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: Suburban Hospital	◉	○	
Your hospital's ID is: 210022	◉	○	
Your hospital is part of the hospital system called Johns Hopkins Heath System	◉	○	
The primary Narrative contact at your hospital is Monique Sanfuentes	◉	○	
The primary Narrative contact email address at your hospital is msanfuentes@jhmi.edu	◉	○	
The primary Financial contact at your hospital is Monique Sanfuentes	◉	○	
The primary Financial email at your hospital is msanfuentes@jhmi.edu	◉	○	

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.

- ☑ Median household income
- ☑ Percentage below federal poverty line (FPL)
- ☑ Percent uninsured
- ☑ Percent with public health insurance
- ☑ Percent with Medicaid
- ☐ Mean travel time to work
- ☑ Percent speaking language other than English at home
- ☑ Race: percent white
- ☑ Race: percent black
- ☑ 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.

Utilization of additional health statistics incorporated and considered in Suburban Hospital's community benefit operations include: Healthy Montgomery, the local health improvement coalition (LHIC), the Hospital's Primary Service Area (PSA) and Community Benefit Service Area (CBSA) data, along with aggregated data from Suburban Hospital's Community Health Improvement initiatives. Examples include biometric screenings, wellness and disease management classes, health education webinars and community building activities. Moreover, statistical data highlighted in the FY2019 CHNA also serves as integral strategic influencer towards the community benefit process and is considered during the FY2021 Community Benefit process.

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

Q7. Suburban Hospital PSA and CBSA Demographics.pdf
1.5MB
application/pdf

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.

This question was not displayed to the respondent.

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?

- [x] Based on ZIP codes in your Financial Assistance Policy. Please describe.

Suburban Hospital’s financial assistance policy supports eligible patients based on the most recent Federal poverty guidelines. The highest number of financial assistance transactions were identified and incorporated into the formula which factored into the Hospital's CBSA. This assessment enables the hospital to respond to the needs of its most vulnerable and underserved patients and community by providing additional services and support. Furthermore, CBSA zip codes (20902, 20906, 20910, 20852 and 20814) are home to safety-net clinics Proyecto Salud Clinic (20906), Montgomery Cares (20910) and Catholic Charities Center (20902), Mobile Medical Care (20814, 20852) of which the Hospital provides financial and/or in-kind support.

- [ ] Based on ZIP codes in your global budget revenue agreement. Please describe.

- [x] Based on patterns of utilization. Please describe.

Suburban Hospital includes Inpatient and Emergency Department utilization and statistics. During the 2019 CHNA process, Suburban Hospital revised the formula for calculating its CBSA to include data from Inpatient Records, Emergency Department (ED) Visits and Charity Financial Assistance Transactions.

- [x] Other. Please describe.

Suburban Hospital does not restrict its community health improvement services to the primary service area. Rather, its Community Benefit Service Area (CBSA) includes specific populations or communities of need to which the Hospital allocates resources through its community benefit plan. The hospital determines its CBSA using data from Inpatient Records, Emergency Department (ED) visits, and Charity Financial Assistance Transactions, which are aggregated and defined by the geographic area contained within the following fourteen zip codes: 20814, 20815, 20816, 20817, 20850, 20851, 20852, 20853, 20854, 20895, 20902, 20904, 20906, and 20910.

Within the CBSA, Suburban Hospital focuses on certain target populations such as un- and under-insured individuals and households, low-income individuals and households, ethnically diverse populations, underserved seniors, and at-risk youth. Although some zip codes within Suburban Hospital’s CBSA are not immediately adjacent to the Hospital, 33.8% of patients treated at the hospital are from zip codes 20902, 20904, 20906, and 20910. Furthermore, Suburban Hospital supports safety net clinics and free health prevention and chronic disease programs in those designated areas.

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

https://www.hopkinsmedicine.org/suburban_hospital/about_the_hospital/index.html

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

Suburban Hospital provides both in-kind and financial contributions to neighboring Prince George's and Calvert Counties to expand behavior change modification and awareness of cardiovascular disease and chronic disease management. While cardiovascular disease is prevalent across the nation and throughout Maryland, it is of particular risk in Southern Maryland, where rates of obesity and physical inactivity are high. It is particularly evident when comparing obesity and physical activity in Montgomery County, the home of Suburban Hospital, to our neighbors to the south, who consistently fall short against the same metrics. When obesity and inactivity are prevalent, high blood pressure, elevated cholesterol, diabetes, and other chronic diseases follow. Suburban Hospital has implemented on-going programs to address these specific issues. In Calvert County, Suburban supports the faith-based health ministry network by enabling each member parish to keep manual blood pressure cuffs on-site for volunteer health professionals to screen for hypertension after services. The majority of Southern Maryland outreach, however, is offered in Prince George's county. In FY21, 122 community health improvement activities were conducted, reaching 1,422 community members living in Prince George's and Calvert Counites. Despite having nearly 100% access to physical activity, just 50% of Prince George's County adults aged 18 and older engage in a regular routine of moderate or high intensity movement. Adults who engage in such activity reduce their risk of many serious chronic health conditions, including obesity, high blood pressure, heart disease, stroke, diabetes, and cancer. The prevalence of these risks – many of which are not meeting the Healthy People 2030 targets – indicate a need for targeted interventions that support increased movement, healthy eating habits, and prevention and management of chronic conditions. Suburban Hospital addresses social determinants of health by approaching the whole person, not simply their health condition. To do this, Suburban applies three lenses to its health improvement initiatives: Healthy Behaviors, Access to Care, and Health Equity. Since 2006, we have sponsored, measured, and tailored the following programs to meet the needs of the community with the goal of reducing disparities and improving health, taking special note that in-person activities were suspended for FY21 due to the global coronavirus pandemic: Senior Shape, health education seminars, blood pressure screenings and hypertension counseling (suspended), Tai Chi (suspended), and Dine, Learn & Move. These free programs and services provide targeted outreach to African Americans age 55 and greater. For more information on each of these programs and activities, please refer to the annual report, Cardiovascular Outreach in Southern Maryland Fiscal Year 2021, in the attachment to this report included in Q129.

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)

06/27/2019

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

https://www.hopkinsmedicine.org/suburban_hospital/_documents/community_health/CHNA_2019.pdf

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

SH CHNA 2019 FINAL.pdf
6MB
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)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	Regularly reports to Hospital executives and Board of Truste processes, best practices and frameworks.
	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)	☐	☐	☐	☑	☑	☑	☑	☑	☑	☑	Regularly reports to Hospital executives and Board of Truste processes, best practices and frameworks.
	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)	☐	☐	☐	☐	☑	☐	☑	☐	☐	☑	Suburban's Chief Medical Officer participated in evaluation s review secondary data for CHNA.
	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)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	Regular integration of population health initiatives beyond the C Health Needs Assessment.
	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)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	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 (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:
Physician(s)	☐	☐	☑	☑	☑	☐	☑	☑	☐	☐	
	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:
Nurse(s)	☐	☐	☐	☑	☑	☑	☑	☑	☑	☐	
	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:
Social Workers	☐	☐	☐	☑	☑	☑	☑	☑	☑	☐	
	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:
Hospital Advisory Board	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	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:
Other (specify) Suburban Hospital's Patient Education Committe, Interdisciplinary Readmission Committee, Quality and Safety Committee, Glucose Steering Committe, Cancer Disparities Taskforce, and Patient and Family Advisory Council	☐	☐	☐	☐	☑	☑	☑	☑	☐	☐	
	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:

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)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	Regularly reports to Hospital executives and Board of Trustees on process best practices and frameworks.
	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)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	Regularly reports to Hospital executives, health system, and Board of Trustees on process best practices and frameworks.
	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)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	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:
Nurse(s)	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	

	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:
Social Workers	☐	☐	☑	☑	☑	☐	☐	☑	☑	☐	
Hospital Advisory Board	☐	☐	☑	☑	☑	☐	☑	☑	☑	☐	
Other (specify) Suburban Hospital's Patient Education Committee, Interdisciplinary Readmission Committee, Quality and Safety Committee, Glucose Steering Committee, Cancer Disparities Taskforce, and Hospital Integrative Service Line Committee	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	

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: Adventist Healthcare Shady Grove Medical Center; Adventist Healthcare White Oak Medical Center; Holy Cross Hospital; Holy Cross Germantown Hospital; MedStar Montgomery Medical Center; Johns Hopkins Hospital; Johns Hopkins Bayview Medical Center; Howard County General Hospital; Johns Hopkins All Children's Hospital; Sibley Memorial Hospital	☑	☑	☑	☑	☐	☑	☑	☑	☑	☑	☑	☑	☑	☑
	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 Department -- Please list the Local Health Departments here: Montgomery County Department of Health and Human Services; Department of Aging & Disability Services	☑	☑	☑	☑	☐	☐	☑	☑	☑	☑	☐	☑	☑	☑

	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: HSCRC; Maryland Hospital Association	☑	☑	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	☐	☑
	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 Council & County Executive; Latino Health Initiative; Montgomery County Police Department	☑	☑	☑	☐	☐	☐	☑	☐	☐	☑	☐	☐	☐	☑
	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 Schools; Jewish Day School; Academy of the Holy Cross High School; Bullis School; Melvin J Berman Hebrew Academy High School; Stone Ridge School of the Sacred Heart; Yeshiva of Greater Washington; St. Jane de Chantal	☑	☑	☐	☐	☐	☐	☑	☑	☐	☐	☐	☐	☐	☐

	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: University of Maryland School of Public Health; American University; University of Florida	☑	☑	☐	☐	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐
	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
Behavioral Health Organizations -- Please list the organizations here: EveryMind; Girls on the Run Montgomery County; Cornerstone Montgomery; National Alliance of Mental Illness	☑	☑	☑	☐	☐	☐	☑	☑	☐	☑	☑	☑	☐	☐
	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
Social Service Organizations -- Please list the organizations here: Linkages to Learning; Parent Encouragement Program (PEP); YMCA - Bethesda Chevy Chase; Jewish Social Service Agency; Montgomery Hospice; Voice Your Choice	☑	☑	☑	☐	☐	☐	☑	☑	☐	☑	☑	☑	☐	☐
	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
Post-Acute Care Facilities -- please list the facilities here: Potomac Home Health Care; Charles E Smith Life Communities; Sunrise of Bethesda; Brighton Gardens of Friendship Heights; Maplewood Park Place; Sunrise of Fox Hills	☑	☑	☐	☐	☐	☐	☑	☑	☑	☐	☐	☑	☑	☑
	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
Community/Neighborhood Organizations -- Please list the organizations here: Washington Area Village Exchange; Bethesda Metro Area Village, Bradley Hills Village, Burning Tree Village, Chevy Chase at Home, Friendship Heights Neighbors Helping Neighbors, Little Falls Village, Maplewood Village, Potomac Community Village, Villages of Rockville, Villages of Kensington, Wyngate Neighbors Helping Neighbors; North Chevy Chase Connection; Bannockburn Village	☑	☑	☑	☐	☐	☑	☑	☑	☐	☑	☐	☑	☐	☑

	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
Consumer/Public Advocacy Organizations -- Please list the organizations here: Greater Bethesda Chevy Chase Chamber of Commerce; Montgomery County Chamber of Commerce; Bethesda Cares; Manna Food	☑	☑	☑	☐	☐	☐	☑	☑	☑	☐	☑	☐	☐	☐
	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: Bethesda Chevy Chase Rotary Club; Mansfield Caseman Health Clinic; Mercy Clinic; Mobile Medical; Proyecto Salud Clinic; Catholic Charities Center; Alpha Phi Alpha Fraternity; A Wider Circle; Washington Metropolitan Oasis; National Institutes of Health; National Institute of Diabetes, Digestive & Kidney Diseases; National Heart, Lung & Blood Institute	☑	☑	☑	☑	☐	☑	☑	☑	☑	☑	☑	☑	☑	☑
	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.

09/23/2019

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

https://www.hopkinsmedicine.org/suburban_hospital/_documents/community_health/CHNA_2019_Implementation_Strategy.pdf

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

Community Health Implementation Plan FINAL.pdf
1.3MB
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
- [x] Health Conditions - Cancer
- [ ] Health Conditions - Chronic Kidney Disease
- [ ] Health Conditions - Chronic Pain
- [ ] Health Conditions - Dementias
- [x] Health Conditions - Diabetes
- [ ] Health Conditions - Foodborne Illness
- [ ] Health Conditions - Health Care-Associated Infections
- [x] Health Conditions - Heart Disease and Stroke
- [x] Health Conditions - Infectious Disease
- [x] Health Conditions - Mental Health and Mental Disorders
- [ ] Health Conditions - Oral Conditions
- [ ] Health Conditions - Osteoporosis
- [ ] Health Conditions - Overweight and Obesity
- [ ] Health Conditions - Pregnancy and Childbirth
- [ ] Health Conditions - Respiratory Disease
- [ ] Health Conditions - Sensory or Communication Disorders
- [ ] Health Conditions - Sexually Transmitted Infections
- [ ] Health Behaviors - Child and Adolescent Development
- [ ] 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
- [ ] Health Behaviors - Sleep
- [ ] Health Behaviors - Tobacco Use
- [ ] Health Behaviors - Vaccination
- [ ] Health Behaviors - Violence Prevention
- [ ] Populations - Adolescents
- [ ] Populations - Children
- [ ] Populations - Infants
- [ ] Populations – LGBT
- [ ] Populations - Men
- [ ] Populations - Older Adults
- [ ] Populations - Parents or Caregivers
- [ ] Populations - People with Disabilities
- [ ] 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
- [ ] Settings and Systems - Hospital and Emergency Services
- [ ] Settings and Systems - Housing and Homes
- [ ] Settings and Systems - Public Health Infrastructure
- [ ] Settings and Systems - Schools
- [ ] Settings and Systems - Transportation
- [ ] Settings and Systems - Workplace
- [ ] Social Determinants of Health - Economic Stability
- [ ] Social Determinants of Health - Education Access and Quality
- [ ] Social Determinants of Health - Health Care Access and Quality
- [ ] Social Determinants of Health - Neighborhood and Built Environment
- [ ] Social Determinants of Health - Social and Community Context
- [x] Other (specify) Unintentional Injury

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

Suburban Hospital conducted its third CHNA in Fiscal Year 2019 using a three-tiered approach: 1) analysis of available local, state, and national data sets for core health indicators for Montgomery County; 2) assessment of community health via electronic survey to assess the needs and insights of residents living in the Hospital's Community Benefit Service Area (CBSA); and, 3) engaging health experts and stakeholders to advise on the needs assessment. The results of primary and secondary data coupled with Suburban's hospital census and county, state, and national health priorities were reviewed to identify the top health needs for Suburban's community. After conducting a measured prioritization process with stakeholders, the following health priorities emerged for Suburban's 2019 Community Health Needs Assessment: Behavioral Health; Cancer; Cardiovascular Health; Diabetes; Infections; Unintentional Injuries. Throughout FY21, Suburban Hospital has used the CHNA and the implementation strategy to make intentional and strategic decisions to design or expand programming in these areas. We have leveraged our partnerships with local government agencies, non-for-profit agencies, and others to address disparities, monitor and evaluate progress, and report outcomes to internal and external stakeholders. Specifically, we have convened a set of Community Thought Leaders for each health priority. Each Thought Leader group comprises of hospital and community leaders who provide specific input on the identified risks and support collaborative approaches to implementing, tracking, and measuring the objectives of the implementation strategy.

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

Q57. Additional information for CHNA.pdf
5.1MB
application/pdf

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	Freedom from Smoking	Considered America's gold standard smoking cessation program for over 25 years—Freedom from Smoking enables people gain the skills and techniques needed to take control of their behavior and quit smoking.	112 participants took the class in FY21 over Zoom	Track Smoke Free days/Self-Reported
Initiative B	Freedom from Smoking Plus	Help people quit smoking/Reduce Tobacco use in Montgomery County, Freedom From Smoking Plus is an interactive online program available anytime, anywhere on a desktop, laptop tablet or smartphone.	None for FY21	Track Smoke Free days/Self-Reported
Initiative C	Tobacco Cessation counseling	Help people quit smoking/Reduce Tobacco use in Montgomery County; One on one assessment with Health Navigator to learn about support options and discuss next steps.	206 one on one session held over Zoom or by telephone	Track Smoke Free days/Self-Reported
Initiative D	Tobacco Cessation targeted education events	Help people quit smoking/Reduce Tobacco use in Montgomery County	3,429 education events occurred in FY21	Track Smoke Free days/Self-Reported
Initiative E	American Lung Associations's Better Breathers Club	A support group for people living with chronic lung disease such as COPD, asthma, lung cancer, pulmonary fibrosis, and others via education and tools.	90 community members attended Better Breathers Club in FY21, held over Zoom.	Registration/Program Evaluation
Initiative F	Roundtable: African Americans & Colorectal Cancer	Increase awareness/screening for Colorectal Cancer in target population	30 community members attended the live webinar over Zoom, broadcast through Facebook live which had over 2,000 views	Program Evaluation/Referral Forms
Initiative G	Roundtable: Young Adults & Colon Cancer	Increase awareness/screening for Colorectal Cancer in target population	26 community members attended the live webinar over Zoom, shown through FaceBook live which had 262 views	Program Evaluation/Referral Forms
Initiative H	Talk & Walk for Cancers Survivorship	Interactive educational meetings for breast cancer survivors	162 community members attended in FY21 over Zoom	# of participants
Initiative I	Yoga for Cancer Survivors	Gentle yoga movements for cancer survivors	101 community members attended in FY21 over Zoom	# of participants
Initiative J	Prostate Cancer Support Group	Monthly support group that provides an opportunity for patients and their families/significant others to share information and gain support during their treatment and recovery.	145 community members attended in FY21 over Zoom	# of participants
All Other Initiatives	Health Education Seminars including Prostate Cancer Symposium and Annual Living with Breast Cancer Symposium	Increase knowledge and awareness of health topics for participants to make informed decisions about their health and wellness, led by Johns Hopkins and community physicians, health practitioners and partners. - Caring for Your Skin - Treatment Approaches for Pancreatic Cancer - Caring for the Skin You're In	331 community members attended various health education webinars over Zoom in FY21	# of participants; self-assessment of behavior change

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	MobileMed/NIH Endocrine Clinic at Suburban Hospital	The MobileMed/NIH Endocrine clinic at Suburban Hospital seeks to reduce the number of deaths in Montgomery County associated from complications from endocrine diseases including diabetes. An Endocrine clinic is held one night a week at Suburban Hospital where uninsured individuals have access to the specialty care of endocrine conditions and diseases, from diagnostic tests, examinations, and one-on-one consultation with a Suburban Hospital Registered Dietitian, at little or no cost. Suburban aims to achieve this by increasing access to specialty care to uninsured, high-risk Montgomery County safety-net clinic patients and managing associated risk factors with endocrine diseases.	Since July 2010, the clinic has served over 2,500 uninsured patients in need of endocrine specialty care who would have otherwise not been seen. Due to the COVID-19 virus, operations were suspended in FY21 and resumed in FY22.	The clinic measures its success by continued improvement of Hemoglobin A1C among patients with Diabetes.
Initiative B	Pre-Diabetes: Laying the Foundation	Provides education on pre-diabetes. Taught by certified nurse diabetes educators.	50 community members attended in FY21 over Zoom	Program Evaluation given out to the participants at the conclusion of program.

Initiative C	Diabetes A-Z: Self Management	Provides strategies for patients living with diabetes. It covers practical information on nutrition, medication, exercise, self-monitoring, and other topics that can help people living with Diabetes in control. Taught by certified nurse diabetes educators.	40 community members attended in FY21 over Zoom	Program Evaluation given out to the participants at the conclusion of program.
Initiative D	Diabetes Thrive 365	A monthly support and education program for people with Type 2 Diabetes, facilitated by certified nurse diabetes educators.	275 community members attended in FY21 over Zoom	Program Evaluation given out to the participants at the conclusion of program.
Initiative E	JDRF Type 1 Support Group	Provide support for people with T1 Diabetes	99 community members attended in FY21 over Zoom	# of participants
Initiative F	Baltimore Metropolitan Diabetes Regional Partnership	Reduction in hospital admission/emergency visits due to diabetes	Currently in planning phase	Hospital data, Medicare claims
Initiative G	Health Education and Cooking Demonstrations	Increase knowledge and awareness of health topics for participants to make informed decisions about their health and wellness, led by Johns Hopkins physicians, health practitioners and partners. In FY21: Dinner Delights with Chef Mike, participants learned how to prepare healthy meals during the holidays.	10 participants attended over Zoom in FY21.	Program Evaluation given out to the participants at the conclusion of program.
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	Yoga from the Heart class	Gentle yoga flow class which explores the movement following a cardiac event. Designed for participants who are post-cardiac rehabilitation who are seeking to maintain their health. Held twice a week.	Total of 910 participants attended this over Zoom in FY21.	# of participants
Initiative B	Senior Shape Exercise Program	Provide on-going group fitness to improve and maintain balance, muscle strength, flexibility, cardiovascular health and reduce social isolation among adults 55 years and greater.	Montgomery County: 1,110 classes, creating 33,461 encounters; summary qualitative survey results; Prince George's County: 99 classes, creating 897 encounters; summary qualitative survey results	Number of participants; range of motion; strength and flexibility; quality of sleep; quality of life; blood pressure; cholesterol; glucose/HbA1c; body weight; number of falls; number of hospitalizations; number of times accessing the emergency room; number of nights spent in the hospital; level of connection to others; feelings of loneliness; feelings of isolation
Initiative C	Dine, Learn & Move	An interactive program that enforces positive behavior change through increased physical activity and improved nutrition.	10 virtual sessions, creating 427 encounters; Summary qualitative evaluation results	Number of participants; number of completed evaluations; participation in physical activity outside of class; increase of nutrition knowledge; increase of cooking knowledge; engaging in healthy activities outside of program; recommendations to friends.
Initiative D	Cocina, Meuvete & Aprende	Promote health habits by increasing access to physical activity and nutrition education through an interactive program. Program in held in Spanish.	60 community members attended this six week course over Zoom in FY21	Program Evaluation given out to the participants at the conclusion.
Initiative E	Blood pressure screenings	Support hypertension through measurement and counseling of patient to take positive action via increased physical activity, improved nutrition, stress management, sleep hygiene, and/or engaging a medical provider.	2 screenings conducted in Calvert County, reaching 17 individuals	Participant blood pressure readings in context of American Heart Association guidelines; number of patients screened
Initiative F	Health Education Seminars	Increase knowledge and awareness of health topics for participants to make informed decisions about their health and wellness. - Be FAST (for Stroke) - Keeping the Beat - Optimizing Acute Stroke Care - Cholesterol and Your Diet - Boosting Your Immunity Through Food	265 participants; summary qualitative evaluation results	# of participants; self-assessment of behavior change
Initiative G	Women's Health Symposium	Increase knowledge and awareness of cardiovascular health and stress affecting women, for participants to make informed decisions about their health and wellness.	82 participants; summary qualitative evaluation results	# of participants; self-assessment of behavior change
Initiative H	MobileMed/NIH Heart Clinic at Suburban Hospital	The MobileMed/NIH Heart clinic at Suburban Hospital seeks to reduce the number of deaths associated with coronary heart disease in Montgomery County. A Cardiovascular clinic is held one night a week at Suburban Hospital where uninsured individuals have access to cardiac care, diagnostic tests, surgery and rehabilitation when needed, at little or no cost. Suburban aims to achieve this by increasing access to specialty care to uninsured, high-risk Montgomery County safety-net clinic patients and managing associated risk factors with coronary heart disease.	Since October 2007, the MobileMed/NIH Heart Clinic at Suburban Hospital has provided expert care to nearly 4,000 patients to date.	# of participants; biometric changes

Initiative I	Nutrition Counseling	One on one health evaluation and personalized nutrition counseling session with Licensed and Registered Dietitian	110 encounters in FY21	change in weight, BMI
Initiative J				
All Other Initiatives				

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

	Health Conditions - Infectious Disease Details			
	Initiative Name	Initiative Goal/Objective	Initiative Outcomes to Date	Data Used to Measure Outcomes
Initiative A	Knots for Shots: Flu Vaccination Initiative	Provide free yearly flu vaccines to the residents of the Scotland Community in Potomac, MD	27 individuals vaccinated in FY21	Number of residents who received a flu vaccine
Initiative B	COVID-19 community vaccination clinics	Increase number of county residents protected from COVID-19 infection with a specific focus on hard to reach populations	Over 25,000 individuals vaccinated in FY21.	# of residents vaccinated
Initiative C	COVID-19 community testing	Increase number of county residents who know their infection status	15,235 individuals tested	# of residents tested
Initiative D	Health Education Seminars	Increase knowledge and awareness of health topics for participants to make informed decisions about their health and wellness, led by Johns Hopkins physicians, health practitioners and partners. - Reopening: How to Go Out and Feel Safe Against COVID-19 - Boost Your Immunity Through Food - Facebook Live: Conversacion con la communidad: En tiempos de COVID-19 - Vitals on COVID-19 Vaccine - Managing Your Medications	205 of participants attended health education webinars over Zoom in FY21	# of participants; self-assessment of behavior change
Initiative E	Charles E. Smith Symposium	Lessons Learned: Risk and Protective Factors; Our Journey Through the Pandemic	223 of participants attended health education webinars over Zoom in FY21	# of participants;
Initiative F				
Initiative G				
Initiative H				
Initiative I				
Initiative J				
All Other Initiatives				

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	Widowed Person Social Group	A monthly gathering of older adults who have lossed their partner. This is a social club aiming to engage widowers and widows who have lost their partner. The aim is to reduce isolation.	25 participants attended two virtual sessions	# of participants
Initiative B	Critical Topics in Parenting	Foster resiliency in children and provide positive strategies to cope with stress and anxiety	350 participants attended the virtual session	# of participants
Initiative C	Men's Health Symposium	Increase knowledge and awareness of health conditions affecting men for participants to make informed decisions about their health and wellness. FY2021 topic was Brain Gut Connection.	55 participants attended the virtual session	# of participants; self-assessment of behavior change
Initiative D	Village Ambassador Alliance	Promote wellness, independence, healthy aging via expanding communication channels, delivering health education and training, and the effective utilization of community resources.	21 COVID-19 resource newsletters reaching over 100 inboxes per edition	# of newsletters distributed
Initiative E	Charles E Smith Symposium	Provide mental health support for mental health professionals	89 participants	# of participants
Initiative F	Concerned Persons Program	Weekly program for individuals help a loved one coping with substance abuse disorder.	144 participants	# of participants
Initiative G	Health Education Seminars	Increase knowledge and awareness of health topics for participants to make informed decisions about their health and wellness. - Self Care with EveryMind - Critical Topics in Parenting: Supporting the Mental Health of Tween and Teens	385 participants	# of participants; self-assessment of behavior change
Initiative H	Language-specific health education seminars	Increase knowledge and awareness of health topics for participants to make informed decisions about their health and wellness. - Conversacions con lost padres de familia	350 participants; 2.3k views on Facebook Live	# of participants
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.

This question was not displayed to the respondent.

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.

This question was not displayed to the respondent.

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

This question was not displayed to the respondent.

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.

This question was not displayed to the respondent.

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.

This question was not displayed to the respondent.

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.

This question was not displayed to the respondent.

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.

This question was not displayed to the respondent.

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	Safe Sitter/ Safety	A comprehensive training course on the essentials of babysitting designed for 11- to 13-year-olds. Course includes tactics for handling emergencies, basic first aid and child care skills.	23 students earned their Safe Sitter completion card in FY21	Process evaluation given out to students at the end of the program
Initiative B	Health Education Seminars	Provide monthly informational webinars on a health topic for the community led by Johns Hopkins physicians, health practitioners and partners. - Hearing Loss and Older Adults - Stay Firm on Your Feet (fa	130 participants; summary qualitative evaluation results	# of participants; self-assessment of behavior change
Initiative C	Medical Exploring/Safety	Health and Medical career exploration for high school students living in Montgomery County, MD	667 encounters during the academic year	End of year qualitative survey
Initiative D				
Initiative E				
Initiative F				
Initiative G				
Initiative H				
Initiative I				

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 - Infectious Disease, Health Conditions - Mental Health and Mental Disorders, Other (specify)
Other: Unintentional Injury

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.

Here are a few examples of Suburban Hospital's efforts to track and reduce health disparities in the community it serves. Since 2007, the MobileMed/NIH Heart Clinic at Suburban Hospital has provided expert care to nearly 4,000 patients and conducted multiple open-heart surgeries at no charge to the patient. This weekly clinic exists to close the gaps for uninsured and underinsured individuals who are in urgent need of specialty inpatient cardiac care and is in partnership with National Heart, Lung and Blood Institute (NHBLI) and Mobile Medical Care. Referred by Mobile Medical Care safety net clinics in the county, each patient is evaluated by a Suburban Hospital cardiologist and clinical staff from the NHBLI. In addition to coordinating the cardiologists and nurses who volunteer their time and services, Suburban absorbs all costs associated with free specialty cardiovascular diagnostic tests, laboratory services, and medical examinations. The MobileMed/NIH Endocrine clinic at Suburban Hospital seeks to reduce the number of deaths in Montgomery County associated from complications from endocrine diseases including diabetes. Held one night a week at Suburban Hospital where uninsured, high-risk individuals have access to the specialty care of endocrine conditions and diseases, from diagnostic tests, examinations, and one-on-one consultation with a Suburban Hospital Registered Dietitian, at little or no cost. In partnership with Mobile Medical Care and National Institute of Diabetes and Digestive and Kidney Diseases, patients receive consults with an NIH endocrine fellow to review labs, progress, and individual care plans. Like the heart clinic, Suburban Hospital absorbs all costs. Since July 2010, the clinic has served over 2,500 uninsured patients in need of endocrine specialty care who would have otherwise not been seen. Due to the COVID-19 virus, operations were suspended in FY21 and resumed in FY22. The Dine, Learn & Move (DLM) program has run once a month to the residents of Prince George's County since its inception in 2006. The program targets adults, but is open to anyone; youth may attend with an adult. In partnership with Prince George's County Parks and Prince George's County Health Department since its inception. The primary objective of DLM is to improve health outcomes among a population with a higher risk of cardiovascular and chronic disease. It is a multifaceted program that seeks to prevent and manage cardiovascular risks affected by diet and physical activity. While web and print promotions extend widely to county residents, the program attracts participants from approximately a dozen zip codes surrounding the community center. The program has always been free of charge for participants, and registration is not required. This, in addition to time of day and day of week, is intended to reduce as many barriers as possible so that both retired and working adults have opportunities to attend. Anonymous evaluations are completed at the end of each session. Demographic information collected includes zip code of residence, age (range), race, and gender. Analysis of this data identifies that the typical participant lives within 5-10 miles from the center, and is a Black female 50 years and greater. For further information on Suburban Hospital's efforts to track and reduce health disparities in Sothern Maryland, please refer to the Cardiovascular Outreach in Southern Maryland FY21 Report for question 129.

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:

- [x] Regional Partnership Catalyst Grant Program
- [ ] The Medicare Advantage Partnership Grant Program
- [x] The COVID-19 Long-Term Care Partnership Grant
- [x] 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.

Q129. Additional Documentation on Suburban Hospital Community Health Improvement Initiatives and Reports.pdf
11.5MB
application/pdf

Q60. Section III - CB Administration

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

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

- [ ] No

Q246. Please describe the third party audit process used.

This question was not displayed to the respondent.

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 Community Benefit Report (CBR) is a composite of multiple community health improvement reports, each of which is reviewed in detail by Suburban Hospital Executive Leadership, the Community Health Improvement Advisory Council (CHIAC), Marketing, Finance (entity/enterprise level), and the Director of Government and Community Relations as well as a third party auditor. CBR is derived from the Community Health Needs Assessment (CHNA), which is conducted every three years in compliance with IRS Section 501(c) Community Health Needs Assessment for Charitable Hospital Organizations. The most recent CHNA was conducted in FY2019 and formally accepted by the Hospital's Board of Trustees in 2019. For additional detail on this process from which needs and priorities were based on primary and secondary data, stakeholder engagement, please refer to Q57 within this report. The CBR is the result of on-going data collection from Hospital colleagues spanning clinical and operational functions. Through continuous education from the Community Health & Wellness community benefit specialists, department and unit leaders have the necessary tools to collect and report accurate and complete community benefit activities quarterly. This allows for continuous review of data by the specialists for quality control purposes. Additional data collection is obtained directly from the Finance department. Examples include Mission-Driven Health Services, Cash and In-Kind Contributions, and Charity Care. As applicable, components of the CBR are tied directly to the annual audited financial statements of the hospital, such as Net Operating Revenue and Expense, Charity Care, Bad Debt, etc. With regards to the Community Benefit narrative, the information submitted is sourced from the aforementioned approved reports. Examples include the primary service areas, which is derived from the HSCRC; the community benefit service area, which is derived from Hospital data (Inpatient Records, Emergency Department (ED) Visits and Charity Financial Assistance Transactions), the Community Health Needs Assessment and the hospital's strategic plan. An additional layer of oversight includes on-going dialogue with system-level colleagues belonging to the Johns Hopkins Community Health Improving Strategic Council. Once a month, the council meets to strategize the coordination and alignment across system entities regarding the core components of the CBR. Much like the Community Health Needs Assessment, Suburban Hospital Executive Leadership, Marketing, and Finance departments and the Director of Government and Community Relations, review the CBR narrative in detail. The financial review includes a one-on-one meeting with the Hospital's chief financial officer (CFO), which brings a unique perspective intersecting both the community benefit mission's financial-operational and health improvement components. The audit's final stage includes the Hospital's President and CFO's narrative and data collection tool review and sign-off before submission to the HSCRC. The report further vetted through the CHIAC and the Hospital's Board of Trustees. Suburban Hospital's Community Health Needs Assessment is on track to be published in Fiscal Year 2022 and will mirror the process described above.

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.

Suburban Hospital community benefit plan is an integral component of the Hospital's strategic approach to addressing the community health needs. Using a collaborative approach that builds on long-standing internal and external partnerships, Suburban effectively plans for and utilizes resources to address identified health needs. This approach starts at the top; the administrative director of Community Affairs & Population Health in the Community Health and Wellness (CHW) division reports directly to the President of Suburban Hospital, ensuring the two strategies remain linked to leverage resources efficiently while meeting objectives. Our commitment to the strategic plan is ongoing; quarterly, progress is reviewed and reported as part of the hospital's overall operation performance scorecard. With constant communication and consideration of community benefit planning and strategy, we are able to effectively align and support hospital operations and overall system goals, even as they change, as evidenced by the COVID-19 global pandemic. While keeping prioritized health needs and strategies in sight, Suburban Hospital and CHW flexed their strengths and leveraged relationships to meet the population's needs at the greatest disadvantage. A prime example was the deliverable shifting of CHW operations to address ongoing COVID-19 testing and vaccination clinic operations.

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

https://www.hopkinsmedicine.org/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
- [ ] 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.

	Is there a gap resulting in a subsidy?		What type of subsidy?
	Yes	No	
Allergy & Immunology	( )	(•)	
Anesthesiology	(•)	( )	Coverage of emergency department call
Cardiology	(•)	( )	Non-resident house staff and hospitalists
Dermatology	( )	(•)	
Emergency Medicine	(•)	( )	Coverage of emergency department call
Endocrinology, Diabetes & Metabolism	(•)	( )	Non-resident house staff and hospitalists
Family Practice/General Practice	( )	(•)	
Geriatrics	(•)	( )	Non-resident house staff and hospitalists
Internal Medicine	( )	(•)	
Medical Genetics	( )	(•)	
Neurological Surgery	(•)	( )	Non-resident house staff and hospitalists
Neurology	(•)	( )	Non-resident house staff and hospitalists
Obstetrics & Gynecology	(•)	( )	Coverage of emergency department call
Oncology-Cancer	( )	(•)	
Ophthamology	(•)	( )	Coverage of emergency department call
Orthopedics	( )	(•)	
Otololaryngology	( )	(•)	
Pathology	(•)	( )	Non-resident house staff and hospitalists
Pediatrics	(•)	( )	Non-resident house staff and hospitalists
Physical Medicine & Rehabilitation	( )	(•)	
Plastic Surgery	( )	(•)	
Preventive Medicine	( )	(•)	
Psychiatry	(•)	( )	Coverage of emergency department call
Radiology	(•)	( )	Non-resident house staff and hospitalists
Surgery	(•)	( )	Physician provision of financial assistance
Urology	(•)	( )	Coverage of emergency department call
Other. (Describe) Gastroenterology; Stroke; Vascular; Infection	(•)	( )	Coverage of emergency department call

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.

As the only state-designated regional trauma center for Montgomery County and the surrounding Washington DC Metropolitan area, Suburban treats a number of complex cases involving motor vehicle accidents, occupation health accidents, stroke, cardiovascular disease, psychiatric and neurological issues that require an unusually high-volume of specialists to be available 24/7. Approximately over 40,000 Emergency Rooms visits occurred in FY2021. As a result, Suburban Hospital provides subsidies to physicians for trauma on-call services that they would otherwise not provide to the Hospital. Specially trained Physicians from Bethesda Emergency Associates staff are provide around-the-clock treatment and care for treating life-threating conditions and serious illnesses. In FY2021, the Hospital contributed $ $1,407,568 in Trauma On Call Coverage and $$273,704 in Emergency Room Coverage. The Hospital staffs a team of hospitalists and intensivists to provide primary care for patients, working collaboratively alongside specialists and patients' primary care physician. Since the beginning of the pandemic, these hospitalists were integral to the care and treatment of COVID-19 patients in designated units. In addition, the Johns Hopkins Cardiothoracic Surgery Program at Suburban Hospital provides specialty cardiac care with three cardiothoracic surgeons. In total, the Hospital supported $10,032,555 for these hospital-based physicians. Further, on call support through specialties including Cardiology, Vascular, ENT, OB/GYN, Urology, Gastroenterology, Anesthesiology and Ophthalmology are necessary to provide effective and timely treatment to patients who are in critical care when arriving to the hospital. As a designated primary stroke center in Montgomery County, Suburban Hospital has a multidisciplinary stroke team who is on-call 24 hours to treat those who are having a stroke in a timely manner to ensure optimal recovery and life-saving measures. In FY 2021, the Hospital provided $934,321 for Stroke On-Call to support the stroke team in treating critical stroke patients in a timely manner. With rising number of patients entering our Emergency Department who have mental health conditions, the need to provide Behavioral Health On-Call support is necessary. On-call psychiatrists work alongside Suburban Hospital's Crisis Intervention Service (CIS) staff, to evaluate patients who are in crisis. These include alcohol/substance abuse problems. In FY202, the Hospital supported $111,742 for additional care to provide support to our staff. The Hospital recognizes the need for specialty care and offers a diabetes management service for inpatients who are diabetic or at risk of developing diabetes. Directed by Dr. Mihail Zilbermint, Director of Endocrinology, Diabetes, and Metabolism Care at Suburban Hospital, the goal of the service is to improve the care of patients living with diabetes and decrease length of stay. It is also important to note that while Endocrinology, Diabetes, and Metabolism Care and Shaw Family Pediatric Emergency Center (Pediatrics) are two specialty services that the hospital supports, it is not a subsidy that is reimbursed. In addition, Suburban Hospital supports the efforts of community physicians who are willing to provide a sliding scale fee for patients unable to pay for service on an as needed basis. In addition, Suburban Hospital supports partnership efforts between community physicians and organizations such as the Primary Care Coalition, Mary's Center, Mercy Clinic and Catholic Charities of the Archdiocese of Washington.

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

Q140. Section VI - Financial Assistance Policy (FAP)

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

JHM Financial Assistance Policy.pdf
169.3KB
application/pdf

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

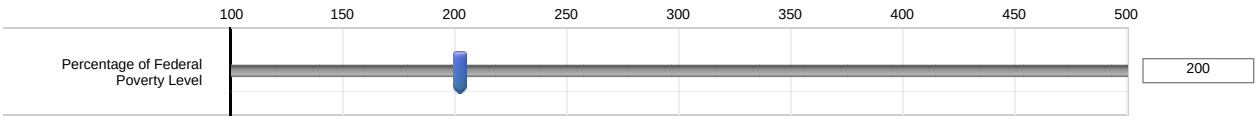
https://www.hopkinsmedicine.org/patient_care/patients-visitors/billing-insurance/financial-assistance.html

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:

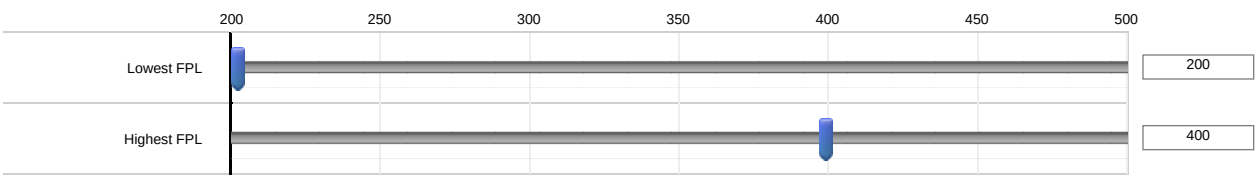
Q143. Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

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



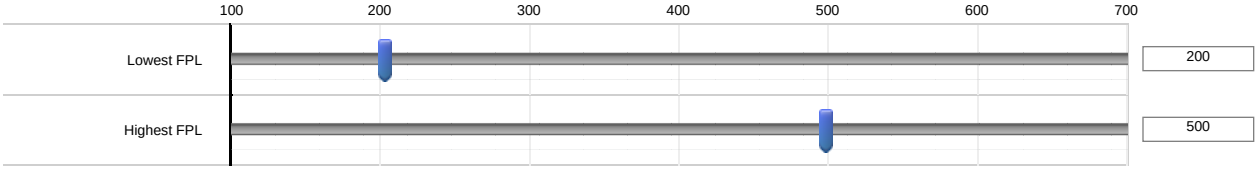
Q144. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

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

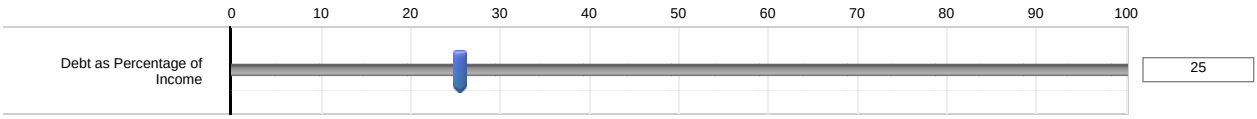


Q145. Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health 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: (39.001495361328, -77.096099853516)

Source: GeoIP Estimation

Community Benefit Report
Suburban Hospital

Primary Service Area

Prepared by:

JHM Planning and Market Analysis
October 25, 2021

This information was developed exclusively for planning and quality improvement purposes and shall not be used, directly or indirectly, to determine physician compensation, or any other monetary or non-monetary benefit to a physician or physician owned entity. Additionally, any information related to past or anticipated referrals may not be used to determine a physician's/physician group's participation in a shared savings, gain sharing, or other program, including, but not limited to the provision of Electronic Health Records items or services. If you have any questions please contact the JHHS Legal Department.

