Health Equity Report 2018

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TABLE OF CONTENTS

1. INTRODUCTION AND DEFINITIONS

1.1 What is Health Equity?

Health equity refers to the absence of health differences (disparities/inequalities) among groups of people that would arise because of their socioeconomic status, geographical area, age, disability, gender or ethnic group. As a result, everyone has a fair opportunity to attain their full health potential and can live a long and healthy life (Whitehead, 1992). Where there is health equity, in a community, there will be no "measurable differences in health experience and health outcomes between different population groups – according to socioeconomic status, geographical area, age, disability, gender or ethnic group" (Whitehead, 1992). Health equity is achieved when people are given fair opportunities and health gaps are eliminated. Equity is not the same as equality – for example, allocating a resource equally may not necessarily mean it is equitable.

1.2 Health Inequities ("Disparities")

"Healthy People 2020" defines health inequity or "disparity" as "a particular type of health difference that is closely linked with social, economic, and environmental disadvantages" (Healthy People 2020, 2017). These differences in health could be between groups of different ages, race, sex, disability, or communities. Disadvantaged groups will have poorer health outcomes including poorer survival chances (Whitehead, 1992). For example, some rural communities may experience increased health disparities, compared to their urban counterparts, due, for example, to geographical isolation, fewer health providers and limited transportation options (Rural Health Information Hub, 2017).

1.3 Determinants of Health

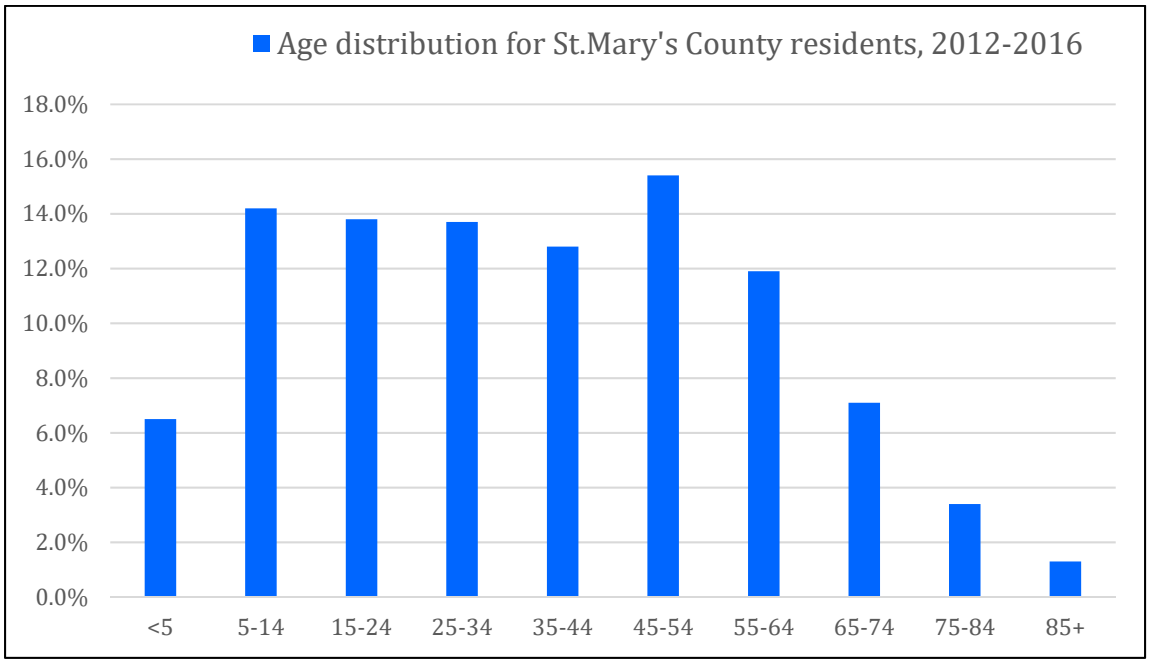
The health status of an individual person is determined not only by their genetics, food consumption, or decisions, but also by environmental, social and economic factors. These other factors (social, economic and environmental) outside the individual person that affect health comprise the social determinants of health (Marmot, 2005). The environment would include the conditions in which we live, learn, work and play - our neighborhoods, schools, access to transportation, grocery stores etc. Because social-economic and environmental factors determine much of the health status of individuals and communities, reducing inequities in these would in turn reduce health disparities.

2. DEMOGRAPHICS OF ST. MARY'S COUNTY

The population of St. Mary's County as reported in the 2016 Maryland Vital Statistics Report was 112,667 people (Maryland Vital Statistics Report 2017). Of that population: 75.8% identify as non-Hispanic White, 15.4% as non-Hispanic Black, 5.2% as Hispanic, 3.2% as Asian or Pacific Islander and 0.4% as American Indian.

Life expectancy (in years) at birth was 79.2 for all races, 79.3 for whites and 77.6 for blacks (Maryland Vital Statistics Report 2017).

