HOLY CROSS HOSPITAL

Community Health Needs Assessment FY 2017

Approved by the Holy Cross Health Board of Directors on October 13, 2016

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EXECUTIVE SUMMARY

In 2010, Congress enacted the Patient Protection and Affordable Care Act that requires non-profit hospitals to conduct a community health needs assessment and adopt an implementation strategy every three years. Holy Cross Health, a Catholic not-for-profit health system based in Montgomery County, Maryland, has been conducting needs assessments for more than 15 years. In 2009, Holy Cross Health partnered with *Healthy Montgomery*, Montgomery County's Community Health Improvement Process to determine the significant unmet needs of the community, consistent with the new IRS requirements. Holy Cross Health also reviewed and analyzed data from multiple sources including Dignity Health's Community Health Need Index, University of Wisconsin Population Health Institute's County Health Rankings Data, and other available needs assessments and reports.

This community health needs assessment focuses on the geographic areas Holy Cross Hospital serves. It provides the foundation for the organization's efforts to guide community benefit planning to improve the health status of the community served. Holy Cross Hospital serves a large portion of Montgomery and Prince George's Counties residents, one of the most culturally and ethnically diverse communities in the nation. Montgomery and Prince George's Counties are fairly affluent in terms of wealth and community resources, however, the complexity of the community challenges the hospital, the county health departments, community-based organizations and other organizations to understand and address unmet needs.

Although access to quality, affordable health care plays a significant role in the health of individuals, health is also affected by other determinants. Understanding determinants of health, such as economics and education, can also lead to reductions in health disparities and improvements in health indicators.

Health indicators, such as causes of death, breast cancer rates, obesity and fruit consumption, can be used to describe the overall health of a population and determine unmet community need. Where available, the most current and up-to-date data was used to determine the health needs of the community. However, data gaps exist. For example, many data are not available by geographic areas within Montgomery or Prince George's County and health risk data on subpopulations such as Hispanic/Latino populations are difficult to measure.

The *Healthy Montgomery* Steering Committee analyzed available data on more than 100 indicators to determine the top-ranked priority areas for the county: Behavioral Health, Obesity, Cancers, Maternal and Infant Health, Diabetes, and Cardiovascular Health. In

addition to selecting the six broad priorities for action, the *Healthy Montgomery* Steering Committee selected three overarching goals for all priorities:

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

Building upon the *Healthy Montgomery* top-ranked priorities and three overarching goals, Holy Cross Health added meeting the needs of the growing senior population as a priority. Holy Cross Health also ranked the priorities based on severity, feasibility, potential to achieve outcomes and prevalence in the population. The following prioritized list of the significant unmet needs identified was developed using scores from each of the categories listed above:

1. Maternal & Infant Health
2. Seniors
3. Diabetes
4. Cancers
5. Cardiovascular Health
6. Obesity
7. Behavioral Health

With this information, Holy Cross Health will address the unmet needs within the context of our overall approach, mission commitments, key clinical strengths, and within the overall goals of *Healthy Montgomery*. Holy Cross Health will focus our community benefit activities on the most vulnerable and underserved individuals and families, including women/children, seniors, and racial, ethnic and linguistic minorities.

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

INTRODUCTION

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

Holy Cross Health has evaluated the needs of its community to support its community benefit plans for more than 15 years. Doing so is consistent with the organization's mission and values. It also closely aligns with advancing Holy Cross Health's strategic principles.

Mission Statement

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

Holy Cross Health’s team will achieve this trust through:

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

Core Values

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

Holy Cross Health's fiscal 2015-2018 strategic plan identifies three strategic principles that are responsive to our mission commitments and the environment in which we operate.

- Attract more people, serve everyone
- Manage quality, costs, and revenue effectively
- Improve and sustain individual and community health through innovation, alignment, and partnership.

These strategic principles guide Holy Cross Health's overall development and in particular, advance our population health efforts, which include our community health needs assessment and the associated community benefit plan.

During the last several years, the term "population health" has been used to describe efforts to improve patient outcomes and community health status while managing costs. As an emerging term, there is no one answer to how "population" should be defined. For instance, public health agencies typically define a population based on geographic areas stratified by demographic characteristics such as race, ethnicity or income. Health care delivery systems define populations based on individual patients they serve such as diabetic or congestive heart failure patients (Gourevitch, Cannell, Boufford, & Summers, 2012). Populations can also be defined as groups for which an entity such as an insurer or employer bears financial risk for health care utilization. Although the definition differs between policy, public health, health care, and other health fields, a population health orientation provides the opportunity for organizations focused on health improvement, including health care delivery systems, to work together to achieve positive outcomes in the communities they serve (Stoto, 2013).

This community health needs assessment focuses on the geographic areas Holy Cross Hospital serves. It provides the foundation for the organization's efforts to guide community benefit planning to improve the health status of the people, particularly those most at-risk, in Holy Cross Hospital's service area.

OVERVIEW OF HOLY CROSS HEALTH

Holy Cross Health is a Catholic not-for-profit health system based in Montgomery County, Maryland that has nearly 200,000 patient visits each year. We offer a full range of inpatient, outpatient, and innovative community-based services and are the region's only three-time winner of The Joint Commission’s highest quality award. Holy Cross Health has a 1,900 member medical staff, employs nearly 4,200 people, has more than 500 volunteers and is the only healthcare provider in Maryland to receive the Workplace Excellence Seal of Approval Award each year since 1999 from the greater Washington, D.C., Alliance for Workplace Excellence. Holy Cross Health is comprised of Holy Cross Hospital, Holy Cross Germantown Hospital, Holy Cross Health Network and the Holy Cross Health Foundation.

Holy Cross Hospital: Located in Silver Spring, Holy Cross Hospital is one of the largest hospitals in Maryland. Founded more than 50 years ago in 1963 by the Congregation of the Sisters of the Holy Cross, today Holy Cross Hospital is a teaching hospital with 423 adult licensed beds, a neonatal unit with 113 newborn bassinets, 46 neonatal intensive care unit bassinets and an on-site obstetrics/gynecology outpatient clinic for uninsured women. The hospital offers a full range of inpatient and outpatient services (see Appendix A), with specialized expertise in senior services, women and infant services, surgery (particularly gynecological), neuroscience, and cancer.

In 2015, with the largest expansion in its 50-year history, Holy Cross Hospital joined Holy Cross Germantown Hospital as the only area hospitals to offer private rooms to all patients. The new seven-story patient care building, the South Building, added 232,000 square feet to the hospital. The "green" design meets all the latest standards for sustainability and aims to obtain Leadership in Energy and Environment Design (LEED) Gold certification.

Holy Cross Germantown Hospital: In October 2014, Holy Cross Health opened Holy Cross Germantown Hospital, the first new hospital in Montgomery County in 35 years. The hospital serves the most rapidly growing region in the county and provides access to high-quality care in an area that had previously been, by far, the largest concentration of people without a hospital in the state. Holy Cross Germantown Hospital has 93 adult licensed beds and a neonatal unit with 17 newborn bassinets and eight premature nursery bassinets. The hospital offers emergency, medical, surgical, obstetric, neonatal and psychiatric care to meet a full range of community needs. All patient rooms are private to enhance patient safety and satisfaction, as well as patient, family and visitor comfort. The facility features sustainable design elements that achieved Leadership in Energy and Environmental Design (LEED) Gold certification.

Holy Cross Health Network: Established in 2012, Holy Cross Health Network is an operating division within Holy Cross Health that is focused on creating the relationships and programs that will help Holy Cross Health better manage care in the communities it serves. Holy Cross Health Network operates Holy Cross Health Centers in Aspen Hill, Gaithersburg, Germantown, and Silver Spring. These primary care sites serve low-income patients who are uninsured or are enrolled in Maryland Physician's Care; a Maryland Medicaid managed care organization. Holy Cross Health Network also operates Holy Cross Health Partners at Asbury Methodist Village and in Kensington, primary care practices specializing in internal medicine and geriatrics, and manages all of Holy Cross Health's community health programs and outreach.

Beyond our campuses, we provide service at multiple locations, including a vital aging center for seniors. We offer more than 50 different types of health and wellness classes at various locations throughout the region and have established a geographic presence at 24

sites that host our senior exercise program and in 65 churches through our faith community nurse program.

Holy Cross Health Foundation: The Holy Cross Health Foundation is a not-for-profit organization devoted to raising philanthropic funds to support the mission of Holy Cross Health and to improve the health of the community. Contributions to the foundation help Holy Cross Health invest in new technologies, nursing education, clinical services, community benefit programs, renovations, and new construction. *The Campaign for Holy Cross* supports the construction of the new Holy Cross Germantown Hospital and the new patient care building at Holy Cross Hospital.

APPROACH AND METHODOLOGY

Holy Cross Health has been conducting needs assessments for more than 15 years and identifies unmet community health care needs in our community in a variety of ways. We collaborate with other healthcare providers to support *Healthy Montgomery*, Montgomery County's community health improvement process. We seek expert guidance from a panel of external participants with expertise in public health and the needs of our community and gather first-hand information from community members through community conversations facilitated by *Healthy Montgomery* staff members and the Montgomery County Department of Health and Human Services. We review other available reports and needs assessments and use them as reference tools and to identify unmet need in various populations. We also use the Community Need Index to geographically identify high need communities in need of programs and services and use internal data sources to conduct an extensive analysis of demographics, health indicators and other determinants of health for the communities we serve.

HEALTHY MONTGOMERY

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

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

Healthy Montgomery's four objectives are to:

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

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

Healthy Montgomery began in June of 2009 when Holy Cross Hospital and the other three hospital systems in Montgomery County each gave $25,000, for a total of $100,000, to the Urban Institute to provide support for the *Healthy Montgomery* work. This included coordinating the environmental scan, which looked at all the existing sources of data (e.g., vital statistics, Department of Health and Mental Hygiene) and needs assessments and improvement plans from organizations in Montgomery County (many of these documents are now available through the *Healthy Montgomery* website), support of the effort to select the 100 indicators to include in the improvement process, preparation of indicators and maps that show the social determinants of health for the county as a whole and for Public Use Microdata Areas (PUMAs) that will be included in the *Healthy Montgomery* Needs Assessment document.

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

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

based on Montgomery County's Community Health Needs Assessment conducted during the 2016-2019 cycle.

Prince George's County has a data collection website similar to that of HealthyMontgomery.org. The website, PGCHealthZone.org, is operated by the Prince George's County Health Department and brings non-biased local health data, local resources, best practices and county information to one accessible, user-friendly location (Prince George's County Health Department, 2016). Holy Cross Health used data from *PGCHealthZone,* coupled with data pulled from the data sources found in *Healthy Montgomery,* to extract data specific to Prince George's County. This allowed analysis of the same health indicators for both counties.

EXTERNAL REVIEW

Each year since 2005, we have invited input and obtained advice from a group of external participants that represent the broad interest of the community we serve. The group reviews our community benefit plan, annual work plan, foundation/key background material, and data supplements to advise us on priority community needs and the direction to take for the next year.

External group participants include the public health officer and the director of Montgomery County Department of Health and Human Services; a variety of individuals from local and state governmental agencies; and leaders from community-based organizations, foundations, churches, colleges, coalitions, and associations (see Appendix C). These participants are experts in a range of areas including public health, health care, minority populations and disparities in health care, social determinants of health, and social services. Through group discussion, they provide input that helps to ensure that we have identified and responded to the most pressing community health needs. On an ongoing basis, we participate in a variety of coalitions, commissions, committees, partnerships and panels and our community health workers spend time in the community as community participants and bring back first-hand knowledge of community needs.

COMMUNITY CONVERSATIONS

Montgomery County residents had the opportunity to participate in the CHNA process by attending one of 15 public community conversations held at various venues throughout the county from May 21, 2015 to October 10, 2015 (see Appendix D for sociodemographic information and number of participants). The purpose of the community conversations was to obtain the perspectives of a broad sample of county residents regarding health and well-being. A total of 367 individuals participated in the community conversations

representing diverse races/ethnicities and several distinct communities (including people with disabilities, seniors, youth, people experiencing homelessness, and the faith-based community). In addition, community conversations were held at various County Regional Service Centers (Mid-County, East County, Bethesda/Chevy Chase, and Up County) to attain geographic diversity. One of the community conversations was conducted in Mandarin, one in Korean, and another in Spanish; the remaining 12 conversations were conducted in English.

The community conversations were facilitated discussions that ranged from one to two hours, depending on the circumstances and the participants. Experienced facilitators, identified by *Healthy Montgomery* staff and the County's minority health initiatives and program, were hired to lead the community conversations using a facilitator's guide that was developed with input from the Community Health Needs Assessment (CHNA) Advisory Committee. The CHNA Advisory Committee, established by *Healthy Montgomery,* helped develop and guide the community conversation process and played a prominent role in helping to organize and, in some cases, host the community conversations. The committee includes representatives from the four county hospital systems, the county's minority health initiatives and program, county public health and social agencies, and other community safety net service providers.

A summary of the community conversations can be found in Appendix E. Summary reports from each of the 2015 *Healthy Montgomery* Community Conversations are available on the *Healthy Montgomery* website at http://www.healthymontgomery.org/index.php?module=Tiles&controller=index&action=display&alias=chnacommunityconversations.

NEEDS ASSESSMENTS AND REPORTS

As available, we also use a range of other specific needs assessments and reports to identify unmet needs, especially for underserved minorities, seniors, and women and children. Our work is built on past available needs assessments, and we use these documents as reference tools, including the following key resources that became available more recently:

- African American Health Program Strategic Plan Toward Health Equity, 2009-2014
- Asian American Health Priorities, A Study of Montgomery County, Maryland, Strengths, Needs, and Opportunities for Action, 2008
- Blueprint for Latino Health in Montgomery County, Maryland, 2015-2025
- Montgomery County Food Council's Community Food Access Assessment; Montgomery County Maryland, 2013 - 2015

- Homelessness in Metropolitan Washington: Results and Analysis from the Annual Point-in-Time (PIT) Count of Persons Experiencing Homelessness, May 2016
- Maryland State Health Improvement Process
- Montgomery County Interagency Commission on Homelessness Annual Report, 2015
- Montgomery Moving Forward's Call To Action: Fueling our Future with Skilled Workers and Good Jobs, 2014
- Prince George's County Health Department: Health Report 2015
- Prince George's County Health Improvement Plan 2011-2014
- The Children' s Agenda: Planning for Results. Measuring for Success. Montgomery County Collaboration Council's 2015 Data Book
- University of Wisconsin Population Health Institute's County Health Rankings Data (see Appendix F)

COMMUNITY NEED INDEX

The Community Need Index (see Figure 1) identifies the severity of health disparities for every ZIP code in the United States and demonstrates the link between community need, access to care, and preventable hospitalizations (Dignity Health, 2011). For each ZIP code in the United States, the Community Need Index aggregates five socioeconomic indicators/barriers to health care access that are known to contribute to health disparities related to income, education, culture/language, insurance and housing. We use the Community Need Index to identify communities of high need and direct a range of community health efforts to these areas.

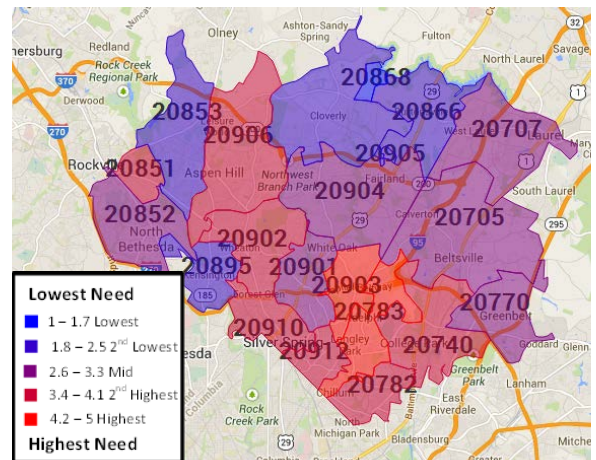

Figure 1: The CNI of the primary service area of Holy Cross Hospital is 3.2, however, several ZIP codes throughout the county rank as high need areas. Source: Dignity Health, 2014 Map data: 2014 © Google.

HOSPITAL QUALITY DATA

Holy Cross Hospital readmission data is used to track the number of patients who are readmitted to the hospital within 30 days of discharge. Centers for Medicare & Medicaid Services (CMS), defines hospital readmission as a patient admission to a hospital within 30 days after being discharged from an earlier hospital stay and the data can be used to

evaluate the quality of hospital care. Prevention Quality Indicators (PQI) are a set of measures that are used with inpatient discharge data to identify the quality of care for ambulatory care sensitive conditions, conditions that evidence suggests could have been potentially avoided through better outpatient care (Agency for Healthcare Research and Quality, 2014). An analysis of hospital readmissions and PQI allow us to identify select indicators related to community health needs and develop methodologies and programs that will improve health outcomes.

OTHER AVAILABLE DATA

We also review our internal patient data (emergency department and discharge readmissions data) and review purchased and publicly available data and analyses on the market, demographics and health service utilization, health indicators, and social determinants of health. These data provide a more detailed look at the community we serve by identifying potential disparities that might not surface when looking at only county or state data. This information then assists us in developing programs to meet the complex needs of the community; paying special attention to vulnerable populations.

SUMMARY OF PROGRESS

Over the past six years, *Healthy Montgomery*, the Montgomery County hospital systems, and other non-profit organizations have been implementing programs and services to address the unmet needs identified through the community health improvement process. Below is a compilation of the results from the *Healthy Montgomery* core measures data that was used to monitor progress made from the first cycle of the community health improvement process (2009-2012) and the second cycle (2012-2015).

ARE WE MAKING PROGRESS?

Among the 37 *Healthy Montgomery* core measures 18 are improving, 18 are worsening, and one could not be assessed since it has had no further updates after its baseline. Among the two Holy Cross Health Core measures for seniors, one is improving and one is worsening. A list of which indicators are improving and which are worsening can be found in the Health Indicators section of this document.

ARE WE ACHIEVING EQUITY?

Of the 34 measures that could be evaluated based on differences across racial/ethnic subgroups, 31 measures had results for White residents, 32 measures had results for African American/Black residents, 26 measures had results for Asian/Pacific Islander residents, and 31 measures had results for Hispanic residents. Results showed Black/African American residents experiencing a widening disparity 38% of the time, the highest proportion of measures across all racial/ethnic groups. Black/African American residents also had the highest proportion of core measures with results that showed their disparity was narrowing at 63% (Healthy Montgomery, 2016).

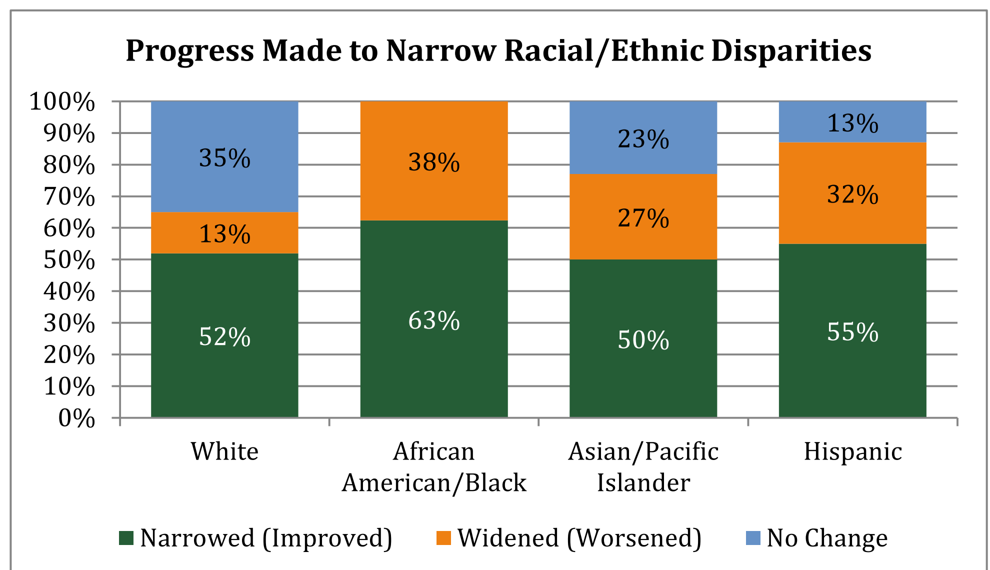

Figure 2: The percentage of Healthy Montgomery core measures that show that health disparities are narrowing, widening or remaining unchanged. Source: Healthy Montgomery 2016.

HOLY CROSS HOSPITAL - DEMOGRAPHICS

Holy Cross Hospital serves a large portion of Montgomery and Prince George's Counties residents (see Figure 3). Our 21 ZIP code primary service area (see Appendix G) includes 662,996 people, of whom 67.4% are minorities. An estimated 1.8 million people in 60 ZIP codes make up our total service area, of whom 69.2% are minorities (see Table 1). Our primary service area is derived from the Maryland ZIP code areas from which the top 60% of our FY13 discharges originated. The next 15% contribute to our secondary service area. We draw 69% of our inpatients and outpatients from Montgomery County.

