Q1.
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission (HSCRC or Commission) is required to collect community benefit information from individual hospitals in Maryland and compile into an annual statewide, publicly available report. The Maryland General Assembly updated §19-303 of the Health General Article in the 2020 Legislative Session (HB1169/SB0774), requiring the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments. The reporting is split into two components, a Financial Report and a Narrative Report. This reporting tool serves as the narrative report. In response to the legislation, some of the reporting questions have changed for FY 2021. Detailed reporting instructions are available here: https://hscrc.maryland.gov/Pages/init_cb.aspx

In this reporting tool, responses are mandatory unless specifically marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

For technical assistance, contact HCBHelp@hilltop.umbc.edu.

Q2. Section I - General Info Part 1 - Hospital Identification

Q3. Please confirm the information we have on file about your hospital for the fiscal year.

	Is this information correct?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: Holy Cross Hospital	◉	○	
Your hospital's ID is: 210004	◉	○	
Your hospital is part of the hospital system called Trinity Health	◉	○	
The primary Narrative contact at your hospital is Monika Driver	◉	○	
The primary Narrative contact email address at your hospital is driverm@holycrosshealth.org	◉	○	
The primary Financial contact at your hospital is Kimberley McBride	◉	○	
The primary Financial email at your hospital is mcbrik@holycrosshealth.org	◉	○	

Q4. The next group of questions asks about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

Q5. Please select the community health statistics that your hospital uses in its community benefit efforts.

- [x] Median household income
- [x] Percentage below federal poverty line (FPL)
- [x] Percent uninsured
- [x] Percent with public health insurance
- [x] Percent with Medicaid
- [ ] Mean travel time to work
- [x] Percent speaking language other than English at home
- [x] Race: percent white
- [x] Race: percent black
- [x] Ethnicity: percent Hispanic or Latino
- [ ] Life expectancy
- [ ] Crude death rate
- [ ] Other

Q6. Please describe any other community health statistics that your hospital uses in its community benefit efforts.

Social Influencers of Health 1 Decrease percent of residents without insurance - Source: US Census Bureau, American Community Survey. 2015-19. 2 Decrease number of people unable to afford to see a doctor - Healthy Montgomery 3 Decrease food insecurity rate - Source: Feeding America. 2017. 4 Decrease households with housing cost burdens - Source: US Census Bureau, American Community Survey. 2015-19. Maternal and Infant Health 1 Increase percent of mothers receiving early prenatal care - Source: MCDHHS/PHS/Planning & Epidemiology; Maryland DHMH/VSA; 2017 2 "Reduce the percent of low birth weight infants - Source: MCDHHS/PHS/Planning & Epidemiology; Maryland DHMH/VSA and MD DHMH, 2017" 3 Decrease infant mortality rate - Source: MCDHHS/PHS/Planning & Epidemiology; Maryland DHMH/VSA; CDC/U.S. Census bridged Population Files; 2017 Seniors 4 Increase life expectancy - Source: Maryland Department of Health and Mental Hygiene; 2015-2017 5 Decrease fall related deaths - Source: Maryland Department of Health and Mental Hygiene; 2015-2017 Cardiovascular Health 6 "Decrease heart disease mortality - Source: CDC Interactive Atlas of Heart Disease and Stroke, 2014- 2016" 7 Decrease stroke mortality - Source: MCDHHS/PHS/Planning & Epidemiology; Maryland DHMH/VSA; CDC/U.S. Census bridged Population Files; 2015-2017 8 Decrease percent of adults told by health professional they have high blood pressure - Source: Maryland Behavioral Risk Factor Surveillance System; 2017 Obesity 9 Decrease percent of high school students with no participation in physical activity - Maryland YRBS; 2014 10 Decrease percent of high school students who are obese - Maryland YRBS; 2014 11 Increase percent of high school students who drank no soda or pop in the past week - Maryland YRBS; 2014 Diabetes 12 Decrease number of adults ever being told they have diabetes (exluding gestational) - Source: Maryland Behavioral Risk Factor Surveillance System; 2017 13 Decrease ER visits for diabetes - Source: MCDHHS/PHS/Planning & Epidemiology; HSCRC; CDC/U.S. Census bridged Population Files; 2015-2017 Behavioral Health 14 Decrease adolescent and adult illicit drug use in past month (12 or older) - Source: National Survey on Drug Use and Health; 2012-2014 15 Decrease percent of adults with any mental illness in past year - Source: National Survey on Drug Use and Health; 2012-2014 16 Decrease mental health related ER visits - Source: Maryland DHMH State Health Improvement Process, 2017 17 Decrease suicide rate - Source: MCDHHS/PHS/Planning & Epidemiology; Maryland DHMH/VSA; CDC/U.S. Census bridged Population Files; 2013-2017 Cancers 18 Increase colorectal cancer screening (colonoscopy or sigmoidoscopy) - Source: Maryland Behavioral Risk Factor Surveillance System; 2016 19 Increase percent of women who have had a Pap in past three years - Source: Maryland Behavioral Risk Factor Surveillance System; 2016 20 Decrease prostate cancer incidence - Source: National Cancer Institute; 2011-2015 21 "Decrease breast cancer mortality - Source: Breast Cancer Death Rates for Montgomery and Prince George's County. Source: NCI, 2011-2015"

Q7. Attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Community Benefit Workplan Dashboard - FY21_Q4.xlsx
221.9KB
application/vnd.openxmlformats-officedocument.spreadsheetml.sheet

Q8. Section I - General Info Part 2 - Community Benefit Service Area

Q9. Please select the county or counties located in your hospital's CBSA.

☐ Allegany County	☐ Charles County	☑ Prince George's County
☐ Anne Arundel County	☐ Dorchester County	☐ Queen Anne's County
☐ Baltimore City	☐ Frederick County	☐ Somerset County
☐ Baltimore County	☐ Garrett County	☐ St. Mary's County
☐ Calvert County	☐ Harford County	☐ Talbot County
☐ Caroline County	☐ Howard County	☐ Washington County
☐ Carroll County	☐ Kent County	☐ Wicomico County
☐ Cecil County	☑ Montgomery County	☐ Worcester County

Q10. Please check all Allegany County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q11. Please check all Anne Arundel County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q12. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q13. Please check all Baltimore County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q14. Please check all Calvert County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q15. Please check all Caroline County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q16. Please check all Carroll County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q17. Please check all Cecil County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q18. Please check all Charles County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q19. Please check all Dorchester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q20. Please check all Frederick County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q21. Please check all Garrett County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q22. Please check all Harford County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q23. Please check all Howard County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q24. Please check all Kent County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q25. Please check all Montgomery County ZIP codes located in your hospital's CBSA.

☐ 20058	☐ 20824	☑ 20850	☐ 20872	☐ 20891	☐ 20907
☐ 20207	☐ 20825	☑ 20851	☑ 20874	☐ 20892	☑ 20910
☑ 20707	☐ 20827	☑ 20852	☐ 20875	☐ 20894	☐ 20911
☐ 20777	☐ 20830	☑ 20853	☑ 20876	☑ 20895	☑ 20912
☐ 20783	☑ 20832	☐ 20854	☑ 20877	☐ 20896	☐ 20913
☐ 20787	☐ 20833	☐ 20855	☑ 20878	☐ 20898	☐ 20914
☐ 20810	☐ 20837	☐ 20857	☑ 20879	☐ 20899	☐ 20915
☐ 20811	☐ 20838	☐ 20859	☐ 20880	☑ 20901	☐ 20916
☐ 20812	☐ 20839	☐ 20860	☐ 20882	☑ 20902	☐ 20918
☑ 20814	☐ 20841	☐ 20861	☐ 20883	☑ 20903	☐ 20993
☑ 20815	☐ 20842	☐ 20862	☐ 20884	☑ 20904	☐ 21770
☑ 20816	☐ 20847	☑ 20866	☐ 20885	☑ 20905	☐ 21771
☑ 20817	☐ 20848	☑ 20868	☑ 20886	☑ 20906	☐ 21797
☐ 20818	☐ 20849	☐ 20871	☐ 20889		

Q26. Please check all Prince George's County ZIP codes located in your hospital's CBSA.

☐ 20233	☑ 20710	☑ 20742	☑ 20772
☐ 20389	☑ 20712	☑ 20743	☐ 20773
☐ 20395	☐ 20715	☐ 20744	☑ 20774
☐ 20588	☑ 20716	☐ 20745	☐ 20775
☐ 20599	☐ 20717	☑ 20746	☑ 20781
☐ 20601	☐ 20718	☑ 20747	☑ 20782
☐ 20607	☑ 20720	☑ 20748	☑ 20783
☐ 20608	☑ 20721	☐ 20749	☑ 20784
☐ 20613	☑ 20722	☐ 20750	☑ 20785
☐ 20616	☐ 20724	☐ 20752	☐ 20790
☐ 20623	☐ 20725	☐ 20753	☐ 20791
☐ 20703	☐ 20726	☐ 20757	☐ 20792
☐ 20704	☐ 20731	☐ 20762	☐ 20799
☑ 20705	☐ 20735	☐ 20768	☐ 20866

- [x] 20706
- [x] 20737
- [x] 20769
- [ ] 20903
- [x] 20707
- [ ] 20738
- [x] 20770
- [x] 20904
- [x] 20708
- [x] 20740
- [x] 20771
- [x] 20912
- [ ] 20709
- [ ] 20741

Q27. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q28. Please check all Somerset County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q29. Please check all St. Mary's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q30. Please check all Talbot County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q31. Please check all Washington County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q32. Please check all Wicomico County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q33. Please check all Worcester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q34. How did your hospital identify its CBSA?

- [ ] Based on ZIP codes in your Financial Assistance Policy. Please describe.
- [ ] Based on ZIP codes in your global budget revenue agreement. Please describe.
- [x] Based on patterns of utilization. Please describe.

  The CBSA primary service area is derived from the Maryland ZIP code areas from which the origin of the top 60% of discharges. The remaining discharges contribute to the secondary service area.

- [ ] Other. Please describe.

Q35. Provide a link to your hospital's mission statement.

https://www.holycrosshealth.org/about-us/about-holy-cross-health/mission-and-values

Q36. (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

Holy Cross Health is a Catholic, not-for-profit health system that serves more than 160,000 individuals each year from Maryland's two largest counties — Montgomery and Prince George's counties. Our community is vibrant, active and diverse, where life is always moving. Holy Cross Health is continuously advancing, too, as a forward-thinking health system committed to helping our community members address their individual needs and goals to achieve a better quality of life. From hospitals and primary care sites to specialty care and wellness programs, Holy Cross Health is accessible throughout the region to meet individuals on their path to good health. Holy Cross Health has been a steward of our diverse community's health for more than 55 years, earning the trust of area residents. Our team of more than 4,000 employees, 2,430 community-based physicians, and 251 volunteers works proactively each day to meet the needs of every individual we touch. And our mission and values mean that we uphold this commitment for every person, without regard for the ability to pay. During the last five fiscal years, Holy Cross Health has provided more than $289 million in community benefit, including more than $176 million in financial assistance. Holy Cross Health earns numerous national awards, clinical designations and accreditations across a wide range of specialties for providing innovative, high-quality health care services. Holy Cross Health is a regional leader in gynecologic surgery, performing more gynecologic and gynecologic oncology surgeries than any other hospital or health system in Maryland. Holy Cross Hospital is one of the largest single-site hospital providers of obstetric services in the Mid-Atlantic region, delivering more babies than any other hospital in Maryland. Holy Cross Hospital's Neonatal Intensive Care Unit (NICU) cares for more critically ill newborns than any other hospital in Maryland, and the hospital's Emergency Center is one of the 10 largest emergency care providers in the state. Holy Cross Health is the only health care provider in Maryland to receive the Workplace Excellence Seal of Approval Award from the Alliance for Workplace Excellence every year since 1999. With a commitment to education, Holy Cross Health has numerous academic partnerships and Holy Cross Germantown Hospital is the first hospital in the nation located on a community college campus to advance educational training and development. Holy Cross Health is constantly seeking innovative ways to improve health, including investing in technologies that allow people to heal and return to their lives. Holy Cross Health is the only health care system in the region to provide all private patient rooms at Holy Cross Hospital and Holy Cross Germantown Hospital, for improved comfort, safety, and privacy of patients and their families. An innovator in minimally invasive surgery, Holy Cross Hospital was first in Montgomery County to offer robotic surgery with the da Vinci® surgical system in 2008 and in 2017, Holy Cross Germantown Hospital was the first community hospital in Montgomery County to acquire the latest, most advanced da Vinci Xi robotic surgical technology. Holy Cross Health is a leader in caring for vulnerable populations, establishing the nation's first and region's only Seniors Emergency Center at Holy Cross Hospital, which is now a national model. Holy Cross Health is also the only health system in Montgomery County to operate its own health centers to provide affordably priced health care to those in financial need, which now provide more than 41,000 patient visits each year. Holy Cross Hospital has long been a leader in cardiac rhythm management as the first community hospital in Maryland to treat a patient with an implantable cardioverter-defibrillator (ICD), implant a biventricular pacemaker outside a research setting, and offer the world's smallest pacemaker for patients with bradycardia. Each day, Holy Cross Health colleagues work hard to move people's lives forward, by providing a continuum of quality care that touches individuals in many ways — from prevention to primary care, to chronic disease management, to inpatient care, to care at home and support groups, making the right level of care more accessible and more coordinated. The Holy Cross Health system includes: Holy Cross Hospital, one of the largest hospitals in Maryland and home to the nation's first and region's only Seniors Emergency Center. Holy Cross Germantown Hospital, the first hospital in the nation to be located on a community college campus and enhanced by an educational partnership, offering high-quality medical, surgical, obstetric, emergency and behavioral health services to the fastest-growing region in the county. Holy Cross Health Network, which operates Holy Cross Health Centers in Aspen Hill, Gaithersburg, Germantown and Silver Spring; provides primary care at Holy Cross Health Partners at Asbury Methodist Village and in Kensington; offers a wide range of innovative health and wellness programs; and leads partner relationships. Holy Cross Health Foundation is a not-for-profit organization devoted to raising philanthropic funds to support the mission of Holy Cross Health and to improve the health of the community. Holy Cross Health is a member of Trinity Health of Livonia, Mich., one of the largest multi-institutional Catholic health care delivery systems in the country, serving diverse communities that include more than 30 million people across 22 states. Holy Cross Health also is a member of the American Hospital Association, the Maryland Hospital Association and the Catholic Health Association.

Q37. Section II - CHNAs and Stakeholder Involvement Part 1 - Timing & Format

Q38.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- (●) Yes
- ( ) No

Q39. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q40. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

10/17/2019

Q41. Please provide a link to your hospital's most recently completed CHNA.

https://www.holycrosshealth.org/assets/documents/community_involvement/holy-cross-hospital-community-health-needs-assesssment-fiscal-year-2020

Q42. Please upload your hospital's most recently completed CHNA.

holy-cross-hospital-community-health-needs-assesssment-fiscal-year-2020.pdf
3.2MB
application/pdf

Q43. Section II - CHNAs and Stakeholder Involvement Part 2 - Internal CHNA Partners

Q44. Please use the table below to tell us about the internal partners involved in your most recent CHNA development.

	CHNA Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
CB/ Community Health/Population Health Director (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
CB/ Community Health/ Population Health Director (system level)	☐	☐	☐	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☑	☑	☐	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Board of Directors or Board Committee (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Board of Directors or Board Committee (system level)	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Clinical Leadership (facility level)	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Clinical Leadership (system level)	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Population Health Staff (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Population Health Staff (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your exp below:
Community Benefit staff (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Community Benefit staff (system level)	☐	☐	☐	☑	☑	☑	☑	☑	☐	☐	
Physician(s)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Nurse(s)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Social Workers	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Q45. Section II - CHNAs and Stakeholder Involvement Part 3 - Internal HCB Partners

Q46. Please use the table below to tell us about the internal partners involved in your community benefit activities during the fiscal year.

	Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	☐	☐	☑	☑	☑	☐	☐	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☑	☑	☑	☐	☑	☐	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system level)	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (facility level)	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (system level)	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)	☐	☐	☐	☑	☑	☐	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (facility level)	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (system level)	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Physician(s)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Nurse(s)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Social Workers	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Q47. Section II - CHNAs and Stakeholder Involvement Part 4 - Meaningful Engagement

Q48. Community participation and meaningful engagement is an essential component to changing health system behavior, activating partnerships that improve health outcomes and sustaining community ownership and investment in programs. Please use the table below to tell us about the external partners involved in your most recent CHNA. In the first column, select and describe the external participants. In the second column, select the level of community engagement for each participant. In the third column, select the recommended practices that each stakeholder was engaged in. The Maryland Hospital Association worked with the HSCRC to develop this list of eight recommended practices for engaging patients and communities in the CHNA process.

Refer to the FY 2021 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is optional for FY 2021, but will be mandatory for FY 2022.

	Level of Community Engagement						Recommended Practices							
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals -- Please list the hospitals here: Suburban Hospital, Medstar Montgomery Medical Center, Adventist Healthcare	☐	☐	☐	☑	☐	☐	☑	☑	☑	☑	☑	☐	☑	☐
Local Health Department -- Please list the Local Health Departments here: Montgomery County Department of Health	☐	☐	☐	☑	☐	☐	☑	☑	☑	☑	☑	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Health Improvement Coalition -- Please list the LHICs here: Healthy Montgomery	☐	☐	☐	☑	☐	☐	☑	☑	☑	☑	☑	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Maryland Department of Health	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other State Agencies -- Please list the agencies here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Local Govt. Organizations -- Please list the organizations here: Montgomery County (MC) Council, MC Commission on Health, MC Department of Planning, MC Commission on People with Disabilities, Asian American Health Initiative, Latino Health Initiative, African American Health Program, MC Recreation Department, Montgomery County Area Agency on Aging	☐	☑	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Faith-Based Organizations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - K-12 -- Please list the schools here: Montgomery County Public School System	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
School - Colleges, Universities, Professional Schools -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Behavioral Health Organizations -- Please list the organizations here: EveryMind	☐	☑	☐	☐	☐	☐	☑	☐	☐	☑	☐	☐	☐	☐
Social Service Organizations -- Please list the organizations here: Primary Care Coalition of Montgomery County, Manna Food Center, Montgomery County Collaboration	☐	☐	☐	☑	☐	☐	☑	☐	☐	☑	☐	☐	☐	☐
Post-Acute Care Facilities -- please list the facilities here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Community/Neighborhood Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other -- If any other people or organizations were involved, please list them here: Holy Cross Health External Review Committee, Holy Cross Health Community Conversations	☐	☑	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	☐

	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
	Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision-making in the hands of the community	Community-Driven/Led - To support the actions of community initiated, driven and/or led processes	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress

Q49. Section II - CHNAs and Stakeholder Involvement Part 5 - Follow-up

Q50. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

- (●) Yes
- ( ) No

Q51. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

10/17/2019

Q52. Please provide a link to your hospital's CHNA implementation strategy.

https://www.holycrosshealth.org/assets/documents/community_involvement/holy-cross-hospital-implementation-strategy_2020-2022

Q222. Please upload your hospital's CHNA implementation strategy.

holy-cross-hospital-implementation-strategy_2020-2022.pdf
2MB
application/pdf

Q53. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q54. Please select the CHNA Priority Area Categories most relevant to your most recent CHNA. The list of categories is based on the Healthy People 2030 objectives available here. This list is not exhaustive. Please select "other" and describe any CHNA Priority Area Categories that are not captured by this list. Select all that apply even if a need was not addressed by a reported initiative.

- ☐ Health Conditions - Addiction
- ☐ Health Conditions - Arthritis
- ☐ Health Conditions - Blood Disorders
- ☑ Health Conditions - Cancer
- ☐ Health Conditions - Chronic Kidney Disease
- ☐ Health Conditions - Chronic Pain
- ☐ Health Conditions - Dementias
- ☑ Health Conditions - Diabetes
- ☐ Health Conditions - Foodborne Illness
- ☐ Health Behaviors - Drug and Alcohol Use
- ☐ Health Behaviors - Emergency Preparedness
- ☐ Health Behaviors - Family Planning
- ☐ Health Behaviors - Health Communication
- ☐ Health Behaviors - Injury Prevention
- ☐ Health Behaviors - Nutrition and Healthy Eating
- ☐ Health Behaviors - Physical Activity
- ☐ Health Behaviors - Preventive Care
- ☐ Health Behaviors - Safe Food Handling
- ☑ Populations - Women
- ☐ Populations - Workforce
- ☐ Settings and Systems - Community
- ☐ Settings and Systems - Environmental Health
- ☐ Settings and Systems - Global Health
- ☐ Settings and Systems - Health Care
- ☐ Settings and Systems - Health Insurance
- ☐ Settings and Systems - Health IT
- ☐ Settings and Systems - Health Policy

☐ Health Conditions - Health Care-Associated Infections	☐ Health Behaviors - Sleep	☐ Settings and Systems - Hospital and Emergency Services
☑ Health Conditions - Heart Disease and Stroke	☐ Health Behaviors - Tobacco Use	☑ Settings and Systems - Housing and Homes
☐ Health Conditions - Infectious Disease	☐ Health Behaviors - Vaccination	☐ Settings and Systems - Public Health Infrastructure
☑ Health Conditions - Mental Health and Mental Disorders	☐ Health Behaviors - Violence Prevention	☐ Settings and Systems - Schools
☐ Health Conditions - Oral Conditions	☐ Populations - Adolescents	☐ Settings and Systems - Transportation
☐ Health Conditions - Osteoporosis	☑ Populations - Children	☐ Settings and Systems - Workplace
☑ Health Conditions - Overweight and Obesity	☑ Populations - Infants	☐ Social Determinants of Health - Economic Stability
☐ Health Conditions - Pregnancy and Childbirth	☐ Populations – LGBT	☐ Social Determinants of Health - Education Access and Quality
☐ Health Conditions - Respiratory Disease	☐ Populations - Men	☑ Social Determinants of Health - Health Care Access and Quality
☐ Health Conditions - Sensory or Communication Disorders	☑ Populations - Older Adults	☐ Social Determinants of Health - Neighborhood and Built Environment
☐ Health Conditions - Sexually Transmitted Infections	☐ Populations - Parents or Caregivers	☐ Social Determinants of Health - Social and Community Context
☐ Health Behaviors - Child and Adolescent Development	☐ Populations - People with Disabilities	☑ Other (specify) SDOH - Food Security

Q56. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Holy Cross Health has been conducting needs assessments for almost 20 years and identifies unmet community health care needs in a variety of ways. We collaborate with other healthcare providers to support Healthy Montgomery, Montgomery County's community health improvement process. We seek expert guidance from a panel of external participants with expertise in public health and the needs of our community and gather first-hand information from community members through community conversations conducted by Holy Cross Health and community conversations conducted by Healthy Montgomery and the Montgomery County Department of Health and Human Services. We review other available reports and needs assessments and use them as reference tools to identify unmet needs in various populations. We also use the Community Need Index to geographically identify high need communities that would benefit from our programs and services and use internal data sources to conduct an extensive analysis of demographics, health indicators and other determinants of health for the communities we serve.

Q57. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q58. Section II - CHNAs and Stakeholder Involvement Part 6 - Initiatives

Q59. Please use the questions below to provide details regarding the initiatives to address the CHNA Priority Area Categories selected in the previous question.

For those hospitals completing the ***optional*** CHNA financial reporting in FY 2021, please ensure that these tie directly to line item initiatives in the financial reporting template.

For those hospitals **not** completing the ***optional*** CHNA financial template, please provide this information for as many initiatives as you deem feasible.

Please note that hospitals will be required to report on each CHNA-related initiative in FY 2022.

Q163. Please describe the initiative(s) addressing Health Conditions - Addiction.

This question was not displayed to the respondent.

Q182. Please describe the initiative(s) addressing Health Conditions - Arthritis.

This question was not displayed to the respondent.

Q183. Please describe the initiative(s) addressing Health Conditions - Blood Disorders.

This question was not displayed to the respondent.

Q184. Please describe the initiative(s) addressing Health Conditions - Cancer.

	Health Conditions - Cancer Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Key Action - Provide community-based breast cancer education	Goal: Reduce the number of new cancer cases, as well as illness, disability, and death caused by cancer. Objective: Increase the number of low-income, uninsured women receiving breast cancer screenings and education on cancer prevention and the importance of early detection	Year One: Provided breast cancer education to 708 community members during 166 educational sessions (community lectures, health fairs, one-to-one). Year Two: Provided 287 virtual breast cancer education encounters	Quarterly reports on encounters

Initiative B	Key Action - Provide access to mammogram services for uninsured, underinsured women	Goal: Reduce the number of new cancer cases, as well as illness, disability, and death caused by cancer. Objective: Increase the number of low-income, uninsured women receiving breast cancer screenings and education on cancer prevention and the importance of early detection	Year One: Received 1,064 referrals from health centers and completed 655 mammograms. Twenty patients enrolled in state BCC program. Mammogram referrals transferred to population health department to expand program to include all specialty referralsYear Two: Completed can 321 screening mammograms and 334 diagnostic mammograms for health center patients.	Quarterly reports on encounters, percent eligible health center patients health center patients receiving referrals, number of mammograms,number navigated to care and cycle time from diagnosis to treatment, number enrolled in state breast and cervical cancer program
Initiative C	Key Action - Provide outreach and education on cancer prevention in Montgomery and Prince George's County through an equitable lens	Goal: Reduce the number of new cancer cases, as well as illness, disability, and death caused by cancer. Objective: Provide educational, community-based and clinical programs to reduce the number of cancer cases, as well as illness, disability, and death caused by cancer.	Year One: Provided outreach and education on cancer prevention (breast, cervical, colorectal, prostate, lung, skin) to 2,567 community members during 456 educational sessions (community lectures, health fairs, one-to-one). Grant funds from MCDHHS for fiscal year 2019 has been secured to continue cancer prevention outreach and education efforts. Year Two: Provided 3,435 encounters outreach and education on cancer prevention virtually and at community barbershops	Quarterly reports on encounters, cancer education provided by type
Initiative D	Key Action - Provide outreach and education on tobacco-free living	Goal: Reduce the number of new cancer cases, as well as illness, disability, and death caused by cancer. Objective: Provide educational, community-based and clinical programs to reduce the number of cancer cases, as well as illness, disability, and death caused by cancer.	Year One: Provided outreach and education on smoking cessation and lung cancer prevention to 1,822 community members during 113 educational sessions (community lectures, health fairs, one-to-one). Grant funds from MCDHHS for fiscal year 2019 has been secured to continue smoking cessation and lung cancer prevention outreach and education efforts. Year Two: Provided 1,062 virtual encounters	Number of class and outreach encounters, class completion rate
Initiative E	Key Action - Offer evidence-based Cancer: Thriving and Surviving (CTS) Program in English and Spanish	Goal: Reduce the number of new cancer cases, as well as illness, disability, and death caused by cancer. Objective: Provide educational, community-based and clinical programs to reduce the number of cancer cases, as well as illness, disability, and death caused by cancer.	N/A	Quarterly reports on encounters, attendance/completion rate, number of safety-net CTS referrals, pre/posttests, self-efficacy survey
Initiative F	Key Action - Provide HC Health Center referrals for breast, colonoscopies, and obesity and tobacco cessation referrals and/or counseling to eligible health center patients	Goal: Reduce the number of new cancer cases, as well as illness, disability, and death caused by cancer. Objective: Provide educational, community-based and clinical programs to reduce the number of cancer cases, as well as illness, disability, and death caused by cancer.	Year One: Provided 1,692 specialty care visits on site at HCHCs. Developed plan to restructure care management team to better meet patient needs; incorporated 1.0 FTE health navigator to assist with specialty referrals and SDOH needs and .5 FTE health navigator to conduct home visits and address SDOH needs; anticipate integration of dietitian in Q1 FY19Year Two:Provided 19 breast services referrals, 11 colon/rectal services referrals, 672 gastroenterology referrals, 9 weight management referrals, and 3 tobacco cessation referrals to health center patients.	Number of referrals made to primary care or othersocial services, % health center patients eligible for screenings receiving referrals (tobacco, mammogram, colonoscopy)
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q185. Please describe the initiative(s) addressing Health Conditions - Chronic Kidney Disease.

This question was not displayed to the respondent.

Q186. Please describe the initiative(s) addressing Health Conditions - Chronic Pain.

This question was not displayed to the respondent.

Q187. Please describe the initiative(s) addressing Health Conditions - Dementias.

This question was not displayed to the respondent.

Q188. Please describe the initiative(s) addressing Health Conditions - Diabetes.

Health Conditions - Diabetes Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Key Action - Provide care management, education and nutrition counseling at HC Health Centers for high-risk patients	Goal: Reduce the disease burden of diabetes mellitus. Objective: Decrease the number of low-income, uninsured/underinsured persons with uncontrolled diabetes	Year One: Added 1.0 MSW to support behavioral health; added 1.5 FTE community resource coordinator to conduct home visits and address SDOH needs; contract with dietitian to provide 1:1 counseling and group education classes; launched Target BP initiative. Year Two: Added 1.0 BSW to support case management; implemented Hypertension Care Management Team; behavioral health, care management and nutrition services moved virtual to support patients throughout the pandemic.	Quarterly reports on health center visits, clinical measures, readmissions/ED utilization, referrals to community health programs and social services
Initiative B	Key Action - Referral process for Montgomery Cares and outside organizations to DSMP classes offered by all health systems	Goal: Reduce the disease burden of diabetes mellitus. Objective: Decrease the number of low-income, uninsured/underinsured persons with uncontrolled diabetes	Year One: All health systems in Montgomery County developed a referral process to refer Montgomery Cares patients to diabetes self-management programs offered by the health systems, allowing patients ability to select programs based on time and location that fit their needs.Year Two: No Report. Program was paused due to the Covid-19 Pandemic	Number of referrals made

Initiative C	Key Action - Expand diabetes programming (English and Spanish) with Nexus Montgomery Regional Partnership Catalyst Diabetes Project (NMRP)(DPP and DSMT metric)	Goal: Reduce the disease burden of diabetes mellitus. Objective: Increase the self-management skills of adults diagnosed with diabetes and increase prevention behaviors in adults at high risk for diabetes	Year One: No report Year Two: In FY21 the NMRP project stood up DPP and DMST referrals through Maryland's CRISP system in the Spring of 2021. Working with NMRP Program Coordinators, this will allow for newly hired NMRP Case Managers to refer to available diabetes prevention and diabetes education programs in the targeted zip codes. The referral process will allow for identifying potentially eligible patients; screen patients for eligibility; refer to diabetes education classes and receive updates on referrals. HCH offered 3 DPP cohorts and 6 DMST cohorts.	# DPP and DSMP cohorts offered by qualified providers
Initiative D	Key Action - Offer Diabetes Prevention Program in English and Spanish	Goal: Reduce the disease burden of diabetes mellitus. Objective: Increase the self-management skills of adults diagnosed with diabetes and increase prevention behaviors in adults at high risk for diabetes	Year One: There were four cohorts in English and one cohort in Spanish with a total of 75 Participants. A staffing plan was developed to increase the number of part-time evidence-based program instructors and expand the number of programs offered.	Quarterly reports on encounters, average % weight loss, increase in physical activity, attendance/completion rate, DPP full recognition status
Initiative E	Key Action - Offer Stanford University's Diabetes Self-Management Program in English and Spanish	Goal: Reduce the disease burden of diabetes mellitus. Objective: Increase the self-management skills of adults diagnosed with diabetes and increase prevention behaviors in adults at high risk for diabetes	Year One: There were 584 encounters and 66% of participants completed the class.Year Two: All classes were moved to a virtual format using the WebEx platform. There were 422 encounters and 79% of participants completed the class	Quarterly reports on encounters, attendance/completion rate, number of safety-net DSMP referrals, pre/posttests, self-efficacy survey
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q189. Please describe the initiative(s) addressing Health Conditions - Foodborne Illness.

This question was not displayed to the respondent.

Q190. Please describe the initiative(s) addressing Health Conditions - Health Care-Associated Infections.

This question was not displayed to the respondent.

Q191. Please describe the initiative(s) addressing Health Conditions - Heart Disease and Stroke.

	Health Conditions - Heart Disease and Stroke Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Key Action - Implement care management team at HC Health Centersfor high-risk patients.	Goal: Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke. Objective: Decrease the number of low-income, uninsured/underinsured persons with uncontrolled hypertension.	Year One: Added 1.0 MSW to support behavioral health; added 1.5 FTE community resource coordinator to conduct home visits and address SDOH needs; contract with dietitian to provide 1:1 counseling and group education classes; launched Target BP initiative. Year Two: Added 1.0 BSW to support case management; implemented Hypertension Care Management Team; behavioral health, care management and nutrition services moved virtual to support patients throughout the pandemic.	Quarterly reports on clinical measures, readmissions/ED utilization, number of referrals to community health programsand social services
Initiative B	Key Action - Provide community-based cardiovascular education andprogramming through an equitable lens	Goal: Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke. Objective: FundProvide educational and community-based programs to improve cardiovascular health.	Year One: Provided cardiovascular education to 3,043 community members during 179 educational sessions (community lectures, health fairs, one-to-one). Implemented a blood pressure screening program at 4 community sites (Langley Park Community Center, Bauer Park Community Center, East County Community Center, White Oak Community Center); 423 blood pressure screenings were provided. Year Two: Provided 361 virtual encounters	Quarterly reports on encounters, number of blood pressures screenings
Initiative C	Key Action - Provide community fitness classes for adults and older adults aged 55+	Goal: Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke. Objective: FundProvide educational and community-based programs to improve cardiovascular health.	Year One: Offered multiple classes, including Zumba Gold, Ballet Gold, and Bollywood. More than 1200 seniors exercised daily through Senior Fit. In the fall of 2019, the Senior Source physical location was closed and all classes were moved to community sites. Colleagues worked diligently to increase partnerships with organizations such as Maryland Youth Ballet and Montgomery County Recreation, to move classes from the Senior Source to community-based locations. All classes were moved to a virtual setting using the WebEx platform in March of 2020. Year Two: Due to the pandemic, Community Health continued to offer fitness classes in a virtual setting. In FY21, there were 8,715 virtual fitness encounters and 45,677 Senior Fit virtual encounters.	Quarterly reports on encounters, number of blood pressures screenings, stroke program developed, number of fitness classes offered
Initiative D	Key Action - Develop evidence and place-based stroke awareness program	Goal: Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke. Objective: FundProvide educational and community-based programs to improve cardiovascular health.	Year One: Developed two stroke programs; one in partnership with Linkages to Learning school-based health centers and one in partnership with the Boys and Girls Club of Montgomery County. Year Two: No report	Stroke program developed

Initiative E	Key Action - Offer Stanford University's Chronic Disease Self-Management Program	Goal: Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke. Objective: FundProvide educational and community-based programs to improve cardiovascular health.	Year One: Received grant from the state of Maryland to train faith community nurses and health ministers to offer DSMP. Six churches recruited (three minority or non-English speaking) and trained seven people to offer DSMP in faith communitiesYear Two: All classes were moved to a virtual format using the WebEx platform. There were 495 encounters and 81% of participants completed the class.	Quarterly reports on encounters, # classes held
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q192. Please describe the initiative(s) addressing Health Conditions - Infectious Disease.

This question was not displayed to the respondent.

Q193. Please describe the initiative(s) addressing Health Conditions - Mental Health and Mental Disorders.

Health Conditions - Mental Health and Mental Disorders Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Key Action - Behavioral Health screenings with links to treatment at all health centers	Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services. Objective: Increase access to appropriate, quality mental health services.	Year One: The health centers had 1,492 behavioral health visits and 262 social work visits were provided and 84.4% of patients received depression screening during their primary care visitYear Two:The health centers had 776 behavioral health visits and 206 social work visits were provided in FY21. 94.9% of patients received depression screening during their primary care visit during CY21	Quarterly reports number behavioral health screenings conducted, #referred to social services and communityhealth programs, # referred to treatment
Initiative B	Key Action - Provide behavioral health services and links to treatment through the Nexus Montgomery Crisis House, ACT Teams, and behavioral health Integration	Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services. Objective: Increase access to appropriate, quality mental health services.	Year One: The average ACT Teams census was 82 and the Crisis House admissions were 351Year Two: Crisis House at 96% occupancy at end of year 2. ACT teams had active census of 148.	Number of persons served by CrisisHouse, number of full capacity ACT Teams; Interagency efforts to reduce hospital use by severely mentally ill patients,readmissions/ED utilization
Initiative C	Key Action - Offer Stanford University's Chronic Pain Self-Management Program	Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services. Objective: Increase access to appropriate, quality mental health services.	Year One: Implemented evidence-based program to provide non-pharmaceutical pain management skills to participants dealing with chronic pain. All health coaches were trained on the program.Year Two: All classes were moved to a virtual format using the WebEx platform. There were 359 encounters and 71% of participants completed the class	Quarterly reports on encounters, # classes held
Initiative D	Key Action - Collaborate with community partners to address behavioral health in the community	Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services. Objective: Increase access to appropriate, quality mental health services.	Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services. Objective: Increase access to appropriate, quality mental health services.	N/A
Initiative E	Key Action - Collaborate with faith community to train faith leadership on how to be first responders for mental health issues within their congregations and community	Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services. Objective: Increase access to appropriate, quality mental health services.	Year One: Scheduled First Aid for Mental Health training for faith community leaders, however, was canceled due to pandemic. Year Two: No report	Number of leaders trained
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q194. Please describe the initiative(s) addressing Health Conditions - Oral Conditions.

This question was not displayed to the respondent.

Q195. Please describe the initiative(s) addressing Health Conditions - Osteoporosis.

This question was not displayed to the respondent.

Q196. Please describe the initiative(s) addressing Health Conditions - Overweight and Obesity.

Health Conditions - Overweight and Obesity Initiative Details

	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes

Initiative A	Key Action - Kids Fit – physical activity program for adolescents	Goal: Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights. Objective: educe the proportion of children and adolescents who are considered obese.	Year One: Kids Fit held at five HOC buildings in upper Montgomery County. Year Two: Kids Fit was not held due to Covid-19.	Quarterly reports on encounters, number of Kids Fit participants, number Kids Fit participants taking PresidentialFitness Challenge, semi-annual fitness assessments
Initiative B	Key Action - BMI assessment and diagnosis of obesity for health center patients	Goal: Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights. Objective: Increase the proportion of primary care physicians who regularly assess body mass index (BMI) in their adult	Year One: CY20 performance for BMI at 57.2%, (Trinity target - 95%)Year Two: CY21 (Jan-June) performance for BMI at 64.5% (Trinity target - 95%)	Quarterly reports on percent patients with high BMI diagnosed as obese
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q197. Please describe the initiative(s) addressing Health Conditions - Pregnancy and Childbirth.

This question was not displayed to the respondent.

Q198. Please describe the initiative(s) addressing Health Conditions - Respiratory Disease.

This question was not displayed to the respondent.

Q199. Please describe the initiative(s) addressing Health Conditions - Sensory or Communication Disorders.

This question was not displayed to the respondent.

Q200. Please describe the initiative(s) addressing Health Conditions - Sexually Transmitted Infections.

This question was not displayed to the respondent.

Q201. Please describe the initiative(s) addressing Health Behaviors - Child and Adolescent Development.

This question was not displayed to the respondent.

Q202. Please describe the initiative(s) addressing Health Behaviors - Drug and Alcohol Use.

This question was not displayed to the respondent.

Q203. Please describe the initiative(s) addressing Health Behaviors - Emergency Preparedness.

This question was not displayed to the respondent.

Q204. Please describe the initiative(s) addressing Health Behaviors - Family Planning.

This question was not displayed to the respondent.

Q205. Please describe the initiative(s) addressing Health Behaviors - Health Communication.

This question was not displayed to the respondent.

Q206. Please describe the initiative(s) addressing Health Behaviors - Injury Prevention.

This question was not displayed to the respondent.

Q207. Please describe the initiative(s) addressing Health Behaviors - Nutrition and Healthy Eating.

This question was not displayed to the respondent.

Q208. Please describe the initiative(s) addressing Health Behaviors - Physical Activity.

This question was not displayed to the respondent.

Q209. Please describe the initiative(s) addressing Health Behaviors - Preventive Care.

This question was not displayed to the respondent.

Q210. Please describe the initiative(s) addressing Health Behaviors - Safe Food Handling.

This question was not displayed to the respondent.

Q211. Please describe the initiative(s) addressing Health Behaviors - Sleep.

This question was not displayed to the respondent.

Q212. Please describe the initiative(s) addressing Health Behaviors - Tobacco Use.

This question was not displayed to the respondent.

Q213. Please describe the initiative(s) addressing Health Behaviors - Vaccination.

This question was not displayed to the respondent.

Q214. Please describe the initiative(s) addressing Health Behaviors - Violence Prevention.

This question was not displayed to the respondent.

Q215. Please describe the initiative(s) addressing Populations - Adolescents.

This question was not displayed to the respondent.

Q216. Please describe the initiative(s) addressing Populations - Children.

	Populations - Children Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Key Action - Expand evidence-based/informed programs to include adolescents	Goal: Improve the health and well-being of women, infants, children, and families. Objective: Improve the health and well-being of women, infants, children, and families by providing educational and community-basedprograms and links to primary care and social services.	Year One: Increased offerings of Girl Talk and Safe Sitter moving programs into the community. All programs paused in March due to the Covid-19 pandemicYear Two: Safe Sitter had one virtual session in March 2021 with 4 registered. We have two more virtual sessions scheduled in September and December of 2021. The in-person class was one 6-hour day with a break for lunch. The first virtual session was three 2-hour sessions. For September and December we are going to do two 3-hour sessions and see which works better.	Quarterly reports on number of encounters, pre/posttests, participant surveys
Initiative B	Key Action - Provide Early Care and Education Program to decrease costs to government; increase educational achievement (and therefore greater earning power); and increase opportunity in adulthood	Goal: Improve the health and well-being of women, infants, children, and families. Objective: Improve the health and well-being of women, infants, children, and families by providing educational and community-basedprograms and links to primary care and social services.	Year One: Piloted one program on the campus of Holy Cross Germantown Hospital in partnership with Thriving Germantown and Sheppard Pratt (formerly Family Services, Inc.). Eighteen participants completed the program and obtained CPR certification. The second pilot was in partnership with Identity, Inc. and PEP and slated to begin in April of 2020. It was cancelled due to the pandemic.Year Two: Reassessed program based on feedback from first pilot cohort, increased partnerships and redesigned the program to increase focus on social and emotional learning, safety and development. Partnered with Montgomery College to increase economic development opportunities by designing the program to create a pathway for unlicensed childcare providers who wanted to obtain a license but faced multiple barriers.	Quarterly reports on number of encounters, pre/posttests, participant surveys
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q217. Please describe the initiative(s) addressing Populations - Infants.

	Populations - Infants Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes

Initiative A	Key Action - Provide prenatal care to 60% of Montgomery County Maternity Partnership Patients	Goal: Improve the health and well-being of women, infants, children, and families. Objective: Increase the proportion of low-income, uninsured pregnant women who receive early and adequate prenatal care.	Year One: There were 879 new admissions, with 19 babies delivered with a low birth weight (<2500 gms) rate of 1.9%.Year Two: There were 1168 new admissions, with 25 babies delivered with a low birth weight (<2500 gms) rate of 2.71%.	Quarterly reports on number of Maternity Partnership admissions, percent Maternity Partnership patients receiving early prenatal care, and percent low-birth weight deliveries; reduction in infant mortality; CHW encounters
Initiative B	Key Action - Provide perinatal education, baby care programs, and support services to expecting and new families in Montgomery & Prince George's County	Goal: Improve the health and well-being of women, infants, children, and families. Objective: Improve the health and well-being of women, infants, children, and families by providing educational and community-basedprograms and links to primary care and social services.	Year One: Provided education, baby care programs, and support services with 4,821 encounters Year Two: Provided education, baby care programs, and support services virtually with 2,207 encounters	Quarterly reports on number of encounters, pre/posttests, participant surveys
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q218. Please describe the initiative(s) addressing Populations - LGBT.

This question was not displayed to the respondent.

Q219. Please describe the initiative(s) addressing Populations - Men.

This question was not displayed to the respondent.

Q220. Please describe the initiative(s) addressing Populations - Older Adults.

	Populations - Older Adults Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Key Action - Provide physical and social activity programs for seniors aged 55+	Goal: Improve the health, function, and quality of life of older adults. Objective: Increase the proportion of older adults, including those with reduced physical or cognitive function, who engage in light,moderate, or vigorous leisure-time physical and/or social activities.	Year One: Provided physical and social activity programs ranging from contemporary discussions to Zumba gold with more than 12,000 encounters.Year Two: Provided physical and social activity programs virtually ranging from contemporary discussions to Zumba gold with more than 9,000 encounters	Quarterly reports on encounters, # programs offered; pre/posttests, participant surveys
Initiative B	Key Action - Partner with organizations and community centers to offer more senior-based services in the community	Goal: Improve the health, function, and quality of life of older adults. Objective: Increase the proportion of older adults, including those with reduced physical or cognitive function, who engage in light,moderate, or vigorous leisure-time physical and/or social activities.	Year One: Expanded partnerships to include the Maryland Youth Ballet, began discussions with MC Department of Recreation to grow existing partnership (paused due to Covid-19)Year Two: No Report	Number of organizations, number of events held at community sites, quarterly reports on encounters, # programs offered; pre/posttests, participant surveys
Initiative C	Key Action - Provide evidence-based falls prevention programs for seniors aged 55+	Goal: Improve the health, function, and quality of life of older adults. Objective: Reduce the rate of falls among older adults.	Year One: Provided balance programs and activities ranging from in person classes to balance/falls screenings with 533 encounters Year Two: No report due to Covid-19	Quarterly reports on encounters, # programs offered; pre/posttests, participant surveys
Initiative D	Key Action - Provide medical, social, rehabilitative and recreational programs for adults with a chronic health problem or are recovering from an acute illness through the Medical Adult Day Center (MADC)	Goal: Improve the health, function, and quality of life of older adults. Objective: Reduce the proportion of noninstitutionalized older adults with disabilities who have an unmet need for long-term services and supports.	Year One: Provided physical and social activity programs ranging from contemporary discussions to Zumba gold with more than 12,000 encounters.Year Two: MADC was closed to face to face services nearly all of FY 21 (participants returned in person late June 2021). We maintained contact with participants and families as well calling all participants every day -and documenting those interactions. July 2020 to November 2020 participants were called 7 days a week. November 2020 to June 2021, calls were made 5 days a week.Total encounters were 10,276	Quarterly reports for encounters, readmission rates, ED utilization, and clinical indicators, MADC daily census; participant surveys
Initiative E	Key Action - Provide education on MOLST/Advanced Directives	Goal: Improve the health, function, and quality of life of older adults. Objective: Reduce the proportion of noninstitutionalized older adults with disabilities who have an unmet need for long-term services and supports.	Year One: Provided education to all MADC participants and caregivers regarding MOLST and Advanced DirectivesYear Two: No report due to Covid-19 Pandemic	Number educated on advanced directives
Initiative F	Key Action - Provide social, rehabilitative, and recreational programs for adults with Alzheimer's disease and other dementia through the Medical Adult Day Center (MADC)	Goal: Improve the health, function, and quality of life of older adults. Objective: Reduce the morbidity and costs associated with, and maintain or enhance the quality of life for, persons with dementia, including Alzheimer's disease.	Year One: No Update. Year Two:Provided resources for online and virtual activities for participants and caregivers and provided a weekly "social hour" to participants. Caregiver support groups continued through out the year virtually.	Quarterly reports for encounters, attendance/completion rate, readmission/ED utilization, and clinical indicators, MADC daily census; participant surveys
Initiative G	Key Action - Provide evidence-based memory programs for seniors aged 55+	Goal: Improve the health, function, and quality of life of older adults. Objective: Reduce the morbidity and costs associated with, and maintain or enhance the quality of life for, persons with dementia, including Alzheimer's disease.	Year One: Provided memory programs and activities ranging from in person classes to memory screenings with 547 encounters from July 2019 - March 2020.Year Two: Due to the pandemic, Community Health moved education and prevention classes to a virtual setting using the WebEx platform. In FY21, there were 659 virtual encounters.	Quarterly reports on encounters, attendance/completion rate, readmission/ED utilization, and clinical indicators, MADC daily census; participant surveys

Initiative H	Key Action - Maintain MADC's status as a Dementia Care Program of Distinction	Goal: Improve the health, function, and quality of life of older adults. Objective: Reduce the morbidity and costs associated with, and maintain or enhance the quality of life for, persons with dementia, including Alzheimer's disease.	Year One: MADC recognized as a Dementia Care Program of Distinction Year Two: No report due to the Covid-19 pandemic. The application was halted due to Covid. Will reapply in FY 22	Quarterly reports for encounters, attendance/completion rate, readmission/ED utilization, and clinical indicators, MADC daily census; participant surveys
Initiative I				
Initiative J				
All Other Initiatives				

Q221. Please describe the initiative(s) addressing Populations - Parents or Caregivers.

This question was not displayed to the respondent.

Q222. Please describe the initiative(s) addressing Populations - People with Disabilities.

This question was not displayed to the respondent.

Q223. Please describe the initiative(s) addressing Populations - Women.

	Populations - Women Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Key Action - Increase the number of programs focusing on healthy birth outcomes for women of color (morbidity and mortality)	Goal: Improve the health and well-being of women, infants, children, and families. Objective: Improve the health and well-being of women, infants, children, and families by providing educational and community-based programs and links to primary care and social services.	Year One: No report. Year Two: Develop evidence-informed program focusing on African American/Black and Latinx pregnant women diagnosed or at-risk for gestational diabetes and pre-eclampsia	Quarterly reports on number of encounters, pre/posttests, participant surveys
Initiative B	Key Action - Develop evaluation framework for perinatal education programs to identify and measure outcome indicators	Goal: Improve the health and well-being of women, infants, children, and families. Objective: Improve the health and well-being of women, infants, children, and families by providing educational and community-based programs and links to primary care and social services.	Year One: Community Health Evaluation Framework developed and implemented	Development of evaluation framework
Initiative C	Key Action - Provide prenatal care to 60% of Montgomery County Maternity Partnership Patients	Goal: Improve the health and well-being of women, infants, children, and families. Objective: Improve the health and well-being of women, infants, children, and families by providing educational and community-based programs and links to primary care and social services.	Year One: There were 879 new admissions, with 19 babies delivered with a low birth weight (<2500 gms) rate of 1.9%.Year Two: There were 1168 new admissions, with 25 babies delivered with a low birth weight (<2500 gms) rate of 2.71%.	Quarterly reports on number of Maternity Partnership admissions, percent Maternity Partnership patients receiving early prenatal care, and percent low-birth weight deliveries; reduction in infant mortality; CHW encounters
Initiative D	Key Action - Provide perinatal education, baby care programs, and support services to expecting and new families in Montgomery & Prince George's County	Goal: Improve the health and well-being of women, infants, children, and families. Objective: Improve the health and well-being of women, infants, children, and families by providing educational and community-based programs and links to primary care and social services.	Year One: Provided education, baby care programs, and support services with 4,821 encounters Year Two: Provided education, baby care programs, and support services virtually with 2,207 encounters	Quarterly reports on number of encounters, pre/posttests, participant surveys
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q224. Please describe the initiative(s) addressing Populations - Workforce.

This question was not displayed to the respondent.

Q225. Please describe the initiative(s) addressing Settings and Systems - Community.

This question was not displayed to the respondent.

Q226. Please describe the initiative(s) addressing Settings and Systems - Environmental Health.

This question was not displayed to the respondent.

Q227. Please describe the initiative(s) addressing Settings and Systems - Global Health.

This question was not displayed to the respondent.

Q228. Please describe the initiative(s) addressing Settings and Systems - Health Care.

This question was not displayed to the respondent.

Q229. Please describe the initiative(s) addressing Settings and Systems - Health Insurance.

This question was not displayed to the respondent.

Q230. Please describe the initiative(s) addressing Settings and Systems - Health IT.

This question was not displayed to the respondent.

Q231. Please describe the initiative(s) addressing Settings and Systems - Health Policy.

This question was not displayed to the respondent.

Q232. Please describe the initiative(s) addressing Settings and Systems - Hospital and Emergency Services.

This question was not displayed to the respondent.

Q233. Please describe the initiative(s) addressing Settings and Systems - Housing and Homes.

	Settings and Systems - Housing and Homes Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Key Action - Partner with community based organizations to deliver GED and ESOL classes	Goal: Create social and physical environments that promote good health for all. Objective: Decrease the proportion of households that experience housing cost burden.	N/A	Strategies developed to advancehealth equity and healthy behaviors; number health equity and healthy behavior strategies implemented
Initiative B	Key Action - Pathways to Independent Employment Program	Goal: Create social and physical environments that promote good health for all. Objective: Decrease the proportion of households that experience housing cost burden.	Year One: Two individuals were hired via the PIE Program Year Two: One individual was hired via the PIE Program	# of individuals hired
Initiative C				
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q234. Please describe the initiative(s) addressing Settings and Systems - Public Health Infrastructure.

This question was not displayed to the respondent.

Q235. Please describe the initiative(s) addressing Settings and Systems - Schools.

This question was not displayed to the respondent.

Q236. Please describe the initiative(s) addressing Settings and Systems - Transportation.

This question was not displayed to the respondent.

Q237. Please describe the initiative(s) addressing Settings and Systems - Workplace.

This question was not displayed to the respondent.

Q238. Please describe the initiative(s) addressing Social Determinants of Health - Economic Stability.

This question was not displayed to the respondent.

Q239. Please describe the initiative(s) addressing Social Determinants of Health - Education Access and Quality.

This question was not displayed to the respondent.

Q240. Please describe the initiative(s) addressing Social Determinants of Health - Health Care Access and Quality.

	Social Determinants of Health - Health Care Access and Quality Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes

Initiative A	Key Action - Operate four health centers for the un/underinsured ingeographically accessible locations	Goal: Create social and physical environments that promote good health for all. Objective: Decrease the number of persons unable to access primary care services.	Year One: 954 above budget for HCHCs (2.23%), -1,164 below budget at Germantown (-13.27%). Pivoted to virtual visits (video and telephone) to continue to provide care during pandemicYear Two: 1,245 above budget for HCHCs (2.65%), -233 below budget at Gaithersburg (-1.87%); moved Aspen Hill health center to new location	Quarterly reports on encounters, patient visits, clinical measures
Initiative B	Key Action - Develop SIOH screening and referral process flow to capture data in EPIC at Holy Cross Health Centers and Health Partners sites	Goal: Create social and physical environments that promote good health for all. Objective: Decrease the number of persons unable to access primary care services.	N/A	Number patients screened, Number of patients referred to resources
Initiative C	Key Action - Use Aunt Bertha Care Coordination software to coordinatecare and link patients, colleagues and community members to social services	Goal: Create social and physical environments that promote good health for all. Objective: Decrease the number of persons unable to access primary care services.	N/A	Number of patients/community members withcoordination plans in Aunt Bertha, number of organizations with claimed sites in Aunt Bertha
Initiative D	Key Action - Implement plan to link uninsured Maternity Partnershippatients to primary care services at HC Health Centers tocreate a medical home for the whole family	Goal: Create social and physical environments that promote good health for all. Objective: Decrease the number of persons unable to access primary care services.	Year One: Initiatives implemented to increase awareness of HCHC in Germantown among Maternity Partnership patients and MPC members. There were 90 unique newborns at GermantownYear Two: Initiatives implemented to increase awareness of HCHC in Germantown among Maternity Partnership patients and MPC members. There were 69 unique newborns at Germantown	Number of maternity partnership patients linked to Germantown health center
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

Q241. Please describe the initiative(s) addressing Social Determinants of Health - Neighborhood and Built Environment.

This question was not displayed to the respondent.

Q242. Please describe the initiative(s) addressing Social Determinants of Health - Social and Community Context.

This question was not displayed to the respondent.

Q243. Please describe the initiative(s) addressing other priorities.

	Other Initiative Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Key Action - Implement support groups to address the social and mental health impact of the Covid-19 pandemic	Goal: Develop programs and initiatives to address emerging trends not identified in the current CHNA. Objective: Address the mental, physical and social impact of Covid-19 on the communities we serve.	N/A	Number of support groups held, number of encounters, pre-post surveys
Initiative B	Key Action - Implement self-management and education program for Covid Long Haulers	Goal: Develop programs and initiatives to address emerging trends not identified in the current CHNA. Objective: Address the mental, physical and social impact of Covid-19 on the communities we serve.	N/A	Quarterly reports on encounters, attendance/completion rate, number of referrals, pre/posttests, self-efficacy survey
Initiative C	Key Action - Collaborate with faith-based, community-based and other organizations to provide vaccine clinics and education to decrease vaccine barriers and hesitancy to increase the Covid-19 vaccination rates in areas with high Covid-19 cases and death rates	Goal: Develop programs and initiatives to address emerging trends not identified in the current CHNA. Objective: Address the mental, physical and social impact of Covid-19 on the communities we serve.	N/A	Number vaccinated, number of encounters, number of vaccination events in target areas
Initiative D	Key Action - Increase availability and access to healthy and/or culturally appropriate food	Goal: Create social and physical environments that promote good health for all. Objective: Reduce household food insecurity and in doing so reduce hunger.	Year One: Rec'd POL funding to implement Community Greenhouse on campus of Holy Cross Germantown Hospital; building postponed due to Covid-19 Year Two: Rec'd POL funding to implement Community Garden on campus of Holy Cross Germantown Hospital	Number partners identified, Number partners involved,Number community members reserving plots, lbs. produce grown
Initiative E	Key Action - Increase food literacy	Goal: Create social and physical environments that promote good health for all. Objective: Reduce household food insecurity and in doing so reduce hunger.	N/A	Number classes held, Number of participants, %improvement in self-efficacy, class completion rate
Initiative F	Key Action - Develop and implement plan for Transforming Communities Initiative (TCI) – Policy, System, and Environmental strategies to address CHNA priorities	Goal: Create social and physical environments that promote good health for all. Objective: Implement policy, system and environmental change strategies that support optimal health and well-being and reduce unhealthful behaviors.	N/A	Number of community members and community organizations engaged in plan development, number CHNA priorities addressed, plan developed
Initiative G	Key Action - Create informal community advisory groups to engage and lead ongoing community conversations to identify needs and develop solutions.	Goal: Create social and physical environments that promote good health for all. Objective: Implement policy, system and environmental change strategies that support optimal health and well-being and reduce unhealthful behaviors.	Year One: Community Conversations held and feedback was used to inform CHNA Year Two: Four virtual Community Conversations were held to connect community members to services and identify needs during the pandemic	Number of community conversations held, number of advisory groups formed and engaged, number of community informed or led solutions developed
Initiative H	Key Action - Advocate for racial justice by leveraging advocacy activities at local, state, and federal level	Goal: Create social and physical environments that promote good health for all. Objective: Implement policy, system and environmental change strategies that support optimal health and well-being and reduce unhealthful behaviors.	N/A	Activities leveraged, plans developed, number of partners engaged, percent of colleague participation in e-advocacy campaign(s)

Initiative I	Key Action - Complete organizational wide cultural competency and anti-racism training	Goal: Create social and physical environments that promote good health for all. Objective: Implement policy, system and environmental change strategies that support optimal health and well-being and reduce unhealthful behaviors.	N/A	Percent of colleagues trained
Initiative J				
All Other Initiatives				

Q130. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- (●) Yes
- ( ) No

Q131.