The median age of residents is 36.3 years old, a relatively young population (US Census Bureau, 2012-2016 American Community Survey 5-Year Estimates). In 2017, persons under the age of 18 years comprised 24.5% of the county population. The St. Mary's County population is growing at a faster rate than the State (0.9% vs 0.5%). The overall age structure is similar to the State and the US, as shown in the figure below.



In the 2016 population estimate, out of 72,507 residents who were 25 years old and over in St. Mary's County, 3% had lower than a 9th-grade education, 7.1% completed 9th - 12th grade, 30.2% either has a diploma or a GED. Beyond high school, 21.7% have attended some college, 8% have an associate's degree, 17.4% have a bachelor's degree, and 12.5% have a graduate degree or higher.

The median household income is $86,987, and the poverty level is at 7.9% (US Census Bureau, 2012-2016 American Community Survey 5-Year Estimates)

About 11.7% of the county's population have a disability (State average is 10.7%) (US Census Bureau, 2012-2016 American Community Survey 5-Year Estimates).

About 28.4% of the county's population resides in the greater Lexington Park area. This area consists of 3 zip code regions, 20634 Great Mills, 20653 Lexington Park, and 20667 Park Hall. The population residing within this area is 31,723. In the area, 56.4% are Non-Hispanic White, 28% Non-Hispanic Black, 6.8% Hispanic, and 4.8% Asian. The median age of residents in the area is 37.8, comparable to the county's average age (US Census Bureau, 2012-2016 American Community Survey 5-Year Estimates).

The education status of residents of the greater Lexington Park area is generally comparable to the county averages. Of the 20,291 residents over the age of 25 years old in this area, 4% has a 9th-grade education, 7.5% completed 9-12th grade, 26.4% has either a diploma or a GED, 25.7%

have attended some college, 6.8% have an associate's degree, 19.5% have a bachelor's degree, and 10% have a graduate degree or higher. The median household income is $73,573, and the poverty rate is at 12.8% (US Census Bureau, 2012-2016 American Community Survey 5-Year Estimates). The greater Lexington Park median household income is much lower than the county's median of $86,987, and the poverty level is much higher than the county's average of 7.9% (US Census Bureau, 2012-2016 American Community Survey 5-Year Estimates).

3. ANALYSIS OF HEALTH DISPARITIES IN ST. MARY'S COUNTY

3.1 Life expectancy

Differences in life expectancy (in years) at birth is a culmination of all the factors that affect an individual's health. Life expectancy (in years) at birth is the number of years a child is expected to live starting from birth. Differences in life expectancy are influenced by the health disparities that exist in the county. Life expectancy (in years) at birth for St. Mary's County residents was 79.2 for all races, 79.3 for whites and 77.6 for blacks (Maryland Vital Statistics Report 2017). Years of Potential Life Lost (YPLL) before age 75 is a measure of premature death and provides, just like "life expectancy", a comprehensive look at overall health status of a population. The YPLL before age 75 per 100,000 population for all causes of death for St Mary's County was 6200 in the 2017 (University of Wisconsin Population Health Institute, County Health Rankings, 2017). Among the various census tracts, life expectancy ranges from 76.4 to 84.2 years, a difference of 7.8 years (US Census Bureau, 2010 Census, USALEEP 2018). The lowest life expectancy in the county is in the greater Lexington Park area.

3. 2 Low birth weight

Low birth weight (LBW, birthweight of 2499 grams or less) is associated with poor health outcomes and a high risk for health problems in the affected children. The percentage of livebirths who were LBW in St Mary's County was 6.4% (Maryland Vital Statistics Administration report 2017). There were inequalities in the percentages of LBW among races/groups in the county: lowest among non-Hispanic Whites (5.6%) and highest among non-Hispanic Blacks (11.5%).

3.3 Infant mortality

Infant mortality rate (IMR, the rate of deaths to infants less than one year of age per 1,000 births) may serve as an indicator for the broader public health issues of access to care and maternal-child health. IMR in St Mary's County was 6.7 (comparable to the statewide average of 6.5). However, at the state level, the IMR was almost three times in black children compared to white children (11.2 versus 4.0) (Maryland Vital Statistics Administration report 2017).

3.4 Cancer

Cancer was the leading cause of death in St. Mary's County in 2017. The age-adjusted rate of death due to malignant neoplasm (cancer) per 100,000 population in St Mary's County was 176.8 [Centers for Disease Control and Prevention (CDC), National Vital Statistics System. Accessed via CDC WONDER. 2012-16]. There are male-female differences in these rates – with

rates being higher in males than females (213.3 versus 145.6). The rate was also higher in blacks (189.6) compared to whites (179.6).

3.5 Cardiovascular disease

Coronary heart disease was the second leading cause of death in St. Mary's County in 2017. The age-adjusted rate of death due to coronary heart disease per 100,000 population in St Mary's County was 102.8 (Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2012-16). There were male-female differences in rates – with rates being higher in males than females (131.6 versus 77.2). The rate was also higher in blacks (115.3) compared to whites (103.4).

