Suburban Hospital
Fiscal Year 2016
Community Benefit Report

JOHNS HOPKINS
MEDICINE

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JOHNS HOPKINS HEALTH SYSTEM

FISCAL YEAR 2016 COMMUNITY BENEFIT REPORT NARRATIVE

SUBURBAN HOSPITAL

TABLE OF CONTENTS

CONTENTS **PAGE**

I. General Hospital Demographics and Characteristics 1

II. Community Health Needs Assessment 12

III. Community Benefit Administration 13

IV. Community Benefit External Collaboration 24

V. Hospital Community Benefit Program and Initiatives 30

VI. Physicians 47

APPENDICES

Appendix I: Financial Assistance Policy Description

Appendix II: Description of changes to Hospital's Financial Assistance Policy since the Affordable Care Act effect on January 1, 2014

Appendix III: Financial Assistance Policy

Appendix IV: Patient Information Sheet

Appendix V: Mission, Vision, and Value Statement

Appendix VI: Community Benefit Service Area Demographics

Appendix VII: Suburban Hospital FY 2016 CBSA Definition

Appendix VIII: Suburban Hospital Community Health Needs Assessment 2016

Appendix IX: Community Health Needs Assessment 2016 Implementation Strategy

Appendix X: Suburban Hospital FY 2016 Strategic Plan

Exhibit 1: Suburban Hospital FY 2016 Community Benefit Programs and Initiatives

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

HOSPITAL INFORMATION:

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. 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, elevated helipad. Every year, more than 40,000 patients are treated at Suburban Hospital's busy Emergency/Shock Trauma Center.

The Hospital's major services include a comprehensive cancer and radiation oncology center accredited by the American College of Surgeons Commission on Cancer; Cardiac Surgery Program, providing 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; and senior care programs. In addition, Suburban Hospital provides services including the NIH-Suburban MRI Center; state-of-the-art diagnostic pathology and radiology departments; an Addiction Treatment Center offering detoxification, inpatient and outpatient programs for adolescents and adults; prevention and wellness programs; and a free physician referral service (Suburban On-Call). Suburban Hospital is one of two hospitals in Montgomery County to achieve the Gold Seal of Approval™ by The Joint Commission for its joint replacement program.

1. Primary Service Area.

The PSA is defined as the Maryland postal zip code areas from which 60 percent of a hospital's inpatient discharges originated during the most recent 12 month period (FY16) where the discharges from each zip code are ordered from largest to smallest number of discharges. This information was provided by the Health Services Cost Review Commission (HSCRC).

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Hospital's Uninsured Patients by county:	Percentage of Hospital's Patients who are Medicaid Recipients:	Percentage of Hospital's Patients who are Medicare beneficiaries:
236	13,265	20814, 20815, 20817, 20850, 20852, 20854, 20874, 20878, 20895,	Holy Cross Hospital, Holy Cross Germantown Hospital, Shady Grove Adventist Hospital, Washington	Montgomery County 75%, Prince George's 7.8%, Anne Arundel 0.8%, Howard County 0.7%, Other Maryland	7.38% of Hospital's Patients are Medicaid Recipients; based on total inpatient/out	48.64% of Hospital's Patients are Medicare beneficiaries; based on total inpatient/out patient

		20902, 20904, 20906,	Adventist Hospital, Medstar Montgomery.	Counties 1.3%, Washington D.C. 3.6%, Fairfax County, VA 1.8%, Other Out of State Counties 3.8%[1]	patient discharges in FY16[2]	discharges in FY16[3]

2. Community Benefits Service Area.

a. Description of Community Benefit Service Area.

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 and does not limit its community services to the primary service area. To determine the Hospital's CBSA, data from Inpatient Records, Emergency Department (ED) Visits, and Community Health Improvement Initiatives and Wellness Activities were aggregated and defined by the geographic area contained within the following fifteen zip codes: 20814, 20815, 20817, 20850, 20851, 20852, 20853, 20854, 20874, 20877, 20878, 20895, 20902, 20906, and 20910. Zip codes (20877-Gaithersburg and 20874-Germantown) were identified and included in the Hospital's CBSA due to an increase in patient and charity care cases and community health and wellness activities.

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. Although some of the zip codes selected for Suburban Hospital's CBSA are not immediately adjacent to Suburban Hospital, the Hospital does treat 35.3% of patients from the Silver Spring, Gaithersburg and Germantown areas (20902, 20906, 20910, 20878 and 20874) which is a 1.7% increase from Fiscal year 2015's percentages of 33.6%. Furthermore, Suburban Hospital substantially supports safety net clinics and free health prevention and chronic disease programs in those designated areas.

In addition to the Primary and Community Benefit Service areas, the Hospital provides both in-kind and financial contributions to expand awareness of cardiovascular diseases and chronic disease management to neighboring counties including Prince George's, Calvert, and St. Mary's, which represent more racially and ethnically diverse and rural communities than the primary service area.

- **Geographic boundary** (city, zip codes, or county)
  - Charity care/bad debt: Of all hospital visits at Suburban, approximately $3,294,018; supported services in charity care and $4,677,135 was allocated to bad debt during FY

[1] Suburban Hospital discharge data
[2] Suburban Hospital discharge data
[3] Suburban Hospital discharge data

16. Within the CBSA zip codes, 2,182 patients' accounts had charity adjustments of $1,614,820.

- ED patient origin: The CBSA area accounted for 33,138 visits to Suburban Hospital, representing 73.5% of all FY 16 ED visits.

- Medically underserved: Suburban Hospital specifically provides both financial and in-kind support to two Montgomery Cares safety net clinics to expand access to primary care services within the Hospital's CBSA identified zip codes: Holy Cross Hospital Health Center in Gaithersburg (20877) and MobileMed (20814, 20817, 20854, 20852, and 20874).

- Ethnic minorities: The CBSA includes a population which is 48.0% White, non-Hispanic; 13.8%, Black non-Hispanic; 19.3% Hispanic; 15.6% Asian and Pacific Islander non-Hispanic; 3.3% All others.

- Health disparities: 2.65% of the population is uninsured within the hospital's CBSA.

• **Outreach approach** (hospital's principal function or specialty areas of focus, e.g., Burn Center)

Suburban Hospital's health improvement and outreach approach connects the hospital, community partners, local stakeholders and other resources with identified health needs. Building a healthy community goes beyond providing health care. Suburban Hospital not only aligns health priorities with the areas of greatest identified need, but also considers where the Hospital's resources will generate the greatest impact. According to the CDC, heart disease continues to be the leading cause of death among African American/Black, white, non-Hispanic and Hispanics in the United States. Within Suburban Hospital's CBSA, the age-adjusted death rate due to coronary artery disease correlates to those in the United States with the African American/black population having a higher age-adjusted death rate due to heart disease of 123.4 compared to the overall rate of 110.8 in Montgomery County. In the state of Maryland, the overall rate of heart disease deaths is 169.9.[4] With that in mind, Suburban Hospital supports programs to reduce the gap in disparities within its CBSA. One example is through the Hospital's funding of four HeartWell clinics in Suburban's targeted CBSA. The goal of the clinics is to establish access to needed cardiovascular specialty care to vulnerable residents in the community. For the past fourteen years, consistent health improvement initiatives such as HeartWell have provided thousands of seniors who have suffered heart attacks or advanced cardiovascular illness access to free cardiovascular health education, disease management, exercise, and nutrition classes. Under the care of four HeartWell nurses, individuals have the opportunity to visit four local senior centers throughout the county several days a week to receive ongoing follow-up care and support, thereby better managing their chronic disease and avoiding possible hospital re-admissions. In recent years, HeartWell has expanded its efforts to reach community members who are pre-diabetic or living with diabetes as the HeartWell nurses facilitate Diabetes Support and Continuing Education meetings at four locations including: 20906 (Wheaton/Glenmont), 20878 (Gaithersburg), 20901 (Silver Spring) and 20814 (Bethesda).

• **Target population** (uninsured, elderly, HIV, cardiovascular disease, diabetes)

While Suburban Hospital's health improvement initiatives are targeted to the needs of various areas of our community, a Community Advisory Board and Visioning team was established in 1998. Composed of

[4] Maryland State Improvement Process (SHIP), 2012-2014, http://dhmh.maryland.gov/ship/pages/home.aspx

several public and private health officials along with other outside organization leaders, the team identified four specific target areas of need: 1.) A focus on health access of minority populations 2.) underserved seniors 3.) at-risk youth and 4.) management of chronic diseases including diabetes for the under/uninsured. Today, almost twenty years later, similar health priorities and areas of targeted focus serve as guiding principles for community health improvement. For instance, our area has a rapidly growing senior population; inside Suburban Hospital's CBSA, 28.4% of the population is over the age of 55.[5] In fact, Montgomery County has one of the longest life expectancy rates in the country: -83.6 years for women and -79.5 years for men.[6] As the community grows older, the need to care for the elderly in specific ways is expanding. For that reason the Hospital earned the NICHE (Nurses Improving Care for Health system Elders) designation from The Hartford Institute for Geriatric Nursing at New York University College of Nursing. NICHE is the only national geriatric initiative designed to improve the care of older hospitalized adults. With this prestigious designation, Suburban Hospital acknowledges the many distinct issues that older patients face, such as hearing and vision loss and gait and balance challenges, and has incorporated best practices in place to provide expert, patient-centered care for these individuals. Examples of this initiative include hospital-wide education programs to help sensitize staff to the specific needs of older adults, and environmental design changes to enhance function and comfort.

Additionally, the Community Health and Wellness Division conducts hundreds of community health improvement programs, screenings, classes, and seminars within the Hospital's CBSA each year reaching populations from school age children to active seniors. Further detail of these partnerships and health initiatives are highlighted throughout the report.

b. Demographics

Table II

Community Benefit Service Area (CBSA) Target Population (# of people in target population, by sex, race, ethnicity, and average age)[7]	Total population within the CBSA: 644,327 <u>Sex:</u> Male: 311,041/48.12% Female: 335,286/51.88% <u>Race/Ethnicity:</u> White, non-Hispanic: 310,459/48.0% Black, non-Hispanic: 89,197/13.8% Hispanic: 124,550/19.3% Asian and Pacific Islander non-Hispanic: 100,681/15.6% All others: 21,440/3.3%

[5] 2016 Truven Health Analytics Inc.
[6] Institute for Health Metrics Evaluation, www.healthmetricsandevaluation.org, 2013
[7] 2016 Truven Health Analytics Inc.

	Age: 0-14: 121,560/18.8% 15-17: 24,115/3.7% 18-24: 49,513/7.7% 25-34: 85,155/13.2% 35-54: 182,152/28.2% 55-64: 84,279/13.0% 65+: 99,553/15.4%
Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside.	Fifteen zip codes included in Suburban's CBSA are 20814, 20815, 20817, 20850, 20851, 20852, 20853, 20854, 20874, 20877, 20878, 20895, 20902, 20906, and 20910. As described in Suburban Hospital's 2016 Community Needs Assessment, of the fifteen zip codes in the CBSA, seven were identified as vulnerable using the Community Need Index (CNI): 20852, 20851, 20910, 20906, 20902, 20874 and 20877.[8]
Median Household Income within the CBSA	Average household income within CBSA is $138,655 compared to $77,135 in the US.[9]
Percentage of households with incomes below the federal poverty guidelines within the CBSA	In Montgomery County, 4.5% of households with incomes are living below the federal poverty guidelines.[10] Data is not available for the CBSA.
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	2.65% of the Suburban Hospital's CBSA population is uninsured.[11]
Percentage of Medicaid recipients by County within the CBSA.	13.1% of the Suburban Hospital's CBSA population receives Medicaid.[12]

[8] Truven Health Analytics Inc. and Dignity Health
[9] 2016 Truven Health Analytics Inc.
[10] www.healthymontgomery.org
[11] 2016 Truven Health Analytics Inc.
[12] 2016 Truven Health Analytics Inc.

Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	The life expectancy is 84.6[13] years at birth in Montgomery County, which is higher than the life expectancy in Maryland (79.8)[14] and the projected National Baseline (78.8).[15] Compared with other counties in Maryland, Montgomery County has a higher life expectancy. Data for Suburban Hospital's CBSA is not available at this time. The life expectancy in Montgomery County for White, non-Hispanic (84.4) individuals is slightly higher than Black, non-Hispanic (82.5).[16]
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Within Suburban Hospital's CBSA, the infant mortality rate for all Races is 4.7 per 1,000 live births; among Caucasians is 3.7 per 1,000 live births and among African Americans is 10.5 per 1,000 live births and among Hispanics is 4.2 per 1,000 live births.[17] Within Montgomery County, the infant mortality rate for all Races is 4.8 per 1,000 live births; among Caucasians is 3.6 per 1,000 live births and among African Americans is 8.3 per 1,000 live births and among Hispanics is 4.4 per 1,000 live births.[18] Age-Adjusted Death Rate due to Heart Disease within Suburban Hospital's CBSA is 108.1 deaths/100,000 population.[19] Age-Adjusted Death Rate due to Heart Disease by Race/Ethnicity within Suburban Hospital's CBSA:[20] – 156.8/100,000 Black – 112.0/100,000 White – 54.8/100,000 Hispanic

[13] Maryland DHMH Vital Statistics Annual Report, 2014, http://dhmh.maryland.gov/vsa/Documents/14annual_revised.pdf
[14] Maryland DHMH Vital Statistics Annual Report, 2014, http://dhmh.maryland.gov/vsa/Documents/14annual_revised.pdf
[15] National Vital Statistics Report, Final data for 2014, http://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_04.pdf
[16] Maryland DHMH Vital Statistics Annual Report, 2014, http://dhmh.maryland.gov/vsa/Documents/14annual_revised.pdf
[17] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "Healthy Montgomery Core Measures Set: Montgomery County and Its Six Montgomery County Hospital Community Benefit Service Areas, 2008-2012 and 2010-2014 Results."
[18] Maryland Vital Statistics, Infant Mortality in Maryland, 2014, http://dhmh.maryland.gov/vsa/Documents/14annual_revised.pdf
[19] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results."
[20] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results."

	– 64.0/100,000 Asian/Pacific Islander Age-Adjusted Death Rate due to Heart Disease in Montgomery County is 110.7 deaths/100,000 population.[21] Age-Adjusted Death Rate due to Heart Disease by Race/Ethnicity in Montgomery County:[22] – 123.4/100,000 Black – 114.0/100,000 White – 51.1/100,000 Hispanic – 62.9/100,000 Asian/Pacific Islander Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke) within Suburban Hospital's CBSA is 25.3 deaths/100,000 population.[23] Age-Adjusted Death Rate due to Cerebrovascular Disease by Race/Ethnicity within Suburban Hospital's CBSA:[24] – 31.7/100,000 Black – 25.2/100,000 White – 18.9/100,000 Hispanic – 21.7/100,000 Asian/Pacific Islander Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke) is 25.3 deaths/100,000 population in Montgomery County.[25] – 27.9/100,000 Black – 24.7/100,000 White – 20.8/100,000 Hispanic

[21] Maryland DHMH Vital Statistics Annual Report, 2014, http://dhmh.maryland.gov/vsa/Documents/14annual_revised.pdf
[22] Healthy Montgomery, www.healthymontgomery.org
[23] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results."
[24] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results."
[25] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results."

	– 22.4/100,000 Asian/Pacific Islander[26] Age-Adjusted Death Rate due to Colorectal Cancer in Montgomery County is 9.1 deaths/100,000 population.[27] Age-Adjusted Death Rate due to Colorectal Cancer by Race/Ethnicity in Montgomery County: – 8.6/100,00 White – 11.6/100,000 Black – 7.2/100,000 Hispanic – 10/100,000 Asian/Pacific Islander[28] Age-Adjusted Death Rate due to Prostate Cancer for men in Montgomery County is 15.6 deaths/100,000 males.[29] Age-adjusted Death Rate due to Prostate Cancer by Race/Ethnicity in Montgomery County: – 15.8/100,000 White – 25.5/100,000 Black – No data Hispanic – 6.2/100,000 Asian/Pacific Islander[30] Within its CBSA, Suburban Hospital has several community initiatives and programs to prevent and decrease these four chronic disease rates.
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources)	1% of Montgomery County residents are low- income and do not live close to a grocery store compared to 3% of residents who live in the state. 26% of children enrolled in Montgomery County public schools are eligible for free lunch compared to 36% of children in Maryland. [31] Within the CBSA, there are several grocery stores, produce stands and farmers markets enabling residents to choose healthier food options. In Montgomery County, most grocery stores along with several farmers markets, including the

[26] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results."
[27] National Cancer Institute, http://statecancerprofiles.cancer.gov/deathrates/deathrates.html
[28] National Cancer Institute, http://statecancerprofiles.cancer.gov/deathrates/deathrates.html
[29] National Cancer Institute, http://statecancerprofiles.cancer.gov/deathrates/deathrates.html
[30] National Cancer Institute, http://statecancerprofiles.cancer.gov/deathrates/deathrates.html
[31] County Health Rankings, http://www.countyhealthrankings.org/

See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx	FRESHFARM Market in Silver Spring, MD 20910[32] and the Rockville Farmers Market in Rockville, MD 20850, accept food stamps.[33] 43.3% of Montgomery County Public School students now or have in the past received Free and Reduced Meals (FARMs).[34] 7% of Montgomery county residents experienced food insecurity at some point during the year.[35] 13.9% of children (under 18 years of age) living in households that experienced food insecurity at some point during the year.[36]
Transportation	Suburban Hospital and its outpatient facility are accessible to public transportation. The Ride-On bus system is the primary public transportation system and serves Montgomery County.[37] In addition, Washington Metro stations are located near the Hospital at the National Institutes of Health campus and in downtown Bethesda, a 30-minute walk to the hospital. Limited bike lanes are also available.[38] The Capital Bike Share program installed 19 docks of bicycles near Suburban Hospital and NIH as part of the Montgomery County Bike Share program in 2014. Located on the corner of Old Georgetown Road and Southwick Road, one block from the Hospital, the Capital Bike Share Program encourages community members to ride to work and other activities as a way to save money, increase travel flexibility while increasing their activity level. [39] Montgomery County includes over 100 miles of park trails for both hikers and bikers. For example, the 11-mile Capital Crescent Trail which begins in Silver Spring, MD, east of the Rock Creek Trestle and curves westward and south through Bethesda, MD into Washington, D.C., to end in the heart of historic Georgetown. It covers a large portion of Suburban's CBSA and affords the opportunity for residents to stay active and healthy.[40]

[32] Fresh Farm Markets, www.freshfarmmarkets.org/
[33] Maryland Farmers Market Association, www.marylandfma.org/
[34] Montgomery County Public Schools, 1995-2016, www.montgomeryschoolsmd.org/departments/regulatoryaccountability/glance/currentyear/schools/county.pdf
[35] Feeding America, 2014, www.feedingamerica.org/hunger-in-america/our-research/map-the-meal-gap/2014/MD_AllCounties_CDs_MMG_2014.pdf
[36] Feeding America, 2014, http://map.feedingamerica.org/county/2014/child/maryland/county/montgomery
[37] Montgomery County Department of Transportation, www.montgomerycountymd.gov/dot-transit/index.html
[38] Washington Metropolitan Area Transit Authority, www.wmata.com
[39] Montgomery Bike Share, www.montgomerycountymd.gov/bikeshare/
[40] Trail Link, www.traillink.com

Education Attainment in Montgomery County[41] People 25+ with a Bachelor's Degree or Higher by Race/Ethnicity[42]	Population 25 years and over: 689,671 Less than 9th grade: 4.9% 9th to 12th grade, no diploma: 3.8% High school graduate (includes equivalency): 14.2% Some college, no degree: 14.5% Associate's degree: 5.1% Bachelor's degree: 26.5% Graduate or professional degree: 30.9% American Indian or Alaska Native: 25.7% Asian: 66.0% Black or African American: 42.2% Hispanic or Latino: 25.1% Native Hawaiian or Other Pacific Islander: 50.4% Other: 13.6% Two or more Races: 47.6% White, Non-Hispanic: 69.5% Overall: 57.4%
Exposure to environmental factors that negatively affect health status by County within the CBSA	According to the American Lung Association, the Ozone Grade is a D based on the annual number of high ozone days in Montgomery County although the county earned an A grade based on Annual Particle.[43] According to the Environmental Protection Agency (EPA), 265 pounds of reported and recognized carcinogens were released into the air in 2014 which is an increase from 13 pounds reported in 2013. In addition, the total net pounds of reported amount of PBT (Persistent, Bioaccumulative, and Toxic Chemicals) released into the environment has also decreased as well from 12,586 in 2009 to 4,236 in 2013. However in 2014, there was a slight decrease to 1,495.[44] 0% of people get water from public water systems that have received at least one health-based violation in the reporting period.[45]
Available detail on race, ethnicity, and language within the CBSA	39.1% of Montgomery County residents speak a language other than English at home. 34.2% are Foreign-born persons living in Montgomery County.[46] Montgomery County is ranked 11th to most Linguistically Diverse County in the nation with 96 languages spoken.[47]

[41] American Community Survey 5-Year Estimates, 2010-2014, www.census.gov
[42] American Community Survey 5-Year Estimates, 2010-2014
[43] American Lung Association, www.stateoftheair.org
[44] U.S. Environmental Protection Agency, www.epa.gov
[45] County Health Rankings & Roadmaps, www.countyrankings.org
[46] American Community Survey, 2009-2013, www.census.gov
[47] U.S English Foundation, Inc., www.usefoundation.org/view/55

Minority owned businesses in Montgomery County[48]	32.4%: Women owned 12.4%: Black 12.1%: Asian 10.0%: Hispanic 0.7%: American Indian- and Alaska Native 0.1%: Native Hawaiian and Other Pacific Islander
Economic Development	Jacqueline Schultz, Executive VP and Interim President, served as a board member of the Montgomery County Chamber of Commerce during FY 16. Ronna Borenstein-Levy, Senior Director, Senior Director, Marketing and Communications, Community Division, National Capital Region is a board member of the Bethesda Chevy Chase Chamber of Commerce in FY 16 and the Hospital supports the BCC Chamber in several events supporting economic growth in Montgomery County. According to the Montgomery County Department of Economic Development, Suburban Hospital is one of the leading employers of Montgomery County, employing over 1,700 residents throughout Metropolitan Washington area. The Division of Small and Minority Business Empowerment within the Department of Economic Development of Montgomery County provides services to more than 80,000 small and minority businesses located in Montgomery County by creating initiatives and forming partnerships with community organizations, business groups, private enterprises, and other public agencies.[49]

[48] US Census, Quick Facts, 2010, www.census.gov
[49] Montgomery Economic Development, www.choosemontgomerymd.com

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 1-2 within the past three fiscal years?

   __✓__ Yes
   ____ No

   Suburban Hospital published its second Community Health Needs Assessment report on **June 1, 2016.**

   Suburban's 2016 Community Health Needs Assessment process included a three-tiered approach: 1) reviewing available local, state, and national datasets for core health indicators for Montgomery County; 2) engaging health experts and stakeholders to advise on the direction of the needs assessment; and 3) conducting a community health survey to assess the needs and insights of residents in high priority zip codes from Suburban's Community Benefit Service Area (CBSA). Results from primary and secondary data, Suburban's medical area of expertise, county, state, and national health priorities were taken into consideration to identify the five top five health needs for Suburban's community. After multiple prioritization discussions with stakeholders, the following main focus areas emerged for Suburban's 2016 Community Health Needs Assessment (presented below in no specific order):
   - Cardiovascular Health
   - Diabetes
   - Obesity
   - Cancer
   - Behavioral Health

   During the first assessment, conducted in 2013, the same conditions were identified as health priorities for Suburban Hospital. Suburban Hospital will continue to build upon existing programs addressing these five health areas and will work diligently with partners over the next three years (2017-2019) to ensure that the valuable information attained from the Community Health Needs Assessment process is an integral tool for monitoring and evaluation of established health targets and goals.

   Suburban Hospital's 2016 Community Health Needs Assessment is available online to the community via:

   http://www.hopkinsmedicine.org/suburban_hospital/_documents/community_health/CHNA_2016.pdf

2. Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 5?

   __✓__ Yes Enter date approved by governing body here: **9/29/16**
   ____ No

   Suburban Hospital's approved health improvement plan connects hospital, community partners, local stakeholders and other resources with identified health needs. Suburban Hospital not only aligns health priorities with the areas of greatest identified need, but also considers where the

Hospital's resources will generate the greatest impact. As such, the implementation plan includes an evaluation component to measure each health outcome identified in the plan. Over the next three years, Suburban Hospital will focus its health improvement efforts to specific populations or communities of need to which the hospital allocates resources, identified in the report as the Community Benefit Service Area (CBSA). Striving to reduce rate of disease and improve health quality associated with the five priorities, the Hospital has established health initiatives, programs and partnerships associated with each priority and is included in the Hospital's implementation plan, serving the community's needs.

- **Cardiovascular Health** – alignment with National Heart Lung and Blood Institute (NHLBI) and Suburban Hospital cardiac surgery program which features an accredited open heart program; MobileMed/NIH Heart Clinic at Suburban Hospital; Latino Health Initiative; 4 HeartWell clinics throughout Montgomery County; American Heart Association.
- **Diabetes** – alignment with National Institutes of Diabetes and Digestive Kidney Diseases (NIDDK), MobileMed/NIH Endocrine Clinic at Suburban Hospital; various support groups at Montgomery County Department of Parks and Recreation centers; Diabetes education in partnership with Sibley Memorial Hospital; Diabetes Lite and Pre-Diabetes Action classes at Suburban Hospital.
- **Obesity** – partnership with Girls on the Run; various Senior Shape Exercise classes held Montgomery County Department of Parks and Recreation centers; Weight Management classes at Suburban Hospital, BCC-YMCA Turkey Chase.
- **Cancer** – alignment with National Cancer Institute (NCI); Montgomery County Cancer Coalition (MCCC); MD Comprehensive Cancer Control Plan, cancer-related support groups and symposia at Suburban; AVON Breast Cancer Crusade, Koman for the Cure; *Check It Out;* American Lung Association;
- **Behavioral Health** – Hospital understands current challenges with identifying and treating patients to appropriate referral services in Montgomery County; alignment with NAMI, Addiction Treatment Center at Suburban; support groups at Suburban Hospital, YMCA/PEP Parenting programs.

If you answered yes to this question, provide the link to the document here.

Suburban Hospital's Implementation Plan in response to the 2016 Community Health Needs Assessment can be accessed via:

http://www.hopkinsmedicine.org/suburban_hospital/_documents/community_health/CHNA_2016_Implementation_Strategy_Report.pdf

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

a. Are Community Benefits planning and investments part of your hospital's internal strategic plan?

__✓__ Yes

____ No

If yes, please provide a description of how the CB **planning** fits into the hospital's strategic plan, and provide the section of the strategic plan that applies to CB.

Yes, Suburban Hospital's Community Benefit Strategic plan is incorporated into the Hospital's strategic plan to ensure that the system continues to build quality relationships with community partners in addressing the health needs of the community. Suburban Hospital's FY 16 strategic plan included the integration of four community benefit health improvement goals. The four goals were 1.) Working in collaboration with Johns Hopkins Medicine National Capital Region (NRC) stakeholders to support "aging in place" initiatives; 2.) Leverage current resources to enhance diabetes education, programs and support groups; 3.) Provide tools and resources that improve family functioning, positive parenting and healthy behaviors among vulnerable populations; 4.) Provide resources that connect residents to counseling, disease prevention and chronic disease management interventions. These goals were measured and reported quarterly as part of the hospital's overall operation performance scorecard.

All four goals were achieved by the end of FY 16. Among the performance measures used to evaluate goal attainment of the goals, included an increase in access of care, expansion of health promotion programs and improved care management coordination. An example of leveraging resources and collaboration through partnerships was met by an evolution of programming. In the fall of FY16, an interactive symposium, *"#Just Girls: 11 Things You Need to Know,"* featuring two Kaiser Permanente specialists who discussed common issues facing preteen girls ages 9 to 12 years old was held at Suburban Hospital. With over 200 participants in attendance, the physicians highlighted issues such as body changes and peer pressure with the girls and their mothers. In the spring of FY16, a "Just Girls" Club was established for the preteen girls living in the Scotland Community in Potomac, MD. The goal of the club is to create a positive atmosphere. Meeting once a month, staff from the Hospital's Community Health and Wellness division discuss a wide range of topics including nutrition, healthy body image, physical exercise and safety. Finally, to meet a need for our older population, the "Abuelitas" Initiative was created to provide health intervention and prevention programs delivered by bi-lingual SH physicians and staff to older Hispanic women at the Rockville Senior Center. Topics highlighted in the "Abuelitas" initiative include medication management, women's health and healthy eating. These initiatives were created to meet the needs of specific populations within the Hospital's CBSA and meet the goals set by the Hospital's strategic plan.

Additionally, Diabetes Support and Continuing Education Meetings were started at three area senior centers in Montgomery County, facilitated by the Hospital's HeartWell nurses. These meetings offer community members living with Diabetes an opportunity to learn the tools for optimal living with Diabetes. Topics discussed include nutrition, exercise, foot and eye care and stress management. Community members are able to provide encouragement to others living with Diabetes. Pre-Diabetes Action classes held at Suburban Hospital were also added. In these classes, community members learn how diabetes progresses and what essential lifestyles modifications can slow or prevent the onset of diabetes. Taught by a registered nurse and certified diabetes educator, the Pre-Diabetes Action classes are ideal for anyone diagnosed with pre-diabetes or at-risk of developing diabetes due to family or personal healthy history.

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and

describe the role each plays in the planning process (additional positions may be added as necessary)

In working with the Montgomery County Department of Health and Human Services and addressing the needs set by Healthy Montgomery, Suburban Hospital's Board of Trustees, President and CEO, and the organization's operations leadership team work thoroughly to ensure that the hospital's strategic and clinical goals are aligned with unmet community needs though the planning, monitoring and evaluation of its community benefit activities.

In addition, nursing leadership, community physicians, health partnership advisory boards, local government and business agencies, and other not-for-profit organizations continue to influence the decision making process and prioritization of Suburban Hospital's community benefit activities.

1. Senior Leadership✓:
   I. Gene E. Green, M.D., M.B.A., President and CEO, Suburban Hospital, (July 2015 –November 2015)
   II. Jacqueline Schultz, M.S.N., R.N., Executive Vice President and Interim President, (November 2015-June 2016)
   III. Marty Basso, Senior Vice President of Finance and Treasurer, Community Division, National Capital Region and Chief Financial Officer, Sibley Memorial Hospital and Suburban Hospital
   IV. Queenie C. Plater, Vice President of Human Resources, Community Division, National Capital Region
   V. June Marlin Falb, Vice President of Development
   VI. Joseph Linstrom, Vice President of Operations
   VII. David Simpkins, Vice President of Marketing and Communications, Community Division, National Capital Region
   VIII. Ronna Borenstein-Levy, Senior Director, Marketing and Communications, Community Division, National Capital Region
   IX. Jason Cole, Senior Director of IT
   X. Brian Ebbitt, Senior Director of Administration
   XI. Sunil Vasudevan, Senior Director of Finance
   XII. Leslie Ford Weber, Director, Campus, Government and Community Affairs, Montgomery County

Senior Leadership plays a crucial role as active members of the Hospital's CBAC by providing feedback and recommendations to the council on Hospital community benefit reporting and population health initiatives. In addition, several members of senior leadership contribute community benefit hours to the Hospital's annual report. Below are a few examples:

– Jacqueline Schultz, Executive VP and Interim President, represented the Hospital by serving on Montgomery Cares Program Advisory Board whose goal is to advise the community leaders on matters relating to the County's uninsured residents in FY 16.
– Marty Basso, Senior Vice President of Finance and Treasurer, Community Division, National Capital Region and Chief Financial Officer, Sibley Memorial Hospital and Suburban Hospital oversees that community benefit dollars are properly reported.

- Ronna Borenstein-Levy, Senior Director, Marketing and Communications, Community Division, National Capital Region, represents the Hospital on the Bethesda Chevy Chase Chamber of Commerce.
- Jason Cole, Senior Director of IT, oversees the Hospital "Recycle My Computer" program which donates used hospital computers to community organizations which serve vulnerable communities.
- Leslie Ford Weber, Director, Montgomery County, Campus, Government and Community Affairs, represented the Hospital on the Montgomery County Chamber of Commerce and the Montgomery Business Development Corporation. Ms. Weber also works with the Hospital's leadership and Board of Directors in approving community contributions which align with the Hospital's health priorities in supporting non-for-profit organizations including the YMCA Bethesda-Chevy Chase, Girls on the Run Montgomery County and A Wider Circle to name a few. In FY 16, Suburban Hospital donated $921,022.08 of in-kind and cash donations.
- Brian Ebbitt, Senior Director of Administration, serves on Suburban's Community Benefit Advisory Council and leads Suburban's strategic planning process. Brian provides continues council on the incorporation and alignment of community health improvement in the organization's strategic goal-setting process.

2. Clinical Leadership✓:
    i. Physicians: Peter Pushkas, M.D., Interim Vice President of Medical Affairs; Diane Colgan, M.D., Board Chair of Medical Staff; Dominique Foulkes M.D., Medical Director of Shaw Family Pediatric Emergency Center, Mihail Zilbermint, MD, Director, Endocrinology, Diabetes and Metabolism Care at Suburban Hospital, Johns Hopkins Community Physicians
    ii. Nurses: LeighAnn Sidone, Vice President and Chief Nursing Officer
    iii. Social Workers: Norma Bent, Corporate Director, Care Coordination Department
    iv. Other(s): Matthew Tovornik, Division Director, Orthopedic & Neurosurgery Service Lines and Rehabilitation; Beth Kane-Davidson, Director of Addiction Treatment Center; Shawn Donnelly, Department Director, Managed Care and Patient Access; Rev. Barbara McKenzie, Director of Pastoral Care; Rhonda Brandes, R.D., L.D.N., Clinical Nutrition Manager;

As with senior leadership, clinical leadership plays an important role in the community benefit process by working closely with the Community Health and Wellness Division on community health initiatives such as health education programs and specialty clinics. In addition, members of clinical leadership are also involved in contributing community benefit health improvement initiatives on a regular basis. Below are a few examples:

- Dr. Peter Pushkas, Interim Vice President of Medical Affairs, supports health improvement initiatives including the MobileMed/NIH Heart Clinic and MobileMed/NIH Endocrine Clinics at Suburban Hospital along with charity care support.
- Dr. Diane Colgan, Board Chair of Medical Staff, serves on the Hospital's CBAC and provides a physician perspective to population health.
- Dr. Dominique Foulkes, volunteers her time providing health tips on the Girls on the Run Montgomery County website and attending the annual Bethesda Chevy Chase YMCA Healthy Kids Day.
- Mihail Zilbermint, MD, Director, Endocrinology, Diabetes and Metabolism Care at Suburban Hospital, Johns Hopkins Community Physicians chairs the Hospital's Glucose Steering Committee whose goal is to improve diabetes management for patients and provides support to the staff of

Community Health and Wellness on health improvement programming involving diabetes prevention and management.

- Matthew Tovornik, Division Director, Orthopedic & Neurosurgery Service Lines and Rehabilitation, offers a variety of free to low cost balance, fall prevention and joint health education classes and seminars at the local senior community centers so that seniors improve their balance and prevent falls.
- Beth Kane-Davidson, Director, Addiction Treatment Center, travels throughout the Montgomery County high schools advises teens and parents on the dangers of substance abuse while offering a forum for open dialogue.
- Shawn Donnelly, Department Director, Managed Care and Patient Access and his team volunteers their time by registering clinic patients for the MobileMed/NIH Heart Clinic and MobileMed/NIH Endocrine Clinic at Suburban Hospital.
- Rhonda Brandes, R.D., L.D.N., Clinical Nutrition Manager and her team of registered and licensed hospital dietitians donate their time and expertise at the MobileMed/NIH Endocrine clinic by educating diabetic patients on practical approaches to managing their diabetes through proper nutrition and food choices.

3. Population Health Leadership and Staff✓:

    i. Patricia M.C. Brown, Senior VP, Managed Care and Population Health, Johns Hopkins Medicine
    ii. Norma Bent, Director, Care Coordination, Suburban Hospital
    iii. Margie Hackett, R.N., B.S.N., B.C. in Geriatrics, C.H-G.C.N., Transition Guide Nurse, Readmissions Initiative, Care Coordination Department, Suburban Hospital
    iv. Monique Sanfuentes, Director, Community Health and Wellness, Suburban Hospital

Describe the role of population health leaders and staff in the community benefit process.

For the staff of Care Coordination and Community Health and Wellness, population health is a natural extension of the synergistic efforts occurring within the hospital and throughout the community. In order to address the need of keeping our most vulnerable community members healthy and out of the hospital, Community Health and Wellness and Care Coordination Transition Guide Nurses combine efforts to better serve the senior living community. Examples of collaboration efforts include the Care Partner Initiative and the Village Ambassador Alliance.

In the Care Partner Initiative, the division of Community Health and Wellness and Care Coordination transition guide nurses work hand in hand to bridge the gap between hospital, community and improved quality of life. In examining hospital data, it was determined that the largest readmission rates were associated with those patients from the Adult Medical Unit. In order to measure improved readmission outcomes and better medication management, a community health nurse works with the patient and a voluntary Care Partner to provide education on the specific and potential needs that patient in advance of discharge to home. Examples include help with medications; follow up with medical care in the community, transportation and meals. The Care Partner is encouraged to be present at the time of discharge instruction to be best prepared to play a vital role in ensuring a safe, successful transition from hospital to home and across the continuum of care. Patients and their Care Partners are contacted after discharge to continue this effort and provide support. The Care Partner initiative is an

evidence-based strategy useful in the prevention of hospitalizations and readmissions. The initiative engages and supports patients in managing their healthcare. The Care Partner is an instrumental, effective resource to assist patients in meeting the challenges they may face on a day-to-day basis that can impact health improvement and recovery.

Through the Washington Area Village Exchange in Montgomery County, Community Health and Wellness is able to link residents to community health improvement programming while Care Coordination bridges the gap in the discharge planning process for patients who live in the villages.

4. Community Benefit Operations✓

The Community Health and Wellness (CHW) Division consists of five public health professionals who oversee 2,595 community health improvement programs, screenings, classes, seminars and activities serving 71,323 individuals throughout Montgomery County as well as Prince George's, Calvert, Charles and St. Mary's Counties. The Community Health and Wellness Division is also responsible for the Hospital's Community Benefit Report and the Community Health Needs Assessment. Individuals manage the Community Benefit process by collecting, reporting and analyzing data and composing the narrative to the HSCRC. By working directly with Healthy Montgomery to complete the Hospital's Community Health Needs Assessment, the Division also administers supplemental community feedback surveys, analyzing its results and composes the assessment and implementation plan during the three year cycle and submits the plan to the IRS. Furthermore, the Division works collaboratively with the Montgomery County Health and Human Services Department, coalitions, community partners and leaders to ensure common goals are established to best leverage and provide resources to our county's most vulnerable residents.

Staff from the Finance department work alongside the Community Health and Wellness Division and are responsible for calculating the dollars attributed to the Community Benefit report.

i. Individuals✓:

- Monique L. Sanfuentes, Director, Community Health and Wellness; (1 FTE)
- Eleni Antzoulatos, Supervisor, Community Health and Wellness Operations, Community Health and Wellness; (1 FTE)
- Sara Demetriou, Coordinator, Health Initiatives and Community Partnerships, Community Health and Wellness; (1 FTE)
- Brian Ebbitt, Senior Director, Administration; (1 FTE)
- Paul Gauthier, Senior Financial Analyst, Financial Planning, Budget and Reimbursement, Finance and Treasury; (1 FTE)
- Lucas McCormley, Manager, Budget and Financial Planning, Finance and Treasury; (1 FTE)
- Kate McGrail, Program Manager, Health Outcomes and Evaluation, Community Health and Wellness; (1 FTE)
- Patricia Rios, Manager, Community Health Improvement, Community Health and Wellness; (1 FTE)
- Sunil Vasudevan, Senior Director, Finance and Treasury, Finance and Treasury; (1 FTE)

- Monique L. Sanfuentes, Director, Community Health and Wellness, oversees the community benefit and community health improvement processes and works collaboratively with senior, clinical, and community leadership to make certain that the Hospital's health priorities and initiatives are being met. She oversees all aspects of the hospital's community benefit operations which includes: financial contributions, health partnerships, community initiatives, strategic affiliations and collaboration with health coalitions, outreach activities, wellness programs and corporate projects.
- Eleni Antzoulatos, Supervisor, Community Health and Wellness Operations, Community Health and Wellness, is responsible for producing Suburban Hospital's Community Benefit Report by collecting, evaluating and reporting data received from hospital staff using CBISA software. She also coordinates the data content for the Community Benefit narrative, which is submitted to the HSCRC. In addition, she oversees many Health Promotion and Community Wellness initiatives at Suburban Hospital through the healthy lifestyle programs known as WellWorks, which offers nutrition, safety, healthy lifestyle and fitness classes to community members and Worksite Wellness initiatives, which help local businesses, encompass healthy lifestyle practices within the workplace. Antzoulatos arranges Suburban Hospital's health and wellness seminars and special events, including the Annual Women's and Men's Health Symposia, alongside the physician liaison, communications and service line administrators.
- Sara Demetriou, Coordinator, Health Initiatives and Community Partnerships, coordinates and evaluates Health Initiatives and Community Partnerships throughout Montgomery County working closely with both adolescents and older adult population. Exercise programs like Senior Shape encourage residents 50 and over to build strength, flexibility and improve balance. In addition, Demetriou's oversight of ongoing blood pressure screenings conducted at various senior centers affords community members access to ongoing monitoring and links to other needed medical services. Throughout the academic school year, Demetriou leads the coordination and programing of the Medical Exploring Program in partnership with the Boy Scouts of America to provide a unique hands-on learning experience to high school students interested in pursuing careers in science and medicine. Furthermore, she collaborates closely with the local chapter of Hadassah to operate the *Check It Out* program which delivers breast cancer awareness and education to 11th and 12th grade female students. She also spends a portion of her time engaging hospital colleagues to contribute and participate in organization wide initiatives that support the United Way as well as the Adopt-A-Family Program. All of these programs contribute to the Hospital's Community Benefit operations.
- Brian Ebbitt is Suburban Hospital's Senior Director of Administration. Ebbitt serves on Suburban's Community Benefit Advisory Council and leads Suburban's strategic planning process. In addition to providing council on the incorporation and alignment of community health improvement in the organization's strategic goal-setting process, Ebbitt ensures support of the Hospital's cardiovascular outreach to southern Maryland priority areas.
- Paul Gauthier, Senior Financial Analyst, Financial Planning, Budget and Reimbursement, Finance and Treasury, complies and completes the financial data into the Community Benefit data collection sheet submitted to the HSCRC.
- Lucas McCormley, Manager, Budget and Financial Planning, Finance and Treasury, aids in complying the financial data into the Community Benefit data collection sheet submitted to the HSCRC.
- Kate McGrail, Program Manager, Health Outcomes and Evaluation, Community Health and Wellness, leads health improvement efforts specifically related to cardiovascular, diabetes, and stroke prevention for the Hospital's community benefit service area as well as in Prince George's, Calvert, Charles, and St. Mary's counties. In this capacity, McGrail coordinates the planning, organization, development and implementation of community education programs, health partnerships, and blood pressure and cholesterol screenings. As program manager of health outcomes and evaluation,

McGrail also leads the implementation planning process, which guides the work of the community health and wellness division and measures the impact of its programs on identified health needs

- Patricia Rios, Manager, Community Health Improvement, Community Health and Wellness spearheads the Hospital's community health needs assessment and implementation processes as she works diligently with County health improvement team to provide feedback and recommendations on the community health improvement plan. She also leads diabetes education efforts for the community, and serves as a liaison for ethnic and multicultural populations. She works closely with safety net clinics and local health coalitions that increase access to chronic disease treatment and prevention for Montgomery County's uninsured and underserved residents. Specific efforts include screening and education for colorectal cancer, hypertension and stroke, as well as nutritional counseling. Rios is also responsible for overseeing the hospital's quarterly blood drive, and is the primary contact for public health internships and volunteering.
- Sunil Vasudevan, Senior Director, Finance and Treasury, supervises and ensures that the completion of the Community Benefit data collection sheet has met the Maryland Health Services Cost Review Commission's (HSCRC) standards and guidelines. Vasudevan supports the management of Suburban Hospital in monitoring the performance metrics/goals to achieve operational targets and utilizes internal and external information to report to health care regulatory agencies.

ii. Committee (please list members):

JHHS Community Benefit Advisory Council✓:

The Johns Hopkins Health System Community Benefit Advisory Council is comprised of health system leadership and is responsible for developing a systematic approach that aligns community benefit objectives with JHM strategic priorities. The Advisory Council purpose is to discuss how JHM intends to fulfill both its mission of community service and its charitable, tax-exempt purpose.

- John Colmers, Senior Vice President, Health Care Transformation and Strategic Planning, Johns Hopkins Health System*
- Kenneth Grant, Vice President, Supply Chain, The Johns Hopkins Health System
- Dan Hale, Special Advisor, Office of the President, Johns Hopkins Bayview Medical Center
- Anne Langley, Senior Director, Health Policy Planning and Community Engagement, John Hopkins Health System
- Marissa McKeever, Director, Government and Community Affairs, Sibley Memorial Hospital
- Adrian Mosley, Community Health Administrator, The Johns Hopkins Hospital
- Monique Sanfuentes, Director, Community Health and Wellness, Suburban Hospital
- Jacqueline Schultz, Executive VP and Interim President, Suburban Hospital
- Sharon Tiebert-Maddox, Director, Strategic Initiatives, Johns Hopkins Government and Community Affairs

*Chairperson

JHHS Community Benefit Work Group✓:

The Johns Hopkins Health System Workgroup is responsible for collecting and reporting community benefit activities to the president of JHHS and each hospital president and chief financial officer, the HSCRC and IRS annually. The Workgroup meets monthly to discuss data collection, infrastructure of community benefit planning and evaluation.