In your most recently completed CHNA, the following community health needs were identified:
Health Conditions - Cancer, Health Conditions - Diabetes, Health Conditions - Heart Disease and Stroke, Health Conditions - Mental Health and Mental Disorders, Health Conditions - Overweight and Obesity, Populations - Children, Populations - Infants, Populations - Older Adults, Populations - Women, Settings and Systems - Housing and Homes, Social Determinants of Health - Health Care Access and Quality, Other (specify)
Other: SDOH - Food Security

Using the checkboxes below, select the needs that appear in the list above that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q132. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q244. Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

Holy Cross Health strives to build healthy communities, through engagement and action, throughout Montgomery and Prince George's Counties. The programs and services we provide go beyond clinical care to improve the health of the community—especially for those most vulnerable. To achieve this goal, we focus on health equity, prevention, and self-management and develop and support sustainable strategies through policy, system, and environmental changes. To advance health equity, we use a framework with three areas of focus: address individual needs, partner for system change, and advocate for public policy change. We use this approach both externally and internally. Internally we address the social needs of our colleagues by assessing colleagues and linking those with identified needs to our community health workers and host monthly food distributions for colleagues in need. In addition, our multi-disciplinary Diversity and Inclusion team focuses on systems change within the health system by raising awareness of systemic racism and health equity issues, reviewing our hiring practices, and implementing unconscious bias training for staff. We also recognize the importance of collecting and reporting accurate Race, Ethnicity, and Language (REaL) data to identify opportunities and measure progress within our health system. In the fall of 2021, we will implement a new electronic health record system to assist us in collecting and reporting accurate REaL data on our patients. Externally we align this framework with our community health needs assessment's identified priorities (social determinants of health, vulnerable populations, and chronic diseases) to develop community programs and initiatives to reduce or eliminate health disparities. However, we realize that we cannot do this work alone and turn to our community partners to leverage resources and implement or expand strategies that support thriving, equitable communities. We also advocate for change at the county, state, and federal levels. For example, we are currently developing a plan with our state government affairs representative/lobbyist to meet with state legislative leaders during the interim to encourage the legislature to declare racism as a public health crisis when it reconvenes in January 2022.

Q245. If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

- [ ] Regional Partnership Catalyst Grant Program
- [ ] The Medicare Advantage Partnership Grant Program
- [ ] The COVID-19 Long-Term Care Partnership Grant
- [ ] The COVID-19 Community Vaccination Program
- [ ] The Population Health Workforce Support for Disadvantaged Areas Program
- [ ] Other (Describe)

Q129. If you wish, you may upload a document describing your community benefit initiatives in more detail.

Q60. Section III - CB Administration

Q61. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- [ ] Yes, by the hospital's staff
- [x] Yes, by the hospital system's staff
- [x] Yes, by a third-party auditor

☐ No

Q246. Please describe the third party audit process used.

The HSCRC financial spreadsheet is included in the annual community benefit plan and undergoes a series of internal reviews by community benefit and accounting staff, prior to the final review by a third party auditor. Trinity Health contracts with a third party auditor to review community benefit financials at the close of each fiscal year. The third party auditor randomly selects occurrences in CBISA and cross-checks these figures with information included in Holy Cross Health's financial management system, and follows up with key personnel if any discrepancies are identified. At the completion of the community benefit audit a summary of the HSCRC spreadsheet is included in the organization's audited financials. The spreadsheet is then added to the annual community benefit plan and undergoes the process described in the community benefit narrative audit process referenced in the next question.

Q62. Does your hospital conduct an internal audit of the community benefit narrative?

◉ Yes
○ No

Q63. Please describe the community benefit narrative audit process.

The HSCRC narrative is included in the annual community benefit plan and undergo a series of internal reviews prior to the final review and approval made by the Holy Cross Health Board of Directors. The annual community benefit plan was written by the community benefit officer and reviewed by the President, Holy Cross Health Network. The community benefit plan was then reviewed by the CEO Review Committee on Community Benefit and Population Health, followed by review and approval by the Mission and Population Health Committee of the Board of Directors. If the Mission and Population Health Committee of the Board of Directors approves the report, it is then recommended for approval by the full Holy Cross Health Board of Directors.

Q64. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

◉ Yes
○ No

Q65. Please explain:

This question was not displayed to the respondent.

Q66. Does the hospital's board review and approve the annual community benefit narrative report?

◉ Yes
○ No

Q67. Please explain:

This question was not displayed to the respondent.

Q68. Does your hospital include community benefit planning and investments in its internal strategic plan?

◉ Yes
○ No

Q69. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

We fully integrate our commitment to community service into our management and governance structures as well as our strategic and operational plans and we are rigorous in monitoring and evaluating our progress. We focus our community benefit activity at the intersection of documented unmet community health needs and Holy Cross Health's organizational strengths and mission commitments. Our community benefit plan is closely aligned with Holy Cross Health's population health management plan and complements our other key planning documents including the budget, the human resources plan and the quality plan. Our annual planning of community benefit programs is guided by the strategic plan. Holy Cross Health's fiscal 2019-2022 strategic plan identifies six three strategic principles that frame our response to the evolving environment. P - People Centered Care: Providing innovative patient care, excellent care delivery and improved clinical outcomes E - Engaged Colleagues: Attracting, developing, and retaining exceptional and committed colleagues. O - Operational Excellence: Ensuring efficient and effective care delivery P - Physician Collaboration: Engaging physicians for mutual benefit in activities that attract patients and better manage care L - Leadership Nationally and Locally: Improving the health and well-being of our community through innovation and expanding expertise E - Effective Stewardship: Stewarding our resources to best manage revenue and expenses.

Q70. If available, please provide a link to your hospital's strategic plan.

https://www.holycrosshealth.org/about-us/about-holy-cross-health/strategic-plan

Q133. Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

- [x] Diabetes - Reduce the mean BMI for Maryland residents
- [ ] Opioid Use Disorder - Improve overdose mortality
- [x] Maternal and Child Health - Reduce severe maternal morbidity rate
- [ ] Maternal and Child Health - Decrease asthma-related emergency department visit rates for children aged 2-17

Q134. (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

Q135. Section IV - Physician Gaps & Subsidies

Q223. Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- (●) No
- ( ) Yes

Q218. As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

This question was not displayed to the respondent.

Q219. Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

This question was not displayed to the respondent.

Q139. Please attach any files containing further information and data justifying physician subsidies your hospital.

This question was not displayed to the respondent.

Q140. Section VI - Financial Assistance Policy (FAP)

Q141. Upload a copy of your hospital's financial assistance policy.

patient-financial-assistance-policy-english_sept-2020.pdf
222.3KB
application/pdf

Q220. Provide the link to your hospital's financial assistance policy.

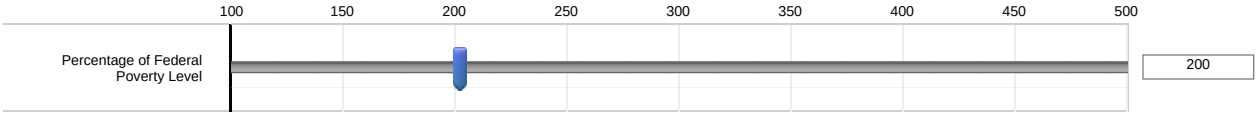
https://www.holycrosshealth.org/assets/documents/financial_forms/patient-financial-assistance-policy-english_sept-2020

Q147. Has your FAP changed within the last year? If so, please describe the change.

- (●) No, the FAP has not changed.
- ( ) Yes, the FAP has changed. Please describe:

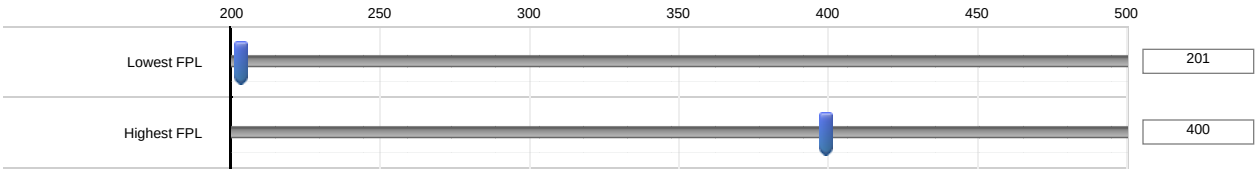
Q143. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

Please select the percentage of FPL below which your hospital's FAP offers free care.



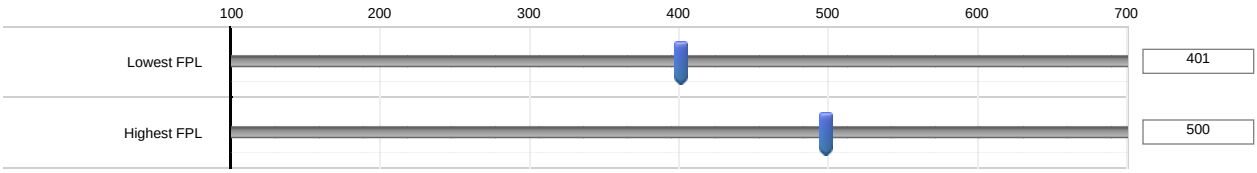
Q144. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care.

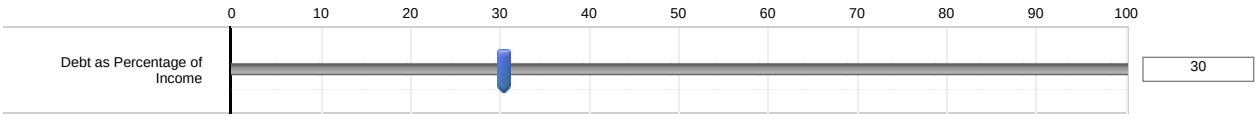


Q145. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care for financial hardship.



Q146. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q221. Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding tax able year (select all that apply)

- [x] Federal corporate income tax
- [x] State corporate income tax
- [x] State sales tax
- [x] Local property tax (real and personal)
- [ ] Other (Describe)

Q150. Summary & Report Submission

Q151.

Attention Hospital Staff! IMPORTANT!

You have reached the end of the questions, but you are not quite finished. Your narrative has not yet been fully submitted. Once you proceed to the next screen using the right arrow button below, you cannot go backward. You cannot change any of your answers if you proceed beyond this screen.

We strongly urge you to contact us at hcbhelp@hilltop.umbc.edu to request a copy of your answers. We will happily send you a pdf copy of your narrative that you can share with your leadership, Board, or other interested parties. If you need to make any corrections or change any of your answers, you can use the Table of Contents feature to navigate to the appropriate section of the narrative.

Once you are fully confident that your answers are final, return to this screen then click the right arrow button below to officially submit your narrative.

Location Data

Location: (39.126907348633, -76.697998046875)

Source: GeoIP Estimation

Summary of Holy Cross Health's Significant Community Benefit Programming in Response to Identified Unmet Health Care Needs: Fiscal 2018, Q2

Maternal and Infant Health

FY2021

Measure	Annual Target	YTD Target	YTD Actual
Maternity Partnership Low-birth Weight	8.5%	8.5%	2.7%
Perinatal Class Encounters	8,000	8,000	2,207

CHNA Impact Measures	Baseline	Target	MC Actual	
Increase percent of mothers receiving early prenatal care*	63.1%	66.9%	70.9%	↑
Reduce the percent of low birth weight infants*	8.2%	8.0%	7.5%	↓
Decrease infant mortality rate*	5.5	6.3	4.60	↓

CHNA Impact Measures	Baseline	Target	PGC Actual	
Increase percent of mothers receiving early prenatal care*	54.0%	66.9%	54.7%	↑
Reduce the percent of low birth weight infants*	10.0%	8.0%	9.8%	↑
Decrease infant mortality rate*	8.6	6.3	8.2	↓

Seniors

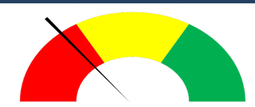
FY2021

Measure	Annual Target	YTD Target	YTD Actual
Senior Program Encounters	13,303	13,303	9,374
Average Senior Fit Weekly Virtual Encounters YTD	800	800	1,192
Falls Risk Assessments (if available) BioSway/Biodex, Get	0	0	No Data

CHNA Impact Measures	Baseline	Target	MC Actual	
Increase average life expectancy*	84.1	79.8	84.8	=
Decrease fall-related deaths*	7.1	7.7	7.3	↑

CHNA Impact Measures	Baseline	Target	PGC Actual	
Increase average life expectancy*	79.2	79.8	79.1	↓
Decrease fall-related deaths*	6.4	7.7	7.7	↑

Cardiovascular Health



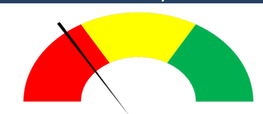
FY2021

Measure	Annual Target	YTD Target	YTD Actual
Senior Fit particpants at or above 75 percentile for 2 minute step test	Baseline	Baseline	No Data
Percent of health center patients with diagnosis of HTN with good blood pressure control	80%	80%	53.5%

CHNA Impact Measures	Baseline	Target	MC Actual	
Decrease heart disease mortality*	136.4	166.3	104.5	↓
Decrease stroke mortality†	30.1	34.8	24.5	↓
Decrease percent of adults told by health professional they have high blood pressure†	21.6%	26.9%	36.0%	↑

CHNA Impact Measures	Baseline	Target	PGC Actual	
Decrease heart disease mortality*	191.2	166.3	178.1	↑
Decrease stroke mortality†	35.2	34.8	41.6	↑
Decrease percent of adults told by health professional they have high blood pressure†	36.3%	26.9%	31.9%	↓

Obesity



FY2021

Measure	Annual Target	YTD Target	YTD Actual
Average Kids Fit Participants per Month	17	17	No Data
% of Health Ctr patients diagnosed w/ high/low BMI w/ documented follow-up plan	95%	95%	64.5%

CHNA Impact Measures	Baseline	Target	MC Actual	
Decrease percent of high students with no participation in physical activityΔ	16.5%	18.0%	17.6%	↑
Decrease percent of students who are obese*	8.7%	10.7%	7.5%	=
Increase percent of students who drank no soda or pop in the past weekΔ	33.0%	28.4%	34.2%	↑

CHNA Impact Measures	Baseline	Target	PGC Actual	
Decrease percent of students with no participation in physical activityΔ	23.2%	18.0%	25.6%	↑
Decrease percent of students who are obese*	13.7%	10.7%	15.1%	↓
Increase percent of students who drank no soda or pop in the past weekΔ	28.0%	28.4%	27.7%	=

Diabetes

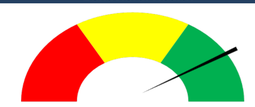
FY2021

Measure	Annual Target	YTD Target	YTD Actual
Average number of DPP sessions attended per quarter	3	3	7.7
% of Health Ctr patients w/ diabetes (type 1 & 2) with most recent HbA1c > 9.0% or was missing a result	19%	19%	49.5%

CHNA Impact Measures	Baseline	Target	MC Actual	
Decrease number of adults ever being told they have diabetes (exluding gestational)◊	5.1%	10.2%	7.0%	↑
Decrease ER visits for diabetes*	102.8	186.3	127.9	↑

CHNA Impact Measures	Baseline	Target	PGC Actual	
Decrease number of adults ever being told they have diabetes (exluding gestational)◊	13.5%	10.2%	12.3%	↑
Decrease ER visits for diabetes*	280.5	186.3	229.2	↑

Behavioral Health



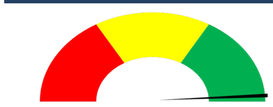
FY2021

Measure	Annual Target	YTD Target	YTD Actual
% of health ctr patients receiving depression screening during primary care visit	96.9%	96.9%	94.9%
Chronic Pain Self Management Encounters	200	200	350

CHNA Impact Measures	Baseline	Target	MC Actual	
Decrease adolescent and adult illicit drug use in past month (12 or older)†	6.1%	9.7%	8.9%	=
Decrease percent of adults with any mental illness in past yearΔ	16.8%	16.8%	16.2%	↓
Decrease mental health related ER visits*	1,528	3,153	2,312	↑
Decrease suicide rate*	6.5	9.0	7.3	↑

CHNA Impact Measures	Baseline	Target	PGC Actual	
Decrease adolescent and adult illicit drug use in past month (12 or older)†	7.1%	9.7%	10.5%	=
Decrease percent of adults with any mental illness in past yearΔ	15.8%	16.8%	15.9%	=
Decrease mental health related ER visits*	2,722	3,153	1,956	↑
Decrease suicide rate*	5.7	9.0	5.7	=

Cancers



FY2021

Measure	Annual Target	YTD Target	YTD Actual
CHW Cancer Education Virtual Encounters	600	600	3435
% of Health Center patients receiving Tobacco Screening	99.0%	99.0%	99.1%

CHNA Impact Measures	Baseline	Target	MC Actual	
Increase colorectal cancer screening (colonoscopy or sigmoidoscopy)◊	72.9%	73.0%	74.2%	↑
Increase percent of women who have had a Pap in past three years◊	83.0%	93.0%	94.4%	↑
Decrease prostate cancer incidence◊	159.3	135.0	111.4	↓
Decrease breast cancer mortality†	19.8	20.7	23.7	↑

CHNA Impact Measures	Baseline	Target	PGC Actual	
Increase colorectal cancer screening (colonoscopy or sigmoidoscopy)◊	71.7%	73.0%	72.4%	↓
Increase percent of women who have had a Pap in past three years◊	82.0%	93.0%	93.2%	↑
Decrease prostate cancer incidence◊	183.3	135.0	147.00	↓
Decrease breast cancer mortality†	28.2	20.7	25.8	↓

* MD SHIP
† HP 2020

Δ Median
◊ Represent

↑↓
↑↓
= No Change

12	2020	Annual Target	YTD Target	YTD Actual	Q1	Q2	Q3	Q4	***Comments*** *Please use this space to explain how you plan to improve your metrics that are in the yellow or red.*	
	Social Care Encounters (Total)	**13297**	13297	20,530	**4109**	**5199**	**5533**	**5689**	*CHWB Trinity Tool*	
Access/Social Influencers of Health	Social Care Encounters: Health Care Access Referrals	**8.7%**	**8.7%**	7.6%	**0**	**7.4%**	**5.90%**	**7.60%**	*Cummulative - pull from colleague assessment tool (column K)/Assessment Total (column B)*	Debra Wylie/Kim McBride
	Holy Cross Germantown Health Center Newborn visits	75	75	69	**19**	**15**	**18**	**17**	*Due to changes in reporting and calculations from PTTS, the data now reflects the number of OB clinic births where the newborn had a pediatric visit at HCHC-GT within 30 days of birth that occurs in the time period: majority of newborn visits are maternity partnership patients*	Jess Kelly
	Social Care Encounters: Food (Run Out)	**8.5%**	**8.5%**	36.70%	**0**	**36.8%**	**38.90%**	**36.70%**	*Cummulative - pull from colleague assessment tool (column I)/Assessment Total (column B)*	Debra Wylie/Kim McBride
	Social Care Encounters: Housing Referrals	**34.3%**	**34.3%**	28.70%	**0**	**28.1%**	**27.70%**	**28.70%**	*Cummulative - pull from colleague assessment tool (column G)/Assessement Total (column B)*	Debra Wylie/Kim McBride
	Food Literacy Encounters	**100**	100	No Data	**No Data**	**No Data**	**No Data**	**No Data**		Michelle Blanc
	Percent Greenhouse plots occupied	**30%**	0	No Data	**No Data**	**No Data**	**No Data**	**No Data**		Jessica Yi
Maternal and Infant Health	Maternity Partnership Low-birth Weight	8.5%	8.5%	2.71%	**2.6%**	**2.63%**	**2.71%**	**2.7%**		Fatima Angeles-Reyes
	Total Perinatal Class Encounters (excluding tours)	8,000	8,000	2,207	**460**	**393**	**608**	**746**		Marianne Wysong
Seniors	Senior Progarm Encounters	13,303	13,303	9,374	**2,014**	**2,246**	**2,602**	**2,512**	Movement/Body (55+), med review and memory academy	Kathleen Williams
	Average Senior Fit Weekly Virtual Encounters YTD	800	800	1,192	**808**	**843**	**1,294**	**1,192**	SF+BB Oct+Nov+Dec/3 months/4 weeks	Kathleen Williams
	Falls Risk Assessments (if available) BioSway/Biodex, Get Up & Go, Chair Stand and Gait & Balance		0	No Data	**No Data**	**No Data**	**No Data**	**No Data**		Kathleen Williams
Cardiovascular Health	Senior Fit particpants at or above 75 percentile for 2 minute step test	Baseline	Baseline	No Data	**No Data**	**No Data**	**No Data**	**No Data**		Kathleen Williams
	Percent of health center patients with diagnosis of HTN with good blood pressure control	80.0%	80.0%	53.5%	**44.6%**	**44.05%**	**37.11%**	**53.5%**		Carolina de la Puente
Obesity	Average Kids Fit Participants per Month YTD	17	17.0	No Data	**No Data**	**No Data**	**No Data**	**No Data**		Sarah McKechnie
	Percent of adult Health Center patients diagnosed with high/low BMI with documented follow-up plan	95.0%	95.0%	64.5%	**62.5%**	**57.21%**	**34.75%**	**64.54%**		Carolina de la Puente
Diabetes	Average number of DPP sessions attended per quarter	3	3	7.7	**5.2**	**8.1**	**6.9**	**7.7**		Margarette Acevero
	Percent of Health Center patients with diabetes (type 1 and 2) with most recent HbA1c > 9.0% or was missing a result	19%	19%	49.5%	**No Data**	**55.9%**	**62.78%**	**49.46%**		Carolina de la Puente
Behavioral Health	Percent of health center patients receivng depression screening during primary care visit	96.9%	96.9%	94.9%	**90.2%**	**91.20%**	**94.6%**	**94.9%**		Carolina de la Puente
	Chronic Pain Self-Managemnt Encounters	200	200	350	**69**	**172**	**48**	**61**		Sarah McKechnie/Daneh
Cancers	CHW Cancer Education Virtual Encounters	600	600	3,435	**3**	**206**	**890**	**2336**		Shelly Tang
	Percent of Health Center patients receiving Tobacco Screening	99.0%	99%	99.1%	**98.8%**	**98.93%**	**98.87%**	**99.06%**		Carolina de la Puente

0.92

2.4

4.67

Met Target
Met ≥ 75% of Target but ≤ 99.9% of Target
Met < 75% of Target
TBD Data not yet available
New metric
Manually enter number; formula does not pull from cell
Target determined once in person prorgramming resumes

3	2021	Annual Target	YTD Target	YTD Actual	Q1	Q2	Q3	Q4	***Comments*** *Please use this space to explain how you plan to improve your metrics that are in the yellow or red.*	
Maternal and Infant Health	Maternity Partnership Admissions	1012	253	**242**	**242**					Nancy Nagel/Fatima Angeles-Reyes
	Percent of Maternity Partnership mothers receiving early prenatal care	66.9%	66.9%	**29.8%**	**29.8%**					Nancy Nagel/Fatima Angeles-Reyes
	Maternity Partnership Low-birth Weight	8.5%	8.5%	**2.56%**	**2.6%**					Nancy Nagel/Fatima Angeles-Reyes
	Total Perinatal Class Encounters (excluding tours)	3,000	750	**409**	**409**				We are exploring alternative delivery methods to reduce barriers to accessibility. Also broadening class choices by reviving classes that were previously not running and offering new classes.	Michelle Blanc/Marianne Wysong
	Holy Cross Germantown Health Center Newborn visits	75	19	**19**	**19**					Jess Kelly
Seniors	Senior Source Encounters	13,303	3,326	**706**	**706**				Provided from Daneh - described as "Kim's Number"	Kathleen Williams
	Fall Assessments BioSway/Biodex, Get Up & Go, Chair Stand and Gait & Balance	328	82	**0**	**0**				Not occurring virtually	Kathleen Williams
	Falls Risk Screening	76	19	**0**	**0**				Not occuring virtually	Kathleen Williams
	Average MADC daily census	28	28	**0**	**42**				Continue with phone calls to all participants 7 days a week.	Kathleen Williams
Cardiovascular Health	CHW Cardiovascular Education Encounters	100	25	**0**	**0**				TARGET - There are no grant funds currently available to support CHW CVD education; FY21 target 100 will reflect CVD education that may be provided paired with funded topics to include cancer and diabetes prevention.	Shelly Tang
	Average Senior Fit Weekly Participants YTD	1271	1271	**808**	**808**				all Q1 virtual. (Mnthly encounters/weeks of month) + all 3 months then divide by 3.	Kathleen Williams
	Percent of health center patients with diagnosis of HTN with good blood pressure control	80.0%	80.0%	**44.6%**	**44.6%**				Telehealth	Carolina de la Puente
Obesity	Average Kids Fit Participants per Month YTD	17	17.0	**No Data**	**No Data**				No Kids Fit Classes being held at this time	Sarah McKechnie
	Number of Kids Fit participants taking Presidential Challenge Award Fitness Test	150	150	**No Data**	**No Data**				No Kids Fit Classes being held at this time	Sarah McKechnie
	Percent of Health Center patients diagnosed with high/low BMI with documented follow-up plan	93.3%	93.3%	**62.5%**	**62.5%**				Telehealth not able to capture	Carolina de la Puente
Diabetes	Number of Participants in Diabetes Prevention Program (DPP)	90	23	**23**	**23**					Margarette Acevero
	Average number of DPP sessions attended per quarter	3	3	**5.2**	**5.2**					Margarette Acevero
	DPP average % weight loss at 6 months	5%	5%	**5.1%**	**5.1%**					Margarette Acevero
	Percent of Health Center patients with diabetes (type 1 and 2) with most recent HbA1c > 9.0% or was missing a result	20%	20%	**No Data**	**No Data**				Unable to capture	Carolina de la Puente
Behavioral Health	Percent of health center patients receivng depression screening during primary care visit and follow-up	96.9%	96.9%	**90.2%**	**90.2%**				Telehealth	Carolina de la Puente
	Nexus Montgomery Average ACT Team Census	100	25	**20**	**20**					Annice Cody
	Crisis House Admissions	228	57	**53**	**53**				Q1 - 109 clients served	Annice Cody
Cancers	Number of Health Center Mammograms	352	88	**49**	**49**				FY21 Annual target will remain 352. No target increase due to the prior impact of COVID 19 and potential future impact.	Jackie Williams-Hubbard
	CHW Cancer Education Encounters	600	150	**3**	**3**				FY21 Target: 600; Virtual cancer educaton will be provided when possible.	Shelly Tang
	Percent of Health Center patients receiving Tobacco Screening and follow-up	90.0%	90%	**98.8%**	**98.8%**				Telehealth	Carolina de la Puente

0.92

2.4

4.52

4.67

Met Target
Met ≥ 75% of Target but ≤ 99.9% of Target
Met < 75% of Target
TBD Data not yet available
New metric
Manually enter number; formula does not pull from cell

12	2020	Annual Target	YTD Target	YTD Actual	Q1	Q2	Q3	Q4	***Comments*** *Please use this space to explain how you plan to improve your metrics that are in the yellow or red.*	
Maternal and Infant Health	Maternity Partnership Admissions	1012	1012	**879**	**263**	**243**	**257**	**116**		Nancy Nagel/Fatima Angeles-Reyes
	Percent of Maternity Partnership mothers receiving early prenatal care	66.9%	66.9%	**50.5%**	**49.0%**	**51.0%**	**51.8%**	**50.5%**		Nancy Nagel/Fatima Angeles-Reyes
	Maternity Partnership Low-birth Weight	8.5%	8.5%	**1.90%**	**1.9%**	**2.13%**	**2.06%**	**1.9%**		Nancy Nagel/Fatima Angeles-Reyes
	Total Perinatal Class Encounters (excluding tours)	8,000	8,000	**4,821**	**1,730**	**1,580**	**1,203**	**308**		Michelle Blanc/Marianne Wysong
	Holy Cross Germantown Health Center Newborn visits	75	75	**90**	**16**	**28**	**18**	**28**	Due to changes in reporting and calculations from FY18, the data now reflects the number of OB clinic births where the newborn had a pediatric visit at HCHC-GT within 30 days of birth that occurs in the time period: majority of newborn visits are maternity partnership patients	Jess Kelly
Seniors	Senior Source Encounters	13,303	13,303	**12,188**	**3,565**	**3,926**	**3,501**	**1,196**	Classes transitioned to virtual. Not all classes/instructors could continue in virtual environment.	Kathleen Williams
	Fall Assessments BioSway/Biodex, Get Up & Go, Chair Stand and Gait & Balance	328	328	**414**	**82**	**147**	**185**	**0**	Paused due to COVID can not take these programs virtual	Kathleen Williams
	Falls Risk Screening	76	76	**56**	**19**	**10**	**27**	**0**	Paused due to COVID can not take these programs virtual	Kathleen Williams
	Average MADC daily census	28	28	**27**	**27**	**26**	**27**	**40**	Q4: 0 in person; telephonic check ins with all participants 7 days a week.	Kathleen Williams
Cardiovascular Health	CHW Cardiovascular Education Encounters	300	300	**869**	**226**	**368**	**275**	**0**	Q4 - There are no grant funds currently available to support CHW CVD education; FY21 target 100 will reflect CVD education that may be provided paired with funded topics to include cancer and diabetes prevention.	Shelly Tang
	Average Senior Fit Weekly Participants YTD	1271	1271	**1,991**	**1,350**	**2,785**	**1,838**	**1,935**	Switch to virtual in March/April. (calculated by adding number of encounters and dividing by 4 weeks then add all three months for total average weekly encounters)	Kathleen Williams
	Percent of health center patients with diagnosis of HTN with good blood pressure control	80.0%	80.0%	**45.0%**	**70.4%**	**71.05%**	**65.85%**	**45%**		Carolina de la Puente
Obesity	Average Kids Fit Participants per Month YTD	17	17.0	**14.0**	**17.0**	**14.0**	**14.0**	**0.0**	This program may be changed in FY21 to respond to Trinity Health priorities - FY21 targets TBD	Sarah McKechnie
	Number of Kids Fit participants taking Presidential Challenge Award Fitness Test	150	150	**No Data**	**No Data**	**No Data**	**No Data**	**0**	Fitness assessments were cancelled due to COVID-19	Sarah McKechnie
	Percent of Health Center patients diagnosed with high/low BMI with documented follow-up plan	70.0%	70.0%	**61.1%**	**77.4%**	**83.76%**	89.20%	**61.07%**	Q4 - telehealth not able to capture	Carolina de la Puente
Diabetes	Number of Participants in Diabetes Prevention Program (DPP)	90	90	**49**	**25**	**No Data**	**No Data**	**24**		Margarette Acevero
	Average number of DPP sessions attended per quarter	3	3	**5.3**	**3.3**	**6.3**	**5.3**	**11**		Margarette Acevero
	DPP average % weight loss at 6 months	5%	5%	**5.7%**	**2.9%**	**No Data**	**5.7%**	**No Data**	Q4 - Session that started in March has not reached 6 months of data.	Margarette Acevero
	Percent of Health Center patients with diabetes (type 1 and 2) with most recent HbA1c > 9.0% or was missing a result	20%	20%	**52.1%**	**49.8%**	**52.1%**	**No Data**	**No Data**		Carolina de la Puente
Behavioral Health	Percent of health center patients receivng depression screening during primary care visit	96.9%	96.9%	**88.9%**	**90.8%**	**91.13%**	**85.7%**	**88.9%**	Q4 - Telehealth	Carolina de la Puente
	Nexus Montgomery Average ACT Team Census	100	100	**82**	**74**	**74**	**86**	**92**	Q4 - in June it reached it's full capacity of 100 clients.	Annice Cody
	Crisis House Admissions	228	228	**351**	**74**	**150**	**76**	**51**	Q4 - the decline was due to significantly reduced admissions in April and May due to COVID-19. Admissions in June were double that of April and May.	Annice Cody
Cancers	Number of Health Center Mammograms	352	352	**577**	**215**	**231**	**123**	**8**	Due to COVID-19 hospital imppact, very few screening mammograms occurred in Q4.	Jackie Williams-Hubbard
	CHW Cancer Education Encounters	1500	1500	**2,587**	**728**	**1139**	**712**	**8**	FY21 Target: 600; Virtual cancer educaton will be provided when possible.	Shelly Tang
	Percent of Health Center patients receiving Tobacco Screening	90.0%	90%	**98.9%**	**98.5%**	**98.90%**	**97.03%**	**98.88%**	Q4 - Telehealth	Carolina de la Puente

0.92
2.4
4.52
4.67

Met Target
Met ≥ 75% of Target but ≤ 99.9% of Target
Met < 75% of Target
TBD Data not yet available
New metric
Manually enter number; formula does not pull from cell

Summary of Holy Cross Hospital's Significant Community Benefit Programming in Response to Identified Unmet Health Care Needs

12	2019	Annual Target	YTD Target	YTD Actual	Q1	Q2	Q3	Q4	***Comments*** *Please use this space to explain how you plan to improve your metrics that are in the yellow or red.*	
Maternal and Infant Health	Maternity Partnership Admissions	1012	1012	958	233	242	260	223		Nancy Nagel
	Percent of Maternity Partnership mothers receiving early prenatal care	66.9%	66.9%	56.4%	58.4%	57.3%	55.5%	56.4%		Nancy Nagel
	Maternity Partnership Low-birth Weight	8.5%	8.5%	2.5%	1.6%	2.7%	2.4%	2.5%		Nancy Nagel
	Total Perinatal Class Encounters (excluding tours)	8,996	8,996	7,490	1,919	1,944	1,873	1,754		Debbie Levine
	Holy Cross Germantown Health Center Newborn visits	Baseline	Baseline	68	20	15	13	20	Due to changes in reporting and calculations from FY18, the data now reflects the number of OB clinic births where the newborn had a pediatric visit at HCHC-GT within 30 days of birth that occurs in the time period: majority of newborn visits are maternity partnership patients	Jess Kelly
Seniors	Senior Source Encounters	16,236	16,236	13,303	2,539	3,489	3,325	3,950		Mary Bulla
	Fall Assessments BioSway/Biodex, Get Up & Go, Chair Stand and Gait & Balance	268	268	45	22	5	6	12		Mary Bulla
	Falls Risk Screening	100	100	39	No data	22	6	11		Mary Bulla
	Average MADC daily census	24	24	30	23	45	92	120		Kathleen Williams
Cardiovascular Health	Number of Heart Failure Education Encounters	18	18	0	0	0	0	0		Mary Bulla
	CHW Cardiovascular Education Encounters	600	600	974	148	78	312	436		Shelly Tang
	Average Senior Fit Weekly Participants YTD	1271	1271	2,844	2,095	2,340	2,075	2,844		Mary Bulla
	Percent of health center patients with diagnosis of HTN with good blood pressure control	74.9%	74.9%	65.3%	71%	69.21%	65.27%	68.68%		Carolina de la Puente
Obesity	Average Kids Fit Participants per Month YTD	17	17.0	15.0	19.0	24.0	26.0	15.0		Sarah McKechnie
	Number of Kids Fit participants taking Presidential Challenge Award Fitness Test	150	150	26	No data	26	No Data	No Data		Sarah McKechnie
	Percent of Health Center patients diagnosed with high/low BMI with documented follow-up plan	77.1%	77.1%	71.9%	77.66%	83.90%	80.71%	71.89%		Carolina de la Puente
Diabetes	Number of Participants in Diabetes Prevention Program (DPP)	90	90	69	49	0	20	0		Margarette Acevero
	Average number of DPP sessions attended per quarter	3	3	4.4	5.2	6.6	6.04	4.35	Data includes Spanish DPP cohort. New English cohort had 1 session in quarter 1	Margarette Acevero
	DPP average % weight loss at 6 months	5%	5%	4.7%	No data	No Data	3.7%	4.66%	Cohort will reach six month benchmark in April 2019.	Margarette Acevero
	Percent of Health Center patients with diabetes (type 1 and 2) with most recent HbA1c > 9.0% or was missing a result	50%	50%	43.4%	36.67%	No Data	47.02%	43.41%		Carolina de la Puente
Behavioral Health	Percent of health center patients receivng depression screening during primary care visit	88.0%	88.0%	88.3%	92.80%	93.33%	81.1%	88.28%		Carolina de la Puente
	Nexus Montgomery Average ACT Team Census	100	100	149	No data	No Data	79	70		Annice Cody
	Crisis House Admissions	228	228	450	46	45	200	159		Annice Cody
Cancers	Number of MAPS Mammograms	352	352	541	143	118	125	155		Melissa Fernandez
	CHW Cancer Education Encounters	3000	3000	3,510	429	285	710	2086	added to track grant requirements and programming on education and prevention; limited staff	Shelly Tang
	Percent of Health Center patients receiving Tobacco Screening	88.0%	88.0%	98.2%	99.22%	99.25%	97.80%	98.19%		Carolina de la Puente

Met Target
Met ≥ 75% of Target but ≤ 99.9% of Target
Met < 75% of Target
TBD Data not yet available
New metric
Manually enter number; formula does not pull from cell

Summary of Holy Cross Hospital's Significant Community Benefit Programming in Response to Identified Unmet Health Care Needs

12	2018	Annual Target	YTD Target	YTD Actual	Q1	Q2	Q3	Q4	*Comments* *Please use this space to explain how you plan to improve your metrics that are in the yellow or red.*	
Maternal and Infant Health	Maternity Partnership Admissions	1112	1112	940	228	208	255	249		Nancy Nagel
	Percent of Maternity Partnership mothers receiving early prenatal care	66.9%	66.9%	59.2%	54.4%	56.0%	56.4%	59.2%		Nancy Nagel
	Maternity Partnership Low-birth Weight	8.5%	8.5%	3.3%	3.9%	3.3%	3.6%	3.3%		Nancy Nagel
	Total Perinatal Class Encounters (excluding tours)	10,368	10,368	10,246	2,512	4,084	1,583	2,067		Debbie Levine
	OB/GYN Referrals to Germantown Health Center	Baseline	Baseline	228	11	23	74	120		Carolina de la Puente
Seniors	Senior Source Encounters	16,236	16,236	18,225	4,704	6,447	3,371	3,703		Mary Bulla
	Fall Assessments BioSway/Biodex, Get Up & Go, Chair Stand and Gait & Balance	268	268	168	85	15	64	4	Due to changes in personnel, we did not have sufficient staff to take the machine out to as many health fairs.	Mary Bulla
	Upright Balance Class Improvement in Gait & Balance	5%	5%	6.6%	4%	15.8%	0.0%		not yet computed	Mary Bulla
	Average MADC daily census	22	22	25	26	25	23	25		Kathleen Williams
Cardiovascular Health	Number of Heart Failure Education Encounters	18	18	0	0					Mary Bulla
	CHW Cardiovascular Education Encounters	2,000	2,000	3,030	715	321	684	1,310		Shelly Tang
	Average Senior Fit Weekly Unduplicated Participants YTD	1271	1271	1,339	1,302	1,338	1,393	1,339		Sarah McKechnie
	Percent of health center patients with diagnosis of HTN with good blood pressure control	83%	83%	70.1%	76%	61.3%	65.3%	70%	Q3 data in Q4 document?	Carolina de la Puente
Obesity	Average Kids Fit Participants per Month YTD	17	17.0	17.0	16.0	18.0	17.0	17.0		Sarah McKechnie
	Number of Kids Fit participants taking Presidential Challenge Award Fitness Test	150	150	90	No Data	No Data	90	84	The number of classes per week was reduced by 3 in FY18 due to programming changes at Shady Grove, Olney Towne Centre and The Willows.	Sarah McKechnie
	Percent sales of healthy vending products	12.75%	12.75%	12.75%	12.75%					Scott Graham/Trinity
	Percent of Health Center patients diagnosed with high/low BMI with documented follow-up plan	60.0%	60.0%	66.2%	39.60%	38.6%	60.05%	66.17%		Carolina de la Puente
Diabetes	Number of Participants in Diabetes Prevention Program (DPP)	57	57	84	61	14	9	0	No new enrollmnents in Q4	Sarah McKechnie
	Average number of DPP sessions attended per quarter	3	3	3.4	2.4	5.7	5.31	3.44		Sarah McKechnie
	DPP average % weight loss at 6 months	5%	5%	6.2%	No Data	5.0%	5.7%	6.21%		Sarah McKechnie
	Percent of Health Center patients with diabetes (type 1 and 2) with most recent HbA1c > 9.0% or was missing a result	50%	50%	50.9%	No Data	53.8%	47.2%	50.86%		Carolina de la Puente
Behavioral Health	Percent of health center patients receivng depression screening during primary care visit	88.0%	88.0%	84.4%	No Data	89.7%	87.9%	84%		Carolina de la Puente
	Nexus Montgomery ACT Team	TBD	TBD	96	No Data	No Data	96			Annice Cody
	Crisis House Admissions	228	152	146	No Data	No Data	146		opened in August - target is one month behind quarter - i.e. quarter 3 multiply 19 by 8 instead of 9	Annice Cody
Cancers	Number of MAPS Mammograms	352	352	655	144	181	145	185		Shelly Tang
	Cycle time from dx referral to actual appointment (days)	28	28	23	20	20	26	25		Shelly Tang
	Percent of Health Center patients receiving Tobacco Screening	80%	80%	97.0%	No Data	96.7%	96.71%	96.95%		Carolina de la Puente

Met Target
Met ≥ 75% of Target but ≤ 99.9% of Target
Met < 75% of Target
TBD Data not yet available
New metric
Manually enter number; formula does not pull from cell

Summary of Holy Cross Hospital's Significant Community Benefit Programming in Response to Identified Unmet Health Care Needs

12	2017	Annual Target	YTD Target	YTD Actual	Q1	Q2	Q3	Q4	*Comments* *Please use this space to explain how you plan to improve your metrics that are in the yellow or red.*	
Maternal and Infant Health	Maternity Partnership Admissions	908	908	1,082	268	260	312	242		Nancy Nagel
	Percent of Maternity Partnership mothers receiving early prenatal care	66.9%	66.9%	56.0%	52.2%	54.8%	53.3%	56.0%	The explanation for percent of MP mothers receiving early prenatal care is that many patients present at their first appointment in the second or third trimester of pregnancy. Upon request for an appointment from the county Service Eligibility Center, patients are scheduled for their first OB Clinic visit within 1-3 days.	Nancy Nagel
	Maternity Partnership Low-birth Weight	8.5%	8.5%	2.5%	2.1%	2.4%	2.7%	2.5%		Nancy Nagel
	Total Perinatal Class Encounters (excluding tours)	10,780	10,780	9,426	2,329	2,203	2,522	2,372		Debbie Levine
	Number of Upcounty Perinatal Classes targeted to at-risk population	6	6	8	3	1	0	4		Debbie Levine
Seniors	Senior Source Encounters	16,236	16,236	17,323	5,294	4,184	3,955	3,890		Mary Bulla
	Fall Assessments BioSway/Biodex, Get Up & Go, Chair Stand and Gait & Balance	268	268	230	99	22	66	43		Mary Bulla
	Upright Balance Class Improvement in Gait & Balance	5%	5%	4.0%	0.0%	4.0%	no data	no data		Mary Bulla
	Percent of high risk health center patients with current pneumococcal vaccination	25%	25%	21.2%	15%	23%	22%	21%	283/1304 Share outcomes with providers and request process for improvements, Q4 292/1377 vaccines obtained elsewhere not captured in data.	Marlene Printz
	Average MADC daily census	20	20	24.3	21	20.3	20.6	24.3		Kathleen Williams
Cardiovascular Health	Number of Heart Failure Education Encounters	24	24	12	8	0	2	2		Mary Bulla
	CHW Cardiovascular Education Encounters	4,000	4,000	5,288	716	1,348	2,597	627		Shelly Tang
	Number of Community Health referrals to health centers			No Data	0	No Data				Michelle Blanc
	Average Senior Fit Weekly Unduplicated Participants YTD	1271	1265	1,342	1,250	1,278	1,342	1,319		Sarah McKechnie
	Percent of health center patients with diagnosis of HTN with good blood pressure control	83%	83%	80.2%	77%	73%	74%	80%	549+122+167/1126 Share outcomes with providers and request process for improvements, Q4 611+139+166/1142. Q1Fy18 567+110+166/1112	Marlene Printz
Obesity	Average Kids Fit Participants per Month YTD	17	17.0	16.8	17.2	17.6	17.2	16.8		Sarah McKechnie
	Number of Kids Fit participants taking Presidential Challenge Award Fitness Test	150	150	164	155	155	164	164		Sarah McKechnie
	Percent sales of healthy vending products	Baseline		No Data	No Data	No Data	No Data	No Data	emailed Trinty to get FY17 data and Keri O'Rourke to get FY16 data; data is not available due to previous contractors not being Canteen. Will be able to obtain data moving forward. Possibly establish Q1 as baseline	Scott Graham/Trinity
	Percent of Health Center patients with BMI>25 with an overwieght or obesity diagnosis	87.3%	87.3%	87.8%	88.6%	88.4%	88.6%	87.79%	Share outcomes with providers. 2157/2457. Q1FY18 3715/3933 from Population Health Report	Marlene Printz
Diabetes	Number of Participants in Diabetes Prevention Program (DPP)	57	57	98	78	5	15	0		Mary Bulla
	Average number of DPP sessions attended per quarter	3	3	6.1	5.4	3.5	5.3	6.12		Mary Bulla
	DPP average % weight loss at 6 months	5%	5%	4.8%	4.1%	4.1%	4.8%	N/A		Mary Bulla
	Number of Community Health referrals to health centers			No Data	No Data	No Data				Michelle Blanc
	Percent of Health Center patients with diabetes (type 1 and 2) with most recent HbA1c > 9.0% or was missing a result	50%	50%	48.8%	54%	53%	50%	48.83%	Target Met. Share outcomes with providers. HgbA1C machines to go live May 2017. Below target is positive result.	Marlene Printz
Behavioral Health	Percent of health center patients receivng depression screening during primary care visit	88.0%	88.0%	89.1%	87.2%	85.5%	86%	89%	5375/6271 Share outcomes with providers and request process for improvements, Q4 5499/6169. Q1FY18 5371/5796	Marlene Printz
	Number of patients enrolled in CareLink behavioral health program	100	100	102	45	57	0	0	Program discontinued in March	Cathy Livingston
	Number of Community Health referrals to health centers			No Data	No Data	No Data				Michelle Blanc
Cancers	Number of MAPS Mammograms	352	352	776	148	187	205	236		Shelly Tang
	Cycle time from dx referral to actual appointment (days)	28	28	30	22	32	38	27	Metric not met due to limited availability of diagnostic slots for MAPS- working with Radiology to resolve and attain additional diagnostic days	Shelly Tang

- Met Target
- Met ≥ 75% of Target but ≤ 99.9% of Target
- Met < 75% of Target
- TBD — Data not yet available
- New metric
- Manually enter number; formula does not pull from cell

Summary of Holy Cross Hospital's Significant Community Benefit Programming
in Response to Identified Unmet Health Care Needs

3	FY2016	Annual Target	YTD Target	YTD Actual	Q1	Q2	Q3	Q4	***Comments*** *Please use this space to explain how you plan to improve your metrics that are in the yellow or red.*	
Maternal and Infant Health	Maternity Partnership Admissions *Actual/Target*	908	227	268	**268**					Nancy Nagel
	Maternity Partnership Low-birth Weight *SHIP Target ≤ 8.5%*	8.5%	8.5%	3.0%	**3.0%**					Nancy Nagel
	Total Perinatal Class Encounters (excluding tours) *Actual/Target*	10,780	2,695	2,329	**2,329**					Debbie Levine
	Number of Upcounty Perinatal Classes targeted to at-risk population *Actual/Target*	6	2	3	**3**					Debbie Levine
Seniors	Senior Source Encounters *Actual/Target*	16,236	4,059	5,294	**5,294**					Michelle Blanc
	Fall Assessments BioSway/Biodex, Get Up & Go, Chair Stand and Gait & Balance *Actual/Target*	268	67	99	**99**					Michelle Blanc
	Upright Balance Class Improvement in Gait & Balance *Actual/Target*	5%	5%	0.0%	**0.0%**					Michelle Blanc
Cardiovascular Health	Number of Heart Failure Education Encounters *Actual/Target*	24	6	8	**8**					Michelle Blanc
	Number of Cardiovascular Education Encounters *Actual/Target*	4,000	1,000	716	**716**					Shelly Tang
	Number of CMO referrals to health centers	0	10	0	**0**					Shelly Tang
	Average Senior Fit Weekly Unduplicated Participants YTD *Actual/Target*	1271	1265	1,250	**1,250**					Sarah McKechnie
	Percent Senior Fit participants scoring at or above average in semi-annual fitness assessments *Actual/Target*	85%	85%	87%	**87%**					Sarah McKechnie
Obesity	Average Kids Fit Participants per Month YTD	17	17.0	16.6	**16.6**					Sarah McKechnie
	Number of Kids Fit participants taking Presidential Challenge Award Fitness Test *Actual/Target*	150	150	155	**155**					Sarah McKechnie
Diabetes	Number of Participants in Diabetes Prevention Program (DPP) *Actual/Target*	57	14	99	**99**					Michelle Blanc
	Number of DPP Encounters	612	153	536	**536**					Michelle Blanc
	Average % weight loss at 12 months *Actual/Target*	5%	5%	5%	**5.1%**					Michelle Blanc
	Percent Patients Receiving Diabetic Pre-Visit Planning *Actual/Target*	80%	80%	No Data	**No Data**				Not monitoring	Marlene Printz
	HbA1c Screening percent *Actual/Target*	91%	91%	79%	**79%**				Not monitoring	Marlene Printz
Behavioral Health	Number CMO referrals to social services and health centers *Actual/Target*	300	75	156	**156**					Shelly Tang
	Percent patients screened using SBIRT tool *Actual/Target*	75%	75%	87%	**87%**				Not monitoring	Marlene Printz
Cancers	Number of Mammograms *Actual/Target*	352	88	148	**148**					Shelly Tang
	Breast Cancers Found *No Target*	0	0	1	**1**					Shelly Tang
	Percentage of health center patients identified as non-tobacco users or referred to tobacco cessation referral in past 24 months	85%	85%	85%	**85%**					Marlene Printz

Met Target
Met ≥ 75% of Target but ≤ 99.9% of Target
Met < 75% of Target
TBD Data not yet available

Manually enter number; formula does not pull from cell

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12	FY2016	Annual Target	YTD Target	YTD Actual	Q1	Q2	Q3	Q4	***Comments*** *Please use this space to explain how you plan to improve your metrics that are in the yellow or red.*	
Maternal and Infant Health	Maternity Partnership Admissions *Actual/Target*	908	908	1,214	**305**	**288**	**308**	**313**		Nancy Nagel
	Maternity Partnership Low-birth Weight *SHIP Target ≤ 8.5%*	8.5%	8.5%	2.4%	**1.6%**	**2.9%**	**3.9%**	**1.2%**		Nancy Nagel
	Total Perinatal Class Encounters (excluding tours) *Actual/Target*	10,780	10,780	9,640	**2,539**	**2,235**	**2,238**	**2,628**		Debbie Levine
	Number of Upcounty Perinatal Classes targeted to at-risk population *Actual/Target*	6	6	8	**3**	**3**	**1**	**1**		Debbie Levine
Seniors	Senior Source Encounters *Actual/Target*	16,236	16,236	13,765	**3,362**	**3,192**	**3,254**	**3,957**		Michelle Blanc
	Fall Assessments BioSway/Biodex, Get Up & Go, Chair Stand and Gait & Balance *Actual/Target*	268	67	107	**48**	**0**	**36**	**23**		Michelle Blanc
	Upright Balance Class Improvement in Gait & Balance *Actual/Target*	5%	5%	4.7%	**5.0%**	**4.7%**	**4.7%**	**0**		Michelle Blanc
Cardiovascular Health	Number of Heart Failure Education Encounters *Actual/Target*	24	24	19	**6**	**11**	**0**	**2**		Michelle Blanc
	Number of Cardiovascular Education Encounters *Actual/Target*	10,000	10,000	10,090	**4,470**	**1,791**	**2,774**	**1,055**		Shelly Tang
	Number of CMO referrals to health centers	15	10	0	**0**	**0**	**0**	**0**		Shelly Tang
	Average Senior Fit Weekly Unduplicated Participants YTD *Actual/Target*	1271	1265	1,213	**1,244**	**1,202**	**1,255**	**1,213**		Sarah McKechnie
	Percent Senior Fit participants scoring at or above average in semi-annual fitness assessments *Actual/Target*	85%	85%	87%	**94%**	**TBD**	**TBD**	**87%**		Sarah McKechnie
Obesity	Average Kids Fit Participants per Month YTD	17	17.0	17.0	**17.6**	**16.9**	**18.5**	**17**		Sarah McKechnie
	Number of Kids Fit participants taking Presidential Challenge Award Fitness Test *Actual/Target*	150	150	155	**No Data**	**No Data**	**No Data**	**155**		Sarah McKechnie
	Percent Kids Fit participants scoring at or above average in semi-annual fitness assessments *Actual/Target*	50%	50%		**No Data**	**No Data**	**No Data**			Sarah McKechnie
Diabetes	Number of Participants in Diabetes Prevention Program (DPP) *Actual/Target*	57	57	93	**38**	**55**	**0**		No new program participants for 22-session program until Q2 FY17.	Michelle Blanc
	Number of DPP Encounters	612	612	1060	**292**	**581**	**187**			Michelle Blanc
	Percent DPP participants with ≥ 5% body weight loss *Actual/Target*	5%	5%	4%	**4.4%**	**4.4%**	**4.4%**			
	Percent DPP participants with ≥150 minutes physical activity/week *Actual/Target*	60%	60%		**No Data**	**No Data**	**No Data**			Michelle Blanc
	Percent Patients Receiving Diabetic Pre-Visit Planning *Actual/Target*	80%	80%	87%	**76%**	**87%**				Marlene Printz
	HbA1c Screening percent *Actual/Target*	91%	91%	84%	**79%**	**84%**				Marlene Printz
Behavioral Health	Number CMO referrals to social services and health centers *Actual/Target*	300	300	183	**68**	**83**	**22**	**10**	Jan and Feb only; March is pending	Shelly Tang
	Percent patients screened using SBIRT tool *Actual/Target*	75%	75%	86%	**61%**	**63%**	**86%**		Q3 = March data	Marlene Printz
Cancers	Number of Mammograms *Actual/Target*	352	352	568	**170**	**131**	**118**	**149**		Shelly Tang
	Breast Cancers Found *No Target*	0	0	0	**0**	**0**	**0**	**0**		Shelly Tang

908

Met Target

Met ≥ 75% of Target but ≤ 99.9% of Target

Met < 75% of Target

TBD Data not yet available

Manually enter number; formula does not pull from cell

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Social Influencers of Health

1 Decrease percent of residents without insurance - Source: US Census Bureau, American Community Survey. 2015-19.

2 Decrease number of people unable to afford to see a doctor - Healthy Montgomery

3 Decrease food insecurity rate - Source: Feeding America. 2017.

4 Decrease households with housing cost burdens - Source: US Census Bureau, American Community Survey. 2015-19.

Maternal and Infant Health

1 Increase percent of mothers receiving early prenatal care - Source: MCDHHS/PHS/Planning & Epidemiology; Maryland DHMH/VSA; 2017

2 Reduce the percent of low birth weight infants - Source: MCDHHS/PHS/Planning & Epidemiology; MarylandDHMH/VSA and MD DHMH, 2017

3 Decrease infant mortality rate - Source: MCDHHS/PHS/Planning & Epidemiology; Maryland DHMH/VSA; CDC/U.S. Census bridged Population Files; 2017

Seniors

4 Increase life expectancy - Source: Maryland Department of Health and Mental Hygiene; 2015-2017

5 Decrease fall related deaths - Source: Maryland Department of Health and Mental Hygiene; 2015-2017

Cardiovascular Health

6 Decrease heart disease mortality - Source: CDC Interactive Atlas of Heart Disease and Stroke, 2014-2016

7 Decrease stroke mortality - Source: MCDHHS/PHS/Planning & Epidemiology; Maryland DHMH/VSA; CDC/U.S. Census bridged Population Files; 2015-2017

8 Decrease percent of adults told by health professional they have high blood pressure - Source: Maryland Behavioral Risk Factor Surveillance System; 2017

Obesity

9 Decrease percent of high school students with no participation in physical activity - Maryland YRBS; 2014

10 Decrease percent of high school students who are obese - Maryland YRBS; 2014

11 Increase percent of high school students who drank no soda or pop in the past week - Maryland YRBS; 2014

Diabetes

12 Decrease number of adults ever being told they have diabetes (exluding gestational) - Source: Maryland Behavioral Risk Factor Surveillance System; 2017

13 Decrease ER visits for diabetes - Source: MCDHHS/PHS/Planning & Epidemiology; HSCRC; CDC/U.S. Census bridged Population Files; 2015-2017

Behavioral Health

14 Decrease adolescent and adult illicit drug use in past month (12 or older) - Source: National Survey on Drug Use and Health; 2012-2014

15 Decrease percent of adults with any mental illness in past year - Source: National Survey on Drug Use and Health; 2012-2014

16 Decrease mental health related ER visits - Source: Maryland DHMH State Health Improvement Process, 2017

17 Decrease suicide rate - Source: MCDHHS/PHS/Planning & Epidemiology; Maryland DHMH/VSA; CDC/U.S. Census bridged Population Files; 2013-2017

Cancers

18 Increase colorectal cancer screening (colonoscopy or sigmoidoscopy) - Source: Maryland Behavioral Risk Factor Surveillance System; 2016

19 Increase percent of women who have had a Pap in past three years - Source: Maryland Behavioral Risk Factor Surveillance System; 2016

20 Decrease prostate cancer incidence - Source: National Cancer Institute; 2011-2015

21 Decrease breast cancer mortality - Source: Breast Cancer Death Rates for Montgomery and Prince George'sCounty. Source: NCI, 2011-2015

HOLY CROSS HOSPITAL

Community Health Needs Assessment FY 2020

Approved by Holy Cross Health Board of Directors on October 17, 2019

We, Holy Cross Health and Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. We carry out this mission in our communities through our commitment to be the most trusted provider of health care services.

