gaithersburg, Germantown, and Aspen Hill promotes cardiovascular health (HCH) • ED-PC Connect- Navigation program Linking Emergency Room patients to primary care, through hospital's established ED-PC connect program. The goal is to improve access to healthcare for low-income uninsured patients, with a focus on continuity of chronic disease management (CV and Diabetes) for improved healthcare status. (MMMC) • MobileMed/NIH Heart Center at Suburban Hospital specializes in cardiac diagnostics, angioplasty and surgery for Montgomery Cares patients (SH) 	<ul style="list-style-type: none"> • Care offered at Health Centers in Silver Spring, Gaithersburg, Germantown, and Aspen Hill provide promotes cardiovascular health (HCH) • Provide financial support to Holy Cross Health Care in Gaithersburg and Proyecto Salud Clinics (SH)

3. Diabetes

Activity	Target Populations					
	Children	Adults	Families	Seniors	Low-Income	Neighborhood
Education and Awareness		<ul style="list-style-type: none"> Nutrition and cooking classes designed specifically for diabetes and cancer patients provided at the Aquilino Cancer Center (AHC) “Stanford Model” free Diabetes Self-Management Program (a 6-week workshop with 2.5 hour sessions once a week); workshops are offered throughout the year in various community locations (AHC) Comprehensive Diabetes Outpatient Education Program; nutritional counseling; diabetes support group (AHC) Diabetes coordinator provides counseling and education during shared medical appointments at Mobile Med (AHC) Diabetes Prevention Program, free 12-month program provides a trained Lifestyle Coach to patients and offers nutritional guidance, exercise sessions and support to help prevent or delay diabetes onset (HCH) Chronic Disease Self-Management Program (HCH) Diabetes classes and support group (MMMC) Quarterly Diabetes management classes, bi-yearly diabetes symposium; quarterly pre-diabetes 		<ul style="list-style-type: none"> Diabetes Prevention Program (HCH) Chronic Disease Self-Management Program (HCH) Quarterly Diabetes management classes, bi-yearly diabetes symposium; quarterly pre-diabetes classes; monthly diabetes support groups throughout Montgomery County; monthly health seminars (SH) 	<ul style="list-style-type: none"> Pre-diabetes classes provided free-of-charge for those at risk of diabetes (AHC) Diabetes coordinator provides counseling and education during shared medical appointments at MobileMed (AHC) “Prescription” for health food for uninsured/underinsured patients with diabetes (can be used at local farmers market for reduced food costs) (AHC-WAH) Diabetes Prevention Program (HCH) Chronic Disease Self-Management Program (HCH) Health Centers in Silver Spring, Gaithersburg, Germantown, and Aspen Hill provide diabetes education to patients (HCH) Ongoing health seminars for low income seniors at Rockville Senior Center, financial support to Proyecto Salud clinic and their diabetes school (SH) 	<ul style="list-style-type: none"> Health Centers in Silver Spring, Gaithersburg, Germantown, and Aspen Hill provide diabetes education to patients (HCH)

Activity	Target Populations					
	Children	Adults	Families	Seniors	Low-Income	Neighborhood
		classes; monthly diabetes support groups throughout Montgomery County; monthly health seminars (SH)				
Screenings and Health Care		<ul style="list-style-type: none"> Heart Health Screenings and packages are offered including glucose screenings, A1c tests, and body fat analyses (AHC) Nutrition counseling for patients with diabetes (SH) Maternity Partnership Program provides prenatal services offered through four local hospitals, including: Holy Cross Hospital, Holy Cross Germantown Hospital, Washington Adventist Hospital, and Shady Grove Medical Center; provides prenatal care, routine laboratory tests, prenatal classes, and a dental screening by a dental hygienist, if referred (DHHS, AHC-WAH, SGMC, HCH) 			<ul style="list-style-type: none"> Diabetes coordinator provides shared medical appointment counseling at MobileMed (AHC) Health Centers in Silver Spring, Gaithersburg, Germantown, and Aspen Hill provide diabetes prevention and treatment (HCH) ED-PC Connect- Navigation program Linking Emergency Room patients to primary care, through hospital's established ED-PC connect program. The goal is to improve access to healthcare for low-income uninsured patients, with a focus on continuity of chronic disease management (cardiovascular and diabetes) for improved healthcare status. (MMMC) MobileMed/NIH Endocrine clinic at Suburban Hospital and nutrition counseling session for patients with dietitians (SH) 	<ul style="list-style-type: none"> Health Centers in Silver Spring, Gaithersburg, Germantown, and Aspen Hill provide diabetes prevention and treatment (HCH)

4. Cancers

Activity	Target Populations					
	Children	Adults	Families	Seniors	Low-Income	Neighborhood
Education and Awareness	<ul style="list-style-type: none"> Check It Out-Breast and testicular cancer awareness program for adolescents (SH) 	<ul style="list-style-type: none"> Weekly, monthly and annual activities for patients diagnosed with cancer and their families and caregivers include support groups, nutrition and cooking classes, fitness/yoga classes; community presentations; tobacco cessation program offering counseling, education, support and Nicotine Replacement Therapy (NRT) for patients and community members. (AHC) Health/wellness classes and educational events including Cancer Support Groups and Yoga for Cancer Patients (MMMC) Breast Center, Cancer Institute, cancer Support groups, lung cancer research, survivorship and cancer awareness events, outreach and education on cancer awareness, early detection and importance of breast self-exam conducted by community health workers, MAPS (mammogram assistance program services) (HCH) Smoking cessation programs, Great American Smoke-out; Facing Forward Breast and Prostate Cancer Support Groups; "Walk and Talk"- exercise and support group for cancer survivors; Prostate and Breast Cancer symposia,; Guided Cancer Nutrition Tour, Look Good Feel Better, wellness classes for cancer survivors; monthly health education seminars; colorectal cancer awareness and education; National Wear Blue Day awareness campaign, documentary screening on HPV (SH) 		<ul style="list-style-type: none"> Monthly Health education seminars (SH) 	<ul style="list-style-type: none"> Health Centers in Silver Spring, Gaithersburg and Aspen Hill implement cancer outreach, screening and prevention programs to increase cancer awareness, screening and early detection, outreach and education by community health workers, MAPS (HCH) A collaborative effort of MedStar Montgomery Medical Center, Olney Proyecto Salud Clinic, Community Radiology Associates, and the Women's Cancer Control Program provides breast education, screening, case management and follow-up navigation for Women's Health Improvement Program women who are patients of Proyecto Salud ages 40 and above (MMMC) Colorectal cancer education and awareness (SH) 	<ul style="list-style-type: none"> Health Centers in Silver Spring, Gaithersburg and Aspen Hill implement cancer outreach, screening and prevention programs to increase cancer awareness, screening and early detection, outreach and education by community health workers, MAPS (HCH)

Activity	Target Populations					
	Children	Adults	Families	Seniors	Low-Income	Neighborhood
Screenings		<ul style="list-style-type: none"> Ongoing low-dose CT lung cancer screenings at a reduced rate targeted for the Asian Community (Shady Grove Medical Center) Annual Cancer Screening Days (AHC) Breast cancer screening and navigation for uninsured women (AHC) Colorectal cancer screening referrals in partnership with the Montgomery County DHHS (AHC) Skin, head and neck cancer screenings provided for cancer patients and survivors (SH) Breast Center, Cancer Institute, Lung cancer screenings through I-ELCAP (International Early Lung Cancer Action Program) research program, MAPS screening program for uninsured women and men. (HCH) 		<ul style="list-style-type: none"> Skin, head and neck cancer screenings provided for community members, cancer patients and survivors (SH) 	<ul style="list-style-type: none"> Free breast cancer screening and navigation for uninsured women (AHC) Health Centers in Silver Spring, Gaithersburg and Aspen Hill implement cancer outreach, screening and prevention programs to increase cancer awareness, screening and early detection, MAPS screening program for uninsured women and men (HCH) A collaborative effort of MedStar Montgomery Medical Center, Olney Proyecto Salud Clinic, Community Radiology Associates, and the Women's Cancer Control Program provides breast education, screening, case management and follow-up navigation for Women's Health Improvement Program women who are patients of Proyecto Salud ages 40 and above (MMMC) Free pap smears for Proyecto Salud patients (SH) 	<ul style="list-style-type: none"> Health Centers in Silver Spring, Gaithersburg and Aspen Hill implement cancer outreach, screening and prevention programs to increase cancer awareness, screening and early detection (HCH)
Health Care		<ul style="list-style-type: none"> Free 1-year tobacco cessation program includes follow-up counseling sessions over the phone and free nicotine replacement therapy; all patients who use tobacco or have a history of tobacco use in the past year are visited by a counselor while in the hospital, provided a brief counseling session, and are offered enrollment in the program (AHC) Adventist HealthCare's Aquilino Cancer Center is a community-based, free-standing, comprehensive cancer center that provides 				

Activity	Target Populations					
	Children	Adults	Families	Seniors	Low-Income	Neighborhood
		<p>screenings and diagnosis, radiation and infusion therapies, surgery, clinical trials, and support and wellness (AHC)</p> <ul style="list-style-type: none"> • Holy Cross Hospital's Cancer Institute provides multi-disciplinary cancer care teams that offer comprehensive care including prevention, treatment, clinical trials and research, and patient support services; includes Breast Center (HCH) • MedStar Montgomery's Comprehensive Cancer Center partners with the Lombardi Comprehensive Cancer Center to deliver coordinated patient-centered care and treatment, clinical trials, cancer care nurse navigator and a psychosocial oncology program (MMMC) • Suburban Hospital's Cancer Program provides a comprehensive range of services, including health education, screening, clinical research, diagnosis, treatment, psychosocial support, Patient Navigator Nurses, and palliative care; affiliated with the National Cancer Institute (SH) • Patient Navigator- nurses provides one on one support to cancer patients as they undergo treatment (SH) 				

Adventist HealthCare (AHC); Holy Cross Health (HCH); MedStar Montgomery Medical Center (MMMC); Suburban Hospital (SH)

E. Community Resources

(Note: The acronyms following each entry below represent the agencies and organizations that provide the resource listed; a list of the agencies and organizations represented by the acronyms can be found at the end of the section).

1. Community Resources: Obesity

a. State and Local Government

Active Living and Healthy Eating

- Health Promoters Program offers health education and other interventions to promote healthy eating and active living (LHI)
- Power Play! workshop teaches healthy eating and active living (AAHP)
- Healthy Living & Activities Club and the African and Caribbean Healthy Living & Activities Club provide healthy eating tips, food tasting, and physical activities (AAHP)
- Health and Wellness Zone encompasses 2 community centers, ice rink, golf course, ball fields, fitness stations, trails, tennis and basketball courts and a farmers market; Health and Wellness Officer coordinates programs and partnerships to promote healthy eating and active living (MNCPPC)
- Assessment of wellness policies and programs at community centers (MNCPPC)
- Summer healthy eating and physical activity program for 5-12 year olds (MCR)
- Health and wellness fitness classes throughout the County (MCR)
- Senior health, wellness and fitness classes throughout the County (MCR)
- Healthy Summer Program for ages 5-12 years old includes health eating and physical activity programming (MCR)
- Wellness, Fitness and Performance Institute enhances the wellness, fitness, and performance of County residents; adopts standards and best practices in wellness, fitness, and performance for the Recreation Department (MCR)
- Evidence-based obesity prevention recommendations were presented by the Montgomery County Commission on Health to the Montgomery County Council to: improve the availability of affordable food and beverage choices in public service venues; provide incentives for the production, distribution, and procurement of foods from local farms; provide incentives to food retailers to locate in and/or offer healthier food and beverage choices in underserved areas; increase support for breastfeeding ; and increase opportunities for extracurricular physical activity (COH)
- Heart health screenings (AAHP)

Active Living

- 3.75-mile Health Freedom Walk and training program (AAHP)
- Senior 300 mile walking program (MNCPPC)
- Safe Routes to Play makes it easier to access parks and recreational facilities (MNCPPC)
- Park Prescription program educates doctors/patients about park system and recreation programs and provides discount pass (MNCPPC)
- Forest wellness walks led by naturalists (MNCPPC)

- Master plans include land use plans that recommend mix of land use to reduce automobile dependency; recommendations also increase walkability and transit accessibility (MNCPPC)
- Functional plans address county-wide planning issues such as Bicycle Master Plan (MNCPPC)
- Implements functional and master plans on a site-by-site basis; ensures implementation of goals of transit-oriented, pedestrian-friendly development are implemented (MNCPPC)
- 20 Community Centers with gyms/fitness centers (MCR)
- Therapeutic recreation for individuals with disabilities include fitness classes (MCR)
- Four indoor aquatic centers with exercise rooms and seven outdoor pools (MCR)

Healthy Eating

- The S.M.I.L.E. (Start More Infants Living Equally Healthy) Program provides breastfeeding support to mothers; I am Black and I Breastfeed encourages mothers to breastfeed (AAHP)
- Health promoters provide healthy eating and nutrient information at health fairs and outreach events (AAHI)
- Nutritious lunches provided to seniors in the community and home-delivered (DHHS)
- Nutrition education for seniors (DHHS)
- Farmers' Market coupons distributed (DHHS)
- Food provided at several sites throughout County for people experiencing homelessness (ICH)
- Builds community gardens (MNCPPC)
- Office of Eligibility and Support Services serves low-income families and individuals facing significant challenges in meeting basic needs to include food; determines eligibility for Supplemental Nutrition Assistance Program (DHHS)
- Montgomery County legislation bans the use of artificial trans-fats for most foods sold in County restaurants and at the prepared food sections of supermarkets (MCC)
- Montgomery County nutrition labeling legislation requires that calories and other nutrition information be provided to customers at restaurant chains with 20 or more locations (MCC)

b. Early Learning Centers, Schools, Colleges and Universities

Active Living

- Catch Kids After School Program is a healthy eating and physical activity program for children in grades K-8 (MCR)
- Girls On The Run after school program promoting healthy habits and an active lifestyle (3rd-8th grades) (SH)

Healthy Eating

- Instruction on good nutrition (MCPS)
- A la carte food items meet wellness regulations (MCPS)
- Calorie information is on school lunch menu; provides salad bar for lunch and school lunches with less sodium and processed foods (MCPS)
- Healthy after-school snacks and suppers (MCPS)
- Meals and snacks accessible to all students; summer and Saturday meal programs provided(MCPS)

c. Health Care Systems, Insurers and Clinicians

- Insurers of non-grandfathered ACA plans provide coverage for obesity screening and counseling for adults and children (including height, weight and BMI measurements for children), diet counseling for adults at high risk of chronic disease, and breast feeding comprehensive support and counseling as well as access to breastfeeding supplies for pregnant and nursing women, at no cost to enrollees (ACA)
- Care for Kids well baby and child visits for low-income children (birth to age 19) include nutrition counseling (PCC)

[Note: Hospital programs and services are provided in the Hospital Alignment Subsection starting on page 94]

d. Businesses and Employers

- Walking routes near County office buildings are available to County employees to use for lunchtime exercise (MCG)
- A vending machine located in the Montgomery County Executive Office Building contains healthful snack foods (MCG)
- LiveWell is the County government joint labor-management employee wellness program available to County employees that cultivates a culture of wellbeing through holistic programs and resources that empower employees to lead a healthier lifestyle (includes healthy eating and active living programs) (MCG)

e. Community, Non-profit, and Faith Based Organizations

Active Living and Healthy Eating

-
- *infoMONTGOMERY* database includes obesity prevention resources (CC)

Active Living

-
- Identity, Inc. County-wide Soccer program for youth ages 12-24 (II)
 - Impact Silver Spring's Long Branch Athletic Association (LBAA) provides youth with access to a range of affordable and accessible after-school sports activities (ISS)

Healthy Eating

-
- University of Maryland Extension provides basic nutrition at no cost by community educators to limited-income families with young children and to other vulnerable populations (UME)
 - 4-H programs offer a wide array of low-cost activities for youth that promote and teach skills, such as cooking and gardening (UME)
 - University of Maryland Extension Master Gardener certification program is offered with a requirement to provide consultation to community gardens (UME)

- Montgomery County Food Council works to: develop and sustain an economically viable County food system that supports producers, processors, distributors, retailers and consumers of local food; increase access to locally produced food among County residents; increase County residents' understanding of the importance of local, healthful food; improve agricultural soils and reduce the environmental impacts of local land and water use and the environmental footprint from non-local food in the County; and pursue or support emerging, dynamic opportunities which promise to build a more inclusive, robust and sustainable food system. (MCFC)
- Manna Food provides low-income grocery shoppers with free shopping tips and nutrition education on-site in grocery stores and kitchens; provides workshops and cooking demos on healthy eating (MF)
- The Women, Infants, and Children (WIC) Program provides healthy foods and nutrition counseling to pregnant women, new mothers, infants and children under age five; also provides breastfeeding support (CCI)
- Montgomery County Office of Agriculture Farmers' Markets provide community access to healthy food; some markets accept SNAP and provide WIC Matching Dollars and nutrition programs (MCOA)

2. Community Resources: Cardiovascular Health

a. State and Local Government

- Education and outreach on cardiovascular health at health fairs and cultural celebrations (AAHI)
- Million Heart Grant and Addressing Chronic Disease through System Change (DHHS)
- Health Heart screenings (AAHP)
- Project Santé Pour Tous is a culturally-competent education program for Francophone immigrant laborers at the CASA de Maryland labor center in Silver Spring that provides health information and linkages to health care resources related to various health topics including cardiovascular health (AAHP)

b. Health Care Systems, Insurers and Clinicians

- Insurers of non-grandfathered Affordable Care Act plans provide coverage for cholesterol screening for adults of certain ages or at high risk, blood pressure screening for adults and children, and tobacco use screening and interventions for all adults (expanded counseling for pregnant women), at no cost to enrollees (ACA)
- Montgomery Cares provides primary and preventive care that includes chronic disease management (DHHS) (PCC)
- MedBank provides access to the pharmaceutical industry's patient-assistance programs (PAPs) for free brand medications to manage chronic conditions such as congestive heart failure (PCC)
- Community Pharmacy provides point-of-service medications in nine medication sites distributed at Montgomery Cares participating clinics; improves patient compliance with prescribed medications and helps to control chronic conditions such as cardiovascular disease (PCC)

c. Community, Non-profit, and Faith Based Organizations

- Circle of Rights Stroke Prevention Education Classes inform individuals and their families about chronic conditions that can lead to stroke; one-hour programs are taught in English and Spanish and cover: exercise, nutrition, diabetes, high blood pressure, high cholesterol, heart disease, and health disparities (CR)

[Note: Hospital programs and services are provided in the Hospital Alignment Subsection starting on page 94]

3. Community Resources: Diabetes

a. State and Local Government

- Maternity Partnership Program provides prenatal services offered through four local hospitals, including: Holy Cross Hospital, Holy Cross Germantown Hospital, Washington Adventist Hospital, and Shady Grove Medical Center; provides prenatal care, routine laboratory tests, prenatal classes, and a dental screening by a dental hygienist, if referred (DHHS) (AHC-WAH) (SGMC) (HCH)
- Education and outreach on cardiovascular health at health fairs and cultural celebrations (AAHI)
- Million Heart Grant and Addressing Chronic Disease through System Change (DHHS)
- Diabetes Dining Club (AAHP)
- Diabetes education classes (AAHP)
- Self-management counseling for diabetes (AAHP)
- School health room technicians (DHHS) (MCPS)

b. Early Learning Centers, Schools, Colleges and Universities

- Diabetes education is included in the MCPS health education curriculum (MCPS)

c. Health Care Systems, Insurers and Clinicians

- Insurers of non-grandfathered ACA plans provide coverage for diabetes screening for adults with high blood pressure, gestational diabetes screening for pregnant women, blood pressure screening for adults and children, and cholesterol screening for adults of certain ages or at high risk, at no cost to enrollees (ACA)
- Montgomery Cares provides primary and preventive care that includes chronic disease management (PCC)
- MedBank provides access to the pharmaceutical industry's patient-assistance programs (PAPs) for free brand medications necessary to manage chronic conditions such as diabetes (PCC)

[Note: Hospital programs and services are provided in the Hospital Alignment Subsection starting on page 94]

4. Community Resources: Cancers

a. State and Local Government

Education/Screening

- Education and outreach on cancer at public events with a focus on breast, cervical, and colorectal cancers based on the need of the Asian American community (AAHI)
- Project Santé Pour Tous is a culturally-competent education program for Francophone immigrant laborers at the CASA de Maryland labor center in Silver Spring that provides cancer prevention and education (AAHP)
- Smoking Cessation Program offers culturally and linguistically appropriate group and individual-level interventions to smokers; provides social support through coaches (LHI)
- Health Promoters Program offers health education and other interventions including tobacco use prevention (LHI)
- The Tobacco Use Prevention and Cessation Program and the Cancer Prevention, Education, Screening and Treatment Program are two major programs funded through the State Cigarette Restitution Fund; funding supports coordination activities among community groups for outreach, screenings, education, and treatment; each of the programs has established coalitions consisting of public health partners, community based organizations, hospitals, and other existing resources that work collaboratively to implement either tobacco-control programs or the statewide goal of early detection and elimination of cancer disparities, whether based on race, ethnicity, age or sex, as well as the establishment of tobacco-control programs (DHHS)
- Women's Cancer Control Program provides screening for early detection of breast cancer and cervical cancer including gynecological examinations, clinical breast examinations, mammograms, ultrasounds and related case-management services for eligible women 40 years and older (DHHS)

Regulation

- Montgomery County Department of Liquor Control conducts tobacco compliance checks annually to reduce tobacco sales to minors under the age of 18 and to ensure product placement laws are followed. (DLC)
- Montgomery County law requires most single-family homes be tested for radon prior to being sold (MCC)
- Montgomery County law bans the use of pesticides on County-owned and private lawns (MCC)
- Montgomery County imposes an excise tax on the distribution of electronic cigarette products (MCC)
- Montgomery County law prohibits smoking in: common areas of apartments and condominiums, within 25 feet of a playground on private property that serves more than one dwelling unit, and in certain public places (e.g., health care facilities, schools, County government buildings, businesses or organizations open to the public, eating and drinking establishments) (MCC)

- Montgomery County law prohibits the use of electronic cigarettes in certain public places; restricts the sale of certain liquid nicotine in retail outlets unless the nicotine is in a container considered to have child resistant packaging; restricts the accessibility of certain tobacco products in retail settings; prohibits the use of electronic cigarettes by minors (MCC)

b. Early Learning Centers, Schools, Colleges and Universities

- Cancer prevention education is included in the MCPS health education curriculum (MCPS)

c. Health Care Systems, Insurers and Clinicians

Screening

- Insurers of non-grandfathered ACA plans provides coverage of preventive cancer screenings (breast cancer, cervical cancer, and colorectal cancer), breast cancer chemoprevention counseling for women at high risk, and tobacco use screening and interventions for all adults (expanded counseling for pregnant women), at no cost to enrollees (ACA)
- Montgomery Cares Safety Net clinics provide primary and preventive care for low-income, uninsured adults in Montgomery County including cancer screening (PCC)
- Breast Health Quality Consortium works across the spectrum of breast health care by identifying and reducing disparities in service delivery with an emphasis on increasing access to screening services for women receiving care at participating County Safety Net Clinics (PCC)
- Proyecto Salud provides Patient Navigation for cancer screenings (PS)

Health Care

- Children's National Outpatient Center of Montgomery County provides hematology & oncology specialties (CN)
- John P. Murtha Cancer Center at the Walter Reed Military Medical Center provides patient-centered hematology and oncology services that consist of comprehensive care for the treatment of cancer; multi-disciplinary approach integrates supportive services such as nutrition, psychology, social work and pastoral services (WR)
- The National Cancer Institute (NCI), located in the County, is part of the National Institutes of Health; NCI coordinates the National Cancer Program which conducts and supports research, training, health information dissemination, and other programs involving the cause, diagnosis, prevention, and treatment of cancers, rehabilitation from cancer, and the continuing care of cancer patients and families of cancer patients (NCI)

[Note: Hospital programs and services are provided in the Hospital Alignment Subsection starting on page 94]

d. Community, Non-profit, and Faith Based Organizations

- Bladder Cancer Advocacy (located in Bethesda) is devoted to advancing bladder cancer research and supporting those impacted by the disease (BCA)

- Hope Connections for Cancer Support (located in Bethesda) provides support groups for people with cancer and caregivers, education programs and presentations, mind/body classes to reduce stress or build strength, and social programs (HC)
- Montgomery County Cancer Crusade raises awareness about benefits of screening, coordinates outreach activities, assists with case management and contacts patients for follow-up, appointments (MCCC)

Affordable Care Act (ACA)
African American Health Program (AAHP)
Asian American Health Initiative (AAHI)
Bladder Cancer Advocacy (BCA)
Children's National Health System (CN)
Circle of Rights (CR)
Community Clinic, Inc. (CCI)
Montgomery County Department of Liquor Control (DLC)
Hope Connections for Cancer Support (HC)
Latino Health Initiative (LHI)
Holy Cross Health (HCH)
Identity, Inc. (II)
Impact Silver Spring (ISS)
Interagency Commission on Homelessness (ICH)
Manna Food (MF)
Maryland National Capital Park and Planning Commission (MNCPPC)
Montgomery County Collaboration Council for Children, Youth and Families (CC)

Montgomery County Cancer Crusade (MCCC)
Montgomery County Commission on Health (COH)
Montgomery County Council (MCC)
Montgomery County Department of Health and Human Services (DHHS)
Montgomery County Food Council (MCFC)
Montgomery County Government (MCG)
Montgomery County Office of Agriculture (MCOA)
Montgomery County Public Schools (MCPS)
Montgomery County Recreation (MCR)
National Cancer Institute (NCI)
Primary Care Coalition (PCC)
Proyecto Salud (PS)
Shady Grove Medical Center (SGMC)
Suburban Hospital (SH)
University of Maryland Extension (UME)
Walter Reed Military Medical Center (WR)
Washington Adventist Hospital (AHC-WAH)

F. What Works

(Note: The acronyms following each entry below represent the source for the evidence-based strategy listed; a list of the acronyms and the source they represent can be found at the end of the section).

1. State and Local Government

Obesity

- Strengthen licensing standards for early learning centers to include nutritional requirements for foods and beverages served (NPS)
- Ensure that foods served or sold in government facilities and government-funded programs and institutions meet nutrition standards consistent with the Dietary Guidelines for Americans (NPS)
- Work with hospitals, early learning centers, health care providers, and community-based organizations to implement breastfeeding policies and programs (NPS)

- Ensure laboratories, businesses, health care, and community partners are prepared to respond to outbreaks of foodborne disease (NPS)
- Use grants, zoning regulations, and other incentives to attract full-service grocery stores, supermarkets, and farmers' markets to underserved neighborhoods, and use zoning codes and disincentives to discourage a disproportionately high availability of unhealthy foods, especially around schools (NPS)
- Implement programs to promote access to healthy foods for high-risk communities (i.e. healthy corner stores, use of Electronic Benefits Transfer for WIC, SNAP participants at farmers' markets) (MCCCP)
- Design safe neighborhoods that encourage physical activity (e.g., include sidewalks, bike lanes, adequate lighting, multi-use trails, walkways, and parks) (NPS) (CG)
- Implement programs to promote opportunities for physical activity in high-risk communities with county park and recreation programs (MCCCP)
- Use point-of-decision prompts to encourage use of stairs (CG)
- Enhance access to places for physical activity combined with informational outreach activities (CG)
- Provide social support in community settings to increase physical activity among adults (CG)
- Provide community-wide, multi-sector and multi-component campaigns to increase physical activity among adults and children (CG)
- Convene partners (e.g., urban planners, architects, engineers, developers, transportation, law enforcement, public health) to consider health impacts when making transportation or land use decisions (NPS)
- Support schools and early learning centers in meeting physical activity guidelines (NPS)
- Ensure availability of transportation to safe, accessible, and affordable places for physical activity (NPS)

Cancers

- Offer group education to increase breast cancer screening that conveys information on indications for, benefits of, and ways to overcome barriers to screening with the goal of informing, encouraging, and motivating participants to seek recommended screening (group education can be given by health professionals or trained laypeople to a variety of groups, in different settings, and by different types of educators with different backgrounds and styles) (CG)
- Provide one-on-one education to increase screening for breast, colorectal, and cervical cancers that delivers information to individuals about indications for, benefits of, and ways to overcome barriers to cancer screening with the goal of informing, encouraging, and motivating them to seek recommended screening; delivered by healthcare workers or other health professionals, lay health advisors, or volunteers, and are conducted by telephone or in person in medical, community, worksite, or household settings (CG)
- Reduce structural barriers (i.e., non-economic burdens or obstacles that make it difficult for people to access cancer screening) to increase screening for breast and colorectal cancers (by mammography and fecal occult blood test, respectively); interventions designed to reduce these barriers include: reducing time or distance between service delivery settings and target populations; modifying hours of service to meet client needs; offering services in alternative or non-clinical settings (e.g., mobile mammography vans at worksites or in residential communities); eliminating or simplifying administrative procedures and other

- obstacles (e.g., scheduling assistance, patient navigators, transportation, dependent care, translation services, limiting the number of clinic visits) (CG)
- Reduce client out-of-pocket costs for breast cancer screening to minimize or remove economic barriers that make it difficult for clients to access cancer screening services; costs can be reduced through a variety of approaches, including vouchers, reimbursements, reduction in co-pays, or adjustments in federal or state insurance coverage (may be combined with measures to provide client education, information about program availability, or measures to reduce structural barriers) (CG)
 - Explore legislative options for expanding access to and payment for palliative and hospice care (MCCCCP)
 - Utilize patient navigators, community health workers, and case managers to increase access to cancer treatment (MCCCCP)
 - Detect and mitigate homes for radon exposure, the most preventable source of background radiation; the U.S. Environmental Protection Agency and U.S. Surgeon General recommend that homeowners take action to reduce radon levels that are 4 pCi/L or higher (EPA, MCCCCP)
 - Provide interventions in outdoor recreational and tourism settings that include skin cancer prevention messages or educational activities for visitors, and may also provide free sunscreen of SPF 15 or greater (CG)
 - Encourage funding for the building of covered structures and implementing signage at public beaches and parks reminding people to wear sunscreen (MCCCCP)
 - Implement and sustain comprehensive tobacco prevention and control programs, including comprehensive tobacco free and smoke free policies and paid media advertising (NPS)
 - Work with the FDA to enforce the provisions set forth in the Tobacco Control Act (NPS)
 - Implement and enforce policies and programs to reduce youth access to tobacco products (e.g., Synar program) (NPS)
 - Balance traditional beliefs and ceremonial use of tobacco with the need to protect people from secondhand smoke exposure (NPS)
 - Adopt state and local policies that restrict the sale, advertising, and promotion of tobacco products by (a) prohibiting the sale of menthol and any other flavored tobacco products; (b) require sale of non-premium cigars in packages of at least five cigars; and (c) adopt additional restrictions on the time, manner, and place of tobacco sales consistent with the First Amendment (MCCCCP)

2. Early Learning Centers, Schools, Colleges and Universities

Obesity

- Implement and enforce policies that increase the availability of healthy foods, including in a la carte lines, school stores, vending machines, and fundraisers (NPS)
- Update cafeteria equipment (e.g., remove deep fryers, add salad bars) to support provision of healthier foods (NPS)
- Eliminate high-calorie, low-nutrition drinks from vending machines, cafeterias, and school stores and provide greater access to water (NPS)
- Implement policies restricting the marketing of unhealthy foods (NPS)
- Provide nutrition education (NPS)
- Promote the formation of local school wellness councils (EWBA)
- Promote breastfeeding and healthier drinks in child care centers (EWBA)