The Johns Hopkins Hospital

- Sherry Fluke, Senior Financial Analyst, Govt. & Community Affairs (GCA)
- Sudanah Gray, Budget Analyst, GCA
- Sharon Tiebert-Maddox, Director, Strategic Initiatives, GCA
- William Wang, Associate Director, Strategic Initiatives, GCA

Johns Hopkins Bayview Medical Center

- Patricia A. Carroll, Manager, Community Relations
- Kimberly Moeller, Director, Financial Analysis and Special Projects
- Selwyn Ray, Director, Community Relations, Health and Wellness

Howard County General Hospital

- Elizabeth Edsall-Kromm, Senior Director, Population Health and Community Relations
- Cindi Miller, Director, Community Health Education
- Fran Moll, Manager, Regulatory Compliance
- Scott Ryan, Senior Revenue Analyst

Suburban Hospital

- Eleni Antzoulatos, Supervisor, Community Health and Wellness Operations, Community Health and Wellness
- Sara Demetriou, Coordinator, Health Initiatives and Community Partnerships, Community Health and Wellness
- Paul Gauthier, Senior Financial Analyst, Financial Planning, Budget and Reimbursement, Finance and Treasury
- Lucas McCormley, Manager, Budget and Financial Planning, Finance and Treasury
- Kate McGrail, Program Manager, Health Outcomes and Evaluation, Community Health and Wellness
- Patricia Rios, Manager, Community Health Improvement, Community Health and Wellness
- Monique Sanfuentes, Director, Community Health and Wellness
- Sunil Vasudevan, Senior Director, Finance and Treasury, Finance and Treasury

Sibley Memorial Hospital

- Marti Bailey, Director, Sibley Senior Association and Community Health
- Courtney Coffey, Community Health Program Manager
- Cynthia McKeever, Manager, Finance Decision Support
- Marissa McKeever, Director, Government and Community Affairs
- Honora Precourt, Community Program Coordinator

All Children's Hospital

- Jill Pucillo, Accounting Manager
- Alizza Punzalan-Randle, Community Engagement Manager

Johns Hopkins Health System

- Janet Buehler, Senior Director, Tax Compliance
- Bonnie Hatami, Senior Tax Accountant
- Sandra Johnson, Vice President, Revenue Cycle Management
- Anne Langley, Senior Director, Health Policy Planning and Community Engagement

iii. Suburban Hospital Community Benefit Advisory Council✓:

Suburban Hospital's Community Benefit Advisory Council (CBAC) is comprised of a diverse group of local business, not-for-profit executives and community advocacy leaders. Chartered by the Hospital's Board of Directors and chaired by a system board trustee, the Advisory Council exists to guide and participate in the planning, development and implementation of programs and activities for the improvement of health in the community served by Suburban Hospital.

- Norman Jenkins, Founder and CEO of Capstone Development, LLC. (Chairman)
- Mark Bergel, Ph.D., Founder and Executive Director, A Wider Circle
- Belle Brooks O'Brien, Community Advocate
- Crystal Carr Townsend, President, Healthcare Initiative Foundation
- Betsy Carrier, Treasurer, Bradley Hills Village
- Eva Cohen, President, Bradley Hills Village
- Diane Colgan, MD, Community Physician and Medical Staff Chair for Suburban Hospital
- Ken Hartman, Regional Services Director, Bethesda Chevy Chase Regional Services Center
- Carla P Larrick, Vice President of Operations, YMCA of Metropolitan Washington
- Elizabeth McGlynn, Executive Director, Girls on the Run Montgomery County
- Carmen Ortiz Larsen, President of AQUAS, Incorporated
- Michael Prather, officer, Montgomery County Police Department
- Michael Smith, MD, Radiologist and brother of Alpha Phi Alpha Fraternity, Montgomery County Chapter
- Dana Stroman, officer, Montgomery County Police Department
- Michael K. Yuen, CPA, Aronson, LLC

Suburban Staff

- Carolee Beckford, RN, Clinical Nurse Manager, Intensive Care Unit
- Ronna Borenstein-Levy, Senior Director, Marketing and Communications, Community Division, National Capital Region
- Brian Ebbitt, Senior Director, Administration
- Monique Sanfuentes, Director, Community Health and Wellness, Suburban Hospital
- Jacqueline Schultz, Executive VP and Interim President
- Leslie Ford Weber, Director, Campus, Government and Community Affairs, Montgomery County

iv. Patient and Family Advisors ✓:

The Patient and Family Advisory Council (PFAC) brings together patient and family advisors and Suburban Hospital clinical, administrative, and executive staff to foster a culture of patient- and family-centered care. The PFAC works to help transform Suburban to a model of care that engages patients and their families as equal partners in care, exchanging information with them in useful and understandable ways, and encouraging and supporting their involvement in health care.

- Stephen Bokat
- Belle Brooks O'Brien
- Ellen Sue Brown
- Elsie Durland
- Howard Gilson
- June Graff
- Joel Hirschhorn
- Carol Hollins
- Kitty Jones
- Barbara Kahl
- Deborah Kovach
- Barrie Kydd
- Beverly Labourdette
- Toby Levin*
- Dan Moskowitz
- Vicki Stearn
- Sarah Steinberg
- Sahiba Zubairi
- Mark Zweig

Staff Advisors

- Diane Colgan, MD, Medical Staff Chair
- Eunice D'Augostine, MSN, RN, Nursing Director, Adult Medical
- Brian Ebbitt, Senior Director, Administration
- Kimberley Kelly, RN, Director, Critical Care
- Joseph H. Linstrom, VP Operations
- Amir Nader, MD, Progressive Cardiac Care Unit, Medical Director
- Jennifer Raynor, Director, Pharmacy

- Atul Rohatgi, MD, Assistant Medical Director, Hospitalist Group
- Jacqueline Schultz, Executive VP and Interim President
- LeighAnn Sidone, Vice President and Chief Nursing Officer*
  *co-chairperson

5. Is there an internal audit (i.e., an internal review conducted at the hospital) of the Community Benefit report?)

   Spreadsheet__✓___Yes _____No
   Narrative __✓___Yes _____No

If yes, describe the details of the audit/review process (who does the review? Who signs off on the review?)

The community benefit report is reviewed in detail by Suburban Hospital Executive Leadership, the Community Benefit Advisory Council (CBAC), and the Planning and Finance Departments which includes a one on one with the CFO. Specifically, weeks before submitting the report, Johns Hopkins Health System hospitals meet for a formal review with the System's President and executive vice president of Johns Hopkins Medicine, Mr. Ronald Peterson. In addition, community benefit is integrated into the system's strategic plan and is reviewed quarterly with members of Management Communication Forum and the Hospital's Leadership Clinical Operations Team. The Johns Hopkins Health System's Executive Vice President, the Hospital's President and CFO all review and sign off the on the narrative and data collection before it is submitted to the HSCRC. Furthermore, the report is vetted though the Community Benefit Advisory Council chaired by Norman Jenkins and the Hospital's Board of Trustees chaired by Howard Gleckman.

6. Does the hospital's Board review and approve the FY Community Benefit report that is submitted to the HSCRC?

   Spreadsheet__✓___Yes_____No
   Narrative __✓___Yes _____No

If no, please explain why.

Led by its chairman, Howard Gleckman, the Hospital's Board of Trustees dedicates time at a board meeting to review and approve the Community Benefit Report. In addition to the Hospital's Board reviewing and approving the complete Community Benefit Report, the FY 16 community benefit deliverables are also reviewed in detail by the CEO and CFO of the Johns Hopkins Health System prior to submission to the HSCRC.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous processes aimed at generating improved population health. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared

processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners.

a. Does the hospital organization engage in external collaboration with the following partners:

__✓___ Other hospital organizations
__✓___ Local Health Department
__✓___ Local health improvement coalitions (LHICs)
__✓___ Schools
__✓___ Behavioral health organizations
__✓___ Faith based community organizations
__✓___ Social service organizations

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative activities with each partner (please add as many rows to the table as necessary to be complete)

The Healthy Montgomery community health improvement process is a community-based effort to improve the health and well-being of Montgomery County residents. Healthy Montgomery is under the leadership of the Healthy Montgomery Steering Committee, which includes planners, policy makers, health and social service providers and community members. The community health improvement process includes data collection, identification of areas for improvement, priority-setting, strategic planning, implementation planning, and collaborative efforts to address the priority needs in Montgomery County and evaluate the success of the improvement efforts.

Organization	Name of Key Collaborator	Title	Collaboration Description
Montgomery County Council	Mr. George Leventhal	Councilmember	Co-chair of Healthy Montgomery
Mana Food Center	Ms. Jackie DeCarlo	Executive Director	Co-chair of Healthy Montgomery
Montgomery County Department of Health and Human Services	Ms. Uma Ahluwalia	Director	Steering Committee Member, Healthy Montgomery
Montgomery County Public Schools	Dr. Jonathan Brice	Associate Superintendent	Steering Committee Member, Healthy Montgomery

Montgomery County Department of Health and Human Services	Dr. Raymond Crowel	Chief, Behavioral Health and Crisis Services	Steering Committee Member, Healthy Montgomery
Maryland General Assembly	Delegate Bonnie Cullison	Member of the House of Delegates	Steering Committee Member, Healthy Montgomery
Kaiser Permanente	Ms. Tanya Edelin	Director, Reporting and Compliance, Community Benefit	Steering Committee Member, Healthy Montgomery
Garvey Associates	Dr. Carol Garvey	Vice President for Health Policy	Steering Committee Member, Healthy Montgomery
Primary Care Coalition of Montgomery County	Ms. Leslie Graham	President and Chief Executive Officer	Steering Committee Member, Healthy Montgomery
Montgomery County Department of Health and Human Services	Dr. Michelle Hawkins	Commission on Health	Steering Committee Member, Healthy Montgomery
Montgomery County Department of Planning	Ms. Amy Lindsey	Senior Planner	Steering Committee Member, Healthy Montgomery
Adventist Healthcare	Dr. Marilyn Dabady Lynk	Executive Director	Steering Committee Member, Healthy Montgomery
Medstar Montgomery Medical Center	Ms. Dairy Marroquin	Community Outreach Coordinator	Steering Committee Member, Healthy Montgomery
Holy Cross Hospital	Ms. Kimberley McBride	Community Benefit Officer	Steering Committee Member, Healthy Montgomery
Ronald D. Paul Companies	Ms. Kathy McCallum	Controller	Steering Committee Member, Healthy Montgomery

Carefirst Blue Cross Blue Shield African American Health Program	Ms. Beatrice Miller	Senior Regional Care Coordinator Member	Steering Committee Member, Healthy Montgomery
Montgomery Parks	Ms. Rachel Newhouse	Park Planner Coordinator	Steering Committee Member, Healthy Montgomery
Asian American Health Initiative	Dr. Nguyen Nguyen	Member	Steering Committee Member, Healthy Montgomery
Montgomery County Department of Transportation	Mr. Samuel Oji	Senior Planning Specialist	Steering Committee Member, Healthy Montgomery
Proyecto Salud Health Center Latino Health Initiative	Dr. Cesar Palacios	Executive Director Member	Steering Committee Member, Healthy Montgomery
Montgomery County Recreation Department	Dr. Joanne Roberts	Program Member	Steering Committee Member, Healthy Montgomery
Amerigroup	Ms. Raquel Samson	Provider Solutions	Steering Committee Member, Healthy Montgomery
Suburban Hospital	Ms. Monique Sanfuentes	Director, Community Health and Wellness	Steering Committee Member, Healthy Montgomery
Georgetown University School of Nursing and Health Studies	Dr. Michael Soto	Professor	Steering Committee Member, Healthy Montgomery
Montgomery County Department of Health and Human Services	Dr. Ulder J. Tillman	Officer and Chief, Public Health Services	Steering Committee Member, Healthy Montgomery
Department of Housing and Community Affairs	Ms. Myriam Torrico	Community Program Manager	Steering Committee Member, Health Montgomery

Suburban Hospital's Community Benefit Advisory Council (CBAC) is comprised of a diverse group of local business, non-for-profit executives and community advocacy leaders. Chartered by the Hospital's Board of Directors and chaired by a system board trustee, the Advisory Council exists to guide and participate in the planning, development and implementation of programs and activities for the improvement of health in the community served by Suburban Hospital. Working directly with the Community Health and Wellness Division, members of CBAC advises the on the direction and implementation process of the Hospital's Community Needs Assessment and Community Benefit Report.

Capstone Development, LLC	Mr. Norman Jenkins	Founder and CEO	Chairman of Suburban Hospital's Community Benefit Advisory Council; facilitates the Advisory meetings; Suburban Hospital Board of Directors.
A Wider Circle	Dr. 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.
Community Advocate	Ms. Belle Brooks O'Brien	Resident of Montgomery County	Member of Suburban Hospital's Community Benefit Advisory Council; Suburban Hospital Board of Directors.
Healthcare Initiative Foundation	Ms. Crystal Carr Townsend	President	Member of Suburban Hospital's Community Benefit Advisory Council
Bradley Hills Village	Ms. Betsy Carrier	Treasurer	Member of Suburban Hospital's Community Benefit Advisory Council
Bradley Hills Village	Ms. Eva Cohen	President	Member of Suburban Hospital's Community Benefit Advisory Council

Community Physician	Dr. Diane Colgan	Medical Staff Chair for Suburban Hospital	Member of Suburban Hospital's Community Benefit Advisory Council
Bethesda Chevy Chase Regional Services Center	Mr. Ken Hartman	Regional Services Director	Member of Suburban Hospital's Community Benefit Advisory Council; provides a facility to many CHW programs.
YMCA of Metropolitan Washington	Ms. Carla P Larrick	Vice President of Operations	Member of Suburban Hospital's Community Benefit Advisory Council
Girls on the Run, Montgomery County	Ms. 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.
AQUAS, Incorporated	Ms. Carmen Ortiz Larsen	President	Member of Suburban Hospital's Community Benefit Advisory Council
Montgomery County Police Department	Mr. 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	Dr. Michael Smith	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
Montgomery County Police Department	Ms. 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	Mr. Michael K. Yuen	Certified Public Accountant	Member of Suburban Hospital's Community Benefit Advisory Council

c. Is there a member of the hospital organization that is co-chairing the Local Health Improvement Coalition (LHIC) in the jurisdictions where the hospital organization is targeting community benefit dollars?

_____Yes _✓_ No

Montgomery County is specifically unique in that there are six hospitals located within a short distance of one another to serve community healthcare needs. For this reason, there was a deliberate decision to not have the hospitals serve as co-chairs and to focus on impartial stakeholders to lead in this role. For example, one co-chair of the County's LHIC is Council Member George Leventhal. However, Suburban Hospital is a committed and consistent steering committee lead of the County's LHIC, Healthy Montgomery (Monique Sanfuentes), Behavioral Health Task Force (BHTF) (Beth Kane-Davidson, Addiction Treatment Center and Susan Webb, Crisis Intervention), Healthy Montgomery Community Needs Assessment committee (Patricia Rios and Kate McGrail) and the Healthy Montgomery Measurement & Evaluation Subcommittee (Patricia Rios and Eleni Antzoulatos). In addition, Suburban Hospital also hosted Healthy Montgomery's Community Conversations, which provided guidance and feedback from the community for the county's community needs assessment.

d. Is there a member of the hospital organization that attends or is a member of the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?

_✓_Yes _____No

Yes, Ms. Monique L. Sanfuentes is a member of the Healthy Montgomery Steering Committee and attends committee's bi-quarterly meetings.

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

Suburban Hospital recognizes the community's unmet or potential health needs by participating in community coalitions, partnerships, advisory groups, boards, panels, committees, and serving on local County commissions and working with public health officials at the Montgomery County Department of Health and Human Services (MCDHHS). In FY 16, Suburban Hospital delivered $21,451,227.73 in community benefit contributions and conducted 2,595 community health improvement programs, screenings, classes, seminars and activities serving 71,323 individuals; of which 43,787 are a high-risk population defined as being homeless, employment or insurance status, from an immigrant community, vulnerable children or the elderly. Minorities in Montgomery County are one of the fastest growing populations representing 52% of Suburban Hospital's CBSA and as a result the Hospital targets programs within those groups to reduce health disparities. (See Exhibit 1)

In 1998, a Community Outreach Vision was established through a community health advisory council comprising health department officials and local community stakeholders. The council approved the following target areas of need: 1.) Access to Care, 2.) Management and Prevention of Chronic Disease, 3.) Underserved Seniors, and 4.) Vulnerable Youth. The Healthy Montgomery needs health assessment validated that the Community Outreach vision established eighteen years ago is still relevant today.

Suburban Hospital continues to work to distinguish health priorities and generate solutions to address the growing challenges of preventing chronic disease, increasing access to care, and building safe and healthy communities in its Community Benefit Service Area.

Below is an example of community benefit activities that met major community needs in FY 16.

- Nurses at four HeartWell clinics - located in Silver Spring, Gaithersburg, Wheaton and Chevy Chase - cared for an average of 738 patients per month, totaling 8,852 preventive clinic visits. The encounters include free blood pressure screenings, one-on-one counseling, disease prevention and management sessions, small and large group educational programs.

- Montgomery Cares patients have received access to expert care from cardiologists, specialty diagnostic screenings, and open heart surgery since the inauguration of the MobileMed/NIH Heart Clinic at Suburban Hospital in 2007, totaling more than 3,600 patient visits. In FY 16, there were 466 encounters, with 301 unduplicated patients at the MobileMed/NIH Heart Clinic.

- More than 1,500 patients have access to the specialty care of endocrine diseases through the MobileMed/NIH Endocrine Clinic at Suburban Hospital that was established in July 2010. In FY 16, there were 355 encounters with 138 unduplicated patients at the MobileMed/NIH Endocrine Clinic.

- To expand access to primary care and medical services for vulnerable residents, Suburban Hospital financially supported the Holy Cross Hospital Health Center in Gaithersburg, MD by donating $100,000 in FY 16, which affords this safety net clinics the ability to extend its hours of operations and supplement additional health care providers.

- Cardiovascular outreach in Southern Maryland through the NIH Heart Center at Suburban Hospital supported nearly 371 events, engaging 5,130 individuals to improve healthy lifestyles in Prince George's, Calvert, and St. Mary's counties.

- Medical Exploring and Job Shadowing resulted in 19 educational events for 781 students interested in pursuing careers in medicine.

- The Safe Sitter course at Suburban has produced 920, 11-13 year - old graduates who learned safety essentials of babysitting in 2016.

- In FY16, Suburban Hospital hosted *"#JustGirls: 11 Things You Need to Know"* featured two Kaiser Permanente specialists who discussed common issues facing preteen girls ages 9 to 12 years old. With over 200 participants in attendance, physicians highlighted issues such as body changes and peer pressure with girls and their mothers.

- 226 monthly blood pressure screenings conducted at area mall-walking programs and community centers contributed to assisting nearly 3,000 individuals to know their numbers and take better charge of their health in Montgomery and Prince George's counties.

- 1,184 Senior Shape classes taught by certified exercise instructors built flexibility, strength, and healthy hearts for thousands of seniors across Montgomery and Prince George's counties.

- Staff from Suburban Hospital coordinated, supported and contributed to 77 health education seminars and awareness events throughout Montgomery County, reaching over 15,000 people, including vulnerable seniors, youth and minority groups. These events are free, open to the public and advertised through the Hospital's newsletter and social media. Topics ranged from: *"Caring for the Skin You're In"* and *"Recipe for a Happy Tummy"* to *"Aging in Place"* and *"Colorectal Cancer education."*

- Since its inception seven years ago, the Knots for Shots health initiative program has provided uninsured and homeless county residents with a free hat, scarf or blanket in exchange for getting a flu shot and in doing so reaching out to close to 1,000 residents in Montgomery County who would otherwise not seek the vaccination.

1. Description of implementation strategy and initiatives

This Information should come from the implementation strategy developed through the CHNA process.

Table III, Initiative 1.MobileMed/NIH Heart Clinic at Suburban Hospital

Identified Need	Cardiovascular Disease; Access to specialty care. In Montgomery County, the age adjusted rate for heart disease is 110.7 deaths per 100,000[50] while in Suburban Hospital's CBSA, the age adjusted death rate is 108.1 per 100,000.[51] In addition, 8.2% of residents in Montgomery County do not have any type of health insurance coverage.[52]

[50] Maryland DHMH Vital Statistics Annual Report, 2014, http://dhmh.maryland.gov/vsa/Documents/14annual_revised.pdf
[51] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results
[52] American Community Survey, 2015

	Suburban Hospital's 2016 Community Health Needs Assessment identified cardiovascular disease as one of its five priorities.
Hospital Initiative	MobileMed/NIH Heart Clinic at Suburban Hospital
Total Number of People within Target Population	The age adjusted rate in Montgomery County is 110.7 deaths per 100,000[53] population while in Suburban Hospital's CBSA, the age adjusted death rate is 108.1 per 100,000.[54] In addition, 8.2% of residents in Montgomery County do not have any type of health insurance coverage.[55]
Total Number of People Reached by Initiative	In FY 16, there were 466 encounters, with 301 unduplicated patients who attend the MobileMed/NIH Heart Clinic at Suburban Hospital.
Primary Objective	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.
Single or Multi-Year Initiative Time Period	Multi-Year; From July 1, 2015 to June 30, 2016, the clinic is opened every Thursday night from 3:30pm-8:00pm in the NIH Heart Center at Suburban Hospital. The clinic has been opened since October 2007.
Key Collaborators in Delivery	Suburban Hospital, MobileMed, Inc., the National Institute of Heart, Lung and Blood (NHLBI), Community Cardiologists. Physicians, nurses, staff and administrators from the three partners-Suburban Hospital, the National Institute of Heart, Lung and Blood and MobileMed-volunteer their time to staff the cardiovascular clinic.
Impact/Outcome of Hospital Initiative	The clinic was evaluated by: – Number of at-risk patients served documented by their primary diagnosis. – Number of racial and ethnic patients served. Outcomes for FY 16: – In FY 16, there were 466 encounters, with 301 unduplicated patients. The top five diagnosis (ICD-10 codes): I10 Essential (primary) hypertension (44.5% of encounters), 401.1 Benign essential hypertension (13.2% of encounters), I25.10 Atherosclerotic heart disease of native coronary artery (8.4% of encounters), R00.2 Palpitations (6.2% of encounters), R07.9 Chest pain, unspecified (5.7% of encounters).

[53] Maryland DHMH Vital Statistics Annual Report, 2014, http://dhmh.maryland.gov/vsa/Documents/14annual_revised.pdf
[54] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results
[55] American Community Survey, 2014

	– In comparison to FY15, there was nearly a 48% increase in the number of patients treated for hypertension (68 in FY 15 vs. 101 in FY16). – The racial breakdown of clinic patients was as follows: 29% Black or African American, 10.3% Asian, 4% White, non-Hispanic, 50% Hispanic, 7% Unreported/Refused to Report.
Evaluation of Outcome (Include process and impact measures)	The MobileMed/NIH Heart clinic at Suburban Hospital has been in operation since 2007. Over the 9-year period, the clinic has served more than 3,600 uninsured patients in need of cardiovascular specialty care. These are individuals that would have not received cardiovascular specialty care. During this same period, we have provided more than 10 open-heart surgeries. Each year, the clinic measures its success by whether the number of patients it serves increases (short-term goal); whether effective treatment of the different conditions that put the patients at risk for cardiovascular disease is reduced (mid-term goal); and by improving their quality of life while reducing their risk from pre-mature coronary heart disease mortality (long-term goal).
Continuation of Initiative	Yes, The MobileMed/NIH Heart Clinic is in its ninth year and continues to expand. Since the clinic is volunteer-based, one of the challenges has been to recruit enough nurses to support the clinic on a weekly basis. One of the ways to meet this challenge has been to increase recruitment efforts throughout the Hospital through an internal communication publication. The mechanism for which the clinic has been successful is through the collaborative process between Suburban Hospital, MobileMed and NHLBI while leveraging resources. For example, the Hospital donates the space and supplies and services to the clinic while NHLBI physicians from donate their time and MobileMed refers the patients to the clinic. This has served as a mechanism for success as it builds on strengthens of each partner.

Expense	A. Total Cost of Initiative	B. Direct offsetting revenue from Restricted Grants
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	$170,206.00	

Table III, Initiative 2. MobileMed/NIH Endocrine Clinic at Suburban Hospital

Identified Need	Diabetes, Access to specialty care. Suburban Hospital's 2016 Community Health Needs Assessment identified diabetes as one of its five priorities. The age-adjusted hospitalization rate due to uncontrolled diabetes is 0.9 per 10,000 population aged 18 years and older.[56] Within Suburban Hospital's CBSA, the age-adjusted rate due to uncontrolled diabetes is 2.9 per 100,000.[57]

[56] The Maryland Health Services Cost Review Commission, 2009-2011.

[57] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "Healthy Montgomery Core Measures Set: Montgomery County and Its Six Montgomery County Hospital Community Benefit Service Areas, 2009-2013 Results."

	8.2% of residents in Montgomery County do not have any type of health insurance coverage.[58]
Hospital Initiative	Mobile Med/NIH Endocrine Clinic at Suburban Hospital
Total Number of People within Target Population	The age-adjusted hospitalization rate due to uncontrolled diabetes is 0.9 per 10,000 population aged 18 years and older.[59] Within Suburban Hospital's CBSA, the age-adjusted rate due to uncontrolled diabetes is 2.9 per 100,000.[60]
Total Number of People Reached by Initiative	In FY 16, there were 355 encounters with 138 unduplicated patients at the MobileMed/NIH Endocrine Clinic.
Primary Objective	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. The objective of clinic is twofold- 1.) Increase access of specialty care to patients who would not otherwise receive care and 2.) Reduce the incidence of complications due to endocrine diseases including diabetes.
Single or Multi-Year Initiative Time Period	Multi- Year; From July 1, 2015 to June 30, 2016, the clinic is opened every Thursday night from 4:00 pm-7:30 pm at the Johns Hopkins Health Care and Surgery Center in Bethesda, MD. The clinic has been opened since July 2010.
Key Collaborators in Delivery	Suburban Hospital, MobileMed., Inc., and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). Physicians, nurses, staff and administrators from the three partners-Suburban Hospital, the National Institute of Diabetes and Digestive and Kidney Diseases and MobileMed-volunteer their time to staff the endocrine clinic.
Impact/Outcome of Hospital Initiative	The clinic is evaluated by: – Number of at-risk patients served documented by their primary diagnosis. – Improved health status of patients. – Number of racial and ethnic patients served. Outcomes for FY 16 : – In FY 16, there were 355 encounters with 138 unduplicated patients. – The clinic continues to see improvements in Hemoglobin A1C (HbA1C) among diabetic patients, as nearly two-thirds of patients lowered their

[58] American Community Survey, 2015
[59] The Maryland Health Services Cost Review Commission, 2009-2011.
[60] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "Healthy Montgomery Core Measures Set: Montgomery County and Its Six Montgomery County Hospital Community Benefit Service Areas, 2009-2013 Results."

	A1C in FY16. The last report number averaged A1C rate dropped from 9.1% to 8.3% (0.8 point decrease) from FY15 to FY16. – Of those 355 encounters, the top five diagnosis (ICD-10 codes) are: E11.9 Diabetes mellitus without mention of complications (32.61% of encounters), E11.65 Type 2 diabetes mellitus with hyperglycemia (26.09%), E11.8 Type 2 diabetes mellitus with unspecified complications (17.39%), 250 Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (14.49%) and E03.9 Hypothyroidism, unspecified (10.87%). – The racial breakdown of clinic patients was as follows: 38.41% Black or African American, 10.87% Asian, 2.90% White, Non-Hispanic, 42.08% Hispanic, 5.80% Other/Refused to Report.
Evaluation of Outcome (Include process and impact measures)	The MobileMed/NIH Endocrine clinic at Suburban Hospital has been in operation since 2010. During the six-year period, the clinic has served over 1,500 uninsured patients in need of endocrine specialty care who would have otherwise not been seen. During this same period, we have seen an improvement of Hemoglobin A1C. Each year, the clinic measures its success by continued improvement of Hemoglobin A1C among diabetic patients (short-term goal); access to quality diabetes management and treatment for at-risk residents (mid-term goal); and by improving patient's quality of life while reducing their risk from complications from diabetes morbidity (long-term goal).
Continuation of Initiative	One of the challenges of the clinic has been to high turnover for a clinic administrator who was responsible for calling patients and registering them for the clinic in the last year. The Hospital has been working with MobileMed in finding stable, dedicated volunteers to help with registration of patients. The MobileMed/NIH Endocrine clinic celebrated its fifth year in FY 15 and continues to expand in FY16.

Expense	C. Total Cost of Initiative	D. Direct offsetting revenue from Restricted Grants
C. Total Cost of Initiative for Current Fiscal Year D. What amount is Restricted Grants/Direct offsetting revenue	$13,570.00	

Table III, Initiative 3. Senior Shape Exercise Program

Identified Need	Cardiovascular Health, Obesity, Behavioral Health. Suburban Hospital's 2016 Community Health Needs Assessment identified cardiovascular, obesity and behavioral health as three of its priorities. Heart disease continues to be the leading cause of death in Montgomery County as the age adjusted rate in Montgomery County is 110.8 deaths per

	100,000[61] while in Suburban Hospital's CBSA, the age adjusted rate is 108.1 deaths per 100,000.[62]
Hospital Initiative	Senior Shape Exercise Program
Total Number of People within Target Population	Heart disease continues to be the leading cause of death in Montgomery County as the age adjusted rate is 110.8 deaths per 100,000[63] while in Suburban Hospital's CBSA, the age adjusted rate is 108.1 deaths per 100,000.[64]
Total Number of People Reached by Initiative	455 Montgomery County residents were enrolled in the Senior Shape classes during FY 16.
Primary Objective	The Senior Shape Program provides active seniors a safe, low to high impact exercise regimen that focuses on strength and weight training, balance, flexibility, stretching and aerobic activity for optimal cardiovascular benefits and stamina. Held in senior and community centers in Montgomery and Prince George's Counties, fitness assessments are performed every six months during their class period to measure the participant's balance, strength, flexibility and endurance. The goal of Senior Shape Program is to increase physical activity and fitness among the senior population by creating access to age-specific exercise programs.
Single or Multi-Year Initiative Time Period	Senior Shape classes are held on an ongoing basis, occurring from July 1, 2015 to June 30, 2016; Multiple exercise classes are held either once or twice a week at nine different senior centers in Montgomery and Prince George's Counties. Bi-annual fitness assessment designed to test the Senior Shape member's balance, strength; flexibility and endurance are held during class time.
Key Collaborators in Delivery	Suburban Hospital Community Health and Wellness Division, Montgomery County Department of Recreation (Holiday Park Senior Center, Margaret Schweinhaut Senior Center, Benjamin Gaither Center, Clara Barton Community Center, Potomac Community Center, Jane E. Lawton Community Center, Wisconsin Place Community Center) Bethesda Regional Service Center, and Parks and Recreation of Prince George's County (Gwendolyn Britt Community Center).
Impact/Outcome of Hospital Initiative	Suburban Hospital holds a bi-annual fitness assessment designed to test the Senior Shape member's balance, strength, flexibility and endurance against national data through 4 exercises twice a year, during class time. These exercises, held at the 9 community centers in Montgomery and Prince George's Counties include the Back Scratch, Arm Curl, 8 Foot Up and Go and

[61] Maryland DHMH Vital Statistics Annual Report, 2014, http://dhmh.maryland.gov/vsa/Documents/14annual_revised.pdf
[62] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results
[63]Maryland DHMH Vital Statistics Annual Report, 2014, http://dhmh.maryland.gov/vsa/Documents/14annual_revised.pdf
[64] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "HEALTHY MONTGOMERY CORE MEASURES SET: Montgomery County and Its Six Montgomery County Hospital Community Benefits Service Care, 2008-2012 through 2010-2014 Results

the Chair Stand. To make the exercises more relevant to their everyday life and to reflect the exercises they do in class, we replaced the 8-foot up-and-go test with the 2 minute step in place and the Back Scratch test with the Chair Sit and Reach in the FY 15 assessment.

Based on the fitness assessment results, all of the seniors either met or exceeded the national average for their age range. Furthermore, when comparing the average results between genders from November to May, the average number of Chair Stands the members are able to perform in 30 seconds increased while the average number of Arm Curls and Chair Sit and Reach decreased. Regarding the 2 Minute Step in Place, the average number for females improved between the assessments while the male's average numbers decreased. Please see below information for specifics.

Senior Shape participants in FY16= 455

Number of sessions held in FY 16 = 1,073

Locations= 8 in Montgomery County & 1 in Prince George's County

Fitness Assessment Results from November 2015:

Test	Average Females	Average National Standard Females	Average Males	Average National Standard Males
Chair Stand (# of stands in 30 seconds)	**16.52**	**4 - 17**	**15.65**	**7 - 12**
Arm Curl (# of reps in 30 seconds)	**20.78**	**8 - 19**	**20.88**	**10 - 22**
2 Minute Step in Place	**105.78**	**44 - 107**	**108.15**	**52 - 116**
Chair Sit & Reach (inches +/-)	**1.46**	**-4.5 - 5.0**	**-1.85**	**-6.5 - 4.0**

Fitness Assessment Results from May 2016:

Test	Average Females	Average National Standard Females	Average Males	Average National Standard Males
Chair Stand (# of stands in 30 seconds)	**16.47**	**4 - 17**	**15.57**	**7 - 12**

Arm Curl (# of reps in 30 seconds)	19.91	8 - 19	20.15	10 - 22
2 Minute Step in Place	**107.47**	**44 - 107**	**107.25**	**52 - 116**
Chair Sit & Reach (inches +/-)	**1.52**	**-4.5 - 5.0**	**-1.88**	**-6.5 - 4.0**

Aside from the bi-annual fitness assessments, a brief qualitative survey was also disseminated in June 2016 to gather feedback from the Senior Shape members on their experience with how this program has impacted their health. Due to the format of the survey and the software used, the members were not required to complete a response for each question. The questions and results from this survey as it relates to their health are as follows:

1. **Please rate your Senior Shape experience in regard to how it has impacted your life and daily activities.**
   a. *It has increased my range of motion.*
   4-strongly disagreed
   0-disagreed
   15-neither agreed or disagreed
   42-agreed
   50-strongly agreed

   b. *It has improved my quality of life.*
   3-strongly disagreed
   0-disagreed
   11-neither agreed or disagreed
   38-agreed
   59-strongly agreed

   c. *My level of strength and flexibility has increased since I started the program.*
   3-strongly disagreed
   0-disagreed
   11-neither agreed or disagreed
   38-agreed
   60-strongly agreed

   d. *The class has improved my health and wellbeing.*
   4-strongly disagreed
   0-disagreed
   7-neither agreed or disagreed
   36-agreed
   65-strongly agreed

2. **I have noticed improvements or have been able to maintain healthy levels of the following health measures**:
   a. *Blood Pressure:*

	2-disagreed 42-neither agreed or disagreed 29-agreed 24-strongly agreed 11-N/A b. *Cholesterol:* 0-disagreed 42-neither agreed or disagreed 34-agreed 20-strongly agreed 12-N/A *c. Glucose and HbA1c (blood sugar:* 0-disagreed 43-neither agreed or disagreed 26-agreed 21-strongly agreed 14-N/A *d. Body Weight:* 3-Strongly disagree 2-disagreed 35-neither agreed or disagreed 38-agreed 24-strongly agreed 7-N/A
Evaluation of Outcome (Include process and impact measures)	The Senior Shape Program classes are designed to improve the cardiovascular health and overall fitness of the participants. The results from the fitness assessment show that they are meeting or, in many cases, exceeding what is considered normal for their age range and therefore meeting the national fitness standard (short-term); increase participant's cardiovascular endurance (mid-term); and improving participant's quality of life while reducing their risk of coronary heart disease and risk factors associated with heart disease and obesity (long-term). Based on the responses from the qualitative survey, most of the respondents have noticed favorable and positive impacts on their health due on their participation in Senior Shape. Therefore, the Senior Shape members have been maintaining or improving cardiovascular health and overall fitness levels.
Continuation of Initiative	Senior Shape classes are scheduled through 2017 with Fitness Assessments slated for November 2016 and May 2017 The first Senior Shape class began in 2001, best practice models continue to replicate and we are on schedule to operate indefinitely. Challenge of program-has been inconsistent follow up of some Senior Shape participants in the fitness assessments.

Expense E. Total Cost of Initiative for Current Fiscal Year F. What amount is Restricted Grants/Direct offsetting revenue	E. Total Cost of Initiative $53,537.00	F. Direct offsetting revenue from Restricted Grants $53,300.00

Table III, Initiative 4.Freedom from Smoking® Class

Identified Need	Cancer. Suburban Hospital's 2016 Community Health Needs Assessment identified cancer as the second leading cause of deaths in Montgomery County. Lung cancer continues to be the leading cause of cancer deaths in both men and women. While age-adjusted death rates due to lung cancer, in Montgomery County, hve declined to 25.0 per 100,000, the disease affects racial ethnic group disproportionally. In blacks, the age-adjusted death rate due to lung cancer is 27.2/100,000- higher than the County average. Cigarette smoking is related to cancer of the lung, blood, colon, rectum, cervix, and others. In 2014, 7.9% of the adult population reported smoking cigarettes.
Hospital Initiative	Freedom From Smoking®
Total Number of People within Target Population	In Montgomery County, in a given month, 13.4% of people aged 12 or older reported smoking cigarettes. Among the adult population 7.9% smoke cigarettes. However, smoking is more common among Asians (11.8%) and Blacks (13.6%) than Hispanic (5.2%) and Whites (6.2%).
Total Number of People Reached by Initiative	In FY16, the Freedom From Smoking® class was highlighted in Suburban's quarterly newsletter "New Directions." The newsletter is mailed to 270,000 homes in Montgomery County. Additionally, the class was advertised to the over 1,200 employees at Suburban Hospital. A total of 9 people registered to participate in the program.
Primary Objective	The primary objective of the program is to help reduce the prevalence of cigarette smoking among the adult population. This goal is achieved by educating the public about the availability of and promoting the use of Freedom From Smoking class. Smoking cessation has been shown to decrease the risk of developing smoking-related cancers. Freedom From Smoking® (FFS) is an evidence-based cessation program utilizing psychological and pharmacological principles and methods in order to help people quit smoking. FFS consists of eight sessions, taught face-to-face by a certified facilitator. The small group format allows smokers to work through the challenges of quitting both individually and as part of a group. The end-goal is to help smokers gain control over their behavior and transition into a smoke-free lifestyle.

Single or Multi-Year Initiative Time Period	The Freedom From Smoking (FFS) ® has been offered at Suburban Hospital since 2014. The 8 class, seven-week series is offered every quarter at Suburban Hospital and will continue to be offered to community members, patients and hospital employees. In FY16, the FFS class was offered: Summer -7/29/15-9/2/2015 Fall- 10/6/15-11/17/2016 Winter- 2/3/16-3/16/2016 Spring- 5/11/16-6/22/2016	
Key Collaborators in Delivery	Key partners and collaborations include the: American Lung Association, Montgomery County Cancer Crusade, Montgomery County Tobacco Coalition, and Suburban Hospital's Community Health & Wellness Department, Respiratory Department, and Cancer Center.	
Impact/Outcome of Hospital Initiative	In FY16, four classes (each 7-week, 8-sessions) were offered to the community. In FY16, 67% of registered participants completed the program and were smoke-free. The average number of relapses was equal to 1.	
Evaluation of Outcome (Include process and impact measures)	Smoking cessation has been shown to decrease the risk of developing smoking-related cancers. To objective of the program is to help people stop smoking. At 1-week after the program completion, 84% of those who completed the program remained smoke free (short-term evaluation). The smoke-free rate dropped to 67%, but remained steady at 3-month and 6-month post program participation (mid-term evaluation). Long term evaluation metrics will look at the number of program participants who stay smoke-free 1 year after program participation thereby helping increase the total number of adults who are smoke-free in Montgomery County, MD.	
Continuation of Initiative	Quitting smoking is hard. People who stop smoking will often attempt to quit several times. However, the FFS class has been proven the gold standard for smoking cessation classes and has helped many people quit. Therefore, Suburban Hospital will continue to offer the FFS to the community. In FY17, Suburban Hospital will work towards increasing visibility of the FFS and increasing program participation. This year, the program experienced low participation rate compared to previous year.	
Expense Total Cost of Initiative for Current Fiscal Year What amount is Restricted Grants/Direct offsetting revenue	Total Cost of Initiative $1,530.00	Direct offsetting revenue from Restricted Grants $250.00

Table III, Initiative 5.Skin Cancer Screenings

Identified Need	Cancer. Suburban Hospital's 2016 Community Health Needs Assessment identified cancer as the second leading cause of deaths in Montgomery County. The Center for Disease Control states that skin cancer is the most common form of cancer in the United States with over 65,000 people diagnosed each year.[65] The Maryland Cigarette Restitution Fund (CRF) Cancer Prevention, Education, Screening and Treatment program has identified skin cancer as one of the seven targeted cancers for the state.[66] According to the State Cancer Profile, in Montgomery County, the age-adjusted incidence rate for melanoma cancer is 18.4/100,000 (2009-2013) - the most common form of skin cancer.[67]
Hospital Initiative	Skin Cancer Screenings
Total Number of People within Target Population	In 2013, it was estimated that 1,530 Maryland residents were diagnosed with melanoma. Each year, 159 people in Maryland die from melanoma. In Montgomery County, the age-adjusted incidence rate for melanoma cancer is 18.4/100,000 (2009-2013). The rate is higher for men (25.2/100,000) than women (13.6/100,000). Whites are at highest risk for developing melanoma. Recent data for Montgomery County reveals the age-adjusted incidence rate for whites as 28.6/100,000. In Maryland, melanoma death rate is on the rise in the age 65 and over population.[68]
Total Number of People Reached by Initiative	Suburban Hospital's skin cancer screenings are offered in the spring and fall. The skin cancer screenings are advertised in Suburban's quarterly newsletter "New Directions," which is mailed to 270,000 homes in Montgomery County. In the Spring session, 62 people were screened compared to 67 in the Fall. In FY16, a total of 129 free full-body skin assessments were provided to the community.
Primary Objective	Early detection of melanoma can save a life. The objective of Suburban Hospital's skin cancer screening program is to reduce morbidity and mortality associated with melanoma by leveraging resources to deliver free early detection prevention screening to Montgomery County residents. Held in partnership with the Sidney J. Malawer Foundation and volunteer board-certified dermatologists, the screening offers full-body assessments for suspicious lesions such as: basal or squamous cell cancers. Participants with abnormal findings are followed-up appropriately by program coordinator. Information on tanning bed and sunscreen usage is collected from all participants. The skin cancer screenings offers an ideal opportunity to provide skin safety education. Screening appointments are given on a first-come first-basis.
Single or Multi-Year Initiative Time Period	Multi-year initiative. Suburban Hospital's free skin cancer screening is offered on a bi-annual basis and it has been in operation for over ten years. In FY16, the skin cancer screenings were held on:

[65] http://www.cdc.gov/cancer/skin/statistics/index.htm
[66] Maryland Comprehensive Cancer Control Plan 2016-2020.
[67] National Cancer Institute, https://www.statecancerprofiles.cancer.gov/incidencerates/index.php?stateFIPS=24&cancer=053&race=00&sex=0&age=001&type=incd&sortVariableName=rate&sortOrder=default#results
[68] https://www.epa.gov/sites/production/files/2014-05/documents/sunsafety_fs_maryland_v6_release_web508.pdf

	(Post-summer) November 2 & 3, 2015 (Pre-summer) May 2 & 3, 2016
Key Collaborators in Delivery	Key partners and collaborations include the: Montgomery County Cancer Crusade, Montgomery County Tobacco Coalition, Sidney J. Malawer Memorial Foundation, African American Health Program, Community Dermatologists, Asian American Health Initiative, Primary Care Coalition, and Suburban Hospital's Community Health & Wellness Department, and Cancer Center.
Impact/Outcome of Hospital Initiative	In FY 16, a total of 129 people participated in the screening. Participant's risk for skin cancer was initially assessed by collecting preventive health information such as sunscreen use and indoor tanning practices. Sunscreen utilization varied: 49% reported using it sometimes, 28% always, 15% rarely, and 6% never. 21% of participants reported using indoor tanning equipment. Normal skin findings were encountered in 115 of the 129 participants. Among the 14 with abnormal skin lesions, one participant was found to have melanoma and the remaining had the following: • Basal cell cancer= 6 • Squamous cell cancer= 5 • Unsure, biopsy recommended= 2
Evaluation of Outcome (Include process and impact measures)	While many programs in the County focus on skin cancer awareness and prevention, Suburban's free skin cancer screening is the only one available directed to early detection. Over the past ten years, Suburban Hospital has provided over 1,500 free full-body skin assessments to the community. Suburban Hospital works very closely with community partners such as the Montgomery County Cancer Crusade to increase awareness of the skin cancer screening, at the community level (short-term). Thereby, increasing access to cancer prevention and early detection services (mid-term). This year, alone, Suburban Hospital has successfully helped to save the lives of 14 community members, reducing costly treatment expenses and other burdens associated with undetected or untreatable stages of skin cancer (long-term).
Continuation of Initiative	The sustainability and success of the skin cancer screening program is attributed heavily to a solid partnership with community dermatologist and the Sidney J. Malawer Foundation. Each year, the program consistently screens over 100 people. The challenge with any screening program is ensuring abnormal findings receive proper follow-up/treatment. This situation becomes particularly challenging, due to the cost, when a community members lacks medical coverage. In such situations, the program coordinator and hospital cancer navigators works very closely with partners to seek appropriate care. The program will continue in FY17 following the same structure as previous years.

Expense A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $2,288	B. Direct offsetting revenue from Restricted Grants $0

2. Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.

While community health needs assessments can point out underlying causes of good or poor health status, health providers and health related organizations—primary users of information found in CHNA's—are not usually in a position to affect all of the changes required to address a health issue. For example, the ability to reduce poverty, improve educational attainment, or affect employment cannot be achieved by a health system alone. Nor can they affect basic demographics like age or gender distribution patterns.

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 those health priorities includes Maternal and Child Health. Suburban Hospital may not be 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 or deliver babies. One reason for not seeking this designation is due to the fact that there are several other community hospitals within 5-10 miles of our Bethesda location that have reputable obstetrics programs. While Suburban Hospital may not be able to directly address this health priority, the Hospital does indirectly support Maternal and Child Health initiatives through funding and programming of several other organizations, which promote the health and well-being of children and their families. Notably, 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 available to the community's families. In addition, Suburban Hospital provides financial support to safety net clinics in Montgomery County who treat specific patients requiring obstetric or pediatric care. The Hospital is also the official health sponsor of Girls on the Run Montgomery County providing discounted CPR and 1st aid training classes to the coaches, purchasing shoes and healthy snacks for students from Title I schools and providing health tips on Girls on the Run Montgomery County website. In addition, the Hospital also provides indirect support to OASIS Montgomery's CATCH Healthy Habits program sponsored through an Amerigroup Foundation grant. CATCH Healthy Habits engages senior adults as mentors to teach children grades K-5 about healthy eating and active living in Montgomery and Prince George's Counties.

