Healthy Delmarva

Building a Healthier Delmarva

COMMUNITY HEALTH NEEDS ASSESSMENT

2025 - 2028

PREPARED IN PARTNERSHIP WITH

Ascendient Healthcare Advisors

Healthy Delmarva

Building a Healthier Delmarva

Dear Neighbor,

The Healthy Delmarva Partnership is a team made up of TidalHealth, Wicomico County Health Department, and Somerset County Health Department. We work together to make our community healthier. We want to understand what health problems affect people in our area so we can fix them.

To build a healthier community, we need to know what problems exist and which ones to fix first. This Community Health Needs Assessment (CHNA) helps us find the main health issues in our area. The results give important information to people who can help make our region healthier. It helps us track progress, set goals, create solutions, and use our resources wisely.

Our Partnership does these health surveys every three years to check how healthy our communities are. We look at all the places where people live, work, learn, and play. We collect numbers and stories from real people. This report will help us decide how to meet health needs better and plan future programs.

Many local groups across the Delmarva region helped make this report possible. Reports like this help us put resources where they will do the most good.

We can only improve public health when community members care about their own health and each other's health. We believe that together, we can make the Delmarva Peninsula a place where everyone can be healthy - at home, at work, at church, at school, and during play.

Most importantly, this report exists because community members shared their thoughts in group talks, interviews, and surveys. We thank everyone who cared enough about our community's health to tell us about their concerns, needs, behaviors, good experiences, and ideas for making things better.

Sincerely,

Kathryn Fiddler

Kathryn Fiddler
Vice President, Population Health
TidalHealth

Danielle Weber

Danielle Weber
Health Officer
Somerset County Health Department

Matthew McConaughey

Matthew McConaughey
Health Officer
Wicomico County Health Department

Publication Date: May 2025

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Acknowledgements

Healthy Delmarva Partnership Steering Committee

This Community Health Needs Assessment (CHNA) is the product of a six-month process led by a Steering Committee with input from multiple individuals, organizations, and groups. The Steering Committee for this process was comprised of staff from TidalHealth, Somerset County Health Department, and Wicomico County Health Department. These individuals were integral in making this comprehensive assessment possible. The Steering Committee would like to extend gratitude to all focus groups participants, community health leaders, and members of the community who gave their time, input, and provided information used in the development of this assessment.

Healthy Delmarva Partnership Steering Committee Members		
Name	**Title**	**Organization**
Kathryn Fiddler	Vice President of Population Health	TidalHealth
Chris Hall	Vice President, Strategy and Business Development	TidalHealth
Kathrine Rodgers	Director of Community Health Initiatives	TidalHealth
Bobbi McDonald	Community Health Educator	TidalHealth
Danielle Weber	Health Officer	Somerset County Health Department
Andra Taylor	Director of Planning, Prevention, and Communication	Somerset County Health Department
Korey Colbert	Health Planner	Somerset County Health Department
Matthew McConaughey	Health Officer	Wicomico County Health Department
Christina Gray	Director, Division of Planning and Assessment	Wicomico County Health Department
Lisa Renegar	Health Planner	Wicomico County Health Department

TidalHealth

TidalHealth's mission remains elegantly simple: *Improve the health of the communities we serve.* While straightforward in concept, accomplishing this mission requires navigating an increasingly complex healthcare landscape and responding to evolving social determinants of health. We pursue this mission while addressing contemporary challenges: cultivating a skilled healthcare workforce, implementing advanced clinical methodologies, and integrating innovative technologies to enhance care delivery while meeting rigorous clinical and regulatory standards.

At the heart of all these efforts is the well-being of each patient. Since our unification in 2020, we have strengthened our position as the region's trusted healthcare resource. TidalHealth was formed when Peninsula Regional Medical Center, Nanticoke Memorial Hospital in Seaford, DE, and McCready Memorial Hospital in Crisfield, MD joined forces under one name to become Better Together. This collaboration has yielded significant results, with TidalHealth now recognized with over 175 national awards, recognitions, and certifications for excellence in healthcare.

Today, TidalHealth Peninsula Regional, TidalHealth Nanticoke, and TidalHealth McCready Pavilion continue to build upon our rich legacy of care. In early 2025, a merger between TidalHealth and Atlantic General Hospital (AGH) was announced but had not yet been completed as of the publication of this report. While not explicitly reflected in this CHNA, future CHNA efforts will ensure AGH is more explicitly included as a part of the TidalHealth service area.

TidalHealth Peninsula Regional remains the largest and most experienced healthcare provider in the region with 266 beds. As the sole tertiary hospital on the Delmarva Peninsula, we provide comprehensive emergency and trauma care, specialized acute and subspecialty services, subacute care, outpatient services, diagnostic capabilities, and community health programs.

Our community-based services extend through an expanded network of family medicine and specialty care practices strategically positioned across the Delmarva Peninsula. These services are delivered through private office locations, health pavilions in Delaware and Maryland, and our mobile health initiatives that bring care directly to rural communities. Our dedicated physicians, staff, and volunteers now provide care to over 550,000 patients annually.

TidalHealth Peninsula Regional's primary service area (PSA) encompasses Wicomico, Worcester, and Somerset Counties. This TriCounty Region represents approximately 80% of patients discharged from TidalHealth Peninsula Regional.

TidalHealth Nanticoke, having celebrated its 73rd anniversary in 2025, continues as a nationally recognized 99-bed community hospital. The facility offers a comprehensive range of specialty and subspecialty services, outpatient care, diagnostic capabilities, and community health programs. Each year, TidalHealth Nanticoke provides care for more than 6,000 admitted patients, serves over 38,000 people in the emergency department, and conducts more than 115,000 outpatient tests and procedures.

The Seaford hospital's primary service area (PSA) includes the cities of Seaford, Laurel, Bridgeville, and Georgetown in Delaware. These four communities account for approximately 80% of patients discharged from TidalHealth Nanticoke.

Mission
To improve the health of the communities we serve

Vision
To achieve world-class health and wellness for our families, friends and neighbors

Somerset County Health Department

The Somerset County Health Department is led by Health Officer Danielle Weber, MS, RN. Approximately 70 employees serve about 25,000 residents through the following programs and services: Administrative Services, Community Health, Emergency Preparedness, Environmental Health, Medical Assistance Transportation, Preventive Health Services, Tri-County Alliance for the Homeless, and Vital Services.

Mission

To serve the public by preventing illness, promoting wellness, and protecting the health of our community

Vision

Healthy People in Healthy Communities

Wicomico County Health Department

The Wicomico County Health Department (WiCHD) is led by Health Officer Matthew McConaughey, MPH. Wicomico County Health Department has over 200 employees that serve over 100,000 residents through the following programs and services: Administration, Behavioral Health, Case Management, Community Health Services, Dental Services, Emergency Preparedness, Environmental Health, Maternal and Child Health, Medical Assistance Transportation, Planning, Prevention and Health Communications, WIC, and Vital Services.

WiCHD has expanded over the years to meet the changing needs of the community and to continually work towards protecting the health and environment of Wicomico County. The behavioral health programs are fully accredited by CARF International (Commission on Accreditation of Rehabilitation Facilities). This achievement is an indication of the organization's dedication and commitment to continually improve services, encourage feedback, and serve the community to improve the quality of the lives of persons served.

Additionally, since 2016, WiCHD has been accredited through the Public Health Accreditation Board (PHAB). PHAB sets standards against which governmental public health departments can continuously improve the quality of their services and performance.

Mission

To maximize the health and wellness of all members of the community through collaborative efforts

Vision

Healthy People in Healthy Communities

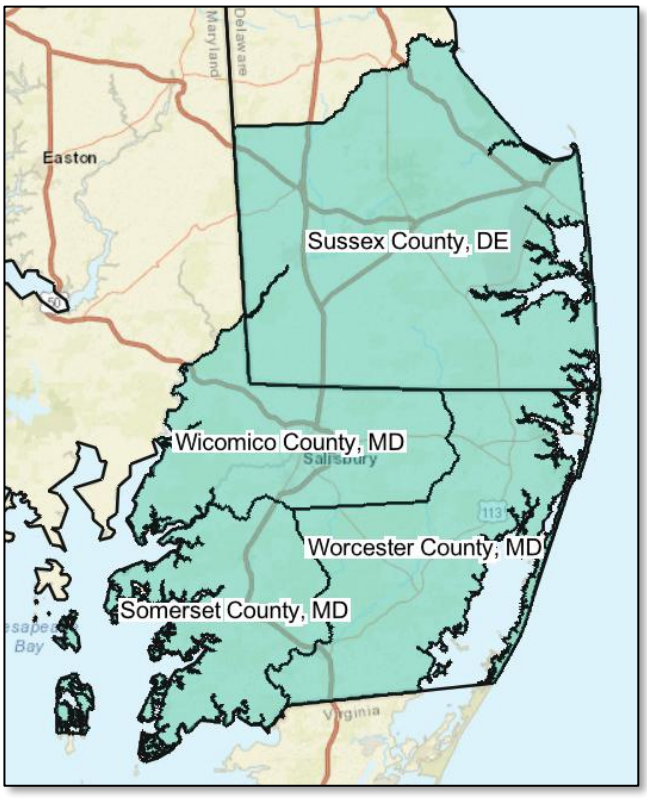
Service Area

TidalHealth Peninsula Regional serves Somerset, Wicomico, and Worcester counties in Maryland - together called the Tri-County Region. TidalHealth Nanticoke serves Sussex County in Delaware.

For this Community Health Needs Assessment (CHNA), TidalHealth worked with the Somerset County Health Department (SCHD) and Wicomico County Health Department (WiCHD) to study this combined four-county area. This area includes 66 zip codes and their census tracts.

Throughout this report, we'll refer to this service area as "the Delmarva Region."

Map of Delmarva Region



Consultants

The Partnership commissioned Ascendient Healthcare Advisors (Ascendient) to support the 2025 CHNA. Ascendient works with healthcare organizations and public health departments nationwide to complete IRS-compliant and Public Health Accreditation Board conforming community health assessments, improvement plans, and progress tracking mechanisms.

The Ascendient team members involved in the development of this report included: Brian Ackerman, MHA, Partner; Chelsey Saari, DrPH, MPH, Manager; and Kristen Lewis, MPH, Consultant. To learn more about Ascendient Healthcare Advisors, please visit their website at www.ascendient.com.

2025

COMMUNITY HEALTH NEEDS ASSESSMENT SUMMARY

Healthy Delmarva

Building a Healthier Delmarva

WHAT IS A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)?

A Community Health Needs Assessment (CHNA) is a report that shows what health problems exist in a community and what resources are available to help. CHNAs are important because they help hospitals and health departments figure out which health issues to focus on first, and they make sure that money and programs go where they are needed most in the community.

GOALS OF THIS REPORT

The goals of this CHNA report are to:

- Identify the biggest health problems in the community by looking at data about who gets sick and why.
- Document gaps in healthcare and other support services in the community.
- Prioritize what issues leaders should focus on fixing first.
- Help partners address regulatory and accreditation requirements.

ASSESSMENT PROCESS

This report is the culmination of a multi-step assessment process is shown in the graphic below.

DATA COLLECTED, ANALYZED & CONSIDERED

Secondary Data

Secondary data for this CHNA were gathered from multiple publicly available sources to describe geographic, demographic, social and economic factors, environmental factors, health status and disease trends, mental and behavioral health trends, and individual health behaviors.

Primary Data

New data were gathered and analyzed through community surveys, key leader surveys, key leader interviews and focus groups.

1,274 COMMUNITY SURVEYS	28 LEADER SURVEYS	53 FOCUS GROUP PARTICIPANTS	9 KEY LEADER INTERVIEWS

2025 PRIORITY HEALTH NEEDS

After a review of available data, the following priority health needs were identified and prioritized through the 2025 CHNA process:

- HEALTHCARE ACCESS
- CHRONIC DISEASE
- BEHAVIORAL HEALTH

The next step of the CHNA process is for health leaders to identify goals, objectives, and strategies for addressing these priority health needs.

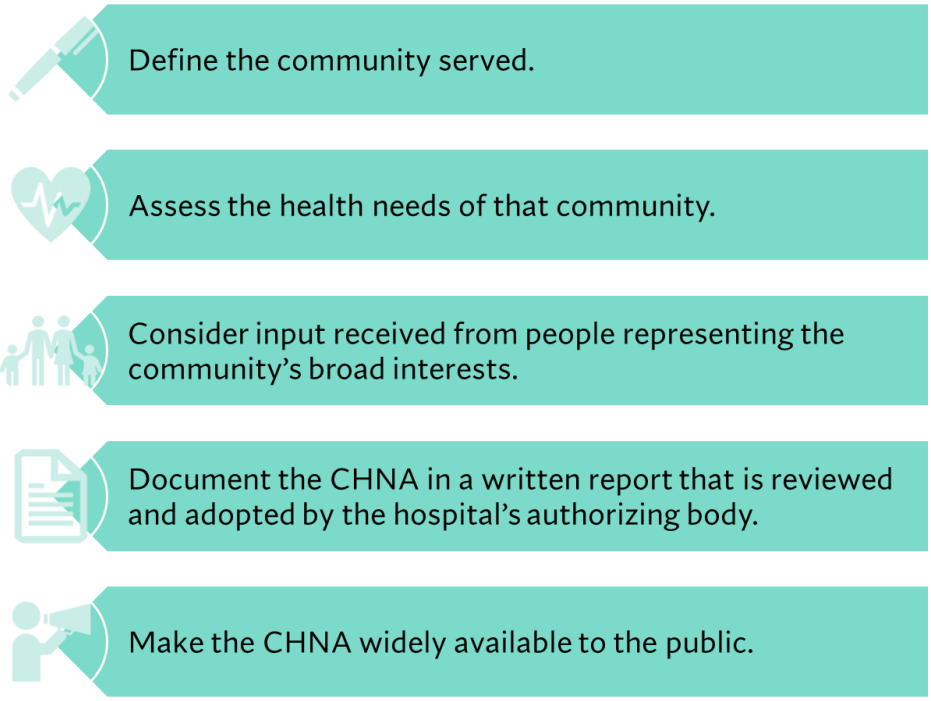
Introduction

The Healthy Delmarva Community Health Needs Assessment (CHNA) demonstrates a comprehensive approach to understanding and addressing community health needs while fulfilling CHNA requirements for both non-profit hospitals per Section 501(r)3 of the Internal Revenue Service (IRS) regulations for non-profit hospitals, and for public health, as defined by the Public Health Accreditation Board (PHAB).

Hospital Requirements

IRS Section 501(r)3 requires nonprofit hospitals to complete a CHNA every three years. The CHNA must consider the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public. More specifically, hospital facilities must do the following to be considered in compliance with this IRS requirement:

Figure I.1: IRS Requirements



Public Health Requirements

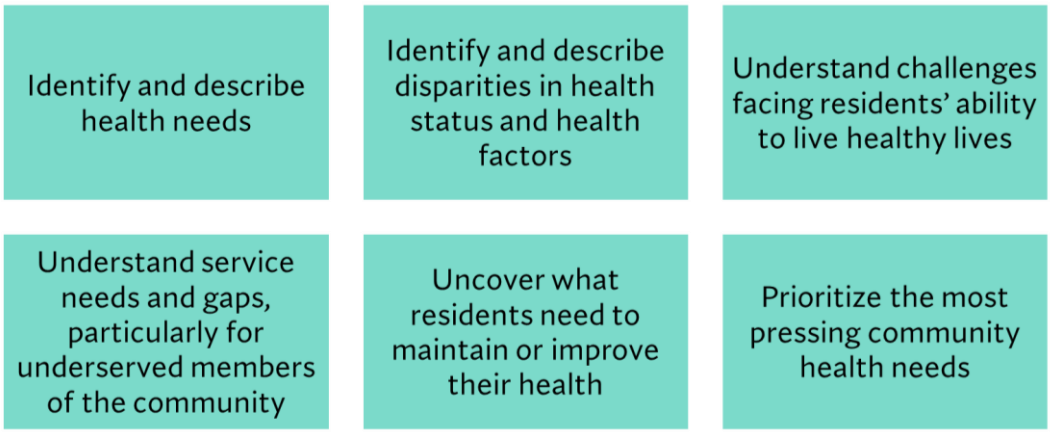
The PHAB Standards and Measures for Initial Accreditation, Version 2022 outline requirements and provide guidance for governmental public health departments seeking to demonstrate their conformity with national practice standards. A community health assessment is required in Standard 1.1, with the purpose of ensuring health departments assess the health of the population served. It is the expectation to inform priority setting, planning, program development policy change, coordination of resources, prepare for funding applications, and to find new ways to collaboratively use community assets while making sure

this information is available to other public health system partners who may also use it for similar purposes.

Process Overview

The process used to produce this CHNA followed several steps and considered numerous data sources. Both primary and secondary data were gathered, analyzed and incorporated into this report to provide a comprehensive overview of health and factors impacting health and wellbeing in the Delmarva region. Key objectives of this process were to:

Figure I.2: Key Objectives



To achieve these objectives, the Steering Committee has worked through a multi-step process documented in the figure below. A more in-depth description of the process used to develop the CHNA is provided in Chapter 1 of this report.

Figure I.3: Multi-Step CHNA Process Overview

CHNA Report Structure

This report includes several chapters and appendices that further describe the processes and data used to arrive at priority health issues for the Healthy Delmarva Partnership. A summary of each major section of the report is provided below. Each bold topic is hyperlinked to its

respective place within this report for ease of navigation. The sections can also be accessed through the report's Table of Contents.

Chapter 1 | Methodology – The methodology chapter provides an overall summary of how data and information were collected and incorporated into the development of this CHNA. This also includes study limitations and the process by which priority health need areas were identified and selected.

Chapter 2 | Community Profile – This chapter details the demographic (such as age, gender, and race), geographic, and socioeconomic characteristics of the Delmarva region.

Chapter 3 | Priority Health Need Areas – This chapter describes each identified priority health need area for the Delmarva region. It summarizes new and existing data that supports and explains each health need area and why they were prioritized. This chapter also describes the impact of health disparities among various sub-groups in the Delmarva region specific to the priority health need areas.

Chapter 4 | Health and Social Service Resource Inventory – This chapter documents existing health and social service resources currently available in the Delmarva region that can be leveraged to address the priority health need areas.

Chapter 5 | Next Steps – This chapter briefly summarizes next steps that will occur to address the priority health need areas discussed throughout the CHNA report.

In addition, the appendices of this report define and describe various data sources used during the development of this report in detail, including:

Appendix 1 | Summary of Prior CHNA Implementation Plans – Information about Steering Committee partners' actions taken to address priority health needs identified in previous CHNAs are presented in Appendix 1.

Appendices 2-4 | Detailed Summary of Secondary Data Measures and Findings – Existing data measures and findings used in the prioritization process are presented in Appendices 2-4.

Appendices 5-6 | Detailed Summary of Primary Findings – Summaries of new data findings from key leader and community health surveys, focus groups, and key leader interviews are presented in Appendices 5-6.

Chapter 1 | Methodology

The process used to assess the Delmarva region's community needs, challenges, and opportunities included multiple steps. Both primary (new) and secondary (existing) data were used to ensure a more complete picture of health needs impacting these communities. Various data sources gathered and reviewed for this CHNA were considered individually and integrated to identify, explain, and assist the Steering Committee in best understanding the most pressing community health needs impacting the Delmarva region.

The following sections describe the data gathered, analyzed, and used to inform the CHNA report and the subsequent prioritization and selection of priority health needs identified from this assessment process.

Primary Data

Engagement and feedback were gathered through multiple data collection processes over the course of several weeks from community residents and leaders throughout the Delmarva region. The Steering Committee worked with Ascendient Healthcare Advisors to administer online community health and key leader surveys, to facilitate in-person and virtual community focus groups, and to complete key leader interviews. Across all four data collection strategies, 1,364 community and key leaders participated and offered their input and insights about health and social issues impacting their communities. These data are summarized in the table below.

Table 1.1. Primary Data Inputs for 2025 CHNA Process

Data Collection Strategy	Total Number of Participants
Community Health (Resident) Survey	1,274
Key Leader Survey	28
Community Focus Groups	53
Key Leader Interviews	9

Community Health Survey

The Steering Committee worked together to develop survey questions for the community health survey. Community members aged 18-years or older were asked to participate in the online survey. Input from residents was gathered on a variety of topics, including perceptions about the most significant health and social needs in the community, personal health status, experiences seeking and receiving healthcare services, perceived barriers to accessing healthcare services, where they seek and receive health information, and health literacy. Additional details about the community health survey tool and administration process can be reviewed in Appendix 5.

Key Leader Survey

The Steering Committee also worked together to develop survey questions for the key leader survey. This survey was disseminated by members of the Steering Committee to key leaders across the region to gather insights on several topics. This survey asked respondents for perceptions around greatest health and social challenges impacting the region, whether these issues have been changing over the past several years, barriers to healthcare and other services, resources currently available in the community to address known challenges, and more. Additional details about the key leader survey can be reviewed in Appendix 5.

Community Focus Groups

Focus groups were held with residents representing each of the region's four counties, as well as with individuals representing the Hispanic, Haitian, and older adult residents of the Delmarva region. Discussion topics included health, social, and environmental needs in the community, healthcare access limitations, the needs and concerns of specific population cohorts, and perceptions of community resources. Focus group participants were asked a standard set of questions about health and social needs to identify trends across various groups and to highlight areas of concern for specific populations. Additional details about the community focus groups can be reviewed in Appendix 5.

Key Leader Interviews

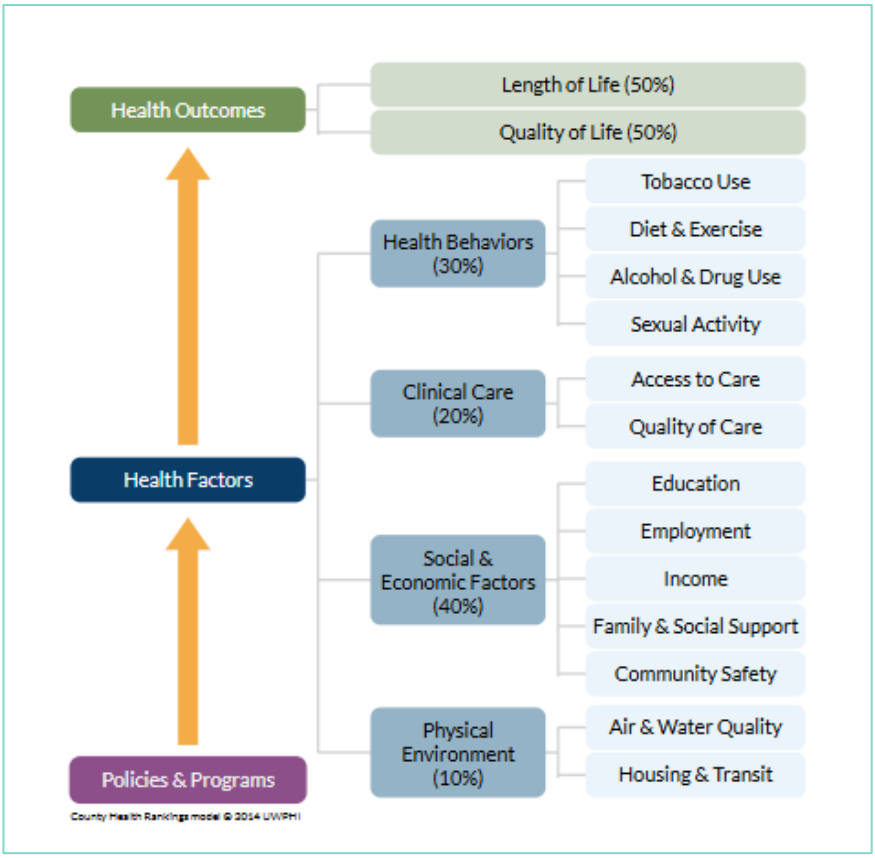
The Steering Committee identified a list of key leaders representing a variety of sectors and different communities within the Delmarva region who were invited to participate in virtual interviews facilitated by Ascendient Healthcare Advisors. Interviewees were asked questions about the community they serve, specifically relating to health, social, and environmental issues and access to healthcare challenges and barriers. Additional details about the key leader interviews can be reviewed in Appendix 5.

Secondary Data

Secondary data for this CHNA were gathered from multiple publicly available sources to describe geographic, demographic, social and economic factors, environmental factors, health status and disease trends, mental and behavioral health trends, and individual health behaviors. Data were gathered, organized, and presented to the Steering Committee following the groupings and subgroupings included in the County Health Rankings Model.[1]

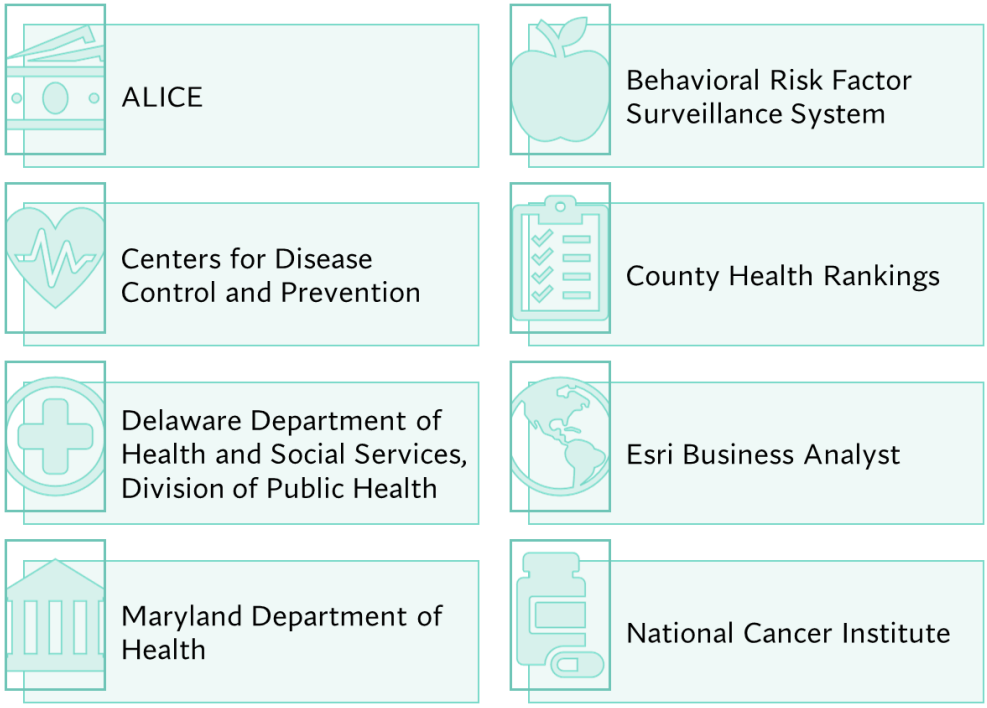
Figure 1.1: County Health Rankings Model[1]

[1] Robert Wood Johnson County Health Rankings and Roadmaps; Retrieved from: https://www.countyhealthrankings.org/what-impacts-health/county-health-rankings-model



A subset of key secondary data sources used to inform the Delmarva region's CHNA process are reflected in the list below and cited throughout this report. Additional information about secondary data sources, such as timeframes for each indicator and indicator definitions are included in Appendix 2.

Figure 1.2: Secondary Data Sources



Comparisons

To understand the relevance of existing data collected throughout the process, each secondary data measure was compared to a benchmark, target, or similar geographic area if possible. This was done to determine how population health and factors impacting health of residents in the service area compared to similar populations or service areas. For this CHNA, indicators were compared to other data as it was available. Specifically, the Steering Committee reviewed comparisons of the Delmarva region counties to the following state and national benchmarks:

- **County Health Rankings Top Performers**[2]: This is a collaboration between the RWJF and the University of Wisconsin Population Health Institute that ranks counties across the nation. Use of this data source supported comparisons across and between the four counties in the Delmarva region, as well as to their respective states and the United States, on a variety of health outcomes and health factors.

- **State of Maryland**: The Steering Committee determined that comparisons with the state of Maryland were appropriate for Somerset, Wicomico, and Worcester counties.

- **State of Delaware**: The Steering Committee determined that comparisons with the state of Delaware were appropriate for Sussex County.

[2]Robert Wood Johnson County Health Rankings and Roadmaps "Compare Counties" Retrieved from: https://www.countyhealthrankings.org/health-data/compare-counties?compareCounties=&year=2024

Data Integration

Primary and secondary data integration is the process of combining information collected directly from community members (primary data) with existing datasets from official sources (secondary data) to create a more comprehensive understanding of health issues.

As noted in previous sections of this report, primary data includes information gathered specifically for the assessment through methods like surveys, interviews, and focus groups. These data provide context, lived experiences, and current perceptions that may not be captured in official statistics. In contrast, secondary data comes from pre-existing sources such as census reports, national and state assessments, hospital records, and research studies. These data offer quantifiable metrics, historical trends, and comparative benchmarks.

Integration involves analyzing where these data sources align or diverge, identifying patterns that appear in both types of data, and using each to provide context for the other. This combined approach produces more robust findings that reflect both statistical realities and community perspectives, leading to more effective and targeted health interventions.

While data and key findings by data source and type are provided individually in the appendices of this CHNA report, data integration across all available sources and types was applied in Chapter 3 to define, describe, and provide context and nuance surrounding the selected priority health needs.

Prioritization Process Overview and Results

The process of identifying and selecting priority health needs for the 2025 CHNA began with the collection, analysis, and discussion of many new and existing measures across several categories. The Steering Committee was first presented with curated secondary data for each of the four counties within the Delmarva region, organized by six categories included within the County Health Rankings model – Length of Life, Quality of Life, Clinical Care, Health Behaviors, Physical Environment, and Social and Economic Environment. Specific measures contained within each of the six categories listed here are detailed in Appendix 2.

As the secondary data were presented, the Steering Committee considered which data demonstrated ‘high need’ or worsening performance as compared to their respective state and national averages. The process by which this determination was made is described in Appendix 3.

Primary data gathered through focus groups, key leader interviews, and community and key leader surveys were also presented to the Steering Committee. These analyses focused on themes emerging from each data source individually, as well as theming across data sources. Detailed results and summary findings from these efforts are included in Appendix 6.

Once the primary and secondary data had been grouped into focus areas detailed in the appendices, the Steering Committee used a group polling process to prioritize health needs of the region while considering the following factors:

- Severity and intensity of the health need based on secondary data;
- Whether possible interventions would be possible and effective;
- Health disparities associated with the need; and
- Importance the community places on addressing the need based on primary data.

The three priority health needs selected through this process are not ranked in order of importance, and each will be addressed by the Steering Committee for the next three years. These needs are highlighted in the figure below.

Figure 1.3: Delmarva Region's 2025 Priority Health Needs

Social determinants of health (SDOH) also emerged as a top concern in the Delmarva region. Recognizing that SDOH impact health disparities and inequities within each of the health priority areas, the Steering Committee decided social determinants of health should be considered a cross-cutting theme in the planning and implementation efforts for each of the three priority health needs identified during this CHNA cycle.

Data Limitations

When considering the findings of this assessment, it is important to recognize the difference between using research methods to identify community needs and processes used to conduct scientific research to produce or discover new knowledge. This CHNA aligns more closely with the former, as it focused on gathering and using data from a variety of sources to identify and understand what is happening in the community. The CHNA accomplished this goal, but not without notable limitations that are described below.

Data limitations in all CHNAs can include:

- Inaccurate or incomplete secondary data,
- Limited sample size in primary data collection,
- Potential biases in self-reported information,
- Lack of data on specific demographics or health disparities,
- Data Collection Methodologies

Inaccurate or Incomplete Secondary Data

Timing - CHNA data may not always reflect current community conditions due to timing challenges with data sources. While developing this assessment, newer information may have been released after our analysis period ended. Most secondary data sources have a one to three-year lag between collection and publication. For instance, Census Bureau data is typically released late the year after it's been collected.

To address these limitations, the Steering Committee gathered supplemental insights through focus groups and online surveys of community members and leaders.

Inconsistent Data Definitions and Methodologies - CHNA metrics often suffer from inconsistent definitions and methodologies across different data sources, making meaningful comparisons challenging. National agencies may collect information using different parameters than state agencies, while states themselves frequently employ varying definitions, measurement approaches, and collection timeframes for the same health indicators. These inconsistencies can manifest in differing age group categories, racial/ethnic classifications, or geographic boundaries, creating data gaps when trying to compare communities across state lines. Additionally, changes in data collection methods over time can disrupt trend analysis, further complicating efforts to identify health disparities or measure progress effectively.

Where possible, the CHNA compares all four counties in the Delmarva region, but there are some instances where comparisons on certain indicators were not possible due to the inclusion of counties from two different states.

Demographic Underrepresentation - It is also worth noting that some existing data sources provide limited demographic breakdowns by factors such as gender, age, race, and ethnicity. Underrepresented populations, including undocumented immigrants, homeless individuals, or those without reliable internet access, are frequently missed in standard data collection processes.

To address these limitations, the Steering Committee conducted focus groups with Hispanic and Haitian members of the community and included interviews with leaders of local organizations who work with and could highlight the needs of underrepresented communities, such as the homeless and undocumented.

Limitations in Primary Data

Elements of this assessment, like web-based surveys, focus groups, and interviews gathered insights from community members and key community health leaders on a variety of topics. Due to time and resource constraints, as well as the community-based versus research-based

approaches to conducting the CHNA, primary data collected for this process was gathered through convenience-based sampling methods.

While the Steering Committee was committed to gathering input from a broad cross-section of the community, it is important to note that the data collected is not fully representative of the community's demography and geography. However, those invited and/or that chose to participate in the process offered their expertise, perceptions, and understanding of health and community issues to the best of their ability based on their own lived experiences and/or interactions with service recipients in the region. The Steering Committee values the input and context provided via the primary data collected through the CHNA process in the Delmarva region, while also acknowledging its limitations as standalone sources of data.

Lack of Data on Specific Demographics or Health Disparities

Given the size of the region in both population and geography, this assessment was limited in its ability to fully capture health disparities and health needs across racial and ethnic groups. While efforts were made to include diverse community members in survey efforts, roughly 83% of all community member survey respondents were white, and only roughly 11% of respondents were Black or African American. Although survey respondents could choose from multiple race or ethnicity categories,[3] limited responses were received from these groups. This made it difficult for the Steering Committee to assess health needs and disparities for other racial/ethnic minority groups in the community. Although the CHNA survey results that were reviewed through this process represented a more diverse cross-section of the population, this survey was not developed specifically for the CHNA and did not ask the same questions of respondents.

In addition, there are existing gaps in information for some population groups. Many available datasets are not able to isolate historically underserved populations, including the uninsured, low-income persons, and/or certain minority groups. Despite the lack of available data, attempts were made to include underserved sub-segments of the greater population through the new data gathered throughout the CHNA process. For example, the Steering Committee chose to have focus groups for specific community members such as seniors, the Hispanic community, and the Haitian Creole community.

[3] Categories included Asian, American Indian/Alaskan Native (AIAN), Black or African American, Hispanic/Latino, Native Hawaiian/Other Pacific Islander (NHPI) and White.

Chapter 2 | Community Profile

This section of the CHNA report describes the service area by geographic and select demographic characteristics. It is broken into two major sections – Geography and Demography - with corresponding sub-sections.

Geography

The lower Delmarva region, encompassing Sussex County in Delaware and Somerset, Wicomico, and Worcester counties in Maryland, represents a distinctive coastal plain that spans 2,107 square miles along the Atlantic seaboard. This area, home to approximately 418,000 residents as of the 2020 Census, maintains a significant rural character with an average of 48% of its population living in rural areas. The region's diverse landscape includes extensive coastal wetlands, maritime forests, and barrier islands along its Atlantic coast, while its western shores are defined by the shallow waters and tidal marshes of the Chesapeake Bay.

The area's rich agricultural heritage is anchored by the poultry industry, with major producers like Perdue and Mountaire Farms operating processing facilities throughout the region, alongside extensive grain farming that supports these operations. The sandy, well-drained soils of the coastal plain also support significant vegetable and melon production, particularly in Sussex County, which ranks among the nation's top lima bean producers. Natural resources play a crucial role in the region's economy, from the productive shellfish beds of the Chesapeake Bay to the Atlantic beaches that drive a robust tourism industry, particularly in Ocean City and the Delaware beaches. The inland areas feature extensive forests, while the coastal bays and wetlands serve as critical habitats for migratory birds along the Atlantic Flyway. This environmental diversity has helped shape a regional economy that balances traditional industries like agriculture and fishing with growing sectors in tourism, healthcare, and light manufacturing, centered around the urban hub of Salisbury in Wicomico County.

Demography

Population figures discussed throughout this chapter were obtained from Esri, a leading GIS provider that utilizes a set of powerful analytical tools paired with an extensive collection of demographics, socioeconomic, consumer spending, behavioral, and psychographic data.

Total Population Overview

The Delmarva region has a total population of 447,012 residents across its four counties. The most populous counties in the region are Wicomico County, Maryland and Sussex County, Delaware.

Table 2.1: Total Population by County, 2024[4]

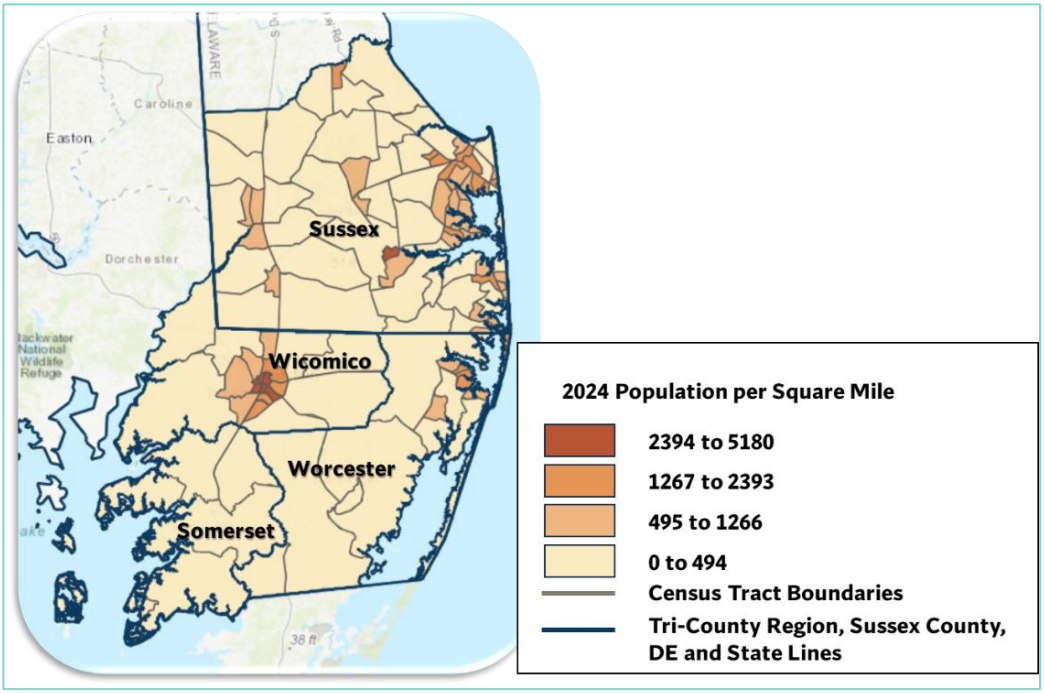
[4] 2024 Esri Business Analyst

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Total Population	**24,396**	**105,394**	**53,531**	6,253,119	**263,691**	1,032,895	338,440,954

Population Density

Population density in the Delmarva region varies widely. The map below shows census tract-level data about population density for the region. The darker colors demonstrate areas with greater population density and the lighter colors show lower population density. The densest population areas in the Delmarva region are in the Salisbury area of Wicomico County, along the eastern coast of Sussex County, and parts of coastal Worcester County.

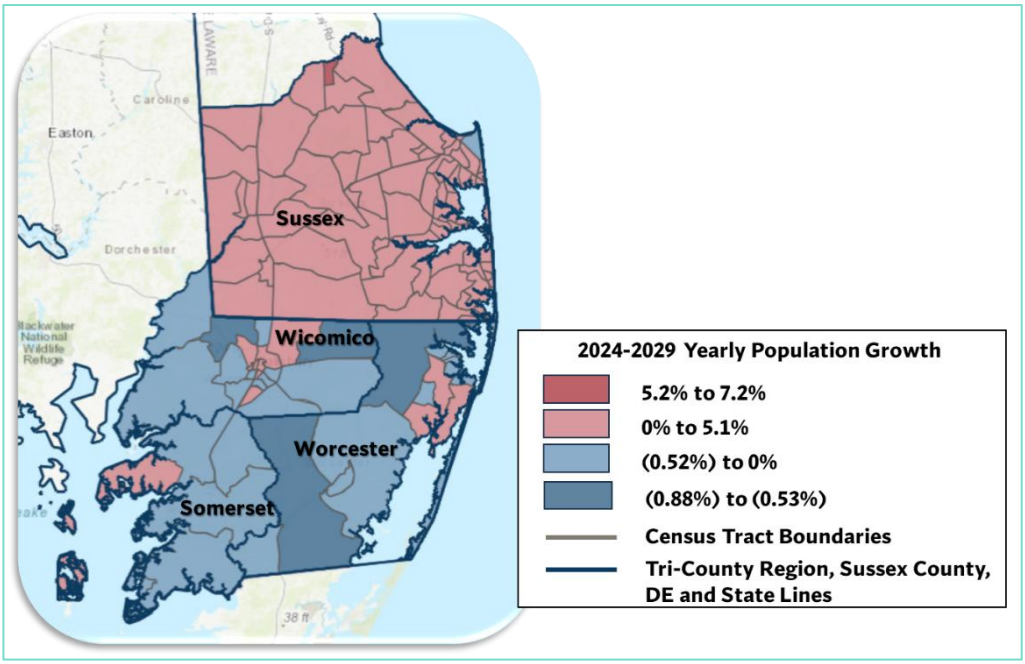
Figure 2.1: Delmarva Region Population Density[4]



Population Projections and Trends

Projected population trends in the Delmarva region differ across the four counties. Sussex County is expected to see 1.61% annual growth in the next five years, while Worcester County is expected to see a population decline of 0.22% annually in the same timeframe. The map below includes census tract-level data about anticipated annual population trends, with red indicating census tracts with projected population growth and blue indicating census tracts with projected population losses.

Figure 2.2: Delmarva Region Projected Annual Population Growth[4]



Age and Sex of Delmarva Region Residents

A clear picture of our community's age and sex makeup helps leaders better understand and meet everyone's health needs. Knowing how many children, adults, and seniors live in the service area - and whether they are male or female – informs decision-making and helps ensure the right health services are being delivered in the right places. These basic details about who lives in the community also help track important health trends and compare the community's health to similar areas and similar populations.

Population Age and Sex Distribution

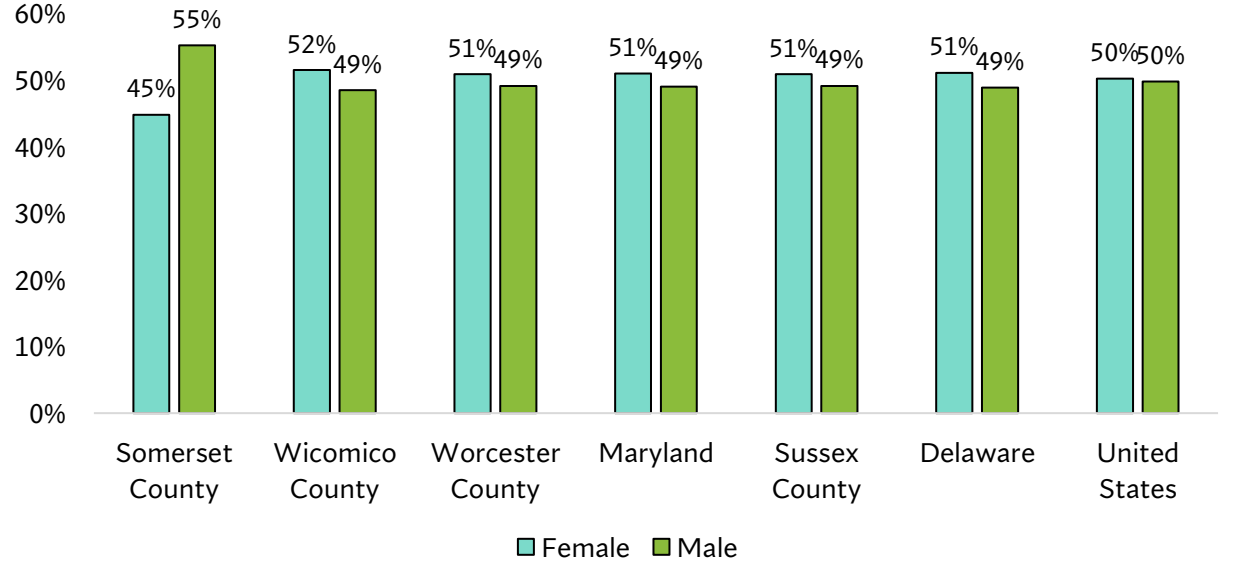
Somerset and Wicomico counties have a slightly younger population when compared with Worcester and Sussex counties. The proportion of the population aged 65 years and older living in Worcester and Sussex counties is higher when compared with state averages, respectively.

Table 2.2: Percent Population Age Distribution by County, 2024[4]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
15 years or younger	**13.7%**	**17.5%**	**13.4%**	17.5%	**16.0%**	16.4%	17.4%
15 to 44 years	**42.2%**	**40.5%**	**30.5%**	40.1%	**32.9%**	37.5%	40.1%
45 to 64 years	**24.0%**	**23.4%**	**26.5%**	25.0%	**28.1%**	24.7%	24.4%
65 years or older	**20.0%**	**18.6%**	**29.7%**	17.4%	**34.4%**	21.4%	18.1%

The sex distribution of Somerset County differs from the Maryland average, with males comprising more than 55% of the total population. Other counties in the Delmarva region have a population sex distribution like respective state averages.

Figure 2.3: Percent Population Sex Distribution by County, 2024[4]



Race, Ethnicity, and Languages Spoken in the Delmarva Region

Different cultural backgrounds can influence how people think about health, when they seek medical care, and what types of treatment they prefer. Language differences can also affect how easily community members can communicate with healthcare providers or understand health information. Some racial and ethnic groups may face higher risks for certain health conditions, like diabetes or heart disease, due to a combination of genetic, social, and environmental factors. By understanding the community's cultural and linguistic makeup, health and other service providers can work to eliminate health disparities and ensure that quality services are accessible to everyone, regardless of their background.

Race and Ethnicity of Residents

White residents make up most of the population in all areas, with Worcester County having the highest proportion of white residents. Black residents represent the second-largest racial group in most Delmarva region counties, with particularly strong representation in Somerset and Wicomico counties. The Hispanic population varies significantly across the region, with a notably larger presence in Sussex County. Asian residents and those identifying as two or more races or other races comprise smaller portions of the population across all areas.

Table 2.3: Percent of Population Racial and Ethnic Distribution by County, 2024[4,5]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States

[5] US Census Bureau, American Community Survey. 2019-2023

White	**52.2%**	**57.8%**	**79.5%**	47.2%	**73.7%**	58.9%	63.4%
Black	**38.9%**	**27.5%**	**11.7%**	29.7%	**10.4%**	22.6%	12.4%
Hispanic	**4.9%**	**7.4%**	**3.9%**	12.7%	**12.0%**	11.3%	19.0%
Asian	**1.1%**	**3.2%**	**1.6%**	7.2%	**1.4%**	4.6%	5.8%
Two or More Races	**4.2%**	**7.1%**	**5.3%**	8.2%	**7.5%**	8.2%	7.12%
Other Race	**3.6%**	**4.5%**	**1.9%**	7.7%	**7.0%**	5.8%	7.7%

Foreign-Born Residents

The proportion of foreign-born residents helps show the diversity of experiences and potential barriers to healthcare in the community. Foreign-born residents may face unique challenges accessing health and other services due to factors like language differences, unfamiliarity with the U.S. healthcare and other systems, or concerns about immigration status. Understanding this population's size and needs when planning health services is important.

Table 2.4: Percent Population Foreign-Born by County, 2019-2023[5]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Foreign-Born Population	**3.8%**	**9.3%**	**5.1%**	17.0%	**8.4%**	10.4%	13.9%

The distribution of foreign-born residents by county is provided Table 2.4. While the percentages seem small when compared to the overall population, it is important to understand the diversity among the foreign-born residents of this service area. In 2022, the three most common birthplaces for foreign-born residents in Somerset, Wicomico, and Worcester counties were Haiti, Mexico, and Pakistan. County level data for birthplace origin for foreign-born Sussex County residents was not available, however the three most common origin countries for immigrants living in Delaware in 2022 were Mexico, India, and Guatemala.[6]

Languages Spoken at Home by Residents

Data about languages spoken in the community helps healthcare and other service providers understand how to effectively communicate with all residents about their health needs and available services. Understanding which languages are commonly spoken allows hospitals, clinics, and health programs to provide appropriate interpreter services and translate

[6]Data USA: "Wicomico, Worcester & Somerset Counties – Salisbury City Puma MD" Retrieved from: https://datausa.io/profile/geo/wicomico-worcester-somerset-counties-salisbury-city-puma-md#demographics

important health information, ensuring all community members can access and understand the care they need.

Table 2.5: Percent Population Languages Spoken at Home by County, 2019-2023[5]							
	Somerset County	**Wicomico County**	**Worcester County**	**Maryland**	**Sussex County**	**Delaware**	**United States**
English Only	**95.6%**	**86.9%**	**93.3%**	79.4%	**87.3%**	85.2%	78.0%
Other Language	**4.4%**	**13.1%**	**6.8%**	22.0%	**12.7%**	14.8%	22.0%

Somerset County has the highest proportion of English-only households, while Wicomico County shows the most linguistic diversity among the Maryland counties shown. Sussex County is closer to the Delaware state benchmark, with most households speaking English-only but still having notable linguistic diversity.

Limited English Proficiency

People with limited English proficiency (LEP) may face challenges accessing care and other community resources that fluent English speakers do not. Language barriers may make it hard to access transportation, medical, and social services as well as limit opportunities for education and employment. Importantly, LEP community members may not understand critical public health and safety notifications.

Table 2.6: Percent Population with Limited English Proficiency by County, 2019-2023[5]							
	Somerset County	**Wicomico County**	**Worcester County**	**Maryland**	**Sussex County**	**Delaware**	**United States**
Population Age 5+ with Limited English Proficiency	**1.7%**	**6.2%**	**1.8%**	7.8%	**6.3%**	5.6%	8.4%

Wicomico County has the highest proportion of LEP residents, while Somerset County has the lowest. Maryland has more LEP residents than any individual county shown and exceeds the national average, while Delaware falls somewhere in the middle.

Disability and Veteran Status in the Delmarva Region

Disability Status

Understanding how many community members live with disabilities helps ensure healthcare services and community programs are accessible and meet everyone's needs. People with disabilities may require specialized healthcare services, accessible medical facilities, or additional support services to maintain their health and independence, making this information essential for healthcare planning.

Table 2.7: Percent Population with any Disability by County, 2019-2023[5]							
	Somerset County	**Wicomico County**	**Worcester County**	**Maryland**	**Sussex County**	**Delaware**	**United States**
Population with Disability	**16.3%**	**12.2%**	**14.9%**	11.4%	**14.5%**	13.9%	13.0%

Each county in the region has a higher percentage of its population with a disability when compared with their respective state and United States averages.

Veteran Status

Knowing how many veterans live in the community helps healthcare providers plan for their unique health needs, which may include service-related injuries or conditions requiring specialized care. Veterans may also be eligible for specific healthcare benefits and services through the VA system, so knowing the size of the veteran population helps coordinate care between local healthcare providers and veteran services.

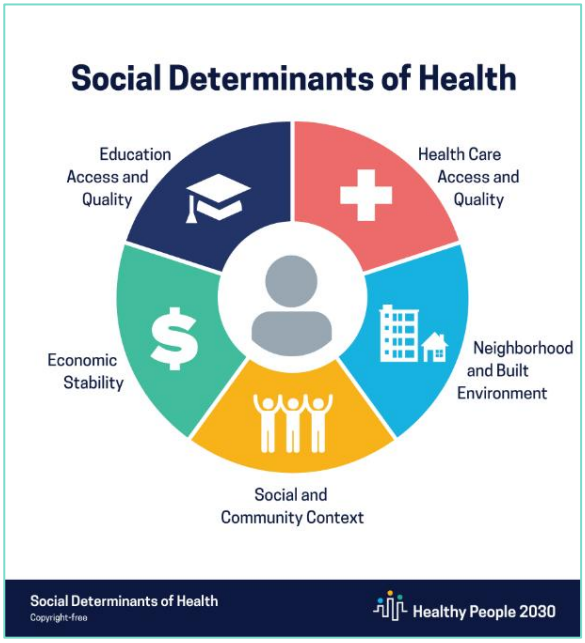
Table 2.8: Percent Population Veterans by County, 2019-2023[5]							
	Somerset County	**Wicomico County**	**Worcester County**	**Maryland**	**Sussex County**	**Delaware**	**United States**
Veteran Population	**6.6%**	**6.3%**	**9.9%**	7.0%	**8.8%**	7.8%	6.4%

Worcester and Sussex counties have a higher Veteran population than the other counties as well as the state and national populations.

Social, Economic, and Environmental Determinants of Health

The conditions in which people live, work, and grow up - known commonly as the social determinants of health (SDOH) - play a crucial role in their overall health and well-being. These factors include access to good jobs, education, safe housing, healthy food, and transportation, as well as experiences of racism or discrimination. When communities lack these basic resources, residents are more likely to develop serious health conditions and may live shorter lives than people in communities with better resources. For example, if a neighborhood doesn't have grocery stores with fresh food or safe places to exercise, residents face a higher risk of conditions like heart disease and diabetes.

Figure 2.4: Social Determinants of Health



While encouraging healthy choices is important, improving community health requires addressing these underlying conditions through partnerships between healthcare providers, public health organizations, and other sectors like housing, education, and transportation. By understanding and improving these social determinants of health, communities can work to reduce health disparities and help all residents live healthier lives.

Figure 2.4 outlines the Healthy People 2030[7] model for social determinants of health that was utilized to guide this CHNA. In the sections that follow, data highlighting social and environmental indicators impacting the health of residents in the Delmarva region are described, including:

- Centers for Disease Control and Prevention's Social Vulnerability Index,
- Centers for Disease Control and Prevention's Environmental Justice Index,
- County Health Rankings Scores for Health Outcomes and Health Factors
- Residential Segregation Index
- Economic Factors Impacting the Delmarva Region
- Poverty and ALICE Households
- Educational Attainment in the Delmarva Region
- Healthcare Access and Quality in the Delmarva Region
- Housing Status in the Delmarva Region

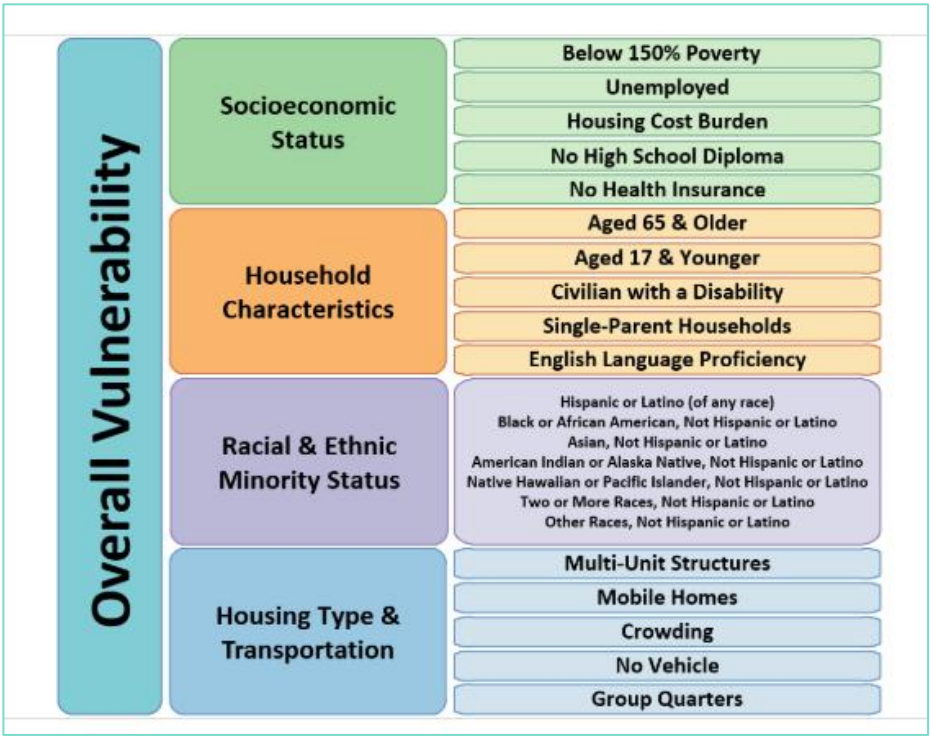
[7] Healthy People 2030 – "Social Determinants of Health" Retrieved from: https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health

Social Vulnerability Index

The Social Vulnerability Index (SVI)[8] helps show which neighborhoods might need extra help during emergencies like natural disasters or disease outbreaks. Created by the CDC, this tool looks at different factors that can make it harder for communities to cope with these challenges, such as poverty, lack of transportation, or language barriers. The SVI combines information about a neighborhood's income levels, housing conditions, racial and ethnic makeup, and other important factors to create a score that shows how vulnerable that area might be to health emergencies. Higher SVI scores usually mean that residents in that area face more challenges staying healthy and may need more support from community services. This information helps healthcare providers and emergency planners know where to focus their efforts to help keep everyone in the community healthy and safe.

The current SVI uses 16 US Census variables from the American Community Survey which are grouped into four themes covering four major areas of social vulnerability. These variables and their corresponding categories are shown in Figure below. The data for these measures are then combined into one measure of overall social vulnerability, which is the SVI metric.

Figure 2.5: CDC/ATSDR Social Vulnerability Index Variables[8]



SVI in the Delmarva Region

The closer an SVI score is to 1, the higher the social vulnerability of that community. In the Delmarva region, the counties with highest level of social vulnerability based on SVI scores are

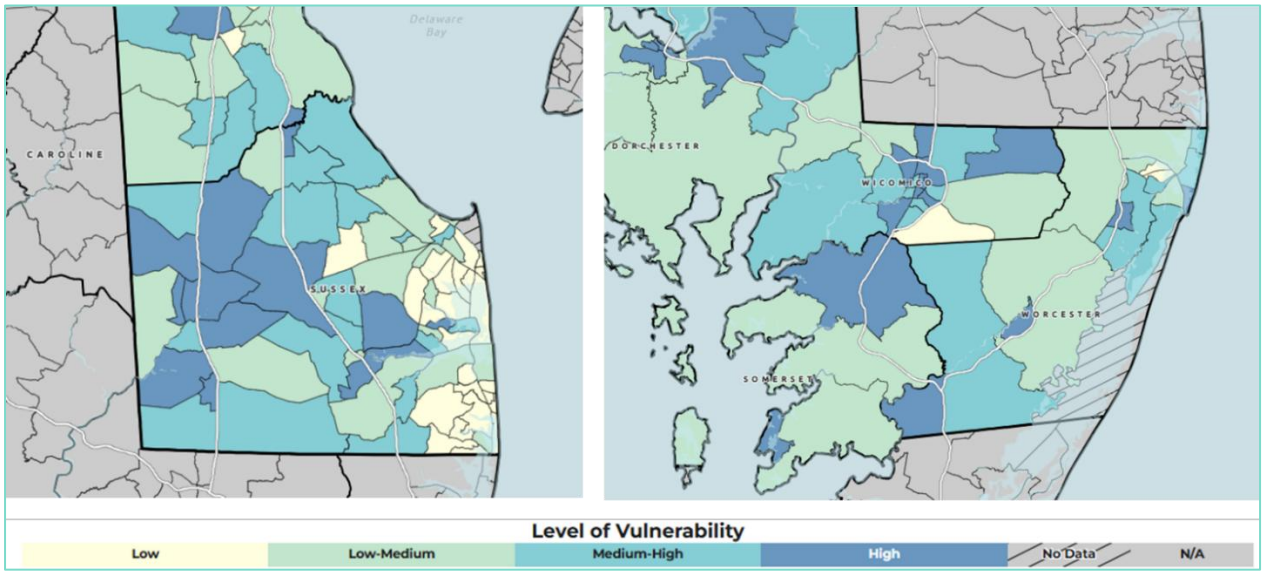
[8]CDC/ATSDR Place and Health – Geospatial Research, Analysis, and Services Program (GRASP) - Social Vulnerability Index (SVI). Retrieved from https://www.atsdr.cdc.gov/place-health/php/svi/index.html

Somerset and Wicomico counties in Maryland. However, there are census tracts within each county that are more vulnerable than others, as depicted in Figure 2.6.

Table 2.9: SVI Scores and Level of Vulnerability by County, 2022[8]

	Maryland			Delaware
	Somerset County	**Wicomico County**	**Worcester County**	**Sussex County**
SVI Score	0.8794	0.7916	0.4305	0.5183
Level of Vulnerability	High	High	Low to Medium	Medium to High

Figure 2.6: SVI Level of Vulnerability by Census Tract, 2022[8]



Environmental Justice Index

The Environmental Justice Index (EJI)[9] helps show which neighborhoods face more environmental health risks than others due to factors like pollution, toxic sites, or other environmental hazards. Created by the CDC, this tool looks at how different environmental problems affect community health, paying special attention to areas where residents might face multiple challenges at once. The EJI combines information about environmental hazards with data about social factors like income and access to resources to create a score for each neighborhood. Higher scores usually mean that residents in that area face more environmental health risks and may need additional support to address these challenges. This information helps community leaders and healthcare providers understand where environmental problems are having the biggest impact on people's health, so they can work to make conditions safer and healthier for everyone.

[9]CDC/ATSDR Place and Health – Geospatial Research, Analysis, and Services Program (GRASP) - Environmental Justice Index (EJI): https://www.atsdr.cdc.gov/place-health/php/eji/index.html

EJI in the Delmarva Region

EJI scores use percentile ranking to show the proportion of census tracts experiencing environmental burden relative to other census tracts in a given geography. In the Delmarva region, the EJI scores for each county are relative to their respective states of Maryland or Delaware. Scores range from 0 to 1, with higher scores (closer to 1) indicating communities that may experience more environmental justice concerns and greater cumulative impacts from environmental hazards and social determinants of health compared with other communities.

In the Delmarva region, the counties with the highest environmental justice vulnerability are those within Somerset and Wicomico counties. The most burdened areas of Somerset County are Crisfield, Mount Vernon, Princess Anne, and Eden, while the most burdened areas of Wicomico County are Salisbury and Delmar.[9]

Table 2.10: EJI Scores and Level of Vulnerability by County, 2022[9]

	Maryland			Delaware
	Somerset County	**Wicomico County**	**Worcester County**	**Sussex County**
EJI Score	0.62	0.58	0.48	0.44
Level of Vulnerability	Moderate to High	Moderate to High	Moderate	Moderate

County Health Rankings – Health Outcomes and Health Factors

The County Health Rankings[2] model uses standard measures of health outcomes and health factors to rank counties on a continuum from the least healthy to healthiest in the nation. There are two rankings, one for health outcomes and one for health factors. The continuums are intended to demonstrate how an individual county fares relative to others in their respective state and the nation. For this CHNA, county health rankings for each county in the Delmarva region were reported and considered as part of the overall assessment process.

Figure 2.7 shows County Health Ranking maps for both Maryland and Delaware for *Health Outcomes*. Compared to other counties across the United States, Worcester County and Sussex County are ranked higher (healthier) when considering health outcomes in the County Health Rankings model than Somerset and Wicomico counties.

Figure 2.7: County Health Rankings State Health Outcomes Maps for Maryland and Delaware, 2024[1]

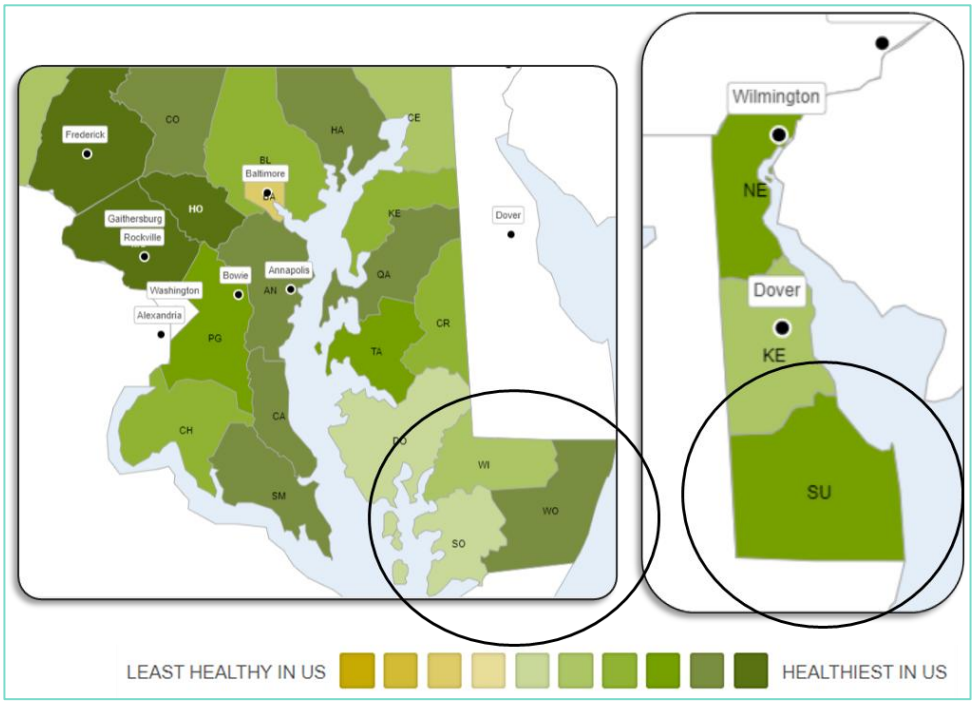
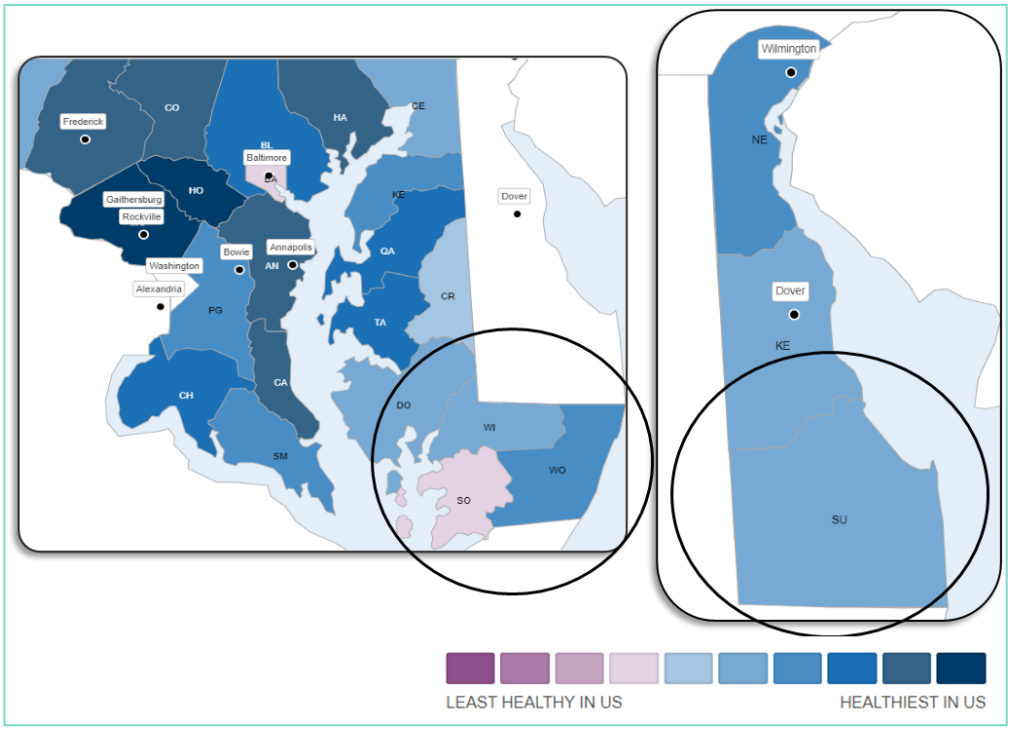


Figure 2.8 shows County Health Ranking maps for both Maryland and Delaware for *Health Factors*. Compared to other counties across the United States, Worcester County is ranked higher (healthier) when considering health factors in the County Health Rankings model than Somerset, Wicomico, and Sussex counties.

Figure 2.8: County Health Rankings State Health Factors Maps for Maryland and Delaware, 2024[1]Error! Bookmark not defined.



Residential Segregation Index

The residential segregation index shows how separated different racial and ethnic groups are within a community. It measures whether everyone has the opportunity to live in any neighborhood or if certain groups are concentrated in specific areas. This separation often results from historical policies and continuing practices that have limited where people can live, leading to differences in access to important resources that affect health, such as quality schools, good jobs, healthcare facilities, and healthy food options. Understanding residential segregation patterns helps explain why some groups face bigger health challenges than others and helps community leaders identify where changes are needed to ensure everyone has fair access to the resources they need to be healthy.

Table 2.11: Racial Segregation Index by County, 2018-2022[11]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Black/White Residential Segregation	**40.2**	**39.8**	**51.3**	63.2	**44.0**	44.0	63.0

Residential segregation measures can range from 0 to 100, with lower values representing less segregation in a community and higher values representing complete segregation. The index score can be interpreted as the percentage of either Black or white residents that would have to move to different geographic areas to produce a distribution that matches that of the larger area. Worcester County has the highest residential segregation among counties in the Delmarva region. However, all counties have index values equal to or lower than their respective state values.

Economic Factors Impacting the Delmarva Region

Understanding economic conditions in a community is crucial for addressing health needs effectively. A family's income level, employment status, and access to health insurance can significantly impact their ability to maintain good health and receive medical care when needed. Economic factors also influence where people live, which can determine their exposure to environmental health risks and their access to resources like grocery stores, pharmacies, and medical facilities. By examining these economic patterns, health planners can better identify barriers to care and services, while also developing programs that make healthcare and other services more accessible and affordable for all community members.

Median Household Income

Median household income shows the typical earnings of households in a community. This information helps show whether families in the area typically have enough money to cover basic needs like housing, food, and healthcare, while also making it easier to compare economic conditions across different communities. All Maryland counties in the Delmarva region have a much lower median household income than the state average of $98,461, while Sussex County is on par with the average for the state of Delaware. Somerset County's median household income is less than half of the average for Maryland overall.