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Suburban Hospital
Primary Service Area
FY 2020 Q2-Q4, FY 2021 Q1
Source: HSCRC, IBM Watson Health
Includes Newborns

Zip Code	Zip City	Suburban Discharges	Suburban Market Share	All Hospital Discharges	Suburban Discharges from Zip Code as a % of all Suburban Discharges***
20015	Washington	78	7.1%	1,105	0.7%
20016	Washington	85	4.3%	1,976	0.8%
20814	Bethesda	842	43.0%	1,960	7.4%
20815	Chevy Chase	544	29.7%	1,831	4.8%
20816	Bethesda	161	18.4%	873	1.4%
20817	Bethesda	812	39.7%	2,047	7.2%
20850	Rockville	459	12.9%	3,546	4.1%
20851	Rockville	172	16.0%	1,077	1.5%
20852	Rockville	1,206	36.5%	3,302	10.7%
20853	Rockville	193	9.1%	2,116	1.7%
20854	Potomac	900	32.8%	2,745	8.0%
20874	Germantown	164	3.8%	4,310	1.4%
20877	Gaithersburg	163	5.1%	3,211	1.4%
20878	Gaithersburg	223	6.2%	3,614	2.0%
20879	Gaithersburg	83	4.4%	1,880	0.7%
20886	Montgomery Village	122	4.6%	2,670	1.1%
20895	Kensington	394	28.7%	1,372	3.5%
20901	Silver Spring	145	5.4%	2,708	1.3%
20902	Silver Spring	426	10.6%	4,009	3.8%
20904	Silver Spring	193	4.0%	4,885	1.7%
20906	Silver Spring	493	7.9%	6,262	4.4%
20910	Silver Spring	349	11.3%	3,084	3.1%
Total		**8,207**	**13.5%**	**60,583**	**72.5%**

*Includes Maryland, DC, Pennsylvania, and Northern VA Hospitals (Source: HSCRC and IBM Watson Health)
**PA data for FY2020Q4 is estimated based on FY2019Q4. FY2021Q1 is estimated based on FY2020Q1
***Suburban had 11,320 discharges between FY 2020 Q2 and FY 21 Q1

Suburban Hospital
Primary Service Area

2021 Insurance Coverage Estimates by Zip Code and Payor Type
Area: Suburban Hospital PSA

Insurance Coverage Estimates								
Zip Code	**Zip City**	**Commercial**	**Medicaid**	**Medicare**	**Other Insured**	**Uninsured**	**Veterans**	**Total Households**
20015	Washington	5,060	379	2,390	240	145	197	**8,411**
20016	Washington	11,737	917	4,051	382	379	391	**17,857**
20814	Bethesda	10,650	675	3,710	420	434	460	**16,349**
20815	Chevy Chase	9,203	680	4,206	494	277	371	**15,231**
20816	Bethesda	4,353	227	2,306	272	114	190	**7,462**
20817	Bethesda	8,891	437	4,854	586	213	405	**15,386**
20850	Rockville	15,307	1,082	5,203	603	742	719	**23,656**
20851	Rockville	3,425	291	1,045	109	182	182	**5,234**
20852	Rockville	15,548	1,453	5,352	576	948	756	**24,633**
20853	Rockville	6,435	410	3,003	356	225	319	**10,748**
20854	Potomac	11,047	525	6,719	817	238	532	**19,878**
20874	Germantown	16,836	1,583	4,183	517	1,136	863	**25,118**
20876	Germantown	6,270	598	1,424	174	456	301	**9,223**
20877	Gaithersburg	8,283	1,176	2,786	278	824	510	**13,857**
20878	Gaithersburg	17,264	1,257	5,664	654	823	772	**26,434**
20879	Gaithersburg	6,674	562	1,992	236	402	347	**10,213**
20886	Montgomery Village	8,371	964	2,546	288	664	475	**13,308**
20895	Kensington	5,287	302	2,171	260	157	228	**8,405**
20901	Silver Spring	9,490	993	2,852	289	490	411	**14,525**
20902	Silver Spring	12,290	1,403	4,056	421	840	631	**19,641**
20904	Silver Spring	13,573	1,818	5,921	608	1,036	814	**23,770**
20906	Silver Spring	15,569	1,964	8,247	821	1,140	998	**28,739**
20910	Silver Spring	14,632	2,148	4,265	381	825	538	**22,789**
Total Households		**236,195**	**21,844**	**88,946**	**9,782**	**12,690**	**11,410**	**380,867**

Source: Sg2 Insurance Coverage Estimates

2021 Demographic Snapshots Area:
Suburban Hospital PSA

DEMOGRAPHIC CHARACTERISTICS

			2021	2026	Population Change	% Change
2021 Total Population	879,988	Male Population	422,428	435,536	13,108	3.1%
2026 Total Population	905,994	Female Population	457,560	470,458	12,898	2.8%
Population Change	26,006					
% Change 2021 - 2026	3.0%					

Age Distribution

	Distribution	
Age Group	Population 2021	% of Total
0-4	53,930	5.9%
5-9	54,982	6.0%
10-14	56,193	6.2%
15-17	33,462	3.7%
18-19	22,157	2.4%
20	10,286	1.1%
21	10,038	1.1%
22-24	30,088	3.3%
25-29	50,091	5.5%
30-34	56,484	6.2%
35-39	61,256	6.7%
40-44	60,229	6.6%
45-49	58,703	6.4%
50-54	58,682	6.4%
55-59	57,523	6.3%
60-61	22,893	2.5%
62-64	31,391	3.4%
65-66	20,143	2.2%
67-69	27,144	3.0%
70-74	37,435	4.1%
75-79	26,534	2.9%
80-84	17,899	2.0%
85-Up	22,445	2.5%
Total	879,988	100.0%

Education Level Distribution

2021 Adult Education Level	Pop Age 25+ 2021	
No Schooling Completed	9,647	1.6%
Nursery - 4th Grade	5,761	0.9%
5th - 6th Grade	7,514	1.2%
7th - 8th Grade	5,104	0.8%
9th Grade	5,081	0.8%
10th Grade	3,995	0.7%
11th Grade	4,050	0.7%
12th Grade - No Diploma	9,676	1.6%
High School Graduate	76,791	12.6%
Some College <1 Year	19,897	3.3%
Some College >1 Year No Degree	57,633	9.5%
Associates Degree	31,014	5.1%
Professional Degree	47,527	7.8%
Bachelors Degree	163,146	26.8%
Masters Degree	121,644	20.0%
Doctorate Degree	40,380	6.6%
Total	608,860	100.0%
Total	628,400	100.0%

Household Income Distribution

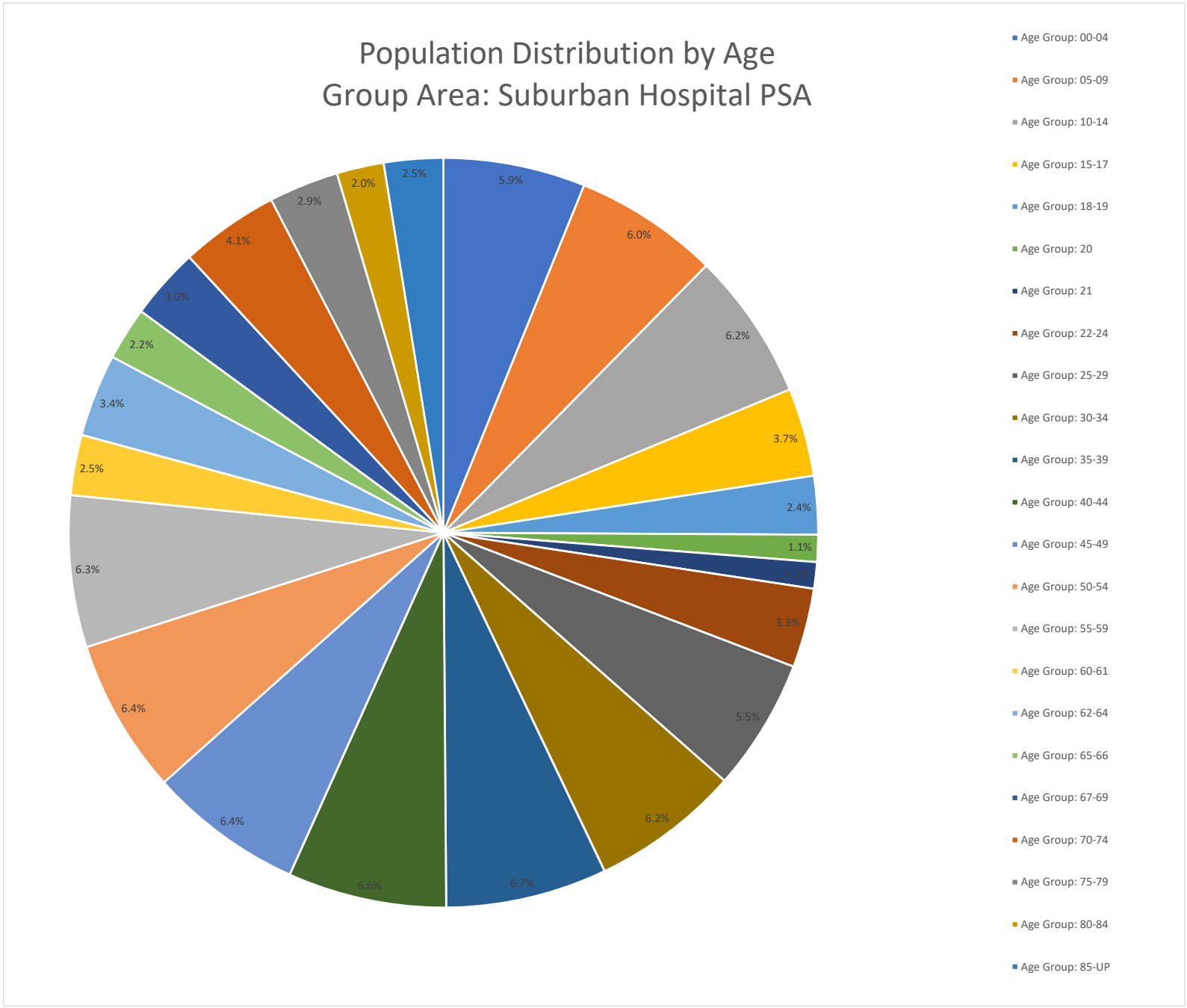
	Income Distribution	
2021 Household Income	Households	% of Total
< $10,000	12,188	3.7%
$10,000 - $14,999	6,553	2.0%
$15,000 - $19,999	5,970	1.8%
$20,000 - $24,999	6,415	1.9%
$25,000 - $29,999	6,937	2.1%
$30,000 - $34,999	7,388	2.2%
$35,000 - $39,999	7,490	2.2%
$40,000 - $44,999	7,488	2.2%
$45,000 - $49,999	7,606	2.3%
$50,000 - $59,999	15,005	4.5%
$60,000 - $74,999	23,850	7.2%
$75,000 - $99,999	38,822	11.6%
$100,000 - $124,999	34,923	10.5%
$125,000 - $149,999	28,406	8.5%
$150,000 - $199,999	39,155	11.7%
$200,000+	85,109	25.5%
Total	333,305	100.0%

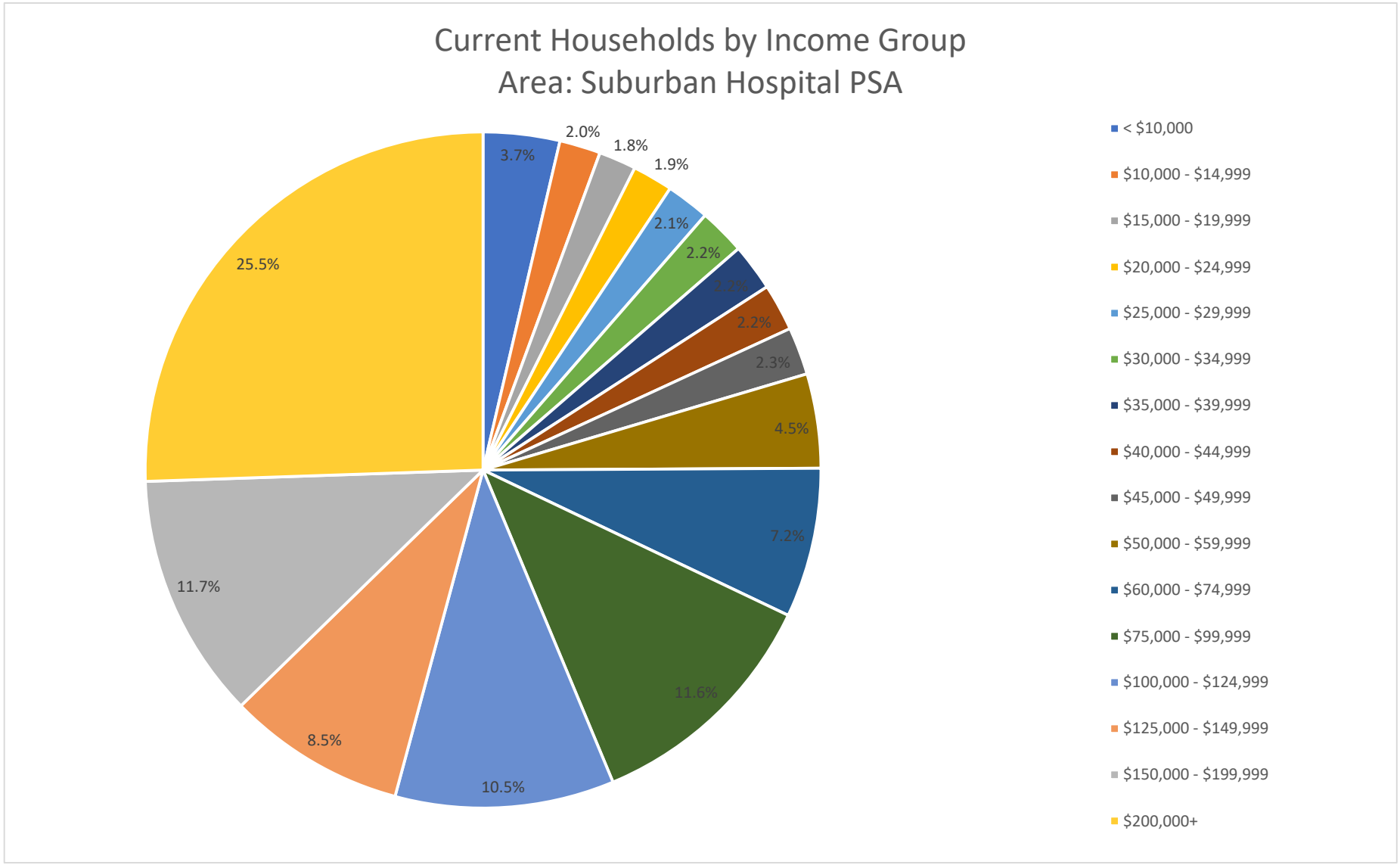
Race/Ethnicity Distribution

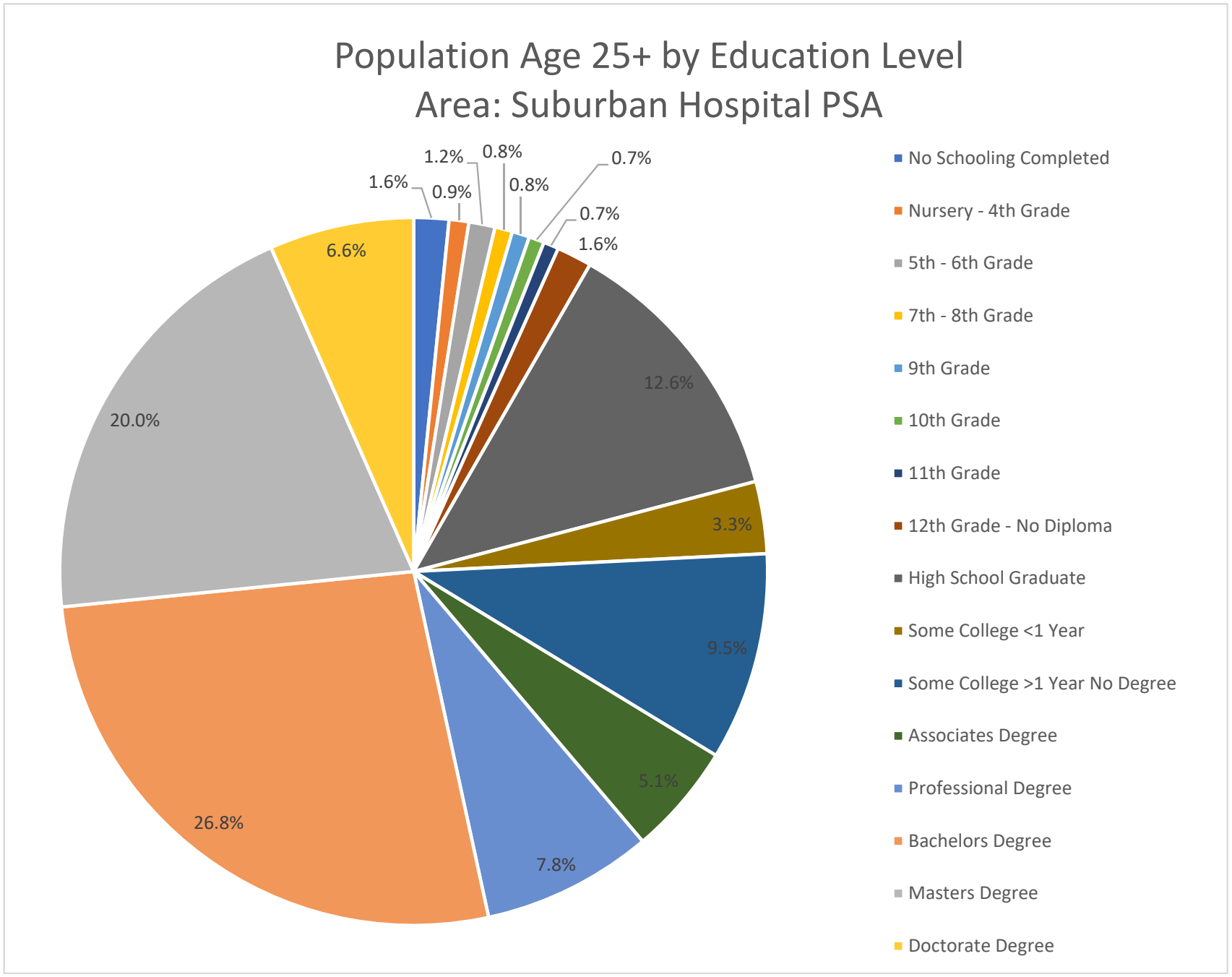
Race	Race Distribution	
	2021 Population	% of Total
American Indian / Alaska Native	3,675	0.4%
Asian	129,424	14.7%
Black / African American	158,824	18.0%
Multiple Races	40,624	4.6%
Native Hawaiian Islander / Pacific Islander	465	0.1%
Other	74,022	8.4%
White	472,954	53.7%
Total	879,988	100.0%

	Ethnicity Distribution	
Ethnicity	2021 Population	% of Total
Hispanic (Any Race)	184,937	21.0%
Non-Hispanic (Any Race)	695,051	79.0%
Total	879,988	100.0%

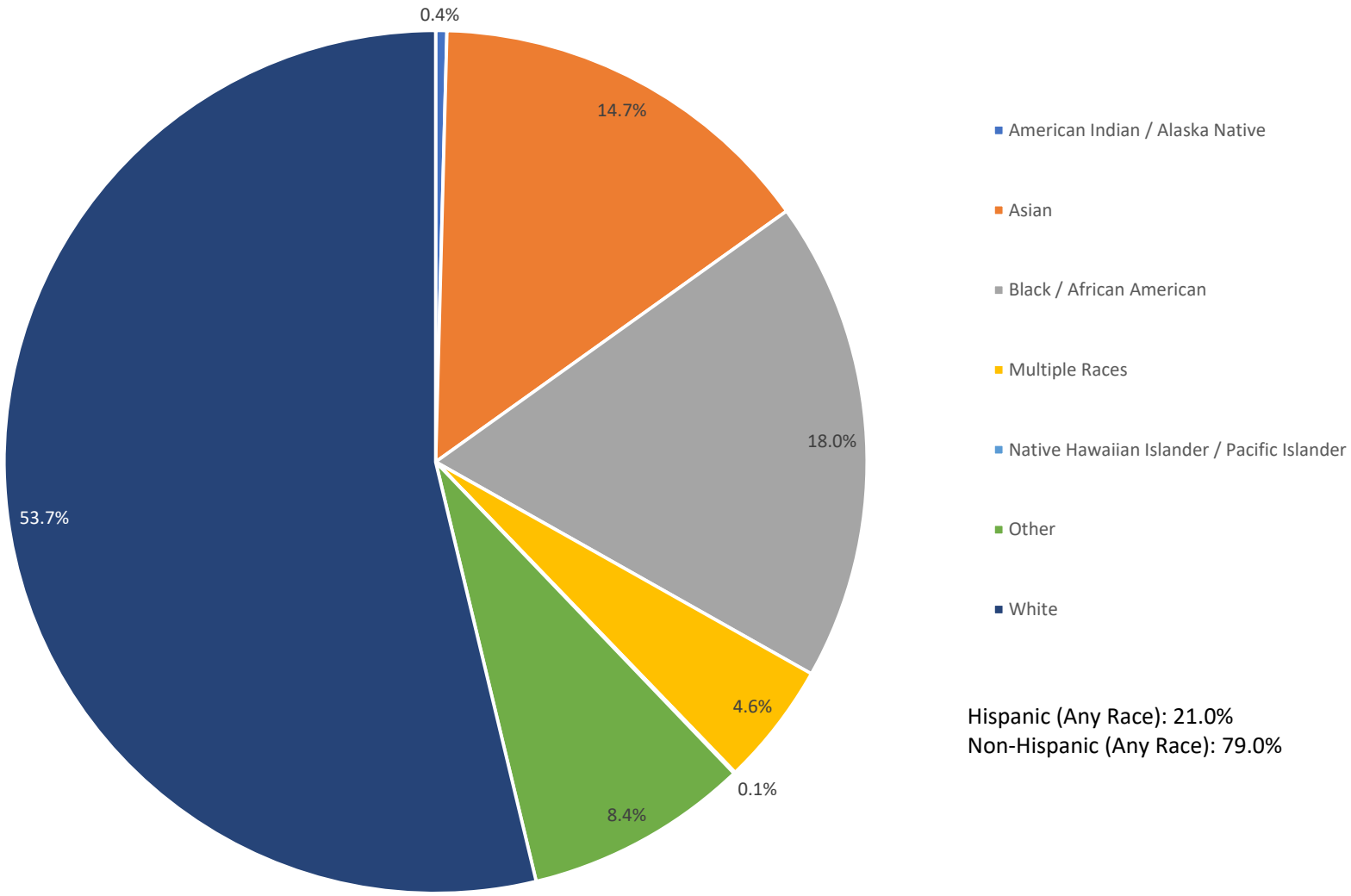
Source: Sg2 Market Demographics Tool


Population Distribution by Age Group Area: Suburban Hospital PSA
5.9%
6.0%
6.2%
3.7%
2.4%
1.1%
3.3%
5.5%
6.2%
6.7%
6.6%
6.4%
6.4%
6.3%
2.5%
3.4%
2.2%
3.0%
4.1%
2.9%
2.0%
2.5%
Age Group: 00-04
Age Group: 05-09
Age Group: 10-14
Age Group: 15-17
Age Group: 18-19
Age Group: 20
Age Group: 21
Age Group: 22-24
Age Group: 25-29
Age Group: 30-34
Age Group: 35-39
Age Group: 40-44
Age Group: 45-49
Age Group: 50-54
Age Group: 55-59
Age Group: 60-61
Age Group: 62-64
Age Group: 65-66
Age Group: 67-69
Age Group: 70-74
Age Group: 75-79
Age Group: 80-84
Age Group: 85-UP


Current Households by Income Group
Area: Suburban Hospital PSA
3.7%
2.0%
1.8%
1.9%
2.1%
2.2%
2.2%
2.2%
2.3%
4.5%
7.2%
11.6%
10.5%
8.5%
11.7%
25.5%
< $10,000
$10,000 - $14,999
$15,000 - $19,999
$20,000 - $24,999
$25,000 - $29,999
$30,000 - $34,999
$35,000 - $39,999
$40,000 - $44,999
$45,000 - $49,999
$50,000 - $59,999
$60,000 - $74,999
$75,000 - $99,999
$100,000 - $124,999
$125,000 - $149,999
$150,000 - $199,999
$200,000+


Population Age 25+ by Education Level
Area: Suburban Hospital PSA
1.6%
1.2%
0.9%
0.8%
0.8%
0.7%
0.7%
1.6%
6.6%
12.6%
20.0%
3.3%
9.5%
5.1%
26.8%
7.8%
No Schooling Completed
Nursery - 4th Grade
5th - 6th Grade
7th - 8th Grade
9th Grade
10th Grade
11th Grade
12th Grade - No Diploma
High School Graduate
Some College <1 Year
Some College >1 Year No Degree
Associates Degree
Professional Degree
Bachelors Degree
Masters Degree
Doctorate Degree

Population Distribution by Race and Ethnicity
Area: Suburban Hospital PSA



Hispanic (Any Race): 21.0%
Non-Hispanic (Any Race): 79.0%

Community Benefit Report
Suburban Hospital

Community Benefit Service Area

Prepared by:

JHM Planning and Market Analysis
October 25, 2021

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Suburban Hospital
Community Benefit Service Area
FY 2020 Q2-Q4, FY 2021 Q1
Source: HSCRC, IBM Watson Health
Includes Newborns

Zip Code	Zip City	Suburban Discharges	Suburban Market Share	All Hospital Discharges	Suburban Discharges from Zip Code as a % of all Suburban Discharges***
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20850	Rockville	459	12.9%	3,546	4.1%
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20852	Rockville	1,206	36.5%	3,302	10.7%
20853	Rockville	193	9.1%	2,116	1.7%
20854	Potomac	900	32.8%	2,745	8.0%
20895	Kensington	394	28.7%	1,372	3.5%
20902	Silver Spring	426	10.6%	4,009	3.8%
20904	Silver Spring	193	4.0%	4,885	1.7%
20906	Silver Spring	493	7.9%	6,262	4.4%
20910	Silver Spring	349	11.3%	3,084	3.1%
Total		**7,144**	**18.3%**	**39,109**	63.1%

*Includes Maryland, DC, Pennsylvania, and Northern VA Hospitals (Source: HSCRC and IBM Watson Health)
**PA data for FY2020Q4 is estimated based on FY2019Q4. FY2021Q1 is estimated based on FY2020Q1
***Suburban had 11,320 discharges between FY 2020 Q2 and FY 21 Q1

Suburban Hospital
Community Benefit Service Area

2021 Insurance Coverage Estimates by Zip Code and Payor Type
Area: Suburban Hospital CBSA

Insurance Coverage Estimates								
Zip Code	**Zip City**	**Commercial**	**Medicaid**	**Medicare**	**Other Insured**	**Uninsured**	**Veterans**	**Total Households**
20814	Bethesda	10,650	675	3,710	420	434	460	**16,349**
20815	Chevy Chase	9,203	680	4,206	494	277	371	**15,231**
20816	Bethesda	4,353	227	2,306	272	114	190	**7,462**
20817	Bethesda	8,891	437	4,854	586	213	405	**15,386**
20850	Rockville	15,307	1,082	5,203	603	742	719	**23,656**
20851	Rockville	3,425	291	1,045	109	182	182	**5,234**
20852	Rockville	15,548	1,453	5,352	576	948	756	**24,633**
20853	Rockville	6,435	410	3,003	356	225	319	**10,748**
20854	Potomac	11,047	525	6,719	817	238	532	**19,878**
20895	Kensington	5,287	302	2,171	260	157	228	**8,405**
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20904	Silver Spring	13,573	1,818	5,921	608	1,036	814	**23,770**
20906	Silver Spring	15,569	1,964	8,247	821	1,140	998	**28,739**
20910	Silver Spring	14,632	2,148	4,265	381	825	538	**22,789**
Total Households		**146,210**	**13,415**	**61,058**	**6,724**	**7,371**	**7,143**	**241,921**

Source: Sg2 Insurance Coverage Estimates

2021 Demographic Snapshots
Area: Suburban Hospital CBSA

DEMOGRAPHIC CHARACTERISTICS

	Selected Area
2021 Total Population	557,660
2026 Total Population	572,397
Population Change	14,737
% Change 2021 - 2026	2.60%

	2021	2026	Population Change	% Change
Total Male Population	266,889	274,456	7,567	2.80%
Total Female Population	290,771	290,771	7,170	2.50%

Age Distribution

	Distribution	
Age Group	Population 2021	% of Total
0-4	31,930	5.7%
5-9	32,980	5.9%
10-14	34,290	6.1%
15-17	20,917	3.8%
18-19	12,852	2.3%
20	6,226	1.1%
21	6,178	1.1%
22-24	18,752	3.4%
25-29	31,864	5.7%
30-34	34,682	6.2%
35-39	37,543	6.7%
40-44	36,758	6.6%
45-49	36,529	6.6%
50-54	36,853	6.6%
55-59	36,942	6.6%
60-61	14,884	2.7%
62-64	20,373	3.7%
65-66	13,376	2.4%
67-69	17,964	3.2%
70-74	25,537	4.6%
75-79	19,125	3.4%
80-84	13,689	2.5%
85-Up	17,416	3.1%
Total	557,660	100.0%

Education Level Distribution

	Education Level Distribution	
2021 Adult Education Level	Pop Age 25+ 2021	% of Total
No Schooling Completed	6,277	1.6%
Nursery - 4th Grade	3,254	0.8%
5th - 6th Grade	4,563	1.2%
7th - 8th Grade	3,192	0.8%
9th Grade	3,043	0.8%
10th Grade	2,462	0.6%
11th Grade	2,497	0.6%
12th Grade - No Diploma	5,657	1.4%
High School Graduate	47,358	12.0%
Some College <1 Year	12,202	3.1%
Some College >1 Year No Degree	36,060	9.2%
Associates Degree	18,298	4.6%
Professional Degree	35,674	9.1%
Bachelors Degree	105,729	26.9%
Masters Degree	79,705	20.3%
Doctorate Degree	27,572	7.0%
Total	393,543	100.0%

Household Income Distribution

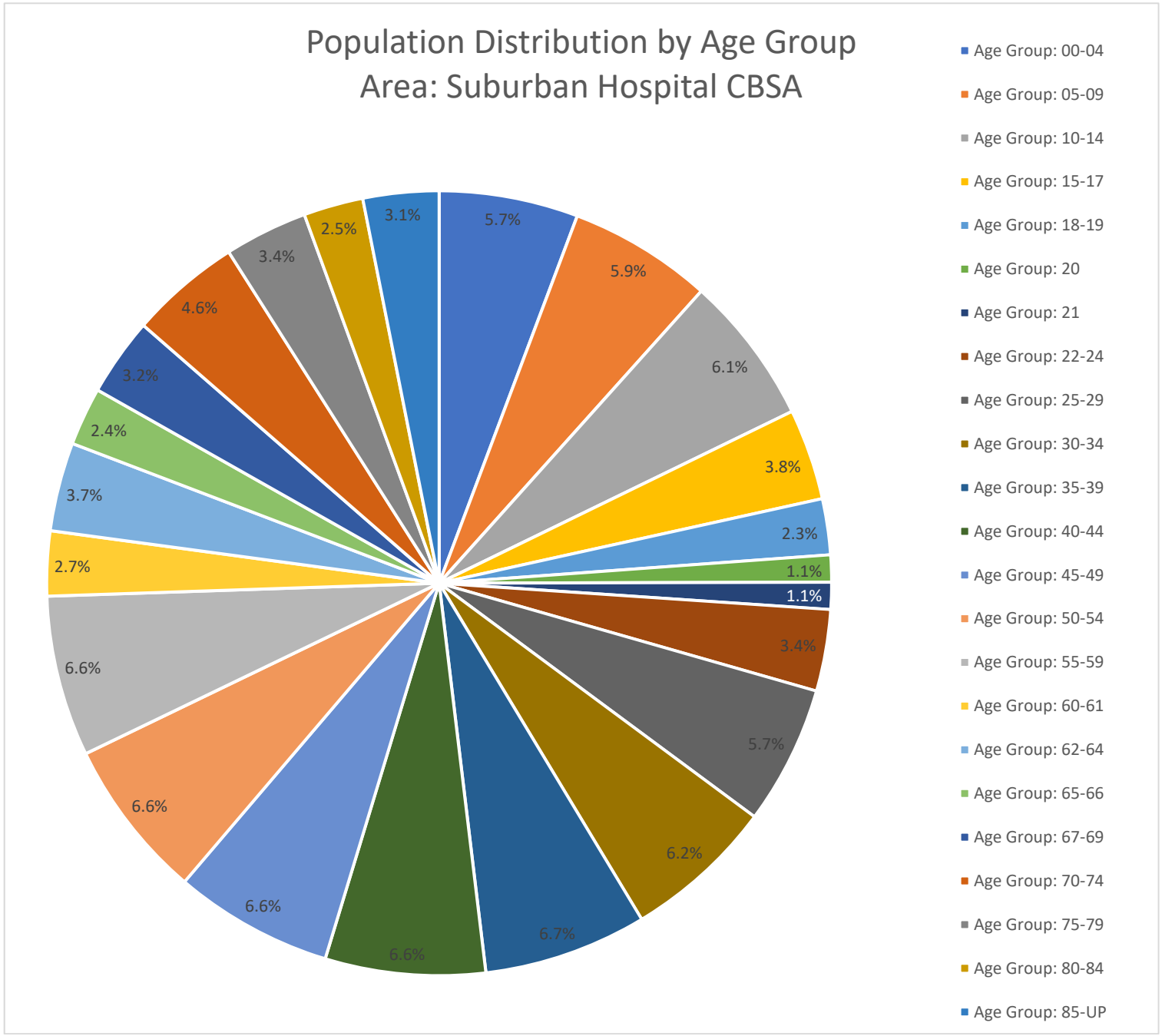
	Income Distribution	
2021 Household Income	Households	% of Total
< $10,000	7,398	3.4%
$10,000 - $14,999	4,317	2.0%
$15,000 - $19,999	3,998	1.9%
$20,000 - $24,999	4,212	2.0%
$25,000 - $29,999	4,283	2.0%
$30,000 - $34,999	4,572	2.1%
$35,000 - $39,999	4,636	2.1%
$40,000 - $44,999	4,716	2.2%
$45,000 - $49,999	4,824	2.2%
$50,000 - $59,999	9,515	4.4%
$60,000 - $74,999	14,797	6.9%
$75,000 - $99,999	24,405	11.3%
$100,000 - $124,999	22,076	10.2%
$125,000 - $149,999	18,208	8.4%
$150,000 - $199,999	25,303	11.7%
$200,000+	58,461	27.1%
Total	215,721	100.0%

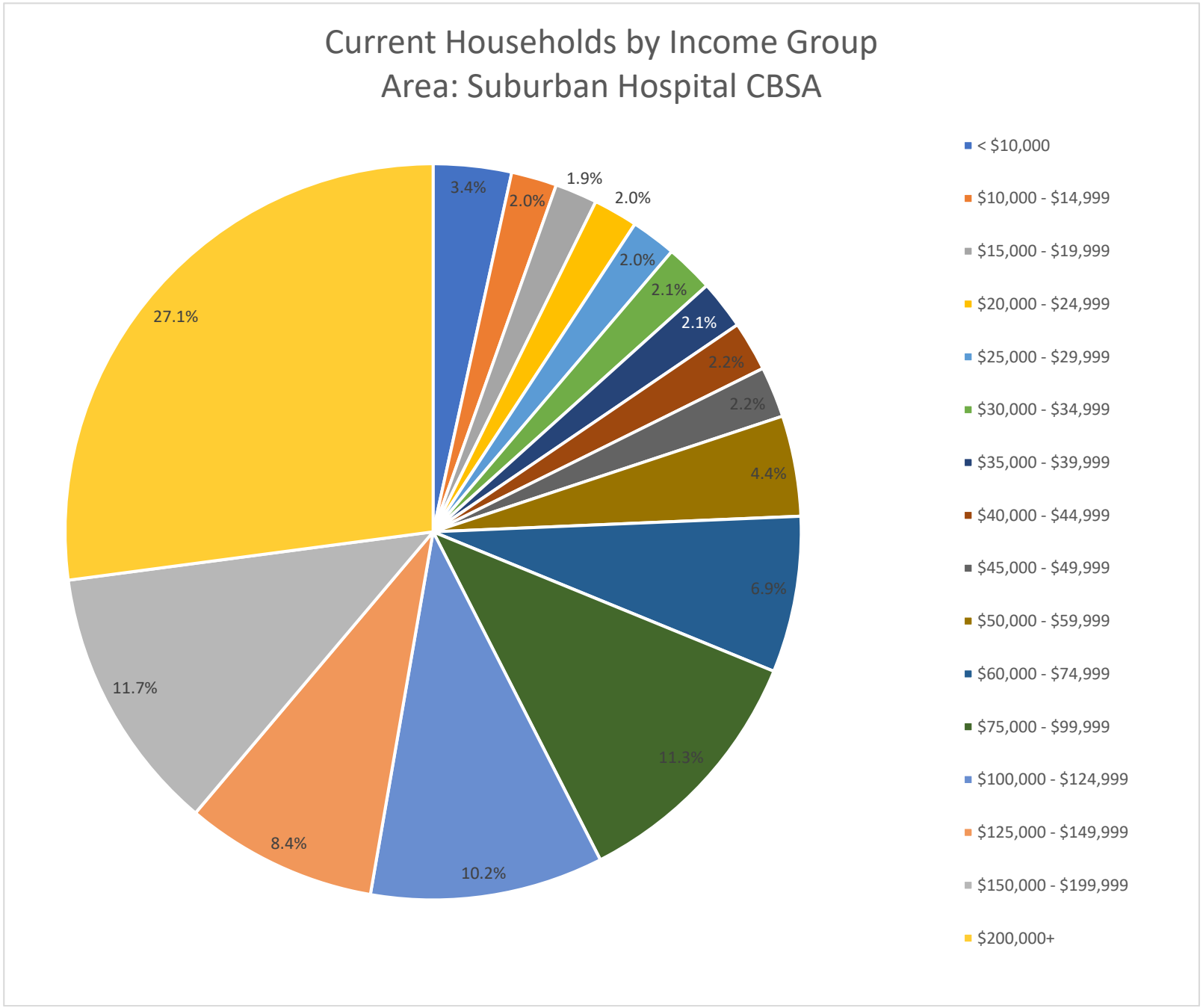
Race/Ethnicity

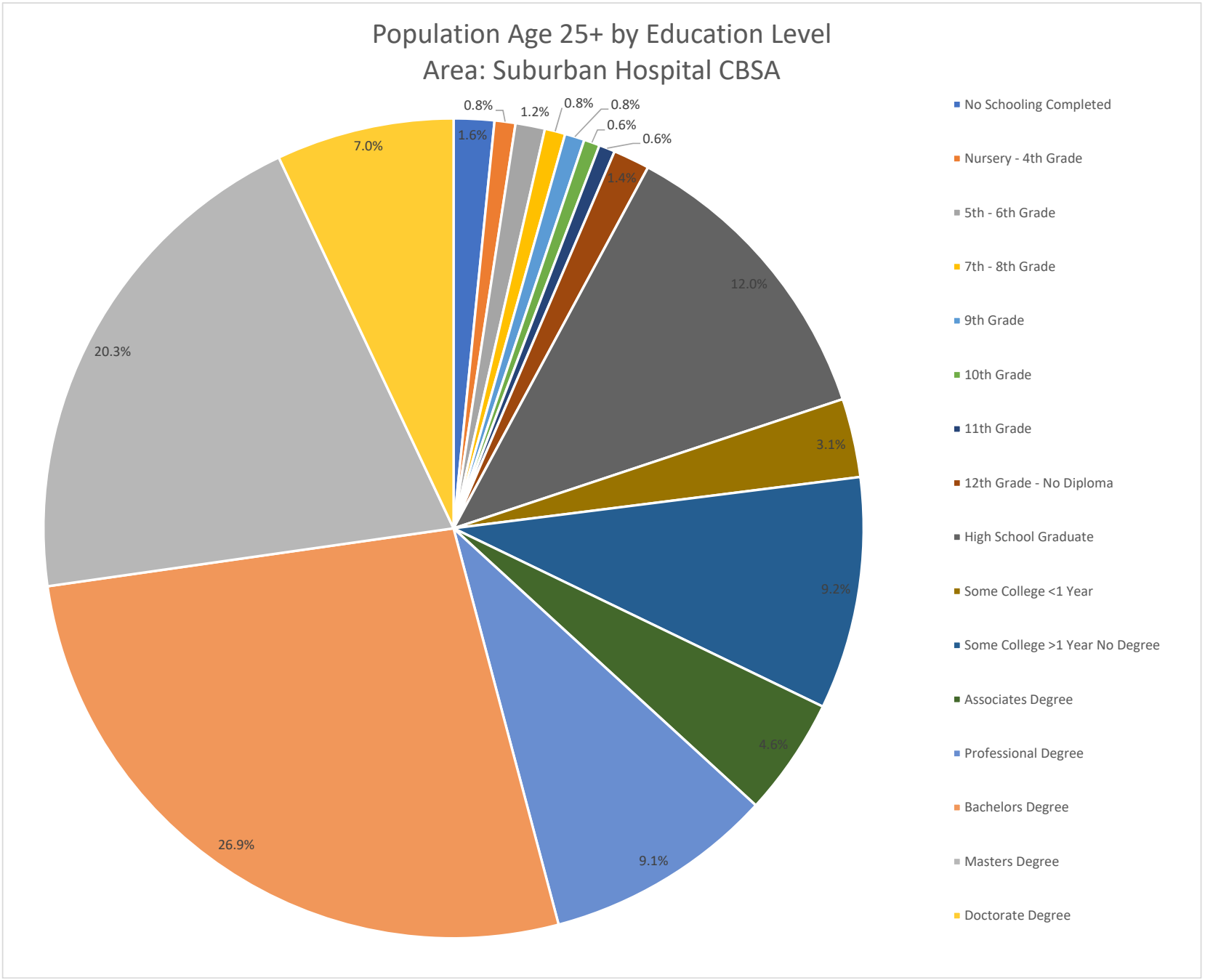
Race	Race Distribution	
	2021 Population	% of Total
American Indian / Alaska Native	2,207	0.4%
Asian	80,738	14.5%
Black / African American	95,892	17.2%
Multiple Races	24,749	4.4%
Native Hawaiian Islander / Pacific Is	304	0.1%
Other	43,375	7.8%
White	310,395	55.7%
Total	557,660	100.0%

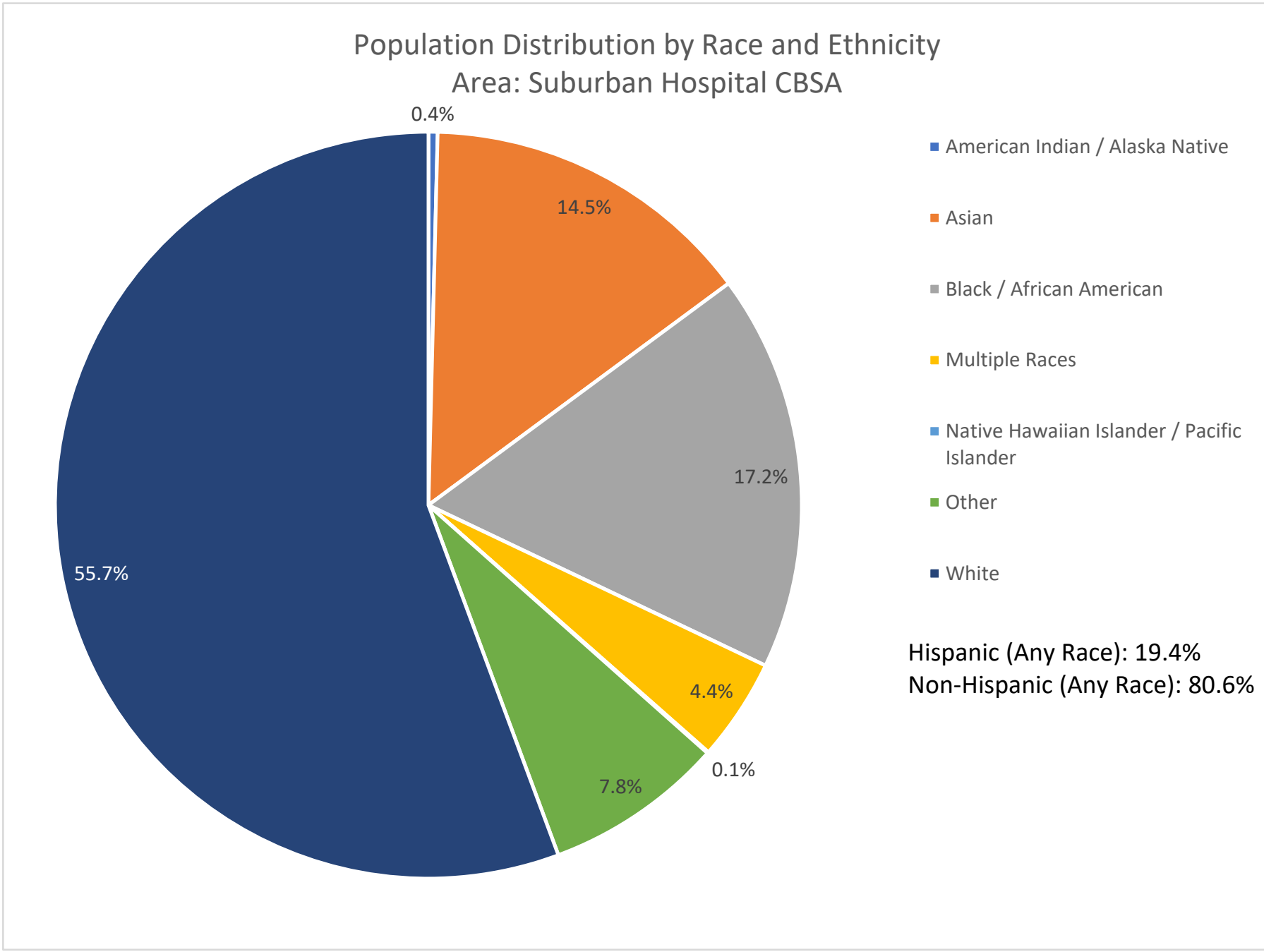
	Ethnicity Distribution	
Ethnicity	2021 Population	% of Total
Hispanic (Any Race)	108,108	19.4%
Non-Hispanic (Any Race)	449,552	80.6%
Total	557,660	100.0%

Source: Sg2 Market Demographics Tool


Population Distribution by Age Group
Area: Suburban Hospital CBSA
5.7%
5.9%
6.1%
3.8%
2.3%
1.1%
1.1%
3.4%
5.7%
6.2%
6.7%
6.6%
6.6%
6.6%
6.6%
2.7%
3.7%
2.4%
3.2%
4.6%
3.4%
2.5%
3.1%
Age Group: 00-04
Age Group: 05-09
Age Group: 10-14
Age Group: 15-17
Age Group: 18-19
Age Group: 20
Age Group: 21
Age Group: 22-24
Age Group: 25-29
Age Group: 30-34
Age Group: 35-39
Age Group: 40-44
Age Group: 45-49
Age Group: 50-54
Age Group: 55-59
Age Group: 60-61
Age Group: 62-64
Age Group: 65-66
Age Group: 67-69
Age Group: 70-74
Age Group: 75-79
Age Group: 80-84
Age Group: 85-UP


Current Households by Income Group
Area: Suburban Hospital CBSA
3.4%
2.0%
1.9%
2.0%
2.0%
2.1%
2.1%
2.2%
2.2%
4.4%
6.9%
11.3%
10.2%
8.4%
11.7%
27.1%
< $10,000
$10,000 - $14,999
$15,000 - $19,999
$20,000 - $24,999
$25,000 - $29,999
$30,000 - $34,999
$35,000 - $39,999
$40,000 - $44,999
$45,000 - $49,999
$50,000 - $59,999
$60,000 - $74,999
$75,000 - $99,999
$100,000 - $124,999
$125,000 - $149,999
$150,000 - $199,999
$200,000+


Population Age 25+ by Education Level
Area: Suburban Hospital CBSA
1.6%
0.8%
1.2%
0.8%
0.8%
0.6%
0.6%
1.4%
12.0%
3.1%
9.2%
4.6%
9.1%
26.9%
20.3%
7.0%
No Schooling Completed
Nursery - 4th Grade
5th - 6th Grade
7th - 8th Grade
9th Grade
10th Grade
11th Grade
12th Grade - No Diploma
High School Graduate
Some College <1 Year
Some College >1 Year No Degree
Associates Degree
Professional Degree
Bachelors Degree
Masters Degree
Doctorate Degree


Population Distribution by Race and Ethnicity
Area: Suburban Hospital CBSA
0.4%
14.5%
17.2%
4.4%
0.1%
7.8%
55.7%
American Indian / Alaska Native
Asian
Black / African American
Multiple Races
Native Hawaiian Islander / Pacific Islander
Other
White
Hispanic (Any Race): 19.4%
Non-Hispanic (Any Race): 80.6%

Community Health Needs Assesmenmt Report

2019

SUBURBAN HOSPITAL

COMMUNITY HEALTH NEEDS ASSESSMENT

2019

SUBURBAN HOSPITAL

JOHNS HOPKINS MEDICINE

Suburban Hospital
Community Health Needs Assessment
2019

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1 ACKNOWLEDGMENTS

Suburban Hospital's 2019 Community Health Needs Assessments (CHNA) was directed by the Community Health & Wellness department and built upon the county-wide health improvement process initiated by Healthy Montgomery, the county's Community Health Improvement Program.

We want to thank our colleagues from Community Health & Wellness, who provided insight and expertise that greatly assisted the development of the assessment:

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We would like to thank the members of Suburban's Community Health Improvement Advisory Committee, Community Health Needs Assessment Ad Hoc Committee, and Johns Hopkins Community Benefits Advisory Council.

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Judith Macon, RN, MA
Reviewer

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Reviewer

John McInerney
Reviewer

We would also like to acknowledge the following organizations for contributing to the development of this assessment:

- Healthy Montgomery
- BroadStreet

2 INTRODUCTION

A. OVERVIEW OF SUBURBAN HOSPITAL

Suburban Hospital is a community-based, not-for-profit hospital serving Montgomery County and the surrounding area since 1943. The hospital provides all major services except obstetrics. The hospital is one of nine regional trauma centers in Maryland and the state-designated level II trauma center for Montgomery County, with a fully equipped and elevated helipad. Suburban Hospital's Emergency/Shock Trauma Center treats more than 40,000 patients a year.

The hospital's primary services include:

- A comprehensive cancer center accredited by the American College of Surgeons Commission on Cancer
- Cardiac surgery, including elective and emergency angioplasty, as well as inpatient diagnostic and rehabilitation services
- Orthopedics with joint replacement and physical rehabilitation
- Behavioral services, including crisis intervention
- Neurosciences, including a designated Primary Stroke Center and a 24/7 stroke team
- Senior Services, such as the Nurses Improving Care for Healthsystem Elders (NICHE) designation from The Hartford Institute for Geriatric Nursing at New York University College of Nursing

Other services include the NIH-Suburban MRI Center; state-of-the-art diagnostic pathology and radiology departments; outpatient Addiction Treatment Center offering programs for adolescents and adults; prevention and wellness programs; free physician referral service (Suburban On-Call); and the Certified Total Joint Replacement Program by The Joint Commission.

During fiscal year 2018, Suburban Hospital was licensed to operate 233 beds with 14,156 inpatient admissions and 46, 080 emergency department visits. A 25-member volunteer Board of Trustees governs Suburban Hospital. See **Appendix A** for Suburban Hospital Board of Trustees 2018-2019.

B. WHY A COMMUNITY HEALTH NEEDS ASSESSMENT?

Under Section 501(c) (3) of the Internal Revenue Code, nonprofit hospitals may qualify for tax-exempt status if they meet specific federal requirements. The 2010 Patient Protection and Affordable Care Act (ACA) added four basic requirements to the Code. One of the additional requirements for tax-exempt status is the provision of a CHNA every three years and an implementation strategy to meet the identified health needs [1].

The purpose of a community health needs assessment is to identify the most important health issues in the geographic area surrounding

the hospital using scientifically valid health indicators and comparative information. The assessment also identifies priority health issues where better integration of public health and health care can improve access, quality, and cost effectiveness of services to residents surrounding the hospital.

This report represents Suburban Hospital's efforts to share information that can lead to improved health status and quality of care available to local residents while building upon and strengthening the community's existing infrastructure of services and providers.

C. COMMUNITY IMPACT SINCE 2016 CHNA

The five health priorities identified through the 2016 Community Health Needs Assessment are as follows:

- Cardiovascular Health
- Obesity
- Cancer
- Diabetes
- Behavioral Health

Thanks to organizational efforts and community partnerships, measurable progress is being made on these priorities. See **Appendix B** for a summarized status update on each priority. Progress on these priorities is provided to the community via Suburban Hospital's annual Community Health Improvement Report.

