



Calvert Health[®]

COMMUNITY HEALTH NEEDS ASSESSMENT

*Improving the health & well-being of
those we serve.*



2026

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CHNA HIGHLIGHTS

DATA COLLECTION METHODS



927

Secondary Data Indicators

Latest available public health metrics compared with 2023 CHNA, Maryland, and national data.



13

Key Informant Interviews

Conducted with 23 community stakeholder participants across 11 organizations.



2

Focus Groups

Convened with 9 community member participants representing diverse lived experiences.

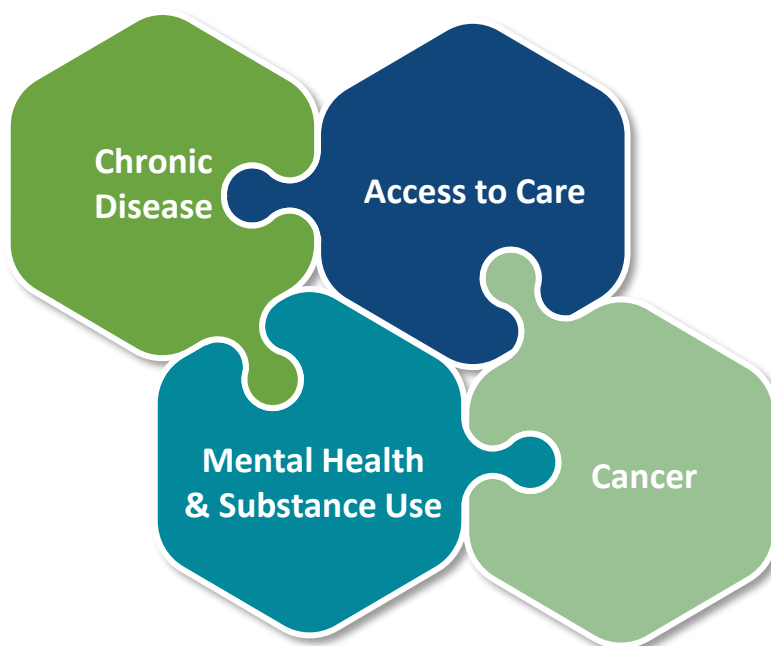


1,064

Community Survey Respondents

Demographically representative of the county population.

PRIORITIZED HEALTH THEMES



EXECUTIVE SUMMARY

CalvertHealth is pleased to present its 2026 Community Health Needs Assessment (CHNA). As federally required by the Affordable Care Act, this report provides an overview of the methods and processes used to identify and prioritize significant health needs across Calvert County, Maryland, the community CalvertHealth serves. CalvertHealth partnered with Berkeley Research Group (BRG) to conduct the 2026 CHNA.

This report is intended to provide a clear, evidence-based picture of the most significant health needs across Calvert County, with particular attention to vulnerable populations, gaps in available services, and the perspectives of community members themselves. The findings will directly inform CalvertHealth's planning efforts, guiding how the organization prioritizes initiatives, allocates resources, and connects residents with the support they need to improve their health, through consistent planning, guiding, allocating, and connecting efforts across the organization.

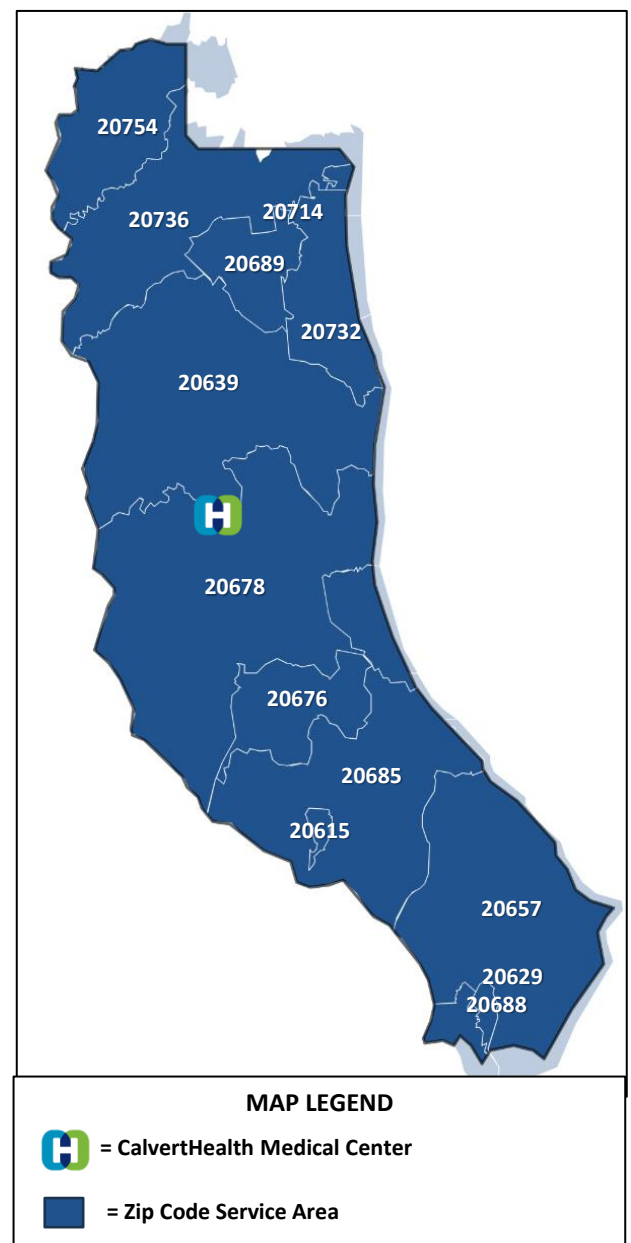
Demographics

Calvert County is home to an aging population, older than both Maryland and the nation, reflecting long-established multigenerational families alongside a steady influx of retirees drawn by the county's natural beauty and quality of life. Adults ages 40 to 64 make up the largest share of residents (33.5%), followed by adults 18 to 39 (26.8%), residents 5 to 17 (17.0%), adults 65 and older (17.0%), and children under 5 (5.7%)²³.

Nearly three-quarters of residents (73.7%) identify as White, followed by African American or Black (12.5%), two or more races (5.8%), Hispanic or Latino (5.6%), and Asian (2.4%)²³. Native American and Pacific Islander or Native Hawaiian residents each account for less than 1% of the population²³.

Economically, Calvert County stands out. Its median household income of \$121,526²³ comfortably outpaces both the Maryland and national medians, potentially as a benefit of its proximity to the Washington, D.C. labor market. That county-wide figure masks real variation, however: African American or Black residents earn roughly \$8,000 less than the county median, and Asian residents report the lowest median income in the county, at \$94,495²³. These economic conditions are also reflected in the county's insurance coverage patterns. Most residents hold employer-sponsored commercial insurance (61.4%), with Medicare enrollment at 17% reflecting the county's older population²³.

FIGURE 1. CALVERTHEALTH SERVICE AREA



Methods for Identifying Community Health Needs

Secondary Data

The assessment incorporates nine hundred twenty-seven secondary data indicators sourced from publicly available state and federal data sources. Indicator values for Calvert County were compared to Maryland and national benchmarks, percentile-ranked against all U.S. ZIP codes, and where applicable compared to 2023 CHNA values to identify trends. Disparities across demographic and socioeconomic factors, such as age, sex, race/ethnicity, and insurance status, were incorporated as additional considerations in identifying areas of need.

Primary Data

Primary data collection combined three complementary methods, each capturing a distinct dimension of community health need. First, thirteen key informant interviews engaged twenty-three stakeholders representing healthcare delivery, public health, behavioral health, education, government, law enforcement, faith communities, and community-based equity organizations. Second, two focus groups brought together nine community members whose backgrounds reflected diverse lived experiences across age, race, profession, and personal health circumstance. Third, a community survey administered throughout Calvert County reached 1,064 respondents, capturing a broad range of information including self-reported health status, barriers to care, and community priorities at scale.

Summary of Findings

The CHNA findings are drawn from 927 secondary data indicators and in-depth primary data from community leaders, residents, and organizations serving the community at large, vulnerable populations, and populations with unmet health needs. Through a synthesis of these sources, the following overall significant health needs were identified, organized into four prioritized themes and three non-prioritized themes.

Prioritized Health Themes



Non-Prioritized Health Themes



Disparities

The identification of disparities across population groups is important for informing and focusing strategies that will address the prioritized health needs. Primary and secondary data revealed significant health disparities based on race/ethnicity, with African American, Non-Hispanic and Hispanic/Latino populations more negatively impacted than other groups, particularly across chronic disease indicators. The most pronounced disparity is observed in diabetes mortality rates, with African American, Non-Hispanic residents experiencing significantly higher mortality than White, Non-Hispanic residents. Older adults, low-income residents, individuals without vehicles, and residents in southern Calvert County also experience disproportionate impacts.

Prioritized Themes

On June 8, 2026, members from various departments within CalvertHealth, the Calvert County Health Department, the Community Health Improvement Roundtable (CHIR), and representative members of the community came together in a hybrid session facilitated by BRG consultants to review assessment findings and rank health themes by priority. Participants ranked all eight health themes from greatest to least priority using a structured nominal voting process, with results collected and aggregated in real time through a digital polling platform.

During the discussion and review of voting results, stakeholders reached consensus to combine Behavioral & Mental Health with Substance Use & Addiction into a single integrated priority theme reflecting overlapping populations, co-occurring disorder considerations. The four priority health areas identified for the 2026-2029 cycle are:

1. Chronic Disease
2. Access to Care
3. Mental Health and Substance Use
4. Cancer

Non-Prioritized Themes

Three additional significant needs were identified through the assessment but not selected as priority themes for direct CalvertHealth action during the 2026–2029 cycle. These themes remain meaningful and will be addressed through partnerships, adjacent strategies, and cross-cutting elements embedded within the four priority themes:

- Basic Needs & Economic Stability
- Environmental & Community Conditions
- Healthy Living & Preventive Measures

Conclusion

This report brings together secondary data analysis, community surveys, key informant interviews, and focus groups to build a comprehensive, evidence-based picture of where Calvert County stands and where the greatest opportunities for impact exist. The four priority themes that emerged from this process, Chronic Disease, Access to Care, Mental Health and Substance Use, and Cancer, will serve as the foundation for CalvertHealth's 2026-2029 Community Health Improvement Plan (CHIP), guiding investments, partnerships, and strategies in the years ahead.

INTRODUCTION

CalvertHealth is pleased to present its 2026 Community Health Needs Assessment, reflecting its ongoing commitment, as a not-for-profit, tax-exempt hospital, to understanding and responding to the health needs of Calvert County.

This report identifies the most pressing health challenges facing the community, with particular attention to populations experiencing the greatest burden, including those who are medically underserved, socioeconomically vulnerable, or navigating gaps in available services. Community voices, gathered through surveys, stakeholder engagement, and direct input, inform the findings throughout.

These findings will directly shape CalvertHealth's priorities, investments, and partnerships in the years ahead. The intent of this assessment extends beyond documenting need. It is designed to ensure that what is learned translates into meaningful, measurable action for the community. Specifically, this report addresses:



About CalvertHealth

CalvertHealth's story began in 1919 in a modest two-story frame building. As Calvert County has grown over the past century, so has the health system—expanding services, investing in advanced technology, enhancing facilities, and continually evolving to meet the healthcare needs of our community.

Today, CalvertHealth is a leading regional healthcare provider recognized for delivering innovative, high-quality care close to home. The health system includes CalvertHealth Medical Center in Prince Frederick, an employed physician network, the Center for Breast Care, weight management and nutrition services, and several joint ventures - including diagnostic imaging and urgent care centers throughout the region. As the largest private employer in Calvert County, CalvertHealth is supported by approximately 1,200 employees and guided by a volunteer Board of Directors whose members represent the community and provide strategic oversight of the organization.

Our medical staff includes approximately 300 providers representing more than 40 specialties. Through clinical partnerships with nationally recognized healthcare organizations, patients have access to specialized expertise without leaving Southern Maryland. These collaborations include partnerships with Sheppard Pratt to strengthen behavioral health services and with Duke Health to bring advanced cancer care, clinical trials, and leading-edge treatment options to our community.

As one of Maryland's few remaining independent community hospitals, CalvertHealth is committed to providing patient-centered care with an unwavering focus on quality, safety, and service. Every decision we make is guided by a simple promise: to deliver the best possible care to every person, every time.

That commitment has earned CalvertHealth national recognition for clinical excellence and patient safety, including a Five-Star Overall Hospital Quality Rating from the Centers for Medicare & Medicaid Services (CMS) and repeated "A" Hospital Safety Grades from The Leapfrog Group. Together with accreditations and recognitions from organizations such as The Joint Commission, the American Heart Association, and others, these achievements reflect the dedication of our physicians, nurses, employees, and volunteers to continuously improve the health and well-being of the communities we serve.

To learn more about CalvertHealth, visit **[CalvertHealthMedicine.org](https://www.CalvertHealthMedicine.org)**.

Acknowledgements

The Community Health Improvement Roundtable (CHIR) currently serves as Calvert's Local Health Improvement Coalition and was formed many years ago to strengthen the close partnership CalvertHealth has with the Calvert County Health Department and other community partners who are stakeholders in the health and wellness of Calvert County residents. The CHIR is led by a steering committee comprised of members from CalvertHealth, the Calvert County Health Department, Calvert County Parks and Recreation, and the Local Behavioral Health Authority. The goal of the CHIR is to improve health outcomes, reduce health disparities, and build a healthy community in Calvert County. The CHIR meets bimonthly and is tasked with performing the work identified through the CHNA. The CHIR also assists in the oversight of the subcommittees focused on the health priorities noted in the CHNA every 3 years.

Community Health Improvement Roundtable Partners

Steering Committee:

- CalvertHealth Medical Center
- Calvert County Health Department
- Calvert County Parks and Recreation
- Local Behavioral Health Authority

Members:

- Calvert County Office on Aging
- Calvert Alliance Against Substance Abuse (CAASA)
- Calvert County Sheriff's Office
- Calvert County Family Network
- Calvert County Library System
- Hospice of the Chesapeake
- Community Mediation Center
- Calvert County Department of Public Safety
- Calvert County Department of Transportation
- Calvert County Department of Community Resources
- Calvert County Public Schools
- Aetna Better Health of Maryland
- Legal Resource Center
- College of Southern Maryland
- NAACP, Calvert Chapter
- Calvert County Department of Social Services
- Maryland Department of Health, Center for Tobacco Control
- Calvert County Department of Planning and Zoning

Thank you for the work of our Subcommittees!

- Cancer and Tobacco Coalition
- Nutrition and Healthy Eating Subcommittee
- Diabetes Subcommittee
- Behavioral Health Access Team
- Health Ministry Team Network

The CalvertHealth Footprint

CalvertHealth's primary service area is Calvert County, Maryland, where it operates as the only hospital and serves a geographically isolated peninsula. The system delivers care across Calvert County through medical office locations in Prince Frederick, Dunkirk, Solomons, and Twin Beaches, as well as urgent care centers and a weight management program in Waldorf, Charles County. Beyond its immediate service area, CalvertHealth expands access to specialized services through a tricounty partnership for radiation oncology and home health care. Although the county is located near the Washington, D.C. region, its long and narrow geography contributes to a largely rural setting and creates transportation barriers. These access challenges are most pronounced for older adults, low-income residents, and individuals living in the southern portion of the county, where provider availability is more limited.

Consultants

CalvertHealth commissioned Berkeley Research Group (BRG) to conduct its 2026 Community Health Needs Assessment. BRG is a leading global consulting firm specializing in independent expert analysis, advanced data analytics, and strategic advisory services. BRG's team applied its expertise in data synthesis, population health strategy, and community-based research to deliver a rigorous, comprehensive assessment of Calvert County's health landscape. To learn more about BRG, please visit thinkbrg.com.

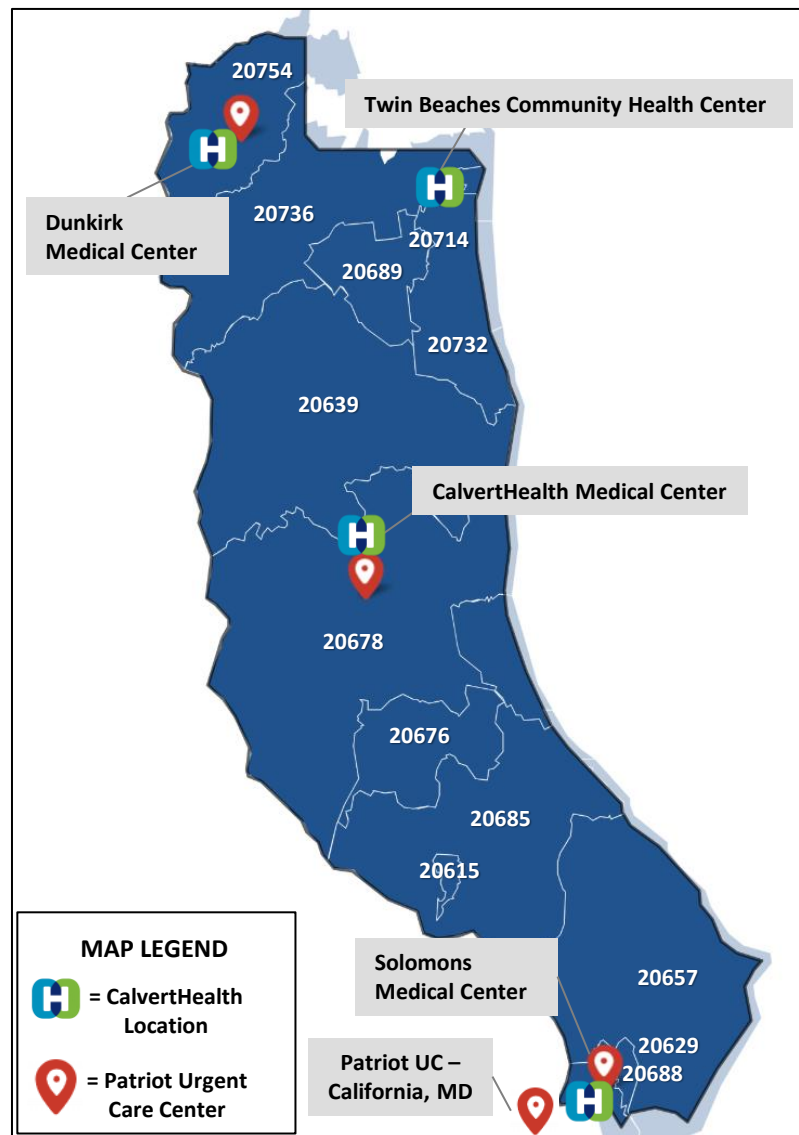
Report authors from BRG include:

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Emma Lerch — Care Innovation and Population Health, Associate

FIGURE 2. CALVERTHEALTH LOCATIONS AND PARTNERING URGENT CARE LOCATIONS



COMMUNITY PROFILE

A community's health is deeply shaped by who makes it up. Age, race, ethnicity, and socioeconomic status all influence the health needs residents face, and understanding these differences is essential to designing health improvement efforts that truly meet people where they are.