- Provide daily physical education and recess that focuses on maximizing time physically active (NPS)
- Participate in fitness testing (e.g., the President's Challenge) and support individualized self-improvement plans (NPS)
- Support walk and bike to schools programs and work with local governments to make decisions about selecting school sites that can promote physical activity (NPS)
- Make physical activity facilities available to the local community (NPS)
- Limit passive screen time (NPS)
- Enhanced school-based physical education to increase physical activity among children and adolescents (CG)
- Use point-of-decision prompts to encourage use of stairs (CG)
- Promote the formation of local school wellness councils (EWBA)
- Promote limits on screen time in child care centers (EWBA)

Cancers

- Provide child care center-based skin cancer prevention using educational and behavioral interventions (information about sun safety and the effects of ultraviolet (UV) radiation directed to children and their caregivers (e.g., staff, parents) and implement sun protection policies (e.g., include increasing the availability of sun-protective items (e.g., sunscreen or protective clothing), adding sun-protective features to the physical environment (e.g., shade structures), and implementing sun-protection policies (e.g., clothing guidelines, restrictions on outdoor activities during peak sunlight hours) (CG)
- Provide primary and middle school interventions to prevent skin cancer including sun-protective environmental and policy changes such as increasing the availability of sun-protective items; adding sun-protective features to the physical environment; and implementing sun-protection policies (e.g., clothing guidelines, restrictions on outdoor activities during peak sunlight hours); interventions also include efforts to change the knowledge, attitudes, and behaviors of caregivers at school or at home (CG)
- Promote tobacco free environments (NPS)
- Restrict the marketing and promotion of tobacco products to children and youth (NPS)

3. Health Care Systems, Insurers and Clinicians

Obesity

- Provide technology-supported, multicomponent coaching/counseling interventions to reduce and maintain weight loss among adults (CG)
- Screen children aged 6 years and older for obesity and offer or refer children to comprehensive, intensive behavioral intervention to improve weight status (CPS) (NPS)
- Screen adults age 18 years and older for obesity and offer or refer to intensive, multicomponent behavioral interventions to improve weight status (CPS) (NPS)
- Assess dietary patterns (both quality and quantity of food consumed), provide nutrition education and counseling, and refer people to community resources (NPS)
- Use maternity care practices that empower new mothers to breastfeed, such as the Baby-Friendly Hospital standards (NPS)

- Provide individually-adapted health behavior change programs to increase physical activity (CG)
- Provide community-wide, multi-sector and multi-component campaigns to increase physical activity among adults and children (CG)
- Use point-of-decision prompts to encourage use of stairs (CG)
- Incorporate Physical Activity as a Vital Sign in clinic settings (EWBA)
- Conduct physical activity assessments, provide counseling, and refer patients to allied health care or health and fitness professionals (NPS)
- Support clinicians in implementing physical activity assessments, counseling, and referrals (NPS)

Cardiovascular Health

- Use clinical decision-support systems (CDSS) -- computer-based information systems designed to assist healthcare providers in implementing clinical guidelines at the point of care for prevention of cardiovascular disease (CG)
- Provide interventions that engage community health workers to prevent cardiovascular disease (CG)
- Reduce patient out-of-pocket costs (ROPC) for medications to control high blood pressure and high cholesterol when combined with additional interventions aimed at improving patient-provider interaction and patient knowledge, such as team-based care with medication counseling, and patient education (CG)
- Offer team-based care to improve blood pressure control (e.g., nurses and pharmacists working in collaboration with primary care providers, patients, and other professionals) (CG)
- Provide self-measured blood pressure monitoring interventions used alone (i.e., patients receive self-measured blood pressure tools, training, and monitoring) to improve blood pressure outcomes in patients with high blood pressure (CG)
- Recommend self-measured blood pressure monitoring interventions combined with additional support (i.e., patient counseling, education, or web-based support) to improve blood pressure outcomes in patients with high blood pressure (CG)
- Offer or refer adults who are overweight or obese and have additional cardiovascular disease risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for cardiovascular disease prevention (CPS)
- Screen for Abdominal Aortic Aneurysm (AAA) in men aged 65 to 75 years who have ever smoked by conducting an abdominal ultrasonography for accuracy (CPS)
- Screen adults in the general population aged 18 years or older for high blood pressure (hypertension). If hypertension is confirmed recommend pharmacological and non-pharmacological therapies (CPS)
- Screen men 35 and older for lipid disorder (cholesterol, dyslipidemia), screen men 20-35 that are at increased risk for coronary heart disease (CHD); screen women 20 and older at increased risk for cardiovascular disease should be screened (CPS)
- Prescribe aspirin as a preventive medication for the prevention of cardiovascular disease for men age 45-79 and women age 55-79 when potential cardiovascular benefit outweighs potential harm of GI hemorrhage (CPS)

Diabetes

- Implement diabetes self-management education (DSME) interventions in (1) community gathering places to improve glycemic control for adults with Type 2 diabetes and (2) homes of children and adolescents who have Type 1 diabetes to improve glycemic control among adolescents with Type 1 diabetes (CG)
- Offer combined diet and physical activity promotion programs for people at increased risk of Type 2 diabetes to reduce new-onset diabetes; programs commonly include a weight loss goal, individual or group sessions (or both) about diet and exercise, meetings with a trained diet or exercise counselor (or both), and individually tailored diet or exercise plans (or both) (CG)
- Provide diabetes case management strategies to improve glycemic control (CG)
- Provide diabetes disease management to improve glycemic control, provider monitoring of glycated hemoglobin (GHb), provider screening for diabetic retinopathy, provider screening of the lower extremities for neuropathy and vascular changes, urine screening for protein, and monitoring of lipid concentrations (CG)
- Screen for abnormal blood glucose in adults aged 40 to 70 years who are overweight or obese with referral to intensive behavioral counseling interventions to promote a healthful diet and physical activity (CPS)
- Screen for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation (CPS)

Cancers

- Incorporate system changes in healthcare provider settings that automatically order recommended cancer screenings for target populations (MCCCCP)
- Adopt policies in Maryland hospitals to provide inpatient counseling and treatment for patients that use tobacco (MCCCCP)
- Provide client reminders to increase screening for breast and cervical cancers and colorectal cancer screening with fecal occult blood testing; reminders are written or telephone messages advising people that they are due for screening; client reminders may be enhanced by one or more of the following: follow-up printed or telephone reminders; additional text or discussion with information about indications for, benefits of, and ways to overcome barriers to screening, and assistance in scheduling appointments (can address the overall target population or one specific person) (CG) (MCCCCP)
- Ensure clinical support through hiring a skilled and certified team of interdisciplinary palliative care professionals and associated support staff in order to implement a palliative care consult service or other delivery model (MCCCCP)
- Collaborate with pharmacies to ensure that pain medication is adequately stocked in all communities for cancer patients and explore legislation that would require pharmacies to stock medication for cancer patients (MCCCCP)
- Use small media (e.g., videos, printed materials such as letters, brochures, and newsletters) tailored to specific individuals or targeted to general audiences to increase: breast cancer screening by mammography, cervical cancer screening by Pap test, and colorectal cancer screening by fecal occult blood test (CG)
- Offer group education for clients to increase breast cancer screening that conveys information on indications for, benefits of, and ways to overcome barriers to screening with the goal of informing, encouraging, and motivating participants to seek recommended screening (group education can be given by health professionals or trained laypeople to a

- variety of groups, in different settings, and by different types of educators with different backgrounds and styles) (CG)
- Provide one-on-one education to increase screening for breast, colorectal, and cervical cancers that delivers information to individuals about indications for, benefits of, and ways to overcome barriers to cancer screening with the goal of informing, encouraging, and motivating them to seek recommended screening; delivered by healthcare workers or other health professionals, lay health advisors, or volunteers, and are conducted by telephone or in person in medical, community, worksite, or household settings (CG)
 - Reduce structural barriers (i.e., non-economic burdens or obstacles that make it difficult for people to access cancer screening) to increase screening for breast and colorectal cancers (by mammography and fecal occult blood test, respectively); interventions designed to reduce these barriers include: reducing time or distance between service delivery settings and target populations; modifying hours of service to meet client needs; offering services in alternative or non-clinical settings (e.g., mobile mammography vans at worksites or in residential communities); eliminating or simplifying administrative procedures and other obstacles (e.g., scheduling assistance, patient navigators, transportation, dependent care, translation services, limiting the number of clinic visits) (CG)
 - Provide assessment and feedback interventions to increase effectiveness in screening for breast cancer (mammography), cervical cancer (Pap test), and colorectal cancer (FOBT) (CG)
 - Use provider reminders and recall systems to increase breast cancer screening by mammography, cervical cancer screening my Pap test, colorectal cancer screening my fecal occult blood test and flexible sigmoidoscopy; informs health care providers it is time for a client's cancer screening test (reminder) or that the client is overdue for screening (recall); reminders can be provided in different ways, such as in client charts or by e-mail (CG)
 - Counsel children, adolescents, and young adults aged 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer (CPS)
 - Screen women who have family members with breast, ovarian, tubal, or peritoneal cancer using one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes; provide genetic counseling for women with positive screening results, and, if indicated after counseling, BRCA testing (CPS)
 - Screen women age 50-74 years for breast cancer biennially (CPS)
 - Screen for cervical cancer in women age 21 to 65 years with cytology (Pap smear) every 3 years or, for women age 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years (CPS)
 - Screen for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years (CPS)
 - Screen annually for lung cancer with low-dose computed tomography (LDCT) in adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years (CPS)
 - Clinicians should engage in shared, informed decision making with women who are at increased risk for breast cancer about medications for risk reduction; for those who have low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications like tamoxifen or raloxifene (CPS)
 - Primary care clinicians should provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents (CPS)

- Implement evidence-based recommendations for tobacco use treatment and provide information to patients on the health effects of tobacco use and secondhand smoke exposure (NPS)
- Implement provider reminder system for tobacco use treatment (e.g., vital signs stamps and electronic medical record clinical reminders) (NPS)
- Reduce or eliminate patient out-of-pocket costs for cessation therapies (NPS)

4. Businesses and Employers

Obesity

- Provide worksite nutrition programs (CG)
- Increase the availability of healthy food (e.g., through procurement policies, healthy meeting policies, farm-to-work programs, farmers' markets) (NPS) (MCCCP)
- Adopt lactation policies that provide space and break time for breastfeeding employees (in accordance with the Affordable Care Act) and offer lactation management services and support (NPS)
- Provide nutrition information to customers (e.g., on menus), make healthy options and appropriate portion sizes the default, and limit marketing of unhealthy food to children and youth (NPS)
- Reduce sodium, saturated fats, and added sugars and eliminate artificial trans fats from products (NPS)
- Implement programs to promote access to healthy foods for high-risk communities (i.e. healthy corner stores, use of Electronic Benefits Transfer for WIC, SNAP participants at farmers' markets) (MCCCP)
- Implement proper handling, preparation, and storage practices to increase food safety (NPS)
- Use Point-of-decision prompts to encourage use of stairs (CG)
- Provide worksite physical activity programs (CG)
- Adopt policies and programs that promote walking, bicycling, and use of public transportation (NPS)
- Design or redesign communities to promote opportunities for active transportation (NPS)
- Sponsor a new or existing park, playground, or trail, recreation or scholastic program, or beautification or maintenance project (NPS)

Cancers

- Support workplace initiatives to encourage continued breastfeeding after return to work (MCCCP)
- Support policies that allow work-time release to obtain cancer-screening services (MCCCP)
- Provide interventions in outdoor occupational settings to prevent skin to increase outdoor workers' sun protective behaviors (e.g., use of sunscreen or sun protective clothing or combination of sun protective behaviors) and reduce sunburns (CG)
- Provide employees and their dependents with access to free or reduced-cost tobacco cessation supports and encourage utilization of these services (NPS)
- Provide evidence-based incentives to increase tobacco cessation, consistent with existing law (NPS)
- Comply with restrictions on the sale, distribution, advertising, and promotion of tobacco products, including those set forth in the Tobacco Control Act (NPS)

- Make work sites (including conferences and meetings) tobacco free and support smoke free policies in communities (NPS)
- Provide smoke free commercial or residential property (NPS)

5. Community, Non-profit, and Faith Based Organizations

Obesity

- Develop and distribute inventory of physical activity, healthy eating, nutrition education, and nutrition counseling resources and encourage resource use (EWBA)
- Lead or convene city, county, and regional food policy councils to assess local community needs and expand programs (e.g., community gardens, farmers markets) that bring healthy foods, especially locally grown fruits and vegetables, to schools, businesses, and communities (NPS)
- Implement culturally and linguistically appropriate social supports for breastfeeding, such as marketing campaigns and breastfeeding peer support programs (NPS)
- Implement programs to promote access to healthy foods for high-risk communities (i.e. healthy corner stores, use of Electronic Benefits Transfer for WIC, SNAP participants at farmers' markets) (MCCCP)
- Provide social support in community settings to increase physical activity among adults (CG)
- Use point-of-decision prompts to encourage use of stairs (CG)
- Provide behavioral interventions to reduce recreational sedentary screen time among children aged 13 and younger (CG)
- Enhance access to places for physical activity combined with informational outreach activities (CG)
- Offer low or no-cost physical activity programs (NPS)
- Develop and institute policies and joint use agreements that address liability concerns and encourage shared use of physical activity facilities (NPS)
- Offer opportunities for physical activity across the lifespan (NPS)

Cancers

- Offer group education to increase breast cancer screening that conveys information on indications for, benefits of, and ways to overcome barriers to screening with the goal of informing, encouraging, and motivating participants to seek recommended screening (CG)
- Provide one-on-one education to increase screening for breast, colorectal, and cervical cancers that delivers information to individuals about indications for, benefits of, and ways to overcome barriers to cancer screening with the goal of informing, encouraging, and motivating them to seek recommended screening; delivered by healthcare workers or other health professionals, lay health advisors, or volunteers, and are conducted by telephone or in person in medical, community, worksite, or household settings (CG)
- Reduce structural barriers (i.e., non-economic burdens or obstacles that make it difficult for people to access cancer screening) to increase screening for breast and colorectal cancers (by mammography and fecal occult blood test, respectively); interventions designed to reduce these barriers include: reducing time or distance between service delivery settings and target populations; modifying hours of service to meet client needs; offering services in alternative or non-clinical settings (e.g., mobile mammography vans at worksites or in residential communities); eliminating or simplifying administrative procedures and other

- obstacles (e.g., scheduling assistance, patient navigators, transportation, dependent care, translation services, limiting the number of clinic visits) (CG)
- Provide multicomponent community-wide interventions to prevent skin cancer using combinations of individual-directed strategies, mass media campaigns, and environmental and policy changes across multiple settings within a defined geographic area in an integrated effort to influence UV-protective behaviors; usually delivered with a defined theme, name, logo, and set of messages (CG)
 - Adopt state and local policies that prohibit the smoking of tobacco products inside multi-unit housing, and inside of any daycare facility (including private homes licensed as such) at all times (MCCCP)
 - Work with local policy makers to implement comprehensive tobacco prevention and control programs (NPS)
 - Implement sustained and effective media campaigns, including raising awareness of tobacco cessation resources (NPS)

Community Guide, Centers for Disease Control and Prevention (CG)

Guide to Clinical Preventive Services, U.S. Preventive Services Task Force (CPS)

Maryland Comprehensive Cancer Control Plan 2011-2015, Maryland Department of Health and Mental Hygiene (MCCCP)

National Prevention Strategy, Surgeon General, U.S. Department of Health and Human Services (NPS)

Healthy Montgomery Eat Well Be Active Partnership (EWBA)

Key Findings: Behavioral Health

With Emerging Issue – Heroin and Other Opioids Misuse

Overview

Behavioral Health encompasses mental health and emotional well-being as well as substance abuse and other addictive behaviors. Behavioral health is critical to overall health and affects a person's ability to cope with life stressors, achieve at school and in the workplace, and lead a productive life. Behavioral health disorders often co-occur with other chronic health conditions such as diabetes, cardiovascular disease, cancer, and obesity. In addition, mental disorders, especially depressive disorders, are strongly related to many risk behaviors for chronic disease such as inadequate physical activity, smoking, excessive drinking, and poor sleep.

There are disparities in behavioral health status and in access to behavioral health prevention services and treatment. These disparities are largely due to social determinants of health such as poverty, inadequate housing, unsafe neighborhoods, inequitable wages, substandard education, and unequal access to quality health care. Exposure to violence, social isolation, and discrimination can also increase the risk of behavioral health disorders.

Stigma, cultural beliefs, and discrimination against people with behavioral health disorders can affect an individual's ability and willingness to seek and receive behavioral health services. Health insurance limits on treatment for mental health and substance use has also historically been a barrier to access. Care management that integrates and coordinates primary care services, mental health and substance abuse treatment, and social services (i.e., housing, education, income, employment, food sufficiency) to treat individuals with behavioral health conditions is currently being promoted to achieve better health outcomes and lower health care costs.³²

A comprehensive review of Montgomery County's behavioral health system was conducted in the last year by the Montgomery County Office of Legislative Oversight (OLO). It examines the prevalence of mental illness and substance abuse in Montgomery County, access to behavioral health services through public and private health insurance, behavioral health services provided through the criminal justice system in the County, behavioral health prevention, referral and recovery support services, data on the behavioral health workforce and facilities in Montgomery County, and major gaps in services.³³

Please note: The contents of this Report section apply to both mental health and substance abuse issue areas. With the inclusion of the Healthy Montgomery Emerging Issue Area on Heroin and Other Opioids Abuse, substance abuse-related content specific to the topic of heroin and opioid abuse is not covered in this section. The section on Heroin and Other Opioid Abuse immediately follows this section. Also note that violence, social isolation, and discrimination are discussed in the Underlying Factors sections of the Report.

³² Centers for Disease Control and Prevention. Accessed at: <http://www.cdc.gov/mentalhealth/basics.htm>; U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). Accessed at: <http://www.samhsa.gov/treatment>; American Public Health Association. Accessed at: <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/58/support-for-social-determinants-of-behavioral-health>

³³ N. Carrizosa, S. Richards. *Behavioral Health in Montgomery County*. July 28th, 2015. Montgomery County Office of Legislative Oversight. Report Number 2015-13. Accessed at: http://www.montgomerycountymd.gov/OLO/Resources/Files/2015_Reports/OLO%20Report%202015-13%20Behavioral%20Health%20in%20Montgomery%20County.pdf

What We Can Do

In Mental Health and Substance Abuse

Leverage/Enhance Existing Efforts:

- **Create an accurate, relevant, and updated inventory of behavioral health services in the County by enhancing infoMONTGOMERY to improve usability and accessibility to vulnerable populations, and inform consumers and professionals about infoMONTGOMERY using an outreach campaign (Healthy Montgomery Behavioral Health Task Force Recommendations)^{34,35} based on the existing efforts of:**
 - Collaboration Council for Children, Youth and Families
 - Montgomery County Minority Health Initiatives and Program
 - Healthy Montgomery Behavioral Health Task Force
- **Train key community members (e.g., adults who work with the older adults, youth, and armed services personnel) to identify the signs of depression and suicide and refer County residents to resources (National Prevention Strategy) based on the existing efforts of:**
 - Family Services Inc.
 - Montgomery County Minority Health Initiatives and Program
 - Holy Cross Health's Community Health Workers
 - Mental Health Association
- **Develop integrated care programs to address mental health, substance abuse and other needs within primary care settings, pilot and evaluate models of integrated mental and physical health in primary care, with particular attention to underserved populations and areas, and to expand access to mental health services (e.g., patient navigation, support groups) and enhance linkages between mental health, substance abuse, disability, and other social services (National Prevention Strategy)³⁶ based on the existing efforts of:**
 - Family Services Inc.
 - Community Clinic, Inc.
 - Montgomery County Collaboration Council for Children, Youth and Families

³⁴Healthy Montgomery Behavioral Health Task Force recommendations are based on National Prevention Strategy recommendations including: expand access to mental health services (e.g., patient navigation, support groups) and enhance linkages between mental health, substance abuse, disability, and other social services and ensure that those in need, especially potentially vulnerable groups, are identified and referred to mental health services.

³⁵ Healthy Montgomery Behavioral Health Task Force Recommendations can be found at www.healthymontgomery.org.

³⁶ Three National Prevention Strategy recommendations are integrated here: develop integrated care programs to address mental health, substance abuse, and other needs within primary care settings; pilot and evaluate models of integrated mental and physical health in primary care, with particular attention to underserved populations and areas; and expand access to mental health services (e.g., patient navigation, support groups) and enhance linkages between mental health, substance abuse, disability, and other social services.

- Montgomery County Department of Health and Humans Services (Behavioral Health and Crisis Services, Children Youth and Family Services, Public Health Services, Aging and Disabilities Services, Special Needs Housing)
- Montgomery County Community Safety-Net Clinics
- Montgomery County hospital systems

Initiate Efforts:

- Create and implement a pilot for a formalized, coordinated system of care (based on a Hub and Pathways model) addressing behavioral health (substance abuse and mental health), medical and social needs of 300 adult consumers (18 years and older) who have a mental health diagnosis and one of the following – chronic homelessness as defined by the federal Department of Housing and Urban Development (HUD), minimal or no supports, multiple acute hospitalizations and/or emergency department (ED) visits; and/or multiple incarcerations (Healthy Montgomery Behavioral Health Task Force recommendations)
.Partners to include:
 - Healthy Montgomery Behavioral Health Task Force
 - Montgomery County Department of Health and Humans Services (Behavioral Health and Crisis Services, Children Youth and Family Services, Public Health Services, Aging and Disabilities Services, Special Needs Housing)
 - Family Services Inc. and other Montgomery County behavioral health service providers
 - Montgomery County Community Safety-Net Clinics
 - Montgomery County hospital systems
 - Montgomery County Department of Corrections and Rehabilitation

In Substance Abuse

Leverage/Enhance Existing Efforts:

- **Educate youth and adults about the risks of drug abuse and excessive drinking (National Prevention Strategy)** based on the existing efforts of:
 - Family Services, Inc.
 - Montgomery County Department of Health and Human Services (Behavioral Health and Crisis Services)
 - Montgomery County Public Schools

*Healthy Montgomery Behavioral Health Task Force Recommendations, Behavioral Health Task Force Community Guide, Centers for Disease Control and Prevention
Guide to Clinical Preventive Services, U.S. Preventive Services Task Force
National Prevention Strategy, Surgeon General, U.S. Department of Health and Human Services*

Information Gathered on Behavioral Health

A. From the Community Conversations

1. Health and Health Care

Assets

- Suicide prevention groups for students

Challenges

- Insufficient mental and behavioral health services
- Mental health service not incorporated with treatment for disabilities
- Lack of culturally and linguistically appropriate mental health outreach and resources for the Asian-American community specifically addressing suicide
- Lack of suicide prevention services for teens
- Lack of programs addressing teen alcohol abuse and DUI
- There is an increasing number of prescriptions written as well as over-medication and unnecessary medical tests taken

Strategies for Improvement

- Integrate primary care and behavioral health
- Incorporate mental health services with treatment for disabilities
- Increase mental and behavioral health services for children and adults
- Promote mental health awareness and provide mental health outreach among culturally and linguistically diverse communities
- Promote and increase investment in prevention efforts

2. Education

Challenges

- High levels of stress among students caused by bullying, excessive standardized testing, pressure from teachers and parents, tough grading

Strategies for Improvement

- Increase suicide prevention services in schools
- Decrease stressful school environment for high school students – more effective regulations and consequences to prevent bullying, reduce excessive standardized testing, tough grading and undue pressure to succeed
- Provide more security in the community and schools to prevent violence, theft and drugs and lower gang involvement (e.g., more police personnel, more security cameras)
- Provide more school counselors
- Improve support for teens to improve their self-image

B. By the Numbers: Are We Making Progress?

Suicide

- While meeting both state and national targets, suicide-related deaths have increased by 8% from its 6.5 per 100,000 baseline in 2006-2008 to 7.0 in 2012-2014.



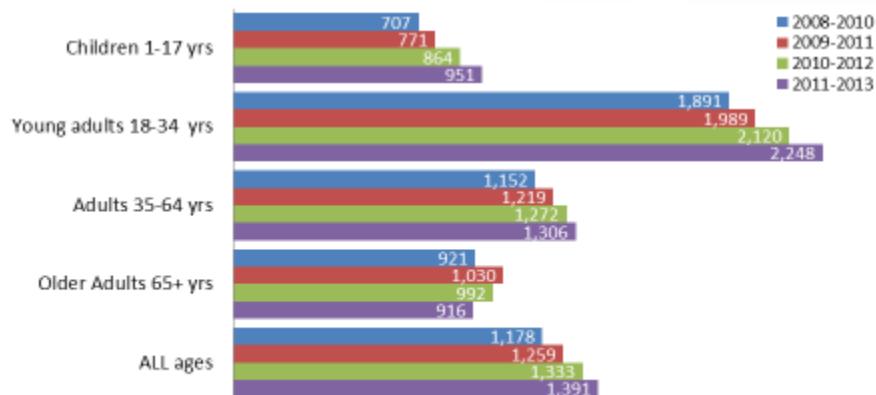
Major Depressive Episode

- Adults with at least one major depressive episode in the past year increased by 10% from 2006-2008 to 2010-2012.



Behavioral Health-Related ER Visit

- There was a 18% increase from 1,178 ER visits per 100,000 in 2008-2010 to 1,391 in 2011-2013; with children under 18 years having the highest increase of 34% within the same timeframe from 707 to 951



MET TARGET

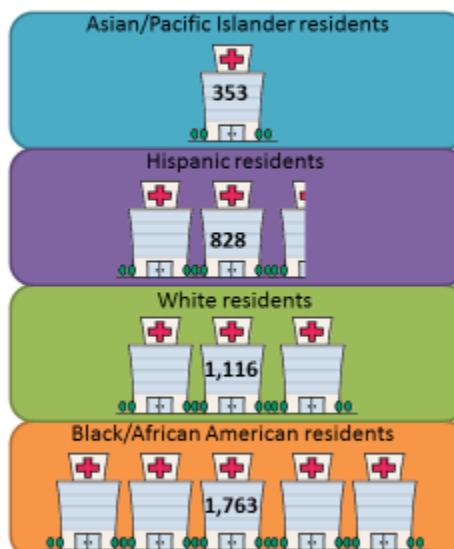


2014 MD SHIP

C. By the Numbers: Are We Achieving Equity?

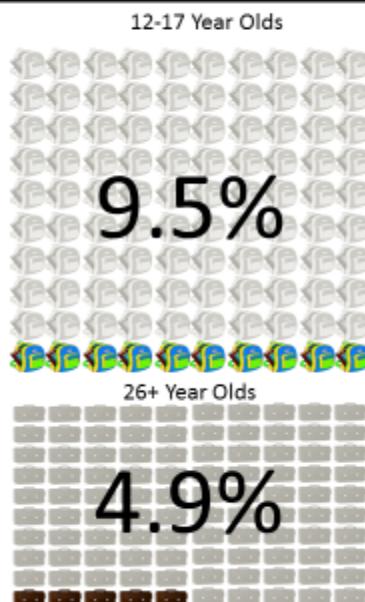
Behavioral Health-Related ER Visits

- Black residents are 5 times more likely than Asian/PI residents to have a behavioral health-(mental health- or substance abuse-) related ER visit;
- White residents are 3 times more likely than Asian/PI residents; and
- Hispanic residents are 2.3 times more likely than Asian/PI residents
- Black disparity gap narrowed slightly (by 8%) from 2008-10 and 2011-13.
- While having the lowest rate, Asian/PI BH ER visit rate worsened the most (by 22%) from 200.2 to 237.4 between 2008-10 and 2011-13.



Illicit Drug Use in the Past Month

- 12-17 year old children are twice as likely than adults 26+ to have used illicit drugs in the past month



D. Hospital Alignment

Activity	Target Populations					
	Children	Adults	Families	Seniors	Low-Income	Neighborhood
Treatment for Substance Abuse	<ul style="list-style-type: none"> Opiate dependence and abuse services for adolescents and adults; partners with local community organizations to deliver drug education for community members and medical professionals; refers hospital patients with substance abuse/chemical dependency to intervention resources and follow-up (AHC) Adolescent Outpatient Program: Open-ended, group-oriented after school treatment for adolescents ages 13 to 18 with emotional and/or behavioral problems; depression, substance abuse, truancy, defiance and legal problems are among the issues addressed (MMMC) Outpatient Addiction 	<ul style="list-style-type: none"> Opiate dependence and abuse services for adolescents and adults; partners with local community organizations to deliver drug education for community members and health professionals; refers hospital patients with substance abuse/chemical dependency to intervention resources and follow-up (AHC) Health Centers provide Screening, Brief Intervention and Referral to Treatment (SBIRT) (HCH) Dual Diagnosis Intensive Outpatient Program: Outpatient group program specifically designed for adults who have been diagnosed as having a psychiatric disorder and a substance dependence; meets three days a 		<ul style="list-style-type: none"> Wellness Support Group focused on Substance Abuse and Mental Health Maintenance at Victory Tower Senior Apartments (AHC) 	<ul style="list-style-type: none"> Wellness Support Group focused on Substance Abuse and Mental Health Maintenance at Victory Tower Senior Apartments (AHC) Health centers provide Screening, Brief Intervention and Referral to Treatment (SBIRT) (HCH) 	

Activity	Target Populations					
	Children	Adults	Families	Seniors	Low-Income	Neighborhood
	Treatment Program offers a broad range of addiction (i.e., alcohol and/or substance abuse) services for adolescents and adults, including: evaluation services and inpatient detoxification; dual diagnosis intensive outpatient program; structured outpatient programs; adolescent substance abuse education and outpatient treatment; additional meetings for parents of teens in trouble with alcohol or other drugs (SH)	week. (MMMC) <ul style="list-style-type: none"> • Outpatient Addiction Treatment Service (OATS): Intensive outpatient program offers treatment to those suffering from addiction; patients remain in their communities and are able to work and continue their usual activities; meets three evenings a week(MMMC) • Outpatient Addiction Treatment Program offers a broad range of addiction (i.e., alcohol and/or substance abuse) services for adolescents and adults, including: evaluation services and inpatient detoxification; dual diagnosis intensive outpatient program; structured outpatient programs; adolescent substance abuse education and outpatient treatment; additional meetings for parents of teens in trouble with alcohol or other drugs (SH) 				

Activity	Target Populations					
	Children	Adults	Families	Seniors	Low-Income	Neighborhood
Prevention of/Treatment for Mental Illness	<ul style="list-style-type: none"> Hospital patients connected with community resources and continuing care as appropriate such as with a Federally Qualified Health Clinic (FQHC) or primary care practice that integrates behavioral health and home-based care management (AHC) 24/7 Mental Health Help Line (MMMC) 	<ul style="list-style-type: none"> Acute inpatient services, partial hospitalization programs, and intensive outpatient programs for behavioral and mental health treatment (AHC-WAH and AHC – BH&WS) Health centers provide access to quality health care and referrals to behavioral and mental health services and social services; Linking Individuals to Community Services (LINCS) increases awareness of mental health problems and referrals to health centers and social services (HCH) 24/7 Mental Health Help Line, hosts postpartum support group (MMMC) Relapse Prevention Program: a step-down service that patients may attend after completing an intensive outpatient addiction program, such as OATS. The program provides additional support and education to help 	<ul style="list-style-type: none"> Crisis Evaluation Unit: The CEU is a unique emergency department program being offered by MedStar Montgomery in conjunction with its Addiction and Mental Health Center; it combines both medical and behavioral health expertise and experience, and provides services to patients experiencing an emotional/behavioral and drug/alcohol crisis; the CEU is a separate area in the ED designed with patient privacy and safety in mind; it is staffed by nurses with specialized training and experience in both behavioral health and emergency 	<ul style="list-style-type: none"> Wellness Support Group focused on Substance Abuse and Mental Health Maintenance at Victory Tower Senior Apartments (AHC) Senior Source (HCH) Mindfulness Meditation, Stress and Anger Management classes, Hope Initiative, Health Education Seminars, Support Groups (SH) 	<ul style="list-style-type: none"> Wellness Support Group focused on Substance Abuse and Mental Health Maintenance at Victory Tower Senior Apartments (AHC) Health centers provide access to quality health care and referrals to behavioral and mental health services and social services; Linking Individuals to Community Services (LINC) increases awareness of mental health problems and referrals to health centers and social services (HCH) Provides transportation to/from programs (MMMC) Mindfulness Meditation, Stress and Anger Management classes, Hope 	<ul style="list-style-type: none"> Health centers provide access to quality health care and referrals to behavioral and mental health services and social services; Linking Individuals to Community Services (LINCS) increases awareness of mental health problems and referrals to health centers and social services (HCH)

Activity	Target Populations					
	Children	Adults	Families	Seniors	Low-Income	Neighborhood
		<p>patients maintain abstinence; meets two evenings a week (MMMC)</p> <ul style="list-style-type: none"> • Mindfulness Meditation, Stress and Anger Management classes, Hope Initiative, Health Education Seminars, Support Groups (SH) 	nursing (MMMC) <ul style="list-style-type: none"> • Family Support Group: open to family and significant others of patients who are enrolled in the Day Treatment Program (SH) 		Initiative, Health Education Seminars, Support Groups (SH)	

Adventist HealthCare (AHC); Adventist HealthCare Behavioral Health & Wellness Services (AHC-BH&WS); Adventist HealthCare Washington Adventist Hospital (AHC-WAH); Holy Cross Health (HCH); MedStar Montgomery Medical Center (MMMC); Suburban Hospital (SH)

E. Community Resources

(Note: The acronyms following each entry below represent the agencies and organizations that provide the resource listed; a list of the agencies and organizations represented by the acronyms can be found at the end of the section).