Race	Primary Service Area (641,761)	Total Service Area (1.7 Million)
White, Non-Hispanic	216,292 (32.6%)	543,353 (30.8%)
Black, Non-Hispanic	175,905 (26.5%)	639,758 (36.3%)
Hispanic	178,868 (27.0%)	343,509 (19.5%)
Asian/Pacific Islander, Non-Hispanic	71,990 (10.9%)	182,549 (10.4%)
All Others	19,941 (3.0%)	53,919 (3.1%)

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

In the early 1990's Prince George's County became a majority-minority county, where the minority population surpasses the white non-Hispanic population, (Fox, 1996). During the last census, Montgomery County joined Prince George's County as one of only 336 "majority-minority" counties in the country (Montgomery County Planning Department, 2011). The foreign-born population of both counties is also higher than the national average. The latest figures from the U.S. Census Bureau show that 32.4% of the population in Montgomery County and 20.7% of the population in Prince George's County are of foreign birth, significantly greater than the state and national rate of 14.2% and 13.0%, respectively (Community Commons, 2016). The community within the Holy Cross Hospital service area has a foreign-born rate of 28.7%. Approximately 485,000 persons (57% of the total foreign-born population in Maryland) reside within our primary and secondary service areas, creating one of the most culturally and ethnically diverse in the nation, challenging the hospital, the county health departments, community-based and other organizations to understand and meet their varied needs.

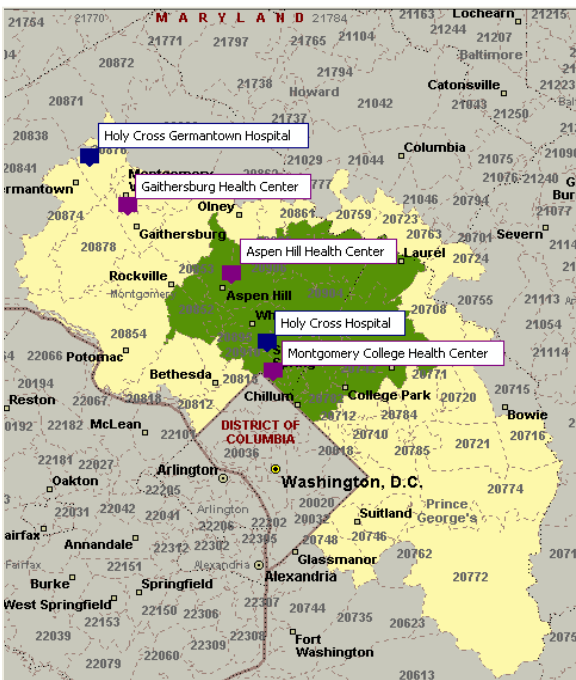

Figure 3: Primary and secondary service area for Holy Cross Hospital

Fluency in English is very important when navigating the health care system as well as finding employment. Approximately 40% of those foreign-born in Montgomery County speak English less than “very well” (U.S. Census Bureau, 2012) and 7.0% of the population aged five and over are linguistically isolated (Community Commons, 2016). The highest rates of linguistic isolation are among Latino Americans and Asian Americans.

More than 183,000 Prince George's County residents, approximately 21% of the total population, are foreign-born. In Prince George's County, 39% of foreign-born residents speak English less than “very well” (U.S. Census Bureau, 2012) and 4.9% of the population aged five and over is linguistically isolated with the most linguistic isolation occurring in northern Prince George's County (Community Commons, 2016).

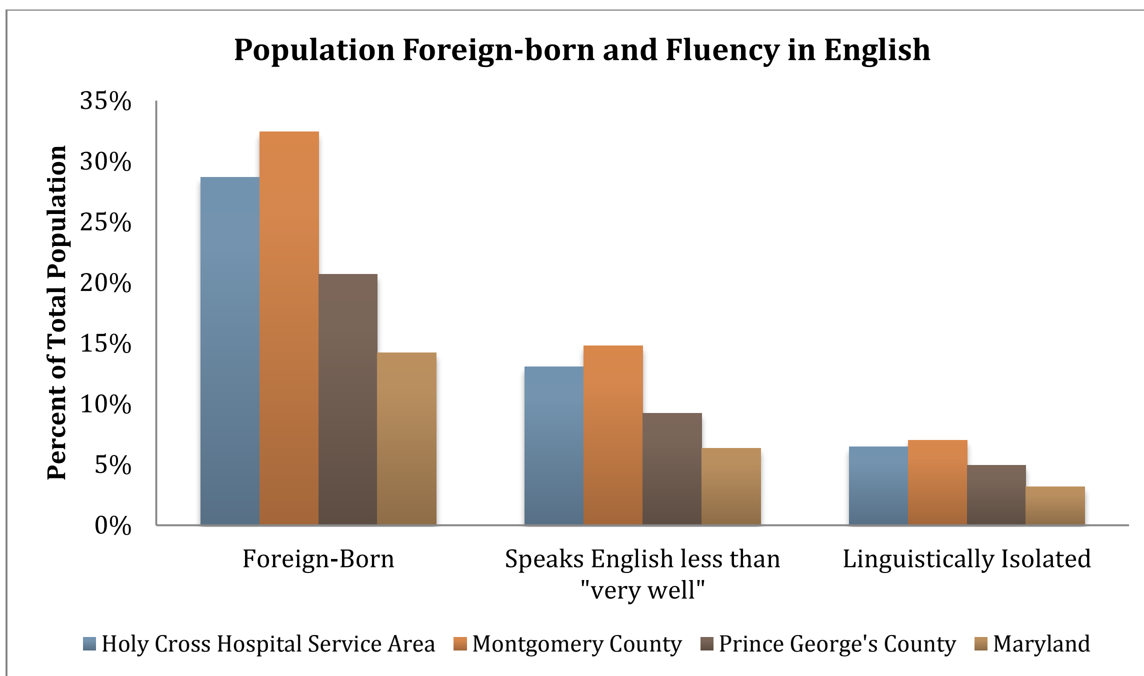

Figure 4: Maryland foreign-born population and fluency in English distribution by county and state. The foreign-born population includes anyone who was not a U.S. citizen or a U.S. national at birth. Prepared by Maryland Department of Legislative Services, 2013. Source: U.S. Census Bureau.

COMMUNITY CONVERSATIONS

Community conversations were held throughout Montgomery County during the spring and summer of 2015. Major themes that were identified during the conversations include community resources and services, health care, transportation, housing, education, access to health food, physical activity and recreation, economics, public safety, equity, county governance, and community advocacy. However, the participants of the community conversations did not address their community health needs in terms of health care or

health services but rather in the context of the determinants of health that affect their day to day living, such as:

- Safe places to walk, bicycle, and be physically active
- Access to healthy, affordable food
- Well-paying jobs
- Affordable housing
- High-quality education
- Crime-free neighborhoods
- Reliable and affordable public transportation, and
- Access to preventive services, health care, and social services

County residents acknowledged that the county is rich in services and resources[1]. However, many are faced with challenges that affect their ability to utilize the services. They noted that there is a lack of coordination of the services available, a need for more culturally and linguistically diverse outreach regarding services, and services available are not keeping pace with the growing population of the county. Despite the many services available throughout the county, the community conversations also identified that there is a growing need for services specifically for vulnerable populations including immigrants, refugees, people with disabilities, low-income families and people experiencing homelessness. For a more detailed summary of the community conversations, see Appendix E.

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[1] For a full list of assets, challenges, and strategies for improvement identified during the community conversations see Healhty Montgomery's full needs assessment at http://www.healthymontgomery.org/content/sites/montgomery/2016_HM_CHNA_Final_June_2_2016_.pdf. For an extensive list of communtiy resources see http://infomontgomery.org/.

DETERMINANTS OF HEALTH

Access to quality, affordable health care plays a significant role in the health of individuals. However, clinical care cannot address all the factors that shape both health behaviors and health itself (Braveman, Egerter, & Mockenhaupt, 2011). Understanding determinants of health, such as economic and social factors can also lead to improvements in health and reductions in health disparities (Williams, Costa, Odunlami, & Mohammed, 2008). Policy, system and environmental changes can also impact health in a positive way. Changing policies, systems and environments that affect where community members live work and play enables individuals to make healthy choices by ensuring that healthy, practical choices are available and accessible for them to choose (Cook County Department of Public Health, 2013).

POLICYMAKING

Policies at the local, state, and federal level affect individual and population health. And often, policies have a greater effect on improving health outcomes than programs and services provided. For example, it is estimated that since 1975 more than 255,000 lives have been saved due to seat belt laws (Centers for Disease Control and Prevention, January). Tobacco policies at the federal, state, and local levels have helped reduce the percentage of current smokers from 23.5% of adults and 34.8% of youths in 1999 to 20.6% of adults and 19.5% of youths ten years later (Centers for Disease Control and Prevention, 2010).

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

SOCIAL DETERMINANTS

Social determinants of health refer to the influences, or social factors, and the physical environment of which we live, work and play (U.S. Department of Health and Human Services , 2016). Social determinants can include physical structures, such as housing or more intrinsic issues, such as racism. According to the University of Wisconsin Population Health Institute, 50% of the factors that influence health are considered social determinants (see Figure 5).

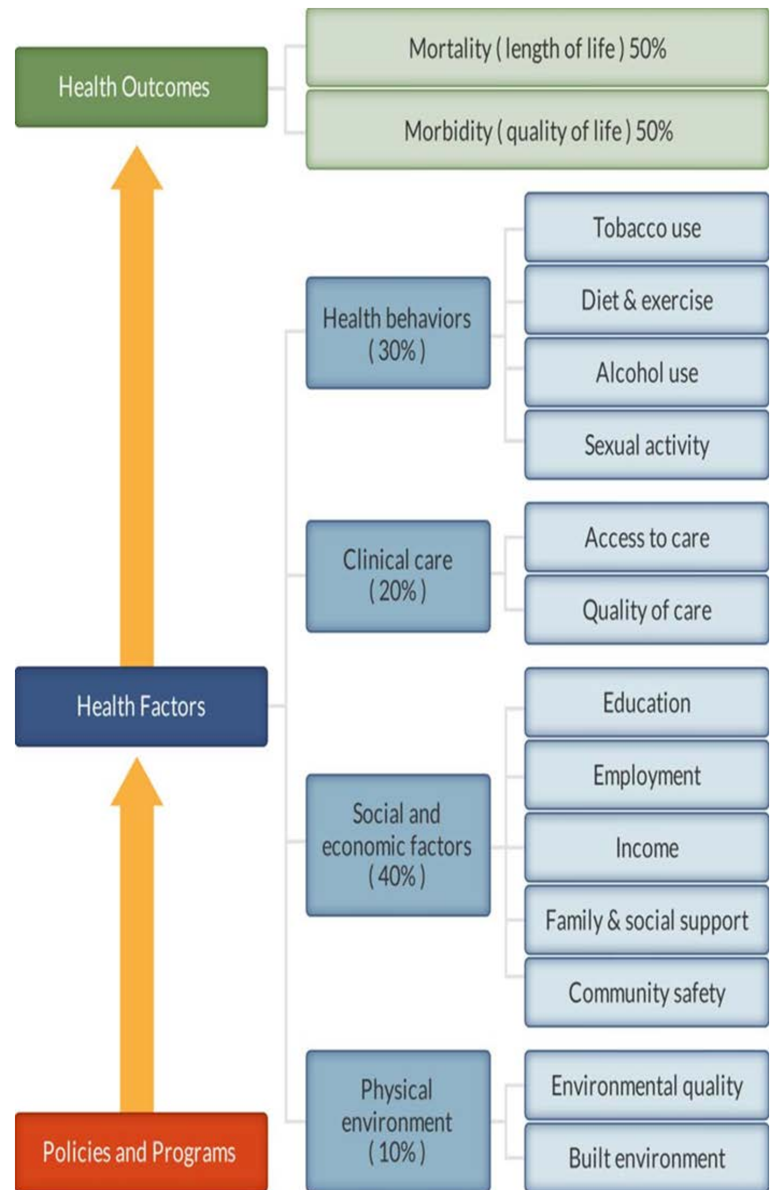


Figure 5. List of factors that, if improved, can help make communities healthier places to live, learn, work and play. Social Determinants (social and economic factors and physical environment) comprise 50% of the factors that influence health. County Health Rankings model ©2012 UWPHI

Economics

Montgomery County, Maryland's most populous jurisdiction with a population of 1,005,087, has a median household income of $98,704 compared to the statewide median household income of $74,149. The county's income level is positively correlated with its level of education; more than half (57.4%) of the county's residents aged 25 and over hold a bachelor's degree or higher compared to 37.3% statewide (U.S. Census Bureau, Population Division, 2014).

Prince George's County, like Montgomery County, is also one of the state's most populous jurisdictions with a population of more than 863,420 residents. Its median household income is $73,856, slightly lower than the state average of $74,149. Less than one-third (30.4%) of the county's residents hold a bachelor's degree or higher (U.S. Census Bureau, Population Division, 2014).

The unemployment rate is a key indicator of the local economy and occurs when local businesses are unable to supply enough jobs for local employees or when the labor force is not able to supply appropriate skills to employers (Healthy Communities Institute, 2014). During periods of unemployment, individuals are likely to feel severe economic strain and mental stress. Unemployment is also related to access to health care, as many individuals receive health insurance through their employer. A high unemployment rate places a strain on financial support systems as unemployed persons qualify for unemployment benefits and food stamp programs.

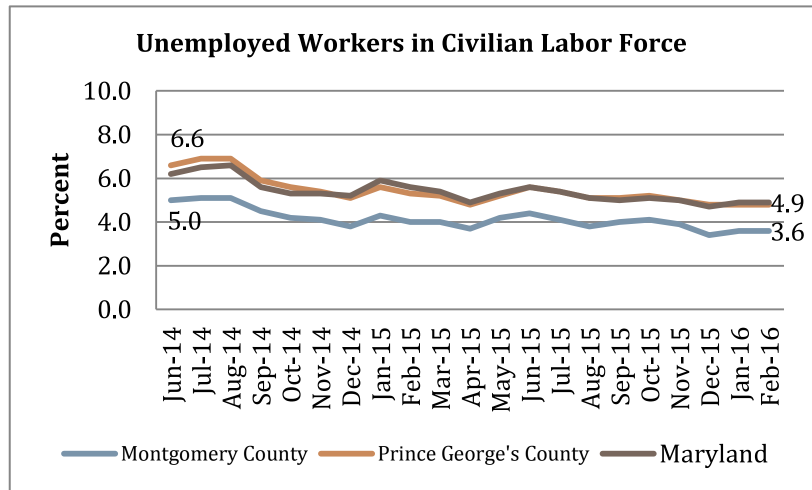


Figure 6: Civilians, 16 years of age and over, whom are unemployed as a percentage of the U.S. civilian labor force. Source: U.S. Bureau of Labor Statistics.

Due to a large number of federal agencies and contractors, both counties generally enjoy low unemployment when compared to the U.S. and the unemployment rates of both counties has been steadily declining since 2011. In February 2016 the unemployment rate was 3.6% in Montgomery County, 4.8% in Prince George's County, and 4.9% for the state. (U.S. Bureau of Labor Statistics, 2016); showing improvement from what was reported in previous years (see Figure 6).

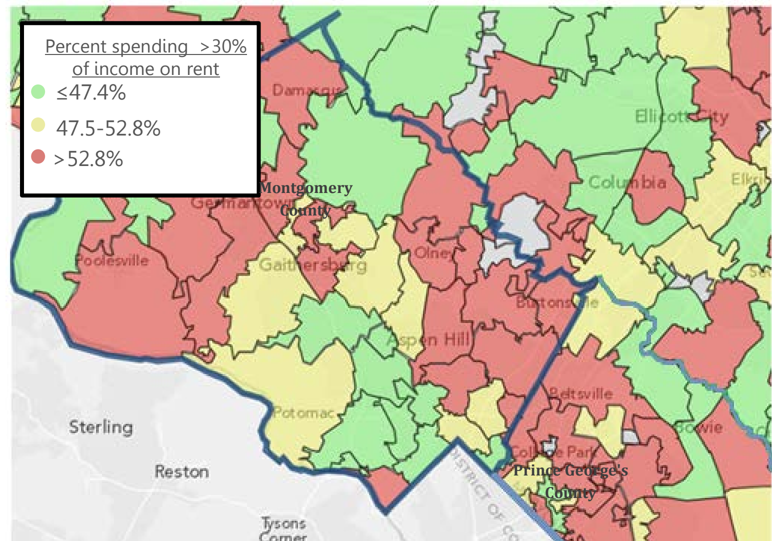


Figure 7: Percentage of renters spending more than 30% of income on rent by ZIP code. Source: Healthy Communities Institute.

Another indicator of the local economy is the percentage of households spending a high percentage of income on rent. Paying a high rent can create a financial hardship, especially for those with a limited income, leaving little money for other expenses such as food, transportation, medical services and savings (Healthy Communities Institute, 2014). On average, 51.5% of renters in Montgomery County and 52.7% of renters in Prince George's County spend more than 30% of their income on rent. However, as shown in the map in Figure 7, the highest percentage of

residents spending more than 30% of their income on rent reside in ZIP codes surrounding Holy Cross Hospital and Holy Cross Germantown Hospital.

Despite the relative affluence and fairly low unemployment rates of both Montgomery and Prince George's Counties, disparities exist. For example, in Montgomery County, key minority populations average lower median income than the income level determined for self-sufficiency (see Figure 8) and in Prince George's County, higher income levels do not help lower the African American infant mortality rate.

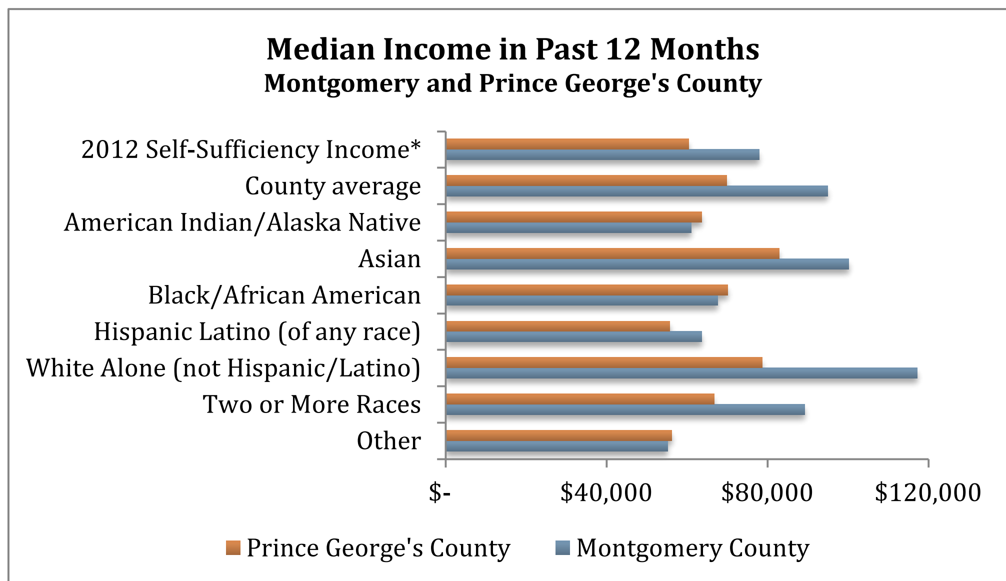


Figure 8: Median household income by race for Montgomery and Prince George's County. Source: U.S. Census Bureau, 2012 ACS, 1-year estimates; The Self-Sufficiency Standard for Maryland, 2012. *Annual self-sufficiency standard for one adult, one preschooler, and one school-age child.

Education

Kindergarten screening measures the readiness of each student to begin kindergarten based on education standards. The readiness standards are set by the Maryland Model for School Readiness and measure seventeen expectations for school readiness, including immunization status, physical development, compliance with rules, communication skills, interactions with peers and adults, demonstration of curiosity, ability to pay attention, and ability to follow directions (Healthy Communities Institute, 2014). For the 2014-2015 school year, 48% of incoming Montgomery County Kindergarteners and 34% of incoming Prince George's County kindergartners met the readiness standards. The State Health Improvement Process set a target to increase the percentage of students ready for Kindergarten to 85.5% by 2017 (Maryland Department of Health and Mental Hygiene, 2016).

High school graduation rates also have a high impact on the health of an individual. Individuals who do not finish high school are more likely than people who finish high school to lack the basic skills required to function in an increasingly complicated job market and society. Adults with limited education levels are more likely to be unemployed, on government assistance, or involved in crime (Healthy Communities Institute, 2014). The goal for the Maryland State Health Improvement Process is to have a graduation rate of 95% by 2017. In 2015, both Montgomery County (89.4%) and Prince George's County (78.8%) fell below this goal. In our service area, census tracts near Wheaton-Glenmont, Aspen Hill, and Gaithersburg in Montgomery County and University Park and Riverdale in Prince George's County have the largest percentages of residents over the age of 25 with less than a high school diploma (see Figure 9).

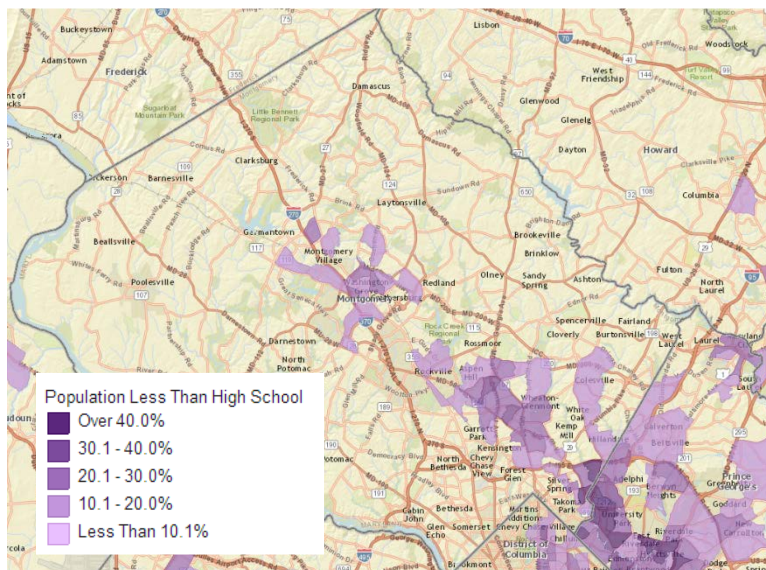


Figure 9: Percentage of the population aged 25 years and older with no high school diploma. Source: Community Commons, 2014.