Table 2.12: Median Household Income and Living Wages by County, 2024[4]							
	Somerset County	**Wicomico County**	**Worcester County**	**Maryland**	**Sussex County**	**Delaware**	**United States**
Median Household Income	**$48,810**	**$65,969**	**$76,652**	$98,461	**$88,713**	$88,002	$75,149

Income Inequality

The income inequality ratio helps show how fairly money is distributed across a community by comparing the income of the richest households to that of the poorest households. Communities with high income inequality often see bigger differences in health outcomes, as some residents have plenty of resources to stay healthy while others struggle to afford basic needs that affect their health, like nutritious food, safe housing, and medical care. Tracking income inequality is important because it can reveal whether economic opportunities are available to everyone in the community or whether certain groups face bigger barriers to achieving financial stability that could affect their health.

The gender pay gap is an important metric because economic inequality directly affects health outcomes through reduced access to healthcare, nutrition, and quality housing. This economic disparity often signals broader systemic inequities that particularly impact women's health and frequently intersects with other social factors like race and caregiving responsibilities, allowing healthcare planners to develop more targeted interventions.

Table 2.13: Income Inequality and Gender Pay Gap by County, 2018-2022[11]							
	Somerset County	**Wicomico County**	**Worcester County**	**Maryland**	**Sussex County**	**Delaware**	**United States**
Income Inequality Ratio	**4.3**	**4.4**	**4.5**	4.6	**4.3**	4.4	4.9
Gender Pay Gap	**0.83**	**0.82**	**0.81**	0.86	**0.84**	0.84	0.81

Income inequality measures the ratio of household income at the 80th percentile and the 20th percentile, whereby a higher income inequality ratio indicates a greater division between the top and bottom ends of the income spectrum in a community. Communities with greater income inequality may have worse outcomes on a variety of metrics, including mortality, poor health, sense of community, and social support. As seen in the table above, counties within the Delmarva region have a similar income inequality ratio and it is lower than ratios for their respective states and the United States overall.

The gender pay gap metric is a ratio of women's median earnings to the median earnings of men for all full-time, year-round workers. In the United States, women earn $0.81 for every $1.00 men earn. Though Maryland and Delaware have a smaller pay gap when compared to that of the United States, the counties within this region have a greater pay gap between women and men.

Poverty and ALICE Households

Many households earn more than the federal poverty level but still struggle to afford basic necessities - these families are often described as ALICE households (Asset Limited, Income Constrained, Employed). The federal government sets poverty guidelines each year, and households earning less than 200% of these guidelines are often eligible for assistance programs since the official poverty level doesn't fully capture the income needed to meet basic needs in most communities. ALICE households include working families who earn more than 200% of the federal poverty level but still have difficulty covering essential expenses like housing, food, transportation, healthcare, and childcare in their local area. Together, the percentage of households below 200% of the federal poverty level combined with ALICE households shows how many families in the community may be struggling financially, even if they aren't considered officially "poor" by federal standards.

In the Delmarva region, more than 25% of families are living in ALICE households. This, coupled with the percentage of the population living in poverty, means that more than 40% of all Delmarva region families are struggling financially to cover the costs of basic expenses like housing, food, transportation, healthcare, and childcare.

Table 2.14: Poverty Rates and ALICE[10] Households by County[11,12]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
% Population Living in Poverty	**10.6%**	**13.1%**	**8.5%**	9.3%	**10.6%**	10.6%	12.5%
% Children in Poverty	**17%**	**16.4%**	**14%**	12.1%	**17%**	14.3%	16.0%
ALICE Households	**26.6%**	**26.4%**	**28.5%**	29%	**26.6%**	29%	29%

Households Receiving SNAP/ Food Stamps

SNAP (Supplemental Nutrition Assistance Program) participation rates serve as a key economic indicator, helping healthcare organizations understand financial stability within their communities. This data helps identify areas where residents may face economic challenges that could impact their ability to maintain good health, allowing for more targeted support and resource allocation.

Table 2.15: Households Receiving SNAP/Food Stamps by County, 2018-2022[11]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States

[10]ALICE stands for "Asset Limited, Income Constrained, Employed Households"
[11]American Community Survey 5-Year Estimates (2018-2022).
[12]United for ALICE. Data retrieved from: https://www.unitedforalice.org/all-reports

Households Receiving SNAP/Food Stamps	**25.7%**	**17.6%**	**10.5%**	10.8%	**10.6%**	10.7%	11.5%

SNAP/Food Stamp usage across the Delmarva region varies, but Somerset County stands out with the highest overall utilization rate. The participation rate in Somerset County is about 25% higher than Wicomico County, and more than double that of Worcester and Sussex counties.

Unemployment

The unemployment rate shows the percentage of people who are actively looking for work but cannot find jobs in the community. This number is important because job loss often means losing health insurance and income, which can make it harder for people to stay healthy and get medical care when needed. Examining unemployment patterns can also reveal whether certain neighborhoods or groups in the community face greater challenges finding stable work, which helps identify areas where additional support services may be needed.

Table 2.16: Unemployment Rate by County, 2022[11]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Unemployment Rate	4.8%	3.8%	5.0%	3.2%	4.4%	4.5%	3.7%

The unemployment rate for Somerset, Wicomico, and Worcester counties are higher than the average for Maryland. All four counties in the Delmarva region have higher unemployment rates than the United States average.

Educational Attainment in the Delmarva Region

Educational attainment shows the highest level of education that adult residents have completed, such as high school, college, or graduate degrees. Education levels are often connected with health outcomes since higher levels of education typically lead to better-paying jobs with health insurance benefits and can help people better understand health information and navigate the healthcare system. Looking at education patterns across different areas of the community can help identify neighborhoods where residents might face more challenges accessing and understanding health information or services.

Figure 2.9: Population without a High School Diploma

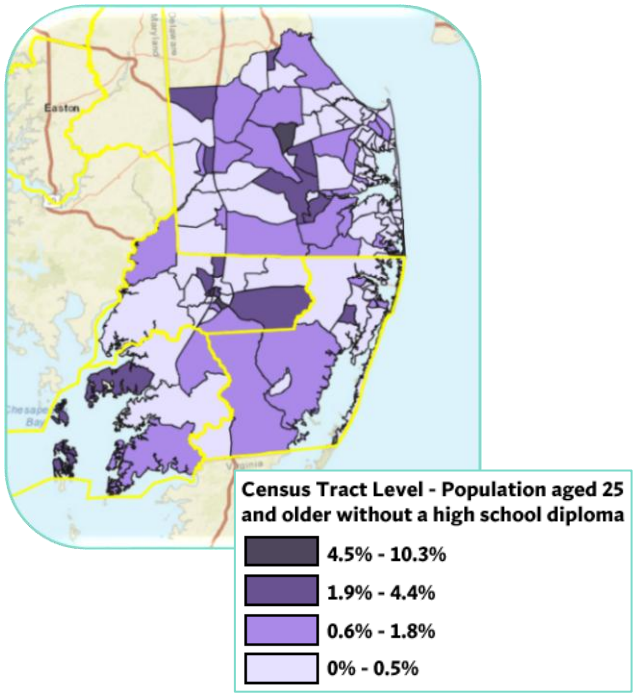


Table 2.17: Percent Population Educational Attainment by County, 2024[4]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Less than 9th Grade	**3.0%**	**3.4%**	**1.4%**	3.5%	**2.3%**	2.2%	4.7%
9-12th Grade/ No Diploma	**10.2%**	**6.3%**	**4.0%**	4.3%	**5.9%**	5.0%	6.1%
High School Diploma	**32.2%**	**30.0%**	**27.8%**	21.2%	**26.2%**	25.3%	26.4%
Some College/ No Degree	**18.7%**	**16.7%**	**20.4%**	15.7%	**17.6%**	17.6%	19.7%
Associate's Degree	**8.7%**	**9.1%**	**8.4%**	7.4%	**10.0%**	8.9%	8.7%
Bachelor's Degree	**13.0%**	**19.2%**	**21.9%**	24.2%	**20.1%**	21.8%	20.9%
Graduate/ Professional Degree	**5.7%**	**12.3%**	**12.9%**	20.9%	**14.8%**	15.9%	13.4%

Educational attainment in the Delmarva region varies by county. Somerset County has the most residents without a high school diploma and less than 20% with a bachelor's degree or higher education. At least 30% of the population in all other Delmarva region counties have a bachelor's or higher education.

Healthcare Access and Quality in the Delmarva Region

Healthcare Access and Quality is crucial in a community health needs assessment because it directly impacts health outcomes through access to preventive care, early diagnoses, and chronic disease management. It helps reveal disparities between different population groups, showing where certain communities might face barriers like transportation challenges or lack of insurance coverage. The data highlights gaps in specific services, such as mental health care or pediatric specialists, allowing healthcare organizations to better direct their resources. Poor access often leads to delayed care and increased emergency department use, resulting in worse outcomes and higher costs. Understanding these patterns helps communities plan targeted improvements to their healthcare system.

Patient-Provider Ratios

Provider-to-patient ratios are crucial metrics because they directly indicate how accessible essential healthcare services are for community members - when there are too few providers for the population, people face longer wait times and may delay or forego needed care. These ratios also help identify potential healthcare deserts where additional resources and recruitment efforts may be needed to ensure equitable access to comprehensive care services across the community. The World Health Organization estimates that 2.5 medical professionals per 1,000 people are needed to provide adequate primary care, but the ideal ratio varies by region, service area, and specialty[13].

Table 2.18: Provider-to-Patient Ratios, 2021-2023[14,15]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Total Population per Primary Care Physician	**2,732**	**1,552**	**1,181**	1,179	**1,628**	1,356	1,330
Total Population per Dentist	**455**	**1,246**	**1,632**	1,238	**4,490**	2,181	1,360
Total Population per Mental Health Provider	**303**	**240**	**352**	292	**446**	309	320

Considering the WHO's ideal patient-provider ratio, all counties in the Delmarva region are experiencing significant gaps in healthcare access. For example, Somerset County has the highest population burden per physician, followed by Wicomico and Sussex counties. Worcester County appears to have the most favorable patient-provider ratio in the region for

[13] World Bank, Databank, Metadata Glossary

[14]Source: American Medical Association (2021). Area Health Resource File. Retrieved from Robert Wood Johnson Foundation (RWJF) & University of Wisconsin Population Health Institute (UWPHI) 2024 County Health Rankings.

[15]Source: CMS National Provider Identification (2023). Area Health Resource File. Retrieved from Robert Wood Johnson Foundation (RWJF) & University of Wisconsin Population Health Institute (UWPHI) 2024 County Health Rankings.

primary care. For mental health services, Wicomico County seems to have the best provider coverage in the region, while Somerset County seems to have the best provider coverage when it comes to dentists.

Housing Status in the Delmarva Region

Housing status describes whether community members own or rent their homes, how much they typically spend on housing costs, and whether they have stable housing at all. When families spend a large portion of their income on housing (more than 30% is considered "cost-burdened"), they may have less money available for healthcare, healthy food, and other necessities that affect their well-being. Housing metrics also track overcrowding, the quality and age of available housing, and homelessness in the community - all factors that can directly impact residents' health through exposure to environmental hazards like mold, lead paint, or unsafe living conditions.

Homeownership

Homeownership rates can indicate economic stability in a community and show whether residents are likely to have roots in the area long-term, which affects how healthcare and other services should be planned and delivered. Owning a home often represents a family's biggest financial asset, which can impact their ability to afford healthcare and maintain stable living conditions that support good health.

Table 2.19: Homeownership Rate by County, 2018-2022[11]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Homeownership	**67.5%**	**59.7%**	**76.6%**	67.5%	**81.4%**	72.0%	65%

Rates of homeownership vary greatly across the Delmarva region, with the highest rates of homeownership in Sussex and Worcester counties and the lowest in Somerset and Wicomico counties, respectively.

Cost of Housing

The amount of money residents spend on housing directly affects how much they can spend on other necessities that impact health, including medical care, healthy food, and recreational activities. When families are forced to spend a large portion of their income on housing costs, they may delay getting medical care, skip medications, or make other choices that can harm their health in both the short and long term.

Table 2.20: Percent Population with Severe Housing Cost Burden, 2018-2022[11]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Population with Severe	**17.5%**	**13.9%**	**14.4%**	14.1%	**11.7%**	12.9%	14%

Housing Cost Burden							

Somerset County has the highest proportion of residents facing severe housing cost burdens in the region, notably exceeding both the Maryland state and the national averages for this indicator. Across counties in the Delmarva region, roughly one in every seven to eight residents faces significant challenges with housing costs, indicating a widespread regional housing affordability concern.

Fair Market Rent and Wages

Fair housing markets and wages are fundamentally linked to community health outcomes because housing stability and affordability directly impact people's ability to meet other basic needs, including healthcare, nutrition, and preventive care. When families are overburdened by housing costs, they often must make difficult tradeoffs between paying rent and other essential expenses like medication, healthy food, or preventive medical visits. Additionally, wage levels that don't keep pace with housing costs can force people into substandard housing conditions that may expose them to health hazards like mold, pest infestations, or poor ventilation, while also creating chronic stress from financial instability that can lead to both physical and mental health challenges.

Table 2.21: Fair Market Rent by Number of Bedrooms, 2024[16]

Number of Bedrooms	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
One Bedroom	**$837**	**$998**	**$1,020**	$1,608	**$988**	$1,310	$1,390
Two Bedroom	**$1,100**	**$1,311**	**$1,145**	$1,909	**$1,298**	$1,594	$1,670
Three Bedroom	**$1,458**	**$1,739**	**$1,614**	$2,437	**$1,656**	$1,992	$2,161
Four Bedroom	**$1,465**	**$1,746**	**$1,797**	$2,811	**$2,037**	$2,306	$2,493

Somerset County consistently has the lowest rent costs across the four counties in the region, while Wicomico and Worcester counties have moderately higher rent costs. For minimum wage workers in all the Delmarva region counties the number of minimum wage work hours needed to afford the cost of rent for a one-bedroom rental unit exceeds the typical 40-hour work week for most workers. For example, minimum-wage workers in Somerset County need to work 43 hours per week for a one-bedroom rental unit, while minimum-wage workers in Wicomico County must work 57 hours and workers in Worcester County must work 51 hours to afford a one-bedroom rental unit.

Homelessness

People experiencing homelessness face significant challenges maintaining their health and accessing regular medical care, making it crucial to understand how many community

[16]Source: National Low Income Housing Coalition (2024). Out of Reach 2024 Report.

members lack stable housing. Homeless individuals often have more complex health needs and may rely heavily on emergency services, so tracking this information helps healthcare providers and community organizations develop appropriate services and outreach programs to better serve this vulnerable population.

Table 2.22: Homelessness in Delmarva Region, 2023[17,18]

	Somerset, Wicomico, and Worcester Counties	Maryland	Sussex County	Delaware	United States
People homeless on a given night	**292**	7,144	**-**	1,082	-
Homeless per 100,000 in the general population	**16.2**	12	**-**	11.2	-
Share of Population Precariously Housed[19]	**-**	-	**7.1%**	8.4%	-

Somerset, Wicomico, and Worcester counties experience a higher rate of homelessness compared to Maryland as a whole. Delaware's homelessness rate falls between these two regions. The table also indicates that Sussex County has a slightly smaller portion of their population living in precarious housing situations compared to the state average.

[17]National Alliance to End Homelessness. "State of Homelessness: State and CoC Dashboards." Retrieved from https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-dashboards

[18]Root Policy Research, 2023 Delaware Housing Survey

[19]Precariously housed person is defined as a person that does not have a permanent household and is living day-to-day in a motel, in a vehicle, with family or friends

Chapter 3 | Priority Health Needs

This chapter describes the Delmarva region's three priority health needs in more detail and discusses supporting data for each priority area. The information in this section includes national and state perspectives while also integrating key findings from secondary data and primary data (including findings from the key leader survey, community member survey, key leader interviews, and focus groups) gathered for this assessment.

Priority health needs were determined through review of all available data, discussion among Steering Committee members, and a voting process. Data was reviewed at various points in the CHNA development process, including during a prioritization meeting held once all data had been analyzed, compiled, and themed. During the prioritization meeting, Steering Committee members participated in a voting process to narrow a list of 12 health concerns and socio-environmental drivers that had emerged as possible priority health needs.

A shorter list of three priority health needs – ***healthcare access, chronic disease, and behavioral health*** – resulted from that voting process and were proposed focus areas for local health leaders to address over the next three years. Additional discussion was held amongst Steering Committee members to ensure these priorities were universally agreed upon. As noted in Chapter 1, the Steering Committee considered the following factors when determining the priority needs reported in this assessment:

- Severity and intensity of the health need based on secondary data;
- Whether possible interventions would be possible and effective;
- Health disparities associated with the need; and
- Importance the community places on addressing the need based on primary data.

While they agreed about the most pressing health concerns in the region, the Steering Committee also noted the importance of social determinants of health (SDOH) in their efforts to address these health concerns in future planning efforts. They agreed SDOH should be a cross-cutting consideration in the three priority health need areas as they are further assessed, defined, and addressed.

The priority health needs reflected in this report are not ranked in any hierarchical order of importance. All will be addressed, with strong consideration of disparities and SDOH, by leaders in health improvement plans created in follow up to this CHNA.

Figure 2.1: Delmarva Region's 2025 Priority Health Needs

Healthcare Access

Chronic Disease

Behavioral Health

While the information presented in this chapter focuses specifically on the Delmarva region's three identified priority health need areas, a broad array of primary and secondary data across various topics was analyzed and reviewed in the process of developing this report.

Complete primary and secondary data findings and corresponding sources of that information are captured in Appendices 2 through 6 of this report.

Topic 1 | Healthcare Access

Context and National Perspective

Access to care means patients can get high quality, affordable healthcare in a timely fashion to achieve the best possible health outcomes. It considers several components, such as insurance coverage, physical access to locations where care is provided, the ability to receive timely care, and whether there are enough providers in the workforce to meet patient demand. Access to healthcare was identified as a priority health need for residents across the Delmarva region.

From a national perspective, approximately one in ten people in the U.S. do not have health insurance, which means they are less likely to have access to a primary care provider or to afford the services or medications they need. [20] Access to healthcare services is a challenge even for those who are insured. [21] Access issues are anticipated to increase in coming years. Growing shortages of both nurses and doctors are being driven by several factors, including population growth, the aging U.S. population requiring higher levels of care, provider burnout (physical, mental and emotional exhaustion) made worse by the COVID-19 pandemic, and a lack of clinical training programs and faculty – particularly for nurses. The aging of the current physician workforce is also driving anticipated personnel shortages.

The availability and distribution of health providers contribute significantly to healthcare access challenges, as well. According to the Association of American Medical Colleges (AAMC), there is estimated to be a shortage of physicians in the U.S., which impacts both primary and specialty care.[22]

The ability to access healthcare is not evenly distributed across groups in the population. Groups who may have trouble accessing care include the chronically ill and disabled (particularly those with mental health or substance use disorders), low-income or homeless individuals, people located in certain geographical areas (rural areas), members of the LGBTQIA+ community, and certain age groups - particularly the very young or the very old.[23] In addition, individuals with limited English proficiency face barriers to accessing care, experience lower quality care, and have worse outcomes for health concerns.[24]

This section of the report is organized into three subcategories:

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[20] Source: U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion (2023). *Healthy People 2030: Health Care Access and Quality*. Retrieved January 6, 2025 from https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality.

[21] Source: Phillips, K.A., Marshall, D.A., Adler, L., Figueroa, J., Haeder, S.F., Hamad, R., Hernandez, I., Moucheraud, C., Nikpay, S. (2023). Ten health policy challenges for the next ten years. *Health Affairs Scholar*. Retrieved from: https://academic.oup.com/healthaffairsscholar/article/1/1/qxad010/7203673.

[22] Source: Association of American Medical Colleges (AAMC) (2024). *The complexities of physician supply and demand: Projections from 2021 to 2036*. Retrieved from: https://www.aamc.org/media/75236/download?attachment .

[23] Source: Joszt, L. (2018). 5 Vulnerable Populations in Healthcare. *American Journal of Managed Care*. Retrieved January 6, 2025 from https://www.ajmc.com/view/5-vulnerable-populations-in-healthcare.

[24] Source: Espinoza, J. and Derrington, S. (2021). How Should Clinicians Respond to Language Barriers That Exacerbate Health Inequity? *AMA Journal of Ethics*. Retrieved from: https://journalofethics.ama-assn.org/article/how-should-clinicians-respond-language-barriers-exacerbate-health-inequity/2021-02.

1.1 Barriers to Healthcare Access
1.2 Healthcare Resource Availability
1.3 Healthcare Utilization and Quality

Each subcategory presents relevant secondary and primary data to highlight key findings from the assessment process.

1.1 Barriers to Healthcare Access

Barriers to healthcare access include financial obstacles like high costs and lack of insurance, which prevent necessary treatments and lead to delayed care. Geographic limitations, especially in rural areas, increase travel time to medical facilities and reduce availability of specialized services. Language and cultural barriers may discourage patients from seeking care or result in miscommunication with providers, affecting treatment adherence.

Financial Barriers and Insurance Coverage

Financial barriers to healthcare services include factors like high out-of-pocket costs and inadequate insurance coverage, which can force patients to delay or forego necessary care. These obstacles disproportionately affect low-income individuals, particularly those diagnosed with chronic conditions who sometimes must choose between healthcare and other essential needs. Financial barriers were among the top issues impacting healthcare access in the Delmarva region.

Secondary Data Findings

Health insurance status is an important indicator because it directly affects whether people can afford to seek medical care when they need it. Uninsured individuals often delay or avoid preventive care and regular check-ups, which can lead to more severe health problems being discovered at later stages. Insurance coverage patterns also reveal potential economic disparities within a community and can help healthcare organizations identify where to focus their outreach efforts and financial assistance programs.

The uninsured rates for the overall population in the Delmarva region are highest in Wicomico and Sussex counties. All counties in the region except Somerset County have higher rates of uninsured than their respective state averages. This suggests greater healthcare access challenges in the counties within the Delmarva region due to insurance status.

Table 3.1: Insurance Status by County, 2018-2022[11]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Uninsured Population	**6.7%**	**8.7%**	**7.6%**	6.9%	**8.7%**	6.9%	10%
Uninsured Adults (<65)	**8.0%**	**9.8%**	**8.5%**	8.1%	**10.2%**	8.1%	-

Uninsured Children (<19)	**3.5%**	**5.9%**	**4.9%**	4.1%	**4.4%**	3.6%	-

Data also suggest that many residents in the Delmarva region struggle to make enough money to afford basic needs, sometimes forcing them to make difficult choices between paying for housing, food, utilities, or medical costs. As noted in the table below, at least 9% of each county's population is living in poverty and more than 25% of households in each county are considered ALICE households. This means nearly 40% of residents across the region are not making enough money to afford necessities, which can create financial barriers to healthcare.

Table 3.2: Income Indicators by County[4,10,11]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
% Population Living in Poverty	**10.6%**	**13.1%**	**8.53%**	9.3%	**10.6%**	10.6%	12.5%
% Children in Poverty	**17%**	**16.4%**	**14%**	12.1%	**17%**	14.3%	16.0%
ALICE Households	**26.60%**	**26.36%**	**28.50%**	29%	**26.60%**	29%	29%
Living Wage	**$46.76**	**$42.36**	**$41.06**	$52.88	**$46.76**	$50.54	-
Median Household Income	**$48,810**	**$65,969**	**$76,652**	$98,461	**$88,713**	$88,002	$75,149

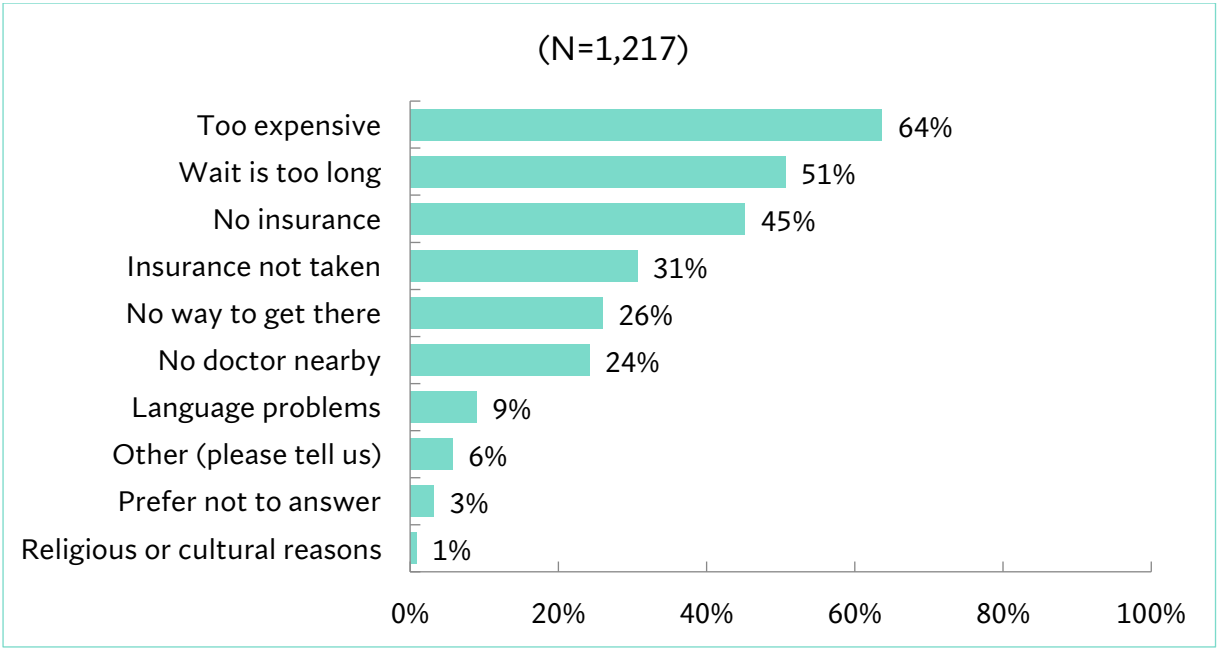
Primary Data Findings

While many residents in the Delmarva region are insured, those responding to the 2025 community health survey indicated that even with insurance, access is not always guaranteed. In fact, among those who responded to the survey, 31% said a barrier to healthcare services is that their insurance is not taken by providers. (Figure)

Input gathered from residents through the 2025 community health survey indicated costs as a significant barrier to accessing healthcare services across the Delmarva region. When asked to identify the three most important reasons people cannot get healthcare when they need it, 64% of all respondents cited cost as the top barrier. Cost of care was the top barrier across all counties in the region, across all age groups, and across racial and ethnic groups for which the data were analyzed.

Focus group participants emphasized high co-pays, deductibles, and medication costs force many residents to prioritize basic needs over healthcare.

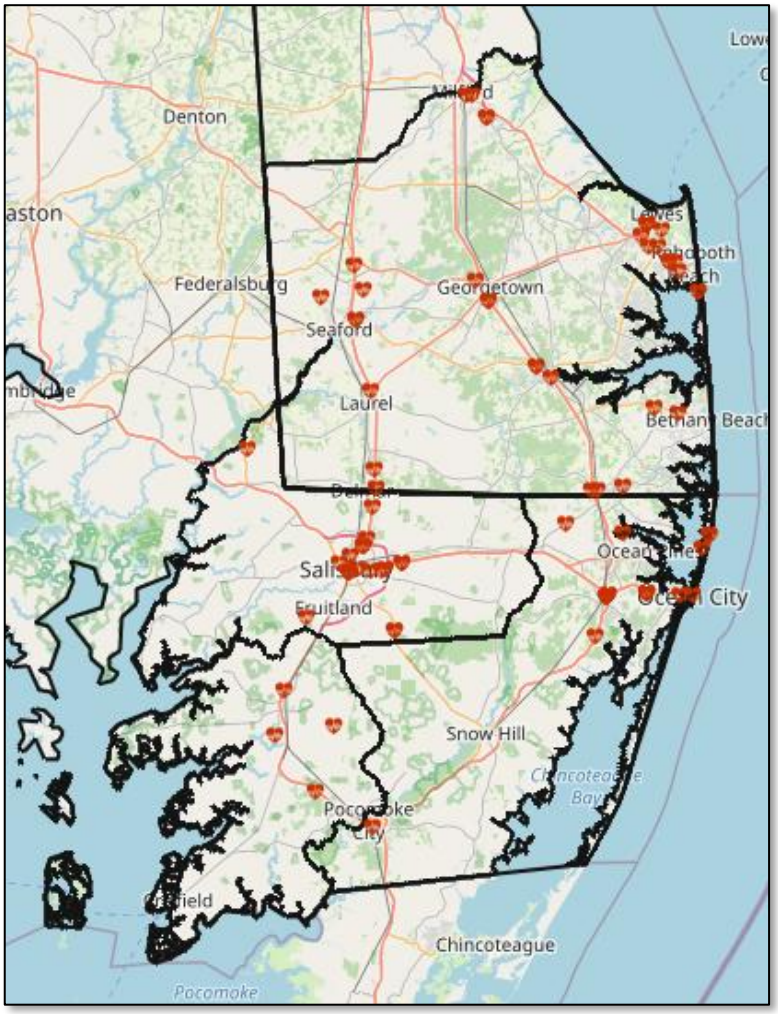
Figure 3.1: Barriers to Healthcare in the Delmarva Region, from the Community Health Survey



Geographic Barriers and Transportation Challenges

Geographic and transportation barriers to healthcare access manifest when patients live far from medical facilities, particularly in rural areas where the nearest hospital or specialist may be hours away. Limited or nonexistent public transportation options compound this problem, forcing patients without personal vehicles to rely on costly alternatives or miss appointments entirely. Travel difficulties are especially problematic for elderly patients, those with disabilities, and individuals managing chronic conditions requiring frequent follow-up visits. These barriers lead to delayed care, missed appointments, and treatment non-adherence, ultimately resulting in preventable complications and emergency department utilization for conditions that could have been managed through regular care.

Figure 3.2: Healthcare Facilities in the Delmarva Region[1]



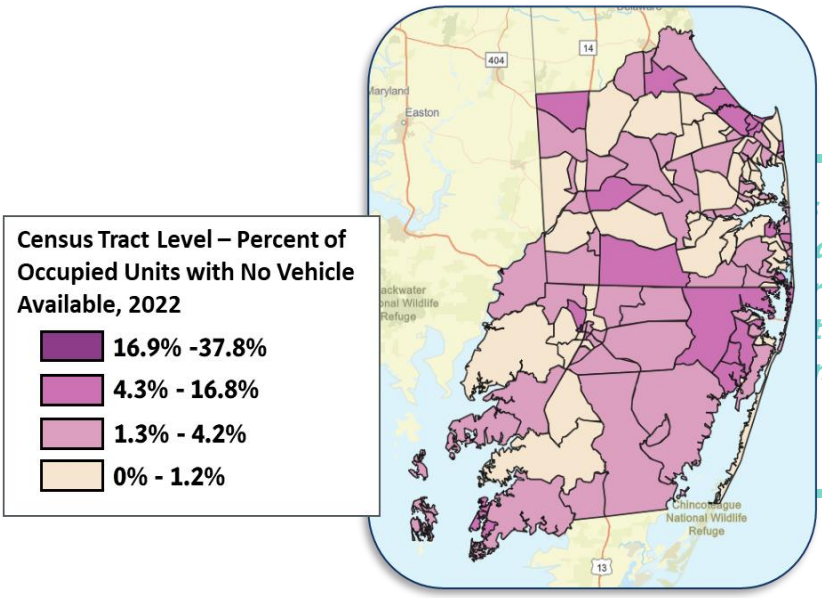
Secondary Data Findings

The Delmarva region is geographically spread out, largely rural, and healthcare resources are dispersed unevenly throughout. Many of the resources for primary care, behavioral health, and dental services are concentrated in more densely populated areas of the service area leaving geographic gaps for those living in more rural parts of the communities.

There are some census tracts in the region where more than 15% of households lack transportation (Figure 3.3). Some parts of the community that seem to have the greatest transportation barriers tend to also be the furthest from primary care, behavioral health, and dental services.

Figure 3.3: Percentage of Occupied Units with No Vehicle Available, by Census Tract (2022)[4]

Primary Data Findings



highlighted amental emphasis on transit. They nsportation to increase

Transportation emerged as one of the most pervasive barriers to healthcare access, especially in rural areas where public transportation is limited or nonexistent. Many residents lack reliable transportation to healthcare facilities, with some routes in rural areas being canceled entirely.

Somerset County reported transportation barriers significantly more than the other three counties in the region in their response to the community health survey. For specialized care, families often must travel long distances to cities like Baltimore or DC, particularly for pediatric specialty services. These trips can take up to 12-14 hours, causing significant hardship as parents may lose an entire day's wages to attend appointments with their children.

Physical infrastructure limitations are evident, with one key informant from Worcester County discussing inadequate healthcare facilities in southern parts of counties compared to northern areas. Focus group participants also noted inequitable distribution of provider locations across the region.

Cultural and Social Barriers

Social and cultural barriers to healthcare access include language differences that impede effective communication between patients and providers, limiting understanding of diagnoses and treatment plans. Cultural beliefs and practices may conflict with Western medical approaches, causing distrust of the healthcare system and reluctance to seek care. Discrimination and implicit bias from healthcare providers can result in disparate treatment quality and damaged patient-provider relationships. Additionally, social stigma surrounding certain conditions like mental health disorders or sexually transmitted infections often prevents individuals from seeking necessary care due to fear of judgment from their communities or families.

Secondary Data Findings

The Delmarva region boasts a diverse community, both in race/ethnicity but also in languages spoken and foreign-born residents. As noted in the Community Profile chapter of this report, Somerset County and Wicomico County are nearly 40% and 28% Black/African American, respectively. Wicomico County also has more than 9% of residents who are foreign-born, while Sussex County has 8.4% foreign-born residents. Many of the foreign-born residents are from Haiti and Mexico.

Because of this diversity, there are gaps in culturally and linguistically appropriate service provision, which is especially relevant for Wicomico and Sussex counties because they each have more than 6% of their population with limited English proficiency and roughly 13% of their population speaking a language other than English at home.

Primary Data Findings

Social and cultural barriers significantly impact healthcare access in the Delmarva region based on the data gathered through community members and key leader input. Trust issues between patients and healthcare providers are common, with some interviewees noting that minority populations, particularly Black patients, feel they are not heard or believed when seeking care. Fear of diagnosis leads some to avoid medical care altogether.

Poor treatment of vulnerable populations by healthcare staff was mentioned, including discrimination against low-income patients. Language and cultural barriers present growing challenges, especially with an increasing Haitian Creole population that has limited access to translation services. While language lines and other translation and interpretation services exist and are implemented, they take additional time and may not be readily available.

The lack of culturally competent providers further complicates care for immigrant populations, who may also have limited understanding of healthcare laws and requirements. Focus group participants emphasized limited provider diversity which impacts cultural competence in care delivery.

These challenges disproportionately affect certain populations, particularly undocumented residents, the local Hispanic/Latino community, and Haitian residents. Seniors and Haitian residents expressed a desire for health providers and leaders to work with patients and community leaders to better understand and meet their needs.

Key Takeaways – Barriers to Healthcare Access
In the Delmarva region, the most cited barriers to healthcare access can be categorized into three groups - financial, geographical, cultural and social.

- Most of the region has ***higher rates of uninsured*** than respective state averages and around ***40% of families are living in poverty or in ALICE households***, suggesting challenges with financial resources for basic needs, including healthcare.
- The region is geographically large with many healthcare resources concentrated in higher population density areas. This means that ***geographical access can be limited for residents***, especially those in rural areas and without access to reliable transportation.
- The Delmarva region is a diverse community when it comes to race, ethnicity, country of origin, and languages spoken. With this diversity comes ***challenges in healthcare access for residents who are seeking health service providers who look, sound, and understand them on a personal, cultural, and linguistic level***.

1.2 Healthcare Resource Availability

Healthcare resource availability challenges include uneven distribution of medical facilities, with rural and low-income urban areas often having fewer hospitals, clinics, and specialists than wealthier regions. Critical shortages of healthcare professionals, particularly primary care providers and mental health specialists, create bottlenecks that delay necessary care and increase disease progression. Additionally, inadequate public health infrastructure for preventive services and health education leaves communities vulnerable to preventable diseases and chronic condition complications. These types of systemic issues limit timely access to preventive and diagnostic services, causing conditions to worsen before treatment begins.

Provider Availability and Inadequate Healthcare Workforce
Secondary Data Findings

Compared to their respective states, counties in the Delmarva region have higher ratios of population to healthcare providers, indicating potential barriers to accessing timely care. The total population per primary care physician in the Delmarva region ranges from 1,181 in Worcester County to 2,732 in Somerset County, higher than both Maryland and Delaware state averages.

The dental provider ratios across the Delmarva region vary widely, with Somerset County showing a notably better ratio compared to the state and national averages. However, Sussex County has a significantly higher population-to-dentist ratio, indicating a potential shortage of dental providers in that area.

Somerset and Wicomico counties have better mental health provider ratios than the national average, while both Worcester County and Sussex County have worse ratios than the national average and their respective state averages. This suggests residents in these Worcester and Sussex counties may face greater challenges accessing mental health services.

Table 3.3: Population to Primary Care, Dental, and Mental Health Provider Ratios[14,15]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Population per PCP	**2,732**	**1,552**	**1,181**	1,179	**1,628**	1,356	1,330
Population per Dentist	**455**	**1,246**	**1,632**	1,238	**4,490**	2,181	1,360
Population per Mental Health Provider	**303**	**240**	**352**	292	**446**	309	320

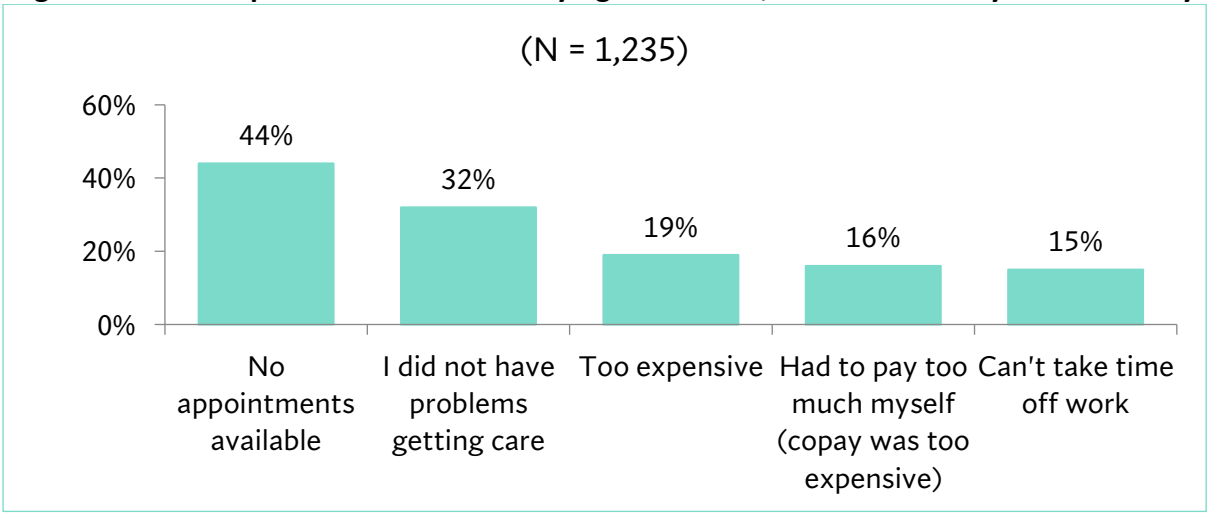
Primary Data Findings

Key informant interviews highlighted significant provider shortages throughout the region. Interviewees consistently mentioned the difficulty of finding primary care providers, with many doctors retiring and not being replaced. Some residents reported it taking up to a year to find a new primary care physician. The shortage extends to specialists, with particularly severe gaps in pediatric specialties, orthopedic care, gastrointestinal specialists, OBGYNs, and dental providers. Wait times for specialists can be extreme, with some reporting 18-month waits for gastrointestinal specialists and over a year for dental care.

Focus group participants also identified long waitlists for both primary and specialty care as a major barrier to accessing healthcare.

When asked for the top reasons why they delayed receiving healthcare, almost half of survey respondents said lack of appointment availability. Without access to primary care, patients frequently rely on urgent care facilities, which subsequently become overwhelmed.

Figure 3.4: Self-Reported Reason for Delaying Healthcare, from Community Health Survey



Workforce recruitment challenges persist throughout the region, with difficulties attracting professionals to rural areas. This is particularly true for physicians compared to nurse practitioners and physician assistants. Provider preferences for work-life balance and concerns about student debt make rural practice less attractive for many healthcare professionals.

Healthcare service consolidation was also identified as a growing concern, with TidalHealth absorbing many local practices, leading to patient perceptions of reduced choices for accessing care. Several interviewees and focus group participants expressed concern about 'quantity versus quality' in healthcare delivery as systems like TidalHealth grow larger and have more market share in the region.

Key Takeaways – Healthcare Resource Availability

The supply of providers in the Delmarva region does not adequately meet the demand, or need, of the residents living in the service area.

- ***Patient-provider ratios are consistently high***, with the greatest need for additional primary care providers noted in Somerset County.
- ***Dental providers are needed*** across the region, as well, but the patient-provider ratio is particularly high in Sussex County.
- Over 40% of residents responding to the community health survey indicated they ***delayed care because they couldn't get a timely appointment*** with a provider when they needed to; focus groups suggested this is an issue with both primary and specialty care providers in the region.

1.3 Healthcare Utilization and Quality

Suboptimal healthcare utilization and quality issues manifest when patients receive inappropriate levels of care—either underutilization of preventive services or overutilization of emergency departments for non-urgent needs. Quality concerns emerge from inconsistent adherence to evidence-based guidelines, resulting in treatment variations that lead to preventable complications and readmissions. Fragmented care coordination between

providers creates dangerous gaps in information exchange, medication management, and follow-up care, particularly affecting patients with complex or chronic conditions. Additionally, limited health literacy prevents many patients from effectively navigating the healthcare system, understanding treatment options, or participating in shared decision-making, which reduces treatment adherence and self-management capabilities.

Health Literacy, System Navigation, and Technological Barriers

Navigating the complex healthcare system poses major challenges, especially for vulnerable populations. Many lack the advocacy skills needed to communicate health needs effectively or struggle with automated phone systems and appointment scheduling. Technology barriers can be due to access issues, or user challenges. For example, poor internet or broadband access makes using internet-based technologies difficult. Using technology can disproportionately affect those who aren't tech-savvy, particularly seniors and low-income individuals. The digital divide creates additional obstacles, with limited internet access in rural areas affecting telehealth utilization. Some older adults express apprehension about using telehealth services, and certain areas lack reliable cell service.

Secondary Data Findings

Access to broadband is a challenge for some in the Delmarva region, particularly those in Somerset County. There are nearly 20% of residents without access to broadband, while that seems to be less of a gap for other counties in the region. There are also many homes across the four counties without a computer. Somerset and Wicomico counties have about 20% of homes without a computer, while Worcester and Sussex counties have about 15% of homes without a computer. This suggests not everyone in the region can readily access these resources to find providers, make appointments, and otherwise communicate or access health and other resources.

Table 3.4: Digital Access Indicators[11]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Broadband Access	**80.9%**	**86.4%**	**88.4%**	90.6%	**88.3%**	90.3%	88%
Households with computer	**79.9%**	**82.2%**	**85.4%**	86.3%	**85.5%**	85.2%	84%

Primary Data Findings

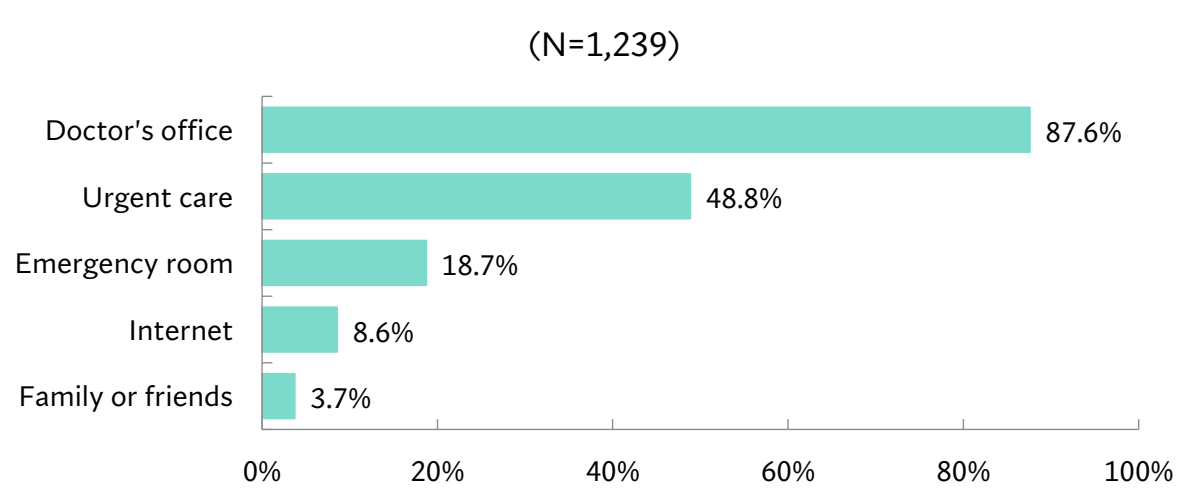
Focus group participants described the complexity of the healthcare system and limited community awareness of available resources. All focus groups raised the issue of not knowing what resources are available or how to access support for their health and social needs.

There are also issues with coordination and duplication of services between providers, with multiple interviewees noting the need for a more coordinated approach to addressing healthcare needs and better communication about available resources.

Health Services Utilization Patterns

When asked where they usually go when sick, over 80% of all survey respondents indicated they usually go to a doctor's office and about half indicated they usually go to urgent care.

Figure 3.5: Self-Reported Healthcare Point of Access, from Community Health Survey



An area of strength in the region is rates of annual mammography for Medicare beneficiaries among residents in the Delmarva region when compared with state averages.

Table 3.5: Quality of Care Metrics[25]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Annual Medicare Mammography	**45%**	**46%**	**49%**	43.0%	**52%**	51%	43%

Key Takeaways – Healthcare Utilization and Quality

Healthcare utilization is influenced by factors like health literacy, complex systems, and technological barriers to care.

- Across the region, ***barriers to services*** can result from limited access to technology like computers and broadband internet necessary for making appointments, communicating with providers, and utilizing virtual services like telehealth.
- There is a ***lack of awareness about what services are available and how to access them***, which suggests an opportunity to better assist residents in navigating the complete health and social service systems in the service area.
- While most residents do seek care via a primary care office, ***nearly 50% of residents seek services from urgent care facilities***.

Conclusion – Healthcare Access, Availability, and Quality

[25] Centers for Medicaid and Medicare Services (CMS) (2021). Mapping Medicare Disparities Tool. Retrieved from RWJF & UWPHI 2024 County Health Rankings.

Access to care emerged as a critical priority across both secondary and primary data sources. The data indicates several key challenges in the Delmarva region:

- ***Provider availability*** is a concern as the Delmarva region has higher provider-to-population ratios compared to state and national averages, particularly for primary care physicians and dental providers.
- ***Financial barriers*** consistently emerged as the top barrier to accessing care across all data sources, including direct service costs, insurance coverage gaps, and affordability of medications and copays.
- ***Transportation challenges*** with limited options prevent many residents from accessing care, especially in Somerset County and more rural areas of the region.
- ***Health literacy and system navigation issues*** create additional barriers as complex healthcare systems and limited awareness of available resources particularly affect non-English speaking residents and immigrant communities.
- ***Inequitable access*** is evident in the data, which reveals significant disparities in healthcare access and utilization across racial, ethnic, and age groups, with higher emergency department utilization among Black and Hispanic residents.
- ***Cultural competence*** remains a challenge with limited provider diversity and cultural competence creating additional barriers, especially for the region's Hispanic/Latino and Haitian communities.

These findings suggest a need for targeted interventions that address both structural barriers (provider availability, transportation, cost) and knowledge-based barriers (health literacy, resource awareness) while focusing on improving equity in healthcare access across the Delmarva region.

Community Recommendations

Focus group participants suggested several improvements to increase access to care:

- Expanding mobile health services
- Implementing nurse consultations and telehealth in community locations
- Improving transportation options
- Creating better systems for communicating available resources to community members
- Working with community leaders to better reach specific populations

Topic 2 | Chronic Disease

Context and National Perspective

As society has changed and people live longer, chronic health conditions have become more common than communicable diseases like typhoid and cholera. As defined by the World Health Organization (WHO), chronic diseases are those with a long duration, that are influenced by a combination of genetic, environmental, psychological, or behavioral factors.[26] Chronic health conditions are extremely common in the United States, with 6 in 10 Americans living with at least one chronic disease, such as diabetes, obesity, cancer, hypertension, or heart disease.[27]

Chronic diseases are the leading cause of death and disability in the United States.[261] According to the WHO, chronic health conditions kill 41 million people globally each year and are responsible for 7 in 10 deaths in the U.S. annually.[26] The number of individuals living with a chronic health condition is expected to increase as the U.S. population continues to age. The population over the age of 50 is expected to increase by 61% to 221.1 million people by 2050.[28] Among those 221 million, nearly two-thirds (142.7 million people) are expected to have at least one chronic health condition, with approximately 15 million people living with multiple chronic health conditions.[28]

The CDC recommends four ways to prevent chronic conditions and maintain good physical health. Recommended healthy behaviors include stopping or refraining from smoking, eating low-fat whole food diets, exercising moderately for at least 150 minutes a week, and limiting or refraining from consuming alcohol.[29] Annual physicals with a primary care provider are also necessary to help prevent or treat chronic health conditions. Yearly screenings can allow providers to identify any warning signs for developing conditions and enable patients to correct or develop healthy behaviors to avoid developing a physical health condition. A CDC study noted that one-third of visits to health centers in 2020 were for preventive care.[30] For those living with chronic conditions, the CDC recommends some general steps people can take to manage their diseases. These include taking medications as prescribed by a provider, self-monitoring symptoms as needed (such as conducting home blood sugar checks), and regularly seeing a provider for check-ups.

This section of the report is organized into four subcategories:

[26] Source: World Health Organization (WHO) (2023). *Noncommunicable diseases*. Retrieved January 6, 2025, from: https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases.
[27] Source: CDC (2024). *National Center for Chronic Disease Prevention and Health Promotion*. Retrieved January 6, 2025, from: https://www.cdc.gov/chronic-disease/about/index.html .
[28] Source: Ansah, J.P. & Chiu, T.C., (2022). Projecting the chronic disease burden among the adult population in the United States using a multi-state population model. *Frontiers in Public Health*. Retrieved January 6, 2025, from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9881650/.
[29] Source: CDC (2024). *Preventing chronic diseases: What you can do now.* Retrieved January 6, 2025 from https://www.cdc.gov/chronic-disease/prevention/index.html
[30] Source: CDC (2022). *Characteristics of visits to health centers: United States, 2020*. Retrieved January 6, 2025, from https://www.cdc.gov/nchs/products/databriefs/db438.htm.

2.1 Overall Physical Health Status in the Delmarva Region
2.2 Prevalent Chronic Conditions in the Delmarva Region
2.3 Risk Factors and Contributing Behaviors
2.4 Barriers to Chronic Disease Management

Each subcategory presents relevant secondary and primary data to highlight key findings from the assessment process.

2.1 Overall Physical Health Status in the Delmarva Region

When compared to other communities both within their respective states and across the US, residents living in the Delmarva region are more likely to report experiencing physical distress and poor physical health.

Table 3.6: 2021 Physical Well-Being[31]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Population Experiencing Frequent Physical Distress	**12.6%**	**11.3%**	**9.7%**	7.9%	**10.8%**	10.0%	10%
Average Poor Physical Health Days per Month	**4.1**	**3.8**	**3.2**	2.8	**3.5**	3.3	3.3

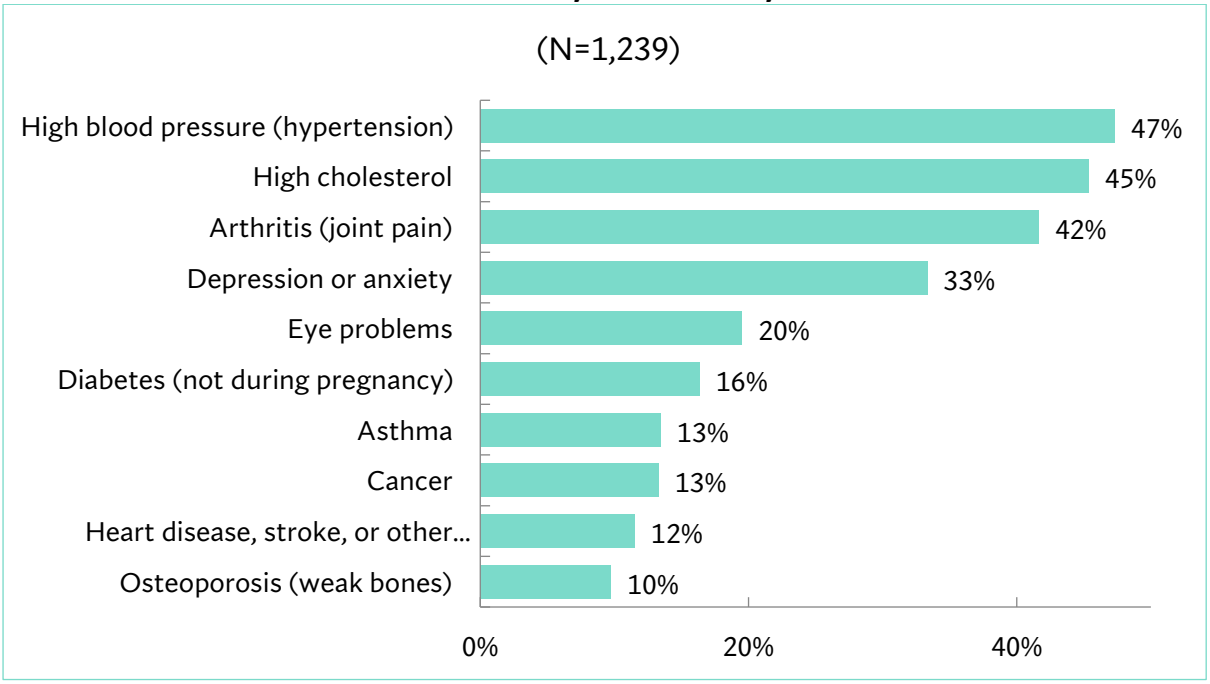
Further, data shows that Somerset and Wicomico counties fall behind state and national averages on health outcomes more often than Worcester and Sussex counties. These findings were supported in the community health survey results, as well. Many respondents reported being diagnosed with chronic conditions like high blood pressure, high cholesterol, arthritis, diabetes, and cancer.

Figure 3.6: Health Outcomes Rankings, from Robert Wood Johnson County Health Rankings, 2024

[31] Behavioral Risk Factor Surveillance System

Almost half of the community health survey respondents indicated they have high blood pressure and high cholesterol, while over 40% indicated a diagnosis of arthritis. Arthritis was also discussed as a major health concern during a focus group held with older adults in Somerset County.

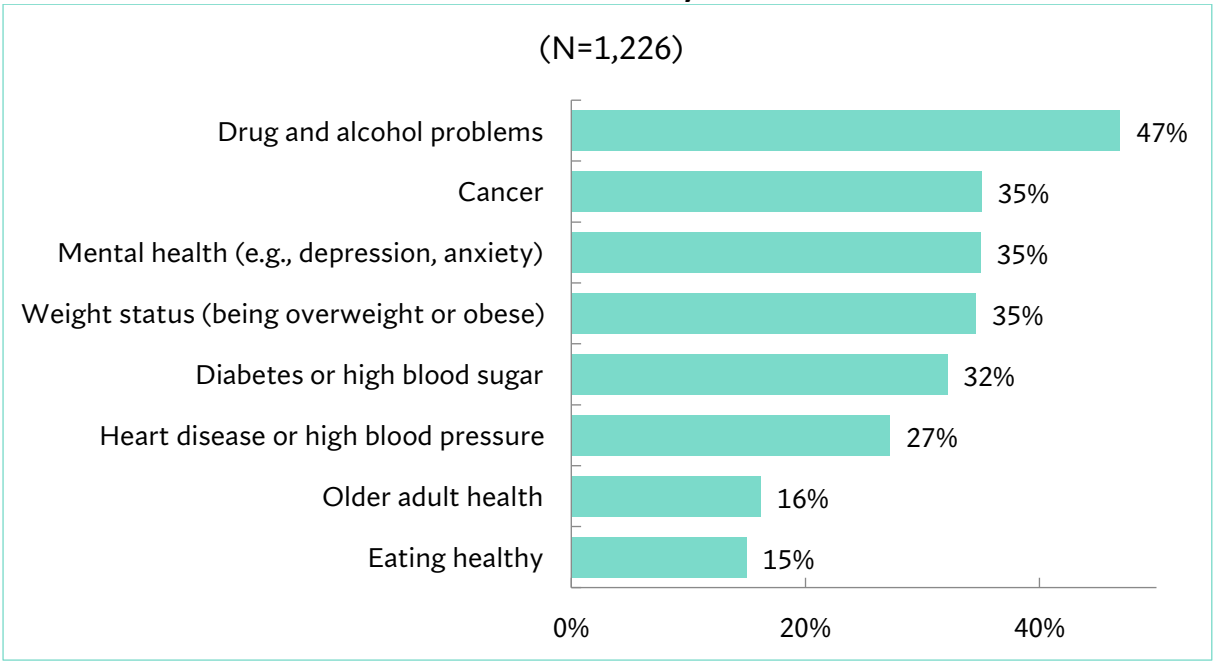
Figure 3.7: Top 10 Self-Reported Health Conditions of Delmarva Region Residents, from the Community Health Survey



2.2 Prevalent Chronic Conditions in the Delmarva Region

Residents in the Delmarva region are impacted significantly by chronic health conditions. This is true when residents self-report their own diagnoses of issues like high blood pressure, high cholesterol, diabetes, and heart disease (Figure 3.7) and when asked to weigh in on their perceptions of biggest health concerns affecting their neighbors and community as a whole (Figure 3.8).

Figure 3.8: Top Health Concerns among Delmarva Region Residents, from the Community Health Survey



Note: Responses included in the figure are limited to those identified by at least 15% of all respondents.

Diabetes and Metabolic Conditions

Diabetes emerged as one of the most significant chronic health concerns across all data sources. Secondary data shows that each Maryland county experiences a higher prevalence of diabetes than the overall Maryland state average.

Table 3.7: Adult Diabetes Prevalence Rates[31]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Adult Diabetes Prevalence	**13.0%**	**11.0%**	**9.9%**	9.8%	**9.5%**	9.9%	10%

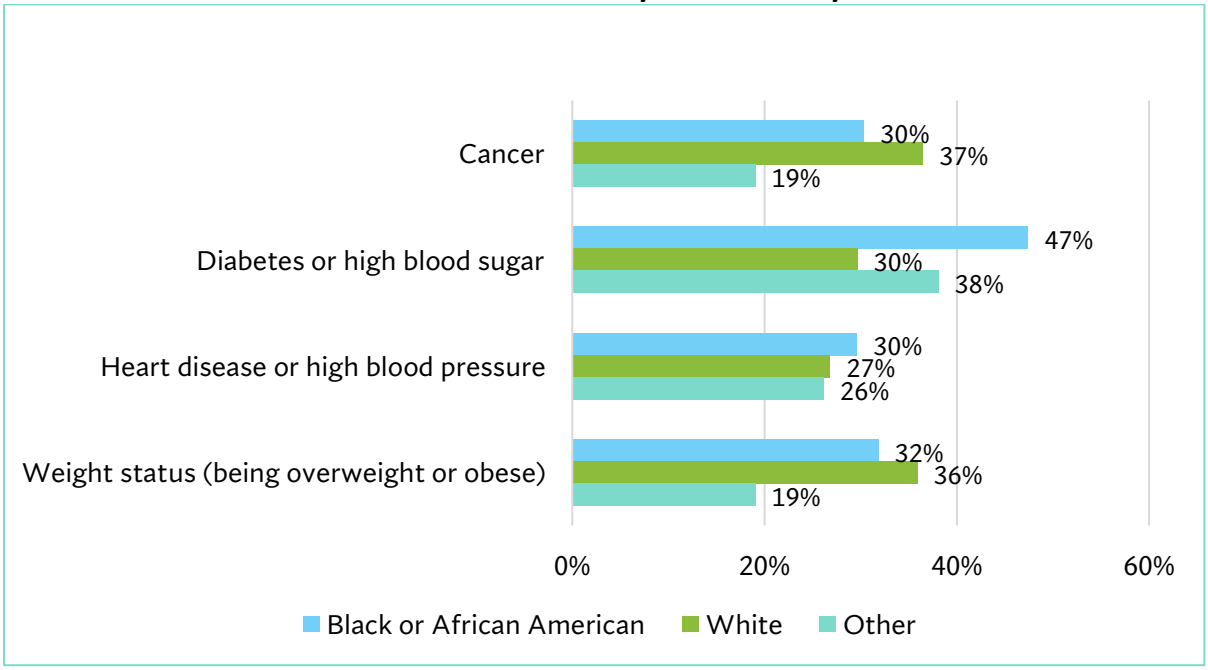
In focus groups, diabetes was consistently identified as one of the most serious health problems, with participants noting its prevalence particularly among African American and Hispanic communities. Many expressed concern that diabetes often goes undetected until serious complications arise, largely due to insufficient screening practices like irregular A1C testing.

Key leader interviews similarly identified diabetes as a major health concern, with one interviewee suggesting that Black or African American individuals have diabetes more often, though they noted this was anecdotal. One key leader also noted a high rate of fatty liver disease among the Latin American community, which they attributed to dietary changes upon migration to the United States.

In the community health survey, diabetes/high blood sugar was identified as a top health concern among all Delmarva region residents (Figure 3.8); Black or African American

respondents reported this concern more frequently than respondents identifying as white (Figure 3.9).

Figure 3.9: Top Chronic Disease Health Concerns by Race, from the Community Health Survey



Cardiovascular Disease

Cardiovascular health issues, including hypertension and heart disease, were identified as major concerns across all data sources. Secondary data shows that each county's Medicare population experiences higher rates of high blood pressure when compared to their respective state and national averages.

Heart disease and cardiovascular issues were frequently mentioned in focus groups as primary health concerns, with one participant sharing personal experiences with heart attacks and atrial fibrillation. Hypertension or high blood pressure was highlighted across multiple groups, especially among Black and Hispanic residents. One focus group participant described the challenge of getting blood pressure medication refilled without having to miss work.

Key leader interviews described heart-related conditions as significant concerns, with one interviewee noting an increasing prevalence of heart issues among younger people. Survey respondents, particularly older adults, also viewed heart disease as a significant health problem.

Obesity and Weight Status

Obesity was characterized in focus groups both as a primary health concern and as a contributing factor to other chronic conditions. Secondary data shows that adult obesity is concerning across the region with all counties' obesity prevalence being higher than their respective state averages. Somerset County in particular stands out as having the highest obesity prevalence with almost half of the population (46.7%) experiencing obesity.

Table 3.8: Adult Obesity Prevalence[31]							
	Somerset County	**Wicomico County**	**Worcester County**	**Maryland**	**Sussex County**	**Delaware**	**United States**
Adult Obesity Prevalence	**46.7%**	**37.6%**	**37.7%**	34.2%	**35.0%**	33.8%	34%

In the community health survey, White respondents were more likely to identify weight status as a major concern compared to Black or African American respondents. (Figure 3.9)

Other Chronic Conditions

While substance use and mental health problems were among the top three health conditions identified by residents in the community health survey , all other issues within the top five health conditions overall were chronic conditions – cancer, weight status, diabetes, and heart disease.

One key leader interviewee specifically cited breast cancer and colon cancer as conditions they were "hearing a lot more of" and had “seen firsthand” as growing concerns.

While less than 10% of survey respondents reported breathing problems as a top health concern for the community, key leader interviews indicated respiratory issues, such as Chronic Obstructive Pulmonary Disease (COPD) as a top concern, particularly among those with occupational exposure to toxins. Children's asthma was also identified as a concern. One interviewee connected these respiratory issues to environmental factors such as poor housing conditions like mold and poor insulation.

Arthritis emerged as a health issue primarily in the community health survey, where over 40% of respondents reported being diagnosed with this condition. It was also discussed as a major health concern among senior residents in a focus group hosted in Somerset County.

Key Takeaways – Prevalent Chronic Conditions in the Delmarva Region

Overall physical health in the Delmarva region lags when compared with state and national averages.

- ***More residents in Somerset and Wicomico counties report poor physical health*** and more days per month of physical distress than other parts of the Delmarva region.
- The chronic conditions of greatest impact to health of residents in the region are ***diabetes and heart disease***.
- About ***two-thirds of residents*** in each of the Delmarva region counties ***are considered overweight or obese***; over 45% of Somerset County adults experience challenges being overweight or obese.

2.3 Risk Factors and Contributing Behaviors

Tobacco Use

Tobacco use contributes to the development and exacerbation of chronic conditions and was identified as a key risk factor for chronic disease in the Delmarva region. Secondary data shows all counties in the region have higher rates of adult smoking than their respective state and United States averages.

Table 3.9: 2021 Tobacco Use[31]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Adult Smoking	**20.6%**	**17.8%**	**16.7%**	10.2%	**15.0%**	14.3%	15.0%

Diet and Physical Activity

Diet and exercise are key factors in preventing many chronic diseases such as diabetes and hypertension. However, access to exercise opportunities and healthy foods is challenging for some people living in the Delmarva region. Residents in Somerset and Sussex counties have very limited access to exercise opportunities, and there are also portions of each counties' population that experience challenges accessing healthy foods.

Table 3.10: Diet and Exercise[31,32,33]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Percent Physically Inactive	**28.8%**	**27.0%**	**21.0%**	21.2%	**26.2%**	26.2%	23.0%
Population with Access to Exercise Opportunities	**9.8%**	**86.4%**	**84.6%**	91.9%	**56.4%**	79.2%	84.0%
Limited Access to Healthy Foods	**5%**	**9%**	**6%**	4%	**7%**	6%	6%

[32] Opportunities ArcGIS Business Analyst and ArcGIS Online; YMCA; US Census TIGER/Line Shapefiles
[33] USDA Food Environment Atlas

In focus groups, limited access to physical activity opportunities and healthy foods were cited as exacerbating factors for obesity and other chronic conditions. Economic factors further complicated chronic disease management, as participants described being unable to afford healthy foods necessary for managing conditions like diabetes.

"It's expensive to eat healthy."
– Delmarva Region Key Leader

Key leader interviews emphasized the role of diet, with one interviewee observing that "it's expensive to eat healthy" leading to consumption of cheaper, less nutritious foods that "creates diabetic conditions."

Key Takeaways – Risk Factors and Contributing Behaviors
There are known factors contributing to rates and severity of chronic diseases in the Delmarva region.

- ***Tobacco use is higher*** in all Delmarva region counties when compared to state and national averages.
- ***More than 20% of residents*** across all counties report being ***physically inactive***; this means at least 1 in 5 adults in the region do not get the recommended amount of exercise.
- There are ***disparities in access to healthy food and exercise opportunities*** across the region. These issues are further exacerbated by financial barriers.

2.4 Barriers to Chronic Disease Prevention and Management

Social Determinants of Health
Secondary data presented in Chapter 2 discusses numerous social and environmental factors that influence health in the Delmarva region. Notably, cost and quality of housing, challenges with income and poverty, and the ability to access resources and services available to residents in the community were described as key factors impacting residents in the region.

Focus group participants noted that housing costs consume a large portion of their income, leaving little for healthcare and proper nutrition. Throughout all discussions, participants emphasized that chronic diseases disproportionately affect economically disadvantaged communities, non-English speakers, elderly populations, and racial/ethnic minorities. Key leader survey respondents expressed a need to address social determinants of health such as housing, access to healthy foods, transportation, and access to exercise spaces to better improve the health of the community.

Cultural, Language, and Health Literacy Barriers
The Community Profile section of this report highlighted the racial, ethnic, and linguistic diversity of the Delmarva Region. Other data collected through the CHNA process emphasized and further described these challenges among specific population groups, especially those participating in focus groups. For example, cultural and language barriers were problematic, particularly for the Haitian community, who expressed frustration with inadequate interpretation services and cultural misunderstandings that prevent effective care.

Health literacy gaps were also evident across all focus groups, with participants describing difficulties understanding chronic disease management requirements, medication regimens, and navigating the complex healthcare system. Additionally, more than 25% of community health survey respondents indicated sometimes, often, or always having difficulty understanding medical information presented by healthcare providers.

Key Takeaways – Barriers to Chronic Disease Prevention and Management
Residents in the Delmarva region experience barriers to effectively preventing and managing their chronic conditions, largely due to social, cultural, and economic factors.

- ***Costs of basic needs in the region, particularly housing costs, create financial barriers for residents***. This impacts their ability to purchase healthier food, access exercise, and engage in preventive healthcare services.
- ***Language, culture, and health literacy barriers impede residents' ability to access and understand information*** and therefore can impact their ability to effectively manage their health.

Conclusion
Both secondary and primary data sources consistently identify chronic health conditions as a significant health concern in the Delmarva region. Diabetes, heart disease, and obesity emerge as particularly prevalent issues across all four counties. The data show that chronic disease disproportionately impacts certain demographic groups, with higher rates observed among older adults and African American residents.

Factors contributing to chronic disease in the region include high rates of smoking, limited access to exercise opportunities, and challenges of accessing healthy foods. Addressing behavioral and environmental factors, along with improving access to healthcare for chronic disease management, will be essential to improving health outcomes. Consideration of social, cultural, and literacy-related barriers will also be imperative when developing new or improving upon existing programs, services, and resources available in the region.

Community Recommendations
Focus group participants offered thoughtful recommendations to improve chronic disease prevention and management:

1. Expanding healthcare services, particularly increasing the number of specialists in rural areas and improving coordination between providers.
2. Community-based solutions such as utilizing schools as venues for health clinics and implementing outreach programs with culturally appropriate messaging.
3. Enhanced health education initiatives, including programs teaching healthy cooking on a budget and better diabetes prevention education.
4. Cultural competency improvements, with the Haitian focus group suggesting "use the Haitian to educate the Haitian" - employing community members as health educators and developing materials in appropriate languages.

Topic 3 | Behavioral Health

Context and National Perspective

The definition of behavioral health often describes conditions related to both mental health and substance use.[34] Mental health is defined as an emotional, psychological, and social state of well-being that impacts every stage of life and affects how one handles relationships, daily stressors, and health behaviors.[35] Substance use disorders (SUDs) are complex conditions in which there is uncontrolled use of a substance (such as alcohol or drugs), despite harmful consequences.[36] After evaluating data from a variety of sources including surveys and focus groups conducted throughout the assessment process, the Steering Committee identified behavioral health to be an area of urgent need within the Delmarva region.