Population

According to U.S. Census Bureau 2025 population estimates, Calvert County is home to approximately 94,400 residents distributed across 14 ZIP codes. Population density is low relative to the Maryland state average, consistent with the county's rural and exurban character. Residential concentration is greatest in the central and northern portions of the county, including Prince Frederick, Huntingtown, and the Twin Beaches communities. Southern Calvert County, including Lusby and Solomons, is more sparsely populated and faces distinct access challenges that emerged consistently throughout community engagement.

FIGURE 3. CALVERT COUNTY POPULATION DISTRIBUTION BY ZIP CODE

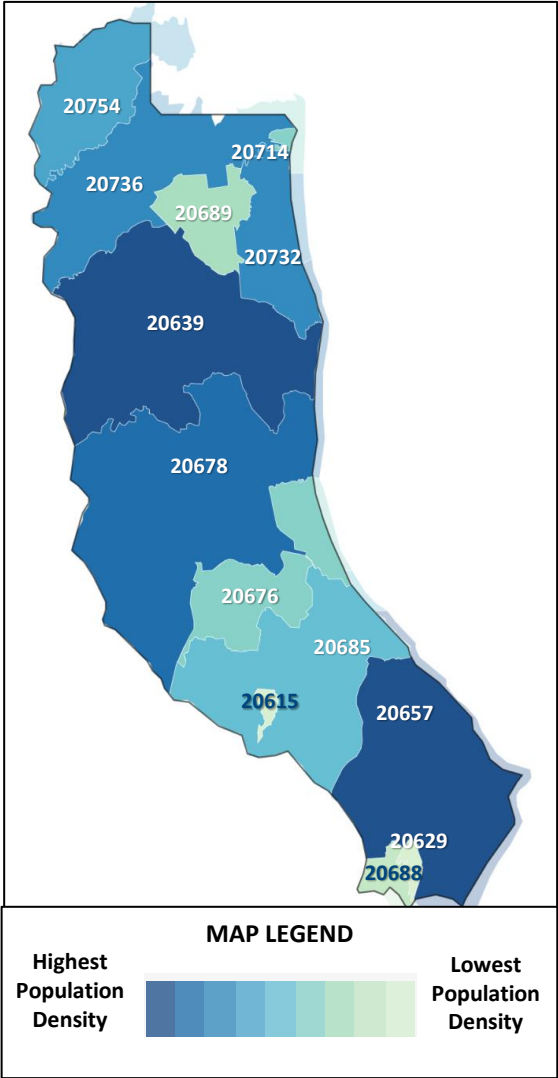
Population Health

County Health Rankings & Roadmaps data indicate that Calvert County residents experience favorable health and well-being outcomes overall. The county reports lower rates of premature death, poor physical health days, poor mental health days, and fair or poor health than both state and national benchmarks. Additionally, 7% of infants are born at a low birth weight, suggesting generally positive maternal and infant health outcomes²¹.

TABLE 1. CALVERT COUNTY POPULATION HEALTH INDICATORS

Indicator	Calvert County	Maryland	United States
Premature death (years lost per 100,000)	7,000	7,700	8,100
Poor physical health days (average days in past 30)	3.8	4.0	4.5
Poor mental health days (average days in past 30)	4.9	5.4	5.7
Poor or fair health (% of adults)	15%	17%	20%
Low birth weight (% of live births under 2,500 g)	7%	9%	8%

²¹ County Health Rankings & Roadmaps. Calvert County, Maryland Health Data, 2025.



^{16, 22, 23} Metopio | Data Source: U.S. Census Bureau: American Community Survey (ACS) (ACS: Table B01001 (sex and age), B03002 (Race/Ethnicity); Decennial Census: Table P012)

Age

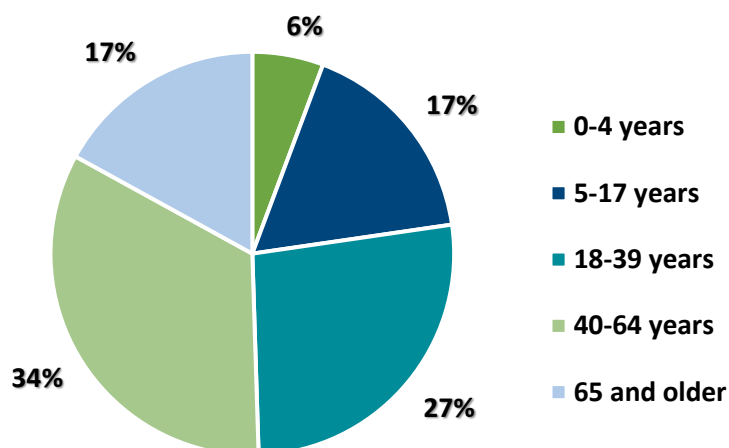
2024 U.S. Census Bureau American Community Survey and Decennial Census^{22,23} data show that Calvert County's population is older than both Maryland and national averages. This demographic profile reflects a combination of long-established multigenerational families and an influx of retirees. The largest share of residents falls within the 40-64 age group (33.5%), followed by adults ages 18-39 (26.8%), residents ages 5-17 (17.0%), adults 65 and older (17.0%), and children ages 0-4 (5.7%).

Race and Ethnicity

According to the U.S. Census Bureau's 2024 American Community Survey²³, Calvert County is less racially and ethnically diverse than Maryland as a whole. Most residents (73.7%) identify as White, followed by African American or Black (12.5%), residents identifying as two or more races (5.8%), Hispanic or Latino (5.6%), and Asian (2.4%). Native American and Pacific Islander or Native Hawaiian populations each represent less than 1% of the county population²³.

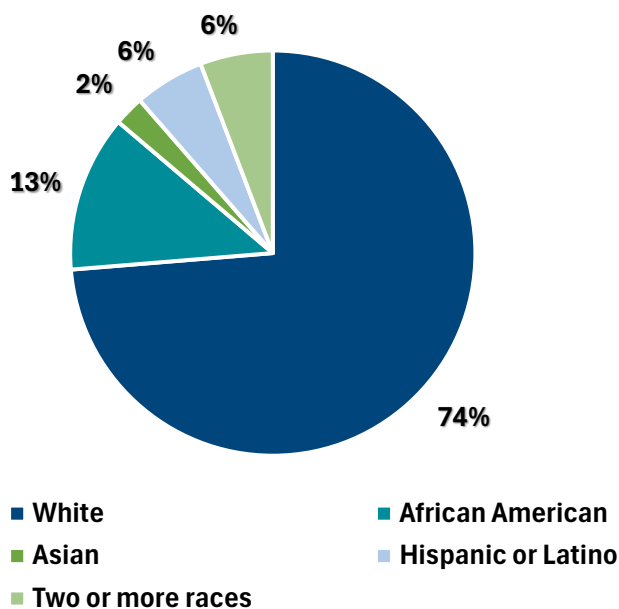
African American and Black residents represent the county's second-largest racial group. Health disparities experienced by this population are documented in detail within the Chronic Disease and Access to Care priority theme sections. The Hispanic and Latino community, while smaller in share, has grown in recent years. Stakeholders identified trust and language barriers as significant obstacles to healthcare engagement for this population. These insights informed the strategic priorities of this assessment.

FIGURE 4. PERCENT POPULATION BY AGE: CALVERT COUNTY, 2024



^{22, 23} Data Source: U.S. Census Bureau: American Community Survey (ACS) (ACS: Table B01001 (sex and age), B03002 (Race/Ethnicity); Decennial Census: Table P012)

FIGURE 5. POPULATION BY RACE/ETHNICITY: CALVERT COUNTY, 2024



^{22, 23} Data Source: U.S. Census Bureau: American Community Survey (ACS) (ACS: Table B01001 (sex and age), B03002 (Race/Ethnicity); Decennial Census: Table P012)

SOCIAL DRIVERS OF HEALTH

Health outcomes reflect more than access to medical care alone. Economic opportunity, educational attainment, healthcare access, neighborhood conditions, and social and community support all play important roles in shaping health and well-being. Across Calvert County, barriers related to affordability, transportation, walkability, access to healthcare and nutritious food continue to affect health outcomes, with disproportionate impacts on older adults, lower income households, residents of southern Calvert County, and populations experiencing racial, ethnic, and socioeconomic inequities.

FIGURE 6. HEALTHY PEOPLE 2030 SOCIAL DETERMINANTS OF HEALTH DOMAINS

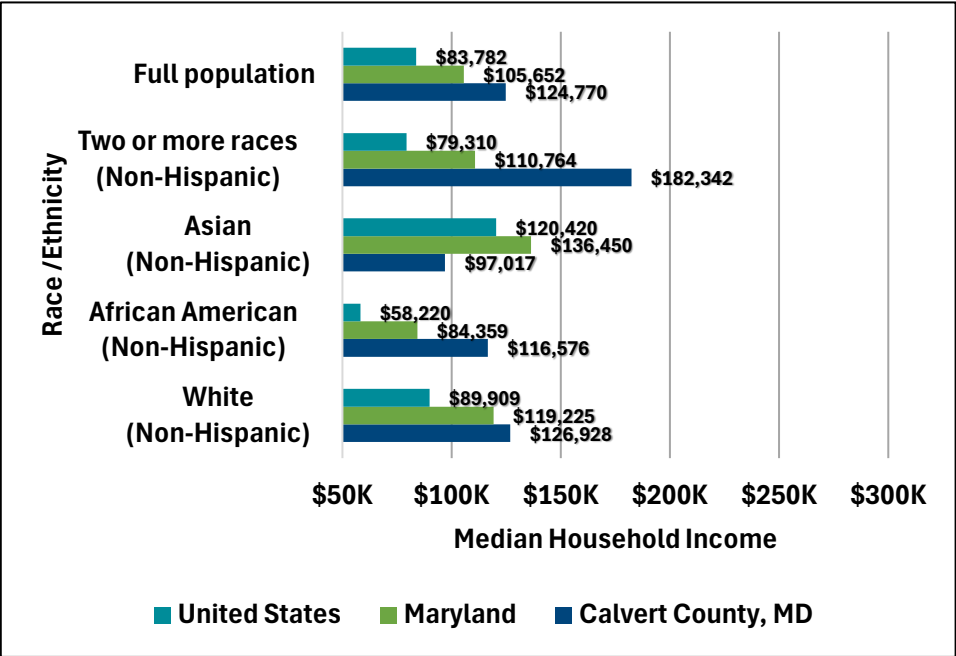


¹⁸ Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved July 1, 2026, from <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>

Economic Stability

Calvert County's median household income of \$121,526 substantially exceeds both the Maryland and national medians, reflecting the county's proximity to the Washington, D.C. metropolitan labor market²³. However, countywide averages do not fully reflect the variation that exists across population groups. African American or Black residents earn approximately \$8,000 below the county median, and Asian residents report the lowest median at \$94,495, a pattern that runs counter to state and national trends²³. These income differences can influence healthcare access, housing stability, and the ability to manage chronic conditions.

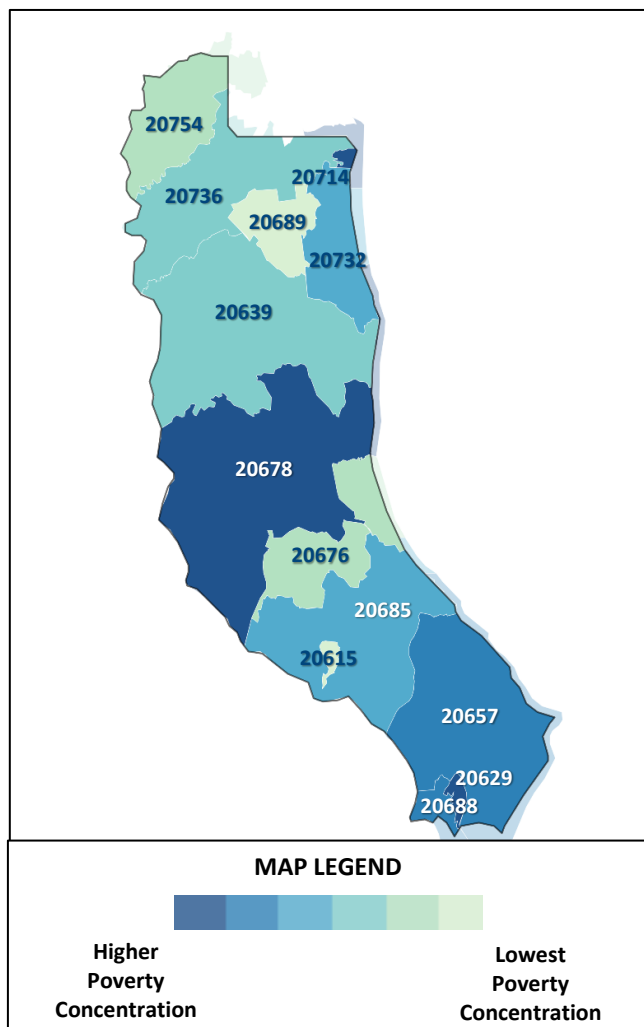
FIGURE 7. MEDIAN HOUSEHOLD INCOME: COUNTY, STATE, AND NATIONAL, 2024



²³ Data Source: U.S. Census Bureau: American Community Survey (ACS) (Table B19013), Median Household Income: Income in the past 12 months

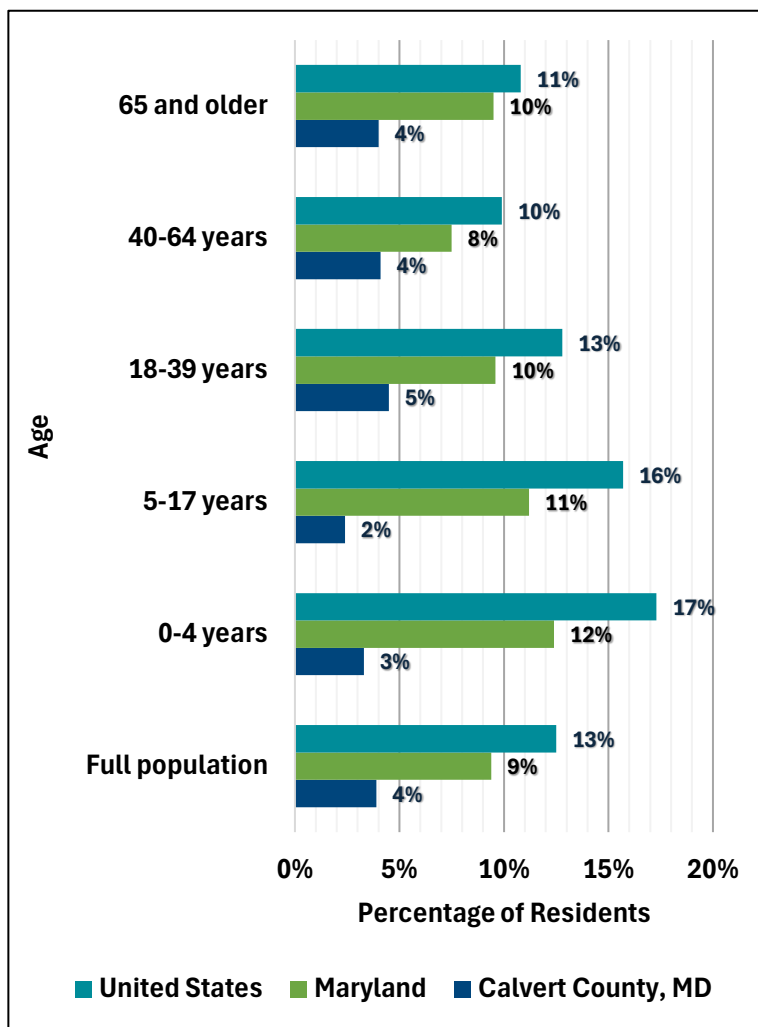
As illustrated in Figure 9, Calvert County's overall poverty rate of 4.8% is substantially below both Maryland and national benchmarks, a pattern that holds consistently across every age group²³. Yet within that favorable picture, older adults stand out. Residents 65 and older carry the highest poverty rate in the county at 6.3%, and unlike younger age groups, they are more likely to be living on fixed incomes, facing rising out-of-pocket healthcare costs, and navigating services independently²³. In a rural, car-dependent county where transportation and access barriers are already pronounced, this economic vulnerability carries health implications that aggregate poverty figures alone do not capture.

FIGURE 8. HOUSEHOLDS BELOW THE ALICE THRESHOLD BY ZIP CODE, 2024



²⁰ Data Source: United for Alice: United Way ALICE Data

FIGURE 9. POVERTY RATE BY AGE: COUNTY, STATE, AND NATIONAL, 2020-2024

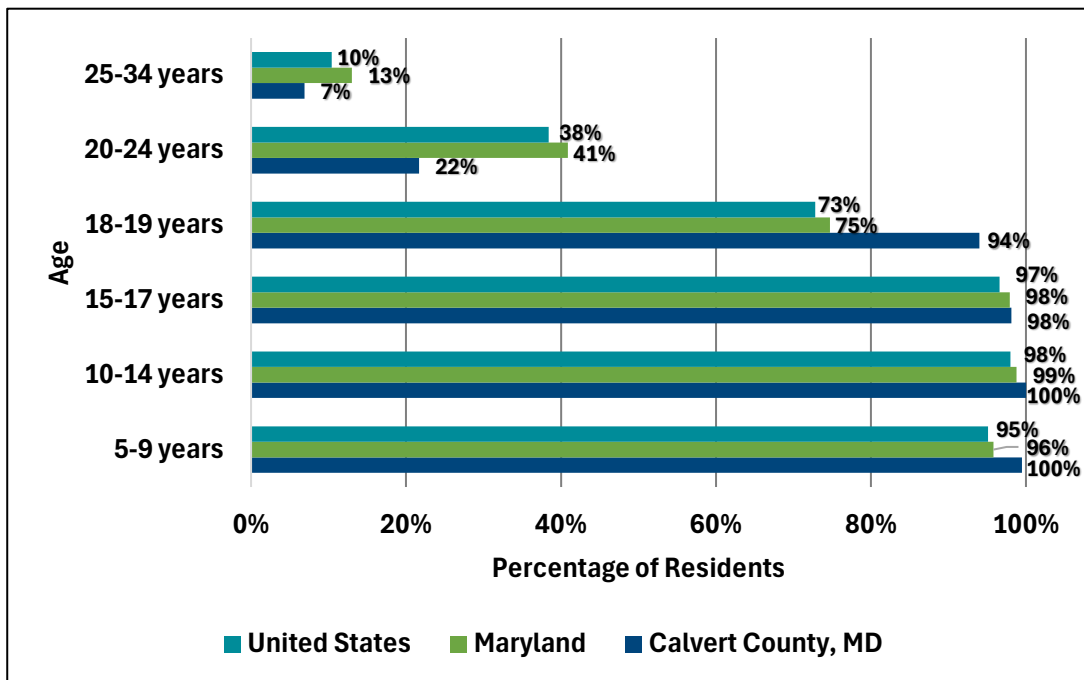


²³ Data Source: U.S. Census Bureau: American Community Survey (ACS) (Table B17001), Poverty rate: Percent of residents in families that are in poverty (below the Federal Poverty Level).

Education Access and Quality

Calvert County exceeds state and national benchmarks for K-12 enrollment, reflecting strong educational participation among school-aged children²³. In contrast, enrollment in education beyond high school is substantially lower. Only 21.7% of residents ages 20-24 and 6.9% of residents ages 25-34 are enrolled in school, both below Maryland and national averages²³. This trend may reflect workforce participation, commuting patterns, or limited access to local higher education opportunities. Findings may also reflect young adults' preference to choose local trades over a college degree for economic reasons.