Furthermore, the Shaw Family Pediatric Emergency Center at Suburban Hospital provides children of all ages with quality care in a kid-friendly, family-centered environment ensuring around-the-clock pediatric expertise and promotes continuity of care. Recognizing the unique medical needs of our youngest

patients, a team of board-certified pediatricians and specially trained pediatric nurses treat everything from sore throats to playground injuries and broken bones to complex illnesses and offers a full range of ancillary care, including radiology and laboratory services. The Center also offers support for children who are undergoing outpatient procedures.

3. How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health? (see links below for more information on the State's various initiatives)

As of 2010, Montgomery County had the highest number of individuals age 60+ of any Maryland jurisdiction and the third highest percentage of minority seniors. With this expanding senior population, Suburban Hospital is working collaboratively with the other five Montgomery County hospitals to reduce readmissions and improve the health and well-being of the county's senior population. One of the ways that Suburban Hospital directs its efforts toward the State's initiatives for improvement in population health is through the collaboration of NexusMontgomery, a community-based care management program to enhance the health and well-being of seniors, age 65 and up and improve the rate of preventable hospital utilization.

Through a six-month grant awarded by Maryland's Health Services Cost Review Commission (HSCRC), NexusMontgomery ties to the goals of Maryland's new all-payer model and to achieve the Triple Aim of enhancing patient care, improving population health and lowering total health care costs for seniors. It is a cooperative partnership comprised of Holy Cross Health, Suburban Hospital, MedStar Montgomery, Adventist Healthcare, the Montgomery County Department of Health and Human Services, 23 subsidized senior living communities, physicians, and community social service resources and other providers. The Primary Care Coalition of Montgomery County serves as the neutral convener and project manager. Expertise on related subject matter is provided by Discern Health (payment modeling), MedChi (physician perspective), and LifeSpan (senior care perspective).

The goal of NexusMontgomery is to better identify residents in senior living communities who are chronically ill and/or at risk for avoidable utilization of health care services, provide care coordination and referral in partnership with individuals' primary care physicians, and supplement individual services with community-based case management and health promotion programs. The program will be piloted with residents of senior living facilities then expand to referrals from hospitals, physicians, and others, focusing on the senior populations in the service areas of the six hospitals in Montgomery County.

In addition, the Care Partner (Health Buddy) Initiative is a collaborative effort between the Hospital's Transition Guide nurses and Community Health and Wellness Division by bridging the gap between Hospital and community. Piloted on May 4, 2015, and administered on the Adult Medical Unit by a HeartWell nurse provider dedicated 20 hours per week of clinical effort introducing the program to patients. Patients enroll in the initiative voluntarily. The nurse provider works with the patient and the Care Partner to provide education on the specific needs and potential needs of the patient when they discharge home. These may include help with medications; follow up with medical care in the community, transportation and meals to name a few. The Care Partner is encouraged to be present at the time of discharge instructors to be best prepared for their role and plays a vital role in ensuring a safe, successful transition from hospital to home and across the continuum of care. Patients and their Care Partner are contacted after discharge to continue this effort and provide support. The Care Partner initiative is an evidence-based strategy useful in the prevention of hospitalizations and readmissions. The initiative engages and supports patients in managing their healthcare. The Care Partner becomes a

resource to assist patients in meeting the challenges they may face on a day-to-day basis that are impacting their health.

The outcomes from the pilot program demonstrated that the Care Partner Initiative was effective in reducing the number of readmission during the five month time period. Those patients who were seen by nurse were readmitted to the hospital at a rate of 13.56% compared to those who did not seen the nurse at 16.28%. In addition, the readmissions rate rose to 17.74% after the pilot program was concluded. As a result of the success from the pilot program, the Care Partner Initiative will begin in FY17 as additional staff has been employed to implement the program, working on the Adult Medical and Acute Medicals Units where our vulnerable patients are cared for during their hospital stay.

VI. PHYSICIANS

1. As required under HG§19-303, provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

Suburban Hospital is concerned about patient access to care, which is endangered by an identified shortage of physicians in Montgomery County practicing in primary care and in several specialties. A study from the Maryland Hospital Association and MedChi found shortages in Primary Care, Dermatology, Hematology/Oncology, Psychiatry, Anesthesiology, Emergency Medicine, Thoracic Surgery, and Vascular Surgery. Maryland also has only a borderline supply of orthopedic surgeons. Suburban Hospital is committed to expanding not only access to primary care for the uninsured, but also collaborates with local health partners like Montgomery Cares, Project Access, Primary Care Coalition, Catholic Charities, Mobile Medical Care, Clinica Proyecto Salud, NHLBI, NIDDK, community cardiologists and orthopedic surgeons to provide much needed specialty care, especially for those who suffer from chronic disease. A few examples of how Suburban Hospital and its partners are working to narrow the gap in availability of these specialty services are outlined below:

For nearly ten years, the MobileMed/NIH Heart Clinic at Suburban Hospital has provided expert care to more than 3,600 patients to date and has conducted multiple open-heart surgeries at no cost to those patients who are in urgent need of these specialty care and inpatient services. Partners- Mobile Medical Care, Inc. and the National Heart, Lung and Blood Institute and Suburban Hospital have operated a specialty cardiac clinic on-site to provide access to care and alleviate the gap in specialty providers for cardiac patients. Referred from safety net clinics in the County operated by MobileMed, Clinica Proyecto Salud and the Holy Cross Hospital Health Centers, each patient is seen by a Suburban cardiologist and clinical staff from the NIH. In addition to coordinating the cardiologists and nurses who volunteer at the clinic, the Hospital absorbs the costs associated with free cardiovascular specialty diagnostic screenings and open-heart surgery for patients who require advanced care.

Based on the best practice model of the MobileMed/NIH Heart Clinic, Suburban Hospital, MobileMed Inc. and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) established a free endocrine clinic providing lifestyle and chronic disease management for people with endocrine diseases. For six years, staff from Suburban Hospital, NIDDK and MobileMed have volunteered their time once a week by providing diagnostic tests, laboratory services and free medical examinations and have treated nearly 2,000 patients. In addition, Endocrine clinic patients have the opportunity to meet one-on-one with Suburban Hospital Registered Dietitians for free nutrition consultations to review individual nutrition plans and examine challenges with dietary restraints.

Suburban Hospital has supported several specialty health initiatives targeted at Clinica Proyecto Salud patients, including Diabetes education and management. In accordance with our 2008 agreement with Montgomery Cares, Suburban Hospital provides in-kind support to Clinica Proyecto Salud and the Holy Cross Hospital Clinic-Gaithersburg, increasing uninsured adult patients' access to primary care, which enables the clinics to employ additional healthcare providers, extend their hours, and provide additional patient appointments. Those without insurance who come to Suburban Hospital's Emergency Department are referred each of these clinics for primary care and follow up. Clinica Proyecto Salud's established patient population has benefited from the expansion of services at the Clinic's existing site in Wheaton, MD, given its convenient location and access to public transportation. The partnership also provides Clinica Proyecto Salud's patients with access to cardiac specialty care through the MobileMed/NIH Heart Clinic at Suburban Hospital.

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please use Table IV to indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand. The categories include: Hospital-based physicians with whom the hospital has an exclusive contract; Non-Resident house staff and hospitalists; Coverage of Emergency Department Call; Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and Physician recruitment to meet community need.

Table IV – Physician Subsidies

Category of Subsidy	**Explanation of Need for Service**
Hospital-Based physicians	As a state-designated regional trauma center for Montgomery County and the surrounding Washington DC Metropolitan area, Suburban Hospital provides subsidies to physicians for trauma on-call services that they would otherwise not provide to the Hospital. Physicians from Bethesda Emergency Associates staff the Hospital's busy Emergency Department, treating 44,275 life-threating and non-life-threatening patients in FY16 including approximately 1,500 trauma patients. In FY16, the Hospital contributed $896,574.86 in Trauma On Call Coverage and $255,996.00 in Emergency Room Coverage.
Non-Resident House Staff and Hospitalists	The Hospital staffs a team of hospitalists and intensivists to provide primary care for patients, working collaboratively alongside specialists and patients' primary care physician. In addition, Suburban Hospital Cardiac surgery program provides specialty cardiac care with three cardiothoracic surgeons. In total, the Hospital supported $4,768,616.62 for these hospital-based physicians. With the rising costs of healthcare for patients living with diabetes, 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.
Coverage of Emergency Department Call	See above
Physician Provision of Financial Assistance	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 Primary Care Coalition and Catholic Charities of the Archdiocese of Washington.
Physician Recruitment to Meet Community Need	Since diabetes was one of the top twenty conditions among readmissions at Suburban Hospital in FY16, Endocrinology, Diabetes, and Metabolism Care at Suburban Hospital was established and overseen by Dr. Mihail Zilbermint.
Other – (provide detail of any subsidy not listed above – add more rows if needed)	ENT On Call OB/GYN On Call Behavioral Health On Call Urology On Call Cardiology On Call Gastroenterology Anesthesiology On Call Ophthalmology On Call Stroke On Call Vascular On Call General Surgery Ortho and Spine Surgery

VII. APPENDICES

Appendix I: Financial Assistance Policy Description
Appendix II: Description of changes to Hospital's Financial Assistance Policy since the Affordable Care Act effect on January 1, 2014
Appendix III: Financial Assistance Policy
Appendix IV: Patient Information Sheet
Appendix V: Mission, Vision, and Value Statement
Appendix VI: Community Benefit Service Area Demographics
Appendix VII: Suburban Hospital FY 2016 CBSA Definition
Appendix VIII: Suburban Hospital Community Health Needs Assessment 2016
Appendix IX: Community Health Needs Assessment 2016 Implementation Strategy
Appendix X: Suburban Hospital FY 2016 Strategic Plan
Exhibit 1: Suburban Hospital FY 2016 Community Benefit Programs and Initiatives

APPENDIX I: FINANCIAL ASSISTANCE POLICY DESCRIPTION

Financial Assistance Policy Description

Description of how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's financial assistance policy.

Suburban Hospital maintains accessibility to all services regardless of an individual's ability to pay. The Hospital policy on charity care is to provide necessary emergency medical care to all persons regardless of their ability to pay and consider for charity care those patients who cannot pay the total cost of hospitalization due to lack of insurance coverage and/or inability to pay. Free care, sliding fee scales and extended payment plans are offered to eligible patients. Approval for charity care, sliding fee scales or payment plans is based on submission of a financial assistance application available upon request at each of our registration points of entry, via mail, or our website, www.suburbanhospital.org.

The Patient Access Department provides all patients registered for emergency, outpatient, or inpatient care a copy of our Financial Assistance Information Sheet. Signs are posted in English and Spanish explaining the availability of financial assistance and where to call for assistance. The signs are located in the Emergency, Pediatrics, Cath Lab, and Financial Counseling Departments, as well as the main registration desk. A financial assistance application is given to every self-pay patient with instructions on how to apply and who to contact for assistance. The same information is provided to all other patients upon request. This information is also available in Spanish.

Suburban Hospital's Financial Counselors and Social Workers are trained to answer patients' questions about financial assistance and provide linkage to other community assistance resources prior to discharge. Registration and Patient Financial Services staff members are trained to answer questions regarding financial assistance and who to contact to apply. The Patient Access Department has Medicaid Specialists onsite to assist patients in applying for Maryland Medical Assistance. All uninsured patients are screened for Medicaid upon admission and provided with information and referral for financial assistance. In addition, since implementation of the Affordable Care Act, Suburban Hospital now has staff members who are Certified Application Counselors and available to assist patients who have questions about eligibility requirements for the Maryland Health Insurance Exchange. Our Certified Application Counselors provide information and assist patients with initiation of online health exchange plan enrollment when requested.

APPENDIX II: DESCRIPTION OF CHANGES TO HOSPITAL'S FINANCIAL ASSISTANCE POLICY SINCE THE AFFORDABLE CARE ACT EFFECT ON JANUARY 1, 2014

Appendix II

Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014.

The Johns Hopkins Health System expanded its definition of Medical Debt to include co-payments, co-insurance and deductibles of patients who purchased insurance through a Qualified Health Plan.

JHHS defines a Qualified Health Plan as:
Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

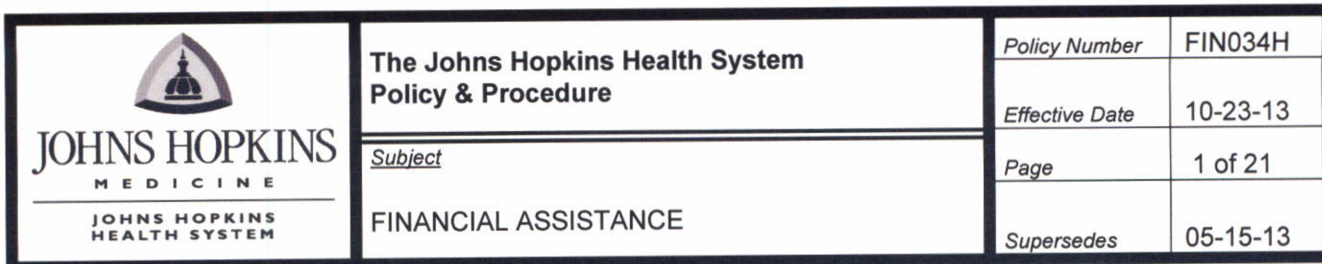
Notice of financial assistance availability was posted on each hospital's website and mentioned during oral communications. Policy was changed to state this is being done. This change is in response to IRS regulation changes.

Previously patient had to apply for Medical Assistance as a prerequisite for financial assistance. JHHS now requires that the patient must apply for Medical Assistance or insurance coverage through a Qualified Health Plan and cooperate fully with the Medical Assistance team or its designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements.

For Medical Hardship
Medical Debt is defined as out of pocket expenses for medical costs for Medically Necessary Care billed by the Hopkins hospital to which the application is made, the out of pocket expenses mentioned above do not include co-payments, co-insurance and deductibles, *unless the patient is below 200% of Federal Poverty Guidelines.*

Suburban Hospital's Financial Assistance Policy is being changed to add an Appendix and language advising that the Appendix lists physicians that provide emergency and medically necessary care at the hospitals and whether the doctor is covered under the hospital's Financial Assistance policy. The Appendix will be updated quarterly and will be posted on the hospital website. The policy and the website instruct patients to direct any questions they may have concerning whether a specific doctor has a financial assistance policy separate and apart from the hospital's policy. This change is in response to IRS regulation changes. Changes expected to be made and approved by the hospital board by February 2015.

APPENDIX III: FINANCIAL ASSISTANCE POLICY



POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) following entities: Howard County General Hospital (HCGH) and Suburban Hospital (SH).

Purpose

JHHS is committed to providing financial assistance to patients who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.

It is the policy of the Johns Hopkins Medical Institutions to provide Financial Assistance based on indigence or excessive Medical Debt for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance can be made, the criteria for eligibility, and the steps for processing each application.

JHHS hospitals will publish the availability of Financial Assistance on a yearly basis in their local newspapers, and will post notices of availability at patient registration sites, Admissions/Business Office the Billing Office, and at the emergency department within each facility. Notice of availability will be posted on each hospital website, will be mentioned during oral communications, also will also be sent to patients on patient bills. A Patient Billing and Financial Assistance Information Sheet will be provided to inpatients before discharge and will be available to all patients upon request.

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. Review for Medical Financial Hardship Assistance shall include a review of the patient's existing medical expenses and obligations (including any accounts placed in bad debt) and any projected medical expenses. Financial Assistance Applications and medical Financial Hardship Assistance may be offered to patients whose accounts are with a collection agency and will apply only to those accounts on which a judgment has not been granted so long as other requirements are met.

Definitions

Medical Debt	Medical Debt is defined as out of pocket expenses for medical costs resulting from medically necessary care billed by the JHHS hospital to which the application is made. Out of pocket expenses do not include co-payments, co-insurance and deductibles. Medical Debt does not include those hospital bills for which the patient chose to be registered as Voluntary Self Pay(opting out of insurance coverage, or insurance billing)
Liquid Assets	Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property immediately convertible to cash. A safe harbor of $150,000 in equity in patient's primary residence shall not be considered an asset convertible to cash. Equity in any other real property shall be subject to liquidation. Liquid Assets do not include retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the Internal Revenue Code or non qualified deferred compensation plans.
Immediate Family	If patient is a minor, immediate family member is defined as mother, father, unmarried minor siblings, natural or adopted, residing in the same household. If

patient is an adult, immediate family member is defined as spouse or natural or adopted unmarried minor children residing in the same household.

Medically Necessary Care — Medical treatment that is absolutely necessary to protect the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice and not mainly for the convenience of the patient. Medically necessary care for the purposes of this policy does not include elective or cosmetic procedures.

Family Income — Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, rental income, retirement/pension income, Social Security benefits and other income as defined by the Internal Revenue Service, for all members of Immediate Family residing in the household

Supporting Documentation — Pay stubs; W-2s; 1099s; workers' compensation, Social Security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments and credit bureau reports, Explanation of Benefits to support Medical Debt.

PROCEDURES

1. An evaluation for Financial Assistance can begin in a number of ways:

   For example:

   - A patient with a self-pay balance due notifies the self-pay collector or collection agency that he/she cannot afford to pay the bill and requests assistance.
   - A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
   - A physician or other clinician refers a patient for Financial-Assistance evaluation for either inpatient or outpatient services.

2. Each Clinical or Business Unit will designate a person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, Administrative staff, Customer Service, etc.

3. Designated staff may meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

   a. All hospital applications will be processed within two business days and a determination will be made as to probable eligibility. To facilitate this process each applicant must provide information about family size and income, as defined by Medicaid regulations. To help applicants complete the process, a statement of conditional approval will be provided that will list the paperwork required for a final determination of eligibility.

   b. Applications received will be sent to the JHHS Patient Financial Services Department for review; a written determination of probable eligibility will be issued to the patient.

   c. At HCGH, complete applications with all supporting documentation submitted at the hospital are approved via the appropriate signature authority process. Once approved

and signed off on, the approved applications will be sent to the JHHS Patient Financial Services Department's to mail patient a written determination of eligibility.

4. To determine final eligibility, the following criteria must be met:

   a. The patient must apply for Medical Assistance and cooperate fully with the Medical Assistance team or its' designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. The Patient Profile Questionnaire (Exhibit B) is used to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.

   b. All insurance benefits must have been exhausted.

5. To the extent possible, there will be one application process for all of the Maryland hospitals of JHHS. The patient is required to provide the following:

   a. A completed Financial Assistance Application (Exhibit A) and Patient Profile Questionnaire (Exhibit B).

   b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).

   c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.

   d. A Medical Assistance Notice of Determination (if applicable).

   e. Proof of disability income (if applicable).

   f. Reasonable proof of other declared expenses.

   g. Non-U.S. citizens must complete the Financial Assistance Application (Exhibit A). In addition, the Financial Counselor shall contact the U.S. Consulate in the patient's country of residence. The U.S. Consulate should be in a position to provide information on the patient's net worth. However, the level of detail supporting the patient's financial strength will vary from country to country. After obtaining information from the U.S. Consulate, the Financial Counselor shall meet with the Director, Revenue Cycle and/or CFO (HCGH) or Director of PFS and/or CFO (SH) to determine if additional information is necessary.

   h. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc...

6. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive Medical Debt. Medical Debt is defined as out of pocket expenses excluding copayments, coinsurance and deductibles for medical costs billed by a JHHS hospital. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on JHMI guidelines. At HCGH, the Financial Counselor will forward to Director, Revenue Cycle for review and final eligibility based upon JHMI guidelines.

a. If the application is denied, the patient has the right to request the application be reconsidered. The Financial Counselor will forward the application and attachments for reconsideration to the CFO (HCGH) or Director PFS and CFO (SH) for final evaluation and decision.

b. If the patient's application for Financial Assistance is based on excessive Medical Debt or if there are extenuating circumstances as identified by the Financial Counselor or designated person, the Financial Counselor will forward the application and attachments to the Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH). This committee will have decision-making authority to approve or reject applications. It is expected that an application for Financial Assistance reviewed by the Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH) will have a final determination made no later than 30 days from the date the application was considered complete. The Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH) will base their determination of financial need on JHHS guidelines.

7. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.

8. Services provided to patients registered as Voluntary Self Pay do not qualify for Financial Assistance.

9. A department operating programs under a grant or other outside governing authority (i.e.: Psychiatry Program) may continue to use a government-sponsored application process and associated income scale.

10. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. If patient is approved for a percentage allowance due to financial hardship it is recommended that the patient makes a good-faith payment at the beginning of the Financial Assistance period. Upon a request from a patient who is uninsured and whose income level falls within the Medical Financial Hardship Income Grid set forth in Appendix B, JHHS shall make a payment plan available to the patient. Any payment schedule developed through this policy will ordinarily not last longer than two years. In extraordinary circumstances and with the approval of the designated manager a payment schedule may be extended.

11. Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% writeoff of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the means-tested social service programs listed by the Health Services Cost Review Commission in COMAR 10.37.10.26 A-2 are deemed Presumptively Eligible for free care provided the patient submits proof of enrollment within 30 days of date of service. Such 30 days may be extended to 60 days if patient or patients representative requests an additional 30 days. Appendix A-1 provides a list of life circumstances in addition to those specified by the regulations listed above that qualify a patient for Presumptive Eligibility.

12. Financial Assistance Applications may only be submitted for/by patients with open and unpaid hospital accounts.

13. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application (Exhibit A) unless they meet Presumptive Financial Assistance

Eligibility criteria (see Appendix A-1). If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH). Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

14. If a patient account has been assigned to a collection agency, and patient or guarantor requests financial assistance or appears to qualify for financial assistance, the collection agency shall notify PFS and shall forward the patient/guarantor a financial assistance application with instructions to return the completed application to PFS for review and determination and shall place the account on hold for 45 days pending further instruction from PFS.

15. Beginning October 1, 2010, if within a two (2) year period after the date of service a patient is found to be eligible for free care on the date of service (using the eligibility standards applicable on the date of service), the patient shall be refunded amounts received from the patient/guarantor exceeding $25. If hospital documentation demonstrates the lack of cooperation of the patient or guarantor in providing information to determine eligibility for free care, the two (2) year period herein may be reduced to 30 days from the date of initial request for information. If the patient is enrolled in a means-tested government health care plan that requires the patient to pay-out-of pocket for hospital services, then patient or guarantor shall not be refunded any funds that would result in patient losing financial eligibility for health coverage.

16. This Financial Assistance policy does not apply to deceased patients for whom a decedent estate has or should be opened due to assets owned by a deceased patient. Johns Hopkins will file a claim in the decedents' estate and such claim will be subject to estate administration and applicable Estates and Trust laws.

REFERENCE[1]

JHHS Finance Policies and Procedures Manual

Policy No. FIN017 - Signature Authority: Patient Financial Services
Policy No. FIN033 - Installment Payments

Charity Care and Bad Debts, AICPA Health Care Audit Guide

Code of Maryland Regulations COMAR 10.37.10.26, et seq
Maryland Code Health General 19-214, et seq
Federal Poverty Guidelines (Updated annually) in Federal Register

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[1] NOTE: Standardized applications for Financial Assistance, Patient Profile Questionnaire and Medical Financial Hardship have been developed. For information on ordering, please contact the Patient Financial Services Department. Copies are attached to this policy as Exhibits A, B and C.

RESPONSIBILITIES - HCGH, SH

Financial Counselor (Pre-Admission/Admission/In-House/ Outpatient) Customer Service Collector Admissions Coordinator Any Finance representative designated to accept applications for Financial Assistance	Understand current criteria for Assistance qualifications. Identify prospective patients; initiate application process when required. As necessary assist patient in completing application or program specific form. On the day preliminary application is received, send to Patient Financial Services Department's for determination of probable eligibility. Review preliminary application (Exhibit A), Patient Profile Questionnaire (Exhibit B) and Medical Financial Hardship Application (Exhibit C), if submitted, to make probable eligibility determination. Within two business days of receipt of preliminary application, mail determination to patient's last known address or deliver to patient if patient is currently an inpatient. Notate patient account comments. If Financial Assistance Application is not required, due to patient meeting specific criteria, notate patient account comments and forward to Management Personnel for review. Review and ensure completion of final application. Deliver completed final application to appropriate management. Document all transactions in all applicable patient accounts comments. Identify retroactive candidates; initiate final application process.
Management Personnel (Supervisor/Manager/Director)	Review completed final application; monitor those accounts for which no application is required; determine patient eligibility; communicate final written determination to patient within 30 business days of receiving completed application. If patient is eligible for reduced cost care, apply the most favorable reduction in charges for which patient qualifies. Advise ineligible patients of other alternatives available to them including installment payments, bank loans, or consideration under the Medical Financial Hardship program if they have not submitted the supplemental application, Exhibit C. [Refer to Appendix B - Medical Financial Hardship Assistance Guidelines.] Notices will not be sent to Presumptive Eligibility recipients.
Financial Management Personnel (Senior Director/Assistant Treasurer or affiliate equivalent) CP Director and Management Staff	Review and approve Financial Assistance applications and accounts for which no application is required and which do not write off automatically in accordance with signature authority established in JHHS Finance Policy No. FIN017 - Signature Authority: Patient Financial Services.

SPONSOR

CFO (HCGH, SH)
Director of Revenue Cycle (HCGH)
Director, PFS (SH)

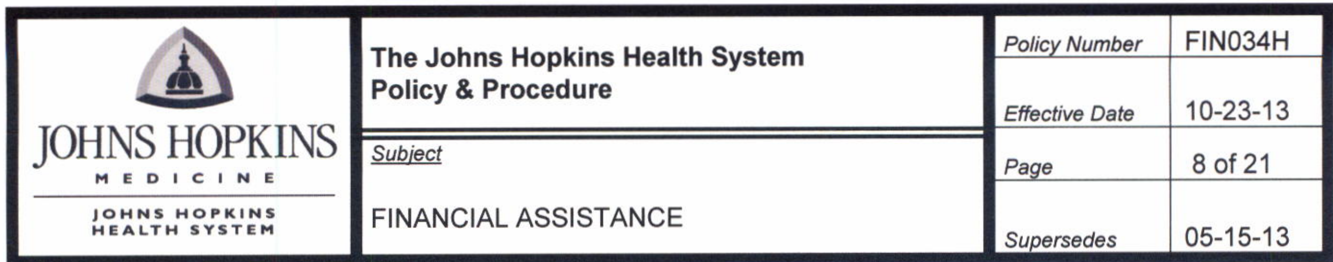
REVIEW CYCLE

Two (2) years

APPROVAL

Sr. VP of Finance/Treasurer & CFO for JHH and JHHS

11-1-2013
Date



APPENDIX A
FINANCIAL ASSISTANCE PROGRAM ELIGIBILITY GUIDELINES

1. Each patient requesting Financial Assistance must complete a JHM/Financial Assistance Application (also known as the Maryland State Uniform Financial Assistance Application) Exhibit A, and Patient Profile Questionnaire, Exhibit B. If patient wishes to be considered for Medical Financial Hardship, patient must submit Medical Financial Hardship Application, Exhibit C.

2. A preliminary application stating family size and family income (as defined by Medicaid regulations) will be accepted and a determination of probable eligibility will be made within two business days of receipt.

3. The patient must apply for Medical Assistance and cooperate fully with the Medical Assistance team or its designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. A Patient Profile Questionnaire (see Exhibit B) has been developed to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.

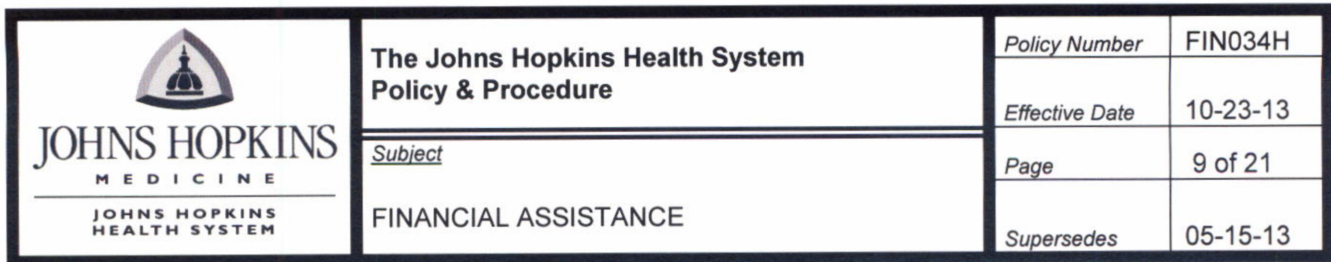
4. Proof of income must be provided with the final application. Acceptable proofs include:
   (a) Prior-year tax return;
   (b) Current pay stubs;
   (c) Letter from employer, or if unemployed documentation verifying unemployed status; and
   (d) A credit bureau report obtained by the JHM affiliates and/or Patient Financial Services Department.
   (e) For non-U.S. citizens, the Financial Counselor shall contact the U.S. Consulate in the patient's country of residence. The U.S. Consulate should be in a position to provide information on the patient's net worth. However, the level of detail supporting the patient's financial strength will vary from country to country. After obtaining information from the U.S. Consulate, the Financial Counselor shall meet with the Director, Revenue Cycle and/or CFO to determine if additional information is necessary.

5. Patients will be eligible for Financial Assistance if their maximum family (husband and wife) income (as defined by Medicaid regulations) level does not exceed each affiliate's standard (related to the Federal poverty guidelines) and they do not own Liquid Assets in excess of $10,000 which would be available to satisfy their JHHS affiliate bills.

6. All financial resources must be used before the Financial Assistance can be applied. This includes insurance, Medical Assistance, and all other entitlement programs for which the patient may qualify. If it is clear that a non-U.S. citizen will not be eligible for Medical Assistance, a Medical Assistance Notice of Determination will not be necessary.

7. Patients who chose to become voluntary self pay patients do not qualify for Financial Assistance for the amount owed on any account registered as Voluntary Self Pay.

8. Financial Assistance is not applicable for non-essential services such as cosmetic surgery, convenience items, and private room accommodations that are not medically necessary. Non-hospital charges will remain the responsibility of the patient. In the event a question arises as to whether an admission is an "Elective Admission" or a "Medically Necessary Admission," the patient's admitting physician shall be consulted and the matter will also be directed to the physician advisor appointed by the hospital.



9. Each affiliate will determine final eligibility for Financial Assistance within thirty (30) business days of the day when the application was satisfactorily completed and submitted. The Financial Counselor will issue the final eligibility determination.

10. Documentation of the final eligibility determination will be made on all (open-balance) patient accounts. A determination notice will be sent to the patient.

11. A determination of eligibility for Financial Assistance based on the submission of a Financial Assistance Application (Exhibit A) will remain valid for a period of six (6) months for all necessary JHM affiliate services provided, based on the date of the determination letter. Patients who are currently receiving Financial Assistance from one JHM affiliate will not be required to reapply for Financial Assistance from another affiliate.

12. All determinations of eligibility for Financial Assistance shall be solely at the discretion of the JHHS affiliate.

Exceptions
The Vice President, Finance/CFO may make exceptions according to individual circumstances.

FREE OR REDUCED COST CARE FINANCIAL ASSISTANCE GRID

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES

Effective 2/1/14

# of Persons in Family	Income Level*	Upper Limits of Income for Allowance Range				
1	**$ 23,340**	$ 25,674	$ 28,008	$ 30,342	$ 32,676	$ 35,010
2	**$ 31,460**	$ 34,606	$ 37,752	$ 40,898	$ 44,044	$ 47,190
3	**$ 39,580**	$ 43,538	$ 47,496	$ 51,454	$ 55,412	$ 59,370
4	**$ 47,700**	$ 52,470	$ 57,240	$ 62,010	$ 66,780	$ 71,550
5	**$ 55,820**	$ 61,402	$ 66,984	$ 72,566	$ 78,148	$ 83,730
6	**$ 63,940**	$ 70,334	$ 76,728	$ 83,122	$ 89,516	$ 95,910
7	**$ 72,060**	$ 79,266	$ 86,472	$ 93,678	$ 100,884	$ 108,090
8*	**$ 80,180**	$ 88,198	$ 96,216	$ 104,234	$ 112,252	$ 120,270
**amt for each member	$8,120	$8,932	$9,744	$10,556	$11,368	$12,180
Allowance to Give:	100%	80%	60%	40%	30%	20%

*200% of Poverty Guidelines
**For family units with more than eight (8) members

EXAMPLE:

EXAMPLE:	Annual Family Income	$54,000
	# of Persons in Family	4
	Applicable Poverty Income Level	$47,700
	Upper Limits of Income for Allowance Range	$57,240 (60% range)

($54,000 is less than the upper limit of income; therefore patient is eligible for Financial Assistance.)

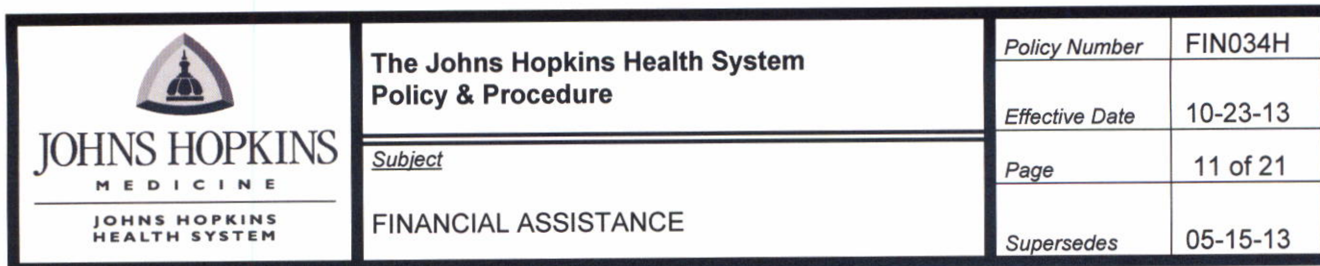
Appendix A-1

Presumptive Financial Assistance Eligibility

There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Active Medical Assistance pharmacy coverage
- QMB coverage/ SLMB coverage
- Primary Adult Care Program (PAC) coverage*
- Homelessness
- Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
- Maryland Public Health System Emergency Petition patients
- active enrollees of the Chase Brexton Health Center (See Appendix C) (applicable for HCGH patients)
- active enrollees of the Healthy Howard Program (see Appendix D) (applicable for HCGH patient)
- Participation in Women, Infants and Children Programs (WIC)*
- Supplemental Nutritional Assistance program (SNAP) or Food Stamp eligibility *
- Households with children in the free or reduced lunch program*
- Low-income household energy assistance program participation*
- Eligibility for other state or local assistance programs which have financial eligibility at or below 200% of FPL
- patients referred to Suburban Hospital by organizations which have partnered with Suburban (See Appendix E)
- Patient is deceased with no known estate
- Health Department moms – For non-emergent outpatient visits not covered by medical assistance
- Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
- Patients returned by SRT as not meeting disability criteria but who meet the financial requirements for Medical Assistance

*These life circumstances are set forth in COMAR 10.37.10.26 A-2. The patient needs to submit proof of enrollment in these programs within 30 days of treatment unless the patient requests an additional 30 days.



APPENDIX B
MEDICAL FINANCIAL HARDSHIP ASSISTANCE GUIDELINES

Purpose

These guidelines are to provide a separate, supplemental determination of Financial Assistance. This determination will be offered to all patients who apply for Financial Assistance.

Medical Financial Hardship Assistance is available for patients who are not eligible for Financial Assistance under the primary section of this policy, but for whom:
1.) Medical Debt incurred over a twelve (12) month period exceeds 25% of the Family Income creating Medical Financial Hardship; and
2.) who meet the income standards for this level of Assistance are met.

For those patients who are eligible for reduced cost care under the Financial Assistance criteria and also qualify under the Medical Financial Hardship Assistance Guidelines, JHHS shall apply the reduction in charges that is most favorable to the patient.

Medical Financial Hardship is defined as Medical Debt for Medically Necessary treatment incurred by a family over a twelve (12) month period that exceeds 25% of that family's income.

Medical Debt is defined as out of pocket expenses for medical costs for Medically Necessary Carebilled by the Hopkins hospital to which the application is made, the out of pocket expenses mentioned above do not include co-payments, co-insurance and deductibles.

The patient/guarantor can request that such a determination be made by submitting a Medical Financial Hardship Assistance Application (Exhibit C), when submitting JHM/Financial Assistance Application, also known as the Maryland State Uniform Financial Assistance Application (Exhibit A), and the Patient Profile Questionnaire (Exhibit B). The patient guarantor must also submit financial documentation of family income for the twelve (12) calendar months preceding the application date and documentation evidencing Medical Debt of at least 25% of family income.

Once a patient is approved for Medical Hardship Financial Assistance, Medical Hardship Financial Assistance coverage shall be effective starting the month of the first qualifying service and the following twelve (12) calendar months. It shall cover those members of the patient's Immediate Family residing in the same household. The patient and the Immediate Family members shall remain eligible for reduced cost Medically Necessary Care when seeking subsequent care at the same hospital for twelve (12) calendar months beginning on the date on which the reduced cost Medically Necessary Care was initially received. Coverage shall not apply to Elective Admissions or Elective or cosmetic procedures However, the patient or the patient's immediate family member residing in the same household must notify the hospital of their eligibility for the reduced cost Medically Necessary Care at registration or admission.

General Conditions for Medical Financial Hardship Assistance Application:

1. Patient's income is under 500% of the Federal Poverty Level.
2. Patient has exhausted all insurance coverage.
3. Patient account balances for patients who chose to register as voluntary self pay shall not counted toward Medical Debt for Medical Financial Hardship Assistance.
4. Patient/guarantor do not own Liquid Assets in excess of $10,000 which would be available to satisfy their JHHS affiliate bills.
5. Patient is not eligible for any of the following:
   - Medical Assistance

- Other forms of assistance available through JHM affiliates

6. Patient is not eligible for The JHM Financial Assistance Program or is eligible but the Medical Financial Hardship Program may be more favorable to the patient.

7. The affiliate has the right to request patient to file updated supporting documentation.

8. The maximum time period allowed for paying the amount not covered by Financial Assistance is three (3) years.

9. If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the Medical Financial Hardship Assistance program, the patient is still required to file a JHHS Medical Financial Hardship Assistance Application but not to submit duplicate supporting documentation.

Factors for Consideration

The following factors will be considered in evaluating a Medical Financial Hardship Assistance Application:

- Medical Debt incurred over the twelve (12) months preceding the date of the Financial Hardship Assistance Application at the JHHS treating facility where the application was made.
- Liquid Assets (leaving a residual of $10,000)
- Family Income for the twelve (12) calendar months preceding the date of the Financial Hardship Assistance Application
- Supporting Documentation

Exceptions

The Vice President, Finance/CFO or designee may make exceptions according to individual circumstances.

Evaluation Method and Process

1. The Financial Counselor will review the Medical Financial Hardship Assistance Application and collateral documentation submitted by the patient/responsible party.

2. The Financial Counselor will then complete a Medical Financial Hardship Assistance Worksheet (found on the bottom of the application) to determine eligibility for special consideration under this program. The notification and approval process will use the same procedures described in the Financial Assistance Program section of this policy.

MEDICAL HARDSHIP FINANCIAL GRID

Upper Limits of Family Income for Allowance Range

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES

Effective 2/1/14

# of Persons in Family	Income Level**		
# of Persons in Family	300% of FPL	400% of FPL	500% of FPL
1	**$ 35,010**	$ 46,680	$ 58,350
2	**$ 47,190**	$ 62,920	$ 78,650
3	**$ 59,370**	$ 79,160	$ 98,950
4	**$ 71,550**	$ 95,400	$ 119,250
5	**$ 83,730**	$ 111,640	$ 139,550
6	**$ 95,910**	$ 127,880	$ 159,850
7	**$ 108,090**	$ 144,120	$ 180,150
8*	**$ 120,270**	$ 160,360	$ 200,450
Allowance to Give:	50%	35%	20%

*For family units with more than 8 members, add $12,180 for each additional person at 300% of FPL, $16,240 at 400% at FPL; and $20,300 at 500% of FPL.

APPENDIX C (HCGH only)
FINANCIAL ASSISTANCE FOR CHASE BREXTON PATIENTS

Purpose

Chase Brexton Health Services, Inc. is a non-profit, community based organization that provides a wide range of medical, psychological and social services on a non-discriminatory basis in Baltimore City, Baltimore County, and Howard County. Chase Brexton offers services to everyone regardless of their ability to pay. Chase Brexton cares for those who are uninsured or under-insured, those with Medicare and Medicaid, and those with commercial insurance. Chase Brexton has Case Managers that work with patients to determine eligibility for care at a low minimum fee, and/or appropriate programs and entitlements available to people with limited resources.

This procedure is for Howard County General Hospital registration sites, verification and scheduling and for Patient Financial Services. It outlines the treatment of patients that have qualified for Chase Brexton Health Services. It is the policy of HCGH to accept patients previously screened by Chase Brexton for financial assistance. Patients will not have to apply for assistance but will need to notify HCGH of their participation in this program.

Inpatient/Outpatient cases
All Chase Brexton inpatients are screened by the Howard County General Hospital's Financial Counselor for possible medical assistance. Appointments are made with Howard County General Hospital's in-house medical assistance Case Worker for the application process. If medical assistance is received, the claim is billed to Medical Assistance for payment. If the patient is not eligible for medical assistance, the insurance plan of FAR.PENDIN, FARB20, FARN40, FARN50, FARN70 FARN80, and FAR100 is assigned to the case and the claim will be automatically written off to the financial assistance/charity care allowance code when the final bill is released. The insurance code assignment is based on the level of charity care the patient has qualified for.

Insurance listed as:	Charity Care	Patient to pay:
FAR.PENDIN	Pending Verification	
FARB20	20% of charges	80% of charges
FARN40	40% of charges	60% of charges
FARN50	50% of charges	50% of charges
FARN70	70% of charges	30% of charges
FARN80	80% of charges	20% of charges
FAR100	100% of charges	0% of charges

PROCEDURE

1. When a patient presents for services at HCGH and states they are associated with the Chase Brexton health center, the registration staff will enter the insurance code of FAR.PENDIN into Meditech if the patient hasn't been seen within the last 6 months. If the patient is in the system with a service date within the last 6 months and the patient was already identified as a Chase Brexton patient that met a certain level of charity care the registrar can allow the insurance code of (FARB20, FARN40 etc,) to be pulled forward.

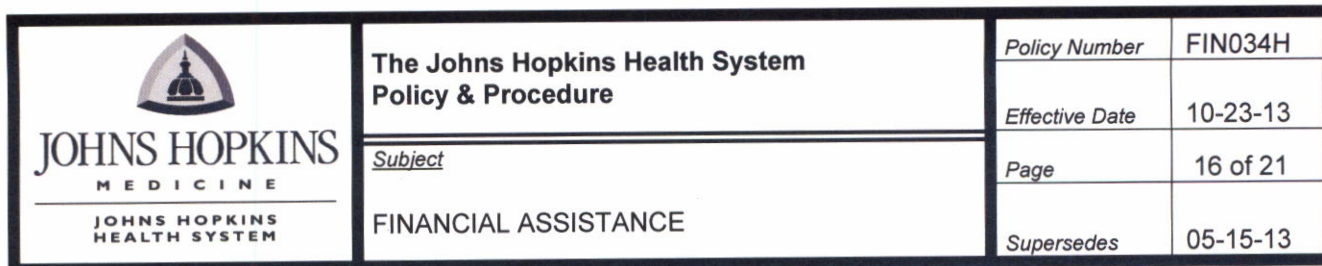
2. The Sr. Financial Counselor receives a daily report with all patients registered with a FAR code.

3. The Sr. Financial Counselor will review all patients on the report daily to validate they are active with the Chase Brexton health center and what level of charity care they qualify for.

4. The Sr. Financial Counselor is responsible for updating the insurance code to reflect the proper level of charity care and collecting the patient balance (if any).

5. The Sr. Financial Counselor is responsible for entering a form and through date into Meditech that the patient is eligible to receive this level of charity care.

6. The Sr. Financial Counselor is responsible for identifying registration errors and forwarding them to the Manager of Admissions for corrective action. These accounts will be changed to self pay and or other insurance as appropriate.



APPENDIX D (HCGH only)
FINANCIAL ASSISTANCE FOR HEALTHY HOWARD PATIENTS

Purpose

The Healthy Howard Access Plan is a new program effective January 1, 2009, designed to connect Howard County residents to affordable health care services and help the community overcome barriers to healthy living. The Plan is not insurance, but offers basic medical and preventative care to eligible residents who would otherwise not be able to afford or obtain health insurance.

This procedure is for Howard County General Hospital registration sites, verification and scheduling, and Patient Financial Services. It outlines the treatment of patients that are enrolled in the Healthy Howard Plan.

Inpatient/Outpatient cases

It is the policy of HCGH to accept Healthy Howard plan patients for referred scheduled services, and emergent/urgent services.

It is the responsibility of the patient to provide their Healthy Howard identification card or inform the registration/scheduling staff of Healthy Howard coverage at the time of service or scheduling.

It is the responsibility of the HCGH registration/authorization staff to verify that coverage is still active by checking eligibility via. MCNET (a web based system administered by JHHC).

For Healthy Howard patients utilizing the emergency department, $100 co-pay is due. However; if admitted or placed into observation the co-pay is waived.

The patient should be registered using the insurance code HLTH.HOW.

The HLTH.HOW insurance code has been programmed to automatically write off the charges to the financial assistance code when the final bill is released.

Procedure

1. When a patient presents for services at HCGH and either presents a Healthy Howard insurance card or notifies the registration staff that they are a member of Healthy Howard the registrar should verify eligibility using MCNET to validate the patient is an active enrollee.
2. If active, the Admission Counselor will register the patient with the insurance code HLTH.HOW.
3. If not active, notify the patient of ineligibility and ask if there is other insurance or means to pay. If not, provide the patient with the HCGH financial assistance application.
4. The Sr. Financial Counselor prints a report on a daily basis of all patients registered with HLTH.HOW.
5. The Sr. Financial Counselor will review all patients on the report to validate they are active with Healthy Howard.
6. The Sr. Financial Counselor is responsible to monitor Healthy Howard in-house inpatient admissions to determine if at some point the patient may become eligible for MD Medical Assistance. If so, the Sr. Financial Counselor will meet with the patient to assist in the application process.
7. The Sr. Financial Counselor is responsible for identifying registration errors and forwarding them to the Manager of Admissions for corrective action. These accounts will be corrected as appropriate.

APPENDIX E (Suburban Hospital only)
FINANCIAL ASSISTANCE FOR MONTGOMERY COUNTY AND LOCALLY BASED PROGRAMS FOR LOW INCOME UNINSURED PATIENTS

Purpose

Suburban Hospital is partnered with several Montgomery County, MD and locally based programs that offer primary care services and/or connection to local specialty and hospital based care. Based on agreements with these partnered programs, Suburban Hospital provides access to inpatient and outpatient care to patients who would not otherwise be able to access or afford medically necessary care.