1. State and Local Government

Mental Health and Substance Abuse

- Access to Behavioral Health Services provides information and referral, screenings, and assessments for uninsured and low-income consumers with mental health and/or substance abuse problems to connect them to community services; also short-term case management and psychiatric services to vulnerable clients (DHHS)
- Clinical Assessment and Transition Services (CATS) includes assessment and post-booking diversion services within 24 hours of booking to inmates with behavioral health issues upon entry into the Montgomery County Detention Center, and discharge planning for inmates who are being released from the Correctional Facility by assessing inmates' behavioral health needs and coordinating access to services in the community (DHHS)
- Adult Outpatient Behavioral Services provides comprehensive and quality outpatient and intensive outpatient services to adults who have co-occurring substance and mental health disorders; priority is given to serving vulnerable populations including intravenous drug users, women who are pregnant or have young children, and those who lack health insurance, are homeless, or medically compromised; many program participants are also involved with the criminal justice system or have chronic medical conditions such as diabetes or HIV/AIDS (DHHS)
- Adult Behavioral Health Program accepts referrals from Access to Behavioral Health Services and Avery Road Treatment Center; services include a comprehensive range of substance abuse and mental health services programs; includes treatment for adults with limited English proficiency and those with specialized cultural and language needs (DHHS)
- Outpatient Addiction and Mental Health Services for clients with co-occurring conditions (DHHS)
- Juvenile Justice Services integrates screening, assessment, case management, community services, and treatment with the juvenile justice legal process; also provides substance abuse prevention, including support and education to promote healthy behaviors and lifestyles (DHHS)
- Shelter Services provides emergency and transitional shelters to families and single adults experiencing homelessness; services include community outreach and engagement, comprehensive needs assessments, and case management services to link people experiencing homelessness to behavioral health and financial and legal programs that address housing barriers (DHHS)
- Permanent Supportive Housing Services provides permanent housing to single adults and families; single adult or head of household must have a documented disabling condition which could include mental health issues, substance dependence, or a co-occurring disorder (DHHS)

Mental Health

- Respite Care provides temporary, occasional care of frail seniors, adults and children with disabilities, and children with severe behaviors and/or medical issues to give relief to families and other primary caregivers (DHHS)
- Community Case Management Services provides intensive social work services to individuals with serious mental illness to ensure effective engagement in needed services and sufficient community supports (DHHS)
- Projects for Assistance in Transition from Homelessness (PATH) is a federal/state program that targets re-entry for mentally-ill individuals in the criminal justice system (DHHS)
- Child and Adolescent Behavioral Health Clinics provide outpatient assessment, psychiatric, and therapeutic treatment to children and adolescents with emotional and behavioral issues (DHHS)
- Home-Based Treatment Team provides specialized, evidence-based mobile treatment specifically for children and families involved with Child Welfare Services (DHHS)
- System of Care Development and Management Team collaborates with local and state partners to plan, develop, and manage publicly-funded mental health and care coordination services for children and adolescents (DHHS)
- 24-Hour Crisis Center provides telephone, walk-in, mobile crisis outreach, and crisis residential services to persons experiencing situational, emotional, or mental health crises (DHHS)
- Mental Health Services for Seniors & People with Disabilities provides outreach mental health services for seniors who cannot or will not access office-based services as well as persons experiencing caregiver stress; provides prevention and early Intervention services for seniors by providing drop-in groups at senior centers, psycho education, consultation to assisted living providers, Housing Opportunities Commission resident counselors and senior center directors; provides mental health training for providers of services for seniors; also provides mental health services to persons who are deaf or hearing impaired (DHHS)
- "Be the One that Makes a Difference" provides videos and photo novels, outreach and education through health fairs and cultural celebrations to Asian-Americans (AAHI)
- Interagency Commission on Homelessness provides crisis hotlines to people experiencing homelessness including 24-hr Adult Protective Services; 24-hr Abused Persons Program; 24-hr Child Abuse and Neglect; 24-hr and crisis outreach unit Crisis Center (2 lines); confidential Veterans Crisis & Suicide Line; 24-hr Victim Assistance/Sexual Assault (ICH)
- Montgomery County Mental Health Advisory Committee monitors, reviews, and evaluates the allocation and adequacy of publicly-funded mental health services within the County (DHHS)

Substance Abuse

- Urine Monitoring Program provides urine testing to detect drug use of clients referred by the courts or social service or mental health agencies and others required to submit to urine surveillance or who require or request urine screening and testing to support recovery from substance abuse (DHHS)
- Jail Addiction Services (JAS) is an intensive jail-based residential addiction treatment program for inmates who suffer from substance related disorders at the Montgomery County Correctional Facility (DHHS)
- Adult Drug Court Program provides outpatient, intensive outpatient, case management and follow-up (DHHS)

- Medication Assistance Treatment Program (Methadone Program) (DHHS)
- Alcohol and Other Drug Abuse Advisory Council identifies local alcohol and other drug abuse prevention program needs, and assists the Department of Health and Human Services in the development of public education programs and an alcohol and drug abuse plan (DHHS)

2. Early Learning Centers, Schools, Colleges and Universities

Mental Health and Substance Abuse

- Youth Mental Health First Aid is designed to teach teachers and school staff how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in a crisis (MCPS)
- Health education curricula for elementary, middle, and high school students includes education regarding the physical, psychological, and social consequences of drug abuse and addiction as well as mental and emotional health (e.g., analyzing influences, accessing information, interpersonal communication, decision making, goal setting, self-stress management, personal wellness, self-esteem, depression and suicide prevention and recognition, managing emotions, self-injury, community resources for mental illness and conflict resolution) (MCPS)

Mental Health

- The Lourie Center for Children's Social & Emotional Wellness specializes in the assessment, treatment and prevention of emotional, behavioral and developmental problems in infants and young children (AHC)(LC)
- Family Services' Linkages to Learning provides comprehensive school-based mental health services in six elementary and two middle schools in the County; services include individual, family and group therapy; psychiatric assessment and intervention; case management; and, prevention/early intervention services (FSI) (MHA) (MCPS) (DHHS)
- YMCA's Linkages to Learning program is a school-based/school-linked service delivery system that is designed to enable at-risk children and adolescents to reach optimal physical and mental health, achieve academic success, and become socially secure in their communities (YMCA) (MHA) (MCPS) (DHHS)
- Dare to be You is a family-focused, 10-week prevention program that is provided at three Montgomery County elementary schools to help families with preschoolers improve parent and child interactions (FSI)
- Prekindergarten/Head Start "Totline" is provided for Prekindergarten/Head Start families to call staff psychologists (MCPS)
- Second Step Program is a classroom-based social-skills program (that builds on cognitive behavioral intervention models) for children aged 4-14 years implemented by school counselors (MCPS)
- School Psychologists conduct psychological assessments to determine eligibility for Section 504, Special Education, Autism Waiver, and transition assessments to determine eligibility for adult services (MCPS)
- School Psychologists conduct suicide risk assessments and individual and small group counseling and related services, e.g. Strong Kids, Strong Teens, and mental health crisis response (MCPS)

- Sources of Strength is a suicide prevention project provided at the following schools: E. Brooke Lee MS, Gaithersburg MS, Churchill HS, Wootton HS, Bethesda Chevy Chase HS, Whitman HS, Springbrook HS, Walker Johnson HS (MCPS) (NAMI)
- School psychologists, in collaboration with the National Alliance for Mental Illness's Parent and Teachers as Allies, offer one-time presentation to all middle and high schools featuring a parent of a child and a young adult that has mental illness (MCPS) (NAMI)
- School principals, in collaboration with National Alliance for Mental Illness, provide a number of afterschool programs at Gaithersburg middle school and high schools, including: GEMS (girls who need adult attention), and Gentleman of Gaithersburg (MCPS) (NAMI)
- Behavior Specialists provides support to students and families with mental health issues (MCPS)
- Positive Behavioral Interventions and Supports (PBIS) Coaches coordinate a plan to create safer and more effective schools by building a better environment through positive disciplinary practices (MCPS)
- Social Workers implement the Head Start Family and Community Partnership Performance Standard to promote service integration; they support students with mental health needs enrolled in programs for students with emotional disabilities (MCPS)
- Pupil Personnel Workers collaborate with administrators, parents, counselors and teachers, and use knowledge of MCPS programs and community resources to determine interventions and placement for students (MCPS)
- Parent Educators plan and conduct parent group seminars in the Preschool Education Program (MCPS)
- Individualized Education Plan (IEP) Teams implement functional behavioral assessment and behavioral intervention plans (MCPS)
- School-Based Health and Wellness Centers provide somatic health, mental health and social services to students enrolled in the schools and their families; each site is staffed with a school nurse, a certified nursing assistant, a site coordinator, a nurse practitioner, a pediatrician, a case manager, and a licensed mental health counselor or therapist (DHHS) (MCPS) (PCC)
- School Psychologist assessment provides an Autism Waiver through Medical Assistance to allow eligible children with an autism spectrum disorder to receive additional waiver services to support them in their home and community (MCPS)

3. Health Care Systems, Insurers and Clinicians

Mental Health and Substance Abuse

- Insurers of non-grandfathered ACA plans provide coverage, at no cost to the enrollees, for alcohol misuse screening and counseling, depression screening for adolescents and adults, domestic violence screening and counseling for all women, behavioral assessments for children of all ages, autism screening for children at 18 and 24 months; and alcohol and drug use assessments for adolescents (ACA)

Mental Health

- Montgomery Cares patients access integrated behavioral health services at most participating clinics including those partnering with the Montgomery Cares Behavioral

Health Program, which embeds behavioral health care management at primary care clinics to identify, diagnose, and treat patients with depression, anxiety, and PTSD (PCC)

[Note: Hospital programs and services are provided in the Hospital Alignment Subsection D above]

4. Community, Non-profit, and Faith Based Organizations

Mental Health and Substance Abuse

- OnTrack Maryland is an early behavioral health intervention program for youth and young adults ages 15-30, who have experienced a first psychotic episode; offers intensive outpatient treatment with weekly sessions of wrap-around services that include medication management, recovery-oriented therapy, substance abuse treatment and education, and work readiness support; families are assisted with illness education and supportive counseling (FSI)
- Step Ahead Program Germantown clinic offers integrated behavioral health services in both Spanish and English that are designed for adults, youth, and families; also provides substance abuse treatment for adolescents and adults and offers specialized treatment for dual-diagnosed clients and specific services for veterans (FSI)
- CareLink Transitions partners with area hospitals in the Maryland metropolitan area; services are geared toward preventing unnecessary hospital readmissions for patients through case management and coordinated care; utilize a comprehensive case management software package that enables program staff to manage client services, needs, and other metrics in a comprehensive manner (FSI)
- Youth Service Centers (YSCs) located in Gaithersburg, Germantown, and Olney offer drug and alcohol awareness education; psychoeducational groups in area schools; youth and family counseling; crisis intervention, information, and referral; tutoring; and community outreach (FSI)
- Healthy Families Montgomery is a voluntary home visiting service for first time parents; participating families are screened for multiple stressors such as mental health or substance abuse concerns, limited self-sufficiency and the experience of abuse or neglect as a child; home-based services begin before the baby is born, and continue on a weekly basis for at least six months; families continue to receive services for up to five years, depending on the nature and severity of their issues; emphasizes health care, child development, parenting education and support, and family self-sufficiency; also offers bilingual group activities to reduce social isolation and enhance the knowledge and skills needed for healthy child development (FSI)

Mental Health

- Pathways to Services connects callers with community resources to assist children with emotional and/or behavioral needs (CC)
- Local Care Team is an interagency team that works to resolve problems of children and youth with complex needs which can only be resolved across agencies (CC)
- Collaboration Council provides wraparound, intensive intervention for youth who are severely emotionally disturbed and/or at risk for out-of-home placement (CC)

- Family Navigation is a peer assistance program in which selected experienced parents assist families to navigate available programs and effectively advocate for their child with intensive behavioral health needs (CC)
- Outpatient Community Mental Health Center is a comprehensive community mental health center that offers a full range of psychiatric assessment and treatment services including psychiatric evaluation and assessment; medication management; individual, group, and family therapy, and case management (FSI)
- Montgomery Station is a community, recovery-focused psychiatric rehabilitation program serving adults in the County with mental illness; services include a day program, residential rehabilitation, a mental health vocational program, and support for independent living; operates four HUD, Section 811 projects (FSI)
- TRACKS is a community, recovery-focused psychiatric rehabilitation program serving transitional age youth (18-24) in the County with mental illness; services include a day program, residential rehabilitation, a mental health vocational program, and support for independent living (FSI)
- "Health Home" consumers involved in Family Service's Psychiatric Rehabilitation Programs are offered care coordination and whole-person integrated behavioral and somatic wellness services (FSI)
- On Our Own of Montgomery County is a consumer-run nonprofit organization promoting mental health and wellness with an emphasis on recovery through peer to peer support (OOOMC)
- Voices Versus Violence works with youth dealing with behavioral issues at school and home, such as truancy, anger and bullying to encourage positive life direction; seeks to avert youth from coming into initial contact with the juvenile justice system and to reduce recidivism; engages with program participants and their families to address academic and mental health issues, as well as connect them to needed community resources through case management (MHA)
- Mental Health Association provides adult and youth talk lines that allow for texting, calling or chatting online with trained specialists (MHA)
- Mental Health Association offers public and private Mental Health First Aid trainings, a national evidence-based 8-hour training that teaches community members how to recognize the signs and symptoms of mental health issues in others and assist them in getting help (MHA)
- N*Common provides clinical mental health services to low-income and uninsured Spanish and French speaking immigrants who are newly arrived to the U.S. and dealing with trauma, loss, and trying to adults to life in the U.S. (MHA)
- National Alliance on Mental Illness provides self-help, support, education and advocacy for people with serious and persistent mental illnesses, their families, friends, and caregivers (NAMI)
- Vesta is an outpatient mental health clinic service provider serving adults diagnosed with severe mental illness; serves children and adolescents as well as veterans; services include individual, family, couples and group therapy, psychiatric assessment and medication management, psycho-education programs, and TelePsychiatry services (Vesta)
- Cornerstone Montgomery is a non-profit organization offering community mental health and substance use disorder treatments and interventions; services include residential rehabilitation, psychiatric rehabilitation, day programs to develop independent living skills,

- vocational training, youth career and academic programs, mental health, psychiatric, and therapeutic treatment services, crisis services, and education programs (CM)
- Affiliated Sante provides crisis psychiatric care and management services, as well as mental health outreach and psychiatric recovery services; crisis response services include a hotline for those in crises, mental health first responders; also provide senior outreach services, such as mental health educational and counseling to seniors (AS)
 - Silver Spring Wellness and Recovery Center, located with Affiliated Sante's psychiatric services, offers peer support to Montgomery County clients who are receiving or have received mental health treatment (SSWRC)
 - Aspire Counseling offers mental health and wellness services for individuals, couples, and families, serving children (birth to 12 years), adolescents, adults, and seniors; services are age appropriate and culturally sensitive and offered by licensed social workers, counselors, psychologists, and psychiatrists who are diverse and speak various languages (AC)
 - Community Connections provides residential services for young adults (ages 18-22) who require a therapeutic environment to manage their psychiatric and emotional problems; also provides life skills training; vocational placement and follow up, medication monitoring, recreation and leisure activities, and educational placement and support (CommC)
 - Islamic Center of Maryland provides no-cost counseling services for men, women, and children for personal, familial, marital, and social challenges (ICM)
 - Montgomery County Federation of Families for Children's Mental Health provides individual and group family-to-family support, education, advocacy, information and referral, and leadership opportunities to parents and other primary caregivers who have children or youth with emotional, behavioral and mental health challenges; support is provided by Family Navigators and Family Support Partners who have extensive experience raising a child with an emotional, behavioral, or mental health challenge and who have first-hand knowledge of how services are provided in the community; also provides youth with emotional, behavioral and mental health challenges opportunities to engage in positive social interactions, give input on system of care development, participate in leadership activities, and create their own peer support network (FFCMH)

Substance Abuse

- Many Voices for Smart Choices works in a variety of ways to address underage drinking, through convening partners, providing mini-grants for prevention projects, and supporting training in healthy life skills for youth and parenting skills for parents (CC)
 - The Landing is an adolescent recovery club house located in Gaithersburg providing recovery support and related services to youth who are currently in substance abuse treatment or those recently discharged from treatment (FSI)
 - Family Services provides a four-hour seminar to educate youth on the harmful effects of drug and alcohol use; for first time offenders referred by the Screening and Assessment Services for Children and Adolescents (SASCA) or self-referred (FSI)
 - Keeping It SAFE is an Under 21 Alcohol Prevention Coalition, a multi-agency, public-private, countywide team that works to deter underage alcohol use, reduce youth access to alcohol and reduce the effects of under 21 alcohol use (KS)
-

Aspire Counseling (AC)
Community Connections (CommC)
Cornerstone Montgomery (CM)
Family Services, Inc. (FSI)
Interagency Commission on Homelessness (ICH)
Keeping It SAFE (KS)
Islamic Center of Maryland (ICM)
Lourie Center for Children's Social & Emotional Wellness (LC)
Mental Health Association of Montgomery County (MHA)
Montgomery County Collaboration Council for Children, Youth and Families (CC)

Montgomery County Department of Health and Human Services (DHHS)
Montgomery County Federation of Families for Children's Mental Health (FFCMH)
Montgomery County Public Schools (MCPS)
National Alliance on Mental Illness,
Montgomery County (NAMI)
On Our Own of Montgomery County (OOOMC)
Primary Care Coalition (PCC)
Silver Spring Wellness and Recovery Center (SSWRC)
Vesta (Vesta)

F. What Works

(Note: The acronyms following each entry below represent the source for the evidence-based strategy listed; a list of the acronyms and the source they represent can be found at the end of the section).

1. State and Local Government

Mental Health and Substance Abuse

- Establish a process and assign a high priority to the identification of specific measures that will alleviate the problem of insufficient and inadequate housing for persons with behavioral health problems (BHTF)
- Identify and implement specific measures that will reduce the barrier that transportation presents in access to care, housing, and supportive services for persons with behavioral health problems (BHTF)
- Create and implement a pilot for a formalized, coordinated system of care (based on a Hub and Pathways model) addressing behavioral health (substance abuse and mental health), medical and social needs of 300 adult consumers (18 years and older) who have a mental health diagnosis and one of the following – chronic homelessness as defined by the federal Department of Housing and Urban Development (HUD), minimal or no supports, multiple acute hospitalizations and/or emergency department (ED) visits; and/or multiple incarcerations (BHTF)

Mental Health

- Enhance data collection systems to better identify and address mental and emotional health needs (NPS)
- Include safe shared spaces for people to interact (e.g., parks, community centers) in community development plans, which can foster healthy relationships and positive mental health among community residents (NPS)
- Ensure that those in need, especially potentially vulnerable groups, are identified and referred to mental health services (NPS)

- Pilot and evaluate models of integrated mental and physical health in primary care, with particular attention to underserved populations and areas (NPS)

Substance Abuse

- Adopt dram shop liability as an effective means of preventing and reducing alcohol-related harms -- owner or server of a retail alcohol establishment where a customer recently consumed alcoholic beverages to be held legally responsible for the harms inflicted by that customer (CG)
- Increase the unit price of alcohol by raising taxes to reduce excessive alcohol consumption and related harms (CG)
- Maintain existing limits on the days of sale on which alcoholic beverages are sold to prevent excessive alcohol consumption and related harms (CG)
- Maintain limits on hours of alcohol sale in on-premises settings to reduce excessive alcohol consumption and related harms (CG)
- Use regulatory authority (e.g., through licensing and zoning) to limit alcohol outlet density for the purpose of discouraging excessive alcohol consumption and related harms (CG)
- Enhanced enforcement of laws prohibiting sale of alcohol to minors to limit underage alcohol purchases (CG)
- Maintain and enforce the age 21 minimum legal drinking age (e.g., increasing the frequency of retailer compliance checks) (NPS)
- Require installation of ignition interlocks in the vehicles of those convicted of alcohol impaired driving (NPS)
- Implement per se drug impairment laws (presence of any illegal drug in one's system), train law enforcement personnel to identify drugged drivers, and develop standard screening methodologies to detect the presence of drugs (NPS)
- Implement strategies to prevent transmission of HIV, hepatitis and other infectious diseases associated with drug use (NPS)

2. Early Learning Centers, Schools, Colleges and Universities

Mental Health

- Ensure students have access to comprehensive health services, including mental health and counseling services (NPS)
- Provide universal, school-based programs to reduce violence that teach all students about violence prevention (e.g., emotional self-awareness, emotional control, self-esteem, positive social skills, social problem solving, conflict resolution, or team work) (CG)

Substance Abuse

- Adopt policies and programs to decrease the use of alcohol or other drugs on campuses (NPS)
- Implement programs for reducing drug abuse and excessive alcohol use (e.g., student assistance programs, parent networking, or peer-to-peer support groups) (NPS)
- Educate youth and adults about the risks of drug abuse and excessive drinking (NPS)

3. Health Care Systems, Insurers and Clinicians

Mental Health and Substance Abuse

- Develop integrated care programs to address mental health, substance abuse, and other needs within primary care settings (NPS)

Mental Health

- Provide individual cognitive-behavioral therapy (CBT) and group CBT for symptomatic youth who have been exposed to traumatic events (CG)
- Provide therapeutic foster care to reduce violence for adolescents ages 12-18 with a history of chronic delinquency (CG)
- Practice collaborative care for the management of depressive disorders to improve depression symptoms, adherence to treatment, response to treatment, and remission and recovery from depression (CG)
- Pass and implement mental health benefits legislation, particularly comprehensive parity legislation, to improve financial protection and increase appropriate utilization of mental health services for people with mental health conditions (mental health benefits legislation is associated with increased access to care, increased diagnosis of mental health conditions, reduced prevalence of poor mental health and reduced suicide rates) (CG)
- Offer home-based depression care management for older adults with depression to improve short-term depression outcomes (CG)
- Provide clinic-based depression care management in primary care clinics for older adults with major depression or chronic low levels of depression (CG)
- Screen adults aged 18 years or older for alcohol misuse and brief behavioral counseling interventions for persons engaged in risky or hazardous drinking (CPS)
- Screen adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up (CPS)
- Screen adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up (CPS)
- Educate parents on normal child development and conduct early childhood interventions to enhance mental and emotional well-being and provide support (e.g., home visits for pregnant women and new parents) (NPS)
- Enhance communication and data sharing (with patient consent) with social services networks to identify and treat those in need of mental health services (NPS)
- Provide individual cognitive-behavioral therapy (CBT) and group CBT for symptomatic youth who have been exposed to traumatic events to reduce psychological harm (CG)

Substance Abuse

- Electronic screening and brief intervention (e-SBI) to reduce excessive alcohol consumption uses electronic devices (e.g., computers, telephones, or mobile devices) to facilitate the delivery of key elements of traditional SBI - screening individuals for excessive drinking, and delivering a brief intervention, which provides personalized feedback about the risks and consequences of excessive drinking (CG)
- Identify and screen patients for excessive drinking using Screening, Brief Intervention and Referral to Treatment (SBIRT), implement provider reminder systems for SBIRT (e.g.,

electronic medical record clinical reminders) and evaluate the effectiveness of alternative methods for providing SBIRT (e.g., by phone or via the internet) (NPS)

4. Businesses and Employers

Mental Health

-
- Implement organizational changes to reduce employee stress (e.g., develop clearly defined roles and responsibilities), and provide reasonable accommodations (e.g., flexible work schedules, assistive technology, adapted work stations) (NPS)
 - Ensure that mental health services are included as a benefit on health plans and encourage employees to use these services as needed (NPS)
 - Provide education, outreach, and training to address mental health parity in employment-based health insurance coverage and group health plans (NPS)

Substance Abuse

-
- Implement policies that facilitate the provision of Screening, Brief Intervention and Referral to Treatment (SBIRT) or offer alcohol and substance abuse counseling through employee assistance programs (NPS)
 - Include substance use disorder benefits in health coverage and encourage employees to use these services as needed (NPS)
 - Implement training programs for owners, managers, and staff that build knowledge and skills related to responsible beverage service (NPS)

5. Community, Non-profit, and Faith Based Organizations

Mental Health and Substance Abuse

-
- Create an accurate, relevant, and updated inventory of behavioral health services in the County through *infoMONTGOMERY*, enhance *infoMONTGOMERY* to improve usability and accessibility to vulnerable populations, and inform consumers and professionals about *infoMONTGOMERY* using an outreach campaign (BHTF)

Mental Health

-
- Provide space and organized activities (e.g., opportunities for volunteering) that encourage social participation and inclusion for all people, including older people and persons with disabilities (NPS)
 - Promote safer and more connected communities that prevent injury and violence (e.g., by designing safer environments, fostering economic growth) (NPS)
 - Implement programs that assist juveniles and adults who are re-entering their communities following incarceration that support their returning to school, securing employment, and leading healthy lifestyles (NPS)
 - Support child and youth development programs (e.g., peer mentoring programs, volunteering programs) and promote inclusion of youth with mental, emotional, and behavioral problems (NPS)

- Train key community members (e.g., adults who work with the older adults, youth, and armed services personnel) to identify the signs of depression and suicide and refer people to resources (NPS)
- Expand access to mental health services (e.g., patient navigation, support groups) and enhance linkages between mental health, substance abuse, disability, and other social services (NPS)
- Provide early childhood home visitation programs (by nurses, social workers, paraprofessionals, community peers) to reduce child maltreatment among high-risk families (CG)

Substance Abuse

- Support implementation and enforcement of alcohol and drug control policies (NPS)
- Educate youth and adults about the risks of drug abuse (including prescription misuse) and excessive drinking (NPS)
- Work with media outlets and retailers to reduce alcohol marketing to youth (NPS)

Community Guide, Centers for Disease Control and Prevention (CG)

Guide to Clinical Preventive Services, U.S. Preventive Services Task Force (CPS)

National Prevention Strategy, Surgeon General, U.S. Department of Health and Human Services (NPS)

Healthy Montgomery Behavioral Health Task Force (BHTF)

Key Findings: Emerging Issue – Heroin and Other Opioids Misuse

Supplement to Behavioral Health



EMERGING ISSUE

Healthy Montgomery partners were surveyed and asked to identify emerging health issues for possible inclusion in the CHNA report – issues not included among the six Healthy Montgomery priority areas. Several emerging issues were reported: heroin and other opioid misuse, oral health, health literacy, and health care for the uninsured. In this section of the Report the focus is on Heroin and Other Opioid Misuse. Unlike the other emerging issues identified, the issue of heroin and other opioid misuse has more recently been identified as a major public health problem in the County and throughout the nation. Given the recent emergence of the issue, an expanded Overview is presented here to provide more background information for Healthy Montgomery partners as they consider Healthy Montgomery's potential role in addressing this issue in the upcoming priority-setting process.