CONTENTS

EXECUTIVE SUMMARY

Holy Cross Health, a Catholic not-for-profit health system based in Montgomery County, Maryland, has been conducting needs assessments for almost 20 years and, in 2009, became a founding member of Healthy Montgomery, Montgomery County's Community Health Improvement Process (CHIP). Healthy Montgomery allowed stakeholders interested in improving the health of the communities we serve to combine expertise and resources to identify priority issues and develop and implement strategies for action. In 2010, Congress enacted the Patient Protection and Affordable Care Act (ACA) that requires non-profit hospitals to conduct a community health needs assessment and adopt an implementation strategy every three years. The CHIP helps the hospitals in Montgomery County to meet the requirements of the ACA and helps the Montgomery County Department of Health and Human Services (DHHS) to meet the requirements of the Public Health Accreditation Board to become an accredited public health department. Together, the four health systems in Montgomery County and the DHHS analyze primary and secondary information continuously to address unmet needs and identify emerging issues in the communities served by each.

This community health needs assessment focuses on the geographic service areas of Holy Cross Hospital. It provides the foundation for the organization's efforts to guide community benefit planning to improve the health status of the community. Holy Cross Hospital serves a large portion of Montgomery and Prince George's Counties' residents, home to some of the most culturally and ethnically diverse communities in the nation. Montgomery and Prince George's Counties are fairly affluent in aggregate, however, significant economic disparities exist.

Access to quality, affordable health care plays a significant role in the health of individuals, but health is also affected by other determinants. Understanding the determinants of health, such as economics and education, can also lead to reductions in health disparities and improvements in health indicators. Health indicators, such as causes of death, breast cancer rates, obesity, and infant mortality, can be used to describe the overall health of a population and determine unmet community need.

Trinity Health, parent company of Holy Cross Health, has selected a series of 21 vital signs to measure across all Trinity Health entities. This will not only identify changes within the community Holy Cross Hospital serves, but will also allow Trinity Health to look at health on a national level in each of the communities it serves. This will allow the organization to identify common needs among all entities in an effort to develop programs and services to address the identified needs on a national scale. The community vital signs are grouped into six categories:

1. Health Outcomes and Behaviors
2. Health and Health Care
3. Education
4. Economic Stability
5. Social Support and Community Context
6. Neighborhood and Build Environment

Holy Cross Hospital's Community Vital Signs scorecard can be seen on the following page.

TRINITY HEALTH COMMUNITY VITAL SIGNS

HOLY CROSS HOSPITAL

Health Outcomes & Behaviors

	HCH Service Area	Maryland	United States
Life expectancy	81.66	79.26	78.69
Mortality – YPLL before age 75	6,947	7,119	6,947
Average poor mental health days	3	3.4	3.8
Low birth weight	8.8%	9.0%	8.2%
Tobacco use	10.4%	15.4%	18.1%
Obesity (BMI > 30)	27.0%	30.6%	28.8%
Drug Overdose	8.11	20.0	15.6
Preventable hospitalizations	35.6	46.7	49.4
30-day hospital readmission*	14.9%	14.9%	14.9%

Health & Health Care

	HCH Service Area	Maryland	United States
Uninsured population	10.4%	7.34%	10.5%
Lack consistent source primary care	15.8%	16.87%	22.07%

Education

	HCH Service Area	Maryland	United States
No high school diploma	11.5%	10.2%	12.7%

Economic Stability

	HCH Service Area	Maryland	United States
Income inequality ǂ	.46	.45	.48
Food insecurity rate	10.8%	10.7%	12%
Poverty rate	21.5%	22.6%	32.8%

Social Support & Community Context

	HCH Service Area	Maryland	United States
Social equity ǂ	.16	.34	.39
Food insecurity rate	281.3	461.8	384.8
Poverty rate	20.4%	19.8%	20.7%

Neighborhood & Build Environment

	HCH Service Area	Maryland	United States
Population living in food deserts	42%	41%	42%
Air quality	.12%	.02%	.10%
Housing cost burden	35.5%	32.7%	32.0%

*Common data for all Trinity Health hospitals was not available at the ZIP code level for readmission rates; therefore, the FY19 readmission rate for the Holy Cross Health System was used.

ǂ County level data was used in place of service area data.

In addition to the Trinity Health Community Vital Signs, the most up-to-date data from more than 100 indicators from Healthy Montgomery's CHIP were collected. Together, the Trinity Health Community Vital Signs and the data from Montgomery County's CHIP were analyzed.

Holy Cross Health used the information available to identify three priority areas: Social Determinants/Influencers of Health, Vulnerable Populations, and Chronic Diseases. Building upon the *Healthy Montgomery* top-ranked priorities and available data, Holy Cross Health identified subcategories for each priority and ranked the priorities and subcategories based on prevalence, severity, intervention feasibility, and potential to achieve outcomes. The following prioritized list of the significant unmet needs identified and their subcategories were developed using scores from each of the categories listed above:

1. Social Determinants/Influencers of Health
    a. Access to Care
    b. Food Insecurity
    c. Housing
2. Vulnerable Populations
    a. Senior Population
    b. Maternal/Infant Population
3. Chronic Diseases
    a. Diabetes
    b. Cancers
    c. Cardiovascular Health
    d. Obesity
    e. Behavioral Health

With this information, Holy Cross Health will address the unmet needs within the context of our overall approach, mission commitments, key clinical strengths, and within the overall goals of Healthy Montgomery. We will focus on addressing the identified priorities by optimizing wellness and equity and striving to eliminate disparities in our communities. To accomplish this, Holy Cross Health's strategy to address unmet community need encompasses the following three key focus areas that concentrate on individual social needs as well as improving community conditions:

Clinical Care: Delivery of efficient and effective people-centered health care services for the uninsured/Medicaid population that is focused on reducing clinical quality outcome disparities and addressing the social needs of patients;

Community Engagement: Connecting efficient and effective wrap-around services, expanding the availability of community-based services, and ensuring that patients, community members, and employees are linked to, and can utilize, these services; and

Community Transformation: Policy, system and environmental change strategies focusing on community building to address the physical environment, economic revitalization, housing and other social determinants/influencers of health.

For further information on how Holy Cross Health plans to address each identified unmet need, please review our Multi-Year CHNA Implementation Plan at http://www.holycrosshealth.org/CHNA implementation-plan.

INTRODUCTION

Overview

In 2010, Congress enacted the Patient Protection and Affordable Care Act (The Affordable Care Act) that put in place a comprehensive health insurance reform to enhance the quality of health care for all Americans. In an effort to enhance the quality of health care, the Affordable Care Act also requires non-profit hospitals to conduct a Community Health Needs Assessment (CHNA) and adopt an implementation strategy, a plan describing how the hospital will address the needs identified, every three years.

Holy Cross Health has evaluated the needs of the community to support its community benefit plans for almost 20 years and doing so is consistent with the organization's mission and values. It also closely aligns with advancing Holy Cross Health's strategic principles. The vision of our *People-Centered Strategy for Success* for fiscal years 2019-2022 is to be a forward-thinking health system with the knowledge and resources to help people address their needs and goals in order to achieve a better quality of life. To achieve this, we are guided by the following six strategic principles (see Figure 1):

People-Centered Care: Providing innovative patient care, excellent care delivery, and improved clinical outcomes

Engaged Colleagues: Attracting, developing and retaining exceptional and committed colleagues

Operational Excellence: Ensuring efficient and effective care delivery

Physician Collaboration: Engaging physicians for mutual benefit in activities that attract patients and better manage care

Leadership Nationally & Locally: Improving the health and well-being of our community through innovation and expanding expertise

Effective Stewardship: Stewarding our resources to best manage revenue and expenses

Figure 1: Holy Cross Health's six strategic principles of the People-Centered Strategy for Success for fiscal years 2019-2022.

Holy Cross Health's fiscal 2019-2022 strategic plan identifies our People-Centered Strategy for Success that is responsive to our mission commitments and the environment in which we operate. These strategic principles guide Holy Cross Health's overall development and in particular, advance our mission and population health efforts, which include our community health needs assessment and the associated implementation strategy. This community health needs assessment focuses on the geographic areas Holy Cross Hospital serves. It provides the foundation for the organization's efforts to guide to improve the health status of the people, particularly those most at-risk, in Holy Cross Hospital's service area.

Organization

Holy Cross Health is a Catholic, not-for-profit health system that provides more than 240,000 patient visits each year with the promise to make health, and the best possible quality of life, more achievable. Holy Cross Health's high-quality care is accessible to community members in Maryland's Montgomery and Prince George's counties through two hospitals, ten primary and specialized care centers, home care and hospice services, and a wide range of community health programs. Our team of 4,100 colleagues, 1,575 community and hospital-based physicians, and more than 400 volunteers work proactively to meet the needs of every individual we serve.

We are a people-centered health system that aims to improve the health and lives of individuals, populations and communities, through episodic health care management, population health management, and community health and well-being initiatives. Holy Cross Health delivers services where, when and how people need us most, with a focus on clinical excellence, innovation and positive experiences that advance individual and community health.

The Holy Cross Health system includes:

Holy Cross Hospital, one of the largest hospitals in Maryland and home to the nation's first and region's only Seniors Emergency Center.

Holy Cross Germantown Hospital, the first hospital in the nation to be located on a community college campus and enhanced by an educational partnership, offering high-quality medical, surgical, obstetric, emergency and behavioral health services to the fastest-growing region in the county.

Holy Cross Health Network, which operates Holy Cross Health Centers in Aspen Hill, Gaithersburg, Germantown, and Silver Spring; provides primary care at Holy Cross Health Partners at Asbury Methodist Village and in Kensington; offers a wide range of innovative health and wellness programs; and leads partner relationships.

Holy Cross Health Foundation, a not-for-profit organization devoted to raising philanthropic funds to support the mission of Holy Cross Health and to improve the health of the community.

Mission and Core Values

We, Holy Cross Health and Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. We carry out this mission in our communities through our commitment to be the most trusted provider of health care services.

Core Values

Reverence: We honor the sacredness and dignity of every person.

Commitment to those who are poor: We stand with and serve those who are poor, especially those most vulnerable.

Justice: We foster right relationships to promote the common good, including sustainability of Earth.

Stewardship: We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care.

Integrity: We are faithful to who we say we are.

APPROACH AND METHODOLOGY

Holy Cross Health has been conducting needs assessments for almost 20 years and identifies unmet community health care needs in a variety of ways. We collaborate with other healthcare providers to support Healthy Montgomery, Montgomery County's community health improvement process. We seek expert guidance from a panel of external participants with expertise in public health and the needs of our community and gather first-hand information from community members through community conversations conducted by Holy Cross Health and community conversations conducted by Healthy Montgomery and the Montgomery County Department of Health and Human Services. We review other available reports and needs assessments and use them as reference tools to identify unmet needs in various populations. We also use the Community Need Index to geographically identify high need communities that would benefit from our programs and services and use internal data sources to conduct an extensive analysis of demographics, health indicators and other determinants of health for the communities we serve.

Healthy Montgomery

Healthy Montgomery is Montgomery County's community health improvement process (CHIP) and serves as the base for Holy Cross Hospital's needs assessment. It is a collaborative, ongoing effort that brings together Montgomery County government agencies, four hospital systems, minority health initiatives/program, advocacy groups, academic institutions, community-based service providers, the health insurance community, and other stakeholders. Healthy Montgomery has a set of goals and objectives aimed to improve the health and well-being of all Montgomery County residents. The goals are to:

- Improve access to health and social services;
- Achieve health equity for all residents; and
- Enhance the physical and social environment to support optimal health and well-being and reduce unhealthful behaviors.

Healthy Montgomery's four objectives are to:

- Establish a comprehensive set of indicators related to health and well-being processes, health outcomes and social determinants of health in Montgomery County that incorporates a wide variety of county and sub-county information resources and utilizes methods appropriate to their collection, analysis, and application;
- Identify and prioritize health and social needs in the county as a whole and in the diverse communities within the county;

- Foster projects to achieve health equity by addressing health and well-being needs, improving health outcomes and reducing demographic, geographic, and socioeconomic disparities in health and well-being; and
- Coordinate and leverage resources to support the community health improvement project infrastructure and improvement projects.

Healthy Montgomery began in June of 2009 when Holy Cross Hospital and the other three hospital systems in Montgomery County each gave $25,000, for a total of $100,000, to the Urban Institute to provide support for the *Healthy Montgomery* work. This included coordinating the environmental scan, support of the effort to select the 100 indicators (available at HealthyMontgomery.org) to include in the improvement process, and preparation of indicators and maps that show the social determinants of health for the county as a whole and for Public Use Microdata Areas (PUMAs) that will be included in the *Healthy Montgomery* Needs Assessment document.

Beginning in 2011, Holy Cross Hospital and the four other individual hospitals in Montgomery County (MedStar Montgomery Medical Center, Shady Grove Adventist Hospital, Suburban Hospital, and Washington Adventist Hospital) have each given $25,000, for a total of $125,000 per year, to the Institute for Public Health Innovation. Funding increased to $150,000 per year in 2014 with the opening of Holy Cross Germantown Hospital. These funds continue to support the *Healthy Montgomery* Steering Committee meetings, preparation and presentation of all the community conversations, preparation of the Needs Assessment Report (quantitative data and information from the community conversations), and support for the prioritization process.

Healthy Montgomery is guided by a cross-sector steering committee that includes planners, policy makers, health and social service providers and community members. The *Healthy Montgomery* Steering Committee informs, advises, and ensures implementation of the CHIP. The CHIP is based on phases intended to occur within a three-year cycle. Phases include data collection and development of a community health needs assessment, development and implementation of improvement plans, and monitoring and evaluation of the resulting achievements. The process is dynamic, thus giving the county and its community partners the ability to monitor and act on the changing conditions affecting the health and well-being of county residents. The material presented in this document is based on Montgomery County's Community Health Needs Assessment conducted during the 2016-2019 cycle.

Prince George's County Health Department maintains PGCHealthZone.org which provides non-biased local health data, local resources, best practices and county information to one accessible, user-friendly location (Prince George's County Health Department, 2016). Holy Cross Health used data from *PGCHealthZone,* coupled with data pulled from the data sources found in *Healthy Montgomery,* to extract data specific to Prince George's County. This allowed analysis of the same health indicators for both counties.

External Review

Each year since 2005, we have invited input and obtained advice from a group of external participants that represent the broad interest of the community we serve. Participants typically include the public health officer and the director of Montgomery County Department of Health and Human Services; a variety of individuals from local and state

governmental agencies; and leaders from community-based organizations, foundations, churches, colleges, coalitions, and associations. These participants are experts in a range of areas including public health, health care, minority populations and disparities in health care, social determinants of health, and social services. They provide input that helps to ensure that we have identified and responded to the most pressing community health needs.

Community Conversations

In 2019, Holy Cross Health partnered with Community Catalyst, a national non-profit advocacy organization working to build the consumer and community leadership that is required to transform the American health system, to gather information about health needs and concerns from residents in the communities we serve. The conversations main goals were to 1) inform the CHNA, 2) identify key community partners for longer term community engagement through the development of Community Advisory Committees, and 3) work with the Community Advisory Committees to implement programs and initiatives to meet the needs identified during the conversations.

From April to June 2019, Holy Cross Health staff from the Health Equity, Health Behavior Department gathered information on the theme of *Health Matters* through three sets of activities:

1. Conducting small *Chat and Chews* to engage local residents in conversations about their health and invite them to the larger Community Conversations,
2. Collecting surveys from residents around the county, and
3. Outreaching to residents and community-based organizations through various listservs inviting them to join the Community Conversations.

During the identified timeframe, Holy Cross Health staff first surveyed community residents at local venues within the service area of Holy Cross Health and held *Chat and Chews*, informal conversations. A short, four-question survey was developed and available in both English and Spanish. Through the survey, Montgomery County residents had the opportunity to gather and share information about their health needs and the challenges they face meeting their health issues. The Chat and Chews were held at various venues throughout the county, and included locations such as Starbucks, the First AME Church of Gaithersburg, and the Montgomery County Boys and Girls Club.

Outreach for the four formal Community Conversations was done through emailing electronic invitations to listservs, posting flyers at Montgomery County Public Libraries and community centers, and posting flyers in public venues. Flyers were also distributed to individuals who completed surveys. Some individual contacts were made to local community-based organizations to invite them and their networks to the conversations. During the Community Conversation activities, graphic facilitators were designed to spark conversation and capture learned information.

Needs Assessments and Reports

As available, we also use a range of other specific needs assessments and reports to identify unmet needs, especially for underserved minorities, seniors, and women and children.

- African American Health Program Strategic Plan Toward Health Equity, 2009-2014
- Asian American Health Priorities, A Study of Montgomery County, Maryland, Strengths, Needs, and Opportunities for Action, 2008
- Blueprint for Latino Health in Montgomery County, Maryland, 2017-2026
- Montgomery County Food Council's Community Food Access Assessment; Montgomery County Maryland, 2013 - 2015
- Homelessness in Metropolitan Washington: Results and Analysis from the Annual Point-in-Time (PIT) Count of Persons Experiencing Homelessness, May 2019
- Maryland State Health Improvement Process
- Montgomery County Interagency Commission on Homelessness Annual Report, 2017
- Montgomery Moving Forward's Call To Action: Early Care and Education, 2018
- Prince George's County Health Department: Health Report 2017
- Prince George's County Health Department 2017-2021 Strategic Plan
- Convening Partners to Build Brighter Futures in Montgomery County. Montgomery County Collaboration Council's 2018 Annual Report
- University of Wisconsin Population Health Institute's County Health Rankings Data
- Maternal and Infant Health Report for Montgomery County, 2008-2017
- Health in Montgomery County Report, 2008 – 2016
- Transformative Change Our Role in Achieving Health Equity for Prince George's County, 2018

Community Need Index

The Community Need Index identifies the severity of health disparities for every ZIP code in the United States and demonstrates the link between community need, access to care, and preventable hospitalizations (Dignity Health, 2011). For each ZIP code in the United States, the Community Need Index aggregates five socioeconomic indicators/barriers to health care access that are known to contribute to health disparities related to income, education, culture/language, insurance and housing. We use the Community Need Index to identify communities of high need and direct a range of community health efforts to these areas (see Figure 2).

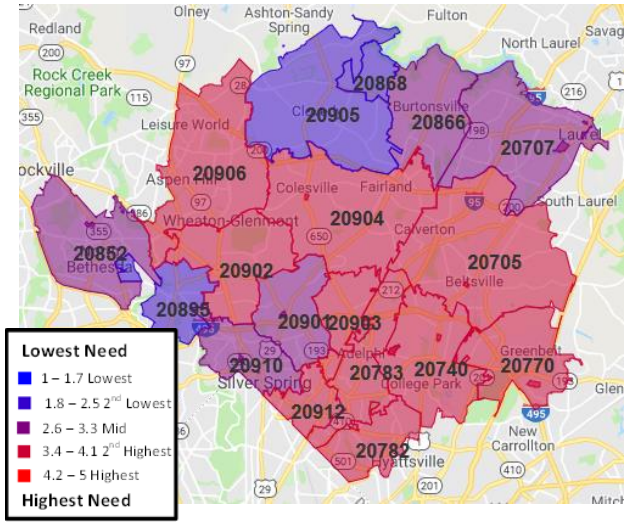


Figure 2: The median CNI of the primary service area of Holy Cross Hospital is 3.4, Holy Cross Health considers any area 3.0 or higher as high need. Source: Dignity Health, 2019 Map data: 2019 © Google

Hospital Quality Data

Holy Cross Hospital readmission data is used to track the number of patients who are readmitted to the hospital within 30 days of discharge. Centers for Medicare & Medicaid Services (CMS), defines hospital readmission as a patient admission to a hospital within 30 days after being discharged from an earlier hospital stay and the data can be used to evaluate the quality of hospital care. Prevention Quality Indicators (PQI) are a set of measures that are used with inpatient discharge data to identify the quality of care for ambulatory care sensitive conditions, conditions that evidence suggests could have been potentially avoided through better outpatient care (Agency for Healthcare Research and Quality, 2014). An analysis of hospital readmissions and PQI allow us to identify select indicators related to community health needs and develop methodologies and programs that will improve health outcomes.

Other Available Data

We also review our internal patient data (emergency department and discharge readmissions data) and review purchased and publicly available data and analyses on the market, demographics and health service utilization, health indicators, and social determinants of health. These data provide a more detailed look at the community we serve by identifying potential disparities that might not surface when looking at only county or state data. On an ongoing basis, we participate in a variety of coalitions, commissions, committees, partnerships and panels and our community health workers spend time in the community as community participants and bring back first-hand knowledge of community needs.

SUMMARY OF PROGRESS

Since 2009, *Healthy Montgomery*, the Montgomery County hospital systems, and other non-profit organizations have been implementing programs and services to address the unmet needs identified through the community health improvement process. Below is a compilation of progress made on the *Healthy Montgomery* core measures.

Are We Making Progress?

Among the 37 *Healthy Montgomery* core measures 22 are improving, 14 are worsening, and one could not be assessed since it has had no further updates after its baseline. More information on *Healthy Montgomery* core measures can be found at www.healthymontgomery.org.

Improving

Social Influencers of Health
Percent of families below federal poverty level
Percent of populations 5+ years that report speaking English less than very well
Percent of adults with adequate social/emotional support
Percent of students comfortable seeking help from adults beside parents
Percent of adults with at least a high school diploma/GED
Behavioral Health
Adults with any mental illness in the past year
Cancers
Prostate cancer incidence rate (age-adjusted)
Percent of women with Pap smear in the past three years
Percent of adults 50+ with recommended colorectal screenings
Cardiovascular Health
Heart disease mortality rate (age-adjusted)
Stroke mortality rate (age-adjusted)
Diabetes
Percent of adults ever being diagnosed with diabetes (excluding gestational diabetes)
Maternal and Infant Health
Infant mortality rate
Percent of births with low birth weight
Obesity*
Percent of adults doing recommended aerobic activity
Percent of students that drank soda or pop in the past week
Cross-Cutting Measures
Percent of adults with routine check-up in the past two years
Percent of residents without health insurance coverage
Percent of adults that currently smoke
Percent of students that currently smoke
Percent of adults with two or fewer poor mental health days in the past month
Percent of adults with two or fewer poor physical health days in the past month

Worsening

Social Influencers of Health
Percent of students currently in the Free and Reduced Meals program
Percent of students participating in any extracurricular activities
Behavioral Health
Percent of adolescents and adults with illicit drug use in the past month
Percent of students who felt sad/hopeless daily for 2+ weeks in the past year that they stopped doing usual activities
Suicide rate (age-adjusted)
Behavioral health emergency room visit rate (age-adjusted)
Cancers
Female breast cancer mortality rate (age-adjusted)
Cardiovascular Health
Percent of adults told they have high blood pressure by a doctor
Diabetes
Diabetes related emergency room visit rate (age-adjusted)
Diabetes related emergency room visit rate (age-adjusted)
Maternal and Infant Health
Percent of births with mothers receiving first trimester prenatal care
Obesity*
Percent of adults consuming 5+ servings of fruits and vegetables daily
Percent of overweight or obese adults
Percent of students with no physical activity in the past week
Percent of overweight or obese students
Cross-Cutting Measures
None

*Also considered Cross-Cutting Measures

Figure 3: OF THE 37 HEALTHY MONTGOMERY CORE MEASURES 22 ARE IMPROVING (LEFT SIDE), 14 ARE WORSENING (RIGHT SIDE), AND ONE COULD NOT BE ASSESSED SINCE IT HAS HAD NO FURTHER UPDATES AFTER ITS BASELINE.

Among the two Holy Cross Health Core measures for seniors, both are improving. In comparison to 2014, Adults 65+ have seen an increase in the number of seniors receiving an influenza and/or pneumonia vaccine. As of 2016, 65.3% of Montgomery County seniors received an influenza vaccine, and 76.3% received a pneumonia vaccine (compared to 62.6% and 73.8% in 2014, respectively). Additionally, the number of deaths from falls for seniors has decreased from 6.9 per 100,000 (2013-15) to 6.5 per 100,000 (2014-16).

Are We Achieving Health Equity?

Progress toward achieving health equity, defined as everyone having the opportunity to attain their highest level of health, can be measured through reduction in health disparities across racial/ethnic subgroups. Of the 34 measures that could be evaluated based on differences across racial/ethnic subgroups, 31 measures had results for White residents, 32 measures had results for African American/Black residents, 26 measures had results for Asian/Pacific Islander residents, and 31 measures had results for Hispanic residents. Results showed Black/African American residents experiencing a widening disparity 38% of the time, the highest proportion of measures across all racial/ethnic groups. Black/African American residents also had the highest proportion of core measures with results that showed their disparity was narrowing at 63% (Healthy Montgomery, 2016).

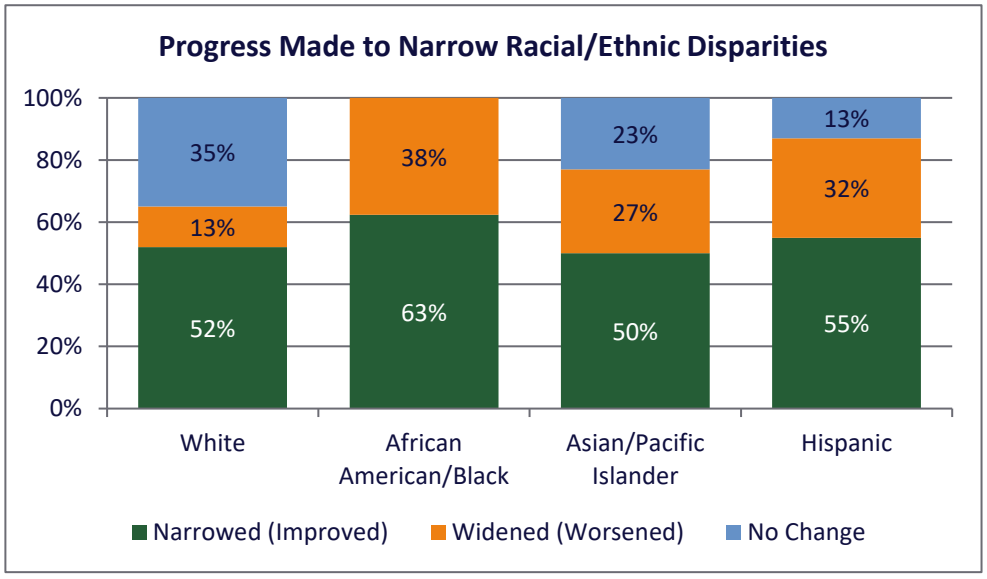


Figure 4: The percentage of Healthy Montgomery core measures that show that health disparities are narrowing, widening or remaining unchanged. Source: Healthy Montgomery 2016.

THE COMMUNITY WE SERVE

Holy Cross Hospital serves a large portion of Montgomery and Prince George's Counties residents (see Figure 5). Our 19 ZIP code primary service area (see Appendix A) includes 663,447 people, and an estimated 1.76 million people in 65 ZIP codes make up our total service area (see Table 1). Our primary service area is derived from the Maryland ZIP code areas from which the top 60% of our FY13 discharges originated. The next 15% contribute to our secondary service area.

The median age of the county is 39 years, up from 33.9 years in 1990. This increase in median age is driven mostly by the aging of the large population of baby boomers residing in the area. In 1990, the county's residents over the age of 65 accounted for only 10% of the population (77,500 residents). It is expected, by 2030, that the baby boomers will increase the county's 65+ population to 19% of the total population (218,000 residents) (Montgomery County Planning Department, 2019) (see Figure 6). In addition to an aging population, Holy Cross Hospital serves a highly diverse community. No racial or ethnic group accounts for more than one-third of residents (see Table 1). The county is also becoming more diverse. In 2016, 56% of county residents were people of color; Hispanics were the fastest growing subgroup followed by the Asian population. From 1990 to 2016, the Hispanic population grew 258% and accounts for 19.1% of the total population and the Asian population grew 153% and accounts from 14.8% of the total population.

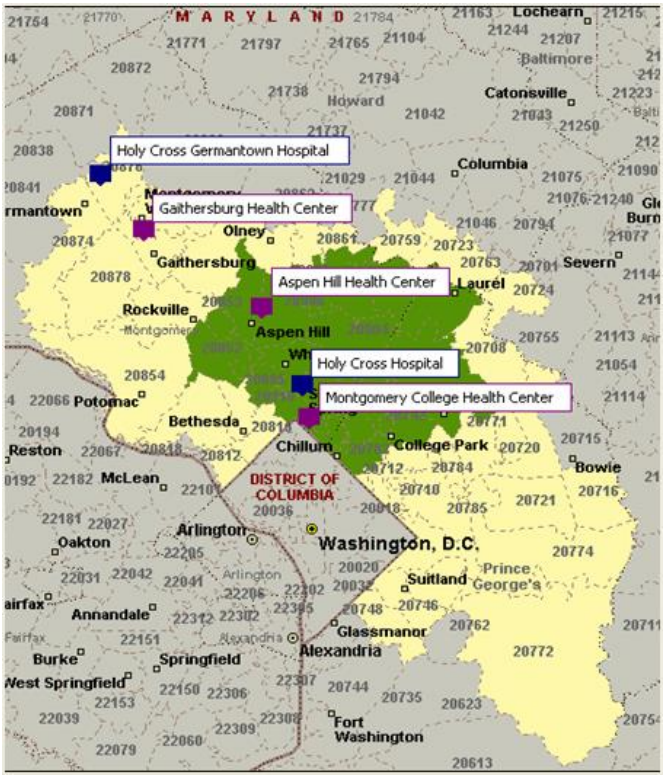


Figure 5: Primary and secondary service area for Holy Cross Hospital.

Table 1: Demographic breakdown of Holy Cross Hospital's service area by race and ethnicity. © 2018 The Nielsen Company, ©2018 Truven Health Analytics Inc.

Race	Primary Service Area (663,447)	Total Service Area (1.76 Million)
White, Non-Hispanic	206,912 (31.2%)	512,811 (29.0%)
Black, Non-Hispanic	177,210 (26.7%)	643,288 (36.4%)
Hispanic	185,152 (27.9%)	364,933 (20.6%)
Asian/Pacific Islander, Non-Hispanic	74,041 (11.2%)	190,563 (10.8%)
All Others	20,132 (3.0%)	55,747 (3.2%)

The community we serve has the highest percentage of foreign-born residents (29.3%) in the state of Maryland, and the majority of the total foreign-born population in Maryland reside within Montgomery County.

In Montgomery County, 32.6% of residents are foreign-born, 40% of foreign-born residents speak English less than "very well" and 7.0% aged five and over are linguistically isolated. In Prince George's County, more than 21% of residents are foreign-born of which 39% speak English less than "very well" and 4.9% of the population aged five and over are linguistically isolated with the most linguistic isolation occurring in northern Prince George's County. The highest rates of linguistic isolation for both Montgomery and Prince George's Counties are among Latino Americans and Asian Americans.

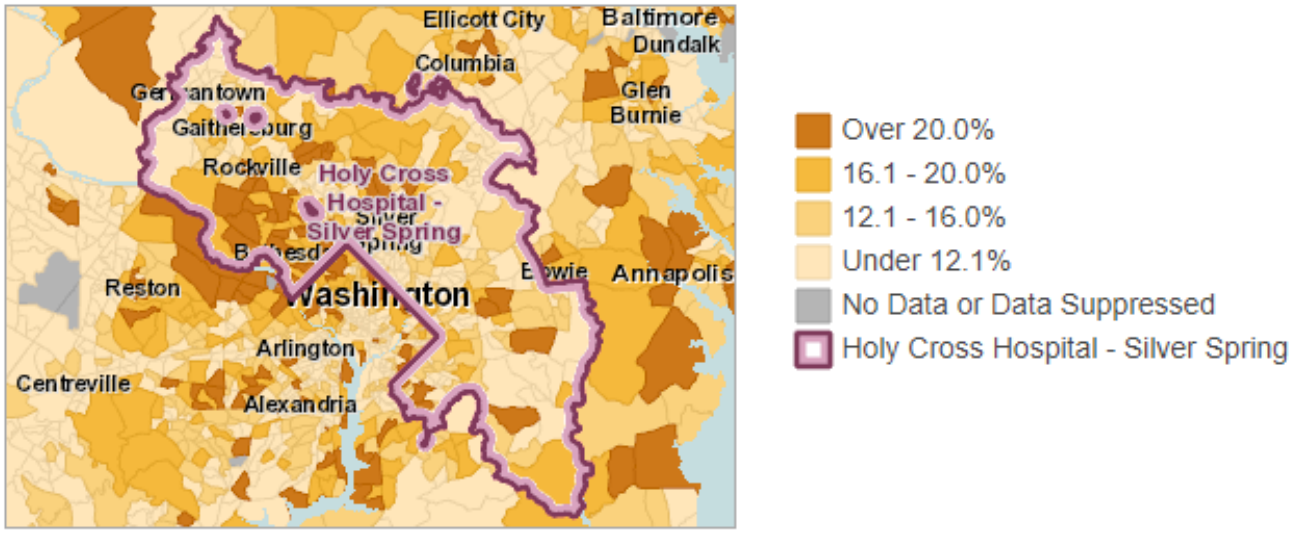


Figure 6: Percentage of population aged 65+. Source: Trinity Health Data Hub, 2019.

Community Conversations

Holy Cross Health gathered information from residents of the communities we serve during the spring and summer of 2019. Information was gathered through three different formats, *Chat and Chews*, surveys, and *Community Conversations*.

All formats focused on the topic "Health Matters" and received feedback from a racially, ethnically, and linguistically diverse group of community residents (see Figure 7) throughout Montgomery County. The conversations and surveys had two goals:

1. To learn from local residents what makes a community healthy
2. To enlist community members to join the Holy Cross Health Advisory Committee.

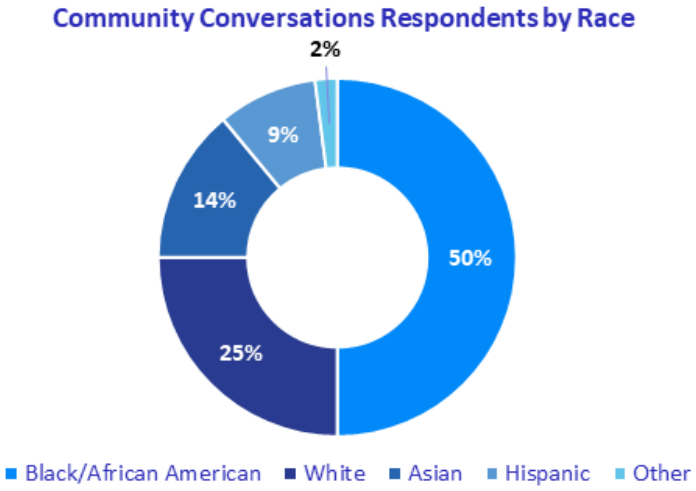


Figure 7: Racial and ethnic percentage of 2019 community conversation participants.

These goals were achieved by asking questions that pertained to access to care, barriers to achieving or maintaining good health, and what was needed to achieve or maintain good health.

Most responded that they were able to access medical care when needed (94%). However, challenges mentioned included lack of affordable medication, lack of access to healthy food, and lack of transportation. When the community was asked what was needed to achieve or maintain good health the top summarized responses were help with diet, nutrition, and food assistance (34%). Participants expressed interest in free classes about healthy eating and nutrition, support with finding affordable healthy groceries, grocery coupons, and a general interest in receiving support to eat healthier. There was also a strong interest in opportunities for exercise and fitness (24%). Participants expressed interest in free or low-cost group exercise classes held during evening hours, support for a gym membership, and more accessible exercise spaces. There was also a strong interest in more senior classes and a continuation of existing Holy Cross Health Senior Fit classes.

In addition to an interest in exercise and nutrition classes, there was also interest expressed for community programming (13.4%). Participants expressed interest in health seminars, support groups, classes explaining what resources are available, and evening senior classes.

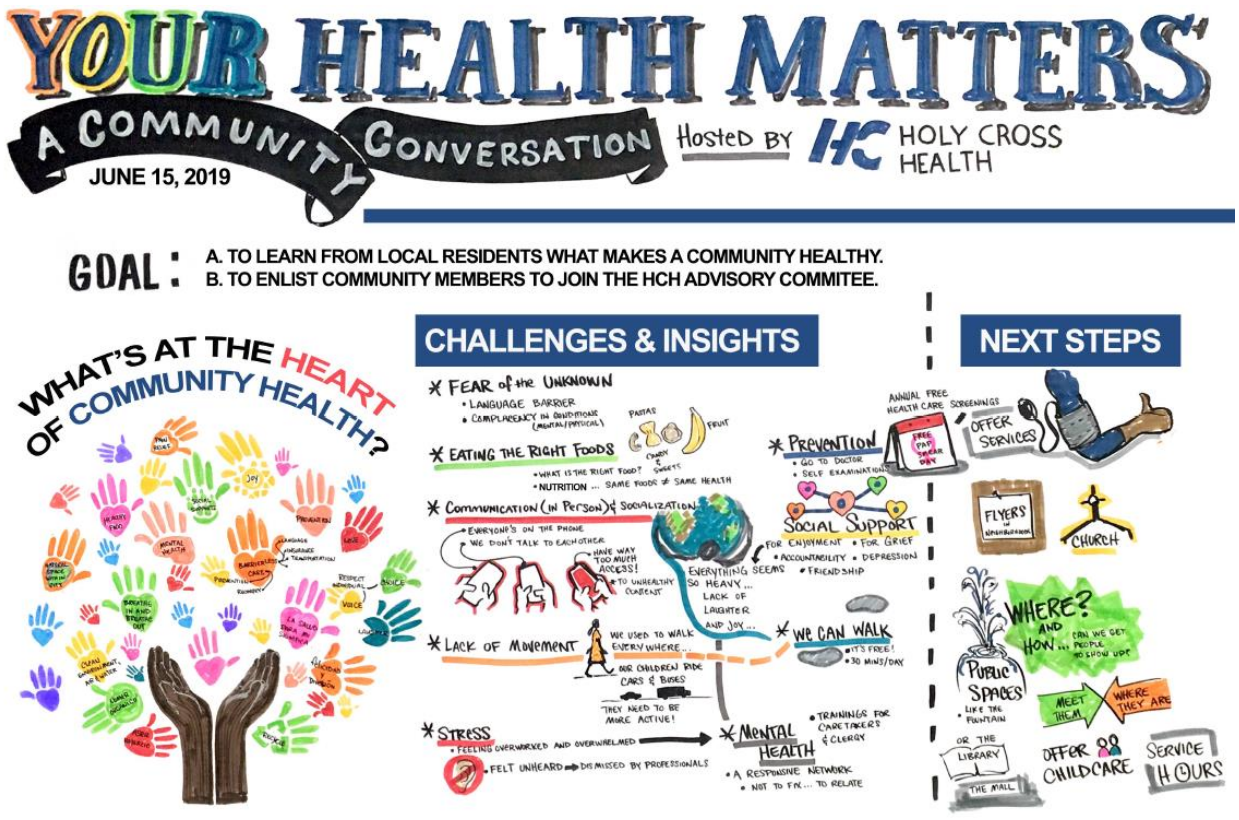


Figure 8: Graphic representation of community conversations and surveys. Participants shared concerns that related to influencers of health, such as movement and exercise, healthy eating/food access, stress, mental health and the need for social connectedness.

DETERMINANTS/ INFLUENCERS OF HEALTH

Introduction

Access to quality, affordable health care plays a significant role in the health of individuals. However, clinical care cannot address all the factors that shape both health behaviors and health itself (Braverman, Egerter, & Mockenhaupt, 2011). The Determinants of Health are factors that contribute to and influence the health (or the decline of health) of a population or group. The Determinants of Health can include macro and micro factors such as personal, social, and environmental factors (U.S. Department of Health and Human Services, 2016).

However, instead of referring to these factors as "determinants" of health and labeling them as something that will definitively affect health, Holy Cross Health and all Trinity Health entities have decided to refer to them as "influencers" of health. Referring to them as something that can influence our health but does not necessarily determine it. Understanding influencers of health, such as economic and behavioral factors can also lead to improvements in health and reductions in health disparities (Wiliams, Costa, Odunlami, & Mohammed, 2008).

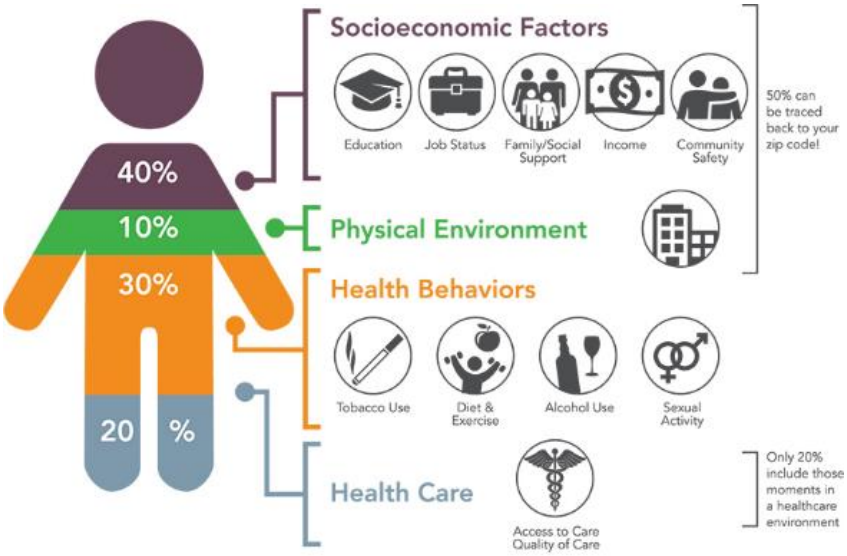


Figure 9: Health influencers and their impact on health. Source: Institute for Clinical Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October, 2014).

The Social Influencers of Health are a complex set of factors that interact within a social system. Social influencers can include physical structures, such as housing or more intrinsic issues, such as racism. According to the University of Wisconsin Population Health Institute, 50% of the factors that influence health are considered social influencers (see Figure 9). The World Health Organization (2019) states that Social Influencers of Health are “shaped by the distribution of money, power, and resources at global, national and local levels” and are largely responsible for health inequities.

Policy, system and environmental changes can also impact health in a positive way. Changing policies, systems and environments that affect where community members live work and play enables individuals to make healthy choices by ensuring that healthy, practical choices are available and accessible for them to choose (Cook County Department of Public Health, 2013).

Often, policies have a greater effect on improving health outcomes than programs and services provided. For example, it is estimated that since 1975 more than 255,000 lives have been saved due to seat belt laws (Centers for Disease Control and Prevention, 2011). Tobacco policies at the federal, state, and local levels have helped reduce the

percentage of current smokers from 23.5% of adults and 34.8% of youths in 1999 to 20.6% of adults and 19.5% of youths ten years later (Centers for Disease Control and Prevention, 2010). The Affordable Care Act (ACA) was designed to address the affordability and accessibility of health care in the U.S while also improving the quality of care that patients receive. It reduced the percent of uninsured residents from 16.0% to 9.2% nationally (Terlizzi, Cohen, & Martinez, 2019). In Maryland, one of 37 states that expanded Medicaid eligibility, the percent of uninsured residents dropped to 6.1% in 2018, down from 13.0% in 2010 (United Health Foundation, 2019).

Achieving positive health outcomes takes a multi-faceted approach and there is a need to go beyond health care and public health agencies to improve the health of communities. Healthy Montgomery recognizes this need and the impact that policy change has on health. During the 2015 priority setting process, steering committee members selected achieving Health in All Policies (HiAP) as one of three strategies Healthy Montgomery will focus on over the next three years. HiAP weaves health through all decision-making processes affecting the community; addressing how each decision could impact social determinants of health just as decision-makers would analyze its impact on budget, the environment and other factors prior to approval. For example, the Safe Routes to School Local Policy Guide uses the Health in All Policies approach to bring transportation and school government together to create routes to school that promote health, physical activity and safety (Rudolph, Caplan, Ben-Moshe, & Dillon, 2013). Instituting a HiAP approach throughout county government could have a strong impact on health outcomes by integrating health considerations across all policymaking sectors, and at all levels, to improve health (Association of State and Territorial Health Officials, 2013).

Socioeconomic Factors

Economics

Montgomery County is an affluent community in aggregate. The median household income is $103,178 compared to the statewide median household income of $78,916. However, nearly 48.4% of households earn less than $100,000 in a community in which the self-sufficiency standard for a family of four (income needed to meet basic needs without public subsidies or private/informal assistance) requires an annual income of $91,252. One adult living in Montgomery County would need to make $37,232—or $17.90 per hour, $2.90 more than the Living Wage (see Figure 10). In Prince George's County, the median household income is $78,607, slightly lower than the state as a whole, and 47.9% of households earn less than $75,000 in a community with a self-sufficiency standard of $71,851 for a family of four. A single parent with one infant would need to make $59,731 (University of Washington, 2019).

Figure 10: Hourly Wage to be self-sufficient in Montgomery County varies by family type. Source: Montgomery County Self-Sufficiency Standard Report, 2018.

An estimated 7% of the population in Montgomery County lives in poverty, with almost 98,000 (9%) of residents living 125% below the poverty level and almost 188,000 (18%) of residents living below 200% of the poverty level. In Prince George's County, an estimated 9.3% of the population lives in poverty. A little over 140,000 (15%) residents live 125% below the poverty level and almost 211,000 residents (23%) live 200% below the poverty level. Children are disproportionately affected. According to the U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, 9% of children are estimated to be living in poverty in Montgomery County and 13% in Prince George's County. In both counties Black and Hispanic children are more likely to be living in poverty than White children.

Food Insecurity

Food insecurity is an economic and social indicator of the health of a community. The U.S. Department of Agriculture (USDA) defines food insecurity as limited or uncertain availability of nutritionally adequate foods or uncertain ability to acquire these foods in socially acceptable ways. Poverty and unemployment are frequently predictors of food insecurity in the United States. A survey commissioned by the Food Research and Action Center (FRAC) found that one in four Americans worries about having enough money to put food on the table in the next year. Food insecurity is associated with chronic health problems in adults including diabetes, heart disease, high blood pressure, hyperlipidemia, obesity, and mental health issues including major depression (Mendy, et al., 2018).

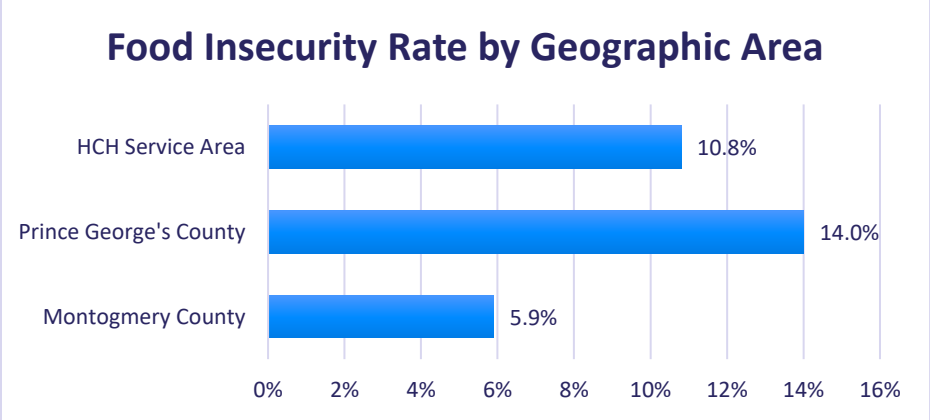


Figure 11: Food Insecurity Rate. The Healthy People 2020 national health target is to reduce household food insecurity and in doing so reduce hunger to 6.0%. Source: Feeding America, 2016.

Free and Reduced Meal Programs

The number of children eligible for free/reduced-price meals at public schools typically reflects the income and poverty levels of the surrounding neighborhoods. In Montgomery County during the 2018-2019 school year, 43,955 children received free lunch and 10,755 children received reduced-price lunch. Over 30% of the county's student population is enrolled in the free/reduced-price meal program. In Prince George's County, over 60,000 children are

enrolled in free lunch and almost 13,000 are enrolled in reduced-price lunch. Just over 60% of the student population is enrolled in free/reduced-price lunch.

Unemployment

The unemployment rate is a key indicator of the local economy and occurs when local businesses are unable to supply enough jobs for local employees or when the labor force is not able to supply appropriate skills to employers (Healthy Communities Institute, 2019). During periods of unemployment, individuals are likely to feel severe economic strain and mental stress. Unemployment is also related to access to health care, as many individuals receive health insurance through their employer. A high unemployment rate places a strain on financial support systems as unemployed persons qualify for unemployment benefits and food stamp programs.

Due to a large number of federal agencies and contractors, both counties generally enjoy low unemployment when compared to the U.S. and the unemployment rates of both counties has been steadily declining since 2011. In November 2018 the unemployment rate was 2.9% in Montgomery County, 3.7% in Prince George's County, and 4% for the state (U.S. Bureau of Labor Statistics, 2016); showing improvement from what was reported in previous years. However, these figures do not account for people who have stopped looking for employment.

Education

Montgomery County and Prince George's County enjoy relatively high education levels. More than half of Montgomery County residents hold a bachelor's degree or higher, and a little more than 30% of Prince George's County residents hold a bachelor's degree or higher. The population of people 25 years and over with no high school diploma are low in both counties, with less than 4% of the population in Montgomery County and less than 7% of the population in Prince George's County compared to 10% nationally.

High School Graduation Rates

High school graduation rates also have a high impact on the health of an individual. Individuals who do not finish high school are more likely than people who finish high school to lack the basic skills required to function in an increasingly complicated job market and society. Adults with limited education levels are more likely to be unemployed, on government assistance, or involved in crime (Healthy Communities Institute, 2019). In our service area, census tracts near Wheaton-Glenmont, Aspen Hill, and Gaithersburg in Montgomery County and University Park and Riverdale in Prince George's County have the largest

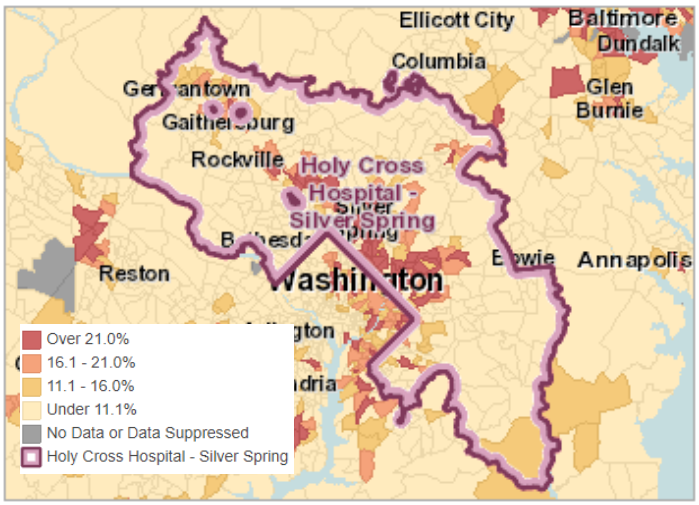


Figure 12: Population with no high school diploma (age 25+). Source: Trinity Health Data Hub, 2019

percentages of residents over the age of 25 with less than a high school diploma. In 2017, Montgomery County surpassed the Healthy People 2020 target of an 87% high school graduation rate with an 89.5% high school graduation rate and Prince George's County (82.7%) was slightly below this target.

Kindergarten Readiness

Kindergarten screening measures the readiness of each student to begin kindergarten based on education standards. The readiness standards are set by the Maryland Model for School Readiness and measure key areas such as language/literacy, mathematics, social skills, and motor development (Montgomery Moving Forward, 2018). For the 2018-2019 school year, 54% (up from 48%) of incoming Montgomery County Kindergarteners and 39% of incoming Prince George's County kindergartners (up from 34%) met the readiness standards. Disparities in kindergarten readiness can be seen in low-income households, English Language Learners, and children with disabilities (Montgomery Moving Forward, 2018)**Error! Reference source not found.**.

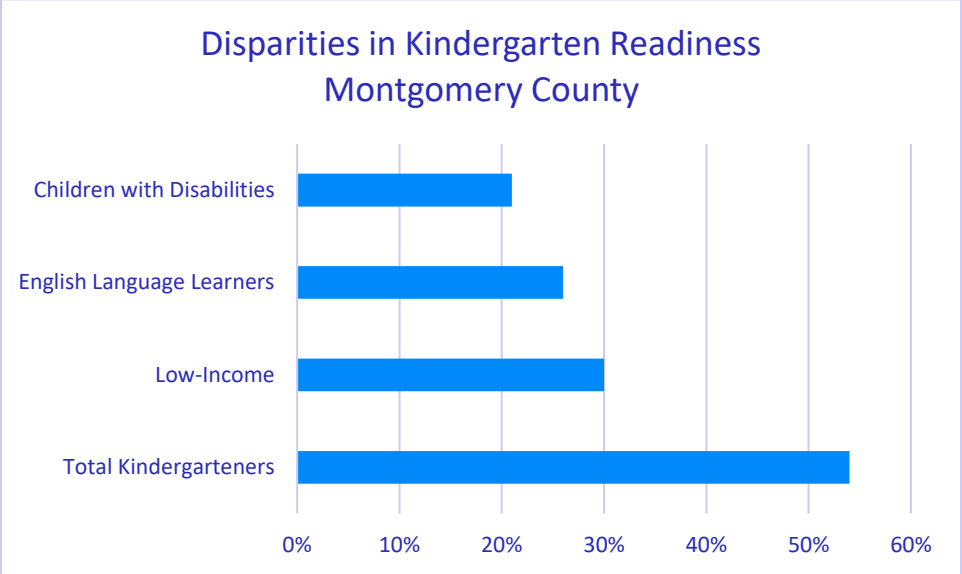


Figure 13: Disparities in kindergarten readiness can be seen in low-income households, English Language Learners, and children with disabilities. Source: Montgomery Moving Forward, 2018.

Physical Environment

Housing, Homes, and Neighborhoods

The home environment, which consists of living conditions and surrounding neighborhoods, has an impact on health status. Substandard neighborhoods and living conditions such as overcrowding, lead paint, and tobacco and alcohol advertising have been linked to poor health outcomes and can lead to an increased risk of cardiovascular disease, mental health issues, and unfavorable birth outcomes. According to the newest report from the Robert Wood Johnson Foundation Commission to Build a Healthier America, almost one-fifth of all Americans live in unhealthy

neighborhoods with limited job opportunities, low-quality housing, and with limited access to healthy food and physical activity (Robert Wood Johnson Foundation Commission to Build a Healthier America, 2014).

The high cost of living affects residents' access to safe, healthy housing. Paying a high rent can create a financial hardship, especially for those with a limited income, leaving little money for other expenses such as food, transportation, medical services and savings (Healthy Communities Institute, 2014). On average, 49.1% of renters in Montgomery County and 52.7% of renters in Prince George's County spend more than 30% of their income on rent. However, the highest percentage of residents spending more than 30% of their income on rent reside in ZIP codes surrounding Holy Cross Hospital and Holy Cross Germantown Hospital.

Safe Housing

Approximately 8.9% of the residents in Holy Cross Hospital's service area live in overcrowded housing, a 1.4% increase from the previous reporting period. Issues such as overcrowding and other substandard living conditions can impact family relationships, the spread of infectious diseases, education, stress and anxiety. A little over 36.3% of residents in our service area live in housing with one or more substandard conditions; slightly higher than the state average of 32.7%. Substandard conditions included at least one of the following living conditions: lacking complete plumbing facilities, lacking complete kitchen facilities, overcrowded (more than one occupant per room), selected monthly owner costs greater than 30% of income, and gross rent greater than 30% of income (Trinity Health, 2019).

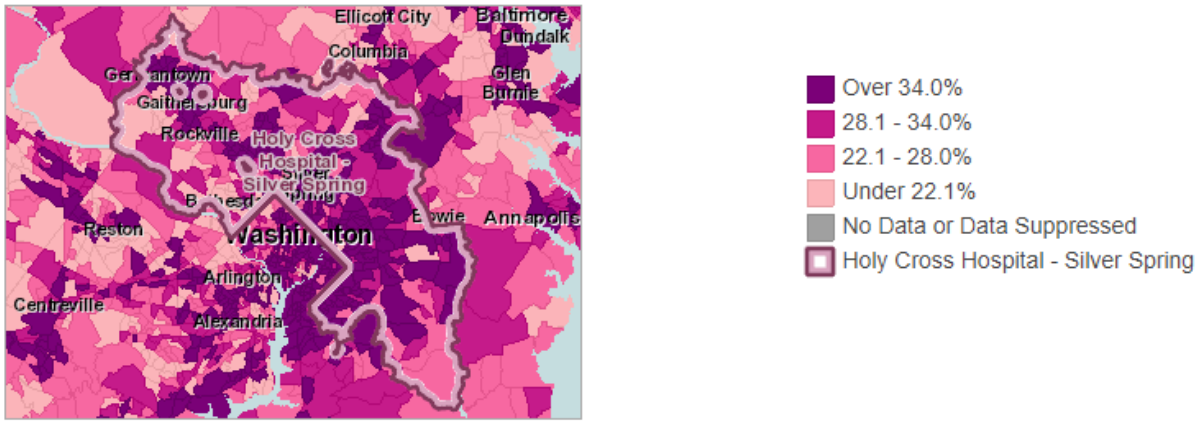


Figure 14: Percent occupied housing units with one or more substandard conditions. Source: Trinity Health Data Hub, 2019.