Policy

Suburban Hospital shall accept charity referrals for medical necessary care from the following providers: Catholic Charities, Mobile Med, Inc., Montgomery County Cancer Crusade, Primary Care Coalition, Project Access, and Proyecto Salud. Care is provided to such patients based on meeting eligibility requirements for one of the aforementioned local programs.
Patients must provide a program generated referral for care as proof of their enrollment in one of the above programs to qualify for presumptive approval for 100% free care. Suburban Hospital shall base acceptance of such referrals on the referring programs' enrollment of patients using their income based eligibility requirements which for these designated programs is at or below a maximum of 250% of the federal poverty guidelines.

Procedure

1. When a patient is scheduled and/or presents for services at SH, the patient must provide a referral form from one of the above programs as proof of enrollment.
2. Once the referral form is received, the Scheduler or Registrar will apply to the account a designated insurance mnemonic for the referring partnered program.
3. If no referral form is received by the patient, the account will be registered as self pay. The patient has 30 days to produce a referral or proof of enrollment in one of the partnered programs. An additional 30 days will be allowed upon request from the patient.
4. A Financial Counselor and/or Registrar will check the real time eligibility or Maryland EVS System to verify enrollment in Maryland Medicaid. If enrolled, Medicaid will prevail and free care presumptive approval will not apply.
5. Each hospital account with a designated insurance mnemonic for one of the partnered programs will be subject to final review for the existence of a program referral prior to application of the program driven charity adjustment. Presumptive approval for 100% free care applies to a single episode of care (account) only.

Exhibit A

Howard County General Hospital
3910 Keswick Road, Suite S-5100
Baltimore, MD 21211

Maryland State Uniform Financial Assistance Application

Information About You

Name ____
First Middle Last

Social Security Number ______-____-______
US Citizen: Yes No

Marital Status: Single Married Separated
Permanent Resident: Yes No

Home Address ______________________________________ Phone ______________

____

______________________________________ ______________
City State Zip code Country

Employer Name ______________________________________ Phone ______________

Work Address ______________________________________

____
City State Zip code

Household members:

Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship

Have you applied for Medical Assistance Yes No
If yes, what was the date you applied? ______________
If yes, what was the determination? ______________________________________

Do you receive any type of state or county assistance? Yes No

Exhibit A

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	________
Retirement/pension benefits	________
Social security benefits	________
Public assistance benefits	________
Disability benefits	________
Unemployment benefits	________
Veterans benefits	________
Alimony	________
Rental property income	________
Strike benefits	________
Military allotment	________
Farm or self employment	________
Other income source	________
Total	________

II. Liquid Assets

	Current Balance
Checking account	________
Savings account	________
Stocks, bonds, CD, or money market	________
Other accounts	________
Total	________

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance ________		Approximate value ________
Automobile	Make ________	Year ______	Approximate value ________
Additional vehicle	Make ________	Year ______	Approximate value ________
Additional vehicle	Make ________	Year ______	Approximate value ________
Other property			Approximate value ________
		Total	________

IV. Monthly Expenses

	Amount
Rent or Mortgage	________
Utilities	________
Car payment(s)	________
Credit card(s)	________
Car insurance	________
Health insurance	________
Other medical expenses	________
Other expenses	________
Total	________

Do you have any other unpaid medical bills? Yes No

For what service? ________________________________

If you have arranged a payment plan, what is the monthly payment? ________________

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

________________________________ ________________

Applicant signature Date

____

Relationship to Patient

Exhibit B

PATIENT FINANCIAL SERVICES
PATIENT PROFILE QUESTIONNAIRE

HOSPITAL NAME: ____

PATIENT NAME: ____

PATIENT ADDRESS: ____
(Include Zip Code)

MEDICAL RECORD #:__________________________________

1. What is the patient's age? _______

2. Is the patient a U.S. citizen or permanent resident? Yes or No

3. Is patient pregnant? Yes or No

4. Does patient have children under 21 years of age living at home? Yes or No

5. Is patient blind or is patient potentially disabled for 12 months or more from gainful employment? Yes or No

6. Is patient currently receiving SSI or SSDI benefits? Yes or No

7. Does patient (and, if married, spouse) have total bank accounts or assets convertible to cash that do not exceed the following amounts? Yes or No

   Family Size:

   Individual: $2,500.00

   Two people: $3,000.00

   For each additional family member, add $100.00

   (Example: For a family of four, if you have total liquid assets of less than $3,200.00, you would answer YES.)

8. Is patient a resident of the State of Maryland? Yes or No
   If not a Maryland resident, in what state does patient reside? ________

9. Is patient homeless? Yes or No

10. Does patient participate in WIC? Yes or No

11. Does patient receive Food Stamps? Yes or No

12. Does patient currently have:
    - Medical Assistance Pharmacy Only Yes or No
    - QMB coverage/ SLMB coverage Yes or No
    - PAC coverage Yes or No

13. Is patient employed? Yes or No
    If no, date became unemployed. ________
    Eligible for COBRA health insurance coverage? Yes or No

Exhibit C

MEDICAL FINANCIAL HARDSHIP APPLICATION

HOSPITAL NAME: ____

PATIENT NAME: ____

PATIENT ADDRESS: ____
(Include Zip Code)

MEDICAL RECORD #: ____

Date: ____

Family Income for twelve (12) calendar months preceding date of this application: ______________

Medical Debt incurred at The Johns Hopkins Hospital (not including co-insurance, co-payments, or deductibles) for the twelve (12) calendar months preceding the date of this application:

Date of service	Amount owed
______________	____________________
______________	____________________
______________	____________________
______________	____________________

All documentation submitted becomes part of this application.

All the information submitted in the application is true and accurate to the best of my knowledge, information and belief.

______________________________ Date: ________________
Applicant's signature

____
Relationship to Patient

For Internal Use: Reviewed By:
______________________________ Date: ____________

Income: ______________ 25% of income= ________________

Medical Debt: ________________ Percentage of Allowance: __________

Reduction: ____________________

Balance Due: ____________________

Monthly Payment Amount: ______________ Length of Payment Plan: ________ month

APPENDIX IV: PATIENT INFORMATION SHEET

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

PATIENT BILLING and FINANCIAL ASSISTANCE INFORMATION SHEET

Billing Rights and Obligations

Not all medical costs are covered by insurance. The hospital makes every effort to see that you are billed correctly. It is up to you to provide complete and accurate information about your health insurance coverage when you are brought in to the hospital or visit an outpatient clinic. This will help make sure that your insurance company is billed on time. Some insurance companies require that bills be sent in soon after you receive treatment or they may not pay the bill. Your final bill will reflect the actual cost of care minus any insurance payment received and/or payment made at the time of your visit. All charges not covered by your insurance are your responsibility.

Financial Assistance

If you are unable to pay for medical care, you **may qualify for Free or Reduced-Cost Medically Necessary Care** if you:

- Have no other insurance options
- Have been denied medical assistance or fail to meet all eligibility requirements
- Meet specific financial criteria

If you do not qualify for Medical Assistance or financial assistance, you may be eligible for an extended payment plan for your medical bill.

Call: **301-896-6088**

With questions concerning:

- Your hospital bill
- Your rights and obligations with regard to your hospital bill
- Your rights and obligations with regard to reduced-cost medically necessary care due to financial hardship
- How to apply for free and reduced-cost care
- How to apply for Maryland Medical Assistance or other programs that may help pay your medical bills

For information about Maryland Medical Assistance

Contact your local department of Social Services
1-800-332-6347 TTY 1-800-925-4434
Or visit: www.dhr.state.md.us

Physician charges are not included in hospital bills and are billed separately.

HOJA INFORMATIVA SOBRE LA FACTURA DE PACIENTES Y LA ASISTENCIA FINANCIERA

Los derechos y obligaciones de la factura

No todos los costos médicos son cubiertos por el seguro. El hospital hace todo lo possible para estar seguro de que usted reciba la factura correcta. Depende de usted proveer la información completa y precisa sobre su cobertura de seguro médico cuando le traen al hospital o cuando visita la clínica ambulatoria. Esto ayudará a asegurar que se manden las facturas a su compañía de seguros a tiempo. Algunas compañias de seguro requieren que se manden las facturas tan pronto como usted recibe el tratamiento, de lo contrario pueden no pagarlas. Su factura final reflejará el verdadero costo de su cuidado, menos cualquier pago que se haya recibido o hecho al momento de su visita. Todo cobro no cubierto por su seguro es responsabilidad suya.

Asistencia financiera

Si usted no puede pagar por su cuidado médico, es possible que califique para cuidado médicamente necesario gratuito o de bajo costo si usted:
• No tiene otras opciones de seguro
• Le ha sido negada la asistencia médica, o no cumple con todos los requistitos de elegibilidad
• Cumple con criterios financieros específicos.
Si usted no califica para la Asistencia Médica o la asistencia financiera, es possible que sea elegible para un sistema de pagos extendidos para sus facturas médicas.

Llame a: 301-896-6088

Con sus preguntas referentes a:
• Su factura del hospital
• Sus derechos y obligaciones en cuanto a su factura del hospital
• Sus derechos y obligaciones de lo que se refiere a la reducción de costo, al cuidado médico necesario debido a dificultades financieras
• Cómo inscribirse para cuidado gratuito o de bajo costo
• Cómo inscribirse para la Asistencia Médica de Maryland u otros programas que le puedan ayudar a pagar sus facturas médicas.

Para más información sobre la Asistencia Médica de Maryland

Por favor llame a su departamento local de Servicios Sociales
1-800-332-6347 TTY 1-800-925-4434
O visite al: www.dhr.state.md.us

Los cobros de los médicos no se incluyen en las facturas del hospital, son facturas aparte.

APPENDIX V: MISSION, VISION, AND VALUE STATEMENT

Mission

Improving health with skill and compassion.

Vision

As a member of Johns Hopkins Medicine, Suburban Hospital will foster the development of an integrated and innovative system of care that provides state of the art clinical care supported by a strong base of medical research and education.

Value Statement

Suburban Hospital is a community-based hospital serving Montgomery County and the surrounding area since 1943. We are a not-for-profit healthcare provider guided by the needs of our patients and community. On June 30, 2009, Suburban Hospital became a member of Johns Hopkins Medicine. The designated trauma center for Montgomery County, Suburban Hospital is affiliated with many local healthcare organizations, including the National Institutes of Health. It is committed to continuous improvement and appropriate use of resources, and creates an environment that encourages the success and fulfillment of our physicians, staff, and volunteers.

Suburban Hospital will set the standard for excellence in healthcare in the Washington metropolitan region. Through our affiliations, we aspire to provide world-class patient care, technology, and clinical research.

Values

- Compassion
- Excellence
- Integrity
- Teamwork
- Accountability

APPENDIX VI: COMMUNITY BENEFIT SERVICE AREA DEMOGRAPHICS

Suburban Hospital

Community Benefit Service Area

FY 2016 Q3

Source: HSCRC, DCHA, VHA

Includes Newborns

Zip Code	Zip City	SH Discharges	SH Market Share	All Hospital Discharges*	SH % Zip**
20814	Bethesda	714	44.5%	1604	7%
20815	Chevy Chase	534	31.9%	1673	5%
20817	Bethesda	728	39.5%	1842	7%
20850	Rockville	371	13.3%	2787	4%
20851	Rockville	145	15.0%	966	1%
20852	Rockville	1056	38.8%	2721	11%
20853	Rockville	218	11.0%	1989	2%
20854	Potomac	768	33.9%	2267	8%
20874	Germantown	196	5.4%	3652	2%
20877	Gaithersburg	131	4.9%	2691	1%
20878	Gaithersburg	251	7.7%	3254	3%
20895	Kensington	357	30.6%	1165	4%
20902	Silver Spring	296	8.4%	3521	3%
20906	Silver Spring	408	7.2%	5687	4%
20910	Silver Spring	170	6.6%	2566	2%
TOTAL		6343	16.5%	38385	64%

*Includes Maryland, DC, and Northern VA Hospitals (Source: HSCRC, DC Hospital Association (DCHA), and Virginia Hospital Association (VHA))

**Note: SH had 13,256 discharges in FY 2016

2016 Demographic Snapshot
Area: CB Service Area FY2016 - Suburban
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	598,272	308,745,538
2016 Total Population	646,327	322,431,073
2021 Total Population	683,185	334,341,965
% Change 2016 - 2021	5.7%	3.7%
Average Household Income	$138,655	$77,135

	2016	2021	% Change
Total Male Population	311,041	329,249	5.9%
Total Female Population	335,286	353,936	5.6%
Females, Child Bearing Age (15-44)	125,107	126,840	1.4%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	**2016**	**% of Total**	**2021**	**% of Total**	**USA 2016 % of Total**
0-14	121,560	18.8%	124,674	18.2%	19.0%
15-17	24,115	3.7%	26,512	3.9%	4.0%
18-24	49,513	7.7%	56,325	8.2%	9.8%
25-34	85,155	13.2%	78,691	11.5%	13.3%
35-54	182,152	28.2%	186,246	27.3%	26.0%
55-64	84,279	13.0%	91,559	13.4%	12.8%
65+	99,553	15.4%	119,178	17.4%	15.1%
Total	**646,327**	**100.0%**	**683,185**	**100.0%**	**100.0%**

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2016 Household Income	**HH Count**	**% of Total**	**USA % of Total**
<$15K	13,167	5.4%	12.3%
$15-25K	10,587	4.3%	10.4%
$25-50K	32,138	13.1%	23.4%
$50-75K	36,044	14.7%	17.6%
$75-100K	30,919	12.6%	12.0%
Over $100K	123,167	50.1%	24.3%
Total	**246,022**	**100.0%**	**100.0%**

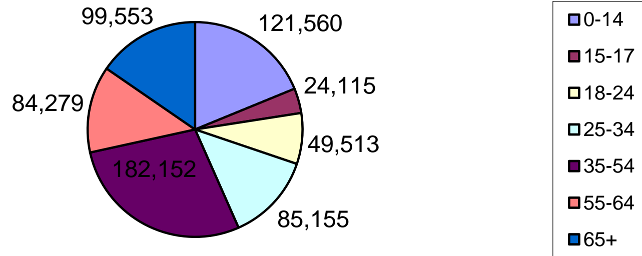
EDUCATION LEVEL

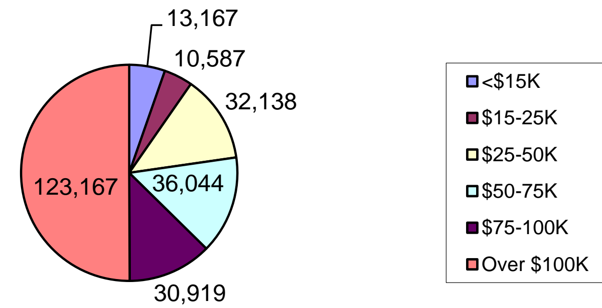
	Education Level Distribution		
2016 Adult Education Level	**Pop Age 25+**	**% of Total**	**USA % of Total**
Less than High School	21,992	4.9%	5.8%
Some High School	16,100	3.6%	7.8%
High School Degree	61,235	13.6%	27.9%
Some College/Assoc. Degree	81,413	18.0%	29.2%
Bachelor's Degree or Greater	270,399	59.9%	29.4%
Total	**451,139**	**100.0%**	**100.0%**

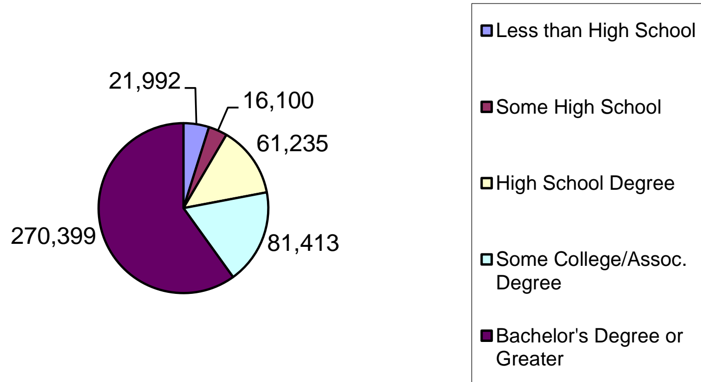
RACE/ETHNICITY

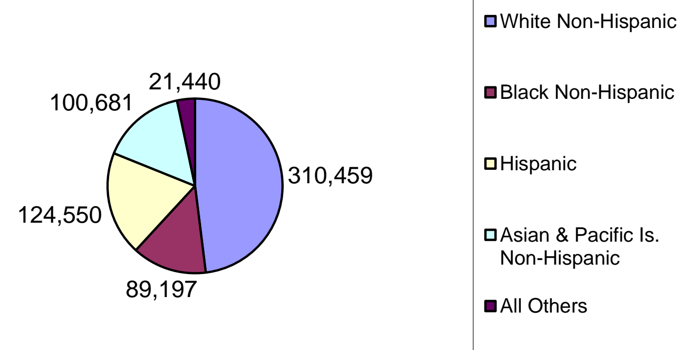
	Race/Ethnicity Distribution		
Race/Ethnicity	**2016 Pop**	**% of Total**	**USA % of Total**
White Non-Hispanic	310,459	48.0%	61.3%
Black Non-Hispanic	89,197	13.8%	12.3%
Hispanic	124,550	19.3%	17.8%
Asian & Pacific Is. Non-Hispanic	100,681	15.6%	5.4%
All Others	21,440	3.3%	3.1%
Total	**646,327**	**100.0%**	**100.0%**

2016 Demographic Snapshot Charts





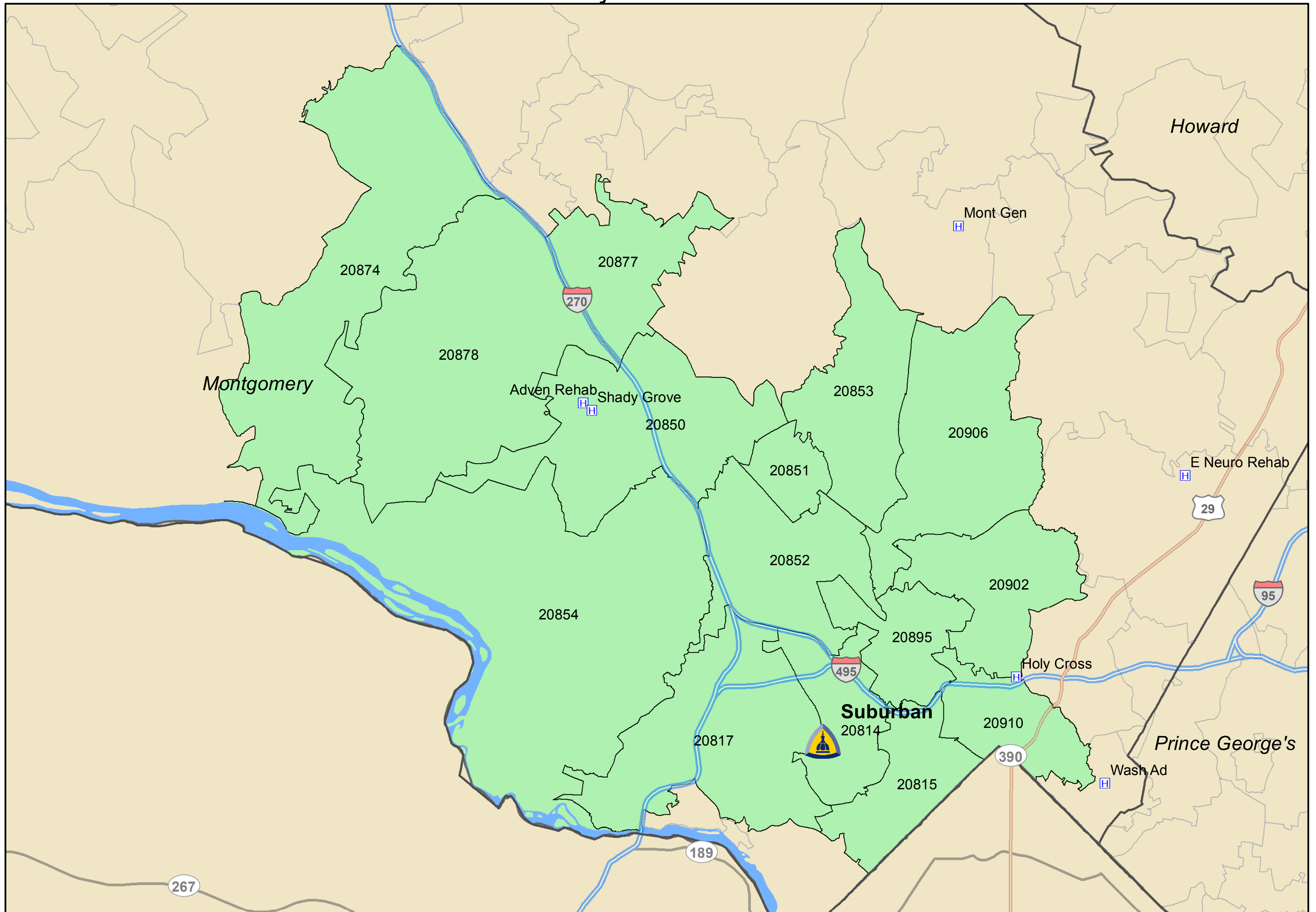




2016 Insurance Coverage Estimates
Area: CB Service Area FY2016 - Suburban
Ranked by ZIP Code(Asc)

		2016 Adjusted Population								
ZIP Code	ZIP City	Total	Medicaid - Pre Reform	Medicaid Expansion	Medicare	Medicare Dual Eligible	Private - Direct	Private - ESI	Private - Exchange	Uninsured
20814	Bethesda	29,581	2,451	748	3,560	560	1,747	19,020	819	677
20815	Chevy Chase	31,022	1,946	638	4,819	743	1,823	19,810	674	571
20817	Bethesda	36,899	2,116	690	4,875	749	2,259	24,817	750	644
20850	Rockville	53,218	4,913	1,545	5,544	883	3,099	34,379	1,525	1,331
20851	Rockville	14,736	1,193	409	1,040	172	925	10,227	452	319
20852	Rockville	47,289	4,622	1,465	5,537	875	2,684	29,454	1,441	1,211
20853	Rockville	30,761	2,301	759	3,544	554	1,837	20,314	801	651
20854	Potomac	51,638	2,390	776	7,247	1,106	3,267	35,175	913	763
20874	Germantown	62,845	6,314	2,183	3,182	558	3,814	43,086	2,078	1,631
20877	Gaithersburg	37,624	6,607	1,907	3,057	492	1,802	20,605	1,495	1,659
20878	Gaithersburg	66,343	4,773	1,742	5,203	851	4,174	46,503	1,789	1,309
20895	Kensington	20,851	1,963	629	2,400	377	1,169	13,207	567	540
20902	Silver Spring	52,845	6,743	2,151	4,278	692	2,864	32,563	1,834	1,720
20906	Silver Spring	68,450	9,569	2,779	10,392	1,615	3,232	36,135	2,196	2,534
20910	Silver Spring	42,225	6,242	1,900	3,373	555	2,240	24,809	1,549	1,557
Total		646,327	64,142	20,320	68,049	10,781	36,937	410,100	18,883	17,117

Suburban Hospital
Community Benefit Service Area



APPENDIX VII: SUBURBAN HOSPITAL FY 2016 CBSA DEFINITION

FY 2016 Suburban Hospital Community Benefit Service Area Definition

Zip Code	City
20906	SILVER SPRING
20902	SILVER SPRING
20878	GAITHERSBURG
20852	ROCKVILLE
20910	SILVER SPRING
20854	POTOMAC
20850	ROCKVILLE
20853	ROCKVILLE
20895	KENSINGTON
20851	ROCKVILLE
20814	BETHESDA
20815	CHEVY CHASE
20817	BETHESDA
20877	GAITHERSBURG
20874	GERMANTOWN

Criteria used to define the Suburban Hospital Community Benefit Service Area (SH CBSA):

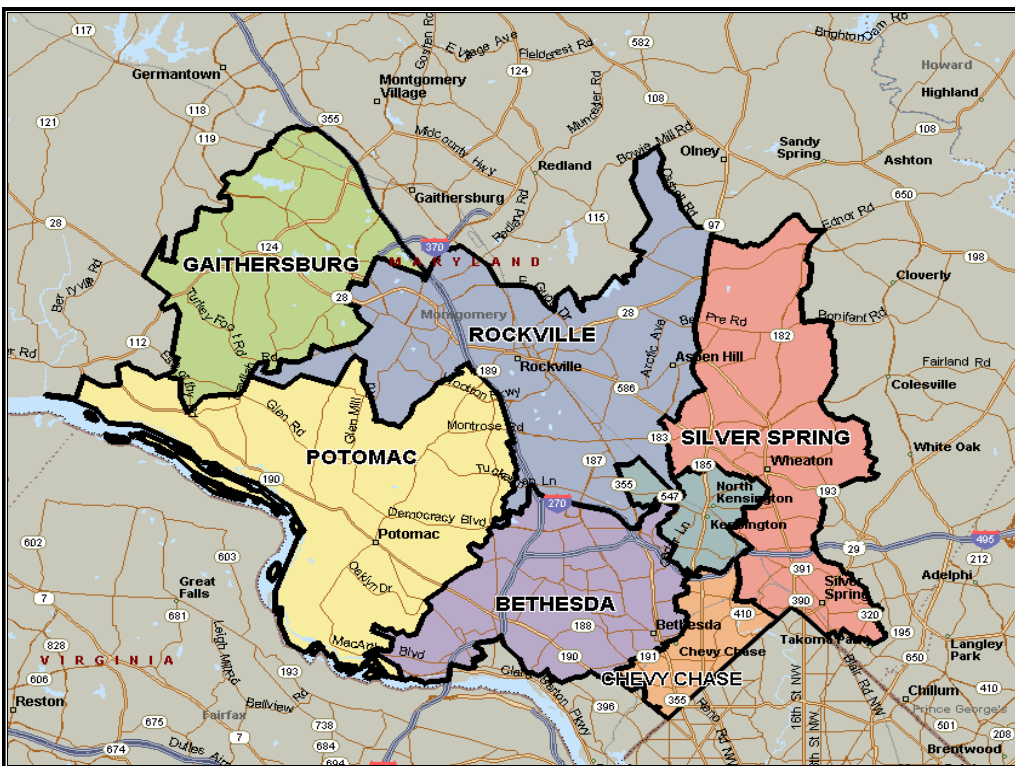
The SH CBSA is defined as the geographic region that includes zip codes that are common to the following:

a) The top 20 zip codes from which Suburban Hospital ED visits originate*
b) The Top 20 zip codes from which Suburban Hospital FY16 inpatients originate*
c) The top 25 zip codes for Suburban Hospital Charity Care cases*
d) The Top 10 zip codes for Suburban Hospital Community Benefit Actitivites**

*As defined by indicated residence of the recipient

** As defined by the total number of Suburban Hospital programs in the indicated zip code

Note: In FY 13 Suburban Hospital added zip code 20877 and 20874 to the previous year's service area definition



APPENDIX VIII: SUBURBAN HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT 2016

COMMUNITY HEALTH NEEDS ASSESSMENT

2016

SUBURBAN HOSPITAL

JOHNS HOPKINS MEDICINE

Suburban Hospital
Community Health Needs Assessment
2016

Table of Contents

Contents **Page**

1. Acknowledgements 4
2. Executive Summary 5
3. Introduction 7
   Federal Requirements 7
   Background on Healthy Montgomery 7
   Overview of Suburban Hospital 8
4. The Community We Serve 8
   Suburban Hospital's Definition of Community Served by Hospital Facility 8
   Demographic Profile of Community Served 9
5. Suburban's Approach to Community Health Needs Assessment 14
   Health Outcomes 15
   Healthy Montgomery Core Measures Set 18
   Data Gaps/Limitations 18
   Top Impatient Diagnosis at Suburban Hospital 18
6. Community Input 20
   Survey Sample Population Calculation 20
   Survey Data Collection 22
   Survey Data Results 22
7. Selecting Priorities 31
   Identified Health Needs 31
   Health Priority Setting 32
   Health Priority Validation and Consensus 34
8. Implementation Strategy 35
   Addressed Needs and Implementation Plan 35
   Unaddressed Identified Needs 39
   Community Assess 40
9. Suburban Hospital 2013 Community Health Needs Assessment Evaluation 41
   Healthy Improvement Measures 41
10. Conclusion 46
11. Appendices 47
   Appendix A. Healthy Montgomery Steering Committee Members
   Appendix B. 2015 Insurance Coverage Estimates for CBSA
   Appendix C. Top Ten Causes of Death in Montgomery County
   Appendix D. Mortality and morbidity rates by race and ethnicity for Montgomery County's leading causes of death.
   Appendix E. Core Measure Indicators for Suburban Hospital's CBSA
   Appendix F. Community Health Survey Tool (English)

Appendix G. Community Benefit Advisory Council, Montgomery County United Way Regional council, and Patient and Family Education Committee members
Appendix H. Suburban Hospital Program & Services Asset Map
Appendix I. Asset Map for Montgomery County
12. References 68

1 ACKNOWLEDGEMENTS

Suburban Hospital's 2016 Community Health Needs Assessments (CHNA) was directed by the Community Health & Wellness department and builds upon the county-wide health improvement process initiated by *Healthy Montgomery*.

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

Eleni Antzoulatos, MPH
Coordinator, Health Promotions and Community Wellness

Kate McGrail, MPH
Program Manager, Health Outcomes and Evaluation

Sara Demetriou, B.S, CHES
Coordinator, Health Initiatives and Community Partnerships

Patricia Rios, MPH
Supervisor, Community Health Improvement

Monique Sanfuentes, MA
Director, Community Health and Wellness Department

We are particularly grateful to our community for their contribution, support, and loyal affiliation to the Hospital's vision without whom over the last 70 years Suburban would have not been able to build valuable relationships in community schools, organizations, and advocacy groups.

We would also like to thank the members of Suburban's Community Benefit Advisory committee, Johns Hopkins Community Benefit Advisory Council, and University of Maryland School of Nursing Shady Grove Campus students. A special thank you goes to:

Valerie Chow, Public Health Fellow, *Data Collection*

Mohammed Chubbard, Surveyor

Ashley Haggard, Surveyor

Judy Macon, Reviewer

Laura Herrera-Scott, Reviewer

2 EXECUTIVE SUMMARY

Suburban Hospital is a community-based, not-for-profit hospital serving Montgomery County, MD and the surrounding area since 1943. Suburban Hospital's mission is to improve health with skill and compassion. The following values are its cornerstones: communication, integrity, teamwork, accountability and compassion. Suburban Hospital prides itself on the various major services offered to patients, as well as the community benefit services, programs and initiatives that extend beyond the hospital walls. The hospital serves a community that is diverse in racial and ethnic background, culture, life stage and socioeconomic status. While Montgomery County is home to some of the most affluent communities in our nation. However, even with great resources, Montgomery County faces unique access to care challenges because of several social and economic disparities. There are approximately 1,016,677 residents living in Montgomery County, of which 47.0% are White non-Hispanics, 17.0% are Black non-Hispanics, 18.3% Hispanic/Latino and 14.0 % Asian/Pacific Islander. The per capita income for White non-Hispanic is $67,181 whereas for Hispanics/Latinos it is only $23,393. The premature death rate in Montgomery County is approximately 3,500 per 100,000 population (age-adjusted) compared to the state average of 6,400 years of potential life lost before age 75. Approximately 7.9% of county residents smoke, 57.4% are overweight or obese, 18% of adults 20 years and older report no physical activity, and 15% partake in excessive or binge drinking. In Montgomery County, 14.8% of residents rely on public health coverage, and 6.9% live below the federal poverty line. The high school graduation rate is 89.7%. Unemployment has decreased over the past three years to 4.4%, and 16.7% of adults report inadequate social and emotional support.

The average infant mortality rate in Montgomery County is 4.8 per 1,000 live births. Among Black non-Hispanics that number increases to 8.3 compared to 3.5 for their White non-Hispanic counterparts. The average life expectancy of an individual living in Montgomery County is 84.3 years; however, it is 82.4 years for Black non-Hispanics compared to 84.3 years for White non-Hispanic. In Montgomery County, the leading causes of death for all races are heart disease, cancer and stroke. Nearly 100,000 residents do not have health insurance, which is equivalent to 9.7% of the total population. Additionally, 10.4 % of adult residents reported not being able to financially afford to see a doctor in the past year with Hispanics/Latinos reporting the highest financial barriers (19.5%).

Mandated by the Internal Revenue Service (IRS) to conduct a Community Health Needs Assessment (CHNA) every three years and to develop an implementation strategy, Suburban Hospital executed this process with a three-tiered approach: 1) reviewing available local, state, and national datasets for core health indicators for Montgomery County; 2) engaging health experts and stakeholders to advise on the direction of the needs assessment; and 3) conducting a community health survey to assess the needs and insights of residents in high priority zip codes from Suburban's Community Benefit Service Area (CBSA).

Suburban Hospital surveyed 427 Montgomery County residents in the seven zip codes that were determined to be part of its Community Benefit Service Area high-need zip codes in order to gain a more comprehensive understanding of the community's health needs. Community members were surveyed with a questionnaire on issues related to their biggest perceived health concern; barriers to health; healthy lifestyle behaviors such as fruit and vegetable consumption, tobacco use, alcohol consumption, seatbelt use and stress management; and self-reported health status.

Community members identified five major health issues in the county today: overweight/obesity, heart disease, cancer, high blood pressure and diabetes. These findings aligned almost identically to the major health priorities of

Healthy Montgomery (Montgomery County's formal Community Health Improvement Process). Respondents said that 'cost' was the most significant barrier to receiving the health care they or others need (28%), followed by lack of health insurance (18%), lack of time (17%), and lack of information (11%). The community was asked to assess their personal health behaviors. Physical activity level was found to be low among respondents, where only 36% reported always engaging in at least 20-30 minutes of moderate physical activity at least five days a week. Fruit and vegetable consumption was also assessed and 27% of the community reported always eating at least five servings every day compared to 7% who said never. Overall, 82% of respondents never used tobacco products, 70% never consume more than five alcoholic drinks a week, 92% always wear a seatbelt while traveling in a vehicle, and 31% are always or often able to manage and control their stress. When asked to rate their own health status, 20% said they have excellent health and 55% said they have good health. While only 11% of respondents did not see a need to change their health behavior, 67% felt at risk of developing a disease.

Results from primary and secondary data, Suburban's medical area of expertise, county, state, and national health priorities were taken into consideration to identify the five the top five health needs for Suburban's community. After multiple prioritization discussions with stakeholders, the following main focus areas emerged for Suburban's 2016 Community Health Needs Assessment: obesity, cancer, diabetes, cardiovascular, and behavioral health. During the first assessment, conducted in 2013, these same conditions were identified as health priorities for Suburban Hospital. Suburban Hospital will continue to build upon existing programs addressing these five health areas and will work diligently with partners over the next three years to ensure that the valuable information attained from the CHNA is an integral tool for monitoring and evaluation of established health targets and goals.

3 INTRODUCTION

About the Federal Requirements

Under Section 501(c) (3) of the Internal Revenue Code, nonprofit hospitals may qualify for tax-exempt status if they meet certain 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 community health needs assessment (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 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.

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

Background on Healthy Montgomery

Healthy Montgomery, launched in June 2009 and initiated by the Montgomery County Department of Health and Human Services, is the 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 permanent steering committee member, providing recommendations and technical expertise to help advance periodic county-wide needs assessments, identification and prioritization of health needs, leverage of population-based data and information, and the research and adoption of best-practice strategies for health improvement. In addition, since 2010, Suburban Hospital has contributed $25,000 annually to support an ongoing health improvement process and infrastructure. **See Appendix A for a list of Healthy Montgomery Steering Committee Members.**

[1] Internal Revenue Bulletin: 2015-5; https://www.irs.gov/irb/2015-5_IRB/ar08.html

Overview of Suburban Hospital

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 is also bordered by the Maryland counties of Frederick, Carroll, Howard and Prince George's, and the Commonwealth of Virginia.

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. 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, elevated helipad. Suburban Hospital's busy Emergency/Shock Trauma Center treats more than 40,000 patients a year.

The hospital's major services include: a comprehensive cancer and radiation oncology center accredited by the American College of Surgeons Commission on Cancer; The NIH Heart Center at Suburban Hospital, providing 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.

Other services provided include: the NIH-Suburban MRI Center; state-of-the-art diagnostic pathology and radiology departments; an Addiction Treatment Center offering detoxification, inpatient and outpatient programs for adolescents and adults; prevention and wellness programs; and a free physician referral service (Suburban On-Call). Suburban Hospital is the only hospital in Montgomery County to achieve the Gold Seal of Approval™ by The Joint Commission for its joint replacement program.

During fiscal year 2015, Suburban Hospital was licensed to operate 220 acute care beds, and had 13,861 inpatient admissions.

4 THE COMMUNITY WE SERVE

Suburban Hospital's Definition of Community Served by Hospital Facility

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). Suburban's Hospital's PSA includes the following zip codes: 20852, 20814, 20854, 20817, 20815, 20850, 20906, 20895, 20902, 20878, and 20874.

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, and Community Health Improvement Initiatives and Wellness Activities were aggregated and defined by the geographic area

contained within the following sixteen zip codes: 20814, 20817, 20852, 20854, 20815, 20850, 20895, 20906, 20902, 20878, 20853, 20910, 20851, 20877 and 20874. Suburban's CBSA extends beyond its primary service area. **See Figure 1**.

Figure 1. Suburban Hospital Community Benefit Service Area (CBSA) Zip Codes.

Demographic Profile of Community Served

This section provides an overview of the demographics of Suburban Hospital's CBSA, with comparison to county, state, and national data as a reference where available. All data are sourced from Healthy Montgomery, Data Montgomery, and the US Census unless otherwise indicated.

Population

Montgomery County is home to 1,016,677 people.[2] Suburban CBSA residents makes up nearly 63% of the total population. The population in the CBSA is growing at a faster pace than the county, state, and national level.

[2] 2015 County Health Ranking

Between 2010 and 2015, the population size in the CBSA grew by 6.4%. Both in the CBSA and at the County level, females make up 52% of the population.[3]

Table 1. Population Growth & Average Household Income

	SH CBSA[3]	Montgomery County	Maryland	USA
2010 Total Population	598,189	971,777	5,773,552	308,745,538
2015 Total Population	638,821	1,016,677	5,928,814	319,459,991
% Change 2010-2015	6.4%	4.4%	2.6%	3.4%
Average Household Income	$138,765	$97,873	$72,482	$74,165

Source: County Health Rankings & Truven Health Analytics, Inc.

Economic Characteristics

In Montgomery County, the average household size is 2.70 persons and the average family size is 3.22 persons.[4] To live in Montgomery County, without any private or public financial assistance, a family of three (one adult, one preschooler, and one school-aged child) requires an annual income of $77,933.[5] The average household income in the CBSA is $138,765 compared to $97,873 in the County.[3] While the per capita income for the county is $49,038, looking at specific racial/ethnic groups reveals great disparities. For example, the per capita income for White non-Hispanic ($67,181) is almost three times that of Hispanics/Latinos ($23,393).[5] **See Figure 2.**

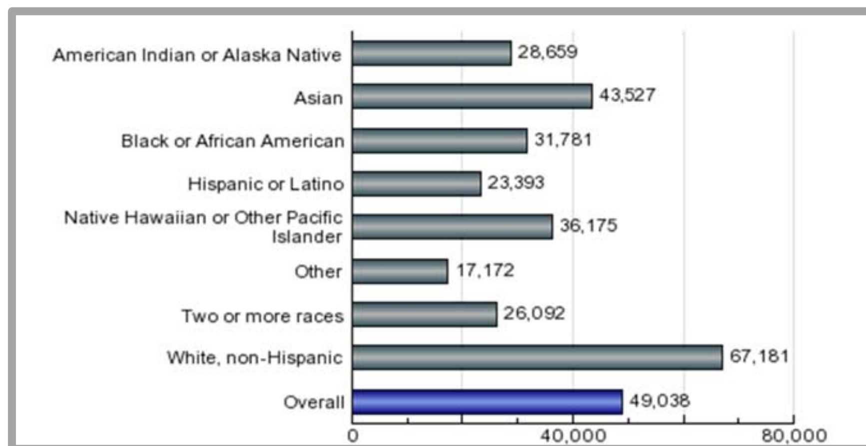


Figure 2. Per Capita Income by Race/Ethnicity

Source: Healthy Montgomery (2010-2014)

[3] (Truven Health Analytics, 2015)

[4] (US Census Bureau FactFinder, 1)

[5] (Healthy Montgomery, 2010-2014)

At the County level, 6.9% of the total population and 4.5% of families live below the federal poverty line.[5] Poverty affects Montgomery County residents disproportionately. Black non-Hispanics (11.5%) and Hispanics/Latinos (11.4%) have the highest rates of poverty in the County. The least impoverished groups are White non-Hispanics (3.6%) and American Indian/Alaska Natives (4.4%).[6]

In the County, 51.5% of renters spend 30.0% or more of their household income on rent leaving minimal resources for other expenses, such as food, transportation, health, and savings (2010-2014).[5] Although the unemployment rate for Maryland remains at 5.8%, in Montgomery County it has decreased from 5.6% to 4.4% since 2013.[2]

Age

The premature death rate in Montgomery County is approximately 3,500 per 100,000 population (age-adjusted) compared to the state, with 6,400 years of potential life lost before age 75.[2] While infant mortality rates at the County level have decreased to 4.8 per 1,000 live births, the rate for White non-Hispanics has increased to 3.5 from 2.9 between 2011 and 2014. Hispanics/Latinos (7.8/1,000) and Black non-Hispanics have the highest (8.3/1,000).[7,5]

The average life expectancy in Montgomery County is 84.3 years at birth, which is higher than the Maryland baseline (79.6). The life expectancy for White non-Hispanics (84.3) is longer than Black non-Hispanics (82.4).[8] The median age in Montgomery County is estimated to be 38.5 years, where 23.5% of the population is under the age of 18, and 13.7% are 65 years of age or older.[4] The current and projected age distribution within Suburban's CBSA is similar to the County level (**See Table 2**).

Table 2. Suburban's CBSA Population Age Distribution

	Age Distribution				
Age Group	2015	% of Total	2020	% of Total	USA 2015 % of Total
0-14	119,379	18.7%	122,463	18.1%	19.1%
15-17	23,838	3.7%	25,964	3.8%	4.0%
18-24	48,925	7.7%	55,633	8.2%	9.9%
25-34	85,180	13.3%	78,386	11.6%	13.3%
35-54	182,077	28.6%	185,765	27.5%	26.3%
55-64	83,568	13.1%	91,893	13.6%	12.7%
65+	95,854	15.0%	115,821	17.1%	14.7%
Total	**638,821**	**100%**	**675,925**	**100%**	**100.0%**

Source: Truven Analytics Inc.

[6] ("Healthy Montgomery: Community Dashboard", n.d.)

[7] (Montgomery Maryland State Health Improvement Process, 2014)

[8] (Maryland Vital Statistics Annual Report, 2013)

Ethnic/Racial Diversity

Montgomery County prides itself on its racial diversity and cultural richness. The County's population is 47.0% White non-Hispanic, 17.3% Black non-Hispanic, and 14.9% Asian.[4] Montgomery County has the largest population of Hispanics/Latinos (18.3%) in Maryland.[2] Foreign-born residents account for 32.4% of the population in Montgomery County. It is not surprising to find that 39.3% of county residents speak a language other than English at home.[4] The most common spoken languages, aside from English (60.7%), include Spanish (15.7%), other Indo-European (10.1%), and Asian and Pacific Islander languages (9.4%).[4] **Table 3** represents the racial/ethnicity distribution at the CBSA level, which mirrors County level information.

Table 3. Suburban Hospital CBSA Race/Ethnicity Distribution

Race/Ethnicity	2015 Pop	% of Total	USA % of Total
White non-Hispanic	312,333	48.9%	61.8%
Black non-Hispanics	86,654	13.6%	12.3%
Hispanic/Latino	121,084	19.0%	17.6%
Asian & Pacific Is. Non-Hispanic	97,898	15.3%	5.3%
All Others	20,852	3.3%	3.1%
Total	**638,821**	**100%**	**100%**

Source: Truven Health Analytics Inc. 2015

Education

Montgomery County has a high percentage (57.1%) of residents over 25 years of age who hold a Bachelor's Degree or higher. Asians (65%) and White non-Hispanics (69%) are the races/ethnicities in Montgomery County with the greatest attainment of Bachelor's Degrees or higher, while Hispanics/Latinos have the lowest rate (24.6%).[5] A college degree is important for obtaining high paying jobs and having access to healthcare services.

Within Suburban's CBSA, the percentage of individuals holding higher education degrees is slightly higher than the County. However, a closer look at the individual zip codes in the CBSA highlights zip code 20877 (Gaithersburg) as having the lowest (34.3%) and 20817 (Potomac) having the highest rate of individuals with a Bachelor's Degree.[6] **See figure 3** for a comparison of college degree attainment across the CBSA zip codes.