FIGURE 10. SCHOOL ENROLLMENT BY AGE: COUNTY, STATE, AND NATIONAL, 2024



²³ Data source: U.S. Census Bureau: American Community Survey (ACS) (Table S1401), School enrollment: Percentage of residents of the specified age group enrolled in school. Includes all schools from pre-K to college and graduate school..

Health Care Access and Quality

County Health Rankings & Roadmaps data indicate that Calvert County experiences favorable healthcare quality outcomes, including lower rates of uninsurance and preventable hospital stays and slightly higher preventive screening and vaccination rates than Maryland²¹. Despite these strengths, higher population-to-provider ratios for primary care, mental health, and dental services suggest more limited access to healthcare providers compared with statewide benchmarks.

TABLE 2. CALVERT COUNTY HEALTH CARE ACCESS AND PREVENTIVE CARE INDICATORS, 2025

Indicator	Calvert County	Maryland
Uninsured	4%	7%
Preventable Hospital Stays	2,398	2,655
Mammography Screening	48%	46%
Flu Vaccination	49%	48%
Primary Care Physician Ratio	2,250:1	1,160:1
Mental Health Provider Ratio	370:1	250:1
Dentist Ratio	1,860:1	1,210:1

²¹ County Health Rankings & Roadmaps. Calvert County, Maryland Health Data, 2025.

Nighborhood and Built Environment FIGURE 11. CALVERT COUNTY RECREATIONAL PARKS, COMMUNITY CENTERS,

Calvert County's low Walkability Index score of 5.9, compared with 10.2 statewide and 9.5 nationally, reflects the rural nature of the community with limited pedestrian infrastructure, lower street connectivity, and greater distances between residential areas and key destinations¹⁰. Just 0.9% of workers commute on foot, compared to 2.3% in Maryland and 2.4% nationally.

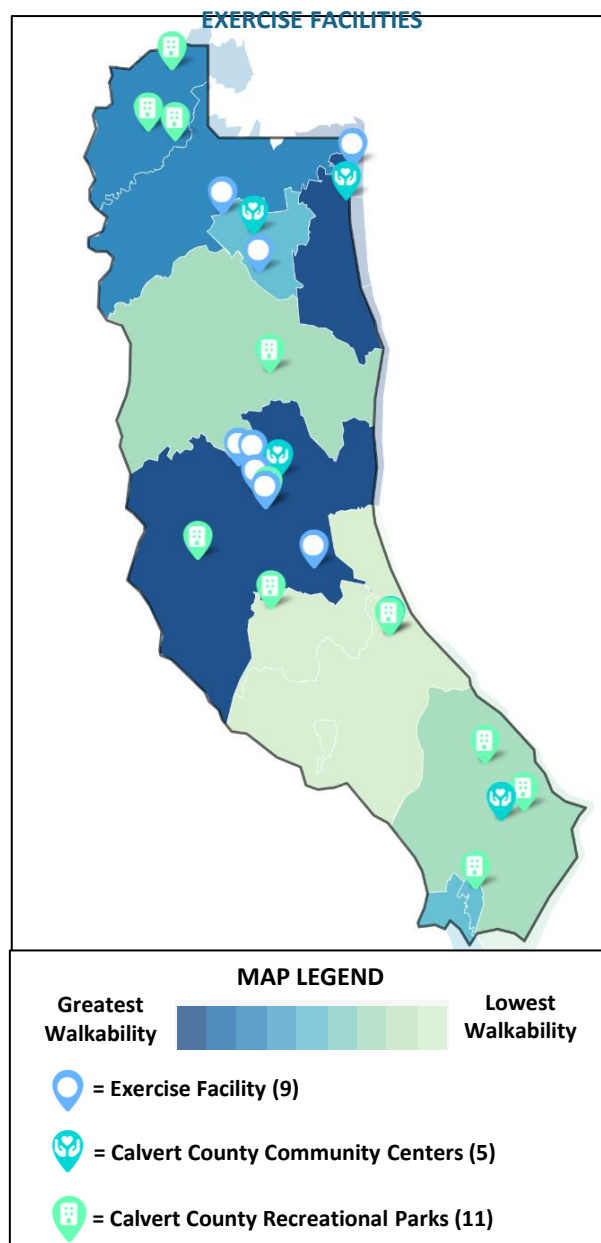
Reliance on personal vehicles is correspondingly high, with 111.2 vehicles per 100 adults, well above state and national levels²¹. More than half of working residents (52.3%) travel outside the county for employment, further reinforcing this dependence.

While Calvert County's parks, open spaces, and natural environment provide residents with a variety of opportunities for outdoor recreation and physical activity, access is often dependent on reliable transportation. The county's low walkability, limited transit options, and dispersed development pattern can make it difficult for residents to routinely reach these destinations, particularly during periods of inclement weather when outdoor activity is less feasible. Dependence on personal vehicles reduces opportunities for active transportation, may contribute to air pollution, and can create barriers to accessing recreational amenities, health care, healthy food, and other essential services. These challenges may be especially significant for older adults, lower-income residents, and individuals without reliable transportation, particularly given the county's high prevalence of chronic disease.

TABLE 3. CALVERT COUNTY PHYSICAL ENVIRONMENT INDICATORS, 2025

Indicator	Calvert County
Driving alone to work	75%
Long commute	61%
Air pollution: particulate matter	6.2%
Access to exercise opportunities	73%

²¹ County Health Rankings & Roadmaps. Calvert County, Maryland Health Data, 2025.



¹⁰ Data source: Centers for Disease Control and Prevention (CDC): Agency for Toxic Substances and Disease Registry - Environmental Justice Index

"If they don't have personal transportation and they have to, either for themselves or for their child, they have to go up to Baltimore, DC, or even Annapolis, that can be enough of a barrier that they just don't get care."

— KII Participant

Social and Community Context

Calvert County's social and community context reflects a population with distinct vulnerabilities shaped by age, geography, and household composition. Veterans make up 12% of the population, and 12.3% of residents live with a disability²³. Nearly one in five seniors (17.6%) lives alone, increasing the risk of social isolation and limiting access to care and community services, particularly in a county where transportation options are limited. Single parent households account for 4.9% of all households²³.

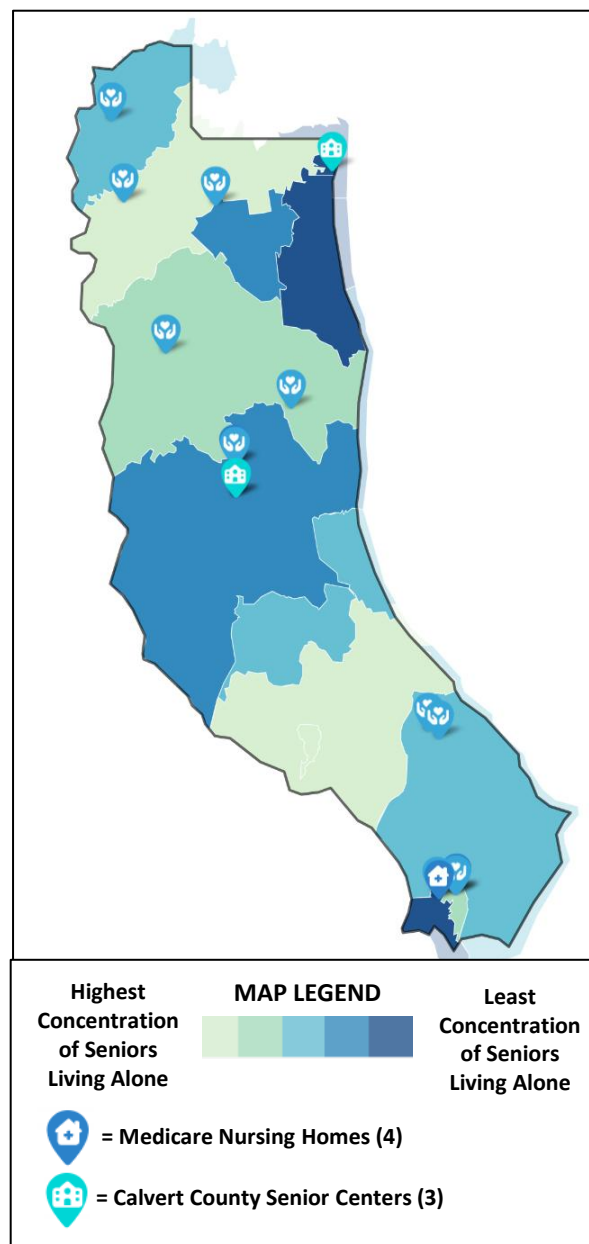
Housing affordability for older adults is a growing concern. Waitlists for assisted living and nursing home placement are long, and many seniors are forced to choose between paying for housing and affording their medications. The county's limited supply of in-county nursing facilities and senior services, concentrated primarily around the Calvert County Senior Center, leaves residents in outlying areas with fewer nearby options for supportive care and community connection.

TABLE 4. CALVERT COUNTY SOCIAL AND COMMUNITY CONTEXT INDICATORS, 2024

Indicator	Calvert County
Veterans	12%
Population with a disability	12.3%
Seniors living alone	17.6%
Single parent households	4.9%

^{16, 23} Metopio | Data Source: U.S. Census Bureau: American Community Survey (ACS)

FIGURE 12. CALVERT COUNTY SENIORS LIVING ALONE, 2020-2024



²³ Data source: U.S. Census Bureau: American Community Survey (ACS) (Table B09020)

"Affordable housing for our older adults is one of the biggest challenges we see. The waitlists for assisted living and nursing-home placement are long, and many seniors are choosing between their housing and their medications."

— KII Participant, Calvert County Office on Aging

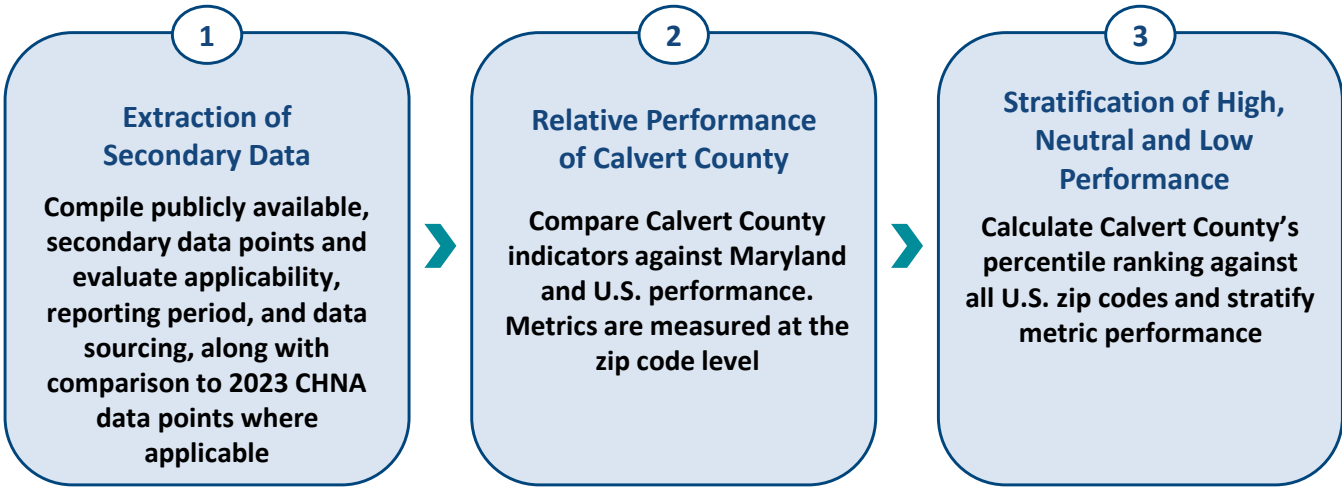
PRIMARY & SECONDARY DATA PROCESS AND KEY FINDINGS

This section provides a high-level overview of the data collection and analytical approach used to inform the 2026 CHNA. It summarizes the primary and secondary data sources, the methods used to synthesize findings, and the process through which significant health needs were identified and prioritized.

Secondary Data Sources & Analysis

The secondary data analysis included 927 indicators. Calvert County results were benchmarked against state and national values, percentile-ranked relative to all U.S. ZIP codes, and compared with 2023 CHNA findings, when available, to evaluate trends over time. Figure 13 summarizes the scoring methodology used to evaluate indicator performance, combining benchmark comparisons, national percentile rankings, and historical trend analysis to identify areas of strength, need, and emerging concern.

FIGURE 13. SECONDARY DATA SCORING METHODOLOGY



² Source: Secondary data analysis and scoring from BRG.

TABLE 5. SECONDARY DATA INDICATOR SCORING RESULTS BY THEME

Theme	High-Performing Metrics	Neutral Performing Metrics	Opportunity for Improvement Metrics
Chronic Disease	1	-	11
Access to Care	19	-	23
Mental Health & Substance Use	5	-	11
Cancer	-	-	16
Healthy Living & Preventive Measures	-	-	3
Basic Needs & Economic Stability	-	-	22
Environmental & Community Conditions	6	1	46

Topic scores derived from the 927-indicator secondary data set. Note: 'Neutral Performing' metrics are those that fall within the mid-range of benchmarks and do not present a concentrated area of strength or concern.

Primary Data Collection & Analysis

Primary data collection included three complementary components: 13 key informant interviews involving 23 stakeholders representing diverse community perspectives, two focus groups with nine community members reflecting a range of lived experiences, and a countywide community survey that generated 1,064 responses. Together, these activities provided critical context to the quantitative analysis and ensured that the assessment reflected the experiences, concerns, and priorities of community members and stakeholders.

Key Informant Interviews

Key informant interviews were conducted in April 2026 with stakeholders representing a broad cross section of the community, including healthcare delivery, public health, behavioral health, education, government, law enforcement, parks and recreation, faith communities, and community-based organizations. To protect confidentiality, participants are not individually identified in this report. Selected quotations are incorporated throughout the report to complement quantitative findings with stakeholder perspectives and lived experiences.

Focus Groups

To ensure a range of community perspectives were represented, participants were drawn from diverse professional backgrounds and lived experiences. Among the participants were individuals with experience in healthcare, education, public service, faith communities, military service, chronic health conditions, and housing instability, including a retired local physician, a retired inpatient psychiatric educator, a probation agent from the Department of Juvenile Services, a health ministry leader, a veteran, an individual living with diabetes, an individual living with Lyme disease, and a young adult experiencing homelessness.

TABLE 6. KEY INFORMANT ORGANIZATIONS⁵

Organization	Participants
The Board of County Commissioners	1
Calvert County Health Department	5
Calvert County Office on Aging	2
Calvert County Parks and Recreation	1
Calvert County Public Schools	4
CalvertHealth Medical Center	2
CalvertHealth Medical Center Physician	1
Local Behavioral Health Authority	2
CalvertHealth Medical Center	2
National Association for the Advancement of Colored People (NAACP, local chapter)	1
United Methodist Church, Huntingtown	1
Total Participants	23

Key Informant & Focus Group Theme Mentions

Key informant interview and focus group transcripts were analyzed to identify recurring themes. Figure 14 displays the themes discussed by participants, the frequency with which they were mentioned, and whether they were generally described as strengths, challenges, or a combination of both. Findings presented throughout this report reflect the themes that emerged most consistently across stakeholder and community discussions.

FIGURE 14. QUALITATIVE THEME MENTIONS IN KEY INFORMANT INTERVIEWS AND FOCUS GROUPS⁵

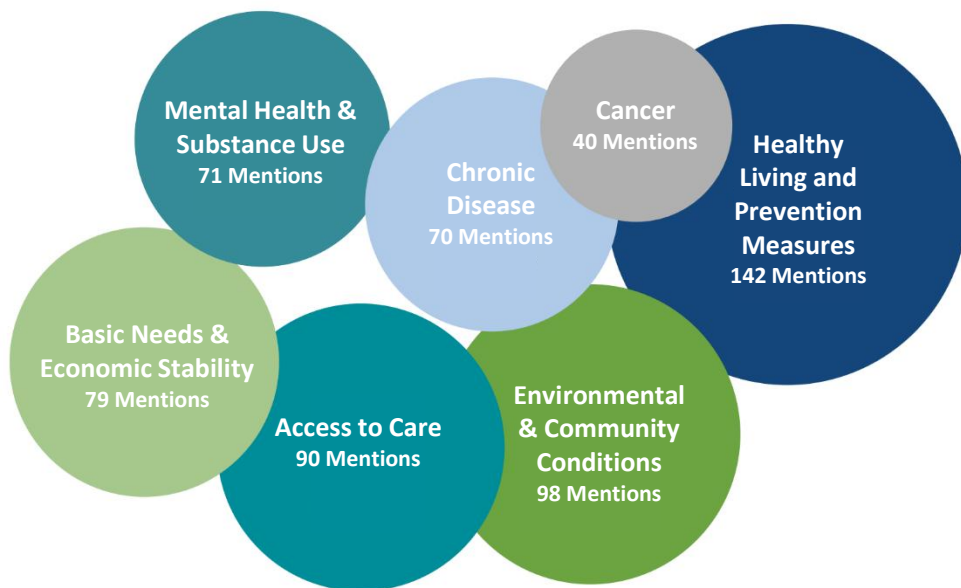


FIGURE 15. HOW FOCUS GROUP PARTICIPANTS DESCRIBED CALVERT COUNTY IN ONE WORD⁵



Community Survey

To complement secondary data and qualitative findings, CalvertHealth conducted a community health survey across Calvert County in April 2026. The 58-question survey, available in English and Spanish, assessed residents' health needs, health status, access to care, and social drivers of health. Responses were collected through online links, paper surveys, and community outreach efforts, including events, faith-based programs, and schools. The survey received 1,064 responses, including 962 valid responses from Calvert County residents. Community participation increased substantially compared to the 2023 survey, with response volume growing by 30.7%, reflecting broader community engagement. Responses from outside the county were excluded from county level analysis to ensure findings accurately represent Calvert County residents.

Demographic Profile of Survey Respondents

The demographic composition of survey respondents closely mirrors that of Calvert County residents. This strong alignment shows the credibility and representativeness of the survey findings. The figures below present the demographic characteristics of the 962 valid respondents against secondary data points from the American Community Survey.

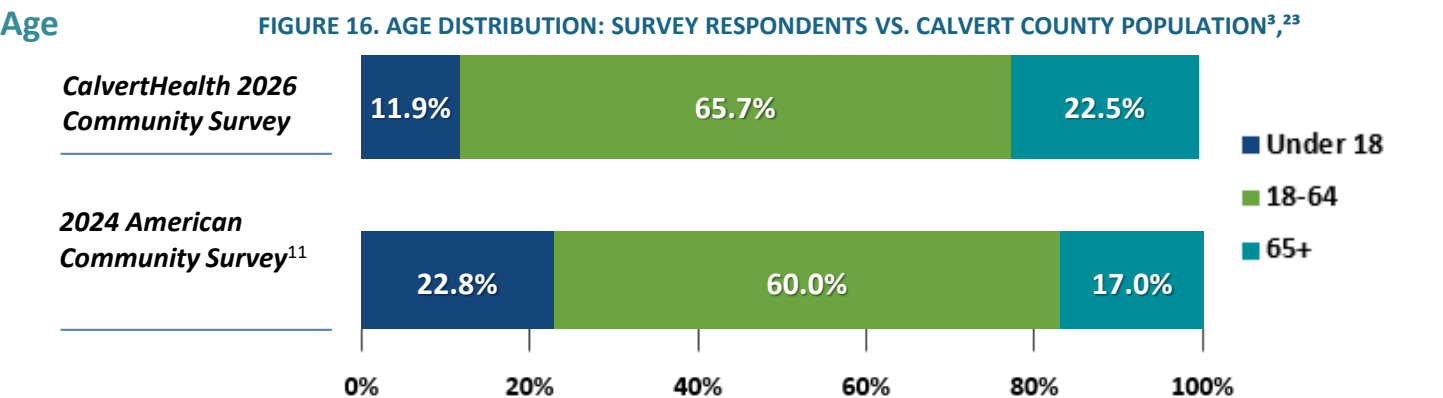


Figure 16 compares the age distribution of community survey respondents against secondary data from the American Community Survey to assess representativeness.