Neighborhoods

Neighborhoods can also be detrimental to the health of the population. Neighborhoods high in crime, polluted, or with limited access to services can affect the healthy behaviors of individuals and families. The ability to be physically active can be affected by the number of and access to safe places to exercise and play. Studies have shown that a person's neighborhood can even affect smoking and a healthy diet among other things (Robert Wood Johnson Foundation Commission to Build a Healthier America, 2014). When compared to the state average, the Holy Cross Hospital service area has an adequate number of recreation and fitness facilities where residents can be active (14.8

for every 100,000 persons in Montgomery County and 7.4 for every 100,000 persons in Prince George's County). However, it also has more than 800 fast-food restaurants. That equates to approximately 84 fast-food restaurants per 100,000 persons residing in our service area. As of 2016, the Holy Cross Hospital service area also has 250 beer, wine, and liquor establishments, a rate of 15.2 per 100,000 persons (Trinity Health, 2019).

Food Deserts

Food deserts, geographic areas where residents' access to affordable, healthy food options (especially fruits and vegetables) is restricted or nonexistent, usually occur in low-income urban and rural neighborhoods. Food deserts are more than a mile away from a supermarket, highly limited in food choices, and usually have an abundance of fast food chains and convenient stores (US Department of Housing and Urban Development, 2019). More than 100,000 residents in Holy Cross Hospital's service area live in food deserts.

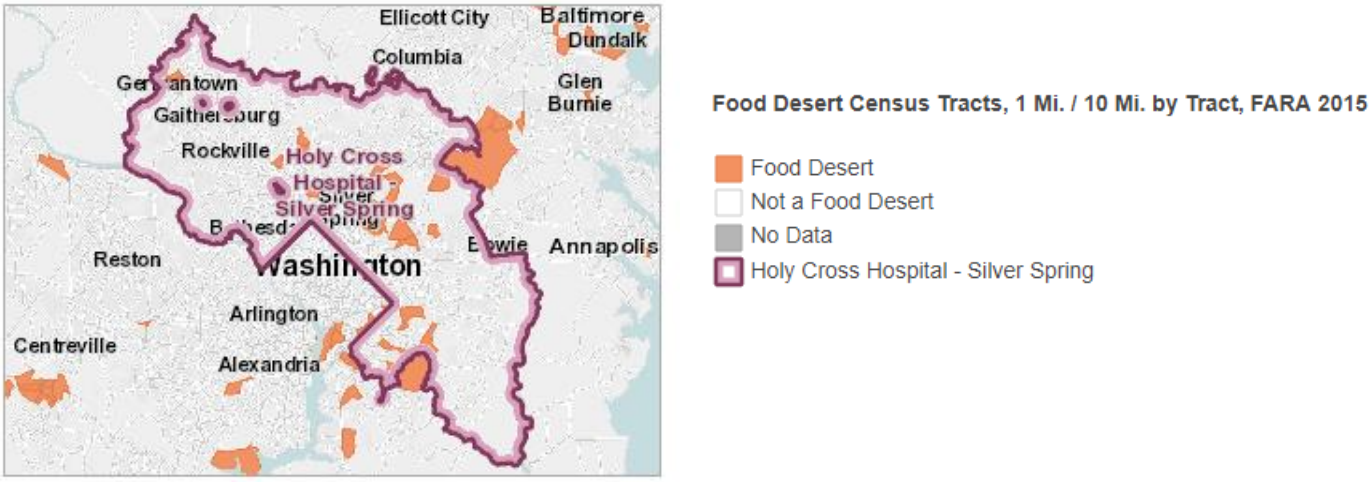


Figure 15: Number of neighborhoods in the report area that are within food deserts. Source: Trinity Health Data Hub, 2019.

Violent Crime

Violent crime can also have an effect on the health of a community. Violent crime can affect the mental and physical health of residents by increasing stress. Increase in stress may negatively affect hypertension and other stress-related disorders. Stress may also contribute to obesity prevalence by deterring residents from pursuing healthy behaviors, such as exercising outdoors (University of Wisconsin Population Health Institute, 2019). During the 2014-2016 reporting period, 4,909 violent crimes occurred in the Holy Cross Hospital service area. The service area's violent crime rate was 281.3, much lower than the statewide rate of 461.8. Violent crime includes homicide, rape, robbery, and aggravated assault.

Individuals exposed to violence at any age are more likely to engage in and experience intimate partner violence or domestic violence (Beyer, Wallis, & Hamberger, 2013). Domestic violence is any criminal offense resulting in physical injury or death of one family or household member by another family or household member, including assault, battery, sexual assault, sexual battery, stalking, kidnapping, or false imprisonment. According to the Commission on

Domestic Violence, domestic violence offenses typically account for about 14% of all criminal offenses annually (Healthy Communities Institute, 2019). Women exposed to intimate partner violence have an increased risk of physical health issues such as injuries, and mental health disorders such as disordered eating, depression and suicide (Raghavan, Mennerich, Sexton, & James, 2006).

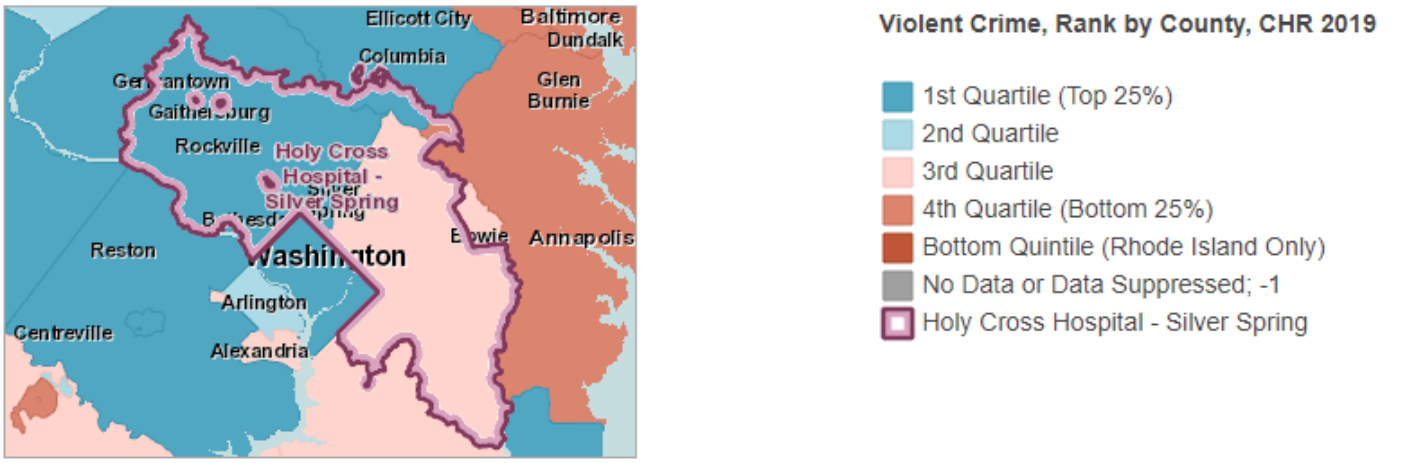


Figure 16: Violent crime ranked by county. The Holy Cross Hospital service area and a violent crime rate of 281.3 per 100,000 population. Source: Trinity Health Data Hub, 2019.

Human Trafficking

Human trafficking, a form of modern slavery where people profit from the control and exploitation of others, has been an issue in Montgomery and Prince George's Counties, Maryland, nationally and internationally. Traffickers use multiple ways such as violence, threats, and debt bondage to force people into sex or labor trafficking against their will (Polaris, 2019). In 2014, former County Executive Ike Leggett created the Montgomery County Human Trafficking Task Force. The purpose of the task force is to increase understanding of the issue in Montgomery County and to develop interagency coordination of strategies for response and prevention. In 2014, MCPD had two verified adult victims and no verified juvenile victims. In 2015, this number increased to 11 adult victims and one juvenile victim. In 2016, it had 10 adult victims and three juvenile victims (Montogmery County Government, 2018). In October 2017, the task force transitioned into the Montgomery County Human Trafficking Prevention Committee. Human trafficking data is very hard to determine, however, based on the rate of calls received from the National Human Trafficking Hotline, Washington, DC area ranks number one with 401 calls per 100,000 people. Since 2007,

Figure 17: Heat map that reflects the cases reported to the National Human Trafficking Hotline. This map only reflects cases in which the location of the potential trafficking was known. Source: National Human Trafficking Hotline.

the National Human Trafficking Hotline has received 4,352 contacts – phone calls, texts, online chats, emails, and webforms – from the state of Maryland (National Human Trafficking Hotline, 2017).

Homelessness

The high cost of housing and a limited number of reduced, affordable options have left many jurisdictions in the surrounding areas with an increasing number of individuals and families at risk for experiencing homelessness (Metropolitan Washington Council of Governments' Homeless Services Planning and Coordinating Committee, 2019). According to the annual point-in-time count conducted by the Metropolitan Washington Council of Governments' Homeless Services Planning and Coordinating Committee (2019), the District of Columbia, Montgomery County, and Prince George's Country have all experienced a decline in the number of persons experiencing homelessness from 2018 to 2019. Montgomery County reported the highest percentage reduction, 41% (1100 to 647 individuals) in its literally homeless count from 2015 to 2019 and Prince George's County had a 29% reduction (627 to 447 individuals). In December 2015, Montgomery County announced it had achieved functional zero homelessness for Veterans. However, this does not include residents who are at risk of losing housing or those who are couch-homeless (those living temporarily with others without guarantee of continued residency or immediate prospects for assessing permanent housing (Canadian Observatory on Homelessness, 2019). The couch-homeless are also referred to provisionally accommodated, precariously housed, doubled up, or couch surfers. The number of couch-homeless individuals is hard to identify and is estimated to be 1-2% of the population, nation-wide (Hoback & Anderson).

Transportation

Transportation plays an integral part in accessing health care and resources that promote health such as parks and recreation facilities; barriers to transportation limit this access and have a negative effect on health. Barriers are especially high for seniors, people with disabilities, and people of limited income. In a survey conducted at Holy Cross Health's Health Centers, 19.5% of patients reported forgoing medical care because of lack of transportation.

Montgomery and Prince George's Counties have a vast network of public transportation options that range from metro rail, bus and train transport, including subsidized services for seniors and people with disabilities. However, ridership dictates the number and location of stops, leaving many residents in less populated areas with limited access to county services and resources.

Health Behaviors

Healthy behaviors like being physically active, eating fruits and vegetables, and maintaining a healthy weight can reduce risks of chronic disease and increase quality of life and life expectancy. Risky behaviors such as poor eating habits, lack of exercise, and smoking increase risks of chronic disease and decrease quality of life and life expectancy. Changing unhealthy habits to adopt a healthier lifestyle and improve health can be difficult and can be viewed as impossible, especially if access to services and support is limited.

Physical Activity and Nutrition

Eating the recommended fruits and vegetables, coupled with a balanced diet, can help maintain a healthy weight and reduce risk factors associated with man chronic disease, including cancer, diabetes and obesity. The USDA currently

recommends two and one-half cups (five servings) of vegetables and two cups of fruits (preferably whole fruits) daily for a 2,000-calorie diet (United States Department of Agriculture, 2019). Despite the health benefits, many people still do not eat the recommended levels. In Montgomery and Prince George's Counties, more than half of residents do not consume the recommended intake of fruits and vegetables (Centers for Disease Control and Prevention, 2015). Only 29.6% of Montgomery County adult residents and 32.4% of Prince George's County adult residents report eating fruits and vegetables five or more times per day.

Like eating a balanced diet, regular physical activity reduces the risk of multiple chronic diseases and helps maintain a healthy weight and reduce body fat. Active adults reduce their risk of many serious health conditions including obesity, heart disease, diabetes, stroke, colon cancer, and high blood pressure. Physical activity also reduces symptoms of anxiety and depression, improves mood and feelings of well-being, and promotes healthy sleep patterns. The American College of Sports Medicine (ACSM) recommends that active adults perform physical activity three to five times each week for 20 to 60 minutes at a time to improve cardiovascular fitness and body composition. Unfortunately, only 40% of adults in the United States engage in the recommended amount of physical activity. However, the percentage of physically active adults in Montgomery County (52.8%) and Prince George's County (47.4%) is higher than the national average (Trinity Health, 2019).

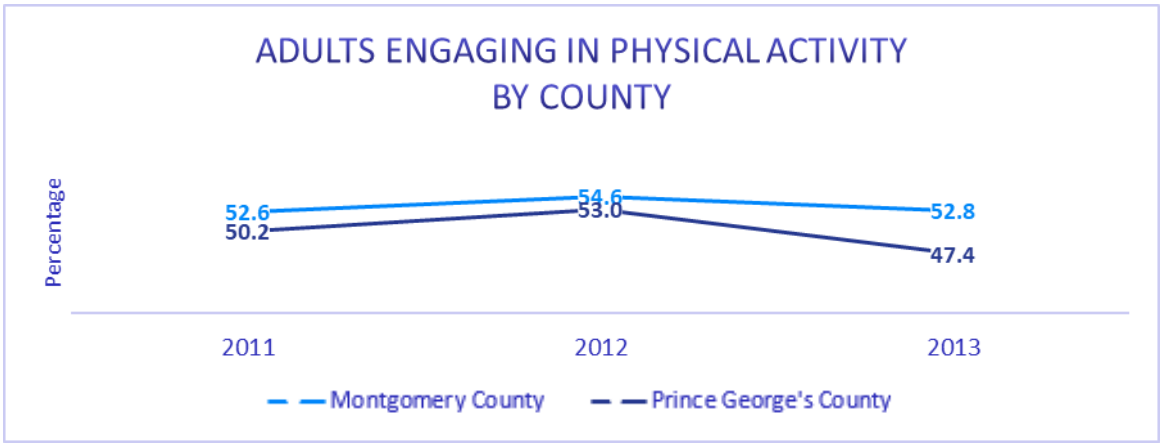


Figure 18: Percentage of adults who engage in regular physical activity. Source: MD BRFSS, 2013.

Smoking

Other behaviors that have a negative impact on health include tobacco use and alcohol consumption. Tobacco use remains the leading cause of preventable death in the United States, killing more than 480,000 people each year.

Both Montgomery and Prince George's Counties have lower rates of tobacco use when compared to the state and national rates. Less than 7% of Montgomery County residents and less than 11% of Prince George's County residents are current smokers (see Table 2).

Table 2: Percent of adults, aged 18+, who self-reported currently smoking cigarettes some days or every day. Source: Centers for Disease Control and Prevention, 2016 Behavioral Risk Factor Surveillance System

Report Area	Age-Adjusted Smoking Rate
Montgomery County	6.2%
Prince George's County	10.3%
Maryland	13.7%
United States	17.1%

Each day, 400 kids under the age of 18 become regular, daily smokers; and almost one-third will eventually die from smoking. If current trends continue, 5.6 million of today's youth will die prematurely from a smoking-related illness. Maryland currently has a near national average rate of high school smoking and adult smoking, when compared to national statistics. However, this still puts an estimated 92,000 children, now under the age of 18, on track to die prematurely due to smoking, with 2,200 children becoming daily smokers every year. The result is an annual health care cost of $2.71 billion that is directly caused by smoking, with an additional $2.22 billion in lost productivity (Preventing Tobacco Addiction Foundation, 2019). In 2019, the state of Maryland joined 17 other states and the District of Columbia and passed Tobacco 21, a law that increases the minimum legal sale age for any tobacco products to 21. The law is intended to cut down on the access that teenagers have to cigarettes and other tobacco and nicotine products, including e-cigarettes.

Many youth are unaware of the potentially serious side effects of electronic vapor products such as e-cigarettes, vapes, electronic nicotine delivery systems, and similar devices. These devices typically deliver nicotine, flavorings, and other additives to users through an inhaled aerosol. Electronic vapor products are usually flavored and are of particular concern due to their high nicotine content and nicotine's harmful effects on the developing adolescent brain. Additionally, the aerosol emissions can contain heavy metals such as nickel, lead and tin, and flavoring such as diacetyl, a chemical linked with lung disease. Currently, electronic cigarette devices are the most used product by youth compared to individual use of cigarettes, cigars, and smokeless tobacco (Prevention and Health Promotion Administration, 2017).

Table 3: Percent of high schoolers (9th-12th grade) who self-reported smoking tobacco products in the past 30 days Source: Centers for Disease Control and Prevention, 2016 YRBS Survey.

Report Area	Electronic Vapor Product	Smokeless Tobacco	Cigarettes or Cigars
Montgomery County	8.8%	3.5%	8.6%
Prince George's County	9.0%	5%	10.0%
Maryland	13.3%	6.2%	8.2%
United States	13.2%	5.5%	8.8%

Alcohol Use

Binge drinking is a common pattern of excessive alcohol use in the United States. Binge drinking can be dangerous and may result in vomiting, loss of sensory perception, and blackouts. The prevalence of binge drinking among men is twice that of women. Male binge drinking is defined as five or more drinks on one occasion, and female binge drinking is four or more drinks on one occasion. In addition, it was found that binge drinkers are 14 times more likely to report alcohol-impaired driving than non-binge drinkers (Bernosky-Smith, Shannon, Roth, & Liguori, 2011). Alcohol abuse is associated with a variety of negative health and safety outcomes including alcohol-related traffic accidents and other injuries, employment problems, legal difficulties, financial loss, family disputes and other interpersonal problems. Both Montgomery and Prince George's Counties report lower excessive alcohol consumption compared to the state and national levels (see Table 3).

Table 4: Percent of adults who self-reported binge drinking at least once during the 30 days prior to the survey. Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2016.

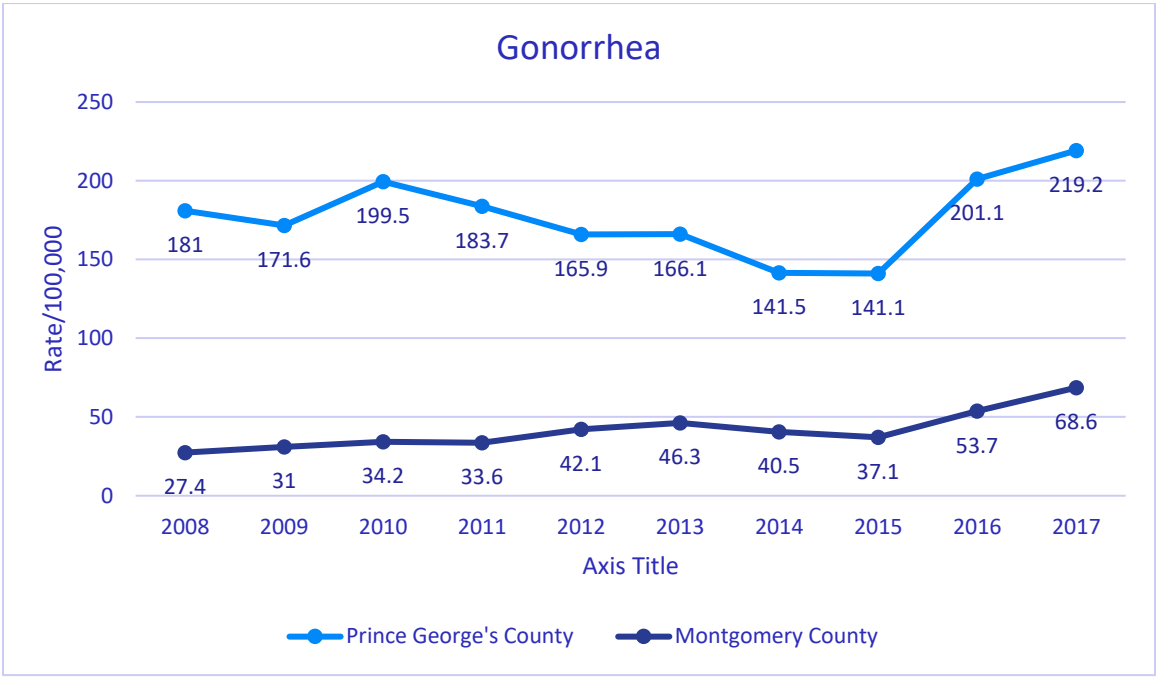
Report Area	Total Population Age 18+	Excessive Alcohol Consumption Rate
Montgomery County	795,544	14.8%
Prince George's County	710,361	14.5%
Maryland	4,648,466	16.5%
United States	247,403,128	18.4%

Sexual Activity

High-risk sexual behavior, such as unprotected sex, multiple sex partners, and starting sexual activity at a young age can result in sexually transmitted infections (Cigna, 2019). In both Montgomery and Prince George's County sexually transmitted infections (STIs), such as Chlamydia and Gonorrhea, have increased significantly over the past ten years.

Chlamydia is one of the most reported STIs in the United States. It is a treatable infection caused by the bacterium, Chlamydia trachomatis. Symptoms are mild or absent but can cause irreversible damage in women, including infertility, before an infection is recognized. Under-reporting of chlamydia is substantial because most people with chlamydia are not aware of their infections and do not seek testing (Healthy Communities Institute, 2019).

Gonorrhea, caused by the Neisseria gonorrhoeae bacterium, is typically asymptomatic. In most circumstances, Gonorrhea is easy to treat. However, over the years, the bacterium has developed resistance to antibiotics. Left untreated, gonorrhea can cause serious and permanent health problems in both women and men. In women, gonorrhea is a common cause of pelvic inflammatory disease. In the United States, the highest reported rates of infection are among sexually active teenagers, young adults, and African Americans (Trinity Health, 2019).



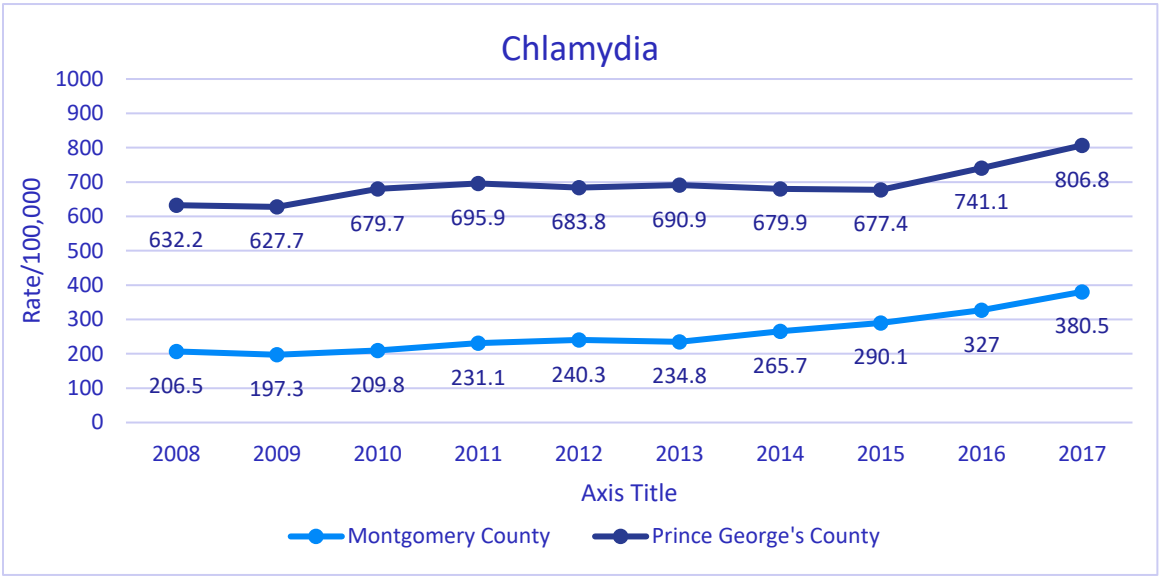


Figure 19: sexually transmitted infections (STIs) such as Chlamydia and Gonorrhea have increased significantly over the past ten years. Source: Centers for Disease Control and Prevention, NCHHSTP AtlasPlus, 2017

The human immunodeficiency virus, the virus that can develop into acquired immunodeficiency syndrome (AIDS), is a chronic and potentially life-threatening condition. If left untreated, HIV typically progresses to AIDS in about 10 years, at which point the immune system is weakened to the point of being unable to fight infections. Men who have sex with men of all races, African Americans, and Hispanics/Latinos are disproportionately affected by HIV.

Today, more people than ever before are living with HIV/AIDS. Better treatment for HIV has resulted in people living longer than in past years. While the total number of people living with HIV in Montgomery and Prince George's County is increasing, the number of annual new HIV infections has remained relatively stable in Montgomery County and declining in Prince George's County (Trinity Health, 2019).

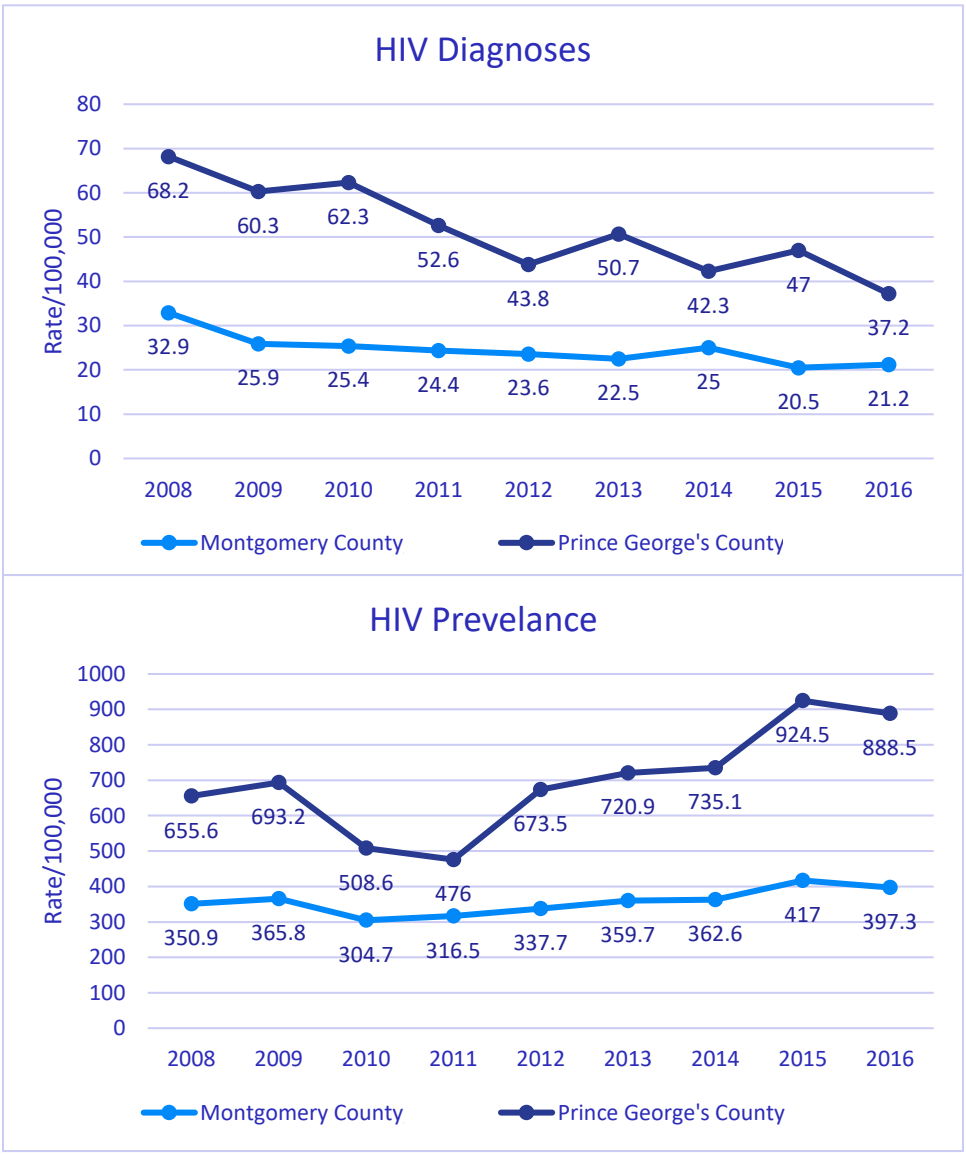


Figure 20: The HIV incidence rate has declined over the last year. Although the prevalence has increased, this can be attributed to better treatment and more people are infected each year than die from the infection. Source: Centers for Disease Control and Prevention. NCHHSTP AtlasPlus. Updated 2017.

Although the incidence rate is stable or declining in the communities, we serve. Montgomery County and Prince George's County have one of the highest incidence rates in the country. An analysis of HIV data conducted by the Centers for Disease and Prevention found that more than half of new HIV diagnoses occurred in only 48 counties,

Washington, D.C., and San Juan, Puerto Rico (Centers for Disease Control and Prevention, 2019). Montgomery County and Prince George's County are among the 48 counties identified.

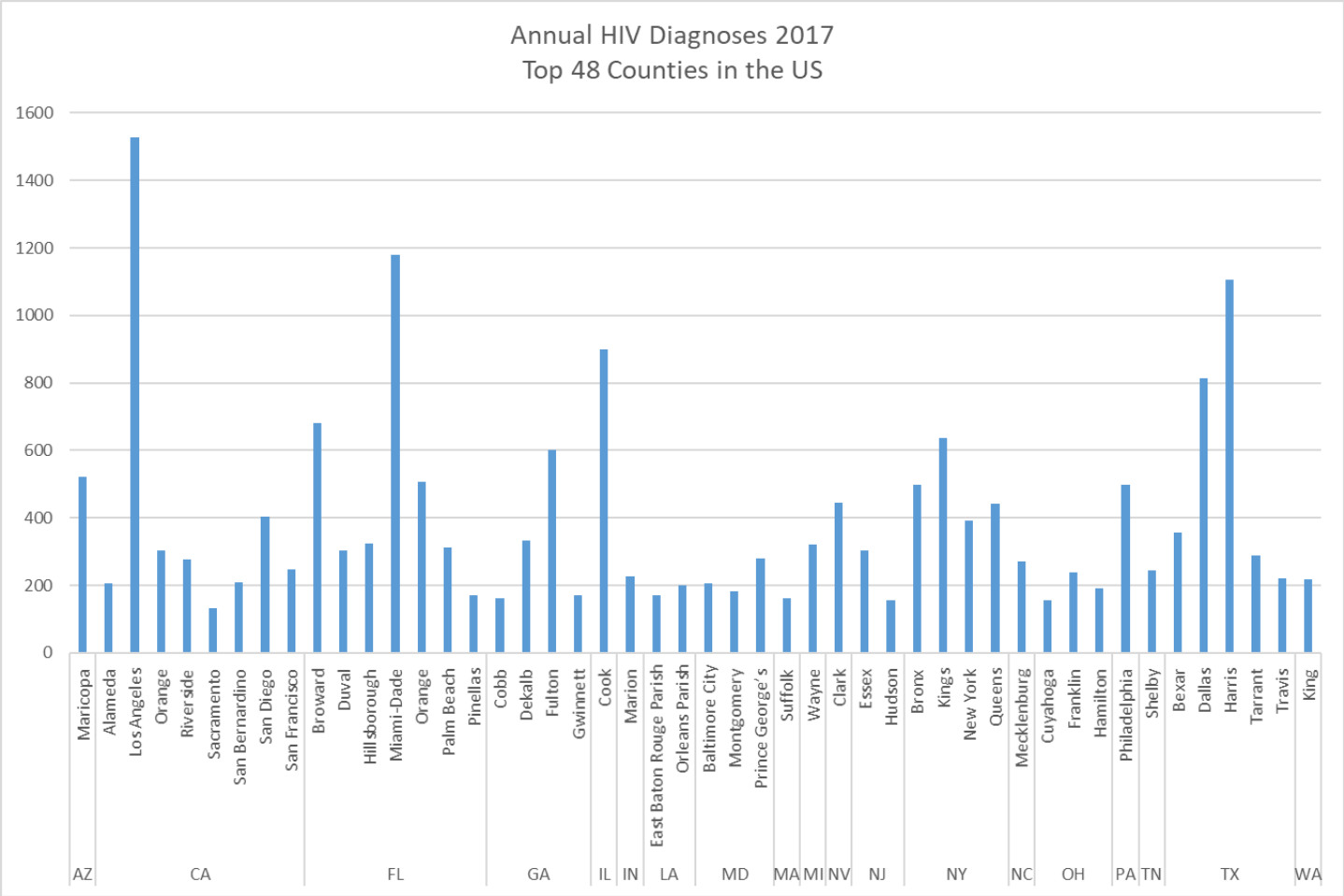


Figure 21: HIV surveillance data for the 48 counties with the highest diagnosed cases of HIV. Source: Centers for Disease Control and Prevention.

Health Care Access

Lack of insurance is a primary barrier to health care access including regular primary care, specialty care, and other health services that contribute to poor health status.

Insurance Coverage

The implementation of the Affordable Care Act's expanded insurance coverage in January of 2014 made insurance accessible to thousands of residents in Montgomery and Prince George's County, possibly for the first time. In the last six months of fiscal year 2014, Medicaid enrollment in Montgomery and Prince George's County increased 30% and

35%, respectively. During the 2019 enrollment period, Maryland Health Benefit Exchange enrolled 153,584 individuals in a qualified health plan and 39,334 in a dental plan (Maryland Health Connection, 2018). Of the 153,584 individuals enrolled in a qualified health plan, approximately 42% of those enrolled reside in Montgomery and Prince George's Counties. As of February 2019, more than one million people are covered under the Maryland Medicaid expansion. At the state level, the majority of uninsured residents are eligible for health insurance. However, approximately 70% (60,000) of uninsured residents in Montgomery County and 49% (52,000) of uninsured residents in Prince George's County will remain uninsured due to ineligibility (Regional Primary Care Coalition, 2019). In Montgomery and Prince George's Counties, Hispanics followed by African Americans have the highest number of uninsured residents (Trinity Health, 2019). Healthy Montgomery, the county's community health improvement process, has ranked access to care for those uninsured and underinsured as an underlying factor that affects all of the selected top health priorities.

Availability and Affordability of Services

Access to affordable health insurance represents only one barrier to access care. Availability, affordability and language also play a role in preventing Montgomery and Prince George's Counties residents from accessing quality health care. In Montgomery County, access to primary care physicians, dentists and mental health providers is higher when compared to surrounding areas. However, despite the high numbers of primary care physicians available in Montgomery County, 10.4% of the population is unable to afford to see a doctor (Trinity Health, 2019).

Table 5: Insurance status in Montgomery County, Prince George's County, and Holy Cross Hospital's service area. Source: Trinity Health Data Hub, 2019.

	Prince George's County	Montgomery County	Holy Cross Hospital Service Area	Holy Cross Hospital Patient Population
Medicaid	21.7%	14.4%	18.1%	47.1%
Uninsured	13.01%	9.1%	10.7%	7.1%

Health Equity

The American Public Health Association (2019) defines health equity as everyone having the opportunity to attain their highest level of health. In order for health equity to be achieved, barriers to health must be removed. These barriers can include Social Influencers of Health such as poverty, lack of access to care, quality education and quality housing.

The American Public Health Association (2019) defines health disparities as differences in health status between people related to social or demographic factors such as race, gender, income or geographic region. Health disparities are a way to measure progress toward achieving health equity (Office of Disease Prevention and Health Promotion, 2019). In the U.S, minority groups typically experience more poverty and worse health outcomes. This is evident in Montgomery and Prince George's Counties. For example:

- Black females experience higher death rates due to breast cancer compared to White females
- Colorectal screening rates for Asians, Blacks and Hispanics are significantly lower than for Whites
- Blacks experience higher colorectal cancer incidence and death rates than Asians, Hispanics and Whites
- Blacks experience higher incidence and death rates for prostate, lung and bronchus cancer
- Hispanic females experience higher cervical cancer incidence rates than Black and White females.
- High blood pressure prevalence is higher for Blacks
- Asian incidence of diabetes is higher than Blacks or Whites

Although infant mortality rates have been steadily declining in both Montgomery and Prince George's counties, Black mothers are disproportionately more likely to experience worse birth outcomes than any other group. For example, even when the income and education level of the mother is considered, Black mothers in Prince George's County are still more likely to experience higher infant mortality rates. Infants are also more likely to be born with low weight to Black mothers in both counties.

HEALTH INDICATORS

Introduction

Health indicators, such as causes of death (see Table 6) are measures designed to summarize information about a given priority topic in population health or health system performance. These indicators can be used to describe the health of a population, health differences within a population, or to determine if a program's objectives are being met. Healthy People 2020 contains 42 topic areas with more than 1,200 objectives. A smaller set of Healthy People 2020 objectives, called Leading Health Indicators (LHIs), have been selected to communicate high-priority health issues and actions that can be taken to address them. The most common HP2020 LHIs are those related to birth and death, such as life expectancy, premature mortality, or adequacy of prenatal care.

In this section, *Healthy Montgomery*'s six top ranked priority areas have been selected, as well as select indicators related to the senior population. Each priority has been coupled with select indicators from Holy Cross Health programs implemented to address the unmet needs identified in our previous CHNAs. This shows a visual representation of Holy Cross Health's effort to impact health improvement for our service area. However, it should be noted that our programs represent only a portion of county resources and many factors influence "moving the needle" in a positive direction.

In addition, Healthy Montgomery has identified a set of core measures for each health priority. The core measures are identified in each section with arrows identifying if the measures have improved or worsened since the last needs assessment.

Table 6: Top five leading causes of death for Montgomery County and Prince George's Counties, 2015-2017 (Source: Maryland Vital Statistics Administration, 2017.

Montgomery County	Age-adjusted Death Rate/100,000 (2017)	Age-adjusted Death Rate/100,000 (2014)
Cancer	115.2	121.7
Heart Disease	100.2	110.7
Stroke	23.1	25.2
Accidents	19.7	17.0
Chronic Lower Respiratory Disease	15.1	17.4

Prince George's County	Age-adjusted Death Rate/100,000 (2017)	Age-adjusted Death Rate/100,000 (2014)
Heart Disease	178.1	172.5
Cancer	157.8	156.5
Stroke	44.4	35.1
Accidents	30.1	25.2
Diabetes	26.9	28.3

Cancer

The National Cancer Institute (NCI) defines cancer as a term used to describe diseases in which abnormal cells divide without control and can invade nearby tissues (National Cancer Institute, 2019). According to the NCI there are over 100 different types of cancer, but breast, colon, lung, pancreatic, prostate, and rectal cancer lead to the greatest number of annual deaths. Risk factors of cancer include, but are not limited to, age, alcohol use, tobacco use, a poor diet, certain hormones, and sun exposure. Although some of these risk factors cannot be avoided, such as age, limiting exposure to avoidable risk factors may lower the risk of developing certain cancers.

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers, however, this disease remains a leading cause of death in the United States, second only to heart disease (Centers for Disease Control and Prevention, 2017). It is the leading cause of death in Montgomery County and the second leading cause of death in Prince George's County (see Table 6). The burden of battling cancers within our community varies; with disparities clearly present.

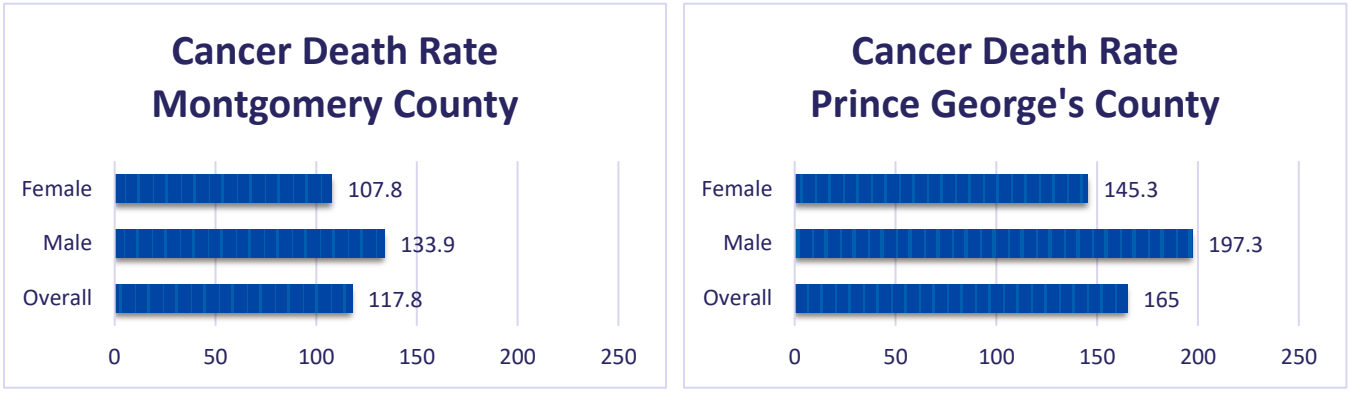


Figure 22: Age-adjusted death rate per 100,000 population due to cancer. (Source: National Cancer Institute (NCI), 2011-2015). The Healthy People 2020 target is to reduce the overall cancer death rate to 161.4 deaths per 100,000 population.

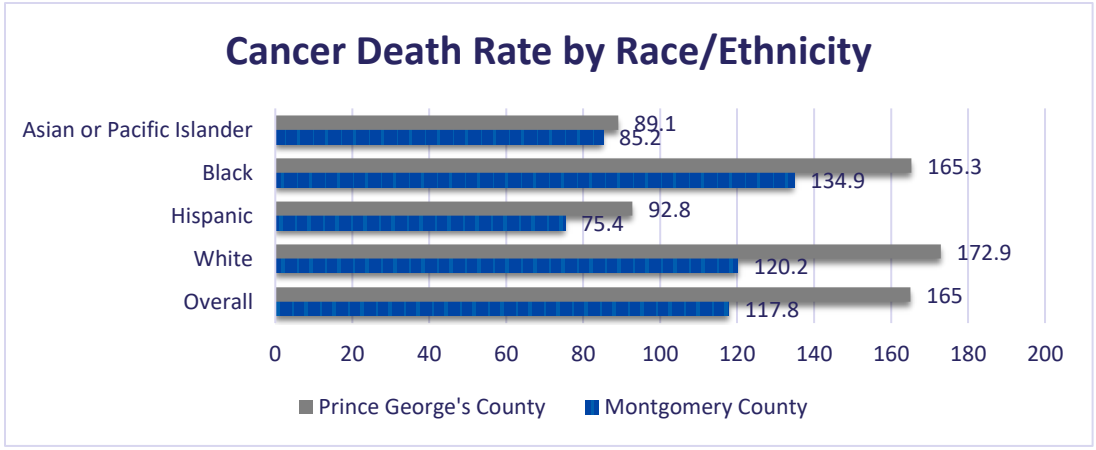
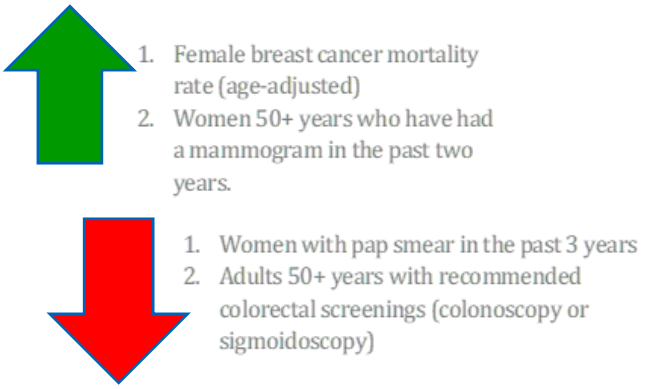


Figure 23: Age-adjusted death rate per 100,000 population due to cancer. Source: NCI, 2011-2015.

Nationwide, the death rate from all cancers has declined steadily over the past two decades, according to annual statistics reporting from the American Cancer Society. As of 2015, the cancer death rate for men and women combined has fallen 26% from its peak in 1991. This decline translates to nearly 2.4 million deaths averted during this period. The drop in cancer mortality is mostly due to steady reductions in smoking and advances in early detection and treatment.



Breast Cancer

Breast cancer is the most common type of cancer in the U.S. followed by lung cancer and prostate cancer (American Cancer Society, 2019). According to the American Cancer Society, about 1 in 8 women will develop breast cancer and about 1 in 36 women will die from breast cancer. Breast cancer is associated with increased age, hereditary factors, obesity, and alcohol use. Since 1990, breast cancer death rates have declined progressively due to advancements in treatment and detection. However, racial disparities still persist in breast cancer. In Montgomery County, although the incidence rate is similar, the mortality rate for African American/Black women is nearly 25% higher than rates for White women (see Figure 24 and Figure 25).

In both Montgomery and Prince George's County, the percent of women over 50 who have received a mammogram in the past two years declined sharply from nearly 80 percent in 2014 to under 65 percent in 2016 (BRFSS, CDC, 2016).

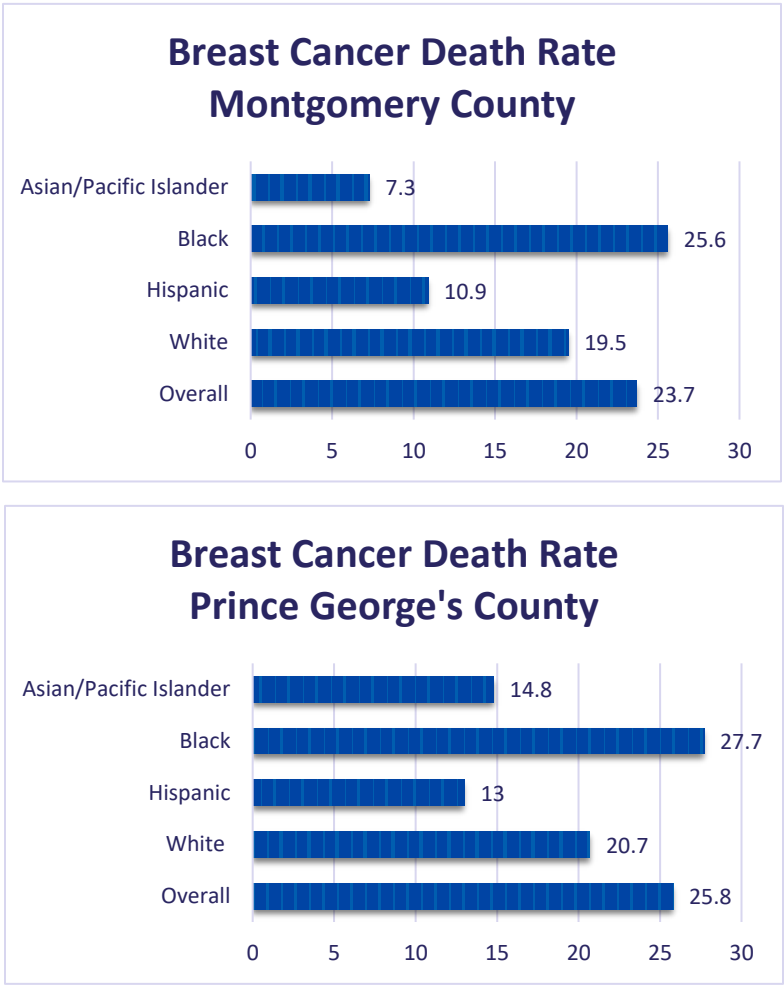


Figure 24: Breast Cancer Death Rates for Montgomery and Prince George's County. Source: NCI, 2011-2015.

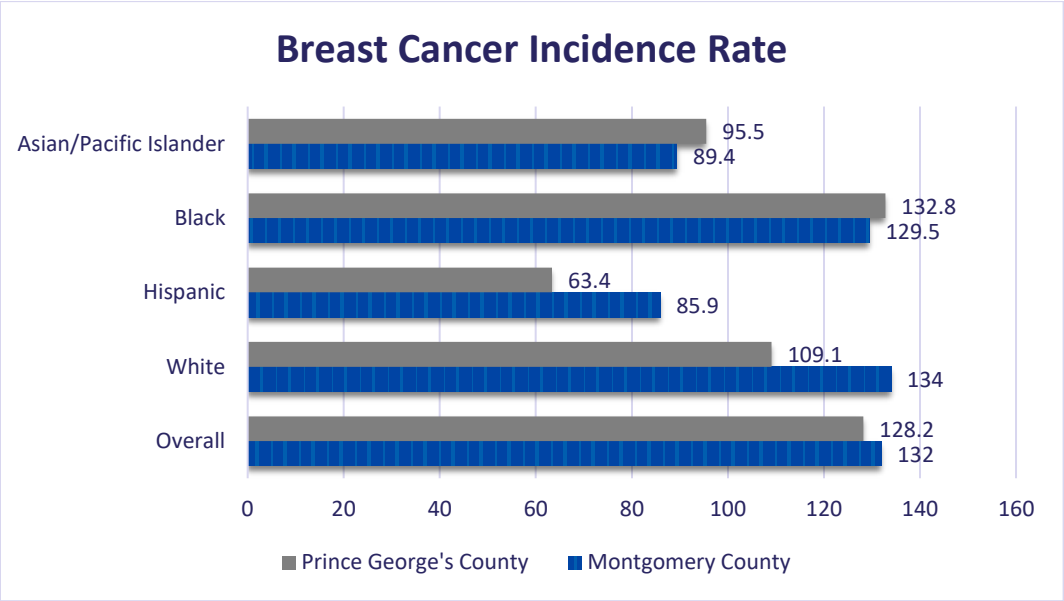


Figure 25: Age-adjusted breast cancer incidence rate cases by race/ethnicity per 100,000 females. Source: National Cancer Institute, 2011-2015.

Colorectal Cancer

According to the Centers for Disease Control and Prevention (CDC), colorectal cancer is one of the most commonly diagnosed cancers in the United States and is the second leading cancer killer in the United States. The CDC estimates that if all adults aged 50 or older had regular screening tests for colon cancer as many as 60% of the deaths from colorectal cancer could be prevented. The US Preventive Service Task Force recommends that screening begin at age 50 and continue until age 75. However, testing may need to begin earlier or be more frequent if colorectal cancer runs in the family or if there is a previous diagnosis of inflammatory bowel disease.

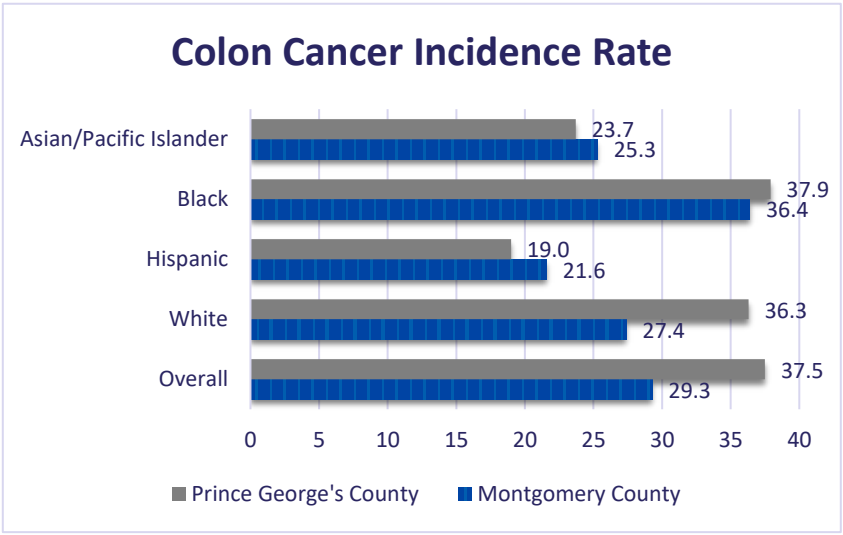
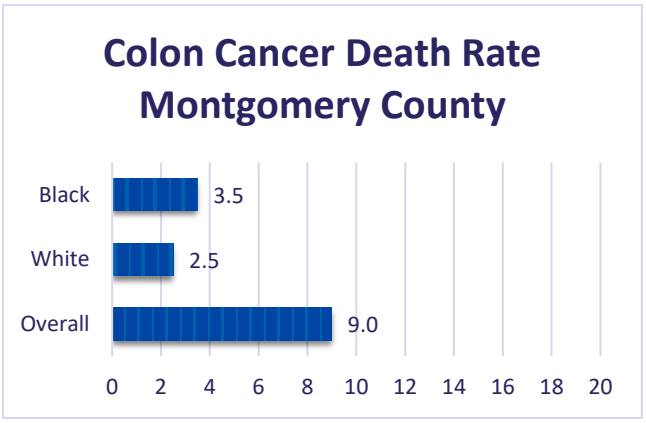


Figure 26: Age-adjusted colon cancer incidence rate cases by race/ethnicity per 100,000 (Source: National Cancer Institute, 2011-2015). The Healthy People 2020 national health target is to reduce the colorectal cancer incidence rate to 39.9 cases per 100,000 population

In both Montgomery and Prince George's Counties, the screening rate for adults 50+ years for colorectal cancer is high at 74.2% and 72.4%, respectively (BRFSS, CDC, 2016), although the rate has dropped in Montgomery County. However, racial

disparities are present in the incident and death rates (see Figure 26 and Figure 27). African American/Blacks have a higher incidence and death rate when compared to the rates of Whites, Asians, and Hispanics.



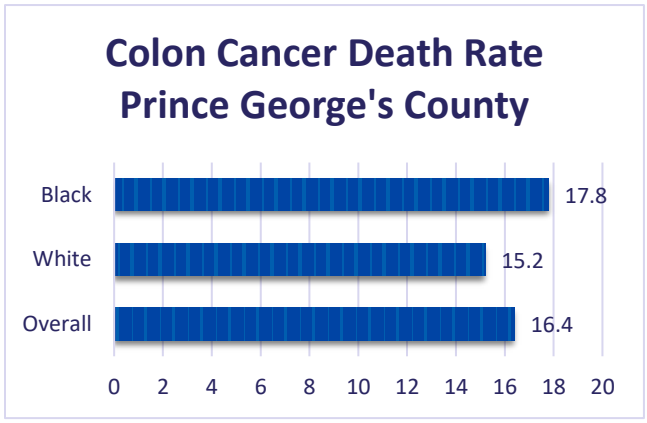
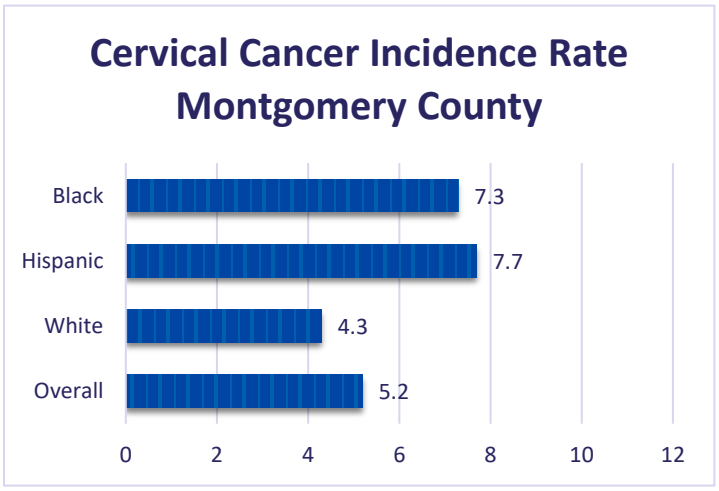


Figure 27: Age-adjusted death rate per 100,000 population due to colorectal cancer (Source: National Cancer Institute, 2011-2015). The Healthy People 2020 national health target is to reduce the colorectal cancer death rate to 14.5 deaths per 100,000 population.

Cervical Cancer

Cervical cancer, when detected early, is one of the most successfully treatable cancers. Cervical cancer is detected by Pap test screenings and is most often caused by the human papillomavirus (HPV), a type of infection transmitted through sexual contact. The American College of Obstetricians and Gynecologists recommends that all women aged 21-29 have a Pap test every 3 years while women aged 30-65 should have a Pap test and an HPV test every 5 years or a Pap test alone every 3 years. The Healthy People 2020 national health target is to increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines to 93.0 percent (both Montgomery and Prince George's Counties exceed the target at 94.4% and 93.2%, respectively). Hispanic women experience the highest incidence rate of cervical cancer (see Figure 28).



