2016 Community Health Needs Assessment

Kaiser Foundation Health Plan of the Mid-Atlantic States, Incorporated

Approved by KFH Board of Directors
May 30, 2016

To provide feedback about this Community Health Needs Assessment, email CHNA-communications@kp.org

KAISER PERMANENTE®

AUTHORS

Destiny-Simone Ramjohn, Ph.D. contributed significantly to the conception, design, execution, analysis and interpretation of the primary and secondary data, and the drafting, reviewing, and revising of the report's intellectual content.

Maya Nadison, Ph.D. contributed significantly to the analysis and interpretation of the secondary data, as well as the drafting, reviewing, and revising of the report's intellectual content.

Stacey Lloyd, M.P.H. contributed significantly to the collection, analysis, and interpretation of the primary data, and reviewing of the report's intellectual content.

Jessica Finkel, M.A. contributed significantly to the collection and interpretation of the primary and secondary data, as well as the reviewing of the report's intellectual content.

ACKNOWLEDGEMENTS

The Kaiser Foundation Health Plan of the Mid-Atlantic States (KFHP-MAS) 2016 Community Health Needs Assessment (CHNA) teamwas primarily composed of independent consultants who worked under the leadership of the CHNA lead at KFHP-MAS: Destiny-Simone Ramjohn, Program Manager, Community Health Strategy, Research, and Evaluation. The CHNA team, along with Tanya Edelin, Director of Compliance, Reporting, and Finance, and Maritha Gay, Executive Director, Community Benefit, would like to thank the following for their participation and assistance:

Access to Wholistic Living
Alexandria City Department of Health
Alexandria Department of Human Services, Office of Community & Human Services
Anne Arundel County Health Department
Arlington Free Clinic
Arlington Pediatric Center
Baltimore City Community College
Baltimore City Foundation
Baltimore City Health Department
Baltimore Community Foundation, Incorporated
Baltimore County Health Department
Baltimore Medical Systems
Baltimore Office of Sustainability/Department of Planning
Bon Secours Community Works
Bread for the City
Care for Kids/ Primary Kids Coalition
Casa de Maryland
Catholic Charities
Central Virginia Health Services
Chase Brexton
Child & Family Center Foundation
Common Health Action
Community Clinic, Incorporated
Community College of Baltimore County
Community Health and Empowerment Through Education and Research, Incorporated
Coppin State University
Crittenton Services of Greater Washington
DC Central Kitchen, Incorporated
DC Department of Health
DC Greens, Incorporated
Department of Social Services
Dru-Mondawmin Health Families, Incorporated
ECO City Farms
Fairfax County Health Department
Food Research and Action Center/DC Hunger Solutions
FoodCorps
Frederick County Health Department
Future Harvest, Incorporated
Greater Baden Medical Services, Incorporated
Health Initiative Foundation
HealthWorks for Northern Virginia
Howard Community College
Howard County Health Department
Institute for Public Health Innovation
Living Classrooms Foundation
Loudoun County Health Department
Loudoun Interfaith Relief
Martha's Table, Incorporated
Maryland Farmers Market Association
Mentoring to Manhood Incorporated
Molina Healthcare of Virginia
Montgomery College, Silver Spring Campus
Montgomery County Department of Health and Human Services
Neighbor's Keeper
Northern Virginia Family Services
Northern Virginia Health Foundation
NOVA Scripts Central
Playworks Baltimore
Prince George's County Health Department
Prince William Health District, Virginia Health Department
Rappahannock Health District, Virginia Health Department
REAL School Gardens
Sentara Hospital
Share our Strength
The Community Foundation for the National Capital Region
The Horizon Foundation
The Marshall Alliance
University of Maryland- School of Nursing
University of Maryland- School of Public Health
US Soccer Foundation
Virginia Association of Free Clinics
Virginia Healthcare Foundation

TABLE OF CONTENTS

List of Tables

List of Figures

List of Appendices

I. EXECUTIVE SUMMARY

"As a trusted partner in total health, we need to collaborate with local business and community leaders, and even our competitors, to create communities that are among the healthiest in the nation. This is critical to fulfill our mission and to make healthcare more affordable for all."
-Bernard Tyson, Chairman and CEO, Kaiser Permanente

A. Community Health Needs Assessment Background

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf).

While Kaiser Permanente has conducted CHNAs for many years to identify needs and resources in our communities and to guide our Community Benefit plans, these new requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhancing compliance and transparency and leveraging emerging technologies. The CHNA process undertaken in 2016 and described in this report was conducted in compliance with current federal requirements.

The 2016 CHNA provides Kaiser Foundation Health Plan of the Mid-Atlantic States, Incorporated (KFHP-MAS) with an unparalleled opportunity to reconsider health care's role in creating healthy communities and increasing the measurably beneficial impacts on population and community health.

KFHP-MAS' commitment to addressing the social determinants of health through business and non-clinical practices has the potential to greatly improve our health system's quality and cost-effectiveness while simultaneously significantly benefiting society. Among other strategic activities, the emphasis on total health requires a greater emphasis on structured and standardized methods for identifying and prioritizing community needs.

The findings of this report represent KFHP-MAS' coordinated first step in addressing identified health needs. Details describing KFHP-MAS' planned response to the needs identified through the CHNA process are outlined in a separate document, the CHNA Implementation Strategy report.

B. Summary of Prioritized Needs

This CHNA was completed through a multi-stage and mixed methods approach designed to integrate findings from secondary data with the experiences, expertise, and opinions of key community stakeholders gathered through primary data collection. Table 1 displays the health needs identified for KFHP-MAS, as well as select indicators that performed unfavorably**.**

For detailed information on the regional health needs and supporting data, please refer to the health need profiles presented in Appendix A.

Table 1. KFHP-MAS CHNA Identified Health Needs

Health Need	Overview	Snapshot of Unfavorable Indicators
Socioeconomic Security	Research – including this study – shows particularly strong and consistent associations between socioeconomic security, such as access to employment, education, and income across time and geography, and a variety of health outcomes. There are also solid, credible mechanisms explaining why lower socioeconomic groups have poorer health outcomes.[1]	Percent of population without high school diploma Rate of high school graduation Percent of 3rd graders not reading at "basic" levels on state exams Rate of unemployment Percent of children living below 100% of Federal Poverty Level Percent of population living below 100% of Federal Poverty Level
Health Care Access	Access to affordable, quality health care is important to physical, social, and mental health, as well as to the achievement of health equity. Health insurance helps individuals and families access needed primary care, specialists, and emergency care, but it does not ensure access on its own. Providers must also offer affordable care, be available to treat patients, and be in relatively close proximity to patients.[2]	Percent of population enrolled in Medicaid Percent of population without health insurance coverage Percent of children who are uninsured Percent of adults without regular health care provider Preventable hospital events per 1,000 Medicare enrollees
Obesity/ Overweight	The environments where we live, learn, work, and play affect our access to healthy food and opportunities for physical activity that, along with genetic factors and personal choices, shape our health and risk of being overweight or obese.[3]	Percent of adults who are obese (Body Mass Index greater than 30.0) Percent of adults with inadequate fruit/ vegetables consumption Percent of adults who are physically inactive Number of recreation and fitness facilities per 100,000 population Percent of adults who are overweight (Body Mass Index between 25.0 and 30.0)
Mental Health	Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through all phases of adulthood. According to the National Alliance on Mental Illness, approximately 1 in 5 adults in the US – 43.8 million, or 18.5% – experiences mental illness in a given year.[4]	Number of mentally unhealthy days in past 30 days Rate of suicide per 100,000 population Rate of drug-related deaths per 100,000 population Rate of mental health providers per 100,000 population
Diabetes	Diabetes is a condition where blood sugar glucose levels are erratic. It is associated with cardiovascular disease, kidney failure, blindness, and amputations.[3] Diabetes affects 29.1 million people in the US (one in eleven people), and is the seventh-leading cause of death. Moderate weight loss and exercise can prevent or delay Type 2 diabetes in individuals at high risk.	Percent of diabetes prevalence in adult population Percent of population living in food deserts
Physical Environment	The housing options and transit systems that shape our communities' built environment affect where we live and how we get from place to place. The choices we make about housing and transportation, and the opportunities underlying these choices, also affect our health.[2]	Percent of adults living in substandard housing Percent of vacant housing units Percent of cost-burdened households (exceeding 30% of income) Percent of population living less than 0.5 miles from transit stop

C. Summary of Needs Assessment Methodology and Process

The KFHP-MAS region consists of three service areas: greater Baltimore (BALT), District of Columbia and Suburban Maryland (DCSM), and Northern Virginia (NOVA). Table 2 presents the cities and counties selected for inclusion in the CHNA by service area. Findings throughout the report are presented by service area. Methods described in the report were repeated for BALT, DCSM, and NOVA unless otherwise specified.

Table 2. KFHP-MAS Cities and Counties Included in CHNA Report

BALT	DCSM	NOVA
Anne Arundel County	District of Columbia	Alexandria City
Baltimore City	Frederick County	Arlington County
Baltimore County	Montgomery County	Fairfax County
Howard County	Prince George's County	Loudoun County
		Prince William County

The needs assessment method and process may be summarized as follows:

Conceptual Framework Identification: The KFHP-MAS CHNA applies the University of Wisconsin Population Health Institute's County Health Rankings model. The County Health Rankings model of population health underscores the multi-level determinants of health with the goal of identifying specific factors that, if improved, can help communities thrive.[5] The framework illustrates the interrelationships among the elements of health, including social and economic factors, health behaviors, clinical care, and physical environment.[5]

Secondary Data Review: In keeping with the County Health Rankings framework, secondary data were reviewed from a wide range of national, state, and local sources to present the multi-level determinants of health, including demographics, mortality, morbidity, health behaviors, clinical care, social and economic factors, and physical environment between October 2015 and January 2016. To facilitate the secondary data review, KFHP-MAS used the Kaiser Permanente CHNA Data Platform.[6] The KP CHNA Data Platform is a web-based platform with pre-populated national, state and local data for over 150 indicators. Select indicators were excluded when the data were non-local sources (e.g., California data sources) or deemed non-essential to draw regional conclusions (e.g., no access to air conditioning). After the selection process, 95 indicators from the platform and other publicly available data sources were selected for closer investigation. These secondary data were then compared to relevant benchmarks, including Healthy People 2020 and other national or state level data where available. A threshold of 10% difference from the benchmark was used to highlight poorly performing indicators. When available, data were stratified by racial/ethnic group.

Community Input Collection: The community input process was completed between December 2015 and February 2016. The process included creating and administering stakeholder surveys and expert interviews, as well as completing inventory of community assets and resources.

Expert Interviews: Input was gathered during 15 interviews with key stakeholders selected with the assistance of the KFHP-MAS Community Benefit Executive Director and staff. Interviewees included health department directors and social service providers, amongst others. Interviews were conducted via telephone for approximately 45 minutes each; conversations were confidential and interviewers adhered to standard ethical research guidelines. Interviewees were asked to identify community health needs, including health outcomes and health drivers, as well as existing community collaborations, assets, and resources to address needs.

Stakeholder Surveys: A total of 58 community leaders and other relevant community representatives with knowledge of their respective service areas provided input via electronic surveys. The survey was developed using SurveyMonkey®. Survey respondents were asked to assess the severity of 30 health outcomes and drivers based on a scale of 1 to 4 (with 1 as "not severe" and 4 as "very severe"). In addition, respondents were asked to rank the top three health issues in their communities in order of severity.

Data Analysis: The CHNA analytic method, the triangulation design, is the most common and well-known approach to mixing methods.[7] The purpose of this design is "to obtain different but complementary data"[8] on the research topic or topics of interest, which in this instance were the health needs of the KFHP-MAS region. Consistent with the triangulation design, the CHNA team implemented quantitative and qualitative methods during the same time frame and with equal weight. Following this model, the CHNA team collected and analyzed the quantitative and qualitative data separately. Discrepant results were converged by comparing, contrasting, and reaching consensus on inconsistencies during the interpretation. This approach to data analysis ensures that valid and well-substantiated conclusions about identified health needs are presented.[9]

The result of the independent analyses of each of the data sets generated three sets of health needs presented by service area (BALT, DCSM, NOVA) and by data source. Identified health needs were then organized into three tiers based on the amount of data indicating a need. The three-tiered approach is defined as follows:

Tier 1: Only one source of data (secondary or survey or interview) indicates a need
Tier 2: Any two sources of data (secondary and/or survey or interview) indicate a need
Tier 3: All three sources of data (secondary and survey and interview) indicate a need

Priority Score Assignment: Tier 3 identified health needs were assigned a priority score based on the following: 1) racial disparities (confirmed by secondary data); 2) severity of the issue (verified by survey data); and 3) community prioritization of the issue (supported by interview data). The priority score was then used to generate a list of top health needs in each of the three service areas, with the highest score representing the greatest need. Once a priority score was assigned, primary and secondary data were compiled into three scorecards (one per service area) displaying health needs with comparisons to the available benchmarks. The scorecards allowed for a comprehensive display across all data sources by listing all identified secondary indicators and primary issues in one location. These scorecards include benchmark data, city and county level data, and indications for whether the health need was flagged based on secondary, survey, and/or interview data. Scorecards are presented Appendix B.

Regional Aggregation: The final task involved aggregating service area findings to provide a regional overview of identified health needs. Similar to the triangulation approach outlined above, regional health needs were identified as those Tier 3 health needs appearing in all three KFHP-MAS service areas.

This report focuses on the Tier 3 identified health needs by service area, as these needs were confirmed by all of the data utilized for this analysis.

D. Organization of Report

The sections that follow in this report reflect the unique geography of the KFHP-MAS region. As explained above, the region comprises three service areas defined as greater Baltimore (BALT), District

of Columbia/ Suburban Maryland (DCSM), and Northern Virginia (NOVA). The remainder of the report presents data and findings by service area.

II. INTRODUCTION/BACKGROUND

A. About Kaiser Permanente

Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health plans. We were created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since our beginnings, we have been committed to helping shape the future of health care. Among the innovations Kaiser Permanente has brought to U.S. health care are:

- Prepaid health plans, which spread the cost to make it more affordable
- A focus on preventing illness and disease as much as on caring for the sick
- An organized coordinated system that puts as many services as possible under one roof—all connected by an electronic medical record

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 10 million members in nine states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Care for members and patients is focused on their Total Health and guided by their personal physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

B. About Kaiser Permanente Community Benefit

For more than 70 years, Kaiser Permanente has been dedicated to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve. We believe good health is a fundamental right shared by all and we recognize that good health extends beyond the doctor's office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. These are the vital signs of healthy communities. Good health for the entire community, which we call Total Community Health, requires equity and social and economic well-being.

Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Historically, Kaiser Permanente has focused our investments in three areas—Health Access, Healthy Communities, and Health Knowledge—to address critical health issues in our communities.

For many years, Kaiser Permanente has worked side-by-side with other organizations to address serious public health issues such as obesity, access to care, and violence. Moreover, Kaiser

Permanente has conducted CHNAs to better understand each community's unique needs and resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sustainable change—and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

C. Purpose of the Community Health Needs Assessment Report

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a CHNA and develop an IS every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document. Both the CHNA Report and the IS for each Kaiser Foundation Hospital facility are available publicly at http://www.kp.org/chna.

D. Kaiser Permanente's Approach to Community Health Needs Assessments

Kaiser Permanente has conducted CHNAs for many years, often as part of long standing community collaboratives. The new federal CHNA requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency and leveraging emerging technologies. Our intention is to develop and implement a transparent, rigorous, and as often as possible, collaborative approach to understanding the needs and assets in our communities. From data collection and analysis to the identification of prioritized needs and the development of an implementation strategy, the intent was to develop a rigorous process that would yield meaningful results.

Kaiser Permanente's innovative approach to CHNAs includes the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of approximately 150 publicly available indicators to understand health through a framework that includes social and economic factors; health behaviors; physical environment; clinical care; and health outcomes.

In addition to reviewing the secondary data available through the CHNA data platform, and in some cases other local sources, each KFH facility, individually or with a collaborative, collected primary data through key informant interviews, focus groups, and surveys. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

Each hospital/collaborative developed a set of criteria to determine what constituted a health need in their community. Once all of the community health needs were identified, they were all prioritized, based on identified criteria. This process resulted in a complete list of prioritized community health needs. The process and the outcome of the CHNA are described in this report.

In conjunction with this report, KFHP-MAS will develop an implementation strategy for the priority health needs we will address. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, http://www.kp.org/chna.

III. COMMUNITY SERVED

A. Kaiser Permanente's Definition of Community Served

Kaiser Permanente defines the community served as those individuals residing within its service area. A service area includes all residents in a defined geographic area surrounding its medical facilities and does not exclude low-income or underserved populations.

B. Map and Description of Community Served

KFHP-MAS operates in 29 locations, serving over 660,000 members in Maryland, Virginia, and the District of Columbia.

A map of the KFHP-MAS region is presented in Figure 1.

i. Map

Figure 1. Map of KFHP-MAS Communities Served

ii. Geographic description of communities served

Cities and counties from the KFHP-MAS region were selected for inclusion in this study based on the following criteria: 1) the city or county contains a Kaiser Permanente Medical Office Building and, 2) the population of the city or county represents greater than 1% of the population served within the Mid-Atlantic States. Table 3 displays the 13 cities and counties selected for CHNA inclusion based on these criteria, as well as the corresponding zip codes.

Table 3. KFHP-MAS List of Cities and Counties, including Corresponding Zip Codes

Service Area	City/County	Zip Codes
BALT		
	Anne Arundel County	20711 20724 20733 20751 20755 20758 20764 20765 20776 20778 20779 21012 21032 21035 21037 21054 21056 21060 21061 21062 21076 21077 21090 21106 21108 21113 21114 21122 21123 21140 21144 21146 21226 21240 21401 21402 21403 21404 21405 21409 21411
	Baltimore City	21201 21202 21203 21205 21206 21209 21210 21211 21212 21213 21214 21215 21216 21217 21218 21223 21224 21225 21229 21230 21231 21233 21235 21239 21241 21251 21278 21281 21287 21290 21297
	Baltimore County	21013 21020 21022 21023 21027 21030 21031 21051 21052 21053 21057 21065 21071 21082 21087 21092 21093 21094 21105 21111 21117 21120 21128 2113121133 21136 21139 21152 21153 21155 21156 21162 21204 21207 21208 21219 21220 21221 21222 21227 21228 21234 21236 21237 21244 21250 21252 21282 21284 21285 21286
	Howard County	20701 20723 20759 20763 20777 20794 21029 21036 21041 21042 21043 21044 21045 21046 21075 21150 21163 21723 21737 21738 21765 21794 21797
DCSM		
	District of Columbia	20001 20002 20003 20004 20005 20006 20007 20008 20009 20010 20011 20012 20013 20015 20016 20017 20018 20019 20020 20022 20024 20026 20027 20030 20032 20035 20036 20037 20038 20039 20040 20041 20042 20043 20044 20045 20046 20049 20050 20052 20056 20057 20058 20059 20060 20062 20064 20065 20066 20068 20070 20071 20076 20080 20082 20090 20091 20201 20202 20204 20206 20207 20210 20212 20219 20220 20222 20223 20224 20226 20228 20229 20230 20233 20237 20240 20241 20242 20250 20260 20301 20303 20310 20314 20317 20318 20319 20330 20340 20350 20372 20373 20374 20375 20376 20380 20388 20390 20391 20392 20393 20394 20395 20398 20401 20405 20407 20408 20410 20413 20415 20416 20418 20420 20421 20422 20426 20429 20431 20433 20435 20436 20439 20447 20451 20460 20463 20472 20500 20501 20502 20503 20505 20506 20507 20508 20510 20511 20515 20520 20522 20523 20525 20526 20527 20528 20529 20530 20531 20534 20535 20536 20538 20540 20543 20544 20546 20547 20548 20549 20551 20552 20553 20554 20560 20565 20566 20571 20572 20577 20579 20580 20581 20585 20590 20591 20593
	Frederick County	21701 21702 21703 21704 21705 21709 21710 21714 21716 21717 21718 21727 21754 21755 21758 21762 21769 21770 21771 21773 21774 21775 21777 21778 21780 21788 21790 21792 21793 21798
	Montgomery County	20810 20812 20813 20814 20815 20816 20817 20818 20824 20825 20827 20830 20832 20833 20837 20838 20839 20841 20842 20847 20848 20849 20850 20851 20852 20853 20854 20855 20857 20859 20860 20861 20862 20866 20868 20871 20872 20874 20875 20876 20877 20878 20879 20880 20882 20883 20884 20885 20886 20889 20891 20892 20894 20895 20896 20897 20898 20899 20901 20902

		20903 20904 20905 20906 20907 20908 20910 20911 20912 20913 20914 20915 20916 20993
	Prince George's County	20607 20608 20613 20623 20703 20704 20705 20706 20707 20708 20709 20710 20712 20715 20716 20717 20718 20719 20720 20721 20722 20725 20726 20731 20735 20737 20738 20740 20741 20742 20743 20744 20745 20746 20747 20748 20749 20752 20753 20757 20762 20768 20769 20770 20771 20772 20773 20774 20775 20781 20782 20783 20784 20785 2078720788 20790 20791 20792 20797 20799
NOVA		
	Alexandria City	22301 22302 22304 22305 22311 22313 22314 22320 22331 22332 22333 22350
	Arlington County	22201 22202 22203 22204 22205 22206 22207 22209 22209 22210 22211 22213 22214 22215 22216 22219 22222 22225 22230 22240 22243 22244 22245 22246
	Fairfax County	20120 20121 20122 20124 20151 20153 20170 20171 20172 20190 20191 20192 20194 20195 20196 22003 22009 22015 22027 22031 22032 22033 22034 22035 22036 22037 22039 22041 22042 22043 22044 22060 22066 22079 22082 22096 22101 22102 22103 22106 22107 22108 22109 22116 22121 22122 22124 22150 22151 22152 22153 22156 22159 22180 22181 22182 22183 22185 22199 22303 22306 22307 22308 22309 22310 22312 22315 22030 22038
	Loudoun County	20101 20102 20103 20104 20105 20117 20118 20129 20131 20132 20134 20141 20142 20146 20147 20148 20152 20158 20159 20160 20164 20165 20166 20167 20175 20176 20177 20178 20180 20189 20197 20598
	Prince William County	20109 20111 20112 20136 20143 20155 20156 20168 20169 20181 20182 22025 22026 22125 22134 22172 22191 22192 22193 22194 22195

The following cities and counties did not meet the established criteria: Fairfax City (pop. est. 23,027); Falls Church City (pop. est. 12,731); Fredericksburg City (pop. est. 25,931); Manassas City (pop. est. 19,658); and Stafford County (pop. est. 66,290).

iii. Demographic description of communities served

An overall demographic profile of the region is presented in Tables 4 and 5. Data for each of the cities and counties included in this report are presented by service area in Figures 2, 3, and 4.

Table 4. Regional Demographic Profile

Demographic Data (Region)	
Total Population	7,303,724
White	54.3%
Black	28.6%
Asian	9.0%
Native American/ Alaskan Native	0.3%
Pacific Islander/ Native Hawaiian	0.1%
Some Other Race	4.3%
Multiple Races	3.4%
Hispanic/Latino*	12.3%

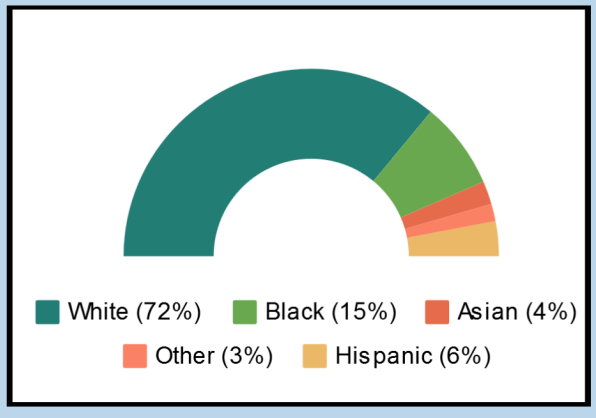
Table 5. Regional Socioeconomic Profile

Socioeconomic Data (Region)	
Living in Poverty (<200% FPL)	21.6%
Children in Poverty (<100% FPL)	12.3%
Unemployed	4.5%
Uninsured	10.6%
No High School Diploma	10.3%

Figure 2. Greater Baltimore Service Area Demographic Profile

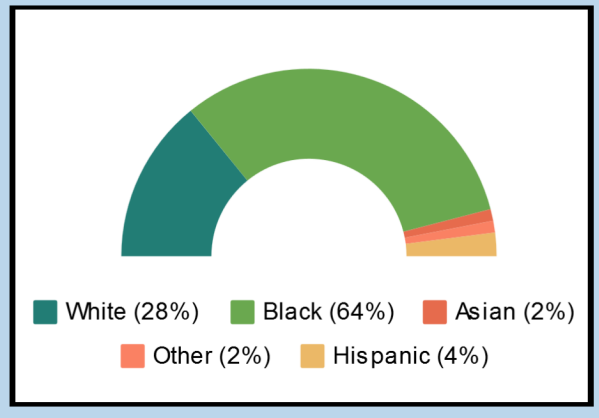
Anne Arundel County

- Population: 544,426
- 50.5% 49.5%
- High school graduation rate: 85.0%
- Uninsured: 7.8%
- Below 100% FPL: 6.3%
- Unemployed: 4.8%
- Median age: 38.5
- 24.0% of service area



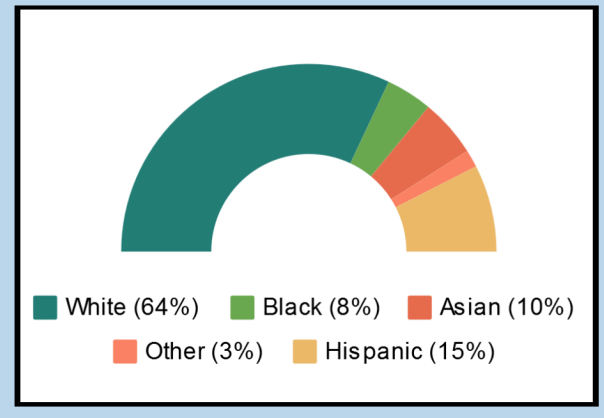
Baltimore City

- Population: 621,445
- 52.9% 47.1%
- High school graduation rate: 66.0%
- Uninsured: 13.1%
- Below 100% FPL: 23.8%
- Unemployed: 8.1%
- Median age: 34.5
- 27.3% of service area



Baltimore County

- Population: 812,261
- 52.7% 47.3%
- High school graduation rate: 84.0%
- Uninsured: 9.4%
- Below 100% FPL: 8.9%
- Unemployed: 5.8%
- Median age: 39.1
- 35.8% of service area



Howard County

- Population: 293,821
- 51.0% 49.9%
- High school graduation rate: 90.0%
- Uninsured: 7.2%
- Below 100% FPL: 4.6%
- Unemployed: 4.2%
- Median age: 38.6
- 12.9% of service area

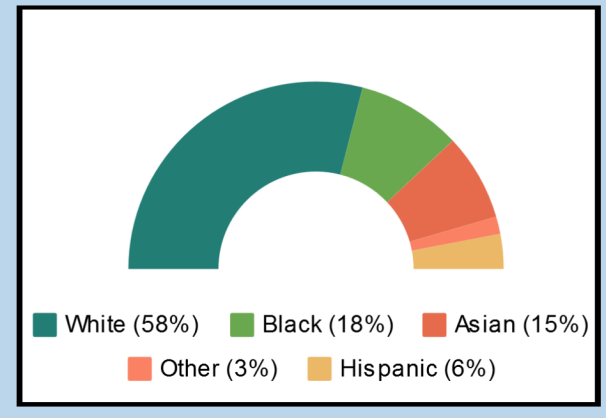
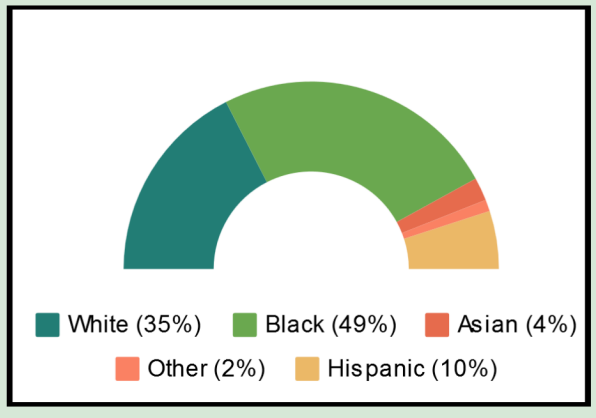


Figure 3. District of Columbia-Suburban Maryland Service Area Demographic Profile

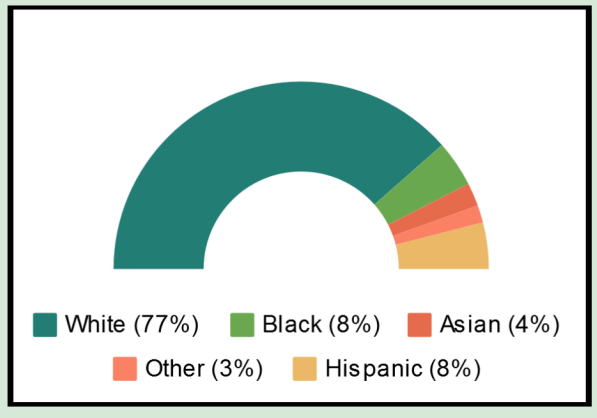
District of Columbia

- Population: 619,371
- 52.7% | 47.3%
- High school graduation rate: 54.0%
- Uninsured: 6.7%
- Below 100% FPL: 18.7%
- Unemployed: 7.7%
- Median age: 33.7
- 22.8% of service area



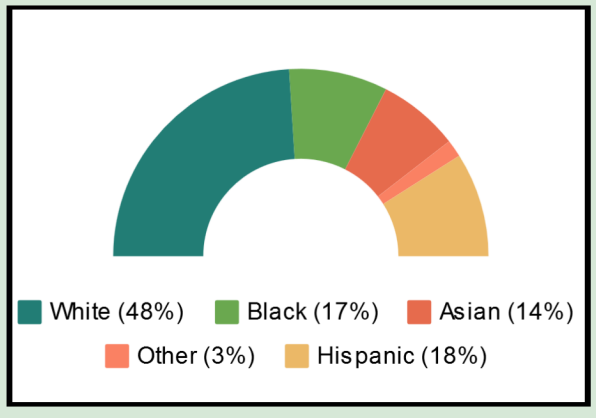
Frederick County

- Population: 236,668
- 50.8% | 49.2%
- High school graduation rate: 93.0%
- Uninsured: 7.8%
- Below 100% FPL: 6.1%
- Unemployed: 7.7%
- Median age: 38.9
- 8.7% of service area



Montgomery County

- Population: 989,474
- 51.9% | 48.1%
- High school graduation rate: 87.0%
- Uninsured: 11.5%
- Below 100% FPL: 6.7%
- Unemployed: 4.2%
- Median age: 38.5
- 36.4% of service area



Prince George's County

- Population: 873,481
- 52.0% | 48.0%
- High school graduation rate: 73.0%
- Uninsured: 15.4%
- Below 100% FPL: 9.4%
- Unemployed: 5.5%
- Median age: 35.5
- 32.1% of service area

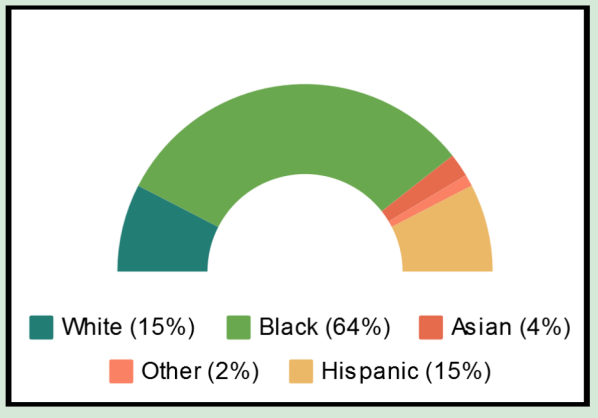
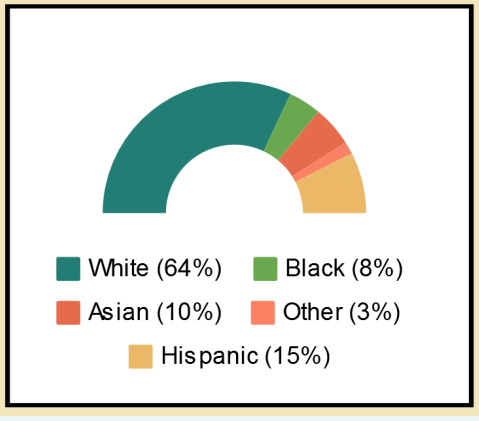


Figure 4. Northern Virginia Service Area Demographic Profile

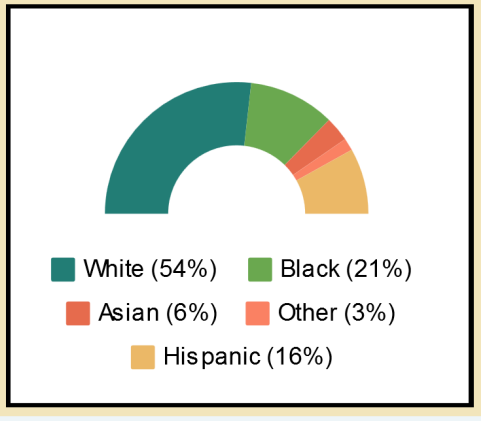
Arlington County

- Population: 214,861
- 50.0% 50.0%
- High school graduation rate: 81.0%
- Uninsured: 10.9%
- Below 100% FPL: 8.0%
- Unemployed: 2.9%
- Median age: 33.8
- 9.8% of service area