The age-adjusted death rate due to stroke (cerebrovascular disease) per 100,000 population in St Mary's County was 36.4 (CDC, National Vital Statistics System. Accessed via CDC WONDER. 2012-16). Unlike in coronary heart disease, the rate in males was lower than females (32.7 versus 38.7) but that in blacks (47.0) remained higher than in whites (34.6).

3.6 Chronic lower respiratory disease

Chronic lower respiratory disease is a major cause of death in St. Mary's County residents. The age-adjusted death rate due to chronic lower respiratory disease (per 100,000 population) in St Mary's County was 41.4 (CDC, National Vital Statistics System. Accessed via CDC WONDER. 2012-16). The age-adjusted rate (deaths per 100,000 population) for males was slightly higher than in females (43.0 versus 40.0) and that for whites (44.9) was much higher compared to that for blacks (30.7).

3.7 Obesity and overweight

About 28.3% of the St Mary's county adult population have healthy weight; the remainder (70.3%) are overweight (32.1%) or obese (38.2%) [Behavioral Risk Factor Surveillance System (BRFSS) MD 2016]. Unhealthy weight puts individuals at risk for poor health outcomes. There are disparities involving overweight/obesity across various county subpopulations. For example, among high school youth: 17.5% of black youth reported being overweight compared to 18.1% of Hispanic/Latino youth and 12.9% of white youth (Youth Risk Behavior Survey (YRBS), 2016). A trend in obesity was noted where more black youth were obese (16.3%) compared to their Hispanic-Latino (14.7%) and white (9.9%) youth counterparts. In adults, there were more females (36%) compared to males (34.4%) who were obese (CDC, National Center for Chronic Disease Prevention and Health Promotion. 2015).

Because unhealthy weight is associated with many chronic diseases (including cardiovascular diseases and diabetes mellitus) and other poor health outcomes, those most affected by obesity and overweight would likely have a preponderance of these conditions. Indeed, a large proportion of deaths in St Mary's County are due to chronic diseases, principally cancer and cardiovascular diseases. In 2017, four chronic diseases (cardiovascular diseases, cancer, chronic lower respiratory diseases and diabetes mellitus) contributed 57% of all deaths and these 4 diseases were among the 5 leading causes of death in the county (Maryland Vital Statistics Administration report 2017). In Maryland, deaths due to cardiovascular diseases and diabetes are higher in blacks compared to whites; this may be following the racial/ethnic disparities seen in overweight/obesity (Maryland Vital Statistics Administration report 2017).

3.8 Asthma

Asthma is often exacerbated by poor environmental conditions. The percentage of adults aged 18 and older in St Mary's County, who self-report that they have ever been told by a doctor, nurse, or other health professional that they had asthma was 11.2% in 2016 (up from 7.6% in 2012) (CDC, BRFSS. Additional data analysis by CARES, 2011-12). At the state level (which may on average reflect what was happening at the county-level) racial/ethnic disparities in these percentages were apparent: blacks had the highest prevalence (13.1%), followed by whites (9.7%), Hispanics (6.2%) and lastly Asians (5.9%). Prevalence was higher in females compared to males (15.8 versus 12.1%). It was also almost twice as high in people with a disability (22.2%) compared to those without (12.0%).

4. FACTORS THAT MAY CONTRIBUTE TO DISPARITIES IN HEALTH

4.1 Access to Health Care

Inadequate access to health care presents a barrier to good health. Access to care could be limited by a limited supply and accessibility of facilities and physicians, lack of adequate health insurance, financial hardship, transportation barriers, and/or cultural and language barriers. Indicators of this factor affecting health equity include: supply of health care providers, patient to primary care provider ratio, discharge rates for ambulatory conditions, and emergency department utilization rates.

St Mary's County has a limited supply (per 100,000 population) of dentists (49.4), mental health providers (125.9), and primary care physicians (41.7) (US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2015; University of Wisconsin Population Health Institute, County Health Rankings, 2018).

The discharge rate (per 1,000 Medicare enrollees) for ambulatory care sensitive (ACS) conditions (such as pneumonia, dehydration, asthma, diabetes - these condition visits may be prevented if adequate primary care resources were available and accessed by those patients) may be an indicator for access to primary care. This rate was higher (57.8%) in St Mary's County compared to the State average (46.7%).

St. Mary's County has a higher patient to primary care provider ratio, 2,650:1, compared to the state average of 1,140:1(University of Wisconsin Population Health Institute, County Health Rankings, 2018). This may make it extremely difficult for people with and without insurance to get the medical help they need to become or remain healthy in St. Mary's County.