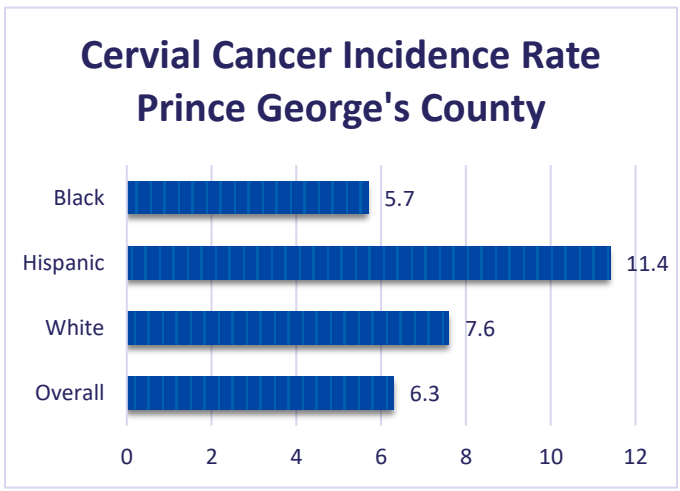
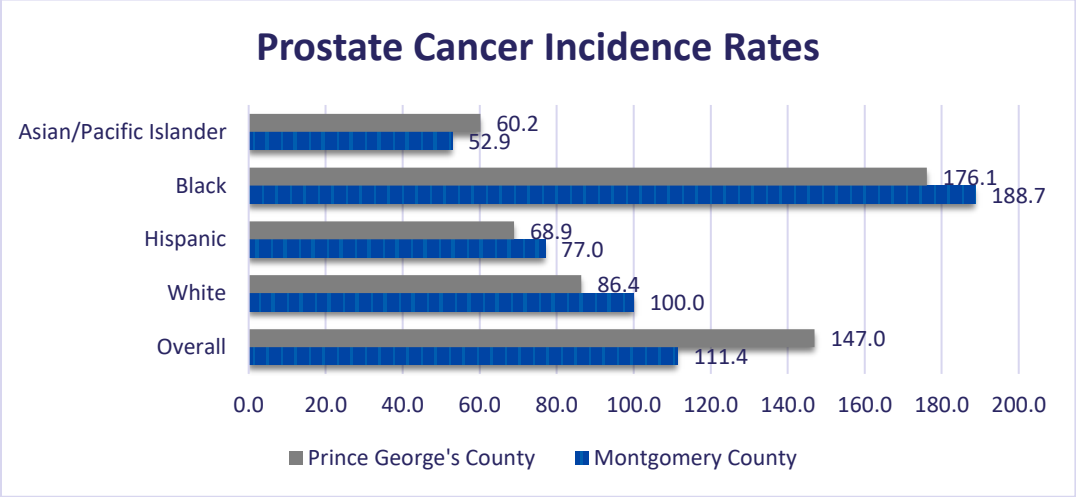
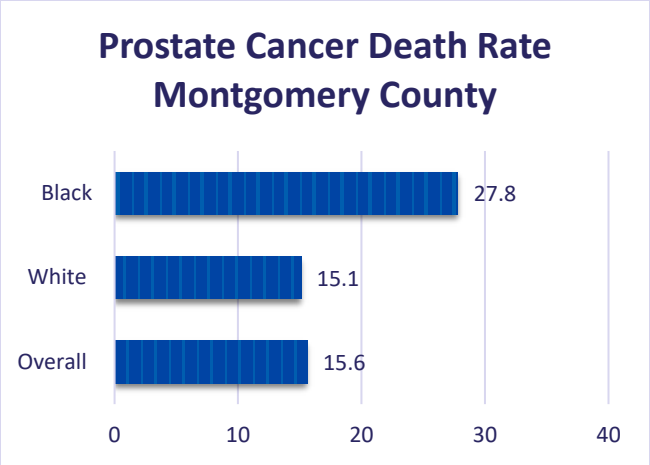


Figure 28: Age-adjusted cervical cancer incidence rate cases by race/ethnicity per 100,000 females (Source: National Cancer Institute, 2011-2015). The Healthy People 2020 national health target is to reduce the uterine cervical cancer incidence rate to 7.1 cases per 100,000 population.

Prostate Cancer

Prostate cancer is a leading cause of cancer death among men in the United States. According to the American Cancer Society, about 1 in 7 men will be diagnosed with prostate cancer and about 1 in 36 will die from prostate cancer. The two greatest risk factors for prostate cancer are age and race; with men over the age of 65 and men of African descent possessing the highest incidence rates of prostate cancer in the U.S. The incidence rate for African American/Black is nearly 50% higher than White men in Montgomery and Prince George's Counties. The death rate of African Americans/Blacks in both counties is also more than 50% higher than their White counterparts (see Figure 29).





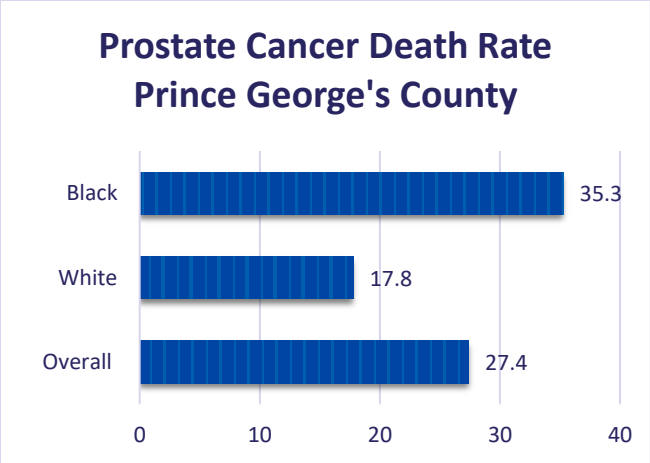


Figure 29: Age-adjusted prostate cancer incidence rates by race/ethnicity per 100,000 males and age-adjusted death rates. Source: National Cancer Institute, 2011-2015.

Lung Cancer

According to the American Lung Association, more people die from lung cancer annually than any other type of cancer, exceeding the total deaths caused by breast cancer, colorectal cancer, and prostate cancer combined. The greatest risk factor for lung cancer is duration and quantity of smoking. While the mortality rate due to lung cancer among men

has reached a plateau, the mortality rate due to lung cancer among women continues to increase. African American/Blacks have the highest risk of developing lung cancer. As shown in Table 2, the smoking rate in Montgomery and Prince George's Counties is lower than the state and the country. In Montgomery County, the lung cancer incidence rates and death rates are nearly equivalent for African American/Blacks and Whites. In Prince George's County Whites have the highest incidence and death rates (see Figure 30 and Figure 31).

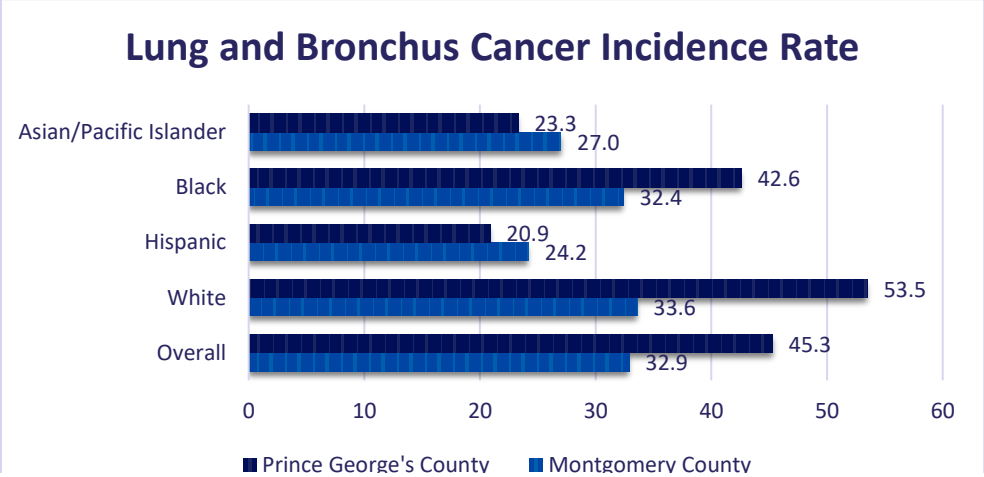
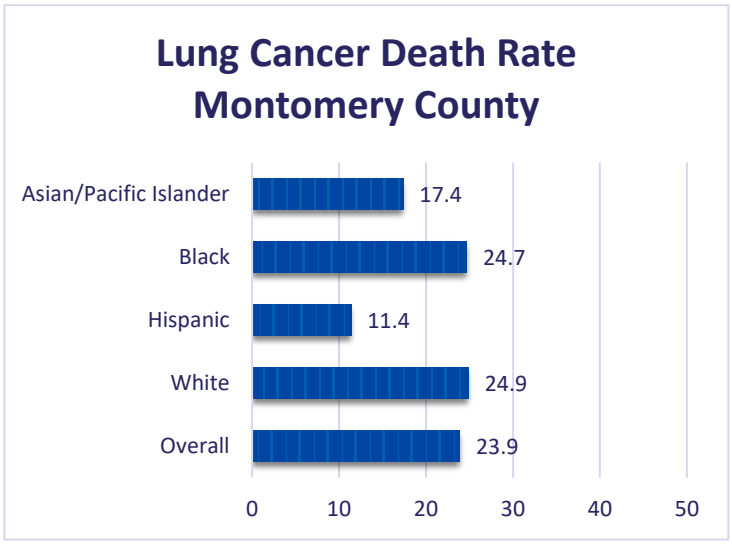


Figure 30: Age-adjusted lung and bronchus cancer incidence rate cases by race/ethnicity per 100,000 population Source: National Cancer Institute, 2011-2015..



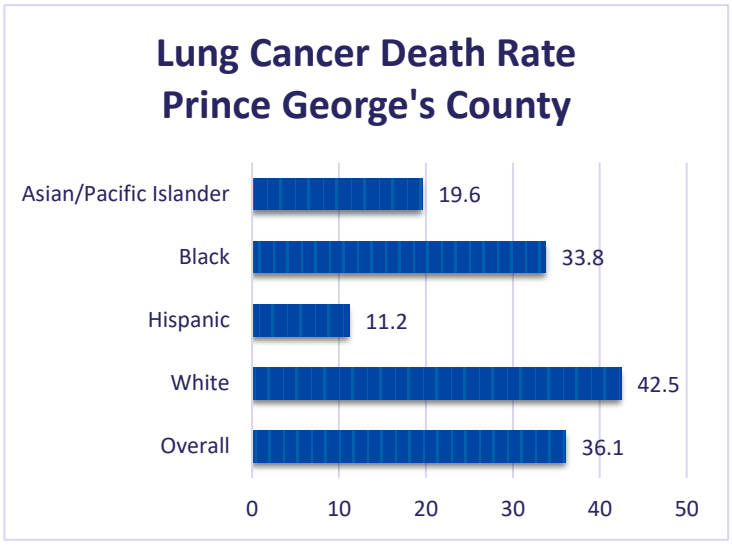
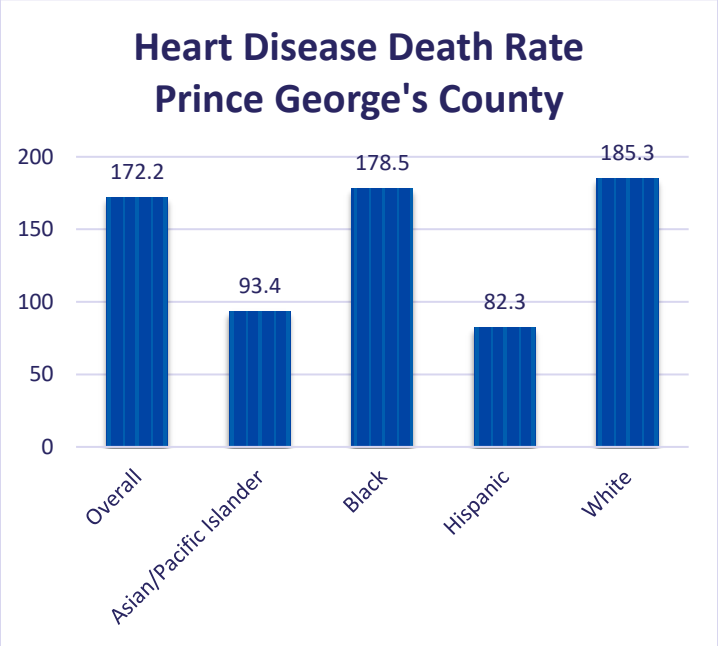


Figure 31: Age-adjusted death rate per 100,000 population due to lung cancer (Source: National Cancer Institute, 2011-2015). The Healthy People 2020 national health target is to reduce the lung cancer death rate to 45.5 cases per 100,000 population.

Cardiovascular Health

Cardiovascular disease is responsible for two of the five leading causes of death in Montgomery and Prince George's Counties. Heart disease is the leading cause of death in Prince George's County and the second leading cause in Montgomery County and stroke is the third leading cause of death in both counties. Together, heart disease, stroke and other cardiovascular diseases are among the most widespread and costly health problems facing the nation today, accounting for approximately $320 billion in health care expenditures and related expenses annually. Fortunately, they are also among the most preventable. The leading controllable risk factors for heart disease and stroke are high blood pressure, high cholesterol, cigarette smoking, diabetes, unhealthy diet and physical inactivity, overweight and obesity. However, controlling risk factors for heart disease and stroke is challenging.

In 2017, heart disease was the second highest age-adjusted death rate for all Montgomery County residents and was highest in Prince George's County (Department of Health and Mental Hygiene, Vital Statistics Administration, 2017). African American/Blacks and Whites had the highest mortality rates (see Figure 33).



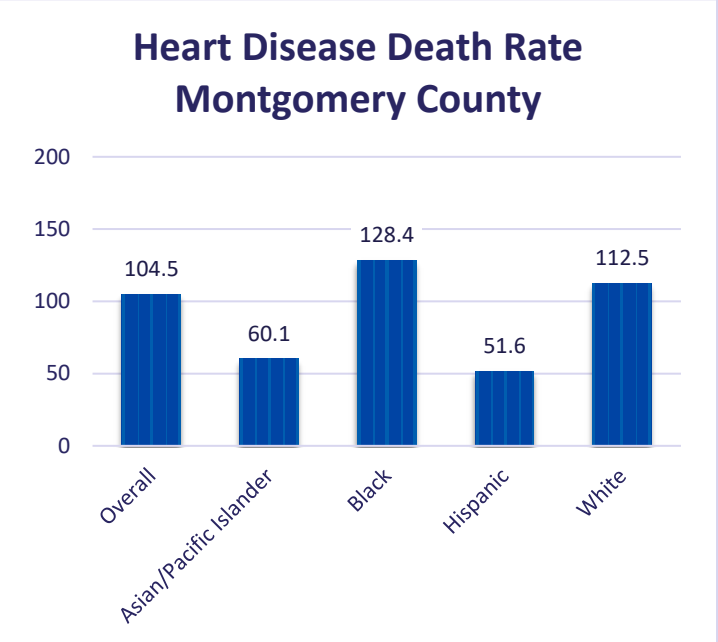
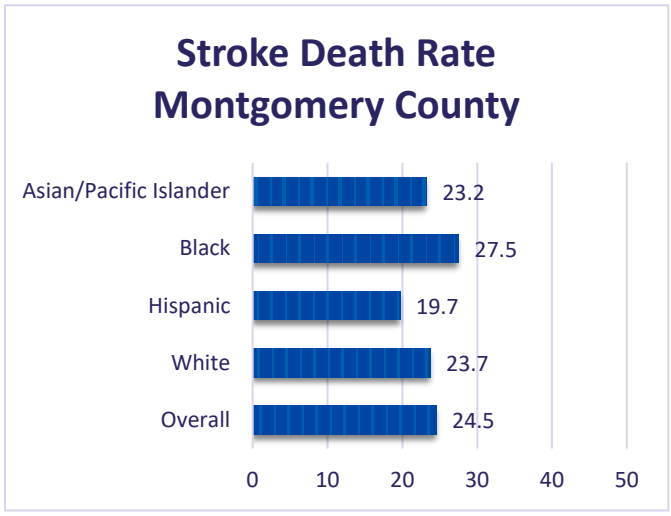


Figure 32: Age-adjusted death rate due to heart disease per 100,000 population (Source: CDC Interactive Atlas of Heart Disease and Stroke, 2014-2016) The Healthy People 2020 national health target is to reduce the heart disease death rate to 103.4 cases per 100,000 population.

Cerebrovascular Disease/Stroke

Each year in the United States, over 795,000 people suffer a stroke, of which 610,000 are first-time events (Centers for Disease Control and Prevention, 2017). Stroke leads to over 140,000 deaths each year, making it the third leading cause of death in the nation and in Montgomery and Prince George's Counties. Stroke occurs when the brain is deprived of oxygen this usually occurs when blood vessels carrying oxygen to the brain become blocked or burst. High

blood pressure is the number one controllable risk factor for stroke and can be prevented through regular care and lifestyle changes.



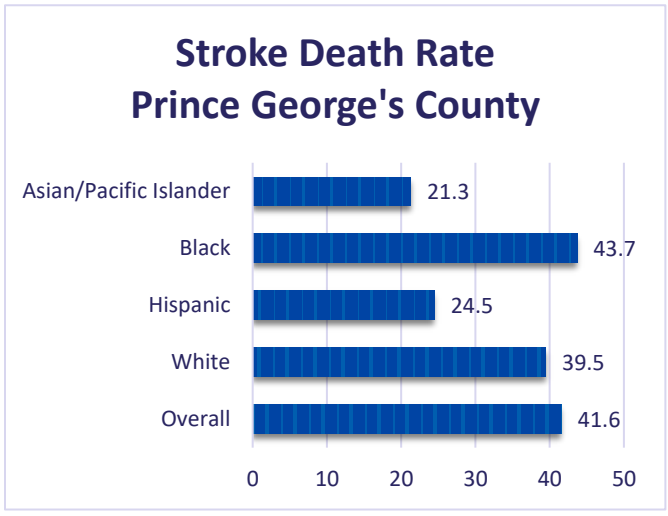
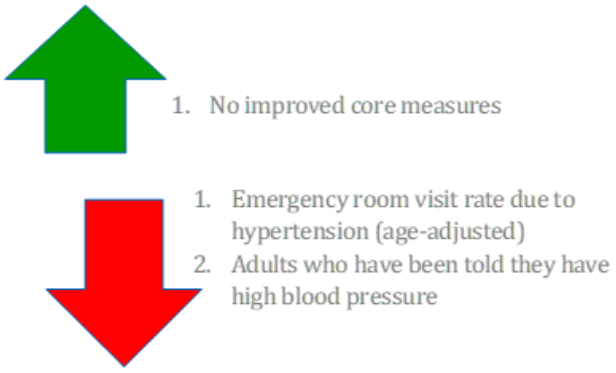


Figure 33: Age-adjusted death rate due to stroke per 100,000 population (Source: MCDHHS/PHS/Planning & Epidemiology; Maryland DHMH/VSA; CDC/U.S. Census bridged Population Files 2013-2015). The Healthy People 2020 national health target is to reduce deaths caused by cerebrovascular disease to no more than 34.8 per 100,000 population.

High Blood Pressure and Cholesterol



High blood pressure (140/90 mm Hg or higher) is the number one modifiable risk factor for stroke. In addition to stroke, high blood pressure also contributes to heart attacks, heart failure, kidney failure, and atherosclerosis. In the United States, one in three adults has high blood pressure, and nearly one-third of these people are not aware that they have it. Because high blood pressure is asymptomatic and goes undetected, it is often called the "silent killer." High blood pressure can occur in people of any age or sex, however, it is more common among those over age 35. It is particularly prevalent in African Americans, older adults, obese people, heavy drinkers, and women taking birth control pills. Blood pressure can be controlled through lifestyle changes, including eating a heart-healthy diet, limiting alcohol, avoiding tobacco, controlling your weight, and staying physically active. According to the Centers for Disease Control and Prevention, about one in six adults have high blood cholesterol. High blood cholesterol is one of the major risk factors for heart disease, asymptomatic and can go undetected. Lowering cholesterol levels lessens the risk for developing heart disease and reduces the chance of having a heart attack.

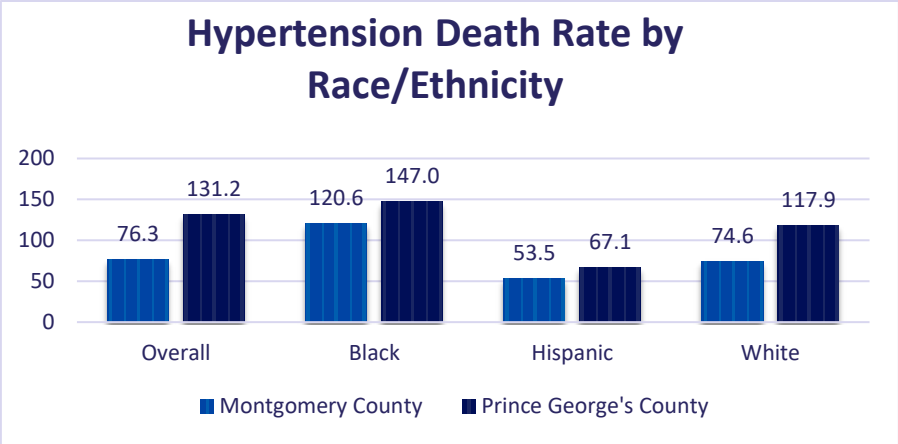


Figure 34: Hypertension death rate per 100,000 population. Source: CDC Interactive Atlas of Heart Disease and Stroke, 2014-2016.

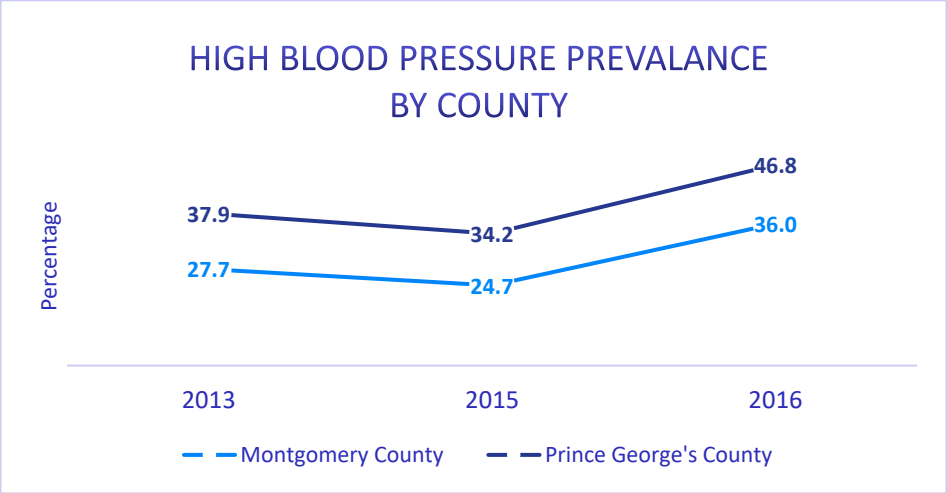


Figure 35: High blood pressure prevalence (Source: MD BRFSS, 2016). The Healthy People 2020 national health target is to reduce the proportion of adults aged 18 years and older with high blood pressure to 26.9%.

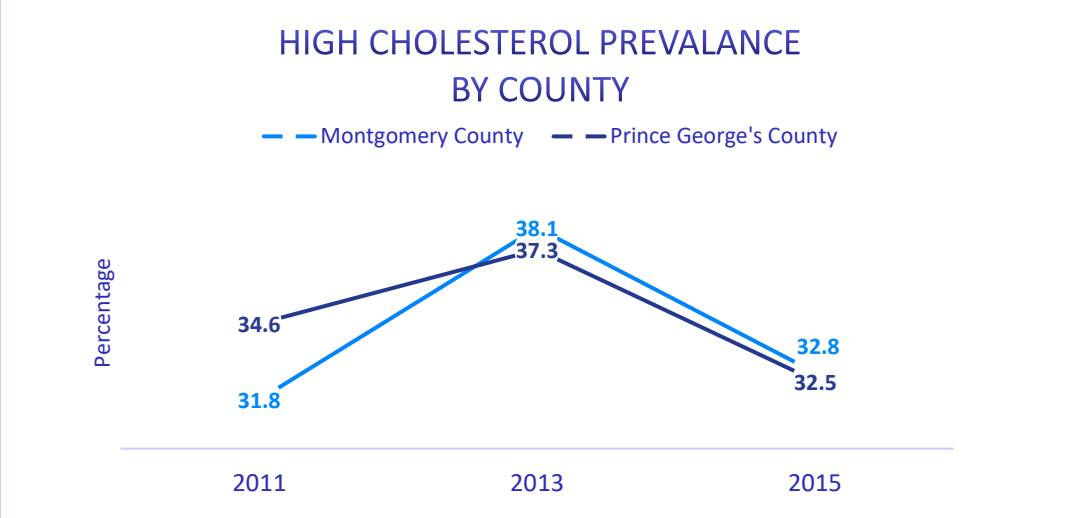
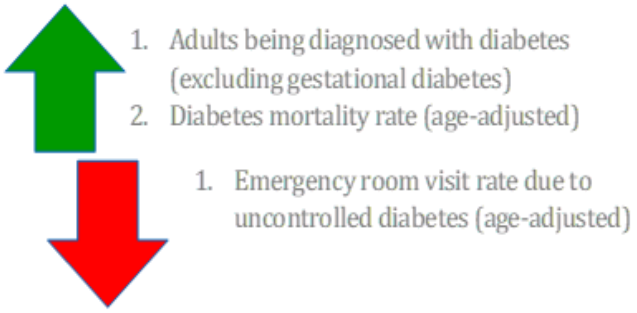
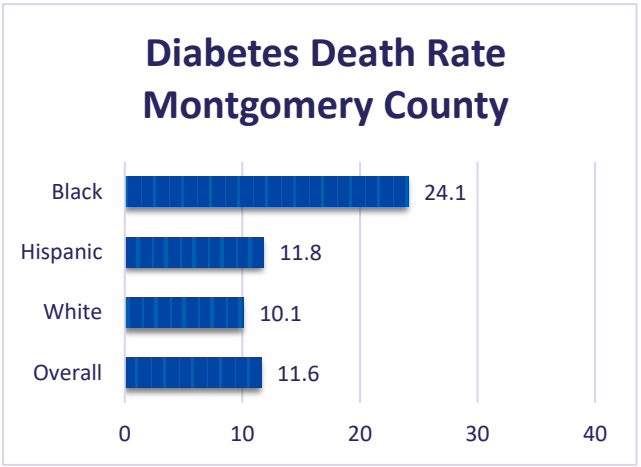


Figure 36: High cholesterol prevalence (Source: MD BRFSS, 2015). The Healthy People 2020 national health target is to reduce the proportion of adults aged 20 years and older with high total blood cholesterol levels to 13.5%.

Diabetes



According to the National Diabetes Statistics Report, more than 30.3 million Americans (9.4% of the population) have diabetes and approximately 25% of adults living with diabetes (7.2 million) are undiagnosed (Centers for Disease Control and Prevention, 2017). Over the years the rate of newly diagnosed diabetes remains steady, however, the incidence rates in 2017 were nearly five times the 1980 rate of 5.8 million (Centers for Disease Control and Prevention, 1990). Factors proposed to account for the increase of people in the United States living with diabetes include changing diagnostic criteria, improved or enhanced detection, increased awareness, growth in minority populations, obesity and lifestyle factors, and decreased mortality. This disease can have a harmful effect on most of the organ systems in the human body; it is a frequent cause of end-stage renal disease, non-traumatic lower-extremity amputation, and a leading cause of blindness among working age adults. Persons with diabetes are also at increased risk for ischemic heart disease, neuropathy, and stroke. According to the CDC, the direct and indirect medical costs for diabetes was over $245 billion in 2012. The average medical cost for an individual diagnosed with diabetes is about $13,700 per year of which about $7,900 can be attributed to diabetes (Centers for Disease Control and Prevention, 2017). Diabetes disproportionately affects minority populations and the elderly, and its incidence is likely to increase as minority populations grow and the U.S. population ages, with risk factors such as obesity, physical inactivity, age, race, and ethnicity. Diabetes is the sixth leading cause of death in Montgomery County and the fifth leading cause in Prince George's County.



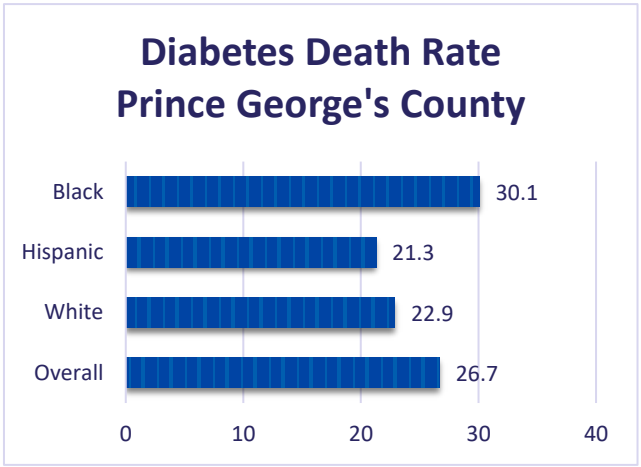


Figure 37: Age-adjusted death Rate due to diabetes per 100,000 population. (Source: Center for Disease Control, 2015-2017). The Healthy People 2020 national health target is to reduce the diabetes death rate to 66.6.

Prediabetes is a serious health condition where blood sugar levels are higher than normal, but not high enough to be diagnosed as type 2 diabetes. Approximately 84 million American adults—more than 1 out of 3—have prediabetes. Of those with prediabetes, 90% do not know they have it. Prediabetes puts individuals at increased risk of developing type 2 diabetes, heart disease, and stroke. Healthy lifestyle choices can help prevent prediabetes and its progression to type 2 diabetes In Montgomery County 8.9% of residents have been told they have prediabetes compared to 12.4% of Prince George's County residents (BRFSS, CDC, 2016).

Seven percent of Montgomery County adult residents have diabetes, which is below both state and national levels. Comparatively, 11.1% of Prince George's County adult residents have diabetes, which is higher than state and national levels, but lower than the 2015 level of 12.5% (BRFSS, CDC, 2016). Emergency department visits for diabetes-related complications may signify that the disease is uncontrolled. In Montgomery County, African American/Blacks are nearly five times more likely to visit the emergency department when compared to their White counterparts and nearly three times more likely in Prince George's County.

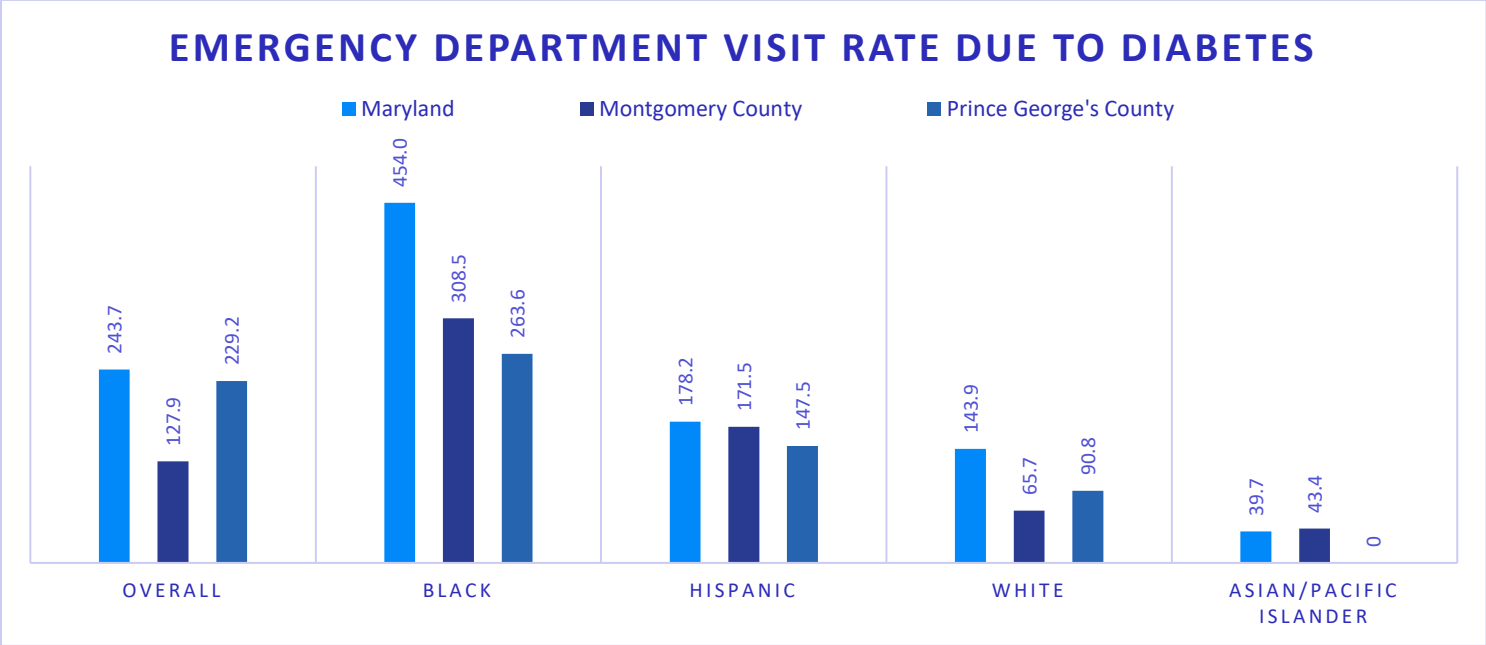


Figure 38: Emergency room visit rate due to diabetes (per 100,000 population). Source: Maryland HSCRC, 2017.

The prevalence of diabetes in the senior population is nearly 25% for those aged 65 or higher (American Diabetes Association, 2018). Since its inception, Medicare has expanded medical coverage of monitoring devices, screening tests and visits, educational efforts, and preventive medical services for its diabetic enrollees. According to the Centers for Medicare and Medicaid (CMS), approximately 25% of Medicare recipients in Montgomery County and 35% of recipients in Prince George's County were treated for diabetes in 2015 (see Figure 40). In 2017, the Medicare per capita spending for diabetes was $15,467 in Montgomery County and $19,231 in Prince George's County.

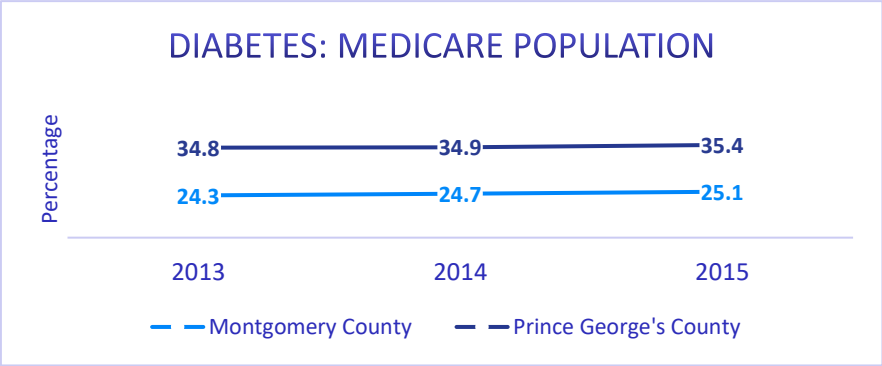


Figure 39: Percentage of Medicare beneficiaries who were treated for diabetes (Source: Centers for Medicare and Medicaid, 2015).

Obesity

During the past twenty years, obesity rates have increased in the United States, doubling for adults and tripling for children. Almost 60% of Montgomery County residents and more than 70% of Prince George's County residents are overweight (Body Mass Index (BMI) of 25.0 to 29.9) or obese (BMI 30.0 or greater) (BRFSS, CDC, 2016). Obesity affects all populations, regardless of age, sex, race, ethnicity and socioeconomic status, however, disparities do exist.

The percentage of obese adults is an indicator of the overall health and lifestyle of a community. Obesity increases the risk of many diseases and health conditions, including heart disease, type 2 diabetes, cancer, hypertension, stroke, liver and gallbladder disease, respiratory problems, and osteoarthritis. Losing weight and maintaining a healthy weight help to prevent and control these diseases. Being obese also carries significant economic costs due to increased healthcare spending and lost earnings.

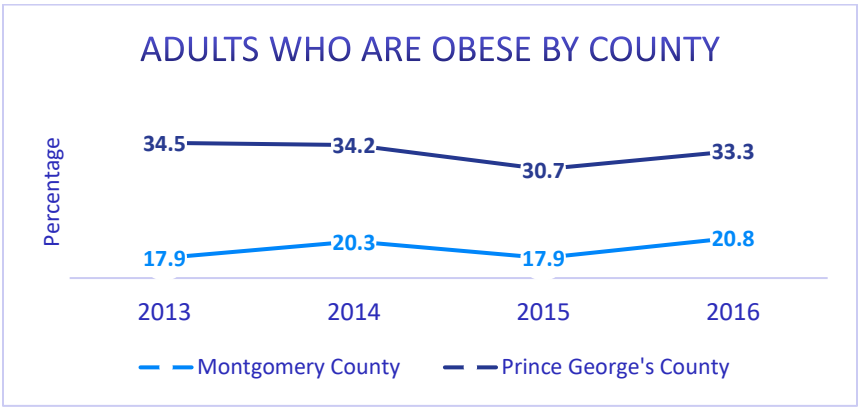


Figure 40: Percentage of adults who are obese (Source: MD BRFSS, 2016). The Healthy People 2020 national health target is to reduce the proportion of adults aged 20 and older who are obese to 30.5%.

Behavioral Health

Social and emotional support refers to the subjective sensation of feeling loved and cared for by those around us. Research has shown that individuals with social and emotional support experience better health outcomes compared to individuals who lack such support. In addition, it has been shown that social and emotional support have beneficial effects on recovery time post cardiac surgery, coping with cancer pain, and overall longevity. About one in every six adults in Montgomery County and one in five adults in Prince George's County report they are not getting the adequate social and emotional support they need (BRFSS, CDC, 2016).

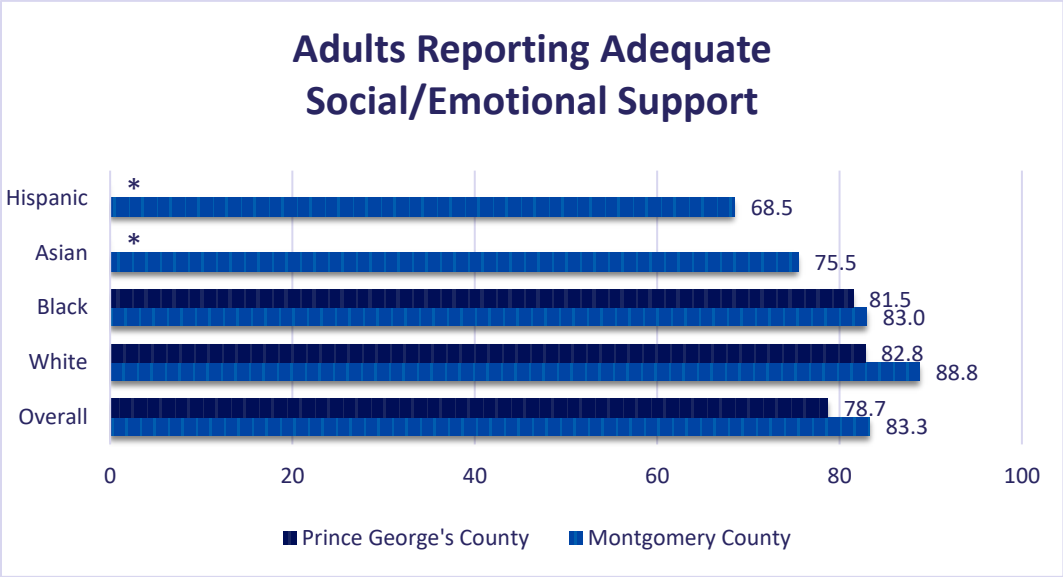


Figure 41: Percentage of adults who report they usually or always get the social and emotional support they need. Source: CDC, BRFSS, 2016. *Sample sizes of <50 are statistically unstable and are not displayed.

Psychological distress can affect all aspects of our lives. It is important to recognize and address potential psychological issues before they become critical. Mental disorders are common across the United States, but only a fraction of those affected receive treatment. Although occasional down days are normal, persistent mental and emotional health problems should be evaluated and treated by a qualified professional. In Montgomery and Prince George's Counties, approximately 80% of both populations have self-reported experiencing two or fewer days of poor mental health in the past month (BRFSS, CDC, 2016).

Mental illnesses, like depression, anxiety, post-traumatic stress and panic disorders, are common in the United States. In 2014, there were an estimated 43.6 million adults aged 18 years or older in the United States with a mental, behavioral, or emotional disorder during the past year, representing 18.1 percent of all U.S. adults (Center for Behavioral Health Statistics and Quality, 2015). Although mental disorders are common, few receive treatment, and of those that do receive treatment, a significant proportion utilize emergency departments. Approximately one in eight visits to emergency departments (EDs) in the United States involves mental and substance use disorders (M/SUDs). ED visits involving M/SUDs are considered potentially avoidable—if these conditions were adequately managed through appropriate outpatient care, then ED visits should be rare. These potentially preventable M/SUD-

related ED visits also affect hospitals, because M/SUD related ED visits are more than twice as likely to result in hospital admission compared with ED visits that do not involve M/SUDs.

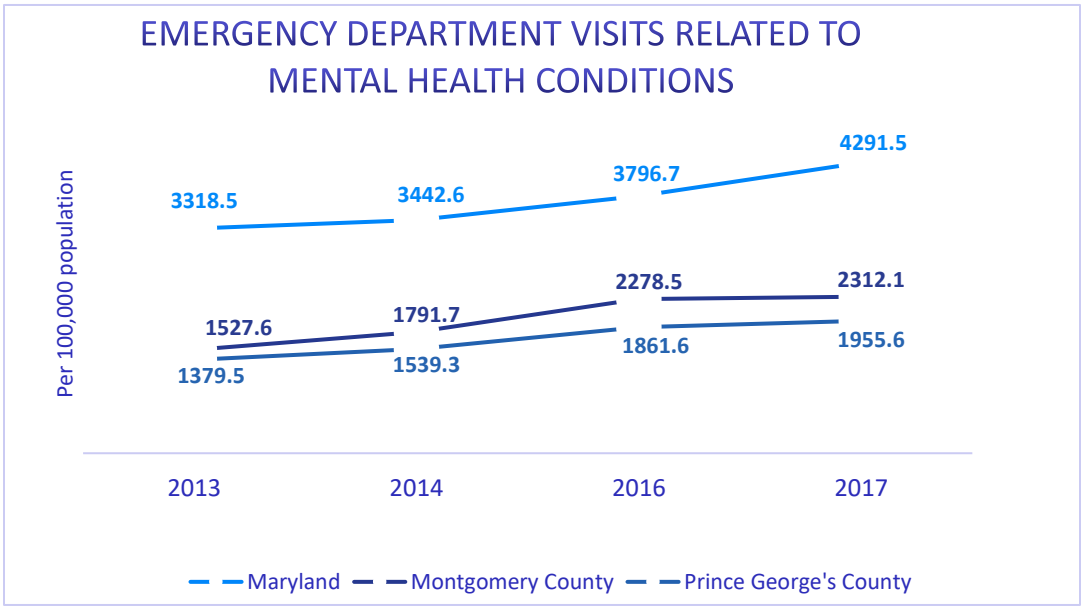


Figure 42: Number of emergency department visits related to mental health conditions per 100,000 population. Source: Maryland DHMH State Health Improvement Process, 2017.

Suicide is a leading cause of death in the United States, presenting a major, preventable public health problem. More than 33,000 people kill themselves each year according to the Centers for Disease Control and Prevention, but suicide deaths only account for part of the problem. An estimated 25 attempted suicides occur per every suicide death, and those who survive suicide may have serious injuries, in addition to having depression and other mental problems. Other repercussions of suicide include the combined medical and lost work costs on the community, totaling to over $30 billion for all suicides in a year, and the emotional toll on family and friends. Men are about four times more likely than women to die of suicide, but three times more women than men report attempting suicide. Suicide occurs at a disproportionately higher rate among adults 75 years and older. In Montgomery County, men are four times as likely to die from suicide than women and five times more likely in Prince George's County.

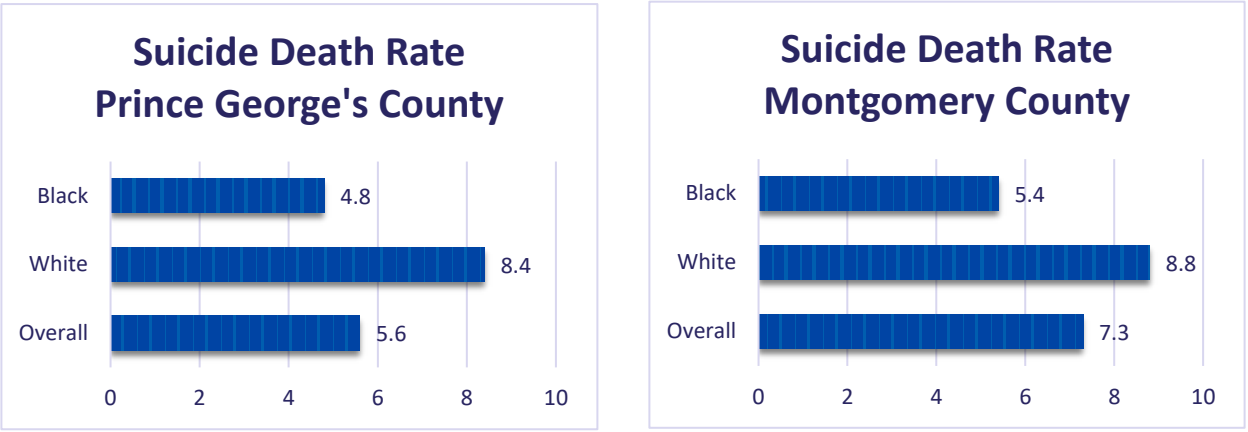


Figure 43: Age-adjusted death rate due to suicide per 100,000 population (Source: CDC, 2013-2017). The Healthy People 2020 national health target is to reduce the suicide rate to no more than 10.2 per 100,000 population.

1. Adults who report they usually or always get the social and emotional support they need
2. Mental health provider rate
3. Adults who report they have been diagnosed with a depressive disorder

1. Emergency room visit rate due to mental health (age-adjusted)
2. Drug use mortality rate (age-adjusted)
3. Medicare beneficiaries who were treated for depression

According to the Centers for Disease Control and Prevention, depression is a medical illness characterized by persistent sadness and sometimes irritability. Depressive disorders go beyond feeling blue or sad for a few days and can interfere with family life, work habits and daily functioning and many individuals suffering from depressive disorders never seek treatment. Examples of depressive disorders include depression, major depression, dysthymia, and minor depression. There is no singular cause for depressive disorders, and is often associated with higher risk for mortality from suicide and heart disease, lower workplace productivity and other illnesses such as anxiety disorders, substance abuse, and cancer. Not only can it interfere with an individual's daily functioning, but it can also have negative impacts on the communities they live in. The National Institute of Mental Health lists major depressive disorder is the leading cause of disability for individuals ages 15-44 in the United States and affects nearly 14.8 million American adults, or about 6.7 percent of the adult population. Although many effective treatment options are available, many individuals who suffer from depression do not have access to treatment or do not seek treatment. Fourteen percent of Montgomery County residents and nearly 10% of Prince George's County residents self-reported being diagnosed with a depressive disorder with Hispanics self-reporting the highest rates of diagnoses in Montgomery County and Whites having higher rates in Prince George's County.

Substance Abuse

Substance abuse and its related problems are among society's most pervasive health and social concerns. Causes of drug-induced deaths include dependent and non-dependent use of drugs (both legal and illegal use) and also poisoning from medically prescribed drugs. Addicted persons frequently engage in self-destructive and criminal

behavior, which can result in injury or death. In addition, recreational drug-use can lead to unintentional overdose and death.

According to the Maryland Department of Health, the number of substance-related deaths occurring in Maryland has increased 9 percent between 2016 and 2017, which marks the seventh straight year of increases. It is a problem that is not specific to any particular jurisdictions or counties, with every county in Maryland experiencing at least four resident deaths from opioid-related causes in 2017. Illegal and prescription opioids continue to be the largest contributing factor, which includes heroin as well as prescription medications used as pain relievers such as morphine, codeine, methadone, oxycodone, hydrocodone, and fentanyl (Healthy Montgomery, 2016).

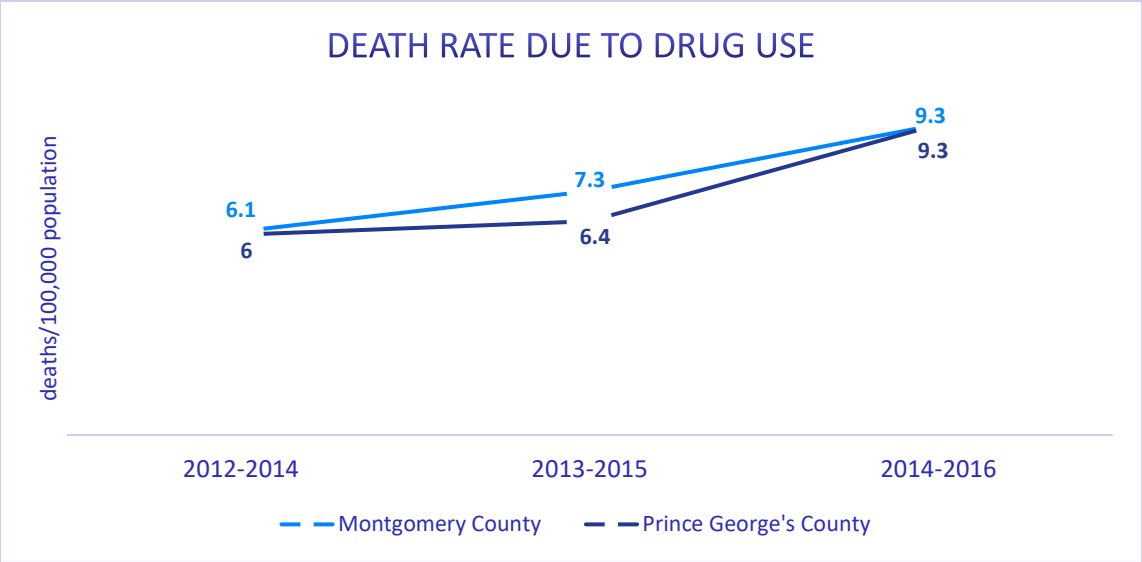


Figure 44: Age-adjusted death rate due to drug use per 100,000 population (Source: MD DHMH, 2014-2016). The Healthy People 2020 national health target is to reduce the drug-induced death rate to 11.3 deaths per 100,000 population.

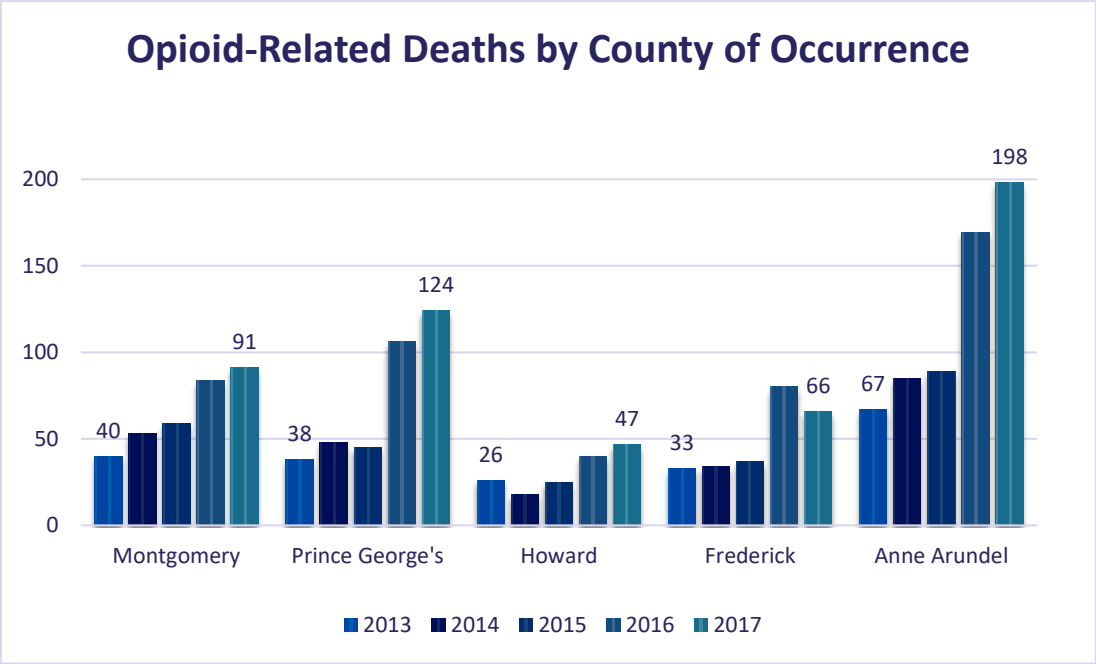


Figure 45: Total number of opioid-related deaths by place of occurrence for Maryland counties surrounding Holy Cross Hospital. Source: MD Vital Statistics, Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland Annual Report, 2017.

Opioid overdose deaths have skyrocketed since the late 1990's. The opioid epidemic has become the worst drug epidemic in modern American history. There were over 42,000 opioid overdose deaths in 2016—accounting for more deaths than from automobile accidents or firearm-related homicides—with over a third of overdose deaths from heroin, which is surging in popularity. Provisional estimates from the CDC indicate the crisis continued to worsen throughout 2017, with over 70,000 opioid overdose-related deaths. One of the main culprits behind the growing opioid epidemic are synthetic opioids like fentanyl (an opioid that is up to 50 times stronger than heroin). These drugs accounted for over 45 percent of opioid overdose deaths in 2016, according to the Centers for Disease Control and Prevention. While fentanyl and other synthetic opioids are used in prescription drugs, these substances are increasingly being illegally manufactured and distributed alongside—or mixed with—illegal drugs like heroin.

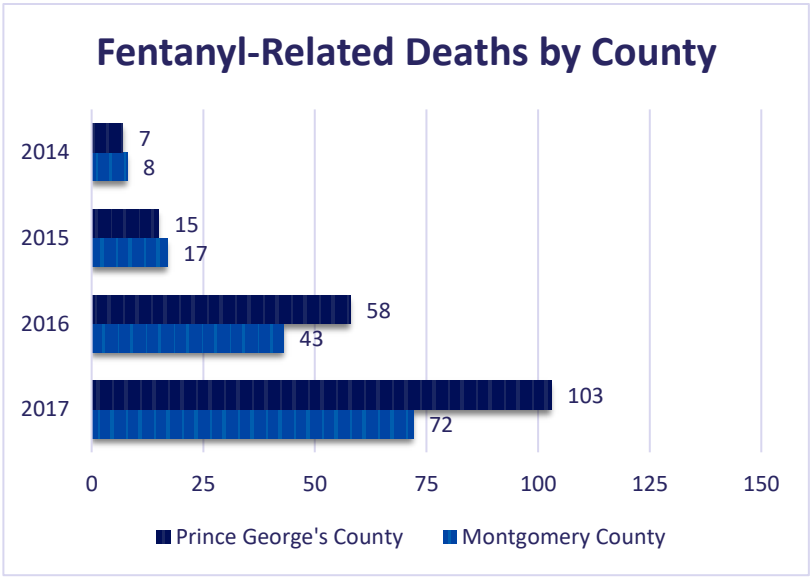


Figure 46: Total number of fentanyl-related deaths by place of occurrence. Source: MD Vital Statistics, Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland Annual Report, 2017.

Heroin and other opioid misuse is an emerging public health issue in Montgomery and Prince George's County as well as across the nation. Overdose from prescription opioid pain relievers is a driving factor in the alarming increase in drug overdose morbidity and mortality (see Figure 45) However, a notable recent trend in Montgomery County and Prince George's County is the increase in heroin overdose as more individuals switch to heroin use, because of its relatively low cost, after becoming addicted to prescription opioids (Maryland Department of Health and Mental Hygiene, 2016).

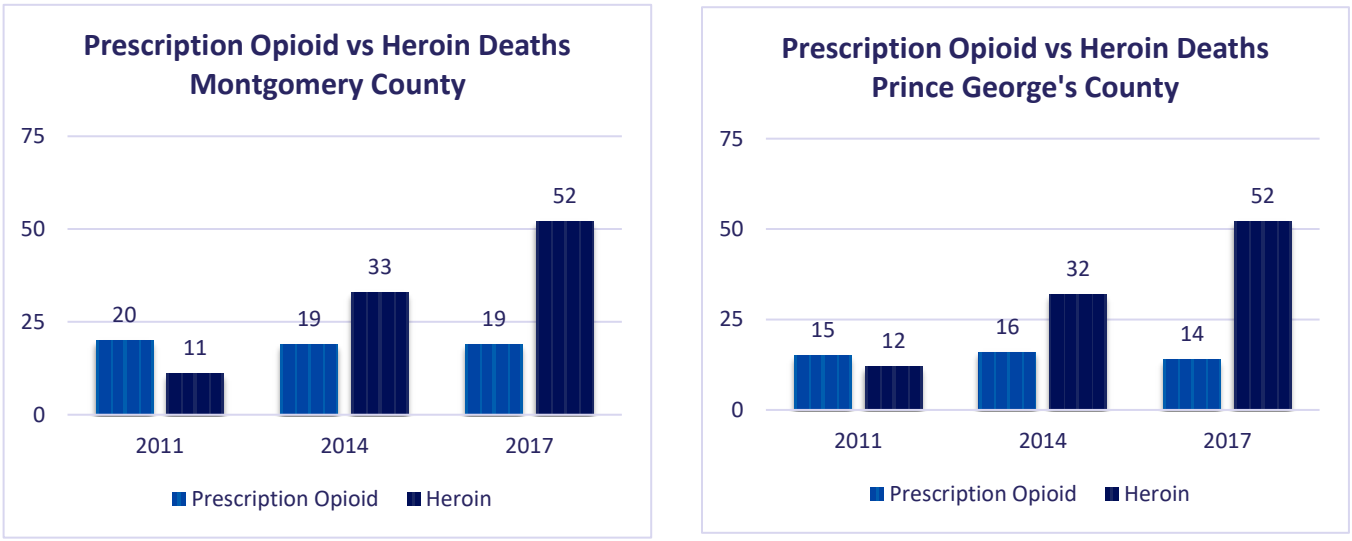


Figure 47: Total number of prescription opioid-related deaths versus heroin-related deaths by place of occurrence. Source: MD Vital Statistics, Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland Annual Report, 2017.

Maternal/Infant Populations

Improving the well-being of mothers, infants, and children is an important public health goal for the United States. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system.

