Community Health Needs Assessment

Final Consolidated Report
2018

Carroll County, Maryland

1. Introduction

The first broad Health Needs Assessment for Carroll County was conducted in 1997 by a Steering Committee of 44 members, with many partners including Carroll County Government and the Carroll County Health Department. The action plan formed to address those needs after the Assessment called for a new collaborative vehicle that would facilitate the work of creating a healthier Carroll County community. The Partnership for a Healthier Carroll County, Inc. (The Partnership), was incorporated in 1999 to be that vehicle. The new organization was also established by Carroll Hospital as the entity to monitor and assess the health needs of our community on an ongoing basis.

The Partnership led a number of major and minor community health assessment projects between 1999 and 2010. When the Affordable Care Act of 2010 mandated a regular three-year community health needs assessment, The Partnership was already experienced in data collection, organization, and analysis, and well-equipped with the resources to carry out that work.

In October 2011, The Partnership Board of Directors voted unanimously to lead another CHNA for Carroll Hospital in compliance with elements of the 2010 Affordable Care Act. Also in October 2011, The Partnership's Board voted to serve as the Local Health Improvement Coalition (LHIC) for Carroll County, responsible for the development and implementation of a Local Health Improvement Plan (LHIP) that meets the requirements as proposed in the State Health Improvement Process (SHIP). In September 2012, The Partnership led a community/hospital/Health Department interactive review of all the data results from both the SHIP and the CHNA, resulting in a *Community Benefit and Health Improvement Plan*, which after approval by the governance of Carroll Hospital and The Partnership, will serve as a major part of each organization's corporate strategic plans.

Our Community Health Needs Assessment (CHNA) projects of 2012 and 2015 allowed us to determine current community health improvement priorities and create *Sharing the S.P.I.R.I.T.* - the Carroll Hospital Board-approved Community Benefit and Health Improvement Plans for FY2014-FY2016 and the most recent plan for FY2017-FY2018.

This Consolidated Report on the **Carroll County 2018 Community Health Needs Assessment** has been prepared to provide valuable information that will help to determine the direction and structure necessary to continue addressing health needs in the community. It includes methodologies specific to each component of the CHNA, a brief results summary from each component, data results, and examples of the data collection tools used. Assessment information is presented in two broad categories: 1. Primary data collected by our own staff via surveys and moderated group discussions, and 2. Secondary data acquired from credible local, state, and national organizations based on surveys and data collection that they perform.

The staff members participating in several components within the CHNA process deserve special recognition and thanks, as do their home agencies of Carroll Hospital, the Carroll County Health Department, and The Partnership. Their dedication to the process made completion of this CHNA possible. As Chairperson of the collaborative 2018 CHNA Committee, I extend my sincerest thanks to the following members of the Committee and their home organizations:

Selena Brewer	Carroll Hospital
Bonnie Higgins	Carroll Hospital
Jim Kunz	The Partnership Board of Directors
Maggie Kunz	Carroll County Health Department
Ron McDade	Carroll Hospital
Theresa Moyer	Carroll County Health Department
Mary Peloquin	Carroll Hospital
Lisa Wack	The Partnership

I would like to thank our technical consultant, Mark Helweick for development of the survey tool and McDaniel College for access to their survey platform. Finally, I want to thank The Partnership staff for their support throughout the entire process.

Dorothy L. Fox

Executive Director and CEO

2. Methodology

Organization Overview

The Partnership for a Healthier Carroll County, Inc. (The Partnership) was established in 1999 by a team of progressive leaders from Carroll Hospital and the Carroll County Health Department. The Partnership collaborates with individuals, organizations and agencies throughout Carroll County to create a healthier community. With support from community partners, this unique organization strives to improve the health of the community by organizing skilled and influential leadership and action teams, influencing policies on both the state and local levels, and promoting healthier lifestyles. The Partnership's success is derived from sharing activities and resources that help people live healthier lives.

The mission of The Partnership is to build the capacity of individuals and organizations to improve the health and quality of life in Carroll County, Maryland. The Partnership continues to work collaboratively with communities and other health organizations to serve as a resource for health promotion and education in Carroll County.

Community Overview

The Partnership for a Healthier Carroll County defined their current service area based on an analysis of the geographic area where individuals utilizing their services reside. The Partnership's service area is considered to be Carroll County, Maryland. The county is situated in the North-Central part of Maryland and encompasses a total population of approximately 167,000.

2018 Community Health Needs Assessment Overview

Beginning in July 2017, The Partnership began a comprehensive community health needs assessment (CHNA) process to evaluate the health needs of individuals living in Carroll County, Maryland to prepare for planning in 2018. The purpose of the assessment was to gather current statistics and qualitative feedback on the key health issues facing county residents. Assessment research activities examined a variety of health indicators, including chronic health conditions, access to health care, and social determinants of health.

The Partnership is committed to the people it serves and to our community where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. This CHNA Final Consolidated Report is a compilation of the overall findings of each research component in the CHNA process. The findings from the research will be utilized to prioritize public health issues and develop a community health improvement plan focused on meeting community needs. The CHNA allows The Partnership to take an in-depth look at the Carroll County community and prioritize its health needs. The final step in the CHNA process is forming an implementation plan to address those needs.

CHNA Research Components (Primary Data)

- Online Community Health Needs Survey
- Key Informant Survey
- Targeted Populations Research

CHNA Secondary Data

This CHNA Final Consolidated Report also includes extensive secondary data which expands the information available for the final prioritization and planning steps in the CHNA process. The secondary data sections are:

- Demographics
- Our Community Dashboard
- Healthy Carroll Vital Signs
- State of Maryland Health Improvement Process and Local Health Improvement Plan
- Other Data

This 2018 CHNA Consolidated Report contains data and information from the components listed above. To complete the CHNA process, the primary (research) data and secondary data in this report will be used to prioritize and plan community health improvement strategies.

CHNA Prioritization and Planning

To develop a focused and relevant community health improvement plan, the information in this report has been, and will continue to be, examined carefully. Assessment, planning and then implementation steps will occur. After a formal process of Prioritization of Needs and action planning, a final implementation plan (*Community Benefit & Health Improvement Plan*) will be written to capture specific objectives, measurements, and responsibilities.

Research Methodology

The CHNA primary research was comprised of both quantitative and qualitative research components. A brief synopsis of the research components is given below with further details provided throughout the document:

- An online Community Health Needs Survey was conducted with Carroll County residents between July and August 2017. The survey was designed to assess their health status, health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. Surveys were completed throughout the county to promote geographical and ethnic diversity among respondents.

- Key Informant Survey sessions were conducted with 78 community leaders and partners between July and August 2017. Key informants represented a variety of sectors,

including public health and medical services, non-profit and social organizations, children and youth agencies, and the business community.

- Five sessions of Targeted Populations Research were conducted in focus sessions with different community groups including African American, Latino, Older Adult, LGBT (Lesbian, Gay, Bisexual and Transgender), and a lower income population group. All sessions were scheduled between July and August 2018, with one session held in early September due to scheduling issues. Research participants were invited to complete a survey specific to their community. In addition, The Partnership led a moderated discussion with each group after completion of the online survey.

Community Representation

Community engagement and feedback are an integral part of the CHNA process. The Partnership sought community input through the online community health needs survey available to all residents, key informant interviews with community leaders and partners, and targeted populations research with minority and underserved population groups. Leaders and representatives of non-profit and community-based organizations as well as clergy and faith organization representatives gave their insights on the community, including the medically underserved, low income, and minority populations. Key partners, local experts, and community leaders, including public health professionals and health care providers, will participate in the prioritization and implementation planning process.

Research Limitations

Language barriers, timeline, and other restrictions may have impacted the ability to survey all community stakeholders. The Partnership sought to mitigate limitations by including representatives of diverse and underserved populations throughout the research components.

3. Community Health Needs Survey

A. Methodology

The Partnership for a Healthier Carroll County used a customized survey tool consisting of approximately 90 questions to assess access to health care, health status and behaviors, and health-related community strengths and opportunities. The design and main elements of the 2018 survey tool were built from The Partnership's 2012 and 2015 Community Health Needs Assessments, so that to the greatest extent possible, answers to the 2018 survey would be comparable to the previous years' assessments. Only minor changes were made to the previous survey instruments ensuring that the survey would provide timely information appropriate to the 2018 planning process while still allowing for meaningful comparisons. The survey was administered online, and was accessed via web links displayed at multiple locations. Extensive promotional activities yielded a broad convenience sampling of the Carroll County population.

The Community Health Needs Survey included a small "Direct Ask" sample of residents employing the identical survey instrument as was used with the primary Community Health Needs Survey population. The only unique aspect of the Direct Ask survey was that individuals were invited in-person to participate in the survey during community events held throughout the county. Committee members attending these events provided participants with iPads on which to complete the survey. Since the motivation and environment for completing the surveys were somewhat different in these Direct Ask situations, the results are presented separately following the primary survey results. In addition, due to the much smaller sample size, the results reported are more limited in scope in order to highlight the most salient points.

Marketing Plan

The 2018 Community Health Needs Survey was promoted through a variety of online advertising vehicles, as well as point-of-purchase displays. Using online ads that linked directly to the survey helped to ensure easier access. Anyone who took the survey was eligible to enter a drawing for one of five $50 gift cards. The survey theme for the advertising content, "Fast-Forward to a Healthier Carroll County," encouraged community members to visit HealthyCarroll.org/Survey and "tell us what you need to live healthier today and every day."

During the months of July and August 2017, geographically targeted online ads were displayed on the Carroll County Times website and The Baltimore Sun Mobile Network. It was also promoted via Carroll Hospital's and The Partnership's websites and Facebook pages along with e-mail blasts to hospital employees and community members. In addition, point-of-purchase displays were produced and distributed to community organizations including the Carroll County Public Schools Central Office, Access Carroll, Tevis Center for Wellness, the county office building, and throughout the library system.

A press release announcing the survey was distributed to local media and publications on June 28, 2017.

The online survey was designed to take approximately 15 to 20 minutes to complete. In total, 1,117 residents started the survey through the primary on-line method. However, 40 participants lived outside of a Carroll County zip code and eight participants were found to be younger than 18 years of age and were excluded from continuing with the survey. Thus, the demographic findings in this report are based on a total of 1,117 participants that started the survey and other questions are based on the number of participants that answered that question. The Direct Ask survey included 54 residents.

B. Results Summary

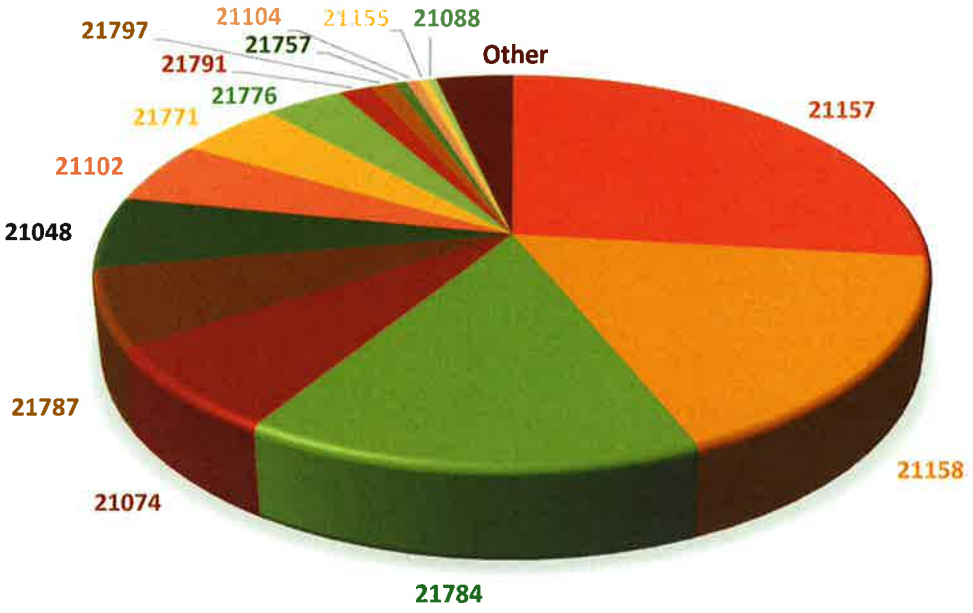
Online Survey Results Summary

The following section provides an overview of the findings from the online survey, including highlights of important health indicators and health disparities. In addition, comparisons to the 2015 and 2012 community health needs survey conducted in Carroll County are provided where applicable.

Demographic Information

The demographic profile of the respondents who started the online survey is depicted in the tables below. Approximately 59% of all respondents resided in zip codes 21157, 21158, and 21784. Of the total 1,117 respondents, 71.5% were female and 22.8% were male. Whites comprised 83.1% of study participants and Blacks/African-Americans represented 1.1%. Approximately 0.7% of all respondents identified as Latino/Hispanic. Slightly more than 41% of all respondents were between the ages of 45 and 64 years. An additional 39.7% of respondents were over the age of 65.

Zip Code	%	Zip Code	%
21157	26.9%	21776	3.7%
21158	17.0%	21791	1.5%
21784	15.0%	21797	1.1%
21074	7.2%	21757	0.6%
21787	6.3%	21104	0.6%
21048	5.9%	21155	0.4%
21102	5.2%	21088	0.4%
21771	4.8%	Other	3.58%



Demographic Information	Count	Percentage
Gender		
Male	255	22.8%
Female	799	71.5%
Identifies as other than male or female	2	0.2%
Did not answer	61	5.5%

Age		
Under 18	8	0.7%
18 - 24	23	2.1%
25 - 34	77	6.9%
35 - 44	102	9.1%
45 - 54	214	19.2%
55 - 64	250	22.4%
65 and over	260	23.3%
Did not answer	183	16.4%

Race/Ethnicity		
White	929	83.0%
Black/African American	12	1.1%
American Indian or Alaska Native	11	1.0%
Asian	6	0.5%
Native Hawaiian or Other Pacific Islander	0	0.0%
Other	11	1.0%
Did not answer	148	13.2%
Hispanic or Latino:		
Yes	8	.7%
No	957	85.7%
Don't know/Not Sure	3	.3%
Did not answer	149	13.3%

Household type was assessed. The majority of respondents (62.5%) were married. The chart below identifies the marital status indicated by all respondents. In addition, 62.1% of the respondents indicated they did not have any children under the age of 18 living in the household. The remaining data on children under 18 living in the household is identified below.

Household Composition	Count	Percentage
Marital Status		
Married	698	62.5%
Divorced	108	9.7%
Never married	76	6.8%
Widowed	46	4.1%
A member of an unmarried couple	23	2.1%
Separated	7	0.6%
Did not answer	159	14.2%

Number of Children Less Than 18 Years in Household		
None	694	62.1%
1 - 2	219	19.6%
3 – 4	44	4%
5 – 6	1	0.08%
Preferred not to answer	8	0.7%
Did not answer	151	13.5%

The socioeconomic status of respondents, including education, employment, and income, was also assessed. The largest percentage of respondents, 48.6%, were college graduates and 25.2% attended some college or technical school. The majority of respondents (55.9%) were currently employed for wages or self-employed and only 0.8% were out of work. About half of respondents (50%) had an annual household income of $50,000 or more. However, 31.4% of the respondents chose not to answer. Almost 7% of respondents had an income less than $25,000.

Socioeconomic Information	Count	Percentage
Level of Education		
Never attended school or only attended kindergarten	0	0.0%
Grades 1-8 (Elementary School)	2	0.2%
Grades 9-11 (Some high school)	6	0.5%
Grade 12 or GED	130	11.6%
College 1 year to 3 years (Some college or technical school)	281	25.2%
College 4 years or more (College graduate)	543	48.6%
Did not answer	155	13.9%

Employment Status		
Employed for wages	585	52.4%
Self-employed	39	3.5%
Out of work for more than 1 year	5	0.4%
Out of work for less than 1 year	4	0.4%
A homemaker	50	4.5%

A student	15	1.3%
Retired	253	22.6%
Unable to work	14	1.3%
Prefer not to answer	5	0.4%
Did not answer	147	13.2%
Annual Household Income from All Sources		
Less than $10,000	11	1.0%
$10,000-$14,999	18	1.6%
$15,000-$19,999	16	1.4%
$20,000-$24,999	30	2.7%
$25,000-$34,999	48	4.3%
$35,000-$49,999	68	6.1%
$50,000-$74,999	150	13.4%
$75,000 and more	409	36.7%
Don't know/Not sure	18	1.6%
Prefer not to answer	205	18.4%
Did not answer	144	13.0%

Respondents were also asked to identify if they served on active duty in the United States Armed Forces. As seen in the following chart, less than 7% of respondents have served or are currently serving as active duty military members and 26.9% of these individuals have served in a combat or war zone.

United States Armed Forces Service Status	Count	Percentage
Active Duty Service		
Yes	67	7.0%
No	902	93.0%

Did you ever serve in a combat or war zone?		
Yes	18	26.9%
No	48	71.6%
Don't know/Not sure	1	1.5%

In comparison to the Carroll County population, there was a much higher percentage of women completing the survey than men. The percentages related to race and age were more comparable to the county, with a majority of respondents indicating White/Caucasian, and more residents 45 years of age or older, than those younger than 45. Other demographic variables cannot be compared accurately due to the number of respondents choosing not to answer. Demographic data for Carroll County can be found in Section 7 of this report.

Access to Health Care

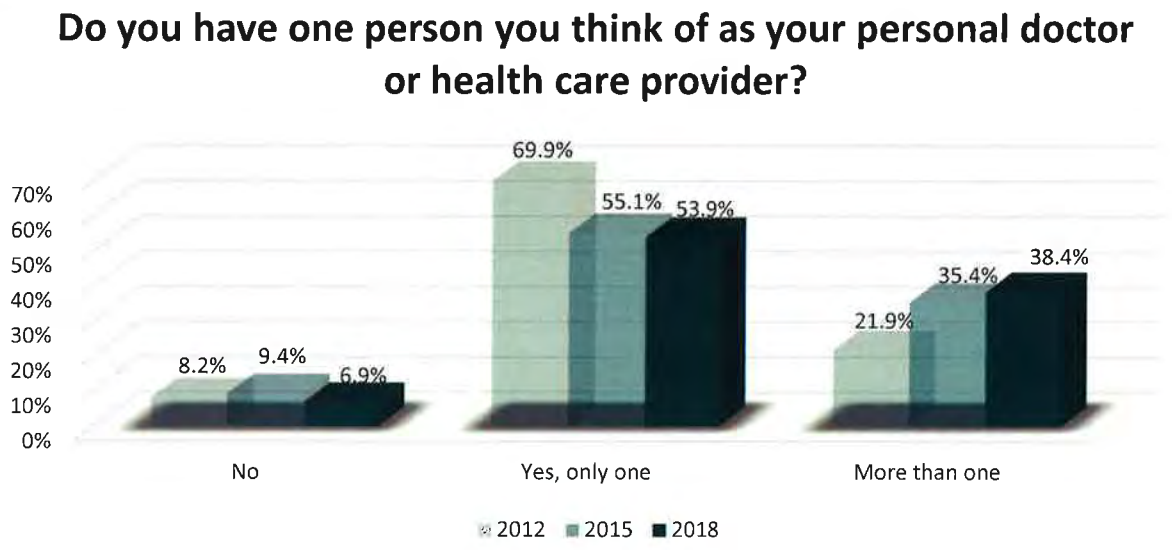
Health Insurance and Resources

New to the survey in 2018 is a question regarding health insurance and a question regarding where people got their health information/education. The majority of respondents (98.6%) do have health insurance. The following chart indicates the resources used by respondents to get health information/education. *Respondents could select all that applied.

Where do you go to get health information and/or education?	Percent of Respondents Who Selected the Measure*
Your physician/healthcare provider	76.4%
Online websites	73.9%
Family/Friends	35.7%
Local providers/organizations/resources	28.6%
Local sources (i.e. hospital, health department)	28.0%
National sources	23.3%
Health blogs	16.1%
Television	11.1%

Primary Care

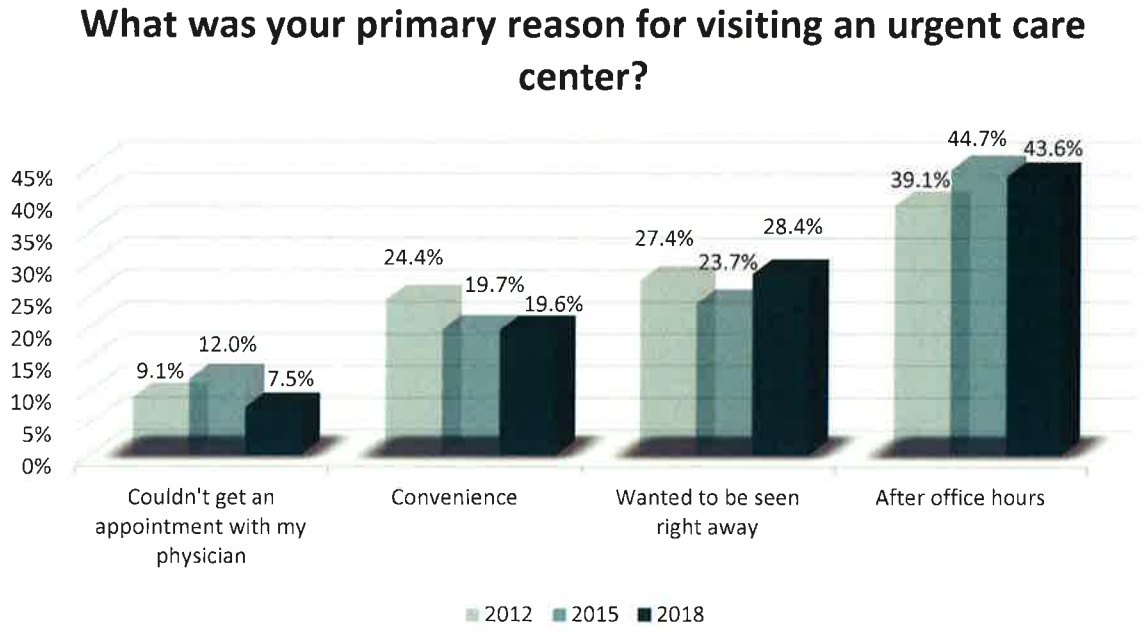
A majority of the respondents (53.9%) have at least one person whom they think of as their personal doctor or health care provider and only 6.9% of respondents reported not having a personal health care provider. There has been growth in the percentage of respondents with more than one health care provider.



Access to care was further assessed by the number of respondents who were inhibited from taking medicine due to cost and the number of respondents who were able to access a primary care physician when they needed one. Fewer than 7% of the respondents reported they stopped taking their medicine in the past year due to cost which shows a continuous decrease in this area. In addition, 93.5% of respondents reported that they can get an appointment with their primary care physician when they need one, which has been consistent over the years.

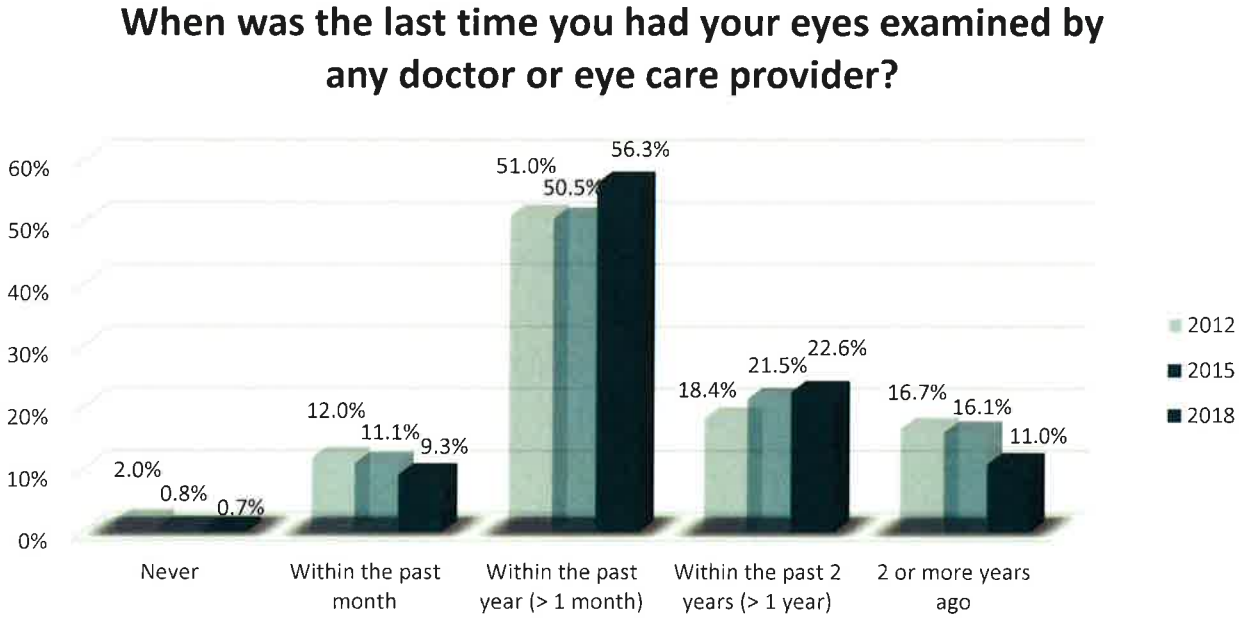
Urgent Care

Approximately 33.7% of participants reported visiting an urgent care center in the past 12 months. The need for after office hours and convenience remain consistent reasons for visiting an urgent care center. Since 2015, more people are reporting wanting to be seen right away as the reason, while fewer people are reporting not being able to get an appointment with their physician as the reason.



Eye Care

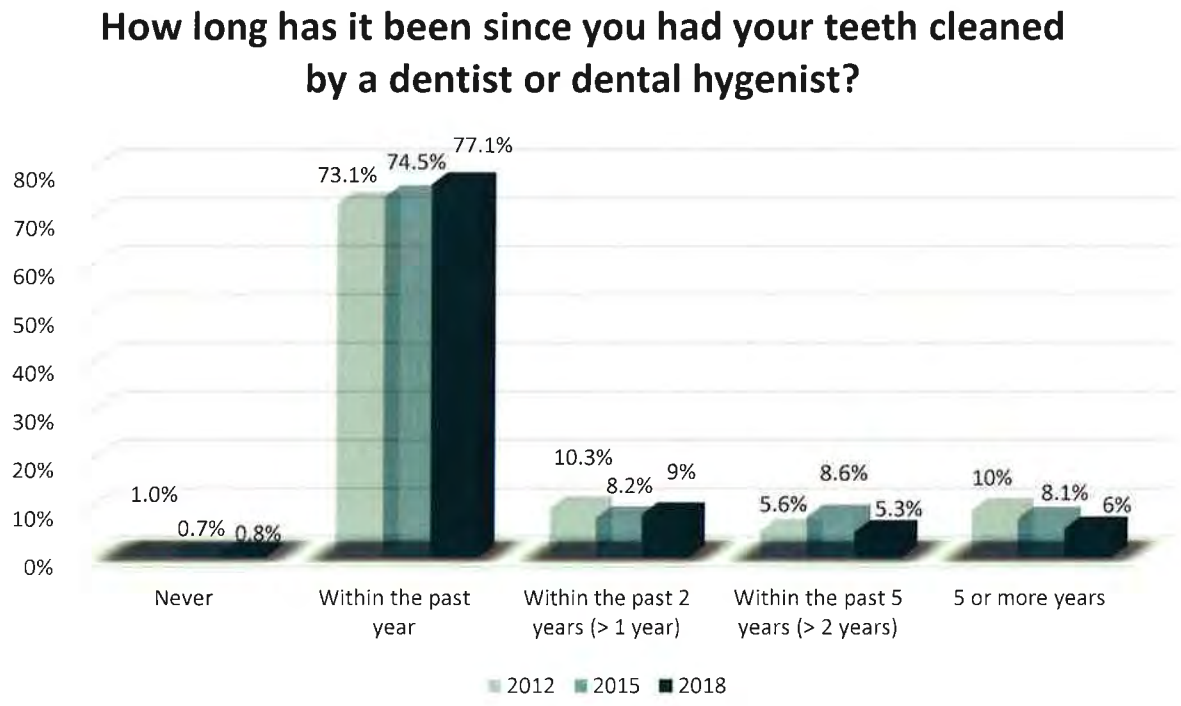
Respondents were first asked to indicate the last time they had their eyes examined by a doctor or eye care provider. Nearly 66% of all respondents reported having their eyes examined within the past year. The second chart indicates the reasons for which respondents did not visit an eye care provider within the past 12 months. The primary reason chosen for not having their eyes examined has consistently been that there was no reason for the respondent to go. Since 2015, there has been a decline in the number of people who do not have their eyes examined due to cost or insurance.



Reason for not visiting an eye care professional in the past 12 months	2018	2015	2012
No reason to go (no problem)	47.8%	45.0%	55.0%
Cost/Insurance	19.8%	26.1%	20.8%
Other	15.8%	15.4%	14.1%
Have not thought of it	10.3%	9.4%	4.6%
Do not have/know an eye doctor	1.2%	1.9%	1.3%
Could not get an appointment	0.8%	1.3%	1.7%
Cannot get to the office/clinic (too far away, no transportation)	0.4%	0.9%	2.5%

Dental & Oral Health Care

The survey asked respondents when they last had their teeth cleaned by a dentist or hygienist. The majority of respondents (77.1%) had their teeth cleaned within the past year. The trend of visiting a dentist or hygienist is continuing to improve over the years.



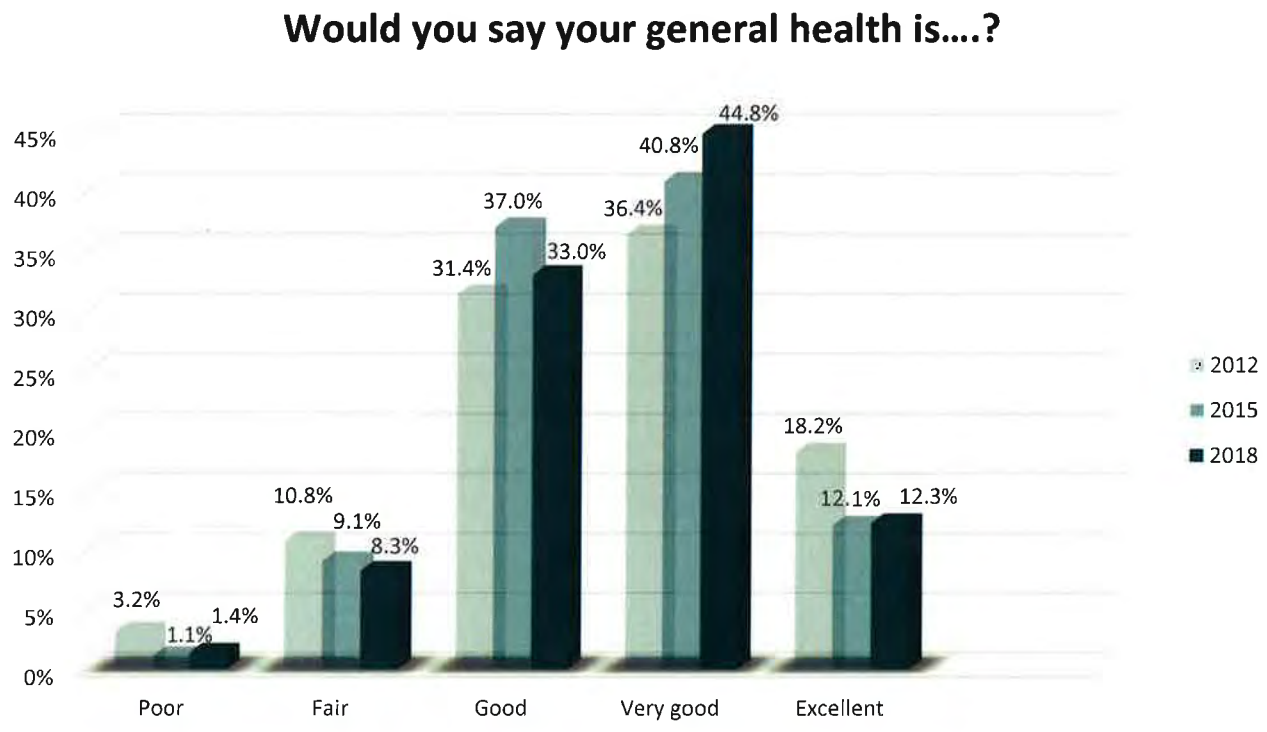
Child Health Care

If respondents indicated there were one or more children under the age of 18 in the household, they were asked if they had regular wellness visits with a medical doctor and dental checkups. The vast majority of participants reported that their child/children have regular wellness visits with a medical doctor and have dental checkups at least once per year (91.5% and 90.7% respectively). The findings are showing a slight decline in the number of children getting wellness exams, but the number of children getting dental exams is consistent with 2012 and 2015.

Health Status: Physical & Mental

Overall Health Status

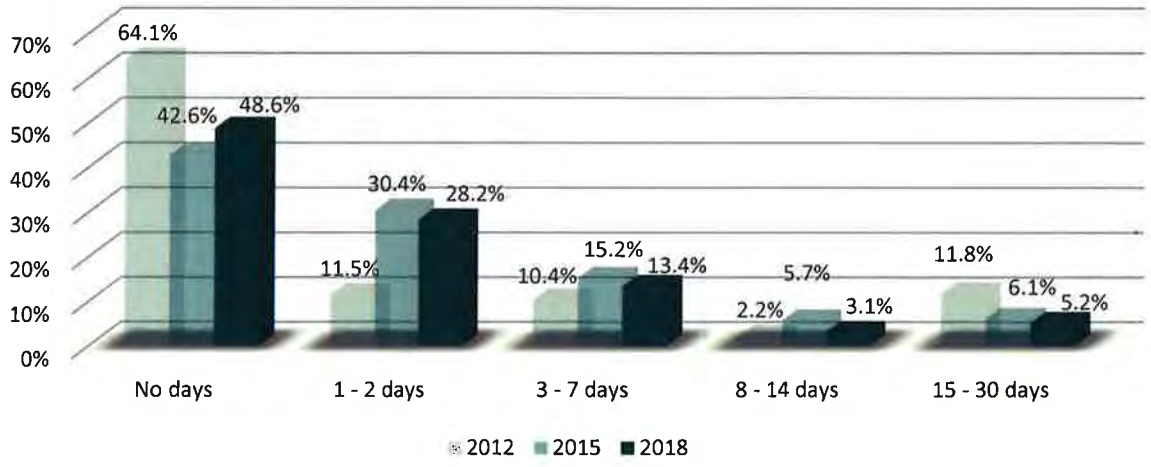
Respondents were asked to rate their overall health, including both physical and mental health. In general, self-reported measures of health are favorable among respondents. Approximately 57% of respondents reported having very good or excellent overall health. While responses of excellent have remained consistent from 2015, the percentage of respondents indicating very good health continues to increase each year. See the following chart for all responses.



Physical & Mental Health Status

Approximately 49% of respondents reported not suffering from physical illness or injury during the past 30 days. This chart is showing a positive trend in respondents' physical health. There continues to be a decline in the number of respondents reporting poor health on one to 30 days and more respondents reporting that they are not experiencing any days of poor physical health.

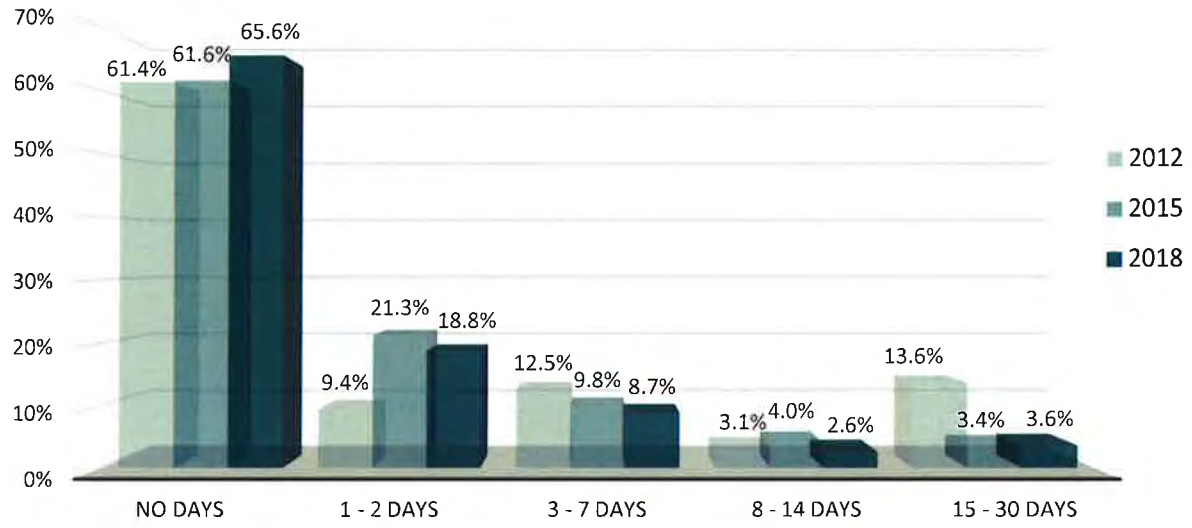
Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?



Performance of Usual Activities

Respondents were asked how often during the past 30 days they were not able to perform their usual activities, such as self-care, work, or recreation due to poor physical or mental health. The majority of respondents (65.6%) reported that they did not have any problems carrying out their usual activities due to poor health, which shows consistent improvement from 2012 and 2015. In addition, all responses indicating days of poor health showed a slight decline or a leveling off from 2012 and 2015.

During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?



Mental Health

Respondents were asked if a health care provider ever told them they had an anxiety disorder, such as, acute stress disorder, anxiety, generalized anxiety disorder, or obsessive-compulsive disorder and 18.7% of the respondents reported that they had or have an anxiety disorder. Respondents that reported they had missed one or more days of work in the last 30 days due to poor physical or mental health were then asked if they were currently receiving treatment from a health care provider for any mental health condition or emotional problem and 38.6% reported that they were receiving treatment. The trend is showing a decline in the number of respondents being diagnosed with an anxiety disorder, but a slight increase in those receiving treatment for a mental health condition or emotional problem.

Veteran's Health

Respondents were asked if they served on active duty in the United States Armed Forces and if their duty involved serving in a combat or war zone. Among the 67 respondents who served in a combat or war zone, 22%, or four respondents, have been diagnosed with depression, anxiety, or post-traumatic stress disorder (PTSD). This is consistent with both 2012 and 2015.

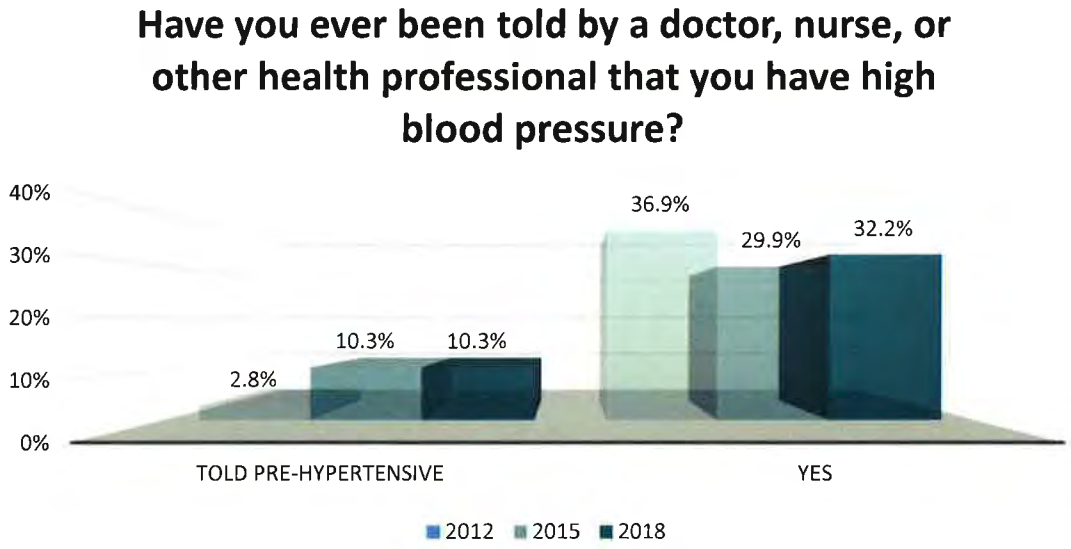
Cognitive Impairment

The early detection of cognitive impairment, such as dementia, is critical for treatment and long-term planning. With this in mind, the survey asked if respondents experienced confusion or memory loss in the past 12 months that is happening more often or is getting worse. While the vast majority of respondents (85.5%) indicated that they did not experience confusion or memory loss, 9.4% reported having these symptoms.

Chronic Health Issues

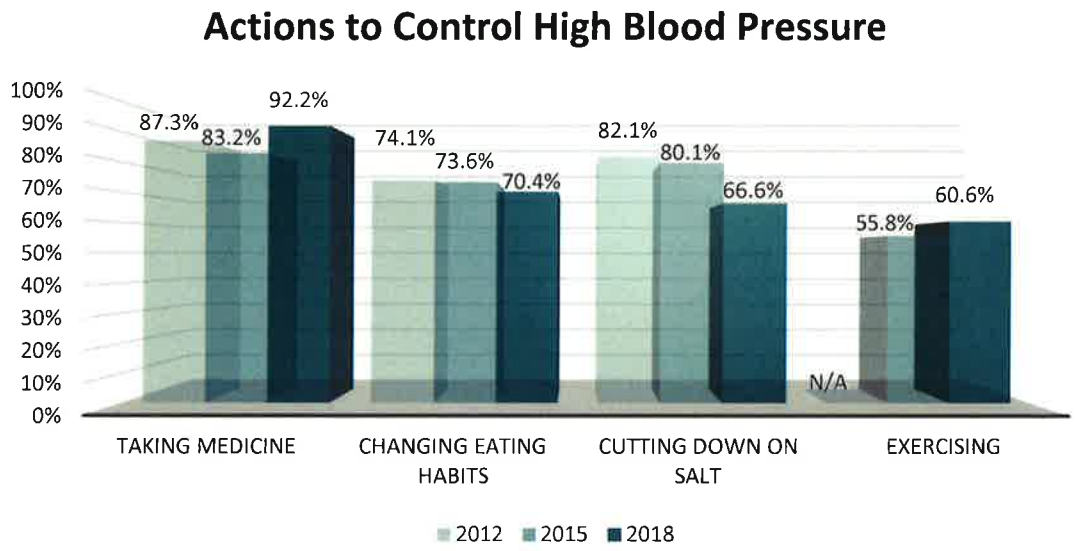
High Blood Pressure & Cholesterol

Slightly more than 32% of respondents have been told by a doctor or health care professional that they have high blood pressure and another 10.3% have been told that they are borderline high or pre-hypertensive. There is a slight increase in the percentage of respondents with high blood pressure since the last survey, but the percentage of those with pre-hypertension remains consistent with 2015; however, the percentage for pre-hypertensive had a large increase from 2012.



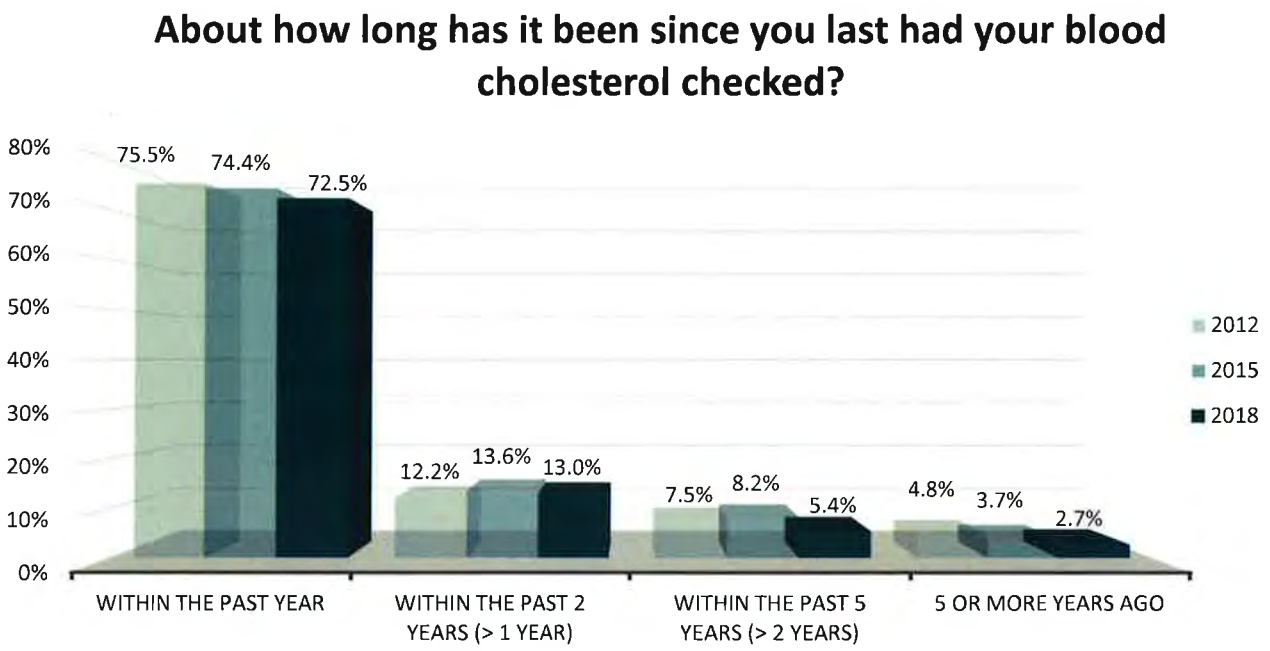
Respondents who reported having high blood pressure were asked to report on the actions they are taking to control their condition. The largest percentage of respondents indicated they were taking medicine and this is an increase from last time. However, fewer respondents are making lifestyle changes such as changing their eating habits and cutting down on salt. A positive trend is seen with respondents exercising more to control high blood pressure. The table below provides details on all actions for this year and past years.

Actions to Control High Blood Pressure	2018	2015	2012
Taking medicine	92.2%	83.2%	87.3%
Changing eating habits	70.4%	73.6%	74.1%
Cutting down on salt	66.6%	80.1%	82.1%
Exercising	60.6%	55.8%	N/A



Cholesterol

Respondents were asked how long it has been since they had their blood cholesterol checked. Approximately 73% of respondents had their cholesterol levels checked within the past year and 13% of respondents had their cholesterol levels checked within the past two years. The combined percentage of 86% is comparable to the 2015 and 2012 percentages of 88% and 87.7% respectively. In 2018, respondents who said that they had ever had their cholesterol checked were asked if they had been informed in the past that they had high cholesterol. 43.5% had indeed been informed in the past that they had high cholesterol and 61.5% of those who had been diagnosed with high cholesterol were currently on medication for high cholesterol. These are new statistics for 2018.



Heart Disease

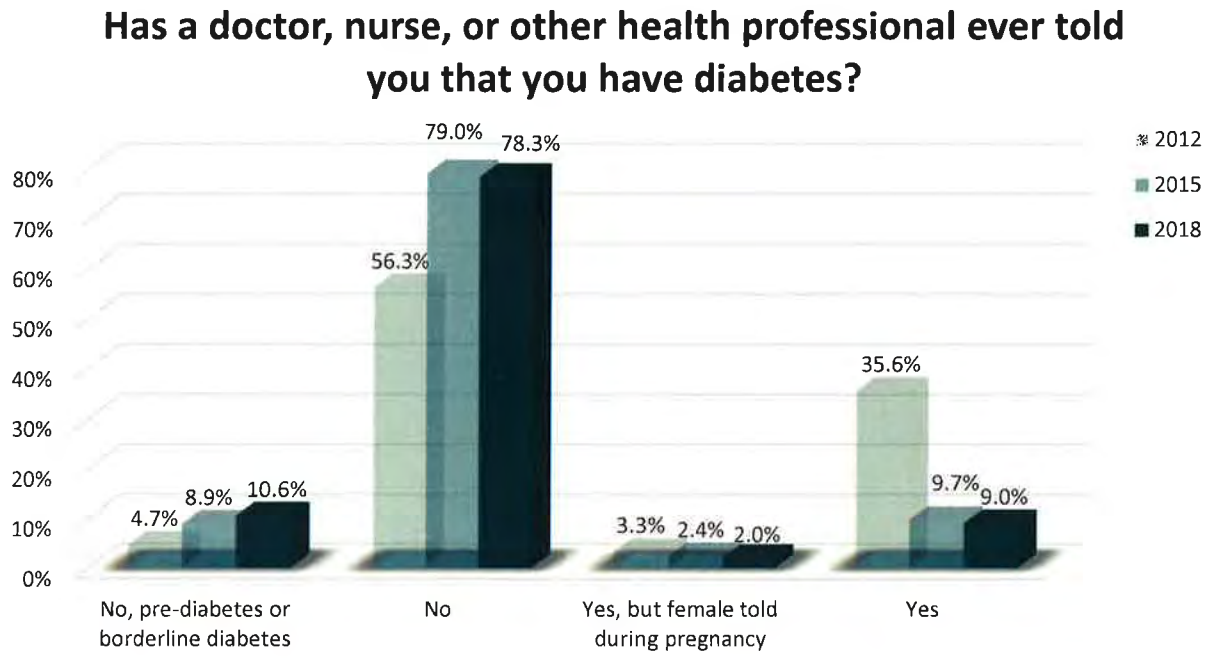
Respondents were asked if they have ever been diagnosed with a number of chronic conditions, including heart disease. The findings for heart disease are positive as 3.9% or fewer respondents reported being diagnosed with a heart attack, coronary heart disease, stroke, and/or congestive heart failure. A new follow-up survey question in 2018 asked respondents if they had ever had a stent or bypass and 3.3% responded that they had. A summary of heart disease diagnoses among respondents, compared to 2015 and 2012, is reported below.

Chronic Condition	2018	2015	2012
Myocardial infarction (Heart attack)	2.7%	2.0%	8.2%
Coronary heart disease/Angina	3.9%	3.2%	5.8%
Stroke	2.1%	1.3%	3.9%
Congestive heart failure	1.0%	0.5%	N/A

Diabetes

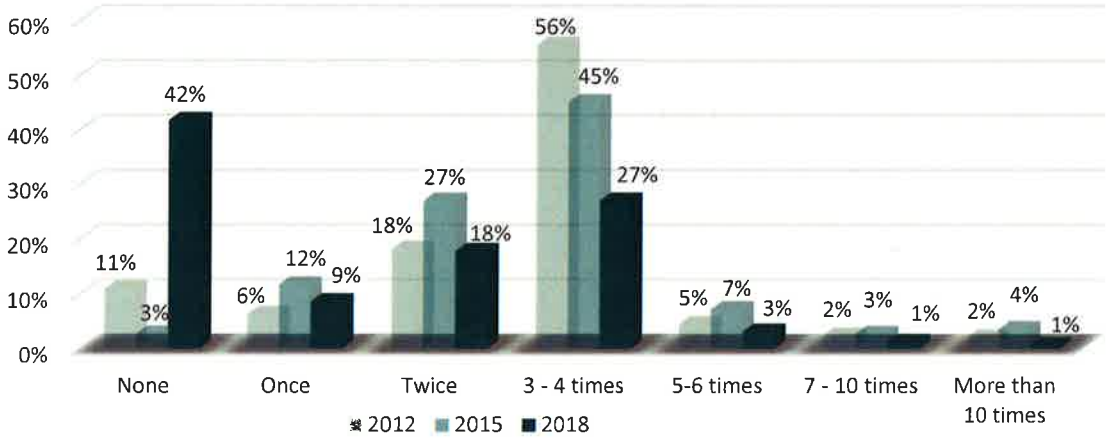
Diabetes is a serious disease that can be managed through appropriate use of medications, physical activity, and diet. Research indicates that the incidence and prevalence rates of diabetes in the U.S. are increasing. Slightly more than 9% of all survey respondents reported having been diagnosed with

diabetes and 2% of female respondents reported having been diagnosed with gestational diabetes during pregnancy. Another 10.6% of participants were told they have pre-diabetes or borderline diabetes. Another follow-up question added in 2018 asked respondents who were diagnosed with diabetes if they were taking statins and 37% of those respondents reported that they had taken a statin in the last three months. The results, as they compare to 2015 and 2012, are reported below.

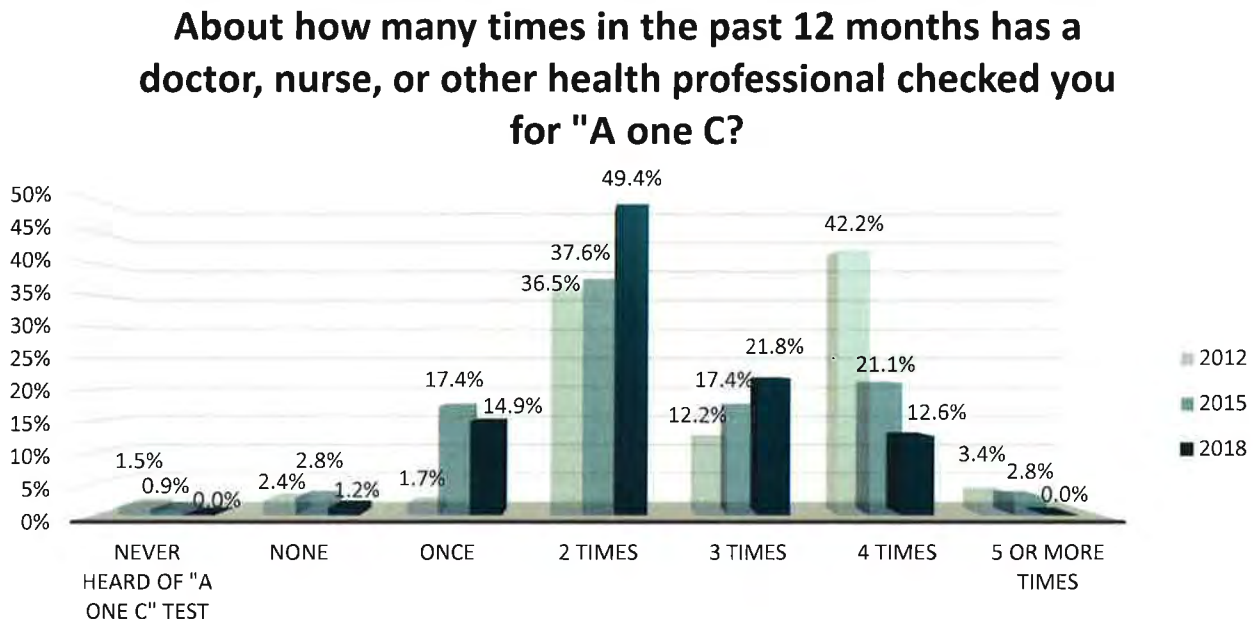


When asked how often they see a provider for their diabetes, 41.7%, reported not seeing their health care provider in the last 12 months. Only 26.4% reported seeing their health care provider once or twice in the past 12 months. In comparison to 2012 and 2015, a much higher percentage of people with diabetes did not see a health professional at all.

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



An A1C or "A one C" lab test measures the average level of blood sugar over a three-month period of time. Survey respondents with diabetes were asked how many times their doctor checked them for an A1C test in the past twelve months. The most common response, with almost half of all respondents, was 2 times in the past year. See the following table for an illustration of all responses.



Diabetes education helps individuals with diabetes learn how to manage their disease and practice healthy behaviors, such as eating healthy, being physically active, and monitoring blood sugar levels. Of those respondents who reported being diagnosed with diabetes, slightly greater than half of the respondents indicated having taken a diabetes training course on how to self-manage their disease which is consistent with the last survey.

Other Chronic Conditions

Respondents were also asked to report on conditions like arthritis, asthma, cancer, and chronic obstructive pulmonary disease (COPD). Arthritis and asthma are the most diagnosed conditions of the respondents of the survey. Approximately 39% of respondents have been told they have arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia and approximately 15% of respondents have been told they have asthma which is consistent with past results. A summary of diagnoses among respondents, compared to 2015 and 2012, is reported below.

Chronic Condition	2018	2015	2012
Arthritis, Rheumatoid Arthritis, Gout, Lupus, or Fibromyalgia	38.7%	35.2%	37.1%
Asthma	15.1%	16.8%	17.4%
COPD	3.0%	3.5%	7.1%
Skin cancer	10.7%	6.4%	7.6%
All other types of cancer	11.0%	9.0%	8.5%

Chronic Condition Management

Respondents who reported having one or more of the above chronic conditions were asked what resources they needed to manage these conditions. On prior surveys, respondents were not given the option to indicate "none" as a resource needed. A majority of the participants (62.5%) expressed that they did not need any help in managing these conditions. A summary of the types of help they do need are listed below for both 2018 and 2015.

Resource for Managing Condition	2018	2015
Help understanding all the directions from the doctors	7.7%	28.2%
Prescription assistance	8.6%	20.3%
Health care in my home and keeping appointments with my doctor (** These were combined in 2015)	6.2% (4.1% were health care in my home and 2.1% were keeping appointments with my doctor)	4.3%*
Transportation assistance	3.8%	2.5%
Help locating resources	11%	40.4%
None	62.5%	NA

Dietary Behaviors and Physical Exercise

Dietary Behaviors

Respondents were asked about their consumption of fruits and vegetables in the past 30 days. The majority of respondents (74%) reported eating fruits and/or vegetables more than seven times per week.

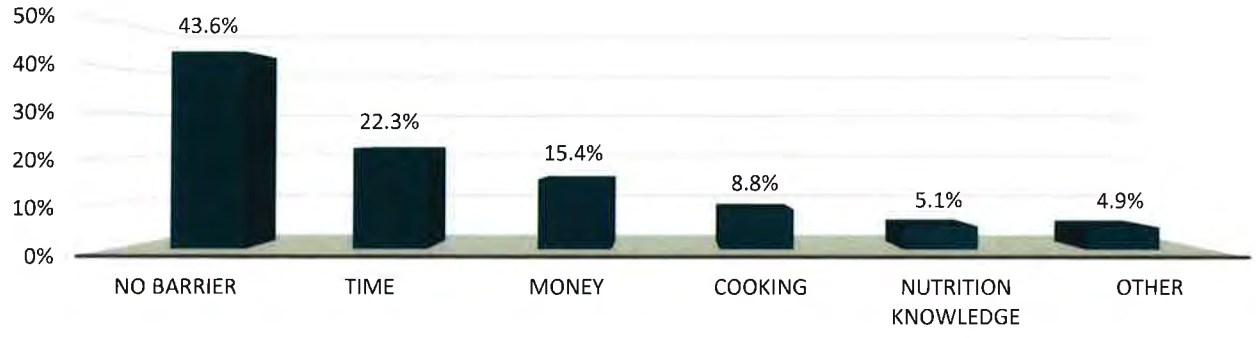
Respondents were asked the number of times per week their family eats fast or take-out food. Approximately 40% of participants reported eating fast or take-out food once per week and 29% reported eating fast or take-out food two to six times per week. The percentage of respondents eating fast or take-out food has remained consistent from the last two reports.

"Fast" or "Take-Out" Food Consumption	2018	2015	2012
Once per week	40.4%	45.0%	45.1%
2 to 6 times per week	29.3%	28.0%	23.3%
More than 6 times per week	1.2%	0.6%	0.8%
Never	29.1%	26.5%	30.8%

Respondents were also asked about their consumption of sugar-sweetened beverages such as Kool-Aid and soda. Almost half of the participants (47%) reported never drinking sugar-sweetened beverages. In 2015, there were fewer people who never drank these beverages at 35.3%. Of those that reported drinking sugar-sweetened beverages, 19.2% reported drinking these once per week.

When asked about barriers to healthy eating, "No Barrier" was mentioned by nearly 44% of respondents. (The option to select "No Barrier" was added this year). Of those that did indicate a barrier, time still had the largest percentage of responses with 22.3% of respondents indicating this was a barrier. Money and cooking skills ranked the next highest with 15.4% and 8.8% respectively. In addition, respondents were asked through an open-ended question to specify other barriers they may be facing. Cravings, emotional eating, laziness/tired, and picky eater were most frequently mentioned.

If any, what are your barriers to healthy eating?

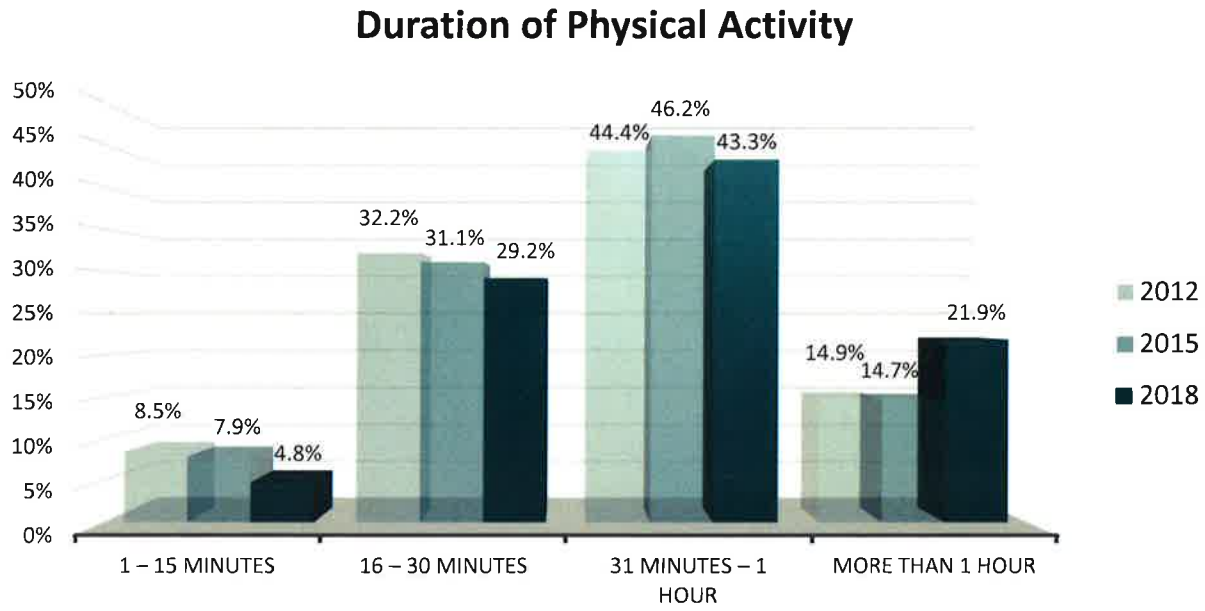


Physical Exercise

Approximately 82% of respondents reported that they participated in leisure time physical activity during the past month which has increased since 2015.

Among respondents who participated in physical activity, the largest percentage of respondents (43.4%) indicated they exercise between 31 and 60 minutes. However, the most significant change from last time was with those that indicated they exercised for more than an hour. The following charts provide these figures.

Duration of Physical Activity	2018	2015	2012
1 – 15 minutes	4.8%	7.9%	8.5%
16 – 30 minutes	29.2%	31.1%	32.2%
31 minutes – 1 hour	43.3%	46.2%	44.4%
More than 1 hour	21.9%	14.7%	14.9%

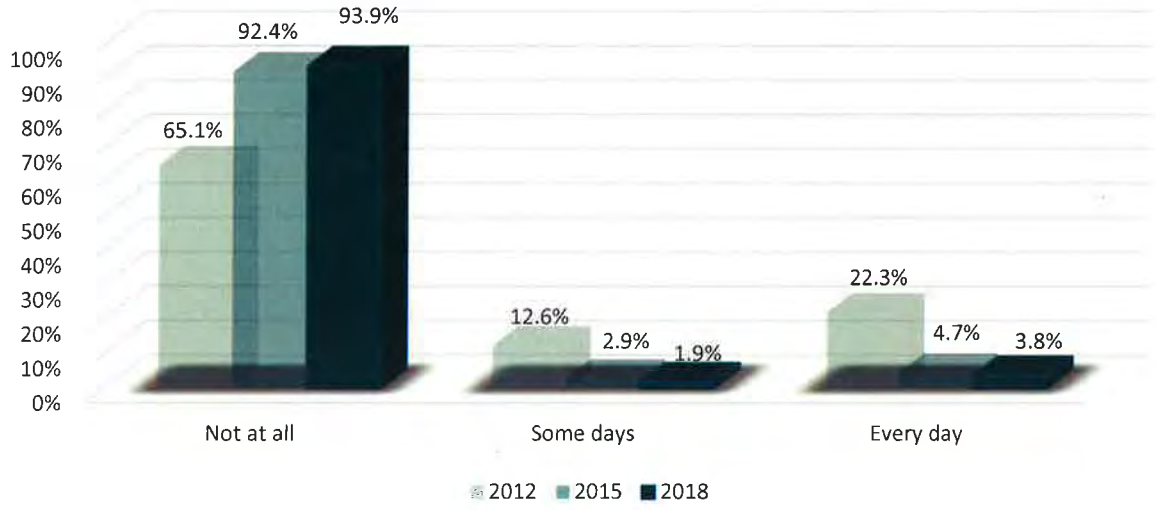


Health Risk Factors

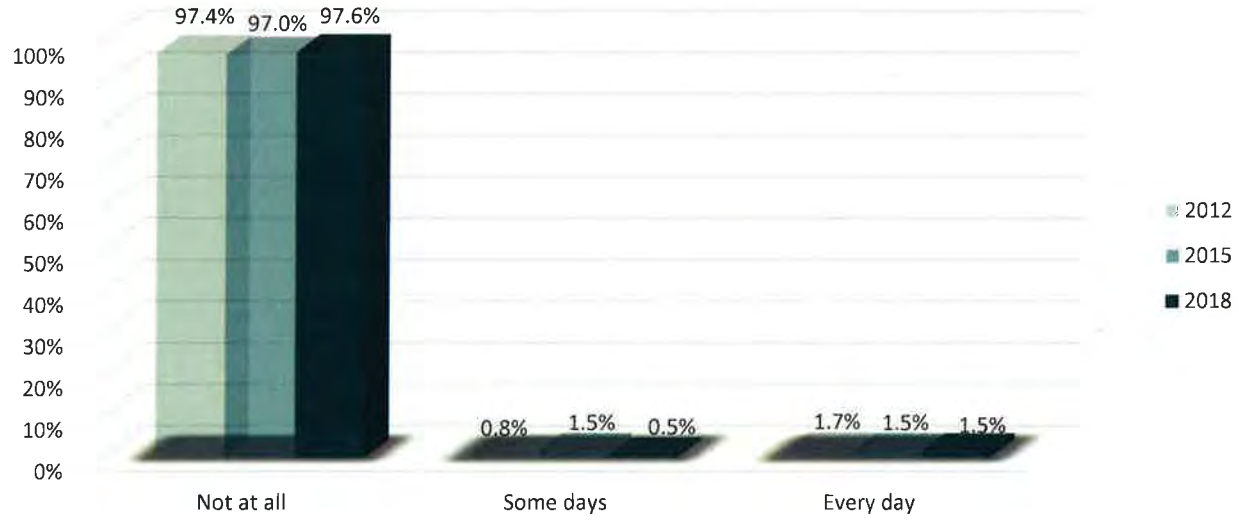
Tobacco Use and Exposure to Second Hand Smoke

Risky behaviors related to tobacco use and involuntary exposure to second hand smoke were measured as part of the survey. The vast majority of respondents reported that they currently do not smoke cigarettes (93.9%) nor use smokeless tobacco such as chewing tobacco, snuff, e-cigarettes or snus (97.6%). The number of respondents reporting using some form of tobacco continues to decrease from year to year. Responses are shown in the following tables.

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



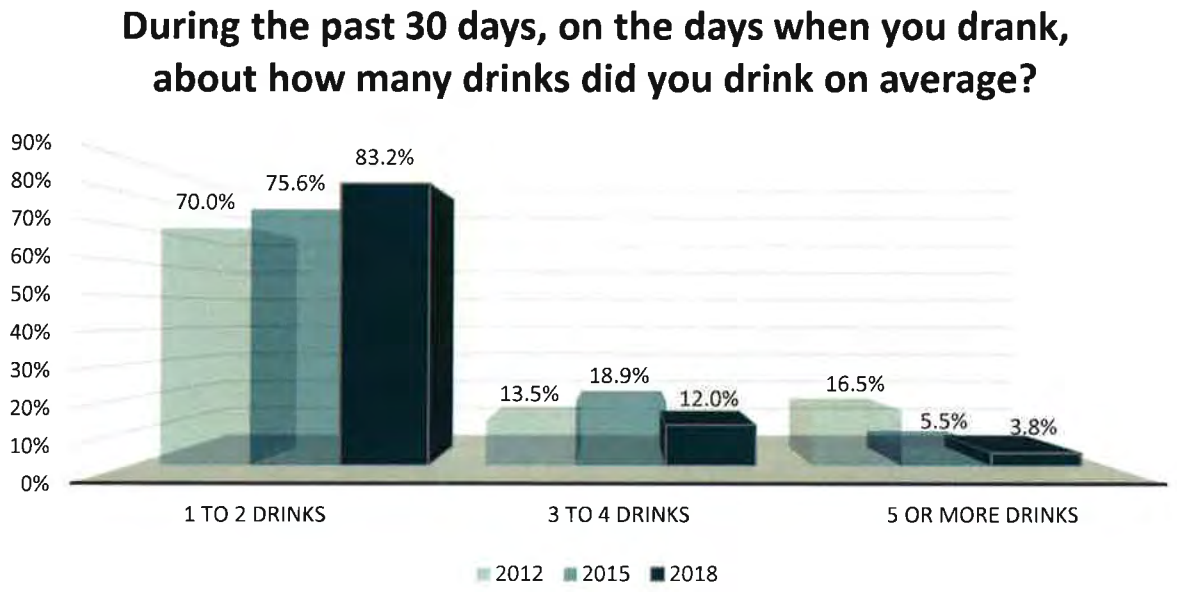
Do you currently use chewing tobacco, snuff, e-cig vaping, or snus every day, some days, or not at all?



Regarding exposure to second hand smoke in the past seven days, 95.8% of respondents reported that they did not have someone smoke tobacco inside their home and 95.1% reported that they did not ride in a vehicle with someone who was smoking. The findings compared to 2015 indicate that fewer respondents are allowing people to smoke in their homes or vehicles.

Alcohol Consumption

In 2018, 34.6% of respondents did not have an alcoholic beverage in the past 30 days. This is a small decrease in the percentage of people abstaining from alcohol compared to 2015, when 39.2% of respondents did not have an alcoholic beverage. Of those who drank alcohol in the past 30 days, 54% of the respondents indicated having a drink on 5 or more days. The majority (83%) of those who drank alcohol, consumed one to two drinks on the days they drank. A higher percentage of respondents in 2018 reported consuming one to two drinks on one occasion, and a lower percentage reported consuming 3 or more drinks.



Substance Abuse

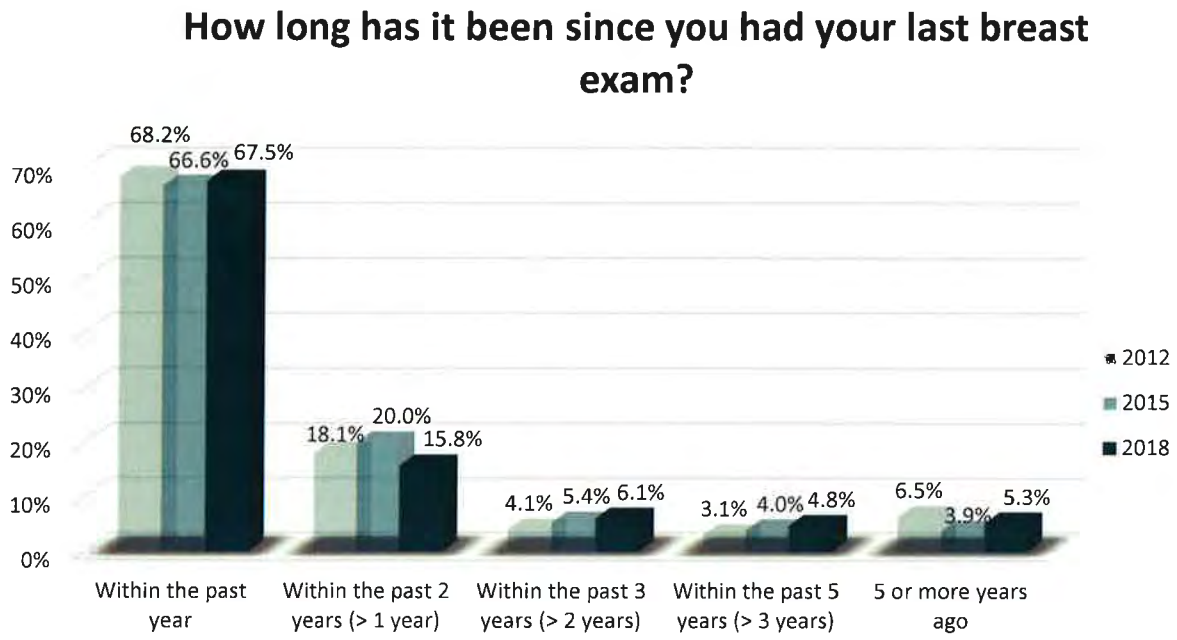
Added in 2018, in addition to alcohol consumption, respondents were also asked if they had used opioids that were not prescribed to them in the last 3 month and if they have a family member or friend that has misused opioids in the last 3 months. Slightly more than 99% of the respondents answered that they had not personally used opioids that were not prescribed to them and 91.5% responded that they did not have a family member or friend who misused opioids within the last 3 months.

Preventive Health Practices

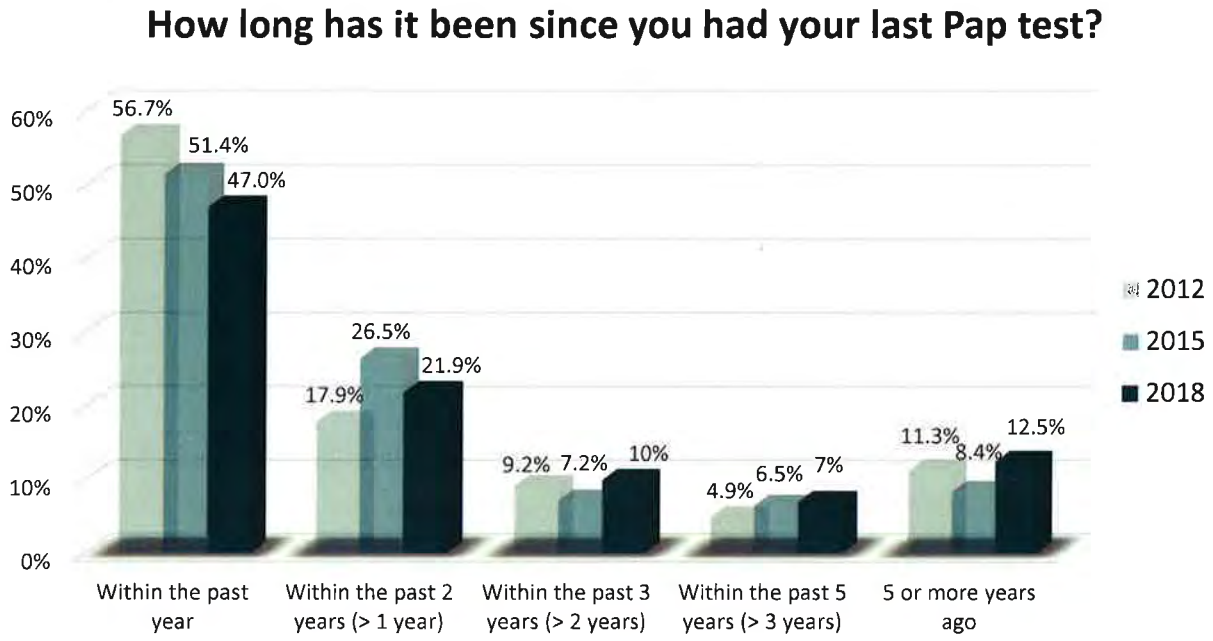
Female Breast & Cervical Cancer Screenings

A clinical breast exam is when a doctor, nurse, or other health professional feels the breasts for lumps. Female respondents were asked if they have ever had a clinical breast exam and if so, when they

received their last exam. Nearly all female respondents (93.9%) received at least one clinical breast exam within the last five years. In addition, 83.3% of respondents received the exam within the past one to two years. The following chart further depicts 2018, 2015, and 2012 survey differences.



A Pap test is a test for cancer of the cervix. Female respondents were asked if they have ever had a Pap test and if so, when they received their last exam. Nearly all female respondents (95.6%) have received at least one Pap test. In addition, 68.9% of respondents received the exam within the past one to two years. There has been a steady decline in the number of respondents getting yearly Pap tests since 2012. Recent changes in recommended screening timeframes may impact these rates. The following chart further depicts 2018, 2015 and 2012 survey differences.



Colon Cancer Screening

Respondents aged 49 years and over were asked if they had ever had a colon cancer screening. More than 79% of the respondents have had a colon cancer screening.

Male Prostate Cancer Screening

Male survey respondents aged 40 years and over were asked if they have ever had a discussion with their health care provider regarding the benefits and risks of prostate cancer screening. Nearly 80% of respondents reported having this discussion. This is a small increase from 2015 when 70% reported having this discussion, and in 2012 when it was 73.9%.

HIV/AIDS Testing

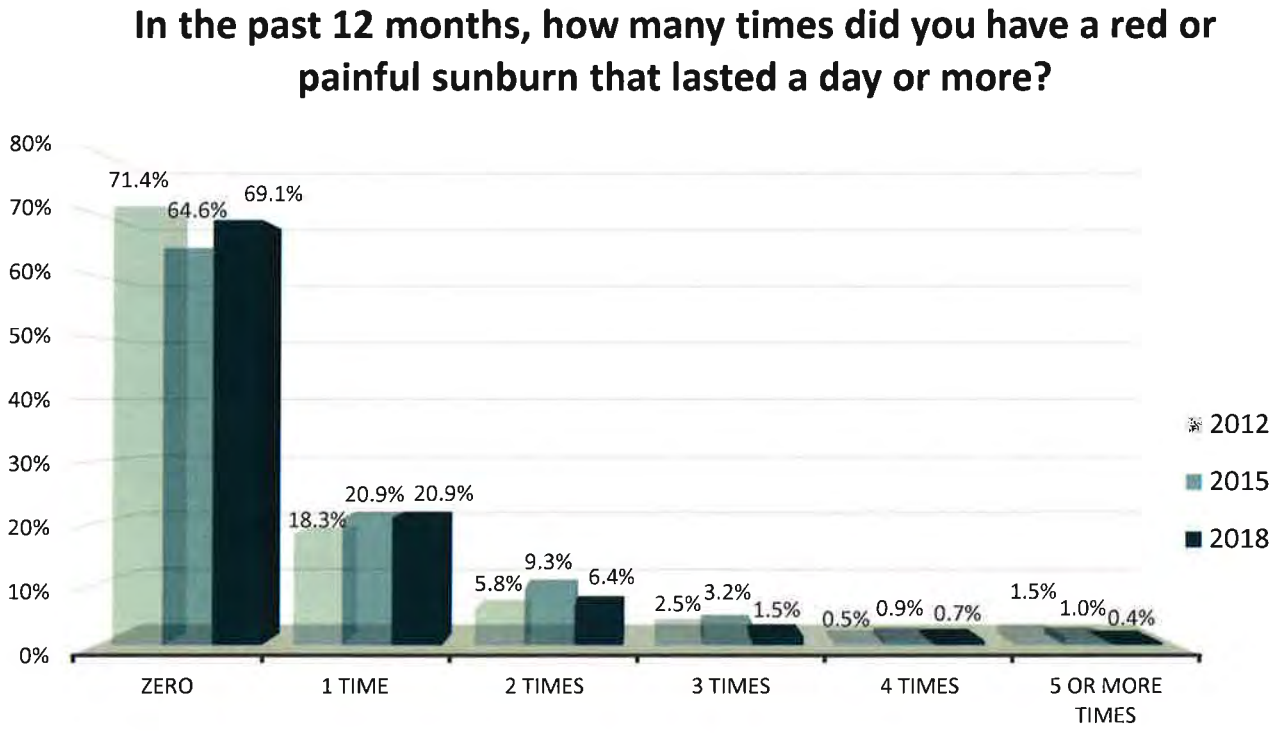
Knowing ones HIV status is key to preventing the spread of HIV and accessing appropriate counseling and medical care. The majority of respondents (60.5%) reported that they have never been tested for HIV. This is a slight decrease from 2015 (63.2%) and 2012 (66.5%).

Seasonal Flu Vaccine

Participants were asked if they had either a seasonal flu shot or a seasonal flu vaccine sprayed in their nose in the past 12 months. Approximately 73% of respondents reported having had a flu shot or vaccine in the past year. A positive trend is continuing as in 2012 only 49.3% of respondents had a flu shot and in 2015, 69% reporting doing so.

Sun Exposure

It is well documented that excess sun exposure increases one's risk of skin cancer. Participants were asked how many times they had red or painful sunburn in the past 12 months that lasted a day or more. More than half of the respondents, 69.1%, did not have sunburn in the past 12 months. The percentage of respondents experiencing at least one sunburn in the past 12 months has remained fairly consistent since 2012.



The results are showing that the majority of participants are taking the same protective measures against the sun as they were in previous years. In 2018, 80.6% wore sunglasses and 78.2% used a sunscreen with an SPF of 15. Of the 28 individuals who selected "other" as their response the most frequently used measure was to stay out of the sun. The following table shows the breakdown of the percent of respondents who selected each protective method. *Percentages are based on participants choosing as many answers as apply.

Rank	Protective Measure	Count	Percent of Respondents Who Selected the Measure*
1	Sunglasses	790	80.6%
2	Sunscreen with an SPF of 15 or higher	767	78.2%
3	Wide brimmed hat	395	40.3%
4	Lip balm with an SPF of 15 or higher	388	39.6%
5	Avoiding peak hours of 10 am and 4 pm	280	28.5%
6	Sun protective clothing	255	26.0%
7	Avoiding artificial UV light	242	24.7%
8	None	50	5.1%
9	Other	28	2.9%

Social Issues

Violence

Respondents were asked if they have ever been physically abused by another member of the household or have ever been a victim of a violent crime in the community. Over 90% of all respondents confirmed they have never been physically abused by another member of the household and 89% indicated they were not a victim of a violent crime.

End of Life Planning

Approximately 50% of respondents indicated that they have a living will or advance directive. In 2015, only 38% of respondents reported having a living will or advance directive.

Direct Ask

The Community Health Needs Survey included a small "Direct Ask" sample of residents employing the identical survey instrument as was used with the primary Community Health Needs Survey population. The only unique aspect of the Direct Ask survey was that individuals were invited in-person to participate in the survey during community events held throughout the county. Committee members attending these events provided participants with iPads on which to complete the survey. Comparisons to the 2015 and 2012 community health surveys are not presented due to the differences in how Direct Ask participants were identified and the setting in which these surveys were conducted. Locations for collecting survey responses included a health fair at St. John's Roman Catholic Church, two Westminster farmers markets, the Common Ground on the Hill Roots Music and Arts Festival, Westminster Sunday concert, a community resource fair, and the Fourth of July Celebration at the Carroll County Farm Museum.

Demographic Information

The demographic profile of the respondents who completed the online direct ask survey is depicted in the following tables. More than half of all participants lived in the Westminster area: 21157 (58.7%) and 21158 (13%). There were 24 females, 20 males, one respondent who did not identify as male or female, and one who skipped the question in the survey. This split is more closely aligned with the Carroll County population when compared to the full community survey respondents where women greatly outnumber men. Of the 46 respondents 89.1% were white, mirroring the county population.

Zip Code	Count	Percentage
21157	27	58.7%
21158	6	13%
21776	3	6.5%
21074	2	4.3%
21771	2	4.3%
21784	1	2.2%
21787	1	2.2%
21048	1	2.2%
21102	1	2.2%
21757	1	2.2%
Other	1	2.2%

Demographic Information	Count	Percentage
Gender		
Male	20	43.5%
Female	24	52.2%
Identifies as other than male or female	1	2.2%
Did not answer	1	2.2%
Age		
18 - 24	3	6.5%
25 - 34	4	8.7%
35 - 44	3	6.5%
45 - 54	13	28.3%
55 - 64	9	19.6%
65 and over	3	6.5%
Did not answer	11	23.9%
Race/Ethnicity		
White	41	89.1%
Black/African American	4	8.7%
American Indian or Alaska Native	0	0
Other	1	2.2%
Asian	0	0
Native Hawaiian or Other Pacific Islander	0	0
Hispanic/Latino	0	0

More than half of the respondents were married (65.2%) followed by 15.2% divorced and 10.9% never married. In addition, the majority of respondents (58.7%) had no children living at home and 37% had 1 - 2 children younger than 18 years of age living in the household.

Household Composition	Count	Percentage
Marital Status		
Married	30	65.2%
Divorced	7	15.2%
Never married	5	10.9%
Widowed	1	2.2%
A member of an unmarried couple	1	2.2%
Separated	0	05
Did not answer	2	4.3%

Number of Children Less Than 18 Years in Household		
None	27	54.3%
1 - 2	17	37%
3 – 4	1	2.2%
5 – 6	0	0
Did not answer	1	2.2%

Socioeconomic responses showed that more than half of the total participants (54.3%) were college graduates and 17.4% attained some college or technical school. The majority of respondents (67.4%) were currently either employed for wages or self-employed. About half of respondents (47.8%) had an annual household income of $75,000 and more and 21.7% of respondents had income less than $25,000.

Socioeconomic Information	Count	Percentage
Level of Education		
Never attended school or only attended kindergarten	0	0
Grades 1-8 (Elementary School)	0	0
Grades 9-11 (Some high school)	4	8.7%
Grade 12 or GED	6	13%
College 1 year to 3 years (Some college or technical school)	8	17.4%

College 4 years or more (College graduate)	25	54.3%
Did not answer	3	6.5%

Employment Status		
Employed for wages	26	56.5%
Self-employed	5	10.9%
Out of work for more than 1 year	1	2.2%
Out of work for less than 1 year	1	2.2%
A homemaker	0	0
A student	3	6.5%
Retired	3	6.5%
Unable to work	5	10.9%
Prefer not to answer	1	2.2%
Did not answer	1	2.2%
Annual Household Income from All Sources		
Less than $10,000	4	8.7%
$10,000-$14,999	2	4.3%
$15,000-$19,999	0	0%
$20,000-$24,999	4	8.7%
$25,000-$34,999	3	6.5%
$35,000-$49,999	5	10.9%
$50,000-$74,999	3	6.5%
$75,000 and more	22	47.8%
Don't know/Not sure	2	4.3%
Did not answer	1	2.2%

Respondents were also asked to identify if they served on active duty in the United States Armed Forces. As seen in the following chart only 5 respondents have served or are currently serving as active duty military members, and 3 of those individuals have served in a combat or war zone.

United States Armed Forces Service Status	Count	Percentage
Active Duty Service		
Yes	5	11.1%
No	40	88.9%

Did you ever serve in a combat or war zone?		
Yes	3	60%
No	2	40%
Don't know/Not sure	0	0

Access to Health Care

Insurance
Almost all of the survey participants had health insurance (94.9%).

Primary and specialist care
More than half of respondents (53.3%) have at least one person whom they think of as their personal doctor or health care provider. More than 91% of the respondents indicated that they could get an appointment with their primary care physician when they requested. When asked about other settings of care, 31.1% of the respondents said that they have visited an urgent care center instead of going to their primary care physician in the past 12 months. For those that have visited an urgent care center the primary reasons for doing so were after office hours, convenience, and wanting to be seen right away.

In terms of eye care and dental health, about 70% of survey respondents said that they had seen practitioners at least once within the past 2 years in each of those specialties. For those reporting that they have children living in their home, the vast majority of participants reported that their child/children have regular wellness visits with a medical doctor (94.4%) and have dental checkups at least once per year (88.9%).

Health Status: Physical & Mental

Overall Health Status

Respondents were asked to rate their overall health, including both physical and mental health. Self-reported measures of health are favorable among respondents. More than half (60%) of respondents reported having very good or excellent overall health and 24.4% reported having good health. Only 6 out of 45 (13.3%) reported having fair or poor health.

Health Related Quality of Life

Approximately half of the respondents (48.9%) reported that they did not have any days when they were suffering from physical illness or injury during the past 30 days. However, 10 respondents (22.2%) reported having one to two days of poor physical health, 5 people reported having three to seven days of poor physical health, and 8 people said they had more than 7 days of poor health during that same time period.

Respondents were asked how often during the past 30 days they were not able to perform their usual activities, such as self-care, work, or recreation due to poor physical or mental health. Just over half of the respondents (55.6%) reported that they did not have any problems carrying out their usual activities due to poor health during this timeframe. Ten respondents (22.2%) reported having had "1 – 2 days" in the past 30 days when they could not perform their usual activities due to poor health. The number of respondents reporting more than 2 days when they were not able to perform their usual activities due to poor health was also 22.2%.

Anxiety and Depression

Respondents were asked if a health care provider ever told them they have an anxiety disorder such as acute stress disorder, anxiety, generalized anxiety disorder, and obsessive-compulsive disorder and whether or not they are currently receiving treatment from a health care provider for any type of mental health condition or emotional problem. More than 44% of the respondents said that they had been told by a provider that they have an anxiety disorder. Half of those respondents indicated that they are now taking medicine or receiving treatment from a provider for a mental health condition or emotional problem.

Cognitive Impairment

The survey asked if respondents experienced confusion or memory loss in the past 12 months that is happening more often or is getting worse. While a significant majority of respondents indicated that they did not experience confusion or memory loss, 9 respondents (20.0%), reported having these symptoms.

Chronic Health Issues

Respondents were asked about their history of chronic health conditions, medications, and other treatment or preventative measures. Key findings are:

- High cholesterol had the largest number of respondents reporting that a provider told them they had this condition (42.9%). Just over half of all respondents (57.8%) had their cholesterol checked within the past year.
- The second most commonly cited chronic health issues were high blood pressure (28.9%) and asthma (29.6%).
- Slightly less than 9% of all survey respondents reported having been diagnosed with diabetes and 2% of female respondents reported having been diagnosed with gestational diabetes during pregnancy. Three respondents (7%) were told they had pre-diabetes.
- Regarding medication, fewer than half of those diagnosed with cholesterol (38.9%) are taking medication for this health issue. However, three quarters of respondents who had been told they have high blood pressure were currently taking medicine for this concern (77.0%).
- Only two respondents (4.4%) said they had ever stopped taking their medicine because of cost.
- In addition to those that are on medication, many of the respondents diagnosed with high blood pressure are taking other actions to control their blood pressure, most notably changing their eating habits, including cutting down on salt and exercising.

The following chart details number of responses to questions asking whether or not a provider has ever told them they have the chronic conditions and illnesses listed.

Chronic Condition /Illness	Count	Percent of respondents*
Arthritis, Gout, Lupus or Fibromyalgia	6	13.3%
Asthma	13	29.6%
Cancer (other than skin cancer)	6	13.3%
Cholesterol	18	42.9%
Chronic Obstructive Pulmonary Disorder	4	8.9%
Congestive Heart Failure	1	2.2%
Coronary Heart Disease/Angina	4	9.1%
Diabetes	4	8.9%
Heart Attack	3	6.7%
High blood pressure	13	28.9%
Skin Cancer	1	2.3%
Stroke	3	6.8%

*Percent of respondents answering each question

Chronic Condition Management

Respondents who reported having one or more of the above chronic conditions were asked what kind of help they need in managing these conditions. Almost 35% indicated that they did not need additional resources.

Resource for Managing Condition	Percentage
Help understanding all the directions from my doctor(s)	14.3%
Prescription assistance	8.6%
Health care in my home	5.7%
Help making appointments with my doctor(s)	8.6%
Transportation assistance	14.3%
Help locating resources	14.3%
None	34.3%

Dietary Behaviors and Physical Exercise

Dietary Behaviors

Respondents were asked about their consumption of fruits and vegetables, as well as their family's consumption of fast food and sugar-sweetened beverages.

- The majority of respondents (57.8%) reported eating fruits and/or vegetables an average of once per day.
- Sixteen respondents (33.3%) said that they never had fast or take-out while ten respondents (21%) indicated that they ate fast food or take-out food more than once per week. Almost a quarter (23.4%) indicated that they had fast food once per week.
- Eighteen people (38%) said that they never drank sugar-sweetened beverages. Of those who answered yes, eight people (38%) indicated that they drank at least one sugar-sweetened beverage per day.

Almost one third of respondents indicated that they didn't have any barriers to healthy eating. For those that had a barrier, time was the largest identified barrier, followed by money.

Physical Exercise

Approximately 84.4% of respondents reported that they participated in leisure time physical activity during the past month. Of the 36 respondents who participated in this physical activity, 25 (67.6%) said that they engaged in these activities more than 30 minutes at a time.

Health Risk Factors

Questions related to tobacco use included cigarette smoking, chewing tobacco, snuff, e-cigs, vaping or snus. In addition, involuntary exposure to second hand smoke was measured as part of the survey. The vast majority of respondents report that they currently do not smoke (75.6%) or use other tobacco products (95.6%) nor are they exposed to second hand smoke at home (86.4%) or in a vehicle (88.9%).

In this sample, alcohol consumption, of at least one drink within the last 30 days was identified by 29 respondents (64.4%), and of that number, a significant majority (89.7%) responded that in the last 30 days, when they consumed alcohol, it was for 1-2 drinks. Only one respondent answered that he or she consumed more than 4 drinks on one occasion within the past 30 days.

While only one respondent indicated that in the last 3 months they used opioids that were not prescribed to them, there were 4 respondents who had a family member or friend that had misused opioids during this same time period.

Preventive Health Practices

All respondents were asked about preventive health practices: colon cancer screening, HIV/AIDS testing, flu vaccination and sun exposure. Then females only were asked about breast and cervical cancer screening, while males were asked about prostate cancer screening.

A majority of respondents (61.1%) have had a colon cancer screening. Slightly less than half of survey participants (46.7%) had ever had an HIV test and 53.3% had received a seasonal flu vaccine during the past 12 months.

When asked about breast cancer screening, 87.5% percent of women had ever had a clinical breast exam with 52.4% percent having had one in the past 12 months. For cervical cancer, 95.8% percent of women had ever had a Pap test, and 78.3% had had one within the past 2 years.

Male survey respondents age 40 years and over were asked if they have ever had a discussion with their health care provider regarding the benefits and risks of prostate cancer screening. Half of the respondents reported having this discussion.

Almost three quarters of respondents (73.3%) did not have sunburn in the past 12 months. The most often mentioned protective measure used against the sun was wearing sunscreen with SPF of 15 or higher, followed closely by wearing sunglasses. The other two measures with 10 or more responses were using a lip balm of SPF of 15 or higher and wearing a wide brimmed hat.

Social Issues

Two questions about violence were asked of survey participants. When asked, "Have you ever been physically abused (beaten, pushed, shoved, or sexually assaulted) by a member of your household?," five indicated that they had been abused. In addition, 6 respondents said they had been a victim of violent crime in this community.

When respondents were asked about end of life planning, about 40% (18 people) said they have a living will or advance directive.

Health Education

Respondents were asked where they are most likely to get health information and education (multiple responses were allowed).

Resource for Health Information	Count
Your physician /health care provider	80%
Local sources (i.e. hospital, health department)	35%
Local providers / organizations /resources	24%
National sources	27%
Online websites	56%
Health blogs	11%
Family / Friends	42%
Television	13%

Additional Remarks

While the Direct Ask survey was a smaller sample size, a general overview comparing these responses to those of the larger community survey show very consistent responses when asked about important health indicators and health behaviors.

In terms of demographics, there were some differences noted. In addition to a much larger percentage of males in the direct ask survey, those with an annual household income of $75,000 and more was about 10 percentage points higher in the direct ask survey. Also, the percentage of respondents who were 65 and over was about four times higher in the community survey (23.3%) as in the direct ask survey (8.6%).

C. Attachment

- Results - Community Online Survey
- Results - Direct Ask
- Survey Tool - Community Health Needs Survey – Online and Direct Ask

4. Key Informant Survey

A. Methodology

There were four Key Informant sessions. A total of 78 informants completed the survey in all sessions combined. Three sessions were composed of designated community leaders and one was held with non-profit direct service providers. The Community Leader section included 58 individuals who participated in one of three sessions scheduled by The Partnership which were held in July and August 2017. Results from the three sessions are reported as one group of Community Leader Key Informants. A separate session with 20 non-profit direct service providers was held during an existing meeting of the Community Services Council (CSC).

The Partnership identified the key informant participants and developed the key informant survey. Key informants were interviewed to gather a combination of quantitative and qualitative feedback through open-ended questions and a moderated discussion. The survey assessed the most pressing issues in the community; barriers to accessing health care; the impact of social determinants on health; health and wellness resources in the community; health promotion efforts; and information to help assist underserved populations.

Community Leaders were defined as community stakeholders with expert knowledge and included public health and health care professionals, social service providers, non-profit leaders, business leaders, faith-based organizations, county government, and other community leaders. The survey questions were answered from the perspective of the communities in which each informant serves or works. Three of the key informants were providers with devoted patient hours of approximately 30 hours per week. A full listing of key informants and their affiliated organizations is included as an attachment in this section.

Results from the Community Leader group are provided in the first section below; results from the CSC session follow separately. It is important to note that the results from all sessions are the perceptions of many community leaders, but may not necessarily represent all community representatives within Carroll County

B. Results Summary

Community Leaders Results Summary

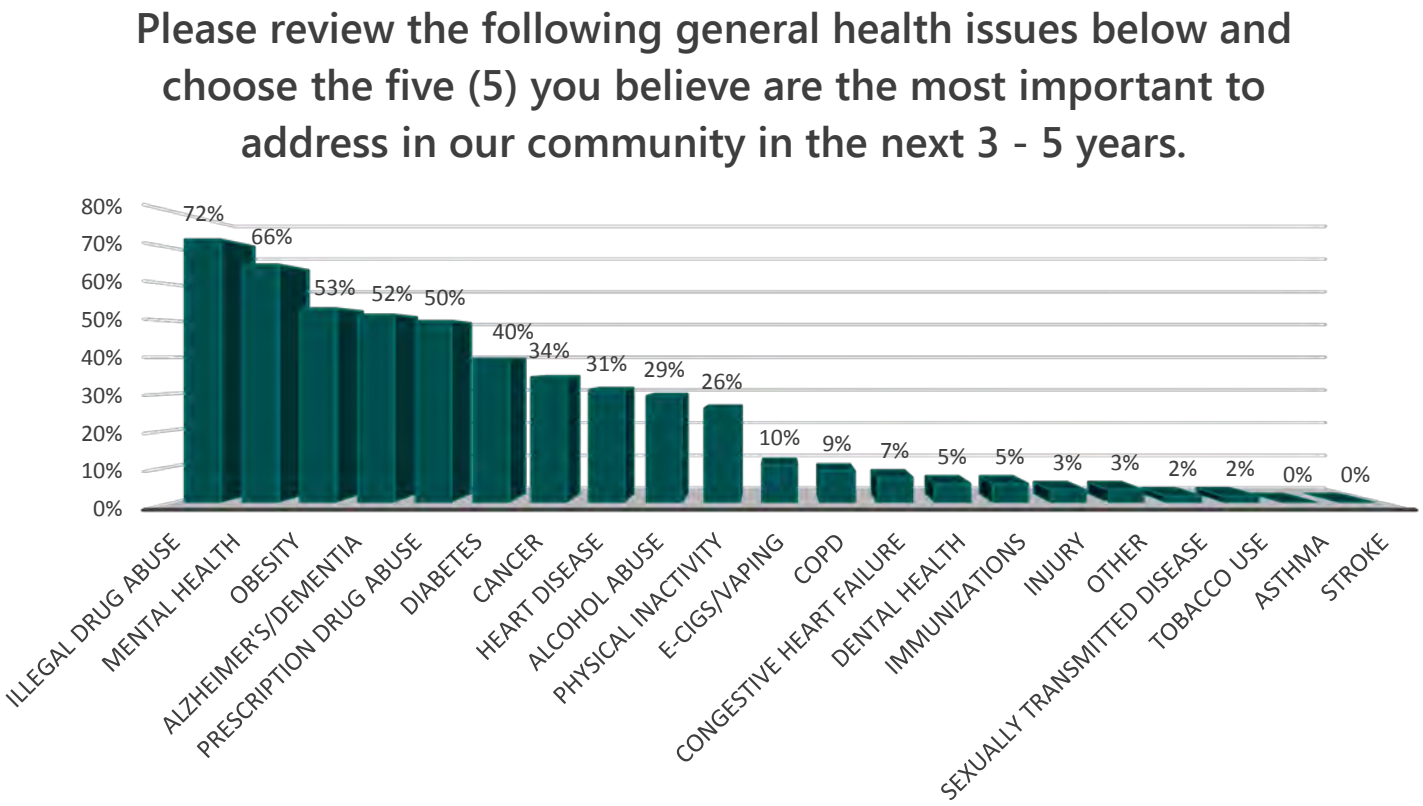
General Health Issues

Key informants were asked to select what they believe to be the five most important health issues in our community. The top five health issues in alphabetical order according to the community leaders include:

- Alzheimer's/ Dementia
- Illegal Drug Abuse
- Mental Health
- Obesity
- Prescription Drug Abuse

Three issues ranked the highest in both 2015 and 2018: illegal drug abuse, mental health, and obesity. Those same three issues also ranked within the top 5 in the 2012 CHNA. The addition of Alzheimer's/Dementia as a top ranked priority in 2018 is notable.

A full listing of health issues, in order by the percentage of key informants who selected the issue as one of the most important is presented in the following graph.



The following table shows the results in detail, including the number of times and percentage of respondents that mentioned the issue as one of their most important. The last column depicts the percent of informants who rated the issue as the one making the single greatest impact.