Mental illnesses are common in the United States: in 2021, an estimated 57.8 million U.S. adults - nearly one in five - were living with a mental illness.[37] There is risk for developing a mental illness across the lifespan, with over one in five children and adults in the U.S. reported to have a mental illness, and nearly one in twenty-five adults currently coping with a serious mental illness (SMI) such as major depression, schizophrenia or bipolar disorder.[38]

Substance use disorders often occur in conjunction with other mental illnesses. In 2023, 16 million (46.9%) young adults aged 18-25 reported having either a SUD or Acute Mental Illness (AMI) in the past year. In that same year, 17.1% (48.5 million) of all U.S. adults were reported as having an SUD.[39] These trends have been increasing in recent years, rising from 3.7% of adults with co-occurring AMI and SUD in 2018 to 13.5% by 2021, with the highest incidence among multiracial adults.

Both mental illnesses and SUDs can occur due to multiple factors, including genetics, drug and/or alcohol usage, isolation, adverse childhood experiences, and chronic health conditions. Additionally, these conditions can act like other chronic health conditions, in that they can worsen or improve depending on the environment. Access to behavioral health services has evolved in the past five years, especially during the COVID-19 pandemic. However, accessing care remains challenging. According to the National Institute of Mental Health, less than half (47.2%) of adults with a common mental illness received any mental health services in 2021, while those with an SMI were more likely (65.4%) to have received services.[37]

The pandemic significantly impacted public mental health and well-being in many ways. Community members continue to grapple with pandemic-related effects of isolation and

[34] Source: American Medical Association (2022). *What is behavioral health?* Retrieved from https://www.ama-assn.org/delivering-care/public-health/what-behavioral-health.
[35] Source: CDC. (2024). About mental health. Retrieved from: https://www.cdc.gov/mentalhealth/learn/index.htm
[36] Source: American Psychiatric Association (2024). *Addiction and Substance Use Disorders*. Retrieved from https://www.psychiatry.org/patients-families/addiction-substance-use-disorders.
[37] Source: National Institute of Mental Health (2023). *Mental Illness*. Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness.
[38] Source: CDC. (2024). Mental health. from https://www.cdc.gov/mentalhealth/learn/index.htm
[39] Source: SAMHSA (2024). *Highlights from the 2023 National Survey on Drug Use and Health*. Retrieved from https://www.samhsa.gov/data/sites/default/files/NSDUH%202023%20Annual%20Release/2023-nsduh-main-highlights.pdf.

loneliness, financial instability, long-term health impacts, and grief, all of which are drivers for developing both mental health conditions and substance use disorders. In addition, both drug overdose and suicide deaths have sharply increased over the past several years - often disproportionately impacting younger people and communities of color.[40]

Access to services that address behavioral health is an ongoing challenge across the U.S. While access to telehealth services has increased, those living in rural areas may still find it difficult to access care. This is a particular concern among those who are low-income or experiencing homelessness, two groups at high risk for developing acute or chronic behavioral health conditions. As of 2023, over seven million people in the U.S. who reported having a mental illness lived in a rural area.[41]

There are multiple common forms of SUDs, such as alcohol use, cocaine use, cannabis use, opioid use, and methamphetamine use disorders. Treatment for behavioral health conditions generally cannot follow a cookie-cutter approach, as each person receiving treatment will have different needs. Treatment is typically provided through various therapies, inpatient admissions, and forms of medication-assisted treatment. Opioid overdoses are one of the most common types of deaths related to SUDs and can be preventable and treatable if caught in time. In 2022, the number of opioid overdoses nationwide surpassed 81,051 - a 63% increase in overdoses since 2019.[42] Multiple efforts have been coordinated to increase the availability of overdose-reversing medications such as Naloxone in public facilities and over-the-counter, as was approved in 2023 by the FDA.

This section of the report is organized into four subcategories:

3.1 Overall Behavioral Health Status in the Delmarva Region
3.2 Prevalent Mental Health and Substance Use Conditions
3.3 Risk Factors and Contributing Behaviors
3.4 Barriers to Behavioral Health Services

Each subcategory presents relevant secondary and primary data to highlight key findings from the assessment process.

3.1 Overall Behavioral Health Status in the Delmarva Region

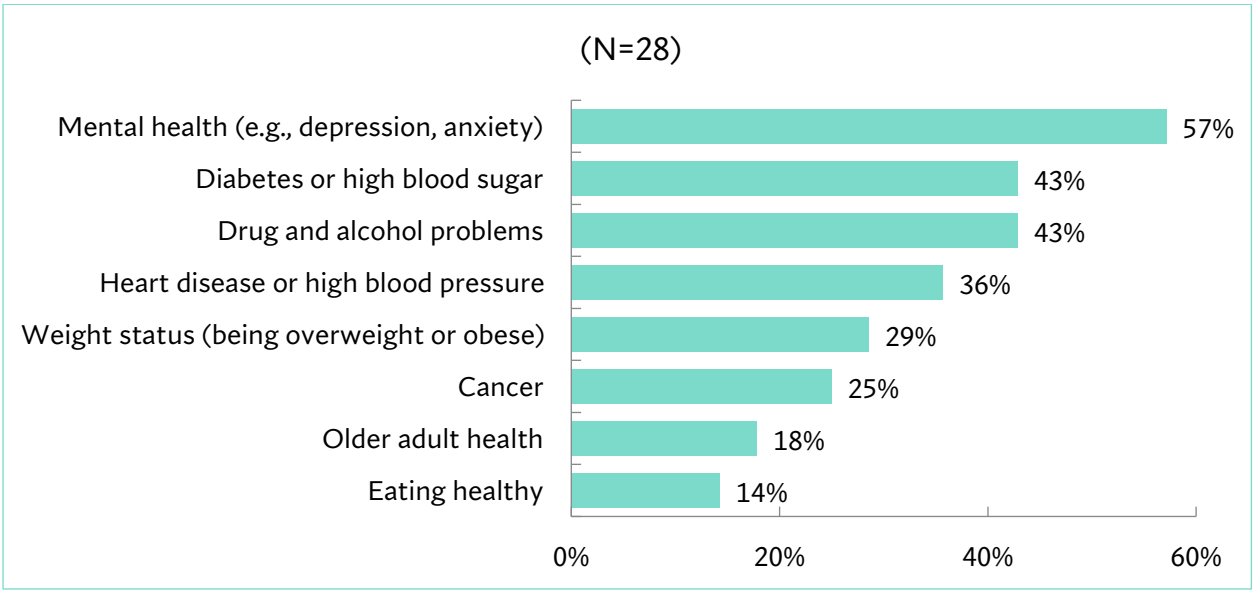
Behavioral health represents a significant concern across the Delmarva region, consistently ranking among the top health priorities identified by both community members and healthcare leaders. Multiple data sources confirm the perception of behavioral health as a critical community health need.

Perceptions about Behavioral Health in the Delmarva Region

[40]Source: Panchal, N., Saunders H., Rudowitz, R. and Cox, C. (2023). The Implications of COVID-19 for Mental Health and Substance Use. Kaiser Family Foundation. Retrieved from https://www.kff.org/mental-health/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use
[41]RHI Hub. (2023). Rural mental health. Retrieved from: https://www.ruralhealthinfo.org/topics/mental-health
[42]Source: KFF. (2023). Saunders, H., Rudowitz, R. (2023). Will the availability of Over-The-Counter Narcan increase access? Retrieved from https://www.kff.org/policy-watch/will-availability-of-over-the-counter-narcan-increase-access/

Community surveys reveal the widespread concern regarding behavioral health issues. For example, 35% of community residents identified mental health (depression, anxiety) as one of the three biggest health problems in their community, while 47% of residents cited drug and alcohol problems as a major health concern, making it the most frequently selected health issue overall. Among community leaders, 57% identified mental health as one of the top three health problems, followed by 43% of leaders ranked drug and alcohol issues as major health concerns, making it the second most frequently identified health priority after mental health.

Figure 3.10: Top Health Concerns among Key Leaders, from the Key Leader Survey



These perceptions are supported by secondary data showing that residents across all counties in the Delmarva region experience frequent mental distress at rates higher than their respective state averages. Wicomico County had the highest average poor mental health days per month (5.6 days per month), followed by Somerset and Worcester counties in Maryland - all are higher than Maryland's average of 4.4 days.

Table 3.11: Mental Well-Being by County[31]

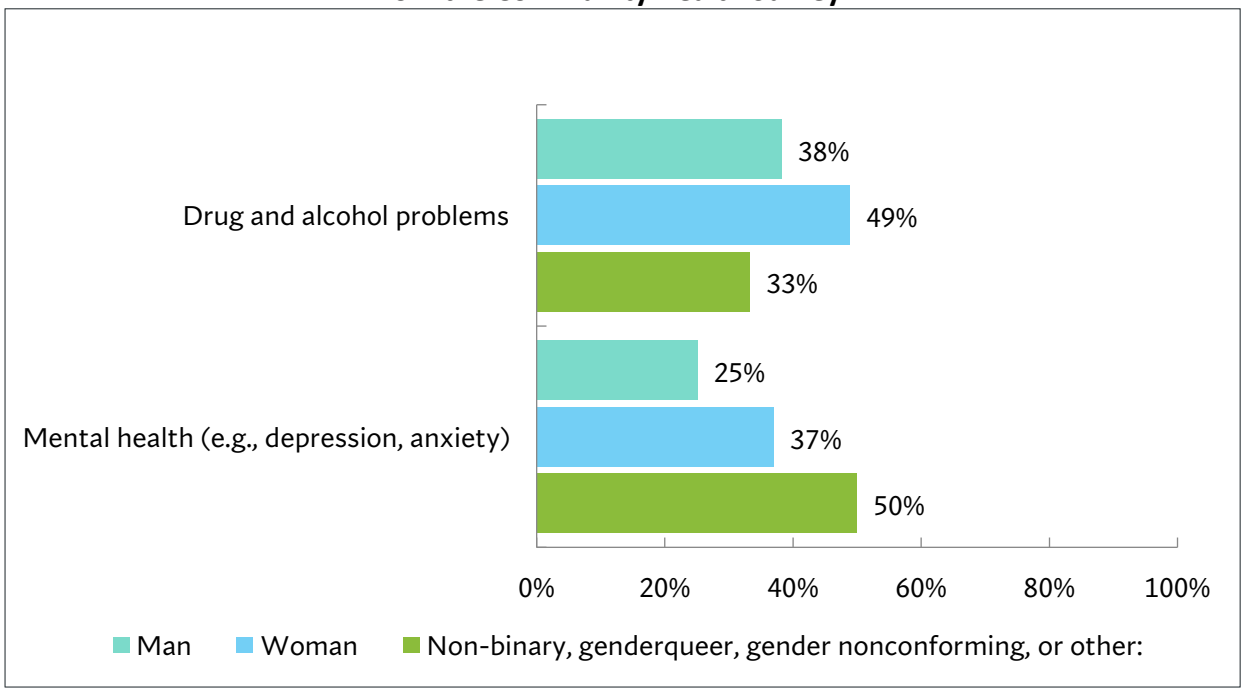
	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Population Experiencing Frequent Mental Distress	**18.0%**	**17.5%**	**15.9%**	13.2%	**14.9%**	13.7%	15.0%

Average Poor Mental Health Days per Month	**5.3**	**5.6**	**5**	4.4	**4.6**	4.4	4.8

Geographic and Demographic Variations

The perception and impact of behavioral health issues vary significantly across demographics and geographic locations. When considering age-based differences, younger respondents (18-24 years) viewed mental health as a significantly bigger problem (68%) compared to older adults (23% of those 65+) (Figure 3.11). Women were more likely than men to identify mental health as a serious community health concern, and 50% of respondents identifying as non-binary/gender-non-conforming identified mental health as a priority. Somerset County residents (55%) were significantly more likely to view drugs and alcohol as a major issue compared to Worcester County residents (35%).

Figure 3.11: Top Behavioral Health Concerns among Delmarva Region Residents by Gender, from the Community Health Survey



Key Takeaways – Overall Behavioral Health Status in the Delmarva Region

There is alignment across different stakeholder groups about the importance of behavioral health issues in the region.

- Community residents (35-47%), key leaders (43-57%), and secondary data all converge to identify ***mental health and substance use as top health concerns***.
- The ***perception and experience of behavioral health issues vary*** substantially by age, gender, and geography.

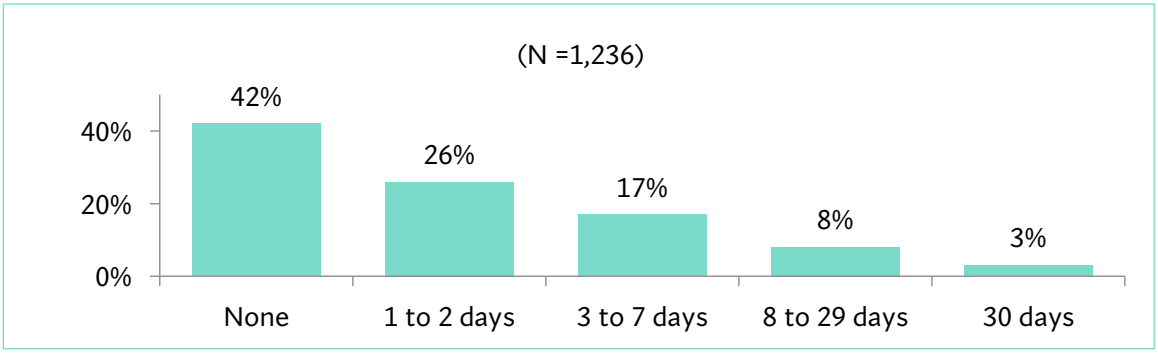
3.2 Prevalent Mental Health and Substance Use Conditions

Despite community perceptions about substance use, personal substance use reporting in the community health survey was relatively low. About half of the survey respondents reported never drinking alcohol, and almost all respondents denied misusing prescription drugs.

General Mental Distress

The secondary data analysis revealed concerning trends in mental health across the Delmarva region. As previously noted, residents in all counties reported more poor mental health days per month than their respective state averages. For example, Wicomico County had the highest average poor mental health days per month (5.6 days), followed by Somerset (5.3 days) and Worcester counties (5.0 days) in Maryland—all higher than Maryland's average of 4.4 days. The percentage of population experiencing frequent mental distress also exceeds state averages across all counties in the region. (Table 3.11 above)

Figure 3.12: Number of Days During the Past 30 Days with 'not good' Mental Health among Delmarva Region Residents, from Community Health Survey



The community health survey also showed more than half of respondents had at least one to two poor mental health days in the past 30 days. More than 25% of community health survey respondents indicated they were getting help for their mental health needs.

Depression and Suicide Rate

Depression rates are notably high across the region, with each county showing elevated rates compared to their state averages. The highest depression rate in the region is reported in Wicomico County, followed by Somerset and Worcester counties.

Table 3.12: Adult Depression Prevalence and Suicide Rates by County[31,43]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Deaths by Suicide (Age-Adjusted Rate	**11.7**	**11.8**	**11.4**	9.9	**11.9**	12.1	14

[43] National Center for Health Statistics, 2017-2021

per 100,000 Population)							
Adults ever diagnosed with depression	**21.4%**	**23.7%**	**20.4%**	18.1%	**19.7%**	19.9%	20.7%

The death by suicide rate is also higher in each Maryland county compared to the state average. Though lower than the state average, Sussex County's suicide rate is the highest in the region at 11.9 deaths per 100,000 population.

Substance Use Conditions

Drug overdose death rates are substantially higher in the Delmarva region than the national average. In all Delmarva region counties, the overdose death rate is more than 25% higher than the national average of 27 deaths per 100,000 population.

Opioid dispensing rates vary across the region, with the lowest rate in Somerset County and the highest in Wicomico County. Despite having the lowest dispensing rate in the region, Somerset County also has the highest rate of overdose deaths in the region.

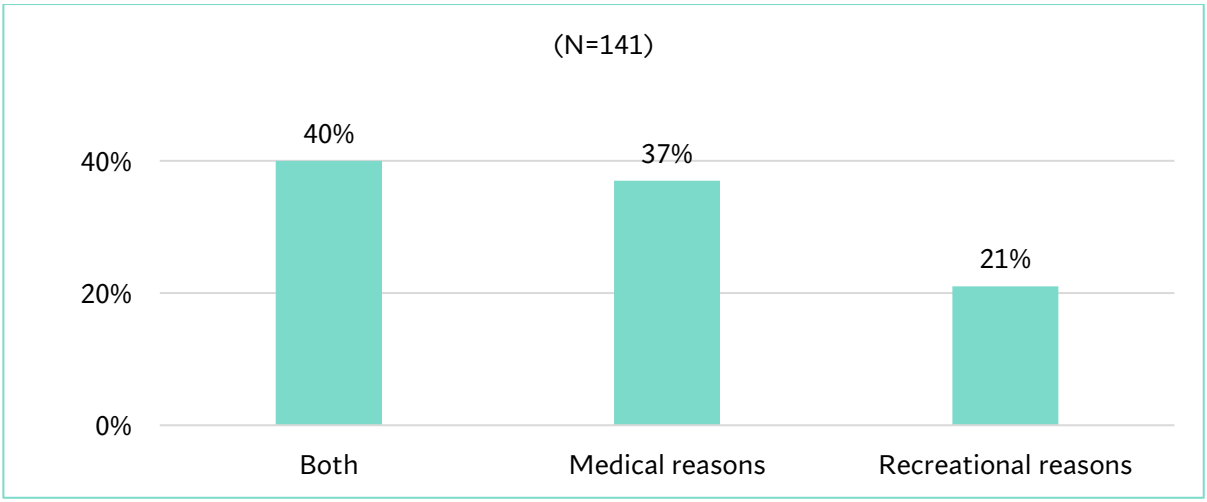
Table 3.13: Opioid Dispensing Rates and Drug Overdose Deaths[4,44]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Drug Overdose Death Rate per 100,000 Population	**48.9**	**38.2**	**34.2**	43.1	**45.3**	47	27
Opioid Dispensing Rate per 100 Persons	**5.8**	**57.9**	**23**	34.8	**49.2**	40.7	39.5

Use of cannabis and cannabis-related products in the region appears to be low among community health survey respondents, with 8% saying they use some days and 3% reporting daily use. Among those who do use cannabis or related products, most use for medical reasons or for both medical and recreational purposes.

Figure 3.13: Type of Cannabis and Cannabis-Related Product Use Among Respondents Who Report Using, from Community Health Survey

[44] Centers for Disease Control and Prevention. Opioid Dispensing Rate Maps. 2022.



Alcohol use, specifically excessive drinking, shows varying patterns across the region. Worcester County reports the highest rate (18.0%), exceeding both Maryland's average and the national average, while Somerset County has the lowest rate of excessive drinking in the region.

Table 3.14: Excessive Drinking[31]

	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Percent of Population Reporting Excessive Drinking	**14.2%**	**16.6%**	**18.0%**	15.2%	**14.6%**	15.6%	18.0%

Key Takeaways – Prevalent Mental Health and Substance Use Conditions

The data reveals a complex behavioral health landscape with significant variations across counties and disparities between conditions and treatment rates within the Delmarva region.

- All counties in the Delmarva region report **more poor mental health days** than their respective state averages, with Wicomico County experiencing the highest rate (5.6 days per month).

- There's a striking **disconnect between community perception, official statistics, and self-reported behavior**. Despite drug overdose death rates being 25-80% higher than the national average, self-reported substance use in community surveys is surprisingly low.
- All Maryland counties in the region **exceed the death by suicide rate for the state**, with rates ranging from 11.4-11.9 per 100,000 population. The rate is even higher in Sussex County, but below the state average for Delaware.

3.3 Risk Factors and Contributing Behaviors

Several behaviors and factors contribute to behavioral health challenges. Data from the community health survey and stakeholder input provided insights into these contributing factors and how they are impacting behavioral health in the Delmarva region.

Secondary data, along with input from multiple stakeholders that engaged in the CHNA process, identified social and economic factors that contribute to behavioral health challenges. Issues like poverty and unemployment, social isolation, and access to healthcare services were important themes that arose in conversations with key stakeholders. Data presented in Chapter 2 of this report showed that nearly 40% of households in the Delmarva region struggle to afford basic needs due to poverty or being considered an ALICE household. A Wicomico County focus group participant further described how behavioral health problems such as "illicit drug use and alcoholism," can be associated with poverty and may make individuals "unemployable," creating a cycle of socioeconomic challenges.

Focus group participants representing other groups and key leader interviews touched on the impacts of the COVID-19 pandemic and how it exacerbated social isolation, particularly among seniors and other vulnerable populations. One participant in a focus group noted that there is a "large populous of seniors who are still afraid to leave their houses" due to pandemic-related anxiety, especially those who live alone. COVID-19's lingering effects on mental health were noted in key informant interviews, with one interviewee commenting that the isolation caused by the pandemic continues to impact families.

Lastly, delays in healthcare seeking behaviors, specifically those geared toward behavioral health needs, can negatively impact behavioral health outcomes. For example, the inability to access preventive care, or early intervention services, can allow behavioral health conditions to worsen before treatment is sought.

Key informant interviews identified populations at particularly high risk for poorer behavioral health related outcomes. For example, some key leaders discussed how they've observed worsening behavioral health needs among children and adolescents in recent years. As previously noted, seniors, especially those living alone, face increased challenges with isolation and anxiety which can exacerbate poor mental health status. Lastly, individuals with substance-exposed newborns were mentioned as a growing concern, with rates comparable to metropolitan areas in some counties.

Key Takeaways – Risk Factors and Contributing Behaviors
Social and economic factors appear to influence and/or exacerbate behavioral health issues in the Delmarva region.

- ***Poverty and behavioral health issues create a self-reinforcing cycle in the Delmarva region***. Nearly 40% of households struggle to afford basic needs, and behavioral health problems like substance use can lead to unemployment, which further entrenches poverty.
- The ***COVID-19 pandemic created enduring behavioral health challenges that disproportionately affect specific groups***. Seniors experience continued isolation and anxiety about leaving their homes, children and adolescents show worsening mental health outcomes, and families continue to struggle with pandemic-related stressors.

3.4 Barriers to Behavioral Health Services

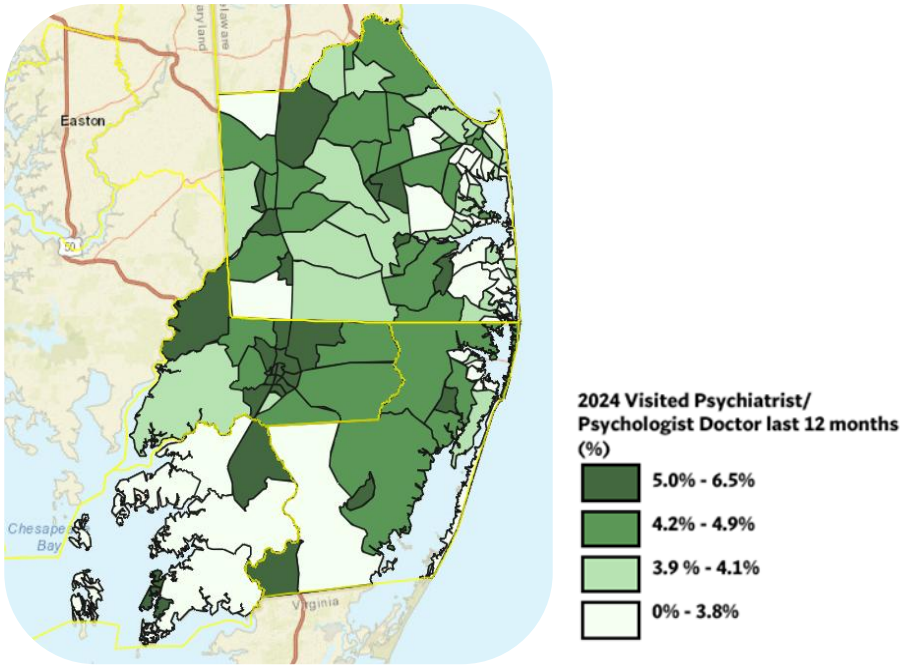
Despite the high prevalence of behavioral health conditions in the Delmarva region, service utilization remains notably low. This observed disconnect between need and service use points to significant barriers that prevent residents from accessing appropriate care.

Secondary data revealed patterns in behavioral health service utilization. For example, less than 10% of the population in each county uses prescription drugs for depression or anxiety, despite depression diagnosis rates of 20-24%. Only about 4-5% of residents in each county have visited a psychiatrist or psychologist in the previous year.

Table 3.15: Mental Health Service Utilization[4]

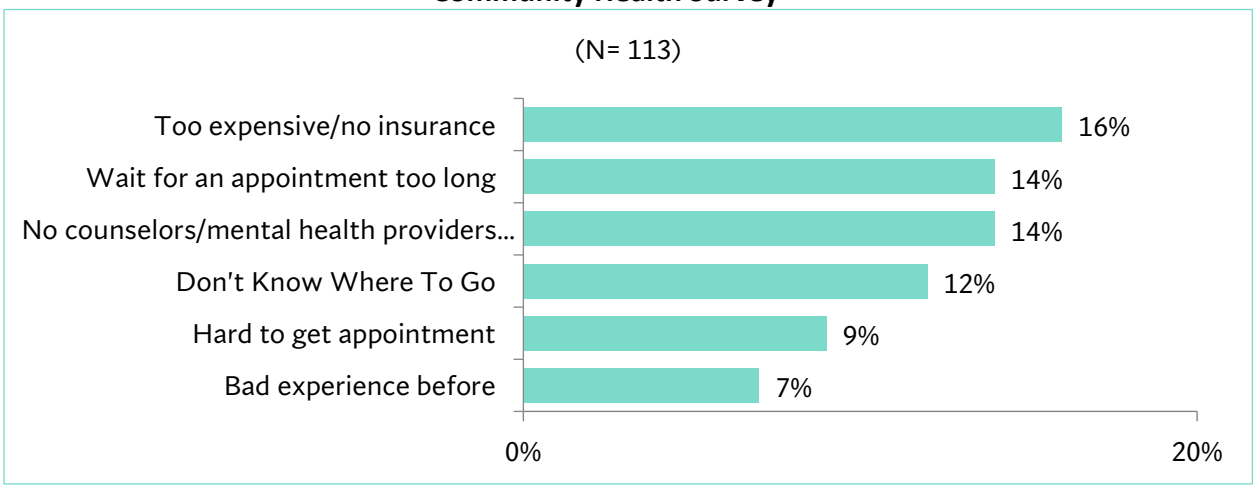
	Somerset County	Wicomico County	Worcester County	Maryland	Sussex County	Delaware	United States
Used Anxiety or Panic Prescription Drug	**9.5%**	**9.3%**	**8.4%**	7.7%	**8.2%**	8.5%	8.4%
Used Depression Prescription Drug	**8.9%**	**8.4%**	**8.2%**	6.9%	**8.0%**	7.8%	7.7%
Visited Psychiatrist/ Psychologist Doctor last 12 months	**4.2%**	**5.1%**	**4.4%**	5.1%	**4.2%**	4.9%	5.0%

Figure 3.14: Percentage of Residents Visiting a Psychiatrist/Psychologist in Last 12 Months, 2024[4]



Based on the map above, mental healthcare utilization varies by location, with more utilization occurring in the Salisbury area of Wicomico County.

Figure 3.15: Barriers to Receiving Mental Health Services when Needed, from the Community Health Survey

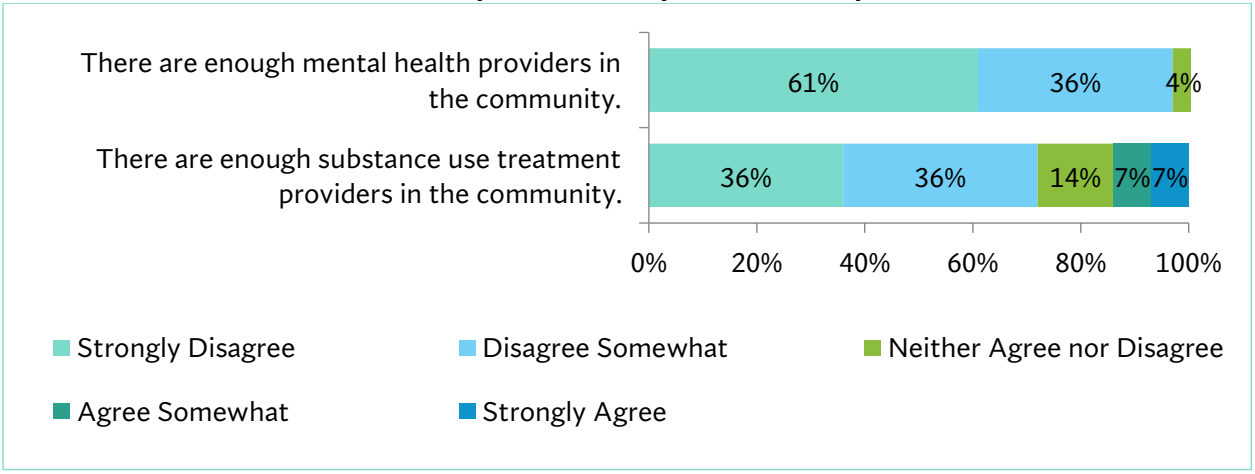


Community health survey respondents who reported being unable to get mental health help when needed (approximately 9% of respondents) identified several key barriers. These included cost or insurance status, long wait-times, lack of provider availability, and not knowing where to find services.

"...lack of understanding that mental health is part of overall health..."
Focus Group Participant

Mental health was identified as an area with significant gaps in services. In the Sussex County focus group, participants noted that while behavioral health providers exist in the community, "there is a lot to be done" and emphasized "a lack of understanding that mental health is a part of overall health." They stressed the need for more behavioral health providers in the area.

Figure 3.16: Key Leader Opinions on Mental Health and Substance Use Treatment Availability, from the Key Leader Survey



Community leaders expressed significant concerns about mental health provider shortages. In the key leader survey, almost all respondents indicated that there are not enough mental health providers in the community and over two-thirds believed there are not enough substance use treatment providers in the community. One healthcare professional stated they "could use 15 more providers" despite already having 80 behavioral health staff

Focus groups and interviews revealed additional barriers to behavioral health care, such as cultural stigma, concerns about quality of services, knowledge gaps, service coordination, and rural challenges for accessing services. Residents and leaders in the Delmarva region described the persistent stigma around mental health and substance use disorders which prevents people from seeking help when they need it. They also expressed concerns about the quality of care that is available, and shared that there is a limited understanding of mental health as a component of overall health.

Because of the inadequate coordination between and across different types of health services, people struggle with continuity of care and receiving appropriate care for their specific needs. Those living in rural parts of the community experience transportation and

other barriers for accessing behavioral health services and struggle to obtain services through telehealth due to broadband and internet connectivity issues.

Key Takeaways – Barriers to Behavioral Health Services
Behavioral health is a priority health concern, but the services needed to address the most pressing needs of residents in the Delmarva region do not meet the demand.

- Despite high depression diagnosis rates (20-24%), less than 10% of residents use prescription medications for depression or anxiety, and ***only 4-5% have visited mental health professionals in the past year.***
- Nearly all community leaders surveyed reported ***insufficient mental health providers*** in the region, with over two-thirds also noting ***inadequate substance use treatment providers***.
- Beyond provider shortages, residents face multiple ***social, economic, geographic, and other barriers*** to accessing behavioral health services.

Conclusion
The behavioral health landscape across the Delmarva region presents significant challenges, with mental health and substance use disorders consistently ranking among top community concerns and prevalence rates exceeding state averages. Despite high rates of depression diagnosis and frequent mental distress, utilization of mental health services remains notably low, with less than 10% using prescription medications and only 4-5% visiting mental health professionals annually.

Access barriers include provider shortages, long wait times, cost concerns, and stigma, all exacerbated by the COVID-19 pandemic. Geographic disparities in substance use indicators, including Somerset County's high overdose death rate despite low opioid dispensing, signal complex underlying issues. While some promising initiatives exist, stakeholder feedback indicates current resources are insufficient to meet growing needs.

Community Recommendations
Some positive efforts were mentioned by community residents and key leaders. These included existing efforts like drop-in centers, peer recovery programs, and school-based initiatives. However, these efforts were also described as insufficient to meet current needs. Several interviewees made suggestions on next steps for the Delmarva region in addressing behavioral health issues. These included:

- Developing more satellite clinics
- Expanding telehealth options (though noting connectivity issues in rural areas)
- Creating more community-based programs to address behavioral health challenges
- Prioritizing and expanding provider capacity
- Addressing social determinants that contribute to behavioral health challenges throughout the region

Chapter 4 | Community Resource Inventory

This chapter outlines resources, facilities, programs, and services throughout the Delmarva region that can be leveraged or better coordinated to address the priority health needs identified through the CHNA process.

Community Resource Inventory

The list of resources below is representative of the services available in the Delmarva region, but this list is not exhaustive. While the resources, facilities, and programs listed in this section have been categorized into common groups, these organizations and programs may offer services beyond that categorization or topic area. It is important to note that while the region overall may be adequately served by what exists currently for a given topic or need area, not all geographies and demographic groups are equally served. The need for more or different resources to better meet community needs may be dependent on population factors.

There are many local organizations and programs currently working to address aspects of each of the priority health needs identified through the 2025 CHNA process. A few examples of these organizations and programs are highlighted below:

Community Resources	Description
COAT	The Community Outreach Addictions Team (COAT) provides support for Emergency Department patients dealing with substance abuse and related behavioral health issues. Peer support specialists in recovery themselves offer navigation, resources, and follow-up care primarily serving Somerset, Worcester, and Wicomico counties, though assistance extends to any ED patient in need.
MAC, Inc	MAC, Inc., The Area Agency on Aging, provides services for active seniors including classes, events, activities, and meals. Their evidence-based programs include Chronic Disease Self-Management (developed by Stanford University), Stepping on Falls Prevention with physical therapist-led exercises, Healthy Living with Hypertension, and other exercise and nutrition classes. These programs help seniors manage chronic conditions, reduce falls, increase confidence, and improve overall health outcomes.
Opioid Intervention Team	The Overdose Prevention Team unites community partners to combat overdose-related deaths and reduce addiction stigma. The team provides education, support for affected individuals and families, and youth engagement initiatives. They conduct Naloxone trainings at outreach events throughout the county, ensuring diverse community access to this life-saving medication. Their

Community Resources	Description
	comprehensive approach includes strategic social media and marketing efforts to maximize community impact across all demographics.
PEARLS	Programs to Encourage Active and Rewarding Lives (PEARLS), administered by MAC Inc., provides evidence-based, one-on-one counseling for adults 60+ experiencing depression, anxiety, or frustration due to life changes. The program helps seniors cope with losses of health, loved ones, and independence. This service became especially vital during COVID-19, when isolation significantly increased among elderly residents in the Tri-County area due to visitation restrictions and family separation.
REACH	The Rural Equity and Access to Community Health (REACH) Project helps community members prevent and manage diabetes and high blood pressure while addressing social determinants of health. Free services include community health programs, healthy lifestyle classes, connections to resources (food, housing, transportation), and healthcare provider referrals. REACH operates through a coalition of healthcare providers, health departments, and nonprofits, with funding from the Maryland Community Health Resources Commission.
SWIFT	SWIFT is a mobile integrated health partnership between the City of Salisbury and Wicomico County Health Department that reduces unnecessary 911 and emergency department use. An interdisciplinary team (nurse practitioner, RN, paramedic, community health worker, and social worker) addresses underlying medical and psychosocial needs of high utilizers by connecting them to primary care, behavioral health services, disease management, medication support, and resources for social needs like housing and food assistance. The SWIFT Minor Definitive Care Now (MDCN) component deploys paramedic-nurse practitioner teams to low-acuity 911 calls, providing home-based care that prevents unnecessary transports and ED visits while building trust with participants to improve their quality of life.
TidalHealth Community Wellness Van	The Community Wellness van is a mobile medical unit that provides community-based screenings. Services may include blood pressure, diabetes risk assessments, referrals and links to primary care,

Community Resources	Description
	seasonal flu shots, and more. The van visits medically underserved communities throughout the Lower Eastern Shore of Maryland and Sussex County, Delaware.

Service Area Asset Mapping

Asset mapping is a strategic process of identifying and documenting a community's existing resources, strengths, and capabilities to better understand and leverage local assets.[45] By mapping these assets, the service area can better visualize the distribution of resources, identify potential service gaps, strengthen partnerships between organizations, and ultimately improve access to essential services for all community members.[46]

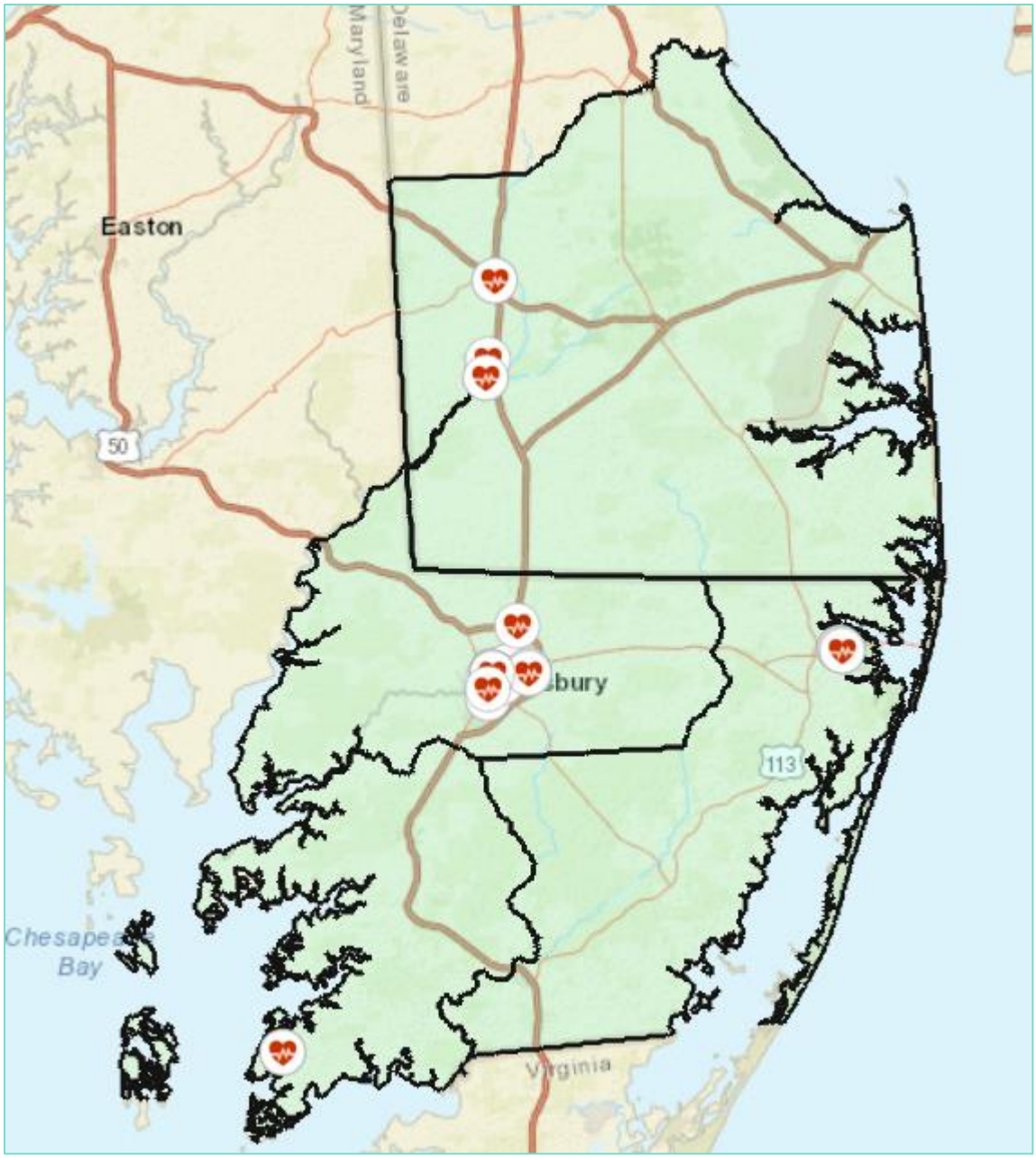
Understanding local assets is particularly valuable for addressing SDOH and ensuring equitable access to resources across the Delmarva region's diverse communities. For the Delmarva region, the asset mapping process included cataloging various resources offered by TidalHealth, including healthcare facilities, providers, and support services.

It should be noted that the maps on the following pages are **not** an exhaustive representation of all community assets and resources available to improve community health and wellbeing in the Delmarva region. Rather, these maps are intended to provide some perspective about what and where resources currently exist in the community so as new resources are developed, they can be strategically deployed to fill gaps in geographic access for those most in need of services.

Community resource directories like 2-1-1 Maryland and findhelp can provide current information about and access to available community resources.

Figure 4.1 TidalHealth Assets Available in Delmarva Region

[45] UCLA Center for Health Policy Research. (n.d.). Asset mapping: Section 1. Health DATA Program – Data, Advocacy and Technical Assistance.
[46] National Center for Farmworker Health. (2021). Community asset mapping guide.



Name	County	State	Address	Description of Services
Alice B. Tawes Nursing & Rehabilitation	Somerset	MD	201 Hall Highway, Crisfield, MD 21817	Skilled nursing and rehabilitation services.
Chesapeake Cove Assisted Living	Somerset	MD	201 Hall Highway, Crisfield, MD 21817	Assisted living facility offering personal care services.
TidalHealth Adult Fitness, Ocean Pines	Worcester	MD	11101 Cathage Road, Berlin, MD 21811	Fitness center providing exercise programs and wellness services.
TidalHealth Adult Fitness, Salisbury	Wicomico	MD	800 S. Salisbury Blvd., Salisbury, MD 21801	Fitness center offering exercise programs and wellness services.

Name	County	State	Address	Description of Services
TidalHealth Allen Cancer Center	Sussex	DE	701 Middleford Road, Seaford, DE 19973	Comprehensive cancer care services.
TidalHealth Breast Center	Wicomico	MD	804 Snow Hill Road, Salisbury, MD 21801	Breast health services including screenings and diagnostics.
TidalHealth Breast Surgery	Sussex	DE	201 Health Services Drive, Seaford, DE 19973	Surgical services for breast conditions.
TidalHealth Bridgeville Pavilion	Sussex	DE	9111 Antique Alley, Bridgeville, DE 19933	Medical services and outpatient care.
TidalHealth Cardiology, Ocean Pines	Worcester	MD	11107 Cathage Road, Suite 201, Berlin, MD 21811	Cardiology services including diagnostics and treatment.
TidalHealth Cardiology, Salisbury North	Wicomico	MD	400 Eastern Shore Drive, Salisbury, MD 21804	Cardiology services including diagnostics and treatment.
TidalHealth Cardiology, Salisbury South	Wicomico	MD	106 Milford St., Suite 605, Salisbury, MD 21804	Cardiology services including diagnostics and treatment.
TidalHealth FamilyLab, Salisbury	Wicomico	MD	951 Mt. Hermon Road, Suite A, Salisbury, MD 21804	Family medicine services.
TidalHealth FamilyLab, Milford Street	Wicomico	MD	106 Milford St., Suite 404, Salisbury, MD 21804	Family medicine services.
TidalHealth FamilyLab, Woodbrooke	Wicomico	MD	1639 Woodbrooke Drive, Salisbury, MD 21804	Family medicine services.
TidalHealth General Surgery, Salisbury	Wicomico	MD	145 E. Carroll St., Suite B202, Salisbury, MD 21801	General surgical services.
TidalHealth Home Care, Salisbury	Wicomico	MD	1001 Mount Hermon Road, Salisbury, MD 21804	Home healthcare services.
TidalHealth Medical Imaging, Salisbury	Wicomico	MD	100 E. Carroll St., Salisbury, MD 21801	Diagnostic imaging services.
TidalHealth Neurology, Salisbury	Wicomico	MD	1630 Woodbrooke Drive, Salisbury, MD 21804	Neurology services.
TidalHealth Outpatient Behavioral Health	Wicomico	MD	200 E. Vine St., Salisbury, MD 21801	Outpatient behavioral health services.

Name	County	State	Address	Description of Services
TidalHealth Outpatient Lab Services, Salisbury	Wicomico	MD	100 E. Carroll St., Salisbury, MD 21801	Laboratory services.
TidalHealth Pediatrics	Wicomico	MD	1639 Woodbrooke Drive, Salisbury, MD 21804	Pediatric care services.
TidalHealth Primary Care, Salisbury	Wicomico	MD	1639 Woodbrooke Drive, Salisbury, MD 21804	Primary care services.
TidalHealth Pulmonary & Critical Care, Salisbury	Wicomico	MD	100 E. Carroll St., Salisbury, MD 21801	Pulmonary and critical care services.
TidalHealth Richard A. Henson Cancer Institute	Wicomico	MD	100 E. Carroll St., Salisbury, MD 21801	Comprehensive cancer care services.
TidalHealth Richard A. Henson Research Institute	Wicomico	MD	100 E. Carroll St., Salisbury, MD 21801	Research services in health and medicine.
TidalHealth Surgery Center	Wicomico	MD	804 Snow Hill Road, Salisbury, MD 21801	Outpatient surgical services.
TidalHealth Urology, Salisbury	Wicomico	MD	1664 Woodbrooke Drive, Suite B, Salisbury, MD 21804	Urological services.
TidalHealth Wound & Hyperbaric, Salisbury	Wicomico	MD	100 E. Carroll St., Salisbury, MD 21801	Wound care and hyperbaric services.
Your Doc's In, North Salisbury	Wicomico	MD	2425 N. Salisbury Blvd., Salisbury, MD 21801	Urgent care services.
Your Doc's In, South Salisbury	Wicomico	MD	1135 S. Salisbury Blvd., Salisbury, MD 21801	Urgent care services.
TidalHealth McCready Pavilion	Somerset	MD	201 Hall Highway, Crisfield, MD 21817	Medical services including outpatient care.
TidalHealth Ocean Pines Campus	Worcester	MD	11101 Cathage Road, Berlin, MD 21811	Medical services including outpatient care.
TidalHealth Allen Cancer Center	Sussex	DE	701 Middleford Road, Seaford, DE 19973	Comprehensive cancer care services.
TidalHealth Bridgeville Pavilion	Sussex	DE	9111 Antique Alley, Bridgeville, DE 19933	Medical services and outpatient care.
TidalHealth Cardiology, Ocean Pines	Worcester	MD	11107 Cathage Road, Suite 201, Berlin, MD 21811	Cardiology services including diagnostics and treatment.

Chapter 5: Next Steps

The CHNA findings will be used by community health leaders to develop effective strategies aimed at addressing the priority health needs identified in this report. The immediate next step in the CHNA process is to develop community-based health improvement strategies and action plans to address the priorities identified in this assessment.

Steering Committee organizations will leverage information from this CHNA to develop implementation and action plans for their local community, while also working with other organizations and agencies in the service area to ensure the priority health need areas are addressed in the most efficient, effective, and collaborative way. The Steering Committee believes that the most effective strategies will be those that have the collaborative support of community organizations and residents. The strategies developed will include measurable objectives through which progress can be measured.

Appendix 1 | Summary of Prior CHNA Implementation Plan

A CHNA is an ongoing process that begins with an evaluation of the previous CHNA. In 2022, TidalHealth, Somerset County, and Wicomico County health departments completed a CHNA and improvement planning process. A summary of the 2022-2025 priority areas and implementation strategies for each of the three entities are shared in the following pages. An evaluation of the impact of actions taken by these partner organizations to implement strategies from the previous CHNA and resulting improvement plan are summarized.

Previous CHNA Goals, Objectives, and Planned Action Steps

Priority Need Area: Access and Health Equity

Access to healthcare and health equity emerged as critical priorities across the Tri-County Region and Sussex County, DE. Secondary data analysis indicated healthcare access challenges, with all counties below state averages for primary care provider rates, non-physician provider rates, and adults with health insurance. The data revealed significant disparities by race, ethnicity, and geography, with Black/African American, Hispanic/Latino, and other minority populations experiencing higher poverty rates and more limited access to care.

Goals

- Improve access to healthcare services for all community members
- Reduce healthcare disparities among underserved populations
- Address barriers to care including transportation, cost, and cultural obstacles
- Enhance healthcare navigation services for vulnerable populations

Objectives

- Increase the number of primary care and non-physician providers in the region
- Improve health insurance coverage rates across all counties
- Enhance cultural competency in healthcare delivery
- Develop transportation solutions for those facing access barriers
- Reduce the percentage of residents reporting cost as a barrier to care

Action Steps

- Expand telemedicine services, particularly in remote areas like Smith Island
- Deploy mobile health units to reach underserved communities
- Implement community health worker programs to help residents navigate healthcare systems
- Develop multilingual healthcare resources and services
- Partner with community organizations to address social determinants of health
- Create innovative transportation solutions for healthcare appointments
- Establish integrated service delivery models that address multiple barriers simultaneously

Priority Need Area: Behavioral Health

Behavioral health, encompassing both mental health and substance use disorders, was identified as a major concern. Data showed alarming rates of drug and opioid-involved overdose deaths exceeding national averages in all counties, with Sussex County reporting 46.6 deaths per 100,000 population. All counties experienced significant increases in death rates due to drug poisoning between 2004-2019. Mental health provider shortages were evident in several areas, and community survey respondents ranked alcohol and drug use (50.1%) and mental health disorders (44.6%) as top health concerns.

Goals

- Reduce instances of opioid-related deaths and overdoses
- Address mental health issues including depression, anxiety, and suicide
- Improve coordination between physical and behavioral health services
- Decrease stigma associated with seeking mental health treatment

Objectives

- Reduce the rate of drug and opioid-involved overdose deaths
- Decrease alcohol-impaired driving deaths
- Increase access to mental health providers
- Reduce emergency department visits related to mental health and substance use
- Expand treatment options for those with behavioral health conditions

Action Steps

- Continue and expand the Community Outreach Addictions Team (COAT) program
- Maintain Opioid Intervention Teams in each county to address prevention, treatment, and enforcement
- Implement the Program to Encourage Active and Rewarding Lives (PEARLS) for older adults with depression
- Expand the Salisbury-Wicomico Integrated First-Care Team (SWIFT) to reduce unnecessary emergency department use
- Increase Narcan training and distribution throughout the community
- Develop crisis intervention services and mental health support programs
- Create educational campaigns to reduce stigma around behavioral health conditions

Priority Need Area: Chronic Disease and Wellness

Chronic disease burden, particularly diabetes, cancer, and heart disease, was substantial throughout the region. Geographic patterns revealed higher concentrations of diabetes in Somerset County and western Sussex County, with similar patterns for heart disease and stroke. Food insecurity was identified as a contributing factor to chronic disease, with several high-need zip codes in Somerset and Worcester counties. Cancer incidence varied by location, with higher rates of certain cancers in specific areas. Survey respondents cited nutrition and healthy eating as top quality of life issues.

Goals

- Improve health outcomes for those with chronic diseases including diabetes, cancer, and heart disease
- Enhance preventive care and early detection services
- Promote healthy lifestyle choices throughout the community

- Address food insecurity as a contributing factor to chronic disease

Objectives

- Reduce diabetes prevalence and improve management among existing patients
- Increase cancer screening rates, particularly for breast, colorectal, and lung cancers
- Lower heart disease and stroke rates through better preventive care
- Improve access to nutritious food and physical activity opportunities
- Enhance self-management skills among those with chronic conditions

Action Steps

- Expand Chronic Disease Self-Management (CDSM) classes throughout the tri-county area
- Enhance the TidalHealth Community Wellness Program to provide screenings and education
- Continue the Sustainable Change and Lifestyle Enhancement (SCALE) program for weight management
- Increase mobile screening services for chronic conditions
- Provide targeted education on nutrition and physical activity
- Partner with local food resources to improve food security and nutritional quality
- Collaborate with cancer institutes to increase screening and early detection
- Develop community-based walking programs and other physical activity opportunities
- Implement worksite wellness programs to reach employed community members

Documented Outcomes from 2022-2025 CHNA and CHIP

Access and Health Equity

Goal 1.1: Increase equitable access to healthcare

Objective 1: By June 2025, increase insurance coverage for populations with disparities in health coverage. Increase coverage for Hispanic residents of Wicomico County to 75%.

Strategies:

- Outreach and MCHP assistance especially for Hispanic residents.

Progress:

- The MCHP program processed over 6,096 Medicaid applications, of which 58% were for the LEP population.
- 2021 Medicaid data: 69.4% Hispanic residents of Wicomico are insured.

Objective 2: By June 2025, increase insurance coverage for populations with disparities in health coverage. Maintain coverage rate for Hispanic residents of Somerset County at 90% (2020 baseline = 90%)

Strategies:

- Continue the work that is currently being done in the migrant program and integrating our Community Health Workers into healthcare facilities.

Progress:

- We are continuing to perform the current work that is being done at the migrant program.
- Community Health Workers have not ventured into healthcare facilities as of yet.
- Insurance coverage rate for Hispanic residents in Somerset County has increased to 92.9%.

Objective 3: By June 2025, increase insurance coverage for populations with disparities in health coverage.

Strategies:

- Screen Patients for health insurance coverage & refer to health insurance assistance programs and navigators.
- Refer children without health insurance at School-Based Wellness Centers to Community Health Worker.

Progress:

- We are unable to measure currently, but we have an established workflow to screen patients for insurance and connect to assistance with enrolling in coverage.
- 43 referrals from SBWellness to Community Wellness at TidalHealth.

Objective 4: By June 2024, establish a process to determine the insurance coverage percentage for the Haitian population.

Strategies:

- Work with LHIC partners to develop and pilot process.

Progress:

- Objective and strategy to be revised.

Objective 5: By December 2023, implement best practices and standardizations of social determinants of health screening and closed-loop, bidirectional referrals across multiple sectors and community-based partners.

Strategies:

- Conduct an environmental scan of community-based partners to assess who is currently utilizing SDOH screenings.
- Increase adoption and use of social care services and resource referral platform among community-based orgs.

Progress:

- We launched an initiative to expand SDOH screening and referrals via the Rural Equity and Access to Community Health (REACH) grant program with coalition partners.
- The coalition is working to expand adoption of findhelp as the social care coordination tool.

Objective 6: By June 2025, expand the diversity of the community health worker workforce within health systems, public health and adjacent sectors.

Strategies (WiCHD):

- Determine baseline measure of Community Health Workers (CHWs), including the number of bilingual CHWs.
- Establish a regional association for CHWs to support workforce development.

Progress (WiCHD):

- CHW survey completed. Initial baseline for Lower Shore = 73.3 FTE Staff, 13 PRN Staff, and 2 volunteers.
- Eastern Shore AHEC has established regional Eastern Shore CHW Network.

Strategies (SCHD):

- Determine baseline measure of Community Health Workers (CHWs), including the number of bilingual CHWs.
- Establish a regional association for CHWs to support workforce development.

Progress (SCHD):

- Our agency has a total of 2 community health workers and are in the process of hiring 3 more.
- There are currently no bilingual CHW's.
- Our CHW's are apart of the Eastern Shore Area Health Education Center (AHEC).

Strategies (TidalHealth):

- Increase access to funding to support certification training and salaries for CHW positions at local health care, public health, and community-based organizations serving marginalized or disadvantaged populations by collaborating on grants and alternative payment agreements with Medicaid.

Progress (TidalHealth):

- We successfully received grant funding through Pathways to Health Equity to provide funding for a CHW at Rebirth and CHW training.

Goal 1.2: Provide education and promote awareness of health equity, including policy recommendations.

Objective 1: By June 2024, develop and adopt Health Equity Frameworks(s) among key partner organizations.

Strategies (WiCHD):

- Establish a subcommittee in the LHIC to be tasked with Health Equity.

Progress (WiCHD):

- Health Equity and Health Access Subcommittee formed March 2024.
- Subcommittee identified several health equity models to adopt.
- LHIC voted and selected the Institute of Healthcare Improvement's Health Equity Model.

Strategies (TidalHealth):

- Participate in health equity learning collaboratives and adopt Institute of Healthcare Improvement's Health Equity framework.

Progress (TidalHealth):

- We completed participation in the Institute for Healthcare Improvement Pursuing Equity Action Community collaborative cohort.

Objective 2: By June 2025, local health coalitions present at least one policy recommendation related to health equity.

Strategies (WiCHD):

- Conduct an environmental scan for community organizations to assess health literacy polices and resources in place.
- Create action plan to address gaps identified in the environmental scan. (Somerset and Wicomico LHICs)

Progress (WiCHD):

- Not started. Health Equity and Health Access Subcommittee will complete.

Strategies (SCHD):

- Conduct an environmental scan for community organizations to assess health literacy policies and resources in place.
- Create action plan to address gaps identified in the environmental scan. (Somerset and Wicomico LHICs)

Progress (SCHD):

- We have not yet conducted an environmental scan.
- Our agency has restructured our CLAS committee to include health equity and is now the Health Equity CLAS Committee (HECC).
- We have also developed our health equity plan.

Objective 3: June 2024, increase engagement of diverse community members in the local health improvement coalitions in Somerset and Wicomico counties. Wicomico and Somerset: Recruit at least 2 LHIC members annually.

Strategies (WiCHD):

- Complete analysis of LHIC membership annually and recruit new members based on gaps identified.
- Promote LHIC to diverse groups to increase engagement and membership among underrepresented groups.

Progress (WiCHD):

- During FY24 membership analysis completed; the LHIC recruited 4 new members.
- Presented at the Salisbury City Council.

Strategies (SCHD):

- Complete analysis of LHIC membership annually and recruit new members based on gaps identified.
- Promote LHIC to diverse groups to increase engagement and membership among underrepresented groups.

Progress (SCHD):

- We have recruited 3 new members to our LHIC (Healthy Somerset) from Chesapeake Housing Commission, Life Crisis Center and Women Supporting Women.

Behavioral Health

Goal 2: Improve behavioral health through prevention, treatment, and recovery.

Objective 1: By June 2025, reduce the rate of suicide deaths in the service area. Wicomico: Reduce rate to 9.0 per 100,000 (Baseline: 11.7 in 2020).

Strategies (WiCHD):

- Increase the number of persons trained in Mental Health First Aid.
- Implement the Talk Saves Lives Program.
- Educate the community about 988 suicide and crisis line.

Progress (WiCHD):

- FY24 trained 149 individuals (108 trained in FY23).
- 2 LBHA staff trained to implement Talk Saves Lives.
- Developed and distributed 988 Rack Cards in multiple languages. Social media campaign completed.

Strategies (TidalHealth):

- Increase access to treatment and prevention services including the Crisis Stabilization Center.
- Conduct PHQ 2 and 9 surveys in primary care settings.

Progress (TidalHealth):

- 213 referrals to behavioral health at TidalHealth;
- 91% of patients screened through PHQ assessment;
- 1,089 patients served by Crisis Center.

Objective 2: By June 2025, reduce and prevent opioid misuse and overdoses. Wicomico: Reduce deaths by 40% (Baseline: 39 in 2020).

Strategies (WiCHD):

- Expand access to Narcan/Naloxone and training in the community.
- Continue linking individuals to treatment via Community Outreach Addiction Team (COAT) services.
- Support regional Go Purple campaigns.

Progress (WiCHD):

- Distributed 1,779 Narcan kits, with 661 kits distributed to those with social experience.
- COAT assisted 435 individuals, with 63.8% linked to treatment.
- Numerous Go Purple events during FY24 including kickoff event at Shorebirds Stadium (over 3,700 individuals), Shatter the Stigma Walk (over 120 walkers) and Overdose Awareness Day at Winterplace Park.

Strategies (TidalHealth):

- Increase access to treatment and prevention services including the Crisis Stabilization Center.
- Provide and promote use of Narcan/Naloxone upon discharge when prescribed opioid medication.
- Provide and promote use of Narcan/Naloxone in community.

Progress (TidalHealth):

- 1,089 patients served by Crisis Center.
- Narcan/Naloxone program active for patients discharged wit opioid medication.

Objective 3: By June 2025, strengthen the integrated behavioral health-primary care model among local healthcare providers.

- Academic Detailing Target = 12 visits
- Hub and Spoke Target = 15 individuals served through care coordination.
- Target: 1,000 referrals to TidalHealth behavioral health therapist annually
- Goal: 90 percent patients screened for PHQ 2/9 (TidalHealth)

Strategies (WiCHD):

- Hub and Spoke Program will support community prescribers to expand care for more patients with opioid use disorder.
- Academic Detailing visits to healthcare providers for best practices in prescribing opioids.

Progress (WiCHD):

- Served 13 individuals.
- Wicomico Detention Center recruited as a new spoke.
- 22 visits completed with somatic care providers and 4 visits completed with non-physician providers.

Strategies (TidalHealth):

- Increase referrals to behavioral health therapist among TidalHealth Medical Partners primary care practices.
- Increase PHQ 2 and 9 screenings at TidalHealth Medical Partners primary care practices.

Progress (TidalHealth):

- 213 referrals made;
- 91% of primary care patients screened.

Objective 4: By June 2025, decrease the proportion of adults reporting excessive poor mental health days. Wicomico: reduce the proportion of adults reporting poor mental health for 14 or more days each month to 12%. (Baseline: 15.3%; MD BRFSS)

Strategies (TidalHealth):

- Expand the PEARLS program.
- Increase referrals to behavioral health.

Progress (TidalHealth):

- 152 patients - 94% screened for PEARLS.
- 108 had either in-person sessions or follow-up calls.
- 96 had 6 or more sessions during this reporting period.
- Total who completed final session during this period - 62.
- 82% had depression at start; 21% had depression at completion.

Chronic Disease and Wellness

Goal 3.1: Reduce the prevalence and mortality rates of chronic diseases in the Partnership area.

Objective 1: By June 2025, reduce the prevalence of diabetes among adults in the service area.

Wicomico: Reduce prevalence to 8.0% (Baseline: 10.9% in 2020)
Strategies (WiCHD):

- Facilitate at least two Diabetes Prevention Program (DPP) cohorts per fiscal year.
- Strengthen referral process between primary and providers and DPP providers.

Progress (WiCHD):

- 4 cohorts (2 English, 1 Spanish and 1 Haitian Creole).
- 94.8% of participants retained by session 4.

Additional Strategies (WiCHD):

- Increase access to the National Diabetes Prevention Program by providing it in community settings.
- Maintain the current referral process and relationship with Chesapeake Healthcare (CHC).
- Also try to connect with other providers to receive additional referrals.

Additional Progress (WiCHD):

- DPP expanded to offer classes in Haitian Creole and Spanish.
- Classes being offered in churches and apartment complexes.

Somerset: Reduce prevalence to 13% (Baseline: 15/7% in 2020)
Strategies (SCHD):

- Facilitate at least three Diabetes Prevention Program (DPP) cohorts per fiscal year.
- Engage at least 2 healthcare providers to refer participants to DPP.

Progress (SCHD):

- We have facilitated 3 Diabetes Prevention program cohorts in FY 2024.
- We have engaged 1 healthcare provider, Chesapeake Health Care, to refer participants to DPP.

Strategies (TidalHealth):

- Increase referrals from TidalHealth primary care providers – utilize CRISP DPP report to identify potential patients for referrals.

Progress (TidalHealth):

- Initial education provided;
- Information shared about ongoing DPP classes.

Objective 2: By June 2025, reduce the rate of hospital ED visits, admissions and readmissions for diabetes and hypertension among adults. Based on Maryland CRISP data provided in 2019: 5% reduction in average hospital encounters for hypertension (rate: 470/1000 5% reduction in average hospital encounters for diabetes (rate: 8/1000).

Strategies (TidalHealth):

- Operate a mobile integrated health program (SWIFT).
- Provide Remote Patient Monitoring to high-risk patients with chronic conditions such as diabetes, CHF, COPD.
- Provide health screening, outreach, and education in the community including diabetes risk assessments and blood pressure checks.

Progress (TidalHealth):

- [No progress reported]

Objective 3: By June 2025, increase the proportion of adults who get evidence-based preventative health care including screenings.

Wicomico: Increase adults receiving recent routine checkup to 90% (Baseline: 81.2% in 2020).
Strategies (WiCHD):

- Complete at least 25 colorectal screenings a year.

Progress (WiCHD):

- [No progress reported]

Somerset: Increase adults receiving recent routine checkup to 85% (Baseline: 76.9% in 2020).
Strategies (SCHD):

- Complete at least 12 colorectal screenings a year.

Progress (SCHD):

- In the year 2023 we completed 6 colorectal screenings.
- In 2024 we completed 22 colorectal screenings.

Sussex: Increase awareness and uptake of recommended prostate cancer screenings
Strategies (TidalHealth):

- Launch an awareness and outreach campaign to increase acceptance and uptake of prostate cancer screenings.

Progress (TidalHealth):

- [No progress reported]

Goal 3.2: Promote & support healthy lifestyles & wellness in the service area to reduce risk of chronic disease

Objective 1: By 2025, decrease the proportion of people with overweight or obesity.

Wicomico: Reduce prevalence to 8.0% (Baseline: 10.9% in 2020).
Strategies (WiCHD):

- Increase participation in Healthy Lifestyle community challenges.
- Promote and expand walking initiatives.
- Promote use of community gardens as a source for healthy, free produce.
- Implement a social marketing campaign promoting healthy lifestyles.

Progress (WiCHD):

- 94 participants.
- 3 walking groups established; 482 participants in walking events.
- Received $50K funding from Rural Healthy Corner Stores, supporting 7 community gardens.
- Completed via Facebook.

Strategies (TidalHealth):

- Promote and expand participation in Chronic Disease Self-Management and Healthy Lifestyle programming.

Progress (TidalHealth):

- MAC EBP - 25 workshops with 190 participants. 81% completion rate;
- REACH grant supported DPP at YMCA;
- healthy lifestyle programming with HDCD and Rebirth.

Objective 2: By 2025, increase the proportion of residents achieving the recommended physical activity level (150 minutes per week of moderate activity or vigorous equivalent).

Wicomico: Increase proportion of residents with recommended physical activity level to at least 55% (Baseline: 50.5% in 2019).
Strategies (WiCHD):

- Promote and increase participation in walking initiatives.

Progress (WiCHD):

- 3 walking groups established via Healthy Lifestyles Challenge.

Somerset: Increase the proportion of residents with recommended physical activity level to at least 45% (baseline: 39.2% in 2019)
Strategies (SCHD):

- Promote and increase participation in walking initiatives.

Progress (SCHD):

- In October 2024 we hosted a Walk Day MD Pumpkin Scavenger Hunt.
- Our agency has conducted a staff walking challenge in 2023 and 2024.

Strategies (TidalHealth):

- Increase and promote physical activity programs through MAC, Inc. for older adults.

Progress (TidalHealth):

- MAC, Inc. had 1,143 monthly membership contracts from July 1, 2023-June 30, 2024. *Many of these are the same members purchasing multiple contracts.
- REACH grant supported 12 memberships at the YMCA.

Appendix 2 | Secondary Data Methodology and Sources

Many individual secondary data measures were analyzed as part of the CHNA process. These data provide detailed insight into the health status and health-related behavior of residents in the county. These secondary data are based on statistics of actual occurrences, such as the incidence of certain diseases, as well as statistics related to social determinants of health.

Methodology

All individual secondary data measures were grouped into six categories and 20 corresponding focus areas based on "common themes." To draw conclusions about the secondary data for the Delmarva region, performance on each data measure was compared to established targets/ benchmarks. If a Delmarva region county's performance was more than five percent worse than the comparative benchmark, it was concluded that improvements could be needed to better the health of the community. Conversely, if an area performed more than five percent better than the benchmark, it was concluded that while a need is still present, the significance of that need relative to others is likely less acute.

The most recently available data were compared to these targets/benchmarks in the following order (as applicable):

- For all available data sources, state and national averages were compared.

The following methodology was used to assign a priority level to each individual secondary data measure:

- If the data were more than 5 percent worse = High need
- If the data were within or equal to 5 percent (better or worse) = Medium need
- If the data were more than 5 percent better = Low need

Secondary Data Sources

The following tables are organized by each of the twenty focus areas and contain information related to the secondary data measures analyzed including a description of each measure, the data source, and most recent data time periods.

