EXHIBIT 2

2019

PRINCE GEORGE'S COUNTY

COMMUNITY HEALTH ASSESSMENT

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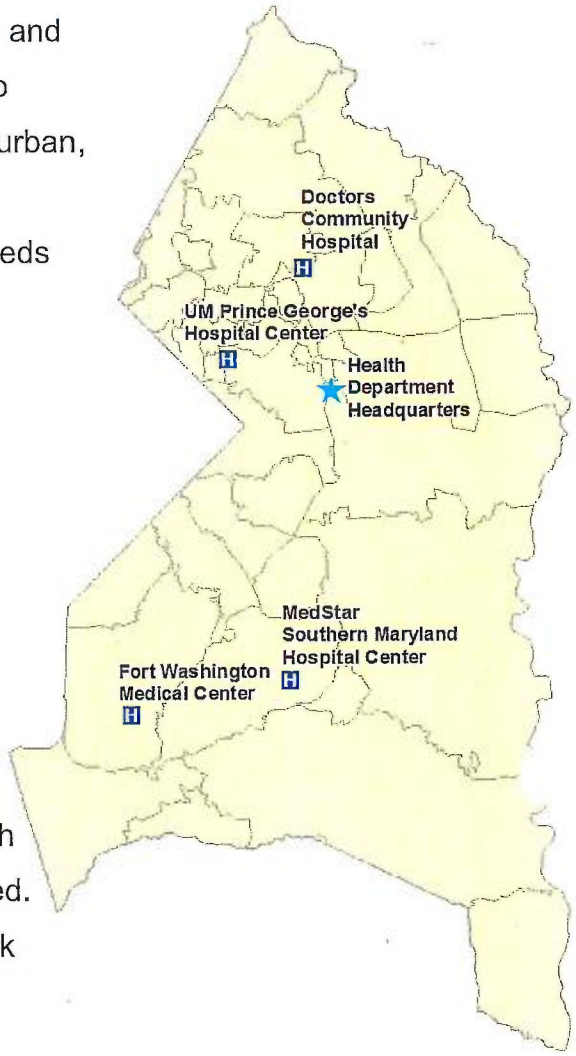
HEALTH DEPARTMENT
Prince George's County

INTRODUCTION

Prince George's County is located in the state of Maryland and is part of the Washington, D.C. metropolitan area. Home to more than 900,000 diverse residents, the county includes urban, suburban, and rural regions. The county, while overall considered affluent, has many communities with higher needs and poor health outcomes.



In 2015, the Prince George's County government and Maryland-National Capital Parks and Planning Commission conducted a special study to develop a Primary Healthcare Strategic Plan[1] in preparation for enhancing the healthcare delivery network. A key recommendation from the plan was to "build collaboration among Prince George's County hospitals", which included conducting a joint community health assessment (CHA) with the Prince George's County Health Department. In 2016, the first inclusive CHA was completed. The hospitals and Health Department agreed to again work collaboratively to update the 2016 CHA in 2019.

CHA Core Team

Doctors Community Health System
Fort Washington Medical Center
MedStar Southern Maryland Hospital Center
Prince George's County Health Department
Prince George's Healthcare Action Coalition
University of Maryland Capital Region Health

There are four hospitals located within the county: Doctors Community Hospital; Fort Washington Medical Center, MedStar Southern Maryland Hospital Center; and UM Prince George's Hospital Center. All four hospitals and the Health Department appointed staff to facilitate the 2019 CHA process. The core team began meeting in September 2018 and included leadership from the Prince George's Healthcare Action Coalition during the data review and prioritization process.

[1] http://www.pgplanning.org/Resources/Publications/PHSP.htm

PROCESS OVERVIEW

The CHA Process was developed to 1) maximize community input, 2) learn from the community experts, 3) utilize existing data, and 4) ensure a comprehensive prioritization process. Elements of the Mobilizing for Action through Planning and Partnerships (MAPP)[2] process where used in the 2019 CHA to shift data collection towards community perceptions of health and consideration of the local health system. The Core Team developed a shared Vision at the start of the process of

"A community focused on health and wellness for all."