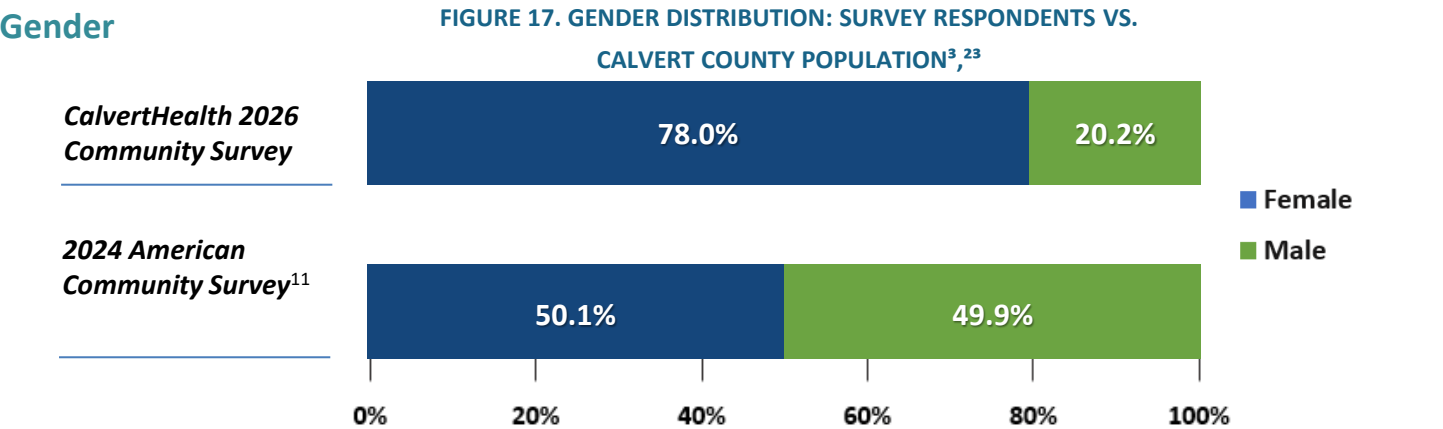


Figure 17 compares the gender distribution of community survey respondents against secondary data from the American Community Survey to assess representativeness.

Race and Ethnicity

FIGURE 18. RACE/ETHNICITY DISTRIBUTION: SURVEY RESPONDENTS VS. CALVERT COUNTY POPULATION^{3, 23}

**CalvertHealth 2026
Community Survey**

**2024 American
Community Survey¹¹**

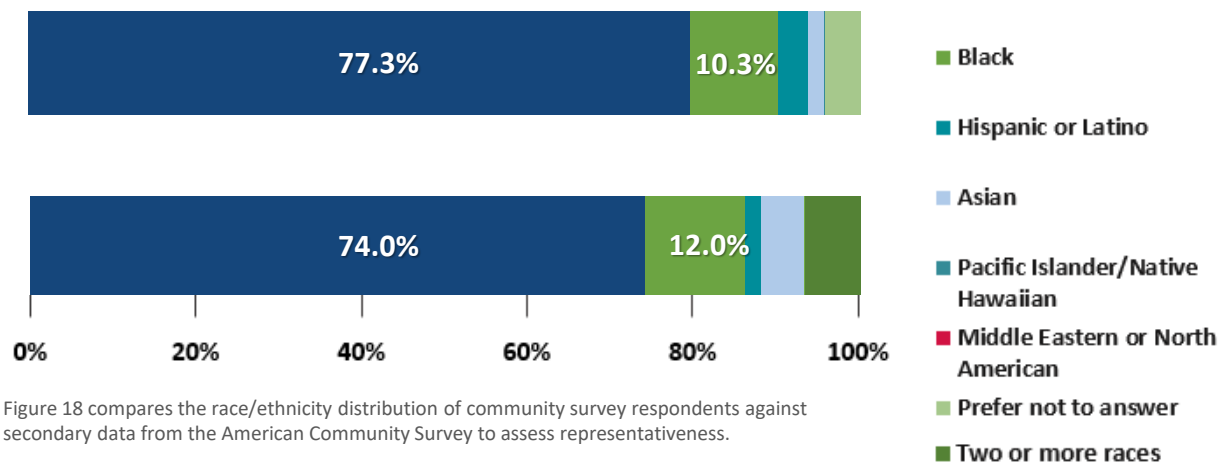
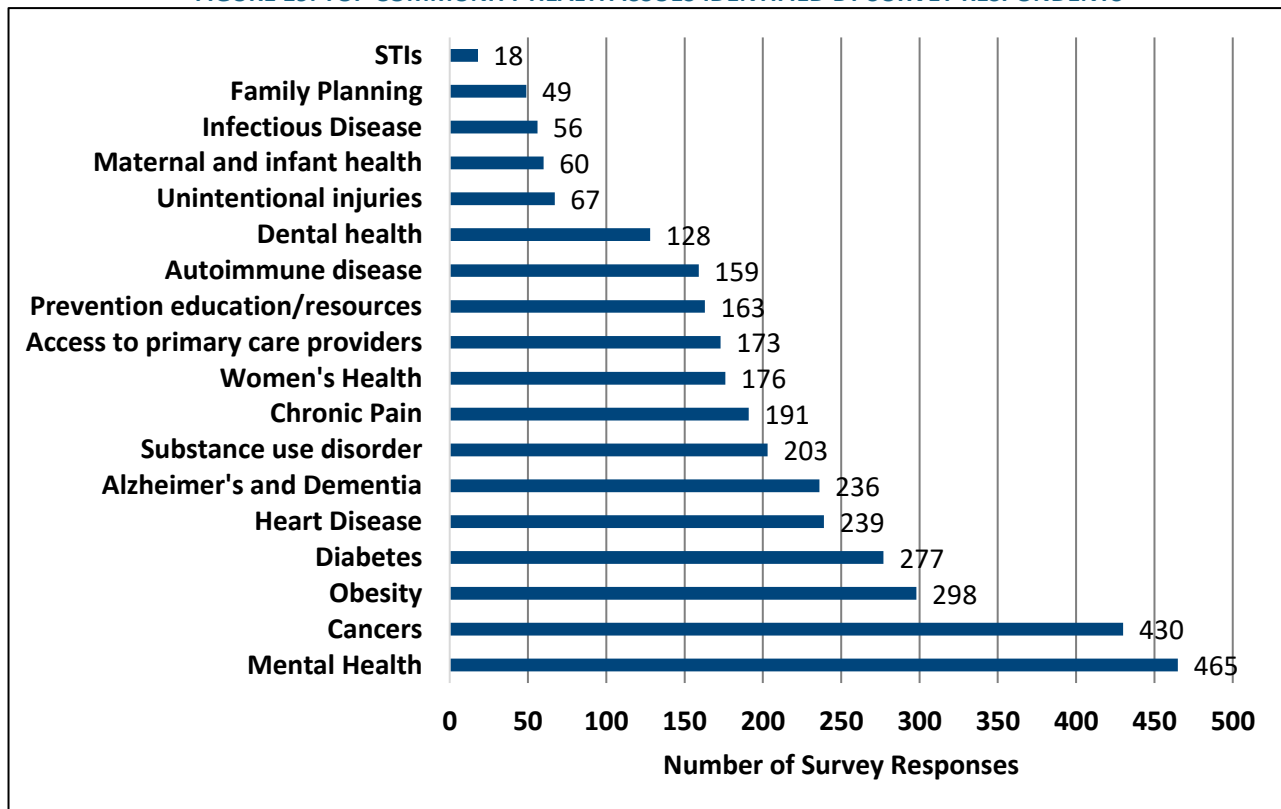


Figure 18 compares the race/ethnicity distribution of community survey respondents against secondary data from the American Community Survey to assess representativeness.

FIGURE 19. TOP COMMUNITY HEALTH ISSUES IDENTIFIED BY SURVEY RESPONDENTS



³ Data Source: 2026 CalvertHealth Community Health Survey, N = 962 valid responses, Respondents' Top Community Health Issues: Measures which health issues respondents identified as the most important in their community. Respondents could select up to five of the eighteen options total. Values represent the number of respondents identifying each issue as a top concern.

Data Considerations

Secondary Data: The assessment draws on a comprehensive set of 927 indicators spanning more than 24 topic areas; however, the depth and availability of data vary across subject areas. Some topics are supported by a robust set of indicators, while others have more limited data available. The social determinant of health indicator analysis is similarly constrained by data availability. For certain indicators, subpopulation data are absent entirely, and for others, values are available only for a select number of racial and ethnic groups, limiting the completeness of the disparity analysis. Additionally, race and ethnicity stratified cancer incidence and mortality data at the county level were not available for this reporting period.

Primary Data: The scope of key informant interview findings is inherently shaped by the selection of participants and the sectors they represent. The community survey, while yielding 962 responses with strong demographic alignment to Calvert County's population characteristics, was administered as a convenience sample, meaning results may be subject to selection bias and should be interpreted as community-informed insight rather than a statistically generalized population estimate. That said, the close alignment between respondent demographics and county population characteristics meaningfully strengthens the credibility of the survey findings.

In all cases, efforts were made to maximize the breadth and representativeness of both secondary and primary data sources to produce the most complete and accurate picture of community health need possible.

DEVELOPMENT & PRIORITIZATION OF THEMES

Identifying and Organizing Significant Health Needs

Findings from secondary data analysis, key informant interviews, and focus groups were synthesized to identify the health issues most affecting Calvert County residents. Quantitative findings were evaluated against state and national benchmarks, peer-community percentile rankings, and select historical results from the 2023 CHNA, while qualitative findings provided additional insight into community experiences, perspectives, and priorities.

Health need themes were identified when consistent evidence emerged across one or more data sources. Themes were informed by patterns across related secondary data indicators that highlighted areas of need or opportunity for improvement, as well as recurring concerns raised by stakeholders and community members through interviews and focus groups. This approach ensured that the assessment reflected both measurable health outcomes and the lived experiences of residents.

This process resulted in the identification of eight significant health need themes. The supporting primary and secondary data findings for each theme were presented to CalvertHealth and community stakeholders to inform the prioritization process. Through stakeholder discussion and deliberation, the Mental and Behavioral Health and Substance Use and Addiction themes were determined to be closely related and were combined into a single priority area. As a result, seven significant health needs were selected to guide the 2026 Community Health Improvement Plan. For transparency, Figure 20 presents all eight health need themes originally advanced for prioritization, including the two themes that were subsequently consolidated.

FIGURE 20. ALL COMMUNITY HEALTH THEMES CONSIDERED PRIOR TO PRIORITIZATION SESSION VOTING^{2, 4}

1	Access to Care
2	Behavioral and Mental Health
3	Basic Needs and Economic Stability
4	Cancer
5	Chronic Disease
6	Substance Use and Addiction
7	Environmental and Community Conditions
8	Healthy Living and Preventive Measures

Participants

On June 8, 2026, members from various departments within CalvertHealth, the Calvert County Health Department, the Community Health Improvement Roundtable (CHIR), and representative members of the community came together in a facilitated session led by consultants from BRG. Prioritization participants included:

- Sarah Bailey, Child and Adolescent Coordinator, Local Behavioral Health Authority
- Jeremy Bradford, Chief Executive Officer, CalvertHealth Medical Center
- Laural Brinkley, CNO/VP of Clinical Services, CalvertHealth Medical Center
- Meka Blizzard, Program Supervisor/Manager, Outreach and Education, Calvert County Health Department
- Rebecca Burgess, Manager, Public Relations and Marketing, CalvertHealth Medical Center
- Laurel Cahill, Epidemiologist, Calvert County Health Department
- Ben Cox, Chief Information Officer, CalvertHealth Medical Center
- Jeana Davis, Project Manager, Strategy and Transformation, CalvertHealth Medical Center
- Denise Dickerson, Director of Behavioral Health, Calvert County Health Department
- Erin Farley, Manager, Community Wellness, CalvertHealth Medical Center
- Noelle Flaherty, Case Management, CalvertHealth Medical Center
- Dr. Michelle Folsom-Elder, Medical Director, Primary Care and Population Health, CalvertHealth Medical Center
- Haley Germann, Office Coordinator, Community Wellness, CalvertHealth Medical Center
- Larisa Goganzer, Senior Vice President of Operations, CalvertHealth Medical Center
- Dr. Kara Harrer, Associate Vice President, Ancillary Services, CalvertHealth Medical Center
- Carolyn Heithaus, Chief Finance Officer, CalvertHealth Medical Center
- Mackenzie Orange, Community Programs and Data Coordinator, CalvertHealth Medical Center
- Christian Sorochty, Vice President, Human Resources, CalvertHealth Medical Center
- Kasia Sweeney, Vice President, Strategy and Business Development, CalvertHealth Medical Center
- Dr. Nimfa Teneza-Mora, Health Officer, Calvert County Health Department
- Heather Wright, Director, Cardiopulmonary Services, CalvertHealth Medical Center

Process

Prior to the prioritization session, stakeholders were presented with a comprehensive summary of findings from the secondary data analysis, key informant interviews, focus groups, and community survey. Using these findings as a foundation, participants engaged in a 60-minute facilitated discussion designed to incorporate diverse perspectives, contextualize the data, and ensure that prioritization decisions reflected both quantitative evidence and community experience. Discussion was guided by the following questions:

- Which of these themes has the greatest impact on the Calvert County community?
- Which populations are most impacted?
- Where are the greatest disparities?
- Where is the greatest opportunity to improve community health outcomes?
- Which themes show the strongest combination of need and readiness to act?

Following the discussion, stakeholders participated in a structured prioritization process to rank the eight significant health need themes. Participants independently ranked each theme from highest to lowest priority, with higher rankings indicating greater perceived importance to the health and well-being of the community. Responses were collected in real time through a digital polling platform, and aggregated results were immediately shared with the group. Stakeholders then reviewed and discussed the results to confirm a shared understanding of the findings and build consensus around the final prioritization of community health needs.

Prioritized Themes

Following the voting and discussion, stakeholders reached consensus to combine Behavioral and Mental Health with Substance Use and Addiction into a single, integrated priority theme reflecting overlapping populations, co-occurring disorder considerations, and integrated service-delivery needs. The following four health themes, in Figure 21 below, were identified as priorities to address during the 2026–2029 cycle:

FIGURE 21. PRIORITIZED HEALTH THEMES⁴



Non-Prioritized Themes

Although the following themes below, in Figure 22, were originally identified as themes through the assessment process, stakeholders determined that these areas are best addressed through community partnerships and cross-cutting strategies embedded within the four selected priority themes rather than as standalone priorities for direct CalvertHealth action during the 2026–2029 cycle.

FIGURE 22. NON-PRIORITIZED HEALTH THEMES⁴



PRIORITIZED HEALTH THEME 1: CHRONIC DISEASE

Chronic diseases, including heart disease, stroke, diabetes, and obesity, represent persistent drivers of poor health outcomes, premature death, and healthcare expenditure. Prevention, early detection, and management of these conditions are central to improving population health and reducing disparities. In Calvert County, elevated mortality rates coexist with relatively moderate prevalence, pointing to meaningful gaps in long-term disease management and care coordination that the 2026-2029 priorities are designed to address.

Primary Data

Community engagement reinforced the significance of chronic disease, and diabetes in particular, as a leading health concern in Calvert County. Residents living with diabetes participated directly in focus group discussions, and stakeholders across key informant interviews consistently named chronic disease management as one of the community's most pressing challenges. Chronic disease received 70 mentions across qualitative transcripts, reflecting broad and consistent recognition of its impact. Stakeholders identified four primary constraints on effective chronic disease management: (1) growing care complexity among the aging population; (2) rising medication costs; (3) transportation barriers to follow-up appointments, and (4) fragmented care coordination across providers and settings. Early intervention and the cultivation of healthy habits among youth were also repeatedly raised as essential long-term strategies for reducing future chronic disease burden in the county.

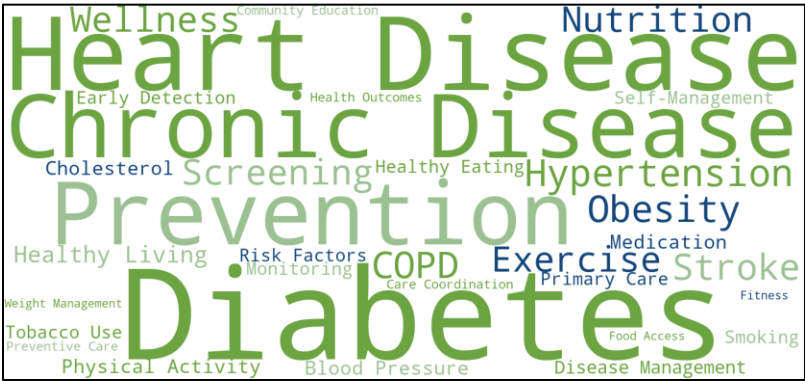
“Focus on youth and developing healthy habits early, including good diet, exercise, and fulfilling hobbies. Any ways to reduce families’ stress financially, such as providing cheaper healthy food options, would go a long way to reduce stress and improve the community’s health.”

— KII Participant

“Getting people physically active together—walking groups, community events—would improve both physical and mental health.”

— Focus Group Participant

FIGURE 23. KEY WORDS MENTIONED BY FOCUS GROUP PARTICIPANTS: CHRONIC DISEASE⁵



Secondary Data

Obesity and hypertension are the leading modifiable chronic disease risk factors in Calvert County; both are examined in detail below. The 35-64 age group represents the population most at risk of progressing from modifiable risk factor to diagnosed chronic disease^{6,7}. Additionally, 32.6% of Calvert County adults report a diagnosis of high blood pressure, slightly above both Maryland (32.5%) and the national rate of 31.1%^{6,7}. Hypertension is among the most prevalent chronic conditions in the county and serves as a primary pathway to heart disease, stroke, and kidney disease.