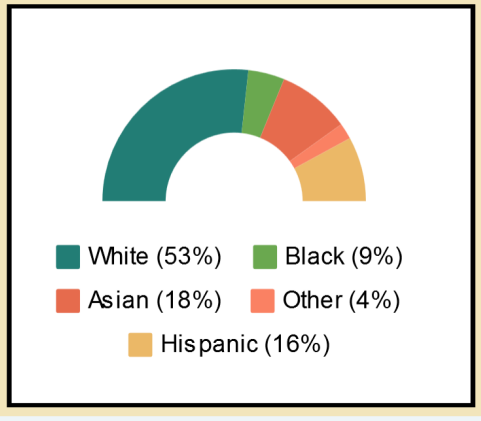
Alexandria County

- Population: 143,684
- 51.7% 48.3%
- High school graduation rate: 75.0%
- Uninsured: 14.4%
- Below 100% FPL: 8.4%
- Unemployed: 3.4%
- Median age: 35.8
- 6.5% of service area



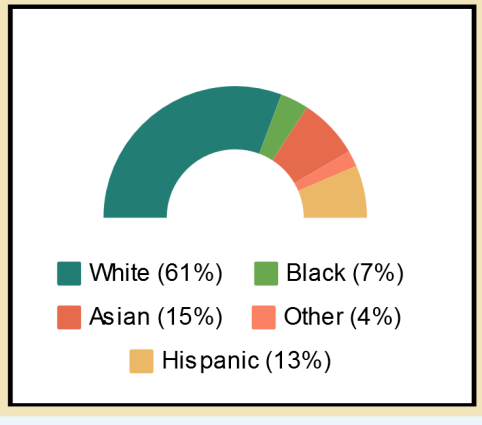
Fairfax County

- Population: 1,101,071
- 50.5% 49.5%
- High school graduation rate: 86.0%
- Uninsured: 12.0%
- Below 100% FPL: 5.9 %
- Unemployed: 3.8%
- Median age: 37.4
- 50.0% of service area



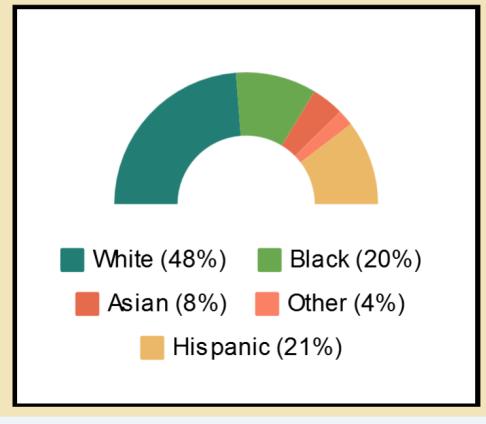
Loudoun County

- Population: 326,477
- 50.5% 49.5%
- High school graduation rate: 92.0%
- Uninsured: 8.4%
- Below 100% FPL: 3.6%
- Unemployed: 3.9%
- Median age: 35.1
- 14.8% of service area



Prince William County

- Population: 416,668
- 50.2% 49.8%
- High school graduation rate: 84.0%
- Uninsured: 13.9%
- Below 100% FPL: 6.3%
- Unemployed: 4.4%
- Median age: 33.7
- 18.9% of service area



IV. WHO WAS INVOLVED IN THE ASSESSMENT

A. Identity and Qualifications of Consultants Used to Conduct the Assessment

Destiny-Simone Ramjohn, Ph.D.: For over a decade, Destiny-Simone Ramjohn, Ph.D., has provided state-of-the-art strategic planning, research, and evaluation expertise to philanthropic institutions, federal agencies, universities, and social profit enterprises in domestic and international communities. She earned her doctorate in Sociomedical Sciences from Columbia University in the City of New York. Dr. Ramjohn's current work advances the social mission of Kaiser Permanente by developing measurement and evaluation strategies for the financial, material, and human resource investments that directly address the social determinants of health and promote health equity across the Mid-Atlantic region. Prior to joining Kaiser Permanente, Dr. Ramjohn provided contract support as a deputy program manager with the Defense Centers of Excellence (DCoE) for Psychological Health (PH) and Traumatic Brain Injury (TBI). There, she developed and implemented a rapid evaluation protocol, a valuable tool for time-sensitive assessment and evaluation of an individual program or a portfolio of public health programs at different stages of maturity. Dr. Ramjohn's thought leadership, superb technical writing skills, and flexibility in meeting shifting and competing demands supported her 51 member team in receiving a three-year, $31 million cost-plus-fixed-fee contract extension under the TRICARE Evaluation, Analysis and Management Support IDIQ. Dr. Ramjohn is an avid proponent of applying social science theories to public health practice and a collaborative team player with a passion for social justice activism.

Maya Nadison, Ph.D., M.H.S.: Dr. Nadison earned her Ph.D. from the Johns Hopkins Bloomberg School of Public Health, focusing on health communication and education sciences. She has extensive experience in program evaluation, quantitative and qualitative data collection and analysis, message development, creation of educational material, and report writing for diverse audiences. Her research interest relates to the design, implementation, and evaluation of school and community-based interventions focused on the prevention of cross-cultural risk behaviors. Interested in early prevention and intervention, Dr. Nadison was awarded six research grants to design school-based public outreach interventions to tackle the problems of school bullying and child sexual abuse. She is passionate about the potential of combining public health interventions with education methodologies and health communication strategies. An avid linguist, Dr. Nadison speaks six languages and has exceptional cross-cultural competencies with work and travel experiences in 60 countries.

Stacey Williams Lloyd, M.P.H., Ph.D. Candidate: Ms. Lloyd is a Ph.D. candidate in the Department of Mental Health and a Brown Scholar in Community Health at the Johns Hopkins Bloomberg School of Public Health. As a Brown Community Health Scholar, she is currently working on several public health issues in Baltimore City, including adverse childhood experiences, early educational attainment, injection drug use, and youth/young adult mortality. In 2008, Ms. Lloyd earned a Master in Public Health degree from the University of North Carolina, Department of Maternal and Child Health. Both before and during her degree pursuit at the University of North Carolina (UNC), Ms. Lloyd worked with the UNC Program on Health Disparities. Over the past eight years, she has worked in a wide range of research positions with duties, ranging from door-to-door participant recruitment and data collection to study design and implementation. With a fresh perspective on geographic inequities and methods from spatial epidemiology, Ms. Lloyd is working towards a dissertation to help city level policymakers effectively and efficiently target place-based interventions to promote the health and well-being of children and youth.

Jessica Finkel, B.S., M.P.P. Candidate: Ms. Finkel is working towards a Master in Public Policy degree with a concentration in Nonprofit Management and Leadership. Originally from Indianapolis, Indiana, she received her B.S. in Psychology in 2012 from Xavier University in Cincinnati. Upon graduating, Ms.

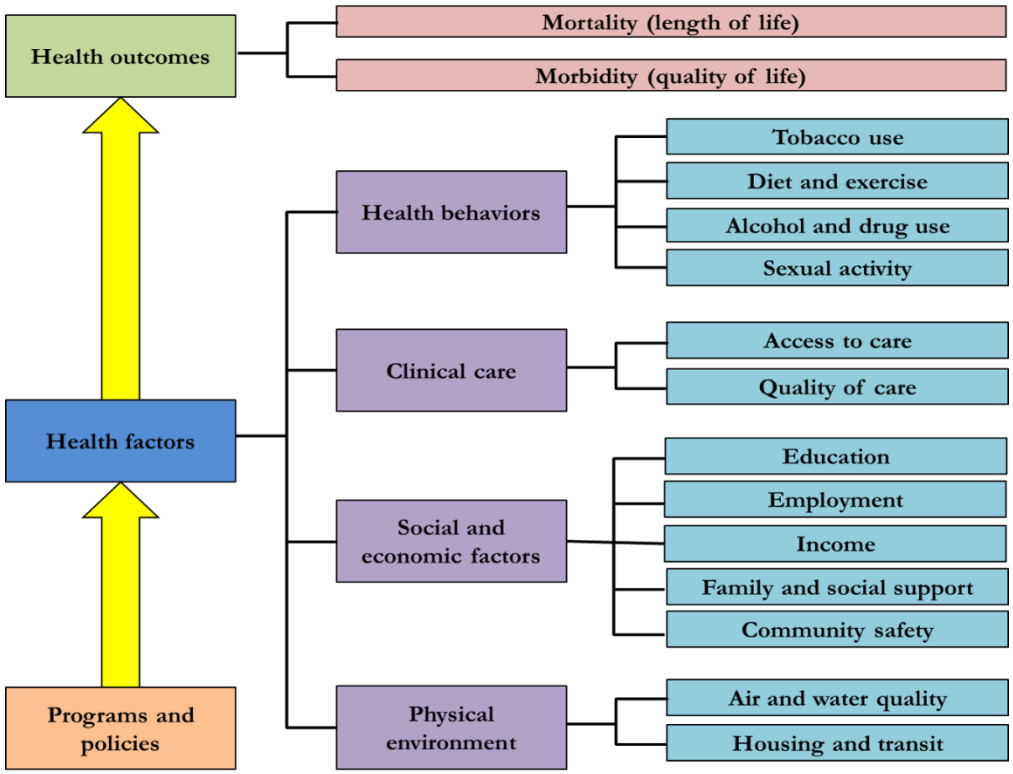
Finkel moved to Washington, D.C., to work in the nonprofit field. For the past three years, she has focused her nonprofit work in two disability-related organizations, the Osteogenesis Imperfecta Foundation and the Association of University Centers on Disabilities, working in program management and development. Along with her interest in nonprofit management, Ms. Finkel is especially interested in disability-related policy, including the area of health disparities and their impacts on minority populations. In addition to working in the disability community, Ms. Finkel is currently on the board for a Council on Independent Living and is working with the Osteogenisis Imperfecta Foundation to implement programming for youth and young adults with osteogenesis imperfecta.

V. PROCESS AND METHODS USED TO CONDUCT THE COMMUNITY HEALTH NEEDS ASSESSMENT

A. Conceptual Framework

The KFHP-MAS CHNA uses the University of Wisconsin Population Health Institute's County Health Rankings model, a model of population health that underscores the multilevel determinants of health with the goal of identifying specific factors that, if improved, can help communities thrive.[5] The framework is depicted in Figure 5. A recent analysis in the American Journal of Preventive Medicine highlighted the factors and their relative contributions to length of life (as measured by premature death) and quality of life (as measured by low birth weight and poor mental or physical health).[2] The analysis found strong support for the model's delineation of the underlying modifiable determinants of health with associated weights: healthy behaviors (30%), which includes indicators for alcohol use, diet and exercise, sexual activity, and tobacco use; physical environment (10%), consisting of air and water quality, housing, and transit; access to and quality of care (20%); and social and economic factors (40%), including indicators for community safety, education, employment, family and social support, and income.[2]

Figure 5. County Health Rankings Model of Population Health



B. Secondary Data

i. Sources and dates of secondary data used in the assessment

KFHP-MAS used the KP CHNA Data Platform (www.chna.org/kp) as the primary source of secondary data for this report. The KP CHNA Data Platform is a web-based resource with pre-populated national, state, and county level data for over 150 indicators. Data on gender and race/ethnicity breakdowns were included for analysis when available.

In order to ensure a minimum level of consistency across the organization, Kaiser Permanente has identified a list of data indicators to be used by all regions conducting a CHNA. The common indicators list includes over 80 nationally available indicators that collectively shed light on the health of a community. After a review of other national and local health assessments (e.g., Healthy People 2020, Mobilizing Action Toward Community Health, Connecticut Association of Directors of Health, San Francisco Health Improvement Partnership), a pattern began to emerge. Most of the assessments were organized according to common themes found in many population health models. These themes are closely aligned with the County Health Rankings model of describing the elements of health and their relationship to each other. While many population health models also include language about the role genetics may play in impacting health outcomes, it is not included in the KFHP-MAS categories because current literature generally considers genetics to be "both non-modifiable and non-measurable."[2]

The secondary data for this report was obtained from the KP CHNA Data Platform from October 2015 through February 2016. The data platform is undergoing continual enhancements and certain data indicators may have been updated since the data were obtained for this report. For the most recent data and/or additional health data indicators, please visit www.chna.org/kp.

To ensure that this CHNA utilized the most recent data available, alternative data sources were identified when data were collected in 2012 or earlier, as it was assumed that these data were used for the 2013 KFHP-MAS CHNA. In instances when data collected prior to 2012 were the most recent data available, it was deemed acceptable to use these indicators for the CHNA. Finally, alternative data sources were included to provide information for health issues that were not included on the list of common indicators but were of interest to the local community (e.g., drug related deaths). Alternative data were identified using the Health Indicators Warehouse (HIW), which is maintained by the Center for Disease Control and Prevention's National Center for Health Statistics.[10] HIW provides access to high quality data, with information about data sources, geographic level (i.e. national, state, and city or county level data) and benchmarking.

ii. Methodology for collection, interpretation, and analysis of secondary data

Secondary data were downloaded from the KP CHNA Data Platform and supplementary resources outlined above. Select indicators were eliminated from consideration when the data were non-local sources (e.g., California data sources) or when the data were deemed non-essential to draw regional conclusions (e.g., no access to air conditioning). After a carefully curated selection process, a total of 95 indicators were included in the final analysis. The complete list of indicators and rationale for elimination of indicators may be found in Appendix C. Once the indicator list was finalized, data were then input into tables in preparation for analysis. Data were presented by service area based on the data source and geographic level; city or county level data were used whenever possible. A listing of the alternative sources and year(s) of data collection for indicators selected for this report may also be found in Appendix C. Both benchmarking and racial/ethnic disparity calculations were used to identify health needs from the secondary data.

Benchmarking is a critical component of the CHNA process that provides a comparison standard against which to measure data to determine whether those data reveal a community health need. A scan of both national and local health assessments revealed that, among the most commonly used benchmarks, two would be most relevant, feasible, and meaningful for the KFHP-MAS CHNA process: Healthy People 2020 (HP 2020) and geographic data (e.g. national, state). Healthy People is a program of nationwide health-promotion and disease-prevention goals set by the United States Department of Health and Human Services. City and county level data were compared to the HP 2020 nationally recognized benchmark (if available) or to the national or state average. Indicators displayed as a rate or count were converted to a percentage and then compared to the benchmark. To assess the difference between the city or county level performance and the benchmark, a percent difference was calculated. Of note, when comparing the service area performance to the benchmark, it was critical to consider the desired direction of change from the benchmark. Taking diabetes as an example, a positive outcome would be an increase in diabetes management and a decrease in diabetes prevalence. Table 6 illustrates this point

Table 6. Benchmarking with Consideration of Directionality

Indicator Name	Benchmark Source	Benchmark Value	Desired Direction
Diabetes prevalence	National	9.11%	↓
Diabetes management (hemoglobin A1c, Medicare population)	National	84.60%	↑

All indicators identified as poorly performing against the benchmark (i.e., 10% in the corresponding direction) were flagged for further consideration.

According to the Department of Health and Human Services, health disparities are defined as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.[11] In an effort to identify health differences and to stay consistent with the conceptual framework of this CHNA, racial/ethnic disparity data were incorporated into the analysis when available. Out of the 95 indicators selected for analysis, 32 indicators (34%) were broken down by race. To calculate a racial disparity ratio, the indicator value for Black, Asian/Pacific Islander, or Hispanic was divided by the indicator value for White; White was used as the reference group for all disparity calculations. For example, a Black/White HIV/AIDS mortality ratio of 4.9 would demonstrate the odds of dying from HIV are nearly five times greater for Blacks than Whites. All indicators with an identified racial/ethnic disparity of 2.0 or greater were flagged for further consideration.

The result of the benchmarking and racial/ethnic disparity calculations generated a list of secondary data identified health needs by service area. The health needs identified by the secondary data analysis are presented in table format in the scorecard in Appendix B.

C. Community Input

i. Description of the community input process

Community input was provided by a broad range of community members through the use of key informant interviews and surveys. Individuals with the knowledge, information, and expertise relevant to the health needs of the community were consulted. These individuals included representatives from local public health departments as well as leaders and representatives of

medically underserved, low-income, and minority populations. Additionally, where applicable, other individuals with expertise of local health needs were consulted.

ii. Methodology for collection, interpretation, and analysis of primary data

Primary data were gathered via expert interviews and stakeholder surveys and designed to ensure a comprehensive portrait of the health needs at multiple levels. The purpose of the expert interviews was to identify health outcomes and health drivers, as well as assets and barriers to accessing resources, for health issues across the region. A list of individuals that provided input via interview may be found in Appendix D. Stakeholder surveys provided insight into the identification and prioritization of health needs by city or county. Individuals identified for the survey were those with the knowledge, information, and expertise relevant to the health needs of the community. The majority of individuals (78%) represented the non-profit service sector, serving primarily low income (87%) and racial and ethnic minority (90%) populations. The complete list of individuals that provided input via survey may be found in Appendix E.

Expert Interviews

A total of 15 telephone interviews representing each of the 13 CHNA cities and counties were conducted in January and February 2016. Experts were selected with the assistance of the KFHP-MAS Community Benefit Executive Director and staff, and included primarily health department directors. In a single case (Arlington County), leadership from a local, total health organization provided input on the most significant health needs in the area when the health department contact proved unreachable. Interviews were confidential and interviewers adhered to standard ethical research guidelines

Conversations were audio-recorded with the permission of the interviewee and a note taker provided written records of the discussion. Interviewees identified the community health needs of their specific geographic location including health outcomes and health drivers, as well as existing community collaborations, assets, and resources to address identified health needs. Interviewees also ranked community health needs along multiple dimensions of severity and detailed promising solutions and strategies to address identified health needs. A copy of the interview protocol may be found in Appendix D. The interview included nine questions, however, an abbreviated interview with three questions specific to identifying and prioritizing health needs was administered to two participants who were unable participate in the complete interview due to scheduling limitations. Sample questions are presented below in Table 7.

Table 7. Sample Questions from Expert Interview Guide

Interviewer: In thinking about the population of <COUNTY>, what are the three most significant health needs of the population? Health needs are defined as a poor health outcome as well as its associated driver, or underlying cause.
<For each health need OR driver listed>, how severe is this issue in the population?
Does it affect a large percentage of the population? Has this issue changed over time (e.g., has it gotten better? Worse?)?
Who is affected the most by the _____? Are particular subgroups of the population more affected by _____ than other groups?
For the next question, we are asking for your input on factors influencing the health of the community ("health drivers").
What factors are influencing the _____ ? What services and programs are available to address the _____ ?

Thirteen interviews were analyzed for the CHNA: BALT n=4, DCSM n=4, and NOVA n=5. Two interviews were removed from the analysis: the first was a pilot interview conducted to improve the interview protocol and enhance the analysis process; the second was from a city excluded from the final CHNA analysis. Thematic analytic techniques were employed. Thematic analysis is a qualitative analytic method for "identifying, analyzing, and reporting patterns or themes within the data. It organizes and describes the data set in rich detail and interprets various aspects of the topic."[12] Themes "capture something important about the data in relation to the question and represents a level of responses or meaning within the data set."[12] The thematic analysis strategies used in this CHNA helped the team move the analysis from a broad listening and reading of the data towards discovering patterns and identifying health needs. The analysis of the expert interviews involved the following six phases: 1) gain familiarity with the data; 2) generate initial codes; 3) search for themes; 4) review themes; 5) independently code the data with four coders, and; 6) achieve group consensus.

Phase 1 involved immersion in the data, repeated listening of the interviews, and repeated reading of the note taker's notes. Phase 2 involved generating an initial list of codes to determine meaningful ways of organizing the data. The initial list of codes included health factors identified by the County Health Rankings framework (e.g., poverty, illicit drug use, access to care) as well as codes that emerged from the data that were not included in the framework (e.g., trauma, structural racism, Lyme disease). An example of the coding process is displayed in Table 8.

Table 8. Sample Quote and Initial Codes Applied

Interview Quote	Initial Codes Applied
"Children, especially unaccompanied minor children coming from Central and South America is a huge issue here, we're seeing children with lots and lots of trauma coming to us. There is a need for bilingual service. There is a huge shortage of bilingual service and mental health providers."	Children/ youth Immigration patterns Trauma Cultural competency Mental health services

Phase 3 involved refocusing the analysis at the broader level of themes and preliminarily analyzing and combining themes to form overarching topics. For example, codes or themes such as "food deserts" and "no access to fruits and vegetables" were organized into the overarching topic of "nutrition access." Phase 4 involved a refinement process to determine whether the list of codes accurately represented themes in the data. This involved further combining multiple themes and eliminating codes or themes for which there were not enough data to support inclusion. For example, only one interviewee mentioned the code "Lyme disease"; therefore, it was removed from the final list of themes due to its limited applicability. Phase 5 involved coding of all 13 interviews by each of the four authors of this report. Coders applied the themes to the expert interview data and recorded the number of times each theme was mentioned by a single respondent. Codes mentioned by multiple respondents within the same service area were flagged for further consideration. For example, two respondents in the BALT service area mentioned the code "HIV"; it was selected for the final list of themes. Phase 6 involved group review and consensus to generate a final list of themes by interviewee and service area. Coders relied on intensive group discussion and simple group consensus as an agreement goal.[13]

The result of the analytic approach described above generated a list of expert interview data-identified health needs by service area. The health needs identified by the expert interview data are presented in table format in the scorecard, which appears in Appendix B.

Stakeholder Surveys

Even in the current era of preference for randomized trials, surveys remain an important method for capturing large quantities of data and providing fundamental insights about health and disease. Surveys provided a unique advantage during the 2016 KFHP-MAS CHNA health needs identification and prioritization process because they allowed the team to collect data from a relatively large sample for a relatively low cost. The survey method was also ideal because it provided participants with a standardized tool for reporting identified health needs, thus reducing biases in interpretation. Finally, the survey method provided an opportunity for more stakeholders to be involved in the health need identification and prioritization process than would have been possible with interviews alone.

A sample of 93 community leaders (representing 86 organizations) with knowledge of the KFHP-MAS service areas were invited to participate in the online survey between January and February 2016. Community Benefit staff, as well as word-of-mouth promotion, helped to identify respondents. The survey was developed using SurveyMonkey® and designed to gather community input on the severity of 30 health outcomes and drivers based on a scale of 1 to 4 (with 1 as “not severe” and 4 as “very severe”). A copy of the survey may be found in Appendix E.

Participants completed the survey with both open- and closed-ended questions. Each respondent was asked to assign a severity score to 30 prominent health needs (poor health outcomes as well as underlying risk factors, or drivers). Respondents were also given the opportunity to write in health needs that were not previously identified, highlighting potentially overlooked health challenges. Lastly, each respondent ranked what he or she perceived as the top three health needs in their respective communities. The survey took approximately 15 minutes to complete.

Of the 93 stakeholders invited, 58 individuals agreed to participate in the survey (i.e., completed the informed consent page) and 56 individuals completed the survey. The survey completion rate was calculated using the guidelines of the Checklist for Reporting Results of Internet E-Surveys (CHERRIES) checklist outlined by Eysenbach [14]:

$$\frac{\text{Number of people submitting the last questionnaire page}}{\text{Number of people who submitted the consent page (first page of survey)}}$$

The calculated survey completion rate was 96%. Of the 56 completed surveys, 25 respondents represented the DCSM service area, 16 represented the BALT service area, and 15 represented the NOVA service area. After surveys were completed, data were entered into Microsoft Excel® and analyzed. The severity scores for health needs were totaled and then divided by the total number of surveys, resulting in a unique severity score for each of the 30 health needs.

Health needs with an average score of 3 or higher (“severe” or “very severe”) by respondents within the same service area and health issues ranked as one of the top three community health needs by multiple respondents within the same service area were flagged for further consideration.

The result of the severity score and ranking calculations generated a list of stakeholder survey data identified health needs by service area. The health needs identified by the expert interview data are presented in table format in Appendix B.

D. Written Comments

To date, KFHP-MAS has not received written comments about previous CHNA reports. KFHP-MAS will continue to track submitted written comments and ensure that submissions are considered and addressed by the appropriate staff.

E. Data Limitations and Information Gaps

Secondary data

The KP CHNA Data Platform includes approximately 150 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there are some limitations with regard to these data, as is true with any secondary data. Some data were only available at a city or county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data around age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health within the community. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old.

Primary data

The expert interviews offered updated, relevant and pragmatic information about health needs in each of the 13 CHNA cities and counties. One limitation of the interview data is that while some key informants spent more time than required completing the interview (up to one hour), others had limited time (15 minutes) for participation and completed an abbreviated interview. This resulted in variation in the amount of data gleaned from each respondent. A second limitation is that, at times, stakeholders identified health issues that were not reflected in the secondary data and not able to be collapsed under other health needs (e.g. Lyme disease).

One limitation of the CHNA survey data is social desirability bias, or the tendency of survey respondents to answer questions in a manner that will be viewed favorably by others.[15] Identifying community health needs may be considered an important or pressing topic where socially desirable responding is of special concern. An additional limitation is with regard to data errors due to non-responses. To minimize this limitation, two surveys with missing data were eliminated from the analysis. Finally the number and type of respondents that participated in the survey may be different from those who chose not to respond. This limitation was minimized by data triangulation during the analysis process to ensure that multiple sources of data confirmed the identified health needs.

VI. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY'S HEALTH NEEDS

A. Identifying Community Health Needs

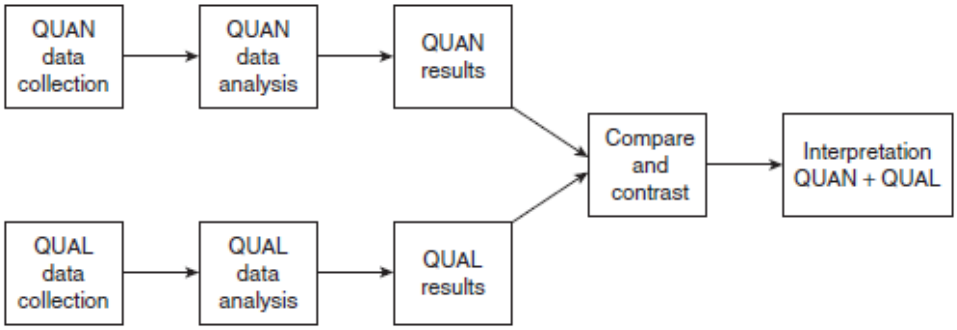
i. Definition of "health need"

For the purposes of the CHNA, Kaiser Permanente defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

ii. Criteria and analytical methods to identify the community health needs

The CHNA analytic approach, the triangulation design, is the most common and well-known approach to mixing methods.[7] Displayed in Figure 6, the purpose of this design is "to obtain different but complementary data on the same topic"[8] - in this instance, the health needs of each of the service areas in the KFHP-MAS region.

Figure 6. Triangulation Design, Convergence Model



The goal of this design is to complement the differing strengths and non-overlapping weaknesses of quantitative methods (large sample size, trends, generalization) with those of qualitative methods (small N, details, in depth).[16] Consistent with the triangulation design, the CHNA team implemented the quantitative and qualitative methods during the same time frame (e.g., December 2015 through February 2016) and with equal weight. The convergence model displayed above in represents the traditional model of a mixed methods triangulation design.[9]

Following this model, the CHNA team collected and separately analyzed the quantitative and qualitative data on the same phenomenon (i.e., health needs) and then converged the results by comparing and contrasting them during the interpretation. This approach ensures that valid and well-substantiated conclusions about community health needs are identified.[9] The criteria for a health need for each of the datasets are outlined below in Table 9.

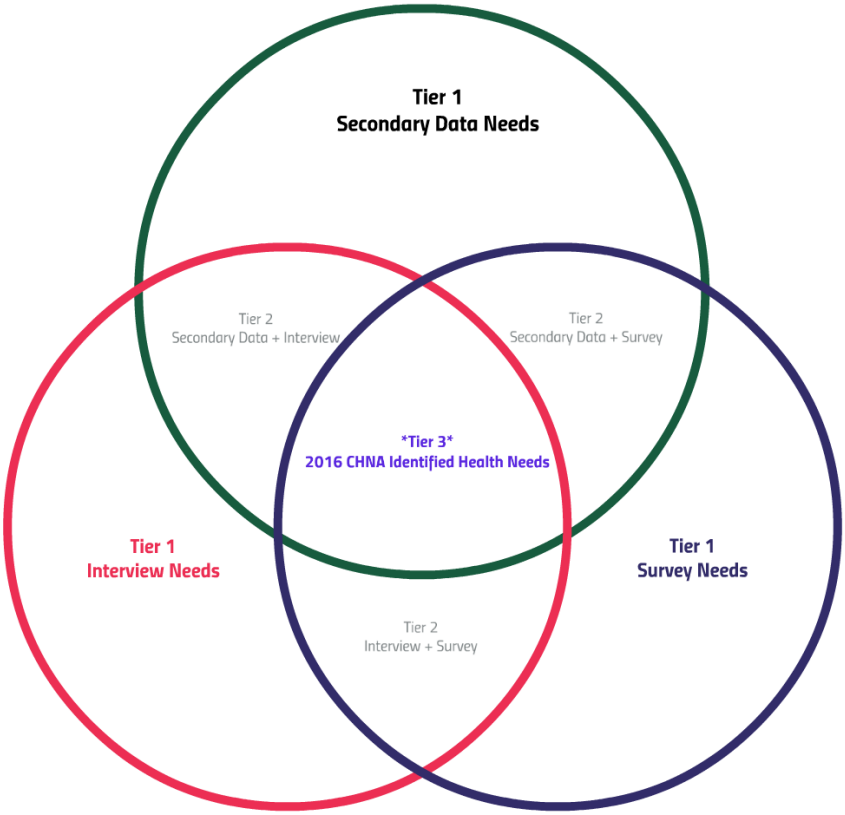
Table 9. Health Need Identification Criteria by Data Source

Secondary Data	Interview Data	Survey Data
Health issues identified as poorly performing against a benchmark (HP 2020, national-level data or state-level data) within the same service area Health issues with an identified racial/ethnic disparity of 2.0 or greater	Health issues identified as a need by multiple respondents within the same service area	Health issues identified as a "severe" or "very severe" need (average score of 3 or higher) by respondents within the same service area Health issues ranked as a top three community health need by multiple respondents within the same service area

The result of the independent analyses of each of the data sets generated three sets of health needs presented by service area (BALT, DCSM, NOVA) and by data source. Identified health needs were then organized into three tiers based on the amount of data indicating a need. As outlined above, the three-tiered approach is defined as follows:

Tier 1: Only <u>one</u> source of data (secondary or survey or interview) indicates a need
Tier 2: Any two sources of data (secondary and/or survey or interview) indicate a need
Tier 3: All three sources of data (secondary and survey and interview) indicate a need

Figure 7. Venn Diagram of KFHP-MAS CHNA Tiering System



B. Process and Criteria Used for Prioritization of the Health Needs

The focus of this report is on the Tier 3 identified health needs by service area as these are the needs that were triangulated, or supported by each of the data gathered for this analysis. During the latter stages of analysis, the CHNA team observed that the Tier 3 health needs had no intrinsic ordering, or no systematic way to order the needs from highest to lowest importance. Thus, it was determined that a value should be calculated to distinguish the needs in order of priority.

<u>Priority score</u>

Tier 3 identified health needs by service area were assigned a priority score based on: 1) racial disparities (confirmed by secondary data); 2) severity of the issue (confirmed by survey data); and 3)

community prioritization of the issue (supported by interview data). The priority score was used to generate a list of top health needs in each of the three service areas, with the highest score representing the greatest need.

Clear disparity between racial/ethnic groups: Racial/ethnic disparity data was collected from the KP CHNA Data Platform and the in-depth interviews when the data were available. Disparity was assessed in two ways. Using the platform, any disparity ratio less than 0.5 or more than 2.0 (reflecting the fact that one racial/ethnic group was performing two times worse than another) was assigned two points. Similarly, the mention of a disparity during the interview was also given two points. When there was no known disparity, only one point was added to the priority score.

Severity of issue: Health need severity was collected from the survey. Each survey respondent assessed the severity of health needs and drivers based on a scale of 1 to 4 (4 representing a "very severe" issue). The score for each health need was totaled and then divided by the number of respondents to obtain a value between 1 and 4 that remained interpretable. For example, an average between 3 and 4 could be interpreted as a health issue having a "severe" to "very severe" impact on the community. The final severity score value was added to the priority score for each health need.

Community prioritizes issue: Data for this criteria was collected from the in-depth interviews. The number of mentions of a specific health need was tallied for each interviewee, and the counts were added to the priority score. Therefore, the more mentions a health need received, the higher the priority score.

The list of health needs is presented by service area in order of priority in Table 10.