The group agreed upon five shared values to provide focus, purpose, and direction for the CHA process:

- Collaboration
- Equity
- Trust
- Safety
- Prevention

The Core Team were also asked to consider what they would like the local health system to look like in five to ten years. The emergent themes included:

- all residents to feel safe accessing health-related services (regardless of immigration status);
- residents will have a better perception of health care in the county;
- better utilization of local services;
- a system that allows residents to access services close to home;
- consideration of needs of all residents.

In summary, the Core Team envisioned **"a system that is perceived as available to serve all with quality services"**.

The Health Department staff led the CHA process in developing the data collection tools and analyzing the results with input from the hospital representatives. The process included:

- A community resident survey available in English, Spanish, and French distributed by the hospitals and health department;

[2] https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

- Secondary data analyses that included the county demographics and population description through socioeconomic indicators, and a comprehensive health indicator profile;
- Hospital Service Profiles to detail the residents served by the core team;
- A community expert survey and key informant interviews; and
- A prioritization process that included the Core Team and Prince George's Healthcare Action Coalition leadership.

While the Core Team led the data gathering process, there was recognition that **health is a shared responsibility**. The community data collection strategies and the prioritization process were intentionally developed with this consideration and set the foundation for coordination moving forward.

After initially reviewing the data collection results (the data reviewed is available in the Prioritization Process section), the Core Team determined that the priorities selected in the 2016 CHA should remain the 2019 priorities based on the community and expert input in the process that focused on these areas, the challenges remaining in the county from the population and health indicators, and acknowledgment that it is realistic for such substantial priorities to require more than three years to "move the needle". The 2019 priorities will continue to be:

- the social determinants of health,
- behavioral health,
- obesity and metabolic syndrome, and
- cancer.

The results of this process will guide the health department and hospitals in addressing the health needs of the county. Additionally, the Core Team committed to reconvene to coordinate assets and resources to addresses the priorities and determine opportunities for further collaboration.

KEY FINDINGS

Drivers of Poor Health Outcomes:

- **Social determinants of health drive many of our health disparities.**
    - Poverty, food insecurity, access to healthy food, affordable housing, employment, lack of educational attainment, inadequate financial resources, access to care, and a disparate built environment result in poorer health outcomes.
    - Growth in the county, while benefiting some, may harm others. For example, in just 3 years the income needed for an efficiency rental has grown by over $13,000. However, the median renter household income has grown by only $3,000, potentially making affordable housing less attainable for some residents.
    - Education was a consistent concern for residents and key informants; resident surveys ranked good schools as the third most important aspect of a healthy community. There is notable disparity in high school graduation rates, with only 66% of Hispanic students graduating compared to 85% and higher for other groups.
    - Resources available in communities with greater needs continue to be perceived as lower quality, such as healthcare and fresh food.
- **Access to health insurance through the Affordable Care Act has not helped everyone.**
    - Many residents still lack health insurance (some have not enrolled, some are not eligible).
    - Those with health insurance struggle to afford healthcare (such as co-pays, high premiums, and deductibles) and prescriptions, and difficulty accessing care due to transportation challenges.
- **Residents lack knowledge of or how to use available resources.**
    - The healthcare system is challenging to navigate, and providers and support services need more coordination.
    - There are services available, but they are perceived as underutilized because residents do not know how to locate or use them.

- Low literacy and low health literacy contribute to poor outcomes.