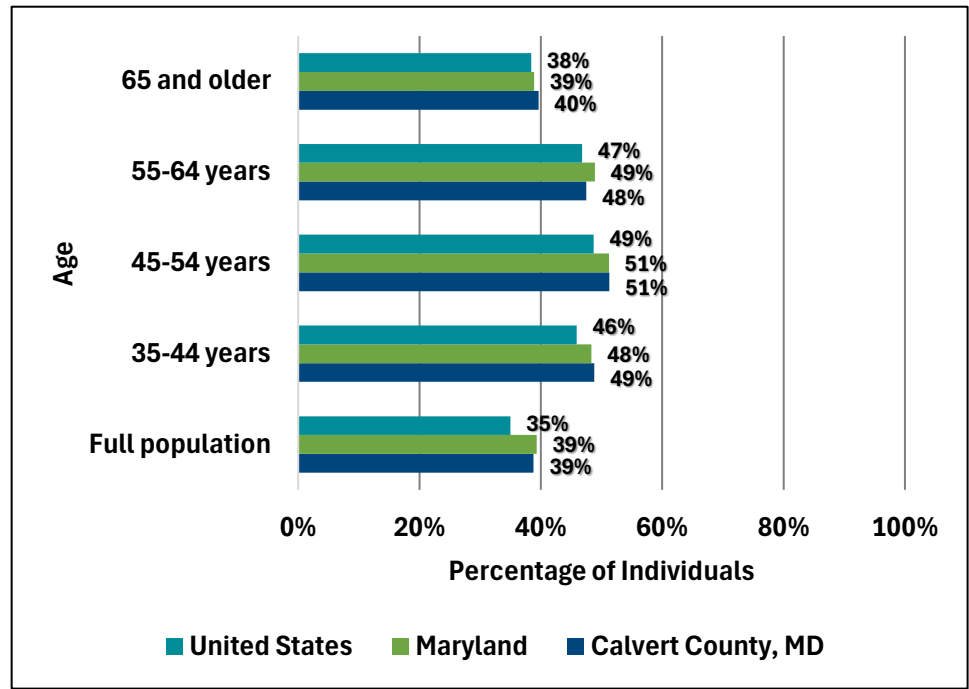
Risk Factors

Obesity and high blood pressure are among the most significant and actionable drivers of diabetes, heart disease, stroke, and other chronic conditions. Both are meaningfully elevated in Calvert County, positioning them as key priorities for chronic disease prevention.

Obesity

As illustrated in Figure 24, obesity rates in Calvert County exceed the national average and are heavily concentrated among midlife adults, with more than half of residents between the ages of 45 and 54 living with obesity. The 35–64 age group represents the population most at risk of progressing from a modifiable risk factor to a diagnosed chronic condition. Without targeted intervention, today's obesity burden in this cohort is likely to translate into tomorrow's diabetes, heart disease, and stroke cases^{13,25}.

FIGURE 24. OBESITY (BMI $\geq$ 30): COUNTY, STATE, AND NATIONAL BY AGE, 2025

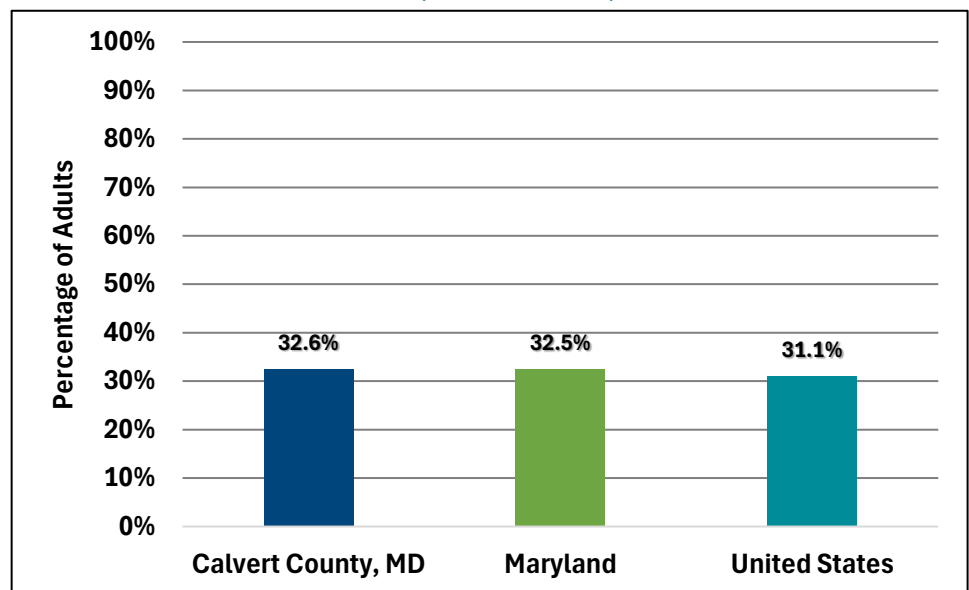


^{13, 25} Data Source: PopHIVE: Epic Cosmos, Obesity (BMI $\geq$ 30): Percent of patient encounters with people whose BMI was greater than or equal to 30.

Hypertension

As shown in Figure 25, 32.6% of Calvert County adults report having been diagnosed with high blood pressure, slightly above both Maryland (32.5%) and the national rate of 31.1%^{6,7}. Hypertension is among the most prevalent chronic conditions in the county and a primary pathway to heart disease, stroke, and kidney disease. Its presence in nearly one in three adults underscores the importance of consistent screening, linkage to care, lifestyle-based management and medication adherence as foundational elements of the county's chronic disease strategy.

FIGURE 25. HIGH BLOOD PRESSURE RATES AMONG ADULTS: COUNTY, STATE, AND NATIONAL, 2023

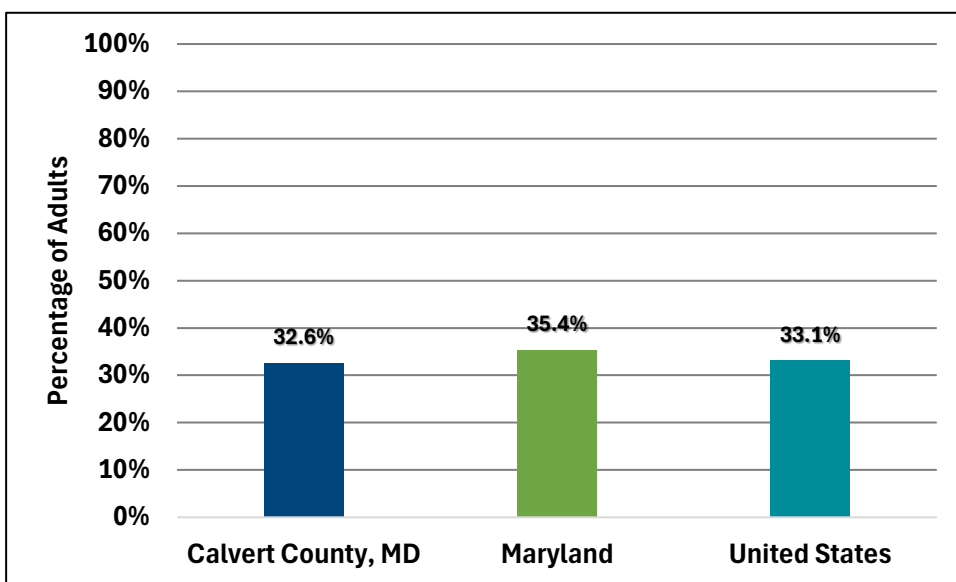


^{6, 7} Data sources: Centers for Disease Control and Prevention (CDC): PLACES (For sub-state geographic levels, including MSA, county, tract, and others), Behavioral Risk Factor Surveillance System (BRFSS) (For state and US), High blood pressure: Adults (18+) ever diagnosed with high blood pressure (hypertension) by a healthcare provider; excludes pregnancy-related and borderline hypertension.

High Cholesterol

Calvert County's high cholesterol rate of 32.6% falls below both the Maryland rate of 35.4% and the national rate of 33.1%, a relative strength in the county's chronic disease risk profile^{6,7}. Still, high cholesterol remains a significant cardiovascular risk factor for nearly one in three county residents and should be considered alongside the elevated heart disease and diabetes mortality rates documented in this section. Sustained cholesterol screening and management remain important components of the county's broader chronic disease prevention strategy.

FIGURE 26. HIGH CHOLESTEROL RATE AMONG ADULTS: COUNTY, STATE, AND NATIONAL, 2023

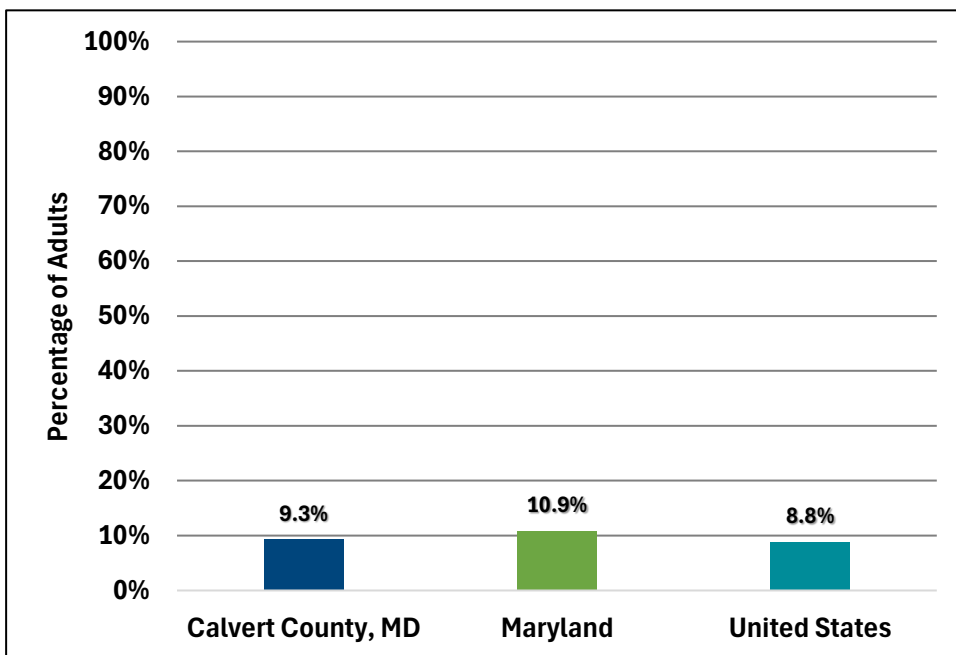


^{6,7} Data source: Centers for Disease Control and Prevention (CDC): PLACES (For sub-state geographic levels, including MSA, county, tract, and others), Behavioral Risk Factor Surveillance System (BRFSS) (For state and US), High cholesterol: Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have high cholesterol.

Diabetes Burden

As shown in Figure 27, Calvert County's diagnosed diabetes rate among adults stands at 9.3%, below the Maryland rate of 10.9% but above the national average of 8.8%, suggesting the county manages diabetes prevalence reasonably well relative to its state peers^{7,9}. Diagnosed prevalence alone does not capture the full picture: the mortality data reveals a more concerning trend. Although diabetes prevalence in Calvert County is moderate, diabetes mortality exceeds both state and national rates. The disparity is most pronounced among adults ages 40–64, suggesting opportunities to strengthen disease management, medication adherence, and access to ongoing care before complications become severe¹¹.

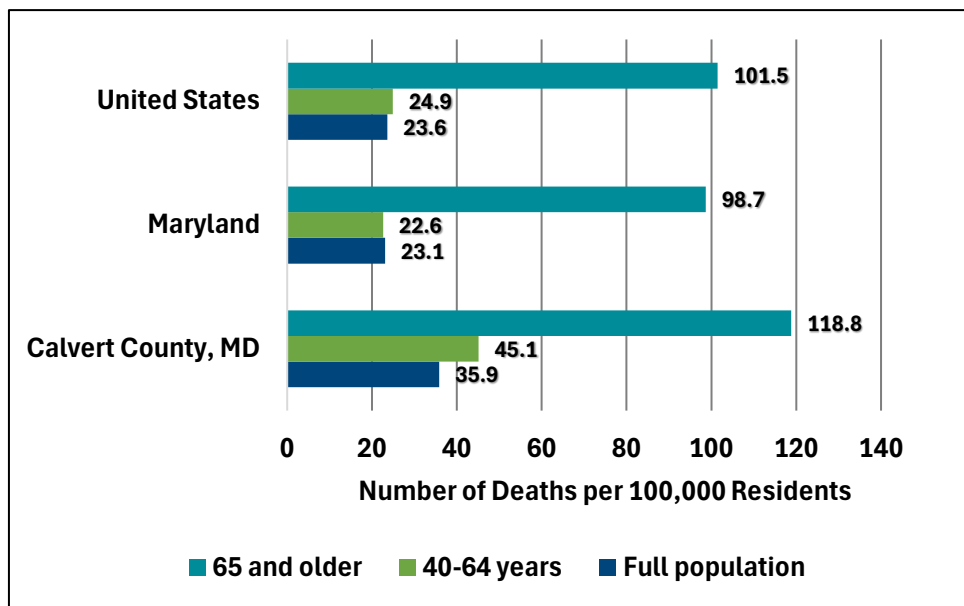
FIGURE 27. DIAGNOSED DIABETES RATE AMONG ADULTS: COUNTY, STATE, AND NATIONAL, 2024



^{7,9} Data source: Centers for Disease Control and Prevention (CDC): PLACES (Sub-county data), Centers for Disease Control and Prevention (CDC): United States Diabetes Surveillance System (County, state, and national level data), Diagnosed diabetes: Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have diabetes, other than diabetes during pregnancy.

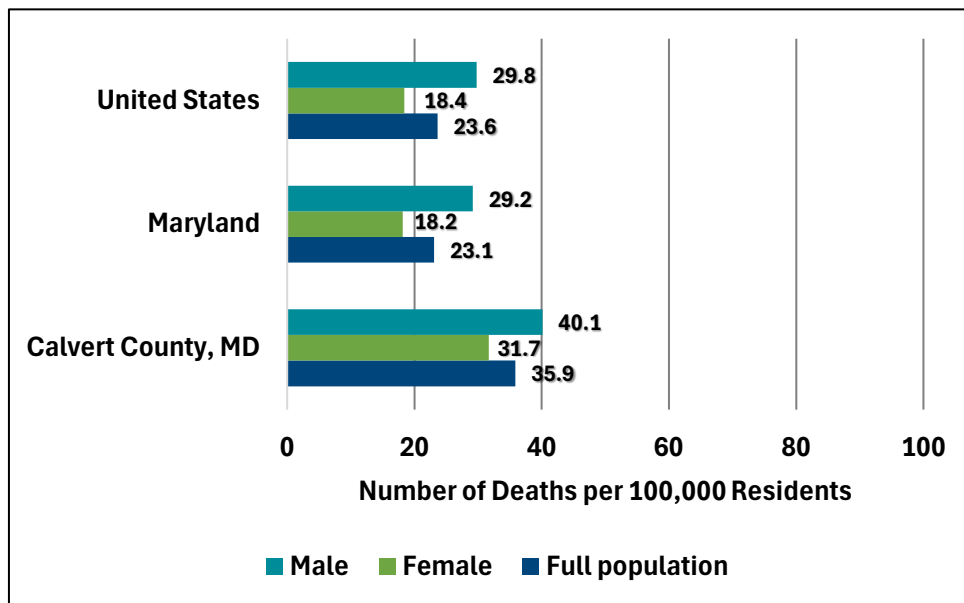
Diabetes mortality increases with age, but Calvert County's largest gap compared with Maryland and the United States is among adults ages 40 to 64. This suggests diabetes complications may be developing earlier among county residents¹¹. Men have higher diabetes mortality than women across the county, state, and nation. Calvert County's rates are elevated for both men and women, indicating a broad need for earlier detection and stronger management of related cardiovascular and kidney risks¹¹.

FIGURE 28. DIABETES MORTALITY RATE AMONG ADULTS: COUNTY, STATE, AND NATIONAL BY AGE, 2020-2024



¹¹ Data source: Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC Wonder), Diabetes mortality: Deaths per 100,000 residents with an underlying cause of diabetes (ICD-10 codes E10-E14).

FIGURE 29. DIABETES MORTALITY RATE AMONG ADULTS: COUNTY, STATE, AND NATIONAL BY SEX, 2020-2024

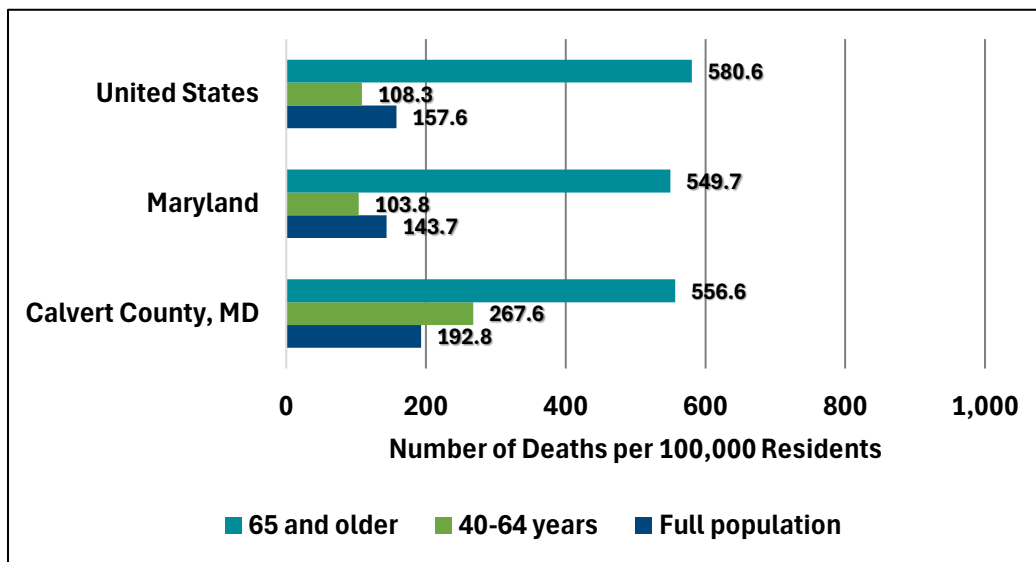


¹¹ Data source: Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC Wonder), Diabetes mortality: Deaths per 100,000 residents with an underlying cause of diabetes (ICD-10 codes E10-E14).

Cardiovascular Burden

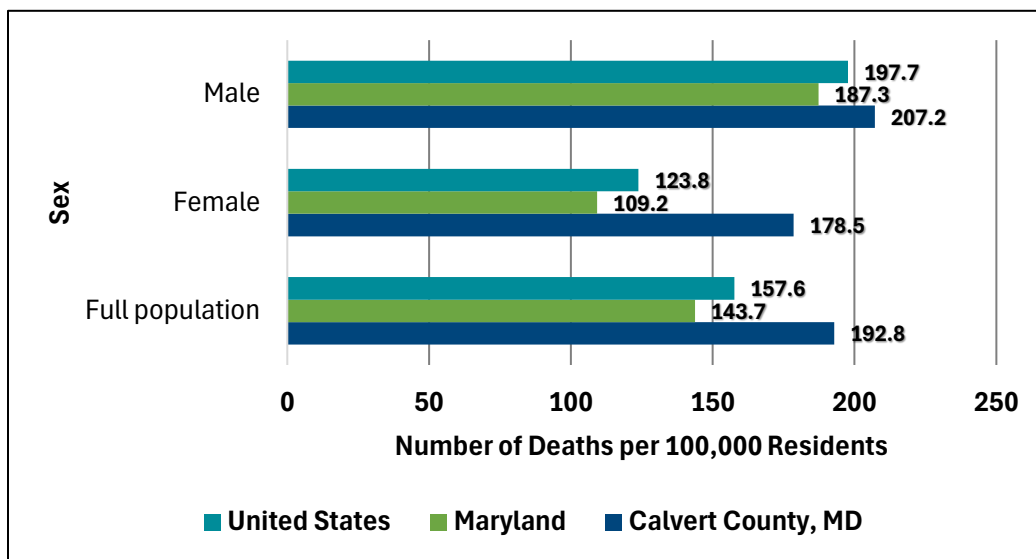
Heart disease mortality in Calvert County stands at 192.8 per 100,000, exceeding both the Maryland rate of 143.7 and the national rate of 157.6¹¹. This reflects the combined impact of an aging population, elevated obesity and hypertension rates, and structural barriers that limit access to sustained preventive care. The burden is most pronounced among adults ages 40-64, where the county's mortality rate of 267.6 is more than double state and national averages, marking midlife as the most consequential window for earlier screening, risk identification, and community-based intervention. Among residents 65 and older, county rates align closely with state and national benchmarks, reinforcing that the greatest opportunity to change long-term outcomes lies in the decades before that threshold¹¹.