3 SUBURBAN HOSPITAL'S METHODOLOGY FOR COMMUNITY HEALTH NEEDS ASSESSMENT

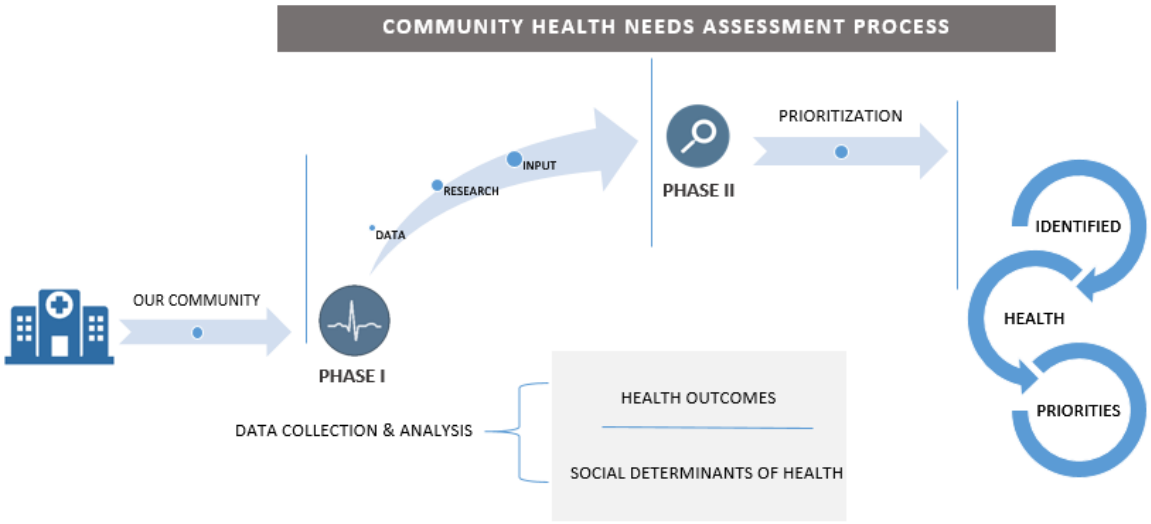


Figure 1. Community Health Needs Assessment Process

To effectively identify and prioritize health needs for Montgomery County residents, Suburban Hospital implemented a two-phase process to execute its CHNA (**See Figure 1, Pg. 6**):

- Phase I - Data collection and analysis
- Phase II - Prioritization of identified health needs

Through this methodology, Suburban ensured optimum collaboration and leverage of resources, reduction of redundancies and support of an ongoing health improvement process and infrastructure.

Phase I. Data Collection & Analysis

The first part of the process consisted of reviewing and collecting data on the health of the **community** we serve. This phase required consulting individuals and organizations that represent the broad interest of the community as well as considering various data sources. The methods used included:

- Collecting primary data (e.g., inpatient and emergency department data) from hospital units and programs
- Collecting secondary datasets for core health indicators (Census, BFFRS, Healthy Montgomery, Health Report MoCo, etc.)
- Consulting Healthy Montgomery
- Engaging health experts and key stakeholders
- Collecting primary data via community conversations and surveys

Phase II. Prioritization Process

The priority setting process allows us to narrow down the top health conditions identified in Phase I. The following methods and considerations were included in the priority setting process:

- The total burden of disease
- Alignment with county-wide health priorities
- Alignment with hospital goals & priorities
- The hospital's ability to feasibly impact the issue

The Identified Health Needs of Our Community

Community health needs were selected using a multi-phase, collaborative and data-driven process. The health priorities identified during this assessment were as follows:

- Cardiovascular Health
- Cancer
- Diabetes
- Behavioral Health
- Emerging Priorities
    - Infections
    - Accidents

4 MONTGOMERY COUNTY, MD DEMOGRAPHICS

Suburban Hospital is located in Montgomery County, MD, one of the most affluent counties in the United States. Montgomery County is adjacent to Washington, D.C. and by the Maryland counties of Frederick, Carroll, Howard and Prince George's, and the Commonwealth of Virginia. Montgomery County has a population of 1.05 million people with a median age of 39 and a median household income of $100,352 [2]. The population in the County has slightly increased since the last CHNA assessment (**Table 1**).

Table 1. Change in Population Size

CHNA	Montgomery County	Maryland	USA
2016	1,016,677	5,928,814	319,459,991
2019	1,058,810	6,052,177	337,947,861
% Change 2016-2019	4.1%	2%	5.8%

Source: County Health Rankings & Truven Health Analytics, Inc., US Census [2&3]

Age

The average life expectancy in Montgomery County is 84.8 years, which is higher than the Maryland baseline (79.1). The life expectancy for White non-Hispanics (84.7) is slightly higher than Black non-Hispanics (83.1) [4]. In 2017, the median age of all people in Montgomery County, MD was 39. Native-born citizens, with a median age of 32.9, are generally younger than foreign-born citizens, with a median age of 44.8. In general, the population in Montgomery County is getting older. In the last assessment, the average age for Montgomery County residents was 38.5 [3].

Ethnic/Racial Diversity

Montgomery County prides itself on its racial diversity and cultural richness with a population that is 60.4% White, 19.7% Black or African American and 15.6% Asian. Foreign-born residents account for 32.6% of the people in the county with the largest Hispanic/Latino (19.6%) community in Maryland. It is not surprising to find that 39.8% of county residents speak a language other than English at home [5]. The most commonly spoken languages, aside from English (60.7%), include Spanish (17.6%), other Indo-European (9.8%), and Asian and Pacific Islander languages (9.8%) [3].

Economic Characteristics

The Montgomery County's average *household* size is 2.8 persons, and the average *family* size is 3.22 persons [3,5]. The average household income in the County continues to rise **(Figure 2).** The current income value is $100,352 compared to $99,435 in the 2016 CHNA [2]. While the per capita income is $49,906, looking at specific racial/ethnic groups reveals great disparities. For example, the per capita income for White non-Hispanics ($69,614) is almost three times that of Hispanics/Latinos ($24,268) [5].

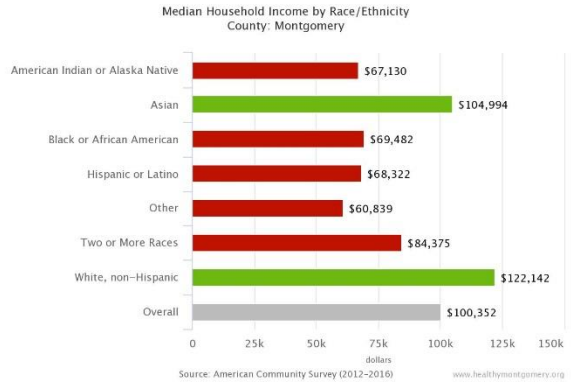
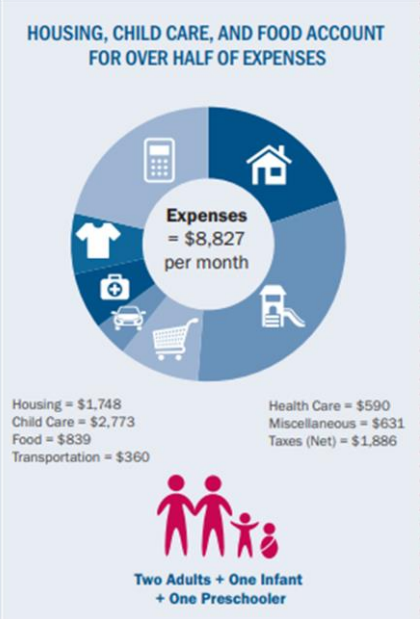


Figure 2. Adapted from Healthy Montgomery

In the County, 49% of renters spend 30% or more of their household income on rent, leaving minimal resources for other expenses such as food, transportation and health (2012-2016) [3]. Compared to the state of Maryland (5.2%), Montgomery County is making faster progress in reducing unemployment. Since 2013, the unemployment rate for Montgomery County has fallen from 5.6% to 4.0% [2].

Poverty levels in Montgomery County have remained steady. At the County level, it is estimated 6.9% of the total population and 4.7 % of families live below the federal poverty line. Poverty affects Montgomery County residents disproportionately. Black non-Hispanic (8.9%) and Hispanic/Latino (9.1%) families have the highest rates of poverty in the County. The least impoverished group are White non-Hispanics (1.8%).

Figure 3. Self-Sufficiency Standard



The Self-Sufficiency Standard defines the amount of income necessary to meet basic needs at a minimally adequate level without public or private assistance. The standard takes into consideration family type and geographic location. The variables taken into consideration include housing, child care, food, transportation, health care, taxes and credits, emergency savings and others. To live in Montgomery County without any private or public financial assistance, a family of four (two adults, one preschooler and an infant) requires an annual income of $86,580 or $8,827 per month (Figure 3). [6]

Education

It has been shown that a college degree is important for obtaining high paying jobs and having access to health care services. Montgomery County has a high percentage (58.1%) of residents over 25 years of age who hold a Bachelor's Degree or higher. More Asians (67.5%) and White non-Hispanics (70.7%) hold Bachelor's Degrees or higher than Hispanics/Latinos. The rate for Hispanics/Latinos is 26.6% for females and 23.9% for males [31].

Health Care Access

People who do not have insurance and cannot afford to see a doctor may not receive proper and timely medical services. Lack of health insurance can also result in increased visits to the emergency room. Whereas 92.6% of the population in Montgomery County is insured, it is estimated 88,472 or 7.1% of adults under the age of 65 are uninsured [2]. Although private health insurance is the most common type of insurance in the County, 66.1% of Montgomery County residents receive coverage through their employer while 15.6% of residents rely on public health coverage [5]. Health insurance does not necessarily guarantee access to health services. Communities that lack a sufficient number of primary care providers (PCP) are more likely to delay necessary care when sick, which can lead to more severe or complicated conditions. The PCP rate in the County has slightly declined since 2013. Nonetheless, the County's rate of 137 PCPs per 100,000 residents is significantly higher than the state (88) and national (75) rates [5].

5 DEFINING OUR COMMUNITY: COMMUNITY BENEFIT SERVICE AREA

A primary service area (PSA) is defined as the postal zip code areas from which 60 percent of a hospital's inpatient discharges originated during the most recent 12 month period. This information is provided by the Maryland Health Services Cost Review Commission (HSCRC). **Appendix C** lists the 26 zip codes defined as Suburban Hospital's PSA.

Definition

For this assessment, Suburban Hospital defines its ***community*** as specific populations or communities of need to which the Hospital allocates resources through its community benefits plan. The term Community Benefit Service Area (CBSA) is used to define the community geographically. Suburban's CBSA extends beyond its primary service area.

Within its CBSA, Suburban Hospital focuses on vulnerable populations such as uninsured individuals and households, underinsured and low-income individuals and households, ethnically diverse populations, underserved seniors and at-risk youth. Approximately 50-60% of hospital service usage originates from these populations. Suburban does not distinguish

based on race, ethnicity, patient status, insurance status, religious affiliation, or ability to pay for health services.

During the 2019 CHNA process, Suburban Hospital revised the formula for calculating its CBSA to include data from Inpatient Records, Emergency Department (ED) Visits and Charity Financial Assistance Transactions. **See Appendix D.**

Once the data were aggregated, fourteen zip codes concentrated within the cities of Rockville, Bethesda, Silver Spring, Chevy Chase, Potomac and Kensington were identified. The following fourteen zip codes define Suburban's CBSA for the 2019 Community Health Needs Assessment cycle: 20814, 20815, 20816, 20817, 20850, 20851, 20852, 20853, 20854, 20895, 20902, 20904, 20906 and 20910. See **Figure 4.**

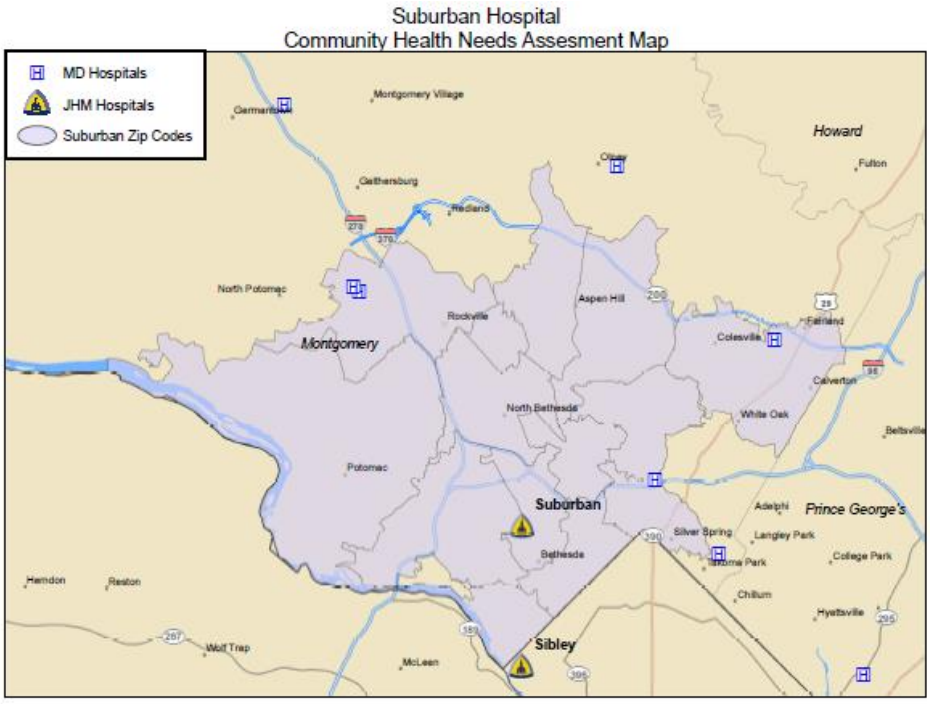


Figure 4. Suburban Hospital Community Benefit Service Area (CBSA) Map.

CBSA Demographics at a Glance

Suburban CBSA residents make up nearly 53% of the total population in Montgomery County (**See Table 1, Page 8**). The population size in our CBSA dropped by 12% (compared to the 2013 CHNA). The reduction is attributed to the incorporation of a revised CBSA formula, which resulted in the replacement of two zip codes. Out of the estimated 558,557 individuals residing the CBSA, 52% are females. While the average household income for Suburban's CBSA is $156,596 [7], 35% of the community's income is below $75,000 and 26% are Medicare or Medicaid beneficiaries. CBSA residents are racially and ethnically diverse. Blacks, Hispanics/Latinos and Asians make-up at least 48% of the community. **See Figures 5-10, Pg. 12**.

Figure 5. CBSA Population Size

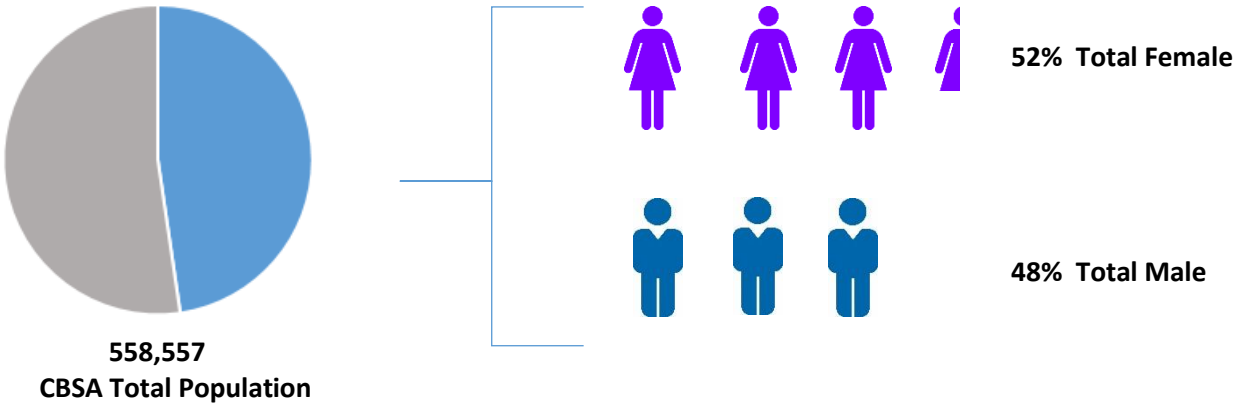


Figure 6. Population Distribution by Age Group

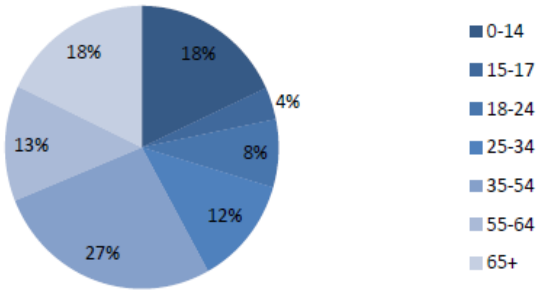


Figure 7. Population Distribution by Race/Ethnicity

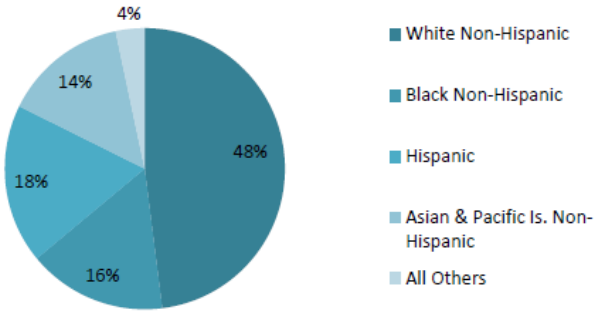
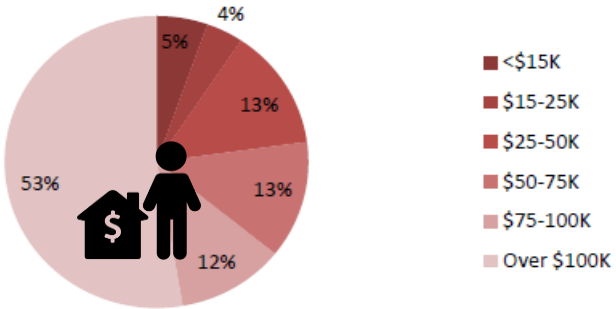


Figure 8. Current Households by Income Group



Average Household Income $156,596

Figure 9. Population Age 25+ by Education Level

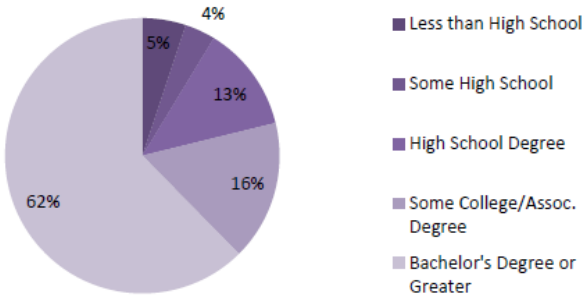
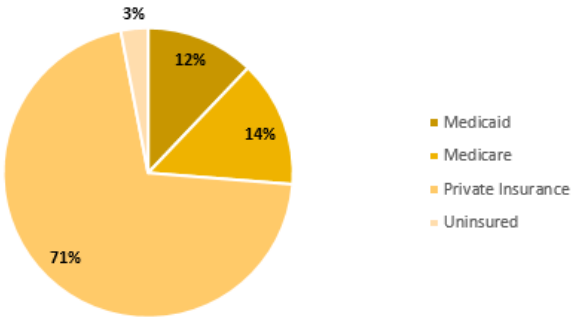


Figure 10. Insurance Coverage Distribution



6 PHASE I: DATA COLLECTION & ANALYSIS

A. HEALTH OUTCOMES

A range of health indicators is used to monitor population health. The most common health outcome indicators include life expectancy, mortality from health conditions, emergency department visits and hospital utilization rates. Unfortunately, available surveillance systems do not collect zip-code level data. Unless otherwise noted, County-level data was used to understand the most pressing health issues affecting Suburban Hospital's CBSA and compared to state and national data, provided as a reference where available. All data are sourced from Healthy Montgomery, Data Montgomery and the US Census unless otherwise indicated.

Life Expectancy & Premature Death

Life expectancy is the average age for which a person born in a specified year can expect to live. The life expectancy in Montgomery County is 84.9 and is high compared to the rest of the state and nation. Premature death occurs before the average age of death in a population. The premature death rate or potential life lost before age 75 in Montgomery County is approximately 3,500 per 100,000 people (age-adjusted) compared to 6,400 for the state [2,5].

Leading Causes of Death in Montgomery County

Cause-of-death or mortality ranking allows for trend comparison and helps illustrate the relative burden of cause-specific deaths. According to the most recent Health Report available for Montgomery County, the leading causes of death were cancer (24%), heart disease (22%), cerebrovascular disease (5%), accident (4%), chronic lower respiratory disease (3%), Alzheimer's disease (3%), influenza and pneumonia (3%), diabetes mellitus (3%), septicemia (2%), and nephritis (2%) [8]. **Table 2** provides county, state and national mortality rate data for the top ten leading causes of death.

Table 2. Top 10 Age-Adjusted Mortality Rate, Montgomery County

Cause of Death	Montgomery County	Maryland	United States*
All deaths	**478.6**	715.3	728.8
Cancer	**115.2**	154.5	155.8
Heart Disease	**110.2**	166.4	165.5
Cerebrovascular Disease	**23.1**	39.3	37.3
Accidents	**19.7**	34.3	47.4
Chronic respiratory disease	**15.1**	30.3	40.6
Alzheimer's Disease	**13.1**	17.0	30.3
Influenza and Pneumonia	**12.5**	15.6	13.5
Diabetes Mellitus	**11.3**	19.4	21
Septicemia	**10.3**	13.0	10.7
Nephritis	**9.0**	12.1	13.1

Data Source: Maryland Vital Statistics Annual Report 2017. Rates are age-adjusted, county-level mortality rates from 2015-2017. Rates are deaths per 100,000 people. [4]
*Health, United States, 2017 Report.[9]

Trends in Mortality & Race/Ethnicity Comparison: Top 5 Causes

Data provided is age-adjusted per 100,000 population (unless otherwise noted)

MORTALITY RATE FOR ALL CAUSES

Figure 11 provides a comparison for county, state and national mortality rates for all causes. Montgomery County's mortality rates continue to fall below state and national levels.

Figure 12 provides a breakdown of mortality rates across gender and ethnic/racial groups. Non-Hispanic Blacks and males have the highest rates of mortality compared to other groups.

Figure 11. County Trend Comparison, 2008-16

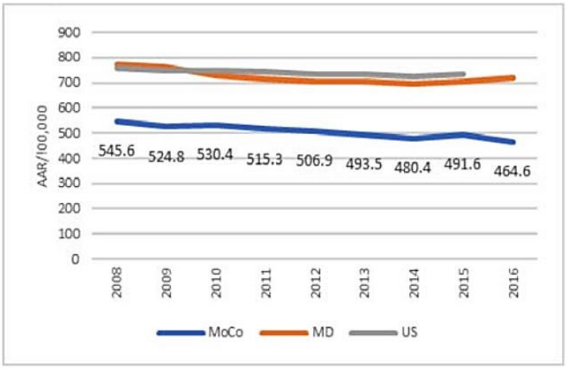
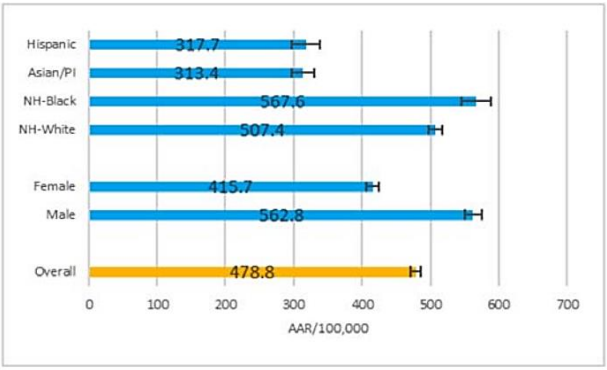


Figure 12. Rate by Sex & Race/Ethnicity, 2014-2016



Source: Adapted from Health in Montgomery County, 2008-2016, Report [8]

MORTALITY RATE TRENDS FOR CANCER

Malignant neoplasms, or cancer, is a group of diseases characterized by uncontrolled growth and spread of abnormal cells. If not treated, it can result in death.

A person's risk for developing cancer can be lowered by avoiding certain risk factors such as tobacco use, sedentary lifestyle and high-fat/low fiber diets. Prevention or delayed onset of cancer can also be achieved through screening methods that allow early detection and removal of precancerous growths, thereby improving health outcomes. Early detection methods are currently available for specific cancers.

While cancer mortality and incidence rates have declined over the past several years in Montgomery County, cancer is now the leading cause of death. According to the American Journal of Managed Care, this is a trend being seen across the US in high-income counties [10]. The age-adjusted cancer mortality rate in Montgomery County (115.2 per 100,000) is less than in Maryland (154.5 per 100,000). Cancer-related deaths continue to be more common among Blacks (132.6 per 100,000) than other racial/ethnic minorities. Men are more likely to die of cancer (135.5 per 100,000) than women (108.1 per 100,000) [11]. **See Figures 13 & 14, Pg. 16**.

Figure 13. County Trend Comparison, 2008-16

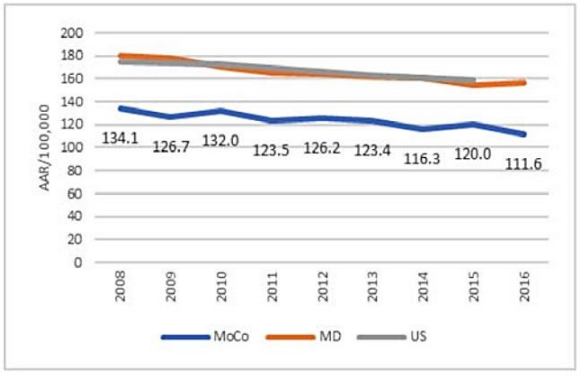
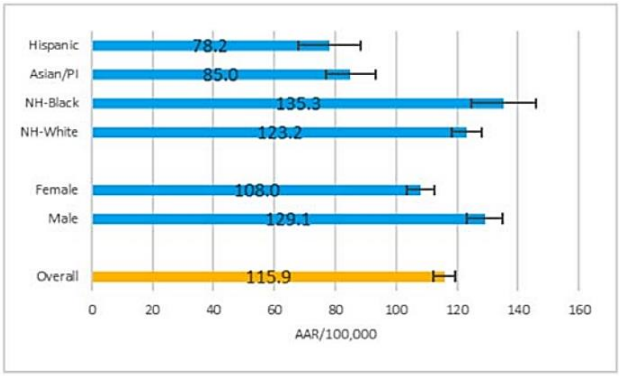


Figure 14. Rate by Sex & Race/Ethnicity, 2014-2016



Source: Adapted from Health in Montgomery County, 2008-2016, Report [8]

When looking at specific types of cancers, breast and prostate have the highest incidence, but more people die from cancer of the lung and bronchus (**Table 3**). Breast cancer is most common among women, while prostate cancer is the most common type of cancer in men. Although the mortality rate due to lung cancer among men has reached a plateau, the rate in women continues to rise. Colorectal and skin cancer rates are lower in Montgomery County than the rest of Maryland.

Table 3. Age-Adjusted Mortality and Incidence Rate by Cancer Type & Jurisdiction, 2010-2014

	Montgomery County		Maryland	
Cause of Death	**Incidence**	**Mortality**	**Incidence**	**Mortality**
Lung & Bronchus Cancer	**32.7**	**24.7**	56.6	43.1
Colon and Rectum Cancer	**29.1**	**9.4**	36.7	14.5
Female Breast Cancer	**128.8**	**17.4**	129.2	22.9
Prostate Cancer	**113.9**	**15.2**	125.4	20.3
Oral Cancer	**8.6**	**1.5**	10.5	2.3
Skin Cancer (Melanoma)	**18.8**	**2.2**	21.4	2.5
Cervical Cancer	**5.2**	**1.1**	6.4	2.0

Data Source: Maryland Department of Health 2017 Cancer Data. Rates are per 100,000 population and age-adjusted to 2000 U.S. standard population [11]

MORTALITY RATE TRENDS FOR HEART DISEASE

Cardiovascular disease (CVD) is an umbrella term for multiple conditions that involve the narrowing or blockage of the blood vessels of the heart, brain, and circulatory system. CVD is the leading cause of death in Maryland and the US. CVD can affect both men and women, without regard to ethnicity, race or socioeconomic status. There are several risk factors associated with CVD, including diabetes, hypertension, high cholesterol, obesity, smoking, alcohol use, poor diet and inactivity [12]. This disease can incur high health care costs due to its complexity.

The most common form of CVD is coronary heart disease, also known as heart disease or coronary artery disease. Coronary heart disease results from clogged arteries (atherosclerosis), which can cause chest pain (angina) and potentially lead to blood clots and a heart attack (myocardial infarction) [13].

Over the years, the age-adjusted death rate due to heart disease has slowly decreased in Montgomery County. The mortality rate in Montgomery County (110.2 deaths per 100,000) is lower than the state of Maryland (166.4 death per 100,000) [5]. **See Figure 15 & 16**.

The US has also seen a reduction in CVD mortality, which can be attributed to increased prevention and improved medical treatments (American Journal of Managed Care). However, disparities are still present across genders and races. [10]

Although CVD is not gender-specific, in Montgomery County men are more likely to die from heart disease. When comparing different races and ethnicities, Black non-Hispanics have the highest number of deaths associated with this health condition. [5]

Figure 15. County Trend Comparison, 2008-16

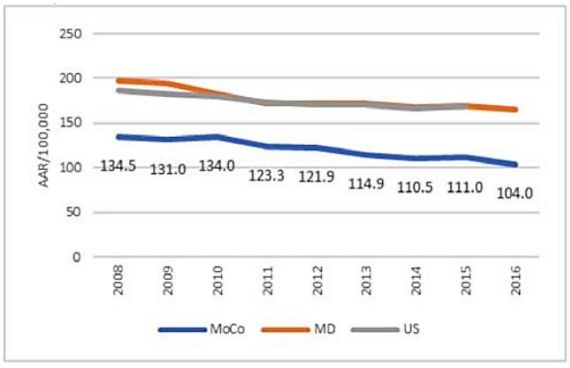
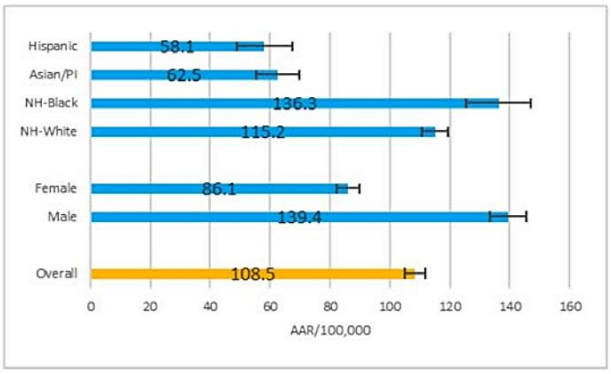


Figure 16. Rate by Sex & Race/Ethnicity, 2014-2016



Source: Adapted from Health in Montgomery County, 2008-2016, Report [8]

According to the Centers for Disease Control & Prevention, approximately 5.7 million people in the United States suffer from congestive heart failure (HF). HF refers to the heart's inability to pump blood and oxygen to the body efficiently.

It is estimated about half of the people who develop HF will die within five years of diagnosis [14]. Coronary heart disease, ischemic heart disease, high blood pressure and myocardial infarctions are risk factors for HF. People with

diabetes are also at an increased risk of developing heart failure due to hypertension and atherosclerosis. In Montgomery County, the age-adjusted Emergency Room (ER) rate due to HF is 1.9 ER visits/10,000 people, while the hospitalization rate is 17.9 hospitalizations per 10,000 people [5]. The County ER and hospitalization HF rates are broken down by age in **Figures 17** and **18,** respectively. Heart failure zip-code level data for the County is provided in **Appendix E**.

With an aging population, the HF prevalence is projected to increase, resulting in higher hospitalization rates and health care costs [15].

Figure 17. Age-Adjusted Emergency Room Rate

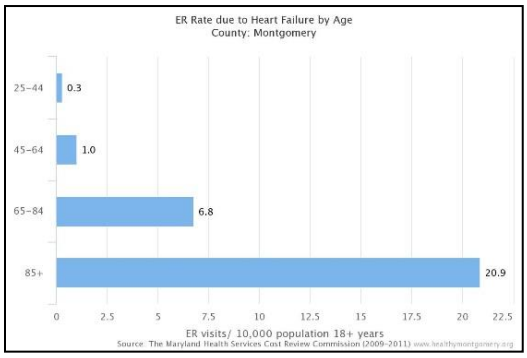
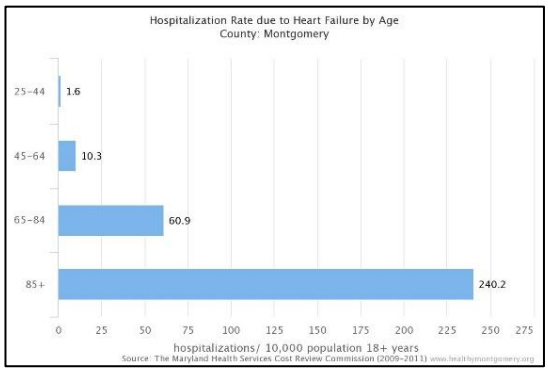


Figure 18. Age-Adjusted Hospitalization Rate



Source: Figures adapted from Healthy Montgomery [8]

MORTALITY RATE TRENDS FOR CEREBROVASCULAR DISEASE

Cerebrovascular disease, or stroke, is the brain's equivalent of a heart attack. The age-adjusted death rate due to stroke in Montgomery County is 23.0 deaths per 100,000 people (**See Figure 19**). Cerebrovascular death rates are broken down by race and gender in **Figure 20**. Cerebrovascular death rates tend to be slightly higher for Black non-Hispanics (27.3 per 100,000) than for White non-Hispanics (22.6 per 100,000). Hispanics/Latinos (19.6 per 100,000) continue to have the lowest rate of deaths attributed to cerebrovascular disease [5,8].

Figure 19. County Trend Comparison, 2008-16

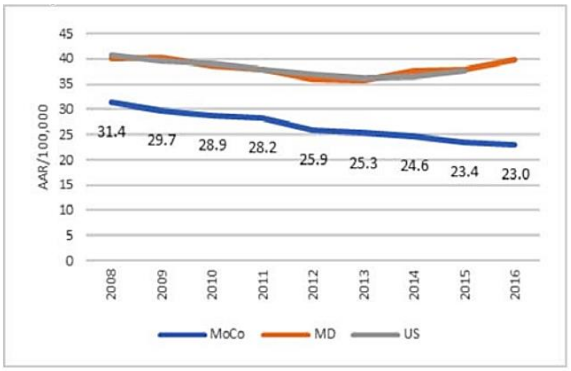
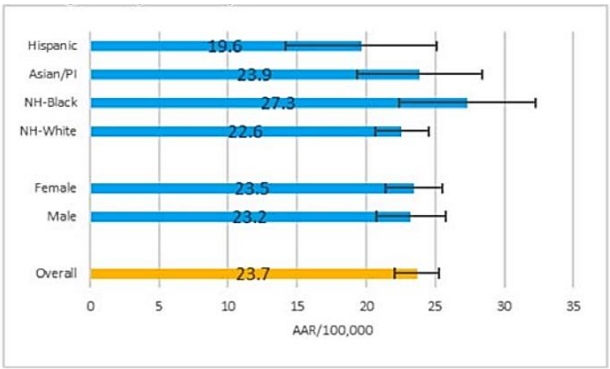


Figure 20. Rate by Sex & Race/Ethnicity, 2014-2016



Source: Figures adapted from Health in Montgomery County, 2008-2016, Report [8]

Hypertension, or high blood pressure, and high cholesterol are two modifiable risk factors that place individuals at significant risk of developing stroke, heart disease, and other chronic conditions. Since the last CHNA, the prevalence rate in Montgomery County for high cholesterol dropped from 38.1% to 32.8%. Hypertension prevalence in the County has been on the rise. Currently, 36% of Montgomery County residents have high blood pressure. The Medicare population accounts for 53.3% of hypertension cases [5].

MORTALITY RATE TRENDS FOR ACCIDENTS

Unintentional injuries or accidents affect everyone, regardless of age, race, or economic status. More Americans under the age of 45 die from accidents such as motor vehicle crashes or falls than from any other cause [16]. The leading cause of accident-related death varies across an individual's lifespan. **Appendix F** lists the ten leading causes of injury-related deaths by age group.

Death rates due to accidents in Montgomery County have increased slightly over the years. The age-adjusted death rate from accidents in Montgomery County is 18.1 per 100,000 people, which is less than state and national rates. The majority of deaths due to unintentional injuries occur in the male population and the older adult population [8]. See **Figure 21 & 22**.

Figure 21. County Trend Comparison, 2008-16

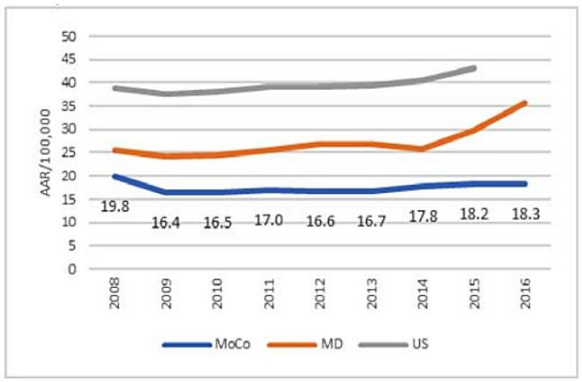
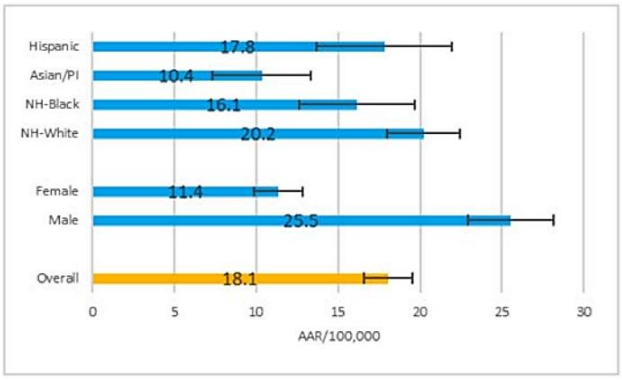


Figure 22. Rate by Sex & Race/Ethnicity, 2014-2016



Source: Figures adapted from Health in Montgomery County, 2008-2016, Report [8]

In 2015, more than 35,000 people died from motor vehicle crashes. In the last ten years, poisonings in the form of opioid overdoses have quadrupled, with more than 15,000 people dying annually from prescription opioid overdoses. Each year, 2.8 million older adults are treated in emergency departments for fall-related injuries. Therefore, it is not surprising to find that falls, motor vehicle accidents and poisonings are the three leading causes of injury-related death in Maryland (**See Table 4, Pg. 20**) [17].

According to the Centers for Disease Control & Prevention, falls are the major cause of preventable death among older adults. It has been reported that more than one out of four

adults aged 65 and older fall each year. One out of five falls can cause a serious injury, such as a broken hip or head injury. After a fall, an individual is twice as likely to fall again. Recovery from a fractured hip is not easy and can make it difficult for people to live independently and perform everyday chores.

As the U.S. population continues to age, the number of hip fractures is expected to increase [18]. Falls are also the leading cause of work-related deaths, especially among construction workers [8]. Healthy People is the nation's framework for improving the health of all Americans. The Healthy People 2020 goal is to reduce fall death rates to 7 or less. The age-adjusted death rate due to falls in Montgomery County is 6.5 deaths per 100,000 people (2014-2016), which is lower than the state rate of 9.6 deaths per 100,000 people [19].

Table 4. Leading Causes of Death Due to Unintentional Injuries in Maryland

Rank	Cause	Deaths	Rate
5	All unintentional injuries	1,674	28.0
1	Falls	572	9.6
2	Motor vehicle	475	7.9
3	Poisoning	281	4.7
4	Choking	65	1.1
5	Drowning	57	1.0

Source: Injury Facts- National Safety County, 2017 Edition [17]

MORTALITY RATE TRENDS FOR CHRONIC LOWER RESPIRATORY DISEASE,

Chronic Lower Respiratory Diseases (CLRD) refers to a group of conditions that affect the lungs, such as asthma, emphysema, bronchitis and chronic respiratory pulmonary disease. In Montgomery County, CLRD mortality rates have been on the decline. The age-adjusted death rate for CLRD is 15.5 per 100,000 (2008-2016). When compared to other groups, the Hispanic and Asian population have the lowest rates of CLRD. **See Figure 23 & 24, Pg. 21.**

Chronic obstructive pulmonary disease (COPD), the deadliest form of CLRD, makes it difficult for an individual to breathe. Cigarette smoking has been identified as the leading cause of COPD, but other factors such as air pollutants, genetics, and respiratory infections can contribute to its development. The average annual age-adjusted hospitalization rate due to COPD is 9.1 per 100,000 people in Montgomery County (2009-2011). COPD is more common among the 65+ population.

The age-adjusted ER and hospitalization rates due to asthma are 34 and 8.4 per 10,000 people, respectively (2009-2011). Children under 5 years of age and adults 65+ are frequently hospitalized due to asthma [8].

Figure 23. County Trend Comparison, 2008-16

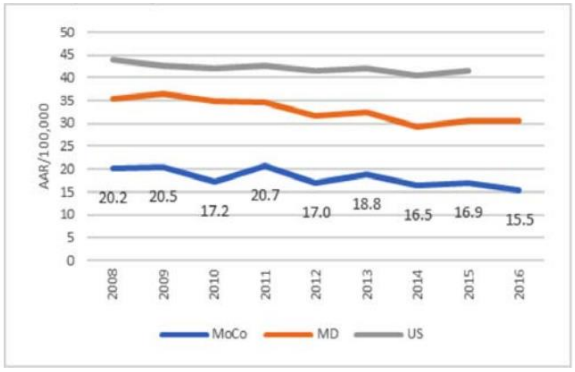
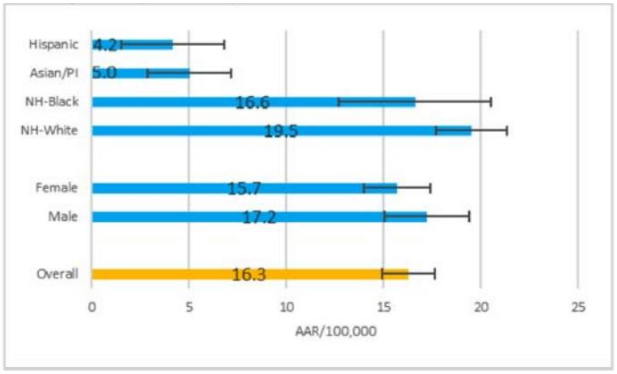


Figure 24. Rate by Sex & Race/Ethnicity, 2014-2016



Source: Adapted from Health in Montgomery County, 2008-2016, Report [8]

Leading Cause of Hospitalization in Suburban's CBSA

Hospitalization data provides insight on the causes of morbidity present in the population. At the County level, the leading cause of hospitalizations are injuries, heart disease, mental health, cerebrovascular disease, diabetes, cancer, CLRD, substance abuse, and suicide [8].

All Patients Refined Diagnosis Related Groups (APR-DRG) is a classification system that categorizes patients according to their reason for hospital admission, severity of illness and risk of mortality. It helps to monitor the quality of care and the utilization of services in a hospital setting [20]. Based on APR-DRG, Suburban Hospital's top causes for hospitalizations in the past two years are reported in **Table 5 (See Pg. 22)**.

Suburban Hospital is a Certified Stroke Center and Level II Trauma Center, as well as a Center of Excellence for cardiac care, orthopedics and joint replacement surgery, neurosciences and oncology. The leading causes of hospitalization at Suburban Hospital in 2017-18 were knee joint replacement (7%), hip joint replacement (6%), septicemia and disseminated infection (6%), major depressive disorders (4%), heart failure (3%), kidney and urinary tract infections (2%), bipolar disorders (2%), pneumonia (2%), cerebral vascular accident (stroke) (2%), and alcohol abuse and dependence (2%). These conditions can be group into four major categories: orthopedic, heart disease, cerebrovascular disease, mental/behavioral health and infections.

The prevalence of obesity, injuries, and the aging population, coupled with higher rates of diagnosis and treatment of advanced arthritis, are growing the demand for improved mobility and quality-of-life through knee and hip replacements procedures [23]. It is estimated over 1 million hip and knee replacement procedures are performed each year in the United States. This number is projected to increase exponentially by 2030. The number of total knee replacements will grow by more than 600% compared to 2005, while total hip replacements are expected to increase by nearly 200 % [24].

Septicemia or sepsis is the body's response to infection. Sepsis is a serious and relatively common disorder and represents the leading

cause of death in non-coronary intensive care units worldwide [1]. Sepsis and septic shock can result from an infection anywhere in the body, such as pneumonia, influenza, or urinary tract infections (UTIs).

According to the Sepsis Alliance, worldwide, one-third of people who develop sepsis die. Many who do survive are left with life-changing effects, such as post-traumatic stress disorder (PTSD), chronic pain and fatigue, organ dysfunction and/or amputations [26]. Although sepsis does not discriminate, those at higher risk include people with chronic conditions (such as diabetes and cancer), compromised immune systems, and pneumonia [27].

Older adults are particularly vulnerable because they often delay treatment and do not recognize the symptoms of infections. For example, UTIs are treated quickly and effectively with antibiotics. However, over 50% of sepsis cases among older adults are caused by a UTI because the infections go undiagnosed [28].

Each year, millions of Americans are affected by behavioral health conditions [29]. One in five adults experience a behavioral health issue, and one in ten young people experience a period of major depression [29]. Individuals with behavioral health disorders are more likely to utilize hospitals and emergency rooms, contributing to a rising cost of care [30].

According to a report by the American Hospital Association, individuals living with serious behavioral health illness are at increased risk of other co-morbidities such as asthma, diabetes, heart disease, high blood pressure, and stroke. Furthermore, those with chronic medical conditions (e.g., asthma or diabetes) also report higher rates of substance use disorders and "serious psychological distress" [30].

Table 5. Top APR-DRG Inpatient Diagnosis at Suburban Hospital

APR-DRG Inpatient Diagnosis Descriptions	2017	2018	Grand Total
Knee Joint Replacement	1108	948	2056
Hip Joint Replacement	793	836	1629
Septicemia & Disseminated Infections	825	782	1607
Major Depressive Disorders & Other/Unspecified Psychoses	542	689	1231
Heart Failure	447	438	885
Kidney & Urinary Tract Infections	324	318	642
Bipolar Disorders	277	345	622
Other Pneumonia	291	298	589
Cva & Precerebral Occlusion W Infarct	273	312	585
Alcohol Abuse & Dependence	239	324	563

Source: Suburban Hospital, EPIC 2018. Number of cases 2017-2018.

Leading Cause of Emergency Room (ER) Visit in Montgomery County

Emergency Room (ER) utilization refers to how often a population uses the ER for a particular reason. ER visits can be attributed to avoidable or non-avoidable conditions. Avoidable visits are those that could have been treated solely by a primary care provider (PCP) or medical home. ER utilization rates are presented below for Montgomery County. The findings in **Table 6** are consistent with the causes of hospitalization at the County-level. Out of the eight conditions listed, mental and behavioral health conditions (substance abuse and suicide) are ranked several times on the list. **Appendix G** provides a list of behavioral health conditions most commonly diagnosed at Suburban Hospital's Emergency Room.

Table 6. Leading Cause of ER Visit by Year, Montgomery County, 2014-16

	2014		2015		2016		2014-16	
	%	Rank	%	Rank	%	Rank	%	Rank
Injuries	28.4	1	25.1	1	22.7	1	25.4	1
Heart Disease	7.0	2	8.5	2	9.3	2	8.2	2
Mental Health	4.8	3	5.5	3	6.9	3	5.8	3
Chronic Lower Respiratory Disease	3.6	4	3.8	4	4.0	4	3.8	4
Substance Abuse	2.0	5	1.9	6	1.7	6	1.8	5
Diabetes Mellitus	1.8	6	2.1	5	2.2	5	2.0	6
Cerebrovascular Disease	0.3	7	0.3	7	0.2	7	0.3	7
Suicide	0.2	8	0.2	8	0.2	7	0.2	8
All Other Causes	51.9		52.6		52.8		52.4	

Source: Adapted from Health in Montgomery County, 2008-2016, Report

B. SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDoH) is defined by the World Health Organization (WHO) as "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels" [21].

The Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute designed a model to illustrate the many factors that influence health outcomes. The model is depicted in **Figure 25, Pg 24**. Clinical/medical care contributes only 20% of the health outcomes of a population. The remaining 80% are modifiable factors (health behaviors, socioeconomic and environmental factors), referred to as SDoH. Thirty indicators are utilized to assess the impact of SDoH factors on the overall health of the community (**See Table 7**, **Pg. 25).**

The health status of our nation and the high expenditure of our health care system are driving providers and legislators to develop multi-solution approaches to address the

complex health problems facing our society. This matter requires numerous sectors committing to a common agenda for solving a specific community-wide problem. The Triple Aim is a model developed by the Institute for Healthcare Improvement (IHI) to optimize health system performance by integrating health care and population health.