Table 10. CHNA Identified Health Needs by Service Area

BALT	DCSM	NOVA
1. Socioeconomic security	1. Socioeconomic security	1. Socioeconomic security
2. Substance use	2. Health care access	2. Health care access
3. Health care access	3. Obesity/Overweight	3. Diabetes
4. Mental health	4. Diabetes	4. Mental health
5. Obesity/Overweight	5. Substance use	5. Hypertension/CVD
6. Diabetes	6. Mental health	6. Obesity/overweight
7. Physical environment-housing	7. Cancer	7. Physical environment-transportation
	8. Hypertension/CVD	8. Oral health
	9. Physical environment-transportation	9. Language barriers
	10. Cancer	

C. Prioritized Description of Health Needs Identified Through the Community Health Needs Assessment

The narrative information below presents descriptive data gleaned from each of the data sources, as well as information about racial/ethnic disparities when available.

i. Greater Baltimore service area health needs

Socioeconomic security: Research, including this study, shows particularly strong and consistent associations between various health outcomes and socioeconomic security, including indicators such as access to employment, education, and income across time and geography. There are also solid, credible mechanisms explaining why lower socioeconomic groups have poorer health outcomes.[1] For example, social and economic conditions adversely affect people's ability to access health care and understand health information.[2] These conditions also constrain a person's ability to make healthy choices, particularly when healthy food or active living options are unaffordable or not nearby.[2] Socioeconomic factors also directly affect an individual's physiology. In addition to epigenetic changes that can drive intergenerational adverse health effects, prolonged social stress—for example, due to living in poverty, having low educational attainment, living in less safe neighborhoods, and/or experiencing burdens imposed by discrimination and racism—takes a physical toll by increasing circulating levels of stress hormones such as cortisol and adrenaline, which over time increase the risk of health problems such as preterm labor, diabetes, hypertension, heart disease, stroke, and certain types of cancer, in addition to depression and other mental health disturbances.[17]

Platform data: In the BALT service area, Baltimore City was the only geographic location that was systematically performing lower than the benchmark on all six indicators of income used in this CHNA. An estimated 23.8% of the population in Baltimore City lives below 100% of the FPL, compared to 6.3% in Anne Arundel County, 8.9% in Baltimore County, and 4.6% in Howard County (benchmark: 15.4%). Additionally, Baltimore City performed considerably lower along multiple indicators of education than other geographic locations in the BALT service area. Baltimore City has the highest percent of population without a high school diploma (19.1%) and the lowest high school graduation percent (66.0%). Baltimore City also had the lowest results on 3rd and 8th grade reading state exams.

Survey data: A large proportion of survey respondents (40%) prioritized poverty as the leading health need for the Baltimore service area. Among all survey participants, 93% described the impact of poverty on their community as "severe" or "very severe." Education was described as a "severe" or "very severe" issue by 80% of respondents. A quarter of respondents ranked education above all other needs in their community.

Interview data: ALL interview participants mentioned income (e.g., poverty) as a prominent driver of poor health outcomes in their community. In addition to income, participants also mentioned poor education and a dearth of employment opportunities as leading health concerns.

Racial/ethnic disparity data: Blacks were roughly two to three times more likely to live below 100% of the FPL compared to Whites in all geographic locations in the BALT service area, with disparity ratios of 2.7, 1.8, 2.9, and 1.9 for Anne Arundel County, Baltimore County, Howard County, and Baltimore City, respectively. In Howard County, Hispanics were over four times more likely to live below 100% of the FPL compared to Whites. In Howard County, Hispanics were almost seven times less likely to have a high school diploma compared to Whites. Blacks

and Asians were also less likely than Whites to have a high school diploma in both Anne Arundel County and Howard County.

Substance use: Substance abuse is an addictive disorder with associated social, physical, mental, and public health problems.[1] Substance abuse has been associated with an increased risk for mental illness, cardiovascular disease, stroke, cancer, teen births, sexually transmitted infections, injury (both intentional and unintentional), homicide, and suicide.

Platform data: In the BALT service area, Anne Arundel County, Baltimore City, and Baltimore County had rates of drug-related deaths that were higher than the national benchmark of 11.6 per 100,000. This issue was most problematic in Baltimore City, which had a rate of 43.5 drug-related deaths per 100,000, nearly four times higher than the national rate.

Survey data: Four survey respondents, or 27%, considered substance abuse to be one of the most prominent health issues in their community.

Interview data: All interview respondents in the BALT service area mentioned substance abuse as one of the top three most significant health needs in their geographic locations. Participants consistently linked substance abuse concerns to untreated mental health needs and inadequate access to treatment for behavioral health conditions among their service population. Opioid abuse was mentioned in two of four interviews (i.e., Anne Arundel County, Howard County).

Racial/ethnic disparity data: The greatest racial disparity for drug-related deaths can be found in Baltimore County, where Whites had a drug-related death rate of 29.2 per 100,000, compared to 15.2 per 100,000 for Blacks. Although rates of drug-related deaths were much higher in Baltimore City, the racial disparity was diminished, with a rate of 46.7 for Blacks and 40.9 for Whites. Racial/ethnic information was missing for Anne Arundel County and Howard County.

Health care access: Access to health care services is a key aspect of the social determinants of health framework. For the CHNA, inequities in access to health care relate to regular source of care, population living in areas with a shortage of health care professionals, and the ratio of physicians to the general population. Lack of culturally competent providers is also a barrier to proper health care.

Platform data: Although Howard County had almost three times the number of primary care physicians per 100,000 compared to the benchmark (195.7 vs. 74.5), health care access was still lacking in many areas of the region. In Baltimore City, 68% of the population was living in an area with a shortage of primary care professionals, thus exacerbating health inequities within the service area.

Survey data: 20% of survey participants ranked access to health care above other health needs. On average, participants ranked both access to preventive services and access to primary care as “severe” health issues.

Interview data: All interview participants mentioned access to health care as a leading health need in their community. In addition to access to care overall, health insurance access was also consistently mentioned as a barrier to health. An additional access issue that emerged from multiple interviews was patient navigation.
Racial/ethnic disparity data: Across the BALT service area, the Hispanic community was four to seven times more likely to be uninsured compared to Whites. Howard County had the greatest racial/ethnic disparity in terms of health coverage: compared to Whites, Blacks were 2.7 times

more likely to be uninsured, while Asians were 3.8 times more likely and Hispanics were 7.4 times more likely to be uninsured.

Mental health: It is estimated that one in four adults in the U.S. have been diagnosed with one or more mental health disorders.[4] Mental health is often characterized by emotional, psychological and social well-being. Mental disorders have been associated with substance abuse, chronic diseases, self-destructive behavior, and suicide. Social determinants that promote positive mental health include safe neighborhoods, quality and affordable housing, employment, education, and access to quality care.

Platform data: Suicide rates in the BALT service area hover around or below the national benchmark (10.2 per 100,000), with Anne Arundel County having the highest rate in the BALT service area (10.8 per 100,000). Baltimore City had the highest number of mentally unhealthy days in the past 30 days, with a rate of 3.9 (compared to the national average of 3.5).

Survey data: Mental health was ranked above other health needs by 25% of survey respondents. Mental health needs were ranked as “severe” or “very severe” by 69% of participants.

Interview data: All interview participants discussed mental health as a priority health need for their service population. Participants spoke of mental health needs associated with access to care, substance abuse (e.g., opioid abuse), and trauma. Economic conditions, including high rates of poverty and insufficient employment opportunities, were often cited as leading drivers for the mental health needs in the area.

Racial/ethnic disparity data: Whites were almost three times more likely to commit suicide compared to Blacks in both Baltimore County and Baltimore City. These figures are consistent with national estimates suggesting that White males account for seven of ten suicides.[4]

Obesity/overweight: Obesity has reached epidemic proportions in the United States, with approximately one in three adults considered obese (i.e., Body Mass Index greater than 30.0).[2] Obesity is associated with premature death and increased risk of cardiovascular disease, diabetes, and certain types of cancer.[3] Regular physical activity and healthy eating cut the risk for many chronic conditions and other obesity-related diseases. Despite the benefits of diet and exercise, it is important to account for disparities, particularly in terms of food access. Some elements to consider in terms of food access include access to transportation, distance to grocery store, density of fast food restaurants, and the availability of food-related government subsidies such as Supplemental Nutrition Assistance Program (SNAP) or Women, Infants, and Children (WIC) benefits.

Platform data: Baltimore City had the highest rates of obesity in the service area with more than one in three (34.1%) adults considered obese. Anne Arundel County had the worst food access in the BALT service area; nearly one in three (31.1%) adults live in an area designated as a food desert (with low or no food access). The number of grocery stores was below the benchmark in both Anne Arundel County and Howard County (18.4 and 15.0 per 100,000, respectively, compared to a benchmark of 21.2 per 100,000). Baltimore City had the highest rate of physical inactivity in the region. The data show that Anne Arundel County and Howard County had a dearth of parks, with only about one-third of adults living within ½ mile of a park, as compared to about one-half of adults in the United States. Baltimore City had limited recreation and fitness facilities (6.7 per 100,000 compared to 9.7 per 100,000 nationally).

Survey data: Among survey participants, 56% ranked obesity/overweight above other health needs and 81% described the impact of obesity/overweight on their community as “severe” or “very severe.” Both physical inactivity and access to healthy foods were ranked “severe” or “very severe” by 80% of participants.

Interview data: 75% of interview participants ranked obesity/overweight above other health conditions for their community. Obesity/overweight was consistently discussed in the context of inadequate access to healthy foods and exercise. Interview participants identified economic forces (i.e., income and poverty) as leading drivers of obesity in their community. Obesity/overweight was generally described alongside the overlapping chronic diseases associated with the condition (e.g. diabetes, hypertension, heart disease).

Racial/ethnic disparity data: Although the percent with low or no food access was slightly higher for Blacks, Asians and Hispanics overall, the disparity ratio was close to one.

Diabetes: Diabetes affects 29.1 million people in the United States – nearly 10% of the population – and is the seventh leading cause of death. Diabetes is associated with cardiovascular disease, kidney failure, blindness, and amputations. Risk factors for diabetes include obesity, lack of physical activity, poor eating habits, family history, and race/ethnicity.

Platform data: Approximately one in eight adults in Baltimore City had diabetes (12.4%), representing the highest rate of diabetes in the region. Anne Arundel County, Baltimore County, and Howard County had rates of 8.8%, 8.9% and 7.6%, respectively – all slightly under the national average of 9.1%.

Survey data: Among survey participants, 38% ranked diabetes above other health needs and 75% described the impact of diabetes on their community as “severe” or “very severe.”

Interview data: Three out of four interview participants ranked diabetes above other health conditions for their community. Diabetes was often discussed in the context of obesity/overweight and the management of associated chronic diseases. Interview participants identified several barriers to the management of diabetes and other chronic diseases, including health insurance status, transportation, and income.

Racial/ethnic disparity data: Rates of diabetes were higher in Black populations compared to White populations. The disparity ratios in diabetes-related deaths (Black to White) were 1.9 for Howard County, 1.5 for Baltimore City and 1.3 for Anne Arundel County. No data was available for Baltimore County.

Physical environment-housing: Housing options are intrinsically related to socioeconomic factors. People with lower incomes are more likely to live in unhealthy, overcrowded, or unsafe housing conditions. Housing insecurity is associated with higher stress levels, mental illness, poor medical care, and numerous poor health behaviors, including alcoholism and substance use.

Platform data: In Baltimore City, nearly 50% of adults live in substandard housing or cost-burdened housing (44.0% and 44.2%, respectively). Approximately 18.5% of Baltimore City’s homes were vacant. The percent of vacant housing units was two to three times higher in Baltimore City when compared to other geographic locations in the BALT service area, highlighting the serious housing problems in Baltimore City.

Survey data: The vast number of respondents perceived housing affordability and housing quality as having a “severe” or “very severe” impact on the community (80% and 73%, respectively).

Interview data: Two of four interview participants described housing issues such as dilapidated infrastructure and residential segregation as prominent contributors of health concerns in their community.

Racial/ethnic disparity data: Racial/ethnic data were not available for selected housing indicators.

ii. District of Columbia-Suburban Maryland service area health needs

Narrative information is provided only for health needs not previously presented.

Socioeconomic security

Platform data: The District of Columbia had the highest poverty rates in the DCSM service area. Nearly one in five adults (18.6%) lives below the 100% FPL, including nearly one in three children (28.7%). Moreover, nearly all students (99.2%) in public schools were eligible for free or reduced price lunches, a figure that was two times the national average of 52.4%.

Survey data: A majority of survey respondents (68%) prioritized poverty as a leading health need. Among all survey participants, 92% described the impact of poverty on their community as “severe” or “very severe.”

Interview data: ALL interview participants mentioned poverty as one of the most prominent contributors to the service area’s poor health outcomes. One participant described poverty as a leading need for all of the priority health conditions identified in the service area.

Racial/ethnic disparity data: There were remarkable racial/ethnic disparities for poverty in DCSM. In the District of Columbia, Blacks were three to four times more likely than Whites to live below the 100% FPL, and Black children were 26.6 times more likely than White children to live in poverty. Hispanic adults were two to three times more likely than Whites to live in poverty in Frederick County and Montgomery County.

Health care access, including health care coverage and preventive services

Platform data: Access to primary care physicians is well below the national average in Frederick County and Prince George’s County, with rates of 58.9 and 56.2 per 100,000, respectively (compared to the national rate of 74.5 per 100,000). In the District of Columbia, 75% of adults live in an area with a shortage of primary care professionals. In the District of Columbia, more than one in four adults were enrolled in Medicaid (27.7%), a rate that is two times higher than in Montgomery County or Frederick County (10.4% and 11.4%, respectively).

Survey data: Twenty-eight percent of survey participants ranked access to health care above other health needs. Access to preventive health care and health care coverage (i.e., insurance) were also ranked above other needs by several of survey respondents. The majority of respondents described the impact of inadequate access to care as “severe” or “very severe” (access to primary source of care 76%, insurance 56%; preventive services 80%).

Interview data: All interview participants mentioned access to health care as one of the most prominent health issues in the region. In addition to access to primary care overall, health insurance access was also consistency mentioned as a barrier to health in the population. Other key health care access issues that arose from the interviews included access to preventive health services and patient navigation. Other barriers to accessing health care included poverty/low income status and limited English proficiency.

Racial/ethnic disparity data: Blacks were two to three times less likely than Whites to have health insurance throughout the DCSM region. The situation was even more precarious for Hispanics, who were four to over ten times less likely than Whites to have health insurance coverage.

Obesity/overweight

Platform data: In Prince George's County, one in three adults was obese (32.5%), compared to the national benchmark of 27.1%. Montgomery County had an obesity percent of 19.0%. In the District of Columbia, 93.3% of the population lives within ½ mile of a park, which is almost twice the national average (48.7%). Prince George's County offers the fewest recreation and fitness facilities in the DCSM service area (7.2 per 100,000 compared to the national rate of 9.7 per 100,000). In Prince George's County, close to 30% of the population lives in an area designated as a food desert.

Survey data: Among survey participants, 60% ranked obesity/overweight above other health needs, and 72% described the impact of obesity/overweight on their community as "severe" or "very severe." Physical inactivity and access to healthy foods were both ranked "severe" or "very severe" by the majority of participants (60% and 80%, respectively).

Interview data: Three of four interview participants described obesity/overweight as one of the most significant health needs in their community. Obesity and overweight was often discussed in the context of health food choices and physical activity. Obesity/overweight was often mentioned as a major driver of the prevalence of chronic diseases (e.g. diabetes, heart disease).

Racial/ethnic disparity data: According to the National Health and Nutrition Examination Survey from 2011-2012, adult Black and Latino populations have substantially higher rates of obesity compared to White populations (47.8%, 42.5% and 32.6%, respectively). This was true for both men and women. Although there were no data at the city or county level for obesity/overweight, trends similar to the national rates may be expected for the DCSM service area.

Diabetes

Platform data: Prince George's County had the highest percent of diabetics (11.5%) across the DCSM service area. All other geographic locations had percentages of diabetics that were below the national benchmark of 9.1%.

Survey data: Among survey participants, 48% ranked diabetes above other health needs and 82% described the impact of diabetes on their community as "severe" or "very severe."

Interview data: Three of four participants ranked diabetes above other health conditions for their community. Diabetes was often discussed in the context of the high prevalence of obesity/overweight in the community. Improved management of chronic diseases, specifically

diabetes and heart disease, was often an identified health need. Economic forces (e.g., poverty), access to care (e.g. patient navigation), healthy eating, and physical inactivity were mentioned by multiple interview participants as barriers to the management of chronic diseases.

Racial/ethnic disparity data: The disparity for diabetes-related deaths in the District of Columbia was almost ten times greater for Blacks (36.4 per 100,000) compared to Whites (3.8 per 100,000). The disparity was attenuated in Montgomery County (18.9 per 100,000 for Blacks and 13.9 per 100,000 for Whites).

Substance use

Platform data: The District of Columbia and Frederick County had the highest drug-related deaths per 100,000 in the DCSM service area with rates of 16.1 and 18.1, respectively, and a benchmark of 11.6 per 100,000.

Survey data: While only 4% of survey respondents ranked substance abuse above the leading health issues in their community, 68% described the impact of drug use on their community as “severe” or “very severe.”

Interview data: All interview respondents in the DCSM service area discussed substance abuse as one of the most significant health needs in their geographic location. The morbidity and mortality associated with opioids was the most common substance use-related health concern described. Participants consistently linked substance abuse concerns to untreated mental health needs and inadequate access to treatment for behavioral health conditions among their service population.

Racial/ethnic disparity data: Although data were missing for all other counties in the DCSM service area, the District of Columbia had a clear disparity in drug-related deaths when comparing Blacks to Whites (25.6 versus 7.2 per 100,000).

Mental health

Platform data: Suicide rates for the service area were highest for Frederick County (10.8 per 100,000) but comparable to the national benchmark (10.2 per 100,000). The number of mentally unhealthy days in the past 30 days was below the benchmark throughout the DCSM service area.

Survey data: Mental health was ranked above other health needs by 40% of survey respondents. Mental health needs were ranked as “severe” or ”very severe” by 52% of participants.

Interview data: All interview participants discussed mental health as a priority health need for their service population. Participants discussed mental health needs associated with inadequate access to mental health treatment, including insurance status, insurance coverage for behavioral health services, patient navigation, and stigma-associated barriers to seeking treatment. Among the leading drivers of mental health needs, participants identified substance abuse (i.e., opioid abuse), poverty, suboptimal housing conditions, and a lack of services to prevent mental illness.

Racial/ethnic disparity data: Suicide rates were two to three times lower for Blacks as compared to Whites in both Montgomery County and Prince George's County. In the District of Columbia, suicide rates were similar for Blacks and Whites (6.3 and 6.1 per 100,000 respectively).

Cancer: Cancer is the second leading cause of death in the United States, costing the lives of more than 500,000 people annually. Although not all cancer can be detected early, prevention is important for cancers that can be detected in the early phase of the disease.

Platform data: Of the cancer-related indicators (rates of breast, cervical, colon, lung, and prostate cancer mortality), rates in the District of Columbia, compared to the other DCSM geographic locations, were consistently higher for all except for lung cancer, which was slightly higher in Frederick County (46.1 versus 44.0 per 100,000, respectively).

Survey: Several survey participants (16%) ranked cancer above other health needs, while 48% described the impact of cancer on their community as "severe" or "very severe."

Interview: Two interview participants discussed cancer as a health need and concern among their population. While overall rates in cancer were similar, disparities in the mortality rates for cancer were identified among racial and ethnic subgroups. Access to preventive health care and cancer screening were described as contributors to the high mortality rates among population subgroups.

Racial/ethnic disparity data: Overall, Blacks had slightly higher rates of cancer mortality compared to Whites, and Whites had up to two times the rates of cancer compared to Hispanics or Asian/Pacific Islanders.

Hypertension/cardiovascular disease: Cardiovascular disease (CVD) is the leading cause of death in the United States, with more than one in three adults suffering from CVD in the United States. CVD is associated with serious illness and disability, a reduced quality of life, and premature death. Hypertension or high blood pressure, a risk factor for CVD, affects one in three adults in the United States. Hypertension has been associated with heart failure, aneurysms, kidney failure, heart attack, stroke, and vision changes or blindness.

Platform data: The rate of heart disease mortality was highest the District of Columbia (142.7 per 100,000), followed by Prince George's County (127.8 per 100,000); both had values above the national benchmark (103.4 per 100,000). Rates of stroke mortality were above the benchmark for Frederick County and Prince George's County (38.0 and 37.5 per 100,000, respectively, compared to a benchmark of 33.8 per 100,000). The percent of adults who do not take medication for high blood pressure was highest in the District of Columbia (23.9% compared to a benchmark of 21.7%). This percent was below the benchmark for the other regions in DCSM.

Survey data: One-fifth of survey respondents ranked CVD and another fifth of respondents ranked hypertension above other health needs in the community. The impact of CVD on the community was described as "severe" or "very severe" by 77% of participants. Hypertension was described as "severe" by 82% of participants.

Interview data: Three of the four interview participants discussed CVD and hypertension as a leading health concern for their service area. Improved management of chronic diseases, specifically diabetes and heart disease, was a consistently identified health need. Economic forces (e.g., poverty), access to care (e.g. patient navigation), healthy eating, and physical

inactivity were mentioned by multiple interview participants as barriers to the management of chronic diseases.

Racial/ethnic disparity data: The rate of heart disease mortality was 2.2 times higher for Blacks in the District of Columbia compared to Whites. In Prince George's County, Whites were 2.4 times more likely to die of heart disease compared to Hispanics.

Physical environment - transportation: The transit systems that shape our communities' built environment affect where we live and how we get from place to place. The choices we make about transportation, and the opportunities underlying these choices, also affect our health. Access to nearby, reliable transportation systems offers more increased options for employment, better grocery store access, and better health care access. For the CHNA, transportation was assessed by the use of public transportation as a primary means of commuting to work and the percentage of the population living less than 0.5 miles from a transit stop.

Platform data: The percent of the population using public transportation as the primary means of work commuting was only 2.7% in Frederick County, about half the national average of 5.0%. Access to public transportation was highest in Montgomery County, followed by the District of Columbia, with 26.6% and 18.9% of the population, respectively, living less than ½ miles from a transit stop.

Survey: Transportation issues were reported as having a "severe" or "very severe" impact on the community by the 60% of survey participants.

Interview: Two of the four interview participants discussed transportation as a significant issue contributing to the health issues their community. Transportation was discussed in the context of access to health care as well as a daily stressor for many people in their communities.

Racial/ethnic disparity data: No information on racial/ethnic disparity was found at the city or county level for transportation.

iii. Northern Virginia service area health needs

Narrative information is provided only for health needs not previously presented.

Socioeconomic security

Platform data: None of the six poverty indicators performed worse than the benchmark in the NOVA service area, highlighting the ways in which city or county level analyses of data may mask neighborhood or local realities. Racial disparities were observed and are discussed below.

Survey data: More than half of survey respondents (53%) prioritized poverty as leading health need. Among all survey participants, 93% described the impact of poverty on the health of their communities as "severe" or "very severe."

Interview data: All interview participants mentioned poverty as one of the most prominent health issues in the service area. Participants described poverty as a leading health need for all of the poor health outcomes discussed in the service area.

Racial/ethnic disparity data: Blacks and Hispanics were two to three times more likely to experience poverty in all five geographic locations of the NOVA service area. The racial

disparity was exacerbated for children. In Arlington County, Black and Hispanic children were 11.7 and 12.0 times more likely than White children to live in poverty, respectively.

Health care access, health care coverage and preventive services

Platform data: The number of primary care physicians per 100,000 was almost two times less in Prince William's County compared to the national benchmark. Additionally, the percent of adults without a regular health care provider was higher than the benchmark (22.1%) in Arlington County, Fairfax County and Alexandria City (26.1%, 24.8% and 28.2%, respectively). When compared to the benchmark, all geographic locations in NOVA had an uninsured population percentage that was lower than the benchmark. However, this did not remain true when the data was broken down by race/ethnicity (see below for more information). The overall percent of uninsured children was above the national benchmark (4.8%) for Fairfax County (5.5%), Prince William County (6.3%) and Alexandria City (6.0%).

Survey data: Fifty-three percent of survey participants ranked access to health care above other health needs. Health care coverage (insurance) and access to preventive health care were also ranked above other needs by a large portion of survey respondents (27% and 33%, respectively). The majority of respondents described the impact of inadequate access to care as "severe" or "very severe" (access to primary source of care 80%, insurance 87%, preventive services 87%).

Interview data: All interview participants mentioned access to care as one of the most prominent health issues in the service area. In addition to access to primary care, access to health insurance and preventive health care were both mentioned by four of the five participants. Other key health care access issues that arose from the interviews included health policies that directly affected low income populations (e.g., Medicaid expansion in Virginia, "uninsurable" populations such as immigrants without documentation). Other barriers to accessing health care included poverty/low income status and limited English proficiency.

Racial/ethnic disparity data: In the NOVA service area, Hispanics were five to over ten times more likely than Whites to be uninsured, while Asians and Blacks were two to five times more likely to be uninsured than Whites. More than one in three (36.8%) Hispanics in Arlington County were uninsured.

Diabetes

Platform data: The percentage of adults with diabetes was below the benchmark across the NOVA service area. Racial/ethnic disparities were observed and are discussed below.

Survey data: Among survey participants, 27% ranked diabetes above other health needs and 80% described the impact of diabetes on their community as "severe" or "very severe."

Interview data: Four of five interview participants mentioned diabetes as a significant health need in their community. Needs associated with diabetes were often discussed alongside other conditions associated obesity/overweight (e.g. hypertension). The most common needs identified were chronic disease management and barriers to healthy living associated with access to nutrition and exercise.

Racial/ethnic disparity data: In Alexandria City, Prince William County and Fairfax County, Blacks were 2.5, 1.5 and 1.4 times more likely, respectively, to die of diabetes-related complications when compared to Whites.

Mental health

Platform data: Rates of mental health providers per 100,000 in Prince William County were approximately two times below the benchmark. Rates of suicide and number of mental health days were below the benchmark across the NOVA service area.

Survey data: Mental health was ranked above other health needs by 40% of survey respondents. Mental health needs were ranked as “severe”/”very severe” by 80% of participants.

Interview data: Four out of five interview participants discussed mental health as a leading health need in their service area. Multiple participants mentioned trauma and drug use as major contributors to the mental health needs in their community. Participants spoke of several barriers to accessing mental health care, including insurance status and coverage, stigma-associated barriers to seeking treatment, and a lack of culturally-appropriate services to meet the needs of the population.

Racial/ethnic disparity data: In Fairfax and Prince William Counties, Whites were two times more likely to commit suicide. This disparity ratio was consistent across all three services areas of the Mid-Atlantic States region.

Hypertension/cardiovascular disease

Platform data: The percentage of heart disease prevalence and rates of stroke mortality and heart disease mortality were lower than the national benchmark across the NOVA service area. However, racial disparities for stroke mortality exist in Arlington County. The percent of adults who do not take their prescribed blood pressure medication was highest for Prince William County (39.1% versus the national average of 21.7%), followed by Arlington and Loudoun Counties (both 27.3%).

Survey data: Among survey respondents, 33% ranked hypertension and 13% ranked CVD above other health needs in the community. The impact of CVD on the community was described as “severe”/”very severe” by 60% of participants, while hypertension was described as “severe” or ”very severe” by 67% of participants.

Interview data: Four out of five interview participants discussed hypertension and/or CVD as a leading health concern for their service area. These conditions were often mentioned in the context of other conditions associated with obesity/overweight. The most common needs identified were chronic disease management and barriers to healthy living associated with access to nutrition and exercise.

Racial/ethnic disparity data: Overall, the rate of heart disease mortality was higher for Blacks than for Whites. In Arlington County, the rate of stroke mortality was 2.1 times higher for Blacks compared to Whites. Additionally, Hispanics present lower rates of stroke mortality compared to Whites in both Fairfax and Prince William Counties. Racial/ethnic data for the other geographic locations in NOVA were unavailable.

Obesity/overweight

Platform data: The percentage of adults who were overweight (BMI between 25.0 and 30.0) was approximately 10% more than the benchmark for Loudoun and Prince William Counties. Obesity rates were below the benchmark across NOVA. Overall, the NOVA service area has poor food access: there were two to five times fewer food stores accepting the WIC program compared to the national benchmark. Fairfax (18.2), Loudoun (17.3) and Prince William Counties (16.4) had fewer grocery stores than the national average for the United States (21.2 per 100,000). Finally, Arlington County, Fairfax County and Alexandria City had more fast food restaurants than desired.

Survey data: Among survey participants, 47% ranked obesity/overweight above other health needs and 93% described the impact of obesity/overweight on their community as "severe" or "very severe." Physical inactivity and access to healthy foods were both ranked "severe" or "very severe" by the majority of participants (87% for both). Nearly all participants described healthy eating as a "severe" or "very severe" health need (93%).

Interview data: Three of the five interview participants ranked obesity/overweight above other health conditions for their community. Obesity/overweight was often discussed in the context of poverty and inadequate access to healthy food and exercise opportunities. Obesity/overweight was also mentioned in the context of the overlapping chronic diseases associated with the condition (e.g. diabetes, hypertension).

Racial/ethnic disparity data: There were few if any racial/ethnic disparities observed for the low or no food access indicator in NOVA.

Physical environment - transportation

Platform data: Loudoun County had the lowest percentage of the population using public transportation as their primary means of commuting to work (2.9%). This was the only transportation indicator performing worse than the benchmark for the NOVA service area.

Survey data: Transportation was ranked above other health needs by 13% of participants. The impact of transportation issues on the needs of community was described as "severe" or "very severe" by 87% of survey participants.

Interview data: Three of the five interview participants discussed transportation issues as a significant need affecting the health of their community.

Racial/ethnic disparity data: No information on racial/ethnic disparity was found at the city or county level for transportation.

Oral health: Good oral health is critical to achieve good overall health, as cavities and oral cancer can cause pain and disability. Effective oral preventive methods are important to reduce future health problems.

Platform data: The number of dentists per 100,000 was below the benchmark for Prince William County.

Survey data: Poor oral health was ranked above other health needs by 47% of survey participants. The impact of poor oral health on the community was described as “severe” or “very severe” by 73% of survey participants.

Interview: Three of the five participants mentioned oral health as a significant health need for the area. Access to preventive dental care was the primary contributor to poor oral health identified by participants. Insurance coverage and low income status were identified as the leading barriers to addressing oral health needs. Oral health needs were described as the most significant among those with socioeconomic status.

Racial/ethnic disparity data: No racial/ethnic information was available for oral health.

Language barriers: Language barriers can have important implications for health and health care. Patients with poor English are less likely to visit a primary care physician regularly, receive less preventive services and are more likely to not adhere to their drug regimen or to misunderstand medical instructions.

Platform data: The percent of population with limited English proficiency was above the benchmark value of 4.8% in Fairfax County (7.5%), Prince William County (6.2%) and Alexandria City (6.3%).

Survey data: One-quarter of participants ranked language barriers above other issues affecting the health and well-being of the population. The vast majority of participants (87%) described the impact of language barriers in their community as “severe” or “very severe.”

Interview data: Two participants reported language barriers as a health need in their community. Often considered alongside recent immigration patterns for the area, limited English proficiency was described as a key barrier to health care access. All participants mentioned the need for culturally-appropriate services to serve the diverse population in the service area.

Racial/ethnic disparity data: No racial/ethnic data was available for limited English proficiency.

Cancer

Platform data: The rate of breast cancer was highest in Arlington County (143.7) and was above the benchmark value (123.0).

Survey: Thirteen percent of survey participants ranked cancer above other health needs for their service area, and 20% described the impact of cancer on their community as “severe” or “very severe.”

Interview: Two of the five interview participants discussed cancer as a health need and concern among their population. Higher rates for cancer were identified for Blacks compared with other racial and ethnic groups.

Racial/ethnic disparity data: In Prince William County, Hispanics were twice as likely to be diagnosed with cervical cancer compared to Whites (11.5 versus 5.3 per 100,000). Hispanics were also two times less likely to be diagnosed with lung cancer compared to Whites (23.4 versus 55.8 per 100,000).

D. Community Resources Potentially Available to Respond to the Identified Health Needs

Community resources potentially available to respond to the identified health needs are outlined in the health need profiles presented in Appendix A.

VII. KFHP-MAS 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. Purpose of 2013 Implementation Strategy Evaluation of Impact

KFHP-MAS' 2013 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2013 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KFHP-MAS Implementation Strategy Report, including the health needs identified in 2013 service areas, the health needs KFHP-MAS chose to address, and the process and criteria used for developing Implementation Strategies, please contact 301-816-5708. For reference, the list below includes the 2013 CHNA health needs that were prioritized to be addressed by KFHP-MAS in the 2013 Implementation Strategy Report:

1. Access to Care
2. Healthy Living
3. Diabetes/Hypertension
4. HIV

KFHP-MAS is monitoring and evaluating progress to date on the 2013 Implementation Strategies for the purpose of tracking the implementation of those strategies, as well as to document the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH in-kind resources. In addition, KFHP-MAS tracks outcomes, including behavior and health outcomes, as appropriate and where available.
As of the documentation of this CHNA Report in March 2016, KFHP-MAS had evaluation of impact information on activities from 2014 and 2015. While not reflected in this report, KFHP-MAS will continue to monitor impact for strategies implemented in 2016.