FIGURE 30. HEART DISEASE MORTALITY: COUNTY, STATE, AND NATIONAL BY AGE, 2024



¹¹ Data source: Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC WONDER), Heart disease mortality: Deaths per 100,000 residents with an underlying cause of heart disease (ICD-10 codes 100-109, 111, 113, 120-151).

FIGURE 31. HEART DISEASE MORTALITY: COUNTY, STATE, AND NATIONAL BY SEX, 2024

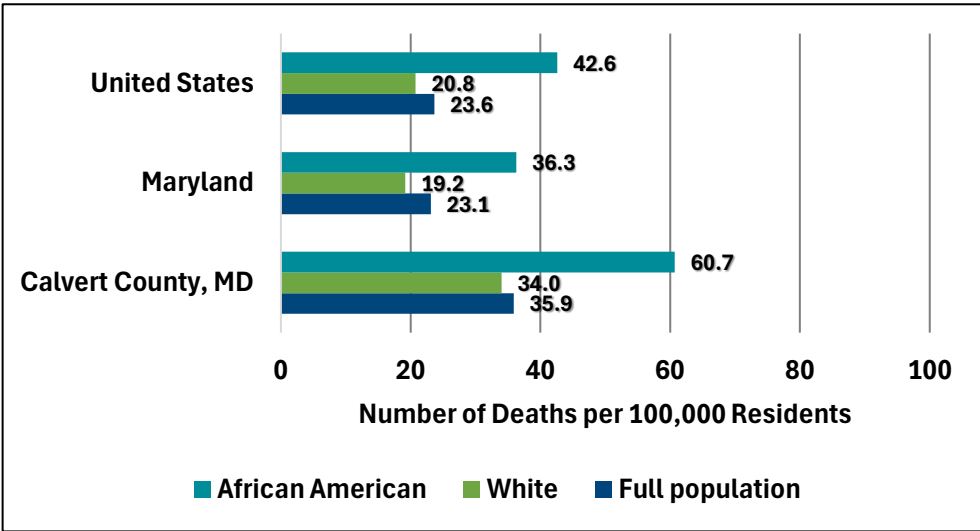


¹¹ Data source: Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC WONDER), Heart disease mortality: Deaths per 100,000 residents with an underlying cause of heart disease (ICD-10 codes 100-109, 111, 113, 120-151).

Health Equity and Disparities

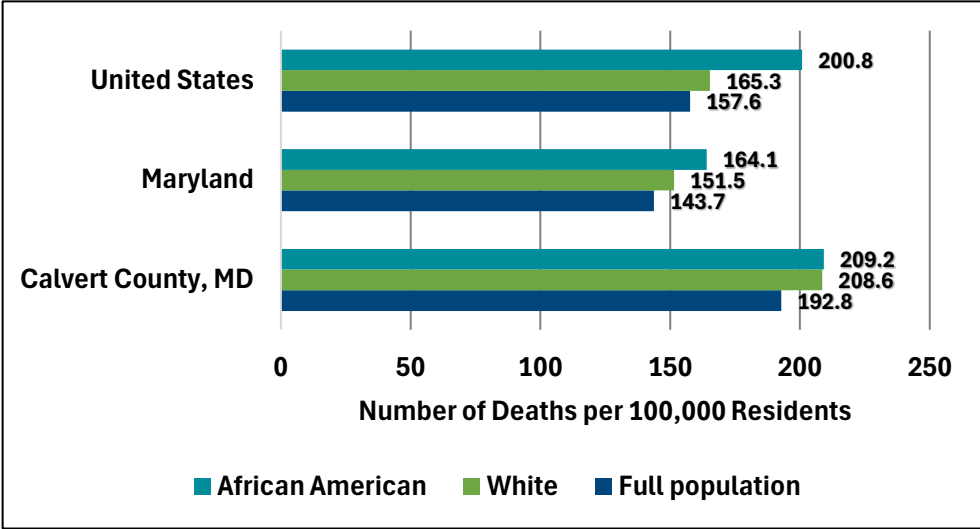
The most significant equity finding in Calvert County's chronic disease data is diabetes mortality. As shown in Figure 32, diabetes mortality among African American, Non-Hispanic residents is 60.7 per 100,000, more than two and a half times the rate of White, Non-Hispanic residents (24.0) and well above the county-wide average of 35.9³. This disparity reflects well-documented structural patterns, including transportation barriers, medication affordability, and access to culturally responsive care, that require intentional, equity-focused strategies. Expanding culturally grounded outreach, earlier screening, and sustained care navigation for African American residents is a central priority embedded throughout CalvertHealth's chronic disease strategies.

FIGURE 32. DIABETES MORTALITY: COUNTY, STATE, AND NATIONAL BY RACE/ETHNICITY, 2020-2024



¹¹ Data source: Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC WONDER), Diabetes mortality: Deaths per 100,000 residents with an underlying cause of diabetes (ICD-10 codes E10-E14).

FIGURE 33. HEART DISEASE MORTALITY: COUNTY, STATE, AND NATIONAL BY RACE/ETHNICITY, 2024



¹¹ Data source: Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC WONDER), Heart disease mortality: Deaths per 100,000 residents with an underlying cause of heart disease (ICD-10 codes 100-109, 111, 113, 120-151).

Strengths and Opportunities

CalvertHealth enters the 2026-2029 cycle with meaningful assets in place. Annual wellness visit rates among Medicare beneficiaries exceed both state and national averages, reflecting a patient population already engaged with the health system and reachable through existing care channels. Diabetes and cholesterol screening rates remain high, and the county's relatively low poverty rate provides a stronger economic foundation for self-management than many rural communities have. The most consequential opportunity lies in closing the gap between detection and outcomes, particularly for midlife adults and African American, Non-Hispanic residents, where mortality rates diverge sharply from the broader population. Strengthening care coordination across primary care, specialty services, and community-based chronic disease management programs, including diabetes self-management education and cardiac rehabilitation, is the highest-leverage near-term step for reducing preventable complications and narrowing documented disparities.

PRIORITIZED HEALTH THEME 2: ACCESS TO CARE

Access to timely, high-quality care is a core driver of community health. When residents can reach primary care, specialty services, and preventive care without barriers related to cost, distance, or availability, outcomes improve and disparities narrow. When access is limited, the burden falls most heavily on residents already facing the greatest challenges.

In Calvert County, access is shaped in large part by geography. The county's long, narrow peninsula creates distance barriers, and the concentration of services in the northern and central portions of the county leaves southern communities, including Lusby and Solomons, with fewer nearby options. As the county's sole hospital, CalvertHealth serves a population that is aging, geographically dispersed, and affected by provider recruitment and retention challenges common in rural and exurban communities. These conditions make flexible, community-based care strategies especially important.

Primary Data

Among the 962 respondents who provided a valid response, 13.4% reported needing physical health care but did not receive it. Access to Care was also one of the most frequently cited themes in the qualitative findings, with 90 mentions across 13 key informant interviews and two focus groups. Stakeholders consistently identified transportation as the most important access barrier, along with limited specialty care availability, digital access challenges affecting older adults and the Latino community, and the need for stronger care coordination across CalvertHealth, the Calvert County Health Department, and community-based organizations.

"If we had to prioritize one thing to improve health overall, fixing transportation would have the biggest impact."

— Focus Group Participant

FIGURE 34. KEY WORDS MENTIONED BY FOCUS GROUP PARTICIPANTS: ACCESS TO CARE



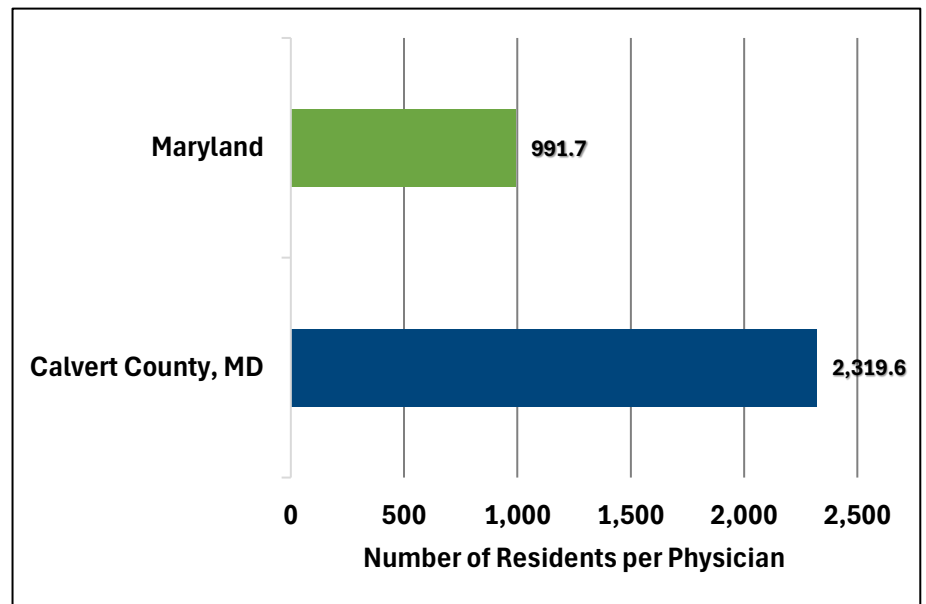
Secondary Data

The secondary data shows a community where most residents have insurance coverage and at least some connection to the health system, but where provider supply, geography, and service capacity continue to limit access. The findings below examine healthcare utilization, provider capacity, disparities, and the main opportunities for action in the 2026-2029 cycle.

Healthcare Utilization

In 2023, 77.3% of Calvert County adults visited a doctor for a routine check-up, above the national average of 75.9% but below Maryland's rate of 79.6% ⁷. This suggests that many residents remain connected to preventive care. It does not fully reflect how access is experienced across the county. In a setting where provider supply is limited and travel can be a barrier, routine visit rates capture those who are able to stay connected to care, but not the added effort required to do so or the residents who remain outside that system.

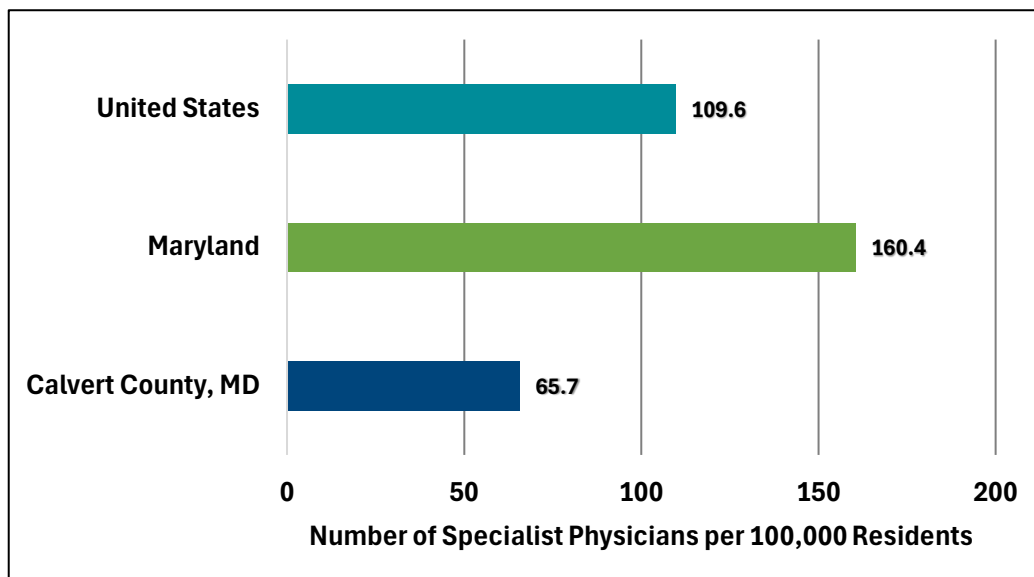
FIGURE 35. RESIDENTS PER PRIMARY CARE PROVIDER: COUNTY AND STATE, 2023



¹⁴ Data source: Health Resources & Services Administration: Area Health Resources Files (AHRF), People per primary care provider: Number of residents for each physician in primary care (general practice, internal medicine, obstetrics and gynecology, or pediatrics). Includes hospital residents. Excludes federal physicians and physicians age 75 or older.

As shown in Figure 36, specialist physician capacity in Calvert County stood at 65.7 per 100,000 residents in 2023, down slightly from 67.7 in 2021⁷. For residents who need services such as cardiology, neurology, or orthopedics, local supply is often not sufficient, making out-of-county travel necessary. Referral relationships with regional academic medical centers help extend access, but travel remains a barrier for many residents, especially older adults and those without reliable transportation.

FIGURE 36. SPECIALIST PHYSICIANS PER CAPITA: COUNTY, STATE, AND NATIONAL, 2023

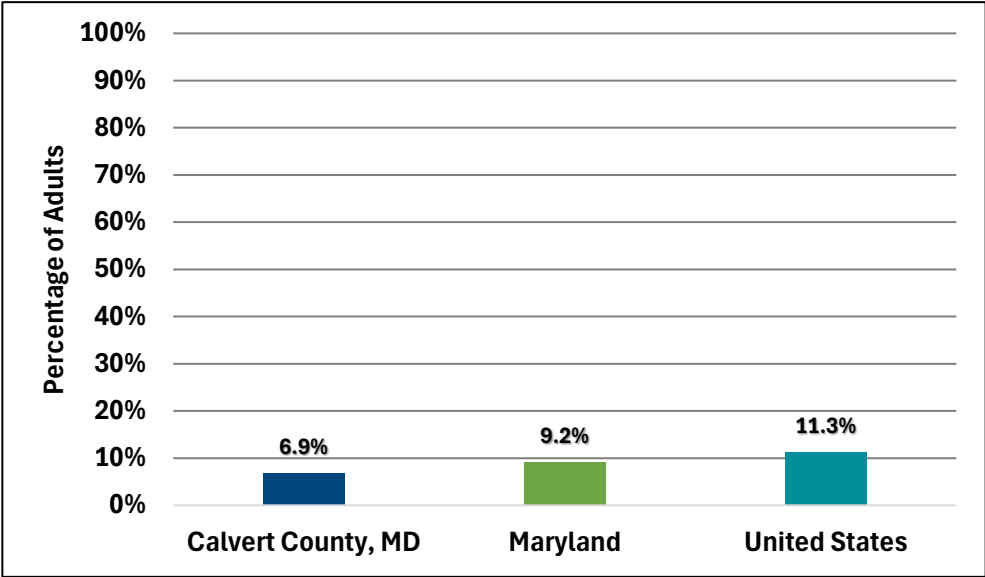


^{1, 14} Data source: Health Resources & Services Administration: Area Health Resources Files (AHRF) (From the AMA Masterfiles via the HRSA Primary Care Service Area data (TS_DOC)), Specialist physicians per capita: Number of physicians in clinically active specialist physicians per 100,000 residents.

Health Equity and Disparities

As shown in Figure 37, Calvert County's uninsured rate of 6.9% is below both the Maryland rate of 9.2% and the national rate of 11.3% ⁴. This is a meaningful strength, but insurance coverage alone does not ensure access. Even insured residents may face long wait times, limited provider availability, and long travel distances. These barriers are felt most strongly by older adults living on fixed incomes, residents in southern Calvert County, and populations for whom language access and cultural responsiveness affect healthcare engagement.

FIGURE 37. ADULTS WITH NO HEALTH INSURANCE COVERAGE: COUNTY, STATE, AND NATIONAL, 2023



^{6, 7} Data sources: Centers for Disease Control and Prevention (CDC): PLACES (For sub-state geographic levels, including MSA, county, tract, and others), Behavioral Risk Factor Surveillance System (BRFSS) (For state and US), No health insurance: Percent of resident adults aged 18 to 64 years who report having no current health insurance coverage.

Strengths and Opportunities

Calvert County's low uninsured rate provides a strong foundation. Most residents have a pathway to coverage, so the larger challenge is making care available, reachable, and timely. CalvertHealth already has important assets in place, including mobile outreach, the Wheels to Wellness transportation initiative, and care navigation services. The strongest near-term opportunities are telehealth expansion and advanced practice provider workforce development, both of which can extend access without requiring new physical infrastructure. These strategies are especially important for residents in southern Calvert County and for older adults facing transportation and scheduling barriers.

PRIORITIZED HEALTH THEME 3: MENTAL HEALTH AND SUBSTANCE USE

Mental health and substance use disorders are among the leading drivers of disability, premature mortality, and healthcare utilization, and their impact varies by community. Rural and exurban areas face distinct structural conditions: thinner provider workforces, more constrained specialty capacity, stigma amplified by small-community dynamics, and longer wait times between a resident in crisis and available care. Calvert County reflects both sides of this reality. The county has genuine strengths in crisis response and peer support, and it also faces a persistent gap between need and available care that remains one of the most pressing challenges facing the local health system.

Primary Data

Survey and qualitative findings reinforce what the secondary data show. Behavioral health needs in Calvert County are substantial, concentrated among specific populations, and outpacing the current capacity of the local system. Mental health services were the most frequently cited service gap across the entire survey, and youth were identified by a wide margin as the population most in need of additional support. Stakeholders across key informant interviews and focus groups consistently pointed to worsening youth mental health, the shift away from the unit-based inpatient educational program toward a self-directed online learning model for adolescents in day-treatment and partial-hospitalization settings and limited psychiatric and child psychology capacity as the most pressing concerns.

Substance use surfaced as an equally significant and closely related concern, led overwhelmingly by alcohol. Respondents and stakeholders alike described substance use as intertwined with the county's broader mental health challenges, often affecting the same individuals and families. Stigma reinforced by small-community dynamics, emerged as a persistent barrier to treatment engagement for both mental health and substance use concerns, discouraging residents from seeking help even when services are available.

“Students are asking for mental health help now. It used to be that most would keep everything under wraps, but now students are coming forward and asking for support.”

— KII Participant, Calvert County Public Schools

“Behavioral health is a huge need, especially among the youth population.”