Transportation

Transportation plays an integral part in accessing health care and resources that promote health such as parks and recreation facilities; barriers to transportation limit this access and have a negative effect on health. Barriers are especially high for seniors, people with disabilities, and people of limited income.

Montgomery and Prince George's Counties have a vast network of public transportation options that range from metro rail, bus and train transport, including subsidized services for seniors and people with disabilities. However, ridership dictates the number and location of stops, leaving many residents in less populated areas with limited access to county services and resources (see Figure 10).

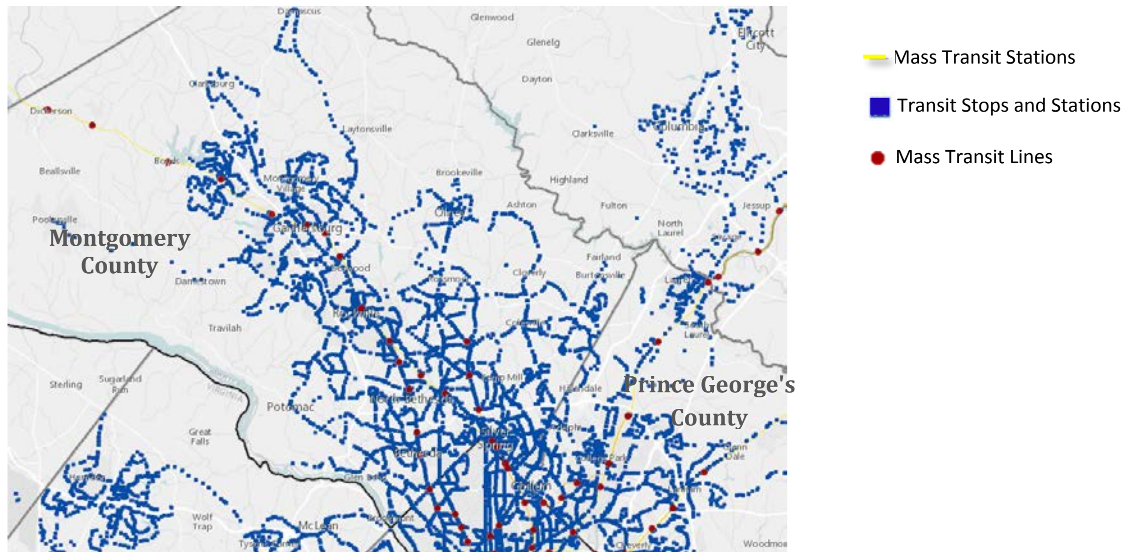


Figure 10: The location of transit lines and stops in Montgomery County and Prince George's County. Source: Environmental Protection Agency, EPA Smart Location Database, 2013; National Transit Authority, 2013, 2014; Community Commons, 2015.

Housing, Homes, and Neighborhoods

The home environment, which consists of living conditions and surrounding neighborhoods, has an impact on health status. Substandard neighborhoods and living conditions such as overcrowding, lead paint, and tobacco and alcohol advertising have been linked to poor health outcomes and can lead to an increased risk of cardiovascular disease, mental health issues, and unfavorable birth outcomes. According to the newest report from the Robert Wood Johnson Foundation Commission to Build a Healthier America, almost one-fifth of all Americans live in unhealthy neighborhoods with limited job opportunities, low-quality housing, and with limited access to healthy food and physical activity (Robert Wood Johnson Foundation Commission to Build a Healthier America, 2014)

Safe Housing

Issues such as overcrowding and other substandard living conditions can impact family relationships, the spread of infectious diseases, education, stress and anxiety. Almost 40% of the Holy Cross Hospital service area resides in substandard housing—housing that has at least one of the following living conditions: lacking complete plumbing facilities, lacking complete kitchen facilities, overcrowded (more than one occupant per room), selected

monthly owner costs greater than 30 percent of income, and gross rent greater than 30 percent of income (Community Commons, 2016). Approximately 7.5% of the Holy Cross Hospital service area lives in overcrowded housing, compared to 4.4% of Montgomery County residents and 16.7% of Prince George's County residents.

Neighborhoods

Neighborhoods can also be detrimental to the health of the population. Neighborhoods high in crime, polluted, or with limited access can affect the healthy behaviors of individuals and families. The ability to be physically active can be affected by the number of and access to safe places to exercise and play. Studies have shown that a person's neighborhood can even affect smoking and healthy diet among other things (Robert Wood Johnson Foundation Commission to Build a Healthier America, 2014).

When compared to the state average, the Holy Cross Hospital service area has an adequate number of recreation and fitness facilities where residents can be active (11.9 for every 100,000 persons compared to 11.1 for the state and 15.4 for Montgomery County). However, it also has more than 1,300 fast food restaurants. That equates to approximately 84 fast food restaurants per 100,000 persons residing in our service area. The Holy Cross Hospital service area also has 250 beer, wine, and liquor establishments; a rate of 15.2 per 100,000 persons (Community Commons, 2016).

Homelessness

The high cost of housing and a limited number of reduced, affordable options have left many jurisdictions in the surrounding areas with an increasing number of individuals and families at risk for experiencing homelessness (Metropolitan Washington Council of Governments' Homeless Services Planning and Coordinating Committee, 2016).

According to the annual point-in-time count conducted by the Metropolitan Washington Council of Governments' Homeless Services Planning and Coordinating Committee (2016), Prince George's County has seen a 15% decline in the number of persons experiencing homelessness over the past five years. Montgomery County experienced a 10.8% decline in the number of persons experiencing homelessness from 2015 to 2016, but there has been no percent change in the overall number of persons experiencing homelessness from 2012 to 2016. The District of Columbia and Frederick County were the only areas to have an increase in the number of persons experiencing homelessness over the five year period. The District of Columbia experienced the greatest increase; a 20% increase from 2012 to 2016 (see Figure 11). Overall, there has been a 3.3% increase in the number of persons experiencing homelessness for the surrounding area.

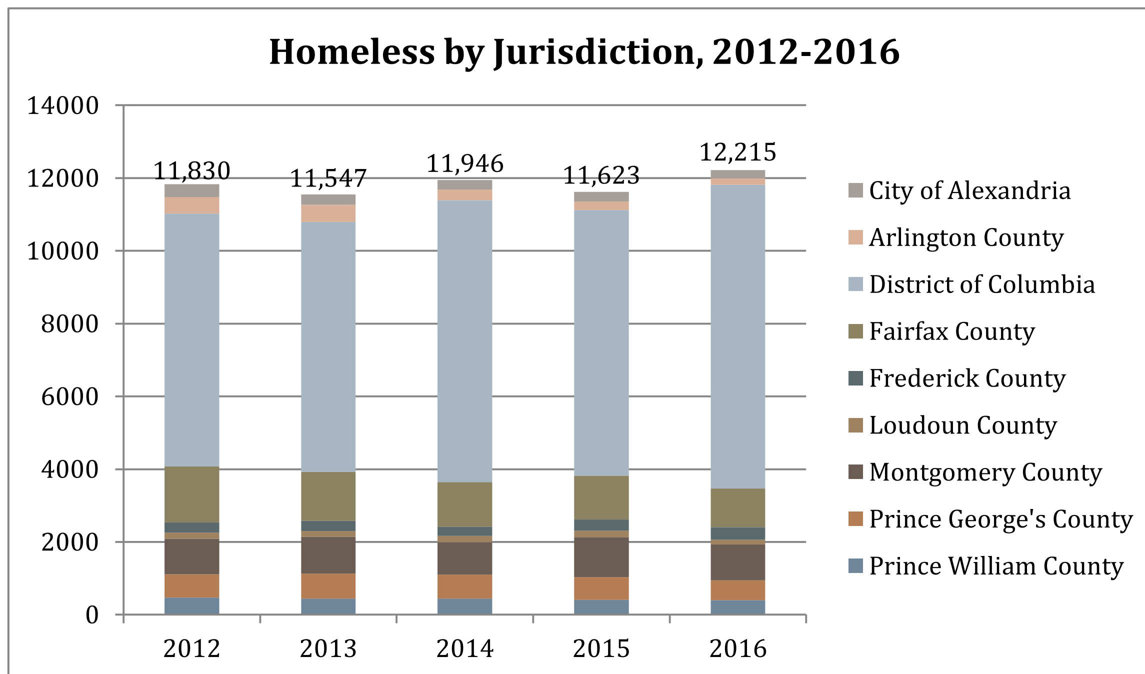


Figure 11. Number of homeless persons, including Households without Children, Households with Adults and Children, and Households with Only Children, who may be sheltered or unsheltered. Source: Metropolitan Washington Council of Governments' Homeless Services Planning and Coordinating Committee, 2016.

Health Insurance

Despite its relative wealth in terms of income, education and support for public services more than 600,000 Maryland residents were uninsured prior to the implementation of the Affordable Care Act. The majority of uninsured residents were minorities, with the largest percentage of uninsured per total racial/ethnic population being American Indian/Alaskan Native (U.S. Census Bureau, 2012). Lack of insurance is a primary barrier to health care access including regular primary care, specialty care, and other health services that contribute to poor health status.

Insurance Coverage

The implementation of the Affordable Care Act's expanded insurance coverage in January of 2014 made insurance accessible to thousands of residents in Montgomery and Prince George's County, possibly for the first time. In the last six months of fiscal year 2014, Medicaid enrollment in Montgomery and Prince George's County increased 30% and 35%, respectively (see Figure 12). During the 2015 enrollment period, Maryland Health Benefit Exchange enrolled 219,849 individuals in Medicaid, 151,147 individuals in a qualified health plan, and 20,028 in a dental plan (Maryland Citizens Health Initiative, 2016). Of the 151,147 individuals enrolled in a qualified health plan, approximately 40% of those enrolled reside in Montgomery and Prince George's Counties. Although the majority of the

uninsured residents (see Figure 13) are eligible for health insurance, thousands will remain uninsured due to ineligibility. *Healthy Montgomery*, the county's community health improvement process, has ranked access to care for those uninsured and underinsured as an underlying factor that affects all of the selected top health priorities.

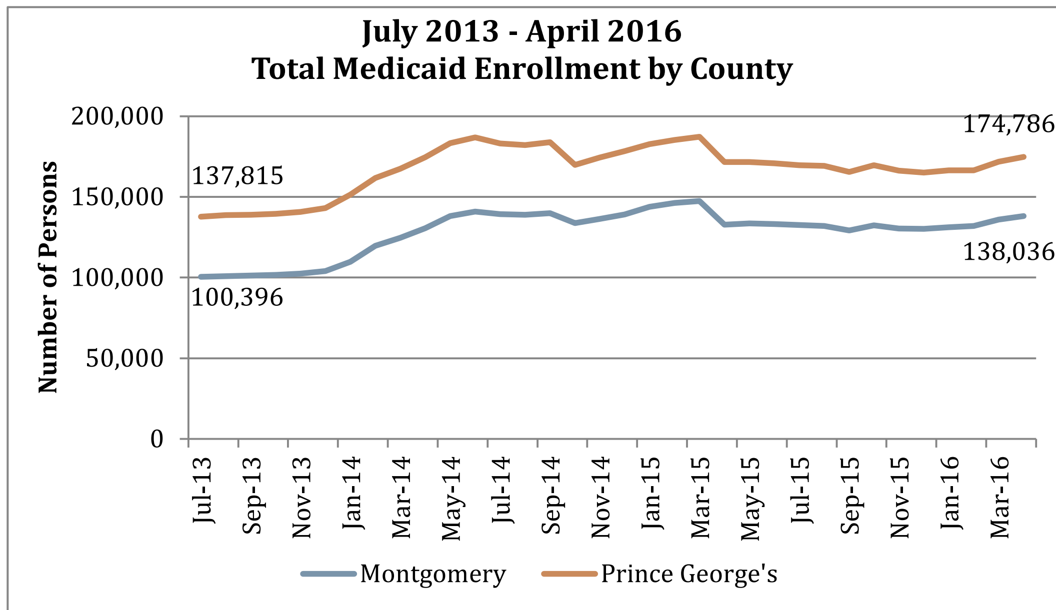


Figure 12: Total number enrolled in a Medicaid plan by county for each month of fiscal year 2016. Source: Maryland Medicaid eHealth Statistics.

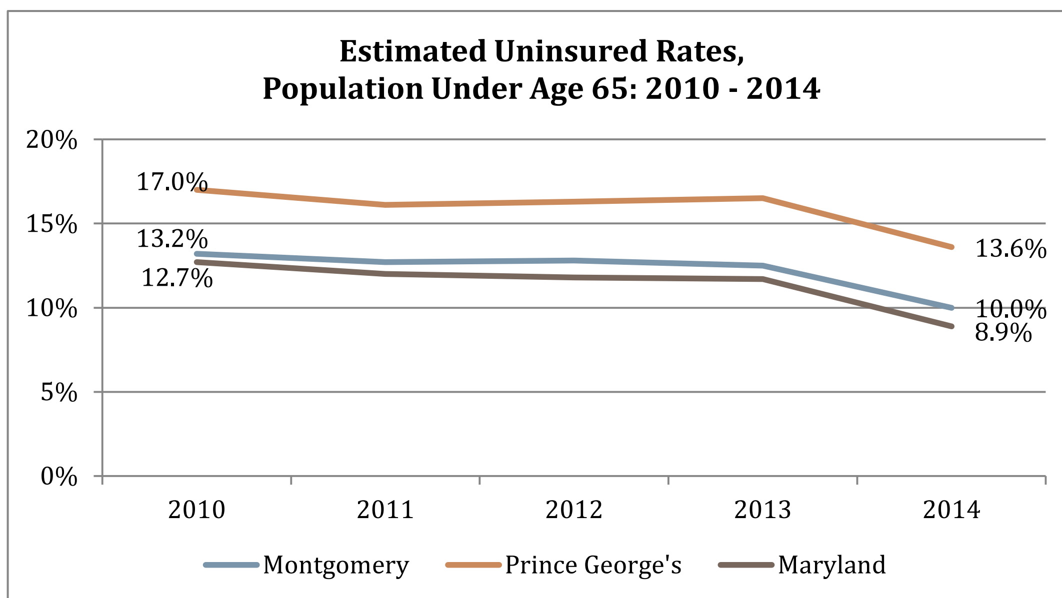


Figure 13: Estimated percent of population uninsured prior to and after implementation of the Affordable Care Act in 2014. Source: U.S. Census Bureau, Small Area Health Insurance Estimates, 2016

Availability and Affordability of Services

Access to affordable health insurance represents only one barrier to access to care. Availability, affordability and language also play a role in preventing Montgomery and Prince George's Counties residents from accessing quality health care.

In Montgomery County, access to primary care physicians, dentists and mental health providers is higher when compared to surrounding areas (see Figure 14). However, despite the high numbers of primary care physicians available in Montgomery County, 10.4% of the population is unable to afford to see a doctor (see Figure 15).

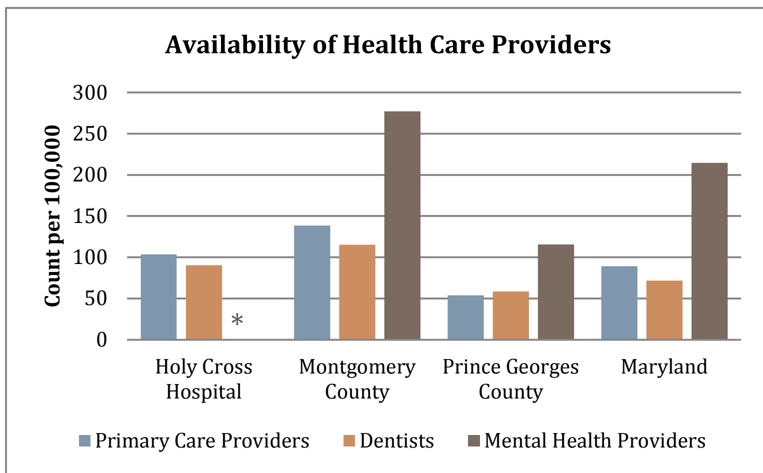


Figure 14: Number of health care providers per 100,000 population. Source: Community Commons, 2016.

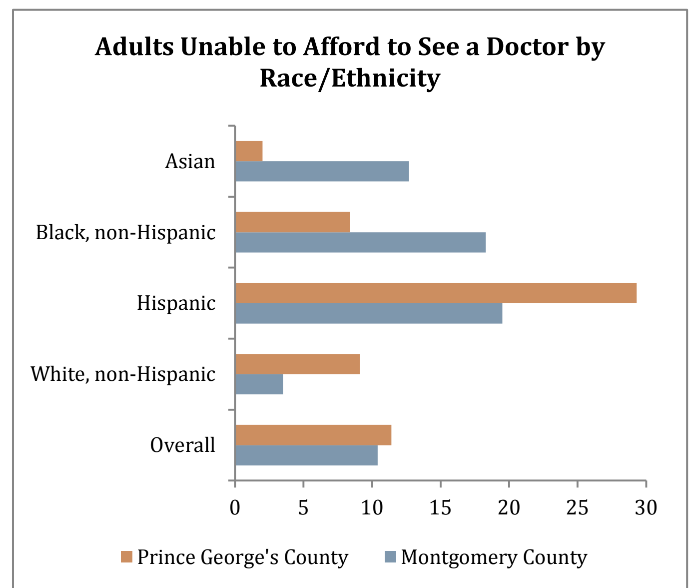


Figure 15: Percent of adults unable to afford to see a doctor by county. Source: Maryland Behavioral Risk Factor Surveillance System, 2014.

INDIVIDUAL BEHAVIOR

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

Only 40 percent of adults in the United States engage in the recommended amount of physical activity. The percentage of physically active adults in Montgomery County (52.8%) and Prince George's County (47.4%) is higher than the national average. Regular physical activity reduces the risk of multiple chronic diseases and helps maintain a healthy weight and reduce body fat (Community Commons, 2016).

Fruit and vegetable consumption also helps maintain a healthy weight. Eating a healthy balanced diet reduces risk factors associated with chronic diseases, including cancer

(Healthy Communities Institute, 2016). The USDA currently recommends two and one-half cups (five servings) of vegetables and two cups of fruits (preferably whole fruits) daily for a 2,000-calorie diet, with higher or lower amounts depending on the caloric level (USDA, 2016). Despite the health benefits, many people still do not eat the recommended levels. In Montgomery and Prince George's Counties, more than half of residents do not consume the recommended intake of fruits and vegetables.

Other behaviors that have a negative impact on health include alcohol consumption and tobacco use. Both Montgomery and Prince George's Counties have lower rates of tobacco use when compared to the state and national rates. Less than 8% of Montgomery County residents and less than 14% of Prince George's County residents are current smokers. Excessive alcohol consumption is also lower when compared to the state and national levels (see Table 2).

Report Area	Total Population Age 18+	Age-Adjusted Smoking Rate	Excessive Alcohol Consumption Rate
Montgomery County	728,670	7.9%	13.2%
Prince George's County	650,433	13.5%	14.0%
Maryland	4,380,821	15.4%	15.4%
United States	232,556,016	18.1%	16.0%

Table 2: Percent of adults, aged 18+, who self-reported currently smoking cigarettes some days or every day. Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2008-14. Percent of adults who self-reported binge drinking at least once during the 30 days prior to the survey. Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2014.

HEALTH INDICATORS

Health indicators, such as causes of death (see Table 3), breast cancer rates and obesity can be used to describe the health of a population, health differences within a population or to determine if program objectives designed to improve health are being met. *Healthy Montgomery* selected approximately 100 indicators to monitor for improvement. In this section, select indicators related to the six *Healthy Montgomery* priorities and select indicators related to the senior population have been identified. Each priority has also been coupled with select indicators from Holy Cross Health programs implemented to address the unmet need (see Appendix H). This shows a visual representation of Holy Cross Health's effort to impact health improvement for our service area. However, it should be noted that our programs represent only a portion of county resources and many factors influence "moving the needle" in a positive direction.

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

Montgomery County	Age-adjusted Death Rate/100,000
Cancer	121.7
Heart Disease	110.7
Stroke	25.2
Chronic Lower Respiratory Disease	17.4
Accidents	17.0

Prince George's County	Age-adjusted Death Rate/100,000
Heart Disease	172.5
Cancer	156.5
Stroke	35.1
Diabetes	28.3
Accidents	25.2

Table 3: Top five leading causes of death for Montgomery and Prince George's Counties, 2011-2014. Source: Maryland Vital Statistics Administration, 2014.

CANCER

Advances in research, detection and treatment have slowed the cancer death rate; however, cancer remains a leading cause of death in the United States (U.S. Department of Health and Human Services, 2010). It is the leading cause of death in Montgomery County and the second leading cause of death in Prince George's County (Maryland Department of Health and Mental Hygiene, 2014). The burden of battling cancers within our community varies; with disparities clearly present. For example, in Montgomery County the breast cancer incidence rate for White women is only slightly higher (0.2%) than it is for African American/Black women, however, the death rate for African American/Black women is more than 38% higher.