Overview

Heroin and other opioid misuse is an emerging public health issue in Montgomery County but is also recognized and being urgently addressed at the federal level and by states and localities across the nation. Opioids include heroin as well as prescription medications used as pain relievers such as morphine, codeine, methadone, oxycodone, hydrocodone, fentanyl, hydromorphone, and buprenorphine. Prescription opioid drugs are highly addictive, providing a euphoric effect when used and then dysphoria when chronic use ceases.³⁷ Overdose from prescription opioid pain relievers is a driving factor in the alarming increase in drug overdose morbidity and mortality. However, a notable recent trend in Maryland and the County is the increase in heroin overdose as more individuals switch to heroin use because of its relatively low cost, after becoming addicted to prescription opioids.³⁸

Opioid overdose can occur when a person misunderstands the directions for use and accidentally takes an extra dose, the prescriber miscalculates the dose, the dispensing pharmacist makes an error, or a person deliberately misuses a prescription opioid or an illicit drug. More commonly, a person who takes opioid medications prescribed for someone else or who combines prescribed or illicit opioids with alcohol, other prescribed or over-the-counter medications that depress breathing, heart rate, and other functions of the central nervous system, is at risk for overdose.³⁹ The rise in prescription drug overdose has mirrored the increase in the number of prescriptions written for opioid medications since the early 1990s.⁴⁰

The complexity of the heroin and opioid misuse problem is recognized as is the need for a multi-stakeholder, multi-pronged solution. Findings of a Community Needs Assessment conducted for the Montgomery County Opioid Misuse Prevention Program in 2015 describes the many facets of the problem in the County including: a lack of pharmacists' and physicians' knowledge about opioid misuse and its effects, insufficient participation by pharmacists and physicians in the state's Prescription Drug Monitoring Program (PDMP); easy social availability of drugs (from friends and family); lack of knowledge by parents and community members on the importance of safe storage and disposal methods; lack of law enforcement resources resulting in low opioid related arrests and few adjudication outcomes; low perceived risk and apathy about law enforcement consequences; community norms that serve to perpetuate the problem; community and family denial of the problem; a lack of awareness of the physical, mental and legal risks associated with opioid misuse; poor communication between healthcare providers and their patients about opioid use and risks; and a lack of awareness and education about opioid addiction and its link to heroin use. The Needs Assessment also explains that the efforts of the County's Opioid Misuse Prevention Program (OMPP) initiative will reach County-wide but

³⁷ A.Kolodny et al. The prescription opioid and heroin crisis: A public health approach to an epidemic of addiction. *Annu. Rev. Public Health* 2015, 36:559-574. Accessed at: <http://www.annualreviews.org/doi/pdf/10.1146/annurev-publhealth-031914-122957>

³⁸ Maryland Opioid Overdose Prevention Plan. January 2013. Accessed at: http://bha.dhmh.maryland.gov/OVERDOSE_PREVENTION/Documents/MarylandOpioidOverdosePreventionPlan2013.pdf; CDC Grand Rounds: Prescription Drug Overdoses – a U.S. Epidemic; *MMWR*, January 13, 2012, 61(01):10-13. Accessed at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6101a3.htm>

³⁹ SAMHSA Opioid Overdose Prevention Toolkit. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2016. Accessed at: <http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2016/SMA16-4742>

⁴⁰ Prescription Drug Abuse. National Institute on Drug Abuse. Accessed at: <https://www.drugabuse.gov/publications/research-reports/prescription-drugs/director>

that there are areas it will also specifically target, especially Up County, including Damascus, Gaithersburg, Germantown, Montgomery Village, and Clarksburg. These are areas of higher prevalence of overdose with the capacity to facilitate and effectively implement the OMPP.⁴¹

The Montgomery County Overdose Prevention Plan was developed in 2013 and is framed in terms of primary, secondary and tertiary prevention to address the many aspects of the problem. The Plan focuses on three primary prevention areas: raising awareness of the risk among providers and the community; promoting safe practices in the home and in primary care settings; and reducing exposure and associated risks in the home and community. The Plan focuses on two areas for secondary prevention: screening procedures (specifically promoting Screening, Brief Intervention and Referral to Treatment (SBIRT) in primary care and case management clinics and providing more outreach to seniors taking multiple medications), and policy changes focusing on Good Samaritan Laws, Marchman Act⁴² and the PDMP. Tertiary prevention strategies in the Plan focus on preventing overdose by addressing the underlying risk factors for death and promoting recovery and resiliency. Tertiary prevention strategies include assisting with the dissemination of educational materials addressing naloxone pharmacotherapy barriers, training and emergency response techniques; educating and certifying those who are able to administer naloxone and targeted education of first responders in opioid overdoses and emergency response actions. More long-term tertiary interventions' focus includes expanding the capacity of the existing treatment options, identifying gaps in treatment and meeting the increased demand as a result of health care reform. The Plan concludes that the success of the Plan will depend on the formation of a functioning coalition "with strong ties to the community and support from each of the key sectors of the community."⁴³

On the state level, the Heroin and Opioid Emergency Task Force (an eleven-member committee with expertise in addiction treatment, law enforcement, education, and prevention, chaired by Lieutenant Governor Boyd Rutherford) issued recommendations in a final report published in December 2015. In summary, The Task Force recommends: expanding access to treatment, enhancing quality of care, boosting overdose prevention efforts, escalating law enforcement options, reentry and alternatives to incarceration, promoting educational tools to youth, parents and school officials, and improving state support services.⁴⁴

⁴¹ Opioid Misuse Prevention Program Community Needs Assessment, Dec. 21, 2015

⁴² Marchman Act provides a legal means for involuntary commitment when addiction constitutes a danger to self (as defined in the Montgomery County Overdose Prevention Plan).

⁴³ Montgomery County Overdose Prevention Plan. 2013. Accessed at:

http://www.montgomerycountymd.gov/council/Resources/Files/agenda/cm/2014/140327/20140327_PSHS1.pdf

⁴⁴ Office of the Lt. Governor. *Maryland Heroin and Opioid Emergency Task Force: Final Report*. December 2015. Accessed at: <https://governor.maryland.gov/ltgovernor/wp-content/uploads/sites/2/2015/12/Heroin-Opioid-Emergency-Task-Force-Final-Report.pdf>

What We Can Do

Leverage/Enhance Existing Efforts:

- **Educate youth and adults about the risks of prescription misuse and how to prevent and manage opioid overdose, and increase awareness on the proper storage and disposal of prescription medications (National Prevention Strategy) (The Prescription Opioid Epidemic: An Evidence-Based Approach)⁴⁵** based on the existing efforts of:
 - Montgomery County Collaboration Council for Children, Youth and Families
 - Many Voices for Smart Choices Alliance
 - YMCA's Youth and Family Services Program
 - Heroin Action Coalition of Maryland
 - Montgomery County Prevention Planning Workgroup Committee
 - Montgomery County Department of Health and Human Services
 - Montgomery County Public School System and
 - Montgomery County hospital systems
- **Expand access to drug take-back programs (The Prescription Opioid Epidemic: An Evidence-Based Approach) and increase awareness on the proper storage and disposal of prescription medications (National Prevention Strategy)** based on the existing efforts of:
 - Montgomery County Police Department and local law enforcement agencies
 - Montgomery County Prevention Planning Workgroup Committee and
 - Many Voices for Smart Choices Alliance
- **Educate prescribers about how to prevent, identify and treat opioid addiction (The Prescription Opioid Epidemic: An Evidence-Based Approach); encourage providers to learn how to prevent and manage opioid overdose (Opioid Overdose Prevention Toolkit); train prescribers on safe opioid prescription practices and institute accountability mechanisms to ensure compliance (NPS); and encourage prescribers to use the state Prescription Drug Monitoring Program (Opioid Overdose Prevention Toolkit)⁴⁶** based on the existing efforts of:
 - Montgomery County Prevention Planning Workgroup Committee
 - Montgomery County Department of Health and Human Services,
 - Maryland Department of Health and Mental Hygiene and
 - Montgomery County hospital systems

⁴⁵ Strategies from three sources are integrated here: educate youth and adults about the risks of drug abuse (including prescription misuse) and excessive drinking and increase awareness on the proper storage and disposal of prescription medications (National Prevention Strategy.; provide clear and consistent guidelines on safe storage of prescription drugs (The Prescription Opioid Epidemic: An Evidence-Based Approach); and encourage providers, persons at high risk, family members, and others to learn how to prevent and manage opioid overdose (Opioid Overdose Prevention Toolkit).

⁴⁶ Several strategies are integrated here: educate prescribers and pharmacists about how to prevent, identify and treat opioid addiction (The Prescription Opioid Epidemic: An Evidence-Based Approach); encourage providers, persons at high risk, family members, and others to learn how to prevent and manage opioid overdose (Opioid Overdose Prevention Toolkit); train prescribers on safe opioid prescription practices and institute accountability mechanisms to ensure compliance (e.g., the use of long-acting opioids for acute pain or in opioid-naïve patients could be minimized) (National Prevention Strategy); and encourage prescribers to use the state Prescription Drug Monitoring Program (Opioid Overdose Prevention Toolkit)

- **Encourage providers to periodically and regularly screen all patients for substance use and substance-related problems (not just those patients who fit the stereotypical picture of addiction) (*Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*) based on the existing efforts of:**
 - Montgomery County Prevention Planning Workgroup Committee
 - Montgomery County Department of Health and Human Services,
 - Montgomery County hospital systems and
 - Montgomery County Community Safety-Net Clinics
- **Educate pharmacists about how to prevent, identify and treat opioid addiction (*The Prescription Opioid Epidemic: An Evidence-Based Approach*) based on the existing efforts of:**
 - Montgomery County Prevention Planning Workgroup Committee
 - Montgomery County Department of Health and Human Services and
 - Pharmacist Education and Advocacy Council of Maryland
- **Encourage providers, persons at high risk, family members, and others to learn how to prevent and manage opioid overdose (*Opioid Overdose Prevention Toolkits*) and ensure ready access to naloxone (*The Prescription Opioid Epidemic: An Evidence-Based Approach*) based on the existing efforts of:**
 - Montgomery County Collaboration Council for Children, Youth and Families
 - Many Voices for Smart Choices Alliance
 - YMCA's Youth and Family Services Program
 - Heroin Action Coalition of Maryland
 - Montgomery County Prevention Planning Workgroup Committee
 - Montgomery County Department of Health and Human Services
 - Montgomery County Public School System
 - Montgomery County hospital systems
 - Maryland Overdose Response Program and
 - Maryland's Behavioral Health Administration
- **Ensure access to treatment for County residents who are misusing or addicted to opioids or who have other substance use disorders (*Opioid Overdose Prevention Toolkit*) based on the existing efforts of:**
 - Heroin Action Coalition of Maryland
 - Montgomery County Prevention Planning Workgroup Committee
 - Montgomery County Department of Health and Human Services and
 - Montgomery County hospital systems

Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration

National Prevention Strategy, Surgeon General, U.S. Department of Health and Human Services

Opioid Overdose Prevention Toolkit, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration

The Prescription Opioid Epidemic: An Evidence-Based Approach, Johns Hopkins Bloomberg School of Public Health

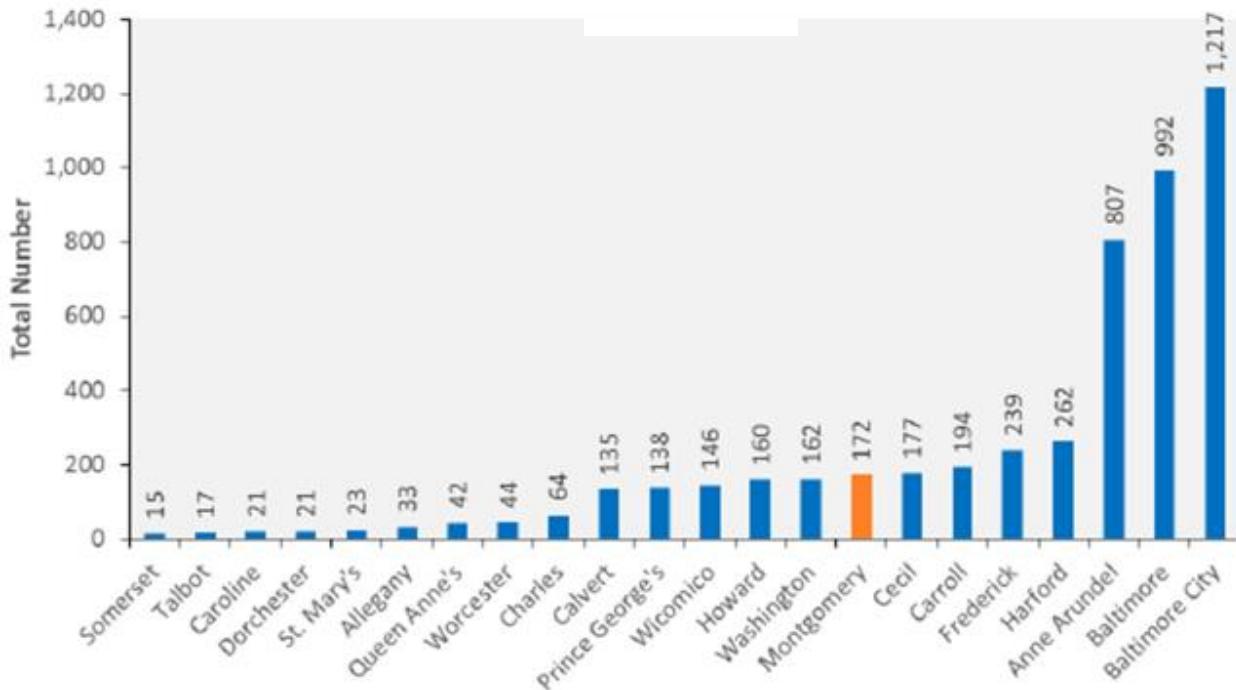
Information Gathered on Heroin and Other Opioids Misuse

A. From the Community Conversations

NOTE: Refer to Behavioral Health's "From the Community Conversations" listed above under the Healthy Montgomery Priority Area: Behavioral Health (page. 138).

B. By the Numbers: Are We Making Progress?

Montgomery County had 172 emergency room visits related to heroin poisoning from 2008-2014, the 8th highest volume among Maryland jurisdictions.⁴⁸



The number of visits related to heroin poisoning tripled from 2009 to 2014, from 13 visits in 2009 to 42 visits in 2014.⁴⁷

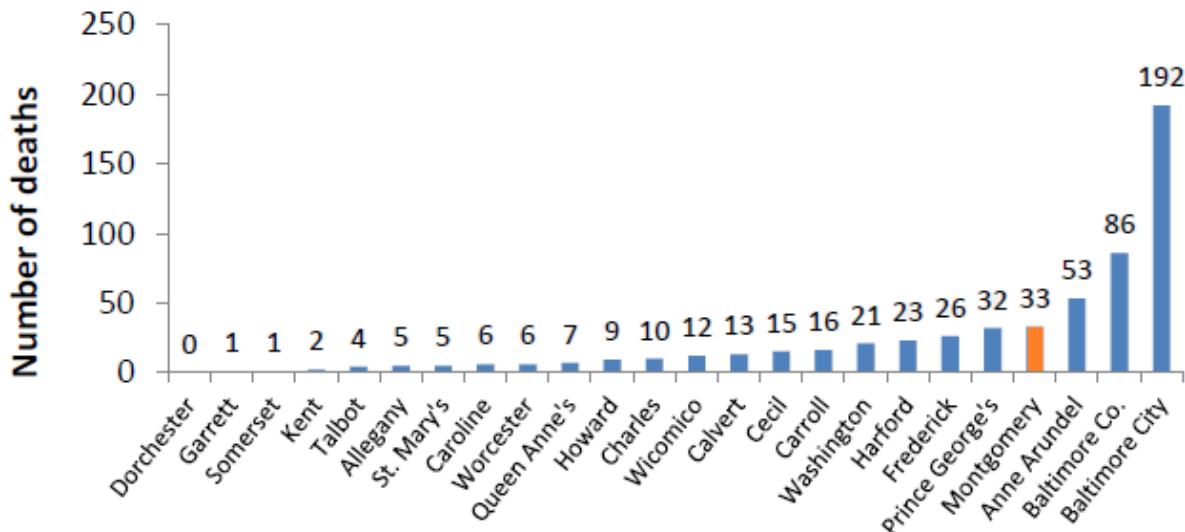
Heroin Poisoning-Related Emergency Room Visits, Montgomery County, 2009-2014



When visits were standardized into rates that take into account population size differences and differences within age distribution across each jurisdiction's populations, Montgomery County had the second-lowest heroin-related age-adjusted emergency room visit rate at 2.4 visits per 100,000 population (Prince George's County had the lowest at 2.0).⁴⁷

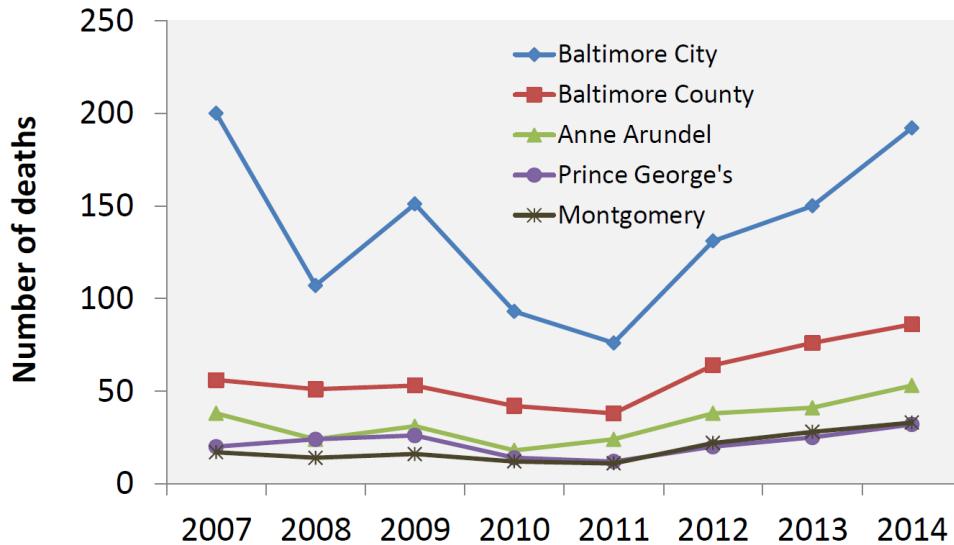
⁴⁷ Maryland Department of Health and Mental Hygiene. Data Report: Drug and Alcohol-related Emergency Department Visits in Maryland, 2008–2014. September 2015. Accessed on 4/27/2016 at http://bha.dhmh.maryland.gov/OVERDOSE_PREVENTION/Documents/Drug%20and%20Alcohol-related%20ED%20Visits_2008-2014.pdf

Number of Heroin-Related Deaths Occurring in Maryland by Place of Occurrence, 2014.



Montgomery County had the 4th highest number of heroin-related deaths among Maryland jurisdictions in 2014 (33 deaths occurred in Montgomery County).⁴⁸

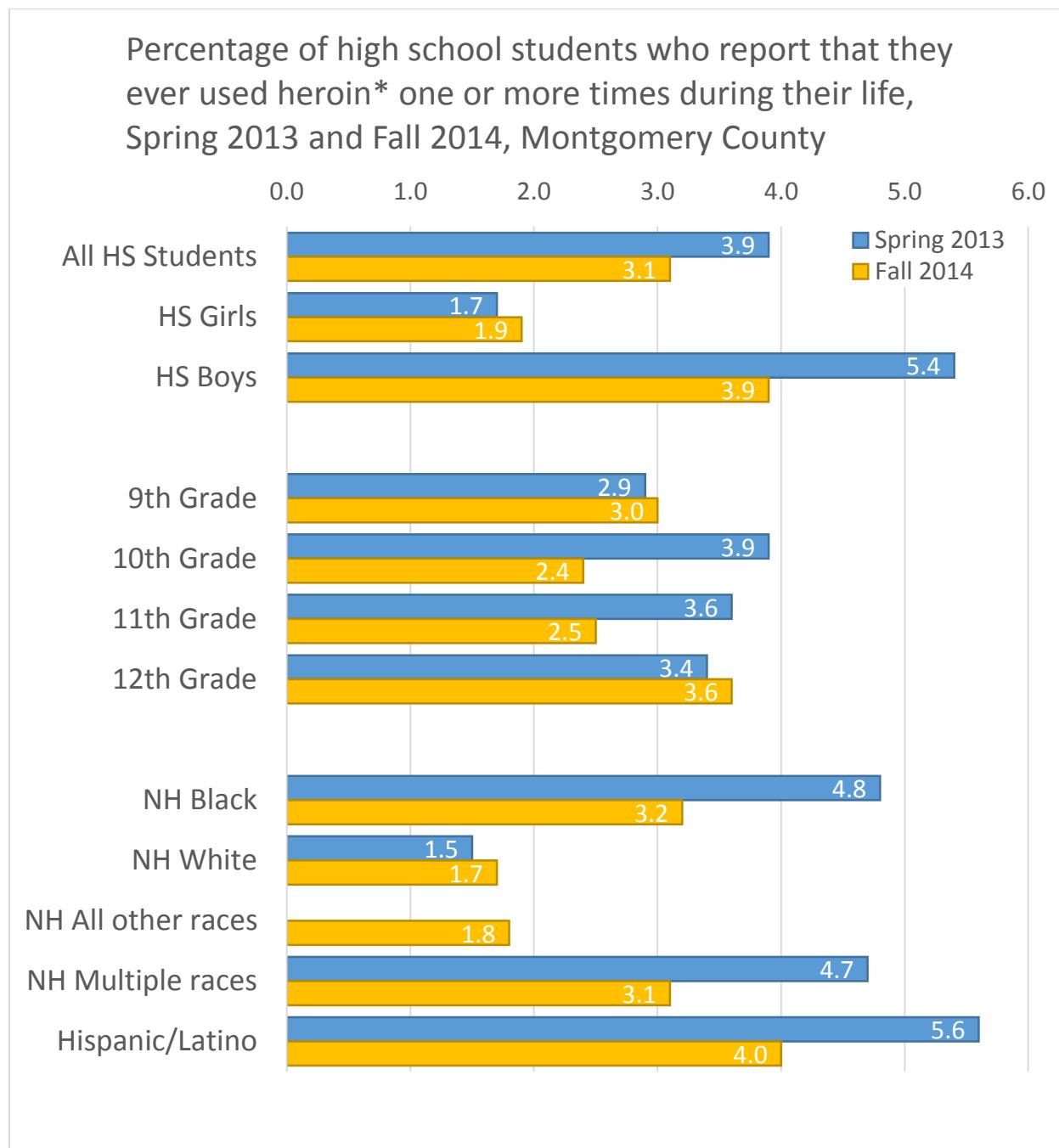
The number of heroin-related deaths in Montgomery County has tripled from 11 deaths in 2011 to 33 deaths in 2014.⁴⁸



⁴⁸ Maryland Department of Health and Mental Hygiene. Vital Statistics Administration. Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2014. May 2015. Accessed on 4/27/2016 at: http://bha.dhmh.maryland.gov/OVERDOSE_PREVENTION/Documents/2015.05.19%20-%20Annual%20OD%20Report%202014_merged%20file%20final.pdf.

C. By the Numbers: Are We Achieving Equity?

The percent of students that report ever using heroin is twice as high among high school boys 3.9% in fall 2014) compared to girls (1.9%); Hispanic/Latino high school students are twice as likely (4.0%) compared to non-Hispanic White high school students (1.7%).



D. Hospital Alignment

Hospital programs and services related to Heroin and Other Opioid Misuse are included in the hospital alignment table found in the Behavioral Health section of the Report above. (See page 130).

E. Community Resources

(Note: The acronyms following each entry below represent the agencies and organizations that provide the resource listed; a list of the agencies and organizations represented by the acronyms can be found at the end of the section).

1. State and Local Government

- Teen Court is a diversion program offered to first-time juvenile offenders who admit to their involvement in the offense and agree to have their case heard before a peer jury of student volunteers in a court setting (MCSA)
- Montgomery County detectives from the Drug Enforcement and Homicide Initiative (District 5) work to identify the source of supply and other associated crimes related to heroin overdose; officers (District 4) participate in opioid misuse related initiatives (MCPD)
- Prescription Drug Take-Back Days held in coordination with local law enforcement agencies to provide a safe, free and anonymous opportunity to dispose of unused, unwanted or expired prescription drugs (MCPD)
- Medication Assisted Treatment-Clinical/Vocational Services (MAT) are provided to adult residents of the County who are diagnosed with substance use disorders; individuals served in the MAT program are opiate dependent, uninsured, and have not been able to succeed in other venues of treatment (DHHS)
- Montgomery County Alcohol and Other Drug Abuse Advisory Council identifies local alcohol and other drug abuse prevention program needs, and assists DHHS in the development of public education programs and an alcohol and drug abuse plan (AODAAC)
- Montgomery County Overdose Fatality Review Team is a multi-disciplinary, multi-agency team that conducts confidential case reviews of overdose deaths in the County with the goal of preventing future deaths (DHHS)
- Montgomery County's Overdose Prevention Plan provides a set of planned and proposed prevention activities that address the County's opioid overdose problem at the primary, secondary, and tertiary levels of prevention (DHHS) Maryland state law expands access to naxolone by authorizing prescribers of naxolone to prescribe the drug to any patient who is believed to be at risk of experiencing an opioid overdose or in a position to assist someone at risk of overdose and by making prescribers of naloxone immune from civil liability (MSG)
- Maryland Good Samaritan law expands the charges from which people assisting in an emergency overdose situation are immune (MSG)
- Maryland's Opioid Overdose Prevention Plan encompasses efforts to reduce unintentional, life-threatening poisonings related to the ingestion of illicit and prescribed opioid drugs, alone or in combination with other drugs (DHMH)
- Maryland's Prescription Drug Monitoring Program (PDMP) collects and securely stores information on drugs that contain controlled substances and are dispensed to patients in

- Maryland; makes prescription data available at no-cost to physicians, nurse practitioners, pharmacists and others that provide pharmaceutical care to their patients to improve providers' ability to manage the benefits and risks of controlled substance medications and identify potentially harmful drug interactions; assists agencies with the investigation of illegal or inappropriate prescribing, dispensing or use of prescription drugs; and supports research and educational initiatives designed to broaden public understanding of prescription drug abuse and develop more effective approaches to addressing it (DHMH)
- Maryland's Overdose Response Program (ORP) trains and certifies qualified individuals (e.g. family members, friends and associates of opioid users, treatment program and transitional housing staff, and law enforcement officers) to administer naloxone (a life-saving medication) to a person dying from an opioid overdose when emergency medical services are not immediately available; local health departments, community organizations, public safety organizations, substance use disorder treatment programs and other health care providers are eligible to apply for approval as authorized training entities under the ORP (DHMH)
 - Maryland's Inter-Agency Heroin and Opioid Coordinating Council includes multiple state agencies and provides the opportunity to share data for the purpose of supporting public health and public safety responses to the heroin and opioid crisis; also serves to develop recommendations for policy, regulations, and legislation (MSG)
 - Maryland's Heroin and Opioid Emergency Task Force, made up of law enforcement professionals, elected officials, and substance abuse experts, meets regularly and solicits input and guidance from a wide variety of sources throughout the state including educators, families of those suffering from addiction and other vested stakeholders (MSG)

2. Early Learning Centers, Schools, Colleges and Universities

- Montgomery County Public Schools Parent Academy organizes educational forums provided by Many Voices Smart Choices and MCPD at County schools (MCPA)
- Health education curricula for elementary, middle, and high school students includes education and skill-building to promote safe practices for using prescription medication as well as education regarding the physical, psychological, and social consequences of drug abuse and addiction (MCPS)

3. Health Care Systems, Insurers and Clinicians

- Insurers of non-grandfathered ACA plans provide coverage, at no cost to the enrollees, for drug use assessments for adolescents (ACA)
- Opiate dependence and abuse services for adolescents and adults; partners with local community organizations to deliver drug education for community members and medical professionals; refers hospital patients with substance abuse/chemical dependency to intervention resources and follow-up (AHC)
- Hospital patients receive transportation tokens and resources for child care services to increase accessibility of opiate dependence and abuse services (AHC)
- Health centers provide Screening, Brief Intervention and Referral to Treatment (SBIRT) (HCH)

4. Community, Non-profit, and Faith Based Organizations

- Pharmacist Education and Advocacy Council of Maryland offers monitoring, testing, education and public workshops to help the pharmacy community battle drug and alcohol addiction (PEAC)
- Collaboration Council is developing a community plan to educate about dangers of opioids and prescription medication use and abuse; provides leadership and support for the Many Voices for Smart Choices Alliance (CC)
- Many Voices for Smart Choices Alliance engages the community to create conditions that prevent and reduce the use of alcohol, tobacco, and other drugs by youth; facilitates the planning and implementation of the County's Opioid Misuse Prevention Program (OMPP); OMPP is currently implementing a community awareness campaign (e.g., transit shelter signage, websites) to educate the public about risks of opioid use and misuse, safe disposal of medications, and the connection between opioid medication misuse and heroin (MVSC)
- Youth and Family Services Program provides school and community-based prevention and early intervention services to at-risk and under-served children and families in the County; addresses social service needs, teaches fundamental life skills, and assists in making healthy choices (YMCA)
- Self-run SOBER living untraditional half-way house located Up County that promotes structure, responsibility, and self-management skills to increase self-confidence of recovering (mainly heroin) addicts (NR)
- Street Outreach Network prevents, neutralizes, and controls hostile behavior in high-risk youth and youth gangs through the development of positive relationships among youth, community stakeholders and outreach workers (SON)
- Oakdale Emory United Methodist Church provides ongoing support and resources to the parents and other family members of prescription opioid and heroin addicts (OEUMC)
- Heroin Action Coalition of Maryland seeks to ensure that appropriate opiate addiction treatment is available to all who request it or need it without regard to income or insurance plan (HAC)
- Montgomery Heroin Action Coalition meets and reports on increases of heroin and prescription drug abuse (MHAC)
- Recovery Oriented Systems of Care is a peer support community network initiative based on the themes of recovery, resilience, and self-determination (ROSC)
- Montgomery County Prevention Planning Workgroup Committee includes County government agencies, service providers and citizens that work to assist in implementing the County's Overdose Prevention Plan (PPWC)

Heroin Action Coalition of Maryland (HAC)
Many Voices for Smart Choices (MVSC)
Maryland Department of Health and Mental Hygiene (DHMH)
Maryland State Government (MSG)
Montgomery County Alcohol and Other Drug Abuse Advisory Council (AODAAC)
Montgomery County Collaboration Council for Children, Youth and Families (CC)

Montgomery County Department of Health and Human Services (DHHS)
Montgomery County Police Department (MCPD)
Montgomery County Public Schools (MCPS)
Montgomery County Public Schools Parent Academy (MCPA)
Montgomery County Prevention Planning Workgroup Committee (PPWC)

Montgomery County State Attorney (MCSA)
Montgomery Heroin Action Coalition (MHAC)
Nathan's Ridge (NR)
Oakdale Emory United Methodist Church
(OEUMC)

Pharmacist Education and Advocacy Council of
Maryland (PEAC)
Recovery Oriented Systems of Care (ROSC)
Street Outreach Network (SON)

F. What Works

(Note: The acronyms following each entry below represent the source for the evidence-based strategy listed; a list of the acronyms and the source they represent can be found at the end of the section).