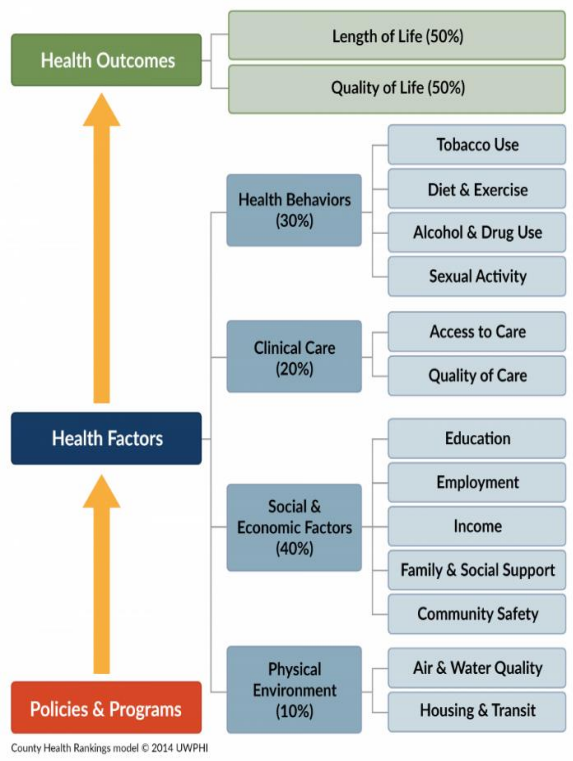


Figure 25. County Health Ranking Model

The goals of the Triple Aim module are to simultaneously improve the patient care experience and overall health of populations while reducing the per capita cost of health care (**Figure 26**). Suburban Hospital recognizes that strategic application of the three Triple Aim goals across the underlying factors that determine health outcomes can improve the health and well-being of Suburban Hospital CBSA residents, reduce inequity, and minimize costs [22].

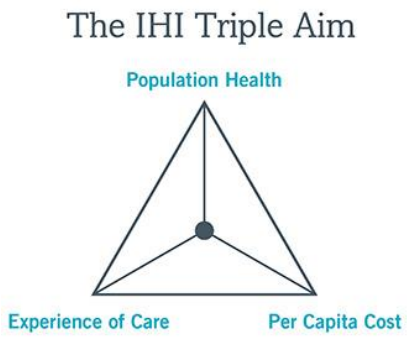


Figure 26. Adapted from IHI

County Health Ranking: Montgomery County Health Factors

The County Health Rankings, supported by The Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, is a report that shows location makes a difference in how well and how long a person lives. At the county level, the health status of a particular community can be measured by evaluating 30 established indicators (outlined in **Table 7, Pg. 25)**. The results of these indicators places Montgomery County as the 9th healthiest county (among 95 counties listed) in the nation [2].

Table 7. Montgomery County Ranking, 2018

Health Factor (weight %)	Focus Area (weight %)	Indicator	Montgomery County	Top U.S. Performers
Health Behaviors (30%)	Tobacco Use (10%)	**Adult smoking** % of adults who are current smokers	7%	14%
	Diet and Physical Activity (10%)	**Adult obesity** % of adults with Body Mass Index of 30 or more	21%	26%
		Food Environment Index Scale 0-10, 0 is worst, 10 is best	9.5	8.6
		Physical inactivity % adults with no leisure-time physical activity	16%	20%
		Access to exercise opportunities % with access to locations for physical activity	100%	91%
	Alcohol and Drug Use (5%)	**Excessive Drinking** % of adults reporting binge drinking or heavy drinking	15%	13%
		Alcohol-impaired driving deaths % of driving deaths with alcohol involvement	26%	13%
	Sexual Activity (5%)	**Sexually transmitted infections** Chlamydia rate per 100,000 population	292.6	145.1
		Teen births Birth rate per 1,000 female population, ages 15-19 years	13	15
Clinical Care (20%)	Access to Care (10%)	**Uninsured** % population under age 65 without health insurance	8%	6%
		Primary care physicians Ratio of population to primary care physicians	730:1	1,030:1
		Dentists Ratio of population to dentists	830:1	1280:1
		Mental health providers Ratio of population to mental health providers	360:1	330:1
	Quality of Care (10%)	**Preventable Hospital Stays** # of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	29	35
		Diabetes Monitoring % of Medicare enrollees with diabetes ages 65-75 years who receive HbA1c	87%	91%

		Mammography screening % of female Medicare enrollees ages 67-69 who receive mammography screening	62%	71%
Social and Economic Environment (40%)	Education (10%)	**High school graduation** % of 9th grade cohort that graduates in 4 years	89%	95%
		Some college % of people 25-44 years with some post-secondary education	77%	72%
	Employment (10%)	**Unemployment** % of people 16 and older unemployed and seeking work	3.3%	3.2%
	Income (10%)	**Children in poverty** % of children under age 18 in poverty	9%	12%
		Income inequality Ratio of income at the 80th and 20th percentile	4.3	3.7
	Family and Social Support (5%)	**Children in single-parent households** % of households headed by a single parent	25%	20%
		Social associations # of membership associations per 10,000 population	9.0	22.1
	Community Safety (5%)	**Violent crime** # reported violent crimes per 100,000 population	177	62
		Injury deaths # deaths due to injury per 100,000 people	33	55
Physical Environment (10%)	Air and Water Quality (5%)	**Air pollution – particulate matter** Average daily density of fine particulate matter (PM2.5)	10.9	6.7
		Drinking water violations Presence of health-related drinking water violations	No	-
	Housing and Transit (5%)	**Severe housing problems** % of households with overcrowding, high housing costs, lack of kitchen, or a lack of plumbing	17%	9%
		Driving alone to work % of workforce who drive alone to work	65%	72%
		Long commute, driving alone % of workers who drive alone with a long commute	53%	15%

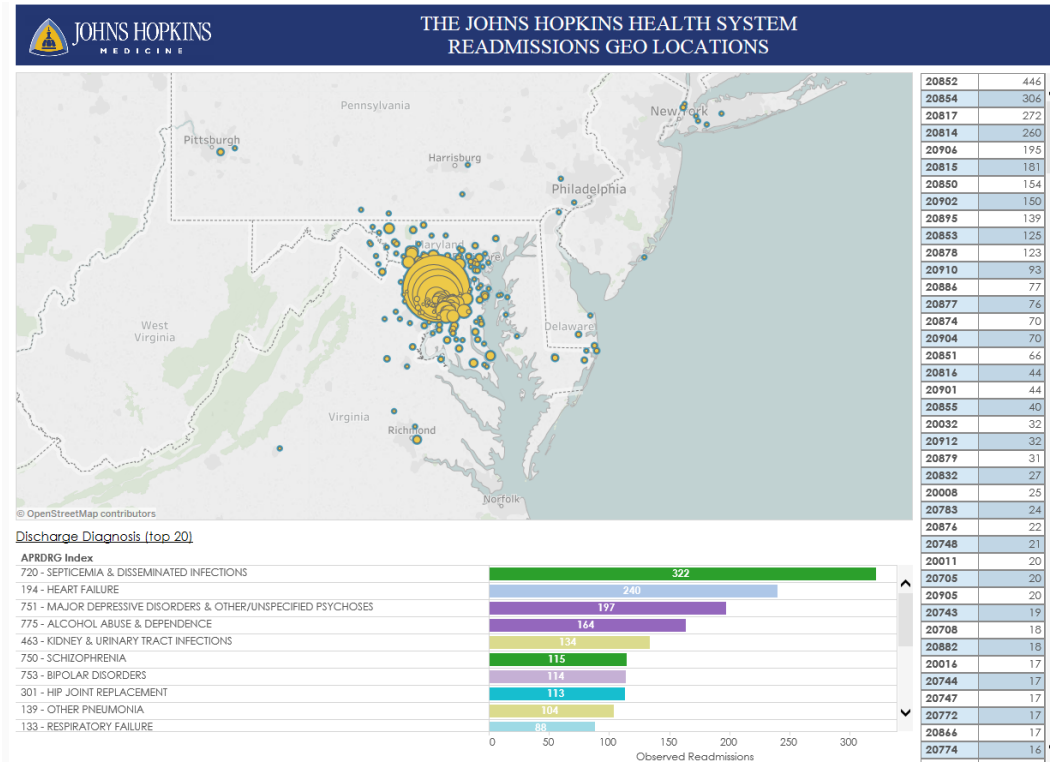
Data source. University of Wisconsin Population Health Institute. County Health Rankings 2018.

Suburban Hospital Patient Re-Admission: Diagnosis & Location

For the 2019 assessment, Suburban Hospital incorporated readmission data to determine drivers of health in our immediate community. Readmission data provides information on causes for unplanned readmission to an acute care hospital up to 30 days after discharge from hospitalization. Readmissions may or may not be related to the original reason for admission. While some readmissions are not preventable, addressing readmissions can help improve the health of populations and reduce cost.

The top ten causes of readmission at Suburban Hospital can be grouped into three categories: infections, heart failure and behavioral/mental health (**See Figure 27**). Residents originating from zip codes 20814, 20817, 20852, and have the highest rate of readmissions. These zip codes are also part of Suburban's Community Benefit Service Area (CBSA). Readmission data for the 14 zip codes in Suburban's CBSA is provided in **Appendix H.**

Figure 27. Suburban Hospital Top Causes of Re-Admission, 2016-2018

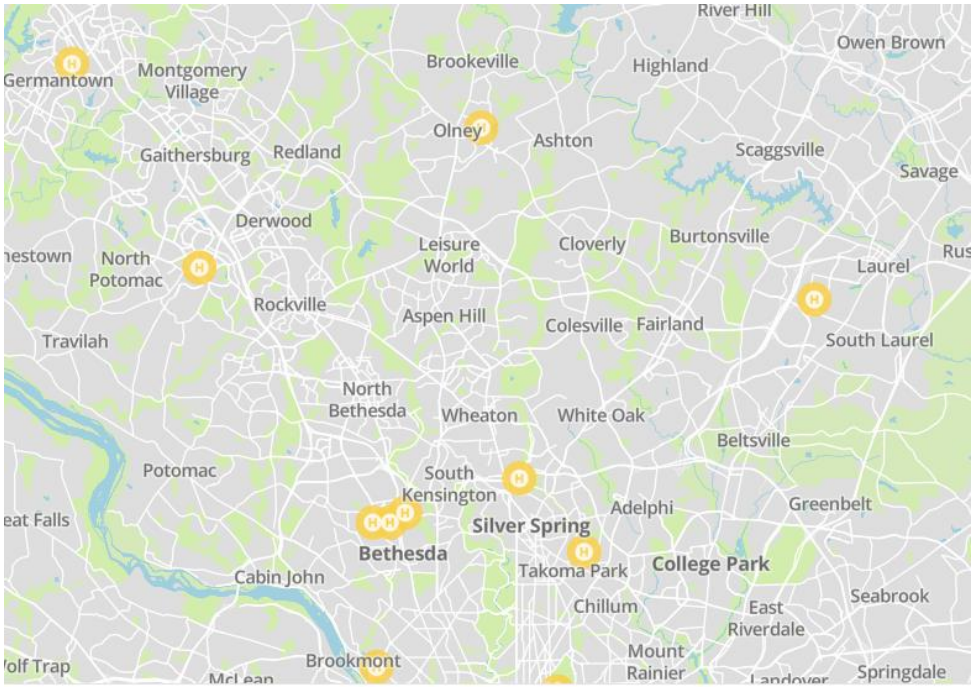


C. HEALTH CARE FACILITIES AND RESOURCES IN OUR COMMUNITY

There are multiple health care facilities and resources within Montgomery County available to respond to community health needs (**Figure 28, Pg. 28**). Six hospitals and affiliated emergency departments serve the critically ill. Dedicated mental and behavioral health facilities

provide psychiatric care. Three Federally Qualified Health Centers (FQHC) and eight Montgomery County Cares safety-net clinic programs provide outpatient clinic and preventive services to uninsured and under-insured individuals.

Figure 28. Existing Health Care Facilities in Montgomery County



In Montgomery County, community health needs are also addressed by resources outside of the traditional health care setting. Available resources include individual programs and initiatives by faith-based, non-profit, academic, and/or government organizations. Examples of such resources include:

- Montgomery County's telephone number for accessing government programs and services
- Dental Services/HIV Dental Program
- Services for Special Populations (i.e., Refugee and Asylee Health Program)
- Minority Health Initiatives/Programs
- Pathways to Services, which assists children with emotional and/or behavioral needs (CC)

For a comprehensive list, please refer to Healthy Montgomery for the County-wide health needs assessment report.

D. IDENTIFIED DATA GAPS/LIMITATIONS

The Healthy Montgomery website was utilized as the primary resource for gathering quantitative data for Montgomery County residents. Where appropriate, census and state databases were also accessed to supplement needed data for the health indicators mentioned in this report.

Despite the search for various resources, there were specific limitations and availability of information on particular racial/ethnic groups. Currently, baseline data for variables aimed to measure social determinants of health are not all-inclusive, limiting group comparison analysis. Furthermore, data at the local level is needed to be able to assess and evaluate health outcomes for specific communities within Suburban's CBSA zip codes.

7 PHASE I: STAKEHOLDER COLLABORATION & ENGAGEMENT

A. HEALTHY MONTGOMERY

Healthy Montgomery, launched in June 2009 by the Montgomery County Department of Health and Human Services, is Montgomery County's formal Community Health Improvement Process (CHIP). Healthy Montgomery aims to improve access to health and social services, achieve health equity, and support optimal health and well-being for Montgomery County residents through a dynamic, ongoing process that allows stakeholders to monitor and act on conditions affecting the health and well-being of its residents.

Healthy Montgomery is governed by a Steering Committee composed of members from the public health system, such as county government and public health officials, advocacy groups, academic institutions, minority health programs/initiatives, and members of health care provider organizations.

Suburban Hospital is a founding and permanent steering committee member, providing recommendations and technical expertise to help advance periodic county-wide needs assessments, identify and prioritize health needs, leverage population-based data and information, and research and adopt best-practice strategies for health improvement. Since 2010, Suburban Hospital has contributed $25,000 annually (or $225,000 to date) to support an ongoing health improvement process and infrastructure. A list of Healthy Montgomery Steering Committee Members is provided in **Appendix I**.

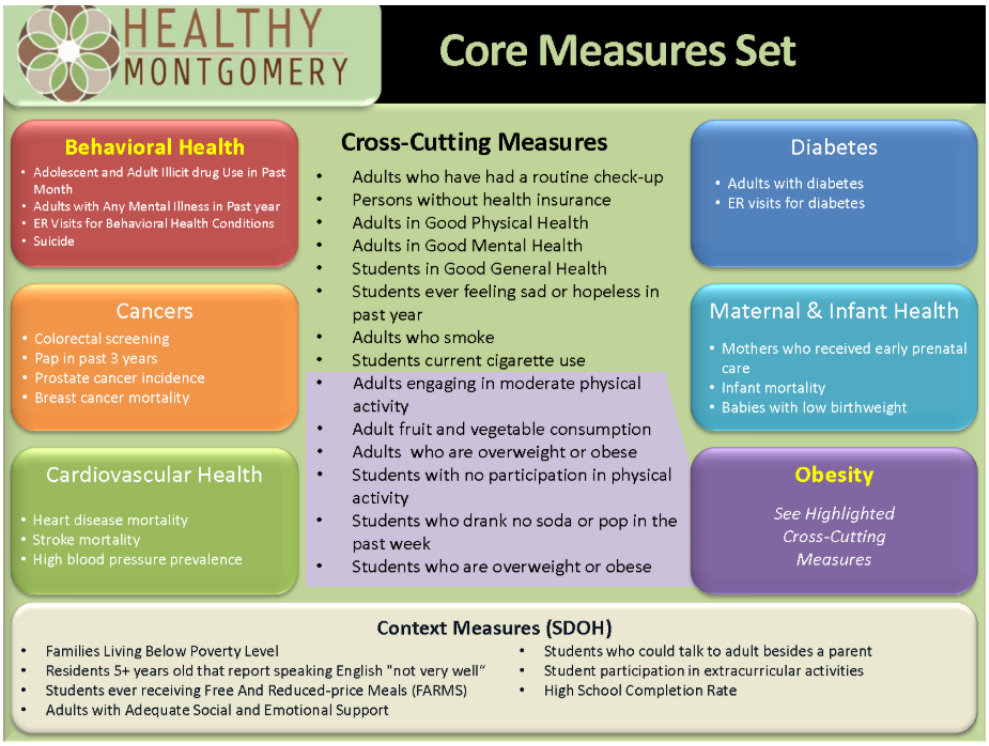
Over the years, the Healthy Montgomery collaborative, through a community and consensus-driven approach, has identified five key health priority areas for Montgomery County residents: obesity, behavioral health, diabetes, cardiovascular disease, cancer and maternal and child health.

By working directly with Healthy Montgomery, Suburban Hospital can (1) align county-wide health priorities and strategies with those identified for Suburban's CBSA community and (2) monitor progress aimed to achieve health equity for all residents.

In September 2014, the Healthy Montgomery Steering Committee adopted a set of core measures that are designed to evaluate outcomes for health and well-being (**See Figure 29**).

To see all 37 core measures in detail, please visit http://www.healthymontgomery.org. This online resource provides detailed documentation on each measure as well as the most recent data for subgroup comparisons and benchmarking to state and federal efforts (MD SHIP, HP2020).

Figure 29. The Healthy Montgomery Core Measures [22]



B. COMMUNITY HEALTH IMPROVEMENT COUNCIL

Suburban Hospital's Community Health Improvement Advisory Council (CHIAC) is comprised of a diverse group of local businesses, not-for-profit executives and community advocacy leaders. Chartered by the Hospital's Board of Trustees and chaired by a trustee, the Advisory Council exists to provide expert recommendations on the health needs of Suburban's community. In addition to helping identify and prioritize community needs, the Council guides and participates in the planning, development and implementation of programs and activities for the improvement of health in the community served by Suburban Hospital. A comprehensive list of Council members who guided the development of the 2019 CHNA is available in **Appendix J**.

C. COMMUNITY INPUT

While secondary data (from sources such as Healthy Montgomery, County Health Rankings, Warehouse Indicators, Data Montgomery, and the MD Vital Statistics Report) provide a macroscopic view of the causes of morbidity and mortality in populations, Suburban Hospital prioritized the need to understand the unmet health needs of our community. This process included the development and distribution of a community health survey tool that allowed the collection of direct input from community

members (See **Appendix K**: Community Health Survey Tool).

The objective of the survey was to gather community input and perspectives on the following topics:

- Biggest health issues or concerns in the community
- Trends relative to demographics and community health status
- Perceived health risks and benefits
- Wellness services lacking in the community
- Barriers and services related to chronic health conditions
- Recommendations for improving health prevention programs in the community

Survey Data Collection

The survey population was sampled randomly, which afforded the best opportunity to gain valuable opinions of residents living in our community. The survey was distributed jointly by Suburban Hospital and a local medical practice. A total of 151 surveys were collected and utilized for data analysis. While the County-wide health needs assessment process "Healthy Montgomery" provides a picture of the health status of Montgomery County residents at-large, the findings from the survey results served as an additional primary source of information for behaviors, needs, and opinions about various health and community issues directly affecting Suburban Hospital's CBSAs. The age distribution of survey respondents varied, but the majority (81%) were over the age of 50 and mostly female (55%) (**See Figure 30**). Survey participants reported living primarily in Bethesda (20817 & 20814), Potomac (20854), and Rockville (20850, 20851, 20852 & 20853) (**See Figure 31**).

Figure 30. Survey Respondents Age Group Distribution

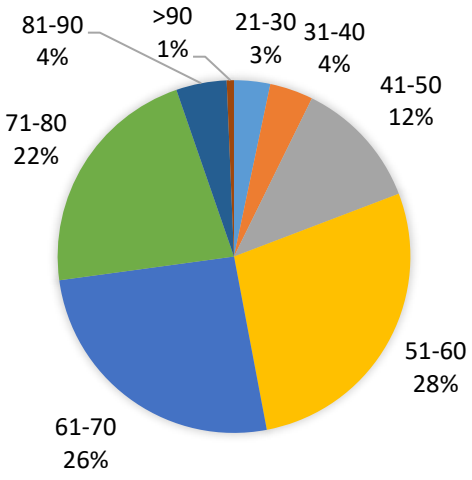
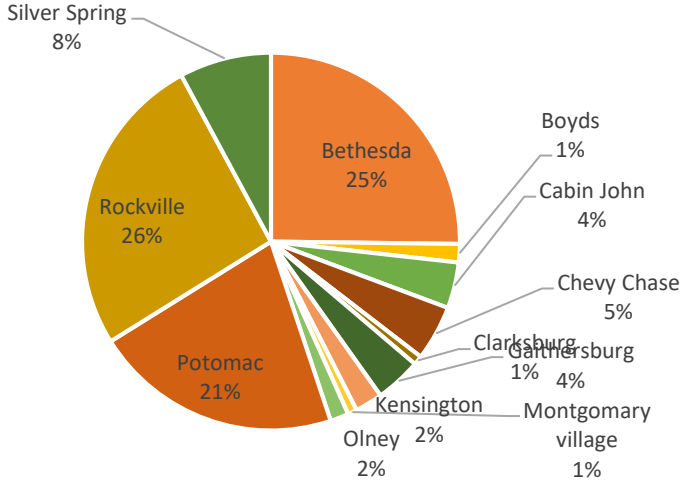


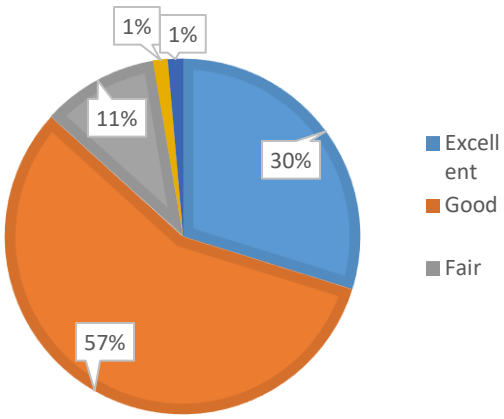
Figure 31. Survey Respondents City of Residence



Health Survey Results

The survey results serve as an information guide for the behaviors, needs, and opinions about various issues directly affecting residents in our CBSA zip codes. The complete survey findings are available in **Appendix L**.

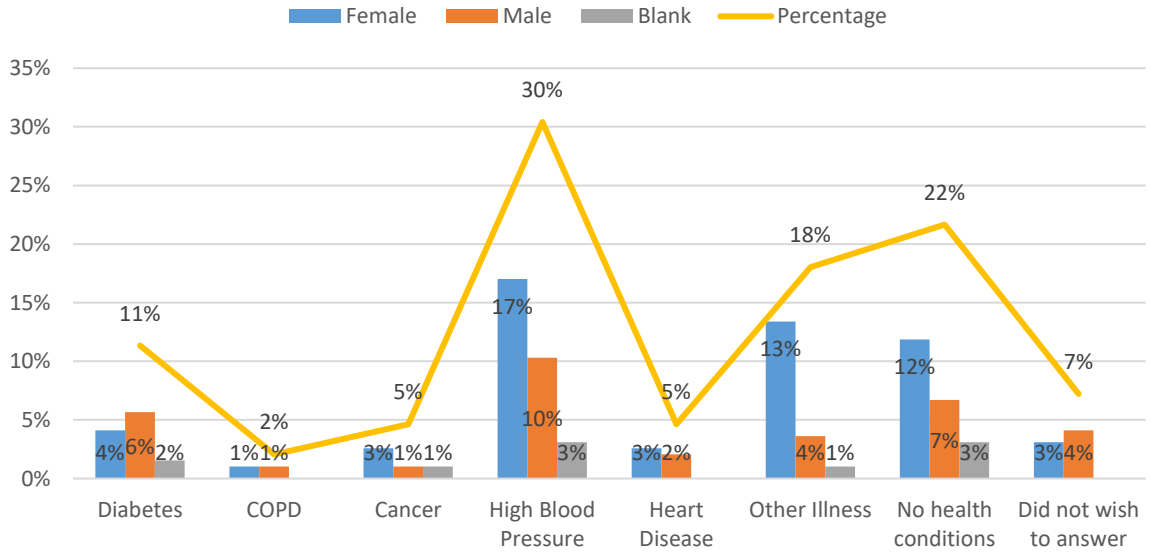
Figure 32. Participants Reported Health Status (%)



Self-Reported Health Status. Self-reported health status is a strong prognostic indicator for subsequent mortality, and in particular for responses that fall in the fair and/or poor category. A significant number of surveyed individuals (87%) reported to either having excellent (30%) or good (57%) health status. A small percentage (4%) reported having fair or poor health status (See **Figure 32**). At the County level, 89.7% of the adult population reported their status as good or better.

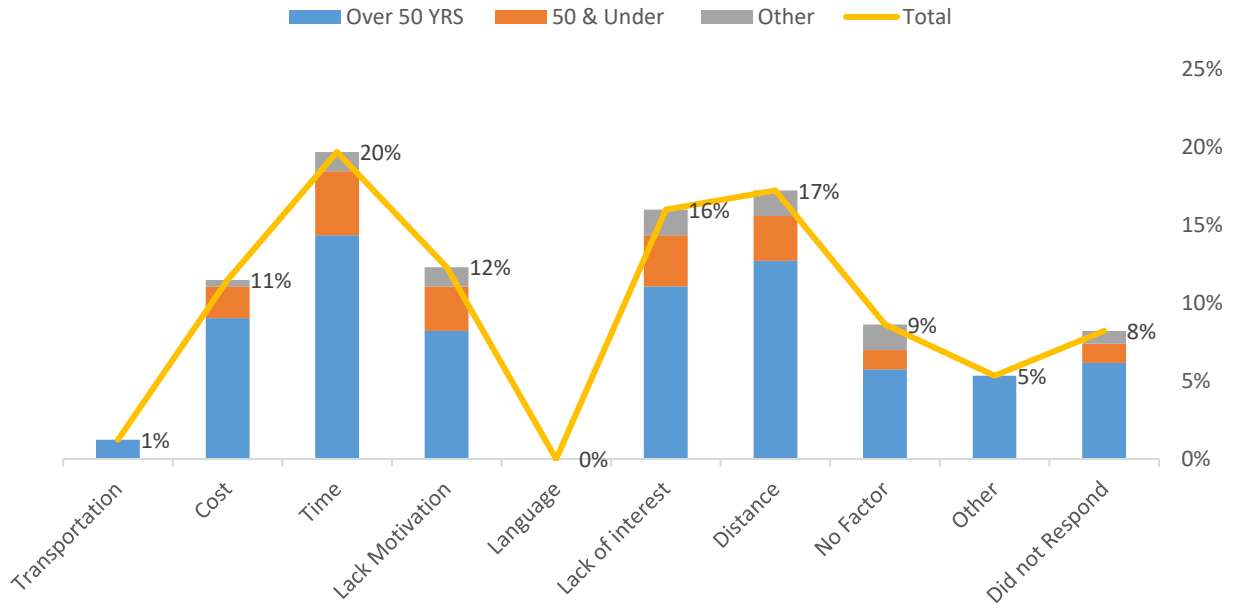
Chronic Disease Prevalence. While 22% of respondents (n=151) reported the absence of any health condition, 63% reported living with at least one chronic condition, and 35% reported living with a least two co-morbidities. The most common diagnoses present in the population were hypertension (30%) and diabetes (11%). Other conditions reported included high cholesterol (2.6%), asthma (3.3%), and arthritis (6.6%). See **Figure 33**.

Figure 33. Prevelance of Chronic Conditions



Health Barriers. Respondents were asked to share the barriers keeping them from accessing health education/prevention programs. Participants were given nine different categories to choose from plus an option to write an open response. **Figure 34** presents the top barriers to health program participation, as reported by respondents. The top three factors preventing individuals from participating in a wellness program include time, distance and lack of interest. Other factors included work schedules and family obligations. However, 9% of participants stated they had no barriers preventing them from participating.

Figure 34. Barriers To Program Participation



Topics of Interest. Participants were provided with a list of wellness topics to assess their interest level. Whereas 42% reported not likely to participate in a wellness program, the remaining participants expressed interest in weight management (24.5%), heart health (16.5%), diabetes self-management (9%), chronic disease self-management (9%), pre-diabetes (7%), and smoking cessation (1%). In addition, 11% listed exercise, pain management, depression, bone health and asthma as other areas of interest.

8 PHASE II: PRIORITIZATION OF HEALTH NEEDS

A. IDENTIFIED HEALTH NEEDS

The datasets presented in Phase I of the assessment were reviewed and used to measure the magnitude of the top health problems in Montgomery County (e.g., causes of morbidity and mortality) and Suburban's community. The outcome is a comprehensive list, comprised of 14 health conditions, which served as the basis for the priority setting process. The list of identified health needs is presented in **Table 8**.

Table 8. Identified Health Needs

Leading Causes of Mortality in Montgomery County	Top Causes of Hospitalization & Emergency Room Utilization in Montgomery County	Top Causes of Hospitalization at Suburban Hospital
Cardiovascular diseases	Cardiovascular diseases	Cardiovascular diseases
Cancer	Cancer	
Cerebrovascular	Cerebrovascular	Cerebrovascular
Diabetes mellitus	Diabetes mellitus	
Chronic respiratory diseases	Chronic respiratory diseases	
Accidents (unintentional injuries)	Accidents (unintentional injuries)	
	Mental Health	Mental Health (Bipolar)
	Substance Abuse	Substance Abuse (Alcohol Abuse)
	Suicide	Suicide (Major Depressive Disorder)
		Orthopedics
Influenza & Pneumonia		Influenza & Pneumonia
Septicemia		Septicemia
Nephritis		Nephritis (Kidney & UTIs)
Alzheimer's Disease		

In Phase II of the assessment, dialogue with key informants was facilitated to share findings from the multiple datasets and to solicit and align recommendations.

Suburban Hospital convened a CHNA Ad Hoc Committee, comprised of key stakeholders from Suburban Hospital's Health Improvement Advisory Council, health care consumer advocates, faith-based and community-based organizations, Montgomery County, and a local health care provider. The Ad Hoc Committee voiced insight into the needs of the community and analyzed needs assessment data gaps. The

Committee also played a critical role in the development of the prioritization process. See **Appendix M** for a list of Ad Hoc Committee Members.

In addition to the expertise contributed by the Committee, Suburban Hospital engaged conversations with quality health experts from Johns Hopkins Health System, Dr. Eric Dobkin, Vice President of Medical Affairs and Ms. Eileen Pummer, Senior Director of Quality & Compliancy, for their first-hand knowledge of the major health concerns, barriers and needs for Suburban's patient population.

B. HEALTH PRIORITY SETTING

Suburban Hospital's Community Health and Wellness (CHW) Division served as a key player in shaping the CHNA process by integrating public health knowledge, principles, and expertise. The CHW Division acted as a public health resource and guide, due in part to the educational background of the staff, strong relationships with the community and firsthand knowledge of major health concerns, barriers and needs. Furthermore, the Division works collaboratively with the Montgomery County Health and Human Services Department and other Montgomery County Hospitals, coalitions, community partners and leaders to ensure common goals are established to best leverage and provide resources to our county's most vulnerable residents.

Suburban Hospital's priority setting process consisted of comparing the health needs identified through data research and aligning them with *Healthy Montgomery's* six county-wide health priorities. This approach fostered a meaningful and comprehensive understanding of the needs of the community.

The prioritization process also included extensive discussion with the CHNA Ad Hoc Committee members and Quality Health Experts to help rank the critical health issues facing Suburban's community as identified in **Table 8**.

Through a voting process, the CHNA Ad Hoc Committee selected eight top health issues from the 14 total conditions presented in table 8. Suburban Hospital Quality Health Experts panel identified six. **Table 9** provides a summary of the health needs identified through our research and community input (see page 36). The information on this table helps to distinguish where findings and recommendation overlap and align with the County's established health priorities and health outcome findings. The data that materialized from this analysis helped support the prioritization process that followed.

Table 9. Alignment of Health Priorities

	Leading Causes of Mortality in Montgomery County	Top Causes of Hospitalizations/ ED Utilization in Montgomery County	Top Causes of Hospitalization/ Readmission at Suburban Hospital	Healthy Montgomery Health Priorities	CHNA Ad Hoc Committee Recommendation	Quality Health Experts Recommendation
Heart disease	X	X	X	X	X	X
Cancer	X	X		X	X	X
Diabetes Mellitus	X	X		X	X	
Chronic lower respiratory diseases	X	X				
Accidents (unintentional injuries)	X	X				X
Obesity				X	X	
Behavioral/Mental Health		X	X	X	X	X
Maternal & Infant Health				X		
Infections (i.e. septicemia)	X		X		X	X
Orthopedics			X			

The CHW Division integrated the identified health needs into Suburban's formula for priority setting (**See Figure 36**). The health needs prioritization process consists of aligning the identified community needs with Suburban's strategic priorities, integrating the hospital's areas of expertise into the decision making, and applying a collective impact approach to strengthening our efficiency and achieving purposeful outcomes.

The priority setting formula helps to build a strong connection and continuum of care to facilitate health equity and optimal health for our community.

Figure 36. Priority Setting Process

C. HEALTH PRIORITY VALIDATION AND CONSENSUS

The structured priority-setting process, led by numerous discussions based on recent health data, guided community stakeholders to the identification of six health priorities for measurement and intervention via our 2019 implementation plan. Initially identified during the first iteration of this assessment in 2013, the data and recommendations validate the following four chronic conditions as continued health priorities for Suburban's community:

- Cardiovascular Disease
- Cancer
- Diabetes
- Behavioral Health

These four health priorities overlap or align with national, state, and local priorities (**See Table 10**). This relationship affords Suburban Hospital the ability to align its community health improvement efforts to existing actions to decrease health inequities, improve access and reduce unhealthy behaviors.

In addition to the four priorities, Suburban identified two focus areas where an absence of coordinated efforts and initiatives currently exist. These two focus areas, which have been labeled as emerging priorities for our community, include unintentional injuries and infections.

As outlined in this assessment, there is sufficient evidence to suggest the need to advance preventive approaches to minimize their future toll in our health care system and support optimal quality of life in our community.

The 2019 implementation plan will describe Suburban's approach for addressing and evaluating these six health priorities.

Table 10. Comparison of Federal, State, and Local Health Priorities

Healthy People 2020: Leading Health Indicators	Maryland State Health Improvement Plan 2017 (SHIP)	Healthy Montgomery 2016
Mental Health, Substance Abuse, & Tobacco	Healthy Communities	Behavioral Health
Access to Health Services, Clinical Preventive Services	Access to Health Care	Cancer
Nutrition, Physical Activity, and Obesity	Qualitative Preventive Care	Obesity
Maternal, Infant, and Child Health	Healthy Beginnings	Maternal and Child Health
Social Determinants	Healthy Living	Diabetes
Environmental Quality, Injury & Violence		Cardiovascular Health
Oral Health, Reproductive and Sexual Health		

Source: US Department of Health and Human Services, MD Department of Health and Mental Hygiene, and Healthy Montgomery, 2019

D. UNADDRESSED IDENTIFIED NEEDS

Suburban Hospital recognizes the importance of supporting needs outside of the five identified health priorities through the innovative leveraging of resources with community partners to improve health outcomes for Montgomery County residents. As such, Suburban Hospital will continue to work directly - contingent upon resource availability - with several community centers, organizations, institutes, and corporations, including, but not limited to AARP, A Wider Circle, Alpha Phi Alpha Fraternity, American Heart Association, American Red Cross, and Bethesda Cares to support unaddressed needs and social determinants of health affecting vulnerable populations.

The Healthy Montgomery Steering Committee established six official health priorities to be tracked, measured, and evaluated based on health inequities, lack of access, and unhealthy behaviors over the next three years. One of these health priorities is Maternal and Child Health. Suburban Hospital is not in a position to affect all of the changes required to address this health priority given that the hospital does not have an obstetrics designation. The reason for not seeking this designation is because there are several other community hospitals within 5-10 miles of our Bethesda location that have an obstetrics program.

While Suburban Hospital may not be able to address this health priority directly, the hospital will continue indirectly support Maternal and Child Health initiatives by providing funding and program support to organizations that promote the health and well-being of children and their families. For example, Suburban Hospital supports the YMCA Youth and Family Services by hosting parenting seminars at the hospital twice a year. Proceeds from the seminars go directly to the YMCA and support its programming for local families.

In addition, Suburban Hospital provides financial support to safety net clinics in Montgomery County that treat patients requiring obstetric or pediatric care. The Hospital is also the official health sponsor of Girls on the Run Montgomery County. Girls On the Run is an organization dedicated to inspiring girls to be healthy and confident through running and an experience-based curriculum. The Hospital provides discounted CPR and First Aid training classes to program coaches, purchases shoes and healthy snacks for students from Title I schools, and provides health tips on Girls on the Run Montgomery County website.

9 CONCLUSION

Suburban Hospital is committed to and invested in caring for the community it serves. Suburban has a long history of dedicated health initiatives addressing the needs of vulnerable populations including the under- and uninsured, low-income, racially and ethnically diverse, underserved seniors and at-risk youth. In collaboration with local community stakeholders and other aligned organizations with a shared vision, Suburban has always strived to meet the needs and demands

of those who reside in Montgomery County and beyond. Along with the establishment of Healthy Montgomery's Community Health Improvement Process and specific supporting data collected from Suburban Hospital's community health needs assessment, the process by which the hospital prioritizes its efforts are more specialized, focused and deliberate to allow it to address the six identified health priorities: *diabetes, cardiovascular disease, cancer, behavioral health, infections and unintentional injuries*.

Furthermore, the CHNA process has afforded Suburban Hospital the opportunity to polish the community health improvement lens, which will guide the organization to a specific focus on identifying barriers to accessing health care, addressing community perceptions of major health concerns, evaluating demographic, economic and health care provider trends, addressing lack of available health services and leveraging resources to improve access to care and overall quality of life.

Suburban Hospital and its partners will continue to work diligently over the next three years to ensure that the valuable information attained from the CHNA is an indispensable tool to measure and evaluate how established health targets and goals are achieved. The health implementation plan will continue to be an evolving hospital strategy and process to produce the best care and services for optimal health and quality of life for Montgomery County residents.

10 APPENDICES

Appendix A. Suburban Hospital Board of Trustees 2018-2019

Name	Title, Company
Sudeep Anand, Ph.D.	Treasurer, Smithsonian Institution (Retired)
Mary Ellen Beliveau	CEO, Knowledge to Practice
Brian Winston Cobb	Chief Technology Officer, Brown Advisory
Linda Courie	Senior Commercial Banker
Jonathan Efron, M.D.	Director, Division of Colorectal Surgery Associate Professor of Surgery, Johns Hopkins Hospital
Lara Eisenberg, M.D.	Community Radiologist
Mark Futrovsky	President, Rolyn Companies, Inc.
Howard Gleckman (Chairman)	Senior Research Associate, The Urban Institute
Maria Gomez	President & CEO, Mary's Center
Ann S. Harrington	Circuit/County Administrative, Law Judge
Norman K. Jenkins	Chairman/CEO, Capstone Development, LLC
Janine Lossing	Consultant
John C. Otsuki	Chief Administrative & Compliance Officer, National Real Estate Advisors
Lily Qi	Office of the County Executive, Montgomery County Government
Jacqueline (Jacky) Schultz	President, Suburban Hospital
William J. Shaw	Chairman, Marriott Vacation Worldwide, Corp.
Alan Sheff, M.D.	President, Potomac Physician Associates
Michael A. Smith, M.D.	Senior Attending Radiologist/ Director Ultrasound, MedStar Medical Group Radiology
Charles Allen Wiebe (Vice Chairman)	BIA Capital Strategies, LLC BIA Digital Partners, LP
Barton Leonard, M.D. (Ex Officio Member)	Medical Staff Chair Emergency Medicine, Suburban Hospital
Kevin Sowers (Ex Officio Member)	President, Johns Hopkins Health System Executive Vice President of Johns Hopkins Medicine

Appendix B. Health Priorities Indicator Progress Since 2016 Assessment

Improvement
Decline
No Change
HM= Healthy Montgomery
*Indicator Re-Defined From 2016

HM Core Measure Indicator by Priority Area	State	County	HP 2020 Goal	MD 2017 Goal	Suburban Hospital Initiatives
Behavavioral Health					
Adolescent and adult illicit drug use <30 days (2012-14)	9.69	8.91	16.6		– Suburban Hospital provides multiple comprehensive Behavioral Health Services for individuals with emotional problems, mental illness and addictive diseases, as well as some services designed to foster mental health – Suburban Hospital offers support groups to help community members manage mental stress associated with chronic and acute health conditions – Suburban Hospital's comprehensive community health improvement programs foster social support, particularly among the senior population, due to the continuous encounters with the same population
Adults with any mental illness <1yr (2012-14)	16.8	16.23			
ER visits for behavioral health conditions (2017)	4291.5	2312.1		3152.6	
Suicide (2014-16)	9.2	7.2	10.2	9	

HM Core Measure Indicator by Priority Area	State	County	HP 2020 Goal	MD 2017 Goal	Suburban Hospital Initiatives
Cancers					
Colorectal Screening* (2016)	73.7	71.3	70.5		– Suburban Hospital has historical partnerships with organizations to deliver free cancer awareness programs, early prevention and service programs for prostate, colorectal, skin, and breast cancer – Suburban's Cancer Center is affiliated with the Bethesda-based National Cancer Institute, offering patients access to extraordinary treatment options and clinical research trials – Cancer-focused patient navigators and support groups
Pap in past 3 years (2011-15)	71.9	86.7	93		
Prostate cancer incidence (2011-15)	125.7	111.4			
Breast cancer mortality (2011-15)	22.4	18.1	20.7		

HM Core Measure Indicator by Priority Area	State	County	HP 2020 Goal	MD 2017 Goal	Suburban Hospital Initiatives
Cardiovascular Health					
Heart disease mortality (2014-16)	166.9	103.7	152.7	166.3	– Through collaboration with the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health and Johns Hopkins Medicine, Suburban Hospital's Heart Center offers state-of-the-art cardiac surgery, angioplasty, cardiac diagnostics and rehabilitation – Suburban's HeartWell Program offers free cardiovascular health education, disease management, and nutrition classes at local senior centers throughout the county – Through partnerships with Montgomery County Departments of Recreation and Senior Services, Suburban Hospital offers fitness exercise programs to the community – Suburban Hospital has a comprehensive health and wellness program available, including blood pressure and cholesterol screenings, educational seminars, and free exercise programs that promote a healthy cardiovascular system – One-of-its kind specialty care clinic held in partnership with Mobile Medical Care, Inc. and the National Institutes of Health, Suburban Hospital offers comprehensive cardiovascular treatment services including diagnostic to open heart-surgery to uninsured Montgomery County residents at low or free cost
Stroke mortality (2015)	40.1	28.1	34.8		
High blood pressure prevalance	33.1%	24.7%	26.9		

HM Core Measure Indicator by Priority Area	State	County	HP 2020 Goal	MD 2017 Goal	Suburban Hospital Initiatives
Diabetes					– Suburban Hospital's one-of-its kind specialty care clinic held in partnership with Mobile Medical Care, Inc. and the National Institutes of Health offers comprehensive endocrine-related treatment at low or free cost to the uninsured population – A long-standing partnership with a safety-net clinic, Proyecto Salud, provides uninsured individuals with quality diabetes management services and outpatient education – Two regional symposia featuring breakthroughs in treatment – Support Group for patients with diabetes – Quarterly pre-diabetes classes – Hospital Glucose Steering Committee & Diabetes Nursing Champions
Adults with diabetes (2019)	11%	8%	7.2		
ER visits for diabetes (2017)	243.7	127.9		186.3	
Age-Adjusted ER Rate due to diabetes (2008-17)*		414.6			

Healthy Montgomery Core Measure Indicator by Priority Area	State	County	HP 2020 Goal	MD 2017 Goal	Suburban Hospital Initiatives
Obesity					– Suburban Hospital's longstanding partnership with Sodexho links nutrition services, by registered dieticians, to communities outside the walls of the hospital – Suburban Hospital collaborates and leverages resources with local organizations to offer free seminars, cooking demos, walking programs, fitness programs, cooking classes to help improve community members' nutrition and exercise level – Suburban Hospital offers specialized weight and chronic disease management programs and services – Suburban Hospital supports Community Supported Agriculture (CSA) programs providing staff and their families the opportunity to purchase local fruits and vegetables on hospital property
Total 20+ Population Physical Inactivity*	20.6%	15.0%	32.6%		
% adults who report consuming fruit < 1x daily (2017)*	34.3%				
Percent Adults with BMI > 30.0 (Obese)* (2015)	30%	21%	30.5%		
Adolescents who are physically active daily (2017)*	17.90%				
Adolescents who drank soda daily (2017)*	14%				
Students who are overweight or obese (2016)	12.6	7.8	16.1	10.7	

Sources:

Maryland Healthcare Services and Cost Review Commission annual emergency room outpatient discharges (HSCRC ER)
Maryland Department of Health & Mental Hygiene (DHMH), Vital Statistics Administration Annual Birth Files, Montgomery County (VSA Births)
Maryland Department of Health & Mental Hygiene (DHMH), Vital Statistics Administration Annual Death Files, Montgomery County (VSA Births)
National Survey on Drug Use and Health (NSDUH)
National Cancer Institute (NCI)
Maryland Behavioral Risk Factor Surveillance System (BRFSS)
Maryland Youth Risk Behavior Survey (YRBS)
American Community Survey (ACS)
Montgomery County Public Schools (MCPS)
Maryland State Health Improvement Process (SHIP)
http://dhmh.maryland.gov/ship/SitePages/Home.aspx
Healthy Montgomery http://www.healthymontgomery.org/
State Cancer Profiles http://statecancerprofiles.cancer.gov/
http://www.dartmouthatlas.org/data/table.aspx?ind=198
Community Commons sessment.communitycommons.org
Health Indicators Warehouse http://www.healthindicators.gov/
Centers for Disease Control (CDC)

Appendix C. Suburban Hospital's Primary Service Area Zip Codes

Zip Code	PSA	City	State	County
20812	PSA	GLEN ECHO	MD	MONTGOMERY
20813	PSA	BETHESDA	MD	MONTGOMERY
20814	PSA	BETHESDA	MD	MONTGOMERY
20815	PSA	CHEVY CHASE	MD	MONTGOMERY
20816	PSA	BETHESDA	MD	MONTGOMERY
20817	PSA	BETHESDA	MD	MONTGOMERY
20818	PSA	CABIN JOHN	MD	MONTGOMERY
20824	PSA	BETHESDA	MD	MONTGOMERY
20825	PSA	CHEVY CHASE	MD	MONTGOMERY
20827	PSA	BETHESDA	MD	MONTGOMERY
20859	PSA	POTOMAC	MD	MONTGOMERY
20889	PSA	BETHESDA	MD	MONTGOMERY
20891	PSA	KENSINGTON	MD	MONTGOMERY
20892	PSA	BETHESDA	MD	MONTGOMERY
20895	PSA	KENSINGTON	MD	MONTGOMERY
20896	PSA	GARRETT PARK	MD	MONTGOMERY
20894	PSA	BETHESDA	MD	MONTGOMERY
20847	PSA	ROCKVILLE	MD	MONTGOMERY
20848	PSA	ROCKVILLE	MD	MONTGOMERY
20849	PSA	ROCKVILLE	MD	MONTGOMERY
20850	PSA	ROCKVILLE	MD	MONTGOMERY
20851	PSA	ROCKVILLE	MD	MONTGOMERY
20852	PSA	ROCKVILLE	MD	MONTGOMERY
20853	PSA	ROCKVILLE	MD	MONTGOMERY
20854	PSA	POTOMAC	MD	MONTGOMERY
20857	PSA	ROCKVILLE	MD	MONTGOMERY

Appendix D. Suburban Hospital 2019 Community Benefit Service Area

Suburban Hospital

2019 Community Health Needs Assessment: Community Benefit Service Area

	2019 CBSA		Criteria for Inclusion			Comparison	
	City	Zip Code	ED (50%)	IP (50%)	Charity Vol (50%)	FY16 CBSA	SH PSA
1	BETHESDA	20814	X	X	X	X	X
2	CHEVY CHASE	20815	X	X	X	X	X
3	BETHESDA	20817	X	X	X	X	X
4	ROCKVILLE	20852	X	X	X	X	X
5	POTOMAC	20854	X	X	X	X	X
6	ROCKVILLE	20850		X	X	X	X
7	ROCKVILLE	20851		X	X	X	X
8	ROCKVILLE	20853		X		X	X
9	SILVER SPRING	20906		X	X	X	
10	SILVER SPRING	20902		X	X	X	
11	SILVER SPRING	20910		X	X	X	
12	SILVER SPRING	20904		X	X		
13	BETHESDA	20816		X			X
14	KENSINGTON	20895	X			X	X

DEFINITIONS

Community Benefit Service Area (CBSA)

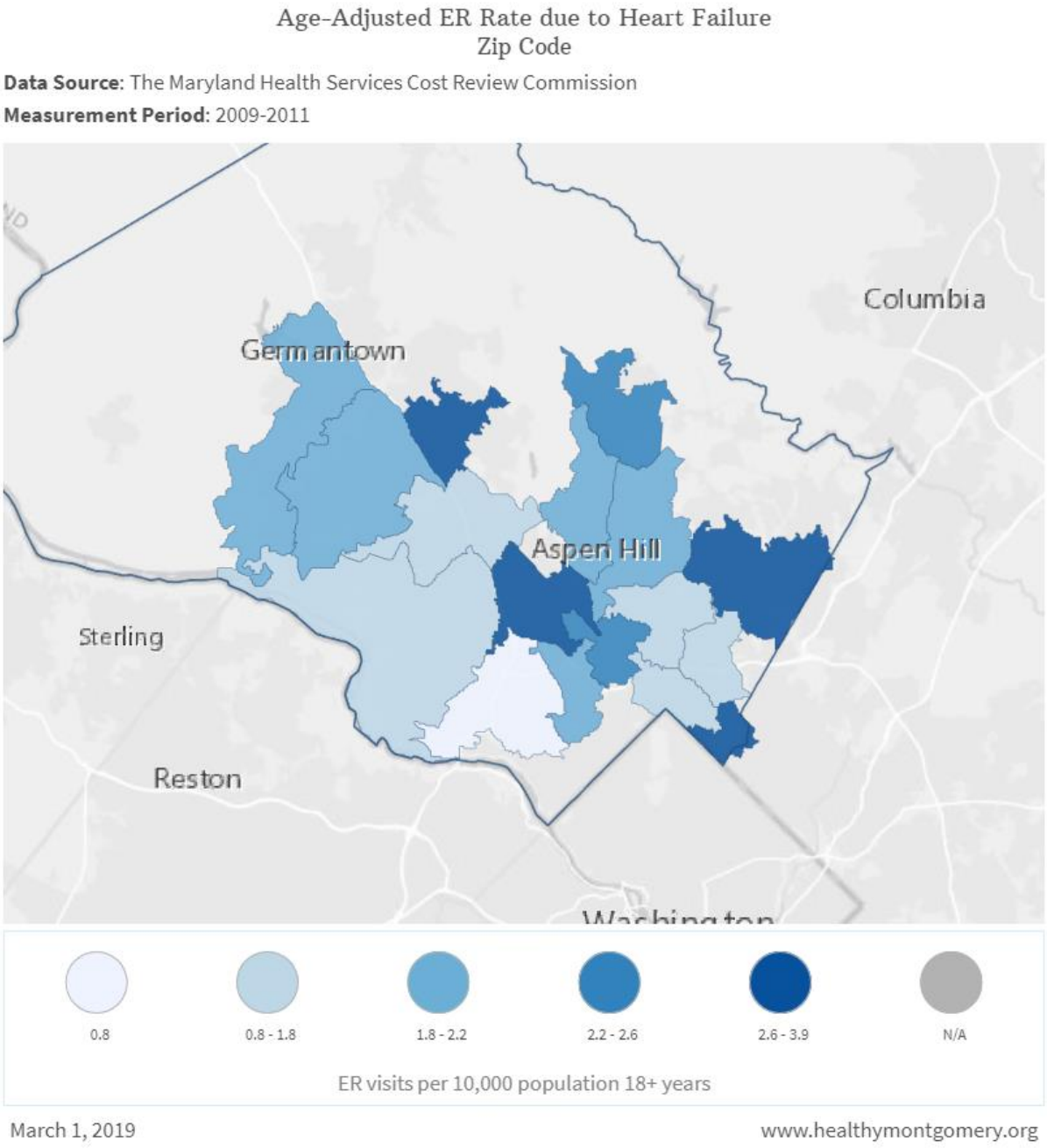
Suburban Hospital considers its Community Benefit Service Area (CBSA) as specific populations or communities of need to which the Hospital allocates resources through its community benefits plan. Within the CBSA, Suburban Hospital focuses on certain target populations such as uninsured individuals and households, underinsured and low-income individuals and households, ethnically diverse populations, underserved seniors and at-risk youth.