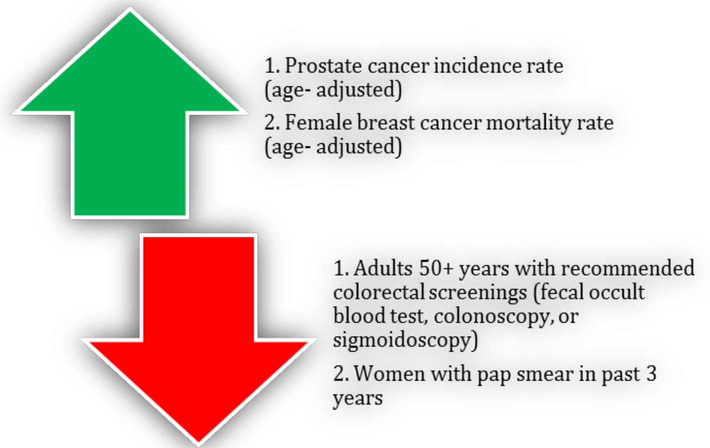


Figure 16: Improvement (or worsening) of cancer core measures identified by Healthy Montgomery. Source: Healthy Montgomery, 2016.

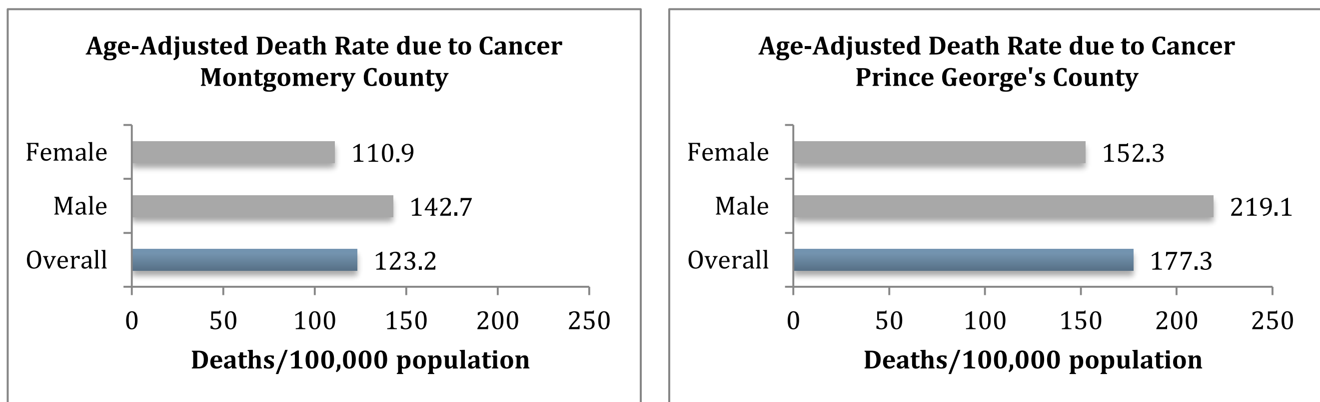


Figure 17: Age-adjusted death rate per 100,000 population due to cancer. Source: National Cancer Institute, 2008-2012.

The percentage of Medicare beneficiaries treated for cancer has also been declining (see Figure 18), driven largely by declining prostate and colon cancer incidence rates, increased colonoscopy screening (and the removal of pre-cancerous polyps), and decreased prostate cancer screening (Maroongroge, et al., 2015).

The National Cancer Institute (NCI) defines cancer as a term used to describe diseases in which abnormal cells divide without control and are able to invade other tissues. There are over 100 different types of cancer, however, lung, colorectal, breast, pancreatic, and prostate cancer lead to the greatest number of deaths each year.

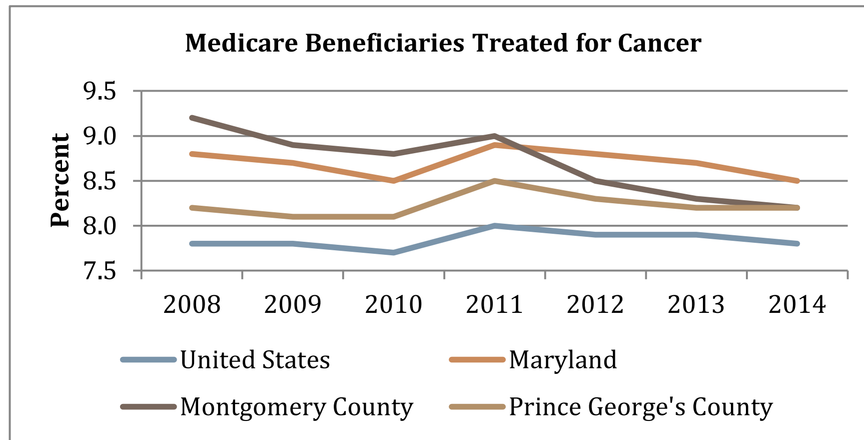


Figure 18: Yearly percentage of Medicare beneficiaries who were treated for cancer (Breast, colorectal, lung and prostate). Source: Centers for Medicaid and Medicare Services, 2014.

Breast Cancer

Breast cancer is the most common type of cancer in the U.S. followed by lung cancer and prostate cancer (American Cancer Society, 2016). It is expected that more than 249,000 women will be diagnosed with breast cancer during 2016 and more than 40,000 will die from the disease. The greatest risk factor in developing breast cancer is age. Since 1990, breast cancer death rates have declined progressively due to advancements in treatment and detection.

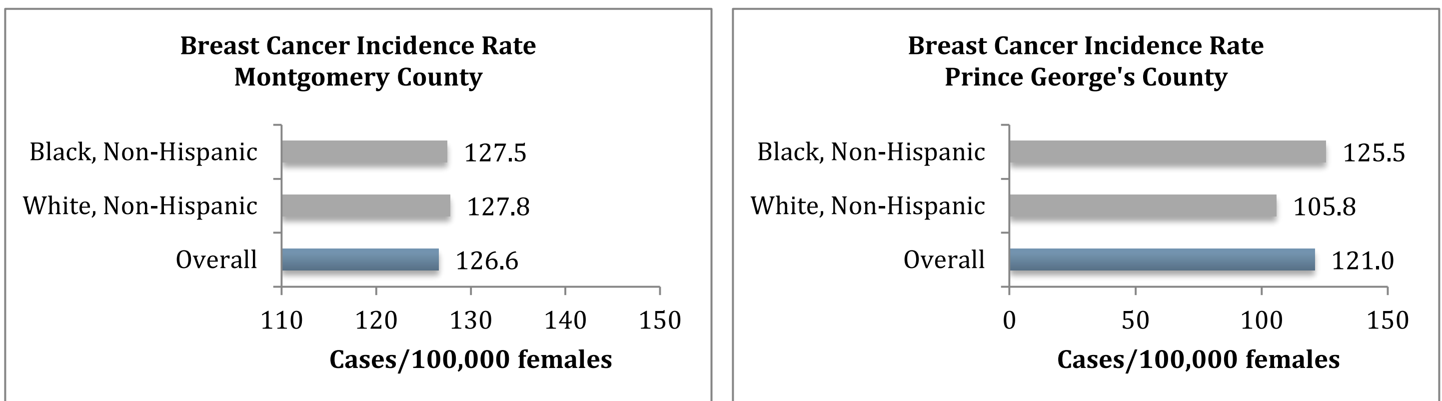
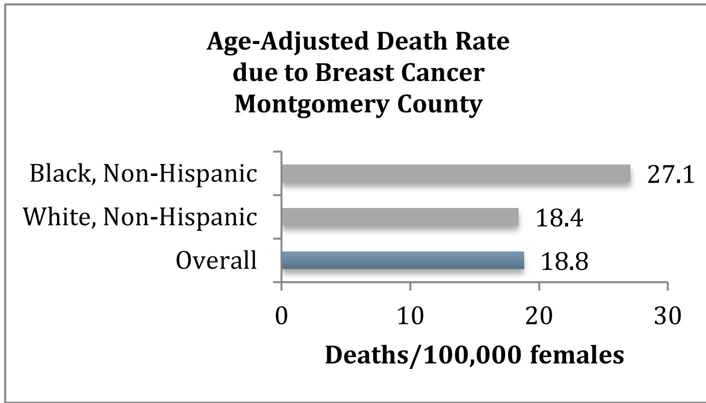


Figure 19: Age-adjusted incidence rate for breast cancer in cases per 100,000 females. Source: National Cancer Institute, 2008-2012.



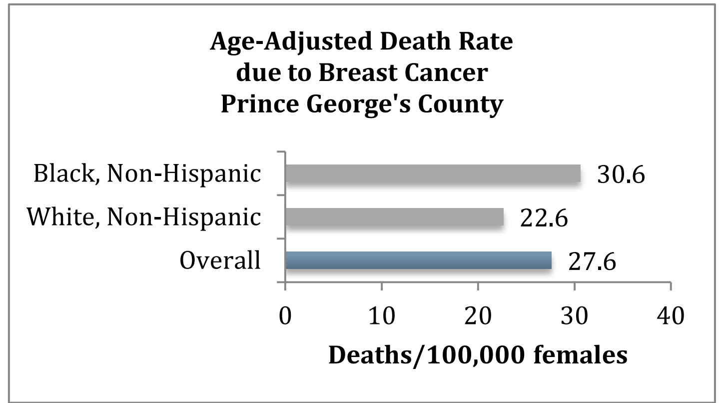
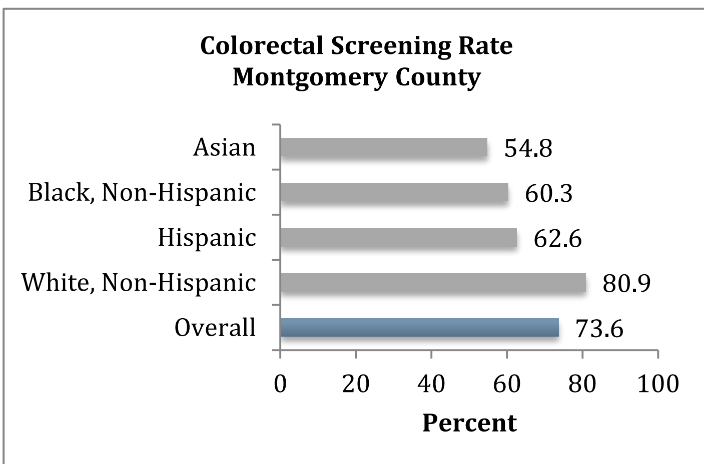


Figure 20: Age-adjusted death rate per 100,000 females due to breast cancer. Source: National Cancer Institute, 2008-2012.

Colorectal Cancer

Colorectal cancer, cancer of the colon or rectum, is the second leading cause of cancer-related deaths in the United States (American Cancer Society, 2016). Early detection plays a significant role in decreasing the death rate for those diagnosed. If adults aged 50 or older had regular screening tests, as many as 60% of the deaths from colorectal cancer could be prevented (Healthy Communities Institute, 2016). In both Montgomery and Prince George's Counties, the screening rate for colorectal cancer is high at 73.6% and 74.7% of the population 50 and over getting screened but racial disparities are present (see Figure 21). There are also racial disparities in the incidence and death rates (see Figure 22). African American/Blacks have a higher incidence and death rate when compared to the rates of Whites, Asians, and Hispanics.



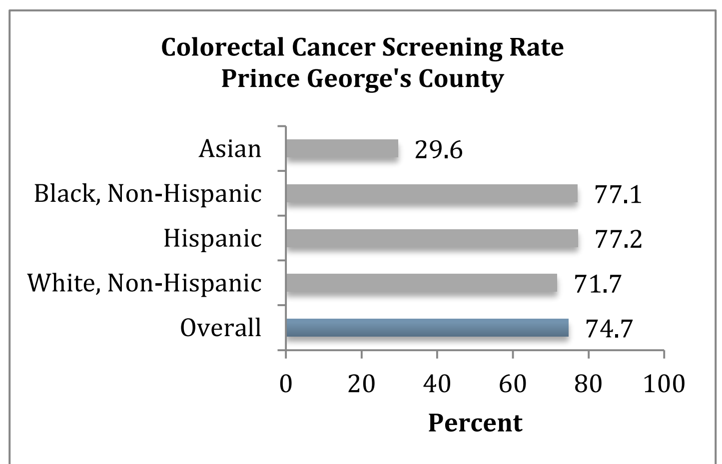
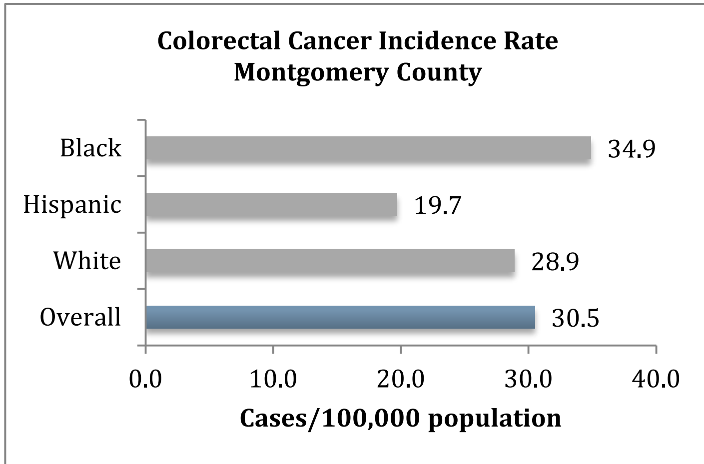


Figure 21: The percentage of adults aged 50 and over who have ever had a sigmoidoscopy or colonoscopy exam. Source: Maryland BRFSS, 2014.



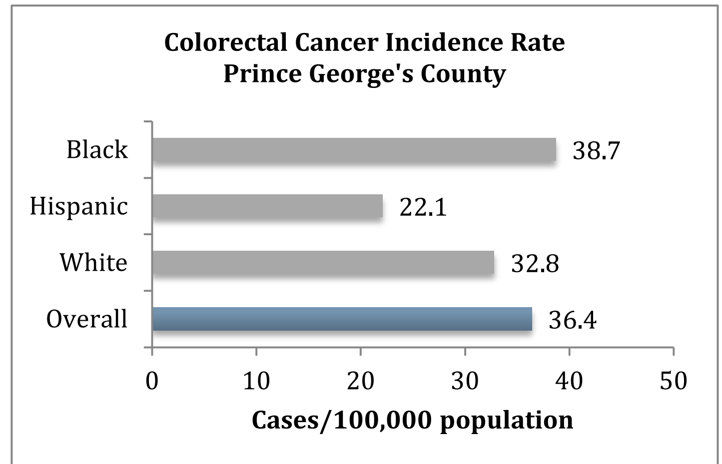
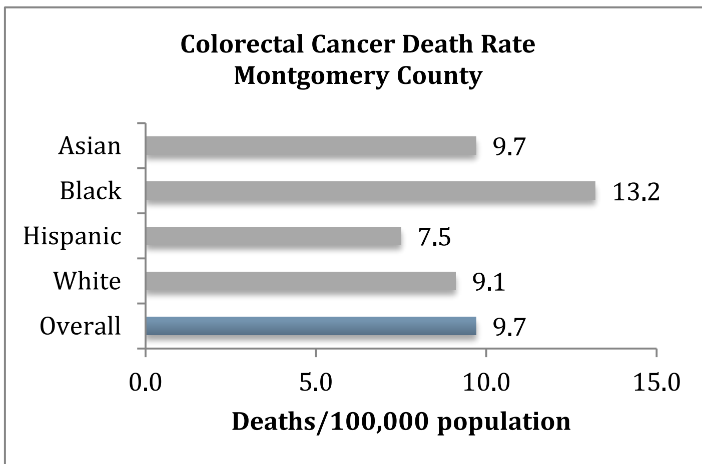


Figure 22: The age-adjusted incidence rate for colorectal cancer in cases per 100,000 population. Source: National Cancer Institute, 2008-2012.



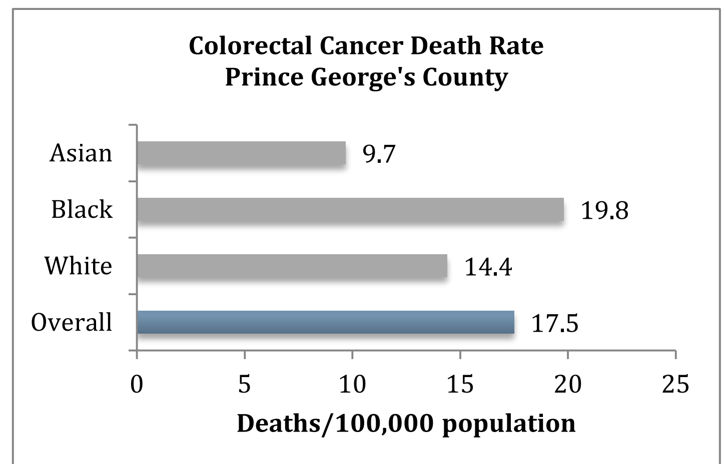
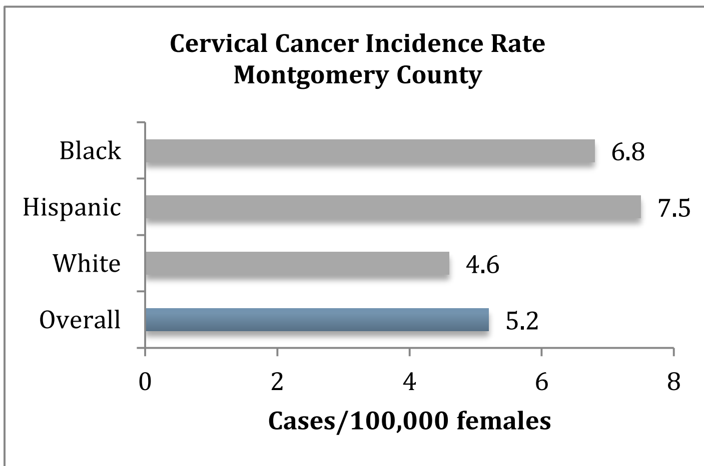


Figure 23: The age-adjusted death rate per 100,000 population due to colorectal cancer. Source: National Cancer Institute, 2008-2012.

Cervical Cancer

Cervical cancer is a common cancer that has a very high cure rate when caught early. The American College of Obstetricians and Gynecologists recommends that all women get regular Pap tests to increase early detection of cervical cancer (see Figure 25). In Montgomery County, Hispanic women's incidence rate of cervical cancer is about a third higher than that of White women (see Figure 24).



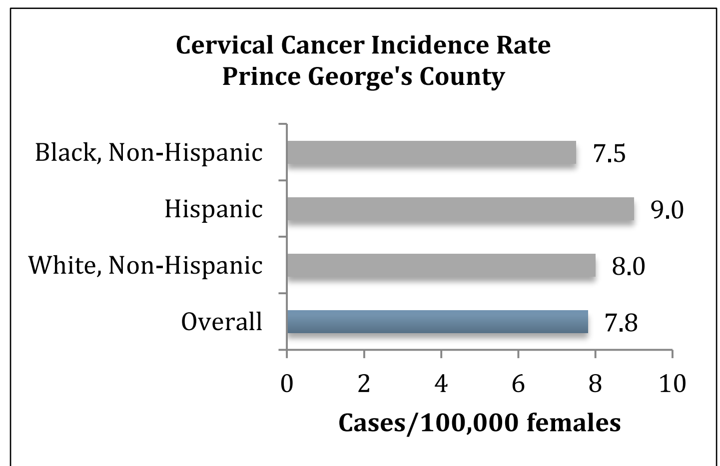
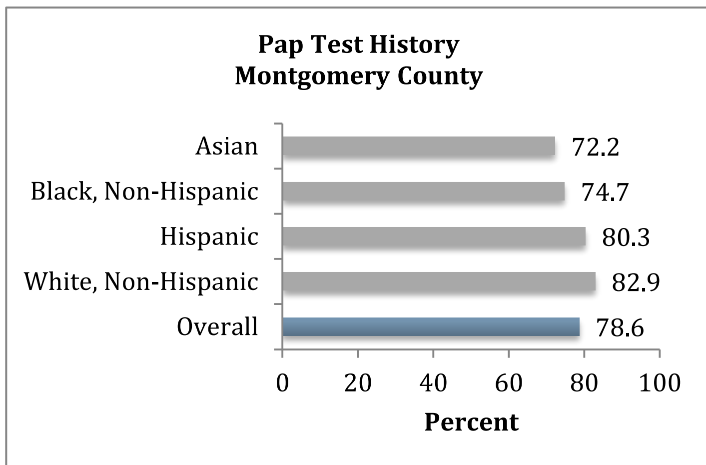


Figure 24: The age-adjusted incidence rate for cervical cancer in cases per 100,000 females. Source: National Cancer Institute, 2008-2012.



