HEALTH POLICY CAPACITY

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Toward understanding the role of health policy in improving health outcomes and promoting health equity in Prince George's County, Maryland

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OVERVIEW

The consequences of not having health policy in place – at the county or sub-county level – have not been fully understood, nor systematically measured. This paper is the second in a series of HPRC white papers to explore the relationship between health policy and health outcomes. In the first paper – *What Difference Does Policy Make? Comparing health outcomes to situations with and without public policy* – we discussed the apparent effects of "having" versus "*not* having" public policy. The paper drew from two instructive policy challenges in Prince George's County, Maryland: an effective state-level response to tobacco control, and a lagging county-level response to the obesity epidemic. We learned that in the absence of policy, major county-wide health challenges go untended – and disparities remain intact.

We now advance our discussion by considering health disparities and health policy at the *sub*-county level (i.e., cities, towns, and municipalities). We turn our attention to three important health disparity variables – race, income, and geography – that must inform the health policy response at the local jurisdictional level. We discuss "health policy infrastructure," identifying key elements such as Census mapping and community participation that enable local jurisdictions to create and sustain policies and improve health outcomes for local residents.

In this paper, we introduce the concept of "health policy capacity," which we define as the structural ability of a jurisdiction to fill policy voids by creating and sustaining policies that will improve health outcomes. We hypothesize that the "health policy capacity" of a jurisdiction is measurably related to health outcomes. This paper develops the exploratory framework for guiding a subsequent HPRC research study that will test this hypothesis, using a quantitative method for measuring and assessing the effects of "health policy capacity."

The overarching goals of these conjoined research efforts are to (1) understand what happens when a jurisdiction lacks policy, (2) describe the role "health policy capacity" in empowering jurisdictions to respond to community health challenges; and (3) explain how to strengthen "health policy capacity" at county and sub-county levels, thereby enabling jurisdictions to maximize their collaborative efforts to improve health outcomes and reduce health disparities.

INTRODUCTION

Policy Lapses

In 2007, Deamonte Driver, a 12-year old Prince George's County resident, needed an $80 extraction for a decayed tooth that was spreading an infection. His mother – struggling, uninsured, and worried – sought out assistance with navigating the healthcare system. Tragically, the support she needed did not arrive quickly enough. The infection soon spread to Deamonte's brain. On February 25 – after two surgeries and six weeks of hospital care totaling more than $250,000 – Deamonte died.

Since then, new policies and local initiatives in Prince George's County have emerged to prevent such horrific tragedies from recurring. One major initiative, funded by the state of Maryland and private foundations, is the Deamonte Driver Dental Project, a three-chair mobile clinic that now provides easy access to dental care for uninsured and underinsured children in Prince George's County and surrounding communities. The mobile clinic, which is housed in a 39-foot, high-tech vehicle, delivers both routine and urgent dental care, including oral surgery, directly to community sites where it is needed.

Of course, not all lapses in public policy and health programming are as glaring, nor as deadly, as that which befell the Driver family. Still, it is clear that the 27 incorporated jurisdictions of Prince George's County, despite the best intentions of local leaders, do not have adequate health policies in place – or, in many cases, even basic policy *infrastructures* – to support public health efforts at the local jurisdictional level. Moreover, there are 84 areas in the County that do not have a local government. This includes 55 Census-designated areas and 29 unincorporated communities that are not recognized by the U. S. Census. These areas, which are urban or rural, rely on the County for public policy and public services. Wide variations in local policy infrastructure, as well as differences in local community health needs, are further complicated by demographic variations such as race, income, and geographic location – key social determinants of health.

While the link between health policy and health outcomes is quite pronounced in the Driver case, it is perhaps less obvious across the much wider terrain of health challenges facing these local jurisdictions. Major health challenges include heart disease, obesity, asthma, diabetes, maternal and child health, and HIV/AIDS. The patchwork of local policies – and the absence of policy infrastructure for most jurisdictions – bear important implications for local capacity to address these many challenges and improve health outcomes for area residents.