To determine the Hospital's CBSA, data from Inpatient Records, Emergency Department (ED) Visits, Charity Care Volume were aggregated and defined by the geographic area

Primary Service Area (PSA)

A PSA or primary service area is defined as the postal zip code areas from which 60 percent of a hospital's inpatient discharges originated during the most recent 12 month period. This information is provided by the Maryland Health Services Cost Review Commission (HSCRC).

Appendix E. Heart Failure Data at the Zip-Code Level, Montgomery County

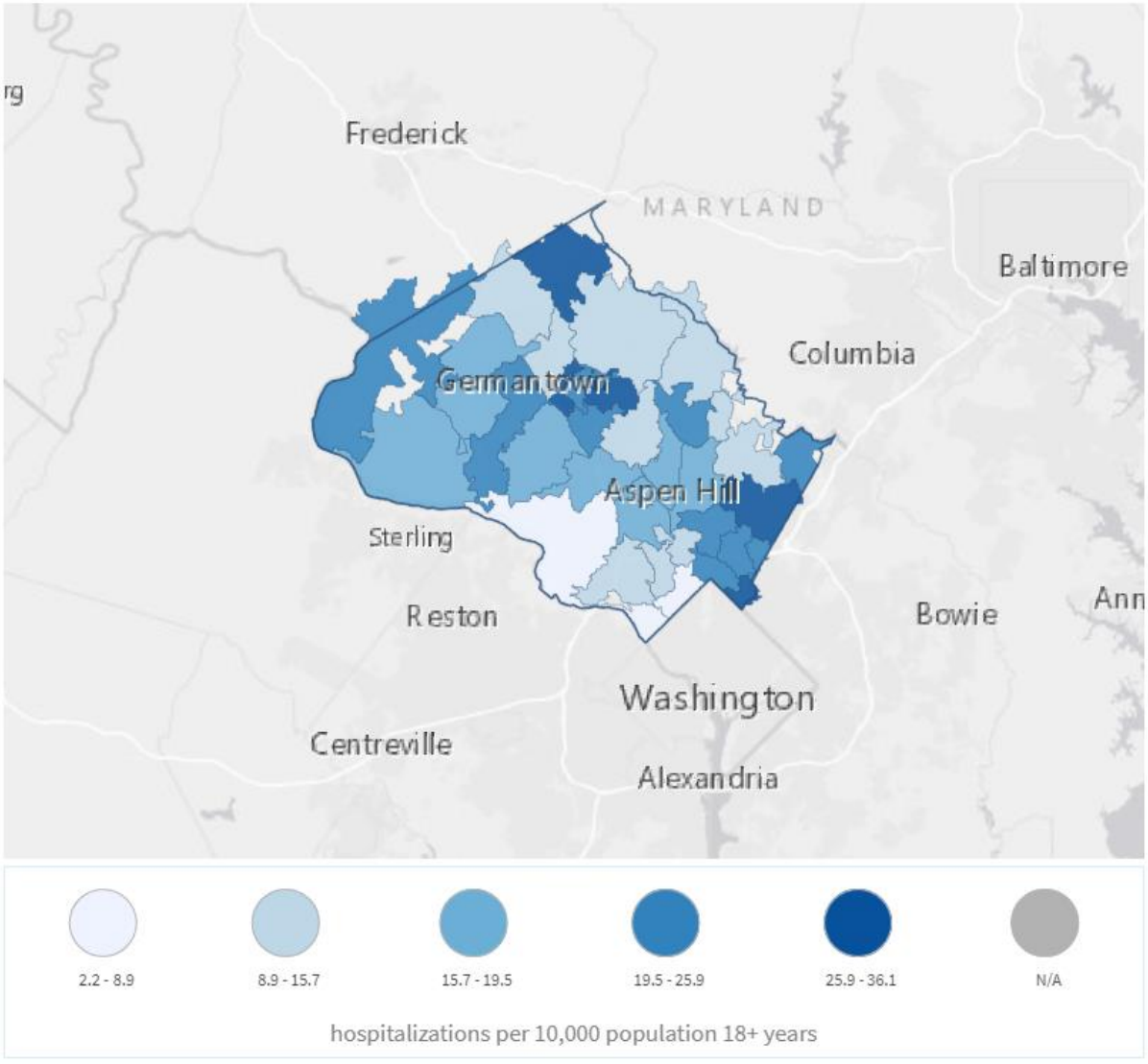


There are **17 Zip Code** values. The lowest value is **0.8**, and the highest value is **3.9**. Half of the values are between **1.7 and 2.5**. The middle (median) value is **2**.

Age-Adjusted Hospitalization Rate due to Heart Failure
Zip Code

Data Source: The Maryland Health Services Cost Review Commission

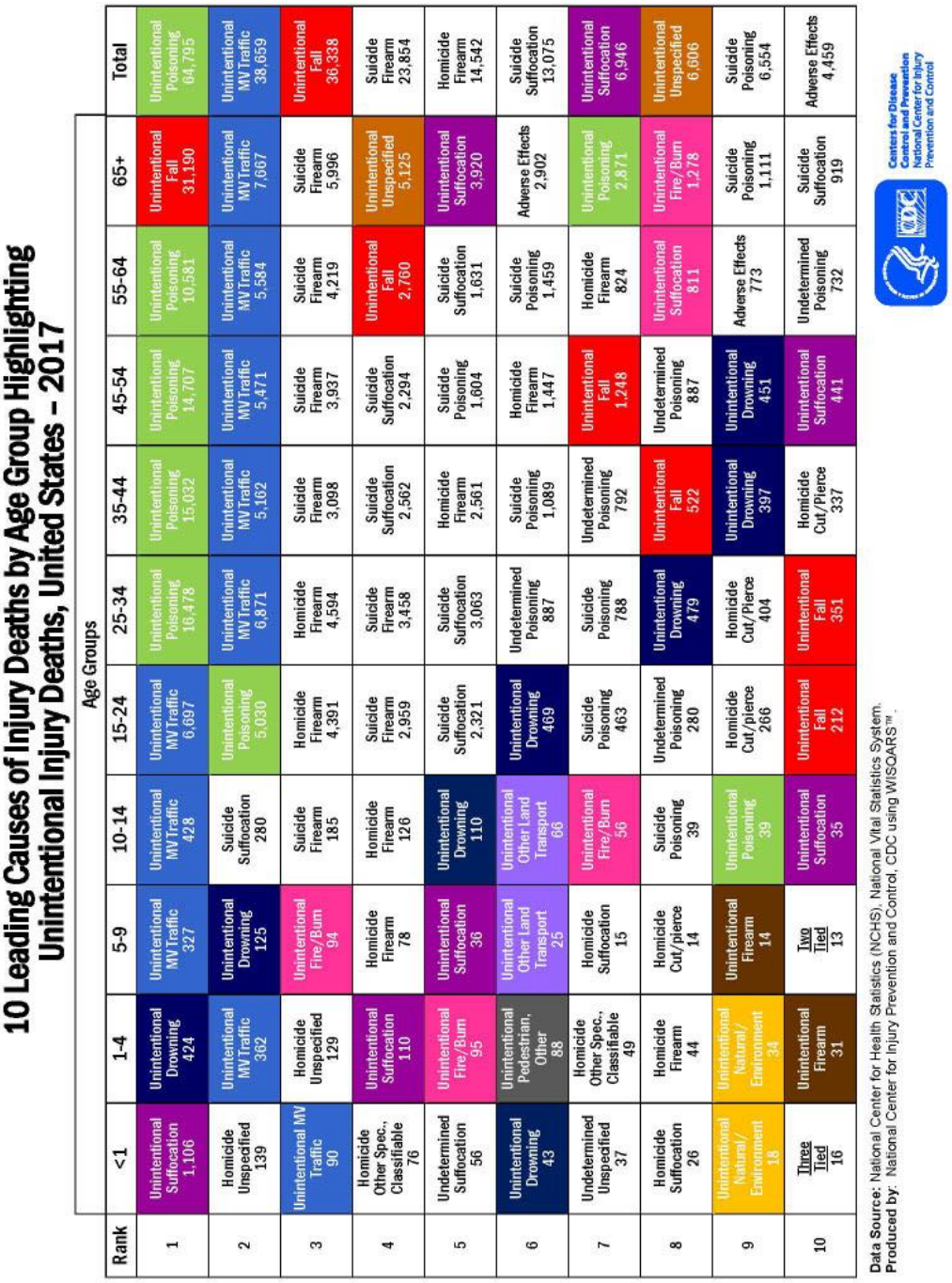
Measurement Period: 2009-2011



March 1, 2019 www.healthymontgomery.org

There are **35 Zip Code** values. The lowest value is **2.2**, and the highest value is **36.1**. Half of the values are between **14.25 and 21.9**. The middle (median) value is **18.8**.

Appendix F. Ten Leading Causes of Unintentional Injuries by Age Group



10 Leading Causes of Injury Deaths by Age Group Highlighting Unintentional Injury Deaths, United States – 2017

Rank	Age Groups											Total
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Unintentional Suffocation 1,106	Unintentional Drowning 424	Unintentional MV Traffic 327	Unintentional MV Traffic 428	Unintentional MV Traffic 6,697	Unintentional Poisoning 16,478	Unintentional Poisoning 15,032	Unintentional Poisoning 14,707	Unintentional Poisoning 10,581	Unintentional Fall 31,190	Unintentional Poisoning 64,795
2	Homicide Unspecified 139	Unintentional MV Traffic 362	Unintentional Drowning 125	Suicide Suffocation 280	Unintentional Poisoning 5,030	Unintentional MV Traffic 6,871	Unintentional MV Traffic 5,162	Unintentional MV Traffic 5,471	Unintentional MV Traffic 5,584	Unintentional MV Traffic 7,667	Unintentional MV Traffic 38,659
3	Unintentional MV Traffic 90	Homicide Unspecified 129	Unintentional Fire/Burn 94	Suicide Firearm 185	Homicide Firearm 4,391	Homicide Firearm 4,594	Suicide Firearm 3,098	Suicide Firearm 3,937	Suicide Firearm 4,219	Suicide Firearm 5,996	Unintentional Fall 36,338
4	Homicide Other Spec., Classifiable 76	Unintentional Suffocation 110	Homicide Firearm 78	Homicide Firearm 126	Suicide Firearm 2,959	Suicide Firearm 3,458	Suicide Suffocation 2,562	Suicide Suffocation 2,294	Unintentional Fall 2,760	Unintentional Unspecified 5,125	Suicide Firearm 23,854
5	Undetermined Suffocation 56	Unintentional Fire/Burn 95	Unintentional Suffocation 36	Unintentional Drowning 110	Suicide Suffocation 2,321	Suicide Suffocation 3,063	Homicide Firearm 2,561	Suicide Poisoning 1,604	Suicide Suffocation 1,631	Unintentional Suffocation 3,920	Homicide Firearm 14,542
6	Unintentional Drowning 43	Unintentional Pedestrian, Other 88	Unintentional Other Land Transport 25	Unintentional Other Land Transport 66	Unintentional Drowning 469	Undetermined Poisoning 887	Suicide Poisoning 1,089	Homicide Firearm 1,447	Suicide Poisoning 1,459	Adverse Effects 2,902	Suicide Suffocation 13,075
7	Undetermined Unspecified 37	Homicide Other Spec., Classifiable 49	Homicide Suffocation 15	Unintentional Fire/Burn 56	Suicide Poisoning 463	Suicide Poisoning 788	Undetermined Poisoning 792	Unintentional Fall 1,248	Homicide Firearm 824	Unintentional Poisoning 2,871	Unintentional Suffocation 6,946
8	Homicide Suffocation 26	Homicide Firearm 44	Homicide Cut/pierce 14	Suicide Poisoning 39	Undetermined Poisoning 280	Unintentional Drowning 479	Unintentional Fall 522	Undetermined Poisoning 887	Unintentional Suffocation 811	Unintentional Fire/Burn 1,278	Unintentional Unspecified 6,606
9	Unintentional Natural/ Environment 18	Unintentional Natural/ Environment 34	Unintentional Firearm 14	Unintentional Poisoning 39	Homicide Cut/pierce 266	Homicide Cut/Pierce 404	Unintentional Drowning 397	Unintentional Drowning 451	Adverse Effects 773	Suicide Poisoning 1,111	Suicide Poisoning 6,554
10	Three Tied 16	Unintentional Firearm 31	Two Tied 13	Unintentional Suffocation 35	Unintentional Fall 212	Unintentional Fall 351	Homicide Cut/Pierce 337	Unintentional Suffocation 441	Undetermined Poisoning 732	Suicide Suffocation 919	Adverse Effects 4,459

Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System.
Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

National Estimates of the 10 Leading Causes of Nonfatal Injuries Treated in Hospital Emergency Departments, United States – 2017

Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Unintentional Fall 120,007	Unintentional Fall 699,107	Unintentional Fall 530,390	Unintentional Struck By/Against 451,267	Unintentional Struck By/Against 755,114	Unintentional Fall 647,408	Unintentional Fall 623,997	Unintentional Fall 828,731	Unintentional Fall 1,047,959	Unintentional Fall 2,970,720	Unintentional Fall 8,591,683
2	Unintentional Struck By/Against 23,356	Unintentional Struck By/Against 254,793	Unintentional Struck By/Against 323,525	Unintentional Fall 451,183	Unintentional Fall 671,408	Unintentional MV-Occupant 579,446	Unintentional Other Specified 436,726	Unintentional Other Specified 473,983	Unintentional Other Specified 356,187	Unintentional Struck By/Against 312,954	Unintentional Struck By/Against 3,685,012
3	Unintentional Other Bite/Sting 13,505	Unintentional Other Bite/Sting 139,941	Unintentional Other Bite/Sting 107,577	Unintentional Overexertion 222,433	Unintentional MV-Occupant 595,092	Unintentional Struck By/Against 528,104	Unintentional Struck By/Against 396,695	Unintentional Overexertion 362,246	Unintentional Struck By/Against 278,211	Unintentional Overexertion 227,817	Unintentional Overexertion 2,569,850
4	Unintentional Other Specified 9,737	Unintentional Foreign Body 121,422	Unintentional Cut/Pierce 88,488	Unintentional Cut/Pierce 99,249	Unintentional Overexertion 493,072	Unintentional Other Specified 517,628	Unintentional Overexertion 395,791	Unintentional Struck By/Against 360,767	Unintentional Overexertion 258,488	Unintentional MV-Occupant 215,666	Unintentional MV-Occupant 2,500,353
5	Unintentional Foreign Body 8,618	Unintentional Cut/Pierce 60,421	Unintentional Overexertion 65,413	Unintentional Unknown/ Unspecified 67,107	Unintentional Cut/Pierce 345,982	Unintentional Overexertion 482,430	Unintentional MV-Occupant 381,110	Unintentional Poisoning 337,444	Unintentional MV-Occupant 249,192	Unintentional Cut/Pierce 162,819	Unintentional Other Specified 2,365,891
6	Unintentional Inhalation/ Suffocation 8,518	Unintentional Overexertion 58,727	Unintentional MV-Occupant 53,791	Unintentional MV-Occupant 64,349	Unintentional Other Specified 331,389	Unintentional Poisoning 401,819	Unintentional Poisoning 321,267	Unintentional MV-Occupant 331,388	Unintentional Poisoning 245,289	Unintentional Other Specified 143,563	Unintentional Cut/Pierce 1,823,358
7	Unintentional Fire/Burn 7,567	Unintentional Other Specified 47,348	Unintentional Foreign Body 52,756	Unintentional Other Bite/ Sting 57,014	Other Assault* Struck By/Against 312,205	Unintentional Cut/Pierce 372,787	Unintentional Cut/Pierce 269,865	Unintentional Cut/Pierce 235,597	Unintentional Cut/Pierce 184,284	Unintentional Poisoning 137,849	Unintentional Poisoning 1,755,044
8	Unintentional Unknown/ Unspecified 4,618	Unintentional Fire/Burn 41,066	Unintentional Pedal Cyclist 39,388	Other Assault* Struck By/Against 54,366	Unintentional Poisoning 246,611	Other Assault* Struck By/Against 355,927	Other Assault* Struck By/Against 212,483	Other Assault* Struck By/Against 171,022	Unintentional Other Bite/Sting 115,933	Unintentional Other Bite/Sting 116,191	Other Assault* Struck By/Against 1,261,580
9	Unintentional Cut/Pierce 3,844	Unintentional Unknown/ Unspecified 38,207	Unintentional Dog Bite 33,586	Unintentional Pedal Cyclist 49,283	Unintentional Other Bite/Sting 147,861	Unintentional Other Bite/Sting 176,855	Unintentional Other Bite/Sting 131,323	Unintentional Other Bite/Sting 135,907	Other Assault* Struck By/Against 95,550	Unintentional Unknown/ Unspecified 96,304	Unintentional Other Bite/Sting 1,142,130
10	Unintentional Poisoning 3,459	Unintentional Poisoning 37,493	Unintentional Unknown/ Unspecified 32,336	Unintentional Other Transport 40,876	Unintentional Unknown/ Unspecified 122,980	Unintentional Unknown/ Unspecified 120,116	Unintentional Unknown/ Unspecified 98,759	Unintentional Unknown/ Unspecified 95,913	Unintentional Unknown/ Unspecified 78,898	Unintentional Other Transport 79,829	Unintentional Unknown/ Unspecified 755,567

*The "Other Assault" category includes all assaults that are **not** classified as sexual assault. It represents the majority of assaults.

Data Source: NEISS All Injury Program operated by the Consumer Product Safety Commission (CPSC).
Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Appendix G. Behavioral Health Diagnosis as seen at Suburban Hospital's Emergency Department

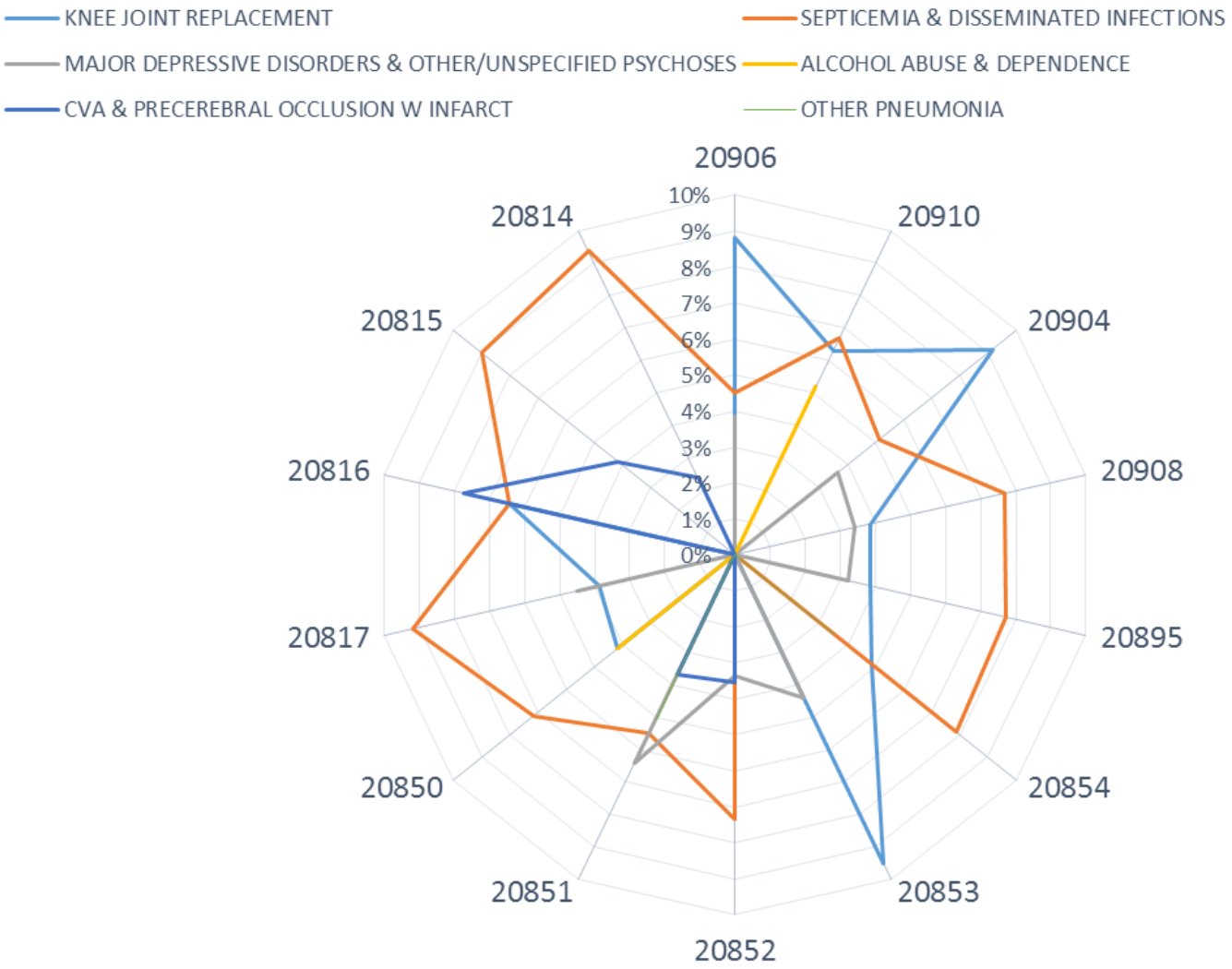
Sum of ED_Visits	Calendar Year			
Row Labels	2016	2017	2018	Grand Total
Acute stress reaction	4	26	13	43
Alcohol abuse with intoxication, uncomplicated	135	258	141	534
Alcohol abuse with intoxication, unspecified	63	150	152	365
Alcohol abuse, uncomplicated	57	92	76	225
Alcohol dependence with withdrawal delirium	53	58	36	147
Alcohol dependence with withdrawal, uncomplicated	100	248	335	683
Alcohol dependence with withdrawal, unspecified	37	85	94	216
Anxiety disorder, unspecified	102	172	162	436
Bipolar disorder, current episode depressed, severe, with psychotic features	22	39	22	83
Bipolar disorder, current episode depressed, severe, without psychotic features	31	52	60	143
Bipolar disorder, current episode manic severe with psychotic features	20	32	26	78
Bipolar disorder, unspecified	39	81	75	195
Major depressive disorder, recurrent severe without psychotic features	144	248	287	679
Major depressive disorder, recurrent, moderate	5	26	36	67
Major depressive disorder, recurrent, severe with psychotic symptoms	28	47	88	163
Major depressive disorder, single episode, severe without psychotic features	28	50	36	114
Major depressive disorder, single episode, unspecified	148	266	194	608
Other psychoactive substance abuse, uncomplicated	18	28	16	62
Panic disorder (episodic paroxysmal anxiety)	28	41	53	122
Postconcussional syndrome	34	58	37	129
Schizoaffective disorder, bipolar type	32	59	77	168
Schizoaffective disorder, depressive type	16	26	43	85
Schizophrenia, unspecified	44	63	60	167
Unspecified dementia with behavioral disturbance	8	21	35	64
Unspecified psychosis not due to a substance or known physiological condition	50	101	86	237
Grand Total	**1246**	**2327**	**2240**	**5813**

ED Behavioral Health Diagnosis for Suburban's CBSA

Dates: FY17, 18, 19 (thru Nov 30, 2018)

Sum of ED_Visits		PAT_ZI									
PRIM_DX	PRIM_DX_NAME	20815	20816	20817	20850	20852	20853	20854	20895	20906	Grand Total
F03.91	Unspecified dementia with behavioral disturbance	8		4	2	14		10	4	1	43
F07.81	Postconcussional syndrome	5	2	15	5	11	4	11	4	8	65
F10.10	Alcohol abuse, uncomplicated	14	0	16	4	14	6	11	8	8	81
F10.120	Alcohol abuse with intoxication, uncomplicated	24	10	36	16	38	14	31	17	11	197
F10.129	Alcohol abuse with intoxication, unspecified	20	7	20	11	26	9	22	10	16	141
F10.230	Alcohol dependence with withdrawal, uncomplicat	17	13	26	37	29	13	33	11	33	212
F10.231	Alcohol dependence with withdrawal delirium	2	2	6	3	9	1	4	2	10	39
F10.239	Alcohol dependence with withdrawal, unspecified	3	6	6	8	7	5	7	2	12	56
F19.10	Other psychoactive substance abuse, uncomplicate	1		7	1	5		2	4	3	23
F20.9	Schizophrenia, unspecified	3	4	11	1	4	2	4	6	10	45
F25.0	Schizoaffective disorder, bipolar type	2	9	6	16	11	4	8	4	5	65
F25.1	Schizoaffective disorder, depressive type	1	3	7	4	4	3	2	2	10	36
F29	Unspecified psychosis not due to a substance or kn	15	5	15	7	23	4	7	10	12	98
F31.2	Bipolar disorder, current episode manic severe wit	5	1	8	3	5	2	9	3	3	39
F31.4	Bipolar disorder, current episode depressed, sever	1	1	7	10	18	3	4	4	7	55
F31.5	Bipolar disorder, current episode depressed, sever	2		7	5	4	1	4		1	24
F31.9	Bipolar disorder, unspecified	8	4	14	7	17	1	9	10	5	75
F32.2	Major depressive disorder, single episode, severe v	5	2	14	5	13	2	7	1	5	54
F32.9	Major depressive disorder, single episode, unspeci	32	11	53	14	44	24	36	28	29	271
F33.1	Major depressive disorder, recurrent, moderate	11	2	8	2	10	3	3	5	2	46
F33.2	Major depressive disorder, recurrent severe witho	30	10	63	21	54	12	21	19	28	258
F33.3	Major depressive disorder, recurrent, severe with p	2	1	6	8	18	1	14	7	10	67
F41.0	Panic disorder (episodic paroxysmal anxiety)	4	2	12	6	15	4	5	5	9	62
F41.9	Anxiety disorder, unspecified	25	10	38	21	49	10	32	9	21	215
F43.0	Acute stress reaction	2		4	3	10		1	2	3	25
Grand Total		242	105	409	220	452	128	297	177	262	2292

Appendix H. Readmission Data for the Suburban's Community Benefit Service Area



Appendix I. Healthy Montgomery Steering Committee Members

Organization	Name of Key Collaborator	Title	Collaboration Description
Manna Food Center	Jackie DeCarlo (Co-Chair)	Executive Director	Co-chair
Montgomery County Department Health and Human Services	Travis Gayles, M.D.	County Health Officer and Chief Public Health Services	Co-chair
Montgomery County Public Schools	Jonathan Brice	Associate Superintendent	Member
Montgomery County Department Health and Human Services	Raymond Crowel, PsyD.	Chief, Behavioral Health and Crisis Services	Member
Maryland General Assembly	Delegate Bonnie Cullison	Member of the House of Delegates	Member
Primary Care Coalition of Montgomery County	Leslie Graham	President & Chief Executive Officer	Member
Kaiser Permanente	Amy Gyau-Moyer	Program Manager, Community Health and Benefits	Member
Commission on Health	Michelle Hawkins	Member, African American Health Program	Member
Montgomery County Department of Planning	Amy Lindsey	Senior Planner	Member
Adventist HealthCare	Marilyn Lynk	Executive Director	Member
MedStar Montgomery Medical Center	Dairy Marroquin	Community Outreach Coordinator	Member
Holy Cross Hospital	Kimberley McBride	Vice President, Community Health	Member
Ronald D. Paul Companies EveryMind (Mental Health Association of Montgomery County)	Kathy McCallum	Controller Member	Member
Carefirst Blue Cross Blue Shield African American Health Program	Beatrice Miller	Senior Regional Care Member	Member

Montgomery Parks	Rachel Newhouse	Park Planner Coordinator	Member
Asian American Health Initiative	Nguyen Nguyen, M.D.	Member	Member
Montgomery County Department of Transportation	Samuel Oji	Chief, Enhanced Mobility and Senior Services Section	Member
Clinica Proyecto Salud Latino Health Initiative	Cesar Palacios, M.D.	Executive Director Member	Member
Montgomery County Recreation Department	Robin Riley	Division Chief	Member
Suburban Hospital	Monique L. Sanfuentes	Administrative Director, Community Affairs & Population Health	Member
Georgetown University School of Nursing and Health Studies	Michael Soto, Ph.D.	Professor	Member
Department of Housing and Community Affairs	Myriam Torrico	Community Program Manager	Member
Montgomery County Collaboration	Elijah Wheeler	Deputy Executive Director	Member

Appendix J. Suburban Hospital Community Health Improvement Advisory Council

Organization	Name	Title	Description
Capstone Development, LLC	Norman Jenkins	Founder and CEO	Chairman of Suburban Hospital's Community Benefit Advisory Council; Facilitates Advisory meetings; Suburban Hospital Board of Trustees
A Wider Circle	Mark Bergel, Ph.D.	Founder and Executive Director	Member of Suburban Hospital's Community Benefit Advisory Council; offers unique community perspective as his organization works with the underserved population.
Total Wine and More	Vanessa Bernarding	Sr. Director, Human Resources	Member of Suburban Hospital's Community Benefit Advisory Council
Community Advocate	Belle Brooks O'Brien	Resident of Montgomery County	Member of Suburban Hospital's Community Benefit Advisory Council; Suburban Hospital Board of Trustees
Healthcare Initiative Foundation	Crystal Carr Townsend	President	Member of Suburban Hospital's Community Benefit Advisory Council
Bradley Hills Village	Betsy Carrier	Treasurer	Member of Suburban Hospital's Community Benefit Advisory Council
Community Physician	Diane Colgan, M.D.	Former Medical Staff Chair for Suburban Hospital	Member of Suburban Hospital's Community Benefit Advisory Council; Suburban Hospital Board of Trustees
Bethesda Chevy Chase Regional Services Center	Ken Hartman	Regional Services Director	Member of Suburban Hospital's Community Benefit Advisory Council; host facility for many CHW programs
YMCA of Metropolitan Washington	Carla P. Larrick	Vice President of Operations	Member of Suburban Hospital's Community Benefit Advisory Council
Girls on the Run, Montgomery County	Elizabeth McGlynn	Executive Director	Member of Suburban Hospital's Community Benefit Advisory Council; Suburban Hospital supports GOTR as it official health sponsor providing financial support, training for coaches and health education at bi-annual races
Chevy Chase Trust	Stacy C. Murchison	Chief Marketing Officer	Member of Suburban Hospital's Community Benefit Advisory Council
AQUAS, Incorporated	Carmen Ortiz Larsen	President	Member of Suburban Hospital's Community Benefit Advisory Council

Montgomery County Police Department	Michael Prather	Officer	Member of Suburban Hospital's Community Benefit Advisory Council; Partners with CHW to bring safety information to the Hospital's CBSA community
Community Physician	Michael A. Smith, M.D.	Radiologist and brother of Alpha Phi Alpha Fraternity, Montgomery County Chapter	Member of Suburban Hospital's Community Benefit Advisory Council; Partners with CHW in bringing health education to Alpha Phi Alpha Montgomery County Chapter
American University	Anastasia Snelling, Ph.D.	Professor and Department Chair, Health Studies	Member of Suburban Hospital's Community Benefit Advisory Council
Montgomery County Police Department	Dana Stroman	Officer	Member of Suburban Hospital's Community Benefit Advisory Council; Partners with CHW to bring safety information to the Hospital's CBSA community
Aronson, LLC	Michael K. Yuen	Certified Public Accountant	Member of Suburban Hospital's Community Benefit Advisory Council

Appendix K. Community Survey Tool

Patient Education Needs Questionnaire

1. **What is your residential zip code? _____ Gender: ☐ M ☐ F**

2. **What is your age?**

☐ 21-30	☐ 41-50	☐ 61-70	☐ 81-90
☐ 31-40	☐ 51-60	☐ 71-80	☐ > 90

3. **How would you rate your health in general?**

☐ Excellent ☐ Good ☐ Fair ☐ Poor

4. **What health conditions do you have? Check all those that apply.**

- ☐ Diabetes
- ☐ COPD
- ☐ Cancer
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Other: _____
- ☐ None
- ☐ Do not wish to answer

5. **How likely are you to attend a wellness education class?**

☐ Very likely ☐ Somewhat Likely ☐ Not likely

If you answered "not likely" to attend a class, what would motivate you to attend a class?

_____

6. **How far are you willing to travel for a wellness class? Please check one.**

- ☐ Less than 30 minutes
- ☐ Up to 45 minutes
- ☐ Up to an hour
- ☐ No preference

7. **What is a convenient time for you to attend a wellness class? Check all that apply.**
   - ☐ Morning (10-11:30 am)
   - ☐ Afternoon (between 2-4 pm)
   - ☐ Early evening (5:30 or later)

8. **Use the list provided below to indicate your level of interest in wellness topics**

Class	Not interested	somewhat Interested	Very Interested
a. Weight Management and Nutrition	1	2	3
b. Diabetes self-management	1	2	3
c. Pre-diabetes management	1	2	3
d. Smoking cessation	1	2	3
e. Heart health	1	2	3
f. Chronic disease self-management	1	2	3

Please list topics of interest not mentioned above:

_____

_____

9. **Will any of the following factors prevent you from attending a wellness class? Check those that apply.**
   - ☐ Lack of transportation
   - ☐ Cost of class
   - ☐ Time of day class will be offered
   - ☐ Lack of motivation
   - ☐ Language
   - ☐ Lack of interest
   - ☐ Distance from home
   - ☐ No factors
   - ☐ Other: _____

If you have any additional comments that you would like to share with us, please write them on the space provided below or send an e-mail to prios@jhu.edu.

Once again thank you for answering the questions

Appendix L. Community Survey Results

Patient Education Needs Survey Results 2018
Total Number of Surveys Collected (N) = 151

1. **Gender**

	Male	Female	Blank	Total
Respondents	53 (35%)	83 (55%)	15 (10%)	**151**

2. Reported Health Status

Health Status	Over 50 YRS (N= 112)		50 & Under (N=24)		Blank (N=15)	Total
	Female	Male	Female	Male		
Excellent	20	8	9	4	4	**45 (30%)**
Good	42	28	4	3	**9**	**86 (57%)**
Fair	6	7	1	1	**1**	**16 (11%)**
Poor	0	1	0	1	**0**	**2 (1%)**
Blank	0	0	1	0	**1**	**2 (1%)**
Total	**68**	**44**	**15**	**9**	**15**	**151 or 100%**

3. Reported Chronic Conditions by Participants (N=151)

Condition	Female	Male	Blank	Total
Diabetes	8	11	3	**22 (11%)**
COPD	2	2	0	**4 (2%)**
Cancer	5	2	2	**9 (5%)**
High Blood Pressure	33	20	6	**59 (30%)**
Heart Disease	5	4	0	**9 (5%)**
Other Illness	26	7	2	**35(18%)**
No health conditions	23	13	6	**42(22%)**
Did not wish to answer	3	1	0	**4 (2%)**
Blank	3	7	0	**10 (5%)**
Total	**108**	**67**	**19**	**194 or 100%**

While 22% or 42 of respondents (n=151) reported no current health conditions, a total of **95** individuals or 63% reported living with at least one chronic condition, and 7% or 14 individuals did not provide an answer. Among those who reported a health condition, a total of **33** individuals (35%) reported living with a least two co-morbidities. The most prominent conditions reported by participants were hypertension (30%) and diabetes (11%). Other conditions reported included: high cholesterol (2.6%), asthma (3.3%), and arthritis (6.6%).

4. Likelihood to Attend a Wellness Class based on Age and Gender

Scale	Over 50 YRS (N= 112)		50 & Under (N=24)		Blank (N=15)	Total
	Female	Male	Female	Male		
Very likely to attend	8	4	2	1	3	**18 (12%)**
Somewhat likely to attend	32	20	7	1	8	**68 (45%)**
Not likely to attend	26	20	6	7	4	**63 (42%)**
Blank	2	0	0	0	0	**2 (1%)**
Total	**68**	**44**	**15**	**9**	**15**	**151**

57% reported either "very likely to attend a class" or "somewhat likely." Participants who reported "not likely to attend" a class were asked to explain what would motivate them to attend a class. The main motivating factor reported was money. That is if participants were paid to attend a class. Other participants indicated (1) having more serious health issues and (2) if the class provided new information, they did not already know as additional motivating factors to participation.

5. Likelihood to Attend a Wellness Class based on Number of Present Chronic Condition

Scale	One Chronic Condition N=95	2+ Chronic Conditions N= 33	Total
Very likely to attend	13 (13%)	5 (15%)	**18 (14%)**
Somewhat likely to attend	45 (47%)	20 (61%)	**65 (51%)**
Not likely to attend	37 (39%)	8 (24%)	**45 (35%)**
Blank	0	0	**0**
Total	**95**	**33**	**128**

Participants who are more likely to attend a class are those living with a chronic condition. The likelihood to attend a class increases as the number of chronic conditions increases.

6. Prefer travel time to class*

Distance in Time	Over 50 YRS	50 & Under	Total
Less than 30 min	93	21	**114 (74%)**
Up to 45 min	8	3	**11 (7)**
Up to 1hr	1	1	**2 (1%)**
No time preference	11	3	**15 (10%)**
Did not response	11	2	**12 (8%)**
Total	**124**	**30**	**154**

7. Preferred time for class*

Time of Day	Over 50 YRS	50 & Under	Total
Morning class	34	6	**40 (24%)**
Afternoon class	30	5	**35 (21%)**
Evening class	35	13	**48 (29%)**
Did not response	33	8	**41 (25%)**
Total	**132**	**32**	**164**

8. Classes & Level of Interest

a) Weight Management

Scale	Over 50 YRS (N= 112)		50 & Under (N=24)		Blank (N=15)	Total
	Female	Male	Female	Male		
Not interested	20	5	3	4	3	**35 or 23%**
Somewhat interested	18	19	3	0	5	**45 or 30%**
Very interested	16	8	5	3	5	**37 or 24.5%**
Did not response	14	12	4	2	2	**34 or 22.5%**
Total	**68**	**44**	**15**	**9**	**15**	**151**

b) Diabetes Self-Management

Scale	Over 50 YRS (N= 112)		50 & Under (N=24)		Blank (N=15)	Total
	Female	Male	Female	Male		
Not interested	30	21	10	5	9	**75 or 50%**
Somewhat interested	4	3	0	1	0	**8 or 5%**
Very interested	5	6	0	1	2	**14 or 9%**
Did not response	29	14	5	2	4	**54 or 36%**
Total	**68**	**44**	**15**	**9**	**15**	**151**

c) Pre-Diabetes

Scale	Over 50 YRS (N= 112)		50 & Under (N=24)		Blank (N=15)	Total
	Female	Male	Female	Male		
Not interested	30	19	9	5	9	**72 or 48%**
Somewhat interested	6	4	0	1	0	**11 or 7%**
Very interested	6	2	1	1	2	**12 or 8%**
Did not response	26	19	5	2	4	**56 or 37%**
Total	**68**	**44**	**15**	**9**	**15**	**151**

d) Smoking Cessation

Scale	Over 50 YRS (N= 112)		50 & Under (N=24)		Blank (N=15)	Total
	Female	Male	Female	Male		
Not interested	37	25	10	6	9	**87 or 58%**
Somewhat interested	1	1	0	0	0	**2 or 1%**
Very interested	0	0	1	0	1	**2 or 1%**
Did not response	30	18	4	3	5	**60 or 40%**
Total	**68**	**44**	**15**	**9**	**15**	**151**

e) Heart Health

Scale	Over 50 YRS (N= 112)		50 & Under (N=24)		Blank (N=15)	Total
	Female	Male	Female	Male		
Not interested	18	10	7	4	4	**43 or 28%**
Somewhat interested	19	10	2	0	5	**36 or 24%**
Very interested	7	12	1	3	2	**25 or 17%**
Did not response	24	12	5	2	4	**47 or 31%**
Total	**68**	**44**	**15**	**9**	**15**	**151**

f) Chronic Disease Self-management

Scale	Over 50 YRS (N= 112)		50 & Under (N=24)		Blank (N=15)	Total
	Female	Male	Female	Male		
Not interested	29	20	10	4	5	**68 or 45%**
Somewhat interested	3	4	0	1	1	**9 or 6%**
Very interested	8	2	0	1	3	**14 or 9%**
Did not response	28	18	5	3	6	**60 or 40%**
Total	**68**	**44**	**15**	**9**	**15**	**151**

Based on responses, the level of interest in classes are as follows (listed from highest level of interest to lowest): weight management class (24.5%), heart health class (16.5%), diabetes self-management class (9%), chronic disease self-management (9%), pre-diabetes (7%) and smoking cessation (1%). 17 (11%) of 151 participants listed other topics of interest, which included exercise, pain management, depression, bone health and asthma.

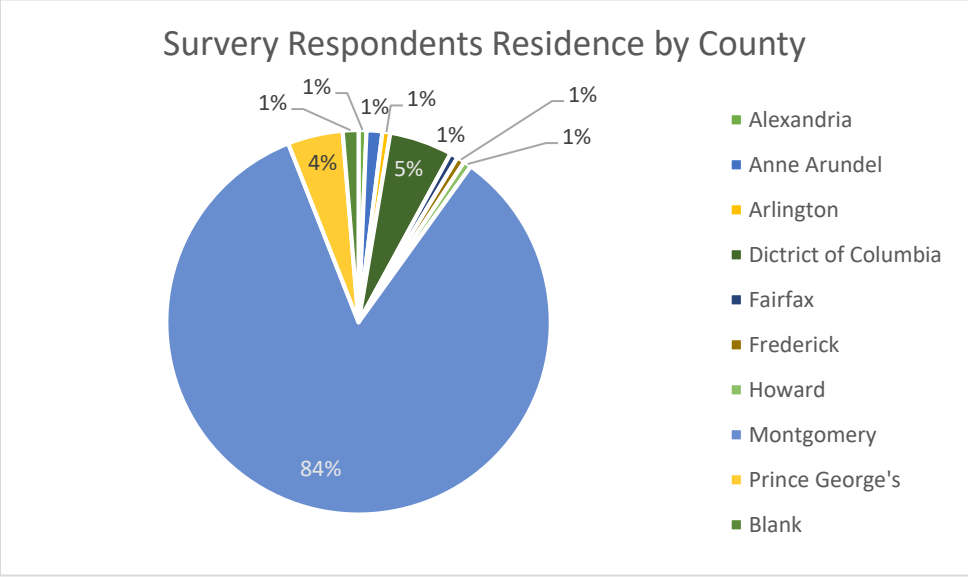
9. Barriers to Health Education Participation*

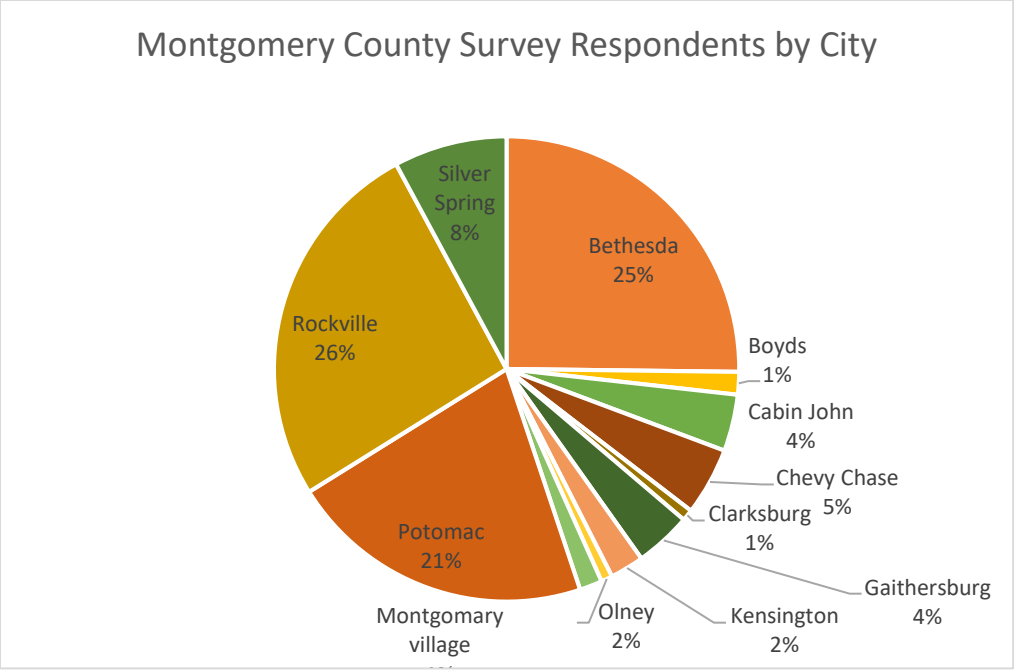
Scale	Over 50 YRS		50 & Under		Blank	Total
	Female	Male	Female	Male		
Transportation	2	1	0	0	0	**3 (1%)**
Cost	14	8	3	2	1	**28 (12%)**
Time	20	15	6	4	3	**48 (20%)**
Lack Motivation	11	9	4	3	3	**30 (12%)**
Language	0	0	0	0	0	**0 (0%)**
Lack of interest	15	12	5	3	4	**39 (16%)**
Distance	18	13	6	1	4	**42 (17%)**
No Factor	7	7	2	1	4	**21 (9%)**
Other	9	4	0	0	0	**13 (5%)**
Did not Respond	11	4	2	1	2	**20 (8%)**
Total	107	73	28	15	21	**244 (100%)**

The top 3 factors prevention individuals from participating in a wellness program include time, distance, and lack of interest. Other factors mentioned, but not listed above included a work schedule and family obligations.