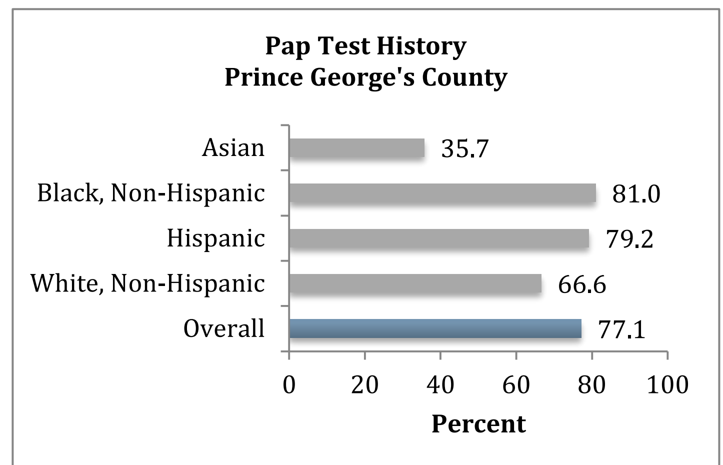
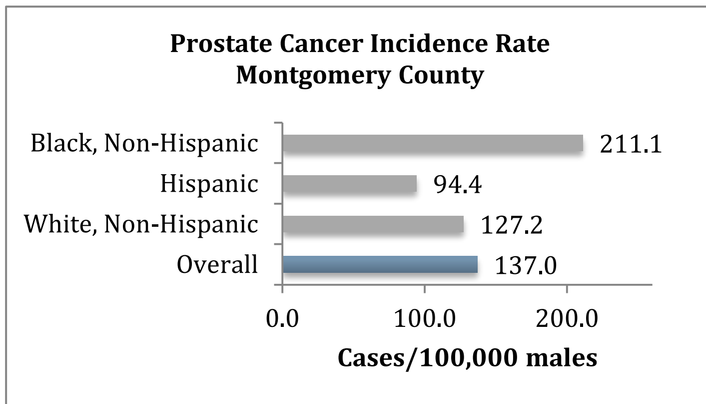


Figure 25: The percentage of women aged 18 and over who have had a Pap smear in the past three years. Source: Maryland BRFSS, 2014.

Prostate Cancer

Prostate cancer is the most common form of cancer among men in the United States and is only second to lung cancer as a cause of cancer-related death among men (Healthy Communities Institute, 2016). Prostate cancer usually occurs in older men and African American/Black men's incidence rate is almost 50% higher than White men in Montgomery County and more than 60% higher in Prince George's County. The death rate of African Americans/Blacks in both counties is also more than 50% higher than their White counterparts (see Figure 26 and Figure 27).



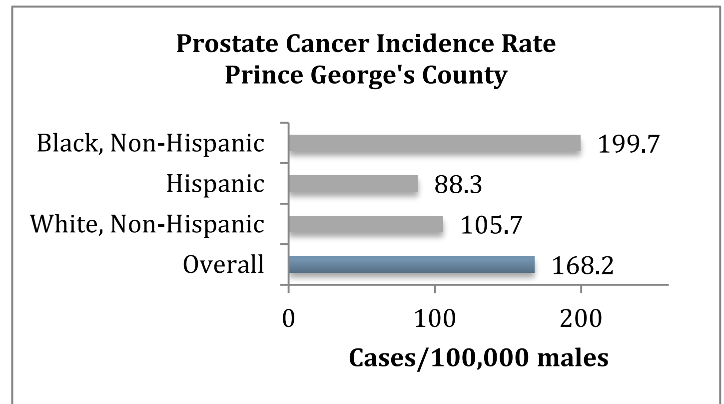
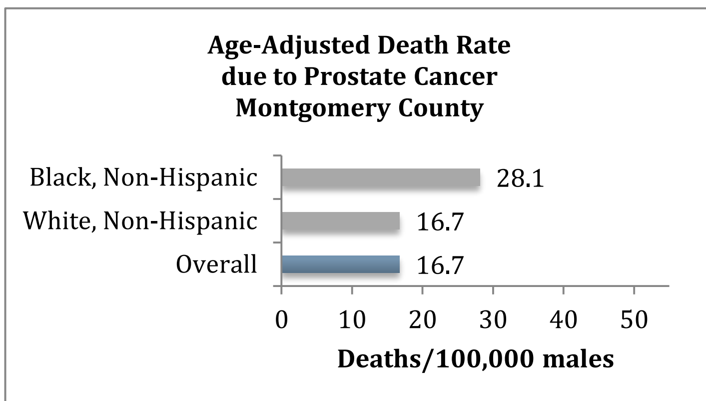


Figure 26: The age-adjusted incidence rate for prostate cancer in cases per 100,000 males. Source: National Cancer Institute, 2008-2012.



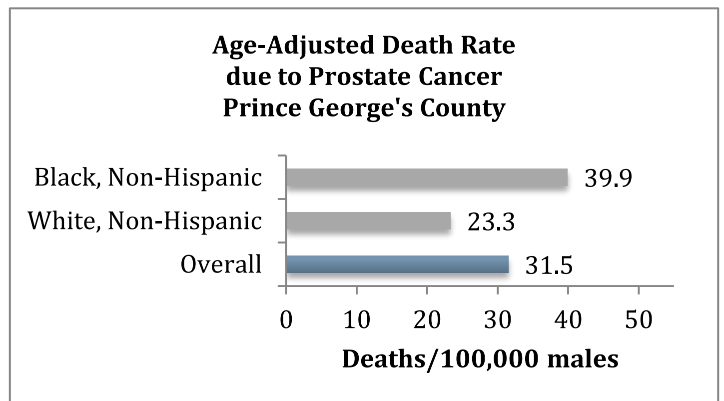
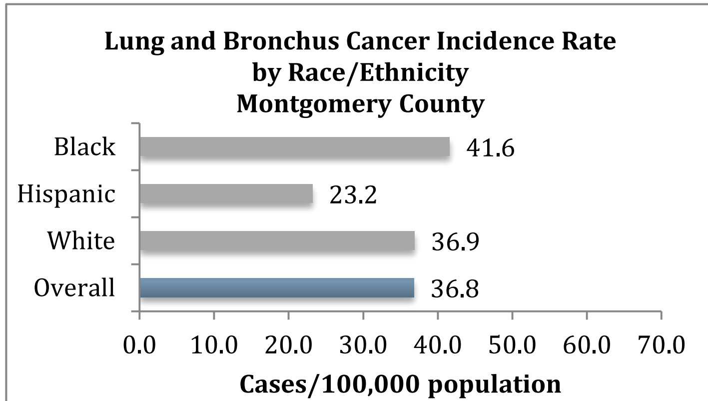


Figure 27: The age-adjusted death rate per 100,000 males due to prostate cancer. Source: National Cancer Institute, 2008-2012.

Lung Cancer

According to the American Lung Association, more people die from lung cancer annually than any other type of cancer, exceeding the total deaths caused by breast cancer, colorectal cancer, and prostate cancer combined. How long a person smokes and how often is the greatest risk factor for lung cancer. As shown in Table 2, the smoking rate in Montgomery and Prince George's Counties is lower than the state and the country. In Montgomery County, African American/Blacks have the highest lung cancer incidence rates and death rates. In Prince George's County, Whites have the highest incidence and death rates (see Figure 28 and Figure 30).



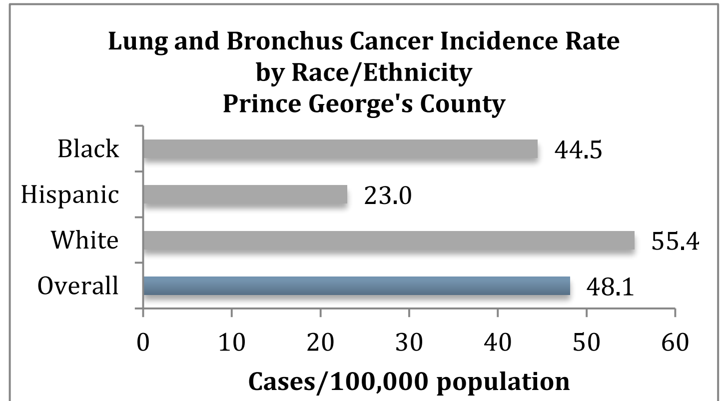
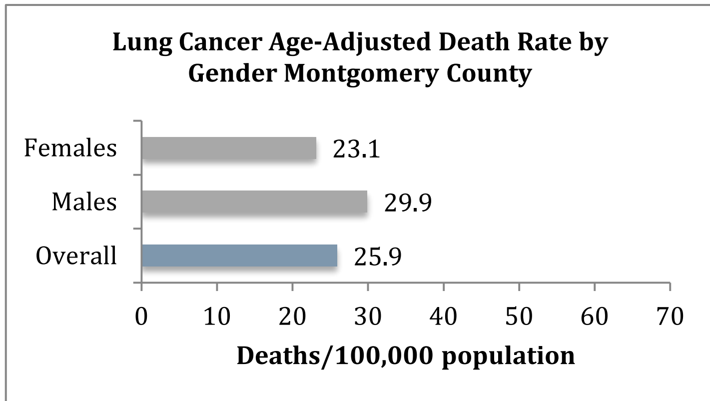


Figure 28: The age-adjusted incidence rate for lung and bronchus cancers in cases per 100,000 population. Source: National Cancer Institute, 2008-2012.



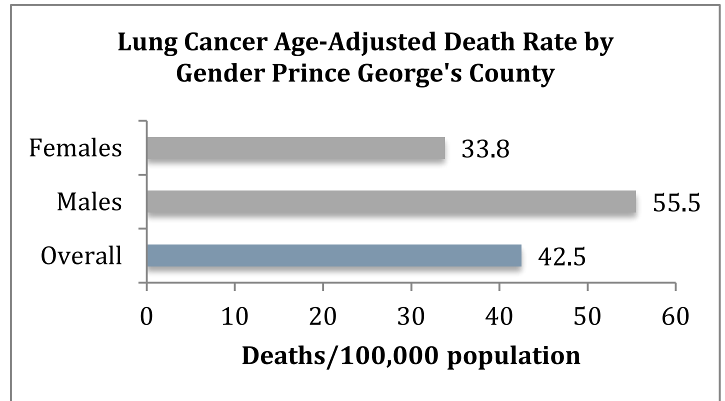
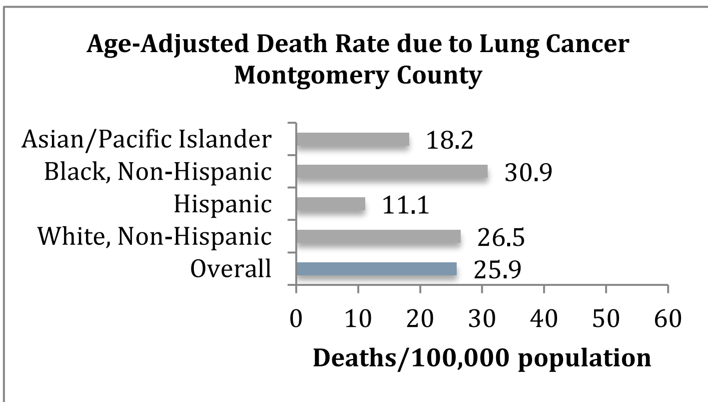


Figure 29: The age-adjusted death rate per 100,000 population due to lung cancer. Source: National Cancer Institute, 2008-2012.



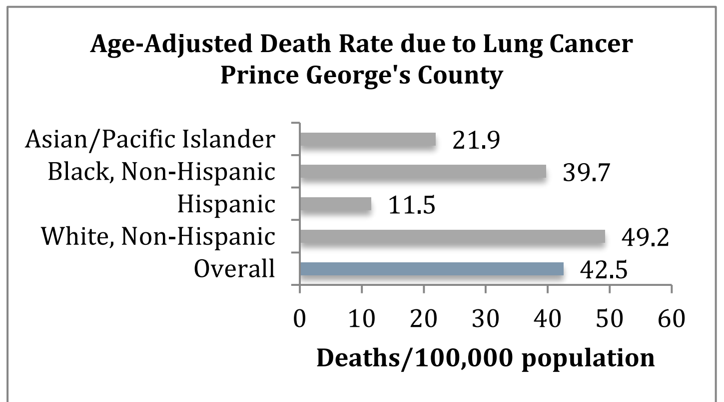


Figure 30: The age-adjusted death rate per 100,000 population due to lung cancer. Source: National Cancer Institute, 2008-2012.

Cardiovascular Disease

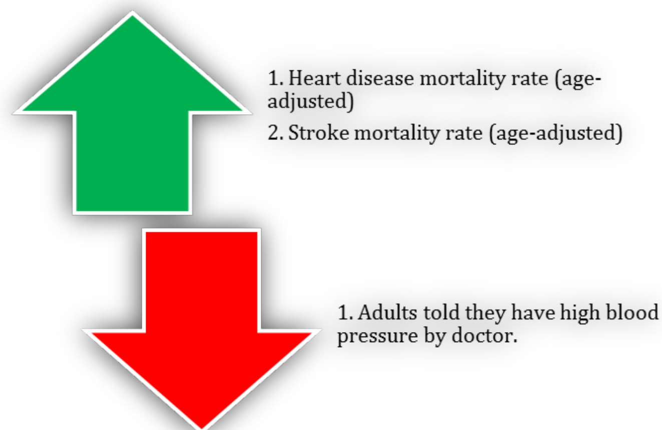


Figure 31: Improvement (or worsening) of cardiovascular core measures identified by Healthy Montgomery. Source: Healthy Montgomery, 2016

Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, they are also among the most preventable. In Montgomery County and Prince George's County, heart disease and stroke are in the top five age-adjusted death rates (see Table 3). In 2014, heart disease accounted for 1,312 deaths in Montgomery County, with the majority of deaths occurring in Whites. It has the highest age-adjusted death rate for Whites and Asian/Pacific Islanders and the second highest for African Americans/Blacks and Hispanics (Department of Health and Mental Hygiene, Vital Statistics Administration, 2014). In Prince George's County heart disease has the highest age-adjusted death rate for all races and accounted for 1,300 deaths in 2014. The majority of deaths occurred in African American/Blacks (see Figure 32).

The *Healthy Montgomery* core measures age-adjusted data on heart disease mortality shows that the Holy Cross Hospital service area has decreased rates of mortality related to heart disease from 119.0 per 100,000 population during the 2008-2012 reporting period to 111.4 per 100,000 population during the 2010-2014.

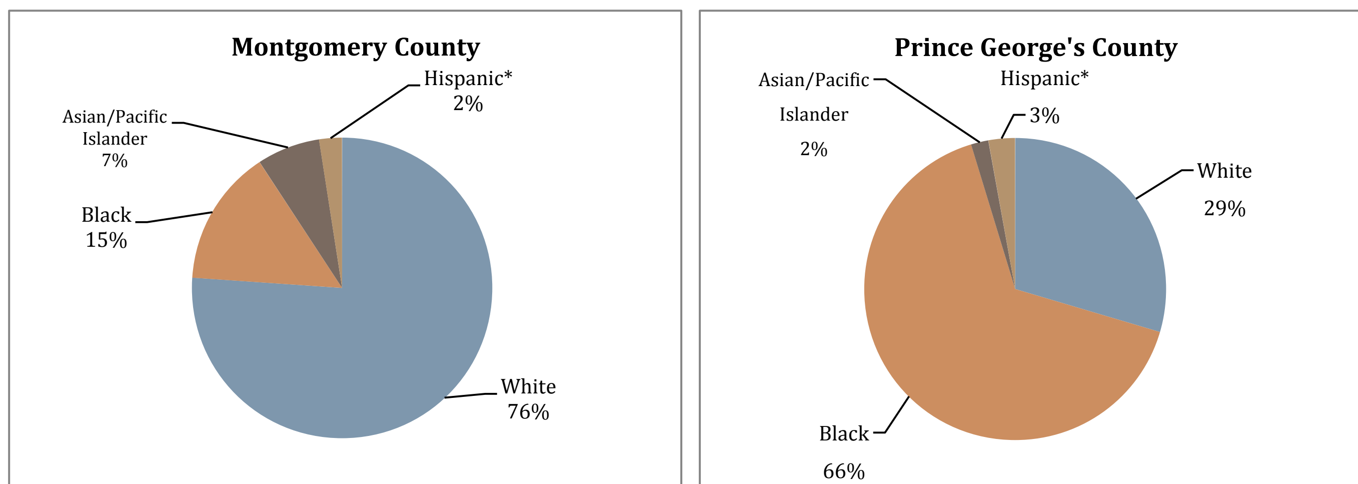


Figure 32: Percentage of deaths from heart disease by race for Montgomery and Prince George's County. Source: Maryland Vital Statistics Administration, 2014.
*Inclusive of all persons of Hispanic origin, regardless of race.

Cerebrovascular Disease

In Montgomery and Prince George's Counties stroke is the third leading cause of death. A stroke occurs when the brain is deprived of oxygen. This usually occurs when blood vessels carrying oxygen to the brain become blocked or burst. Age is a large risk factor for stroke, with the risk doubling for each decade after 55, however, the largest modifiable risk factors for stroke are high blood pressure, high cholesterol and diabetes mellitus (Healthy Communities Institute, 2016). There is an overall decrease in stroke-related mortality rates among the total population served by Holy Cross Hospital compared to the rest of the county.

High Blood Pressure and Cholesterol

High blood pressure (140/90 mm Hg or higher) is a risk factor for many diseases including heart disease, kidney failure, and stroke. High blood pressure is often called the "silent killer" because it can be asymptomatic and go undetected. High blood pressure can occur in people of any age or sex; however, it is more common among those over age 35. In Montgomery and Prince George's Counties, the populations with the highest rates of high blood pressure are Black, Non-Hispanics, and White, Non-Hispanics (see Figure 33). High cholesterol is also a major risk factor for heart disease and can go undetected. It is important for both men and women to maintain low cholesterol levels to reduce their chance of developing heart disease (Healthy Communities Institute, 2016).

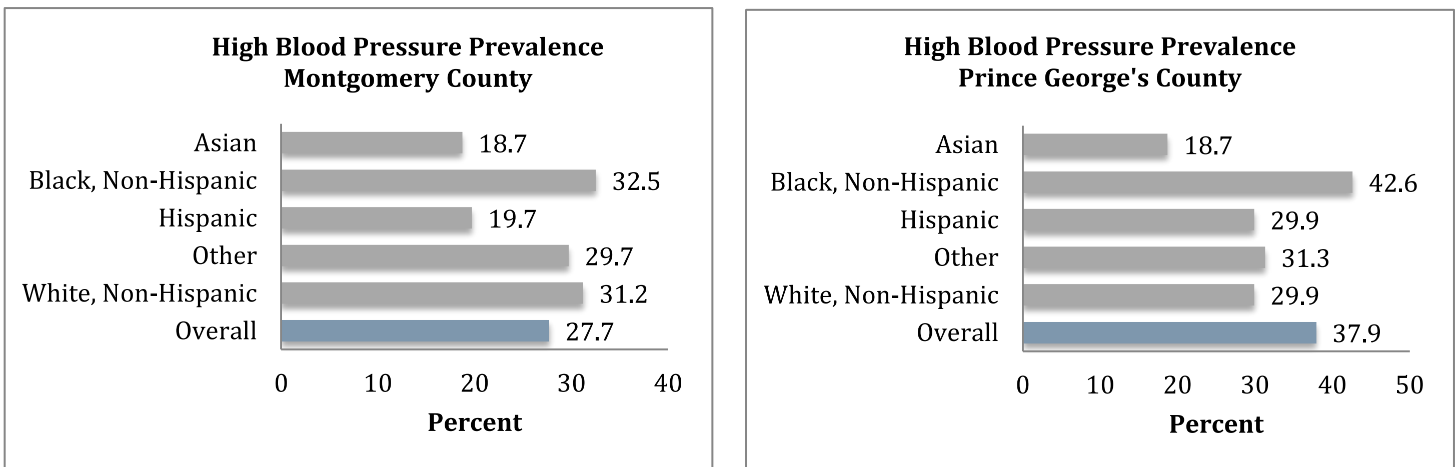


Figure 33: The percentage of adults who have been told they have high blood pressure. Source: Maryland BRFSS, 2013.

Diabetes

In 2012, 29.1 million Americans, or 9.3% of the population, had diabetes up from 25.8 million and 8.3% in 2010 (American Diabetes Association, 2016). Diabetes disproportionately affects minority populations and the elderly and its incidence is likely to increase as minority populations grow and the U.S. population becomes older. Persons with diabetes are also at increased risk for ischemic heart disease, neuropathy, and stroke. Diabetes is also a costly disease. It is estimated that the average medical expenditures for a person diagnosed with diabetes is 2.3 times higher than it would be if that person did not have diabetes (American Diabetes Association, 2016).

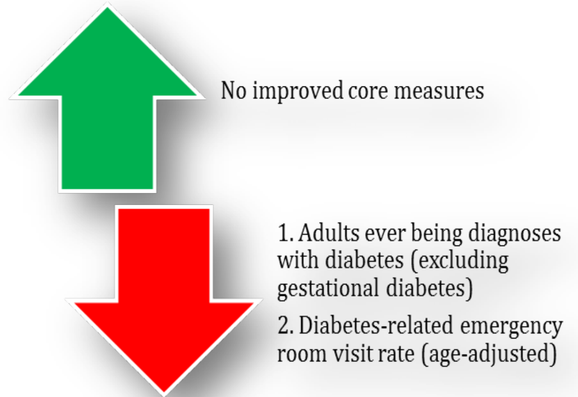
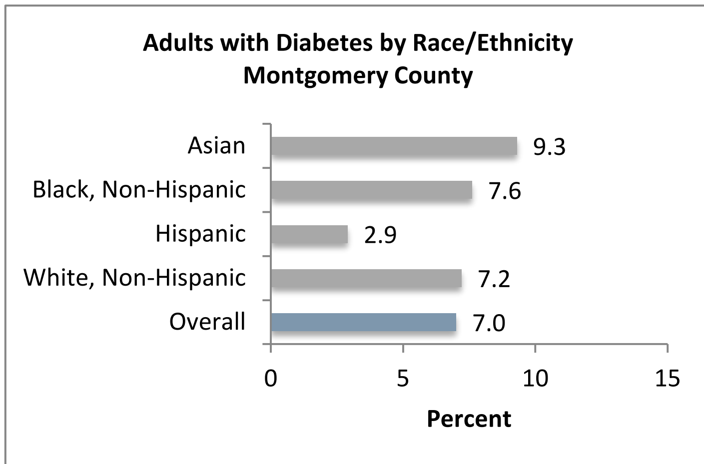


Figure 34: Improvement (or worsening) of diabetes core measures identified by Healthy Montgomery. Source: Healthy Montgomery, 2016.