In fact, policy vacuums at the sub-county level can thwart crucial funding opportunities for important health initiatives at the federal, state, and county levels. Policy voids can also undermine program implementation. For example, according to Maryland Hunger Solutions, Prince George's County is substantially underutilizing the National School Lunch Program. Most students who are financially eligible for the lunch program are not concurrently enrolled in the federally-funded, state-managed School Breakfast Program – yet there appear to be no major policy initiatives at local jurisdictional levels that would encourage neighborhood students to participate in the available breakfast program. The result:

- Most children who qualify for the National School Lunch Program in Prince George's County do not also get the *available* breakfast to start their school day.
- In 2009-2010, an additional 14,000 eligible low-income students could have received breakfast at school if local initiatives to promote the program had been more robust.
- In 2009-2010, Prince George's County lost out on $3.5 million in *unclaimed* federal funding for this important school-based health initiative.

As evidenced by the local school lunch and breakfast programs, and by the tragic loss of Deamonte Driver, health challenges in Prince George's County intersect not only with the issue of service availability but also intertwine with race, income, and geographic location. This means that local policy infrastructures – if they are to exist and be effective – must have mechanisms that are attuned to the social determinants of health

experienced by local communities. Local policy infrastructures must also have viable windows for community engagement in the policy process to guide local health policy initiatives. We believe that health policy capacity is a harbinger of a jurisdiction's ability to identify, understand, and proactively respond to community health needs. It is also an indicator of a jurisdiction's ability to collaborate with federal, state, and county health partners. Ultimately, health policy capacity is a key measure of the empowerment of community members as frontline change agents in the effort to reduce health disparities.

BACKGROUND

Improving health outcomes, reducing health disparities

Persistent, pervasive, and well-documented, health disparities refer to differences in health outcomes that are closely linked with social, economic, and environmental disadvantages. Disparities also refer to differences in healthcare access and quality[2]. Disparities often arise from the social determinants of health – the conditions in which people live, learn, work, and play. In real terms, health disparities equate to measurable inequities in human health, including lower life expectancy and higher infant mortality. Disparities are also not without economic impact. One study, *The Economic Burden of Health Inequalities in the United States*, found that the combined costs of health disparities and premature death were $1.2 trillion between 2003 and 2006.[3]

Increasingly, federal, state, and county governments have adopted comprehensive health policy initiatives designed to close the health gap. These initiatives mandate evidence-based programs, activities and other interventions designed to reduce disparities across race, ethnicity, income, and other variables. These policy initiatives also serve as policy models for guiding health disparity reduction efforts at multiple jurisdictional levels, and support collaboration between jurisdictions.

At the federal level, the HHS National Action Plan to Reduce Racial and Ethnic Disparities[4] builds on the federal government's goals and objectives for addressing disparities as set forth in Healthy People 2020. The HHS Plan also leverages key provisions of the Affordable Care Act as well as inter-agency HHS initiatives. These federal efforts are rigorously supported by the federal Office of Minority Health (OMH) and the National Institute for Minority Health and Health Disparities (NIMHD).

At the state level, in 2004, House Bill 86 and Senate Bill 177 created the Maryland Office of Minority Health and Health Disparities (see Appendix A) which seeks to eliminate disparities by partnering with the public and private sector, engaging local communities, and regularly assessing the health status of key populations, including African Americans, Hispanic/Latino Americans, and Native Americans.

In 2012, the Maryland governor signed into law the Maryland Health Improvement and Disparities Reduction Act (see Appendix A), establishing a $4 million pilot project and a number of permanent provisions to improve healthcare access and health outcomes related to infant mortality, obesity, cancer, and other disparity areas.

At the county level, in 2012 the Prince George's County Health Department launched a 10-year Health Improvement Plan (see Appendix B), establishing six priority health areas. The Department's Health Report 2014 provides local data "to assist planning efforts to address these critical needs as well as measure progress." Additionally, Plan Prince George's 2035, which provides the strategic blueprint for growth and development for the next two decades, establishes six health-specific policies and two health-related policies[5] (see Appendix B).