Table A2.1: Access to Care

Measure	Description	Data Source	Most Recent

			Data Year(s)
Uninsured Population (All Ages)	Percentage of the population without health insurance coverage. Numerator = Number of people currently uninsured in the county. Denominator = Number of people in the county u.	U.S. Census Bureau ACS Table S1501 5-Year Estimates, 2018-2022	2022
Uninsured Adults (19 to 64)	Uninsured Adults is the percentage of the population ages 19 to 64 that have no health insurance coverage in a given county. Numerator = Number of people ages 19 to 64 who currently have no health insurance coverage. A person is uninsured if they are not currently covered by insurance through a current/former employer or union, purchased from an insurance company, Medicare, Medicaid, Medical Assistance, any kind of government-assistance plan for those with low incomes or disability, TRICARE or other military health care, Indian Health Services, VA, or any other health insurance or health coverage plan. Denominator = County population ages 19-64	U.S. Census Bureau ACS Table S1501 5-Year Estimates, 2018-2022	2022
Uninsured Children (<19)	Uninsured Children is the percentage of the population under age 19 that has no health insurance coverage in a given county. Numerator = Number of people under age 19 who currently have no health insurance coverage. A person	U.S. Census Bureau ACS Table S1501 5-Year Estimates, 2018-2022	2022

	is uninsured if they are not currently covered by insurance through a current/former employer or union, purchased from an insurance company, Medicare, Medicaid, Medical Assistance, any kind of government-assistance plan for those with low incomes or disability, TRICARE or other military health care, Indian Health Services, VA, or any other health insurance or health coverage plan. Denominator = County population under age 19		
Primary Care Provider Ratio	Primary Care Physicians is the ratio of the population to primary care physicians. The ratio represents the number of individuals served by one physician in a county, if the physicians were equally distributed across the population. Left: Represents county population Right: Represents the primary care physicians corresponding to county population. Primary care physicians include practicing non-federal physicians (M.D.s and D.O.s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics	Area Health Resource File/American Medical Association Robert Wood Johnson Foundation (RWJF) & University of Wisconsin Population Health Institute (UWPHI), County Health Rankings. Accessed October 2024.	2021
Dentist Ratio	The ratio of the population to dentists. The ratio represents the population served by one dentist if the entire population of a county were distributed equally across all practicing dentists.	Area Health Resource File/National Provider Identifier RWJF & UWPHI, County Health	2022

	Left: Represents county population Right: Represents the dentists corresponding to county population. Registered dentists with a National Provider Identifier are counted.	Rankings. Accessed October 2024.	
Mental Health Provider Ratio	The ratio of the population to mental health providers. The ratio represents the number of individuals served by one mental health provider in a county, if providers were equally distributed across the population. Left: Represents county population Right: The right side of the ratio represents the mental health providers corresponding to county population. Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental health care	CMS, National Provider Identification RWJF & UWPHI, County Health Rankings. Accessed October 2024.	2023
Children Receiving Dental Care (ages 0 to 20)	This indicator reflects the percentage of children (aged 0-20 years) enrolled in Medicaid (320+ days) who received at least one dental visit during the past year.	Maryland Department of Health (MDH), State Health Improvement Process (SHIP). Data accessed October 2024.	2021
ED visit rate due to addiction-related conditions	This indicator shows the rate of emergency department visits related to substance use	MDH SHIP. Data accessed October 2024.	2017

	disorders (per 100,000 population).		
ED visit rate due to diabetes	This indicator shows the emergency department visit rate due to diabetes (per 100,000 population).	MDH SHIP. Data accessed October 2024.	2017
ED visit rate due to hypertension	This indicator shows the rate of emergency department visits due to hypertension (per 100,000 population).	MDH SHIP. Data accessed October 2024.	2017
ED visit rate for Dental Care	This indicator shows the rate of emergency department visits due to dental needs (per 100,000 population).	MDH SHIP. Data accessed October 2024.	2017
ED visit rate for Asthma	This indicator shows the rate of emergency department visits due to asthma (per 100,000 population).	MDH SHIP. Data accessed October 2024.	2017
Children Receiving Blood Level Screenings		MDH SHIP. Data accessed October 2024.	2021
Child Elevated Blood Lead Levels		MDH SHIP. Data accessed October 2024.	2020
Persons with a usual primary care provider	This indicator shows the percentage of people who reported that they had one person they think of as their personal doctor or healthcare provider.	MDH SHIP. Data accessed September 2024.	2021
Uninsured ED Visits	This indicator shows the percentage of persons without health (medical) insurance who seek care through the Emergency Department.	MDH SHIP. Data accessed September 2024.	2017

Table A2.2: Built Environment

Measure	Description	Data Source	Most Recent Data Year(s)
Food Environment Index	The Food Environment Index ranges from a scale of 0 (worst) to 10 (best) and equally weights two	USDA Food Environment Atlas; Map the Meal Gap	2019 & 2021

(index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best))	indicators of the food environment: 1) Limited Access to Healthy Foods estimates the percentage of the population that is low income and does not live close to a grocery store. Low income is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size. Living close to a grocery store is defined differently in rural and non-rural areas; in rural areas, it means living less than 10 miles from a grocery store whereas in non-rural areas, it means less than 1 mile. 2) Food Insecurity estimates the percentage of the population without access to a reliable source of food during the past year. A two-stage fixed effects model was created using information from the Community Population Survey, Bureau of Labor Statistics, and American Community Survey to estimate Food Insecurity.	from Feeding America RWJF & UWPHI, County Health Rankings. Accessed September 2024.	
% Broadband Access	Broadband Access is the percentage of households with a broadband internet connection through subscription. Numerator = Number of households in a county with a broadband internet subscription of any type (e.g., cable, DSL, fiber-optic, cell phone, or satellite) at their place of residence. The	American Community Survey (ACS), 5-year estimates RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2018-2022

	numerator includes affirmative responses to the ACS question: "At this house, apartment, or mobile home- do you or any member of this household have access to the Internet?" Denominator = Total number of households in county		
Households with Computer	Estimate of the percentage of households that own a computer.	Esri Business Analyst. Data accessed September 2024.	2024

Table A2.4: Diet and Exercise

Measure	Description	Data Source	Most Recent Data Year(s)
Physical Inactivity	Percentage of adults aged 18 and over reporting no leisure-time physical activity (age-adjusted). Numerator = Number of respondents who answered "no" to the question, "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?" Denominator = Number of respondents age 18 and older	Behavioral Risk Factor Surveillance System (BRFSS) RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2021
Population with Access to Exercise Opportunities	Access to Exercise Opportunities measures the percentage of individuals in a county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities. Individuals are considered to have adequate access to exercise opportunities if they:	Opportunities ArcGIS Business Analyst and ArcGIS Online; YMCA; US Census TIGER/Line Shapefiles RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2020, 2022, 2023

• reside in a census block that is within a half mile of a park, or
• reside in a census block that is within one mile of a recreational facility in an urban area, or
• reside in a census block that is within three miles of a recreational facility in a rural area.

Numerator = The numerator is the total 2020 population living in census blocks with adequate access to at least one location for physical activity. Adequate access is defined as census blocks where the border is a half-mile or less from a park, 1 mile or less from a recreational facility in an urban area, or 3 miles or less from a recreational facility in a rural area. Parks include local, state, and national parks. Recreational facilities include YMCAs as well as businesses including a wide variety of facilities such as gyms, golf courses, tennis courts and pools, identified by the following Standard Industry Classification (SIC) codes: 799101, 799102, 799103, 799106, 799107, 799108, 799109, 799110, 799111, 799112, 799201, 799701, 799702, 799703, 799704, 799707, 799711, 799717, 799723, 799901, 799908, 799958, 799969, 799971, 799984, or 799998.

	Denominator = 2020 resident county population		
Physical Activity (percentage)	This indicator shows the percentage of persons who reported at least 150 minutes of moderate physical activity or at least 75 minutes of vigorous physical activity per week.	MDH SHIP. Data accessed September 2024.	2019

Table A2.5: Education

Measure	Description	Data Source	Most Recent Data Year(s)
School Segregation Index	School Segregation measures how evenly representation of racial and ethnic groups in the student population is spread across schools using Theil's Index, a segregation index. The index ranges from 0 to 1 with lower values representing a school composition that approximates race and ethnicity distributions in the student populations within the county, and higher values representing more segregation.	National Center for Education Statistics RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2022-2023
School Funding Adequacy	School Funding Adequacy is the average gap in dollars between actual and required spending per pupil among school districts. Required spending is an estimate of dollars needed to achieve United States average test scores in each school district. This measure looks at funding through an equity lens, not every district's needs for funding are the same, and this measure of school funding takes that into account.	School Finance Indicators Database RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2021

% Less than 9th Grade	Percentage of adults over age 25 who have less than a 9th grade education.	U.S. Census Bureau ACS Table S1501 5-Year Estimates, 2018-2022	2022
% Some High School	Percentage of adults over age 25 who attended some high school but did not earn their diploma or alternative credential.	U.S. Census Bureau ACS Table S1501 5-Year Estimates, 2018-2022	2022
% High School Graduate	Percentage of adults over age 25 who earned a high school diploma.	U.S. Census Bureau ACS Table S1501 5-Year Estimates, 2018-2022	2022
% Some College	Percentage of adults over age 25 who attended some college but did not earn their diploma.	U.S. Census Bureau ACS Table S1501 5-Year Estimates, 2018-2022	2022
% Associate's Degree	Percentage of adults over age 25 who earned an Associate's degree.	U.S. Census Bureau ACS Table S1501 5-Year Estimates, 2018-2022	2022
% Bachelor's Degree	Percentage of adults over age 25 who earned a four-year college Bachelor's degree.	U.S. Census Bureau ACS Table S1501 5-Year Estimates, 2018-2022	2022
% Graduate/ Professional Degree	Percentage of adults over age 25 who earned a graduate or professional degree.	U.S. Census Bureau ACS Table S1501 5-Year Estimates, 2018-2022	2022

Table A2.6: Employment and Income

Measure	Description	Data Source	Most Recent Data Year(s)
Unemployment Rate (ages 16+)	Numerator = Total number of people in the civilian labor force, ages 16 and older, who are unemployed but seeking work. Unemployed persons are defined as persons who had no employment during	U.S. Census Bureau ACS Table S2301 5-Year Estimates, 2018-2022	2022

	the reference week, were available for work, except for temporary illness, and had made specific efforts to find employment some time during the 4-week period ending with the reference week. Persons who were waiting to be recalled to a job from which they had been laid off need not have been looking for work to be classified as unemployed. Denominator =Total number of people in the civilian labor force, ages 16 and older. The civilian labor force includes all persons in the civilian noninstitutional population classified as either employed or unemployed. Employed persons are all persons who, during the reference week (the week including the 12th day of the month), (a) did any work as paid employees, worked in their own business or profession or on their own farm, or worked 15 hours or more as unpaid workers in an enterprise operated by a member of their family, or (b) were not working but who had jobs from which they were temporarily absent because of vacation, illness, bad weather, childcare problems, maternity or paternity leave, labor-management dispute, job training, or other family or personal reasons, whether or not they were paid for the time off or were seeking other jobs. Each employed person is counted only once,	

	even if he or she holds more than one job.		
Children in Poverty	Numerator = Number of people under age 18 living in a household whose income is below the poverty level. Poverty status is defined by family; either everyone in the family is in poverty or no one in the family is in poverty. The characteristics of the family used to determine the poverty threshold are: number of people, number of related children under 18, and whether or not the primary householder is over age 65. Family income is then compared to the poverty threshold; if that family's income is below that threshold, the family is in poverty. Denominator = Total number of people under age 18 in a county.	ACS, 5-year estimates RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2018-2022
Hourly Living Wage	The Living Wage methodology includes household composition, varies geographically, and is based on market-driven costs for each element of the basic needs budget; savings and leisure expenditures are not included in the Living Wage. Basic household expenses include the cost of food (USDA low-cost food plan), childcare, health care (insurance premiums and out of pocket costs), housing, transportation, other necessities (clothing, personal care items), civic engagement, broadband service, and cell phone	The Living Wage Institute RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2023

	service.1 This contrasts with the official federal poverty thresholds which are based on a multiple of the most basic food budget (USDA lowest cost, thrifty food plan) for a household and do not vary geographically (they are the same for all states and D.C.). The Living Wage reflects an hourly wage.		
Minimum Wage	The lowest wage that a worker may be paid per hour.	U.S. Department of Labor. Data accessed September 2024.	2024
Median Household Income	Income where half of households in a county earn more and half of households earn less. Income, defined as "Total income", is the sum of the amounts reported separately for: wage or salary income; net self-employment income; interest, dividends, or net rental or royalty income or income from estates and trusts; Social Security or Railroad Retirement income; Supplemental Security Income (SSI); public assistance or welfare payments; retirement, survivor, or disability pensions; and all other income. Receipts from the following sources are not included as income: capital gains; money received from the sale of property (unless the recipient was engaged in the business of selling such property); the value of income "in kind" from food stamps, public housing subsidies, medical care, employer contributions for individuals, etc.; withdrawal	U.S. Census Bureau ACS Table S1901 5-Year Estimates, 2018-2022.	2018-2022

	of bank deposits; money borrowed; tax refunds; exchange of money between relatives living in the same household; gifts and lump-sum inheritances, insurance payments, and other types of lump-sum receipts.		
Income Inequality Ratio	Income Inequality is the ratio of household income at the 80th percentile to that at the 20th percentile Numerator = 80th percentile of median household income in a county. Income, defined as "total income," is the sum of the amounts reported separately for wage or salary income; net self-employment income; interest, dividends, or net rental or royalty income or income from estates and trusts; Social Security or Railroad Retirement income; Supplemental Security Income (SSI); public assistance or welfare payments; retirement, survivor, or disability pensions; and all other income. Receipts from the following sources are not included as income: capital gains, money received from the sale of property (unless the recipient was engaged in the business of selling such property); the value of income "in kind" from food stamps, public housing subsidies, medical care, employer contributions for individuals, etc.; withdrawal of bank deposits; money borrowed; tax refunds;	ACS, 5-year estimates RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2018-2022

	exchange of money between relatives living in the same household; gifts and lump-sum inheritances, insurance payments, and other types of lump-sum receipts. Denominator = 20th percentile of median household income by county.		
Percentage of Population Living in Poverty	Number of people living below poverty level as percent of total population.	U.S. Census Bureau, ACS Table S1701 5-Year Estimates, 2018-2022	2018-2022
Children in Poverty	Numerator = Number of people under age 18 living in a household whose income is below the poverty level. Poverty status is defined by family; either everyone in the family is in poverty or no one in the family is in poverty. The characteristics of the family used to determine the poverty threshold are: number of people, number of related children under 18, and whether or not the primary householder is over age 65. Family income is then compared to the poverty threshold; if that family's income is below that threshold, the family is in poverty. Denominator = Total number of people under age 18 in a county.	ACS, 5-year estimates RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2018-2022

Table A2.7: Environmental Quality

Measure	Description	Data Source	Most Recent Data Year(s)
Air Pollution	Air Pollution - Particulate Matter is a measure of the fine particulate matter in the		2019

	air. It is reported as the average daily density of fine particulate matter in micrograms per cubic meter. Fine particulate matter is defined as particles of air pollutants with an aerodynamic diameter less than 2.5 micrometers (PM2.5).	Environmental Public Health Tracking Network RWJF & UWPHI, County Health Rankings. Accessed September 2024.	
Presence of Water Violation	Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.	Safe Drinking Water Information System RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2022

Table A2.8: Family, Community, and Social Support

Measure	Description	Data Source	Most Recent Data Year(s)
Percentage of children that live in single-parent household	Children in Single-Parent Households is the percentage of children (under 18 years of age) living in family households that are headed by a single parent. Numerator = Number of children in family households where the household is headed by a single parent (male or female head of household with no spouse present). Denominator = Number of children living in family households in a county. Foster children and children living in non-family households or group quarters are not included in either the numerator or denominator.	RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2018-2022

Social Associations **(membership associations per 10,000 population)**	Social Associations measures the number of membership associations per 10,000 population. Rates measure the number of events in a given time period divided by the average number of people at risk during that period. Rates help us compare health data across counties with different population sizes. Numerator = The numerator is the total number of membership associations in a county. The membership organizations (NAICS code) in this measure include civic organizations (813410), bowling centers (713950), golf clubs (713910), fitness centers (713940), sports organizations (711211), religious organizations (813110), political organizations (813940), labor organizations (813930), business organizations (813910), and professional organizations (813920). Denominator = Total resident population of county.	County Business Patterns RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2021
Disconnected Youth	Numerator = Number of people, ages 16-19, who are neither working nor in school. Denominator = Total county population, ages 16-19	ACS, 5-year estimates RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2018-2022
Residential Segregation - Black/White	Racial/ethnic residential segregation refers to the degree to which two or more groups live separately from one another in a geographic area. The index of dissimilarity is a demographic measure of the evenness with	ACS, 5-year estimates RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2018-2022

	which two groups (Black and white residents, in this case) are distributed across the component geographic areas (census tracts, in this case) that make up a larger area (counties, in this case). The residential segregation index ranges from 0 (complete integration) to 100 (complete segregation). The index score can be interpreted as the percentage of either Black or white residents that would have to move to different geographic areas in order to produce a distribution that matches that of the larger area.		
Percentage not proficient in English	Percentage of population that is not proficient in English.	ACS, 5-year estimates RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2018-2022
Childcare Cost Burden	Child Care Cost Burden is the cost of child care for a household with two children as a percent of median household income. Numerator = Child care cost data provided by the Living Wage Institute Denominator = Median household income data calculated from the Small Area Income and Poverty Estimates.	The Living Wage Institute; Small Area Income and Poverty Estimates RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2022 & 2023
Childcare Centers	Child Care Centers measures the number of child care centers per 1,000 population under age 5.	Homeland Infrastructure Foundation-Level Data (HIFLD)	2010-2022

	Numerator = Total number of child care centers in a county. The data include center-based child daycare locations (including those located at school and religious institutes) and does not include group, home, or family-based child care. Denominator = Total resident population under 5 years old in a county.	RWJF & UWPHI, County Health Rankings. Accessed September 2024.	

Table A2.9: Food Security

Measure	Description	Data Source	Most Recent Data Year(s)
Food Insecurity	Food Insecurity estimates the percentage of the population who did not have access to a reliable source of food during the past year. Numerator = Population with a lack of access, at times, to enough food for an active, healthy life or with uncertain availability of nutritionally adequate foods. Denominator = Total county population.	Map the Meal Gap RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2021
Limited access to healthy foods	Limited Access to Healthy Foods measures the percentage of the population that is low income and does not live close to a grocery store. Numerator = Number of people who are low income and do not live close to a grocery store. Living close to a grocery store is defined differently in rural and nonrural areas; in rural areas, it means living less than 10	USDA Food Environment Atlas RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2019

	miles from a grocery store; in nonrural areas, less than one mile. Low income is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size. Denominator = 2010 U.S. Census Population		
Children eligible for free or reduced-price lunch	Children Eligible for Free or Reduced Price Lunch is the percentage of children enrolled in public schools that are eligible for free or reduced price lunch. Numerator = Number of public school students, grades PK-12, eligible for free or reduced price lunch. Children eligible for free lunch live in a family with income less than 130% of the federal poverty level or who are directly certified, while children eligible for reduced price lunch live in a family with income less than 185% of the federal poverty level. Students are directly certified to receive free meals if they belong to a household receiving selected federal benefits or are migrant, homeless, in foster care, or in Head Start. Denominator = Total number of students enrolled in public schools, grades PK-12	RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2021-2022
Households receiving food stamps /SNAP	Percent of households receiving food stamps /SNAP	U.S. Census Bureau ACS Table S2201 5-Year Estimates, 2018-2022	2018-2022

Table A2.10: Housing and Homelessness

Measure	Description	Data Source	Most Recent Data Year(s)
Severe Housing Problems	Numerator = Number of households with 1 of 4 housing problems: lack of kitchen facilities, lack of plumbing facilities, overcrowding, or high housing costs. Incomplete kitchen facilities is defined as a unit which lacks a sink with running water, a stove or range, or a refrigerator. Incomplete plumbing facilities is defined as lacking hot and cold piped water, a flush toilet, or a bathtub/shower. Overcrowding is defined as more than one person per room. Severe cost burden is defined as monthly housing costs (including utilities) that exceed 50% of monthly income. Denominator = Total number of households in county	Comprehensive Housing Affordability Strategy (CHAS) data RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2016-2020
Homeownership	Homeownership is the percentage of occupied housing units that are owned. Numerator = Total number of owner-occupied housing units in a county. Denominator = Total occupied housing units in a county.	U.S. Census Bureau ACS Table H10 Decennial Census, 2020.	2020
Severe Housing Cost Burden	Severe Housing Cost Burden is the percentage of households that spend 50% or more of their household income on housing. Numerator = Total number of households in a county that spend 50% or more of their	ACS, 5-year estimates RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2018-2022

	household income on housing. Denominator = Total occupied housing units for which housing cost burden is computed in a county.		
Affordable Housing	This indicator shows the percentage of housing units sold that are affordable on the median teacher's salary.	MDH SHIP. Data accessed September 2024.	2020
Share of Population Precariously Housed	Percent of population without permanent housing.	Root Policy Research from the 2023 Delaware Snowball Survey.	2023
People homeless on a given night	Number of people experiencing homelessness on a given night.	National Alliance to End Homelessness.	2023
Homeless per 100,000 in the general population	Rate of population experiencing homelessness.	National Alliance to End Homelessness.	2023

Table A2.11: Length of Life

Measure	Description	Data Source	Most Recent Data Year(s)
Premature Death **(years of potential life lost before age 75 per 100,000 population age-adjusted)**	Premature Age-Adjusted Mortality measures the number of deaths among residents under the age of 75 per 100,000 population. Rates measure the number of events (e.g., deaths, births) in a given time period divided by the average number of people at risk during that period. Numerator = Number of total deaths under the age of 75 Denominator = Total population under the age of 75	National Center for Health Statistics (NCHS) RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2019-2021
Premature Age-Adjusted Mortality	All the years of potential life lost in a county during a 3-	NCHS	2019-2021

(number of deaths among residents under age 75 per 100,000 population, age-adjusted)	year period are summed and divided by the total population of the county during that same time period. This value is then multiplied by 100,000 to calculate the years of potential life lost under age 75 per 100,000 people. Numerator = Cumulative number of years of potential life lost from deaths among county residents under age 75, over a three-year period Denominator = Aggregate population under age 75 for the three-year period	RWJF & UWPHI, County Health Rankings. Accessed September 2024.	
Life Expectancy	Life Expectancy measures the average number of years from birth people are expected to live, according to the current mortality experience (age-specific death rates) of the population. Life Expectancy calculations are based on the number of deaths in a given time period and the average number of people at risk of dying during that period.	NCHS RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2019-2021

Table A2.12: Maternal and Infant Health

Measure	Description	Data Source	Most Recent Data Year(s)
Low Birthweight (< 2500 grams)	Percentage of live births where the infant weighed less than 2,500 grams (approximately 5 lbs., 8 oz.). Numerator = Number of live births for which the infant weighed less than 2,500 grams (approximately 5 lbs., 8 oz.) over seven years.	NCHS RWJF & UWPHI, County Health Rankings. Accessed October 2024.	2016-2022

	Denominator = Total number of live births for which weight was recorded over seven years.		
Infant Mortality	Number of all infant deaths (within 1 year), per 1,000 live births. Numerator = Cumulative number of deaths occurring before one year of age. Denominator = Total number of live births.	NCHS RWJF & UWPHI, County Health Rankings. Accessed October 2024.	2015-2021
Child Mortality	Number of deaths occurring before age 20 per 100,000 population. Numerator = Number of deaths occurring before the age of 20. Denominator = Total population under the age of 20.	NCHS RWJF & UWPHI, County Health Rankings. Accessed October 2024.	2018-2021

Table A2.13: Mental Health

Measure	Description	Data Source	Most Recent Data Year(s)
Average Number of Mentally Unhealthy Days	Poor Mental Health Days is the average number of mentally unhealthy days reported in the past 30 days. Numerator = Number of days respondents reported to the question "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" Denominator = Total number of adult respondents in a county.	BRFSS RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2021

Frequent Mental Distress	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted). Numerator = Number of adults who reported 14 or more days in response to the question, "Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" Denominator = Total number of adult respondents in a county.	BRFSS RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2021
Mental Health ED Visit Rate	This indicator shows the rate of emergency department visits related to mental health disorders (per 100,000 population).	MDH SHIP. Data accessed September 2024.	2017
Suicide Rate	Number of deaths due to suicide per 100,000 population (age-adjusted). Numerator = Number of deaths in a county over the 5-year period due to suicide as defined by ICD-10 codes X60-X84 (self-harm). Denominator = Aggregate county population over the 5 year period.	NCHS RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2017-2021
% Visited Mental Health Provider	Percent of adults who saw a psychologist or psychiatrist in the past 12 months.	ESRI Business Analyst. Data accessed September 2024.	2024
% Used Prescription Antidepressant Medications	Percent of adults who were prescribed and used antidepressant medications in the last 12 months.	ESRI Business Analyst. Data accessed September 2024.	2024
% Used Prescription Antianxiety Medications	Percent of adults who were prescribed and used	ESRI Business Analyst. Data	2024

	antianxiety medications in the last 12 months.	accessed September 2024.	
Adults ever diagnosed with depression	Percent of adults reporting that a health professional has told them that they have a depressive disorder.	ESRI Business Analyst. Data accessed September 2024.	2024

Table A2.14: Physical Health

Measure	Description	Data Source	Most Recent Data Year(s)
Poor to Fair Health	Poor or Fair Health is the percentage of adults in a county who consider themselves to be in poor or fair health. Numerator = Number of respondents who answered "Would you say that in general your health is Excellent/Very good/Good/Fair/Poor?" with fair or poor. Denominator = Total number of adult respondents in a county.	BRFSS RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2021
Poor Physical Health Days per Month	Poor Physical Health Days measures the average number of physically unhealthy days reported in the past 30 days. Numerator = Average number of days reported by respondents to the question "Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?" Denominator = Total number of adult respondents in a county.	BRFSS RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2021

Adult Obesity (BMI >= 30)	Adult Obesity is based on responses to Behavioral Risk Factor Surveillance System (BRFSS) surveys and is the percentage of the adult population (ages 18 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2. Participants are asked to self-report their height and weight; BMIs are calculated from these reported values. Numerator= Number of adult respondents age 18 and older with a BMI greater than or equal to 30kg/m2. Denominator = Number of adult respondents age 18 and older	Maryland BRFSS. Data accessed July 2024.	2022
Frequent Physical Distress	Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted). Numerator = Number of adults who reported 14 or more days in response to the question, “Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?” Denominator = Total number of adult respondents in a county	BRFSS RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2021
Adult Diabetes Prevalence	Numerator = Number of adults 18 years and older who responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Both Type 1 and Type 2 diabetes diagnoses are included. Women who	Maryland BRFSS. Data accessed July 2024.	2022

	indicated that they only had diabetes during pregnancy were not considered to have diabetes. Denominator = Total number of respondents (age 18 and older) in a county.		
Insufficient Sleep	Percentage of adults who report fewer than 7 hours of sleep on average. Numerator = Number of adults who responded to the following question by stating they sleep less than 7 hours per night: "On average, how many hours of sleep do you get in a 24-hour period?" Denominator = Total number of adult respondents in a county.	BRFSS RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2020
Adolescent Obesity	This indicator shows the percentage of adolescent public high school students who are obese.	Maryland Youth Risk Behavior Survey. Data accessed July 2024.	2021-2022
Sudden Unexpected Infant Death Rate	This indicator shows the rate of sudden unexpected infant deaths (SUIDs) per 1,000 live births. Sudden unexpected infant deaths (SUIDs) include deaths from Sudden Infant Death Syndrome (SIDS), unknown cause, accidental suffocation and strangulation in bed.	MDH SHIP. Data accessed September 2024.	2017-2021
Adults who are NOT Overweight or Obese	This indicator shows the percentage of adults who are not overweight or obese.	MDH SHIP. Data accessed September 2024.	2021
Cancer Mortality Rate	This indicator shows the age-adjusted mortality rate from cancer (per 100,000 population).	MDH SHIP. Data accessed September 2024.	2019-2021
Age-Adjusted Mortality Rate from Heart Disease	This indicator shows the age-adjusted mortality rate from heart disease (per 100,000 population).	MDH SHIP. Data accessed September 2024.	2019-2021

Ischemic Heart Disease Prevalence (Medicare Population)	This indicator reports the hospitalization rate for Ischemic stroke among Medicare beneficiaries age 65 and older for hospital stays	Centers for Medicare and Medicaid Services	2018-2021
Hypertension Prevalence (Medicare Population)	This indicator reports the unsmoothed age-adjusted rate of hypertension prevalence for Medicare FFS population in 2022. Data were obtained from the CMS Mapping Medicare Disparities tool.	Centers for Medicare and Medicaid Services	2022

Table A2.15: Quality of Care

Measure	Description	Data Source	Most Recent Data Year(s)
Preventable Hospital Stays (Medicare)	Preventable Hospital Stays measures the number of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. Rates measure the number of events (e.g., deaths, births) in a given time period divided by the average number of people at risk during that period. Numerator = Number of discharges for Medicare beneficiaries ages 18 years or older continuously enrolled in Medicare fee-for-service Part A and hospitalized for any of the following reasons: diabetes with short or long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure,	Mapping Medicare Disparities Tool (MMDT) RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2021

	dehydration, bacterial pneumonia, or urinary tract infection. Denominator = Number of Medicare beneficiaries ages 18 years or older continuously enrolled in Medicare fee-for-service Part A. Individuals enrolled in Medicare Advantage at any point during the year are excluded. In addition, beneficiaries who died during the year, but otherwise were continuously enrolled up until the date of death, as well as beneficiaries who became eligible for enrollment following the first of the year, but were continuously enrolled from that date to the end of the year, are included in the denominator.		
Mammography Screening (Medicare)	Mammography Screening is the percentage of female fee-for-service (FFS) Medicare enrollees, ages 65-74, who received an annual mammogram. Numerator = Number of women ages 65-74 enrolled in Medicare Part B for at least one month of the selected year who have had a mammogram in the last year (Current Procedural Terminology/Healthcare Common Procedure Coding System codes: 77052, 77057, 77063, G0202). Denominator = Number of female Medicare beneficiaries ages 65-74 enrolled in Medicare Part B for at least one month of the selected year. Individuals enrolled in	MMDT RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2021

	Medicare Advantage at any point during the year are excluded.		
Flu Vaccinations (Medicare)	Flu Vaccinations is the percentage of fee-for-service Medicare enrollees who had a reimbursed flu vaccination during the year. Numerator = This numerator is the number of Medicare beneficiaries enrolled in fee-for-service Medicare Part B for at least one month of the selected year and who have received a covered influenza vaccine in the last year (Current Procedural Terminology/Healthcare Common Procedure Coding System codes: 90630, 90653-90657, 90660-90662, 90672-90674, 90685-90688, Q2035-Q2039, G0008). Denominator = The denominator is the number of Medicare beneficiaries enrolled in fee-for-service Medicare Part B for at least one month of the selected year. Individuals enrolled in Medicare Advantage at any point during the year are excluded.	MMDT RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2021
Children receiving blood lead screening	This indicator reflects the percentage of children (aged 12-35 months) enrolled in Medicaid (90+ days) screened for lead in their blood.	MDH SHIP. Data accessed September 2024.	2021
Children with elevated blood lead levels	Number of children (0-72 months old) with blood lead levels > 10 µg/dL divided by the Total Number of Children (0-72 months old) tested.	MDH SHIP. Data accessed September 2024.	2020

Table A2.16: Safety

Measure	Description	Data Source	Most Recent Data Year(s)
Injury Mortality Rate	Injury Deaths is the number of deaths that result from injuries per 100,000 people. This measure includes injuries from intentional causes (such as homicide or suicide) and unintentional causes (such as motor vehicle accidents). Rates measure the number of events (e.g., deaths, births) in a specific time period divided by the average number of people at risk during that period. Numerator = Number of deaths with an underlying cause of injury (ICD-10 codes *U01-*U03, V01-Y36, Y85-Y87, Y89) during the five-year period. Denominator = Aggregate annual population for the five year period.	NCHS RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2017-2021
Motor Vehicle Crash Death Rate	Motor Vehicle Crash Deaths is the number of deaths due to traffic accidents involving a motor vehicle per 100,000 population Numerator = includes traffic accidents involving motorcycles, 3-wheel motor vehicles, cars, vans, trucks, buses, street cars, ATVs, industrial, agricultural, and construction vehicles, and bicyclists or pedestrians when colliding with any of these vehicles, over a seven-year period (ICD10 codes: V02-V04 (.1, .9), V09.2, V12-V14 (.3-.9), V19 (.4-.6), V20-V28 (.3-	NCHS RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2015-2021

	.9), V29-V79 (.4-.9), V80 (.3-.5), V81.1, V82.1, V83-V86 (.0-.3), V87 (.0-.8), and V89.2). Deaths due to boating accidents and airline crashes are not included in the numerator. Denominator = Aggregate annual population over the seven-year period.		
Homicide Rate	Homicides is the number of deaths from assaults per 100,000 population. Numerator = Number of deaths in a county over the 7-year period due to homicide as defined by ICD-10 codes X85-Y09 (assault). Denominator = Aggregate annual population over the seven-year period.	NCHS RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2015-2021
Firearm Fatality Rate	Firearm Fatalities is the number of deaths due to firearms in a county per 100,000 population. Numerator = number of deaths in a county over the 5-year period due to firearms as defined by ICD-10 codes W32-W34, X72-X74, X93-X95, Y22-Y24, and Y35.0. Denominator = Aggregate annual population over the 5 year period. .	NCHS RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2017-2021
Juvenile Arrests	Numerator = Number of delinquency cases formally processed in juvenile court (petitioned) and the number of delinquency cases informally handled (non-petitioned) for individuals ages 0 to the upper age of jurisdiction for a juvenile court. Non-petitioned cases	Easy Access to State and County Juvenile Court Case Counts RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2021

	often result in dismissal or informal sanctions such as fines, community service, informal probation, or referral to a social services agency. Petitioned cases could also be dismissed, but the accused juvenile offender still has their case processed by a juvenile court judge before determining their decision. The upper age in which a juvenile court has jurisdiction is 17. It is important to note that the numerator is cases and not offenders as a juvenile could have multiple delinquency violations. Denominator = Population ages 10 to the upper age of jurisdiction. The upper age is 17. The population value is rounded to the nearest 100. The age range of 10 to upper age is used because 99.4% of all juvenile arrests occur among those who are 10 and older.		

Table A2.17: Sexual Health

Measure	Description	Data Source	Most Recent Data Year(s)
Sexually Transmitted Infections (Chlamydia Rate)	Numerator = Number of reported chlamydia cases in a county Denominator = Total county population	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2021

Teen (Ages 15-19) Birth Rate	Teen Births is the number of births to females ages 15-19 per 1,000 females in a county. Numerator = Total number of births to mothers ages 15-19 in the 7-year time period Denominator = Aggregate female population, ages 15-19, over the 7-year time period	NCHS RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2016-2022
HIV Prevalence	HIV Prevalence is the rate of diagnosed cases of HIV for people aged 13 years and older in a county per 100,000 population. Rates measure the number of events in a given time period divided by the average number of people at risk during that period. Numerator = Number of diagnosed cases of HIV for people aged 13 years and older. HIV is a reportable disease meaning that when a provider treats a patient for HIV they are required to report that case to their health department. Denominator = Total population aged 13 years and older.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2021
HIV Incidence Rate	This indicator shows the rate of adult/adolescent cases (age 13+) diagnosed with HIV (per 100,000 population).	MDH SHIP. Data accessed September 2024.	2021

Table A2.18: Substance Use Disorders

Measure	Description	Data Source	Most Recent Data Year(s)
Excessive Drinking	Excessive Drinking is the percentage of adults that	BRFSS	2021

	report binge or heavy drinking in the past 30 days. Numerator = Number of adult respondents reporting either binge drinking or heavy drinking. Binge drinking is defined as a woman consuming more than four alcoholic drinks during a single occasion or a man consuming more than five alcoholic drinks during a single occasion. Heavy drinking is defined as a woman drinking more than one drink on average per day or a man drinking more than two drinks on average per day. Denominator = Total number of adult respondents in a county.	RWJF & UWPHI, County Health Rankings. Accessed September 2024.	
Alcohol-Impaired Driving Deaths	Alcohol-Impaired Driving Deaths is the percentage of motor vehicle crash deaths with alcohol involvement. Numerator = Total number of alcohol-impaired motor vehicle crash deaths in the 5-year period. The National Highway Traffic Safety Administration classifies a fatal crash as alcohol-related or alcohol-involved if either a driver or a non-motorist (usually a pedestrian or bicyclist) had a measured or estimated blood alcohol concentration of 0.01 grams per deciliter or above. Denominator = Total number of motor vehicle crash deaths in the 5-year period.	Fatality Analysis Reporting System RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2017-2021
Drug Overdose Death Rate	Rates measure the number of events (e.g., deaths, births) in	NCHS	2019-2021

	a given time period divided by the average number of people at risk during that period. Rates help us compare health data across counties with different population sizes. Drug Overdose Deaths is the number of deaths due to drug poisoning per 100,000 population. Numerator = Deaths from accidental, intentional, and undetermined drug poisoning by and exposure to: 1) nonopioid analgesics, antipyretics and antirheumatics, 2) antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, 3) narcotics and psychodysleptics (hallucinogens), not elsewhere classified, 4) other drugs acting on the autonomic nervous system, and 5) other and unspecified drugs, medicaments and biological substances, over a 3-year period. ICD-10 codes used include X40-X44, X60-X64, X85, and Y10-Y14. Denominator = Aggregate annual population over the 3 year period	RWJF & UWPHI, County Health Rankings. Accessed September 2024.	
Opioid Prescription Dispensing Rate	Opioid prescriptions dispensed (per 100 persons).	Center for Disease Control and Prevention. Data accessed September 2024.	2022

Table A2.19: Tobacco Use

Measure	Description	Data Source	Most Recent

			Data Year(s)
Adult Smoking	Adult Smoking is the percentage of the adult population in a county who both report that they currently smoke every day or some days and have smoked at least 100 cigarettes in their lifetime. Numerator = The numerator is the number of adult respondents who reported "Yes" to the following question: Have you smoked at least 100 cigarettes in your entire life? and "Every day or some days" to the question: Do you now smoke cigarettes every day, some days, or not at all? Denominator = Total number of adult respondents in county	BRFSS RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2021
Adolescent Tobacco Use	This indicator shows the percentage of adolescents (public high school students) who used any tobacco product in the last 30 days.	MDH SHIP. Data accessed September 2024.	2021

Table A2.20: Transportation Options and Transit

Measure	Description	Data Source	Most Recent Data Year(s)
Driving Alone to Work	Numerator = Number of workers who commute alone to work via car, truck, or van. Denominator = Total workforce.	ACS, 5-year estimates RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2018-2022
Long Commute/Driving Alone	Numerator = Number of workers who drive alone (via car, truck, or van) for more	ACS, 5-year estimates	2018-2022

	than 30 minutes during their commute. Denominator = Number of workers who drive alone (via car, truck, or van) during their commute.	RWJF & UWPHI, County Health Rankings. Accessed September 2024.	
Traffic Volume	Traffic Volume at the county level is calculated with EJScreen data by aggregating all the census block data within a county, and weighting by the number of people in the corresponding blocks. The measure is reported as the average count of vehicles per meter per day within 500 meters of a census block centroid (the center point of a census block), divided by distance in meters, presented as the population-weighted average of blocks in each county. The closest traffic is given more weight through inverse distance weighting. A highway with 16,000 Annual Average Daily Traffic (AADT) at 400 meters distance would result in a score of 16,000/400=40. Numerator = Average count of vehicles per meter per day within 500 meters of a census block centroid (the center point of a census block). Denominator = Includes all interstate, principal arterial, other National Highway System, and HPMS sample section roads.	EJSCREEN: Environmental Justice Screening and Mapping Tool RWJF & UWPHI, County Health Rankings. Accessed September 2024.	2023

Appendix 3 | Secondary Data Comparisons

Description of Focus Area Comparisons

When viewing the secondary data summary tables, please note that the following color shadings have been included to identify how Delmarva Region County compares to Maryland and the national benchmark. If both statewide Maryland and national data was available, Maryland data was preferentially used as the target/benchmark value.

Secondary Data Summary Table Color Comparisons

Color Shading	Priority Level	Delmarva Region Description
	Low	Represents measures in which Delmarva County scores are **more than five percent better** than the most applicable target/benchmark and for which a low priority level was assigned.
	Medium	Represents measures in which Delmarva County scores are comparable to the most applicable target/benchmark scoring **within or equal to five percent**, and for which a medium priority level was assigned.
	High	Represents measures in which Delmarva County scores are **more than five percent worse** than the most applicable target/benchmark and for which a high priority level was assigned.

Note: Please see the methodology section of this report for more information on assigning need levels to the secondary data.

Please note that to categorize each metric in this manner and identify the priority level, the Delmarva County value was compared to the benchmark by calculating the percentage difference between the values, relative to the benchmark value:

(Delmarva County Value – Benchmark Value)/(Benchmark) x 100 = % Difference Used to Identify Priority Level

For example, for the % Limited Access to Healthy Foods metric for Somerset County, the following calculation was completed:

(5.5-3.6)/(3.6) x 100% = 34.2% = Displayed as **High Priority Level**, Shaded in Red

This metric indicates that the percentage of the population with limited access to healthy foods in Somerset County is 34.2 percent worse (or, in this case, higher) than the percentage of the population with limited access to healthy foods in the state of Maryland.

Detailed Focus Area Benchmarks – Somerset County, Maryland

Table A3.1: Access To Care

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
% Uninsured	10.0%	6.9%	6.7%	2022	Medium
% Uninsured Adults	N/A	8.1%	8.0%	2022	Medium
% Uninsured Children	N/A	4.1%	3.5%	2022	Low
Primary Care Physicians Ratio	1330	1179	2732	2021	High
Dentist Ratio	1360	1238	455	2022	Low
Mental Health Provider Ratio	320	292	303	2023	Medium
Children Receiving Dental Care (ages 0 to 20)	N/A	56.3%	52.20%	2021	High
ED Visit Rate for Addiction Related Conditions	N/A	2017	1538.3	2017	Low
Uninsured ED Visits %	N/A	8.6%	6.40%	2017	Low
ED Visits rate due to hypertension	N/A	351.2	460.4	2017	High
ED Visit Rate for Dental Care	N/A	362.7	982.2	2017	High
ED Visit Rate for Diabetes	N/A	243.7	381	2017	High
ED Visit Rate For Asthma	N/A	68.4	122.9	2017	High
Children Receiving Blood Level Screenings	N/A	67.1%	69.7%	2021	Medium
Child Elevated Blood Lead Levels	N/A	0.2%	0%	2020	Low
Persons with a Usual PCP %	N/A	87.3%	91.30%	2021	Medium

Table A3.2: Built Environment

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
Food Environment Index	7.7	8.8	7.4	2019-2021	High
% Households with Broadband Access	88.0%	90.6%	80.9%	2018-2022	High
HH with Computer %	84.0%	86.3%	79.88%	2024	High

Table A3.3: Diet and Exercise

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
% Physically Inactive	23.0%	21.2%	28.8%	2021	High
Physical Activity	N/A	52.2%	41.20%	2019	High

% With Access to Exercise Opportunities	84.0%	91.9%	9.8%	2020-2023	High

Table A3.4: Education

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
Segregation Index	0.24	0.26	0.06	2022-2023	Low
School Funding Adequacy	$634	($1,854)	($3,486)	2021	High

Table A3.5: Employment and Income

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
% Unemployed	3.7%	3.2%	4.78%	2022	High
% Population Living in Poverty	12.4%	9.4%	20.97%	2018-2022	High
% Children in Poverty	16.0%	12.1%	27.9%	2018-2022	High
ALICE Households	29%	29%	33.17%	2022	High
Income Inequality Ratio	4.9	4.6	5.3	2018-2022	High
Gender Pay Gap	0.81	0.86	0.83	2018-2022	Medium
Living Wage (1 adult with 2 children)	N/A	$52.88	$40.98	2023	Low
Median Household Income	$75,149	$100,479	$48,810.00	2024	High

Table A3.6: Environmental Quality

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
Average Daily PM2.5	7.4	7.4	7	2019	Low
Presence of Water Violation	N/A	No	No	2022	Low

Table A3.7: Family, Community, and Social Support

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
% Children in Single-Parent Households	25.0%	25.7%	29.4%	2018-2022	High
% Household Income Required for Child Care Expenses	27.0%	23.5%	30.2%	2021	High
Child Care Centers per 1,000 Children	7	6.2	8.0	2018-2022	Low
Social Association Rate	9.1	8.8	11.4	2018-2022	Low
% Not Proficient in English	N/A	3.4%	1.3%	2022/2023	Low
Residential Segregation - Black/White Index	63.0	63.2	40.0	2010-2022	Low

Table A3.8: Food Security

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
% Food Insecure	10.0%	9.7%	13.8%	2021	High
% Limited Access to Healthy Foods	6.0%	3.6%	5.5%	2019	High
% Enrolled in Free or Reduced Lunch	51.0%	41.9%	57.3%	2021-2022	High
Households Receiving Food Stamp/SNAP	11.50%	10.8%	25.7%	2018-2022	High

Table A3.9: Housing and Homelessness

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
% Severe Housing Problems	17.0%	15.5%	20.0%	2016-2021	High
% Homeowners	65.0%	67.5%	67.5%	2020	Medium
% Households with Severe Cost Burden	14.0%	14.1%	17.5%	2018-2022	High
Affordable Housing %	N/A	56.7%	90.10%	2020	Low

Table A3.10: Length of Life

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
Years of Potential Life Lost Rate	8,000	7,921	9,849	2019-2021	High
Premature Deaths	390	375	450	2019-2021	High
Life Expectancy	77.6	78	74.7	2019-2021	Medium

Table A3.11: Maternal and Infant Health

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
Child Mortality Rate	50.0	50.3	44.8	2018-2021	Low
Infant Mortality Rate	6.0	6.2	14.1	2015-2021	High
% Low Birthweight	8.0%	8.7%	11.0%	2016-2022	High

Table A3.12: Mental Health

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
Adults ever diagnosed with depression	20.7%	18.1%	21.4%	2022	High
Suicide Rate (Age-Adjusted)	14	9.9	11.7	2017-2021	High
Average Number of Mentally Unhealthy Days	4.8	4.4	5.3	2020	High
% Frequent Mental Distress	15.0%	13.2%	18%	2021	High
% Visited Mental Health Provider	5.0%	5.1%	4.20%	2024	Low

% Used Prescription Antidepressants	7.7%	6.9%	8.92%	2024	High
% Used Antianxiety Medications	8.4%	7.7%	9.53%	2024	High
Mental Health ED Visit Rate	N/A	4291.5	2696.1	2017	Low

Table A3.13: Physical Health

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
% Poor to Fair Health	14.0%	13.1%	20.4%	2021	High
Average Number of Physically Unhealthy Days	3.3	2.8	4.1	2021	High
% Frequent Physical Distress	10.0%	7.9%	12.6%	2021	High
% Insufficient Sleep	33.0%	34.1%	38.7%	2020	High
% Adults with Diabetes	10.0%	9.8%	13.0%	2021	High
% Adults with Obesity	34.0%	34.2%	46.7%	2022	High
Age-Adjusted Death Rate from Heart Disease	N/A	165.7	284.3	2019-2021	High
Cancer Mortality Rate	N/A	142.5	176.5	2019-2021	High
Adults who are not obese %	N/A	31.8%	19.20%	2021	High
Alzheimer's/ Dementia Hospitalization Rate	N/A	515.5	365.5	2017	Low

Table A3.14: Quality of Care

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
% with Annual Mammogram	43.0%	43.0%	45%	2021	Medium
% Vaccinated	46.0%	51.0%	40%	2021	High
Preventable Hospitalization Rate	2681	2508	1460	2021	Low

Table A3.15: Safety

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
Injury Death Rate	80	91.8	89.6	2017-2021	Medium
Firearm Fatalities Rate	13	12.9	9.4	2017-2021	Low
Motor Vehicle Mortality Rate	12	9.3	14.0	2015-2021	High
Juvenile Arrest Rate	N/A	10.9	76.8	2021	High

Table A3.16: Sexual Health

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
HIV Incidence	N/A	15	9.3	2021	Low
HIV Prevalence Rate	382	643.4	496.2	2021	Low
Chlamydia Rate per 100,000	481.3	506.7	554.1	2022	High
Teen Birth Rate	17	13.3	15.4	2016-2022	High

Table A3.17: Substance Use

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
% Excessive Drinking	18.0%	15.2%	14.2%	2021	Low
% Driving Deaths with Alcohol Involvement	26.0%	29.4%	26.1%	2017-2021	Low
Drug Overdose Mortality Rate	27	43.1	48.9	2019-2021	High
Opioid Dispensing Rate	N/A	34.8	5.8	2022	Low

Table A3.18: Tobacco Use

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
% Adults Reporting Currently Smoking	15.0%	10.2%	20.6%	2021	High
Adolescents who use tobacco products	N/A	15.6%	21.40%	2021	High

Table A3.19: Transportation and Transit

Measure	National Benchmark	Maryland Benchmark	Somerset County Data	Most Recent Year of Data	Somerset County Need
% Drive Alone to Work	72.0%	68.2%	73.20%	2018-2022	High
% Long Commute - Drives Alone	36.0%	49.2%	37%	2018-2022	Low
Traffic Volume	108	163	22	2023	Low

Detailed Focus Area Benchmarks – Wicomico County, Maryland

Table A3.20: Access To Care

Measure	National Benchmark	Maryland Benchmark	Wicomico County Data	Most Recent Year of Data	Wicomico County Need
% Uninsured	10.0%	6.9%	8.7%	2022	High
% Uninsured Adults	N/A	8.1%	9.8%	2022	High
% Uninsured Children	N/A	4.1%	5.9%	2022	High
Primary Care Physicians Ratio	1330	1179	1552	2021	High
Dentist Ratio	1360	1238	1246	2022	Medium
Mental Health Provider Ratio	320	292	240	2023	Medium
Medicaid Children Receiving Dental Care within last year %	N/A	56.3%	54.60%	2021	Medium
ED Visit Rate for Addiction Related Conditions	N/A	2017	1643.3	2017	Low
Uninsured ED Visits %	N/A	8.6%	8.30%	2017	Medium
ED Visits rate due to hypertension	N/A	351.2	743.3	2017	High
ED Visit Rate for Dental Care	N/A	362.7	1346.1		High
ED Visit Rate for Diabetes	N/A	243.7	530.9	2017	High
ED Visit Rate For Asthma	N/A	68.4	102.9	2017	High
Children Receiving Blood Level Screenings	N/A	67.1%	63.40%	2017	High
Child Elevated Blood Lead Levels	N/A	0.2%	0.20%	2017	Medium
Persons with a Usual PCP %	N/A	87.3%	86%	2021	Medium

Table A3.21: Built Environment

Measure	National Benchmark	Maryland Benchmark	Wicomico County Data	Most Recent Year of Data	Wicomico County Need
Food Environment Index	7.7	8.8	7.3	2019-2021	High
% Households with Broadband Access	88.0%	90.6%	86.4%	2018-2022	Medium
HH with Computer %	84.0%	86.3%	82.19%	2024	Medium

Table A3.22: Diet and Exercise

Measure	National Benchmark	Maryland Benchmark	Wicomico County Data	Most Recent Year of Data	Wicomico County Need
% Physically Inactive	23.0%	21.2%	27%	2021	High
Increased Physical Activity	N/A	52.2%	50.70%	2019	Medium

% With Access to Exercise Opportunities	84.0%	91.9%	73.1%	2020-2023	High

Table A3.23: Education

Measure	National Benchmark	Maryland Benchmark	Wicomico County Data	Most Recent Year of Data	Wicomico County Need
Segregation Index	0.24	0.26	0.1	2022-2023	Low
School Funding Adequacy	$634	($1,854)	$723.24	2021	Low

Table A3.24: Environmental Quality

Measure	National Benchmark	Maryland Benchmark	Wicomico County Data	Most Recent Year of Data	Wicomico County Need
Average Daily PM2.5	7.4	7.4	7.4	2019	Medium
Presence of Water Violation	N/A	No	No	2022	Low

Table A3.25: Employment and Income

Measure	National Benchmark	Maryland Benchmark	Wicomico County Data	Most Recent Year of Data	Wicomico County Need
% Unemployed	3.7%	3.2%	3.8%	2022	High
% Population Living in Poverty	12.4%	9.4%	13.1%	2018-2022	High
% Children in Poverty	16.0%	12.1%	16.4%	2018-2022	High
ALICE Households	29%	29%	26.36%	2022	Low
Income Inequality Ratio	4.9	4.6	4.4	2018-2022	Medium
Gender Pay Gap	0.81	0.86	0.82	2018-2022	High
Living Wage (1 adult with 2 children)	N/A	$52.88	$42.36	2023	Low
Median Household Income	$75,149	$100,479	$65,969	2024	High

Table A3.26: Family, Community, and Social Support

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
% Children in Single-Parent Households	25.0%	25.7%	28.2%	2018-2022	High
% Household Income Required for Child Care Expenses	27.0%	23.5%	19.9%	2021	Low
Child Care Centers per 1,000 Children	7	6.2	6.16	2018-2022	Medium
Social Association Rate	9.1	8.8	16.37	2018-2022	Low
% Not Proficient in English		3.4%	1%	2022/2023	Low
Residential Segregation - Black/White Index	63.0	63.2	51.53	2010-2022	Low

Households Receiving Food Stamp/SNAP	11.50%	10.8%	10.5%	2018-2022	Medium

Table A3.27: Length of Life

Measure	National Benchmark	Maryland Benchmark	Wicomico County Data	Most Recent Year of Data	Wicomico County Need
Years of Potential Life Lost Rate	8,000	7,921	9908	2019-2021	High
Premature Deaths	390	375	1671	2019-2021	High
Life Expectancy	77.6	78	75.0	2019-2021	Medium

Table A3.28: Maternal and Infant Health

Measure	National Benchmark	Maryland Benchmark	Wicomico County Data	Most Recent Year of Data	Wicomico County Need
Child Mortality Rate	50.0	50.3	57.1	2018-2021	High
Infant Mortality Rate	6.0	6.2	8.7	2015-2021	High
% Low Birthweight	8.0%	8.7%	9.30%	2016-2022	High

Table A3.29: Mental Health

Measure	National Benchmark	Maryland Benchmark	Wicomico County Data	Most Recent Year of Data	Wicomico County Need
Adults every diagnosed with depression	20.7%	18.1%	23.70%	2022	High
Suicide Rate (Age-Adjusted)	14	9.9	11.8	2017-2021	High
Average Number of Mentally Unhealthy Days	4.8	4.4	5.6	2020	High
% Frequent Mental Distress	15.0%	13.2%	17.50%	2021	High
% Visited Mental Health Provider	5.0%	5.1%	5.18%	2024	N/A
% Used Prescription Antidepressants	7.7%	6.9%	8.42%	2024	N/A
% Used Antianxiety Medications	8.4%	7.7%	9.30%	2024	N/A
Mental Health ED Visit Rate	N/A	4291.5	2897.6	2017	Low

Table A3.30: Physical Health

Measure	National Benchmark	Maryland Benchmark	Wicomico County Data	Most Recent Year of Data	Wicomico County Need
% Fair or Poor Health	14.0%	13.1%	17%	2021	High
Average Number of Physically Unhealthy Days	3.3	2.8	3.8	2021	High
% Frequent Physical Distress	10.0%	7.9%	11.30%	2021	High
% Insufficient Sleep	33.0%	34.1%	36.10%	2020	High
% Adults with Diabetes	10.0%	9.8%	11%	2021	High

% Adults with Obesity	34.0%	34.2%	37.60%	2022	High
Age-Adjusted Death Rate from Heart Disease	N/A	165.7	243.8	2019-2021	High
Cancer Mortality Rate	N/A	142.5	165.9	2019-2021	High
Adults who are not obese %	N/A	31.8%	35.30%	2021	Low
Alzheimer's or Dementia Hospitalization Rate	N/A	515.5	23.20%	2017	High

Table A3.31: Quality of Care

Measure	National Benchmark	Maryland Benchmark	Wicomico County Data	Most Recent Year of Data	Wicomico County Need
% with Annual Mammogram	43.0%	43.0%	46%	2021	Low
% Vaccinated	46.0%	51.0%	46%	2021	High
Preventable Hospitalization Rate	2681	2508	1467	2021	Low

Table A3.32: Safety

Measure	National Benchmark	Maryland Benchmark	Wicomico County Data	Most Recent Year of Data	Wicomico County Need
Injury Death Rate	80	91.8	86.9	2017-2021	Medium
Homicide Rate	6	9.9	5.7	2015-2021	Low
Firearm Fatalities Rate	13	12.9	11.4	2017-2021	Low
Motor Vehicle Mortality Rate	12	9.3	13.6	2015-2021	High
Juvenile Arrest Rate	N/A	10.9	31.4	2021	High

Table A3.33: Sexual Health

Measure	National Benchmark	Maryland Benchmark	Wicomico County Data	Most Recent Year of Data	Wicomico County Need
HIV Incidence	N/A	15	10.3	2021	Low
HIV Prevalence Rate	382	643.4	304.9	2021	Low
Chlamydia Rate per 100,000	481.3	506.7	696.5	2022	High
Teen Birth Rate	17	13.3	16.9	2016-2022	High

Table A3.34: Substance Use

Measure	National Benchmark	Maryland Benchmark	Wicomico County Data	Most Recent Year of Data	Wicomico County Need
% Excessive Drinking	18.0%	15.2%	16.6%	2021	High
% Driving Deaths with Alcohol Involvement	26.0%	29.4%	24.6%	2017-2021	Low
Drug Overdose Mortality Rate	27	43.1	38.19	2019-2021	Low
Opioid Dispensing Rate	N/A	34.8	57.9	2022	High

Table A3.35: Tobacco Use

Measure	National Benchmark	Maryland Benchmark	Wicomico County Data	Most Recent Year of Data	Wicomico County Need
% Adults Reporting Currently Smoking	15.0%	10.2%	18%	2021	High
Adolescents who use tobacco products	N/A	15.6%	19.5%	2021	High

Table A3.36: Transportation and Transit

Measure	National Benchmark	Maryland Benchmark	Wicomico County Data	Most Recent Year of Data	Wicomico County Need
% Drive Alone to Work	72.0%	68.2%	80.8%	2018-2022	High
% Long Commute - Drives Alone	36.0%	49.2%	26.9%	2018-2022	Low
Traffic Volume	108	163	63.1	2023	Low

Detailed Focus Area Benchmarks – Worcester County, Maryland

Table A3.37: Access To Care

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
% Uninsured	10.0%	6.9%	7.6%	2022	High
% Uninsured Adults	N/A	8.1%	8.5%	2022	Medium
% Uninsured Children	N/A	4.1%	4.9%	2022	High
Primary Care Physicians Ratio	1330	1179	1181	2021	Medium
Dentist Ratio	1360	1238	1632	2022	High
Mental Health Provider Ratio	320	292	352	2023	High
Medicaid Children Receiving Dental Care within last year %	N/A	56.3%	54.5%	2021	Medium
ED Visit Rate for Addiction Related Conditions	N/A	2017	1977.1	2017	Medium
Uninsured ED Visits %	N/A	8.6%	6.4%	2017	Medium
ED Visits rate due to hypertension	N/A	351.2	417.2	2017	Low
ED Visit Rate for Dental Care	N/A	362.7	1051.9	2017	High
ED Visit Rate for Diabetes	N/A	243.7	310.5	2017	High
ED Visit Rate For Asthma	N/A	68.4	79.1	2017	High
Children Receiving Blood Level Screenings	N/A	67.1%	70.3%	2017	High
Child Elevated Blood Lead Levels	N/A	0.2%	0.3%	2017	Medium
Persons with a Usual PCP %	N/A	87.3%	89.6%	2021	High

Table A3.38: Built Environment

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
Food Environment Index	7.7	8.8	7.60	2019-2021	High
% Households with Broadband Access	88.0%	90.6%	88%	2018-2022	Medium
HH with Computer %	84.0%	86.3%	85.4%	2024	Medium

Table A3.39: Diet and Exercise

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
% Physically Inactive	23.0%	21.2%	21%	2021	Medium
Increased Physical Activity	N/A	52.2%	54.30%	2019	Medium

% With Access to Exercise Opportunities	84.0%	91.9%	84.6%	2020-2023	High

Table A3.40: Education

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
Segregation Index	0.24	0.26	0.07	2022-2023	Low
School Funding Adequacy	$634	($1,854)	$7,561.41	2021	Low

Table A3.41: Environmental Quality

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
Average Daily PM2.5	7.4	7.4	7.3	2019	Low
Presence of Water Violation	N/A	No	No	2022	Low

Table A3.42: Employment and Income

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
% Unemployed	3.7%	3.2%	3.8%	2022	High
% Population Living in Poverty	12.4%	9.4%	13.1%	2018-2022	High
% Children in Poverty	16.0%	12.1%	16.4%	2018-2022	High
ALICE Households	29%	29%	26.36%	2022	Low
Income Inequality Ratio	4.9	4.6	4.4	2018-2022	Medium
Gender Pay Gap	0.81	0.86	0.82	2018-2022	High
Living Wage (1 adult with 2 children)	N/A	$52.88	$42.36	2023	Low
Median Household Income	$75,149	$100,479	$65,969	2024	High

Table A3.43: Family, Community, and Social Support

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
% Children in Single-Parent Households	25.0%	25.7%	28.2%	2018-2022	High
% Household Income Required for Child Care Expenses	27.0%	23.5%	19.9%	2021	Low
Child Care Centers per 1,000 Children	7	6.2	6.16	2018-2022	Medium
Social Association Rate	9.1	8.8	16.37	2018-2022	Low
% Not Proficient in English		3.4%	1%	2022/2023	Low
Residential Segregation - Black/White Index	63.0	63.2	51.53	2010-2022	Low

Households Receiving Food Stamp/SNAP	11.50%	10.8%	10.50%	2018-2022	Medium

Table A3.44: Length of Life

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
Years of Potential Life Lost Rate	8,000	7,921	7102.3	2019-2021	Low
Premature Deaths	390	375	827	2019-2021	High
Life Expectancy	77.6	78	79.1	2019-2021	Medium

Table A3.45: Maternal and Infant Health

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
Child Mortality Rate	50.0	50.3	25.4	2018-2021	Low
Infant Mortality Rate	6.0	6.2	7.75	2015-2021	High
% Low Birthweight	8.0%	8.7%	6.60%	2016-2022	Low

Table A3.46: Mental Health

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
Adults every diagnosed with depression	20.7%	18.1%	20.40%	2022	High
Suicide Rate (Age-Adjusted)	14	9.9	11.4	2017-2021	High
Average Number of Mentally Unhealthy Days	4.8	4.4	5.0	2020	High
% Frequent Mental Distress	15.0%	13.2%	15.90%	2021	High
% Visited Mental Health Provider	5.0%	5.1%	4.43%	2024	N/A
% Used Prescription Antidepressants	7.7%	6.9%	8.18%	2024	N/A
% Used Antianxiety Medications	8.4%	7.7%	8.42%	2024	N/A
Mental Health ED Visit Rate	N/A	4291.5	3502.8	2017	Low

Table A3.47: Physical Health

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
% Fair or Poor Health	14.0%	13.1%	13.30%	2021	Medium
Average Number of Physically Unhealthy Days	3.3	2.8	3.2	2021	High
% Frequent Physical Distress	10.0%	7.9%	9.70%	2021	High
% Insufficient Sleep	33.0%	34.1%	31.10%	2020	Low
% Adults with Diabetes	10.0%	9.8%	9.90%	2021	Medium

% Adults with Obesity	34.0%	34.2%	37.70%	2022	High
Age-Adjusted Death Rate from Heart Disease	N/A	165.7	168.30	2019-2021	Medium
Cancer Mortality Rate	N/A	142.5	129.8	2019-2021	Low
Adults who are not obese %	N/A	31.8%	23.50%	2021	High
Adolescents who are obese %		15.9%	18%	2021	High
Alzheimer's or Dementia Hospitalization Rate	N/A	515.5	407.7	2017	Low

Table A3.48: Quality of Care

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
% with Annual Mammogram	43.0%	43.0%	49%	2021	Low
% Vaccinated	46.0%	51.0%	53%	2021	Medium
Preventable Hospitalization Rate	2681	2508	2029	2021	Low

Table A3.49: Safety

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
Injury Death Rate	80	91.8	88.78	2017-2021	Medium
Homicide Rate	6	9.9	0.00		Low
Firearm Fatalities Rate	13	12.9	8.42	2017-2021	Low
Motor Vehicle Mortality Rate	12	9.3	11.25	2015-2021	High
Juvenile Arrest Rate	N/A	10.9	82.33	2021	High

Table A3.50: Sexual Health

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
HIV Incidence	N/A	15	2.1	2021	Low
HIV Prevalence Rate	382	643.4	187.50	2021	Low
Chlamydia Rate per 100,000	481.3	506.7	343.40	2022	Low
Teen Birth Rate	17	13.3	11.48	2016-2022	Low

Table A3.51: Substance Use

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
% Excessive Drinking	18.0%	15.2%	18.0%	2021	High
% Driving Deaths with Alcohol Involvement	26.0%	29.4%	35.6%	2017-2021	High
Drug Overdose Mortality Rate	27	43.1	34.2	2019-2021	Low

Opioid Dispensing Rate	N/A	34.8	23.0	2022	Low

Table A3.52: Tobacco Use

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
% Adults Reporting Currently Smoking	15.0%	10.2%	17%	2021	High
Adolescents who use tobacco products	N/A	15.6%	19.8%	2021	High

Table A3.53: Transportation and Transit

Measure	National Benchmark	Maryland Benchmark	Worcester County Data	Most Recent Year of Data	Worcester County Need
% Drive Alone to Work	72.0%	68.2%	78.2%	2018-2022	High
% Long Commute - Drives Alone	36.0%	49.2%	27.5%	2018-2022	Low
Traffic Volume	108	163	51.31	2023	Low

Detailed Focus Area Benchmarks – Sussex County, Delaware

Table A3.54: Access to Care

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
% Uninsured	10.0%	6.9%	8.7%	2022	High
% Uninsured Adults	N/A	8.1%	10.2%	2022	High
% Uninsured Children	N/A	3.6%	4.4%	2022	High
Primary Care Physicians Ratio	1330	1,356	1628	2021	High
Dentist Ratio	1360	2,181	4490	2022	High
Mental Health Provider Ratio	320	309	446	2023	High

Table A3.55: Built Environment

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
Food Environment Index	7.7	7.8	8.0	2019-2021	Medium
% Households with Broadband Access	88.0%	90.3	88.3	2018-2022	Medium
HH with Computer %	84.0%	85.2%	85.5%	2024	Medium

Table A3.56: Diet and Exercise

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
% Physically Inactive	23.0%	26.2	26.2	2021	Medium
Increased Physical Activity	N/A	26.0%	26.0%	2019	Medium
% With Access to Exercise Opportunities	84.0%	79.2%	56.4%	2020-2023	High

Table A3.57: Education

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
Segregation Index	0.24	0.1	0.1	2022-2023	Low
School Funding Adequacy	$634	($179.00)	($2630.80)	2021	High

Table A3.58: Environmental Quality

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
Average Daily PM2.5	7.4	7.6	7.6	2019	Medium
Presence of Water Violation	N/A	No	Yes	2022	High

Table A3.59: Employment and Income

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
% Unemployed	3.7%	4.5%	4.4%	2022	Medium

% Population Living in Poverty	12.4%	10.6%	10.6%	2018-2022	Medium
% Children in Poverty	16.0%	14%	17%	2018-2022	High
ALICE Households	29%	29%	26.6%	2022	Low
Income Inequality Ratio	4.9	4.4	4.3	2018-2022	Medium
Gender Pay Gap	0.81	0.84	0.84	2018-2022	Medium
Living Wage (1 adult with 2 children)	N/A	50.54	46.76	2023	Low
Median Household Income	$75,149	$88,002.00	$88,713.00	2024	Medium

Table A3.60: Family, Community, and Social Support

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
% Children in Single-Parent Households	25.0%	28.9%	27.4%	2018-2022	Low
% Household Income Required for Child Care Expenses	27.0%	27.5%	24.4%	2021	Low
Child Care Centers per 1,000 Children	7	7.2	6.5	2018-2022	High
Social Association Rate	9.1	10.2	9.5	2018-2022	High
% Disconnected Youth	7.0%	5.1%	8.4%	2018-2022	High
% Not Proficient in English	N/A	2.1%	2.6%	2022/2023	High
Residential Segregation - Black/White Index	63.0	44.0	44.0	2010-2022	Medium
Households Receiving Food Stamp/SNAP	11.5%	10.7%	10.6%	2018-2022	Medium

Table A3.61: Food Security

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
% Food Insecure	10.0%	9.9%	10.2%	2021	Medium
% Limited Access to Healthy Foods	6.0%	6.3%	6.9%	2019	High

Table A3.62: Housing and Homelessness

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
% Severe Housing Problems	17.0%	14.1%	13.8%	2016-2021	Medium
% Homeowners	65.0%	72.0%	81.4%	2020	Low
% Households with Severe Cost Burden	14.0%	12.9%	11.7%	2018-2022	Low
Share of Population Precariously Housed	N/A	8.4%	7.1%	2023	Low

Table A3.63: Length of Life

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
Years of Potential Life Lost Rate	8,000	8,590.2	8596.1	2019-2021	Medium
Premature Deaths	390	390.0	370.0	2019-2021	Low
Life Expectancy	77.6	77.4	77.8	2019-2021	Medium

Table A3.64: Maternal and Infant Health

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
Child Mortality Rate	50.0	54.3	48.0	2018-2021	Low
Infant Mortality Rate	6.0	6.6	5.5	2015-2021	Low
% Low Birthweight	8.0%	9.06%	8.25%	2016-2022	Low

Table A3.65: Mental Health

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
Adults every diagnosed with depression	20.7%	19.9%	19.70%	2022	Medium
Suicide Rate (Age-Adjusted)	14	12.1	11.9	2017-2021	Medium
Average Number of Mentally Unhealthy Days	4.8	4.4	4.6	2020	Medium
% Frequent Mental Distress	15.0%	14%	15%	2021	High
% Visited Mental Health Provider	5.0%	4.9%	4.2%	2024	N/A
% Used Prescription Antidepressants	7.7%	7.8%	8.0%	2024	N/A
% Used Antianxiety Medications	8.4%	8.5%	8.2%	2024	N/A

Table A3.66: Physical Health

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
% Fair or Poor Health	14.0%	14%	15%	2021	Medium
Average Number of Physically Unhealthy Days	3.3	3.3	3.5	2021	High
% Frequent Physical Distress	10.0%	10%	10.8%	2021	High
% Insufficient Sleep	33.0%	34%	32%	2020	Low
% Adults with Diabetes	10.0%	10%	10%		Medium
% Adults with Obesity	34.0%	34%	35%	2022	Medium
Age-Adjusted Death Rate from Heart Disease	N/A	148.4	138.4	2019-2021	Low

Age-adjusted death rate due to cancer	N/A	158.1	153.6	2019-2021	Low
Adolescents who are obese %		0.7	0.8	2021	High
Alzheimer's or Dementia Hospitalization Rate	N/A	28.3	24.6	2017	Low

Table A3.67: Quality of Care

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
% with Annual Mammogram	43.0%	51%	52%	2021	Medium
% Vaccinated	46.0%	55%	55%	2021	Medium
Preventable Hospitalization Rate	2681	2,922.0	2086.0	2021	Low

Table A3.68: Safety

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
Injury Death Rate	80	93.5	93.0	2017-2021	Medium
Homicide Rate	6	7.2	3.1		Low
Firearm Fatalities Rate	13	12.3	9.8	2017-2021	Low
Motor Vehicle Mortality Rate	12	12.9	15.8	2015-2021	High
Juvenile Arrest Rate	N/A	25.7	26.9	2021	Medium

Table A3.69: Sexual Health

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
HIV Incidence	N/A	8.6	6.3	2021	Low
HIV Prevalence Rate	382	410.2	349.6	2021	Low
Teen Birth Rate	17	16.0	27.2	2016-2022	High

Table A3.70: Substance Use

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
% Excessive Drinking	18.0%	15.6%	14.6%	2021	Low
% Driving Deaths with Alcohol Involvement	26.0%	22.8%	22.5%	2017-2021	Medium
Drug Overdose Mortality Rate	27	47.0	45.3	2019-2021	Medium
Opioid Dispensing Rate	N/A	40.7	49.2	2022	High

Table A3.71: Tobacco Use

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
% Adults Reporting Currently Smoking	15.0%	14%	15%	2021	Medium

Adolescents who use tobacco products	N/A	3.2%	5.3%	2021	High

Table A3.72: Transportation and Transit

Measure	National Benchmark	Delaware Benchmark	Sussex County Data	Most Recent Year of Data	Sussex County Need
% Drive Alone to Work	72.0%	75.2%	78.8%	2018-2022	Medium
% Long Commute - Drives Alone	36.0%	34.2%	38.7%	2018-2022	High
Traffic Volume	108	111.5	34.5	2023	Low

Appendix 4 | Secondary Data Summary

The figure below includes a summary of potential priority need areas, as identified by the secondary data analysis process, as well as priority areas of need identified by other state, local, and national sources.