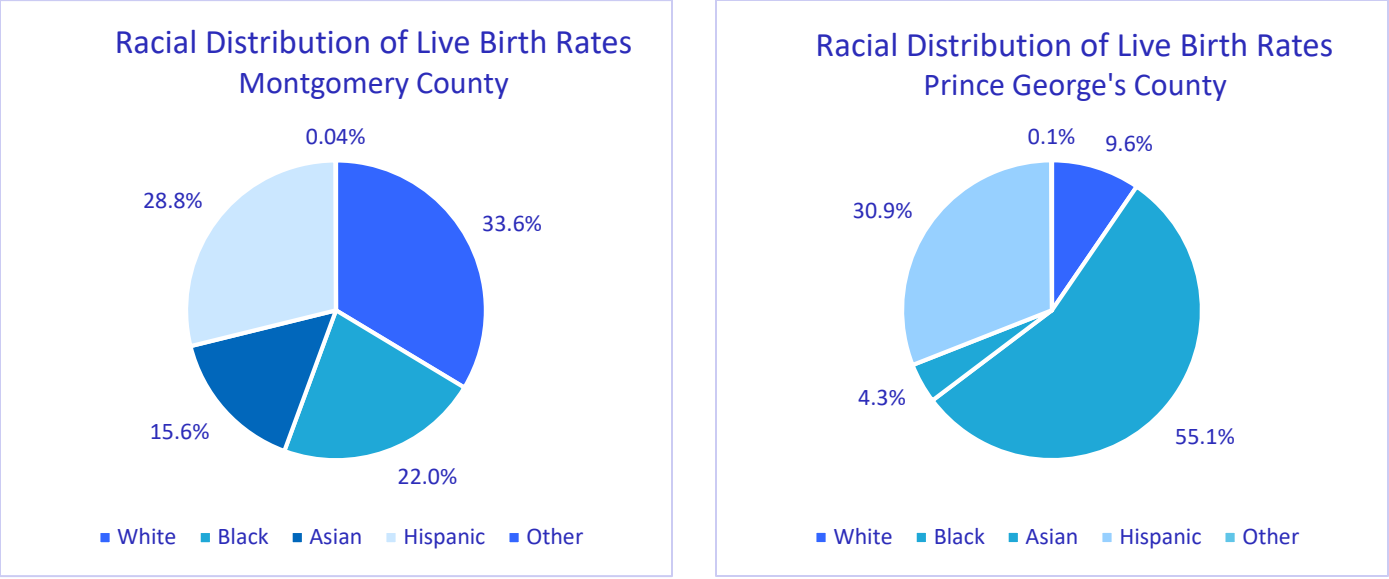


Figure 48: Maryland infant births by race/ethnicity, 2017. Source: MD Vital Statistics 2017.

Babies born with low birth weight (newborn weighed less than 2,500 grams or 5 pounds, 8 ounces) are more likely than babies of normal weight to have health problems and require specialized medical care in the neonatal intensive care unit. Low birth weight is typically caused by premature birth and fetal growth restriction, both of which are influenced by a mother's health and genetics. The most important things an expectant mother can do to prevent low birth weight are to seek prenatal care, take prenatal vitamins, stop smoking, and stop drinking alcohol and using drugs. Montgomery County's low-birth-weight (LBW) percentage has remained consistently below the Healthy People 2020 target of 7.8%. However, the rate for African American/Black and Asian/Pacific Islander births is above the target.

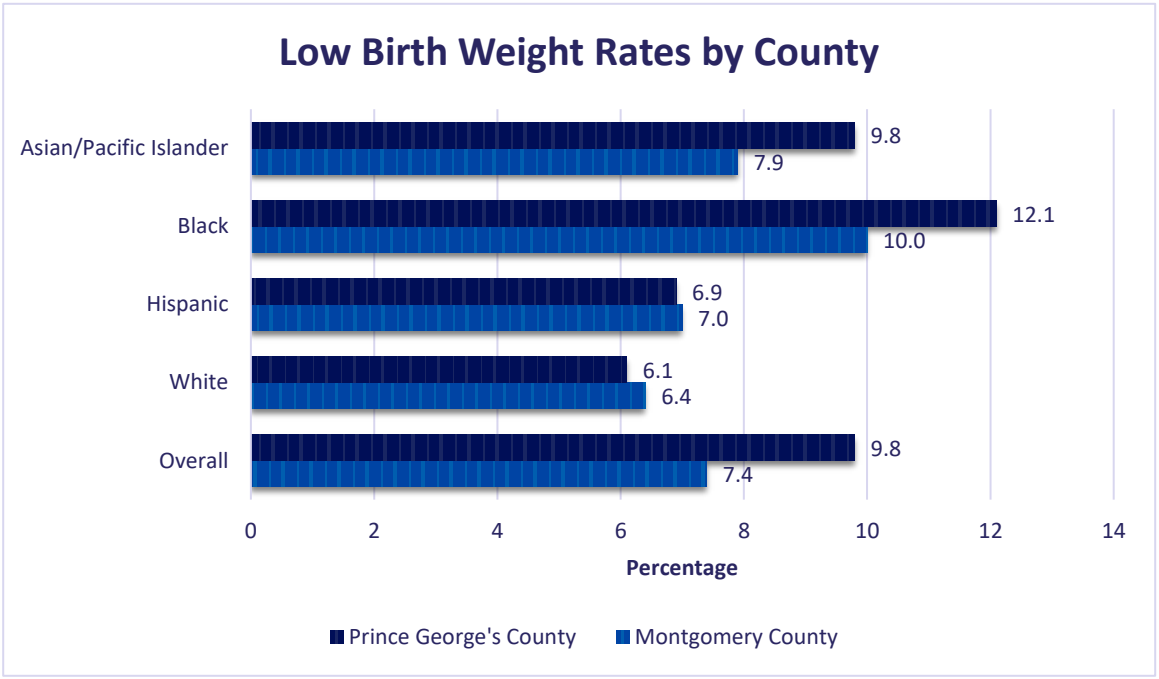


Figure 49: Percentage of babies with low birth weight (Source: MCDHHS/PHS/Planning & Epidemiology; Maryland DHMH/VSA and MD DHMH, 2017). The Healthy People 2020 national health target is to reduce the proportion of infants born with low birth weight to 7.8%.

Conversely, Prince George's County maintains a higher LBW percentage, also with African American/Black and Asian/Pacific Islander births above target.

Infant mortality rate continues to be one of the most widely used indicators of the overall health status of a community. The leading causes of death among infants are birth defects, pre-term delivery, low birth weight, Sudden Infant Death Syndrome (SIDS), and maternal complications during pregnancy. Montgomery County has an infant death rate of 4.9 deaths per 1,000 live births, which is below the Healthy People 2020 target of 6.0 per 1,000 live births. Prince George's County had experienced a rise in the rate of infant death, from 6.9 in 2014 to 8.9 in 2016, but is beginning to decline, with a 2017 rate of 8.2. Racial disparities exist in both counties, with African American/Black infant mortality rates being significantly higher than women of other races (Healthy Communities Institute, 2019).

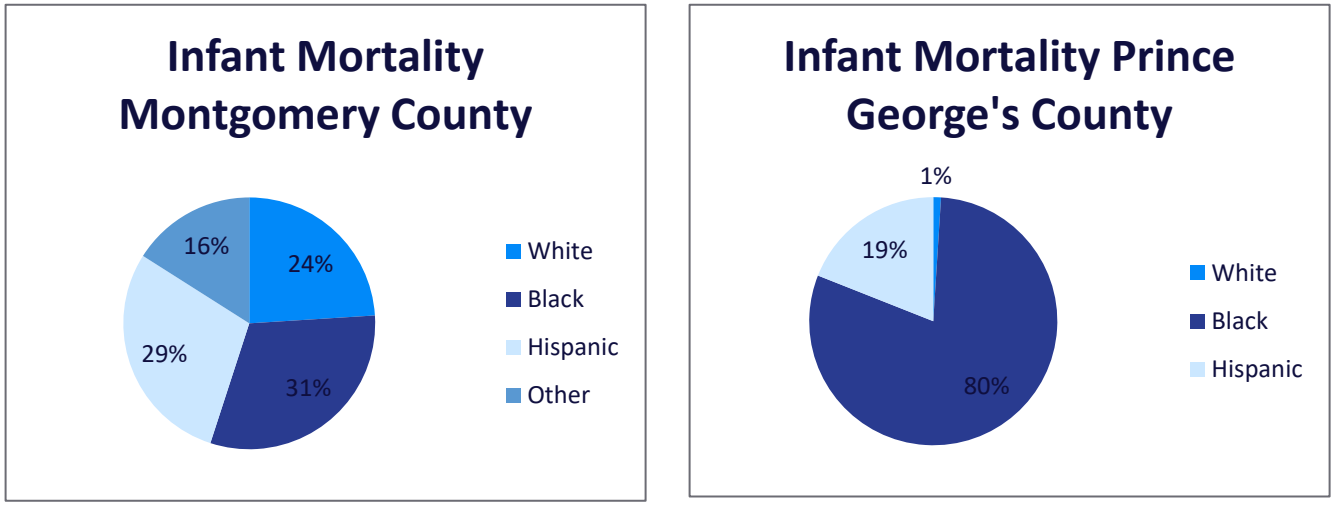
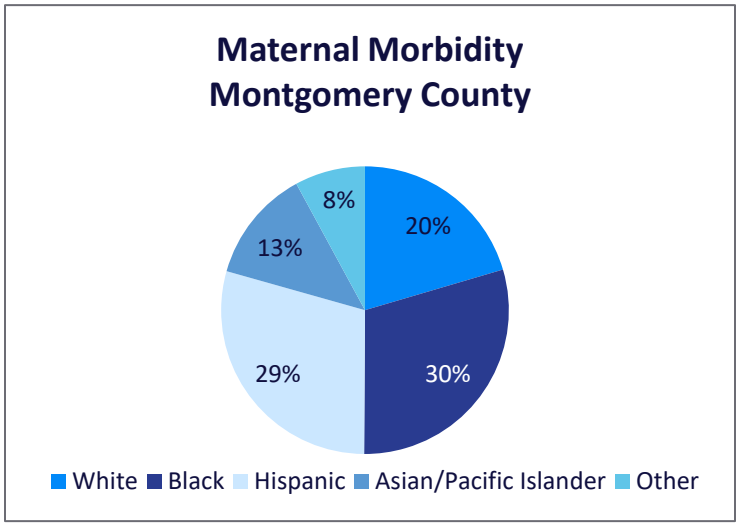


Figure 50: Infant Deaths percentage by race/ethnicity, 2017. Source: MD Vital Statistics Administration.

Over the past three decades, the world has seen a steady decline in the number of women dying from childbirth; with the United States being a notable outlier. In fact, the United States is one of only 13 countries in the world where the rate of maternal mortality is now worse than it was 25 years ago. In Maryland, the mortality rate had consistently been higher than the national average, however, for the period from 2012 to 2016, the state rate was slightly lower than the national rate for the first time. This rate still remains above the Healthy People 2020 target of 11.4 maternal deaths per 100,000 live births. High blood pressure and cardiovascular disease are two of the leading causes of maternal death, according to the Centers for Disease Control and Prevention, and hypertensive disorders in pregnancy, including pre-eclampsia, have been on the rise over the past two decades, increasing 72 percent from 1993 to 2014.



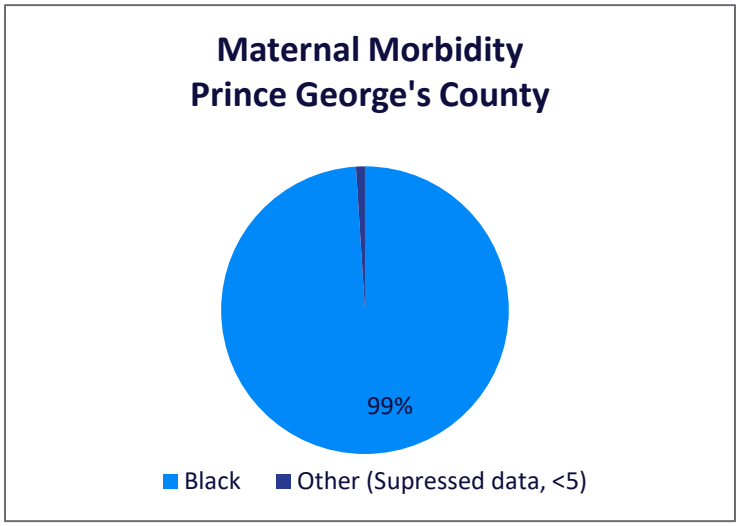
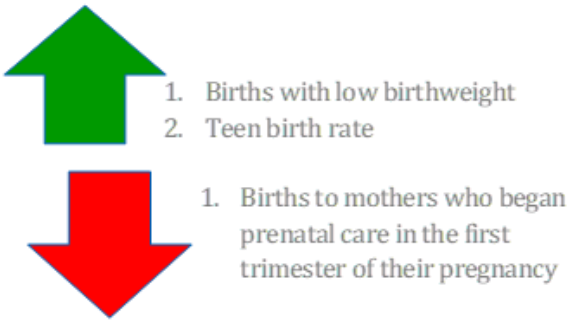


Figure 51: Percent maternal morbidity cases by race/ethnicity, 2014-2016. Source: Maternal and Infant Health in Montgomery County, MD report, 2008-2017. Maryland Maternal Mortality Review, 2016-2018.

Experts in maternal health blame the high U.S. rate on poverty, untreated chronic conditions and a lack of access to health care, especially in rural areas where hospitals and maternity units have closed. Nationally, racial disparities in pregnancy-related mortality exist. During 2011-2014, there were 40.0 deaths per 100,000 live births for African American/Black women compared to 12.4 deaths per 100,000 live births for white women (Maternal and Infant Health, CDC, 2019). Specifically, African American/Black women in the US are three to four times more likely to die from a pregnancy-related death than White women. In Maryland, African American/Black mothers die due to pregnancy 2.7 times more than white mothers in the state. While black women are at higher risk for the conditions that negatively impact maternal mortality, such as higher rates of obesity and diabetes, these factors do not account for such a wide disparity in maternal health. It is theorized that African American women enter into pregnancies with high levels of cumulative stress that may cause their bodies to age faster than the bodies of their counterparts (Geronimus, et al., 2010). In addition, African American women may also encounter racism and sexism when receiving healthcare that can contribute even more to stress.

Babies born to mothers who do not receive prenatal care are three times more likely to have a low birth weight and five times more likely to die than those born to mothers who do get care. Early prenatal care (i.e. care in the first trimester of a pregnancy) allows women and their health care providers to identify and, when possible, treat or correct health problems and health-compromising behaviors. Increasing the number of women who receive prenatal care, and who do so early in their pregnancies, can improve birth outcomes and lower health care costs by reducing the likelihood of complications during pregnancy and childbirth. Healthy



People 2020 has a target of 77.6% of pregnant women receiving early and adequate prenatal care; 70.9% of Montgomery County and 59% of Prince George's County women received care in the first trimester (Maryland Department of Health and Mental Hygiene, 2017).

Senior Populations

Montgomery County and Prince George's County have the highest population of seniors aged 65+ in the state of Maryland. Between 2010 and 2040, the Montgomery County senior population is projected to grow from 119,769 to 243,950—increasing from 12% of the Montgomery County population in 2010 to 20% of the population in 2040. The Prince George's County senior population growth is similar to Montgomery County and will account for 18% of the overall population by 2040; double what it was in 2010 (Maryland State Data Center, 2015).

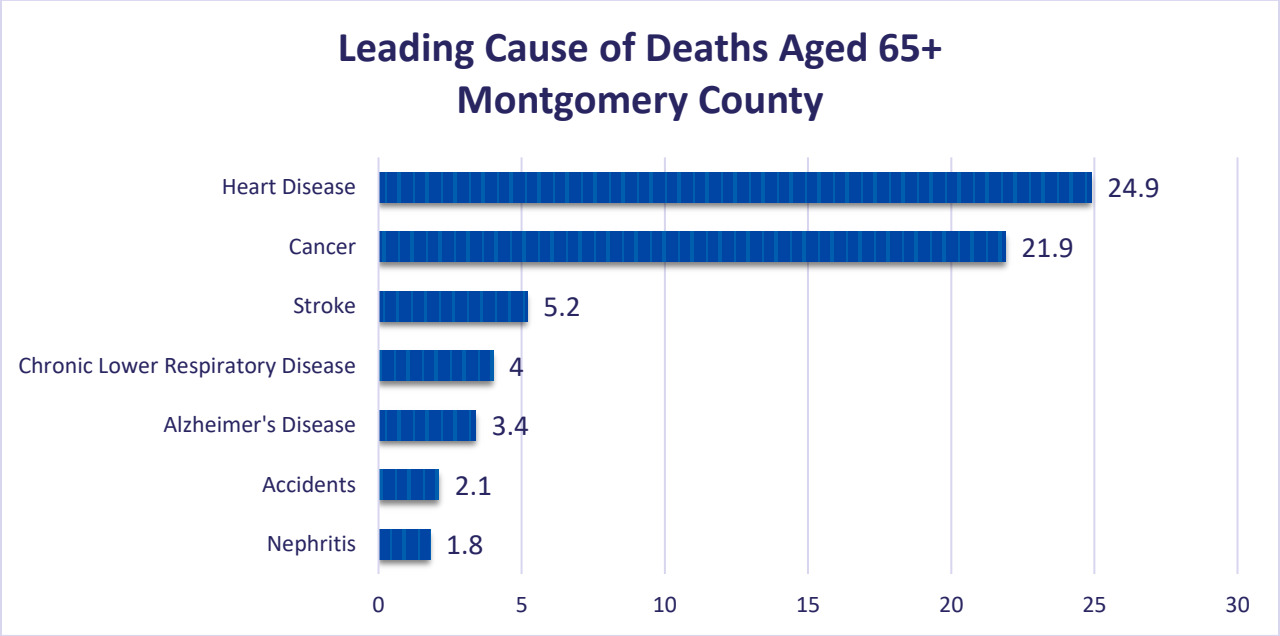
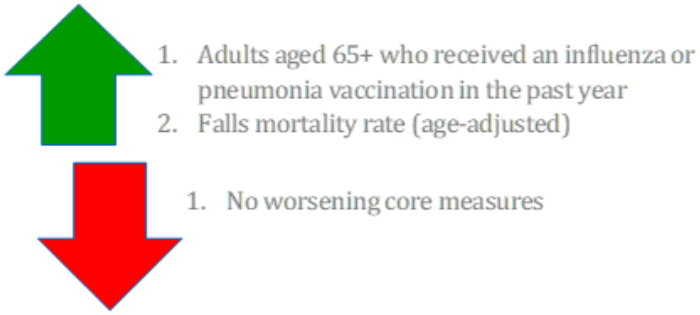


Figure 52: Leading causes of death in Montgomery County population, aged 65 and over. Source: Health In Montgomery County Report, 2008-2016.

The average life expectancy for Montgomery County is 84.8 years and 79.1 years for Prince George's County; the Maryland State Health Improvement Target is 79.8. The aging population affects every aspect of society, with the largest effects occurring in public health, social services, and health care systems (Centers for Disease Control and Prevention, 2013).

Approximately 80% of older adults have at least one chronic disease, and 77% have at least two, experiencing disproportionate rates of heart disease, cancer, diabetes, congestive heart failure, arthritis and dementia (including Alzheimer's) (Centers for Disease Control and Prevention, 2013). Chronic conditions can lower quality of life for older adults and contribute to the leading causes of death among this population.

In the 65 and over population of Montgomery and Prince George's Counties, deaths from influenza and pneumonia and deaths from accidents are listed in the top 10 causes of death and are highly preventable. Pneumococcal pneumonia is the leading cause of vaccine-preventable death and illness in the United States--it kills about 1 out of every 20 people who develop the disease. Influenza can be dangerous for people with heart or breathing conditions and can lead to pneumonia and deaths, especially in the elderly (Healthy Communities Institute, 2019). The Centers for Disease Control and Prevention (CDC) estimates that in the United States, 5% to 20% of the population on average gets the flu and more than 200,000 people are hospitalized each year. While flu seasons can vary in severity, during most seasons, people 65 years and older bear the greatest burden of severe flu disease and have the highest flu-related mortality. The pneumococcal and influenza vaccines can prevent serious illness and death, however, as shown in the chart below, both counties fall below the HP2020 target of 90% of adults aged 65 years and older receiving a pneumonia and influenza vaccination (BRFSS, CDC, 2016).



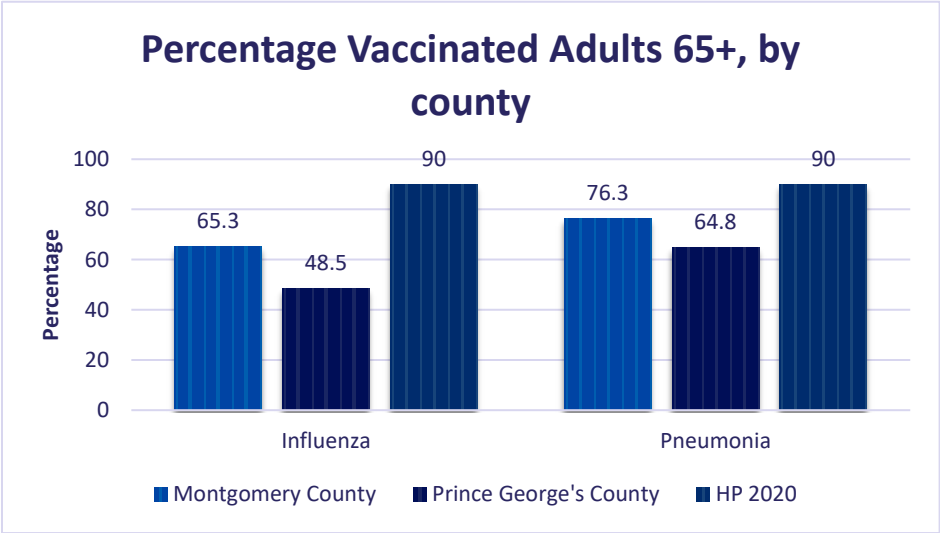


Figure 53: Percentage of adults 65+ who have received the influenza or pneumonia vaccine. Source: MD BRFSS, 2016.

Chronic lower respiratory disease (CLRD) refers to a diverse group of disorders characterized by airway obstruction, causing shortness of breath and impaired lung function, and includes asthma, emphysema, bronchitis, and chronic obstructive pulmonary disease (Centers for Disease Control and Prevention, 2017). Prior to 1999, CLRD was synonymous with Chronic Obstructive Pulmonary Disease (COPD); however, in 1999, the definition of CLRD was expanded to include asthma. CLRD is a leading cause of death and generally occurs among older adults. While mortality rates of other leading causes of death have decreased, deaths due to CLRD continue to rise, and is most prevalent in adults 65+. This is thought to be due to age-associated changes in the structure and function of the

lung. Smoking cigarettes as well as exposure to secondhand smoke and chemical irritants are important risk factors. According to the Centers for Disease Control and Prevention, over 30 billion dollars are spent annually on chronic lower respiratory diseases.

Falls are a leading cause of unintentional injury and injury death, however most are preventable. Falls commonly produce bruises, hip fractures, and head trauma. These injuries can increase the risk of early death and can make it difficult for older adults to live independently. Effective prevention strategies create safer environments and reduce risk factors, from installing handrails and improving lighting and visibility, to reducing tripping hazards and exercising regularly to enhance balance. In 2014, older adults in Maryland generated over $253 million in fall-related hospitalizations cost and fall-related ED visit charges were over $20 million (HSCRC, 2014).

Hospital Readmissions

Centers for Medicare and Medicaid Services (CMS) defines a hospital readmission as an episode when a patient who had been discharged from a hospital is admitted again within 30 days of discharge, adding the cause of the readmission does not need to be related to the cause of the initial hospitalization. The time frame was set at 30 days because readmissions during this time can be influenced by the quality of care received at the hospital and how well discharges were coordinated. Readmission rates have increasingly been used as an outcome measure in health services research and as a quality benchmark for health systems, and can be indicators of poor care or missed opportunities to better coordinate care. Hospital readmission rates were formally included in reimbursement decisions for the Centers for Medicare and Medicaid Services (CMS) as part of the Patient Protection and Affordable Care Act (ACA) of 2010, which penalizes health systems with higher than expected readmission rates through the Hospital Readmission Reduction Program.

As research suggests, monitoring the number of patients who experience unplanned readmissions can improve quality of care through the development of hospital-based initiatives designed to improve communication with patients and their caregivers and potentially avert many readmissions (HSCRC, 2014). An analysis of hospital readmissions allows us to identify select indicators related to community health needs and develop methodologies and programs that will improve health outcomes.

During the timeframe January 2013 – December 2018, Holy Cross Hospital had 201,851 total discharges. Of this, 9,576 (4.7%) individual patients were readmitted to the hospital within 30 days of discharge (all-cause, including one day length of stay), with some patients being readmitted more than one time, accounting for 13,721 total readmissions within 30 days of discharge (6.8% 30-day readmission rate). A small group of 201 patients were readmitted five or more times within 30 days. They comprised just 2.1% of individual patients who were readmitted, but 10.6% of total readmissions. African Americans (48.1%) and Medicare recipients (52.3%) had the highest percent of readmissions for race/ethnicity and payer group, respectively.

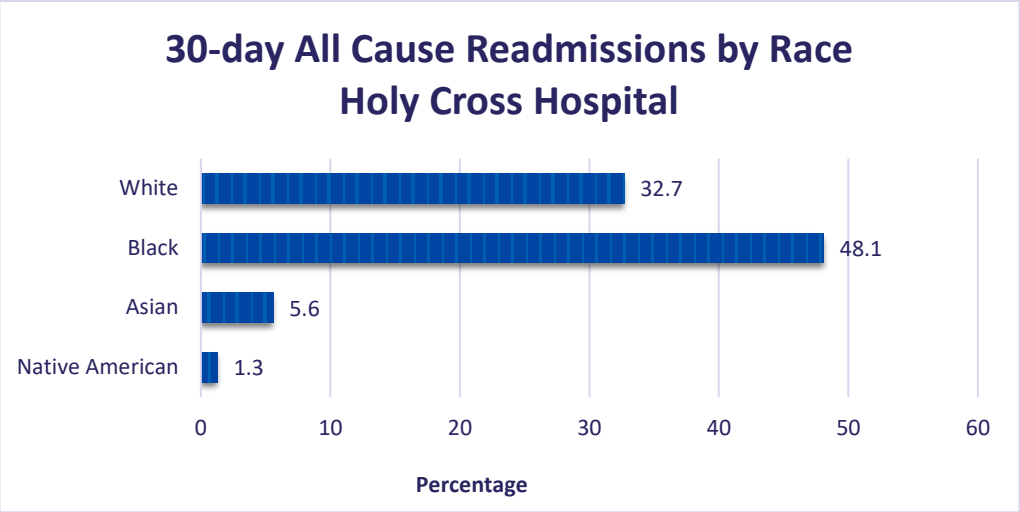


Figure 54: Percentage of HCH patients readmitted within 30 days after discharge by race (Jan 2013 – Dec 2018).

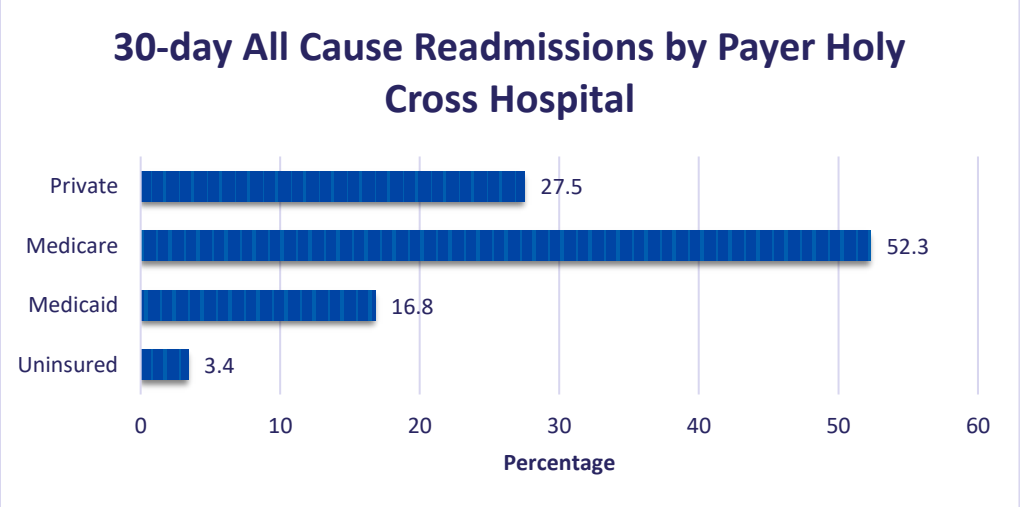


Figure 55: Percentage of HCH patients readmitted within 30 days after discharge by payer (Jan 2013 – Dec 2018).

DATA GAPS IDENTIFIED

Where available, the most current and up-to-date data was used to determine the health needs of the community. Although the data set available is rich with information and more information is available today when compared to the needs assessment conducted in fiscal year 2012, data gaps still exist. Additionally, some of the data measures have not had updated information since the FY2017 needs assessment.

- Data such as health insurance coverage and cancer screening, incidence and mortality rates are not available by geographic areas within Montgomery or Prince George's Counties.
- Data are not available on all topics to evaluate health needs within each race/ethnicity by age-gender specific subgroups.
- Diabetes prevalence is not available for children, a group that has had an increasing risk for type 2 diabetes in recent years due to increasing overweight/obesity rates.
- Health risk behaviors that increase the risk for developing chronic diseases, like diabetes, are difficult to measure accurately in subpopulations, especially the Hispanic/Latino populations, due to BRFSS methodology issues.
- County-wide data that characterize health risk and lifestyle behaviors like nutrition, exercise, and sedentary behaviors are not available for children.
- Analysis of linked birth-death records would provide detailed information about characteristics and risk factors that contribute to fetal and infant losses in Montgomery and Prince George's Counties among those populations that could be at elevated risk for poor birth outcomes.
- An ongoing source of Pregnancy Risk Assessment Monitoring System (PRAMS) data at the county level at least every three years would improve policy and planning efforts in maternal, fetal and infant health.
- LGBT+ data is only available at the county level for same-sex couples living in the same household. Single LGB individuals, as well as transgender individuals, do not have measures for absolute number at any geographic level or related health measures.
- Community Conversations where limited to Montgomery County.

RESPONSE TO FINDINGS

Holy Cross addresses unmet needs within the context of our overall approach, mission commitments and key clinical strengths, and within the overall goals of *Healthy Montgomery.*

Key findings from all data sources, including data provided by *Healthy Montgomery*, our external review group and hospital available data were reviewed and the most pressing needs were incorporated into our implementation strategy. The CHNA Implementation Strategy reflects Holy Cross Hospital's overall approach to improving community health by targeting the intersection between the identified needs of the community and the key strengths and mission commitments of the organization (see Figure 57) to help build the continuum of care. We have established leadership accountability and an organizational structure for ongoing planning, budgeting, implementation and evaluation of community health activities, which are integrated into our multi-year strategic and annual operating planning processes.

Figure 56: How Holy Cross Health aligns targeted programs with the mission and strengths of the hospital and unmet community needs.

Guiding Principles

The multi-year CHNA Implementation Strategy addresses the priority areas and overarching themes by focusing our activities on populations experiencing vulnerability and under resourced individuals and families, including women/children, seniors, and racial, ethnic and linguistic minorities. To select outreach priorities for the implementation strategy, Holy Cross Health linked community health care needs to our mission and strategic priorities.

Holy Cross Health's community health programs and services are well positioned to lead in the identification of and response to existing and emerging community needs in our service area. To address the unmet needs, Holy Cross Health will focus on addressing downstream issues through prevention, education, and disease management programs and upstream issues through policy, system and environmental change strategies.

In alignment with our mission and vision, Holy Cross Health strives to optimize wellness and equity and eliminate disparities in our communities. This is accomplished by addressing an individual's social needs as well as improving community conditions. Holy Cross Health's community health and well-being strategy to address unmet community need encompasses three key focus areas:

Clinical Care: Delivery of efficient and effective people-centered health care services for the uninsured/Medicaid population that is focused on reducing clinical quality outcome disparities and addressing the social needs of patients;

Community Engagement: Connecting efficient and effective wrap around services, expanding the availability of community-based services, and ensuring that patients, community members, and employees are linked to, and can utilize, these services; and

Community Transformation: Policy, system and environmental change strategies focusing on community building to address the physical environment, economic revitalization, housing and other social determinants/influencers of health

Based on findings in Holy Cross Hospital's 2019 CHNA and other supporting documents, three priorities were selected to address the unmet need of the communities we serve. The main priorities are Social Influencers of Health, Vulnerable Populations, and Chronic Diseases. Due to the breadth of each priority, superiorities have been identified.

Unmet Need

Holy Cross Health used the information from the community health needs assessment to identify three priority areas: Social Determinants/Influencers of Health, Vulnerable Populations, and Chronic Diseases. Building upon the Healthy Montgomery top-ranked priorities and available data, Holy Cross Health identified subcategories for each priority and ranked the priorities and subcategories based on severity, feasibility, potential to achieve outcomes and prevalence in the population. The following prioritized list of the significant unmet needs identified and their subcategories were developed using scores from each of the categories listed above:

1. Social Determinants/Influencers of Health
    a. Access to Care
    b. Food Insecurity
    c. Housing
2. Vulnerable Populations
    a. Senior Population
    b. Maternal/Infant Population
3. Chronic Diseases
    a. Diabetes
    b. Cancers
    c. Cardiovascular Health
    d. Obesity
    e. Behavioral Health

For further information on how Holy Cross Health plans to address each identified unmet need, please review our Multi-Year CHNA Implementation Plan at http://www.holycrosshealth.org/CHNA implementation-plan.

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APPENDICES

Appendix A: Holy Cross Hospital 19 ZIP Code Primary Service Area

ZIP Code	City
20705	Beltsville
20707	Laurel
20740	College Park
20742	College Park
20770	Greenbelt
20782	Hyattsville
20783	Hyattsville
20852	Rockville
20866	Burtonsville
20868	Spencerville
20895	Kensington
20901	Silver Spring
20902	Silver Spring
20903	Silver Spring
20904	Silver Spring
20905	Silver Spring
20906	Silver Spring
20910	Silver Spring
20912	Takoma Park

Appendix B: Holy Cross Hospital's Comprehensive Services

Holy Cross Health offers our community access to a wide-range of quality health care. Our programs at Holy Cross Hospital in Silver Spring, Md. provides area adults and children an array of inpatient and outpatient services. Holy Cross Health also offers community health care, health education and support services, as well as home-based health and hospice care to meet a lifetime of health needs.

SPECIALTIES AND SERVICES	
CANCER INSTITUTE	HOME-BASED SERVICES
EMERGENCY CENTER	HOSPITALISTS AND INTENSIVISTS
NEUROSCIENCES	MEDICAL IMAGING SERVICES
SENIOR SERVICES	PAIN MANAGEMENT CENTER
SURGICAL SERVICES	PALLIATIVE CARE
WOMEN AND INFANT SERVICES	PEDIATRIC SERVICES
CARDIAC SERVICES	PHYSICAL MEDICINE AND REHABILITATION PROGRAM
CRITICAL CARE	SLEEP CENTER
DIALYSIS SERVICES	

For a detailed list of our specialties and services, please visit http://www.holycrosshealth.org/programs-services.

Appendix C: 2019 Healthy Montgomery Steering Committee Members

Organization	Name of Key Collaborator	Title	Collaboration Description
Public Health Services, Montgomery County DHHS	Dr. Travis Gayles	County Health Officer and Chief	Co-Chair
Manna Food Center	Ms. Jackie DeCarlo	Executive Director	Co-Chair
African American Health Program/Montgomery County Commission on Health	Ms. Michelle Hawkins	Liaison	Member
MedStar Montgomery Medical Center	Ms. Dairy Marroquin	Community Outreach Coordinator	Member
Montgomery County Department of Health and Human Services	Dr. Raymond Crowel	Director	Member
House of Delegates, Maryland General Assembly	Ms. Bonnie Cullison	Delegate	Member
Montgomery Parks	Ms. Rachel Newhouse	Park Planner Coordinator	Member
Primary Care Coalition of Montgomery County	Ms. Leslie Graham	President & Chief Executive Officer	Member
Montgomery County Department of Transportation (MCDOT)	Mr. Samuel Oji	Chief, Enhanced Mobility and Senior Services Section	Member
Montgomery County Department of Planning	Ms. Amy Lindsey	Senior Planner	Member
Holy Cross Health	Ms. Kimberley McBride	Vice President, Community Health	Member
Ronald D. Paul Companies	Ms. Kathy McCallum	Chief Operating Officer	Member
Carefirst Blue Cross Blue Shield	Ms. Beatrice Miller	Sr. Regional Care Coordinator	Member
African American Health Program		Member	
Kaiser Permanente	Ms. Amy Gyau-Moyer	Program Manager, Community Health and Benefits	Member

Asian American Health Initiative	Dr. Nguyen Nguyen	Member	Member
Proyecto Salud Health Center	Dr. Cesar Palacios	Executive Director	Member
Latino Health Initiative		Member	
Montgomery County Public Schools	Dr. Jonathan Brice	Associate Superintendent	Member
Montgomery County Recreation Department	Ms. Robin Riley	Division Chief	Member
Suburban Hospital	Ms. Monique Sanfuentes	Director, Community Health and Wellness	Member
Georgetown University School of Nursing and Health Studies	Dr. Michael Stoto	Professor	Member
Adventist HealthCare	Dr. Marilyn Dabady Lynk	Executive Director	Member
Montgomery County Collaboration	Mr. Elijah Wheeler	Deputy Executive Director	Member
Department of Housing and Community Affairs (DHCA)	Ms. Myriam Torrico	Community Program Manager	Member

Updated: 8/19/2019

Appendix D: Key Highlights from Holy Cross Health's Community Benefit External Review

On June 5th, 2019 the following organizations were represented at the External Review Meeting:

Montgomery County Food Council
Holy Cross Health Center – Aspen Hill
Nexus Montgomery Reg. Partnership
Healthcare Initiative Foundation
Montgomery County Dept. of HHS
Montgomery County Council
Silver Spring Village
Montgomery County Collaboration
Council for Children, Youth and Families

Suggestions made for our FY20 Annual Community Benefit Plan

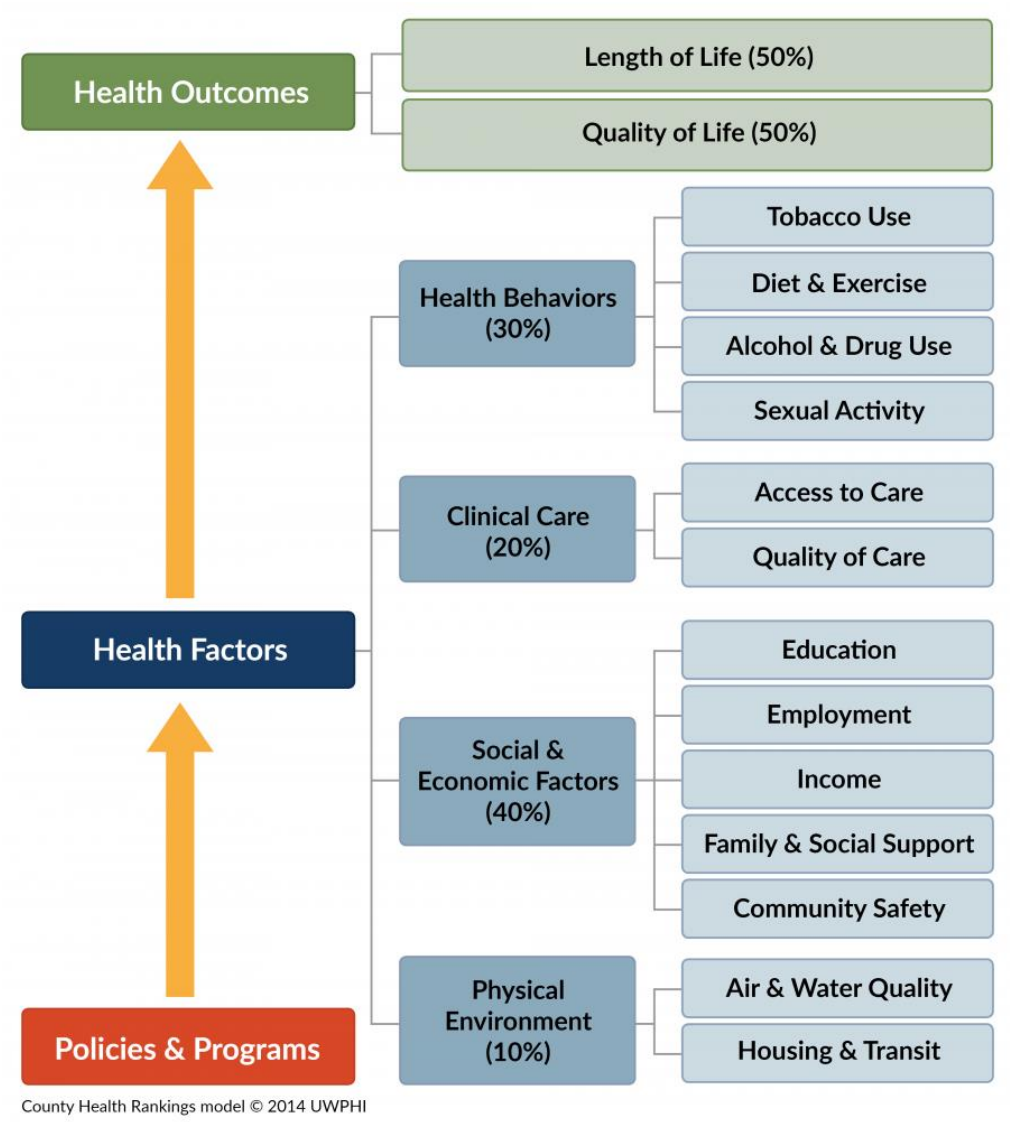
- ❖ Memory Clubs for those who are experiencing early dementia stages.
- ✓ Increase maternal child focus.
- ✓ Increase screening for food insecurity by providers.
- ✓ Increase access to culturally appropriate foods and education.
- ✓ Support SNAP enrollment, particularly among seniors.
- ✓ Increase professional awareness and patient navigation to outpatient mental health services.
- ✓ Focus on birth to five age group.
- ✓ Address undiagnosed behavioral health issues for children especially related to adverse childhood events.
- ❖ Support early diagnoses of autism.
- ✓ Focus on prevention and wellness for seniors, including isolation issues.
- ❖ Meet needs of growing number of single mothers new to this country with school age children.
- ✓ Improve medical literacy.
- ✓ Increase screenings for health center patients.
- ✓ Improve navigation for military and veteran services.
- ✓ Use community health workers for engagement.
- ✓ Assist veterans with access to care and navigation

Key

- ✓ Accomplished or in process
- ❖ Still considering

Appendix E: Maryland County Health Rankings

Rank	County
1	Montgomery (MO)
2	Howard (HO)
3	Frederick (FR)
4	Carroll (CO)
5	St. Mary's (SM)
6	Calvert (CA)
7	Queen Anne's (QA)
8	Anne Arundel (AN)
9	Talbot (TA)
10	Harford (HA)
11	Prince George's (PG)
12	Charles (CH)
13	Baltimore (BL)
14	Kent (KE)
15	Garrett (GA)
16	Worcester (WO)
17	Washington (WA)
18	Cecil (CE)
19	Wicomico (WI)
20	Allegany (AL)
21	Caroline (CR)
22	Dorchester (DO)
23	Somerset (SO)
24	Baltimore City (BA)



Appendix F: Summary of Holy Cross Health's Significant Community Benefit Programming in Response to Identified Unmet Health Care Needs: Fiscal Year 2019

Maternal and Infant Health

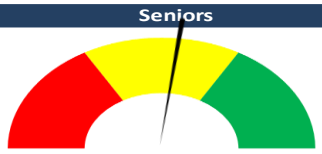
FY2019

Goal	Annual Target	YTD Target	YTD Actual
Maternity Partnership Admissions	1,012	1,012	958
Partnership % Low-birth weight infants	8.5%	8.5%	2.5%
Perinatal Class Encounters	8,996	8,996	7,490
Holy Cross Germantown Health Center Newborn visits	Baseline	Baseline	68

CHNA Impact Measures	Baseline	Target	MC Actual	
Increase percent of mothers receiving early prenatal care*	63.1%	66.9%	67.5%	↓
Reduce the percent of low birth weight infants*	8.2%	8.0%	7.4%	↓
Decrease infant mortality rate*	5.5	6.3	4.9	=

CHNA Impact Measures	Baseline	Target	PGC Actual	
Increase percent of mothers receiving early prenatal care*	54.0%	66.9%	53.1%	↑
Reduce the percent of low birth weight infants*	10.0%	8.0%	9.7%	↑
Decrease infant mortality rate*	8.6	6.3	8.9	↑

Seniors



FY2019

Goal	Annual Target	YTD Target	YTD Actual
Senior Source Encounters (excluding Senior Fit)	16,236	16,236	13,303
Fall Assessments BioSway/Biodex, Get Up & Go, Chair Stand and Gait & Balance	268	268	45
Falls Risk Screening	100	100	39
Average MADC daily census	24	24	30

CHNA Impact Measures	Baseline	Target	MC Actual	
Increase life expectancy*	84.1	79.8	84.9	↑
Decrease fall-related deaths*	7.1	7.7	6.5	↓

CHNA Impact Measures	Baseline	Target	PGC Actual	
Increase life expectancy*	79.2	79.8	79.6	↓
Decrease fall-related deaths*	6.4	7.7	7.5	↑

Cardiovascular Health

FY2019

Goal	Annual Target	YTD Target	YTD Actual
CHW Cardiovascular Education Encounters	600	600	974
Average Senior Fit Weekly Participants	1271	1271	2,844
Percent of health center patients with diagnosis of HTN with good blood pressure control	75%	75%	68.7%

CHNA Impact Measures	Baseline	Target	MC Actual	
Decrease heart disease mortality*	136.4	166.3	107.5	↓
Decrease stroke mortality†	30.1	34.8	24.5	↓
Decrease percent of adults told by health professional they have high blood	21.6%	26.9%	36.0%	↑

CHNA Impact Measures	Baseline	Target	PGC Actual	
Decrease heart disease mortality*	191.2	166.3	174.0	↑
Decrease stroke mortality†	35.2	34.8	39.2	↑
Decrease percent of adults told by health professional they have high blood pressure†	36.3%	26.9%	46.8%	↑

Obesity

FY2019

Goal	Annual Target	YTD Target	YTD Actual
Average Kids Fit Participants per Month	17	17	26
Number of Kids Fit participants taking Presidential Challenge Test	150	150	26
% of Health Ctr patients diagnosed w/ high/low BMI w/ documented follow-up plan	77%	77%	71.9%

CHNA Impact Measures	Baseline	Target	MC Actual	
Decrease percent of students with no participation in physical activityΔ	16.5%	18.0%	16.5%	=
Decrease percent of students who are obese*	8.7%	10.7%	7.5%	↑
Increase percent of students who drank no soda or pop in the past	33.0%	28.4%	33.0%	=

CHNA Impact Measures	Baseline	Target	PGC Actual	
Decrease percent of students with no participation in physical activityΔ	23.2%	18.0%	23.2%	=
Decrease percent of students who are obese*	13.7%	10.7%	16.7%	↑
Increase percent of students who drank no soda or pop in the past weekΔ	28.0%	28.4%	28.0%	=

Diabetes

FY2019

Goal	Annual Target	YTD Target	YTD Actual
Number enrolled in Diabetes Prevention Program (DPP)	90	90	69
Average number of DPP sessions attended per quarter	3	3	4
DPP average % weight loss at 6 months	5%	5%	4.7%
% of Health Ctr patients w/ diabetes (type 1 & 2) with most recent HbA1c > 9.0% or was missing a result	50%	50%	43.4%

CHNA Impact Measures	Baseline	Target	MC Actual	
Decrease number of adults ever being told they have diabetes (exluding gestational)◊	5.1%	10.2%	7.0%	↑
Decrease ER visits for diabetes*	102.8	186.3	100.0	↑

CHNA Impact Measures	Baseline	Target	PGC Actual	
Decrease number of adults ever being told they have diabetes (exluding gestational)◊	13.5%	10.2%	11.1%	↓
Decrease ER visits for diabetes*	280.5	186.3	169.0	↓

Behavioral Health

FY2019

Goal	Annual Target	YTD Target	YTD Actual
% of health ctr patients receiving depression screening during primary care visit	88.0%	88.0%	88.3%
Nexus Montgomery ACT Team Census	100	100	149
Crisis House Admissions	228	228	450

CHNA Impact Measures	Baseline	Target	MC Actual	
Decrease adolescent and adult illicit drug use in past month (12 or older)†	6.1%	9.7%	8.9%	=
Decrease percent of adults with any mental illness in past yearΔ	16.8%	16.8%	16.2%	↓
Decrease mental health related ER visits*	1,528	3,153	1,848	↑
Decrease suicide rate*	6.5	9.0	7.3	↑

CHNA Impact Measures	Baseline	Target	PGC Actual	
Decrease adolescent and adult illicit drug use in past month (12 or older)†	7.1%	9.7%	10.5%	=
Decrease percent of adults with any mental illness in past yearΔ	15.8%	16.8%	15.9%	=
Decrease mental health related ER visits*	2,722	3,153	1,539	↓
Decrease suicide rate*	5.7	9.0	5.6	↓

Cancers

FY2019

Goal	Annual Target	YTD Target	YTD Actual
Number of MAPS mammograms	352	352	541
CHW Cancer Education Encounters	3000	3000	3510
% of Health Center patients receiving Tobacco Screening	88.3%	88.3%	98.2%

CHNA Impact Measures	Baseline	Target	MC Actual	
Increase colorectal cancer screening (colonoscopy or sigmoidoscopy)◊	72.9%	73.0%	74.2%	↑
Increase percent of women who have had a Pap in past three years◊	83.0%	93.0%	94.4%	↑
Decrease prostate cancer incidence◊	159.3	135.0	117.5	↓
Decrease breast cancer mortality†	19.8	20.7	23.7	↑

CHNA Impact Measures	Baseline	Target	PGC Actual	
Increase colorectal cancer screening (colonoscopy or sigmoidoscopy)◊	71.7%	73.0%	72.4%	↓
Increase percent of women who have had a Pap in past three years◊	82.0%	93.0%	93.2%	↑
Decrease prostate cancer incidence◊	183.3	135.0	154.40	↓
Decrease breast cancer mortality†	28.2	20.7	27.0	↑

Appendix G: Healthy Montgomery Priority Setting Process

The Montgomery County Community Health Improvement Process launched in June 2009 with a comprehensive scan of all existing and past planning processes. Past assessment, planning, and evaluation processes were compiled that related to health and well-being focus and social determinants of health across a multitude of sectors, populations, and communities within Montgomery County. By 2010, the focus was on establishing a core set of indicators that could be examined through a comprehensive needs assessment that resulted in approximately 100 indicators being released at the launch of the Healthy Montgomery website on February 2011.

During 2011, this information was compiled into the Healthy Montgomery Needs Assessment, which was sent to the Healthy Montgomery Steering Committee (HMSC) in September 2011.

In October 2011, the HMSC held a half-day retreat to choose the strategic priority areas for improvement activities. The priority setting process utilized an online survey tool that the Steering Committee members completed prior to the retreat to enable them to independently evaluate potential priority areas by five criteria:

How many people in Montgomery County are affected by this issue?

How serious is this issue?

What is the level of public concern/awareness about this issue?

Does this issue contribute directly or indirectly to premature death?

Are there inequities associated with this issue? (Health inequities are differences in health status, morbidity, and mortality rates across populations that are systemic, avoidable, unfair, and unjust.)

The survey results were compiled for each member and for the entire HMSC. The results were ranked and provided at the retreat to initiate the group process. Through multi-voting and consensus discussion, the Steering Committee narrowed the top-ranked priority areas to be the following:

- Behavioral Health;
- Cancers;
- Cardiovascular Health;
- Diabetes;
- Maternal and Infant Health; and
- Obesity

In addition to selecting the six broad priorities for action, the HMSC selected three overarching themes (lenses) that Healthy Montgomery should address in the health and well-being action plans for each of the six priority areas.

The themes are lack of access, health inequities, and unhealthy behaviors.

The process taken in 2011 was repeated in 2014 and 2017. In 2017, Healthy Montgomery voted to extend the CHNA cycle from every three years to every five years. The priorities of this needs assessment used the most recent process available.

Appendix H: Healthy Montgomery Strategy Selection Process

The 2016 Community Health Needs Assessment (CHNA) Report identified 63 strategies to address the existing Healthy Montgomery priority issues of obesity, behavioral health, diabetes, cardiovascular disease, cancers, and maternal and infant health. These strategies are derived from the key findings of the qualitative data (community conversations), quantitative data (review of national and state data sources), community resources (including the hospital systems' activities), and evidence-based strategies. In addition, the strategies were considered within the framework of Healthy Montgomery's goals of achieving health equity for all residents; improving access to health and social services; and enhancing the physical and social environment to support optimal health and well-being and reduce unhealthful behaviors.

To prepare for the priority-setting retreat, each Healthy Montgomery Steering Committee (HMSC) member was provided a worksheet and a summary of the CHNA report. The HMSC members were asked to select up to ten strategies they believed should be a priority for Healthy Montgomery's 2017-2019 Community Health Improvement Cycle. The HMSC members considered each strategy in light of five collective impact criteria:

- Addresses demonstrated inequities among specific groups
- Data/trends can be monitored over time using a shared measurement approach
- Includes multiple sectors
- Involves program and system changes (not an individual program/single organization)
- Demonstrates an alignment with a Healthy Montgomery health outcome

On the worksheet, HMSC members also indicated their respective organization's ability to commit the time and effort needed to support the action planning and implementation of the selected strategies. This would assist with the action planning efforts that will follow the HMSC's final priority-setting determinations. Healthy Montgomery staff tallied the results of the priority-setting worksheets. The top ten strategies were used during the priority-setting retreat.

A skilled facilitator was recruited to guide the HMSC through the priority-setting process during a four-hour retreat. The facilitator divided the process into two stages. The first stage included a group discussion of the ten priorities that emerged from the worksheets. The group discussion was guided by the following questions:

- Does the strategy meet the five community impact criteria?
- Are there particular issues, concerns, and challenges moving forward that will need to be addressed in relation to the strategy?
- Is the strategy realistic and achievable in three years? The response to this question was extremely important as it also addressed collective buy-in and allocation of resources to assure implementation.

In 2017, Healthy Montgomery voted to extend the CHNA cycle from every three years to every five years. The strategy selection of this needs assessment used the most recent process available.

For each strategy, the key points raised by the group were documented and discussed in detail amongst the HMSC members. During the second stage of the process, the group voted on the top three priorities for Healthy Montgomery to address over the next three years. In making their final decisions, the HMSC was reminded of the collective impact criteria and the goals of Healthy Montgomery.

The group voted using a "dot method" to identify each member's top three strategies. Specifically, each participant was allotted three dot-stickers and was asked to place the dots on their preferred strategies. Participants were allowed to place more than one dot on a particular strategy. The top three strategies receiving the most dots would serve as the 2017 – 2019 priority strategies.

Given the clustering of votes, the group decided unanimously to move forward with the top three highest-ranked strategies (complete description provided below) for calendar years 2017-2019:

Ranking of Healthy Montgomery Priority Strategies

1. Health In All Policies (16 votes)
2. Integrating behavioral health care programs into primary care settings (14)
3. Combined diet and physical activity promotion programs (13)
4. Increase the dissemination and use of evidence based health literacy practices and interventions (7)
5. Support pregnant women obtaining prenatal care in the first trimester (5)
6. Identify and help connect residents to key resources (5)
7. Ensure availability of transportation to safe, accessible, affordable places for physical activity (5)
8. Use of school, retail, and other community sites for provision of preventive services (2)
9. Train key community members to identify signs of depression & suicide and refer residents to resources; heroin and opioid misuse (2)
10. Reduce client costs and structural barriers to cancer screenings (0)

*A full description of each of the strategies is included in the 2016 Healthy Montgomery CHNA Report at www.healthymontgomery.org.

Establish and sustain a Health in All Policies (HiAP) model within Montgomery County that brings together professionals from a range of sectors (e.g., transportation, health, environment, labor, education, and housing) with community representatives to ensure that community health needs are identified and that needs and barriers are addressed and implements processes to ensure that County residents are actively engaged in decisions that affect [their] health.

Offer combined diet and physical activity promotion programs for County residents at increased risk of type 2 diabetes to reduce new-onset diabetes; programs commonly include a weight loss goal, individual or group sessions (or both) about diet and exercise, meetings with a trained diet or exercise counselor (or both), and individually tailored diet or exercise plans (or both) by leveraging/enhancing existing efforts within the County. Develop integrated care programs to address mental health, substance abuse and other needs within primary care settings, pilot and evaluate models of integrated mental and physical health in primary care, with particular attention to underserved populations and areas, and to expand access to mental health services (e.g., patient navigation, support groups) and enhance linkages between mental health, substance abuse, disability, and other social services by leveraging/enhancing existing efforts within the County. During the course of the upcoming months, Healthy Montgomery staff will prepare for the action planning efforts in relation to the priorities identified by the HMSC during the 2016 HMSC Retreat, enabling the achievement of key milestones throughout the 2017-2019 cycle.