Together, these multijurisdictional initiatives – both independently and collaboratively – provide evidence-based intervention models for improving health outcomes and reducing health disparities at the sub-county level. Understanding the ability of sub-county jurisdictions to support and sustain these efforts – and to create *local* policy initiatives tailored to *local* health needs – requires a *core knowledge* of key

variables that give rise to disparities. It also requires a conceptualization of local health policy infrastructure. As discussed below, these two components – Core Knowledge and Health Policy Infrastructure – are essential components of a jurisdiction's Health Policy Capacity, or HPC. See Figure 1.

Figure 1. Components of Health Policy Capacity

CORE KNOWLEDGE COMPONENT OF HEALTH POLICY CAPACITY

Race, socioeconomic status, and geographic location are three important variables that give rise to health disparities. A fundamental understanding of these variables – and their interactive influence on health outcomes and health disparities – is an essential knowledge component of health policy capacity.

1. Race and demographic trends

Prince George's County is the largest predominately African-American county in the United States. African Americans comprise 65%, Hispanics make up 15%, and Asian-American/Pacific Islanders and Native American Indians represent 4% and 1%, respectively, of the county's total population. Whites comprise 19%, though their proportion of the county's population is declining.

As a social construct, race is an important consideration for health policy capacity because it plays an important role in determining health status and in understanding how health policy needs can differ significantly based upon a jurisdiction's racial and ethnic composition.

Compared to their white counterparts, African Americans living in rural or urban areas consistently report significant health disparities, including poorer health, less access and utilization of healthcare services, and lower quality of healthcare. African Americans have a higher risk of morbidity and mortality for many health conditions, including HIV/AIDS, heart disease, obesity, and many types of cancer. In Prince George's County, African Americans have the highest death rate for both heart disease and cancer among all racial and ethnic group in the county. African Americans also comprise nearly 9 in 10 of all HIV/AIDS cases among adults/adolescents living in the county.

Residents of minority and other underserved communities have increased exposure to health-negating environmental factors, such as exposure to industrial pollutants, toxic waste sites, and hazardous waste landfills. These communities are more likely to face inadequate zoning regulations and slack enforcement of environmental regulations, potentially putting them at higher health risk. Additionally, African Americans and other underserved communities often face inadequate local municipal services. Neighborhoods that have more consistent access to these social services report lower mortality rates and longer life spans.

Research has shown that many factors contribute to racial disparities in health, including socioeconomic status, segregation, and stress[6]. Racism – at the individual, interpersonal, and structural levels – has also been identified as a causal factor in racial disparities[7]. For example, two landmark reports – the Institute of Medicine's *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* and the Department of Justice's *Investigation of the Ferguson Police Department*[8] – both identified "racial bias" as a major factor in how African Americans are treated by physicians and police officers, respectively.

Thus, given the pervasive and multilevel effect of race and racism on the health and wellness of minority populations, a policy infrastructure that use a "one-size-fits-all" approach is not likely to be successful in addressing racial and ethnic disparities in health. Simply put, when it comes to health disparities, a rising tide will not lift all boats. Health policies that use a "one-size-fits-all" approach are more likely to experience policy voids.

Demographic trends are another important consideration for health policy capacity. While many surrounding counties are experiencing growth and, at the same time, becoming more racially integrated, Prince George's County is also growing but becoming increasingly segregated – that is, becoming "more black." This demographic trend is characterized by four social phenomenon: (1) the county continues to attract middle class Africans Americans; (2) whites continue to leave; (3) the county has been less successful than neighboring counties in attracting Asians; and (4) Hispanics, the county's fastest growing segment, are not dispersing throughout the county, but instead are carving out ethnocentric enclaves. Over the past decade, the county's white population has declined by 50,000, while the number of Hispanics has soared by 72,000. Hispanics are not moving into areas that are predominately African-American, but are mainly clustered in the neighborhoods around Beltsville and Langley Park (where more than 85% of the residents are Hispanic).