Figure A4.1

Potential Priority Area	Secondary Data Findings	Bayhealth Hospital	Beebe Healthcare	Atlantic General Hospital	Maryland SIHIS	Delaware SHIP	Healthy Delmarva CHIP (2023)	US Office of the Surgeon General	Healthy People 2030
Healthcare Access, Availability & Quality	✓	✓		✓	✓		✓		
Communicable Disease				✓				✓	
Safety & Violence								✓	
Health Equity & Social Determinants of Health	✓	✓				✓	✓		✓
Infant Health						✓			
Maternal Health					✓	✓			
Mental & Behavioral Health		✓	✓	✓		✓	✓	✓	
Obesity & Chronic Disease		✓	✓	✓	✓	✓	✓		
Sexual Health & Pregnancy	✓					✓			
Social Connection								✓	
Social Media & Misinformation								✓	
Substance Use and Associated Mortality	✓			✓	✓	✓	✓		
Tobacco Use				✓		✓			
Workforce Wellness								✓	

Appendix 5 | Primary Data Methodology and Sources

This CHNA's development incorporated primary data collection via multiple methods: focus group discussions, key leader interviews, web-based key leader and community health surveys. An overview of the processes, tools, analytic methods used to determine key findings, and brief key findings from each data source are provided in this Appendix. More detailed findings from each primary data source are provided in Appendix 6.

Community Health Survey

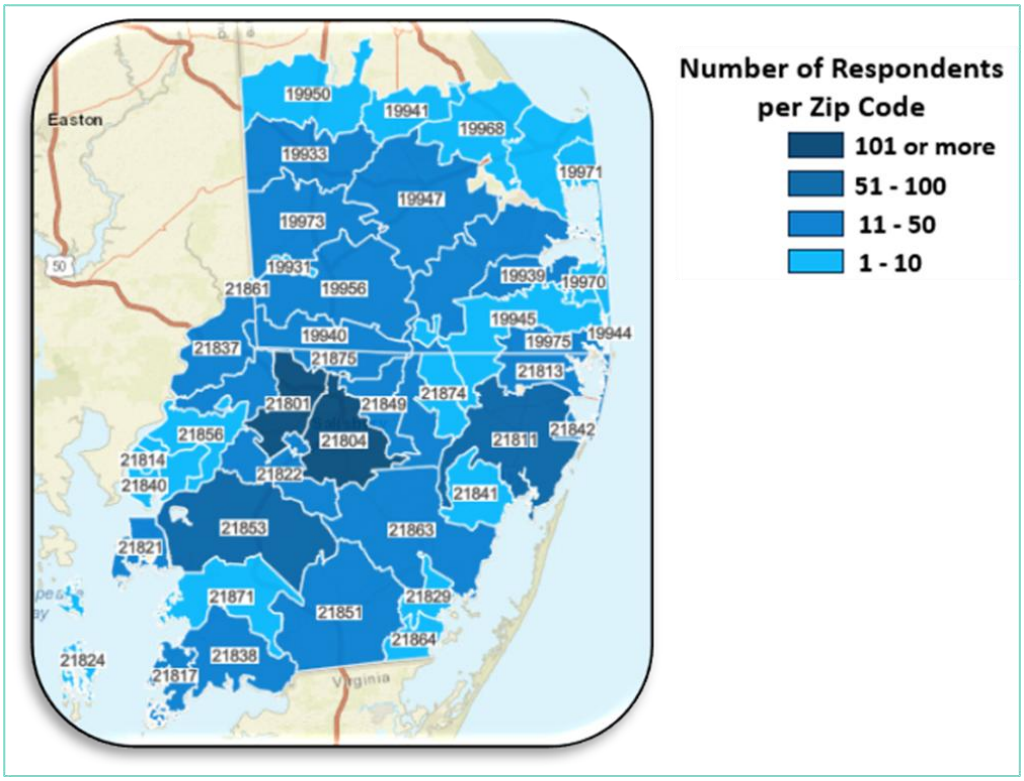
Overview

A total of 1,274 residents accessed the community survey and approximately 1,243 provided answers. Survey participants had to be 18 years of age or older and live, work, or receive healthcare in Somerset, Wicomico, or Worcester counties in Maryland or Sussex County in Delaware. The survey was available in English, Spanish, Haitian Creole, Arabic, and Portuguese. It was administered using an online survey platform; Steering Committee members also distributed paper copies of the survey to specific target populations throughout the region.

In general, survey questions focused on community health problems and concerns, community social/ environmental problems and concerns, access and barriers to healthcare, and physical health, mental health, and substance use topics.

Figure A5.1 shows the number of survey respondents by zip code. The two zip codes with the most

Figure A5.1: Community Survey Respondent Zip Code of Residence



participation were both in Salisbury, MD. Additional demographic data about community health survey respondents is described in the figures that follow.

Figure A5.2: Respondents by Gender Identity

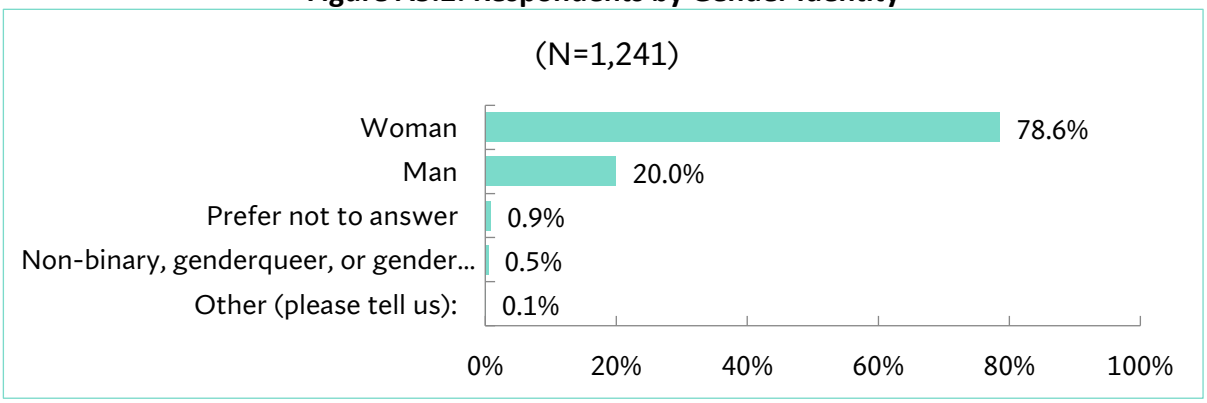


Figure A5.3: Respondents by Age

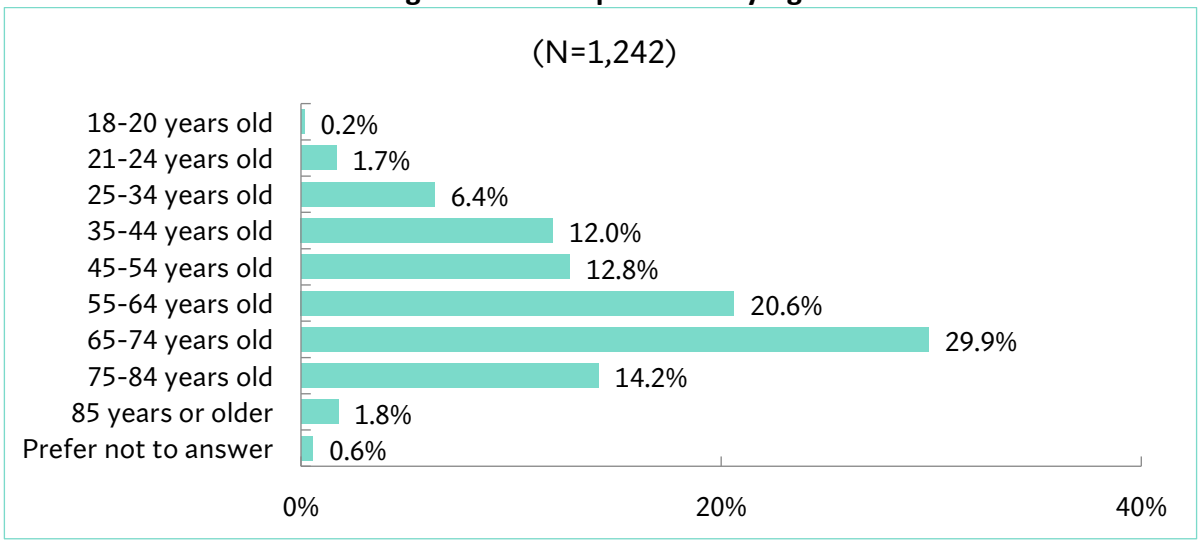
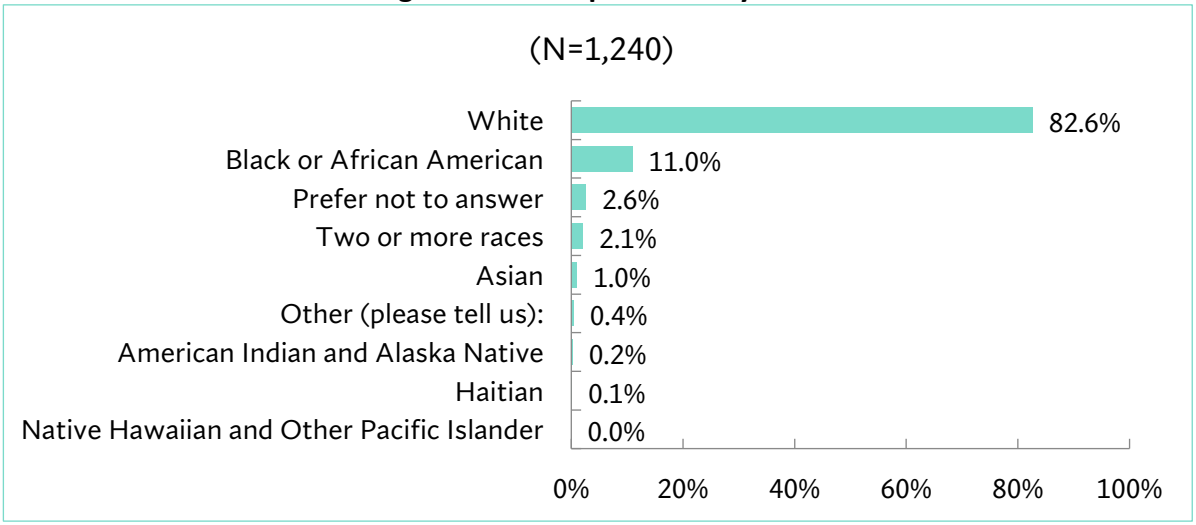


Figure A5.4: Respondents by Race



Summary of Key Findings from Community Health Survey

The key findings from the Community Survey are detailed below:

- Community members' top health concerns are ***drug and alcohol problems, cancer, mental health, and weight status.***
- The community believes the top three reasons people do not receive healthcare when they need it are ***cost, long wait-times, and lack of insurance.***
- The three biggest social or environmental factors impacting health are ***inability to get a doctor, poverty, and housing problems or homelessness.***

Community Health Survey Instrument

Below are the questions from the community member survey instrument:

Dear Neighbor,
We'd like you to take our health survey. This survey helps TidalHealth, Somerset County Health Department, and Wicomico County Health Department learn what our community needs to be healthier in 2025.

Your answers are private - we won't know who filled out the survey. Your answers will help hospitals and health groups make our area healthier. This includes Somerset, Wicomico, and Worcester counties in Maryland and Sussex County in Delaware. The survey takes about 10 minutes to complete.

Before You Start:
You must be 18 or older to take this survey
Please answer all questions

If you have questions about this survey, please email chelseysaari@ascendient.com. Ascendient Healthcare Advisors is helping us with this survey
.
Thank you for your time and participation!

Topic: Demographics

1. Are you 18 or older? (Select one option)
Yes
No

2. Where do you live?
*(a) County _____
*(b) Zip Code _____

3. Where do you work or get your healthcare? (Check all that apply)
Somerset County, Maryland
Wicomico County, Maryland
Worcester County, Maryland
Sussex County, Delaware
None of the above

4. How old are you? (Pick one) (Select one option)

18-20 years old
21-24 years old
25-34 years old
35-44 years old
45-54 years old
55-64 years old
65-74 years old
75-84 years old
85 years or older
Prefer not to answer

5. Which of the following best describes your gender? (Pick one) (Select one option)
Man
Woman
Non-binary, genderqueer, or gender nonconforming
Prefer not to answer
Other (please tell us):

6. Are you Hispanic or Latino, or is your family from a Spanish-speaking country? (Pick one) (Select one option)
Yes
No
Not sure
Prefer not to answer

7. How would you best describe your race? (Pick one) (Select one option)
American Indian and Alaska Native
Asian
Black or African American
Haitian
Native Hawaiian and Other Pacific Islander
White
Two or more races
Prefer not to answer
Other (please tell us):

8. Which language is most often spoken in your home? (Pick one) (Select one option)
Arabic
English
Haitian Creole
Portuguese
Spanish
Prefer not to answer
Other (please tell us)

9. What is the highest level of school you finished? (Pick one)
Less than 9th grade
Some high school, no diploma
High school graduate or GED
Some college (no degree)
2-year college degree or training certificate
4-year college degree
Master's degree or higher
Prefer not to answer

10. What is your job situation? (Check all that apply)
Working full-time (40 or more hours each week)
Working part-time (less than 40 hours each week)
Retired
In the military
Own business/self-employed
Stay-at-home parent/caregiver
Cannot work because of health
Not working for less than 1 year
Not working for more than 1 year
Prefer not to answer
Other (please tell us) _
None of these

11. How much money does your household make each year before taxes? (Pick one)

Include all money from: jobs, Social Security, family help, welfare, retirement, investments, and other sources. (Select one option)

Less than $15,000
$15,000 - $24,999
$25,000 - $34,999
$35,000 - $49,999
$50,000 - $74,999
$75,000 - $99,999
$100,000 - $149,999
$150,000 - $199,999
$200,000 or more
Prefer not to answer

12. Do any of these describe you? (Check all that apply)

I have a disability
I am active duty Military
I am a former service member / veteran
I am an immigrant or refugee
Prefer not to answer
I do not identify with any of these

13. What are the 3 most important things that make a community healthy? [Please select at most 3 options.]

Access to doctors and hospital
Affordable homes
Healthy eating and exercise
Good jobs
People helping in the community
Safe neighborhoods
Good schools
Less sickness
Clean air and water
Diversity
Fair rules for everyone
Parks and places to play
Strong families
Religious or spiritual values
Art and culture events
Other (Please tell us)

14. What are the 3 biggest health problems in your community? [Please select at most 3 options.]

Drug and alcohol problems
Alzheimer's disease and other dementias
Cancer
Children's health problems
Long-lasting health problems (e.g., autoimmune disorders, chronic pain)
Breathing problems (e.g., lung disease, asthma, COPD)
Diabetes or high blood sugar
Heart disease or high blood pressure
Mom and baby health
Mental health (e.g., depression, anxiety)
Eating healthy
Older adult health
Teeth and mouth health
Sexually transmitted infections
Smoking or tobacco use
Stroke
Weight status (being overweight or obese)
Other (please tell us)

15. What are the 3 biggest problems that affect health in your community? [Please select at most 3 options.]

Hard to get to a doctor
Hard to get insurance
Not enough sidewalks or parks
Child abuse or neglect
Treating people unfairly because of disability
Treating people unfairly because of age
Treating people unfairly because of race
Treating people unfairly because of gender
Violence at home
Environment (examples: climate change, water or air pollution, lead poisoning)
Housing problems or homelessness
Not enough child care
Hard to find jobs
Hard to find healthy food
Feeling lonely
Poor schools
No places to exercise
Unsafe neighborhoods
Poverty (not enough money)
Hard to get around (transportation)
Other (please tell us)

16. Where do you go most often in your community? (Check all that apply)

Parks
Church
Movie Theaters
Library
Rivers/Lakes/Woods
Gyms
Sports Fields
Swimming Pools
Live Theaters
Social Clubs
Senior Center
Other (please tell us)
None of these

17. What would help make your community healthier? (Check all that apply)

Better information sharing
More local health programs
Better healthcare
Focus on fixing health differences
Including different community leaders
More doctors, nurses, or other healthcare providers
Asking the community what they need
Better parks and streets
Taking more action
New businesses that think about health
Working together more
Online health information
Other (please tell us)
None of these

18. What are the 3 main reasons people in your community can't get healthcare when they need it? [Please select at most 3 options.]

Too expensive
Wait is too long
No insurance
No doctor nearby
No way to get there
Insurance not taken
Language problems
Religious or cultural reasons
Prefer not to answer
Other (please tell us)

19. Do you have health insurance? (Pick one) (Select one option)

Yes
No
Don't Know
Prefer not to answer

NOTE: Answer the below question only if answer to Q#19 is **Yes**

20. What kind of health insurance do you have? (Check all that apply)

Medicaid
Medicare
Insurance from a job
Insurance from Healthcare.gov (Affordable Care Act (ACA) also known as "Obama Care")
Insurance I buy myself
Indian Health Services
Veteran's Administration
COBRA
I pay cash
Prefer not to answer
Other (please tell us)
None of these

NOTE: Answer the below question only if answer to Q#19 is **Yes**

21. DURING THE PAST 12 MONTHS, has a doctor said they won't take your insurance? (Pick one) (Select one option)

Yes
No
Don't know
Prefer not to answer

22. Where do you usually go when you're sick? (Check all that apply)

Doctor's office
Urgent care
Health department
Family or friends
Internet
Emergency room
Veterans' clinic
Different places
Not sure
Prefer not to answer
Some other place (please tell us) ____
None of these

23. Who do you trust for health information? (Check all that apply)

A doctor, nurse, or other healthcare provider
Health screenings
One-on-one help
Written information
Self-help programs
A friend/family member
Health fairs
Online programs
Church or faith group
Group meetings
Phone help
Videos or DVDs
Prefer not to answer
Other (please tell us)
None of these

24. How do you like to get health information? (Check all that apply)

E-mail
In Person
Website
Mail
Text
Phone
Social Media (Facebook, X, Other)
Podcasts
Prefer not to answer
Other (please tell us)
None of these

25. There are many reasons people delay getting medical care. What made it hard to get medical care in the PAST 12 MONTHS? (Check all that apply)

No way to get there
Can't take time off work
Too expensive
Had to pay too much myself (copay was too expensive)
Doctor is too far away
No child care
No appointments available
Take care of others
Nervous about seeing doctor
I did not have problems getting care
Insurance costs too much
Other (please tell us)
None of these

26. How worried are you about paying medical bills if you get sick or hurt? (Pick one)

Very worried
Somewhat worried
Not worried
Don't know
Prefer not to answer

27. In the past 12 months, did you need dental care but couldn't get it? (Pick one) (Select one option)

Yes
No, I got the services I needed
I did not need dental care in the past 12 months
Prefer not to answer

28. In the past 12 months, how many times did you go to the emergency room instead of a regular doctor? (Pick one) (Select one option)

Never
1 Time
2 Times
3 Times
4 Times
5 Times
6 or More Times
Prefer not to answer

29. Why did you go to the emergency room instead of a doctor's office or clinic? (Check all that apply)

Doctor's office was closed
Don't have a regular doctor
Don't have insurance
Too expensive elsewhere
It was an emergency/life threatening situation
Regular doctor wait too long
Needed food or shelter
Prefer not to answer
Other (please tell us)
None of these

30. What health problems did you go to the emergency room for? (Check all that apply)

Diabetes (high blood sugar)
Heart Disease
Asthma
Chronic Obstructive Pulmonary Disease (COPD)
Hypertension (high blood pressure)
Mental Health
Substance Use
Prefer not to answer
Other (Please tell us)
None of these

31. How easy is it for you to fill out medical forms on your own? (Pick one)

Very easy
Easy
Somewhat easy
Hard
Very hard
Prefer not to answer

32. How often is it hard to understand what your doctor tells you? (Pick one)

Always
Often
Sometimes
Rarely
Never
Prefer not to answer

33. Thinking about your MENTAL health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health NOT good?

None
1 to 2 days
3 to 7 days
8 to 29 days
30 days
Prefer not to answer

34. In the past 12 months, was there a time you needed mental health help but couldn't get it? (Pick one) (Select one option)

Yes
No
Don't know
Prefer not to answer

NOTE: Answer the below question only if answer to Q#34 is **Yes**

35. Why couldn't you get mental health help? (Pick one) (Select one option)

Too expensive/no insurance
Too far away
Don't Know Where To Go
Worried about privacy
Office hours did not work for schedule

No child care
No counselors/mental health providers available
No way to get there
Bad experience before
Stigma or Embarrassed
Too busy
Wait for an appointment too long
Hard to get appointment
None of these
Not sure
Prefer not to answer
Other (please tell us)

36. Are you getting help for mental health now (medicine, therapy, or counseling)? (Pick one)

Yes
No
Not sure
Prefer not to answer

37. Considering your physical health (which is the condition of your body, including how well your organs and systems function, and whether you have any illnesses or injuries) overall, how healthy is your body right now? (Select one option)

Very Healthy
Healthy
Okay
Not Very Healthy
Not Healthy At All
Prefer not to answer

38. Within the last 12 months, have you:

a. Had a physical or check-up with a healthcare provider?
Yes
No
Prefer not to answer

b. Had your teeth cleaned at the dentist?
Yes
No
Prefer not to answer

39. Has a doctor, nurse, or other healthcare provider ever told you that you have any of these health problems (check all that apply)

Arthritis (joint pain)
Liver disease
Asthma
Long COVID
Cancer
Lung disease
Chronic Obstructive Pulmonary Disease (COPD)
Dementia/Short-term memory loss
Osteoporosis (weak bones)
Physical disabilities
Depression or anxiety
Mental illness not otherwise listed (including bipolar disorder, schizophrenia, borderline personality disorder, dissociative identity disorder)
Diabetes (not during pregnancy)
Sexually transmitted infections (including chlamydia, syphilis, gonorrhea and HIV)
Heart disease, stroke, or other cardiovascular disease
High blood pressure (hypertension)
Stroke
Eye problems
High cholesterol
Don't know
Immunocompromised condition not otherwise listed
Kidney disease
Other (please tell us)
None of these
Prefer not to answer

40. What do you need to take care of your health? (Check all that apply)

I don't have health problems
Help with medicine instructions

Healthy food
Help paying for medicine
Better insurance
Home health care
Safe places to exercise
Help when seeing different doctors
Help finding a doctor
Don't know
Help getting to appointments
Prefer not to answer
Help making appointments
None of these
Help understanding doctor's instructions
Other (please tell us)

41. How often do you drink alcohol (beer, wine, or liquor)? (Pick one) (Select one option)
Every Day
Some Days
Never
Prefer not to answer

42. How often do you use cannabis/marijuana/THC Products (Pick one)
Every Day
Some Days
Never
Prefer not to answer

43. Do you use cannabis/marijuana/THC products for medical reasons, recreational reasons, or both? (Select one option)
Medical reasons
Recreational reasons
Both
Prefer not to answer

NOTE : Answer the below question only if answer to Q#42 is **Every Day OR Some Days**

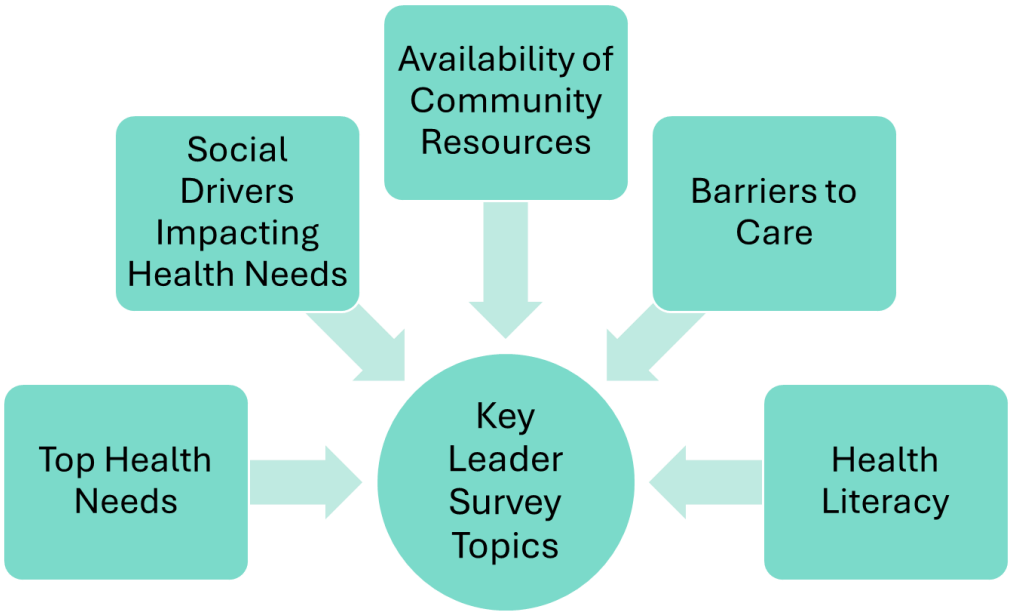
44. In the past year, have you or someone in your home used prescription drugs in ways they weren't supposed to? (Pick one) (Select one option)
Yes
No
Prefer not to answer

45. What one thing would you change to make your community better?

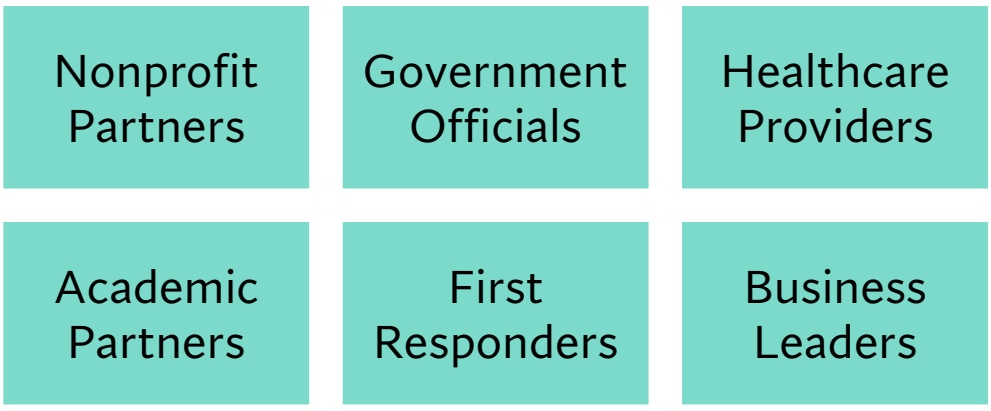
Key Leader Surveys

Overview

A total of 28 key leaders completed the web-based key leader survey, which was open for responses between December 9, 2024 and February 10, 2025. In general, key leader survey questions focused on the topics depicted in the graphic below.

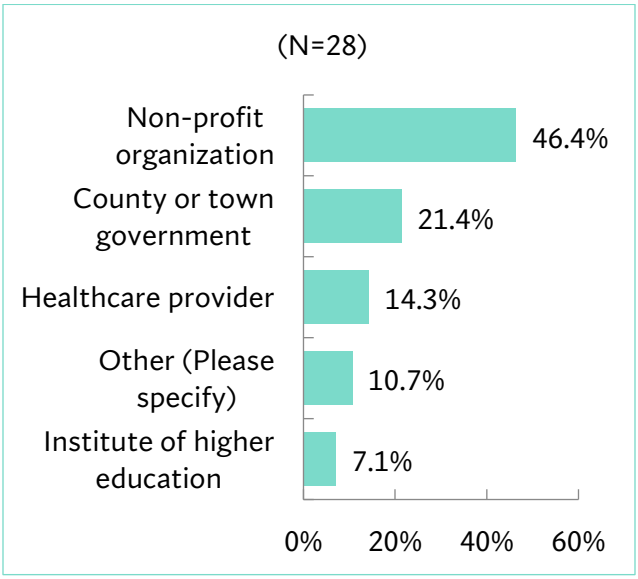


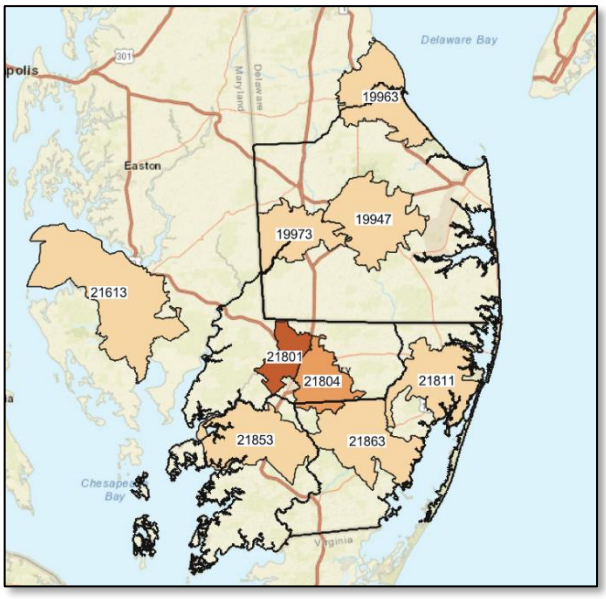
Key leaders represented a variety of organizations and geographies throughout the Delmarva region. Broad categories of key leader survey participants included:



The chart below shows the distribution of key leader survey respondents by type of organization, while the map shows the geographic distribution of key leader survey respondents based on the zip code in which their organization is located.

Figure A5.5: Key Leader Survey Participant Organization Type and Service Location





Summary of Key Findings from Key Leader Surveys

Key findings from the key leader survey are detailed below:

- ***Cost, lack of insurance, and language problems*** were selected as the top 3 barriers to healthcare by key leaders. Almost half also said transportation was a top barrier.
- ***Mental health, diabetes/high blood sugar, and drugs and alcohol*** are the biggest health problems in the community, according to key leaders.
- ***Housing and homelessness*** were the top problems affecting the health of the community. Half also selected poverty.
- Over 70% of leaders believe ***more community specific outreach*** would encourage and support the health of their community.
- Over 60% said getting ***community input, increasing healthcare practitioners in the region, focusing on health inequities, and increasing communication*** would be useful strategies.

Key Leader Survey Instrument

The questions administered via the Key Leader Survey instrument are below:

Dear Community Leader,

Thank you in advance for your participation in this survey, which is being conducted by TidalHealth, Wicomico County Health Department, and Somerset County Health Department as a part of a Community Health Needs Assessment (CHNA). Input from community leaders is a critical component of this assessment process.

Questions in this survey were developed to assess the perceived health and social needs of residents throughout Somerset, Wicomico, and Worcester counties in Maryland and Sussex County, Delaware. Findings will be used to help identify specific groups within the region most in need of additional resources. The survey should take no more than 15 minutes to complete, and your answers are anonymous and confidential.

Ascendient Healthcare Advisors is the consultant partner for this CHNA process. For questions about this survey, please contact Ascendient Healthcare Advisors: chelseysaari@ascendient.com

Thank you for your time and participation!

---

1. Please select the category that best describes your organization. (Select one option)

- Faith-based organization
- Non-profit organization
- Media
- County or town government
- Institute of higher education
- Healthcare provider
- Public – private partnership
- Community Development Corporation
- Other (Please specify) _____

NOTE : Answer the below question only if answer to (Q#1 is Healthcare provider)

2. What types of healthcare services does your organization provide? (Select one option)

- Behavioral Health
- Primary Care
- Other (Please specify)

3. What is the zip code of your organization/facility?

4. What is the name of the organization you work for?

5. What are the 3 most important things that make a community healthy? [Please select at most 3 options.]

- Access to doctors and hospitals
- Affordable homes
- Healthy eating and exercise
- Good jobs
- People helping in the community
- Safe neighborhoods
- Good schools
- Less sickness
- Clean air and water
- Diversity
- Fair rules for everyone
- Parks and places to play
- Strong families
- Religious or spiritual values
- Art and culture events
- Other (Please tell us) _____

6. How do you believe the health of the community you serve has changed over the past three years? (Select one option)

- Greatly improved
- Improved
- No change
- Worsened
- Greatly worsened
- Prefer not to answer

NOTE: Answer the below question only if answer to (Q#6 is Greatly improved OR Improved)

In what way(s) has the health of the community you serve improved?

NOTE: Answer the below question only if answer to (Q#6 is Worsened OR Greatly worsened)

In what way(s) has the health of the community you serve worsened?

7. What are the 3 main reasons people in your community can't get healthcare when they need it? [Please select at most 3 options.]

- Too expensive
- Wait is too long
- No insurance
- No doctor nearby
- No way to get there
- Insurance not taken
- Language problems
- Religious or cultural reasons
- Prefer not to answer
- Other (please tell us)

8. What are the 3 biggest health problems in your community? [Please select at most 3 options.]

- Drug and alcohol problems
- Alzheimer's disease and other dementias
- Cancer
- Children's health problems
- Long-lasting health problems (e.g., autoimmune disorders, chronic pain)
- Breathing problems (e.g., lung disease, asthma, COPD)
- Diabetes or high blood sugar
- Heart disease or high blood pressure
- Mom and baby health
- Mental health (e.g., depression, anxiety)
- Eating healthy
- Older adult health
- Teeth and mouth health
- Sexually transmitted infections
- Smoking or tobacco use
- Stroke
- Weight status (being overweight or obese)
- Other (please tell us)

9. Do you know of any resources available in the community to address some of the health issues you identified in the previous question? (Select one option)

- Yes
- No
- Not sure
- Prefer not to answer

If yes, please name at least one resource that could be leveraged.

10. What are the 3 biggest problems that affect health in your community? [Please select at most 3 options.]

- Hard to get to a doctor
- Hard to get insurance
- Not enough sidewalks or parks
- Child abuse or neglect
- Treating people unfairly because of disability
- Treating people unfairly because of age
- Treating people unfairly because of race
- Treating people unfairly because of gender
- Violence at home
- Environment (examples: climate change, water or air pollution, lead poisoning)
- Housing problems or homelessness
- Not enough child care
- Hard to find jobs
- Hard to find healthy food
- Feeling lonely
- Poor schools
- No places to exercise
- Unsafe neighborhoods
- Poverty (not enough money)
- Hard to get around (transportation)
- Other (please tell us)

11. Do you know of any resources in the community to address some of the social/ environmental issues you identified in the previous question? (Select one option)

- Yes
- No
- Not sure
- Prefer not to answer

If yes, please name at least one resource that could be leveraged

12. In your opinion, are health and social/environmental needs similar across the Delmarva region? (Somerset, Wicomico, and Worcester counties in Maryland and Sussex County, Delaware) (Select one option)

- Yes
- No
- Prefer not to answer
- Not Sure

NOTE: Answer the below question only if answer to (Q#16 is No)

Which geographic areas do you feel experience the greatest level of need?

13. What do you believe could encourage and support health in your community? (Select all that apply.)

- Increased communication/awareness
- More community-specific outreach
- Better quality healthcare
- Increased focus on health inequities
- Engaging diverse leaders/residents
- Increased healthcare practitioners
- Opportunities for community input
- Improvement to the physical environment
- Increased action/implementation
- Renovated/new business development with health considerations
- Increased partnerships
- Web-based resources
- Other (Please specify)

14. Which subpopulation(s) on this list does your organization serve? (Select all that apply.)

- Black/African American community
- Children/youth
- Haitian Community
- Hispanic/Latino community
- LGBTQIA+ community
- Justice-involved individuals
- Military and veterans
- Persons experiencing homelessness
- Persons in poverty
- Persons with disabilities
- Refugees/immigrants
- Seniors/elderly
- Uninsured population
- Women in pregnancy
- Young adults
- Youth in foster care
- Other (Please specify)
- None of the above

15. Among those served by your organization, which subpopulation(s) appear to have the greatest unmet needs when it comes to health and social services? [Please select at most 3 options.]

- Black/African American community
- Children/youth
- Haitian Community
- Hispanic/Latino community
- LGBTQIA+ community
- Justice-involved individuals
- Military and veterans
- Persons experiencing homelessness
- Persons in poverty
- Persons with disabilities
- Refugees/immigrants
- Seniors/elderly
- Uninsured population
- Women in pregnancy
- Young adults
- Youth in foster care
- Other (Please specify)
- None of the above

16. Please rate each of the following statements for the community you serve:

Answer choices:

- Strongly Disagree
- Somewhat Disagree
- Neither Agree nor Disagree
- Somewhat Agree
- Strongly Agree

Residents can access a doctor, including nurse practitioners and physician assistants (Family/General Practitioner, Ob/Gyn, Pediatrician) when needed.
Residents can access a medical specialist (Cardiologist, Dermatologist, etc.) when needed.
There are enough providers accepting Medicaid in the community.
There are enough providers accepting Medicare in the community.
There are enough providers accepting patients without insurance in the community.
There are enough dentists in the community.
There are enough culturally competent healthcare providers in the community. Cultural competence is the ability of an individual to understand and respect values, attitudes, beliefs, and more that differ across cultures, and to consider and respond appropriately to these differences in planning, implementing, and evaluating health education and promotion programs and interventions.
There are enough mental health providers in the community.
There are enough substance use treatment providers in the community.

17. From the list provided, where do you feel members of the community you serve most frequently seek medical care? (Select all that apply.)

- Alternative Medicine Provider (acupuncture, chiropractic, naturopath, etc.)
- Community Clinic/FQHC
- Emergency Department
- Health Department
- Hospital/Medical Campus
- Primary care provider (physician, nurse, etc.)
- Telehealth or virtual visit
- Walk-in or Urgent Care
- A Veterans Affairs (VA) Hospital or Clinic
- Do not seek care
- Prefer not to say
- Other (Please specify)
- None of the above

18. Do you believe that the people in the community you serve are health literate, or able to understand health-related information when it is presented to them? (Select one option)

- Yes
- No
- Prefer not to answer
- Not Sure

NOTE: Answer the below question only if answer to (Q#23 is No)

24. If no, what do you see as the biggest challenges/issues with health literacy among the populations served by your organization?

25. What is working well in the community?

26. What suggestions do you have for health leaders in your community to improve the health and well-being of the community? Please write suggestions below.

Focus Groups

Overview

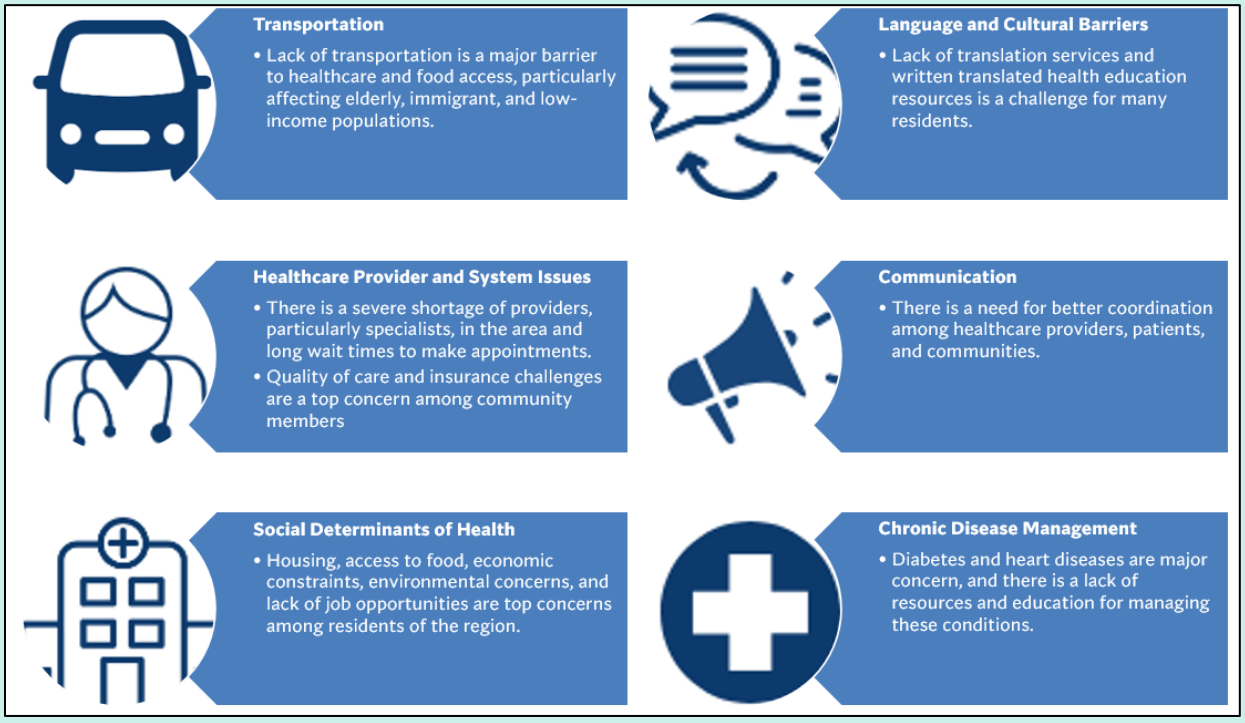
The following seven focus groups were conducted either virtually or in person between January 12, 2025 and February 5, 2025. These groups included representation from community leaders, non-profit partners, patients, and community members with over 50 participants providing responses.

- St. Francis Church in Salisbury, MD with Hispanic Adult Residents
- Senior Center in Somerset County, MD with Older Adult Residents
- Fire Station 16 in Wicomico County, MD with Haitian Adult Residents
- Two virtual focus groups with Wicomico County adult residents
- One virtual focus group with Somerset County adult residents
- One virtual focus group with Sussex County adult residents

Summary of Key Findings from Focus Groups

Key findings from the CHNA focus groups are highlighted in the figure below. More detailed findings can be found in Appendix 6.

Figure A5.6: Key Takeaways from Focus Groups



Focus Group Discussion Guide Script and Questions

The discussion guide used to guide semi-structured conversations with each focus group is provided below.

Healthy Delmarva
Building Thriving Communities

Healthy Delmarva 2025 CHNA
Focus Group Discussion Guide

Facilitator Name	
Date	
Time	
Location	
Population(s) Represented	
Number of Participants	

FACILITATOR INTRODUCTION:

"Thank you for being a part of today's focus group! My name is [NAME] and I'm here on behalf of [ORGANIZATION]. We are conducting a community health needs assessment to find out more about some of the health and social issues facing residents in [NAME] County. The results of this focus group will be used to help health leaders throughout the county develop programs and services to address some of the issues we'll be talking about today. We may record today's discussion to assist with notetaking, but we will not be using any identifying information, like participant names, in our results. We would also like to ask you to fill out this demographic form, so we can understand a little bit more about who is participating in this focus group."

PARTICIPANT INTRODUCTIONS

1. Please tell us your first name, how long you've lived in [NAME] County and something you like about living here.

HEALTH AND WELLNESS

2. What are some of the issues that keep residents in [NAME] County from living healthy lives?

3. What are the most serious health problems facing people who live in [NAME] County?

    a. Are there particular groups of people (i.e. race, ethnicity, age, LGBTQ+, etc.) who are more affected by these problems than others?

    b. Are there particular areas in the county that are more affected by these problems than others?

Healthy Delmarva 2025 CHNA Focus Group Guide
Page 1 of 2

4. Thinking about the health problems you described, what do you think could be done to address these issues?

SOCIAL DETERMINANTS OF HEALTH

5. What are some of the environmental and/or social conditions that affect quality of life for people living in [NAME] County?
    a. Examples of social and environmental issues that negatively impact health: availability or access to health insurance, domestic violence, housing problems, homelessness, lack of job opportunities, lack of affordable childcare, limited access to healthy food, neighborhood safety/ street violence, poverty, racial/ethnic discrimination, limited/poor educational opportunities.
6. Thinking about the social and environmental issues you described, how do you think these issues could be addressed?

ACCESS TO CARE

7. What are some reasons people in [NAME] County do not get health care when they need it? How can these issues be addressed?
8. What do you think about the health-related services that are available in your community, including medical care, dental care and behavioral health care?
    a. Are there enough locations providing these types of care for people who need it?
    b. Can you find medical, dental or behavioral health care within a reasonable timeframe when you need it?
    c. Are your experiences with providers (doctors, dentists, nurses, therapists, emergency personnel, etc.) more positive or negative, and why?

SUGGESTIONS

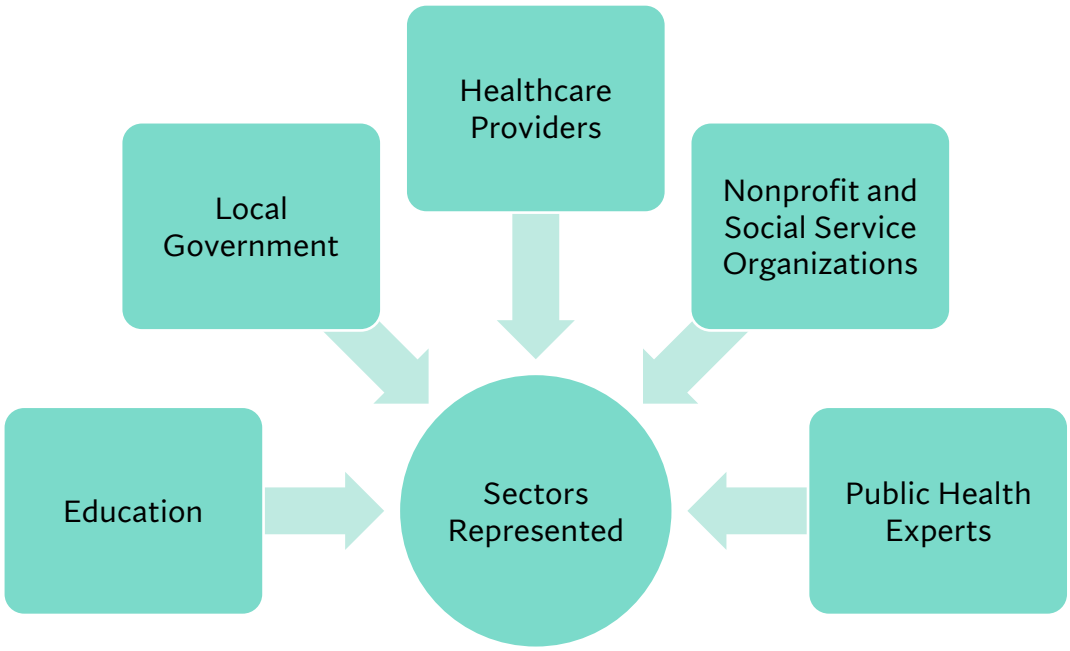
9. What are some of the strengths or community assets in [NAME] County that can help residents live healthier lives?
10. What do you think local health leaders should do to improve health and quality of life in [NAME] County? What do you want local health leaders to know?
11. What actions can local residents take to help improve the health of the community?

Key Leader Interviews

Overview

From December 2024 through February 2025, nine key leader interviews were conducted with individuals representing organizations across the region to gain perspective on the health and well-being of residents. Participants provided insights into various aspects of healthcare and community life.

Participating organizations included:



Summary of Key Findings from Key Leader Interviews

Some of the key findings from the key leader interviews conducted for the CHNA process included the following:

- Three main health issues were consistently observed by leaders as having the greatest impact in the community – obesity, diabetes, and hypertension.
- Accessing healthcare is a challenge for many in the region, most notably due to lack of providers and transportation issues.
- Housing - including availability, quality, and costs - is a top concern and is preventing community members from living healthy lives.
- Key leaders expressed a need and desire to work collaboratively, emphasizing opportunities to have greater impact and better serve the community's needs if resources were better coordinated.

Key Leader Interview Questions

A copy of the data collection instrument used to guide semi-structured key leader interviews for the CHNA process is provided below.

Healthy Delmarva
Building Thriving Communities

Healthy Delmarva 2025 CHNA
Key Informant Interview Guide

Facilitator Name	
Date	
Time	
Participant Name	
Participant Organization	

SUMMARY OF KEY DISCUSSION THEMES:

FACILITATOR INTRODUCTION:

"Thank you for participating in a key informant interview today! My name is [NAME] and I'm part of an organization called Ascendient Healthcare Advisors. We are conducting a community health needs assessment to find out more about the health and social issues facing residents in [NAME] County, the ways those needs are currently being addressed, and where there might be opportunities to address them more effectively. We are speaking to a variety of different community stakeholders and organizations through this process, and the results of these interviews will help health leaders throughout [NAME] County develop programs and services to address some of these challenges. We expect this interview to take 45 to 60 minutes, and we are so appreciative of your time today. We may record today's discussion to assist with notetaking, but we will not be using any identifying information, like participant names, in our results. Can I answer any questions for you before we begin the interview?

INTRODUCTION

1. Can you please tell me a little bit about your role and the organization you work for? Is your work focused on specific populations or geographic areas of [NAME] County?

HEALTH AND WELLNESS

2. What are some of the most significant problems or concerns in the community you serve?
    a. Which populations are most impacted by these concerns?

Healthy Delmarva 2025 CHNA Key Informant Interview Script
1

b. How have these concerns changed over the past three years (have they gotten better, worse or stayed the same?)

3. I'd like you to think more specifically about health conditions impacting the community you serve. What are the most serious health problems facing people who live in [NAME] County?

   a. Are there particular groups of people (i.e. race, ethnicity, age, LGBTQ+, etc.) who are more affected by these problems than others?

   b. Are there particular areas in the county that are more affected by these problems than others?

   c. What resources are currently available to address these issues?

4. Thinking about the health problems you just described, what programs, interventions or strategies could be implemented to address these issues in the future?

SOCIAL & ENVIRONMENTAL DETERMINANTS OF HEALTH

5. What are some of the environmental and/or social conditions that affect quality of life for members of the community you serve?

   a. Examples of social and environmental issues that negatively impact health: availability or access to health insurance, domestic violence, housing problems, homelessness, lack of job opportunities, lack of affordable childcare, limited access to healthy food, neighborhood safety/ street violence, poverty, racial/ethnic discrimination, limited/poor educational opportunities.

   b. Are there particular groups of people (i.e. race, ethnicity, age, LGBTQ+, etc.) who are more affected by these problems than others?

   c. Are there particular areas in the county that are more affected by these problems than others?

   d. What resources are currently available to address these issues?

6. Thinking about the social and environmental issues you described, what programs, interventions or strategies could be implemented to address these issues in the future?

ACCESS TO CARE

7. What are some of the barriers that prevent people in [NAME] County from getting health care when they need it?

   a. What suggestions do you have for addressing these barriers?

8. What are your perceptions of the health-related services that are available in [NAME] County, including medical care, dental care and behavioral health care?
    a. Are there enough locations providing these types of care for people who need it?
    b. Do you think community members can find medical, dental or behavioral health care within a reasonable timeframe when they need it?

SUGGESTIONS

9. What are some of the strengths or community assets in [NAME] County that can help residents live healthier lives?
10. What do you think local health leaders should do to improve health and quality of life in [NAME] County? What do you want local health leaders to know?

Appendix 6 | Detailed Primary Data Findings

Community Health Survey

Charts detailing findings from the community health survey are displayed below:

Topic: Demographics

Figure A6.1: Where do you live?

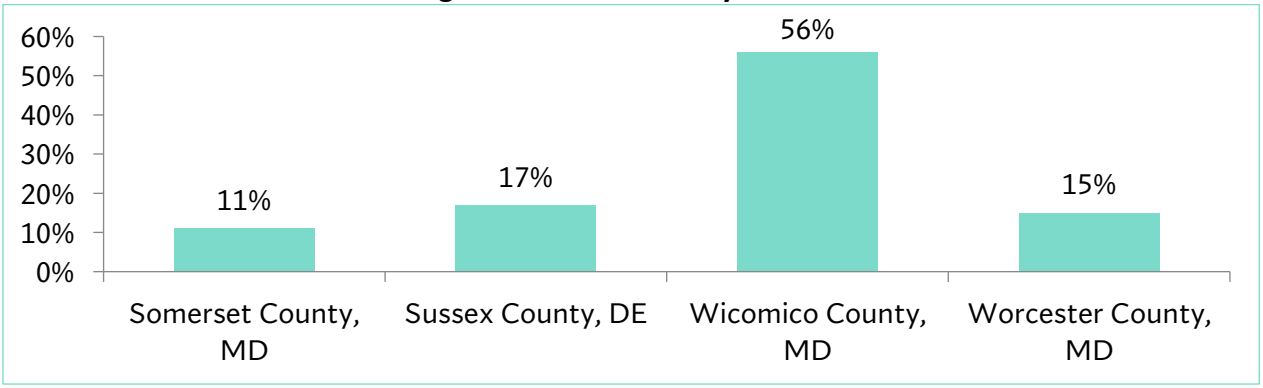


Figure A6.2: Where do you work or get your healthcare?

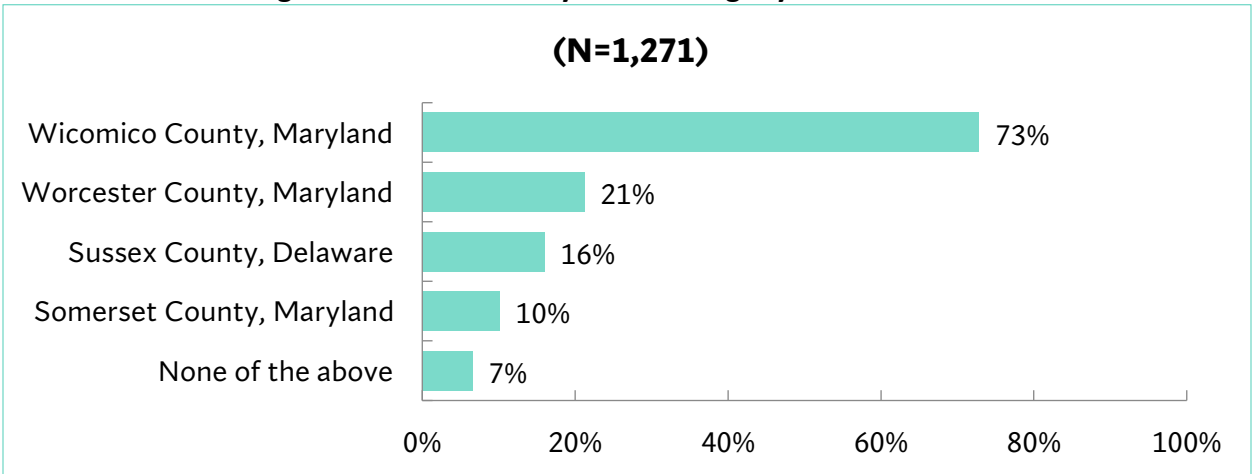


Figure A6.3: What is the highest level of school you finished?

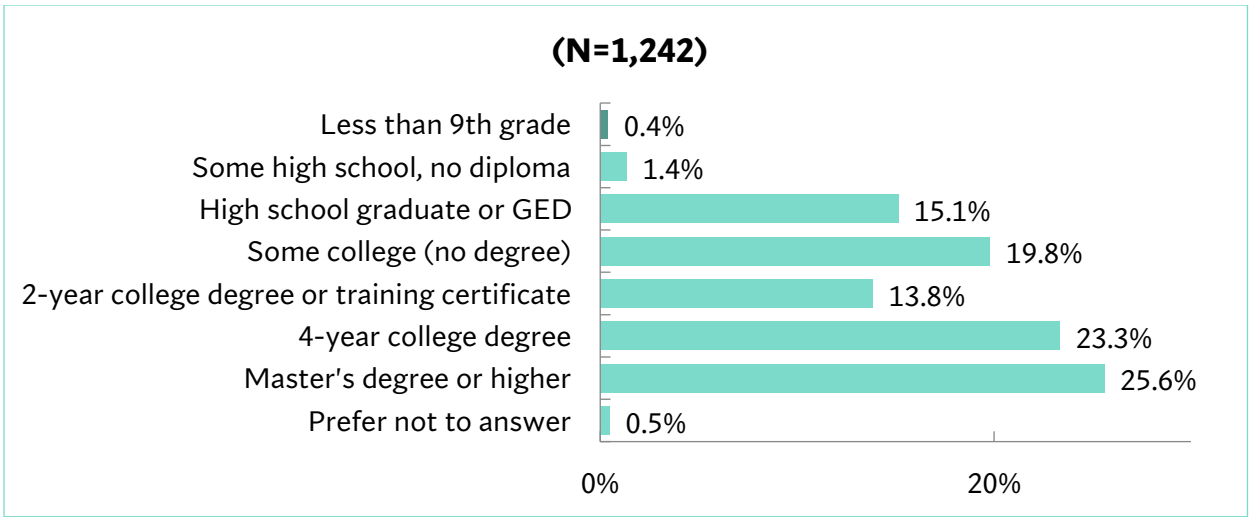


Figure A6.4: How much money does your household make each year before taxes?

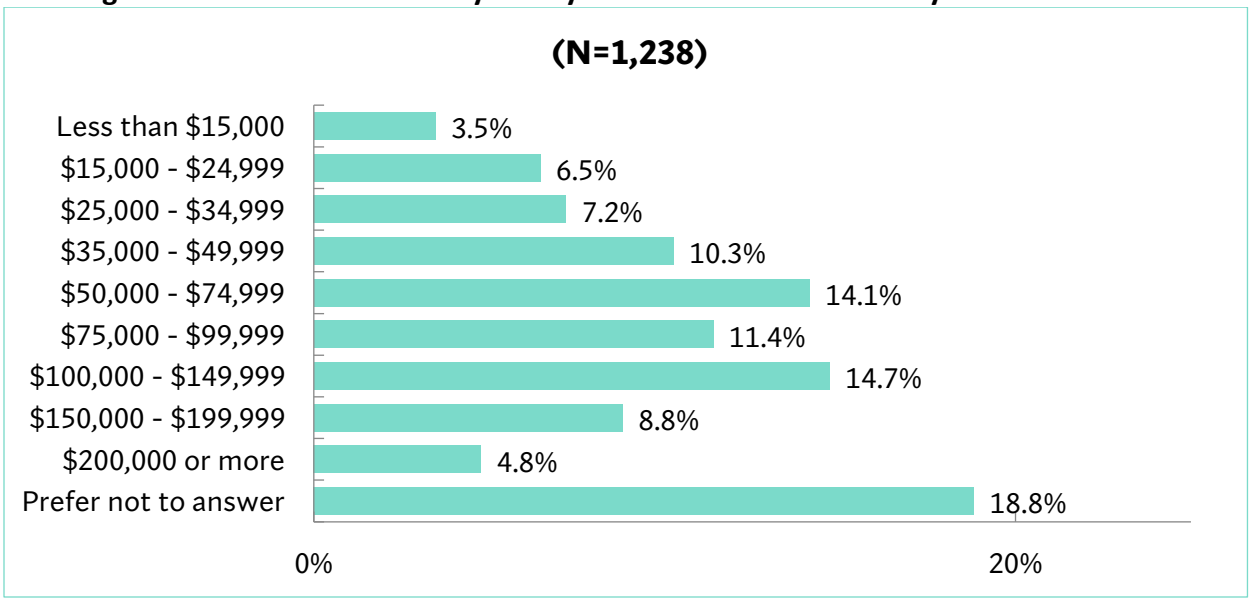
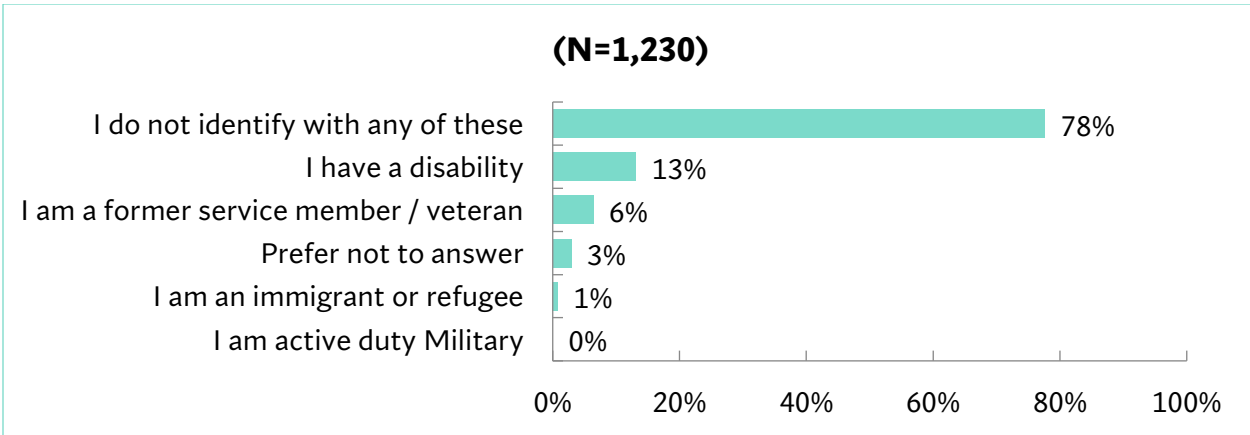
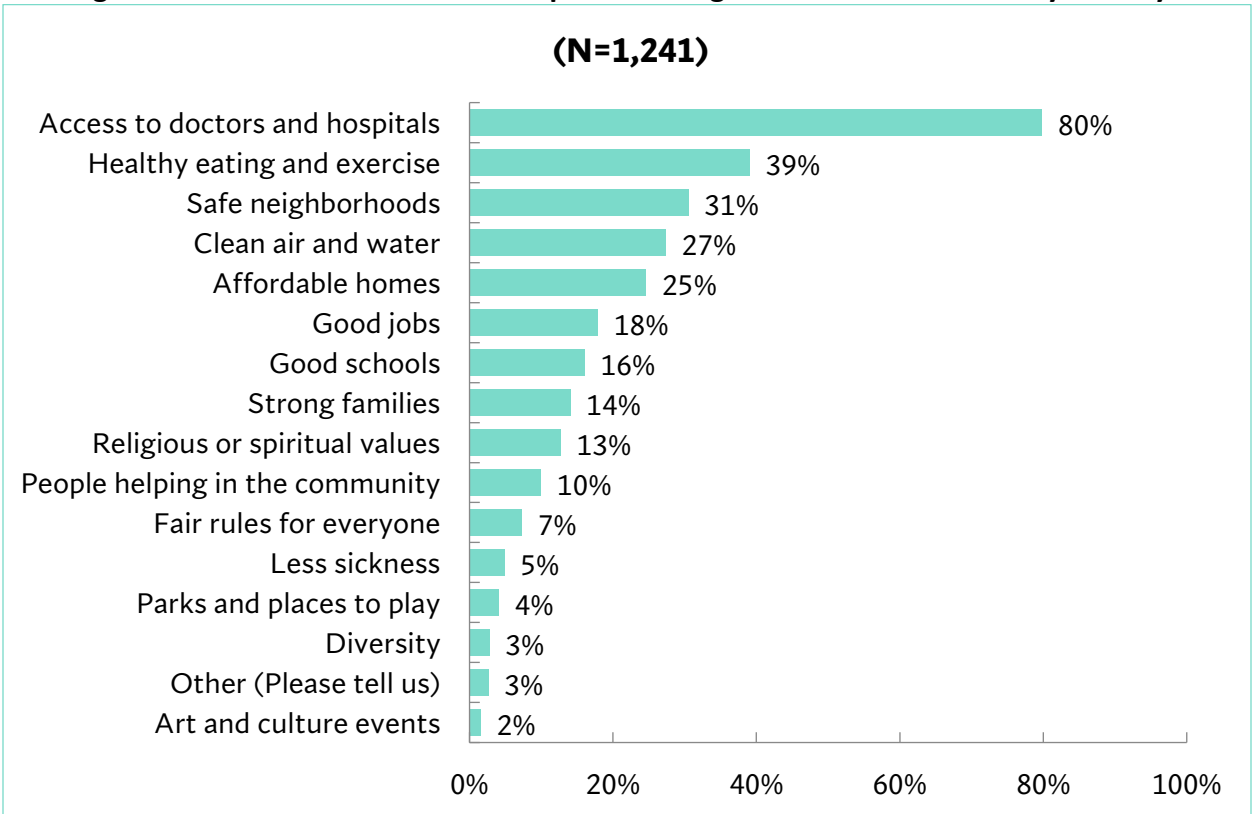


Figure A6.5: Do any of these describe you?



Topic: Community Opinion Questions

Figure A6.6: What are the 3 most important things that make a community healthy?

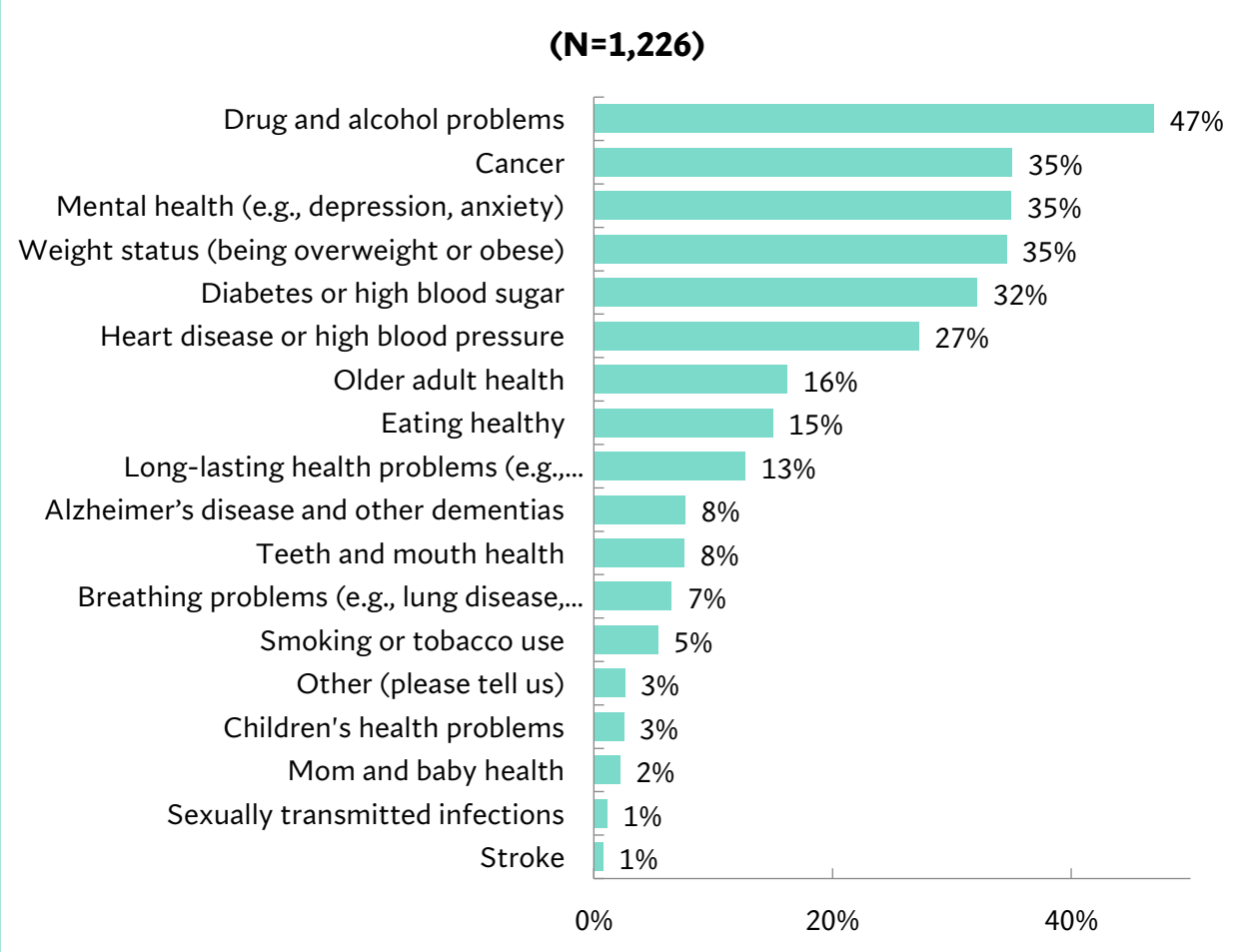


Themes from those who selected "Other":

- **Affordable Healthcare**: The most frequently mentioned factor across responses. People emphasize both access to healthcare and its affordability, including medications, insurance, preventative care, and specialist services. As one respondent put it: "Affordable Healthcare. Affordable medications. Insurance companies that cover testing and preventative medicine that the doctor orders."

- **Quality Healthcare Services**: Beyond affordability, respondents value healthcare providers who are attentive, reliable, and efficient. One person emphasized the need for "doctors that take their time with patients."
- **Economic Security and Resources**: Responses highlight the importance of financial stability, as captured by: "Jobs that pay for daily living. Not living paycheck to paycheck."
- **Social Connection and Values**: Some responses emphasize community cohesion: "People who actually Love thy neighbor. Helping others, work together, practice selfless acts."
- **Environmental Factors**: Clean surroundings appear in several responses, with one answer mentioning "healthy eating and exercise, less sickness, clean air and water, fairness, safety, family and unity."
- **Education and Knowledge**: Including both formal education and health education/awareness.
- **Mental Health Support**: Recognized as a distinct community health need, alongside specialized support for conditions like autism and traumatic brain injury.

Figure A6.7: What are the 3 biggest health problems in your community?



Themes from those who selected "Other":

- **Healthcare Access Issues**: Many responses point to problems with access, including "Little to no access. Not enough specialists....dental, etc." and "Having my appointments canceled."

Another person highlighted "Lack of quality expert care" and "variety of healthcare professionals" as significant concerns.

- **Healthcare System Problems**: Several respondents mention issues with healthcare delivery, including "Rude and entitled behavior of providers with zero accountability" and "Lack of pro-active medical practices." Affordability was also highlighted: "Unaffordable health care."
- **Specific Health Conditions**: Several specific health concerns were identified, including "Tick borne diseases — Lyme disease," "Autism," "Parkinson's Disease," and "TBI resources are limited."
- **Social Determinants of Health**: Responses point to broader social issues affecting health, including "Transportation," "Homeless," and "lack of health education." One detailed response mentioned "Crime, selfishness, illiteracy, guns, racism, immaturity."
- **Community Concerns**: Some respondents identified community-level issues, mentioning "Crime," "GANGS," and "Illegal immigrants, gang warfare" as major health problems.
- **Educational Factors**: Beyond direct healthcare, some pointed to "uninformed electorate, lack of critical thinking" as underlying community health problems.

Figure A6.8: What are the 3 biggest health problems in your community (by county)?