In 2014, diabetes was the ninth leading cause of death in Montgomery County and the fourth leading cause of death in Prince George's County. Diabetes can lower life expectancy by up to 15 years and increases the risk of heart disease by 2 to 4 times. It is also the leading cause of kidney failure, lower limb amputations, and adult-onset blindness (American Diabetes Association, 2016).



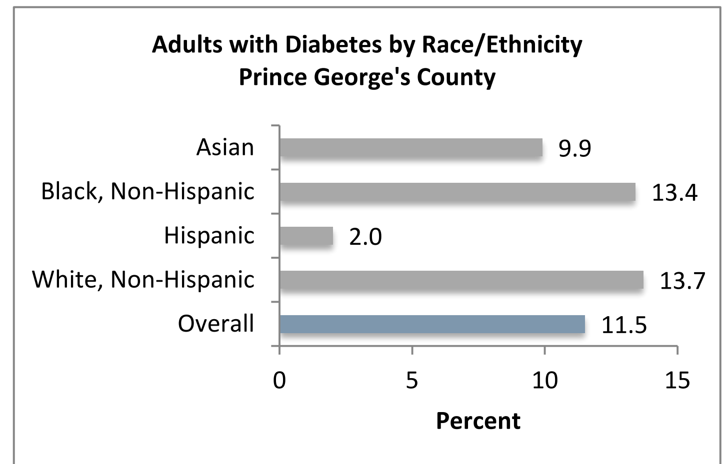


Figure 35: The percentage of adults who have ever been diagnosed with diabetes, not including women who were diagnosed with diabetes only during pregnancy. Source: Maryland BRFSS, 2014.

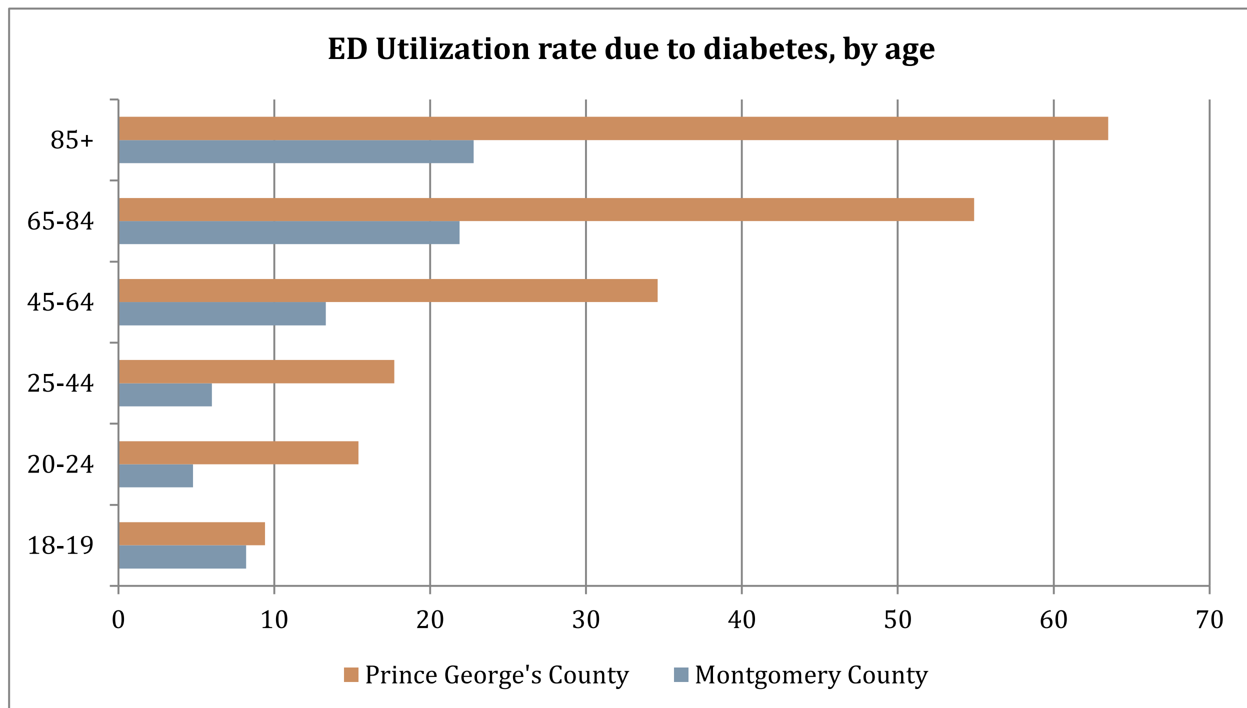


Figure 36: The average annual age-adjusted emergency department visit rate due to diabetes per 10,000 population aged 18 years and older. Cases of gestational diabetes were excluded. Source: Maryland HSCRC, 2010-2012.

Obesity

During the past twenty years, obesity rates have increased in the United States; doubling for adults and tripling for children. Almost 60% of Montgomery County residents and more than 70% of Prince George's County residents are overweight or obese (Centers for Disease Control and Prevention, 2014) and both obesity metrics tracked by Healthy Montgomery have worsened (see Figure 37). Obesity affects all populations, regardless of age, sex, race, ethnicity and socioeconomic status (U.S. Department of Health and Human Services, 2010), however, disparities do exist and rates are affected by race/ethnicity, sex and age.

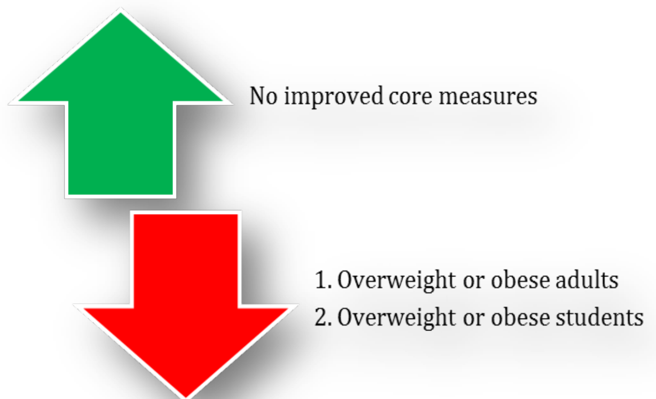


Figure 37: Improvement (or worsening) of obesity core measures identified by Healthy Montgomery. Source: Healthy Montgomery, 2016.

In both Montgomery and Prince George's Counties, obesity levels (Body Mass Index (BMI) at or above 30.0) are lowest among the Asian/Pacific Islander adults and highest among African-American/Black and Hispanic adults (see Figure 38). In both counties, men are more likely to be overweight or obese and all men and adults aged 45-64 are less likely to engage in moderate activity for 30 minutes or more per day. Hispanic/Latino adults and White adults are more likely than Asian/Pacific Islander and African American/Black adults to engage in at least light-to-moderate physical activity.

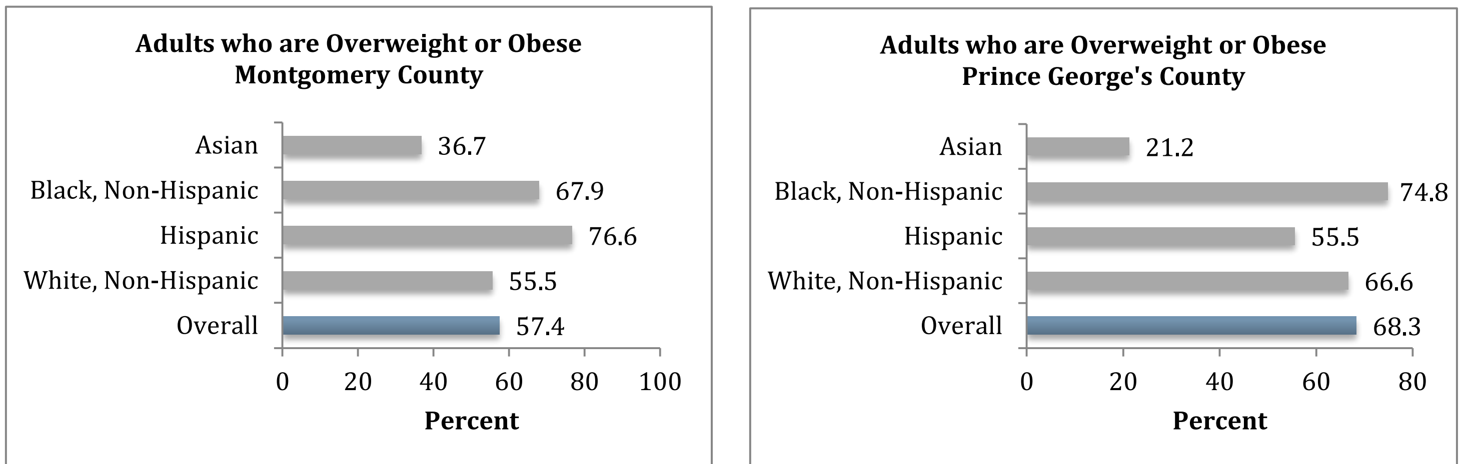


Figure 38: The percentage of adults who are overweight or obese according to the BMI. Source: Maryland BRFSS, 2012.

Behavioral Health

Adequate social and emotional support has been shown to have a positive influence on health during times of stress by decreasing stress hormones and reducing blood pressure. Research has shown that individuals with social and emotional support (i.e. the subjective sensation of feeling loved and cared for by those around) experience better health outcomes compared to individuals who lack such support (Healthy Communities Institute, 2016). One in every six adults in Montgomery County and one in five adults in Prince George's County report they are not getting the adequate social and emotional support they need.

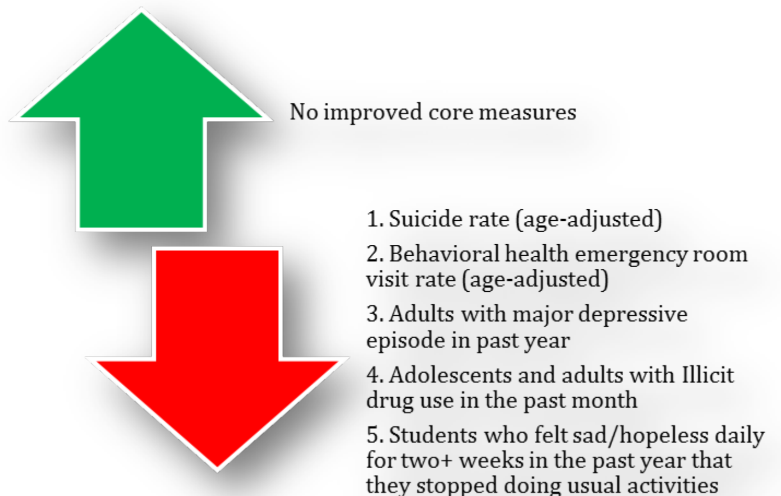


Figure 39: Improvement (or worsening) of behavioral health core measures identified by Healthy Montgomery. Source: Healthy Montgomery, 2016

Like inadequate social and emotional support, psychological distress can also have a negative effect on health. It is important to be able to recognize potential issues before they elevate to critical levels. In Montgomery and Prince George's Counties approximately 80.0% of both populations said that they experienced two or fewer days of poor mental health in the past month (Centers for Disease Control and Prevention, 2014).

Depressive disorders go beyond feeling blue or sad for a few days and can interfere with family life, work habits and daily functioning and many individuals suffering from depressive disorders never seek treatment. Examples of depressive disorders include depression, major depression, dysthymia, and minor depression and can often occur with other illnesses such as anxiety disorders, substance abuse, and cancer. Major depressive disorders account for more than two-thirds of all suicides (Healthy Communities Institute, 2016). Fourteen percent of Montgomery County residents and almost 10% of Prince George's County residents self-reported that they have been diagnosed with a depressive disorder with Whites self-reporting higher rates of diagnoses.

Suicide is a major preventable public health problem and can be closely linked to major depressive disorders. In 2014, suicide was the 11th leading cause of death in Montgomery County and the 15th leading cause of death in Prince George's County. In Montgomery County, men were more than twice as likely to die from suicide than women and White individuals were more than four times more likely to die of suicide than African American/Blacks and Hispanic individuals combined. In Prince George's County, men were four times more likely to die from suicide than women (see Figure 40). Suicide among white males aged 55+ has been steadily increasing over the past 10 years in the state, increasing from 102 deaths in 2004 to 161 deaths in 2014 (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2016).

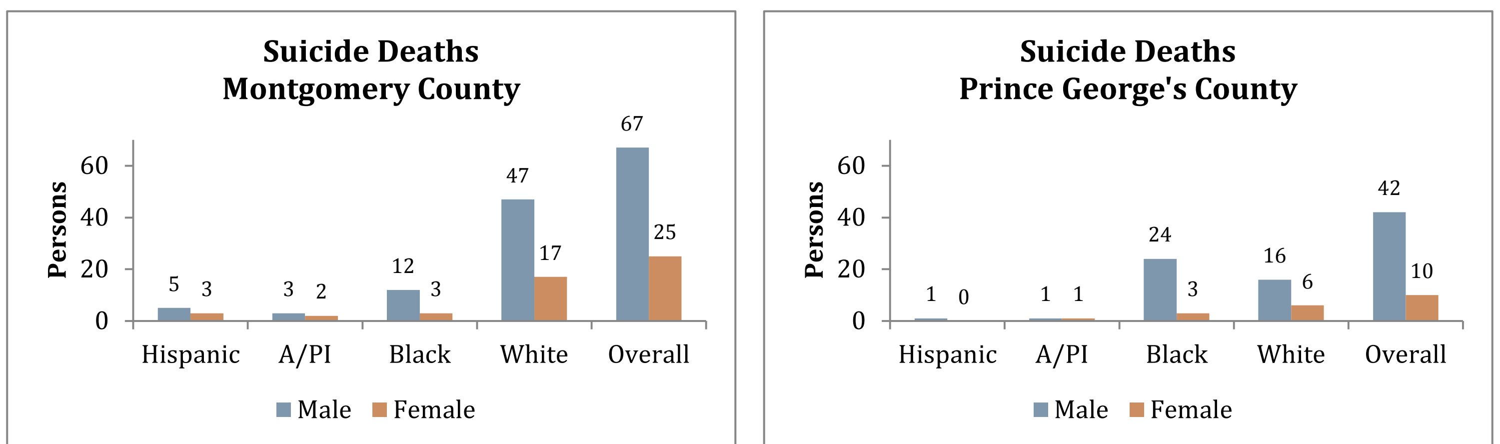


Figure 40: Montgomery and Prince George's County suicide deaths by race/ethnicity and sex. Source: Maryland DHMH, 2014.

Mental disorders, like depression, anxiety, post-traumatic stress and panic disorders, are common across the United States. Although mental disorders are common, few receive

treatment. Nationally, of those that do receive treatment, a significant proportion utilize emergency departments; between 1992 and 2003 mental health related emergency department visits increased 75% (Bazelon, 2012). In 2014 there were 1791.7 mental health related emergency department visits per 100,000 population in Montgomery County and 1539.3 mental health related emergency department visits per 100,000 population in Prince George's County. Both counties were well below the Maryland State Health Improvement Process target of 3152.6 per 100,000 visits but the number of visits in both counties increased compared to the number of 2010 visits related to mental health conditions (Maryland Department of Health and Mental Hygiene, 2016).

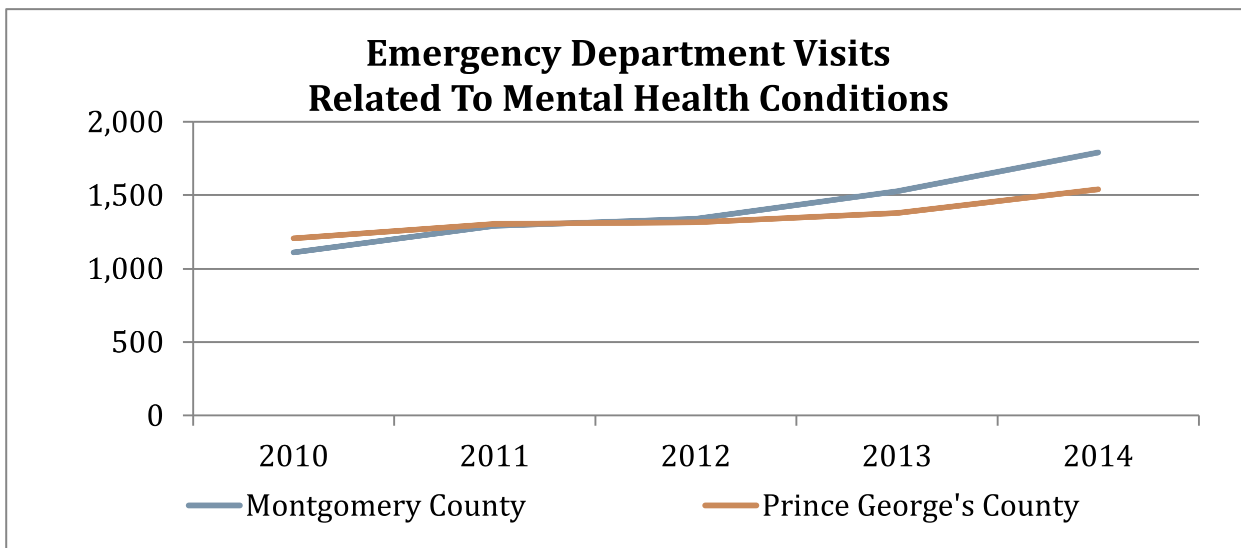
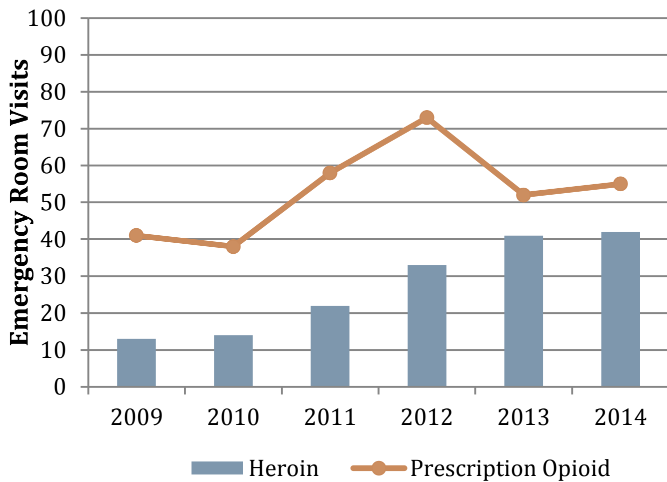


Figure 41: The number of emergency department visits related to mental health conditions. Source: Maryland DHMH State Health Improvement Process, 2016.

Substance abuse, the recurrent use of alcohol and/or other drugs, can cause major health problems, job loss and other issues at work, school or home (SAMSA). Heroin and other opioid misuse is an emerging public health issue in Montgomery and Prince George's County as well as across the nation. Opioids include heroin as well as prescription medications used as pain relievers such as morphine, codeine, methadone, oxycodone, hydrocodone, fentanyl, hydromorphone, and buprenorphine (Healthy Montgomery, 2016).

Overdose from prescription opioid pain relievers is a driving factor in the alarming increase in drug overdose morbidity and mortality. However, a notable recent trend in Maryland and the County is the increase in heroin overdose as more individuals switch to heroin use because of its relatively low cost, after becoming addicted to prescription opioids (Maryland Department of Mental Health, 2016). Over a six-year time span, the number of visits related to heroin use tripled in Montgomery County and doubled in Prince George's County (see Figure 42). The number of deaths related to heroin overdose are also on the rise (see Figure 43).