Additionally, the national trend in aging bears important implications for health policy capacity at local levels. Despite persistent racial disparities in life expectancy, the number of African Americans aged 65 and older continue to grow – and is expected to triple from 3.2 million in 2008 to 9.9 million by 2050[9]. The Hispanic older population is also projected to nearly triple from 2.7 million in 2008 to over 17 million in 2050. In fact, by the end of the current decade, Hispanics will comprise the largest racial/ethnic segment of the older population in the U.S.

Prince George's County

Key Demographic Trends that Inform HPC

- Black population growing and segregating
- White departure continues
- Hispanic population growing and segregating
- Asian population showing nominal growth
- Older population growing

This mix of demographic trends in race, ethnicity and aging will increasingly challenge health policy capacity at the national, state, and local levels. Policymakers, community members and other stakeholders will need to understand the complex interplay between race, ethnicity, aging, and demographic shifts. Policy stakeholders will need to understand how these factors affect health outcomes and help define healthcare needs for local communities.

2. Socioeconomic Status (SES)

Income, education, and occupation are important determinants of health status. These factors, which are commonly referred to as socioeconomic status, or SES, determine where a person lives, the availability of resources for living, and the overall quality of life. In turn, SES plays a vital role in shaping health outcomes and determining access to healthcare.

As a general rule, higher SES correlates with better health outcomes. That is, poorer groups are more likely to suffer preventable diseases, higher mortality, and less access and lower quality of healthcare. Low SES influences key risk factors, such as poor nutrition, inadequate housing, and unhealthy environmental exposures, which all contribute to health status.

Overall, in contrast to Maryland and the United States, Prince George's County has a higher socioeconomic status. Compared to Maryland, the median income for Prince George's County is slightly greater ($73,623 versus $73,538) and the county's poverty rate is slightly lower (9.4% versus 9.8%). Compared to the United States, Prince George's County is substantially wealthier (with a median income of $73,623 versus $53,046) and it has a much lower poverty rate (9.4% versus 15.4%).

Most notably, Prince George's County has an exceptionally high SES among African Americans. According to the *Washington Post*, the county "has neighborhoods unlike no others in the United States: segregated African American enclaves with median household incomes above $100,000." Most of these solid middle class communities live outside the Beltway in the central areas of the county in local jurisdictions like Lake Arbor, Marlboro Meadows, and Brock Hall.

However, in the context of health disparities, Prince George's County is counterintuitive. Despite a remarkably high SES, the county's African American population faces serious health disparities. African Americans have the worse overall health status of any racial group in the county. The peculiar coexistence of high SES and severe health disparities in Prince George's County is instructive for two reasons. First, it suggests that not *all* of the county enjoys the higher end of the SES gradient. Indeed, nearly 1 in 10 county residents lives in poverty. In fact, among DC's suburban counties in 2009, Prince George's County had the second largest poor population after Montgomery County.[10] In 2012, approximately 82,000 residents of Prince George's County were living in poverty[11].

Second, the social construct of race has a deleterious effect on the normal association between SES and health. That is, higher SES for African Americans does *not* necessarily translate into better health because SES is mitigated by race. The complex interplay between race, SES, and health status is hardly unique to Prince George's County (though the phenomenon is perhaps more pronounced at the county's distinctively high SES level). Major studies have shown that health inequities often hold constant even when controlling for SES. For example, according to the Institute of Medicine's report *Unequal Treatment*, even when researchers controlled for SES and insurance status, African Americans were still more likely to experience a lower quality of care compared to their white counterparts.

Thus, health policy interventions should not be predicated on SES alone, but should also address the confluence of race on SES and on the broader mix of factors that influence health.

3. Geography

Research has increasingly shown that "place matters." *Where* you live determines *how* you live[12]. As the research efforts of PolicyLink have rigorously shown, "neighborhood environmental factors—from local economic opportunities, to social interactions with neighbors, to the physical environment, to services such as local grocery stores where people can buy nutritious food—all affect individual health." The PolicyLink framework identifies four key dimensions of *place* – the economic, social, physical, and service environments – each bearing important implications for health outcomes and health policy.