Appendix I: Community Resources

Type	Name	Address	City, State, Zip
Access to Healthcare Services	Affordable Healthcare Program	114 W. Montgomery Ave	Rockville, MD 20850
Access to Healthcare Services	Affordable Healthcare Program	12900 Middlebrook Rd	Germantown, MD 20874
Access to Healthcare Services	Maryland Children's Health Program (MCHP)	12900 Middlebrook Road	Gaithersburg, MD 20874
Access to Healthcare Services	Medical Assistance Programs (Medicaid/MA)	12900 Middlebrook Road	Gaithersburg, MD 20874
Access to Healthcare Services	Open Enrollment Under the Affordable Care Act	12900 Middlebrook Road	Germantown, MD 20874
Access to Healthcare Services	Medical Assistance Programs (Medicaid/MA)	1335 Piccard Drive	Rockville, MD 20850
Access to Healthcare Services	Open Enrollment Under the Affordable Care Act	1335 Piccard Drive	Rockville, MD 20850
Access to Healthcare Services	Prescription Assistance	14015 New Hampshire Avenue	Silver Spring, MD 20904
Access to Healthcare Services	Prescription Assistance	14015 New Hampshire Avenue, Rooms 126 & 125	Silver Spring, MD 20904
Access to Healthcare Services	Emergency Financial Assistance	15855 Crabbs Branch Way	Rockville, MD 20855
Access to Healthcare Services	Medical Expense Assistance	17550 W. Willard Rd	Poolesville, MD 20837
Access to Healthcare Services	Affordable Healthcare Program	19236 Montgomery Village Ave	Gaithersburg, MD 20886
Access to Healthcare Services	Medical Equiptment Closet - Lollipop Kids	20 Southlawn Court, Suite D	Rockville, MD 20855
Access to Healthcare Services	Maryland HealthChoice Insurance	2000 Dennis Ave	Silver Spring, MD 20902
Access to Healthcare Services	Prescription Assistance	301 Muddy Branch Road	Gaithersburg, MD 20878
Access to Healthcare Services	Emergency Assistance	3425 Emory Church Road	Olney, MD 20832

Access to Healthcare Services	Open Enrollment Under the Affordable Care Act	401 Hungerford Drive	Rockville, MD 20850
Access to Healthcare Services	Emergency Assistance	501 Sligo Avenue	Silver Spring, MD 20910
Access to Healthcare Services	Affordable Healthcare Program	608 North Horners Lane	Rockville, MD 20850
Access to Healthcare Services	Affordable Healthcare Program	7-1 Metropolitan Court	Gaithersburg, MD 20878
Access to Healthcare Services	Prescription Assistance	7728 Woodmont Avenue	Bethesda, MD 20814
Access to Healthcare Services	Affordable Healthcare Program	8 West Middle Lane	Rockville, MD 20851
Access to Healthcare Services	Emergency Assistance	8 West Middle Lane	Rockville, MD 20851
Access to Healthcare Services	Sheperd's Table Resource Center	8210 Dixon Avenue	Silver Spring, MD 20910
Access to Healthcare Services	Affordable Healthcare Program	8238 Georgia Ave	Silver Spring, MD 20910
Access to Healthcare Services	Maryland Children's Health Program (MCHP)	8630 Fenton Street	Silver Spring, MD 20910
Access to Healthcare Services	Medical Assistance Programs (Medicaid/MA)	8630 Fenton Street	Silver Spring, MD 20910
Access to Healthcare Services	Open Enrollment Under the Affordable Care Act	8630 Fenton Street	Silver Spring, MD 20910
Access to Healthcare Services	Prescription Assistance	8757 Georgia Avenue	Silver Spring, MD 20910
Access to Healthcare Services	Medical Assistance Programs (Medicaid/MA)	8818 Georgia Ave	Silver Spring, MD 20906
Access to Healthcare Services	Open Enrollment Under the Affordable Care Act	8818 Georgia Ave	Silver Spring, MD 20906
Access to Healthcare Services	Emergency Assistance	8818 Georgia Avenue	Silver Spring, MD 20910
Access to Healthcare Services	Emergency Financial Assistance	P.O. Box 34094	Bethesda, MD 20827

Access to Healthcare Services	Prescription Assistance	P.O. Box 608	Germantown, MD 20875
Cancer	The Arc of Montgomery County - Respite Services	11600 Nebel Street	Rockville, MD 20852
Cancer	Montgomery County Family Center	12247 Georgia Avenue	Silver Spring, MD 20902
Cancer	Immunization Program	12900 Middlebrook Road	Gaithersburg, MD 20874
Cancer	Care for Your Health	13925 New Hampshire AVe	Silver Spring, MD 20904
Cancer	Cancer Screening	1401 Rockville Pike	Rockville, MD 20852
Cancer	Immunization Program	14105 New Hampshire Avenue, Suite 115	Silver Spring, MD 20904
Cancer	Immunization Program	2000 Dennis Ave	Silver Spring, MD 20902
Cancer	Johns Hopkins Health Care and Wellness Center	20500 Seneca Meadows Parkway	Germantown, MD 20876
Cancer	Food & Friends	219 Riggs Road, NE	Washington, DC 20006
Cancer	Ama Tu Vida	401 Hungerford Drive	Rockville, MD 20850
Cancer	Immunization Program	4910 Macon Road	Rockville, MD 20852
Cancer	Hope Connections for Cancer Support	5430 Grosvenor Lane	Bethesda, MD 20814
Cancer	Hope Connections for Cancer Support	5430 Grosvenor Lane	Bethesda, MD 20814
Cancer	Immunization Program	8630 Fenton Street	Silver Spring, MD 20910
Cancer	Immunization Program	8630 Fenton Street	Silver Spring, MD 20910
Cancer	Healthy Choices	9700 New Church Street	Damacus, MD 20872
Cancer	Freedom from Smoking at Holy Cross	9805 Dameron Dr, Silver Spring, MD 20902	Silver Spring, MD 20910
Cancer	Holy Cross Hospital Medical Adult Day Center	9805 Dameron Drive	Silver Spring, MD 20910

Cardiovascular	Introduction to Stroke Prevention	11 Duncich Manor Place	Gaithersburg, MD 20877
Cardiovascular	Senior Fit - Holy Cross	1150 Carnation Drive	20850
Cardiovascular	Senior Fit - Holy Cross	11711 Georgia Ave.	20902
Cardiovascular	Care for Your Health	13925 New Hampshire AVe	Silver Spring, MD 20904
Cardiovascular	Senior Fit - Holy Cross	14625 Bauer Drive	20853
Cardiovascular	Senior Fit - Holy Cross	14906 Old Columbia Pike	20866
Cardiovascular	Senior Fit - Holy Cross	15 Crescent Road	20770
Cardiovascular	Senior Fit - Holy Cross	1500 Merrimac Drive	20783
Cardiovascular	Senior Fit - Holy Cross	15300 New Hampshire Ave.	20905
Cardiovascular	AAHP Heart Health	1700 April Lane	Silver Spring, MD 20904
Cardiovascular	AAHP Heart Health	1700 April Lane	Silver Spring, MD 20904
Cardiovascular	Senior Fit - Holy Cross	1700 April Lane	20904
Cardiovascular	Senior Fit - Holy Cross	18800 New Hampshire Ave.	20861
Cardiovascular	Senior Fit - Holy Cross	18905 Kingsview Road	20874
Cardiovascular	Senior Fit - Holy Cross	19561 Scenery Drive	20876
Cardiovascular	Senior Exercise - Medstar Montgomery	2004 Queensguard Road	Silver Spring, MD 20906
Cardiovascular	Introduction to Stroke Prevention	201 E Diamond Ave	Gaithersburg, MD 20877
Cardiovascular	Johns Hopkins Health Care and Wellness Center	20500 Seneca Meadows Parkway	Germantown, MD 20876
Cardiovascular	Senior Fit - Holy Cross	2450 Lyttonsville Road	20910
Cardiovascular	Senior Fit - Holy Cross	3310 Gateshead Manor Way	20904
Cardiovascular	Ama Tu Vida	401 Hungerford Drive	Rockville, MD 20850
Cardiovascular	Senior Fit - Holy Cross	409 and 417 Russell Ave.	20877-2801
Cardiovascular	Senior Fit - Holy Cross	4100 Northview Drive	20716

Cardiovascular	Senior Fit - Holy Cross	4817 Blagden Avenue, NW	20011
Cardiovascular	Senior Fit - Holy Cross	6120 Sargent Road	20782
Cardiovascular	Senior Fit - Holy Cross	635 Aspen Street, NW	20012
Cardiovascular	Senior Fit - Holy Cross	6600 Adelphi Road	20783
Cardiovascular	Senior Fit - Holy Cross	8580 Second Avenue	20910
Cardiovascular	Senior Fit - Holy Cross	8700 Piney Branch Road	20901
Cardiovascular	Healthy Choices	9700 New Church Street	Damacus, MD 20872
Cardiovascular	Senior Fit - Holy Cross	9701 Veirs Drive	20850
Cardiovascular	Diabetes Education Program at Holy Cross	9805 Dameron Dr, Silver Spring, MD 20902	Silver Spring, MD 20910
Cardiovascular	Freedom from Smoking at Holy Cross	9805 Dameron Dr, Silver Spring, MD 20902	Silver Spring, MD 20910
Diabetes	Diabetes Support & Continuing Education Meetings at Suburban	1000 Forest Glen Road	Silver Spring, MD 20901
Diabetes	Diabetes Prevention Program	11 Duncich Manor Place	Gaithersburg, MD 20877
Diabetes	Food Supplement Nutrition Education/Market to Mealtime	1101 University Blvd E	Takoma Park, MD 20912
Diabetes	Kids Kitchen: Food, Fitness, and Fun!	11800 Monticello Ave	Md, Silver Spring 20902
Diabetes	Kids Kitchen: Food, Fitness, and Fun!	12701 Goodhill Rd	Silver Spring, MD 20906
Diabetes	Food Supplement Nutrition Education/Market to Mealtime	15 Fulks Corner Avenue	Gaithersburg, MD 20877
Diabetes	Diabetes Self-Management Education (DSME) at MedStar Montgomery	18101 Prince Philip Drive	Olney, MD 20832

Diabetes	EFNEP Adult & Youth Nutrition Programs	18410 Muncaster Rd	Derwood, MD 20855
Diabetes	Johns Hopkins Health Care and Wellness Center	20500 Seneca Meadows Parkway	Germantown, MD 20876
Diabetes	Kids Kitchen: Food, Fitness, and Fun!	2400 Bel Pre Rd	Silver Spring, MD 20906
Diabetes	AAHP Diabetes Education	3310 Gateshead Manor Way	Silver Spring, MD 20904
Diabetes	Diabetes Support & Continuing Education Meetings at Suburban	3950 Ferrara Drive	Wheaton, MD 20906
Diabetes	Healthy Eating at Rolling Terace Elementary School	705 Bayfield St	Takoma Park, MD 20912
Diabetes	Healthy Eating at Piney Branch Elementary School	7510 Maple Ave	Takoma Park, MD 20912
Diabetes	Diabetes Support & Continuing Education Meetings at Suburban	80A Bureau Drive	Gaithersburg, MD 20878
Diabetes	Manna Food Center	8900 Georgia Ave	Silver Spring, MD 20910
Diabetes	Kids Kitchen: Food, Fitness, and Fun!	910 Schindler Drive	Silver Spring, MD 20903
Diabetes	Healthy Choices	9700 New Church Street	Damacus, MD 20872
Diabetes	Diabetes Prevention and Education at Holy Cross	9805 Dameron Dr, Silver Spring, MD 20902	Silver Spring, MD 20910
Diabetes	Diabetes Education Program at Holy Cross	9805 Dameron Dr, Silver Spring, MD 20902	Silver Spring, MD 20910
Food	Manna Food Pantry	10000 Brunswick Ave	Silver Spring, MD 20910
Food	SHARE Food Network	1006 Larch Avenue	Takoma Park, MD 20912
Food	Emergency Assistance - Carribean Help Center	10140 Sutherland Rd	Silver Spring, MD 20901
Food	Food Bank	1111 Taft Street	Rockville, MD 20850

Food	Selma Sweetbaum Senior Satellite Program	1132 Arcola Ave	Silver Spring, MD 20902
Food	Food Pantry	11435 Grandview Avenue Wheaton	Silver Spring, MD 20902
Food	Food Pantry	11800 Darnestown Road	Gaithersburg, MD 20878
Food	Food Assistance	12247 Georgia Avenue	Silver Spring, MD 20902
Food	Manna Food Pantry	12247 Georgia Avenue	Wheaton, MD 20902
Food	Community Gardens	12718 Veirs Mill Rd	Rockville, MD 20852
Food	Manna Food Pantry	12800 New Hampshire Avenue,	Silver Spring, MD 20904
Food	Faith Community Food Outreach	13618 Layhill Rd	Silver Spring, MD 20906
Food	Food Bank	1408 Merrimac Drive	Silver Spring, MD 20904
Food	SHARE Food Network	149 Ritchie Ave	Silver Spring, MD 20910
Food	Community Supper	15225 Old Columbia Pike	Burtonsville, MD 20866
Food	Food Bank	15300 New Hampshire Ave	Silver Spring, MD 20905
Food	Food Bank	15300 New Hampshire Ave	Silver Spring, MD 20905
Food	Manna Food Pantry	15516 Old Columbia Pik	Burtonsville, MD 20866
Food	Emergency Food Delivery	15855 Crabbs Branch Way	Rockville, MD 20855
Food	Manna Food Pantry	1600 Camillus Drive	Silver Spring, MD 20904
Food	Food Bank	1600 St. Camillus Dr.	Silver Spring, MD 20904
Food	Maryland's Best Farmer's Market	1600 St. Camillus Drive	Silver Spring, MD 20903

Food	Food Bank	1700 Powder Mill Rd	Silver Spring, MD 20903
Food	Manna Food Pantry	17314 New Hampshire Ave	Ashton, MD 20905
Food	Emergency Food Assistance	17550 W. Willard Rd	Poolesville, MD 20837
Food	Food Bank	17604 Washington Grove Lane,	Gaithersburg, MD 20877
Food	Food Pantry	17620 Washington Grove Lane	Gaithersburg, MD 20877
Food	Community Gardens	18041 Central Park Circle	Boyds, MD 20841
Food	Community Gardens	18110 Washington Grove Lane	Gaithersburg, MD 20877
Food	Food SHARE	19615 Goshen Rd	Gaithersburg, MD 20877
Food	SHARE Food Network	19615 Goshen Road	Gaithersburg, MD 20879
Food	Helping Kids Eat Weekend Backpack Food Program	19642 Club House Rd. Suite 620	Montgomery Village, MD 20886
Food	Women Who Care Ministries	19642 Club House Rd. Suite 620	Montgomery Village, MD 20886
Food	Food Bank	20021 Aircraft Drive	Germantown, MD 20874
Food	Manna Food Pantry	20021 Aircraft Drive	Germantown, MD 20874
Food	Food Assistance	201 E Diamond Av 3rd floor	Gaithersburg, MD 20877
Food	Food Bank	201 S. Frederick Ave.	Gaithersburg, MD 20877
Food	Food Bank	201 S. Frederick Ave.	Gaithersburg, MD 20877
Food	Food Bank	2106 Linden Lane	Silver Spring, MD 20910
Food	Community Gardens	2161 Briggs Chaney Rd	Silver Spring, MD 20905

Food	Briggs Chaney Community Garden	2161 Briggs Chaney Road	Silver Spring, MD 20905
Food	Food & Friends	219 Riggs Road, NE	Washington, DC 20006
Food	Food Bank	21925 Frederick Road	Boyds, MD 20841
Food	SHARE Food Network	22420 Frederick Road	Clarksburg, MD 20871
Food	Maryland's Best Farmer's Market	225 N. Washington Street	Rockville, MD 20850
Food	Food Pantry	23 West Diamond Avenue	Gaithersburg, MD 20877
Food	Maryland's Best Farmer's Market	2410 Spencerville Road	Burtonsville, MD 20868
Food	SHARE Food Network	2518 Fairland Road	Silver Spring, MD 20904
Food	SHARE Food Network	2631 Norbeck Road	Silver Spring, MD 20906
Food	SHARE Food Network	2900 Sandy Spring Road	Olney, MD 20832
Food	Maryland's Best Farmer's Market	301 Main Street	Gaithersburg, MD 20878
Food	Food Bank	301 Muddy Branch Road	Gaithersburg, MD 20878
Food	Food Bank	33 University Blvd E	Silver Spring, MD 20675
Food	Food SHARE	3300 Briggs Chaney Rd	Silver Spring, MD 20904
Food	Manna Food Pantry	3300 Briggs Chaney Road	Silver Spring, MD 20904
Food	Food Bank	3315 Greencastle Road	Burtonsville, MD 20866
Food	Food Bank	3400 Spencerville Rd	Burtonsville, MD 20866
Food	Emergency Food Delivery	3425 Emory Church Road	Olney, MD 20832
Food	Maryland's Best Farmer's Market	3701 Howard Avenue	Kensington, MD 20895

Food	SHARE Food Network	4115 Plyers Mill Road	Kensington, MD 20895
Food	SHARE Food Network	420 University Blvd. East	Silver Spring, MD 20901
Food	Senior Lunch Program	4401 Muncaster Mill Rd	Rockville, MD 20853
Food	Capital Area Food Bank	4900 Puerto Rico Avenue, NE	Washington, DC 20016
Food	Community Gardens	4920 Macon Rd	Rockville, MD 20852
Food	Emergency Food Program	501 Sligo Avenue	Silver Spring, MD 20910
Food	SHARE Food Network	608 North Horners Lane	Rockville, MD 20850
Food	Manna Food Pantry	630 E. Diamond Ave.	Gaithersburg, MD 20877
Food	Community Gardens	6400 Orchard Ave	Takoma Park, MD 20912
Food	Crossroads Community Food Network	6930 Carroll Avenue, Suite 426	Takoma Park, MD 20912
Food	Food Pantry	7001 New Hampshire Avenue	Takoma Park, MD 20912
Food	Manna Food Pantry	7051 Carroll Ave	Takoma Park, MD 20912
Food	SHARE Food Network	7201 16th Pl	Hyattsville, MD 20783
Food	Maryland's Best Farmer's Market	7600 Arlington Road	Bethesda, MD 20837
Food	Manna Food Pantry	7620 Maple Ave	Takoma Park, MD 20912
Food	Community Gardens	7620 Maple Avenue	Takoma Park, MD 20912
Food	Maryland's Best Farmer's Market	7777 Maple Avenue	Takoma Park, MD 20912
Food	Community Gardens	7904 Fenton St	Silver Spring, MD 20910
Food	Food Assistance	7949 15th Ave	Hyattsville, MD 20782

Food	Community Gardens	7980 Georgia Avenue	Silver Spring, MD 20910
Food	SHARE Food Network	8200 Emory Grove Road	Gaithersburg, MD 20879
Food	Community Meals	8210 Colonial Lane	Silver Spring, MD 20910
Food	Interfaith Works Empowerment Center	8210 Dixon Avenue	Silver Spring, MD 20910
Food	Food Pantry	8238 Georgia Ave	Silver Spring, MD 20910
Food	Manna Food Pantry	8700 Piney Branch Road	Silver Spring, MD 20901
Food	Community Gardens	8701 Hartsdale Ave	Bethesda, MD 20814
Food	Cooking Matters at the Store with Manna Food Center	8750 Arliss St	Silver Spring, MD 20901
Food	Project Neighbor Care	8818 Piney Branch Road	Sandy Spring, MD 20903
Food	Arleeta's Pantry	8900 Georgia Avenue	Silver Spring, MD 20910
Food	Food Bank	8900 Georgia Avenue	Silver Spring, MD 20910
Food	Manna Food Pantry	8902 Manchester Rd	Silver Spring, MD 20901
Food	Food Bank	9100 Colesville Road	Silver Spring, MD 20910
Food	Manna Food Pantry	9311 Gaither Rd	Gaithersburg, MD 20877
Food	Cooking Matters at the Store with Manna Food Center	9311 Gaither Rd	Gaithersburg, MD 20877
Food	Community Gardens	9500 Brunett Avenue	Silver Spring, MD 20904
Food	Maryland's Best Farmer's Market	9601 Medical Center Drive	Rockville, MD 20850

Food	Food Bank	9727 Georgia Avenue	Silver Spring, MD 20910
Food	Maryland's Best Farmer's Market	9908 South Glen Road	Potomac, MD 20854
Food	Maryland's Best Farmer's Market	Anne St.(between University Blvd. & Hammond Ave	Takoma Park, MD 20912
Food	Maryland's Best Farmer's Market	Corner of Fulks corner Avenue & MD Rt. 355	Gaithersburg, MD 20877
Food	Maryland's Best Farmer's Market	Damascus High School	Damacus, MD 20872
Food	Maryland's Best Farmer's Market	Fenton St & Ellsworth Dr	Silver Spring, MD 20910
Food	Maryland's Best Farmer's Market	Laurel Avenue between Carroll Avenue & Eastern Avenue	Takoma Park, MD 20912
Food	Emergency Food Delivery	P.O. Box 34094	Bethesda, MD 20827
Food	Emergency Food Program	P.O. Box 608	Germantown, MD 20875
Food	Emergency Food Delivery	P.O.Box 126	Damacus, MD 20872
Food	Maryland's Best Farmer's Market	Public House Road & Clarksburg Road	Clarksburg, MD 20871
Food	Maryland's Best Farmer's Market	Reedie Drive & Viers Mill Road	Wheaton, MD 20902
Food	Maryland's Best Farmer's Market	Rt 28 and Monroe St	Rockville, MD 20850
Housing	Emergency Shelter	1070 Copperstone Court	Rockville, MD 20852
Housing	Inwood House	10921 Inwood Avenue	Silver Spring, MD 20902
Housing	Montgomery Avenue Women's Center	112 W. Montgomery Avenue	Rockville, MD 20850
Housing	Hand to Hand Eviction Prevention	114 W. Montgomery Ave	Rockville, MD 20850

Housing	Eviction Prevention	11435 Grandview Avenue Wheaton	Silver Spring, MD 20902
Housing	Shelter Services	12120 Plum Orchard Drive	Silver Spring, MD 20904
Housing	Rock Creek Foundation	12120 Plum Orchard Drive	Silver Spring, MD 20904
Housing	Emergency Eviction Prevention	12247 Georgia Avenue	Wheaton, MD 20902
Housing	Shelter Services	12247 Georgia Avenue	Wheaton, MD 20902
Housing	Wilkins Avenue Women's Assessment Center	12250 Wilkins Avenue	Rockville, MD 20852
Housing	Independent Living Services	12301 Old Columbia Pike	Silver Spring, MD 20904
Housing	Supportive Housing Services	12400 Kiln Ct	Burtonsville, MD 20705
Housing	Compass, Inc	12400 Kiln Ct	Burtonsville, MD 20705
Housing	Emergency Eviction Prevention	12900 Middlebrook Road	Gaithersburg, MD 20874
Housing	Shelter Services	12900 Middlebrook Road	Gaithersburg, MD 20874
Housing	Housing Counseling and Education	12900 Middlebrook Road	Germantown, MD 20874
Housing	Abused Persons Program	1301 Piccard Dr	Rockville, MD 20850
Housing	Emergency Eviction Prevention	1301 Piccard Dr	Rockville, MD 20850
Housing	Rental Assistance	1301 Piccard Dr	Rockville, MD 20850
Housing	Shelter Services	1301 Piccard Dr	Rockville, MD 20850
Housing	Independent Housing Program	1398 Lamberton Drive	Silver Spring, MD 20902
Housing	Emergency Housing Assistance	14015 New Hampshire Avenue	Silver Spring, MD 20904
Housing	Emergency Housing Assistance	14015 New Hampshire Avenue, Rooms 126 & 125	Silver Spring, MD 20904

Housing	Homecrest House	14508 Homecrest Rd	Silver Spring, MD 20906
Housing	Jewish Foundation for Group Homes	1500 East Jefferson Street	Rockville, MD 20852
Housing	Rainbow Place	215 West Montgomery Avenue	Rockville, MD 20850
Housing	Rebuilding Together Montgomery County	3925 Plyers Mill Road	Kensington, MD 20895
Housing	Shelter Services	438 N. Frederick Ave	Gaithersburg, MD 20877
Housing	Permanent Housing Program	4715 Cordell Ave	Bethesda, MD 20814
Housing	St. Ann's Center for Children, Youth and Families	4901 Eastern Avenue	Hyattsville, MD 20782
Housing	Abused Persons Program	50 Maryland Avenue	Rockville, DC 20850
Housing	Supportive Housing Services	5020 Sunnyside Ave	Beltsville, MD 20705
Housing	Men's Emergency Shelter	600 A Gude Drive	Rockville, MD 20850
Housing	Permanent Housing Program	600 B East Gude Dr	Rockville, MD 20850
Housing	Home First	600 B East Gude Dr	Rockville, MD 20850
Housing	Abused Persons Program	600 Jefferson Street	Rockville, MD 20850
Housing	Montgomery Housing Partnership	6040 Southport Drive	Bethesda, MD 20814
Housing	Family Services Shelter	610 E. Diamond Ave.	Gaithersburg, MD 20877
Housing	Revitz House	6111 Montrose Road	Rockville, MD 20852
Housing	Charles E. Smith Life Communities	6121 Montrose Rd	Rockville, MD 20852
Housing	Emergency Eviction Prevention	620 E. Diamond Ave.	Gaithersburg, MD 20877
Housing	Shelter Services	620 E. Diamond Ave.	Gaithersburg, MD 20877

Housing	The Dwelling Place, Inc.	620 E. Diamond Avenue	Gaithersburg, MD 20877
Housing	Family Stabilization Program	6301 Greentree Road	Bethesda, MD 20817
Housing	Greentree Shelter	6301 Greentree Road	Bethesda, MD 20817
Housing	Bethesda Cares	7728 Woodmont Avenue	Bethesda, MD 20814
Housing	Interfaith Works Empowerment Center	8210 Dixon Avenue	Silver Spring, MD 20910
Housing	Emergency Eviction Prevention	8513 Piney Branch Road	Silver Spring, MD 20901
Housing	Shelter Services	8513 Piney Branch Road	Silver Spring, MD 20901
Housing	Abused Persons Program	8552 Second Avenue	Silver Spring, MD 20910
Housing	Abused Persons Program	8818 Georgia Ave	Silver Spring, MD 20910
Housing	Emergency Eviction Prevention	8818 Georgia Ave	Silver Spring, MD 20906
Housing	Shelter Services	8818 Georgia Ave	Silver Spring, MD 20906
Housing	Habitat for Humanity	9110 Gaither Road	Gaithersburg, MD 20877
Housing	Silver Spring Interfaith Housing Coalition	914 Silver Spring Ave, Suite 203	Silver Spring, MD 20910
Housing	Carroll House Men's Shelter	9625 Dewitt Dr	Silver Spring, MD 20910
Housing	Abused Persons Program	981 Rollins Ave	Rockville, MD 20852
Housing	Supportive Housing Program	P.O. Box 83851	Gaithersburg, MD 20883
Mental Health	Domestic Workers Law & Advocacy	100 Maryland Avenue	Rockville, MD 20850
Mental Health	EveryMind	1000 Twinbrook Parkway	Rockville, MD 20851
Mental Health	N*Common - Multicultural Mental Health Services	1000 Twinbrook Parkway	Rockville, MD 20851

Mental Health	Anger Management for Parents	10100 Connecticut Ave	Kensington, MD 20895
Mental Health	Mental Health Program - Identity, Inc.	10301 Apple Ridge Rd	Gaithersburg, MD 20879
Mental Health	Adult Behavioral Health Program	11002 Viers Mill Road	Wheaton, MD 20902
Mental Health	National Alliance on Mental Illness of Montgomery County	11718 Parklawn Drive	Rockville, MD 20852
Mental Health	National Alliance on Mental Illness of Montgomery County	11718 Parklawn Drive	Rockville, MD 20852
Mental Health	Center for Therapeutic Concepts, Inc.	1300 Mercantile Lane	Largo, MD 20744
Mental Health	Abused Persons Program	1301 Piccard Dr	Rockville, MD 20850
Mental Health	24 Hour Crisis Center	1301 Piccard Dr	Rockville, MD 20850
Mental Health	Montgomery County Family Justice Center	13321 New Hampshire Avenue	Silver Spring, MD 20904
Mental Health	Child and Adolescent Behavioral Health Program	1401 Rockville Pike	Rockville, MD 20852
Mental Health	Adventist HealthCare Behavioral Health & Wellness Services	14901 Broschart Road	Rockville, MD 20850
Mental Health	John L. Gildner Regional Institute for Children and Adolescents	15000 Broschart Road	Rockville, MD 20850
Mental Health	Willow Oak Therapy Center	15841 Crabbs Branch Way	Rockville, MD 20855
Mental Health	Collaborative Care: Integrated Behavioral Health	16220 Frederick Ave.	Gaithersburg, MD 20877
Mental Health	Adolescent Psycho-educational Groups	16220 S. Frederick Avenue	Gaithersburg, MD 20877

Mental Health	World Organization for Resource Development and Education	19650 Club House Road	Montgomery Village, MD 20854
Mental Health	Collaborative Care: Integrated Behavioral Health	19735 Germantown Road	Germantown, MD 20874
Mental Health	Collaborative Care: Integrated Behavioral Health	200 Girard Street	Gaithersburg, MD 20877
Mental Health	Contemporary Therapeutic/Family Services	20400 Observation Drive	Germantown, MD 20876
Mental Health	The Family Tree - Stress Line	2108 North Charles Street	Baltimore, MD 21229
Mental Health	Abused Persons Program	27 Courthouse Square	Rockville, MD 20850
Mental Health	Counseling Services - Islamic Society of the Washington Area	2701 Briggs Chaney Rd	Silver Spring, MD 20905
Mental Health	Mental Health Program - Identity, Inc.	314 S Frederick Ave	Gaithersburg, MD 20877
Mental Health	Domestic Violence	3300 Briggs Chaney Road	Silver Spring, MD 20904
Mental Health	Center for Adoption Support and Education	4000 Blackburn Lane	Burtonsville, MD 20866
Mental Health	Mental Health Medical Assistance	401 Hungerford Drive	Rockville, MD 20850
Mental Health	Mental Health Program - Identity, Inc.	415 East Diamond Ave.	Gaithersburg, MD 20877
Mental Health	Counseling - CASE Bethesda Office	4848 Battery Lane	Bethesda, MD 20814
Mental Health	Abused Persons Program	600 Jefferson Street	Rockville, MD 20850
Mental Health	Mental Health Program - Identity, Inc.	7676 New Hampshire Avenue	Takoma Park, MD 20912

Mental Health	Collaborative Care: Integrated Behavioral Health	7676 New Hampshire Avenue Suite 220	Takoma Park, MD 20912
Mental Health	Christ Lutheran Church of Bethesda counseling center	8011 Old Georgetown Rd	Bethesda, MD 20814
Mental Health	Potomac Ridge Behavioral Health Eastern Shore	821 Fieldcrest Rd	Cambridge, MD 21613
Mental Health	Potomac Ridge Behavioral Health Eastern Shore	821 Fieldcrest Rd	Cambridge, MD 21613
Mental Health	Domestic Violence Prevention Program	847-J Quince Orchard Blvd.	Gaithersburg, MD 20878
Mental Health	Abused Persons Program	8552 Second Avenue	Silver Spring, MD 20910
Mental Health	Abused Persons Program	8818 Georgia Ave	Silver Spring, MD 20910
Mental Health	Child and Adolescent Behavioral Health Program	8818 Georgia Ave	Silver Spring, MD 20910
Mental Health	Allies in the Arts at WRNMMC	8901 Rockville Pike	Bethesda, MD 20899
Mental Health	Abused Persons Program	981 Rollins Ave	Rockville, MD 20852
Mental Health	Greater Washington Jewish Coalition Against Domestic Abuse	PO Box 2266	Rockville, MD 20847
Maternal Infant Health	Parent Encouragement Program	10100 Connecticut Ave	Kensington, MD 20895
Maternal Infant Health	Sanctuaries for Life - Prenatal Care	12247 Georgia Avenue	Silver Spring, MD 20902
Maternal Infant Health	Early Head Start	12301 Academy Way	Rockville, MD 20852
Maternal Infant Health	Rockville Pregnancy Clinic	12730 Twinbrook Pkwy	Rockville, MD 20852
Maternal Infant Health	Maryland Children's Health Program (MCHP)	12900 Middlebrook Road	Gaithersburg, MD 20874

Maternal Infant Health	Maternity Partnership/Prenatal Care	12900 Middlebrook Road	Gaithersburg, MD 20874
Maternal Infant Health	Maternity Partnership/Prenatal Care	1335 Piccard Drive	Rockville, MD 20850
Maternal Infant Health	Start More Infants Living Equally Healthy (AAHP)	14015 New Hampshire Avenue	Silver Spring, MD 20904
Maternal Infant Health	AAHP Healthy Infants	14015 New Hampshire Avenue	Silver Spring, MD 20904
Maternal Infant Health	Baby Steps Health Screenings	1500 Forest Glen Rd	Silver Spring, MD 20910
Maternal Infant Health	Aspire Counseling - Healthy Mothers, Healthy Babies	16220 Frederick Ave.	Gaithersburg, MD 20877
Maternal Infant Health	Parenting Program/Pregnancy Classes	16220 South Frederick Ave	Gaithersburg, MD 20877
Maternal Infant Health	PEARLS - Pregnant or Parenting High School Students	314 S Frederick Ave	Gaithersburg, MD 20877
Maternal Infant Health	St. Ann's Center for Children, Youth and Families	4901 Eastern Avenue	Hyattsville, MD 20782
Maternal Infant Health	PEARLS - Pregnant or Parenting High School Students	51 University Blvd E	Silver Spring, MD 20901
Maternal Infant Health	Baby Steps Health Screenings	610 E. Diamond Ave.	Gaithersburg, MD 20877
Maternal Infant Health	Early Head Start	7833 Walker Dr. Suite 610	Beltsville, MD 20705
Maternal Infant Health	Maryland Children's Health Program (MCHP)	8630 Fenton Street	Silver Spring, MD 20910
Maternal Infant Health	Maternity Partnership/Prenatal Care	8630 Fenton Street	Silver Spring, MD 20910
Maternal Infant Health	Gestational Diabetes Prevention Program	9805 Dameron Drive	Silver Spring, MD 20910

Maternal Infant Health	Baby Steps Health Screenings	9901 Medical Center Drive	Rockville, MD 20850
Maternal Infant Health	Angel Friend Support and Resources Program	P.O. Box 2116	Bowie, MD 20718
Senior	Elderly Ministries Program	1010 Grandin Avenue	Rockville, MD 20851
Senior	Selma Sweetbaum Senior Satellite Program	1132 Arcola Ave	Silver Spring, MD 20902
Senior	ElderSAFE	6121 Montrose Rd	Rockville, MD 20852
SDOH	AALEAD Mentoring Program	10111 Colesville Road	Silver Spring, MD 20901
SDOH	Multi-Lingual Legal Helpline - Asian Pacific American Legal Resource Center	1012 14th Street, NW	Washington, DC 20005
SDOH	After School Program - Identity, Inc.	10301 Apple Ridge Rd	Gaithersburg, MD 20879
SDOH	After School Program - Identity, Inc.	10631 Stedwick Rd	Montgomery Village, MD 20886
SDOH	City of Rockville Hispanic/Latino Community Outreach	111 Maryland Avenue	Rockville, MD 20850
SDOH	AALEAD After School Program	11135 Newport Mill Rd	Kensington, MD 20895
SDOH	AALEAD After School Program	11311 Newport Mill Rd	Kensington, MD 20895
SDOH	Proyecto Salud Clinic	11435 Grandview Aveive	Wheaton, MD 20902
SDOH	ESOL - Adult English as a Second Language Classes at CCACC	1150 Carnation Dr.	Rockville, MD 20850
SDOH	Citizenship Preparation	11701 Georgia Ave.,	Wheaton, MD 20902
SDOH	AALEAD After School Program	12601 Dalewood Dr	Wheaton, MD 20906
SDOH	After School Program - Identity, Inc.	12601 Dalewood Dr	Wheaton, MD 20906

SDOH	Civic Engagement for Beginning English Language Learners	12601 Dalewood Dr	Wheaton, MD 20906
SDOH	After School Program - Identity, Inc.	12700 Middlebrook Rd	Germantown, MD 20874
SDOH	Citizenship Preparation	12900 Middlebrook Road	Germantown, MD 20874
SDOH	AAHP HIV and AIDS Program	14015 New Hampshire Avenue	Silver Spring, MD 20904
SDOH	Proyecto Salud Clinic	18111 Prince Philip Dr.	Olney, MD 20832
SDOH	Citizenship Preparation	18330 Montgomery Village Ave.	Gaithersburg, MD 20886
SDOH	After School Program - Identity, Inc.	18501 Cinnamon Dr	Germantown, MD 20874
SDOH	ESOL - Adult English as a Second Language Classes at CCACC	18905 Kingsview Road	Germantown, MD 20874
SDOH	AALEAD After School Program	1901 Randolph Rd	Silver Spring, MD 20902
SDOH	Crossroads - Resources for Underserved Minority Populations	19650 Club House Road	Montgomery Village, MD 20854
SDOH	GUYS Youth Mentoring	2 Teachers Way	Gaithersburg, MD 20877
SDOH	AAHP HIV and AIDS Program	2000 Dennis Ave	Silver Spring, MD 20902
SDOH	After School Program/Catching Up Program	201 Valleybrook Dr	Silver Spring, MD 20904
SDOH	After School Program - Identity, Inc.	20301 Brandermill Dr	Germantown, MD 20876
SDOH	After School Program - Identity, Inc.	314 S Frederick Ave	Gaithersburg, MD 20877

SDOH	Civic Engagement for Beginning English Language Learners	314 S Frederick Ave	Gaithersburg, MD 20877
SDOH	Civic Engagement for Beginning English Language Learners	314 S Frederick Ave	Gaithersburg, MD 20877
SDOH	The People's Community Baptist Church Wellness Center	3300 Briggs Chaney Rd	Silver Spring, MD 20904
SDOH	Adult ESOL classes	35 N Summit Ave	Gaithersburg, MD 20877
SDOH	ESOL - Adult English as a Second Language Classes at CCACC	357 Frederick Avenue	Rockville, MD 20850
SDOH	ESL for Parents	3612 Woodley Rd. NW	Washington, DC 20016
SDOH	Ama Tu Vida	401 Hungerford Drive	Rockville, MD 20850
SDOH	Asian American Health Initiative (AAHI)	401 Hungerford Drive	Rockville, MD 20850
SDOH	Health Promoters Program "Vias de la Salud"	401 Hungerford Drive	Rockville, MD 20850
SDOH	Latino Asthma Management Program	401 Hungerford Drive	Rockville, MD 20850
SDOH	Youth Opportunity Center	415 East Diamond Ave.	Gaithersburg, MD 20877
SDOH	ESOL - Korean American Senior Citizens Association, Inc	4401 Muncaster Mill Rd	Rockville, MD 20853
SDOH	Health Education - Korean American Senior Citizens Association, Inc	4401 Muncaster Mill Rd	Rockville, MD 20853
SDOH	AALEAD After School Program	4610 W Frankfort Dr	Rockville, MD 20853
SDOH	AAHP HIV and AIDS Program	51 Mannakee St	Rockville, MD 20850

SDOH	AALEAD After School Program	51 University Blvd E	Silver Spring, MD 20901
SDOH	After School Program/Catching Up Program	51 University Blvd E	Silver Spring, MD 20901
SDOH	City of Rockville Hispanic/Latino Community Outreach	5911 Ridgeway Ave	Rockville, MD 20851
SDOH	Adult ESOL classes	610 E. Diamond Ave.	Gaithersburg, MD 20877
SDOH	GUYS Youth Mentoring	610 E. Diamond Ave.	Gaithersburg, MD 20877
SDOH	After School Program - Identity, Inc.	6505 Muncaster Mill Rd	Derwood, MD 20855
SDOH	AALEAD After School Program	651 Falls Rd	Rockville, MD 20850
SDOH	Washington Youth Foundation Mentoring Program	706-B East Gude Drive	Rockville, MD 20850
SDOH	Legal Services - CASA de Maryland	734 University Blvd E	Silver Spring, MD 20903
SDOH	Social Services Program - CASA de Maryland	734 University Blvd E	Silver Spring, MD 20903
SDOH	AAHP HIV and AIDS Program	7600 Takoma Avenue	Takoma Park, MD 20912
SDOH	Youth Opportunity Center	7676 New Hampshire Avenue	Takoma Park, MD 20912
SDOH	After School Program/Catching Up Program	7777 Maple Ave	Takoma Park, MD 20912
SDOH	African Arts, Culture and Education (ACE) Academy	7777 Maple Avenue	Takoma Park, MD 20912
SDOH	Golden Age Project for Seniors - Association of Vietnamese Americans	8121 Georgia Ave	Silver Spring, MD 20910

SDOH	New Americans Advocacy Services (NAAS) - Association of Vietnamese Americans	8121 Georgia Ave	Silver Spring, MD 20910
SDOH	Legal Services - CASA de Maryland	8151 15th Ave.	Hyattsville, MD 20783
SDOH	AAHP HIV and AIDS Program	8210 Colonial Lane	Silver Spring, MD 20910
SDOH	ESOL Program - Korean Community Service Center	847-J Quince Orchard Blvd.	Gaithersburg, MD 20878
SDOH	Latino Health Initiative	8630 Fenton Street	Silver Spring, MD 20910
SDOH	Golden Age Project for Seniors - Association of Vietnamese Americans	8700 Piney Branch Road	Silver Spring, MD 20901
SDOH	Alfabetización En Espanol	8800 Garland Ave.	Silver Spring, MD 20901
SDOH	After School Program/Catching Up Program	8860 Piney Branch Rd	Silver Spring, MD 20903
SDOH	African Arts, Culture and Education (ACE) Academy	8860 Piney Branch Road	Silver Spring, MD 20910
SDOH	CCACC Pan Asian Volunteer Health Clinic	9318 Gaither Road, Suite 205	Gaithersburg, MD 20877
SDOH	Chinese Culture And Community Service Center (CCACC)	9366 Gaither Rd	Gaithersburg, MD 20877
SDOH	ESOL - Adult English as a Second Language Classes at CCACC	9366 Gaither Road	Gaithersburg, MD 20877
Senior	Friendly Visitor Program - EveryMind	1000 Twinbrook Parkway	Rockville, MD 20851
Senior	Elderly Ministries Program	1010 Grandin Avenue	Rockville, MD 20851
Senior	Inwood House	10921 Inwood Avenue	Silver Spring, MD 20902

Senior	CCACC Senior Program	1150 Carnation Dr.	Rockville, MD 20850
Senior	Senior Fit - Holy Cross	1150 Carnation Drive	20850
Senior	Senior Fit - Holy Cross	11711 Georgia Ave.	20902
Senior	Senior Outreach and Spanish Speaking Outreach Programs	12200 Tech Road, Suite 330	Silver Spring, MD 20904
Senior	Jewish Council for the Aging	12320 Parklawn Drive	Rockville, MD 20852
Senior	Arts for the Aging	12320 Parklawn Drive	Rockville, MD 20852
Senior	Care for Your Health Clinic	13925 New Hampshire AVe	Silver Spring, MD 20904
Senior	Adult Protective Services	1401 Rockville Pike	Rockville, MD 20850
Senior	Top Banana Home Delivered Groceries	14100 Brandywine Road	Brandywine, MD 20613
Senior	CALMRA's Adult Day Program	14205 Park Center Dri	Laurel, MD 20707
Senior	Homecrest House	14508 Homecrest Rd	Silver Spring, MD 20906
Senior	Senior Fit - Holy Cross	14625 Bauer Drive	20853
Senior	Senior Fit - Holy Cross	14906 Old Columbia Pike	20866
Senior	Senior Fit - Holy Cross	15 Crescent Road	20770
Senior	Senior Fit - Holy Cross	1500 Merrimac Drive	20783
Senior	Senior Fit - Holy Cross	15300 New Hampshire Ave.	20905
Senior	Senior Fit - Holy Cross	1700 April Lane	20904
Senior	Hirsh Health Center	1801 Jefferson Streey	Rockville, MD 20852
Senior	Adult Medical Day Program - Winter Growth, Inc.	18110 Prince Philip Dr	Olney, MD 20832
Senior	Senior Fit - Holy Cross	18800 New Hampshire Ave.	20861
Senior	Senior Fit - Holy Cross	18905 Kingsview Road	20874
Senior	CCACC Senior Program	18905 Kingsview Road	Germantown, MD 20874

Senior	Senior Fit - Holy Cross	19561 Scenery Drive	20876
Senior	JSSA Senior Services	200 Wood Hill Road	Rockville, MD 20850
Senior	Alzheimer's Disease Research (ADR)	22512 Gateway Center Dr	Clarksburg, MD 20871
Senior	Senior Fit - Holy Cross	2450 Lyttonsville Road	20910
Senior	Dental Services for Seniors	31 South Summit Avenue	Gaithersburg, MD 20877
Senior	Arts for the Aging	3310 Gateshead Manor Way	Silver Spring, MD 20904
Senior	Senior Fit - Holy Cross	3310 Gateshead Manor Way	20904
Senior	Friendly Visitation - Senior Connection of Montgomery County, Inc.	3950 Ferrara Dr.	Silver Spring, MD 20906
Senior	Grocery Shopping Services - Senior Connection of Montgomery County, Inc.	3950 Ferrara Dr.	Silver Spring, MD 20906
Senior	Grocery Shopping Services	3950 Ferrara Dr.	Silver Spring, MD 20906
Senior	Adult Foster Care Unit	401 Hungerford Drive	Rockville, MD 20850
Senior	Randolph Hills Adult Medical Day Care	4011 Randolph Road	Wheaton, MD 20902
Senior	Senior Fit - Holy Cross	409 and 417 Russell Ave.	20877-2801
Senior	Senior Fit - Holy Cross	4100 Northview Drive	20716
Senior	Korean American Senior Citizens Association, Inc	4401 Muncaster Mill Rd	Rockville, MD 20853
Senior	Korean American Senior Citizens Association, Inc	4401 Muncaster Mill Rd	Rockville, MD 20853
Senior	Korean American Senior Citizens Association, Inc	4401 Muncaster Mill Rd	Rockville, MD 20853
Senior	Senior Lunch Program - Korean American Senior Citizens Association, Inc	4401 Muncaster Mill Rd	Rockville, MD 20853

Senior	Social Services at Korean American Senior Citizens Association	4401 Muncaster Mill Rd	Rockville, MD 20853
Senior	Senior Fit - Holy Cross	4817 Blagden Avenue, NW	20011
Senior	Senior Fit - Holy Cross	6120 Sargent Road	20782
Senior	ElderSAFE - Hirsh Health Center	6121 Montrose Rd	Rockville, MD 20852
Senior	JSSA Senior Services	6123 Montrose Road	Rockville, MD 20852
Senior	Senior Fit - Holy Cross	635 Aspen Street, NW	20012
Senior	Senior Fit - Holy Cross	6600 Adelphi Road	20783
Senior	Fitness Room	7315 New Hampshire Avenue	Takoma Park, MD 20912
Senior	Fitness Room	7500 Maple Avenue	Takoma Park, MD 20912
Senior	Game Room Open Play	7500 Maple Avenue	Takoma Park, MD 20912
Senior	Dental Services for Seniors	80A Bureau Drive	Gaithersburg, MD 20878
Senior	Golden Age Project for Seniors - Association of Vietnamese Americans	8121 Georgia Ave	Silver Spring, MD 20910
Senior	Senior Fit - Holy Cross	8580 Second Avenue	20910
Senior	Holy Cross Hospital Senior Source	8580 Second Avenue	Silver Spring, MD 20910
Senior	Care for Your Health Clinic	8615 Piney Branch Road	Silver Spring, MD 20901
Senior	Golden Age Project for Seniors - Association of Vietnamese Americans	8700 Piney Branch Road	Silver Spring, MD 20901
Senior	Arts for the Aging	8700 Piney Branch Road	Silver Spring, MD 20901
Senior	Senior Fit - Holy Cross	8700 Piney Branch Road	20901
Senior	CCACC Adult Day Healthcare Center	9366 Gaither Rd	Gaithersburg, MD 20877

Senior	CCACC Senior Program	9366 Gaither Road	Gaithersburg, MD 20877
Senior	Senior Fit - Holy Cross	9701 Veirs Drive	20850
Senior	Holy Cross Hospital Medical Adult Day Center	9805 Dameron Drive	Silver Spring, MD 20910
Substance Abuse	Avery Road Combined Care	14701 Avery Road	Rockville, MD 20853
Substance Abuse	Adult & Adolescent Intensive Outpatient Program for Chemical Dependency	14901 Broschart Road	Rockville, MD 20850
Substance Abuse	Step Ahead, FSI	19530 Doctors Dr	Germantown,MD 20874
Substance Abuse	Maryland's Commitment to Veterans	201 W. Preston Street	Baltimore,MD 21201
Substance Abuse	Mental Health Medical Assistance	401 Hungerford Drive	Rockville, MD 20850
Substance Abuse	Family Services, Inc	610 E. Diamond Ave.	Gaithersburg, MD 20877
Substance Abuse	DUI Education/Treatment Program	640 East Diamond Avenue, Suite B	Gaithersburg , MD 20877
Substance Abuse	Vesta, Inc. - Veteran's Services	8737 Colesville Rd	Silver Spring, MD 20910

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CONTACT INFORMATION

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An electronic version of this Community Health Needs Assessment is publically available at http://www.holycrosshealth.org/community-health-needs-assessment and print versions are available upon request.

A full version of the Healthy Montgomery Community Health Needs Assessment is publically available at http://www.healthymontgomery.org.

No comments were received regarding the previous needs assessment for Holy Cross Hospital.

HOLY CROSS HOSPITAL

Community Health Needs Assessment Implementation Strategy
Fiscal Years 2020 - 2022

CONTENTS

Holy Cross Hospital completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors in October 17, 2019. Holy Cross Hospital performed the CHNA in adherence with applicable federal requirements for not-for-profit hospitals set forth in the Affordable Care Act (ACA) and by the Internal Revenue Service (IRS). The assessment took into account a comprehensive review of secondary data analysis of patient outcomes, community health status, and social determinants of health, as well as primary data collection including input from representatives of the community, community members, and various community organizations.

The complete CHNA report is available electronically at http://www.holycrosshealth.org/community-health-needs-assessment, or printed copies are available by contacting Monika Driver at 301-754-8406 or driverm@holycrosshealth.org.

ORGANIZATIONAL OVERVIEW

Overview

Holy Cross Health is a Catholic, not-for-profit health system that serves more than 240,000 patient visits each year with the promise to make health, and the best possible quality of life, more achievable. Holy Cross Health's high-quality care is accessible to community members in Maryland's Montgomery and Prince George's counties through two hospitals, 10 primary and specialized care centers, home care and hospice services, and a wide range of community health programs. Our team of 4,100 colleagues, 1,575 community and hospital-based physicians, and more than 400 volunteers works proactively to meet the needs of every individual we serve.

We are a people-centered health system that aims to improve the health and lives of individuals, populations and communities, through episodic health care management, population health management, and community-health and well-being initiatives. Holy Cross Health delivers services where, when and how people need us most, with a focus on clinical excellence, innovation and positive experiences that advance individual and community health.

The Holy Cross Health system includes:

Holy Cross Hospital, one of the largest hospitals in Maryland and home to the nation's first and region's only Seniors Emergency Center.

Holy Cross Germantown Hospital, the first hospital in the nation to be located on a community college campus and enhanced by an educational partnership, offering high-quality medical, surgical, obstetric, emergency and behavioral health services to the fastest-growing region in the county.

Holy Cross Health Network, which operates Holy Cross Health Centers in Aspen Hill, Gaithersburg, Germantown and Silver Spring; provides primary care at Holy Cross Health Partners at Asbury Methodist Village and in Kensington; offers a wide range of innovative health and wellness programs; and leads partner relationships.

Holy Cross Health Foundation, a not-for-profit organization devoted to raising philanthropic funds to support the mission of Holy Cross Health and to improve the health of the community.

Mission and Core Values

We, Holy Cross Health and Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. We carry out this mission in our communities through our commitment to be the most trusted provider of health care services.

HOLY CROSS HEALTH'S TEAM WILL ACHIEVE THIS TRUST THROUGH:

- Innovative, high-quality and safe health care services for all in partnership with our physicians and others
- Accessibility of services to our most vulnerable and underserved populations
- Outreach that responds to community health need and improves health status
- Ongoing learning and sharing of new knowledge
- Our friendly, caring spirit

CORE VALUES

- Reverence: We honor the sacredness and dignity of every person
- Commitment to those who are poor: We stand with and serve those who are poor, especially those most vulnerable
- Justice: We foster right relationships to promote the common good, including sustainability of Earth
- Stewardship: We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care
- Integrity: We are faithful to who we say we are

THE COMMUNITY WE SERVE

Demographics

Holy Cross Hospital serves a large portion of Montgomery and Prince George's Counties residents (see Figure 1). Our 19 ZIP code primary service area includes 663,447 people, and an estimated 1.76 million people in 65 ZIP codes make up our total service area. Our primary service area is derived from the Maryland ZIP code areas from which the top 60% of our FY13 discharges originated. The next 15% contribute to our secondary service area.

The median age of the county is 39 years, up from 33.9 years in 1990. This increase in median age is driven mostly by the aging of the large population of baby boomers residing in the area. In 1990, the county's residents over the age of 65 accounted for only 10% of the population (77,500 residents). It is expected, by 2030, that the baby boomers will increase the county's 65+ population to 19% of the total population (218,000 residents) (see **Error! Reference source not found.**). In addition to an aging population, Holy Cross Hospital serves a highly diverse community. No racial or ethnic group accounts for more than one-third of residents (see Table 1). The county is also becoming more diverse. In 2016, 56% of county residents were people of color; Hispanics were the fastest growing subgroup followed by the Asian population. From 1990 to 2016, the Hispanic population grew 258% and accounts for 19.1% of the total population and the Asian population grew 153% and accounts from 14.8% of the total population.

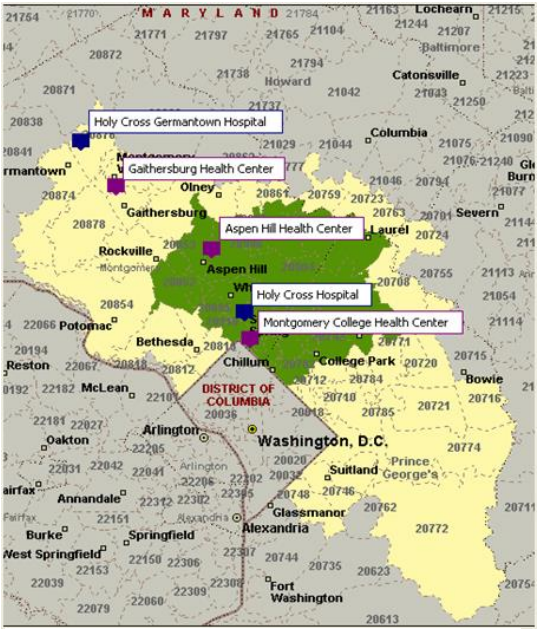

Figure 1: Primary and secondary service area for Holy Cross Hospital.

Table 1: Demographic breakdown of Holy Cross Hospital's service area by race and ethnicity. © 2016 The Nielsen Company, ©2019 Truven Health Analytics Inc.

Race	Primary Service Area (663,447)	Total Service Area (1.76 Million)
White, Non-Hispanic	206,912 (31.2%)	512,881 (29.0%)
Black, Non-Hispanic	177, 210 (26.7%)	643,288 (36.4%)
Hispanic	185,152 (27.9%)	364,933 (20.6%)
Asian/Pacific Islander, Non-Hispanic	74,041 (11.2%)	190,563 (10.8%)
All Others	20,132 (3.0%)	55,747 (3.2%)

The community we serve has the highest percentage of foreign-born residents (29.3%) in the state of Maryland, and the majority of the total foreign-born population in Maryland reside within Montgomery County. In Montgomery County, 32.6% of residents are foreign-born, 40% of foreign-born residents speak English less than "very well" and 7.0% aged five and over are linguistically isolated. In Prince George's County, more than 21% of residents are foreign-born of which 39% speak English less than "very well" and 4.9% of the population aged five and over are linguistically isolated with the most linguistic isolation occurring in northern Prince George's County. The highest

rates of linguistic isolation for both Montgomery and Prince George's Counties are among Latino Americans and Asian Americans.

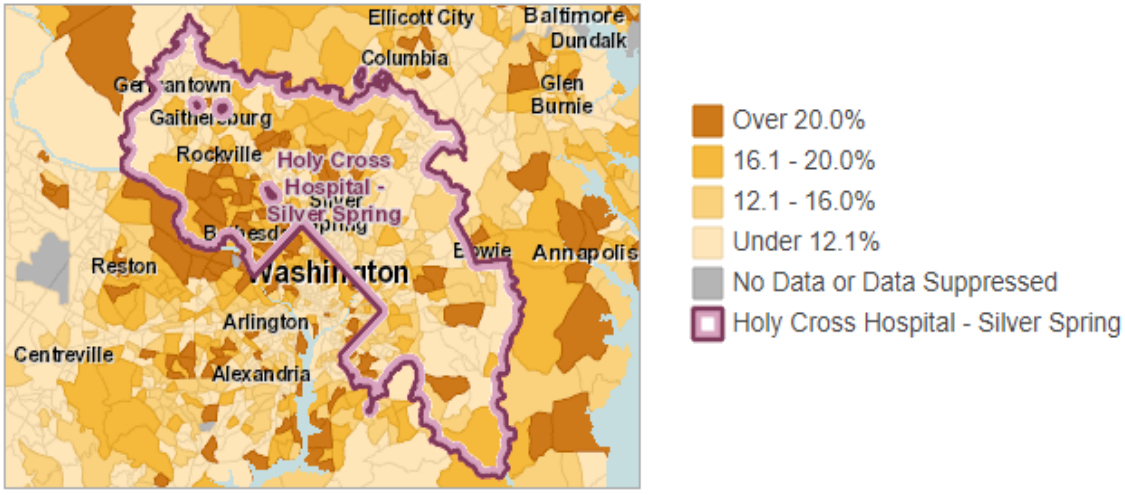

Figure 2: Percentage of population aged 65+. Source: Trinity Health Data Hub, 2019.

Community Conversations

Holy Cross Health gathered information from residents of the communities we serve during the spring and summer of 2019. Information was gathered through three different formats, *Chat and Chews*, surveys, and *Community Conversations*.

All formats focused on the topic "Health Matters" and received feedback from a racially, ethnically, and linguistically diverse group of community residents (see Figure 3) throughout Montgomery County. The conversations and surveys had two goals:

1. To learn from local residents what makes a community healthy
2. To enlist community members to join the Holy Cross Health Advisory Committee.