This shortage in primary care may lead to the abundance of Emergency Department (ED) visits. In 2016, MedStar St. Mary's Hospital reported that in one year it experienced 52,429 ED visits (MedStar St. Mary's Hospital - Facts & Figures, 2016). ED utilization rates per 100,000 in 2016 for St. Mary's County residents were higher than statewide averages for a variety of health conditions - including diabetes (249.7 vs 222.9), mental health (5804.2 vs 3796.7), hypertension (482.6 vs 313.4), asthma (75.1 vs 73.3), and dental care (645.2 vs 585.7). Furthermore, within St. Mary's County residents, racial/ethnic disparities in ED utilization for these conditions was

striking, primarily when comparing non-Hispanic black residents to non-Hispanic white residents. (Maryland Health Services Cost Review Commission, Research Level Statewide Outpatient Data Files 2016).

4.2 Health Insurance

Lack of health insurance is a primary barrier to access to healthcare including primary care and other types of health services, and may itself represent a factor influencing health equity – those with no or poor coverage may sustain greater financial hardship and thus experience other barriers to health equity. An indicator of this factor affecting health equity is the percentage of the population that is uninsured.

About 6% of the population in St Mary's County is uninsured (US Census Bureau, 2012-2016 American Community Survey 5-Year Estimates). In St Mary's County about 6.8% males and 5.4% females are uninsured. Disparities are seen by race/ethnicity – the uninsured among White, Asian, Black, and Native American populations in the county is 5%, 7%, 7.1% and 26.9%, respectively.

4.3 Transportation Policy

Transportation policy is a main factor influencing health equity. In St. Mary's County, transportation is considered a barrier to obtaining health care (Healthy St. Mary's Partnership 2015 Community Health Assessment). Availability of transportation allows access to health care, healthy foods, physical activity facilities, employment work places, childcare facilities and many other factors that contribute to good health. Indicators of this factor affecting health equity include: utilization of public transportation, access to a private vehicle, utilization of transportation support programs, and utilization of emergency transportation systems.

Approximately 2.5% of residents in St. Mary's County use public transportation (US Census Bureau, 2011-2015 American Community Survey 5-Year Estimates). However, in certain areas of the county such as the greater Lexington Park region the percentage is 5.2%. Over 5% of residents in this area also report that they do not have access to a private vehicle (US Census Bureau, 2013-2017 American Community Survey 5-Year Estimates).

Current public transportation routes and schedules may limit where residents may seek health care and when residents can access these services. This may lead to delays in health care services or complete gaps in service access. Medical conditions may worsen during these delays and could lead to a need for higher intensity, more expensive care. Additionally, residents may more heavily rely upon emergency transportation (and consequent use of the emergency department) for non-emergent or preventable needs.

The public transportation system in St. Mary's County involves a public bus system, the St. Mary's Transit System (STS). Over 30,000 riders utilize the transit system every month (St Mary's County, Department of Public Works and Transportation). The ability to buy passes is available at the main office, but the buses only accept exact change. STS provides paratransit services to people who meet the guidelines and obtain a pass from the central office. Also provided is specialized statewide transportation assistance to the elderly and people with disabilities who do not live close to a route if they meet the requirements. There are scheduled "zone" days with an increased fleet in certain zones on a particular day to provide this assistance.

A potential downfall of this though is that it may limit concurrent operations in other zones – for example, if a resident lives in zone 1 and it is a zone 2 day, then their service is limited. This system provides 9 routes and around 13 stops per line in one direction (St Mary's County, Department of Public Works and Transportation)

The St. Mary's County Health Department, via its Medical Assistance Transportation Program, directly provides or arranges transportation to those who are Medical Assistance (Medicaid) beneficiaries and need transportation to a verified medical appointment. Per federal and state policies, many criteria need to be met before a person or appointment is eligible for this service. The process determining eligibility and certifying appointments necessitates last minute transportation takes some time and coordination. Given this and the eligibility criteria, not all residents may be able to meet their needs through this program. In fiscal year 2018, this program allowed St. Mary's County residents to keep a collective 22,328 medical appointments.

4.4 Economic Stability

Economic stability in communities and families is a prime influence on health and health inequities. Indicators of this factor affecting health equity include: unemployment rates and poverty levels. Unemployment directly leads to higher poverty levels in a community and affects health equity.

The average annual unemployment rate in St. Mary's County was 4% in 2017 (US Department of Labor, Bureau of Labor Statistics. 2018). Low income creates barriers to healthy foods, health care, quality housing and other basic necessities. About 7.8% of the St Mary's County population is below the poverty level (US Census Bureau, 2013-2017 American Community Survey 5-Year Estimates). Disparities in poverty varied with gender, race, household type, education and disability status. A higher percentage of persons were below the poverty level in females than males (10.0 vs 6.4%), Black or African-Americans than Asians or Whites (18.5, 7.5, and 6.0%, respectively), in female householders and other living arrangements than in married-couple families (23.8, 17.5 vs 2.4%), in those with less than high school diploma than those with at least high school diploma or less (18.0 vs 10.3%), and in those with a disability than those without (15.4 versus 7.4%).