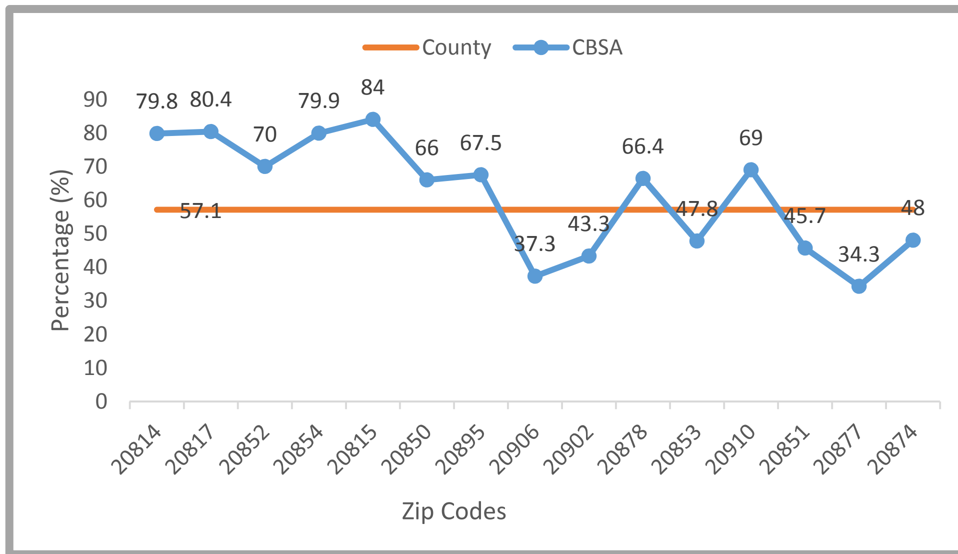


Figure 3. Percentage of people age 25 and over with a Bachelor's Degree

Healthcare Access

Whereas 87.2% of the population in Montgomery County is insured, 14.8% of residents rely on public health coverage. A closer look at the uninsured population (9.7%) reveals that an individual in the 18-34 age group is most likely to be uninsured (19.3%) followed by the 35-64 age group (10.9%). These numbers, however, have decreased in the past three years.[5]

Uninsured individuals make up 3.61% of Suburban's total CBSA population, less than the County average. Within Suburban's CBSA, individuals living in zip code 20854 (Potomac) are most likely to be insured. In comparison, residents in 20906 (Silver Spring) and 20877 (Gaithersburg) have the highest percentage of uninsured residents in Suburban's CBSA, with rates of 6.14% and 5.22% respectively.[3] **See Appendix B for 2015 Insurance Coverage Estimates for Suburban Hospital's CBSA.**

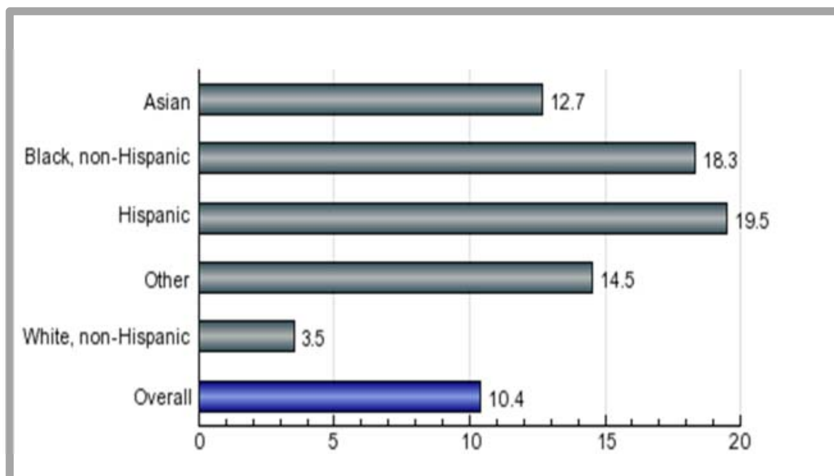


Figure 4. Adults Unable to Afford to See a Doctor by Race/Ethnicity

Source: Healthy Montgomery, 2014

People who do not have insurance and are unable to afford to see a doctor may not receive proper and timely medical services when needed. In 2014, 10.4% of the adult population in Montgomery County reported being unable to see a doctor in the past 12 months. This number decreased by 3% since 2011.[5] When accessing care, there is a significant variation among the racial/ethnic groups. In Montgomery County, Hispanics/Latinos (19.5%) and Black non-Hispanics (18.3%) continue to be the major race/ethnic groups most affected by the inability to afford to see a doctor.[5] **See Figure 4**.

5 SUBURBAN HOSPITAL'S APPROACH TO COMMUNITY HEALTH NEEDS ASSESSMENT

To effectively identify and prioritize health needs for Montgomery County residents, Suburban Hospital implemented a three-part process to execute its Community Health Needs Assessment: (1) Engage health experts and key stakeholders, (2) review secondary datasets for core health indicators, and (3) collect primary data via a community health survey. Through this methodology, Suburban ensured optimum collaboration and leverage of resources, reduction of redundancies and support of an ongoing health improvement process and infrastructure.

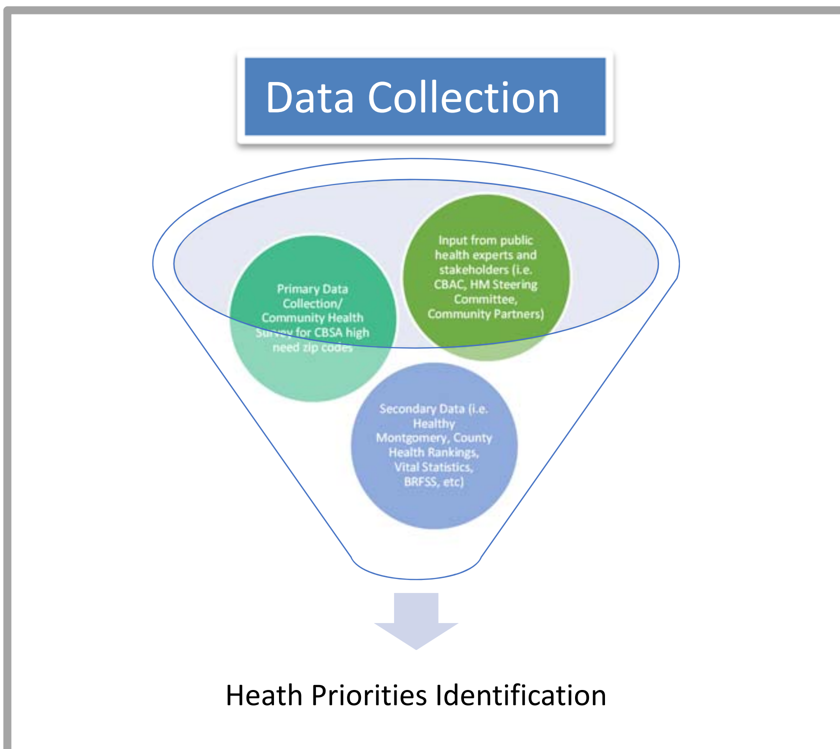


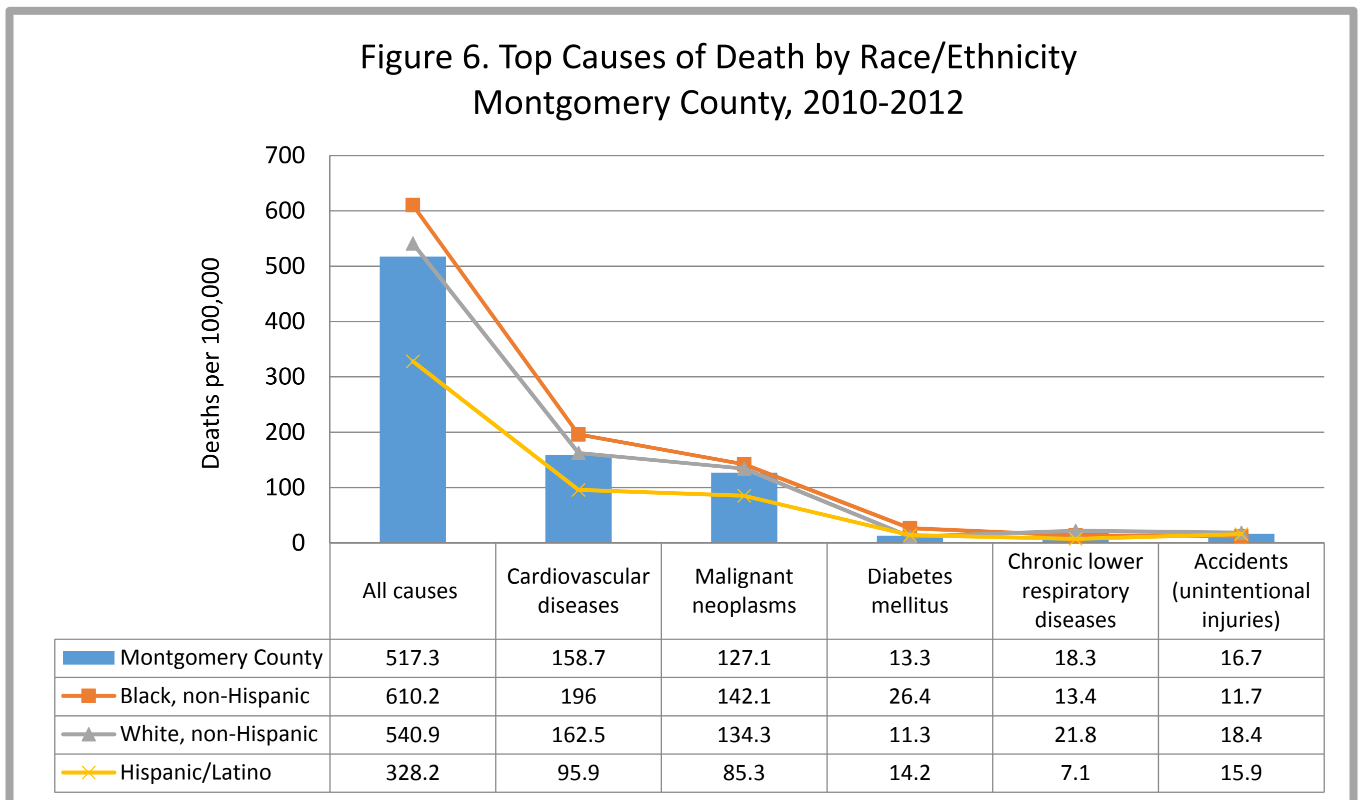
Figure 5. Suburban Hospital's Data Assessment Process.

Health Outcomes

Top Leading Causes of Death in Montgomery County

The chances of pre-mature death in Montgomery County (3,500 per 100,000) is low compared to the state of Maryland (6,400 per 100,000) and that of all the other counties that make up the state.[2] Most recent data for Montgomery County reports 517.3 total deaths per 100,000 population. Cardiovascular disease (158.7 per 100,000) continues to be the leading cause of death for Montgomery County residents, followed by malignant neoplasms (127.1 per 100,000), and chronic lower respiratory diseases (18.3 per 100,000).[9] **See Appendix C for a list of the top ten causes of death in Montgomery County**.

Data Montgomery, the County's portal to direct access to a variety of datasets, reveals that cardiovascular diseases and malignant neoplasms (cancer) were the top two main causes of mortality in Montgomery County for White non-Hispanics, Black non-Hispanics, and Hispanic/Latinos between 2012-2012. Differences in disease prevalence are seen outside these top two conditions, where the third leading cause of death for Black non-Hispanics is diabetes (26.4 per 100,000), accidents for Hispanics/Latinos (15.9 per 100,000), and chronic lower respiratory disease for White non-Hispanics (21.8 per 100,000).[9] See Figure 6.



	All causes	Cardiovascular diseases	Malignant neoplasms	Diabetes mellitus	Chronic lower respiratory diseases	Accidents (unintentional injuries)
Montgomery County	517.3	158.7	127.1	13.3	18.3	16.7
Black, non-Hispanic	610.2	196	142.1	26.4	13.4	11.7
White, non-Hispanic	540.9	162.5	134.3	11.3	21.8	18.4
Hispanic/Latino	328.2	95.9	85.3	14.2	7.1	15.9

Source: Data Montgomery

[9] (Population Health Measures: Age-Adjusted Mortality Rates, n.d.)

Cardiovascular disease

Cardiovascular disease, or CVD, is not a single disease, it is but an umbrella term for multiple conditions that involve narrowing or blockage of the blood vessels of the heart, the brain, and the 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. Most forms of CVD include coronary heart disease and cerebrovascular disease. There are several risk factors associated with CVD. Some of these are: diabetes, hypertension, high cholesterol, obesity, smoking, alcohol use, poor diet and inactivity. Due to the complexity of this disease, it can incur higher health care costs.

Coronary heart disease is also known as heart disease. Over the years, the age-adjusted death rate due to heart disease has slowly decreased in Montgomery County. In fact, the mortality rate in Montgomery County (108.0 deaths per 100,000) is lower than the state of Maryland (172.8 death per 100,000).[9,10] Although this condition is not gender specific, men are more likely to die from heart disease than women. When comparing different races and ethnicities, Black non-Hispanics have the highest number of deaths associated with this health condition.[9] **See Figure 7.**

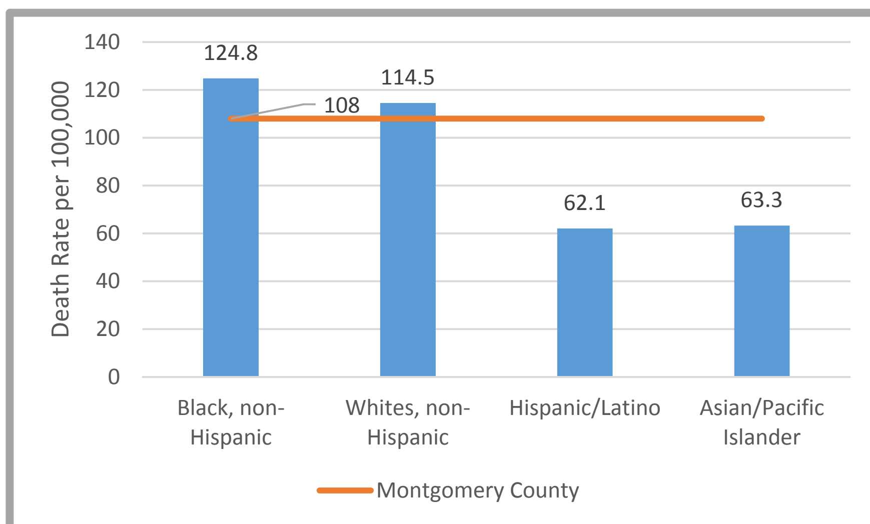


Figure 7. Age-Adjusted Death Rate per 100,000 due to Heart Disease by Race/Ethnicity.

Source: National Center for Health Statistics, 2011-2013

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 25.6 deaths per 100,000 population. Cerebrovascular death rates tend to be slightly higher for Black non-Hispanics (27.3 per 100,000) than for White non-Hispanics (25.0 per 100,000). Hispanics/Latinos (20.7 per 100,000) have the lowest rate of deaths attributed to cerebrovascular disease.[10]

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. As of 2013, 38.1% of Montgomery County residents were reported to have high cholesterol. High cholesterol is more common among those 65 and over (55.3%), followed by 45-64 years (44.8%), and 18-44 years (21.6%) age groups.[6] High blood pressure is present

[10] (National Center for Health Statistics, 2011-2013)

in 27.7% of County residents. Although 61.1% of those with high blood pressure are age 65 and over, this condition is also present in younger age groups: 18-44 years (9.0%) and 45-64 years (34.1%).[5] Males are more likely than women to suffer from higher cholesterol and hypertension.

Malignant Neoplasms (Cancer)

Malignant neoplasms, or cancer, is a group of diseases characterized by uncontrolled growth and spread of abnormal cells. If the spread is not controlled, it can result in death. A person's risk for developing cancer can be lowered by avoiding certain risk factors such as tobacco use, lack of physical activity, and high-fat/low fiber diets. In addition, prevention or delayed onset of cancer can 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.

Cancer ranks as the second leading cause of death in Montgomery County for both men and women. The baseline for age-adjusted cancer rates is less in Montgomery County (127.1 per 100,000) than in Maryland (160.9 per 100,000) and the National rate (163.2).[10] According to Data Montgomery, cancer related deaths are more common in Black non-Hispanics (142.1 per 100,000) than other racial/ethnic minorities.[9] Men are more likely to die of cancer (142.7 per 100,000) than women (110.9 per 100,000).[5]

Table 4. Montgomery County Age-Adjusted Death Rate due to Specific Cancer Type

Cancer Type	Rate per 100,000
Breast	18.8
Colorectal	9.7
Lung	25.9
Prostate	16.7

Source: Healthy Montgomery, 2008-2012

When looking at specific types of cancers, there are disparities among the various racial/ethnic groups. Breast cancer is the leading cause of cancer deaths among women. However, Black non-Hispanic women die more frequently from breast cancer than any other racial group. Recent Montgomery County data show that 27.1 per 100,000 Black non-Hispanic women died of breast cancer compared to 18.4 per 100,000 White non-Hispanic women. Hispanics/Latinas (7.4 per 100,000) and Asian and Pacific Islander (8.4 per 100,000) women have the lowest mortality rate from breast cancer.[5]

Colorectal cancer ranks fourth in cancer related deaths. The age-adjusted death rate due to colorectal cancer in Montgomery County is 9.7 deaths per 100,000 population. More men (11.3 per 100,000) than women (8.6 per 100,000) die from this disease, even though both groups get screened at almost equal rates. In Montgomery County, more Black non-Hispanics (13.2 per 100,000) die from colorectal cancer than White non-Hispanics (9.1 per 100,000) and Asian/Pacific Islanders (9.7 per 100,000). Hispanics/Latinos (7.5 per 100,000) have the lowest reported death rate in the County for this cancer. [6]

Prostate cancer is the most common type of cancer in men. The age-adjusted death rate due to prostate cancer is 16.7 deaths per 100,000 males. Prostate cancer claims more Black non-Hispanics (28.1 per 100,000) lives than

colorectal cancer and is more common in this group than in White non-Hispanic men (16.7 per 100,000). County level data is unavailable for the Hispanic and Asian/Pacific Islander population.[6]

At the national level and in Montgomery County, lung cancer claims more lives than any other cancer. Although the mortality rate due to lung cancer among men has reached a plateau, the rate in women continues to rise. Lung cancer mortality is high for both Black non-Hispanics (30.9 per 100,000) and White non-Hispanic (26.5 per 100,000). According to available data, Asian/Pacific Islanders have an age-adjusted death rate of 18.2 per 100,000 due to lung cancer while Hispanics/Latinos have the lowest rate (11.1 per 100,000) compared to all other groups.[6]

Chronic Lower Respiratory Diseases

Chronic lower respiratory diseases (CLRD) refers to a group of conditions that affect the lungs. Currently, 6.8 million of adults in the US suffer from a type of CLRD. In Montgomery County, the age-adjusted death rate for CLRD is 18.3 per 100,000 – a decrease from previous years.[9] The most deadly CLRD is chronic obstructive pulmonary disease (COPD) which makes it difficult for an individual to breathe. Asthma, chronic bronchitis, and emphysema are the most common forms of COPD. Asthma accounted for 34.3 per 10,000 emergency room visits in 2011 and the age-adjusted hospitalization rate was 8.4 per 10,000 (2009-2011). [5]

COPD is more common among those 65 and older. Cigarette smoking has been identified as the main cause of COPD, but other factors such as air pollutants, genetics, and respiratory infections can contribute to the development of COPD.[11] In 2004, the healthcare expenditure for COPD reached over $20 billion. The average annual age-adjusted hospitalization rate due to COPD is 9.1 per 100,000 in Montgomery County (2009-2011).[5]

See Appendix C for mortality and morbidity rates by race and ethnicity for Montgomery County's leading causes of death.

Healthy Montgomery Core Measures Set

In 2013, through a multi-sectorial collaborative of local data experts, Healthy Montgomery identified a set of 37 community indicators that would represent the six health priority areas identified through the 2011 county-wide community health needs assessments. The six health priorities were: behavioral health, obesity, cancer, cardiovascular health, diabetes, and maternal and infant health. The 37 core indicators aim to capture key social determinant measures, help highlight areas of disparities and inequities, include metrics that are part of the Maryland State Health Improvement Process, Robert Wood Johnson's County Health ranking, and the national Healthy People 2020 Benchmarks. Furthermore, the 37 core measures presented in **Figure 6** allows planners, policy makers, and community members to establish common benchmarks and tracks progress towards important health and quality of life indicators.[6]

The 37 core indicators and their corresponding datasets are monitored and publicly available through Montgomery County's population-based database at www.healthymontgomery.org. The 37 core indicators serve as a systematic and quantitative source for comparing severity and improvement across the identified health priorities for Montgomery County. With the assistance of Montgomery County Department of Health and Human Services

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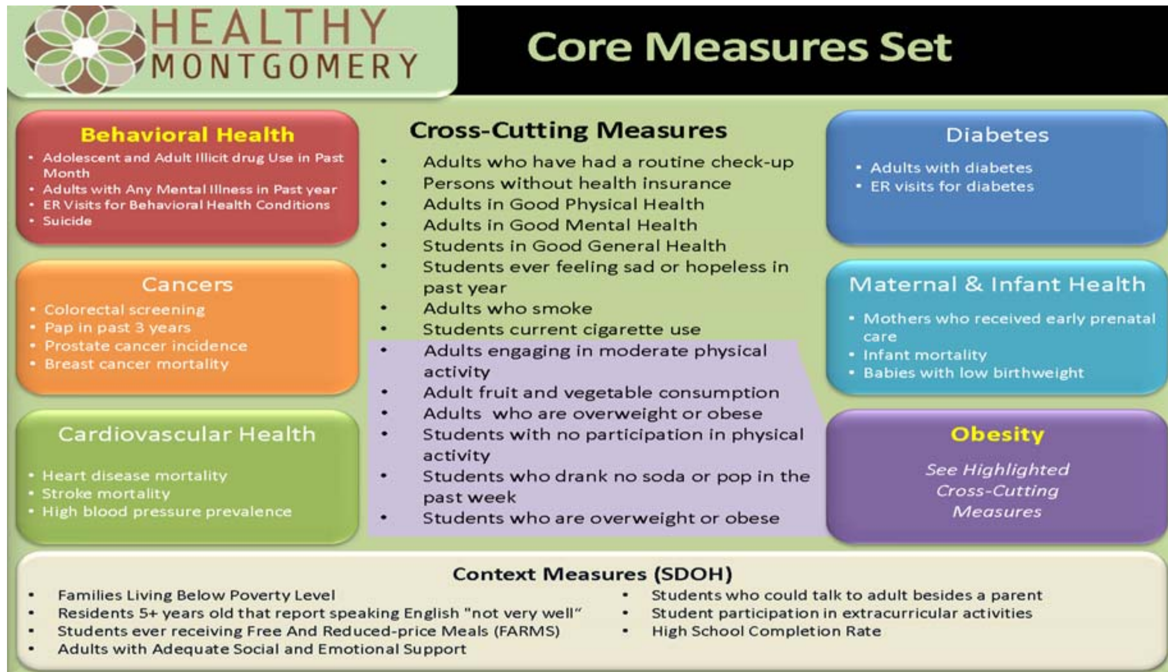
[11] (Centers for Disease Control and Prevention, 2015)

(DHHS), key core measures were analyzed and processed for all six Montgomery County hospitals' community benefit service areas, including Suburban Hospital. Therefore, these indicators and their available datasets were adopted as a source for secondary data for Suburban's CHNA. **See Appendix D for an analysis of Core Measure Indicators for Suburban Hospital's CBSA.**

Figure 8. Healthy Montgomery Core Measure Indicators



Data Gaps/Limitations Identified

The Healthy Montgomery website was utilized as the main data 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 Community Benefit Service Area zip codes.

Top Inpatient Diagnoses at Suburban Hospital

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.[12] Suburban Hospital's top causes of hospitalizations, based on APR-DRG, for the past three years are reported in **Table 5**.

Suburban Hospital is distinguished as 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 most common reasons for hospitalizations at Suburban is a reflection of the causes of morbidity in users and Suburban's area of medical expertise.

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

APRDRG	APR-DRG Description	2013	2014	2015
302	KNEE JOINT REPLACEMENT	780	864	1049
720	SEPTICEMIA & DISSEMINATED INFECTIONS	592	745	920
301	HIP JOINT REPLACEMENT	526	597	755
751	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	572	518	539
753	BIPOLAR DISORDERS	462	455	458
194	HEART FAILURE	359	337	377
139	OTHER PNEUMONIA	354	290	336
45	CVA & PRECEREBRAL OCCLUSION W INFARCT	251	272	321
308	HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT	219	234	260
775	ALCOHOL ABUSE & DEPENDENCE	266	251	242

Source: Suburban Hospital, EPIC 2016

6 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 what the unmet health needs are in communities of greatest need within Suburban's Community Benefit Service Area zip codes through primary data analysis. This process included the development and distributions of a community health survey tool that allowed the collection of direct input from community members residing in Suburban's Community Benefit Service Area (CBSA) high need zip codes. **See Appendix E: Community Health Survey Tool.**

Survey Sample Population Calculation

In 2004, Dignity Health and Truven Health Institute developed the Community Need Index, or CNI, to assist in identifying areas that have greater need than others. CNI scores range from 1 to 5, with the higher the score

[12] (Shafrin, 2012)

reflecting the higher the need. CNI scores are calculated using socioeconomic barriers to health, such as income, cultural, education, insurance and housing. [13]

Suburban understands the importance of prioritizing and effectively distributing hospital resources to communities of greatest need. Suburban's 15 CBSA zip codes were rated using the CNI score system. Seven of the total CBSA zip codes (listed in **Table 6**) were identified to have a CNI score of 2.5 or greater.

Table 6. Suburban's CBSA top CNI score

City	Zip Code	CNI Score	Population Size
North Bethesda	20852	2.6	45,984
Germantown	20874	2.6	61,341
Rockville	20851	3.0	14,815
Silver Spring	20910	3.2	41,070
Wheaton-Glenmont	20902	3.6	51,468
Aspen Hill	20906	3.6	66,892
Gaithersburg	20877	3.8	36,133

To understand the greatest needs and barriers facing the residents of these seven zip codes a quantitative and qualitative community health survey tool was developed. The objective of this survey was to gather community input and perspectives on the following topics:

- Biggest issues or concerns in the community
- Trends relative to demographics, the economy, the health care provider community, and community health status
- Problems people face in obtaining health care and/or social services
- Services lacking in the community
- Barriers and services related to chronic health conditions
- Perceived health risks and benefits
- Recommendations for improving access to care and the health of the community

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[13] (Truven Health Analytics)

Survey Data Collection

The population was sampled randomly, which afforded the best opportunity to gain valuable opinions of residents living in the identified seven zip codes. The survey was distributed throughout diverse locations, such as shopping centers, day laborer sites, public libraries, train and bus stops, food restaurant chains, senior centers, patient waiting room areas at safety-net clinics, and large community events. A team of interviewers was assembled to distribute the self-administered questionnaire and to assist respondents with questions.

The survey distribution period started in March 2015 and reached completion in June of 2015. A total of 427 surveys were collected from more than 25 different locations 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 a primary source of information for behaviors, needs, and opinions about various health and community issues directly affecting Suburban Hospital's seven vulnerable CBSAs.

Health Survey Results

Suburban Hospital community benefit programs target populations residing in 15 specific zip codes in Montgomery County. The 15 Community Benefit Service Area (CBSA) zip codes were rated using the Community Needs Index (CNI) score to determine those communities with the highest need. Seven zip-codes in Suburban's CBSA were identified to have the highest need, with a CNI score of 2.5 or higher. Residents from these seven zip codes were surveyed to understand barriers and drivers to health. The survey results presented serve as an information guide for the behaviors, needs, and opinions about various issues directly affecting those residents in the top seven CBSA zip codes.

Survey Demographics

The survey sample size for specific zip codes was dependent on the population size for that particular zip code. Zip code 20874 had the largest population size while 20851 had the smallest among all seven zip codes. The respondent distribution across the seven zip codes is represented in **Figure 9**.

Survey participation was evenly distributed among females (50%) and males (49%). Respondents reported English (67%) as their preferred language for communication, followed by Spanish (28%), and other (5%) languages such as French, Portuguese, Farsi, and Chinese.

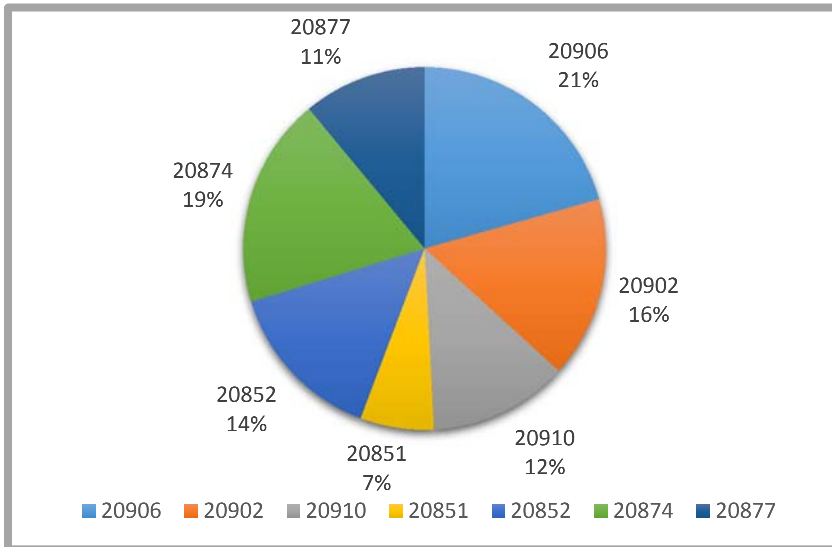


Figure 9: Survey Response by Zip Code

Montgomery County is one of the most diverse counties in the country. The level of diversity was evident at the zip code level, where 74% of respondents were found to be ethnically and racially diverse (**See Figure 10**). Nearly 70% of respondents were under the age of 50 years old.

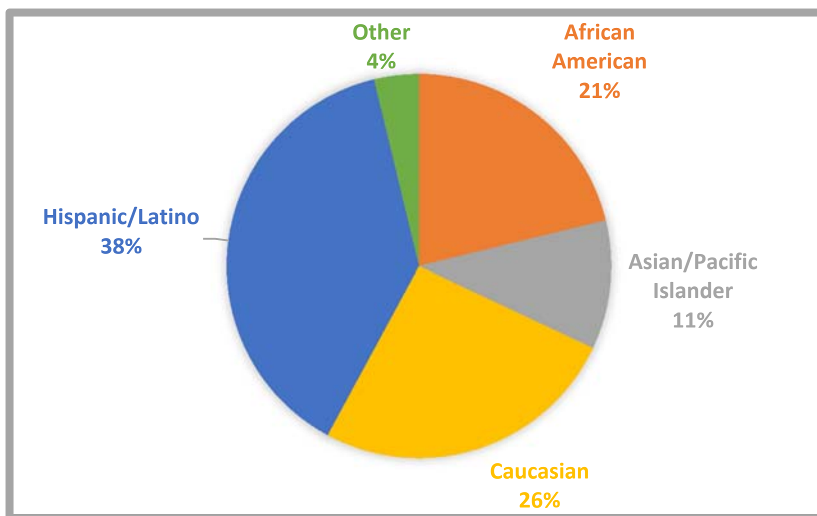


Figure 10. Survey Respondents Race & Ethnicity Distribution

Higher education level attainment has long been linked to better health. According to the Robert Woods Johnson Foundation, college graduates can expect to live five years longer than those who have not completed high school. Furthermore, research shows that adults with limited education levels are more likely to be unemployed, on government assistance, or involved in crime.

The percentage of high school graduates in Montgomery County has slowly increased over the years. Although 89.7% of students graduate from high school, Montgomery County has not reached the 2017 Maryland goal of

95%.[5,14] A Bachelor's degree is correlated with a better life. While 57.4% of residents in Montgomery County hold a Bachelor's degree, American Indians/Alaska Natives (25.7%) and Hispanics/Latinos (25.1%) are reported to have the lowest percent of individuals holding a bachelor's or higher degrees when compared to other racial/ethnic groups.[5] These percentages have increased over the years. Among the sampled population, only 38% of survey respondents reported having a Bachelor's degree or higher (**Figure 11**).

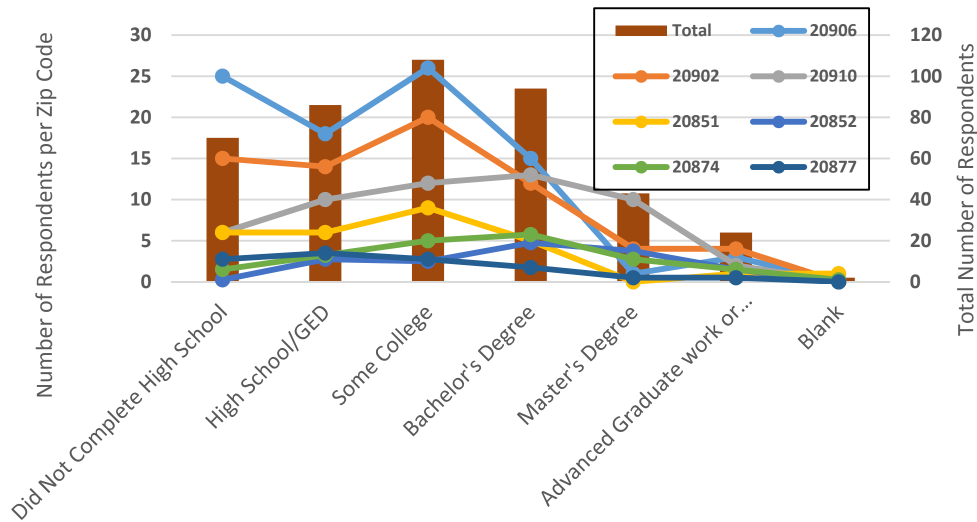


Figure 11: Survey Respondents Highest Level of Education Completed

Health Behaviors

The American Academy of Family Physicians suggests that to improve health, individuals should (among other things) exercise regularly, eat a healthy diet, avoid any form of tobacco, drink alcohol in moderation (if at all) and use a seatbelt when riding in a vehicle.[15] These behaviors have been identified as modifiable risk factors that can improve an individual's health outcome.

Physical Activity. Physical activity has been linked with reducing many serious health conditions including obesity, heart disease, diabetes, colon cancer, and hypertension while improving mood and promoting healthy sleeping patterns. [6] Approximately 52.7% of adults in the County engage in regular physical activity, while 18% report physical inactivity.[2,6]

The 2008 Guidelines for Physical Activity for Americans define moderate physical activity as engaging in 150 minutes of aerobic exercise a week plus two or more days of strength training exercises. Survey respondents were asked how often they engage in moderate physical activity (at least 2.5 hours per week) outside of work. Exercise frequency was common among respondents. Thirty-six percent reported "always" exercising the recommended

[14] (Montgomery Maryland State Health Improvement Process, 2014)

[15] (America's Health Ranking Report, 2012)

amount, 52% "often" and/or "occasionally," and 12% "never." Altogether 64% of the sampled population does not always obtain the recommended amount of exercise. **See Figure 12.**

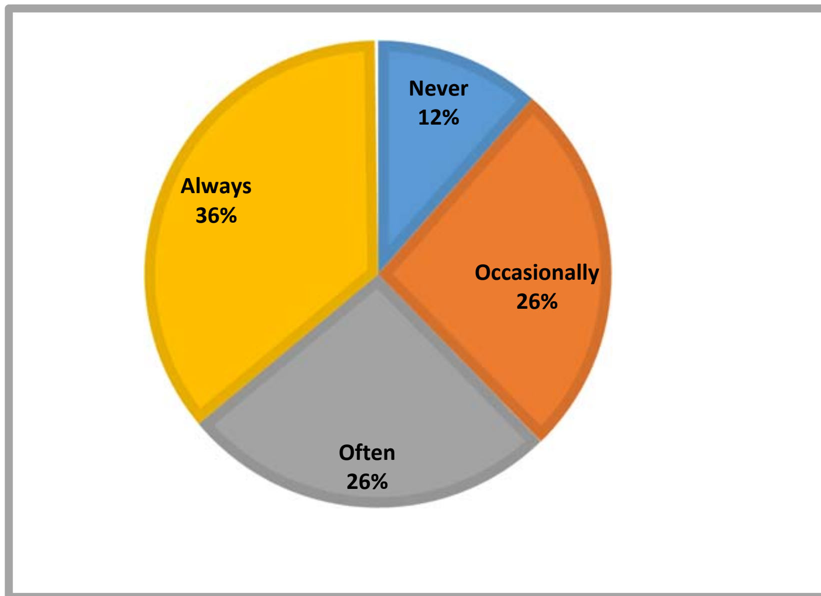


Figure 12. Survey Respondents Exercise Frequency.

Fruit and Vegetable Consumption. Only 29.6% of adults in Montgomery County consume the recommended five or more servings of fruits and vegetables a day according to the Behavioral Risk Factor Surveillance System (BRFSS).[6] In order to maintain a healthy weight and prevent chronic disease, numerous studies have shown that consuming vegetables and fruits in large quantities and varieties can decrease the risk of disease.

Survey respondents were asked to assess their frequency of fruits and vegetables consumption. One serving of fruit/vegetable is approximately equal to one-half cup. While 93% of respondents were found to consume fruits and vegetables, the frequency of consumption was not optimal. Consistent with the entire County, less than 30% of respondents were found to always consume the recommended portion and quantity of fruits and vegetables. **See Figure 13.**

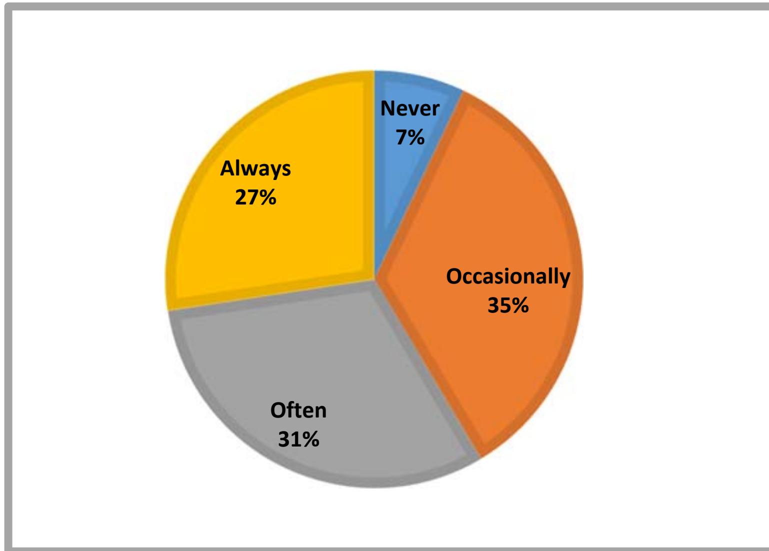


Figure 13. Survey Respondents Fruit and Vegetable Consumption

Tobacco. In Montgomery County, 7.9 % of the adult population currently smokes or smokes most days (2014).[14] Usage of tobacco products is linked with poor health outcomes, including pre-mature death. Respondents were asked how often they use tobacco products such as cigarettes, smokeless tobacco, cigars, and pipes. **Figure 14** demonstrates that 82% of respondents do not use tobacco products while 18% reported using some form of tobacco products- almost 2.5 times as many in the general county population).

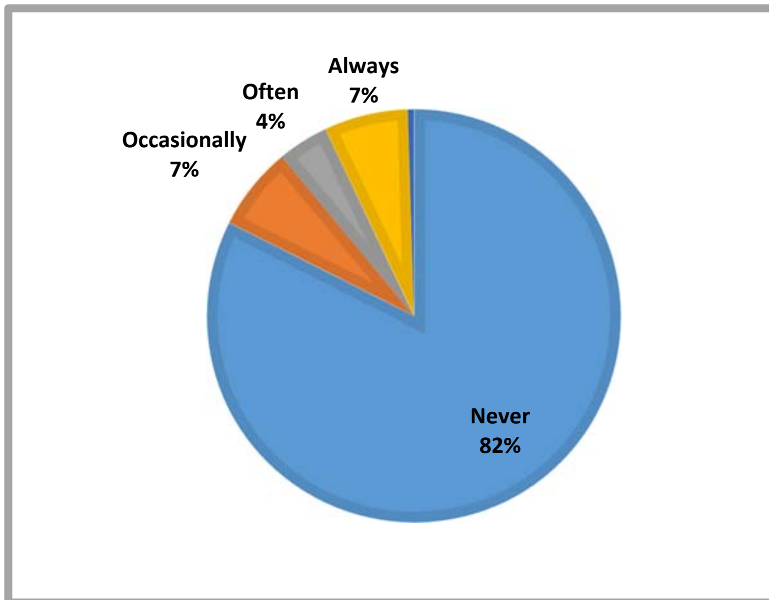


Figure 14. Survey Respondents Tobacco Use

Alcohol Consumption. Excessive drinking, defined as consumption of five or more alcoholic beverages at one occasion, is a serious problem and can lead to deadly consequences. A recommended moderate consumption of alcohol is equal to one drink a day for women and up to two drinks for men. Generally, anything greater than

moderate drinking can be harmful to one's health. The rate at the County level (15%) for excessive drinking is lower than the State (17%).[2] When asked if they consume more than five alcoholic drinks a week (beer, liquor, wine), 70% of respondents self-reported never exceeding this quantity. However, the rate of consumption was found to be twice as high as the overall County. **See Figure 15.**

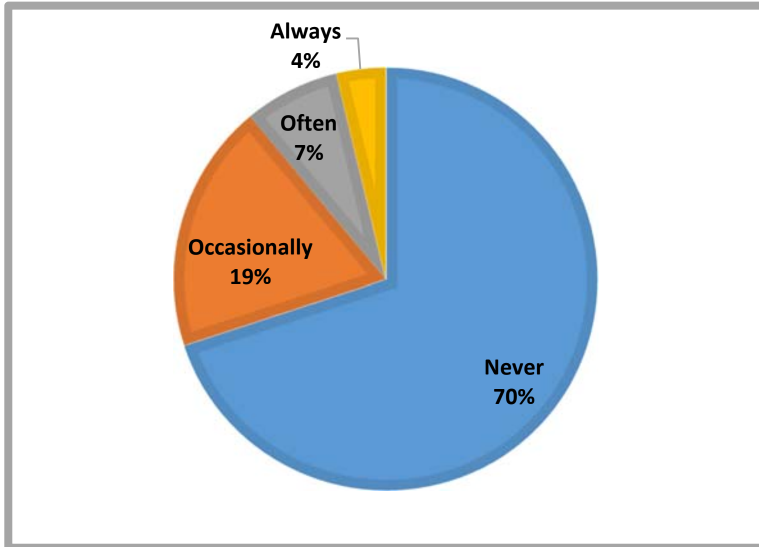


Figure 15. Survey Respondents Alcohol Consumption

Seatbelt Usage. The County's age-adjusted death rate due to motor vehicle collisions is 6.4 per 100,000 population.[6] Statistics demonstrate that seatbelt use helps save lives and prevent serious injury. When assessing seatbelt usage while traveling in a vehicle, more than 90% of respondents were found to wear their seatbelt at all times. The small percentage of participants that selected "never" as a response were individuals that used public transportation as their only source of transportation. Seatbelts are not made available in public buses or subways serving the Montgomery County area. **See Figure 16.**

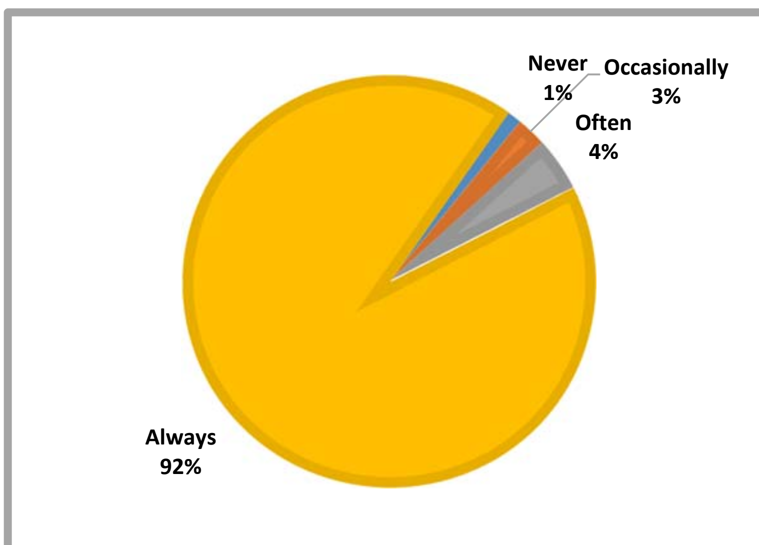


Figure 16. Survey Respondents Seatbelt Use

Stress Management. High levels of stress can lead to serious health problems. Effective stress management can reduce these negative impacts. Among those surveyed, 94% of respondents were found to be able to manage and control their stress. However, only 30% of individuals reported being able to manage their stress all the time, compared to those who are able to manage it often (49%) and occasionally (15%). **See Figure 17.**

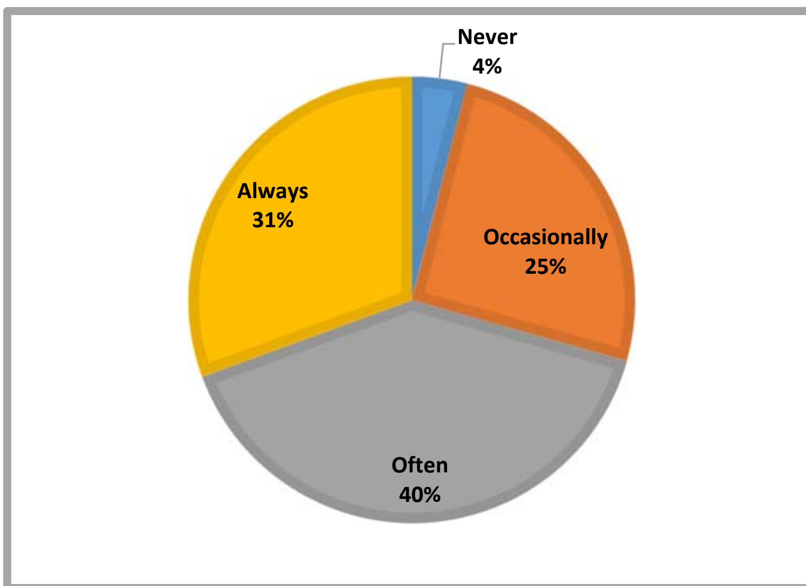


Figure 17. Survey Respondents Stress Management

Self-Reported Areas of Behavior Modification. A person's perceived health benefit serves as an indicator of a person's willingness to adapt secondary prevention behaviors and an assessment of how valuable the adaptation of a new behavior is to the person in decreasing their risk for developing a disease.[16] To assess perceived health benefit, respondents were asked to select an area of their health that needed the most improvement. Close to 90% of respondents indicated that they needed to improve certain health behaviors, with 35% indicating that physical activity was their top-rated area for behavior modification. Healthy eating and stress management were also listed as areas needing attention. **See Figure 18.**

[16] Jones and Bartlett Publishers. Health Belief Model, Chapter 4

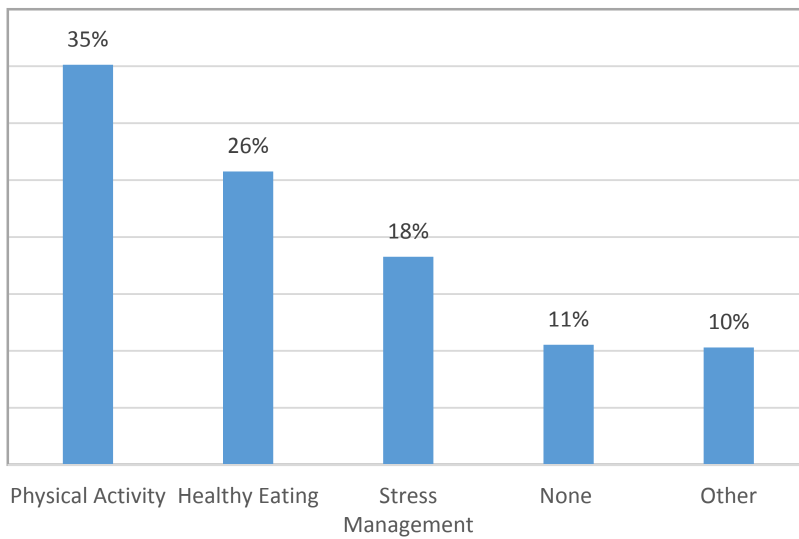


Figure 18. Self-Reported Areas of Behavior Modification by Survey Respondents

Health Priorities

Respondents were asked to rate their top five health concerns. Participants were given 13 different options to choose from, plus an option to write an open response. **Figure 19** presents the top five health concerns for the sample population, which are: diabetes/sugar (32%), high blood pressure/stroke (31%), cancer (26%), heart disease (25%), and overweight/obesity (20%).