1. State and Local Government

Safe Storage and Disposal

- Increase awareness on the proper storage and disposal of prescription medications (NPS)
- Expand access to drug take-back programs (JHSPH)

Training/Education

- Train prescribers on safe opioid prescription practices and institute accountability mechanisms to ensure compliance (e.g., the use of long-acting opioids for acute pain or in opioid-naïve patients could be minimized) (NPS)
- Educate prescribers and pharmacists about how to prevent, identify and treat opioid addiction (JHSPH)
- Train prescribers on safe opioid prescription practices and institute accountability mechanisms to ensure compliance (e.g., the use of long-acting opioids for acute pain or in opioid-naïve patients could be minimized) (NPS)
- Educate prescribers and pharmacists about how to prevent, identify and treat opioid addiction (JHSPH)
- Encourage providers, persons at high risk, family members, and others to learn how to prevent and manage opioid overdose (SAMHSA)
- Encourage the public to call 911 (SAMHSA)
- Encourage prescribers to use state Prescription Drug Monitoring Program (SAMHSA)
- Convene an inter-agency task force to ensure that current and future national public education campaigns about prescription opioids are informed by the available evidence and that best practices are shared (JHSPH)
- Develop and disseminate a public education campaign about the important role for treatment in addressing opioid addiction (JHSPH)

Monitoring/Surveillance

- Expand access to the state Prescription Drug Monitoring Program (JHSPH)
- Invest in surveillance to ascertain how patients in treatment for opioid abuse and those who have overdosed obtain their supply (JHSPH)
- Invest in surveillance of opioid addiction (JHSPH)

- Empower licensing boards for health professions and law enforcement to investigate high-risk prescribers and dispensers (JHSPH)
- Improve monitoring of pharmacies, prescribers and beneficiaries (JHSPH)
- Proactively use Prescription Drug Monitoring Program data for enforcement and education purposes (JHSPH)
- Incentivize electronic prescribing (JHSPH)
- Authorize third-party payers to access Prescription Drug Monitoring Program data with proper protections (JHSPH)
- Support restricted recipient (lock-in) programs (JHSPH)

Law Enforcement

- Implement per se drug impairment laws (presence of any illegal drug in one's system), train law enforcement personnel to identify drugged drivers, and develop standard screening methodologies to detect the presence of drugs (NPS)

Regulation

- Pass state legislation to require mandatory registration and querying of the Prescription Drug Monitoring Program (JHSPH)
- Repeal existing permissive and lax prescription laws and rules (JHSPH)

Treatment

- Work with insurers and other third-party payers to ensure coverage of naloxone products (JHSPH)
- Ensure access to treatment for individuals who are misusing or addicted to opioids or who have other substance use disorders (SAMHSA)
- Provide treatment funding for communities with high rates of opioid addiction and limited access to treatment (JHSPH)
- Ensure ready access to naloxone (SAMHSA)
- Partner with community-based overdose education and naloxone distribution programs to identify stable funding sources to ensure program sustainability (JHSPH)

Comprehensive Approaches

- Convene a stakeholder meeting with broad representation to create guidance that will help communities undertake comprehensive approaches that address the supply of, and demand for, prescription opioids in their locales; implement and evaluate demonstration projects that model these approaches (JHSPH)

2. Early Learning Centers, Schools, Colleges and Universities

- Increase awareness on the proper storage and disposal of prescription medications (NPS)
- Educate youth and adults about the risks of drug abuse (including prescription misuse) and excessive drinking (NPS)
- Provide physician training in pain management and opioid prescribing and establish a residency in pain medicine for medical school graduates (JHSPH)

- Convene a stakeholder meeting to assess the current product environment (e.g., products available, evidence to support effectiveness, regulatory issues) and identify high-priority future directions for engineering-related solutions (JHSPH)
- Sponsor design competitions to incentivize innovative packaging and dispensing solutions (JHSPH)

3. Health Care Systems, Insurers and Clinicians

Training/Education

- Train prescribers on safe opioid prescription practices and institute accountability mechanisms to ensure compliance (e.g., the use of long-acting opioids for acute pain or in opioid-naïve patients could be minimized) (NPS)
- Increase awareness on the proper storage and disposal of prescription medications (NPS)
- Encourage providers, persons at high risk, family members, and others to learn how to prevent and manage opioid overdose (SAMHSA)
- Educate prescribers and pharmacists about how to prevent, identify, and treat opioid addiction (JHSPH)
- Engage with the healthcare professional community to advance consensus guidelines on the co-prescription of naloxone with prescription opioids (JHSPH)
- Provide physician training in pain management (JHSPH)

Monitoring/Surveillance

- Identify, track, and prevent inappropriate patterns of prescribing and use of prescription drugs and integrate prescription drug monitoring into electronic health record systems (NPS) (JHSPH)
- Encourage prescribers to use state Prescription Drug Monitoring Program (SAMHSA)
- Incentivize electronic prescribing (JHSPH)
- Improve management and oversight of individuals who use controlled substances (JHSPH)
- Engage in consensus process to identify evidence-based criteria for using Pharmacy Benefit Managers (PBMs) and pharmacy claims data to identify people at high risk for abuse and in need of treatment (JHSPH)
- Proactively use Prescription Drug Monitoring Program data for enforcement and education purposes (JHSPH)

Treatment

- Ensure access to treatment for individuals who are misusing or addicted to opioids or who have other substance use disorders (SAMHSA)
- Ensure ready access to naloxone (SAMHSA)
- Expand access to buprenorphine treatment (JHSPH)
- Require oversight of pain treatment (JHSPH)
- Periodically and regularly screen all patients for substance use and substance-related problems (not just those patients who fit the stereotypical picture of addiction); especially helpful when the primary care physician or specialist is prescribing opioids for the treatment of pain; physicians may provide office-based treatment or refer to treatment in another setting (SMHSA Clinical Guidelines)

- Work with insurers and other third-party payers to ensure coverage of naloxone products (JHSPH)

4. Businesses and Employers

- Partner with product developers to design naloxone formulations that are easier to use by nonmedical personnel and less costly to deliver (JHSPH)
- Convene a stakeholder meeting to assess the current product environment (e.g., products available, evidence to support effectiveness, regulatory issues) and identify high-priority future directions for engineering-related solutions (JHSPH)
- Sponsor design competitions to incentivize innovative packaging and dispensing solutions (JHSPH)

5. Community, Non-profit, and Faith Based Organizations

- Educate youth and adults about the risks of drug abuse (including prescription misuse) and excessive drinking (NPS)
- Increase awareness on the proper storage and disposal of prescription medications (NPS) (JHSPH)
- Expand access to drug take-back programs (JHSPH)
- Encourage providers, persons at high risk, family members, and others to learn how to prevent and manage opioid overdose (SAMHSA)
- Ensure access to treatment for individuals who are misusing or addicted to opioids or who have other substance use disorders (SAMHSA)
- Ensure ready access to naloxone (SAMHSA)
- Encourage prescribers to use state Prescription Drug Monitoring Program (SAMHSA)

Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA Clinical Guidelines)

National Prevention Strategy, Surgeon General, U.S. Department of Health and Human Services (NPS)

SAMHSA Opioid Overdose Prevention Toolkit, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)

The Prescription Opioid Epidemic: An Evidence-Based Approach, Johns Hopkins Bloomberg School of Public Health (JHSPH)

Key Findings: Maternal and Infant Health

Overview

Health outcomes for mothers and babies are influenced by the preconception health of the mother and the quality of the prenatal and post-partum care she receives. Other factors, including race, ethnicity, age, and income can be associated with a higher risk of pregnancy complications. These factors can affect a woman's ability to avoid an unintended pregnancy, obtain quality medical care, and practice healthy behaviors. Improving a women's health before, during, and after pregnancy can enhance her pregnancy and delivery experiences and improve the health of her baby.

Interventions to improve maternal and infant health include increasing access to high quality, comprehensive preconception and prenatal care (especially for low-income and at-risk women) that includes: screening for infectious diseases and intimate partner violence; counseling patients about factors such as alcohol, tobacco and other drugs, poor nutrition, stress, and chronic diseases (e.g., hypertension, diabetes and obesity); providing teen parenting programs; providing coordinated vaccination programs to increase vaccination rates for infants and children; and access to high quality newborn care.⁴⁹

What We Can Do

Leverage/Enhance Existing Efforts:

- **Educate communities, clinicians, pregnant women, and families on how to prevent infant mortality (e.g., nutrition, stress reduction, SIDS risk reduction, infant safety, postpartum and newborn care) and advise patients about factors that affect birth outcomes, such as alcohol, tobacco and other drugs, poor nutrition, stress, lack of prenatal care, and chronic illness or other medical problems (National Prevention Strategy)⁵⁰ based on the existing efforts of:**
 - Montgomery County hospital systems
 - Maternity Partnership Program
 - Montgomery County Department of Health and Human Services (African American Health Program's S.M.I.L.E. (Start More Infants Living Equally Healthy) and Public Health Service's Community Health Services and School Health Services)
 - Montgomery Cares
 - Montgomery County Interagency Coalition on Adolescent Pregnancy Prevention

⁴⁹ Centers for Disease Control and Prevention. Accessed at:
<http://www.cdc.gov/reproductivehealth/maternalinfanthealth/index.html>;
<http://www.cdc.gov/chronicdisease/resources/publications/aag/maternal.htm>

⁵⁰ Two strategies recommended by the National Prevention Strategy are combined here: educate communities, clinicians, pregnant women, and families on how to prevent infant mortality (e.g., nutrition, stress reduction, postpartum and newborn care) and advise patients about factors that affect birth outcomes, such as alcohol, tobacco and other drugs, poor nutrition, stress, lack of prenatal care, and chronic illness or other medical problems.

- **Support pregnant women obtaining prenatal care in the first trimester (e.g., transportation services, patient navigators) to increase access to comprehensive preconception and prenatal care, especially for low-income and at-risk women (National Prevention Strategy)⁵¹** based on the existing efforts of:
 - Montgomery County hospital systems
 - Maternity Partnership Program
 - Montgomery County Minority Health Initiatives and Program
 - Montgomery County Department of Health and Human Services (African American Health Program's S.M.I.L.E. (Start More Infants Living Equally Healthy) and Public Health Service's Community Health Services and School Health Services)
 - Montgomery Cares
 - Montgomery County Fetal and Infant Mortality Review Board (FIMR) and Community Action Team (CAT)
 - Healthy Montgomery Eat Well Be Active Partnership
- **Provide interventions during pregnancy and after birth to promote and support breastfeeding (Guide to Clinical Preventive Services) and to implement culturally and linguistically appropriate social supports for breastfeeding, such as marketing campaigns and breastfeeding peer support programs (National Prevention Strategy)** based on the existing efforts of:
 - Montgomery County hospital systems
 - Maternity Partnership Program
 - Montgomery County Department of Health and Human Services (African American Health Program's S.M.I.L.E. (Start More Infants Living Equally Healthy) and Public Health Service's Community Health Services and School Health Services)
 - Montgomery Cares
 - Community Clinic, Inc.
 - Mary's Center
 - Montgomery County Minority Health Initiatives and Program
 - Healthy Montgomery Eat Well Be Active Partnership
- **Support teen parenting programs and assist parents in completing high school, which can promote health for teen parents and children and implement evidence-based practices to prevent teen pregnancy and HIV/STIs and ensure that resources are targeted to communities at highest risk (National Prevention Strategy)⁵²** based on the existing efforts of:
 - Montgomery County Department of Health and Human Services (including Community Health Services and School Health Services Intensive Teaming for pregnant teens)
 - Montgomery Cares
 - Montgomery County Interagency Coalition on Adolescent Pregnancy Prevention
 - Montgomery County Public Schools
 - Healthy Montgomery Eat Well Be Active Partnership

⁵¹ Two strategies recommended by the National Prevention Strategy are combined here: support pregnant women obtaining prenatal care in the first trimester (e.g., transportation services, patient navigators) and increase access to comprehensive preconception and prenatal care, especially for low-income and at-risk women.

⁵² Two strategies recommended by the National Prevention Strategy are combined here: support teen parenting programs and assist parents in completing high school, which can promote health for teen parents and children and implement evidence-based practices to prevent teen pregnancy and HIV/STIs and ensure that resources are targeted to communities at highest risk.

- **Encourage all clinicians to ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco (*Guide to Clinical Preventive Services*) based on the existing efforts of:**
 - Montgomery County hospital systems
 - Montgomery Cares
 - Maternity Partnership Program

Initiate Efforts:

- **Implement policies and procedures to ensure culturally competent and confidential reproductive and sexual health services and strengthen delivery of quality reproductive and sexual health services (e.g., family planning, HIV/STI testing) (*National Prevention Strategy*)⁵³**
Partners to include:
 - Montgomery County hospital systems,
 - Maternity Partnership Program
 - Montgomery County Minority Health Initiatives and Program
 - Community Clinic, Inc. – Teen and Youth Adult Health Connection (TAYA)
 - Mary's Center
 - Montgomery County Department of Health and Human Services
- **Provide community-wide education campaigns to promote the use of folic acid supplements among women of childbearing age to increase the number of these women who consume folic acid supplements (*Community Guide*)** Partners to include:
 - Montgomery County hospital systems
 - Maternity Partnership Program
 - Montgomery County Minority Health Initiatives and Program
 - Montgomery County Department of Health and Human Services
 - Community Clinic, Inc.
 - Mary's Center

Community Guide, Centers for Disease Control and Prevention

Guide to Clinical Preventive Services, U.S. Preventive Services Task Force

National Prevention Strategy, Surgeon General, U.S. Department of Health and Human Services

⁵³ Two strategies recommended by the National Prevention Strategy are combined here: implement policies and procedures to ensure culturally competent and confidential reproductive and sexual health services and strengthen delivery of quality reproductive and sexual health services (e.g., family planning, HIV/STI testing).

Information Gathered on Maternal and Infant Health

A. From the Community Conversations

1. Health and Health Care

Assets

- Increased accessibility to health insurance coverage through Affordable Care Act (ACA)
- Increased eligibility for Medicaid
- Care provided for the uninsured
- County community-based health clinics provide low-cost, quality health care
- Domestic violence services
- Top notch health care practitioners and facilities
- County efforts to provide health care services to diverse populations
- Community clinics and County hospitals
- Health events targeting specific communities and populations including local health screenings

Challenges

- High cost of health care
- High hospital fees
- High prescription drug costs
- Language and cultural barriers that keep people from seeking health care

Strategies for Improvement

- Increase access to health screenings
- Increase access to low-cost vaccines
- Include free dental care as part of a prenatal package of services for low-income pregnant mothers
- Increase use of mobile health care units
- Promote County services more effectively
- Provide more clinical services for the growing population
- Address language and cultural barriers to seeking health care
- Provide more low-cost specialty care, especially for residents on Medicaid
- Increase the number of providers who accept Medicaid, especially specialists
- Increase hospital outreach programs that are free or affordable to address diabetes and other health conditions
- Make the cost of prescription drugs more affordable
- Focus domestic violence programs on community-level interventions

2. Transportation

Assets

- Improved pedestrian safety
- Well-maintained bicycle paths
- Bike lanes
- Bike share program

Challenge

- Bicyclists are at risk for injury and would benefit from increased off-road bicycle trails

Strategies for Improvement

- Increase reliability and affordability of public transportation to increase access to services and programs
- Continue County efforts to address dangerous conditions for pedestrians (e.g., complicated intersections, driver texting and phone use, lots of traffic); increased signage, speed and red light cameras, crosswalks and lights for pedestrians are needed as is the enforcement of laws prohibiting drinking and phone use while driving
- Provide more off-road bicycle trails

3. Access to Healthy Food

Assets

- Healthier options and better food labeling in grocery stores and restaurants
- Farmer's markets
- Healthier options in vending machines
- Regulation prohibiting restaurants from using trans fats
- WIC/SNAP benefits, food banks, food stamps provided for residents in need

Challenges

- High cost of healthy food; unhealthy food is inexpensive
- Too few farmers' markets
- Too many fast food restaurants

Strategies for Improvement

- Increase food stamp allotment
- Provide greater access to affordable, healthy food including more community gardens and partnerships with local farms to provide affordable food
- Provide incentives to restaurants to offer healthy food and buy food from local farmers
- Regulate food prices

4. Parks and Recreation

Assets

- Parks, trails, recreation centers
- Availability of pools, tennis courts, soccer fields, golf courses, playgrounds
- School tracks open to the public
- Shopping malls open to the public for walking

Challenges

- Places to be active are not within walking distance
- Community centers close early

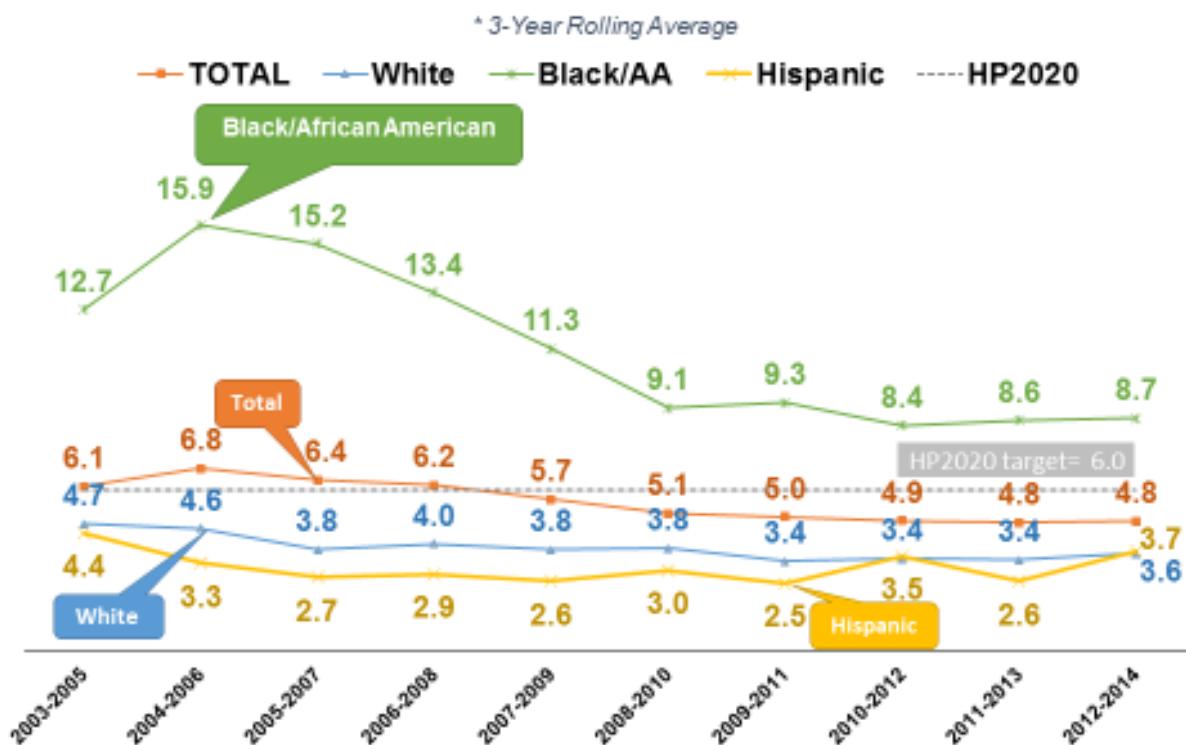
Strategies for Improvement

- Provide more places to be active that are in walking distance
- Increase promotion and coordination of parks and recreation services and programs to increase use
- Make it easier to access recreation services and programs, especially among populations of diverse cultures and languages

B. By the Numbers: Are We Making Progress?

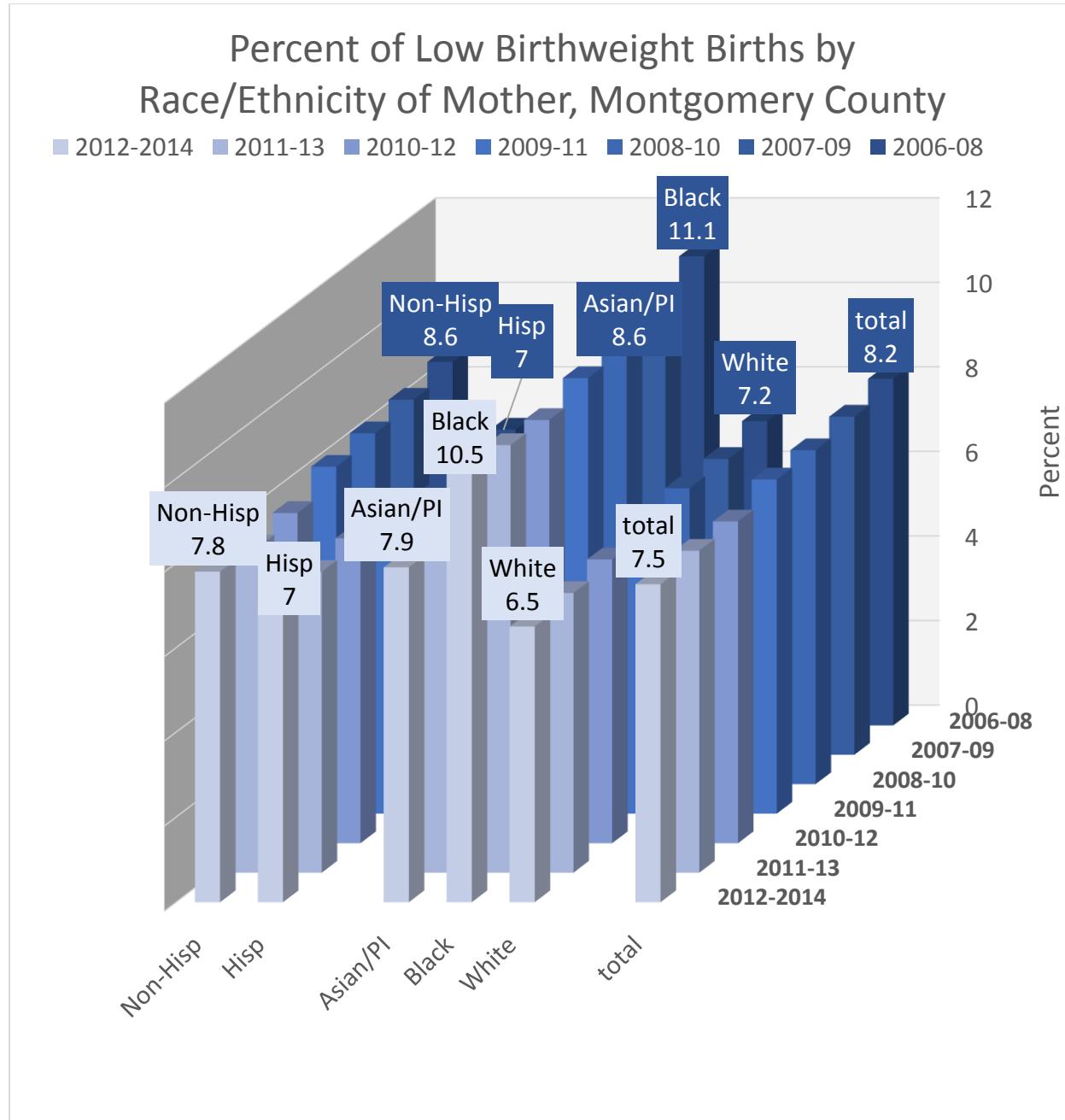
Infant mortality rates (IMR) remained the same between 2013 and 2014 at 4.8 deaths per 1,000 live births, meeting the Healthy People 2020 target of 6.0 and the MD SHIP2017 Goal of 6.3. Montgomery County ranked 7th among 24 Maryland jurisdictions in IMR, according to the County Health Rankings.

Infant Mortality Rates by Race and Ethnicity, Montgomery County 2003-2005 through 2012-2014*

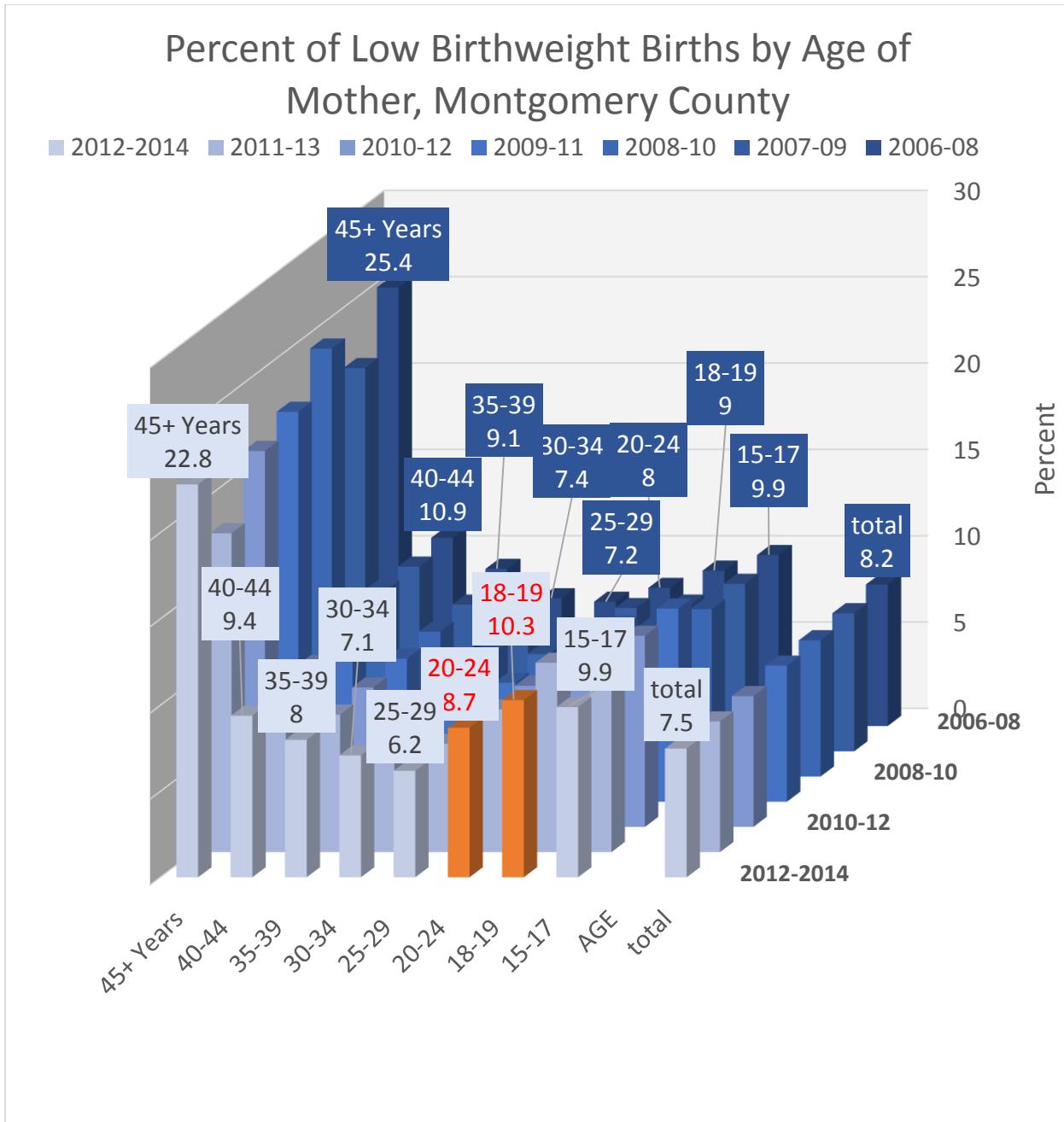


C. By the Numbers: Are We Achieving Equity?

Work remains in narrowing the gap in Black/African American infant mortality rates and those of white infants. Since 2006-2008, the disparity has narrowed for the Black/African American infant disparity ratio, a 47% narrowing from 4.7 in 2006-2008 to 2.4 in 2012-2014.

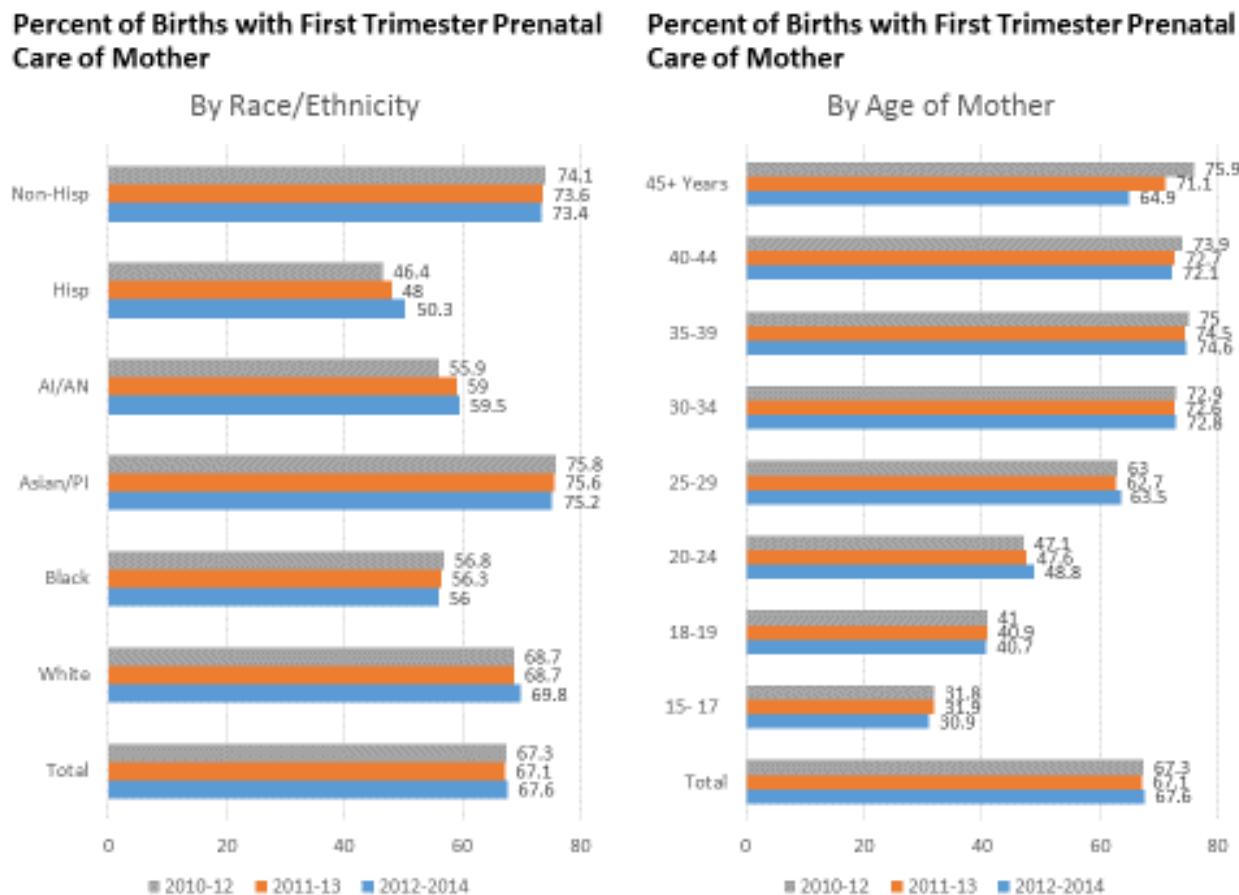


There have been improvements in low birthweight (LBW) birth disparities among White infants, Black infants, and Asian/Pacific islander infants compared to Hispanic low birthweight births.



LBW trends are decreasing among all maternal age groups with the exception of adolescent mothers 18-19 years and 20-24 years which have shown a 14% increase and 9% increase respectively from the 2006-2008 baseline year.

Early prenatal care has been improving among births to Hispanic mothers and white mothers. Early prenatal care is worsening among births to mothers 54+ years as well as adolescent births (15-19 years). While almost 75% of births to mothers 35-39 years have early prenatal care, only 31% of births to mothers 15-17 years have had timely early prenatal care.



D. Hospital Alignment

Activity	Target Population and Setting				
	Children	Adults	Seniors	Low-Income	Neighborhood
Education and Awareness	<ul style="list-style-type: none"> • Big Brother & Big Sister Class (AHC) • Baby Sitting Classes (AHC) • Girl Talk - girls 8-11 and their mothers explore puberty change, menstrual cycles, and opening up the lines of communications (HCH) • Safe Sitter – comprehensive babysitting course for 11- to 14-year-olds (HCH) • Sibling Class (Age 3-10) helps siblings take steps toward becoming big brothers and sisters (HCH) • Safe Sitter (SH) • Interactive safety 	<ul style="list-style-type: none"> • Support groups including Discovering Motherhood; Breastfeeding Education Support and Togetherness (B.E.S.T); Hecho de Pecho (Spanish language breastfeeding support group). (AHC) • Warm Line (free breastfeeding support via phone with a certified lactation consultant) (AHC) • Parent and family education classes including: Childbirth; Baby Care Basics; Breastfeeding; Fatherhood 101; and Infant CPR (AHC) • One-on-One Gestational Diabetes nutritional counseling with a certified diabetes educator (AHC) • Childbirth and parenting education classes, exercise classes and support groups: Teen Pregnancy Class, A Baby? Maybe?, Baby Care-Instructions, Becoming a Father, Birth by Cesarean, Breastfeeding Support Group, Breastfeeding: Beyond the Early Weeks, Child CPR and 	<ul style="list-style-type: none"> • Grandparent Class (AHC) • Survival Guide for 1st time Grandparent class (SH) 	<ul style="list-style-type: none"> • Perinatal Community Health Worker Outreach (HCH) • Scotland Health Community Partnership conducts free flu vaccinations, social support and health and wellness programs for vulnerable families and seniors (SH); • The Gabriel Project- hand-knitted items to baby's and their mothers provided by Hospital Auxiliary (SH); • Knots for Shots- free flu vaccinations for families in exchange for a hand-knitted scarf and hat (SH); • Adopt-A-Family-in partnership with Montgomery County Public Schools and A Wider Circle where household necessities and food items are donated to Montgomery County Residents (SH) 	<ul style="list-style-type: none"> • Perinatal Community Health Worker Outreach (HCH)

Activity	Target Population and Setting				
	Children	Adults	Seniors	Low-Income	Neighborhood
	<p>workshops in Hospital Pediatric Department for local boy and girl scout troops facilitated by Pediatric chairperson (SH)</p> <ul style="list-style-type: none"> • Maternal/Neonatal Classes and Support Groups (infant care, childbirth, breastfeeding support, post-partum support) (MMMC) • YMCA Parenting Classes (SH) 	<p>Safety (English and Spanish), Childbirth Preparation, Childbirth-Just the Facts, Comfort Measures for Labor, Fertility Care-Natural Family Planning, First Aid, Getting Started with Breastfeeding, Healthy Birth & Baby (Spanish), Infant CPR and Safety (Birth to Age 1), K.I.S.S.-Kids in Safety Seats, Moms on the Move, Mother-to-Mother Connection, Online Childbirth Education Class, Postnatal Yoga/Pilates for Moms & Babies, Postpartum Depression Support Group, Prenatal Exercise, Prenatal Yoga, Prenatal Café, Grandparents-to-be-Class (HCH)</p>			
Health Services		<ul style="list-style-type: none"> • Ob/Gyn Clinic, Maternity Partnership Program (AHC), (HCH) • Lactation Services Breastfeeding Telephone Consultations (HCH) 		<ul style="list-style-type: none"> • Ob/Gyn Clinic, Maternity Partnership Program (AHC), (HCH) • Breast pump rental for the uninsured (HCH) 	

Adventist HealthCare (AHC); Holy Cross Health (HCH); MedStar Montgomery Medical Center (MMMC); Suburban Hospital (SH)

E. Community Resources

(Note: The acronyms following each entry below represent the agencies and organizations that provide the resource listed; a list of the agencies and organizations represented by the acronyms can be found at the end of the section).