The issues receiving the highest percentage of individuals selecting it as one their five most important is consistent with the issues chosen by informants as making the greatest impact. They are illegal drug abuse, mental health, and obesity.

General Health Issues	Total Count for all respondents selecting the Issue	Percentage of Respondents who Selected the Issue	Percentage of Respondents who Selected the Issue as Making the Greatest Impact
Illegal Drug Abuse	42	72.4%	31.0%
Mental Health	38	65.5%	22.4%
Obesity	31	53.4%	17.2%
Alzheimer's/Dementia	30	51.7%	5.2%
Prescription Drug Abuse	29	50.0%	8.6%
Diabetes	23	39.7%	1.7%
Cancer	20	34.5%	3.4%
Heart Disease	18	31.0%	1.7%
Alcohol Abuse	17	29.3%	1.7%
Physical Inactivity	15	25.9%	3.4%
E-cigs/Vaping	6	10.3%	0
COPD	5	8.6%	1.7%
Congestive Heart Failure	4	6.9%	0
Dental Health	3	5.2%	0
Immunizations	3	5.2%	1.7%
Injury	2	3.4%	0
Sexually Transmitted Disease	1	1.7%	0
Tobacco Use	1	1.7%	0
Asthma	0	0	0
Stroke	0	0	0

After selecting the top health issue, respondents were asked to share why they believe their choice is the number one priority in the community. The following section highlights a selection of responses related to the key issues. The comments were provided through open-ended questions on the survey or identified during the moderated discussion; some are provided verbatim, and others have been summarized.

Illegal Drug Abuse was the most frequently selected issue with approximately 72% of informants selecting it as one of their top five key health issues. In addition, 31% of respondents selected it as their number one priority. Key informants acknowledged that the opioid epidemic continues to have an enormous impact on Carroll County residents and current efforts have required collaboration between a wide range of community experts and resources. Comments focused primarily on identified gaps in treating individuals struggling with illegal drug abuse, as well as the importance of understanding the inter-connectedness of illegal drug abuse with so many sectors of the community.

Select Comments Related to Illegal Drug Abuse

- Drugs have become rampant in our city and society in general. Because of this crime rates go up and the community suffers in all aspects of life.
- Heroin is impacting all economic levels and resulting in death.
- The opioid epidemic affects otherwise healthy young people and has tremendous ripple effects, destroying families, taxing social services, leading to other mental health problems and crime.
- Overdose deaths are now the 3rd leading cause of death in all age groups and are entirely preventable.
- People need the resources to get into rehab and stay clean. People also need to be held accountable for their actions.
- The opioid epidemic is ever increasing and having a devastating impact in our community.
- Three issues are driving addiction – people locked out of economic jobs (some requiring high tech skills), affordable housing, and mental illness.

Mental Health was the second most frequently selected issue with 65.5% of informants selecting it among the top five key health issues. In addition, 22% of respondents ranked it as their number one priority. Key informants frequently highlighted the fact that mental health concerns can affect anyone, regardless of background, and without treatment and support will ultimately affect all aspects of a person's life.

Select Comments Related to Mental Health

- If you don't have mental health, physical health is almost irrelevant.
- 60-70% of those people in our community who have a chronic disease suffer from a mental health or substance abuse diagnosis that often is a barrier to them getting the care that they need or engaging in their own health.
- Obesity, with food as a drug, springs from mental health issues.
- Mental health issues affect everyone and are not inclusive to one population. When untreated they lead to crises in family, employment, relationships, and living situations.
- Mental health concerns lead to multiple issues such as drug use, death by suicide or terrorism.
- As a society we are doing the mentally ill a disservice.
- People talk about heart disease but not mental health issues.
- Anxiety and depression is believed to affect 80-90% of people in the county, but is not always thought of as a mental health issue. People do not want to "burden" others with their problems so they keep

quiet or they don't wish to recognize the issue.
- Significantly higher threat of chronic disease in children who have mental health issues.

Obesity was the third most frequently selected issue with just over half of the informants selecting it among the top five key health issues, and 17% selecting obesity as their top priority.

Select Comments Related to Obesity

- Being overweight worsens all of the other health issues.
- You are what you eat and improving eating habits and making healthy choices will decrease the incidence of most disease. Obesity is a risk factor for most diseases.
- Obesity leads to so many other problems.

Alzheimer's/Dementia Alzheimer's/Dementia was the fourth most frequently selected issue at 51.7%, however, it ranked fifth at 5.2% when key informants ranked their number one priority.

Select Comments Regarding Alzheimer's/Dementia

- As our aging population grows, more individuals are being diagnosed with a form of dementia.
- I believe more awareness of taking care of a loved one diagnosed and having more readily available resources would help.
- Family members become frustrated and don't have the right tools or understanding of the disease.

Prescription Drug Abuse Prescription drug abuse was the fifth most frequently selected issue at 50%; however, it ranked fourth at 8.6% when key informants ranked their number one priority.

Select Comments Related to Prescription Drug Abuse

- I have seen too many people handed prescription drugs for pain and they are not monitored.
- Mental health is tied in with prescription drug use.
- Illegal substance abuse stems from prescription drug overuse. Both issues are related.

In addition to the topics highlighted as highest priority above, key informants also identified other topics of concern. A sampling of those are summarized below.

Additional Comments Regarding Health Issues in the Community

- Chronic lung disease affects a large population in this area.
- I believe more awareness of taking care of a loved one diagnosed with chronic lung disease and having more readily available resources would help.
- Many children from low income families need to get the immunizations necessary to keep healthy and

prevent any outbreaks.

- Physical activity increases social interaction, which positively improves both mental and physical health outcomes later in life.
- Physical activity and exercise has been demonstrated to improve cell body functioning in the brain and promote brain health demonstrated through cognitive assessments.
- Other selected categories can tie into heart related illnesses.
- Alcohol, illegal substance use, prescription drug use, and even tobacco are all somewhat related and are treated/prevented in a similar manner. I do not think separating them out is necessarily productive. Especially prescription drugs and illegal substances – the one generally leads to the other.
- A key aspect of prevention is to foster healthy lifestyles.
- Would love to see Westminster/Carroll become a "green" city with green space, community advocacy for healthy, outdoor events, etc.
- Sexual violence is a huge (under reported) issue as well.
- Sexual violence needs to be broken out from other violence.
- Begin education with preschool children on healthy lifestyles.
- The county seems to be lagging behind in smoking cessation unfortunately. Smoking related illnesses like COPD are quite prevalent and preventable.
- Transient homeless population poses great concerns.
- Carroll County is quiet regarding problems of their citizens. People need to be able to speak out in order to find resources. When people are afraid to discuss their issues it puts pressure on people to be perfect.
- Interconnectedness of physicians in early intervention is important for kids to be healthy.

Availability of Health Care Services

After rating the top five health issues facing Carroll County, key informants were asked to assess the ability of local residents to access health care services such as primary care providers, medical specialists, and dentists. In addition, key informants assessed access to transportation for medical appointments, health care resources, and the ability of residents to pay for health care services. Respondents rated statements on a scale of 1 (Strongly Disagree) through 5 (Strongly Agree). The results are displayed in the following table.

"On a scale of 1 (Strongly Disagree) through 5 (Strongly Agree), please rate each of the following statements about Health Care Access in our Community"

Statements	Percent of respondents who "Disagree" or "Strongly Disagree"	Neutral	Percent of respondents who" Agree" or "Strongly Agree"
The majority of residents in Carroll County have access to a local primary care provider.	12.0%	15.5%	72.4%
The majority of residents in Carroll County have access to a local medical specialist.	18.9%	17.2%	63.8%
The majority of residents in Carroll County are able to access a local dentist when needed.	18.9%	34.5%	46.5%
Transportation for medical appointments is available and easy to access for the majority of residents.	51.7%	36.2%	12.0%
Health care resources are available and accessible. Example: weight loss classes, gym memberships and diabetes education.	22.4%	37.9%	39.7%
The majority of residents in Carroll County have the ability to pay for health care services.	38.0%	41.4%	20.7%

As illustrated in the preceding table, the majority of informants agree that in general, members of our community have the ability to access primary and specialty health care. The ability to pay for health care services was a perceived problem with only 20.7% of respondents agreeing or strongly agreeing that a majority of residents do in fact have the ability to pay. Transportation was seen as a significant challenge to Carroll County residents with only 12% of key informants stating that they agree or strongly agree that transportation is easy to access and just over half rated their opinion on the availability and ease of transportation as disagree/strongly disagree.

A significant number of informants who shared comments regarding access to care emphasized that transportation and cost remain key barriers to obtaining needed health care services. However, there were respondents who felt that it is actually a minority of the population that suffers from the lack of a transportation system and that there are other more pressing issues related to availability of care in Carroll. In the moderated session, many participants agreed that there is a disparity throughout the county as to those that can access care and those that cannot.

Additional Comments Regarding Availability of Care in Carroll County

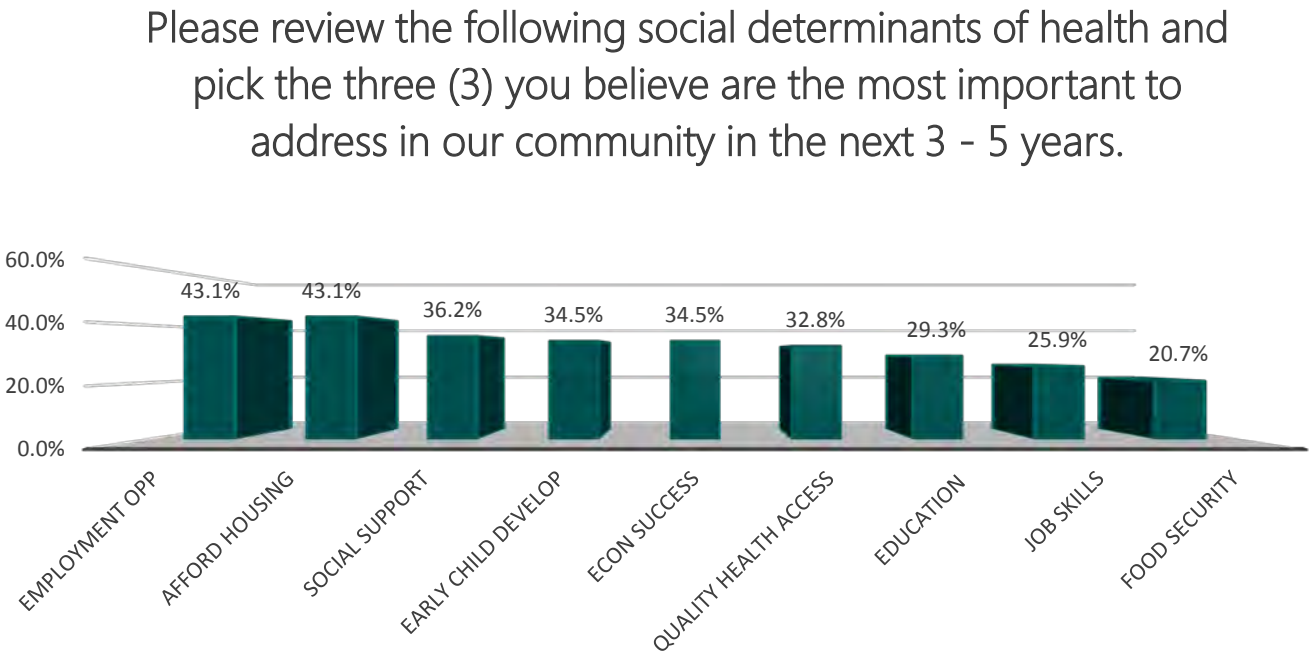
- It is my experience that timely access to dental services can be problematic. Most people have very little dental benefit coverage.
- Transportation is a huge need in our area due to patients not having accessibility to transportation or being able to afford it. Homebound individuals are also in need of home visiting physicians.
- Ability to pay is hitting the middle class the hardest due to coverage shortfalls and lack of subsidies.
- Issues such as transportation are a problem but only for a small majority of the county population. A disproportionate amount of resources are spent on the management and development of transportation.
- The demographics of our county would suggest that medical services and transportation are available. However, there is a population that is uneducated to available services, especially transportation.
- A lot of services are available but not in a sufficient amount to serve the needs of the county.
- Many of these things are available but are cost prohibitive.
- Whereas health care is accessible, the ability to use it is based on economics. If you have a job with health care benefits, you have access. If you do not have that, health care is so costly, you put it off until it is critical.
- Without a car in this county, it is very difficult to get to health care.
- Affordability is becoming more of an obstacle every year, especially for middle class, self-employed, small-medium business owners and their employees.
- The majority may have access and financial resources, but those limited in access and resources are creating the greatest costs and overwhelming resources in this community.

Social Determinants of Health

The informants were then asked to select three social determinants of health that they believe are the most important to address in their community in the next three to five years. The top three social determinants of health in alphabetical order are:

- Affordable Housing
- Employment Opportunities
- Social Support

A full listing of the social determinants of health, in order by the percentage of key informants who selected the determinant, is presented in the following graph.



Respondents were also asked to identify which social determinant of health of the three they selected would have the greatest impact in the community, if addressed. As depicted in the following table, quality health care access and affordable housing received the highest rating with 15.5% of key informants selecting each as potentially having the most impact. Early childhood development and affordable housing received the second and third highest ratings for having the greatest impact in the community.

The following table shows the results in detail, including a summary of the number and percent of times a determinant was chosen as one of the three they believe to be the most important to address. The last column depicts the percent of informants who rated the determinant as having the greatest impact in the community.

Social Determinant of Health	Percent of Respondents Who Selected the Issue	Percent of Respondents Who Selected the Issue as Making the Greatest Impact
Employment Opportunities	43.1%	13.8%
Affordable Housing	43.1%	15.5%
Social Support	36.2%	10.3%
Early Child Development	34.5%	10.3%
Economic Success	34.5%	12.1%

Quality Health access	32.8%	15.5%
Education	29.3%	12.1%
Job Skills	25.9%	3.4%
Food Security	20.7%	6.9%

Informants were asked through open-ended questions to give additional information regarding their reasons for ranking the social determinants of health as one of the most important. Comments related to the key social determinants of health are summarized in the following section.

Select Comments Regarding Employment Opportunities

- Working makes one feel better about themselves and in turn get healthy.
- We need the workforce to meet health care and other service needs in the future.
- If there is job opportunity and economic growth, better health will correlate.
- If people can earn, they can pay for services needed and it takes the burden off of other tax payers.
- We need good paying jobs to allow our community to prosper and grow.
- If people were successfully employed they would have the stability and better access to the services they need.

Select Comments Regarding Affordable Housing

- If we buy the Housing First model, which I think we should, we need to create an environment in which every person can reasonably expect a roof over their heads, an address, literally a "home base" from which to address other issues.
- Housing is a basic necessity that is out of reach for many, including those who may have a good education and employment.
- A safe, clean home is a great place to start as long as it is affordable. Then people are able to work on employment and children have foundation to thrive.

Select Comments Regarding Social Support

- Without economic success much more social support is needed.
- Aiding residents is important to position themselves in a place to be self-sufficient.
- It has been shown that isolation is one of the most contributing factors in drug addiction. Having a social support network helps to keep people with a range of issues engaged in the community and their own healing and/or solutions.
- We are seeing more homeless and struggling families needing help and coming for community meals.

Select Comments Regarding Early Childhood Development

- If children are hungry they cannot learn. If children are hungry parents are distressed. If the food available is poor then health is impacted long range.
- Too many children do not have access to child care and for many it is expensive. Getting off to a good start is all important.
- Developing brains are hugely influenced by everything around them. When the youngest of children receive quality health care, education, positive social skills, and good role models in a safe, nurturing, healthy environment, we set them up for a healthy and productive future.
- Thinking long-term, providing for the development of children in the area can lead to greater advancements in the community over time.
- Teaching children healthy eating habits at a young age is key. They will then educate their parents, creating a ripple effect.

Additional Comments Regarding Social Determinants of Health

- I believe early detection and prevention are crucial to be aware early of any illness or disease, to reduce the progress of disease, an in the end will reduce expenses.
- Difficulty accessing appropriate services in a timely, affordable fashion with transportation access is driving the crisis.
- Food insecurity is a problem when people cannot afford healthy food or that only shop for food in the dollar store. When you buy cheap products it pushes the individual closer to disease.
- Food insecurity can have catastrophic effects on health thereby influencing ability to learn and work.
- If families have healthier food options available for the same cost, they may be able to eat better. The Roving Radish in Howard County is a good example of how this can work.
- Education provides opportunities to gain employment and provides opportunity for people to read about and independently study health cause, effects and best practices.

Programs, Services, & Promotion

Informants were asked to describe programs or services that they feel should be developed and offered to people living in Carroll County. There were a variety of ideas provided. Some of the suggestions are new but many of the programs and services may be offered in some capacity already. However, the comments reinforce the desire to see progress made to increase, enhance, or take a new approach to address the needs. In some cases, promotion of existing services may be necessary.

Select Comments Regarding Programs and Services that Need to be Developed

Built Community
Facilities and services for the homeless
Opportunity for telecommuting
Bike and walking trails
Eliminate food deserts

Education/Support
Education about healthy life habits, especially for at-risk populations (e.g., how to prepare healthy foods and snacks on a budget)
Parenting classes for all families, regardless of socio-economic status
Education about detriments of smoking and vaping
Solid early childhood development
Prevention programs
Support groups for caregivers (including those with family member with Alzheimer's)

Behavioral Health
On-demand, local detox and access to other awareness and treatment programs
More mental health outreach and therapeutic options
Inpatient and outpatient mental health services for children

Other Health Care Services
More dental care
Formal hospital/school partnership

Wellness Programming (Physical Activity/Lifestyle)
Running programs in schools (e.g. Girls on the Run)
Incentive based weight-loss programs
Walking prescriptions – resources in providers' offices regarding free physical education and other wellness programs

Economic
Workforce development (technology)
Retirement planning beyond finances
Education on health savings plans
Hospital insurance plan
Housing risk management for property owners

Informants were asked to rate existing services and outreach activities in Carroll County on a scale of 1 (poor) to 4 (excellent). About half (56.1%) rated existing efforts as good, while about one-third

(36.8%) rated them as fair. Informants were also asked to give comments and suggestions on how health and wellness efforts are best promoted in the community.

Select Comments Regarding Health and Wellness Promotion Programs

Increased workplace outreach
Offering information at community meals with the faith community
Provide materials and information at existing community activities
Integration into school activities
Providing information at libraries
Increased social media or text alerts – newspapers are not read as much anymore

General Feedback

Next, participants were asked to identify:

Specific Populations in the Community They Feel Are Not Being Adequately Served

Deaf community
Developmentally and intellectually disabled
Elderly below the poverty line
Homebound
Homeless
Lower and middle income
Mentally ill
People in recovery
Pre-diabetic
Single parent households
Undocumented
Uninsured
Victims of sexual violence
Undocumented

Areas of Community Health and Wellness That Need to Be Addressed but Were Not Covered In the Survey

Sexual assault/domestic violence
Support services for seniors living at home
Medical respite
Social health (active engagement with community)

Key informants were asked to identify two key elements they feel are important to the success of achieving a better quality of life for Carroll County residents. The most frequently mentioned elements are summarized in the following table.

KEY ELEMENTS	
Mental health treatment	Non-economic retirement planning
Opioid addiction treatment	Providers educating patients on drug use
Public transportation	Personal coaching and accountability
Increased economic development	Exercise and active living programs
Employment opportunities	Improved air quality
Social connectedness	Healthy eating habits/nutrition
Job training	Access to health care
Sense of pride in the community	Cleaner community
Education on drug use	Group health and exercise programs
Nutrition education	Affordable housing
Addressing homeless population	Improved parks and recreation facilities
Health coaching	Businesses investing in employee health
Opportunities for physical activity	Walkability
Mental health evaluation/screening	Emphasis on annual physicals/screenings
Access to quality education	Wellness Centers
Reasonable cost housing	Dental care

Lastly, key informants were asked to provide any final comments. Many key informants expressed gratitude for the opportunity to share their opinions.

One key informant expressed a sentiment felt by many: "The community is only as strong as its most vulnerable members. We are all in this together." Another person wanted to emphasize that there is a need to "continually recognize our weak areas while celebrating our strengths." In that vein, while most community leaders recognize that there are many issues to address to improve health, we are fortunate to live in an area with significant collaboration and support among its members.

Community Services Council Results Summary

The Community Services Council (CSC) is a community-based organization with representatives from the public and private sector who express a commitment to improving the provision of human services in Carroll County. Many of the individuals on this council have regular client contact so their responses may reflect this perspective. The survey was conducted during a regularly scheduled meeting of the CSC on July 20, 2017.

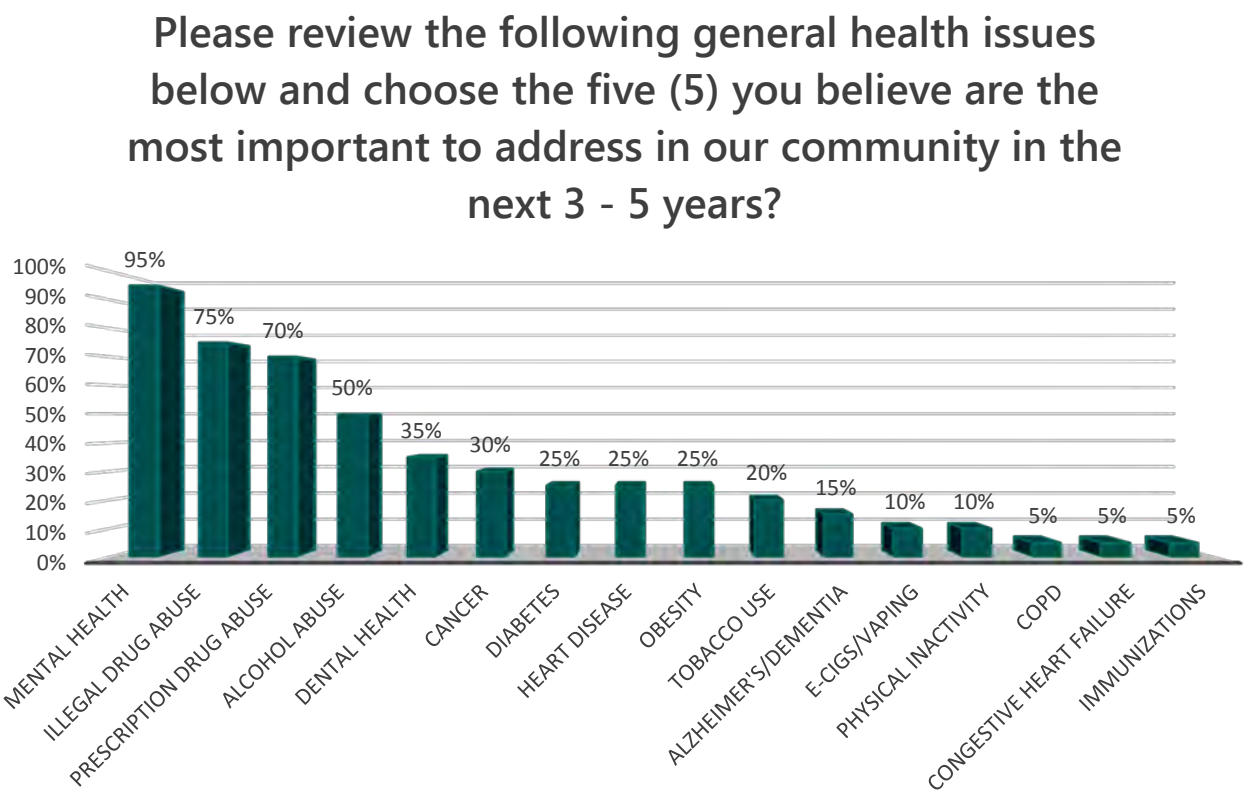
General Health Issues

Key informants were asked to select what they believe to be the five most important health issues in our community. The top five health issues in alphabetical order according to the CSC key informants include:

- Alcohol Abuse
- Dental Health
- Illegal Drug Abuse
- Mental Health
- Prescription Drug Abuse

Three of these areas were the same as the other 2018 community key informant groups: mental health, illegal drug abuse and prescription drug abuse. However, the CSC group identified Alcohol Abuse and Dental Health to round out the 5, whereas the community leaders included Obesity and Alzheimer's/Dementia.

A full listing of health issues, in order by the percentage of CSC key informants who selected the issue, is presented in the following graph. Note: Asthma, Injury, Sexually Transmitted Disease and Stroke are absent from the graph as they were not identified in the responses.



Respondents were also asked to identify which issue of the five they selected is the number one priority in the community. Illegal drug abuse received the highest ranking with 35% of respondents selecting it as their highest priority, followed by mental health (30.0%) and cancer (10.0%).

The following table shows the results in detail, including a summary of the number of times an issue was mentioned as a top five health issue and the percent of informants who selected that health issue. The last column depicts the percent of informants who rated the issue as being the number one priority.

General Health Issues	Total Count for all respondents selecting the	Percentage of Respondents who Selected the Issue	Percent of Respondents who selected the issue as a Priority
Mental Health	19	95.0%	30%
Illegal Drug Abuse	15	75.0%	35%
Prescription Drug Abuse	14	70.0%	5%
Alcohol Abuse	10	50.0%	0
Dental Health	7	35.0%	5%
Cancer	6	30.0%	10%
Diabetes	5	25.0%	5%
Heart Disease	5	25.0%	0
Obesity	5	25.0%	5%
Tobacco Use	4	20.0%	0
Alzheimer's/Dementia	3	15.0%	0
E-cigs/Vaping	2	10.0%	0
Physical Inactivity	2	10.0%	5%
COPD	1	5.0%	0
Congestive Heart Failure	1	5.0%	0
Immunizations	1	5.0%	0
Asthma	0	0.0%	0
Injury	0	0.0%	0
Sexually Transmitted Disease	0	0.0%	0
Stroke	0	0.0%	0

After selecting the top health issue, respondents were asked to share why they believe their choice is the number one priority in the community. The following section highlights a selection of responses related to the key issues. The comments were provided through open-ended questions on the survey or identified during the moderated discussion; some are provided verbatim, and others have

been summarized.

Mental Health was chosen as their number one priority by almost all respondents with 95% of informants selecting it as one of their top 5 health issues, and 30% selecting it as their number one priority. A common theme throughout much of the informants' responses was the fact that mental health affects almost all other aspects of a person's life and its effects will extend to family members as well. Many of them stressed that there is a strong association between mental health and other health care issues. In addition, many in the CSC group expressed concern that mental health resources are not sufficient in the county.

Select Comments Related to Mental Health

- Mental health doesn't necessarily lead to addiction, and vice versa, but there is a close connection/trend.
- Mental health is often the primary issue resulting in other concerns and need for services.
- There is a lack of mental health resources.
- Mental health aid is slim to none in this community. I would love to see this become another large topic we focus on.
- It is great that Access Carroll includes Mental Health as part of general health now.
- Most of the health problems noted have their roots in mental health.
-

Illegal Drug Abuse was also seen as an extremely critical health issue for 75% of the key informants who chose it as one of their top five issues. In fact, the highest number of respondents, (35%) selected illegal drug abuse as their number one priority. They saw the opioid epidemic in Carroll County affecting all residents regardless of age, social-economic status, race or location of residence.

Select Comments Related to Illegal Drug Abuse

- People have barriers in passing the drug testing. The underlying issue of mental health and substance abuse make it difficult for people to get jobs, training and skills.
- Current opioid epidemic makes illegal drug abuse the most urgent health problem.
- Drug abuse ruins families.
- Opioid epidemic is linked to mental health in the county.

Prescription Drug Abuse was the third most frequently selected issue with 70% of informants selecting it among the top five key health issues. However, when asked to choose just one top health priority, prescription drug abuse was only mentioned by 5% of respondents, with mental health and illegal drug abuse seen as much more critical.

Select Comments Related to Prescription Drug Abuse

- People are typically unaware of the risks of prescription drug abuse. People believe they are safe because they come from a doctor.
- Over-prescribing of prescription opioids and lack of communication with doctors can lead people to become dependent by taking as prescribed.

Alcohol Abuse and **Dental Health** were the fourth and fifth most frequently selected issues with alcohol abuse mentioned by 50% of informants and dental health by 35%. However, there were no key informants who chose alcohol abuse as their number one priority and only 5% of respondents mentioned dental health as the most urgent health problem. The main issue cited for dental health concerns is that a lot of people, especially after age 21, don't have or can't afford dental insurance or care.

In addition to the topics highlighted as highest priority above, CSC members also identified other topics of concern. A sampling of those are summarized below.

Additional Comments Regarding Health Issues in the Community

- Diabetes is a huge issue in Carroll County. A large amount of the population does not know how to control their diabetes or even what diabetes is. Education and widespread prevention of this disease could help solve many other health problems.
- It seems like a majority of our ride requests to medical appointments are for people who have cancer or complications from cancer.
- A large majority of our population has very poor nutrition and drink only soda and raid the vending machines on a regular basis. Coupling inactivity and very poor eating habits are very harmful for the intellectual and developmentally disabled population.
- Obesity is also a pressing concern because it gives rise to so many of the other health issues (heart disease diabetes, etc.) and because it affects people as a chronic disease that requires a lifestyle change – greater cultural changes are needed to prevent the continued rise of obesity.

Availability of Health Care Services

After rating the top five health issues facing Carroll County, key informants were asked to assess the ability of local residents to access health care services such as primary care providers, medical specialists, and dentists. In addition, key informants assessed access to transportation for medical appointments, health care resources, such as weight loss classes, and the ability of residents to pay for health care services. Respondents rated statements on a scale of 1 (Strongly Disagree) through 5 (Strongly Agree). The results are displayed in the following table.

"On a scale of 1 (Strongly Disagree) through 5 (Strongly Agree), please rate each of the following statements about Health Care Access in our community."

Statement	Percent of respondents who "Disagree" or "Strongly Disagree	Neutral	Percent of respondents who "Agree" or "Strongly Agree"
The majority of residents in Carroll County have access to a local primary care provider.	25%	35%	40%
The majority of residents in Carroll County have access to a local medical specialist.	35%	40%	25%
The majority of residents in Carroll County are able to access a local dentist when needed.	50%	35%	15%
Transportation for medical appointments is available and easy to access for the majority of residents.	80%	20%	0
Health care resources are available and accessible. Example: weight loss classes, gym memberships and diabetes education.	30%	40%	30%
The majority of residents in Carroll County have the ability to pay for health care services.	85%	15%	0

As with the other key informant groups, transportation and the ability to pay were seen as the greatest challenge to Carroll County residents. None of the CSC participants agreed or strongly agreed to the statements that transportation is easy to access or that the majority of residents have the ability to pay for health care services. Access to a local dentist is also a concern to CSC members.

Select Comments Regarding Transportation

- Transportation is a huge issue in Carroll County. The faster we can come together to create a solution, the better our county's health will become.
- Even with medical assistance, there are so many hoops people need to jump through to get certification for the transportation. Also, if you have a vehicle even if not running, you can't qualify for transportation.
- For seniors to live independently transportation is a huge component because they have little or no ability to be independent because they don't have reliable transportation.
- People may be put in unsafe situations when they have to use bikes because of a lack of reliable transportation.
- At Caring Carroll vast majority of need is for transportation. An example is when they need to go to the pharmacy after their doctor appointment – the bus won't take them there.

- Transportation outside of doctor appointments is also a problem because they don't run on weekends – this impacts school, work, and social life if they need to sit in their apartment all weekend with no transportation.
- It is hard to access tickets for the bus – there are only so many and none left for people who get there late – it doesn't seem to be managed well. It is an important piece when looking at mental health.

Additional Comments Regarding Availability of Care in Carroll County

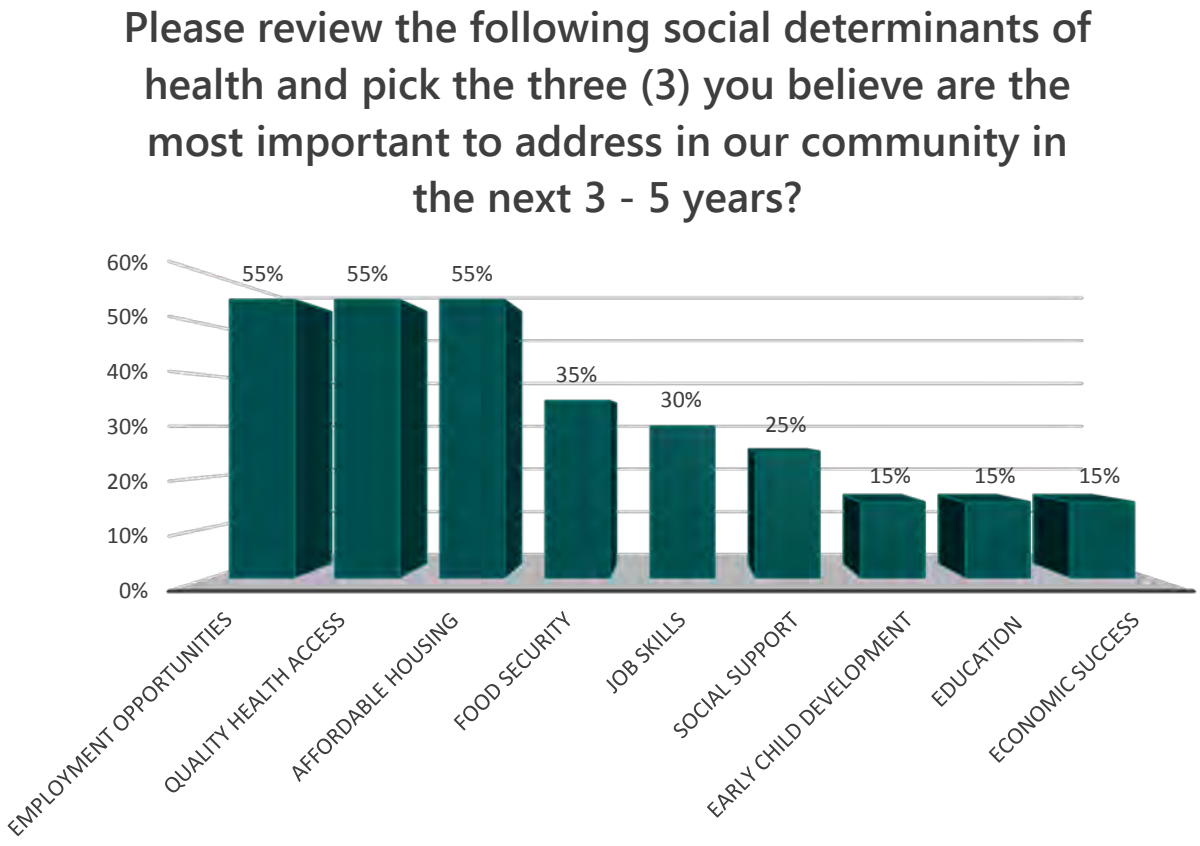
- Many of the clients we work with often cannot pay for health care services they need. They call our volunteers to take them to the emergency room because they say they can't afford to pay for an ambulance.
- There are a limited number of providers (primary care, specialists, dentists, etc.) that take Medicaid in the county.
- The word "access" is nebulous. Just because there is an open office there doesn't mean you can access the office hours. Access can also be "I have no insurance," or "I have no transportation."
- Many people work outside of Carroll County and as a result many that commute may get providers outside of the county to make it easier to see providers during the day. This is unique demographic of our county.
- There are many new insurance providers out there, and health care providers don't take the insurance, even if Medical Assistance or Medicare.
- Mental Health providers may not participate with new insurance. Organizations need to call agencies to find out what they take and many don't take these new providers.
- People in Union Bridge/New Windsor don't have access to food without transportation. We do have food deserts in the county.

Social Determinants of Health

The informants were then asked to select the top three social determinants of health they believe are the most important to address in their community in the next three to five years. There were three social determinants of health that had an equal number of respondents selecting it as a top priority:

- Affordable Housing
- Employment Opportunities
- Quality Health Access

A full listing of health issues, in order by the percentage of CSC key informants who selected the issue is presented in the following graph.



Respondents were also asked to identify which social determinant of health of the three they selected would have the greatest impact in the community, if addressed. As depicted in the following table, quality health care access and affordable housing received the highest rating with 25% of key informants selecting them as potentially having the most impact. Early childhood development was the only determinant that did not have any respondents selecting it as their top choice.

The following table shows the results in detail, including the percent of informants who selected the determinant as one of their top three issues. The last column depicts the percent of informants who rated the determinant as having the greatest impact in the community. Although there are some difference in ranking of the determinants between both questions, quality health access and affordable housing are consistently chosen most frequently both in terms of percent of respondents who selected the issue as well as percent that selected the issue as making the greatest impact.

Social Determinant of Health	Percent of Respondents Who Selected the Issue	Percent of Respondents Who Selected the Issue as Making the Greatest Impact
Employment Opportunities	55%	10%
Quality Health access	55%	25%
Affordable Housing	55%	25%
Food Security	35%	5%
Job Skills	30%	10%
Social Support	25%	10%
Early Child Development	15%	0
Education	15%	10%
Economic Success	15%	5%

After selecting the top health issue, respondents were asked to share why they believe their choice is the most urgent health problem in the community. The following section provides a brief summary of key health issues and a selection of responses related to the issue. The comments were provided through open-ended questions on the survey or identified during the moderated discussion; some are provided verbatim, and others have been summarized.

Select Comments Regarding Employment Opportunities

- If you want to keep young people and new revenue coming into our community, quality paying jobs need to be established in different fields.
- Employment opportunities at a living wage can open doors to healthy living.
- We hear that a lot of people leave the county for work. From a young person's perspective – you are trying to grow and there are no jobs here. There is a nice cushion for lower paying jobs for people just starting out, but for that middle group there is nothing.
- Transportation plays into the employment piece. You can't go out of the county because there is no connection. The underlying issue of mental health and substance abuse also make it difficult for people to get jobs, training and skills. People have barriers in passing the drug testing. It is costing the industry dollars because they can't get qualified workers.
- The workforce is changing in that the traditional retirement age is increasing. Older people are staying in the workforce longer so positions are not opening up for younger people.
- Lack of education makes it difficult to secure employment.

Select Comments Regarding Quality Health Access

- There is a great uncertainty as to what will happen with health insurance and affordability and access. It seems accessible health care could be out of reach for many, including children, working poor families and individuals with disabilities.
- If there was adequate access to care in the county that was affordable to the community then this

would overall improve the health of the county population. The community would do primary prevention efforts as well as being able to manage their conditions better.
- If we don't have access to quality health care, we might as well not promote any type of use of it.

Select Comments Regarding Affordable Housing

- Housing expenses far outweigh county salaries leading to increased homelessness and community instability.
- Without affordable housing it becomes difficult to hold down a job and turns into a vicious cycle of people going in and out of homelessness. Finding affordable housing seems to be the first step to creating a sustainable, healthy lifestyle. From what I've heard, affordable housing is a huge issue in our county.
- The majority of a family's household budget is spent on housing. 60,000 people in Carroll County live in households where more than 30% of income is spent on housing. This burden causes families not to spend their money on many other needed services and causes stress on the family as a whole, which contributes to other mental health conditions.
- At the root of so many concerns is affordable housing. The Carroll County Master Plan states that over 50% of renters pay over 1/3 income for housing, 23% of homeowners pay over 30% of income for housing expense. That is unsustainable.
- When families are burdened by housing they have to make difficult decisions about health care, transportation and they are under undue stress and enter into bad coping mechanisms for the harsh reality that they can't survive on their income.
- Housing worries turn into behavioral health issues.
- Housing burden is causing ripple effects.
- A social justice committee at a church just met, and problems all come down to non-affordable housing.

Additional Comments Regarding Social Determinants of Health

- Social support allows people to pursue their other needs. If a person has a support network, they can better access community resources and feel empowered to make changes in their lives. Not to say that people need social support more than the other determinants, but social support is sadly lacking in our individualistic society.
- A person's quality of health will affect every other aspect of their life.
- You have to be stable in order to think beyond day to day needs.
- I also believe that early childhood development is an issue but not a social determinant of health. Environment and opportunity for those in the area I believe to be larger issues.
- Transportation is a major social determinant of health issue in the county as well.

Programs, Services, & Promotion

Informants were asked to describe programs or services that they feel should be developed and offered to people living in Carroll County. In general, respondents feel that existing services are either good or fair. There is an overall feeling that Carroll County includes many individuals and non-profits that are willing to work together for the betterment of the community and this includes providing needed services. However, areas that may require additional support include those targeted at mental health issues and those that may require transportation to access the services the way they are currently offered.

Select Comments Regarding Programs and Services That Need to be Developed

- Affordable and accessible nutrition counseling and classes which include a support component.
- Services must offer flexible hours.
- Education needs to be broken down for different people.
- Affordable dental care for adults. If a person can't afford to get a bad tooth removed, they go back into medicating themselves – barrier to getting a job.
- Literacy – we assume people can read what we give them but many perhaps can't read or have no idea how to do what they are asked to do. Even if they are literate they may not be able to understand what to do.
- Free or low-cost child care
- Transportation so that people can get to their doctor appointments and obtain basic needs such as groceries.
- A safe respite care location for healing.
- More psychiatric access for vulnerable population.
- More advertising of the many wonderful programs and services in Carroll County.
- Mental health services and chronic disease management education programs at free or low cost.
- Job training
- Easier access to physicians

Informants were asked to rate existing services and outreach activities in Carroll County on a scale of 1 (poor) to 4 (excellent). More than half of informants (55.0%) rated existing efforts as good, while 45% rated them as fair. Informants were also asked to give comments and suggestions on how health and wellness efforts are best promoted in the community. Key informants felt that a lot of people may be unaware of existing programs. One key informant explained "Unfortunately, there is no one secret solution. A diversity of programming in a wide array of situations, at the grassroots level, is the only way forward."

Select Comments Regarding Ideas for
Health and Wellness Promotion Programs

- Workplace promotion – could offer to come in to do trainings on nutrition or anything physical being offered in the community.
- School programming – a lot of younger kids sit more than they're outside playing.
- Fairs
- Promoting workplace wellness in the area
- Outreach events that really reach the heart of the community.
- Outreach events to children
- Social media and online calendars
- Meeting people in places they are comfortable and frequent.
- Social media, banners and posters
- Holding teaching seminars in work places
- Tied to incentives to encourage participation
- Libraries and promoting in places where individuals already are like grocery store
- Health fairs
- Support groups
- Outreach events at soup kitchens and other sources of help.

General Feedback

Participants were asked to identify:

Specific populations in the community they feel are not being adequately served. Groups that were most frequently mentioned include:

- Elderly, especially those living alone
- Farmers (or others that work or live in relative isolation)
- Homeless
- Individuals with developmental and intellectual disabilities
- Low income
- Non-English speaking
- Those with mental illness
- Working poor – may make too much to qualify for programs but extremely limited budget

Areas of community health and wellness that need to be addressed but were not covered in the survey.

- LGBTQ support and outreach
- Need additional well-qualified professionals in certain fields – dermatologist and endocrinologist come to mind
- Need for basic screenings of hearing, vision, blood pressure

- Expanded educational time when with a primary care provider

Key informants were asked to identify two key elements they feel are important to the success of achieving a better quality of life for Carroll County residents. The most frequently mentioned elements are summarized in the following table.

Key Elements	
Dedication of the team to promote and then measure results and then adjust	Educate in schools – exercise, weight control, eat healthy
Mental health issues	Addressing substance abuse issues
Stable employment	Public transportation
Higher paying job opportunities	Meeting all socioeconomic classes
More affordable health care	Outreach and education for all populations
Better transportation	Diet and exercise
Employment opportunities in county	Social Support
Managing the stress of work/life balance	Affordable housing
Access to affordable and quality health care	

C. Attachments

- Key Informants – Community Leaders
- Results – Key Informants – Community Leaders
- Key Informants – Community Service Council
- Results – Key Informants – Community Service Council
- Survey Tool – Key Informants
- Transcripts

Key Informants - Community Leaders

NAME		AGENCY
Marie	Alford - Bennett	ASL Interpreter Corps, LLC
Kimberly	Baker	Adfinitast Health at Carroll Hospital
Melissa	Batten	Carroll Lutheran Village
Gary	Bauer	Retired
Tammy	Black	Access Carroll
Lisa	Carroll	Carroll County Department of Recreation and Parks
Patricia	Corbin	Westminster Fire Engine and Hose Co. No. 1, Inc
Robert	Cumberland	Westminster Fire Engine & Hose Co. No. 1, Inc.
Casey	Davis	LT360
Andrea	Drenner-Hannley	Carroll County Health Department
Jessamine	Duvall	Girls on the Run of Central Maryland
Megan	Eaves	Baltimore Gas & Electric
Kristen	Ellis	Enter Exit Escape
Ann	Fagan	Stanley Black and Decker
Ellen	Finnerty Myers	Carroll Hospital
Monica	Fisher	Fisher Tire and Auto Service, Inc
Jo	Fleck	Gypsy's Tearoom
Dorothy	Fox	The Partnership for a Healthier Carroll County
Mark	Goldstein	Carroll Hospital
Marshall	Green	CLSI
George	Hardinger	Carroll County Detention Center
Lauren	Hickey	Right at Home In-Home Care & Assistance
Beth	Hill	Long View Healthcare Center, LLC
Kevin	Kelbly	Carroll Hospital
Janice	Kispert	RCIS
Judy	Klinger	Carroll County Public Schools
Marty	Kuchma	St. Paul's United Church of Christ
Jim	Kunz	McDaniel College
Jeffrey	Laird	Hilltop Communications, LLC/ WTTR AM/FM
Barbara	Leasure	Carroll Lutheran Village
Carmen	Lennartson	Gerstell Academy
Amber	Lesane	Girl Scouts of Central Maryland
Brian	Lewis	BKZ Insurance Group Inc
Sally	Long	PHCC Board Member
Jessica	Macdonald	Grand Canyon University
Pamela	Malkin	Carroll Lutheran Village
Diane	Martin	McDaniel College
Cindy	Marucci-Bosley	Carroll County Health Department

Key Informants - Community Leaders

NAME		AGENCY
Kathy	Mayan	Carroll Community College
James	McCarron	City of Taneytown/Retirement Funding Solutions (RFS)
Sharon	McClernan	Carroll Hospital
Steve	Moore	Run Moore
Kimberly	Muniz	Carroll County Public Schools
Cindi	Offutt	Citizen
Sandy	Oxx	Carroll County Arts Council
John	Pardoe	Byte Right Support, Inc.
Anne Marie	Parish	AMP Up Health
Joni	Rampolla	Martin's Food Markets
Stephanie	Reid	Carroll Hospital
Denise	Rickell	Carroll County Business/Employment Resource Center (BERC)
Jill	Rosner	Rosner Healthcare Navigation
Kim	Royer	Westminster Fire Engine and Hose Co. No. 1, Inc.
William	Schroeder	Giulianova Groceria and Deli
Kathryn	Sheridan	Dean Robert Camlin & Associates, Inc.
Ed	Singer	Carroll County Health Department
Richard	Turner	Community Media Center
Leslie	Wagner	Department of Citizen Services
Lynn	Wheeler	Carroll County Public Library

Results - Key Informants - Community Leaders

Profile - Please enter the following information:

Name (Required)	Agency (Required)	Address	City	State	Zip	Phone	Fax	Physician Only: Hours per week devoted to patients
Amber Lesane	Girl Scouts of Central Maryland	4806 Seton Drive	Baltimore	MD	21215	410-358-9711		
Andrea Drenner-Hanley	Carroll County Health Departmnet	290 South Center Street	Westminster	MD	21157	443-744-9108	410-876-4430	
Ann Fagan	Stanley Black and Decker	626 Hanover Pike	Hampstead	MD	21074	410-239-5121		
Anne Marie Parish	AMP Up Health	PO Box 2383	Westminster	MD	21158	845-519-7338		
Barbara leasure	Carroll Lutheran village	300 St. LukeCcircle	Westminster	MD	21158	410-848-0090		
Beth Hill	Long View Healthcare Center	3332 Main Street	Manchester	MD	21102	410-239-7139	410-239-6460	
Brian Lewis	BKZ Insurance Group	15 E Main St., Ste 220	Westminster	MD	21157	410-777-5801	410-777-5892	
Carmen Lennartsson	Gears tell Academy	2500 Old Westminster Pike	Finksburg	MD	21048	410-861-7413	410-861-3006	
Casey Davis	Life Transformation 360			MD	21157	240-440-1379		60
Cindi Offutt	N/A	593 Sunshine Way	Westminster	MD	21157	443-547-8028		

Cindy Marucci-Bosley	Carroll County Health Dept.	290 S. Center Street	Westminster	MD	21157	410-876-4925	410-876-4959	
Cindy Marucci-Bosley	Carroll County Health Department	290 S. Center Streer	Westminster	MD	21157	410-876-4925	410-876-4959	
Denise Rickell	Carroll County Business/Employment Resource	224 N. center St	Westminster	MD	21157	410-386-2824		
Diane Martin	Center for the Study of Aging McDaniel			MD				
Dorothy Fox	The Partnership for a Healthier Carroll County	535 Old Westminster Pike	Westminster	MD	21157	410-871-6373		
Edwin Singer	Carroll County Health Department	290 South Center Street	Westminster	MD	21157	410-876-4974		
Ellen Finnerty Myers	Carroll Hospital							
Gary Bauer	Retired	924 century St.	Hampstead	MD	21074	443-507-5121	Same	
George Hardinger	Carroll County Sheriff's Office, Detention	100 North Court Street	Westminster	MD	21157	410-383-620		
James Mccarron	City of Taneytown	17 E Baltiomore St	Taneytown	MD	21787	410-751-1100		
Janice A. Kispert	RCIS	224 North Center Street	Westminster	MD	21157	410-857-0900		
Jeffrey M. Laird	WTTR AM/FM	101 Wttr Lane	Westminster	MD	21158	410-848-5511	410-876-5095	
Jessamine Duvall	Girls on the Run of Central Maryland	9150 Rumsey Rd, Suite A7	Columbia	MD	21045	443-583-7740		
Jessica Macdonald	Grand Canyon University		Eldersburg	MD				
Jill Rosner	Rosner Healthcare Navigation	PO Box 1896	Westminster	MD	21158	410-591-6378	410-876-0928	

Jim Kunz	McDaniel College			MD				
Jo Fleck	Gypsy's Tearoom	111 Stoner Ave.	Westminster	MD	21157	410-857-0058	410-857-9248	
John Pardoe	Byte Right Support	1840 Snydersburg road	Westminster	MD	21157	410-259-5665		
Joni Rampolla	Martin's Food Markets	1320 Londontown Blvd	Eldersburg	MD	21784	410-552-5107		
Judy Klinger	Carroll County Public Schools	125 N Court St	Westminster	MD	21157	410-751-3125	410-751-3695	
Kathryn Sheridan	Dean Robert Camlin and Associates	182 East Main Street	Westminster	MD	21157	410-876-6900	410-876-9268	
Kathy Mayan	Carroll Cammunity College	1601 Washington Road	Westminster	MD	21157	410-386-8110		
Kevin Kelbly	Carroll Hospital Center	Memorial Ave	Westminster	MD	21158	410-871-6868		
Kim Baker	Admin it's Health at Carroll Hospital	200 Memorial Ave	Westminster	MD	21157			Hospitalist 30 hrs
Kim Royer	Westminster Fire Dept	28 John Street	Westminster	MD	21157	410-848-1800		
Kimberly Muniz	Carroll County Public Schools							
Kristen Ellis	Enter Exit Escape	1902 Back Acre Circle	Mount Airy	MD	21771	301-703-5258		
Lauren Hickey	Right at Home In-Home Care & Assistance	826 Washington Rd suite 103	Westminster	MD	21157	410-871-9804	410-871-9807	
Leslie Wagner	Department of Citizen Services	10 Distillery Drive, Ste 101	Westminster	MD	21157	410-386-3818		
Lisa Carroll	Carroll County Dept. Of Recreation and	300 South Center Steer	Westminster	MD	21157	410-386-2103		

Lynn Wheeler	Carroll County Public Library	1100 Green Valley Road	New Windsor	MD	21776	443-293-3136	410 -386-4509	
Marie Alford-Bennett	ASL Interpreter Corps, LLC	1213 Liberty Rd Suite 280	Sykesville	MD	21784	877-826-7791		
Mark Goldstein	Carroll hospital	2314 East Ridge Rd.	Timonium	MD	21093	202-316-3954		Emergency medicine - 30 hrs
Marshall Green	Partnership/church of God	831 South Main Street	Hampstead	MD	21074	4.1E+09		
Marty Kuchma	St. Paul's United Church of Christ	17 Bond Street	Westminster	MD	21157	410-848-5975		
Megan Eaves	BGE			MD				
Melissa Batten	Carroll Lutheran Village	300 St. Luke Circle	Westminster	MD	21158	443-605-1032	443-605-1093	
Monica Fisher	Fisher Tire and Auto Service, Inc.	1148 Old Manchester Rd	Westminster	MD	21157	410-876-2305		
Pamela Malkin	Carroll Lutheran Village	300 St. Luke Drive	Westminster	MD	21158	443-605-1011		5 hrs
Patricia Corbin	Westminster Fire Engine and Hose Co. No.1, Inc.	28 John St.	Westminster	MD	21157	410-848-1800		
Richard Turner	Community Media Center	1301 Washington Rd	Westminster	MD	21157			
Robert cumberland	Westminster Fire Department	PO Box 357 28 John Street	Westminster	MD	21158	410-848-1800		
Sally Long	None			MD	21157			
Sandra Oxx	Carroll County Arts Council	91 West Main St.	Westminster	MD	21157	410-848-7272	410-848-8962	
Sharon Mcclernan	Carroll Hospital	200 Memorial Ave.	Westminster	MD	21158	410-871-6776		

Stephanie Reid	Carroll Hospital Center	200 Memorial Ave		MD	21157	410-871-7107	410-871-6672	
Steve Moore	Run Moore	13 Liberty St.	Westminster	MD	21157	443-201-8203		
Tammy Black	Access Carroll	10 Distillery Drive, Suite 200	Westminster	MD	21157	410-871-1478	410-871-3219	
William	Giulianova Groceries	11 East Main	Westminster	MD	21157	410-876-7425		

General Health and Behaviors

GHB1 -Please review the following general health issues below and choose the five (5) you believe are the most important to address in our community in the next 3-5 years.

#	Answer	%	Count
1	Alcohol Abuse	5.90%	17
2	Alzheimer's	10.30%	30
3	Asthma	0.00%	0
4	Cancer	6.90%	20
5	Chronic	1.70%	5
6	Congestive Heart	1.40%	4
7	Dental Health	1.00%	3
8	Diabetes	8.00%	23
9	E-cigs/ Vaping	2.10%	6
10	Heart Disease	6.20%	18
17	Illegal Drug	14.50%	42
11	Immunizations	1.00%	3
12	Injury	0.70%	2
13	Mental Health	13.10%	38
14	Obesity	10.70%	31
15	Sexually	0.30%	1
16	Stroke	0.00%	0
18	Tobacco Use	0.30%	1
19	Prescription	10.00%	29
20	Physical	5.20%	15
21	Other:	0.70%	2
	Total	100%	290

GHB2 - Of the 5 General Health issues you selected, what do you believe is the number one priority?

#	Answer	%	Count
1	Alcohol Abuse	1.70%	1
2	Alzheimer's	5.20%	3
3	Asthma	0.00%	0
4	Cancer	3.40%	2
5	Chronic	1.70%	1
6	Congestive Heart	0.00%	0
7	Dental Health	0.00%	0
8	Diabetes	1.70%	1
9	E-cigs/ Vaping	0.00%	0
10	Heart Disease	1.70%	1
11	Illegal Drug	31.00%	18
12	Immunizations	1.70%	1
13	Injury	0.00%	0
14	Mental Health	22.40%	13
15	Obesity	17.20%	10
16	Sexually	0.00%	0
17	Stroke	0.00%	0
18	Tobacco Use	0.00%	0
19	Prescription	8.60%	5
20	Physical	3.40%	2
	Total	**100%**	**58**

GHB3 - Why do you believe that your choice is the most urgent health problem to be addressed?

* Overdose deaths continue to climb and are now the 3rd leading cause of death in all age groups. These deaths are entirely preventable. Substance use has a negative impact on almost all aspects of our society.
* Drugs have become rampant in our city and society in general. Because of this crime rates go up and the community suffers in all aspects of life
* As our aging population grows, more individuals are being diagnosed with a form of dementia. I believe more awareness of taking care of a loved one diagnosed and having more readily available resources would help. Family members become frustrated and don't have the right tools or understanding of the disease.
* This population has significant and complex needs. Underserved, perhaps due to the the long term nature and that more typical community/ business partnerships are not comprehensive enough to support sustained treatment or 24 hour care required by this population. Expense a factor as well.
* Chronic lung disease affects a large population in this area, and patients with chronic lung disease have a severely limited quality of life without proper resources.
* Because I have seen too many people, handed prescription drugs for pain and they are not monitered.
* Because a lot of physical health issues .... Alcohol and drug abuse ..... Obesity w/ food as a drug .... spring from mental health issues.
* MD has a significant problem with opioids, Carroll County is in the mix of the problem.
* Leads to multiple issues such as drug use, death by suicide or terrorism.
* I work with a lot of overweight customers and a large number of health issues seem to stem from being overweight.

* Reading and hearing about the increasing number of drug overdoses and deaths. Only going to get worse.
* 60-70% of those people In our community who have a chronic disease suffer from a mental health or substance abuse diagnosis that often is a barrier to them getting the care that they need or engaging in their own health.
* Heroin is impacting all economic levels and resulting in death
* Very prevalent and need additional resources.
* Growing epidemic within the community,etc.
* Being overweight worsens all of the other health issues
* Many children from low income families need to get the immunizations necessary to keep healthy and prevent any outbreaks.
* You are what you eat and improving eating habits and making healthy choices will decrease incidence of most disease. Obesity is a risk factor for most diseases
* Linked to poor health outcomes in later life, including three of the remaining four top of my top five. Also physical activity increases social interaction, which positively improves both mental and physical health outcomes in later life. Also, physical activity and exercise has been demonstrated to improve cell body functioning in the brain and promote brain health demonstrated through cognitive assessments.
* If you don't have mental health, physical health is almost irrelevant
* Because it is affecting so many lives
* The opiate epidemic effects otherwise young healthy people and has tremendous ripple effects, destroying families, taxing social services, leading to other ,metal health problems and crime
* Because it cause many health problems & the use of resources that puts a burden on the health system and their resources
* It addresses the root cause of the other selections
* Taxing resources for nonprofits.
* People need the resources to get into rehab and stay clean. People also need to be held accountable for their actions.
* It impacts many other aspects of health
* Other selected categories can tie into Heart related illnesses
* Mental health issues effect every one and is not inclusive to one population. When untreated it leads to crises in family, employment, relationships and living situations.
* The opioid abuse epidemic is ever increasing and having a devastating impact in n our community
* Limited resources, pervasive stigma, non parity in reimbursement of professional services, growing rates, expensive recidivism
* If you help people control weight, you may reduce the risk of diabetes, heart disease, cancer and sedentary behavior at the same time.
* It has in impact on all the other health conditions.
* Because all of society if a victim --- not just the person using the illegal drugs. Arresting these people doesn't work - we need treatment and rehab options.
* Education and outreach
* Impacts the community greatly as it leads to many other social issues.
* Drug addiction and related socio-economic issues are ravaging the homeless community in particular as a vulnerable population. When I interviewed 11 homeless people for my Homeless Life Story Collection Project, all 11 interviewees named drugs as a pivotal issue affecting their lives in detrimental ways, either by way of their own drug use, or the use of drugs by others and the loss of friends to overdose, jail, etc..
* Most people effected

* In conversation after conversation with affected families, there is a distressing level of recognition that resources, within the county and beyond, are limited and overburdened. Mental health issues are often invisible to the public eye, but I believe in large part it is due to the stigma associated with this array of illnesses that there is an under recognized population in need. I believe that practitioners and professionals within this field of care would agree with me without hesitation.
* Substance abuse impacts the entire family and contributes significantly to criminal behavior
* Fules other areas of the community such as crime and disrupts families
* Seeing the increase in weight in the past few decades - overweight, obesity and morbid obesity which leads to higher instances of diabetes, cardiovascular disease, cancer and other illness/ diseases. From 20% to up to 30%-40% in many States, including MD at 28.9%.
* I believe we need to educate and motivate community residents to make healthy food choices and become more active.
* It is related to so many other problems including stroke and other heart issues.
* Epidemic of Cognitive impairment leading to quality of life issues for the person affected and family members. Increase in exploitation of vulnerable adults.
* Resources are limited and sometimes lacking in effectiveness. Misunderstandings of the community at large, in relation to mental health issues and behaviors, can lead to improper and destructive treatment of those individuals, exacerbating the problems. Mental heath challenges, when not diagnosed and treated early and openly, often lead to troubles with the law, drug abuse, and physical ill health, which burden the community as well as the individual.
* A sedentary lifestyle contributes to several other items on this list - obesity, heart disease, diabetes, and poor mental health.
* News reports and statistics for the area indicate an increase in overdoses. There are also indicators that show this is effecting teenage and young adult populations that most. Addressing the issue now may be able to lead to less cases and help sustain a population in the area.
* Because it impacts all areas of the community; health, economic and safety.
* Hearing reports about the amount of deaths in our area related to drugs, makes me think there is an imminent problem.
* Greatest negative community impact
* The complete lack of dietary knowledge
* Opioid epidemic is having significant negative effect on our community, state and nation.
* Growing epidemic of this disease without growing work force to take care of needs.
* Mental wellness is the pre requisite to fully functioning in society. Mental wellness is so closely tied to physical well being.
* Such a large part of the population is obese
* There is an access issue with limited services in the hospital and not enough appropriate providers or programs in the community.
*The mental health of our children and adults significantly impacts many areas related to community health.

GHB4 - Additional comments regarding health issues in the community (optional):

* Alcohol, illegal substance use, prescription drug use,alcohol abuse, and even tobacco are all somewhat related and are treated/prevented in a similar manner. I do not think separating them out is necessarily productive. Especially prescription drugs and illegal substances. The one generally leads to the other.

* Treating certain diagnoses is important as is the prevention of same. A key aspect of prevention is to foster healthy lifestyles. Would love to see Westminster/ Carroll become a "green" city/county with green space, community advocacy for healthy, outdoor events, etc.
* Also feel Mental Health is tied in with prescription drug use.
* As a society we are doing the mentally ill a disservice.
* I think the problem also stems from prescription drug overuse...both issues are related and a significant problem.
* I think we are headed in the right direction but inactivity is still a large problem in the area.
* Sexual violence is a huge (under reported) issue as well.
* Begin education with preschool children on healthy lifestyles
* Obesity and drug abuse (particularly opioid) are very close in urgency. Obesity because it leads to so many other problems. Opioid abuse is an epidemic that affects millions every year, including our own family.
* This county seems to be lagging behind in smoking cessation unfortunately. Smoking related illnesses like copd are quite prevelent and preventable
* Transient homeless population.
* Mental health is a big issue. Not available to everyone when they need it.
* E-cig and drug abuse are mostly directed to the younger population. I see so many young people that do not know how to choose a healthy meal.
* Both drugs and alcohol abuse appear to be on the rise.
* I see the overweight issue and the unhealthy food choices, use of cigarettes and Vapes - I believe these are important concerns.
* The decision between Dementia/ Drug abuse is difficult. We can no longer be a County among also an epidemic and silently not address this issue which is affecting every aspect of the community.
* I believe it is important to educate kids about the importance of lifelong exercise and the many ways they can incorporate physical activity into their lives. By starting with children, hopefully they will never fall into the trap of sedentary living.
* With so many vaping & e-cig stores popping up, it appears this trend is here to stay. Do we know enough about the health risks associated to these types of tools & do we need more rules/laws involved to control use?
* Need to assess and address linkages between behaviors addressing more causal issues to increase impact
* We should be starting with robust programs in the school system for healthy eating, increased activity and mental health awareness. A hospital -public school partnership to jointly develop programs that are unified across the county would be a game changer in 10 years.
* These is an increasing number of younger and younger children with significant mental health

GHB5 - On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about Health Care Access in our community.

#	Question	Strongly disagree		Somewhat disagree		Neither agree nor disagree		Somewhat agree		Strongly agree		Total
1	A: The majority of residents in Carroll County have access to	1.70%	1	10.30%	6	15.50%	9	50.00%	29	22.40%	13	**58**
2	B: The majority of residents in Carroll County have access to	1.70%	1	17.20%	10	17.20%	10	52.00%	30	12.10%	7	**58**
3	C: The majority of residents in Carroll County are able to	3.40%	2	15.50%	9	34.50%	20	38.00%	22	8.60%	5	**58**
4	D: Transportation for medical appointments is available and easy to	17.20%	10	34.50%	20	36.20%	21	10.30%	6	1.70%	1	**58**
5	E: Healthcare resources are available and accessible.	1.70%	1	20.70%	12	38.00%	22	32.80%	19	6.90%	4	**58**
6	F: The majority of residents in Carroll County have the ability	12.10%	7	25.90%	15	41.40%	24	20.70%	12	0.00%	0	**58**

GHB6 - Additional comments regarding health care access (optional):

* It is my experience that timely access to dental services can be problematic. Most people have very little dental benefit coverage.
* Transportation is a huge need in our area due to patients not having accessibility to transportation or being able to afford it. Home bound individuals are also in need of home visiting physicians.
* The demographics of our county would suggest that medical services and transportation are available. However, there is a population that is uneducated to available services, especially transportation.
* A lot of services are available but not in a sufficient amount to serve the needs of the county.
* Many of these things are available but are cost prohibitive.
* Whereas healthcare is accessible, the ability to use it is based on economics. If you have a job with healthcare benefits, you have access. If you do not have that, healthcare is so costly, you put it off until it is critical. Without a car in this county, it is very difficult to get to healthcare.
* I personally am not a county resident, so unsure of services offered in the county, hitch led to my neutral responses. The statements I addressed were based off data from the aging in place survey data, as well as the organizations to which I belong.

* Affordability is becoming more of an obstacle every year, especially for middle class, self-employed, small-medium business owners and their employees
* The majority may have access and financial resources, but those limited in access and resources are creating the greatest costs and overwhelming resources in this community.
* Issues such as transportation is a problem but only for a small majority of the County Population. A disproportionate amount of resources are spent on the management and development of transportation. Time and money could be used more effieciently and effectively. Primary physicians and medical specialist are available however getting a timely appointment is not. Structure of hospital and practice billing has increased the amount of "services" resulting in multiple co-pays for one visit. Ability to pay is hitting the middle class the hardest due to coverage shortfalls and lack of subsidies.
* Baseline medical services are theoretically available to homeless and otherwise marginalized people. Access Carroll in particular does heroic and vital work. But there is far from a reliable and comprehensive service system for most people on the edges -- including meaningful relationships with medical providers over time. Transportation is a critical lack, and funding seems to be spotty.
* Answering these questions as worded (that the majority...) implies I know the economic demographics of the county. I do not. Within the context of my personal experience and that of the business I work for, it would seem the answer to these questions would be within the agree array. But I do believe that here are many within the county that do not have the ability to pay for medical care or transport themselves, I just do not know what per cent of the population it makes up.
* Transportation remains an issue or barrier for many and those with limited resources suffer the most. In summary, what is needed is a comprehensive system of public transportation.
*Health care cost are a strain on every segment of our population except the exceptiononally wealthy
* I suspect the The majority of residents have access to and resources for health care. However, that does not consider the toll it takes on a budget (and what families must give up) when insurance premiums and prescriptions are so costly. The rest of the residents who have no access are often overlooked.
* I don't know a lot about the state of healthcare access in Carroll County. I imagine that transportation, the cost of care, and high insurance premiums are an issue here as they are nationally.
* I am not knowledgeable enough of the area to agree or disagree to any of the above listed questions.
* While the majority have access and ability to pay for health and wellness services, those that do not are increasing and are impacting the whole community.

Social Determinants of Health

Social Determinants of Health are defined by the Centers for Disease Control as the conditions in which people are born, grow, live and age.

SD1 - Please review the following social determinants of health and pick the three (3) you believe are the most important to address in our community in the next 3-5 years.

#	Answer	%	Count
1	Early Childhood	11.50%	20
2	Educational	9.80%	17
3	Job Skills	8.60%	15
4	Employment	14.40%	25
5	Food Security	6.90%	12
6	Quality Health Access	10.90%	19
7	Affordable Housing	14.40%	25
8	Economic Success	11.50%	20
9	Social Support	12.10%	21
	Total	**100%**	**174**

SD2 - Of the 3 Social Determinants of Health you selected, which one do you believe would make the greatest impact to the health of our community?

#	Answer	%	Count
1	Early Childhood	10.30%	6
2	Education Attainment	12.10%	7
3	Job Skills	3.40%	2
4	Employment	13.80%	8
5	Food Security	6.90%	4
6	Quality Health Access	15.50%	9
7	Affordable Housing	15.50%	9
8	Economic Success	12.10%	7
9	Social Support	10.30%	6
	Total	**100%**	**58**

SD3 - Why do you believe that this determinant is the most important social issue to address?

* Quality affordable housing is key because substandard housing contributes to poor health overall.
* The more educational opportunities available starting in early childhood will most likely determine a successful outcome for that individual
* Having more employment opportunities will naturally bring people into a social setting, as well as financial benefits for livelihood.
* More money more services
* Throughout the spectrum of life, access to quality healthcare is vital to ensuring people develop well and remain healthy enough to provide for themselves (and their families). As people age, access to quality healthcare remains just as important, so that in the last phase of life, they can maintain just as good of a quality of life as they did when they were young, in spite of their increasing needs.
* Need information on how to proceed health wise, when the need arises.
* It's important to have healthy citizens so that they can contribute to the quality of life in the county.
* It is a basic need. Those without housing are at a significant advantage to being successful in all other areas.

* The more education one attains, the better livelihood. Whether it's higher learning or awareness, education is crucial for one to succeed.
* Giving people the ability to support themselves financially will help lead to better life choices.
* Decent paying jobs within close proximity of where someone lives increases their quality of life. Less commuting time. More family and social time. Also need to have access to affordable housing.
* Social support to connect people to necessary resources.
* Many of our residents live paycheck to paycheck or are under employed. Unforeseen medical bills can greatly impact a family
* Needed by all to remain well and be functional in their life and society
* Once you have housing you can afford, you are no longer homeless.
* If a person is not able to gain employment they will have no income. Therefore without government program help they would not be able to afford health care.
* A resource to turn to for all the social determinants
* My fous and knowledge are optimal aging. Social support is a key determinant to promote that regardless of physical or cognitive ability.
* The majority of the population cannot be self sufficient without an education
* With out it, you do not access to any thing
* This was a traditionally rural county with a large family based agricultural economy for many years. I believe the rise in drug abuse has tracked closely with the loss of traditional occupational structure and perceived lack of upward mobility. We see this trend in communities across the nation.
* If the cost of health care continue to go in the direction it is today I believe there will be less people being able to have coverage
* Difficult question. Based on my 3 choices above, without education, you could have all of the financial resources necessary but still make incorrect choices. Conversely, if you had education without financial resources to make appropriate choices, your education wouldn't matter (although it would help you to be more conscious of your decisions). Lastly, you could have education and finances without food, and neither would matter.
* Current population is taxing resources for healthcare in which they are calling 911 for basic healthcare needs. Oftentimes first responders are acting as a taxi service.
* If people are mentally and physically well they have a better chance of WANTING to be a productive member of sociality.
* Any barriers to health whether perceived or real cause patients to not seek out basic care
* Knowing how and understanding where to find and access support
* When you don't have a place to call home or your own then there is no stability in all aspects of your life.
* The high cost of housing, and lack of affordable housing, causes financial stress that negatively impacts our residents (and makes them choose between other necessities, such as health care)
* Cost of living requirements to acquire even minimal housing is way above average hourly wage earning in Carroll County.
* Food security is an issue that I work closely with. I have many clients that believe they cannot afford healthy food or that only shop for food in the dollar store. When you buy only cheap products it pushes the individual closer to disease.
* Food insecurity can have catastrophic effects on health thereby influencing ability to learn, and work.
* If people can earn, they can pay for services needed and it takes burdens off other tax payers.
* Is a beginning point for long term change
* It creates the most struggle. Without economic success much more social service support is needed.

* If we buy the Housing First model -- which I think we should, we need to create an environment in which every person can reasonably expect a roof over their heads, an address, literally a "home base" from which to address other issues.
* Life's patterns are formed
* If children are hungry they cannot learn. If children are hungry parents are distressed. If the food available is poor then health is impacted long range.
* Too many children do not have access to child care and for many it is very expensive. Getting off to a good start is all important.
* Aiding residents to position themselves in a place to be self sufficient
* I believe early detection and prevention are crucial to be aware early of any illness or disease, to reduce the progress of disease and in the end will reduce expenses.
* It has been shown that isolation is one of the most contributing factors in drug addiction. Having a social support network helps to keep people with a range of issues engaged in the community and their own healing and/or solutions.
* Difficulty accessing appropriate services in a timely , affordable fashion with transportation access is driving the crisis!
* Developing brains are hugely influenced by everything around them. When the youngest of children receive quality health care, education, positive social skills, and good role models in a safe, nurturing, healthy environment, we set hem up for a healthy and productive future.
* Access to healthy food is key to community health. Lower-income families tend to rely on unhealthy food options that are inexpensive, like fast food and processed meals. If families have healthier food options available for the same cost, they may be able to eat better. The Roving Radish in Howard County is a good example of how this can work.
* Thinking long term, providing for the development of the children in the area can lead to greater advancements in the community over time. Provide a way for children to learn, be creative and innovative and they can bring ideas to their community as they continue to grow. Healthy and happy residents tend to stay in an area and will later decide to raise kids there.
* Housing is a basic necessity that is out of reach for many, including those who may have a good education and employment. So many have to move away from social support or family to obtain affordable housing or must find employment outside of the community to afford local housing but results in long commutes.
* A safe, clean home is a great place to start as long as it is affordable. Then, people are able to work on employment & children have a foundation to thrive.
* Dependent upon definition, social influence on behaviors can increase healthy outcomes
* Working makes one feel better about themselves and in turn get healthy
* Education provides opportunity to gain employment and provides opportunity for people to read about and independently study health cause, effects and best practices.
* We need the workforce to meet healthcare and other service needs in the future
* Around the world, wellness is directly connected to economics. If there is job opportunities and economic growth, better health will correlate.
* We need good paying jobs to allow our community to prosper and grow
* If people were successfully employed they would have the stability and better access to services they need.
* Early intervention is vital to the health of our community. We need more resources to address the growing concerns in this area.

SD4 - Additional comments regarding social determinants of health (optional):

* Over 60% of Carroll countians work outside of the county. We need more employment opportunities with wages such that a person can live here.
* Social support is equally important. Need affordable access to daycare, availability of peer support groups and even organized recreational activities to maintain community cohesion.
* Need more affordable housing options such as single room occupancy, smaller apartments, etc
* Well being should be an area of focus as it combines many of the SDOH.
* This is a hard set of options. All of them matter and are important to address. Housing was an easy first choice, economic success and opportunity seem to follow that as a need. And I am worried about how current realities affect children and young people, upcoming generations. We are seeing more homeless and struggling families needing help and coming for community meals.
* NO additional comments
* Many of the determinants affect overall health of the community
* Access to affordable solutions is limited.
* Teaching children healthy eating habits at a young age is key. They will then educate their parents, creating a ripple effect.
* It was tough to limit this category to just three options. If allowed, I would have definitely included social support and quality health access.

Programs, Services & Promotion

PSP1 - Please describe any programs or services that you feel should be developed and offered to those who live in our community.

* Prevention programs of all types are key to reducing the overall burden on the health care system. Substance use prevention, healthy lifestyles programs (to prevent obesity, diabetes, etc.) contribute to reducing chronic diseasses.
* Continue to focus on drug and alcohol awareness especially the Rx drug epidemic
* More support groups for caregivers taking care of a loved one. More Alzheimer's specific support groups.
* Better access to substance abuse treatment programs. Easier access to appointments for community service programs such as Access Carroll.
* Mental Health is important because it is the most overlooked
* Mental health screening or testing in young children can head off a problem before it gets worse and becomes a bigger problem.
* I would like to see more incentive based programs for weight loss. Offering a program like a large scale couch to 5k program with incentives for participation could help boost community spirit and morale.
* Bike and walking trails.
* Expansion of access to drug treatment. Places that are locally accessible for people to seek treatment when they are ready. Not three weeks later.
* Financial transparency before procedures
* Educational offerings in community as to healthcare options, etc
* Workforce development.... Updating skills using technology.
* Easy access to affordable insurance (not just to those in economic despair.

* Retirement planning beyond finances
* School vouchers for children to choose schools where they'd be a better fit, like being to go to Carroll Christian for example. More hospital systems establishing health insurance like geisinger and Kaiser. Care is delivered more efficiently for less cost and a holistic approach from cradle to grave
* Job training for people lack the skills to work in a world class economy
* More comprehensive 24/7 mental health and addiction resources. These should be coordinated wig public schools to identify at-risk students when they are first developing their addiction.
* Maybe a good community based health care program
* As an example, I would recommend follow up to the Partnership's knowing that 30% of the community is diabetic, but WHO are they and what incentives do they have to change.
* More in the community resources which are easily assessable to a specific demographic population. Thinking outside the box and development current resources to be able to treat instead of transporting to the hospital.
* Housing programs that allow/encourage people to better themselves. More accountable for people that have overdosed. Get them immediate help, many have to wait to enter rehab.
* Education about healthy life habits especially for rising risk patient populations.
* Walking prescriptions and Doc on the Park programs. Resources provided in physician offices regarding free walking or physical education programs that promote health and wellness.
* Transportation, permanent supportive housing
* Development of affordable housing; in addition, we need to improve our transportation system, so that residents can get to places where there are jobs (even if those jobs are outside the county)
*Affordable housing, job and skill education with child are waivers during the educational process .
* How to prepare healthy foods and snacks on a budget.
* Facilities and services for the homeless to help them return to being a productive member of society.
* Parenting classes and support for all families, regardless of socio-economic status
* Better hospital services. More cooperative and supportive of the business community. More health programs to improve health in communities.
* On-demand, local detox in our community
* opportunity for at home employment (telecommuting)
* More mental health outreach and therapeutic options. Increase resources!!!
* First is substance abuse and mental health programs.
* More information and access to nutrition and healthy eating. More encouragement and access to physical activity. Education about detriment of smoking and Vaping.
* More transportation, access to physicians without a 3 month waiting list. Treatment centers for drug and ETOH abuse (in-patient). Services for Aging with cognitive impairments
*I would like to see Girls on the Run in every Carroll public school. There are comparable programs for boys (Heroes, Let me Run) as well. Our program uses running to teach important emotional and social skills. The lessons in confidence, caring, community, compassion, and more are better retained because of the link to physical activity during each lesson. A bonus side effect is that girls become more physically active. It serves the whole girl.
* Without as much knowledge of the area as I would like, it is hard to say. I would definitely like to see more programming or services for drug prevention, understanding mental health and developing coping and conflict resolution skills.
* Affordable mental health and addiction services.
* Transportation,
* Direct engagement and incentives/disincentives toward target populations

* Access Carroll
* Lifelong Dental care starting at birth
* Additional transportation options. Wellness programs that are geared to families and to all generations-more parks and walking trails with fitness stations,etc
* Continued efforts in strengthening families and the necessity of solid early childhood development. Breaking the cycle of poverty, family dysfunction,drug abuse and mental health issues is a priority.
* A formal Hospital/school partnership
* We need a in-patient and out-patient mental health services for children. Many of the families of children with this need either cannot or will not drive to Baltimore for treatment.

PSP2 - How do you think health and wellness are best promoted in our community? (Example: fairs, workplace, class education, outreach events, other)

* Workplace programs are a great idea if the employer buys in. Giving the employee an opportunity to improve their health improves productivity and morale. Events that raise awareness and encourage healthy habits can be effective but are not as sustainable long-term.
* Very good and getting better each year
* Seniors on the Go Expo, carroll hospital center, senior centers and educational programs, health fairs
* Workplace events and outreach events.
* Education
* Expos, fairs, radio programs, open houses at the hospital are all good ways to get the community involved.
* All of the above. Broad promotion ensures the greatest number of community members have awareness of what's available.
* Outreach events and class education
* Radio and health fairs are great. I think a lot of this stems from work and knowledge at home. Parents that are active tend to have kids thar are active. The city of Westminster does mile races that encourage parents to run with their kids. Those are great places to see parents and kids work together.
* Outreach events
* Outreach events, educational materials and events, particularly in our schools. Could do better expanding to workplaces etc.
* Fairs, outreach, workplace as a variety meets more community members needs.
* All of the above because each targets a different audience.
* Outreach events close to services already being used. Promote via social media and billboards.
* Outreach events
* Fairs, class education, large Carroll County events such as fall Harvest Days, create a new look for the annual events to draw new young families
* Outreach events, employee seminars through hr department
* With a stick and carrot approach. Motivation through rewards and punishments
* Fairs, community outreach
* Workplace, schools, outreach events
* Word of mouth, social and print media
* I don't think that it is a one size fits all And that each of the options provided would reach unique participants
* Outreach events , school details, fairs

* All of the above
* All of the above. Need to reach those that are not engaged and those new to the County/community.
* Education, workplace
* Fairs, outreach events, social media
* We are a very coordinated community concerning Health and wellness , but ongoing networking and planned strategies will ensure ongoing success
* outreach events, workplace
* Any outreach and education including public events as well as daily in the libraries and places of employment.
* Very hard to determine as there are considerable generational differences. I don't think its a one size fits all response. Some generations like hard copies, others only social media and in between there are those who want a website to visit.
* workplace
* All of the above
* I don't see any health and wellness promotion in the community.
* Carroll County is exceptional in the level of integrated services it provides to people in need. That said, there is still so very much to do. I would guess that each of the means of promotion listed above are important in one way or another. Offering services at daily community meals also seems to be an underutilized means of reaching marginalized people. For example, DSS now comes monthly to our meal and they are kept quite busy. Can we do more of that?
* outreach events
* Support of non profits that focus on these areas. Workplace information distribution. Finding a way to reach the less affluent with information and support
* For those employed the work place is best. But outreach where efforts are made to reach people wherever they are. True outreach needs to be a two way street.
* Promoting via community activities such as walk carroll
* Health Fairs, workplace health Ed, seminars and workshops, outreach events. Any community event have information displayed.
* A combination of strategies works best. The more people see the same message the better. Outreach events, talks, education conducted through civic organizations, clubs, schools and churches. Maybe train a core of people representing each group (ie Rotary, scouts, ministers, etc) to help with presentations in the groups they participate in.
* Media. Fairs, free events for promotion, Senior Centers. Childcare Centers, Banks! , restaurants
* Schools (for youth) and outreach events (for adults).
* Integration into school activities (other than PE), education about the impact of minor changes on your health (e.g., eliminating sodas, adding a veggie to each meal, walking or biking to the store). Health fairs are also great.
* Fairs, educational seminars, and outreach events.
* All of the above are good examples but it should be easily accessible and available during a variety of time frames. Use of technology should be explored.
* Schools, community centers churches
* Outreach
* Schools, libraries, workplace
* Workplace,school, friendly competitions. Entwined drowns for healthiest status
* Workplace, schools, commercial/ Grocery stores, eateries.
* Local fairs, school programs and speciality events

* In the schools and at physician offices
* I think it's important to address these in multiple ways in order to reach the most amount of people.

PSP3 - Related to health and well-being, how would you describe existing services, outreach and promotion in Carroll County?

#	Answer	%	Count
1	Poor	5.30%	3
2	Fair	36.80%	21
3	Good	56.10%	32
4	Excellent	1.75%	1
	Total	**100%**	**57**

General Feedback

GF1 - Are there specific populations in the community that you feel are not being adequately served? If so, who?

* It is difficult to reach the lower income populations because it is not a priority and it is difficult to convince them to make it a priority when they are struggling with other issues.
* Aging population, lower income residents
* I think there are many services in place, but maybe not enough knowledge is given to the providers in the area in order to refer patients to these resources.
* Drug abusers
* As stated before the mentally ill are not being adequately helped and especially the poorer segments of the county who are mentally ill.
* Anyone without adequate transportation to access services.
* Young adults
* I know of two Baltimore programs that teach running to drug and alcohol rehab residents. I think a group that helped recovering addicts could be a great thing for the county and I don't know of anything like that around here.
*Victims of sexual violence.
* People with mental health disorders. People who are pre-disposed to diabetes.
* Those lower socio-economic groups in our community. Knowledge deficits more here.
* Unsure
* The middle class who earn just enough to not qualify for services.
* Middle class
* Current focus on elder health and wellbeing is treatment. A lot of new evidence on optimal aging physical and cognitive health and functioning is not incorporated in existing plans which can decrease healthcare costs
* Lower middle class
* Uneducated, those lacking the skills to find good paying jobs
* There is a need for more home-based resources for economically disadvantaged elderly patient (those who do not have coverage beyond basic Medicare)
* Homeless
* Yes, as always, the Deaf community

* Homeless
* Low income that get caught in the middle
* Low income elderly,
* Developmentally and physically challenged individuals
* Single parent households
* There is a growing immigrant population whose needs may not be met.
* Mental health and substance abuse, low income families needing affordable housing
* Middle class. The services are not identified to fit this population, most are "problem focused" therefore not addressing the group that potentially and quickly find themselves in a position of need.
* homeless/mentally ill
* Business community
* Drug addicted homeless people remain a particular concern. Also, with the shelters full and with waiting lists for the foreseeable future, homeless families are a special concern if only in the sense of passing on issues from one generation to the next.
* Always those who cannot afford health insurance. The aged.
* The elderly are served and those below the poverty linr.
* Homeless
* The poor and low income residents.
* Not sure
* Mental Health! Aging. Those with Abuse issues
* Mental health population
* No
* Mental health
* Those with mental illness
* Lower income families
* No
* Poor, undocumented populations
* Folks who cannot afford to go to gyms, some seniors that are somewhat home bound
* Families in poverty.

GF2 - Are there any areas of community health and wellness not identified in this survey that you feel need to be addressed?

* No
* No
* Mental health issues
* No
* No
* No
* Sexual assault/violence
* Not that I can think of.
* We offer is many services that our community doesn't know is available.
* No
* The population of the baby boomers who are living at home but in reality should be in assisted living facilities. Often those people need additional assistance "manpower " to help with a fall or other care.
* Cost

* Collaboration with agencies in order to compliment services offered
* Also concerned about health insurance and potential loss of insurance by low-income residents * On a federal level, oral health access needs to be addressed as well; Medical respite for homeless and transient residents; Transportation is a critical barrier to obtaining available services, jobs, etc
* Maintaining health, how to get to a place to recognize ongoing need to strive for health instead of waiting for an illness to strike or developing a chronic illness.
* Not time to reflect...
* Additional activities to keep families active.
* Social media can be used more effectively
* Exploitation; Sex trafficking/ abuse (it is happening here!)
* Social health (being active and engaged in community and with others)
* No
* I think the all areas have been covered
* No
* No
* Increasing the awareness of the importance of exercise and healthy eating
* Affordable childcare

GF3 - If you had to identify two key elements you feel will be important to the success of achieving a better quality of life by those who live here, what would they be?

#1	#2
Sustainable healthy habbits	Increased opportunities for physical activity
Solving the drug problem	Addressing the mental Heath issues
Health	Support
Education	Low/no costs services
A healthier population leads to a better quality of life	Dealing with mental health issues earlier through
Public Transportation	
Illegal drug use	Access to education
Financial security	Better education on health
More businesses	Decent wages
Access to mental health treatment	Pre-diabetes prevention and intervention.
Increasing knowledge of options and resources.	Accessibility to programs
Employment opportunities that offer good pay	Housing at reasonable cost
Affordable access to insurance for all	Informative brochures on healthcare
Education	Positive attitude
Social connectedness	Non economic retirement planning
Opioid addiction treatment	More access to education/job skills training
Job training	Opportunities for employment
Sense of purpose and pride in the community	Better access to mental health resources
Better education on drug use	Doctors educating there patients on the drug they
Nutritional education	Personal coaching & accountability
Addressing the community's current homeless	Addressing treatment needs for those people who
Involvement	Accountability
Health navigator, health coaching	Exercise and active living programs
Improve health	Improve wellness
Affordable housing	Affordable and available transportation
Lower cost of living	Affordable housing
Affordable housing	Transportation
Sustainable healthy habbits	Increased opportunities for physical activity
Solving the drug problem	Addressing the mental Heath issues
Health	Support
Education	Low/no costs services
A healthier population leads to a better quality of life	Dealing with mental health issues earlier through
Public Transportation	
Illegal drug use	Access to education
Financial security	Better education on health
More businesses	Decent wages
Access to mental health treatment	Pre-diabetes prevention and intervention.
Increasing knowledge of options and resources.	Accessibility to programs
Employment opportunities that offer good pay	Housing at reasonable cost
Affordable access to insurance for all	Informative brochures on healthcare
Education	Positive attitude
Social connectedness	Non economic retirement planning
Opioid addiction treatment	More access to education/job skills training

#1	#2
Job training	Opportunities for employment
Sense of purpose and pride in the community	Better access to mental health resources
Better education on drug use	Doctors educating there patients on the drug they
Nutritional education	Personal coaching & accountability
Addressing the community's current homeless	Addressing treatment needs for those people who
Involvement	Accountability
Health navigator, health coaching	Exercise and active living programs
Improve health	Improve wellness
Affordable housing	Affordable and available transportation
Lower cost of living	Affordable housing
Affordable housing	Transportation
Waste reduction	Address lowest air quality in State
Employment opportunities	Affordable housing
More jobs in county to lower commutes	Trade education opportunities
Dealing with the opioid epidemic and drug abuse	Housing homeless people
diet/nutrition	education
Educate	Nutrition
Education	Inspiration
Healthy eating habits	Physical activity and exercise.
Access to healthcare	Outdoor recreation (not necessarily organized) and
Informational/ direction hotline with resources that	Increase in services with the financial means to follow
Mental health services (early and consistently)	Early childhood care in all areas of physical, social, and
Integration of physical activity into daily life	Health education
Mental health treatment	Drug abuse education and treatment
Reliable transportation	Well paying jobs
Cleaner community	Better Parks & rec facilities
Accessible care	Engagement towards early intervention
Better nutrition	Less vaping
Education	Access to wellness centers and dental care
Enough qualified staff	Businesses investing in their employees health
Employment	Comprehensive treatment for drug/alcohol abuse
Organize group health and exercise programs	Push annual physicals and screenings
School aged education regarding healthy eating	Better access to mental health programs in the

GF4 - Please share any other feedback you may have below:

* Carroll County in general reacts to the squeaky wheel, so to speak at the expense of the issues that are more efficient, effective and have the highest rate of return. Although we have an obligation as a society to take care of the vulnerable it seems we have unnecessarily enlarged the definition to include some creature comforts. Example Transportation: arriving an hour early to a dr.s appt. for free transportation is reasonable(creature comfort) - 3-5hours early isn't reasonable (vulnerability). Establishing a new physician during times of wellness or managed chronic condition care that are closer to home (creature comfort), switching dr.s in the middle of health crisis (vulnerability). Also, remembering the small population for whom transportation is an issue versus the dollars spent to provide and manage the service borders on insanity. Personal drivers for those with transportation needs would be more cost effective as would providing cars for those who can drive than the current

programming we currently have. Developing Uber or Zip cars programs is an option, also allowing those in need transportation to own the responsibility of scheduling their rides would be empowing. This doesn't need to be a County run service, the Health Departments multi-million $ annual contract to provide transportation services. Example Crisis: Carroll Countians and Carroll business have a pattern of responding to a random crisis instead of staying the course and managing the problem. We tend to become sidetracked and make assumptions and decisions that will undo years of progress because someone shouted loudly and put heat on the right people. Usually the crisis is short lived but the damage to established programming is long term and in the end makes the vulnerable more vulnerable.
* Drug awareness messaging doesn't reflect the true picture, it is more closely related to a scare tactic. Yes, there were 20 overdoses in two weeks but 5 of those OD'd twice, 3 OD'd three times and 1 OD'd once- so it's really only 9 (unique) people, less than half of reported cases. Also, linking the OD's to RX pain pills is no longer accurate either. Yes, several years back some of the people prescribed pain pills became addicted. Yes, stollen narcotics became a Pharm party favorite but the OD's are currently related to the use of other drugs that are laced with an Opiod not from doctors prescriptions. We need to assure that physicians prescribe narcotic pain pills to those who need it and not have patients suffer in pain just in case someone steals their pills while visiting or someone else chooses to using the medication outside prescribed dosage. Although drug use and abuse can effect the County in ways such as theft and violence we still need to keep in mind the population size of this group. Kept this in mind, Aging population is nearing 20%, =34,000 individuals, household without vehicle 4.5% or 765 households, death rate from drug use 24 per 100,000 = 40 individuals annually. How much has the County invested for transportation for those 765 households per year? How much for death related to drug abuse of 40 individuals. Now obesity is 68.3 % or 115,000 individuals, and Cancer death rate 226 annually. Annual deaths related to drug abuse 40, annual deaths from Cancer 226 and annual deaths related to obesity 427 annually. We need to stay on course and effect life saving for measures for health related deaths which at the lowest end is 16X greater than deaths related to drugs abuse.
* The community is only as strong as its most vulnerable members. We are all in this together.
* Not enough time to reflect on these questions. Sorry.
* We need to continually reconize our weak areas while celebrating our strengths. Those whom we consider that are making baby steps in our eyes are monumental leaps in their eyes . Encouraging them will keep them on a positive path to healthy community and strong families
* Excited about this program!!!
* As an organization based outside Howard County, I can only offer limited insight. As an outside observer, I see that their is room for educating residents about healthy living. This is especially key for low income populations.
* The partnership for a healthier Carroll County has played an important role in bringing an awareness about the health needs and resources in our community. It has helped to focus energy to address health issues and improve community health.

Key Informants - CSC

NAME		AGENCY
Stephanie	Averett	HSP
Cara	Chamberlain	The Arc Carroll County
Caitlin	Cross	The Partnership for a Healthier Carroll County
Donna	Devilbiss	The Shepherd's Staff
Anne	Grauel	Carroll County Health Department
Karen	Koenigsberg	Mosaic Community Services / Get Connected Family RC
Diana	Latane	Judy Center Partnership
Bryan	Lyburn	Habitat for Humanity of Carroll County
Kacey	Mason	Carroll Hospital
Kara	McFalls	Carroll Child Care and Learning Center
Michelle	McVay	Carroll County Health Department
Raiana	Mearns	Carroll Community College
Barbara	Norman	Retired and Senior Volunteer
Teresa	Perrera	Calm Acres
Angela	Phillips	Westminster Rescue Mission
Heather	Powell	BERC
Dawn	Sander	Carroll County Community Mediation Center
Kristin	Saurborn	Access Carroll
Becky	Smith	Caring Carroll
Olivia	Steadman	Carroll Hospital

Results - Key Informants - CSC

Profile - Please enter the following information:

Name (Required)	Agency (Required)	Address	City	State	Zip	Phone	Fax
Angela Phillips	Westminster Rescue Mission			MD			
Anne Grauel	Carroll County Health Dept			MD			
Barbara Norman	Retired and Senior Volunteer Program	255 Clifton Boulevard	Westminster	MD	21157	443-789-0906	
Becky Smith	Caring Carroll	255 Clifton Blvd. Suite 315	Westminster	MD	21157	410-775-5596	
Bryan Lyburn	Habitat for Humanity of Carroll County	255 Clifton Blvd, Suite 301	Westminster	MD	21157	410-751-7722	
Caitlin Cross	The Partnership for a Healthier Carroll County	535 Old Westminster Pike	Westminster	MD	21158	443-605-3653	
Cara Chamberlain	The Arc Carroll County	180 Kriders Church Road	Westminster	MD	21158	410-848-4124	
Dawn Sander	Carroll County Community Mediation	255 Clifton Blvd., Suite 311	Westminster	MD	21157	410-848-1764	
Diana Latane'	Judy Center Partnership	100 Kings Dr	Taneytown	MD	21787	410.751-3282	
Donna Devilbiss	The Shepherd's Staff	30 Carroll St	Westminster	MD	21158	410-857-5944	
Heather Powell	BERC	224 North Center Street	Westminster	MD	21157	410-386-2832	

Kacey Mason	Carroll Hospital	200 Memorial Ave	Westminster	MD	21157	410-871-6125	410-871-6944
Kara Mcfalls	Carroll Child Care and Learning Center	Po box 1382	Westminster	MD	21158	410-840-7925	
Karen Koenigsberg	Mosaic Community Services/Get	255 Clifton Blvd.Suite 202	Westminster	MD	21157	410-871-0008	410-871-0228
Kristin Saurborn	Access Carroll	10 Distillery Drive, Suite 200	Westminster	MD	21157	410-871-1478	410-871-3219
Michelle McVay	CCHD	290 S Center St.	Westminster	MD	21157	410-876-4802	410-876-4832
Olivia Steadman	Carroll Hospital	291 Stoner Ave	Westminster	MD	21157	410-871-6167	
Raiana Mearns	Carroll Community College	224 North Center St	Westminster	MD	21157	410-386-8646	410-386-8631
Stephanie Averett	HSP	10 Distillery Dr	Westminster	MD	21158		
Teresa Perrera	Calm Acres			MD			

General Health and Behaviors

GHB1 -Please review the following general health issues below and choose the five (5) you believe are the most important to address in our community in the next 3-5 years.

#	Answer	%	Count
1	Alcohol Abuse	10.00%	10
2	Alzheimer's Disease or Dementia	3.00%	3
3	Asthma	0.00%	0
4	Cancer	6.00%	6
5	Chronic Obstructive Pulmonary Disease (COPD)	1.00%	1
6	Congestive Heart Failure	1.00%	1
7	Dental Health	7.00%	7
8	Diabetes	5.00%	5
9	E-cigs/ Vaping	2.00%	2
10	Heart Disease	5.00%	5
17	Illegal Drug Abuse	15.00%	15
11	Immunizations	1.00%	1
12	Injury	0.00%	0
13	Mental Health	19.00%	19
14	Obesity	5.00%	5
15	Sexually Transmitted Disease	0.00%	0
16	Stroke	0.00%	0
18	Tobacco Use	4.00%	4
19	Prescription Drug Abuse	14.00%	14
20	Physical Inactivity	2.00%	2
21	Other	0.00%	0
	Total	**100%**	**100**

GHB2 - Of the 5 General Health issues you selected, what do you believe is the number one priority?

#	Answer	%	Count
1	Alcohol Abuse	0.00%	0
2	Alzheimer's Disease or Dementia	0.00%	0
3	Asthma	0.00%	0
4	Cancer	10.00%	2
5	Chronic Obstructive Pulmonary Disease (COPD)	0.00%	0
6	Congestive Heart Failure	0.00%	0
7	Dental Health	5.00%	1
8	Diabetes	5.00%	1
9	E-cigs/ Vaping	0.00%	0
10	Heart Disease	0.00%	0
11	Illegal Drug Abuse	35.00%	7
12	Immunizations	0.00%	0
13	Injury	0.00%	0
14	Mental Health	30.00%	6
15	Obesity	5.00%	1
16	Sexually Transmitted Disease	0.00%	0
17	Stroke	0.00%	0
18	Tobacco Use	0.00%	0
19	Prescription Drug Abuse	5.00%	1
20	Physical Inactivity	5.00%	1
	Total	**100%**	**20**

GHB3 - Why do you believe that your choice is the most urgent health problem to be addressed?

* Lives are being lost; Families are being torn apart; Children are being ignored by parents and being raised by others
* The need is great, but services are so limited. The problem is affecting soooooo many families now. Both children and adults are suffering. Mental illness is often the primary issue resulting in other concerns and need for services.
* This issue influences so many other issues: public safety, education, homelessness, family stability
* Diabetes is a huge issue in Carroll county. A large amount of the population does not know how to control their diabetes or even what diabetes is. Education and wide spread precention of this disease could help solve many other health issues.
* It seems like a majority of our ride requests to medical appointments are for people who have cancer or complications from cancer.
* People are typically unaware of the risks of prescription drug abuse - people believe they are "safe" because they come from a doctor; rise of counterfeit pills containing fentanyl, carfentanil, etc. leading to more overdoses and overdose deaths; over-prescribing of prescription opioids and lack of communication with doctors can lead people to become dependent by taking as prescribed
* Stigma of seeking treatment/health care coverage
* Current opioid epidemic
* Drug abuse ruins families.
* So widespread in all age groups
* The incidence of overdoses has grown dramatically.
* There are limited resources in the county to address this issue. The limited providers that are in the area are not taking new patients and/or not taking all insurances especially Medicare and Medicaid.
* It is key to the other priorities
* Most of the health problems noted have their roots in Mental Health.
* A large majority of our population has very poor nutrition and drink only soda and raid the vending machines on a regular basis.they would often prefer to sit and do that than participate in any type of physical activity. Coupling inactivity and very poor eating habits are very harmful for the ID/DD population.
* Lack of mental health resources
* After 21, a lot of people don't have or can't afford dental insurance or care
* It is happening more and more frequently in our community and can be prevented.

GHB4 - Additional comments regarding health issues in the community (optional):

* Mental health aid is slim to none in this community. I would love to see this become another large topic we focus on.
* Obesity is also a pressing concern because it gives rise to so many of the other health issues (heart disease, diabetes, etc) and because it affects people as a chronic disease that requires a lifestyle change - greater cultural changes are needed to prevent the continued rise of obesity
* Opioid epidemic is also a major issue and is linked to mental health in the county.

GHB5 - On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about Health Care Access in our community.