— KII Participant

FIGURE 38. KEY WORDS MENTIONED BY FOCUS GROUP PARTICIPANTS: MENTAL HEALTH AND

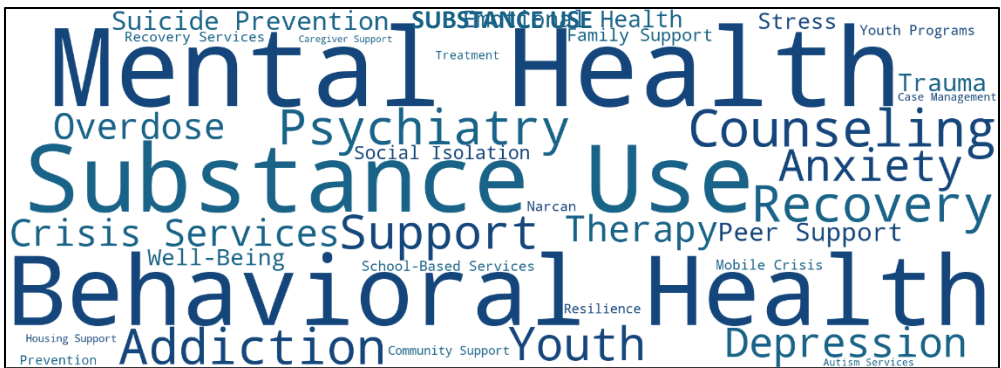
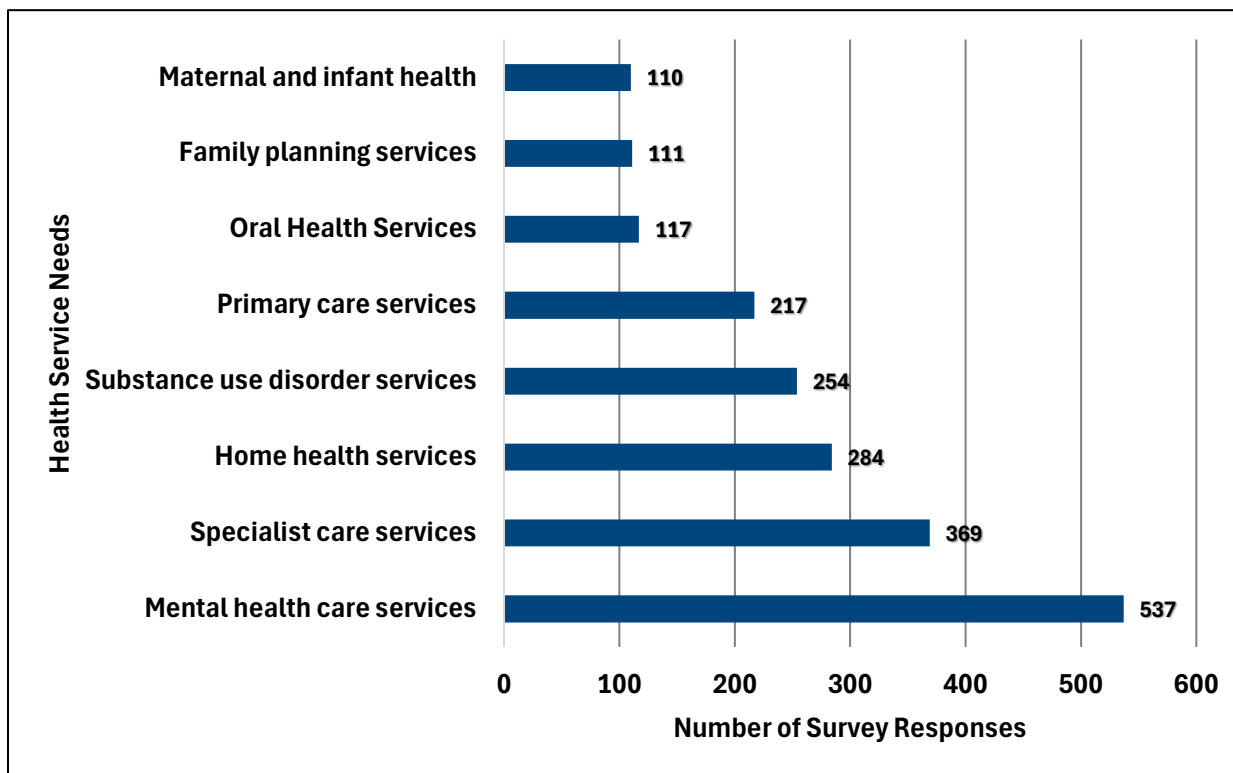
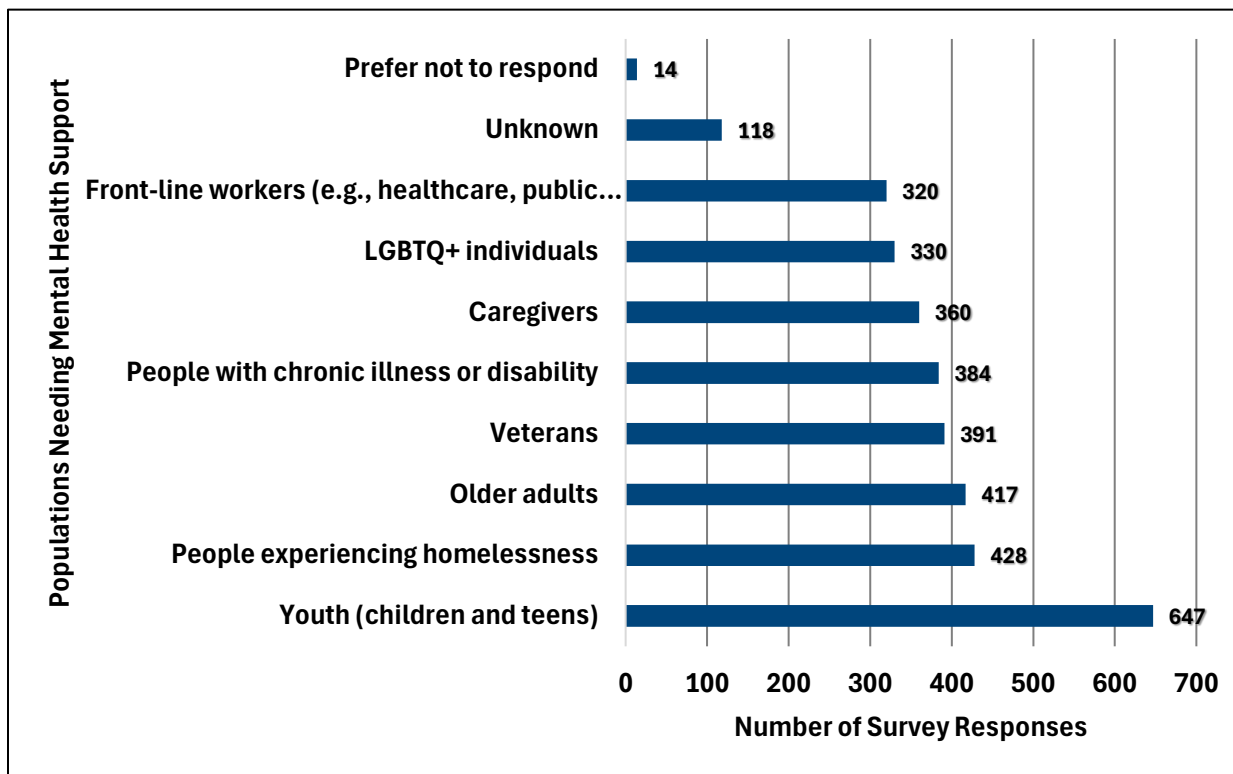


FIGURE 39. SURVEY RESPONDENTS' SELF-IDENTIFIED HEALTH SERVICES NEEDS



³ Data source: CalvertHealth Community Health Survey, Respondents' Identified Needs in Community Health Services: Measures which health services respondents believe are insufficient in their community. Respondents answered a multi select question. Values represent the number of respondents selecting each service gap.

FIGURE 40. SURVEY RESPONDENTS' SELF-IDENTIFIED POPULATIONS NEEDING MENTAL HEALTH SUPPORT



³ Data source: CalvertHealth Community Health, Survey Respondents' Populations Needing Mental Health Support: Measures which population groups respondents believe need additional mental health support. Respondents answered a multi select question. Values represent the number of respondents selecting each group.

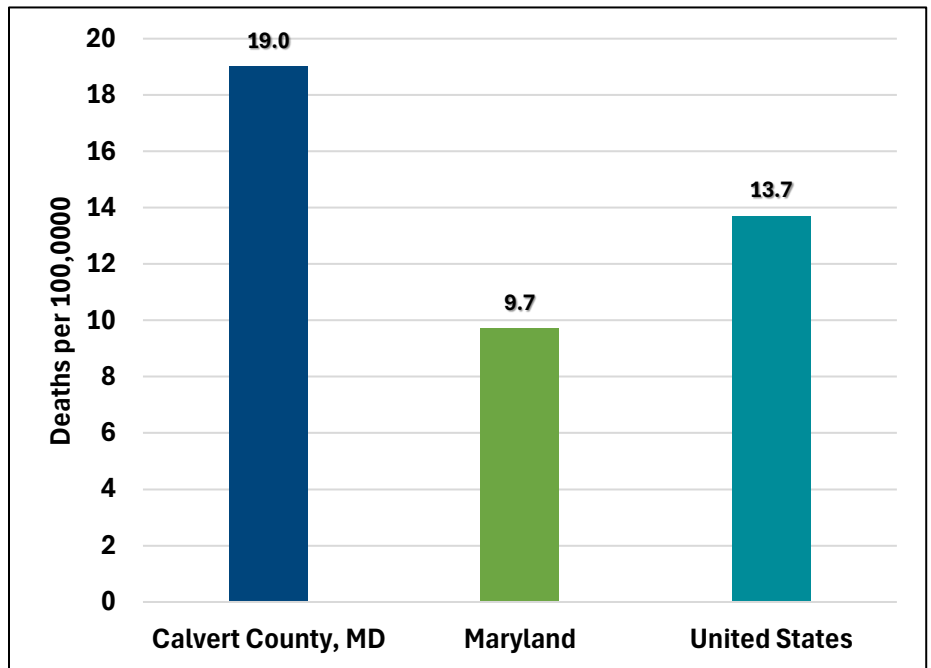
Secondary Data

The secondary data confirms what community voices describe. Behavioral health needs in Calvert County are substantial, concentrated, and constrained by limited infrastructure. Suicide mortality exceeds the Maryland benchmark. Self-reported poor mental health days are comparable to national averages but reflect a persistent baseline of unmet need among adults. Provider and facility data show the sharpest gaps. Calvert County has roughly half the mental health providers per 100,000 residents of Maryland's rate, just 5 psychiatrists per 100,000 residents compared to 18 statewide, and a single child psychologist serving the entire county¹². Substance use, led by excessive alcohol consumption, is a closely related challenge, and treatment facility capacity has declined even as need has grown. Together, these indicators describe a behavioral health system under real strain, driven not by lack of commitment but by the workforce and infrastructure gaps common to rural and exurban communities.

Mental Health and Substance Use Burden

Calvert County's behavioral health burden is not defined by any single indicator, but by the accumulation of persistent signals across mental health and substance use. As shown in Figure 41, suicide mortality stands at 11.9 per 100,000, above Maryland's rate of 9.5¹¹, and nearly one in six adults reports 14 or more poor mental health days per month, reflecting a chronic and widespread baseline of emotional distress beyond acute crisis. On the substance use side, excessive drinking affects approximately 20% of adults, above state and national averages, with downstream effects visible in alcohol-impaired driving death rates that substantially exceed Maryland benchmarks²¹. According to Maryland Department of Health data, drug overdose mortality has declined meaningfully in recent years, with 10 deaths recorded from April 2025 through March 2026, progress that shows why sustained investment in prevention and response is still needed to maintain it¹⁵.

FIGURE 41. SUICIDE MORTALITY: COUNTY, STATE, AND NATIONAL, 2024



¹¹ Data source: Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC WONDER), Suicide mortality: Deaths per 100,000 residents due to suicide (ICD-10 codes *U03, X60-X84, Y87.0). In the United States, decisions about whether deaths are listed as suicides on death certificates are usually made by a coroner or medical examiner. The definition of suicide is "death arising from an act inflicted upon oneself with the intent to kill oneself."

Treatment Facility and Provider Capacity

Behavioral health providers and treatment facilities in Calvert County are concentrated in the northern and central portions of the county, leaving southern communities with limited coverage. This pattern is consistent with access disparities seen across other health themes.

Calvert County has 569.6 residents per mental health provider compared to Maryland's ratio of 311.2, nearly double the state figure¹². This means residents here compete for far fewer available appointments than their counterparts statewide. Mental health treatment facilities per capita also fall below Maryland's rate. Substance use treatment facility capacity has declined from a peak of 7.2 per 100,000 in 2023 to 5.7 in 2025, even as Maryland's rate has continued to rise¹⁹. Together, this combination of workforce scarcity and shrinking facility capacity represents the central supply-side challenge facing the county's behavioral health system.

FIGURE 42. PEOPLE PER MENTAL HEALTH PROVIDER: COUNTY, STATE, AND NATIONAL, 2025

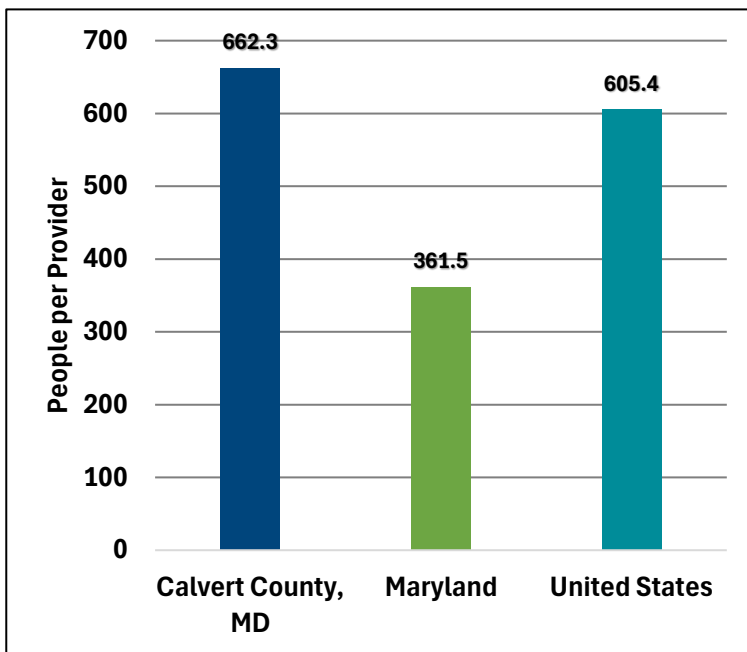
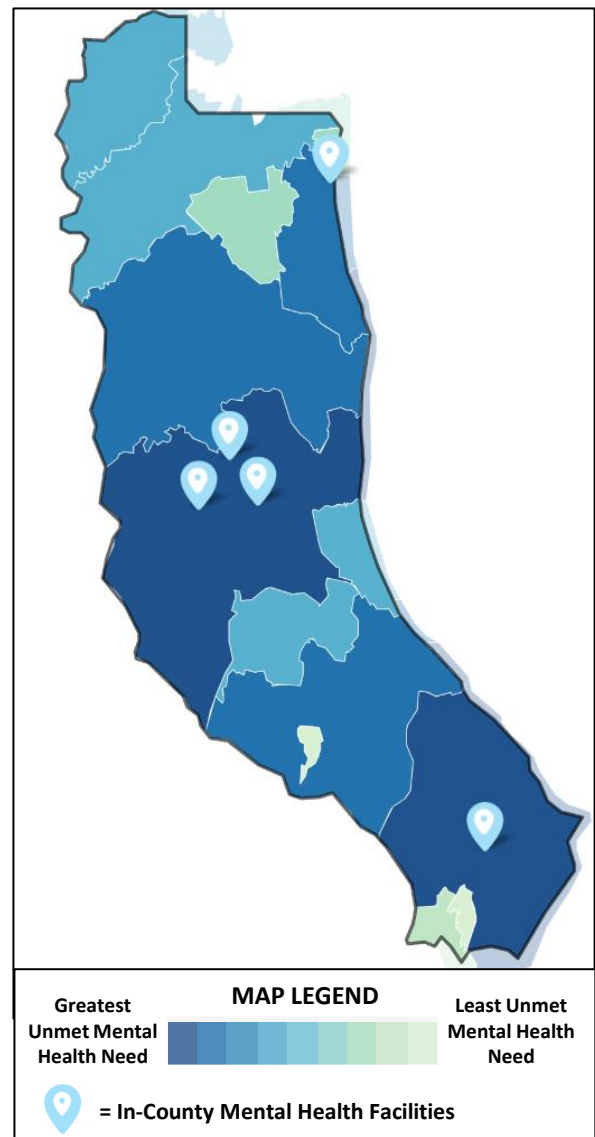


FIGURE 43. MAP OF IN-COUNTY MENTAL HEALTH FACILITIES



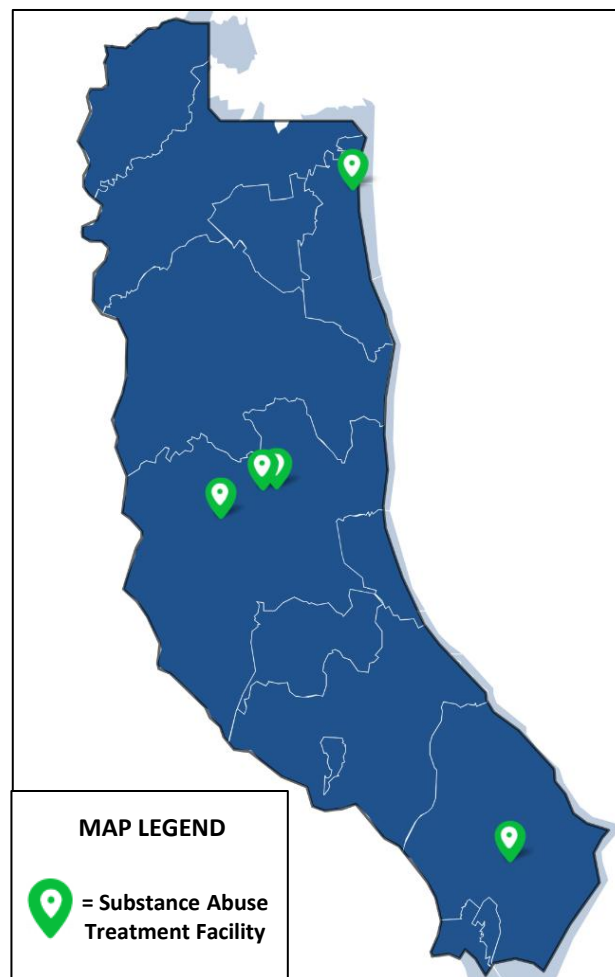
¹² Data source: Centers for Medicare & Medicaid Services (CMS): National Provider Identifier Files (NPI), People per mental health provider: Number of residents per mental health provider, such as psychiatrists, psychologists, and specialists in addiction medicine, counseling, therapy, and behavioral health. Includes advanced practice nurses and nurse practitioners working in mental health.

^{3, 19} Data source: CalvertHealth Community Health Survey 2026, Substance Abuse and Mental Health Services Administration (SAMHSA), FindTreatment.gov Treatment Locator

Health Equity and Disparities

Transitional-age young adults (ages 18–25) face unique barriers to accessing mental health and substance use treatment services in Calvert County. Stakeholder input identified a shortage of providers serving this age group, particularly for behavioral health and substance use treatment, creating challenges during a critical period of transition from pediatric to adult care. Limited local provider availability, transportation barriers, and long travel distances to specialty services may delay or prevent access to needed care. These challenges are further amplified by the county's rural development pattern and limited public transportation options, making it difficult for young adults to obtain timely behavioral health support.