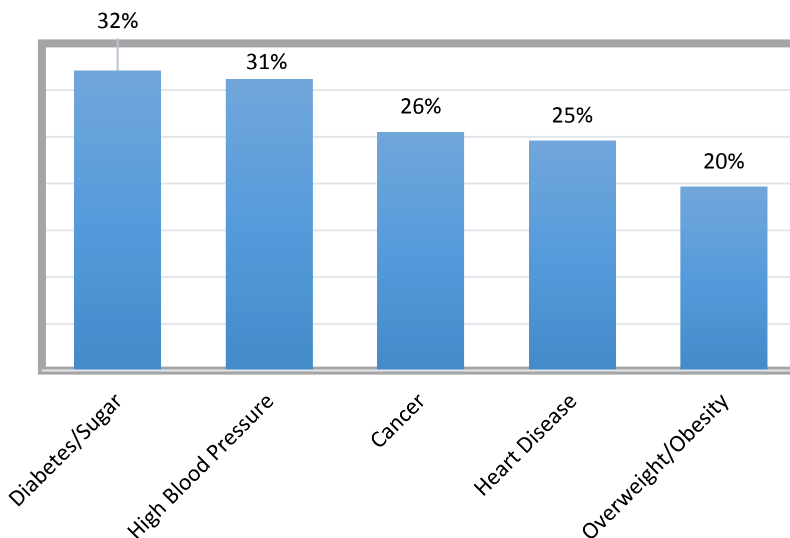


Figure 19: Top Five Health Concerns among Survey Respondents

Perceived risk is used to assess the likelihood to adopt a positive behavior to decrease one's risk. Participants were asked to assess their risk for developing a health condition. Sixty-five percent of respondents felt at risk for developing a health condition while 33% did not feel any risk. Diabetes (18%) was at the top of the list, followed by cancer (14%) and heart disease (14%). **See Figure 20.**

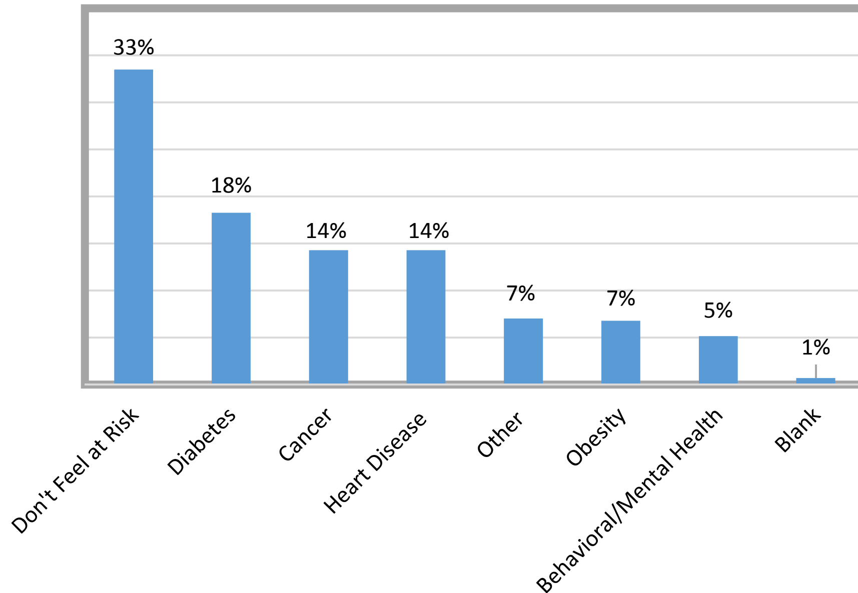


Figure 20. Perceived Health Risk among Survey Respondents

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. The majority of surveyed individuals reported to either have good (55%) or fair (22%) health status. A small percentage (4%) reported having fair or poor health status. At the County level, 10% of the adult population reported poor or fair health status.[2] **See Figure 21.**

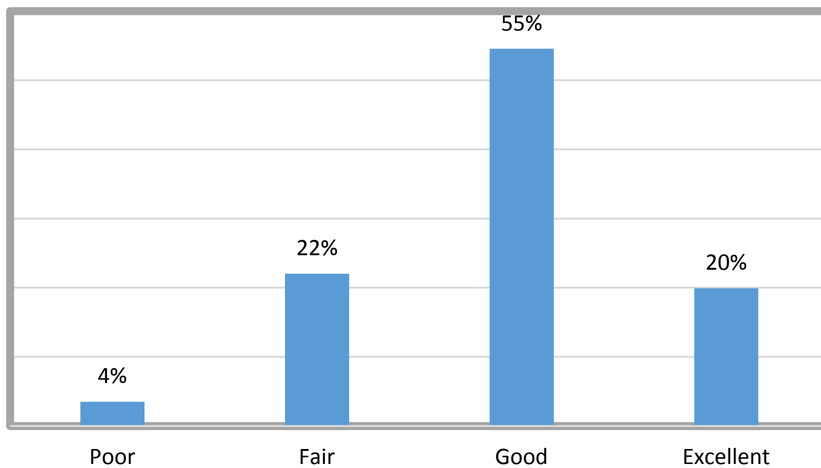


Figure 21. Survey Respondents Health Status

Health Barriers

Respondents were asked to share the barriers keeping them from getting the health care they need. Participants were given 10 different options to choose from plus an option to write an open response. **Figure 22** presents the top five barriers to health as reported by respondents. Cost (28%) was found to be the single most important barrier to health followed by lack of health insurance (18%), time (17%), and information (11%). However, 42% of participants stated they had no barriers preventing them from getting the care they need.

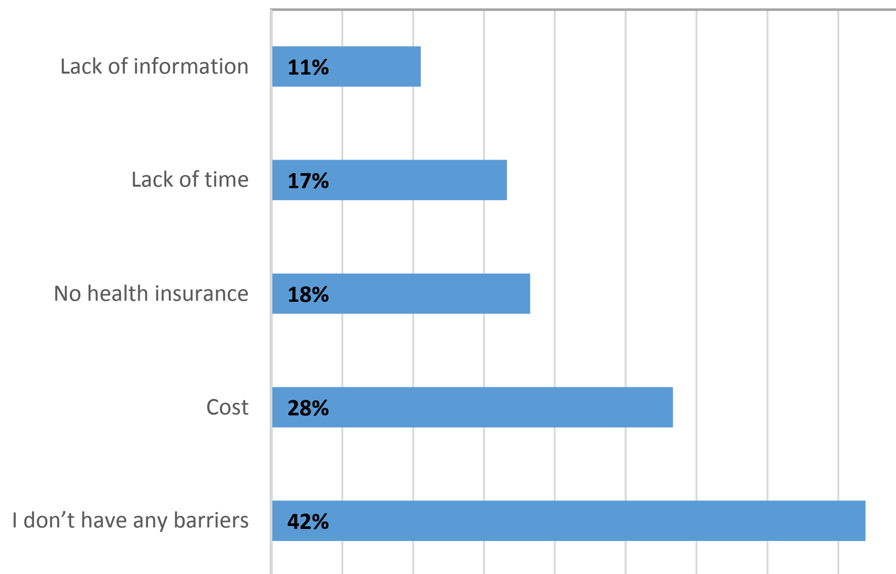


Figure 22. Survey Respondents Top Barriers to Better Health

7 SELECTING PRIORITIES

Identified Health Priorities

Suburban hospital began its priority setting process by identifying the main health issues affecting the community. The public health data previously presented was reviewed and used to assess the magnitude of top health problems in Montgomery County (i.e. causes of morbidity and mortality). The results from the community surveys helped to assess what common health conditions were of most importance to vulnerable residents in Suburban's CBSA. These findings were compared with Suburban's areas of medical expertise and current health improvement programs. Due to Suburban's active participation in the County's health improvement process -Healthy Montgomery- the County-wide six health priorities were also taken into consideration in the priority identification process. The outcome is a comprehensive list containing the top 10 health issues for Montgomery County, particularly Suburban Hospital's community benefit service area. **See Table 7. Health Needs Facing Suburban's Community.**

Table 7. Health Needs Facing Suburban's Community

	Primary Data (Community Input & Inpatient Diagnosis)	Secondary Data (County, National, & state Datasets)	Suburban Hospital's Medical Specialties	Suburban Hospital's Health Improvement Programs Programming	Healthy Montgomery Health Priorities
Cardiovascular diseases	√	√	√	√	√
Cancer	√	√	√	√	√
Diabetes mellitus	√	√		√	√
Chronic Lower Respiratory Diseases (CLRD)	√				
Accidents (unintentional injuries)	√		√		
Obesity		√		√	√
Behavioral Health	√	√	√	√	√
Maternal & Infant Health					√
Hypertension		√		√	
Dental		√			

Health Priority Setting

Suburban Hospital engaged in prioritization activities and discussions to align identified preliminary health needs with County-wide goals that would have a positive impact on the health of Montgomery County residents. The process included leading community conversations with key stakeholders to not only share findings from the multiple datasets, but also to include and align recommendations. Key stakeholders included member's from Suburban Hospital's Health Advisory Council, the United Way Regional Advisory Council, and Suburban's Patient and Family Education Committee.

In 2011, Suburban Hospital identified the need to establish an Advisory Council that would guide and participate in the planning, development and implementation of programs and activities for the improvement of health in the community served by Suburban Hospital. In June 2012, the hospital held its first Community Benefit Advisory Council (CBAC) meeting. Chartered by the hospital's Board of Trustees and chaired by a trustee, the Advisory Council is comprised of a diverse group of local businesses, non-for-profit executives and community advocacy leaders who represent the perspective of the County's medically underserved, low-income and racially/ethnically diverse populations. The Council represents diverse sectors of the Suburban Hospital service area and acts as a liaison between the community and the hospital to identify health improvement opportunities and needs.

The Council played a critical role in the development of the community health needs assessment process, particularly in the prioritization process. Their role included providing a voice and insight into the needs of the community, and analyzing needs assessment data and community assets. In addition to the expertise contributed by the Council, Suburban Hospital's Community Health and Wellness (CHW) Department served as a key player in shaping the CHNA process by integrating public health knowledge, principles and expertise. The CHW Department acted as a public

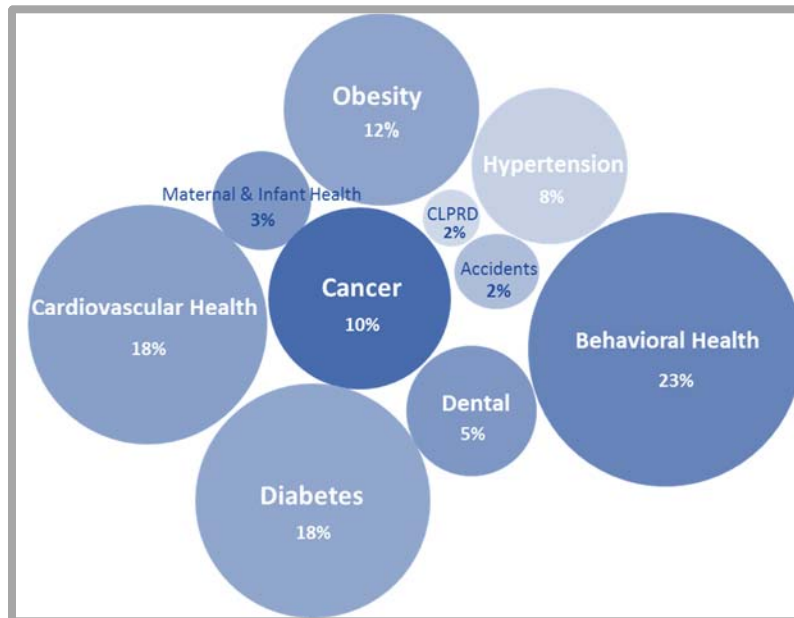
health resource and guide, due in part to the educational background of the staff, and the strong relationships built in the community and firsthand knowledge of the major health concerns, barriers and needs.

The Montgomery County United Way Regional Council (MCUWRC) consists of volunteers from business, public, and nonprofit sectors in the County. Regional Council members serve as representatives of their community by providing advice about unique situations and needs. Moreover, the Council oversees the allocation of the United Way's Community Impact Fund grant for Montgomery County.

The Patient and Family Education Committee serves in an advisory capacity and as a resource for the staff of Suburban Hospital. The committee is responsible for the development of facility-wide patient and family education goals and plans and performs the following functions: assists in identifying facility-wide patient education needs and establishing priorities, reviews patient education materials (print, audiovisual, etc.) for quality and suitability for Suburban's patient population, and advises departments on how to obtain or develop educationally sound patient education materials. (**See Appendix G: Community Benefit Advisory Council, Montgomery County United Way Regional council, and Patient and Family Education Committee members)**

As prominent members of Montgomery County, members of the CBAC, MCURC, and Patient and Family Education Committee participated in the health need prioritization process, which involved extensive discussion and a vote to help rank essential health issues in the community. The results from the voting process is represented in **Figure 23**.

Figure 23. Ranking of Identified health Needs



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 five health priorities for Montgomery County. The five official health priorities to be tracked, measured and evaluated over the next three years are presented below in no particular order:

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

These five health priorities overlap or align with national, state, and local priorities (see Table 8) as well as Suburban's 2013 CHNA findings. This relationship affords Suburban Hospital the ability to parallel its community health improvement efforts to existing actions in order to decrease health inequities, lack of access and unhealthy behaviors.

Table 8. Comparison of Federal, State, and Local Health Priorities

Healthy People 2020: Leading Health Indicators	Maryland State Health Improvement Plan 2017 (SHIP)	Healthy Montgomery 2013
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, 2016

8 IMPLEMENTATION STRATEGY

Addressed Needs and Implementation Plan

In working with the Montgomery County Department of Health and Human Services and addressing shared health priorities, Suburban Hospital's Board of Trustees, President and CEO, and the organization's operations executive and leadership team will work thoroughly to ensure that the hospital's strategic and clinical goals are aligned with these five official health priorities: **behavioral health, obesity, diabetes, cancer, and cardiovascular health**. See Table 9.

Furthermore, Suburban Hospital will aim to influence the decision making process and prioritization of Suburban Hospital's community benefit activities through the planning, monitoring and evaluation of unmet community needs over the next three years. Suburban Hospital's commitment to improving the health and well-being of the community will be demonstrated through the deliberate planning of health education initiatives and screenings; providing financial and in-kind support to community clinics and programming of wellness activities that directly align with our 2016 needs assessment and identified social determinants of health. Collaboration with several key partnerships, coalition committees, non-profit organizations, corporations, institutes and county government will be instrumental in leveraging resources to ensure that all stakeholders are engaged. Suburban Hospital's annual *Community Benefit* report and the *2016 Implementation Strategy* report, both available through Suburban Hospital's website, will serve to guide and document progress for the identified five health priorities over the next three years.

Table 9. Suburban Hospital's Top 5 Health Priorities

↓ A decrease in rate since 2013 CHNA report
↑ An increase in rate since 2013 CHNA report

Hospital Priority	Behavioral Health
Quantitative Reason	– ↑ 1791.7 per 100,000 population have used a hospital ED for a behavioral health condition (2014)[14] – ↓ 16.7% of Montgomery County residents report not having adequate social and emotional support (2010) [6] – ↑ 80.4% of residents self-reported experiencing two or fewer days of poor mental health in the past month (2014)[6] – The average number of mentally unhealthy days reported over a 30-day period is 2.6 (2006-2012) [14] – ↓ 15.0% of Montgomery County adult residents use alcohol in excess and 7.9% smoke (2020-2012)[2,6]
Qualitative Reason	– Suburban Hospital's Advisory Council unanimously voted mental health as a top health priority for Montgomery County – 5 % of Community Input Survey respondents reported mental health problems to be a top health concern for them – Only 31% of Community Input Survey respondents reported being able to "Always" manage their stress

Hospital Initiatives	– 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
Alignment with local, regional, state, or national goals	– Healthy People 2020 Goal: Mental Health & Mental Disorders – Maryland State Health Improvement Plan 2017: Qualitative Preventive Care Measures (2 of 39 indicators) – Montgomery County Healthy Montgomery Health Priority: Behavioral Health
Hospital Priority	**Obesity**
Quantitative Reason	– ↑ 57.4% of adults in Montgomery County are obese or overweight (2013)[14] – ↓ 7.1% of children's and adolescents in Montgomery County are reported to be obese and only 52.7% of adults report getting the recommended amount of physical activity (2013)[6,14] – The food environment index (factors that contribute to a healthy food environment) for Montgomery County is 9.2 out of 10 (2015) [2]
Qualitative Reason	– 20% of Community Input Survey respondents reported overweight/obesity to be a top health concern for them – 27% of Community Input Survey respondents reported "Always" consuming five servings of fruits and vegetables – 36% of Community Input Survey respondents reported "Always" engaging in moderate physical activity outside of work at least 20 to 30 minutes for a minimum of 5 days per week
Hospital Initiatives	– 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
Alignment with local, regional, state, or national goals	– Healthy People 2020 Goal: Nutrition & Weight Status – Maryland State Health Improvement Plan 2017: Healthy Living Measures (2 of 39)

	– Montgomery County Healthy Montgomery Health Priority: Obesity
Hospital Priority	**Diabetes**
Quantitative Reason	– ↑ 7.1% of adults in Montgomery County have diabetes (2014)[5] – ↓ The rate of ED visits for diabetes is 95.0 per 100,000 population (2014)[5] – ↑ The age-adjusted death rate due to diabetes is 13.3 per 100,000 population (2010-2012)[5] – ↑ 86% of diabetic Medicare enrollees received HbA1c screening[2] compared to 89% which is the national benchmark (2015)[2] – ↓ 9.7% of adults in Montgomery County do not have health insurance and 10.4% of adults could not afford to see a doctor in a 12-month period (2014)[6]
Qualitative Reason	– 22% of Community Input Survey respondents reported diabetes to be a top health concern for them – 18% of Community Input Survey respondents reported "lack of health insurance" as a barrier to health for themselves and/or others – 28% of Community Input Survey respondents reported cost as a barriers to health for themselves and/or others
Hospital Initiatives	– 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
Alignment with local, regional, state, or national goals	– Healthy People 2020 Goal: Diabetes – Maryland State Health Improvement Plan 2017: Qualitative Preventive Care Measures (1 of 39 indicators) – Montgomery County Healthy Montgomery Health Priority: Diabetes
Hospital Priority	**Cancer**
Quantitative Reason	– ↓ The death rate due to cancer is 127.1 per 100,000 (2011-2013) [6] – ↑ The age-adjusted death rate per 100,000 females due to breast cancer is 18.8 (2008-2012)[6] – ↓ The age-adjusted death rate per 100,000 population due to colorectal cancer is 9.7 (2008-2012)[6] – ↓ The age-adjusted incidence rate for prostate cancer is 137.0 cases per 100,000 males (2008-2012)[6]

	– ↓ 79.5% of women aged 50 and over who have had a mammogram in the past two years (2014)[6] – ↓ 10.4% of adults could not afford to see a doctor in a 12-month period (2014)[6]
Qualitative Reason	– 26% of Community Input Survey respondents reported Cancer to be a top health concern for them – 18% of Community Input Survey respondents reported access to health services to be a top health concern for them
Hospital Initiatives	– 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
Alignment with local, regional, state, or national goals	– Healthy People 2020 Goal: Cancer – Maryland State Health Improvement Plan 2017: Qualitative Preventive Care Measures (1 of 39 of indicators) – Montgomery County Healthy Montgomery Health Priority: Cancer
Hospital Priority	**Cardiovascular Health**
Quantitative Reason	– ↓ The age-adjusted death rate due to heart disease in Montgomery County is 108.0 per 100,000 deaths (2012-2014)[6] – ↑ 141.0 per 100,000 ED visits in Montgomery County hospitals were due to hypertension (2014)[6] – ↑ 27.7% of the adult population in Montgomery County has hypertension and 53.5% of Medicare recipients were treated for hypertension (2013)[6] – ↑ 38.1% of adults who have had their blood cholesterol checked have been told that it was high (2013)[6]
Qualitative Reason	– 25% of Community Input Survey respondents reported heart disease to be a top health concern for them – 31% of Community Input Survey respondents reported hypertension/stroke to be a top health concern for them – 64% of Community Input Survey respondents reported not "always" engaging in the recommended amount of physical activity.
Hospital Initiatives	– 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
Alignment with local, regional, state, or national goals	– Healthy People 2020 Goal: Heart Disease and Stroke – Maryland State Health Improvement Plan 2017: Quality Preventive Care Measures (3 of 39 indicators) – Montgomery County Healthy Montgomery Health Priority: Cardiovascular Health

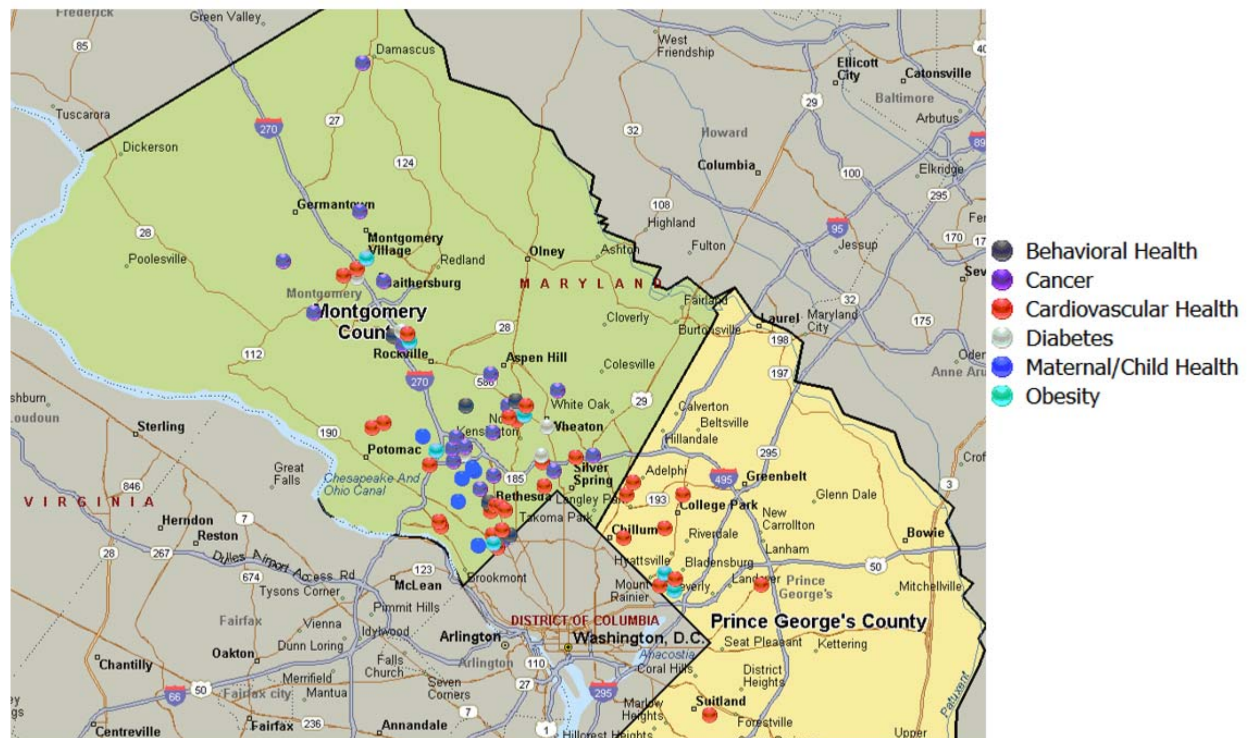
Unaddressed Identified Needs

Suburban Hospital recognizes the importance of supporting needs that are outside the identified five health priorities through innovative leverage of resources with community partners in order to improve health outcomes for Montgomery County residents. As such, Suburban Hospital will continue to work directly - and contingent upon resource availability - with several community centers, organizations, institutes, and corporations, including the AARP, A Wider Circle, Alpha Phi Alpha Fraternity, American Heart Association, American Red Cross, and Bethesda Cares to name a few, to support undressed 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 includes 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 or deliver babies. The reason for not seeking this designation is due to the fact that 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 directly address this health priority, the hospital does and will be able to indirectly support Maternal and Child Health initiatives through funding and programming of several other 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 available to the community's 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 inspire girls to be healthy and confident using running and an experience-based curriculum. The Hospital provides discounted CPR and First Aid training classes to the coaches, purchasing shoes and healthy snacks for students from Title I schools, and providing health tips on Girls on the Run Montgomery County website. The Hospital also provides indirect support to OASIS Montgomery's CATCH Healthy Habits program sponsored through an Amerigroup Foundation grant. CATCH Healthy Habits engages senior adults as mentors to teach children grades K-5 about healthy eating and active living in Montgomery and Prince George's Counties.

Community Assets

Suburban's long-standing commitment to health equity has promoted the design and implementation of best-practice models pertaining to obesity, diabetes, cardiovascular health, cancer, and behavioral health. Suburban Hospital has been addressing these five focus areas for many years and has established programing in Montgomery and Prince George's Counties. In the area of cardiovascular health, for example, Suburban Hospital has 35 recognized sites providing services ranging from blood pressure screenings to health education sessions to provision of specialty care. Figure 24 provides a snapshot, by health need, of the various locations where Suburban Hospital's health improvement programs are held across the County. Health priority specific asset maps for Suburban Hospital sponsored programs is made available in **Appendix H**.



As part of the county-wide community health needs assessment conducted by Healthy Montgomery, the six hospital systems (Shady Grove Adventist, Holy Cross, Holy Cross Germantown, MedStar Montgomery, Suburban, and Washington Adventist) gathered information about existing community resources. **Appendix I** is a compilation resources, programs, funding etc. related to the identified Healthy Montgomery priority issue areas.

9 SUBURBAN HOSPITAL 2013 COMMUNITY HEALTH NEEDS ASSESSMENT EVALUATION

Suburban's initial Community Health Needs Assessment (CHNA) 2013 and Implementation Strategy (IS) were made publicly available through the hospital website on June 1, 2013. A statement accompanied the release of the report soliciting community stakeholder's feedback. Since it was published, the report has been referenced and used a guide internally and externally by various organizations, including Suburban's Cancer Program, Alpha Phi Alpha Fraternity, Healthy Montgomery, and Montgomery County's Senior Connection. To date, no input has been received regarding the content of the 2013 CHNA or the IS.

Health Improvement Measures

We measure progress in the areas of access, health inequities and unhealthy behaviors to assess our progress and generate solutions that promote safe and healthy communities. Suburban Hospital routinely monitors and evaluates the impact of community health improvement efforts in Suburban's Community Benefit Service Area. Program outcomes are shared with the County and State governing bodies, community partners, and program beneficiaries to share knowledge and engage stakeholders. Recently released results for key Suburban Hospital best-practice initiatives are presented in **Table 10**.

Table 10. 2013 Health Priorities Program Outcomes

CARDIOVASCULAR DISEASE	
Identified Need	Cardiovascular Disease; Access to specialty care. Heart disease continues to be the leading cause of death in Montgomery County as the age-adjusted rate in Montgomery County is 108.0 deaths per 100,000 [6] while in Suburban Hospital's CBSA, the age adjusted death rate is 111.7 per 100,000.[17] In addition, 9.7% of residents in Montgomery County do not have any type of health insurance coverage.[7]
Hospital Initiative	MobileMed/NIH Heart Clinic at Suburban Hospital
Primary Objective	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.
Initiative Time Period	Multi-Year; From July 1, 2014 to June 30, 2015, the clinic is opened every Thursday night from 3:30pm-8:00pm in the NIH Heart Center at Suburban Hospital. The clinic has been opened since October 2007.

[17] Montgomery County Department of Health and Human Services, Public Health Services, Planning and Epidemiology Program. "Healthy Montgomery Core Measures Set: Montgomery County and Its Six Montgomery County Hospital Community Benefit Service Areas, 2009-2013 Results."

Key Collaborators in Delivery	Suburban Hospital, MobileMed, Inc., the National Institute of Heart, Lung and Blood (NHLBI), community cardiologists. Physicians, nurses, staff and administrators from the three partners-Suburban Hospital, the National Institute of Heart, Lung and Blood and MobileMed-volunteer their time to staff the cardiovascular clinic.
Impact/Outcome of Hospital Initiative	The clinic is evaluated by: – Number of at-risk patients served documented by their primary diagnosis. – Number of racial and ethnic patients served. Outcomes for FY 15: – In FY 15, there were 502 encounters, with 317 unduplicated patients. The top five conditions treated were: Hypertension (21% of encounters), Unspecified Chest Pain (9%), Coronary Atherosclerosis of Native Coronary Artery (8%), Other Chest pain (7%), and Unspecified Essential Hypertension (6%). The racial breakdown of clinic patients was as follows: 27% Black non-Hispanics, 14% Asian, 14% White non-Hispanic, 35% Other Race, 9% Unreported/Refused to Report, 0.6% Native Hawaiian or Other Pacific Islander. Out of the 317 patients who were treated, 45% reported their Ethnicity as Hispanic/Latino, 3% refused to report. – In comparison to FY14, there was nearly a three-fold increase in the number of patients treated for hypertension (28 in FY 14 vs. 68 in FY 15)
Evaluation of Outcome	The MobileMed/NIH Heart clinic at Suburban Hospital has been in operation since 2007. Over the 8-year period, the clinic has served 3,200 uninsured patients in need of cardiovascular specialty care. These are individuals that would have not received cardiovascular specialty care. During this same period, Suburban has provided more than 10 open-heart surgeries. Each year, the clinic measures its success by the number of patients it serves (short-term goal); effective treatment of the different conditions that put the patients at risk for cardiovascular disease (mid-term goal); and by improving their quality of life while reducing their risk from pre-mature coronary heart disease mortality (long-term goal).
DIABETES	
Identified Need	Diabetes; Access to specialty care. The Montgomery County average age-adjusted ER visit rate due to uncontrolled diabetes is 0.4 per 10,000 population aged 18 years and older. Within Suburban Hospital's CBSA, the age-adjusted rate due to uncontrolled diabetes is 2.9 per 100,000.[17] Nearly 10% of residents in Montgomery County do not have any type of health insurance coverage.[6]
Hospital Initiative	Mobile Med/NIH Endocrine Clinic at Suburban Hospital
Primary Objective	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. The 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, including 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.

	The objective of clinic is two-fold: 1.) Increase access of specialty care to patients who would not otherwise receive care; and 2.) Reduce the incidence of complications due to endocrine diseases including diabetes.
Initiative Time Period	Multi- Year; From July 1, 2014 to June 30, 2015, the clinic was open every Thursday night from 4:00 pm-7:30 pm at the Johns Hopkins Health Care and Surgery Center in Bethesda, MD. The clinic has been open since July 2011.
Key Collaborators in Delivery	Suburban Hospital, MobileMed., Inc., and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). Physicians, nurses, staff and administrators from the three partners-Suburban Hospital, the National Institute of Diabetes and Digestive and Kidney Diseases and MobileMed-volunteer their time to staff the endocrine clinic.
Impact/Outcome of Hospital Initiative	The clinic is evaluated by: – Number of at-risk patients served documented by their primary diagnosis. – Improved health status of patients. – Number of racial and ethnic patients served. Outcomes: – In FY 15, there were 157 unduplicated patients; with 364 encounters. – The clinic continues to see improvements in Hemoglobin A1C (HbA1C) among diabetic patients, as patient's results remain stable or improved slightly in FY 15. The last report number averaged a drop from 8.9% to 7.8% (1.1 point decrease) – Of those 364 encounters, the top five diagnosis are: diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled (22.88% of encounters); goiter (8.50%); thyrotoxicosis (6.54%); diabetes with unspecified complication, type II or unspecified type, uncontrolled (6.54%), and hypothyroidism (5.88%). – The racial breakdown of clinic patients was 33% Black non-Hispanics, 12% Asian, 19% White non-Hispanic, 31% other race, 4% unreported/refused to report. – Of the 157 patients who were treated, 43% reported their ethnicity as Hispanic/Latino.
Evaluation of Outcome	The MobileMed/NIH Endocrine clinic at Suburban Hospital has been in operation since 2010. During the 5-year period, the clinic has served 1,500 uninsured patients in need of endocrine specialty care who would have otherwise not been seen. During this same period, there was an improvement of Hemoglobin A1C. Each year, the clinic measures its success by continued improvement of Hemoglobin A1C among diabetic patients (short-term goal); access to quality diabetes management and treatment for at-risk residents (mid-term goal); and by improving patient's quality of life while reducing their risk from complications from diabetes morbidity (long-term goal).
OBESITY AND BEHAVIORAL HEALTH	
Identified Need	Cardiovascular Health, Obesity, Behavioral Health. Heart disease continues to be the leading cause of death in Montgomery County as the age adjusted rate in Montgomery County is 108.0 deaths per 100,000 [6] while in Suburban Hospital's CBSA, the age adjusted rate is 111.7 deaths per 100,000.[17] Twenty-five percent of people over the age of 65 live alone. People who live alone are vulnerable to social

	isolation and lack of access to care.[6] Exactly 57.4% of adults in Montgomery County are either overweight or obese according to their Body Mass Index.
Hospital Initiative	Senior Shape Exercise Program
Primary Objective	The Senior Shape Program provides active seniors a safe, low to high impact exercise regimen that focuses on strength and weight training, balance, flexibility, stretching and aerobic activity for optimal cardiovascular benefits and stamina. Held in senior and community centers in Montgomery and Prince George's Counties, fitness assessments are performed bi-annually in order to measure the participant's balance, strength, flexibility and endurance. The goal of Senior Shape Program is to increase physical activity and fitness among the senior population by creating access to age-specific exercise programs and providing social support.
Key Collaborators in Delivery	Suburban Hospital Community Health and Wellness department, Montgomery County Department of Recreation (Holiday Park Senior Center, Margaret Schweinhaut Senior Center, Gaithersburg Upcounty Senior Center, Clara Barton Community Center, Potomac Community Center, Jane E. Lawton Community Center, Wisconsin Place Community Center), Bethesda Regional Services Center, and Parks and Recreation of Prince George's County (Gwendolyn Britt Community Center).
Impact/Outcome of Hospital Initiative	Suburban Hospital holds a bi-annual fitness assessment designed to test the Senior Shape members' balance, strength, flexibility and endurance against national data using 4 exercises. These exercises, held at the nine community centers in Montgomery and Prince George's Counties include the back scratch, arm curl, 8-foot up-and-go, and chair stand. Based on the fitness assessment results, all of the seniors either met or exceeded the national average for their age range. Please see below information for specifics. **Outcomes of Fitness Assessment:** Program participants= 500 Number of sessions held in FY 15 =1,100 Locations= 8 in Montgomery County & 1 in Prince George's County FY 15 program participant fitness assessment results:

Test	Average Females	Average National Standard Females	Average Males	Average National Standard Males
Chair Stand (# of stands in 30 seconds):	15.73	7-14	15.02	11-16
Arm Curl (# of reps in 30 seconds):	20.17	10-17	21.60	13-19
2-minute step in place	101.57	63-95	111.52	74-104
Chair Sit & Reach (inches +/-)	+1.47	-4.5-5.0	-0.30	-6.5-4.0

Evaluation of Outcome	The Senior Shape Program classes are designed to improve the cardiovascular health and overall fitness of the participants. The results from the fitness assessment show that they are meeting or, in many cases, exceeding what is considered normal for their age range and therefore meeting the national fitness standard (short-term); increase participant's cardiovascular endurance (mid-term); and improving participant's quality of life while reducing their risk of coronary heart disease and risk factors associated with heart disease and obesity.

CANCER	
Identified Need	Cancer. According to Healthy Montgomery, the age-adjusted death rate for breast cancer is 18.8 per 100,000 in Montgomery County (2008-2012)[6] Within Suburban's CBSA, the age-adjusted death rate is slightly higher at 18.9 per 100,000. Furthermore, the age-adjusted death rate among Black non-Hispanics is 30.4 compared to 19.9 in White non-Hispanics within Suburban's CBSA.[17] If detected early, breast cancer is highly treatable.
Hospital Initiative	*Check It Out* Program
Primary Objective	The Check It Out program is a free breast health awareness program where a Suburban Hospital Cancer Program nurse addresses to 11th and 12th grade young women in Montgomery County during one class period of school about the importance of breast health. In addition to the nurse, a breast cancer survivor, usually a member of the school facility, shares her story about her diagnosis and treatment with the young women, encouraging them to regularly perform self-breast health exams.
Initiative Time Period	The *Check It Out* program is offered every two years from January to April. In FY 15, it occurred from January 2015 to April 2015.
Key Collaborators in Delivery	Suburban Hospital Cancer Program and Community Health and Wellness Division, the Greater Washington Chapter of Hadassah, Montgomery County Public Schools, and local private high schools.
Impact/Outcome of Hospital Initiative	At every *Check It Out* session, participants were given a knowledge based evaluation which included twelve questions- 10 based on knowledge and 2 to assess their confidence level. Specifically, participants were asked: 1.) *Are all breast lumps cancer?* 99.50% answered correctly, that all breast lumps are not cancerous. 2.) *Does an injury to the breast cause cancer?* 98.20% answered correctly, that an injury to the breast does not cause cancer. 3.) Do *younger women develop breast cancer as often as older women?* 89.40% answered correctly, while young women could develop breast cancer, it occurs more frequently in older women. 4.) *Do large-breasted women have a greater chance of developing breast cancer than small-breasted women?* 97.40% answered correctly, that the chance of a women developing breast cancer does not depend on the size of her breasts. 5.) *Should women begin having mammograms at age 20?* 73.00% answered correctly, that women should begin to have mammograms after the age of 40. 6.) *Are breast self-exams (BSE) important for cancer detection?* 98.40% answered correctly that monthly breast self-examinations are an important tool for early detection. 7.) *When is the best time for a woman for perform a BSE?* 96.10% answered correctly that a woman should perform a breast self-examination 7 to 10 days after her period 8.) *If exercising 3 to 5 hours a week can help reduce the risk of breast cancer?* 97.90% answered correctly, that exercise does reduce the risk of breast cancer. 9.) *Can a woman is pregnant, is she still at risk for breast cancer*? 96.10% answered correctly, women can still get breast cancer even when pregnant.

	10.) *Does breast cancer only develop in women?* 98.10% answered correctly, men can also develop breast cancer 11.) *Did Check It Out help them understand the importance of breast self-examination as a regular health habit?* 98.40% answered Yes 12.) *Did the presence of a breast cancer survivor add to the learning experience?* 95.60% answered Yes
Evaluation of Outcome	Every two years, the Check It Out program measures its success by the number of students it is able to reach (short-term goal); increase awareness of breast awareness among the young women who attend the program (mid-term goal); and by improving the student's quality of life while reducing their risk from breast cancer mortality (long-term goal).

10 CONCLUSION

Suburban Hospital is committed to and invested in caring for the community it serves. Suburban has a long history of dedicating health initiatives to address the needs of vulnerable populations such as 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 the Healthy Montgomery Community Health Needs Assessment and specific supporting data collected from Suburban Hospital's community benefit service area, the process which the hospital prioritizes its efforts are more specialized, focused and deliberate to meet the identified community health needs, which include five established health priorities. The CHNA process has afforded Suburban Hospital the opportunity to sharpen the community health improvement lens, which will guide the organization to a specific focus on barriers to accessing health care, addressing community perceptions of major health concerns, considering 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 integral 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 all.

11 APPENDICES

Appendix A. List of Healthy Montgomery Steering Committee Members

Organization	Name of Key Collaborator	Title	Collaboration Description
Montgomery County Council	Mr. George Leventhal	Councilmember	Co-chair of Healthy Montgomery
ICF International	Ms. Sharan London	Vice President	Co-chair of Healthy Montgomery
Montgomery County Department of Health and Human Services	Ms. Uma Ahluwalia	Director	Steering Committee Member, Healthy Montgomery
Public Health Foundation	Mr. Ron Bialek	President	Steering Committee Member, Healthy Montgomery
MedStar Montgomery Medical Center	Ms. Gina Cook	Marketing, Communications Manager	Steering Committee Member, Healthy Montgomery
Maryland General Assembly	Delegate Bonnie Cullison	Member of the House of Delegates	Steering Committee Member, Healthy Montgomery
Kaiser Permanente	Ms. Tanya Edelin	Senior Project Manager for Community Benefit	Steering Committee Member, Healthy Montgomery
Garvey Associates	Dr. Carol Garvey	Principal	Steering Committee Member, Healthy Montgomery
Primary Care Coalition of Montgomery County	Ms. Leslie Graham	President and Chief Executive Officer	Steering Committee Member, Healthy Montgomery
Family Services, Inc.	Mr. Thomas Harr	Executive Director	Steering Committee Member, Healthy Montgomery
Asian American Health Initiative	Ms. Karen Ho Chaves	Member	Steering Committee Member, Healthy Montgomery
Commission on Veterans Affairs	Ms. Lorrie Knight-Major	Member	Steering Committee Member, Healthy Montgomery
Commission on Aging	Dr. Samuel P. Korper	Member	Steering Committee Member, Healthy Montgomery

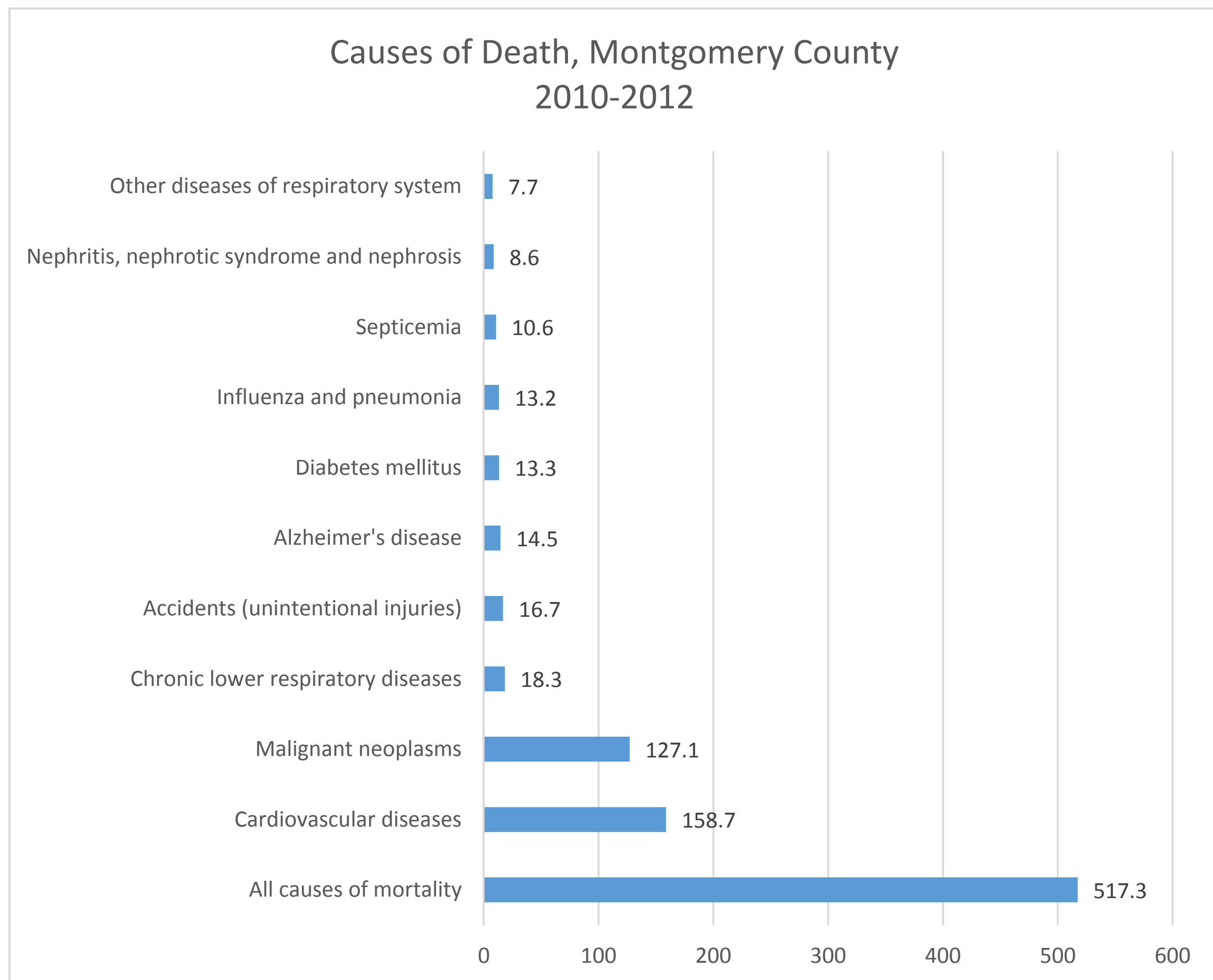
Montgomery County Department of Planning	Ms. Amy Lindsey	Senior Planner	Steering Committee Member, Healthy Montgomery
Holy Cross Hospital	Ms. Kimberley McBride	Community Benefit Officer	Steering Committee Member, Healthy Montgomery
Ronald D. Paul Companies	Ms. Kathy McCallum	Controller	Steering Committee Member, Healthy Montgomery
Carefirst Blue Cross Blue Shield/African American Health Program	Ms. Beatrice Miller	Senior Regional Care Coordinator/Member	Steering Committee Member, Healthy Montgomery
Commission on People with Disabilities	Dr. Seth Morgan, MD	Member	Steering Committee Member, Healthy Montgomery
Asian American Health Initiative	Dr. Nguyen Nguyen	Member	Steering Committee Member, Healthy Montgomery
Clinica Proyecto Salud / Latino Health Initiative	Dr. Cesar Palacios	Executive Director/ Member	Steering Committee Member, Healthy Montgomery
Montgomery County Recreation Department	Dr. Joanne Roberts	Program Member	Steering Committee Member, Healthy Montgomery
Suburban Hospital	Ms. Monique L. Sanfuentes	Director, Community Health and Wellness	Steering Committee Member, Healthy Montgomery
Georgetown University School of Nursing and Health Studies	Dr. Michael Soto	Professor	Steering Committee Member, Healthy Montgomery
Montgomery County Department of Health and Human Services	Dr. Ulder J. Tillman	Officer and Chief, Public Health Services	Steering Committee Member, Healthy Montgomery
Adventist Health Care	Dr. Deidre Washington	Research Associate, Center for Health Equity & Wellness	Steering Committee Member, Health Montgomery
Commission on Veterans Affairs	Ms. Marie Wood	Member	Steering Committee Member, Health Montgomery
Montgomery County Public Schools	Dr. Andrew Zuckerman	Chief of Staff	Steering Committee Member, Healthy Montgomery

Appendix B. 2015 Insurance Coverage Estimates for Suburban Hospital's CBSA

2015 Insurance Coverage Estimates
Area: Suburban_FY2015_CB_SA
Ranked by ZIP Code(Asc)

ZIP Code	ZIP City	2015 Adjusted Population								
		Total	Medicaid - Pre Reform	Medicaid Expansion	Medicare	Medicare Dual Eligible	Private - Direct	Private - ESI	Private - Exchange	Uninsured
20814	Bethesda	29,349	2,455	1,145	3,495	531	1,543	18,789	464	926
20815	Chevy Chase	30,814	1,965	943	4,738	704	1,640	19,646	402	776
20817	Bethesda	36,685	1,935	1,016	4,793	709	2,074	24,931	453	773
20850	Rockville	52,497	4,786	2,337	5,393	830	2,742	33,782	861	1,767
20851	Rockville	14,556	1,292	665	997	160	803	9,895	266	478
20852	Rockville	46,769	4,604	2,213	5,495	835	2,343	28,795	805	1,678
20853	Rockville	30,499	3,178	1,423	3,478	524	1,528	18,681	497	1,191
20854	Potomac	51,401	2,236	1,152	7,059	1,041	2,985	35,431	575	922
20874	Germantown	62,031	5,434	3,067	2,971	514	3,480	43,436	1,161	1,968
20877	Gaithersburg	36,644	6,464	2,696	2,954	460	1,551	19,525	748	2,247
20878	Gaithersburg	65,168	4,450	2,649	4,907	783	3,729	45,942	1,050	1,659
20895	Kensington	20,683	2,014	1,013	2,364	358	1,036	12,833	325	740
20902	Silver Spring	52,020	6,406	3,108	4,185	655	2,555	31,844	987	2,279
20906	Silver Spring	67,761	9,720	4,004	10,118	1,515	2,845	34,876	1,142	3,542
20910	Silver Spring	41,944	6,156	2,718	3,253	521	1,949	24,417	811	2,118
Total		638,821	63,096	30,148	66,200	10,140	32,803	402,823	10,546	23,064

Appendix C. Top Ten Causes of Mortality in Montgomery County



Appendix D. Mortality and Morbidity Rates by Race and Ethnicity for Montgomery County's Leading Causes of Death.