These goals were acheieved by asking questions that pertained to access to care, barriers to

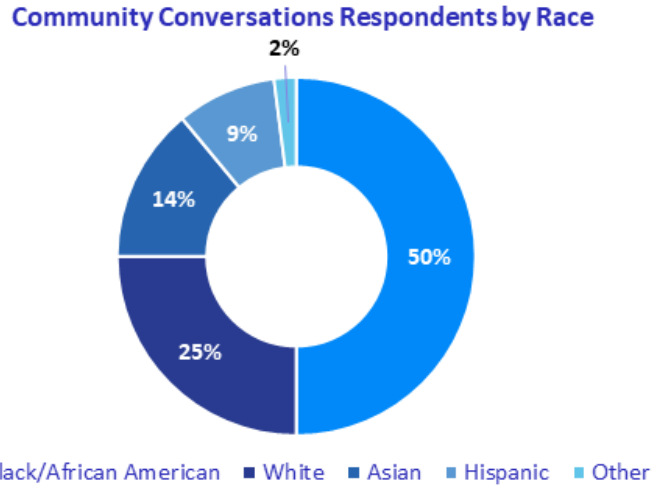

Figure 3: Racial and ethnic percentage of 2019 community conversation participants.

achieving or maintaining good health, and what was needed to achieve or maintain good health.

Most responded that they were able to access medical care when needed (94%). However, challenges mentioned included lack of affordable medication, lack of access to healthy food, and lack of transportation. When the community was asked what was needed to achieve or maintain good health the top summarized responses were help with diet, nutrition, and food assistance (34%). Participants expressed interest in free classes about healthy eating and nutrition, support with finding affordable healthy groceries, grocery coupons, and a general interest in receiving support to eat healthier. There was also a strong interest in opportunities for exercise and fitness (24%). Participants expressed interest in free or low-cost group exercise classes held during evening hours, support for a gym membership, and more accessible exercise spaces. There was also a strong interest in more senior classes and a continuation of existing Holy Cross Health Senior Fit classes.

In addition to an interest in exercise and nutrition classes, there was also interest expressed for community programming (13.4%). Participants expressed interest in health seminars, support groups, classes explaining what resources are available, and evening senior classes.

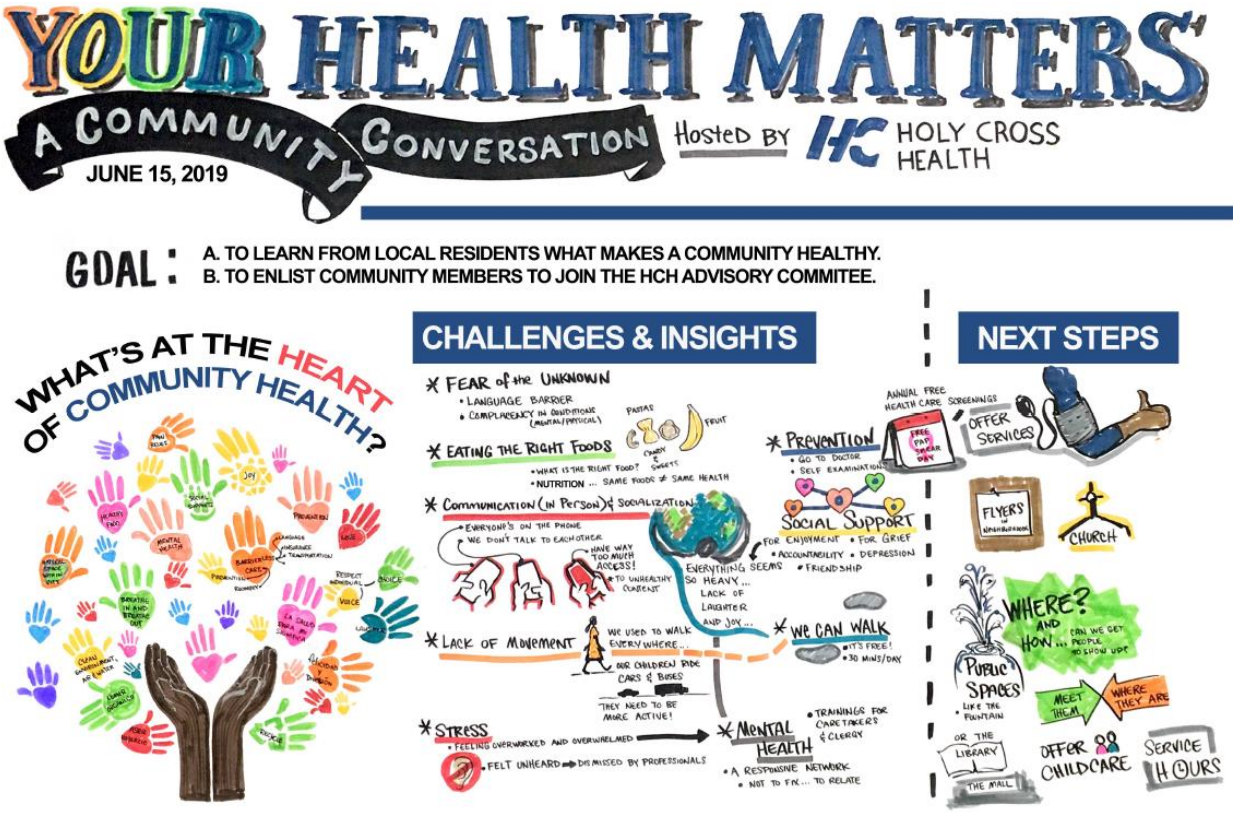

Figure 4: Graphic representation of community conversations and surveys. Participants shared concerns that related to influencers of health, such as movement and exercise, healthy eating/food access, stress, mental health and the need for social connectedness.

HEALTH NEEDS OF THE COMMUNITY

Holy Cross Health has been conducting needs assessments for almost 20 years and identifies unmet community health care needs in a variety of ways. We collaborate with other healthcare providers to support *Healthy Montgomery*, Montgomery County's community health improvement process. We seek expert guidance from a panel of external participants with expertise in public health and the needs of our community and gather first-hand information from community members through community conversations conducted by Holy Cross Health and community conversations conducted by *Healthy Montgomery* and the Montgomery County Department of Health and Human Services. We review other available reports and needs assessments and use them as reference tools to identify unmet needs in various populations. We also use the Community Need Index to geographically identify high need communities that would benefit from our programs and services and use internal data sources to conduct an extensive analysis of demographics, health indicators and other determinants of health for the communities we serve.

Unmet Need

Holy Cross Health used the information from the community health needs assessment and other sources to identify three priority areas: Social Determinants/Influencers of Health, Vulnerable Populations, and Chronic Diseases. Building upon the *Healthy Montgomery* top-ranked priorities and available data, Holy Cross Health identified subcategories for each priority and ranked the priorities and subcategories based on severity, feasibility, potential to achieve outcomes and prevalence in the population. The following prioritized list of the significant unmet needs identified and their subcategories were developed using scores from each of the categories listed above:

1. Social Determinants/Influencers of Health
    a. Housing
    b. Food Insecurity
    c. Access to Care
2. Vulnerable Populations
    a. Senior Population
    b. Maternal/Infant Population
3. Chronic Diseases
    a. Diabetes
    b. Cancers
    c. Cardiovascular Health
    d. Obesity
    e. Behavioral Health

Vulnerable Populations	• **Maternal and Infant Health**	• Montgomery County African American/Black infant mortality rate is 8.3 deaths per 1,000 live births; the rate is 12.0 per 1,000 live births in Prince George's County. • Mothers who received early prenatal care is 70.9% in Montgomery County and 59% in Prince George's County
	• **Seniors**	• The senior population of Montgomery County is expected to increase to 20% of the total population by 2040; Prince George's County's senior population is anticipated to increase to 18% by 2040 • Both Montgomery and Prince George's Counties seniors have influenza and pneumonia vaccine rates below the targeted 90% for this population.
Chronic Disease	• **Diabetes**	• Diabetes disproportionately affects minority populations and the elderly • In Montgomery County, 8.9% of residents have been informed they are pre-diabetic, compared to 12.4% of Prince George's County residents. • In Montgomery County, African American/Blacks are nearly five times more likely to visit the emergency department for diabetes-related complications and three times more likely in Prince George's County compared to their White counterparts.
	• **Cancers**	• Cancer is the leading cause of death in Montgomery County. It is the second leading cause of death in Prince George's County and the US. • In both Montgomery and Prince George's County, the percent of women over 50 who have received a mammogram in the past two years declined sharply from nearly 80% in 2014 to under 65% in 2016.
	• **Cardiovascular Health**	• In 2017, heart disease was the second leading cause of death in Montgomery County and the first leading cause of death in Prince George's County • In Montgomery and Prince George's County stroke, which can be caused by cerebrovascular disease, is the third leading cause of death.
	• **Obesity**	• Almost than 60% of Montgomery County residents and more than 70% of Prince George's County residents are overweight or obese • Approximately 30% of Montgomery and Prince George's County adults consume fruits and vegetables five or more times each day
	• **Behavioral Health**	• In Montgomery County, men are four times more likely to die from suicide than women and five times more likely in Prince George's County. • Fourteen percent of Montgomery County residents and nearly 10% of Prince George's County residents self-reported that they have been diagnosed with a depressive disorder • Both Montgomery and Prince George's Counties are experiencing an increase in heroin deaths over prescription opioid deaths, due to their lower cost.
SIOH	• **Food Insecurity**	• Montgomery County's food insecurity rate has dropped from 7.0% in 2014 to 5.9% in 2016; Prince George's County's rate has dropped from 15.5% in 2014 to 14.0% in 2016.
	• **Housing**	• On average, 49.1% of renters in Montgomery County and 52.7% of renters in Prince George's County spend more than 30% of their income on rent • Montgomery County reported the highest percentage reduction, 41% in its literally homeless count from 2015 to 2019 and Prince George's County had a 29% reduction
	• **Access to Health Care**	• In Montgomery and Prince George's Counties, Hispanics followed by African Americans have the highest number of uninsured residents • Despite the high numbers of primary care physicians available in Montgomery County, 10.4% of the population is unable to afford to see a doctor

CHNA MULTI-YEAR INITIATIVES

Overview

Holy Cross addresses unmet needs within the context of our overall approach, mission commitments and key clinical strengths, and within the overall goals of *Healthy Montgomery*.

Key findings from all data sources, including data provided by *Healthy Montgomery*, our external review group and hospital available data were reviewed and the most pressing needs were incorporated into our implementation strategy. The CHNA Implementation Strategy reflects Holy Cross Hospital's overall approach to improving community health by targeting the intersection between the identified needs of the community and the key strengths and mission commitments of the organization (see Figure 5) to help build the continuum of care. We have established leadership accountability and an organizational structure for ongoing planning, budgeting, implementation and evaluation of community health activities, which are integrated into our multi-year strategic and annual operating planning processes.

Figure 5: How Holy Cross Health aligns targeted programs with the mission and strengths of the hospital and unmet community needs.

Guiding Principles

This multi-year implementation strategy addresses the priority areas and overarching themes by focusing our community benefit activities on populations experiencing vulnerability and under resourced individuals and families, including women/children, seniors, and racial, ethnic and linguistic minorities. To select outreach priorities for the implementation strategy, Holy Cross Health linked community health care needs to our mission and strategic priorities.

Strategic Plan

The vision of our People-Centered Strategy for Success, fiscal years 2019-2022, is to be a forward-thinking health system with the knowledge and resources to help people address their needs and goals in order to achieve a better quality of life. To achieve this we are guided by six strategic principles:

People-Centered Care: Providing innovative patient care, excellent care delivery and improved clinical outcomes

Engaged Colleagues: Attracting, developing and retaining exceptional and committed colleagues

Operational Excellence: Ensuring efficient and effective care delivery

Physician Collaboration: Engaging physicians for mutual benefit in activities that attract patients and better manage care

Leadership Nationally & Locally: Improving the health and well-being of our community through innovation and expanding expertise

Effective Stewardship: Stewarding our resources to best manage revenue and expenses

National Objectives

Healthy People 2020 (HP2020) is a national initiative that provides science-based, 10- year national objectives for improving the health of all Americans, establishes benchmarks, and monitors progress over time in order to:

- Encourage collaborations across communities and sectors.
- Empower individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Holy Cross Health values the vision of HP2020 to create "a society in which all people live long, healthy lives" and has incorporated many of the HP2020 goals and objectives into our multi-year initiatives that address each identified priority.

This not only allows us to join communities across the nation and work collaboratively to improve health, but it also gives us bench marks and specific metrics we can use to measure impact.

Transforming Community Health

Holy Cross Health's community health programs and services are well positioned to lead in the identification of and response to existing and emerging community needs in our service area. To address the unmet needs, Holy Cross Health will focus on addressing downstream issues through prevention, education, and disease management programs and upstream issues through policy, system and environmental change strategies.

Holy Cross Health, in alignment with our mission and vision, strives to optimize wellness and equity and eliminate disparities in our communities. This is accomplished by addressing an individual's social needs as well as improving community conditions. Holy Cross Health's community health and well-being strategy to address unmet community need encompasses three key focus areas:

Clinical Care: Delivery of efficient and effective people-centered health care services for the uninsured/Medicaid population that is focused on reducing clinical quality outcome disparities and addressing the social needs of patients;

Community Engagement: Connecting efficient and effective wrap around services, expanding the availability of community-based services, and ensuring that patients, community members, and employees are linked to, and can utilize, these services; and

Community Transformation: Policy, system and environmental change strategies focusing on community building to address the physical environment, economic revitalization, housing and other social determinants/influencers of health

Action Plans 2020-2022

The following pages outline the major activities Holy Cross Hospital will be implementing to address the unmet needs identified in the 2020 Community Health Needs Assessment. The first table summarizes the activities by priority and key focus area and the following pages go into more detail about the specific interventions or initiatives that we will undertake to address the unmet needs identified. The objectives listed for each priority were derived from Healthy People 2020[1]. This document should be considered a living document and will be updated, at a minimum, each year or as emerging needs arise.

[1] Healthy People 2020 (Internet). Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited 8/1/2017]. Available from: https://www.healthypeople.gov.

Summary of Holy Cross Hospital's Significant Community Benefit Programming in Response to Identified Unmet Health Needs

Community		Holy Cross Hospital			
Identified Unmet Needs		Response to Unmet Need			Method of Evaluation
		Clinical Care	Community Engagement	Community Transformation	
1. Populations experiencing vulnerability	Maternal and Infant Health Improve the health and well-being of women, infants, children, and families.	Ob/Gyn Clinic Maternity Partnership (MP) program, HC Health Center Germantown	Maternal Infant and Child Education (MICEdu) classes, expand perinatal education to include adolescents	MP program, MICEdu outreach, Health Equity (HE) community advisory groups	# of admissions to MP, % MP patients receiving early prenatal care, % low birth weight deliveries, reduction in infant mortality, # encounters, pre/posttest, participant survey, evaluation framework, MP patients linked to HCHC Germantown, # advisory group meetings
	Seniors Improve the health, function, and quality of life of older adults.	HC Health Centers Silver Spring, Gaithersburg, Aspen Hill, Germantown; NexusMontgomery (NM) WISH program and Project Access	Medical Adult Day Center, Caregiver Resource Center, Falls Prevention programs, Memory Academy, advanced directives, Senior Source physical activity and social programs; Faith Community Nursing (FCN)	HE community advisory groups, Elizabeth Square	# of encounters, # programs offered, pre/posttests, participant surveys, evaluation framework, attendance/completion rate, falls assessments, gait and balance scores, readmission/ED utilization, clinical indicators, MADC daily census, # WISH health surveys completed, # educated on advanced directives, # uninsured referred to specialty care
2. Chronic Diseases	Diabetes Reduce the disease burden of diabetes mellitus.	HC Health Centers Silver Spring, Gaithersburg, Aspen Hill, Germantown; HCHC Care management team; NM Project Access; ED/PC Connect, Care Coordination	Diabetes Prevention Program (DPP), Diabetes Self-Management Program (DSMP); Diabetes Survival Skills, FCN	DSMP, DPP and Diabetes Survival Skills classes offered in Spanish, community health navigator, HE community advisory groups, safety- net clinic referral process for diabetes program	# of health center visits, clinical measures, readmission/ED utilization, referrals to community health programs and social services, # of encounters, average % weight loss, increase in physical activity, attendance/completion rate, pre/posttest, self-efficacy survey, DPP full recognition status, # safety-net DSMP referrals, # uninsured referred to specialty care, # advisory group meetings, # ED patient referred to health center, # ED patients with kept appointments
	Cancers Reduce the number of new cancer cases, as well as illness, disability, and death caused by cancer.	HC Health Centers Silver Spring, Gaithersburg, Aspen Hill, Germantown; Specialty Care Referrals, ED/PC Connect, Care Coordination, NM Project Access	Smoking cessation, Transforming Communities Initiative (TCI) tobacco-free living PSE strategies (Tobacco 21)	CHW Cancer outreach, screening and prevention programs, community health navigator, HE community advisory groups; TCI smoking reduction strategies	# of encounters, % health center patients eligible for screenings receiving referrals/screenings (tobacco, mammogram, colonoscopy), # of mammograms, # navigated to care and cycle time, # educated on BSE, # of breast cancers found; # enrolled in MD BCCP, cancer education provided by type, referrals to community health programs and social services, # PSE strategies implemented, # community partnerships, # advisory group meetings, # ED patient referred to health center, # ED patients with kept appointments
	Cardiovascular Health Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke.	HC Health Centers Silver Spring, Gaithersburg, Aspen Hill, Germantown; HCHC care management team, ED/PC connect, Care Coordination, NM Project Access	Community Fitness classes, Senior Fit; Chronic Disease Self-Management, Senior Source fitness classes, community-based stroke awareness program, FCN	HE community advisory groups, community health navigator	clinical measures, readmissions/ED utilization, # referrals to community health programs and social services, # BP screening, stroke program developed, # fitness classes offered, # advisory group meetings, # ED patient referred to health center, # ED patients with kept appointments
	Obesity Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights.	HC Health Centers Silver Spring, Gaithersburg, Aspen Hill, Germantown; HCHC care management team, Care Coordination	*Kids Fit*	HE community advisory groups, TCI obesity strategies, community health navigator	clinical measures, readmissions/ED utilization, # referrals to community health programs and social services, # BP screening, stroke program developed, # fitness classes offered, # advisory group meetings, # ED patient referred to health center, # ED patients with kept appointments

	Behavioral Health Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.	HC Health Centers Silver Spring, Gaithersburg, Aspen Hill, Germantown behavioral health screening; ED/PC connect; Care Coordination; NM ACT teams, Crisis House, and behavioral health integration	System-wide opioid plan	Community health navigator and community advisory groups	# patients screened, #referred to social services and community health programs, # referred to treatment, opioid plan developed, # Crisis House persons served per year, #full capacity ACT teams, Interagency efforts to reduce hospital use by severely mentally ill patients, # connected to primary care/other services, readmissions/ED utilization
3. SDOH/SIOH	Food Insecurity – Reduce household food insecurity and in doing so reduce hunger	KJS Fund, social work program	SIOH Plan, Pathways to Independent Employment	Montgomery County Food Security Plan, Living Wage	# patients screened, #receiving food subsidies, SIOH plan development,#PIE participants, #food security plans completed
	Housing – Decrease the proportion of households experiencing housing cost burden	KJS Fund, social work program	Pathways to Independent Employment	Coalition on Homelessness, Living Wage, Elizabeth House, Montgomery Housing Partnership	#rent subsidies, coalition on homelessness membership, #PIE participants, entry level salaries
	Access to Health Care – Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines	HC Health Centers Silver Spring, Gaithersburg, Aspen Hill, Germantown	Pathways to Independent Employment, Faith Community Nurse Program	340b Plan Advocacy, Living Wage	#patients, #PIE participants, 340b advocacy, #FCN programs, entry level salaries

Priority 1: Populations Experiencing Vulnerability

Priority 1a: Maternal/Infant Populations (CHNA pg. 56-59)

Goal 1: Improve the health and well-being of women, infants, children, and families.

OBJECTIVE 1.1

Increase the proportion of low-income, uninsured pregnant women who receive early and adequate prenatal care.

CHNA IMPACT	CHNA BASELINE	TARGET
• Increase percent of mothers receiving early prenatal care	63.1%	66.9%*
• Percent low birth weight infants	8.2%	8.0%*
• Decrease infant mortality rate	5.5	5.5*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
1.1.1 Provide prenatal care to 60% of Montgomery County Maternity Partnership Patients	x	x	x	$265,000	$290,000	Montgomery County DHHS

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on number of Maternity Partnership admissions, percent Maternity Partnership patients receiving early prenatal care, and percent low-birth weight deliveries; reduction in infant mortality

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

OBJECTIVE 1.2

Improve the health and well-being of women, infants, children, and families by providing educational and community-based programs and links to primary care and social services.

CHNA IMPACT	CHNA BASELINE	TARGET
• Increase percent of mothers receiving early prenatal care	63.1%	66.9%*
• Percent low birth weight infants	8.2%	8.0%*
• Decrease infant mortality rate	5.5	5.5*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
1.2.1 Provide perinatal education, baby care programs, and support services to expecting and new families in Montgomery & Prince George's County	x	x	x	$250,000	$140,000	Montgomery County AAHP, FIMR, Community Action Team, and Interagency
1.2.2 Increase perinatal education programs for adolescents	x	x	x	$10,000		Montgomery County Housing Partnership, Boys and Girls Club

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on number of encounters, pre/posttests, participant surveys

Priority 1b: Senior Populations (CHNA pg. 59-63)

Goal 2: Improve the health, function, and quality of life of older adults.

OBJECTIVE 2.1

Increase the proportion of older adults, including those with reduced physical or cognitive function, who engage in light, moderate, or vigorous leisure-time physical and/or social activities

CHNA IMPACT	CHNA BASELINE	TARGET
• Increase life expectancy	79.2	79.8*
• Decrease fall-related deaths	6.4	7.7*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
2.1.1 Provide physical and social activity programs for seniors aged 55+ through Holy Cross Senior Source	x	x	x	$294,000	$30,000	Montgomery County HOC and Recreation Department, Maryland Department on Aging
2.1.2 Partner with organizations and community centers to offer more senior based services in the community	x	x	x	$20,000		Montgomery County HOC and Recreation Department, Sunrise Assisted Living, Montgomery County Villages, NLCS

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on encounters, # programs offered; pre/posttests, participant surveys,

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

OBJECTIVE 2.2

Reduce the rate of falls among older adults

CHNA IMPACT	CHNA BASELINE	TARGET
• Increase life expectancy	79.2	79.8*
• Decrease fall-related deaths	6.4	7.7*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
2.2.1 Provide evidence-based falls prevention programs for seniors aged 55+ through Holy Cross Senior Source	✖	✖	✖	$21,000	$5,000	Montgomery County HOC and Recreation Department, Maryland Department on Aging

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports for encounters, attendance/completion rate, falls assessments, and gait and balance scores; participant surveys, pre/posttests

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

OBJECTIVE 2.3

Reduce the proportion of noninstitutionalized older adults with disabilities who have an unmet need for long-term services and supports

CHNA IMPACT	CHNA BASELINE	TARGET
• Increase life expectancy	79.2	79.8*
• Decrease fall-related deaths	6.4	7.7*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE Y1	Y2	Y3	COMMITTED RESOURCES* HCH	Other Sources	POTENTIAL PARTNERS
2.3.1 Provide medical, social, rehabilitative and recreational programs for adults with a chronic health problem or are recovering from an acute illness through the Medical Adult Day Center (MADC)	x	x	x	$306,000	$394,000 on Aging; AAOA, MAADS,	Montgomery County DHHS, GROWS, Maryland Department Alzheimer's Foundation, Alzheimer's Association, ARC
2.3.2 Provide health coach to independent-living Medicare beneficiaries who are at increased risk for hospitalization through the NexusMontgomery WISH program	x	x	x	$7,500		Sisters of the Holy Cross, GROWS, Alpha Kappa Alpha Theta Omega Omega Chapter
2.3.3 Provide free, confidential health surveys for seniors with Medicare who live independently in the community to reduce avoidable hospital use by connecting older adults to the services they need through the NexusMontgomery	x	x	x			HSCRC, Adventist HealthCare, Medstar Montgomery Medical Center, Suburban Hospital
2.3.4 Provide education on MOLST/Advanced Directives	x	x	x	See 2.3.1	See 2.3.1	

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports for encounters, readmission rates, ED utilization, and clinical indicators, MADC daily census; participant surveys; # WISH health surveys completed, number educated on advanced directives

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

OBJECTIVE 2.4

Reduce the morbidity and costs associated with, and maintain or enhance the quality of life for, persons with dementia, including Alzheimer's disease.

CHNA IMPACT	CHNA BASELINE	TARGET
• Increase life expectancy	79.2	79.8*
• Decrease fall-related deaths	6.4	7.7*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE Y1	Y2	Y3	COMMITTED RESOURCES* HCH	Other Sources	POTENTIAL PARTNERS
2.4.1 Provide social, rehabilitative, and recreational programs for adults with Alzheimer's disease and other dementia through the Medical Adult Day Center (MADC)	x	x	x	See 2.3.1	See 2.3.1	Montgomery County DHHS, GROWS, Maryland Department on Aging; AAOA, MAADS, Alzheimer's Foundation, Alzheimer's Association, ARC
2.4.2 Provide evidence-based memory programs for seniors aged 55+ through the Holy Cross Senior Source	x	x	x	$7,000		
2.4.3 Maintain MADC's status as a Dementia Care Program of Distinction	x	x	x			Alzheimer's Foundation

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports for encounters, attendance/completion rate, readmission/ED utilization, and clinical indicators, MADC daily census; participant surveys

Priority 2: Chronic Diseases

Priority 2a: Diabetes (CHNA pg. 47-49)

Goal 3: Reduce the disease burden of diabetes mellitus.

OBJECTIVE 3.1

Decrease the number of low-income, uninsured/underinsured persons with uncontrolled diabetes.

CHNA IMPACT	CHNA BASELINE	TARGET
• Decrease ER visits for diabetes	280.5	186.3*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE Y1	Y2	Y3	COMMITTED RESOURCES* HCH	Other Sources	POTENTIAL PARTNERS
3.1.1 Provide care management, education and nutrition counseling at HC Health Centers for high-risk patients	x	x	x	See SIOH		Montgomery County DHHS, Montgomery Cares Montgomery Cares, Adventist Health, Medstar Montgomery, and Suburban
3.1.2 Referral process for Montgomery Cares safety-net clinic patients to Diabetes Self-Management classes offered by all health systems in Montgomery County	x	x	x			

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on health center visits, clinical measures, readmissions/ED utilization, referrals to community health programs and social services

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

OBJECTIVE 3.2

Increase the self-management skills of adults diagnosed with diabetes and increase prevention behaviors in adults at high risk for diabetes

CHNA IMPACT	CHNA BASELINE	TARGET
• Decrease number of adults ever told they have diabetes	13.5%	10.2%◊
• Decrease ER visits for diabetes	280.5	186.3*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
3.2.1 Offer Diabetes Prevention Program in English and Spanish	x	x	x	$30,000	$30,000	Montgomery County DHHS; Montgomery County DHHS, Maryland Dept. of Health
3.2.2 Offer Diabetes Self-Management Program in English and Spanish	x	x	x	$5,000	$4,000	Montgomery County DHHS, HQI

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on encounters, average % weight loss, increase in physical activity, attendance/completion rate, and number of safety-net DSMP referrals, pre/posttests, self-efficacy survey, DPP full recognition status, #referrals made,

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

Priority 2b: Cancers (CHNA pg. 38-43)

Goal 4: Reduce the number of new cancer cases, as well as illness, disability, and death caused by cancer.

OBJECTIVE 4.1

Increase the number of low-income, uninsured women receiving breast cancer screenings and education on cancer prevention and the importance of early detection.

CHNA IMPACT	CHNA BASELINE	TARGET
• Decrease breast cancer mortality	19.8	20.7†

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
4.1.1 Provide community-based breast cancer education	x	x		$4,000		Montgomery County DHHS
4.1.2 Provide access to mammogram services for uninsured, underinsured women	x	x	x	$100,000	$60,000	Kevin J. Sexton Fund, Primary Care Coalition

***Committed resources for year one; other sources are from grants and/or fees**

Monitoring/evaluation approaches:

Quarterly reports on encounters, percent eligible health center patients receiving referrals, number of mammograms, number navigated to care and cycle time from diagnosis to treatment, number of cancers found, number enrolled in state breast and cervical cancer program,

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

OBJECTIVE 4.2

Provide educational, community-based and clinical programs to reduce the number of cancer cases, as well as illness, disability, and death caused by cancer.

CHNA IMPACT	CHNA BASELINE	TARGET
• Increase colorectal cancer screening	72.9%	73.0%◊
• Increase percent of women who have had a Pap in past 3 years	83.0%	93.0%◊
• Decrease prostate cancer incidence	159.3	135.0◊
• Decrease breast cancer mortality	19.8	20.7†

* MD SHIP Target Δ Median or mean value for all counties in the state

† HP 2020 Target ◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
4.2.1 Provide outreach and education on cancer prevention in Montgomery and Prince George's County through an equitable lens	x	x			$13,500	Maryland Dept. of Health
4.2.2 Provide outreach and education on tobacco-free living	x	x			$17,000	Montgomery DHHS Cigarette Restitution Fund
4.2.3 Provide HC Health Center referrals and screening for mammograms and colonoscopies, and tobacco cessation	x	x	x	See SIOH		

***Committed resources for year tow; other sources are from grants and/or fees**

Monitoring/evaluation approaches:

Quarterly reports on encounters, cancer education provided by type, number of referrals made to primary care or other social services, % health center patients eligible for screenings receiving referrals (tobacco, mammogram, colonoscopy)

Priority 2c: Cardiovascular Health (CHNA pg. 44 – 47)

Goal 5: Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke.

OBJECTIVE 5.1

Decrease the number of low-income, uninsured/underinsured persons with uncontrolled hypertension.

CHNA IMPACT	CHNA BASELINE	TARGET
• Decrease heart disease mortality	136.4	166.3*
• Decrease stroke mortality	30.1	34.8†
• Decrease percent of adults told they have high blood pressure	21.6%	26.9%†

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
5.1.1 Implement care management team at HC Health Centers for high-risk patients	x	x	x	See SIOH		Montgomery County DHHS, Montgomery Cares

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on clinical measures, readmissions/ED utilization, number of referrals to community health programs and social services

OBJECTIVE 5.2

Provide educational and community-based programs to improve cardiovascular health.

CHNA IMPACT	CHNA BASELINE	TARGET
• Decrease heart disease mortality	136.4	166.3*
• Decrease stroke mortality	30.1	34.8†
• Decrease percent of adults told they have high blood pressure	21.6%	26.9%†

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
5.2.1 Provide community-based cardiovascular education and programming through an equitable lens	x	x		$5,000		
5.2.2 Provide community fitness classes for adults and older adults aged 55+	x	x	x	$245,835 also see Seniors	$60,000	Kaiser Permanente of the Mid-Atlantic States, National Lutheran Communities & Services, Montgomery County Department of Recreation, Maryland National Capital Park and Planning Commission, Faith-Based Organizations and
5.2.3 Develop community-based stroke awareness program	x	x		$2,500		Montgomery County DHHS, MCPS
5.2.4 Offer Stanford University's Chronic Disease Self-Management Program	x	x	x	$5,000		Montgomery County DHHS, Area Agency on Aging

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on encounters, number of blood pressures screenings, stroke program developed, number of fitness classes offered

Priority 2d: Obesity (CHNA pg. 50)

Goal 6: Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights.

OBJECTIVE 6.1

Reduce the proportion of children and adolescents who are considered obese.

CHNA IMPACT	CHNA BASELINE	TARGET
• Decrease percent students with no physical activity	23.2%	18.0%Δ
• Decrease percent of students who are obese	13.7%	10.7%*
• Increase percent of students who drank no soda in past week	28.0%	28.4% Δ

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
6.1.1 Kids Fit – physical activity program for adolescents	✖	✖	✖	$8,000		Montgomery County HOC

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on encounters, number of Kids Fit participants, number Kids Fit participants taking Presidential Fitness Challenge, semi-annual fitness assessments

OBJECTIVE 6.2

Increase the proportion of primary care physicians who regularly assess body mass index (BMI) in their adult patients

CHNA IMPACT	CHNA BASELINE	TARGET
• Adults who are overweight or obese	55.2%	64.3%*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
6.2.1 BMI assessment and diagnosis of obesity for health center patients	✖	✖	✖	See SIOH Themes		Montgomery Cares

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on percent patients with high BMI diagnosed as obese

Priority 2e: Behavioral Health (CHNA pg.50 – 54)

Goal 7: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.

OBJECTIVE 7.1

Increase access to appropriate, quality mental health services.

CHNA IMPACT	CHNA BASELINE	TARGET
• Decrease illicit drug use	6.1%	9.7%†
• Decrease percent of adults with any mental illness	16.8%	16.8%Δ
• Decrease mental health related ER visits	1,528	3,153*
• Decrease suicide rate	6.5	9.0*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE Y1	Y2	Y3	COMMITTED RESOURCES* HCH	Other Sources	POTENTIAL PARTNERS
7.1.1 Behavioral Health screenings with links to treatment at all health centers	x	x	x	See SIOH		Montgomery Cares
7.1.2 Create Health System-wide plan to address behavioral health	x	x				Maryland Dept. of Health, Montgomery County DHHS, Trinity Health, Healthy Montgomery HSCRC, Adventist HealthCare, Medstar Montgomery Medical Center, Suburban Hospital
7.1.3 Provide behavioral health services and links to treatment through the NexusMontgomery Crisis House, ACT Teams, and behavioral health Integration	x	x	x			
7.1.4 Implement non-pharmaceutical pain management program	x	x	x	$10,000		EveryMind, Montgomery County DHHS

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports number behavioral health screenings conducted, ; #referred to social services and community health programs, # referred to treatment, development of opioid abuse plan; number of persons served by Crisis House, number of full capacity ACT Teams; Interagency efforts to reduce hospital use by severely mentally ill patients, readmissions/ED utilization

Priority 3: Social Influencers of Health

Priority 3a: Health Care Access (CHNA pg. 34-35)

Goal 8: Create social and physical environments that promote good health for all.

OBJECTIVE 8.1

Decrease the number of persons unable to access primary care services.

CHNA IMPACT	CHNA BASELINE	TARGET
• Decrease uninsured rate in HCH Service Area	7.1%	0.0%†
• Decrease number of people unable to afford to see a doctor	4.7%	4.2†

* MD SHIP Target Δ Median or mean value for all counties in the state
† HP 2020 Target ◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE Y1	Y2	Y3	COMMITTED RESOURCES* HCH	Other Sources	POTENTIAL PARTNERS
8.1.1 Operate four health centers for the un/underinsured in geographically accessible locations	x	x	x	$2.5M	$2.4M	Montgomery Cares, Medstar Montgomery, Trinity Health, Maryland Dept. of Health
8.1.2 Add Community Health Navigator to Care Management Team to address social determinants of health for health center patients	x	x	x	$35,000		
8.1.3 Implement plan to link uninsured Maternity Partnership patients to primary care services at HC Health Centers to create a medical home for the whole family	x	x	x			Maternity Partnership, Montgomery Cares

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on encounters, patient visits, clinical measures, number of patients/community members with Pathways Care Coordination plans, number of patients navigated by Community Health Navigator, number of maternity partnership patients linked to Germantown health center

Priority 3b: Housing (CHNA pg. 27)

Goal 8: Create social and physical environments that promote good health for all.

OBJECTIVE 8.2

Decrease the proportion of households that experience housing cost burden.

CHNA IMPACT	CHNA BASELINE	TARGET
• Decrease ER visits for diabetes	280.5	186.3*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
8.2.1 Partner with community based organizations to deliver GED and ESOL classes.	x	x	x	$2,000	$2,000	Montgomery College, MCAEL, IMPACT Silver Spring
8.2.2 Pathways to Independent Employment Program	x	x	x	$20,000		Workforce Montgomery, AIMHire
8.2.3 Advocate for policy and system changes that support housing	x	x	x	Included in staff salaries		Montgomery Housing Partnership, Wider Circle

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on health center visits, clinical measures, readmissions/ED utilization, referrals to community health programs and social services

Priority 3c: Food Insecurity (CHNA pg. 24-25)

Goal 8: Create social and physical environments that promote good health for all.

OBJECTIVE 8.2

Reduce household food insecurity and in doing so reduce hunger.

CHNA IMPACT	CHNA BASELINE	TARGET
• Decrease percent of households that are food insecure	10.8%	6.0†

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE Y1	Y2	Y3	COMMITTED RESOURCES* HCH	Other Sources	POTENTIAL PARTNERS
8.2.1 Implement Social Influencers of Health project, addressing food insecurity	x	x	x	$20,000		Montgomery County Food Council, Montgomery County DHHS, Manna Food Center
8.2.2 Advocate for policy and system changes that support food security	x	x	x			

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on health center visits, clinical measures, readmissions/ED utilization, referrals to community health programs and social services

Holy Cross Health: Patient Financial Assistance

Owner/Dept: Julie Keese, VP Revenue Mgmt/ Office of Chief Financial Officer	**Date approved: 09/29/2020**
Approved by: Anne Gillis (RHM Chief Financial Officer), Annice Cody (President Holy Cross Health Network), Doug Ryder (RHM President), Louis Damiano (RHM President)	**Next Review Date: 09/29/2022**
Affected Departments: Collections, Emergency Registration, Financial Counseling, HCH Ob-Gyn Clinic, HCHC Aspen Hill, HCHC Gaithersburg, HCHC Germantown, HCHC Silver Spring, Insurance Billing, Legal Services, Office of the CFO, Patient Access Services, Patient Accounting, Patient Registration, Pre-Arrival Services	

Purpose

Holy Cross Health's mission includes ensuring the availability of medically necessary care to patients in the communities it serves who are in need regardless of their ability to pay. Since all care has associated cost, any "free" or "discounted" service provided through this program results in that cost being passed on to other patients and their payers. Holy Cross Health therefore has a dual responsibility to cover those in need while ensuring it can pursue its mission and that the cost of care is not unfairly transferred to individuals, third party payers and the community in general.

It is the purpose of this policy to:

- Ensure a consistent, efficient and equitable process to provide, consistent with all applicable law, free or reduced-cost medically necessary services to patients who reside in the state of Maryland or who present with an urgent, emergent or life-threatening condition and do not have the ability to pay.
- Ensure regulatory agencies and the community at large that Holy Cross Health documents the financial assistance provided to these patients so that their eligibility for the assistance is appropriately demonstrated.
- Protect a stated level of each patient's assets when determining their eligibility for financial assistance.
- Provide care, without discrimination, for emergency medical conditions to individuals regardless of their eligibility for financial assistance.

Applies to:

Services, locations and facilities listed in the Covered Services section.

Policy Overview

The Holy Cross Health patient financial assistance policy applies in those cases where patients do not have sufficient income or assets to pay for their care and fulfill their obligation to cooperate with and avail themselves of all programs for medical coverage (including Medicare, Medicaid, commercial insurances, workers' compensation, and other state and local programs). The financial assistance policy is comprised of the following programs, each of which may have its own application and/or documentation requirements. If a patient meets the eligibility requirements of more than one of the programs listed below, Holy Cross Health will apply the reduction in charges that is most favorable to the patient.

- **Scheduled Financial Assistance Program:** Holy Cross makes available financial assistance, consistent with this policy and applicable law, to eligible patients who have a current or anticipated need for inpatient or outpatient medical care. This assistance requires completion of an application and provision of supporting documentation. Once approved, such financial assistance remains in effect for a period of six months after the determination unless the patient's financial circumstances change or they become eligible for coverage through insurance or available public programs during this time.

- **Presumptive Financial Assistance Program:** Holy Cross makes available presumptive financial assistance to eligible patients as follows:

    - Patients, unless otherwise eligible for the Maryland Medical Assistance Program (Medicaid) or Maryland Children's Health Program (CHIP), who are beneficiaries of the social services programs listed below are eligible for free medically necessary care, provided that the patient submits proof of enrollment within 30 days unless a 30-day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below:
        - Households with children in the free or reduced-cost meal program;
        - Supplemental Nutritional Assistance Program (SNAP);
        - Maryland Energy Assistance Program;
        - Special Supplemental Food Program for Women, Infants and Children (WIC);
        - Any other social service program as determined by the Maryland Department of Health (DOH) and the Health Services Cost Review Commission (HSCRC).

    - Patients who are beneficiaries of the Montgomery County programs listed below are eligible for 60% financial assistance, provided that the patient submits proof of enrollment within 30 days unless a 30-day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below:
        - Montgomery Cares;

- Project Access;
- Care for Kids

Note: Patients in these County programs may also be eligible and evaluated for 100% financial assistance based upon completion of a Uniform Financial Assistance Application and provision of supporting documentation.

- Deceased patients with no known estate, patients who are homeless, unemployed, had their debts discharged by bankruptcy and members of religious organizations who have taken a vow of poverty and have no resources individually or through the religious order.

- Uninsured patients receiving services at Holy Cross Health Centers and/or the Obstetrics/Gynecology Clinics. In some cases, both the eligibility and documentation requirements will reflect the processes and policies of County or other public programs for financial assistance. This assistance is based on the same financial assistance eligibility schedule, but normally requires a less extensive documentation process. In accordance with County policy, patients are expected to make the minimum required co-payments and/or contractual payments regardless of the level of charity care for which the patient would otherwise be eligible.

- Patients qualifying for public assistance programs who receive non-covered medically necessary services.

Holy Cross Health recognizes that not all patients are able to provide complete financial and/or social information and Holy Cross Health may elect to approve financial support based on available information, including third-party, predictive modeling software, prior to referring an outstanding balance to an external collection agency to ensure those patients who cannot afford to pay for care are appropriately identified regardless of documentation provided.

- **Medical Financial Hardship Program:** Holy Cross Health also makes available financial assistance to “medically indigent” patients who demonstrate a financial hardship as a result of medical debt. "Financial hardship" means medical debt, incurred by a family over a 12-month period, that exceeds 25% of family income. "Medical debt" means out-of-pocket expenses, excluding co-payments, coinsurance, and deductibles, for medical costs billed by a hospital. This program requires a more extensive documentation process. Reduced-cost financial assistance will remain in effect during the 12-month period after the date the reduced-cost medically necessary care was initially received and will apply to the patient or any

immediate family member of the patient living in the same household when seeking subsequent care at a Holy Cross Health facility.

- **Timeframes:** Within two business days of the receipt of a patient request for financial assistance, a preliminary eligibility determination will be made. When a patient submits a completed application for financial assistance, Holy Cross Health will determine the patient's eligibility under this policy within 14 days and will suspend any billing or collections actions while eligibility is being determined. Final determination is subject to validation of the information on the Uniform Financial Assistance Application. Holy Cross Health will require from patients or their guardians only those documents required to validate information provided on the application.

The documentation requirements and processes used for each financial assistance program are listed in this policy and the Uniform Financial Assistance Application and accompanying instructions.

Amount Generally Billed (AGB)

An individual who is eligible for assistance under this policy for emergency or other medically necessary care will never be charged more than the amounts generally billed (AGB) to an individual who has insurance coverage for such care. We determine the AGB using the Medicare prospective method as permitted under Federal Internal Revenue Code (IRC) section 501(r) regulations and this provides the reduction in charges that is most favorable to the patient eligible for assistance under this policy.

The charges to which a discount will apply are set by the State of Maryland's Health Services Cost Review Commission (HSCRC) and are the same for all payers (i.e. commercial insurers, Medicare, Medicaid or self-pay). Holy Cross's AGB is 92.3% of charges which represents the amount Medicare would allow for the care. This includes both the amount Medicare would pay and the amount, if any, the individual is personally responsible for paying in the form of co-payments, coinsurance and deductibles.

Covered Services

The financial assistance policy applies only to charges for medically necessary patient services that are rendered at facilities operated solely by Holy Cross Health. These facilities include Holy Cross Hospital, Holy Cross Germantown Hospital, Holy Cross Health Centers, Holy Cross Health Partners and Holy Cross Dialysis Center at Woodmore. It does not apply to services that are operated by a "joint venture," "affiliate," or other non-controlled entity in which Holy Cross Health participates. Hospital-based contracted physicians (Emergency Medicine, Anesthesia, Pathology, Radiology, Hospitalists, Intensivists, Surgicalists, and Neonatologists) also honor scheduled financial assistance determinations made by Holy Cross Health.

Provision of services specifically for the uninsured: To ensure appropriate stewardship of its resources, in the event Holy Cross Health provides a more cost-effective setting for medically needed services (such as its Obstetrics/Gynecology Clinics or the Health Centers), which may include cooperation with community groups or contracted physicians, specific financial assistance and payment terms apply that may differ from the general Holy Cross Health financial assistance program. In these heavily discounted programs, patients are expected to make the minimum co-payments that are required regardless of the level of charity care for which the patient would otherwise be eligible. Those minimum obligations are not then eligible to be further reduced via the scheduled financial assistance policy.

Services Not Covered

Services not covered by this financial assistance policy are:

- Private physician services (except for the contracted providers described above) or charges from facilities in which Holy Cross Health has less than full ownership.
- Cosmetic, convenience, and/or other medical services which are not medically necessary. Medical necessity will be determined by Holy Cross Health consistent with all applicable regulatory requirements after consultation with the patient's physician and must be determined prior to the provision of any non-emergent service.
- Services for patients who decline to cooperate reasonably with the documentation requirements of this policy, or to obtain coverage for their services from County, State, Federal, or other assistance programs for which they are eligible.

Note: A comprehensive list of providers who participate and do not participate in the Holy Cross Health financial assistance program can be found on Holy Cross Health's external website and is made available upon request.

Patient Eligibility Requirements

Holy Cross Health provides various levels of financial assistance to Maryland residents and patients who present with an urgent, emergent or life-threatening condition whose income is less than 400% of the federal poverty level and whose cumulative household monetary assets that are convertible to cash do not exceed $10,000 as an individual or $25,000 within a family. Holy Cross Health will also provide assistance to patients with family income up to 500% of the federal poverty level that demonstrate a financial hardship as a result of incurring hospital medical debt that exceeds 25% of family income over a 12-month period. Monetary assets that are convertible to cash that will be excluded from consideration in all instances in calculating eligibility are:

- At a minimum, the first $10,000 of monetary assets;
- A safe harbor equity of $150,000 in a primary residence;
- Retirement assets that the Internal Revenue Service has granted preferential tax treatment as a retirement account, including deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred-compensation plans;
- One motor vehicle used for the transportation needs of the patient or any family member of the patient;
- Any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act; and
- Prepaid higher education funds in a Maryland 529 Program account or other government administered college savings plan.

Monetary assets excluded from the determination of eligibility for free and reduced-cost care under this policy shall be adjusted annually for inflation in accordance with the Consumer Price Index.

In determining the family income of a patient (and otherwise for purposes of this policy as applied to a family), Holy Cross Health will include in the household size, at a minimum: the patient and patient's spouse, regardless of tax filing status; biological children, adopted children, and/or stepchildren; and anyone for whom the patient claims a personal exemption in a federal or state tax return. If the patient is a child, the family/household size will include: the biological parents, adopted parents, stepparents or guardians; biological siblings, adopted siblings or stepsiblings; and anyone for whom the patient's parents or guardians claim a personal exemption in a federal or state tax return.

Holy Cross Health does not use a patient's citizenship or immigration status as an eligibility requirement for financial assistance or withhold financial assistance or deny a patient's application for financial assistance on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, or on the basis of disability.

Any patient or the patient's authorized representative may make a request to reconsider the level of reduced-cost care approved or denial of free or reduced-cost care by Holy Cross Health for the patient. In such cases, requests are to be made to the financial counseling manager who will consider the total financial circumstances of the patient including outstanding balances owed to Holy Cross Health, debt and medical requirements, as well as the patient's income and assets. The financial counseling manager will assemble the patient's request and documentation and present it to the financial assistance exception committee (comprised of the Chief Mission Officer, Chief Financial Officer, Chief Clinical Officer and Vice President, Revenue Management) for consideration. The financial counseling manager will also notify the patient or the patient's authorized representative of the availability of the Maryland Health Education and Advocacy Unit (HEAU) to assist in filing and mediating a reconsideration request and will provide the patient or the patient's authorized representative all contact information for the HEAU including the address, phone number, facsimile number, e-mail address, mailing address, and the website.

If an application is received within 240 days of the first post-discharge billing statement, and the account is with a collection agency, the agency will be notified to suspend all Extraordinary Collection Actions (ECA) until the application and all appeal rights have been processed.

In any case where the patient's statements to obtain financial assistance are determined to be materially false, all financial assistance that was based on the false statements or documents will be rescinded, and any balances due will be processed through the normal collection processes.

The scheduled financial assistance program provides free medically necessary care to those most in need – patients who have income equal to or less than 200% of the federal poverty level. It also provides for a 60% reduction in charges for those whose income is between 201% and 300% of the poverty level, and 30% assistance from 301% to 400% of the federal poverty level. For those patients who demonstrate a medical financial hardship, a minimum of 30% assistance is available from 401% to 500% of the federal poverty level. Patient co-pay, deductible and coinsurance amounts are also eligible for financial assistance based on the sliding scale above provided that there is no conflict with contractual arrangements with the patient's insurer or enrollment in a Montgomery County program.

Holy Cross Health's schedule of financial assistance will change according to the annual update of federal poverty levels published in the HHS Federal Register.

Continuing financial obligation of the patient: Patients who receive partial financial assistance have been determined to be capable of making some payment for their care. Unless a specific patient financial assistance exception request is made and approved, or Holy Cross Health management formally adopts a procedure that exempts collection processes for particular services, patients are expected to pay the amount of the reduced balance. In cases other than the above, any patient who fails to pay their reduced share of the account in question will have that account processed through our normal collection procedures, including the use of outside agencies and credit reporting. However, Holy Cross Health will not pursue a judgment against anyone who has legitimately qualified for any scheduled level of Holy Cross Health financial assistance. Payment plans are also made available to uninsured patients with family income between 200% and 500% of the federal poverty level that request assistance.

Notice of Financial Assistance

Holy Cross Health provides notice of this policy to the patient, the patient's family, or the patient's authorized representative in multiple ways, as described below, and in all instances, consistent with applicable law, before discharging the patient and in each communication to the patient regarding the hospital bill. The information will be made available via the following methodologies:

1) A simplified language summary of Holy Cross Health's financial assistance policy, financial assistance applications, and the Hospital Information Sheet is prominently displayed in all registration and cashier areas, the facilities' main lobby, cafeteria and the emergency center, and the health center campuses in English, Spanish and in the predominant languages represented by our patient population as required by then-applicable regulations. All documents can also be accessed, viewed, downloaded and printed from Holy Cross Health's external website.

2) Notice of financial assistance availability is indicated on the Patient Consent to Conditions of Treatment form and on all Holy Cross Health billing statements along with a reference to the external website and phone number where inquiries can be made.
3) The Hospital Information Sheet is provided to the patient, the patient's family, or the patient's authorized representative before discharge, with the hospital bill, on request and in each written communication to the patient regarding collection of the hospital bill.
4) All self-pay patients are advised of the existence of the financial assistance program during the pre-registration and registration process.
5) Information regarding eligibility and applications for financial assistance will be mailed to any patient who requests it at any time – including after referral to collection agencies.
6) A notice will be published each year in a newspaper of wide circulation in the primary service areas of Holy Cross Health.

The actions that Holy Cross Health may take in the event of nonpayment are described in a separate policy entitled "Billing and Collection of Patient Payment Obligations". A copy of the policy is available through our financial counseling department upon request.

Related Documents

- Billing and Collection of Patient Payment Obligations Policy
- Holy Cross Health Financial Assistance Program – Participating Providers
- Holy Cross Health Financial Assistance Program – Non-Participating Providers

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References

- Trinity Health. Trinity Health Finance Policy No. 1, "Financial Assistance to Patients", September 27, 2017.
- Federal Poverty Guidelines, HHS Federal Register
- Code of Maryland Regulations (COMAR) 10.37.10.26A and 10.24.10.04
- Patient Protection and Affordable Care Act: Statutory Section 501(r)
- Maryland Code Annotated, Health-General Article § 19-214.1

Questions and More Information

Contact the financial counseling department at 301-754-7195 or the financial counseling manager at extension 301-754-7193 with questions and for more information.

Policy Modifications

The Holy Cross Health Board of Directors must approve modifications to this policy. In addition, this policy will be presented to the Board for review and approval every two years.

Approval This policy was reviewed and approved by the Holy Cross Health Executive Team and on behalf of the full Holy Cross Health Board of Directors by the Executive and Governance Committee of the Board on September 29, 2020.

From: Laura Spicer
To: Kimberley McBride
Cc: Monika Clark Driver; Willem Daniel -MDH-; Hilltop HCB Help Account
Subject: RE: FY 2022 Hospital Community Benefit Reporting Guidelines
Date: Friday, August 12, 2022 12:21:02 PM
Attachments: image001.png
image002.png
Holy Cross_HCBNarrative_FY2021_20211216.pdf

Hi Kim,

Thank you again for completing the optional CHNA reporting for 2021 and requesting feedback! As noted in the webinar, you were 2 of the 3 hospitals that completed this optional reporting. Your responses were very helpful to us as we prepare for receiving these data from all hospitals for 2022.

Please see the comments below for Holy Cross and Holy Cross Germantown:

- Great level of detail and effort put into providing a thorough list.
- The agreement between the initiatives itemized in the financial report and those listed in the narrative report was commendable.
- We took a look at your CHNA as we reviewed the initiatives and noted that Holy Cross has an excellent CHNA.
- This list of CHNA initiatives in the optional tab includes physician subsidies that do not appear to be related to a specific need in your CHNA.
  The CHNA notes that access to physicians and other providers is higher when compared to surrounding areas (but noted that affordability is a concern). Physician subsidies should only be included on this tab if they tie directly to a CHNA need.
- Providing more specificity in the following areas would be helpful:
  - Spell out acronyms included in the "CHNA Initiative(s)" column (we were able to figure out some but not all).
  - For initiatives that address more than one need, in addition to selecting "Multi Need" for the "CHNA Priority Area (Category)" column, the CHNA priority areas addressed through the program should be specified in the "CHNA Priority Area" column. More columns may be created as necessary in order to note multiple priority areas.

Additionally, we encountered an item in the narrative report that requires clarification:

> The response provided for Question 223 of page 5 (attached) indicates that Holy Cross did not report physician subsidies on its Fiscal Year 2021 community benefit financial report. However, the financial report lists physician subsidies (3 for Holy Cross and 2 for Germantown) . In order to clarify this discrepancy, please provide details about the reported subsidies using the following supplemental surveys:
> https://umbc.co1.qualtrics.com/jfe/form/SV_7UkXPHgDgRgHDx4?Q_CHL=gl&Q_DL=XRUPCqGxcLXQtPj_7UkXPHgDgRgHDx4_CGC_YdyYBV7aLB1sJeP and
> https://umbc.co1.qualtrics.com/jfe/form/SV_2t7JmA86Dbm7de6?Q_CHL=gl&Q_DL=7QU0zGdaXpo9SGa_2t7JmA86Dbm7de6_CGC_YdyYBV7aLB1sJeP

Please let me know if you have any questions about these items or would like to chat.

Thank you very much,
Laura

Laura Spicer
Director, Health Reform Studies

The Hilltop Institute

410-455-6536
lspicer@hilltop.umbc.edu

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From: Kimberley McBride <mcbrik@holycrosshealth.org>
Sent: Wednesday, August 10, 2022 11:30 AM
To: Laura Spicer <lspicer@hilltop.umbc.edu>
Cc: Monika Clark Driver <driverm@holycrosshealth.org>
Subject: RE: FY 2022 Hospital Community Benefit Reporting Guidelines

Hi Laura,
I just wanted to touch base to see when the feedback would be available. We'd like to see it prior to completing this year's report, which we will begin working on next week. We submit the report to our board in October.

Thanks,
Kim
O: 301.754.7149 | C: 225.205.9133 | mcbrik@holycrosshealth.org

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From: Laura Spicer <lspicer@hilltop.umbc.edu>
Sent: Friday, July 1, 2022 4:13 PM
To: Kimberley McBride <mcbrik@holycrosshealth.org>
Cc: Monika Clark Driver <driverm@holycrosshealth.org>
Subject: [External] RE: FY 2022 Hospital Community Benefit Reporting Guidelines

Hi Kim,

Yes, we will certainly share feedback! We are awaiting a few items from HSCRC before finalizing the FY 21 report.

Thank you for reaching out,
Laura

Laura Spicer
Director, Health Reform Studies
The Hilltop Institute
410-455-6536
lspicer@hilltop.umbc.edu

follow us 

From: Kimberley McBride <mcbrik@holycrosshealth.org>
Sent: Friday, July 1, 2022 1:56 PM
To: Laura Spicer <lspicer@hilltop.umbc.edu>
Cc: Monika Clark Driver <driverm@holycrosshealth.org>
Subject: RE: FY 2022 Hospital Community Benefit Reporting Guidelines

Hi Laura,
Will we receive feedback on the FY21 reports? We completed the optional portion and would like to receive feedback on what was submitted.

Thanks,
Kim
O: 301.754.7149 | C: 225.205.9133 | mcbrik@holycrosshealth.org

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From: Laura Spicer <lspicer@hilltop.umbc.edu>
Sent: Friday, July 1, 2022 10:42 AM
To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Cc: Willem Daniel -MDH- <willem.daniel@maryland.gov>
Subject: [External] FY 2022 Hospital Community Benefit Reporting Guidelines

Attached please find the guidelines and instructions for the FY 2022 community benefit reporting period. The only substantive change is that the optional reporting items for FY 2021 will be made mandatory for FY 2022. We will be holding a training webinar, and an invitation will be sent out shortly. Individual hospital narrative reporting links will be issued in the coming weeks; the list of narrative questions is attached to this email for your reference.

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