4.5 Housing

Housing is a factor influencing health equity. Inadequate good quality housing and homelessness are barriers to good health. Indicators of the housing factor affecting health equity include: rates of owner-occupied housing, renter-occupied households, and housing cost burden. Additional housing indicators are summarized in the housing analysis for St. Mary's County excerpted from the Maryland Department of Housing and Community Development Housing Market County Profiles (December 2017, https://dhcd.maryland.gov/Documents/DHCD_Housing_Market_Profiles_MDCounties.pdf). (Appendix A)

Owner-occupied housing unit rates for St. Mary's County for the 2012-2016 period is 71.9% (US Census Bureau, 2012-2016 American Community Survey 5-Year Estimates or the US census report: https://www.census.gov/quickfacts/fact/table/stmaryscountymaryland,US/PST045217#PST0452

17). This figure aligns with the YRBS results from 2016. Percentage of students who report that their parents or guardians own the home or place where they live was 73.1% for St Mary's County as a whole. Disparities exist among different people groups. The percentage among black, Hispanic-Latino, white and multiple-race students who report that their parents or guardians own the home or place where they live was 48.8, 57.8, 81.3, and 68%, respectively. Renter-occupied households was highest among blacks (47.2%) compared to whites (23.8%).

The housing cost burden (the percentage of the households where housing costs exceed 30% of total household income) is an indicator for housing affordability and excessive shelter costs. This indicator was 27.4% in St Mary's County in the 2012-2016 period (US Census Bureau, 2012-2016 American Community Survey 5-Year Estimates). The housing cost burden was highest amongst rental households (40.6%) compared to owner-occupied households: 24.6% if they had mortgage or 16.2% if they did not have mortgage (US Census Bureau, 2012-2016 American Community Survey 5-Year Estimates).

4.6 Community Zoning, Infrastructure and the Built Environment

Community zoning policies, infrastructure (including water treatment and public sewer access), and the built environment are important factors in health outcomes and health equity. An indicator of these factors include: number of recreation/fitness facilities per population.

Mixed-use zoning allows for more residents to live close to where they may work, recreate, and access community resources such as grocery stores, open spaces, and health care facilities. This may encourage residents to use active means of transportation (walking, bicycling) either alone or in combination with public transportation to access destinations. Community water and sewer infrastructure plays a significant role in attaining mixed-use development as development potential would not be limited by soil types and ability to maintain on-site septic systems.

Built environment refers to the man-made or designated physical parts of the environment where we work and live. The design of built environment, related to community zoning and other development policies, may enhance or decrease an individual's access to healthy opportunities. The "Complete Streets" concept of street design provides for safe use by all modes of transportation (including walkers and cyclists). This lessons injury, lowers transportation costs, provides alternatives to private cars, encourages physical activity, creates a sense of place, improves social interaction, and improves economic stability by helping adjacent property values (St. Mary's County Planning Commission, 2016). The built environment also includes the accessibility of the population to recreation and fitness facilities (as defined by North American Industry Classification System (NAICS) Code 713940, and measured by the number of recreation and fitness facilities per 100,000 population), an indicator that may encourage physical activity and other healthy behaviors. An environment with fewer exercise facilities and opportunities may contribute to poor health outcomes. St. Mary's County had 7.61 recreation and fitness facilities per 100,000 population in 2012 (US Census Bureau, County Business Patterns, and CARES. 2016).

4.7 Food Environment

Healthy food access and food insecurity contribute to the food environment which is a factor that influences health equity. Indicators for this factor include: rates of fast food establishments,

density of these and other limited-service restaurants, and percentages of population affected by low food access.

The density of fast-food establishments/outlets (limited-service establishments primarily engaged in providing food services (except snack and nonalcoholic beverage bars) where clients generally order or select items and pay before eating) in a community may be an indicator of healthy food access. St. Mary's County had 72.3 fast food restaurants per 100,000 population in 2016 (US Census Bureau, County Business Patterns, and CARES. 2016). The highest density of limited-service restaurants is in the California-Lexington Park-Great Mills areas (Zip code areas – 20619, 20620, 20653 and 20670).

Low food access (living more than ½ mile from the nearest supermarket, supercenter, or large grocery store) could be an indicator for food insecurity. In St Mary's County, 22.3% of the population had low food access in the 2010-2015 period (US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2015). The population in St Mary's County with low or no healthy food access was 56.3% with some disparities among different races – White, 54.3%, Black, 64.6%, Asian, 62.6%, Native American, 58.3%, and Hispanic-Latino, 64% (CDC, Division of Nutrition, Physical Activity, and Obesity, 2011).

4.8 Education

The level of education of community members affects all aspects of the community including health outcomes. Education is among the strongest predictors of health - the more schooling people have the better their health is likely to be (Freudenberg & Ruglis, 2007). An indicator of this factor influencing health equity is high school graduation rate.