#	Question	Strongly disagree		Somewhat disagree		Neither agree nor disagree		Somewhat agree		Strongly agree		Total
1	A: The majority of residents in Carroll County have access to	5.00%	1	20.00%	4	35.00%	7	40.00%	8	0.00%	0	20
2	B: The majority of residents in Carroll County have access to	10.00%	2	25.00%	5	40.00%	8	25.00%	5	0.00%	0	20
3	C: The majority of residents in Carroll County are able to	10.00%	2	40.00%	8	35.00%	7	15.00%	3	0.00%	0	20
4	D: Transportation for medical appointments is available and easy to	50.00%	10	30.00%	6	20.00%	4	0.00%	0	0.00%	0	20
5	E: Healthcare resources are available and accessible.	10.00%	2	20.00%	4	40.00%	8	30.00%	6	0.00%	0	20
6	F: The majority of residents in Carroll County have the ability	15.00%	3	70.00%	14	15.00%	3	0.00%	0	0.00%	0	20

GHB6 - Additional comments regarding health care access (optional):

* Transportation is a huge issues In Carroll county. The faster we can come together to create a solution, the better our counties health will become.
* Many of the clients we work with often cannot pay for health care services they need. They call our volunteers to take them to the emergency room because they say they can't afford to pay for an ambulance.
* I am not very familiar with the resources available to Carroll County residents - recent transplant to the area
* Limited providers (primary care, specialists, dentists, etc) that take Medicaid in the county
* Transportation is a weak point in this county

Social Determinants of Health

Social Determinants of Health are defined by the Centers for Disease Control as the conditions in which people are born, grow, live and age.

SD1 - Please review the following social determinants of health and pick the three (3) you believe are the most important to address in our community in the next 3-5 years.

#	Answer	%	Count
1	Early Childhood Development	5.00%	3
2	Educational Attainment	5.00%	3
3	Job Skills	10.00%	6
4	Employment Opportunities	18.33%	11
5	Food Security	11.67%	7
6	Quality Health Access	18.33%	11
7	Affordable Housing	18.33%	11
8	Economic Success	5.00%	3
9	Social Support	8.33%	5
	Total	**100%**	**60**

SD2 - Of the 3 Social Determinants of Health you selected, which one do you believe would make the greatest impact to the health of our community?

#	Answer	%	Count
1	Early Childhood	0.00%	0
2	Education Attainment	10.00%	2
3	Job Skills	10.00%	2
4	Employment	10.00%	2
5	Food Security	5.00%	1
6	Quality Health Access	25.00%	5
7	Affordable Housing	25.00%	5
8	Economic Success	5.00%	1
9	Social Support	10.00%	2
	Total	**100%**	**20**

SD4 - Additional comments regarding social determinants of health (optional):

* I also believe that early childhood development is an issue but not a social determinant of health. Environment and opportunity for those in the area I believe to be larger issues.
* Transportation is a major social determinants of health issue in the county as well.

Programs, Services, & Promotion

PSP1 - Please describe any programs or services that you feel should be developed and offered to those who live in our community.

* We definitely need more services to address mental health issues.
* Affordable and accessible nutrition counseling and classes which includes a support component.
* Transportation. Access to care for those who cannot afford insurance.
* I think public transportation needs to be greatly improved. People cannot get to their doctor appointments and cannot get their groceries.
* Free or low-cost child care, transportation to constructive social as well as medical/legal appointments
* Stronger public transportation system, a safe respite care location for healing, more psychiatric access for vulnerable population
* We really need affordable housing. People who are very low income or have mental health issues are out of luck in CC.
* Carroll county has many wonderful programs and services. Advertising them is important.
* Affordable transportation, mental health services, chronic disease management education programs at free or low cost
* Affordable housing across the full spectrum of housing.
* Continue to offer the opiate programs.
* Additional transportation opportunities
* Job training; Transportation
* Easier access to physicians because most are not taking new patients or take limited insurance plans.

PSP2 - How do you think health and wellness are best promoted in our community? (Example: fairs, workplace, class education, outreach events, other)

* All of those mentioned above
* Meeting where people from various agencies come together are most helpful.
* Workplace, social media and online calendars
* Fairs and newspaper. We need to do a better job at promoting workplace wellness in the area.
* Outreach events that really reach the heart of the community
* Outreach events, especially to children
* Meeting people in places they are comfortable and frequent
* Outreach events, social media, banners & posters, holding teaching seminars in work places.
* Tied to incentives to encourage participation.
* All of the examples are great and needed
* Workplace, library, promoting in places where individuals are like grocery
* Health fairs, support groups
* Outreach events at soup kitchens and other sources of help
* All of the above. Unfortunately, there is no one secret solution. A diversity of programming is a wide array of situations, at the grassroots level, is the only way forward.

* Workplace - could offer to come in to do trainings on nutrition or anything physical being offered
in the community. Class education would be beneficial too, as a lot of younger kids sit more than they're outside playing.
* Everything mentioned should be tried
* We have several programs throughout the community such as health fairs and class education. I believe the one I see the most are health fairs.

PSP3 - Related to health and well-being, how would you describe existing services, outreach and promotion in Carroll County?

#	Answer	%	Count
1	Poor	0.00%	0
2	Fair	45.00%	9
3	Good	55.00%	11
4	Excellent	0.00%	0
	Total	**100%**	**20**

General Feedback

GF1 - Are there specific populations in the community that you feel are not being adequately served? If so, who?

* Homeless
* People who are considered our working poor are least served.
* Low income, non English speaking, low literacy
* The elderly and blue collar poor. This includes some farmers and people that work or live in isolation.
* The elderly who live in their own homes are underserved. Those living in assisted living and nursing homes have the ombudsman program to help protect them but those aging in place don't seem to be aware of resources and aren't served as well.
* Unsure - new to Carroll County
* Those with mental health disease, it's an underlying condition of many other problems.
* Mentally ill
* Seniors aging in place.
* Working families are busy so they may not be adequately served due to their time constraints.
* Medicare population, if they are unable to afford any additional insurance and do not qualify for government assistance. Most of this population is on a limited income and cannot afford food, pay medical bills, or afford primary prevention efforts for their chronic conditions.
* Services to mentally ill who are not hospitalized
* Yes. Families who are working, but do not have access to programs as they make too much to qualify, but don't make enough to survive. See United Way ALICE report.
* I'm not sure how we handle individuals with mental health concerns. Especially The homeless population. I know we have the cold weather shelter, but I'm unaware of any programs to help them combat the mental illness. We may have one, but it's not always well communicated.
* Mentally ill
* Those with both mental health and developmental disabilities

* Intellectual disabilities
* I think there are resources available to all populations in our community you just have to be willing to look.

GF2 - Are there any areas of community health and wellness not identified in this survey that you feel need to be addressed?

* While education is included, education while with your primary care provider needs to be expanded.
* LGBTQ support and outreach
* We have a lack of well qualified professionals in certain fields- dermatologist and endocrinologist come to mind.
* Maybe basic screenings of hearing, vision, blood pressure.

GF3 - If you had to identify two key elements you feel will be important to the success of achieving a better quality of life by those who live here, what would they be?

#1	#2
Dedication of the team to promote and then	Educate in schools - exercise, weight control,eat
Mental health issues	Substance abuse issues
Stable employment	Affordable housing
Higher paying job opportunities	Transportation and education
Affordable housing	Public transportation
Social support	Transportation
More affordable health care	More affordable housing options
Better transportation	Affordable housing
Employment opportunities in county	
Managing the stress of work/life balance.	
Transportation	Meeting all socioeconomic classes needs
Access to affordable and quality healthcare	Outreach and education for all populations
Affordable healthcare	Transportation
Access to healthcare	Diet and exercise

GF4 - Please share any other feedback you may have below:

* Thank you for the focus!

Survey Tool – Key Informants

Profile

Please enter the following information:

- ☐ Name (Required)
- ☐ Agency (Required)
- ☐ Address
- ☐ City
- ☐ State
- ☐ Zip
- ☐ Phone
- ☐ Fax
- ☐ Physician Only: Specialty
- ☐ Physician Only: Hours per week devoted to patients

General Health and Behaviors

GHB1: General Health and Behaviors - Please review the following general health issues below and choose the five (5) you believe are the most important to address in our community in the next 3-5 years.

- ☐ Alcohol abuse
- ☐ Alzheimer's Disease/Dementia
- ☐ Asthma
- ☐ Cancer
- ☐ Chronic Obstructive Pulmonary Disease/COPD
- ☐ Congestive Heart Failure
- ☐ Dental Health
- ☐ Diabetes
- ☐ E-Cigs/Vaping
- ☐ Heart Disease
- ☐ Illegal Substance Abuse

- ☐ Immunization
- ☐ Injury
- ☐ Mental Health
- ☐ Obesity
- ☐ Prescription Drug Abuse
- ☐ Physical Inactivity
- ☐ Sexually Transmitted Disease and Infection
- ☐ Stroke
- ☐ Tobacco Use
- ☐ Other (please specify):

GHB2: Of the 5 General Health issues you selected, what do you believe is the number one priority?

- ☐ Alcohol Abuse
- ☐ Alzheimer's Disease or Dementia
- ☐ Asthma
- ☐ Cancer
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Congestive Heart Failure
- ☐ Dental Health
- ☐ Diabetes
- ☐ E-cigs/Vaping
- ☐ Heart Disease
- ☐ Illegal Drug Abuse
- ☐ Immunizations
- ☐ Injury
- ☐ Mental Health
- ☐ Obesity
- ☐ Physical Inactivity
- ☐ Prescription Drug Abuse
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Tobacco Use

GHB3: Why do you believe that your choice is the most urgent health problem to be addressed?

GHB4: Additional comments regarding health issues in the community (optional):

GHB5: On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about Health Care Access in our community.

	Strongly Disagree (1)	Somewhat Disagree (2)	Neither agree nor disagree (3)	Somewhat Agree (4)	Strongly Disagree (5)
A: The majority of residents in Carroll County have access to a local primary care	o	o	o	o	o
B: The majority of residents in Carroll County have access to local medical specialists.	o	o	o	o	o
C: The majority of residents in Carroll County are able to access a local dentist when needed.	o	o	o	o	o

D: Transportation for medical appointments is available and easy to access for the majority of residents.	o	o	o	o	o
E: Healthcare resources are available and accessible. Example: Weight loss classes, gym memberships and diabetes education.	o	o	o	o	o
F: The majority of residents in Carroll County have the ability to pay for health care services.	o	o	o	o	o

GHB6: Additional comments regarding health care access (optional):

Social Determinants

Social Determinants of Health are defined by the Centers for Disease Controls and Preventions as the conditions in which people are born, grow, live and age.

SD1: Please review the following social determinants of health and pick the three (3) you believe are the most important to address in our community in the next 3-5 years.

- ☐ Early Childhood Development
- ☐ Educational Attainment
- ☐ Job Skills
- ☐ Employment Opportunities
- ☐ Food Security
- ☐ Quality Health Access
- ☐ Affordable Housing
- ☐ Economic Success
- ☐ Social Support

SD2: Of the 3 Social Determinants of Health you selected, which one do you believe would make the greatest impact to the health of our community?

- ☐ Early Childhood Development
- ☐ Education Attainment
- ☐ Job Skills
- ☐ Employment Opportunities
- ☐ Food Security
- ☐ Quality Health Access
- ☐ Affordable Housing
- ☐ Economic Success
- ☐ Social Support

SD3: Why do you believe that this determinant is the most important social issue to address?

SD4: Additional comments regarding social determinants of health (optional):

Programs, Services & Promotion

PSP1: Please describe any programs or services that you feel should be developed and offered to those who live in our community.

PSP2: How do you think health and wellness are best promoted in our community? (Example: fairs, workplace, class education, outreach events, other)

PSP3: Related to health and well-being, how would you describe existing services, outreach and promotion in Carroll County?

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Excellent

General Feedback

GF1: Are there specific populations in the community that you feel are not being adequately served? If so, who?

GF2: Are there any areas of community health and wellness not identified in this survey that you feel need to be addressed?

GF3: If you had to identify two key elements you feel will be important to the success of achieving a better quality of life by those who live here, what would they be?

- ☐ #1 _____
- ☐ #2 _____

GF4: Please share any other feedback you may have below:

Key Informant
July 12, 2017
Shauck Auditorium

**** Note: Moderator comments in bold.**

General Health and Behavior

Results are not surprising – it is what we are seeing all along. A lot of mental health issues this year. Mental health takes the lead this year at 14%.

Comments

Illegal drug use (we struggled with concerns about dividing prescription and illegal drug use.) We wondered if we separated this would we see good data? It was important for the hospital to separate this use, but interesting to see both of them rank high. But, just naming one? Illegal drug use is very high, almost as high as mental health. This information goes into the Community Benefit Plan for next 3 years. Last year mental health did not rank high – it didn't play in to our work. It was a supplemental measure. Always something to keeping in mind how to include it.

Which is the #1 priority?

Illegal drug use and prescription use is almost as high as mental health. Last year mental health did not rank in the top 4.

Why do you believe that your choice is the most urgent health problem to be addressed?

Additional comments regarding health issues in the community?

On a scale of 1 – 5, rate statements about health care access in our community.

Rating statements – interestingly – results are consistent that people have access to PCP – some rated low but for the most part you agree with this.

Access to specialist is lower. 50% agree or strongly agree.

Dentists' different story – middle no one strongly agreed or disagreed (2-4) in the middle between 3-4

Transportation is sorely lacking. 40% strongly disagreed that people have access to transportation, 1/3 just disagree, 70% totally disagree, that is consistent with what we are hearing.

Health resources availability are in the middle of the pack (weight loss and gym memberships, etc.) – some do some don't.

Ability to pay – do the majority of residents have ability to pay? 60% said the majority of patients do not have the ability to pay.

75% of the people said majority don't have ability to pay health bills. It fits with what we expected.

Could also be there are certain things people can pay for, but some have large deductibles, co-pays & co-insurance even if can pay for insurance, so still have barriers in paying health bills.

Social determinants…Pick 3 most important to address in our community in next 3 – 5 years

Dot explained this term social determinants. What each person has to carry in their invisible "backpack" – issues affecting their health as they try to get care (hungry, no transportation, bad living environment that we as providers don't see but are issues that affect their health).

Early childhood development was the lowest this year but was the highest last year – seeing that turnaround is interesting.

Employment is always important here, but most hits this year.

A lot ranking in the top. Shows the development in our county and that the work we do in our county affects the results and ranking in our county for the next years.

Out of the nine determinants last year, only four were touched. This year it seems that all were touched. Is it leveling out or are there just other needs? Quite a change from last year. Social determinants this year are employment, education, jobs, and security is low as well, which is surprising.

Discussion?

Is transportation a social determinant of health that the federal government identifies/qualifies? Dot said that there are different charts one can use.

The increased recognition of mental health & (legal and illegal) drug use being a problem reflects the national dialogue and recognition around drugs as well. It didn't just crop up in 2017 but has been around BUILDING for several years, but is now popping up in our own community - we reflect and recognize it locally - It is in our community not just other places.

A lot of medical approaches are accepting mental health as part of our general health.

Surprising Census number showing the median salary is $84,000, yet high results show people can't pay for their health care.

Employment – noted that 60% work outside of county and travel up to 2 hours to get to jobs. How can we get jobs here yet no transportation system to support it?

Stats show we have the longest commute in the state of MD and we don't car pool.

Affordable housing comes into view here. We need to take into account we have groups of high wages (because of commuting to high income work areas) – but a lot of low income in county. High income is from outside of county, but low income pocket in this county is critical piece. We are looking at the median, but not looking at the pocket of low which is the critical piece.

Affordable housing – mixed ranking. It doesn't feel affordable, but we are actually ranking third in the state of MD, so we actually are good as per rankings. Takes into account……. A lot of information which balances each other out.

Tammy shared at the Circle of Caring analysis for average rent is $900 rent, the average wage earner would need to earn $17.50 per hour to pay for a 1 bedroom apartment. We have affluent but also a huge wedge of disparity to lower income - which is where the density of expense occurs in regards to these issues. The middle class group has been stretched a bit. CMS says Alaska had a 203% increase in

premiums in 1 year. The people participating dropped. That wedge of income spread is increasing yet doesn't compensate for the people living below a certain level.

Heavy commuting county also touches on quality of life issues. Both members of the household are commuting hours each day, you are spending a lot of time and energy stressful outside of the home.

We actually rank high in quality of life, have some high standings, it has less weight to it than things we rank low in. I.E. We are worst in state for air quality. It was #3 for health factors.

A lot of inequality and pockets, United Way report – not poverty threshold but the cost of living threshold. Westminster 51% are below standard – over half.

When it comes to health care ability – the nation we focus on coverage piece. If you don't make a lot of money, you have access to things, but the middle class, who do not quality for subsidy, don't have access to a lot of services. No insurance, no care, smaller companies can't afford insurance.

If you don't make much money you have access to coverage, middle class doesn't fall into area of getting coverage. Today healthcare bills are the #1 reason for bankruptcy.

We were REGIONAL partner of HBE, and we see how things are changing. Hard to discuss without making political statements. We aren't done seeing the changes. At some point we need to concentrate on the cost of care which is not being touched. Affordability versus having insurance?

Looking at 600 on-line surveys – all have it, everyone has insurance, but it is not affordable to pay bills/co-pays once you have it.

Programs/Services - Describe programs or services that you feel should be developed & offered to those who live in our community.

One idea – can Carroll Hospital or Life Bridge develop an insurance plan to provide more comprehensive care, or a more effective holistic approach to health management rather than just treating diseases? Job skills – increase likelihood of having/affording health care insurance. More Mental Health services, partnering with public Schools –to identify at risk people before it becomes a problem in the community.

Take large level demo data – like we know 30% of community have diabetes. Do we know who they are and what are we doing to prevent progression?

Target specific populations with programs common to that group.

Housing, safe life habits, walk in prescription services (24 hour services), transportation, affordable housing (again & again), safety.

In general – feeling is that we sort of meet needs, but not overwhelming support how well we do that.

How do we promote each person needs to take some accountability for their own health? Where does that start? How soon do you begin that? Parents are struggling, just surviving and bringing up a family. Children are sponges, can we start at a younger age to promote mental health, by teaching them how to meditate, how to deal with anger, sadness, depression…we are up here trying to solve problems, (we have food, clothing, shelter) but we need to begin again to figure it out - we need both – how to treat

but how do we prevent? Smoking is a big one that leads to addiction, social support, all so intermixed it is hard to pick one thing.

The public school system is very aware and great partners. We know even trauma to youth makes one more likely to develop a chronic disease later on. The school system recognizes this, there are good programs happening. It is very important, we still have to provide a healthy environment.

I heard the term food deserts mentioned – it is said they don't exist in Carroll County – but they do. People can't get to the food. Very important to know, if you live in Union Bridge the closest market is Taneytown – you are looking at a good 9-20 miles. This is a food desert if you don't have a car. Looking at supplemental measures - we have to be cognizant when our numbers say one thing but we know it is something very different.

Affordable housing has existed for a long time. There have been efforts to address it 30 yrs. Never gone anywhere in this county - negative political ideas. Community housing – never gone anywhere – negative political ideas.

Opioid addition problem, they look at Baltimore city providing Narcan. That is a start, but there are 3 issues driving addiction: 1. people locked out of economic jobs, high tech, economy, skills - lack of skills, 2. affordable housing, and 3. mentally ill people on the streets because we shut down the hospitals and the services have not kept up. We need to address this issue and help people by getting the services they need or they are just trying to self-medicate. Need to address housing and Jobs. Lack of job skills and training needs to be addressed locally and nationally to bring people's skills up to get the jobs they need. They need to be retrained. Need the technical skills and training!

Affordable housing (SROs or perm supportive housing is needed but trying to find funding for it); There is a heart – a lot of mental health issues do stem from trauma and mental health issues and drug use. Address the housing first approach, and then everyone feels better when in home. Our homeless number is statistically low (serving 300 homeless at Access Carroll) in Carroll County, so we won't get a big initiative come in.

We don't have a public housing authority (Section 8), we have a certain number of Housing Choice vouchers. There is a wait list. Westminster city and the county as a whole.

Asked our percentage of homeless…About 300 homeless served at Access Carroll

We don't have public housing authority (Section 8). We are given a certain number and there is a wait list (city and county as whole). We are researching in the strategic planning committee. There are options, but getting funding in place is the issue. Our numbers are not drawing the help. It only takes one problem in a person's life to get them to a homeless state. Maybe 2,100 vouchers here. Also, there is an issue getting landlords on board as well.

Shared was information about options for repairs. Housing Risk Management is a collective fund that helps landlords claim for damage done. Several cities have done this. If risk involved they can claim money for damage. Five large cities – and over 1 year only 2 cities had claim plan and only 1 claim in each city. Takes being able to have right dialog with the landlord and having Case Management put in place. Just like transportation – this is a political issue.

How do you think health & wellness are best promoted in our community?

Related to health & well-being, how would you describe existing services, outreach & promotion in CC?

We are good - but it is something we can work on.

How can we can get the information out?

Someone that served 8 years on council in Hampstead said that things would be done but he would get calls from people about not being informed. People are too busy to take time to look around. It was in the paper, but no one reads paper. Hard to get the information out, something has to draw attention to it when it is not something part of their lives. Not something they look for. If they leave the county for work, by the time they get home they are tired and not looking for information.

We need to focus on preventative care, we are always reactionary. If you recognize something early & quickly it costs much less. We need a big push with kids, i.e. an award for preventative, or punishment - 10% charge on taxes if not keeping preventative appointments. This may lower the cost of care.

Many have a high deductible. We need to get cost of care down. We would need a very bad issue in order to have anything paid on our care.

There are many diagrams: secondary, tertiary – critical care – the cost of this patient is quadrupled from what the rest of the county population would spend.

Dot shared that some of our focus groups will go to shelters and low income groups, so we will be able to hopefully get other opinions in order to pull this data together and get as much information as we can.

People use phones – example of the Health Department putting out a notice of a dog bite in the community and many people shared it. Shows we can get information out this way.

Community Services Council of Carroll County Key Informant
July 26, 2017
Non-Profit Center in Westminster

**** Note: Moderator comments in bold.**

Dot reviewed results

General Health & Behaviors

The highest ranking is mental health.

Illegal drug abuse & prescription drug abuse are ranked #2. Dot showed the graph which showed how advanced they are compared to the others.

Choose #1 – answer was illegal drug abuse and mental health

THOUGHTS?

Rescue mission: "We serve men struggling with alcohol/drug abuse, and seldom is there a straight line into that situation that has not at some point had mental health concerns. It is a path that follows closely with both of those issues. Not necessarily have to have both issues; mental health doesn't necessary lead to addiction and vice versus, but there is a close connection/trend."

"We are seeing the trend in health care climb. It is great that Access Carroll is including mental health as part of general health now."

When we look at addiction/alcohol, illicit drug abuse – these are mental health concerns, these are mental health diagnosis of addiction. Ultimately, it is a mental health concern - people are sick and need help with their health problems.

Identify issues outside of what you do - How many work in field of mental health? Not a majority but can still identify the issues outside of your work experience.

On scale of 1-5, rate statements about Health Care Access in our community:

Do people have access to a PCP? Somewhat disagree is the biggest category – it was spread-out, no one strongly agreed or disagreed.

Additional comments?

The word "access" is nebulous. Just because there is an open office doesn't mean you can access the office hours. Access could be I have no insurance or transportation. This added confusion to my answer. It was agreed by many that "access" was too large to identify.

Is transportation to medical appointments available and easy to access? The answers show strongly disagree is the largest answer, but also somewhat disagree. Definitely a problem all are familiar with.

Even with medical assistance, there are so many hoops people need to jump through to get certification for the transportation. Also, if you have a vehicle even if it is not running, you can't quality for

transportation. Time frames are horrible – they are not on time or needing to arrive several hours early because it is the only time you can be picked up – even though people are paying for the transportation.

Same issue for WRM food pantry – clients pay to get there (mission), but sit there for hours to get transportation. It is a common scenario for Access Carroll as well.

For seniors to live independently, this is a huge component as to having to go into alternative housing – because they have little or no ability to be independent because they don't have reliable transportation.

Caring Carroll - vast majority of need is for transportation. What if they need to go to the pharmacy after their doctor appointment? The bus won't take them there, etc.

Transportation Outside of medical appointments? – Yes, grocery, socially/volunteering – but don't run on weekends. This impacts school, work; impacts someone's social life; they need to sit in their apartment all weekend with no transportation.

It is hard to have access to tickets for the bus. There are only so many and none left for people who get there late. It doesn't seem to be managed well. This impacts a lot; Not only the person's mental health and seeking unhealthy interactions and alternatives, but also what the community is missing by not having him participate. It is an important piece when looking at mental health.

People in Union Bridge/NW area don't have access to food without transportation. It was acknowledged that we do have food deserts in the county.

Conversations with people regarding bikes for transportation. If they need to use for work, etc. they are put into unsafe conditions. Recently, a young man was hit by a car as he had to ride at night for work– safety is an issue because of lack of reliable transportation issues.

Maybe this leads to more students going to the ER instead of getting help during the day because of not having transportation to a doctor office, or other resources. The #1 reason they are absent from programs is they have been to the ER overnight – not that they saw a doctor and are staying home, but there was an emergency and they went to the ER.

Dot shared about TAC and that they are working on these issues

Do the majority of Carroll County residents have ability to pay for health care?

We think of "majority" as those in our own program (clients) which isn't a good picture of the demographics of the whole county. If you look at hard numbers, the majority of residents probably do have access, but there is a strong minority that don't have the ability, which are the clients we see in our programs.

Key informant is clients. What do you see in the people you work with? Focus groups – info is regarding more one's self, your community. These answers will be different. This is why the groups are so important – we get to see groups of people that we might not have heard from.

Many people work outside of Carroll County, and as a result, many that commute may get providers outside of the county to make it easier to see providers during the day. This is a unique demographic of our county.

Carroll County is ranked as one of longest travel time to work counties.

Usually discussed is what does ability to pay mean?

With the new Healthcare Reform ACT, ability to pay means a lot of different things. If this group is speaking for their clients, many clients have public assistance.

Issues that are seen - So many new insurance providers out there, health care providers don't take the insurance, even if medical assistance or Medicare. There are many out there and still popping up.

Dot spoke of the PHGG – hospital/community leaders are talking about things like this – we can get this info to open panel.

Mental health providers – a top thing on the surveys – with some of the new insurances, we are calling agencies to find out what they take and many don't take these new providers.

Social determinants - Pick 3 most important to address in our community in next 3-5 years: Employment opportunities, quality health access and affordable housing were the top 3. They were followed by food security and job skills.

For Carroll County - Food is easy to get for people within a couple of hours. Carroll County provides meals for people, across the line it is not accessed as well. We have many organizations that provide food and meals for people.

What are obstacles to employment opportunities and housing?

We hear that a lot of people leave the county for work. Employment is a big thing, as a young person's perspective – you are trying to grow and there are no jobs here. There is a nice cushion for lower paying jobs for people just starting out, but for that middle group there is nothing. For young people to come back and increase health of county this curve needs to change, the employment needs to change.

We have problems getting grants because our county income seems high – like a reverse bell curve.

Transportation plays into the employment piece - is an issue – you can't go out of the county because there is no connection. The underlying issue of mental health and substance abuse also make it difficult for people to get jobs, training and skills. People have barriers in passing the drug testing. It is costing the industry dollars because they can't get qualified workers.

The work force is changing in that the traditional retirement age is increasing. Older people are staying in the work force longer so positions are not opening up for younger people. This will continue, and for some people they can't afford to retire.

We have a fast growing older population hitting Carroll County in the next couple of years. There is planning being done, but there is only so much that we can do. A lot of our issues will focus in the future on the older population.

At the root of so many of these concerns is lack of affordable housing. The Carroll County Master Plan states that over half of renters pay over a third of their income for housing and 23% of homeowners pay over 30% of income for housing expense. That is unsustainable. Part of the fallout from that is what we see in other categories. When families are burdened by housing they have to make difficult decisions about health care, transportation, they are under undue stress and enter into bad coping mechanisms for the harsh reality that they can't survive on their income. A whole lot of stress could come out of the

family unit without housing worries. Turns into behavioral health issues. If 60,000 people affected in Carroll County live in households paying more than 30%, then that is almost 1 in 3! This burden is causing ripple effects. If a crisis happens it creates a problem /ripple effect (i.e. can't make mortgage payment, etc.) A social justice committee at a church just met, and problems all come down to non-affordable housing. "Who do we need to contact in our county in regards to this problem?"

Which do you believe would make the greatest impact to the health of our community? Quality health access and affordable housing were the top 2.

Programs and services

Describe programs or services that you feel should be developed and offered to those who live in our community. How do you think health and wellness are best promoted in our community? Related to health and well-being, how would you describe existing services, outreach & promotion in Carroll County?

Responses were good and fair. Existing services are attributed to the community. We have amazing people that are willing to work together and many non-profits are all about working together for the betterment of the community.

What are hold up's to "fair" response? Barriers?

The information is disseminated to those who need it, but so many pockets of people don't understand what help is available and where to find it. There is all kinds of help available, but people don't know about it. Also, there is a stigma to obtaining help. A barrier is that people are afraid/embarrassed to seek help. The "pull yourself up by your bootstraps" mentality. You need to be able to let your guard down, submit, be vulnerable and seek help, and admit you are doing your best but still need help.

A warm handoff is needed. You need a human touch to connect to the next step and not just a flyer or handout. People need the human touch to connect to the next step you are taking.

Hours of services are a barrier. If a person is working, they can't obtain services from 9-5. Services must offer flexible hours to make services more available to obtain. Many people need "hand holding" to get the resources and services such as follow-up, calls, etc. Also, literacy because we assume people can read what we give them but many can't read or have no idea how to do what they are asked to do. Even if they are literate, they may not be able to understand what to do.

Carroll County has a different demographic (i.e. telling farmers to wear sunscreen – but they won't do it). They may not understand the health facts of what could happen to them with certain behaviors. Since doctors only have 15 minutes with a patient, they can't get the education piece across to people. The younger generation is more in tune with the education piece.

Information such as telling someone what can happen to them, education, etc. needs to be broken down for people.

Every answer on the community chalk boards (is part of what The Partnership did to collect data) will be included. It was broken down into 3-4 areas: social justice was high (tolerance, respecting diversity), kindness, connection & community, having groups of friends – people – a connection – the support; health care was also high (drug addiction, Mental Health).

Dot spoke about WOOW where attendees gave comments of what a healthy community looks like and an artist was commissioned to do a painting of the same. Cards were distributed with a copy of the painting and the original painting will be going around to other nonprofits & will end at the hospital to showcase the painting.

Also not being addressed is affordable dental care for adults. Even if you have dental insurance, it pays for cleanings but doesn't really pay for anything further. It is more and more an issue. If a person can't afford to get a bad tooth removed, they go back into medicating yourself which is a barrier to getting a job.

Access Carroll has a dental clinic – for a nominal fee $40 for an appointment (4 extractions), and there are still people who can't afford that. They average 80 calls a day to the dental clinic. This is a county need that is not met yet.

Mission of Mercy has a triage in some locations, but there really isn't something that many people can afford to do. It is not a luxury. It was acknowledged that proper mouth care is important for health and lack of it can even cause death. It was noted that one needs proper mouth health for chemo (cancer patients).

Access Carroll does a great job with addressing health issues. They are building a structure that incorporates the whole human (mental health). They continue to add as the needs come in. It is amazing the new ideas and concepts they are building on.

All were invited to take the online survey at the Healthy Carroll web page and encourage other people to do it. Spread the word. Visit our site for other information.

We're at 1,100 responses. We still have a month to go, but have met our goal already, and we are able to track it this year.

Key Informant
August 2, 2017
Shauck Auditorium

**** Note: Moderator comments are in bold.**

Sharon McClernan gave the Welcome. There were 14 people in attendance.

Assessment shows our commitment to the community and used by many organizations for their strategic planning.

There are three components: 1. an online survey (community at large – 1200 responses so far), 2. a focus groups (underserved populations), 3. and key informants (a business response aiming for 80 responses).

General Health & Behaviors

Mental health is still ranked #1. Illegal substance abuse was a close second, and prescription drugs and heart disease tied for third.

Stroke and tobacco use are not on here but has come in higher in past years.

What are you seeing regarding mental health with the people you are working with?

All things on the list are important for people in our community, but we know that 60-70% people with chronic disease also have a mental health or substance abuse diagnosis. It will be difficult to address all of the other things regarding health if we don't address the mental health issues standing in the way.

Someone that works in several counties noticed that sometimes we are quiet here in Carroll County. It seems that in other counties, people are more open and blunt about their problems. People here need to be able to speak out a little more in order to find resources. She sees it with mental health but also with other issues as well (works in higher education - with nurses & teachers & schools).

It is a little quieter here in Carroll. It would help if people would speak out more and get help. Not being afraid to talk about the elephant in the room but talk about it. Sometimes a leader is helpful to talk about it and model the behavior. In general there is a lot of stress on parents & kids. Transparency is wonderful but it puts a lot of pressure on people to be perfect.

People are out there talking about their heart disease, but not mental health issues. We need to learn how to start conversations and get people to talk about it. Just like if someone has health issues like COPD, etc.; people should feel free to talk about it. Anxiety and depression are big parts of mental health and there are astronomical numbers of people suffering with symptoms. People don't want to be a bother or burden to others in their family, so they keep things pushed down. Sometimes people don't want to recognize it.

It is the day to day operation of life now in 2017 – both parents working, not home with children the way it was, spend so much time and energy, life is so go, go, go. Older people think they can't follow, or people don't take time for themselves. When we think mental health we don't think anxiety and depression. It probably affects 80 - 90% of people in our county and could be a large component of mental health.

Dot pointed out that our online survey asks this specific question about anxiety and depression, so we should get follow-up on this.

It was pointed out about the aging generation in Carroll County and that we need to keep our eye on these issues starting to occur.

What do we think of when we say mental health? We think of the chronic people who have depleted their resources, or the institutionalized person, but there are things that come along at certain stages of life that affect everyone. It is there and part of life like stroke or other episodes of chronic illness, and people need to know that for certain time periods maybe medication or other resources may support them better. We need to take it apart and make it more mainstream.

People experience things every day like financial problems, etc., and you can be happy today, depressed tomorrow. We need to recognize everyone has mental health at some degree. We need to think of it in a different way. It is more of a person's health. They need to stay mentally well and maintain mental health before one has an issue. It is not the negative such as bad or poor mental health.

A lot of sleep deprivation is impacting anxiety issues. We are glamorizing that we don't get eight hours of sleep a night and these things are building up on people.

It was mentioned that the hospital has a refresh room. It doesn't label anyone, but people can go into an uplifting space. It includes "a little B12,"massage chairs, aroma therapy, etc. for associates. Good feedback indicating that it has helped has been received. People are doing so much and pilling so much on and not taking time for themselves. Things pile on and on and snap before they recognize what is happening to themselves. There are other components, but everyone can benefit from help. Need to build on health in a positive way and build on phrasing it in a positive way.

Talk about drug use – why is this a top one?

"I believe we are all a little off mentally or have an issue or challenge." (Spoke of a family member with mental health and addict issues. Healthy right this minute.) "When we mainstreamed people in mental institutions, we don't have the resources to take care of them." We sweep problems under the rug and throw money to it, with no logic to it. But, services are not being done right. A person has 15 min with the psychiatrist and then to another counselor and this is not helping. People are not getting the services they need. It has been a 10 year battle.

The radio station does a lot of work with sheriff department, DA, do shows, attend seminars, etc. This county is ahead of some other counties as to how we are dealing with it, but it is never enough. Narcan is not the solution and is not fixing the underlying root of problem. Like asthmatics, etc. We treat people and problems, but not the root problem why they continue needing help. What kind of things do we need in our communities to be able to address why these things are happening to people in our community.

On scale of 1-5, rate statements about Health Care Access in our community

Social determinants…pick 3 most important to address in our community in next 3-5 years - Very even results; Last year only five were mentioned in focus groups.

1st is job skills & employment opportunities, (job preparedness, availability)

2nd is Social support and housing

Why do you believe this determinant is the most important social issue to address?

Housing for young people, new home owners to get into the market – unless making good wages or double earners – not a lot of growth in multi type/variety of housing other counties have. It is expensive housing here now. Very few under 30 years old that can afford housing and we don't offer townhomes. Maybe we are not embracing younger people. Many people go to PA or other areas. Commented about tie in with schools closing because not seeing growth of young children. The growth in Carroll County is diminishing as they can't afford to be in the county. There is no affordable housing for college age/people just starting out. Generations are changing. There is a natural pattern with the older population aging up.

"United way does an annual report called the Alice Report. It breaks down social determinants and we are ranked #3 in state of having affordable housing."

The income level is higher in Carroll, but we have a low income. We don't have jobs for middle income in Carroll. We see the extremes, so we don't get the grants/resource that middle income earners would get. Because of top end, our median doesn't reflect our community. Decisions are made on the average as it doesn't reflect us correctly. This number translates into housing as well.

People got into houses, but lost jobs. They regain but not at same level, so people are working part-time jobs to make ends meet. These things are hidden in our community. Paying thousands of dollars for before and after school care for children. This is a pressure point that affects mental health and security. It reflects the social support piece.

A lot of young families still live at home with parents. They are married with children and can't afford a home on their own. Parents are raising grandkids so parents can work. This is a change of dynamic in community.

When we went to pick only one issue, mental health fell back and illegal drug abuse went higher. With social determinants, quality health access is the top and education a close second. Prescription drug was #3 but dropped when picking only one.

Programs/services

Describe programs or services that you feel should be developed and offered to those who live in our community.

How do you think health and wellness are best promoted in our community?

Related to health and well-being, how would you describe existing services, outreach & promotion in Carroll County? - Results were good and fair.

Are there specific populations in the community that you feel are not being adequately served? If so, who?

Are there any areas of community health and wellness not identified in this survey that you feel need to be addressed?

Ability to pay for doctor appointment. Not just paying for it, but transparency on how much things will cost. There is a level of uncertainty on what the bill will be afterwards. People are paycheck to paycheck so a medical bill could throw families off.

High deductible plans – While services are available to people, not all are accessible to people.

Work for company out of state, HR may not understand MD laws, there is more confusion in general in understanding the rules. People may be able to pay if they understand the rules. Need education on health savings plans and how they can help pay for health care. With high deductible, people don't seek treatment until it is an emergent need – when it is more expensive.

Transportation is not easy to access for medical appointments was also rated high. It is available, but sometimes cost prohibitive for people.

Strongly agree – that people have access to local Primary Care Physicians.

Any topics you are seeing that we have not addressed?

Sexual violence is very prevalent in this county and you don't see it or hear about. It is a huge problem. **When asked if it should it be broken out from "other" violence, the answer was yes.**

Outreach to a more diverse community (color, disabilities, etc.). **Need to do a group for deaf and hard of hearing – other disabilities. Dot explained that we do have focus groups for Hispanic, African American, low income, LGBT, elderly – then will also get together to prioritize and focus resources on certain areas. Not ruling out issues, but identify someone else to handle it. We went to Community Service Council which included many non-profits.**

Alzheimer's and dementia is a key component in our county, especially with our aging population. There are support groups and memory units available. But, many family members taking care of parents are having a hard time coping with the disease, knowing the right approach, how to handle the disease. There are support groups, but need people to know about resources and know there are resources regarding how to care for them correctly – before it falls into abuse. Challenging, affordability, or don't qualify because they aren't that advanced in cognitive impairment, but the danger is real with the cognitive impairment.

STDs are becoming problems with our aging population now as well. So, awareness and protection are needed. It may be managed quite differently. We will see a lot more of these problems. We are aware it will happen and can't wait until it shows itself as a problem. The community does a lot already, i.e. memory care units. There are waiting lists for them as it is growing: Assisted living services, nursing homes.

Also mentioned was the lack of mental health facilities including availability. In addition, insurance pushes these patients out too soon because decisions are based on economics and not the health of patients. Or, it is never convenient when patients are ready to go into facilities. There are numerous facilities up and down the coast. This participant had to leave the county for services. It is all around you - neighbors, and up and down Main Street.

Mention was made about an article in the county about a local place trying to help people where someone snuck in a number for people to call in Florida – a facility trying to steal patients.

There are waiting lists for funding programs – Medicaid waiver, AERS to assess individuals to get on county programs, etc.

Money runs out quickly at Bureau of Aging, transportation fund money is gone in a week.

Money is used for transportation for getting people down to Baltimore for specialists, VA hospital, etc.

Key Informant
August 8, 2017
Shauck Auditorium

**** Note: Moderator comments in bold.**

General Health & Behaviors

Which is the #1 priority?

On scale of 1-5, rate statements about Health Care Access in our community

Additional comments?

Illegal drug abuse is #1; Obesity is #2; Mental Health is #3

Thoughts about Illegal drug abuse?

It's an epidemic. Drug and alcohol issues are through the lifespan.

Thoughts on prescription drug use?

The whole move toward pain management made a decade ago plays some role (that people should not be in pain) giving them more access to opioids to relieve their pain. It was too expensive to maintain prescription drugs. First, we were dealing with pain. Now we are dealing with the epidemic of abuse and addiction.

How do people turn to heroin?

It starts with prescription narcotics or pain management, getting cut off, then to a cheaper source. Start targeting prescription drugs.

Dot explained rationale in separating prescription drug abuse vs illegal drug abuse.

There's a difference between best practices and what is cost effective and it seems we confuse the two. In efforts to save money, it is presented as a best practice. But, in reality, it is how to cover the costs. We need to get beyond it and focus on really what works. Whatever it costs, we need to do it even if it is hefty. Then, we have to get out of the 1960s approach or we are fighting a losing battle. The governor says he is putting everything at it, but that is believed to be nonsense.

It is a combination of mental health, prescription, and illegal drugs that is a high ranking issue.

Get to causes - Shortage of mental health help in community - This problem is one outcome of that shortage.

At Focus groups – older population and Hispanic community recognized other things, but when picking just 1 they all picked drug abuse (thinking outside themselves and looking at the community).

Fee for service health care approach is hurting not helping. It is supposedly about accountability and effectiveness, but is really about saving money. When it started changing and getting worse, it tracks closely to fee for service.

Ron explained we are no longer fee for service at the hospital. We were at one time, but no longer the case. It is not true on the physician and ambulatory side of the world. Conversations are happening regarding population health, and how to keep people out of the hospital and treat people well in the most cost effective way.

If they don't have means to pay or they don't have insurance, then it is just a means of denying the service.

The impact is that the linkages of areas that have impact to the individuals who rely on law enforcement to get them into services. But, it also impacts children in families that can't address issues and have a multitude of long term generational issues. We don't understand how deep that goes.

It is shown that there is a significant higher threat of chronic disease in children that have crisis mental health issues. It turns into later disease.

Obesity is #2

Physical inactivity is one person's top issue and obesity is the result, as is poor mental health and heart disease. Focusing on getting people moving will impact the other problems as well. Exercise is needed for mental health and overall health and is a way to combat several of these things.

We are now seeing a swing toward action and preventing chronic disease.

One is not a resident of Carroll County with knowledge of Carroll County. There are young people involved in sports so that could help.

What can we do in the schools?

Interconnectedness of physicians in early intervention is important. The early environment for kids needs to be healthy, mentally and physically, role modeling, and educational. It all has to start early.

Also diet. A study looked at what people reached for at home and school. It is sodas and non- nutritious caloric sources that lead to disease.

Commented how bad it is out there regarding the ages of dementia patients that are only 55 years old and younger. It is a tremendous problem linked to all these other things. The financial exploitation that is coming hand in hand with drug abuse - young adults exploiting their parents and grandparents, everyone is being exploited in the community – you would not believe it. The banks have regular discussions about it – it is a huge problem affecting kids, grandkids, and the whole sandwich generation.

Seven people recognized dementia as being as one of top issues.

We need to start early with school age kids, i.e. seatbelt use. If we do it regarding foods and activity, then we will see a difference in coming years. This respondent grew up in CA and said that kids there are active all the time and have fresh foods. We need to start that lifestyle early here.

Often choices can be difficult and it is tied in to affluence. People have multiple jobs, which is something to recognize. People struggle just to put food on the table and a roof over their heads, so don't lose sight of that fact.

Social determinants…pick 3 most important to address in our community in next 3-5 years - Early childhood development and employment opportunities are top choices.

Think broader than a childhood development center - not just preschool and kindergarten – but parenting and early childhood in the home. What is happening in the homes?

We're seeing younger and younger kids with needs in school. They would benefit from inpatient hospitalization, but we don't have that here and caregivers are not taking their 5 year old to Baltimore or elsewhere.

Carroll County population is over 170,000 with the lowest crime rate in state and substance abuse but not as bad as other places. We have manageable numbers, but need to concentrate the resources on whatever the problem is to make an impact. We have kids with behavioral problems, but it is a manageable number. We can identify who they are. Target the resources to make an impact. There are children with problems, but it is a manageable number and we could touch each one.

What is the capacity for our community to deal with these issues?

What is going on with the 5 year old child? Address it early and get services.

When the mental health of a child is already imbalanced, what is going on to address the services? Story of autism spectrum – training that is needed in understanding it, misinterpretation that can happen with police, etc. - it goes back to early development including social and mental - have expectations on school system but can't get enough services and education out to parents and give support they need to do a great job raising kids - it does fall on the school. We know the kids are at the school.

But sometimes it is too late by then – too much damage is done. The issue is strong families. What abuse is happening with the parents and gets pushed down to the children? It is not just child development but parenting skills. The issue is the parents are not educated or are not able to handle things so they lash out at the child. They don't have the needed coping skills and mechanisms. Then the child mimics their parent's coping mechanisms who never had the education either. There is a limited amount of time they can spend in the schools to get help.

Housing comments?

Affordable housing – If you are a chapter person getting subsidies, then you are getting a food stamp card. The abuse on MD food stamps card is amazing. What us as taxpayers buy the people who have these cards. At a local convenience store, 80% of his business is done with food stamp cards, and 100% of product he has in the store is poison to put in one's body and overpriced. "I see much abuse, homeless, four generations on welfare now. My #1 choice is obesity – you can't put poison in your body." (Participant lost a lot of weight). "I see a lot that goes on downtown outside of my store. It is what I see. Carroll County had an election for mayor. Out of 16,000 registered voters, 900 people voted. So, I don't know how to get the message out, but can just be true to myself and my store, and give to my community and hope people will begin to get it. I see four generations now. The lack of education as far as nutrition goes is a paramount wrong in this country. The pure poison that people put in their bodies is horrible and you feel better if you eat better. I didn't need to get a new knee because I lost weight. If you have a job and you are eating properly you will feel better about yourself. You will look forward to other good things to get into if you are employed. But, when it is easier to get a

check from the government and food stamp and cell phone and you don't want to get up and go to work because the government gives you everything you possibly need anyway, it gives no incentive in one's life to get better."

What about the food desert?

You need transportation to get to the grocery store. It is definitely in large cities. There may be 1 or none. That is where convenience stores become the resource for people. When we talk about transportation we talk about medical care, not getting groceries and getting it back to your home. Hard to carry it back to your home. The roads are a dangerous place to be walking, too. Your resources are limited. People are doing the best that they can. They are not sitting in an arena like this doing problem solving, etc.

"I would like to expound on addiction. I think a lot of processed and packaged foods are convenient and cheap (for $3 get a meal at McDonalds). A lot of those foods with sugar, corn syrup, actually sets up a cycle of addiction, a similar kind of addiction to the drugs we are talking about but not illegal. It gives you a rush, you have a crash, so then eat a snickers, crash, then get something "good" and get cheese crackers. It is a cycle of rush and crash. It does the same kind of thing to your brain. I wonder if we should start looking at nutrition at an addiction perspective as opposed to does everybody have good food. The molecular composition of sugar is the same as cocaine and stimulates the same part of the brain as heroin and cocaine. On an empty stomach, the pancreas shoots up that blood sugar and now you get a sugar high and then you crave more sugar. I am a health educator and am surprised at the meals at some of the schools. Many get a donut for breakfast which is sugar! At schools, the first thing in the day is sugar."

They had a program from the state (included nurses, teachers, etc.) and removed vending machines and sweets and sugar (candies) as rewards (many teachers use candy as a reward). They gave them something else. This was in the state of NY 10 years ago. Do we do anything comparable here? One could not be punished with missing recess or PE which was physical activity. So, it was an extensive program. Another excellent program in Oregon involved a family, a box, and intervention for 0-5 year olds. If you see situations, you need to report it. There were 9 criteria. It started in the YMCA with a grant and built over the years. A gentleman donated a facility that had a room for infants, a room for toddlers, anger management classes, and parenting skills class for parents. With the drug situation, many parents are in jail. There was 1 grandma taking care of 7 children. It is called Family Building Blocks.

In Carroll County we have many services, but the problem is engagement – getting people to realize that this is important and engage in the services. Once you get someone engaged, then transportation is a problem.

How well are we doing in encouraging health & wellbeing – looks like our score for promoting is good and fair, some poor and some excellent. What can we do to promote it better?

Services was the key word here – outreach with The Partnership - there are a lot of programs we do to get people moving. There are programs in place, but are the services available. They are financial based/driven. Mental health for small children or in general? For alcohol & drug use? You can get in the hospital, and then three days later after detox, what services are there after hospitalization, etc.? We

send them home on Sunday, they have to wait until Monday to look for rehab and there is nothing out there in the community. Facilities from here to the Eastern Shore are full. Services are poor. Access is poor. If you need a neurologist, there is a three month wait list. What if you have a brain tumor? If you have loved ones with dementia and they are walking out of the house in their underwear and the police are picking them up and taking them home – try getting them to a neurologist or neuro-Psychiatrist. Adult protective services are just not there.

What is the capacity of our health care system in Carroll County? You're talking capacity and access. If programs are in place, what is the capacity and access? Word services is conflicting to me because I don't want to negate the good we have here. It is conflicting; tease it out; don't want to negate community programs because they are good.

Anything else to discuss?

One experience was recognizing when voicing an opinion of a majority of residents in the county having access. "I've lived here a long time, but I feel the way the question was worded that I could not answer – a sense of economic breakdown - as I don't have demographics for it." In surveys, how questions are worded can often really impact – they almost answer the question sometimes, or ask you to give opinion not based on any information that you have to back it up – it is just an opinion.

Look at our language – we use transportation all the time.

Sometimes if you look at wording of surveys, some information prior to engaging the survey may be useful. "You have this economic breakdown, we have these numbers going in." In some respect, educate the person writing because they can provide some additional perspective.

There are community assets that would be helpful to map and make sure they are continuing to be strengthened and approached to meet needs. Sometimes we have a half empty approach, but show these are some strengths we have. If it is an asset we have, what is being done to support that should be part of the conversation.

"I would like to see merchants at "ground zero" to be trained in Narcan administration. I see abuse every day as a small business owner in downtown Westminster. People up and down route 140 don't see it. It is the heart of darkness down there. I would love to lead a grassroots effort – I don't know about the treatment, but I would like to save a life, I would like to get an outreach to other businesses downtown."

We talk about vicious cycles. It is whatever we choose – the child coming into school, what happened to them before coming into the school system; or the parent - maybe they were in high school and didn't care about school anymore so they didn't learn trades in order to survive so now are going down a bad path. Also, not ignoring the aging population, everybody is important, but focus on a starting point and seeing the long term effect occur. It is all different starting points. It is picking one and focus on the starting point.

Identification and data gathering – where is the shared accountability at a community level where we can all invest together and make an impact? "As a non-profit charged with communications in this community I am not exposed to that at all. That is not happening in a way that allows me to identify a

way for me to lead my board as to this kind of investment in our community that would make a great impact within the community."

Preventative measures is the most cost effective.

5. Targeted Populations

A. Methodology

A total of five focus groups were held with targeted population groups at various locations throughout Carroll County. One session was held with each group: African American; Hispanic/Latino; Low Income; Lesbian, Gay, Bisexual and Transgender (LGBT); and the Older Adult community. Sessions were scheduled for July and August 2017; only one session was held in September due to scheduling issues. Session topics addressed access to care, general health issues, cultural competency, and social determinants of health. Each session lasted between 60 and 90 minutes and was conducted using an online survey followed by a moderated discussion. A bilingual community leader was present for the session with Hispanic/Latino community members.

In total, 71 people participated in the five sessions. It is important to note that the results reflect the perceptions of a limited subset of community members, and do not necessarily represent the opinions of all residents of Carroll County.

Sessions were held in locations that each group suggested or approved and participants were recruited through a variety of outreach initiatives. The African American focus group was held at the Non-Profit Center in Westminster and the Carroll County chapter of the NAACP assisted with recruiting participants. The Hispanic/Latino community members met at Carroll Hospital Shauck Auditorium and outreach to potential participants was made through St. John Roman Catholic Church as well as with colleagues of The Partnership staff. LGBT participants were invited to join the focus group through contacts made with the local Carroll County PFLAG (Parents, Families and Friends of Lesbians and Gays) chapter. The session was held at St. Pauls' United Church of Christ in Westminster. Lower income residents were invited to join the focus group by referral of staff at the Human Services Program of Carroll County. The group met in a conference room of the Citizen Services office. The older adult focus group was held on-site at Carroll Lutheran Village (CLV), a retirement community in Westminster. All participants were residents of CLV.

B. Results Summary

African American Population Results Summary

Demographics

Fourteen African American community members participated in the session. The participants were equally male and female. Most participants were between the ages of 45 and 64 years (42.8%) or 65 years and over (50%). Approximately 86% of participants lived in a single-family house, 92.9% had one to three people living in their household, and 35.7% resided in zip code 21157. All of the participants lived in Carroll County for more than 10 years.

Demographic Information	Count	Percentage
Gender		
Male	7	50%
Female	6	42.9%
Identifies as other than male or female	0	0.0%
Did not answer	1	7.1%

Age		
18 - 25	0	0.0%
26 - 34	0	0.0%
35 - 44	1	7.1%
45 - 54	3	21.4%
55 - 64	3	21.4%
65 and over	7	50.0%

Number of People in Household		
1	4	28.6%

2	6	42.9%
3	3	21.4%
4	0	0.00%
5	0	0.00%
More than 5	1	7.1%

Type of Housing Unit		
Single-family home	12	85.7%
Apartment	1	7.1%
Townhome	1	7.1%
Mobile home	0	0.0%
Condo	0	0.0%
Other	0	0.0%

Zip Code		
21048	1	7.1%
21157	5	35.7%
21776	4	28.6%
21784	1	7.1%
21787	1	7.1%
21791	1	7.1%
Did not answer	1	7.1

Length of Residence in Carroll County		
Less than 1 year	0	0.0%
1 – 3 years	0	0.0%
4 – 5 years	0	0.0%
6 – 10 years	0	0.0%
More than 10 years	14	100.0%

Access to Health Care

In 2018, respondents were asked if they had health insurance. All of the respondents in the African American focus group were insured. In addition, they were asked where they got information and education on health. The top 2 resources were:

- Physician/Health care provider
- Online websites

Following the top two, the following all ranked equally:

- Family/friends
- Local sources (i.e. hospital)
- Local providers/organizations/resources

As illustrated in the following table, the majority of participants agreed or strongly agreed with the community's ability to access health care. The exception was for those residents needing available and easily accessible transportation. *Signage and promotions for health that reflect their community* and *its needs and transportation* garnered the fewest number of respondents who agree or strongly agree indicating that these issues may be posing the greatest challenges.

"On a scale of 1 (Strongly Disagree) through 5 (Strongly Agree), please rate each of the following statements about Health Care Access in your community."

Statement	Neutral	Percentage of Respondents who "Agree" or "Strongly Agree"
The majority of residents in my community have access to a local primary care provider.	7.7%	69.2%
The majority of residents in my community have access to necessary medical specialists.	7.7%	61.5%
The majority of residents in my community are able to access a local dentist when needed.	23.1%	53.8%
Transportation for medical appointments is available and easy to access for the majority of residents.	23.1%	38.5%
Signage and promotions for health services reflect my community and its needs.	15.4%	23.0%

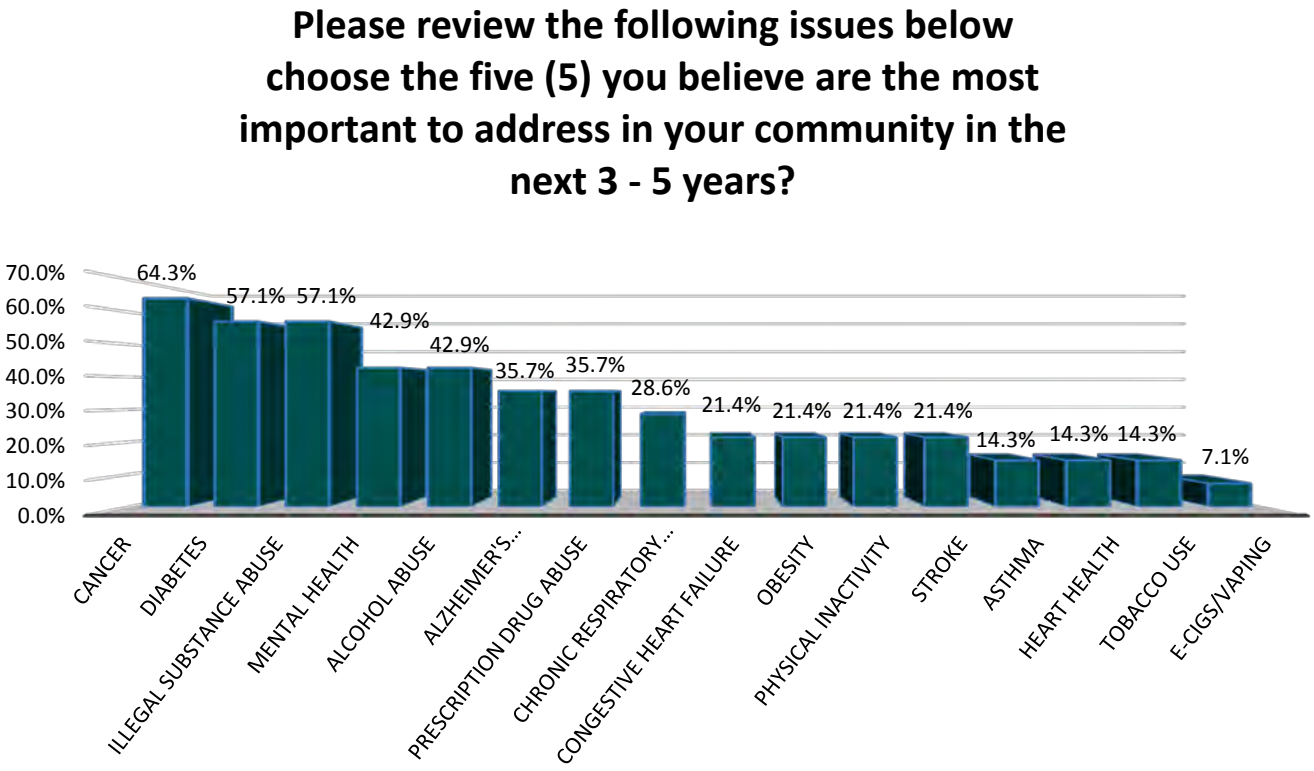
There are health care providers who understand my population and its health risks.	14.3%	42.9%
Health care services are provided in my language.	0.0%	92.3%

General Health Issues

African American participants were also asked to identify the five most important health issues that need to be addressed in the next three to five years. The top five health issues were:

- Cancer
- Diabetes
- Illegal Substance Abuse
- Alcohol Abuse
- Mental Health

A full listing of the health issues, in order by the percentage of participants who selected the issue, is presented in the graph below. Note: E-Cigs/Vaping, Dental Health, Immunization/Vaccination, Injury, and Sexually Transmitted Disease are absent from graph as they were not represented in the responses.



When asked to indicate the number one priority in their community, Alzheimer's Disease/Dementia, COPD, Illegal Substance Abuse, and Prescription Drug Abuse all ranked as the highest priority. During the discussion, COPD was identified as an important health need. Obesity, mental health, cancer, and Alzheimer's were then identified as equally important behind COPD.

Comments Regarding COPD

- There needs to be more education about what COPD means.
- Early intervention with education will make us healthier down the road.

Comments Regarding Illegal Substance Abuse and Prescription Drug Abuse

- A difference is not seen between the two as both are a substance put into the body to get high. This is no different than with alcohol.
- Abuse comes from socioeconomic conditions. Kids that abuse the prescription drugs don't carry the same stigma as the guy buying on the street corner.
- People addicted to opioids and pain meds can get to a methadone clinic, but cannot get to work. How can you get people off of drugs if you give them drugs? It isn't a treatment program, but rather a maintenance system. Methadone affects job contribution, impact on selling drugs, and perpetuating drug abuse with others.
- It is a waste of tax payers' money to have a program to give drugs.
- This is now seen as an opioid epidemic since it is affecting white kids in the suburbs, but before it was a drug problem with black kids in the city.

Additional concerns with medication include proper education not being distributed with the prescription, medication not available in the pharmacies, and medication for one illness causing side effects requiring additional medication for the side effects. Participants commented that the use of marijuana should be legal, but "our conservative nature is a barrier" in getting these although they are also less expensive.

Additional Comments Regarding Health Issues

- In regards to diabetes, it is typically a result of obesity. "Obesity is in the country (the big picture), but diabetes is important in our community."
- Carroll County is a commuter county and people travel outside of the county to work. Doctors' offices do not have office hours late enough for commuters.
- Many facilities do not accept Medical Assistance or all insurances.
- Affordable Care Act is providing more people with insurance, but it is limiting the amount of appointments available.

- Doctors need education on diseases specific to the African American culture. (i.e. – specific skin conditions)

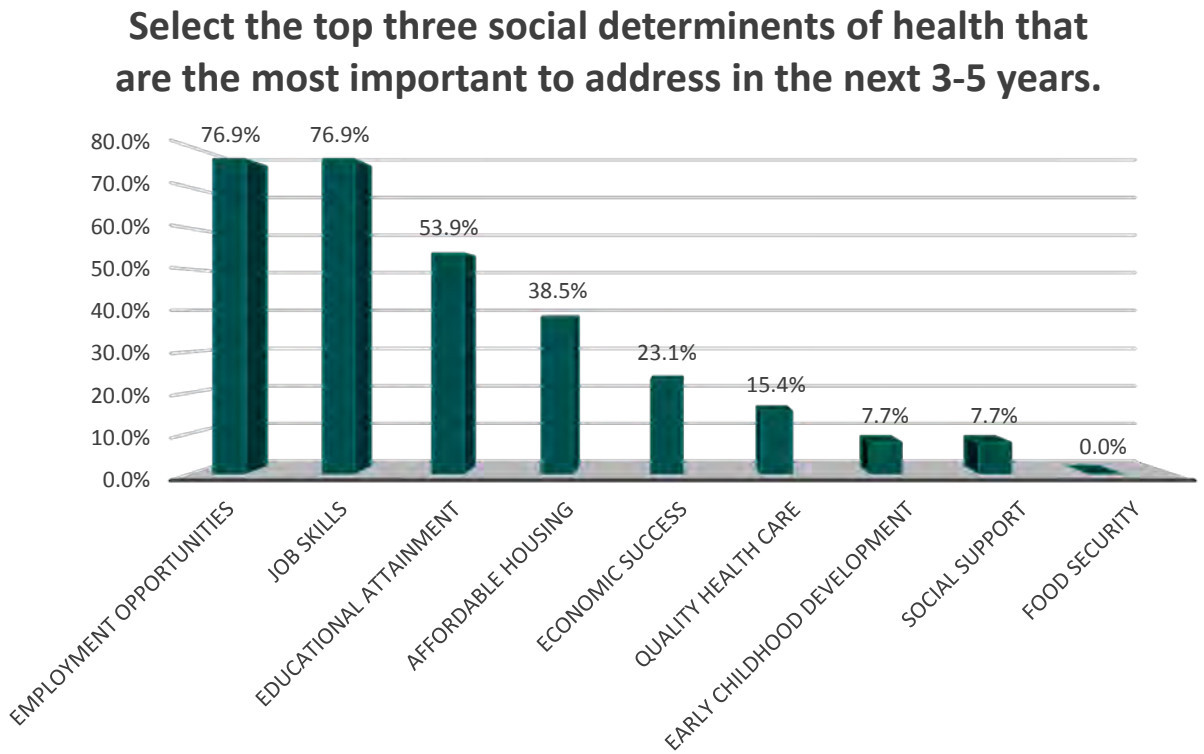
Social Determinants of Health

Health outcomes are determined not only by health behaviors like eating well and staying active, but also by the extent of social and economic resources and opportunities available in homes, neighborhoods, and communities. The concept helps explain in part why some population groups are healthier than others.

With this in mind, participants were asked to select the top three social determinants of health that they believe are the most important to address in their community in the next three to five years. The top three social determinants were:

- Employment Opportunities
- Job Skills
- Educational Attainment

A full listing of the social determinants of health, in order by the percentage of participants who selected the determinant, is presented in the following graph.



The respondents were asked to identify the one social determinant that will make the greatest impact to the health of the community and it was equally divided between affordable housing, educational attainment, and job skills.

Additional Comments Regarding Affordable Housing

- The need to commute for better paying jobs affects the quality of life.
- Respondents would like to see Carroll County be inclusive – work here and see doctors here.
- There is no longer the concept of the "community doctor" who lives in the community so they know the problems of the community.

Hispanic/Latino Population Results Summary

Demographics

Eleven Hispanic/Latino community members participated in the session. Approximately two-thirds of participants were female. Seventy-three percent of the participants were over the age of 45. Approximately two-thirds of participants lived in a single-family house and all participants had two or more members in their household. All participants lived in zip codes 21157, 21158, and 21784 and two-thirds have lived in Carroll County for more than 10 years.

Demographic Information	Count	Percentage
Gender		
Male	4	36.4%
Female	7	63.6%
Identifies as other than male or female	0	0.0%

Age		
18 - 25	0	0.0%
26 - 34	3	27.3%
35 - 44	0	0.0%
45 - 54	3	27.3%
55 - 64	4	36.4%
65 and over	1	9.1%

Number of People in Household		
1	0	0.0%
2	3	27.3%
3	5	45.5%
4	2	18.2%
5	1	9.1%
More than 5	0	0.0%

Type of Housing Unit		
Single-family home	7	63.6%
Apartment	3	27.3%
Townhome	1	9.1%
Mobile home	0	0.0%
Condo	0	0.0%
Other	0	0.0%

Zip Code		
21157	3	27.3%
21158	5	45.5%
21784	3	27.3%

Length of Residence in Carroll County		
Less than 1 year	0	0.0%
1 – 3 years	3	27.3%
4 – 5 years	0	0.0%
6 – 10 years	1	9.1%
More than 10 years	7	63.6%

Access to Health Care

In 2018, respondents were asked if they had health insurance. Almost all (91% or 10 out of 11) of the respondents in the Hispanic/Latino focus group were insured. In addition, they were asked where they got information and education on health. The top 3 resources identified:

- Online websites
- Your physician/health care provider
- Family/friends

As illustrated in the following chart, the largest percentage of respondents believe that residents in the community have access to a local primary care provider (PCP) and that there are health care providers who understand their population and its health risks. A low percentage of respondents believe that transportation for medical appointments is available and easy to access for the majority of residents.

"On a scale of 1 (Strongly Disagree) through 5 (Strongly Agree), please rate each of the following statements about Health Care Access in your community."

Statement	Neutral	Percentage of Respondents who "Agree" or "Strongly Agree"
The majority of residents in my community have access to a local primary care provider.	18.2%	45.5%
The majority of residents in my community have access to necessary medical specialists.	27.3%	36.4%
The majority of residents in my community are able to access a local dentist when needed.	18.2%	36.4%
Transportation for medical appointments is available and easy to access for the majority of residents.	27.3%	9.1%
Signage and promotions for health services reflect my community and its needs.	45.5%	27.3%
There are health care providers who understand my population and its health risks.	27.3%	45.5%
Health care services are provided in my language.	36.4%	27.3%

Comments Regarding Access to Care

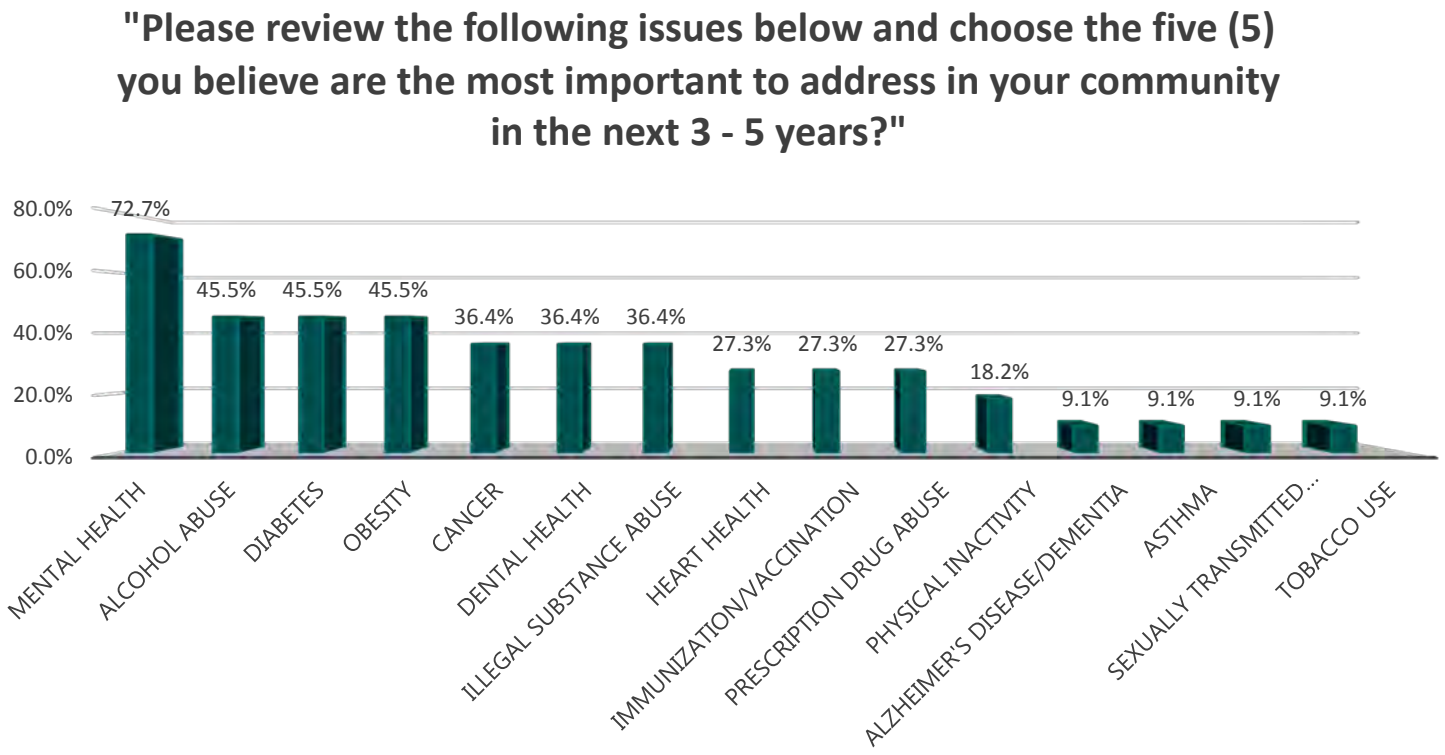
- The lack of transportation, language barriers, education for parents, prevention, yearly tests, and health insurance results in a lack of quality health care.
- As a result of the translation of mental health terminology, there needs to be a place to send people (i.e. Kennedy Krieger) and information needs to be available regarding who to call and how to get in to see these people.

General Health Issues

Hispanic/Latino participants were also asked to identify the most important health issues that need to be addressed in the next three to five years. Mental health was clearly identified by more participants as a top health issue above all others. The top four health issues identified were:

- Mental Health
- Alcohol Abuse
- Diabetes
- Obesity

A full listing of the health issues, in order by the percentage of participants who selected the issue, is presented in the following graph. Note: Tobacco use, Chronic Respiratory



Disease/COPD, Congestive Heart Failure, e-Cigs/Vaping, Injury, Stroke, & Other are absent because they were not represented in the responses.

When asked to identify the number one health issue priority, the majority of Hispanic/Latino participants selected Illegal Substance Abuse. Alcohol and Diabetes tied as the second priority.

Comments Regarding Health Issues

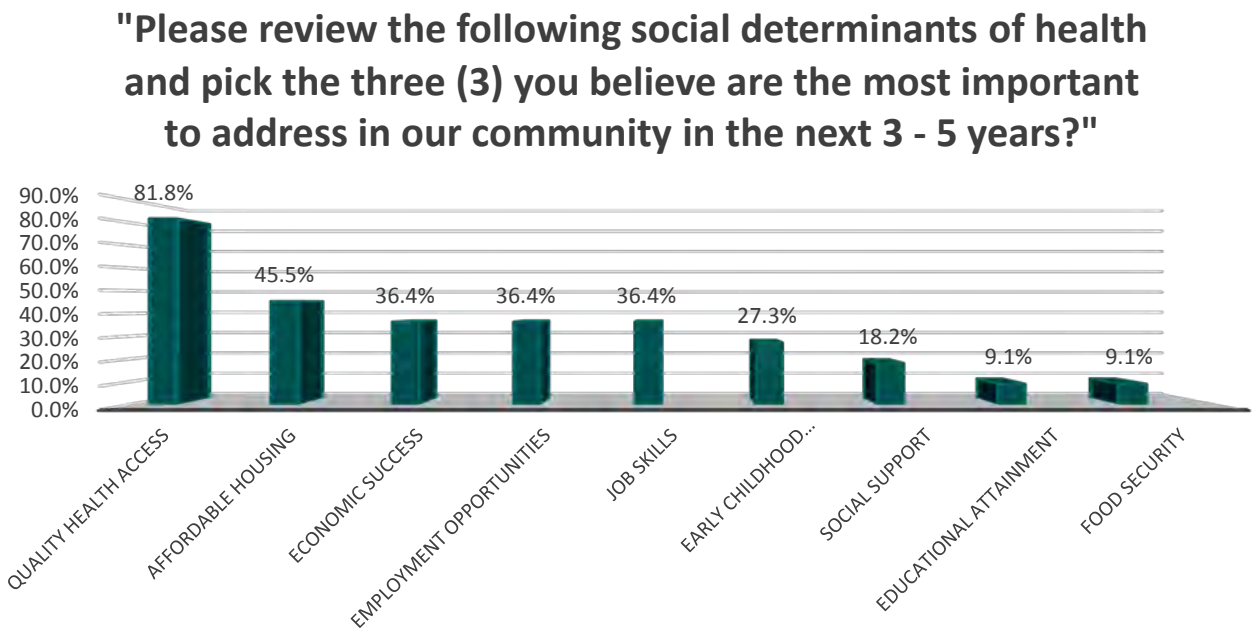
- Mental health is seen as a behavior/temperament and not as a disease, therefore people do not seek treatment.
- People are afraid to discuss mental health because they will be viewed as "crazy."
- There needs to be a diagnosis in child development for mental health.
- There is a lack of information on mental health as a disease and treatment.
- It is believed that the 90-day prescription of pills is contributing to the increase in overdoses. If people do not use them, they are sold or dispersed to others.
- There needs to be an individual that speaks Spanish at the hospital so that patients and/or parents feel confident talking to someone.
- Medical Assistance Cards only provide for a pediatrician for children and not a specialist.
- Specialists need to be available at the same costs as a PCP. There also needs to be payment plans that individuals can commit to.

Social Determinants of Health

Participants were asked to select the top three social determinants of health that they believe are the most important to address in their community in the next three to five years. The top social determinants of health identified were:

- Quality Health Access
- Affordable Housing
- Economic Success
- Employment Opportunities
- Job Skills

After quality health access and affordable housing, equally identified were economic success, employment opportunities, and job skills. A full listing of the social determinants of health, in order by the percentage of participants who selected the determinant, is presented in the following graph.



When asked to identify the social determinant that they believe will make the greatest impact to the health of the community, quality health access was the top priority.

LGBT Population - Results Summary

Demographics

The Lesbian, Gay, Bi-sexual, Transgender (LGBT) population was represented by 16 individuals. Thirteen of these individuals identified themselves as LGBT and three of them were representing family members. All family members were female and identified individuals were 68.8% female, 25% male, and 6.2% that did not identify with either male or female. All but one individual was over the age of 35. Fifty percent of the participants lived in a household with four people and 75% lived in a single-family home. Eighty-six percent lived in either 21157 or 21158 and the remaining two lived in 21784. All participants have lived in Carroll County for four or more years.

Demographic Information	Count	Percentage
Gender		
Male	4	25.0%
Female	11	68.8%

Identifies as other than male or female	1	6.2%

Age		
18 - 25	1	6.25%
26 - 34	0	0.00%
35 - 44	3	18.75%
45 - 54	8	50.0%
55 - 64	3	18.75%
65 and over	1	6.25%

Number of People in Household		
1	2	12.5%
2	4	25.0%
3	1	6.25%
4	8	50.0%
5	1	6.25%
More than 5	0	0.0%

Type of Housing Unit		
Single-family home	12	75.0%
Apartment	1	6.25%
Townhome	3	18.75%
Mobile home	0	0.0%
Condo	0	0.0%
Other	0	0.0%
Zip Code		
21157	9	60.0%
21158	4	26.7%
21784	2	13.3%

Length of Residence in Carroll County		
Less than 1 year	0	0.0%
1 – 3 years	0	0.0%
4 – 5 years	2	12.5%
6 – 10 years	3	18.75%
More than 10 years	11	68.75%

Access to Health Care

All respondents indicated they did have health insurance. Almost all respondents, 93.7%, indicated they received health information and/or education from their physician/health care provider. In addition, 81.2% received information from online websites and 56.2% from family and friends.

The following chart reflects the combined responses from both the individuals that identify as LGBT and the family that represents them. The lowest percentage of participants that "agree" or "strongly agree" that transportation is available and easy to access. The highest percentage of participants believed health care is provided in the individuals' language. The majority of the participants agreed or strongly agreed that PCP, specialists, and dentists were accessible. However, lower responses were reported for transportation, signage and promotions, and for understanding the population and its health risks.

"On a scale of 1 (Strongly Disagree) through 5 (Strongly Agree), please rate each of the following statements about Health Care Access in your community."

Statements	Neutral	Percentage of Respondents who "Agree" or "Strongly Agree"
The majority of residents in my community have access to a local primary care provider.	12.5%	62.5%
The majority of residents in my community have access to necessary medical specialists.	12.5%	50%
The majority of residents in my community are able to access a local dentist when needed.	12.5%	56%

Transportation for medical appointments is available and easy to access for the majority of residents.	31.2%	6.25%
Signage and promotions for health services reflect my community and its needs.	25%	25%
There are health care providers who understand my population and its health risks.	18.7%	37.5%
Health care services are provided in my language.	6.25%	87.5%

Comments Regarding Access to Health care

- The participants indicated that getting a counselor was by "word of mouth" only.
- It was also stated that it was difficult to find a LGBT supportive and understanding pediatrician.
- There is a need for more transgender specialists in the area.
- Pediatricians need to be more concerned with LGBT specific concerns.
- There is a need for an endocrinologist trained in transgender issues in the county. It was indicated that people had to travel 45 minutes one way to get to a doctor.
- There is also a need for more therapists trained in issues specific to transgender individuals. The suicide rate is high among the transgender community.

General Health Issues

LGBT focus group participants were asked to identify the five most important health issues that need to be addressed in the next three to five years.

The LGBT individuals indicated the following:

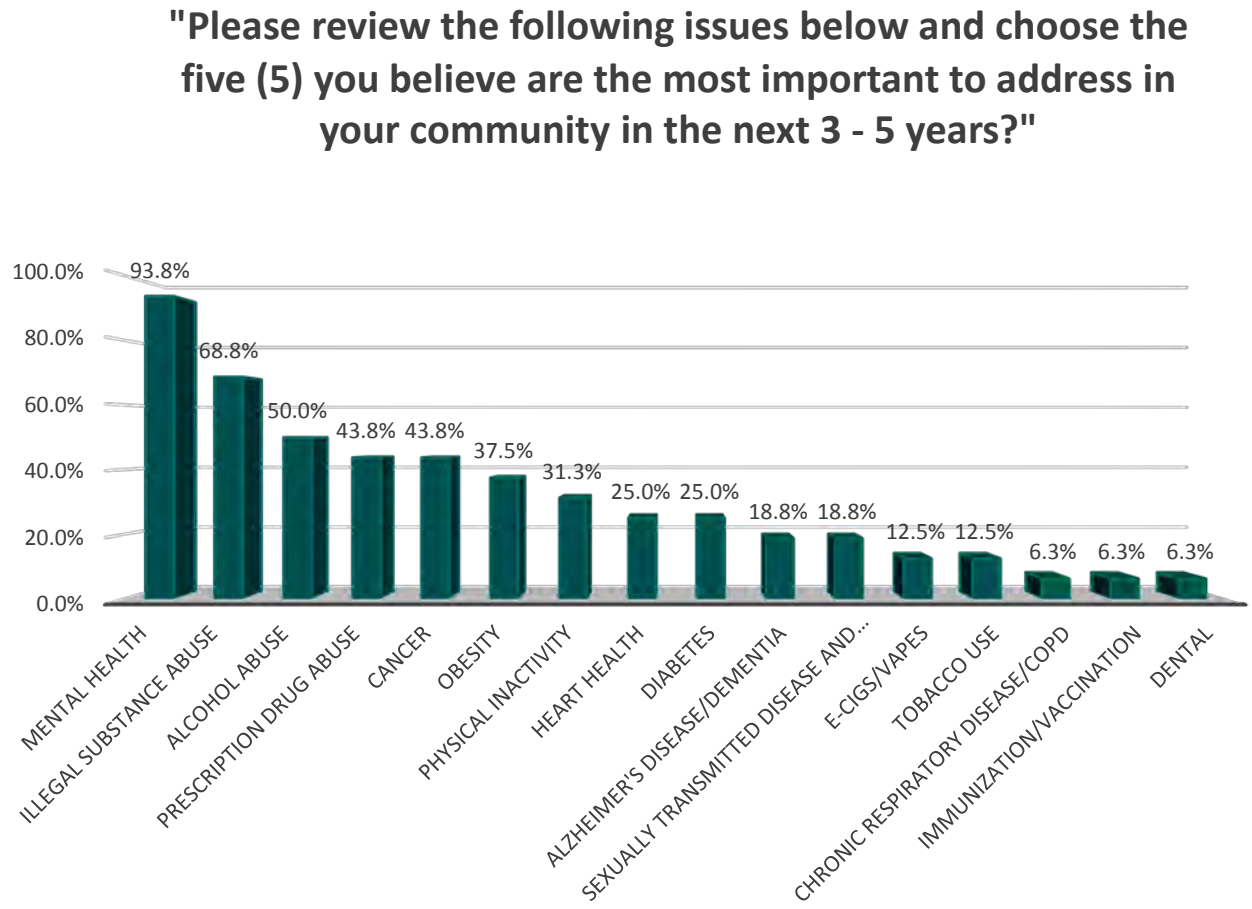
- Mental Health
- Illegal Substance Abuse
- Prescription Drug Abuse

Alcohol abuse, cancer, obesity, and physical inactivity were all equally identified after the top three above.

The LGBT family members indicated the following:

- Mental Health
- Alcohol Abuse
- Illegal Substance Abuse
- Cancer

Alzheimer's/Dementia, dental health, diabetes, obesity, and prescription drug abuse were equally identified after mental health, alcohol abuse, illegal substance abuse, and cancer by the individuals representing the LGBT community. Note: Asthma, Congestive Heart Failure, Dental Health, Injury, and Stroke are absent in the graph as they were not represented in the responses.



When asked what the top priority of all health issues, mental health was identified by half of all respondents. An additional 25% indicated substance abuse.

Comments Regarding Illegal Substance Abuse

- Self-medicating, alcohol, and legal drugs are all substances.
- People run out of money, rob people, become homeless, etc. all as a result of mental health.

Social Determinants of Health

Participants were asked to select the top three social determinants of health that they believe are the most important to address in their community in the next three to five years.

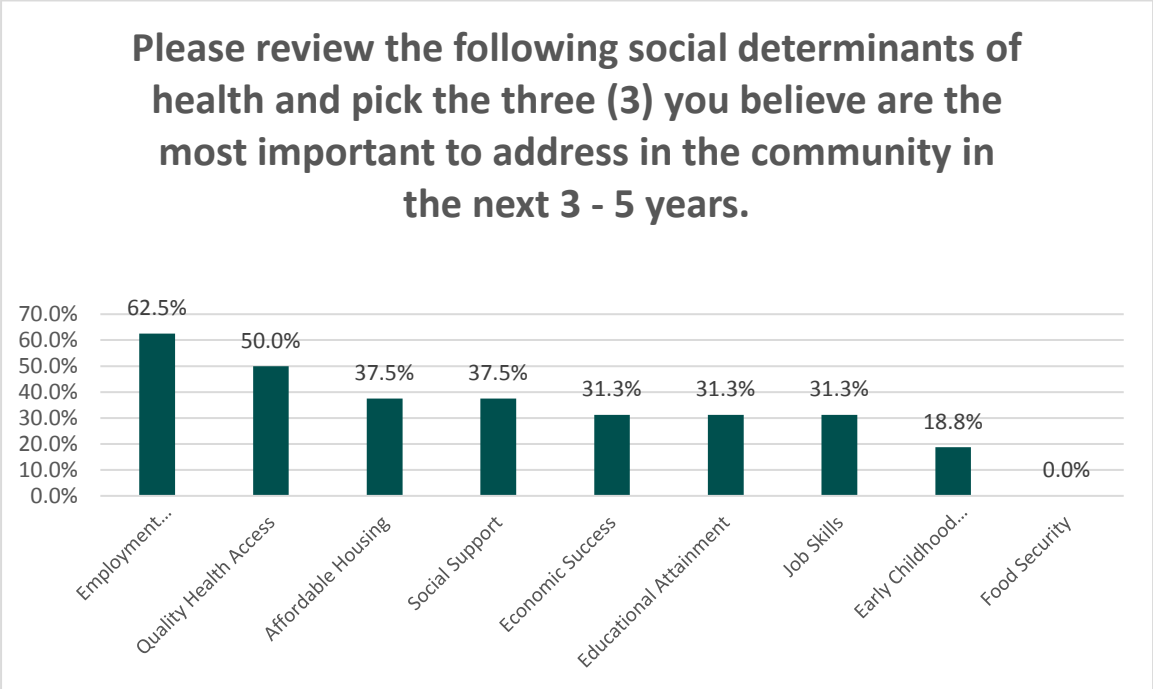
The LGBT individuals identified the following as the top determinants:

- Quality Health Access
- Employment Opportunities
- Social Support
- Affordable Housing

The LGBT family members identified:

- Employment Opportunities
- Job Skills

A full listing of the social determinants of health, in order by the percentage of participants who selected the determinant, is presented in the following graph.



The LGBT individuals identified employment and social support as the social determinants with the greatest impact to health. However, the family members identified employment and educational attainment as having the greatest impact to health.

Comments Regarding Social Determinants

- It was discussed that there is difficulty finding mental health providers and services at the college.
- Guidance Counselors in the schools are ill prepared to handle LGBT issues and concerns.
- There need to be more specific questions leading to a LGBT lifestyle on health care surveys to avoid unnecessary questions.
- There is discrimination in the workforce. This includes both getting a job and in working with co-workers. There needs to be more diversity training and education.
- There needs to be more social support in the community to understand transgender issues and that this is not a mental illness.

Low Income Population Results Summary

Demographics

Nine low income community members participated in the session. The majority of participants, 77.8% or 7 respondents, were female. Over 80% of participants lived in a single-family house, townhome, or apartment and over 66% of the participants were members of a household with at least four people. More than 75% of participants lived in zip codes 21157 or 21158 and 78% have lived in Carroll County for six or more years.

Demographic Information	Count	Percentage
Gender		
Male	2	22.2%
Female	7	77.8%
Identifies as other than male or female	0	0.0%

Age		
18 - 25	0	0.0%
26 - 34	3	33.3%
35 - 44	3	33.3%
45 - 54	0	0.0%
55 - 64	3	33.3%
65 and over	0	0.0%

Number of People in Household		
1	1	11.1%
2	2	22.2%
3	0	0.0%
4	5	55.6%
5	1	11.1%
More than 5	0	0.0%

Type of Housing Unit		
Single-family home	3	33.3%
Apartment	3	33.3%
Townhome	2	22.2%
Mobile home	0	0.0%
Condo	0	0.0%
Other	1	11.1%

Zip Code		
21157	5	55.6%
21158	2	22.2%
21757	1	11.1%
21784	1	11.1%

Length of Residence in Carroll County		
Less than 1 year	2	22.2%
1 – 3 years	0	0.0%
4 – 5 years	0	0.0%
6 – 10 years	3	33.3%
More than 10 years	4	44.4%

Access to Health Care

When asked if they had health insurance, 66.7% of the low income participants responded that they were insured. There was not one particular resource that ranked the highest for health information and education with the low income respondents. It was divided amongst online websites (24%), local sources or family/friends (20% each), and physicians and local providers/organizations/resources (16% each).

As illustrated in the following table, a majority of the participants "agree" or "strongly agree" that access to a PCP, specialist, or dentist is available. The majority of participants were not able to agree or disagree with the community's ability to access health care due to transportation being available and easy to access.

"On a scale of 1 (Strongly Disagree) through 5 (Strongly Agree), please rate each of the following statements about Health Care Access in your community."

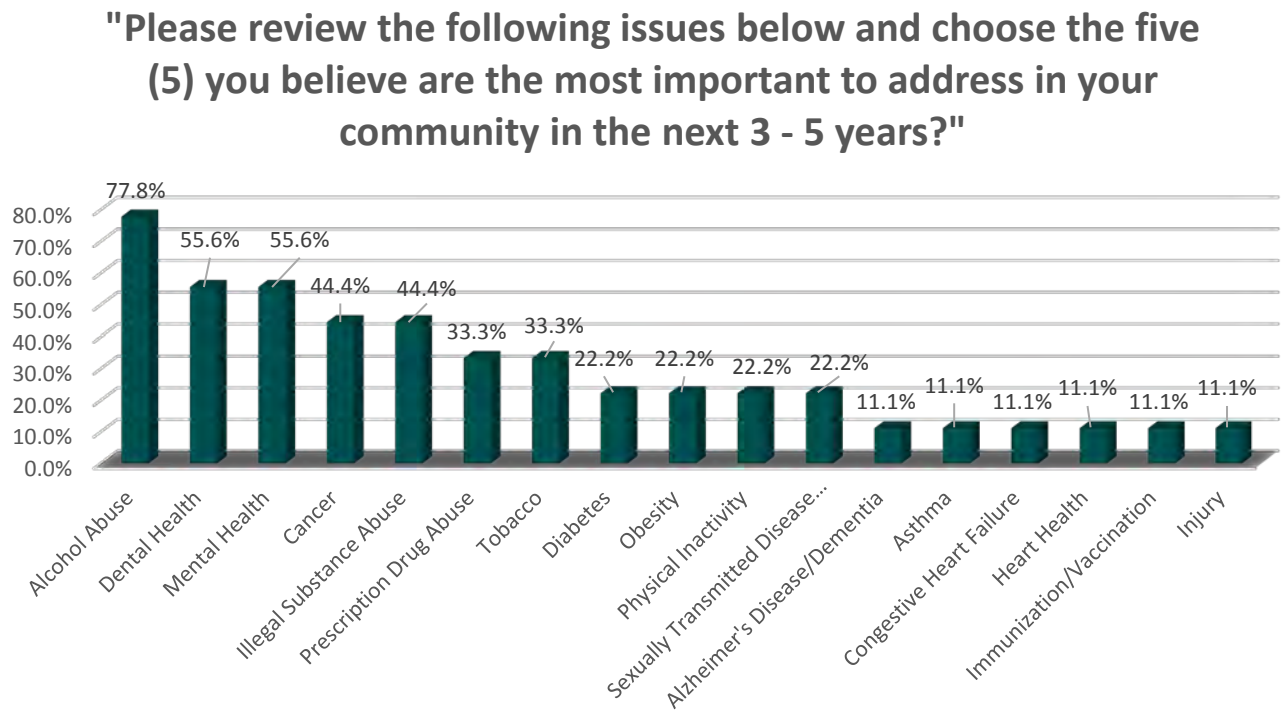
Statements	Neutral	Percentage of Respondents who "Agree" or "Strongly Agree"
The majority of residents in my community have access to a local primary care provider.	11.1%	66.67%
The majority of residents in my community have access to necessary medical specialists.	22.2%	55.6%
The majority of residents in my community are able to access a local dentist when needed.	11.1%	66.7%
Transportation for medical appointments is available and easy to access for the majority of residents.	55.6%	22.2%
Signage and promotions for health services reflect my community and its needs.	66.7%	33.3%
There are health care providers who understand my population and its health risks.	44.4%	44.4%
Health care services are provided in my language.	0.0%	77.7%

General Health Issues

Low income participants were also asked to identify the five most important health issues that need to be addressed in the next three to five years. The top five health issues according to low income participants are:

- Alcohol Abuse
- Dental Health
- Mental Health
- Illegal Substance Abuse
- Cancer

A full listing of the health issues, in order by the percentage of participants who selected the issue, is presented in the graph below. Note: Chronic Respiratory Disease/COPD, E-Cigs/Vaping, Stroke and Other are absent from this graph as they were not represented in the responses.



More than a third of the respondents indicated that mental health was their top priority in health issues. It was followed by alcohol abuse and cancer (both at 22.2%).

Comments Regarding Health Issues

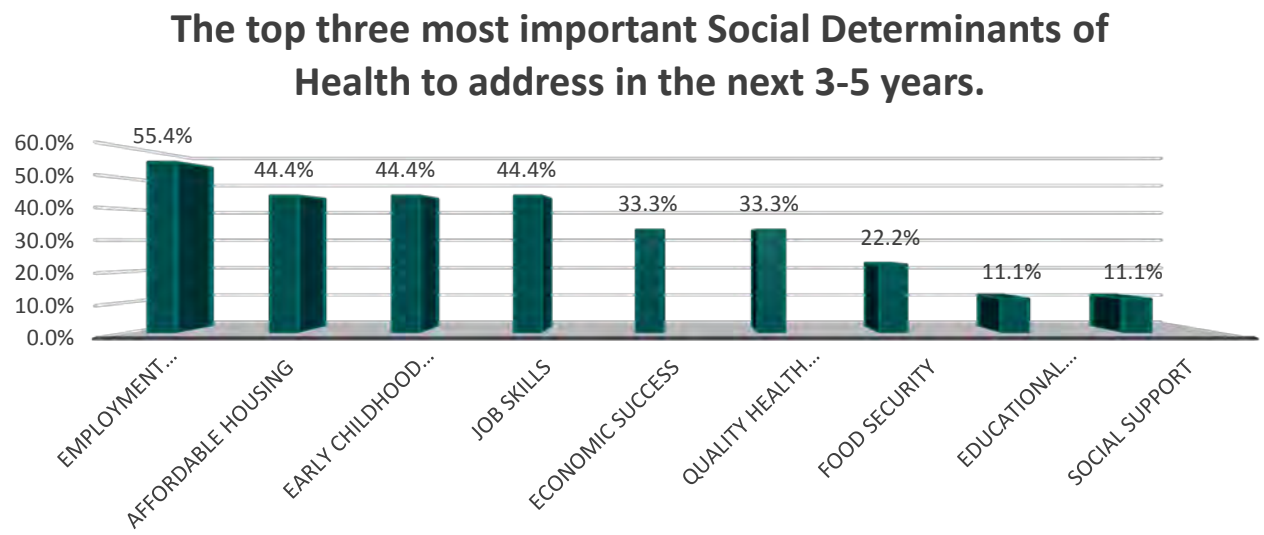
- Alcohol is legal and easily available. It is considered socially normal. There needs to be more attention to the effect alcohol has on overall health. Alcohol is seen as an obstacle to success.
- There is a stigma with mental health and it is looked down upon. There is access to help, but getting assistance is not acceptable. It is seen as a weakness and not one that is dealt with outside of the home.
- There needs to be more education in school about the effect drinking and smoking has on our health.
- There needs to be more discussions in schools about cancer.
- Having a mental illness is brushed under the carpet and not dealt with.
- There needs to be more education on mental illness as a disease that can be treated and is acceptable to be treated.

Social Determinants of Health

Participants were asked to select the top three social determinants of health that they believe are the most important to address in their community in the next three to five years. The top issue was employment opportunity, and was then followed by the next three social determinants of health equally:

- Employment Opportunities
- Early Childhood Development
- Affordable Housing
- Job Skills

A full listing of the social determinants of health, in order by the percentage of participants who selected the determinant, is presented in the following graph.



Economic success was identified as the social determinant with the greatest impact to health by 33.3% of the respondents. Affordable housing and quality health care were ranked second with 22.2% each.

Comments Regarding Social Determinants

- Participants emphasized that the requirement for health insurance was cost prohibitive. After paying for insurance, housing, and deductibles each month, there is very little left to live on.
- Affordable housing is really not "affordable."
- It is more financially beneficial to be a stay-at-home mom.
- There is a gap between education and working hard for opportunity. Education does not guarantee a position utilizing skills as others may have more skills. It is not possible to stop working, go back to school for more education, and still have money to live. It is easier to get assistance and be a stay-at-home mom instead of going to work because the salary is not enough to live on.
- There is limited job security.

Older Adult Population Results Summary

Demographics

Twenty-one adults aged 55 or older participated in the session. The majority of participants (81%) were female. Approximately 76% of participants lived in an apartment and more than 90% of participants were members of household with one or two people. All participants live in zip code 21158 and 75% have lived in Carroll County for more than 10 years.

Demographic Information	Count	Percentage
Gender		
Male	4	19.5%
Female	17	81.0%
Identifies as other than male or female	0	0.0%

Age		
18 - 25	0	0.0%
26 - 34	0	0.0%
35 - 44	0	0.0%
45 - 54	0	0.0%
55 - 64	1	4.8%
65 and over	20	95.2%

Number of People in Household		
1	10	47.6%
2	10	47.6%
3	1	4.8%
4	0	0.0%
5	0	0.0%
More than 5	0	0.0%

Type of Housing Unit		
Single-family home	3	14.3%
Apartment	16	76.2%
Townhome	0	0.0%
Mobile home	0	0.0%
Condo	1	4.8%
Other	1	4.8%

Zip Code		
21158	17	100.0%

Length of Residence in Carroll County		
Less than 1 year	0	0.0%
1 – 3 years	3	15.0%
4 – 5 years	1	5.0%
6 – 10 years	1	5.0%
More than 10 years	15	75.0%

Access to Health Care

All respondents indicated that they had health insurance. When asked where they got health information and/or education, 34.1% indicated from their physician, 20.5% indicated by local sources, and 15.9% indicated from online websites.

As illustrated in the following table, 70% of the participants "agreed" or "strongly agreed" that residents did have access to both PCP and specialists. An even higher percentage of participants "agreed" or "strongly agreed" that their health needs and concerns are understood and that health care services were available in their language. The lowest percentage of "agree" or "strongly agree" was regarding the use of signage and promotions for health services that reflect the older population's community and its needs.

"On a scale of 1 (Strongly Disagree) through 5 (Strongly Agree), please rate each of the following statements about Health Care Access in your community."

Statement	Neutral	Percentage of Respondents who "Agree" or "Strongly Agree"
The majority of residents in my community have access to a local primary care provider.	15.0%	70.0%
The majority of residents in my community have access to necessary medical specialists.	20.0%	70.0%

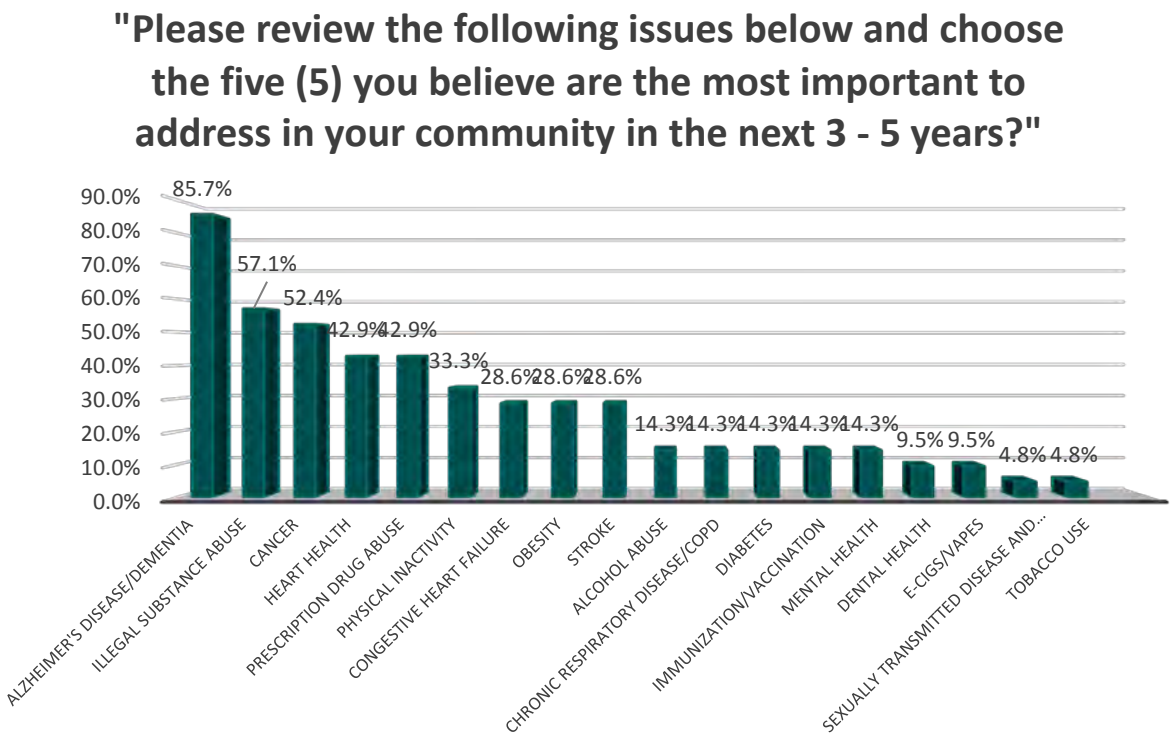
The majority of residents in my community are able to access a local dentist when needed.	10.5%	68.4%
Transportation for medical appointments is available and easy to access for the majority of residents.	25.0%	55.0%
Signage and promotions for health services reflect my community and its needs.	50.0%	35.0%
There are health care providers who understand my population and its health risks.	20.0%	75.0%
Health care services are provided in my language.	0.0%	90.0%

General Health Issues

Senior participants were also asked to identify the five most important health issues that need to be addressed in the next three to five years. The top five health issues include:

- Alzheimer's Disease/Dementia
- Illegal Substance Abuse
- Cancer
- Heart Health
- Prescription Drug Abuse

A full listing of the health issues, in order by the percentage of participants who selected the issue, is presented in the following graph. Note: Asthma, Injury and Other are absent from this graph as they were not represented in the responses.