- **KFHP-MAS Programs**: From 2014-2015, KFHP-MAS supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:

    - Medicaid: Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFHP-MAS provided services for Medicaid beneficiaries, both members and non-members.

    - Medical Financial Assistance: The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.

    - Charitable Health Coverage: Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.

- Workforce Training: Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.

- Research: Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes.

- **Grantmaking**: For 70 years, Kaiser Permanente has shown its commitment to improving Total Community Health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2014-2015, KFHP-MAS awarded 26 grants amounting to a total of over $1.7m in service of 2013 health needs. Additionally, KFHP-MAS has funded significant contributions to The Community Foundation of the National Capitol Region in the interest of supporting effective long-term, strategic community benefit initiatives within the Mid-Atlantic States. During 2014-2015, a portion of money managed by this foundation was used to award 36 grants totaling close to $2.8m in service of 2013 health needs.

- **In-Kind Resources**: Kaiser Permanente's commitment to Total Community Health means reaching out far beyond our membership to improve the health of our communities. Volunteerism, community service, and providing technical assistance and expertise to community partners are critical components of Kaiser Permanente's approach to improving the health of all of our communities. In 2014, 634 KFHP-MAS employees participated in 129 unique events logging approximately 3,491 hours of service. In 2015, 791 employees participated in 705 events logging an estimated 6,655 hours of service. From 2014-2015, KFHP-MAS donated several in-kind resources in service of 2013 Implementation Strategies and health needs, including:

    - **Martin Luther King, Jr. Day of Service**: KFHP-MAS has a long tradition of honoring the legacy of Dr. Martin Luther King Jr's call to serve by providing rewarding opportunities for employees to get involved. In 2015 employees and their families supported youth and local schools in the Baltimore-Washington Metro area with a variety of opportunities, including positive school climate by providing human capital as well as beautification and resources to provide an improved student experience. MLK Day of Service projects included painting murals and accents, light construction, organization, kit-making and workshops for youth. 65 employees logged approximately 261 hours.

    - **NBC 4 Health & Fitness Expo** is the largest, best-attended Consumer Wellness Expo in the country, driving 85K+ attendees every year. KFHP-MAS featured interactive and fun educational activities for the whole family including screenings at the Mobile Health Vehicle, getting fit with exercise anytime/anywhere, engaging attendees with careers in healthcare, and inspiring young and old to picture their healthy future at the KP photo pod. 34 employees logged approximately 132 hours during the event.

- **Bmore Healthy Expo** is the largest, indoor, free admission public event in Maryland and the premiere first quarter event in the State, empowering families to take action and make choices to be healthier. 34 employees logged approximately 134 hours during the event.

- **Collaborations and Partnerships**: Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2014-2015, KFHP-MAS engaged in several partnerships and collaborations in service of 2013 Implementation Strategies and health needs, including:

  - OneBaltimore is a public-private partnership committed to building strong, sustainable connections among organizations and individuals who will work collaboratively to transform Baltimore into a city where race and class are less significant determinants of a resident's ability to be safe, healthy, educated and employed.

  - The Greater Washington Workforce Collaborative is a coalition of local workforce investors who share a common commitment to addressing poverty and income inequality by helping workers advance their skills and credentials so they can earn family-sustaining wages.

  - In 2011, a small group of Washington Regional Association of Grantmakers (WRAG) members formed the Washington Regional Convergence Partnership - now the Washington Regional Food Funders - with the support of the national Convergence Partnership. The group seeks to identify policy solutions and opportunities for aligned investment on the supply side of our region's food systems to advance equitable workforce solutions and sustainable practices.

B. 2013 Implementation Strategy Evaluation of Impact by Health Need

KFHP-MAS Priority Health Need: Access to Care

Long Term Goal: The long term goal of implementation strategies for the Access to Care priority health need was to increase access to health care and coverage across multiple cities and counties in the Mid-Atlantic States.

Intermediate Goals: Intermediate goals for addressing this priority health need included: 1) reduce the barrier of "ability to pay" in accessing medically necessary care and; 2) expand the capacity of local safety net clinics and nonprofits to increase healthcare access among uninsured and underinsured populations.

Access to Care KFHP-MAS Administered Program Highlights

KFHP-MAS Program Name	KFHP-MAS Program Description	Results to Date
Medicaid	Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFHP-MAS provided services for Medicaid beneficiaries, both members and non-members. In November 2013, KFHP-MAS entered into Virginia as a Medicaid Managed Care Organization (MCO). MCO participation was expanded to Maryland in June 2014.	• In 2014, KFHP-MAS reached 18,027 individuals through Medicaid/CHIP. Additionally, KFHP-MAS implemented three value added services: adult dental, adult vision and transportation. • In 2014, the KFHP-MAS funded a total of $1,377,657 in Medicad/CHIP losses and funded $7,379,866 in cost-based losses for Priority Partners and Medicaid startup costs. • In 2015, KFHP-MAS reached 39,939 individuals through Medicadi and CHIP. KFHP-MAS continued to implement adult dental, adult vision and transportation services. • In 2015, the Health Plan funded a total of $11,720,227 in Medicaid/CHIP losses and $16,935,514 in cost-based losses for Medicaid MCO, Priority Partners and Medicaid startup costs.
Medical Financial Assistance	The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.	• In 2014, KFHP-MAS funded $19,689,858 in MFA awards to 78,874 patients. Approximately 90% of MFA awards were distributed to patients at or below 300% FPL. • In 2014, 46,483 medical encounters and 108,343 prescriptions were financed through the MFA program. • In 2015, the KFHP-MAS funded $30,534,616 in MFA awards to 107,174 patients. Approximately 82% of MFA awards were distributed to patients at or below 300% FPL. • In 2015, 68,852 medical encounters and 31,416 prescriptions were financed through the MFA program.

Charitable Health Coverage	Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.	• In 2014, funding for the Community Health Access Program (CHAP) and Medical Care for Children Partnership (MCCP) initiatives totaled $15,880,377, which covered 5,809 individuals. • In 2015, funding for the CHAP and MCCP initiatives totaled $28,926,944, which covered 10,684 individuals.
Access to Care Collaboration/Partnership Highlights		
Organization/Collaboration Name	**Collaborative/ Partnership Goal**	**Results to Date**
Healthy Communities Working Group	The Healthy Communities Working Group (HCWG) is committed to improving health in communities and addressing issues of disparities in health status and outcomes related to race, ethnicity, and class. HCWG brings together more than 16 funders of the Washington Regional Association of Grantmakers (WRAG) who are committed to improving health in the region.	• KFHP-MAS has played an integral role in the HCWG as a convener; KFHP-MAS staff also serve in various leadership capacities, including Co-Chair of the group. • In 2014, under the leadership of the KFHP-MAS Co-Chair WRAG's Health Working Group changed its name to the Healthy Communities Working Group to more fully focus on the upstream determinants of health. • In 2015, the Co-Chair supported the development of a theory of change and a draft list of evaluation indicators on issues related to the implementation of the ACA, particularly its impact on low-income populations.
Access to Care In-Kind Resources Highlights		
Recipient	**Description of Contribution and Purpose/Goals**	
Johns Hopkins Urban Health Institute and DC-Baltimore Research Center on Child Health Disparities	Kimberly L. Fox, Director, Charitable Health and Coverage programs and Maia McCuiston Jackson, MD, FAAP, Physician Director of Multicultural Services collaborated to identify efforts to address ACA gaps at the Johns Hopkins Urban Health Institute the Latino Health Conference "Land of Opportunity? Latino Immigrants and the Affordable Care Act (ACA)". The event provided a dynamic forum for KPMAS to discuss challenges and opportunities associated with changes in the healthcare system and the rapid growth of the Latino community in Maryland. The conference brought together scholars, policy experts, clinicians, and community advocates interested in improving access and quality of healthcare for Latino immigrants and their families. Collaborative efforts to address the identified gaps remains ongoing.	

KFHP-MAS Priority Health Need: HIV

Long Term Goal: The long term goal of implementation strategies for the HIV priority health need was impact positive, measurable changes in HIV/AIDS client health outcomes.

Intermediate Goal: Intermediate goals for addressing this priority health need included: 1) disseminate HIV best practices to community nonprofit organizations and; 2) optimize multidisciplinary HIV care.

HIV Grantmaking Highlights

Summary of Impact: During 2014 and 2015, there was one active KFHP-MAS grant totaling $200,000 that addressed HIV in the KFHP-MAS region.[1]

Grantee	Grant Amount	Project Description	Results to Date
Washington AIDS Partnership	$100,000/per year	Positive Pathways is an evidence-based intervention that addresses barriers to HIV medical care for African Americans in Washington, D.C. and Prince George's County, MD. Through a network of trained peer Community Health Workers (CHWs) placed in community, primary medical care, and managed care settings, Positive Pathways identifies out-of-care individuals, builds peer-based trust, and provides personalized assistance to help them navigate service systems. The goal of the program is to support HIV positive women throughout the early part of their medical care until they are fully engaged.	• In 2014, thirteen CHWs were placed in community, primary care, and managed care settings. • From March 2014 through February 2015, CHWs enrolled 365 out-of-care individuals. CHWs also worked with 242 ongoing clients and re-engaged 52 clients from previous years who had fallen out of care. The total number of individuals served was 659. • A review of 2014 project data showed that of Positive Pathways clients who completed at least one assessment with a CHW, 96% attended at least one medical visit with an HIV provider, 92% were taking their HIV medications, and 61% were virally suppressed. • Data collection remains ongoing.

[1] This total grant amount may include grant dollars that were accrued (i.e. awarded) in a year prior to 2014, though the grant dollars were paid in years 2014 and 2015.

HIV Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Safety Net HIV/AIDS Convening	The purpose of the Safety Net HIV/AIDS convening is to create a forum for local safety nets who care for HIV/AIDS patients to collaborate and share best practices on improving health outcomes informed by Kaiser Permanente experts.	• In 2014, KFHP-MAS in partnership with Mid-Atlantic Permanente Medical Group launched the Safety Net HIV/AIDS convening; the Inaugural convening included ten clinics from across the Mid-Atlantic States. • KFHP-MAS has played an integral role in the Safety Net HIV/AIDS partnership as a convener; KFHP-MAS staff also serve in various leadership capacities, including Chair of the group. A MAPMG physician champion is also among the leadership of the group. • In 2014 and 2015, approximately four convenings were held at KP facilities to review HIV/AIDS treatment best practices, as well as case study reviews and protocol.

HIV In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Department of Health and Human Services and National Committee for Quality Assurance	KPMAS physician champion Dr. Michael Horberg has played an integral role in the HIV Quality Improvement and Performance Program. HIV quality performance measurements are critical to evaluating a care program's success in areas of testing, access to and retention in care, care processes and outcomes. Under Dr. Horberg's leadership, the HIV Quality Improvement and Performance program assessed the care and outcomes for HIV-positive patient populations across the KP enterprise. In addition, HIV testing practices among HIV-uninfected patients presenting with a sexually transmitted infection were examined. Findings indicate that for most individual care measures, improvement over time was noted, with 85% or more performance seen on some measures (e.g., accessing care and initiating antiretroviral therapy). Opportunities for improvement were identified on other measures, such as diagnosing HIV at an earlier stage of infection. The KP HIV mortality rate is favorable performing 50% less than that of the overall U.S. rate. The study has ongoing implications for improving KP's care process, and has been used by the Department of Health and Human Services and National Committee for Quality Assurance for informing new national standards.
National Institutes of Health	KPMAS physician champion Dr. Horberg has provided critical support to the development of the KP HIV Registry. The Registry fills important operational and clinical support needs and plays a key role in fully developing the research program of the Mid-Atlantic Permanente Research Institute. In 2014 and 2015, the HIV registry continued its expansion of case definition to closely align with other KP regions' case definitions. Further, demographic and risk data was added, as well as AIDS defining events. The registry data is extensively used in research, most recently the National Institutes of Health (NIH) sponsored North American AIDS Cohort Collaboration on Research and Design (NA-ACCORD), as well as other KPMAS HIV specific projects.

KFHP-MAS Priority Health Need: Healthy Living

Long Term Goal: The long term goal of implementation strategies for the Healthy Living priority health need was to increase opportunities for healthy lifestyles by promoting healthy eating and active living at policy, systems, environmental levels.

Intermediate Goal: Intermediate goals for addressing this priority health need included: 1) provide grantmaking and technical assistance to communities to develop sustainable, vibrant, livable environments that support safe, active multimodal transportation and opportunities for neighborhood access to healthy foods; 2) provide grantmaking and collaborate with state, regional, and local networks and coalitions to increase access to safe, multimodal transportation; 3) collaborate with state, regional, and local networks and coalitions to develop policies and programs that increase access to healthy, nutritious food resources and opportunities for physical activity and; 4) conduct grantmaking activities with organizations that implement evidence-based efforts to increase access, knowledge, and behavior change supporting healthy eating and active living (HEAL).

Healthy Living Grantmaking Highlights

Summary of Impact: During 2014 and 2015, there were 24 active KFHP-MAS grants, totaling $1,664,734, addressing healthy living in the KFHP-MAS service area.[2] In addition, a portion of money managed by a donor advised fund at The Community Foundation for the National Capitol Region was used to award 17 grants, totaling $1,469,384, in service of KFHP-MAS 2013 healthy living implementation strategies. These grants are denoted by an asterisk (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Port Towns Community Health Partnership	$150,000	The Port Towns Community Health Partnership (PTCHP) is comprised of various community residents, organizations, and funders collaborating to improve community conditions in the Port Towns and greater Prince George's County area. The goal of the PTCHP is to make the Port Towns a healthy place to live, learn, work, play, and worship. The PTCHP represents KFHP-MAS' most visible investment in HEAL policy and systems change. Since the Partnership began, the KFHP-MAS has invested more than $2.5m in technical assistance, project management, evaluation, and strategy implementation.	• In 2014 and 2015, the PTCHP built on policy successes to advance place-based HEAL work in the Port Towns by conducting multiple resident education activities (e.g., gardening, cooking and nutrition classes), faith-based leaders HEAL training, and summer youth farmer training. • In 2014, a youth wellness leadership institute was developed and an affordable community supported agriculture (CSA) program was launched. • In 2015, a community farm on a 400-unit public housing complex in Bladensburg, MD (a designated food desert) was also implemented. • In 2015, several resolutions were passed, which resulted in the creation of a food equity council in Prince George's County, Maryland. • PTCHP's continued activities are well positioned to improve food access, with the potential to reach

[2] This total grant amount may include grant dollars that were accrued (i.e. awarded) in a year prior to 2014, though the grant dollars were paid in years 2014 and 2015.

			as many as 850,000 residents in surrounding neighborhoods within Prince George's county.
Institute for Public Health Innovation	$270,000	The Institute for Public Health Innovation (IPHI) supports the HEAL Cities & Towns Campaign for the Mid-Atlantic, which helps municipal leaders create healthy, prosperous communities. The work represents a coordinated effort between KPMAS, IPHI, the Maryland Municipal League and Virginia Municipal League, among other partners.	• To date, 51 local jurisdictions in Maryland and Virginia, covering over 1,387,182 people, have adopted resolutions and other policies to shape their communities into places where it is easier for residents and employees to make healthy choices about physical activity and nutrition. • In 2014, IPHI's technical assistance activities in the form of sample policies, fact sheets, webinars, crafting compelling messages, and benchmarking guided more than 20 municipalities in the region to adopt HEAL policies or resolutions. • In 2015, IPHI offered $40,000 to local governments in Maryland and Virginia to implement policies that promote physical activity. Through this grant, the City of Frederick, Maryland created nearly six miles of bike lane striping and share use, or "sharrow," markings, making it safe for residents to bicycle as a method of active transportation and as a commuting option.
Maryland Farmer's Market Association*	$45,000	The Maryland Farmer's Market Association (MDFMA) "Building Towards Sustainability and Success" project is designed to enhance the organization's capacity for solidifying infrastructure, strategic planning, program growth, and long-term sustainability.	• In 2014, MDFMA achieved several key milestones including promoting brand awareness through a robust marketing, outreach, and promotional campaign and increasing MDFMA's capacity to meet constituent needs. During the grant period, additional resources for farmers market managers were developed and key investments in staff training and development were made. • A successful public event occurred to launch the MDFMA marketing and fundraising campaign, resulting in over $3,600 raised for programming. • In addition, MDFMA increased services to members with the release of an updated "Guide to Accepting Federal Benefits in Maryland." The Guide includes updated information on technology solutions for accepting SNAP/EBT as well as information on federal benefit programs available for redemption through farmers markets.

Baltimore Food Policy Initiative	$45,000	The Baltimore Food Policy Initiative (BFPI) plays a critical role in the Baltimore Office of Sustainability, with a goal of improving health outcomes by increasing access to healthy, affordable food in food deserts. The purpose of the project was to amplify Baltimore's food access strategies by expanding SNAP at City's Farmers Market, expand CSA Wellness, and provide technical assistance for urban farms in food deserts.	• During the grant period, BFPI achieved several milestones including working to ensure that close to 50% of Baltimore Farmers' Market and Bazaar (BFMB) vendors accept SNAP, credit, debit, and Maryland Market Money (MMM) and conducting a pilot of the Double Incentive Dollar program by introducing new smartphone technology. • As a result of grant activities, there was an 11 percent increase in SNAP sales at BFMB events, from $12,701 to $14,108. • The technology piloted resulting in a 59% rise in registrants, from 180 to 296. In addition, there was a 258 percent increase in the amount of dollars doubled for SNAP from 2014 to 2015; MMM doubled $21,724 in vouchers to provide a total purchasing power of $43,448 for farmers market consumers.
Healthy Living Collaboration/Partnership Highlights			
Organization/ Collaborative Name		**Collaborative/ Partnership Goal**	**Results to Date**
Washington Regional Food Funders		The goal of the Washington Regional Food Funders collaborative is to increase philanthropic and government investment in food access/hunger issues and encourage collective action to create equitable access of healthy foods across the region.	• KFHP-MAS has played an integral role in this collaborative including presenting briefings for funders and legislators throughout the year, providing public testimony in support of relevant bills, such as the federal Healthy Food Financing Initiative (HFFI) and DC Food Policy and representing the funding community on conference panels to raise the visibility of regional concerns, such as healthy food access and food security.
Port Towns Community Health Partnership		The PTCHP is a collaboration of community residents, organizations and funders, working together to support healthy living in the Port Towns and be a catalyst for wellness policies in the county. Partners include Port Towns youth and adult residents, schools, non-profit organizations, businesses, local and county government leaders.	• KFHP-MAS has supported the vision of the Partnership to make Port Towns the best place for residents to live, learn, work and play by serving as a catalyst for community action, promoting HEAL, and disseminating information on Port Towns as a model for community collaboration and advocacy for systems change related to health equity.

Healthy Living In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Schools across the Region- Thriving Schools	To increase efforts to address child health in school settings, KFHP-MAS launched the Thriving Schools initiative in 2013. Thriving Schools employs sustainable strategies to support student, staff and teacher health and wellness in K-12 schools throughout the region, with emphasis in DC, Baltimore City and Northern Virginia schools. The initiative engages national partners, including the Alliance for a Healthier Generation (AHG), Safe Routes to Schools (SRTS), and the Alliance for School-based Health Centers (ASBHC). KFHP-MAS deploys a variety of resources, including Educational Theatre, Healthworks, employee volunteers, grants, and evidence-based HEAL practices. In 2014, 52 schools signed agreements to participate with AHG on the Healthy School Program (HSP), in four school districts (Fairfax County, City of Alexandria, Baltimore City Public Schools and District of Columbia Public Schools, and DC Charter). 100 schools received support for teachers and students from HealthWorks and employee volunteers. In addition, Playworks and Food Corp were awarded grants to work with 18 and 8 schools, respectively, in support of active living and healthy eating. Safe Routes to Schools/Fire Up Your Feet reached 274 schools.
Schools across the Region- Educational Theater Program	KFHP-MAS' Educational Theatre Program (ETP) has provided professional, award-winning health education for Pre-K through 12 for over 25 years in Maryland, Virginia, and the District of Columbia. In 2014, ETP performed 513 times at 148 different venues for approximately 47,000 children and adults at schools and other locations. The performances consisted of three age-appropriate shows with supplemental resource materials for students, teachers, and parents that reinforce the presentation. The three scripted shows were Professor Bodywise's Traveling Menagerie, The Amazing Food Detective, and Secrets. Also in 2014, ETP presented five classroom workshops on Bullying Prevention, Obesity Prevention, and HIV/AIDS prevention. Throughout the 2014 and 2015, ETP conducted 310 workshops to 9,062 students and adults, presented its Corner Store exhibit to educate youth and adults on ways to make healthy food shopping decisions and conducted Poverty Simulations to inform the public on the challenges of low-income households. ETP also distributed self-produced videos describing the benefits of and dispelling the myths surrounding seasonal flu shots as well as a video teaching the benefits of nutritionally-balanced meals.

KFHP-MAS Priority Health Need: Chronic Conditions

Long Term Goal: The long term goal of implementation strategies for the Chronic Conditions priority health need was to increase awareness about and use of quality improvement initiatives and increased the number of adults with access to evidence-based care and prevention programs.

Intermediate Goal: Intermediate goals for addressing this priority health need included replicating A-L-L /P-H-A-S-E in safety nets as well as sharing related best practices, lessons learned, tools and metrics.

Chronic Conditions Grantmaking Highlights

Summary of Impact: During 2014 and 2015, there were no active KFHP-MAS grants addressing chronic conditions, however,[3] a portion of money managed by a donor advised fund at The Community Foundation of the National Capitol Region was used to award 2 grants, totaling $347,500, in service of KFHP-MAS' 2013 chronic conditions implementation strategies. These grants are denoted by an asterisk (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Mid-Atlantic Association of Community Health Centers Inc.*	$250,000	A-L-L /P-H-A-S-E (Aspirin, Lisinopril, Lipid lowering drugs to Preventing Heart Attacks and Strokes Everyday) is an evidence based cost effective means of improving health outcomes for diabetic and hypertensive patients community clinic patients aged 50 and over. A-L-L /P-H-A-S-E clinics identify diabetic patients ages 50 and over and patients at risk for CVD and apply the ALLPHASE intervention of aspirin, lisinopril (an ACE inhibitor) and a lipid lowering medication, (specifically statins). ALLPHASE patients are also educated on healthy lifestyle changes and are encouraged to create self-management goals. .	• In 2014, KFHP-MAS continued an active partnership with four clinics: Community Clinic, Incorporated; Greater Baden Medical Services; Alexandria Neighborhood Health Services and; Loudoun Free Clinic. • A cumulative total of 1,097 patients were engaged in the program across the region. • It is projected that over a three-year period, patients that receive the A-L-L /P-H-A-S-E treatment protocol will have a 60 percent lower incidence of hospitalizations for heart attacks and strokes, saving the health care system at least $4 million in expenditures.

Chronic Conditions Collaboration/Partnership Highlights

Organization/ Collaborative Name	Collaborative/ Partnership Goal	Results to Date
Greater Washington Workforce Development Collaborative	A skilled, diverse, and dynamic public health workforce and network of partners is crucial to promote health and prevent chronic disease at the national, state, and local levels. To this end,	• In 2014, the Workforce Collaborative's Accelerating Advancement Initiative (AAI) helped local education and training

[3] This total grant amount may include grant dollars that were accrued (i.e. awarded) in a year prior to 2014, though the grant dollars were paid in years 2014 and 2015.

	the Greater Washington Workforce Development Collaborative, an initiative of the Community Foundation for the National Capital Region, brings together local foundations, individual philanthropists, and businesses around a shared vision for a Metropolitan Washington region where every individual has an opportunity to realize their potential, secure a family-sustaining job, and both benefit from and contribute to our regional economic prosperity.	programs pilot, strengthen, or scale "career pathways" efforts. • Under the AIA initiative, 125 low-income workers were helped to secure marketable credentials, family-sustaining employment in key industry sectors, and gain training to support additional education and career advancement opportunities. • KFHP-MAS played an integral role in the AIA learning network, a peer learning community for Collaborative grantees.
Chronic Conditions In-Kind Resources Highlights		
Recipient	**Description of Contribution**	
Safety Net Clinic Partners	KFHP-MAS' Community Ambassador Program supports the capacity of local safety net clinics to increase health care access for underinsured and uninsured populations through the placement of nurse practitioners and physician assistants in community clinics around the region. In 2014, 29 FTEs served as KFHP-MAS community ambassadors working in 16 partner safety net clinics. Combined, the 16 clinics reported a total of 76,822 encounters, representing a 12% increase in the amount of encounters over the previous year. Community ambassadors in 15 of 16 clinics performed at or above National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) benchmarks along four of six quality metrics tracked (i.e., adult tobacco use assessment, adult coronary artery disease (CAD) therapy, adult asthma therapy, and adult ischemic vascular disease (IVD) therapy). In 2015, 23 FTEs served as KFHP-MAS community ambassadors working in 12 partner safety net clinics. Combined, 12 clinics reported a total of 67,163 encounters.	

Appendix A
KFHP-MAS Health Need Profiles

Kaiser Foundation Health Plan Mid-Atlantic States 2016 Community Health Needs Assessment

Executive Summary

The Kaiser Foundation Health Plan of the Mid-Atlantic States (KFHP-MAS) conducted this community health needs assessment (CHNA) to identify community resources and to guide Community Benefit plans. New requirements under the Patient Protection and Affordable Care Act enacted in 2010 provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhancing compliance and transparency. The 2016 CHNA process was conducted in compliance with current federal requirements. CHNA findings provide KFHP-MAS with an unparalleled opportunity to reconsider health care's role in creating healthy communities and increasing measurable impacts on population health.

This summary provides only the highlights from our complete assessment. For a copy of the full CHNA report, call (301) 816-5708.

KFHP-MAS 2016 Prioritized Health Needs

The 2016 CHNA was completed through a multi-stage and mixed-methods approach designed to integrate findings from secondary data with the experiences, expertise, and opinions of key community stakeholders gathered through primary data collection. Findings revealed the following six health needs across the Mid-Atlantic region:

- SOCIOECONOMIC SECURITY
- MENTAL HEALTH
- HEALTH CARE ACCESS
- DIABETES
- OBESITY/ OVERWEIGHT
- HYPERTENSION/ CARDIOVASCULAR DISEASE

Community Served

KFHP-MAS serves over 600,000 members in Maryland, Virginia, and the District of Columbia. The 2016 CHNA focuses on the following 13 cities and counties in KFHP-MAS' three distinct service areas:

BALT	DCSM	NOVA
Anne Arundel County	District of Columbia	Arlington County
Baltimore City	Frederick County	Alexandria County
Baltimore County	Montgomery County	Fairfax County
Howard County	Prince George's County	Loudoun County
		Prince William County

The overall demographic profile of KFHP-MAS service area depicts racial/ethnic diversity and considerable socioeconomic need.

DEMOGRAPHIC DATA	
Total population	7,303,724
White	54.3%
Black	28.6%
Asian	9.0%
Some Other Race	4.3%
Multiple Races	3.4%
Hispanic/Latino	12.3%

SOCIOECONOMIC DATA	
Living in poverty (<200% FPL)	21.6%
Children in poverty (<100% FPL)	12.3%
Unemployed	4.5%
Uninsured	10.6%
No high school diploma	10.3%

Methods for CHNA

We used a mixed-methods approach to identify and prioritize health needs.

95 indicators from secondary sources

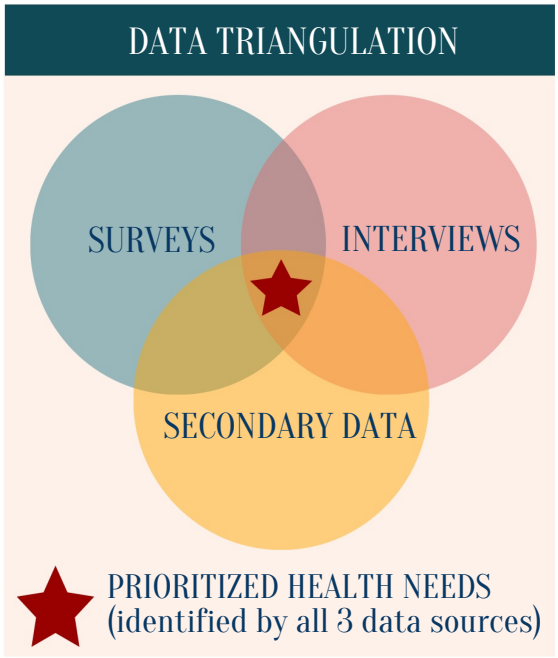
We compared 95 carefully selected indicators to national benchmarks. Indicators performing at least 10% worse than benchmark were flagged.

15 key informant interviews

We conducted 15 telephone interviews with health department directors, government officials and social service providers to identify community health needs.

58 surveys with stakeholders

Using SurveyMonkey®, we asked 58 community leaders to complete an online survey about the severity of health outcomes in their communities.



Community Assets and Resources

Stakeholders identified several strengths and assets across the Mid-Atlantic States. These include synergy across health systems, strong multidisciplinary coalitions to improve population health outcomes, and community resources to address health needs.

> *"I think that the unrest we experienced last April [2015] after the death of Freddie Gray has shed a light on Baltimore City and helped people to see how really difficult an environment it is to live in, because of that I think that there is a renewed interest in Baltimore." -- Expert Interviewee*

- In Baltimore City, stakeholders described considerable momentum to move further "upstream" and tackle the root causes of poor health.
- Prince George's County was described as made up of an energized government leadership team implementing a bold vision to dramatically transform neighborhoods facing significant economic, health, public safety and educational challenges.
- Prince William County was described as a rapidly growing city whose diversity of cultures was a strength.

Community residents and stakeholders were asked to identify what they see as the most promising solutions and strategies to address health. The overarching themes below were identified:

- Addressing the social determinants of health
- Closing health care gaps for uninsured and underinsured populations
- Investing in interdisciplinary, collaborative, and community driven approaches
- Enhancing youth engagement and development opportunities
- Providing health and social support services directly in the community

Implementation Strategy

The CHNA findings represent a coordinated first step in addressing identified health needs. We are committed to developing and implementing effective strategies to address community health needs in collaboration with community stakeholders and leaders.

Details describing KFHP-MAS' planned response to the needs identified through the CHNA process are outlined in the CHNA Implementation Strategy report, which will be available in December 2016.

SOCIOECONOMIC SECURITY

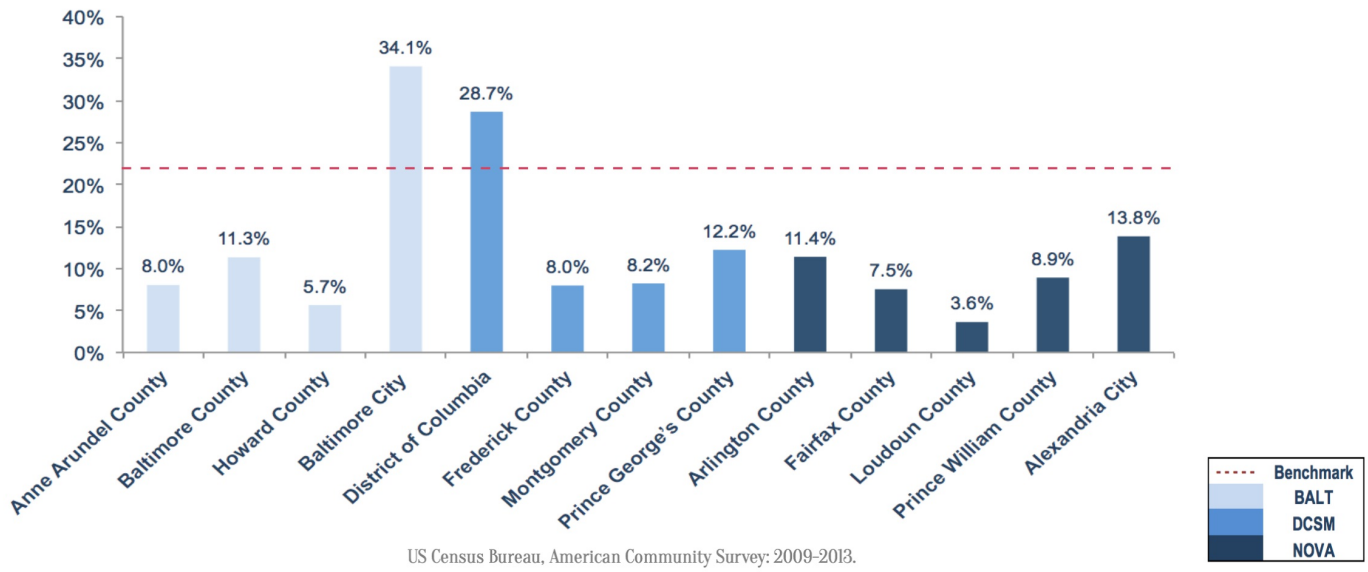
Findings from the 2016 KFHP-MAS CHNA revealed that socioeconomic security is a critical health need in the Mid-Atlantic region. Socioeconomic security is measured as a combination of education, income, and occupation. It underlies three major determinants of health: health care, environmental exposure, and health behavior. Poverty affects housing options, work environment, school choices, health care, and other social factors (1). Educational attainment compounds the issue of economic well-being. Both poverty and education are intrinsically correlated with poor health and poor health care access and are associated with an increased risk for chronic disease, injury, mental illness, and premature death (2).