Health Indicator	Blacks, non-Hispanic	Whites, non-	Hispanic or Latino	Asian/Pacific Islander	CBSA	MoCo	Definition
Cardiovascular Disease+	196	162.5	95.9			158.7	Age-Adjusted Death Rate per 1000,000 (2010-2012)
Heart Disease*	124.8	114.5	62.1	63.3	111.7	108.0	Age-Adjusted Death Rate per 100,000 (2011-2013)
Cerebrovascular Disease*	27.3	25.0	20.7	24.1	26.3	25.6	Age-Adjusted Death Rate per 100,000 (2011-2013)
Cancer+	142.1	134.3	85.3	88.4		127.1	Age-Adjusted Death Rate per 1000,000 (2010-2012)
Colorecal Cancer	13.2	9.1	7.5	9.7		9.7	Age-Adjusted Death Rate (2008-2012)
Prostate Cancer	28.1	16.7				16.7	Age-Adjusted Death Rate (2008-2012)
Breast Cancer	27.1	18.4	7.4	8.4		18.8	Age-Adjusted Death Rate (2008-2012)
Lung Cancer	30.9	26.5	11.1	18.2		25.9	Age-Adjusted Death Rate (2008-2012)
Adults with Diabetes (%)	7.6	7.2	2.9	9.3		7.0	Percentage of Adults who have ever been diagnosed with diabetes (2014)
ER Rate Due to Long-Term Complications	16.6	4.3		2.3		5.6	ER Visits/10,000 populations 18+ years n(2009-2011)
Diabetes Mellitus+	26.4	11.3	14.2			13.3	Age-Adjusted Death Rate per 100,000 (2011-2013)
Chronic lower respiratory disease+	13.4	21.8	7.1			18.3	Age-adjusted deaths per 100,000 (2010-2012)
Hospitalization due to Pediatric Asthma	21.5	6.4		8.4		12.3	Age-Adjusted per 10,000 populationn under 18 years (2009-2011)
Hospitalization Rate due to COPD	14.5	9.1			2.9	9.1	Age-Adjusted per 10,000 population 18+ years (2009-2011)
Accidents (Unintentional Injuries)+	11.7	18.4	15.9			16.7	Age-Adjusted per 10,000 population 18+ years (2010-2012)
Motor Vehicle Traffic*	5.2	3.6	6.6			4.1	Age-Adjusted Death Rate per 100,000 (2011-2013)
Falls deaths, unintentional*		8.5				7.4	Age-Adjusted Death Rate per 100,000 (2011-2013)
Poisoning deaths*	4.9	8.3				5.9	Age-Adjusted Death Rate per 100,000 (2011-2013)
Firearms-related deaths*	4.5	4.2				3.7	Age-Adjusted Death Rate per 100,000 (2011-2013)

Source
*Health Indicators Warehouse
Healthy Montgomery
+Data Montgomery

Appendix E. Core Measure Indicators for Suburban Hospital's CBSA

Behavioral Health	Measure	Source
Adolescent and adult illicit drug use <30 days	Percent of people aged 12 or older who used an illicit drug a month preceding survey	NSDUH
Adults with any mental illness <1yr	Percent of adults who had any mental illness in the past year	NSDUH
ER visits for behavioral health conditionals	Age Adjusted Rate-Per American Community Survey 100,000 Population	HSCRC ER
Suicide	Age Adjusted Rate-Per American Community Survey 100,000 Population	VSA Deaths
Cancers		
Colorectal Screening	Percentage of adults aged 50 and over who have had a blood stool test within the past two years	BRFSS
Pap in past 3 years	Percentage of women aged 18 and over who have had a Pap smear in the past three	BRFSS
Prostate cancer incidence	Age-Adjusted incidence rate for prostate cancer in cases per 100,000 males	NCI
Breast cancer mortality	Age Adjusted Rate- Per American Community Survey 100,000 Population	VSA Deaths
Cardiovascular Health		
Heart disease mortality	Age Adjusted Rate- Per American Community Survey 100,000 Population	VSA Deaths
Stroke mortality	Age Adjusted Rate- Per American Community Survey 100,000 Population	VSA Deaths
High blood pressure prevalance	Percentage of adults who have been told they have high blood pressure (above 140/90 mm Hg)	BRFSS
Diabetes		
Adults with diabetes	Percentage of adults who have ever been diagnosed with diabetes	BRFSS
ER visits for diabetes	Emergency room visit rate due to diabetes per 100,000 population	SHIP
Age-Adjusted Rate due to diabetes	Average annual age-adjusted emergency room visit rate due to diabetes per 10,000 population aged 18 years and older	HSCRC ER
Maternal & Infant Health		
Mother's who received early prenatal care	Percent of births to women with prenatal care beginning in the first trimester	VSA Births
Infant mortality	Crude Rate- Deaths Per 1,000 Live Births	VSA Deaths
Babies with low birth birthweight	Percent of births in which the newborn weighed less than 2,500 grams (5 pounds, 8	VSA Births
Obesity		
Adults engaging in moderate physical activity	Percentage of adults who participate in at least 150 minutes of aerobic physical activity per week	BRFSS
Adults fruit and vegetable consumption	Percentage of adults who eat fruits and vegetables five or more times per day	BRFSS
Adults who are overweight or obese	Percentage of adults who are overweight or obese according to the Body Mass Index (BMI)	BRFSS
Students with no partcipation in physicial activity	Percentage of high school students who were not physically active for at least 60 minutes on one day the past seven days	YRBS
Students who drank no soda or pop in the past week	Percentage of high school students who did not drink a can, bottle, or glass of soda or pop during the past seven days	YRBS
Students who are overweight or obese	Percentage of high school students who are overweight or obese according to BMI	YRBS
Cross-Cutting Measures		
Adults who have had a routine check-up	Percentage of adults that report having visited a doctor for a routine checkup within the last two years	BRFSS
Persons without health insurance	Percentage of people who do not have any type of health insurance coverage	ACS
Adults in good physical health	Percentage of adults who stated that they experienced two or fewer days of poor physical health in the past month	BRFSS
Adults in good mental health	Percentage of adults who stated that they experienced two or fewer days of poor mental health in the past month	BRFSS
Students in good general health	Percentage of high school students who described their health in general as "very good" or "excellent"	YRBS
Students ever feeling sad or hopeless in the past year	Percentage of high school students who felt so sad or hopeless almost every day for at least two consecutive weeks that they stopped doing some usual activities during the past 12 months	YRBS
Adults who smoke	Percentage of current smokers (smoked at least 100 cigarrettes in their lifetime and currently smoke)	BRFSS
Students current cigarette use	Percentage of high school students who smoked cigarettes on one or more of the past 30 days	YRBS

Context Measures (SDOH)

Families living below poverty level %	Percentage of families living below the federal poverty level	ACS
Residents 5+years old that report speaking English "not very well"	Percentage of the population aged 5 years and over who report speaking English less than "very well"	ACS
Students ever reveiving free and reduced-price meals (FARMS)	Percentage of students who now or in the past have received free or reduced price school lunches	MCPS
Adults with adequate social and emotional support	Percentage of adults who report they usually or always get the social and emotional support they need	BRFSS
Students who could talk to adult besides a parent	Percentage of high school students who would feel comfortable seeking help from one or more adults besides their parents if they had an important question affecting	YRBS
Students participation in extracurricular activities	Percentage of high school students who participate in any extracurricular activities at school	YRBS
High School Completion Rate	Percentage of people aged 25 years and over who have completed a high school degree or the equivalent	ACS

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/

	State	County	CBSA	HP 2020 Goal	MD 2017 Goal
Behavioral Health					
Adolescent and adult illicit drug use <30 days	7.56	7		16.6	
Adults with any mental illness <1yr	17.4	17.9			
ER visits for behavioral health conditions	3442.6	1791.7	778.2		3152.6
Suicide	9	7.3	7.2	10.2	9
Cancers					
Colorectal Screening	16.5	23.1		70.5	
Pap in past 3 years	79.8	83		93	
Prostate cancer incidence	141.1	137			
Breast cancer mortality	23.7	18.8	**18.9**	20.7	
Cardiovascular Health					
Heart disease mortality	172.8	108.0	111.7	152.7	166.3
Stroke mortality	36.8	25.6	26.3	34.8	
High blood pressure prevalance	28	27.7		26.9	
Diabetes					
Adults with diabetes	10.1	7.1		7.2	
ER visits for diabetes	204	95.0	**583.3**		186.3
Age-Adjusted Death Rate due to diabetes		13.3			
Maternal & Infant Health					
Mother's who received early prenatal care (%)	66.6	63.1	73.1	77.9	66.9
Infant mortality	6.6	4.7	4.6	6	6.3
Babies with low birthweight (%)	8.6	7.5	**7.6**	7.8	8
Obesity					
Adults engaging in moderate physical activity		52.7		47.9	50.4
Adults fruit and vegetable consumption		29.6			
Adults who are overweight or obese	64.9	57.4			
Students with no partcipation in physicial activity (teens)	18	16.5			
Students who drank no soda or pop in the past week	28.4	33			
Teens who are overweight or obese	25.8	20			

	State	County	CBSA	HP 2020 Goal	MD 2017 Goal
Cross-Cutting Measures					
Adults who have had a routine check-up	89.3	86.2			
Persons without health insurance	7.9	9.7		0	
Adults in good physical health	77.6	79.4		79.8	
Adults in good mental health	76.7	77.8		80.1	
Students in good general health	49.9	52.3			
Students ever feeling sad or hopeless in the past year	27	26.9			
Adults who smoke	14.6	7.9		12	15.5
Students current cigarette use (teens)	11.9	8.5			
Context Measures (Social Determinants Of Health)					
Families living below poverty level %	6.9	4.5			
Residents 5+years old that report speaking English "not very well"	6.3	15.1			
Students ever receiving free and reduced-price meals (FARMS)		43.3			
support		83.3			
Students who could talk to adult besides a parent	77.3	73.9		83.2	
Students participation in extracurricular activities	67.4	72.1			
High School Completion Rate (%)	89	89.7			

Appendix F. Community Health Survey Tool (English)

Code #: ___________

Community Health Survey

Your health and wellbeing is our passion. Help us prioritize your needs by participating in this confidential survey (also available online via www.suburbanhospital.org).

1. What is your home zip code? _________

2. What language do you prefer to speak? ______________

3. What is the highest level of education you have completed?
   - ☐ Did Not Complete High School
   - ☐ High School/GED
   - ☐ Some College
   - ☐ Bachelor's Degree
   - ☐ Master's Degree
   - ☐ Advanced Graduate work or Ph.D.

4. What is your gender?
   - ☐ Male
   - ☐ Female

5. What is your age?
   - ☐ Under 19 years
   - ☐ 20-30 years
   - ☐ 31-40 years
   - ☐ 41-50 years
   - ☐ 51-60 years
   - ☐ 61-70 years
   - ☐ 71-80 years
   - ☐ 81-90 years
   - ☐ Older than 91 years

6. What is your race/ethnicity?
   - ☐ African American
   - ☐ Asian/Pacific Islander
   - ☐ Caucasian
   - ☐ Hispanic/Latino
   - ☐ Other: ____________________________

7. Which health condition do you feel you are most at risk of developing? Please select ONLY **one**.
   - ☐ Cancer
   - ☐ Obesity
   - ☐ Heart Disease
   - ☐ Diabetes
   - ☐ Behavioral/Mental Health
   - ☐ Other:_______________
   - ☐ I don't feel at risk of developing any health conditions

8. What health concern(s) do YOU have? Please check **no more than five**.
   - ☐ Heart Disease
   - ☐ Cancer
   - ☐ Diabetes/Sugar
   - ☐ Asthma/Lung Disease
   - ☐ Smoking/Drug and Alcohol Use
   - ☐ Mental Health Issues (depression, anxiety, etc.)
   - ☐ High Blood Pressure
   - ☐ Other
   - ☐ Stroke
   - ☐ Traffic Accidents
   - ☐ Maternal/Child Health
   - ☐ Overweight/Obesity
   - ☐ Access to Health Care
   - ☐ No Health Insurance
   - ☐ Environmental Health
   - ☐ Dental
   - ☐ None

   If you checked "Other," please explain:

   ____

Please turn the page over →

9. What barriers are keeping you from getting the health care YOU need? Please check **all** that apply.
   - ☐ No health insurance
   - ☐ Cost
   - ☐ No transportation
   - ☐ Lack of information
   - ☐ Difficulty getting an appointment with my doctor
   - ☐ Lack of time
   - ☐ Language
   - ☐ Child care
   - ☐ I have health insurance, but local doctors are not on my insurance plan
   - ☐ I don't have any barriers
   - ☐ Other

   If you checked "Other", please explain:

   ____

10. Please circle the number which best identifies your response to the following statements.

In the past month, I have:	Never	Occasionally	Often	Always
a. Been physically active outside of work for at least 2.5 hours a week (i.e. very brisk walking).	1	2	3	4
b. Eaten at least five servings of fruits and vegetables every day (1 serving = 1/2 cup).	1	2	3	4
c. Used tobacco products (cigarettes, cigars, smokeless tobacco, e-cigarettes, and pipes).	1	2	3	4
d. Consumed more than 5 alcoholic drinks a week (1 drink= 12 fl oz of beer, 1.5 fl oz shot "hard liquor", 5 fl oz of wine).	1	2	3	4
e. Worn a seat belt when traveling in a vehicle.	1	2	3	4
f. Been able to manage and control my stress.	1	2	3	4

11. Which area of your health do you think you need to improve the most? Please select ONLY **one**.
    - ☐ Physical activity
    - ☐ Healthy eating
    - ☐ Smoking/tobacco use
    - ☐ Alcohol consumption
    - ☐ Driving safety
    - ☐ Stress management
    - ☐ None

12. How would you rate your current health status?
    - ☐ Excellent
    - ☐ Good
    - ☐ Fair
    - ☐ Poor

Thank you for completing the survey.

Office Use Only:			
Date: __________	Location: ____________	Zip Code: ___________	Surveyor: ____________

Appendix G. Community Benefit Advisory Council

Organization	Name	Title	Description
Capstone Development, LLC	Mr. Norman Jenkins	Founder and CEO	Chairman of Suburban Hospital's Community Benefit Advisory Council; facilitates the Advisory meetings.
A Wider Circle	Dr. 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.
Community Advocate	Ms. Belle Brooks O'Brien	Resident of Montgomery County	Member of Suburban Hospital's Community Benefit Advisory Council
Healthcare Initiative Foundation	Ms. Crystal Carr Townsend	President	Member of Suburban Hospital's Community Benefit Advisory Council
Bradley Hills Village	Ms. Betsy Carrier Ms. Eva Cohen	Treasurer President	Member of Suburban Hospital's Community Benefit Advisory Council
Bradley Hills Village	Ms. Eva Cohen	co-President and chair	Member of Suburban Hospital's Community Benefit Advisory Council
Community Physician	Dr. Diane Colgan	Medical Staff Chair for Suburban Hospital	Member of Suburban Hospital's Community Benefit Advisory Council
Bethesda Chevy Chase Regional Services Center	Mr. Ken Hartman	Regional Services Director	Member of Suburban Hospital's Community Benefit Advisory Council; provides a facility to many CHW programs.
YMCA of Metropolitan Washington	Ms. Carla P Larrick	Vice President of Operations	Member of Suburban Hospital's Community Benefit Advisory Council
Girls on the Run	Ms. 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.

AQUAS, Incorporated	Ms. Carmen Ortiz Larsen	President	Member of Suburban Hospital’s Community Benefit Advisory Council
Montgomery County Police Department	Mr. 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	Dr. Michael Smith	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
Montgomery County Police Department	Ms. 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.
Association of Community Cancer Centers	Ms. Lisa Townsend	Marketing Manager	Member of Suburban Hospital’s Community Benefit Advisory Council
Aronson, LLC	Mr. Michael K. Yuen	Certified Public Accountant	Member of Suburban Hospital’s Community Benefit Advisory Council

Appendix G. Montgomery County United Way Regional Council Members

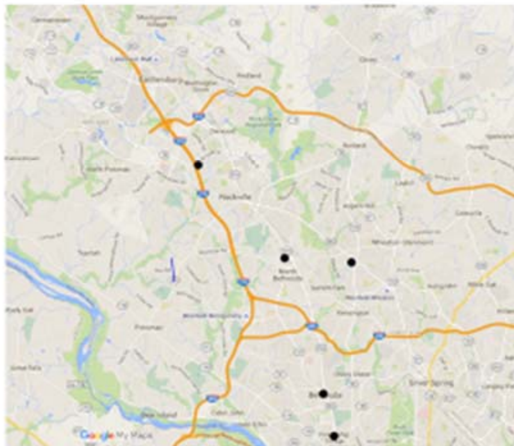
Randy R. Schools, Council Chair, Nominating Chair	Bill Carey
President	Director of Membership and Community Relations
Recreation-Welfare Association	Strathmore Hall Foundation, Inc.
NIH-NOAA	5301 Tuckerman Lane
9000 Wisconsin Avenue	North Bethesda, MD 20852
Bethesda, MD 20892	**Office:** 301-581-5135
Office: 301-251-1743	**Email:** bcarey@strathmore.org
Email: schoolsr@ors.od.nih.gov	
Rudy Oswald, Community Impact Chair	**Lawrence Cooper**
Retired	General Counsel : DC Office of Cable TV, Film, & Entertainment
11804 Devilwood Dr.	District of Columbia Government
Potomac, MD 20854	1899 9th Street, NE,
Home: 301-340-7569	Washington, DC 20018
Email: rudyosw@verizon.net	(Bethesda Resident)
	Office: (202) 671-0066
	Email: lncooper@verizon.net
Michele M. Hamilton	**Torrie Cooke**
Retired from US Government Accountability Office (GAO)	Detective
10003 Stoneybrook Drive	Montgomery County Police Department
Kensington, MD 20895	18512 Office Park Drive
Home: 301-585-5521	Montgomery Village, MD 20886
Email: mhcager@aol.com	**Cell:** 240-793-1462
	Email: tcooke35@verizon.net
Jay Wilson	**Tony Marciante**
Sr Staff Accountant	Chef Proprietor & CSO
9520 Ament Street	Chef Tony's
Silver Spring, MD 20910	4926 St. Elmo Avenue
Cell: 404-295-5451	Bethesda, MD 20817
Email: jlwilson82@gmail.com	**Office:** 301-654-3737
	Email: alltonysmail@gmail.com
Patricia Rios	**Frank Gangi**
Supervisor, Community Health Improvement	Friendship Heights Store
Surburban Hospital	Nordstrom (Bethesda resident also)
8600 Old Georgetown Road	5333 Wisconsin Avenue,
Bethesda, MD 20814	Washington DC 20015
Office: (301) 896-2849	**Office:** 202.697.4100
Email: PRios@jhu.edu	**Email:** frank.gangi@nordstrom.com

Appendix G. Suburban Hospital Patient and Family Education Committee members

Name	Suburban Hospital Title
Atul Rohatgi MD	Hospitalist
Barbara Kohl PFAC	Community Member
Barbara Olivier	Manager, Patient Access
Cathy Clark	Nursing Supervisor, Nursing Education
Charlotte Savarino	Nurse, Pediatrics
Debbie Kovach PFAC	Community Member
Debra Scheinberg	Manager, Marketing & Communications
Jacky Schultz	EVP & COO, Administration
Judy Holloway	Coordinator, Quality Management
June Graft PFAC	Community Member
Karen Carlson	Director, OR Minor
Kathrine Carongoy	Nurse, Adult Surgical
Kristina Kepner	Nurse, Nursing Education
Leighann Sidone	VP CNO, Administration
Matilde Hazeley-Muhongi	Nurse, Intensive Care Unit
Norma Bent	Director, Care Coordination
Pamela Fogan	Director, Volunteer Services
Pamela Gurian	Nurse, PACU
Patricia Rios	Supervisor, Community Health & Wellness
Quentin Simeone	Coordinator, Clinical Support
Sarah Rassmussen	Eppic Informatics, MIS
Shawn Donnelly	Director, Managed Care
Steve Bokat PFAC	Community Member
Teresa MCCannon	Nurse Educator, Nursing Education
Toby Levin PFAC	Community Member

Appendix H. Suburban Hospital Program & Services Asset Map

Behavioral Health



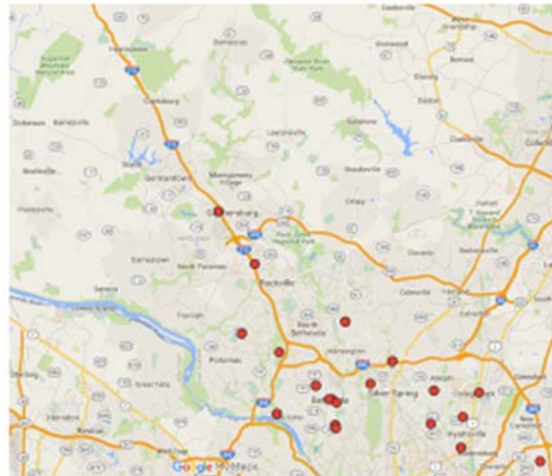
5 sites

- Support groups (host & facilitate)
  - Nutrition
  - Bipolar disorders
  - Stroke
  - Diabetes
  - Cancer
  - Respiratory
- Health education seminars
- Addiction treatment center (includes outreach)
- Mindfulness Meditation classes

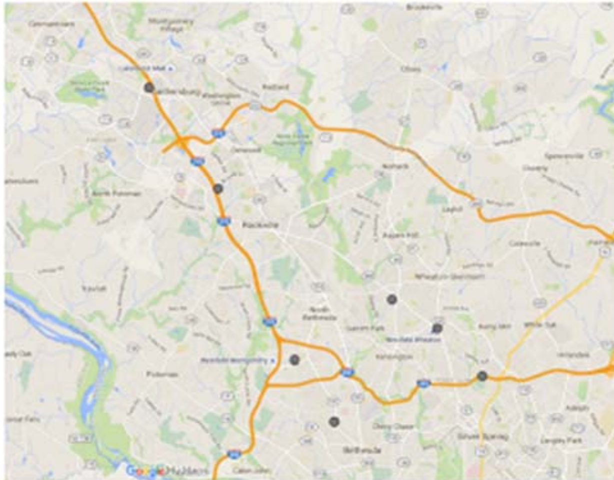
Cardiovascular Health

35 sites

- HeartWell Clinics
- Blood pressure screenings
- Cholesterol screenings
- MobileMed/NIH Heart Clinic
- Dine & Learn
- Physical activity classes
  - Senior Shape
  - Mall walking
  - Tai Chi
- Health education seminars and symposia
- Health fairs
- CPR classes
- Financial support for safety net clinics



Diabetes



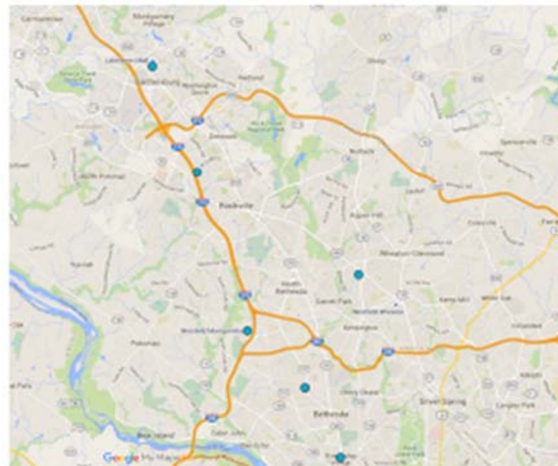
7 sites

- Pre-diabetes and diabetes management classes
- Support groups
- Nutrition counseling
- MobileMed/NIH Endocrine Clinic
- Health education seminars
- Diabetes symposium
- Financial support for safety net clinics
- Support of Protecyo Salud diabetes school

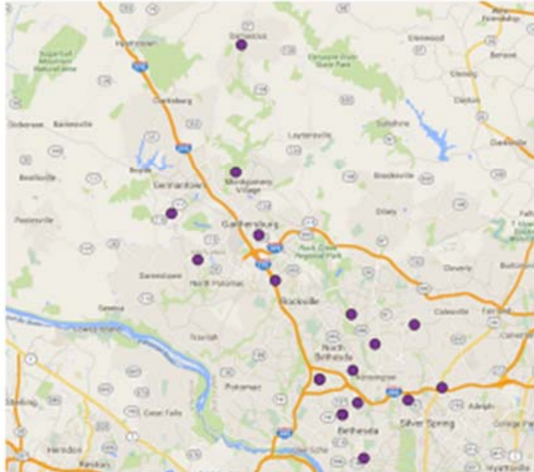
Obesity

9 sites

- Dine & Learn
- Senior Shape
- Physical activity
  - Girls on the Run
  - Fun runs
- Nutrition counseling
- Nutrition classes & seminars
- Cooking demonstrations



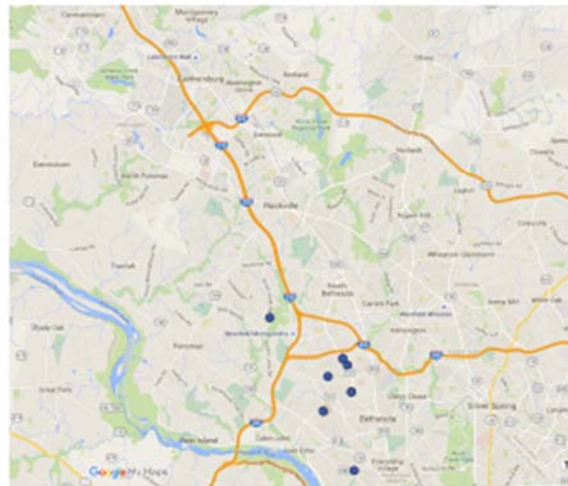
Cancer



24 sites
- Screenings (skin, head, neck)
- Free pap smears for Proyecto Salud patients
- Patient navigators
- Symposia
  - Breast
  - Prostate
- Survivor support groups
- Colorectal awareness day
- Health education seminars & classes
  - Check it Out (breast & testicular)
  - Yoga
  - Look Good, Feel Better

Maternal and Child Health

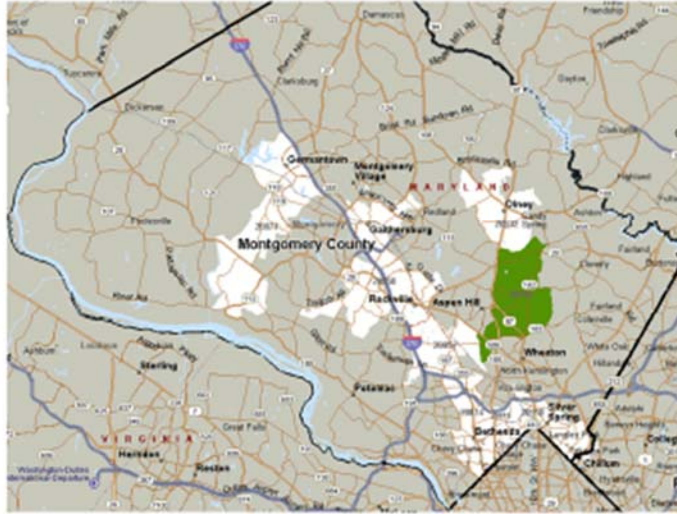
9 sites
- Safe Sitter
- Adopt-a-Family
- Parenting seminars
- Survival guide for first-time grandparents
- The Gabriel Project & Knots for Shots



Appendix I. Asset Map for Montgomery County

Behavioral Health

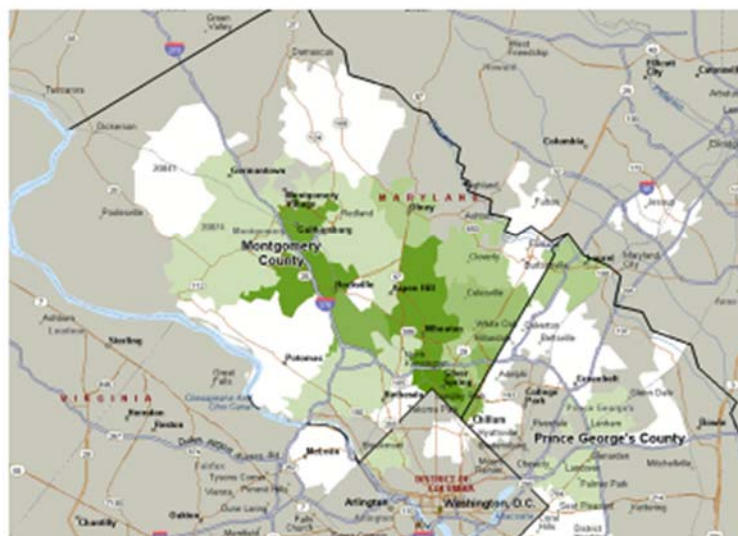
Gradient shading based on number of programs in ZIP code; darker the shading, higher number of programs



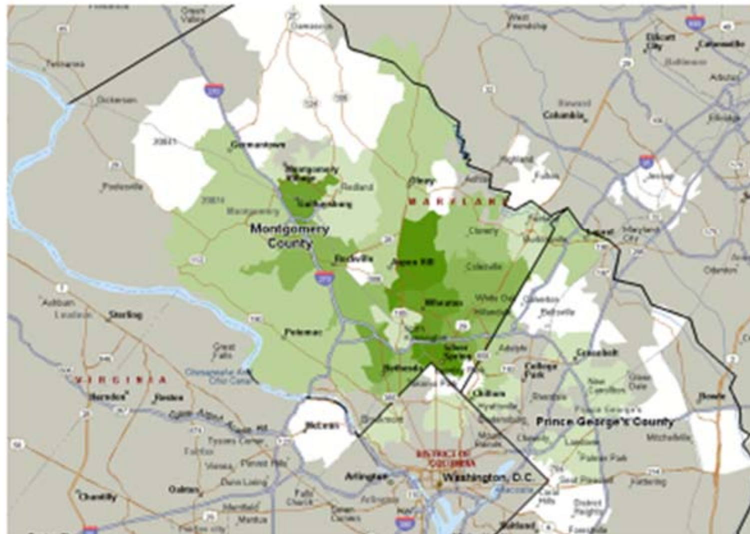
Obesity

Maternal and Infant Health

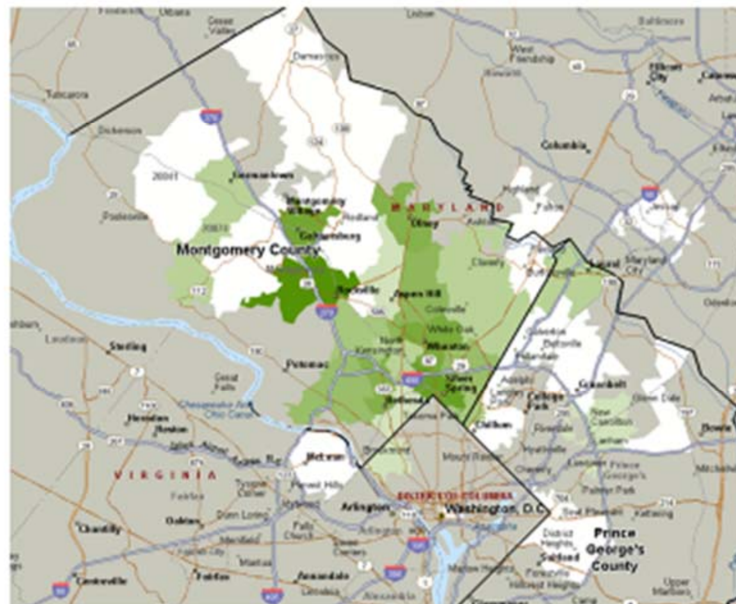
Diabetes



Cardiovascular



Cancer



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APPENDIX IX: COMMUNITY HEALTH NEEDS ASSESSMENT 2016 IMPLEMENTATION STRATEGY

Suburban Hospital

Implementation Strategy

In response to the

Community Health Needs Assessment

Fiscal Year 2016

SUBURBAN HOSPITAL

JOHNS HOPKINS MEDICINE

SUBURBAN HOSPITAL

COMMUNITY HEALTH IMPROVEMENT IMPLEMENTATION STRATEGY

FY 2016

TABLE OF CONTENTS

CONTENTS **PAGE**

I. Introduction

Overview of Suburban Hospital 3

Community Health Needs Assessment 3

II. Hospital Health Priorities 4

III. The Community We Serve 4

IV. Implementation Strategy

a. Addressed Needs and Implementation Plan 5

b. Health Priority: Behavioral Health 7

c. Health Priority: Obesity 8

d. Health Priority: Cancer 10

e. Health Priority: Diabetes 12

f. Health Priority: Cardiovascular Health 14

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. 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, elevated helipad. Suburban Hospital's busy Emergency/Shock Trauma Center treats more than 45,000 patients a year.

The Hospital's major services include a comprehensive cancer and radiation oncology center accredited by the American College of Surgeons Commission on Cancer; a cardiac center providing 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 is the only hospital in Montgomery County to achieve the Gold Seal of Approval™ by The Joint Commission for its joint replacement program. Other services provided include a state-of-the-art diagnostic pathology and radiology departments; an Addiction Treatment Center offering 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 2015, Suburban Hospital was licensed to operate 220 acute care beds and had 13,861 inpatient admissions.

B. 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 certain 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 community health needs assessment (CHNA) once every three years and an implementation strategy to meet the identified health needs. (Request for Comments Regarding Additional Requirements for Tax-Exempt Hospitals, 2010)

In Fiscal Year 2016, Suburban Hospital conducted a community health needs assessment to identify the most important health issues surrounding the hospital using scientifically valid health indicators and comparative information. The assessment helped to identify priority health issues affecting Montgomery County as a whole and specifically residents' of Suburban Hospital's Community Benefit Service Area (CBSA). Suburban Hospital's Community Health Needs Assessment FY 2016 is available to the public via SuburbanHospital.org. This report describes Suburban Hospital's implementation strategy for addressing the identified health needs in the community in order to improve health status and quality of care available to our residents, while building upon and strengthening the community's existing infrastructure of services and providers.

Suburban Hospital Health Priorities

As a result of using similar data sources and integrating historical partners / stakeholders in setting local health priorities over the years, the summary of key data findings conducted by the Montgomery County health improvement process, referred to as Healthy Montgomery, are similar, if not identical to health inequities identified by Suburban Hospital through community member surveying, discussions with community members, and hospital data. This relationship easily affords Suburban Hospital the ability to align its community health improvement efforts to five of the six priorities identified by the Healthy Montgomery Steering Committee in order to decrease health inequities, lack of access, and unhealthy behaviors. The five official health priorities to be addressed, tracked, and evaluated over the next three years are presented below in no particular order:

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

The Community We Serve

Suburban Hospital is located in Montgomery County, one of the most affluent counties in the United States. Montgomery County is adjacent to the nation's capital, Washington, D.C., and is also bordered by the Maryland counties of Carroll, Frederick, Howard and Prince George's, and the Commonwealth of Virginia.

A close review of service utilization led to the identification of Suburban Hospital's primary service area (PSA). The PSA is defined as the Maryland postal zip code areas from which 60 percent of a hospital's inpatient discharges originated during the most recent 12 month period after the discharges from each zip code are ordered from largest to smallest number of discharges. This information was provided by the Maryland Health Services Cost Review Commission (HSCRC).

As part of the PSA definition process, Suburban Hospital began to look at specific populations or communities of need to which the Hospital allocates resources through its community benefit plan. This in-depth process required an analysis of data from the Hospital's Inpatient Records, Emergency Department (ED) Visits, and Community Health Improvement Initiatives and Wellness Activities. The product was a geographic area, identified as Suburban Hospital's Community Benefit Service Area (CBSA) and contains the following fifteen zip codes: 20814, 20817, 20852, 20854, 20815, 20850, 20895, 20906, 20902, 20878, 20853, 20910, 20851, 20874, and 20877. A close look revealed that Suburban Hospital's CBSA has increased by two zip codes (20874 and 20877) from fiscal year 2013 and is not limited to the primary service area.

Addressed Needs and Implementation Strategy

Suburban Hospital's CHNA taskforce conducted an analysis of current Suburban Hospital's community benefit activities, while also taking into consideration Suburban Hospital's major services of excellence, and found present efforts to be aligned, in some capacity, with the five health priorities mentioned above. Because the Hospital does not have an obstetrics designation or deliver babies, Suburban Hospital does not include Maternal and Child Health initiatives as an identified health priority, the sixth Healthy Montgomery priority. Suburban Hospital does, however, indirectly support Maternal and Child Health initiatives through funding and programming of several other organizations which promote the health and well-being of children and their families.

Suburban Hospital's approved health improvement plan connects hospital, community partners, local stakeholders and other resources with identified health needs. Suburban Hospital not only aligns health priorities with the areas of greatest identified need, but also considers where the Hospital's resources will

generate the greatest impact. As such, the implementation plan includes an evaluation component to measure each health outcome identified in the plan. Over the next three years, Suburban Hospital will focus its health improvement efforts to specific populations or communities of need to which the hospital allocates resources, identified above as the Community Benefit Service Area (CBSA). Within the CBSA, Suburban Hospital will focus on certain target populations such as uninsured individuals and households, underinsured and low-income individuals and households, ethnically diverse populations, underserved seniors, or at-risk youth.