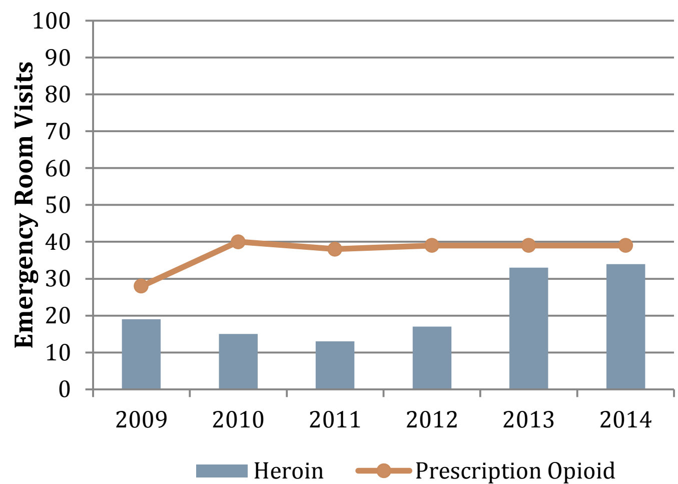


Figure 42: Heroin- and Prescription Opioid-related Emergency Room utilization from 2009-20014. Source: Maryland Department of Health and Mental Hygiene. Data Report: Drug and Alcohol-related Emergency Department Visits in Maryland, 2008–2014

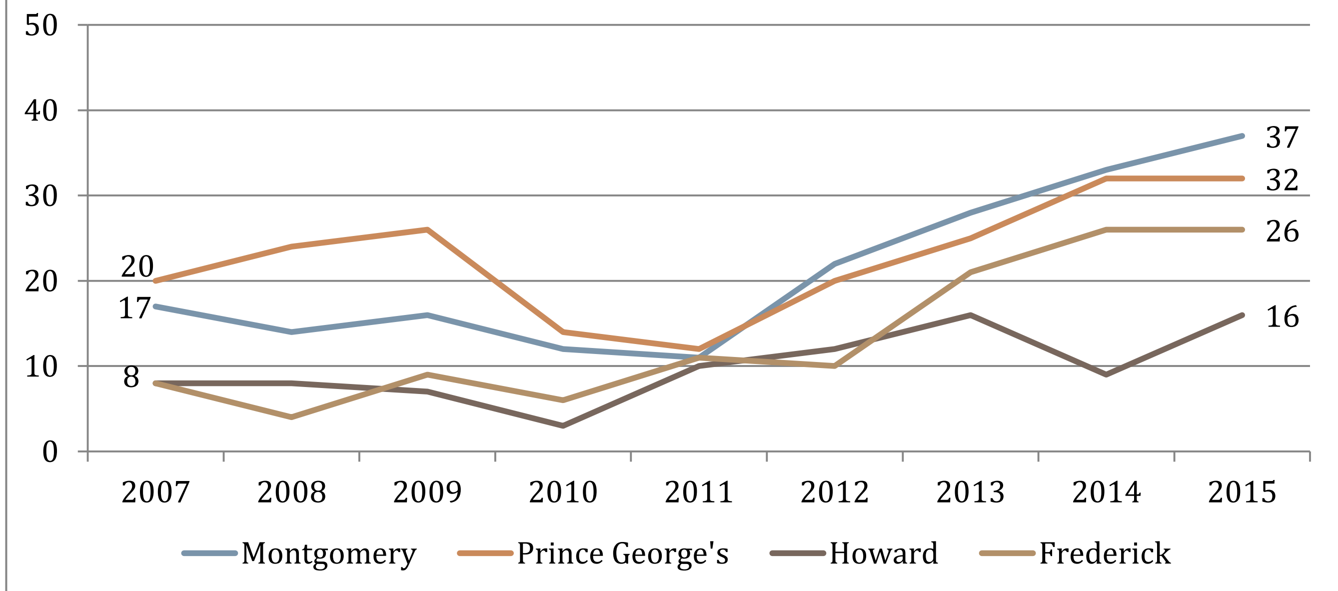


Figure 43: Number of heroin-related deaths for Maryland counties surrounding Holy Cross Health. Source: Maryland Department of Health and Mental Hygiene. Vital Statistics Administration. Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2014

Maternal/Infant Health

The health and well-being of women, infants and children determines the health of the next generation and can help predict future public health challenges for families, communities and the health care system (U.S. Department of Health and Human Services, 2010).

Between 2010 and 2014 Montgomery County's low-birth-weight (LBW) percentage has remained consistently below the Healthy People 2020 target of 7.8%. However, the rate for African American/Black births is above the target, especially for 18-19-year-old women.

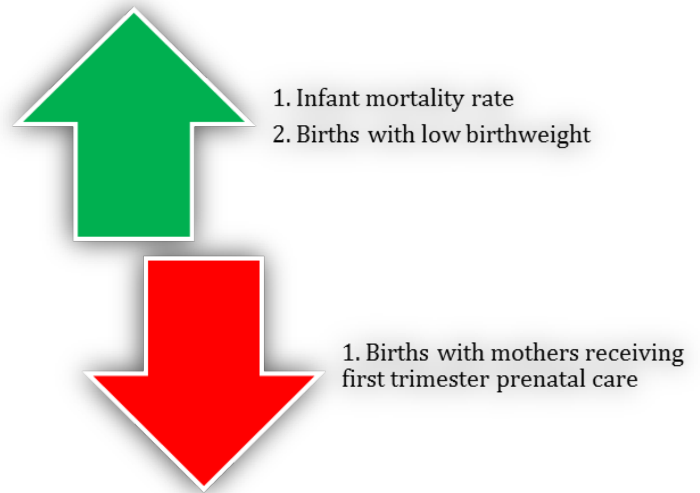


Figure 44: Improvement (or worsening) of maternal/infant health core measures identified by Healthy Montgomery. Source: Healthy Montgomery, 2016

The percentage of very low-birth-weight (VLBW) births has also remained constant, averaging 1.4% for the five-year time span, meeting the Healthy People 2020 target. The LBW births in Prince George's County have been steadily declining for the past five years, decreasing almost 10% from 10.2% in 2010 to 9.2% in 2014 (see Figure 45). The VLBW births have also declined from 2.4% in 2010 to 2.0% in 2014 (Maryland Department of Health and Mental Hygiene, 2014).

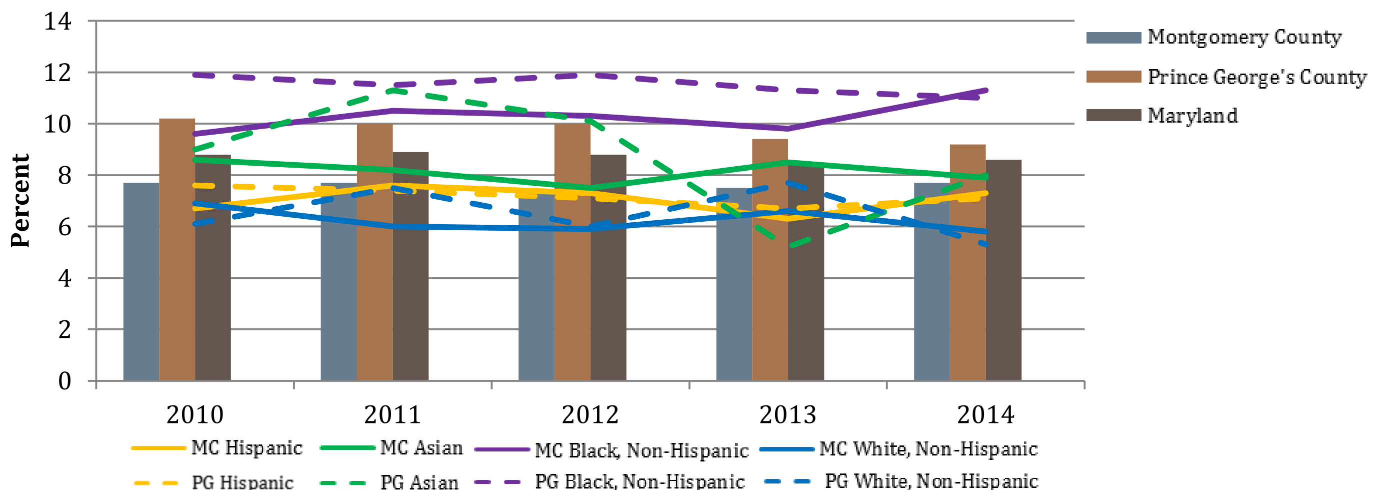


Figure 45: Percentage of LBW births by county and race/ethnicity of mother. Source: Maryland DHMH Vital Statistics Report, 2014

Montgomery County has an infant death rate of 4.8 deaths per 1,000 live births, which is below the Healthy People 2020 target of 6.0 per 1,000 live births. Prince George's County's infant death rate (6.9) falls short of the Healthy People 2020 target by 14%, however, the death rate has declined 27% from 2011 to 2014. The African American/Black infant mortality rate of both counties is significantly higher than the county rate.

Mothers who lack prenatal care are three times more likely to deliver low-birth-weight babies and their infants are five times more likely to die when compared to mothers who do receive prenatal care (Health Resources and Services Administration, 2016). Increasing the number of women who receive prenatal care, and who do so early in their pregnancies (within the first trimester), can improve birth outcomes and reduce the likelihood of complications during pregnancy and childbirth.

Teen mothers and mothers under 25 years of age are most likely not to have entered care within their first trimester. In 2014, only 21.4% of Montgomery County teen mothers under the age of 18 and 34.4% of Prince George's County teen mothers under the age of 18 entered care in their first trimester, well below the Healthy People 2020 target of 77.9%.

Seniors

Montgomery County and Prince George's County have the highest population of seniors aged 65+ in the state of Maryland. Between 2010 and 2040, the Montgomery County senior population is projected to grow from 119,769 to 243,950—increasing from 12% of the Montgomery County population in 2010 to 20% of the population in 2040 (see Figure 47). The Prince George's County senior population growth is similar to Montgomery County and will account for 18% of the overall population by 2040; double what it was in 2010 (Maryland State Data Center, 2015).

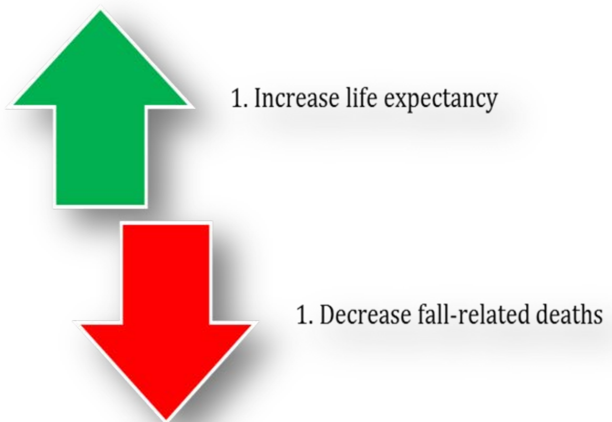
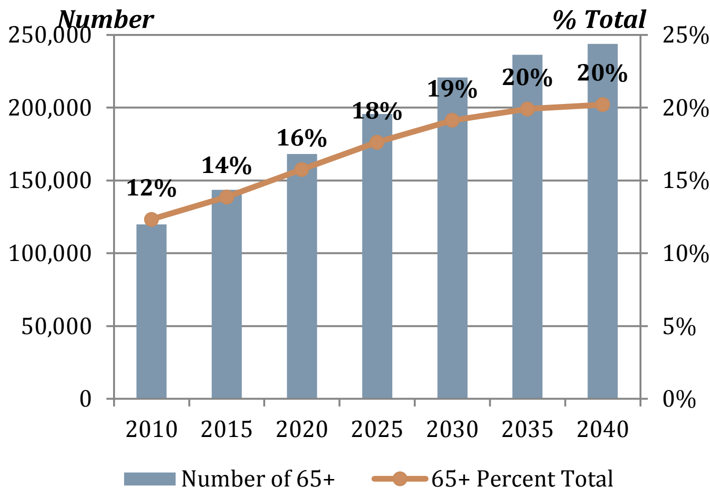


Figure 46: Improvement (or worsening) of seniors core measures identified by Holy Cross Health.

The average life expectancy for Montgomery County is 84.6 years and 80.0 years for Prince George's County; both counties higher than the Maryland State Health Improvement Target of 79.8. The aging population affects every aspect of society, with the largest effects occurring in public health, social services, and health care systems (Centers for Disease Control and Prevention, 2013).



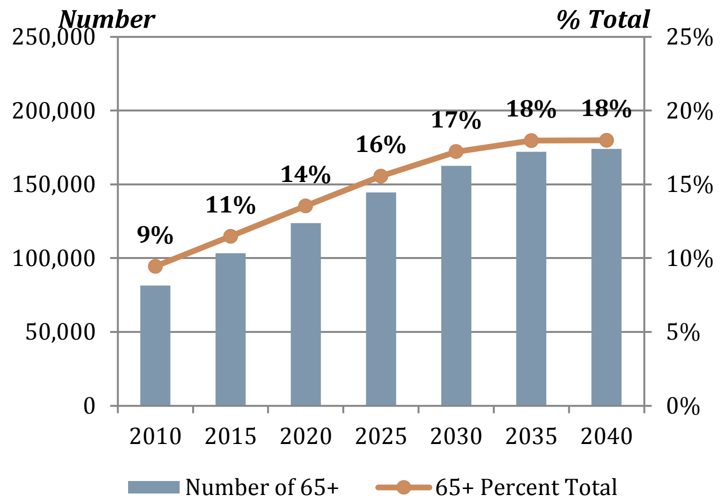


Figure 47: Senior Population Growth of Montgomery and Prince George's Counties. Source: Maryland State Data Center, Department of Planning, 2015.

Two out of every three older Americans have multiple chronic conditions and experience disproportionate rates of heart disease, cancer, diabetes, congestive heart failure, arthritis and dementia (including Alzheimer's) (Centers for Disease Control and Prevention, 2013). The leading causes of death in the Montgomery and Prince George's County population aged 65 and over are similar to the leading causes of the total population but there are some differences (see Table 3, Figure 48 and Figure 49).

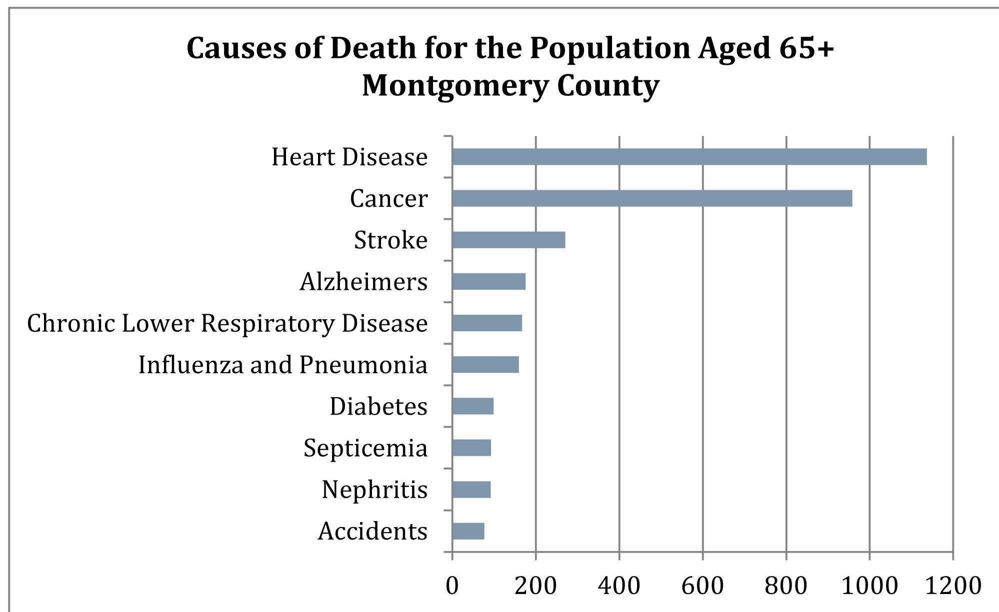


Figure 48: Leading causes of death in the Montgomery County population aged 65 and over. Source: Maryland Assessment Tool for Community Health, 2010.

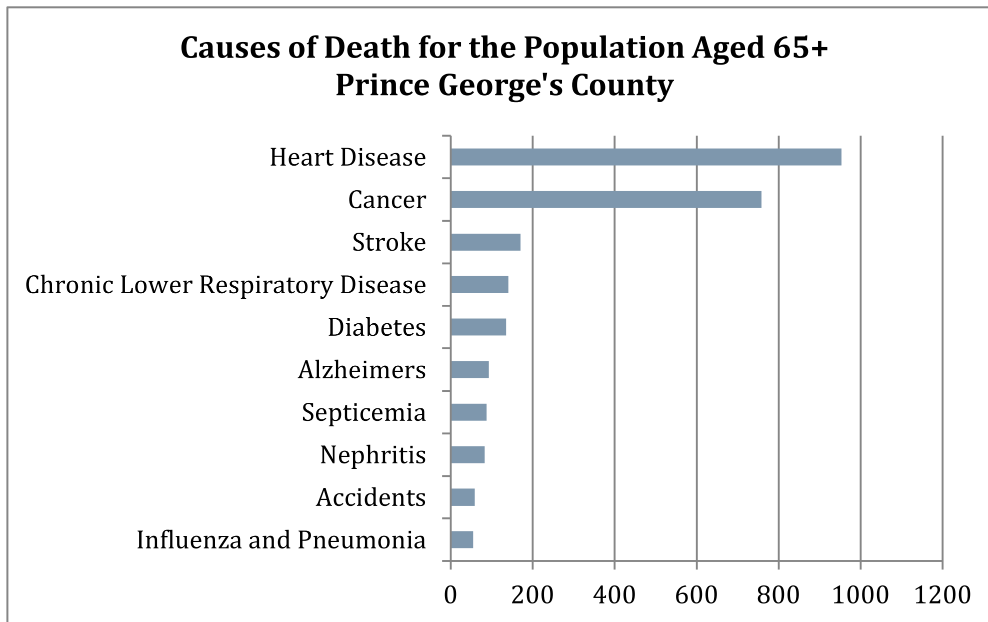


Figure 49: Leading causes of death in the Prince George's County population aged 65 and over. Source: Maryland Assessment Tool for Community Health, 2010.

In the 65 and over population of Montgomery and Prince George's Counties, deaths from influenza and pneumonia and deaths from accidents are listed in the top 10 causes of death and are highly preventable. Influenza can be dangerous for people with heart or breathing conditions and can lead to pneumonia and deaths, especially in the elderly (Healthy Communities Institute, 2016). The influenza vaccine can prevent serious illness and death, however, only 62.6% of Montgomery County residents and 59.7% of Prince George's County residents said they received an influenza vaccination in 2014 (Centers for Disease Control and Prevention, 2014).

Pneumococcal pneumonia is the leading cause of vaccine-preventable death and illness in the United States. The pneumonia vaccine is very effective at preventing severe disease, hospitalization, and death. In Montgomery and Prince George's County 73.8% and 66.0%, respectively, said they received a pneumococcal pneumonia vaccination in 2014 (Centers for Disease Control and Prevention, 2014).

Deaths from accidents are the 10th leading cause of death in Montgomery County and the 9th leading cause of death in Prince George's County for seniors. Between 2000 and 2010 falls accounted for 65.3% of the deaths from accidents in Montgomery County with 54.7% of falls occurring in residents 85 and over (see Figure 50) and 46.6% of the deaths from accidents in Prince George's County with almost equal amounts of fall deaths occurring in residents aged 75-84 and 85 and over (see Figure 51).

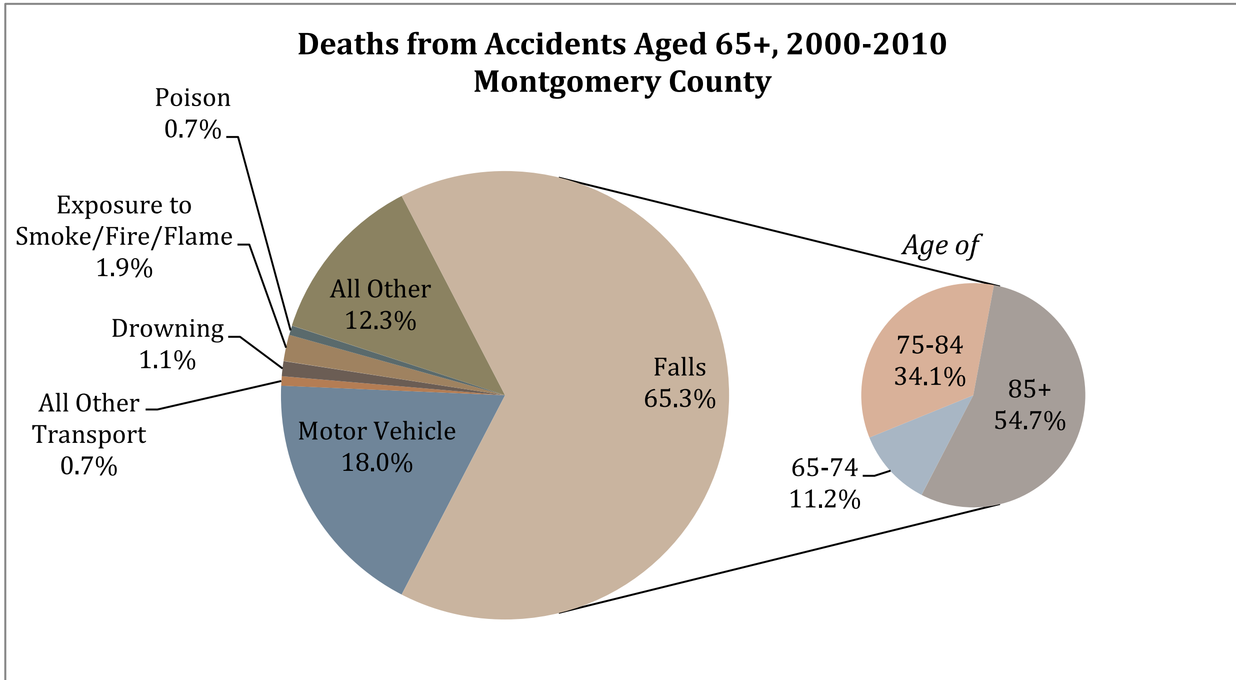


Figure 50: Deaths from accidents in Montgomery County from 2000-2010. Source: Maryland Assessment Tool for Community Health, 2010

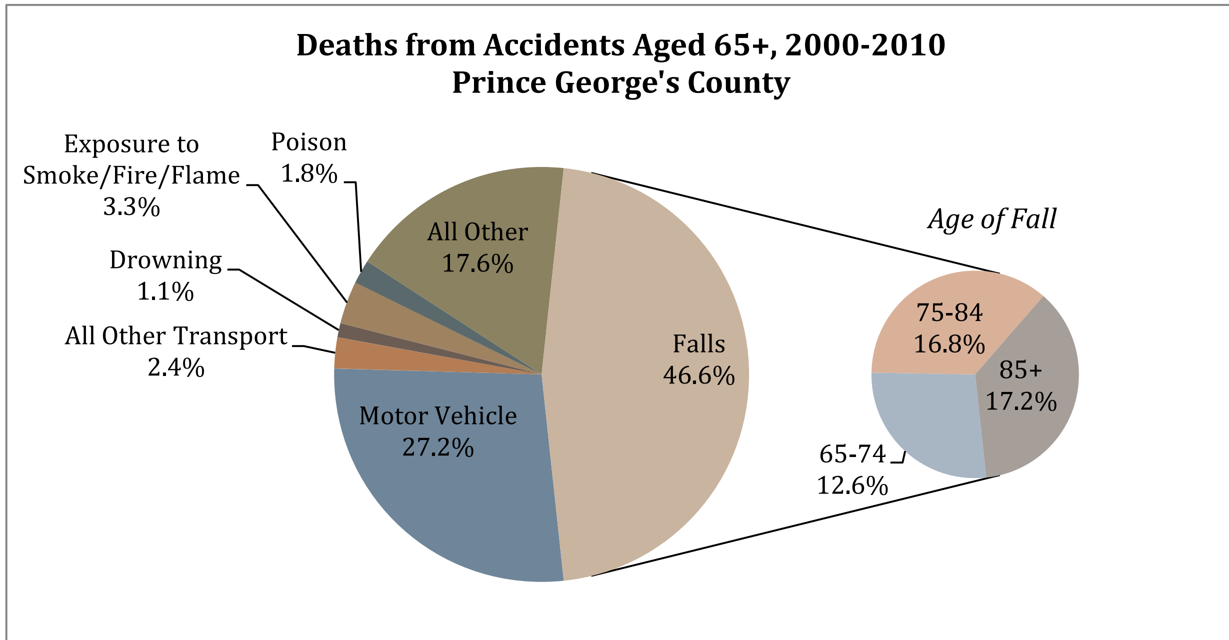


Figure 51: Deaths from accidents in Prince George's County from 2000-2010. Source: Maryland Assessment Tool for Community Health, 2010

Hospital Readmissions and Emergency Department Utilization

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

Holy Cross Health, in alignment with the Centers for Medicare & Medicaid Services (CMS), defines a hospital readmission as a patient admission to a hospital within 30 days after being discharged from an earlier hospital stay. From April 2010-June 2013, Holy Cross Hospital discharged 111,135 patients. Of this, 5,883 patients were readmitted within 30 days (all cause, including 1-day LOS) accounting for 8,596 readmissions (7.73 % 30-day readmission rate) and 147 (2.5%) patients were admitted five or more times within 30 days accounting for 1,110 (12.91%) of readmissions. A disproportionate percentage of readmissions were African Americans (43.1%) and Medicare recipients.