"A lot of it comes really comes down to economic opportunity in that young people don't feel hopeful about their future. In that they can make more money in the drug trade, which is a dangerous trade, rather than staying in school and working a job at minimum wage that is not enough to support a family." -- Expert Interviewee

DATA SNAPSHOT

Population below 100% Federal Poverty Level (FPL)

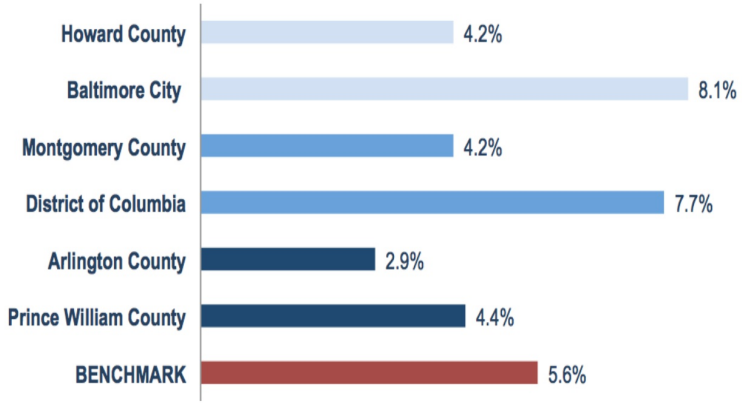
Percent of population below 100% FPL



US Census Bureau, American Community Survey: 2009-2013.

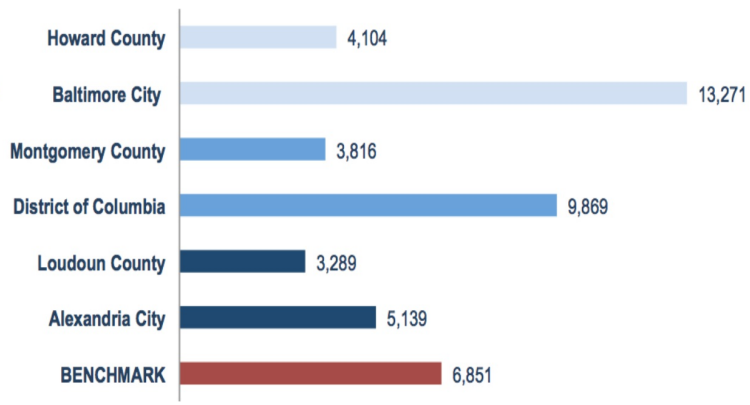
Rate of unemployment

Percent of adult population that is unemployed



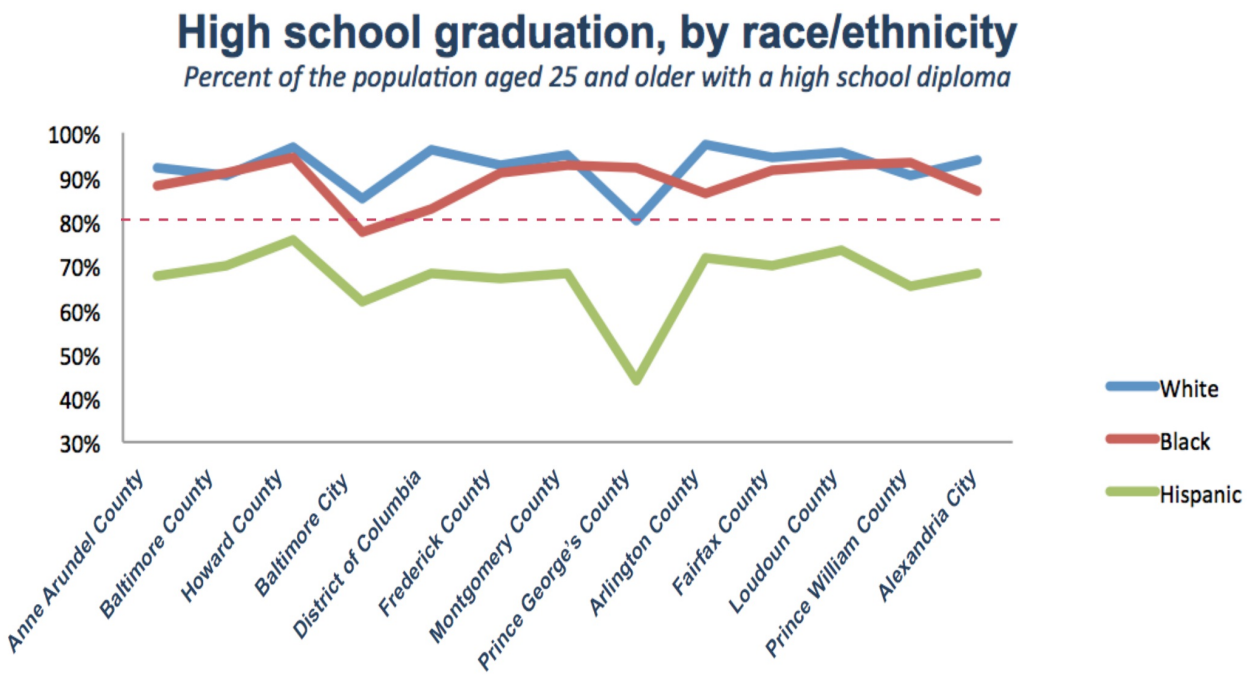
Premature death

Years of life lost before age 75 per 100,000 population



US Census Bureau, American Community Survey: 2009-2013.

RACIAL/ETHNIC DISPARITIES



University of Wisconsin Population Health Institute, County Health Rankings: 2014

COMMUNITY ASSETS

BALT - Catholic Charities of Baltimore
Provides a variety of programs relating to homelessness, poverty, and unemployment for individuals and families to achieve self-sufficiency and improve their lives. http://www.catholiccharities-md.org
(410) 547-5490

DCSM - A Wider Circle
Provides programs to help individuals and families furnish their homes and provides job readiness counseling and support.
http://awidercircle.org
(301) 608-3504

NOVA - Community Empowerment Northern Virginia
Supports low-income families, specifically single mothers, by providing after-school child care, summer programs, ESL programs for adults, financial literacy, and nutrition classes.
http://www.communityenv.org
(703) 982-2368

SOURCES

(1) Marmot, M., Friel, S., Bell, R., Houweling, T. A., Taylor, S., & Commission on Social Determinants of Health. (2008). Closing the gap in a generation: health equity through action on the social determinants of health. The Lancet, 372(9650), 1661-1669.
(2) Ross, C. E., & Wu, C. L. (1995). The links between education and health. American sociological review, 719-745.

HEALTH CARE ACCESS

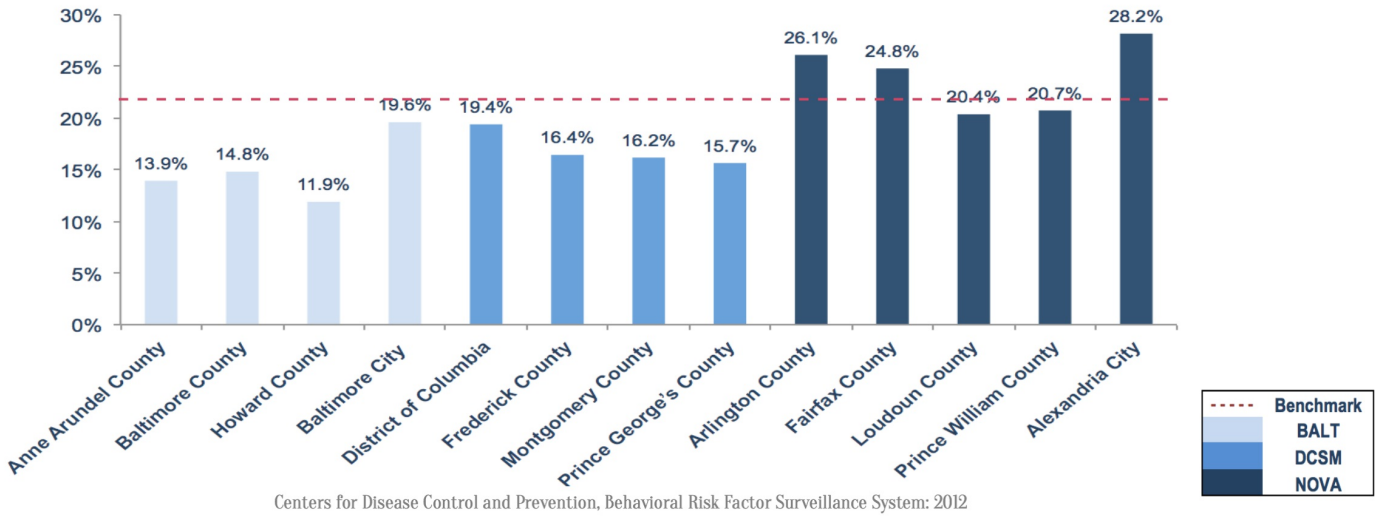
Findings from the 2016 KFHP-MAS CHNA revealed that health care access is a critical health need in the Mid-Atlantic region. Access to health care services, preventive services, and health care coverage are key aspects of the social determinants of health framework. Preventive services are critical to ensure good overall health and to reduce the risk of certain debilitating diseases (1). Preventive services encompass vaccinations, screening tests, and routine check-up. Uninsured individuals are significantly less likely to receive preventive services (yearly check-ups, vaccinations) or purchase the medication they require if they are not covered by insurance. Lack of health care coverage can have severe or fatal consequences when preventable conditions go undetected.

"There is not as much preventive care in the healthcare programs for the uninsured. They tend to be more reactive. So people come only when they are sick. I think if people had access to health care and health insurance and preventive care too, the outcomes would be different. People often wait until they are very, very sick before they come to us." -- Expert Interviewee

DATA SNAPSHOT

Lack of consistent source of primary care

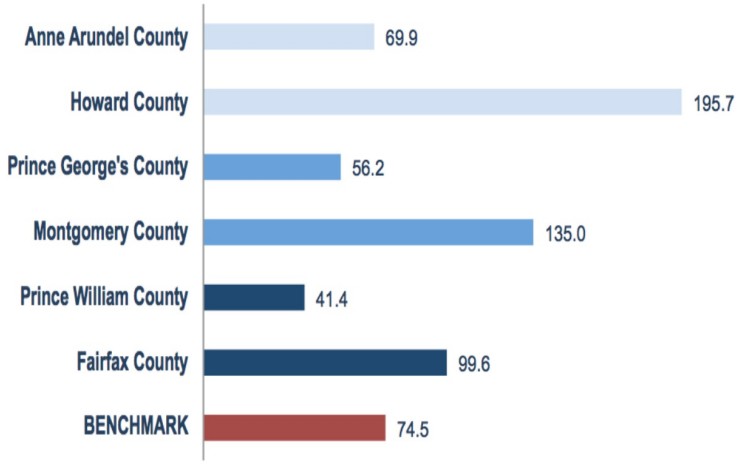
Percent without regular health care provider



Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2012

Access to primary care

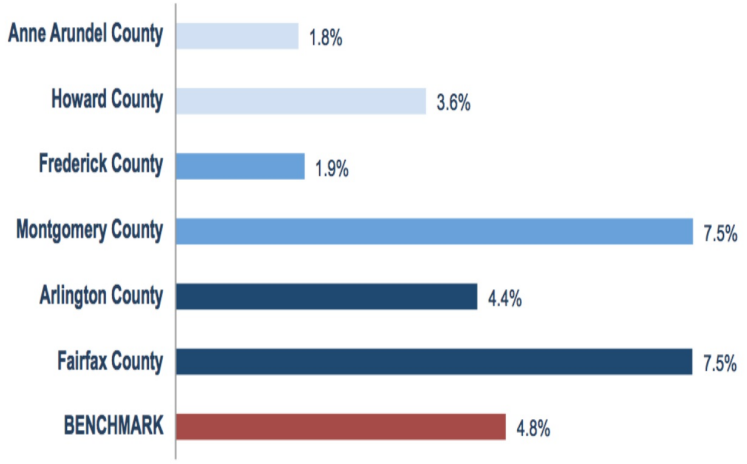
Number of primary care physicians per 100,000 population



University of Wisconsin Population Health Institute, County Health Rankings: 2014

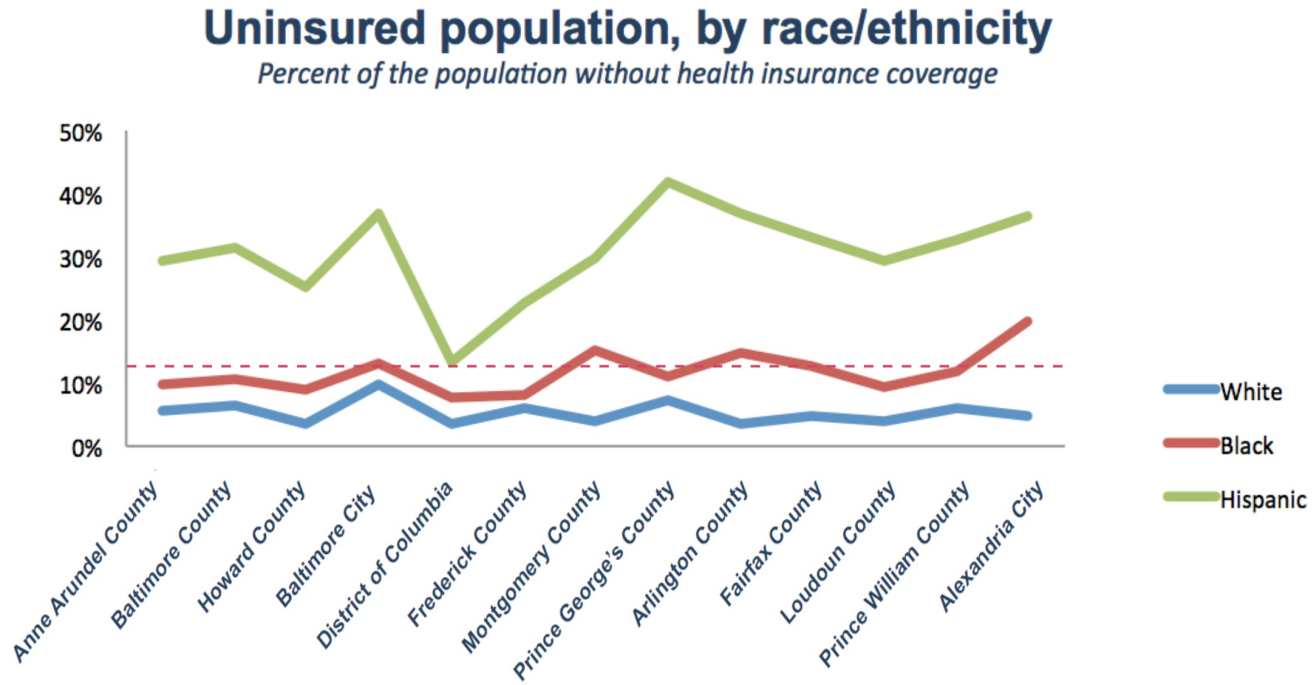
Limited english proficiency

Percent of the population who speak a language other than English at home and speak English less than "very well"



US Census Bureau, American Community Survey: 2009-2013

RACIAL/ETHNIC DISPARITIES



US Census Bureau, American Community Survey: 2009-2013

COMMUNITY ASSETS

BALT - Health Care Access Maryland
Focuses on creating a healthier Maryland by connecting individuals to insurance and care, educating the community, and advocating for more equitable health.
http://www.healthcareaccessmaryland.org
(410) 649-0521

DCSM - Healthcare Initiative Foundation
Offers solutions to improve the quality and delivery of high-quality and cost-effective health care to DC residents.
http://www.hifmc.org
(301) 907-9144

NOVA - Virginia Association of Free and Charitable Clinics
Free clinic membership that supports and provides opportunities to the free and charitable clinics across the state.
http://www.vafreeclinics.org
(804) 340-3434

SOURCES

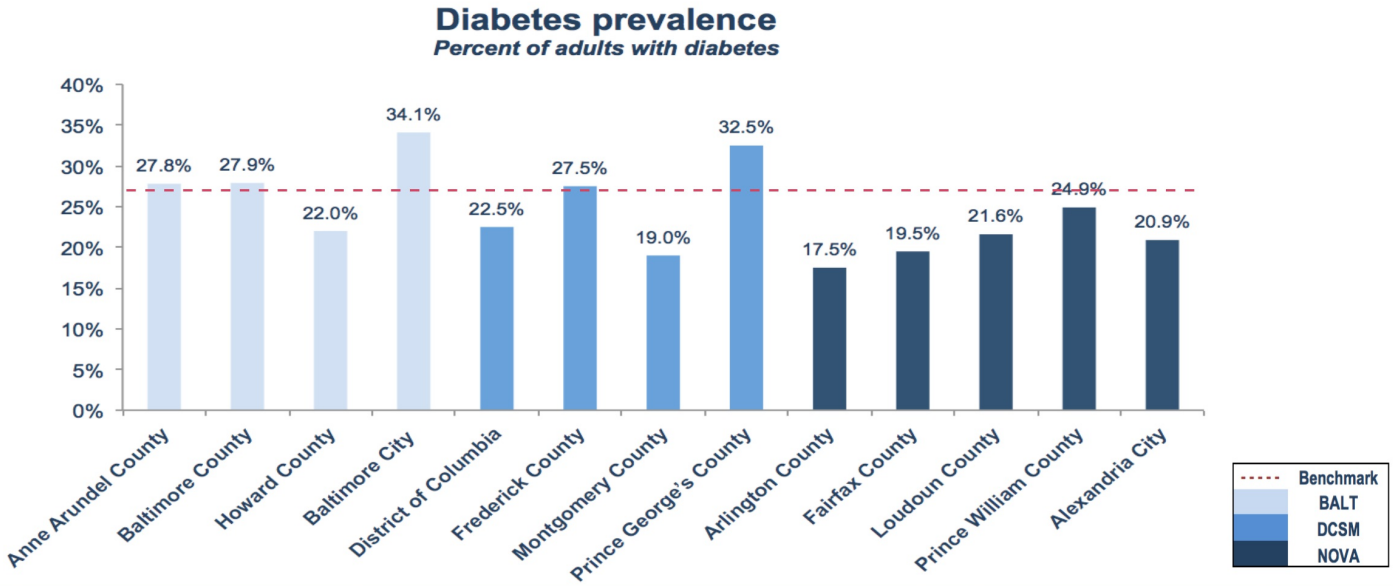
(1) Marmot, M., Friel, S., Bell, R., Houweling, T. A., Taylor, S., & Commission on Social Determinants of Health. (2008). Closing the gap in a generation: health equity through action on the social determinants of health. The Lancet, 372(9650), 1661-1669.
(2) Racial and Ethnic Disparities in Access to Health Insurance and Health Care. (n.d.). Retrieved March 11, 2016, from http://kff.org/disparities-policy/fact-sheet/racial-and-ethnic-disparities-in-access-to/

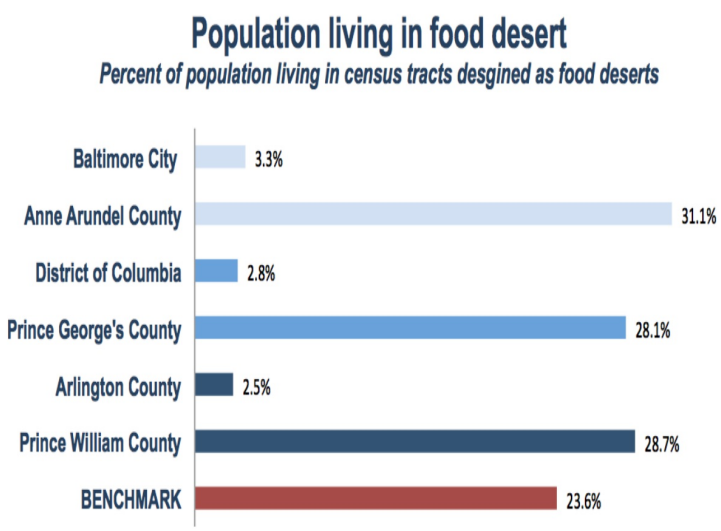
OBESITY/ OVERWEIGHT

Findings from the 2016 KFHP-MAS CHNA revealed that obesity is a critical health need in the Mid-Atlantic region. Obesity has reached epidemic proportions in the United States with approximately one in three adults considered obese (with a Body Mass Index greater than 30.0). Obesity is associated with premature death and increases the risk of cardiovascular disease, diabetes, and certain types of cancer (1). Regular physical activity and healthy eating cut the risk for many chronic conditions, diabetes and certain types of cancer. Neighborhood disparities in food access (i.e. grocery store access, fast food restaurants) are compounding the obesity problem and are associated with poverty (2).

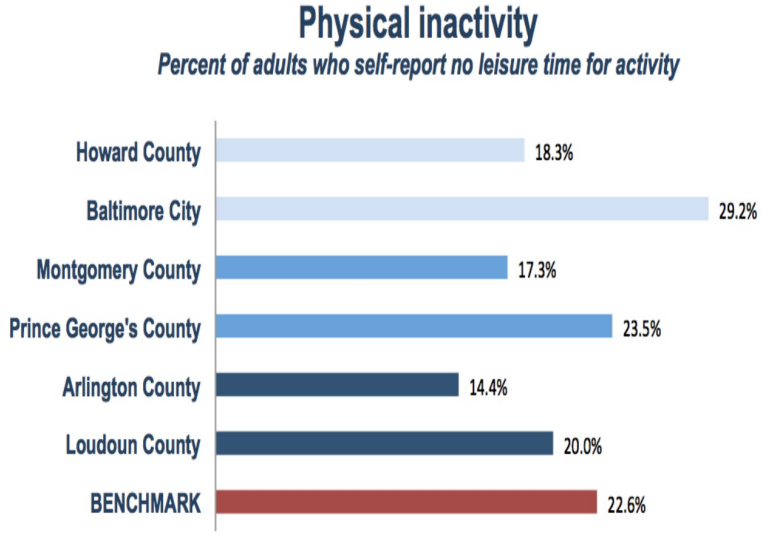
"It's so expensive [to live] here that there's not a lot [of money] left over at the end of the day to actually pay for your food. So if you're wondering what you're going to feed your family, and you're driving by McDonald's which has the dollar menu and you can feed your family of four for $10-12 because you can get ten things off the dollar menu vs. going to a store and buying healthy food fresh produce, then going home, having to prepare it, maybe not knowing how to prepare it [...] that is a significant barrier." -- Expert Interviewee

DATA SNAPSHOT



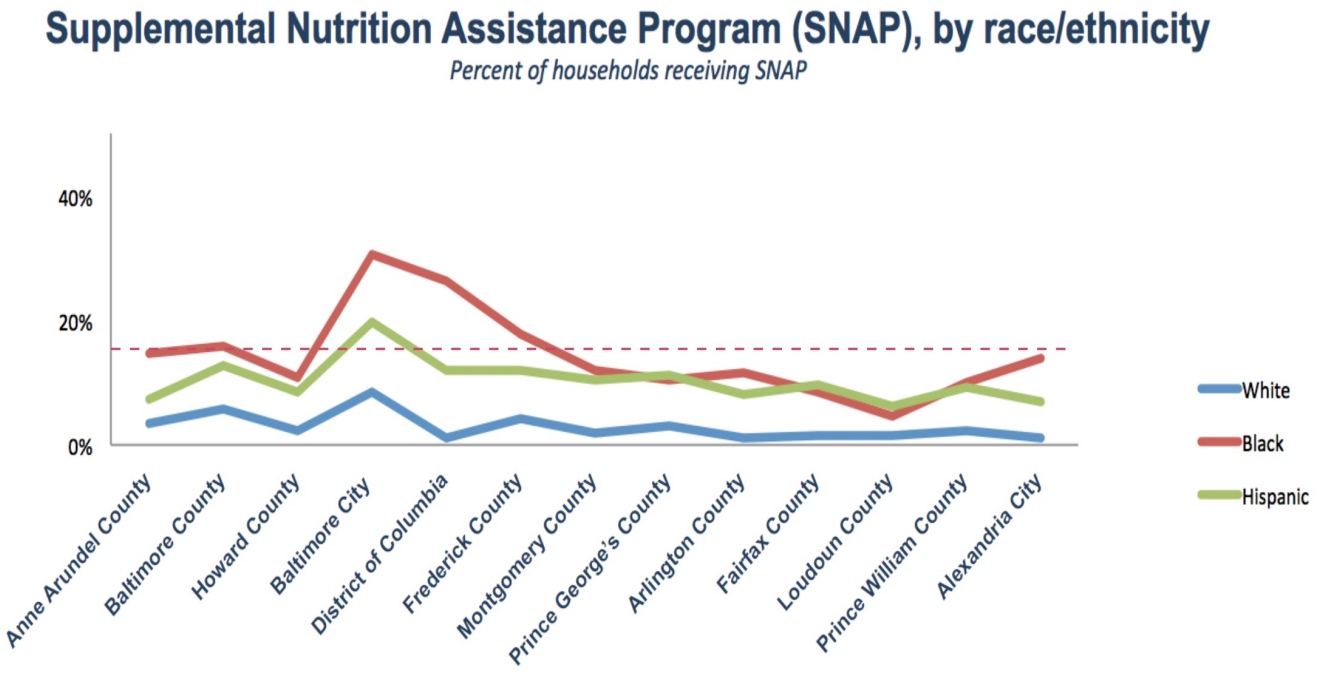


University of Wisconsin Population Health Institute, County Health Rankings: 2014



US Census Bureau, American Community Survey: 2009-2013

RACIAL/ETHNIC DISPARITIES



Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity: 2011

COMMUNITY ASSETS

BALT - BmoreFit Baltimore Fitness Academy

Focuses on the classroom experiences, teaching children about living a healthier lifestyle, physical activity, and healthy eating.
http://www.bmorefit.org
(410) 925-5698

DCSM - DC Central Clinic

Works to reduce hunger by recycling unwanted food, serving healthy school lunch meals, and promoting healthy eating.
http://www.dccentralkitchen.org
(202) 234-0707

NOVA - Virginia Weight and Wellness

Provides long-term affordable weight loss care and health improvements by focusing on weight loss, nutrition, exercise, education, and motivation.
http://www.virginiaweightloss.com
(804) 726-1500

SOURCES

(1) Ogden, C. L., Carroll, M. D., Fryar, C. D., & Flegal, K. M. (2015). Prevalence of Obesity Among Adults and Youth: United States, 2011-2014. NCHS data brief, (219), 1-8.
(2) Larson, N. I., Story, M. T., & Nelson, M. C. (2009). Neighborhood environments: disparities in access to healthy foods in the US. American journal of preventive medicine, 36(1), 74-81.

MENTAL HEALTH

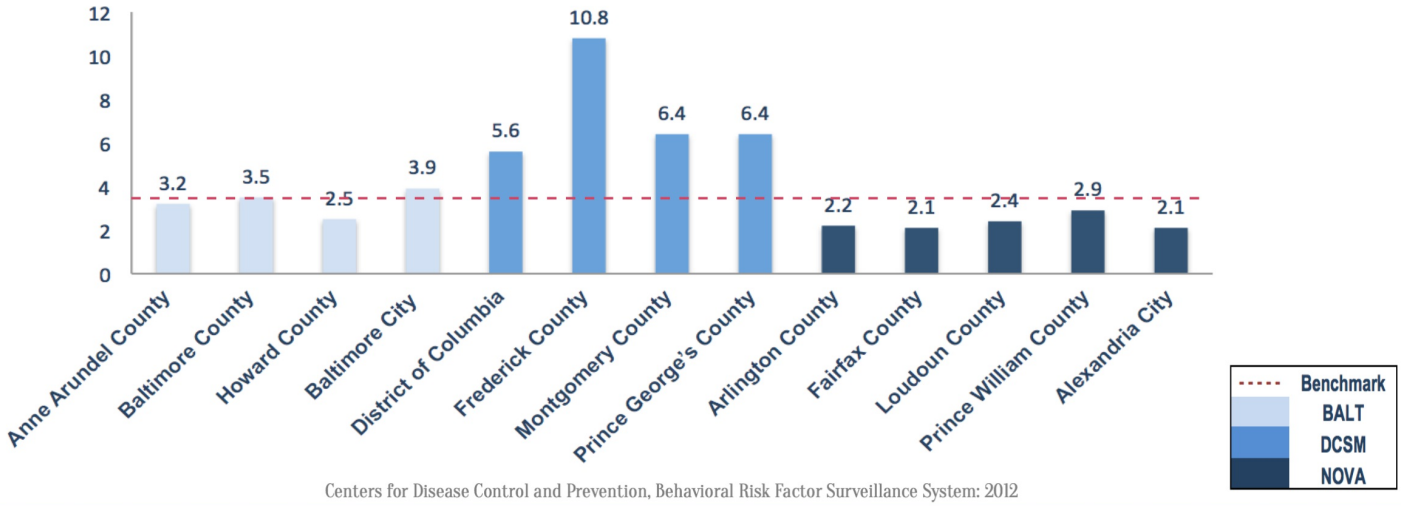
Findings from the 2016 KFHP-MAS CHNA revealed that mental health is a critical health need in the Mid-Atlantic region. It is estimated that one in four adults in the U.S. have been diagnosed with one or more mental health disorders (1). Mental health is often characterized by emotional, psychological, and social well-being. Mental disorders have been associated with substance abuse, chronic diseases, self-destructive behavior, and suicide. Social determinants of mental health that promote positive mental health include safe neighborhoods, family and social support, decent housing, employment, education, and access to quality care (2).

"What we have found to be the drivers [of mental health need] is less clinical, but more the social determinants of health, or the non-medical factors that come into play for any health outcome [...] employment is one, there's also disparate outcomes related educational attainment, housing, poverty, and even where they live geographically."-- Expert Interviewee

DATA SNAPSHOT

Mentally unhealthy days

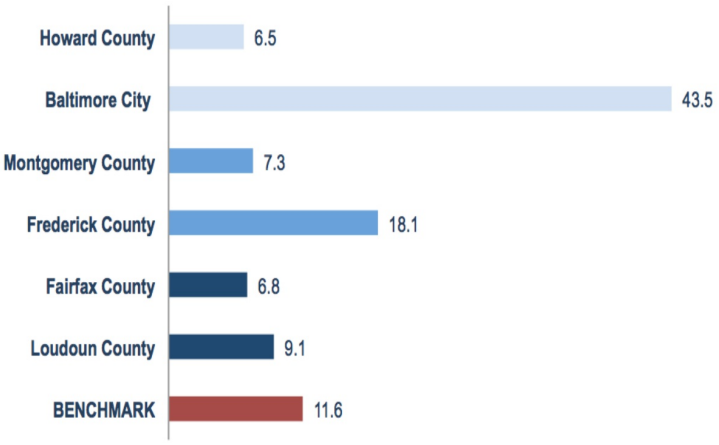
Number of mentally unhealthy days in past 30 days



Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2012

Drug-related mortality

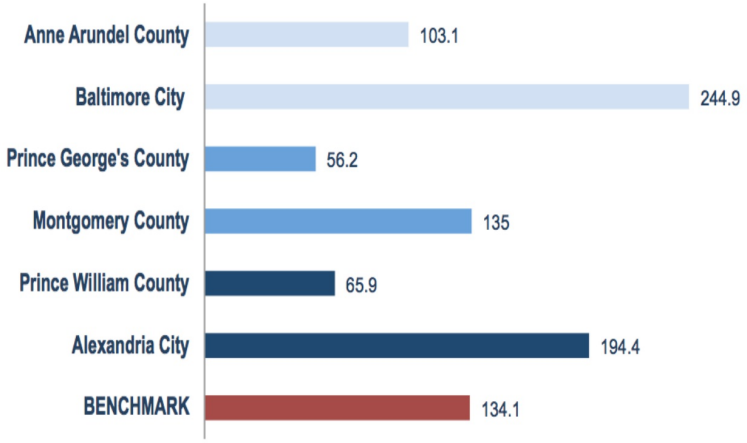
Rate of drug-related deaths per 100,000 population



CDC, Wide-ranging Online Data for Epidemiologic Research (WONDER): 2014

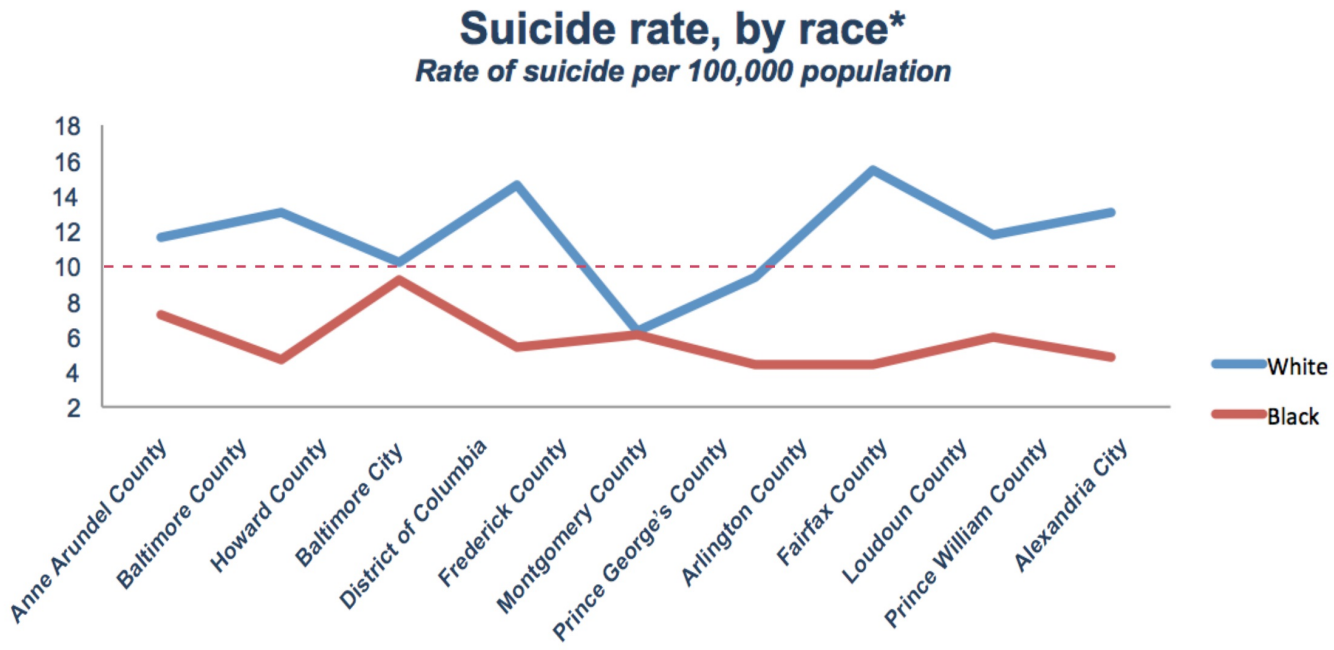
Access to mental health providers

Number of mental health providers per 100,000 population



University of Wisconsin Population Health Institute, County Health Rankings: 2014

RACIAL/ETHNIC DISPARITIES



* Data were missing for Frederick County, Arlington County, Loudoun County and Alexandria City. No ethnicity data were available.