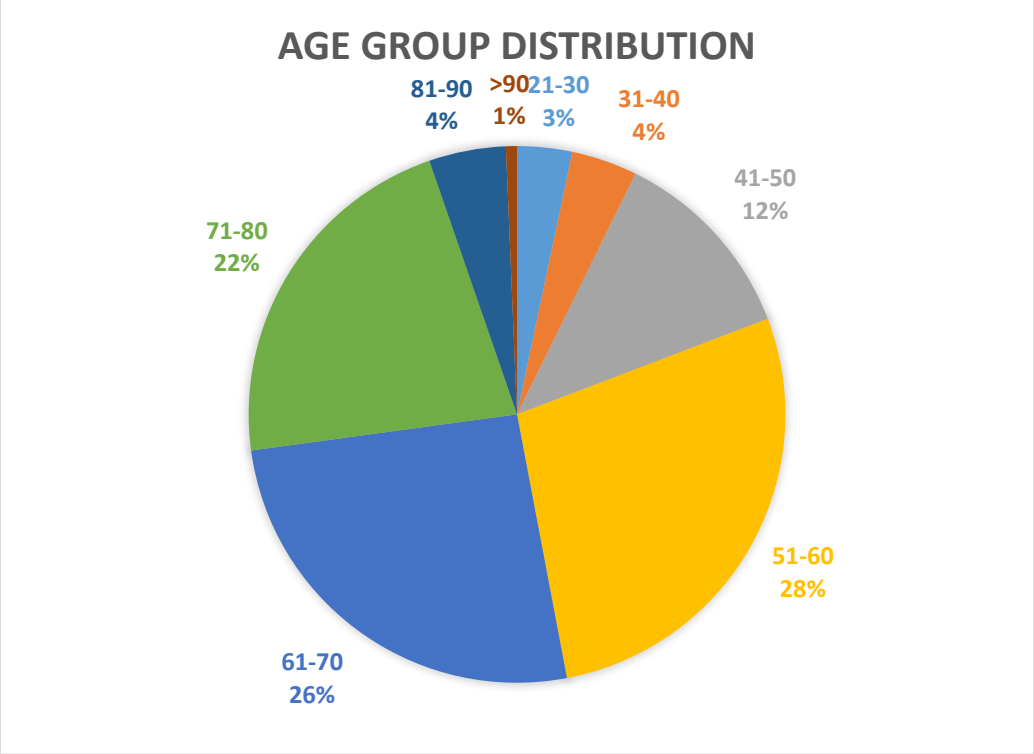
10. Zip Code Breakdown

Survey participants reside in 39 zip codes, originating from 25 different cities in 9 counties across the National Capital Region. Majority of respondents (84%) live in Montgomery County. 72% of Montgomery County residents who participated in the survey reported living in Bethesda (20817 & 20814), Potomac (20854) and Rockville (20850, 20851, 20852 & 20853).





11. Age Breakdown



**Total does not equal 151 because respondents provided more than one answer.*

Appendix M. Suburban Hospital's Community Health Needs Assessment Ad Hoc Committee

Leslie Ford Weber
Director, Campus, Government & Community Affairs,
Montgomery County
Johns Hopkins University

Dr. Anastasia Snelling
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Brian Ebbitt
Chief of Staff,
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Betsy Carrier
Community Organizer,
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Elizabeth McGlynn
Executive Director
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Barbara Squiller
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Mitch Markowitz
Vice President, Business Development
Family Nursing Care

Ken Hartman
Director, Bethesda-Chevy Chase Regional Service Center Montgomery County
Department of Health & Human Services

Dr. Langston Smith
Health Ministry Director
Colesville Baptist Church

Steven Bokat
Community Activist
Patient Family Advisory Council
Suburban Hospital

Sister Romana Uzodimma
Program Manager
Catholic Charities Healthcare Network of Washington DC

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Community members are invited to submit their comments and/or questions in response to Suburban's 2019 CHNA via email at SHI-Health4u@jhmi.edu or by phone at 301-896-3572.

Suburban Hospital

FISCAL YEAR 2019

SUBURBAN HOSPITAL IMPLEMENTATION STRATEGY

In Response to the Community Health Needs Assessment

TABLE OF CONTENTS

INTRODUCTION

WHO WE ARE

Suburban Hospital is a community-based, not-for-profit hospital serving Montgomery County, Maryland and the surrounding area since 1943. The hospital provides all major services except obstetrics. One of nine regional trauma centers in Maryland, the Hospital is the state-designated level II trauma center for Montgomery County with a fully equipped helipad. Suburban Hospital's Emergency/Shock Trauma Center treats more than 45,000 patients a year.

The Hospital's primary services include:

- Comprehensive cancer and radiation oncology center accredited by the American College of Surgeons Commission on Cancer;
- Heart center providing specialty cardiac surgery, elective and emergency angioplasty as well as inpatient diagnostic and rehabilitation services;
- Orthopedics with joint replacement and physical rehabilitation;
- Behavioral health;
- Neurosciences including a designation as a Primary Stroke Center and a 24/7 stroke team;
- Pediatrics and senior care programs.

Suburban Hospital has achieved the Gold Seal of Approval™ by The Joint Commission for its joint replacement program. Other offerings include a state-of-the-art diagnostic pathology and radiology departments; an Addiction Treatment Center with detoxification, inpatient and outpatient programs for adolescents and adults; prevention and wellness programs; and a free physician referral service (Suburban On-Call). During fiscal year 2019, Suburban Hospital was licensed to operate 226 acute care beds and had 13,506 inpatient admissions. In 2019, Suburban received the prestigious Magnet designation for nursing excellence from the American Nurses Credentialing Center.

BACKGROUND

COMMUNITY HEALTH NEEDS ASSESSMENT

Under Section 501(c)(3) of the Internal Revenue Code, non-profit hospitals may qualify for tax-exempt status if they meet certain federal requirements. In addition to the general requirements, the 2010 Patient Protection and Affordable Care Act (ACA) included additional obligations specifically for hospital facilities, one being the provision of a Community Health Needs Assessment (CHNA) and associated implementation strategy once every three years.

In Fiscal Year 2019, Suburban Hospital conducted its third CHNA since the implementation of these requirements. The CHNA utilizes scientifically-valid health indicators and comparative information to identify the most important health issues affecting the community in which the hospital operates, an area referred to as the Community Benefit Service Area (CBSA).

Health issues identified were prioritized based on primary and secondary data and stakeholder input. The 2019 CHNA prioritized the following five health priorities:

- Behavioral health;
- Cancer;
- Diabetes;
- Heart disease;
- Infections, and
- Unintentional injury.

The full report is available to the public at www.SuburbanHospital.org.

BACKGROUND

IMPLEMENTATION STRATEGY

This report describes Suburban Hospital's implementation strategy for addressing the significant health needs in the CBSA in order to improve health status and quality of care, while building upon and strengthening the community's existing infrastructure of services and providers. In accordance with IRS Section 501(r)(3), Community Health Needs Assessment for Charitable Hospital Organizations, this report represents Suburban Hospital's written plan to describe how it will address each identified health need, specifically noting the actions the hospital intends to take and the anticipated impact of these actions. The report lists the resources committed to address each health need, as well as planned collaboration between the hospital facility and other organizations to address the needs.

Suburban Hospital's work is not conducted in a silo. Where possible, efforts are taken to align other initiatives with the shared mission of improving the health of Montgomery County. The County's health improvement process is referred to as *Healthy Montgomery*. As a result of using similar data sources and stakeholders in setting local priorities over the years, the summary of key findings is similar, if not identical across both assessments.

KEY TERMS

The following terms are used throughout this report to clarify how the community health implementation plan operates:

DESIRED OUTCOME

The observed short- to mid-term effects of an activity or output.

IMPACT

The degree to which an outcome is attributable to the activities completed and not confounding factors.

STRATEGY

A plan of action outlined to achieve the desired outcome, recognizing that additional steps are required in coordination with both internal and external stakeholders to achieve progress toward long-term impact.

INTERSECTING STRATEGIES

A set of strategies that apply to multiple health priorities.

ACTION PLAN

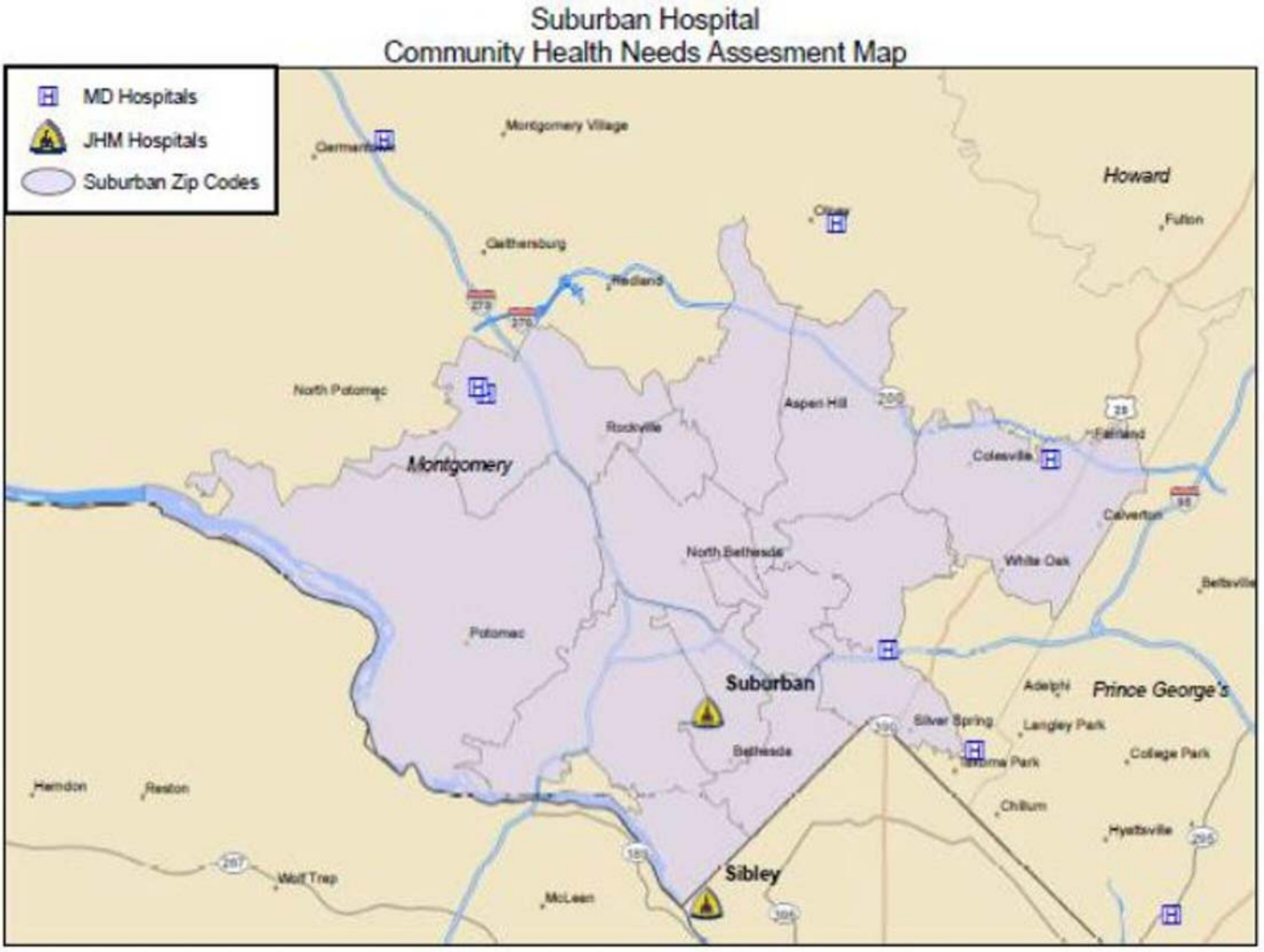
A set of steps taken to accomplish a given strategy.

PARTNERSHIPS

Internal and external stakeholders committed to strategies that align with common desired outcomes to improve community health.

THE COMMUNITY WE SERVE

Suburban Hospital is located in Montgomery County, Maryland, which shares the northern border of the nation's capital. With a population of 1.05 million people, Montgomery County represents nearly 12% of the state's population of 6.05 million. Due to its proximity to Washington, DC, the county has a richly diverse community, of which nearly 40% speak a language other than English at home. Sixty percent of residents are White, 19.7% are Black or African American, and 15.6% are Asian. Montgomery County also has the largest population of Hispanics/Latinos in the state, at 19.6% of the total population.



Montgomery County has an aging population. Fifteen percent of the population is 65 years or older. The average life expectancy for county residents is 84.8 years, which is longer than that of the state (79.1 years).

The target population strongly influences the way in which Suburban Hospital approaches community health improvement and implementation strategies to address its identified health priorities. Because such an in-depth and deliberate approach was taken to define the community benefit service area, it is applied consistently throughout this report unless expressly stated.

Specific activities may target a select population, such as those age 65 and older, or people who are uninsured. As previously noted, regardless of the people addressed in any specific element of the implementation strategy, health equity is embedded throughout all of Suburban Hospital's health improvement work. To live out our mission of improving health with skill and compassion, it is imperative, that we ensure everyone has the opportunity to live a healthier life, regardless of who they are, where they live, or how much money they earn.

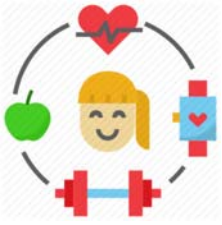
SUBURBAN'S COMMITMENT

Suburban Hospital dedicates a variety of resources to carry out its implementation strategy. This strategy is encompassed within the hospital's community benefit process, which measures all activities that exceed the hospital's charge of direct patient care and operations. Community benefit is a planned, organized and measured approach by a non-profit health care organization to meet identified community health needs within its service area. Resources are grouped and measured across several areas, including mission-driven health care services, community health services and community-building activities, among others. These activities represent the Hospital's commitment to identified community needs in the form of time spent addressing health improvement above and beyond a typical scope of work. In addition to delivering high-quality clinical care, our employees dedicate their time providing health education in the community, volunteering at specialty care clinics and organizing learning activities to support physical activity and mentorship for youth. To learn more about how Suburban Hospital utilizes a strategic, thoughtful approach to health improvement in the community, refer to the Community Health Improvement Report at www.suburbanhospital.org.

LENSES: A VIEW OF THE WHOLE PERSON

The World Health Organization (WHO) defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. This definition aligns firmly with the hospital's mission to improve health with skill and compassion. The 2019 CHNA identified health priorities as a set of diseases or conditions, Suburban Hospital fully acknowledges that health improvement addresses the whole person and not just their health condition. An individual's overall health is linked not just to the medical care they receive, but to the conditions in which they live, learn, work and play. These conditions are also known as social determinants of health. To fulfill the WHO definition of health, Suburban Hospital applies three lenses through which the whole person is viewed: access to care, healthy behaviors and health equity. These lenses are used to sharpen the focus on the complex health needs of the community, while also highlighting and leveraging the vast wealth of resources in Montgomery County. Suburban Hospital defines these lenses as the following and applies them in this report, CHNA and Community Benefit Report (CBR):

Access to Care: Create opportunities to enable and promote connections across health care, social services and public health systems to meet the needs of individuals and communities.



Healthy Behaviors: Provide individuals and families with the knowledge and tools to make choices that lead to the healthiest lives possible.

Health Equity: Ensure that everyone has the opportunity to live a healthier life, no matter who they are, where they live, or how much money they make.

HEART DISEASE

Cardiovascular Disease (CVD) is not a single disease, but an umbrella term for multiple conditions that involve the narrowing or blockage of the blood vessels of the heart, brain and circulatory system.

Impact

Reduce the mortality rate from heart disease and stroke

Desired Outcomes

1. Individuals understand the risks associated with their condition
2. Individuals with poorly or uncontrolled hypertension are identified
3. Identified individuals are referred to a provider and linked to ongoing health and wellness programs for monitoring

Strategies

1 Increase access to specialty heart care, management and treatment for vulnerable populations

2 Prevent and reduce chronic disease by focusing on risk factors, such as social determinants of health, with a specific focus on congestive heart failure (CHF)

Partnerships

- American Heart Association
- American Lung Association
- Benjamin Gaither Center
- Friendship Heights Village Center
- Glenarden Senior Nutrition Program
- Holiday Park Senior Center
- Lakeview House Apartments
- Margaret Schweinhaut Senior Center
- Mobile Medical Care, Inc.
- Montgomery County Department of Health and Human Services
- National Institutes of Health
- Prince George's County Department of Recreation
- Rockville Senior Center
- Spellman House Apartments
- Waverly House Apartments

HEART DISEASE

ACTION PLAN

Provide free or low-cost access to specialty providers, diagnostic screenings, treatment and rehabilitation

- MobileMed/NIH Heart Clinic at Suburban Hospital
- Johns Hopkins Community Physicians Heart Care

Create ongoing opportunities to connect 1:1 with a health professional to assess risks and receive counseling

- Blood pressure screenings at Montgomery County and Prince George's County Senior Activity Centers and housing units
- HeartWell *Know Your Numbers* clinics

Deliver ongoing opportunities for individuals to eat better and move more

- Cooking demonstrations
- Dine, Learn & Move
- Gentle Yoga for Seniors
- Healthy Choices
- Healthy Weigh
- Nutrition One-on-One
- Pilates for Seniors
- Senior Shape
- Tai Chi
- Yoga From the Heart

HEART DISEASE

ACTION PLAN, CON'T

Provide ongoing health education seminars and classes

- Aging in Place Forums
- Annual Women's Health Symposium
- Annual Women's Health Symposium
- Chronic Disease Self-Management Program
- Community seminars at Senior Activity Centers

Connect CHF patients to clinical access points

- HeartWell *Know Your Numbers* clinics
- Deployment of Transition Guide Nurses for care managment

DIABETES

Diabetes is a disease that occurs when blood glucose, or blood sugar, is too high because the body does not properly process food for use as energy.

Impact

Reduce diabetes prevalence and associated health complications

Desired Outcomes

1. Individuals understand the risks associated with their condition
2. Individuals with diabetes are referred to an appropriate disease prevention or management program

Strategies

1 Increase awareness of risk factors associated with diabetes by facilitating linkages to available resources

2 Increase access to endocrine specialty care, management and treatment for vulnerable populations

Partnerships

- Health Quality Innovators
- Juvenile Diabetes Research Foundation
- Mobile Medical Care, Inc.
- Montgomery County Department of Recreation
- National Institutes of Health - National Institute of Diabetes and Digestive and Kidney Diseases

DIABETES

ACTION PLAN

Deliver ongoing health education seminars, classes and 1:1 counseling

- Annual Diabetes Symposium
- Education Classes/Programs
  - Diabetes A-Z
  - Diabetes Fine-Tuning
  - Diabetes Self-Management Class (in English & Spanish)
  - Healthy Choices
  - Healthy Weigh
  - Pre-Diabetes Action
  - Thrive 365

Provide support groups

- Type 1 Peer Support Group
- Diabetes Support and Continuing Education Meetings

INTERSECTING STRATEGIES

In alignment with the Montgomery County Community Health Implementation Plan, several of Suburban Hospital's strategies within the Heart Disease and Diabetes priorities intersect. Chronic diseases, such as heart disease, diabetes, obesity and cancers, can be addressed more effectively through combined diet and physical activity promotion programs. As such, the following action plans are mirrored for both Heart Disease and Diabetes.

- **1:1 counseling**
- **Ongoing physical activity programs**
- **Cooking demonstrations**

BEHAVIORAL HEALTH

Behavioral health is a blanket term that includes mental health. It describes the connection between behaviors and the health and well-being of the body, mind and spirit. It includes how diseases such as substance use disorders impact physical and mental health.

Impact

A supportive culture in which mental and behavioral health barriers are broken

Desired Outcome

1. Decrease stigma surrounding behavioral health conditions and substance use disorders
2. Facilitate access to services available in Montgomery County

Strategies

1 Expand and promote population-specific community-based programming

2 Link patients in need of behavioral and mental health services to appropriate community resources

Partnerships

- Bette Carol Thompson Scotland Recreation Center
- EveryMind
- Girls on the Run Montgomery County
- Montgomery County Department of Health and Human Services
  - Office of Aging and Disability Services
  - Screening and Access Services for Children and Adolescents
- National Alliance on Mental Illness
- The Mindfulness Center

BEHAVIORAL HEALTH

ACTION PLAN

Deliver ongoing programs and initiatives that foster social and emotional support

- #JustGirls Social Club
- Parenting Seminars
- Parent and Teen Substance Abuse Education Classes
- Senior Fitness Programs
- Support Groups
- Village Ambassador Alliance

Residents with significant behavioral health needs will have equitable access to effective, clinically appropriate treatment

- Suburban Hospital
  - Addiction Treatment Center
  - Behavioral Health Services
  - Crisis Intervention Team
  - Screening, Brief Intervention and Referral to Treatment (SBIRT)
  - Suburban On-Call
- Mindoula Care Coordination

INTERSECTING STRATEGIES

In recognition of the Montgomery County Department of Health and Human Services report, *A Collective Vision for Behavioral Health in Montgomery County, Maryland*, Suburban Hospital will leverage opportunities to align with findings identified to have cross-cutting themes that span the behavioral health continuum. For example, building a sense of community and belonging and fighting the stigmas associated with mental and behavioral health conditions. In addition to addressing these issues within the Behavioral Health priority, these themes are addressed within our population-specific programming for seniors, youth, and those who speak a language other than English.

CANCER

Malignant neoplasms, or cancer, are a group of diseases characterized by uncontrolled growth and spread of abnormal cells.

Impacts

- Reduce the cancer mortality rate
- Increase cancer survivorship rates

Desired Outcomes

1. Increase awareness of risk factors associated with cancer
2. Increase the rate of screenings that lead to early detection
3. Increase utilization of existing cancer prevention and treatment services and resources at the community level

Strategies

1 Support initiatives that encourage behavior changes that reduce the risk of cancer

2 Ensure that individuals screened are referred to a provider, if appropriate, for necessary follow up

Partnerships

- American Lung Association
- Greater Washington Chapter of Hadassah
- Look Good, Feel Better program
- Montgomery County Cancer Crusade
- Montgomery County Public and Private Schools
- Sidney J. Malawer Memorial Foundation

CANCER

ACTION PLAN

Deliver ongoing health education seminars, classes and support groups

- Annual Cancer Symposia
  - Breast
  - Prostate
- Check It Out (breast cancer awareness program)
- Freedom from Smoking
- Look Good, Feel Better program
- Support Groups:
  - Facing Forward (Breast Cancer)
  - Head and Neck Cancer
  - Prostate Cancer
  - Talk and Walk (Breast Cancer)
- Yoga for Cancer Survivors

Provide access to preventative cancer screenings

- Oral, Head and Neck
- Skin

UNINTENTIONAL INJURY

Unintentional injuries, or accidents, include events such as motor vehicle crashes or falls. They affect everyone, regardless of age, race or economic status.

Impact

Reduce the rate of preventable fall-related injuries among older adults

Desired Outcome

1. Reduce emergency department visits through enrollment and participation in senior fitness classes
2. Increase the capacity of villages to serve as champions of injury prevention among older adults

Strategies

1 Support healthy aging initiatives with a focus on those that build and maintain strong, healthy bodies

2 Champion aging-in-place initiatives by reducing barriers for villages to serve as a neighborhood resource

Partnerships

- Benjamin Gaither Center
- Bethesda Regional Service Center
- Clara Barton Community Center
- Holiday Park Senior Center
- Margaret Schweinhaut Senior Center
- Montgomery County Department of Health and Human Services
  - Office of Aging and Disability Services
- National Institute on Aging at NIH - Go4Life
- North Potomac Community Center
- Potomac Community Center
- Prince George's County Department of Recreation
- Suburban Hospital
  - Physical Medicine
  - Trauma
- Wisconsin Place Community Recreation Center

UNINTENTIONAL INJURY

ACTION PLAN

Deliver evidence-based fall prevention programming

- Balancing Act
- Stepping On

INTERSECTING STRATEGIES

The ongoing fitness classes delivered on behalf of Suburban Hospital focus on four elements of physical health: balance, endurance, flexibility and strength. Incorporating each type in a regular fitness routine enhances functional health for older adults, in addition to chronic disease prevention and management, as described previously.

Deliver ongoing physical activity programming that focuses on improved balance

- Gentle Yoga for Seniors
- Pilates for Seniors
- Senior Shape
- Tai Chi
- Yoga From the Heart

INFECTIONS

An infection is an invasion and multiplication of microorganisms such as bacteria, viruses and parasites that are not normally present within the body. In many cases, it may cause no observable symptoms but can often result in a more severe condition called septicemia, the body's response to an infection. Infections commonly treated at Suburban include pneumonia, influenza and urinary tract infections.

Impact

Older adults are able to recognize signs and symptoms of serious infection and seek appropriate treatment to avoid hospitalization.

Desired Outcome

1. Increase in awareness of risk factors and signs of infection among older adults

Strategy

1 Link individuals identifed with high risk of infection to appropriate resources

2 Expand interventions that support healthy behaviors based on discharge dispostion, e.g., to home, to managed care facility, etc.

Partnerships

- Sepsis Alliance
- Suburban Hospital
  - Sepsis Treatment Management Team (STAT)
  - Transition Guide Nursing

INFECTIONS

ACTION PLAN

Build and deliver disposition-specific and community-based programming to increase awareness of the risks and warning signs of sepsis

- Education seminars at Senior Centers
- Deployment of Transition Guide Nurses for care management
- Village Ambassador Alliance

MEASUREMENT

BENCHMARKING PROGRESS

The CHNA is a deliberate, thoughtful approach to identifying the most pressing needs to be addressed for community health improvement. To efficiently and effectively utilize the resources committed by the hospital, particularly in the new era of health care, the actions outlined in the implementation strategy seek to create positive, measurable, and financially-responsible improvements that benefit the community in each priority area as well as overall.

Operating in a complex, multifaceted health care system, it is often difficult for one organization or entity to create a direct association between their actions and any observable change. To the extent possible, Suburban Hospital utilizes evidence-based approaches to evaluate its programs and initiatives. Each set of steps laid out in the implementation plan has an associated structure for measuring change, the progress of which will be reported in the 2021 needs assessment. Reportable measurements will be tied to desired outcomes. Examples of measurements are pre- and post- surveys and evaluations to identify changes in behaviors. Tracking and comparing attendance and number of events indicate the level of engagement. Year-to-year, additional activities are added to a growing schedule of opportunities to learn, move and engage. Much of the measurement conducted by Suburban Hospital is included in the annual Community Benefit Report, which tracks the hospital's planned activities to address identified health needs. In addition to viewing health improvement at the hospital level, many indicators are linked to the 25 core measures included in the Montgomery County Community Health Improvement Process, or CHIP. When working towards shared outcomes, Suburban Hospital can apply a collective impact model to its health improvement strategies.

Suburban Hospital acknowledges that health improvement is fluid and ever-changing. For that reason, assessment is ongoing and will be monitored, evaluated and tailored throughout the three-years. Our existence in a complex system of social and political factors is one facet of an environment of health and well-being in Montgomery County. We are honored to have served our community with skill and compassion for the past 75 years, and we will continue to grow and evolve with and for our community to meet its needs.

ACKNOWLEDGEMENTS

COLLABORATION & SUPPORT

Suburban Hospital's 2019 Community Health Needs Assessment and Implementation Strategy was coordinated and conducted by Community Health and Wellness with support from Hospital Executive Staff and the Board of Trustees.

A special thanks to the Community Health and Wellness Division:

Eleni Antzoulatos, MPH
Supervisor, Community Health and Wellness Operations

Sara Demetriou, CHES
Coordinator, Health Initiatives and Community Partnerships

Kate McGrail, MPH
Program Manager, Health Outcomes and Evaluation

Patricia Rios, MPH
Manager, Community Health Improvement

Monique Sanfuentes, MA, MBA
Administrative Director, Community Affairs and Population Health

Additional gratitude is extended to the following, whose valuable contributions shaped this product:

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Consultant

Alexandra Gagno
Consultant

John McInerney
Reviewer

Judith Macon, RN, MA
Reviewer

Suburban Hospital 2019 Community Health Needs Assessment

PROJECT MANAGEMENT PLAN

PREPARED BY: PATRICIA RIOS

PROJECT CHARTER

0. General Information

Project Title: Community Health Needs Assessment 2019

Project Sponsor: Suburban Hospital

Project Manager: Patricia Rios

Project Start Date: January 1, 2018

Date Prepared: December 9, 2017

Project Customer: Community Health & Wellness Dept.

Project Completion Date: June 20, 2019

1. Project Purpose or Justification:

The project will identify the top 5 prominent health issues affecting the community served by the Hospital. The project is a requirement by the federal government to maintain not-for-profit status and will help to target health improvement strategies that meet the needs of the community.

2. Project Stakeholders

Position	Title/Name/Organization	Phone	Email
Director, SH CHW	Monique Sanfuentes, Suburban Hospital	301-896-3572	Msanfue1@jhmi.edu
Chair, Community Health Improvement Council			
Chari, SH Board of Trustees			
CEO, Suburban Hospital			
Director, SH Finance			

3. Key Success Factors

- CHNA process is approved by hospital administration
- 400 Community Surveys are collected
- MoCo epidemiolist provides zip-code level data for top diabetes, heart disease, cancer, obesity, and behavioral health
- CHNA report is included in the IRS 1099 Form in 2019
- CHNA findings are used to prioritize and strategize health improvement initiatives

SCOPE STATEMENT

Project Name: 2019 Community Health Needs Assessment (CHNA)

Project Manager: Patricia Rios

Date: Saturday, November 4, 2017

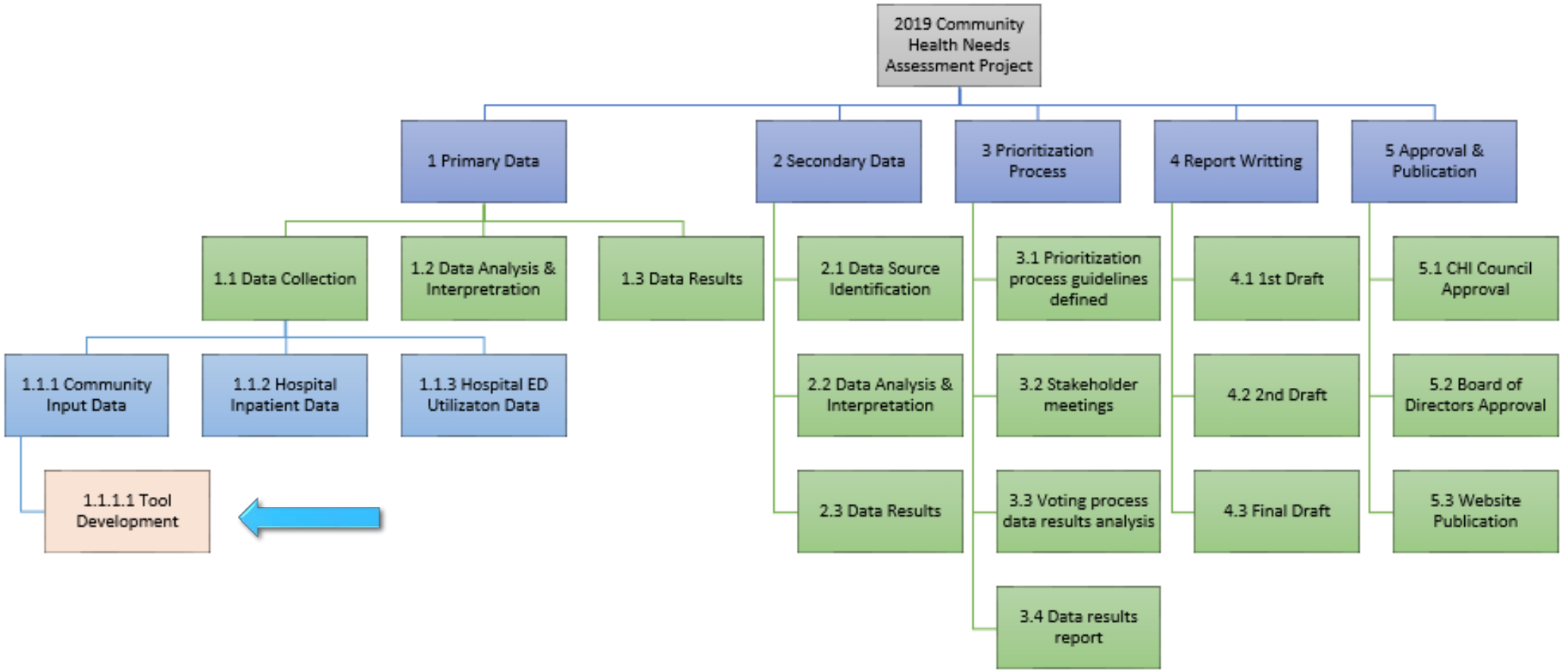
1. Project Closure Report Version Control

Version	Date	Author	Change Description
1	11/4/17	Patricia Rios	Create Document
2	12/5/17	Patricia Rios	Update Document

2. Project Scope Description

The Community Health Needs Assessment is a process that incorporates qualitative and quantitative data to identify barriers to achieving optimal health, population specific-health disparities, and perceived health needs in a community. Through primary and secondary data analysis, the top 5 health needs affecting MoCo residents residing in Suburban Hospital's Community Benefit Service Area (CBSA) will be identified and ranked.

Work Breakdown Structure



WBS Dictionary

Project: 2019 Community Health Needs Assessment **Date Prepared:** 11/24/17

Work Package Name: Tool Development	**Code of Account:** 1.1.1.1
Description of Work: A tool will be developed to collect community input for inclusion in the CHNA report. The delivery method for the tool will also be defined.	**Assumptions and Constraints** Data collected will be representative of the population

ID	Activities	Due Date	Milestones	Due Date
2.0	Utilize Secondary data Findings	**3/1/18**	Top 10 causes of morbidity and mortality in MoCo identified	**3/16/18**
1.1.1.1.1	Identify tool development team	**2/16/18**	Names of data analyst, public health professional, anthropologist, and field expert assigned to the team	**2/16/18**
1.1.1.1.2	Schedule meetings with development team	**3/2/18**	Meeting dates confirmed	**3/2/18**
1.1.1.1.3	Meet with team to develop tool and method of delivery	**3/16/18**	Method of delivery for tool identified 1st Tool draft	**3/30/18**
1.1.1.1.4	Manage tool approval process	**3/30/18**	Pilot test conducted Director sign-off on tool	**4/6/18**
1.1.1.1.5	Send tool for translation	**4/6/18**	Translated tool	**4/20/18**
1.1.1.1.6	Add last touches to the tool, last final approval	**4/25/18**	PDF copy of tool (questionnaire) English/Spanish Sign-off form signed	**4/26/18**

Activity List and Attributes

ID	Dependency Description	Predecessor Activity	Successor Activity
2.0	**Mandatory** – 2nd data findings are needed to justify and guide questions to be included in the tool.	**0**	1.1.1.1.2
1.1.1.1.1	**Discretionary**- Hiring and assigning development team for the community input tool	**0**	1.1.1.1.2
1.1.1.1.2	**Mandatory**- Schedule meetings with identified development team members	1.1.1.1.1	1.1.1.1.3
1.1.1.1.3	**Mandatory** Meet with team to design tool and method of delivery	1.1.1.1.2 & 2.0	1.1.1.1.4
1.1.1.1.4	**Mandatory**- Once 1st draft of tool is ready for the approval process, sign-offs and pilots will have been conducted	1.1.1.1.3	1.1.1.1.5
1.1.1.1.5	**Mandatory** – Approved has been sent to company for translation into needed languages.	1.1.1.1.5	1.1.1.1.6
1.1.1.1.6	**Mandatory** Tool is finalized and available for use in the languages needed	1.1.1.1.5	**1.1.1.2**

Activity Duration Estimates

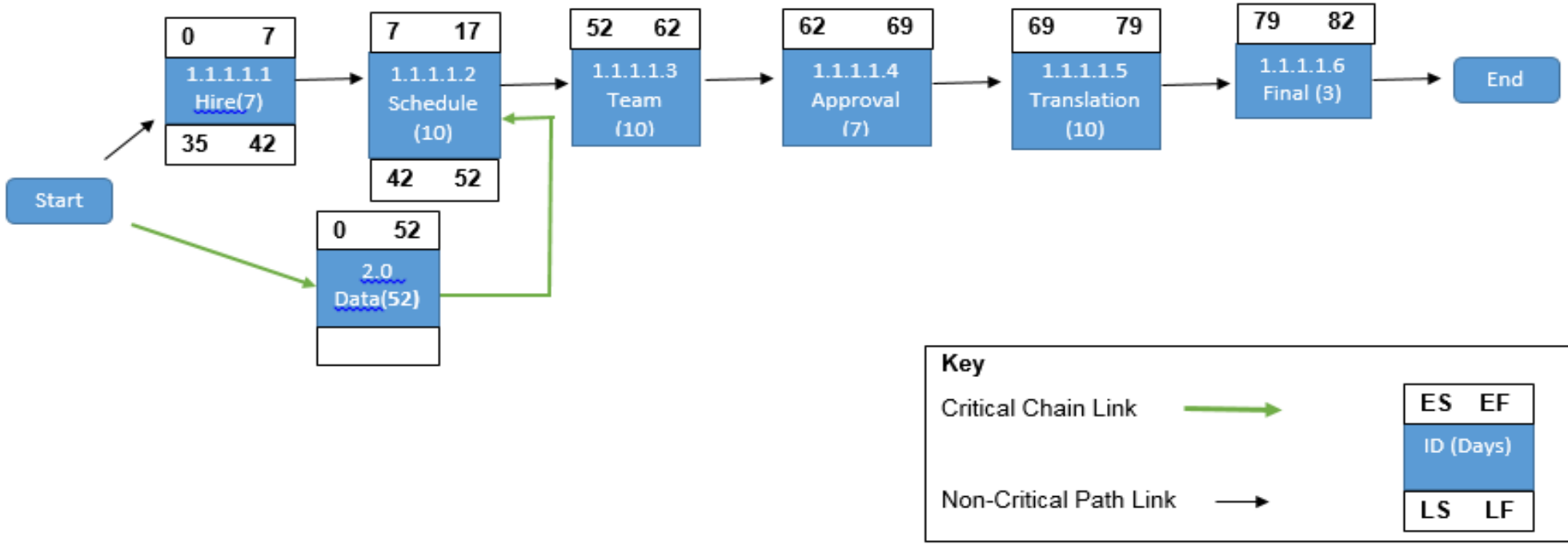
ID	Activity Definition	People, equipment , etc	How long it will take?	Estimating Method Used
2.0	Utilize Secondary data Findings (Research and analyze public health data)	- Computer - Epidemiologist - Data Analysis Software - Workspace - 2 Interns	640 Hrs /16 weeks/80 days Duration = 6.4 Weeks or 52 days	**PERT**
1.1.1.1.1	Identify tool development team	- Data analyst (In-house) - Public health professional (In-house) - Anthropologist (Contractor) - Field expert (Contractor)	56 Hrs/ 1.4 week(s)/7 days	**PERT**
1.1.1.1.2	Schedule meetings with development team	- Meeting Space - Office supplies (pens) - Computer -Admin Staff	80 hours/2 week(s)/ 10 days	**Analogous**
1.1.1.1.3	Team will meet twice a week to design the tool and method of delivery	- Data analyst - Public health professional - Anthropologist - Field expert - Admin Staff	19 hours – 9.5 days	**Analogous**
1.1.1.1.4	Tool approval process: Pilot test & Stakeholder sign-off	- Software - Admin staff - Field expert - PM	54 hours, 7 days	**Analogous**
1.1.1.1.5	Tool translation	Translation company	2 (weeks), 10 days	**Analogous**
1.1.1.1.6	Tool finalized- Stakeholder sign-off	Admin staff Software	72 hours, 3 days	**Analogous**
Restrictions: Staff assigned to project work on other company projects.			**Assumptions:** Staff will work 8 hours, 40 hours per week. No over-time allowed.	

Network Diagram (Precedence Diagramming Method)

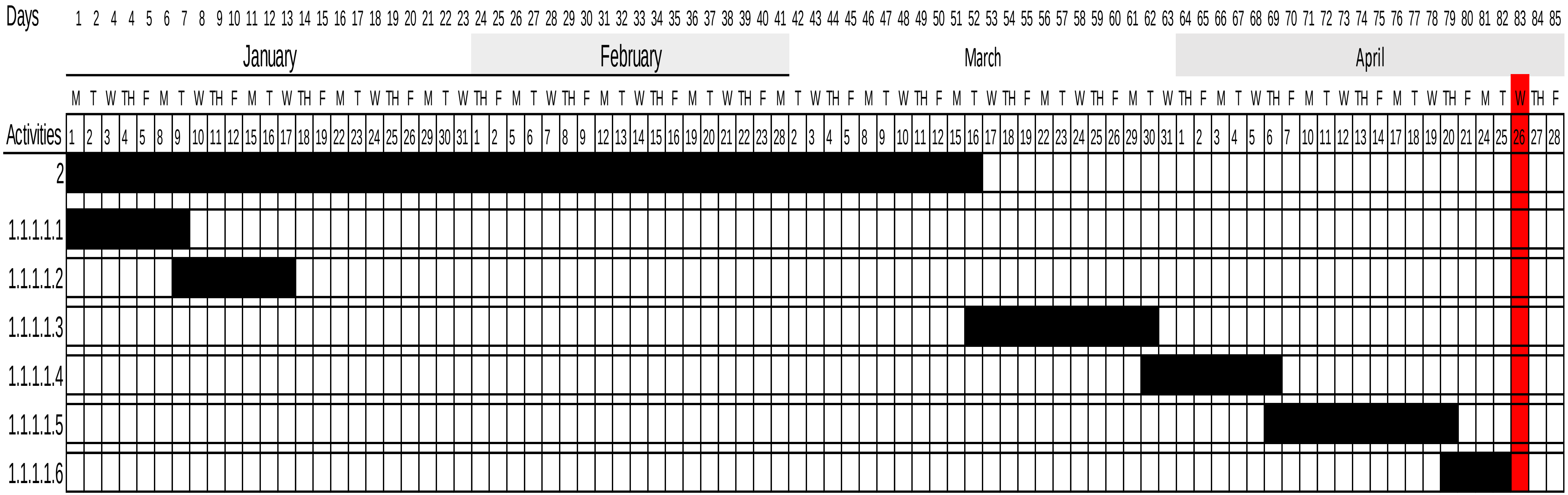
Project Title: 2019 Community Health Needs Assessment

Date Prepared: TBD

Work Package: Tool Development



Schedule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1.1.1.1.6

Project Risk List

Project Title: 2019 Community Health Needs Assessment

Date Prepared: TBD

Work Package: Tool Development

Risk ID	Risk			Risk Score	Planned Risk Response
	Description	Probability	Impact		
T	Project Dependency	**High**	**High**	**1**	**Avoid**- The schedule will need to be modified if activities in the critical path are not completed in the scheduled time. Tool development is contingent upon successful completion of the 2nd data analysis results.
T	Communication	**High**	**High**	**3**	Several strategies will be put in place to facilitate communication for the team, including a DropBox for exchange and easy access to documents.
T/O	Resources	**Low**	**High**	**2**	At least 50% of staff assigned to the project come from the organization. Staff is assigned to work on other projects, their time can provide a risk/opportunity depending on the load of other projects. This risk as a thread will be avoided by getting support from C-Suite on priority.

Impact:

Low (1) – One objective/activity impacted

Medium (2) – Two objectives impacted

High (3) – Three objectives impacted

Probability

Low (1) – 15% or less chance

Medium (2) – 20-30% of chance

High (3) – 50% of chance

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

2019 Community Health Needs Assessment

Planning & Advise Seeking Process

Suburban Hospital

April 26, 2018

Content

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

- Background
- 2016 CHNA Review
  - Process
  - Identified Health Priorities
- 2019 CHNA Framework

CHNA Icebreaker

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

Go to **www.menti.com** and use the code **41 19 31**

Please do not close your browser after participating in the poll.

Background

The purpose of a community health needs assessment is to identify the most important health issues surrounding the hospital using scientifically valid health indicators and comparative information. The assessment also identifies priority health issues where better integration of public health and healthcare can improve access, quality, and cost effectiveness of services to residents surrounding the hospital.