At the sub-county geography, health variations are evident between rural, urban, and suburban areas, as are health variations between local neighborhoods within a local jurisdiction. Drawing from the PolicyLink framework, these differences arise from the economic, social, physical, and service environments and characteristics of each locality. These variations can translate into major health disparities. For example, in the report *Place Matters for Health in Baltimore: Ensuring Opportunities for Good Health for All*, researchers found that differences in life expectancy between the healthiest and least healthiest urban census tracts in Baltimore was three decades (29.6 years)[13].

To be sure, health disparities are hardly confined to urban areas. The dental tragedy experienced by the family of Deamonte Driver in Largo, a small urban area with a median income of $80,645, could easily have unfolded in a poor rural community. According to the Rural Maryland Health Care Council Work Committee, 12 of the states 24 jurisdictions (23 counties and Baltimore City) face a shortage of dentists, "especially those who treat Medicaid patients." As a result, the rate of total tooth loss in rural Maryland is twice the rate of the rest of the state[14].

Moreover, rural health disparities certainly go far beyond oral health. Compared to the state's general population, rural Marylanders generally tend to be older, poorer, and less healthy. Medicaid enrollment is 27% higher in Maryland's rural jurisdictions, and 34% fewer primary care providers serve rural locations, compared to the state in general.[15] Studies have shown that rural communities generally tend to have higher mortality rates and a higher prevalence of behavioral risk factors for chronic conditions such as obesity, heart disease, and cancer[16].

As with SES, race complicates place. Rural African Americans tend to live 4 years less than their white counterparts, with rural African American men showing

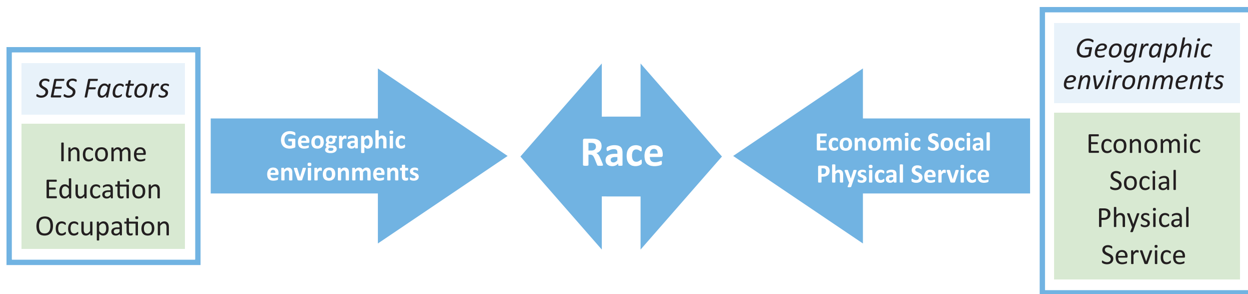

Figure 2. Interaction of Race, SES, and Geography

the lowest life expectancy (67.7 years) of all rural groups[17]. In Kent County, Maryland, where 73% of the population is rural, approximately 30% of county residents are low-income or living in poverty – and the county's African American population experiences disproportionately higher rates of poverty[18], which, in turn, is a predictor of poor health. Hence, race, SES, and geography (See Figure 2) all interact, within the four dimensions of place, to produce health disparities, posing a triple challenge for the knowledge component of a jurisdiction's health policy capacity.

HEALTH POLICY INFRASTRUCTURE COMPONENT OF HEALTH POLICY CAPACITY

While having a core knowledge of the relationship between race, SES, and geography is an essential of health policy capacity, it is not enough. What is also needed is a policy infrastructure – an organized system of resources, tools, and processes for engaging the health policy process. The health policy infrastructure component of HPC comprises two key elements: (1) visibility and structure and (2) community participation.