US Census Bureau, American Community Survey: 2009-2013

COMMUNITY ASSETS

BALT - Behavioral Health System Baltimore
Leadership organization in the areas of mental and behavioral health, moving towards approaches in prevention, early intervention, and recovery to build stronger families and communities.
http://www.bhsbaltimore.org/
(410) 637-1900

DCSM - DC Department of Mental Health
Promotes positive mental health by providing an array of services to promote recovery along a culture of diversity.
http://ww.dbh.dc.gov
(202) 673-2200

NOVA - Inova Behavioral Health
Offers a full spectrum of mental health and addiction treatment services to the surrounding Northern Virginia and Washington, D.C., metropolitan community.
http://www.inova.org/healthcare-services/behavioral-health/index.jsp
703-289-7560

SOURCES

(1) Any Anxiety Disorder Among Adults. (n.d.). Retrieved March 11, 2016, from http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml
(2) Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. International Review of Psychiatry, 26(4), 392-407.

DIABETES

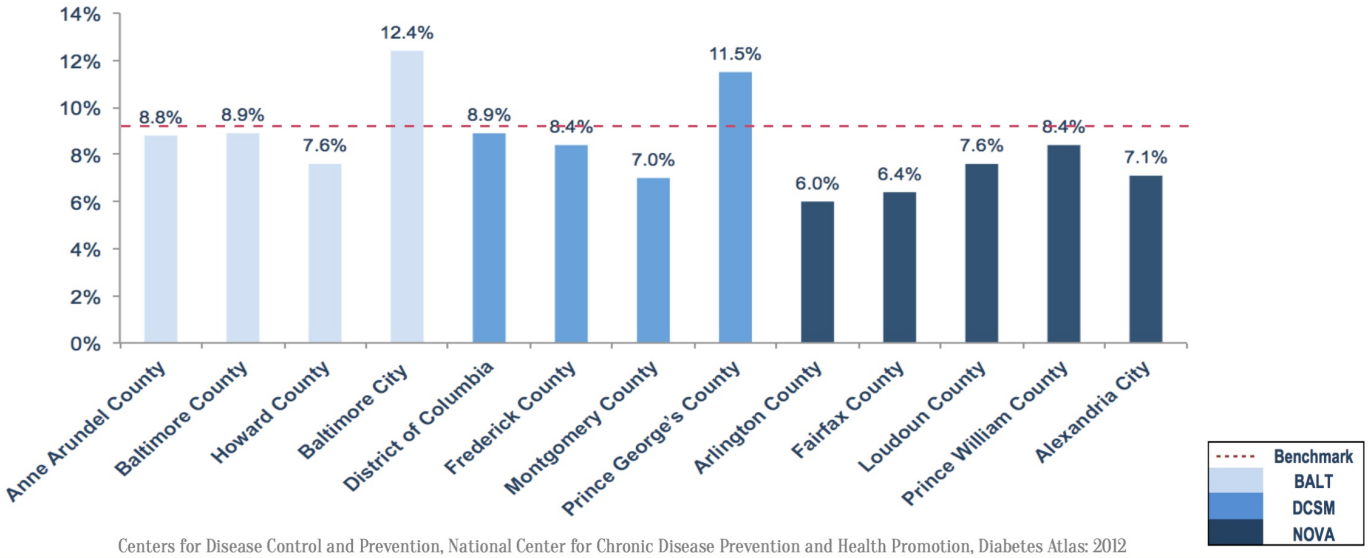
Findings from the 2016 KFHP-MAS CHNA revealed that diabetes is a critical health need in the Mid-Atlantic region. Diabetes affects 29.1 million people in the United States (one in eleven people), and is the seventh leading cause of death. Diabetes is associated with cardiovascular disease, kidney failure, blindness, and amputations. Some risk factors for diabetes include obesity, lack of physical activity, poor eating habits, family history, and race/ethnicity (1). Many of the risk factors for Type 2 diabetes include lifestyle decisions that can be controlled with time and effort. External barriers to diabetes care include income and nutrition access (2).

"[There is a] lack of information about how to prevent diabetes as opposed to simply how to treat it [...]. Since there are not a lot of safety net clinics, there are not a lot of medical options for low-income folks who have this problem [diabetes]... Because there's so few of them, there's often a waitlist." -- Expert Interviewee

DATA SNAPSHOT

Diabetes prevalence

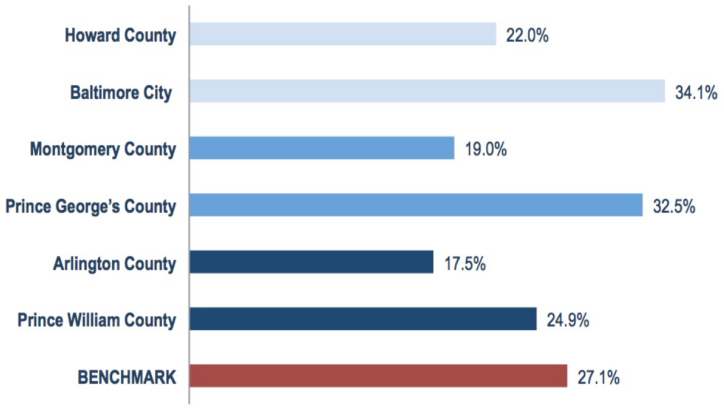
Percent of adults with diabetes



Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Diabetes Atlas: 2012

Adult obesity

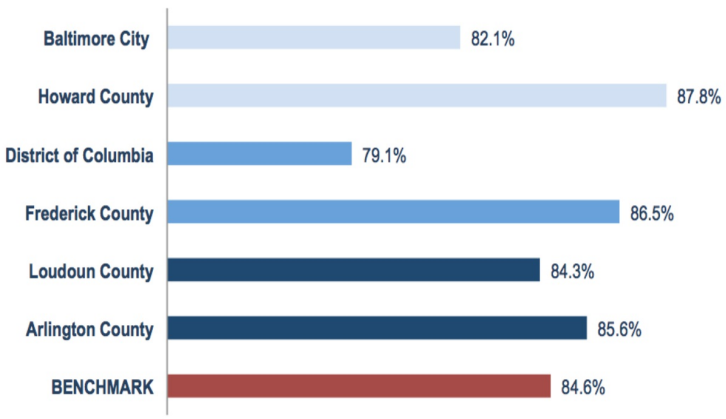
Percent of the adult population with a Body Mass Index greater than 30.0



CDC, National Center for Chronic Disease Prevention and Health Promotion. 2012.

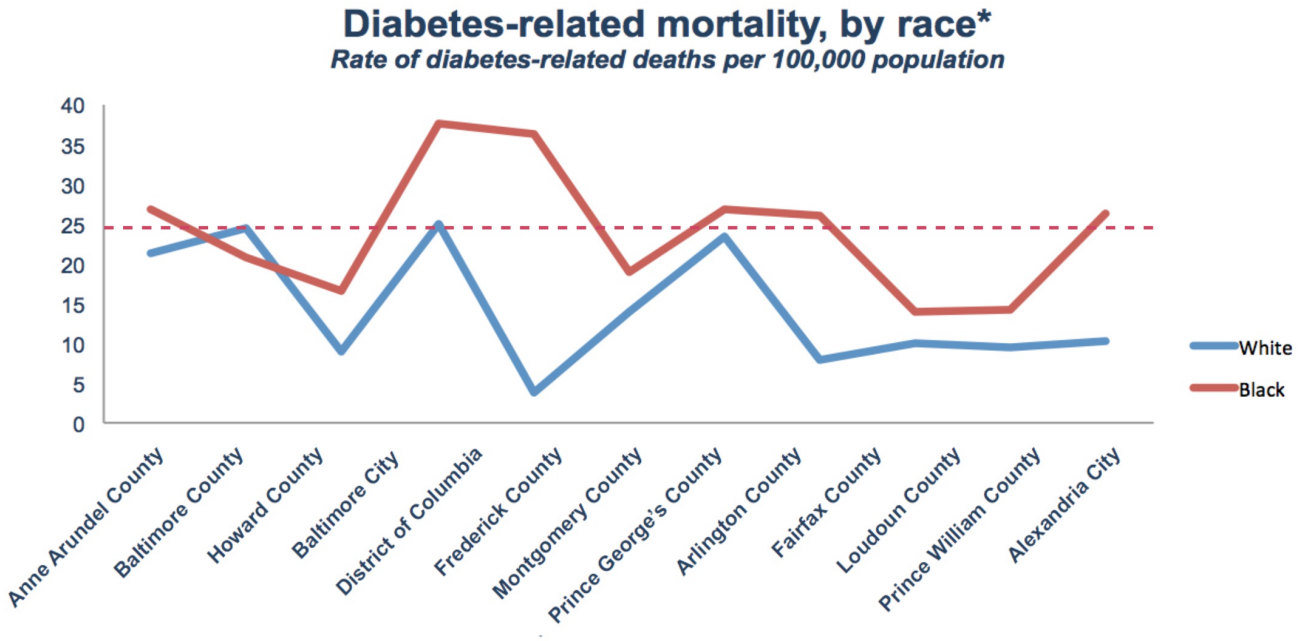
Diabetes management

Percent of diabetic patients who had their A1C checked in past year



CDC, Wide-ranging Online Data for Epidemiologic Research (WONDER)

RACIAL/ETHNIC DISPARITIES



* Data were missing for Frederick County and Loudoun County. No ethnicity data were available.

CDC, Wide-ranging Online Data for Epidemiologic Research (WONDER): 2014

COMMUNITY ASSETS

BALT - Johns Hopkins Comprehensive Diabetes Center
Offers diagnosis, assessment, education, management, and multidisciplinary care for patients with diabetes.
http://www.hopkinsmedicine.org/diabetes/
(410) 955-2815

DCSM - YMCA DC Diabetes Prevention Program
Educates individuals on the risks of diabetes and prevention practices through a focus on healthy eating, weight management, and physical activity.
http://www.diabetes.org/in-my-http://www.ymcadc.org/page.cfm?p=30
(202) 862-9622

NOVA - Inova Diabetes Services
Offers comprehensive diabetes education classes, programs, and support groups at Inova facilities throughout Northern Virginia.
http://www.inova.org/healthcare-services/diabetes/locations/inova-fairfax-hospital/index.jsp
1-877-511-4625

SOURCES

(1) American Diabetes Association. (2014). National Diabetes Statistics Report, 2014. Estimates of diabetes and its burden in the epidemiologic estimation methods. Natl Diabetes Stat Rep, 2009-2012.
(2) Zgibor, J. C., & Songer, T. J. (2001). External barriers to diabetes care: Addressing personal and health systems issues. Diabetes spectrum, 14(1), 23.

PHYSICAL ENVIRONMENT

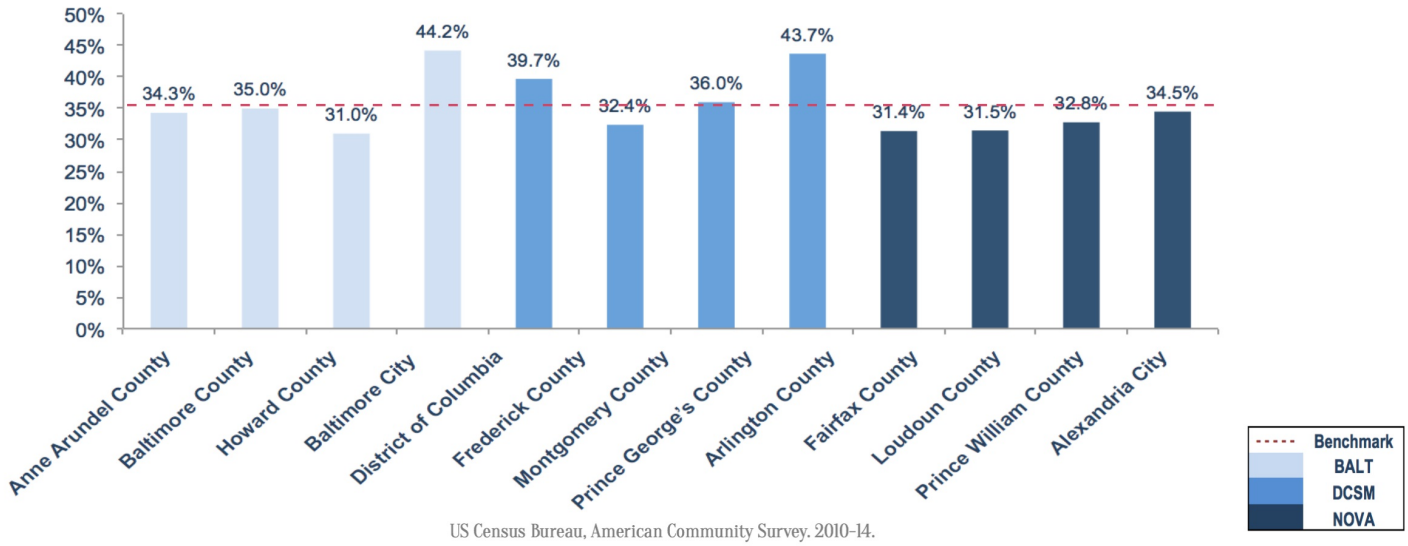
Findings from the 2016 KFHP-MAS CHNA revealed that physical environment is a critical health need in the Mid-Atlantic region. Transit systems and housing options shape the communities' built environment. The choices we make about housing and transportation, and the opportunities underlying these choices, impact our health (1). Access to a vehicle is important for increasing employment retention, and access to public transit is important for job opportunities. Access to reliable transportation systems also offers more options for housing, better grocery stores, and better health care access overall (2).

"We're a suburban community with urban hotspots so transit is another big issue from a social determinants standpoint. It is very hard to be poor in an unaffordable community."
-- Expert Interviewee

DATA SNAPSHOT

Cost-burdened households

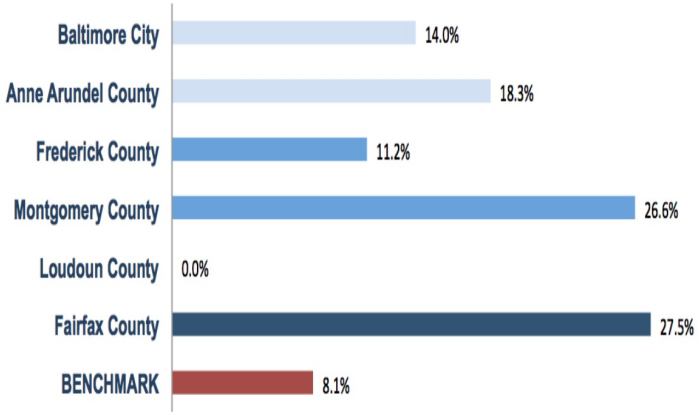
Percent of the households where housing costs exceed 30% of total household income



US Census Bureau, American Community Survey. 2010-14.

Access to public transportation

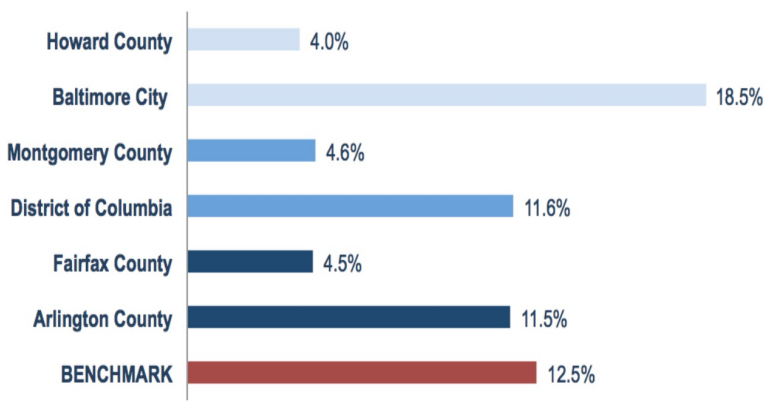
Percent of population living less than 0.5 miles from transit stop



Environmental Protection Agency, EPA Smart Location Database, 2011.

Vacant housing

Percent of housing units that are vacant



US Census Bureau, American Community Survey. 2010-14.

ASSOCIATED FACTORS

Substandard housing

***Percent of occupied households with substandard conditions**

	Anne Arundel County	Baltimore County	Howard County	Baltimore City	District of Columbia	Frederick County	Montgomery County	Prince George's County	Arlington County	Fairfax County	Loudoun County	Prince William County	Alexandria City	United States
Percent of households with one or more substandard conditions	31.6%	33.7%	29.6%	43.3%	38.9%	32.0%	35.2%	42.6%	31.0%	30.5%	30.5%	33.3%	33.8%	**35.6%**
Percent of households lacking complete plumbing facilities	0.4%	0.6%	0.4%	0.7%	0.4%	0.3%	0.3%	0.3%	0.4%	0.3%	0.3%	0.4%	0.2%	**0.5%**
Percent of households lacking complete kitchen facilities	1.0%	1.3%	1.0%	7.7%	1.6%	1.8%	0.7%	0.9%	1.0%	0.7%	0.8%	0.6%	0.5%	**3.0%**
Percent of occupied households lacking telephone service	2.7%	6.5%	1.8%	7.3%	4.1%	4.1%	4.1%	2.9%	2.4%	3.8%	2.3%	3.1%	2.9%	**4.2%**

** This indicator reports the number and percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1.01 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30 percent, and 5) gross rent as a percentage of household income greater than 30 percent.*

U.S. Census Bureau: A Compass for Understanding and Using American Community Survey Data: 2008.

COMMUNITY ASSETS

BALT - BNI-Maryland
A Fair Housing Organization, BNI-Maryland provides assistance in ensuring equal opportunity housing in Maryland through tenant-landlord programs and public activities.
http://www.bni-maryland.org
(800) 487-6007

DCSM - Tri-County Council for Southern Maryland
A program that works to identify issues affecting Southern Maryland, including economic development and transportation.
http://tccsmd.org
(301) 274-1922

NOVA - Northern Virginia Transportation Commission
The goal is to plan, coordinate, and fund successful and functional transit systems in Northern Virginia.
http://www.novatransit.org
(703) 524-3322

SOURCES

(1) http://www.countyhealthrankings.org/our-approach/health-factors/housing-transit
(2) Thakuriah, P., & Metaxatos, P. (2000). Effect of residential location and access to transportation on employment opportunities. Transportation Research Record: Journal of the Transportation Research Board, (1726), 24-32.

Appendix B
KFHP-MAS Scorecard

BALT SERVICE AREA	Comparison level	Benchmark	Anne Arundel	Baltimore County	Howard County	Baltimore City	KP platform	Survey	Interviews	Priority score
Indicator flagged based on poor performance compared to benchmark (cutoff: 10%)										
** Indicator Flagged based on race/ethnicity disparity ratio (cutoff: ≥ 2.0 or ≤0.5)*										
X: Denotes the source that flagged health need/driver (Platform, Survey AND/OR Interview)										
Tier 3 health needs/drivers identified by all 3 data sources (Platform, Survey AND Interview)										
Priority score: tier 3 health needs/drivers were assigned a priority score to create a rank order										
HP: Healthy People 2020, N: National, S: State										
HEALTH NEEDS										
Asthma							**X**	**X**		
Percent of adults diagnosed with asthma	N	**13.4%**	12.6%	12.7%	14.7%	18.2%				
Cancer							**X**	**X**		
Rate of breast cancer per 100,000 population	N	**123.0**	129.0	136.9	130.8	127.5				
Rate of cervical cancer per 100,000 population	HP	**7.1**	6.4	6.7	5.1	10.8				
Rate of colon and rectum cancer per 100,000 population	HP	**38.7**	34.4	40.6	33.9	48.3				
Rate of lung cancer per 100,000 population	N	**63.7**	67.1	69.0	44.6	81.5				
Rate of prostate cancer per 100,000 population	N	**131.7**	146.8	124.8	122.2	148.9				
Rate of cancer mortality per 100,000 population	HP	**160.6**	175.4	171.4*	132.0	226.5*				
Cardiovascular disease							**X**	**X**		
Percent of heart disease prevalence in adult population	N	**4.4%**	4.9%	4.2%	4.1%	4.2%				
Rate of stroke mortality per 100,000 population	HP	**33.8**	39.6	39.5	31.4	51.3				
Rate of heart disease mortality per 100,000 population	HP	**103.4**	100.7	116.5*	85.5	161.2*				
Diabetes							**X**	**X**	**X**	**8.1**
Percent of diabetes prevalence in adult population	N	**9.1%**	8.8%	8.9%	7.6%	12.4%				
Percent of diabetic Medicare patients who had A1c checked in past year	N	**84.6%**	84.5%	84.2%	87.8%	82.1%				
Rate of diabetes-related deaths per 100,000 population	N	**24.1**	20.9	22.7	9.4	36.1				

BALT SERVICE AREA	Comparison level	Benchmark	Anne Arundel	Baltimore County	Howard County	Baltimore City	KP platform	Survey	Interviews	Priority score
Disability							X			
Percent of population with a disability	N	**12.1%**	9.5%*	11.2%*	7.0%	15.3%*				
HIV/AIDS							X	X		
Rate of HIV prevalence per 100,000 population	N	**340.4**	312.1*	449.5*	168.7*	2450.8*				
Percent of teens and adults who have ever been screened with HIV	N	**62.8%**	57.2%	53.4%	57.1%	38.2%				
Hypertension							X	X		
Percent of adults who are not taking medication for their high blood pressure	N	**21.7%**	24.4%	18.1%	27.7%	13.4%				
Infant health							X			
Percent of total births under 2500g	HP	**7.8%**	8.3%	8.9%	8.0%	12.3%				
Rate of deaths to infants less than one year of age per 1,000 births	HP	**6.0**	7.3*	6.9*	5.0*	12.4*				
Intentional injury							X		X	
Number of violent crimes per 100,000 population	N	**395.5**	507.3	526.4	200.9	1448.9				
Number of juvenile arrests for violent and non-violent offenses, per 10,000 youths	S	**405.5**	437.6	623.6	325	651.3				
Rate of homicide per 100,000 population	N	**5.3**	3.0*	5.7*	2.1	30.0*				
Mental health							X	X	X	**8.8**
Number of mentally unhealthy days in past 30 days	N	**3.5**	3.2	3.5	2.5	3.9				
Rate of suicide per 100,000 population	HP	**10.2**	10.8	10.2*	8.7	8.1*				
Obesity/ overweight							X	X	X	**8.4**
Percent of adults who are obese (BMI greater than 30.0)	N	**27.1%**	27.8%	27.9%	22.0%	34.1%				
Percent of adults who are overweight (BMI between 25.0 and 30.0)	N	**35.8%**	36.5%	34.6%	35.3%	30.6%				
Oral health							X			
Percent of adults with poor dental health	N	**15.7%**	12.0%	16.2%	6.7%	20.4%				

BALT SERVICE AREA	Comparison level	Benchmark	Anne Arundel	Baltimore County	Howard County	Baltimore City	KP platform	Survey	Interviews	Priority score
Physical health							**X**	**X**		
Percent of adults with poor general health	N	**15.7%**	10.7%	14.2%	8.8%	18.7%				
Years of Potential Life Lost (YPLL) before age 75 per 100,000 population	N	**6,851**	6,285	6,967	4,104	13,271				
STIs (other)							**X**			
Rate of chlamydia incidence per 100,000 population	N	**456.7**	282.9	373.5	167.8	1245.2				
Unintentional injury							**X**		**X**	
Rate of death due to unintentional injury (accident) per 100,000 population	HP	36.0	23.3	27.5	18.1	33.1				
Percent of death due to motor vehicle crashes per 100,000 population	N	**10.8**	7.8	8	5.3	8.2				
Percent of death due to pedestrian accidents per 100,000 population	HP	**1.3**	2.0	2.4	0.3	1.9				
HEALTH DRIVERS										
Alcohol use							**X**			
Number of beer, wine, and liquor stores per 100,000 population	N	**10.5**	18.2	21.1	20.9	39.1				
Percent of adults who report heavy alcohol consumption	N	**16.9%**	19.2%	16.5%	15.2%	17.7%				
Percent of motor vehicle crash deaths with alcohol involvement	S	**34.0%**	38.0%	32.0%	38.0%	30.0%				
Air pollution										
Percent of days a year with poor air quality (population adjusted average)	N	**1.2%**	0.6%	0.7%	0.8%	0.8%				
Cancer screening										
Percent of adult women who received Pap test in past three years	N	**78.5%**	84.3%	83.9%	87.6%	82.1%				
Percent of adult men aged 50+ who ever received sigmoidoscopy or colonoscopy	N	**61.3%**	71.3%	67.3%	75.1%	61.8%				
Percent of female Medicare enrollees who received mammogram in past two years	N	**63.0%**	64.3%	65.5%	66.0%	63.7%				
Dental care access							**X**			
Number of dentists per 100,000 population	N	**63.2**	65.9	72.9	80.1	57.1				
Percent of population living in area with shortage of dental health professionals	N	**32.0%**	0.0%	0.0%	0.0%	92.8%				
Percent of adults who have not received dental care in past year	N	**30.2%**	20.8%	26.7%	17.8%	35.7%				

BALT SERVICE AREA	Comparison level	Benchmark	Anne Arundel	Baltimore County	Howard County	Baltimore City	KP platform	Survey	Interviews	Priority score
Drug use							**X**	**X**	**X**	**9.3**
Rate of drug-related deaths per 100,000 population	N	**11.6**	22	23.2	6.5	43.5				
Education							**X**	**X**	**X**	**7.1**
Percent of population without high school diploma	N	**13.6%**	8.9%*	9.8%*	-	19.1%*				
Rate of high school graduation	N	**82.2**	85.0	84.0	90.0	66.0				
Percent of 3rd graders reading at "basic" levels on state exams	S	**23.0%**	14.0%	20.0%	14.0%	44.0%				
Percent of 8th graders reading at "basic" levels on state exams	S	**23.0%**	22.0%	23.0%	13.0%	45.0%				
Percent of population age 3-4 that is enrolled in school	N	**47.7%**	50.0%	55.1%	58.5%	50.0%				
Employment							**X**		**X**	
Rate of unemployment	N	**5.6**	4.8	5.8	4.2	8.1				
Family and social support							**X**	**X**		
Percent of children in single-parent household	S	**34.0%**	25.0%	35.0%	22.0%	66.0%				
Percent of adults with insufficient social and emotional support	N	**20.7%**	16.9%	20.3%	15.3%	29.1%				
Healthcare access							**X**	**X**	**X**	**9.1**
Number of primary care physicians per 100,000 population	N	**74.5**	69.9	104.6	195.7	92.7				
Percent of population living in area with shortage of primary care professionals	N	**34.1%**	0.0%	20.2%	0.0%	68.0%				
Percent of adults without regular healthcare provider	N	**22.1%**	13.9%	14.8%	11.9%	19.6%				
Health insurance							**X**		**X**	
Percent of population enrolled in Medicaid	N	**20.2%**	10.7%	14.2%	8.0%	34.2%				
Percent of population without health insurance coverage	N	**14.9%**	7.9%*	9.4%*	7.2%*	13.1%*				
Percent of children who are uninsured	S	**14.8%**	4.1%	5.3%	3.9%	4.1%				
Healthy eating							**X**	**X**		
Percent of adults with inadequate fruit/ vegetables consumption	N	**75.7%**	72.8%	74.1%	70.9%	75.6%				

BALT SERVICE AREA	Comparison level	Benchmark	Anne Arundel	Baltimore County	Howard County	Baltimore City	KP platform	Survey	Interviews	Priority score
Housing							**X**	**X**	**X**	**7.1**
Percent of adults living in substandard housing	N	**33.1%**	33.2%	34.4%	30.3%	44.0%				
Percent of housing units that are vacant	N	**12.5%**	6.7%	6.5%	4.0%	18.5%				
Percent of cost-burdened households (exceeding 30% of income)	N	**35.5%**	34.3%	35.0%	31.0%	44.2%				
Income									**X**	
Median household income per household (in dollars)	N	**53,482**	89,031	66,940	41,819	41,819				
Language barrier										
Percent with limited English proficiency	N	**4.8%**	1.8%	2.7%	3.6%	2.1%				
Mental health access									**X**	
Rate of mental health providers per 100,000 population	N	**134.1**	103.1	174.4	187.2	244.9				
Poverty							**X**	**X**	**X**	**9.5**
Percent of children living under 100% of the FDL	N	**21.6%**	8.0%*	11.3%*	5.7%*	34.1%*				
Percent of population living under 100% of the FPL	N	**15.4%**	6.3%*	8.9%	4.6%*	23.8%				
Percent of population living under 200% of the FPL	N	**34.2%**	16.0%	22.0%	11.7%	44.8%				
Percent of population that experienced food insecurity in past year	N	**15.2%**	9.3%	12.9%	8.1%	22.7%				
Percent of public school students eligible for free or reduced price lunches	N	**52.4%**	31.9%	47.4%	19.2%	84.7%				
Percent of population receiving SNAP benefits	N	**15.2%**	7.1%*	11.9%*	5.2%*	35.0%*				
Nutrition access							**X**	**X**	**X**	**7.5**
Number of fast food restaurants per 100,000 population	N	**72.7**	86.5	94.3	88.1	111.6				
Number of grocery stores per 100,000 population	N	**21.2**	18.4	19.6	15.0	47.7				
Number of food stores accepting WIC program per 100,000 population	N	**15.6**	9.9	10.7	8.2	38.3				
Percent of population living in food deserts (low food access)	N	**23.6%**	31.1%	20.6%	24.2%	3.3%				
Prenatal care access									**X**	
Percent of women without prenatal care during 1st trimester	N	**17.3%**	5.0%	7.0%	5.8%	7.2%				

BALT SERVICE AREA	Comparison level	Benchmark	Anne Arundel	Baltimore County	Howard County	Baltimore City	KP platform	Survey	Interviews	Priority score
Preventative health services							**X**	**X**		
Preventable hospital events per 1,000 Medicare enrollees	N	**59.2**	62.2	58.8	40.5	67.1				
Percent of adults who received pneumonia vaccine	N	**67.5%**	70.7%	68.4%	73.2%	65.3%				
Physical activity							**X**	**X**	**X**	**7.3**
Percent of adults who are physically inactive	N	**22.6%**	22.1%	24.7%	18.3%	29.2%				
Percent of population living within 1/2 mile of a park	N	**48.7%**	33.8%	44.7%	36.9%	73.0%				
Number of recreation and fitness facilities per 100,000 population	N	**9.7**	13.2	13.4	13.6	6.8				
Quality of care							**X**			
Number of federally qualified health centers	N	**1.9**	0.4	0.5	0.7	4.83				
Smoking							**X**			
Percent of adults who currently smoke	N	**18.1%**	15.6%	17.2%	8.2%	23.9%				
Teen births							**X**			
Rate of teen births per 1,000 female population aged 15-19	N	**36.6**	25.4*	24.6*	11.2*	60.6*				
Transportation							**X**	**X**		
Percentage of population using public transportation to commute to work	N	**5.0%**	3.5%	4.6%	3.7%	17.8%				
Percent of population living less than 0.5 miles from transit stop	N	**8.1%**	18.3%	18.1%	16.6%	14.0%				
Water quality										
Percent of population with unsafe drinking water	N	**10.2%**	0.0%	0.0%	0.0%	-				