1. State and Local Government

- Maternity Partnership Program provides, via contract, comprehensive prenatal services for low-income uninsured pregnant women; services are offered at four local hospitals, including: Holy Cross Hospital, Holy Cross Germantown, Washington Adventist Hospital, and Shady Grove Medical Center and include: prenatal care clinic visits, routine laboratory tests, sonograms, and delivery of the baby; oral Health Services are offered by the County's Dental program to women during their pregnancy (DHHS) (AHC-WAH)(SGMC) (HCH)
- The Fetal and Infant Mortality Review (FIMR) Program's goal is to improve birth outcomes and enhance the health and well-being of women, infants and families in Montgomery County by strengthening community resources and service delivery systems; the FIMR Board's Community Action Team, an advisory and advocacy group, develops and implements an annual action plan based on the FIMR recommendations and monitors FIMR systems changes in the public and private sectors (DHHS)
- Community Health Services , in collaboration with County hospitals, provides perinatal education and case management services in two regional health centers to pregnant women, pregnant and parenting teens, children up to one year of age, and infants at risk using a family-centered approach; services include home visits, assistance with accessing medical services in the community, and family planning services; other services provided by the health centers include immunization clinics for children under age 19, STD services, pregnancy testing and lead poisoning prevention (DHHS)
- Infant at Risk Case Management Program accepts referrals to case manage mothers and infants, ages birth to one, with medical or social problems that could affect their health, development or well-being (DHHS)
- Dental Services/HIV Dental Program provides dental services to promote oral health in six dental clinics and offers services to income-eligible Montgomery County pregnant women (DHHS)
- Trauma Services provides integrated services including services to domestic violence victims; programming for domestic violence also includes information and referral, crisis intervention, safety planning, and placement in emergency shelter (DHHS)
- The S.M.I.L.E. (Start More Infants Living Equally Healthy) Program's goal is to reduce the number of premature babies and babies with low birth weight, born to African American or Black women in Montgomery County; services include: assessment of high risk pregnancies; parenting support; case management and home visiting for mothers and infants; education; support groups; breastfeeding support, counseling and referrals (AAHP)
- I am Black and I Breastfeed encourages mothers to breastfeed (AAHP)
- Health Promoters Program offers health education as well as navigation and referral services to health and human services for children and families (LHI)
- Asthma Management Program offers culturally and linguistically appropriate group interventions on asthma to parents and caregivers of children with asthma (LHI)

- WIC provides supplemental food to nursing, pregnant women, and children 5 years old and under at various County locations; also provides breastfeeding support (WIC)

2. Early Learning Centers, Schools, Colleges and Universities

- Teen Pregnancy Prevention Program's school nurses provide Montgomery County Public School (MCPS) students with education and referrals that promote healthy lifestyle choices; male and female students can meet with their school nurse for a one-on-one meeting and receive accurate information regarding their reproductive health. The school nurse can refer to community partners for more resources, as needed (DHHS) (MCPS)
- Teen Parent Support Program provides peer group education on raising children, healthy relationships, and prevention of repeat teenage pregnancy to Montgomery County Public School (MCPS) students who are pregnant or parenting; support groups are led by school nurses and assisted by MCPS staff and/or community partners and are available in all high schools, depending on need (DHHS) (MCPS)
- Children, Youth and Family Services provides evaluation, assessment, family support, and early intervention services to families with children from birth up to four or five years of age when there is a concern about development, or when a developmental delay is documented; services are delivered using a family-centered approach and are provided by staff employed by Montgomery County Public Schools, DHHS and private community service providers (DHHS) (MCPS)

3. Health Care Systems, Insurers and Clinicians

- Insurers of non-grandfathered ACA plans provide coverage, at no cost to the enrollees, for obesity screening and counseling for adults and diet counseling; screenings for pregnant women including: anemia screening, urinary tract or other infection screening, gestational diabetes screening, Hepatitis B screening, Rh incompatibility screening, tobacco use screening and counseling for tobacco users, syphilis screening and domestic and interpersonal violence screening and counseling; also provides breastfeeding comprehensive support and counseling as well as access to breastfeeding supplies for pregnant and nursing women, and folic acid supplements for women who may become pregnant; and for newborns: vaccinations, congenital hypothyroidism screenings, hearing screenings, gonorrhea preventive medication for the eyes, hemoglobinopathies or sickle cell screening, and phenylketonuria (PKU) screening for genetic disorder (ACA)
- Mary's Center provides health care, family literacy, and social services to individuals whose needs go unmet by the public and private systems (MC)
- The Montgomery Cares safety-net clinic program (public-private partnership administered by the Primary Care Coalition and composed of 12 independent clinics, four hospital systems, and the Montgomery County Department of Health and Human Services) provides primary and preventive health care services, specialty care, and limited behavioral health and dental services for low-income, uninsured adults who, because of immigration status, may not qualify for Medicaid (DHHS) (PCC)

[Note: Hospital programs and services are provided in the Hospital Alignment Subsection D above]

4. Community, Non-profit, and Faith Based Organizations

- Montgomery County Interagency Coalition on Adolescent Pregnancy is an alliance of public and private organizations and programs committed to collaborating and advocating for resources to positively impact adolescent pregnancy prevention and parenthood (ICAP)
- Baby Steps program provides universal, hospital-based health screenings to new mothers and newborns; nurses link new parents to community health services and provide appropriate follow up as needed through telephone consultations and/or home visits (FSI) (DHHS)

Affordable Care Act (ACA)
African American Health Program (AAHP)
Family Services, Inc. (FSI)
Holy Cross Health (HCH)
Latino Health Initiative (LHI)
Mary's Center (MC)
Montgomery County Department of Health and Human Services (DHHS)
Montgomery County Interagency Coalition on Adolescent Pregnancy (ICAP)
Montgomery County Public School System (MCPS)
Shady Grove Medical Center (SGMC)
Women, Infants and Children (WIC)
Washington Adventist Hospital (ACH-WAH)

F. What Works

(Note: The acronyms following each entry below represent the source for the evidence-based strategy listed; a list of the acronyms and the source they represent can be found at the end of the section).

1. State and Local Government

- Implement culturally and linguistically appropriate social supports for breastfeeding, such as marketing campaigns and breastfeeding peer support programs (NPS)
- Work with hospitals, early learning centers, health care providers, and community-based organizations to implement breastfeeding policies and programs (NPS)
- Increase access to comprehensive preconception and prenatal care, especially for low-income and at-risk women (NPS)
- Strengthen delivery of quality reproductive and sexual health services (e.g., family planning, HIV/STI testing) (NPS)
- Implement evidence-based practices to prevent teen pregnancy and HIV/STIs and ensure that resources are targeted to communities at highest risk (NPS)

2. Early Learning Centers, Schools, Colleges and Universities

- Provide vaccination programs in organized child care centers to increase vaccination rates (programs should be offered in a variety of school and organized care settings and include two or more of the following components: immunization education and promotion (could include reduced client out-of-pocket costs and enhanced access to vaccination services);

- assessment and tracking of vaccination status; referral of under-immunized school or child care center attendees to vaccination providers; providing vaccinations on site (CG)
- Support teen parenting programs and assist parents in completing high school, which can promote health for teen parents and children (NPS)

3. Health Care Systems, Insurers and Clinicians.>

- Implement policies and procedures to ensure culturally competent and confidential reproductive and sexual health services (NPS)
- Screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services (CPS)
- Recommend that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid (CPS)
- Provide vaccination for Hepatitis B virus and Human Papillomavirus, as recommended by the Advisory Committee on Immunization Practices (NPS)
- Advise patients about factors that affect birth outcomes, such as alcohol, tobacco and other drugs, poor nutrition, stress, lack of prenatal care, and chronic illness or other medical problems (NPS)
- Ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco (CPS)
- Provide interventions during pregnancy and after birth to promote and support breastfeeding (CPS)
- Implement culturally and linguistically appropriate social supports for breastfeeding, such as marketing campaigns and breastfeeding peer support programs (NPS)
- Screen pregnant women for:
 - Asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at their first prenatal visit, if later (CPS)
 - Gestational diabetes mellitus (GDM) in asymptomatic pregnant women after 24 weeks of gestation (CPS)
 - Hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit (CPS)
 - Syphilis infection (CPS)
 - HIV, including those who present in labor who are untested and whose HIV status is unknown (CPS)
- Provide coordinated vaccination interventions in WIC settings to increase vaccination coverage in children; interventions involve activities to assess the immunization status of infants and children participating in the program, and to promote and assist efforts to obtain recommended vaccinations (CG)

4. Businesses and Employers

- Fortify food products with folic acid to prevent birth defects (CG)
- Provide health coverage and employee assistance programs that include family planning and reproductive health services (NPS)
- Provide time off for pregnant employees to access prenatal care (NPS)

5. Community, Non-profit, and Faith Based Organizations

- Provide community-wide education campaigns to promote the use of folic acid supplements among women of childbearing age on to increase the number of these women who consume folic acid supplements (CG)
- Support pregnant women obtaining prenatal care in the first trimester (e.g., transportation services, patient navigators) (NPS)
- Educate communities, clinicians, pregnant women, and families on how to prevent infant mortality (e.g., nutrition, stress reduction, SIDs risk reduction, infant safety, postpartum and newborn care) (NPS)
- Implement culturally and linguistically appropriate social supports for breastfeeding, such as marketing campaigns and breastfeeding peer support programs (NPS)
- Promote and offer HIV and other STI testing and enhance linkages with reproductive and sexual health services (e.g., counseling, contraception, HIV/STI testing and treatment) (NPS)

Community Guide, Centers for Disease Control and Prevention (CG)

Guide to Clinical Preventive Services, U.S. Preventive Services Task Force (CPS)

National Prevention Strategy, Surgeon General, U.S. Department of Health and Human Services (NPS)



HEALTHY MONTGOMERY 2016 COMMUNITY HEALTH NEEDS ASSESSMENT

APPENDICES SECTION

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Appendix I

2015 CHNA Community Conversations

Date	Hosting Organization	Participants (367)	Location (City)
5/21/15	Suburban Hospital Medical Explorers Youth Program	28	Bethesda
6/10/15	Commission on People with Disabilities	60	Rockville
6/17/15	Latino Health Initiative/ Mid-County Regional Services Center (held in Spanish)	44	Wheaton
6/24/15	East County Regional Services Center	15	Silver Spring
6/29/15	Bethesda-Chevy Chase Regional Service Center	8	Bethesda
7/13/15	Holiday Park Senior Center	20	Wheaton
8/5/15	Health Care for the Homeless (women's shelter)	17	Rockville
8/11/15	Asian American Health Initiative	23	Rockville
8/20/15	Health Care for the Homeless (men's shelter)	17	Rockville
9/10/15	African American Health Program/ Silver Spring Regional Service Center	63	Silver Spring
9/15/15	Cross Cultural Infotech (held in Korean)	7	Rockville
9/19/15	Germantown Pedestrian Group/ Upcounty Regional Services Center	8	Germantown
9/26/15	Chinese American Parents and Students Association (held in Mandarin)	23	Rockville
10/1/15	Faith Community Advisory Council's Neighbors in Need Working Group	21	Rockville
10/10/15	Viet Nam Medical Assistance Program	13	Rockville

Appendix II. Community Conversations – Socio-Demographic Description

Gender Distribution of Respondents

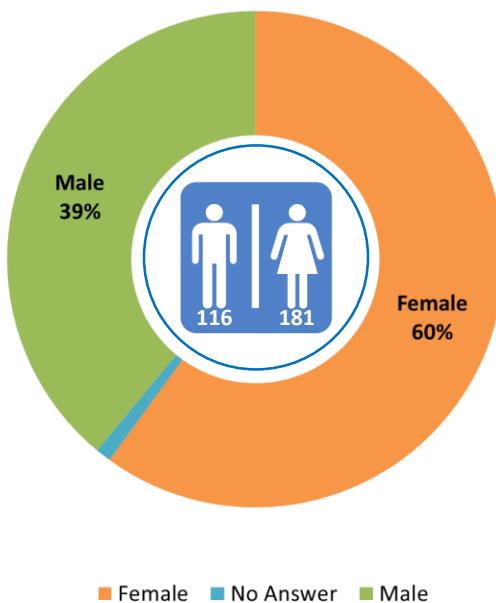
Across all conversations, there were more female than male participants.

3 Conversations had more male than female participants:

- Suburban Hospital - Youth
- Bethesda-Chevy Chase
- East County

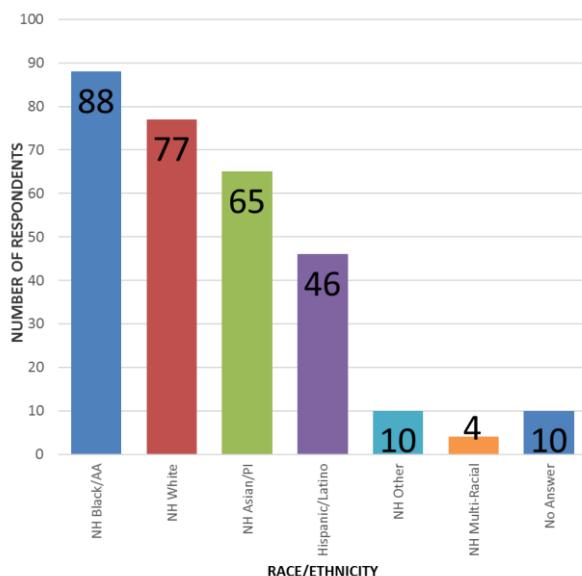
3 Conversations were single gender:

- Male Homeless Shelter
- Female Homeless Shelter
- Viet Nam Medical Assistance Program (all male)



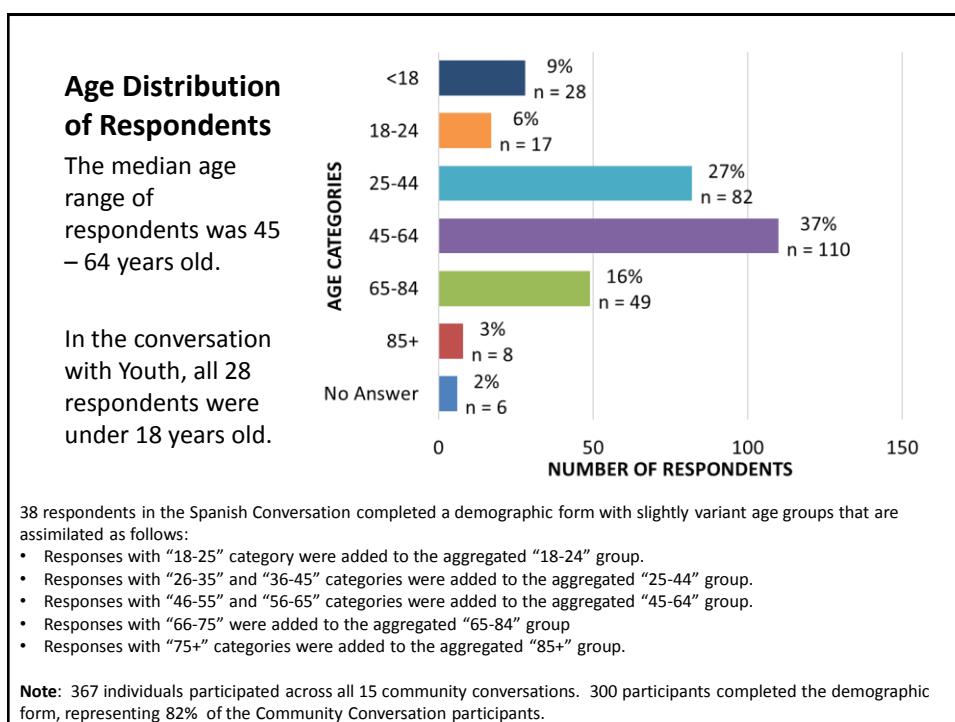
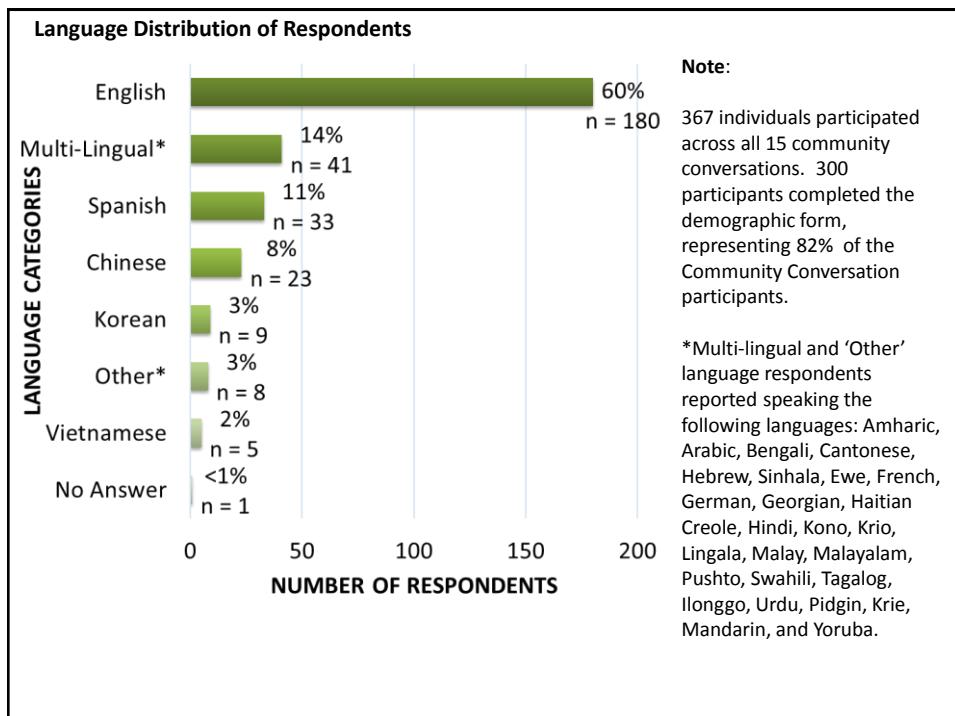
Note: 367 individuals participated across all 15 community conversations. 300 participants completed the demographic form, representing 82% of the Community Conversation participants.

Race/Ethnicity Distribution of Respondents

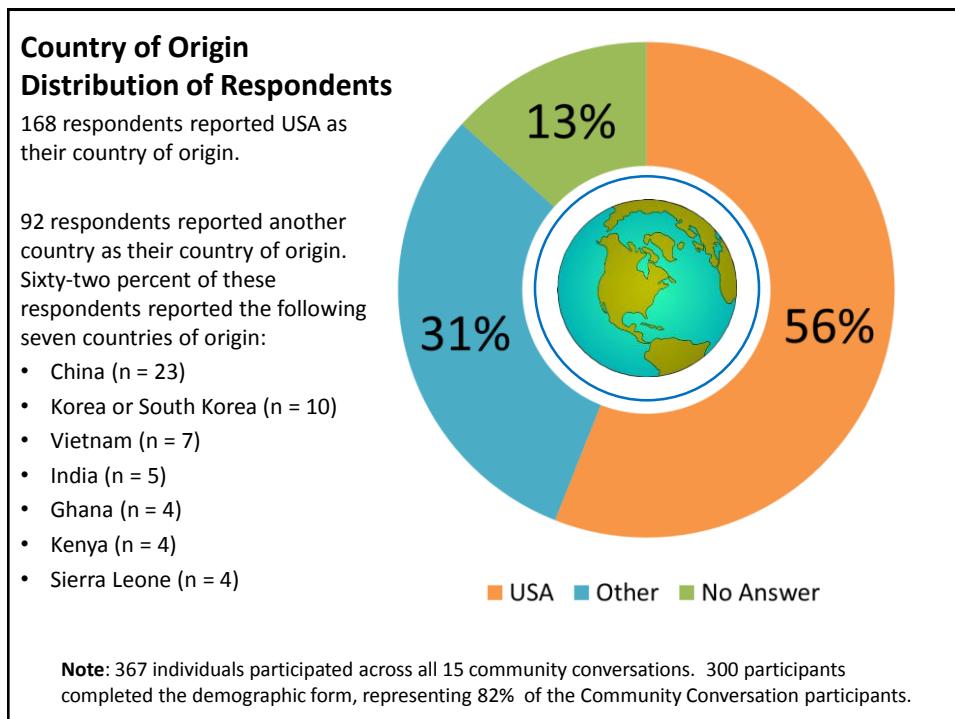
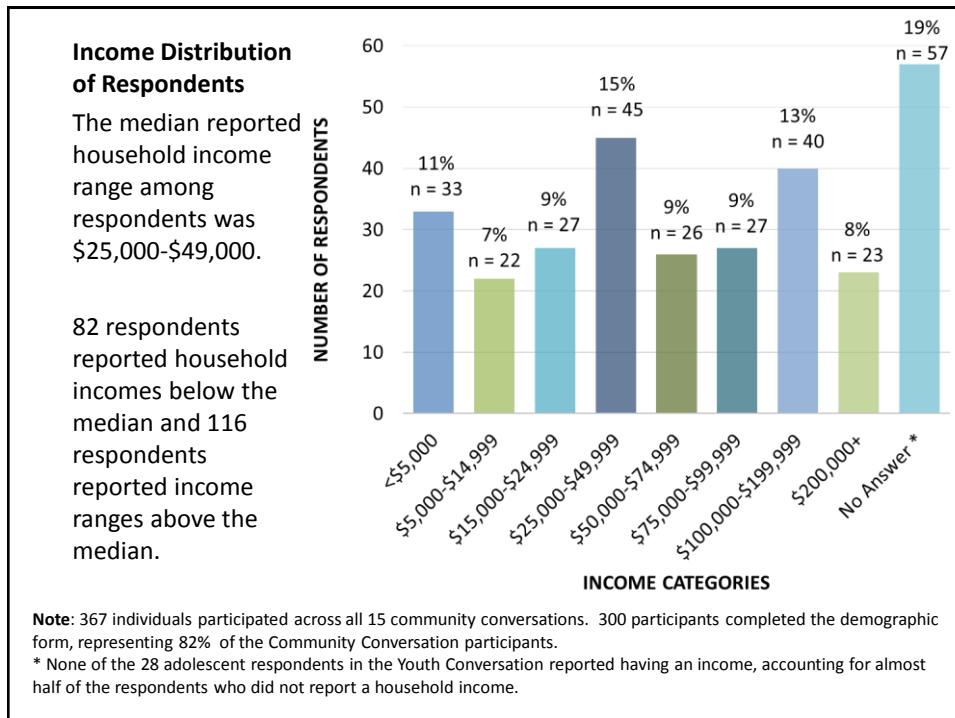


Note: 367 individuals participated across all 15 community conversations. 300 participants completed the demographic form, representing 82% of the Community Conversation participants.

Appendix II. Community Conversations – Socio-Demographic Description



Appendix II. Community Conversations – Socio-Demographic Description



Appendix III. Community Conversations – Table of Key Themes.

This table offers a visual summary of the themes discussed across the fifteen community conversations. The theme, as signified by the ●, was discussed as an asset, challenge or as a strategy for improvement.

Note: The organizations included in the table are those that hosted a community conversation.

15 Healthy Montgomery Community Conversations	Community Conversation Themes									
	Community Resources & Services	Health & Health Care	Transportation	Housing	Access to Healthy Food	Physical Activity & Recreation	Education	Business/Economy	Public Safety	Equity
East County Regional Services Center	●	●	●	●	●	●	●	●	●	●
Commission on People with Disabilities	●	●	●	●	●	●	●	●	●	●
Latino Health Initiative (Mid-County Regional Services Center)-(held in Spanish)	●	●	●	●		●	●	●	●	●
Suburban Hospital - Youth ¹	●	●	●		●	●	●	●	●	●
Holiday Park Senior Center	●	●	●	●	●	●				
Homeless Shelter - Male ²	●	●	●	●	●			●		
Homeless Shelter - Female	●	●	●	●	●	●		●		
Bethesda-Chevy Chase Regional Service Center	●	●	●	●	●	●	●	●	●	●
Asian American Health Initiative	●	●	●			●	●	●	●	
African American Health Program (Silver Spring Regional Service Center)	●	●	●	●	●	●	●	●	●	●
Cross Cultural Infotech – (held in Korean)	●	●	●		●	●	●		●	
Chinese American Parents and Students Association - (held in Mandarin)	●	●	●	●	●	●	●	●	●	
Up-County Regional Service Center ³	●	●	●	●	●	●	●	●	●	●
Faith Community Advisory Council ⁴	●	●		●				●		●
Viet Nam Medical Assistance Program	●	●	●		●	●	●	●	●	●

¹ Suburban Hospital hosted a conversation with the Medical Explorers Youth Program.

² Health Care for the Homeless hosted the community conversations at the women's and men's shelters.

³ The conversation held at the Up County Regional Service Center was hosted by the Germantown Pedestrian Group

⁴ The Faith Community Advisory Council's Neighbors in Need Working Group hosted the faith-based community conversation.

Appendix IV. Healthy Montgomery Core Measures Scorecard

This scorecard for all Healthy Montgomery 37 measures is compiled to summarize the results of the quantitative assessment process. The scorecard provides the following details (the numbers correspond to the illustration below of the scorecard features):

1. Priority area assignment for measure (primary home) – keeping in mind that several measures are used across multiple Key Finding Areas (especially among context and cross-cutting measures)
2. Title of measure
3. Measure Type
4. Measure Data Source
5. Baseline Year
6. Baseline Value
7. Current Value Year
8. Current Value
9. Percent Change
10. Disparities Identified with a flag for differences – Yellow for differences over 5% but less than 10% and Red flags for differences of 10% or more – within the comparison groups
 - a) Gender
 - b) Age
 - c) Race/ethnicity
11. Benchmark Comparisons – are provided when appropriate with either target/goal comparisons of improving, worsening, or met target noted for HP2020 and MD SHIP 2017 evaluations or the ranking for Montgomery County to the other Maryland jurisdictions for the County Health Rankings results.
 - a) MD SHIP 2017 Goals
 - b) County Health Rankings for Maryland in 2015
 - c) Healthy People 2020 Targets

Priority Area	Core Measure	Measure Type	Data Source	Baseline Value	Baseline Year	Update Value	Update Year	Progress	Disparities Identified	Race/Ethnicity	Benchmarks		
									Gender	Age	MD SHIP n/a	CHR n/a	HP2020 n/a
Cross Cutting 5	Percentage of students who described their health in general as excellent or very good	Health Status/ Outcome	MD YTRBS (Middle & High Schools)	55.0	2012-2013	Not yet available	2014-2015	n/a	☒	☒	Met 2017 Target (15.5)	Best (1st) ranked in MD	Met HP2020 Target (12.0)
Cross Cutting 6	Percentage of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	Health Status/ Outcome	MD YTRBS (Middle & High Schools)	26.0	2012-2013	Not yet available	2014-2015	n/a	☒	☒	n/a	n/a	n/a
Cross Cutting 7	Percent of adults that self-reported smoking 100 or more cigarettes in their lifetime and currently smoke	Health Behavior	MD BRFSS	11.3	2011	8.2	2013	● -27%	☒	☒	Met 2017 Target (15.5)	Best (1st) ranked in MD	Met HP2020 Target (12.0)
Cross Cutting 8	Percentage of students who smoked cigarettes on one or more of the past 30 days	Health Behavior	MD YTRBS (Middle & High Schools)	7.0	2012-2013	Not yet available	2014-2015	n/a	☒	☒	n/a	n/a	n/a
Cross Cutting (Obesity) 9	Percent of adults that self reported at least 150 minutes of moderate physical activity or at least 75 minutes of vigorous physical activity per week	Health Behavior	MD BRFSS	52.6	2011	52.8	2013	● 0.4%	no	☒	Met 2017 Target (50.4)	n/a	Met HP2020 Target (50.4)

[Healthy Montgomery Core Measures Scorecard follows this page]

Priority Area	Core Measure	Measure Type	Data Source ¹	Baseline Value	Baseline Year	Update Value	Update Year	Progress	Disparities Identified ²			Benchmarks		
									Gender	Age	Race/Ethnicity	MD SHIP	CHR	HP2020
Context 1	Percentage of families whose income in the past 12 months is below the poverty Level	Socio-Economic Factor	ACS	4.9	2010	4.6	2014	● -6.1%	n/a (families)	n/a (families)	▶	n/a	Ranked 6th in MD (children in poverty)	n/a
Context 2	Percent of adults that report usually or always getting needed social and emotional support	Social/Emotional Support	MD BRFSS	78.1	2009	83.3	2010	● 6.7%	NO	NO	▶	n/a	n/a	n/a
Context 3	Percentage of students who would feel comfortable seeking help from one or more adults besides their parents if they had an important question affecting their life	Social/Emotional Support	MD YTRBS (High Schools)	73.9	Spring 2013	76.9	Fall 2014	● 4.1%	NO	NO	▶	n/a	n/a	n/a
Context 4	Percentage of students who participate in any extracurricular activities at school such as sports, band, drama, clubs, or student government	Social/Emotional Support	MD YTRBS (High Schools)	72.1	Spring 2013	70.7	Fall 2014	◆ -1.9%	NO	▶	▶	n/a	n/a	n/a
Context 5	Percent of adults 25 years and older that have at least a high school diploma or GED (General Equivalency Degree)	Socio-Economic Factor	ACS (ACS table S1501)	90.6	2010	90.9	2014	● 0.3%	NO	NO	▶	Related MD SHIP 2017 Goal-Health Factors: High School Completion-Target not Met	Related CHR Health Factors: Rank: 7th best, high school graduation	Related HP2020 Target-Complete high school 4 years after 9th grade-Target Met
Context 6	Percent of students currently receiving free and reduced-price meals (FARMS)	Socio-Economic Factor	MCPS Schools at a Glance	32.3	2011-2012	35.1	2014-2015	◆ 8.7%	NO	n/a	▶	n/a	n/a	n/a
Context 7	Percent of resident population 5 years and older that report not speaking "English only" and report speaking English "less than very well"	Socio-Economic Factor	ACS	15.6	2010	14.6	2014	● -6.4%	n/a	n/a	n/a	n/a	n/a	n/a
Cross Cutting 1	Percent of adults that self-report they have visited a doctor for a routine check-up at least once in the past two years	Clinical Care	MD BRFSS	85.0	2011	86.9	2014	● 2.2%	▶	▶	▶	n/a	n/a	n/a
Cross Cutting 2	Percent of residents that report no health insurance coverage	Clinical Care	ACS	12.5	2010	9.7	2014	● -22.4%	▶	▶	▶	n/a	CHR Health Factors: Rank: 13th of 24 jurisdictions	HP2020: target 100% coverage, - Target Not Met
Cross Cutting 3	Percent of adults that self-report 2 or fewer poor physical health days in the 30 days preceding the survey	Health Status/Outcome	MD BRFSS	82.4	2011	79.8	2014	◆ -3.2%	NO	▶	▶	n/a	Ranked 2nd best in MD	n/a
Cross Cutting 4	Percent of adults that self-report 2 or fewer poor mental health days in the 30 days preceding the survey	Health Status/Outcome	MD BRFSS	77.1	2011	80.5	2014	● 4.4%	▶	▶	▶	n/a	Ranked 2nd best in MD	n/a
Cross Cutting 5	Percentage of students who described their health in general as excellent or very good	Health Status/Outcome	MD YTRBS (High Schools)	52.3	Spring 2013	No update	Not in Fall 2014 survey	n/a	▶	▶	▶	n/a	n/a	n/a
Cross Cutting 6	Percentage of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	Health Status/Outcome	MD YTRBS (High Schools)	26.9	Spring 2013	27.5	Fall 2014	◆ 2.2%	▶	▶	▶	n/a	n/a	n/a