- **The county does not have enough healthcare providers to serve the residents.**
  - There is a lack of behavioral health providers, dentists, specialists, and primary care providers (also noted in the 2015 Primary Healthcare Strategic Plan for the county[3]). While there has been some growth in providers, it has struggled to keep pace with the population growth and has been unable address deficits.
- **There is a perception that the county lacks quality healthcare providers.**
  - Surrounding jurisdictions are perceived to have better quality providers; residents with resources are perceived as often traveling outside the county for healthcare needs.
  - There is a lack of culturally competent and bilingual providers.
- **Lack of ability to access healthcare providers**
  - There are limited transportation options available, and the supply does not meet the need. There is also a lack of transportation for urgent but non-emergency needs that cannot be scheduled in advance.
  - The distribution of providers is uneven in the county; some areas have a high geographic concentration of providers, while other areas have very few or no providers available nearby.
- **Disparities in health outcomes are complicated**
  - Even though Black, non-Hispanic residents are more likely to be screened for cancer, they still have higher cancer mortality rates. The infant mortality rate for Black, non-Hispanic residents is significantly higher compared to other race/ethnic groups. It is challenging to determine how elements such as stress, culture, structural racism, and implicit bias contribute to health disparities along with the social determinants of health, healthcare access, and healthcare utilization, for example.

[3] Primary Healthcare Strategic Plan, 2015, http://www.pgplanning.org/Resources/Publications/PHSP.htm

Leading Health Challenges

- **Chronic conditions such as heart disease, diabetes, and stroke continue to lead in poor outcomes for many county residents.**
    - Residents have not adopted behaviors that promote good health, such as healthy eating and active living.
    - An estimated three-fourths of adults and one-third of high school students in the county are obese or overweight.
    - The lack of physical activity and increased obesity is closely related to residents with **metabolic syndrome**[4], which increases the risk for heart disease, diabetes, and stroke.
- **Behavioral health needs often overlap with other systems and can be exacerbated by other unmet needs such as housing.**
    - The hospitals, public safety, and criminal justice system see many residents needing behavioral health services and treatment.
    - The county lacks adequate resources needed to address residents with significant behavioral health issues.
    - Homeless residents often have unmet behavioral health needs, but addressing those needs is not often possible without stable housing.
    - Stigma around behavioral health continues to be an ongoing challenge in the county.
- **While the trends for many health issues have improved in the county, we still have significant disparities. For example:**
    - **Cancer:** Black residents in the county had higher mortality rates for breast, and prostate cancers, despite having higher screening rates.
    - **HIV:** Prince George's County had the second highest rate of HIV diagnoses in the state in 2017 and had the highest number of actual cases in the state.
    - **Substance Use:** White, non-Hispanic residents have a drug-related mortality rate nearly three times higher compared to Black, non-Hispanic residents (2015-2017).

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[4] Metabolic Syndrome is a group of risk factors that raises the risk of heart disease and other health problems such as diabetes and stroke. The risk factors include: a large waist; high triglycerides (fat in the blood); low HDL or "good" cholesterol; high blood pressure, and high blood glucose (sugar). Source: NIH, accessed on 6/1/16, http://www.nhlbi.nih.gov/health/health-topics/topics/ms

- **Teen Births:** The Hispanic Teen Birth Rate is four times higher than Black, non-Hispanic teens and eleven times higher than White, non-Hispanic teens (2017).

Recommendations

- **Increase care coordination resources**
  - Trained community health workers were recognized as improving health outcomes for residents by navigating services and ensuring residents have the support and knowledge they need.
  - Residents need education about the available resources, and how to utilize and navigate them.
- **Increase community-specific outreach and education**
  - Similar to the 2016 findings, more outreach and education is needed at a community-level to be culturally sensitive and reach residents.
- **More funding and resource for health and support services.**
  - Funding is needed to strengthen the health safety net for those unable to access health insurance or unable to afford what is available.
  - There must be a focus on ensuring basic needs are being met for residents experiencing vulnerabilities in order for them to manage their health.
- **Attract a culturally-diverse quality healthcare workforce.**
  - One in five residents in the county were born outside the U.S. A diverse workforce would potentially help to address the cultural and language barriers experienced by residents.
  - Incentives to attract and academic partnerships to develop a quality workforce are needed to address identified deficits as well as increase provider availability in the county.
- **Increased partnerships and collaborative efforts are needed.**
  - Current coordinated efforts in the county were recognized as improving outcomes through care coordination and by and addressing systemic issues in the county.