High school graduation rate in St. Mary's County is 94% (US Department of Education, EDFacts. Accessed via DATA.GOV. Additional data analysis by CARES. 2015-16). In St Mary's county, 10.1% of the total population aged 25 and older are without a high school diploma (or equivalency) or higher (US Census Bureau, 2012-2016 American Community Survey 5-Year Estimates). The distribution is almost equal between male and female among these persons (Male 10.8% and female 9.4%). There are disparities when race is considered – the percentage is lowest among whites (8.5%), 10.7% in Native American/Alaska Native, 11.9% in Asians, and highest among blacks (19.2%).

5. PUBLIC HEALTH EFFORTS TO ADDRESS HEALTH EQUITY FACTORS

The St. Mary's County Health Department (SMCHD) operates or participates in a variety of initiatives to address factors influencing health equity. Some of these initiatives involve policy and environmental change within the community, as well as social change and cultural change. The community factors addressed contribute to higher health risks and poorer health outcomes in specific populations experiencing health disparities. A selection of initiatives is highlighted below; more detailed information is available through specific program documents.
SMCHD developed and coordinates the Healthy St. Mary's Partnership (HSMP) as the major vehicle for engaging a variety of community partners around health issues. HSMP serves as the

local health improvement coalition for the county and addresses priority health areas identified by the most current cycle of the community health improvement process (Healthy St. Mary's Partnership, 2017). Currently the coalition mobilizes members through four priority action teams to address the key health issues in St. Mary's: Access to Care, Behavioral Health, Healthy Eating & Active Living and Tobacco Free Living.

5.1 Access to Care

The Amish comprise a community within the county where cultural traditions play a significant role in health care access. This community traditionally uses holistic and alternative medicine, and believes in the power of prayer for healing. Some community members may use the larger healthcare system after consultation and approval by Amish Elders. Those who do so face many barriers including stigma, challenges with communication mediums, low health literacy, and lack of health insurance.

Historically, the Amish do not vaccinate their children, though community members may individually choose to do so. In an effort to support social change related to vaccination practices, SMCHD operates a mobile, home-based clinic for the Amish community. This mobile intervention works through the Amish Elders and lay health advisors to provide infectious disease education; immunizations for infants, children and adults; and health exams for children in the Amish community. The clinic operates in a manner that is sensitive to the cultural identity of the Amish community and offers services/vaccine at no cost. Over the years it has reduced access barriers and improved health in this underserved population in the county.

5.2 Transportation

5.2.1 Medical Assistance Transportation Program

The Medical Assistance Transportation Program is a transportation assistance program addresses transportation barriers leading to health inequities. SMCHD provides this service to county residents with Medical Assistance that meet transportation eligibility requirements. This service provides door-to-door shared ride services to and from scheduled medical appointments throughout the county. For services that are not provided within St. Mary's County, transportation can be scheduled to locations in Washington, D.C., and around the state. If transportation is not directly provided by SMCHD or its transportation contractors, program participants may receive other services such as gas vouchers and public bus system vouchers (St. Mary's Health Department, Medical Transportation).

5.2.2 Transportation Policy Improvements

SMCHD works with the HSMP Access to Care action team to address policy improvements that would alleviate transportation barriers affecting health. The policy focus includes:

- Advocate for a reduced number of restrictions on the Medical Assistance Transportation Program
- Advocate for the expansion of public transportation options (e.g., extended schedules, additional routes, additional vehicles, increase frequency, lowered prices, alternative options, and connector services to outside of St. Mary's)
- Support the implementation of the St. Mary's Transit System Development Plan (e.g., installation of additional bus stop signs and shelters, initiation of evening hours on the southern route, Sunday service expansion to the Leonardtown/Charlotte Hall

areas, increased frequency in Lexington Park/Great Mills, initiation of fixed route service to the Seventh District and Piney Point, and extended services connecting local routes to Baltimore and Washington, DC)

- Support centralized locations for multiple health care providers/services which are easily accessible by public transportation (Healthy St. Mary's Partnership, 2015).

5.2.3 Wheels 2 Wellness Pilot Transportation Project

SMCHD has been working with community partners through the HSMP Access to Care Action Team to pilot a regional transportation model called "Wheels 2 Wellness". This systems change intervention establishes agreements across individual transportation services/programs in order to extend use of their vehicles during non-peak hours. Involved health care facilities (primarily hospitals) can contact a central number and arrange transportation for patients under the collaborative agreements. Planned expansion of the project would allow broader use by multiple community organizations and participants.

5.3 Community Zoning, Infrastructure, and the Built Environment

5.3.1 Infrastructure

SMCHD worked with a task force of key partners to change local annotated code policy (Chapter 113 section 10) of the St Mary's County Metropolitan Commission in order to ease connections to public water and public sewer lines by resident households and businesses in the county. Such policy change supports housing availability (including multi-unit residences) and development of community resource (St. Mary's County Metropolitan Commission) near where residents live or work. SMCHD continues to work with the county Metropolitan Commission to use state Bay Restoration Fund resources to support residential/business connection to public sewer and advocate for state policy that allows such use.