1. Visibility and structure

Invisibility in the policy arena is not a viable strategy for effectuating the social, economic, and political changes needed in a jurisdiction to improve health outcomes and reduce health disparities. As previously mentioned, there are 84 unincorporated areas in Prince George's County; these are communities that do not have a local government. This includes 55 Census-designated areas (that are recognized by the U.S. Census) 29 unincorporated areas (that are not recognized by the U.S. Census. These areas rely on the county to provide policy and public services such as policing, public safety measures, and public health clinics.

It is important to note that unincorporated counties generally do not have the full operating components of a policy infrastructure – such as a health department, a health commission or committee, a strategic health plan, or health policies and initiatives designed to identify health priorities, address health needs and improve health outcomes in local communities. The lack of policy structure often means that no formal processes are available for community engagement with the policy process at the local level (because a policy process does not exist), and there is minimal or no coordination and advocacy to support state-level and county-level health policies and health programming.

For unincorporated areas that do not appear on the U.S. Census, the absence of a basic policy infrastructure is further compounded by the area's low visibility to planners – who are likely to view the Census as a rationale starting point for setting political priorities. In essence, Census mapping creates an "on ramp" for local communities to join the policy arena, thereby improving their chances of being well-represented and well-served. In the report *California Unincorporated: Mapping Disadvantaged Communities in the*

San Joaquin Valley, researchers explained: "Mapping equips residents with information about their communities and others', provides them with a tool in their advocacy, and facilitates recognition within the policymaking process."[19]

There are also important implications for the relationship between race, demographic shifts, and incorporation status. For example, although people living in incorporated and unincorporated alike use county health services, as populations continue to grow there is no guarantee that counties will have adequate resources to keep pace with growth. The squeaky will get the oil. That is, visible incorporated communities (with effective policy infrastructures in place) will be better positioned to mount policy campaigns needed to address the increase in local health needs – and to implement new health programming.

2. Community Participation

Just as a community without a dot on the map is not seen, a community without a voice is not heard. A substantial body of literature on Community-Based Participatory Research (CBPR) has shown that community input plays a critical role in health programs research, design, implementation, and evaluation. However, while the role of community in the development of health policy has received far less attention, we believe that the prevailing disconnect between policymakers and the served community is counterintuitive to what we already know about the critical role of community in health programming. Indeed, health policy researchers have increasingly valued the indispensable role of community engagement as an evidence-based "strategy for building health communities and promoting health through policy change."[20]

In our work to understand the relationship between health policy and health outcomes, we share the CBPR definition put forth by the Kellogg Community Health Scholars Program. CBPR is "a collaborative process that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities."

In defining the role of community in health policy infrastructure and health policy capacity, we advance the CBPR model[21] by applying it specifically to health policy research and development. Accordingly, we recognize and incorporate the empowerment elements of community engagement established in the CBPR model[22] (see Table 1).

Engaging community in the policy process – and facilitating their role as change agents – is a fundamental aspect of health policy infrastructure. It requires attention to three key areas that support engagement and health policy literacy among community members. First, it requires that community members have a core knowledge of the role of race, SES, and geography in influencing health needs, health outcomes, and healthcare access and quality. As change agents, community members must also have a basic understanding of key mechanisms such as strategic health plans and major health policies and initiatives that require their engagement.

Lastly, community engagement in the health policy infrastructure requires policymaker accessibility and windows of opportunities and mechanisms for community members to engage the policy process. Community organizations that are committed to addressing health disparities may also need technical support and capacity building to ensure that community leaders are familiar with policy tools such community health needs assessments (CHNAs), Health Impact Assessments (HIAs) and asset mapping. By equipping communities with the resources, tools, and mechanisms for engaging the health policy process, local jurisdictions strengthen their health policy capacity – and systematically strengthen efforts to improve health outcomes and reduce health disparities for all communities regardless of race, place, or socioeconomic status.