Alzheimer's and Dementia were the highest concern among the aging population. The specific concerns were how to recognize early signs, where to find a health professional to help, and whether or not there will be enough health professionals in the next 10 years as the aging population increases. Illegal substance abuse was identified as one of the top five health issues in the community. Participants further explained that they do not believe this issue affects them directly, but is a huge issue to loved ones and other community members.

Comments Regarding Health Care

- Learning how to recognize early signs of Alzheimer's and dementia is a concern.
- The 62 and older population will increase in the next 10 years and having enough practitioners to care for all of the people diagnosed with these diseases is a concern.

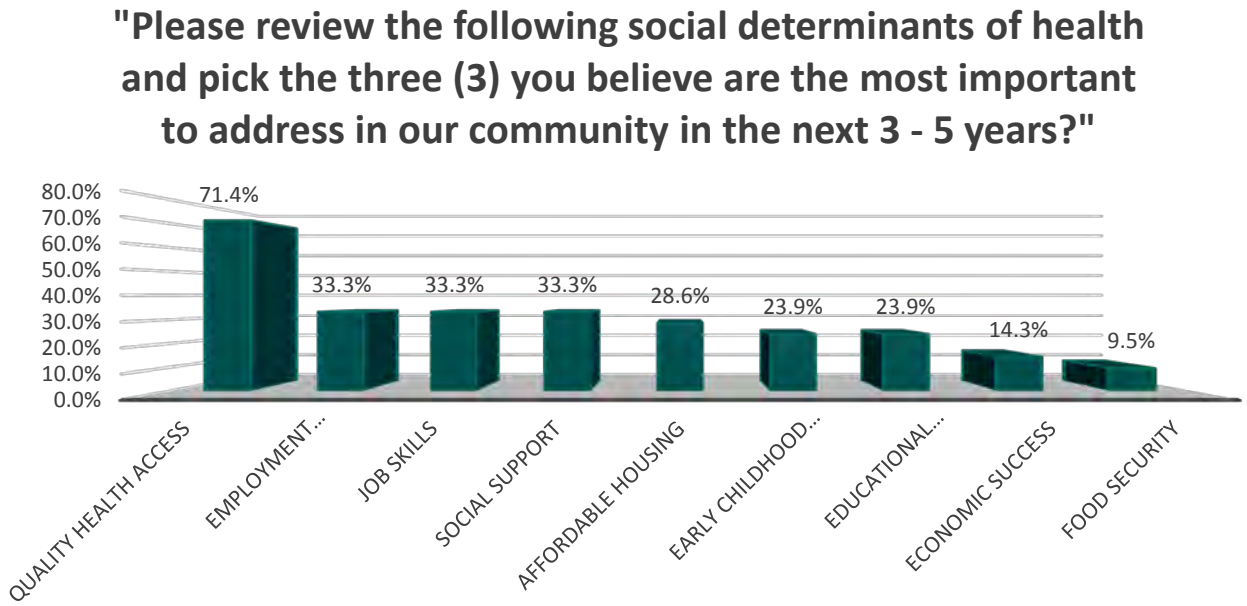
Social Determinants of Health

Participants were asked to select the top three social determinants of health that they believe are the most important to address in their community in the next three to five years. The top social determinant reported was quality health access by a large percentage. The top four social determinants of health among seniors include:

- Quality Health Access
- Employment Opportunities
- Job Skills

- Social Support

A full listing of the social determinants of health, in order by the percentage of participants who selected the determinant, is presented in the following graph.



Quality health access ranked as the top social determinant with the greatest impact to health with 71.4%. The participants made comments regarding the desire to have information on health practitioners in print.

Comments Regarding Social Determinants

- Transportation to and from practitioners is a concern.
- Doctors divide their time between 2 or more offices restricting the availability of hours.
- Not having an onsite physician at retirement communities is an issue.

Research Findings (All Groups)

Community members who participated in the sessions identified a number of challenges to improving health. All of the population groups have unique health and socioeconomic needs. Signage and promotions for health services ranked the highest in the lower income, Hispanic/Latino, and older population groups. Transportation being available and accessible ranked lowest in the low income and LGBT groups.

Participants also identified general health issues and social determinants of health that they believe are the most important to address in their community in the next three to five years. As expected, rankings differed between groups depending on the unique needs of the community. In terms of health care, four of the five groups identified mental health as a concern in the top four. Illegal substance abuse, cancer, and alcohol abuse were identified as issues in three of the five groups.

In terms of social determinants, employment opportunities ranked as concerns in four of the five groups and both quality health care and affordable housing ranked high in three of the five groups.

C. Attachments

- Results and Transcript – African American Focus Group
- Results and Transcript – Hispanic/Latino Focus Group
- Results and Transcript – LGBT Focus Group
- Results and Transcript – Low Income Focus Group
- Results and Transcript – Older Population Focus Group
- Survey Tool – Targeted Populations

Please note: Every effort was made to transcribe focus group discussions as accurately as possible. Some variation may have occurred due to the multiple steps in the transcription process.

Results - African American Focus Group

Demographics

Gender

#	Answer	%	Count
1	Male	53.85%	7
2	Female	46.15%	6
3	Identifies as other	0.00%	0
	Total	**100%**	**13**

Age

#	Answer	%	Count
1	18 - 25 years	0.00%	0
2	26 - 34 years	0.00%	0
3	35 - 44 years	7.14%	1
4	45 - 54 years	21.43%	3
5	55 - 64 years	21.43%	3
6	65 years and over	50.00%	7
	Total	**100%**	**14**

Number of People in Your Home

#	Answer	%	Count
1	1	28.57%	4
2	2	42.86%	6
3	3	21.43%	3
4	4	0.00%	0
5	5	0.00%	0
6	More than 5	7.14%	1
	Total	**100%**	**14**

Type of Housing Unit

#	Answer	%	Count
1	Single-Family Home	85.71%	12
2	Apartment	7.14%	1
3	Townhome	7.14%	1
4	Mobile Home	0.00%	0
5	Condo	0.00%	0
6	Other	0.00%	0
	Total	**100%**	**14**

Zip Code

#	Answer	%	Count
1	21048	7.69%	1
2	21074	0.00%	0
3	21088	0.00%	0
4	21102	0.00%	0
5	21104	0.00%	0
6	21155	0.00%	0
7	21157	38.46%	5
8	21158	0.00%	0
9	21757	0.00%	0
10	21771	0.00%	0
11	21776	30.77%	4
12	21784	7.69%	1
13	21787	7.69%	1
14	21791	7.69%	1
15	21797	0.00%	0
16	None of the Above	0.00%	0
	Total	**100%**	**13**

Number of Years Lived in Carroll County

#	Answer	%	Count
1	Less than 1 year	0.00%	0
2	1 - 3 years	0.00%	0
3	4 - 5 years	0.00%	0
4	6 - 10 years	0.00%	0
5	More than 10 years	100.00%	14
	Total	**100%**	**14**

Do you have health insurance?

#	Answer	%	Count
1	Yes	100.00%	14
2	No	0.00%	0
3	Don't know/Not sure	0.00%	0
	Total	**100%**	**14**

General Health Issues and Behaviors

Gen1 - Please review the following issues below and choose the five (5) you believe are the most important to address in your community in the next 3-5 years.

#	Answer	%	Count
1	Alcohol abuse	8.57%	6
2	Alzheimers Disease/	7.14%	5
3	Asthma	2.86%	2
4	Cancer	12.86%	9
5	Chronic Respiratory	5.71%	4
6	Congestive Heart	4.29%	3
7	Dental Health	0.00%	0
8	Diabetes	11.43%	8
9	E-Cigs / Vaping	1.43%	1
10	Heart Health	2.86%	2
11	Immunization/	0.00%	0
12	Injury	0.00%	0
13	Illegal Substance	11.43%	8
14	Mental Health	8.57%	6
15	Obesity	4.29%	3
16	Prescription Drug	7.14%	5
17	Physical Inactivity	4.29%	3
18	Sexually Transmitted	0.00%	0
19	Stroke	4.29%	3
20	Tobacco Use	2.86%	2
21	Other	0.00%	0
	Total	**100%**	**70**

Gen2 - Of the 5 General Health issues you selected, what do you believe is the number one priority.

#	Answer	%	Count
1	Alcohol Abuse	0.00%	0
2	Alzheimers Disease /	15.38%	2
3	Asthma	0.00%	0
4	Cancer	7.69%	1
5	Chronic Respiratory	15.38%	2
6	Congestive Heart	0.00%	0
7	Dental Health	0.00%	0
8	Diabetes	7.69%	1
9	E-Cigs / Vaping	0.00%	0
10	Heart Health	7.69%	1
11	Immunization/	0.00%	0
12	Injury	0.00%	0
13	Illegal Substance	15.38%	2
14	Mental Health	7.69%	1
15	Obesity	7.69%	1
16	Prescription Drug	15.38%	2
17	Physical Inactivity	0.00%	0
18	Sexually Transmitted	0.00%	0
19	Stroke	0.00%	0
20	Tobacco Use	0.00%	0
	Total	**100%**	**13**

Health Care Access

HCA1 - On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about Health Care Access in your community.

#	Question	Strongly disagree (1)		Some-what disagree (2)		Neither agree nor disagree (3)		Some-what agree (4)		Strongly agree (5)		Total
1	The majority of	7.69%	1	15.38%	2	7.69%	1	53.85%	7	15.38%	2	13
2	The majority of	7.69%	1	23.08%	3	7.69%	1	53.85%	7	7.69%	1	13
3	The majority of	23.08%	3	0.00%	0	23.08%	3	38.46%	5	15.38%	2	13
4	Transportation for	23.08%	3	15.38%	2	23.08%	3	23.08%	3	15.38%	2	13
5	Signage and	23.08%	3	38.46%	5	15.38%	2	23.08%	3	0.00%	0	13
6	There are health care	14.29%	2	28.57%	4	14.29%	2	21.43%	3	21.43%	3	14
7	Health care services	7.69%	1	0.00%	0	0.00%	0	23.08%	3	69.23%	9	13

HCA2 - Where do you go to get health information and/or health education? Choose all that apply.

#	Answer	%	Count
1	Your physician /	28.95%	11
2	Local sources	13.16%	5
3	Local providers /	13.16%	5
4	National sources	5.26%	2
5	Online websites	23.68%	9
6	Health blogs	2.63%	1
7	Family / Friends	13.16%	5
8	Television	0.00%	0
	Total	**100%**	**38**

Social Determinants of Health

Social Determinants of Health are defined by the Centers for Disease Controls as the conditions in which people are born, grow, live and age.

SD1 - Please review the following social determinants of health and pick the three (3) you believe are the most important to address in our community in the next 3-5 years.

#	Answer	%	Count
1	Affordable Housing	12.82%	5
2	Early Childhood	2.56%	1
3	Economic Success	7.69%	3
4	Educational	17.95%	7
5	Employment	25.64%	10
6	Food Security	0.00%	0
7	Job Skills	25.64%	10
8	Quality Health Access	5.13%	2
9	Social Support	2.56%	1
	Total	**100%**	**39**

SD2 - Of the 3 Social Determinants of Health you selected, which one do you believe will make the greatest impact to the health of our community?

#	Answer	%	Count
1	Affordable Housing	27.27%	3
2	Early Childhood	9.09%	1
3	Economic Success	0.00%	0
4	Educational	27.27%	3
5	Employment	9.09%	1
6	Food Security	0.00%	0
7	Job Skills	27.27%	3
8	Quality Health Access	0.00%	0
9	Social Support	0.00%	0
	Total	**100%**	**11**

Target Population – Focus Group
African American Focus Group
Non-Profit Center in Westminster
September 7, 2017

**** Note: Moderator comments in bold.**

Most of the participants have lived in Carroll County over 10 years and all of them have health insurance.

General Health: Please review the following General Health issues below and choose the five you believe are the most important to address in your community in the next 3 – 5 years. Of the five, choose the number one priority? Why is this the number one priority? Additional comments.

The most important issue reported was chronic respiratory or COPD. Others were equal: obesity, mental health, heart health, cancer, and Alzheimer's. How has COPD impacted lives?

We need more education about what COPD means. EDUCATION needs to be put out about this! You get to a point you need a lung transplant and you can't get a lung, doctors & hospitals don't know how to take care of you. I can't get surgery because I can't be put under anesthesia because of COPD. With education one can understand what a person goes through. Education is for anybody. It can make you feel like you have other problems – treat you as a heart patient, etc. and not treated as to the COPD. I was treated as a heart patient, given nitro, it put me into a fit. Discussed wanting to separate diseases (asthma, COPD, etc.)

Diabetes was ranked second and is high for one respondent for this community. It is typically a result of obesity. Obesity is in the country (big picture), but diabetes is important in our community.

Education component is important; they know what is going on. Up to 30 years old, had asthma but not many health problems, but past 10 years have had to deal with health issues. Didn't know the things are all connected. Started having cardiac episodes leading to more medicine, BP medicine, vasospastic angina, now recommended to have a sleep study. Now diagnosed with sleep apnea, got a CPAP machine. The angina went away & BP lowered. I had no idea sleep played such a role in health. Had I known about the sleep issue - would I have these issues now? Important to have active lifestyle, be educated about all of these things. Early intervention with education makes us healthier down the road.

Do you feel if you would have been diagnosed earlier with education?

Yes

What does illegal substance use & prescription drug abuse look like to you?

Don't see a difference, both is a substance to put in your body to get high however you came to do it – recreational or dealing with pain. No different with that or alcohol abuse.

The public perception is, if it is a prescription it is ok.

Abuse may not come on part of the person getting script, but other family members - it is still illegal if the child takes the parent's meds. Comes from socioeconomic conditions. Kids that abuse the prescription drugs don't carry the same stigma as the guy buying on the street corner.

I've seen people on methadone - they can't get up to go to work but they can get to the methadone clinic at 5am? How can you get people off drugs if you give them drugs? It isn't a treatment but a maintenance system.

Methadone affects job contribution, and impact on selling drugs, perpetuating drug abuse with others.

They shouldn't have the program to give drugs – it is a waste of taxpayer money.

What do you do with them if they have an addiction?

The problem is the selling & lack of contribution to society.

Need support groups where you are accountable to others, and if that someone has been there before. It will be the hardest thing they do, but if your life is important to you, you will make that choice. So many things that are addictive but if they are taking your life, you need to ask yourself do you want to live or die? It is sacrifices you make. I feel taken advantage of. If you are an addict you need help, but if you are not trying to get help then you are working the system on my dime!

When did it become a life sustaining thing to use methadone? Education! At what age do you educate people on these things, when they become an addict it is too late. Other aspects of teaching, people get lost in the communities. That is where you live.

There is risk in everything you do in life. If you don't educate early enough they won't be able to stay off drugs. Since society makes alcohol readily available people have the opportunity to abuse it.

Some people have an addictive personality. When they go from heroin to methadone maintenance, there should be a transition from methadone to zero. I've worked with folks on that program, some come out and they spit the drug out and sell it. Education, lack of transition, job performance.

The public doesn't know about the program, the reasons for it, "to protect my stuff" issue – if he doesn't get it fixed that way he will another way, (stealing, killing) so it is a safety factor for the general public.

Wantz put out "not in my county" – problems with county approach to this. Baltimore City always had a problem. Carroll said we don't have a problem, did not want to acknowledge a problem here with "white kids" – now we have a problem. The stigma went away, when we found it is white kids. Now called an "opioid epidemic," but before was a "drug problem" with black kids.

In spring, I had sciatica. I went thru surgery without pain meds as I can't tolerate it. I dealt with a Pain Management individual in the county who put me on a patch. By week #3 I was like a crazy person. I thought I shouldn't be on the road driving. I didn't know if I could make it home. It took a week to recover from the side effects of that drug. One person got a script Thursday and the pharmacy (Walgreens) didn't have it and was told to come back on Friday. She went back Friday and the pharmacy was closed so couldn't get the medication. On Saturday morning called Walgreens, was on hold 15 minutes. They were closed because they didn't have a pharmacist to work. They called Eldersburg who didn't have the medication either. The medication paper said if you pass out from this go to the hospital. (How can you go to the hospital if you are passed out?) Monday was in such agony she took it. The doctor's office (pain management) called last minute to cancel her appointment and made it 6 days later (11th to the 17th).

This could be a public issue. (Having medications trapped in the pharmacy.)

Doctor said she was giving her the least amount of the pain medicine, but she did not get the proper education regarding the medicine she was given to take.

Would the pharmacy give your physical prescription back to you if they don't have the medicine?

We tell professionals we can't tolerate the medicine but they still give it. We need to put things in plain terms – not "I can't tolerate it", but "I throw up and fall on the floor."

I suffer from arthritis – going for medicines, but not until I changed to another doctor. They checked for sleep apnea and that helped. The arthritis got worse; "just take the medicine", insurance company doesn't want you to have the shot and just go to therapy. I want it fixed now – not run a round for all the rigmarole.

Arthritis is a progressive disease, it was diagnosed, but the cause wasn't until the lack of reparative sleep was diagnosed. Because of this there are more symptoms, then goes around to self-blame – they blame your weight.

Arthritis doctor tested for it; Prednisone weakened system so got shingles. You lose work time, go to doctor all the time, can't get disability because you need to be out of work for a year, what else can I do but keep going to the doctor. It impacts my job if I am always needing to go to the doctor. Affects my ability to lead a healthy life. Few doctors are open for working people. Open 1 Saturday a month – what do you do in the mean time? Need longer hours that cater to people that work – be more attentive to what the patient is saying. When I say I'm not feeling well, don't tell me it is my imagination. If I need an injection, don't tell me I need to go to weeks of therapy first.

Do you feel you need to deal with insurance companies more than you need to?

Meds are very expensive and meds are the same color.

I had back pain, tried to lose weight for pain, finally went to doctor and it was broken. Did injections, took OxyContin's, didn't like it (mentally, stomach) had surgery. I found it is a conservative county, but I used cannabis. It helped me more than expensive prescriptions from the doctor and with no side effects. Liniments, etc. – had more success with that than any injections, etc. It was more effective and less expensive. Our conservative nature is a barrier, or are we going back to doctor and they don't know what we need.

I went away 10 days and did alternative medicine. My BP and cholesterol dropped. I dropped weight and my sugar went down. Insurance paid for preventative medicine. But I found it myself, not the doctor. My body didn't like the medicine, started getting pain so I got rid of all of that.

Have other alternatives been offered to you as a solution? Acupuncture?

Didn't work, costs money. Talking several hundreds of dollars and people can't afford it. Not many acupuncture places, if you don't have transportation to get there it is a problem.

We go on what we hear from people we trust.

That's the problem. It's all about money. People are making money off of people's pain.

Every doctors' office is a business and they have to pay their people. Is the cost giving sub quality care?

Yes.

Carroll County is a commuter country, people travel outside of county to get to work. If doctor's office not open in evening, then hours are not for commuters. Taking time off for visit are hindrances to providing the type of care that we need in general. My daughter had braces, couldn't get an appointment outside of school hours, and the only place insurance paid for and I had to go to work late. Need later office hours. With Urgent care you pay out of pocket but sometimes go because it is quicker.

The doctor (which I've been going to for years) can see you 3 weeks from now. It's a business so they book to fill pocketbooks.

I burned my hand and went to Urgent Care. The physician they had didn't have a license to write a prescription for narcotics, so I had to go to another office to pick up the prescription. Then they gave her cream on her hand, and a prescription to get some more. I have no trust that the doctor knows what she is doing, I can't get an appointment at burn center for another 2 weeks out, they wanted $700 to go see a doctor and my hand was halfway healed by that point. Some problems are creating more issues.

What is the deciding factor to go to urgent care versus doctor?

Need help immediately. But ER takes so long. Has to do with your trust with the facility in their competence. I moved here in 1977 and went to the ER and the ER door was locked.

Insurance - work with people with different backgrounds, a lot have medical assistance. Many facilities don't accept medical assistance. Then you have problem person can't get what they need because the facility doesn't take their insurance. What is medical community doing with insurances? Why are they backing out? My children are now in their 20's. When younger, orthodontists would not help with dentistry. Had to go to Gaithersburg for care – multiple times in a month. That was 15 years ago and it has gotten worse. How can we change this? Disparity of health care will continue.

There are more doctors here, but affordable care act people have more insurance so doctor's appointments are full. They can only afford to take a certain number of Medicaid & Medicare patients.

If pain is driving care – maybe we need to do something to help with pain management.

Not enough doctors to meet the need. We need to keep people well on the outside

We are committed to make these changes for the community.

Educate doctors to know what scripts they are prescribing. Doctors need to listen to the patients.

We need to be more involved with our own healthcare. Don't compare me to your wife's pain. I am a chronic pain sufferer. Listen to me when I tell you, life is not to pop pills. I suffer because I don't take all that is prescribed for me. Do you feel like your whole self is being assessed? LISTEN to me. (Doctors need to listen to the patient).

I take a list to the Doctor office and they asked me what is a priority – they are all priorities!

My daughter went to a doctor for skin problems, (they need education on skin problems for people of color) and we were told it is a rash. It is not, so asked for another doctor. Finally got a medicine. Age might be an issue or it could be skin color – don't listen to us and do things to us that aren't necessary.

Need less unnecessary tests not less tests. They want to cut you open because they get more money. With Psoriatic Arthritis some people break out – when that came they treated her with stuff. Went to an African American doctor and she diagnosed it.

A doctor told a woman black people don't get sunburned.

My husband had leukemia for two years. Found son had the sickle cell trait. Found it at St. Agnes not Carroll County.

Care received at Carroll County is difference in race. It may be a lack of exposure, regular exposure of people of race or other ethnicities. If they can go outside of the county and get better care, why is it not happening here? If other supports can be here, why can't it be here for people of color? It may not be true, but it is perceived as true. Need to learn to treat the targeted audience here. It was thought that having LifeBridge that we would have more doctors coming out here.

Foundation Money stays here in Carroll County – money given and should be used for the purpose here.

Social Determinants: Choose the 3 most important social determinants to address in our community in next 3-5 years? What is the number one priority? Why? Additional comments.

Affordable housing, job skills, education. Not talking section 8 – but average working families.

Longer commute times affect quality of life. We want to see Carroll County be inclusive – work here, see doctors here.

"Community Doctor" term – is long gone. The doctor who lived in the community so he knows the problems of the community.

Results - Hispanic Focus Group

Demographics

Demo1 - Gender

#	Answer	%	Count
1	Male	36.36%	4
2	Female	63.64%	7
3	Identifies as other	0.00%	0
	Total	**100%**	**11**

Demo2 - Age

#	Answer	%	Count
1	18 - 25 years	0.00%	0
2	26 - 34 years	27.27%	3
3	35 - 44 years	0.00%	0
4	45 - 54 years	27.27%	3
5	55 - 64 years	36.36%	4
6	65 years and over	9.09%	1
	Total	**100%**	**11**

Demo3 - Number of People in Your Home

#	Answer	%	Count
1	1	0.00%	0
2	2	27.27%	3
3	3	45.45%	5
4	4	18.18%	2
5	5	9.09%	1
6	More than 5	0.00%	0
	Total	**100%**	**11**

Demo4 - Type of Housing Unit

#	Answer	%	Count
1	Single-Family Home	63.64%	7
2	Apartment	27.27%	3
3	Townhome	9.09%	1
4	Mobile Home	0.00%	0
5	Condo	0.00%	0
6	Other	0.00%	0
	Total	**100%**	**11**

Demo5 - Zip Code

#	Answer	%	Count
1	21048	0.00%	0
2	21074	0.00%	0
3	21088	0.00%	0
4	21102	0.00%	0
5	21104	0.00%	0
6	21155	0.00%	0
7	21157	27.27%	3
8	21158	45.45%	5
9	21757	0.00%	0
10	21771	0.00%	0
11	21776	0.00%	0
12	21784	27.27%	3
13	21787	0.00%	0
14	21791	0.00%	0
15	21797	0.00%	0
16	None of the Above	0.00%	0
	Total	**100%**	**11**

Demo6 - Number of Years Lived in Carroll County

#	Answer	%	Count
1	Less than 1 year	0.00%	0
2	1 - 3 years	27.27%	3
3	4 - 5 years	0.00%	0
4	6 - 10 years	9.09%	1
5	More than 10 years	63.64%	7
	Total	**100%**	**11**

Q7 - Do you have health insurance?

#	Answer	%	Count
1	Yes	90.91%	10
2	No	9.09%	1
3	Don't know/ Not sure	0.00%	0
	Total	**100%**	**11**

General Health Issues and Behaviors

Gen1 - Please review the following issues below and choose the five (5) you believe are the most important to address in your community in the next 3-5 years.

#	Answer	%	Count
1	Alcohol abuse	10.00%	5
2	Alzheimers Disease /	2.00%	1
3	Asthma	2.00%	1
4	Cancer	8.00%	4
5	Chronic Respiratory	0.00%	0
6	Congestive Heart	0.00%	0
7	Dental Health	8.00%	4
8	Diabetes	10.00%	5
9	E-Cigs / Vaping	0.00%	0
10	Heart Health	6.00%	3
11	Immunization/	6.00%	3
12	Injury	0.00%	0
13	Illegal Substance	8.00%	4
14	Mental Health	16.00%	8
15	Obesity	10.00%	5
16	Prescription Drug	6.00%	3
17	Physical Inactivity	4.00%	2
18	Sexually Transmitted	2.00%	1
19	Stroke	0.00%	0
20	Tobacco Use	2.00%	1
21	Other	0.00%	0
	Total	**100%**	**50**

Gen2 - Of the 5 General Health issues you selected, what do you believe is the number one priority.

#	Answer	%	Count
1	Alcohol Abuse	20.00%	2
2	Alzheimers Disease /	0.00%	0
3	Asthma	0.00%	0
4	Cancer	10.00%	1
5	Chronic Respiratory	0.00%	0
6	Congestive Heart	0.00%	0
7	Dental Health	0.00%	0
8	Diabetes	10.00%	1
9	E-Cigs / Vaping	0.00%	0
10	Heart Health	0.00%	0
11	Immunization/	10.00%	1
12	Injury	0.00%	0
13	Illegal Substance	40.00%	4
14	Mental Health	0.00%	0
15	Obesity	10.00%	1
16	Prescription Drug	0.00%	0
17	Physical Inactivity	0.00%	0
18	Sexually Transmitted	0.00%	0
19	Stroke	0.00%	0
20	Tobacco Use	0.00%	0
	Total	**100%**	**10**

Health Care Access

HCA1 - On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about Health Care Access in your community.

#	Question	Strongly disagree (1)		Some-what disagree (2)		Neither agree nor disagree (3)		Some-what agree (4)		Strongly agree (5)		Total
1	The majority of	0.00%	0	36.36%	4	18.18%	2	45.45%	5	0.00%	0	**11**
2	The majority of	9.09%	1	27.27%	3	27.27%	3	36.36%	4	0.00%	0	**11**
3	The majority of	9.09%	1	36.36%	4	18.18%	2	36.36%	4	0.00%	0	**11**
4	Transportation for	27.27%	3	36.36%	4	27.27%	3	9.09%	1	0.00%	0	**11**
5	Signage and	0.00%	0	27.27%	3	45.45%	5	18.18%	2	9.09%	1	**11**
6	There are health care	9.09%	1	18.18%	2	27.27%	3	45.45%	5	0.00%	0	**11**
7	Health care services	18.18%	2	18.18%	2	36.36%	4	27.27%	3	0.00%	0	**11**

HCA2 - Where do you go to get health information and/or health education? Choose all that apply.

#	Answer	%	Count
1	Your physician /	24.00%	6
2	Local sources (i.e.	12.00%	3
3	Local providers /	4.00%	1
4	National sources	0.00%	0
5	Online websites	28.00%	7
6	Health blogs	4.00%	1
7	Family / Friends	20.00%	5
8	Television	8.00%	2
	Total	**100%**	**25**

Social Determinants of Health

Social Determinants of Health are defined by the Centers for Disease Controls as the conditions in which people are born, grow, live and age.

SD1 - Please review the following social determinants of health and pick the three (3) you believe are the most important to address in our community in the next 3-5 years.

#	Answer	%	Count
1	Affordable Housing	15.15%	5
2	Early Childhood	9.09%	3
3	Economic Success	12.12%	4
4	Educational	3.03%	1
5	Employment	12.12%	4
6	Food Security	3.03%	1
7	Job Skills	12.12%	4
8	Quality Health Access	27.27%	9
9	Social Support	6.06%	2
	Total	**100%**	**33**

SD2 - Of the 3 Social Determinants of Health you selected, which one do you believe will make the greatest impact to the health of our community?

#	Answer	%	Count
1	Affordable Housing	9.09%	1
2	Early Childhood	18.18%	2
3	Economic Success	0.00%	0
4	Educational	0.00%	0
5	Employment	18.18%	2
6	Food Security	0.00%	0
7	Job Skills	0.00%	0
8	Quality Health Access	45.45%	5
9	Social Support	9.09%	1
	Total	**100%**	**11**

Target Population – Focus Group
Hispanic Population
August 7, 2017
Shauck Auditorium

**** Note: Moderator comments in bold.**

General Health: Please review the following General Health issues below and choose the five you believe are the most important to address in your community in the next 3 – 5 years. Of the five, choose the number one priority? Why is this the number one priority? Additional comments.

Most of the respondents had health insurance.

The #1 health issue is mental health.

In our community, Latinos see behavior but don't seek treatment. There is no information that it is a disease, so they feel it is just a temperament and not a condition that can be addressed with medicine. There is no information which shows a great educational need.

Is there stigma to this?

People feel afraid to speak about it. Mental health is viewed as because they have mental issue they think they are crazy and don't want to be involved in that. Discussed diagnosing early stages: (child development) people can't recognize that their child may have a mental problem and it is not addressed and they don't seek medical attention, they think it is a behavior problem. With a Medical Assistance card – they can see a pediatrician, but not a specialist, no other services are covered.

Alcohol abuse – many don't see mental health as the alcohol abuse. They know they have a problem with alcohol, but people don't know they have a problem with mental health. No information for family to recognize mental health issues in their family members.

Adults don't speak English so it is hard to express symptoms of illness that they have. Children can communicate but not in the same way (to express symptoms).

Do you find mental health is a concern with a specific age group?

It is a place that we should start- problems are overlooked in young children. If noticed right away, in development of child, there may be an issue there.

Would addressing in school system be good?

Families don't have education about children having mental problems. Back in their home country they don't have mental things at home, so here don't know how to recognize in a child. More about education for parents, trying to get help from doctors, but no one speaks Spanish so the mother can't communicate how her child is acting and what she needs. It is hard to find information & someone to help her. Language barrier – there are also differences in words/Spanish used in some places compared to others. In our community the language barrier is a big problem. Is there a place they can find information? Then let's send people there. Kennedy Krieger – a good place to go but people don't

know who to call to get in or how to go there. There is not one place to go get all the needed information for all, including Infant & toddlers, not just children.

Some people don't have a Social Security number, so where can they get help? Access Carroll can help a lot, but sometimes they can't pay for everything. One participant told of a woman who had a needle in her foot, but was sent from Access Carroll to the ER. The ER couldn't help her either. People need information as to where they can go for help if they don't have a Social Security number or insurance.

Another participant told of a person who went to the ER, was treated and sent home, no one talked to her about a payment plan. She is new with a green card, no Social Security number, no money to pay bills, she went to the ER two times with the same problem. They went to try and get help to resolve bills, but was told that she should have applied for help earlier. But no one told her that! She is in collections now. Problem - miscommunication about medical, payment, and bills. When discharging a patient, a person should come to tell them at that time how to apply for help to pay the bill, and give the application form right away before dismissed.

What would help this be better? How best to get information to you?

Families go to the library for information, get information through church, schools, and programs at the Health Department.

What is the best means?

Flyers are the best means of communication as not all people have computers. For example, ESL class information is on flyers with numbers to call for information. It was suggested to have prevention programs for people involved in more than one subject matter. (i.e. have alcohol classes but talk about mental health problems, too.)

Sometimes there's a reach at fairs on tables, but people are afraid to pick up the flyers (or embarrassed if with a friend, etc.). It was suggested to have already prepared packages including information along with the give aways so that the information is concealed. This way, if people are with a group and afraid to pick up information they can still get it. Have flyers identifying signs and symptoms.

Is there comfort to talk to Doctors & nurses about issues, or are there other barriers in bringing them to a health care provider? Is language the only barrier?

Mental Health involves different things – and people are scared because there are unclear issues, many issues.

It is easier to be approached by physicians if one knows they have the information already (i.e. through another family member or the school worker – because they have the history already). It is good for families to know about different kinds of programs, people don't know it (Mental Health behaviors) is a disease – but think it is a behavior problem. They don't know the behavior is not normal. As the parents we don't recognize behavior as a mental health problem. Can be complemented by the school – they see the behavior, they already know and can make the connection. School counselor can send information to doctors and parents. It is important for the Pediatrician to tell the parents.

It would help to have someone that speaks Spanish working at the hospital so patients can feel confident speaking to someone being able to communicate. It is important how providers talk to you as

a parent. Some Providers are very easy to talk to and interested in the kids, and can speak to the parents while others are not. “Here is information you can read and learn... you need to speak to a psychiatric doctor”. The way they talk to parents and approach them makes a difference. Parents are already stressed out by being there, miscommunication comes, and there is no education, the parent stops there in seeking help.

A participant has the example of a woman with an autistic child, she doesn’t speak English, she can’t explain the baby’s behaviors to the doctor and the doctor said they had no problem. She pushed and pushed and went to a specialist with the help of a family member, the neurologist said, yes the child has autism. The pediatrician didn’t like that the patient did that.

Diabetes #2 tie with alcohol abuse; 3 way tie – Mental health and cancer; Also listed were obesity, immunization, cancer, and alcohol abuse. Which is the #1 priority? #1 now changed to illegal substance abuse. Why #1?

In Carroll County this issue gets bigger & bigger, a lot of overdoses becoming a problem more than in the past. One thing contributing – 90 day prescriptions of pills. If you don’t use it, other people do (they sell or disperse the pills).

Is this awareness only? One participant felt that within the Latino community drug abuse is not a problem, but is in the community at large. We get offended when we are asked if we do drugs, we are a tight family and we know what they are doing. But it is a scary problem in the community – but not affecting our community. Alcohol yes, but not drugs.

This group has been strong about dental care and alcohol as issues.

In Latin countries people drink a lot, but starting to hear more about teenagers getting involved in drugs (in schools). It is a social disease, we have a different way to see addiction, if we have family with drug addiction, and we cover it up or try to solve the problem. It is different from other cultures. We tend to cover something. Close family support plays a role.

One participant disagreed saying that some people are using drugs, maybe not to excesses, but some people in the Latino community do and it comes from high school. He had a suggestion – in high school, they used to take people to the gym and do a speech, and he appreciated that a lot. It was like a mirror to see themselves in. Kids in high school are using drugs. Marijuana is an easy thing to get, cocaine, pills, Xanax, PCP - they start with less expensive drugs which are worse because they mix them with other stuff which can make people sick.

It was mentioned by staff that the Health Department does outreach into some schools, but can’t do a full auditorium presentation yet. However, schools are becoming more open. They do meet in health classes, starting in elementary schools, to give out information.

Maryland is still not open to this and are way behind. We had a DARE program who came to the schools, but that program is gone now. We still do a prevention expo at the Ag Center. We do try to do outreach in the community about drugs, date rape, and drinking & driving, drug use. Information is out there, but it is a matter of continued dissemination & training. Kids have the opportunity to break the cycle, but not if education does not go a little further. Kids see parents or see friends doing drugs, there is peer pressure… and someone could put drugs in your drink.

Social Determinants: Choose the 3 most important social determinants to address in our community in next 3-5 years? What is the number one priority? Why? Additional comments.

Quality health access is #1. Housing, economics, employment come in the same. Talk about quality health access – where are the problems to access?

Transportation, language barrier, education for parents, offer prevention to all of the family, yearly tests, access to health insurance. Main problem is not having insurance. If wanting to look for a specialist they don't qualify. Hospital has a good pregnancy program and people get very good care. They feel secure. Many people don't have this security. More affordable care.

A specialist at the same rate of a PCP - would that increase access?

Yes, it would make a difference. Also payment plans you can commit to would help as you need to make a budget and don't have money right away.

Not being able to have insurance because they don't have information that they may qualify and assume they won't qualify, or they don't know where to go for help to get a plan. It is not so simple for them. When you qualify you can be at a certain rate – but it can change. An example was given of a friend who, when her company decided to give her a raise, not even $200, she stepped into the next level where she could not qualify for anything. So now she doesn't have enough money to pay for anything but also no longer qualifies for any help. There are some families that work hard and still qualify, but then for some reason don't qualify anymore. Some of Latin people have a different mentality - they don't want to invest in their health and think everything is free. Like life insurance, the government should pay for it. They don't have the same mentality. Some have means to pay for health insurance but they don't pay. They think, why should I pay for it when I can go to the hospital? Many people take chances and never have insurance or go to the doctor. Prevention isn't considered. Why do I need life insurance because when I die I won't have to worry?

Could there be a list of doctors that can see our Spanish community? Where people can just pay money without insurance? They get sick they don't know where to go, like on a Saturday or Sunday.

#2 was affordable housing, economic success and employment; Economic and financial – affordable housing seems to rate high. Early childhood development came up high also when you had to pick one. What is the biggest obstacle?

The cost of rental, on minimum salary, with 4 kids, mother & father, need more bedrooms but can't afford to pay more. Location is important if you don't have a car, need to be near the job. How about upkeep/structure – can't choose good condition housing because of the price. Standard family raises 2 children, most Latin people have more than 2 – they need more bedrooms, but can't afford it. A smaller family has choices. People renting houses that are in critical condition, but they can't afford to complain to landlords about bad situations.

In Puerto Rico they have a department that takes complaints about houses, cars, quality, prices, etc. – they have mediation with the owner. Here you have to accept the house even if it is in bad shape. Here there is no one to complain to. A point – you have limited choices when in a certain economic place.

There are places full of bed bugs and cockroaches but management doesn't help and people can't do anything.

Are there any areas of community health and wellness not identified in this survey that you feel need to be addressed?

What are you trying to do with this information? Will you have information for the Spanish community? The language barrier won't rank high in other focus groups but is highest in our group, is that still food for thought to look at when making decisions?

Dot explained CHNA and the work in trying to identify top priorities. In focus groups we will rank priorities and work on them. Priorities will be different. For instance mental health will be across all groups, but not the language barrier.

Results - LGBT Focus Group

Demographics

Demo1 - Gender

#	Answer	%	Count
1	Male	30.77%	4
2	Female	61.54%	8
3	Identifies as other	7.69%	1
	Total	**100%**	**13**

Demo2 - Age

#	Answer	%	Count
1	18 - 25 years	7.69%	1
2	26 - 34 years	0.00%	0
3	35 - 44 years	7.69%	1
4	45 - 54 years	61.54%	8
5	55 - 64 years	15.38%	2
6	65 years and over	7.69%	1
	Total	**100%**	**13**

Demo3 - Number of People in Your Home

#	Answer	%	Count
1	1	15.38%	2
2	2	15.38%	2
3	3	7.69%	1
4	4	53.85%	7
5	5	7.69%	1
6	More than 5	0.00%	0
	Total	**100%**	**13**

Demo4 - Type of Housing Unit

#	Answer	%	Count
1	Single-Family Home	76.92%	10
2	Apartment	7.69%	1
3	Townhome	15.38%	2
4	Mobile Home	0.00%	0
5	Condo	0.00%	0
6	Other	0.00%	0
	Total	**100%**	**13**

Demo5 - Zip Code

#	Answer	%	Count
1	21048	0.00%	0
2	21074	0.00%	0
3	21088	0.00%	0
4	21102	0.00%	0
5	21104	0.00%	0
6	21155	0.00%	0
7	21157	50.00%	6
8	21158	33.33%	4
9	21757	0.00%	0
10	21771	0.00%	0
11	21776	0.00%	0
12	21784	16.67%	2
13	21787	0.00%	0
14	21791	0.00%	0
15	21797	0.00%	0
16	None of the Above	0.00%	0
	Total	**100%**	**12**

Demo6 - Number of Years Lived in Carroll County

#	Answer	%	Count
1	Less than 1 year	0.00%	0
2	1 - 3 years	0.00%	0
3	4 - 5 years	7.69%	1
4	6 - 10 years	23.08%	3
5	More than 10 years	69.23%	9
	Total	**100%**	**13**

Q7 - Do you have health insurance?

#	Answer	%	Count
1	Yes	100.00%	13
2	No	0.00%	0
3	Don't know/ Not	0.00%	0
	Total	**100%**	**13**

General Health Issues and Behaviors

Gen1 - Please review the following issues below and choose the five (5) you believe are the most important to address in your community in the next 3-5 years.

#	Answer	%	Count
1	Alcohol abuse	7.69%	5
2	Alzheimers Disease /	3.08%	2
3	Asthma	0.00%	0
4	Cancer	7.69%	5
5	Chronic Respiratory	1.54%	1
6	Congestive Heart	0.00%	0
7	Dental Health	0.00%	0
8	Diabetes	4.62%	3
9	E-Cigs / Vaping	3.08%	2
10	Heart Health	6.15%	4
11	Immunization/	1.54%	1
12	Injury	0.00%	0
13	Illegal Substance	13.85%	9
14	Mental Health	18.46%	12
15	Obesity	7.69%	5
16	Prescription Drug	9.23%	6
17	Physical Inactivity	7.69%	5
18	Sexually Transmitted	4.62%	3
19	Stroke	0.00%	0
20	Tobacco Use	3.08%	2
21	Other	0.00%	0
	Total	**100%**	**65**

Gen2 - Of the 5 General Health issues you selected, what do you believe is the number one priority.

#	Answer	%	Count
1	Alcohol Abuse	0.00%	0
2	Alzheimers Disease /	0.00%	0
3	Asthma	0.00%	0
4	Cancer	7.69%	1
5	Chronic Respiratory	0.00%	0
6	Congestive Heart	0.00%	0
7	Dental Health	0.00%	0
8	Diabetes	7.69%	1
9	E-Cigs / Vaping	7.69%	1
10	Heart Health	0.00%	0
11	Immunization/	0.00%	0
12	Injury	0.00%	0
13	Illegal Substance	23.08%	3
14	Mental Health	46.15%	6
15	Obesity	0.00%	0
16	Prescription Drug	7.69%	1
17	Physical Inactivity	0.00%	0
18	Sexually Transmitted	0.00%	0
19	Stroke	0.00%	0
20	Tobacco Use	0.00%	0
	Total	**100%**	**13**

Health Care Access

HCA1 - On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about Health Care Access in your community.

#	Question	Strongly disagree (1)		Some-what disagree (2)		Neither agree nor disagree (3)		Some-what agree (4)		Strongly agree (5)		Total
1	The majority of	7.69%	1	7.69%	1	7.69%	1	61.54%	8	15.38%	2	**13**
2	The majority of	0.00%	0	30.77%	4	7.69%	1	46.15%	6	15.38%	2	**13**
3	The majority of	7.69%	1	15.38%	2	7.69%	1	61.54%	8	7.69%	1	**13**
4	Transportation for	23.08%	3	38.46%	5	30.77%	4	7.69%	1	0.00%	0	**13**
5	Signage and	15.38%	2	38.46%	5	30.77%	4	15.38%	2	0.00%	0	**13**
6	There are health care	15.38%	2	30.77%	4	7.69%	1	23.08%	3	23.08%	3	**13**
7	Health care services	7.69%	1	0.00%	0	7.69%	1	23.08%	3	61.54%	8	**13**

HCA2 - Where do you go to get health information and/or health education? Choose all that apply.

#	Answer	%	Count
1	Your physician /	31.58%	12
2	Local sources	5.26%	2
3	Local providers /	5.26%	2
4	National sources	7.89%	3
5	Online websites	26.32%	10
6	Health blogs	0.00%	0
7	Family / Friends	18.42%	7
8	Television	5.26%	2
	Total	**100%**	**38**

Social Determinants of Health

Social Determinants of Health are defined by the Centers for Disease Controls as the conditions in which people are born, grow, live and age.

SD1 - Please review the following social determinants of health and pick the three (3) you believe are the most important to address in our community in the next 3-5 years.

#	Answer	%	Count
1	Affordable Housing	12.82%	5
2	Early Childhood	7.69%	3
3	Economic Success	10.26%	4
4	Educational	10.26%	4
5	Employment	17.95%	7
6	Food Security	0.00%	0
7	Job Skills	7.69%	3
8	Quality Health Access	20.51%	8
9	Social Support	12.82%	5
	Total	**100%**	**39**

SD2 - Of the 3 Social Determinants of Health you selected, which one do you believe will make the greatest impact to the health of our community?

#	Answer	%	Count
1	Affordable Housing	15.38%	2
2	Early Childhood	0.00%	0
3	Economic Success	0.00%	0
4	Educational	15.38%	2
5	Employment	23.08%	3
6	Food Security	0.00%	0
7	Job Skills	7.69%	1
8	Quality Health Access	15.38%	2
9	Social Support	23.08%	3
	Total	**100%**	**13**

Results - Representatives for LGBT Focus Group

Demo1- Gender

#	Answer	%	Count
1	Male	0.00%	0
2	Female	100.00%	3
3	Identifies as other	0.00%	0
	Total	**100%**	**3**

Demo2 - Age

#	Answer	%	Count
1	18 - 25 years	0.00%	0
2	26 - 34 years	0.00%	0
3	35 - 44 years	66.67%	2
4	45 - 54 years	0.00%	0
5	55 - 64 years	33.33%	1
6	65 years and over	0.00%	0
	Total	**100%**	**3**

Demo3 - Number of People in Your Home

#	Answer	%	Count
1	1	0.00%	0
2	2	66.67%	2
3	3	0.00%	0
4	4	33.33%	1
5	5	0.00%	0
6	More than 5	0.00%	0
	Total	**100%**	**3**

Demo4 - Type of Housing Unit

#	Answer	%	Count
1	Single-Family Home	66.67%	2
2	Apartment	0.00%	0
3	Townhome	33.33%	1
4	Mobile Home	0.00%	0
5	Condo	0.00%	0
6	Other	0.00%	0
	Total	**100%**	**3**

Demo5 - Zip Code

#	Answer	%	Count
1	21048	0.00%	0
2	21074	0.00%	0
3	21088	0.00%	0
4	21102	0.00%	0
5	21104	0.00%	0
6	21155	0.00%	0
7	21157	100.00%	3
8	21158	0.00%	0
9	21757	0.00%	0
10	21771	0.00%	0
11	21776	0.00%	0
12	21784	0.00%	0
13	21787	0.00%	0
14	21791	0.00%	0
15	21797	0.00%	0
16	None of the Above	0.00%	0
	Total	**100%**	**3**

Demo6 - Number of Years Lived in Carroll County

#	Answer	%	Count
1	Less than 1 year	0.00%	0
2	1 - 3 years	0.00%	0
3	4 - 5 years	33.33%	1
4	6 - 10 years	0.00%	0
5	More than 10 years	66.67%	2
	Total	**100%**	**3**

Q7 - Do you have health insurance?

#	Answer	%	Count
1	Yes	100.00%	3
2	No	0.00%	0
3	Don't know/	0.00%	0
	Total	**100%**	**3**

General Health Issues and Behaviors

Gen1 - Please review the following issues below and choose the five (5) you believe are the most important to address in your community in the next 3-5 years.

#	Answer	%	Count
1	Alcohol abuse	20.00%	3
2	Alzheimers Disease /	6.67%	1
3	Asthma	0.00%	0
4	Cancer	13.33%	2
5	Chronic Respiratory	0.00%	0
6	Congestive Heart	0.00%	0
7	Dental Health	6.67%	1
8	Diabetes	6.67%	1
9	E-Cigs / Vaping	0.00%	0
10	Heart Health	0.00%	0
11	Immunization/	0.00%	0
12	Injury	0.00%	0
13	Illegal Substance	13.33%	2
14	Mental Health	20.00%	3
15	Obesity	6.67%	1
16	Prescription Drug	6.67%	1
17	Physical Inactivity	0.00%	0
18	Sexually Transmitted	0.00%	0
19	Stroke	0.00%	0
20	Tobacco Use	0.00%	0
21	Other	0.00%	0
	Total	**100%**	**15**

Gen2 - Of the 5 General Health issues you selected, what do you believe is the number one priority.

#	Answer	%	Count
1	Alcohol Abuse	0.00%	0
2	Alzheimers Disease /	0.00%	0
3	Asthma	0.00%	0
4	Cancer	0.00%	0
5	Chronic Respiratory	0.00%	0
6	Congestive Heart	0.00%	0
7	Dental Health	0.00%	0
8	Diabetes	0.00%	0
9	E-Cigs / Vaping	0.00%	0
10	Heart Health	0.00%	0
11	Immunization/	0.00%	0
12	Injury	0.00%	0
13	Illegal Substance	33.33%	1
14	Mental Health	66.67%	2
15	Obesity	0.00%	0
16	Prescription Drug	0.00%	0
17	Physical Inactivity	0.00%	0
18	Sexually Transmitted	0.00%	0
19	Stroke	0.00%	0
20	Tobacco Use	0.00%	0
	Total	**100%**	**3**

Health Care Access

HCA1 - On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about Health Care Access in your community.

#	Question	Strongly disagree (1)		Some-what disagree (2)		Neither agree nor disagree (3)		Some-what agree (4)		Strongly agree (5)		Total
1	The majority of	0.00%	0	66.67%	2	33.33%	1	0.00%	0	0.00%	0	**3**
2	The majority of	0.00%	0	66.67%	2	33.33%	1	0.00%	0	0.00%	0	**3**
3	The majority of	0.00%	0	66.67%	2	33.33%	1	0.00%	0	0.00%	0	**3**
4	Transportation for	33.33%	1	33.33%	1	33.33%	1	0.00%	0	0.00%	0	**3**
5	Signage and	33.33%	1	66.67%	2	0.00%	0	0.00%	0	0.00%	0	**3**
6	There are health care	0.00%	0	33.33%	1	66.67%	2	0.00%	0	0.00%	0	**3**
7	Health care services	0.00%	0	0.00%	0	0.00%	0	33.33%	1	66.67%	2	**3**

HCA2 - Where do you go to get health information and/or health education? Choose all that apply.

#	Answer	%	Count
1	Your physician /	33.33%	3
2	Local sources	11.11%	1
3	Local providers /	0.00%	0
4	National sources	0.00%	0
5	Online websites	33.33%	3
6	Health blogs	0.00%	0
7	Family / Friends	22.22%	2
8	Television	0.00%	0
	Total	**100%**	**9**

Social Determinants of Health

Social Determinants of Health are defined by the Centers for Disease Controls as the conditions in which people are born, grow, live and age.

SD1 - Please review the following social determinants of health and pick the three (3) you believe are the most important to address in our community in the next 3-5 years.

#	Answer	%	Count
1	Affordable Housing	11.11%	1
2	Early Childhood	0.00%	0
3	Economic Success	11.11%	1
4	Educational	11.11%	1
5	Employment	33.33%	3
6	Food Security	0.00%	0
7	Job Skills	22.22%	2
8	Quality Health Access	0.00%	0
9	Social Support	11.11%	1
	Total	**100%**	**9**

SD2 - Of the 3 Social Determinants of Health you selected, which one do you believe will make the greatest impact to the health of our community?

#	Answer	%	Count
1	Affordable Housing	0.00%	0
2	Early Childhood	0.00%	0
3	Economic Success	0.00%	0
4	Educational	33.33%	1
5	Employment	66.67%	2
6	Food Security	0.00%	0
7	Job Skills	0.00%	0
8	Quality Health Access	0.00%	0
9	Social Support	0.00%	0
	Total	**100%**	**3**

Target Population – Focus Group
LGBT Focus Group
August 8, 2017
St. Pauls' United Church of Christ in Westminster

**** Note: Moderator comments in bold.**

All of the participants had health insurance.

General Health: Please review the following General Health issues below and choose the five you believe are the most important to address in your community in the next 3 – 5 years. Of the five, choose the number one priority? Why is this the number one priority? Additional comments.

Mental health ranked as highest, illegal substance abuse came in second. What does mental health mean as a health condition?

Getting a counselor is by word of mouth, there was no way I would have found a counselor without word of mouth.

Is this the same for adults and children?

Getting an LGBT supportive and understanding pediatrician is hard to find. Just being able to have a conversation and treating your child like a child. My son recognized he was gay and when he told us he was 12. When telling the doctor he immediately asked if he was sexually active. We were not talking about sex. We are transitioning to another doctor so I went to the doctor to see if I was comfortable with transitioning to him for my son.

Are there any other specialties?

It would be nice if we had a transgender endocrinologist here in town so I didn't have to drive to the other side of the world. I travel 45 miles one way – to downtown Baltimore. The doctor in Columbia (Chase Braxton) was so overwhelmed they can't keep up with everybody. I've waited two hours for an appointment. One time I left because I waited in the office for so long. Case load - they are absolutely booked. They don't say no (not accept patients), but Chase Braxton deals with more than people like me, they have everyone in the world that comes in there. Just started going to new John Hopkins Center for transgender health.

We do a lot of doctor share when we see needs, and what you are saying will make it back to the hospital president and I will recommend that we doctor share with specialties we need.

You can't just go to any endocrinologist - you need to go to one who deals with hormone therapy for transgender therapy. Even a regular endocrinologist is booked out for months.

I was looking for a transgender therapist by a LGBT grief counseling after my partner passed away last year. On line resources were nonexistent. I found one gay psychologist but he was no longer taking patients. The one person I went to I stopped going after 2 times because he didn't understand what I was going through.

When you find someone who can help, then you need to find someone in-network. You need to pay out of pocket. Need to go to Reisterstown, found someone not as qualified.

Are there any on-lines services or gay doctor finding services you have tried to use?

There are several gay friendly sites, but doctors are not on there.

If you do a therapist search, everyone is listed as dealing with gay issues, but when you call them they are not. Why waste my time reading your bio when it says you deal with GBLT issues? When I tried to find a therapist it was like finding a needle in the ocean. But I found two.

As a student I had nowhere to go, especially for LGBT issues. Maybe have an outreach to local colleges regarding resources for students so they know about them. So, they know of resources outside of the colleges resources.

With the college it has been a constant complaint they had difficulty finding mental health providers and services.

Music to my ears – seems like a great opportunity for collaboration for the hospital……

Not only will this plan help the hospital allocate funds, but broken in to many organizations for their plans. We can pull together resources.

In our conservative town, have an LGBT health services at the hospital, at least kind of a clearing house where resources are available to get the information out, to college & everything else. Tie together 4-5 different specialties & make it accessible.

The next is substance abuse.

Sometimes it stems from mental health. Whether it is self-medicating with alcohol and legal drugs all are substances. They run out of money, rob people, then are homeless, so many different issues in the community can be traced back to mental health issues. Say avoidance or coping mechanisms, not self-medicating. I think it can be self medicating to some extent.

Illegal prescriptions and alcohol are used in equal quantities. Abuse of alcohol is a more hidden problem than the use of illegal drugs.

Very similar to my next question: knowing it was a big thing around here. Classify as different because of change of policy. Illegal problems stem from prescription problems out of control. No morphine or dilaudid offered at the hospital….. did not want to push the two together. Maybe we can …. Separate out the numbers….

If only picking one, which would you choose? Injury, dental health, asthma didn't get recognized.

Sometimes hard to distinguish and it is not coming right up in the conversation, really have people who have experience along that continuum would really be good……..

Ask if they are sexually active……

If that isn't part of the STANDARD PATIENT HISTORY FORM. Do you prefer to have that noted? (A lot of head shakes….Make change – married, single, sexually active. We can make that change for sure)

If not having sex there is a lot of stuff that comes with that too.

Healthcare providers – a strong disagree. Where do you get information? Physician, online, Family friends.

Would you like to see more medical info?

Every time I go to a LB health provider – they know nothing about me and I have to fill out a 6 page questionnaire when I walk in. This should already be in your records. I start from ground zero. Why can't it carry across?

CHG keeps MR separate from LB. There is a national system called CRISP. A closed file across the state of MD – physicians can get that information. CHD has access but can't get into individual medication. Pharmacies have to know what other pharmacies have given you. Many times they don't get into the record until they are entering information.

Social Determinants: Choose the 3 most important social determinants to address in our community in next 3-5 years? What is the number one priority? Why? Additional comments.

Employment opportunities – specific to Carroll County?

Talk about the hiring and actual day to day employment – stress. Are there other issues? Do you see Co-worker mistreatment? Employer mistreatment? See a lot of uneducated…….don't understand…..about living the life that we do…..

What do you feel is the solution for that?

A lot of companies don't want …….some companies offer it but don't require….at my company it is required.

Affordable housing - Is this just Carroll County?

It's just Maryland in general, for younger kids getting out of college they have to move away from families because it is too expensive to live here. They graduate here but can't live here as it is too expensive.

Quality of housing?

There's nice housing for income, others are dumps – really nasty apartments in town, and we have a slum landlord down the street, plaster walls coming down, mold, and health violations when it was inspected. Places on Main Street is horrible, down by library – a lot of drugs there but the only place where you can afford an apartment. A real difference between nice houses and the ones that are minimum wage people. Housing that is affordable there are really bad things. There are not enough inspections on the dumpy locations to make things safe.

I live a block from PA Ave. and it's not good; lower income and subsidized area not an environment to start out in.

I'm also 1 block from PA Avenue – when I was looking to move here it was 1 of 3 I could afford.

Representatives all think affordable housing is Section 8 housing, so they are hesitant to have the affordable housing blocks and will bring in population they don't want. It is fear based.

What is needed as far as social support?

It has to start in the schools; Education at the educator level. I had an interesting conversation with someone suffering from mental illness. Can you define that mental illness? No, then how do you treat it? Need to be specific as how to treat it. That's not specific to me but general, but transgender people are viewed as crazy. "Gay" is still classified as a mental illness. The good news is there are mental health providers in Carroll County. There are possible medication for health issues because I had experienced sexual assault. The psychiatrist was an older gentleman. Since I am a lesbian he made it clear that he thought that was the reason I was assaulted. That was unfortunate.

I think it is an interesting part of this discussion is that this happened to you and this is why education is huge. When a young child comes out? Why do you expect a gay child? I will say my son went to college at McDaniel and felt safe on the college campus. He knew he would never would in Philadelphia. I would love to see a gay couple walking down the street holding hands.

Results - Low Income Focus Group

Demographics

Demo1 - Gender

#	Answer	%	Count
1	Male	22.22%	2
2	Female	77.78%	7
3	Identifies as other	0.00%	0
	Total	**100%**	**9**

Demo2 - Age

#	Answer	%	Count
1	18 - 25 years	0.00%	0
2	26 - 34 years	33.33%	3
3	35 - 44 years	33.33%	3
4	45 - 54 years	0.00%	0
5	55 - 64 years	33.33%	3
6	65 years and over	0.00%	0
	Total	**100%**	**9**

Demo3 - Number of People in Your Home

#	Answer	%	Count
1	1	11.11%	1
2	2	22.22%	2
3	3	0.00%	0
4	4	55.56%	5
5	5	11.11%	1
6	More than 5	0.00%	0
	Total	**100%**	**9**

Demo4 - Type of Housing Unit

#	Answer	%	Count
1	Single-Family Home	33.33%	3
2	Apartment	33.33%	3
3	Townhome	22.22%	2
4	Mobile Home	0.00%	0
5	Condo	0.00%	0
6	Other	11.11%	1
	Total	**100%**	**9**

Demo5 - Zip Code

#	Answer	%	Count
1	21048	0.00%	0
2	21074	0.00%	0
3	21088	0.00%	0
4	21102	0.00%	0
5	21104	0.00%	0
6	21155	0.00%	0
7	21157	55.56%	5
8	21158	22.22%	2
9	21757	11.11%	1
10	21771	0.00%	0
11	21776	0.00%	0
12	21784	11.11%	1
13	21787	0.00%	0
14	21791	0.00%	0
15	21797	0.00%	0
16	None of the Above	0.00%	0
	Total	**100%**	**9**

Demo6 - Number of Years Lived in Carroll County

#	Answer	%	Count
1	Less than 1 year	22.22%	2
2	1 - 3 years	0.00%	0
3	4 - 5 years	0.00%	0
4	6 - 10 years	33.33%	3
5	More than 10 years	44.44%	4
	Total	**100%**	**9**

Q7 - Do you have health insurance?

#	Answer	%	Count
1	Yes	66.67%	6
2	No	33.33%	3
3	Don't know/	0.00%	0
	Total	**100%**	**9**

General Health Issues and Behaviors

Gen1 - Please review the following issues below and choose the five (5) you believe are the most important to address in your community in the next 3-5 years.

#	Answer	%	Count
1	Alcohol abuse	15.56%	7
2	Alzheimers Disease /	2.22%	1
3	Asthma	2.22%	1
4	Cancer	8.89%	4
5	Chronic Respiratory	0.00%	0
6	Congestive Heart	2.22%	1
7	Dental Health	11.11%	5
8	Diabetes	4.44%	2
9	E-Cigs / Vaping	0.00%	0
10	Heart Health	2.22%	1
11	Immunization/	2.22%	1
12	Injury	2.22%	1
13	Illegal Substance	8.89%	4
14	Mental Health	11.11%	5
15	Obesity	4.44%	2
16	Prescription Drug	6.67%	3
17	Physical Inactivity	4.44%	2
18	Sexually Transmitted	4.44%	2
19	Stroke	0.00%	0
20	Tobacco Use	6.67%	3
21	Other	0.00%	0
	Total	**100%**	**45**

Gen2 - Of the 5 General Health issues you selected, what do you believe is the number one priority.

#	Answer	%	Count
1	Alcohol Abuse	22.22%	2
2	Alzheimers Disease /	11.11%	1
3	Asthma	0.00%	0
4	Cancer	22.22%	2
5	Chronic Respiratory	0.00%	0
6	Congestive Heart	0.00%	0
7	Dental Health	0.00%	0
8	Diabetes	0.00%	0
9	E-Cigs / Vaping	0.00%	0
10	Heart Health	0.00%	0
11	Immunization/	0.00%	0
12	Injury	0.00%	0
13	Illegal Substance	11.11%	1
14	Mental Health	33.33%	3
15	Obesity	0.00%	0
16	Prescription Drug	0.00%	0
17	Physical Inactivity	0.00%	0
18	Sexually Transmitted	0.00%	0
19	Stroke	0.00%	0
20	Tobacco Use	0.00%	0
	Total	**100%**	**9**

Health Care Access

HCA1 - On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about Health Care Access in your community.

#	Question	Strongly disagree (1)		Some-what disagree (2)		Neither agree nor disagree (3)		Some-what agree (4)		Strongly agree (5)		Total
1	The majority of	0.00%	0	22.22%	2	11.11%	1	55.56%	5	11.11%	1	**9**
2	The majority of	11.11%	1	11.11%	1	22.22%	2	55.56%	5	0.00%	0	**9**
3	The majority of	11.11%	1	11.11%	1	11.11%	1	44.44%	4	22.22%	2	**9**
4	Transportation for	0.00%	0	22.22%	2	55.56%	5	11.11%	1	11.11%	1	**9**
5	Signage and	0.00%	0	0.00%	0	66.67%	6	33.33%	3	0.00%	0	**9**
6	There are health care	0.00%	0	11.11%	1	44.44%	4	33.33%	3	11.11%	1	**9**
7	Health care services	0.00%	0	22.22%	2	0.00%	0	44.44%	4	33.33%	3	**9**

HCA2 - Where do you go to get health information and/or health education? Choose all that apply.

#	Answer	%	Count
1	Your physician /	16.00%	4
2	Local sources (i.e.	20.00%	5
3	Local providers /	16.00%	4
4	National sources	0.00%	0
5	Online websites	24.00%	6
6	Health blogs	0.00%	0
7	Family / Friends	20.00%	5
8	Television	4.00%	1
	Total	**100%**	**25**

Social Determinants of Health

Social Determinants of Health are defined by the Centers for Disease Controls as the conditions in which people are born, grow, live and age.

SD1 - Please review the following social determinants of health and pick the three (3) you believe are the most important to address in our community in the next 3-5 years.

#	Answer	%	Count
1	Affordable Housing	14.81%	4
2	Early Childhood	14.81%	4
3	Economic Success	11.11%	3
4	Educational	3.70%	1
5	Employment	18.52%	5
6	Food Security	7.41%	2
7	Job Skills	14.81%	4
8	Quality Health Access	11.11%	3
9	Social Support	3.70%	1
	Total	**100%**	**27**

SD2 - Of the 3 Social Determinants of Health you selected, which one do you believe will make the greatest impact to the health of our community?

#	Answer	%	Count
1	Affordable Housing	22.22%	2
2	Early Childhood	11.11%	1
3	Economic Success	33.33%	3
4	Educational	0.00%	0
5	Employment	0.00%	0
6	Food Security	0.00%	0
7	Job Skills	11.11%	1
8	Quality Health Access	22.22%	2
9	Social Support	0.00%	0
	Total	**100%**	**9**

Target Population – Focus Group
Low Income
August 15, 2017
Citizen Services Office

**** Note: Moderator comments in bold.**

General Health: Please review the following General Health issues below and choose the five you believe are the most important to address in your community in the next 3 – 5 years. Of the five, choose the number one priority? Why is this the number one priority? Additional comments.

The biggest concerns were regarding the number of people in the home, housing units, demographics and 1 in 4, and zip code. The largest number of people had lived in Carroll County for 6 or more years. A great amount had health insurance, but a few did not.

Why do you not have health insurance?

I currently have health insurance, but it is very cost prohibitive. Through employer 2 people paying $600 per month, with more pay checks per month it is more per month, 7-8- almost $900 per month, deductible is high - $5,000, so what is the point? So I pay $500-$600 for health insurance, and then after I pay $5,000 the insurance helps me with something?

What portion of income do you use?

Housing is supposed to be 30% of income. When we purchased our house, I was also working, now am just a stay at home mom. We can keep $2000 -$3000 maximum. Out of that is $500-$600 for insurance. If I go to doctor or get script we pay hundreds of dollars because it doesn't kick in because of the $5,000 deductible. Or pay for higher plan with lower deductible ($400 per month).

I really hope we can come up with some way to actually reform that isn't shifting the cost and making a federal mandate that you have insurance. It is like saying everyone has to take the bus, etc. it is not one size fits all. And the cost for everyone is to have something that is really, really up there.

Because I can get it through the employer, I do not qualify for other insurance. They only look at what the cost would be for only the husband – which isn't as bad, but there are 4 of us in the family. What happens if kids get hurt or I get pregnant? It is not affordable and not fair they choose to call it affordable. It is $654 per month for all four of us to get insurance.

Alcohol abuse is #1. Why is this a concern as a health issue? Do we see it as something that leads to other issues or creates medical complications?

It is legal and easy to access, considered socially normal, it is not wrong to bring home a bottle of vodka and drink what I want, but how does it impact my overall health, what does it do to my liver? Having AA so normal, having liquor stores everywhere it is more normalized. In years it will be the same with marijuana, not a big deal because it is 'legal." But you need to look at what it does to overall health, what happens when you become addicted, it takes a lot of your money, probably more liquor stores than places I can go to get what I actually need.

Do you feel it leads to criminal activities?

It makes you wonder. People I know who are hooked, you wonder where they get the money – you know they aren't working and don't have an income, but every week they get alcohol. But when you talk about buying food, they go to the food kitchens. It's all about the alcohol.

People walk the streets and come up and ask for money saying they haven't had anything to eat. But you know they are alcoholics, so if you give money you know where they go - they are buying liquor instead of food. It gets me frustrated, because I don't mind helping people out. I've been straight myself 7 years now.

Do you see it as an obstacle to success?

YES definitely – one of my co-workers lost their job because they came in with a hangover. It was not an acceptable reason to have a sick day.

One thing I have noticed is a lot of people I counsel say they started with alcohol. Alcohol leads to other things, it turns into substance abuse. It is legal and easy to buy it….but it leads to other things.

Mental Health and Cancer are #2

In terms of race, mental health issue is looked down upon in the African Americans community. We brush it under the rug and don't want to talk about it or deal with it, but is a big issue. So many people suffer from depression and anxiety and we don't want to deal with it. "This doesn't happen to black people." It is stigmatized; looked down upon. You can suffer from PTSD because you lost your mom, but people don't want to talk about it. They feel they are not normal if they have a mental health issue. If we as people deal with it more, the world might be easier to thrive in. Maybe easier for people to become employed or to put down the drugs, not take this drug because this will help me calm down. This is also an issue that we put kids on pills, why not deal with initial stages of problem before putting them on drugs right away.

Culturally there is a stigma and it is ignored, not talked about.

Don't think it is a problem with access. I'm a sociologist, and I did research on this; 97% of the students at my school stated that mental health in the black community is not acceptable. It is not about education or access, but comes from generational things that we need to be normal.

It is looked upon as a weakness. From an adult standpoint; an adult weakness. It should be something you are able to deal with. You don't go outside the house to deal with it. If a problem at home it stays within the home.

Tell me about access? Do you have access to mental health care?

I have family members that deal with disorders, a relative has a personality disorder but says she is fine, she becomes toxic and we can't interact with her. She does horrible things. If she would acknowledge it and deal with her diagnosis and get help she would have a more full life with her family. An uncle is schizophrenic and an alcoholic. He says he is fine and refuses to get help and take medication. It is not healthy and poisoning people around him and he could get help but won't acknowledge it. It is very much stigmatized. We joke around and call people crazy, but it is an actual problem. If your arm is broken would you leave it and just say sorry about your life? I guess you will need to live with your arm broken? Because it is chemically going on in your brain it is taboo and something strange we don't want

to deal with. We need to be adult, acknowledge it, get the help we need and it would be easier to do life. First you need to meet your expensive deductible. In my insurance, once we meet deductible it is covered. If we are willing to pay the $5,000 up front help is unlimited.

It impacts relationships.

Another thing, there is a breakdown within the mental health field, when someone has a diagnosis. I worked with someone with a mental illness. He was a great person working with the kids, but once he stopped taking his meds it changed. There was a disconnect. He was getting help but when he was fine, he stopped getting help. People need to understand that you need to keep getting help to be in good condition. Need education that you won't be magically fine and that you need to keep doing what you are doing to remain well.

Which is the #1 priority? Cancer ranked high; Mental health did too.

Cancer has definitely affected my family. My mom died from ovarian cancer. Another member from pancreatic cancer. Ovarian cancer & pancreatic cancer are not talked about, we don't hear about it at all. We don't hear about cancer at all except for breast cancer. I am a survivor of cervical cancer. When the doctor told me I had cancer, I was shocked. What are you talking about? A 22 year old with cancer?? It was never talked about we don't understand it.

When having sex conversations in school, we should also talk about cancer too. Talk about it at a young age, talk about other cancers as well. We don't understand the process, so how will children understand? It is any cancer – not just female. Look at kids, it seems there is a child dying from cancer all the time on Facebook. We only rush to talk about sex with our kids, but let's talk about the different kinds of cancer.

I agree with the educational point. Some things like lung cancer should be talked about – when you have one cancer you could end up with another cancer. My Grandfather had lung cancer, but also ended up with emphysema and COPD. He smoked and smoked. He poisoned his lungs. There is a correlation. Educate our kids and help them understand more and maybe they won't have issues that we have now. There are vaccines for HVP. Understand about it, what is the purpose, how do I avoid it? COPD – how do I avoid it? My grandmother smoked for 5 years and still ended up with COPD. Education piece, knowing that our decisions and things we do in life will have an impact on our later life. If I choose to drink and don't understand responsibility, or maybe I am predisposed to having addictions, illness, more predisposed in my family and more likely to have problems. What will it look like financially, health wise, what are things associated with cigarettes, alcohol, what are the risks? Education is important. If I play Russian roulette, what are the implications? Having knowledge is important. Knowledge is power. If you know how cancers work you know how to help yourself. You can make an informed decision as to how to help yourself if you know the end result of things.

Social Determinants: Choose the 3 most important social determinants to address in our community in next 3-5 years? What is the number one priority? Why? Additional comments.

Affordable housing, early childhood development, employment opportunities, job skills all tied for #1. With employment opportunities and job skills – what is the gap?

Goes back to missing education piece, how many work, how jobs are created, the greatest resource is human being and creativity, which is unlimited. The understanding of what it takes to start opportunity. This country was founded on potential and opportunity. Willing to work hard for it, many people's lives were transformed. I see a great gap in education in how that operates, just not there.

Are there positions to fill? For every level?

If jobs are available, are you going to get a good wage? I went back to college, applying for jobs with a BS and people applying with a doctorate. With a BS degree I got a job making donuts at a gas station. I can apply to whatever is within walking distance, but will I be able to afford to live, pay my housing and food, water and electric bill, etc. Looking at services I can get as a stay at home mom, it is mind boggling that it is not worth going back to work, then I would pay thousands of dollars to live for child care, it wouldn't balance out. It is almost a catch 22. If I don't work you will help me, if I do work you won't help me anymore; get assistance with water and electric bills because you are making money, but the salary is not enough to cover your bills. Who can pay for their education? If you sign up at college to better ourselves, where does the money come from, who is paying my bills if I am not working, who is watching my kids? You can't live in your parent's basement anymore. Nice to have job opportunities, but ones that allow me to pay my bills and have health insurance. Has to be a place where there is a living wage and it is affordable to be alive and not have 10 roommates to make it work. Who doesn't want to work? If we are working at current skill and can't afford to go to school

Depending where you work, you can lose your job tomorrow, or if you need more education for the jobs that are available require more than you have, you can't afford to do that. It is all over, not just Carroll County. I can't afford to go to college. Every time you're working, if you lose a position, you have to become re-educated again to find a job. If you have a masters you take a job that is "less" because you take what you can. You want to make it so you can afford to live. Making an average wage doesn't so it anymore. We are looked at as if we are not working, if jobs not available to us what are we supposed to do? If no job, no employer discount for insurance, then you have to figure out other insurance and where does the money come from. It is a big ball of craziness. I get angry every time I have to reapply for everything. Is it worth getting talked down to again? Sorry if you are having a bad day, but I am trying! Are you trying?

Affordable housing?

It is too expensive, with rent, car & health insurance, food, how much do you have - it is tough… when it is $600 month for insurance. With family and kids it is tough. Kids don't understand that stuff that all your money goes for the expenses. You have to have a balance with your job and family. In the winter the electric bill is crazy.

Insurance creates an obstacle for success as it has so much of an impact on finances.

My 1st apartment in Carroll County was a 1 bedroom, on sale for $650 a month – that was 10 years ago. Insurance for our family is $700 a month. So will we have a place to live or will we have insurance if income does not increase?

Do you feel 33% is reasonable expectation for housing?

No – with the right deal it is possible but not without that bargain. If you are trying to buy a home – I was shocked at home prices. We didn't see a single house under $200,000 that was livable – that you could live in without 1,000s and 1,000s of dollars of work. A middle priced home is hard to come by,

Anything else to talk about?

One thing I found frustrating – going from paying for everything as a professional to staying at home with the kids – being talked down to by the energy assistance people, and finding out months later there is a fund to get help and get glasses for free. There should be some way these people understand that we aren't coming because we are poor, but we need help. Everywhere I have gone for assistance I've dealt with that. If I need help with glasses, oil and electric, can you refer that there are places to get help, like you wear glasses – there is a place to get free glasses. If you only make this amount of money, let me help you out with other things. There is a place you can get help with such and such. There has to be more communication. I get grumped at almost every time. We aren't bored with life and want to sit around and do nothing, we need help.

People need to understand – I work at Opportunity Works and I don't know of all the services. I try to go the extra mile to find out where services are and then I can refer out.

There should be a list of resources. I didn't get assistance because I didn't get information in advance. I go and they ask me for the paperwork, did I know I needed paperwork? No…..please connect the dots.

There are people out there who will refer you to what you need.

It is an education to those in the system to know there are resources available in multiple areas. In Carroll County there are so many more resources available here than there are in Baltimore County and Baltimore City. It is amazing how many resources there are.

Challenge you to think this way – say there are limited resources – say there are only 10 pair of glasses a year, what are the long term affects – would it be managed the same way?

If limited – would it be "wait until asked" and not giving them away because we may run out….how do you determine who needs the help the most? We can't give it to everybody because we may run out. If we only have 3 MRIs a month, who do you pick to get the help?

If my clients don't tell me what they need, I don't know what they need. If I can't see you I don't know what you need. It is not just communication for the people who work there, but the clients need to communicate also. I'm not Jesus and I don't know what they want. I can't say, let's go to substance abuse if I don't know they need help.

Results - Older Population Focus Group

Demo1 - Gender

#	Answer	%	Count
1	Male	19.05%	4
2	Female	80.95%	17
3	Identifies as other	0.00%	0
	Total	**100%**	**21**

Demo2 - Age

#	Answer	%	Count
1	18 - 25 years	0.00%	0
2	26 - 34 years	0.00%	0
3	35 - 44 years	0.00%	0
4	45 - 54 years	0.00%	0
5	55 - 64 years	4.76%	1
6	65 years and over	95.24%	20
	Total	**100%**	**21**

Demo3 - Number of People in Your Home

#	Answer	%	Count
1	1	47.62%	10
2	2	47.62%	10
3	3	4.76%	1
4	4	0.00%	0
5	5	0.00%	0
6	More than 5	0.00%	0
	Total	**100%**	**21**

Demo4 - Type of Housing Unit

#	Answer	%	Count
1	Single-Family Home	14.29%	3
2	Apartment	76.19%	16
3	Townhome	0.00%	0
4	Mobile Home	0.00%	0
5	Condo	4.76%	1
6	Other	4.76%	1
	Total	**100%**	**21**

Demo5 - Zip Code

#	Answer	%	Count
1	21048	0.00%	0
2	21074	0.00%	0
3	21088	0.00%	0
4	21102	0.00%	0
5	21104	0.00%	0
6	21155	0.00%	0
7	21157	0.00%	0
8	21158	100.00%	17
9	21757	0.00%	0
10	21771	0.00%	0
11	21776	0.00%	0
12	21784	0.00%	0
13	21787	0.00%	0
14	21791	0.00%	0
15	21797	0.00%	0
16	None of the Above	0.00%	0
	Total	**100%**	**17**

Demo6 - Number of Years Lived in Carroll County

#	Answer	%	Count
1	Less than 1 year	0.00%	0
2	1 - 3 years	15.00%	3
3	4 - 5 years	5.00%	1
4	6 - 10 years	5.00%	1
5	More than 10 years	75.00%	15
	Total	**100%**	**20**

Q7 - Do you have health insurance?

#	Answer	%	Count
1	Yes	100.00%	21
2	No	0.00%	0
3	Don't know/	0.00%	0
	Total	**100%**	**21**

General Health Issues and Behaviors

Gen1 - Please review the following issues below and choose the five (5) you believe are the most important to address in your community in the next 3-5 years.

#	Answer	%	Count
1	Alcohol abuse	2.86%	3
2	Alzheimers Disease /	17.14%	18
3	Asthma	0.00%	0
4	Cancer	10.48%	11
5	Chronic Respiratory	2.86%	3
6	Congestive Heart	5.71%	6
7	Dental Health	1.90%	2
8	Diabetes	2.86%	3
9	E-Cigs / Vaping	1.90%	2
10	Heart Health	8.57%	9
11	Immunization/	2.86%	3
12	Injury	0.00%	0
13	Illegal Substance	11.43%	12
14	Mental Health	2.86%	3
15	Obesity	5.71%	6
16	Prescription Drug	8.57%	9
17	Physical Inactivity	6.67%	7
18	Sexually Transmitted	0.95%	1
19	Stroke	5.71%	6
20	Tobacco Use	0.95%	1
21	Other	0.00%	0
	Total	**100%**	**105**

Gen2 - Of the 5 General Health issues you selected, what do you believe is the number one priority.

#	Answer	%	Count
1	Alcohol Abuse	0.00%	0
2	Alzheimers Disease /	25.00%	5
3	Asthma	0.00%	0
4	Cancer	10.00%	2
5	Chronic Respiratory	0.00%	0
6	Congestive Heart	5.00%	1
7	Dental Health	0.00%	0
8	Diabetes	0.00%	0
9	E-Cigs / Vaping	0.00%	0
10	Heart Health	15.00%	3
11	Immunization/	0.00%	0
12	Injury	0.00%	0
13	Illegal Substance	30.00%	6
14	Mental Health	0.00%	0
15	Obesity	5.00%	1
16	Prescription Drug	5.00%	1
17	Physical Inactivity	5.00%	1
18	Sexually Transmitted	0.00%	0
19	Stroke	0.00%	0
20	Tobacco Use	0.00%	0
	Total	**100%**	**20**

Health Care Access

HCA1 - On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about Health Care Access in your community.

#	Question	Strongly disagree (1)		Some-what disagree (2)		Neither agree nor disagree (3)		Some-what agree (4)		Strongly agree (5)		Total
1	The majority of	0.00%	0	15.00%	3	15.00%	3	30.00%	6	40.00%	8	**20**
2	The majority of	0.00%	0	10.00%	2	20.00%	4	40.00%	8	30.00%	6	**20**
3	The majority of	10.53%	2	10.53%	2	10.53%	2	47.37%	9	21.05%	4	**19**
4	Transportation for	10.00%	2	10.00%	2	25.00%	5	30.00%	6	25.00%	5	**20**
5	Signage and	5.00%	1	10.00%	2	50.00%	10	25.00%	5	10.00%	2	**20**
6	There are health care	5.00%	1	0.00%	0	20.00%	4	60.00%	12	15.00%	3	**20**
7	Health care services	10.00%	2	0.00%	0	0.00%	0	10.00%	2	80.00%	16	**20**

HCA2 - Where do you go to get health information and/or health education? Choose all that apply.

#	Answer	%	Count
1	Your physician /	34.09%	15
2	Local sources (i.e.	20.45%	9
3	Local providers /	6.82%	3
4	National sources	4.55%	2
5	Online websites	15.91%	7
6	Health blogs	4.55%	2
7	Family / Friends	9.09%	4
8	Television	4.55%	2
	Total	**100%**	**44**

Social Determinants of Health

Social Determinants of Health are defined by the Centers for Disease Controls as the conditions in are born, grow, live and age.

SD1 - Please review the following social determinants of health and pick the three (3) you believe are the most which people important to address in our community in the next 3-5 years.

#	Answer	%	Count
1	Affordable Housing	10.53%	6
2	Early Childhood	8.77%	5
3	Economic Success	5.26%	3
4	Educational	8.77%	5
5	Employment	12.28%	7
6	Food Security	3.51%	2
7	Job Skills	12.28%	7
8	Quality Health Access	26.32%	15
9	Social Support	12.28%	7
	Total	**100%**	**57**

SD2 - Of the 3 Social Determinants of Health you selected, which one do you believe will make the greatest impact to the health of our community?

#	Answer	%	Count
1	Affordable Housing	10.53%	2
2	Early Childhood	0.00%	0
3	Economic Success	10.53%	2
4	Educational	10.53%	2
5	Employment	21.05%	4
6	Food Security	0.00%	0
7	Job Skills	10.53%	2
8	Quality Health Access	36.84%	7
9	Social Support	0.00%	0
	Total	**100%**	**19**

Target Population – Focus Group
Older Population
August 4, 2017
Carroll Lutheran Village

**** Note: Moderator comments in bold.**

General Health: Please review the following General Health issues below and choose the five you believe are the most important to address in your community in the next 3 – 5 years. Of the five, choose the number one priority? Why is this the number one priority? Additional comments.

Ranked #1 was Alzheimer's & dementia; Cancer came in strongly second along with illegal substance abuse. Not identified at all were injury and asthma.

A concern is making sure there is availability for how to recognize when you are starting to have problems with dementia, subtle ways you can be aware that something is changing, most of the time it may be people around you. Where is there a health professional to help identify for you and catch it early? Concerns are around the pattern of early stage of catching problems before progressing into disease.

Primary doctors are supposed to give you a simple test as to whether you may be beginning to fail in that area.

Is this being done? It is being done in one case – is everyone seeing that?

Some feel doctors gather that information by just speaking with you. Isn't some of the memory test required by Medicare?

Can't say yes or no, but there is "Meaningful Use" where doctors are strongly encouraged to use certain tests and it affects their reimbursement rates.

Residents stated that the test was offered here before, but it is not done regularly. Melissa Batten shared that we're a part of doing the National Memory Testing day (November) with The Alzheimer's Foundation of America but can do any time of the year. We just did one when we did a competition on the longest day and that was through the Alzheimer's Association. There is also a mini mental which physicians do and our Social Workers do on admission – gives base line on memory. We can do that at any point of time and is very accepted across a national scale with physicians and The Alzheimer's Foundation. It is very general but doesn't cover all the details. We are aware here because of our memory unit. It is appreciated that they represented a population that perhaps is not here.

Someone had a friend that just turned 65, and her doctor did her first Medicare exam with a mini mental, and she was surprised – so, yes, they are doing the testing.

Will there be enough practitioners to care for all the people diagnosed with these diseases of the aging population?

There are efforts started at Carroll Hospital as to how we will addresses the aging population issues.

We are getting feedback on this. Carol Ann is on the Healthy Aging Team which has about 40 members and 25 regularly attend meetings. This team consists of experts who get together that are

focused on this problem. The community is aware of issues, but doesn't mean everything will be addressed timely.

It was asked how Carroll County compares demographically with other counties with this?

Comparatively, there is a decrease in younger ages, as we can see with our problems of having to close some area schools. But we anticipate it will increase in 10 years. And 20% of our population will turn over 62 years old within the next 10 years. It is important to think about as we do planning. Dot is involved in Long Term planning – which is deeper than just medical issues, also doing things like planning sidewalks, walking paths.

Cancer was a strong 2nd along with illegal substance abuse – do you see a difference between prescription and illegal drugs?

Drug abuse is not HERE (CLV) but in our community – it is publicized as being in the community. Many young people are dead because of this problem so we need to be conscious of this. People are concerned about their grandkids, and the use of Marijuana as the gateway to drugs. It was commented that there is no talk publicized about trying to address it at its beginning – where people start using drugs - why do people feel the need to start using something? Why are they choosing to self-medicate? Why isn't there some kind of movement to change this at the beginning?

Many people wanted to combine drug abuse – but we kept illegal and prescription drug abuse separate because a lot of illegal substance abuse came from prescription use at the start. The hospital does not give Dilaudid anymore without a 3-peer review. Not as many opioids are prescribed at the hospital. It was asked – what about some physicians that re-prescribe and re-prescribe. Community physicians can make their decisions, but we can give hospital affiliated doctors guidelines regarding prescribing.

One participant related how a friend was in the ER and right away they prescribed OxyContin – and the patient didn't need it. It made her sick. How about Tylenol first and then something stronger later if you need it?

Dot said it is patient driven. Dot shared that the doctor can't call it in once you leave if you needed something more. Discussed that many people don't know what they are getting when the doctor gives them the prescription. The group agreed that many people just trust the doctor and take medications without knowing what they are or what they are for.

When narrowed down to 1 – illegal substance abuse is higher than Alzheimer's & dementia.

Illegal drug abuse affects more a variety of people throughout the county than just one disease, it has a more far reaching effect.

Dot interpreted that you stepped outside yourself – you are looking at the health of other people in the community.

Don't you think that Dementia/Alzheimer's are something that you probably haven't brought on yourself – illegal drugs is something you ask for yourself – you're using this.

There was a comment that the two questions don't hone in on our group evenly at all. Dementia is more confined to people over 60 and over – illegal drugs are in the whole community. It is not confined to the 60 and over group.

Social Determinants: Choose the 3 most important social determinants to address in our community in next 3-5 years? What is the number one priority? Why? Additional comments.

By a landslide – quality health access is high but there are a lot of really close answers.

Urban versus rural. If you have transportation then resources are more accessible, so there is a benefit to be in an urban place in regards to transportation.

One person disagreed – and considers this place urban (Westminster). One person was raised in Keymar and it is hard because of no public transportation. There used to be a train. If you really want expert help you need to go to Hopkins, and it is a hop, skip and a jump from here.

How do you feel about doctors that split their time between 2 places? If you are available on that one day (Wednesday) it is fine. It may not be as convenient – but it is better than none.

The Elephant in the room here (at CLV), is we thought we would have a physician here – we have had it at times, and times not. Many have gone outside CLV to select a physician in the area.

Do you feel comfortable being able to pick a physician in the community? (Is the knowledge and information available to you?)

One participant just moved here 2 years ago, and if she didn't have good friends who are nurses that know, even then it has been hard to find a doctor and you have to ask around. We lost primary care here, and it is hard to know how good they really are. Are they people who will really pay attention to you? She is still going to Montgomery County to see her doctors because she knows for a fact how good they are. I wish there was a way to talk to people and find out. Because PCP is your entry spot for the medical world. Wish there was a solution.

PARKING LOT: getting information on quality doctors – this is lacking for people.

How about also attracting new physicians?

The hospital tries to attract new physicians and has a whole department that does that.

For FUTURE reference – someone mentioned that it would be helpful to put the results up on the screen.

It was mentioned that one could call Care Connect and get information on a physician. Someone asked how would somebody know that if they just moved here? Who would tell them that? We need a consumers' report book with that information.

We will send Melissa information and she can disseminate that information.

When doctors come out from other hospitals you can see them here for the diagnosis, but treatment is at their main office somewhere else, so transportation can be troublesome depending on your transportation. As far as community at large, there is Access Carroll and different places, but I have heard it can be difficult to be seen there. There are only so many appointments in a day. Mission of

Mercy is only here occasionally, and they have a dentist. Access Carroll also has a dentist but has a waiting list. The Health Department dentist is children only.

Dot explained Access Carroll and the medical home services it provides: pharmacist, dental, and mental health/behavioral health/substance abuse. This is for the underinsured.

CHG has a book with a list of doctors and specialties.

One participant moved here in 2005 and has been a patient of 4 different doctors and now doesn't have any. One moved to Manchester, 2nd & 3rd became a hospitalist, 4th one was here and moved away – now looking for a 5th doctor.

Dot summarized: You don't know what doctors are out there or where to find them. Don't know who is good and who is not. Also, urban setting issues and specialists with expertise that need to come on other days than just Wednesday.

Access Carroll is where the CLV social worker went.

When asked to narrow down social determinants of health to one, quality access is still big, along with employment opportunities. This is for others. It impacts people not having money to pay for physicians; we educate them and they leave the county and they don't return. They take their expertise elsewhere to get the higher pay. Not necessarily attached to medical issues. Discussed having the longest commuting time for Carroll residents. We have people with high and low paying jobs, plus the aging community. But the whole "middle" is missing. Not as much middle jobs/population, to support those who are aging.

Additional comments?

One person would like to talk about homelessness - the whole thing and how the health is impacted by that. Without a permanent address it is hard to get anything done or get self established in a job. Shelters, on the street, sleeping at another house, may be an environments that does not encourage health (bad air quality, too far out for transportation, etc.) The person is wearing the "invisible backpack" (no fresh food, asthma, no money for medications, etc.) – it affects one's health.

Discussed the yearly count. Discussed numbers of homelessness, homeless children, people cycle in and out of homelessness. There are shelters for families and children, provisions supplied, etc., plans for a Medical Respite Home.

Are there studies as to how many people come into Carroll County from the city because they can get more resources here?

Discussed "No Wrong Door" – getting people into help.

Someone shared about a friend that volunteers at the hospital who wheeled out a patient that was going to walk to the bridge as he was homeless and lived under the railroad**.**

Information gathered from this group is skewed since 99.9 % of us are covered by Medicare – it is hard for us to get out of our skin. Dot reiterated that we are looking for group representation – we want you to give us your picture. Out of focus groups gather data there are different groups giving their

own story. When we go into prioritization we know where to start. We also have key informant groups and on-line surveys.

Does all this data really help? And how much time do we spend on studies when we need to do something about it?

We prioritize urgency of issues. Issues have changed over the years. We have 40 top executives that look at data and do the prioritization to impact urgent issues. It is developed into a Community Health Improvement Plan Used to allocate resources to the community, partners will help impact changes (school system, libraries, etc.) Spoke of schools adding a la cart vegetables & fruits, etc.

Survey Tool – Targeted Populations Focus Groups

Demographics

Gender

- ☐ Male
- ☐ Female
- ☐ Identifies as other than male or female

Age

- ☐ 18 - 25 years
- ☐ 26 - 34 years
- ☐ 35 - 44 years
- ☐ 45 - 54 years
- ☐ 55 - 64 years
- ☐ 65 years and over

Number of People in Your Home

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ More than 5

Type of Housing Unit

- ☐ Single-Family Home
- ☐ Apartment
- ☐ Townhome
- ☐ Mobile Home
- ☐ Condo
- ☐ Other _____

Zip Code

- ☐ 21048
- ☐ 21074
- ☐ 21088
- ☐ 21102
- ☐ 21104
- ☐ 21155
- ☐ 21157
- ☐ 21158
- ☐ 21757
- ☐ 21771
- ☐ 21776
- ☐ 21784
- ☐ 21787
- ☐ 21791
- ☐ 21797

Number of Years Lived in Carroll County

- ☐ Less than 1 year
- ☐ 1 - 3 years
- ☐ 4 - 5 years
- ☐ 6 - 10 years
- ☐ More than 10 years

Do you have health insurance?

- ☐ Yes
- ☐ No
- ☐ Don't know/Not sure

General Health Issues and Behaviors

Gen1: Please review the following issues below and choose the five (5) you believe are the most important to address in your community in the next 3-5 years.

- ❑ Alcohol abuse
- ❑ Alzheimer's Disease/Dementia
- ❑ Asthma
- ❑ Cancer
- ❑ Chronic Respiratory Disease/COPD
- ❑ Congestive Heart Failure
- ❑ Dental Health
- ❑ Diabetes
- ❑ E-Cigs/Vaping
- ❑ Heart Health
- ❑ Immunization/Vaccination
- ❑ Injury
- ❑ Illegal Substance Abuse
- ❑ Mental Health
- ❑ Obesity
- ❑ Prescription Drug Abuse
- ❑ Physical Inactivity
- ❑ Sexually Transmitted Disease and Infection
- ❑ Stroke
- ❑ Tobacco Use
- ❑ Other (please specify): _____

Gen2: Of the 5 General Health issues you selected, what do you believe is the number one priority?

- ❑ Alcohol abuse
- ❑ Alzheimer's Disease/Dementia
- ❑ Asthma
- ❑ Cancer
- ❑ Chronic Respiratory Disease/COPD
- ❑ Congestive Heart Failure
- ❑ Dental Health
- ❑ Diabetes
- ❑ E-Cigs/Vaping
- ❑ Heart Health
- ❑ Immunization/Vaccination
- ❑ Injury
- ❑ Illegal Substance Abuse
- ❑ Mental Health
- ❑ Obesity
- ❑ Prescription Drug Abuse
- ❑ Physical Inactivity
- ❑ Sexually Transmitted Disease and Infection
- ❑ Stroke
- ❑ Tobacco Use
- ❑ Other (please specify): _____

Health Care Access

HCA1: On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about Health Care Access in your community.

	1	2	3	4	5
The majority of residents in my community have access to a local primary care provider.	❍	❍	❍	❍	❍
The majority of residents in my community have access to necessary medical specialists.	❍	❍	❍	❍	❍
The majority of residents in my community are able to access a local dentist when needed.	❍	❍	❍	❍	❍
Transportation for medical appointments is available and easy to access for the majority of residents.	❍	❍	❍	❍	❍
Signage and promotions for health services reflect my community and its needs.	❍	❍	❍	❍	❍
There are health care providers who understand my population and its health risks.	❍	❍	❍	❍	❍
Health care services are provided in my language.	❍	❍	❍	❍	❍

HCA2: Where do you go to get health information and/or health education? Choose all that apply.

- ❑ Your physician/health care provider
- ❑ Local sources (i.e. hospital, health department)
- ❑ Local providers/organizations/resources
- ❑ National sources
- ❑ Online websites
- ❑ Health blogs
- ❑ Family/Friends
- ❑ Television

Social Determinants of Health

Social Determinants of Health are defined by the Centers for Disease Controls and Preventions as the conditions in which people are born, grow, live and age.

SD1: Please review the following Social Determinants of Health and pick the three (3) you believe are the most important to address in our community in the next 3-5 years.

- ❑ Affordable Housing
- ❑ Early Childhood Development
- ❑ Economic Success
- ❑ Educational Attainment
- ❑ Employment Opportunities
- ❑ Food Security
- ❑ Job Skills
- ❑ Quality Health Access
- ❑ Social Support

SD2: Of the 3 Social Determinants of Health you selected, which one do you believe will make the greatest impact to the health of our community?

- ❑ Affordable Housing
- ❑ Early Childhood Development
- ❑ Economic Success
- ❑ Educational Attainment
- ❑ Employment Opportunities
- ❑ Food Security
- ❑ Job Skills
- ❑ Quality Health Access
- ❑ Social Support

6. Identified Key Issues

After the prioritization process, the following health issues were identified as the most significant to address in Carroll County. They are presented in alphabetical order, and will be further refined as the Community Benefit Plan is reviewed and prepared for FY 2019 – FY 2021.

- Alcohol Abuse
- Cancer
- Dental Health
- Diabetes
- Heart Disease
- Illegal Substance Abuse
- Immunization
- Mental Health
- Obesity
- Physical Inactivity
- Prescription Drug Abuse
- Stroke
- Tobacco

7. Demographics

A. Methodology

Demographic data is included in this CHNA Consolidated Report, as required by HSCRC guidelines and by the Affordable Care Act of 2010. Information about the population and its characteristics is necessary to understand a community's health strengths and needs. Two other components of this Report — the Community Health Survey and *Our Community Dashboard* — also provide demographic information. Values for similar data points may vary according to time frame and source.

The following data sets from the **Carroll County Department of Economic Development** website**,** CarrollBiz.org, accessed in October 2017, are given in this section:

- Area Profile
- Population
- Projected Population
- Household estimates
- Population estimates by election districts
- Age distribution
- Ethnic Diversity
- Educational Attainment
- Education
- Employment and unemployment
- Labor Force Summary
- Major Employers
- Average Wage and Salary
- Median Household Income
- Per Capita Income
- Effective Buying Income
- Cost of Living Index

B. Demographic Summary

Carroll County residents enjoy relatively good economic status, and are comparatively well-educated. The median household income for Carroll County was $84,790 for 2013, compared with the Maryland household income median of $73,538. According to the US Census American Community Survey, the median household income for the United States was $52,250 in 2013. This higher income is slightly

offset by the fact that the 2016 Cost of Living Index (COLI) for Carroll County, at 106.7, is higher than the national COLI of 100.

The 2017 Carroll County civilian unemployment rate is estimated at 3.5% - below the Maryland rate of 4.0% for July 2017, and below the national rate of 4.4%. The poverty rate is 5.6%, as compared with 9.7% for Maryland, and 12.7% for the United States as a whole (US Census Quick Facts). The top five employers in number of employees are Carroll County Public Schools, Carroll Hospital, Springfield Hospital Center, Penguin Random House, and Integrace-Fairhaven.

The Carroll County Public School (CCPS) System consistently ranks as one of the top-performing systems in Maryland. The number of students enrolled in public school for 2016-2017 was approximately 25,200 (CCPS data). This is down from a peak enrollment of 28,914 in 2005-2006. Enrollment is not expected to rise again in the next 10 years. About 91.5% of adults have graduated from high school, and about 32% have a bachelor's degree or higher.

Carroll County has a fairly low level of racial and ethnic diversity. Over 90% of all residents are white or Caucasian, and African-Americans comprise less than 4% of all residents. Hispanic or Latino residents, estimated at less than 1% of the population, may be under-counted due to unofficial residency status.

The number and percentage of older adults in the community has increased, and will continue to grow. The percentage of residents over age 64 was about 11% in 2000. The current percentage is estimated at 16%. According to the Maryland Department of Planning's projections, the percentage of residents aged 65+ is expected to rise to about 27% of the population by 2035.

Sustainability data compiled by the Maryland Department of Planning indicate that Carroll has a higher percentage of residents who commute alone to work than the State as whole, and the mean travel time to work is slightly higher than the State average. Although Carroll has 28.4% of its resource land in preservation status, this has decreased from 34.5% since our 2015 CHNA Report. More of Carroll's remaining agricultural and resource land is threatened by development, as compared with the rest of the State (43% vs 27.5%).

C. Attachments

- Demographic Data - *Carroll County Department of Economic Development*
- Carroll County, Maryland Brief Economic Facts - *Maryland Department of Business and Economic Development*
- Demographic and Socio-Economic Outlook - *Maryland Department of Planning*
- Sustainability Indicators for Carroll County - *Maryland Department of Planning*
- Quick Facts - Carroll County Maryland - *United States Census Bureau*

Carroll County Maryland
ECONOMIC DEVELOPMENT
Right Place, **Right Time**

Area Profile

Carroll County, Maryland is a 452 square mile area that lies 31 miles northwest of Baltimore and 56 miles north of Washington D.C. It is one of the seven jurisdictions that define the Baltimore metropolitan area. The County seat is Westminster and includes seven other incorporated towns.