Priority Area	Core Measure	Measure Type	Data Source ¹	Baseline Value	Baseline Year	Update Value	Update Year	Progress	Disparities Identified ²			Benchmarks		
									Gender	Age	Race/Ethnicity	MD SHIP	CHR	HP2020
Cross Cutting 7	Percent of adults that self-reported smoking 100 or more cigarettes in their lifetime and currently smoke	Health Behavior	MD BRFSS	11.3	2011	7.9	2014	● -30.1%	▶	▶	▶	Met 2017 Target (15.5)	Best (1st) ranked in MD	Met HP2020 Target (12.0)
Cross Cutting 8	Percentage of students who smoked cigarettes on one or more of the past 30 days	Health Behavior	MD YTRBS (High Schools)	8.5	Spring 2013	6.0	Fall 2014	● -29.4%	▶	▶	▶	Met 2017 Goal (15.2)	n/a	Met HP2020 Target (21%)
Cross Cutting (Obesity) 9	Percent of adults that self reported at least 150 minutes of moderate physical activity or at least 75 minutes of vigorous physical activity per week)	Health Behavior	MD BRFSS	52.6	2011	52.8	2013	● 0.4%	NO	▶	▶	Met 2017 Target (50.4)	n/a	Met HP2020 Target (47.9)
Cross Cutting (Obesity) 10	Percent of adults that reported consuming five or more fruits and vegetables a day	Health Behavior	MD BRFSS	20.2	2011	20	2013	◆ -1.0%	▶	▶	▶	n/a	n/a	n/a
Cross Cutting (Obesity) 11	Percent of adults with self-reported height and weight that resulted in a Body Mass Index (BMI) of 25.0 or higher (overweight or obese)	Health Status/Outcome	MD BRFSS	56.1	2011	57.4	2013	◆ 2.3%	▶	▶	▶	Met imputed 2017 Target: 36.6% adults at healthy weight (44.2% in 2013)	Best (1st) ranked in MD for lowest % adults with obesity	Met HP2020 target: Reduce obese adults to 30.5% (17.9% in 2013)
Cross Cutting (Obesity) 12	Percentage of students who were physically active for a total of at least 60 minutes per day on 0 of the past seven days	Health Behavior	MD YTRBS (High Schools)	16.5	Spring 2013	17.6	Fall 2014	◆ 6.7%	▶	▶	▶	n/a	n/a	n/a
Cross Cutting (Obesity) 13	Percentage of students who drank a can, bottle, or glass of soda or pop 0 times per day during the past seven days	Health Behavior	MD YTRBS (High Schools)	33.0	Spring 2013	34.2	Fall 2014	● 3.6%	▶	NO	▶	n/a	n/a	n/a
Cross Cutting (Obesity) 14	Percent of students with weight status of overweight or obese (at or above the 85th percentile of body mass index values)	Health Status/Outcome	MD YTRBS (High Schools)	20.0	Spring 2013	21	Fall 2014	◆ 5.0%	▶	▶	▶	Met MDSHIP 2017 target (Reduce to 10.7) for obese students at baseline (7.1)	n/a	Met H02020 target for obese (Reduce to 16.1) at baseline (7.1)
Cardiovascular Health 1	Heart disease mortality rate (age-adjusted per 100,000 population) (3-yr rolling average)	Health Status/Outcome	MD VSA-Mortality	136.4	2006-2008	110.8	2012-2014	● -18.8%	▶	▶	▶	Met MD SHIP 2017 Goal (152.7)	n/a	HP2020 Target (103.4) Not Met
Cardiovascular Health 2	Stroke (cerebrovascular disease) mortality rate (age-adjusted per 100,000 population) (3-yr rolling average)	Health Status/Outcome	MD VSA-Mortality	30.1	2006-2008	25.3	2012-2014	● -15.9%	NO	▶	▶	n/a	n/a	Met HP2020 Target (34.8)
Cardiovascular Health 3	Percent of adults that report being told by a health professional that they have high blood pressure	Health Status/Outcome	MD BRFSS	21.6	2011	27.7	2013	◆ 28.2%	▶	▶	▶	n/a	n/a	HP2020 Target (26.9) Not Met
Diabetes 1	Percent of adults that report ever being diagnosed with diabetes (excluding diagnoses during pregnancy (i.e. gestational diabetes))	Health Status/Outcome	MD BRFSS	5.1	2011	7	2014	◆ 37.3%	NO	▶	▶	n/a	n/a	n/a
Diabetes 2	Diabetes (primary diagnosis)-related emergency room visit rate (age-adjusted, per 100,000 population)	Clinical Care	MD HSCRC ER	81.9	2008-2010	98.4	2011-2013	◆ 20.1%	▶	▶	▶	Met MD SHIP 2017 Goal (186.3)	n/a	n/a

Progress Key: Green Circle = Improving
 Red Diamond = Worsening

Disparity Key: Yellow Flag = 5-9% difference
 Red Flag = 10% or more difference

Priority Area	Core Measure	Measure Type	Data Source ¹	Baseline Value	Baseline Year	Update Value	Update Year	Progress	Disparities Identified ²			Benchmarks		
									Gender	Age	Race/Ethnicity	MD SHIP	CHR	HP2020
Cancers 1a	Percent of adults 50 years and older that report having a blood stool test using a home kit in the past 2 years	Clinical Care	MD BRFSS	23.1	2012	19.5	2014	◆ -15.6%	NO	►	►	n/a	n/a	n/a
Cancers 1b	Percent of adults 50 years and older that report having a sigmoidoscopy or colonoscopy exam in the past 2 years	Clinical Care	MD BRFSS	32	2012	29.6	2014	◆ -7.5%	►	►	►	n/a	n/a	n/a
Cancers 2	Percent of women 18 years and older that report having a pap smear in the past 3 years	Clinical Care	MD BRFSS	83.2	2012	73.2	2014	◆ -12.0%	Females only	►	►	n/a	n/a	n/a
Cancers 3	Male prostate cancer incidence rate (age-adjusted per 100,000 population)	Health Status/Outcome	NCI SEER (Baseline 2003-2007)	159.3	2004-2008	137	2008-2012	● -14.0%	Males only	Data not available	►	n/a	n/a	n/a
Cancers 4	Female breast cancer mortality rate (age-adjusted per 100,000 population) (3-yr rolling average)	Health Status/Outcome	MD VSA-Mortality	19.8	2006-2008	18.3	2012-2014	● -7.6%	Females only	►	►	n/a	n/a	Met HP2020 Target (20.7)
Behavioral Health 1	Suicide mortality rate (age-adjusted per 100,000 population) (3-yr rolling average)	Health Status/Outcome	MD VSA-Mortality	6.5	2006-2008	7	2012-2014	◆ 7.7%	►	►	►	Met 2017 Target (9.0)	n/a	Met HP2020 Target (10.2)
Behavioral Health 2	Behavioral health-related (primary/secondary diagnosis) ER visit rate (age adjusted, per 100,000 population)	Health Status/Outcome	HSCRC-ER	1178	2008-2010	1391	2011-2013	◆ 18.1%	►	►	►	Met 2014 Target for any listed diagnosis (no 2017 Goal)	n/a	n/a
Behavioral Health 3	Percent of adults aged 18 or older that had at least one major depressive episode in the past year	Health Status/Outcome	SAMHSA NSDUH	5.83	2006-2008	6.39	2010-2012	◆ 9.6%	Data not available	►	Data not available	n/a	n/a	HP2020 Target (5.8) Not Met
Behavioral Health 4	Illicit drug use in the past month among adolescents and adults ages 12 or older	Health Behavior	SAMHSA NSDUH	6.1	2006-2008	7.03	2010-2012	◆ 15.2%	Data not available	►	Data not available	n/a	n/a	HP2020 Target (7.1) Not Met
Maternal & Infant Health 1	Mothers who received early prenatal care (3-yr rolling average)	Clinical Care	MD VSA-Natality	67.3	2010-2012	67.6	2012-2014	◆ 0.4%	Females only	►	►	MD SHIP 2017 Goal (66.9)	n/a	HP2020 Target (77.9) Not Met
Maternal & Infant Health 2	Infant mortality rate (per 1,000 live births) (3-yr rolling average)	Health Status/Outcome	MD VSA-Mortality	6.3	2006-2008	4.9	2012-2014	● -22.2%	►	►	►	Met MD SHIP 2017 Goal (6.3)	7th Lowest in MD	Met HP2020 Target (6.0)
Maternal & Infant Health 3	Percent of births with low birthweight (less than 2,500 grams at birth) (3-yr rolling average)	Health Status/Outcome	MD VSA-Natality	8.2	2006-2008	7.5	2012-2014	● -8.5%	Data not available	►	►	Met MD SHIP 2017 Goal (8.0)	7th Lowest Rate in MD	Met HP2020 Target (7.8)

¹ Details on each data source is provided in Table ?? - Major Data Sources for Healthy Montgomery Core Measures Set.

Measure	Context 1	Context 2	Context 3	Context 4	Context 5
Title	Families living below poverty levels	Adults with adequate social and emotional support	Students who could talk to adult beside a parent	Student participation in extracurricular activities	High school diploma or GED
Measure Type	Socio-Economic Factor	Social/Emotional Support	Social/Emotional Support	Social/Emotional Support	Socio-Economic Factor
Data Source	US Census American Community Survey	Maryland BRFSS	Maryland YRBS	Maryland YRBS	US Census American Community Survey
Target Population(s)	Families	adults	High School students, grades 9-12th grade	High School students, grades 9-12th grade	25 years and older
Measure Description	Percentage	Percentage	Percentage	Percentage	Percentage
Current Rate	4.6 (2014)	83.3 (2010) MD BRFSS discontinued collection of this measure in 2010.	76.9 (Fall 2014)	70.7 (Fall 2014)	90.9 (2014)
Progress Status	Improved	Improved	Improved	Slightly worsened	Relatively no change from 2010 to 2014
Highlights	Decreased (6%) since 2010 baseline	Increased 7% from 2009 baseline of 78.1%	Increased by 4% from Spring 2013 baseline of 73.9%	Slight decline from Spring 2013 baseline of 72.1%	Relatively no change from 2010 baseline of 90.6
Gender	Not applicable (family households)	No differences noted by gender	No differences noted by gender	No differences noted by gender	No differences noted by gender
Age	Not applicable (family households)	No sustained disparity over time- young adults had best rate in 2010 after having worst rate in 2009.	No differences noted by grade; only 3-5% differences across grades	Slight differences noted by grade; differences by grade were under 10%; 12th graders were 7% less likely to participate than 11th graders	No differences noted by age; 3% and less differences measured in rates across age groups
Race	Compared to White families, Hispanic and Black/African American families are 3 times more likely and Asian families are 2 times more likely to live below poverty levels; families in poverty increased 28% among Asian families (from 4.3 to 5.5) between 2010 to 2014	Hispanic adults 30% less likely and Asian adults 18% less likely to have emotional/social support compared to White, NH	Multi-racial students were 15% less likely to report being comfortable seeking help from a non-parent adult	The rate of participation in extracurricular activities was one-third lower among Hispanic students and 15% less likely among Black/AA students	Hispanic residents are 44% less likely to have attained HS diploma or GED compared to NH white residents
HP 2020 Target	Not applicable	Not applicable	<i>Not comparable to YRBS, for reference only: Increase to 83.2% percent of adolescents aged 12 to 17 years had an adult in their lives with whom they could talk about serious problems, as reported in 2008 NSDUH</i>	<i>Not comparable to YRBS, for reference only: Increase to 90.6% of adolescents aged 12 to 17 years participated in extracurricular and/or out-of-school activities in the past 12 months per National Survey on Child Health</i>	<i>Not comparable to this measure on educational attainment, provided for reference only: Increase the proportion of students who graduate with a regular diploma 4 years after starting 9th grade to 84%</i>
HP2020 Target Comparison (target met, higher rate, lower rate)	Not applicable	Not applicable	Not applicable	Not applicable	<i>Montgomery County had 89.7% high school completion in 2013-2014 - Met HP2020 Target</i>
MD SHIP (goal, target met/unmet)	Not applicable	Not applicable	Not applicable	Not applicable	<i>Increase to 95%; Target Not met</i>
CHR (county ranking out of 24 jurisdictions)	Children in poverty: Montgomery County ranked 6th in Maryland; Income inequality ratio: Montgomery County ranked 11th in Maryland	Not applicable	Not applicable	Not applicable	<i>High school graduation rate: Montgomery County ranked 7th in Maryland</i>
Direction/ Progress	2015 ranking is an improvement from 2010 ranking for income equality where Montgomery County ranked 18th in Maryland	Not applicable	Not applicable	Not applicable	<i>Met target, No change</i>
Hospital Partnerships	Holy Cross (Silver Spring) Holy Cross (Germantown) MedStar Montgomery Medical Center Shady Grove Adventist Washington Adventist Suburban Hospital	Holy Cross (Silver Spring) Holy Cross (Germantown) Suburban Hospital			Holy Cross (Silver Spring), Holy Cross (Germantown), MedStar Montgomery Medical Center, Suburban Hospital

Measure	Context 6	Context 7	Cross-Cutting 1	Cross-Cutting 2	Cross-Cutting 3
Title	Students currently receiving free and reduced priced meals (FARMS)	Residents 5 years and older that report speaking English "not very well"	Adults who have had a routine check-up	Persons without health insurance	Adults in good physical health
Measure Type	Socio-Economic Factor	Socio-Economic Factor	Clinical Care	Clinical Care	Health Status/ Outcome
Data Source	MCPS Schools at a Glance	US Census American Community Survey	Maryland BRFSS	US Census American Community Survey	Maryland BRFSS
Target Population(s)	students	5 years and older	adults	adults	adults
Measure Description	Percentage	Percentage	Percentage	Percentage	Percentage
Current Rate	35.1 (2014-2015 school year)	14.6 (2014)	86.9 (2014)	9.7 (2014)	79.8 (2014)
Progress Status	Worsened	Improved	Slightly improved	Improved	Worsened
Highlights	Increased 8.7% from 2011-2012 to 2014-2015 school year	Decreased 6% from 2010 to 2014	Slight (2%) increase in percentage of routine check-ups in the past 2 years since the 2011 baseline of 85%	Decreased 22% since 2010 baseline of 12.5% to 9.7% in 2014	Decreased 3% in percent of adults reporting 2 or fewer poor physical health days since 2011 baseline of 82.4%
Gender	No differences noted by gender	Not available	Males 11% less likely to have had routine check-up	Males are 25% more likely to not have health insurance- widening disparities with females since 2010 when males were 19% more likely to be uninsured	No difference
Age	Not available	Not available	Young Adults (18-34) 15% less likely and adults 35-49 years are 10% less likely than adults 65+ years to have had routine checkup in past 2 years	Between 2012 and 2014 the percent of uninsured has decreased in adults 19-25 years; adults 19-25 are 6 times more likely to not have health insurance than 65+ year olds	Older adults (65+) 13% less likely to report 2 or fewer days of poor physical health compared to the adults 35-49 years
Race	Hispanic/Latino were 83% more likely to receive FARM compared to whole population; NH Black/African American students were 55% more likely to receive FARM compared to the whole population both populations have declined from 2011-2012 to 2014-2015 school years- Black/African American decreased by 1.4% while Hispanic students decreased by 8.5%	Not available	Hispanic population 10% less likely to have had routine check-up compared to Non-Hispanic white adults; Hispanic adults have improved since 2011 when they were 34% more likely than Non-Hispanic white adults	Rate of uninsured has decreased 19% from 2010 (32.7%) to 2014 (25%) among Hispanics; Hispanic residents are 4.6 times more likely to not have health insurance than White residents (a slight narrowing from 4.7 times more likely in 2010)	Non-Hispanic Black adults had highest rate of being in good physical health (82.0%), but differences across racial/ethnic groups are small: White NH is 3% less likely, Asian/Pacific Islander adults is 2.5% less likely, and Hispanic is 5% less likely to be in good physical health.
HP 2020 Target	Not applicable	Not applicable	Not applicable	0% (100% persons with medical insurance)	Not applicable
HP2020 Target Comparison (target met, higher rate, lower rate)	Not applicable	Not applicable	Not applicable	Target not met, improving; need to reduce by 9.7% to achieve target	Not applicable
MD SHIP (goal, target met/unmet)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
CHR (county ranking out of 24 jurisdictions)	Not applicable	Not applicable	Not applicable	Not insured: Montgomery County Ranked 13th- behind 12 other jurisdictions- in Maryland	Poor physical health days: Montgomery County Ranked #2 in Maryland
Direction/ Progress	Not applicable	Not applicable	Not applicable	HP2020 Target not met, but improving	Not applicable
Hospital Partnerships	N/A	Holy Cross (Silver Spring), Holy Cross (Germantown), Washington Adventist	MedStar Montgomery Medical Center, Suburban Hospital	Holy Cross (Silver Spring), Holy Cross (Germantown), MedStar Montgomery Medical Center, Shady Grove Adventist, Washington Adventist, Suburban Hospital	Suburban Hospital

Measure	Cross-Cutting 4	Cross-Cutting 5	Cross-Cutting 6	Cross-Cutting 7	Cross-Cutting 8
Title	Adults in good mental health	Students in good general health	Students ever feeling sad or hopeless in past year	Adults who smoke	Students current cigarette use
Measure Type	Health Status/ Outcome	Health Status/ Outcome	Health Status/ Outcome	Health Behavior	Health Behavior
Data Source	Maryland BRFSS	Maryland YRBS	Maryland YRBS	Maryland BRFSS	Maryland YRBS
Target Population(s)	adults	HS students	HS students	adults	HS students
Measure Description	Percentage	Percentage	Percentage	Percentage	Percentage
Current Rate	80.5 (2014)	52.3 (Spring 2013)	27.5 (Fall 2014)	7.9 (2014)	6.0 (Fall 2014)
Progress Status	Improved	baseline only (not collected in Fall 2014)	Slightly worsened	Improved	Improved
Highlights	4% improvement from 2011 baseline of 77.1	Baseline only available.	2% increase from Spring 2013 baseline of 26.9%	Improved by 30% since 2011 baseline of 11.3%	Improved by 29% since Spring 2013 baseline of 8.5%
Gender	Females are 9.7% less likely to be in good mental health	females 45% more likely to describe their health in general as good or excellent	Females are 85% more likely to report feeling sad or hopeless in past year than male students; disparities narrowed (improved) by 6.5% from Spring 2013 with male students	Males are 2 times more likely to smoke than females; disparity narrowing by 8% between gender groups	Male students are 27% more likely to smoke, with disparity gap with female students widening by 7% since 2013.
Age	Young adults were 15% less likely than older adults 65+ years to be in good mental health; improved from being 28% more likely in 2011	11th graders are 10% less likely to report general health as very good or excellent compared to 9th, 10th and 12th graders	11th graders are 29% more likely to report being depressed (followed next by 12th graders who were 21% more likely) than 9th graders.	Young Adults 18-34 years (5.2%) smoking rates are only 8% higher than rates for older adults (65+ years (4.8%)); rates have declined for young adults by 70% since 2011 while rates have increased by 89% among adults 50-64 years	12th graders are 2.2 times more likely to smoke than 9th graders, 11th graders are 87% more likely than 9th graders, and 10th graders are 26% more likely than 9th graders to smoke.
Race	Non-Hispanic White adults have highest rate of being in good mental health, other race differences are small, while NH Black adults are 12% less likely, Hispanic and Asian/Pacific Islander adults are 2% less likely to be in good mental health	Hispanic and Asian students were almost 30% less likely to describe their general health as very good or excellent; Black/AA students were 16% less likely	Hispanic students were 51% more likely than Non-Hispanic White students and Non-Hispanic Black students were 16% more likely to report feeling sad or hopeless in the past year; 35% of Hispanic students and 27% of Non-Hispanic Black students reported feeling sad or hopeless in the past year.	Non-Hispanic Black adult smoking rate (13.6) is 2.6 times the rate of Hispanic adults (5.2)	Hispanic students are 84% more likely than Non-Hispanic Black students to smoke
HP 2020 Target	Not applicable	Not applicable	Not applicable	Reduce cigarette smoking by adults to 12%	Reduce use of cigarettes by adolescents (past month) to 21%,
HP2020 Target Comparison (target met, higher rate, lower rate)	Not applicable	Not applicable	Not applicable	Target met and improving	Target Met
MD SHIP (goal, target met/unmet)	Not applicable	Not applicable	Not applicable	Reduce to 15.5%, Target Met and improving	Target-15.2 Target met, percentage of adolescents who used any tobacco product in the last 30 days.
CHR (county ranking out of 24 jurisdictions)	Poor mental health days: Montgomery County Raked #2 in Maryland	Not applicable	Not applicable	Adult Smokers- Ranked #1 in Maryland	N/A
Direction/ Progress	Not applicable	Not applicable	Not applicable	Target met	Target Met, improving
Hospital Partnerships	Holy Cross (Silver Spring) Holy Cross (Germantown) MedStar Montgomery Medical Center Shady Grove Adventist Washington Adventist Suburban Hospital		Holy Cross (Silver Spring), Holy Cross (Germantown), Shady Grove Adventist, Washington Adventist	MedStar Montgomery Medical Center, Shady Grove Adventist, Washington Adventist, Suburban Hospital	

Measure	Obesity (Cross-cutting 9)	Obesity (Cross-cutting 10)	Obesity (Cross-cutting 11)	Obesity (Cross-cutting 12)	Obesity (Cross-cutting 13)
Title	Adults engaging in moderate physical activity	Adult fruit and vegetable consumption	Adults who are overweight or obese	Students with no participation in physical activity	Student who drank no soda or pop in the past week
Measure Type	Health Behavior	Health Behavior	Health Status/ Outcome	Health Behavior	Health Behavior
Data Source	Maryland BRFSS	Maryland BRFSS	Maryland BRFSS	Maryland YRBS	Maryland YRBS
Target Population(s)	Adults	Adults	Adults	HS students, grades 9-12	HS students, grades 9-12
Measure Description	Percentage	Percentage	Percentage	Percentage	Percentage
Current Rate	52.8 (2013)	20.0 (2013)	57.4 (2014)	17.6 (Fall 2014, HS)	34.2 (Fall 2014, HS)
Progress Status	No change (less than 1% difference)	No change (1% difference)	Slightly worsened	Worsened	Improved
Highlights	Increased slightly by 0.4% from 2011 baseline of 52.6%	Decreased slightly by 1% from 2011 baseline of 20.2%	Decreased by 2.3% from 2011 baseline of 56.1%	Increased 7% from Spring 2013 baseline of 16.5%	4% improvement from Spring 2013 baseline of 33%
Gender	Females are 5% less likely to engage in mod PA in 2013; Males were 4% less likely than females in 2012; no established disparity between genders.	Men are 24% less likely to consume 5 or more fruits/ vegetables a day than women	Males are 23% more likely to be overweight or obese	High school female students are 57% more likely to not engage in any physical activity in the past week	Males are 20% more likely to have consumed soda
Age	Young adults 18-34 years were 11% less likely than adults 65+ years; trends improving for young adults and adults (18-49 years) while its worsening among adults 50+ years	Adults 18-34 years are 33% less likely than adults 35-49 years to consume 5 or more fruits/vegetables a day	Compared to young adults 18-34 years-adults (50-64) are 37% more likely and adults 35-49 years are 19% more likely to be overweight or obese	11th graders are 43% less physically active compared to 9th graders; 12th graders are 38% less active compared to 9th graders	Less than 5% difference across grades 9-12 (no difference).
Race	Hispanics are 59% less likely to engage in physical activity than White, NH adults	Asian/Pacific Islander and Hispanic adults are about 35% less likely than Non-Hispanic Black adults to consume 5 or more fruits/vegetables daily	68% of Black, NH are overweight or obese. Hispanic adults have the greatest disparity with 2 times the likelihood compared to Asian/Pacific Islander adults to be overweight or obese.	Non Hispanic Black students (21.6%) and Hispanic students (21.6%) are almost 2 times more likely to have no physical activity compared to NH White students (11.2%)	Hispanic students are most likely (73%) to have consumed soda or pop in past week
HP 2020 Target	Increase to 47.9	Not applicable	Reduce the proportion of adults who are obese to 30.5	Not applicable	Not applicable
HP2020 Target Comparison (target met, higher rate, lower rate)	Target met, better than target	Not applicable	20.3% Montgomery County adults were obese in 2014- met HP2020 Target	Not applicable	Not applicable
MD SHIP (goal, target met/unmet)	Increase to 50.4 Target met (better than target)	Not applicable	Increase to 36.6% the percent of adults who are at a healthy weight; Target Met with 42.6% County adults being a healthy weight	Not applicable	Not applicable
CHR (county ranking out of 24 jurisdictions)	Physical inactivity: Montgomery County Ranked #1 in Maryland with lowest % inactive adult population (17%)	Not applicable	Percent of adults who are obese- Montgomery County ranked #1 with lowest percent of obese adults	Not applicable	Not applicable
Direction/ Progress	Target met	Not applicable	Target met but trend is worsening; need to reverse trend.	Not applicable	Not applicable
Hospital Partnerships	Holy Cross (Silver Spring), Holy Cross (Germantown), MedStar Montgomery Medical Center, Shady Grove Adventist, Washington Adventist, Suburban Hospital	Holy Cross (Silver Spring) Holy Cross (Germantown) MedStar Montgomery Medical Center Shady Grove Adventist Washington Adventist Suburban Hospital	Holy Cross (Silver Spring) Holy Cross (Germantown) MedStar Montgomery Medical Center Shady Grove Adventist Washington Adventist Suburban Hospital		

Measure	Obesity (Cross-cutting 14)	Cardiovascular Disease 1	Cardiovascular Disease 2	Cardiovascular Disease 3	Diabetes 1
Title	Students who are overweight or obese	Heart disease mortality	Stroke mortality	High blood pressure prevalence	Adults with diabetes
Measure Type	Health Status/ Outcome	Health Status/ Outcome	Health Status/ Outcome	Health Status/ Outcome	Health Status/Outcome
Data Source	Maryland YRBS	Maryland Vital Statistics Administration Annual Mortality	Maryland Vital Statistics Administration Annual Mortality	Maryland BRFSS	Maryland BRFSS
Target Population(s)	HS students, grades 9-12	adults	adults	adults	Adults (excludes diagnoses of women with gestational diabetes during pregnancy)
Measure Description	Percentage	Age-adjusted rate per 100,000 population	Age-adjusted rate per 100,000 population	Percentage	Percentage
Current Rate	21% in Fall 2014	110.8 (2012-2014)	25.3 (2012-2014)	27.7 (2013)	7.0 (2014)
Progress Status	Worsened	Improved	Improved	Worsened	Worsened
Highlights	Increased 5% from spring 2013 baseline of 20%	Decreased by 19% from 2006-2008 baseline of 136.4	Decreased by 16% since 2006-2008 baseline of 30.1	Increased by 28% from 2011 baseline of 21.6%	Increased 37% from the 2011 revised baseline of 5.1%
Gender	Males are 33% more likely to be overweight or obese; disparities narrowed from 2103 when males were 43% more likely to be overweight or obese	Males are 60% more likely to die from heart disease than females	Men are slightly (2%) more likely to die from stroke than women; narrowing the disparity from the 10% difference across gender in 2006-2008	Men are 20% more likely than women report ever being diagnosed with high blood pressure	No difference trended; males were 22% more likely than females in 2014 and females were 15% more likely than males in 2013
Age	10th graders were 21% more likely to be overweight/obese than 12th graders; 11th graders were 13% more likely	Heart disease mortality is 180 times higher among older adults (65+) and is 9 times higher among adults 35-64 years compared young adults 18-34 years(age group with the lowest rate). There were too few events to compile rates for children	Stroke is 32 times more common among older adults (65+) compared to 35-64 year olds	Adults 65 and older are over 6 times more likely to have high blood pressure than young adults 18-34 years	Older adults (65+) are almost 5 times more likely than adults 35-49 years and adults 50-64 years are 2 times more likely; Older adults have highest rate (19.2%) but adults 35-49 years have had the most drastic spike in diabetes prevalence from 3.2% in 2011 to 4.1% in 2014, a 28-percent increase.
Race	Hispanics are 2.3 times more likely to be overweight or obese than NH white high school students; NH Black students are 2 times more likely; both Non-Hispanic Black and Hispanic students showed improvement in disparities when compared to Non-Hispanic White high school students	Black and White residents are over 2 times more likely than Hispanics to die from heart disease	Compared to Hispanic residents, Black residents are 34% more likely White residents are 19% more likely, and Asian/PI residents are 7.7% more likely to die from stroke	Non-Hispanic Black adults report highest rate of high blood pressure compared to Asian/Pacific Islander adults, 73% more likely to have high BP	Asian/Pacific Islander adults were 3 times more likely than Hispanic adults to report being diagnosed with diabetes; Non-Hispanic Black adults were 2.6 times more likely and Non-Hispanic White adults were 2.5 times more likely than Hispanic adults. Asian/Pacific Islander adults increased three-fold from 3.2 in 2011 to 9.3 in 2014.
HP 2020 Target	<i>Not comparable (different source, age group, and only for obesity): Reduce proportion of children and adolescents aged 2 to 19 years old who are considered obese to 14.5</i>	Decrease to 103.4	Reduce to 34.8	Reduce to 26.9	Not applicable
HP2020 Target Comparison (target met, higher rate, lower rate)	Target met (7.5 % in Fall 2014) but worsening	Making progress toward target- need to reduce current rate by an additional 6.7% to reach HP2020 target	Target met	Target not met, rate needs to be reduced by 3% to meet target	Not applicable
MD SHIP (goal, target met/unmet)	Reduce obesity in students to 10.7 (Target met but worsening)	Goal-Reduce to 166.3 Target Met	Not Applicable	Not applicable	Not applicable
CHR (county ranking out of 24 jurisdictions)	Not applicable	Not Applicable	Not Applicable	Not applicable	Not applicable
Direction/ Progress	Target met, but worsening	HP2020 Target not met but improving; MD SHIP 2017 target met and improving	Target met and improving	Target not met, and worsening (moving away from target)	Not applicable
Hospital Partnerships		Holy Cross (Silver Spring), Holy Cross (Germantown), MedStar Montgomery Medical Center, Shady Grove Adventist, Washington Adventist, Suburban Hospital	Holy Cross (Silver Spring), Holy Cross (Germantown), MedStar Montgomery Medical Center, Shady Grove Adventist, Washington Adventist, Suburban Hospital	HCSS, HCG, MMG, SJHM	Holy Cross (Silver Spring), Holy Cross (Germantown), MedStar Montgomery Medical Center, Shady Grove Adventist, Washington Adventist, Suburban Hospital