Community Health Need: BEHAVIORAL HEALTH

Target Population: CBSA residents

Goal: Improve behavioral health through prevention and linkage to appropriate services

We expect these activities will lead to the following change in 7-10 years

Focus Area / Lens *How we view the health need*	**Outcome / Impact** *The change we want to see*	**Action Plan** *How we address the change*	**Activities** *The programs and services we provide as part of action plan*	**Evaluation Plan** *How we measure the change*	**Partnering Organization(s)** *Who has committed to making an impact*
PROMOTION OF HEALTHY BEHAVIORS	By June 2019, improve positive behavioral health outcomes by conducting deliberate interventions that foster social and emotional support	Increase the proportion of seniors that participate in educational and community-based programs, e.g. reduce isolation Provide on-going tools and resources that improve family functioning and positive parenting	• Support groups • Senior fitness programs ○ Tai Chi ○ Pilates ○ Senior Shape ○ Mall Walking • Village Ambassador Alliance • Parenting seminars	• Referrals to programs • Attendance in programs	• Montgomery County Department of Recreation Senior Centers • AARP • OASIS • Montgomery County Stroke Association Bethesda-Chevy Chase YMCA • Bethesda-Chevy Chase Youth & Family Services • Parenting Encouragement Program (PEP) • Johns Hopkins University Press • WAVE
ACCESS TO HEALTHCARE SERVICES	By June 2019, increase knowledge of behavioral health resources in Montgomery County and facilitate access to available services and resources	Link patients in need of behavioral health services to appropriate community resources	• Suburban On-Call • Behavioral inpatient and outpatient services ○ Support Groups • Mindoula / Magellan Care Coordination Services	• Established alliances • Readmission rates	• National Alliance on Mental Illness of Montgomery County • Alcoholics Anonymous • Narcotics Anonymous • Healthy Montgomery

Community Health Need: OBESITY					
Target Population: CBSA residents					
Goal: Reduce obesity rates through promotion of healthy lifestyles *We expect these activities will lead to the following change in 7-10 years*					
Focus Area / Lens *How we view the health need*	**Outcome / Impact** *The change we want to see*	**Action Plan** *How we address the change*	**Activities** *The programs and services we provide as part of action plan*	**Evaluation Plan** *How we measure the change*	**Partnering Organization(s)** *Who has committed to making an impact*
PROMOTION OF HEALTHY BEHAVIORS	By June 2019, increase awareness of risk factors associated with obesity	Deliver structured and deliberate educational messages and promote existing services that support healthy eating and physical activity	Promote and provide, in coordination with public and private agencies, affordable, structured on-going programs to increase knowledge and utilization of available obesity reduction and prevention services, including: • Health seminars • Cooking demonstrations • Fitness classes o Senior Shape o Tai Chi o Pilates o Mall walking • HeartWell clinics o Know Your Numbers • Nutrition counseling o Healthy Weigh o Healthy Choices o Nutrition One on One	• Individuals' perceived self-efficacy with regards to weight loss and healthy behavior modifications • Class attendance rates	• Montgomery County Department of Recreation Senior Centers • Lakeforest Mall • Friendship Heights Village Center • Girls on the Run of Montgomery County • Scotland Health Partnership • Bethesda-Chevy Chase YMCA • Rotary Club

			Collaborate with and support organizations that promote healthy eating and physical activity in children and youth (including: • Girls on the Run • #JustGirls • Turkey Chase		
		Assess individuals' risk factors for obesity through screenings and health assessments	Provide on-going health screenings: • BMI	Metrics for increased health risk, approved by American Heart Association and/or Centers for Disease Control and Prevention	

Community Health Need: CANCER					
Target Population: CBSA residents					
Goal: Increase cancer prevention and survivorship rates *We expect these activities will lead to the following change in 7-10 years*					
Focus Area / Lens *How we view the health need*	**Outcome / Impact** *The change we want to see*	**Action Plan** *How we address the change*	**Activities** *The programs and services we provide as part of action plan*	**Evaluation Plan** *How we measure the change*	**Partnering Organization(s)** *Who has committed to making an impact*
PROMOTION OF HEALTHY BEHAVIORS (1 of 2)	By June 2019, increase awareness of cancer risk factors	Deliver on-going, structured educational messages and promote existing services that support healthy behaviors.	• Check It Out • Community seminars and symposiums • Smoking cessation programs	Assess individuals' self-efficacy with regards to management healthy behaviors	• Greater Washington Chapter of Hadassah • Montgomery County Public Schools • Lymphoma & Leukemia Foundation • Susan G. Komen Foundation • Montgomery County Cancer Crusade
PROMOTION OF HEALTHY BEHAVIORS (2 of 2)	By June 2019, increase awareness of existing cancer prevention resources at community level	Partner with public and private organizations that serve communities at high risk of cancer to educate them on the existing free or low-cost cancer prevention and screening resources available in the community	• Suburban Hospital Cancer Program • Walk and Talk	Referrals to programs	• Project Access • Catholic Charities • Proyecto Salud • Alpha Phi Alpha, Inc. fraternity • Montgomery County Cancer Crusade • Sidney J. Malawer Memorial Foundation

					• Mobile Medical Care, Inc.
ACCESS TO HEALTHCARE SERVICES (1 of 2)	By June 2019, increase access to cancer prevention and early detection services	Leverage resources to link and/or deliver free or low-cost early detection prevention screening and treatment programs	Provide on-going health screenings and testing: • Skin • Prostate • Colorectal • Breast • Head & neck • Cervical • Lung	• Number of patients served • Resources allocated to serving patients	• Project Access • Catholic Charities • Proyecto Salud • Alpha Phi Alpha, Inc. fraternity • Montgomery County Cancer Crusade • Sidney J. Malawer Memorial Foundation • Mobile Medical Care, Inc.
ACCESS TO HEALTHCARE SERVICES (2 of 2)	By June 2019, increase availability of support systems for those diagnosed with cancer, survivors, and family/ caretakers	Provide cancer-specific patient navigation services, deliver information, knowledge, support, and guidance needed to manage a cancer diagnosis and treatment Design wellness classes and programs for cancer patients, caretakers, and survivors to reduce stress and anxiety around dealing	• Nurse patient navigators • Look Good, Feel Better • Exercise programs for cancer survivors • Cancer-specific support groups	Referral to programs	• American Cancer Society • Leukemia & Lymphoma Society • Primary Care Coalition • Montgomery County Cancer Crusade • Whole Foods

Community Health Need: DIABETES					
Target Population: CBSA residents					
Goal: Reduce diabetes prevalence and associated health complications *We expect these activities will lead to the following change in 7-10 years*					
Focus Area / Lens *How we view the health need*	**Outcome / Impact** *The change we want to see*	**Action Plan** *How we address the change*	**Activities** *The programs and services we provide as part of action plan*	**Evaluation Plan** *How we measure the change*	**Partnering Organization(s)** *Who has committed to making an impact*
PROMOTION OF HEALTHY BEHAVIORS	By June 2019, increase awareness of risk factors associated with diabetes	Deliver structured educational messages and promote existing services that support: • Healthy eating and physical activity • Diabetes self-management, including Fine Tuning initiative	Provide affordable, on-going health seminars, cooking demonstrations, fitness classes, support groups, counseling services, and on-site nutrition services	Assess individuals' self-efficacy with regards to management of diabetes	• Montgomery County Department of Recreation Senior Centers • Sodexo • Sibley Memorial Hospital • African American Health Program
ACCESS TO HEALTHCARE SERVICES	By June 2019, increase access to quality endocrine specialty care, management, and treatment for uninsured CBSA residents	Provide free or low-cost access to: • Endocrinologists • Specialty state-of-the-art diagnostic screenings • Treatment • Rehabilitation	Partner with public and private organizations to deliver quality specialty cardiovascular and endocrine medical treatment: • MobileMed / NIH Endocrine Clinic • Project Access • Catholic Charities	Number of patients served Resources allocated to serving patients	• Mobile Medical Care, Inc. • National Institutes of Health • Primary Care Coalition • Montgomery Cares safety net clinics

BUILDING BRIDGES WITHIN THE COMMUNITY	By June 2019, increase collaboration with community partners to implement/support collective impact	Advocate for collective impact	Participate in Montgomery County Community Health Improvement Process (Healthy Montgomery)	• Align reporting metrics for health priorities across all Montgomery County hospitals • Implement evidence-based strategies to integrate health literacy and equity into care and services provided	• Healthy Montgomery Steering Committee members • Montgomery County hospital working group

Community Health Need: CARDIOVASCULAR HEALTH					
Target Population: CBSA residents					
Goal: Improve cardiovascular health through prevention strategies *We expect these activities will lead to the following change in 7-10 years*					
Focus Area / Lens *How we view the health need*	**Outcome / Impact** *The change we want to see*	**Action Plan** *How we address the change*	**Activities** *The programs and services we provide as part of action plan*	**Evaluation Plan** *How we measure the change*	**Partnering Organization(s)** *Who has committed to making an impact*

PROMOTION OF HEALTHY BEHAVIORS	By June 2019, increase awareness of behavior change associated with cardiovascular disease	By June 2019, increase awareness of risk factors associated with cardiovascular disease
		
		Assess individuals' risk factors for chronic diseases through screenings and health assessments
			Provide affordable, on-going programs and services:
			• Health seminars
			• Cooking demonstrations
			• Fitness classes
			  ○ Senior Shape
			  ○ Pilates for Senior
			  ○ Tai Chi
			  ○ Mall walking
			• Screenings
			  ○ Body composition
			  ○ Blood pressure
			  ○ Varicose vein
			  ○ Cholesterol
			• On-site nutrition services
			• Heart Smart Classes
			• HeartWell in Action
			
			Provide on-going health screenings:
			• Blood pressure
			• TC/HDL cholesterol
			• Fitness assessments
				Individual's perceived self-efficacy with regards to management of chronic diseases
				
				Metrics for increased health risk, approved by American Heart Association and/or Centers for Disease Control and Prevention
					• Montgomery County Department of Recreation Senior Centers
					  ○ Clara Barton Community Center
					  ○ Friendship Heights Village Center
					  ○ Benjamin Gaither Center
					  ○ Holiday Park Senior Center
					  ○ Jane E. Lawton Community Center
					  ○ Margaret Schweinhaut Senior Center
					  ○ Potomac Community Center
					  ○ Rockville Senior Center
					• Bethesda Regional Service Center

					• Johns Hopkins University Montgomery County Campus • Lakeforest Mall • Sibley Memorial Hospital • OASIS at Macy's Home Store • Wisconsin Place Apartments • Montgomery County Public Schools • Girls on the Run of Montgomery County • Sodexo
ACCESS TO HEALTHCARE SERVICES (1 of 2)	By June 2019, increase access to quality cardiovascular specialty care, management, and treatment for uninsured CBSA residents	Provide free or low-cost access to: • Cardiologists • Specialty state-of-the-art diagnostic screenings • Treatment • Rehabilitation	Partner with public and private organizations to deliver quality specialty cardiovascular and endocrine medical treatment: • MobileMed / NIH Heart Clinic • Project Access • Catholic Charities	• Number of patients served • Resources allocated to serving patients	• Mobile Medical Care, Inc. • National Institutes of Health • Primary Care Coalition • Montgomery Cares safety net clinics
ACCESS TO HEALTHCARE SERVICES (2 of 2)	By June 2019, reduce frequency of hospital admissions/re-admissions due to cardiovascular disease	Connect individuals to existing programs and services at both the hospital and throughout the community, including regular counseling and disease prevention and	HeartWell Clinics Re-Admission Initiative	• Referrals made to Suburban or community programs • Unadjusted Medicare 30-day readmission rate	• HeartWell Clinics • Montgomery County Department of Recreation Senior Centers

		management education sessions			• Skilled nursing facilities
BUILDING BRIDGES WITHIN THE COMMUNITY	By June 2019, increase collaboration with community partners to implement/support collective impact	Advocate for collective impact	Participate in Montgomery County Community Health Improvement Process (Healthy Montgomery)	• Align reporting metrics for health priorities across all Montgomery County hospitals • Implement evidence-based strategies to integrate health literacy and equity into care and services provided	• Healthy Montgomery Steering Committee members • Montgomery County hospital work group

APPENDIX X: SUBURBAN HOSPITAL FY 2016 STRATEGIC PLAN

Johns Hopkins Medicine
FY16 Strategic Objectives

Johns Hopkins Community Division
Affiliate: Suburban Hospital

	GOAL	METRIC	O	√ -	√	√ +
	Ensure that medical and biomedical education at Johns Hopkins is transformative as reflected by curricula that emphasize cutting-edge science, novel treatments, wise use of technology, and avoidance of unnecessary medical tests and procedures.	Provide care coordination models that enhance transitions of care.	Failure to develop a plan.	Plan developed but not implemented.	Plan developed, one model implemented.	Two care coordination models implemented.
	Ensure that medical and biomedical education at Johns Hopkins is transformative as reflected by curricula that emphasize cutting-edge science, novel treatments, wise use of technology, and avoidance of unnecessary medical tests and procedures.	Working in collaboration with NCR stakeholders to support "aging in place" initiatives.	Failure to launch initiative.	Initiative planned but not implemented.	Two initiatives leveraged.	Three additional "aging in place" partners identified and alliances developed.
	Increase access to quality diabetes management and treatment for CBSA residents.	Leverage current NCR resources to enhance diabetes education, programs and support groups.	Model exists, but no progress.	One quality diabetes component leveraged.	Two quality diabetes components leveraged.	Three quality components leveraged for diabetes management model.
	Improve positive mental health outcomes by conducting diliberate interventions that foster social and emotional support.	Provide tools and resources that improve family functioning, positive parenting and healthy behaviors among volnerable populations.	No additional tools or resources provided.	One intervention for seniors implemented.	One Intervention targeted to seniors and one intervention targeted to parents.	Multiple interventions targeting an age, language and population specific community.
	Reduce frequency of hospital admissions due to cardiovascular disease for underserved Montgomery County residents	Resources that connect residents to counseling, disease prevention and chronic disease management interventions.	No operating resources.	Utilize exhisting resources.	Collaborate in one additional outpatient resource.	Collaboration and implementation of a resource tool to connect residents to chronic disease management interventions.

EXHIBIT 1: SUBURBAN HOSPITAL FY 2016 COMMUNITY BENEFIT PROGRAMS AND INITIATIVES

Suburban Hospital Community Benefit Report - FY 2016 (July 1, 2015 - June 30, 2016)

Community Health & Wellness Department- Southern MD Initiatives

	Date	Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
SOUTHERN MARYLAND INITIATIVES							
Prince George's County							
Ongoing Cardiac Initiatives & Partnership Programs							
	Twice Weekly	Senior Shape Exercise Class at Gwendolyn Britt Senior Activity Center	20722	104	20	2,080	1,976
	Once a Week	Tai Chi Class at Gwendolyn Britt Senior Activity Center	20722	52	11	572	543
		Section Subtotal		**156**	**31**	**2,652**	**2,519**
Screenings							
	Twice Monthly - Mondays	Blood Pressure Screenings at Glenarden Senior Nutrition Center	20706	24	10	240	240
	Twice Monthly - Tuesdays	Blood Pressure Screenings at Gwendolyn Britt Senior Activity Center	20722	24	13	312	296
	Twice Monthly - Tuesdays	Blood Pressure Screenings at PG Plaza Community Center	20782	24	10	240	228
	Once a month- Thursdays	Blood Pressure Screenings at Spellman House Apts in partnership with Capital Area Food Bank	20740	12	15	180	171
	Once a month- Wednesdays	Blood Pressure Screening at Langley Park Senior Activity Center	20783	12	9	108	103
	February 2016	Gwendolyn Britt Senior Shape Fitness Health Assessment	20722	1	24	24	23
	June 22, 2016	Suitland Dine & Learn Mini-Health Screening: Blood Pressure, Weight and Waist Circumference	20747	1	12	12	12
	March 23, 2016	Suitland Dine & Learn Full Health Screening: Blood Pressure, Weight, Waist Circumference, and Total Cholesterol	20747	1	14	14	14
		Section Subtotal		**99**	**107**	**1,130**	**1,087**
Worksite Wellness							
	9/23/2015	Capital Cadillac TC/HDL Cholesterol Screening	20770	1	25	25	12
		Section Subtotal		**1**	**25**	**25**	**12**
Presentations/Seminars							
	August 2015	The Healthy Side of Container Gardening (Langley Park Senior Activity Center)	20783	1	11	11	10
	September 2015	Body Fat Composition & Body Mass Index (Langley Park Senior Activity Center)	20783	1	11	11	10
	October 2015	The Basics: Memory Loss, Dementia, and Alzheimers Disease (Langley Park Senior Activity Center)	20783	1	11	11	10
	October 2015	Aromatherapy for Health (Gwendolyn Britt Senior Activity Center)	20722	1	16	16	16
	November 2015	Tame Your Sweet Tooth: Tips for Healthy Holiday Indulging (Langley Park Senior Activity Center & Gwendolyn Britt Senior Activity Center)	20783, 20722	2	27	27	25
	December 2015	How Sweet it Is: Limiting Sugar in Your Diet (Gwendolyn Britt Senior Activity Center)	20722	1	16	16	16
	January 2016	The Cure for Falling (Langley Park Senior Activity Center)*	20783	1	11	11	10
	February 2016	The Basics: Memory Loss, Dementia, and Alzheimers Disease (Langley Park Senior Activity Center)	20783	1	10	10	9
	February 2016	Breathe Easy, Breathe Better! (Gwendolyn Britt Senior Activity Center)*	20722	1	15	15	15
	March 2016	Waist Circumference & Body Mass Index (Langley Park Senior Activity Center)	20783	1	10	10	9
	March 2016	How Old is Your Heart? (Gwendolyn Britt Senior Activity Center)	20722	1	22	22	22
	April 2016	Keeping a Healthy Heart (Langly Park Senior Activity Center)*	20783	1	13	13	12
	April 2016	100 Calorie Wonders: Cooking Demonstration (Gwendolyn Britt Senior Activity Center)	20722	1	22	22	21
	May 2016	Breathe Easy, Breathe Better! (Langley Park Senior Activity Center)*	20783	1	13	13	12
	May 2016	Put Pain in its Place: How to Get Osteoarthritis Pain Under Control (Gwendolyn Britt Senior Activity Center)	20722	1	9	9	9
	June 2016	Put Pain in its Place: How to Get Osteoarthritis Pain Under Control (Langley Park Senior Activity Center)	20783	1	12	12	11
	June 2016	Living Your Best Life with Diabetes (Gwendolyn Britt Senior Activity Center)	20722	1	10	10	10
	July 2015	Suitland Dine & Learn: Raising the Salad Bar	20747	1	30	30	30
	July 2015	Rollingcrest-Chillum Dine & Learn: Raising the Salad Bar	20782	1	29	29	29
	August 2015	Suitland Dine & Learn: Lunch with a Punch	20747	1	27	27	27
	September 2015	Suitland Dine & Learn: If Heart Healthy You Must Be, Eat More Fish from the Sea	20747	1	16	16	16
	October 2015	Suitland Dine & Learn: Cooking with Food Trends	20747	1	10	10	10
	October 2015	Rollingcrest-Chillum Dine & Learn: Cooking with Food Trends	20782	1	10	10	10
	November 2015	Suitland Dine & Learn: Tame Your Sweet Tooth: Tips for Healthy Holiday Indulging	20747	1	17	17	17
	February 2016	Suitland Dine & Learn: Creamy & Dreamy	20747	1	5	5	5
	March 2016	Suitland Dine & Learn: National Nutrition Month: Savor the Flavor	20747	1	23	23	23
	April 2016	Suitland Dine & Learn: Boosting Your Brainpower	20747	1	19	19	19
	May 2016	Suitland Dine & Learn: Rockin' the Spice Rack	20747	1	26	26	26
	June 2016	Suitland Dine & Learn: Farm to Table Fresh: Eating from the Ground Up	20747	1	32	32	32
	June 2016	Rollingcrest-Chillum Dine & Learn: Farm to Table Fresh: Eating from the Ground Up	20782	1	12	12	12
		Section Subtotal		**31**	**495**	**495**	**482.9**

Suburban Hospital Community Benefit Report - FY 2016 (July 1, 2015 - June 30, 2016)

Community Health & Wellness Department- Southern MD Initiatives

	Date	Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
SOUTHERN MARYLAND INITIATIVES							
Meetings/Conference Calls							
	Biannual	Reminder calls for Suitland Dine & Learn pre- and post-health assessement appointments	20747	2	13	26	26
	Bimonthly	Prince George's Healthcare Action Coalition (PGHAC) Chronic Disease Work Group Meeting	20774	3	10	30	27
	February 2016	Suitland Dine & Learn Planning Conference Calls	20747	2	3	6	4
	April 2016	Support Service for Gwendolyn Britt Senior Shape participant, Gail Houle	20722	2	3	3	0
	May 2016	Site visit to Rollingcrest Commons and Victory Crest housing communities to market Dine & Learn	20782	1	1	2	2
		Section Subtotal		**10**	**30**	**67**	**59**
Health Fairs							
	May 14, 2016	Fairlands Health Fair TC Screening in Laurel, MD*	20787	1	50	50	49
		Section Subtotal		**1**	**50**	**50**	**49**
		Prince George's County Total		**298**	**738**	**4,419**	**4,209**
Calvert County							
Ongoing Cardiac Initiatives & Partnership Programs							
		BP Kit Partnership Program - Potter's Place Baptist Church	20685	1	2	2	0
		Section Subtotal		**1**	**2**	**2**	**0**
Screenings							
	Monthly	Blood Pressure at Our Lady Star of the Sea Catholic Church, Solomons, MD	20688	10	18	180	15
	Monthly	Blood Pressure at Middleham/St. Peter's Parish, Lusby, MD and SMILE	20657	12	10	120	36
	Monthly	Blood Pressure at Huntingtown United Methodist Church, Huntingtown, MD	20639	12	7	84	0
	Monthly	Blood Pressure at Crossroad Christian Church, St. Leonard, MD	20685	7	7	49	30
	Monthly	Blood Pressure at Waters Memorial United Methodist Church, St. Leonard, MD	20685	10	9	90	0
	Monthly	Blood Pressure at Friendship Community Baptist Church, Dunkirk, MD	20754	5	5	25	0
	Monthly	Blood Pressure at Calvary Bible Church, Lusby, MD	20657	12	12	144	15
		Section Subtotal		**68**	**68**	**692**	**96**
Meetings/Conference Calls							
	March 2016	Calvert County Blood Pressure Program - introduction/check-in call	20678	1	2	4	0
	Bimonthly	Calvert County Health Ministry Meetings	20678	2	6	12	0
		Section Subtotal		**3**	**8**	**16**	**0**
		Calvert County Total		**72**	**78**	**710**	**96**
St. Mary's County							
Ongoing Cardiac Initiatives & Partnership Programs							
		MedStar St. Mary's Hospital's Congestive Heart Failure Program and Partnership: BP monitors and Bathroom Scales	20650	0	0	0	0
Meetings/Conference Calls							
	March 2016	St. Mary's CHF Program - introduction/check-in call	20650	1	1	1	0
		Saint Mary's County Total		1	1	1	1
		SOUTHERN MARYLAND INITIATIVES TOTAL		**371**	**817**	**5,130**	**4,306**

Suburban Hospital Community Benefit Report - FY 2016 (July 1, 2015 - June 30, 2016)
Community Health & Wellness Department- Health Partnerships

Date	Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
COMMUNITY OUTREACH HEALTH PARTNERSHIPS						
Medical Exploring Crew 1984						
9/21/2016	Medical Exploring Open House	20814	1	120	120	0
10/5/2016	Medical Exploring Program Kick-Off	20814	1	70	70	0
10/19/2016	Tour of ER/Trauma Bay & Helipad with Dr. Westerband	20814	1	63	63	0
11/2/2016 & 4/11/2016	Suturing with Dr. Rotello	20814	2	34	68	0
11/16/2016	Military occupational and Environmental Medicine	20814	1	70	70	0
11/30/2016	Interventional Radiology	20814	1	57	57	0
12/14/2016	Holiday Mixer/Adopt a Family	20814	1	36	36	0
1/18/2016	Surgery Observation at Inova Heart and Vascular Center	22042	1	27	27	0
2/15/2016	Tour of Sunrise at Foxhill	20817	1	18	18	0
2/29/2016	Dentistry	20814	1	44	44	0
3/14/2016	Sports Medicine and Orthopedics	20814	1	45	45	0
3/25/2016	Tour of National Museum of Health and Medicine	20910	1	20	20	0
3/28/2016	B-CC Rescue Squad Tour	20814	1	28	28	0
5/2/2016	Dr. Corcoran and Dr. Siegenthaler Cardiothoracic	20814	1	29	29	0
5/16/2016	Pharmacy Profession & End of the Year Celebration	20814	1	52	52	0
6/16/2016	Organization Meeting for School Year 2016-17	20814	1	2	2	0
6/21/2016	CPR/AED training	20814	2	16	32	0
	Subtotal		***19***	***731***	***781***	***0***
Scotland Health Partnership						
8/4/2015	National Night Out at Scotland	20854	1	100	100	100
10/8/2015	Knots for Shots at Scotland: Flu Vaccination Initiative	20854	1	18	18	18
3/18/2016	#JustGirls Social Club/ Ice Breaker Session	20854	1	13	13	13
6/10/2016	#JustGirls Social Club/ 11 Things You Need to Know	20854	1	13	13	13
6/17/2016	#JustGirls Social Club/ Poetry in Motion	20854	1	12	12	12
	Subtotal		***5***	***156***	***156***	***156***
Support Groups						
Monthly	Montgomery County Stroke Association Support Group	20814	12	10	120	12
	Subtotal		***12***	***10***	***120***	***12***
Suburban Hospital Auxiliary						
Various	Board Meetings	20814	3	8	24	0
11/6/2015	Auxiliary Tea	20854	1	120	120	0
	Subtotal		***4***	***128***	***144***	***0***
American Red Cross Blood Drive						
Various	Donor Table Recruitment*	20814	9	150	1350	0
9/9/2015	Fall Blood Drive*	20814	1	51	51	0
12/3/2015	Winter Blood Drive*	20814	1	39	39	0
2/24/2016	Spring Blood Drive*	20814	1	51	51	0
5/11/2016	Summer Blood Drive*	20814	1	46	46	0
	Subtotal		***13***	***337***	***1537***	***0***
Safe Sitter Program						
	North Bethesda Middle School	20817	16	12	192	0
	Pyle Middle School	20817	24	16	384	0
	Westland Middle School	20816	8	14	112	0
	St Jane de Chantal	20814	4	15	60	0
	Suburban Hospital	20814	10	16	160	0
	Girl Scout Troop	20817	1	12	12	0
	Subtotal		***63***	***85***	***920***	***0***

Suburban Hospital Community Benefit Report - FY 2016 (July 1, 2015 - June 30, 2016)

Community Health & Wellness Department- Health Partnerships

	Date	Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
OSHER Education Program*							
	2/7/2016	MCC Faculty Luncheon	20850	1	22	22	0
	4/5/2016	Osher-Medicine: Advances in Health Research and Treatment with Dr. Channing Paller	20850	1	75	75	0
	4/12/2016	Osher-Medicine: Advances in Health Research and Treatment with Dr. Liana Rosenthal	20850	1	70	70	0
	4/19/2016	Osher- Medicine: Advances in Health Research and Treatment with Dr. Ranganath Muniyappa	20850	1	90	90	0
	4/26/2016	Osher- Medicine: Advances in Health Research and Treatment with Dr. Greg Kumkumian	20850	1	70	70	0
	5/3/2016	Osher- Medicine: Advances in Health Research and Treatment with Dr. John Lynch	20850	1	75	75	0
	5/10/2016	Osher- Medicine: Advances in Health Research and Treatment with Dr. John Lynch	20850	1	90	90	0
		Subtotal		***7***	***492***	***492***	***0***
Girls on the Run-Montgomery County							
	various	First Aid Classes	20814	3	4	12	0
	various	Heartsaver AED/CPR	20814	4	5	20	0
	11/15/2015	Girls on the Run 5K*	20817	1	500	500	250
	5/22/2016	Girls On the Run 5K*	20817	1	500	500	250
		Subtotal		***9***	***1009***	***1032***	***500***
SCHOOL PARTNERSHIPS							
Ashburton Elementary School Partnership*							
	12/18/2015	Ashburton Chorus Visit	20814	1	146	146	146
	varies	Ashburton Adopt-A-Family Holiday Initiative	20814	1	28	28	28
		Subtotal		***2***	***174***	***174***	***174***
Bradly Hills Elementary School Partnership*							
	2/11/2016	Bradley Hills Elementary School Valentine's Day Card Delivery	20814	1	110	110	0
		Subtotal		**1**	**110**	**110**	**0**
Check It Out Breast Cancer Awareness Program- Montgomery County Public Schools*							
	4/5/2016	CIO Planning Meeting	20852	1	8	8	0
		Subtotal		**1**	**8**	**8**	**0**
Bethesda Chevy Chase High School*							
	12/3/2015	Bethesda Chamber of Commerce and BCC High School Career Partnership Day	20814	1	6	6	1
		Subtotal		**1**	**6**	**6**	**1**

Suburban Hospital Community Benefit Report - FY 2016 (July 1, 2015 - June 30, 2016)

Community Health & Wellness Department- Health Partnerships

	Date	Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
Montgomery County Recreation- Senior Shape Program							
		Clara Barton Community Center	20818				
		Aerobics/Strength/Stretch (Monday & Wednesday)		104	58	6,032	6,032
		Aerobics/Strength/Stretch (Tuesday & Thursday)		104	29	3,016	3,016
		Weight Training		52	27	1,404	1,404
		Potomac Community Center	20854				
		Advanced Aerobics		52	22	1,144	1,144
		Aerobics/Strength/Stretch		104	62	6,448	6,448
		Bethesda Regional Service Center	20814				
		Aerobics/Strength/Stretch		52	28	1,443	1,443
		Weight Training		52	34	1,768	1,768
		Benjamin Gaither Center (formally known as Gaithersburg Senior Center)	20878				
		Weight Training		52	19	988	988
		Flexible Strength		52	13	689	689
		Stability Ball		40	8	320	320
		Margaret Schweinhaut Senior Center	20901				
		Weight Training~33		52	33	1,716	1,716
		Stability Ball		52	10	533	533
		Holiday Park Senior Center	20906				-
		Stability Ball~12		52	14	715	715
		Advanced Weight Training		52	21	1,066	1,066
		Weight Training		52	19	988	988
		Jane E. Lawton Community Center	20815				
		Weight Training		104	44	4,524	4,524
		Wisconsin Place Community Center	20815				
		Advanced Aerobics		52	18	936	936
	7/30/2015	Senior Shape Lunch and Learn*	20816	1	127	127	127
		Subtotal		**1,081**	**585**	**33,730**	**33,730**
		Health Partnership Initiatives Total		**1,218**	**3,831**	**39,210**	**34,573**

Suburban Hospital Community Benefit Report - FY 2016 (July 1, 2015 - June 30, 2016)
Community Health & Wellness Department- Health Initiatives

Date		Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
WellWorks Signature Programs							
Monthly Blood Pressure Screenings							
	3rd Wednesday	Clara Barton Community Center	20818	12	12	144	72
	Last Monday	Lakeview House Senior Living	20817	12	8	96	96
	2nd Tuesday	Coffield Community Center	20910	12	10	120	120
	2nd Wednesday	Bethesda Regional Service Center	20814	12	15	180	90
	2nd Tuesday	Potomac Community Center	20854	11	7	77	77
	4th Friday	Waverly House Senior Living	20814	7	10	70	70
	1st Wednesday	The Oaks at Olde Towne Senior Living	20877	12	6	72	72
		Subtotal		**78**	**68**	**759**	**597**
Weekly Mall Walking							
	Wednesdays	"Rise n Shine" Lakeforest Mall (Wednesdays)	20877	52	15	780	260
Diabetes Lite Program							
	Monthly	Glucose Steering Committee Meetings*	20814	6	10	60	0
	Various	Diabetes Continuum Education & Support Group Meetings @ SH*	20814	4	7	28	5
	11/18/2015	Diabetes Symposium at Suburban Hospital*	20814	1	124	124	0
	Various	Pre-Diabetes Class: Laying the Foundation	20814	4	40	160	0
	Various	Pre-Diabetes Class: What Should I Eat?	20814	2	15	30	0
		Subtotal		**17**	**196**	**402**	**5**
Worksite Wellness Programs							
	9/15/2015	Diabetes seminar at Lockheed Martin	20817	1	18	18	5
	10/20/215	Cholesterol Screening at NASDAQ	20850	1	35	35	0
	10/21/2015	Stress Management seminar at Association of Community Cancer Centers (ACCC) with Leni Barry	20852	1	35	35	0
	2/22/2016	Let's Beat Procrastination seminar at Healthy Destinations	20817	1	20	20	0
	4/14/2016	Sport Chevrolet TC/HDL Screening in Silver Spring, MD	20904	1	39	39	20
	4/15/2016	Sport Honda TC/HDL Screening in Silver Spring, MD	20904	1	34	34	17
	5/31/2016	Worksite Wellness Fair at American Society of Healthsystem Pharmacists (ASHP)	20814	1	40	40	0
	6/27/2016 & 6/28/2016	First Aid and CPR Training for employees of American Society of Healthsystem Pharmacists (ASHP)	20814	1	13	13	0
		Subtotal		**8**	**234**	**234**	**42**
WellWorks Health & Safety							
		CPR for Friends & Family	20814	4	5	20	0
		First Aid Basic and Adult CPR	20814	1	3	3	0
		Heartsaver AED Adult CPR	20814	2	3	6	0
		Community CPR	20814	3	6	18	0
		Survival Guide for First Time Grandparents	20817	5	6	30	0
		Subtotal		**15**	**23**	**77**	**0**
WellWorks Nutrition & Weight Management							
		Nutrition Counseling	20814	128	1	128	12
		Healthy Choices	20906	10	5	50	0
		Healthy Weigh	20906	32	5	160	4
		Healthy Cooking Classes at Suburban Hospital	20814	8	6	48	2
		Subtotal		**178**	**17**	**386**	**18**

Suburban Hospital Community Benefit Report - FY 2016 (July 1, 2015 - June 30, 2016)
Community Health & Wellness Department- Health Initiatives

Date		Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
WellWorks Signature Programs							
WellWorks Health Assessments							
		Cholesterol Screening	20814	3	6	18	0
		Osteoporosis Screening	20814	1	5	5	0
		Subtotal		**4**	**11**	**23**	**0**
Well Works Healthy Lifestyle Programs							
		Learn to Understand Your Anger	20814	3	4	12	0
		Learn to Manage Your Anger	20814	1	3	3	0
		Let's Beat Procrastination	20814	0	0	0	0
		Simplify Your Life	20814	3	5	15	0
		Mindfulness Meditation	20814	30	11	330	0
		Freedom From Smoking	20814	16	5	80	0
		American Lung Association Better Breathers Club	20814	4	5	18	18
		Subtotal		**57**	**33**	**458**	**18**
WellWorks Fitness Programs							
		Tai Chi for Seniors at Bethesda Regional Service Center	20814	30	7	210	0
		Tai Chi for Seniors at Clara Barton Community Center	20818	18	5	90	0
		Tai Chi for Seniors at Jane E. Lawton Community Center	20815	12	9	109	0
		Tai Chi for residents at Maplewood Park Place	20814	10	15	150	30
		Zumba Gold	20815	30	6	180	0
		Zumba Gold-Toning	20815	6	5	30	0
		Balancing Act	20906	8	10	80	40
		Pilates for Seniors	20814	66	14	924	185
		Pilates for Seniors residents at Brighton Gardens of Friendship Heights	20815	40	12	480	0
		Subtotal		**220**	**83**	**2253**	**255**
		Well Works Initiatives Total		**629**	**680**	**5,372**	**1,195**

Suburban Hospital Community Benefit Report - FY 2016 (July 1, 2015 - June 30, 2016)
Community Health & Wellness Department

	Date	Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
Community Seminars & Special Events*							
July							
	7/15/2015	Healthy Habits for a Healthier You Health Seminar at Friendship Heights Village Center	20815	1	14	14	0
	7/23/2015	Lyme Disease: The Great Imitator Rockville Senior Center Seminar	20850	1	32	32	32
	7/21/2015	Your Arch Enemy Health Seminar at Holiday Park Senior Center with Dr. Danielle Venegonia	20906	1	34	34	5
August							
	8/2/2015	Salvadorean Health Festival*	20902	1	480	480	480
	8/12/2015	Finding Relief from Spinal Stenosis Seminar at Friendship Heights Village Center with Dr. A. Jay Khanna	20815	1	36	36	0
	8/17/2015	CPR for Friends and Family for Private Group	20814	1	4	4	0
	8/27/2015	Moving Forward with Parkinson's Disease Rockville Senior Center Seminar	20850	1	43	43	43
September							
	9/9/2015	Tipping the Scale to a Healthy Heart Seminar at Friendship Heights Village Center with Karen Lieberman	20815	1	9	9	0
	9/15/2015	Dashing Away Knee Pain Seminar at Holiday Park Senior Center with Dr. William Sadlack	20906	1	40	40	5
	9/16/2015	The HOPE Initiative Pilot	20814	1	20	20	0
	9/24/2015	Keep Your Eye on the Prize! Rockville Senior Center Seminar	20850	1	31	31	31
	9/27/2015	Latino Health Fair @ Lakeforest Mall	20877	1	30	30	30
	9/30/2015	Hispanic Heritage Month: Celebrando Ser Mujer con Dr. Gonzalez	20816	1	32	32	32
	9/30/215	Don't be Blue, Protect Against the Flu Seminar at Holiday Park Senior Center with Rita Tonner	20906	1	6	6	0
October							
	10/8/2015	The HOPE Initiative	20814	1	30	30	0
	10/10/2015	5th Annual GWAPI/GGSF Health Fair	20850	1	46	46	19
	10/13/2015	Eat This, Not That seminar at Holiday Park Senior Center with Rhonda Brandes	20906	1	40	40	10
	10/14/2015	Get Your Back on Track Seminar at Friendship Heights Village Center with Matt Tovornik	20815	1	13	13	0
	10/15/2015	The HOPE Initiative	20814	1	25	25	0
	10/21/2016	United Way Kick-Off Day @ Suburban Hospital	20814	1	200	200	Unk
	10/22/2015	The HOPE Initiative	20814	1	25	25	0
	10/22/2015	Get Relief From Bladder Matters Rockville Senior Center Seminar	20850	1	38	38	38
	10/23/2015	#JustGirls: 11 Things You Need to Know	20814	1	146	146	0
	10/27/2015	Aging in Place @ Holiday Park	20906	1	40	40	30
	10/29/2015	The HOPE Initiative	20814	1	20	20	0
November							
	11/4/2015	Act F.A.S.T with Stroke Awareness seminar at Friendship Heights Village Center	20815	1	20	20	0
	11/15/2015	The HOPE Initiative	20814	1	15	15	0
	11/17/2015	Stay Firm on Your Feet seminar at Holiday Park Senior Center with Alex Sterling	20906	1	50	50	5
	11/16/2015	Great American SmokeOut @ SH	20814	1	40	40	18
	11/19/2015	Homeless Resource Fair Day	20877	1	150	150	150
	11/19/2015	The Basics: Memory Loss, Dementia and Alzheimer's Disease- Rockville Senior Center Seminar	20850	1	39	39	39
	11/23/2015	Colorectal Cancer Education @ Waverly House Clinic	20814	1	12	12	3
	11/25/2015	Colorectal Cancer Education @ Proyecto Salud Clinic	20902	1	13	13	13
	11/26/2015	33rd Annual Turkey Chase	20814	1	10000	10000	0
	11/30/2015	Colorectal Cancer Education @ Proyecto Salud Clinic	20902	1	16	16	16
December							
	12/9/2015	Listen Up! Surgical Options for Hearing Loss seminar at Friendship Heights Village Center with Dr. Wade Chien	20815	1	8	8	0
January							
	1/13/2016	Feel It in Your Bones seminar at Friendship Heights Village Center with Dr. Jay Shapiro	20815	1	13	13	0
	1/19/2016	Dealing with the Blues seminar at Holiday Park Senior Center with Suburban Hospital Behavioral Health Social Worker	20906	1	20	20	10
February							
	2/9/2016	Rotary Heart Luncheon with Dr. Misha Zilbermint	20816	1	75	75	0
	2/10/216	Breaking the Ice seminar at Friendship Heights Village Center in partnership with Jewish Social Service Agency	20815	1	13	13	0
	2/12/2016	Heart Health event at Suburban	20814	1	500	500	100
	2/18/2016	14th Annual Women's Health Symposium at Kenwood Country Club with Dr. Astrid Von Walter Gonzalez and Dr. Carla Sandy	20816	1	88	88	10
	2/23/2016	A Healthy Relationship with Alcohol seminar at Holiday Park Senior Center with Cheryl Moore from Suburban's Addiction Treatment Center	20906	1	21	21	10
	2/25/2016	A Heart to Heart- Rockville Senior Center Seminar	20850	1	21	21	21
March							
	3/4/2016	Wear Blue Day @ Suburban Hospital	20814	2	10	20	16
	3/7/2016	Sustainability Series with Bethesda Green: Clean Air and Your Building seminar	20814	1	21	21	0
	3/92016	Recipe for a Happy Tummy seminar at Friendship Heights Village Center with Dr. Daphne Keshishian	20815	1	50	50	3

Suburban Hospital Community Benefit Report - FY 2016 (July 1, 2015 - June 30, 2016)

Community Health & Wellness Department

	Date	Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
Community Seminars & Special Events*							
	3/18/2016	Colon Cancer Awareness: Facebook Post	20814	1	620	620	Unk
	3/23/2016	United Way Video Taping @ Suburban Hospital	20814	1	12	12	0
	3/22/2016	Creating Your Diabetic Plate seminar at Holiday Park Senior Center with Wendy Weisblatt	20906	1	45	45	15
	3/24/2016	Moving the Needle with Acupuncture - Rockville Senior Center Seminar	20850	1	30	30	30
April							
	4/6/2016	A Better Body at Any Age seminar at Friendship Heights Village Center with Jeanmarie Gallagher	20815	1	17	17	0
	4/6/2016	The Big Event	20814	1	150	150	0
	4/7/2016 & 4/8/2016	JHU-Montgomery County Bread Baking Event	20850	2	55	110	20
	4/16/2016	AAHP Community Day- Nurse Volunteer	20906	1	200	200	200
	4/16/2016	6th Annual Education Symposium On the Horizon: New Approaches in Alzheimer's Prevention, Treatment and Research	20852	1	190	190	90
	4/19/2016	Hearts A Flutter seminar at Holiday Park Senior Center with Dr. Erich Wedam	20906	1	34	34	5
	4/30/2016	Safe Kids Coalition- Safe Kids Day	20903	1	100	100	100
	4/30/2016	Healthy Kids Day @ the "Y" with Peds Staff	20814	1	80	80	40
May							
	5/10/2016	Relieving Knee Pain- Margaret Schweinhaut Senior Center Seminar	20901	1	10	10	10
	5/11/2106	Catch Your Z's with Ease seminar at Friendship Heights Village Center with Dr. Pavel Klein	20815	1	18	18	0
	5/12/2016	Showcase 2016	20852	1	150	150	0
	5/16/2016	Sustainability Series with Bethesda Green: Local Eats and Sustainable Food	20814	1	20	20	0
	5/17/216	Take as Directed seminar at Holiday Park Senior Center with Suburban Hospital Pharmacist	20906	1	14	14	5
	5/26/2016	Rockville Senior Center Annual Health Fair	20850	1	150	150	150
	5/26/2016	Breaking the Ice- Rockville Senior Center Seminar	20850	1	14	14	14
June							
	6/8/2016	Caring for the Skin You're In seminar at Friendship Heights Village Center with Dr. Benjamin Lockshin	20815	1	16	16	0
	6/8/2016	Community Health Improvement Lunch & Learn for SH Staff	20814	1	18	18	15
	6/15/2016	13th Annual Men's Health Symposium at Suburban Hospital with Dr. Juan Litvak and Dr. Mark Rosenblum	20814	1	52	52	7
	6/21/216	Ten Ways to Love Your Brain seminar at Holiday Park Senior Center in partnership with the Alzheimer's Association	20906	1	36	36	10
	6/23/2016	Catching Your Zz's with Ease- Rockville Senior Center Seminar	20850	1	38	38	38
	6/30/2016	Employee Health Fair @ Suburban Hospital/ Tobacco Cessation Education	20814	1	300	300	150

	Date	Event	Zip Code	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
"Abuelitas" Initiative at Rockville Senior Center							
	4/7/2016	Pre-Diabetes Presentation- CHW	20850	1	10	10	10
	5/19/2016	Healthy Eating- Wendy Weisblatt, RD*	20850	1	10	10	10
	6/16/2016	Women's Health with Dr. Astrid Gonzalez*	20850	1	18	18	18

	Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
Special Events Total	***77***	***15,036***	***15,101***	***2,106***

Suburban Hospital Community Benefit Report - FY 2016 (July 1, 2015 - June 30, 2016)

Community Health & Wellness Department- Partnerships

		Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
Activities					
	Community Benefit Operations				
	Suburban Hospital Community Benefit Advisory Council	3	20	60	0
	Subtotal	***3***	***20***	***60***	***0***
	Community Health and Wellness State & County Health Initiatives				
	CHIP Community Health Improvement Process (Healthy Montgomery)	6	30	180	0
	Healthy Montgomery Hospital Workgroup Meeting	4	10	40	0
	Healthy Montgomery Evaluation Workgroup	4	5	20	0
	Subtotal	***14***	***45***	***240***	***0***
	Partnership Meetings held at Suburban				
	Annual Mobile Med Meeting at Suburban Hospital	1	75	75	0
	Subtotal	***1***	***75***	***75***	***0***
	Village Partnerships				
	Bannockburn Village				
	Bradley Hills Village	3	3	9	0
	Burning Tree Village				
	Chevy Chase Village	1	60	60	0
	Farmland Village	1	50	50	0
	Little Falls Village				
	Maplewood Village				
	Rockville Village	2	25	25	0
	Village of Kensington	1	30	30	0
	Wyngate Village				
	Subtotal	***8***	***168***	***174***	***0***
	FY2016 Coalition/Partnerships/Affiliations Meetings				
	AARP Driver Safety Course	4	15	60	60
	A Wider Circle Adopt-A-Family Holiday Initiative	1	21	21	21
	AHCN Advisory Council/Catholic Charities of Washington, DC Meetings	3	15	45	0
	Alpha Phi Alpha MLK Breakfast	1	250	250	0
	American Lung Association	3	5	15	0
	Lung Expo 2016	4	5	20	0
	BCC-YMCA Board	4	25	100	0
	Bethesda Chevy Chase Rotary Club Meetings and Community Development events	50	55	2750	0
	Charles E. Smith Life Communities	10	10	100	0
	Girls on the Run-Montgomery County Partnership Initiative	3	5	15	0

Suburban Hospital Community Benefit Report - FY 2016 (July 1, 2015 - June 30, 2016)

Community Health & Wellness Department- Partnerships

		Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
	Health and Wellness Advisory Council	2	30	30	0
	Hispanic Chamber of Commence Leadership Breakfast	1	100	100	100
	Innovations in Workplace and Community Wellness: Bridging Personal and Population Health U.	1	70	70	40
	Jewish Social Service Agency	1	3	3	0
	Kaiser Permanente	20	10	200	10
	Latino Health Initiative	4	9	32	32
	Leadership Montgomery Workgroup meeting	1	100	100	0
	Mobile Med/NIH Heart Clinic at Suburban Hospital	50	15	750	750
	MobileMed/NIH Endocrine Clinic at Suburban Hospital	50	10	500	500
	Montgomery Cares	2	30	60	10
	Montgomery County Cancer Coalition	4	10	40	30
	Montgomery County Chamber of Commerce	1	100	100	50
	Montgomery County Senior Sub-cabinet group-Health and Wellness Advisory Committee	5	10	50	2
	Nexus Montgomery	18	8	144	0
	Primary Care Coalition	3	8	24	0
	Project Access	2	2	8	0
	Safe Kids Coalition	2	6	12	2
	Scotland Community Partnership- National Night Out Planning Meetings	2	10	20	0
	Sunrise at Fox Hills	3	5	15	0
	Tobacco Free Coalition	2	8	16	0
	United Way National Capital Region				
	United Way Awareness Tables	4	150	600	0
	United Way MoCo Regional Council	5	5	25	0
	United Way Conference Calls	5	10	50	0
	United Way Planning Meetings	11	8	70	0
	Village to Village Network Initiative	2	20	40	0
	Washington Metropolitan OASIS	15	5	75	0
	Partnership Subtotal	***299***	***1,148***	***6,510***	***1,607***

Suburban Hospital Community Benefit Report - FY 2016 (July 1, 2015 - June 30, 2016)

Community Health & Wellness Department- Partnerships

List of Total Partnerships, Coalitions and Affiliations		Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
	A Wider Circle				
	AARP				
	Alpha Phi Alpha Fraternity				
	American Red Cross				
	American Lung Association				
	Archdioceses Healthcare Network/Catholic Charities of Washington DC				
	Ashburton Elementary School Blanket Donation				
	BCC YMCA				
	Bethesda Cares				
	Bethesda Chevy Chase Rotary Club				
	Bethesda-Chevy Chase Chamber of Commerce				
	Boy Scouts of America				
	Charles E. Smith Life Communities				
	Girls on the Run of Montgomery County				
	Jewish Social Service Agency				
	Kaiser Permanente				
	Latino Health Initiative				
	Leadership Montgomery				
	MobileMed Inc.				
	Montgomery Cares				
	Montgomery County Cancer Coalition				
	Montgomery County Chamber of Commerce				
	Montgomery County Department of Health and Human Services				
	Montgomery County Department of Parks and Recreation				
	Montgomery County Housing Opportunity Commission				
	Montgomery County Office on Aging				
	Montgomery County Public Schools				
	Montgomery County Stroke Association				
	Montgomery Hospice				
	National Institutes of Health- National Heart Lung and Blood Institute				
	National Institutes of Health-National Institute of Diabetes and Digestive and Kidney Diseases				
	Primary Care Coalition				
	Project Access				
	Proyecto Salud Clinic				
	Safe Kids Coalition				
	Safe Sitter, Inc.				
	Scotland Community Partnership				

Suburban Hospital Community Benefit Report - FY 2016 (July 1, 2015 - June 30, 2016)

Community Health & Wellness Department- Partnerships

		Number of Events	# of Encounters	Total Number of Encounters	Undeserved Population
	Sunrise at Fox Hills				
	Tobacco Free Coalition				
	United Way National Capital Region				
	United Way Regional Council- Montgomery County				
	Village to Village Network Initiative				
	Washington Metropolitan OASIS				
	YMCA Youth and Family Services.				

Suburban Hospital Community Benefit Report - FY 2016 (July 1, 2015 - June 30, 2016)

Community Health & Wellness Department- Partnerships

		QTY	Financial ($)	Total $
Community Donations/ Community Contributions				
	4.15.2015 Aromatherapy seminar at Langley Park Senior Center			$170.00
	Ashburton Elementary School Blanket Donation to Pediatric Dept.	75	150	150
	Ashburton Elementary School Plush Toy and DVD Player Donation to Pediatric Dept.	104	643	643
	Blood Pressure Cards	2	$250.00	$500.00
	Contribution to purchase stethoscopes and BP cuffs for BP Kit Program in Calvert County	5	$167.26	$405.00
	Equipment Donation to Gwendolyn Coffeild Community Center	10	2	22
	Equipment Donation to Safe Kids Montgomery County Coalition	100	100	100
	Facility Rental for Senior Shape Classes at Potomac Community Center	1	$900.00	$900.00
	Food Expenses for Cooking Demos at Gwendolyn Britt & Langley Park Senior Activity Centers Healt	2	$150.00	$300.00
	Food Expenses for Suitland Dine and Learn Program	15	$50.00	$750.00
	Food for Latino Health Symposium	50	$1,962.00	$1,962.00
	Food for the Women's Health Symposium		$2,544.84	$2,544.84
	Instructor Fees for Free Senior Shape Class at Gwendolyn Britt in Prince George's County	100	$45.00	$4,500.00
	Instructor Fees for Free Tai Chi Class at Gwendolyn Britt Senior Activity Center in Prince George's C	50	$45.00	$2,250.00
	Instructor Fees for Gwendolyn Britt & Langley Park Senior Activity Centers Health Seminar Series	0	$0.00	$0.00
	Instructor Fees For Rollingcrest Dine and Learn Program	4	$150.00	$600.00
	Instructors for Girls on the Run CPR and 1st aid classes		$503.50	$503.50
	Healthy Snacks and Shoes for Girls on the Run		$10,280.74	$10,280.74
	Instructors for Senior Shape Classes in Montgomery County	5	$39,340.00	$56,760.00
	Sponsorship for 33rd YMCA Turkey Chase		$2,500.00	$2,500.00
	Suitland Dine and Learn Health Assessment Cholesterol Testing	30	$30.00	$900.00
	Support to Suitland Dine and Learn Program (Chef/Instructor fees)	11	$150.00	$1,650.00
	Cholesterol Screening for Ama Tu Vida	190	$2,515.00	$2,515.00
	Validation Parking Stickers for Mobile Med/NIH Endocrine Clinic	510	$4,940.00	$4,940.00
	Holy Cross Healthy Clinic	4	$25,000.00	$100,000.00
	TOTAL	***1268***	***$ 92,418.21***	***$ 195,845.30***