Market Location

- Part of the nation's fourth largest consumer market, supporting over 7.2 million people, 2.6 million households and producing a collective personal income of $215 billion
- Access to one of the most comprehensive and reliable transportation networks in the country - highways, ports and rail
- Overnight access to over 70 million people

General Information

County Seat: Westminster
Land Area: 452 square miles
Elevation: 300 to 1,000 feet above sea level
Government: Five commissioners elected by district for four-year terms

Climate

Yearly Precipitation (inches): 44.0
Yearly Snowfall (inches): 32.7
Summer Temperatures (F): 72.5
Winter Temperatures (F): 33.7
Duration of Freeze-Free Period: 181 days

http://carrollbiz.org/datacenter/index.phpv - accessed October 2017

Carroll County Maryland
ECONOMIC DEVELOPMENT
Right Place, **Right Time**

DATA CENTER - Population

CENSUS	CARROLL COUNTY	BALTIMORE PMSA*	MARYLAND
1990 Census	123,372	2,382,172	4,780,753
2000 Census	150,897	2,552,994	5,296,486
2010 Projection	182,800	2,721,950	5,897,600
2015 Projection	195,000	2,812,800	6,176,075
2020 Projection	206,100	2,863,750	6,386,225
2025 Projection	216,600	2,900,400	6,570,150
2030 Projection	226,700	2,932,100	6,737,750

DATA CENTER - Projected Population by Age Group

AGE GROUP	2010	2015	2020	2025	2030
0 - 4	11,310	12,850	13,650	13,640	13,620
5 - 19	41,570	41,980	43,500	45,950	48,570
20 - 44	56,410	58,890	62,470	67,250	69,180
45 - 64	51,720	54,570	54,630	51,860	50,590
65+	21,790	26,710	31,860	37,910	44,740
Total	178,340	195,000	206,100	216,600	226,700

DATA CENTER - Household Estimates

	2010	2015	2020	2025	2030
Household Population	178,340	190,370	201,290	211,460	221,080
Total Households	64,675	69,900	74,800	79,700	84,600
Avg. Household Size	2.76	2.72	2.69	2.65	2.61
Group Quarters Population	4,460	4,630	4,810	5,140	5,620

Source: MD Dept. of Planning, Planning Data Services November 2007

http://carrollbiz.org/datacenter/index.phpv - accessed October 2017

Carroll County Maryland
ECONOMIC DEVELOPMENT
Right Place, **Right Time**

DATA CENTER - Population & Household Estimates by Election District

MUNICIPALITY/ELECTION DISTRICT	1990	2000C	2010C	2015	2016	APR - 17
Taneytown ED	2,756	2,739	2,710	2,729	2,748	2,751
City of Taneytown	3,842	5,128	6,745	6,985	7,031	7,053
Uniontown ED	3,709	4,188	4,128	4,194	4,205	4,208
Myers ED	4,921	5,385	5,516	5,569	5,581	5,595
Woolerys ED	14,250	16,329	17,487	17,951	18,065	18,104
Freedom ED	15,635	21,866	24,277	25,471	25,688	25,726
Town of Sykesville	2,345	4,197	4,436	4,795	4,811	4,811
Manchester ED	8,168	8,619	9,193	9,319	9,341	9,350
Town of Manchester	2,829	3,329	4,808	5,335	5,370	5,375
Westminster ED	13,770	16,524	18,162	18,685	18,790	18,803
City of Westminster	13,582	16,731	18,590	18,953	18,989	19,020
Hampstead ED	7,867	8,051	8,475	8,570	8,584	8,598
Town of Hampstead	2,756	5,060	6,323	6,364	6,387	6,397
Franklin ED	6,460	7,459	7,372	7,478	7,503	7,523
Middleburg ED	1,348	1,442	1,422	1,442	1,450	1,453
New Windsor ED	2,330	2,349	2,281	2,318	2,326	2,326
Town of New Windsor	757	1,303	1,396	1,409	1,428	1,452
Union Bridge ED	652	530	576	596	599	599
Town of Union Bridge	912	989	975	977	977	977
Mt. Airy ED	3,363	4,084	4,475	4,566	4,580	4,592
Town of Mt. Airy (Total)	3,892	6,425	9,288	9,780	9,786	9,786
Town of Mt. Airy (Carroll)	2,239	2,980	5,503	5,995	6,001	6,004
Berrett ED	11,095	11,615	12,281	12,550	12,674	12,702
County Total*	125,586	150,897	167,134	172,240	173,129	173,419
Total Incorporated**	29,262	39,717	48,759	50,804	50,994	51,089
Total Unincorporated	96,324	111,180	118,375	121,436	122,135	122,330

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Carroll County Maryland
ECONOMIC DEVELOPMENT
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MUNICIPALITY/ELECTION DISTRICT	1990	2000C	2010C	20 15	2016	APR - 17
Taneytown ED	970	1,005	1,117	1,124	1,131	1,132
City of Taneytown	1,357	1,816	2,554	2,649	2,666	2,674
Uniontown ED	1,281	1,481	1,607	1,623	1,627	1,628
Myers ED	1,624	1,911	2,068	2,086	2,090	2,095
Woolerys ED	4,754	5,732	6,443	6,605	6,646	6,660
Freedom ED	5,001	7,319	8,603	9,006	9,080	9,093
Town of Sykesville	858	1,407	1,474	1,607	1,613	1,613
Manchester ED	2,674	2,956	3,377	3,420	3,428	3,431
Town of Manchester	1,008	1,151	1,713	1,885	1,897	1,899
Westminster ED	4,800	5,989	6,834	7,027	7,067	7,072
City of Westminster	5,415	6,476	7,684	7,829	7,844	7,857
Hampstead ED	2,675	2,907	3,157	3,190	3,195	3,200
Town of Hampstead	1,122	1,884	2,500	2,509	2,522	2,526
Franklin ED	2,061	2,482	2,650	2,684	2,693	2,700
Middleburg ED	462	500	545	551	554	555
New Windsor ED	763	814	896	909	912	912
Town of New Windsor	291	503	566	571	578	587
Union Bridge ED	232	198	235	241	243	243
Town of Union Bridge	355	376	429	430	430	430
Mt. Airy ED	1,051	1,462	1,521	1,552	1,557	1,561
Town of Mt. Airy**	793	1,112	2,011	2,171	2,173	2,173
Berrett ED	3,541	4,029	4,422	4,496	4,498	4,499
County Total*	43,088	53,400	62,406	64,165	64,444	64,540
Total Incorporated**	11,199	14,651	18,931	19,651	19,723	19,759
Total Unincorporated	31,889	39,669	43,475	44,514	44,721	44,781

**County totals are end of year figures unless otherwise noted. 2000c & 2010c denote Census figures.*
***Includes Carroll County portion of Mt. Airy only*
Source: Carroll County Department of Planning
Last updated: May 17, 2017

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Carroll County Maryland
ECONOMIC DEVELOPMENT
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DATA CENTER - Age Distribution

Age Sex: 2000 (Census 2000)

		Percent of total population						Males per 100 females	
GEOGRAPHIC AREA	TOTAL POPULATION	UNDER 18	18-24	25-44	45-64	65 +	MEDIAN AGE	ALL AGES	18+
MARYLAND	5,296,486	25.6	8.5	31.4	23.1	11.3	36	93.4	89.8
Allegany	74,930	20.6	11.2	26.8	23.5	17.9	39.1	99.2	96.9
Anne Arundel	489,656	25.2	8.1	32.8	23.9	10	36	99.1	97.1
Baltimore County	754,292	23.6	8.5	29.8	23.4	14.6	37.7	90	86
Calvert	74,563	29.6	6.4	31.7	23.4	8.9	35.9	97.3	94
Caroline	29,772	26.8	7.7	28.9	23.1	13.5	37	95.9	91.7
Carroll	150,897	27.7	7	30.6	23.9	10.8	36.9	97.4	94
Cecil	85,951	27.7	7.5	31.2	23.2	10.5	35.5	98.2	95.7
Charles	120,546	28.7	7.6	33.2	22.7	7.8	34.6	95.5	92.2
Dorchester	30,674	23.3	6.7	26.8	25.5	17.7	40.7	89.8	86.4
Frederick	195,277	27.6	7.4	32.7	22.6	9.6	35.6	96.9	93.9
Garrett	29,846	25.1	7.8	27.6	24.6	14.9	38.3	97.2	93.8
Harford	218,590	27.9	6.8	31.6	23.7	10.0	36.2	96	92.5
Howard	247,842	28.1	6.3	34.4	23.8	7.5	35.5	96.6	92.9
Kent	19,197	20.8	10.9	23.7	25.3	19.3	41.3	91.9	88.9
Montgomery	873,341	25.4	6.9	32.3	24.2	11.2	36.8	92.1	88.1
Prince George's	801,515	26.8	10.4	33	22.1	7.7	33.3	91.5	87.2
Queen Anne's	40,563	25.4	5.8	30.1	25.9	12.9	38.8	99.2	96.8
St. Mary's	86,211	27.9	8.9	32.6	21.5	9.1	34.2	101.8	100.8
Somerset	24,747	18.5	15.7	29.5	22.2	14.2	36.5	114.6	119.1
Talbot	33,812	21.7	5.6	25.2	27.2	20.4	43.3	91.2	87.6
Washington	131,923	23.4	8.1	31.3	23	14.2	37.4	104.5	104
Wicomico	84,644	24.8	11.8	28	22.6	12.8	35.8	91	86.8
Worcester	46,543	20.5	6.2	26.4	26.9	20.1	43	95.2	92.3
Baltimore city	651,154	24.8	10.9	29.9	21.2	13.2	35	87.4	82.9

(X) Not applicable
Source: U.S. Census Bureau, Census 2000 Summary File 1, Matrices PCT12 and P13.

Carroll County Maryland
ECONOMIC DEVELOPMENT
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DATA CENTER – General Housing Characteristics and Ethnic Diversity

SUBJECT	NUMBER	PERCENT
OCCUPANCY STATUS		
Total housing units	54,260	100.0
Occupied housing units	52,503	96.8
Vacant housing units	1,757	3.2
TENURE		
Occupied housing units	52,503	100.0
Owner-occupied housing units	43,048	82.0
Renter-occupied housing units	9,455	18.0
VACANCY STATUS		
Vacant housing units	1,757	100.0
For rent	425	24.2
For sale only	505	28.7
Rented or sold, not occupied	175	10.0
For seasonal, recreational, or occasional use	117	6.7
For migratory workers	3	0.2
Other vacant	532	30.3
RACE OF HOUSEHOLDER		
Occupied housing units	52,503	100.0
One race	52,252	99.5
White	50,713	96.6
Black or African American	1,054	2.0
American Indian and Alaska Native	112	0.2
Asian	270	0.5
Native Hawaiian and Other Pacific Islander	6	0.0
Some other race	97	0.2
Two or more races	251	0.5

(continued)

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Carroll County Maryland
ECONOMIC DEVELOPMENT
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HISPANIC OR LATINO HOUSEHOLDER AND RACE OF HOUSEHOLDER		
Occupied housing units	52,503	100.0
Hispanic or Latino (of any race)	383	0.7
Not Hispanic or Latino	52,120	99.3
White alone	50,459	96.1
AGE OF HOUSEHOLDER		
Occupied housing units	52,503	100.0
15 to 24 years	1,090	2.1
25 to 34 years	7,562	14.4
35 to 44 years	14,398	27.4
45 to 54 years	12,338	23.5
55 to 64 years	7,582	14.4
65 years and over	9,533	18.2
65 to 74 years	5,132	9.8
75 to 84 years	3,433	6.5
85 years and over	968	1.8

NOTE:For information on confidentiality protection, nonsampling error, and definitions, visit the U.S. Census Factfinder Website
(X)= Not applicable
Source: U.S. Census Bureau, Census 2000 Summary File 1

DATA CENTER - Educational Attainment

EDUCATION LEVEL	PERCENT
High School/GED	31.10%
Some College	20.00%
Associate Degree	7.70%
Bachelor's Degree	20.00%
Graduate or Professional Degree	12.70%

Other statistics:

• High School Attainment: 91.5% / Bachelor's Degree or Higher Attainment: 32.7%

• Forty-six percent (46%) of Carroll residents that work outside of the County have a Bachelor's degree or higher as compared to 36% of Carroll residents that work in Carroll County

• Thirty-seven percent (37%) of surveyed Carroll residents hold special licenses or certifications that are required by their occupation

Source: U.S. Census, American Communities Survey 2013

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Carroll County Maryland
ECONOMIC DEVELOPMENT
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Education

Carroll County boasts a wide variety of educational institutions within the county for students of all levels including **public schools**, **private schools**, **career and technology centers**, **Carroll Community College**, and **McDaniel College**. There are also many education institutions that are just an easy commute away.

Carroll County Public Schools

The **Carroll County Public School System** consistently ranks as one of the top-performing school systems in the state of Maryland. Numerous awards, at both the state and national level, have been bestowed upon Carroll's instructional staff and students. The educational programs developed in the Carroll County Public School system are also recognized statewide and nationally for their high standards and innovative approaches.

Carroll County students consistently score above state and national averages on the Scholastic Aptitude Test and other standardized tests. Carroll County also has one of the highest college attendance rates in the State. Today, more than 27,000 students are enrolled in Carroll County Public Schools.

Elementary Schools (22)
• Average Class Size - 20.5

Middle Schools (8)
• Average Class Size - 22.4

High Schools (7)
• Average Class Size - 24.3
48.2% of students enter 4-year colleges
32.4% of students enter 2-year colleges

Career & Technology Centers (2)
• National award-winning teachers, students and programs
• Offers 23 accredited programs
• Students can earn college credit
• 99% student employment rate
• 98% employer satisfaction rate

Average SAT Scores *(from 2012)*
• Carroll County 1549
• Maryland 1487
• Nation 1498

Student attendance rate - 96%

Student dropout rate - 1%

(Education, continued)

Carroll County Career & Technology Centers

Carroll County Public School's award-winning career and technology educational programs are among the best in the state. The purpose of the programs is to meet the challenge of continuing to supply employers with skilled, productive and independent workers. Programs of study include drafting, computer technology, machine technology, electrical construction, engineering, nursing, and business training are offered at the two career and technology centers and the eight comprehensive high schools.

Carroll Community College

Over the past five years, total enrollment in degree-credit and continuing education courses at Carroll Community College has been increasing at twice the rate of Maryland community colleges statewide. Official state forecasts suggest Carroll's enrollment will grow another 38 percent by 2016.

Over 13,000 individuals take a class at Carroll Community College each year.

Carroll Community College enrolls more Carroll County residents than any other college or university. Half of Carroll County residents starting college in Maryland as full-time students start at Carroll; 70 percent of all County residents attending college part-time attend Carroll.

Carroll Community College offers five transfer programs and eleven career programs. Within the Arts and Sciences program, the college has identified 12 transfer patterns preparing students for baccalaureate study in fields such as Criminal Justice, Music, Psychology, and Theater. With proper advising and planning, students may begin any baccalaureate degree at Carroll.

Programs producing the most graduates in recent years are Arts and Sciences, General Studies, Business Administration, Nursing, and Physical Therapist Assistant.

Carroll consistently has one of the highest transfer rates among community colleges in the state. During the past five years, Carroll students transferred to over 300 different colleges and universities.

The college's Office of Continuing Education and Training designs custom training programs to meet the needs of a specific business or industry. Classes are held at the company site or at the college's **Hikel Business Training Center**. The Center is equipped with computer labs, seminar rooms, teleconference center, interactive video training room and lab space for technical training.

McDaniel College

A private four-year liberal arts and sciences college founded as Western Maryland College in 1867. This prestigious college offers bachelor and graduate study programs including preparatory programs in engineering and the health professions. Centrally located in Westminster on a 160-acre campus, the college has recently completed construction on new academic buildings, lifestyle centers and residence halls.

McDaniel was one of only 40 colleges recognized in the book, "Colleges That Change Lives". The college also sponsors sports, theater, lectures, workshops and other special community events.

(Education, continued)

Private Schools

Carroll Christian Schools

- Preschool through high school
- Before- and after-school care
- Bus Service (limited)
- American Association of Christian Schools
- Maryland Association of Christian Schools

Carroll Lutheran School

- Kindergarten through 8th grade
- Before- and after-school care
- Christian based education
- Accredited

Gerstell Academy

- Kindergarten through 12th grade (eventually)
- College preparatory focusing on leadership, moral & ethical decision-making
- An independent, co-educational, non-sectarian school

Faith Christian School

- Pre-school through 12th grade
- Bible-centered curriculum
- Before- and after-school care

Montessori School of Westminster

- Pre-school through 9th grade
- All day kindergarten
- Before- and after-school care
- AIMS Accredited
- Private, Montessori-based, co-educational, non-secular

North Carroll Community School

- Kindergarten through 8th grade
- All day kindergarten
- A co-educational, multi-age program with an emphasis on character, values and in-depth learning

St. John's Catholic School

- Kindergarten through 8th grade
- Before- and after-school care
- Bus transportation available (Limited)
- Strong, formalized computer education program
- Accredited, Middle States Association of Colleges and Schools Commission on Elementary Schools

(Education, continued)

Other Private School Options

The following Baltimore-based private schools serve a special segment of the educational needs for some Carroll County families.

- St. Paul's School
- St. Paul's School for Girls
- McDonogh School
- Garrision Forest School

An Easy Commute

World class institutions within a 50-mile/one hour commute include the University of Maryland, Johns Hopkins University, Hood College, Loyola College, Mount St. Mary's, University of Baltimore, Towson University, Georgetown University and American University are the academic homes to many local residents. Both undergraduate and graduate degree programs are offered in virtually any field including the sciences, humanities, engineering, arts, law and medicine.

- American University
- Baltimore Hebrew University
- Bowie State University
- College of Notre Dame of Maryland
- Coppin State
- Georgetown University
- Gettysburg College
- Goucher College
- Hood College
- Howard University
- Johns Hopkins University
- Loyola College
- Maryland Institute of Art
- Morgan State University
- Mount Saint Mary's College
- St. John's College
- Stevenson University
- Towson University
- United States Naval Academy
- University of Baltimore
- University of Maryland at Baltimore
- University of Maryland, Baltimore County
- University of Maryland at College Park
- York College

Carroll County Maryland
ECONOMIC DEVELOPMENT
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DATA CENTER - Employment and Unemployment in Carroll County, MD

2017 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	93,996	94,547	95,372	95,099	94,508	96,016	97,154	95,741					95,305
Emp.	90,446	90,933	92,000	92,225	91,496	92,655	93.665	92,542					91,995
UnEmp.	3,550	3,614	3,372	2,874	3,012	3,364	3,489	3,199					3,309
Rate	3.8	3.8	3.5	3.0	3.2	3.5	3.6	3.3					3.5

2016 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	92,826	93,322	94,027	94,086	93,875	95,308	95,681	94,436	93,884	94,926	94,319	94,744	94,286
Emp.	89,019	89,418	90,327	90,830	90,717	91,716	91,947	90,888	90,793	91,670	91,332	91,954	90,884
UnEmp.	3,807	3,904	3,700	3,256	3,158	3,592	3,734	3,548	3,091	3,256	2,987	2,790	3,402
Rate	4.1	4.2	3.9	3.5	3.4	3.8	3.9	3.8	3.3	3.4	3.2	2.9	3.6

2015 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	91,979	92,552	92,711	92,996	93,888	95,532	95,937	94,777	94,117	95,176	94,528	94,383	94,048
Emp.	87,236	88,062	88,304	89,221	89,736	90,936	91,498	90,700	90,230	91,111	90,664	90,970	89,889
UnEmp.	4,743	4,490	4,407	3,775	4,152	4,596	4,439	4,077	3,887	4,065	3,864	3,413	4,159
Rate	5.2	4.9	4.8	4.1	4.4	4.8	4.6	4.3	4.1	4.3	4.1	3.6	4.4

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2014 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	93,865	93,910	94,359	94,090	94,579	95,093	95,714	94,880	94,011	94,270	94,121	93,853	94,395
Emp.	88,654	88,745	89,330	89,835	89,957	90,001	90,153	89,399	89,729	90,055	90,019	89,998	89,635
UnEmp.	5,211	5,165	5,142	4,255	4,504	5,092	5,561	5,481	4,282	4,215	4,102	4,226	4,760
Rate	5.6	5.5	5.3	4.5	4.8	5.4	5.8	5.8	4.6	4.5	4.4	4.5	5.0

2013 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	95,941	96,013	96,086	95,589	95,708	96,548	96,356	95,303	95,600	95,260	95,776	95,046	95,769
Emp.	89,554	89,877	90,269	90,395	90,169	90,336	90,356	89,709	90,659	90,190	90,828	90,322	90,222
UnEmp.	6,387	6,136	5,817	5,194	5,539	6,212	6,000	5,594	4,941	5,070	4,948	4,724	5,547
Rate	6.7	6.4	6.1	5.4	5.8	6.4	6.2	5.9	5.2	5.3	5.2	5.0	5.8

2012 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	93,593	94,296	94,439	93,567	93,534	94,532	95,341	94,161	93,988	95,544	95,143	95,250	94,449
Emp.	87,514	87,909	88,543	88,182	87,984	88,293	89,086	87,995	88,493	90,140	89,683	89,558	88,615
UnEmp.	6,079	6,387	5,896	5,385	5,550	6,239	6,255	6,166	5,495	5,404	5,460	5,692	5,834
Rate	6.5	6.8	6.2	5.8	5.9	6.6	6.6	6.5	5.8	5.7	5.7	6.0	6.2

2011 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	92,412	92,233	93,197	92,595	93,009	94,046	94,681	93,864	93,508	94,180	93,850	93,738	93,443
Emp.	86,042	85,887	87,190	87,241	87,499	88,000	88,332	87,584	87,723	88,718	88,747	88,449	87,618
UnEmp.	6,370	6,346	6,007	5,354	Â 5,510	6,046	6,349	6,280	5,785	5,462	5,103	5,289	5,825
Rate	6.8	6.9	6.4	5.8	5.9	6.4	6.7	6.7	6.2	5.8	5.4	5.6	6.2

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Carroll County Maryland
ECONOMIC DEVELOPMENT
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2010 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	93,049	92,574	93,119	92,644	93,128	93,265	93,903	93,449	92,781	93,162	93,141	92,778	93,083
Emp.	85,683	85,080	86,309	86,966	87,306	87,227	87,510	87,108	87,020	87,685	87,303	87,277	86,873
UnEmp.	7,366	7,494	6,810	5,678	5,679	6,038	6,393	6,341	5,761	5,477	5,838	5,501	6,210
Rate	7.9	8.1	7.3	6.1	6.3	6.5	6.8	6.8	6.2	5.9	6.3	5.9	6.7

2009 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	94,091	93,331	93,203	92,622	92,861	93,902	94,311	92,889	91,735	92,249	91,193	91,763	92,930
Emp.	87,757	86,588	86,865	87,123	86,854	87,636	88,031	87,141	86,187	86,289	86,371	85,841	86,890
UnEmp.	6,334	6,743	6,338	5,499	6,007	6,266	6,280	5,758	5,548	5,960	5,822	5,922	6,040
Rate	6.7	7.2	6.8	5.9	6.5	6.7	6.7	6.2	6.0	6.5	6.3	6.5	6.5

2008 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	95,016	95,172	95,572	95,327	96,208	96,754	97,719	96,199	94,889	95,650	95,315	94,901	95,727
Emp.	91,847	91,862	92,476	92,586	93,125	93,355	93,874	92,597	91,527	91,769	90,979	90,173	92,181
UnEmp.	3,169	3,310	3,096	2,741	3,083	3,399	3,845	3,602	3,362	3,881	4,336	4,728	3,546
Rate	3.3	3.5	3.2	2.9	3.2	3.5	3.9	3.7	3.5	4.1	4.5	5.0	3.7

2007 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	95,182	94,296	94,737	93,801	94,072	94,676	96,120	94,237	94,239	94,973	95,207	94,772	94,693
Emp.	91,584	90,753	91,742	91,217	91,451	92,479	92,514	91,211	91,515	92,074	92,560	92,059	91,763
UnEmp.	3,598	3,543	2,995	2,584	2,621	3,197	3,606	3,026	2,724	2,899	2,647	2,713	2,929
Rate	3.8	3.8	3.2	2.8	2.8	3.4	3.8	3.2	2.9	3.1	2.8	2.9	3.1

http://carrollbiz.org/datacenter/index.phpv - accessed October 2017

Carroll County Maryland
ECONOMIC DEVELOPMENT
Right Place, **Right Time**

2006 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	91,890	92,075	92,356	92,689	92,973	93,907	95,113	93,908	93,298	94,305	94,410	94,448	93,445
Emp.	88,938	89,281	89,787	90,351	90,427	90,811	91,549	90,740	90,641	91,669	91,589	91,848	90,636
UnEmp.	2,952	2,794	2,569	2,338	2,546	3,096	3,564	3,168	2,657	2,636	2,821	2,581	2,810
Rate	3.2	3.0	2.8	2.5	2.7	3.3	3.7	3.4	2.8	2.8	3.0	2.7	3.0

2005 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	87,931	88,180	88,672	89,380	90,501	91,247	91,828	91,290	90,189	90,868	90,658	90,928	90,139
Emp.	84,757	84,808	85,392	86,763	87,829	88,077	88,456	88,079	87,690	88,400	87,862	88,528	87,220
UnEmp.	3,174	3,372	3,280	2,617	2,672	3,170	3,372	3,211	2,499	2,468	2,796	2,400	2,919
Rate	3.6	3.8	3.7	2.9	3.0	3.5	3.7	3.5	2.8	2.7	3.1	2.6	3.2

2004 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	85,517	85,652	85,269	85,230	85,569	86,669	87,782	86,827	85,748	85,688	85,935	85,935	85,906
Emp.	82,479	82,112	82,572	83,082	83,438	85,668	84,882	84,047	83,622	83,594	83,852	82,965	83,526
UnEmp.	3,298	3,540	2,697	2,148	2,124	2,442	2,900	2,780	2,126	2,094	2,083	2,020	2,521
Rate	3.9	4.1	3.2	2.5	2.5	2.8	3.3	3.2	2.5	2.4	2.4	2.4	2.9

2003 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	84,623	84,781	85,052	84,707	85,022	85,815	86,954	85,537	84,362	84,677	84,404	84,085	85,002
Emp.	81,319	81,420	81,845	82,163	82,597	83,170	83,893	82,926	82,042	82,373	81,999	81,552	82,275
UnEmp.	3,304	3,361	3,207	2,544	2,425	2,645	3,061	2,611	2,320	2,304	2,405	2,533	2,727
Rate	3.9	4.0	3.8	3.0	2.9	3.1	3.5	3.1	2.8	2.7	2.8	3.0	3.2

http://carrollbiz.org/datacenter/index.phpv - accessed October 2017

Carroll County Maryland
ECONOMIC DEVELOPMENT
Right Place, **Right Time**

2002 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	83,006	83,474	83,708	83,015	83,512	85,140	85,724	85,222	83,940	84,238	83,858	83,047	83,990
Emp.	79,875	80,182	80,885	80,651	81,122	82,375	82,882	82,469	81,610	81,770	81,435	80,753	81,334
UnEmp.	3,131	3,292	2,823	2,364	2,390	2,765	2,842	2,753	2,330	2,468	2,423	2,294	2,656
Rate	3.8	3.9	3.4	2.8	2.9	3.2	3.3	3.2	2.8	2.9	2.9	2.8	3.2

2001 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	83,419	83,544	83,283	82,844	83,300	85,048	85,901	84,767	84,754	84,804	84,933	84,574	84,264
Emp.	80,539	80,734	81,148	81,104	81,399	82,666	83,308	82,471	82,272	82,613	82,595	82,309	81,930
UnEmp.	2,880	2,810	2,135	1,740	1,901	2,382	2,593	2,296	2,482	2,191	2,338	2,265	2,334
Rate	3.5	3.4	2.6	2.1	2.3	2.8	3.0	2.7	2.9	2.6	2.8	2.7	2.8

2000 Civilian Labor Force Employment and Unemployment - Carroll County, MD

ITEM	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	ANN AVG.
Labor Force	82,572	82,896	82,659	82,230	82,699	84,436	84,714	83,517	83,470	83,721	83,568	83,354	83,320
Emp.	79,868	79,680	80,345	80,342	80,656	81,797	82,073	81,099	81,287	81,639	81,657	81,627	81,006
UnEmp.	2,704	3,216	2,314	1,888	2,043	2,639	2,641	2,418	2,183	2,082	1,911	1,727	2,314
Rate	3.3	3.9	2.8	2.3	2.5	3.1	3.1	2.9	2.6	2.5	2.3	2.1	2.8

Source: Maryland Department of Labor, Licensing and Regulation
Note: These data are not seasonally adjusted. They are estimates relating to the week of the 12th of each month. the count is of persons by place of residence.

Last updated: September 27, 2017

Carroll County Maryland
ECONOMIC DEVELOPMENT
Right Place, Right Time

DATA CENTER - Labor Force Summary

Carroll County Business Composition - Annual Average 2015

SECTOR	# OF FIRMS	% OF TOTAL	# OF EMPLOYEES	% OF TOTAL	AVERAGE WAGE*
Total Employment	4,557	100.0%	56,765	100.0%	795
Public Employment	96	2.1%	8,205	14.5%	865
Federal Government	20	0.4%	287	0.5%	1,148
State Government	11	0.2%	1,296	2.3%	963
Local Government	65	1.4%	6,622	11.7%	834
Private Employment	4,461	97.9%	48,560	85.5%	783
Construction	827	18.1%	5,498	9.7%	983
Manufacturing	131	2.9%	3,792	6.7%	1,157
Natural Resources and Mining	50	1.1%	428	0.8%	682
Trade, Transportation & Utilities	881	19.3%	11,760	20.7%	652
Information	40	0.9%	326	0.6%	870
Financial Activities	333	7.3%	1,355	2.4%	1,236
Professional & Business Services	934	20.5%	6,614	11.7%	1,082
Education and Health Services	503	11.0%	9,792	17.3%	797
Leisure and Hospitality	340	7.5%	6,779	11.9%	288
Other Services / UNCLASSIFIED	420	9.2%	2,216	3.9%	622

Note: percentages may not total 100 due to rounding
Data is for employers covered by Unemployment Insurance
** Average Weekly Wage Per Worker*
Source: MD Department of Labor, Licensing and Regulation
Last Updated: June 22, 2016

http://carrollbiz.org/datacenter/index.phpv - accessed October 2017

Carroll County Maryland
ECONOMIC DEVELOPMENT
Right Place, **Right Time**

DATA CENTER - Labor Force

Civilian Total Labor Force 2008-2013

CARROLL COUNTY	2008	2009	2010	2011	2012	2013
Labor Force	95,727	92,930	93,083	93,443	94,449	95,769

Source: Maryland Department of Labor, Licensing and Regulation

Jobs by Place of Work 1990-2020

TYPE OF WORK	1990	1995	2000	2005	2010	2020
Total Jobs (1,000)	52.5	57.4	68.3	73.5	76.8	80.6
Farm	1.8	1.6	1.5	1.4	1.3	1.2
Ag, Serv., Forest, Fish, Other	1.1	1.4	1.7	1.8	1.9	2.0
Mining	(L)	(L)	(L)	(L)	(L)	(L)
Construction	7.2	7.2	8.7	9.3	9.6	9.9
Manufacturing	6.6	6	6.2	6.2	6.1	6.0
Transportation & Public Utilities	1.6	1.7	2.2	2.3	2.4	2.5
Wholesale Trade	3	3.4	3.3	3.5	3.6	3.8
Retail Trade	9	10.9	12.7	13.4	13.8	14.6
Finance, Insurance & Real Estate	3.2	3.4	4.8	5.3	5.6	6.1
Services	13.2	15.5	19.7	22.5	24.7	26.4
Government	6.2	6.8	7.5	7.8	7.8	8.1

(L) = Less than 50 jobs
Source: Maryland Office of Planning, Planning Data Services

Labor Availability

CARROLL COUNTY CIVILIAN LABOR FORCE (2013 ANNUAL AVERAGES)*	
Total Civilian Labor Force	95,769
Employment	90,222
Unemployment	5,547
Unemployment Rate	5.8%
Residents commuting outside the County to work (2005)	58%

** By place of residence.*
Sources: Maryland Department of Labor, Licensing and Regulation, Office of Labor Market Analysis and Information: Maryland Department of Planning in conjunction with U.S. Bureau of the Census

http://carrollbiz.org/datacenter/index.phpv - accessed October 2017

Carroll County Maryland
ECONOMIC DEVELOPMENT
Right Place, Right Time

DATA CENTER - Major Employers

COMPANY NAME	PRODUCT/SERVICE TYPE
Carroll County Public Schools	Education (K-12)
Carroll Hospital Center	Health Care
Springfield Hospital Center	Mental Health Services
Penguin Random House	Book Warehousing & Distribution
Integrace - Fairhaven	Retirement / Assisted Living
McDaniel College	Higher Education (Private)
Carroll County Commissioners	Local Government
Carroll Community College	Higher Education (Public)
EVAPCO	Cooling Equipment Manufacturer
Carroll Lutheran Village	Retirement / Assisted Living
Northrop Grumman	Electronic Manufacturing/Testing
English American Tailoring	Clothing Manufacturer
C.J. Miller, LLC	Paving & Excavating Contractor
Arc of Carroll County	Non-Profit / Health Care
Flowserve Corporation	Industrial Pumping Equipment
Knorr Brake	Railroad Brake Manufacturer
S.H. Tevis / Modern Comfort	Oil / Fuel, Heating & AC
PFG/Carroll County Foods	Wholesale / Distribution
BB&T	Banking Services
Long View Nursing Home	Nursing / Assisted Living
Lehigh Cement	Portland Cement Manufacturer
Lorien - Mt. Airy	Nursing / Assisted Living
Dart Container / Solo Cup Corp	Warehousing & distribution
Black & Decker	Warehousing & distribution
GSE Systems, Inc	Technology Engineering
Finch Services, Inc	Agriculture Equipment
General Dynamics Robotic Systems	Technology Manufacturing
Taney Corporation	Wood Products Manufacturer

Selected Employers with workforce of 100 or more.
Last Updated: Nov. 01, 2016

http://carrollbiz.org/datacenter/index.phpv - accessed October 2017

Carroll County Maryland
ECONOMIC DEVELOPMENT
Right Place, **Right Time**

DATA CENTER - Average Wage & Salary

Mid-Maryland Hourly Wage Rates* 2016

SELECTED OCCUPATIONS	MEAN	MEDIAN
Accountants	38.08	34.83
Bookkeeping/accounting clerks	22.06	21.30
Brick / Block Masons	22.94	22.49
Computer systems analysts	51.14	46.88
Customer service representatives	19.69	18.52
Electrical engineers	45.88	42.85
Equipment Operators, Construction	23.68	23.62
Freight,stock and material movers, hand	15.25	14.46
Healthcare Support Workers	16.91	14.26
Industrial truck operators	20.00	19.38
Landscaping/Groundskeeper Workers	14.09	13.97
Machinists	26.06	25.65
Maintenance workers, machinery	19.57	19.13
Network administrators	54.94	50.08
Paralegals & Legal Assistants	24.98	24.78
Police/Sheriff's Patrol Officers	29.97	28.77
Registered Nurses	35.75	35.44
Teachers & Instructors	26.16	23.73

For a more comprehensive list, visit the MD DLLR Ocupational Wage Estimates page.

Note: These wages are an estimate of what workers might expect to receive in the Mid-Maryland region (Carroll and Howard Counties). Wages may vary by industry, employer and locality.

Source: Maryland Department of Labor, Licensing and Regulation, Office of Labor Market Analysis and Information. Updated: April 2017

Carroll County Maryland
ECONOMIC DEVELOPMENT
Right Place, **Right Time**

DATA CENTER - Median Household Income

Household Income 1990 - 2013

HOUSEHOLDS IN	1990	1995	2000	2011	2013
INCOME FOR	1989	1994	1999	2010	2012
Under $10,000	2.7	1.9	1.2	3.9	2.8
$ 10,000 - 14,999	2.2	1.6	1.0	1.5	2.4
$15,000 - 24,999	4.9	3.7	2.7	7.4	6.5
$25,000 - 34,999	6.1	4.3	2.9	5.6	6.5
$35,000 - 49,999	10.1	8.2	5.6	9.7	9.8
$50,000 - 74,999	10.6	13.5	15.5	17	15.5
$75,000 - 99,999	5.7	13.8	22.8	15.1	15.1
$100,000 - 149,999	*	*	*	23.5	22.3
$150,000 - 199,999	*	*	*	10.3	11.6
$200,000 or more	*	*	*	6.8	7.6
Median Income	$42,378	$55,548	$70,304	$84,117	$84,790
Mean Income	$46,595	$61,319	$81,094	$95,240	$99,179

Source: U.S. Census, 2013 American Community Survey
** = Prior to 2011 top listed earnings backet was "$75,000 or more"*

DATA CENTER - Effective Buying Income

2000 - Percent Households

DISTRIBUTION	CARROLL COUNTY	MARYLAND	U.S.
Under $25,000	18.6	22.3	31.6
$25,000 - $49,999	30.9	29.5	30.2
$50,000 - $74,999	30.5	25.0	20.5
$75,000 and over	20.0	23.2	17.7
Median Household	$50,364	$48,421	$39,130
Average Household	$54,257	$56,244	$49,252
Per Capita	$19,079	$20,844	$18,426
Total Effective Buying Income (Millions)	$2,919	$111,206	$5,230,825

Note: Effective Buying Income is money income less personal tax and nontax payments. It is commonly known as "disposable income." Percentages may not add up due to rounding.

http://carrollbiz.org/datacenter/index.phpv - accessed October 2017

Carroll County Maryland
ECONOMIC DEVELOPMENT
Right Place, **Right Time**

DATA CENTER - Per Capita Income

Per Capita Income 1990-2030*

1990	2000	2005	2010	2015	2020	2025	2030
$26,866	**$32,371**	**$33,044**	**$37,017**	**$40,749**	**$42,608**	**$44,120**	**$45,779**

**** Constant 2000 Dollars***
Source: MD Dept. of Planning, Planning Data Services November 2007; U.S. Bureau of Economic Analysis (BEA)

DATA CENTER - Cost of Living Index (COLI)

March 2016

Carroll County: 106.7

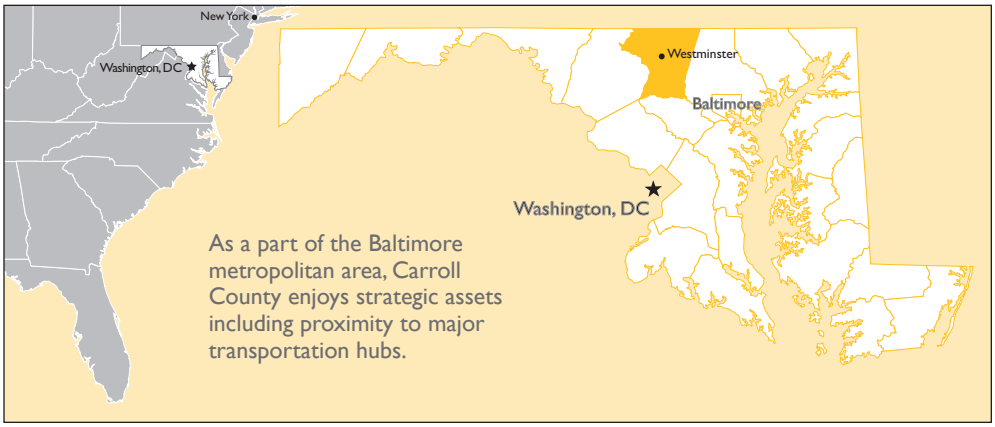
National Average: 100.0

Source: www.city-data.com

Brief Economic Facts

CARROLL COUNTY, MARYLAND

Carroll County's central location in the state attracts a diversity of business interests. The business composition in the county includes a significant number of firms in manufacturing, transportation, and health and business service sectors. Agriculture remains a viable industry with an emphasis on nurturing bioscience and other emerging enterprises.



As a part of the Baltimore metropolitan area, Carroll County enjoys strategic assets such as proximity to major transportation hubs including the Port of Baltimore and Baltimore/Washington International Thurgood Marshall Airport. The Carroll County Regional Airport, a full-service airport boasting corporate hangars and a 5,100 foot runway, supports corporate and smaller commercial aircraft operations.

Carroll County's 4,490 businesses employ 49,600 workers, and over 65 of these businesses have 100 or more workers.

Major manufacturing and distribution firms in the county include Northrop Grumman, Penguin Random House, Flowserve, EVAPCO and Ridge Engineering. Recent expansions or relocations to the county include Strouse Corporation, Fuchs North America, FR Conversions and Advanced Thermal Batteries.

LOCATION

Driving distance from Westminster:	Miles	Kilometers
Atlanta, Georgia	663	1,066
Baltimore, Maryland	31	50
Boston, Massachusetts	417	672
Chicago, Illinois	656	1,056
New York, New York	207	332
Philadelphia, Pennsylvania	116	186
Pittsburgh, Pennsylvania	193	310
Richmond, Virginia	155	249
Washington, DC	51	82

CLIMATE AND GEOGRAPHY[1]

Yearly Precipitation (inches)	44.0
Yearly Snowfall (inches)	26.0
Summer Temperature (°F)	72.5
Winter Temperature (°F)	33.1
Days Below Freezing	107.7
Land Area (square miles)	452.0
Water Area (square miles)	0.5
Elevation (feet)	260 to 1,120

POPULATION[2,3]

	Carroll County Households	Carroll County Population	Baltimore Metro*	Maryland
2000	52,503	150,897	2,552,994	5,296,486
2010	59,786	167,134	2,710,489	5,773,552
2020**	65,025	175,900	2,881,500	6,224,550

*Baltimore City, Anne Arundel, Baltimore, Carroll, Harford, Howard and Queen Anne's counties

**Projections

Selected places population (2010): Eldersburg 30,531; Westminster 18,590; Taneytown 6,728; Hampstead 6,323; Mount Airy 5,503; Manchester 4,808; Sykesville 4,436

POPULATION DISTRIBUTION[2,3] (2016)

Age	Number	Percent
Under 5	8,620	5.1
5 - 19	32,276	19.3
20 - 44	47,632	28.4
45 - 64	51,892	31.0
65 and over	27,236	16.2
Total	167,656	100.0
Median age		42.7 years

Brief Economic Facts // CARROLL COUNTY, MARYLAND

LABOR AVAILABILITY[3,4,5] (BY PLACE OF RESIDENCE)

Civilian Labor Force (2016 avg.)	County	Labor Mkt. Area*
Total civilian labor force	93,859	907,364
Employment	90,567	868,113
Unemployment	3,292	39,251
Unemployment rate	3.5%	4.3%
Residents commuting outside the county to work (2011-2015)	Number 47,185	Percent 54.5%
Employment in selected occupations (2011-2015)		
Management, business, science and arts	37,890	43.0%
Service	14,148	16.0%
Sales and office	20,078	22.8%
Production, transp. and material moving	6,884	7.8%

* Carroll, Baltimore and Frederick counties, MD and York County, PA

MAJOR EMPLOYERS[6,7] (2016)

Employer	Product/Service	Employment
Carroll Hospital Center	Medical services	1,995
McDaniel College	Higher education	800
Penguin Random House	Book warehousing and distribution	755
Integrace	Nursing care	700
Carroll Community College	Higher education	660
EVAPCO	Cooling equipment	440
Carroll Lutheran Village	Nursing care	425
English American Tailoring	Men's clothing	425
Northrop Grumman	Industrial equipment	425
C.J. Miller	General contractor	335
Arc of Carroll County	Medical and social services	325
Jos. A. Bank Clothiers	HQ / men's clothing	320
Flowserve	Industrial pumping equipment	265
Knorr Brake	Railroad brakes	265
Tevis Energy	Oil and related products	260
Spectrum Support	Services for the disabled	250
PFG-Carroll County Foods	Food products distribution	210
M.T. Laney	Grading, paving services	200
Lehigh Cement	Cement	160
Fuchs North America	Spices and extracts	150

Excludes post offices, state and local governments, national retail and national foodservice; includes higher education

EMPLOYMENT[4] (2016, BY PLACE OF WORK)

Industry	Estab-lishments	Annual Avg. Empl.	Emp. %	Avg. Wkly. Wage
Federal government	19	299	0.5	$1,089
State government	11	1,239	2.1	975
Local government	65	6,611	11.4	831
Private sector	4,485	49,634	85.9	794
Natural resources and mining	49	433	0.7	695
Construction	842	5,964	10.3	1,006
Manufacturing	130	3,751	6.5	1,172
Trade, transportation and utilities	869	11,926	20.6	642
Information	44	272	0.5	1,036
Financial activities	348	1,547	2.7	1,290
Professional and business services	929	6,873	11.9	1,100
Education and health services	497	9,806	17.0	792
Leisure and hospitality	340	6,815	11.8	296
Other services	436	2,247	3.9	634
Total	4,580	57,783	100.0	804

Includes civilian employment only

HOURLY WAGE RATES[4] (2016)

Selected Occupations	Median	Entry	Experienced
Accountants	$34.83	$24.56	$44.78
Bookkeeping/accounting clerks	21.30	15.23	25.48
Computer systems analysts	46.88	29.21	62.10
Computer user support specialists	26.40	19.50	31.65
Customer service representatives	18.52	12.78	23.15
Electrical engineers	42.85	32.78	52.43
Electronics engineering technicians	25.06	17.99	32.59
Freight, stock and material movers, hand	14.46	10.07	17.84
Industrial truck operators	19.38	13.91	23.04
Inspectors, testers, sorters	22.75	14.32	28.29
Machinists	25.65	20.61	28.79
Network administrators	50.85	35.80	64.50
Packaging and filling machine operators	14.97	12.12	21.73
Secretaries	17.74	11.68	21.77
Shipping/receiving clerks	16.12	11.93	19.48
Team assemblers	11.37	9.12	14.64
Telemarketers	14.12	9.76	20.31

Wages are an estimate of what workers might expect to receive in Carroll and Howard counties and may vary by industry, employer and locality

Brief Economic Facts // CARROLL COUNTY, MARYLAND

SCHOOLS AND COLLEGES[3,8]

Educational Attainment - age 25 & over (2011-2015)

High school graduate or higher	92.1%
Bachelor's degree or higher	33.1%

Public Schools

- Number: 22 elementary; 8 middle/combined; 7 high
- Enrollment: 25,255 (Sept. 2016)
- Cost per pupil: $13,253 (2014-2015)
- Students per teacher: 14.2 (Oct. 2016)
- High school career / tech enrollment: 3,174 (2016)
- High school graduates: 2,184 (July 2016)

Nonpublic Schools

- Number: 28 (Sept. 2016)

Higher Education (2016)	Enrollment	Degrees
2-year institution		
Carroll Community College	3,362	614
4-year institution		
McDaniel College	2,903	731

TAX RATES[9]

	Carroll Co.	Maryland
Corporate Income Tax (2017)	none	8.25%
Base – federal taxable income		
Personal Income Tax (2017)	3.03%	2.0%-5.75%*
Base – federal adjusted gross income *Graduated rate peaking at 5.75% on taxable income over $300,000		
Sales & Use Tax (2017)	none	6.0%
Exempt – sales for resale; manufacturer's purchase of raw materials; manufacturing machinery and equipment; purchases of materials and equipment used in R&D and testing of finished products; purchases of computer programs for reproduction or incorporation into another computer program for resale		
Real Property Tax (FY 18)	$1.018	$0.112
Effective rate per $100 of assessed value In an incorporated area, a municipal rate will also apply		
Business Personal Property Tax (FY 18)	$2.515	none
Rate per $100 of depreciated value Exempt – manufacturing and R&D machinery, equipment, materials and supplies; manufacturing, R&D and warehousing inventory In an incorporated area, a municipal rate will also apply; municipal exemptions may be available		

Major Tax Credits Available

Job Creation, More Jobs for Marylanders, R&D, Biotechnology and Cybersecurity Investment, New Jobs, Gateway Improvement Program

INCOME[3] (2011-2015)

Distribution	Percent Households Carroll Co.	Maryland	U.S.
Under $25,000	11.7	15.3	23.0
$25,000 - $49,999	16.3	17.9	23.5
$50,000 - $74,999	15.2	17.1	17.8
$75,000 - $99,999	15.1	13.4	12.1
$100,000 - $149,999	21.9	18.2	13.1
$150,000 - $199,999	12.0	9.0	5.1
$200,000 and over	7.8	9.2	5.3
Median household	$85,385	$74,551	$53,889
Average household	$101,314	$97,801	$75,558
Per capita	$36,936	$36,897	$28,930
Total income (millions)	$6,079	$211,875	$8,834,710

HOUSING[2,3,10]

Occupied Units (2011-2015) 60,004 (82.0% owner occupied)

Housing Transactions	Units	Median Selling Price
All arms-length transactions (2015)	2,037	$305,000
All multiple-listed properties (2016)*	2,510	$291,161

*Excludes auctions and FSBO

BUSINESS AND INDUSTRIAL PROPERTY[6]

Carroll County has a variety of industrial sites ranging from one to 100+ acres. Most industrial properties are located in or near incorporated towns with infrastructure in place. Both finished and unfinished parcels are available.

The **Westminster Technology Park** offers state-of-the-art technology infrastructure with high visibility on MD 97 and easy access to the Carroll County Regional Airport. Finished lots, ranging from 2 to 8 acres, are available for sale.

Also in Westminster, build-to-suits are available at the **Carroll County Commerce Center**, with 300,000 sf at build out.

The **Warfield Corporate Center**, a redevelopment project in Sykesville, consists of 12 existing buildings totaling over 158,000 sf. The historic buildings are eligible for state and federal tax credits. Buildings are for lease and several pad sites are also available for development ranging in size from one to 12 acres.

Market Profile Data (2016)	Low	High	Average
Land – cost per acre			
Industrial / Office	$30,000	$250,000	$175,000
Rental Rates – per square foot			
Warehouse / Industrial	$3.00	$7.00	$5.00
Flex / R&D / Technology	$7.50	$9.50	$8.50
Class A Office	$12.00	$22.50	$14.00

Brief Economic Facts // CARROLL COUNTY, MARYLAND

TRANSPORTATION

Highways: I-70, MD 97 and MD 140; county arteries connect to I-695, I-795 and U.S. 15

Rail: CSX Transportation; Maryland Midland Railway, Inc. (short line service)

Truck: 72 local and long-distance trucking establishments are located in the county

Water: Port of Baltimore, 50' channel; a leading U.S. automobile and break-bulk port; seven public terminals including the state-of-the-art Intermodal Container Transfer Facility; one of only four ports on the East Coast able to accommodate super post-Panamax ships

Air: Served by Baltimore/Washington International Thurgood Marshall Airport (BWI); served locally by the Carroll County Regional Airport offering charter and air taxi services, 5100' runway, with seven corporate hangars on site

RECREATION AND CULTURE

Parks and Recreation: Multiple parks and facilities provide an array of leisure activities; outdoor enthusiasts will enjoy a variety of equestrian, hiking, cycling and cross country ski trails as well as sailing, tennis, fishing, hunting, swimming and picnicking; 11 recreation councils offer many recreational programs for all ages including baseball, soccer, lacrosse, football, basketball, martial arts, crafts and dance

Sports: Carroll County Sports Complex hosts regional and national competitive softball tournaments

Golf: Six golf courses challenge golfers in beautiful settings

Cultural: Antique shops, gift boutiques, historical sites, bookstores, art galleries and local wineries

Attractions: Hashawha Environmental Center offers environmental education and conservation programs; Carroll County Farm Museum presents rural life as it was in the past and serves as home to many special exhibits and events

Events: The Maryland Wine Festival, Westminster Flower & Jazz Mart, Corbit's Charge Commemoration: Battle of Westminster, Surf & Turf Summertime Fun Festival, Old-Fashioned Corn Roast, Civil War Living History Reenactment, Fourth of July Celebration, Carroll County 4-H/FFA Fair

UTILITIES

Electricity: Baltimore Gas and Electric and the Allegheny Power System; customers of investor-owned utilities and major cooperatives may choose their electric supplier

Gas: Natural gas supplied by Baltimore Gas and Electric; customers may choose their gas supplier

Water and Sewer: Municipal or county systems serve Hampstead, Manchester, Mount Airy, New Windsor, Sykesville-Freedom, Taneytown, Union Bridge, and Westminster

Telecommunications: Verizon Maryland offers Verizon Business Ethernet and voice, data, and 4G LTE wireless services; Comcast offers Business Class Services for internet, phone, TV and Ethernet; Quantum Internet Services offers a variety of internet and telephone services; Freedom Broadband is a local wireless internet service provider; Carroll County government is a member of the Maryland Broadband Cooperative (MDBC) which develops "middle-mile" fiber optic networks through its membership; City of Westminster and Ting have a public-private partnership to develop a city-owned fiber optic network; Carroll Broadband, a 112-mile public fiber optic network, leases "dark fiber" directly to corporations and service providers

GOVERNMENT[11]

County Seat: Westminster

Government: Five commissioners elected by district for four-year terms; commissioner form of government limits county legislative power to areas authorized by the General Assembly
C. Richard Weaver, President, Board of County Commissioners
410.386.2044

Website: www.ccgovernment.carr.org

County Bond Rating: AAA (S&P); Aa1 (Moody's); AAA (Fitch)

Carroll County Department of Economic Development
225 North Center Street, Suite 101
Westminster, Maryland 21157
Telephone: 410.386.2070
Metropolitan Baltimore: 410.876.2450 ext. 2070
Email: info@carrollbiz.org
www.carrollbiz.org

Sources:
1 National Oceanic and Atmospheric Administration (1981-2010 normals); Maryland Geological Survey
2 Maryland Department of Planning
3 U.S. Bureau of the Census
4 Maryland Department of Labor, Licensing and Regulation, Office of Workforce Information and Performance
5 U. S. Bureau of Labor Statistics
6 Carroll County Department of Economic Development
7 Maryland Department of Commerce
8 Maryland State Department of Education; Maryland Higher Education Commission
9 Maryland State Department of Assessments and Taxation; Comptroller of the Treasury
10 Maryland Association of Realtors
11 Maryland State Archives; Maryland Association of Counties

Carroll County

DEMOGRAPHIC AND SOCIO-ECONOMIC OUTLOOK

	Historical					Projected					
	1970	1980	1990	2000	2010 *	2015	2020	2025	2030	2035	2040
Population Characteristics:											
Total Population	69,006	96,356	123,372	150,897	167,134	168,550	175,900	179,450	183,250	186,200	189,550
Male	33,956	47,384	60,748	74,470	82,510	83,080	86,460	87,850	89,240	90,300	91,700
Female	35,050	48,972	62,624	76,427	84,624	85,470	89,440	91,600	94,000	95,900	97,860
Non-Hispanic White **	N/A	92,414	118,675	143,654	152,428	151,610	155,720	156,710	158,260	159,190	160,540
All Other **	N/A	3,942	4,697	7,243	14,706	16,940	20,180	22,740	24,980	27,010	29,020
Selected Age Groups:											
0-4	5,644	6,446	9,761	10,110	9,031	8,230	9,460	10,360	10,510	10,050	9,630
5-19	19,454	25,401	26,673	35,513	36,723	33,750	31,700	30,300	31,790	34,130	35,390
20-44	22,486	37,914	50,752	52,889	48,473	46,230	50,040	53,380	54,080	53,470	53,520
45-64	14,310	17,604	23,653	36,118	51,098	53,860	52,470	46,470	40,990	39,080	41,760
65+	7,112	8,991	12,533	16,267	21,809	26,480	32,240	38,950	45,890	49,480	49,260
Total	69,006	96,356	123,372	150,897	167,134	168,550	175,900	179,450	183,250	186,200	189,550
Total Household Population	63,960	92,514	120,457	147,316	163,815	165,142	172,360	175,727	179,255	181,871	184,882
Total Households	19,623	30,631	42,248	52,503	59,775	61,325	65,025	68,025	70,000	71,125	72,075
Average Household Size	3.26	3.02	2.85	2.81	2.74	2.69	2.65	2.58	2.56	2.56	2.57
Labor Force:											
Total Population 16+	48,573	71,529	94,022	113,461	131,350	136,050	144,080	146,730	148,490	150,430	153,980
In Labor Force	27,898	46,998	67,905	80,767	92,050	93,150	96,310	95,410	93,680	92,660	94,190
% in Labor Force *	57.4	65.7	72.2	71.2	70.1	68.5	66.8	65.0	63.1	61.6	61.2
Male Population 16+	23,579	34,777	45,719	54,958	64,200	66,470	70,150	71,070	71,420	71,960	73,450
In Labor Force	17,467	27,472	37,522	43,139	48,650	49,250	50,700	50,210	49,250	48,660	49,370
% in Labor Force *	74.1	79.0	82.1	78.5	75.8	74.1	72.3	70.6	69.0	67.6	67.2
Female Population 16+	24,994	36,752	48,303	58,503	67,140	69,580	73,930	75,660	77,070	78,470	80,530
In Labor Force	10,431	19,526	30,383	37,628	43,400	43,900	45,610	45,200	44,430	44,000	44,820
% in Labor Force *	41.7	53.1	62.9	64.3	64.6	63.1	61.7	59.7	57.6	56.1	55.7
Jobs by Place of Work :	27,223	36,133	52,388	68,111	81,611	85,800	91,300	95,900	98,600	101,800	104,500
Personal Income :											
Total (million of constant 2009$)	$1,299.4	$2,418.6	$4,003.3	$6,086.4	$7,393.5	$7,995.8	$9,089.5	$9,780.7	$10,374.9	$10,946.7	$11,592.1
Per Capita (constant 2009$)	$18,713	$24,972	$32,262	$40,186	$44,211	$47,439	$51,674	$54,504	$56,616	$58,790	$61,156

** For 2010 to 2040 non-hispanic white population is equal to "non-hispanic white alone", and all other population is equal to "all other races", alone and two or more races.

* Labor force participation rates for 2010 are estimates based on the 2008-2012 American Community Survey. These participation rates are applied to the Census 2010 population by age/sex to yield labor force estimates.

SOURCE: Projections prepared by the Maryland Department of Planning, July 2014. Population and houshold data from 1970 thru 2010 are from the U.S. Census Bureau, as is the labor force data from 1970 thru 2000. Labor force participation rate data for 2010 is an estimate by the Maryland Department of Planning based on 2008-2012 American Community Survey data. 1990 race and sex population is from modified age, race, sex data (MARS) and 2000 race and sex population from modified race data, both from the U.S. Census Bureau. Historical jobs, total personal income and per capita personal income data are from the U.S. Bureau of Economic Analysis.

Projections are rounded, therefore numbers may not add to totals.

Sustainability Indicators for Carroll County, Maryland and State of Maryland

Sustainability Indicator	Carroll		Maryland	
	Estimate	(+/-) Percent MOE*	Estimate	(+/-) Percent MOE*
Transportation				
Share of commuters who don't drive alone to work	16.9%	1.4%	26.4%	0.3%
Mean travel time to work (minutes)	34.9	0.9	32.2	0.1
Housing				
Percent homeowners paying 35.0 percent or more of income for housing	23.5%	1.8%	25.3%	0.4%
Percent renters paying 35.0% or more of income for rent	41.7%	4.4%	42.4%	0.6%
Equity				
Poverty rate	6%	0.8%	10.2%	0.2%
Share of income held by top 5% of households	16.74%	1.05%	20.29%	0.24%
Economic Development				
Percent of jobs inside PFAs held by residents living in the PFA	48.0%		41.7%	
2014 annual average unemployment rate	5%		5.8%	
Percent bachelor's degree or higher	31.9%	1.3%	37.1%	0.2%
Income				
Median household income (dollars)	$81,600	$2,723	$72,345	$375
Development				
Percent of single-family residential parcels developed inside of PFAs, 2007-2011	66.6%		71.9%	
Ratio of preserved land to developed land	0.96		0.97	
Percent of resource land preserved	28.4%		25.7%	
Percent of agricultural and resource lands which are unstable	43.0%		27.5%	

* MOE= Margin of error for the 90 percent confidence interval. The estimate, plus and minus the MOE, gives you the lower and upper bounds around the estimate, indicating the range in which there is a 90 percent probability that the range contains the true value. The smaller the margin of error, the more reliable the estimate.

Prepared by the Maryland Department of Planning, March 2015.

EXPLANATION OF SUSTAINABILITY MEASURES

TRANSPORTATION

Definition: This indicator shows the average number of minutes a person spends traveling to work.

Significance: Time spent traveling means less time to spend with family or on other activities. Longer commute times are also related to longer distances traveled, which will increase air pollution and other environmental impacts.

Source: 2011-2013 American Community Survey

HOUSING

Definition: This indicator shows the percent of households that have housing costs greater than 35 percent of their income. It was calculated by dividing total households with housing costs greater than 35% of income by total households in the community.

Significance: Housing is generally considered affordable if it accounts for roughly 35 percent* or less of a household's monthly budget. Households that spend more money on housing may have less money to spend on other needs such as health care and education.

Source: 2011-2013 American Community Survey

EQUITY - Poverty Rate

Definition: This indicator shows the percent of all people who live in poverty.

Significance: The higher the poverty rate the more stress is on a community and the more unsustainable is the health of a community

Source: 2011-2013 American Community Survey

EQUITY - Income Concentration

Definition: This indicator shows the share of income within the community held by the 5 percent of households with the highest incomes.

Significance: This indicator suggests the extent to which wealth is concentrated in a small number of households. A value of 5 percent would mean that every household's income is equal. The higher the value, the more wealth is concentrated.

Source: 2011-2013 American Community Survey

ECONOMIC DEVELOPMENT - PERCENT OF JOBS IN PFAs HELD BY RESIDENTS LIVING IN PFAs

Definition: This indicator shows the percent of a jurisdiction's jobs inside their priority funding areas that are held by residents that live in the jurisdiction's priority funding areas

Significance: Priority funding areas (PFAs) are local/state designated growth areas. Most jobs are located in PFAs, and the higher the percentage of workers living in PFAs, the more likely that commute times and distance would be minimized.

Source: Maryland Department of Planning using data from the 2011 Longitudinal Employer-Household Dynamics Program (U.S. Census Bureau)

ECONOMIC DEVELOPMENT - UNEMPLOYMENT RATE

Definition: This indicator shows the unemployment rate, or the percentage of the total workforce who are unemployed and are looking for a paid job. The unemployment rate does not include long-term unemployed who have given up looking for work.

Significance: A higher unemployment rate indicates a depressed economy that may not provide an adequate standard of living for all its residents.

Source: Maryland Department of Labor, Licensing and Regulation - 2014 annual averages

ECONOMIC DEVELOPMENT - EDUCATION

Definition: This indicator shows the share of the community's population that holds a college degree, including 2-year, 4-year, or advanced degrees

Significance: A post-secondary education is essential to many of today's jobs, especially higher-paying jobs. A well-educated workforce can provide a competitive advantage to communities for helping to attract and retain businesses. College graduates can expect to earn over 80 percent more over their lifetime than high school graduates; even an Associate's degree can boost earnings by one-third*.

* Carnevale, A.P., S.J. Rose, and B. Cheah. "The College Payoff: Education, Occupations, and Lifetime Earnings." Georgetown University Center on Education and the Workforce. Based on analysis of the 2007-2009 American Community Survey

Source: 2011-2013 American Community Survey

INCOME

Definition: This indicator shows the income level that is exceeded by half of the households in the community. It is defined as the income in the past 36 months in 2013 inflation-adjusted dollars.

Significance: A higher median income indicates a more prosperous community. In comparison to the average or "mean" income, which may be skewed by a small number of high-income households, the median income provides an indicator of the wealth of a broader section of the population.

Source: 2011-2013 American Community Survey

DEVELOPMENT - PERCENT OF SINGLE-FAMILY PARCELS DEVELOPED INSIDE OF PFAS

Definition: This indicator shows the percent of single-family parcels on 20 acres or less which are developed inside of PFAs over the last five years.

Significance: The higher the percent of single-family residential development inside of PFAs, the more compact the development and the less land consumed by that development.

Source: Maryland Department of Planning from MD Property View

DEVELOPMENT - RATIO OF PRESERVED LAND TO DEVELOPED LAND THROUGH FY 2012

Definition: This indicator shows the ratio of the acres of permanently preserved land to the acres of developed land.

Significance: It is a a State goal to have a balance of preserved and developed land, specifically to preserve an acre of land for every acre developed.

Source: Maryland departments of Planning, Agriculture, Natural Resources, and Maryland counties.

DEVELOPMENT - PERCENT OF RESOURCE LAND PRESERVED

Definition: This indicator shows the percentage of land outside areas planned for growth, development and sewer service that is permanently preserved by state, federal or local programs

Significance: Preserving agricultural, forested, and important natural and water resource lands is a State priority.

Source: Maryland departments of Planning, Agriculture, Natural Resources, and Maryland counties.

DEVELOPMENT - PERCENT OF AG AND RESOURCE LANDS WHICH ARE UNSTABLE

Definition: Unstable resource lands are those already or are most likely to be residentially subdivided and developed inconsistent with State goals for land and resource conservation.

Significance: Maryland's land preservation goals call for local plans and land use tools that limit subdivision and development commensurate with achievement of those goals.

Source: Maryland departments of Planning, Agriculture, Natural Resources, and Maryland counties.

United States Census Bureau

QuickFacts

selected: Carroll County, Maryland

QuickFacts provides statistics for all states and counties, and for cities and towns with a ***population of 5,000 or more***.

Table

All Topics	Carroll County, Maryland
Population estimates, July 1, 2016, (V2016)	**167,656**
PEOPLE	
Population	
Population estimates, July 1, 2016, (V2016)	**167,656**
Population estimates base, April 1, 2010, (V2016)	167,138
Population, percent change - April 1, 2010 (estimates base) to July 1, 2016, (V2016)	0.3%
Population, Census, April 1, 2010	167,134
Age and Sex	
Persons under 5 years, percent, July 1, 2016, (V2016)	5.1%
Persons under 5 years, percent, April 1, 2010	5.4%
Persons under 18 years, percent, July 1, 2016, (V2016)	21.9%
Persons under 18 years, percent, April 1, 2010	24.7%
Persons 65 years and over, percent, July 1, 2016, (V2016)	16.2%
Persons 65 years and over, percent, April 1, 2010	13.0%
Female persons, percent, July 1, 2016, (V2016)	50.6%
Female persons, percent, April 1, 2010	50.6%
Race and Hispanic Origin	
White alone, percent, July 1, 2016, (V2016) (a)	92.5%
Black or African American alone, percent, July 1, 2016, (V2016) (a)	3.6%
American Indian and Alaska Native alone, percent, July 1, 2016, (V2016) (a)	0.2%
Asian alone, percent, July 1, 2016, (V2016) (a)	1.8%
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2016, (V2016) (a)	0.1%
Two or More Races, percent, July 1, 2016, (V2016)	1.8%
Hispanic or Latino, percent, July 1, 2016, (V2016) (b)	3.4%
White alone, not Hispanic or Latino, percent, July 1, 2016, (V2016)	89.6%
Population Characteristics	
Veterans, 2011-2015	12,150

Foreign born persons, percent, 2011-2015	3.6%
Housing	
Housing units, July 1, 2016, (V2016)	63,623
Housing units, April 1, 2010	62,406
Owner-occupied housing unit rate, 2011-2015	82.0%
Median value of owner-occupied housing units, 2011-2015	$321,300
Median selected monthly owner costs -with a mortgage, 2011-2015	$2,020
Median selected monthly owner costs -without a mortgage, 2011-2015	$574
Median gross rent, 2011-2015	$1,079
Building permits, 2016	294
Families & Living Arrangements	
Households, 2011-2015	60,004
Persons per household, 2011-2015	2.73
Living in same house 1 year ago, percent of persons age 1 year+, 2011-2015	92.7%
Language other than English spoken at home, percent of persons age 5 years+, 2011-2015	5.2%
Education	
High school graduate or higher, percent of persons age 25 years+, 2011-2015	92.1%
Bachelor's degree or higher, percent of persons age 25 years+, 2011-2015	33.1%
Health	
With a disability, under age 65 years, percent, 2011-2015	6.2%
Persons without health insurance, under age 65 years, percent	⚠ 4.4%
Economy	
In civilian labor force, total, percent of population age 16 years+, 2011-2015	68.8%
In civilian labor force, female, percent of population age 16 years+, 2011-2015	63.3%
Total accommodation and food services sales, 2012 ($1,000) (c)	246,824
Total health care and social assistance receipts/revenue, 2012 ($1,000) (c)	950,258
Total manufacturers shipments, 2012 ($1,000) (c)	1,019,422
Total merchant wholesaler sales, 2012 ($1,000) (c)	723,877
Total retail sales, 2012 ($1,000) (c)	2,245,218
Total retail sales per capita, 2012 (c)	$13,427
Transportation	
Mean travel time to work (minutes), workers age 16 years+, 2011-2015	35.2
Income & Poverty	
Median household income (in 2015 dollars), 2011-2015	$85,385
Per capita income in past 12 months (in 2015 dollars), 2011-2015	$36,936
Persons in poverty, percent	⚠ 6.2%

BUSINESSES

Businesses	
Total employer establishments, 2015	4,220

Total employment, 2015	49,067
Total annual payroll, 2015 ($1,000)	1,923,241
Total employment, percent change, 2014-2015	-1.5%
Total nonemployer establishments, 2015	12,230
All firms, 2012	14,688
Men-owned firms, 2012	8,376
Women-owned firms, 2012	4,670
Minority-owned firms, 2012	1,032
Nonminority-owned firms, 2012	13,234
Veteran-owned firms, 2012	1,524
Nonveteran-owned firms, 2012	12,512

GEOGRAPHY

Geography	
Population per square mile, 2010	373.4
Land area in square miles, 2010	447.60
FIPS Code	24013

https://www.census.gov/quickfacts/fact/table/carrollcountymaryland/PST045216

Value Notes

This geographic level of poverty and health estimates are not comparable to other geographic levels of these estimates

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable. Click the Quick Info icon to the left of each row in TABLE view to learn about sampling error.

The vintage year (e.g., V2016) refers to the final year of the series (2010 thru 2016). *Different vintage years of estimates are not comparable.*

Fact Notes

- **(a)** Includes persons reporting only one race
- **(b)** Hispanics may be of any race, so also are included in applicable race categories
- **(c)** Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

Value Flags

- **-** Either no or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest or upper interval of an open ended distribution.
- **D** Suppressed to avoid disclosure of confidential information
- **F** Fewer than 25 firms
- **FN** Footnote on this item in place of data
- **NA** Not available
- **S** Suppressed; does not meet publication standards
- **X** Not applicable
- **Z** Value greater than zero but less than half unit of measure shown

QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area SHealth Insurance Estimates, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits.

22 results are available, use up and down arrow keys to navigate.

8. Our Community Dashboard

A. Methodology

In 2012, a contract was established between the Healthy Communities Institute (now Conduent) of Berkley, California, an industry leader in the community health data collection and reporting, and The Partnership for a web-based reporting system to provide local data for Carroll County on an ongoing basis. Data points, (indicators) tracked in this system were selected to be generally consistent with those used by other communities nationally and by agencies of the State of Maryland. This system is licensed via an annual fee, and the data is displayed on The Partnership's website, HealthyCarroll.org.

The online data reporting interface, known as **Our Community Dashboard**, provides current and historical data values for 158 indicators in these seven broad areas:

- Health
- Economy
- Education
- Environment
- Public Safety
- Social Environment
- Transportation

There are 27 topics of data within these seven broad areas. *Healthy People 2020* targets and *Maryland SHIP* targets are given for indicators that match up with data points used in those systems. An explanation of why each indicator is important and data sources are provided.

Dashboard features include:

- *Promising Practices* - reports from other communities describing ways they have improved poor performance areas.
- The *Disparities Dashboard* for viewing data broken out by racial, ethnic, age, and gender groups to identify disparities within the population.
- *A Demographics* section for exploring population characteristics.
- A *Report Assistant* to quickly integrate site content into reports for sharing.
- *The Indicator Comparison Report* allowing users to view multiple indicators across available locations.

Conduent also provides a tool with the system that sorts and ranks categories and indicators to show possible issues of concern. This feature, called the **Data Scoring Tool**, generates reports in chart form that ranks the 27 topics and 158 indicators according to a statistical methodology. This ranking is a statistical analysis and does not capture the entire significance or burden to health represented by any one data point or health topic. However, it can point out areas where more investigation is needed, or be used to help determine priorities.

To visit *Our Community Dashboard* go to HealthyCarroll.org/assessments-data/our-community-dashboard/.

B. Results Summary

The results of the **Data Scoring Tool** are attached. In the first report, "Indicator Topic Scores", the 27 topics are listed in order of most to least concern. The second report, "Indicator Scores", lists the 158 indicators in order of most to least concern.

According to these Data Scoring Tool reports, the topics of most concern for Carroll County are **Transportation**, **Prevention & Safety**, and **Heart Disease & Stroke**. Least-concerning topics are Maternal, Fetal, & Infant Health, Social Environment, and Men's Health.

The specific indicators of most concern compared with state and national data, listed in order of severity, are:

1. **Age-Adjusted Death Rate due to Falls**
2. **Age-Adjusted Death Rate due to Drug Use**
3. **Age-Adjusted Death Rate due to Suicide**
4. **Death Rate due to Drug Poisoning**
5. **Melanoma Incidence Rate**
6. **Solo Drivers with a Long Commute**
7. **Workers who Drive Alone to Work**
8. **Age-Adjusted Death Rate due to Melanoma**
9. **Mean Travel Time to Work**
10. **Adults with a Healthy Weight**

The indicators of least concern are: Food Insecurity Rate, Households with Cash Public Assistance Income, People 65+ Living Below Poverty Level, Unemployed Workers in Civilian Labor Force Teen Birth Rate, Cervical Cancer Incidence Rate, Families Living Below Poverty Level, and Age-Adjusted Death Rate due to Prostate Cancer.

These scoring results are to be considered collectively with the entire results of the CHNA.

C. Attachments

- Scoring Methodology - *Healthy Communities Institute*
- Category List by Score - *Healthy Communities Institute*
- Indicator Ranking Results - *Healthy Communities Institute*

HCI DATA SCORING TOOL

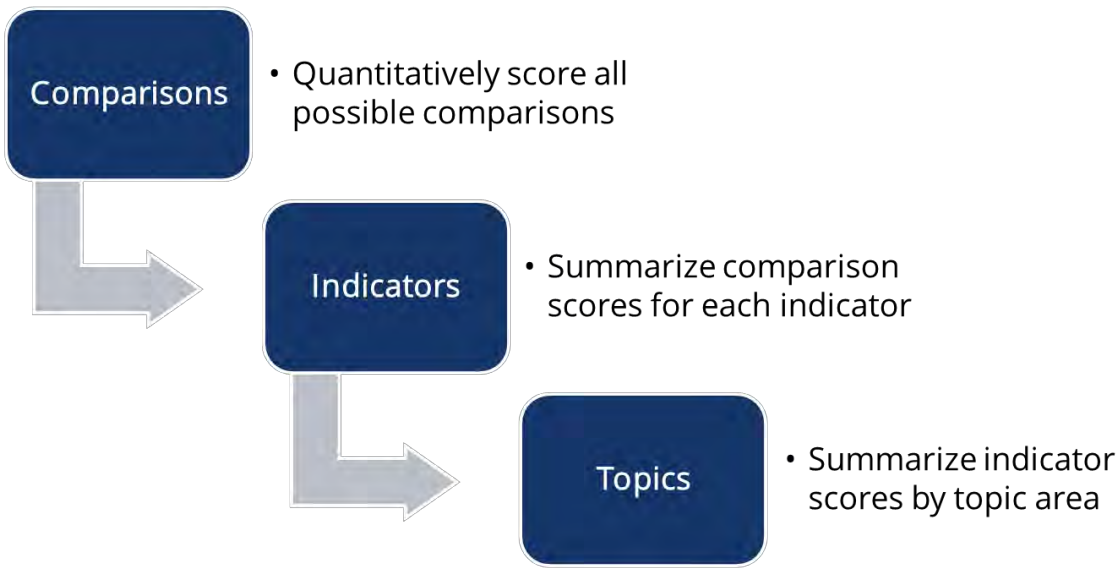
FEBRUARY 2015

METHODOLOGY

PURPOSE

The HCI Community Dashboard includes a large number of indicators that cover many areas of health and health-related topics. The value for each of these indicators can be compared to other communities, nationally or locally set targets, or historical trends for an assessment of the need for improvement. However, the prioritization of these needs requires a standardized method of summarizing those comparisons across the community dashboard. HCI's Data Scoring Tool ranks indicators on the HCI Community Dashboard according to a systematic summary of comparisons. These indicators can be further grouped into topic areas for a higher level ranking of community health needs. The resulting rankings can be used along with other considerations such as community input and the feasibility of impact when setting priorities for community health improvement.

OVERVIEW



COMPARISON SCORING

For each indicator, the community is assigned a score based on their comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time. For each indicator on the community dashboard, all possible comparisons are considered in data scoring regardless of visibility on the community dashboard.

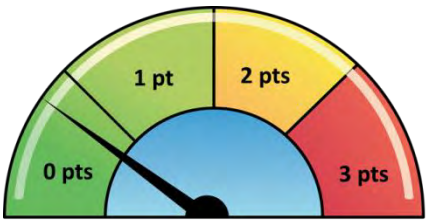
Because the smallest geographic granularity that is available for most health indicators is the county-level, HCI's Data Scoring Tool scores and ranks indicator data for counties.

COMPARISON TYPES

DISTRIBUTION OF COUNTY VALUES: WITHIN STATE AND NATIONAL

A distribution is created by taking all county values, ordering them from low to high, and dividing them into four equally sized groups based on their order. The comparison score for a county distribution is determined by which of these four groups (quartiles) your county falls in.

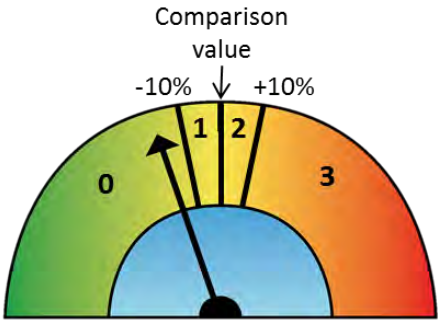
If the county value falls within the first (or best) quartile, it receives a score of 0 for the indicator. Falling in the second quartile results in a score of 1; the third quartile a score of 2, and the fourth (or worst) quartile a score of 3.



COMPARISON VALUES: STATE, NATIONAL, AND TARGETS

The county is compared to the state value, the national value, and target values. Targets may be nation-wide health goals (Healthy People 2020) or goals that have been set for a more specific community (such as state or county health improvement plans). For all value comparisons, the scoring depends on whether the county value is better or worse than the comparison value, with severity determined by the percent difference between the two values.

$$\% \text{ difference} = \frac{\text{county value} - \text{comparison value}}{\text{comparison value}}$$



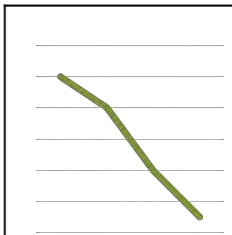
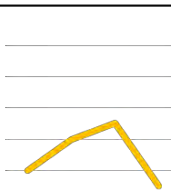
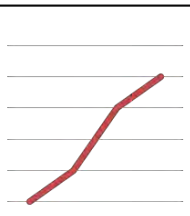
If the county value is better than the comparison value and the percent difference is more than 10%, then the indicator is scored 0. If the county value is equal to or better than the comparison value, but by 10% or less, then the resulting score is 1. If the county value is worse than the comparison value by 10% or less than the resulting score is 2; if worse by more than 10% the resulting score is 3.

In the rare case that there are multiple locally set targets for an indicator, the scores are calculated for each local target separately and then the scores are averaged for up to 5 targets.

TREND OVER TIME

The Mann-Kendall statistical test for trend is used to assess whether the county value is increasing over time or decreasing over time, and whether the trend is statistically significant.

The trend comparison uses the four most recent comparable values for the county, and statistical significance is determined at the 90% confidence level. If the indicator value is trending in the good (improving) direction, and is statistically significant, the indicator is scored 0. If the value is trending in the good direction overall, but is *not* statistically significant, the resulting score is 1. If there is no evidence of a trend in either direction, the score is 1.5. If trending in the bad (worsening) direction, but *not* statistically significant, the score is 2. And if the trend is in the bad direction and is statistically significant, the score is 3.

Good direction			Bad direction	
Significant	NOT significant	Neutral	NOT significant	Significant
				
→ Score: 0	→ Score: 1	→ Score: 1.5	→ Score: 2	→ Score: 3

MISSING VALUES

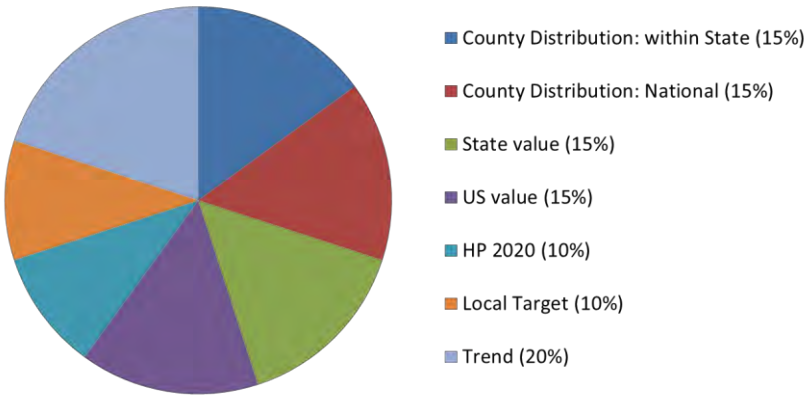
Indicator scores are calculated using the comparison scores, availability of which depends on the data source. If the comparison type is possible for an adequate proportion of indicators on the community dashboard, it will be included in the indicator score. To be included in scoring, most comparison types (county distributions, state value, US value, and trend) must be possible for at least 25% of indicators. HP2020 and local target comparisons must be possible for at least 10% of indicators to be included in scoring.

After exclusion of comparison types with inadequate availability, all missing comparisons are substituted with a value of 1.5 for the purposes of calculating the weighted average. The 1.5 substitution is intended to assign a "neutral" value when information is unknown due to lack of comparable data, and assumes that the missing comparison score is neither good nor bad.

INDICATOR SCORING

Indicator scores are calculated as a weighted average of all included comparison scores. If any comparisons have been excluded due to inadequate availability, all remaining comparisons are increased in weight proportionally.

Relative Weights of Comparisons in Indicator Score



If none of the included comparison types are possible for an indicator, no score is calculated and the indicator is excluded from the data scoring results.

PRECISION

Each indicator score is accompanied by a level of precision, which indicates whether each score was calculated from a high, medium, or low number of actual comparisons (as opposed to 1.5 substitutions for missing comparisons).

TOPIC SCORING

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topic areas if appropriate. A topic score is only calculated if it includes at least three indicators.

Topic	Matching Indicators	Score
Transportation	6	1.90
Prevention & Safety	5	1.79
Heart Disease & Stroke	11	1.74
Mortality Data	19	1.72
Substance Abuse	9	1.58
Mental Health & Mental Disorders	8	1.55
Older Adults & Aging	22	1.55
Oral Health	5	1.55
Exercise, Nutrition, & Weight	23	1.45
Women's Health	5	1.45
Cancer	17	1.40
Environment	19	1.38
Other Chronic Diseases	3	1.38
Respiratory Diseases	13	1.38
Children's Health	9	1.29
Access to Health Services	13	1.28
Immunizations & Infectious Diseases	9	1.28
Wellness & Lifestyle	7	1.24
Public Safety	5	1.22
Environmental & Occupational Health	5	1.19
Diabetes	5	1.08
Education	8	1.03
Teen & Adolescent Health	5	1.03
Economy	21	1.01
Maternal, Fetal & Infant Health	7	0.95
Social Environment	3	0.85
Men's Health	3	0.70

Showing 1 to 27 of 27 Topics

Healthy Communities Institute
Data Scoring Tool

Scoring Results by Topic

County: Carroll
Carroll Hosp Center (MD)
Total indicators: 158
Wednesday 4th of October 2017 07:40:43 AM

Scoring Results by Topic - TRANSPORTATION

Score: 1.90

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Solo Drivers with a Long Commute	3	3	3	3	1.5	1.5	2	2.5	High
Workers who Drive Alone to Work	3	3	3	3	1.5	1.5	2	2.5	High
Mean Travel Time to Work	3	3	2	3	1.5	1.5	2	2.35	High
Workers Commuting by Public Transportation	2	0	3	3	3	1.5	1.5	1.95	High
Households with No Car and Low Access to a Grocery Store	1	1	1.5	1.5	1.5	1.5	1.5	1.35	Low
Households without a Vehicle	0	1	0	0	1.5	1.5	1.5	0.75	High

Scoring Results by Topic - PREVENTION & SAFETY

Score: 1.79

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Age-Adjusted Death Rate due to Falls	3	1.5	3	3	3	3	3	2.78	High
Death Rate due to Drug Poisoning	2	3	3	3	1.5	1.5	3	2.55	High
Age-Adjusted Death Rate due to Unintentional Injuries	3	1.5	1	0	1	1.5	3	1.68	High
Pedestrian Injuries	1	1.5	0	1.5	2	0	2	1.2	High
Severe Housing Problems	0	1	0	0	1.5	1.5	1.5	0.75	High

Scoring Results by Topic - HEART DISEASE & STROKE

Score: 1.74

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
High Blood Pressure Prevalence	3	1.5	3	3	3	1.5	1.5	2.33	Medium
Atrial Fibrillation: Medicare Population	3	3	3	3	1.5	1.5	1	2.3	High
Hyperlipidemia: Medicare Population	3	3	3	3	1.5	1.5	1	2.3	High
Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	3	1.5	3	3	3	1.5	1	2.23	High
Age-Adjusted Death Rate due to Heart Disease	2	1.5	2	2	1.5	2.5	3	2.13	High
Ischemic Heart Disease: Medicare Population	2	2	2	2	1.5	1.5	1	1.7	High
Hypertension: Medicare Population	1	2	2	2	1.5	1.5	1	1.55	High
High Cholesterol Prevalence	0	1.5	1	1	3	1.5	1.5	1.28	Medium
Age-Adjusted ER Rate due to Hypertension	0	1.5	0	1.5	1.5	0	3	1.2	Medium
Heart Failure: Medicare Population	2	1	2	1	1.5	1.5	0	1.2	High
Stroke: Medicare Population	0	2	0	1	1.5	1.5	1	0.95	High

Scoring Results by Topic - MORTALITY DATA

Score: 1.72

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Age-Adjusted Death Rate due to Falls	3	1.5	3	3	3	3	3	2.78	High
Age-Adjusted Death Rate due to Drug Use	2	1.5	3	3	3	3	3	2.63	High
Age-Adjusted Death Rate due to Suicide	1.5	1.5	3	3	3	3	3	2.55	High
Death Rate due to Drug Poisoning	2	3	3	3	1.5	1.5	3	2.55	High
Age-Adjusted Death Rate due to Melanoma	2	2	3	3	3	1.5	2	2.35	High
Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	3	1.5	3	3	3	1.5	1	2.23	High
Age-Adjusted Death Rate due to Heart Disease	2	1.5	2	2	1.5	2.5	3	2.13	High
Alcohol-Impaired Driving Deaths	2	2	2	3	1.5	1.5	1.5	1.95	High
Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	3	1.5	3	2	1.5	1.5	1	1.93	Medium
Age-Adjusted Death Rate due to Unintentional Injuries	3	1.5	1	0	1	1.5	3	1.68	High
Age-Adjusted Death Rate due to Breast Cancer	1	2	1	2	2	1.5	1.5	1.55	High
Age-Adjusted Death Rate due to Influenza and Pneumonia	1.5	1.5	1	1	1.5	1.5	2	1.45	Medium
Age-Adjusted Death Rate due to Colorectal Cancer	2	1	2	2	2	1.5	0	1.4	High
Age-Adjusted Death Rate due to Cancer	1	1	2	2	2	2.5	0	1.35	High
Age-Adjusted Mortality Rate From Cancer	1.5	1.5	1.5	1.5	2	2	0	1.3	Medium
Age-Adjusted Death Rate due to Lung Cancer	1	1	2	2	2	1.5	0	1.25	High
Age-Adjusted Death Rate due to Diabetes	0	1.5	0	0	1.5	1.5	1.5	0.83	Medium
Infant Mortality Rate	0	1.5	0	1.5	0	0	1	0.65	High
Age-Adjusted Death Rate due to Prostate Cancer	0	0	0	0	0	1.5	0	0.15	High

Scoring Results by Topic - SUBSTANCE ABUSE

Score: 1.58

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Age-Adjusted Death Rate due to Drug Use	2	1.5	3	3	3	3	3	2.63	High
Death Rate due to Drug Poisoning	2	3	3	3	1.5	1.5	3	2.55	High
Liquor Store Density	2	3	2	3	1.5	1.5	2	2.2	High
Alcohol-Impaired Driving Deaths	2	2	2	3	1.5	1.5	1.5	1.95	High
Adults who Binge Drink	2	1.5	3	2	0	1.5	1	1.63	High
Teens who Smoke: High School Students	1	1.5	2	1.5	0	1.5	0	1.05	Medium
Teens who Use Tobacco	0	1.5	1	1.5	0	0.5	1.5	0.95	Medium
Age-Adjusted ER Rate due to Alcohol/Substance Abuse	1	1.5	0	1.5	1.5	0	0	0.75	Medium
Adults who Smoke	0	1.5	0	0	1	0	1	0.53	High

Scoring Results by Topic - MENTAL HEALTH

Score: 1.55

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Age-Adjusted Death Rate due to Suicide	1.5	1.5	3	3	3	3	3	2.55	High
Self-Reported Good Mental Health	2	1.5	3	1.5	1.5	1.5	2	1.9	Medium
Age-Adjusted Hospitalization Rate Related to Alzheimer's and Other Dementias	3	1.5	3	1.5	1.5	3	0	1.8	Medium
Depression: Medicare Population	2	2	2	1	1.5	1.5	2	1.75	High
Alzheimer's Disease or Dementia: Medicare Population	2	2	1	1	1.5	1.5	1	1.4	High
Adequate Social and Emotional Support	0	1.5	1	1.5	1.5	1.5	1.5	1.2	Low
Age-Adjusted ER Rate due to Mental Health	1	1.5	1	1.5	1.5	1	1	1.2	Medium
Frequent Mental Distress	0	0	0	0	1.5	1.5	1.5	0.6	Medium

Scoring Results by Topic - OLDER ADULTS & AGING

Score: 1.55

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Age-Adjusted Death Rate due to Falls	3	1.5	3	3	3	3	3	2.78	High
Atrial Fibrillation: Medicare Population	3	3	3	3	1.5	1.5	1	2.3	High
Hyperlipidemia: Medicare Population	3	3	3	3	1.5	1.5	1	2.3	High
Rheumatoid Arthritis or Osteoarthritis: Medicare Population	3	2	2	2	1.5	1.5	2	2.05	High
Age-Adjusted Hospitalization Rate Related to Alzheimer's and Other Dementias	3	1.5	3	1.5	1.5	3	0	1.8	Medium
Diabetes: Medicare Population	1	2	1	2	1.5	1.5	3	1.8	High
People 65+ with Low Access to a Grocery Store	3	2	1.5	1.5	1.5	1.5	1.5	1.8	Low
Depression: Medicare Population	2	2	2	1	1.5	1.5	2	1.75	High
Ischemic Heart Disease: Medicare Population	2	2	2	2	1.5	1.5	1	1.7	High
Adults 65+ with Pneumonia Vaccination	2	1.5	2	2	3	1.5	0	1.58	High
Cancer: Medicare Population	1	3	1	2	1.5	1.5	1	1.55	High
Hypertension: Medicare Population	1	2	2	2	1.5	1.5	1	1.55	High
COPD: Medicare Population	1	1	2	1	1.5	1.5	2	1.45	High
Alzheimer's Disease or Dementia: Medicare Population	2	2	1	1	1.5	1.5	1	1.4	High
Osteoporosis: Medicare Population	2	2	1	1	1.5	1.5	1	1.4	High
Asthma: Medicare Population	1	1	1	1	1.5	1.5	2	1.3	High
Adults 65+ with Influenza Vaccination	1	1.5	1	1	1.5	1.5	1.5	1.28	Medium
Heart Failure: Medicare Population	2	1	2	1	1.5	1.5	0	1.2	High
Diabetic Monitoring: Medicare Population	0	1	1	1	1.5	1.5	1.5	1.05	High
Stroke: Medicare Population	0	2	0	1	1.5	1.5	1	0.95	High
Chronic Kidney Disease: Medicare Population	0	0	0	0	1.5	1.5	2	0.7	High
People 65+ Living Below Poverty Level	0	0	0	0	1.5	1.5	1	0.5	High

Scoring Results by Topic - ORAL HEALTH

Score: 1.55

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Adults who Visited a Dentist	3	1.5	3	1.5	1.5	1.5	1.5	1.95	Medium
Children in Medicaid who Visited a Dentist	3	1.5	3	1.5	1.5	2.5	1	1.95	Medium
Dentist Rate	2	0	3	1.5	1.5	1.5	1.5	1.58	Medium
Oral Cavity and Pharynx Cancer Incidence Rate	1	1	2	1	1.5	1.5	2	1.45	High
Age-Adjusted ER Visit Rate due to Dental Problems	0	1.5	0	1.5	1.5	0	1	0.8	Medium

Scoring Results by Topic - EXERCISE, NUTRITION, & WEIGHT

Score: 1.45

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Adults with a Healthy Weight	3	1.5	3	3	1.5	3	1.5	2.33	High
Adults who are Obese	2	1.5	3	3	3	1.5	2	2.28	High
Adult Fruit and Vegetable Consumption	3	1.5	3	1.5	1.5	1.5	1.5	1.95	Low
Food Insecure Children Likely Ineligible for Assistance	3	1.5	3	3	1.5	1.5	0	1.88	Medium
Children with Low Access to a Grocery Store	3	2	1.5	1.5	1.5	1.5	1.5	1.8	Low
People 65+ with Low Access to a Grocery Store	3	2	1.5	1.5	1.5	1.5	1.5	1.8	Low
SNAP Certified Stores	2	3	1.5	1.5	1.5	1.5	1	1.7	Medium
Grocery Store Density	2	2	1.5	1.5	1.5	1.5	1.5	1.65	Medium
Low-Income Persons who are SNAP Participants	2	2	1.5	1.5	1.5	1.5	1.5	1.65	Low
People with Low Access to a Grocery Store	2	2	1.5	1.5	1.5	1.5	1.5	1.65	Low
Fast Food Restaurant Density	1	2	1.5	1.5	1.5	1.5	2	1.6	Medium
Low-Income Preschool Obesity	1	2	1.5	1.5	1.5	1.5	2	1.6	Medium
Adults who are Overweight or Obese	1	1.5	2	2	1.5	1.5	1	1.48	Medium
Households with No Car and Low Access to a Grocery Store	1	1	1.5	1.5	1.5	1.5	1.5	1.35	Low
Low-Income and Low Access to a Grocery Store	2	1	1.5	1.5	1.5	0	1.5	1.35	Medium
Farmers Market Density	1	1	1.5	1	1.5	1.5	1.5	1.28	Medium
Access to Exercise Opportunities	1	0	2	1	1.5	1.5	1.5	1.2	Medium
Recreation and Fitness Facilities	0	0	1.5	1.5	1.5	1.5	2	1.15	Medium
Adults Engaging in Regular Physical Activity	0	1.5	1	0	1	1.5	1.5	0.93	Medium
Child Food Insecurity Rate	1	0	1	0	1.5	1.5	1	0.8	High
Adolescents who are Obese	0	1.5	0	1.5	0	0	1.5	0.75	Medium
Food Environment Index	0	0	0	0	1.5	1.5	2	0.7	High
Food Insecurity Rate	0	0	0	0	1.5	1.5	1	0.5	High

Scoring Results by Topic - WOMEN'S HEALTH

Score: 1.45

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Breast Cancer Incidence Rate	3	3	2	2	1.5	1.5	1	2	High
Mammogram in Past 2 Years: 50+	3	1.5	2	1	1.5	1.5	1.5	1.73	Medium
Life Expectancy for Females	1	1	2	2	1.5	1.5	2	1.6	High
Age-Adjusted Death Rate due to Breast Cancer	1	2	1	2	2	1.5	1.5	1.55	High
Cervical Cancer Incidence Rate	0	0	0	0	0	1.5	1	0.35	High

Scoring Results by Topic - CANCER

Score: 1.40

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Melanoma Incidence Rate	3	3	3	3	1.5	1.5	2	2.5	High
Age-Adjusted Death Rate due to Melanoma	2	2	3	3	3	1.5	2	2.35	High
Breast Cancer Incidence Rate	3	3	2	2	1.5	1.5	1	2	High
Mammogram in Past 2 Years: 50+	3	1.5	2	1	1.5	1.5	1.5	1.73	Medium
Colon Cancer Screening: Sigmoidoscopy or Colonoscopy	2	1.5	2	1	1.5	1.5	1.5	1.58	Medium
Age-Adjusted Death Rate due to Breast Cancer	1	2	1	2	2	1.5	1.5	1.55	High
Cancer: Medicare Population	1	3	1	2	1.5	1.5	1	1.55	High
Oral Cavity and Pharynx Cancer Incidence Rate	1	1	2	1	1.5	1.5	2	1.45	High
Age-Adjusted Death Rate due to Colorectal Cancer	2	1	2	2	2	1.5	0	1.4	High
Age-Adjusted Death Rate due to Cancer	1	1	2	2	2	2.5	0	1.35	High
Age-Adjusted Mortality Rate From Cancer	1.5	1.5	1.5	1.5	2	2	0	1.3	Medium
Age-Adjusted Death Rate due to Lung Cancer	1	1	2	2	2	1.5	0	1.25	High
Lung and Bronchus Cancer Incidence Rate	1	1	2	1	1.5	1.5	1	1.25	High
Colorectal Cancer Incidence Rate	1	1	2	1	1	1.5	1	1.2	High
Prostate Cancer Incidence Rate	0	1	0	1	1.5	1.5	1	0.8	High
Cervical Cancer Incidence Rate	0	0	0	0	0	1.5	1	0.35	High
Age-Adjusted Death Rate due to Prostate Cancer	0	0	0	0	0	1.5	0	0.15	High

Scoring Results by Topic - ENVIRONMENT

Score: 1.38

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Liquor Store Density	2	3	2	3	1.5	1.5	2	2.2	High
Children with Low Access to a Grocery Store	3	2	1.5	1.5	1.5	1.5	1.5	1.8	Low
People 65+ with Low Access to a Grocery Store	3	2	1.5	1.5	1.5	1.5	1.5	1.8	Low
SNAP Certified Stores	2	3	1.5	1.5	1.5	1.5	1	1.7	Medium
Grocery Store Density	2	2	1.5	1.5	1.5	1.5	1.5	1.65	Medium
People with Low Access to a Grocery Store	2	2	1.5	1.5	1.5	1.5	1.5	1.65	Low
Fast Food Restaurant Density	1	2	1.5	1.5	1.5	1.5	2	1.6	Medium
Recognized Carcinogens Released into Air	1.5	1.5	1.5	1.5	1.5	1.5	2	1.6	Low
PBT Released	1.5	1.5	1.5	1.5	1.5	1.5	1	1.4	Low
Households with No Car and Low Access to a Grocery Store	1	1	1.5	1.5	1.5	1.5	1.5	1.35	Low
Low-Income and Low Access to a Grocery Store	2	1	1.5	1.5	1.5	0	1.5	1.35	Medium
Farmers Market Density	1	1	1.5	1	1.5	1.5	1.5	1.28	Medium
Access to Exercise Opportunities	1	0	2	1	1.5	1.5	1.5	1.2	Medium
Recreation and Fitness Facilities	0	0	1.5	1.5	1.5	1.5	2	1.15	Medium
Drinking Water Violations	1	1	0	1.5	1.5	1.5	1.5	1.13	Medium
Annual Ozone Air Quality	0	1	1.5	1.5	1.5	1.5	1	1.1	Medium
Severe Housing Problems	0	1	0	0	1.5	1.5	1.5	0.75	High
Blood Lead Levels in Children	1	1.5	0	0	1.5	0	1	0.73	High
Food Environment Index	0	0	0	0	1.5	1.5	2	0.7	High

Scoring Results by Topic - OTHER CHRONIC DISEASES

Score: 1.38

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Rheumatoid Arthritis or Osteoarthritis: Medicare Population	3	2	2	2	1.5	1.5	2	2.05	High
Osteoporosis: Medicare Population	2	2	1	1	1.5	1.5	1	1.4	High
Chronic Kidney Disease: Medicare Population	0	0	0	0	1.5	1.5	2	0.7	High

Scoring Results by Topic - RESPIRATORY DISEASES

Score: 1.38

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Adults with Asthma	3	1.5	1.5	3	1.5	1.5	2	2.05	Medium
Adults with Influenza Vaccination	2	1.5	3	1.5	3	3	1	2	High
Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	3	1.5	3	2	1.5	1.5	1	1.93	Medium
Adults 65+ with Pneumonia Vaccination	2	1.5	2	2	3	1.5	0	1.58	High
Age-Adjusted Death Rate due to Influenza and Pneumonia	1.5	1.5	1	1	1.5	1.5	2	1.45	Medium
COPD: Medicare Population	1	1	2	1	1.5	1.5	2	1.45	High
Asthma: Medicare Population	1	1	1	1	1.5	1.5	2	1.3	High
Adults 65+ with Influenza Vaccination	1	1.5	1	1	1.5	1.5	1.5	1.28	Medium
Age-Adjusted Death Rate due to Lung Cancer	1	1	2	2	2	1.5	0	1.25	High
Lung and Bronchus Cancer Incidence Rate	1	1	2	1	1.5	1.5	1	1.25	High
Children with Asthma	0	1.5	0	1.5	1.5	1.5	1.5	1.05	Low
Age-Adjusted ER Rate due to Asthma	0	1.5	0	1.5	1.5	0	1	0.8	Medium
Tuberculosis Incidence Rate	0	1.5	0	0	0	1.5	1	0.58	High