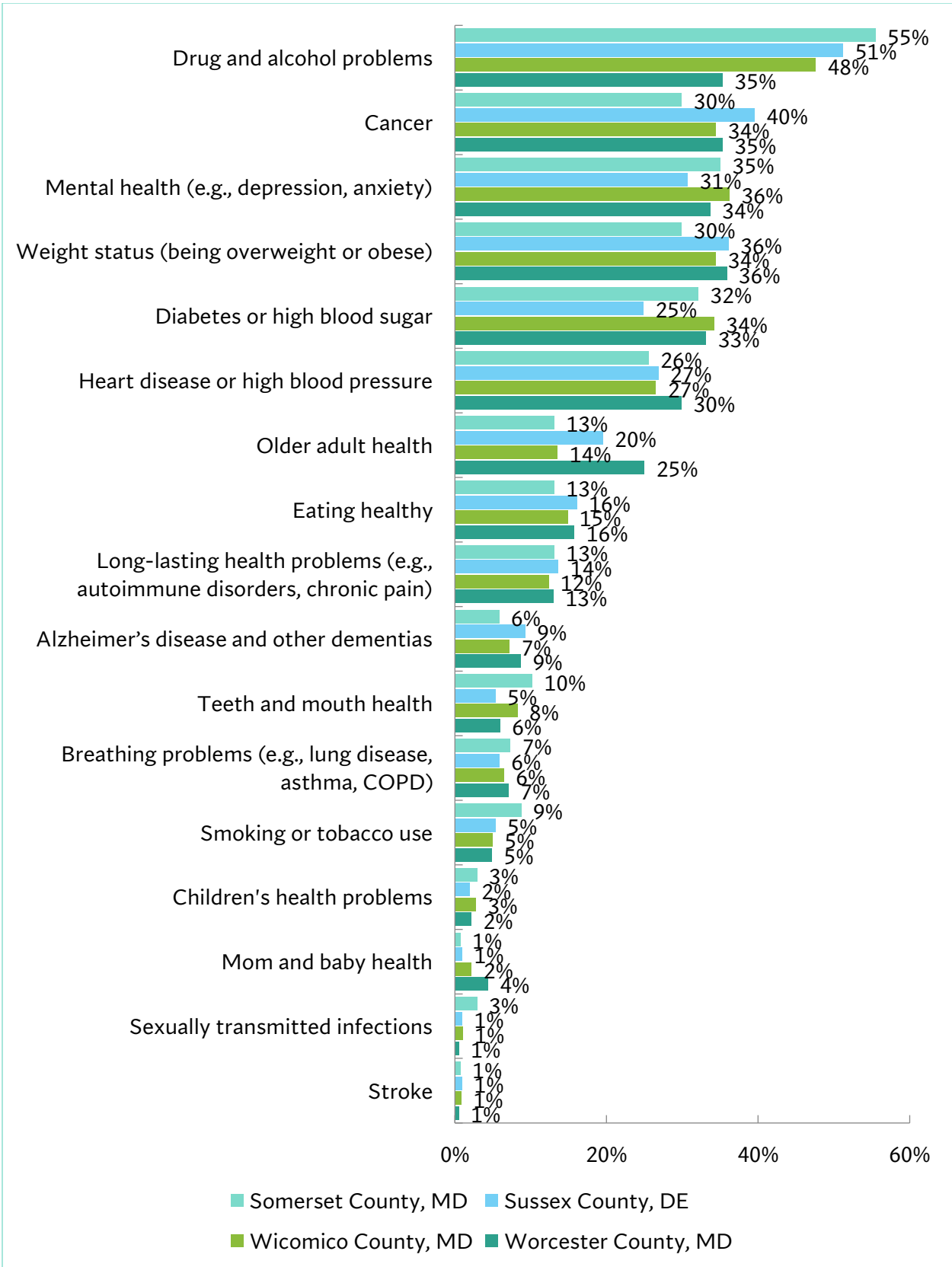


Figure A6.9: What are the 3 biggest health problems in your community (by race)?

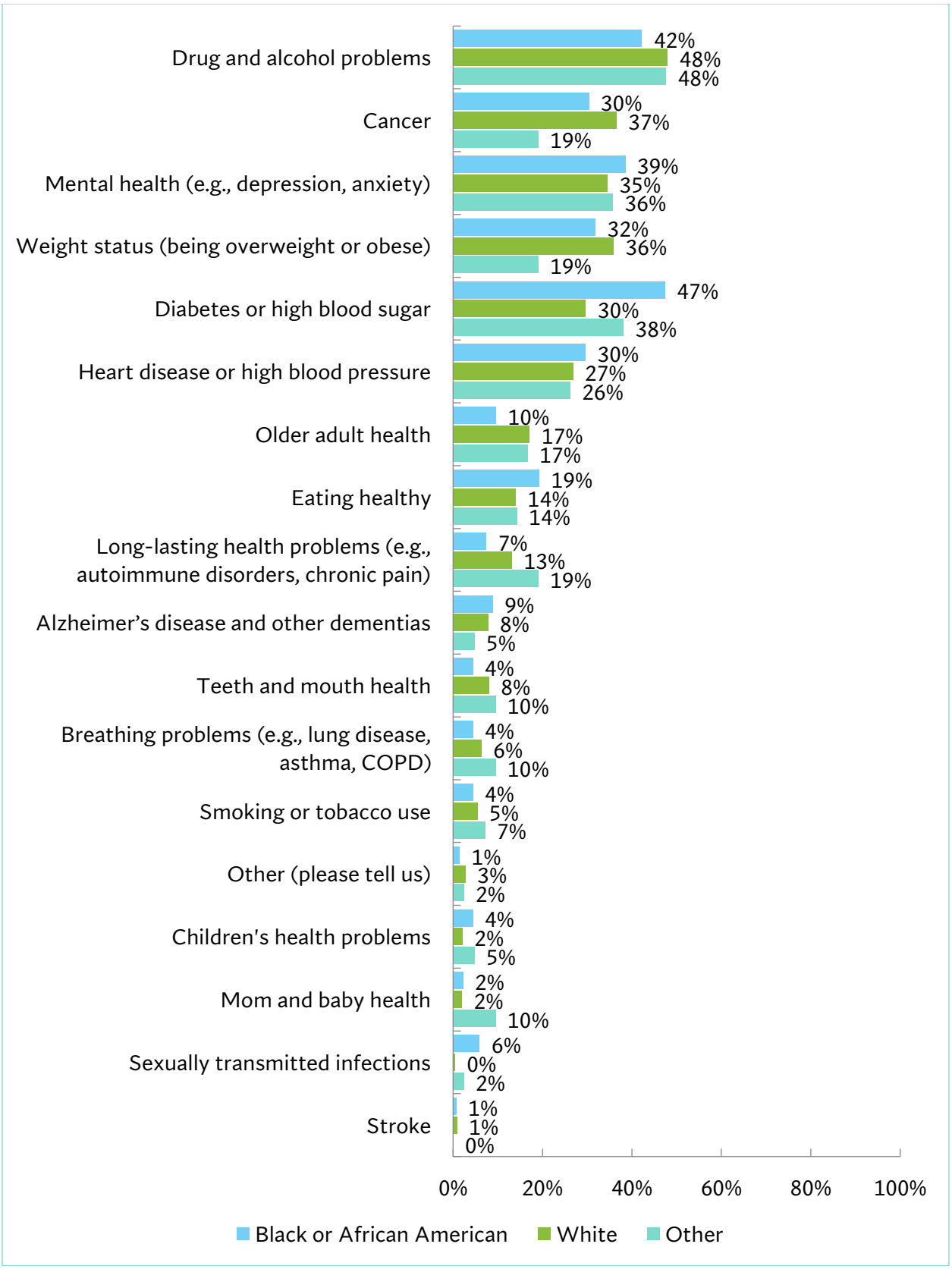


Figure A6.10: What are the 3 biggest health problems in your community (by gender)?

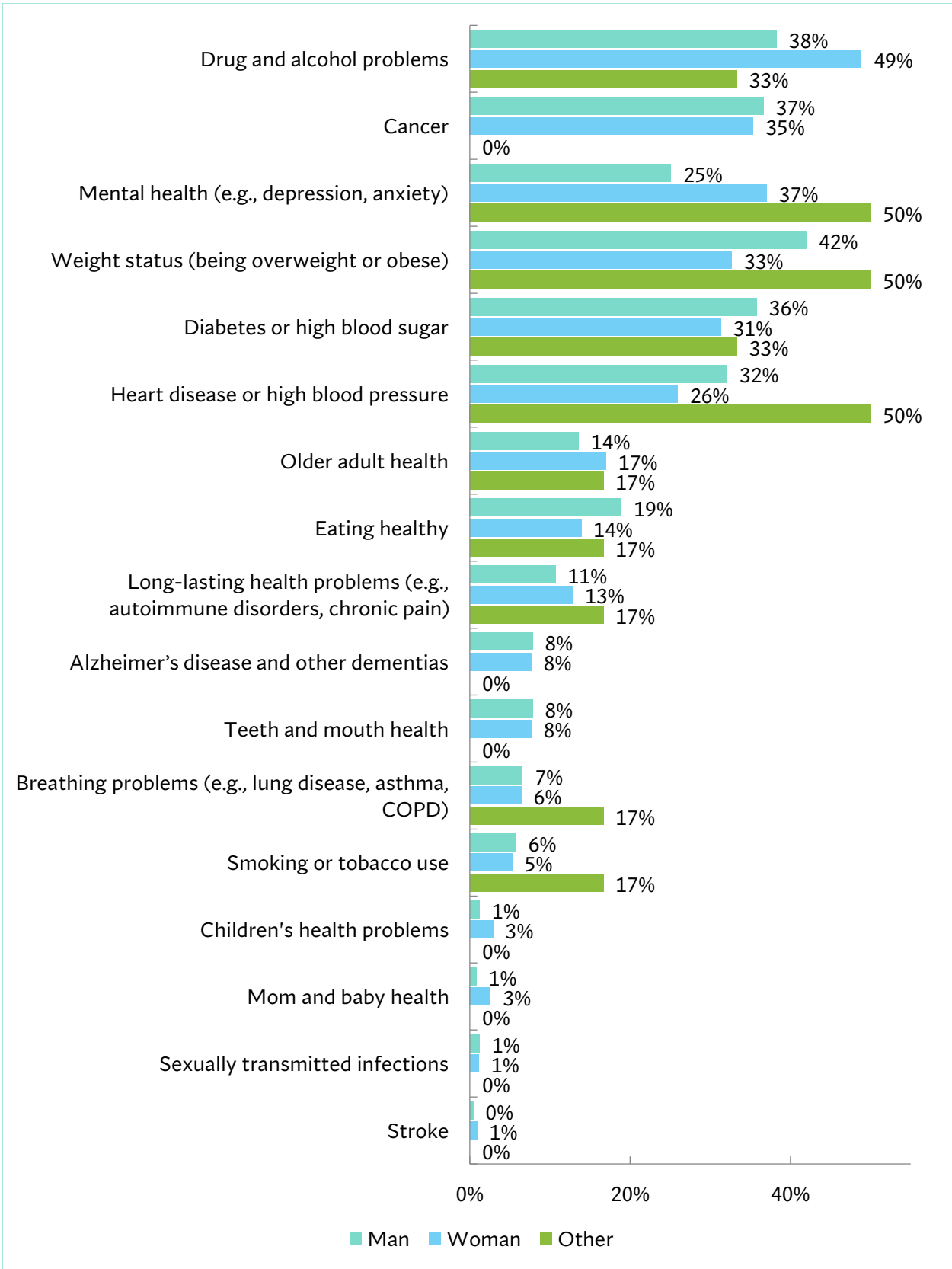


Figure A6.11: What are the 3 biggest health problems in your community (by age)?

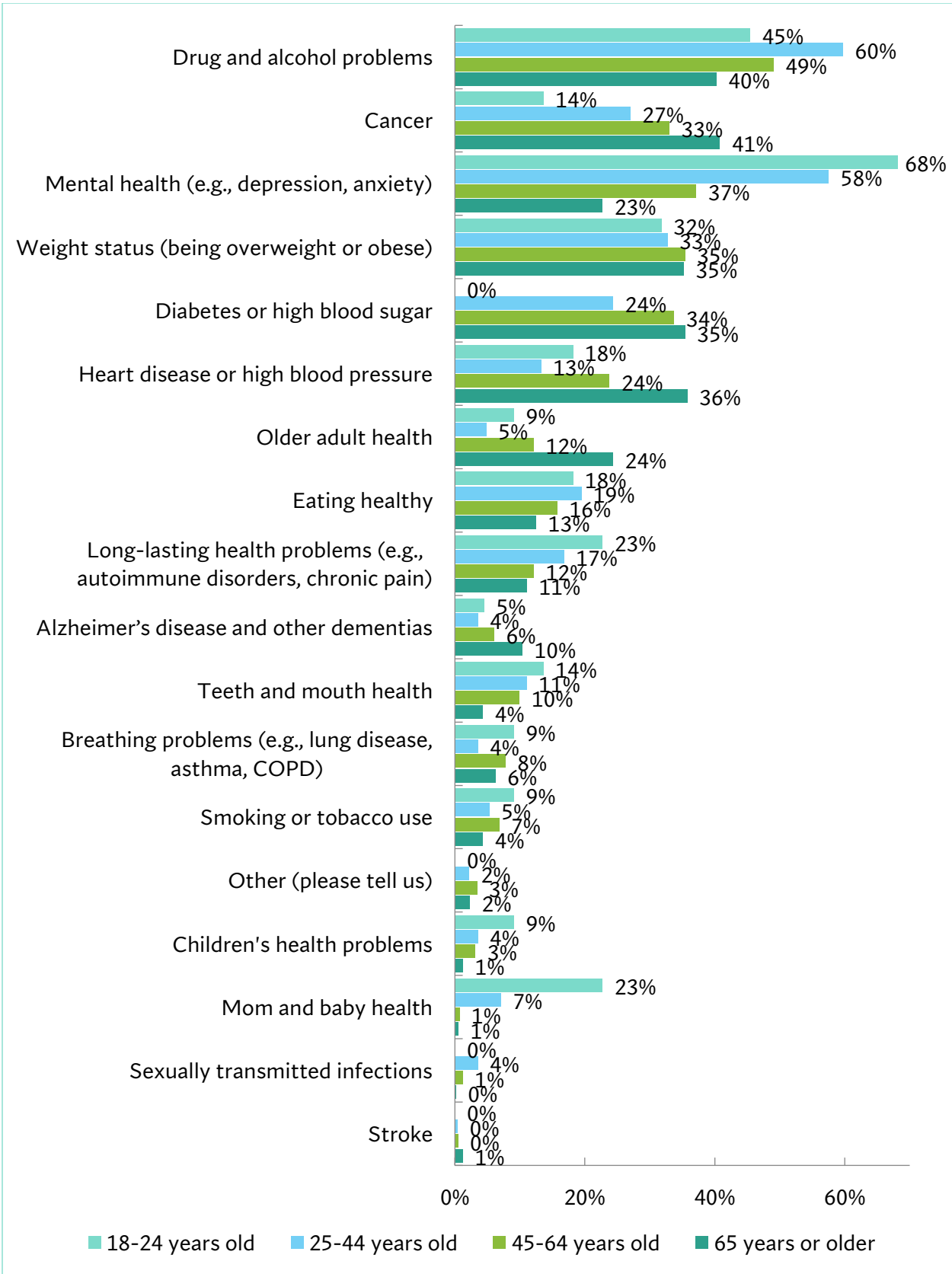
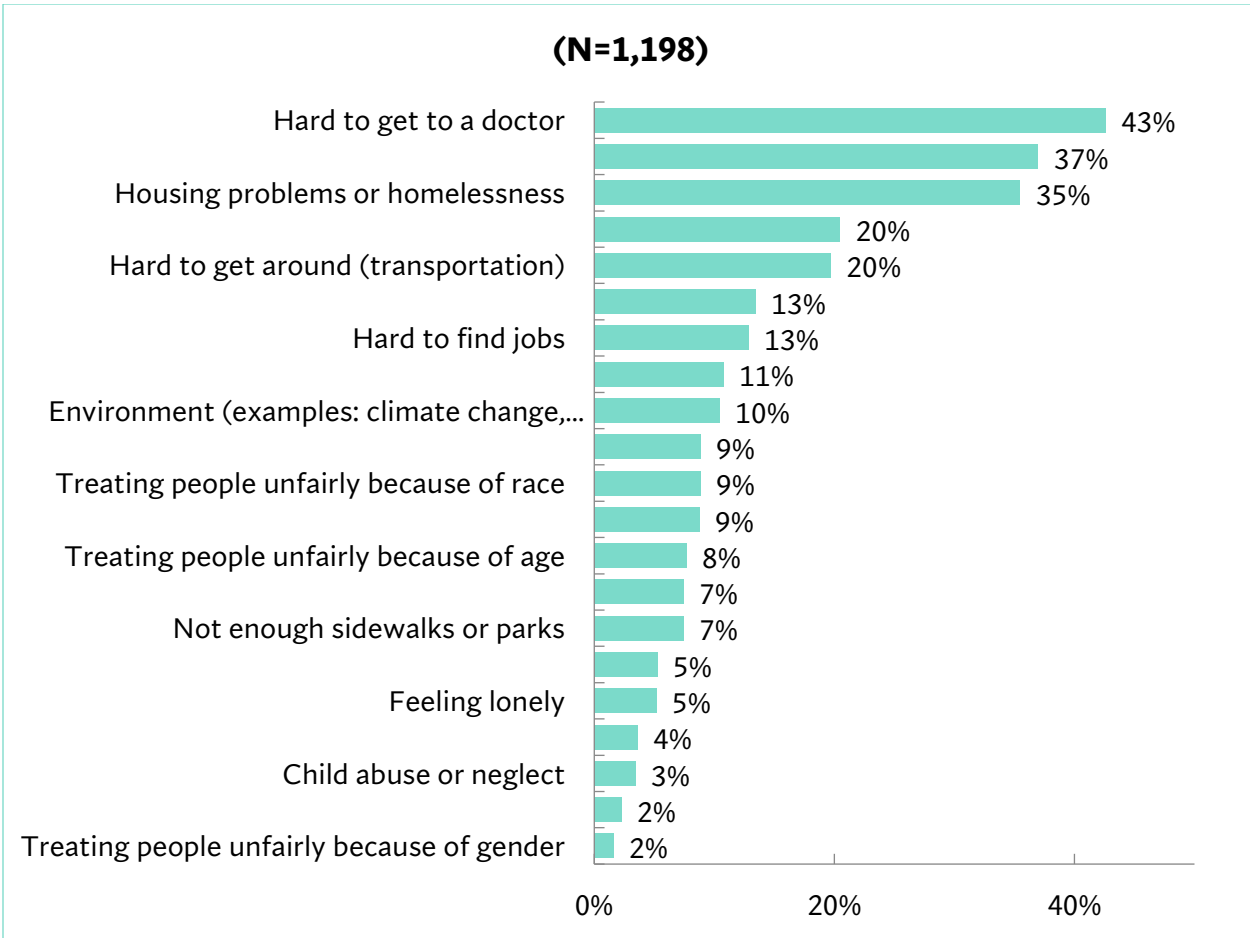


Figure A6.12: What are the 3 biggest problems that affect health in your community?



Themes from those who selected "Other":

- **Healthcare Access and Affordability**: The most prevalent concern across responses is difficulty accessing affordable healthcare. As one respondent noted: "Cost of health care/insurance" while others mentioned "Affordable Health Insurance" and "Healthcare costs $$$$$." Many highlighted problems with "Not enough doctors" and "Hard to get specialist doctors to take you as a patient."
- **Healthcare System Issues**: Respondents identified structural problems like "For-Profit Healthcare System," "Difficulty navigating insurance and healthcare," and wait times: "Difficulty in getting medical care when needed (long wait times for basic appts)." One person noted: "Down here in my area they can't keep the same doctors at the place."
- **Economic Factors**: Many responses point to financial barriers, including "Price of healthy foods for fixed income," "Limited high paying jobs," and "The cost of living is 10% higher than the metro areas." One detailed response highlighted broader economic issues: "Unfairness in general, stress to the middle class because they aren't rich enough not to care or poor enough to get assistance."
- **Social and Community Factors**: Several responses identify community-level issues like "Poverty, crime, unsafe areas," "Not enough family-oriented outside activities," and "Isolation, food deserts, learned helplessness." One respondent mentioned "Lack of community leadership to promote growth."

- **Education and Awareness**: Many highlighted "Lack of education about nutrition," "Lack of knowledge how to stay healthy," and "Society not valuing or being aware of good health practices." One person observed: "The mindset that a pharmaceutical can fix a problem rather than getting to the root causes of our diseases and disorders."
- **Mental Health Access**: Several responses specifically mentioned mental health challenges, including "Hard to find mental health care" and "Lack of access to mental health resources."
- **Lifestyle Factors**: Some responses point to behavioral issues: "Drug addiction, poor nutrition training, children & youth playing video games and not playing outside" and "People don't take care of themselves. Over worked. Less time for exercise, outdoors, cooking, therapy."

Figure A6.13: What are the 3 biggest problems that affect health in your community (by county)?

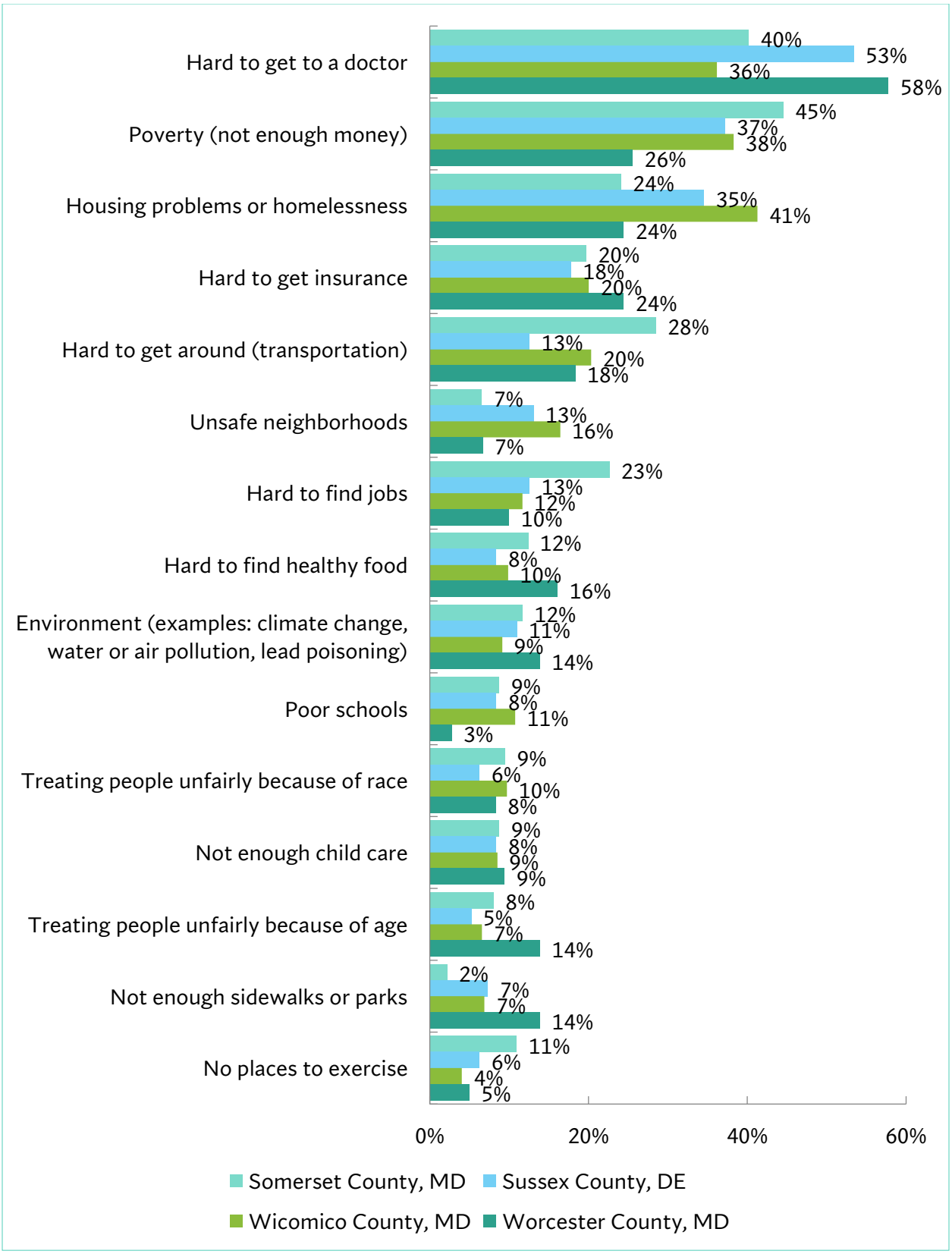


Figure A6.14: What are the 3 biggest problems that affect health in your community (by race)?

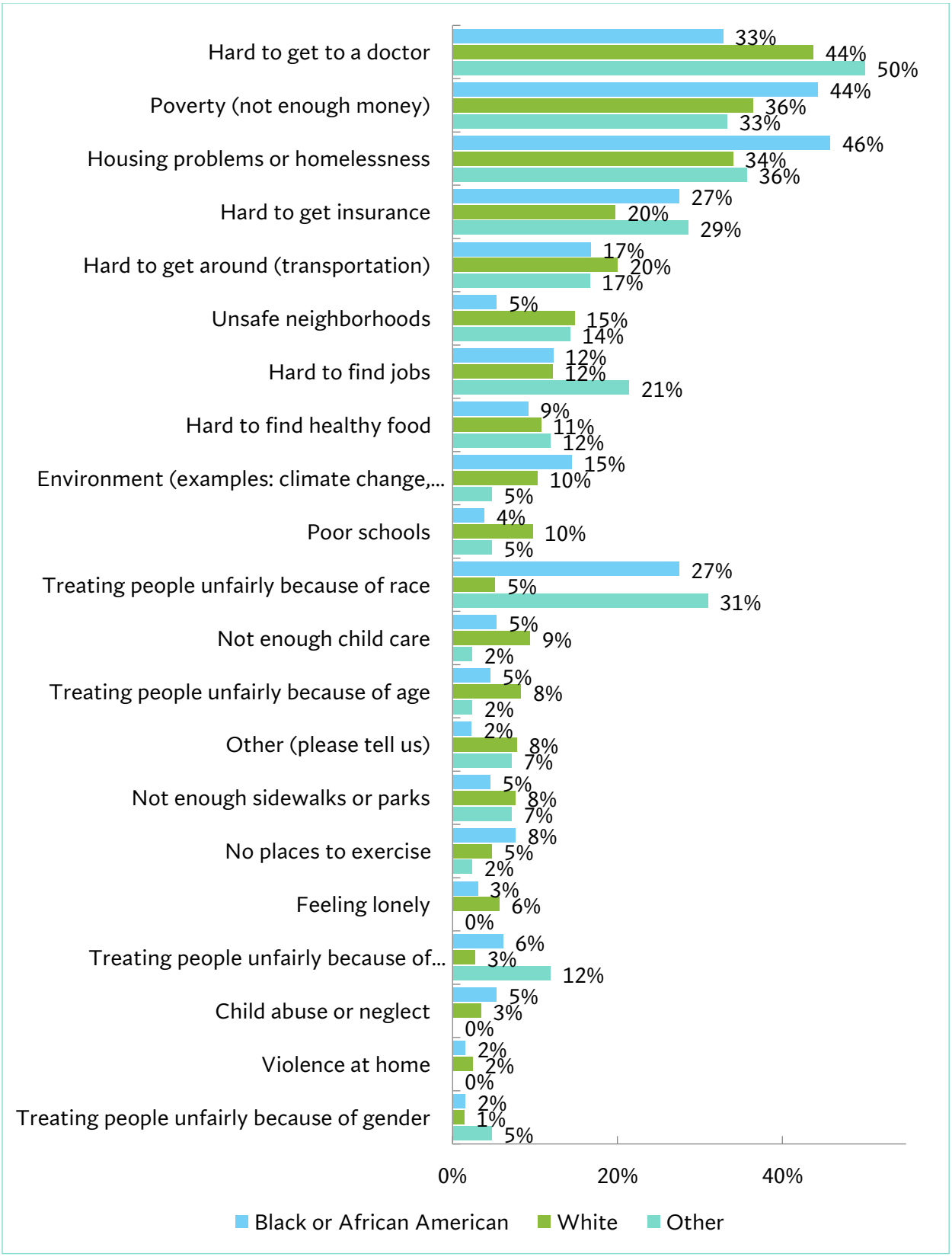


Figure A6.15: What are the 3 biggest problems that affect health in your community (by gender)?

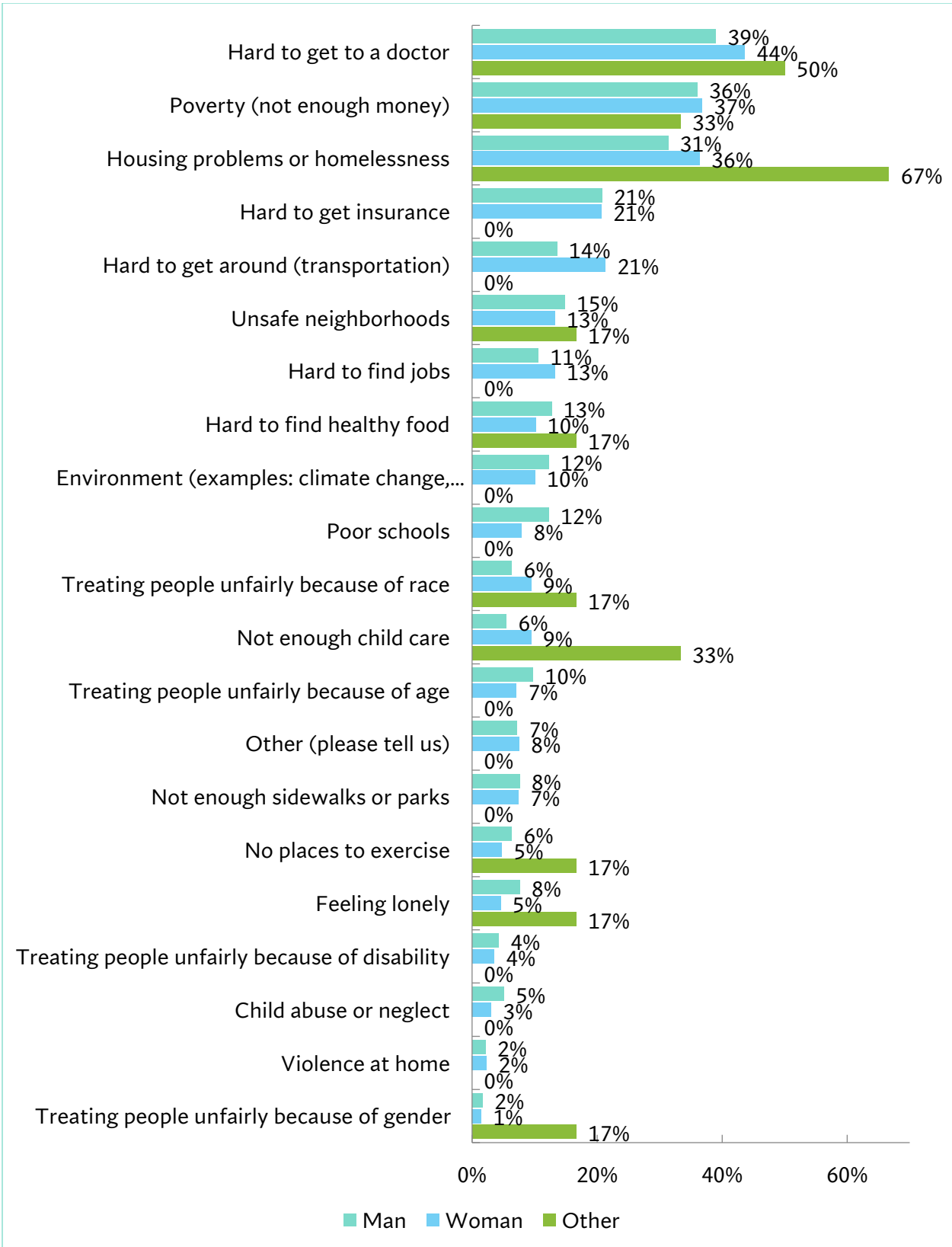


Figure A6.16: What are the 3 biggest problems that affect health in your community (by age)?

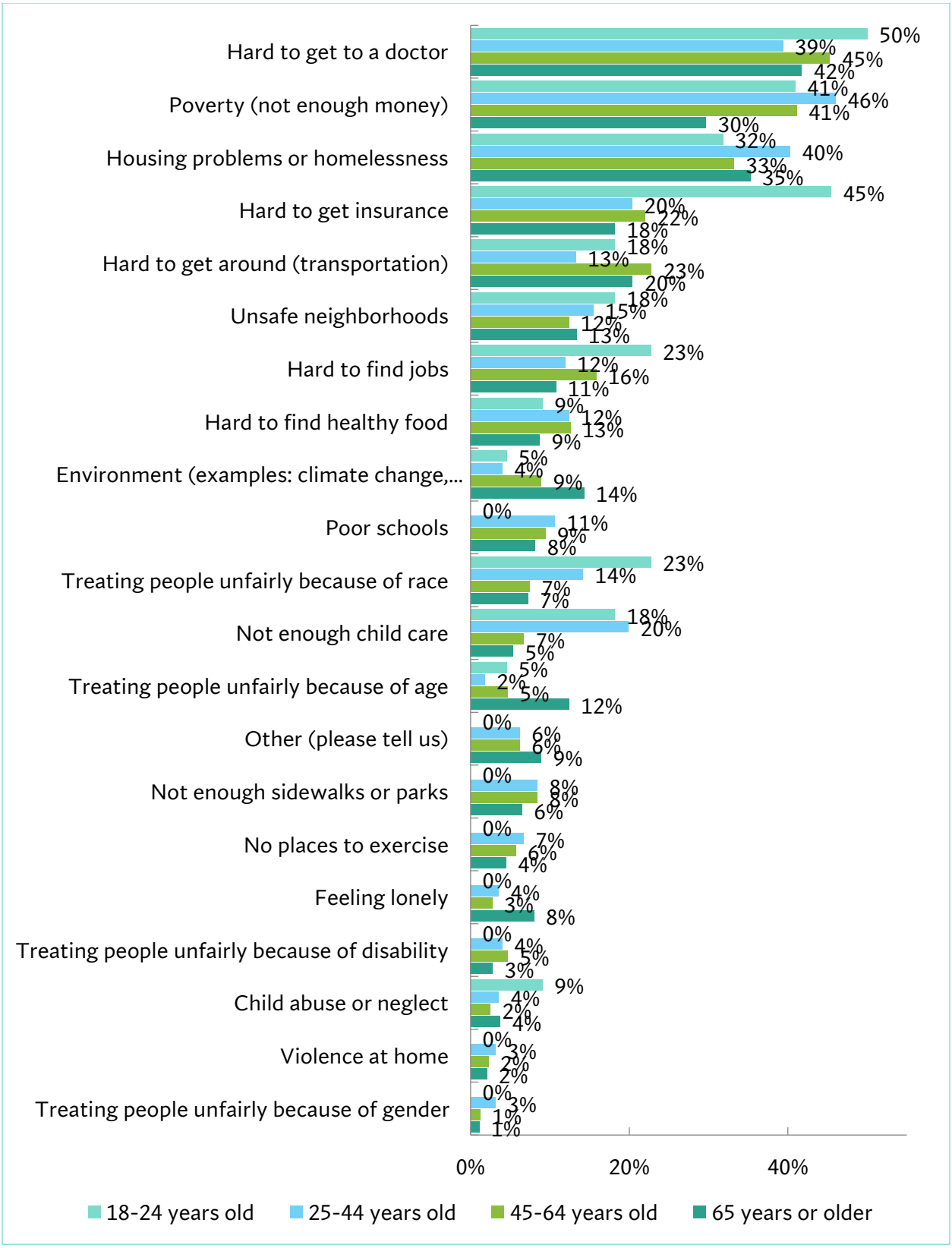
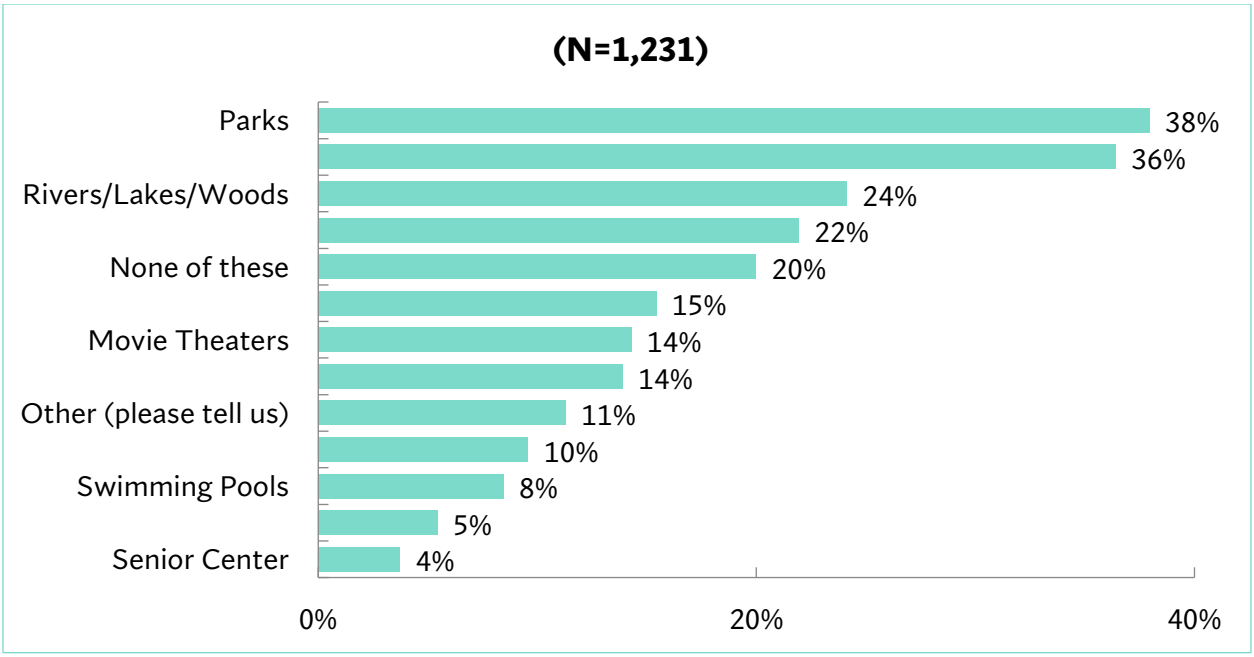


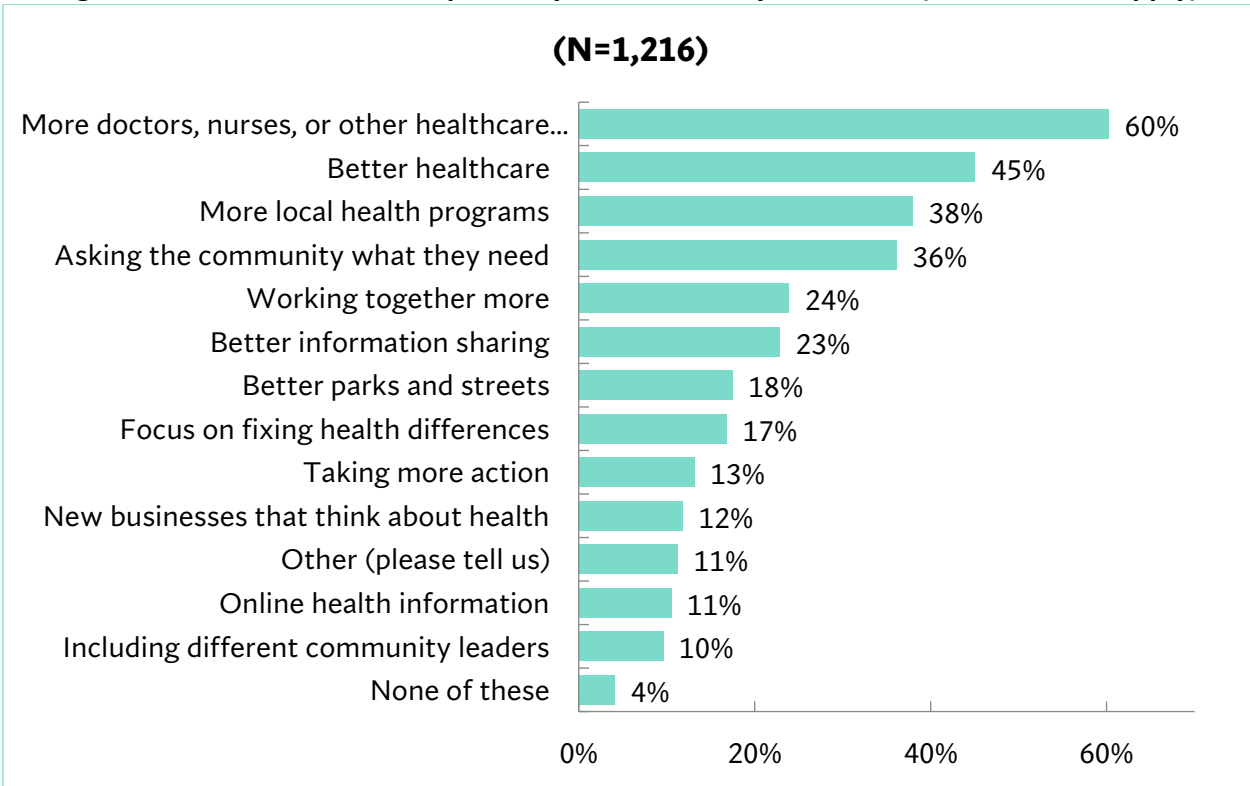
Figure A6.17: Where do you go most often in your community? (Check all that apply)



Themes from those who selected "Other":

- **Natural Areas and Outdoor Recreation**: Many respondents visit outdoor locations including "Assateague island," "Beach," "Bike trail," "Walking trails," "Nature," "Ocean and bay," and "Walking outside in the country." One person mentioned their "50 acre property" while another noted "Tangier Sound and Chesapeake Bay."
- **Restaurants and Food-Related Locations**: Eating out is popular, with responses like "Foodie Restaurants," "Restaurants & shopping," and "go out to lunches with friends." Grocery stores were also frequently mentioned: "Grocery store, coffee shop," "Grocery Store, Downtown Berlin."
- **Social Connections**: Visiting others ranked highly, with many respondents citing "Family and friends homes," "Socialize with friends & neighbors," "Visiting friends," and "Family visits."
- **Shopping and Retail**: Shopping destinations appeared frequently, including "Shopping centers," "Thrift stores," "Walmart," and "stores. ex: Target, Walmart & The Mall."
- **Healthcare Settings**: Several people mentioned medical appointments as their primary destinations: "Doctor, lab, chemo suite," "Dr appointments," and "To get my hair done. Doctor's appts."
- **Limited Mobility/Options**: Some respondents indicated limited community engagement: "Home only," "Disabled, waiting for diabetic clearance for knee surgery," "I care for my adult son 24/7," and "Not many options, stores of interest are limited."
- **Cultural and Entertainment Venues**: Some mentioned "Salisbury University cultural events and exhibitions," "Live music venues," "Music venues," and "classes and organized meetings." One detailed response highlighted missing cultural amenities: "We miss GOOD cultural offerings here, such as high professional level classical music... To us, there is no Life without Art."
- **Community and Recreational Facilities**: Several people mentioned community spaces like "Kingdom Hall," "Judy center," "Firehouse," "Legion," "Pickleball," and "Yoga at YMCA."

Figure A6.18: What would help make your community healthier? (Check all that apply)

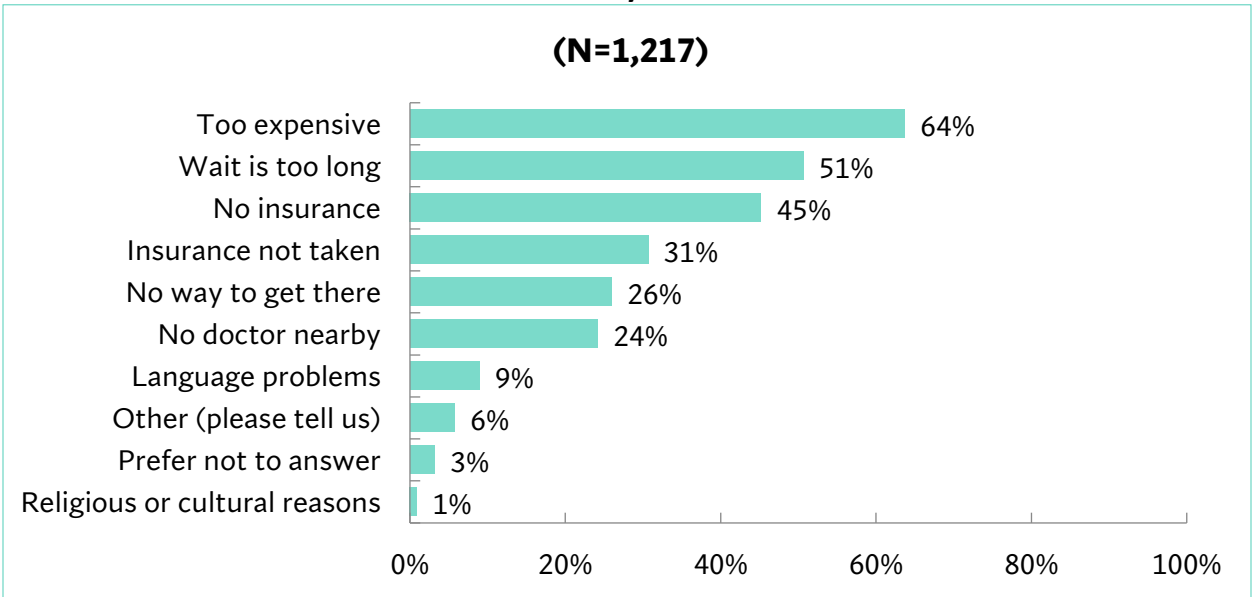


Themes from those who selected "Other":

- **Healthcare Affordability and Access**: The most frequently mentioned improvement is affordable healthcare: "Affordable care," "Affordable healthcare," and "Making health insurance available to people that currently don't qualify but can barely afford to live!" Many highlighted the need for "Better access to dental care" and "Access to specialists, imaging and testing in a timely manner."
- **Healthcare Quality and Systems**: Respondents want improved healthcare services: "Better quality doctors, nurses, and health support staff."
- **Affordable Healthy Food Access**: Many emphasized food-related improvements: "Access to healthily foods we have too many options for burgers fries, shakes but limited on salads and healthy options," "Better stores selling more quality organic food," and "Quality food at affordable prices."
- **Community Infrastructure**: Respondents highlighted needs for "Safe and convenient places to walk," "Off road bicycle/hiking trails," "More parks and places for people to play, gather, relax," and "Intelligent urban planning that focuses on creating walkable mixed residential business spaces."
- **Transportation**: Several responses mentioned "Better access to transportation," "Public transportation," and "Transportation for elderly" as key improvements.
- **Housing**: Affordable housing was a priority: "Affordable housing for all - reduce predatory leasing," "Safe, adequate and affordable housing," and "Housing!"

- **Economic Factors**: Economic security was emphasized: "Higher wages," "Recruiting good employers," and "Affordable housing. Higher paying jobs."
- **Education and Awareness**: Many suggested improved education: "Nutrition education starting in elementary school," "Education and opportunity," and "In person education (budgeting for healthy food and how to prepare it)."
- **Mental Health Services**: Responses highlighted mental health needs: "Mental health resources available and easily accessible," "Increase mental health for TBI patients," and "Offering more psychologist that stay for meds."
- **Community Support Services**: Support for vulnerable populations was mentioned: "More aggressive young adult mentoring; 'adopt a family' who needs support," "Training programs to help people raising children that are struggling," and "More focus on early childhood education and wrap around family support services."

Figure A6.19: What are the 3 main reasons people in your community can't get healthcare when they need it?



Themes from those who selected "Other":

- **Healthcare System Limitations**: Many responses highlight structural issues, including "Double booked doctors, immediate care not open during posted hours, not enough doctors for community size." Long wait times are frequently mentioned.
- **Provider Shortages and Quality**: Respondents emphasize insufficient medical staff: "Insufficient ratio of doctors/Patients," "not enough PC DOCTORS - I do not want to see a PA/NP," and "Lack of specialists, long wait time for specialists." Quality concerns were noted such as treatment of patients by providers.
- **Insurance and Cost Barriers**: Financial obstacles were frequently cited: "Insurance not taken and/or no insurance," "Insurance denying claims," and "too expensive no insurance." One detailed response noted: "Most are restaurant employees and they don't offer insurances.

Others are fisherman or work on boats and also don't have insurance opportunities that aren't a crazy amount."

- **Transportation and Access Issues**: Physical access barriers were mentioned: "Transportation," "traffic too heavy" and "having to travel to see a doctor." One respondent noted "poor rural internet for telehealth" as a barrier.
- **Specialist Shortages**: Several respondents highlighted the lack of specific medical specialties: "Lack of doctors specializing in the needed discipline," "not enough gastroenterology specialists," and "not enough specialty for pediatrics...our future."
- **Discrimination and Trust Issues**: Some responses point to bias and mistrust: "Doctor office's limit access to certain avenues of healthcare because of a person's current or past lifestyle," "People are distrustful of healthcare system," and "Previous provider mistreatment. I have intersex and transgender friends, there's only one NP that would recommend in the area."
- **Knowledge and Education Gaps**: Some noted information barriers: "Don't know what's available, whether it's expensive or not. Need more community health education forums."
- **Systemic Inequities**: A few responses highlighted broader social issues such as immigration status and poverty.

Figure A6.20: What are the 3 main reasons people in your community can't get healthcare when they need it (by county)?

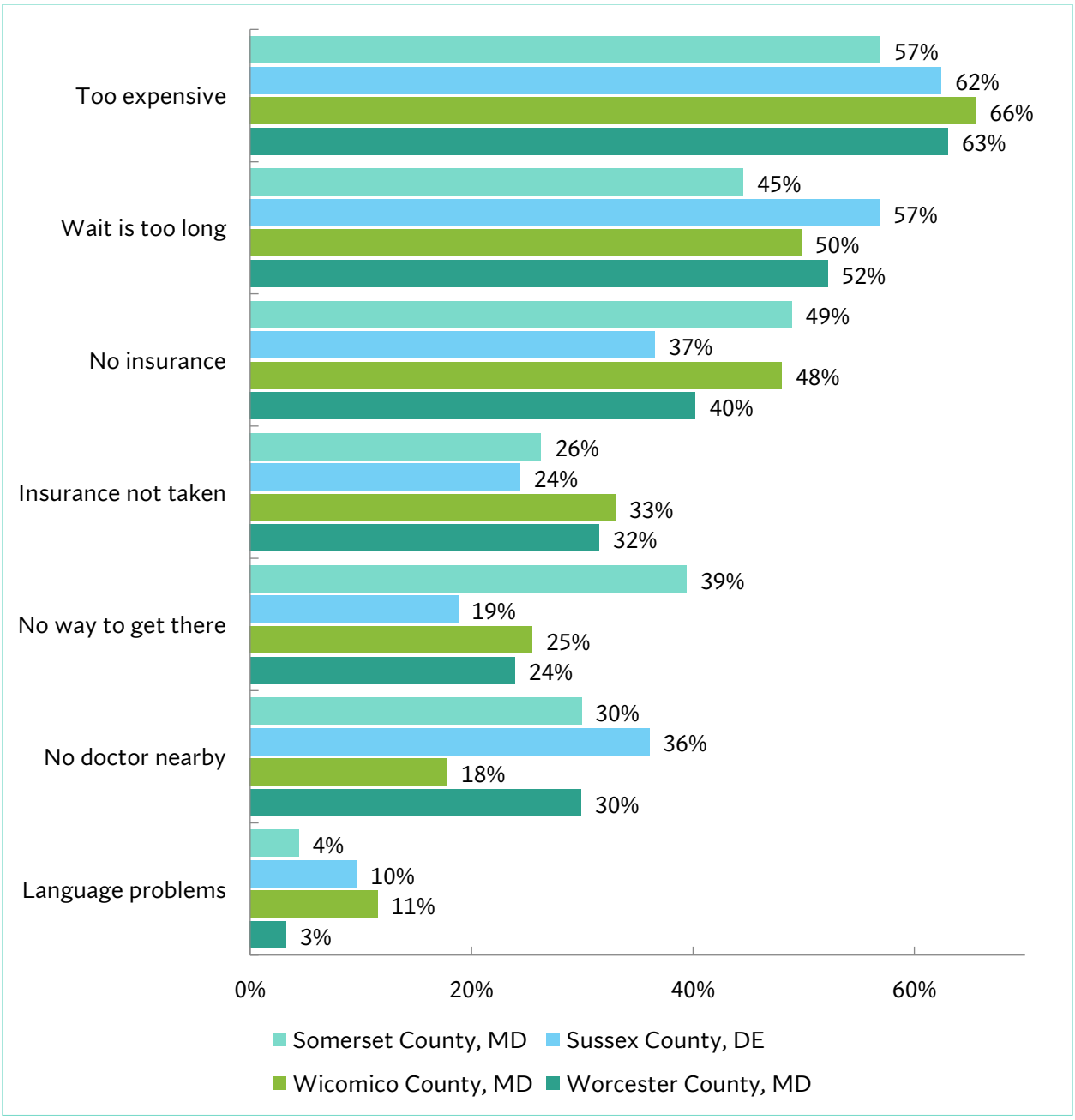


Figure A6.21: What are the 3 main reasons people in your community can't get healthcare when they need it (by race)?

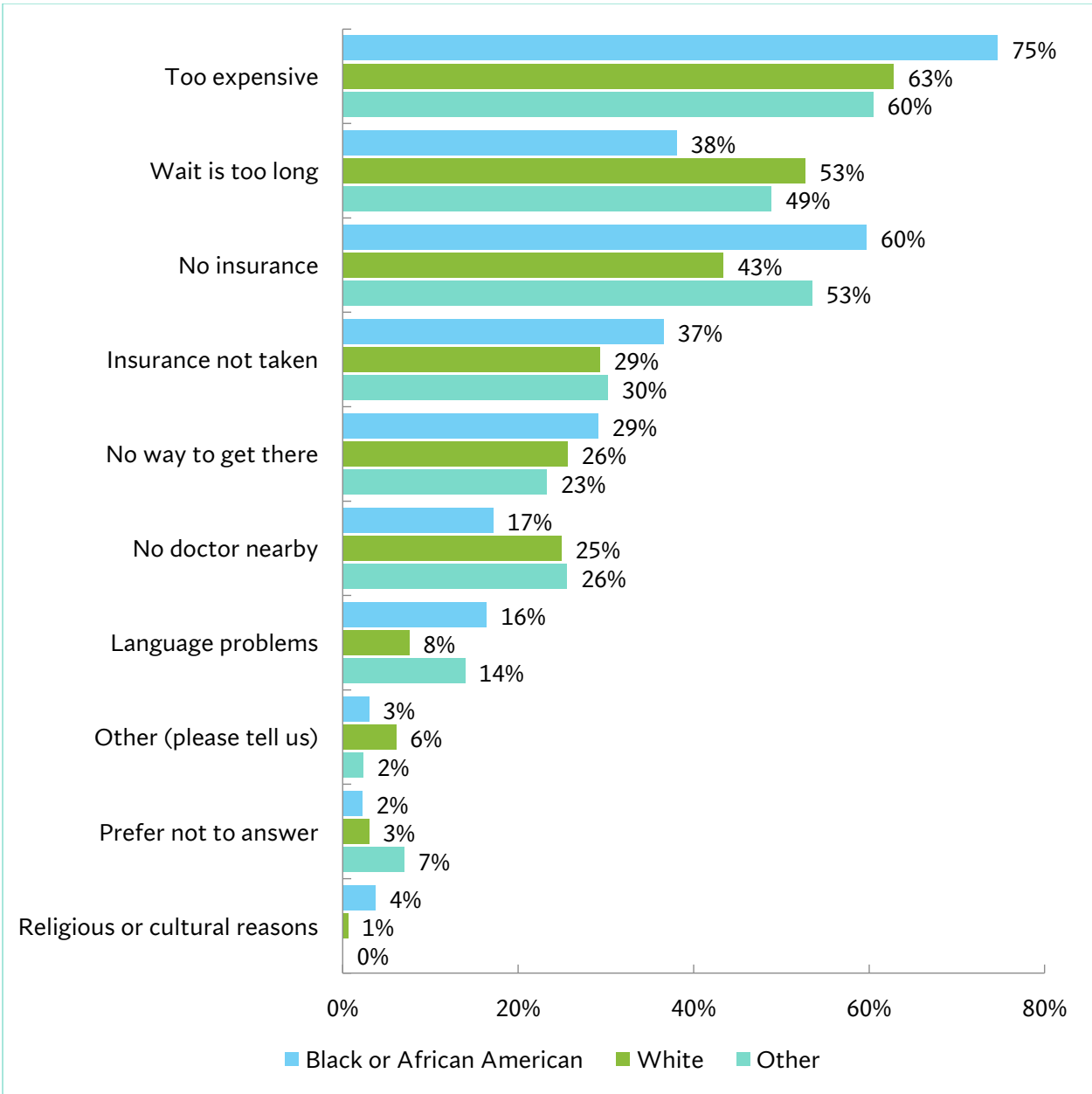


Figure A6.22: What are the 3 main reasons people in your community can't get healthcare when they need it (by gender)?

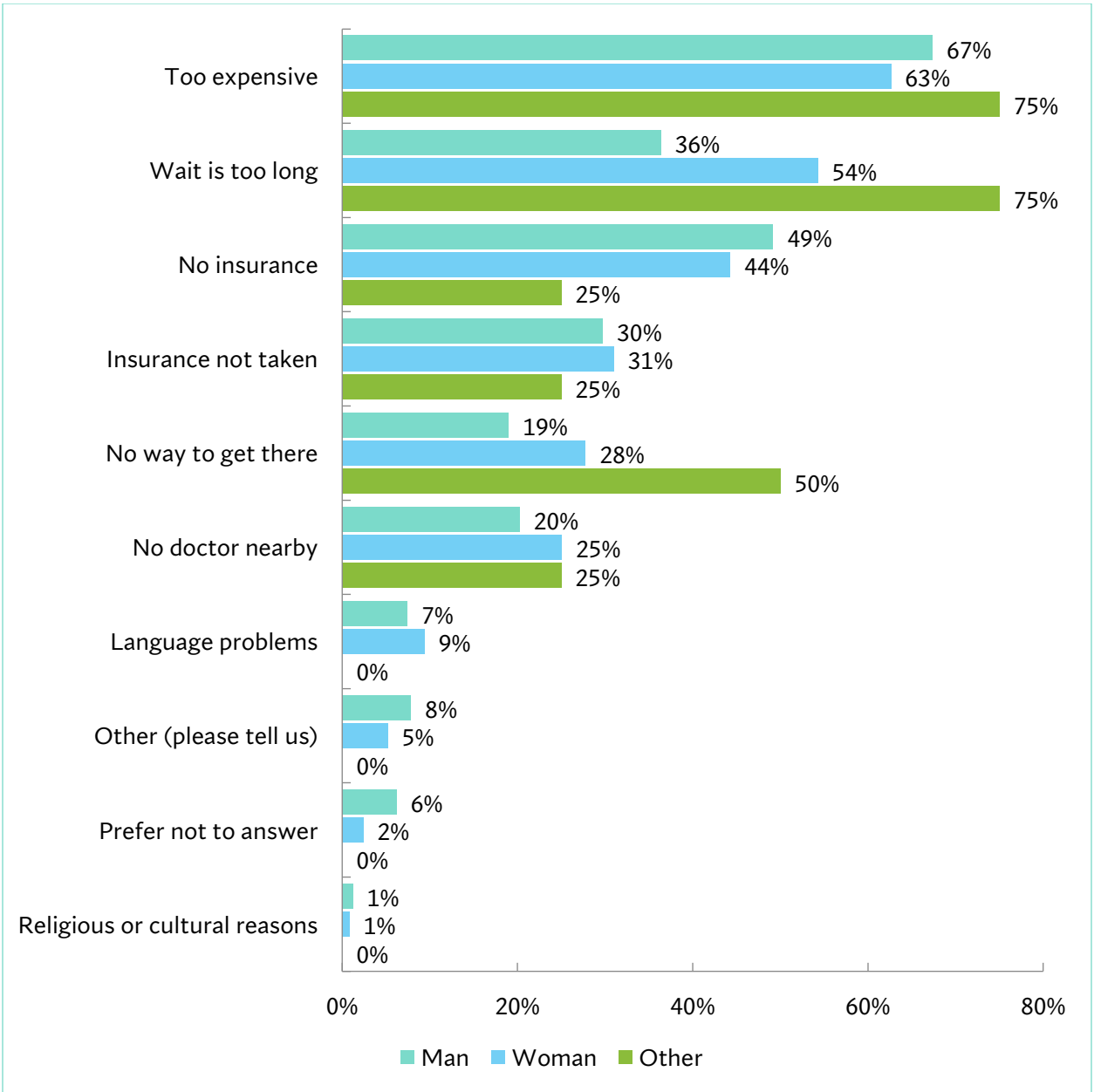
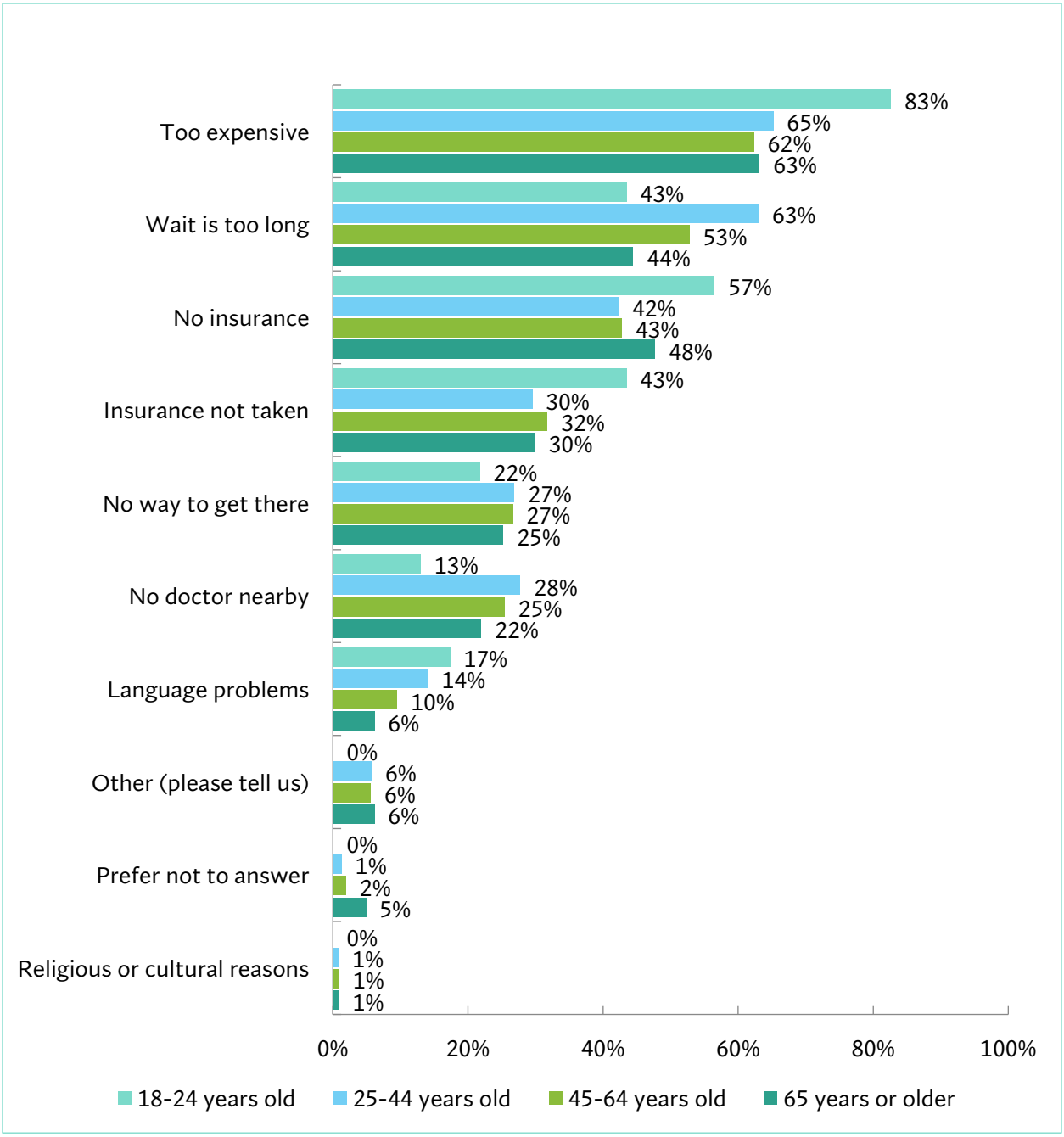


Figure A6.23: What are the 3 main reasons people in your community can't get healthcare when they need it (by age)?



Topic: Access to Care

Figure A6.24: Do you have health insurance? (Pick one)

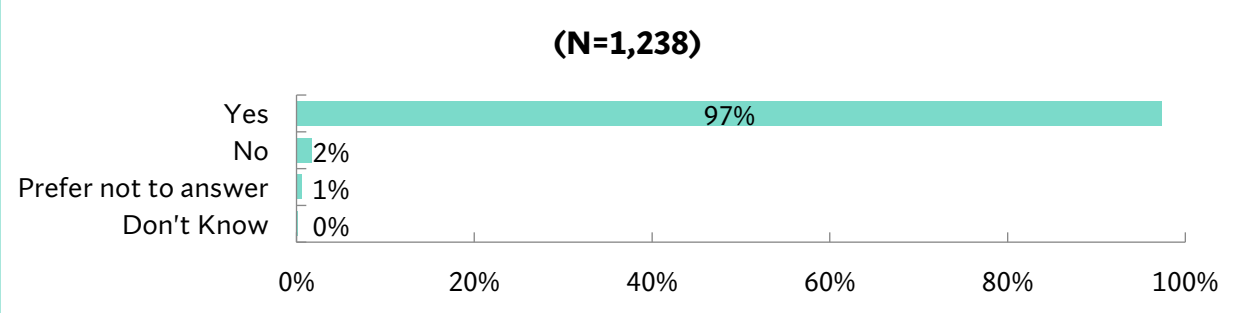


Figure A6.25: What kind of health insurance do you have? (Check all that apply)[47]

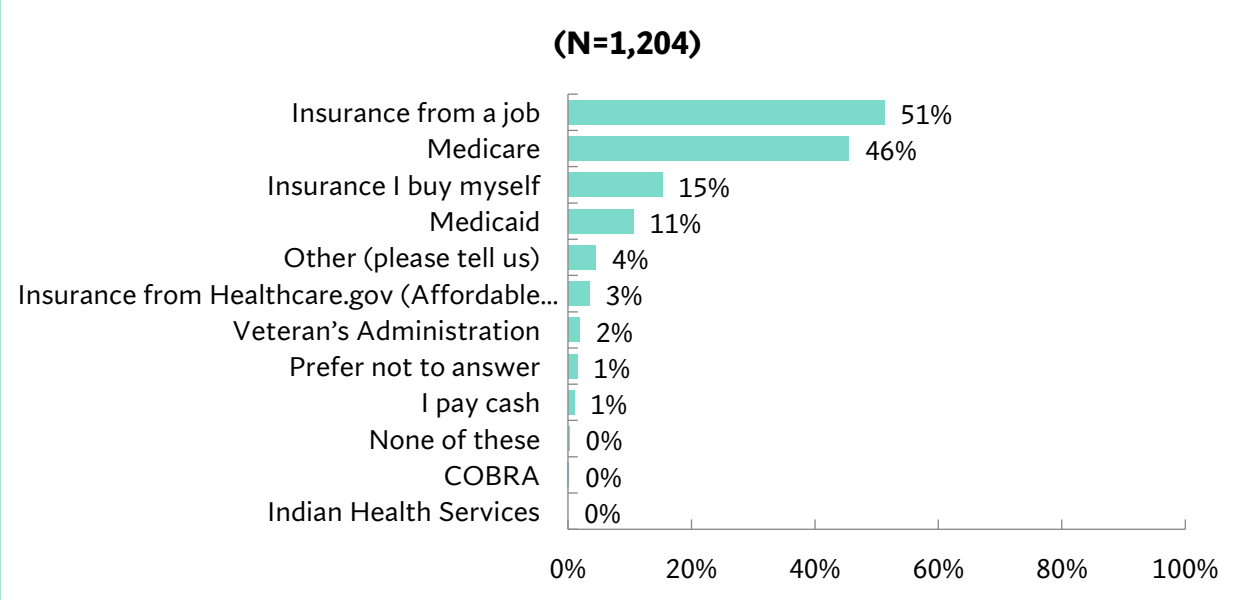


Figure A6.26: DURING THE PAST 12 MONTHS, has a doctor said they won't take your insurance? (Pick one)[48]

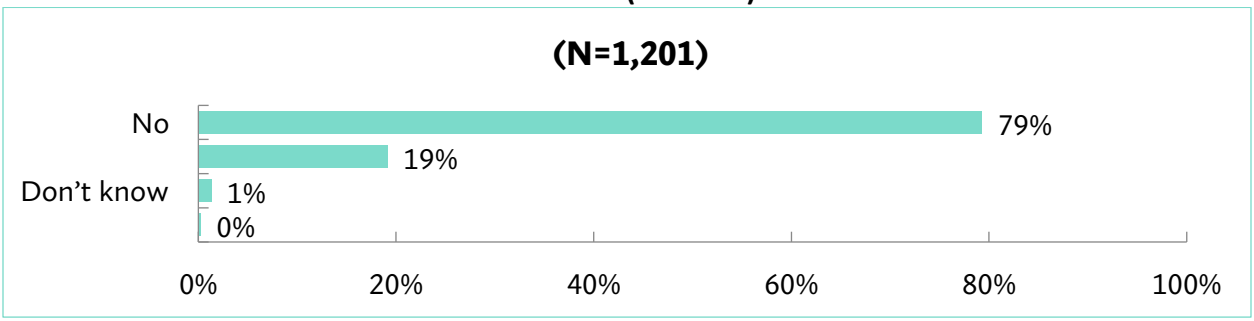
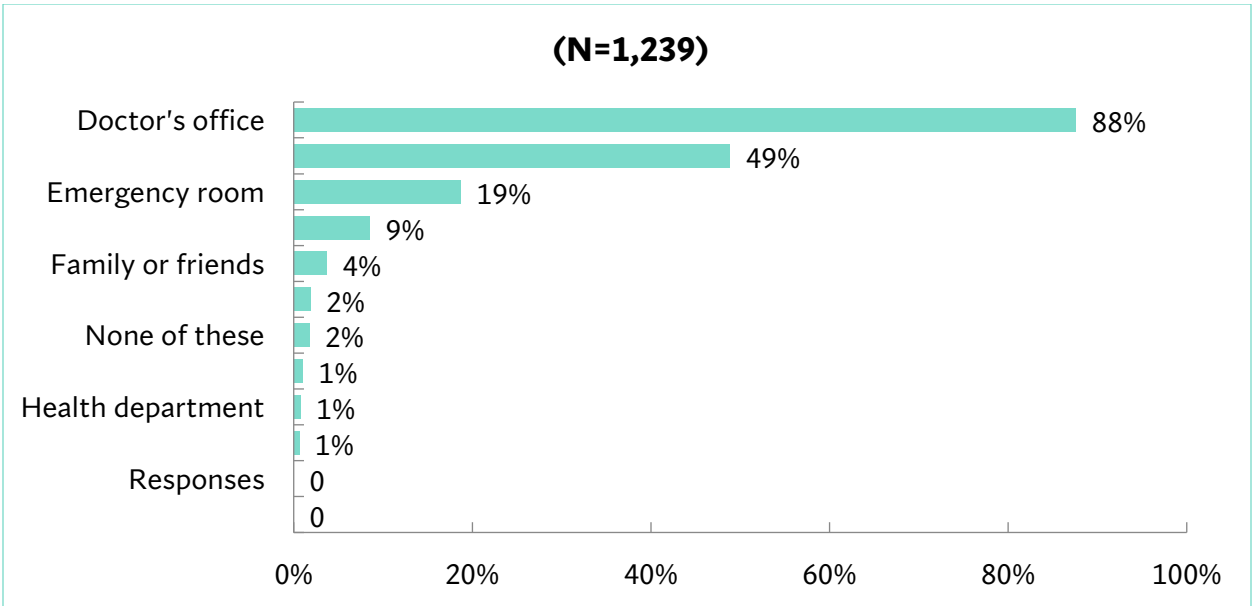


Figure A6.27: Where do you usually go when you're sick? (Check all that apply)

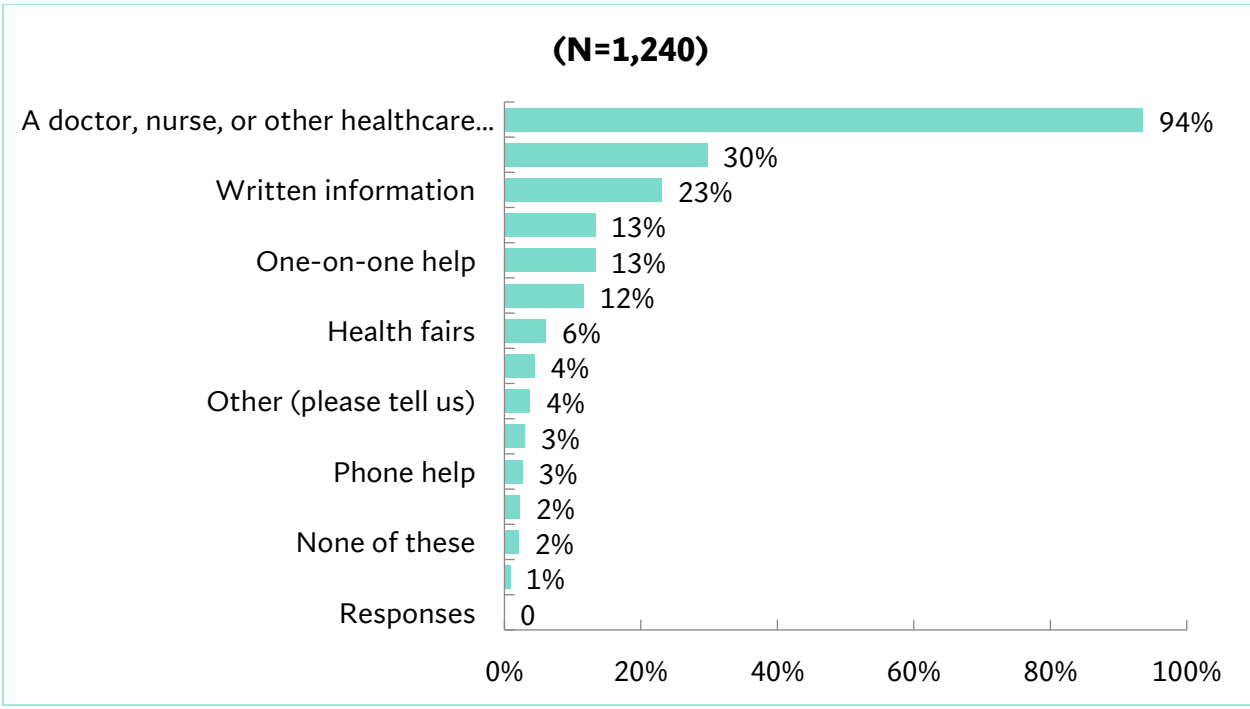
[47] Note: This question was only asked to respondents who indicated they have health insurance in previous question.
[48] Note: This question was only asked to respondents who indicated they have health insurance in previous question.