5.3.2 Complete Streets

Complete Streets is a major focus of the HSMP Healthy Eating Active Living (HEAL) action team coordinated by SMCHD. One of the many ways the action team is carrying out this initiative is by educating elected officials and community leaders on the health benefits and the criteria of "complete streets". SMCHD also informed development of the Lexington Park Development District Master Plan and advocated for the inclusion of mixed-use zoning policies and complete streets ordinances that would support a healthy built environment for the area of the county that experiences the greatest health disparities. In February 2016, the St. Mary's County Commissioners adopted this plan. This plan recommends to "establish and implement a "Complete Streets" policy that considers the needs of all users, including pedestrians, cyclists, and people with disabilities through strategies suggested by or adapted from the National Complete Streets Coalition of Smart Growth America" (St. Mary's County Planning Commission, 2016). This change would promote healthy lifestyles for those living in the Lexington Park area. For those that rely on public transportation, this means safe sidewalks for them to walk and stand on while waiting for the bus. Alternatively, for those that want to cycle, they would have designated lanes for them to utilize. Access to places like a pharmacy or grocery store would be safer and easier with community wide sidewalks and bike lanes.

6. HEALTH DEPARTMENT PROCEDURES AND POLICIES TO SUPPORT HEALTH EQUITY

SMCHD maintains an agency Health Equity Policy to ensure all agency programs and work includes consideration of health equity in the program development, implementation, and evaluation phases. This policy intends to ensure SMCHD programs take into consideration disparities that impact minority racial/ethnic groups, the greater Lexington Park geographic region of the county, individuals with disabilities, and those living in poverty.

The SMCHD Strategic Plan 2017-2018 includes Health Equity as one of three strategic priorities for the agency. Goals supporting this priority include: To increase health department capacity to address health equity; assess health equity in St. Mary's County; educate community members about health disparities in the county; and reduce health disparities in health care access and quality of health care services. Various objectives and strategies are identified to achieve these important goals.

Additionally, SMCHD has incorporated a Health Equity focus in its Workforce Development Plan. This is reflected in workforce development training schedules. SMCHD also considers the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Human Care, developed by the US Department of Health and Human Services Office of Minority Health, when considering workforce development related to health equity. SMCHD maintains language translation services via phone for multiple languages, and more recently hired an onsite Spanish interpreter to assist all health department units.

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8. APPENDIX

APPENDIX A: The State of Maryland DHCD Housing Market Profile for St. Mary's County

HOUSING MARKET PULSE

ST. MARY'S COUNTY, MARYLAND

BRIEF COUNTY HISTORY

Origin: What would become St. Mary's County was land where the Conoy Indians lived. Here, the settlement of Lord Baltimore's Maryland began with the arrival of the passengers who had set sail on the Ark and the Dove from Cowes, England, on November 22, 1633. They landed at St. Clement's Island in the Potomac River on the southwestern side of present-day St. Mary's County on March 25, 1634. The date of their landing is commemorated annually as Maryland Day.

Established in 1637 (probably by an order of the Governor), St. Mary's, the first Maryland county, was named in honor of Mary, the mother of Jesus.

SOURCE: Maryland State Archives

RELATIVE LOCATION

HOUSING INDICATORS*

	2000	2007	2013	2016
Existing Home Sales	1,009	1,120	1,067	1,494
New Home Sales	288	431	267	144
Median Home Price	$145,250	$326,179	$268,369	$264,300
Inventory	715	899	634	695
Months' Supply	N/A	8.6	7.7	5.8
Days on Market	N/A	N/A	94	104
Building Permits	1,011	935	402	696
Starts	1,011	935	402	696
Completions	855	800	473	519

SOURCE: MD Association of Realtors; CoreLogic; Economy.com; DHCD, HERO

*Sales, permits, starts, and completions are *cumulative*; price, inventory, supply, and days on the market are annual *averages*.

DELINQUENCY INDICATORS*

	2007	2010	2013	2016
Defaults	23	274	402	222
Foreclosure Sales	287	292	234	240
Lender Purchases	9	120	68	186
Negative Equity Share	N/A	27.3%	14.8%	10.0%

SOURCE: RealtyTrac, CoreLogic

*Defaults, sales, and purchases are *cumulative;* equity share is an annual *average*

DEMOGRAPHICS

	2000	2010	2013	2015
Median Household Income	$55,503	$81,726	$85,672	$86,810
Income by Age				
15-24	$26,051	$44,125	$44,338	$44,216
25-44	$82,114	$84,223	$90,890	$92,189
45-64	$98,707	$93,471	$102,870	$101,573
65+	$50,945	$48,292	$53,726	$53,394
Households by Tenure				
Owner-Occupied	71.8%	72.9%	72.9%	72.3%
Renter-Occupied	28.2%	27.1%	27.1%	27.7%
Rented Units	8,646	9,835	10,189	10,593
Renters by Age				
25-34	31.7%	28.0%	27.8%	31.2%
35-44	27.5%	23.9%	22.4%	19.0%
45-54	13.5%	17.0%	17.0%	16.6%
55-59	6.8%	3.9%	7.5%	10.1%
60+	4.0%	13.4%	14.0%	14.7%