Scoring Results by Topic - CHILDREN'S HEALTH

Score: 1.29

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Children in Medicaid who Visited a Dentist	3	1.5	3	1.5	1.5	2.5	1	1.95	Medium
Food Insecure Children Likely Ineligible for Assistance	3	1.5	3	3	1.5	1.5	0	1.88	Medium
Children with Low Access to a Grocery Store	3	2	1.5	1.5	1.5	1.5	1.5	1.8	Low
Low-Income Preschool Obesity	1	2	1.5	1.5	1.5	1.5	2	1.6	Medium
Children with Asthma	0	1.5	0	1.5	1.5	1.5	1.5	1.05	Low
Child Abuse Rate	0	1.5	0	1.5	1.5	1.5	1	0.95	Medium
Children with Health Insurance	0	0	1	1	2	1.5	1	0.85	High
Child Food Insecurity Rate	1	0	1	0	1.5	1.5	1	0.8	High
Blood Lead Levels in Children	1	1.5	0	0	1.5	0	1	0.73	High

Scoring Results by Topic - ACCESS TO HEALTH SERVICES

Score: 1.28

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Adolescents who have had a Routine Checkup: Medicaid Population	3	1.5	3	1.5	1.5	3	1	2	Medium
Adults who Visited a Dentist	3	1.5	3	1.5	1.5	1.5	1.5	1.95	Medium
Children in Medicaid who Visited a Dentist	3	1.5	3	1.5	1.5	2.5	1	1.95	Medium
Primary Care Provider Rate	2	1	3	1.5	1.5	1.5	1.5	1.73	Medium
Non-Physician Primary Care Provider Rate	2	1	3	1.5	1.5	1.5	1	1.63	Medium
Dentist Rate	2	0	3	1.5	1.5	1.5	1.5	1.58	Medium
Adults who have had a Routine Checkup	1	1.5	2	1	1.5	1.5	1	1.33	Medium
People with a Usual Primary Care Provider	0	1.5	1	1.5	1.5	1	1	1.05	Medium
Children with Health Insurance	0	0	1	1	2	1.5	1	0.85	High
Uninsured Emergency Department Visits	0	1.5	0	1.5	1.5	0	1	0.8	Medium
Adults Unable to Afford to See a Doctor	0	1.5	0	0	1.5	0	1.5	0.68	Medium
Persons with Health Insurance	0	0	1	1.5	2	1	0	0.68	High
Adults with Health Insurance	0	0	1	0	2	1.5	0	0.5	High

Scoring Results by Topic - IMMUNIZATION & INFECTIOUS DISEASES

Score: 1.28

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Adults with Influenza Vaccination	2	1.5	3	1.5	3	3	1	2	High
Adults 65+ with Pneumonia Vaccination	2	1.5	2	2	3	1.5	0	1.58	High
Salmonella Infection Incidence Rate	1	1.5	0	1.5	3	2	2	1.5	High
Age-Adjusted Death Rate due to Influenza and Pneumonia	1.5	1.5	1	1	1.5	1.5	2	1.45	Medium
Adults 65+ with Influenza Vaccination	1	1.5	1	1	1.5	1.5	1.5	1.28	Medium
Chlamydia Incidence Rate	0	1.5	0	1.5	1.5	0	3	1.2	Medium
Gonorrhea Incidence Rate	0	1.5	0	1.5	1.5	1.5	2	1.15	Medium
HIV Incidence Rate: Aged 13+	0	1.5	0	0	1.5	0	2	0.78	High
Tuberculosis Incidence Rate	0	1.5	0	0	0	1.5	1	0.58	High

Scoring Results by Topic - WELLNESS & LIFESTYLE

Score: 1.24

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Average Life Expectancy	2	1.5	2	1.5	1.5	2	2	1.8	Medium
Self-Reported Good Physical Health	2	1.5	3	1.5	1.5	1.5	1.5	1.8	Medium
Life Expectancy for Females	1	1	2	2	1.5	1.5	2	1.6	High
Life Expectancy for Males	1	0	1	1	1.5	1.5	2	1.15	High
Self-Reported General Health Assessment: Good or Better	0	1.5	1	1	1.5	1.5	1.5	1.13	Medium
Frequent Physical Distress	0	0	0	0	1.5	1.5	1.5	0.6	Medium
Insufficient Sleep	0	0	0	0	1.5	1.5	1.5	0.6	Medium

Scoring Results by Topic - PUBLIC SAFETY

Score: 1.22

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Alcohol-Impaired Driving Deaths	2	2	2	3	1.5	1.5	1.5	1.95	High
Pedestrian Injuries	1	1.5	0	1.5	2	0	2	1.2	High
Domestic Violence Offense Rate	1	1.5	0	1.5	1.5	0	2	1.15	Medium
Child Abuse Rate	0	1.5	0	1.5	1.5	1.5	1	0.95	Medium
Violent Crime Rate	0	1.5	0	0	1.5	1.5	1.5	0.83	Medium

Scoring Results by Topic - ENVIRONMENTAL & OCCUPATIONAL HEALTH

Score: 1.19

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Adults with Asthma	3	1.5	1.5	3	1.5	1.5	2	2.05	Medium
Asthma: Medicare Population	1	1	1	1	1.5	1.5	2	1.3	High
Children with Asthma	0	1.5	0	1.5	1.5	1.5	1.5	1.05	Low
Age-Adjusted ER Rate due to Asthma	0	1.5	0	1.5	1.5	0	1	0.8	Medium
Blood Lead Levels in Children	1	1.5	0	0	1.5	0	1	0.73	High

Scoring Results by Topic - DIABETES

Score: 1.08

	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Diabetes: Medicare Population	1	2	1	2	1.5	1.5	3	1.8	High
Diabetic Monitoring: Medicare Population	0	1	1	1	1.5	1.5	1.5	1.05	High
Age-Adjusted ER Rate due to Diabetes	0	1.5	0	1.5	1.5	0	2	1	Medium
Age-Adjusted Death Rate due to Diabetes	0	1.5	0	0	1.5	1.5	1.5	0.83	Medium
Adults with Diabetes	0	1.5	0	0	1.5	1.5	1	0.73	Medium

Scoring Results by Topic - EDUCATION

Score: 1.03

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
4th Grade Students Proficient in Reading	0	1.5	1	1.5	1.5	1.5	1.5	1.2	Low
School Readiness at Kindergarten Entry	0	1.5	0	1.5	1.5	3	1.5	1.2	Medium
People 25+ with a Bachelor's Degree or Higher	1	0	3	0	1.5	1.5	1	1.1	High
4th Grade Students Proficient in Math	0	1.5	0	1.5	1.5	1.5	1.5	1.05	Low
8th Grade Students Proficient in Math	0	1.5	0	1.5	1.5	1.5	1.5	1.05	Low
8th Grade Students Proficient in Reading	0	1.5	0	1.5	1.5	1.5	1.5	1.05	Low
Student-to-Teacher Ratio	1	1	1	1.5	1.5	1.5	0	0.98	Medium
High School Graduation	0	1.5	1	0	0	0.5	1	0.63	High

Scoring Results by Topic - TEEN & ADOLESCENT HEALTH

Score: 1.03

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Adolescents who have had a Routine Checkup: Medicaid Population	3	1.5	3	1.5	1.5	3	1	2	Medium
Teens who Smoke: High School Students	1	1.5	2	1.5	0	1.5	0	1.05	Medium
Teens who Use Tobacco	0	1.5	1	1.5	0	0.5	1.5	0.95	Medium
Adolescents who are Obese	0	1.5	0	1.5	0	0	1.5	0.75	Medium
Teen Birth Rate: 15-19	0	1.5	0	0	1.5	0	0	0.38	High

Scoring Results by Topic - ECONOMY

Score: 1.01

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Affordable Housing	3	1.5	3	1.5	1.5	3	2	2.2	Medium
Food Insecure Children Likely Ineligible for Assistance	3	1.5	3	3	1.5	1.5	0	1.88	Medium
SNAP Certified Stores	2	3	1.5	1.5	1.5	1.5	1	1.7	Medium
Low-Income Persons who are SNAP Participants	2	2	1.5	1.5	1.5	1.5	1.5	1.65	Low
Low-Income Preschool Obesity	1	2	1.5	1.5	1.5	1.5	2	1.6	Medium
Low-Income and Low Access to a Grocery Store	2	1	1.5	1.5	1.5	0	1.5	1.35	Medium
Renters Spending 30% or More of Household Income on Rent	1	2	1	1	1.5	1.5	1.5	1.35	High
Students Eligible for the Free Lunch Program	0	0	0	1.5	1.5	1.5	3	1.13	Medium
People Living 200% Above Poverty Level	0	0	0	0	1.5	1.5	3	0.9	High
Child Food Insecurity Rate	1	0	1	0	1.5	1.5	1	0.8	High
Per Capita Income	1	0	1	0	1.5	1.5	1	0.8	High
Severe Housing Problems	0	1	0	0	1.5	1.5	1.5	0.75	High
Children Living Below Poverty Level	0	0	0	0	1.5	1.5	2	0.7	High
Homeownership	0	0	0	0	1.5	1.5	2	0.7	High
People Living Below Poverty Level	0	0	0	0	1.5	1.5	2	0.7	High
Median Household Income	1	0	0	0	1.5	1.5	1	0.65	High
Food Insecurity Rate	0	0	0	0	1.5	1.5	1	0.5	High
Households with Cash Public Assistance Income	0	0	0	0	1.5	1.5	1	0.5	High
People 65+ Living Below Poverty Level	0	0	0	0	1.5	1.5	1	0.5	High
Unemployed Workers in Civilian Labor Force	0	0	0	0	1.5	1.5	1	0.5	High
Families Living Below Poverty Level	0	0	0	0	1.5	1.5	0	0.3	High

Scoring Results by Topic - MATERNAL, FETAL, & INFANT HEALTH

Score: 0.95

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Sudden Unexpected Infant Death Rate	2	1.5	2	2	3	3	2	2.13	High
Mothers who Received Early Prenatal Care	2	1.5	0	1.5	2	2	1.5	1.45	High
Babies with Very Low Birth Weight	0	1.5	0	1.5	0	1.5	1	0.8	Medium
Babies with Low Birth Weight	0	1.5	0	1.5	0	0	1	0.65	High
Infant Mortality Rate	0	1.5	0	1.5	0	0	1	0.65	High
Preterm Births	0	1.5	0	0	0	1.5	1	0.58	High
Teen Birth Rate: 15-19	0	1.5	0	0	1.5	0	0	0.38	High

Scoring Results by Topic - SOCIAL ENVIRONMENT

Score: 0.85

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Child Abuse Rate	0	1.5	0	1.5	1.5	1.5	1	0.95	Medium
Single-Parent Households	0	0	0	0	1.5	1.5	3	0.9	High
Children Living Below Poverty Level	0	0	0	0	1.5	1.5	2	0.7	High

Scoring Results by Topic - MEN'S HEALTH

Score: 0.70

Indicator	County Distribution		Value		Target		Trend	Score	Precision
	State	US	State	US	HP2020	Local			
Life Expectancy for Males	1	0	1	1	1.5	1.5	2	1.15	High
Prostate Cancer Incidence Rate	0	1	0	1	1.5	1.5	1	0.8	High
Age-Adjusted Death Rate due to Prostate Cancer	0	0	0	0	0	1.5	0	0.15	High

Healthy Communities Institute
Data Scoring Tool

County: Carroll
Carroll Hosp Center (MD)
Total indicators: 158
Wednesday 4th of October 2017 07:40:43 AM

	County Distribution		Value		Target				
Indicator	State	US	State	US	HP2020	Local	Trend	Score	Precision
Age-Adjusted Death Rate due to Falls	3	1.5	3	3	3	3	3	2.78	High
Age-Adjusted Death Rate due to Drug Use	2	1.5	3	3	3	3	3	2.63	High
Age-Adjusted Death Rate due to Suicide	1.5	1.5	3	3	3	3	3	2.55	High
Death Rate due to Drug Poisoning	2	3	3	3	1.5	1.5	3	2.55	High
Melanoma Incidence Rate	3	3	3	3	1.5	1.5	2	2.50	High
Solo Drivers with a Long Commute	3	3	3	3	1.5	1.5	2	2.50	High
Workers who Drive Alone to Work	3	3	3	3	1.5	1.5	2	2.50	High
Age-Adjusted Death Rate due to Melanoma	2	2	3	3	3	1.5	2	2.35	High
Mean Travel Time to Work	3	3	2	3	1.5	1.5	2	2.35	High
Adults with a Healthy Weight	3	1.5	3	3	1.5	3	1.5	2.33	High
High Blood Pressure Prevalence	3	1.5	3	3	3	1.5	1.5	2.33	Medium
Atrial Fibrillation: Medicare Population	3	3	3	3	1.5	1.5	1	2.30	High
Hyperlipidemia: Medicare Population	3	3	3	3	1.5	1.5	1	2.30	High
Adults who are Obese	2	1.5	3	3	3	1.5	2	2.28	High
Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	3	1.5	3	3	3	1.5	1	2.23	High
Affordable Housing	3	1.5	3	1.5	1.5	3	2	2.20	Medium
Liquor Store Density	2	3	2	3	1.5	1.5	2	2.20	High
Age-Adjusted Death Rate due to Heart Disease	2	1.5	2	2	1.5	2.5	3	2.13	High
Sudden Unexpected Infant Death Rate	2	1.5	2	2	3	3	2	2.13	High
Adults with Asthma	3	1.5	1.5	3	1.5	1.5	2	2.05	Medium
Rheumatoid Arthritis or Osteoarthritis: Medicare Population	3	2	2	2	1.5	1.5	2	2.05	High
Adolescents who have had a Routine Checkup: Medicaid Population	3	1.5	3	1.5	1.5	3	1	2.00	Medium
Adults with Influenza Vaccination	2	1.5	3	1.5	3	3	1	2.00	High
Breast Cancer Incidence Rate	3	3	2	2	1.5	1.5	1	2.00	High
Adult Fruit and Vegetable Consumption	3	1.5	3	1.5	1.5	1.5	1.5	1.95	Low
Adults who Visited a Dentist	3	1.5	3	1.5	1.5	1.5	1.5	1.95	Medium
Alcohol-Impaired Driving Deaths	2	2	2	3	1.5	1.5	1.5	1.95	High
Children in Medicaid who Visited a Dentist	3	1.5	3	1.5	1.5	2.5	1	1.95	Medium
Workers Commuting by Public Transportation	2	0	3	3	3	1.5	1.5	1.95	High
Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	3	1.5	3	2	1.5	1.5	1	1.93	Medium
Self-Reported Good Mental Health	2	1.5	3	1.5	1.5	1.5	2	1.90	Medium
Food Insecure Children Likely Ineligible for Assistance	3	1.5	3	3	1.5	1.5	0	1.88	Medium
Age-Adjusted Hospitalization Rate Related to Alzheimer's and Other Deme	3	1.5	3	1.5	1.5	3	0	1.80	Medium
Average Life Expectancy	2	1.5	2	1.5	1.5	2	2	1.80	Medium
Children with Low Access to a Grocery Store	3	2	1.5	1.5	1.5	1.5	1.5	1.80	Low
Diabetes: Medicare Population	1	2	1	2	1.5	1.5	3	1.80	High
People 65+ with Low Access to a Grocery Store	3	2	1.5	1.5	1.5	1.5	1.5	1.80	Low
Self-Reported Good Physical Health	2	1.5	3	1.5	1.5	1.5	1.5	1.80	Medium
Depression: Medicare Population	2	2	2	1	1.5	1.5	2	1.75	High
Mammogram in Past 2 Years: 50+	3	1.5	2	1	1.5	1.5	1.5	1.73	Medium
Primary Care Provider Rate	2	1	3	1.5	1.5	1.5	1.5	1.73	Medium
Ischemic Heart Disease: Medicare Population	2	2	2	2	1.5	1.5	1	1.70	High
SNAP Certified Stores	2	3	1.5	1.5	1.5	1.5	1	1.70	Medium
Age-Adjusted Death Rate due to Unintentional Injuries	3	1.5	1	0	1	1.5	3	1.68	High
Grocery Store Density	2	2	1.5	1.5	1.5	1.5	1.5	1.65	Medium
Low-Income Persons who are SNAP Participants	2	2	1.5	1.5	1.5	1.5	1.5	1.65	Low
People with Low Access to a Grocery Store	2	2	1.5	1.5	1.5	1.5	1.5	1.65	Low
Adults who Binge Drink	2	1.5	3	2	0	1.5	1	1.63	High
Non-Physician Primary Care Provider Rate	2	1	3	1.5	1.5	1.5	1	1.63	Medium
Fast Food Restaurant Density	1	2	1.5	1.5	1.5	1.5	2	1.60	Medium
Life Expectancy for Females	1	1	2	2	1.5	1.5	2	1.60	High
Low-Income Preschool Obesity	1	2	1.5	1.5	1.5	1.5	2	1.60	Medium
Recognized Carcinogens Released into Air	1.5	1.5	1.5	1.5	1.5	1.5	2	1.60	Low
Adults 65+ with Pneumonia Vaccination	2	1.5	2	2	3	1.5	0	1.58	High
Colon Cancer Screening: Sigmoidoscopy or Colonoscopy	2	1.5	2	1	1.5	1.5	1.5	1.58	Medium
Dentist Rate	2	0	3	1.5	1.5	1.5	1.5	1.58	Medium
Age-Adjusted Death Rate due to Breast Cancer	1	2	1	2	2	1.5	1.5	1.55	High
Cancer: Medicare Population	1	3	1	2	1.5	1.5	1	1.55	High
Hypertension: Medicare Population	1	2	2	2	1.5	1.5	1	1.55	High
Salmonella Infection Incidence Rate	1	1.5	0	1.5	3	2	2	1.50	High
Adults who are Overweight or Obese	1	1.5	2	2	1.5	1.5	1	1.48	Medium
Age-Adjusted Death Rate due to Influenza and Pneumonia	1.5	1.5	1	1	1.5	1.5	2	1.45	Medium
COPD: Medicare Population	1	1	2	1	1.5	1.5	2	1.45	High
Mothers who Received Early Prenatal Care	2	1.5	0	1.5	2	2	1.5	1.45	High
Oral Cavity and Pharynx Cancer Incidence Rate	1	1	2	1	1.5	1.5	2	1.45	High
Age-Adjusted Death Rate due to Colorectal Cancer	2	1	2	2	2	1.5	0	1.40	High
Alzheimer's Disease or Dementia: Medicare Population	2	2	1	1	1.5	1.5	1	1.40	High
Osteoporosis: Medicare Population	2	2	1	1	1.5	1.5	1	1.40	High
PBT Released	1.5	1.5	1.5	1.5	1.5	1.5	1	1.40	Low
Age-Adjusted Death Rate due to Cancer	1	1	2	2	2	2.5	0	1.35	High
Households with No Car and Low Access to a Grocery Store	1	1	1.5	1.5	1.5	1.5	1.5	1.35	Low
Low-Income and Low Access to a Grocery Store	2	1	1.5	1.5	1.5	0	1.5	1.35	Medium
Renters Spending 30% or More of Household Income on Rent	1	2	1	1	1.5	1.5	1.5	1.35	High
Adults who have had a Routine Checkup	1	1.5	2	1	1.5	1.5	1	1.33	Medium
Age-Adjusted Mortality Rate From Cancer	1.5	1.5	1.5	1.5	2	2	0	1.30	Medium
Asthma: Medicare Population	1	1	1	1	1.5	1.5	2	1.30	High
Adults 65+ with Influenza Vaccination	1	1.5	1	1	1.5	1.5	1.5	1.28	Medium
Farmers Market Density	1	1	1.5	1	1.5	1.5	1.5	1.28	Medium
High Cholesterol Prevalence	0	1.5	1	1	3	1.5	1.5	1.28	Medium
Age-Adjusted Death Rate due to Lung Cancer	1	1	2	2	2	1.5	0	1.25	High

Healthy Communities Institute
Data Scoring Tool

County: Carroll
Carroll Hosp Center (MD)
Total indicators: 158
Wednesday 4th of October 2017 07:40:43 AM

	County Distribution		Value		Target				
Indicator	State	US	State	US	HP2020	Local	Trend	Score	Precision
Lung and Bronchus Cancer Incidence Rate	1	1	2	1	1.5	1.5	1	1.25	High
4th Grade Students Proficient in Reading	0	1.5	1	1.5	1.5	1.5	1.5	1.20	Low
Access to Exercise Opportunities	1	0	2	1	1.5	1.5	1.5	1.20	Medium
Adequate Social and Emotional Support	0	1.5	1	1.5	1.5	1.5	1.5	1.20	Low
Age-Adjusted ER Rate due to Hypertension	0	1.5	0	1.5	1.5	0	3	1.20	Medium
Age-Adjusted ER Rate due to Mental Health	1	1.5	1	1.5	1.5	1	1	1.20	Medium
Chlamydia Incidence Rate	0	1.5	0	1.5	1.5	0	3	1.20	Medium
Colorectal Cancer Incidence Rate	1	1	2	1	1	1.5	1	1.20	High
Heart Failure: Medicare Population	2	1	2	1	1.5	1.5	0	1.20	High
Pedestrian Injuries	1	1.5	0	1.5	2	0	2	1.20	High
School Readiness at Kindergarten Entry	0	1.5	0	1.5	1.5	3	1.5	1.20	Medium
Domestic Violence Offense Rate	1	1.5	0	1.5	1.5	0	2	1.15	Medium
Gonorrhea Incidence Rate	0	1.5	0	1.5	1.5	1.5	2	1.15	Medium
Life Expectancy for Males	1	0	1	1	1.5	1.5	2	1.15	High
Recreation and Fitness Facilities	0	0	1.5	1.5	1.5	1.5	2	1.15	Medium
Drinking Water Violations	1	1	0	1.5	1.5	1.5	1.5	1.13	Medium
Self-Reported General Health Assessment: Good or Better	0	1.5	1	1	1.5	1.5	1.5	1.13	Medium
Students Eligible for the Free Lunch Program	0	0	0	1.5	1.5	1.5	3	1.13	Medium
Annual Ozone Air Quality	0	1	1.5	1.5	1.5	1.5	1	1.10	Medium
People 25+ with a Bachelor's Degree or Higher	1	0	3	0	1.5	1.5	1	1.10	High
4th Grade Students Proficient in Math	0	1.5	0	1.5	1.5	1.5	1.5	1.05	Low
8th Grade Students Proficient in Math	0	1.5	0	1.5	1.5	1.5	1.5	1.05	Low
8th Grade Students Proficient in Reading	0	1.5	0	1.5	1.5	1.5	1.5	1.05	Low
Children with Asthma	0	1.5	0	1.5	1.5	1.5	1.5	1.05	Low
Diabetic Monitoring: Medicare Population	0	1	1	1	1.5	1.5	1.5	1.05	High
People with a Usual Primary Care Provider	0	1.5	1	1.5	1.5	1	1	1.05	Medium
Teens who Smoke: High School Students	1	1.5	2	1.5	0	1.5	0	1.05	Medium
Age-Adjusted ER Rate due to Diabetes	0	1.5	0	1.5	1.5	0	2	1.00	Medium
Student-to-Teacher Ratio	1	1	1	1.5	1.5	1.5	0	0.98	Medium
Child Abuse Rate	0	1.5	0	1.5	1.5	1.5	1	0.95	Medium
Stroke: Medicare Population	0	2	0	1	1.5	1.5	1	0.95	High
Teens who Use Tobacco	0	1.5	1	1.5	0	0.5	1.5	0.95	Medium
Adults Engaging in Regular Physical Activity	0	1.5	1	0	1	1.5	1.5	0.93	Medium
People Living 200% Above Poverty Level	0	0	0	0	1.5	1.5	3	0.90	High
Single-Parent Households	0	0	0	0	1.5	1.5	3	0.90	High
Children with Health Insurance	0	0	1	1	2	1.5	1	0.85	High
Age-Adjusted Death Rate due to Diabetes	0	1.5	0	0	1.5	1.5	1.5	0.83	Medium
Violent Crime Rate	0	1.5	0	0	1.5	1.5	1.5	0.83	Medium
Age-Adjusted ER Rate due to Asthma	0	1.5	0	1.5	1.5	0	1	0.80	Medium
Age-Adjusted ER Visit Rate due to Dental Problems	0	1.5	0	1.5	1.5	0	1	0.80	Medium
Babies with Very Low Birth Weight	0	1.5	0	1.5	0	1.5	1	0.80	Medium
Child Food Insecurity Rate	1	0	1	0	1.5	1.5	1	0.80	High
Per Capita Income	1	0	1	0	1.5	1.5	1	0.80	High
Prostate Cancer Incidence Rate	0	1	0	1	1.5	1.5	1	0.80	High
Uninsured Emergency Department Visits	0	1.5	0	1.5	1.5	0	1	0.80	Medium
HIV Incidence Rate: Aged 13+	0	1.5	0	0	1.5	0	2	0.78	High
Adolescents who are Obese	0	1.5	0	1.5	0	0	1.5	0.75	Medium
Age-Adjusted ER Rate due to Alcohol/Substance Abuse	1	1.5	0	1.5	1.5	0	0	0.75	Medium
Households without a Vehicle	0	1	0	0	1.5	1.5	1.5	0.75	High
Severe Housing Problems	0	1	0	0	1.5	1.5	1.5	0.75	High
Adults with Diabetes	0	1.5	0	0	1.5	1.5	1	0.73	Medium
Blood Lead Levels in Children	1	1.5	0	0	1.5	0	1	0.73	High
Children Living Below Poverty Level	0	0	0	0	1.5	1.5	2	0.70	High
Chronic Kidney Disease: Medicare Population	0	0	0	0	1.5	1.5	2	0.70	High
Food Environment Index	0	0	0	0	1.5	1.5	2	0.70	High
Homeownership	0	0	0	0	1.5	1.5	2	0.70	High
People Living Below Poverty Level	0	0	0	0	1.5	1.5	2	0.70	High
Adults Unable to Afford to See a Doctor	0	1.5	0	0	1.5	0	1.5	0.68	Medium
Persons with Health Insurance	0	0	1	1.5	2	1	0	0.68	High
Babies with Low Birth Weight	0	1.5	0	1.5	0	0	1	0.65	High
Infant Mortality Rate	0	1.5	0	1.5	0	0	1	0.65	High
Median Household Income	1	0	0	0	1.5	1.5	1	0.65	High
High School Graduation	0	1.5	1	0	0	0.5	1	0.63	High
Frequent Mental Distress	0	0	0	0	1.5	1.5	1.5	0.60	Medium
Frequent Physical Distress	0	0	0	0	1.5	1.5	1.5	0.60	Medium
Insufficient Sleep	0	0	0	0	1.5	1.5	1.5	0.60	Medium
Preterm Births	0	1.5	0	0	0	1.5	1	0.58	High
Tuberculosis Incidence Rate	0	1.5	0	0	0	1.5	1	0.58	High
Adults who Smoke	0	1.5	0	0	1	0	1	0.53	High
Adults with Health Insurance	0	0	1	0	2	1.5	0	0.50	High
Food Insecurity Rate	0	0	0	0	1.5	1.5	1	0.50	High
Households with Cash Public Assistance Income	0	0	0	0	1.5	1.5	1	0.50	High
People 65+ Living Below Poverty Level	0	0	0	0	1.5	1.5	1	0.50	High
Unemployed Workers in Civilian Labor Force	0	0	0	0	1.5	1.5	1	0.50	High
Teen Birth Rate: 15-19	0	1.5	0	0	1.5	0	0	0.38	High
Cervical Cancer Incidence Rate	0	0	0	0	0	1.5	1	0.35	High
Families Living Below Poverty Level	0	0	0	0	1.5	1.5	0	0.30	High
Age-Adjusted Death Rate due to Prostate Cancer	0	0	0	0	0	1.5	0	0.15	High

9. Healthy Carroll Vital Signs

A. Methodology

Since the early 2000s, The Partnership has annually recorded and monitored a number of consistently available, valid-source data points, or indicators, related to the health of people in our community. This work is carried out through a system called *Healthy Carroll Vital Signs* (HCVS).

HCVS now tracks 20 indicators in priority areas determined through the Community Health Needs Assessment and planning process. These data points are linked to improvement objectives in the Community Benefit and Health Improvement Plan for Carroll County. Each indicator is aligned with a particular health improvement strategy, and has a specific target value. Accountability for each strategy, and thus for progress in reaching the indicator target, is written into the Community Benefit and Health Improvement Plan.

The targets in HCVS are adopted from Healthy People 2020 Objectives, Maryland SHIP Goals, and American Cancer Society Goals. When no expert outside target is available, targets are developed by Carroll Hospital's Community Benefit Planning and Evaluation Team. Data in HCVS is regularly checked by the Community Benefit Team and by staff of The Partnership, Leadership Team members, and community health improvement partners, as all strive together to meet the plan's objectives. With HCVS, those working on the plan can objectively evaluate progress and, if necessary, adjust actions to move the numbers in a positive direction.

Data sources are consulted twice a year for new information. Any new data is entered in the HCVS database. The process of researching the data from various sources and entering new numbers into the HCVS database is carried out by staff of The Partnership. Data reports for HCVS are published on June 1 and on December 1, and are available for public viewing on HealthyCarroll.org under "Assessments & Data."

The current HCVS data report is attached here for a perspective of progress toward FY2017-FY2018 Community Benefit Plan objectives. For some HCVS indicators, the data saved goes back even further in time, and long-term trend information is available on request.

B. Data Summary

HCVS data is organized by the priority areas of the FY2017-FY2018 Community Benefit Plan:

- **Diabetes**
- **Heart Health**

- **Cancer**
- **Obesity**
- **Behavioral Health**

Data for the **Diabetes** indicators *percentage of adults with diabetes* and *emergency department visit rate due to diabetes* are at or better than the target values. However, the data trend is moving away from target for *percentage adults with diabetes*, and *data for emergency department visit rate due to diabetes* is static. The *diabetes death rate* is higher than the desired target, and higher than the previous (2014) data.

Two of the **Heart Health indicators**, *% of adults with high blood pressure* and % of *adults with high cholesterol* show improvement, but have not yet reached the target. Death rates for heart disease and stroke remain above target. Only results for *emergency department visit rate due to hypertension* and *% of adults who engage in regular physical activity* are on target.

In the area of **Cancer**, the *age-adjusted cancer mortality rate* and the *melanoma incidence rate* have improved, but they have not reached their targets. The melanoma rate remains high in comparison with other counties in Maryland and in the US. The *percentage of adults who smoke* increased, moving further away from the target, but the percentage of adolescents using tobacco products decreased, and is now on target.

In the **Obesity** area, data for the percentage of *adults who are obese* shows continued improvement. Data for *percentage of children and adolescents who are obese* is also improved, so that the targets for both indicators are currently met.

Behavioral Health indicators are mixed. Data is improved and at target for *patients admitted to CH inpatient unit 3+ times / year for behavioral health diagnosis*. The rates for *emergency department visits related to mental health conditions* and *emergency department visits for addictions-related conditions* are also at target levels. However, the *suicide mortality rate* and the rate of deaths caused by prescription or illicit drugs are both worsening and moving away from target values.

C. Attachment

- Healthy Carroll Vital Signs data report – December 2017
  The Partnership for a Healthier Carroll County

Healthy Carroll Vital Signs ™ are the *measures of health* (health indicators) for our community of Carroll County, MD

INDICATOR and data source (data source in parentheses) Indicator is for the entire population of Carroll County, MD unless otherwise stated.	Most recent available DATA FY 2017 – FY 2018 (year data was collected is in parentheses)					TREND	DESIRED TREND	AT TARGET or better?	TARGET & Target Source
	Jun. 2016 BASELINE	Dec. 2016	Jun. 2017	Dec. 2017	Jun. 2018				a) CB-HIP b) SHIP 2017 c) Healthy People 2020
Priority: DIABETES									
1. % of adults with diabetes (MD BRFSS)	**9.8%** (2014)	**8.9%** (2015)	**8.9%** (2015)	**9.7%** (2016)		↑	↓	✓	a) 10.4%
2. Age-adjusted death rate due to diabetes per 100,000 (MVS)	**12.0** (2014)	**12.0** (2014)	**14.2** (2015)	**14.2** (2015)		↑	↓		a) 12.0
3. Emergency department visit rate due to diabetes (MHCRC) *	**117.4** (2014)	**117.4** (2014)	**117.4** (2014)	**117.4** (2014)		-	↓	✓	b) 186.3
Priority: HEART HEALTH									
4. Age-adjusted death rate due to CVA (stroke) - rate per 100,000 (MVS)	**42.2** (2014)	**42.2** (2014)	**46.4** (2015)	**46.4** (2015)		↑	↓		c) 33.8
5. Age-adjusted death rate due to heart disease - rate per 100,000 (MVS)	**178.2** (2014)	**178.2** (2014)	**184.2** (2015)	**184.2** (2015)		↑	↓		b) 166.3
6. % of adults with high blood pressure (MD BRFSS)	**32.2%** (2013)	**40.9%** (2015)	**40.9%** (2015)	**34.0%** (2016)		↓	↓		c) 26.9%
7. % of adults with high cholesterol (MD BRFSS)	**40.9%** (2013)	**32.8%** (2015)	**32.8%** (2015)	**32.8%** (2015)		↓	↓		c) 13.5%
8. Emergency department visit rate due to hypertension (MHCRC) *	**150.4** (2014)	**150.4** (2014)	**150.4** (2014)	**150.4** (2014)		-	↓	✓	b) 234
9. % of adults who engage in regular physical activity, 150 min. moderate or 75 min. vigorous per week (MD BRFSS)	**52.3%** (2013)	**48.7%** (2015)	**48.7%** (2015)	**48.7%** (2015)		↓	↑	✓	c) 47.9%

Priority: CANCER										
10.	Age-adjusted cancer mortality rate per 100,000 (MVS)	**161.9** (2014)	**161.9** (2014)	**156.8** (2015)	**156.8** (2015)		↓	↓		b) 147.4
11.	Melanoma incidence rate per 100,000 (Maryland Cancer Registry)	**32.2** (2012)	**34.1** (2013)	**34.1** (2013)	**32.1** (2014)		↓	↓		a) 24.8
12.	% of adults who smoke tobacco (MD BRFSS)	**17.3%** (2014)	**11.6%** (2015)	**11.6%** (2015)	**15.0%** (2016)		↑	↓		c) 12%
13.	Adolescents who use tobacco products (MD Youth Tobacco Survey)	**18.7%** (2013)	**18.7%** (2013)	**15.0%** (2014)	**15.0%** (2014)		↓	↓	✓	b) 15.2%
Priority: OBESITY										
14.	% of adults who are overweight or obese (MD BRFSS)	**69.3%** (2014)	**68.3%** (2015)	**68.3%** (2015)	**62.4%** (2016)		↓	↓	✓	b) 63.4%
15.	Children and adolescents who are obese (MD Youth Risk Behavior Survey)	**9.6%** (2013)	**9.6%** (2013)	**8.9%** (2014)	**8.9%** (2014)		↓	↓	✓	b) 10.7%
Priority: BEHAVIORAL HEALTH										
16.	# of BH patients admitted to CH inpatient unit 3+ times / year for behavioral health diagnosis (CH)	**41** (2015)	**41** (2015)	**37** (2016)	**37** (2016)		↓	↓	✓	a) 50
17.	Suicide mortality rate per 100,000 (MD Vital Statistics)	**14.8** (2014)	**14.8** (2014)	**15.1** (2015)	**15.1** (2015)		↑	↓		b) 9
18.	Emergency department visits related to mental health conditions - rate per 100,000 (MHCRC) *	**3140.8** (2014)	**3140.8** (2014)	**3140.8** (2014)	**3140.8** (2014)		-	↓	✓	b) 3156.2
19.	Drug-induced mortality rate - deaths caused by prescription or illicit drugs – rate per 100,000 (MVS)	**20.8** (2014)	**20.8** (2014)	**23.9** (2015)	**23.9** (2015)		↑	↓		b) 12.6
20.	Emergency department visits for addictions-related conditions (MHCRC) *	**1064.0** (2014)	**1064.0** (2014)	**1064.0** (2014)	**1064.0** (2014)		-	↓	✓	b) 1400.9

KEY TO ABBREVIATIONS

CH - Carroll Hospital
MD BRFSS – Maryland Behavioral Risk Factor Surveillance System
MVS – Maryland Vital Statistics
MHCRC - Maryland Health Services Cost Review Commission

☐ - Bold box indicates new data added since the last report.

CVA - Cardiovascular Accident
CB-HIP - Community Benefit & Health Improvement Plan
SHIP – Maryland State Health Improvement Plan

* *The ICD system used by the MHCRC to classify diseases for reporting is currently being updated. No new data will be available until after June 2018.*

10. Healthy Community Vision

A. Methodology

From September 1 to November 15, 2016 The Partnership for a Healthier Carroll County installed large chalkboards around the county to collect input from local residents in answer to the question, "To me, a healthy community is…" These chalkboards were just one component of The Partnership's *Healthy Community Vision* project, which employed innovative methods to get community involvement in determining the key health issues facing Carroll.

Residents were encouraged by seeing the boards to use the chalk provided and write down their thoughts and ideas about improving the health of Carroll County. There were both large 3-sided boards with each side measuring 8 ft x 4 ft. and also smaller 6 ft boards that were used for inside locations. In addition, at a few locations, the boards were painted onto walls with chalkboard paint. The boards were placed in more than 20 locations including

- TownMall of Westminster
- Tevis Wellness Center
- Access Carroll
- Carroll County Health Department
- Branches of the Carroll County Public Library
- Carroll County Government Office Building
- Boys and Girls Club of Westminster
- Fall festivals
- Carroll Arts Center
- Mt Airy Wellness Pavilion
- Carroll Hospital Departments at Knit Building

B. Results

Approximately 1,000 responses were collected and analyzed by The Partnership staff to determine trends and to identify those issues that were most compelling to the community.

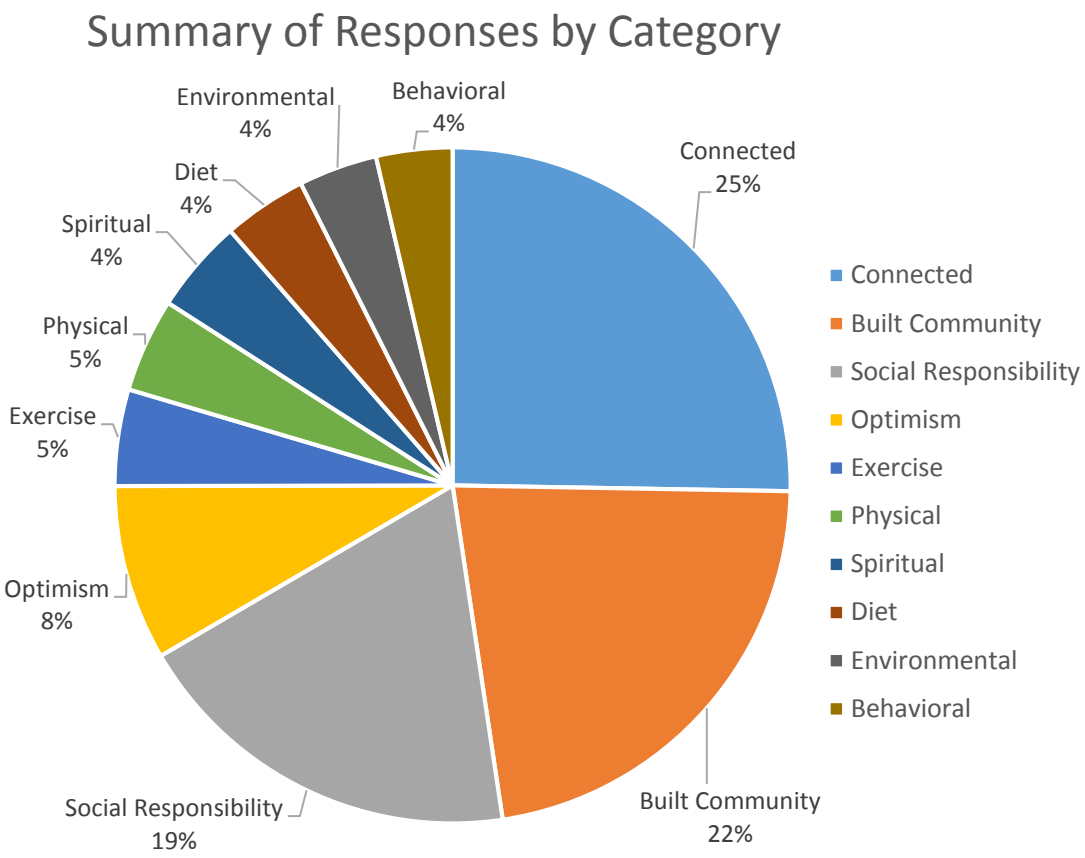
The results of the campaign ranged from comments about individual health and health care goals, such as exercising more and eating healthy foods, to responses about the importance of the well-being of the entire community. Many responses expressed an awareness that nurturing the health of a community can lead to better overall health.

Entries such as "A healthy community is parks connected by bike trails", "A healthy community is respectful of diversity", and "A healthy community is families helping families" are just a few examples of the comments that were received. Once compiled, the results were organized by category.

The largest percentage of responses fell into three major areas:

- Connections
- Built Community
- Social Responsibility

These areas encompass a wide range of issues related to health, with a particular emphasis on social determinants of health. *Connections* refers to people's strong desire to work cooperatively with friends, neighbors and family members. These connections help to support individuals both physically and emotionally as they live, work and play. Comments about *built community* refer to open spaces, bike and walking trails, safety and accessible transportation. As seen in both the community survey and key informant discussions, these items allow for community members to more easily engage in regular physical activity and even impact employment. Finally, *social responsibility* was mentioned in comments such as: accepting, diverse, engaged, respectful and tolerant. Issues such as mental health concerns, employment and job skills can be affected by a person's ability to see a support system in place that is accepting of them and their needs.


Summary of Responses by Category
Environmental 4%
Behavioral 4%
Connected 25%
Diet 4%
Spiritual 4%
Physical 5%
Exercise 5%
Optimism 8%
Social Responsibility 19%
Built Community 22%
Connected
Built Community
Social Responsibility
Optimism
Exercise
Physical
Spiritual
Diet
Environmental
Behavioral

11. Carroll Hospital Data

A. Methodology

For data specific to Carroll Hospital, Horizon Performance Manager (HPM) software is utilized by both the Finance and Business Development departments. Both inpatient (IP) and outpatient (OP) volumes are available, and the data are updated weekly. The Finance Department maintains a monthly report to track the following: admissions, births, observation cases, patient and outpatient surgeries and emergency department (ED) visits. Finance also tracks various patient indicators, such as high utilization and ED visits, and they do an extensive physician-based reporting of caseloads, admission rates, length of stay and peer evaluation reporting. Due to the changing health care environment, Finance now closely tracks Readmissions, Performance Quality Indicators and Potentially Preventable Conditions. Periodically, Business Development runs HPM reports for specific service lines or procedures to calculate future volume projections; diagnosis codes to determine reasons for admissions and ED visits; payor mix to track commercial payors, Medicare and Medicaid utilization, and patient demographics.

The volumes for this analysis were extracted from HPM (which is fed data from Paragon, the hospital's electronic medical records system) for the most recent calendar year, using groupings defined by the International Classification of Diseases Tenth Revision (ICD-10) diagnosis codes, All Patient Refined Diagnosis-Relate Group (APR DRG) codes, or Medicaid Severity Diagnosis-Relate Group (MS DRG) codes. Patients with any diagnosis of the following conditions were selected: Congestive Heart Failure, Dementia, Diabetes, Mental Health, Substance or Alcohol Abuse, Obesity, Tobacco Use, Low Birth Weight Newborns, Premature Newborns and Drug Addicted Newborns. The visit totals include inpatient, observation, psychiatric and ED patient types. The data were then loaded into an Access database along with readmission reports. The Patient Account Numbers in the data from HPM were compared with the Patient Numbers

B. Results Summary

These ten conditions were selected for the analysis because they are focus areas for Carroll Hospital's population health initiatives and/or our Community Health Needs Assessment Survey. Since reducing readmissions is a continuing immediate organizational wide objective, IP readmissions and ED return data were included for each of the conditions. The age breakout was included in order to highlight the specific populations in need of care. Of all conditions, Mental Health and Substance or Alcohol Abuse account for the most visits, patients and readmissions; it also spans all age groups, with the majority of patients in the 36-64 age range. Tobacco Use follows as the condition with the next highest level of visits and patients and accounts for the most ED to

ED 3-day returns. While diabetes has the fourth highest level of patients and visits, this condition accounts for the second highest number of inpatient readmissions at 2,899. Congestive Heart Failure (CHF), diabetes and dementia are areas of focus for the 65+ population and Carroll Hospital will continue to monitor newborn conditions. The utilization and readmissions data in general will continue to be closely tracked along with other conditions that affect the health of the community.

C. Attachment

- Carroll Hospital Data (chart)

Carroll Hospital Data

Timeframe: Calendar Year 2016

	Categories									
Metrics	Congestive Heart Failure	Dementia	Diabetes	Mental Health	Substance or Alcohol Abuse	Obesity	Tobacco Use	Low Birth Weight	Premature Newborn	Drug Addicted Newborn
Total Visits*	2,596	2,041	6,712	11,716	11,405	3,398	9,877	42	80	47
Readmissions										
INP to INP	301	121	399	495	263	260	203	2	2	2
INP to Emergency	137	94	282	389	233	190	188	3	6	2
Return to ER in 3 Days	23	22	139	471	752	29	647	0	0	0
Demographics (Unique Patients)										
0 to 18	0	11	43	693	290	54	154	42	80	47
19 to 35	9	13	334	2,312	3,981	368	3,460	0	0	0
36 to 64	495	123	2,576	4,573	5,803	1,534	5,025	0	0	0
65 to 85	1,402	1,031	3,147	2,976	1,211	1,286	1,121	0	0	0
86 or older	690	863	612	1,162	120	156	117	0	0	0
Total Patients	1,451	1,325	2,899	6,963	6,493	2,613	5,585	40	76	46

* Visits do not represent total individual patients

Source: Horizon Performance Manager

12. Maryland State Health Improvement Process (SHIP) and Local Health Improvement Process (LHIP)

A. Methodology

The Maryland State Health Improvement Process (SHIP) provides a framework for accountability, local action, and public engagement to advance the health of Maryland residents. The mission of the Maryland Department of Health (MDH) Office of Population Health Improvement (OPHI), which oversees the SHIP, is to transform public health through data, partnerships, and funding initiatives.

OPHI supports and guides each local health department in Maryland to identify and address local public health priorities. The Carroll County Health Department coordinates these efforts through the Local Health Improvement Coalition. This group guides the Local Health Improvement Process (LHIP), determined by state data and guidance combined with local health assessment data.

The Partnership provides critical data and information to the community, local organizations, Carroll Hospital and Carroll County Health Department which in turn supports LHIC work by conducting the Community Health Needs Assessment and providing rich local data for planning. The LHIC uses this data in combination with state data to identify health priorities. The Partnership serves as the coordinating hub for identified health priorities and builds the capacity of individual and organizations to improve health and quality of life in Carroll County.

B. Results Summary

The SHIP data includes measures for 39 health-related issues. The vision areas of SHIP include: Healthy Beginnings, Healthy Living, Healthy Communities, Access to Health Care, and Quality Preventive Care. These state data measures, combined with the Community Health Needs Assessment results and feedback from the LHIC, will be used to develop an updated Local Health Improvement Plan (LHIP) in 2018. The LHIP will address top priority public health issues and suggested actions to improve community health outcomes.

Current LHIC priorities are:

- Behavioral Health
- Diabetes
- Obesity

- Heart Health
- Dental/Oral Health

Access to Care is addressed as part of strategies for each priority, and social determinants of health are included in LHIC discussions.

C. Attachments

The chart below was prepared using SHIP data and comparing Carroll County to other Maryland counties. This data can be accessed at: http://ship.md.networkofcare.org/ph/
Notes:

- Priority measures for Carroll are highlighted
- MD 2017 Goal – Maryland goal for 2017
- HP 2020 Goal – Healthy People 2020 goals established by the United States Department of Health and Human Services

Healthy Beginnings

Indicator	Year	Value	State Rank	MD 2017 Goal	HP 2020 Goal
Infant death rate	2015	3.0 per 1,000 live births	Lowest rate in state	6.3	6
Babies with low birth weight	2015	5.9% of all live births	4th lowest rate in state	8%	7.8%
Sudden Unexpected Infant Death Rate (SUIDs)	2015	.28 per 1,000 live births	Lowest rate in state	.86	.84
Teen birth rate	2015	6.8 per 1,000 teens aged 15-19	2nd lowest in state	17.8	NA
Early prenatal care (1st trimester)	2015	75.9% of pregnant women	14th lowest in state	66.9%	77.9%
Students entering kindergarten ready to learn	2015	55% of children entering Kindergarten	4th highest in state	NA	NA
High school graduation rate	2015	95% of students graduate from HS in 4 years	Highest in state	95%	82.4%
Children receiving blood lead screening	**2015**	**49% children 12-35 months enrolled in Medical Assistance**	**2nd lowest in state**	**69.5%**	**NA**

Healthy Living

Indicator	Year	Value	State Rank	MD 2017 Goal	HP 2020 Goal
Adults who are not overweight or obese	2015	31.7% of adults are not overweight or obese	12th lowest in state	36.6%	33.9%
Adolescents who are obese	2014	8.9% of public high school students who are obese	3rd lowest in state	10.7%	16.1%
Adults who currently smoke	**2015**	**11.6% of adults currently smoke**	**4th lowest in state**	**15.5%**	**12%**
Adolescents who use tobacco	**2014**	**15% of public high school students who used any tobacco product in last 30 days**	**4th lowest in state**	**15.2%**	**21%**
HIV incidence rate	2015	4.2 per 100,000	4th lowest in state	26.7	NA
Chlamydia infection rate	2015	210 per 100,000	3rd lowest in state	431	NA
Life expectancy	2013-15	79.3 years	13th highest in state	79.7	NA
Increase physical activity	2015	48.7% of adults report at least 150 mins of moderate physical activity or 75 minutes of vigorous physical activity per week	8th lowest in state	50.4%	47.9%

Healthy Communities

Indicator	Year	Value	State Rank	MD 2017 Goal	HP 2020 Goal
Child maltreatment rate	2015	3.6 per 1000 under 18	3rd lowest rate	NA	NA
Suicide rate	**2013-15**	**15.1 per 100,000**	**Highest rate of 10 counties reporting**	**9 per 100,000**	**10.2 per 100,000**
Domestic violence	2015	407 per 100,000	9th lowest	445 per 100,000	**NA**
Children with elevated blood lead levels	2015	0.1% of children tested	Tied for 2nd lowest	.28%	NA
Fall-related death rate	**2013-15**	**13.9 per 100,000**	**Highest rate of 8 counties reporting**	**7.7 per 100,000**	**7 per 100,000**
Pedestrian injury rate on public roads	2015	18.5 per 100,000	2nd lowest	35.6 per 100,000	20.3 per 100,000
Affordable Housing	**2015**	**26% housing units affordable on median teacher salary**	**2nd lowest**	**54.4% housing units**	**NA**

Access to Health Care

Indicator	Year	Value	State Rank	MD 2017 Goal	HP 2020 Goal
Adolescents who received a wellness checkup in the last year	**2014**	**47.4% adolescents aged 13-20 enrolled in Medicaid**	**3rd lowest**	**57.4%**	**NA**
Children receiving dental care in the past year	**2015**	**56.0% of children aged 0-20 enrolled in Medicaid**	**3rd lowest**	**64.6%**	**NA**
Persons with a usual primary care provider	2015	93.7% adults	4th highest	83.9%	NA
Uninsured ED visits	2015	5.4% of visits to ED by persons without insurance (no charge or self-pay)	5th lowest	14.7%	NA

Quality Preventive Care

Indicator	Year	Value	State Rank	MD 2017 Goal	HP 2020 Goal
Cancer mortality rate	2013-15	156.8 deaths per 100,000 people	8th lowest	147.4	160.6
Emergency Department visit rate due to diabetes	2014	117.4 visits per 100,000 people	3rd lowest	186.3	NA
Emergency Department visit rate due to hypertension	2014	150.4 visits per 100,000 people	4th lowest	234	NA
Drug-induced death rate	**2013-15**	**23.9 per 100,000 people**	**6th highest of 13 counties reporting**	**12.6**	**11.3**
Emergency Department visit rate related to mental health conditions	2014	3140.8 per 100,000 people	8th lowest	3152.6	NA
Hospitalization rate related to Alzheimer's or other dementias	**2014**	**257.1 per 100,000 people**	**3rd highest**	**199.4**	**NA**
Children (19-35 months old) who receive recommended vaccines	2015	NA	NA	72% children 19-35 months	80%
Annual seasonal influenza vaccinations	**2015**	**36.8% adults vaccinated annually**	**8th lowest in state**	**49.1%**	**70%**
Emergency department visit rate due to asthma	2014	26.9 per 10,000 people	Lowest in state	62.5 per 10,000	NA

Age-adjusted mortality rate from heart disease	**2013-15**	**184.2 per 100,000 people**	**10th highest in state**	**166.3 per 100,000**	**152.7 per 100,000**
Emergency Department Visits for Addictions-Related Conditions	2014	1064 per 100,000 people	7th lowest in state	1400.9 per 100,000	NA
Emergency department visit rate for dental care	2014	533 per 100,000 people	5th lowest in state	792.8 per 100,000	NA

MARYLAND RURAL HEALTH ASSOCIATION

2018 MARYLAND Rural Health Plan

MDRuralHealth.org
MDRuralHealthPlan.org

Maryland Department of Health
State Office of Rural Health

RMC
Rural Maryland Council

Robert Wood Johnson Foundation

ACKNOWLEDGMENTS

The Maryland Rural Health Association was tasked with updating the Maryland Rural Health Plan, a document that gives life to the health care status of rural Marylanders. This project would not be possible without the support from the State Office of Rural Health, the Rural Maryland Council, and the Robert Wood Johnson Foundation; for that we extend our sincerest gratitude.

The Maryland Rural Health Association would also like to extend its appreciation to the following organizations and individuals for their support in making the 2018 Maryland Rural Health Plan a success. Acknowledgements include:

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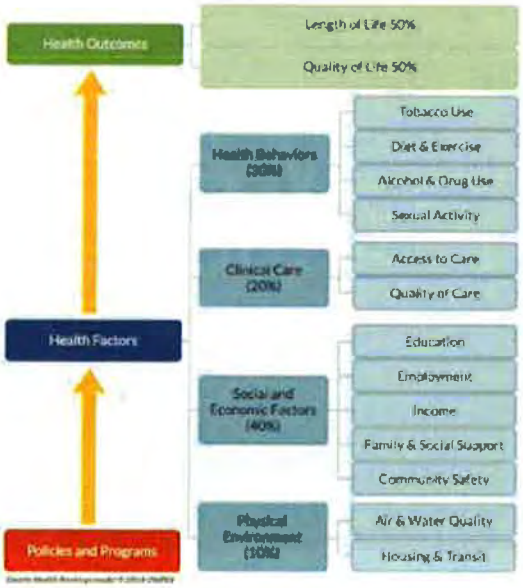
- Maryland Rural Health Association Board of Directors: PRESIDENT: Mark Boucot, Garrett Regional Medical Center; VICE-PRESIDENT. Susan Stewart, AHEC West; SECRETARY: Jennifer Berkman, Eastern Shore AHEC; TREASURER: Andrea Mathias, Worcester County Health Department; BOARD MEMBERS: Meena Brewster, St. Mary's Health Department; Stephanie Garrity, Cecil County Health Department; Annie Kronk, Retired from The Johns Hopkins Institutions; Michael Meit, NORC Walsh Center for Rural Health Analysis, NORC at the University of Chicago; Larry Polsky, Calvert County Health Department; John Ness, West Cecil Health Center, Inc.; Robert Stephens, Garrett County Health Department; Patti Willis, University of Maryland Shore Regional Health; Christine Wray, MedStar St. Mary's Hospital; STATE AGENCY LIAISON(S)/NON-VOTING: Temi Oshiyoye, State Office of Rural Health, Maryland Department of Health; Jennifer Witten, Maryland Hospital Association; Meredith Donaho, Rural Maryland Council; EX-OFFICIO MEMBER/NON-VOTING: Most recent past MRHA Board President: Lori Werrell, MedStar St. Mary's Hospital.
- Focus Group Moderators: Shelley Argabrite, Garrett County Health Department: Shannon Bingham, St. Mary's County Health Department; Mallory Callahan, Harford County Health Department; Melissa Clark, AHEC West; Daniel Coulter, Cecil County Health Department; Dennis DiCintio, Wicomico County Health Department; Jenifer Faulkner, Calvert County Health Department; Katherine Gunby, Worcester County Health Department; Maggie Kunz, Carroll County Health Department; Mary McPherson, Washington County Health Department; Angela Mercier, Dorchester County Health Department; Jenna Mulliken, St. Mary's County Health Department; Victoria Persetic, Calvert County Health Department; John Pesaniello, LCADC, Worcester County Health Department; Rebecca Rice, Kent County Health Department; Amber Starn, Charles County Health Department; Craig Stofko, Somerset County Health Department; Maryann Thompson, Queen Anne's County Health Department; Fredia Wadley, MD, Talbot County Health Department; Rissah Watkins, Frederick County Health Department

The Maryland Rural Health Association uses the following Robert Wood Johnson Foundation



MARYLAND RURAL HEALTH ASSOCIATION

2018 MARYLAND Rural Health Plan

EXECUTIVE SUMMARY

The updated Maryland Rural Health Plan is the result of a comprehensive examination of the rural health care needs of Maryland. This updated plan was made possible by a collaboration between the Maryland Rural Health Association (MRHA); the Maryland State Office of Rural Health; the Rural Maryland Council; and the Robert Wood Johnson Foundation.

The Maryland State Office of Rural Health reports that 25% of Marylanders live in rural communities. Rural residents may face structural, economical, and physical barriers to health care while rural health care providers seek strategies and opportunities to increase access and services available to their communities.

The Maryland Rural Health Plan examined existing county health plans, Community Health Needs Assessments, State Health Improvement Process (SHIP) data, results from a state appointed study on Maryland's Eastern Shore, and feedback from citizens and health care professionals in each of Maryland's rural counties to understand the state of rural health. Data was triangulated by topic. Themes found in multiple data sources emerged as key priorities. Findings were collated for the state, with county profiles highlighting their specific results. Preliminary findings were reviewed by the MRHA Board of Directors.

The resulting areas of need that were identified are:

I. Access to care: reduce barriers, remove gaps, and increase access to quality health care for rural Marylanders.
   - Areas of concern include access to general practitioners, specialists, behavioral health and oral health providers, as well as urgent care and emergency facilities.

II. Sustainable funding mechanisms for health care services: secure permanent funding streams, explore new, innovative reimbursement systems, and work to improve funding regulations for all parts of health care infrastructure.
   - Areas of concern were largely centered around hospitals, federally qualified health centers, and emergency medical services.

III. Care coordination: explore mechanisms to link health care consumers to services and improve coordination and collaboration between health care providers within rural Maryland.
   - The two main needs around care coordination were expansion of care coordination services to more providers, and increase coordination and knowledge of services between health care entities.

IV. Chronic disease prevention and management: reduce the incidence of new chronic diseases and increase ability for people to manage their conditions.
   - Findings show three main areas of concern: health program locations and costs, lack of assistance for programs from Medicaid and Medicare, and sliding scale fees for vulnerable populations.

V. Health literacy and health insurance literacy: explore ways to increase individual health literacy and health insurance literacy of consumers.

- The need was largely around the ability to understand health information and health insurance information, as well as transforming facilities/organizations to be easier for both health care professionals and consumers to navigate.

VI. Outreach and education: work with community-based services and health care infrastructure to provide outreach and education to citizens on relevant and emergent health issues.
- The need centered around the lack of awareness, knowledge, and accessibility of some of the outreach and education efforts in the community.

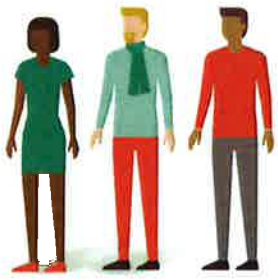
To accomplish sustained change, several recommendations in three categories were identified:

Policy Recommendations:
- Medical Transportation and Emergency Medical Services Reimbursement
- Establishment of a Plain Language Policy
- Behavioral Health Treatment Policy
- Telehealth Expansion and Reimbursement
- Study of Best Practices for Recruitment and Retention of Rural Providers
- Reimbursement for Care Coordination

Systems-Based Recommendations
- Training for Transportation Professionals
- Telehealth Expansion and Medication Management
- Care Coordination and No Wrong Door Approach
- Database of Existing Resources for Rural Health
- School-Based Health Centers
- Mobile Health and Crisis Services
- Transportation Services
- Best Practices for the All Payer Model
- Community Trust Building
- Stigma Reduction
- Social Media and Marketing Services
- Expansion of Non-Clinical Health Professionals

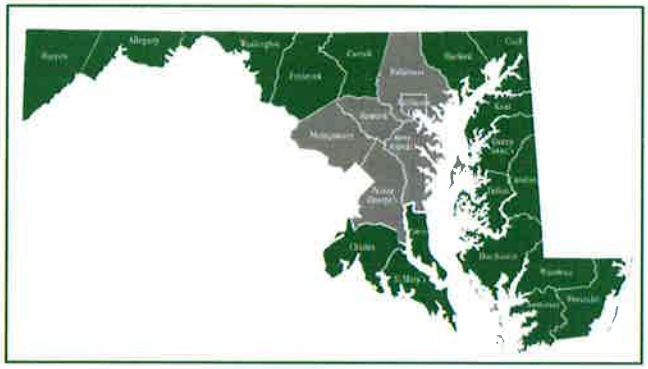
Individual Recommendations
- Health Insurance Literacy Education
- Patient Advocacy
- Healthy Lifestyle Education
- Addressing the Unintended Consequences

The goal of each recommendation is to be general but specific enough to allow clarity for stakeholders to understand each recommendation's intent, while allowing flexibility to meet specific county needs. The Maryland Rural Health Plan seeks to document needs, as well as serve as a roadmap to creating healthier rural communities.



MRHA will now work with state-wide partners to begin actualizing changes based on the outlined findings. Please visit the Maryland Rural Health Plan website to stay up-to-date on the implementation of the updated Maryland Rural Health Plan.

OVERVIEW OF RURAL MARYLAND



Rural communities throughout Maryland are varied, differing in population density, remoteness from urban areas, economic make-up, and social characteristics. Rural Maryland represents almost 80 percent of Maryland's land area and 25 percent of its population.

The state and federal government define rural jurisdictions differently. This publication defines "rural" at the state's level of acknowledgment in which rural Maryland is made up of eighteen of the twenty-four counties in the state as show in green in the above map: Allegany, Calvert: Allegany, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Kent, Queen Anne's, Somerset, St. Mary's, Talbot, Washington, Wicomico, and Worcester.

Maryland law states that "many rural communities in the State face a host of difficult challenges relating to persistent unemployment, poverty, changing technological and economic conditions, an aging population and an out-migration of youth, inadequate access to quality housing, health care and other services, and deteriorating or inadequate transportation, communications, sanitations, and economic development infrastructure," (West's Annotated Code of Maryland, State Finance and Procurement § 2-207.8b, http://mgaleg.maryland.gov/2018rs/statute_google/gsf/2-207.pdf). The Robert Wood Johnson Foundation identifies four interdependent sectors which impact rural health: health behaviors, clinical care, social and economic factors, and physical environment. These encompass and build on the Annotated Code by providing more context for each focus area.

While rural Maryland provides a rich culture for its communities, it has negative implications in terms of access to health care. Rural Maryland is scattered with Medically Underserved Areas and Populations (MUA/P), and Health Professional Shortage Areas (HPSA). Maryland's county health departments play a vital role in the health of their communities; this is especially evident in those rural Maryland counties with a limited health care system. And while Maryland is one of the richest states, there is great disparity in how wealth is distributed. The greatest portion of wealth resides around the Baltimore/Washington Region, with the close proximity to many government facilities and for-profit businesses. Further away from the I-95 corridor, differences in the social and economic environment are very apparent.

Maryland's landscape stretches from the Appalachian Mountains to the Atlantic Ocean. Healthy People 2020 acknowledges some of the distinctive cultural, social, economic and geographic characteristics that define rural America and place rural populations at greater risk for a myriad of diseases and health disorders (Southwest Rural Health Research Center, https://srhrc.tamhsc.edu/). Residents of rural Maryland are acutely aware of these disparities, but not always aware of programs aimed at creating solutions. The Maryland Rural Health Plan, last updated in 2007, aims at addressing these health concerns. The goal of the Maryland Rural Health Plan is to continually revitalize the voice of the rural counties, address the gaps in health care, and identify resources that can help bring quality health care closer to those residing in rural Maryland.

PLAN DEVELOPMENT

FUNDING

The Maryland Rural Health Association (MRHA) was contracted by the Maryland State Office of Rural Health, Maryland Department of Health (MDH) to complete an update of Maryland's Rural Health Plan. MRHA was able to leverage these funds and secure additional funding from the Rural Maryland Council and Robert Wood Johnson Foundation. The partnership between these four organizations has made this project possible at the level of detail and attention it deserves to shed light on Maryland's most vulnerable rural populations.

TYPES OF DATA AND ITS ANALYSIS

MRHA compiled primary and secondary data to develop the Plan. The goal of using multiple data sources was to a) create county-specific snapshots of the health care infrastructure, b) provide shared data findings from both consumers and providers from each county, and c) draw conclusions and recommendations to create a cohesive picture of rural health in Maryland.

1. **Community Health Needs Assessments**

   All rural county Community Health Needs Assessments that were available as of June 1, 2017 are incorporated into the findings. The top three priority areas from each county are highlighted within this report.

2. **Focus Group Data**

   MRHA conducted two focus groups in each rural county. The first focus group sought the voice of health care consumers, while the second sought provider insight on the status of health care. The questions were developed by Dr. Virginia Brown, University of Maryland Extension, with review, input and approval from MRHA's Executive Director, Board of Directors, as well as MDH staff. Feedback and edits were integrated into the focus group scripts. Prior to data collection, the focus group questions and research methods were approved by the University of Maryland Institutional Review Board.

   Focus group moderators were recruited from each county health department and/or community organizations. A training was conducted by Dr. Brown to review study goals and questions, data usage, and provide training on how to effectively moderate focus groups. Moderators worked collaboratively to recruit and conduct focus groups. Focus group moderators from neighboring counties were asked to conduct one another's groups to reduce potential discomfort from consumers speaking openly and honestly about the status of health care. Focus group participants were recruited from each county using the following methods: advertisements, word of mouth, letters, personal invitations and other related methods.

   Prior to starting the focus groups, moderators discussed the purpose of the study, use of data and how participants were to be protected. Participants signed a study consent form acknowledging they understood this information prior to the study group. Finally, they were asked to complete a demographic information form so that there is a record of who contributed to the findings. Focus groups were recorded and notes were taken to capture all data. After the focus group, each moderator prepared a snapshot of who participated, a general overview of responses, and a description of group interactions.

Consent forms, notes, demographic forms, field reports, and audio files were scanned and uploaded into the study Dropbox; hard copies were sent to Dr. Brown. Once received, moderators were asked to destroy copies of all materials to preserve the anonymity of study participants. A thematic analysis was conducted on the focus group data. Focus groups were reviewed individually, with findings coded by category and question. Findings were compared to the field reports and a fidelity check was conducted to ensure validity of results.

3. **Rural Health Care Delivery Work Group**
   The findings from the Senate Bill 707 Rural Health Care Delivery Work Group on the five mid-shore counties of the Eastern Shore (Caroline, Dorchester, Kent, Queen Anne's, Talbot) are highlighted and incorporated into the final review.

4. **Secondary Data**
   MRHA collaborated with MDH in accessing the State Health Improvement Plan (SHIP) data, which reports findings from 2014 and 2015. Demographic information was also extrapolated from the 2010 Census and Maryland Vital Statistics websites. Additional data was collected from various sources and publications, which are referenced in Appendix III: Sources of Data.

ROLE OF THE BOARD

MRHA has an interactive and engaged Board of Directors. The Board is comprised of rural health leaders from across the state and has representation from each rural region of Maryland. Board members participated in this project from inception to fruition: from reviewing focus group scripts; to providing staff support for the focus groups; and continually providing feedback on the draft versions. The MRHA Board of Directors played an integral role in the success of this project.

WHAT THE DATA TELLS US

COMMUNITY HEALTH NEEDS ASSESSMENTS

Local county health departments and hospital systems conduct Community Health Needs Assessments to create a plan to improve health outcomes. Every county is not on the same cycle and each county has designed the assessment based on their county's needs. This results in different questions being asked and different plan formats being used. Therefore, these alone could not be used to create the Maryland Rural Health Plan; rather it is one piece contributing to its development. Below is a summary of key findings from all of Maryland's rural Community Health Needs Assessments broken down by the Robert Wood Johnson Foundation framework from page 2. MRHA used the Community Health Needs Assessments from each rural county that were available as of June 1, 2017.

Social & Economic Factors (40%) and Physical Environment (10%)

Education, employment, income, family and social support, community safety, air and water quality, and housing and transit all impact health and can contribute to the presence or prevention of health conditions. Ensuring a community has a supportive infrastructure is crucial to improving the health and wellness of the community.

The following were identified by most Community Health Needs Assessments as priorities:

- Access to care and providers
- Social determinants of health

Accessing care and providers is the first step in receiving quality health care. Inadequate access to care and providers can be caused by a variety of factors such as lack of transportation, insufficient providers, poor provider retention, and hours of service that are incompatible with residents' schedules. Access to care can also include affordability and literacy of the health care system. Access to care and providers is a broad term to describe a large problem that has been identified as a priority in rural Maryland.

Finally, addressing social determinants of health are noted as high importance to many communities. Social determinants include affordable housing, access to affordable and healthy food, and social support for those seeking health care. Addressing any of the previously listed social determinants of health not only improves health, but also can direct a community towards health and wellness.

Health Behaviors (30%) and Clinical Care (20%)

Rural Maryland counties identified the following as their most concerning health conditions: obesity, diabetes, heart disease, behavioral health, and cancer. Obesity is a risk factor for many chronic health conditions and adverse health outcomes. In order to address this concern, health care providers may focus on nutrition education, creating an environment compatible with physical activity, and increasing social support for weight loss.

Diabetes was also identified as a priority health condition. For those who already have diabetes, complications can be minimized through proper nutrition, exercise, and diligent monitoring of blood glucose levels. Rural Marylanders would benefit greatly from diabetes management, prevention programs, and community support.

The next priority health condition is heart disease. Heart disease risk can be decreased by exercise and proper nutrition. Smoking is another risk factor that should be examined in order to decrease the prevalence of heart disease in rural Maryland. Physical activity programs, nutrition education, and smoking cessation programs have the potential to go a long way in preventing heart disease.

Behavioral health is discussed by many counties as being a top health concern. Behavioral health includes mental health, substance abuse, and other behavioral risk factors such as sexual practices and preventative screenings. Intervention at a young age is critical for many behavioral health problems. Understanding the root of behavioral health conditions, and setting up a supportive environment for those suffering from behavioral health conditions, will greatly improve the life of rural Marylanders.

Many counties expressed a desire for more screening and prevention services within their counties. Counties wanted to offer annual screenings for diseases such as diabetes and cancer, expand outreach and health education, and emphasize safety in order to minimize health risk behaviors.

Rural Marylanders are also concerned with cancer prevalence in their communities. There are many different types of cancer and those diagnosed with cancer have varying outcomes. Cancer screenings, lifestyle changes such as smoking cessation and healthy eating, and HPV vaccinations are evidence-based ways to approach cancer prevention. Setting up an environment where these can be easily obtained may decrease new incidences of cancer or improve the outcome of those already diagnosed.

FOCUS GROUP DATA

Both consumer and provider focus groups were asked to discuss current availability of health care providers and services, barriers to use, gaps in service, and provided recommendations on how to address them. Additionally, they were each asked about community health services and ways to expand their access. Providers were asked to discuss the implementation of the Total Cost of Care All-Payer Model. Finally, all were also asked to brainstorm potential solutions they would implement to increase the health of their county.

CONSUMER FOCUS GROUPS

ACCESS BARRIERS

Health care consumers face a variety of barriers when seeking care. Running into access barriers can be frustrating and prevents consumers from receiving the best possible care. Health care consumers throughout rural Maryland discussed the following five things as the biggest barriers to accessing care:

- **Transportation**
- **Health insurance**
- **Overbooked providers**
- **Hours of services**
- **Lack of care coordination**

Consumers identified transportation as the most common barrier to care. Bus routes are not comprehensive enough to allow all people to travel to appointments on time without having to commit an unreasonable portion of their day. Some county health care services provided transportation for health care consumers, but these services are often dependent on income, excluding a large percentage of the population.

Health insurance coverage and networks was another common barrier that consumers face when seeking health care. Health insurance does not cover everything, and each insurance plan is different. Consumers discussed having to pay out of pocket for tests that their doctors had recommended because health insurance would not cover the exam. Some people struggle to afford co-pays, deductibles, or prescription costs. Finally, navigating the system and identifying in-network providers was difficult, or at times limiting, when few options are available in the area.

Consumers in rural Maryland also identified overbooked providers as a barrier to accessing services. A shortage of primary care providers and specialists in rural areas causes long wait times for appointments. Because of this, consumers spoke of needing to use urgent care or emergency department physicians as their primary care physician. This action causes overuse of emergency medical services and prevents those with actual emergencies from receiving care.

TOTAL CONSUMER FOCUS GROUP PARTICIPANTS
from 18 Rural Counties

151

109 FEMALES **42** MALES

50% Married
50% Single

The majority of participants who indicated him or herself as a parent, reported raising two children.

White	69%
Black/African American	29%
Hispanic or Other	2%

AGES

≤ 24	1%
25-34	12%
35-44	10%
45-54	18%
55-64	24%
65-74	20%
≥ 75	9%
Unknown	6%

EDUCATION *Some participants selected more than one education level.*

Did Not Graduate High School	7%
High School Diploma	93%
Some Higher Education	24%
Associate's Degree	9%
Bachelor's Degree	18%
Master's Degree or Higher	18%

INCOME

< $25,000	44%
$25,000 - $34,999	11%
$35,000 - $49,999	15%
$50,000 - $74,999	16%
$75,000 - $99,999	6%
$100,000+	8%

Most participants reported their health as being good or very good.

CONSUMER FOCUS GROUPS

In addition to the long wait times, service hours that are currently offered by primary care doctors, specialists, and urgent care are a barrier for many rural Marylanders. Hours of service are not compatible with a typical work schedule and lack of evening and weekend hours force consumers to choose between prioritizing health and their career.

Lack of care coordination was another barrier that health care consumers discussed. Consumers discussed having to travel long distances to have their health care needs met and felt providers did not understand what a burden the lack of coordination was on consumers and their families. Consumers would like assistance in identifying local services to help care for and manage their health, including providers and community services.

GAPS

Health care consumers in rural Maryland identified several gaps in health care services. The more remote areas experienced even more drastic gaps, as often services are isolated in the hubs of rural counties. Three gaps that consumers noted most were:

1. **Lack of specialists and oral health services was the most commonly discussed gap in the consumer focus groups.**
   Consumers discussed having to travel out of the county and sometimes up to three hours in order to see a specialist. Further, access to pediatric specialists seemed to have a larger gap than adult specialists. This puts a burden on the entire family as they are forced to travel long distances and be put on long waiting lists.

2. **Lack of behavioral health was another gap that many consumers noted.**
   Many counties do not have enough providers or the proper infrastructure, such as inpatient rehabilitation, to meet county needs. Once again, the gap in behavioral health care services is emphasized when seeking behavioral health services for children or adolescents.

3. **Oral health services available to rural Maryland residents is lacking.**
   Not only are there not enough oral health providers in rural areas, but also payment for these services can be costly and assistance for oral health services is limited.

CONSUMER FOCUS GROUPS

POTENTIAL SOLUTIONS

Health care consumers also were able to give unique solutions for these barriers and gaps. The most commonly agreed upon ideas were:

- **Recruit and retain providers**
- **Peer support groups**
- **Health education in schools**

Consumers discussed several ways to recruit and retain providers. Creating a scholarship program for local youth interested in health care was one suggested way to recruit providers that already have a stake in the community. This would likely be more effective than identifying young doctors from non rural areas who do not see the draw of rural medicine.

Peer support groups were suggested to address the lack of behavioral health counselors, and lack of health care providers in general. These groups could range from the typical recovery groups to diabetes management peer groups, and would draw from resources already in place in the community.

Consumers would also like to see more health education in the schools. They would like to have increased access to prevention services before children reach late adolescence. Residents want children to learn about practical ways they can achieve the best health care possible. This could lead to a cultural shift toward prioritizing health and preventative care.

PROVIDER FOCUS GROUPS

TOTAL HEALTH CARE PROVIDERS OR PARTNERS
from 18 Rural Counties

178

141 FEMALES

37 MALES

102
Work for public organizations

146
Work for not-for-profit organizations

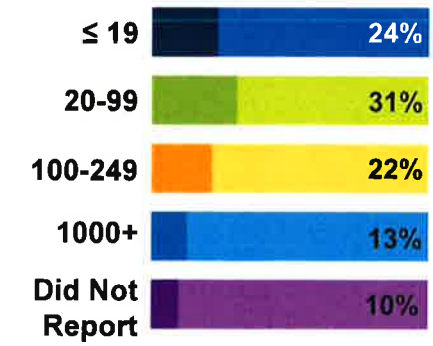
White	82%
Black/African American	12%
Asian-American	6%
Hispanic or Latino	3%

(Some participants selected more than one category.)

EDUCATION

High School Diploma	4%
Some College	9%
Associate's Degree	9%
Bachelor's Degree	26%
Master's Degree	52%

Size of Organization
(by number of employees)



ACCESS BARRIERS

Barriers occur when a service or provider is present, but a social, infrastructure and/or personal factor prevents access. Identifying and limiting these barriers ensures that more people will be able to access the health care services that are already present in their county. Providers throughout rural Maryland identified the following five barriers:

- **Transportation**
- **Stigma and culture**
- **Insurance coverage and affordability**
- **Awareness of services**
- **Health literacy and health insurance literacy**

According to health care professionals, transportation is the most common barrier patients encounter when seeking health care. Every county discussed transportation as being a barrier that limits access to health care. Transportation insufficiencies include bus routes not being comprehensive enough, hours of operation being limited or lack of medical transportation. When in existence, many bus routes are seen as having unreasonable schedules that would require people to take an entire day off work in order to make an hour-long appointment. Other communities have no public transit system at all, requiring people to use friends or family, volunteers or even pay for commercial transportation, if available, to facilities.

The limited availability of affordable health insurance plans and high out of pocket costs are barriers for many in rural Maryland. Many providers are concerned for the working poor- those making too much to qualify for government assistance, but too little to realistically afford copays, deductibles, or prescriptions. In addition to the cost of insurance

PROVIDER FOCUS GROUPS

and often times limited coverage, people often struggle to navigate the insurance system and are unaware of which procedures are covered.

Health literacy and health insurance literacy are related to all other barriers. Patients may be unaware of what resources they need and how to get the kind of treatment they require. Use of plain language in health care would allow more people to feel empowered as advocates for their health.

The health department is for the use by anyone in the county, with many of the programs offered without income restrictions. However, many people feel that using the health department is something to be ashamed of. Stigma about behavioral health treatment was also discussed as a possible barrier preventing people in rural counties from seeking treatment. Health care providers discussed the possibility of patients having preconceived ideas about what kind of people need behavioral health care and do not want to identify with those stigmas. Eliminating these stigmas is a difficult task because it is ingrained in culture, and cultural shifts take time.

In addition, limited staff and hours, cultural beliefs about health care, including fear of deportation, and poor advertisement for health care services were discussed as possible barriers. Many counties had a lot of resources that went unused because residents are unaware of the different services available to them.

GAPS

As medically underserved areas, many rural counties have gaps in health care services. These gaps include a lack of heath care services, facilities, or inadequate services that do not meet the needs of the county. Identifying and filling the gaps in service allows residents in rural Maryland to have access to the best possible health care services. The providers identified the following gaps:

- **Lack of behavioral and oral health services, and language skills**
  Lack of behavioral health care providers and services was discussed as the top gap in service for rural Maryland. Further, behavioral health problems were discussed as the most common health problem in many counties. Increasing behavioral health care, especially for adolescents, will help those who are suffering from a wide range of behavioral health problems and promote a more robust society.

PROVIDER FOCUS GROUPS

Another service gap is oral health providers. Residents are often put on long waiting lists for oral health care due to the increased need and growing population of many rural counties. There is also a lack of government assistance for oral health care, preventing many from being able to afford the dental work they may need.

Health care providers also discussed translation services as a gap for rural Maryland. Maryland is becoming increasingly diverse and not all health care providers are set up to provide care to those who speak languages other than English. Providers would like an increase in language services in order to serve everyone in the county.

Lack of stable funding, lack of social support, and inadequate resources for older adults and adolescents were other gaps identified as problematic for rural Maryland.

POTENTIAL SOLUTIONS

The health care providers in the community know the specific needs of their community members and have generated innovative and creative ideas about how to improve the health care of the community. The most commonly discussed ideas were:

- Community health centers
- Telehealth services
- Mobile health units
- Database of existing resources

Many providers suggested creating a community health center that would include a "no wrong door" policy in order to better coordinate care. This would serve as a one stop shop for services and comprehensive care for residents that is streamlined, effective, and seamless.

In order to address the barrier of transportation, telehealth and mobile health units were suggested as a new or supplemental service to already existing similar services. Telehealth would allow for health care professionals to remotely care for patients, thus eliminating the barrier of attracting and retaining doctors and specialists to rural Maryland. Mobile health units are resources available already in many rural counties, but the services offered in these units and the availability of these services to all residents is limited. Expanding the mobile health unit services would allow more residents to be served without a complete and costly overhaul of public transportation.

PROVIDER FOCUS GROUPS

Providers would like to see a database of all the community resources that would allow consumers to see what services are already available in the county and any requirements for their use. Many counties have resources available to residents, but do not see these programs being used as often as they would like. Raising awareness of programs through this kind of database would optimize already existing programs in the community.

RURAL HEALTH CARE DELIVERY WORKGROUP

MRHA was a member of the Rural Health Care Delivery Workgroup established by Senate Bill 707 in 2016. This year-long study assessed the unique challenges facing the health system serving the five Mid-Shore counties of Maryland's Eastern Shore: Caroline, Dorchester, Kent, Queen Anne's, and Talbot.

The Workgroup recognized that health care systems of the future need to accommodate a culturally diverse population; this includes a growing number of vulnerable residents, elders with chronic health conditions, and that addressing social determinants of health is crucial in promoting a healthy society. Also, stakeholders must support an integrated care delivery system that promotes health equity, quality, and comprehensive services across a continuum of care.

The Workgroup's recommendations can be broadly placed into three categories. Each of the final recommendations promote policies that:

- foster collaboration and build coalitions in rural areas to serve rural communities;
- bring care as close to the patient as possible to improves access; and
- foster participation in statewide models and programs in rural Maryland.

Key Workgroup recommendations include:

1. **Establish a Mid-Shore Coalition:** bringing together community residents and leaders from health care, emergency medical services, public health, behavioral health, oral health, social services, transportation, education, business and law enforcement who would accelerate identifying the most pressing needs and prioritizing actions to address them.
2. **Create a "rural community health demonstration program:"** allowing clinicians to test new delivery models before scaling them to other rural communities in Maryland and, where applicable, urban communities. One example includes creating Patient-Centered Health Neighborhoods that can serve as a coordinated one-stop shop for diverse health needs.
3. **Invest in expanding the health care workforce, community-based health literacy, and technology:** including the creation of incentives to attract and retain the health workforce, such as a loan repayment program for local residents, and investments to expand the capacity of residents, health care workers and others to support health and well-being.

The final report outlining each recommendation in detail can be found here:
http://mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups_rural_health.aspx

The Workgroup's recommendations tie in very closely to many of the findings from the focus groups and data collection for the Maryland Rural Health Plan. While it is important to note the obvious overlap between the two projects, not all Workgroup recommendation may be feasible for other rural counties across Maryland that are more geographically isolated or that differ topographically and demographically. Not only is there no one-size-fits-all solution to the five Mid-Shore counties, but this rings especially true when considering all 18 rural counties across Maryland. Appendix I: County Profiles highlight each rural county's distinctiveness.

SECONDARY DATA

Quantitative data was collected from the Maryland State Health Improvement Process (SHIP), as well as US Census 2010 website and Maryland's Vital Statistics website. Data was gathered on the following measures as they best relate to the areas of concern highlighted by most rural county Community Health Needs Assessments:

- Teen Birth Rate
- Early Prenatal Care
- Adults Who Are Not Overweight or Obese
- Adolescents Who Have Obesity
- Adults Who Currently Smoke
- Adolescents Who Use Tobacco
- Children Receiving Dental Care in the Last Year
- Uninsured Emergency Department (ED) Visits
- Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence

A Look Into Maryland's Rural Health Data

The table below shows the data for each county and the Maryland average for each measure.

	Teen Birth Rate *(per 1000 teenage females)*	Early Prenatal Care	Adults Who Are Not Overweight or Obese	Adolescents Who Have Obesity *(only 2014 data available)*	Adults Who Currently Smoke	Adolescents Who Use Tobacco *(only 2014 data available)*	Children Receiving Dental Care in the Last Year	Uninsured Emergency Department (ED) Visits	Total Number of Drug and Alcohol-Related Deaths Occurring in Maryland by Place of Occurrence **
Allegany	24.7	77.2%	27.2%	13.5%	22.1%	24.9%	58.4%	5.6%	22
Calvert	9.6	72.1%	22.8%	10.1%	15.5%	20.7%	58.6%	4.8%	20
Caroline	27.0	76.7%	21.2%	13.9%	23.5%	26.1%	72.1%	6.8%	3
Carroll	6.8	75.9%	31.7%	8.9%	11.6%	15.0%	56.0%	5.4%	40
Cecil	18.3	78.2%	44.4%	14.1%	17.5%	25.2%	55.5%	5.8%	32
Charles	15.3	67.6%	23.1%	12.3%	18.4%	17.9%	50.7%	8.5%	22
Dorchester	50.7	78.1%	25.6%	17.2%	19.8%	24.9%	68.7%	6.8%	1
Frederick	11.0	77.5%	39.1%	9.1%	21.6%	16.3%	68.1%	9.3%	40
Garrett	31.8	80.9%	38.9%	16.0%	29.4%	33.0%	72.2%	5.8%	5
Harford	8.8	78.6%	27.7%	10.0%	20.7%	19.2%	60.2%	3.4%	50
Kent	18.2	81.9%	27.2%	12.8%	*	22.9%	71.9%	4.7%	3
Queen Anne's	6.8	75.3%	32.9%	11.7%	17.2%	24.3%	69.9%	5.1%	4
Somerset	22.5	80.5%	31.2%	17.5%	25.0%	27.5%	68.8%	7.6%	6
St. Mary's	14.8	77.2%	31.3%	10.3%	14.5%	22.6%	56.0%	6.9%	18
Talbot	15.4	76.3%	40.8%	10.3%	*	21.6%	73.2%	6.6%	5
Washington	24.7	70.2%	31.6%	14.3%	22.0%	23.7%	58.6%	9.8%	64
Wicomico	20.0	78.8%	34.5%	11.9%	23.0%	21.5%	64.4%	10.0%	18
Worcester	20.9	80.4%	40.4%	13.5%	*	22.5%	63.8%	7.4%	16
MARYLAND	**16.9**	**66.9%**	**35.0%**	**11.5%**	**15.1%**	**16.4%**	**64.3%**	**10.7%**	**1259**

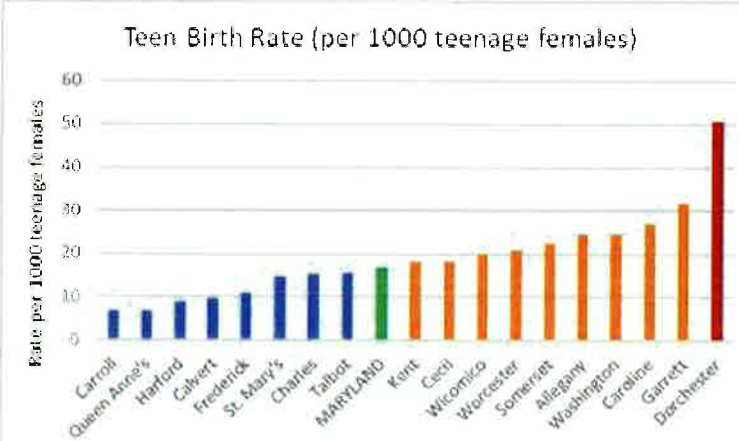
All data is from 2015 unless otherwise indicated. Additional "Data Details" can be found in Appendix II. This table includes data provided by the Maryland State Health Improvement Process (SHIP); the Maryland SHIP does not endorse this report or its conclusions.

* Data for this county did not meet the threshold required for reporting so was therefore withheld for privacy purposes.

** Data provided here is from the "Drug- and Alcohol- Related Intoxication Death in Maryland, 2015" report found here: https://bha.health.maryland.gov/OVERDOSE_PREVENTION/Documents/2015%20Annual%20Report_final.pdf
Also, it is important to note that this is the data for where the death OCCURRED, not the county where the individual RESIDED/LIVED.

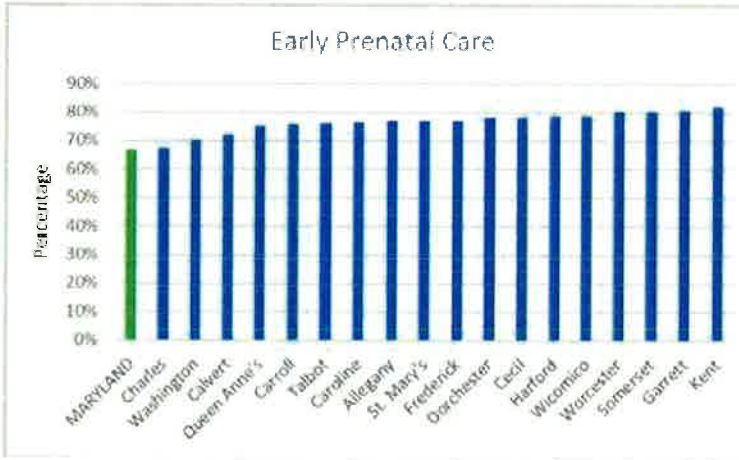
The previous table titled "A Look Into Maryland's Rural Health Data" shows the data for each rural county as well as for the state of Maryland, for comparison purposes. A summary of each data measure follows:

- All data is from 2015 unless otherwise indicated
- The x-axis for each chart represents Maryland's Rural Counties
- For additional "Data Details" please view the previous data table footnotes as well as Appendix II



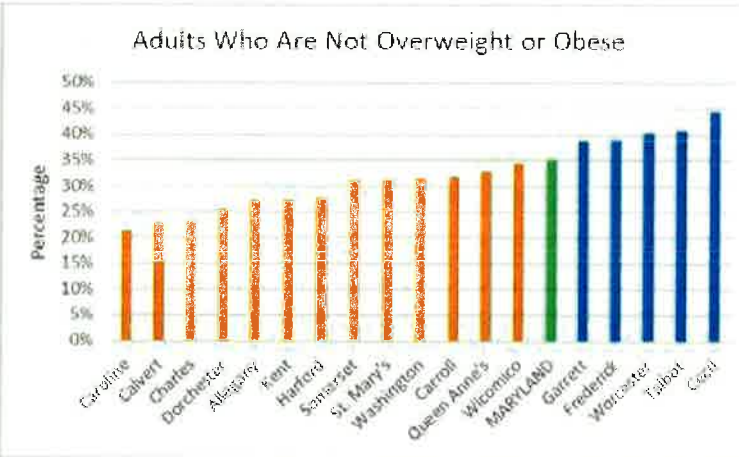
16.9

The 2015 Maryland teen birth rate (per 1000 teenage females) is 16.9. Eight rural counties have a teen birth rate less than the statewide teen birth rate, ranging from 6.8 in Queen Anne's and Carroll Counties, to 15.4 in Talbot County. For the ten counties with teen birth rates greater than the Maryland teen birth rate, the range is 18.2 in Kent County to 50.7 in Dorchester County.



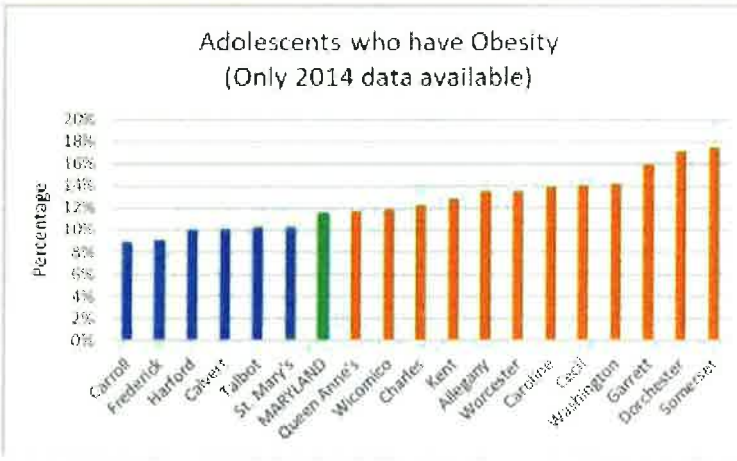
66.9%

The percentage of pregnant women in 2015 in Maryland receiving early prenatal care, beginning in the first trimester, is 66.9%. Each Maryland rural county has the same or a greater percentage of women receiving early prenatal care than the statewide percentage, ranging from 67.6% in Charles County to 81.9% in Kent County.



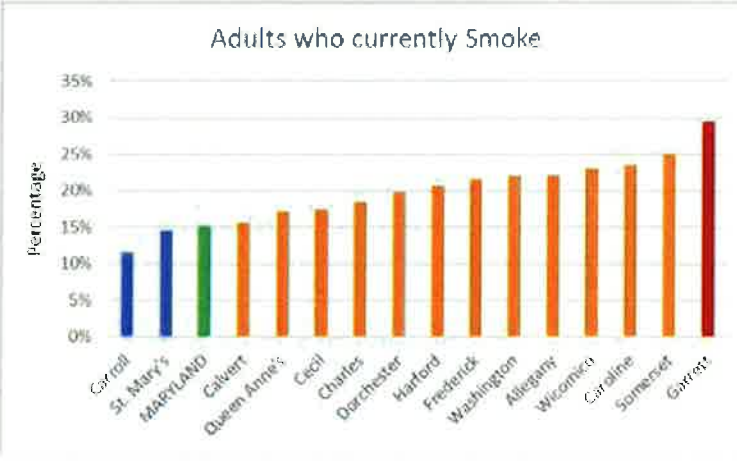
35.0%

The percentage of Maryland adults in 2015 who are not overweight or obese is 35.0%. A little over seventy percent of rural counties have a lower percentage than the statewide percentage, ranging from 21.2% in Caroline County to 34.5% in Wicomico County. Almost thirty percent of rural counties have a higher percentage than the statewide percentage of adults who are not overweight or obese, ranging from 38.9% in Garrett County to 44.4% in Cecil County.



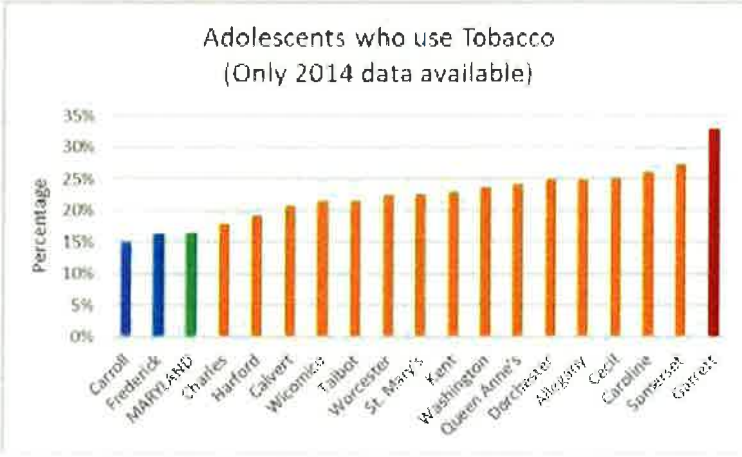
11.5%

The percentage of Maryland adolescents who have obesity, based on 2014 data, is 11.5%. One-third of the rural counties have a lower percentage compared with the statewide percentage, ranging from 8.9% in Carroll County to 10.3% in Talbot and St. Mary's Counties. The remaining two-thirds of counties have an equal or greater percentage of adolescents who have obesity, when compared with the state, ranging from 11.7% in Queen Anne's County to 17.5% in Somerset County.



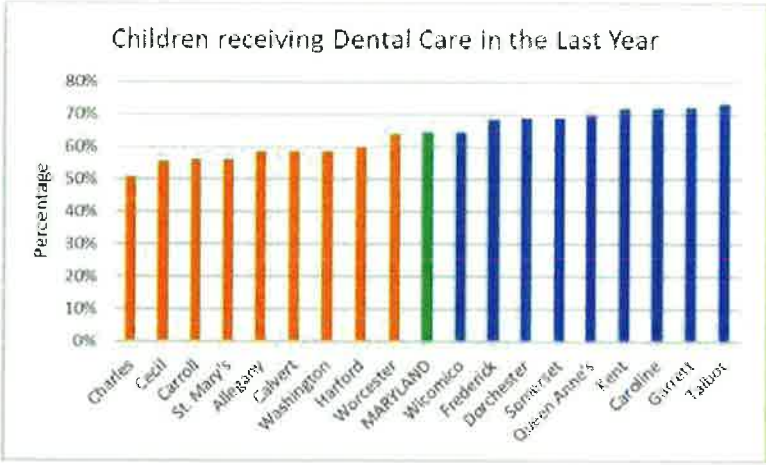
15.1%

The percentage of Maryland adults in 2015 who currently smoke is 15.1%. Only two counties have an equal or lower percentage than the state: Carroll County, 11.6%, and St. Mary's County, 14.5%. The remaining thirteen rural counties have a higher percentage of adults who smoke, when compared with the statewide percentage, ranging from 15.5% in Calvert County to 29.4% in Garrett County. Data from Kent, Worcester, and Talbot Counties were not reported because they did not meet the threshold required for reporting and were therefore withheld for privacy purposes.



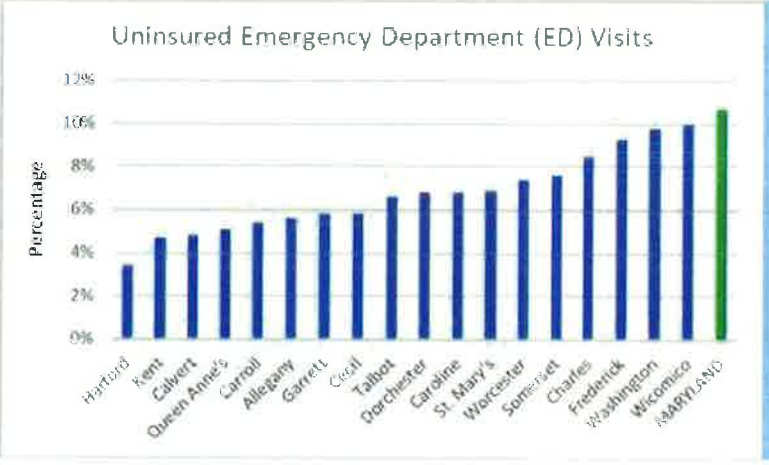
16.4%

The percentage of Maryland adolescents, according to 2014 data, who use tobacco products is 16.4%. Sixteen rural counties have a greater percentage of tobacco usage among adolescents than the state percentage. These counties range from 17.9% in Charles County to 33%, almost two times the statewide percentage, in Garrett County. Only two rural counties, Carroll and Frederick, have a smaller percentage of adolescents who use tobacco when compared with the state percentage.



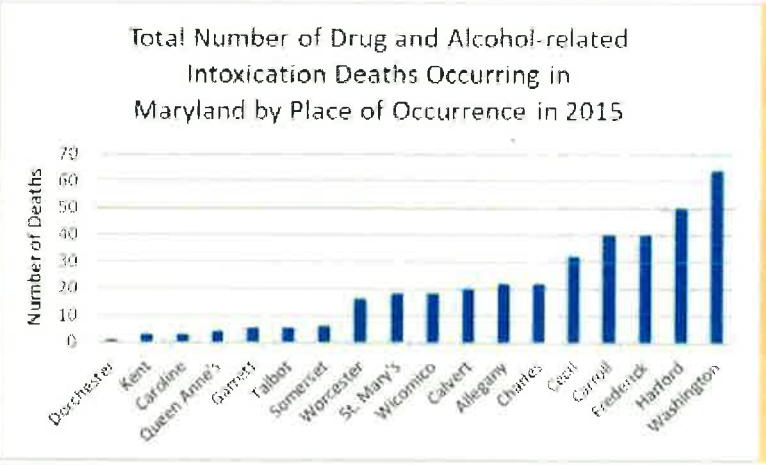
64.3%

In 2015, the percentage of Maryland children receiving dental care is 64.3%. Half of the rural counties report a smaller percentage of children receiving dental care than the statewide percentage, while the other nine rural counties report percentages equal or greater than the state. County results range from 50.7% in Charles County to 73.2% in Talbot County.