2016 CHNA Process

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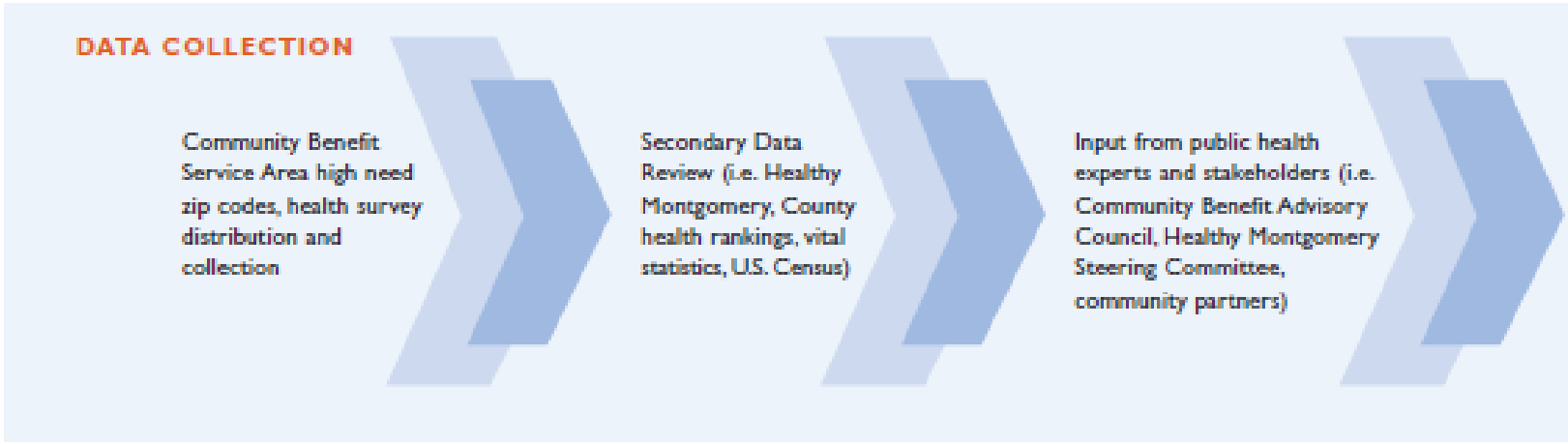

2016 CHNA Health Priorities

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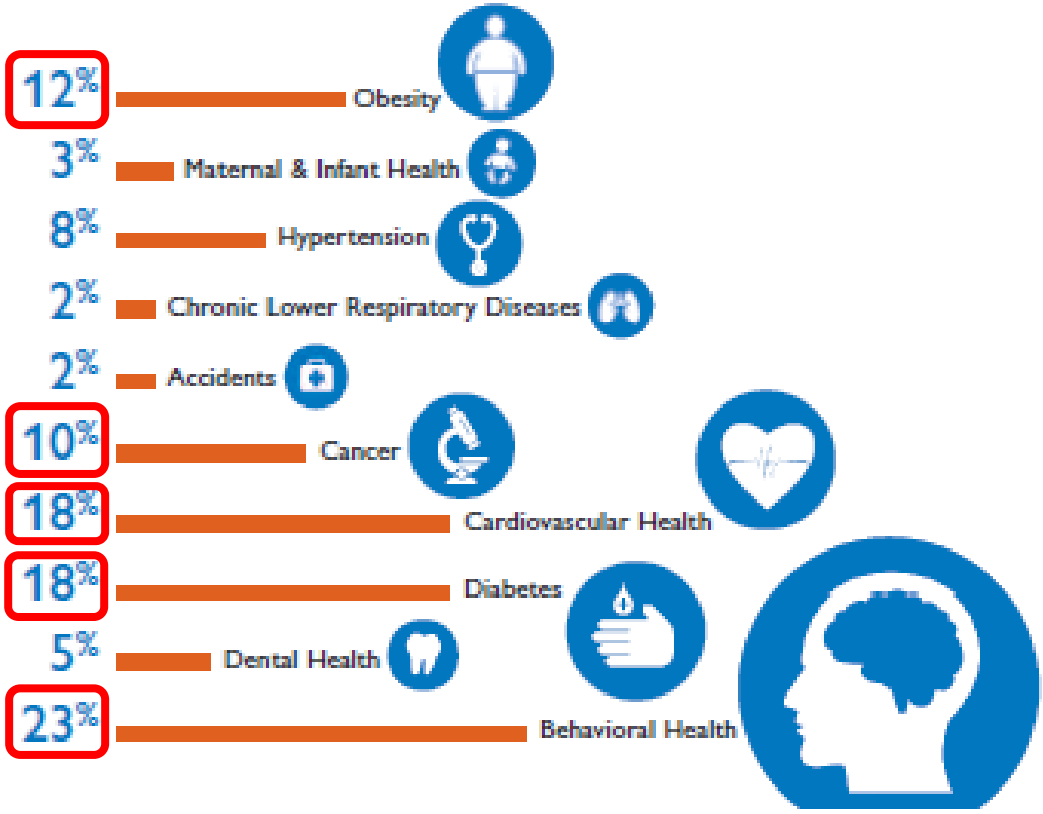
Identified Health Priorities



Building the framework for the 2019 CHNA

CHNA Advise-Seeking Process

Go to **www.menti.com** and use the code **41 19 31**

Question:
Out of the five health priorities identified in 2016, which health priority should be a focus in the 2019 CHNA report? (Select maximum two)

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

Thank You

Suburban Hospital
2019 Community Health Needs Assessment Ad Hoc Committee

Planning Meeting Document

January 28, 2019
6410 Rockledge Dr., Bethesda, MD

Meeting Roles
Facilitator: ALL
Time-Keeper: Eleni
Refreshments: Patricia
Note-taker: Eleni
Supplies: Sara

Agenda:

1. **Welcome & Introductions- Monique (10 mins)**
   - Ground Rules
     - Recording/Consent
     - Questions on blank pieces of paper
   - Why a CHNA?
   - Review of IRS requirements

2. **New Model of Care: Challenges and Opportunities- Kate (20 mins)**
   - Introduction to the triple aim
   - Global budget & Re-admissions
   - Challenges MoCo hospitals face
   - Snapshot of what makes Suburban Hospital unique
   - Pillars of Excellent at Suburban

3. **Coffee break (5 minutes)**

4. **Report Highlights- Patricia (20 mins)**
   - A snapshot of Montgomery County
   - Mortality trends in MoCo and State of MD
   - Our community
     - Formula
     - Zip Codes
     - Demographics
     - Causes of Morbidity
     - Demographics
     - Readmission Rates
     - Causes of ED utilization for SH

- Mapping of all health priorities as identified via the 2019 CHNA

5. **Health Priorities Discussion – Monique (20 mins)**

    - **Summary to key points presented**

    - **Questions to address:**

    1. *Based on the conversation today, are there other health issues/priorities that were not listed that should be taken into consideration?*

    2. *Based on the content that was presented this afternoon, what additional evidence/metrics/data is missing from the report that could help paint a better picture of (1) the population Suburban Hospitals serves and the (2) health challenges we face as an organization?*

    3. *Based on what you learned and heard today, where do you think Suburban Hospital can contribute to improving the greatest health impact?*

    - **Priority Setting- Dot Activity**

6. **Wrap-up (Monique) (5 min)**

    - Draft report for review

Supplies: tape recorder, tent cards with name and business, playdoh, color sticky notes, dots for priority activity

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

2019 Community Health Needs Assessment Ad Hoc Committee

Monday, January 28, 2019
Suburban Hospital

Meeting Objectives:

1. Understand modern health care focus on population health management
2. Identify gaps that can result in a comprehensive community health needs assessment report
3. Identify the needs of Suburban Hospital's community

Agenda:

Time	Item	Presenter
12:00	**Welcome/Introductions** - Review of IRS requirements	**Monique S.**
12:15	**New Model of Care: Challenges and Opportunities** - What makes Suburban unique	**Kate M.**
12:35	**2019 CHNA Report Data Highlights** - Morbidity and Mortality trends	**Patricia R.**
1:00	**Health Priorities Discussion**	**ALL**
1:30 pm	**Adjourn**	

Suburban Hospital

2019 Community Health Needs Assessment Ad Hoc Committee

Meeting Notes, Monday, January 28, 2019

In Attendance:

Dr. Stacy Snelling, American University
Ken Hartman, Montgomery County
Leslie Weber, Johns Hopkins/Suburban Hospital
Elizabeth McGlynn, Girls on The Run, Montgomery County
Langston Smith, Colesville United Methodist Church
Mitch Markowitz, Family and Nursing Care
Sister Romana Uzodinma, Catholic Charities of Archdiocese of Washington
Steve Bokat, Suburban PFAC
Barbara Squiller, Suburban Hospital Cancer Program
Kate McGrail, Community Health and Wellness, Suburban Hospital
Patricia Rios, Community Health and Wellness, Suburban Hospital
Monique Sanfuentes, Community Health and Wellness, Suburban Hospital
Eleni Antzoulatos, Community Health and Wellness, Suburban Hospital

Thank you for everyone for being here. Welcome and Introductions. Each and every one of you are chosen and appreciate you taking the time for being here.

Process that you are integral to. As non-profit hospitals conduct a needs assessment which we are in our third process. Requirement by IRS, approved by our board. We have done a lot of the background work. Every JH entity has a different approach. Looking at our new model of care.

New Model of Care: Challenges and Opportunities
-What makes Suburban unique?

Kate: A lot has changed in the new era of healthcare and affect how we approach and define our needs. In the past, it has been illness and treatment. We identify problems and treat the patient however the model has changed. The cost of care has gotten more expensive while people are getting sicker.

Triple Aim: Looks at groups, looks at the disputation of patient outcome, also looks at determines of health outcomes, looks at policies and interventions that are impacted by health. Policies and systems that inhibit care. Triple aim looks to optimizing the model – must be done at the same time.

- Improve population health
- Reduce per capita of care
- Improve experience of care

Patient experience- sum of all their interactions, influence by their hospital experience and navigating the system can be difficult.

Monique: To add: Take a way: it is about the value of our patients and influence their behavior change. A great way to be in medicine what works best for our patients, before folks get to the hospital, what is

our greatest impact before they get to the hospital. We are reimburse by treating less patients not by more and to get better at our approach of treating patients, better to change behavior change.

Kate: How we are approaching triple aim and population health. Hospital revenue. You get paid for treating patient. But not, we have a global payment system which means the state sets the rate by the HSCRC, so now we have a fixed dollar rate along with patient experience. Now we have a fixed dollar to treat patients while providing excellent care. Payments are set by our readmission rates.

Monique: how do we approach this with MD be unique and more efficient with care. Best approach by working with the model. How do we work with our colleagues to work in the new culture.

EM: why did MD have this approach?

LW: 1970s waiver. States applied for waiver. 1990s MD is the only way to run the pilot program. MD new division CMS when ACA came. Fee for service MD has a new model. We are now doing the third version of what MD is doing. IF we went off the system, it would be highly disruptive and costly.

KM: What makes SH unique? It is our demographics. Looking at our CBSA. They are older, highly educated, want the five star experience. We also live in a diverse region.

Populated: MD, DC, VA area, we see a lot of patients and the age of the patients, they are sicker and have a multiple conditions.

Behavioral health affects everyone. SH has pillars of excellence: cardiac, oncology, joint, stroke, and trauma.

Also, have strong existing programs, community partners, making new layers, fine tuning so that we can meet the needs of community.

MS: Combination: Slides that visual this new era. It is about our partners that do the work. We cannot do this by ourselves. What we do well, who our partners are to help us do our work, who are the folks to helps us do our work.

2019 CHNA Report Data Highlights

-Morbidity and Mortality trends

Patricia Rios:

Thank you for your time for being here. Sent a copy of the working draft of the CHNA. I will provide a high level of the report. Color paper with three questions-take notes to help answer the questions.

Focus on high level data:

Excited?

Overview of our CHNA process- phase 1: analyst, collection of Primary data (US census, Health Montgomery, Hospital data); feedback from community

Few facts: highly populated in Montgomery County, expected to grow by 2020. The average age is 39 but the population is getting older. 64-74; Montgomery County is one of the affluent, and highly educated counties. Very expensive to live here. But we are not free from disease. Slide 3 from top.

LW: Over three year period, how consist it has been?

SB: disease of aging, typically found in older populations.

PR: since our last CHNA, heart disease was number 1 now it is number 2. you can see Cancer is number 1. This tells a little bit of picture and so we looked at Hospital data.

LW: Mortality table. Is heart disease better management of the disease?

PR: right, there is less deaths from Heart disease with behavior change. No smoking, better diets.

Hospital data: what do you observe from the graphic page 3?

SB: the last two in boxes are related to mental health conditions.

PR: once we looked at ED and inpatient data sets, we see behavioral health is listed higher and is consistently on the list.

Page 4: SH data: ten conditions that can be grouped into four categories.

PR: areas of service of excellence.

Orthopedics, behavioral, cardiac and infections.

MS: orthopedics if they are living longer, our joints needs help. A product of the population is living longer.

BS: cancer is outpatient so how does that affect the data that we see in hospitals.

LW: Infections- we haven't talked about that before

PR: yes, we have been having that discussion as well. So again, digging deeper we wanted to look at our data with our CBSA. CBSA looks like: 14 zip codes (Silver Spring, Rockville, Bethesda, Potomac) we see that 15% of users come from these 14 zip codes as well as charity care. If we look at why people use our hospital: heart related, infection or behavioral health.

MS: based on data that we see from those folks who come into our hospital. What would have been an indicator to have before they came to the hospital? What is the factor that we might be missing? Who is missing from our table of partners to help us do our work? Looking at social determines?

KH: mother has Alzheimer's. Every two months goes to hospital for UTI. Infection.

MS: that is what we want to hone down. We are looking at the baby steps to look at resources. We come together in small groups to look at what we are missing.

AS: second slide on page 7, what is overlay of social determine. SES People are coming to SH for similar things.

MS: That's another layer to look at. We will have the greater impact of social determinants of health.

AS: when aggregate SES. Looks rich but there are pockets of low SES. And need different strategy for low SES. Look how much it costs to live in this county, higher social economic ladder. Social determinants of health might need to be a focus. Isolation being part of Social determine of Health is important too.

MS: looking at resources, living in a condo who has resources but isolated or is it the person who doesn't speak the language. So it is both. What are the interrupters to change isolation?

PR: Readmission rates at SH. Top diagnoses of why people are readmitted to the hospital. Heart failure and septeses are why people are being readmitted to the hospital 20852, 20817

KH: does your data allow you to plot where exactly in the zip codes are they readmissions coming?

PR: Yes, for example, 20852 with the other hospitals are seeing the same kinds of people

LW: looking at HOC and see if there are any clusters.

KH: Plot any non-emergency care sites in those two zip codes. Is there a desert?

PR: comparison of all the data that has been mentioned. Looking at the themes and feedback. Listed the 10 on the wall.

Health Priorities Discussion

1. ***Based on the content that was presented this afternoon, what additional evidence/metrics/data is missing from the report that could help paint a better picture of (1) the population Suburban Hospitals serves and the (2) health challenges we face as an organization?***

SB: Observing the hospital as a volunteer. Behavioral health is top of mind. Talking to families, it is the lack of treatment and beds to accommodate the patients with behavioral health needs. Lack of facilities for these patients. Worry from the love ones- patients have been multiple times and great need that has not been met.

MS: resources- taking the tolls of loved ones with stress

SB: what data do we need? Alcohol, drug, mental illness and consolidating the data, where are they coming from? Is it income?

EM: Mental health is separate out from suicide. How are defining them separate? Is that put under mental health or substance abuse?

MS: that is a category. What then would do we see how to avoid to get to that point of substance abuse. Where would we be better to best serve the community as social determinants?

AS: prevention/promotion. Youth risk factors. Helping the schools these issues head on. Bullying and what schools are doing and how we can partner with them. It is not one age group- Suicide and bullying in over the age group

LW: behavioral health chart page 4. Bottom Primary look at the secondary is a behavioral health. Co-concurring. Does heart failure, is there a secondary to diabetes?

EM: we are underreporting if first was admission was substance abuse while the second could be a mental health illness.

LW; older person is depression has trouble managing their disease

LS: where are we with the oral health needs of the community? As we look at infections, there is a connection with dental health. Look at oral health as a need.

MS: looking at oral health as a group- with other behavioral health. Vaping?

MS: dot activity. Where should SH focus? We are we going to be most affected.

MM: do you consider dementia/Alzheimer's under mental health

PR: yes, but if you would like to add it as a separate, we can.

MS: that's why you are here. Anything else we are missing.

LS: yes, I would agree that dementia/Alzheimer's as a separate health priority.

EM: prevention of mental health.

MS: That would be under our lenses, prevention, access, and social determinants of health. Are we missing anything else?

SR: Can it be tie to injuries? Because of jobs, social factors. Trauma, accidents with low economic recovery, transportation issues.

BS: how to handle cost? Finance, lack of insurance, and not be eligible for home health care.

SR: they don't go for screenings, they do not get them done and then we see them at the last stages.

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

2019 Community Health Needs Assessment

Community Healthy Improvement Advisory Council

March 28, 2019

SUBURBAN HOSPITAL
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Community Health Needs Assessment

CHNA Comparison: 2016 vs 2019

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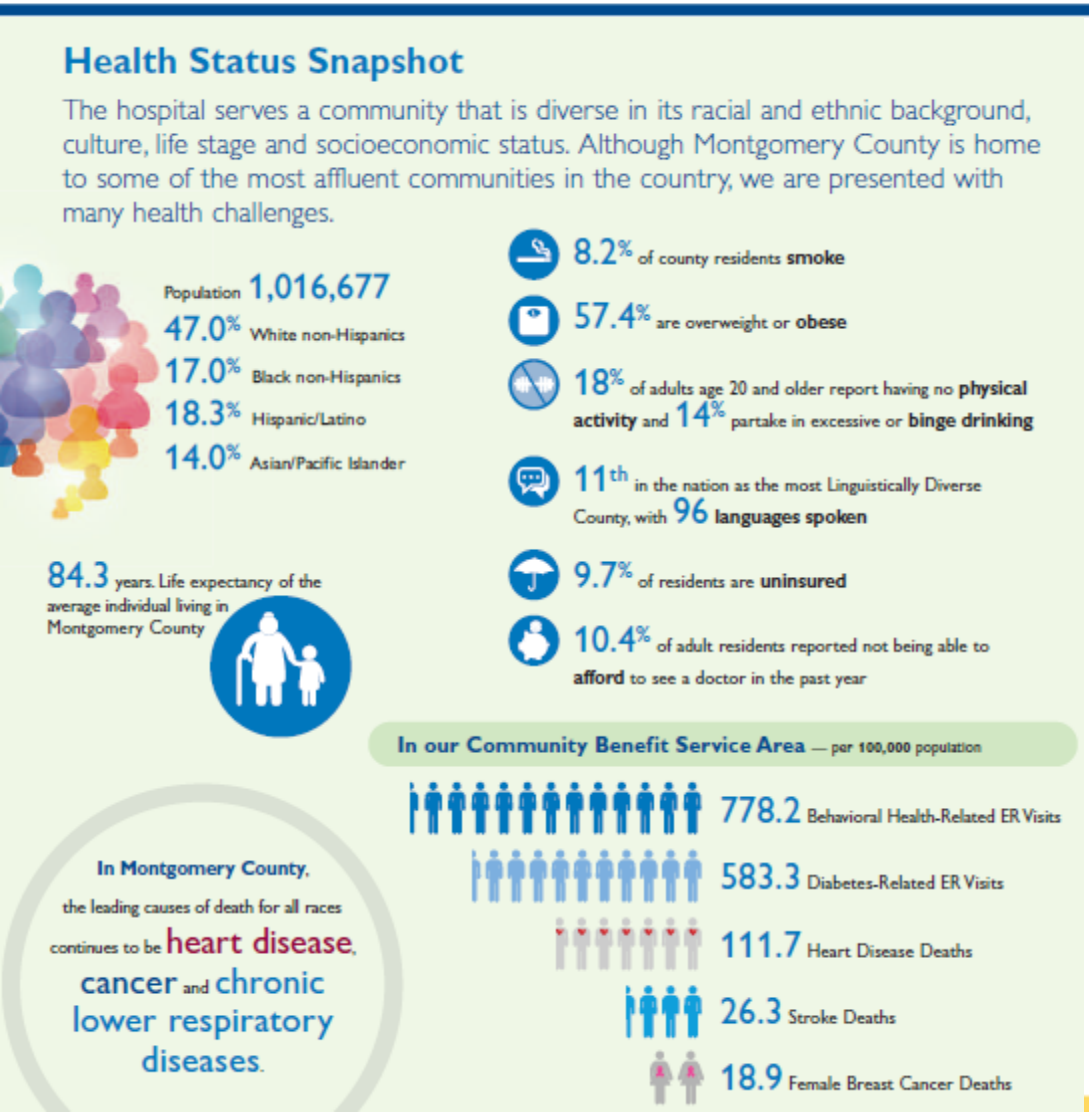

2016 Health Priorities

- Diabetes
- Cancer
- Behavioral Health
- Heart Disease

New Era of Healthcare: Population Health

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Community Health Needs Assessment Process 2019

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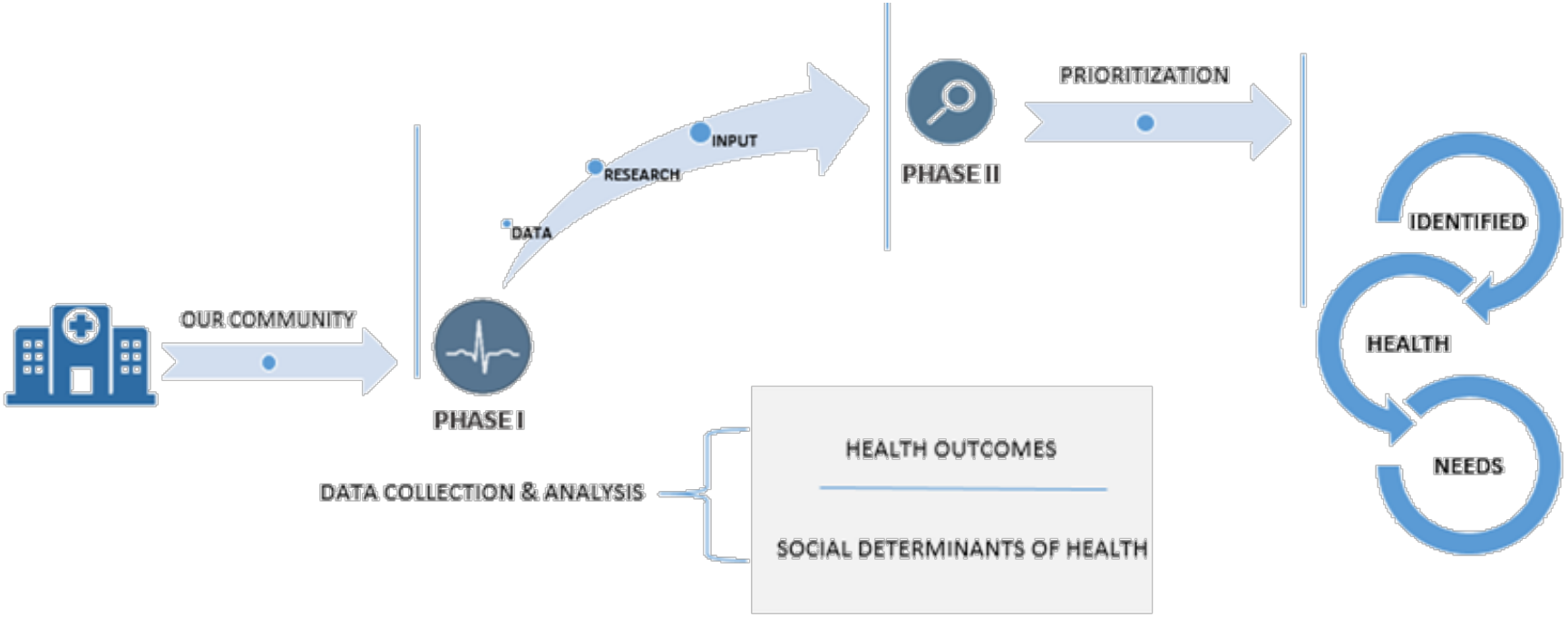

2019 Community Health Needs Assessment (CHNA)

Data from the CHNA drives decision making to address the needs of our community.

Aim for Precision in Everything We Do

Community Benefit Service Area: OUR Community

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14 Priority Postal Zip Codes

Service excellence beyond the walls of the hospital.

Support the Well-Being of Our People and Our Communities

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CHNA 2019 Findings

Summary of Mortality

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Table 1. Leading Cause of Deaths by Year, Montgomery County, 2014-16

	2014		2015		2016		2014-16	
	%	Rank	%	Rank	%	Rank	n (%)	Rank
Cancer	23.6	1	23.8	1	23.5	1	4,146 (23.7)	1
Heart Disease	22.9	2	22.3	2	22.0	2	3,925 (22.4)	2
Cerebrovascular Disease	5.1	3	4.9	3	5.1	3	881 (5.0)	3
Accident	3.5	4	3.5	4	3.6	4	615 (3.5)	4
Chronic Lower Respiratory Disease	3.4	5	3.4	5	3.3	5	589 (3.4)	5
Alzheimer's Disease	2.6	7	2.9	6	2.8	6	481 (2.7)	6
Influenza & Pneumonia	2.8	6	2.8	7	2.4	7	471 (2.7)	7
Diabetes Mellitus	2.4	9	2.3	9	2.4	7	416 (2.4)	8
Septicemia	2.6	7	2.5	8	1.9	9	409 (2.3)	9
Nephritis	1.5	10	1.9	10	1.6	10	291 (1.7)	10
All Other Causes	29.7		29.7		31.4		30.3	

Source: Health in Montgomery County, 2008-2016.

Summary of Hospitalizations

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

Table 5. Leading Cause of Hospitalization by Year, Montgomery County, 2014-16

	2014		2015		2016		2014-16	
	%	Rank	%	Rank	%	Rank	%	Rank
Injuries	18.5	1	15.2	1	9.5	2	14.5	1
Heart Disease	12.8	2	12.9	2	14.7	1	13.4	2
Mental Health	5.8	3	6.3	3	6.2	3	6.1	3
Cerebrovascular Disease	3.9	4	3.6	4	3.2	6	3.6	4
Diabetes Mellitus	3.3	5	3.4	5	3.6	4	3.6	4
Cancer	2.8	6	2.9	6	3.3	5	3.0	6
Chronic Lower Respiratory Disease	2.7	7	2.3	7	2.1	7	2.4	7
Substance Abuse	1.7	8	1.7	8	1.5	8	1.6	8
Suicide	0.6	9	0.5	9	0.4	9	0.5	9
All Other Causes	47.9		51.2		55.5		54.9	

Source: Health in Montgomery County, 2008-2016.

Summary of ER Visits

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

Table 9. Leading Cause of ER Visit by Year, Montgomery County, 2014-16

	2014		2015		2016		2014-16	
	%	Rank	%	Rank	%	Rank	%	Rank
Injuries	28.4	1	25.1	1	22.7	1	25.4	1
Heart Disease	7.0	2	8.5	2	9.3	2	8.2	2
Mental Health	4.8	3	5.5	3	6.9	3	5.8	3
Chronic Lower Respiratory Disease	3.6	4	3.8	4	4.0	4	3.8	4
Substance Abuse	2.0	5	1.9	6	1.7	6	1.8	5
Diabetes Mellitus	1.8	6	2.1	5	2.2	5	2.0	6
Cerebrovascular Disease	0.3	7	0.3	7	0.2	7	0.3	7
Suicide	0.2	8	0.2	8	0.2	7	0.2	8
All Other Causes	51.9		52.6		52.8		52.4	

Summary Hospitalizations for Suburban Hospital

APR-DRG Inpatient Diagnosis Descriptions	2017	2018	Grand Total
KNEE JOINT REPLACEMENT	1108	948	2056
HIP JOINT REPLACEMENT	793	836	1629
SEPTICEMIA & DISSEMINATED INFECTIONS	825	782	1607
MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	542	689	1231
HEART FAILURE	447	438	885
KIDNEY & URINARY TRACT INFECTIONS	324	318	642
BIPOLAR DISORDERS	277	345	622
OTHER PNEUMONIA	291	298	589
CVA & PRECEREBRAL OCCLUSION W INFARCT	273	312	585
ALCOHOL ABUSE & DEPENDENCE	239	324	563

Source: Suburban Hospital, EPIC 2018. Number of cases 2017-2018.

Summary Hospitalizations for Suburban Hospital: Orthopedic

APR-DRG Inpatient Diagnosis Descriptions	2017	2018	Grand Total
KNEE JOINT REPLACEMENT	1108	948	2056
HIP JOINT REPLACEMENT	793	836	1629
SEPTICEMIA & DISSEMINATED INFECTIONS	825	782	1607
MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	542	689	1231
HEART FAILURE	447	438	885
KIDNEY & URINARY TRACT INFECTIONS	324	318	642
BIPOLAR DISORDERS	277	345	622
OTHER PNEUMONIA	291	298	589
CVA & PRECEREBRAL OCCLUSION W INFARCT	273	312	585
ALCOHOL ABUSE & DEPENDENCE	239	324	563

Source: Suburban Hospital, EPIC 2018. Number of cases 2017-2018.

Summary Hospitalizations for Suburban Hospital: Behavioral Health

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

APR-DRG Inpatient Diagnosis Descriptions	2017	2018	Grand Total
KNEE JOINT REPLACEMENT	1108	948	2056
HIP JOINT REPLACEMENT	793	836	1629
SEPTICEMIA & DISSEMINATED INFECTIONS	825	782	1607
MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	542	689	1231
HEART FAILURE	447	438	885
KIDNEY & URINARY TRACT INFECTIONS	324	318	642
BIPOLAR DISORDERS	277	345	622
OTHER PNEUMONIA	291	298	589
CVA & PRECEREBRAL OCCLUSION W INFARCT	273	312	585
ALCOHOL ABUSE & DEPENDENCE	239	324	563

Source: Suburban Hospital, EPIC 2018. Number of cases 2017-2018.

Summary Hospitalizations for Suburban Hospital: Cardiovascular

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

APR-DRG Inpatient Diagnosis Descriptions	2017	2018	Grand Total
KNEE JOINT REPLACEMENT	1108	948	2056
HIP JOINT REPLACEMENT	793	836	1629
SEPTICEMIA & DISSEMINATED INFECTIONS	825	782	1607
MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	542	689	1231
HEART FAILURE	447	438	885
KIDNEY & URINARY TRACT INFECTIONS	324	318	642
BIPOLAR DISORDERS	277	345	622
OTHER PNEUMONIA	291	298	589
CVA & PRECEREBRAL OCCLUSION W INFARCT	273	312	585
ALCOHOL ABUSE & DEPENDENCE	239	324	563

Source: Suburban Hospital, EPIC 2018. Number of cases 2017-2018.

Summary Hospitalizations for Suburban Hospital: Infections

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

APR-DRG Inpatient Diagnosis Descriptions	2017	2018	Grand Total
KNEE JOINT REPLACEMENT	1108	948	2056
HIP JOINT REPLACEMENT	793	836	1629
SEPTICEMIA & DISSEMINATED INFECTIONS	825	782	1607
MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	542	689	1231
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OTHER PNEUMONIA	291	298	589
CVA & PRECEREBRAL OCCLUSION W INFARCT	273	312	585
ALCOHOL ABUSE & DEPENDENCE	239	324	563

Source: Suburban Hospital, EPIC 2018. Number of cases 2017-2018.

Top Hospitalizations for “OUR” Community

SUBURBAN HOSPITAL
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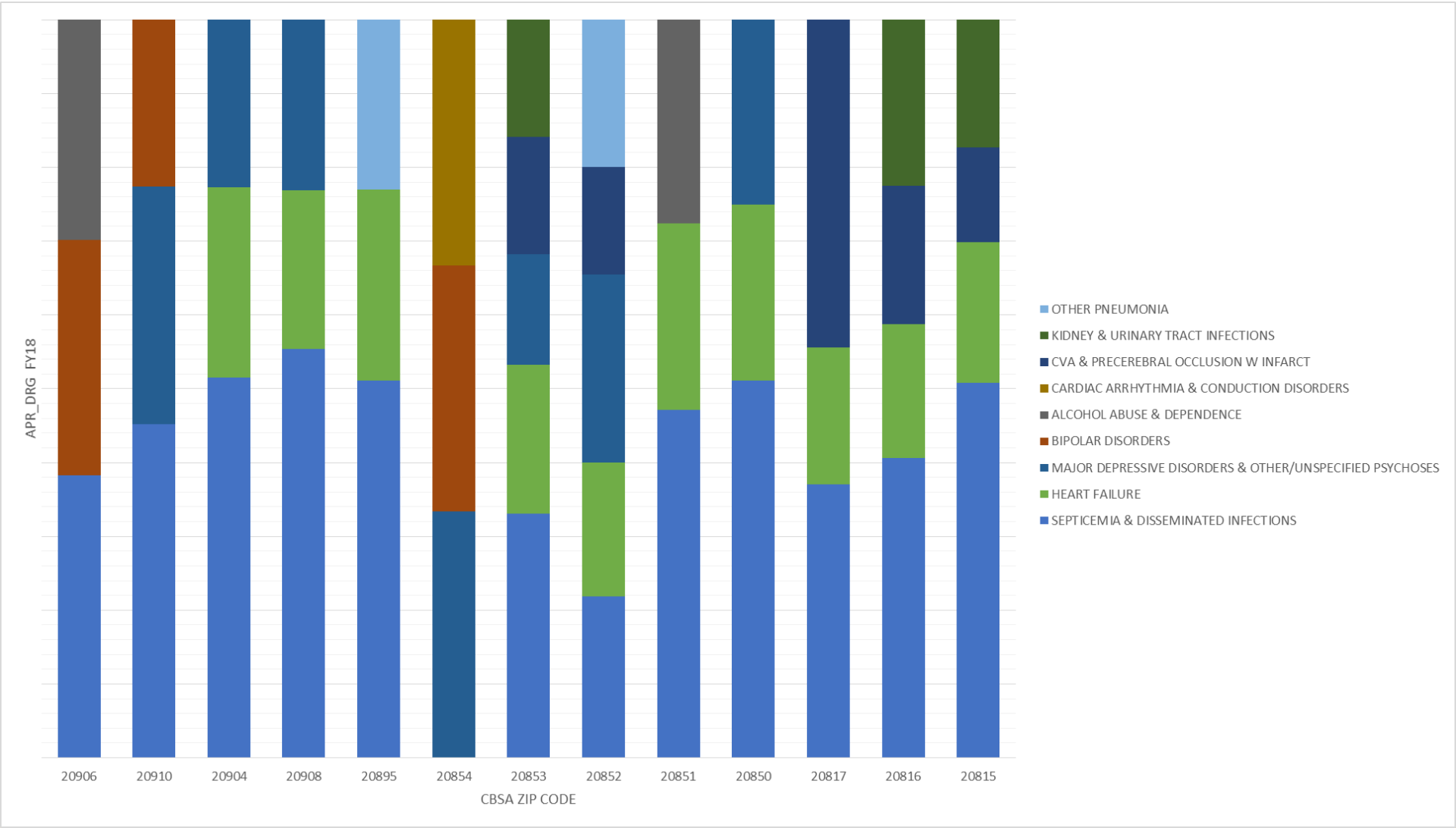

Re-Admissions by Diagnosis & Zip Code: Suburban Hospital

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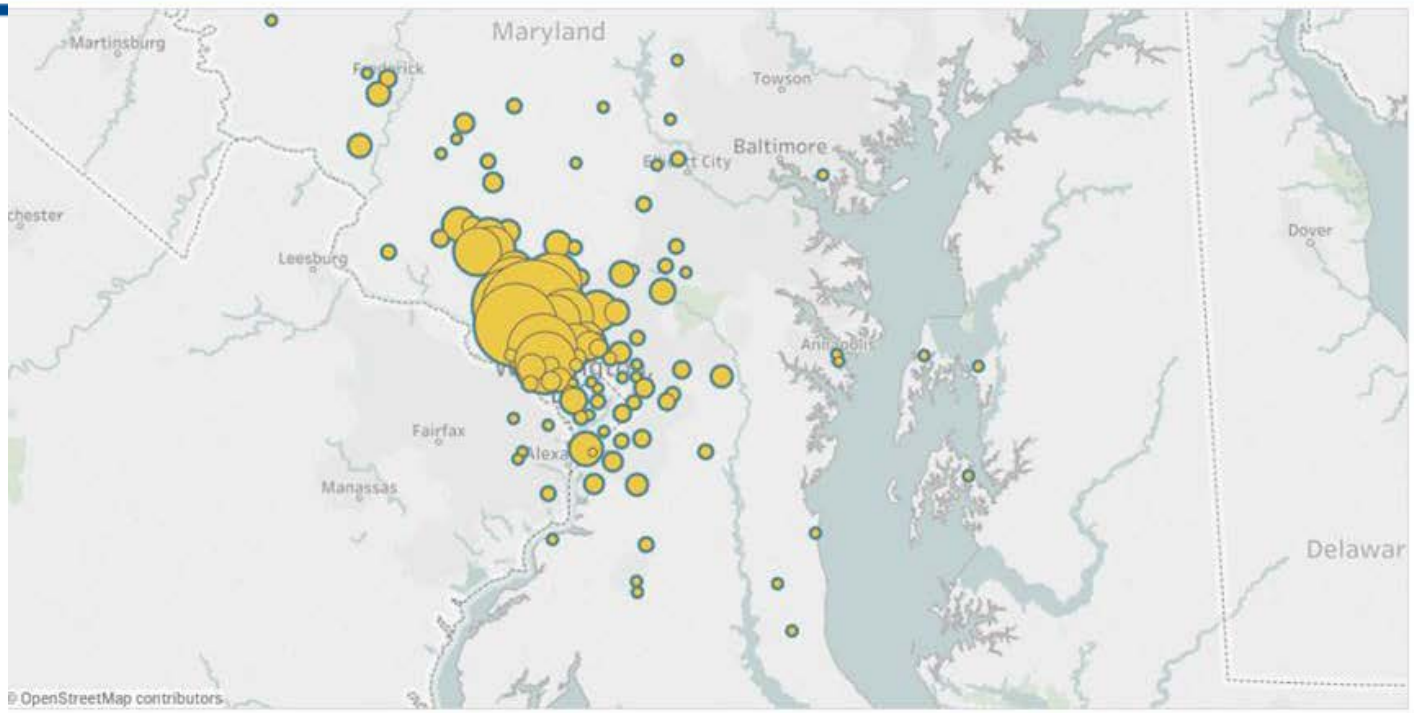
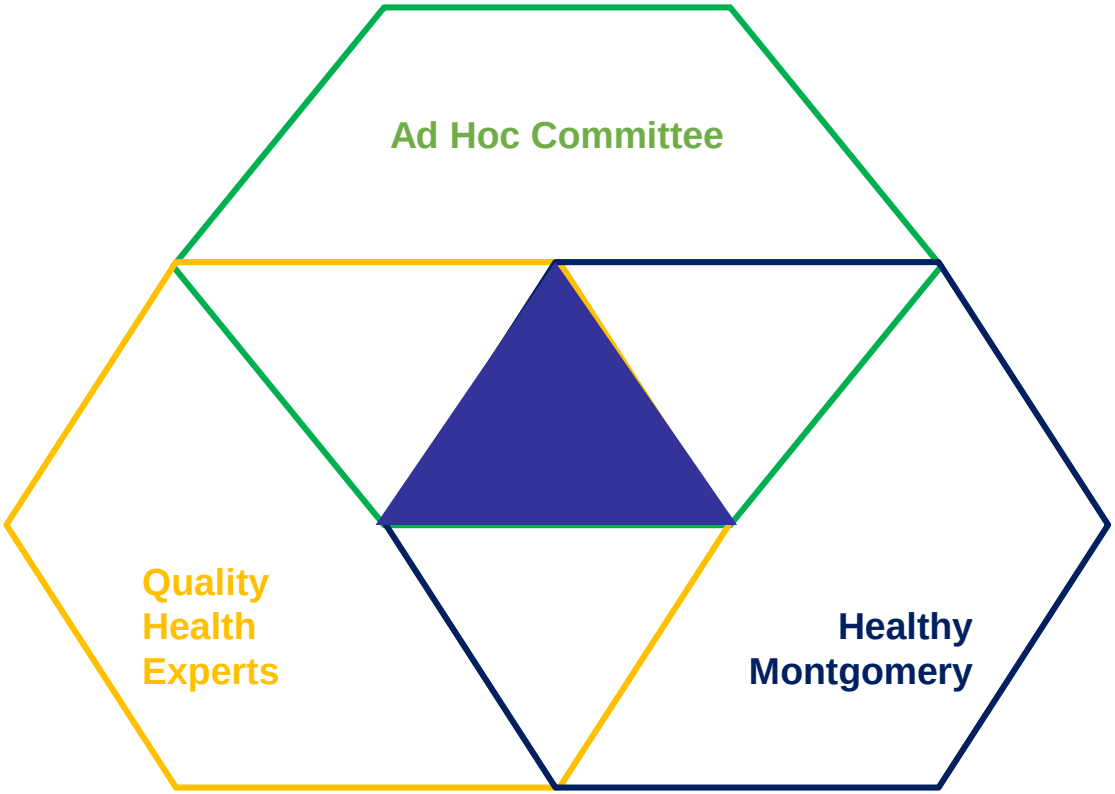


20852	137
20817	86
20854	69
20814	62
20815	48
20850	47
20906	41
20902	38
20895	34
20853	28
20878	28
20877	25
20910	22
20851	19
20904	19
20855	16
20886	16
20901	14
20032	13
20874	13
20816	10
20912	10
20005	8
20832	8
20008	7
20705	7
20708	7
20866	7
20879	6
21703	6
21710	6
20016	5
20716	5
20735	5
20740	5
20876	5
23231	5
20015	4
20657	4
20744	4

Community Stakeholder Input

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE



Summary of Identified Health Needs

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

	Leading Causes of Mortality in Montgomery County	Top Causes of Hospitalizations/ ED Utilization in Montgomery County	Top Causes of Hospitalization/ Readmission at Suburban Hospital	Healthy Montgomery Health Priorities	Ad Hoc Committee Conversation	Quality Health Experts
Heart disease	X	X	X	X	X	X
Cancer	X	X		X	X	X
Diabetes Mellitus	X	X		X	X	
Chronic lower respiratory diseases	X	X				
Accidents (unintentional injuries)	X	X				X
Obesity				X	X	
Behavioral/Mental Health		X	X		X	
Maternal & Infant Health				X		
Infections (i.e. septicemia)	X		X		X	X
Orthopedics			X			

2019 CHNA Health Priorities

SUBURBAN HOSPITAL
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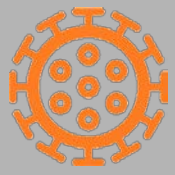
Emerging Priorities

Infections



Accidents

Continued Priorities

Diabetes

Cancer

Behavioral Health

Heart Disease

SUBURBAN HOSPITAL

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Suburban Hospital Implementation Strategy

In response to the Community Health Needs Assessment

Fiscal Years 2019-2021

BACKGROUND

Community Health Needs Assessment & Implementation Strategy

SUBURBAN HOSPITAL
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Regulatory Requirements

Internal Revenue Code 501 (c) (3) – for any non-profit organization to qualify for tax-free status

4 new requirements for non-profit hospitals

2010 Patient Protection and Affordable Care Act

1. **Provision of a Community Health Needs Assessment and associated implementation strategy – Section 501 (r) (3)**
2. Financial assistance policy and emergency medical care policy – Section 501 (r) (4)
3. Limitation on charges – Section 501 (r) (5)
4. Billing and collections – Section 501 (r) (6)

Suburban Hospital Compliance

Posted on facility website per regulations

1. FY 2013 – 2015
2. FY 2016 – 2018
3. FY 2019 – 2021

HEALTH PRIORITIES

Identified in the FY 2019 Community Health Needs Assessment

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Priority-Setting Process

Results

Heart Disease	Diabetes	Cancer
Behavioral Health	Unintentional Injury	Infections

MISSION-FOCUSED

Social Determinants of Health

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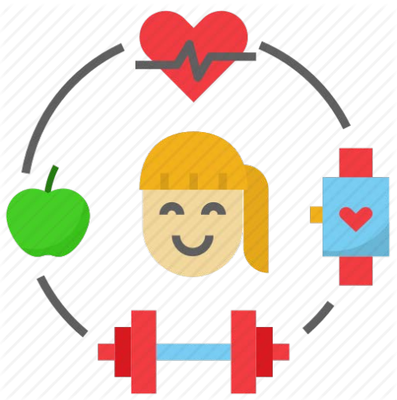
Lenses: A View of the Whole Person

- **Overall Health = medical care + conditions in which one lives, learns, works, and plays**
- **Sharpened focus on the complex health needs of the community**

Access to Care



Healthy Behaviors

Healthy Equity

KEY ELEMENTS

of the Implementation Strategy

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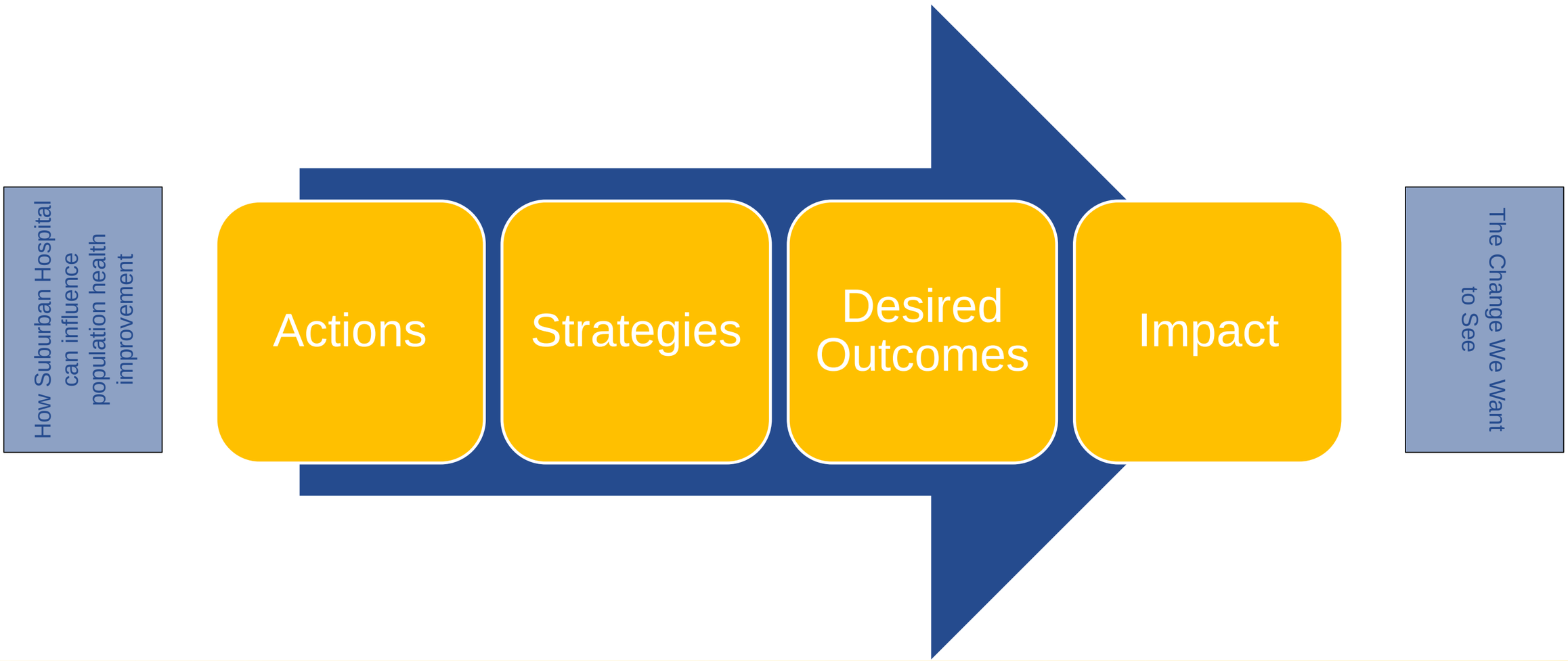
ACTION STEPS · RESOURCES · PARTNERS

Requirements of Section 501 (r) (3)



HEART DISEASE

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ACTION PLAN

Provide free or low-cost access to specialty providers, diagnostic screenings, treatment, and rehabilitation

Create on-going opportunities to connect 1:1 with a health professional to assess risks and receive counseling

Deliver on-going opportunities for individuals to eat better and move more

Provide on-going health education seminars and classes

STRATEGIES

Increase access to specialty heart care, management, and treatment for vulnerable populations

Prevent and reduce chronic disease by focusing on risk factors, such as social determinants of health, with a specific focus on congestive heart failure

DESIRED OUTCOMES

Individuals understand the risks associated with their condition

Individuals with poorly or un-controlled hypertension are identified

Individuals identified are referred to a provider and linked to on-going health and wellness programs for monitoring

IMPACT

Reduce the mortality rate from heart disease and stroke

DIABETES

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ACTION PLAN

Deliver on-going health education seminars, classes, and 1:1 counseling

Provide support groups

Intersecting strategies targeting chronic diseases, e.g. heart disease and cancer, through combined diet and physical activity promotion programs

STRATEGIES

Increase awareness of risk factors associated with diabetes by facilitating linkages to available resources

Increase access to endocrine specialty care, management, and treatment for vulnerable populations

DESIRED OUTCOMES

Individuals understand the risks associated with their condition

Individuals with diabetes are referred to appropriate disease prevention or management program

IMPACT

Reduce diabetes prevalence and associated health complications

BEHAVIORAL HEALTH

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ACTION PLAN

Deliver on-going programs and initiatives that foster social and emotional support

Residents with significant behavioral health needs will have equitable access to effective, clinically appropriate treatment

STRATEGIES

Expand and promote population-specific community-based programming

Link patients in need of behavioral and/or mental health services to appropriate community resources

DESIRED OUTCOMES

Decrease stigma surrounding behavioral health conditions and substance use disorders

Facilitate access to services available in Montgomery County

IMPACT

A supportive culture in which mental and behavioral health barriers are broken

CANCER

SUBURBAN HOSPITAL
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ACTION PLAN

Deliver on-going health education seminars, classes, and support groups

Provide access to preventative cancer screenings

STRATEGIES

Support initiatives that encourage behavior changes that reduce risk of cancer

Ensure that individuals screened are referred to a provider, if appropriate, for necessary follow up

DESIRED OUTCOMES

Increase awareness of risk factors associated with cancer

Increase rate of screenings that lead early detection

Increase utilization of existing cancer prevention services and resources at the community level

IMPACT

Reduce the cancer mortality rate

Increase cancer survivorship rates

EMERGING PRIORITIES

Newly identified in FY 2019 CHNA

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Growing roots to build robust programming and initiatives to influence positive health impacts

UNINTENTIONAL INJURY

Emerging Priority

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SNAPSHOT:

Top 10 Leading Cause of Death in Montgomery County

Fall-related injury among older adults

Motor vehicle crashes

Poisonings from opioid overdoses

ACTION PLAN

Deliver evidence-based fall prevention programming

Intersecting strategies targeting physical activity programming with a focus on improving balance

STRATEGIES

Support healthy aging initiatives, with a focus on those that build and maintain strong, healthy bodies

Champion aging-in-place initiatives by reducing barriers for Villages to serve as a neighborhood resource

DESIRED OUTCOMES

Majority of participants enrolled in fitness classes report zero visits to an emergency department

Increase capacity of Villages to serve as champions of injury prevention among older adults

IMPACT

Reduce the rate of preventable fall-related injuries among older adults

INFECTIONS

Emerging Priority

SUBURBAN HOSPITAL
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SNAPSHOT:

Top APR-DRG Inpatient Diagnosis at Suburban Hospital

Septicemia & Disseminated Infection
Kidney & Urinary Tract Infections
Other Pneumonia

ACTION PLAN
STRATEGIES
DESIRED OUTCOMES
IMPACT

ESTABLISHED BEST PRACTICES:

Vaccinations for vulnerable populations
Hand hygiene for all – hospital staff and general public
Improved overall health and well-being
Knowledge and awareness of Sepsis

RESOURCES & PARTNERS

Internal & External Commitments

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Hospital Commitments

- **Community Health Improvement Report**
- **Community Benefit Process**
  - Planned, organized and measured approach to meet identified health needs

Internal Partners

- **Content experts in clinical care and quality improvement**
- **Critical links between hospital and community**

External Partners

- **Long-standing relationships**
  - **Healthy Montgomery**
- **Opportunities to leverage resources through strategic alignment**
  - **Montgomery County Health Improvement Process**

INTERSECTING STRATEGIES

Cross-cutting efficiencies for population health improvement

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Montgomery County Health Improvement Process (CHIP)

- **Chronic Disease: Heart Disease, Diabetes, Cancer**
- **Behavioral Health**
- **Fall Prevention**

MEASUREMENT

Benchmarking progress

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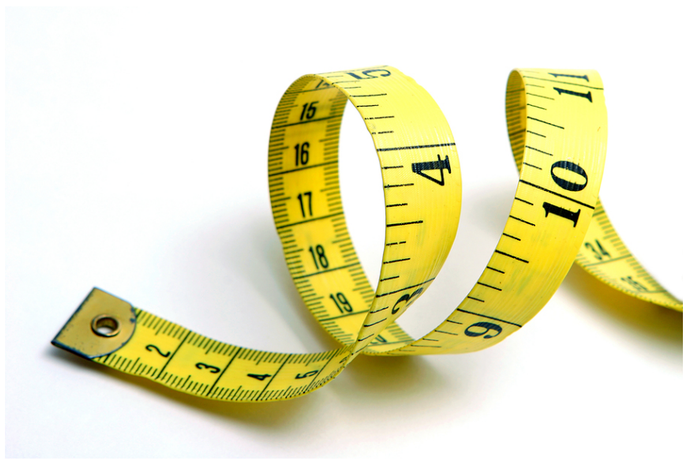

Established Priorities

- Surveys and evaluations
- Discharge data
- Community benefit tracking

Emerging Priorities

- Establishing baselines
- Identifying target populations

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Questions?