DCSM SERVICE AREA	Comparison level	Benchmark	District of Columbia	Frederick County	Montgomery County	Prince George's County	KP platform	Survey	Interviews	Priority score
Indicator flagged based on poor performance compared to benchmark (cutoff: 10%)										
** Indicator Flagged based on race/ethnicity disparity ratio (cutoff: ≥ 2.0 or ≤0.5)*										
X: Denotes the source that flagged health need/driver (Platform, Survey AND/OR Interview)										
Tier 3 health needs/drivers identified by all 3 data sources (Platform, Survey AND Interview)										
Priority score: tier 3 health needs/drivers were assigned a priority score to create a rank order										
HP: Healthy People 2020, N: National, S: State										
HEALTH NEEDS										
Asthma							**X**			
Percent of adults diagnosed with asthma	N	**13.4%**	15.4%	15.2%	11.8%	13.0%				
Cancer							**X**	**X**	**X**	**7.4**
Rate of breast cancer per 100,000 population	N	**123.0**	141.7	122	126.6	121				
Rate of cervical cancer per 100,000 population	HP	**7.1**	9.6	5.6	5.2	7.8				
Rate of colon and rectum cancer per 100,000 population	HP	**38.7**	44	46.1	30.5	36.4				
Rate of lung cancer per 100,000 population	N	**63.7**	59.6	55.5	36.8	48.1				
Rate of prostate cancer per 100,000 population	N	**131.7**	184.1	124.5	137	168.2				
Rate of cancer mortality per 100,000 population	HP	**160.6**	182.6	155.7	120.4	172.3*				
Cardiovascular disease							**X**	**X**	**X**	**7.8**
Percent of heart disease prevalence in adult population	N	**4.4%**	3.2% *	3.7%	2.9%	3.4% *				
Rate of stroke mortality per 100,000 population	HP	**33.8**	33.0	38.0	26.5	37.5				
Rate of heart disease mortality per 100,000 population	HP	**103.4**	142.7	104.1	71.3	127.8				

DCSM SERVICE AREA	Comparison level	Benchmark	District of Columbia	Frederick County	Montgomery County	Prince George's County	KP platform	Survey	Interviews	Priority score
Diabetes							**X**	**X**	**X**	**8.1**
Percent of diabetes prevalence in adult population	N	**9.1%**	8.9%	8.4%	7.0%	11.5%				
Percent of diabetic Medicare patients who had A1c checked in past year	N	**84.6%**	79.1%	86.5%	86.0%	81.1%				
Rate of diabetes-related deaths per 100,000 population	N	**24.1**	18.1*	16.8	12.8*	27.1				
Disability							**X**			
Percent of population with a disability	N	**12.1%**	11.2*	9.4% *	7.5% *	8.2% *				
HIV/AIDS							**X**			
Rate of HIV prevalence per 100,000 population	N	**340.4**	-	149.7*	416.8*	830.1*				
Percent of teens and adults who have ever been screened with HIV	N	**62.8%**	32.5%	57.9%	58.1%	44.8%				
Hypertension							**X**	**X**	**X**	**6.9**
Percent of adults who are not taking medication for their high blood pressure	N	**21.7%**	23.9%	21.6%	20.4%	16.9%				
Infant health							**X**		**X**	
Percent of total births under 2500g	HP	**7.8%**	10.5*	8.0%	7.9%	10.3%				
Rate of deaths to infants less than one year of age per 1,000 births	HP	**6.0**	10.6*	4.4	5.2 *	10.2				
Intentional injury							**X**			
Number of violent crimes per 100,000 population	N	**395.5**	1259.4	274.3	181.8	624.2				
Number of juvenile arrests for violent and non-violent offenses, per 10,000 youths	S	**405.5**	563	314.4	179.7	242.8				
Rate of homicide per 100,000 population	N	**5.3**	15.1	2.8	1.9	10.0				
Mental health							**X**	**X**	**X**	**7.7**
Number of mentally unhealthy days in past 30 days	N	**3.5**	2.9	3.2	2.6	3.0				
Rate of suicide per 100,000 population	HP	**10.2**	5.6	10.8	6.4*	6.4*				

DCSM SERVICE AREA	Comparison level	Benchmark	District of Columbia	Frederick County	Montgomery County	Prince George's County	KP platform	Survey	Interviews	Priority score
Obesity/ overweight							**X**	**X**	**X**	**8.2**
Percent of adults who are obese (BMI greater than 30.0)	N	**27.1%**	22.5%	27.5%	19.0%	32.5%				
Percent of adults who are overweight (BMI between 25.0 and 30.0)	N	**35.8%**	30.0%	35.6%	36.1%	38.6%				
Oral health									**X**	
Percent of adults with poor dental health	N	**15.7%**	12.9%	10.7%	8.7%	12.7%				
Physical health							**X**	**X**		
Percent of adults with poor general health	N	**15.7%**	12.2%	10.5%	9.2%	12.8%				
Years of Potential Life Lost (YPLL) before age 75 per 100,000 population	N	**6851.0**	9,869	5,125	3,816	7,719				
STIs (other)							**X**			
Rate of chlamydia incidence per 100,000 population	N	**456.7**	1101.6	245.4	244.6	692.9				
Unintentional injury							**X**			
Rate of death due to unintentional injury (accident) per 100,000 population	HP	**36.0**	30.8	24.3	16.4	26.2*				
Percent of death due to motor vehicle crashes per 100,000 population	N	**10.8**	5.7*	8.9	4.7	10.3				
Percent of death due to pedestrian accidents per 100,000 population	HP	**1.3**	1.4	1.0	1.1	3.0				
HEALTH DRIVERS										
Alcohol use							**X**			
Number of beer, wine, and liquor stores per 100,000 population	N	**10.5**	29.8	20.6	14.1	16.3				
Percent of adults who report heavy alcohol consumption	N	**16.9%**	19.6%	17.0%	14.6%	10.1%				
Percent of motor vehicle crash deaths with alcohol involvement	S	**34.0%**	32.0%	32.0%	35.0%	34.0%				
Air pollution										
Percent of days a year with poor air quality (population adjusted average)	N	**1.2%**	0.4%	1.1%	0.6%	0.4%				

DCSM SERVICE AREA	Comparison level	Benchmark	District of Columbia	Frederick County	Montgomery County	Prince George's County	KP platform	Survey	Interviews	Priority score
Cancer screening										
Percent of adult women who received Pap test in past three years	N	**78.5%**	86.1%	83.1%	82.4%	84.9%				
Percent of adult men aged 50+ who ever received sigmoidoscopy or colonoscopy	N	**61.3%**	65.8%	68.1%	71.0%	70.8%				
Percent of female Medicare enrollees who received mammogram in past two years	N	**63.0%**	63.9%	61.6%	63.7%	61.7%				
Dental care access										
Number of dentists per 100,000 population	N	**63.2**	116.5	65.0	115.2	58.4				
Percent of population living in area with shortage of dental health professionals	N	**32.0%**	33.4%	3.6%	6.3%	3.2%				
Percent of adults who have not received dental care in past year	N	**30.2%**	26.8%	23.6%	19.1%	29.6%				
Drug use							**X**	**X**	**X**	**7.1**
Rate of drug-related deaths per 100,000 population	N	**11.6**	16.1	18.1	7.3	7.9				
Education							**X**	**X**		
Percent of population without high school diploma	N	**13.6%**	11.1*	8.3%*	8.7%*	14.4*				
Rate of high school graduation	N	**82.2**	54.0	93.0	87.0	73.0				
Percent of 3rd graders reading at "basic" levels on state exams	S	**23.0%**	26.0%	12.0%	20.0%	30.0%				
Percent of 8th graders reading at "basic" levels on state exams	S	**23.0%**	20.0%	17.0%	16.0%	32.0%				
Percent of population age 3-4 that is enrolled in school	N	**47.7%**	73.1%	47.9%	56.6%	48.8%				
Employment							**X**			
Rate of unemployment	N	**5.6**	7.7	4.8	4.2	5.5				
Family and social support							**X**	**X**		
Percent of children in single-parent household	S	**34.0%**	33.0%	23.0%	24.0%	45.0%				
Percent of adults with insufficient social and emotional support	N	**20.70%**	22.2%	15.4%	18.8%	22.8%				

DCSM SERVICE AREA	Comparison level	Benchmark	District of Columbia	Frederick County	Montgomery County	Prince George's County	KP platform	Survey	Interviews	Priority score
Healthcare access							**X**	**X**	**X**	**8.2**
Number of primary care physicians per 100,000 population	N	**74.5**	113.9	58.9	135.0	56.2				
Percent of population living in area with shortage of primary care professionals	N	**34.1%**	75.5%	3.6%	6.3%	48.0%				
Percent of adults without regular healthcare provider	N	**22.1%**	19.4%	16.4%	16.2%	15.7%				
Health insurance							**X**	**X**	**X**	**6.7**
Percent of population enrolled in Medicaid	N	**20.2%**	27.7%	10.4%	11.4%	17.8%				
Percent of population without health insurance coverage	N	**14.9%**	6.7%*	7.8%*	11.5*	15.4*				
Percent of children who are uninsured	S	**4.8%**	4.6%*	4.8%*	5.1%*	5.4%*				
Healthy eating								**X**	**X**	
Percent of adults with inadequate fruit/ vegetables consumption	N	**75.7%**	67.9%	74.3%	66.7%	70.7%				
Housing							**X**	**X**		
Percent of adults living in substandard housing	N	**33.1%**	40.1%	31.8%	35.7%	43.8%				
Percent of housing units that are vacant	N	**12.5%**	11.6%	5.0%	4.6%	7.6%				
Percent of cost-burdened households (exceeding 30% of income)	N	**35.5%**	39.7%	32.4%	36.0%	43.7%				
Income									**X**	
Median household income per household (in dollars)	N	**53,482**	69,235	84,480	98,704	73,856				
Language barrier							**X**		**X**	
Percent with limited English proficiency	N	**4.8%**	2.6%	1.9%	7.5%	5.0%				
Mental health access									**X**	
Rate of mental health providers per 100,000 population	N	**134.1**	113.9	58.9	135	56.2				

DCSM SERVICE AREA	Comparison level	Benchmark	District of Columbia	Frederick County	Montgomery County	Prince George's County	KP platform	Survey	Interviews	Priority score
Poverty							**X**	**X**	**X**	**8.6**
Percent of children living under 100% of the FDL	N	**21.6%**	28.7%	8.0%	8.2%	12.2%				
Percent of population living under 100% of the FPL	N	**15.4%**	18.6*	6.1%*	6.7%*	9.4%*				
Percent of population living under 200% of the FPL	N	**34.2%**	32.7%	16.6%	17.4%	23.7%				
Percent of population that experienced food insecurity in past year	N	**15.2%**	1.8%	8.4%	7.9%	14.8%				
Percent of public school students eligible for free or reduced price lunches	N	**52.4%**	99.2%	26.2%	34.2%	61.5%				
Percent of population receiving SNAP benefits	N	**15.2%**	24.0*	7.3%*	6.0%*	11.3*				
Nutrition access							**X**	**X**		
Number of fast food restaurants per 100,000 population	N	**72.7**	136.3	79.3	81.6	87.2				
Number of grocery stores per 100,000 population	N	**21.2**	30.6	17.6	21.1	18.4				
Number of food stores accepting WIC program per 100,000 population	N	**15.6**	4.2	12.2	9.0	15.4				
Percent of population living in food deserts	N	**23.6%**	2.8%	22.0%	17.9%	28.1%				
Prenatal care access									**X**	
Percent of women without prenatal care during 1st trimester	N	**17.3%**	5.4%	5.4%	4.4%	7.8%				
Preventative health services							**X**	**X**	**X**	**7.3**
Preventable hospital events per 1,000 Medicare enrollees	N	**59.2**	47.2	58.3	35	48.3				
Percent of adults who received pneumonia vaccine	N	**67.5%**	60.2%	71.4%	70.2%	61.4%				
Physical activity							**X**	**X**	**X**	**6.9**
Percent of adults who are physically inactive	N	**22.6%**	17.6%	19.5%	17.3%	23.5%				
Percent of population living within 1/2 mile of a park	N	**48.7%**	93.3%	42.0%	83.3%	70.8%				
Number of recreation and fitness facilities per 100,000 population	N	**9.7**	14.1	13.7	15.4	7.2				
Quality of care							**X**			
Number of federally qualified health centers	N	**1.9**	6.7	0.0	0.4	0.6				

DCSM SERVICE AREA	Comparison level	Benchmark	District of Columbia	Frederick County	Montgomery County	Prince George's County	KP platform	Survey	Interviews	Priority score
Smoking										
Percent of adults who currently smoke	N	**18.1%**	15.5%	14.7%	8.0%	13.5%				
Teen births							**X**			
Rate of teen births per 1,000 female population aged 15-19	N	**36.6**	46.4*	20.3*	18.8*	34.2*				
Transportation							**X**	**X**	**X**	**5.8**
Percentage of population using public transportation to commute to work	N	**5.0%**	38.4%	2.7%	15.4%	17.5%				
Percent of population living less than 0.5 miles from transit stop	N	**8.1%**	18.9%	11.2%	26.6%	18.1%				
Water quality										
Percent of population with unsafe drinking water	N	**10.2%**	3.5%	2.8%	0.0%	0.0%				

NOVA SERVICE AREA	Comparison level	Benchmark	Arlington County	Fairfax County	Loudoun County	Prince William County	Alexandria City	KP platform	Survey	Interview	Priority score
Indicator flagged based on poor performance compared to benchmark (cutoff: 10%)											
** Indicator Flagged based on race/ethnicity disparity ratio (cutoff: ≥ 2.0 or ≤0.5)*											
X: Denotes the source that flagged health need/driver (Platform, Survey AND/OR Interview)											
Tier 3 health needs/drivers identified by all 3 data sources (Platform, Survey AND Interview)											
Priority score: tier 3 health needs/drivers were assigned a priority score to create a rank order											
HP: Healthy People 2020, N: National, S: State											
HEALTH NEEDS											
Asthma											
Percent of adults diagnosed with asthma	N	**13.4%**	11.2%	14.3%	9.2%	13.4%	11.3%				
Cancer								**X**	**X**	**X**	**5.9**
Rate of breast cancer per 100,000 population	N	**123.0**	143.7	125.9	123.4	111.4	111.3				
Rate of cervical cancer per 100,000 population	HP	**7.1**	3.4	5.9	4.2	5.0*	4.6				
Rate of colon and rectum cancer per 100,000 population	HP	**38.7**	31.3	33.2	32.3	33.7	27.4				
Rate of lung cancer per 100,000 population	N	**63.7**	37.2	41.0	44.2	52.1*	33.2				
Rate of prostate cancer per 100,000 population	N	**131.7**	99.0	109.1	105.3	110.2	114.3				
Rate of cancer mortality per 100,000 population	HP	**160.6**	135.6	126.6	136.1	148.7	135.2				
Cardiovascular disease								**X**	**X**	**X**	**7.8**
Percent of heart disease prevalence in adult population	N	**4.4%**	0.3%	2.8%	2.0%	3.0%	3.1%				
Rate of stroke mortality per 100,000 population	HP	**33.8**	35.1*	29.1	29.3	34.5	30.2				
Rate of heart disease mortality per 100,000 population	HP	**103.4**	60.1	51.8	63.2	71.4*	76.1				
Diabetes								**X**	**X**	**X**	**9.2**
Percent of diabetes prevalence in adult population	N	**9.1%**	6.0%	6.4%	7.6%	8.4%	7.1%				
Percent of diabetic Medicare patients who had A1c checked in past year	N	**84.6%**	85.6%	84.7%	84.3%	83.4%	84.2%				
Rate of diabetes-related deaths per 100,000 population	N	**24.1**	10.6*	10.2*	10.7	9.2	-				

NOVA SERVICE AREA	Comparison level	Benchmark	Arlington County	Fairfax County	Loudoun County	Prince William County	Alexandria City	KP platform	Survey	Interview	Priority score
Indicator flagged based on poor performance compared to benchmark (cutoff: 10%)											
** Indicator Flagged based on race/ethnicity disparity ratio (cutoff: ≥ 2.0 or ≤0.5)*											
X: Denotes the source that flagged health need/driver (Platform, Survey AND/OR Interview)											
Tier 3 health needs/drivers identified by all 3 data sources (Platform, Survey AND Interview)											
Priority score: tier 3 health needs/drivers were assigned a priority score to create a rank order											
HP: Healthy People 2020, N: National, S: State											
Disability											
Percent of population with a disability	N	**12.1%**	5.2%	6.4%	5.1%	6.8%	6.4%				
HIV/AIDS								**X**			
Rate of HIV prevalence per 100,000 population	N	**340.4**	751.9*	259.8*	114.5*	230.1*	1070.0*				
Percent of teens and adults who have ever been screened with HIV	N	**62.8%**	46.2%	58.2%	68.2%	46.8%	45.6%				
Hypertension								**X**	**X**	**X**	**8.8**
Percent of adults who are not taking medication for their high blood pressure	N	**21.7%**	27.3%	20.2%	27.3%	39.1%	16.3%				
Infant health								**X**			
Percent of total births under 2500g	HP	**7.8%**	6.6%	7.0%*	6.8%	7.4%	7.4%				
Rate of deaths to infants less than one year of age per 1,000 births	HP	**6.0**	4.4	4.9	4.2	6.1	5.0				
Intentional injury											
Number of violent crimes per 100,000 population	N	**395.5**	150.3	90	88.5	148.4	180.4				
Number of juvenile arrests for violent/ non-violent offenses, per 10,000 youths	S	**405.5**	-	-	-	-	-				
Rate of homicide per 100,000 population	N	**5.3**	-	1.7	-	2.2	-				
Mental health									**X**	**X**	
Number of mentally unhealthy days in past 30 days	N	**3.5**	2.2	2.1	2.4	2.9	2.1				
Rate of suicide per 100,000 population	HP	**10.2**	7.3	9.1	10.3	8.9	9.2				

NOVA SERVICE AREA	Comparison level	Benchmark	Arlington County	Fairfax County	Loudoun County	Prince William County	Alexandria City	KP platform	Survey	Interview	Priority score
Indicator flagged based on poor performance compared to benchmark (cutoff: 10%)											
** Indicator Flagged based on race/ethnicity disparity ratio (cutoff: ≥ 2.0 or ≤0.5)*											
X: Denotes the source that flagged health need/driver (Platform, Survey AND/OR Interview)											
Tier 3 health needs/drivers identified by all 3 data sources (Platform, Survey AND Interview)											
Priority score: tier 3 health needs/drivers were assigned a priority score to create a rank order											
HP: Healthy People 2020, N: National, S: State											
Obesity/ overweight								**X**	**X**	**X**	**8.5**
Percent of adults who are obese (BMI greater than 30.0)	N	**27.1%**	17.5%	19.5%	21.6%	24.9%	20.9%				
Percent of adults who are overweight (BMI between 25.0 and 30.0)	N	**35.8%**	36.2%	36.2%	39.6%	39.9%	32.9%				
Oral health									**X**	**X**	
Percent of adults with poor dental health	N	**15.7%**	9.2%	5.9%	5.7%	7.3%	6.2%				
Physical health									**X**		
Percent of adults with poor general health	N	**15.7%**	8.2%	7.4%	10.5%	14.3%	10.4%				
Years of Potential Life Lost (YPLL) before age 75 per 100,000 population	N	**6851.0**	3841.0	3616.0	3289.0	4881.0	5139.0				
STIs (other)											
Rate of chlamydia incidence per 100,000 population	N	**456.7**	266.2	168.4	163.8	322.2	337.5				
Unintentional injury										**X**	
Rate of death due to unintentional injury (accident) per 100,000 population	HP	**36.0**	18.5	20.5	20.4	27.1	22.0				
Percent of death due to motor vehicle crashes per 100,000 population	N	**10.8**	2.7	5.4	5.0	6.0	4.5				
Percent of death due to pedestrian accidents per 100,000 population	HP	**1.3**	1.4	0.8	0.6	1.2	2.1				

NOVA SERVICE AREA	Comparison level	Benchmark	Arlington County	Fairfax County	Loudoun County	Prince William County	Alexandria City	KP platform	Survey	Interview	Priority score
Indicator flagged based on poor performance compared to benchmark (cutoff: 10%)											
** Indicator Flagged based on race/ethnicity disparity ratio (cutoff: ≥ 2.0 or ≤0.5)*											
X: Denotes the source that flagged health need/driver (Platform, Survey AND/OR Interview)											
Tier 3 health needs/drivers identified by all 3 data sources (Platform, Survey AND Interview)											
Priority score: tier 3 health needs/drivers were assigned a priority score to create a rank order											
HP: Healthy People 2020, N: National, S: State											
HEALTH DRIVERS											
Alcohol use								**X**			
Number of beer, wine, and liquor stores per 100,000 population	N	**10.5**	6.3	5	6.4	4.2	7.1				
Percent of adults who report heavy alcohol consumption	N	**16.9%**	18.9%	20.2%	17.8%	18.5%	21.0%				
Percent of motor vehicle crash deaths with alcohol involvement	S	**34.0%**	17.0%	26.0%	33.0%	23.0%	23.0%				
Air pollution											
Percent of days a year with poor air quality (population adjusted average)	N	**1.2%**	0.3%	0.3%	0.3%	0.3%	0.3%				
Cancer screening								**X**			
Percent of adult women who received Pap test in past three years	N	**78.5%**	88.5%	81.9%	82.3%	813.0%	86.3%				
Percent of adult men aged 50+ who ever received colonoscopy	N	**61.3%**	67.0%	75.4%	63.9%	68.2%	77.2%				
Percent of female Medicare enrollees who received mammogram in past 2 years	N	**63.0%**	64.4%	60.9%	61.7%	56.1%	58.6%				
Dental care access								**X**	**X**	**X**	**8.1**
Number of dentists per 100,000 population	N	**63.2**	55.6	93.5	60.1	47.0	73.2				
Percent of population living in area with shortage of dental health professionals	N	**32.0%**	0%	0%	0%	0%	0%				
Percent of adults who have not received dental care in past year	N	**30.2%**	16.4%	17.2%	20.7%	17.3%	18.3%				
Drug use										**X**	
Rate of drug-related deaths per 100,000 population	N	**11.6**	-	6.8	9.1	8.3	-				

NOVA SERVICE AREA	Comparison level	Benchmark	Arlington County	Fairfax County	Loudoun County	Prince William County	Alexandria City	KP platform	Survey	Interview	Priority score
Indicator flagged based on poor performance compared to benchmark (cutoff: 10%)											
** Indicator Flagged based on race/ethnicity disparity ratio (cutoff: ≥ 2.0 or ≤0.5)*											
X: Denotes the source that flagged health need/driver (Platform, Survey AND/OR Interview)											
Tier 3 health needs/drivers identified by all 3 data sources (Platform, Survey AND Interview)											
Priority score: tier 3 health needs/drivers were assigned a priority score to create a rank order											
HP: Healthy People 2020, N: National, S: State											
Education								**X**	**X**		
Percent of population without high school diploma	N	**13.6%**	6.6%*	8.2%*	6.5%*	10.3%*	8.7%*				
Rate of high school graduation	N	**82.2**	81.0	86.0	92.0	84.0	75.0				
Percent of 3rd graders reading at "basic" levels on state exams	S	**23.0%**	-	-	-	-	-				
Percent of 8th graders reading at "basic" levels on state exams	S	**23.0%**	-	-	-	-	-				
Percent of population age 3-4 that is enrolled in school	N	**47.7%**	61.7%	57.2%	63.9%	42.4%	56.7%				
Employment											
Rate of unemployment	N	**5.6**	2.9	3.8	3.9	4.4	3.4				
Family and social support									**X**	**X**	
Percent of children in single-parent household	S	**34.0%**	23.0%	18.0%	15.0%	23.0%	31.0%				
Percent of adults with insufficient social and emotional support	N	**20.7%**	17.1%	13.7%	13.2%	20.5%	13.7%				
Healthcare access								**X**	**X**	**X**	**10.3**
Number of primary care physicians per 100,000 population	N	**74.5**	69.7	99.6	71.8	41.4	69.0				
Percent of population living in area with shortage of primary care professionals	N	**34.1%**	0%	0%	0%	0%	0%				
Percent of adults without regular healthcare provider	N	**22.1%**	26.1%	24.8%	20.4%	20.7%	28.2%				

NOVA SERVICE AREA	Comparison level	Benchmark	Arlington County	Fairfax County	Loudoun County	Prince William County	Alexandria City	KP platform	Survey	Interview	Priority score
Indicator flagged based on poor performance compared to benchmark (cutoff: 10%)											
** Indicator Flagged based on race/ethnicity disparity ratio (cutoff: ≥ 2.0 or ≤0.5)*											
X: Denotes the source that flagged health need/driver (Platform, Survey AND/OR Interview)											
Tier 3 health needs/drivers identified by all 3 data sources (Platform, Survey AND Interview)											
Priority score: tier 3 health needs/drivers were assigned a priority score to create a rank order											
HP: Healthy People 2020, N: National, S: State											
Health insurance								**X**	**X**	**X**	**9.4**
Percent of population enrolled in Medicaid	N	**20.2%**	4.6%	6.8%	4.6%	9.6%	9.3%				
Percent of population without health insurance coverage	N	**14.9%**	10.4%*	12.0%*	8.4%*	13.9%*	14.4%*				
Percent of children who are uninsured	S	**4.8%**	4.5%	5.5%	4.7%	6.3%	6.0%				
Healthy eating									**X**		
Percent of adults with inadequate fruit/ vegetables consumption	N	**75.7%**	63.50%	75.70%	73.60%	71.70%	66.90%				
Housing									**X**	**X**	
Percent of adults living in substandard housing	N	**33.1%**	31.4%	31.4%	32.1%	34.6%	34.3%				
Percent of housing units that are vacant	N	**12.5%**	11.5%	4.5%	4.9%	4.9%	10.2%				
Percent of cost-burdened households (exceeding 30% of income)	N	**35.5%**	31.4%	31.5%	32.8%	34.5%	34.8%				
Income											
Median household income per household (in dollars)	N	**53,482**	105,10	112,12	123,96	98,514	87,319				
Language barrier								**X**	**X**	**X**	**7.3**
Percent with limited English proficiency	N	**4.8%**	4.35%	7.45%	4.61%	6.19%	6.25%				
Mental health access								**X**	**X**	**X**	**9.1**
Rate of mental health providers per 100,000 population	N	**134.1**	88.4	112.6	83.1	65.9	194.4				

NOVA SERVICE AREA	Comparison level	Benchmark	Arlington County	Fairfax County	Loudoun County	Prince William County	Alexandria City	KP platform	Survey	Interview	Priority score
Indicator flagged based on poor performance compared to benchmark (cutoff: 10%)											
** Indicator Flagged based on race/ethnicity disparity ratio (cutoff: ≥ 2.0 or ≤0.5)*											
X: Denotes the source that flagged health need/driver (Platform, Survey AND/OR Interview)											
Tier 3 health needs/drivers identified by all 3 data sources (Platform, Survey AND Interview)											
Priority score: tier 3 health needs/drivers were assigned a priority score to create a rank order											
HP: Healthy People 2020, N: National, S: State											
Poverty								**X**	**X**	**X**	**10.4**
Percent of children living under 100% of the FDL	N	**21.6%**	11.4%*	7.5%*	3.6%*	8.9%*	13.8%*				
Percent of population living under 100% of the FPL	N	**15.4%**	8.0%*	5.9%*	3.6%*	6.3%*	8.4%*				
Percent of population living under 200% of the FPL	N	**34.2%**	16.8%	15.2%	10.0%	17.6%	20.8%				
Percent of population that experienced food insecurity in past year	N	**15.2%**	8.7%	6.1%	4.7%	6.9%	10.8%				
Percent of public school students eligible for free or reduced price lunches	N	**52.4%**	31.4%	27.3%	17.5%	38.3%	56.3%				
Percent of population receiving SNAP benefits	N	**15.2%**	3.4%*	4.0%*	2.7%*	6.9%*	6.1%*				
Nutrition access								**X**	**X**	**X**	**7.0**
Number of fast food restaurants per 100,000 population	N	**72.7**	116.1	82.9	79.4	67.2	84.3				
Number of grocery stores per 100,000 population	N	**21.2**	20.2	18.2	17.3	16.4	25.7				
Number of food stores accepting WIC program per 100,000 population	N	**15.6**	3.2	5.5	6.1	7.2	6.9				
Percent of population living in food deserts	N	**23.6%**	2.5%	19.5%	18.9%	28.7%	0.0%				
Prenatal care access											
Percent of women without prenatal care during 1st trimester	N	**17.3%**	-	-	-	-	-				
Preventative health services									**X**	**X**	
Preventable hospital events per 1,000 Medicare enrollees	N	**59.2**	32.9	37.1	52.0	49.0	49.4				
Percent of adults who received pneumonia vaccine	N	**67.5%**	68.8%	74.2%	68.3%	76.2%	66.9%				

NOVA SERVICE AREA	Comparison level	Benchmark	Arlington County	Fairfax County	Loudoun County	Prince William County	Alexandria City	KP platform	Survey	Interview	Priority score
Indicator flagged based on poor performance compared to benchmark (cutoff: 10%)											
** Indicator Flagged based on race/ethnicity disparity ratio (cutoff: ≥ 2.0 or ≤0.5)*											
X: Denotes the source that flagged health need/driver (Platform, Survey AND/OR Interview)											
Tier 3 health needs/drivers identified by all 3 data sources (Platform, Survey AND Interview)											
Priority score: tier 3 health needs/drivers were assigned a priority score to create a rank order											
HP: Healthy People 2020, N: National, S: State											
Physical activity								**X**	**X**	**X**	**7.1**
Percent of adults who are physically inactive	N	**22.6%**	14.4%	15.4%	20.0%	18.5%	16.3%				
Percent of population living within 1/2 mile of a park	N	**48.7%**	89.8%	70.5%	22.3%	36.1%	77.2%				
Number of recreation and fitness facilities per 100,000 population	N	**9.7**	21.7	13.2	13.1	10.7	16.4				
Quality of care								**X**			
Number of federally qualified health centers	N	**1.9**	0.5	0.2	0.6	0.3	2.1				
Smoking											
Percent of adults who currently smoke	N	**18.1%**	9.8%	11.0%	9.5%	16.6%	9.1%				
Teen births								**X**			
Rate of teen births per 1,000 female population aged 15-19	N	**36.6**	20.1*	14.6*	12.1*	29.5*	41.2*				
Transportation								**X**	**X**	**X**	**8.3**
Percentage of population using public transportation to commute to work	N	**5.0%**	27.2%	9.4%	2.9%	5.6%	21.5%				
Percent of population living less than 0.5 miles from transit stop	N	**8.1%**	20.5%	27.5%	0.0%	0.0%	19.2%				
Water quality											
Percent of population with unsafe drinking water	N	**10.2%**	0%	0%	0%	0%	0%				

Appendix C
KFHP-MAS Secondary Data Record:
Indicator List, Eliminated Indicators, Added Indicators

List of indicators selected for 2016 CHNA

DEMOGRAPHICS	
1	**Total population** *Total number of people in a specific geographic area*
2	**Total population, by gender** *Total number of people in a specific geographic area, by gender*
3	**Total population, by age groups** *Total number of people in a specific geographic area, by age groups*
4	**Total population, by race** *Total number of people in a specific geographic area, by race*
5	**Hispanic population, by race** *Total number of Hispanic people in a specific geographic area, by race*
6	**Non-Hispanic population, by race** *Total number of non-Hispanic people in a specific geographic area, by race*
7	**Median age** *Median age according to the 2010 Census population estimate*
8	**Change in total population** *Percent difference in population counts from the 2000 Census population estimate to the 2010 Census population estimate*
HEALTH NEEDS	
Asthma	
10	**Asthma prevalence** *Percent of adults who self-report that they have ever been told by a doctor, nurse, or other health professional that they had asthma*
Cancer	
11	**Breast cancer incidence** *Age adjusted incidence rate of females with breast cancer per 100,000 population*
12	**Cervical cancer incidence** *Age adjusted incidence rate (cases per 100,000 population per year) of females with cervical cancer*
13	**Colon and rectum cancer incidence** *Age adjusted incidence rate of colon and rectum cancer per 100,000 population*
14	**Lung cancer incidence** *Age adjusted incidence rate per 100,000 population per year*
15	**Prostate cancer incidence** *Age adjusted incidence rate of males with prostate cancer per 100,000 population per year*
16	**Cancer mortality** *Death rate due to malignant neoplasm (cancer) per 100,000 population*
Cardiovascular disease	
17	**Heart disease prevalence** *Percentage of adults who have ever been told by a doctor that they have any kind of heart disease*
18	**Stroke death** *Death rate due to cerebrovascular disease (stroke) per 100,000 population*
19	**Heart disease mortality** *Death rate due to coronary heart disease per 100,000 population*
Diabetes	
20	**Diabetes prevalence** *Percent of adults who have ever been told by a doctor that they have diabetes*
21	**Diabetes management (hemoglobin A1c test)** *Percentage of diabetic Medicare patients who have had a hemoglobin A1c (hA1c) test, a blood test which measures blood sugar levels, administered by a health care professional in the past year*

22 **Diabetes-related mortality**
Rate of diabetes-related mortality per 100,000 population

Disability

23 **Population with any disability**
Percent of the total civilian non-institutionalized population with a disability

HIV/AIDS

24 **HIV prevalence**
Prevalence rate of HIV per 100,000 population

25 **HIV screening**
Percent of teens and adults who self-report having never been screened for HIV