Themes from those who selected "Other":

- **Primary Care Provider**: Most respondents turn to their personal doctor when ill. Communication methods vary, with some using traditional visits while others connect digitally: "Message PCP on portal" and "MyChart to message my PCP."
- **Telehealth Services**: Virtual healthcare is increasingly popular, with multiple responses specifically mentioning telehealth: "Telehealth through my insurance," "Telehealth provider offered through my federal government insurance," and "I use online Telehealth as well its faster and easier than trying to get into my own doctors office."
- **Urgent Care and Emergency Services**: When primary care isn't available, many use alternative care settings: "doctor's, if not avail. then 'doc's in', or if needed ER" and "Hospitals in Baltimore."
- **Self-Care at Home**: Some respondents manage illness independently: "Home - nurse oneself," suggesting they treat minor illnesses themselves before seeking professional care.
- **Alternative Healthcare Providers**: A few seek non-traditional care: "Acupuncturist, chiropractor," "Nutritionist," and "Pain management," indicating a broader approach to healthcare beyond conventional medicine.
- **Pharmacies and Retail Health**: Some use pharmacy-based services: "Walgreen's or Rite Aid if they are able to do test or to get over the counter depending on need" and "Pharmacy," showing how retail health services serve as accessible care points.
- **Employer-Provided Resources**: Workplace healthcare options appear in responses: "Wellness Center provided by employment" and "Doc by phone through insurance/work," highlighting the role of employer benefits.
- **Insurance and Financial Constraints**: One response directly addresses financial limitations: "I have Medicare, no secondary insurance. Cannot afford any medical services other than routine physical exam," indicating how insurance status affects healthcare choices.

Figure A6.28: Who do you trust for health information? (Check all that apply)

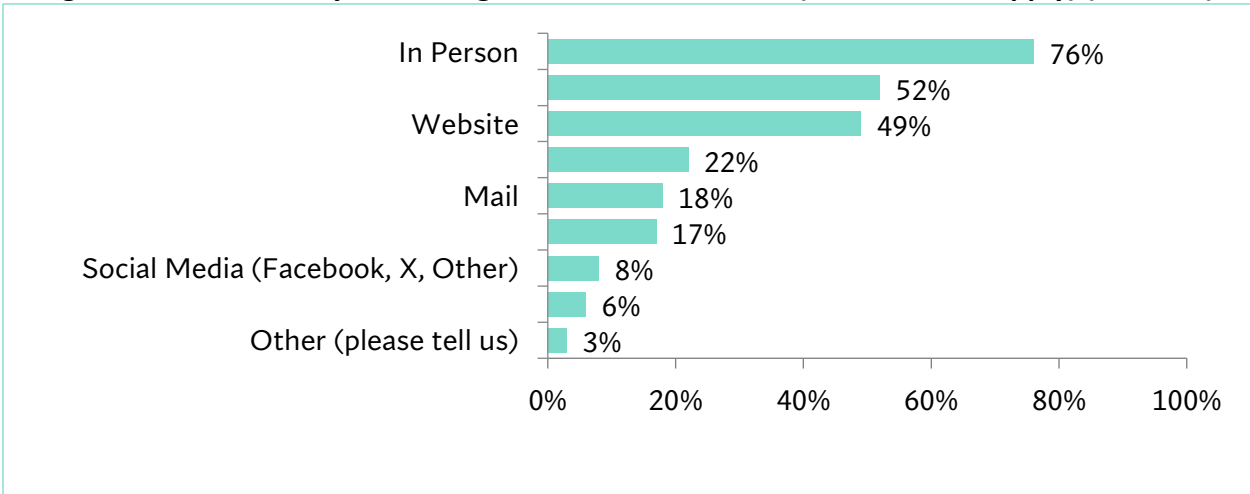


Themes from those who selected "Other":

- **Medical Professionals and Institutions**: Many respondents trust established healthcare sources including "Specifically my primary care physician," "Trustworthy, science-based guidance from medical authorities like WHO, CDC, NIH," and "Documented research from NIH." Some specifically mention prestigious institutions: "Online: Mayo Clinic, John's Hopkins, Cleveland Clinic" and "Reputable clinic information online, such as Cleveland and Mayo clinics."
- **Personal Research**: A significant number of respondents conduct their own investigations: "My own research," "Personal extensive research," and "Information I research myself from trusted sources." This indicates a desire to be active participants in health decisions.
- **Medical Literature and Evidence-Based Sources**: Many rely on scientific publications: "Research based journals," "scientific literature," "medical journals," and "Published research articles," showing a preference for evidence-based information.
- **Alternative and Holistic Practitioners**: Some trust non-conventional sources: "Naturopaths, holistic health coaches, functional medicine drs, chiropractors," "Doctors that work with natural medicines," and "Naturopathic doctors," reflecting interest in complementary approaches.
- **Online Resources**: Digital sources are popular: "Internet research," "WebMd, Mayo Clinic," and "medically reviewed website." Some respondents specified "reputable on line resource like Webb MD or Mayo Clinic," indicating discernment about online sources.
- **Family and Personal Connections**: Some rely on knowledgeable family members, as one detailed: "My daughter who is a mental health counselor, my daughter who is a Veterinarian, my daughter's partner who an infectious disease doctor, and my job as a clinical laboratory scientist."

- **Skepticism and Trust Issues**: Several responses indicate lack of trust in information sources: "It is hard to know who to trust these days," "No one," and "Very difficult finding healthcare practitioners who you can trust," reflecting a broader erosion of confidence in health information.
- **New Technology**: A few mentioned newer information sources including "AI (Chat GPT / Perplexity)" and "social media - I found my highly qualified surgeon on Facebook b/c no one could help me nor diagnose me no refer me."

Figure A6.29: How do you like to get health information? (Check all that apply) (N=1,237)

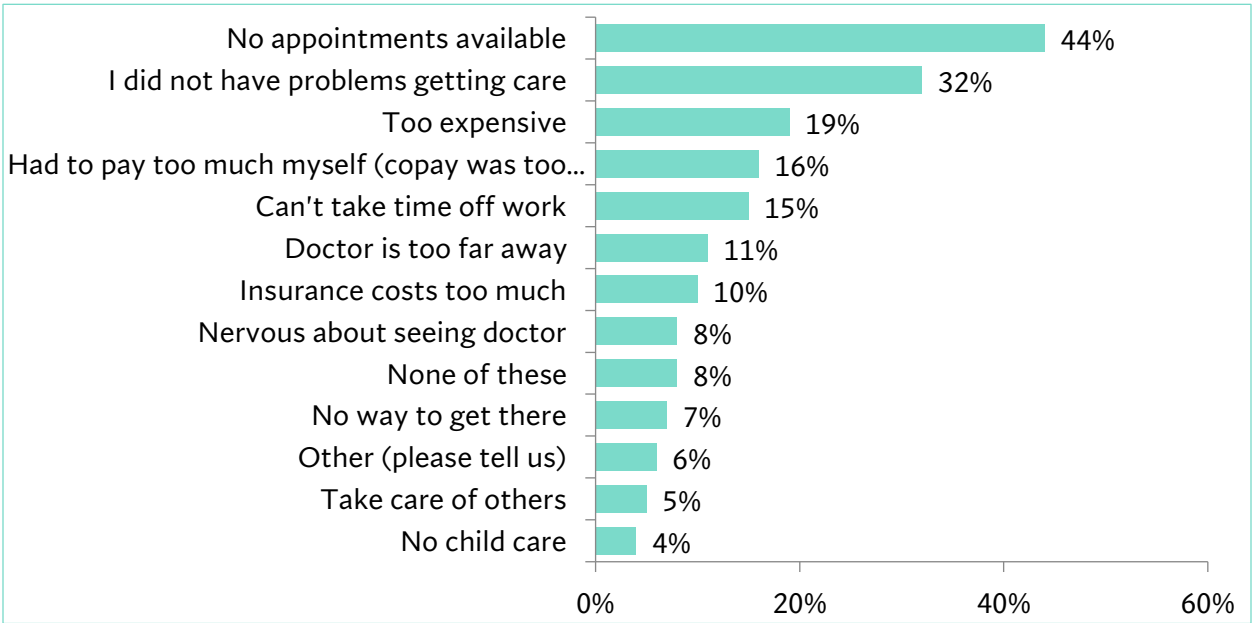


Themes from those who selected "Other":

- **Direct from Healthcare Providers**: Many respondents prefer information directly from medical professionals: "From my doctors," "Through a trusted source like my Providers," and "Doctor." This suggests a continued trust in healthcare professionals for personalized information.
- **Digital Patient Portals**: Several mentioned using technology to connect with their healthcare providers: "Doctor's patient portal," "Patient portal," and "My chart info on tests and follow up from my chosen providers," highlighting the importance of patient-provider digital communication tools.
- **Reputable Medical Websites**: Respondents seek trusted online sources: "Depending on what I am looking for, the CDC website, Mayo Clinic, Johns Hopkins," and "NIH, WHO," showing a preference for established institutional websites.
- **Scientific and Research Publications**: A significant number prefer evidence-based sources: "evidence-based research articles," "Reading journal research based articles, literature review," and "Medical science journals etc," indicating a desire for verified information.
- **Self-Directed Research**: Many take an active approach: "Google it," "research," and "I am a nurse - know approp sources," suggesting comfort with finding information independently.
- **Traditional and Print Media**: Some prefer conventional formats: "Books," "Written/published," and "Radio/television broadcast," showing continued value for established media.

- **Digital Video Content**: Video platforms are emerging as health information sources: "YouTube" and "Medical lecturers from YouTube from real Drs," indicating the importance of visual learning for health topics.
- **Self-Determined Information Access**: Some respondents expressed a preference for controlling when they receive health information: "If I want health info, I'll go find it. Otherwise leave me alone," showing a desire for autonomy in health information consumption.
- **Diverse Preferences**: The variety of responses indicates that information delivery should be tailored to different audiences through multiple channels, as one respondent noted: "depends on the information."

Figure A6.30: There are many reasons people delay getting medical care. What made it hard to get medical care in the PAST 12 MONTHS? (Check all that apply) (N=1,235)



Themes from those who selected "Other":

- **Provider Availability Issues:** Long wait times and provider shortages created significant barriers. "Had to wait months for an appointment" and "Limited physicians with openings... Waiting over a year for colonoscopy." Provider turnover complicated care continuity: "Doctors either leave or retire." Communication failures further limited access.
- **Geographic Barriers:** Many patients have to travel far for adequate care: "I have to go across the bridge for real quality care." Those with complex conditions faced additional challenges: "I often must go out of town/state for knowledgeable providers," leading to "much higher health care expenses in the way of travel, overnight accommodations and meals."
- **Quality of Care Concerns:** Quality concerns deterred many patients. Some experienced "Lack of knowledgeable doctors" with serious consequences: "No one locally could diagnose me...

10 year delay to diagnosis." Others worried about provider qualifications: "I'm scared to have [nurse practitioners] as sole provider: their training has very little clinical time."

- **Insurance and Cost Barriers:** Financial obstacles prevented access to needed care, from "high deductible" to specific coverage limitations: "can't get eating disorder treatment because Medicare doesn't cover nutrition therapy."
- **Negative Healthcare Experiences:** Past negative encounters created reluctance to seek care: "Fear of going to office due to bad experience."
- **Specific Population Challenges:** Certain groups faced unique barriers, particularly for dental care: "No dental care in the community for regular adults." Caregivers struggled to prioritize their own health: "I cannot leave [my husband] for long periods of time so getting care for myself is next to impossible."

Figure A6.31: How worried are you about paying medical bills if you get sick or hurt? (N=1,239)

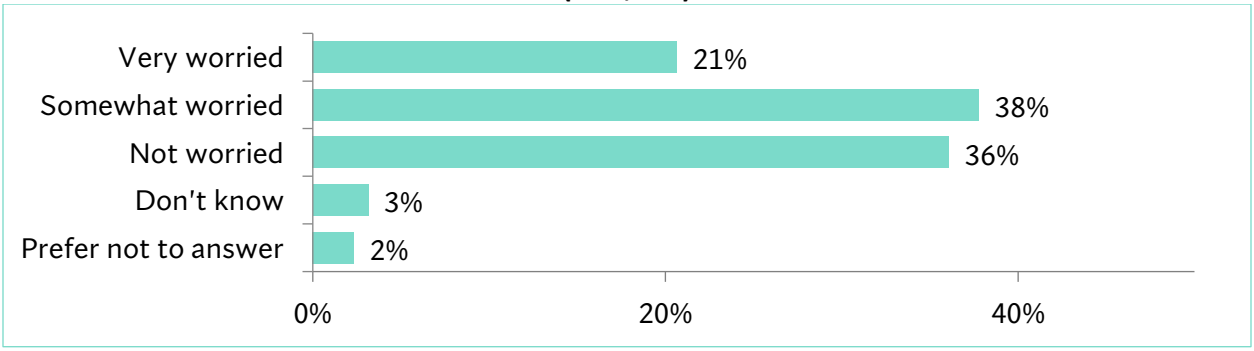
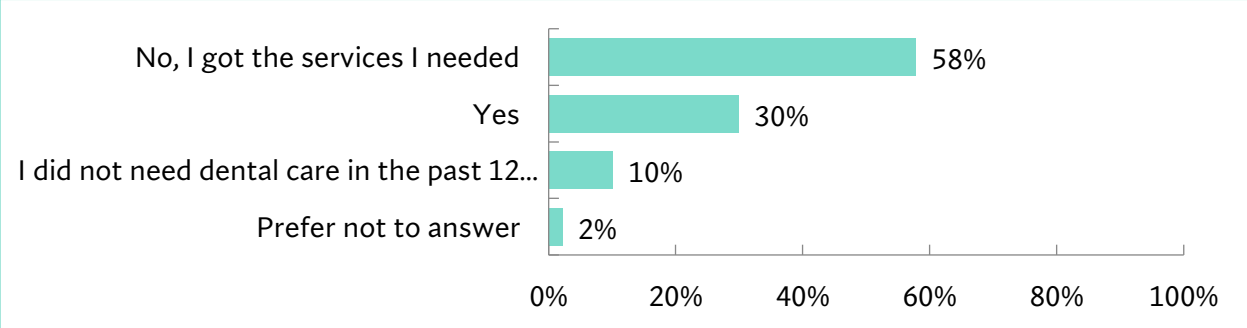


Figure A6.32: In the past 12 months, did you need dental care but couldn't get it? (Pick one)



Topic: Healthcare Utilization

Figure A6.33: In the past 12 months, how many times did you go to the emergency room instead of a regular doctor?

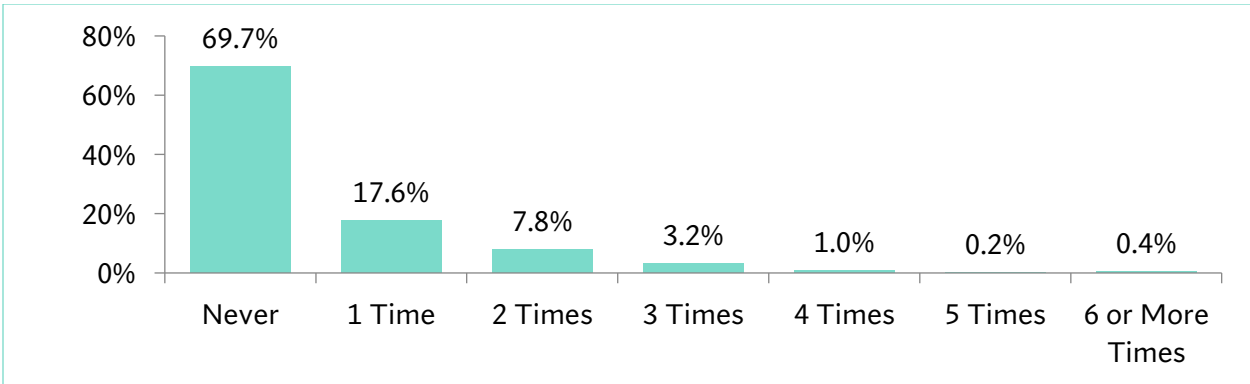
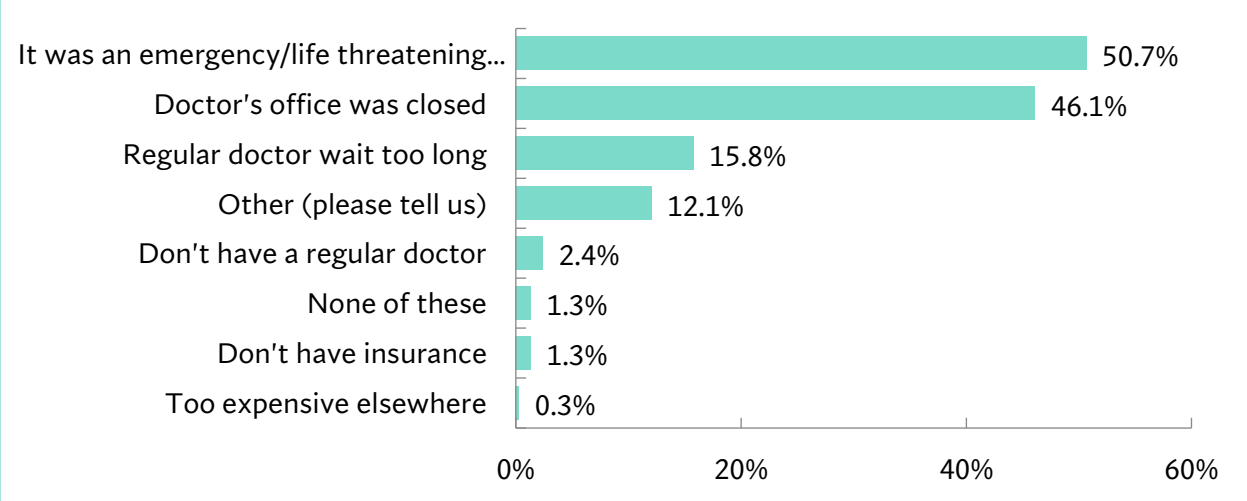


Figure A6.34: Why did you go to the emergency room instead of a doctor's office or clinic?[49] (N = 373)

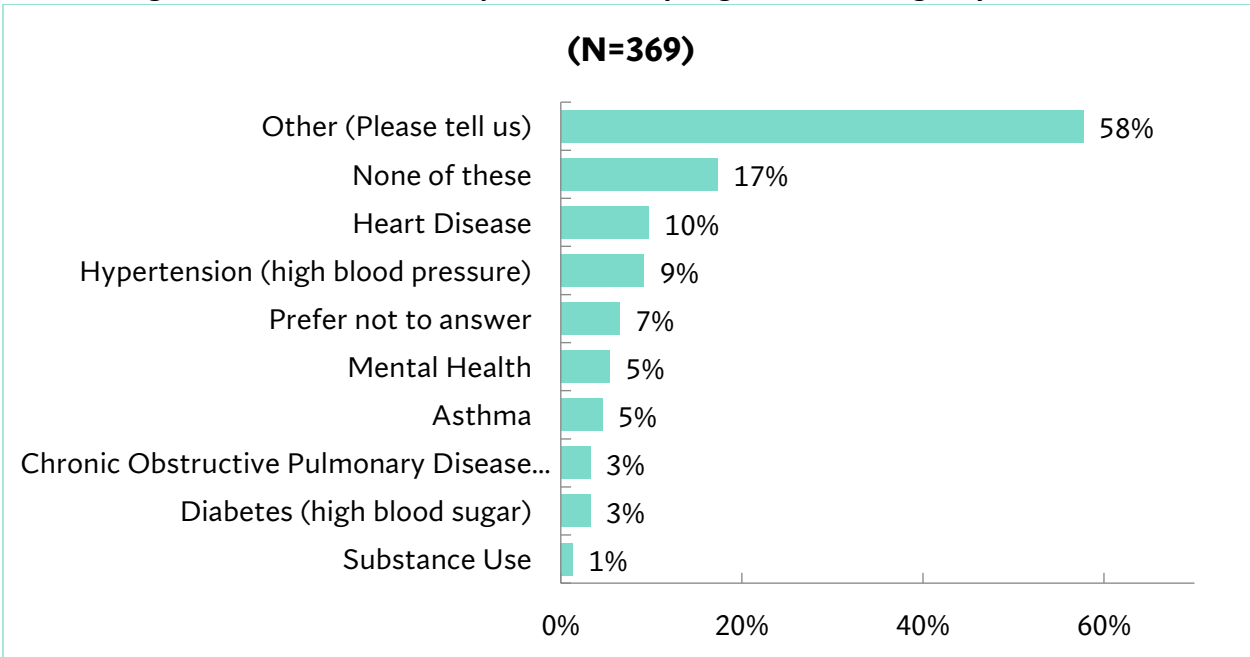


Themes from those who selected "Other":

- **Medical Professional Referrals:** Patients sought emergency care when their primary care physician was unavailable or had no appointments. On-call providers sometimes instructed patients to go to the ER while they were out of town.
- **Timing and Availability Issues:** Emergency visits occurred after-hours when doctor's offices were closed. Geographic limitations, such as the absence of pediatric neurology offices on the Eastern Shore, forced patients to use emergency services.
- **Acute Injuries:** Patients visited the ER for sports injuries, falls requiring immediate attention, and motor vehicle accidents.
- **Urgent Medical Conditions:** Cancer-related emergencies prompted ER visits. Patients also sought emergency care for dehydration requiring IV fluids, Flu A, gastroparesis, and diabetes-related issues.
- **Resource-Related Reasons:** Lack of dental insurance led some patients to use emergency services. Others needed specific diagnostic tests like CT scans that weren't readily available elsewhere.

[49] Note: only includes responses from those who responded that gone to the emergency room instead of a regular doctor in previous question.

Figure A6.35: What health problems did you go to the emergency room for?



Themes from those who selected "Other":

- Cardiac and Circulatory Issues
- Injuries and Trauma
- Digestive/Gastrointestinal Issues
- Respiratory Issues
- Infections and Related Issues
- Neurological Issues
- Allergic Reactions
- Pregnancy and Child-Related
- Chronic Disease Complications

Topic: Health Literacy

Figure A6.36: How easy is it for you to fill out medical forms on your own?

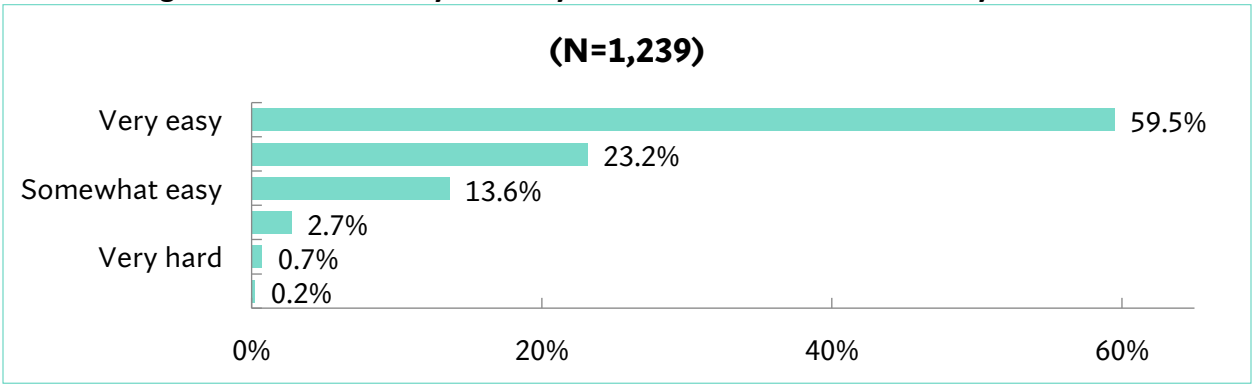
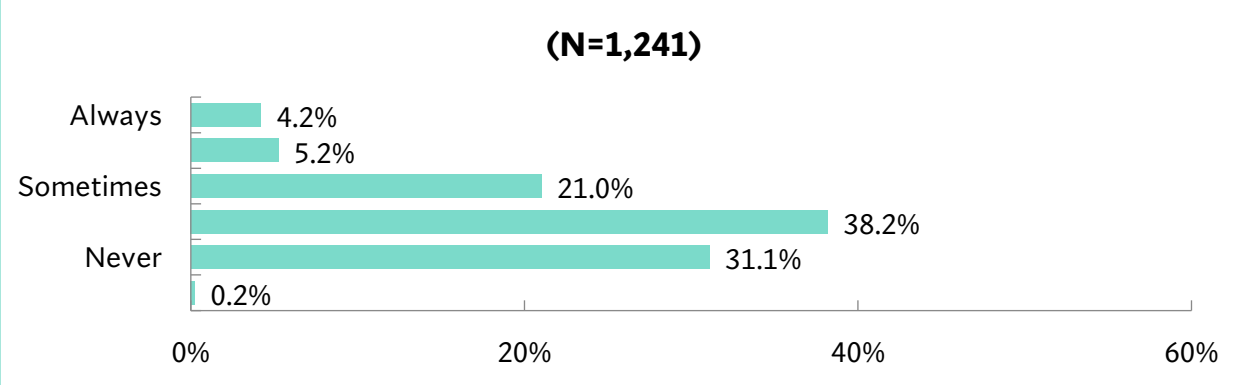


Figure A6.37: How often is it hard to understand what your doctor tells you?



Topic: Mental Health

Figure A6.38: Thinking about your MENTAL health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health NOT good?

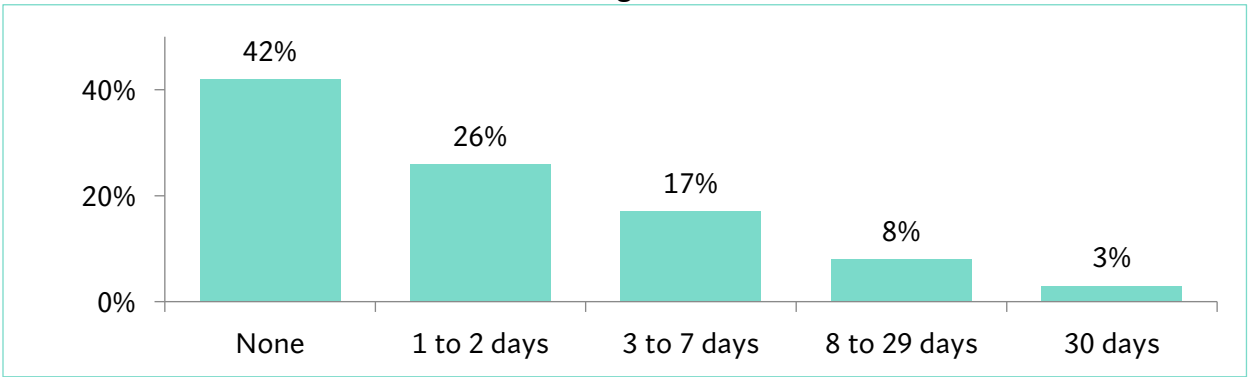


Figure A6.39: In the past 12 months, was there a time you needed mental health help but couldn't get it? (N=1,239)

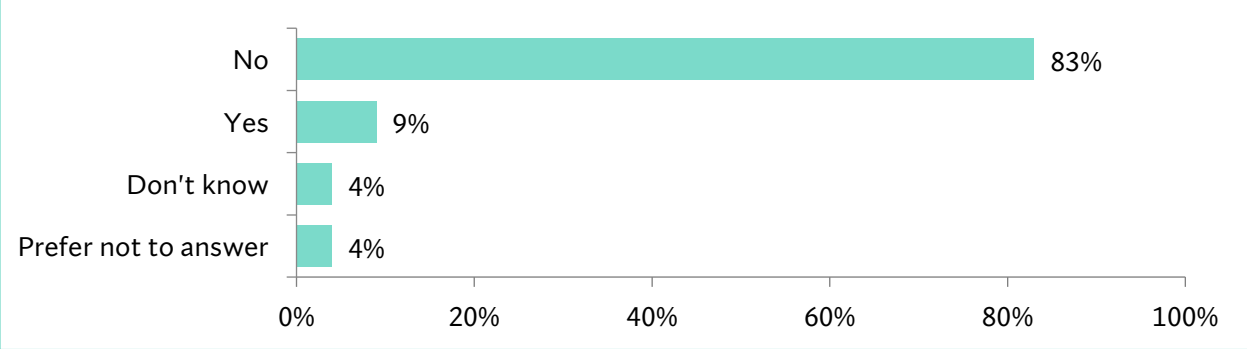
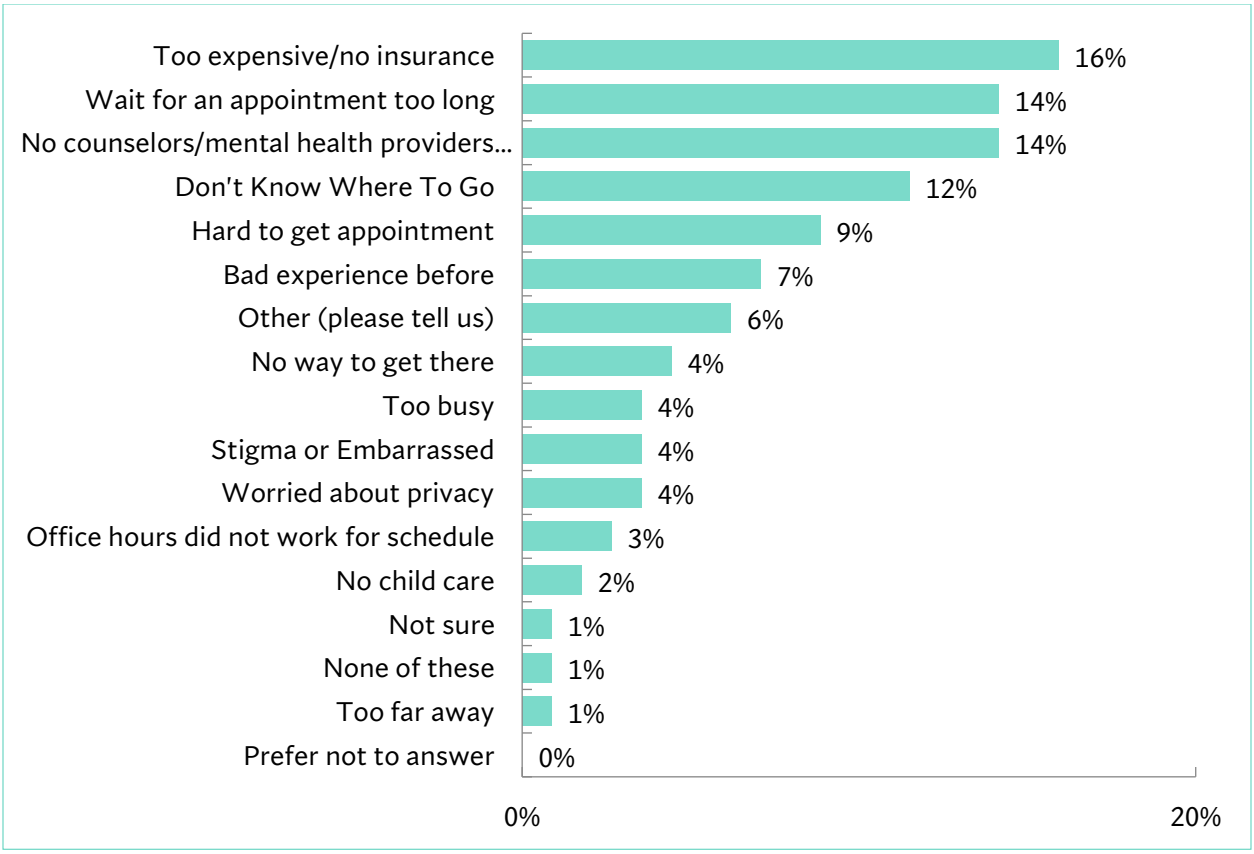


Figure A6.40: Why couldn't you get mental health help? (N=113)[50]

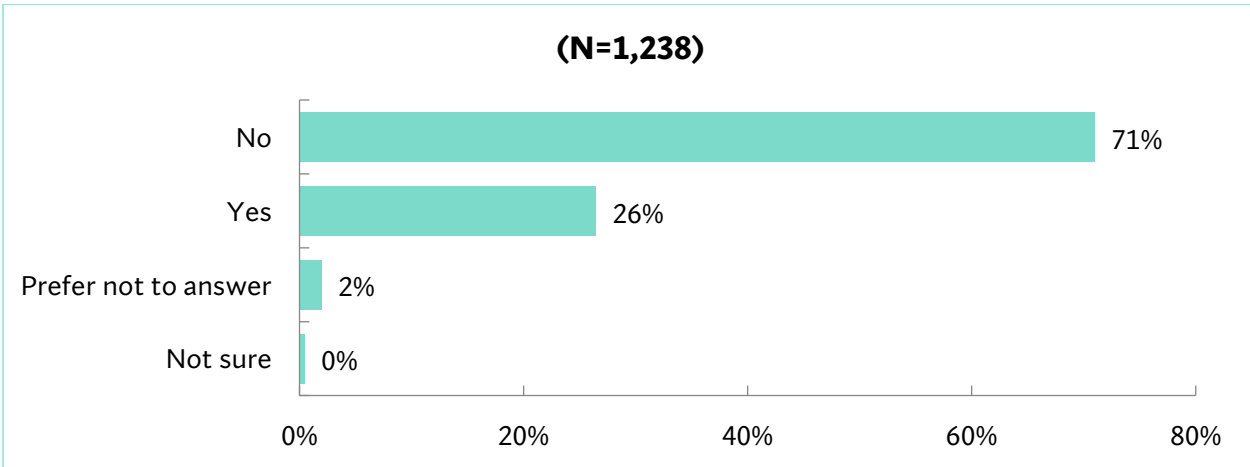
[50] Note: question only asked to those who indicated that they could not get mental health help when they needed it.



Themes from those who selected "Other":

- **Accessibility Barriers:** No availability on weekends for mental health services. Work demands create obstacles as employees face consequences such as write-ups when taking time off for mental health, despite official policies stating otherwise.
- **Treatment Approach Concerns:** Patients with past substance abuse history express discomfort with recommended programs, preferring individual therapy over substance abuse programs, especially when already maintaining sobriety. Some believe addressing physical health conditions like Crohn's Disease would resolve most of their mental health issues.
- **Communication and Coordination Challenges:** Patients report that providers sometimes don't understand them. Treatment requires coordination with caregivers, adding complexity to accessing care.
- **Personal Circumstances:** Complicated living situations make it difficult for patients to maintain consistent mental health treatment.

Figure A6.41: Are you getting help for mental health now (medicine, therapy, or counseling)? (Pick one)



Topic: Physical Health

Figure A6.42: Considering your physical health (which is the condition of your body, including how well your organs and systems function, and whether you have any illnesses or injuries) overall, how healthy is your body right now? (N=1,241)

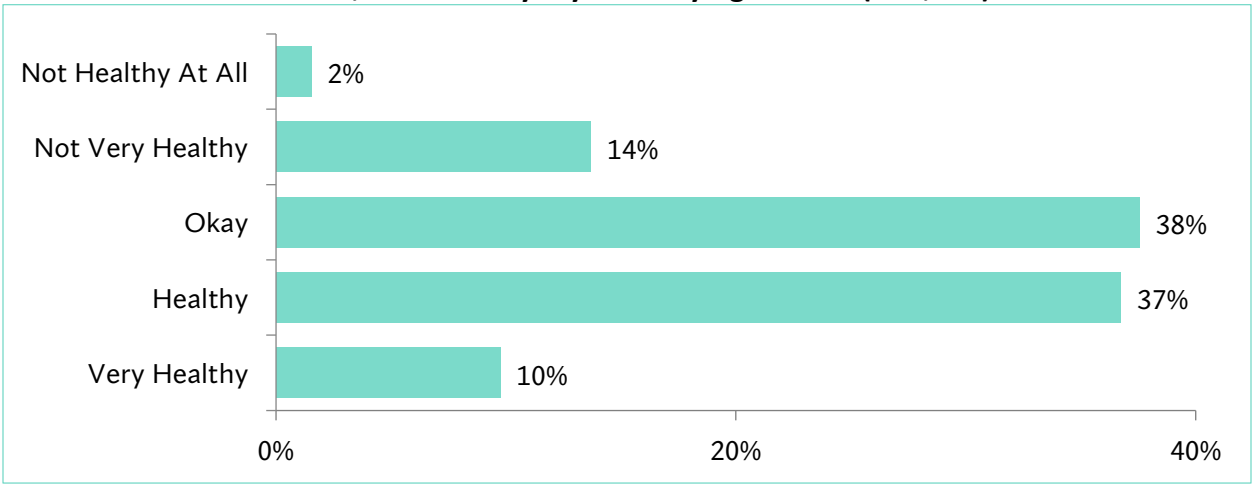


Figure A6.43: Within the last 12 months, have you:

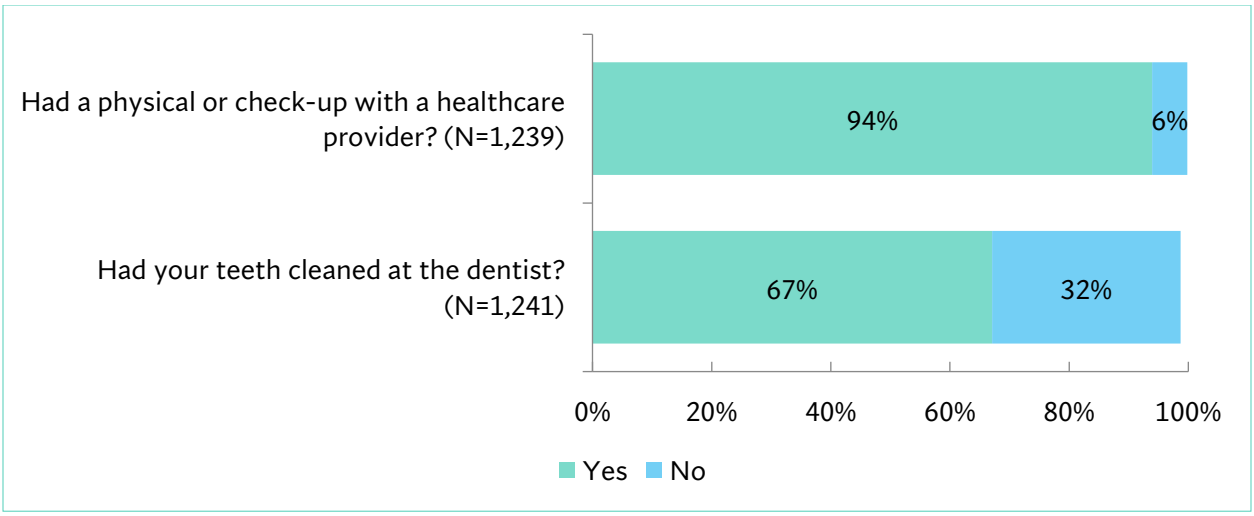
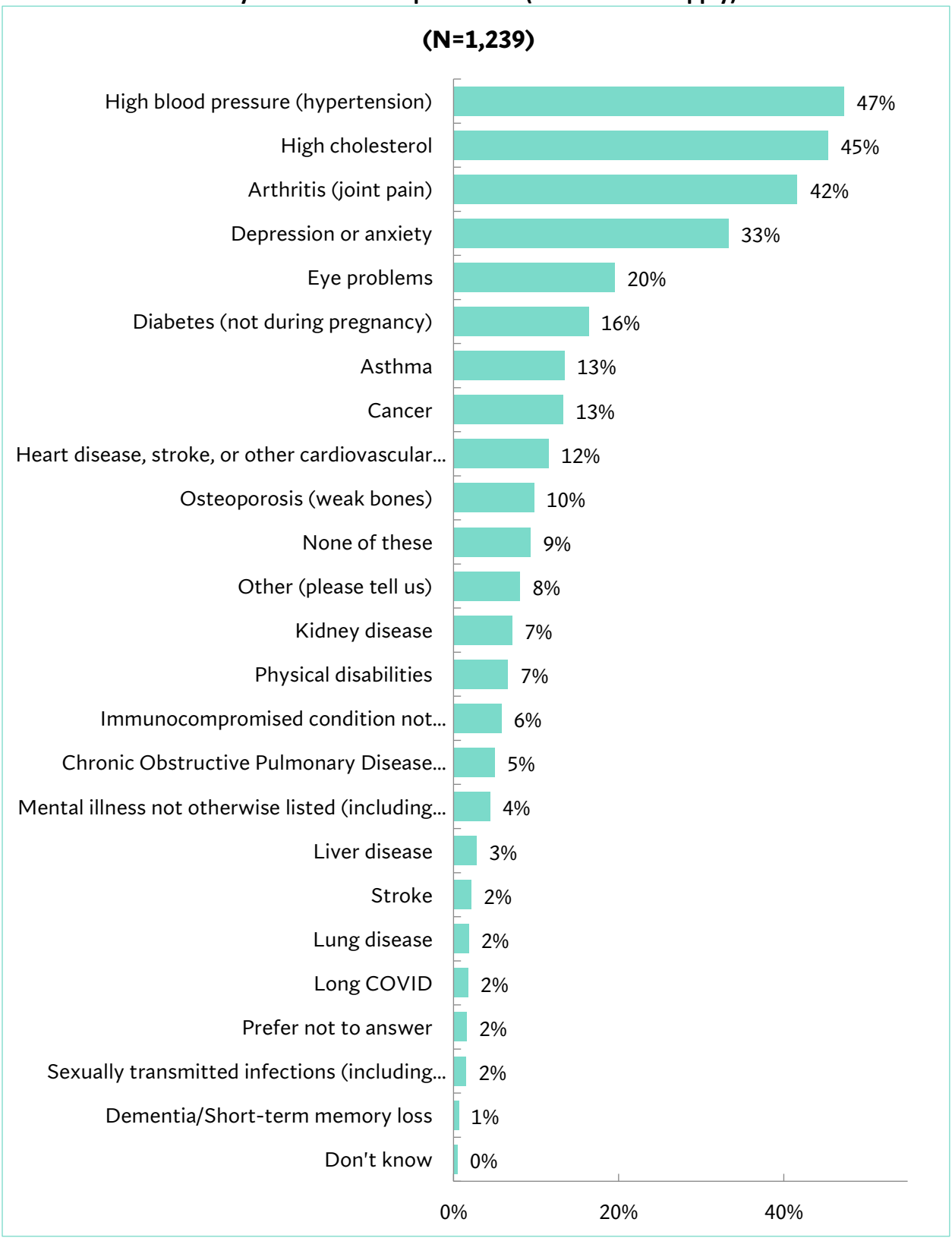

Had a physical or check-up with a healthcare provider? (N=1,239)
94%
6%
Had your teeth cleaned at the dentist? (N=1,241)
67%
32%
0%
20%
40%
60%
80%
100%
Yes
No

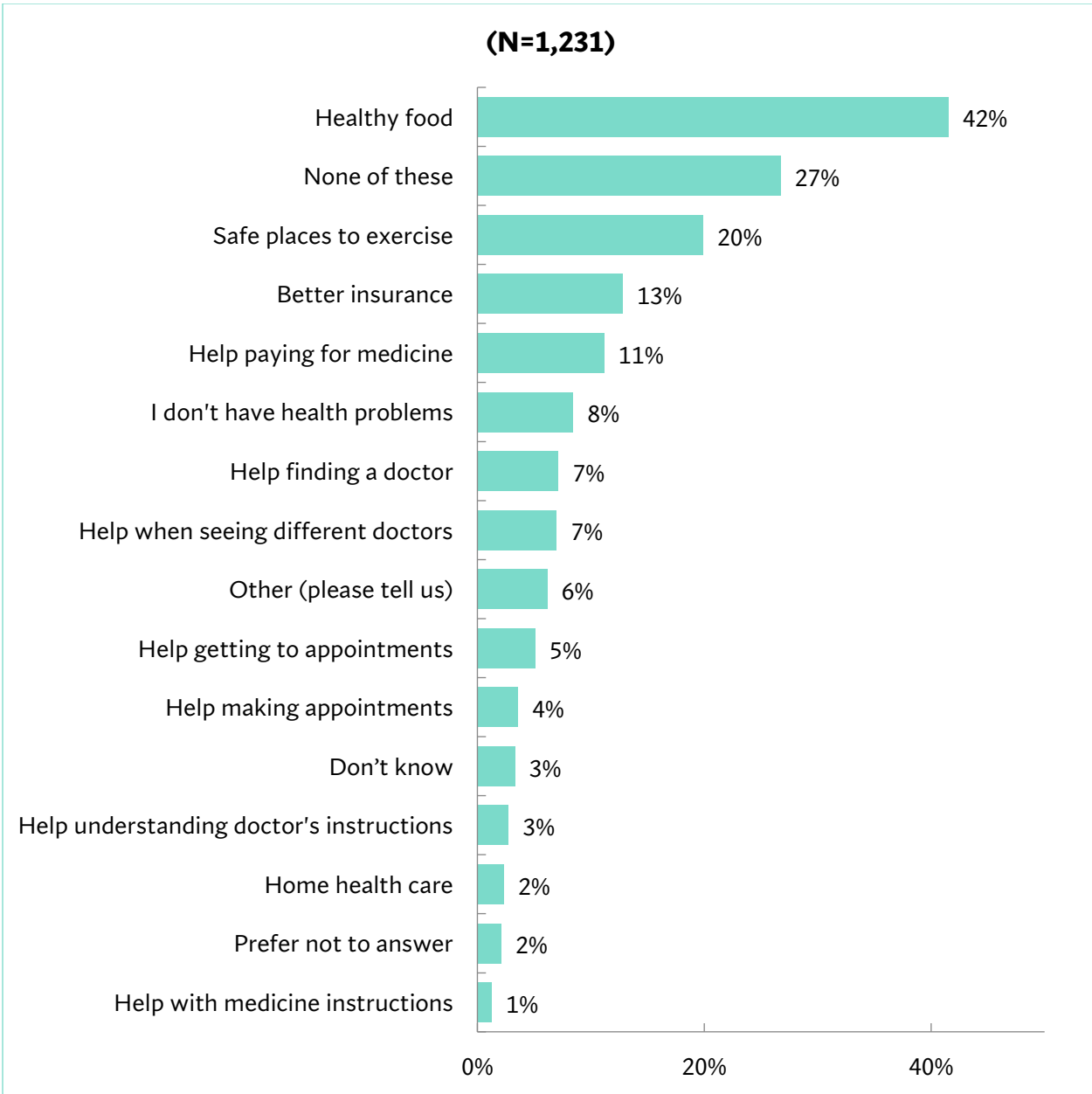
Figure A6.44: Has a doctor, nurse, or other healthcare provider ever told you that you have any of these health problems? (Check all that apply)



Themes from those who selected "Other":

- **Cardiovascular Conditions:** Tachycardia, CHF (Congestive Heart Failure), heart valve issues, heart murmur, SVT (Supraventricular Tachycardia), Microvalve Prolapse, PAD (Peripheral Artery Disease), pulmonary hypertension, hypotension, varicose vein, may have heart problems.
- **Autoimmune Disorders:** Autoimmune disease, Hashimoto's, Fibromyalgia, Lupus, Systemic Lupus, Multiple Sclerosis, Ehlors Danlos Syndrome, MCAS (Mast Cell Activation Syndrome), Lichen Planus, Myasthenia Gravis, Ulcerative Pancolitis, Crohn's Disease.
- **Endocrine System Disorders:** Hypothyroidism, Hashimoto's Hypothyroid disease, thyroid disease, thyroid issues, underactive thyroid, diabetes, prediabetes, obesity, PCOS (Polycystic Ovary Syndrome), insulin resistance.
- **Neurological Conditions:** Autism Spectrum Disorder, ADHD, epilepsy, chronic migraines, hemiplegic migraine, migraine, vertigo, vestibular migraines, essential tremor, TBI (Traumatic Brain Injury), autonomic dysfunction, dysautonomia.
- **Musculoskeletal Disorders:** Osteoarthritis, osteopenia, degenerative disc disease, spinal stenosis, Spinal Sclerosis, scoliosis, herniated L5S1, tendonitis, torn rotator cuffs, sciatica, costochondritis.
- **Gastrointestinal Conditions:** GERD (Gastroesophageal Reflux Disease), reflux, gastroparesis, gastritis, eosinophilic esophagitis, fatty liver, NASH (Non-Alcoholic Steatohepatitis), diverticulitis, rhinitis.
- **Reproductive System Issues:** Endometriosis, ovarian cysts, PCOS, severe adenomyosis, infertility, ED (Erectile Dysfunction).
- **Blood and Immune System Disorders:** Chronic anemia, iron level low, clotting disorder, anemia, allergies, Alpha-Gal.
- **Sensory System Conditions:** Hearing deficiency, ear problems, blind, macular degeneration (dry).
- **Renal and Urological Conditions:** Kidney CA - Partial Nephrectomy, kidney stones.
- **Skin Conditions:** Psoriasis, dry skin, other skin conditions.
- **Mental Health Conditions:** PTSD, mental/learning disabilities, cognitive & developmentally disabled.
- **Other Health Concerns:** Sleep apnea, gout, low B12, need to lose a few lbs., overweight, POC (possibly Polycystic Ovaries), borderline high sugar, have been treated for Osteo with Fosamax.

Figure A6.45: What do you need to take care of your health? (Check all that apply)



Themes from those who selected "Other":

- **Access to Medical Care:** Participants struggle with long wait times for appointments, particularly for specialists, often waiting 2-5 months.
- **Quality of Care:** Many desire providers with better bedside manner who listen attentively rather than rush through appointments.
- **Specialist Availability:** There's a significant need for more specialists in the local area, especially for pediatric and uncommon conditions that currently require travel.
- **Dental Care:** Access to affordable dental care is a major concern, particularly for those with state insurance or living at poverty level.

- **Mental Health Services:** Respondents want dedicated mental health providers separate from substance abuse programs, with a preference for in-person therapy.
- **Affordability:** Many struggle with the costs of insurance, prescriptions, and healthy foods, noting that financial constraints affect their health choices.
- **Local Services:** Having healthcare facilities and exercise options closer to home would make maintaining health more convenient.
- **Preventive Care/Lifestyle:** Several mention needing support for exercise routines and healthy eating habits to manage their conditions.
- **Care Coordination:** Some find it challenging to manage their healthcare across multiple providers and wish for better collaboration between doctors.

Topic: Alcohol and Substance Use

Figure A6.46: How often do you drink alcohol (beer, wine, or liquor)? (N=1,239)

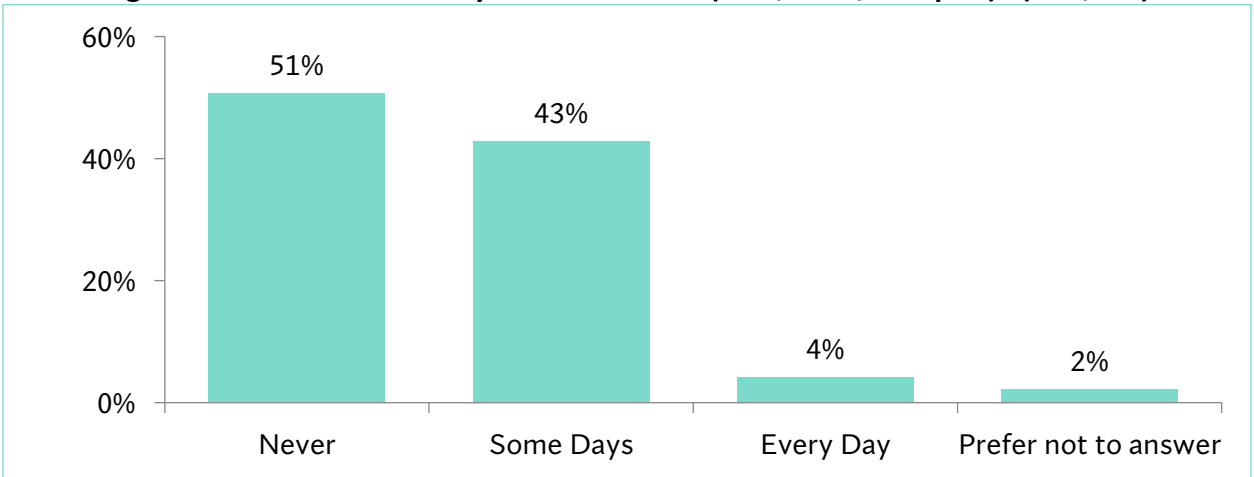


Figure A6.47: In the past year, have you or someone in your home used prescription drugs in ways they weren't supposed to? (N=1,241)

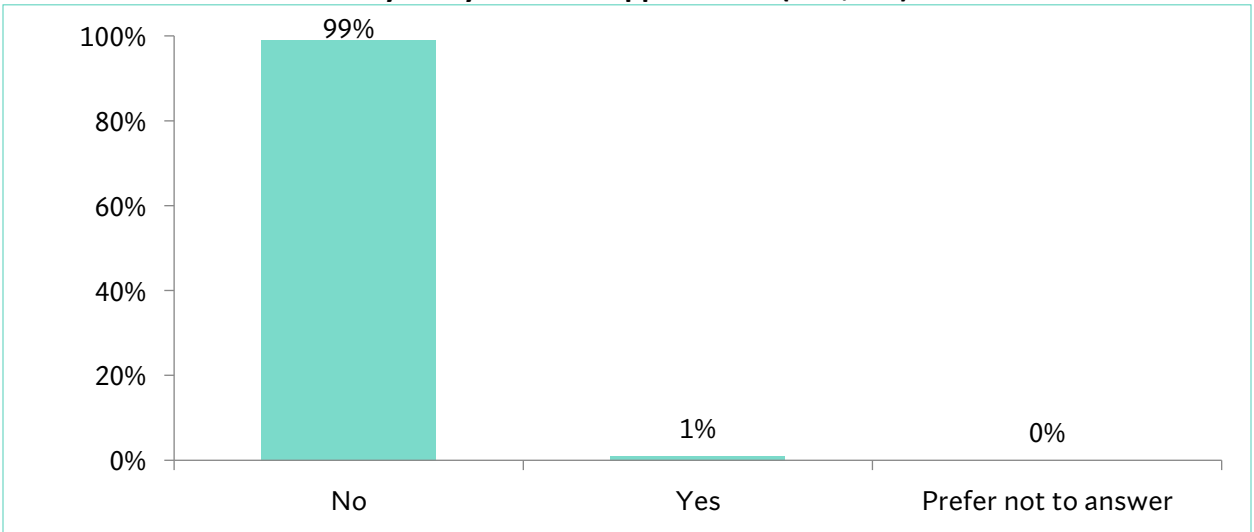


Figure A6.48: How often do you use cannabis/marijuana/THC products? (N=1,242)

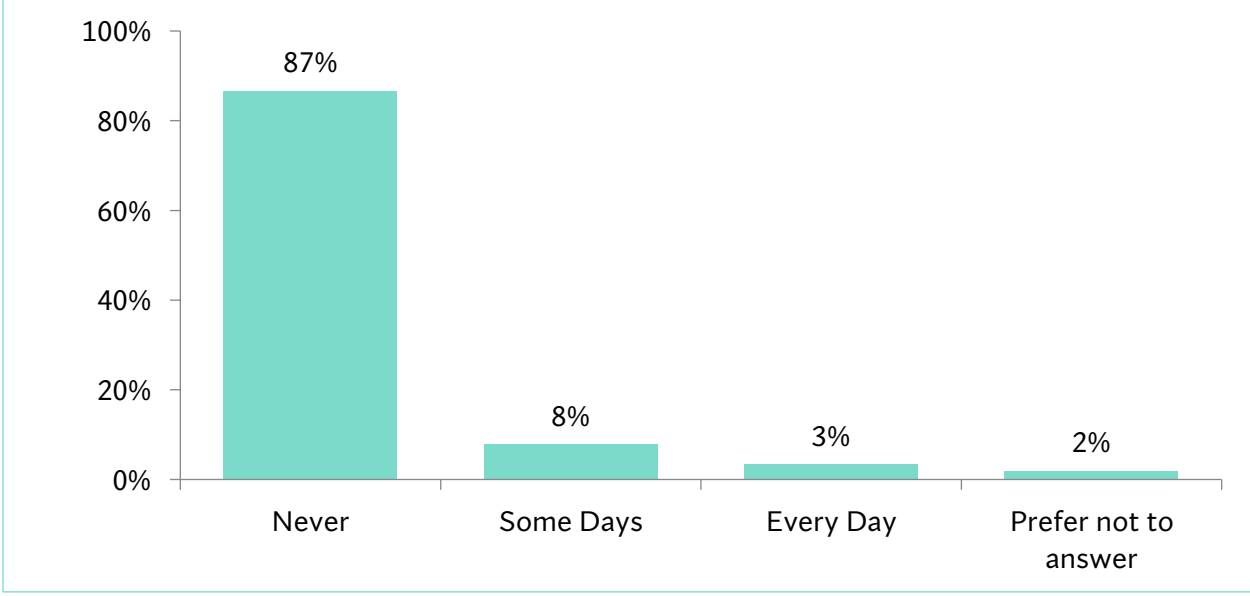
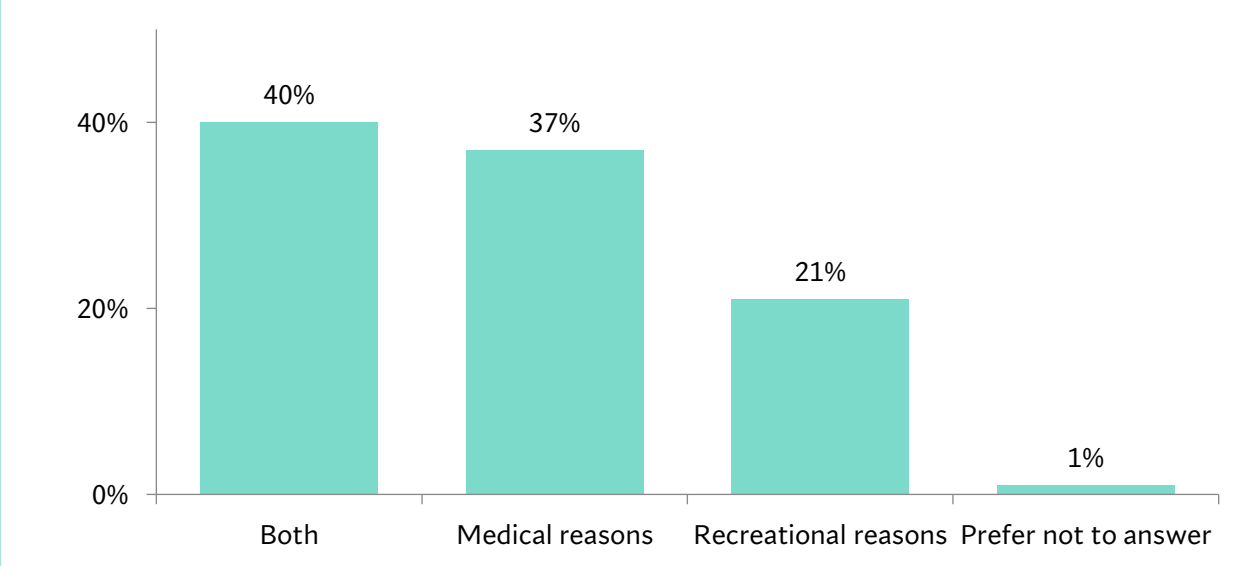


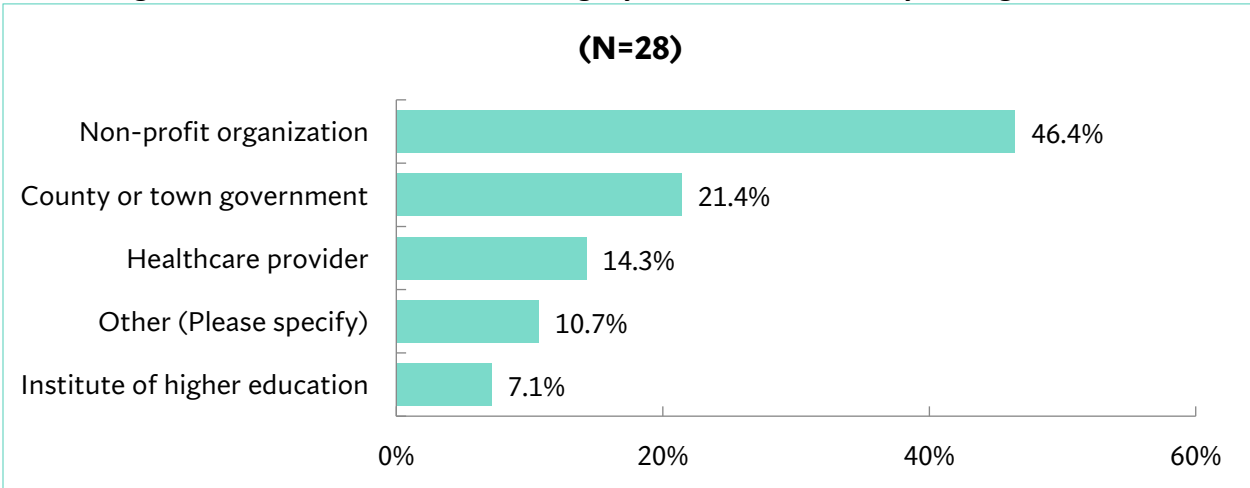
Figure A6.49: Do you use cannabis/marijuana/THC products for medical reasons, recreational reasons, or both?[51]



[51] Note: only respondents who indicated cannabis use in previous question was asked current question.

Key Leader Surveys

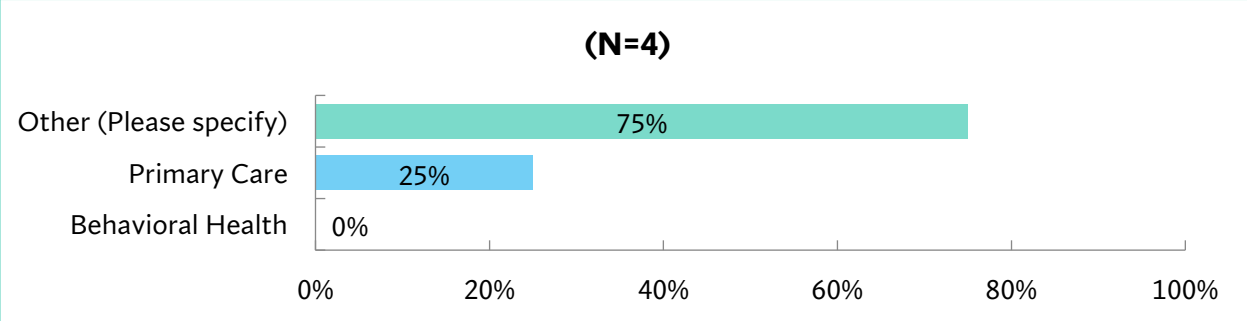
Figure A6.50: Please select the category that best describes your organization.



Other Responses:

- Community Coalition
- Education/university
- Nursing student

Figure A6.51: What types of healthcare services does your organization provide?



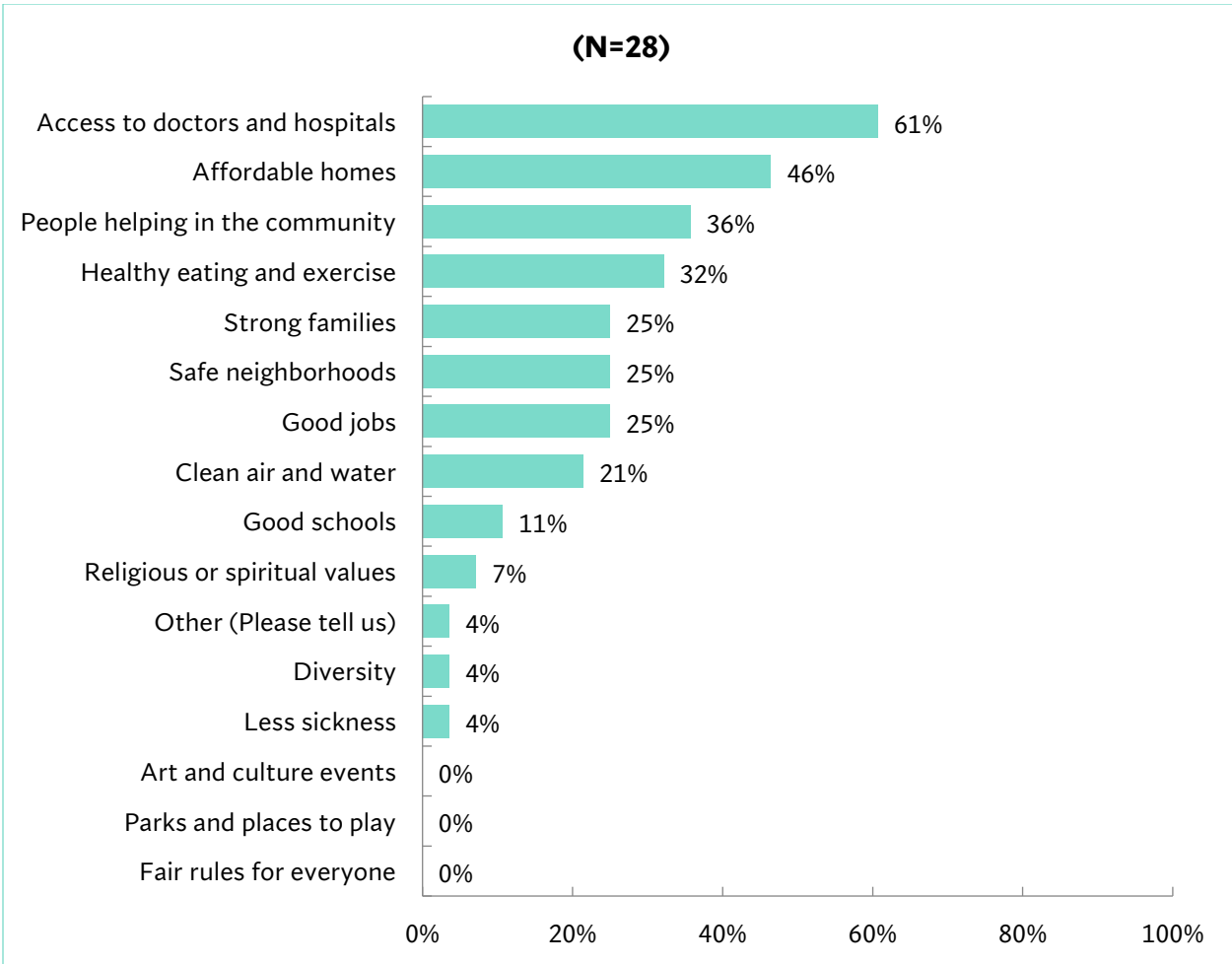
Other Responses:

- Integrated Behavioral Health and Primary Care
- Community Wellness

Figure A6.52: What is the name of the organization you work for?[52]

Figure A6.53: What are the 3 most important things that make a community healthy?

[52] To maintain anonymity, types of organizations are listed below without the specific names.



Other Responses:

- Quality Public Safety

Figure A6.54: How do you believe the health of the community you serve has changed over the past three years?