FIGURE 44. MAP OF IN-COUNTY SUBSTANCE USE TREATMENT FACILITIES



¹⁹ Data source: Substance Abuse and Mental Health Services Administration (SAMHSA), [FindTreatment.gov](https://www.findtreatment.gov) Treatment Locator

Strengths and Opportunities

CalvertHealth enters the 2026-2029 cycle with a behavioral health infrastructure that few rural communities of comparable size can match. Crisis response capacity, including the mobile crisis team, 988 integration, emergency department peer support, and Screening, Brief Intervention, and Referral to Treatment (SBIRT), gives the county a strong foundation of services already reaching residents at their most vulnerable. Opioid treatment provider capacity modestly exceeds the national average, reflecting sustained investment in one of the county's most visible substance use challenges. The clearest opportunities going forward are to expand telehealth-enabled psychiatric and counseling access for residents who cannot reach in-person services and deepen partnerships with schools, faith communities, and senior centers to reach priority populations through channels the community already trusts.

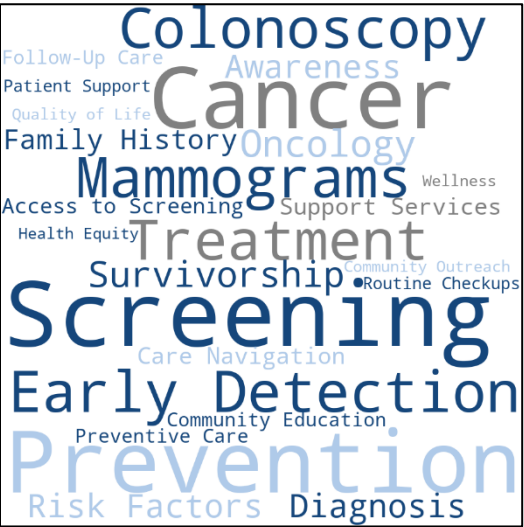
PRIORITIZED HEALTH THEME 4: CANCER

Cancer remains one of the most consequential health challenges facing communities nationwide, with outcomes shaped as much by where people live and what resources they can access as by biology alone. Disparities in cancer outcomes by race, age, and geography are well documented, and access to screening, care coordination, and timely follow-up largely determines who is diagnosed early and who is not. In Calvert County, distance, transportation, and workforce constraints shape cancer outcomes for a largely rural, aging, and geographically dispersed population. CalvertHealth and its community partners are addressing these challenges through targeted screening, navigation, and outreach strategies.

Primary Data

Cancer generated fewer mentions across qualitative engagement than other themes, but stakeholder observations were consistent and specific, showing that the community understands its significance. Stakeholders noted an apparent rise in cancer diagnoses among younger adults, growing survivorship needs such as coordinated follow-up care and psychosocial support, and the role of historical and environmental exposures in the county's cancer burden. The travel demands of specialty oncology care were a recurring concern, particularly for older adults and residents without reliable transportation, underscoring the need for locally accessible navigation and support services alongside specialized care that often requires travel outside the county.

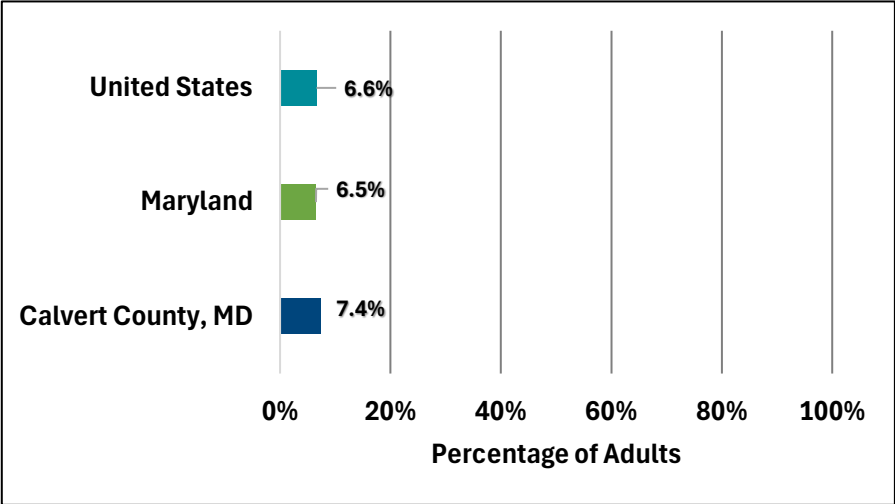
FIGURE 45. KEY WORDS MENTIONED BY FOCUS GROUP PARTICIPANTS: CANCER



Secondary Data

The secondary data shows a consistent pattern of elevated mortality rates, rising diagnosis trends, persistent screening gaps, and environmental risk factors that together call for expanded prevention, earlier detection, and more coordinated care. The following sections examine four areas, overall burden, cancer-specific findings, health equity and disparities, and strengths and opportunities.

FIGURE 46. SELF-REPORTED CANCER DIAGNOSIS: COUNTY, STATE, AND NATIONAL, 2023



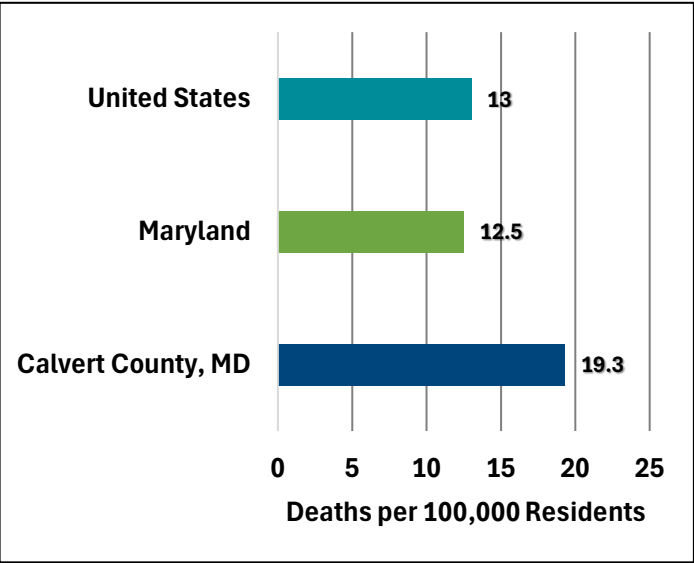
^{6, 7} Data sources: Centers for Disease Control and Prevention (CDC): PLACES (For sub-state geographic levels, including MSA, county, tract, and others), Behavioral Risk Factor Surveillance System (BRFSS) (For state and US), Have ever had cancer: Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have cancer (other than skin cancer).

Cancer-Specific Burden

Cancer outcomes in Calvert County are shaped by more than access to clinical care. The county's older-than-average population and the access barriers documented throughout this report both contribute to mortality rates that exceed state and national benchmarks, with the largest gaps among older adults, the same population CalvertHealth's screening, navigation, and outreach strategies are designed to reach. A growing share of county adults report a personal history of cancer, reflecting both improved detection and a survivorship population whose long-term care needs are an increasingly important part of the county's health landscape.

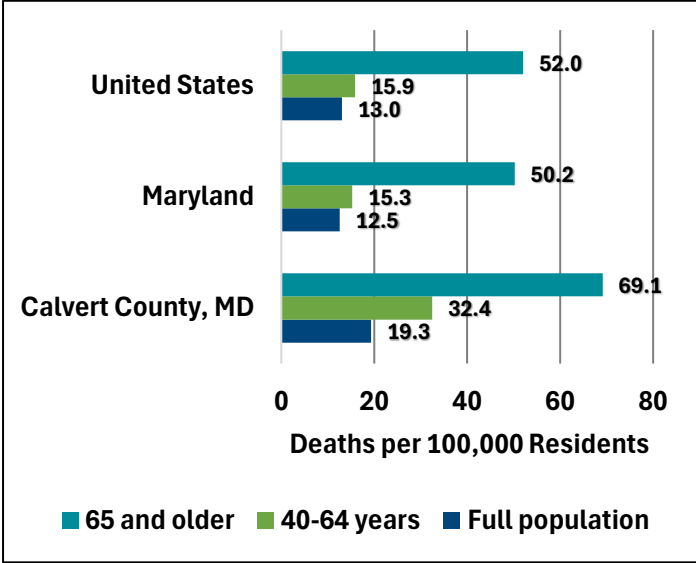
Breast cancer mortality is the most elevated finding in the county. Female residents experience mortality rates that substantially exceed both state and national averages¹¹, making breast cancer the highest-priority cancer-specific concern for the 2026-2029 cycle. Prostate cancer mortality among male residents is the second most notable finding, with rates that trended above national benchmarks in recent reporting periods before showing modest improvement. Colorectal cancer mortality is broadly in line with benchmarks at the population level but rises sharply among older adults. Breast, prostate, and colorectal cancer are therefore the top cancer-specific priorities for CalvertHealth's targeted screening, early detection, and care coordination strategies.

FIGURE 47. COLORECTAL CANCER MORTALITY: COUNTY, STATE, AND NATIONAL, 2020-2024



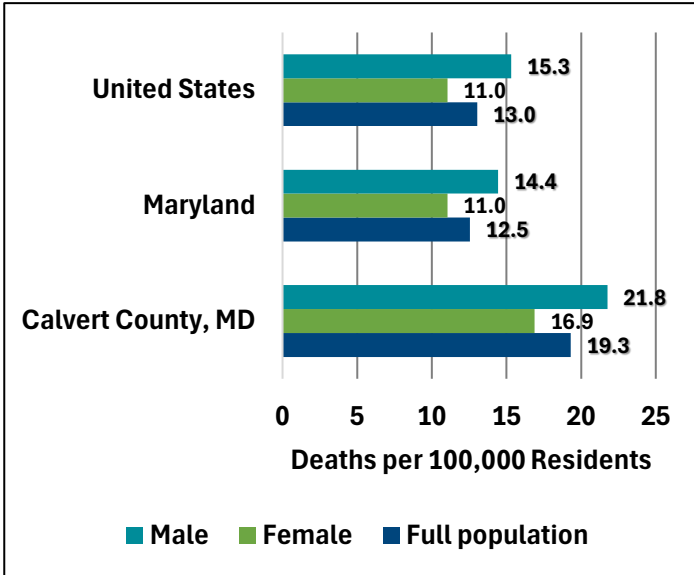
¹¹ Data source: Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC WONDER), Colorectal cancer mortality: Deaths per 100,000 residents due to colorectal cancer (ICD-10 codes C18-C21).

FIGURE 48. COLORECTAL CANCER MORTALITY: COUNTY, STATE, AND NATIONAL BY AGE, 2020-2024



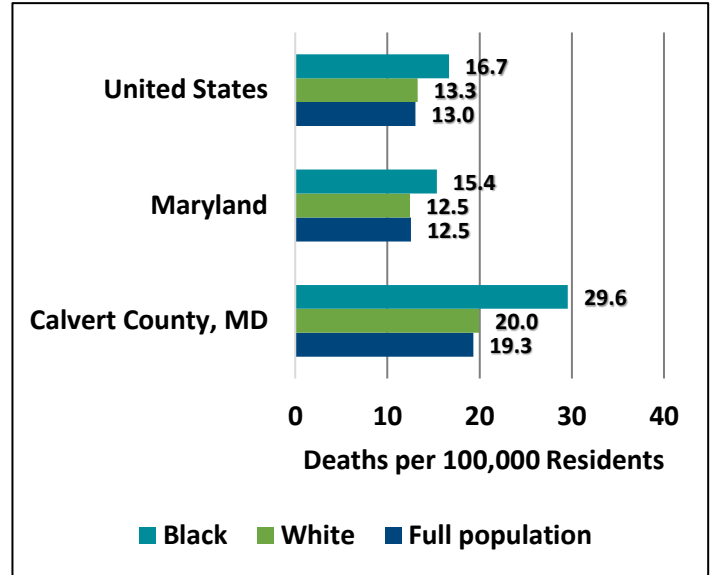
¹¹ Data source: Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC WONDER), Colorectal cancer mortality: Deaths per 100,000 residents due to colorectal cancer (ICD-10 codes C18-C21).

FIGURE 49. COLORECTAL CANCER MORTALITY: COUNTY, STATE, AND NATIONAL BY SEX, 2020-2024



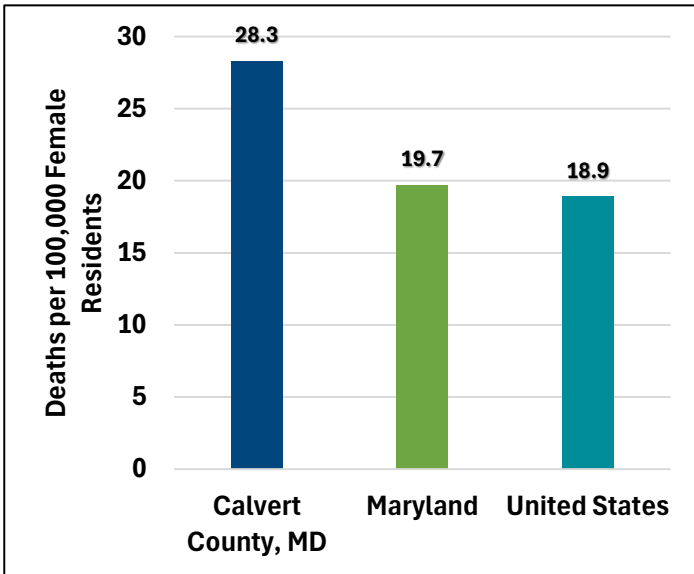
¹¹ Data source: Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC WONDER), Colorectal cancer mortality: Deaths per 100,000 residents due to colorectal cancer (ICD-10 codes C18-C21).

FIGURE 50. COLORECTAL CANCER MORTALITY: COUNTY, STATE, AND NATIONAL BY RACE/ETHNICITY, 2020-2024



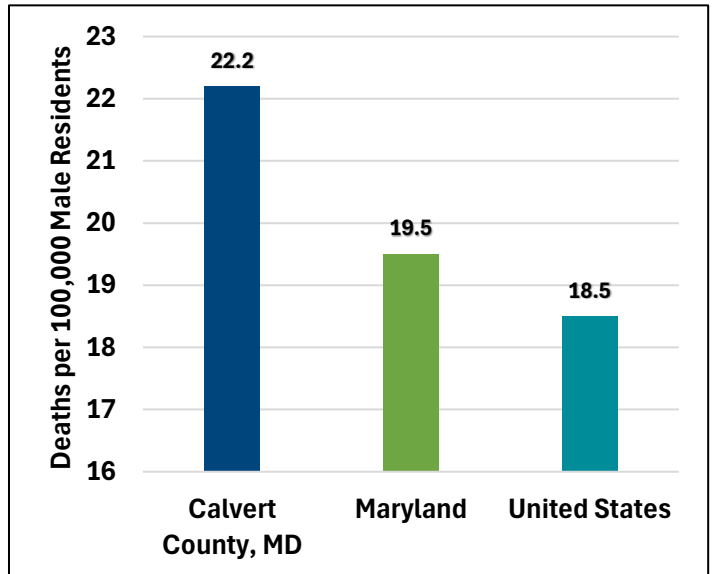
¹¹ Data source: Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC WONDER), Colorectal cancer mortality: Deaths per 100,000 residents due to colorectal cancer (ICD-10 codes C18-C21).

FIGURE 51. BREAST CANCER MORTALITY (FEMALES ONLY): COUNTY, STATE, AND NATIONAL, 2020-2024



¹¹ Data source: Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M) (CDC WONDER), Breast cancer mortality (females only): Deaths per 100,000 female residents due to breast cancer (ICD-10 code C50). Excludes male residents.

FIGURE 52. PROSTATE CANCER MORTALITY (MALES ONLY): COUNTY, STATE, AND NATIONAL, 2020-2024



¹¹ Data source: Centers for Disease Control and Prevention (CDC): National Vital Statistics System-Mortality (NVSS-M), Prostate cancer mortality (males only): Deaths per 100,000 residents due to prostate cancer (ICD-10 code C61).

Health Equity and Disparities

Adults 65 and older in Calvert County face cancer mortality rates well above both Maryland and national averages, consistent with the county's older population and the access barriers that can delay screening and follow-up for this age group. Among cancers that affect both sexes, such as colorectal cancer, male residents have higher diagnosis and mortality rates than female residents, with colorectal cancer showing the largest gap.

A few limitations shape how cancer data is presented in this section. Rates are shown as five-year averages rather than single-year figures because cancer case counts can be small and fluctuate sharply from year to year; averaging over five years smooths out this volatility and produces more stable, reliable trends, consistent with reporting standards used by the CDC's U.S. Cancer Statistics program and the National Cancer Institute's SEER Program^{8,17}. Data also defaults to adults 65 and older, since cancer risk rises sharply with age and this group provides the largest, most statistically reliable population to report on, while younger age groups often have too few cases to report without risking patient privacy, also consistent with these reporting standards. These are limitations in how cancer data is structured nationally, not gaps in local screening or care, and should be kept in mind when interpreting the disparities above.

Strengths and Opportunities

CalvertHealth enters the 2026-2029 cycle with meaningful cancer-related infrastructure in place, including a breast cancer screening campaign, colorectal cancer screening campaign, abnormal-screening referral pathway, oncology social worker, and cancer survivorship programming. Pap smear test prevalence has rebounded to 81.0%, above the Maryland rate, reflecting strong cervical cancer screening engagement among county women. The clearest opportunities ahead are expanding screening reach for breast and colorectal cancer among older adults and southern county residents, strengthening the pathway from abnormal screening results to timely follow-up, and developing transportation and financial navigation support for residents whose cancer care requires travel outside the county.

CONCLUSION

This report describes the process and findings of a comprehensive health needs assessment for the residents of Calvert County, Maryland. The 2026 CHNA is grounded in 927 secondary data indicators, 13 key informant interviews with 23 stakeholder participants, two focus groups, and 1,064 community survey respondents. Synthesis of these sources identified eight significant health needs, and through facilitated stakeholder voting on June 8, 2026, four were confirmed as priorities for the 2026-2029 cycle: Chronic Disease, Access to Care, Mental Health and Substance Use, and Cancer.

These priorities will guide the community health improvement efforts of CalvertHealth and its partners. Following publication of this CHNA, CalvertHealth will outline how it plans to address these four priorities in its 2026-2029 Community Health Improvement Plan (CHIP), in partnership with the Community Health Improvement Roundtable, the Calvert County Health Department, and other community stakeholders. Each priority theme will include equity-focused strategies that respond to the disparities documented in this assessment: diabetes and chronic disease outcomes among African American, Non-Hispanic residents; behavioral health capacity for youth and transitional-age adults; transportation and digital access for older adults and southern-county residents; and cancer screening, early detection, and care coordination for the county's aging population.

CalvertHealth remains committed to serving Southern Maryland residents through high-quality care and community health improvement. This CHNA provides the evidence base for that work, and its findings will directly inform the strategies, partnerships, and investments CalvertHealth pursues over the 2026-2029 cycle.



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APPENDICES



**2026
COMMUNITY
HEALTH NEEDS
ASSESSMENT**

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