SOURCE: Census

DHCD INVESTMENTS (in millions $)

	FY 2014	FY 2015	FY 2016
Mortgage Financing			
Maryland Mortgage Program	$3.79	$13.47	$10.02
Special Loans	$0.08	$0.02	$0.00
Rental Housing			
Multifamily Construction	$28.59	$0.00	$2.47
Rental Assistance	$1.65	$1.64	$2.00
Neighborhood Revitalization	$1.08	$1.16	$0.96
Local Gov't Infrastructure	N/A	$22.57	$0.00
Business Lending	N/A	$0.00	$0.00

SOURCE: DHCD, HERO data is reported on Fiscal Year (July 1 – June 30th)

PROGRAM ECONOMIC IMPACT (in millions $)

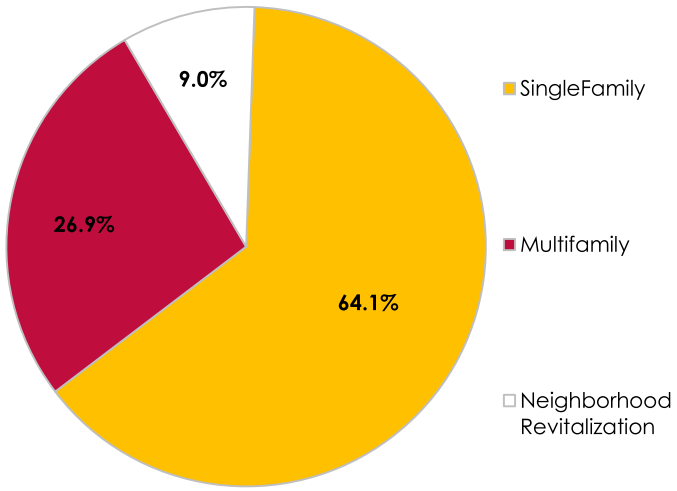
	FY 2016
Total Investment	$20.1
Direct Investment	$16.8
Indirect Investment	$3.4
Jobs	57
Wages and Salaries	$2.2
Local Taxes	$0.0

SOURCE: DHCD, HERO data is reported on Fiscal Year (July 1 – June 30th)

DHCD Program Analysis

St. Mary's County, Maryland

DHCD PROGRAM INVESTMENTS



SINGLE FAMILY INVESTMENTS

- MMP activity issued 53 loans to county residents in FY16
- Average home loan in the county was $188,987
- The average loan financed is 28.5% percent lower than the median home price in the county
- DPA investments averaged $5,609 per household
- Single family energy investments totaled $466,919 helping 100 families with energy needs

Home Ownership Insight

- 10,593 or 27.7% of households are renter-occupied, of which 76.9% of renters are between the ages of 25 to 59 years.
- This group has an average income of $96,881, which is 79.8% higher than the national average of $53,889
- A significant drop in rentership from the 25-34 to 35-44 age brackets suggest a strong interest in ownership during the early 30's

RENTAL HOUSING INVESTMENTS/CONSTRUCTION

- Multifamily investments in the county totaled $4.5 million in total project costs in FY16
- Investments added 32 units of affordable units in Lexington Park for families and elderly
- County received nearly $2.0 million of project based rental housing subsidies to help alleviate the cost of housing for its vulnerable and low income residents

Rental Housing Insight

- Affordable housing remains a serious issue in the County. Core Logic rental trends estimates the minimum rental rate in 2016 ranged from $1,283 for a one bedroom unit and as much as $2,340 for a four-bedroom with 49.2% of residents paying more than 30.0% of their income on rental units. Shortage of affordable units in the county makes it difficult for low-moderate income residents to afford decent housing in the county.

# of Rooms	Min Rental Rate	Max Rental Rate
1 Bedroom	$993	$1,561
2 Bedroom	$1,176	$1,800
3 Bedroom	$1,385	$2,155
4 Bedroom	$1,782	$2,637

- Shortage, the deficit of affordable housing in the county, totals 3,120 units spread among those with income in 30.0%, 50.0% and 80.0% of the HUD Adjusted Median Family Income (HAMFI)
  - 30.0% shortage totals 1,430 units
  - 50.0% shortage totals 1,161 units
  - 80.0% shortage totals 529 units

NEIGHBORHOOD REVITALIZATION INVESTMENTS

- Total investment in the county was $1.5 million in FY16
- Program invested in six awardees in the county
- Projects funded in FY16 were located in Lexington Park and Leonardtown
- Community Legacy funds were used to assist in the rehabilitation of approximately ten townhomes that support the housing of homeless families

NEIGHBORHOOD BUSINESSWORKS INVESTMENTS

- There were no NBW investments in the county in FY16

LOCAL GOVERNMENT INVESTMENTS

- There were no local government investments in the county in FY16