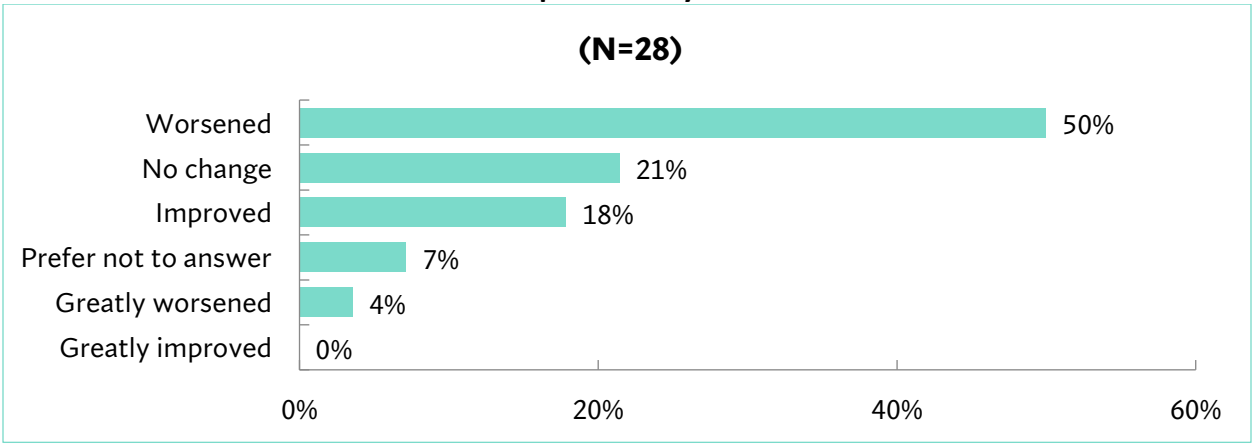


Figure A6.55: In what way(s) has the health of the community you serve improved?

Access and Equity:

- "Working at greater equitable access"
- "A lot of outreach have been conducted to help underserved people in accessing to health care facilities in addition to language accessibility"
- "Improved access to alternative methods of care"

Community Engagement and Recreation:

- "Improved access to recreational activities and community activities"

Collaboration and Communication:

- "Communication has been a key factor in collaboration"
- "Through health education and collaborations with health organizations in the area"

Figure A6.56: In what way(s) has the health of the community you serve worsened?

Housing and Economic Instability:

- "Less opportunities for affordable housing and employment"
- "Jobs don't pay enough for cost of living"

Healthcare Access and Quality:

- "Inconsistency in care coordination"
- "Difficulty with payors"
- "Less access to specialty physicians and primary care doctors"
- "Lack of providers"
- "Can't afford care"

Food Security and Nutrition:

- "Higher grocery costs for healthy food"
- "Lack of programs to promote healthy eating"

Public Health and Infrastructure:

- "Ineffective Population Health Initiatives"
- "Programs and resources are continually underfunded"
- "Lack of funding in schools"
- "STD increased"

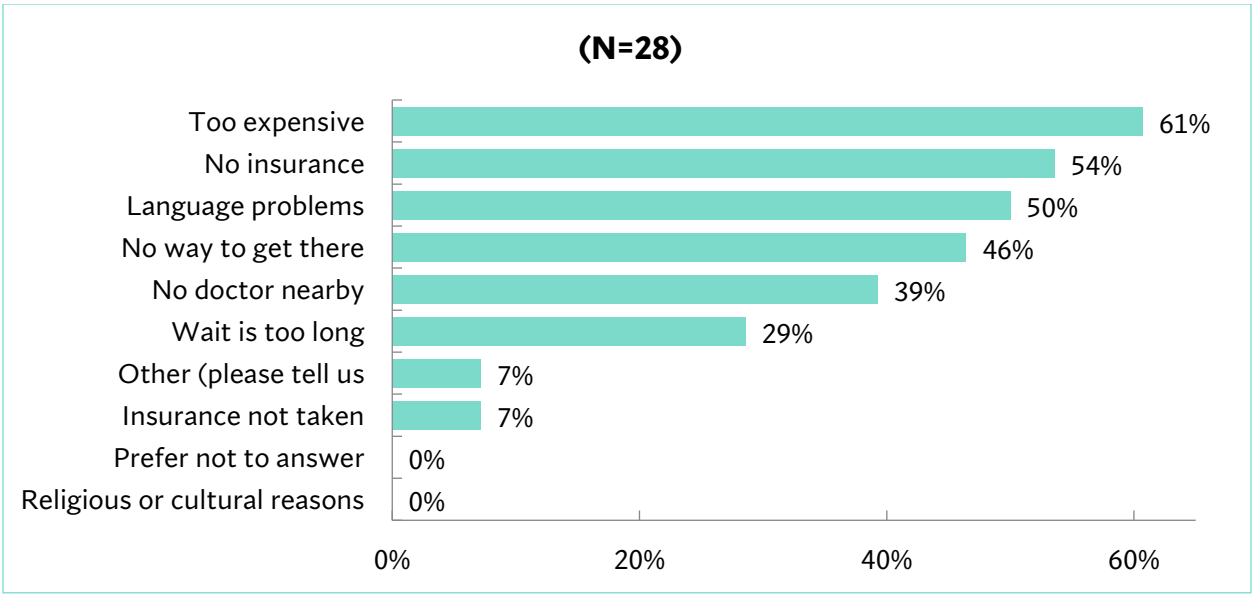
Chronic Disease and Health Conditions:

- "Chronic disease (diabetes, HTN, Heart disease, behavior health)"
- "Increase in unmanaged chronic conditions"

Social Issues:

- "People fighting against human rights"

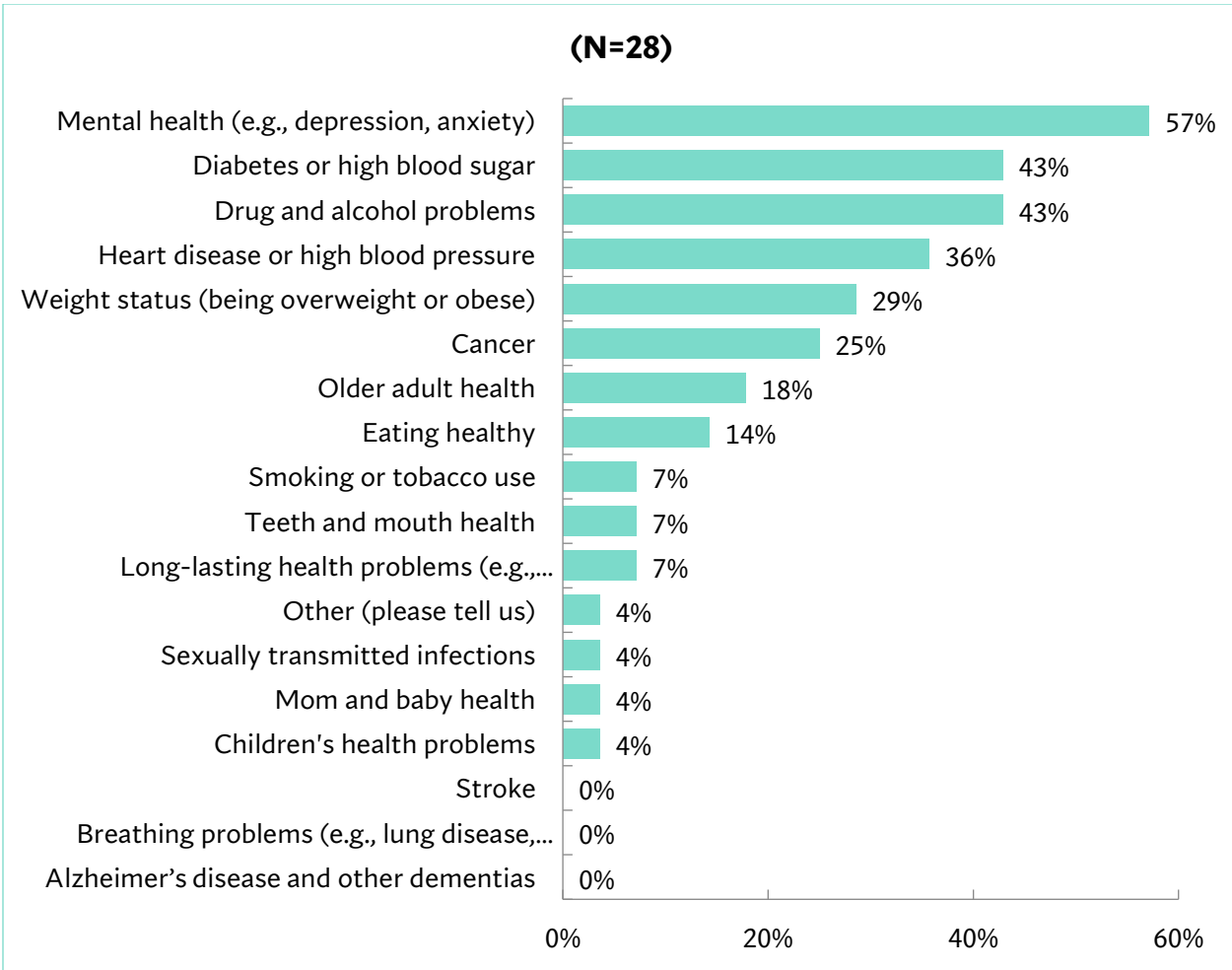
Figure A6.57: What are the 3 main reasons people in your community can't get healthcare when they need it?



Other Responses:

- They don't have the resources to keep their lives organized. They have to use all their energy to focus on the immediate needs (food and staying safe) and they don't have the space to think of physical health
- Long wait lists to see a doctor/ Medical billing errors make it too expensive and time consuming to receive care

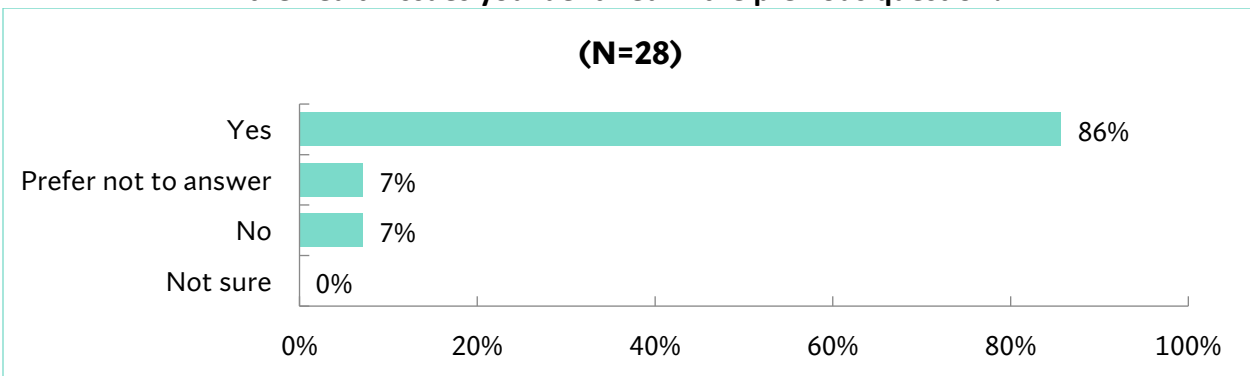
Figure A6.58: What are the 3 biggest health problems in your community?



Other Responses:

- Accessibility services

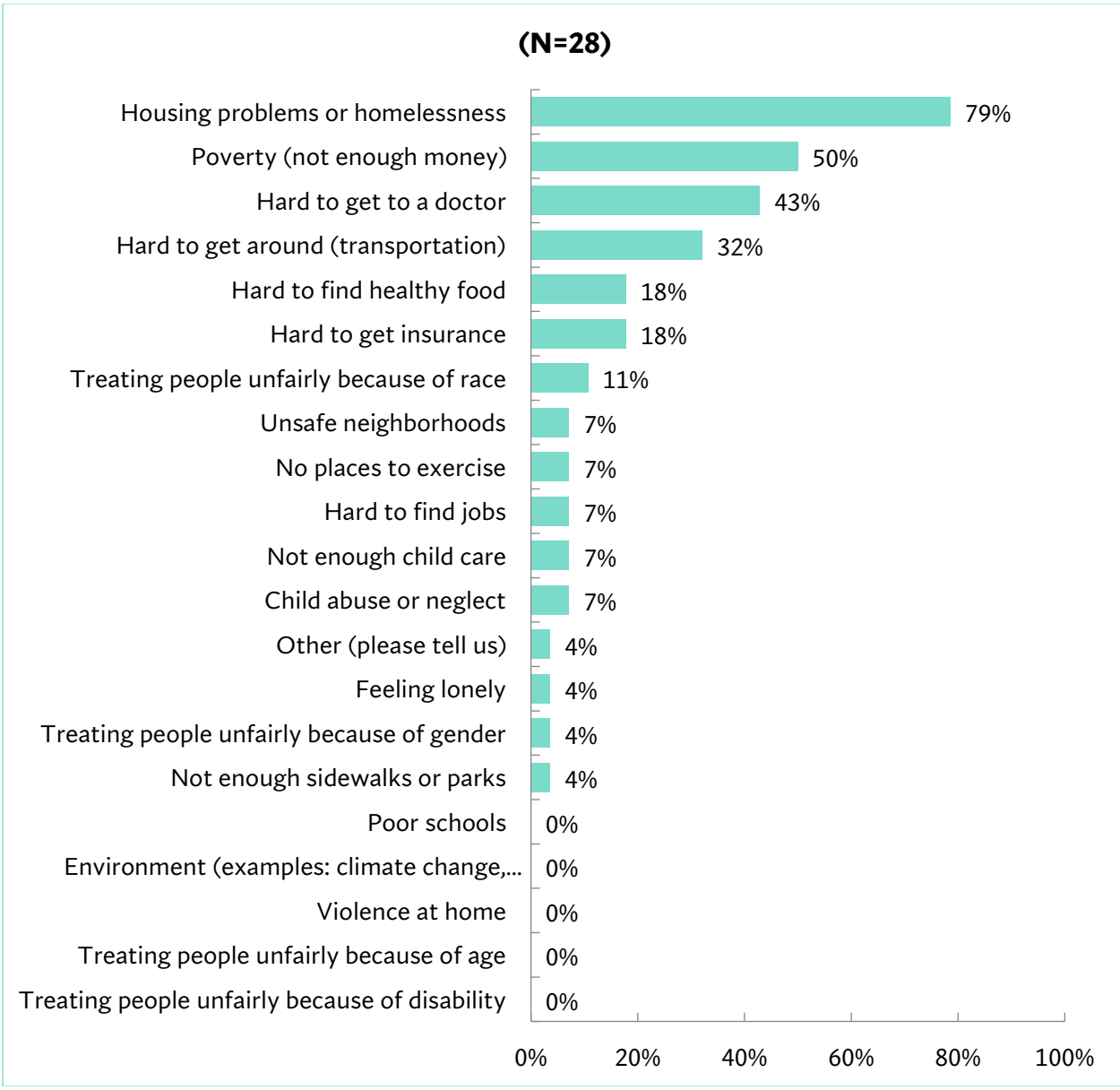
Figure A6.59: Do you know of any resources available in the community to address some of the health issues you identified in the previous question?



If yes, please name at least one resource that could be leveraged:

- Healthy Eating Initiatives from the hospital
- Community Health Nursing- REACH grant
- TidalHealth Crisis Center
- Health Department
- Tidal Health, Health Department, MAC
- Diabetes Prevention Program
- Free mobile screenings and wellness checks
- Wicomico Health department
- NAMI
- FQHC
- Diabetes Education Course at Tidal Health, Healthy Eating Classes at Health Depts.
- •TidalHealth, Wicomico County Health Department and Ephphata Medical Center
- Health port and the Act team
- The Diabetes Prevention Program and Diabetes Self-Management, Wicomico County Health department smoking cessation program
- Private doctors and Community clinics
- Food Bank of Delaware Healthy Pantry Center
- centers that help those with substance abuse problems like Impact Life etc.
- Mobile health units.
- I have been working closely with several other community members to identify resources
- Primary care physicians or specialists. Both are hard to come by.
- Health Departments
- Community-based programs and services provided by the University of Delaware Cooperative Extension Health & Well-being program.
- Diabetes education offered at TidalHealth, DPP through Wicomico Health department, Chronic disease self-management through MAC, BP and diabetes screenings within community
- Programs through the Health Department
- There are many organizations for drug and alcohol recovery such as the recovery resource center and private rehab facilities. There are 12-step meetings held in downtown Salisbury. I think there could be more education and outreach for smoking cessation among college students to prevent lifelong illness. Improved walkability/bike safety in downtown Salisbury may assist with promoting walking and biking as a form of exercise.

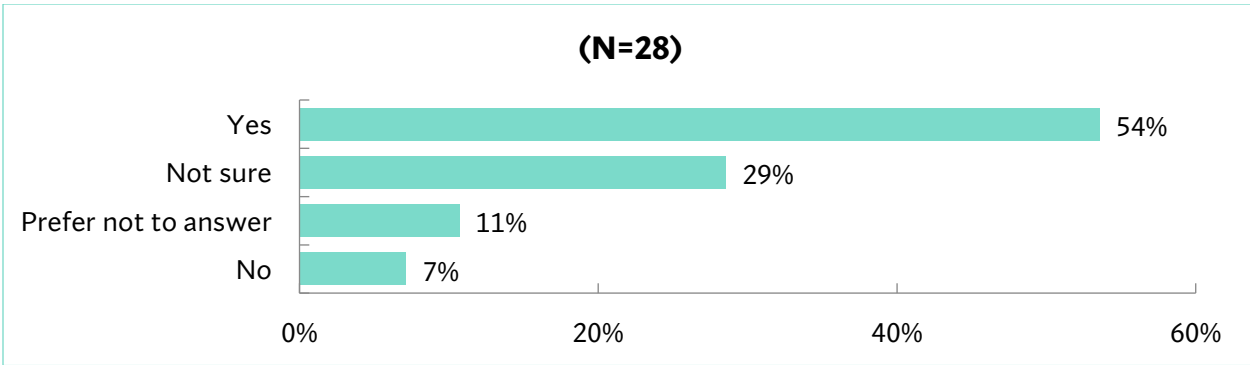
Figure A6.60: What are the 3 biggest problems that affect health in your community?



Other Responses:

- Prevention Services

Figure A6.61: Do you know of any resources in the community to address some of the social/environmental issues you identified in the previous question?



If yes, please name at least one resource that could be leveraged

- Shelters for homeless. Direct outreach and site visits by mobile health practitioners.
- Habitat for Humanity
- city improvement plan and insurance sites
- Wicomico County Health department helps with insurance. Unable to think of transportation or housing programs
- Children & Families First
- There are many just not aligned
- The Health Equity Community
- "Habitat for humanity
- Healthport
- Lower shore workforce alliance"
- Habitat for Humanity, food pantry, Workforce Alliance. These organizations are helping but for my experience, help has never been possible any time I refer someone. It's always a long waiting list and they never got a call back.
- Food Bank of Delaware Healthy Pantry Center
- Love inc of Mid Delmarva
- Housing authority is not accepting applications for vouchers. For childcare, LSCCRC; however, there are not enough childcare facilities on the shore. MD Office of Civil Rights; however, changing biases in healthcare is difficult because everyone is stereotyped into a category and herded like cattle through medical facilities due to lack of resources.
- University of Delaware Cooperative Extension Health & Well-being programs and services.
- One-stop job market helps with employment
- There are organizations such as Halo that work to provide food and housing to those experiencing homelessness.

Figure A6.62: In your opinion, are health and social/environmental needs similar across the Delmarva region? (Somerset, Wicomico, and Worcester counties in Maryland and Sussex County, Delaware)

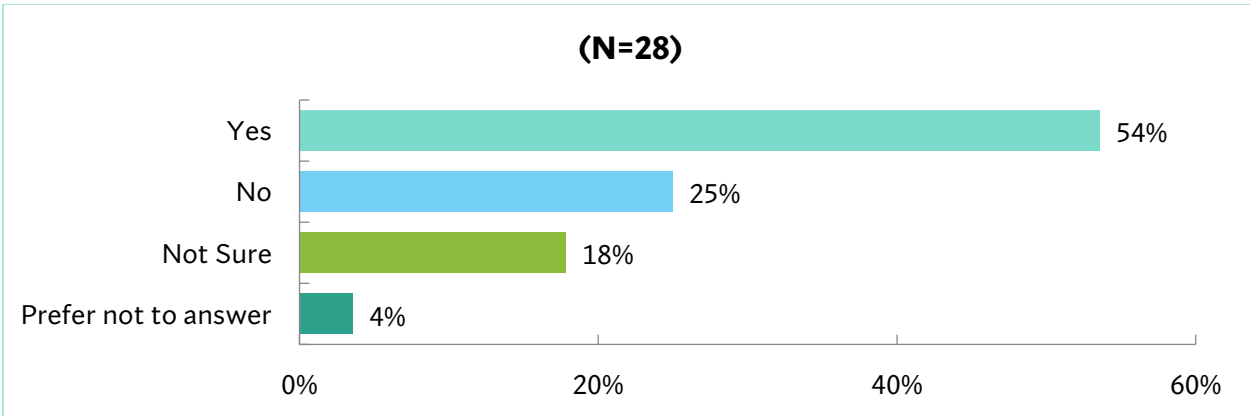
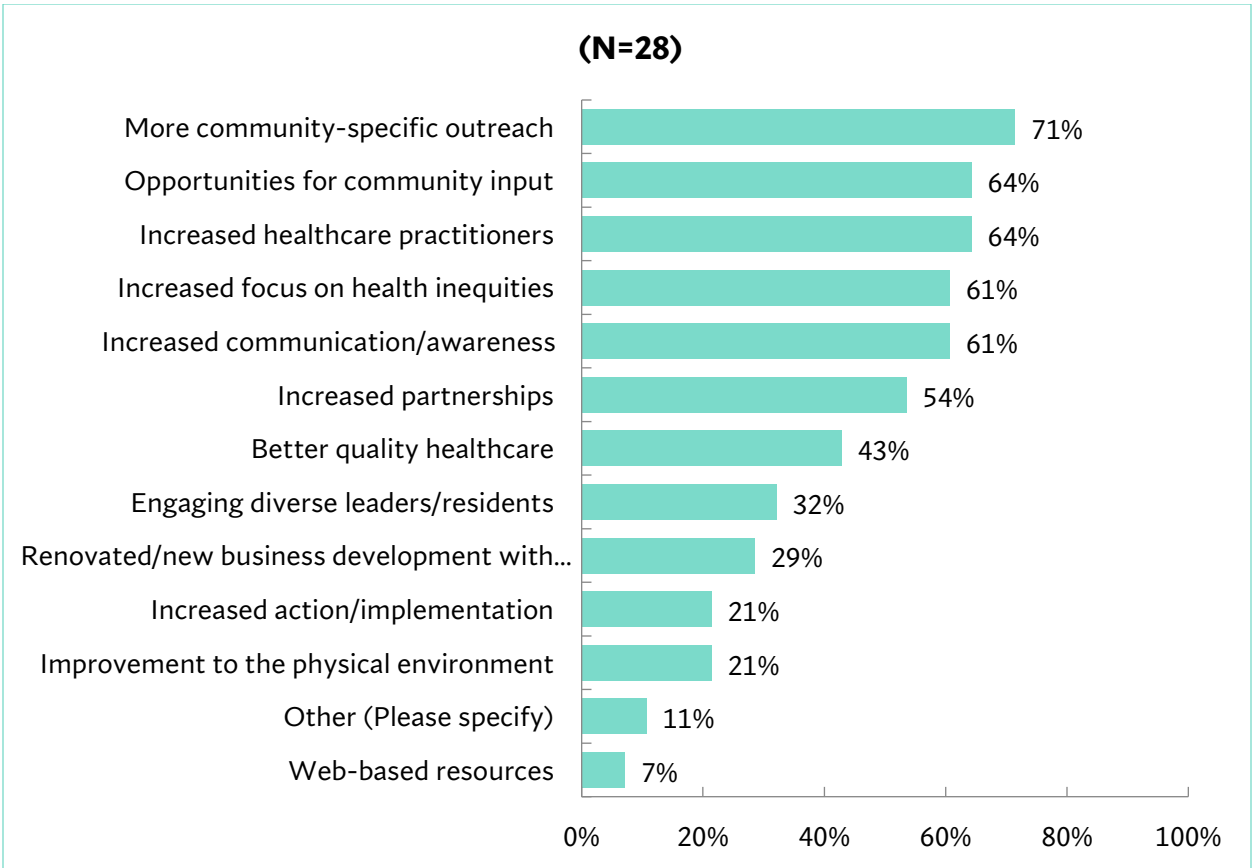


Figure A6.63: Which geographic areas do you feel experience the greatest level of need?

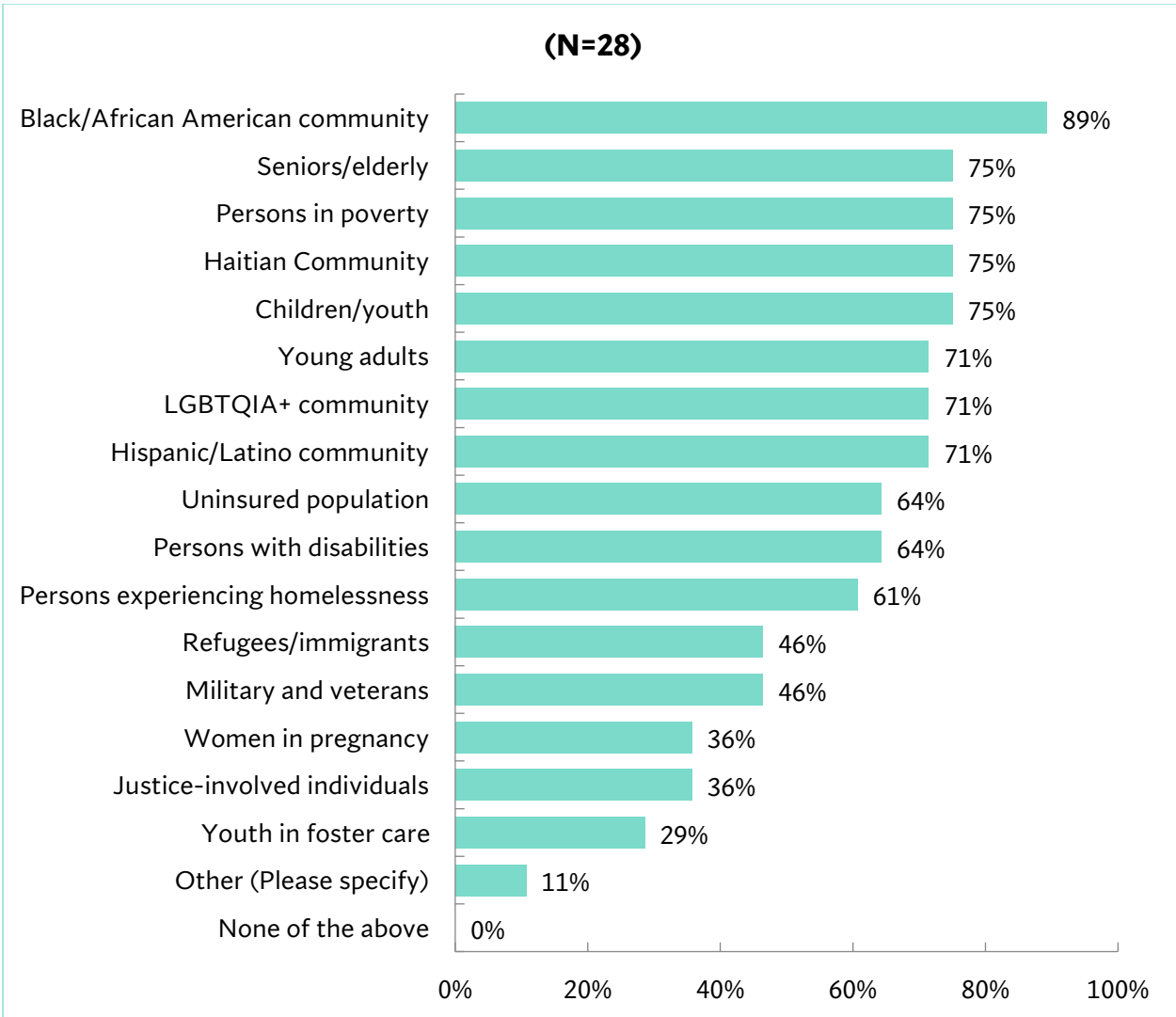
Figure A6.64: What do you believe could encourage and support health in your community? (Select all that apply.)



Other Responses:

- prevention and prevention funding
- Affordable housing
- equitable funding in Sussex County for health programs and initiatives

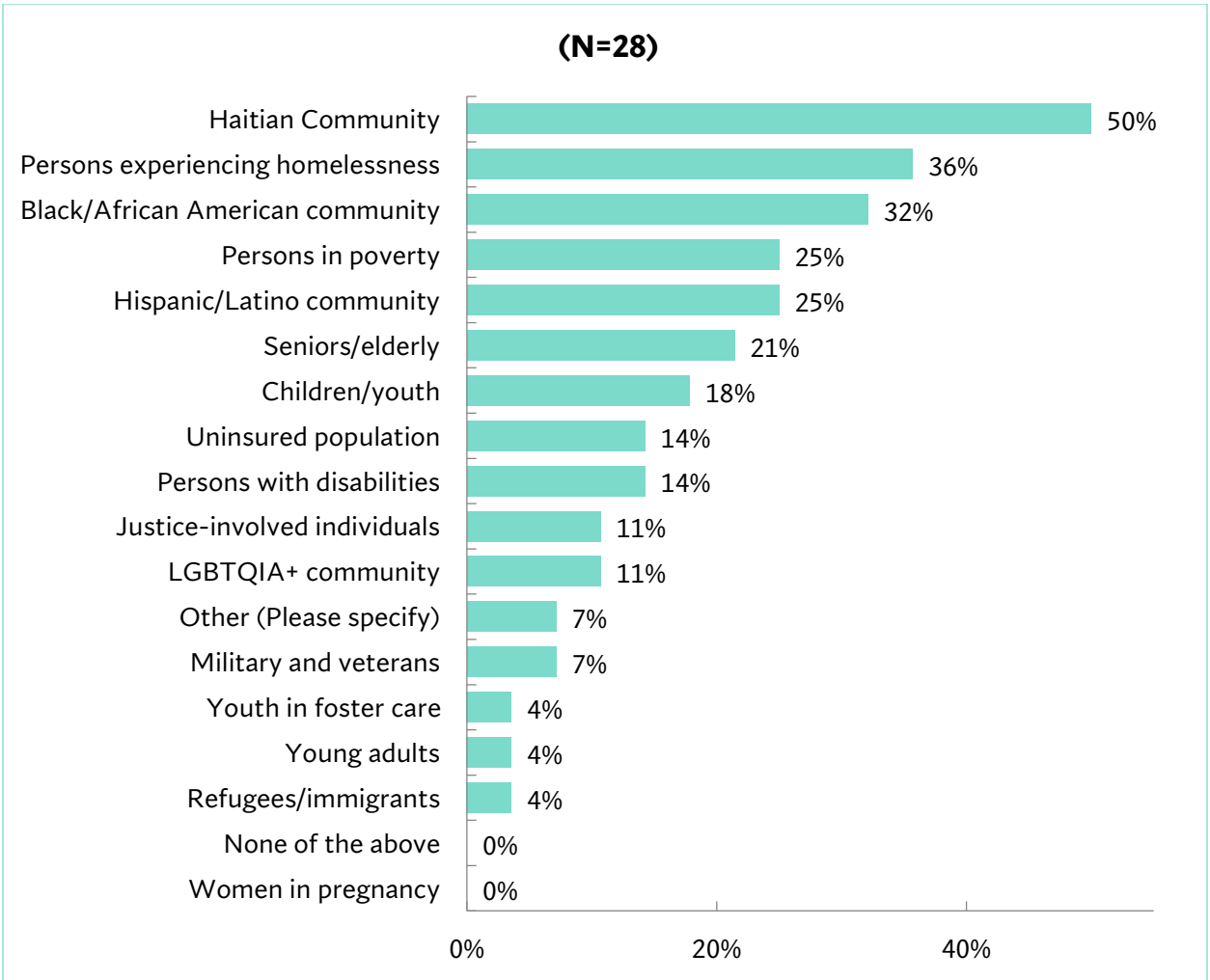
Figure A6.65: Which subpopulation(s) on this list does your organization serve? (Select all that apply.)



Other Responses:

- We support agencies that support all Sussex County Residents
- We serve ALL Delawareans
- Student populations of all races

Figure A6.66: Among those served by your organization, which subpopulation(s) appear to have the greatest unmet needs when it comes to health and social services?



Other Responses:

- Individuals with disabilities
- young working families, retirees who are on a fixed income

Figure A6.67: Please rate each of the following statements for the community you serve:

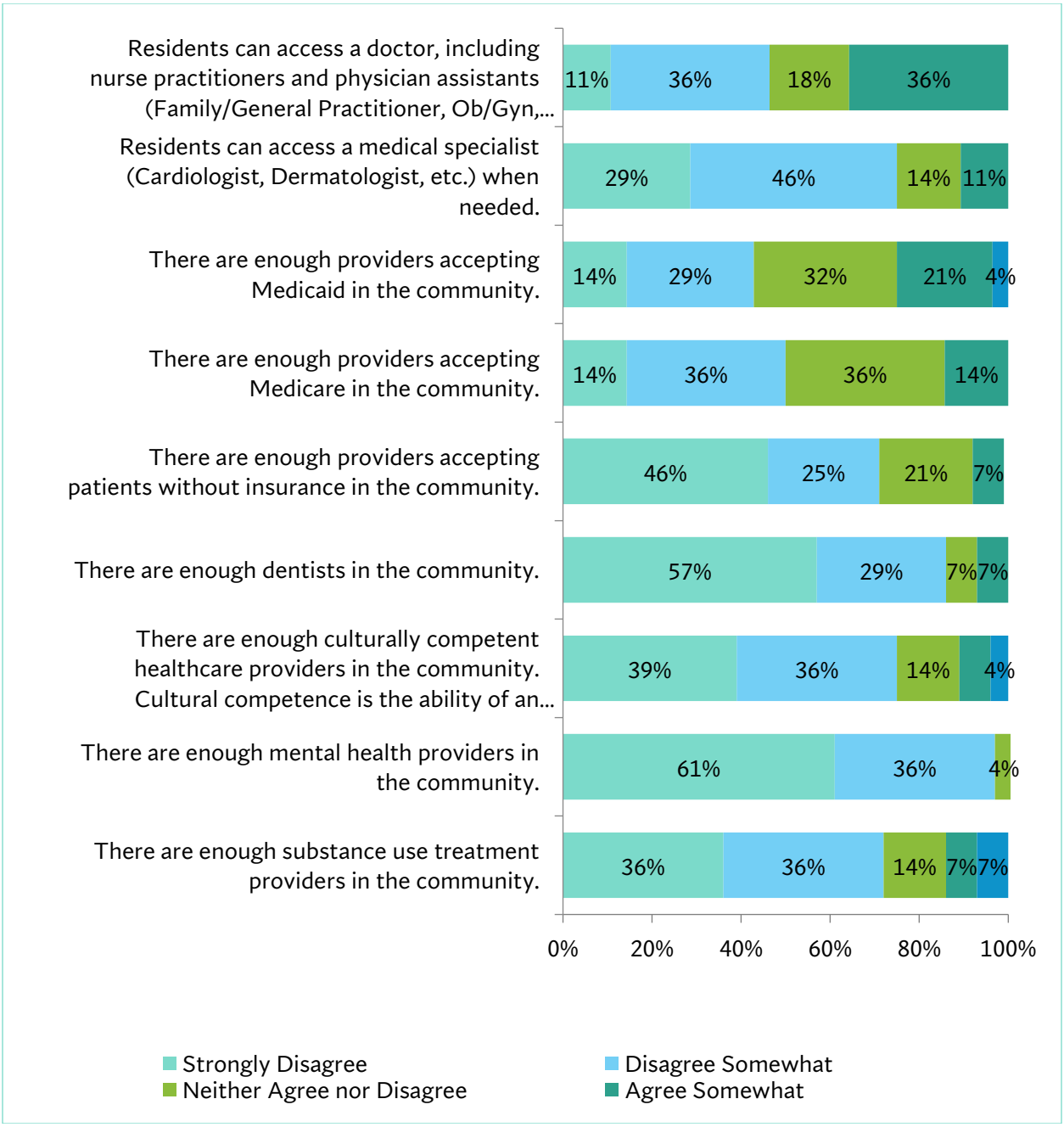
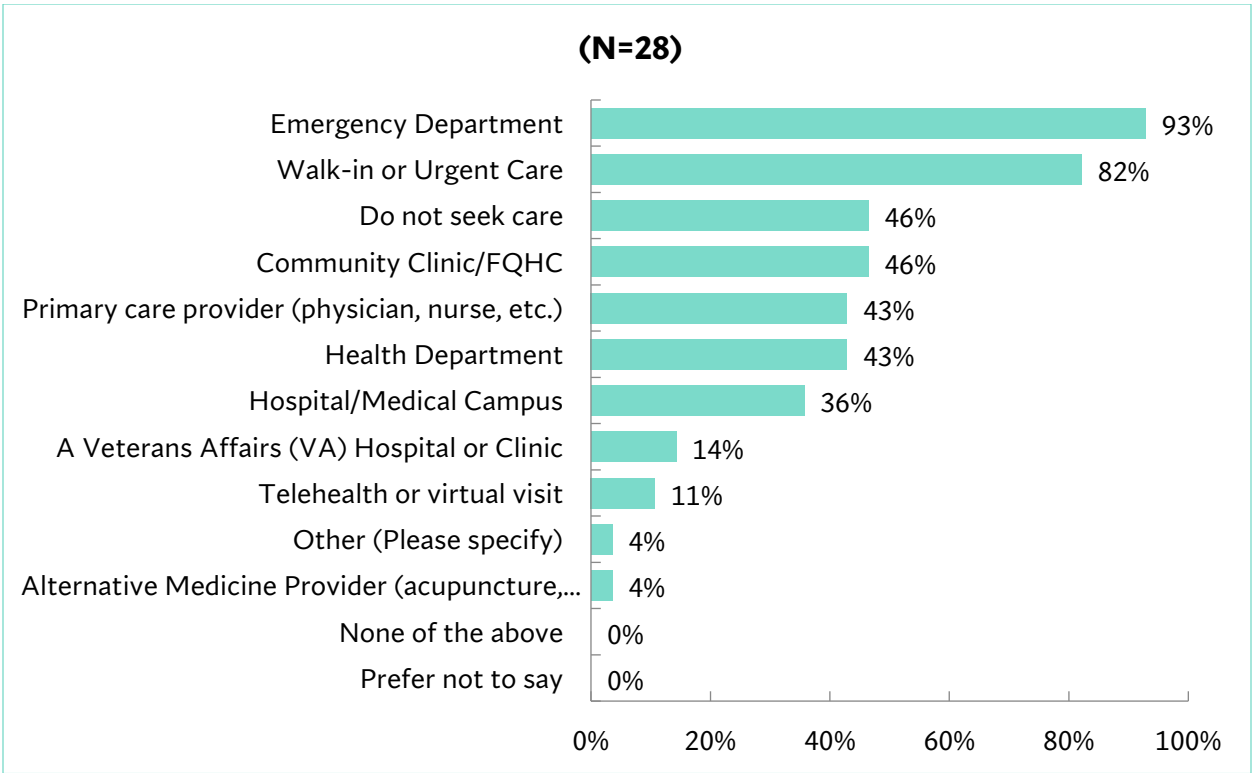


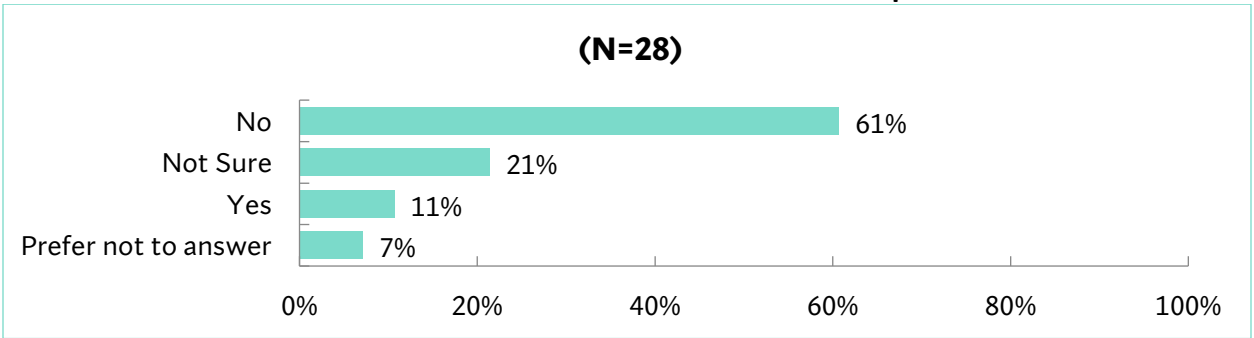
Figure A6.68: From the list provided, where do you feel members of the community you serve most frequently seek medical care? (Select all that apply.)



Other Responses:

- Call 911 for an ambulance

Figure A6.69: Do you believe that the people in the community you serve are health literate, or able to understand health-related information when it is presented to them?



If no, what do you see as the biggest challenges/issues with health literacy among the populations served by your organization?

- **Language and Communication Barriers:** Many respondents highlight difficulties serving non-English speaking populations without adequate interpretation services. "Language barrier, not enough of them that speak English and not hired interpreters to interpret for them." The absence of materials in patients' native languages further compounds this issue: "Do not have education in their own language."
- **Literacy and Comprehension:** General reading ability affects health understanding, with several respondents noting baseline literacy as a fundamental challenge. "Overall literacy rate for general reading and understanding of information" impacts patients' ability to process health information regardless of how it's presented.
- **Medical Terminology:** Healthcare providers often fail to adjust their communication style to match patients' education levels, using technical language that creates barriers. "The providers do not consider the patient level of education while providing their help information. The use of terminologies that are not understood by patients."
- **Healthcare System Navigation:** The complexity of healthcare systems presents challenges for many patients who struggle to understand how services are structured and accessed. As one respondent notes, patients face "overall difficulty navigating healthcare systems."
- **Information Quality and Context:** Health information is often presented inappropriately or at the wrong time, making it less useful. "Information can be out of context making it somewhat confusing" and "information is presented after the immediate need for information."
- **Patient Engagement:** Organizations struggle with motivating individuals to take an active role in their healthcare. "It is a challenge to have some individuals show effort and put work into their own health. They have to be their own advocate."
- **Cultural Factors:** Cultural differences affect health behaviors and information reception. "A culture where unhealthy lifestyle habits are normalized" contributes to health literacy challenges, particularly among specific populations.
- **Education Needs:** There's insufficient education about health conditions and the impact of lifestyle choices. "More education is needed about various diseases" and there's a "lack of education regarding the severity of lifestyle choices."

Figure A6.70: What is working well in the community?

- **Partnerships and Collaboration:** Respondents frequently highlight the value of organizations working together. "There are many community partnerships that are working to improve overall community health." "The community is doing well in attempting to collaborate services." "Partnerships/Collaboration" is specifically called out as a strength.
- **Community Outreach:** Mobile and direct outreach efforts that meet people where they are show promise. "Zip code specific interventions that are mobile and meeting the people where they are" and "direct outreach" are making an impact in reaching vulnerable populations.
- **Community Health Workers:** These frontline public health workers are making a difference. "Community health workers are making an impact on the community" by connecting with residents directly.
- **Support for Vulnerable Populations:** Organizations focused on serving those most in need are recognized. "There are community organizations who truly seek to help vulnerable

populations in our community" and "The Health Equity Community is working together to provide resources."

- **Basic Needs Services:** Programs addressing fundamental needs like food security are valuable. "Monthly food distribution" and "Food banks and pantries to decrease food insecurity" are mentioned as working well.
- **Health Education:** Collaborative efforts to educate the community about health issues are making progress. "Health education through collaborations with local healthcare organizations in the area" is highlighted as effective.
- **Language Services:** Some progress is being made on language barriers. "Increasing access to language line" and "translated material/literature" are helping to bridge communication gaps.
- **Institutional Resources:** Local institutions provide valuable resources. "Salisbury university has a lot of resources and the potential to create positive change in the local community" and "Large organizations with grant funding to help smaller organizations."
- **Future Development:** There's optimism about developing the healthcare workforce. "Excited about a residency program at TidalHealth to entice more physicians to stay in the area."
- **Community Support Systems:** Informal networks provide important support. "The members of the community help each other out and support each other" through churches and other social connections.

Figure A6.71: What suggestions do you have for health leaders in your community to improve the health and well-being of the community? Please write suggestions below.

- **Cultural Competence:** Respondents emphasize the need for healthcare providers to better understand diverse cultures. "Develop a better understanding of the various cultures and become more culturally competent." "Have more culturally component providers in the community." This includes language services: "Hire more interpreters and get more Haitian organizations involved in health education."
- **Mental Health Resources:** Expanding mental health services is a priority. "Increased mental health resources" and "More affordable access to mental health professionals" are needed as "There is also a huge amount of untreated mental illness in our community."
- **Affordable Services:** Cost barriers need to be addressed. "Free or low-cost services/resources," "Reduction of health care cost," and "Affordable dental care and/or Dental practices that take insurance" would improve access.
- **Preventive Care:** Many suggest shifting focus from treatment to prevention. "Prevention/Prevention/Prevention" and "More focus should be put on prevention and healthy lifestyles vs treatment."
- **Collaboration and Coordination:** Better partnership between organizations is recommended. "Continue working together to leverage one another's strengths. Try not to duplicate the same services" and "More coordination, collaboration and integration."
- **Basic Needs and Social Determinants:** Addressing fundamental needs is essential. "Encompass the hierarchy of needs with housing being top of the list" and "Advocate for affordable housing" reflect understanding that health begins with basic stability.

- **Healthy Lifestyle Support:** Practical resources for healthy living are requested. "Increase education on how to prepare healthy meals," "Safe spaces to exercise," and "More free exercise programs" would support healthier behaviors.
- **Provider Recruitment and Retention:** Increasing the healthcare workforce is critical. "Increase in number of providers" and "More housing so young professionals in the field of medicine will choose Wicomico County as their home."
- **Community Engagement:** Meaningful involvement of residents in planning is valued. "Instead of assuming what the issue is, talk with the community about what the issues are" and "get feedback and involve the community members in implementation strategies."
- **Transportation and Access:** Improving ability to reach care is important. "Transportation & follow up care for patients" and "better transportation options for patients to get to care" would remove significant barriers.

Community Survey and Key Leader Survey Analysis

Three questions were asked in both the community health and key leader surveys. A comparison of findings across surveys was conducted to identify similarities and differences between the two data sources. A summary of similarities, differences, and key takeaways of the comparative analysis for each of these three questions are provided here.

Question 1

What are the 3 most important things that make a community healthy?

Between key leaders and community residents, the following was observed in survey responses regarding what makes a community healthy.

Key Similarities:

1. **Access to doctors and hospitals** ranks as the top priority for both groups, though community members rate it significantly higher (80%) compared to leaders (61%).
2. **Healthy eating and exercise** appear to be the top priorities for both groups (39% for community, 32% for leaders).
3. **Safe neighborhoods** are important to both groups (31% for community, 25% for leaders).

Key Differences:

1. **Housing affordability** shows a major difference in prioritization:
    - Leaders rank "Affordable homes" as their second highest priority (46%).
    - Community members rank it fifth (25%).
2. **People helping in the community**:
    - Leaders place much higher importance on this (36%, their third highest priority).
    - Community members rank it much lower (10%, ninth place).
3. **Strong families**:
    - Leaders value this more highly (28%, fourth place).
    - Community members rate it lower (14%, seventh place).
4. **Parks and places to play**, **Fair rules for everyone**, and **Art and culture events**:
    - These appear on the community list (albeit with low percentages).
    - These items don't register at all (0%) among leaders.

Analysis: These differences reveal interesting perspectives which are summarized below.

Leaders appear to take a more systems-oriented approach, emphasizing structural elements like affordable housing and community engagement.	***Community members focus more on immediate, tangible needs*** like healthcare access and environmental factors (clean air/water).	Some lower-priority items for the community (parks, fair rules, art/culture) don't register at all for leaders, suggesting ***potential blind spots in leadership perspectives***.

Question 2

What are the 3 main reasons people in your community can't get healthcare when they need it?

Between key leaders and community residents, the following was observed in survey responses regarding barriers to timely healthcare access**.**

Key Similarities:

1. **Cost concerns** are paramount for both groups, with "*too expensive*" ranking highest for both leaders (61%) and community members (64%).
2. **No insurance** is recognized as a significant barrier by both groups, though leaders rank it higher (54%, second highest) than community members (45%, third highest).
3. **Transportation issues** ("*no way to get there*") are acknowledged by both groups, though leaders perceive this as a more significant barrier (46%, fourth highest) compared to community members (26%, fifth highest).

Key Differences:

1. **Language barriers** show the most dramatic difference:
    - Leaders rank "language problems" as their third highest barrier (50%).
    - Community members rank it much lower (9%, seventh highest).
2. **Wait times**:
    - Community members consider "*wait is too long*" their second biggest barrier (51%).
    - Leaders rank it lower (29%, sixth highest).
3. **Insurance not taken**:
    - Community members view this as a significant issue (31%, fourth highest).
    - Leaders consider it a minor concern (7%, tied for seventh/eighth).

Analysis: These differences in response reveal interesting perception gaps between community residents and leaders which are summarized below.

Leaders significantly ***overestimate language barriers*** (50% vs 9%), suggesting they may be attributing healthcare access issues to communication problems more than necessary.

Community members place much higher emphasis on practical issues like wait times and insurance acceptance that affect their day-to-day healthcare experiences.

Leaders and community members ***align on cost and insurance availability as major barriers***, indicating some shared understanding of structural issues.

The differences suggest that ***leaders might benefit from greater awareness of the practical barriers*** (wait times, insurance acceptance) that community members experience when seeking healthcare.

Question 3

What are the 3 biggest health problems in your community?

Between key leaders and community residents, the following was observed in survey responses regarding perceived biggest health problems in the community**.**

Key Similarities:

1. **Drug and alcohol problems** rank high for both groups (43% for leaders, 47% for community members), though community members rank it as their top concern while leaders rank it tied for second/third.
2. **Diabetes (high blood sugar)** is considered a significant health problem by both groups (43% for leaders, 32% for community members).
3. **Heart disease and high blood pressure** appear in both groups' top concerns (36% for leaders, 27% for community).

Key Differences:

1. **Mental health issues**:
    - Leaders rank "mental health" as their top health concern (57%).
    - Community members rank it lower (35%, tied with other issues).
2. **Cancer**:
    - Community members rank it as their second highest health concern (35%).
    - Leaders rank it lower (25%, sixth highest).
3. **Weight status**:
    - Community members rank obesity/overweight as a top concern (35%, tied for with other health issues for 2-4).
    - Leaders rank it somewhat lower (29%, fifth highest).

Analysis: These differences highlight interesting perspective gaps between community residents and leaders, which are summarized below.

Leaders place significantly more emphasis on mental health concerns than community members, suggesting they ***may perceive mental health as a more urgent priority.***

Community members show greater concern about cancer than leaders do, which may reflect differences in how visible certain health conditions are within the community.

Leaders appear to overlook certain conditions entirely (Alzheimer's, breathing problems, stroke) that community members identify as concerns, suggesting ***potential blind spots in leaders' understanding of community health issues***.

Both groups recognize substance abuse, diabetes, and heart disease as significant community health problems, showing some ***alignment on chronic disease concerns***.

Focus Groups

Key findings from each focus group completed for the 2025 CHNA process are summarized in this section.

Hispanic Community Focus Group

On January 12, 2025, a focus group was conducted at St. Francis Church in Salisbury, MD with eight members of the Hispanic community. The discussion revealed a complex relationship with local healthcare services, highlighting both strengths and challenges within the system.

Participants noted significant concerns about stigma and lack of insurance, mentioning that many community members with serious conditions like HIV would return to their home countries "never to be seen again" rather than seek treatment locally. While acknowledging that the health department provides valuable services, there is a general lack of awareness about how to access available services. Participants also expressed frustration with lengthy processing times for insurance applications and prescription fulfillment.

Access to specialty care was highlighted as particularly challenging, with many residents having to travel to Baltimore for specialized treatment. However, participants positively noted that transportation services are provided by both the health department and hospital for cancer patients. They specifically praised MADAP (Maryland AIDS Drug Assistance Program) for assisting uninsured individuals with primary care and prevention services, and Chesapeake Health for its income-based approach, community outreach, and availability of interpreters.

Chronic diseases, including heart disease, diabetes, and high blood pressure were identified as common health concerns, with participants acknowledging the health department's effective assistance with these conditions. For communication improvements, participants suggested distributing Spanish-language flyers in locations frequently visited by Hispanic community members, particularly grocery stores, noting that flyers placed at the health department often go unnoticed. Creating a Spanish radio station and leveraging existing Facebook pages were mentioned as additional effective channels for disseminating information about available services.

Participants commended TidalHealth for providing financial assistance in serious healthcare situations, including covering expenses for a patient to receive treatment in Mexico, and for offering payment plans for emergency department visits. Regarding food access and security, participants reported no significant issues obtaining healthy foods. Transportation was described as limited but adequate, with suggestions to simplify routes for better understanding.

The focus group highlighted the importance of culturally appropriate outreach and communication strategies to better connect the Hispanic community with existing healthcare resources, emphasizing that many valuable services exist but remain underutilized due to awareness and accessibility barriers.

Senior Center

On January 14, 2025, a focus group was conducted in-person with senior residents of Somerset County. Participants had varying lengths of residency in the county, ranging from 5 years to lifelong residents. They expressed appreciation for the socialization opportunities, community feel, and the MAC Center, while noting significant healthcare challenges within the county.

The participants identified healthcare access as the primary barrier to healthy living. They emphasized the lack of local healthcare providers, particularly specialists, forcing residents to travel to Salisbury or even as far as Washington, DC for specialized care like nephrology. Transportation was highlighted as a critical issue, with participants noting that ambulance response times can reach up to an hour. Housing conditions were also cited as problematic, with many senior housing units lacking ADA compliance (such as walk-in showers) and property managers being slow to address maintenance issues. Environmental concerns included the prevalence of chicken farms in the area and the widespread marijuana smell since legalization.

Regarding health conditions, diabetes was identified as a serious problem, with participants noting that doctors often fail to adequately monitor A1C levels, leading to late-stage kidney failure diagnoses. Arthritis was also highlighted, with suggestions for more accessible exercise options like yoga or tai chi. Participants expressed concerns about doctors dismissing their health concerns due to age or weight, creating reluctance to seek care. They noted a strong correlation between insurance coverage and quality of care, with underinsured patients receiving less attentive treatment.

Suggested improvements included ensuring doctors take adequate time to properly examine and diagnose patients, citing an example of a misdiagnosed case of gum cancer that proved fatal. Participants expressed frustration with being primarily seen by physician assistants rather than doctors, feeling that this compromised their quality of care, especially for those with pre-existing conditions. They highlighted medication management as a significant challenge, with doctors prescribing medications but rarely reviewing or discontinuing them when no longer needed.

Participants valued the quieter pace of life in Somerset County, the manageable traffic, and proximity to essential services like grocery stores, the library, and post office. However, they expressed concerns about TidalHealth's growing dominance in the regional healthcare market, noting that the closure of a medical center in Crisfield had created service gaps. They suggested that healthcare quality tends to decline as healthcare organizations consolidate and grow larger. A key takeaway was the need for better communication about available resources, as many seniors living in poor housing conditions don't know where to turn for assistance.

Haitian Community at Fire Station 16

On January 14, 2025, a focus group was conducted at Fire Station 16 with six members of the Haitian Creole community plus an interpreter. The participants noted that the low attendance was due to ineffective outreach methods, as flyers are not effective for the Haitian community, which responds better to verbal communication.

The participants identified language barriers as a fundamental challenge to healthy living, with many community members relying on interpreters for healthcare visits, raising privacy concerns. One focus group participant discussed how it is not always comfortable for community members (particularly women) to have to rely on their children or other family members to interpret for them at healthcare visits.

Cultural differences were highlighted as significant obstacles, particularly regarding healthcare-seeking behaviors, with many Haitians preferring natural remedies over visiting doctors and only seeking medical care in emergencies. Mental health stigma was noted as especially problematic.

Healthcare access was described as challenging, with participants reporting a lack of Haitian healthcare providers or providers who speak Haitian Creole, particularly dentists, and difficulty obtaining appointments for specialized care like dental and vision services. Transportation was identified as a major barrier, with many community members relying on expensive taxis to reach distant medical appointments.

Suggested improvements included better health education tailored to the Haitian community, with an emphasis on using Haitian community members to educate their peers ("use the Haitian to educate the Haitian").

Participants also stressed the need for in-person interpreters rather than language lines or Google Translate, which often lack cultural context and miss important nonverbal cues. Several participants specified that there needs to be a full time interpreter rather than relying on nurses or other medical staff who speak Haitian Creole to be interpreters on top of their regular responsibilities.

They emphasized the importance of true partnership between health institutions and the Haitian community saying that they would rather have the institutions work “with” them rather than “for” them. The group suggested creating dedicated health advocate positions for Haitian liaison roles within healthcare administration.

Participants expressed frustration about inadequate funding allocation to Haitian-specific initiatives and a lack of inclusion in strategic planning, despite their significant contribution to the local workforce and economy. They noted that health systems often engage with the community during crises or outbreaks (quote, “when they need something from us”) but fail to maintain consistent relationships afterward. The focus group emphasized that the Haitian community should not be conflated with the broader Black community, as resources allocated to one do not automatically reach the other.

Virtual Focus Group: Somerset County Adults

On February 3, 2025, a virtual focus group was conducted with two Somerset County residents. The participants had lived in the county for relatively short periods - one since summer 2021 and the other for four years, though her parents had been residents for nearly 20 years. Both

expressed appreciation for the slower, laid-back pace of life, with one specifically mentioning the sunsets as a favorite aspect of living in the area.

The participants identified healthcare access as a primary barrier to healthy living, specifically noting the lack of local medical facilities and difficulties scheduling with specialists, which often requires traveling to Salisbury or beyond with wait times of two months or longer. The absence of local dentists was highlighted as particularly problematic. Transportation challenges compound these issues, especially for residents without personal vehicles. Food access was also cited as a significant concern, with the county described as a "food desert" limiting access to healthier food options for those without transportation.

Regarding prevalent health conditions, diabetes, hypertension, and obesity were identified as serious problems in the African American community, though participants noted these issues affect residents across all demographics. Nutrition issues, including what one participant described as "starvation" (bodies not getting proper nourishment), and kidney problems were also mentioned as significant health concerns.

Social determinants affecting health included poverty, limited employment opportunities, and illicit drug use and alcoholism that can make individuals "unemployable." Childcare was described as "almost non-existent" and prohibitively expensive when available. The housing situation was characterized as critical, with "outrageous" rental prices and a concerning trend of the county cracking down on people living in campers without addressing alternative housing solutions, potentially increasing homelessness.

Participants identified several barriers to healthcare access beyond geographic distance and transportation, particularly for the African American community. These included lack of knowledge about health issues and available services, fear of being stereotyped, distrust of the medical system, and financial constraints even when insured, as copays can be "exorbitant." One participant noted that when basic needs like food and shelter are priorities, healthcare often gets neglected until conditions become severe, leading to worse outcomes and higher mortality rates.

Suggested improvements included increasing the number of health facilities in the area, particularly for primary care and dental services, with mention of TidalHealth potentially opening a kidney specialty center. Participants recommended more frequent deployment of the Wagner Wellness Van for community screenings and educational programs. They suggested leveraging the public school system more effectively by hosting health clinics and expanding beyond the current vision and hearing screenings for students. One participant emphasized focusing health education on children as a strategic approach, noting that "when kids are young, they are moldable" and can potentially influence healthy habits in their parents and grandparents.

Virtual Focus Group: Sussex County Adults

On February 5, 2025, a virtual focus group was conducted with four participants from Sussex County, MD. Participants expressed appreciation for their community, noting its connectedness, supportive atmosphere, and potential for growth. One participant who has lived in Seaford since

1998 emphasized that "if you need something, everyone wants to help in some way and if they don't know how to help they'll find someone who can."

The participants identified limited healthy food options as a significant barrier to healthy living, noting an abundance of fast food restaurants and few home-cooked dining establishments. They highlighted that while many residents desire to live healthier lifestyles, financial constraints often make this difficult. Food distribution locations were mentioned as sometimes lacking in nutritious options, possibly due to limited knowledge about preparing healthy meals on a budget. Transportation was cited as a major challenge, particularly in rural areas where public transportation (DART) doesn't reach all locations, making it difficult for those without vehicles to access services.

Regarding health conditions, diabetes and cancer (particularly breast cancer) were identified as the most serious health problems in the county, along with weight management issues. Participants noted that Sussex County may not receive the same health programs as other Delaware counties, with challenges exacerbated by the county's large geographic area. They also mentioned that grocery shopping for diabetics is especially difficult due to limited sugar-free options in local stores.

Social determinants affecting health included homelessness, with participants noting that "if you don't have proper housing, it's hard to focus on other things like health, education, well-being." Trust issues were highlighted as barriers to accessing services, with some families described as protective of their personal information and therefore reluctant to provide details required for assistance programs. Technology barriers were identified as particularly challenging for older adults, with one participant expressing frustration that TidalHealth staff primarily communicate through the MyChart portal when many seniors prefer phone calls. Language barriers, especially within the Haitian community, were noted as significant challenges, along with limited health literacy across populations.

Participants acknowledged several positive community resources, including libraries that offer health programs, though they noted barriers such as transportation, family obligations, and inconvenient timing of programs during work hours, suggesting evening sessions might be more accessible. They praised the Sussex County Health Coalition for working to leverage community resources to improve health, though they suggested better coordination of existing services.

Suggestions for improvement included implementing mobile health services to meet people where they are, expanding communication beyond Facebook to reach seniors through traditional channels like senior centers, meals on wheels programs, and churches, and encouraging residents to share information about healthcare resources through word of mouth. Participants valued the local hospital's presence, emphasizing that "having healthcare available right there is huge, many do not have a hospital readily accessible," while suggesting that outpatient services need to be strategically distributed to ensure accessibility for all residents.

Two Virtual Focus Groups: Wicomico County Adults

On January 17 and February 4, 2025, two separate virtual conversations were conducted with Wicomico County residents. One had lived in the area for 10 years, and the other participant had grown up in the area, lived in DC where she was exposed to 9/11, and returned to the region with several chronic health conditions.

Both participants identified language barriers and healthcare access as fundamental challenges to healthy living. One participant emphasized that many non-English speakers face significant difficulties when seeking care, noting that the way they are treated when language barriers exist often discourages them from returning. The second participant highlighted transportation challenges, particularly for those who cannot drive or afford a car. Both mentioned that specialist care is particularly difficult to access, with long wait times for appointments that can result in worsened health conditions, sometimes with fatal consequences.

Regarding prevalent health conditions, both mentioned chronic diseases including heart disease, diabetes, and high blood pressure. One participant observed that the Health Department's diabetes prevention program sees higher rates of diabetes among Black/African American and Hispanic populations, while also noting kidney issues and high blood pressure as prevalent among these communities. The second participant also mentioned obesity as a serious issue, suggesting that adding sidewalks and green spaces might encourage more physical activity.

Communication and provider interactions were extensively discussed by both participants. The second participant described generational gaps in communication, with young doctors potentially lacking skills to effectively communicate with older adults, particularly women who might not feel confident speaking up. She noted that 15-minute appointments are insufficient for addressing complex health needs and that "doctors are mean so patients need advocates or 'back-up.'" The first participant shared personal experiences of discrimination, describing how providers made assumptions based on her last name, assuming she couldn't speak English and making her wait for interpretation services she didn't need, which made her "feel like they care less about her."

Social determinants affecting health included economic disadvantages, housing problems, and insurance challenges. The first participant emphasized that while health education is valuable, "the main issue is people do not have money. You can tell people to eat healthy but they cannot afford food." She noted that many residents are ineligible for insurance due to immigration status or face difficulties enrolling outside open enrollment periods. The second participant described the housing situation as "horrible," sharing that she had experienced homelessness, living in her car for three months despite previously working for the federal government and in healthcare, and waited three years for senior housing.

Both participants expressed concerns about TidalHealth's growing dominance in the region. The second interviewee stated, "TidalHealth has bought up everything and they can't handle what they have," emphasizing the need for accountability mechanisms for poor quality care. She described a traumatic experience where an asthma attack led to a heart attack due to inadequate emergency care, followed by premature discharge and readmission with multiple clots.

Suggested improvements included enhancing language services and cultural competence, establishing better transportation systems, improving coordination between healthcare providers, creating accessible community spaces designed with seniors in mind, and developing mechanisms for accountability in healthcare. Both emphasized the need for better communication about available services and resources, with one noting, "People don't know what they don't know."

Key Leader Interviews

Key leaders representing a variety of sectors in the Delmarva region were interviewed as part of the assessment process. Findings from these interviews are presented based on key topic areas in this section of the report.

Healthcare Access and Barriers

Access to healthcare services emerged as a significant challenge across all counties. Interviewees consistently mentioned provider shortages, particularly for specialists, pediatric care, dental services, and behavioral health. Many noted extraordinarily long wait times for appointments, with some specialties having waiting periods of 12-18 months. Transportation barriers were universally cited as a critical issue preventing healthcare access, especially in rural areas. Multiple interviewees described how lack of reliable transportation forces patients to miss appointments, leading to gaps in preventive care and worsening health outcomes.

The consolidation of healthcare services was highlighted as a concern, with several interviewees mentioning that one health system has been acquiring many smaller practices. While this consolidation may create efficiencies, some interviewees worried about reduced patient choice and the potential for gaps in care. Many interviewees also noted that service availability differs significantly between the northern and southern parts of counties, with southern and more rural areas typically having fewer resources and facilities.

Social Determinants of Health

Housing emerged as a critical social determinant affecting health outcomes across the region. Interviewees described a severe lack of affordable housing, increasing homelessness (including among seniors), and poor housing conditions contributing to health problems like asthma, COPD, and other respiratory issues. Many homes were reported to have mold, asbestos, lead, and inadequate insulation, directly impacting residents' health. One interviewee specifically mentioned that "handicap accessible ramps" are among the most needed home modifications, yet they are prohibitively expensive for many residents.

Food insecurity was frequently mentioned as contributing to poor health outcomes. Interviewees described how many residents make difficult choices between paying for medication, housing, or food. They noted that healthier food options are typically more expensive, leading economically disadvantaged residents to purchase less nutritious but more affordable and shelf-stable foods. This directly contributes to health conditions like obesity and diabetes.

Economic challenges were consistently highlighted, with interviewees describing how lower income levels throughout the region affect residents' ability to access healthcare, nutritious food, and safe housing. Several interviewees mentioned that jobs in the area often don't provide adequate health insurance benefits or sick leave, forcing residents to choose between seeking healthcare and maintaining employment.

Health Conditions and Concerns

Chronic health conditions were consistently identified as primary health concerns, with diabetes, hypertension, obesity, heart disease, and respiratory conditions (asthma, COPD) mentioned most frequently. Multiple interviewees connected these conditions to environmental and social factors such as poor housing conditions, limited access to healthy food, lack of safe spaces for physical activity, and barriers to preventive healthcare.

Behavioral health needs were emphasized by nearly every interviewee as a growing and critical concern. They described insufficient mental health and substance use disorder resources throughout the region, with particular gaps for children and adolescents, culturally appropriate care for diverse populations, and crisis services. Several interviewees mentioned the long-term impacts of COVID-19 on mental health, noting lingering effects of isolation on families.
Maternal and child health concerns were raised by several interviewees, who described limited access to obstetric care, prenatal services, and pediatric specialists. One interviewee specifically mentioned that teen pregnancy rates had declined but seemed to be increasing again recently.

Vulnerable Populations
Several interviewees highlighted the challenges faced by the region's growing immigrant communities, particularly Haitian Creole and Hispanic/Latino populations. Language barriers were frequently mentioned as limiting healthcare access, with few providers and services available in languages other than English. Cultural differences in healthcare understanding and navigation were also noted as creating barriers to care.

The aging population was consistently identified as a group with significant and growing needs. Interviewees described how the region is experiencing a "gray tsunami" with increasing numbers of retirees and older adults who require specialized services. They noted that older adults often face challenges related to transportation, healthcare costs, home safety, isolation, and care coordination.

Children and youth were identified as a vulnerable population with unique needs. Several interviewees mentioned concerns about childhood obesity, asthma, mental health issues starting at younger ages, and limited access to specialized pediatric care in the region.

Resources and Strengths
Interviewees identified several community strengths and resources, including strong collaboration among organizations, passionate community members willing to help others, and creative approaches to addressing complex challenges with limited resources. Several mentioned the health departments as key assets providing essential services and coordination.

Specific programs were highlighted as effective resources, including school-based health centers, community health worker programs, transportation assistance, food banks, and housing improvement initiatives. Many interviewees mentioned that while these resources are valuable, they are often insufficient to meet the full scope of community needs.

Recommendations for Improvement
Interviewees suggested numerous strategies for improving health outcomes in the region. Enhanced coordination among healthcare and social service providers was frequently mentioned as a way to maximize limited resources and reduce duplication of efforts. Many suggested expanding outreach efforts to bring services directly to where people live, work, and learn, particularly for underserved communities.

Addressing transportation barriers through expanded public transportation routes, ride-sharing programs, or mobile services was a common recommendation. Several interviewees suggested implementing more prevention-focused programs to address health issues before they become serious, particularly for conditions like diabetes, heart disease, and obesity.

Increased funding for existing effective programs was emphasized, with many interviewees noting that current resources are insufficient to meet community needs.

Several mentioned the importance of sustainable funding rather than short-term grants to ensure program continuity and impact.

Overall, the interviews reflected a complex healthcare landscape with significant challenges but also dedicated professionals working to improve community health through innovative approaches and strong partnerships.

What do you think local health leaders should do to improve health and quality of life in your community? What do you want local health leaders to know?

Leader 1: "In a rural area, services shouldn't be duplicated, they should complement each other. We work well together but also compete – we should move away from the competition and see where we can work together."

Leader 2: "Work with Parks and Recreation – they are developing a wonderful walking trail going across the county, and they do a great job of promoting health. We could have more partners like that – more initiatives to promote health."

Leader 3: "[Health professionals should] take a little bit of time to educate patients. Don't assume they know stuff. Some can't read but are handed [information] pamphlets."

Leader 4: "The community should work together instead of duplicating efforts. Additionally, mobile health units are not being utilized effectively."

Leader 5: "It is important to listen to the community and address their needs."

Leader 6: "It would be nice if TidalHealth built [a patient] advocacy component into their services. Quantity is not always quality – TidalHealth is taking over a lot, they need to build the customer/patient relationship and be able to have the resources out there so that they're not sending thousands of patients to one provider."

Leader 7: "If you're a hospital, before you make some drastic change, make sure you do some community-based planning with other support systems that'll pick up where you're going to leave off."

Leader 8: "Let's all quit doing the same thing on our own and just all do things together."

Leader 9: "Find a systematic way to co-exist with non-profits and how [we] can serve each other."