Key Aspects of Community Engagement in Health Policy

1. Recognize community as a unit of identity.
2. Build on strengths and resources within the community.
3. Facilitate a collaborative, equitable partnership in all phases of research, involving an empowering and power-sharing process that attends to social inequalities.
4. Foster co-learning and capacity building among all partners.
5. Integrate and achieve a balance between knowledge generation and intervention for the mutual benefit of all partners.
6. Focus on the local relevance of public health problems and on ecological perspectives that attend to the multiple determinants of health.
7. Involve systems development using a cyclical and iterative process.
8. Disseminate results to all partners and involve them in the wider dissemination of results.
9. Involve a long-term process and commitment to sustainability.
10. Openly address issues of race, ethnicity, racism, and social class, and embody "cultural humility."
11. Work to ensure research rigor and validity but also seeks to broaden the bandwidth of validity" with respect to research relevance.

TABLE 1

CONCLUSION

A core knowledge of the relationship between race, socioeconomic status, and geography is fundamental to understanding health disparities. This core knowledge is likewise essential to understanding the pathway between health policy infrastructure and a jurisdiction's "capacity" to fill policy voids, improve health outcomes, and reduce health disparities.

Today, key challenges face local jurisdictions in Prince George's County: Unincorporated status fosters invisibility in the policy process. Demographic trends resulting in older, more segregated African American and Hispanic enclaves bear important implications for determining community health needs and allocating health resources in the years ahead. To address current and future needs, county and sub-county jurisdictions will need a better understanding of how to measure and strengthen "health policy capacity."

To support the need for innovative policy tooling – and to build upon our research on the link between health policy and health outcomes – HPRC will conduct a research study to develop an evidence-based technique for measuring "health policy capacity," and for evaluating HPC against jurisdictional policy efforts and health outcomes.

APPENDICES

A. Highlights of Major Health Equity Policies at State Level

B. Highlights of Major Health Equity Policies in Prince George's County

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APPENDIX A

HIGHLIGHTS OF MAJOR HEALTH EQUITY POLICIES AT STATE LEVEL

Maryland Health Improvement and Disparities Reduction Act of 2012

- Create Health Enterprise Zones where health outreach will be targeted, with grants for community nonprofits and government agencies along with tax breaks for health care providers who come to practice there.
- Standardize data collection on race and ethnicity in health care (public and private providers) and ensure carriers are tracking and reducing disparities.
- Require hospitals to describe their efforts to track and reduce disparities.
- Establishes a process to set criteria for health care providers on cultural competency and health literacy training and continuing education.

Maryland Office of Minority Health and Health Disparities

- Advocate for improvement of minority health and preventive health care education efforts.
- Collect, analyze and report data on health disparities.
- Serve as a clearinghouse and resource library on health disparities.
- Develop a statewide plan to increase the number of minority health care professionals.
- Develop training courses and programs on cultural competency and health literacy with universities and colleges of health professional schools.
- Distribute grants to community-based health groups to promote the health of minority populations.

APPENDIX B

HIGHLIGHTS OF MAJOR HEALTH EQUITY POLICIES IN PRINCE GEORGE'S COUNTY

Prince George's County 10-Year Health Improvement Plan

- **Priority 1** – **Access to Care:** Ensure That Prince George's County Residents Receive the Health Care They Need, Particularly Low Income, Uninsured/Underinsured Adults and Children
- **Priority 2** – **Chronic Diseases:** Prevent and Control Chronic Disease In Prince George's County
- **Priority 3** – **Maternal and Infant Health:** Improve Reproductive Health Care and Birth Outcomes for Women in Prince George's County, Particularly Among African American Women
- **Priority 4** – **Infectious Diseases:** Prevent and Control Infectious Disease In Prince George's County
- **Priority 5** – **Physical Safety:** Ensure that Prince George's County Physical Environments are Safe and Support Health, Particularly in At-Risk Communities
- **Priority 6** – **Social Safety:** Ensure that Prince George's County Social Environments are Safe and Support Health

Plan Prince George's 2035 Health-Specific Policies

- **Policy 1** – Integrate community health into the master plan and development review processes.
- **Policy 2** – Improve residents' access to fresh foods, in particular for households living in low-income areas with limited transportation options, and promote sources of fresh foods
- **Policy 3** – Educate and build awareness of health and wellness initiatives that prevent and control chronic disease.
- **Policy 4** – Improve access to health services and programs.

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