Measure	Diabetes 2	Cancers 1a	Cancers 1b	Cancers 2	Cancers 3
Title	ER visits for diabetes	Colorectal screening: blood stool test in past 2 years	Colorectal screening: colonoscopy/ sigmoidoscopy in past 2 years	Pap test in past 3 years	Prostate cancer incidence
Measure Type	Clinical Care	Clinical Care	Clinical Care	Clinical Care	Health Status/ Outcome
Data Source	Maryland Healthcare Services Cost Review Commission Annual ER Utilization	Maryland BRFSS	Maryland BRFSS	Maryland BRFSS	NCI SEER-Gender, Race, Ethnicity, No Data Below County Level
Target Population(s)	Adults	50 years and older	50 years and older	women, 18 years and older	adults
Measure Description	Age-adjusted rate per 100,000 population	Percentage	Percentage	Percentage	Age-adjusted rate per 100,000 male population
Current Rate	98.4 (2011-2013)	19.5% (2014)	29.6% (2014)	73.2% (2014)	137 (2008-2012)
Progress Status	Worsened	Worsened	Worsened	Worsened	Improved
Highlights	Increased 20% from 2008-2010 baseline of 81.9	Decreased 16% from 2012 baseline of 23.1%	Decreased 8% from 2012 baseline of 32%	Decreased 12% from 2012 baseline of 83.2%	Decreased by 14% from 2004-2008 baseline of 159.3
Gender	Males are 14% more likely to visit ER for diabetes than females	No differences noted by gender; Males had better screening rates in 2014, females had better screening in 2012.	Males are 8% less likely compared to females	Not applicable	Not applicable
Age	Older adults 65+ are 9x more likely to have visited the ER for diabetes than children (under 18 years); adults 35-64 years are 5x more likely and young adults 18-34 years are 2x more likely than children; while the rate is smallest among children under 18, their rate increased the most from 2008-10 (20.6) to 2011-13 (26.4) - a 28% increase	Adults 50-64 are almost 94% less likely than older adults (65+) to use blood stool at home test.	Adults 50-64 are 36% less likely than older adults 65-74 years to have screening via colonoscopy or sigmoidoscopy in past 2 years	Young women 18-34 years (59%) least likely to have screening within past 3 years, about 30% fewer than women 35-49 years (83%)	Not applicable
Race	Black residents visit the ER for diabetes 6.7 times the rate of Asian/PIs, Hispanic visit the ER for diabetes at twice the rate of Asian/PI residents and white residents visit at 1.4 times the rate of Asian/PI residents	NH Black adults are half as likely as Hispanic adults to get screened	Asian/Pacific Islander adults are 36% less likely than Hispanic adults 50 year and older to have had a colonoscopy/sigmoidoscopy in the past 2 years.	Slight differences noted; Non-Hispanic Black, Asian/Pacific Islander, and Hispanic women are 4-7% less likely to have had pap test in past 3 years compared to Non-Hispanic White women.	Black residents have over 2-fold higher prostate cancer diagnoses compared to Hispanics; White residents have 30% higher rate of prostate cancer diagnoses compared to Hispanic males(rates by race for earlier years not available to examine specific trends)
HP 2020 Target	Not applicable	[Not applicable, provided for reference: Increase to 70.5% (broadly measuring <u>all</u> colorectal screening methods)]	[Not applicable, provided for reference: Increase to 70.5% (broadly measuring <u>all</u> colorectal screening methods)]	Not applicable	Not Applicable
HP2020 Target Comparison (target met, higher rate, lower rate)	Not applicable	Target not applicable to one type of screening; no comparison can be made	Target not applicable to one type of screening; no comparison can be made	Not applicable	Not Applicable
MD SHIP (goal, target met/unmet)	Goal-186.3 Target Met (better than target)	Not applicable	Not applicable	Not applicable	Not applicable
CHR (county ranking out of 24 jurisdictions)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Direction/ Progress	MD SHIP 2017 target met but trend moving in wrong direction (increasing)	Not applicable	Not applicable	Not applicable	Not applicable
Hospital Partnerships	Holy Cross (Silver Spring), Holy Cross (Germantown), MedStar Montgomery Medical Center, Shady Grove Adventist, Washington Adventist, Suburban Hospital	Holy Cross (Silver Spring) Holy Cross (Germantown) MedStar Shady Grove Adventist Washington Adventist Suburban Hospital	Holy Cross (Silver Spring) Holy Cross (Germantown) MedStar Montgomery Medical Center Shady Grove Adventist Washington Adventist Suburban Hospital	HCG,HCSS, SGA, WA, SJHM	Holy Cross (Silver Spring), Holy Cross (Germantown), MedStar Montgomery Medical Center, Shady Grove Adventist, Washington Adventist, Suburban Hospital

Measure	Cancers 4	Behavioral Health 1	Behavioral Health 2	Behavioral Health 3	Behavioral Health 4
Title	Breast cancer mortality	Suicide	ER visits for behavioral health conditions	Adults with at least one major depressive episode in the past year	Adolescent/adult illicit drug use in past month
Measure Type	Health Status/ Outcome	Health Status/ Outcome	Clinical Care	Health Status/ Outcome	Health Behavior
Data Source	Maryland Vital Statistics Administration Annual Mortality	Maryland Vital Statistics Administration Annual Mortality	Maryland Healthcare Services Cost Review Commission Annual ER Utilization	SAMHSA National Survey on Drug Use and Health	SAMHSA National Survey on Drug Use and Health
Target Population(s)	women, 18 years and older	All Ages	All Ages	Adults 18+ years	12 years and older
Measure Description	Age-adjusted rate per 100,000 female population	Age-adjusted rate per 100,000 population	Age-adjusted rate per 100,000 population	Percentage	Percentage
Current Rate	18.3 (2012-2014)	7.0 (2012-14)	1391 (2011-2013)	6.39 (2010-2012)	7.03 (2010-2012)
Progress Status	Improved	Worsened	Worsened	Worsened	Worsened
Highlights	Decreased by 8% from 2006-2008 baseline of 19.8	Increased 8% from 2006-2008 baseline of 6.5 per 100,000 population	Increased 18% from 2008-2010 baseline of 1178 ER visits per 100,000 population	Increased by 10% from 5.83% in 2006-2008	Increased by 15.2% from 6.1% in 2006-2008
Gender	Not applicable	Males suicide rate is over 4 times higher than females- disparity widening; rate reduced by 30% for females while increased by 26% among males	Males are 11% more likely to visit the ER for behavioral conditions, gap is narrowing slightly	Data not available	Data not available
Age	Breast Cancer mortality is 4 times higher among older women (65+ years) compared to 35-64 year olds	Adults 65+ years have highest suicide rate	Adults 18-34 years are almost 2.5 times more likely than children (lowest rate); while rate is lower for children (951 in 2011-2013), children ER visits increased the most among age groups from 2008-2010 to 2011-2013 (707 to 951), a 34% increase.	Not available	12-17 year old children are twice as likely than adults 26+ years to have used illicit drugs in the past month
Race	Black female breast cancer mortality rate (23.1) is 2.2 times higher than Asian mortality rate	White suicide rate is 1.6 times the rate of Black/AA rate; Black rate worsened by 65% while white rate worsened by 12%; Asian/Pacific Islander rates improved by 45% (there were too few events for Hispanic population to compile rates- data were suppressed)	Black are 5 times more likely than Asian/Pacific Islanders, White are 3 times more likely than Asian/Pacific Islanders, Hispanics are 2.3 times more likely than Asian/Pacific Islanders; Black disparity gap is narrowing slightly. While lowest rate, Asian/Pacific Islanders rate increased the worst from 290 to 353 (22% increase)	Not available	Not available
HP 2020 Target	Decrease breast cancer mortality to 20.7	Reduce to 10.2	Not Applicable	MHMD-4.2: Reduce the proportion of adults aged 18 years and older who experience major depressive episodes (MDEs) to 5.8	SA-13.3: Reduce the proportion of adults reporting use of any illicit drug in past 30 days to 7.1
HP2020 Target Comparison (target met, higher rate, lower rate)	Target met at baseline	Target met	Not Applicable	Worsening - Moving away from target; need to improve by 10% to meet target	Target Met at baseline
MD SHIP (goal, target met/unmet)	Not Applicable	Reduce to 9.0; Target Met	Not Applicable	Not Applicable	Not Applicable
CHR (county ranking out of 24 jurisdictions)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Direction/ Progress	HP2020 Target met and improving	Target met (below target), but worsening from 2006-2008 baseline	Not Applicable	Not Applicable	Target met at baseline but at risk for not meeting target
Hospital Partnerships	Holy Cross (Silver Spring), Holy Cross (Germantown), MedStar Montgomery Medical Center, Shady Grove Adventist, Washington Adventist, Suburban Hospital	Holy Cross (Silver Spring), Holy Cross (Germantown), Shady Grove Adventist, Washington Adventist	Holy Cross (Silver Spring), Holy Cross (Germantown), Shady Grove Adventist, Washington Adventist, Suburban Hospital	Holy Cross (Silver Spring), Holy Cross (Germantown), Shady Grove Adventist, Washington Adventist, Suburban Hospital	Holy Cross (Silver Spring) Holy Cross (Germantown) Shady Grove Adventist Washington Adventist Suburban Hospital

Measure	Maternal and Infant Health 1	Maternal and Infant Health 2	Maternal and Infant Health 3
Title	Mothers who received early prenatal care	Infant mortality	Babies with low birthweight
Measure Type	Clinical Care	Health Status/ Outcome	Health Status/ Outcome
Data Source	Maryland Vital Statistics Administration Annual Mortality	Maryland Vital Statistics Administration Annual Mortality	Maryland Vital Statistics Administration Annual Mortality
Target Population(s)	Infants	Infants	Infants
Measure Description	Percentage	Rate per 1,000 live births	Percentage
Current Rate	67.6% (2012-2014)	4.9 (2012-2014)	7.5 (2012-2014)
Progress Status	No change (less than 1% difference)	Improved	Improved
Highlights	Increased 0.4% from revised 2010-2012 baseline of 67.3%	Decreased 22% from 2006-2008 baseline of 6.3	Decreased by 9% from 2006-2008 baseline of 8.2%
Gender	Not applicable	Infant boys have a slightly higher mortality rate than infant girls (2% difference)	Not available
Age	Births to mothers 15-17 years (30.9%) report getting early prenatal care less than half the frequency of mothers 25+ years (63.5-74.6%); births to mother 18-19 years get early prenatal care 50-80% less often than among births to mothers 25+ years	Neonatal infant death rate (deaths within first 28 days of life) is about 2.4 times higher than postneonatal death rate (deaths within 29-365 days of life)	Mothers 45+ are almost 4 times more likely than mothers 25-29 years to give birth to infants with LBW
Race	Hispanic/Latino are 50% less likely, Black mothers are 34% less likely, and White mothers are 7.7% less likely to receive early prenatal care than Asian mothers	Infant mortality rate is 2.4 times higher in Black infants (with disparities narrowing by 35% since 2006-2008) compared to Asian/Pacific Islander infants; Infant mortality rates improved among all race groups (by 10-35%) by not among Hispanic infants - Hispanic infant mortality rate worsened by 28% from 2006-2008 (2.9) to 2012-2014 (3.7)	Black infants are 61% more likely to be born with LBW than White infants; Hispanic LBW births made no improvements since 2006-2008 and are now 7% higher than white LBW births after historically being best (lowest) group
HP 2020 Target	Increase to 77.9%	Reduce to 6.0	Decrease to 7.8%
HP2020 Target Comparison (target met, higher rate, lower rate)	Target not met; Need to improve by 15% to reach HP 2020 Target	Target met and continuing to improve	Target met and continuing to improve
MD SHIP (goal, target met/unmet)	MDSHIP 2017 Goal= 66.9; Target met.	Target is met for MDSHIP 2017 Goal of 6.3	MD SHIP2017 Goal = Reduce to 8%; Goal Met and continuing to improve (except for Hispanic LBW births)
CHR (county ranking out of 24 jurisdictions)	Not applicable	Montgomery County Ranked #7 in Maryland in infant mortality rate	Montgomery County Ranked #10 in Maryland in low birthweight births
Direction/ Progress	HP2020 Target not met; MD SHIP 2017 Goal met at baseline; no change	Target Met and improving (worsening among Hispanic infants);	Target Met and improving
Hospital Partnerships	Holy Cross (Silver Spring) Holy Cross (Germantown) Shady Grove Adventist Washington Adventist Suburban Hospital	Holy Cross (Silver Spring) Holy Cross (Germantown) Shady Grove Adventist Washington Adventist Suburban Hospital	Holy Cross (Silver Spring) Holy Cross (Germantown) Shady Grove Adventist Washington Adventist Suburban Hospital

Data Source Name	Acronym	Periodicity	Population Subgroups						Sub-geography Subgroups					
			Gender	Race	Ethnicity	Age	Income	Education	National	State	County	Zip Code	Census Tract	Other (Block, School enrollment area)
Maryland Behavioral Risk Factor Surveillance System	MD BRFSS	Annual- Core module Biannual-Optional modules	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✗	✗
Maryland Births	MD VSA Births	Annual	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓ ¹
Maryland Deaths	MD VSA Deaths	Annual	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓ ¹
Maryland Youth Tobacco and Risk Behavior Survey	MD YTRBS	Biannual	✓	✓	✓	✓	✗	n/a	✓	✓	✓	✗	✗	✗
Maryland Healthcare Services Cost Review Commission Inpatient Discharges	MD HSCRC Inpatient	Annual	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✗
Maryland Healthcare Services Cost Review Commission ER Discharges	MD HSCRC ER	Annual	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✗

¹ With street address can assign other geographies based on street address (planning areas, transportation zones, school enrollment boundaries, etc.)

Data Source Name	Acronym	Periodicity	Population Subgroups						Sub-geography Subgroups				
			Gender	Race	Ethnicity	Age	Income	Education	National	State	County	Zip Code	Census Tract
National Cancer Institute SEER	NCI SEER	Annual	✓	✓	✓	✓	✗	✗	✓	✓	✓	✗	✗
National Survey on Drug Use and Health	SAMHSA NSDUH	Annual	✓	✗	✗	✓	✗	✗	✓	✓	✓	✗	✗
U.S. Census American Communities Survey	ACS	Annual	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓ ²	✓
Montgomery County Public Schools – School at a Glance	MCPS Schools at a Glance	Annual	✓	✓	✓	✓	✗	n/a	✗	✗	✓	✗	✓ ³

² Zip code tabulation area (ZCTA) – not always equivalent to zip code.³ School enrollment area; elementary, middle, and senior high schools.

Leading Causes of Death By Race/Ethnicity
ALL Montgomery County, Maryland Residents | 2012-2014 Combined

Note: Total values for populations (N) and total values for specific causes of death (n) are not displayed when counts are greater than zero but less than 18 over three years combined). Suppressed counts are indicated by (---).

Age Group and Ranking (ALL)

Population= 39,876 Males and Females Under 1 Year	N= 190 Total	N= 22 A/PI	N= 74 Black	N= 89 White	N= 39 Hispanic
1 Certain Conditions Originating in the Perinatal Period (n= 105)	(---)	Certain Conditions Originating in the Perinatal Period (n= 45)	Certain Conditions Originating in the Perinatal Period (n= 46)	(---)	
2 Congenital Malformations, deformations and chromosomal abnormalities (n= 40)	(---)	(---)	(---)	Congenital Malformations, deformations and chromosomal abnormalities (n= 23)	(---)
3 (---)	(---)	(---)	(---)	(---)	(---)
4 (---)	(---)	(---)	(---)	(---)	(---)
5 (---)	(---)	(---)	(---)	(---)	(---)

Population= 678,345 Males and Females 1-17 Years	N= 96 Total	N= (---) A/PI	N= 28 Black	N= 57 White	N= 21 Hispanic
1 Accidents (Unintentional Injuries) (n= 19)	(---)	(---)	(---)	(---)	(---)
2 (---)	(---)	(---)	(---)	(---)	(---)
3 (---)	(---)	(---)	(---)	(---)	(---)
4 (---)	(---)	(---)	(---)	(---)	(---)
5 (---)	(---)	(---)	(---)	(---)	(---)

Population= 654,223 Males and Females 18-34 Years	N= 370 Total	N= 28 A/PI	N= 107 Black	N= 226 White	N= 69 Hispanic
1 Accidents (Unintentional Injuries) (n= 94)	(---)	(---)	Accidents (unintentional injuries) (n= 23)	Accidents (Unintentional Injuries) (n= 60)	Accidents (unintentional injuries) (n= 24)
2 Intentional Self-Harm (suicide) (n= 52)	(---)	(---)	Assault (homicide) (n= 18)	Intentional Self-Harm (Suicide) (n= 33)	(---)
3 Malignant Neoplasms (n= 42)	(---)	(---)	(---)	Malignant Neoplasms (n= 28)	(---)
4 Diseases of Heart (n= 30)	(---)	(---)	(---)	(---)	(---)
5 Assault (homicide) (n= 26)	(---)	(---)	(---)	(---)	(---)

Population= 1,273,235 Males and Females 35-64 Years	N= 3,051 Total	N= 278 A/PI	N= 749 Black	N= 1,992 White	N= 272 Hispanic
1 Malignant Neoplasms (n= 1,163)	Malignant Neoplasms (n= 137)	Malignant Neoplasms (n= 254)	Malignant Neoplasms (n= 760)	Malignant Neoplasms (n= 90)	
2 Diseases of Heart (n= 583)	Diseases of Heart (n= 42)	Diseases of Heart (n= 165)	Diseases of Heart (n= 371)	Diseases of Heart (n= 41)	
3 Accidents (unintentional injuries) (n=139)	(---)	Diabetes Mellitus (n= 32)	Accidents (unintentional injuries) (n= 109)	Accidents (Unintentional Injuries) (n= 21)	
4 Intentional Self-Harm (suicide) (n=115)	(---)	Cerebrovascular Diseases (n= 24)	Intentional self-harm (suicide) (n= 94)	(---)	
5 Diabetes Mellitus (n= 102)	(---)	Septicemia (n= 21)	Diabetes Mellitus (n= 61)	(---)	

Population= 406,154 Males and Females 65+ Years	N = 13,510 Total	N= 964 A/PI	N= 1,588 Black	N= 10,921 White	N= 491 Hispanic
1	Diseases of Heart (n= 3,364)	Malignant Neoplasms (n= 259)	Malignant Neoplasms (n= 371)	Diseases of Heart (n= 2,781)	Malignant Neoplasms (n= 128)
2	Malignant Neoplasms (n= 2,922)	Diseases of Heart (n= 210)	Diseases of Heart (n= 365)	Malignant Neoplasms (n= 2,286)	Diseases of Heart (n= 87)
3	Cerebrovascular Disease (n= 809)	Cerebrovascular Diseases (n= 77)	Cerebrovascular Diseases (n= 90)	Cerebrovascular Diseases (n= 640)	Cerebrovascular Diseases (n= 35)
4	Chronic Lower Respiratory Diseases (n= 555)	Influenza and Pneumonia (n= 35)	Diabetes Mellitus (n= 78)	Chronic Lower Respiratory Diseases (n= 493)	Alzheimer's Disease (n= 20)
5	Alzheimer's Disease (n= 433)	Septicemia (n= 31); Diabetes Mellitus (n= 31)	Influenza and Pneumonia (n= 47)	Alzheimer's Diseases (n= 363)	Septicemia (n= 19) AND Diabetes Mellitus (n= 19)

Population= 3,051,833 Males and Females ALL AGES	N = 17,217 Total	N= 1,300 A/PI	N= 2,546 Black	N = 13,285 White	N= 892 Hispanic
1	Malignant Neoplasms (n=4,144)	Malignant Neoplasms (n= 403)	Malignant Neoplasm (n= 636)	Disease of Heart (n= 3,170)	Malignant Neoplasms (n=231)
2	Diseases of Heart (n=3,983)	Diseases of Heart (n=255)	Diseases of Heart (n=543)	Malignant Neoplasms (n=3,085)	Diseases of Heart (n=135)
3	Cerebrovascular Disease (n=893)	Cerebrovascular Diseases (n= 89)	Cerebrovascular Diseases (n= 114)	Cerebrovascular Disease (n=686)	Accidents (unintentional injuries) (n=63)
4	Chronic Lower Respiratory Disease (n= 599)	Influenza and Pneumonia (n= 40)	Diabetes Mellitus (n=113)	Chronic Lower Respiratory Disease (n=525)	Cerebrovascular Diseases (n=51)
5	Accidents (unintentional injuries) (n=557)	Septicemia (n= 39)	Accidents (Unintentional Injuries) (n=75)	Accidents (Unintentional Injuries) (n=442)	Diabetes Mellitus (n=36)

Leading Causes of Death By Race/Ethnicity

FEMALE Montgomery County, Maryland Residents | 2012-2014 Combined

Note: Total values for populations (N) and total values for specific causes of death (n) are not displayed when counts are greater than zero but less than 18 over three years combined). Suppressed counts are Indicated by (- - -).

Age Group and Ranking (Females Only)

Population= 19,448 Females Under 1 Year	N = 92 Total	N= (- - -) A/PI	N= 33 Black	N= 46 White	N= 20 Hispanic
1 Certain Conditions Originating in the Perinatal period (n= 52)	(- - -)	Certain Conditions Originating in the Perinatal period (n= 23)	Certain Conditions Originating in the Perinatal period (n= 22)	(- - -)	(- - -)
2 Congenital malformations, deformations and chromosomal abnormalities (n= 20)	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)
3	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)
4	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)
5	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)

Population= 332,746 Females 1-17 Years	N= 35 Total	N= (- - -) A/PI	N= (- - -) Black	N= 18 White	N= (- - -) Hispanic
1	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)
2	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)
3	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)
4	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)
5	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)

Population= 326,997 Females 18-34 Years	N= 106 Total	N= (- - -) A/PI	N= 34 Black	N= 61 White	N= (- - -) Hispanic
1 Accidents (unintentional injuries) (n= 20) AND Malignant Neoplasms (n= 20)	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)
2	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)
3	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)
4	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)
5	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)

Population= 668,405 Females 35-64 Years	N= 1,253 Total	N= 125 A/PI	N= 341 Black	N= 773 White	N= 96 Hispanic
1 Malignant Neoplasms (n= 604)	Malignant Neoplasms (n= 73)	Malignant Neoplasms (n= 138)	Malignant Neoplasms (n= 385)	Malignant Neoplasms (n= 47)	Malignant Neoplasms (n= 84)
2 Diseases of Heart (n= 165)	(- - -)	Diseases of Heart (n= 68)	Diseases of Heart (n= 84)	(- - -)	(- - -)
3 Septicemia (n= 39) AND Diabetes Mellitus (n= 39)	(- - -)	(- - -)	Accidents (unintentional injuries) (n= 29)	(- - -)	(- - -)
4	(- - -)	(- - -)	Septicemia (n= 26)	(- - -)	(- - -)
5 Accidents (unintentional injuries) (n= 37)	(- - -)	(- - -)	Intentional self-harm (suicide) (n= 23)	(- - -)	(- - -)

Population= 233,419 Females 65+ Years	N= 7,569 Total	N= 505 A/PI	N= 880 Black	N= 6,164 White	N= 306 Hispanic
1	Diseases of Heart (n= 1,802)	Malignant Neoplasms (n= 134)	Malignant Neoplasms (n= 191)	Diseases of Heart (n= 1,518)	Malignant Neoplasms (n= 71)
2	Malignant Neoplasms (n= 1,548)	Diseases of Heart (n= 99)	Diseases of Heart (n= 181)	Malignant Neoplasms (n= 1,219)	Diseases of Heart (n= 51)
3	Cerebrovascular Diseases (n = 520)	Cerebrovascular Diseases (n= 44)	Cerebrovascular Diseases (n=56)	Cerebrovascular Disease (n= 419)	Cerebrovascular Diseases (n= 22)
4	Chronic Lower Respiratory Diseases (n= 318)	Diabetes Mellitus (n= 21)	Diabetes Mellitus (n= 48)	Chronic Lower Respiratory Diseases (n= 285)	(- - -)
5	Alzheimer's Disease (n=304)	Septicemia (n= 18); Influenza and Pneumonia (n= 18)	Alzheimer's Disease (n= 29)	Alzheimer's Disease (n= 257)	(- - -)

Population= 1,581,015 FEMALE ALL AGES	N = 9,055 Total	N= 650 A/PI	N= 1,302 Black	N= 7,062 White	N= 449 Hispanic
1	Malignant Neoplasms (n=2,180)	Malignant Neoplasm (n= 210)	Malignant Neoplasm (n=336)	Malignant Neoplasms (n=1,622)	Malignant Neoplasms (n=124)
2	Diseases of Heart (n=1,980)	Disease of Heart (n= 111)	Diseases of Heart (n=254)	Diseases of Heart (n= 1,607)	Diseases of Heart (n= 61)
3	Cerebrovascular Diseases (n=551)	Cerebrovascular Diseases (n= 50)	Cerebrovascular Diseases (n=65)	Cerebrovascular Disease (n= 434)	Cerebrovascular Diseases (n=25)
4	Chronic Lower Respiratory Diseases (n=342)	Diabetes Mellitus (n= 25)	Diabetes Mellitus (n=63)	Chronic Lower Respiratory Disease (n= 301)	Accidents (Unintentional Injuries) (n = 21)
5	Alzheimer's Disease (n=308)	Septicemia (n= 21)	Influenza and Pneumonia (n=34)	Alzheimer's Disease (n= 260)	Septicemia (n = 18)

Leading Causes of Death By Race/Ethnicity
MALE Montgomery County, Maryland Residents | 2012-2014 Combined

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Age Group and Ranking (Males Only)

Population= 20,428 Males Under 1 Year	N= 98 Total	N= (- - -) A/PI	N=41 Black	N= 43 White	N= 19 Hispanic
1	Certain Conditions originating in the perinatal period (n= 53)	(- - -)	Certain Conditions Originating in the Perinatal Period (n= 22)	Certain Conditions Originating in the Perinatal Period (n= 24)	(- - -)
2	Congenital Malformation; deformation and chromosomal abnormalities (n= 20)	(- - -)	(- - -)	(- - -)	(- - -)
3	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)
4	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)
5	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)

Population= 345,599 Males 1-17 Years	N= 61 Total	N= (- - -) A/PI	N= (- - -) Black	N= 39 White	N= (- - -) Hispanic
1	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)
2	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)
3	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)
4	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)
5	(- - -)	(- - -)	(- - -)	(- - -)	(- - -)

Population= 327,226 Males 18-34 Years	N= 264 Total	N= 20 A/PI	N= 73 Black	N= 165 White	N= 52 Hispanic
1	Accidents (unintentional injuries) (n= 74)	(- - -)	Accidents (Unintentional Injuries) (n=18)	Accidents (unintentional injuries) (n= 47)	Accidents (Unintentional Injuries) (n=19)
2	Intentional Self-Harm (Suicide) (n=43)	(- - -)	(- - -)	Intentional Self-Harm (suicide) (n= 30)	(- - -)
3	Assault (homicide) (n=22)	(- - -)	(- - -)	(- - -)	(- - -)
4	Malignant Neoplasms (n= 22)	(- - -)	(- - -)	(- - -)	(- - -) (- - -)
5	Diseases of Heart (n=20)	(- - -)	(- - -)	(- - -)	(- - -)

Population= 604,830 Males 35-64 Years	N= 1,798 Total	N= 153 A/PI	N= 408 Black	N= 1,219 White	N= 176 Hispanic
1	Malignant Neoplasms (n= 559)	Malignant Neoplasm (n=64)	Malignant Neoplasms (n= 116)	Malignant Neoplasms (n= 375)	Malignant Neoplasms (n= 43)
2	Diseases of Heart (n=418)	Diseases of Heart (n= 31)	Diseases of Heart (n= 97)	Diseases of Heart (n=287)	Diseases of Heart (n=35)
3	Accidents (unintentional injuries) (n= 102)	(- - -)	Diabetes Mellitus (n= 20)	Accidents (unintentional injuries) (n= 80)	Accidents (Unintentional Injuries) (n= 19)
4	Intentional Self-Harm (Suicide) (n= 85)	(- - -)	(- - -)	Intentional self-harm (suicide) (n= 71)	(- - -)
5	Diabetes Mellitus (n= 63)	(- - -)	(- - -)	Diabetes Mellitus (n= 38)	(- - -)

Leading Causes of Death By Race/Ethnicity
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Age Group and Ranking (Males Only)

Population= 172,735 Males 65+ Years	N= 5,941 Total	N= 459 A/PI	N= 708 Black	N= 4,757 White	N= 185 Hispanic
1	Diseases of Heart (n= 1,562)	Malignant Neoplasms (n= 125)	Diseases of Heart (n= 184)	Diseases of Heart (n= 1,263)	Malignant Neoplasms (n= 57)
2	Malignant Neoplasms (n=1,374)	Diseases of Heart (n= 111)	Malignant Neoplasms (n= 180)	Malignant Neoplasms (n= 1,067)	Diseases of Heart (n= 36)
3	Cerebrovascular Diseases (n= 289)	Cerebrovascular Diseases (n= 33)	Cerebrovascular Diseases (n= 34)	Cerebrovascular Diseases (n= 221)	(- - -)
4	Chronic Lower Respiratory Disease (n= 237)	(- - -)	Diabetes Mellitus (n= 30)	Chronic Lower Respiratory Diseases (n= 208)	(- - -)
5	Influenza and Pneumonia (n= 201)	(- - -)	Influenza and Pneumonia (n= 21)	Influenza and Pneumonia (n= 163)	(- - -)

Population= 1,470,818 MALES ALL AGES	N = 8,162 Total	N= 650 A/PI	N= 1,244 Black	N= 6,223 White	N= 443 Hispanic
1	Disease of Heart (n=2,003)	Malignant Neoplasm (n=193)	Malignant Neoplasm (n= 300)	Diseases of Heart (n=1,563)	Malignant Neoplasms (n=107)
2	Malignant Neoplasms (n=1,964)	Diseases of Heart (n= 144)	Diseases of Heart (n=289)	Malignants Neoplasms (n=1,463)	Diseases of Heart (n=74)
3	Accidents (Unintentional Injuries) (n=348)	Cerebrovascular Diseases (n= 39)	Accidents (Unintentional Injuries) (n=58)	Accidents (Unintentional Injuries) (n=226)	Accidents (Unintentional Injuries) (n=42)
4	Cerebrovascular Disease (n=342)	Accidents (Unintentional Injury) (n= 22)	Diabetes Mellitus (n=50)	Cerebrovascular Diseases (n= 252)	Cerebrovascular Diseases (n=26)
5	Chronic Lower Respiratory Diseases (n=257)	Influenza and Pneumonia (n= 21)	Cerebrovascular Diseases (n=49)	Chronic Lower Respiratory Disease (n=224)	Diabetes Mellitus (n=19)