Living document

On-going

Evolving

Collaborative

Improving health with skill and compassion

Community Health Needs Assessment

Patient Needs Survey Results 2018
Total Number of Surveys Collected (N) = 151

1. **Gender**

	Male	Female	Blank	Total
Respondents	53 (35%)	83 (55%)	15 (10%)	**151**

2. Reported Health Status

Health Status	Over 50 YRS (N= 112)		50 & Under (N=24)		Blank (N=15)	Total
	Female	Male	Female	Male		
Excellent	20	8	9	4	4	**45 (30%)**
Good	42	28	4	3	**9**	**86 (57%)**
Fair	6	7	1	1	**1**	**16 (11%)**
Poor	0	1	0	1	**0**	**2 (1%)**
Blank	0	0	1	0	**1**	**2 (1%)**
Total	**68**	**44**	**15**	**9**	**15**	**151 or 100%**

3. Reported Chronic Conditions by Participants (N=151)

Condition	Female	Male	Blank	Total
Diabetes	8	11	3	**22 (11%)**
COPD	2	2	0	**4 (2%)**
Cancer	5	2	2	**9 (5%)**
High Blood Pressure	33	20	6	**59 (30%)**
Heart Disease	5	4	0	**9 (5%)**
Other Illness	26	7	2	**35(18%)**
No health conditions	23	13	6	**42(22%)**
Did not wish to answer	3	1	0	**4 (2%)**
Blank	3	7	0	**10 (5%)**
Total	**108**	**67**	**19**	**194 or 100%**

While 22% or 42 of respondents (n=151) reported no current health conditions, a total of **95** individuals or 63% reported living with at least one chronic condition and 7% or 14 individuals did not provide an answer. Among those who reported a health condition, a total of **33** (35%) individuals reported living with a least two co-morbidities. The most prominent conditions as reported by participants were hypertension (30%) and diabetes (11%). Other conditions reported included: high cholesterol (2.6%), asthma (3.3%), and arthritis (6.6%).

4. Likelihood to Attend a Wellness Class based on Age and Gender

Scale	Over 50 YRS (N= 112)		50 & Under (N=24)		Blank (N=15)	Total
	Female	Male	Female	Male		
Very likely to attend	8	4	2	1	3	**18 (12%)**
Somewhat likely to attend	32	20	7	1	8	**68 (45%)**
Not likely to attend	26	20	6	7	4	**63 (42%)**
Blank	2	0	0	0	0	**2 (1%)**
Total	**68**	**44**	**15**	**9**	**15**	**151**

57% reported either "very likely to attend a class" or "somewhat likely." Participants who reported "not likely to attend" a class were asked to explain what would motivate them to attend a class. The main motivating factor reported was money. That is, if participants were paid to attend a class. Other participants indicated (1) having a more serious health issues and (2) if the class provided new information they did not already know as additional motivating factors to participation.

5. Likelihood to Attend a Wellness Class based on Number of Present Chronic Condition

Scale	One Chronic Condition N=95	2+ Chronic Conditions N= 33	Total
Very likely to attend	13 (13%)	5 (15%)	**18 (14%)**
Somewhat likely to attend	45 (47%)	20 (61%)	**65 (51%)**
Not likely to attend	37 (39%)	8 (24%)	**45 (35%)**
Blank	0	0	**0**
Total	**95**	**33**	**128**

Participants who are more likely to attend a class at those living with a chronic condition. The likelihood to attend a class increases as the number of chronic conditions present also increases.

6. Prefer travel time to class*

Distance in Time	Over 50 YRS	50 & Under	Total
Less than 30 min	93	21	**114 (74%)**
Up to 45 min	8	3	**11 (7)**
Up to 1hr	1	1	**2 (1%)**
No time preference	11	3	**15 (10%)**
Did not response	11	2	**12 (8%)**
Total	**124**	**30**	**154**

7. Preferred time for class*

Time of Day	Over 50 YRS	50 & Under	Total

Morning class	34	6	**40 (24%)**
Afternoon class	30	5	**35 (21%)**
Evening class	35	13	**48 (29%)**
Did not response	33	8	**41 (25%)**
Total	**132**	**32**	**164**

8. Classes & Level of Interest

a) Weight Management

Scale	Over 50 YRS (N= 112)		50 & Under (N=24)		Blank (N=15)	Total
	Female	Male	Female	Male		
Not interested	20	5	3	4	3	**35 or 23%**
Somewhat interested	18	19	3	0	5	**45 or 30%**
Very interested	16	8	5	3	5	**37 or 24.5%**
Did not response	14	12	4	2	2	**34 or 22.5%**
Total	**68**	**44**	**15**	**9**	**15**	**151**

b) Diabetes Self-Management

Scale	Over 50 YRS (N= 112)		50 & Under (N=24)		Blank (N=15)	Total
	Female	Male	Female	Male		
Not interested	30	21	10	5	9	**75 or 50%**
Somewhat interested	4	3	0	1	0	**8 or 5%**
Very interested	5	6	0	1	2	**14 or 9%**
Did not response	29	14	5	2	4	**54 or 36%**
Total	**68**	**44**	**15**	**9**	**15**	**151**

c) Pre-Diabetes

Scale	Over 50 YRS (N= 112)		50 & Under (N=24)		Blank (N=15)	Total
	Female	Male	Female	Male		
Not interested	30	19	9	5	9	**72 or 48%**
Somewhat interested	6	4	0	1	0	**11 or 7%**
Very interested	6	2	1	1	2	**12 or 8%**
Did not response	26	19	5	2	4	**56 or 37%**
Total	**68**	**44**	**15**	**9**	**15**	**151**

d) Smoking Cessation

Scale	Over 50 YRS (N= 112)		50 & Under (N=24)		Blank (N=15)	Total
	Female	Male	Female	Male		
Not interested	37	25	10	6	9	**87 or 58%**

Somewhat interested	1	1	0	0	0	**2 or 1%**
Very interested	0	0	1	0	1	**2 or 1%**
Did not response	30	18	4	3	5	**60 or 40%**
Total	**68**	**44**	**15**	**9**	**15**	**151**

e) Heart Health

Scale	Over 50 YRS (N= 112)		50 & Under (N=24)		Blank (N=15)	Total
	Female	Male	Female	Male		
Not interested	18	10	7	4	4	**43 or 28%**
Somewhat interested	19	10	2	0	5	**36 or 24%**
Very interested	7	12	1	3	2	**25 or 17%**
Did not response	24	12	5	2	4	**47 or 31%**
Total	**68**	**44**	**15**	**9**	**15**	**151**

f) Chronic Disease Self-management

Scale	Over 50 YRS (N= 112)		50 & Under (N=24)		Blank (N=15)	Total
	Female	Male	Female	Male		
Not interested	29	20	10	4	5	**68 or 45%**
Somewhat interested	3	4	0	1	1	**9 or 6%**
Very interested	8	2	0	1	3	**14 or 9%**
Did not response	28	18	5	3	6	**60 or 40%**
Total	**68**	**44**	**15**	**9**	**15**	**151**

Based on responses, the level of interest in classes are as follows (listed from highest level of interest to lowest): weight management class (24.5%), heart health class (16.5%), diabetes self-management class (9%), chronic disease self-management (9%), pre-diabetes (7%) and smoking cessation (1%). 17 (11%) of 151 participants listed other topics of interest, which included exercise, pain management, depression, bone health and asthma.

9. Barriers to Health Education Participation*

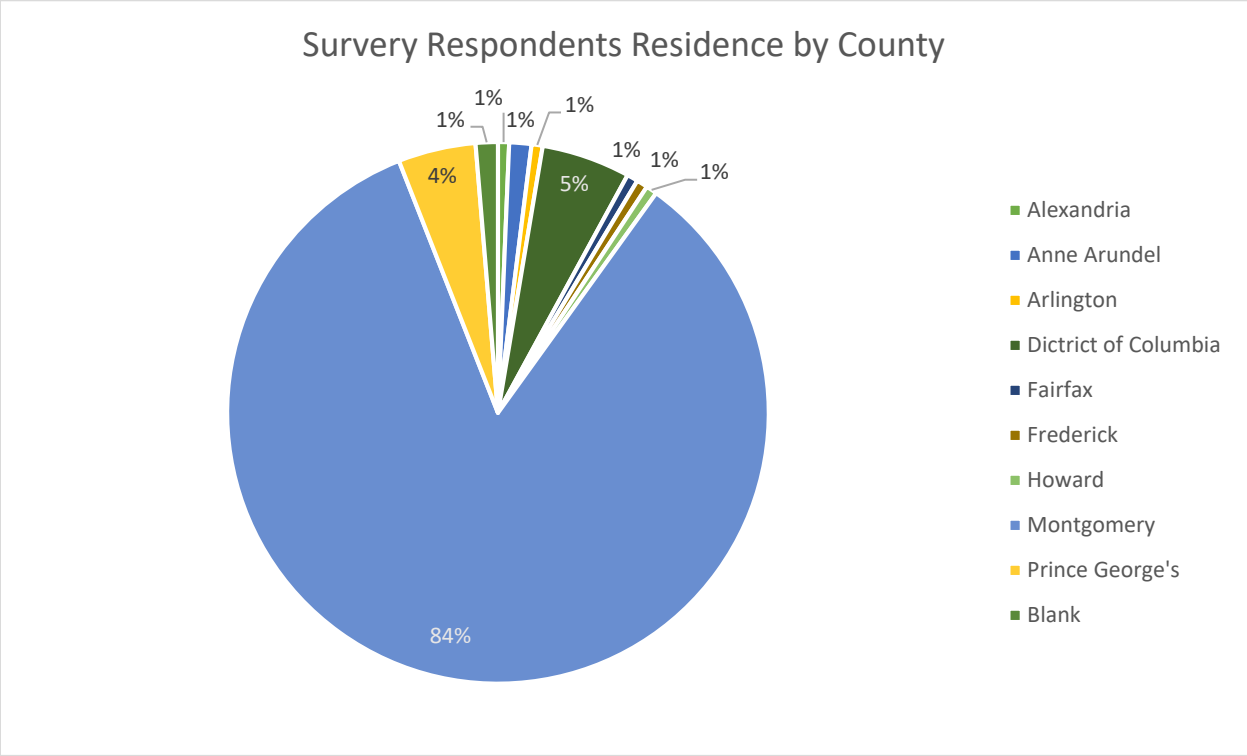
Scale	Over 50 YRS		50 & Under		Blank	Total
	Female	Male	Female	Male		
Transportation	2	1	0	0	0	**3 (1%)**
Cost	14	8	3	2	1	**28 (12%)**
Time	20	15	6	4	3	**48 (20%)**
Lack Motivation	11	9	4	3	3	**30 (12%)**
Language	0	0	0	0	0	**0 (0%)**
Lack of interest	15	12	5	3	4	**39 (16%)**
Distance	18	13	6	1	4	**42 (17%)**

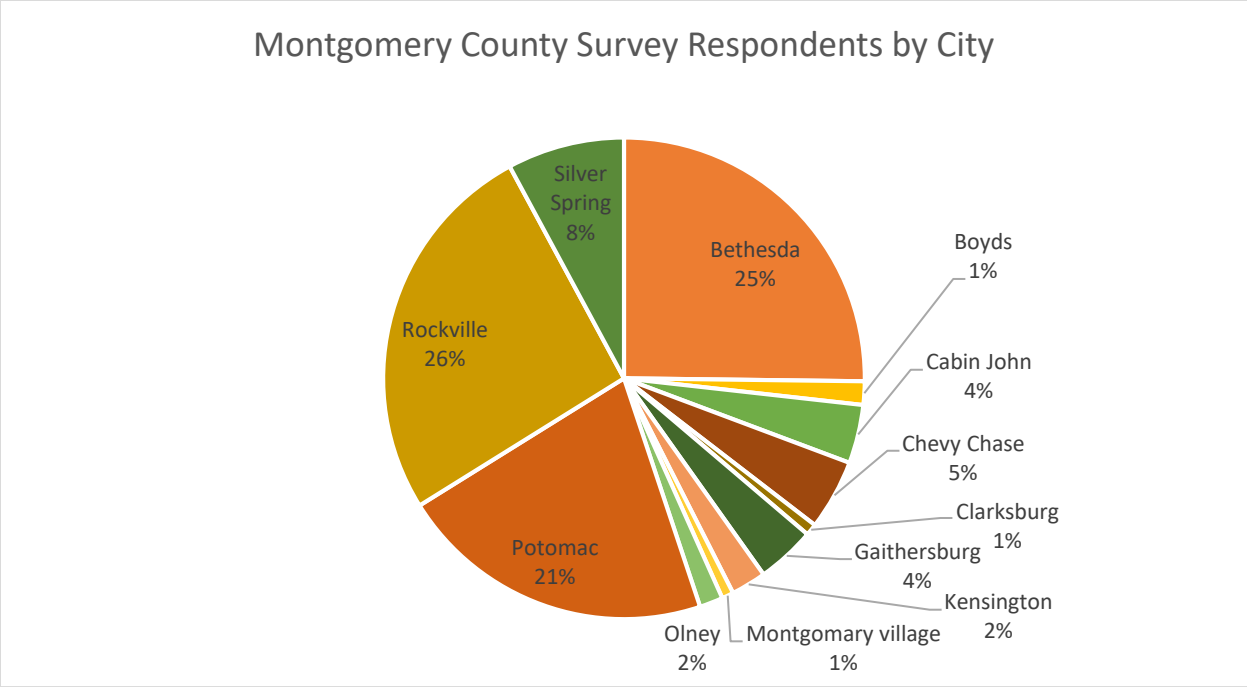
No Factor	7	7	2	1	4	**21 (9%)**
Other	9	4	0	0	0	**13 (5%)**
Did not Respond	11	4	2	1	2	**20 (8%)**
Total	107	73	28	15	21	**244 (100%)**

The top 3 factors prevention individuals from participating in a wellness program include time, distance, and lack of interest. Other factors mentioned, but not listed above included: work schedule and family obligations.

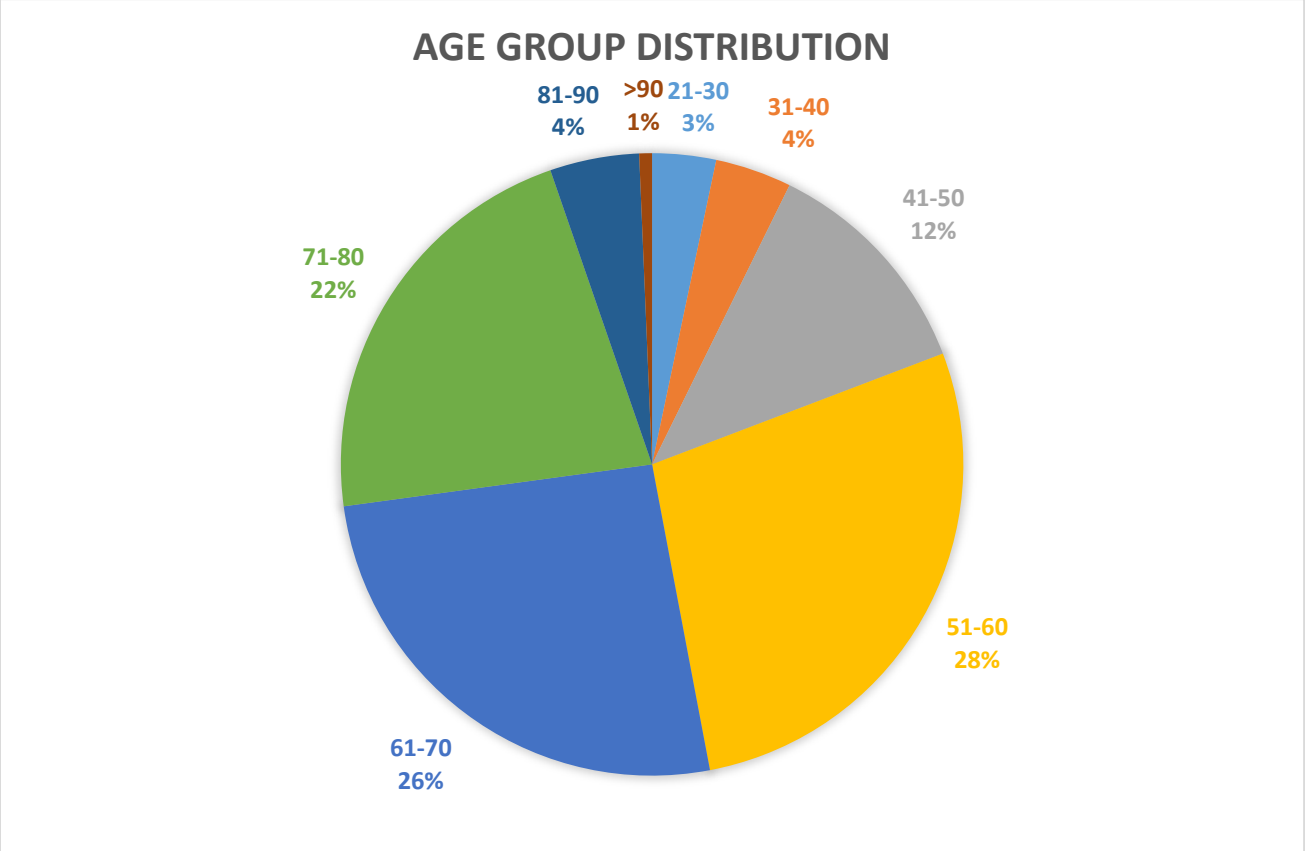
10. Zip Code Breakdown

Survey participants reside in 39 zip codes, originating from 25 different cities in 9 counties across the National Capital Region. Majority of respondents (84%) live in Montgomery County. 72% of Montgomery County residents who participated in the survey reported living in Bethesda (20817 & 20814), Potomac (20854) and Rockville (20850, 20851, 20852 & 20853).





11. Age Breakdown



**Total does not equal 151 because respondents provided more than one answer.*

Key Informant Conversation- Behavioral Health Needs

April 2017

Why mental health is so prevalent today:

- Less extended families –more youth living alone
- Less stigma- people are actually speaking up about this
- Environmental availability for drugs- easier to obtain
- Lack of insurance
- Internet, social media
- Stress/anxiety/isolation at an all-time high
- Trump causing families to split, causing stress

Important Questions:

- How do we bring/connect resources to the hospital?
- What is the need?
- Where do we begin?
- What resources are out in the community right now?
- How do we address their background (immigration status)

Behavioral Health Interventions Meeting Notes

- Problem-limited mental health programs for Latino Youth
- Multiple barriers to treatment: culture, fear, stigma, lack of insurance, language barrier
- Support existing programs in the community and expand access ex) Girls on the Run (use the same audience and provide a speaker to talk about mental health issues)
- Improve information referral- update information and develop a referral directory
- Need a better way to access insurance information (main issue is that we give patients a list of doctors but we cannot tell them if they take their insurance- this causes frustration)
- Improve school treatment- coach school counselors
- Start a “Public Health Campaign”
- Start talking about substance abuse early- middle school students- post about it on parent page
- There are programs dedicated to opioid abuse (ex: Speak up, Save a Life) but the problem is getting people to come
- Existing opioid abuse classes are too light- should bring in clinical component to class to provide more information (problem is that these people want to be paid to come speak to class)
- Sexual abuse is relevant in Latino Youth, especially for those who do not live with immediate family- how do we reach these girls? How do we provide resources?

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

Celebración del Mes de la Herencia Hispana

Salud Mental: Mitos & Realidades

 # de participantes = 116 **Evaluaciones retornadas = 84 (72%)**

1. **¿Que tema de salud mental es importante para Usted?**
   - ☐ Stress/Ansiedad (51/ 60%)
   - ☐ Depresión (49/ 58%)
   - ☐ Alcohol/Drogas/Marihuana (27)
   - ☐ Dementia (13)
   - ☐ Salud mental del adulto mayor (38)
   - ☐ Salud mental en los adolescentes (46/55%)
   - ☐ La hiperactividad (16)
   - ☐ Otro: (1)
   - ☐ No respuesta (1)

2. **¿Qué tipo(s) de apoyo/programa/asistencia necesita Usted para mejorar su estado de salud mental? (34)**
   - Ninguno (23)
   - No respuesta (16)
   - Terapia para mi hija
   - Ayuda para mi (# de telf..) 3
   - Recibir más información sobre el tema
   - Información/lectura 2
   - Consulta medica
   - Programa básico
   - Salud mental en los adolescentes
   - Psicologos 2
   - Ansiedad 4
   - Todos los que estén disponibles y a mi alcance medico
   - Ayuda para manejar mi ansiedad y obesidad
   - Manejo estrés 3
   - Mindfulness, meditación
   - Salud mental en adulto mayor
   - Consejería para adultos y jóvenes 3
   - Que ensenen técnicas
   - Para victimas de derrame
   - Medicina
   - Profesionales locales para diagnostico
   - Programa para niños
   - Como detectar síntoma de depresión y/o estrés
   - Todas las terapias
   - Par la personas de 3ra edad

¡Gracias por su asistencia!

3. **¿Qué barrera(s) tiene Usted o personas que conoce para acceder servicios de salud mental?** (50)
    - Ninguno (28)
    - No respuesta (16)
    - El tiempo
    - La escuela
    - Información/No saber sobre programas/servicios disponibles 7
    - El idioma 5
    - Miedo/Pena 4
    - Falta de Seguro medico o limitado 11
    - La barrera de no aceptar el problema/negación 4
    - Los costos son algo elevados 5
    - Estar solo en este país
    - Psicólogo a bajo costo 3
    - Lugares que atiendan en español, pronto y a un bajo costo 2
    - Stress, ansiedad y depresión
    - Falta de ánimo para actuar
    - Mi seguro medico (medicaid)
    - Profesionales bilingües 2
    - Estigma

4. **¿Cómo se informo acerca de este evento?**

☐ St. Catherine Church (45/54%)
☐ Folleto (7)
☐ Amigo (15)
☐ Email (9)
☐ Otro (6):_____
☐ No respuesta (2)

Comentario o sugerencia adicional:

- Que las charlas sean más extensas
- Me gustaría tener más información acerca de la salud mental, podemos tener de nuevo otra charla? (salud mental)
- Muchas gracias por aclarar mis dudas
- Fue un poco corto el tiempo ya que el tema es bien interesante y la exposición fue precisa aunque no se abarco algunos temas
- Pueden hacer esto más seguido? Y con más tiempo?
- Trabajar obtener psicóloga que nos ayudara
- Otra sesión de como apoyar a una persona con Ansiedad, como prepararse y educarse para eso!
- Gracias por este tipo de charlas (2)
- Excelente conferencia, Excelente preguntas de la concurrencia. Se ve que hubo mucho interés.
- Tener al final las láminas del PPT

¡Gracias por su asistencia!

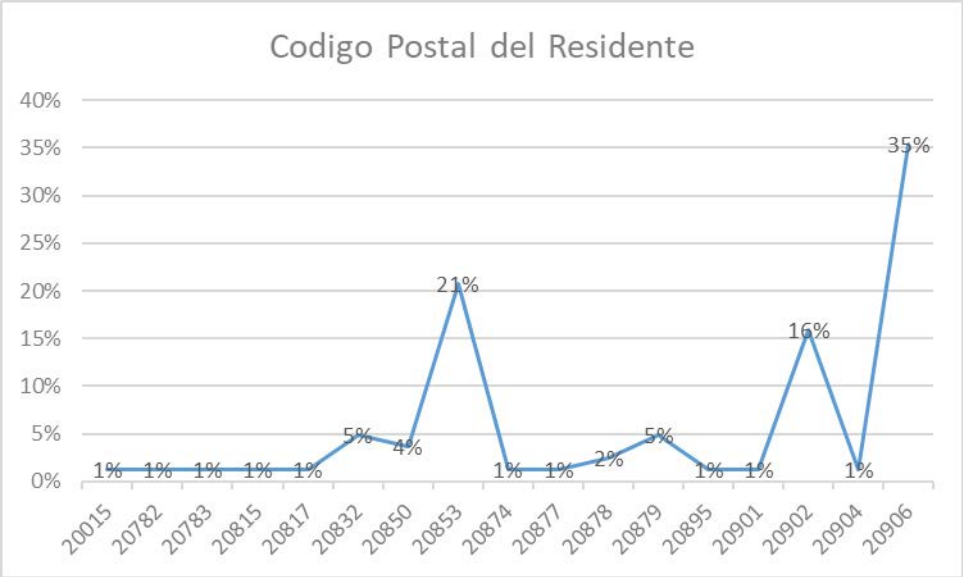
- Sería de gran ayuda un programa de este tipo para los adolescentes
- Gracias por ayudarnos a entender sobre la salud mental
- Que sigan estas charlas, hay mucho tabú en la comunidad todavía
- Gracias, muy interesante (2)
- Excelente
- Un tema sobre hipertensión
- Una charla muy importante. Que se siga haciendo aún más seguido.
- Que se repita con un seminario de más tiempo
- Aprendí mucho lo pondré en práctica. Sugiero que haiga más # charlas
- Felicitarles por el tema
- Mas programas de información

Barómetro de Estrés Reporte

A. Datos Demograficos:

N= 82

Hombre = 18, 22%
Mujer = 64, 78%



¡Gracias por su asistencia!

B. Estado de amino el día del evento

Excelente	Muy Bien	Bien	No muy bien	Mal	
					
17%	46%	17%	7%	4%	Blank=9%

C. Problemas en los últimos 7 días

A. **Problemas prácticos** ***29%***

- Cuidado de los niños – 20%
- Alojamiento -7%
- Seguro financiero -19%
- Transporte -10%
- Trabajo/ escuela- 29%
- Decisiones de tratamiento -14%

B. **Problemas familiares** **19%**

- Tratando con niños -18%
- Tratar con pareja -33%
- Capacidad de tener hijos – 14%
- Problemas de salud familiar – 35%

C. **Problemas emocionales** **49%**

- Depresión – 9%
- Miedos – 13 %
- Nerviosismo – 17%
- Tristeza – 21%
- Preocupación – 28%
- Pérdida de interés en las actividades habituales – 12%

D. **Preocupaciones espirituales / religiosos** 3%

¡Gracias por su asistencia!

The "S" Word Film Screening & Discussion
EVALUATION Summary

Location: AFI Silver Theater and Cultural Center, Silver Spring, MD
Date: October 25, 2018
Total number of registrations: ~116
Total number of attendees: ~90
Total number of evaluations returned: 57

Questions:

1. **What did you gain from this event? (Check all that apply)**

- ☐ Increased knowledge about the warning signs of suicide **(28)**
- ☐ Increased knowledge about community resources **(36)**
- ☐ Increased motivation to help someone in crisis **(26)**
- ☐ Names of other people/organizations to contact **(35)**
- ☐ Nothing new **(0)**
- ☐ Other: **(3)**
  - Increased perspective of how it would impact my loved ones if I were to go through with it
  - Increased knowledge of suicide attempt survivors.
- ☐ Blank: **(1)**

2. **What is the most important thing you learned today?**

- Btheone.org (2)
- Resources and community contacts in Montgomery County
- A simple "I love you" or "I care," can really make a difference
- Increased knowledge about the aftermath of an attempt
- Suicide, personal testimony
- About the project in the movie, efforts to stop suicide, resources
- Not to come on to strong when addressing MH/BH/suicide, but with finesse
- Tell someone
- Stats
- That people are never alone
- Community resources and websites
- To ask how I can help. To talk about my feelings & seek help
- Resources are available
- To ask (2)
- Keep talking!
- To speak up and know that there is always someone to help
- Additional resources and actions taken to get the word about suicide prevention
- Resources/tools for mental health crisis
- How to talk to someone who might be in crisis
- I am not alone
- It does not take much to help someone in need. A few simple words is a good start
- Stories of survivors
- That a lot of people feel alone
- That we need more awareness
- Importance of community
- That people with much more severe suicidal thoughts than mine have survived and continue to thrive
- Always ask and reach out
- Do not stay quiet – listen – let people know you care

- How well people may appear to be functioning while suffering so much
- Suicide is the 2nd leading cause of persons between 15-24 years old and is preventable
- Ask the hard questions. You are not alone
- How easily we can give people hope with simple words and actions
- That the black community is neglected in moco – the film only showed 2 black people out of 100
- Resources available to use for clients in the future
- The need to encourage discussion of depression and be more alert to symptoms
- Information county hotline
- How big the movement to end the silence is
- Shocking facts about the rate of suicide in US and MoCo; Resources available
- The struggle after an attempt can be lifelong and needs ongoing support
- Hearing from the survivor and what was helpful to him
- Anti-depressants are appropriate for the dying
- How to support someone who is suicidal
- Listen, prevent sense of aloneness
- Local resources
- About the need to people to feel heard!
- Signs of suicide, how to talk to someone, contact/websites

3. **Will you do anything differently as a result of your participation in today's event?** *Please explain your answer*:

☐ Not applicable **(1)**
☐ Blank **(1)**
☐ No **(7)**

- I work in mental health so I already know the techniques
- Very informative

☐ Yes **(41)**

- Ask what they are living for more
- I saved the hotline number and will spread the word on Btheone.org & NIH trials
- More inclined to ask someone tough questions
- Good to know hotline is not just for extreme suicide thoughts. Reach out to more sad/troubled people,
- Use my knowledge to help those of African American/African decent and close the gap between disparities regarding the numbers
- talk to others more openly,
- I will make it a priority to talk to individuals and spread information about all of the resources available,
- I am a faith community nurse, will share info
- Pay attention
- Ask for help, connect
- More sharing of resources
- Learn to talk, but always afraid of retaliation from superiors
- Try and apply to my volunteer work
- I am willing to talk to someone who may hurt themselves
- Continue to assess individuals to provide appropriate resources
- Listen, really listen
- Talk to my friend who has mentioned to me more than once that she feels depressed sometimes and has suicidal thoughts
- Connect folks to Btheone
- I am training to be a therapist

- I am a middle school teacher and ironically the school counselor did a lesson on suicide – I admitted to my students I suffer from depression
  Listen more and help
- Give hotline to patients
- To ask
- Bring awareness to my religious community
- Listen more carefully to everyone
- My thoughts about how it would affect my children and husband, friends, siblings and parents – I felt their pain so much more viscerally after seeing this film
- Reach out to those that I know are suffering from mental illness – check in more often
- Look for one or more reasons my loved one has to live, survive and thrive
- Check in more & differently with people I care about who may be experiencing sadness, etc.
- Know whom to call for help
- I have small children and now know what to look for
- Every time I engage in events such as these, I feel the move and more motivated to use my voice
- Will be more alert of signs of suicide in those around me and talk openly to those people around me about resources, spread awareness and become an advocate
- Use the crisis line for support or resources or support someone else
- Pay more attention to family members who may be struggling and have courageous conversations
- Support EveryMind and more frequent checks on my struggling students
- Put your cards in my waiting room
- How to talk to someone about suicide, contact info

4. **What follow-up after today's event do you think would be helpful?**
   - Email reminders about B the One
   - None at the moment, N/A, Not sure (2)
   - Discussion on what concrete things we can come up with for prevention
   - Another segment
   - If there had been a sign-up sheet there could be a follow-up email with resources – but the folder is great – can go on website
   - More stats on suicide/ER visits/rehabilitation,
   - People telling their story
   - More mini-sessions and chances to volunteer
   - More open-discussion and communication to hear to people's stories
   - More involvement from teachers
   - Have more of these events in Spanish
   - Do more advocacy on MH in MD/MCPS schools,
   - I will surely email my suggestions to Laura
   - Talk to friends who are sad
   - Listen more
   - Talking to people about my depression
   - More info throughout county and local ERs
   - Bringing film and Q&A to schools
   - More awareness on college campuses, more discussion
   - Call the hotline, checking & follow-up
   - We need more help for pregnant women
   - A check-in email – maybe reiterating resources & links. It is an emotional movies & brought up a bit of emotions
   - Send email to participants to assess practical utility
   - We need more of this – possibly a way for participants to take what they learn to their communities
   - Become familiar with resources available

- Share BeTheOne & hotline numbers more
- <ore on how people can help at the moment
- Additional information regarding trials at NIMH for depression
- Local resources via email
- No answer (26)

5. To what extent did the following influence your attending this event?

		Strongly Influenced	Influenced	Did Not Influence
a.	Topic/Content	**(49)**	**(4)**	**(0)**
b.	Format (Film & Q/A)	**(32)**	**(14)**	**(1)**
c.	Location	**(26)**	**(15)**	**(5)**
d.	Sponsor(s)	**(29)**	**(4)**	**(8)**
e.	Other:	**(7)**	**(0)**	**(2)**

- African American health program wanted me to attend
- communication
- speakers; all
- personal connection
- wife
- sister invited me

6. What additional behavioral health resources/support do you feel are needed in Montgomery County?

- Doing a good job collaborating
- More resources that are for bilingual and undocumented people
- Child mental health services with private insurance, child PHP facilities
- Needed in PG county or underfunded
- More that addressed cultural differences regarding mental health
- Elder mental health services
- Everything in Spanish
- Define specific causes and how group for solutions
- More school social workers and school psychs!
- Mon-sworn personnel in the Montgomery County Police need more programs/training to deal with stress of sworn supervisors
- Resources for students who are being bullied
- None-so good!
- Start awareness in elementary schools
- Stress how involved NAMI is – collaborate
- More awareness in schools, anti-bullying messages
- More counselors at schools
- Resources for youth, access for all people, drugs,
- Not sure (2)
- Ways to connect to neighbors & build a nurturing community
- Ability to come to person's home/place of work to provide help. Similar to CPAP in DC
- More focus in MCPS, reduce stigma
- Tips for working with elementary age students to figure out who may be struggling with dark thoughts, etc.
- I think it is really difficult for people without insurance to get quality help
- Not sure that the list is helpful
- Bring this to elementary schools

- More resources are needed to make more of a dent in stigma
- Support groups for not only teenagers & adults, but younger age group (i.e. middle & elementary schoolers)
- Cards with hotline number available for all students
- Peer support! Organizations & resources
- More bilingual/cultural sensitive therapists
- Free therapy and access to psychiatrists for low income
- Youth/teen anti-bullying education/resources
- Mental health resources for people of color
- Post-partum
- All – immediate access – traveler health care for mental health

7. How can we improve this type of event?

- Go into local high schools & colleges
- Provide refreshments (2)
- You are doing great
- Call the teen and the parent
- Add more survivors, because Minor's storytelling made it real
- I cannot think of anything! It was great! Very thought provoking and inspirational
- I thought I was great! & informational
- great and informative
- Invite high school & counselors
- Everything was wonderful
- Promoting and presenting this type of discussion more often
- More times and places
- N/A
- Elected officials in MD go into session Jan-April – make sure they see this early in session before the end of Jan.
- Earlier in the evening
- Send to school counselors to get more teachers involved
- Have more of them
- More access for community
- Invite HS and college students
- Broad advertisement prior to event
- Do one focused on/for teens
- Better advertisement – I heard about this event from a partner
- Enjoyed the event – particularly the format of the film & Q/A,
- Involve it in a conference format? Really, just reach as many people as possible to get them talking
- Because of the timing (end of day) – have a more energetic person moderate (no offense Mr. Crowel, you did well ☺)
- More discussion- through this
- More details on how to help, questions to ask, signs, etc
- More minorities on panel
- Advertise

8. How did you hear about tonight's event? *(Please circle one)*

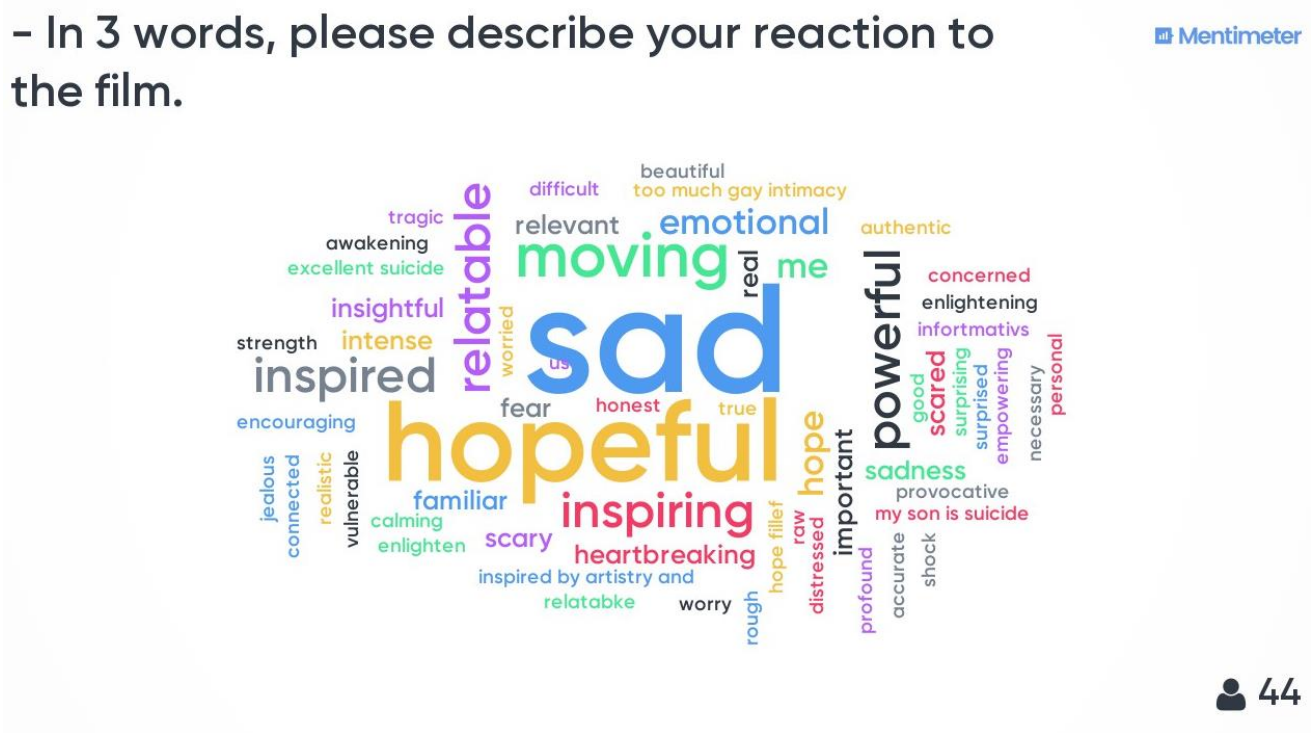
- Friend/Relative **(19)**
- EveryMind **(17)**
- E-Mail **(12)**
- Hospital**(6)**
    - Suburban

- Montgomery County **(5)**
- Facebook (**4)**
    - EveryMind
    - MoCo Mental Health Wellness (PTA) Page
- Other **(6)**
    - AAHP
    - Healthy Montgomery
    - CASA MoCo (2)
    - Work for a MD delegate
    - Suburban Hospital/Sister
- Blank **(1)**

9. Additional comments/feedback provided:

- Too much gay intimacy was the only problem
- Gandhi Brigade PSA contest
- Really appreciated minors story as opening for Q&A
- Great job!
- These always look good but really do not show much
- Thank you!

MENTIMETER RESULTS

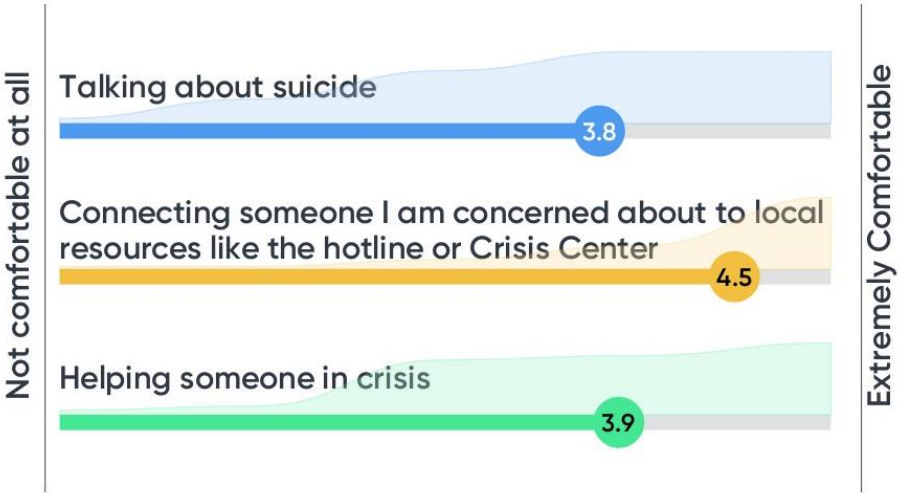


Presented by:

Adventist HealthCare | EveryMind. Your mental wellness. Our mission. | HC HOLY CROSS HEALTH | MedStar Montgomery Medical Center | healthy montgomery | Montgomery County Maryland | SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE

- How would you rate these statements? I feel comfortable....

Mentimeter



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Presented by:

Adventist HealthCare
EveryMind. Your mental wellness. Our mission.
HOLY CROSS HEALTH
MedStar Montgomery Medical Center
healthy montgomery
SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE

Celebracion del mes de la Herencia Hispana
October 26, 2018
"La Diabetes"

Total # of participants: 38
Total # of evaluations returned: 28

1. What is your gender?
    a. Male: 7
    b. Female: 19
    c. Blank: 2
2. What is your age?

Gender	Under 50	Over 50	Total
Females	2	17	19
Males	2	5	7
Blank	0	2	2

    a. Females:
        i. 20-30: 1
        ii. 31-40: 0
        iii. 41-50: 1
        iv. 51-60: 8- **(highest population)**
        v. 61-70: 7
        vi. 70+: 2
    b. Males:
        i. 20-30: 1
        ii. 31-40: 1
        iii. 41-50: 0
        iv. 51-60: 1
        v. 61-70: 3- **(highest population)**
        vi. 70+: 1
3. What is your zip code?

Gender	Silver Spring (20901,20904, 20906,20912)	Wheaton (20902)	Rockville (20851, 20832, 20850, 20853)	Bethesda (20895)	Arlington (22204)
Females	8 **Prediabetes=2** **Diabetes = 1**	3 **Prediabetes=1**	8 **Prediabetes=1** **Diabetes= 2**	1	0
Males	4 **Prediabetes=1**	1	1 **Prediabetes=1**	0	1

Silver Spring (

a. Females:
    i. 20901: 2- silver spring
    ii. 20902: 3
    iii. 20904: 1
    iv. 20906: 3
    v. 20912: 2
    vi. 20832: 1
    vii. 20850: 2
    viii. 20851: 2
    ix. 20853: 3
    x. 20895: 1
b. Males:
    i. 20901: 1
    ii. 20902: 1
    iii. 20906: 3
    iv. 20853: 1
    v. 22204: 1

4. Do you have diabetes, prediabetes or no diabetes?
    a. Female:
        i. Diabetes: 3- **more females have diabetes (each from different age groups)**
        ii. Prediabetes: 4- **(all ages 51-60)**
        iii. No diabetes: 11

Gender	Diabetes	Prediabetes	No Diabetes	Blank
Females	3	4 (ages 51-60)	11	1
Males	0	2	5	0

    b. Male:
        i. Diabetes: 0
        ii. Prediabetes: 2- **(one was 61-70 group and other was 70+ group)**
        iii. No diabetes: 5
5. What they liked most about the event? (both genders)
    a. Content (information): 20
    b. Guest speakers: 16
    c. The food: 7
    d. Other: 0
6. This talk/discussion has motivated and/or empowered you to change some habit?
    a. Yes: 26
    b. No: 0
    c. Indifferent: 0
7. How did the program qualify tonight?
    a. Excellent: 24
    b. Good: 1

c. Regular: 0
d. Bad: 0

8. What health issue is important to you?
    a. Asthma: 9
    b. Obesity: 11
    c. Heart Disease: 10
    d. Mental Health: 14- **The most voted**
    e. Stroke: 8
    f. Cancer: 9
    g. Domestic Violence: 6
    h. Other: Auto immune disease (Lupus), cholesterol, physical activity

Gender	Asthma	Obesity	Heart Disease	Mental Health	Stroke	Cancer	Domestic Violence	Other
Female	8	8	7	11	7	7	5	2
Male	1	3	3	2	0	2	1	1
Blank	0	1	2	2	2	0	0	0

9. What change of habit will you make as a result of your participation?
    a. Exercise and/or increase exercise
    b. Change diet and eat healthier
    c. Learn more about diabetes
    d. Plan diet for the week and weekend
    e. Increase vegetable intake
    f. Portion control
    g. Drink more water
    h. Limit sugar intake and fatty foods/carbs
    i. Watch diet closely
10. What kind of support/education would you like to receive next?
    a. Females:
        i. Cancer
        ii. AIDS
        iii. Depression
        iv. Female reproductive system
        v. Child and adult nutrition
        vi. Obesity
        vii. Asthma
        viii. Diabetes
    b. Male:
        i. Education on good health
        ii. Information about the best diets
        iii. Nutrition
        iv. Websites about diabetes
        v. Be able to talk to doctor if he has any complications

11. How did you hear about this event? (both male and female)
    a. St. Catherine: 7
    b. Flyer: 0
    c. Friend: 13
    d. Email: 2
    e. Suburban Hospital: 6

From: Eleni Antzoulatos
To: Hilltop HCB Help Account
Cc: Monique Sanfuentes; Kate McGrail
Subject: FW: Clarification Required - Suburban Hospital FY 21 Community Benefit Narrative
Date: Thursday, June 23, 2022 4:48:54 PM

Report This Email

Good afternoon,

Below is the clarification of the answer to Question 145 on the Community Benefit Narrative for FY21. Please let us know if there are any further questions.

Best,

Eleni

From: Monique Sanfuentes <msanfue1@jhu.edu>
Sent: Friday, May 27, 2022 11:45 AM
To: Eleni Antzoulatos <eantzoulatos@jhmi.edu>; Kate McGrail <kmcgrai2@jhmi.edu>
Subject: Fwd: Clarification Required - Suburban Hospital FY 21 Community Benefit Narrative

See below from Hilltop

Begin forwarded message:

> From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
> Date: May 27, 2022 at 10:54:14 AM EDT
> To: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>, Monique Sanfuentes <msanfue1@jhu.edu>
> Subject: Clarification Required - Suburban Hospital FY 21 Community Benefit Narrative

Thank you for submitting the FY 2021 Hospital Community Benefit Narrative report for Suburban Hospital. In reviewing the narrative, we encountered an item that requires clarification:

- In response to Question 145 on page 24 of the attached, you selected 200% FPL as the lowest threshold for financial hardship but your financial assistance policy states that the lowest threshold is 400%. Please clarify whether you intended to select 400% as the lowest threshold.

"Mis-Click" In the financial policy, it states that JHM will provide a reduced cost of medically necessary care to patients with family income above 400% of FPL but below 500% of the Federal Poverty Level. This was an oversight on our part. Thank you again for bringing this to our attention.

Please provide your clarifying answers as a response to this message.