10.7%

In 2015 in Maryland, the percentage of uninsured Emergency Department (ED) visits is 10.7%. The percentage of uninsured ED visits in the rural counties ranges from 3.4% in Harford County to 10.0% in Wicomico County, all of which are lower than the statewide percentage.



1259

The total number of drug and alcohol-related intoxication deaths in Maryland by place of occurrence in 2015 is 1259. Of these deaths, 29.3% occur in rural counties. The county with the fewest drug and alcohol related deaths is Dorchester County, with 1 death, and the county with the highest number of deaths is Washington County, with 64.

SUMMARY OF FINDINGS

Throughout all combined data sources, several common themes emerged as most crucial to improving Maryland's rural health. The themes identified in the majority of data sources include the following:

- **Access to Care**
- **Sustainable Funding Mechanisms for Health Care Services**
- **Care Coordination**
- **Chronic Disease Prevention and Management**
- **Health Literacy, Health Insurance Literacy, and Health Literate Organizations**
- **Outreach and Education to Health Care Consumers**

ACCESS TO CARE

Reduce barriers, remove gaps, and increase access to quality health care for rural Marylanders.

Access to care was the top concern throughout rural Maryland. In county-based plans, 72% of rural counties specifically identified access as a priority, while the other five counties had it as an underlying consideration or barrier to addressing specific health conditions.

HIGHLIGHTED CONCERNS

- Long waits
- Limited appointment availability
- Limited time during appointments
- Retention of qualified doctors
- Travel time
- Incorrect usage of emergency medical services due to lack of services and coordinated care
- Lack of oral health providers
- Overcrowded waiting rooms
- Cost of emergency services
- Confidentiality concerns
- Transportation

General Practitioners

As stated previously, several rural Maryland counties are classified as physician shortage areas. In the focus groups, both providers and consumers discussed having long waits or limited availability for appointments. While some health care providers had experimented with flexing hours, having walk-in appointments, or weekend hours, this was not available in all areas and had varying degrees of success.

There was also a sense among consumers that providers shuffled them through like pieces on an assembly line, spending limited time during each appointment in a rush to get to the next patient. Some voiced the desire to change doctors, while others acknowledged that there are few, if any, options for other providers in their area. For those who liked their doctor, many stated they had them for years and are not looking forward to someday having to find a new one.

In some provider focus groups, the recruitment and retention of providers was discussed. They acknowledged that many providers are attracted to rural areas as a way to help get medical loans repaid; keeping

them after this repayment was difficult, especially for young doctors. A handful of counties stated the main barriers to retention of qualified doctors are the lack of good jobs for highly educated or qualified spouses and a perceived inadequacy of the county school system.

Specialty Care, Behavioral Health, and Oral Health Services

The issue of access and service gaps was more profound for specialists. This issue included not only physical health, but behavioral and oral health services, as well.

Access to specialists is limited throughout Rural Maryland. This is primarily due to the large medical hubs within Maryland: DC Metropolitan area, Greater Baltimore region, and the Annapolis area. While some specialists have set up practice in rural Maryland, most people talked about having to travel to access providers. This travel time can be up to three or more hours each way from the Western-most and Eastern-most ends of the state.

Behavioral health services include both substance abuse and mental health conditions. In the Community Health Needs Assessments, fifteen of the eighteen counties indicated that behavioral health is a priority area. Focus group participants, both consumer and provider, discussed the need for more providers and facilities throughout rural Maryland. Needs included certified behavioral health providers, hospital facilities and beds for those in crisis, rehabilitation facilities for those in recovery, social support groups, and medication management from current providers, including Suboxone. The lack of behavioral health services for adolescents was especially concerning to many focus group participants.

Lack of services and coordinated care has led many people in crisis to incorrectly or over use emergency medical services, travel across multiple counties or to neighboring states to seek care, or forego treatment altogether. Some primary care providers are becoming certified to dispense Suboxone to help fill the service gap, but this practice does not appear to be widespread. Peer support services (including Peer Recovery Specialists) have been established to help citizens recover. However, both providers and consumers expressed the need to further expand these services.

Lack of services and coordinated care has led many people in crisis to incorrectly or over use emergency medical services, travel across multiple counties or to neighboring states to seek care, or forego treatment altogether.

Oral health was discussed as a need in both the Community Heath Needs Assessments and focus groups. While not explicitly identified in all the county plans, many discussed oral health in context to overall gaps and access issues. While there was an acknowledgement that children have access to more oral health resources, large gaps in adult coverage remained. This seemed to be mostly among adults on government-sponsored health insurance as there are not enough oral health providers that accepted the insurance. Further, mandating coverage will not fix the lack of providers in the rural regions, nor will it require providers to accept Medicaid.

Emergency and Urgent Care Services

Access to different types of emergency or urgent medical services varied regionally throughout rural Maryland. On the Western shore, there is a hospital located in each county; on the Eastern shore, there is an average of 1 hospital for every 2 counties and access to urgent care facilities varies. Some focus groups discussed the local urgent care centers having limited hours of operation during evenings and weekends; this led to an increase in emergency department usage when urgent care may have been more appropriate.

The perception of care quality for hospitals left many wary of seeking their services. While many consumers are happy with their local hospital, this did not negate the discussion of various health service issues. People discussed overcrowding in waiting rooms and the cost of emergency department services made many wary of using them to get care. Finally, a few discussed privacy and confidentiality concerns when being seen in busy emergency departments.

Emergency medical services provide vital, life-saving services to those in need. Feedback from consumers and providers was largely positive, with many people commenting on the professionalism and empathy emergency medical service workers exhibit. On the Eastern shore, several focus groups discussed the establishment of Mobile Health/Crisis Units. While the partnership entities varied between counties, the goal of these units was to a) stabilize patients to prevent hospital admittance, b) provide emergency department diversion for behavioral health consumers, and c) provide wellness checks for high risk or high utilizer consumers in the region. Program success is largely due to interagency partnerships as the funding mechanism for emergency medical services is through transportation budgets and not medical services. This has led county emergency medical services to partner with county commissioners, urgent care facilities, case workers and others to provide funding and ensure program continuity. Anecdotally, the health care providers spoke of the success these programs had in preventing unnecessary hospitalizations among consumers.

Transportation

Transportation to and from health care facilities was an issue throughout rural Maryland for all types of health care appointments. Public transportation, including taxis, buses, car share services, and independent transportation professionals, is lacking in rural settings. While many counties have a bus system, its service hours and stops are limited. Many people discussed that the public bus system did not go beyond the city centers, thus preventing those living in the most rural areas from accessing them.

Transportation to and from health care facilities was an issue throughout rural Maryland for all types of health care appointments. Public transportation, including taxis, buses, car share services, and independent transportation professionals, is lacking in rural settings.

The medical transportation that is available to rural health consumers, and often times is covered by health insurance, appears to have several limitations for use. First, this service is often limited to those who qualify for medical assistance programs and can only be used by the consumer or, in cases of youth, by the consumer and one parent or guardian. Second, appointments often have to be made 48 hours in advance, thus eliminating usage for acute care appointments. Finally, the hours of operation tend to be limited, causing pickup to be early morning hours for midday appointments, regardless of office location.

SUSTAINABLE FUNDING MECHANISMS

Secure permanent funding streams, explore new and innovative reimbursement systems, and work to improve funding regulations for all parts of the health care infastructure.

HIGHLIGHTED CONCERNS

- Overuse of emergency services causing emergency department diversion or temporary closure of emergency departments
- Elimination of Medicaid expansion, reducing health care workforce or closing clinics
- Void in emergency medical service reimbursements

Funding continues to be of concern among Maryland rural health services. The decrease in funding streams, or fear of these changes, was felt at all levels of health care.

Hospitals

State regulations have shifted from a fee for service model to a value based payment model. All of Maryland's hospitals are given a global budget or "lump sum" payment to care for all patients in a given year. The Global Budget Revenue model was based on the Total Patient Revenue model that was previously or continuously used by many rural Maryland hospitals. The global budget incentivizes hospitals to prevent unnecessary hospital admissions and readmissions and help promote community-based care in their local communities. Global budget incentives encourage hospitals to reduce emergency department use and rewards hospitals for efforts that improve outcomes by reducing hospitalizations (medical adherence by consumers, coordination of follow-up appointments, etc.). Hospitals strive to provide efficient and clinically effective services as close to the patient as practical. A large increase in volume without a corresponding decrease in avoidable hospital use will challenge hospital resources that are limited under the global budget. At the same time, global budgets provide long-term financial stability, particularly for smaller hospitals with fluctuating volume.

Federally Qualified Health Centers

Many more Marylanders now have access to primary care services through Federally Qualified Health Systems, allowing for preventive care and health management outside of the hospital system. However, many are worried about how potential changes at the federal level will affect their services. In particular, providers are worried that elimination of Medicaid expansion may force reduction in the health care workforce or closing of clinics altogether.

Emergency Medical Services

Under Maryland regulations, emergency medical services are reimbursed under the transportation system and not medical services. This creates a void in reimbursements anytime emergency medical service personnel successfully divert patients from the hospital through stabilization in the home or through use of other care facilities. Grants, patient billing and other mechanisms are used to fund these programs, but a stable funding mechanism is seen as necessary for program growth.

CARE COORDINATION

Explore mechanisms to help link health care consumers to services and improve coordination and collaboration between health care providers and services within rural Maryland.

HIGHLIGHTED CONCERNS

- Limited ability to cohesively use electronic medical records throughout the health care system
- Lack of care coordination and services

Care coordination was a concept both explicitly named and discussed or described by many of the focus groups and Community Health Needs Assessments. For the purposes of this plan, we have adopted the Agency for Health Care Research and Quality's care coordination definition: *"Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care." (https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html)*

Levels and formality of care coordination can vary based on health insurance plans, complexity of illness, and availability of services and physicians. An example of minimal care coordination is the use of electronic medical records by multiple physicians to facilitate medical testing and care protocols for optimal health outcomes for a person. A more intensive form of care coordination can involve the assignment of a care coordinator or case manager to help manage and navigate a patient through multiple physician visits, procedures, and care recommendations.

Formal care coordination, through use of a case manager, is offered through limited plans. Medicare offers reimbursable coordination through its Medicare Part B (AAFP) Medicare Advantage Plans. For private insurers, care coordination is varied, with some plans offering no coordination and others offering them to special populations. With electronic medical records, there is no standard platform providers and facilities use, thus limiting their ability to be used cohesively throughout the health care system.

This holds true for the rural health infrastructure of Maryland, as well. Consumers discussed having to carry records from provider to provider because of the lack of coordinated medical records. Others discussed

how invaluable care coordination is for their health, while many others expressed the desire to have it expanded and available to more audiences.

Providers also shared their desire for care coordination. Many felt that the problem with rural health in their communities was not the lack of services, but the *lack of coordination and awareness* of services. Providers wanted a centralized, user-friendly, up-to-date database of rural health services that could be easily accessed and used to refer people to services. They felt this could help the population achieve and maintain their health.

CHRONIC DISEASE PREVENTION AND MANAGEMENT

Reduce the incidence of new chronic diseases and increase ability for people to manage their conditions.

HIGHLIGHTED CONCERNS

- Health program locations and costs for chronic diseases
- Lack of assistance for programs from Medicare or Medicaid
- Sliding scales used by very few programs

The prevention and management of chronic disease was defined as a priority by ALL counties in either the focus groups or their Community Health Needs Assessments. Chronic disease is one lasting three months or more, by the definition of the U.S. National Center for Health Statistics. Chronic diseases generally cannot be prevented by vaccines or cured by medication, nor do they just disappear.

Chronic diseases, including heart disease, stroke, cancer, and arthritis are among the most costly and preventable illnesses of all conditions (CDC, 2016). Seven of the ten top causes of deaths are chronic diseases, with heart disease and cancer accounting for 48% of deaths. In 2010, 86% of health care spending was for people with one or more chronic diseases, with heart disease and cancer alone costing an estimated $315.4 billion.

Preventing and managing chronic disease would lower health care costs, increase worker productivity and increase quality of life among rural Marylanders. This could be accomplished through chronic disease management services and programs, care coordination, and through the use of community health programs and services.

All counties documented community health programs that help lower the prevalence of chronic diseases. Current strategies and community health programs cited include the Living Well program (Maryland's name for the Stanford Chronic Disease Management Program), weight-loss services, YMCA-based programs, faith outreach, employee wellness programs and other related efforts. Further, many no-cost community resources, including parks and recreation services, were discussed and may serve as venues to promote healthy lifestyles and reduce chronic disease.

The two main barriers to access and use of programs are location and cost. Services and programs tended to be offered in county seats or city centers, making access for those with transportation issues limited. Additionally, most services had a cost associated with use, thereby creating a barrier for low-income individuals without assistance from Medicare or Medicaid. Sliding scales are used by a few select programs to increase access by low-income audiences and would be useful to explore with future efforts.

HEALTH LITERACY AND HEALTH INSURANCE LITERACY

Explore ways to increase individual health literacy and health insurance literacy of consumers.

HIGHLIGHTED CONCERNS

- Health insurance information too hard to access
- Health insurance too hard to understand
- Health care facilities too hard to navigate
- Difficult for providers to navigate the health care infrastructure

Several focus groups and Community Health Needs Assessments had an underlying message: *information can be too hard to access and understand, health insurance is complicated, and the health care facilities are too hard to navigate.* This was further complicated as care became more complex, necessitating the management of multiple doctors and medications, sometimes located in different areas of the state. Further, consumer skills and knowledge to understand the cost of care, and how to navigate networks and self-advocate is sporadic and variable. Finally, health care providers acknowledged and discussed the difficulties people had navigating the health care infrastructure to get the needed care.

These difficulties are directly related to the concepts of health literacy, health insurance literacy, and the availability of health literate organizations. Health literacy is the ability to access, understand and use health information to manage health. Research shows that only 12% of US adults has proficient health literacy at a given time (National

Assessment of Adult Literacy, https://nces.ed.gov/naal/). Health literacy is a fluid and dynamic concept, and an individual's level can change based on the health situation they find themselves.

Health insurance literacy is a related but more complicated concept. Health insurance literacy is the degree to which individuals have the knowledge, ability and confidence to find and evaluate information about health plans, select the best plan for their own financial and health circumstances, and use the plan once enrolled. Encompassing health literacy, financial literacy, numeracy and document literacy components, health insurance literacy expects consumers to navigate complex health insurance networks, understand how to calculate out of pocket costs, and know how to access care for them and their family.

These two components put the onus on individuals to understand their health, access information and use health insurance resources to manage care. Many have acknowledged that the consumer level burden is too great. Health literate organizations have been created to make it easier for people to navigate, understand and use information and services to take care of their health.

Increasing health literacy and health insurance literacy increases confidence and skills to use health insurance, increases adaptation of self-care management practices, and increases overall quality of life. Some facilities employ Insurance Enrollment professionals to help people purchase insurance and navigate the system, while others have partnered to deliver classes to teach people to effectively use their plans. Finally, health literate organizations enable organizations to better serve consumers and the community, thus increasing the likelihood of healthy lifestyle adaptation, controlling costs, and increasing overall quality of life.

OUTREACH AND EDUCATION

Work with community-based service providers and health care infrastructure to provide outreach and education to citizens on relevant and emergent health issues.

When trying to create and foster a culture of health throughout rural Maryland, both social and economic factors and the physical environment need to be targeted.

Outreach and education was cited by most focus groups and Community Health Needs Assessments as a necessary component to increase health outcomes. Topics were numerous and varied, ranging from parenting classes to cooking classes and positive youth development programs. All are seen as necessary components to not only increase current family health but also grow youth into healthy, thriving adults.

Further, there are numerous community partners cited as being able to assist in this effort. For instance, the YMCA was cited by many counties

HIGHLIGHTED CONCERNS

- Lack of awareness and coordinated marketing efforts
- Unsure how to access programs or services
- Programs are not accessible to all

as a low-cost facility that offered physical activity and health classes to all people. Senior centers are seen as a venue to increase the health and wellbeing of older adults. Hospital-based programs and health department services, including smoking cessation, the Living Well program, and healthy pregnancy programs for at-risk mothers, are seen as valuable to community health. Community Health Workers, from both public and private entities, are seen by many as valuable resources for community health, with more being desired to meet county needs. Finally, university partners including the University of Maryland Extension classes and 4-H, as well as private non-profit organizations, are also cited as available resources for health programs.

What was missing or preventing the use of these resources was the lack of awareness and coordinated marketing efforts. Similar to care coordination, not all people are aware these programs or services exist or are unsure about how to access them. Further, at times they are not accessible to all, limiting their use by everyone who could potentially benefit. More efforts need to be made to increase access and use of health outreach and education to rural Marylanders.

UNINTENDED CONSEQUENCES

Finally, consumers and providers discussed the emergence of two unintended consequences from recent health care reforms and public health crises. These are:

- **The perception that people are being discharged sicker from the hospital or not admitted to save money.**
- **People in pain management protocols are being mislabeled as addicts by the health care community.**

Consumers and providers alike perceive that people are being discharged earlier than before, making follow-up care with their providers more intensive. There was also discussion around the possible decrease in hospital admittance from the emergency department. Many reported seeing an increase in the number of people classified as "under observation" in the emergency department, lowering the number of admissions. While lowering hospital admission is ultimately the goal of the health system, the perception by many in the focus groups was that it may not be in the best interest of the patient.

The second unintended consequence is a result for the opioid epidemic. Many people deal with chronic pain issues and have pain management protocols requiring the use of opioids. The emergence and awareness of the opioid epidemic, coupled with continued changes in pharmacy networks, has caused people to change pharmacies. This behavior can appear to mimic drug seeking behavior, causing those with pain management needs to be mislabeled as "addicts" and experience stigma from the health care system.

Providers and consumers spoke of the need for current, up-to-date databases which can help pharmacies properly identify addicts and to expand pharmacy networks to include local, independent store-fronts that are more familiar with the needs of long-term clients.

The issues facing Maryland's rural health system are layered and multifaceted. To adequately address each issue and create positive, lasting change, a multifaceted approach to change is needed. Please note that while a recommendation may have been identified as targeting multiple findings, each recommendation will only be described once.

POLICY RECOMMENDATIONS

Medical Transportation & Emergency Medical Services Reimbursement

Medical transportation and emergency medical services are vital to people accessing and receiving care. Currently, emergency medical transportation services, publicly funded non-emergency medical transportation, and transportation programs funded through the state transportation budget are limited in their ability to fully meet local needs. There are many privately or grant-funded transportation programs that attempt to fill these holes, however major gaps still remain. Policy changes need to be explored and new regulations established to expand existing services and support continued diversion of unnecessary hospital admittance.

Establishment of a Plain Language Policy

The Federal Plain Writing Act of 2010 was passed requiring all federal agencies to "...improve the effectiveness and accountability of Federal agencies to the public by promoting clear Government communication that the public can understand and use." The Centers for Disease Control and Prevention subsequently adopted the policy and created the Clear Communication Index to assist agencies in adapting to the new policy. Based on the secondary data and focus group findings, a clear communication or plain language policy would be beneficial in helping Marylanders understand health information. Clear communication or plain language policy also includes large print, audio formats, video formats, or other accessible/alternative language formats based on county need.

Behavioral Health Treatment Policy

Behavioral health, its impact on individuals and families, and the difficulty with treatment dominated many conversations. One barrier to effective treatment is the limited number of providers and services in the area. Further, care coordination between behavioral health providers and other health practitioners was seen by many as limited in rural Maryland. A policy or study needs to occur to better understand the impact on behavioral health treatment.

Telehealth Expansion and Reimbursement

Telehealth programs are used throughout rural Maryland to increase access to health providers. However, there remains a gap between the number of health specialists and the need statewide. Telehealth could serve to fill part of this gap while new recruitment and retention efforts are developed to attract more rural health providers. To make this happen, medical reimbursement policies and stable funding streams need to be established, as well as stable infrastructure (broadband, etc.) in rural locations to support it.

Study of Best Practices for Recruitment and Retention of Rural Providers

One of the largest barriers to rural health is the recruitment and retention of providers. Virtually all data sources emphasized the difficulty of both finding qualified providers to work in rural areas and then retaining them once hired. This problem exists across disciplines, affecting primary care providers, specialists, behavioral health physicians, and oral health providers. To correct the problem, policy makers, administrators, rural health professionals, and others need to study barriers to recruitment and retention and identify best practices. After completion, an action plan to make changes should be developed and enacted to improve Maryland's rural health.

Reimbursement for Care Coordination

Care coordination or case management was identified throughout rural Maryland as a needed service for health system navigation. Research shows that care coordination can both improve health outcomes and reduce or control health care costs for the individual and system (Substance Abuse and Mental Health Services Administration, https://www.samhsa.gov/health-care-health-systems-integration). Currently, most people are only able to access reimbursable care coordination through Medicare with limited insurance companies offering it to other audiences. Mechanisms for expansion and reimbursement need to be explored to help control costs and achieve better health for rural Marylanders.

SYSTEMS-BASED RECOMMENDATIONS

Training for Transportation Professionals

Transportation and overall access to care was a concern for rural Maryland. Public transportation was often cited as having limited routes, while medical transportation was only available to certain health consumers. Further, the availability of handicapped-accessible vehicles and the training of transportation professionals to assist individuals with disabilities appears to be limited. An interagency and cross-sector approach should be used to ensure safe, medically appropriate transport of health care consumers. The health care system needs to better facilitate access for handicapped audiences through a) expanded access of specialized vehicles and b) appropriate training of medical transportation staff on how to work with special populations.

Telehealth Expansion and Medication Management

This recommendation further builds on the Policy Recommendation #4 and addresses one limitation of telehealth: medication management. Telehealth professionals are often called on to diagnose and treat rural health consumers that do not have local access to providers. During treatment, people are often prescribed medication to address and help manage their condition. This may require multiple adjustments to treatment protocols and immediate treatment of medication side effects. To ensure medication needs are properly monitored, a partnership between telehealth providers and on-site physicians needs to be established.

Care Coordination and No Wrong Door Approach

Several counties' focus groups discussed the invaluable nature of care coordination and how its expansion would positively impact consumer health. It is important for the health care system to explore innovative methods to institute care coordination. Potential avenues include a) funding by different organizations to establish shared care coordinators, b) a shared office space or no wrong door policy where each sector works together to direct consumers, and c) a continued community platform for health providers to share services and direct consumers.

Database of Existing Resources for Rural Health

This recommendation focuses on either the expansion of Maryland Access Point or the establishment of a new integrated database of rural health services. One barrier to programs and services cited was the lack of knowledge or awareness of its existence by both providers and consumers. During the focus groups, many participants were pleasantly surprised to learn about new resources, but frustrated there was not a centralized approach to share them. An online database of resources would allow consumers to be more aware of community programs and assist providers in reaching new audiences for services.

School-Based Health Centers

Access to and availability of health care providers was limited for adults and more challenging for youth.

People discussed the need for child specialists, particularly behavioral health, and the lack of qualified providers. Many people discussed having to travel long distances for child appointments, which necessitated the parent missing work and the child missing school. One approach to begin addressing these needs is through the establishment of school-based health centers in each county. This would enable providers to meet youth where they are. Further, mid-level health professionals, such as nurse practitioners and master's-level therapists, would be able to help identify health issues early and establish care.

Mobile Health and Crisis Services

The success of local mobile health and crisis services was discussed in several counties. While the programs varied by individual county needs, emergency medical service professionals are used for making health wellness visits with high utilizers to avoid hospitalization, stabilization services calls to prevent transport to hospitals, and providing crucial links between the physical health and mental health community. These programs have been successful in decreasing hospital admissions and readmissions and helping people stay in their community.

Policy Recommendation #1 advocates for the exploration and establishment of secure funding for these services. This system recommendation advocates for new partnerships between emergency medical service, hospitals, health providers and Community Health Workers throughout all rural Maryland for replication of this service. Several models exist for how the partnership can be structured, allowing each county to hear lessons learned and explore options that would work for them.

Transportation Services

As previously discussed, transportation services are truncated throughout rural Maryland. Bus stops and routes tend to be limited to city centers, preventing many of the most rural citizens from using it. Patchwork solutions, including volunteers, for-hire personal drivers (e.g. Uber, etc.) and private grant funding is used to augment the current system. The health care system needs to explore new transportation methods and cross-sector partnerships, including both formal and informal networks, to increase health care access.

Best Practices for the All Payer Model

As previously discussed, Maryland has transitioned to using a Global Budget Revenue model. While this approach may be new for some hospitals, there are a few rural hospitals who have been operating successfully on the model for years. Examination of practices and policies used by these hospitals can be studied to assist others in adjusting care and administration practices to this system.

Community Trust Building

During the focus groups, a few sessions discussed the distrust and tension between health care providers and consumers. In some cases, this had been existing for years while others seemed to indicate it was a new phenomenon. No matter the length of time, the lack of trust can be harmful to the system, consumer and community. The Maryland Center for Health Equity has created a trust-building program to help communities learn from one another, heal old wounds and start establishing a new, trust-based relationship.

Stigma Reduction

During some of the focus groups and many of the Community Health Needs Assessments, stigma was raised as a large barrier to care. In particular, stigma around being diagnosed and treated for behavioral health conditions and stigma about using health department resources was discussed. In some communities, the health department serves as one of the only primary care and behavioral health providers. To reduce and eliminate both barriers to treatment, the counties need to engage in both a marketing campaign and community education to increase understanding about services offered and increase understanding of behavioral health conditions.

Social Media and Marketing Services

Many focus groups discussed lack of knowledge about different community services and ways to access them. Three strategies should be explored. First, the development and expansion of a community resource database described in System-Based Recommendation #4 for use by the public. Second, services need to engage in comprehensive marketing campaigns to expose communities to their offerings and ways they can access them. Third, health promotion campaigns need to be developed to reach more diverse audiences and equip people with the necessary skills to improve their health and wellness.

Expansion of Clinical and Non-Clinical Health Professionals

Several data points discussed the need for the recruitment and retention of health professionals. Clinical Health Professionals are those who are employed in formal health settings and require credentialing prior to practicing. Currently, the process for reimbursement is laborious, leading to delayed or loss reimbursement, or loss of qualified professionals to other states. It is recommended that hospital administrators, state health professionals, and health insurance companies work together to review and streamline the current process. Many counties and agencies currently employ non-clinical health professionals to increase consumer access to services, facilitate the adaptation of health behaviors, and foster a healthy living environment statewide. This group includes, but is not limited to, Community Health Workers, peer support and recovery specialists, insurance enrollment professionals, extension educators and case managers. These professionals are positively viewed by most because of their acceptance by the community and success in reaching diverse groups. Availability and access to these professionals varies, limiting the audiences who can benefit from them. Expansion of these positions to new audiences and situating professionals in partner agencies would increase the system's ability to serve health care consumers.

INDIVIDUAL RECOMMENDATIONS

Health Insurance Literacy Education

Numerous counties and focus groups discussed the difficulty of people adequately accessing and using the health care system, understanding their benefits, tracking costs associated with care and general use of their health insurance plan. While the onus to navigate the system cannot be put solely on the individual, people do need to be educated on how to use the system. Health insurance education programs have been found to increase consumer confidence and capability in navigating the system. Community Health Workers and Insurance Enrollment professionals, and partnerships between these professionals and rural health organizations, should be expanded to meet this need.

Patient Advocacy

Patient advocacy was discussed in multiple focus groups. This pertained largely to patients being able to ask and communicate with physicians, ensuring that their needs as patients are recognized and met and that their voices are heard in health care decisions. There are a couple ways to accomplish this recommendation. First, formal advocates, either volunteers or employees, are used by many systems to help ensure medical care is patient-centered. These advocates can and do consist of Peer Recovery Specialists, Community Health Workers, and case managers situated in different agencies and organizations. Second, patient or family members can be educated on ways to ensure their voice and needs are part of the decision-making process. This will increase the likelihood of medical adherence and behavior change in the consumer's everyday life.

Healthy Lifestyle Education

The need for more consumer education about healthy lifestyles, disease prevention and management was discussed. This included nutrition and cooking classes, parenting skills,

gardening, tobacco cessation classes, chronic disease management and prevention, physical activity and other related topics. Many community organizations employ Community Health Workers and educators to offer these services with perceived success from community members. Ways to increase access to these services should be explored.

Addressing the Unintended Consequences

As previously discussed, there are two unintended consequences that emerged from the focus groups. First, both consumers and providers perceive that people are being discharged from the hospital sicker or do not understand why some patients are observed before being admitted or released. Second, consumers who have pain management issues have seen an increase in stigma and being mislabeled as addicts. To begin mitigation of these issues, the following recommendations have been made.

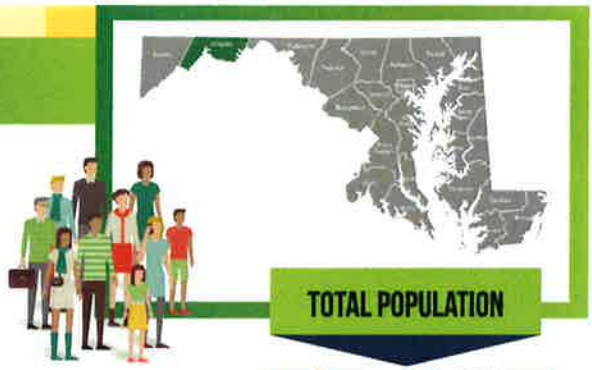
- **Patient Discharge and Hospital Admission**
  Increased patient education is necessary regarding the reasons for patient placement on observation versus admission, and the importance of treatment in the community versus in the hospital. The state also needs to conduct a comprehensive review of patients who are discharged and how well they recover in the community. While the perception is that people are sicker when leaving, it needs to be assessed by a rigorous research process.

- **Pain Management and Unintended Stigmatization**
  The state, pharmacies and other appropriate personnel need to update the CRISP database and ensure its continued use. This will help all pharmacies and appropriate medical personnel see the medical and medication history of patients and help identify those who may be drug-seeking and those with pain management issues. In many rural counties, people have personal relationships with long-standing independent pharmacies that understand their health history and needs, which may be an informal protective factor from stigma. An increase in the number of in-network pharmacies for Medical Assistance, Medicaid and Medicare to include local independent pharmacies would benefit rural residents. Finally, education and stigma reduction efforts need to be developed for health care providers.

APPENDIX I
County Profiles

Allegany	Dorchester	Somerset
Calvert	Frederick	St. Mary's
Caroline	Garrett	Talbot
Carroll	Harford	Washington
Cecil	Kent	Wicomico
Charles	Queen Anne's	Worcester

Allegany



Important County Data

Teen Birth rate (per 1000 population)	24.7
Early Prenatal Care	77.2%
Adults Who are Not Overweight or Obese	27.2%
Adolescents Who have Obesity (only 2014 data available)	13.5%
Adults Who Currently Smoke	22.1%
Adolescents Who use Tobacco (only 2014 data available)	24.9%
Children Receiving Dental Care in the Last Year	58.4%
Uninsured ED Visits	5.6%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	22

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.

TOTAL POPULATION

75,087

48% FEMALES **52%** MALES

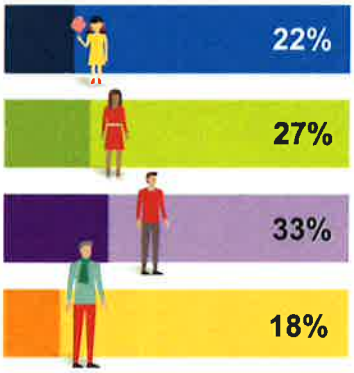
ETHNICITY

Hispanic or Latino	1.4%
Non-Hispanic or Latino	98.6%

RACE

White	89.2%
Black or African American	8.0%
American Indian and Alaska Native	0.2%
Asian	0.8%
Native Hawaiian or Other Pacific Islander	0.0%
Two or More Races or Some Other Race	1.8%

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

What the People Said...

CONSUMERS

Barriers and Service Gaps
Transportation
After hours health care
Lack of specialists

What Works
Diabetes clinic and cooking classes
Family support network for disabilities

PROVIDERS

Barriers and Service Gaps
Transportation
Stigma towards behavioral health
Lack of services outside the city

What Works
Home health care options and services
Health care system navigation

COUNTY PRIORITIES

Substance abuse

Poverty

Heart disease

Consumer Solutions

- **More specialists are recruited and retained**
- **Database for locating providers and other services**

Provider Solutions

- **Increase behavioral health treatment**
- **Living wage for health care workers**
- **Early health education in schools**

Calvert

Important County Data

Teen Birth rate (per 1000 population)	9.6
Early Prenatal Care	72.1%
Adults Who are Not Overweight or Obese	22.8%
Adolescents Who have Obesity (only 2014 data available)	10.1%
Adults Who Currently Smoke	15.5%
Adolescents Who use Tobacco (only 2014 data available)	20.7%
Children Receiving Dental Care in the Last Year	58.6%
Uninsured ED Visits	4.8%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	20

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.

TOTAL POPULATION

88,737

51% FEMALES

49% MALES

ETHNICITY

Hispanic or Latino	2.7%
Non-Hispanic or Latino	97.3%

RACE

White	81.4%
Black or African American	13.4%
American Indian and Alaska Native	0.4%
Asian	1.4%
Native Hawaiian or Other Pacific Islander	0.0%
Two or More Races or Some Other Race	3.4%

What the People Said...

CONSUMERS

Barriers and Service Gaps
Transportation
Health insurance options
Lack of specialists and behavioral health

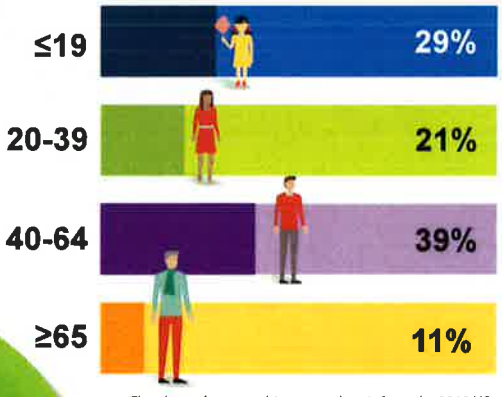
What Works
YMCA

PROVIDERS

Barriers and Service Gaps
Transportation
Care coordination
No behavioral health inpatient options

What Works
Mobile crisis units
Telehealth programs
Community health education

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

COUNTY PRIORITIES

- Cancer prevention and treatment
- Substance abuse and behavioral health
- Access to care and providers

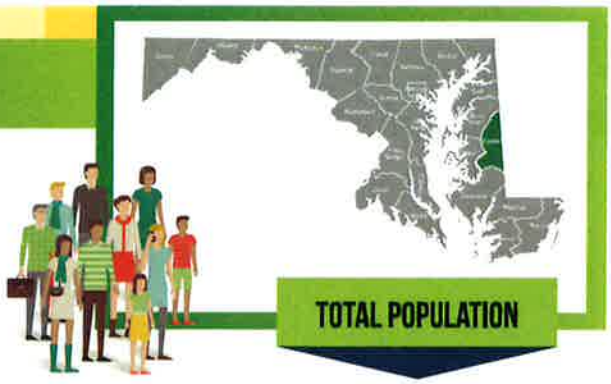
Consumer Solutions

- Right care at the right time - on demand care

Provider Solutions

- Care coordination
- Trust building between providers and consumers

Caroline



Important County Data

Teen Birth rate (per 1000 population)	27.0
Early Prenatal Care	76.7%
Adults Who are Not Overweight or Obese	21.2%
Adolescents Who have Obesity (only 2014 data available)	13.9%
Adults Who Currently Smoke	23.5%
Adolescents Who use Tobacco (only 2014 data available)	26.1%
Children Receiving Dental Care in the Last Year	72.1%
Uninsured ED Visits	6.8%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	3

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.

TOTAL POPULATION

33,066

51% FEMALES

49% MALES

ETHNICITY

Hispanic or Latino	5.5%
Non-Hispanic or Latino	94.5%

RACE

White	79.8%
Black or African American	13.9%
American Indian and Alaska Native	0.3%
Asian	0.6%
Native Hawaiian or Other Pacific Islander	0.2%
Two or More Races or Some Other Race	5.2%

What the People Said...

CONSUMERS

Barriers and Service Gaps
Transportation
Health insurance networks
Lack of oral health care

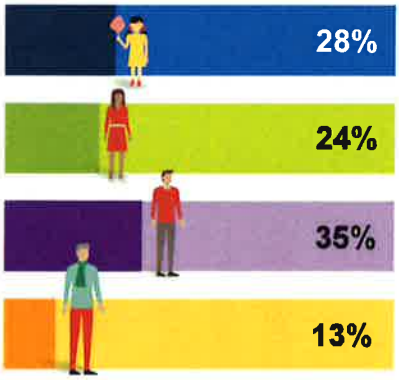
What Works
Emergency medical services
Community response to opioid crisis
Health department events

PROVIDERS

Barriers and Service Gaps
Transportation
Fear of deportation
Culture and stigma surrounding care

What Works
Telehealth programs
Mobile integrated health
Partners in Care volunteer program

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

COUNTY PRIORITIES

Obesity

Diabetes prevention and management

Heart disease/stroke

Consumer Solutions

- Health education/holistic health center
- Youth activities
- Examine new ways to retain doctors

Provider Solutions

- Community health center with care coordination services
- Expansion of mobile integrated health
- Database of best practices

Carroll

Important County Data

Teen Birth rate (per 1000 population)	6.8
Early Prenatal Care	75.9%
Adults Who are Not Overweight or Obese	31.7%
Adolescents Who have Obesity (only 2014 data available)	8.9%
Adults Who Currently Smoke	11.6%
Adolescents Who use Tobacco (only 2014 data available)	15.0%
Children Receiving Dental Care in the Last Year	56.0%
Uninsured ED Visits	5.4%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	40

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.

TOTAL POPULATION

167,134

51% FEMALES

49% MALES

ETHNICITY

Hispanic or Latino	2.6%
Non-Hispanic or Latino	97.4%

RACE

White	92.9%
Black or African American	3.2%
American Indian and Alaska Native	0.2%
Asian	1.4%
Native Hawaiian or Other Pacific Islander	0.1%
Two or More Races or Some Other Race	2.2%

What the People Said...

CONSUMERS

Barriers and Service Gaps
Transportation
Health insurance-networks and cost

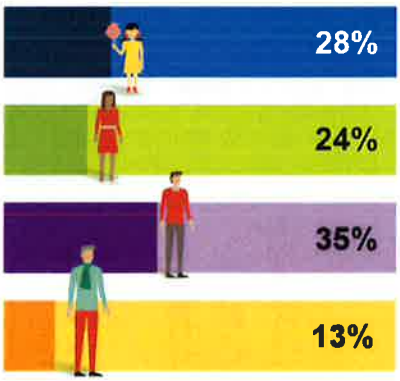
What Works
Carroll Health group
Peer suport groups

PROVIDERS

Barriers and Service Gaps
Transportation
Stigma and culture
Health insurance-networks and cost

What Works
Case managers and system navigators

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

COUNTY PRIORITIES

- Health care access
- Behavioral health
- Prevention of chronic health conditions

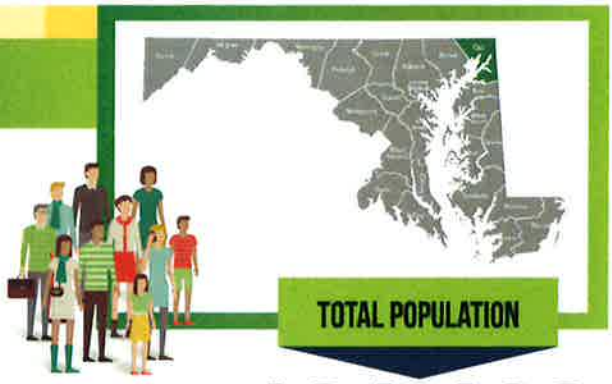
Consumer Solutions

- Sober homes
- 24/7 crisis beds for behavioral health
- More crisis intervention team police officers

Provider Solutions

- Peer mentors
- Behavioral health added to urgent care facilities
- Computer literacy for care coordination

Cecil



Important County Data

Teen Birth rate (per 1000 population)	18.3
Early Prenatal Care	78.2%
Adults Who are Not Overweight or Obese	44.4%
Adolescents Who have Obesity (only 2014 data available)	14.1%
Adults Who Currently Smoke	17.5%
Adolescents Who use Tobacco (only 2014 data available)	25.2%
Children Receiving Dental Care in the Last Year	55.5%
Uninsured ED Visits	5.8%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	32

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.

TOTAL POPULATION

101,108

50% FEMALES

50% MALES

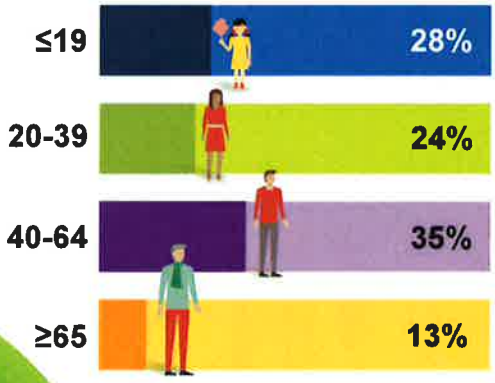
ETHNICITY

Hispanic or Latino	3.4%
Non-Hispanic or Latino	96.6%

RACE

White	89.2%
Black or African American	6.2%
American Indian and Alaska Native	0.3%
Asian	1.1%
Native Hawaiian or Other Pacific Islander	0.0%
Two or More Races or Some Other Race	3.2%

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

What the People Said...

CONSUMERS

Barriers and Service Gaps
Transportation
Provider shortage
Health insurance-networks and cost

What Works
Emergency medical services
Access to behavioral health

PROVIDERS

Barriers and Service Gaps
Transportation
Limited staff
Health insurance-networks and cost

What Works
Telehealth
Collaborative partnerships
WATCH Teams (Wellness Action Teams of Cecil and Harford)

COUNTY PRIORITIES

Social determinants of health

Behavioral health

Prevention of chronic health conditions

Consumer Solutions

- Peer support groups
- Expanded health insurance networks
- Preventive health (individual and societal)

Provider Solutions

- Care coordination with real-time data
- Integrated health centers throughout the county
- Mobile care unit

Charles

Important County Data

Teen Birth rate (per 1000 population)	15.3
Early Prenatal Care	67.6%
Adults Who are Not Overweight or Obese	23.1%
Adolescents Who have Obesity (only 2014 data available)	12.3%
Adults Who Currently Smoke	18.4%
Adolescents Who use Tobacco (only 2014 data available)	17.9%
Children Receiving Dental Care in the Last Year	50.7%
Uninsured ED Visits	8.5%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	22

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.

TOTAL POPULATION

146,551

52% FEMALES

48% MALES

ETHNICITY

Hispanic or Latino	4.3%
Non-Hispanic or Latino	95.7%

RACE

White	50.3%
Black or African American	41.0%
American Indian and Alaska Native	0.7%
Asian	3.0%
Native Hawaiian or Other Pacific Islander	0.1%
Two or More Races or Some Other Race	4.9%

What the People Said...

CONSUMERS

Barriers and Service Gaps
Transportation
Provider shortage
Lack of preventive care

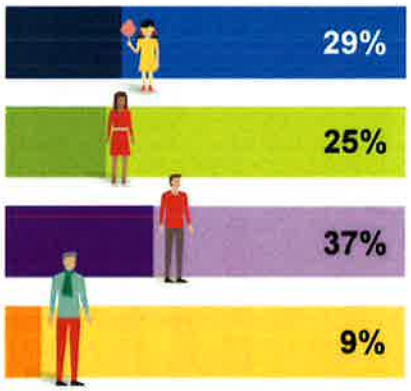
What Works
Mobile health unit
Community health fair
Partnerships

PROVIDERS

Barriers and Service Gaps
Transportation
Insurance
Adolescent mental health

What Works
Outpatient diabetes center
Workplace wellness
Partnerships

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

COUNTY PRIORITIES

Access to care

Behavioral health

Prevention of chronic health conditions

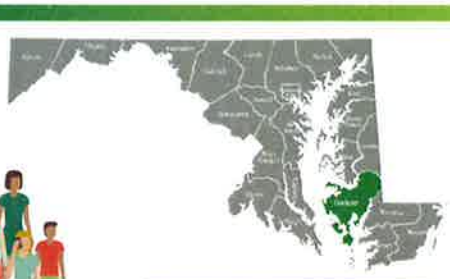
Consumer Solutions

- Community garden
- Faith-based interventions
- Community center

Provider Solutions

- Link up mental health care with mobile health unit
- Partnerships with local farms
- Prevention programs

Dorchester



TOTAL POPULATION

32,618

Important County Data

Teen Birth rate (per 1000 population)	50.7
Early Prenatal Care	78.1%
Adults Who are Not Overweight or Obese	25.6%
Adolescents Who have Obesity (only 2014 data available)	17.2%
Adults Who Currently Smoke	19.8%
Adolescents Who use Tobacco (only 2014 data available)	24.9%
Children Receiving Dental Care in the Last Year	68.7%
Uninsured ED Visits	6.8%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	1

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.

52% FEMALES **48%** MALES

ETHNICITY

Hispanic or Latino	3.5%
Non-Hispanic or Latino	96.5%

RACE

White	67.6%
Black or African American	27.7%
American Indian and Alaska Native	0.4%
Asian	0.9%
Native Hawaiian or Other Pacific Islander	0.0%
Two or More Races or Some Other Race	3.4%

What the People Said...

CONSUMERS

Barriers and Service Gaps
Health education/Health care system education
Provider shortage
Rehab facility

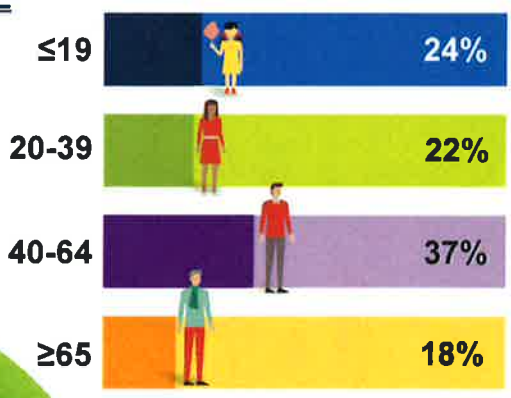
What Works
YMCA

PROVIDERS

Barriers and Service Gaps
Transportation
Behavioral health inpatient center
Care coordination

What Works
Mobile crisis
Community health education
Telehealth

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

COUNTY PRIORITIES

Obesity

Behavioral health

Cancer

Consumer Solutions

- **On-demand care**

Provider Solutions

- **Care coordination**
- **Trust building between providers and consumers**

Frederick

Important County Data

Teen Birth rate (per 1000 population)	11.0
Early Prenatal Care	77.5%
Adults Who are Not Overweight or Obese	39.1%
Adolescents Who have Obesity (only 2014 data available)	9.1%
Adults Who Currently Smoke	21.6%
Adolescents Who use Tobacco (only 2014 data available)	16.3%
Children Receiving Dental Care in the Last Year	68.1%
Uninsured ED Visits	9.3%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	40

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.

TOTAL POPULATION

233,385

51% FEMALES

49% MALES

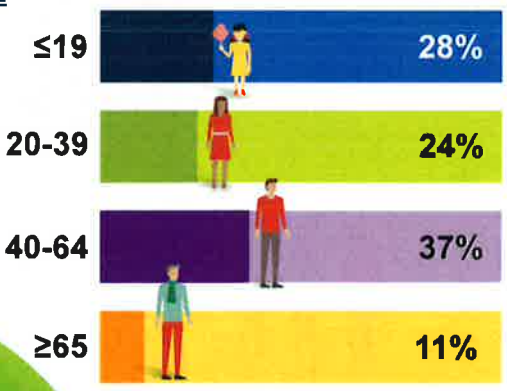
ETHNICITY

Hispanic or Latino	7.3%
Non-Hispanic or Latino	92.7%

RACE

White	81.5%
Black or African American	8.6%
American Indian and Alaska Native	0.3%
Asian	3.8%
Native Hawaiian or Other Pacific Islander	0.1%
Two or More Races or Some Other Race	5.7%

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

What the People Said...

CONSUMERS

Barriers and Service Gaps

Limited health insurance networks for the underinsured
Lack of specialists
Behavioral health providers

What Works

Department of Aging
Church meal programs
Police department opioid outreach

PROVIDERS

Barriers and Service Gaps

Transportation
Adolescent resources
Community involvement

What Works

Community baby shower
Group therapy
SOAR volunteer transit

COUNTY PRIORITIES

Chronic disease

Behavioral health

Cancer

Consumer Solutions

- Care coordination
- Scholarships for youth interested in health care
- Community center

Provider Solutions

- Care coordination
- Mental health intervention team
- Addiction services

Garrett

Important County Data

Teen Birth rate (per 1000 population)	31.8
Early Prenatal Care	80.9%
Adults Who are Not Overweight or Obese	38.9%
Adolescents Who have Obesity (only 2014 data available)	16.0%
Adults Who Currently Smoke	29.4%
Adolescents Who use Tobacco (only 2014 data available)	33.0%
Children Receiving Dental Care in the Last Year	72.2%
Uninsured ED Visits	5.8%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	25

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.

TOTAL POPULATION

30,097

50% FEMALES

50% MALES

ETHNICITY

Hispanic or Latino	0.7%
Non-Hispanic or Latino	99.3%

RACE

White	97.8%
Black or African American	1.0%
American Indian and Alaska Native	0.1%
Asian	0.3%
Native Hawaiian or Other Pacific Islander	0.0%
Two or More Races or Some Other Race	0.8%

What the People Said...

CONSUMERS

Barriers and Service Gaps
Transportation
Overbooked providers
Behavioral health providers

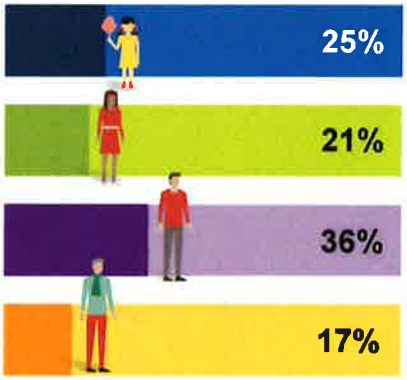
What Works
Emergency medical services
Patient medical home
New hospital-based program

PROVIDERS

Barriers and Service Gaps
Transportation
Hours of service
Stigma

What Works
Telehealth
Home health workers
Care coordination

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

COUNTY PRIORITIES

Chronic disease

Behavioral health

Nutrition and physical activity

Consumer Solutions

- **24 hour urgent care**
- **Health education in the schools**
- **Behavioral health center**

Provider Solutions

- Mobile wellness center
- Health education in the schools
- Adult daycare

Harford

Important County Data

Teen Birth rate (per 1000 population)	8.8
Early Prenatal Care	78.6%
Adults Who are Not Overweight or Obese	27.7%
Adolescents Who have Obesity (only 2014 data available)	10.0%
Adults Who Currently Smoke	20.7%
Adolescents Who use Tobacco (only 2014 data available)	19.2%
Children Receiving Dental Care in the Last Year	60.2%
Uninsured ED Visits	3.4%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	50

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.

TOTAL POPULATION

244,826

51% FEMALES

49% MALES

ETHNICITY

Hispanic or Latino	3.5%
Non-Hispanic or Latino	96.5%

RACE

White	81.2%
Black or African American	12.7%
American Indian and Alaska Native	0.2%
Asian	2.4%
Native Hawaiian or Other Pacific Islander	0.1%
Two or More Races or Some Other Race	3.4%

What the People Said...

CONSUMERS

Barriers and Service Gaps
Transportation
Limited hours
Health insurance - costs and networks

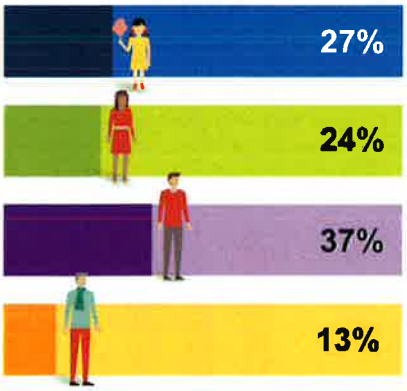
What Works
Emergency medical services
Healthy Harford
Community events

PROVIDERS

Barriers and Service Gaps
Transportation
Health insurance - uninsured and underinsured
Stigma

What Works
Behavioral health services in the school system
Interdisciplinary team/interagency coordination

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

COUNTY PRIORITIES

- Chronic disease
- Behavioral health
- Maternal and child health

Consumer Solutions

- Community clinics
- Behavioral health rehab
- Care coordination

Provider Solutions

- No wrong door/care coordination
- Reimbursement of emergency medical services
- Health education in the schools

Kent

Important County Data

Teen Birth rate (per 1000 population)	18.2
Early Prenatal Care	81.9%
Adults Who are Not Overweight or Obese	27.2%
Adolescents Who have Obesity (only 2014 data available)	12.8%
Adults Who Currently Smoke	*
Adolescents Who use Tobacco (only 2014 data available)	22.9%
Children Receiving Dental Care in the Last Year	71.9%
Uninsured ED Visits	4.7%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	3

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.
** Data for this county did not meet the threshold required for reporting so was therefore withheld for privacy purposes.*

TOTAL POPULATION

20,197

52% FEMALES **48%** MALES

ETHNICITY

Hispanic or Latino	4.5%
Non-Hispanic or Latino	95.5%

RACE

White	80.1%
Black or African American	15.1%
American Indian and Alaska Native	0.2%
Asian	0.8%
Native Hawaiian or Other Pacific Islander	0.0%
Two or More Races or Some Other Race	3.8%

What the People Said...

CONSUMERS

Barriers and Service Gaps
Transportation
Patient advocacy
Health insurance - costs and networks

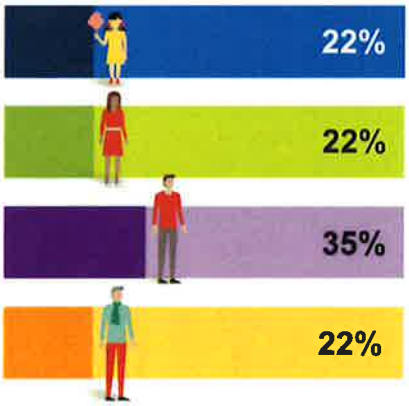
What Works
Community health outreach education
Parks and recreation
Employee wellness

PROVIDERS

Barriers and Service Gaps
Transportation
Low cost community health services
Lack of specialists

What Works
Coordinating care with the health department
Increase in detox beds
Satellite offices

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

COUNTY PRIORITIES

Chronic disease

Behavioral health

Access to care

Consumer Solutions

- Free clinic
- Women's health
- Health center in each county

Provider Solutions

- Care coordination
- Specialists
- Older adult services

Queen Anne's

TOTAL POPULATION

47,798

Important County Data

Teen Birth rate (per 1000 population)	6.8
Early Prenatal Care	75.3%
Adults Who are Not Overweight or Obese	32.9%
Adolescents Who have Obesity (only 2014 data available)	11.7%
Adults Who Currently Smoke	17.2
Adolescents Who use Tobacco (only 2014 data available)	24.3%
Children Receiving Dental Care in the Last Year	69.9%
Uninsured ED Visits	5.1%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	4

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.

50% FEMALES **50%** MALES

ETHNICITY

Hispanic or Latino	3.0%
Non-Hispanic or Latino	97.0%

RACE

White	88.7%
Black or African American	6.9%
American Indian and Alaska Native	0.3%
Asian	1.0%
Native Hawaiian or Other Pacific Islander	0.0%
Two or More Races or Some Other Race	3.1%

What the People Said...

CONSUMERS

Barriers and Service Gaps
Transportation
Treatment of behavioral health
Health insurance - costs and networks

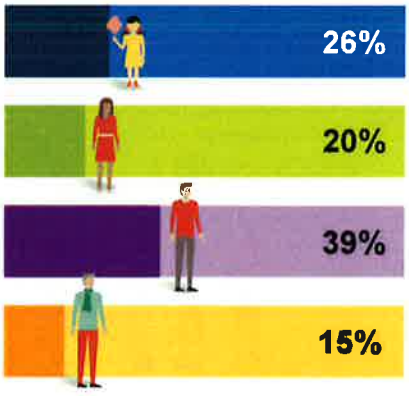
What Works
Nursing program at Chesapeake College
Telehealth

PROVIDERS

Barriers and Service Gaps
Transportation
Community behavioral health services
Lack of stable funding

What Works
Mobile crisis
Community dental clinics
Pharmacy delivery

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

COUNTY PRIORITIES

- Obesity
- Behavioral health
- Access to care/ prevention

Consumer Solutions

- Physician employment incentives to stay
- Integrated health centers
- Dental care for all

Provider Solutions

- Invest in youth
- Elderly services
- Behavioral health

Somerset

Important County Data

Teen Birth rate (per 1000 population)	22.5
Early Prenatal Care	80.5%
Adults Who are Not Overweight or Obese	31.2%
Adolescents Who have Obesity (only 2014 data available)	17.5%
Adults Who Currently Smoke	25.0%
Adolescents Who use Tobacco (only 2014 data available)	27.5%
Children Receiving Dental Care in the Last Year	68.8%
Uninsured ED Visits	7.6%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	6

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.

TOTAL POPULATION

26,470

47% FEMALES

53% MALES

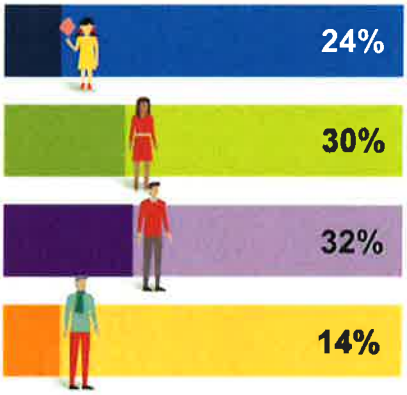
ETHNICITY

Hispanic or Latino	3.3%
Non-Hispanic or Latino	96.7%

RACE

White	53.5%
Black or African American	42.3%
American Indian and Alaska Native	0.4%
Asian	0.7%
Native Hawaiian or Other Pacific Islander	0.0%
Two or More Races or Some Other Race	3.1%

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

What the People Said...

CONSUMERS

Barriers and Service Gaps
Transportation
Behavioral health support services
Health insurance networks

What Works
Emergency medical services
Consumer advocates

PROVIDERS

Barriers and Service Gaps
Transportation
Language
Health insurance and cost of services

What Works
Patient navigators
Weekend service hours

COUNTY PRIORITIES

Health risks

Prevention

Access to care

Consumer Solutions

- Free clinics and health services
- Peer support
- Rehab and recovery centers

Provider Solutions

- Invest in youth
- Elderly services
- Behavioral health

St. Mary's

Important County Data

Teen Birth rate (per 1000 population)	14.8
Early Prenatal Care	77.2%
Adults Who are Not Overweight or Obese	31.3%
Adolescents Who have Obesity (only 2014 data available)	10.3%
Adults Who Currently Smoke	14.5%
Adolescents Who use Tobacco (only 2014 data available)	22.6%
Children Receiving Dental Care in the Last Year	56.0%
Uninsured ED Visits	6.9%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	18

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.

TOTAL POPULATION

105,151

50% FEMALES **50%** MALES

ETHNICITY

Hispanic or Latino	3.8%
Non-Hispanic or Latino	96.2%

RACE

White	78.6%
Black or African American	14.3%
American Indian and Alaska Native	0.4%
Asian	2.5%
Native Hawaiian or Other Pacific Islander	0.1%
Two or More Races or Some Other Race	4.1%

What the People Said...

CONSUMERS

Barriers and Service Gaps
Overbooked providers and wait times
Lack of specialists
Cultural barriers

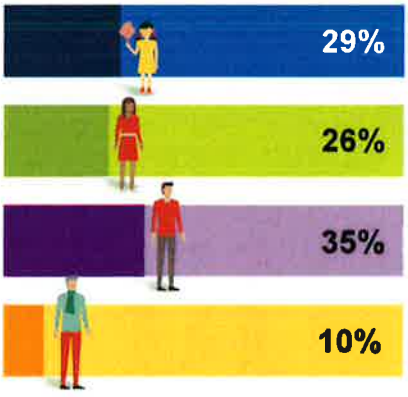
What Works
Dental van
Community outreach events

PROVIDERS

Barriers and Service Gaps
Transportation
Health insurance - qualification, network costs, etc.
Language

What Works
Telehealth
Provider outreach
Increased case management

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

COUNTY PRIORITIES

Chronic disease

Social determinants of health

Obesity

Consumer Solutions

- Care coordination
- Assisted living
- Behavioral health services
- Emergency medical services

Provider Solutions

- Integrated behavioral health and physical health services
- Scholarships for students to stay in community
- Free fitness center

Talbot

Important County Data

Teen Birth rate (per 1000 population)	15.4
Early Prenatal Care	76.3%
Adults Who are Not Overweight or Obese	40.8%
Adolescents Who have Obesity (only 2014 data available)	10.3%
Adults Who Currently Smoke	*
Adolescents Who use Tobacco (only 2014 data available)	21.6%
Children Receiving Dental Care in the Last Year	73.2%
Uninsured ED Visits	6.6%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	5

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.

** Data for this county did not meet the threshold required for reporting so was therefore withheld for privacy purposes.*

TOTAL POPULATION

37,782

52% FEMALES

48% MALES

ETHNICITY

Hispanic or Latino	5.5%
Non-Hispanic or Latino	94.5%

RACE

White	81.4%
Black or African American	12.8%
American Indian and Alaska Native	0.2%
Asian	1.2%
Native Hawaiian or Other Pacific Islander	0.1%
Two or More Races or Some Other Race	4.3%

What the People Said...

CONSUMERS

Barriers and Service Gaps
Transportation
Care coordination
Dental health care

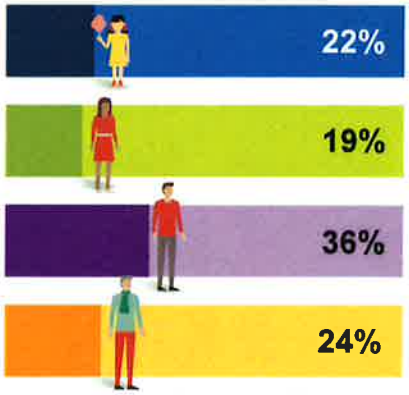
What Works
Senior centers
Parks and recreation

PROVIDERS

Barriers and Service Gaps
Transportation
Health insurance - networks
Jobs for well-educated spouses and reciprocity laws

What Works
Mobile crisis
Flexible appointments and open access days
School health facilities

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

COUNTY PRIORITIES

Health status monitoring

Shortage analysis

Priority to areas of greatest need

Consumer Solutions

- Care coordination between agencies
- Incentives to bring specialists to communities

Provider Solutions

- Telehealth with medical oversight by primary care provider
- Data infrastructure for real-time decisions
- Living wage for citizens

Washington

Important County Data

Teen Birth rate (per 1000 population)	24.7
Early Prenatal Care	70.2%
Adults Who are Not Overweight or Obese	31.6%
Adolescents Who have Obesity (only 2014 data available)	14.3%
Adults Who Currently Smoke	22.0%
Adolescents Who use Tobacco (only 2014 data available)	23.7%
Children Receiving Dental Care in the Last Year	58.6%
Uninsured ED Visits	9.8%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	64

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.

TOTAL POPULATION

147,430

49% FEMALES

51% MALES

ETHNICITY

Hispanic or Latino	3.5%
Non-Hispanic or Latino	96.5%

RACE

White	85.1%
Black or African American	9.6%
American Indian and Alaska Native	0.2%
Asian	0.1%
Native Hawaiian or Other Pacific Islander	1.4%
Two or More Races or Some Other Race	3.6%

What the People Said...

CONSUMERS

Barriers and Service Gaps
Health insurance - networks and acceptance
Behavioral health
Overbooked providers

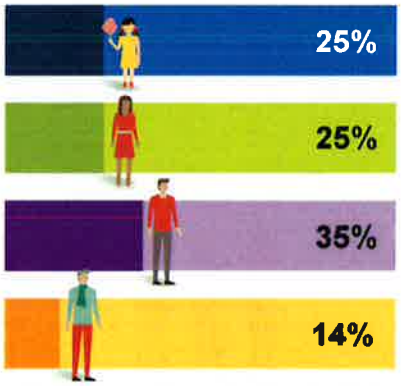
What Works
Nurse case managers
Quality of specialists at Robinwood medical facilities

PROVIDERS

Barriers and Service Gaps
Transportation
Health insurance - high co-pays/out of pocket costs
Dental health

What Works
Care coordination
Probation period for new patients

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

COUNTY PRIORITIES

Obesity

Behavioral health

Health care affordability

Consumer Solutions

- Disease prevention (cancer and heart)
- Food systems overhaul
- Drug prevention and education

Provider Solutions

- Mobile health
- Case management/care coordination
- Urgent Care in areas of low provider access (neighborhood clinics)

Wicomico

Important County Data

Teen Birth rate (per 1000 population)	20.0
Early Prenatal Care	78.8%
Adults Who are Not Overweight or Obese	34.5%
Adolescents Who have Obesity (only 2014 data available)	11.9%
Adults Who Currently Smoke	23.0%
Adolescents Who use Tobacco (only 2014 data available)	21.5%
Children Receiving Dental Care in the Last Year	64.4%
Uninsured ED Visits	10.0%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	18

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.

TOTAL POPULATION

98,733

52% FEMALES

48% MALES

ETHNICITY

Hispanic or Latino	4.5%
Non-Hispanic or Latino	95.5%

RACE

White	68.7%
Black or African American	24.2%
American Indian and Alaska Native	0.2%
Asian	2.5%
Native Hawaiian or Other Pacific Islander	0.0%
Two or More Races or Some Other Race	4.4%

What the People Said...

CONSUMERS

Barriers and Service Gaps
Health insurance - networks and underinsured
Behavioral health
Overbooked providers

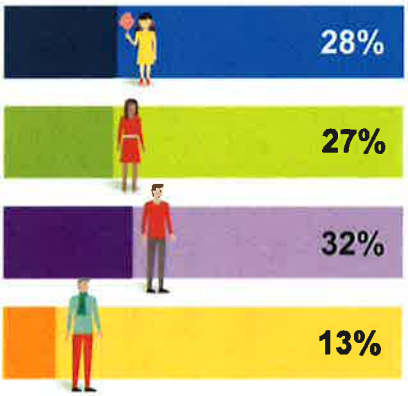
What Works
Smoking cessation classes
Transitional mental health services from adulthood
Emergency medical services

PROVIDERS

Barriers and Service Gaps
Health care navigation
Culture
Care coordination

What Works
Hospital-specific transportation
Community health events

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

COUNTY PRIORITIES

Chronic disease

Behavioral health

Access to health care

Consumer Solutions

- **Rehab facility and transportation**
- **Integrated health centers with transportation**
- **Access to new and cutting edge drugs**

Provider Solutions

- Care coordination via website
- Community-based health workers
- Medicare gap funding

Worcester

Important County Data

Teen Birth rate (per 1000 population)	20.9
Early Prenatal Care	80.4%
Adults Who are Not Overweight or Obese	40.4%
Adolescents Who have Obesity (only 2014 data available)	13.5%
Adults Who Currently Smoke	*
Adolescents Who use Tobacco (only 2014 data available)	22.5%
Children Receiving Dental Care in the Last Year	63.8%
Uninsured ED Visits	7.4%
Total Number of Drug and Alcohol-related Intoxication Deaths Occurring in Maryland by Place of Occurrence	16

The above data is a direct copy of the data provided in the chart on page #8 of this document. Please review the footnotes on that page for additional details, sources, and information.

** Data for this county did not meet the threshold required for reporting so was therefore withheld for privacy purposes.*

TOTAL POPULATION

51,454

51% FEMALES **49%** MALES

ETHNICITY

Hispanic or Latino	3.2%
Non-Hispanic or Latino	96.8%

RACE

White	82.0%
Black or African American	13.6%
American Indian and Alaska Native	0.3%
Asian	1.1%
Native Hawaiian or Other Pacific Islander	0.0%
Two or More Races or Some Other Race	3.0%

What the People Said...

CONSUMERS

Barriers and Service Gaps
Transportation
Care coordination
Dental

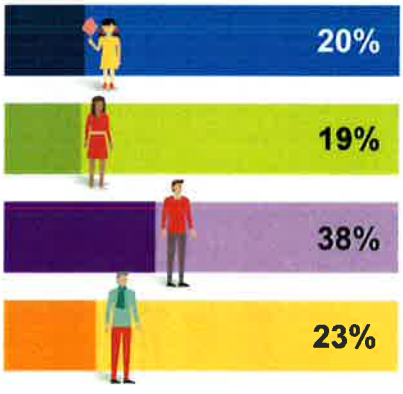
What Works
Health Department
Emergency medical services

PROVIDERS

Barriers and Service Gaps
Transportation
Lack of specialists
Behavioral health services

What Works
BRIDGE program
Telehealth
Community health outreach

AGE



The above demographic county data is from the 2010 US Census website: www.census.gov/2010census

COUNTY PRIORITIES

Access to care

Health risk behaviors

Behavioral health

Consumer Solutions

- Diversion program with police and youth
- Multiple methods of education and communication
- Health education in the schools

Provider Solutions

- Transportation for the elderly
- Primary care provider in every town

APPENDIX II
Maryland SHIP Data Detail

Measure Name	SHIP Website Description	Source	Numerator	Denominator	Threshold	Censorship (if below threshold)	Calculation & Metric
Adults Who Currently Smoke	This indicator shows the percentage of adults who currently smoke 7,500 adults in Maryland die each year due to tobacco-related causes, and 150,000 more suffer from tobacco-related diseases such as COPD, emphysema or cancers. Non-smokers – especially young children (and even pets) – are also affected by tobacco through exposure to the toxins found in secondhand smoke.	Maryland DHMH Behavioral Risk Factor Surveillance System (BRFSS) (www.marylandbrfss.org)	Maryland adults who reported currently smoking cigarettes some days or every day	Maryland adults age 18 and over	50 or relative standard error >=30.0%	Rate not reported. Count not reported.	Weighted (Numerator / Denominator) * 100 = Single-Year Calculation
Adults Who Are Not Overweight or Obese	This indicator shows the percentage of adults who are not overweight or obese. In Maryland in 2015, of adults considered obese, 52% had high blood pressure, 44% had high cholesterol, and 21% had diabetes. Healthy weight can aid in the control of these conditions if they develop.	Maryland DHMH Behavioral Risk Factor Surveillance System (BRFSS) (www.marylandbrfss.org)	Maryland adults with BMI of less than 25 kg/m2	Maryland adults age 18 and over	50 or relative standard error >=30.0%	Rate not reported. Count not reported.	Weighted (Numerator / Denominator) * 100 = Single-Year Calculation
Prenatal Care, Early	This indicator shows the percentage of pregnant women who receive prenatal care beginning in the first trimester. Inadequate prenatal care services have been linked to higher rates of infant mortality, low birth weight and pre-term deliveries. While Maryland as a whole ranks better than the National average and the Healthy People 2020 Target, disparities still exist. Due to the change in methodology for collecting information on the Maryland birth certificate, data collected in 2010 and after are not comparable to data collected in earlier years.	Maryland DHMH Vital Statistics Administration (VSA) Annual Report	Number of mothers who began prenatal care in the first trimester	Number of live births from Maryland DHMH Vital Statistics Administration (VSA) - Number of mothers with "Not Stated" prenatal care	5	Rate not reported if below threshold. Counts may be available upon request.	(Numerator / Denominator) * 100
Teen Birth Rate	This indicator shows the rate of births to teens ages 15-19 years (per 1,000 population). Teen pregnancy is linked to a host of social problems such as poverty, lack of overall child well-being, out-of-wedlock births, lack of responsible fatherhood, health issues, school failure, child abuse and neglect and at-risk behaviors.	Maryland DHMH Vital Statistics Administration (VSA) Annual Report	Number of births to mothers 15-19 years of age	Population of females aged 15-19 years from Maryland DHMH Vital Statistics Administration (VSA)	5	Rate not reported if below threshold. Counts may be available upon request.	(Numerator / Denominator) * 1,000
Uninsured ED Visits	This indicator shows the percentage of persons without health (medical) insurance who seek care through the Emergency Department. People without health insurance are more likely to be in poor health than the insured. Lack of health insurance can result in increased visits to the emergency department and decreased routine care visits with a primary care provider.	Maryland Health Services Cost Review Commission (HSCRC), Research Level Statewide Outpatient Data Files	Number of emergency department visits when the primary payor is self-pay or no charge	Total number of emergency department visits	Numerator <50 OR Denominator <1000	Rate not reported if below threshold.	(Numerator / Denominator) * 100; Single-year calculation
Children Receiving Dental Care in The Last Year	This indicator reflects the percentage of children (aged 0-20 years) enrolled in Medicaid (320+ days) who received at least one dental visit during the past year. Poor oral health can lead to problems with nutrition, growth, school and workplace readiness, and speech. Adoption and use of recommended oral hygiene measures are critical to maintaining overall health.	Maryland Medicaid Service Utilization	Children aged 0 to 12 and 13 to 20 years in the fee-for-service (FFS) Medicaid or full HealthChoice managed care organization (MCO) programs. Enrollees in the following coverage groups were excluded from the analysis: undocumented immigrants (X02), Breast and Cervical Screening Program (W01), and Family Planning Program (P10). Individuals enrolled in the Primary Adult Care (PAC) program (S09) were also excluded because dental services are not a required benefit for these enrollees.	Children who had at least one dental visit during the measurement year. Dental visits were identified by FFS claims in the Medicaid Management Information System (MMIS2). For these measures, a dental visit is defined as one unique contact between a provider and an enrollee that may not exceed one per day.	?	Rate not reported. Counts not reported.	(Numerator / Denominator) * 100 = Single-Year Calculation
Adolescents Who Use Tobacco Products	This indicator shows the percentage of adolescents (public high school students) who used any tobacco product in the last 30 days. Preventing youth from using tobacco products is critical to improving the health of Marylanders. This highly addictive behavior can lead to costly illnesses and death to users and those exposed to secondhand smoke.	Maryland Youth Risk Behavior Survey (YRBS) (http://pbha.dhmh.maryland.gov/ccdpc/Reports/Pages/yrbs.aspx)	Number of adolescents (Maryland public high school youth) who reported using any kind of tobacco product	Number of persons attending Maryland public high schools (population) via Maryland Youth Risk Behavior Survey (YRBS)	50 and/or coefficient of variation > 0.30	Rate not reported if below threshold. Counts may be available upon request. Data is not presented for all years/ counties for the race /ethnicity category "Asian" because the populations are too small to display.	(Numerator / Denominator) * 100 = Single-Year Calculation
Adolescents Who Have Obesity	This indicator shows the percentage of adolescent public high school students who are obese. In the last 20 years, the percentage of overweight/obese children has more than doubled and, for adolescents, it has tripled. Overweight/obese children are at increased risk of developing life-threatening chronic diseases, such as Type 2 diabetes.	Maryland Youth Risk Behavior Survey (YRBS) http://pbha.dhmh.maryland.gov/ccdpc/Reports/Pages/yrbs.aspx	Number of adolescent public high school youth who have a Body Mass Index (BMI) (determined through self-reported height and weight) equal to or above the 95th percentile for age and gender	Number of adolescent public high school youth (population) via Maryland Youth Risk Behavior Survey (YRBS)	n<50 and/or coefficient of variation > 30	Rate not reported if below threshold. Counts may be available upon request.	(Numerator / Denominator) * 100 = Single-Year Calculation

APPENDIX III
References

Agency for Healthcare Research and Quality, Care Coordination
https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html

American Academy of Family Physicians
http://www.aafp.org/home.html

Centers for Disease Control
https://www.cdc.gov/

Healthy People 2020
https://www.healthypeople.gov/

Maryland State Health Improvement Process (SHIP)
http://ship.md.networkofcare.org/ph/

Maryland General Assembly
http://mgaleg.maryland.gov/webmga/frm1st.aspx?tab=home

Maryland's Vital Statistics Administrations
https://health.maryland.gov/vsa/Pages/home.aspx

National Assessment of Adult Literacy (NAAL)
https://nces.ed.gov/naal/

Plain Language Act of 2010
http://www.plainlanguage.gov/plLaw/law/index.cfm

Substance Abuse and Mental Health Services Administrations (SAMHSA)
https://www.samhsa.gov/

Southwest Rural Health Research Center
https://srhrc.tamhsc.edu

United States Census
https://www.census.gov/2010census/popmap/ipmtext.php

MRHA also referenced the Community Health Needs Assessments from each rural Maryland county that was available as of June 1, 2017.

For additional resources and promising practices visit the Maryland Rural Health Plan website www.MDRuralHealthPlan.org

APPENDIX IV
DISSEMINATION & FEEDBACK

DISSEMINATION AND FEEDBACK OF UPDATED MARYLAND RURAL HEALTH PLAN

It was very important to MRHA and all stakeholders that this assessment process would be collaborative and inclusive. In addition to the collective nature of the data gathering, there was an extensive process put in place to ensure that feedback on the draft was both widespread and diverse.

The draft Maryland Rural Health Plan was shared extensively by MRHA as well as its partners and collaborators. The draft was posted on the MRHA website and the link was distributed widely. Additionally, MRHA held a working session at the 2017 Maryland Rural Health Conference on Friday, October 6, 2017 to garner feedback from conference participants.

Below is a list of organizations that participated in this feedback process, listed alphabetically:

Access Carroll	Eastern Shore Land Conservancy	Maryland Hospital Association	Rural Maryland Council
Adfinitas Health	Eastern Shore Oral Health Task Force	Maryland State Office of Rural Health	Somerset County Health Department
Affiliated Sante Group Eastern Shore Crisis Response	Family Healthcare of Hagerstown	Mary's Center	St. Mary's County Health Department
AHEC West	Family Services, Inc.	MCC Medical Clinic	Talbot County Health Department
Allegany County Health Department	Frederick County Health Department	McCready Memorial Hospital	The Lower Shore Clinic
Atlantic General Hospital	Frederick Memorial Hospital	MedChi, The Maryland State Medical Society	The Youth Ranch
Baltimore Area Health Education Center	Frostburg State University	MedStar St. Mary's Hospital	Three Lower Counties Community Services
Baltimore County Health Department	Garrett County Health Department	Mental Health Association of Frederick	Tri-County Council for the Lower Eastern Shore
Behavioral Health Administration, MDH	Garrett Regional Medical Center	Meritus Medical Center	Tri-State Community Health Center
Behavioral Health System Baltimore	Greater Baden Medical Services, Inc.	Mid Shore Behavioral Health, Inc.	Union Hospital of Cecil County
Bon Secours Baltimore Health System	Harford County Health Department	Mid-Atlantic Association of Community Health Centers	University of Maryland Charles Regional Medical Center
Brain Injury Association of Maryland	Health Care Financing, MDH	MidShore Regional Council	University of Maryland Eastern Shore
Calvert County Health Department	Health Partners	Mobile Medical Care	University of Maryland Extension
Calvert Memorial Hospital	Heron Point	Montgomery County Health Department	University of Maryland Harford Memorial Hospital
CalvertHealth Medical Center	Kennedy Krieger Institute	Mosaic Community Services	University of Maryland Medical Center at Dorchester
Caroline County Health Department	Kent County Health Department	Mountain Laurel Medical Center	University of Maryland Medical Center, Baltimore
Carroll County Health Department	Lifespan Network	NORC Walsh Center for Rural Health Analysis	University of Maryland Psychiatry
Carroll Hospital Center	Maryland Academy of Family Physicians	Office of Communications, MDH	University of Maryland School of Public Health
Cecil County Health Department	Maryland Area Health Education Center	Office of Governmental Affairs, Policy & Regulation, MDH	University of Maryland Shore Regional Health
Charles County Health Department	Maryland Association of County Health Officers	Office of Population Health Improvement, MDH	University of Maryland Upper Chesapeake Health
Chesapeake Voyagers, Inc.	Maryland Citizens' Health Initiative Education Fund, Inc.	Office of Process Transformation, MDH	Walden Sierra, Inc.
Choptank Community Health System, Inc.	Maryland Community Health Resources Commission	Office of Public Health Services, MDH	Washington County Health Department
Co-Chairs of Rural Health Care Delivery Workgroup	Maryland Dental Action Coalition	Owensville Primary Care	Way Station, Inc.
Cornerstone Montgomery	Maryland Department of Agriculture	Pascal Youth and Family Services	West Cecil Health Center
Crisfield Clinic	Maryland Department of Health	Peninsula Regional Medical Center	Western Maryland Health System
Dorchester County Health Department	Maryland Department of Natural Resources	People Encouraging People	Wicomico County Health Department
Eastern Shore Area Health Education Center	Maryland Head Start Association	Potomac Healthcare Foundation	Worcester County Health Department
Eastern Shore Entrepreneurship Center	Maryland Health Care Commission	Pressley Ridge	Worchester County Health Department
Eastern Shore Hospital Center	Maryland Health Services Cost Review Commission	Queen Anne's County Health Department	

MDRuralHealth.org
MDRuralHealthPlan.org

14. Other Data

A. Methodology

This section of additional data was assembled to further inform our community health needs assessment process. The CHNA report will be used by Carroll Hospital for several important strategic planning purposes. The immediate intention is the creation of a Community Benefit Plan in fulfillment of the hospital's mission and in compliance with the requirements of our status as a not-for-profit organization. An understanding of many different determinants of health is required for a complete assessment of a community's health needs.

The scope of information available about the Carroll County community has been enriched for this CHNA by the data collection efforts by local agencies and national organizations.

Information is included from both the United Way's **ALICE Report** and the Maryland Community Action Partnership's **Self-Sufficiency Standard for Maryland.** According to the Center for Women's Welfare, both the Self-Sufficiency Standard and the ALICE project demonstrate that the official poverty measure may be too low as it undercounts the number of households struggling to make ends meet. These reports seek to shed light on issues related to the cost of living in different geographic areas, but they may not be appropriate for policy or programming decisions.

The **County Health Rankings** report, prepared annually by the prestigious Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, compares Carroll County data to data from other counties in Maryland and in the nation, and gives yet another perspective about our community's health strengths and weaknesses. In the County Health Rankings, counties in each of the 50 states are ranked according to summaries of a variety of health measures. Those having high ranks, e.g., 1 or 2, are considered to be the "healthiest." Counties are ranked relative to the health of other counties in the same state.

The County Health Rankings team draws upon the most reliable and valid measures available to compile the Rankings. The methodology is described in more detail in the attached County Health Rankings 2015 Report for Maryland.
The County Health Rankings team calculates eight summary composite scores:

1. Overall Health Outcomes
2. Health Outcomes – Length of life
3. Health Outcomes – Quality of life
4. Overall Health Factors
5. Health Factors – Health behaviors
6. Health Factors – Clinical care
7. Health Factors – Social and economic factors
8. Health Factors – Physical environment

Many of the measures used to calculate the Rankings are also tracked by The Partnership as part of our system for continuously monitoring community health data, *Healthy Carroll Vital Signs*.

More information about this report's methodology can be found in the report itself, and at http://www.countyhealthrankings.org/.

B. Results Summary

Data results in this section are supplemental to the primary data collected by the Community Health Needs Survey, Key Informant Survey, and Targeted Populations focus groups.

In 2017, the **County Health Rankings** placed Carroll County #3 out of 24 for overall Health Outcomes, and #1 out of 24 for Quality of Life. Every year since the Rankings were first published in 2010, Carroll County has consistently ranked near the top of all 24 Maryland jurisdictions in Health Factors as well as Health Outcomes.

The Maryland Community Action Partnership publishes the **Self-Sufficiency Standard for Maryland** which calculates how much income a family must earn to meet basic needs, with the amount varying by family composition and where they live. A summary is provided in Section C. The full report can be found at www.maryland-cap.org.

In Maryland, the amount needed to be economically self-sufficient varies considerably by geographic location. Carroll County falls within in the second highest cost group of all counties and Baltimore city, requiring wages between $52,775 and $58,669 per year to meet basic needs. Besides Carroll, this group includes St. Mary's, Harford, Baltimore, Frederick, Prince George's, Queen Anne's, Calvert, and Charles counties. By comparison, the most affordable counties in Maryland are located in western Maryland and the Eastern Shore region. The counties of Allegany, Garrett, Somerset, and Dorchester require between $34,040 and $36,756 annually for a family with one adult and one preschooler.

The **ALICE Study of Financial Hardship** is a United Way project. ALICE stands for Asset Limited, Income Constrained, Employed. Similar to the Self-Sufficiency Standard, this report measures households that are above the Federal Poverty Level, but do not earn enough for basic necessities. The ALICE report then calculates a bare-minimum Household Survival Budget that does not allow for any savings, leaving a household vulnerable to unexpected expenses. In Carroll, the report estimates that 28% of households are at or below both ALICE and poverty levels. A summary of the report is provided in Section C. The full report can be found at www.uwcm.org/main/alice

C. Attachments

- 2017 County Health Rankings and Roadmap for Maryland
  Robert Wood Johnson Foundation and
  University of Wisconsin Population Health Institute

- Summary of The Self-Sufficiency Standard for Maryland 2016

- Summary of ALICE Study of Financial Hardship
  Maryland State Association of United Way

County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program

2017 *County Health Rankings*

Maryland

A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

University of Wisconsin Population Health Institute
SCHOOL OF MEDICINE AND PUBLIC HEALTH

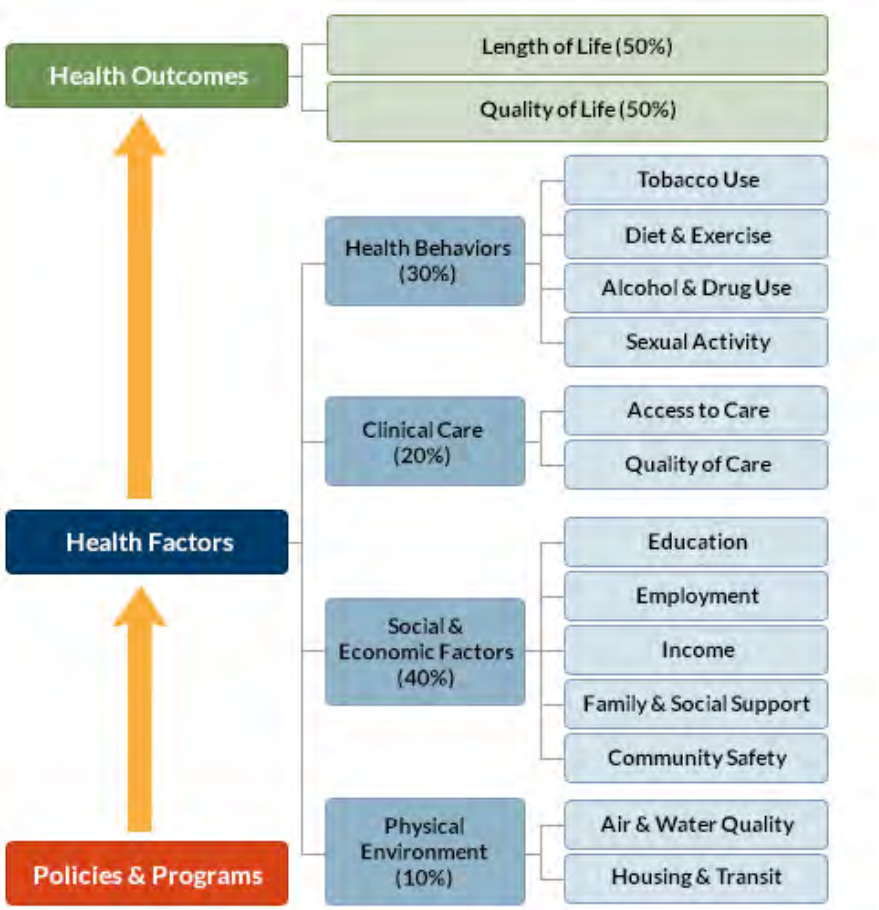
Support provided by
Robert Wood Johnson Foundation

INTRODUCTION

The *County Health Rankings & Roadmaps* program brings actionable data and strategies to communities to make it easier for people to be healthy in their homes, schools, workplaces, and neighborhoods. Ranking the health of nearly every county in the nation, the *County Health Rankings* illustrate what we know when it comes to what is making people sick or healthy. The *Roadmaps* show what we can do to create healthier places to live, learn, work, and play. The Robert Wood Johnson Foundation (RWJF) collaborates with the University of Wisconsin Population Health Institute (UWPHI) to bring this program to cities, counties, and states across the nation.

WHAT ARE THE *COUNTY HEALTH RANKINGS*?

Published online at **countyhealthrankings.org**, the *Rankings* help counties understand what influences how healthy residents are and how long they will live. The *Rankings* are unique in their ability to measure the current overall health of nearly every county in all 50 states. They also look at a variety of measures that affect the future health of communities, such as high school graduation rates, access to healthy foods, rates of smoking, obesity, and teen births. Communities use the *Rankings* to help identify issues and opportunities for local health improvement, as well as to garner support for initiatives among government agencies, healthcare providers, community organizations, business leaders, policy makers, and the public.



DIGGING DEEPER INTO HEALTH DATA

Although we know that a range of factors are important for good health, every state has communities that lack both opportunities to shape good health and strong policies to promote health for everyone. Some counties lag far behind others in how well and how long people live – which we refer to as a "health gap." Find out what's driving health differences across your state and what can be done to close those gaps. Visit countyhealthrankings.org/reports.

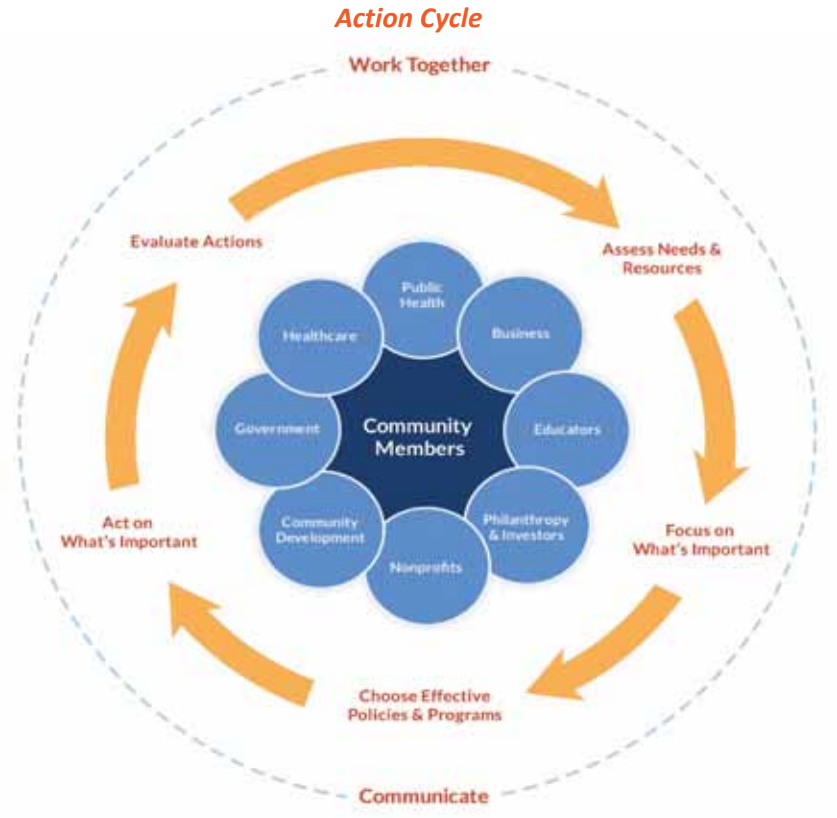
To further explore health gaps and other data sources in your community, check out the feature to find more data for your state and dig deeper on differences in health factors by geography or by population sub-groups. Visit countyhealthrankings.org/using-the-rankings-data.

MOVING FROM DATA TO ACTION

Roadmaps to Health help communities bring people together to look at the many factors that influence health and opportunities to reduce health gaps, select strategies that can improve health for all, and make changes that will have a lasting impact. The *Roadmaps* focus on helping communities move from *awareness* about their county's ranking to *actions* designed to improve everyone's health. The *Roadmaps to Health* Action Center is a one-stop shop of information to help any community member or leader who wants to improve their community's health by addressing factors that we know influence health, such as education, income, and community safety.

Within the Action Center you will find:

- Online step-by-step guidance and tools to move through the Action Cycle
- *What Works for Health* – a searchable database of evidence-informed policies and programs that can improve health
- Webinars featuring local community members who share their tips on how to build a healthier community
- Community coaches, located across the nation, who provide customized consultation to local leaders who request guidance in how to accelerate their efforts to improve health. You can contact a coach by activating the Get Help button at countyhealthrankings.org



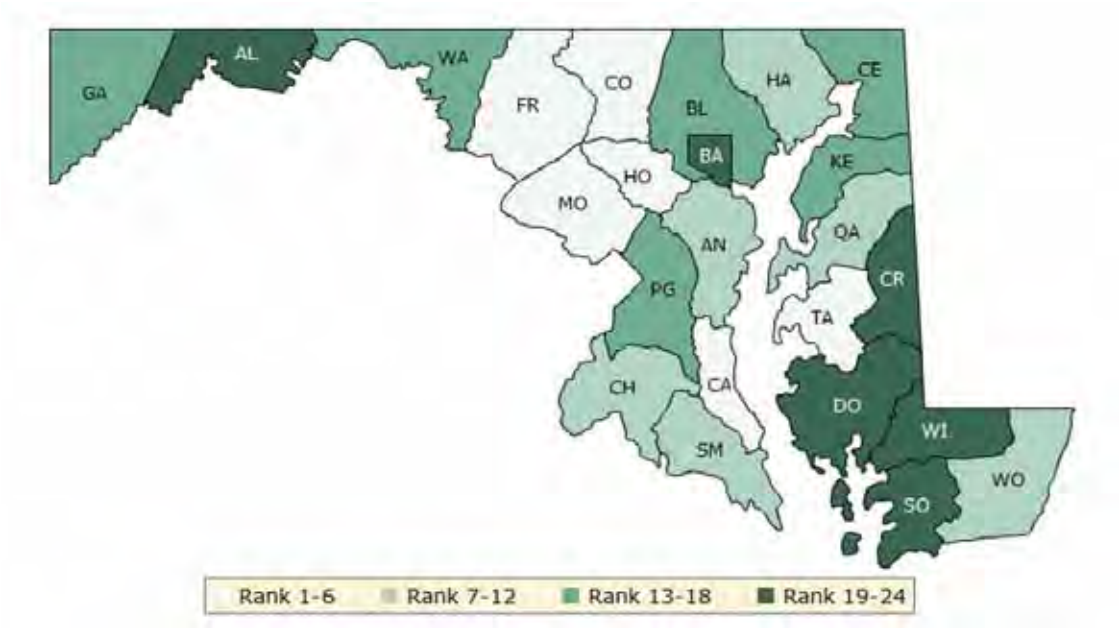
HOW CAN YOU GET INVOLVED?

You might want to contact your local affiliate of United Way Worldwide, the National Association of Counties, Local Initiatives Support Corporation (LISC), or Neighborworks– their national parent organizations have partnered with us to raise awareness and stimulate action to improve health in their local members' communities. By connecting with other leaders interested in improving health, you can make a difference in your community. In communities large and small, people from all walks of life are taking ownership and action to improve health. Visit countyhealthrankings.org to get ideas and guidance on how you can take action in your community. Working with others, you can improve the health of your community.

HOW DO COUNTIES RANK FOR HEALTH OUTCOMES?

The green map below shows the distribution of Maryland's **health outcomes**, based on an equal weighting of length and quality of life.

Lighter shades indicate better performance in the respective summary rankings. Detailed information on the underlying measures is available at **countyhealthrankings.org**.

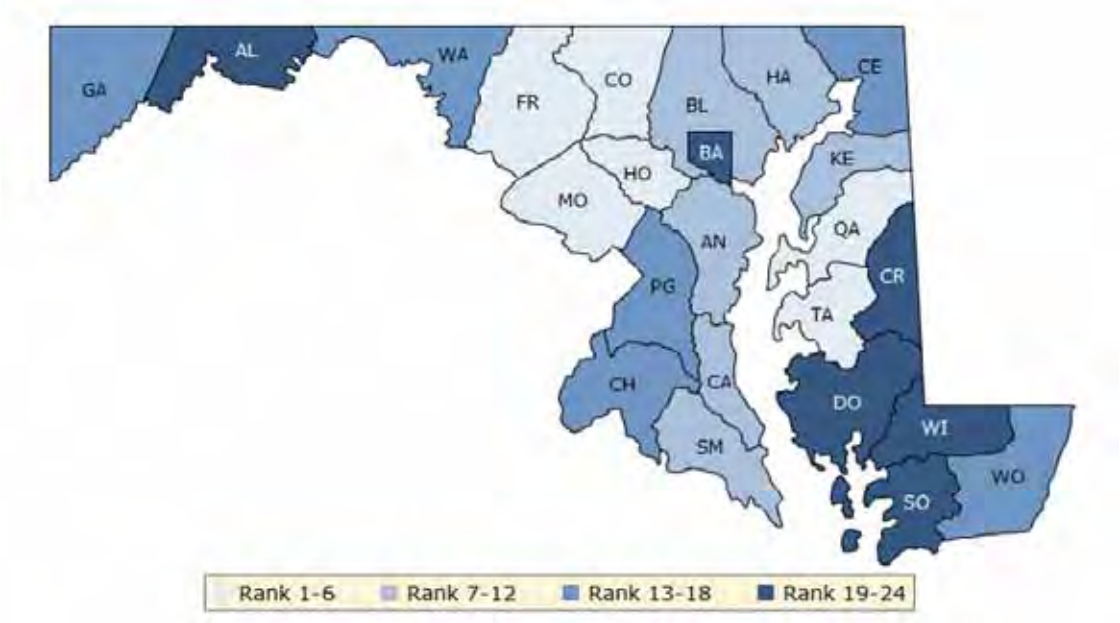


County	Rank	County	Rank	County	Rank	County	Rank
Allegany	19	Carroll	3	Harford	9	Somerset	22
Anne Arundel	11	Cecil	15	Howard	2	St. Mary's	8
Baltimore	13	Charles	12	Kent	18	Talbot	5
Baltimore City	24	Dorchester	23	Montgomery	1	Washington	17
Calvert	6	Frederick	4	Prince George's	14	Wicomico	20
Caroline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

HOW DO COUNTIES RANK FOR HEALTH FACTORS?

The blue map displays Maryland's summary ranks for **health factors**, based on weighted scores for health behaviors, clinical care, social and economic factors, and the physical environment.