Hypertension

26 **High blood pressure management**
Percent of adults who self-report not taking medication for their high blood pressure

Infant health

27 **Low birth weight**
Percent of total births that were under 2500g

28 **Infant mortality**
Rate of deaths to infants less than one year of age per 1,000 births

Intentional injury

29 **All violent crimes**
Number of violent crimes per 100,000 population

30 **Juvenile arrests**
Number of arrests of juveniles, ages 10-17, for violent and non-violent offenses, per 10,000 youths ages 10-17

31 **Homicide**
Death rate due to assault (homicide) per 100,000 population

Mental health

32 **Poor mental health days**
Average number of mentally unhealthy days (during past 30 days) among survey respondents age 18 and older

33 **Suicide**
Death rate due to intentional self-harm (suicide) per 100,000 population

Obesity/overweight

33 **Obesity (adult)**
Percent of adults who self-report that they have a Body Mass Index (BMI) greater than 30.0 (obese)

34 **Overweight (adult)**
Percent of adults who self-report that they have a Body Mass Index (BMI) between 25.0 and 30.0 (overweight)

Oral health

35 **Poor dental health**
Percent of adults who self-report that six or more of their permanent teeth have been removed due to tooth decay, gum disease, or infection

Physical health

36 **Poor general health**
Percent of adults age 18 and older who self-report having poor or fair health

37 **Premature death**
Years of Potential Life Lost (YPLL) before age 75 per 100,000 population for all causes of death

STI(s) other	
38	**Chlamydia** *Incidence rate of chlamydia per 100,000 population*
Unintentional injury	
39	**Motor vehicle accident – mortality** *Percent of death due to motor vehicle crashes per 100,000 population*
40	**Pedestrian accident – mortality** *Percent of death due to pedestrian accidents per 100,000 population*
41	**Unintentional injury (accident) – mortality** *Rate of death due to unintentional injury (accident) per 100,000 population*
Alcohol use	
42	**Excessive consumption of alcohol** *Percentage of adults 18 and older who self-report heavy alcohol consumption (defined as more than two drinks per day on average for men and one drink per day on average for women)*
43	**Liquor store access** *Number of beer, wine, and liquor stores per 100,000 population*
44	**Alcohol-impaired driving deaths** *Percentage of motor vehicle crash deaths with alcohol involvement*
Air pollution	
45	**Particulate matter days** *Percent of days during the year that air quality in a county was over the National Ambient Air Quality Standard for fine particulate matter (FPM, < 2.5 µm in diameter)*
Cancer screening	
46	**Cervical cancer screening (pap test)** *Percent of adult women who self-report receiving a Pap test in the past three years*
47	**Cancer screening – sigmoid/ colonoscopy** *Percent of adult men aged 50 and older who self-report ever receiving a sigmoidoscopy or colonoscopy*
48	**Cancer screening – mammogram** *Percentage of female Medicare enrollees who have received one or more mammograms in the past two years*
Dental care access	
49	**Access to dentists** *Number of dentists per 100,000 population*
50	**Health professional shortage area – dental** *Percent of the population living in a geographic area designated as a HPSA, defined as having a shortage of dental health professionals*
51	**Dental care utilization** *Percentage of adults aged 18 and older who self-report that they have not visited a dentist, dental hygienist or dental clinic within the past year*
Drug use	
52	**Drug-related mortality** Rate of drug-related deaths per 100,000 population
Education	
53	**Educational attainment** *Percent of population over the age of 25 who have less than high school graduate, high school graduate, some college or associate's degree, or bachelor degree or higher*
54	**High school graduation rate** *Percent of the population aged 25 and older without a high school diploma*
55	**Third graders' reading achievement levels** *Percent of 3rd graders reading at "basic, advanced and proficient" levels on state exams*
56	**Eighth graders' reading achievement levels**

Percent of 8th graders reading at "basic, advanced and proficient" levels on state exams

57 **School Enrollment Age 3-4**

Percentage of the population age 3-4 that is enrolled in school

Employment

58 **Unemployment rate**

Percent of the civilian non-institutionalized population aged 16 and older that is unemployed (non-seasonally adjusted)

Social support

59 **Children in single-parent households**

Percentage of children in family households that live in a household headed by a single parent (male or female head of household with no spouse present)

60 **Lack of Social or Emotional Support**

Adults who self-report receiving sufficient social and emotional support all or most of the time

Healthcare access

61 **Access to primary care**

Number of primary care physicians per 100,000 population

62 **Health professional shortage area – primary care**

Percent of the population living in a geographic area designated as a HPSA

63 **Lack of a consistent source of primary care**

Percentage of adults aged 18 and older who self-report that they do not have at least one person who they think of as their personal doctor or health care provider

Health insurance

64 **Population receiving Medicaid**

Percent of the population that is enrolled in Medicaid

65 **Uninsured population**

Percent of the total civilian non-institutionalized population without health insurance coverage

66 **Uninsured children**

Number and percent of people under age 19 who are uninsured

Healthy eating

67 **Inadequate fruit/vegetable consumption (adult)**

Percent of adults who self-report consuming less than 5 servings of fruits and vegetables each day

Housing

68 **Substandard housing**

Percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1.01 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30 percent, and 5) gross rent as a percentage of household income greater than 30 percent

69 **Vacant housing**

Number and percentage of housing units that are vacant. A housing unit is considered vacant by the American Community Survey if no one is living in it at the time of interview

70 **Housing Cost Burden (30%)**

Percentage of the households where housing costs exceed 30% of total household income

Income

71 **Median income per household**

Median income (in dollars) per household in the past 12 months

Language barriers

72 **Linguistically isolated population**

Percent of the population aged 5 and older who speak a language other than English at home and speak English less than "very well"

Mental health access

73	**Access to mental health providers** *Number of mental health providers (including psychiatrists, psychologists, clinical social workers, and counselors) per 100,000 population*
Poverty	
74	**Children below 100% FPL** *Percent of children aged 0-17 living under 100% of the Federal Poverty Line (FPL)*
75	**Population below 100% FPL** *Percent of the population living under 100% of the FPL*
76	**Population below 200% FPL** *Percent of the population living under 200% of the FPL*
77	**Food insecurity rate** *Estimated percentage of the population that experienced food insecurity at some point during the report year*
78	**Children eligible for free/ reduced price lunch** *Percent of public school students eligible for free or reduced price lunches*
79	**Supplemental nutrition assistance program (SNAP) recipients** *Average percent of the population receiving SNAP benefits*
Nutrition access	
80	**Fast food restaurants** *Number of fast food restaurants per 100,000 population*
81	**Grocery stores** *Number of grocery stores per 100,000 population*
82	**WIC - authorized food stores** *Number of food stores and other retail establishments per 100,000 population that are authorized to accept WIC Program (Special Supplemental Nutrition Program for Women, Infants, and Children) benefits*
83	**Population living in food deserts** *Percent of the population living in census tracts designated as food deserts*
Prenatal care access	
84	**Lack of prenatal care** *Percentage of women who do not obtain prenatal care during their first trimester of pregnancy*
Preventative health services	
85	**Preventable hospital events** *Patient discharge rate (per 1,000 Medicare enrollees) for conditions that are ambulatory care sensitive (ACS)*
86	**Pneumonia vaccination** *Percentage of adults aged 65 and older who self-report that they have ever received a pneumonia vaccine*
Physical activity	
87	**Physical inactivity (adult)** *Percent of adults who self-report no leisure time for activity*
88	**Park access** *Percent of population living within 1/2 mile of a park*
89	**Recreation and fitness facility access** *Number of recreation and fitness facilities per 100,000 population*
Quality of care	
90	**Federally qualified health centers** *Number of FQHCs in the community*
Smoking	
91	**Tobacco use** *Percent of adults who self-report currently smoking cigarettes some days or every day*
Teen births	

92	**Teen births (age 15-19)** *Rate of total births to women aged 15-19 per 1,000 female population aged 15-19*
Transportation	
93	**Transit - Public Transit within 0.5 Miles** *Proportion of the population living within 0.5 miles of a GTFS or fixed-guide way transit stop*
94	**Transportation use** *Percent of the population using public transportation as their primary means of commuting to work*
Water quality	
95	**Drinking water safety** *Percentage of the population getting drinking water from public water systems with at least one health-based violation*

Rationale for the elimination of indicators for the CHNA

Eliminated indicators	Rationale for elimination
Population with limited English proficiency	Not required, information captured elsewhere
Commute over 60 minutes	Not essential
Households with no vehicle	Not essential
Head Start program facilities	Not essential
Reading below proficiency	Data collected prior to 2012, found alternative
Assault (crime)	Not essential, data collected prior to 2012
Rape (crime)	Not essential, data collected prior to 2012
Robbery (crime)	Not essential, data collected prior to 2012
Ozone (O3)	Not essential, data collected prior to 2012
Canopy cover	Not essential, data collected prior to 2012
Drought severity	Not essential
Heat index days	Not essential
No access to air conditioning	Missing data
Assisted housing	Not essential
Road network density	Not essential, data collected prior to 2012
Depression among Medicare beneficiaries	Medicare population only
Alcohol - expenditures	Missing data
Breastfeeding (any) *	State level only
Breastfeeding (exclusive) *	State level only
Physical inactivity (youth)	State level only
Obesity (youth) *	State level only
Overweight (youth) *	State level only
Soft drink expenditures	Missing data
Tobacco expenditures	Missing data
Fruit/ vegetable expenditures	Missing data
Alone in car	Not essential
Walking/biking to work	Not essential
Walkability *	State level only

*** Common indicators**

List of Added Indicators

Supplemental indicators	Source
Educational attainment	American Community Survey, 2009-2013
Children in single-family households	American Community Survey, 2009-2013
Diabetes-related deaths	CDC, WONDER, 2014
Drug-related deaths	CDC, WONDER, 2014
Third graders' reading achievement levels	National KIDSCOUNT, 2015
Eighth graders' reading achievement levels	National KIDSCOUNT, 2015
Uninsured children	National KIDSCOUNT, 2015
Juvenile arrests	FBI Uniform Crime Reporting, 2014
Alcohol-impaired driving deaths	Fatality Analysis Reporting System, 2009-2013

Appendix D
Community Input Tracking: Expert Interview Respondents and Interview Protocol

Service Area	Name and Title	Organization	DATE
BALT	Darcy Phelan-Emrick Chief Epidemiologist	Baltimore City Department of Public Health	1/20/16
BALT	Jinlene Chan Health Officer	Anne Arundel Department of Public Health	2/1/16
BALT	Laura Culbertson Public Health Nurse Administrator	Baltimore County Department of Public Health	1/22/16
BALT	Maura Rossman Health Officer	Howard County Department of Public Health	2/1/16
BALT	Barbara Brookmyer Health Officer	Frederick County Department of Public Health	1/15/16
DCSM	Uma Ahluwalia Director	Montgomery County Department of Public Health	1/20/16
DCSM	Bettye Muwwakkil Director	Access to Wholistic Living	1/19/16
DCSM	Pamela Brown-Creekmur Health Officer	Prince George's County Department of Public Health	2/2/16
DCSM	Fern Clarke-Johnson, Director Anneta Arno, Director Marcus Williams, Communications Ivan Torres, Community Relations	District of Columbia Department of Public Health	2/25/16
NOVA	Melinda Gray Social Worker	Alexandria City Department of Public Health	2/10/16
NOVA	Sharon Arndt Health Promotion & Privacy Coordinator	Fairfax Health District	2/10/16
NOVA	Brooke Rossheim Director	Rappahannock Health District	2/5/16
NOVA	David Goodfriend Medical Director	Loudon County Department of Public Health	1/15/16
NOVA	Alison Ansher Health Director	Prince William Health District	1/21/16
NOVA	Patricia Mathews President & CEO	Northern Virginia Health Foundation	1/19/16

KP CHNA 2016

Key Informant Interview Script

Health Needs, Assets, & Challenges

1. I would like to start by asking you tell me a little more about your organization and your role. Please start by telling me what <ORGANIZATION> does.

    - Who does <ORGANIZATION> serve?
    - Tell me more about the demographics of the population <ORGANIZATION> serves, including population size. What is the function of your organization in <COUNTY>?

2. In thinking about the population of <COUNTY>, what are the **three most significant health needs** of the population? Health needs are defined as a poor health outcome as well as its associated driver, or underlying cause.

    <After respondent list top three, ask the following questions for each health need listed>

    - *<For each health need OR driver listed>,* how severe is this issue in the population? Does it affect a large percentage of the population? Has this issue changed over time (e.g., has it gotten better? Worse?)?
    - Who is affected the most by the _____? Are particular subgroups of the population more affected by the _____ than other groups?
    - For the next question, we are asking for your input on factors influencing the health of the community ("health drivers")**.** What factors are influencing the _____ ?
    - What services and programs are available to address the _____ ?
    - What types of **challenges** does your service population experience when trying access these resources?

3. With number one being the most significant health need, how would you **rank the three health needs** you listed?

4. One population for which we have had identified gaps in our data is the **health and wellbeing of youth**. Do other significant health needs come to mind when you think about this population in <COUNTY>? Is physical activity and/or obesity a major concern for the youth in area you serve?

5. Thinking more broadly than specific health outcomes, what are **the primary issues or challenges** affecting the population of <COUNTY>?

6. Have any **recent events or developments** had an impact on the health and wellbeing of the population of <COUNTY>? [negative or positive]

Solutions and Strategies

7. As <TITLE> for <SERVICE AREA>, what do you see as your role in addressing the specific health needs we discussed today?

8. What do you see as the most promising solutions and strategies addressing the health needs we discussed today in <COUNTY>? …for preventing the health needs we discussed today?

9. What existing collaborations are currently working to address the health needs we discussed today? Do you see any potential areas for collaboration or coordination among providers to better meet the needs of your service population? Who would need to be involved in the collaboration ("at the table") from your service area?

Thank you <KI NAME>. These are all of the questions I have for you today. We look forward to sharing our CHNA with you in the spring of 2016. At this stage, we will begin developing our implementation strategy for investing resources to address critical health needs in your service area. Your input is very valuable. We hope to collaborate with you further in the future.

10. Is there anything else you would like to add before we close?

Appendix E
Community Input Tracking: Stakeholder Survey Respondents and Survey Protocol

Service Area	First Name	Last Name	Title	Organization
BALT	Karl	Alexander	Founder	The Marshall Alliance
BALT	Tori	Burns	Director	Foundation and Corporate Relations, Community College of Baltimore County
BALT	Amy	Crone	Executive Director	Maryland Farmers Market Association
BALT	Laura	Flamm	Baltimarket & Food Access Coordinator	Baltimore City Health Department
BALT	Holly	Freishtat	Baltimore City Food Policy Director	Baltimore Office of Sustainability/Department of Planning
BALT	Kimberli	Hammonds	Executive Director	Dru-Mondawmin Health Families, Inc
BALT	Dr. Kathleen	Hetherington	President	Howard Community College
BALT	Talib	Horne	Executive Director	Bon Secours Community Works
BALT	Richard	Larison	Executive Director	Chase Brexton
BALT	Dena	Leibman	Executive Director	Future Harvest Inc
BALT	Patricia	McLaine, DrPh, MPH, RN	Director, Community/Public Health Nursing Specialty	University of Maryland School of Nursing
BALT	Dr. Tracey	Murray	Dean	Health and Human Services, Coppin State University
BALT	Glenn E.	Schneider	Chief Program Officer	The Horizon Foundation
BALT	Shirley	Sutton	Executive Director	Baltimore Medical Systems
BALT	Michelle	Towson, JD	Director	Grants Development, Baltimore City Community College
BALT	Mary	Urban	Development Manager	Playworks Baltimore
BALT	Marva	Williams	Media Outreach & Events Director	Baltimore City Foundation
BALT	Sharon	Wylie		Baltimore Community Foundation Inc
DCSM	Patricia	Arty	Development Manager	US Soccer Foundation
DCSM	Alexandra	Ashbrook	Director of Special Projects & Initiatives/Director	Food Research and Action Center/DC Hunger Solutions
DCSM	Bruce	Baker	Executive Director	Community Health and Empowerment Through Education and Research Inc.
DCSM	Natalie	Burke	President & CEO	Common Health Action
DCSM	Jane	Clark	Dean	University of Maryland School of Public Health
DCSM	Susan	Comfort	Executive Director	Playworks Education
DCSM	Shari	Curtis	Independent Contractor	Department of Social Services
DCSM	Tara	Egan	Deputy Director	Crittenton Services of Greater Washington

DCSM	Caron	Gremont	Senior Director, Healthy Eating	Martha's Table, Inc
DCSM	Melony	Griffith	Vice President Government & External Affairs	Greater Baden Medical Services, Inc
DCSM	George	Jones	Executive Director	Bread for the City
DCSM	Kathleen	Knolhoff	Executive Director	Community Clinic Inc
DCSM	Michelle	LaRue	Senior Manager Health & Social Service Programs	Casa de Maryland
DCSM	Colenthia	Malloy	Executive Director	Greater Baden Medical Services
DCSM	Robert Barrett	Malone	Chair & Co-Founder	Mentoring to Manhood Incorporated
DCSM	Michele	Matyasovsky	National Director of Partnerships	FoodCorps
DCSM	Alexander	Moore	Chief Development Officer	DC Central Kitchen Inc
DCSM	Margaret	Morgan Hubbard	Founder & CEO	ECO City Farms
DCSM	Benton	Murphy	Senior Director, Philanthropic Services	The Community Foundation for the National Capital Region
DCSM	Michael	Rhein	President & CEO	Institute for Public Health Innovation
DCSM	Lauren	Shweder Biel	Executive Director	DC Greens Inc
DCSM	Grace	Song	Coordinator, Corporate Partnerships	Share our Strength
DCSM	Brad J.	Stewart	Vice President and Provost	Montgomery College, Silver Spring Campus
DCSM	Crystal	Townsend	Executive Director	Health Initiative Foundation, Business
DCSM	Michael	Wilson	Director, Maryland Hunger Solutions	Food Research and Action Center/DC Hunger Solutions
NOVA	Robin	Adams		Sentara Hospital
NOVA	Rachele	Bowman	Health Planner	Prince William Health District, Virginia Health Department
NOVA	Carol G.	Jameson, MSW	Chief Executive Officer	HealthWorks for Northern Virginia
NOVA	Donney	John, PharmD	Executive Director	NOVA Scripts Central
NOVA	Cheryl	Jones	VP Marketing / Child & Family Center Foundation	Department of Family Services
NOVA	Ondrea	McIntyre-Hall		Northern Virginia Family Services
NOVA	Jennifer	Montgomery	Executive Director	Loudoun Interfaith Relief
NOVA	Richard	Nagel	Executive Director	Neighbor's Keeper

NOVA	Deborah	Oswalt	President	Virginia Healthcare Foundation
NOVA	Wanda	Rixon	CHCN Program Coordinator	Molina Healthcare of Virginia
NOVA	Tricia	Rodgers	Program Officer	Northern Virginia Health Foundation
NOVA	Hope	Toye	Division of Community Programs, Office of Community Services	Office of Community & Human Service
NOVA	Nancy	White	Executive Director	Arlington Free Clinic
NOVA	Linda	Wilkinson, ED	CEO	Virginia Association of Free Clinics
NOVA	Dr. Tatiana	Zenzano	Executive Director	Arlington Pediatric Center

Kaiser Permanente of the Mid-Atlantic States
2016 Community Health Needs Assessment

WELCOME

Kaiser Permanente's commitment to community health is an essential part of our mission. We have a proud history of investing in community health programs and partnering with other organizations to identify and address the most urgent health needs in the communities we serve. At Kaiser Permanente of the Mid-Atlantic States (KPMAS), we recognize that we cannot accomplish this mission alone. To better understand the health needs of the communities we serve, we are conducting a community health needs assessment, or CHNA.

The CHNA is systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of our community health assessment is to develop strategies to address the community's health needs and identified issues. You are a critical piece of this assessment.

KPMAS appreciates your help in identifying the health needs of the communities you serve. Your expertise of the community will help us gain an important understanding of the challenges faced by the populations across our service area. The following survey should take about 15 minutes to complete. The information you provide will not be associated with your name, or the name of your organization, and will only be reported in an aggregated manner. The results from this survey will inform KPMAS in developing Community Benefit implementation strategies for summer 2016.

Please contact Stacey Lloyd at KPMASCHNA@gmail.com with any questions about this survey. We value your time and assistance, and greatly appreciate your input. Thank you so much for your participation!

By clicking next, you agree to participate in this survey.

Kaiser Permanente of the Mid-Atlantic States
2016 Community Health Needs Assessment

DEMOGRAPHIC INFORMATION

* 1. In this section, we would like to ask you to answer a few questions about you and the community you serve. Remember, the answers you provide in this survey will be reported in an aggregated manner and will not be linked to your name, title, or organization. The data from this question will be used for tracking and coordination purposes only.

Name

Organization (required)

Title

Email

* 2. What type of organization do you work for? Please select all that apply.

- [ ] Public
- [ ] Non-profit
- [ ] For-profit
- [ ] Other (please specify)

* 3. Which sector(s) do you and your organization represent? Please select all that apply.

- [ ] Health
- [ ] Community-based
- [ ] Religious
- [ ] Education
- [ ] Grassroots
- [ ] Social Welfare
- [ ] Other (please specify)

4. Have you or your organization received any money in the form of grants, sponsorship or donation from Kaiser Permanente since 2013? Please check all that apply.

- [ ] Grant
- [ ] Sponsorship
- [ ] Donation
- [ ] None

COMMUNITY SERVED

Please tell us about the community you serve.

* 5. Please identify the jurisdiction below that is your primary service area. If you serve populations from more than one jurisdiction, please select ONE area based on the residence of the majority of your clientele and the area with which you are most familiar. Please keep this service area in mind as you answer the remaining questions on the survey.

- [ ] Alexandria City
- [ ] Anne Arundel County
- [ ] Arlington County
- [ ] Baltimore City
- [ ] Baltimore County
- [ ] District of Columbia
- [ ] Fairfax City
- [ ] Fairfax County
- [ ] Falls Church City
- [ ] Frederick County
- [ ] Fredericksburg City
- [ ] Howard County
- [ ] Loudoun County
- [ ] Manassas City
- [ ] Montgomery County
- [ ] Prince George's County
- [ ] Prince William County
- [ ] Stafford County
- [ ] Other (please specify)

6. We would like to learn more about the population that you serve. Please select all criteria that apply to at least 50% of your target population.

- [ ] People from racial and ethnic minority groups
- [ ] People who have recently immigrated to the United States (within approximately 5 years)
- [ ] People who identify as lesbian, gay, bisexual, or transgender
- [ ] People who live in a household with income below the Federal Poverty Level ($24,250 for family of 4)
- [ ] People who lack permanent housing
- [ ] People over the age of 25 who do not have a high school diploma or equivilant degree
- [ ] People with limited English proficiency
- [ ] People who have impairments, activity limitations, and/or participation restrictions (i.e., disabilities)
- [ ] People with chronic health conditions

Other (please specify)

HEALTH NEEDS

In this section, we are asking for your input to determine which health concerns represent areas of greatest need. Below, we list 14 prominent health needs in alphabetical order; and NOT by order of importance. When considering your responses, please keep your specific service area and community in mind. Please think about how severely each of these items impacts the community you serve.

1 Not Severe	2 Moderately Severe	3 Severe	4 Very Severe
The health need slightly impacts the lives of individuals affected by it, but the community is not generally impacted by it.	The health need slightly impacts the lives of individuals affected by it, and the community is slightly impacted by it.	The health need greatly impacts the lives of individuals affected by it, but the community is not generally impacted by it.	The health need greatly impacts the lives of individuals affected by it, and the community is greatly impacted by it.

* 7. Please rate the severity of health needs in the community you serve.

	1 (Not Severe)	2 (Moderately Severe)	3 (Severe)	4 (Very Severe)
Asthma	○	○	○	○
Cancer	○	○	○	○
Cardiovascular disease	○	○	○	○
Diabetes	○	○	○	○
Disability	○	○	○	○
HIV/AIDS	○	○	○	○
Hypertension (high blood pressure)	○	○	○	○
Infant mortality	○	○	○	○
Injury - intentional (excluding suicide)	○	○	○	○
Injury - unintentional	○	○	○	○
Obesity/overweight	○	○	○	○
Poor oral health	○	○	○	○
Poor physical health (overall)	○	○	○	○
Poor mental health (overall)	○	○	○	○
STIs/STDs in general	○	○	○	○
Suicide	○	○	○	○

8. Please list any other pertinent health needs in the community you serve that were not mentioned in the previous section. Respond to answers in rows based on severity of the need(s).

1 - Not Severe	
2 - Moderately Severe	
3 - Severe	
4 - Very Severe	

* 9. In your opinion, what is the **most critical health need** in the community you serve? Please feel free to list ANY health need that is important to your community (even if this need was not mentioned previously).

Other (please specify and rank severity of health need)

* 10. In your opinion, what is the **second most critical health need** in the community you serve? Please feel free to list ANY health need that is important to your community (even if this need was not mentioned previously).

Other (please specify and rank severity of health need)

* 11. In your opinion, what is the **third most critical health need** in the community you serve? Please feel free to list ANY health need that is important to your community (even if this need was not mentioned previously).

Other (please specify and rank severity of health need)

HEALTH NEEDS - CHILDREN AND YOUTH

12. We would now like you to think about the health and wellbeing of a specific population in the community you serve - children (ages 0-17) and youth/young adults (ages 18-24). What health needs come to mind when you think about this population? **Please list the top three health needs for children and youth in the community you serve.**

Most critical health need for children and youth

Second most critical health need for children and youth

Third most critical health need for children and youth

HEALTH DRIVERS

In this section, we are asking for your input to prioritize factors influencing the health of the community ("health drivers") you serve and determine which represent areas of greatest need. Below, we list 18 prominent health factors in alphabetical order; and NOT by order of importance. When considering your responses, please keep your specific service area and community in mind. Please think about how severely each of these items impacts the community you serve.

1 Not Severe	2 Moderately Severe	3 Severe	4 Very Severe
The health driver slightly impacts the lives of individuals affected by it, but the community is not generally impacted by it.	The health driver slightly impacts the lives of individuals affected by it, and the community is slightly impacted by it.	The health driver greatly impacts the lives of individuals affected by it, but the community is not generally impacted by it.	The health driver greatly impacts the lives of individuals affected by it, and the community is greatly impacted by it.

* 13. Please rate the severity of factors influencing the health of the community that you serve.

	1 (Not Severe)	2 (Moderately Severe)	3 (Severe)	4 (Very Severe)
Access to healthy food	○	○	○	○
Access to preventative services	○	○	○	○
Alcohol use	○	○	○	○
Air and water quality	○	○	○	○
Community safety	○	○	○	○
Drug use	○	○	○	○
Education	○	○	○	○
Family and social support	○	○	○	○
Health care access (regular source of care)	○	○	○	○
Health care coverage (insurance)	○	○	○	○
Healthy eating	○	○	○	○
Housing affordability	○	○	○	○
Housing quality	○	○	○	○
Limited English proficiency	○	○	○	○
Poverty	○	○	○	○
Physical inactivity	○	○	○	○
Quality of health care	○	○	○	○
Teen births	○	○	○	○
Tobacco use	○	○	○	○
Transportation	○	○	○	○

14. Please list any other factors influencing the health needs of the community you serve that were not mentioned in the previous section. Respond to answers in appropriately labeled rows based on severity of the need(s).

1 - Not Severe	
2 - Moderately Severe	
3 - Severe	
4 - Very Severe	

* 15. In your opinion, what is the **most critical driver of health needs** in the community you serve? Feel free to list ANY health driver that is important to your community (even if this need was not mentioned previously).

Other (please specify)

* 16. In your opinion, what is the **second most critical driver of health needs** in the community you serve? Feel free to list ANY health driver that is important to your community (even if this need was not mentioned previously).

Other (please specify)

* 17. In your opinion, what is the **third most critical driver of health needs** in the community you serve? Feel free to list ANY health driver that is important to your community (even if this need was not mentioned previously).

Other (please specify)

Thank you

THANK YOU FOR TAKING THE TIME TO COMPLETE OUR SURVEY!

We look forward to sharing our CHNA with you in the spring of 2016. At this stage, we will begin developing our implementation strategy for investing resources to address critical health needs in your service area. We hope to collaborate with you further in the future.

If you have follow-up questions or comments, please contact Stacey Lloyd at KPMASCHNA@gmail.com

Appendix F
Glossary of Terms

Glossary of Terms

The goal of this glossary is to create a shared language for key terms used throughout the KPMAS 2016 Community Health Needs Assessments (CHNA). This glossary was adapted from the 2013 Kaiser Foundation Hospital – Los Angeles CHNA.

Benchmark: A benchmark is a measurement that serves as a standard to which other measurements are compared. In the case of the CHNA reports, the term "benchmark" indicates a standard by which a community can determine how well or not well the community is performing in comparison to the standard for specific health outcomes.

Community assets: People, places, and relationships that provide resources to bring about positive change and promote maximal functioning of a community.

Community health needs assessment (CHNA): A systematic process involving the review of public data and input from a broad cross-section of community resources and participants to identify and analyze community health needs and assets.

Drivers of health: Drivers of health are risk factors that may positively or negatively impact a health outcome.

Health disparity: Diseases and health problems do not affect all populations in the same way. Health disparity refers to the disproportionate impact of a disease or a health problem on specific populations. This CHNA focuses on racial and ethnic differences, although health disparities are also correlated with gender, age, and other factors, such as disability or housing status.

Health driver: Health drivers are behavioral, environmental, social, economic, and clinical-care factors that positively or negatively impact health. For example, smoking (behavioral) is a health driver for lung cancer, and access to safe parks (environmental) is a health driver for obesity/overweight.

Health indicator: A characteristic of an individual, population, or environment that is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population.

Health need: Based on the Mobilizing Action Toward Community Health (MATCH) framework used for this CHNA, a health need is defined as a poor *health outcome* and its associated health driver and/or a *health driver/factor* associated with poor health outcome(s), where the outcome itself has not yet arisen as a need.

Health outcomes: Snapshots of diseases in a community that can be described in terms of both morbidity and mortality.

Healthy People 2020: Healthy People 2020 provides science-based, 10-year national objectives for improving the health of all Americans. Healthy People 2020 is considered the gold standard to which measurements are compared.

Primary data: Primary data are new data collected or observed directly from first-hand experience. They are typically qualitative (not numerical) in nature. For this CHNA, primary data were collected through interviews with key stakeholders and an online survey.

Qualitative data: These are typically descriptive in nature and not numerical, although qualitative data can be coded into numeric categories for analysis. Qualitative data is considered to be more subjective than quantitative data.

Quantitative data: Data that has a numeric value. Quantitative data is considered to be more objective than qualitative data.

Secondary data: Data that has already been collected and published by another party. Typically, secondary data collected for CHNAs is quantitative (numerical) in nature. Secondary data are useful in highlighting in an objective manner health outcomes that significantly impact a community.

Works Cited

1. Braveman, P., Egerter, S., and Williams, D. R. (2011). The social determinants of health: Coming of age. Annual Review of Public Health, 32(p. 381.
2. Hood, C. M., Gennuso, K. P., Swain, G. R., and Catlin, B. B. (2016). County health rankings: Relationships between determinant factors and health outcomes. American Journal of Preventive Medicine, 50(2): p. 129-135.
3. Forum One. County health rankings & roadmaps: Diet and exercise. [Website]. Available from: http://www.countyhealthrankings.org/our-approach/health-factors/diet-and-exercise.
4. National Alliance on Mental Illness. Mental health by the numbers. [Website]. Available from: https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers - sthash.tN7U7YJi.dpuf.
5. Forum One. County health rankings & roadmaps: Our approach. [Website]. Available from: http://www.countyhealthrankings.org/our-approach.
6. Institute for People, P., And Possibility. Community Commons [Website]. Available from: http://www.communitycommons.org/.
7. Creswell, J. W., Gutmann, M. L., and Hanson, W. E. (2003). Advanced mixed methods research designs. Handbook of mixed methods in social and behavioral research: p. 209-240.
8. Morse, J. M. (1991). Approaches to qualitative-quantitative methodological triangulation. Nursing research, 40(2): p. 120.
9. Creswell, J. W. and Miller, D. L. (2000). Determining validity in qualitative inquiry. Theory into practice, 39(3): p. 124-130.
10. Centers for Disease Control and Prevention. Health Indicators Warehouse. [Website]. Available from: http://www.healthindicators.gov/Indicators/Selection.
11. United States Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthypeople.gov: Disparities. [Website]. Available from: https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities.
12. Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2): p. 77-101.
13. Harry, B., Sturges, K. M., and Klingner, J. K. (2005). Mapping the process: An exemplar of process and challenge in grounded theory analysis. Educational researcher, 34(2): p. 3-13.
14. Eysenbach, G. (2004). Improving the quality of web surveys: The checklist for reporting results of internet e-surveys (CHERRIES). Journal of Medical Internet Research, 6(3).
15. Demaio, T. J. (1984). Social desirability and survey. Surveying Subjective Phenomena, 2: p. 257.
16. Patton, M. Q. (1990). Qualitative education and research methods. Newbury Park: Sage.
17. Williams, D. R. (2015). Wrag 2015 annual meeting: "The house that racism built". [Video]. Available from: https://www.youtube.com/watch?v=gj3UELq0w.