Lighter shades indicate better performance in the respective summary rankings. Detailed information on the underlying measures is available at **countyhealthrankings.org**



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

2017 *COUNTY HEALTH RANKINGS*: MEASURES AND NATIONAL/STATE RESULTS

Measure	Description	US Median	State Overall	State Minimum	State Maximum
HEALTH OUTCOMES					
Premature death	Years of potential life lost before age 75 per 100,000 population	7,700	6,400	3,500	12,300
Poor or fair health	% of adults reporting fair or poor health	16%	13%	10%	20%
Poor physical health days	Average # of physically unhealthy days reported in past 30 days	3.8	3.5	2.4	4.5
Poor mental health days	Average # of mentally unhealthy days reported in past 30 days	3.8	3.4	2.8	4.2
Low birthweight	% of live births with low birthweight (< 2500 grams)	8%	9%	7%	12%
HEALTH FACTORS					
HEALTH BEHAVIORS					
Adult smoking	% of adults who are current smokers	17%	15%	9%	24%
Adult obesity	% of adults that report a BMI ≥ 30	31%	29%	20%	42%
Food environment index	Index of factors that contribute to a healthy food environment, (0-10)	7.3	8.2	5.6	9.4
Physical inactivity	% of adults aged 20 and over reporting no leisure-time physical activity	26%	22%	16%	31%
Access to exercise opportunities	% of population with adequate access to locations for physical activity	62%	93%	13%	100%
Excessive drinking	% of adults reporting binge or heavy drinking	17%	16%	14%	19%
Alcohol-impaired driving deaths	% of driving deaths with alcohol involvement	30%	33%	20%	56%
Sexually transmitted infections	# of newly diagnosed chlamydia cases per 100,000 population	294.8	462.6	165.3	1,180.7
Teen births	# of births per 1,000 female population ages 15-19	38	25	10	53
CLINICAL CARE					
Uninsured	% of population under age 65 without health insurance	14%	9%	5%	14%
Primary care physicians	Ratio of population to primary care physicians	2,030:1	1,130:1	3,230:1	510:1
Dentists	Ratio of population to dentists	2,570:1	1,350:1	2,830:1	740:1
Mental health providers	Ratio of population to mental health providers	1,105:1	490:1	2,330:1	270:1
Preventable hospital stays	# of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	56	46	31	75
Diabetes monitoring	% of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring	86%	85%	81%	90%
Mammography screening	% of female Medicare enrollees ages 67-69 that receive mammography screening	61%	64%	59%	75%
SOCIAL AND ECONOMIC FACTORS					
High school graduation	% of ninth-grade cohort that graduates in four years	88%	87%	70%	96%
Some college	% of adults ages 25-44 with some post-secondary education	57%	69%	38%	85%
Unemployment	% of population aged 16 and older unemployed but seeking work	5.3%	5.2%	3.9%	10.6%
Children in poverty	% of children under age 18 in poverty	22%	14%	7%	36%
Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile	4.4	4.5	3.6	6.3
Children in single-parent households	% of children that live in a household headed by a single parent	32%	34%	20%	65%
Social associations	# of membership associations per 10,000 population	12.6	8.9	6.2	18.4
Violent crime	# of reported violent crime offenses per 100,000 population	198	465	130	1,389
Injury deaths	# of deaths due to injury per 100,000 population	77	58	32	110
PHYSICAL ENVIRONMENT					
Air pollution – particulate matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	9.2	9.5	8.3	11.1
Drinking water violations	Indicator of the presence of health-related drinking water violations. Yes - indicates the presence of a violation, No - indicates no violation.	NA	NA	No	Yes
Severe housing problems	% of households with overcrowding, high housing costs, or lack of kitchen or plumbing facilities	14%	17%	13%	24%
Driving alone to work	% of workforce that drives alone to work	81%	74%	60%	85%
Long commute – driving alone	Among workers who commute in their car alone, % commuting > 30 minutes	30%	48%	19%	64%

2017 COUNTY HEALTH RANKINGS: DATA SOURCES AND YEARS OF DATA

	Measure	Data Source	Years of Data
HEALTH OUTCOMES			
Length of Life	Premature death	National Center for Health Statistics – Mortality files	2012-2014
Quality of Life	Poor or fair health	Behavioral Risk Factor Surveillance System	2015
	Poor physical health days	Behavioral Risk Factor Surveillance System	2015
	Poor mental health days	Behavioral Risk Factor Surveillance System	2015
	Low birthweight	National Center for Health Statistics – Natality files	2008-2014
HEALTH FACTORS			
HEALTH BEHAVIORS			
Tobacco Use	Adult smoking	Behavioral Risk Factor Surveillance System	2015
Diet and Exercise	Adult obesity	CDC Diabetes Interactive Atlas	2013
	Food environment index	USDA Food Environment Atlas, Map the Meal Gap	2010 & 2014
	Physical inactivity	CDC Diabetes Interactive Atlas	2013
	Access to exercise opportunities	Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files	2010 & 2014
Alcohol and Drug Use	Excessive drinking	Behavioral Risk Factor Surveillance System	2015
	Alcohol-impaired driving deaths	Fatality Analysis Reporting System	2011-2015
Sexual Activity	Sexually transmitted infections	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2014
	Teen births	National Center for Health Statistics - Natality files	2008-2014
CLINICAL CARE			
Access to Care	Uninsured	Small Area Health Insurance Estimates	2014
	Primary care physicians	Area Health Resource File/American Medical Association	2014
	Dentists	Area Health Resource File/National Provider Identification file	2015
	Mental health providers	CMS, National Provider Identification file	2016
Quality of Care	Preventable hospital stays	Dartmouth Atlas of Health Care	2014
	Diabetes monitoring	Dartmouth Atlas of Health Care	2014
	Mammography screening	Dartmouth Atlas of Health Care	2014
SOCIAL AND ECONOMIC FACTORS			
Education	High school graduation	EDFacts[1]	2014-2015
	Some college	American Community Survey	2011-2015
Employment	Unemployment	Bureau of Labor Statistics	2015
Income	Children in poverty	Small Area Income and Poverty Estimates	2015
	Income inequality	American Community Survey	2011-2015
Family and Social Support	Children in single-parent households	American Community Survey	2011-2015
	Social associations	County Business Patterns	2014
Community Safety	Violent crime	Uniform Crime Reporting – FBI	2012-2014
	Injury deaths	CDC WONDER mortality data	2011-2015
PHYSICAL ENVIRONMENT			
Air and Water Quality	Air pollution - particulate matter [2]	CDC National Environmental Public Health Tracking Network	2012
	Drinking water violations	Safe Drinking Water Information System	FY2013-14
Housing and Transit	Severe housing problems	Comprehensive Housing Affordability Strategy (CHAS) data	2009-2013
	Driving alone to work	American Community Survey	2011-2015
	Long commute – driving alone	American Community Survey	2011-2015

[1] State sources used for California and Texas.
[2] Not available for AK and HI.

CREDITS

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County Health Rankings & Roadmaps
Building a Culture of Health, County by County

countyhealthrankings.org

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County Health
Rankings & Roadmaps
Building a Culture of Health, County by County

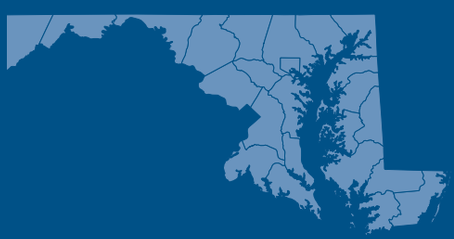
Carroll (CO)

	Carroll County	Error Margin	Top U.S. Performers^	Maryland	Rank (of 24) ^
Health Outcomes					3
Length of Life					6
Premature death	6,000	5,600-6,500	5,200	6,400	
Quality of Life					1
Poor or fair health **	10%	10-10%	12%	13%	
Poor physical health days **	2.7	2.5-2.8	3.0	3.5	
Poor mental health days **	3.2	3.1-3.4	3.0	3.4	
Low birthweight	7%	6-7%	6%	9%	
Health Factors					4
Health Behaviors					5
Adult smoking **	13%	12-14%	14%	15%	
Adult obesity	28%	25-31%	26%	29%	
Food environment index	9.2		8.4	8.2	
Physical inactivity	21%	18-24%	19%	22%	
Access to exercise opportunities	90%		91%	93%	
Excessive drinking **	18%	17-19%	12%	16%	
Alcohol-impaired driving deaths	34%	28-39%	13%	33%	
Sexually transmitted infections	165.3		145.5	462.6	
Teen births	14	13-15	17	25	
Clinical Care					5
Uninsured	5%	5-6%	8%	9%	
Primary care physicians	1,950:1		1,040:1	1,130:1	
Dentists	1,690:1		1,320:1	1,350:1	
Mental health providers	600:1		360:1	490:1	
Preventable hospital stays	45	43-48	36	46	
Diabetes monitoring	88%	85-92%	91%	85%	
Mammography screening	64%	60-67%	71%	64%	
Social & Economic Factors					2
High school graduation	96%		95%	87%	
Some college	71%	68-74%	72%	69%	
Unemployment	4.3%		3.3%	5.2%	
Children in poverty	7%	5-9%	12%	14%	
Income inequality	3.9	3.7-4.2	3.7	4.5	
Children in single-parent households	23%	20-26%	21%	34%	
Social associations	9.5		22.1	8.9	
Violent crime	202		62	465	
Injury deaths	67	62-73	53	58	
Physical Environment					24
Air pollution - particulate matter	11.1		6.7	9.5	
Drinking water violations	Yes				
Severe housing problems	13%	12-14%	9%	17%	
Driving alone to work	85%	84-86%	72%	74%	
Long commute - driving alone	58%	56-60%	15%	48%	

Areas to Explore Areas of Strength

^ 10th/90th percentile, i.e., only 10% are better.
Note: Blank values reflect unreliable or missing data
** Data should not be compared with prior years

2017



THE SELF-SUFFICIENCY STANDARD FOR MARYLAND 2016

Prepared for **Maryland Community Action Partnership**

UNIVERSITY OF WASHINGTON · 1861 · LVX · SIT

MARYLAND COMMUNITY ACTION PARTNERSHIP

Maryland Community Action Partnership (MCAP) is a nonprofit, multi-regional association. MCAP advocates on behalf of Community Action Agencies (CAAs) and partnering organizations that serve individuals and families with low-income who reside in Maryland, Delaware, and the District of Columbia to ensure their voices are heard at the local, state, and national levels. MCAP supports the mission and activities of its member agencies throughout the three regions. With an anti-poverty focus, agencies provide direct human and social services in all cities and counties in the three service areas as they work to lead families to self- sufficiency and independence of public programs.

MISSION. MCAP strengthens members' capacity to provide quality services and opportunities that empower individuals and families to achieve economic stability.

VISION. All individuals and families are stable, economically secure, and live in safe and thriving communities.

HISTORY. Community Action Agencies are nonprofit organizations and governmental agencies created by President Lyndon B. Johnson's signing of the Economic Opportunity Act of 1964. This Act embodies the philosophy that low–income individuals can best identify the problems their community face and also develop solutions that will resolve the issues. Currently, 1,100 community action agencies in the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands and the Trust Territories provide direct human services to 95 percent of the nation's counties.

SERVICES. In Maryland, Community Action Agencies and partnering organizations perform 40+ essential and basic services and programs, with services designed to meet local needs, including: Head Start/ early childhood programs, weatherization and energy assistance, food and shelter services, job training and placement, services for seniors and the disabled, free tax help and financial education, and transportation assistance. MCAP supports the combined network by providing services such as:

- Advocacy (state/regional/federal)
- Full-scale state lobbying and legislative representation services
- Legislation tracking (state and federal)
- Legislative Breakfast
- Information dissemination and sharing
- Annual Human Services Conference
- Customized training and technical assistance services
- Strength-based Family Worker Certification Program
- Training Scholarships
- College Internship Program
- Legal Services via CAPLAW
- Regional events and information
- Networking
- Strategic planning

For more information on the Maryland Community Action Partnership please visit www.maryland-cap.org.

THE SELF-SUFFICIENCY STANDARD FOR MARYLAND 2016

By Diana M. Pearce, PhD • December 2016

DIRECTOR, CENTER FOR WOMEN'S WELFARE
UNIVERSITY OF WASHINGTON SCHOOL OF SOCIAL WORK

PREPARED FOR

The Maryland Community Action Partnership

THE SELF-SUFFICIENCY STANDARD FOR MARYLAND 2016

ACKNOWLEDGMENTS

The Self-Sufficiency Standard for Maryland 2016 has been prepared through the cooperative efforts of Lisa Manzer, Lisa Mikesell, and Karen Segar at the University of Washington, Center for Women's Welfare, and Antonio Coffield, Sr., Angela Martin, and Michael E. Young of the Maryland Community Action Partnership, Inc. (MCAP).

A number of other people have also contributed to the development of the Standard, its calculation, and the writing of state reports over the past 20 years. Jennifer Brooks, Maureen Golga, and Kate Farrar, former Directors of Self-Sufficiency Programs and Policies at Wider Opportunities for Women, were key to the early development of initiatives that promoted the concept of self-sufficiency and the use of the Standard, and were instrumental in facilitating and nurturing state coalitions. Additional past contributors to the Standard have included Laura Henze Russell, Janice Hamilton Outtz, Roberta Spalter-Roth, Antonia Juhasz, Alice Gates, Alesha Durfee, Melanie Lavelle, Nina Dunning, Maureen Newby, and Seook Jeong.

This project was made possible with generous support from the Maryland Community Action Partnership. MCAP strengthens members' capacity to provide quality services and opportunities that empower individuals and families to achieve economic stability. (Learn more from the inside cover and at www.maryland-cap.org.) The following agencies also supported the development of this report:

- Anne Arundel Community Action Agency, Inc.
- Baltimore City Community Action Partnership
- Community Assistance Network, Inc. (CAN)
- Delmarva Community Services, Inc.
- Harford County Community Action Agency, Inc.
- Human Services Programs of Carroll County, Inc.
- Maryland Rural Development Corporation
- Montgomery County Community Action Agency (Department of Health & Human Services)
- Neighborhood Services Center, Inc.
- SHORE UP! Inc.
- Southern Maryland Tri-County Community Action Committee, Inc. (SMTCCAC)
- United Communities Against Poverty, Inc. (UCAP)

Additional support for this report provided by:

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And, the Maryland Department of Housing and Community Development (DHCD). DHCD is committed to promoting and preserving homeownership and affordable rental housing and improving Maryland's communities. Learn more at http://dhcd.maryland.gov.

The conclusions and opinions contained within this document do not necessarily reflect the opinions of those listed above. Any mistakes are the author's responsibility.

PREFACE

Maryland Community Action Partnership is publishing *The Self-Sufficiency Standard for Maryland 2016* in an effort to ensure the best data and analyses are available to enable Maryland's families and individuals to make progress toward real economic security. The result is a comprehensive, credible, and user-friendly tool. This report presents and analyzes *The Self-Sufficiency Standard for Maryland 2016*. This measure calculates how much income a family must earn to meet basic needs, with the amount varying by family composition and where they live. The Standard presented here is a tool that can be used in a variety of ways—by clients of workforce and training programs seeking paths to self-sufficiency, by program managers to evaluate program effectiveness, and by policymakers and legislators seeking to create programs and pathways that lead to self-sufficiency for working families.

As with all Self-Sufficiency Standard reports, *The Self-Sufficiency Standard for Maryland 2016* was authored by Dr. Diana M. Pearce and produced by the Center for Women's Welfare at the University of Washington. This report, plus tables providing county-specific information for 472 family types, is available online at www.selfsufficiencystandard.org/Maryland and www.maryland-cap.org.

Dr. Diana Pearce developed the Self-Sufficiency Standard while she was the Director of the Women and Poverty Project at Wider Opportunities for Women (WOW). The Ford Foundation provided funding for the Standard's original development.

Over the past 20 years the Standard has been calculated for 38 states as well as the District of Columbia and New York City. Its use has transformed the way policies and programs for low-income workers are structured and has contributed to a greater understanding of what it takes to have adequate income to meet one's basic needs in the United States.

For further information about any of the other states with the Standard, including the latest reports, the Standard data itself, and related publications such as demographic reports (which analyze how many and which households are above and below the Standard), please see www.selfsufficiencystandard.org. A list of Self-Sufficiency Standard state partners is also available on this website.

For further information, contact Lisa Manzer with the Center at (206) 685-5264/lmanzer@uw.edu, or the report author and Center Director, Dr. Diana Pearce, at (206) 616-2850/pearce@uw.edu.

KEY FINDINGS

At the heart of this report is the Self-Sufficiency Standard itself. This measure describes how much income families of various sizes and compositions need to make ends meet without public or private assistance in each county in Maryland, at a minimally adequate level.

Note that these budgets are "bare bones," with just enough allotted to meet basic needs, but no extras. Thus the food budget is only for groceries, with no takeout or restaurant food, not even a pizza or a latte. Nevertheless, throughout Maryland the Self-Sufficiency Standard shows that incomes well above the official federal poverty guidelines are far below what is needed to meet families' basic needs.

SELECTED FINDINGS FROM THE SELF-SUFFICIENCY STANDARD FOR MARYLAND 2016

- **The Standard varies by family type; that is, by how many adults and children are in a family and the age of each child.** One adult living in Baltimore County needs an hourly wage of $13.56 ($28,633 annually) to meet basic needs. For families with children, the amount needed to cover basic needs increases considerably. If the adult has a preschooler and a school-age child, the amount necessary to be economically secure more than doubles, increasing to $30.57 per hour ($64,558 annually) in order to cover the cost of child care, a larger housing unit, and increased food and health care costs. See *Table 1 on page 6.*

- **In Maryland, the amount needed to be economically self-sufficient also varies considerably by geographic location.** For instance, the amount needed to make ends meet for one adult and one preschooler child varies from $16.12 per hour ($34,040 annually) in Somerset County on the Eastern Shore, to $33.98 per hour ($71,755 annually) in Montgomery County neighboring Washington, D.C., or from 212% of the federal poverty guidelines to 448% of the federal poverty guidelines for a family of two. See *Figure A on page 7.*

- **For families with young children, the cost of housing and child care combined typically make up nearly 50% of the family's budget.** For example, for a family with two adults, one infant, and one preschooler in Charles County, child care is 25% of the family's budget while housing is 22%. See *Figure B on page 8.*

- **The 2016 Self-Sufficiency Standard for Baltimore City is comparable to Rust Belt and smaller East Coast cities.** The Self-Sufficiency Standard for one adult, one preschooler, and one school-age child in Baltimore City ($25.22 per hour) is most comparable to Milwaukee, WI ($26.99 per hour). Montgomery County is most similar in cost to other suburbs of major metropolitan areas such as Fairfax County, VA and Stamford, CT. See *Figure C on page 10 and Figure D on page 11.*

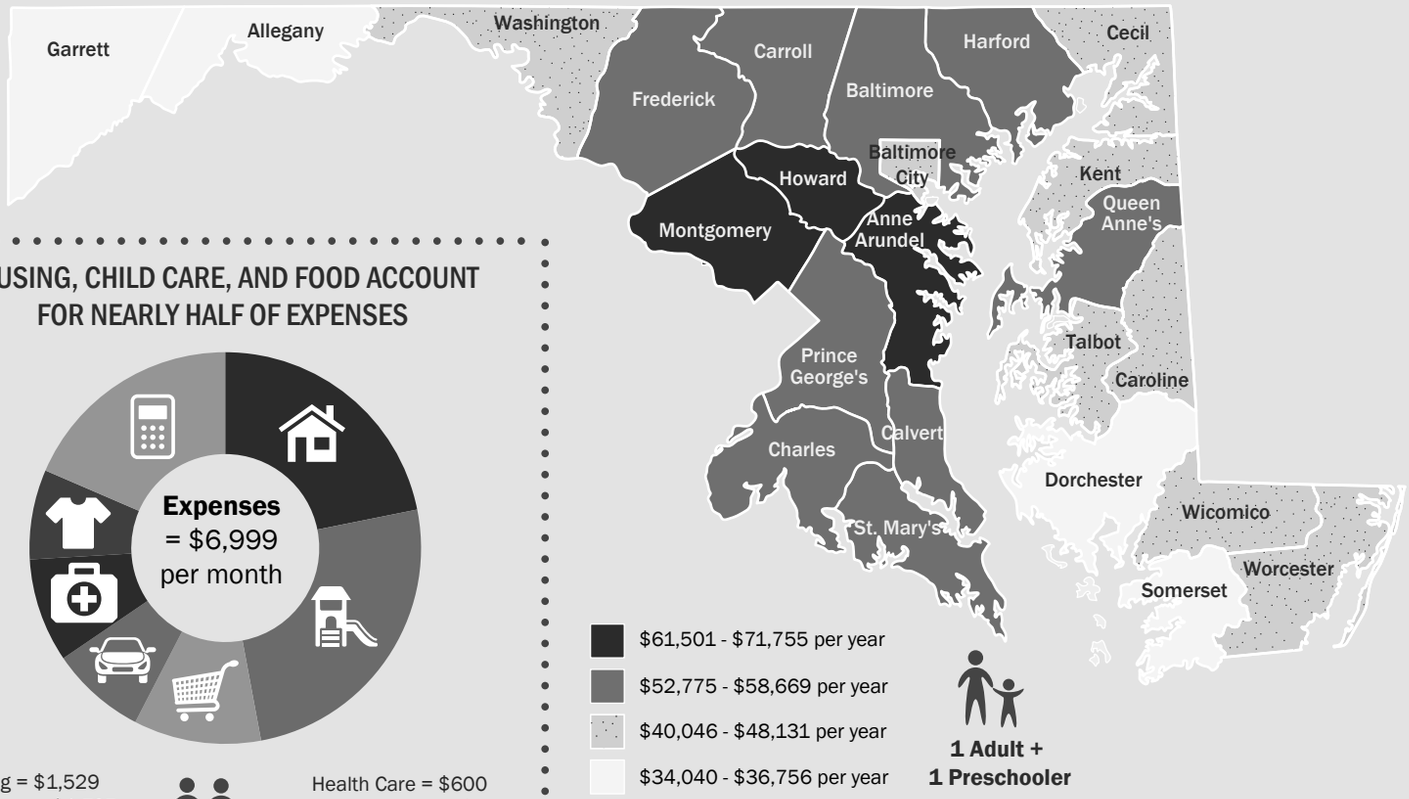
THE SELF-SUFFICIENCY STANDARD AT A GLANCE

HOW MUCH IS ENOUGH IN MARYLAND?

THE SELF-SUFFICIENCY STANDARD DEFINED

The Self-Sufficiency Standard calculates how much income families of various sizes and compositions need to make ends meet at a minimally adequate level without *public or private assistance*.

ANNUAL INCOME TO BE SELF-SUFFICIENT VARIES BY COUNTY



HOUSING, CHILD CARE, AND FOOD ACCOUNT FOR NEARLY HALF OF EXPENSES

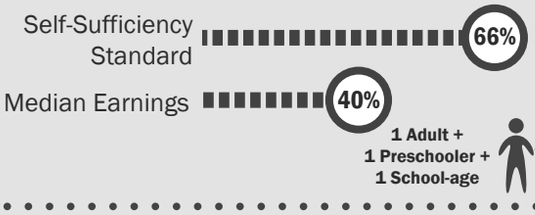
Housing = $1,529
Child Care = $1,765
Food = $737
Transportation = $553

Health Care = $600
Miscellaneous = $518
Taxes (Net) = $1,296

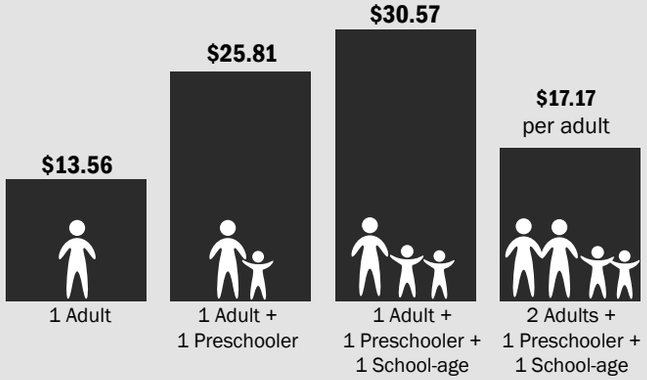
Charles County
Two Adults + One Infant + One Preschooler

THE MEDIAN WAGE HAS NOT KEPT UP WITH INCREASES IN THE COST OF LIVING

Statewide Percentage Change (2001-2016)



HOURLY WAGE TO BE SELF-SUFFICIENT VARIES BY FAMILY TYPE



Baltimore County

To download the full report and data for all 472 family types visit www.selfsuficiencystandard.org/Maryland

- **The amount needed to meet the costs of basic needs increased between 2001 and 2016 in all Maryland counties, despite the financial crisis.** For a family with one adult, one preschooler, and one school-age child, the Standard increased between 42% and 90%, on average by 66%, across the state. This contrasts with the median wage, which only increased 40% over this time period. See *Figure E on page 12* and *Table 2 on page 14.*

- **The federal poverty guidelines for three-person families ($20,160 annually) is set at a level well below what is minimally needed to meet a family's basic needs.** For example, the federal poverty measure is 40% of the Standard for one adult, one preschooler, and one school-age child in Kent County ($24.02 per hour and $50,733 annually). See *Figure H on page 16.*

- **Even working full time, a parent earning the 2016 Maryland minimum wage ($8.75 per hour) will fall short of meeting the Standard for a family with two young children.** If she has one preschooler and one school-age child, and lives in Kent County, she would be able to cover only 34% of her family's basic needs (with her take-home pay after accounting for taxes). See *Figure H on page 16.*

- **Although a fifth of Maryland workers hold one of the top ten most common occupations in Maryland (measured by the number of workers), only two of these occupations have median wages above the Standard for a family of three in St. Mary's County.** General and operations managers and registered nurses have median wages above the Self-Sufficiency Standard for one adult, one preschooler, and one school-age child in St. Mary's County, which is $29.62 per hour ($62,564 annually), while the median wages for the other eight most common occupations are below this family type's Standard in St. Mary's County. See *Figure I on page 20.*

- **Maintaining an emergency savings fund is a crucial step towards economic security.** A single parent with a preschool-aged child living in Allegany County needs to earn $2,899 per month to meet her basic needs. She needs to earn an additional $165 per month to have an emergency savings fund. If she lives in Prince George's County she needs $4,652 per month to be self-sufficient and an additional $171 per month to save for emergencies. See *Table 6 on page 33.*

The Self-Sufficiency Standard for Select Maryland Places and Family Types, 2016

County	One Adult	One Adult One Preschooler	One Adult One Preschooler One School-age	Two Adults One Preschooler One School-age
Allegany	$20,990	$34,788	$39,550	$47,742
Anne Arundel	$34,177	$61,501	$74,801	$81,935
Baltimore City	$22,905	$44,132	$53,258	$57,678
Baltimore County	$28,633	$54,506	$64,558	$72,521
Charles	$35,460	$58,669	$68,160	$75,962
Kent	$22,847	$42,143	$50,733	$58,765
Montgomery	$37,807	$71,755	$86,580	$91,252
Prince George's	$32,550	$55,822	$65,791	$71,851
Somerset	$21,479	$34,040	$41,194	$48,601

An Excel file of all 472 family types for each county can be downloaded at: www.selfsufficienstandard.org/Maryland

GETTING TO SELF-SUFFICIENCY

Closing the wage gap between current wages and the Self-Sufficiency Standard requires both *reducing* costs and *raising* incomes.

HOW DOES THE STANDARD COMPARE?

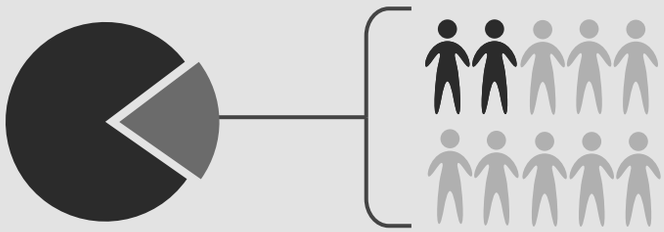
Kent County
1 adult + 1 preschooler + 1 school-age

40% The amount of basic needs covered by the federal poverty level

Number of hours a minimum wage worker must work per week to meet basic needs — **110**

HOW DO MARYLAND'S JOBS STACK UP?

St. Mary's County
1 adult + 1 preschooler + 1 school-age



The ten most common occupations cover a fifth of Maryland's workforce

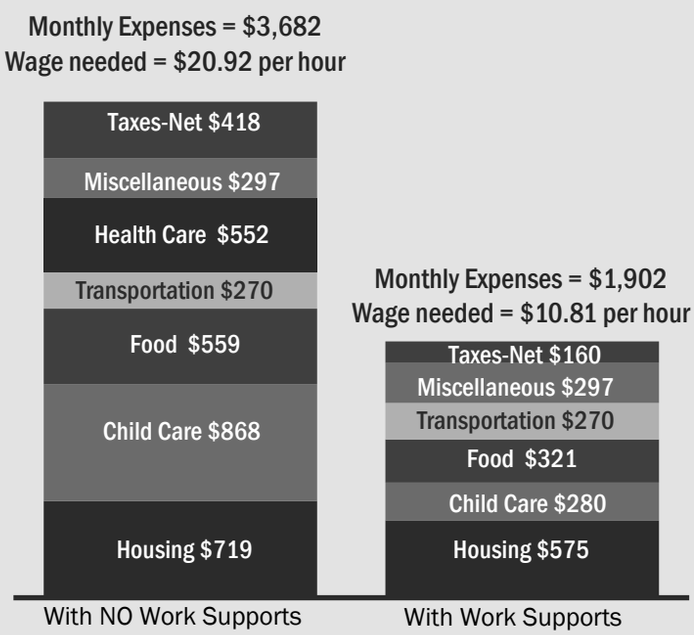
Only **TWO** of these occupations have median wages above the Standard for this family type in St. Mary's County

HOW DO WORK SUPPORTS HELP FAMILIES MEET BASIC NEEDS?

Somerset County
1 adult + 1 preschooler + 1 school-age

This figure shows how work supports can reduce a family's expenses, so they can get by on a lower wage until the adult is able to earn a Self-Sufficiency level wage.

- A housing voucher reduces costs from $719 to $575 per month (30% of income).
- Child care assistance reduces child care costs from $868 to $280 per month.
- Food assistance reduces groceries from $559 to $321 per month.
- Medicaid reduces health care costs from $552 to $0 per month.



To download the full report and data for all 472 family types visit www.selfsuficiencystandard.org/Maryland

A PARENT WORKING FULL TIME AND EARNING THE 2016 MARYLAND MINIMUM WAGE ($8.75 PER HOUR) WILL FALL SHORT OF MEETING THE STANDARD FOR A FAMILY WITH TWO YOUNG CHILDREN.

Clearly, meeting basic needs is difficult for many Maryland families, and has only been made worse due to stagnating wages and difficult economic times. Further, what it takes to become self-sufficient in Maryland depends on where a family lives, how many people are in the family, and the number and ages of children.

WHAT THE SELF-SUFFICIENCY STANDARD MEANS FOR MARYLAND

Closing the gap between current wages and the Self-Sufficiency Standard requires both reducing costs and raising incomes.

REDUCING COSTS *means ensuring families who are struggling to cover basic costs have access to work supports—such as child care assistance, food benefits, and the Earned Income Tax Credit—that offer stability and resources while they become self-sufficient*. Most individuals cannot achieve self-sufficiency through stopgap measures or in a single step, but require support through transitional work supports and programs, as well as the removal of barriers to help families work towards self-sufficiency over time. The report finds that:

- **Work supports are crucial for helping families meet their basic needs.** A single parent in Somerset County with one preschooler and one school-age child transitioning from welfare to work with the help of child care assistance, food assistance (SNAP/WIC), and transitional Medicaid would be able to meet her family's needs on a wage of $11.97 per hour. This is significantly less than the full wage needed of $20.92 per hour without work supports, though it is well above the minimum wage. See *Table 5 on page 25.*

- **Even at the minimum wage, work supports can help families meet their needs while working towards self-sufficiency.** A single parent with one preschooler and one school-age child living in Harford County and working a full-time minimum wage job, which is currently $8.75 in Maryland, earns only 34% of the income needed to meet her family's basic needs if she is not receiving any work supports. However, with the help of housing, child care, food, and health care work supports, this parent could meet 90% of her family's needs. See *Figure K on page 26.*

RAISING INCOMES *means enhancing skills as well as improving access to jobs that pay self-sufficient wages and have career potential.* A strong economy will mean good jobs that pay self-sufficient wages, a workforce with the skills necessary to fill those jobs, and enhancing links and removing barriers between those jobs and the workers that need them. Key to raising incomes are public policies such as living/minimum wage policies and paid sick and family/medical leave, that increase wages directly. Likewise,

access to education, training, and jobs that provide real potential for skill and career advancement over the long term is also important.

The Self-Sufficiency Standard can be used as a tool to:

- Evaluate proposed policy changes
- Target resources toward job training for fields that pay self-sufficiency wage
- Evaluate outcomes for clients in employment programs
- Assist grant-makers with needs analyses of their communities to assess the impacts of their grants
- Serve as a counseling tool in work training programs

The Self-Sufficiency Standard is currently used to better understand issues of income adequacy, analyze policy, and help individuals striving to be self-sufficient. Community organizations, academic researchers, foundations, policy institutes, legal advocates, training providers, community action agencies, and state and local officials, among others, are using the Self-Sufficiency Standard.

THE REPORT IN A NUTSHELL

The report begins with putting the Self-Sufficiency Standard in context, describing how it is a unique and important measure of income adequacy, comparing and contrasting it with federal poverty measures. The report then leads readers through a description of what a self-sufficient wage is for Maryland families, how it differs depending on family type and geographic area, and how it has changed over the past 15 years. The report compares Maryland to other places in the United States and contrasts the Maryland Standard to other commonly used benchmarks of income. For families without adequate income, the report models how public supports, such as child care assistance, can be a valuable resource to help families cover their basic needs as they move toward self-sufficiency. It concludes with a brief discussion of the various pathways to economic self-sufficiency.

The appendices provide a more detailed explanation of the methodology and data sources used to calculate the Maryland Standard; detailed tables of the Standard, including the specific costs of meeting each basic need and the Self-Sufficiency Wage for eight selected family types in all counties; and detailed calculations behind the modeling of work supports' impact on wage adequacy in the report itself. Note that the data for the full set of 472 family types, for every Maryland county and the City of Baltimore, is available at www.selfsufficiencystandard.org/Maryland and www.maryland-cap.org.

WHAT IT TAKES TO MAKE ENDS MEET IN MARYLAND

How much income families need to be economically self-sufficient depends both on family composition—the number of adults, the number of children, and the children's ages—and where they live. **Table 1** illustrates how substantially the Standard varies by family type by showing the Standard for four different family configurations in Baltimore County.

- A single adult needs to earn $13.56 per hour working full time to be able to meet his or her basic needs, which is nearly five dollars more than the 2016 state minimum wage ($8.75 per hour).
- Adding a child nearly doubles this requirement; one parent caring for one preschool-aged child needs to earn $25.81 per hour to be self-sufficient.
- Adding a second child further increases the needed wages: one parent with two children—a preschooler and school-age child—needs $30.57 per hour to meet her family's basic needs. This is the equivalent of nearly three and a half full-time minimum wage jobs in Maryland.[3]
- When there are two adults, the additional adult adds some costs, but splits the economic burden; nevertheless, two parents with one preschooler and one school-age child *each* need to earn a minimum of $17.17 per hour, working full time, to meet their family's basic needs.

In addition to varying by family composition, the Self-Sufficiency Standard also varies by geographic

TABLE 1. The Self-Sufficiency Standard for Select Family Types*
Baltimore County, MD 2016

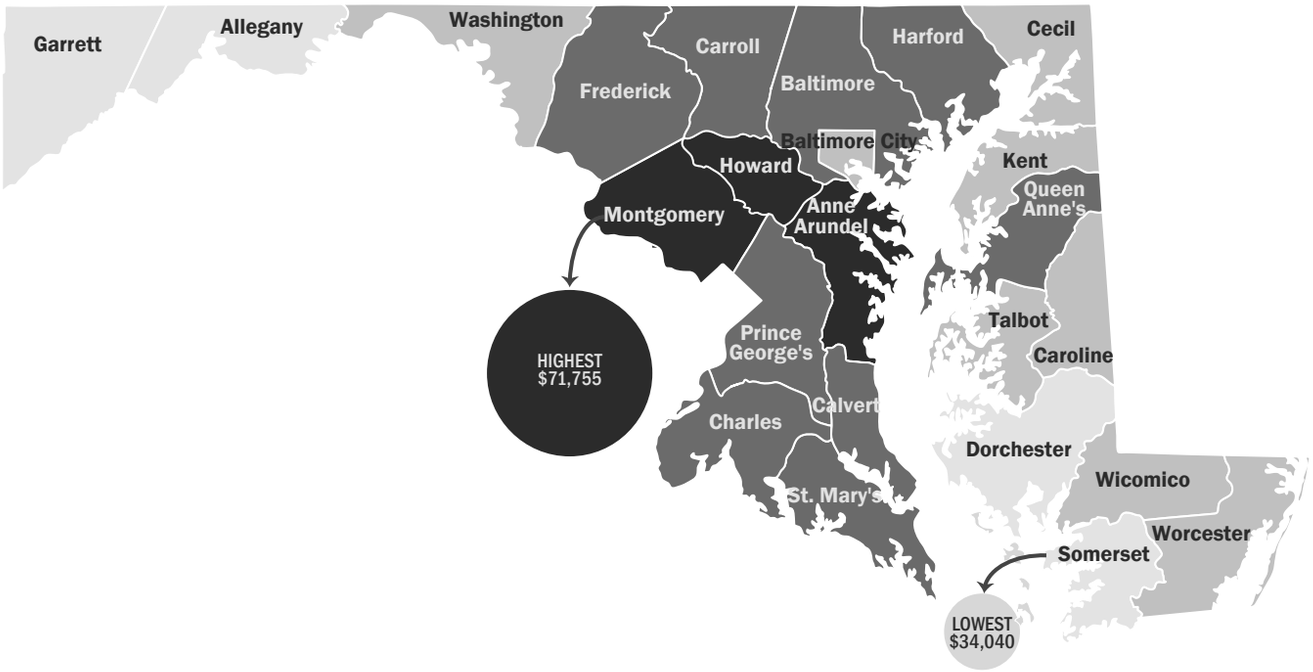
	1 ADULT	1 ADULT 1 PRESCHOOLER	1 ADULT 1 PRESCHOOLER 1 SCHOOL-AGE	2 ADULTS 1 PRESCHOOLER 1 SCHOOL-AGE
MONTHLY COSTS				
Housing	$959	$1,206	$1,206	$1,206
Child Care	$0	$889	$1,401	$1,401
Food	$256	$387	$585	$803
Transportation	$294	$301	$301	$575
Health Care	$182	$530	$551	$606
Miscellaneous	$169	$331	$404	$459
Taxes	$526	$1,031	$1,199	$1,260
Earned Income Tax Credit (-)	$0	$0	$0	$0
Child Care Tax Credit (-)	$0	($50)	($100)	($100)
Child Tax Credit (-)	$0	($83)	($167)	($167)
SELF-SUFFICIENCY WAGE				
Hourly**	**$13.56**	**$25.81**	**$30.57**	**$17.17 per adult**
Monthly	$2,386	$4,542	$5,380	$6,043
Annual	$28,633	$54,506	$64,558	$72,521

* The Standard is calculated by adding expenses and taxes and subtracting tax credits. The "Taxes" row includes payroll and sales taxes plus federal and state income taxes.
** The hourly wage is calculated by dividing the monthly wage by 176 hours (8 hours per day times 22 days per month). The hourly wage for families with two adults represents the hourly wage that each adult would need to earn, while the monthly and annual wages represent both parents' wages combined.
Note: Totals may not add exactly due to rounding.

location. The map in **Figure A** displays the geographic variation in the cost of meeting basic needs across Maryland for families with one adult and one preschooler. The 2016 Self-Sufficiency Standard for a single adult with one preschooler ranges from $34,040 to $71,755 per year depending on the county, or 212% of the federal poverty guidelines to 448% of the federal poverty guidelines for a family of two.

- The most affordable counties in Maryland are located in western Maryland and the Eastern Shore region. The counties of Allegany, Garrett, Somerset, and Dorchester require between $34,040 and $36,756 annually for a family with one adult and one preschooler.
- The second lowest cost group requires between $40,046 and $48,131 annually for a family with one adult and one preschooler. This group includes Baltimore City and Caroline, Worcester, Kent, Wicomico, Washington, Cecil, and Talbot counties.
- The second highest cost group requires wages between $52,775 and $58,669 per year to meet basic needs and includes St. Mary's, Carroll, Harford, Baltimore, Frederick, Prince George's, Queen Anne's, Calvert, and Charles counties.
- The most expensive counties require wages between $61,501 and $71,755 annually to meet basic needs and include the counties of Anne Arundel, Howard, and Montgomery.

FIGURE A. Map of Counties by Level of Annual Self-Sufficiency Wage
One Adult and One Preschooler, MD 2016



ANNUAL SELF-SUFFICIENCY WAGE FOR ONE ADULT AND ONE PRESCHOOLER

$34,040 - $36,756		$40,046 - $48,131		$52,775 - $58,669		$61,501 - $71,755	
Somerset	$34,040	Caroline	$40,046	St. Mary's	$52,775	Anne Arundel	$61,501
Garrett	$34,653	Worcester	$41,198	Carroll	$53,240	Howard	$68,055
Allegany	$34,788	Kent	$42,143	Harford	$54,178	Montgomery	$71,755
Dorchester	$36,756	Wicomico	$42,245	Baltimore	$54,506		
		Washington	$42,879	Frederick	$55,450		
		Baltimore City	$44,132	Prince George's	$55,822		
		Cecil	$47,097	Queen Anne's	$55,979		
		Talbot	$48,131	Calvert	$57,583		
				Charles	$58,669		

HOW HAS THE COST OF LIVING CHANGED OVER TIME IN MARYLAND?

This is the fourth time the Self-Sufficiency Standard has been calculated for Maryland. This section examines how the 2016 Self-Sufficiency Standard and cost components compare to the results in 2001, 2007, and 2012.

The map in **Figure E** depicts the changes in the cost of living (as measured by the Self-Sufficiency Standard) for one family type—one adult, one preschooler, and one school-age child—by county between 2001 and 2016.

Over the last 15 years, the Self-Sufficiency Standard for this three-person family has increased on average across all Maryland counties by 66%, or an annual average growth rate of 3.4% per year. However, there is considerable variation by county, ranging from 42% to 90%. Anne Arundel County's costs increased at one of the fastest rates: in 2001, a family with one adult, one preschooler, and one school-age child in Anne Arundel County needed about $40,000 per year to meet their basic needs, but by 2016 that amount had nearly doubled to about $75,000, increasing by about $2,300 each year in average (an annual average growth rate of 4.3%).

The largest percentage increase in the Standard since 2001 occurred in both Kent and Queen Anne's counties, where costs increased by 90%. Housing, child care, and taxes especially increased at a much higher rate in these counties than on average in Maryland. However, Montgomery County had the largest dollar increase in costs since 2001. The Self-Sufficiency Standard for a one-adult family with one preschooler and one school-age child increased from about $50,000 in 2001 to about $87,000, or roughly $2,500 per year on average.

Over time, costs have increased fairly steadily, although with some variation, as can be seen in **Figure F** on page 13. Tracing the changes in the Standard for this three-person family in four counties illustrates a few trends. First, while all counties increased over the 15 years, the variation in rates of change increased the difference (or spread) between higher cost and lower cost counties in 2016. For these four counties, the difference between the highest cost and lowest cost county increased from about $15,000 to about $26,000.

FIGURE E. Percentage Change in the Self-Sufficiency Standard for Maryland between 2001 and 2016
One Adult, One Preschooler, and One School-Age Child: MD 2016

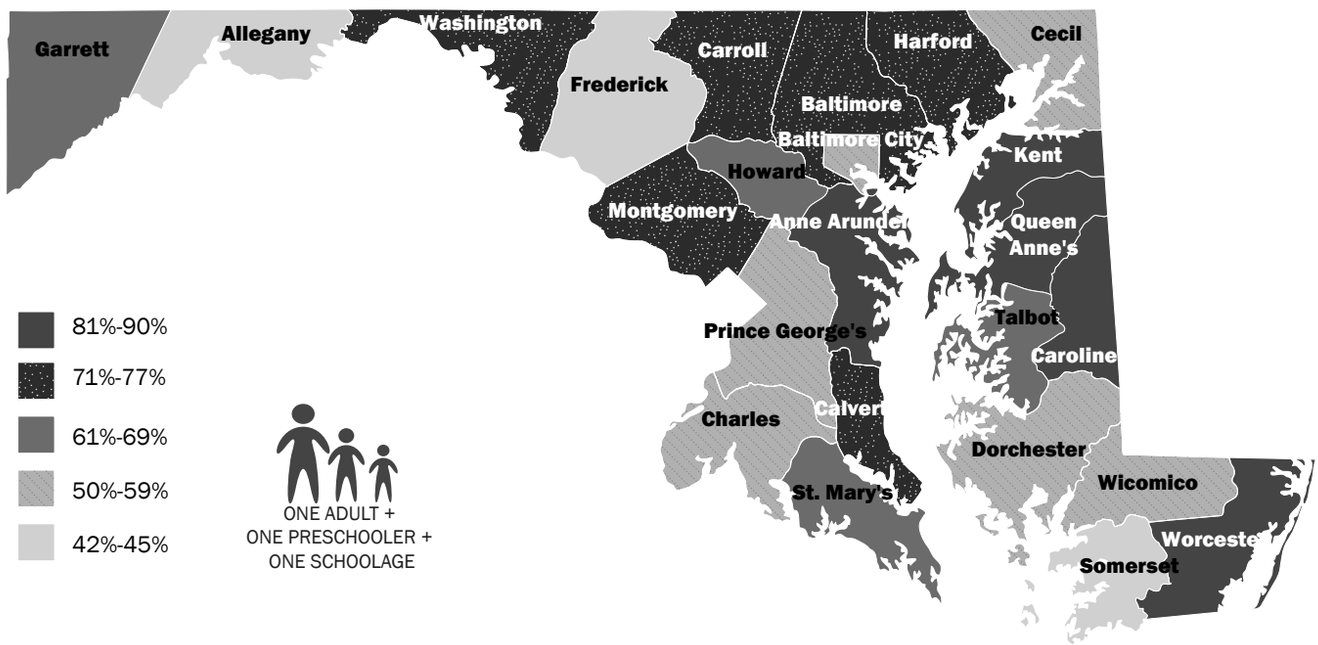
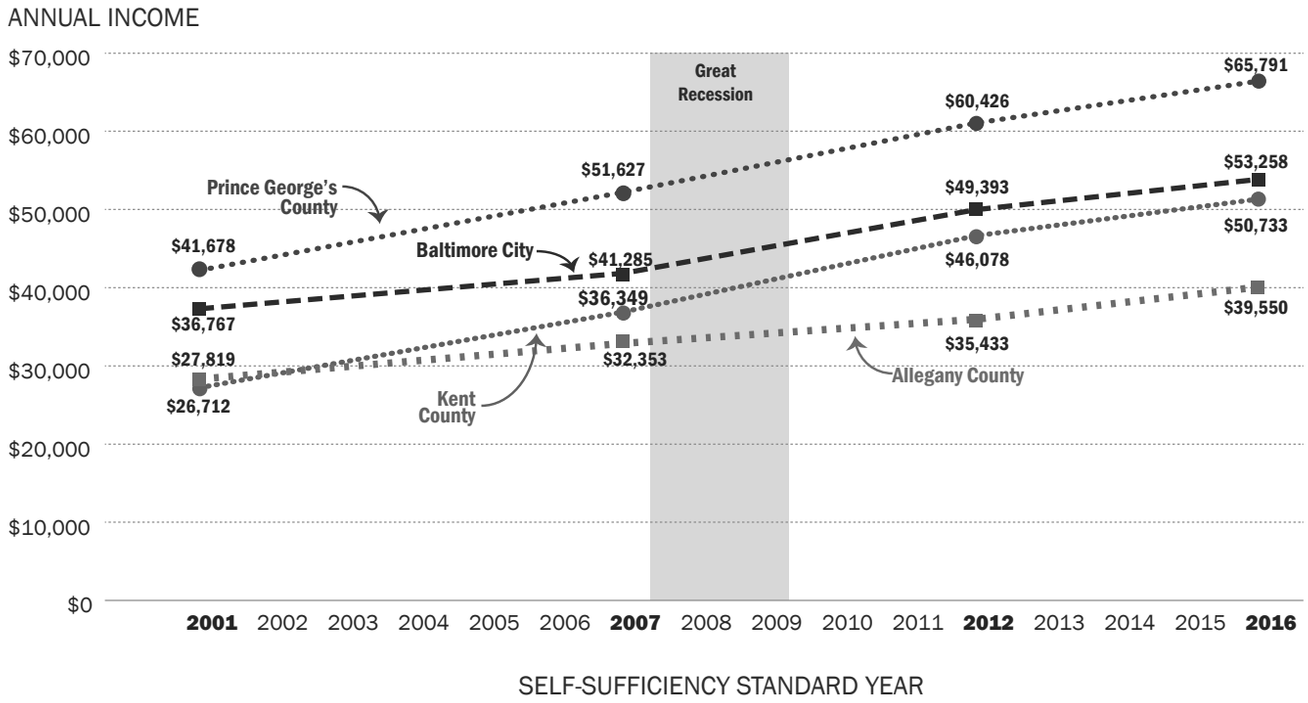


FIGURE F. The Self-Sufficiency Standard for Maryland by Year for Select Counties
One Adult, One Preschooler, and One School-age Child: 2001, 2007, 2012, and 2016



Second, there is no significant slowing of cost increases during the Great Recession or the recovery after 2009 (shown by the blue bar in **Figure F**). That is, despite the increases in the minimum wage, the cost of living has continued to rise in Maryland.

Although the Standard increased to various degrees in different counties in Maryland (fairly steadily), this masks sizable variation in how much *each cost* increased across counties. Using the same three-person family as above (one adult, one preschooler, and one school-age child), **Table 2** shows the actual cost and percentage of change for each basic need since 2001 in Howard County, as well as statewide.

- Health care was the largest increase, rising by 122% in Howard County, almost the same rate (131%) as the statewide average.
- The increase in child care costs was 51% for Howard County, somewhat lower than the statewide average increase of 67%. In dollar terms, the cost of child care increased by $572 per month in Howard County over this time period.

THERE IS NO SIGNIFICANT SLOWING OF COST INCREASES DURING THE GREAT RECESSION OR THE RECOVERY AFTER 2009. THAT IS, DESPITE INCREASES IN THE MINIMUM WAGE, THE COST OF LIVING HAS CONTINUED TO RISE.

- The cost of housing increased 74% since 2001, growing from $913 to $1,591 per month for a two-bedroom housing unit in Howard County. Housing costs increased 52% on average statewide.
- Food costs increased by 70% in Howard County, above the statewide average of 56%.
- Transportation costs in Howard County *decreased* by 8% since 2001 due to lower insurance rates, and have only gone up by 1% across the state.

TABLE 2. Percent Change in the Self-Sufficiency Standard Over Time, 2001-2016
Howard County, MD: One Adult, One Preschooler, and One School-Age Child

COSTS	2001	2016	PERCENT CHANGE 2001-2016	
			Howard County	Statewide
Housing	$913	$1,591	74%	52%
Child Care	$1,115	$1,687	51%	67%
Food	$396	$672	70%	56%
Transportation	$305	$279	-8%	1%
Health Care	$248	$551	122%	131%
Miscellaneous	$298	$478	61%	59%
Taxes	$862	$1,681	95%	89%
Tax Credits*	($180)	($267)	48%	41%
SELF-SUFFICIENCY WAGE				
Monthly	$3,956	$6,672	69%	66%
Annual	$47,467	$80,065		
MEDIAN EARNINGS**				
Howard County	$38,889	$56,830	46%	
Statewide	$29,881	$41,833		40%

* Total Tax Credits is the sum of the monthly EITC, CCTC, and CTC.
** U.S. Census Bureau, 2014 American Community Survey, "B20002: Median Earnings in the Past 12 Months by Sex for the Population 16 Years and Over with Earnings in the Past 12 Months, Maryland and Howard County" and Census 2000 Summary File 3, P085, "Median Earnings in 1999 (Dollars) by Sex for the Population 16 Years and Over with Earnings in the Past 12 Months," http://factfinder2.census.gov (accessed August 1, 2016). Median earnings from 1999 and 2014 updated using the Employment Cost Index (ECI). U.S. Department of Labor, Bureau of Labor Statistics, Employment Cost Index, Wages and salaries for All Civilian workers in All industries and occupations, Employment Cost Index Historical Listing – Volume II, March 2013, http://www.bls.gov/ncs/ect/sp/ecconst.pdf, and http://data.bls.gov/cgi-bin/srgate, Series CIS10200000000000I (accessed August 1, 2016).

COST OF LIVING INCREASES VERSUS EARNINGS INCREASES. While the Self-Sufficiency Standard for this three-person family in Howard County increased by 69% over the past 15 years, workers' median earnings increased by 46% (from $38,889 to $56,830) in Howard County over the same time period, at roughly the same level. Statewide median earnings, however, have increased by only 40%, while statewide costs have increased by 66%. Clearly, the fact that cost increases have far outstripped wage increases puts pressure on family budgets.

DOCUMENTING CHANGES IN LIVING COSTS WITH THE STANDARD VERSUS THE CONSUMER PRICE INDEX

Nationally, the official measure of inflation is the U.S. Department of Labor's Consumer Price Index (CPI). The CPI is a measure of the average changes in the prices paid by urban consumers for all goods and services. Since the Standard measures the costs of only basic needs, the question is how the increases in costs documented here compare to official inflation rates. We examine this question in **Figure G** by comparing the actual increase in the Self-Sufficiency Standard to what the numbers would be if we had just updated the 2001 Standard with the CPI. Since the CPI does not incorporate taxes or tax credits, these items have been removed from the Standard shown in **Figure G.** Using the same three-person family as above (one adult, one preschooler, and one school-age child), this comparison was done for two places in Maryland: Kent and Prince George's counties.

The South Region Consumer Price Index (CPI) increased 36% between 2001 and 2016. If the 2001 Self-Sufficiency Standard for Kent County ($25,696 per year without taxes/tax credits), was increased by this amount, the CPI-adjusted cost of basic needs in 2016 would be estimated to be $35,118 per year.[9] However, the *actual* 2016 Standard for Kent County, (without taxes or tax credits) is considerably higher: $43,770 per year for this family type, a 70% increase over the last 15 years. Similarly, when the CPI inflation rate is applied to the 2001 Standard for Prince George's County ($35,118 without taxes in 2001), the CPI adjusted estimate for 2016 would be $48,091. However, the actual 2016 Self-Sufficiency Standard amount for Prince George's County (without taxes or tax credits) is $54,055, 54% higher than in 2001.

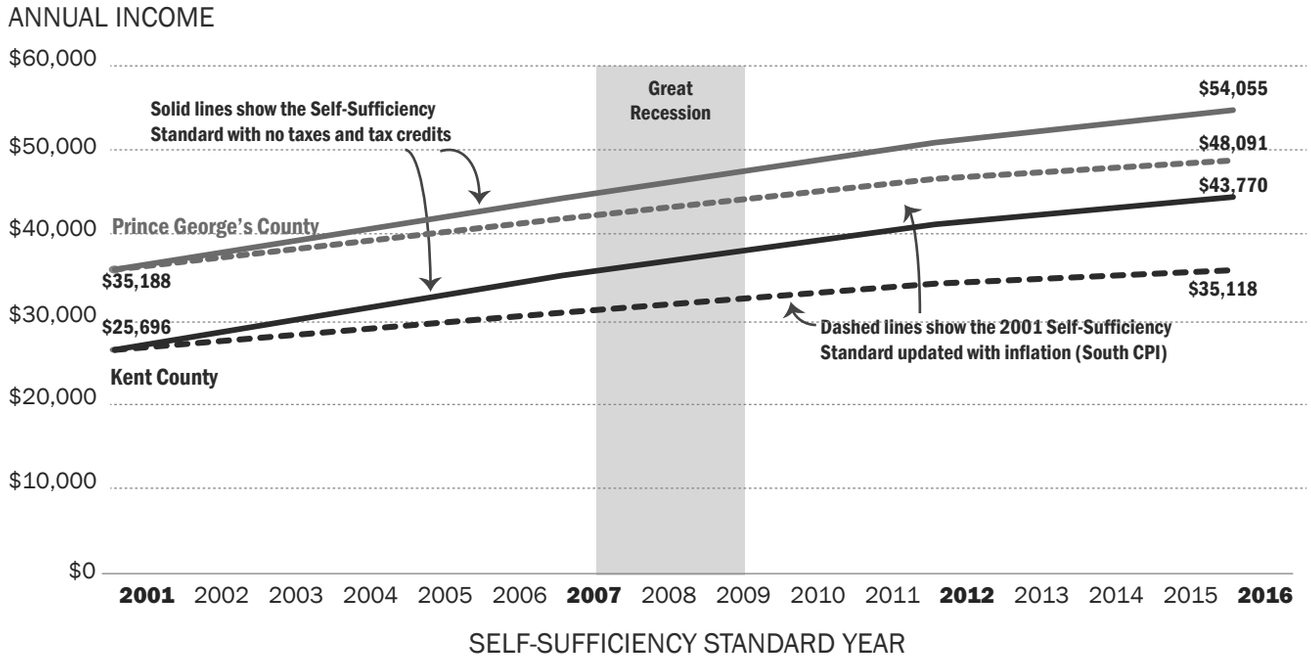
In sum, **Figure G** demonstrates that the rate of inflation as measured by the CPI substantially underestimates the rising costs of basic needs; instead of increasing

OVER THE LAST 15 YEARS, THE SELF-SUFFICIENCY STANDARD FOR THIS THREE-PERSON FAMILY HAS INCREASED ON AVERAGE ACROSS ALL MARYLAND COUNTIES BY 66%, AT AN ANNUAL GROWTH RATE OF 4.7% PER YEAR.

ESTIMATING THE INCREASE IN COSTS USING THE CPI DRASTICALLY UNDERESTIMATES THE REAL INCREASES IN THE COST OF BASIC NEEDS FACED BY MARYLAND FAMILIES, LEAVING THEM THOUSANDS OF DOLLARS SHORT.

36%, costs rose by 70% in Kent County and 54% in Prince George's County. Indeed, using the CPI for this family type in Prince George's County results in a 2016 estimate of costs that is about $12,000 less than the actual costs in the 2016 Standard, and about $8,000 less for Kent County. That is, estimating the increase in costs using the CPI drastically underestimates the real increases in the cost of basic needs faced by Maryland families, leaving them thousands of dollars short. This analysis also suggests that assuming that the CPI reflects the experience of households equally across the income spectrum hides the lived experience of those at the lower end. For lower income families, not only have wages stagnated, but basic costs are rising faster than for higher income families, aggravating the economic crunch that they are experiencing.

FIGURE G. CPI*-Measured Inflation Underestimates Real Cost of Living Increases: A Comparison of the Self-Sufficiency Standard and the Consumer Price Index, 2001-2016
Kent and Prince George's Counties, MD 2016: One Adult, One Preschooler, and One School-Age Child



* U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index, "South Region All Items, 1982-84=100-CUURA101SAO," http://data.bls.gov/cgi-bin/surveymost?cu (accessed July 11, 2016).
** Since the CPI does not incorporate taxes or tax credits, these items have been taken out of the Self-Sufficiency Standard for this comparison figure.

HOW DOES THE SELF-SUFFICIENCY STANDARD COMPARE TO OTHER BENCHMARKS OF INCOME?

As a measure of income adequacy, how does the Standard compare to other commonly used measures? **Figure H** compares the Kent County Self-Sufficiency Standard for one adult, one preschooler, and one school-age child to the following income benchmarks for three-person families:

- Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP, formerly the Food Stamps Program), and WIC (Women, Infants and Children)
- The federal poverty guidelines (FPG)
- The 2016 Maryland minimum wage
- The Lower Living Standard Income Level
- HUD income eligibility limits

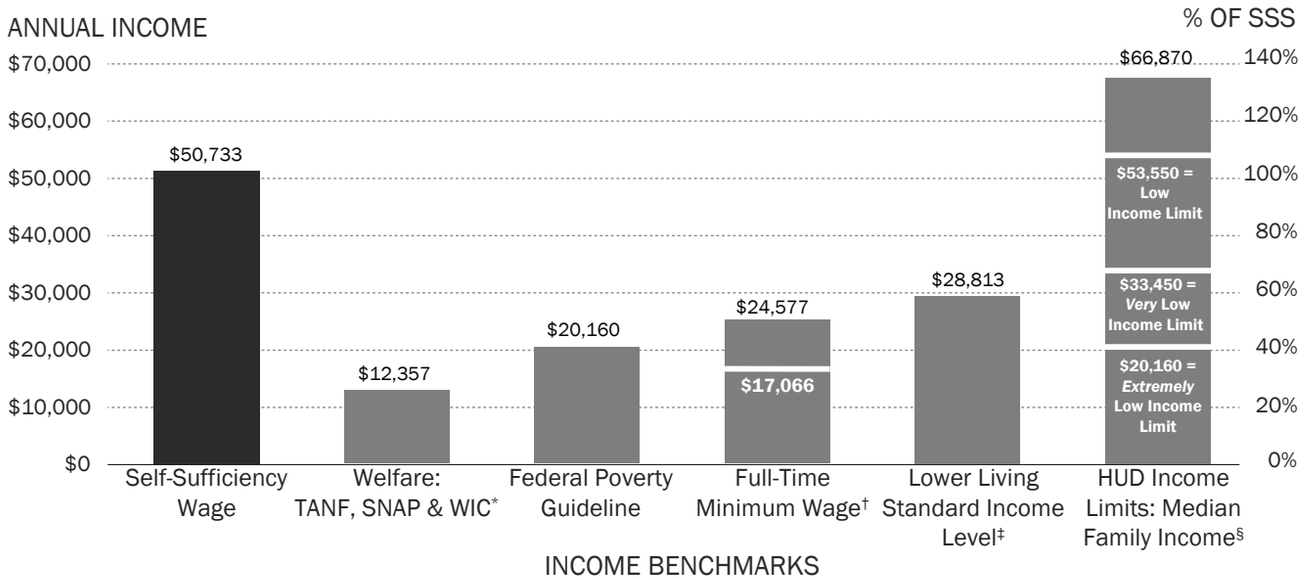
As indicated in the first bar in **Figure H**, the Self-Sufficiency Wage for this family type in Kent County is $50,733 per year.

TANF, SNAP AND WIC. The second bar on the left in **Figure H** calculates the cash value of the basic public assistance package, assuming no other income, and includes the cash value of SNAP (formerly food stamps), WIC, and TANF. This public assistance package totals $12,357 per year for three-person families in Maryland, which is just 24% of the Self-Sufficiency Standard for a three-person family in Kent County, and 61% of the FPG for a three-person family.

FEDERAL POVERTY GUIDELINES. A three-person family, regardless of composition or where they live, would be considered "poor" with an income of $20,160 annually or less, according to the 2016 federal poverty guidelines. The FPG for three-person families is just 40% of the Self-Sufficiency Standard for this Kent County family.

This comparison is for just one family type. In Kent County, the Self-Sufficiency Standard is 169% of the FPG for a household with one adult and three

FIGURE H. The Self-Sufficiency Standard Compared to Other Benchmarks
One Adult, One Preschooler, and One School-Age Child: Kent County, MD 2016



* For FY 2016, the maximum Temporary Assistance for Needy Families (TANF) benefit amount is $7,322 annually, the Supplemental Nutrition Assistance Program (SNAP) benefit amount is $4,493 annually, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) benefit amount is $542 annually for a family of three in Maryland.

† The Maryland minimum wage is $8.75 per hour as of July 1, 2016. This amounts to $18,480 per year; however, assuming this family pays federal and state taxes and receives tax credits, the net yearly income would be a larger amount, $24,577 as shown. The dashed line shows the annual income received after accounting for taxes ($16,091) but without the addition of tax credits, which are received as a yearly lump sum after filing taxes the following year.

‡ Lower Living Standard Income Level (LLSIL) limits are 2016 limits for South non-metro areas.

§ The U.S. Department of Housing and Urban Development (HUD) uses area median family income as a standard to assess families' needs for housing assistance. The HUD median family income limits are for FY 2016.

teenagers and 252% of the FPG for a household consisting of one adult with one preschooler and one school-age child.

There is also considerable variation by place. **Table 3** compares the percentage of the FPG needed to meet basic needs for one adult, one preschooler, and one school-age child across Maryland, and finds that the Self-Sufficiency Standard for this family type ranges from 196% of the FPG in Allegany County to 429% of the FPG in Montgomery County. For a two-adult family with a preschooler and school-age child (with a FPG of $24,250), also shown in **Table 3**, there is a similarly wide range, with the Standard varying from 196% of the FPG in Allegany County to 376% of the FPG in Montgomery County.

MINIMUM WAGE. Although the minimum wage is incrementally increasing in Maryland (sidebar page 28), the 2016 minimum wage is $8.75 per hour, which amounts to $18,480 per year working full time. Because this is earned income, payroll taxes (Social Security and Medicare) are subtracted and eligible tax credits (EITC and CTC) are added. Altogether a working parent with two children would have a net cash income of $24,577 per year. This net "take home" amount is more than the worker's earnings alone because the tax credits the family qualifies for are more than the taxes owed.

A full-time minimum wage job in Maryland provides 48% of the amount needed to be self-sufficient for this family type in Kent County. More realistically, if it is assumed that the worker pays taxes *monthly* through withholding, but receives tax credits *annually* (as is true of all workers), her take-home income would be $17,066 over the year, shown by the dashed line on the third bare in **Figure H**. Without including the impact of tax credits in either the minimum wage or Self-Sufficiency Standard income (but still accounting for payment of taxes), a minimum wage job amounts to just 34% of the Self-Sufficiency Standard for this family type in Kent County.

THE STANDARD IS A CONSERVATIVE MEASURE OF THE MINIMUM REQUIRED TO BE SELF-SUFFICIENT IN KENT COUNTY.

Put another way, including the value of tax credits, at the minimum wage she would need to work more than two full-time jobs to meet her basic costs of living. If tax credits are excluded from current income (as they are actually received the next year at tax filing), she would need to work *three* full-time jobs to meet her basic costs.

LOWER LIVING STANDARD INCOME LEVEL. The Workforce Innovation and Opportunity Act (WIOA) of 2014 requires the Department of Labor to publish the Lower Living Standard Income Level (LLSIL) annually. Under WIOA one of the criteria to be considered low income, is if a family's income does not exceed the higher of the FPG or 70% of the LLSIL.[10] The LLSIL was last revised in 1981 by the Bureau of Labor Statistics and has only been updated for inflation. For 2016 a three-person family in the non-metropolitan South, of which Kent County is a part, the LLSIL is $28,813 and 70% of the LLSIL is $20,169, which is only $9 above the FPG for this family size.[11]

MEDIAN FAMILY INCOME LIMITS. The U.S. Department of Housing and Urban Development (HUD) uses percentages of area median family income (i.e., half of families in the area have income above this amount, and half below) to determine families' eligibility for housing assistance on the assumption that area median income is a rough measure of the local cost of living. The Fiscal Year 2016 HUD median income for a three-person family in Kent County is $66,870 annually.[12] HUD income limits define three levels:

- "Low income" three-person families in Kent County have incomes between 50% and 80% of area median income, i.e., between $33,450 and $53,550.
- "Very low income" three-person families have incomes between 30% of area median income and 50% of area median income, or $20,160 and $33,450.
- Families with incomes below 30% of area median income are considered "extremely low income."[13]

The Self-Sufficiency Standard of $50,733 for this family type in Kent County is in the HUD "low income" range, demonstrating that the Standard is a conservative measure of the minimum required to be self-sufficient in Kent County. (Due to limited resources, most federal housing assistance goes to families with incomes that are considered "very low" or "extremely low.")

TABLE 3. The Self-Sufficiency Standard as a Percentage of Other Benchmarks of Income, 2016
Two Family Types, All Maryland Counties and Baltimore City

	Self-Sufficiency Standard for One Adult + One Preschooler + One School-age				Self-Sufficiency Standard for Two Adults + One Preschooler + One School-age			
	Annual Self-Sufficiency Standard	As Percentage of:			Annual Self-Sufficiency Standard	As Percentage of:		
		Federal Poverty Guidelines	Minimum Wage	Median Family Income		Federal Poverty Guidelines	Minimum Wage	Median Family Income
COUNTY								
Allegany County	$39,550	196%	214%	61%	$47,742	196%	129%	66%
Anne Arundel County	$74,801	371%	405%	96%	$81,935	337%	222%	95%
Baltimore County	$64,558	320%	349%	83%	$72,521	298%	196%	84%
Baltimore City	$53,258	264%	288%	68%	$57,678	237%	156%	67%
Calvert County	$67,364	334%	365%	69%	$75,620	311%	205%	70%
Caroline County	$48,643	241%	263%	75%	$56,138	231%	152%	78%
Carroll County	$63,700	316%	345%	82%	$71,555	294%	194%	83%
Cecil County	$56,445	280%	305%	78%	$63,555	262%	172%	79%
Charles County	$68,160	338%	369%	70%	$75,962	313%	206%	70%
Dorchester County	$45,512	226%	246%	70%	$50,438	208%	136%	70%
Frederick County	$64,265	319%	348%	66%	$71,691	295%	194%	66%
Garrett County	$39,713	197%	215%	61%	$47,844	197%	129%	66%
Harford County	$64,727	321%	350%	83%	$72,480	298%	196%	84%
Howard County	$80,065	397%	433%	103%	$87,066	358%	236%	100%
Kent County	$50,733	252%	275%	76%	$58,765	242%	159%	79%
Montgomery County	$86,580	429%	469%	89%	$91,252	376%	247%	84%
Prince George's County	$65,791	326%	356%	67%	$71,851	296%	194%	66%
Queen Anne's County	$65,089	323%	352%	83%	$73,491	302%	199%	85%
St. Mary's County	$62,564	310%	339%	72%	$70,258	289%	190%	72%
Somerset County	$41,194	204%	223%	63%	$48,601	200%	131%	67%
Talbot County	$56,386	280%	305%	82%	$64,395	265%	174%	84%
Washington County	$50,423	250%	273%	78%	$57,628	237%	156%	80%
Wicomico County	$49,385	245%	267%	76%	$56,679	233%	153%	79%
Worcester County	$50,928	253%	276%	78%	$58,658	241%	159%	81%

Definitions: The federal poverty guidelines for family of three = $20,160 and for a family of four = $24,300. Annual minimum wage is the gross amount of full-time, year-round work at an hourly wage of $8.75 per hour (assumes both adults work). Area median family income varies by county and is calculated based on HUD's FY2016 Low Income Limit (50% of median family income).

OTHER APPROACHES TO POVERTY MEASUREMENT

For a more in-depth look at how the Standard compares to the federal poverty measure please visit www.selfsufficiencystandard.org/measuring-poverty

ALICE®

ASSET LIMITED, INCOME CONSTRAINED, EMPLOYED

MARYLAND

ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, COLORADO, **CONNECTICUT**, DELAWARE, **FLORIDA**, GEORGIA, HAWAII, **IDAHO**, ILLINOIS, **INDIANA**, **IOWA**, KANSAS, KENTUCKY, **LOUISIANA**, MAINE, **MARYLAND**, MASSACHUSETTS, **MICHIGAN**, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, **NEW JERSEY**, NEW MEXICO, **NEW YORK**, NORTH CAROLINA, NORTH DAKOTA, **OHIO**, OKLAHOMA, **OREGON**, PENNSYLVANIA, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, TEXAS, UTAH, VERMONT, **VIRGINIA**, **WASHINGTON**, WEST VIRGINIA, **WISCONSIN**, WYOMING

Fall 2016

STUDY OF FINANCIAL HARDSHIP

GIVE. ADVOCATE. VOLUNTEER.

Maryland State Association of United Ways

UnitedWayALICE.org/Maryland

LIVE UNITED

United Way

THE UNITED WAY *ALICE PROJECT*

The United Way *ALICE Project* provides a framework, language, and tools to measure and understand the struggles of the growing number of households in our communities that do not earn enough to afford basic necessities, a population called ALICE. This research initiative partners with state United Way organizations, such as those in Maryland, to deliver research-based reports that can stimulate meaningful discussion, attract new partners, and ultimately inform strategies that affect positive change.

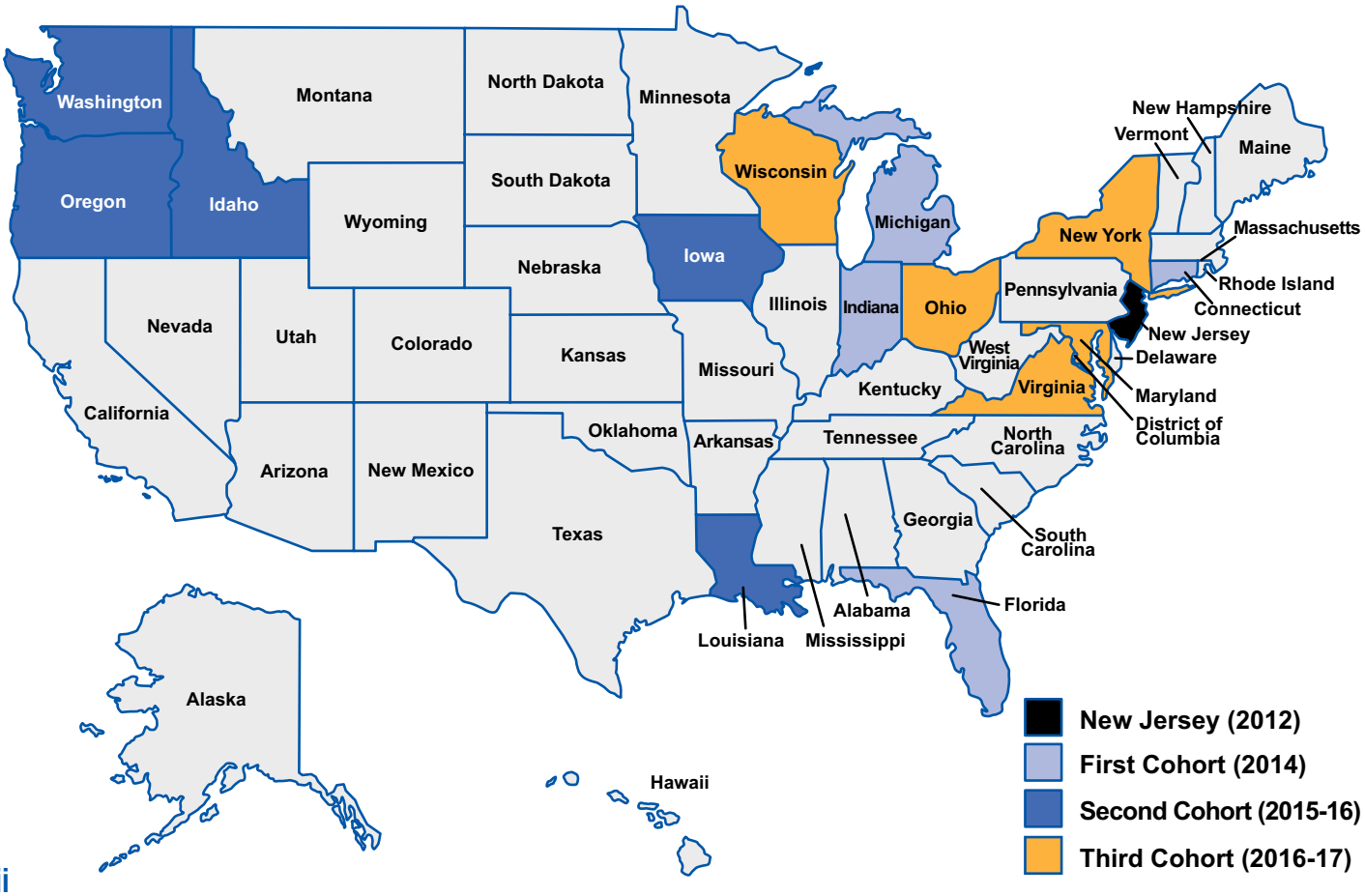
Based on the overwhelming success of this research in identifying and articulating the needs of this vulnerable population, the United Way *ALICE Project* has grown from a pilot in Morris County, New Jersey in 2009, to the entire state of New Jersey in 2012, and now to the national level with 15 states participating in the United Way *ALICE Project*.

More than one-third of households in the United States either live in poverty or are ALICE. Maryland's United Way organizations are proud to join some 450 United Ways from the participating states to better understand the struggles of ALICE. The result is that ALICE is rapidly becoming part of the common vernacular, appearing in grant applications, in the media, and in public forums discussing financial hardship in communities across the country.

Together, United Ways, government agencies, nonprofits, and corporations have the opportunity to evaluate the current solutions and discover innovative approaches to give ALICE a voice, and to create changes that improve life for ALICE and the wider community.

To access reports from all states, visit UnitedWayALICE.org

States with United Way ALICE Reports



THE ALICE RESEARCH TEAM

The United Way *ALICE Project* provides high quality, research-based analysis to foster a better understanding of who is struggling in our communities. To produce the United Way ALICE Report for Maryland, a team of researchers collaborated with a Research Advisory Committee, composed of 20 representatives from across the state, who counseled United Way on the development of the Report. This collaborative model, practiced in each state, ensures each United Way ALICE Report presents unbiased data that is replicable, easily updated on a regular basis, and sensitive to local context. Working closely with United Ways, the United Way *ALICE Project* seeks to equip communities with information to create innovative solutions.

Lead Researcher

Stephanie Hoopes, Ph.D. is the lead researcher and director of the United Way *ALICE Project*. Dr. Hoopes' work focuses on the political economy of the United States and specifically on the circumstances of low-income households. Her research has garnered both state and national media attention. She began the United Way *ALICE Project* as a pilot study of the low-income community in affluent Morris County, New Jersey in 2009, and has overseen its expansion into a broad-based initiative to more accurately measure financial hardship in states across the country. In 2015, Dr. Hoopes joined the staff at United Way of Northern New Jersey in order to grow this work in new and innovative ways as more and more states become involved.

Dr. Hoopes was an assistant professor at the School of Public Affairs and Administration (SPAA), Rutgers University-Newark, from 2011 to 2015, and director of Rutgers-Newark's New Jersey DataBank, which makes data available to citizens and policymakers on current issues in 20 policy areas, from 2011 to 2012. SPAA continues to support the United Way *ALICE Project* with access to research resources.

Dr. Hoopes has a Ph.D. from the London School of Economics, a master's degree from the University of North Carolina at Chapel Hill, and a bachelor's degree from Wellesley College.

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EXECUTIVE SUMMARY

In Maryland, 743,738 households – fully 35 percent – struggled to afford basic household necessities in 2014.

MAJOR FINDINGS

Who is ALICE?

With the cost of living higher than what most people earn, **ALICE** families – an acronym for **A**sset **L**imited, **I**ncome **C**onstrained, **E**mployed – have income above the Federal Poverty Level (FPL), but not high enough to afford a basic household budget that includes housing, child care, food, transportation, and health care. ALICE households live in every county in Maryland – urban, suburban, and rural – and they include women and men, young and old, and all races and ethnicities.

Who is struggling?

While the Federal Poverty Level reports that only 10 percent of Maryland households face financial hardship, an additional 25 percent (534,801 households) qualify as ALICE.

Why are there so many ALICE households in Maryland?

Low wage jobs dominate the local economy: More than 53 percent of all jobs in Maryland pay less than $20 per hour, with most paying between $10 and $15 per hour ($15 per hour full time = $30,000 per year). These jobs – especially service jobs that pay wages below $20 per hour and require a high school education or less – will grow far faster than higher-wage jobs over the next decade.

The basic cost of living outpaces wages: The cost of basic household expenses in Maryland is more than most of the state's jobs can support. The average annual Household Survival Budget for a Maryland family of four (two adults with one infant and one preschooler) is $61,224 – more than double the U.S. family poverty level of $23,850.

Jobs are not located near housing that is affordable: The Great Recession caused economic hardship throughout Maryland: Housing affordability fell by 17 percent, and job opportunities fell by 14 percent. From 2010 to 2014, housing affordability improved by 8 percent; job opportunities and community resources fluctuated during this period, only to return to their 2010 levels. ALICE households in many parts of Maryland continue to struggle with finding both housing that is affordable and jobs that can support them in the same area.

Public and private assistance helps, but doesn't provide financial stability: The income of ALICE and poverty-level households in Maryland is supplemented with $15.2 billion in government, nonprofit, and health care resources. Presuming that the benefits are distributed evenly and allocated according to need, there is still a 15 percent Unfilled Gap for all households to meet the ALICE Threshold for economic survival. In addition, because government expenditure is increasingly composed of health care spending, which consists of services and cannot be transferred to meet other needs, there are actually larger gaps in other areas, such as housing (45 percent) and child care (54 percent).

What are the consequences, and what would improve the economic situation for ALICE households?

Consequences: When ALICE households cannot make ends meet, they are forced to make difficult choices such as forgoing health care, accredited child care, healthy food, or car insurance. These "savings" threaten their health, safety, and future – and they reduce productivity and raise insurance premiums and taxes for everyone. The costs are high for both ALICE families and the wider community.

Long-term change: While short-term strategies can make conditions less severe, only structural economic changes will significantly improve the prospects for ALICE and enable hardworking households to support themselves. Strengthening the Maryland economy and meeting ALICE's challenges are linked: Improvement for one would directly benefit the other. The ALICE tools can help policymakers, community leaders, and business leaders to better understand the magnitude and variety of households facing financial hardship, and to create more effective change.

GLOSSARY

ALICE is an acronym that stands for **A**sset **L**imited, **I**ncome **C**onstrained, **E**mployed, comprising households with income above the Federal Poverty Level but below the basic cost of living.

Household Survival Budget calculates the actual costs of basic necessities (housing, child care, food, health care, and transportation) in Maryland adjusted for different counties and household types.

ALICE Threshold is the average level of income that a household needs to afford the basics defined by the Household Survival Budget for each county in Maryland. (Please note that unless otherwise noted in this Report, households earning less than the ALICE Threshold include both ALICE and poverty-level households.)

Household Stability Budget is greater than the basic Household Survival Budget and reflects the cost for household necessities at a modest but sustainable level. It adds a savings category, and is adjusted for different counties and household types.

ALICE Income Assessment is the calculation of all sources of income, resources, and assistance for ALICE and poverty-level households. Even with assistance, the Assessment reveals a significant shortfall, or Unfilled Gap, between what these households bring in and what is needed for them to reach the ALICE Threshold.

Economic Viability Dashboard is comprised of three Indices that evaluate the economic conditions that matter most to ALICE households – Housing Affordability, Job Opportunities, and Community Resources. A Dashboard is provided for each county in the state.

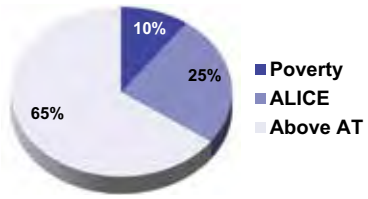
AT-A-GLANCE: MARYLAND

2014 Point-in-Time Data

Population: 5,976,407 | **Number of Counties:** 24 | **Number of Households:** 2,166,102
Median Household Income (state average): $73,971 (national average: $53,657)
Unemployment Rate (state average): 7.2% (national average: 7.2%)
Gini Coefficient (zero = equality; one = inequality): 0.45 (national average: 0.48)

How many households are struggling?

ALICE, an acronym for **A**sset **L**imited, **I**ncome **C**onstrained, **E**mployed, are households that earn more than the U.S. poverty level, but less than the basic cost of living for the state (the ALICE Threshold, or AT). Combined, the number of poverty and ALICE households (35 percent) equals the total Maryland population struggling to afford basic needs.



Income Assessment for Maryland

The total annual income of poverty-level and ALICE households in Maryland in 2014 was $17.1 billion, which includes wages and Social Security. This is only 45 percent of the amount needed just to reach the ALICE Threshold of $38.2 billion statewide. Government and nonprofit assistance made up an additional 40 percent, or $15.2 billion, but that still leaves an Unfilled Gap of 15 percent, or $5.9 billion.

ALICE Threshold	–	Income and Assistance	=	Unfilled Gap
$38.2 billion	–	$32.3 billion	=	$5.9 billion

What does it cost to afford the basic necessities?

This bare-minimum Household Survival Budget does not allow for any savings, leaving a household vulnerable to unexpected expenses. Affording only a very modest living in each community, this budget is still significantly more than the U.S. poverty level of $11,670 for a single adult and $23,850 for a family of four.

Monthly Costs – Maryland Average – 2014

	SINGLE ADULT	2 ADULTS, 1 INFANT, 1 PRESCHOOLER	PERCENT CHANGE, 2007–2014
Housing	$807	$1,123	25%
Child Care	$-	$1,214	19%
Food	$202	$612	20%
Transportation	$364	$722	27%
Health Care	$138	$552	58%
Miscellaneous	$179	$464	26%
Taxes	$274	$415	31%
Monthly Total	$1,964	$5,102	26%
ANNUAL TOTAL	$23,568	$61,224	26%
Hourly Wage	*$11.78*	*$30.61*	*26%*

Note: Percent increases are an average of the increases in each category for a single-adult and a four-person family.
Source: See Appendix C

AT-A-GLANCE: MARYLAND

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Population: 5,976,407 | **Number of Counties:** 24 | **Number of Households:** 2,166,102
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Gini Coefficient (zero = equality; one = inequality): 0.45 (national average: 0.48)

Maryland Counties, 2014

COUNTY	TOTAL HH	% ALICE & POVERTY
Allegany	29,348	39%
Anne Arundel	203,775	28%
Baltimore City	238,897	45%
Baltimore County	311,099	40%
Calvert	31,200	34%
Caroline	11,842	38%
Carroll	59,430	28%
Cecil	36,857	35%
Charles	54,600	32%
Dorchester	13,419	43%
Frederick	89,084	32%
Garrett	11,851	35%
Harford	92,304	34%
Howard	109,651	22%
Kent	7,448	40%
Montgomery	364,854	27%
Prince George's	307,022	38%
Queen Anne's	17,354	29%
Somerset	8,498	53%
St. Mary's	39,179	32%
Talbot	16,140	39%
Washington	54,722	42%
Wicomico	37,036	35%
Worcester	20,492	31%

Sources: ***2014 Point-in-Time Data****: American Community Survey, 2014.* ***ALICE Demographics:*** *American Community Survey, 2014, and the ALICE Threshold, 2014.* ***Income Assessment:*** *Office of Management and Budget, 2015; Department of Treasury, 2016; U.S. Department of Agriculture (USDA), 2016; American Community Survey, 2014; National Association of State Budget Officers, 2015; NCCS Data Web Report Builder, 2012; see Appendix E.* ***Budget:*** *U.S. Department of Housing and Urban Development (HUD); USDA; Bureau of Labor Statistics (BLS); Internal Revenue Service (IRS) and Comptroller of Maryland; Maryland Family Network, 2014.*

A Comparison of the Self-Sufficiency Standard and United Way's ALICE

By Diana Pearce, Center for Women's Welfare
November 2016

Summary

1. Both measures seek to address a major shortcoming of the federal poverty measure, which is that it is too low, so that no family could meet its basic needs at that level.
2. The SSS started in 1996, and is now found in 39 states and 2 cities; ALICE began in 2009, and has produced reports in 15 states.
3. The family budgets that are key to both measures are similar, though ALICE's survival budget is generally slightly lower; the SSS provides 700 family budgets for each place, while ALICE provides 6 family types.
4. The calculation of how many have income below the budgets is done quite differently; while SSS uses standard demographic methods, ALICE uses published tables, and a single budget number, resulting in higher numbers.

Introduction

The official poverty measure was developed over five decades ago by Mollie Orshansky. Though innovative for its time, its methodology is now out of date and it is no longer an accurate measure of poverty. Even the Census Bureau now characterizes the official poverty measure as a "statistical yardstick rather than a complete description of what people and families need to live."[1] The most significant shortcoming of the official poverty measure is that for most families, in most places, it is simply too low.

Over time, a variety of alternative measures have been developed to address some of the common critiques of the official poverty measure.[2] Two of these alternative measures include the Self-Sufficiency Standard developed by Dr. Diana Pearce and the Household Survival Budget developed as part of United Way's ALICE project. Both the Self-Sufficiency Standard and the United Way's ALICE share many similarities but at the same time they have different approaches to the development, calculation, and analysis done with each measure. Below is an overview of each measure, a comparison of their methodologies, and an explanation of how they differ in answering two basic questions, "How much does it cost to live at a minimally adequate level?" and "How many people lack adequate income to meet their basic needs?"

The Self Sufficiency Standard

The Self-Sufficiency Standard project was first calculated in 1996 by Diana Pearce, who at that time was Director of the Women and Poverty Project at Wider Opportunities for Women. The Self-Sufficiency Standard project is now housed at the University of Washington's Center for Women's Welfare. Originally, the Standard was developed to measure progress of workforce program participants towards the goal of economic self-sufficiency but has since been used in a wide variety of settings, to evaluate programs,

1 Carmen DeNavas-Walt and Bernadette Proctor, "Income and Poverty in the United States: 2014," U.S. Census Bureau, Current Population Reports, Series P60-252, https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf (accessed May 9, 2016).
2 For examples, see https://www.census.gov/hhes/povmeas/publications/other/udusbd3.pdf and https://gallery.mailchimp.com/bf2b9b3cf3fdd8861943fca2f/files/Insight_MeasuringUp_FullReport_Web_01.pdf

analyze policy impacts, and to document the nature and extent of poverty. The Standard has now been calculated over a 100 times across 38 states plus the District of Columbia.

The Self-Sufficiency Standard is published in state reports by the Center for Women's Welfare. The state reports provide a detailed overview of the cost of living at a basic needs' level within a given state. The Center for Women's Welfare *Overlooked and Undercounted* report series analyzes the characteristics of households above and below the Self-Sufficiency Standard in a given state or city.

ALICE: Asset Limited, Income Constrained, Employed

The United Way ALICE project was started in 2009 by the United Way of Northern New Jersey and expanded to other states in 2014. ALICE is an acronym that stands for "Asset Limited, Income Constrained, Employed" and has now been calculated in 15 states. Most of the content of the ALICE reports are focused on the overall negative effects of income inadequacy on ALICE families, their communities, and the state.

Comparison #1: Differences in Family Budgets

The definition of the family budgets for both ALICE and the Self-Sufficiency Standard are very similar. The ALICE report defines the Household Survival Budget as one that, in Indiana for example, "calculates the actual costs of basic necessities (housing, child care, food, health care, and transportation) in Indiana, adjusted for different counties and household types" (Indiana ALICE, 2016, p. 3).[3] Likewise the Self-Sufficiency Standard "measures how much income a family of a certain composition in a given place needs to adequately meet their basic needs—without public or private assistance" (Wyoming SSS, 2016, pg. 1).[4] Both family budgets include the same basic cost components: housing, child care, food, health care, transportation, miscellaneous, and taxes. Both family budgets are designed for working-age adults and built around the minimum actual costs a family would face. As the ALICE budget is focused on "survival" versus "self-sufficiency," the methodology choices made by ALICE typically result in a somewhat lower budget.

The largest difference in the budget calculations is in the number of budgets calculated. While originally calculated for 70 family types, the Standard now provides budgets for a comprehensive set of over 700 family types, making it a useful tool for practitioners as well for policy analysis.[5] The Standard is calculated at a county level and sub-county areas (such as cities), data permitting. The ALICE Household Survival Budget is calculated for six family types and reported at the county level (although cost data does not actually always vary at the county level).

Nevertheless, while many of the data sources and assumptions are similar, there are significant methodological differences in the calculation of the Self-Sufficiency Standard and the Household Survival Budget, as compared in Appendix A. Table 1 shows the resulting difference in each cost component of the two budgets for a single adult and a family with two adults, one infant, and one preschooler in Thurston County, Washington.

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3 See http://www.unitedwayalice.org/documents/16UW%20ALICE%20Report_INDUpdate_lowres_9.23.16.pdf. Note, ALICE also calculates a Household Stability Budget, however, the ALICE Threshold is based on the Household Survival Budget. Thus, this comparison is limited to the Household Stability Budget.

4 See http://www.selfsufficiencystandard.org/sites/default/files/selfsuff/docs/WY2016.pdf

5 The Self-Sufficiency Standard calculates costs for infants, preschoolers, school-age children, and teenagers. The Standard is calculated for household combinations of up to ten adults and ten children for the four different age groups. ALICE reports data for households with one adult and households with two adults, one infant and one preschooler. The Rutgers website also includes budgets for the following: "two adults; one adult one child; one adult one childcare; two adults two childcare." One child is indicated to be an infant and two children implies one infant and one preschooler. There appears to be no description as to the difference of one child versus one childcare (both include the child care cost category).

Table 1 *Comparison of the ALICE Household Survival Budget and the Self-Sufficiency Standard: Thurston County, WA 2013 and 2014*

	Single Adult		2 Adults, 1 Infant, 1 Preschooler	
	ALICE 2013	**SSS 2014**	**ALICE 2013**	**SSS 2014**
Housing	$721	$838	$963	$1,026
Child Care	-	$0	$1,267	$1,695
Food	$191	$251	$579	$716
Transportation	$350	$255	$700	$502
Health Care	$119	$116	$474	$482
Miscellaneous	$156	$146	$425	$442
Taxes-Net	$183	$274	$270	$575
Monthly	$1,720	$1,879	$4,678	$5,438
Annual	$20,640	$22,553	$56,136	$65,255
Hourly	$10.32	$10.68	$14.04 *per adult*	$15.45 *per adult*)
See http://www.unitedwayalice.org/documents/15UW%20ALICE%20Report_PNW_Lowres_10.27.16.pdf and http://selfsufficiencystandard.org/sites/default/files/selfsuff/docs/WA2014_SSS_Aug2015Rev.pdf				

Comparison #2: Difference in Demographic Methods

While the above shows that the budget calculations do differ somewhat, by far the greatest difference between these two measures is in how the budgets are used to calculate the number of people falling below the respective budget thresholds. *ALICE uses a method for calculating the numbers below its threshold that is rudimentary, leading to overestimations overall, and inaccurate over and under estimations for specific groups, such as by race; the Standard uses established demographic methods and Census data to calculate the numbers above and below the Standard.*

While each project uses the same data source, different methodological decisions are made. Both projects determine how many households are struggling to meet basic needs by comparing their thresholds with data from the U.S. Census Bureau's American Community Survey (ACS). This is where the similarity ends, however. Below is a step-by-step comparison of how each measure derives its numbers of how many households with working-age adults lack adequate income.[6]

1. Define Thresholds

a. *Self-Sufficiency Standard:* The Standard codes each household in the ACS Public Use Microdata Sample dataset with the appropriate Self-Sufficiency Standard, based on their family type (originally 152 variations, now 700+) and geographic location.[7]

b. *ALICE:* The ALICE project calculates one "ALICE Threshold" per county. The ALICE Threshold for householders under 65 is calculated by adding together the single adult Household Survival Budget

6 Note on households whose heads are over 65 years old: The Self-Sufficiency Standard assumes that all adults work, and that all income is from earnings, and therefore includes expenses incurred by workers, such as transportation, as well as tax rates applicable to those under 65 who are employed. A separate measure, the Retirement-Adjusted Standard is calculated, taking into account the different expenses and taxes for those over 65. Demographic counts to date have only used the Self-Sufficiency Standard, and exclude seniors and those with work-limiting disability. ALICE uses the same budgets for seniors and those with disabilities, without adjustment as were developed for working age households. ALICE demographic calculations create a separate threshold for senior households. For households over 65, the single adult budget is multiplied by the average senior household size to obtain the over 65 threshold, which is also rounded to the Census bracket. Published tables are then used to estimate the number over 65 households below ALICE, the same method as used with under 65 households.

7 Note that for confidentiality the ACS data is pooled into Public Use Microdata Areas (PUMAs) which are statistical geographic areas that contain at least 100,000 people. If a PUMA contains more than one county, a population weighted Standard is used.

and the Household Survival Budget for a four-person family (two adults, one infant, and one preschooler). This amount is then divided by five to obtain a per person average amount, which is then multiplied by the average household size. Finally, this amount is then rounded to the nearest Census bracket. This rounded number becomes the ALICE threshold. Using Thurston County as an example, this would be the calculation for its ALICE threshold:

$20,640 + $56,136 = $76,776/5 = $15,355 x 2.89 = $44,328; Rounded = $45,000.

2. Counting the Number Below the Thresholds:

a. *Self-Sufficiency Standard:* The income of each household in the ACS microdata sample is compared to its SSS threshold; if income is less than the threshold, the household is deemed to have inadequate income. The number of households below the threshold is then summed. This is the method used in Census reports to report official poverty, that is, each household is compared to its poverty threshold to determine poverty status.

b. *ALICE:* The number of households (under 65) which have income that falls below the single ALICE threshold (income bracket) are determined, using Census tables. Note that the ALICE project uses the published ACS "Detailed Tables" with income brackets that vary by $5,000 increments, not an individual person or household file.

EXAMPLE: Comparing Results of Demographic Calculations

Both the United Way ALICE and the Center for Women's Welfare have calculated the percentage of households below the Standard in Washington State using the 2013 American Community Survey.[8] Using the methodology described above, ALICE calculates that 34% of households in Thurston County have incomes below ALICE. In contrast, the Center for Women's Welfare calculates that 26% of households in Thurston County, with a working-age adult, are below the Standard.

Table 2 *Households Below ALICE and Below the Self-Sufficiency Standard: Thurston County, WA 2013*

ALICE (householder under 65)		**Self-Sufficiency Standard (householder under 65, without work-limiting disability)**	
Total households	76,389	Total households	*67,352*
ALICE Threshold	$45,000	Varies by 152 family types	--
Number of households below ALICE Threshold	**25,650**	**Number of households below SSS**	**17,728**
Percentage of households below ALICE	**34%**	**Percentage of households below SSS**	**26%**

Sources: Number of households by household income: http://factfinder.census.gov/bkmk/table/1.0/en/ACS/13_1YR/B19037/0400000US53.05000; ALICE Threshold for Thurston County: http://unitedwayalice.org/documents/15UW%20ALICE%20Report_PNW_Lowres_1.12.16.pdf (page 155 and 334)

The budgets in the Self-Sufficiency Standard for Thurston County are quite a bit higher than the Household Survival Budgets used to calculate the ALICE Thresholds. However, the ALICE methodology results in a count of MORE households estimated to be struggling to meet their basic needs. *A lower budget threshold should*

8 See http://www.unitedwayalice.org/documents/15UW%20ALICE%20Report_PNW_Lowres_10.27.16.pdf and "What the Great Recession Hath Wrought" (paper presented at the 2016 American Sociological Association Annual Meeting).

result in fewer households with inadequate income not more households. What accounts for the difference in the counts? The major reason for the difference is that in ALICE all households, regardless of size, are treated the same, i.e., compared to the same threshold. This results in smaller households being over-counted, and larger households being undercounted.

The ALICE methodology harkens back to the approach taken by the Council of Economic Advisers under President Kennedy; they used a threshold of $1,000 for individuals, and $3,000 for all families, regardless of size. This concerned Mollie Orshansky, then with the Social Security Administration, as she felt it underestimated poverty among larger families, and was the impetus for her to develop the official poverty measure still in use today, which varies by the number of adults and the number of children (for a total of 51 thresholds for working-age households). Using just a single threshold, as is done by ALICE, as with the 1960s Council of Economic Advisers, overestimates the number of small households lacking adequate income, and underestimates the number of larger households lacking adequate income. Because household size varies by race/ethnicity, those groups with larger households on average will have their poverty underestimated compared to race or ethnic groups with smaller average household size. Overall, there is no way to know whether the over and undercounts balance out, across places; however, when comparisons are possible, ALICE estimates tend to be somewhat higher than those done with the Standard using standard demographic methods.

Conclusion

Both the Self-Sufficiency Standard and the ALICE project demonstrate that the official poverty measure is too low and undercounts the number of households struggling to make ends meet. The ALICE Household Survival Budget is not designed to be sustainable over time and thus provides a more modest budget than the Self-Sufficiency Standard. The ALICE project provides a communication tool for United Ways to give voice to the communities served by United Ways. The Self-Sufficiency Standard is used extensively in workforce and community organizations directly with clients where a more comprehensive and accurate set of calculations by family type and place is required, including in online applications that estimate benefit eligibility and to determine self-sufficiency strategies. While creating a limited number of family budgets is sufficient for storytelling and raising awareness, readers should heed caution in using ALICE for decision making in program evaluation, client counseling, and policy making, particularly estimates of the demographics of this population.

Appendix A. Comparison of the Methodologies used by The Self-Sufficiency Standard and United Way's ALICE

Family Budgets		
	Center for Women's Welfare Self-Sufficiency Standard	United Way's ALICE Household Survival Budget
Family Types	Builds each individual budget from scratch for 700+ family types.	Builds budgets for 6 family types and supplies multipliers for estimating the costs for additional children.
Housing	Uses U.S. Housing and Urban Development 40th percentile Fair Market Rents. Metro areas with more than one county in an FMR are varied using rent ratios calculated using ACS 3-year rent estimates. Assumes one bedroom for a single adult, and where there are two or more members of a household, adults and children will have separate bedrooms, with up to two adults or children per room.	Uses U.S. Housing and Urban Development 40th percentile Fair Market Rents. Assumes the cost of a studio apartment for a single person, a one-bedroom apartment for a head of household with a child, and a two-bedroom apartment for a family of three or more.
Food	Uses the USDA Low-Cost food plan, adjusting for county variation using Map the Meal Gap's Nielsen Grocery data.	Uses the USDA Thrifty food plan, adjusting for variation by census region.
Health Care	Insurance premiums are obtained from the Insurance Component of the Medical Expenditure Panel Survey (MEPS). The health insurance exchange benchmark plan is used to vary the average state premium from MEPS by the geographic rating areas. Data for out-of-pocket health care costs (by age) are also obtained from the MEPS, adjusted by Census region using the MEPS Household Component Analytical Tool.	Includes average out-of-pocket expenditures from the Consumer Expenditure Survey and the Affordable Care Act penalty for not having coverage.
Child Care	Calculated using market rate survey at the *75th percentile* for child care costs. Infants and preschoolers are assumed to be in full-time care, and school-age children in part-time care. Calculates the cost of care based on a weighted average of family and center care (reflecting average choices by age).	Uses the *average* cost of family home care for 1 infant & 1 preschooler, from Child Care Aware of America's survey of Child Care Resource & Referral Network. State averages are used for missing data. School-age costs are not calculated.
Transportation	Public transportation is assumed when 7% of the population uses public transportation to commute. The cost for public transportation is based on the cost of a monthly transit pass. The Standard calculates private transportation costs based on the expense of owning and operating a car, using state-level per-mile costs, commuting distances, auto insurance premiums (varied within state), and U.S. average fixed costs of car ownership. Travel is limited to commuting to work and day care plus one shopping trip per week.	Public transportation is assumed when 8% of the population uses public transportation to commute. The cost for public transportation is the average expenditures from the Consumer Expenditure Survey (CEX) for bus, trolley, subway, elevated train, railroad, and ferryboats. Private transportation costs are calculated via the average expenditures for transportation by from the CEX.
Miscellaneous	10% of all other budget items pre-tax.	10% of all other budget items, including taxes.

Taxes	Includes federal and state income taxes, the Child Tax Credit, the Child and Dependent Care Credit, state tax credits, as well as Social Security and Medicare taxes. Also includes the Earned Income Tax Credit and sales tax on miscellaneous expenses.	Includes federal and state income taxes, the Child Tax Credit, the Child and Dependent Care Credit, state tax credits, as well as Social Security and Medicare taxes. EITC is NOT included.
Demographic Analysis		
Threshold	Using Census microdata, each household is matched to the Standard for their family type and place, and then evaluated to see if their income is above or below the threshold of the Standard.	One income threshold is calculated for each county based on the two family types (single adult and one four-person family type) for those below 65 years of age, and compared to bracketed income data. All families below the income threshold are considered ALICE.
Seniors	The Self-Sufficiency Standard is designed for working-age adults. Thus, seniors are excluded from demographic counts. (A separate measure for seniors is calculated as the Retirement-Adjusted Standard; see note.)	Includes households headed by seniors with no cost adjustments; one income threshold is calculated using the single adult threshold multiplied by average senior household size, and compared to bracketed income data.
Disabilities	The Self-Sufficiency Standard is designed for working-age adults. Thus, it excludes adults with work-limiting disability.	Includes households headed by adults with disabilities with no cost adjustments.