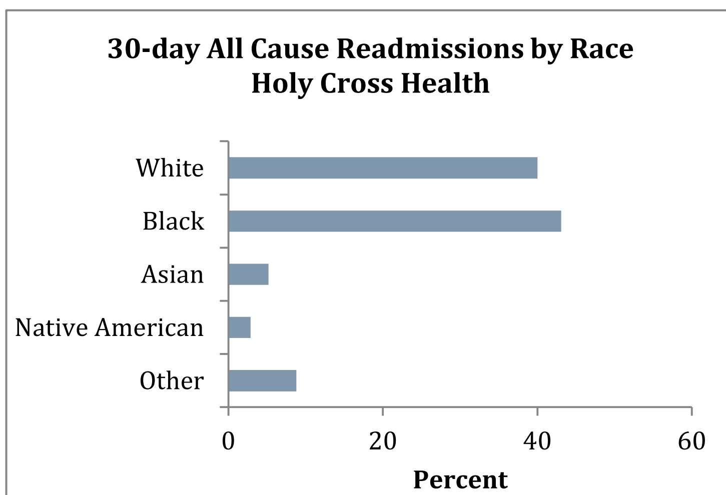


Figure 53: Holy Cross Hospital percentage of patient admissions within 30 days after being discharged by race, data from April 2010-June 2013.

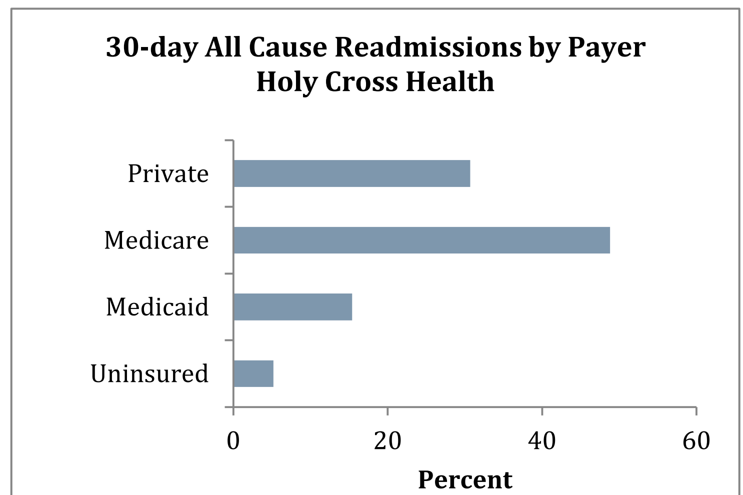


Figure 52: Holy Cross Hospital percentage of patient admissions within 30 days after being discharged by payer, data from April 2010-June 2013.

Prevention quality indicators (PQI) are a set of measures that can be used with hospital inpatient discharge data to identify ambulatory care sensitive conditions (ACSCs). ACSCs are conditions for which hospitalization could have been potentially prevented in the presence of good outpatient care or for which an early intervention could possibly prevent complications or more severe disease (Department of Health and Human Services Agency for Healthcare Research and Quality, 2007).

The PQIs consist of the following 16 ambulatory care sensitive conditions, which are measured as rates of admission to the hospital (top five Holy Cross Health PQIs in bold):

- **Bacterial pneumonia**
- Hypertension
- Dehydration
- **Adult asthma**
- Pediatric gastroenteritis
- Pediatric asthma
- **Urinary tract infection**
- Chronic obstructive pulmonary disease
- Perforated appendix
- Diabetes short-term complication
- Low birth weight
- Diabetes long-term complication
- Angina without procedure
- Uncontrolled diabetes
- **Congestive heart failure**
- **Lower-extremity amputation (diabetes)**

Prevention Quality Indicators (PQI's)	Number of Discharges
Diabetes short-term complication	212
Perforated appendix	794
Diabetes long-term complication	791
Chronic obstructive pulmonary disease (COPD)	924
Hypertension	421
Congestive heart failure (CHF)	2,030
Low birth weight	15
Dehydration	366
Bacterial pneumonia	1,420
Urinary tract infection	1,340
Angina without procedure	80
Uncontrolled diabetes	99
Adult asthma	1,216
Lower-extremity amputation among patients with diabetes	1,121
Total	10,829

Table 4: Holy Cross Hospital's Ambulatory Care Sensitive Condition discharges.

DATA GAPS IDENTIFIED

Where available, the most current and up-to-date data was used to determine the health needs of the community. Although the data set available is rich with information and more information is available today when compared to the needs assessment conducted in fiscal year 2012, data gaps still exist.

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

RESPONSE TO FINDINGS

In 2012, through multi-voting and consensus discussion, the *Healthy Montgomery* Steering Committee, which included representation from a Holy Cross Health executive team member, analyzed available data on more than 100 indicators to determine the following top-ranked priority areas (more detailed information on the priority setting process can be found in Appendix I):

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

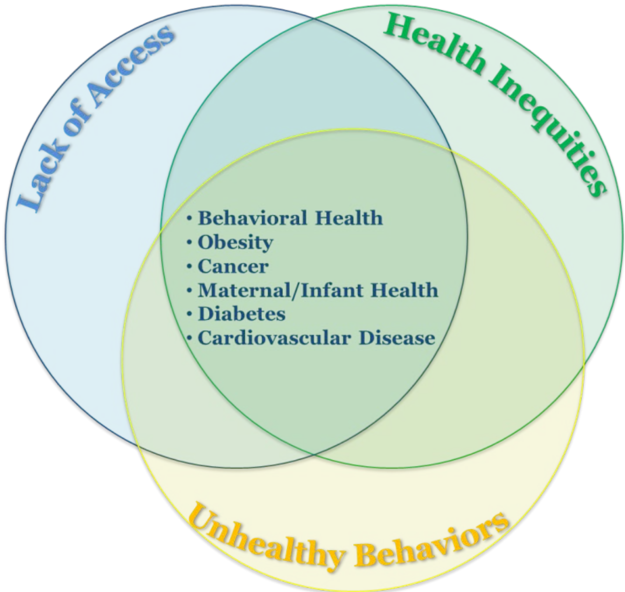


Figure 54: Healthy Montgomery priorities and overarching themes.

In addition to selecting the six broad priorities for action, the *Healthy Montgomery* Steering Committee selected three overarching themes: Improve access to health and social services, Achieve health equity for all residents, and enhance the physical and social environment to support optimal health and well-being and reduce unhealthful behaviors (see Figure 54).

In 2016, *Healthy Montgomery* identified 63 strategies to address the existing *Healthy Montgomery* priority issues of obesity, behavioral health, diabetes, cardiovascular disease, cancers, and maternal and infant health. These strategies are identified in their community health needs assessment and were derived from the key findings of the qualitative data (community conversations), quantitative data (review of national and state data sources), community resources (including the hospital systems' activities), and evidence-based strategies. To narrow down the list, *Healthy Montgomery* Steering Committee members were asked to select up to ten strategies that they believed should be a priority for *Healthy Montgomery's* 2017-2019 Community Health Improvement Cycle. During the second stage of the process, a full day retreat was held where the steering committee voted on the top three priorities for *Healthy Montgomery* to address over the next three years. Each participant was allotted three dot stickers and was asked to place the dots on their preferred strategies (Participants were allowed to place more than one dot on a particular strategy). The following strategies serve as the 2017 – 2019 priority strategies: 1) Establish

and sustain a Health in All Policies (HiAP) model within Montgomery County; 2) Offer combined diet and physical activity promotion programs for County residents at increased risk of type 2 diabetes to reduce new-onset diabetes; and 3) Develop integrated care programs to address mental health, substance abuse and other needs within primary care settings. For a more detail list of the strategy selection process and for more information on the three strategies selected, see Appendix J.

Building upon the work of *Healthy Montgomery*, Holy Cross Health's needs assessment reveals particular areas that have a large number of people who are poor, of child-bearing age, elderly, racially and ethnically diverse, and of limited English speaking ability. We focus our community benefit activities on the most vulnerable and underserved individuals and families, including women/children, seniors and racial, ethnic and linguistic minorities.

Demographic analysis from Holy Cross Health's needs assessment also reveals that the senior population of Montgomery and Prince George's Counties is growing at an unprecedented rate, increasing the need for senior services such as housing and health care. In an effort to be proactive in meeting the growing needs of this population we have included seniors as a priority focus in addition to the priorities set by *Healthy Montgomery*.

GUIDING PRINCIPLES

Holy Cross Health's multi-year community benefit implementation plan addresses the priority areas and overarching themes by focusing our community benefit activities on the most vulnerable and underserved individuals and families, including women/children, seniors, and racial, ethnic and linguistic minorities. To select outreach priorities for the implementation plan, Holy Cross Health linked community health care needs to our mission and strategic priorities. We developed a set of principles to help determine our highest priorities and guide our decision-making about community benefit:

- Be the Montgomery County leader and a state/national model
- Take prudent risks and ensure sound financial stewardship and sustainability
- Be focused on the primary service area
- Prioritize needs that are consistent with the organization's strengths
  - Women/children (particularly infant mortality and obesity)
  - Seniors (particularly cardiovascular disease, diabetes, and obesity)
  - Cancer (particularly breast cancer)
- Meet Holy Cross Health's overall commitment to improving access to care and addressing identified community need

    - Access, especially for vulnerable and underserved populations (racial and ethnic population subgroups; uninsured residents; primary care access, especially for chronic conditions including diabetes and heart failure)
    - Outreach to targeted populations (especially for cancer prevention in African American, African/Caribbean American, Latino American, Asian American, Native American populations)
    - Demonstrated improvements in health status (reduction in infant mortality; reduction in percentage of children and adults with obesity; reduction in rate of breast cancer deaths; reduction in preventable hospital admissions for chronic disease)
    - Ongoing learning and sharing of new knowledge (public education)
- Have measurable outcomes and be integrated with planning and budgeting
- Reflect partnership.

PRIORITIZING SIGNIFICANT UNMET NEEDS

With this information, Holy Cross Health will address unmet needs within the context of our overall approach, mission commitments and key clinical strengths and within the overall goals of *Healthy Montgomery*. We recognize that we are equipped to address each significant unmet need identified by *Healthy Montgomery* and Holy Cross Health; however, prioritizing the needs will allow us to utilize our resources and expertise to ensure we have the biggest impact on the unmet needs in our community.

To prioritize the top-ranked health priorities, members of the CEO Review on Population Health and Community Benefit were asked to rate each priority on the following criteria: severity of the need, feasibility of our organization to address the need, and the potential each need has for achievable and measurable outcomes. Each need was also scored on its prevalence in the population. The following prioritization was determined by tallying all the scores received for each unmet need:

1. Maternal & Infant Health
2. Seniors
3. Diabetes
4. Cancers
5. Cardiovascular Health
6. Obesity
7. Behavioral Health

Community Benefit Implementation Strategy

As the county's community health improvement process evolves, priorities will be determined, and with this information, Holy Cross Hospital will address unmet needs within the context of our overall approach, mission commitments and key clinical strengths and within the overall goals of *Healthy Montgomery*.

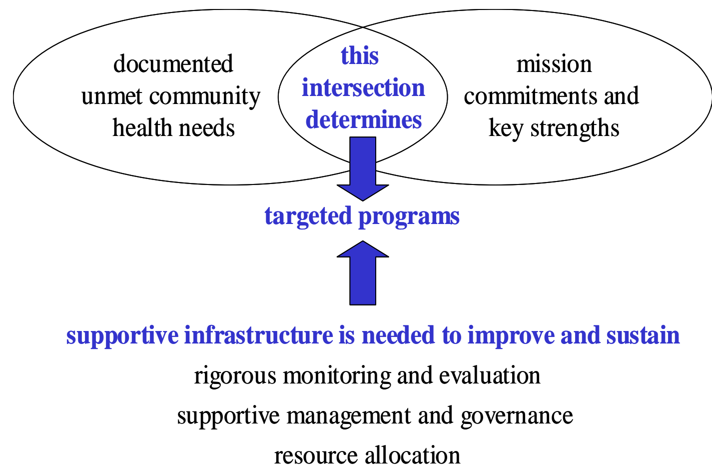


Figure 55: How Holy Cross Health aligns targeted programs with the mission and strengths of the hospital and unmet community needs.

Key findings from all data sources, including data provided by *Healthy Montgomery*, our external review group (see Appendix C for highlights) and hospital available data were reviewed and the most pressing needs were incorporated into our annual community benefit plan. The community benefit plan reflects Holy Cross Hospital's overall approach to community benefit by targeting the intersection between the identified needs of the community and the key strengths and mission commitments of the organization (see Figure 55) to help build the continuum of care. We have established leadership accountability and an organizational structure for ongoing planning, budgeting, implementation and evaluation of community benefit activities, which are integrated into our multi-year strategic and annual operating planning processes. Holy Cross Hospital's Community Benefit Implementation Strategy is presented in a separate document.

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Appendix A: Holy Cross Hospital's Comprehensive Services

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

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

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

Appendix B: 2016 Healthy Montgomery Steering Committee Members

Organization	Name of Key Collaborator	Title	Collaboration Description
Montgomery County Council	Mr. George Leventhal	Councilmember	Co-Chair
Vice President	Ms. Sharan London	ICF International	Co-Chair
Montgomery County Department of Health and Human Services	Ms. Uma Ahluwalia	Director	Member
Public Health Foundation	Mr. Ron Bialek	President	Member
Montgomery County Commission on Health		Member	
MedStar Montgomery Medical Center	Ms. Gina Cook	Marketing, Communications Manager	Member
Montgomery County Department of Health and Human Services	Dr. Raymond Crowel	Chief, Behavioral Health and Crisis Services	Member
House of Delegates, Maryland General Assembly	Bonnie Cullison	Delegate	Member
Kaiser Permanente	Ms. Tanya Edelin	Director, Reporting and Compliance, Community Benefit	Member
Garvey Associates	Dr. Carol Garvey	Vice President for Health Policy	Member
Primary Care Coalition of Montgomery County	Leslie Graham	President & Chief Executive Officer	Member
Commission on Aging	Dr. Samuel P. Korper	Member	Member
Montgomery County Department of Planning	Ms. Amy Lindsey	Senior Planner	Member
Holy Cross Health	Ms. Kimberley McBride	Community Benefit Officer	Member
Ronald D. Paul Companies	Ms. Kathy McCallum	Controller	Member
Carefirst Blue Cross Blue Shield	Ms. Beatrice Miller	Sr. Regional Care Coordinator	Member
African American Health Program		Member	
Commission on People with Disabilities	Dr. Seth Morgan, Physician	Member	Member
Asian American Health Initiative	Dr. Nguyen Nguyen	Member	Member
Proyecto Salud Health Center	Dr. Cesar Palacios	Executive Director	Member
Latino Health Initiative		Member	
Montgomery County Public Schools	Dr. Chrisandra Richardson	Associate Superintendent	Member
Montgomery County Recreation Department	Dr. Joanne Roberts	Program Manager	Member
Suburban Hospital	Ms. Monique Sanfuentes	Director, Community Health and Wellness,	Member
Georgetown University School of Nursing and Health Studies	Dr. Michael Stoto	Professor	Member
Montgomery County Department of Health and Human Services	Dr. Ulder J. Tillman	Officer and Chief, Public Health Services	Member
Center for Health Equity & Wellness, Adventist HealthCare	Dr. Deidre Washington	Research Associate	Member

*updated 6/30/2016

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

On June 7th, 2016 the following organizations were represented at the External Review Meeting:

- Montgomery County Department of Health and Human Services
- University of Maryland Extension
- Silver Spring Village
- African American Health Program, Montgomery County Department of Health and Human Services
- Eastern Montgomery County Regional Center, Montgomery County Government
- Latino Health Initiative, Montgomery County Department of Health and Human Services
- Cancer and Tobacco Prevention, Montgomery County Department of Health and Human Services
- Mental Health Association of Montgomery County

Suggestions made for our FY16 Annual Community Benefit Plan

- ✓ Address senior mental health issues: dementia, social isolation, and caregiver support, including for non-English speakers.
- • Increase focus on youth to address obesity, teen mothers, and behavioral health issues
- • Decrease the adverse effects of opioid use through community-based services, forensic hospital capacity and availability of opiate antidotes
- ✓ Stress nutrition education during pregnancy and during postpartum, increase focus on obesity in pregnancy and early infancy, postpartum weight loss and educate women on a high fat maternal diet during pregnancy and its influence on increasing disease risks in children.
- ✓ Connect chronic disease patients to hospital and community-based programs and monitor referrals
- ✓ Expand community health worker (CHW) services in the community and health centers. Address health literacy, health insurance literacy, parenting skills, mental health 1st aid, life skills, etc. Unite CHWs across county to pool resources, create competencies, and expand beyond just health.
- • Increase access to eyeglasses
- ✓ Provide pre-employment support and employment recognizing its role as a social determinant of health
- • Address nutrition deficiencies due to food deserts, eligible residents not accessing food insecurity benefits, and an overabundance of fast food.
- ✓ Address tobacco utilization, recognizing links between mental health diagnoses and tobacco use
- ✓ Address the needs of vulnerable populations including people who are undocumented, homeless or refugees, especially for post-acute care

Key

- ✓ Accomplished or in process
- • Still considering

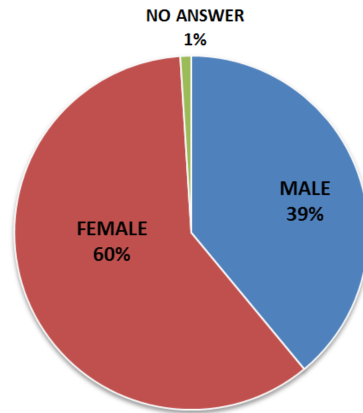
Appendix D: Demographics of the Montgomery County Community Conversations

Gender Distribution of Respondents

Across all conversations, there were more female than male participants.

4 Conversations had more male than female participants:
* Youth
* Bethesda Chevy Chase
* East County

3 Conversations were single gender:
* Male Homeless Shelter
* Female Homeless Shelter
* Vietnamese (Male)



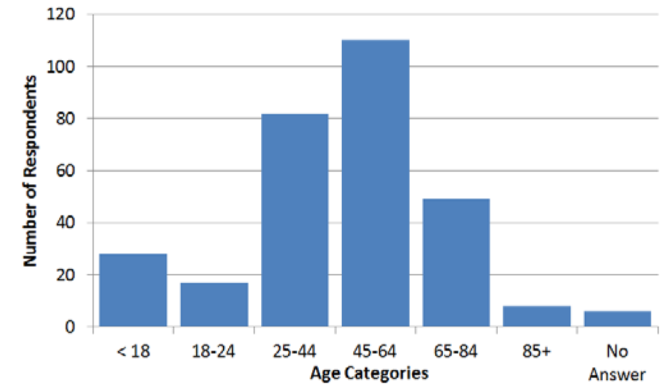
Male: 116
Female: 181

Note: 367 individuals participated across all 15 community conversations. 300 participants completed the demographic form, representing 82% of the Community Converstion participants.

Age Distribution of Respondents

The median age range of respondents was 45-64 years old.

In the conversation with Youth, all 26 respondents were under 18 years old.



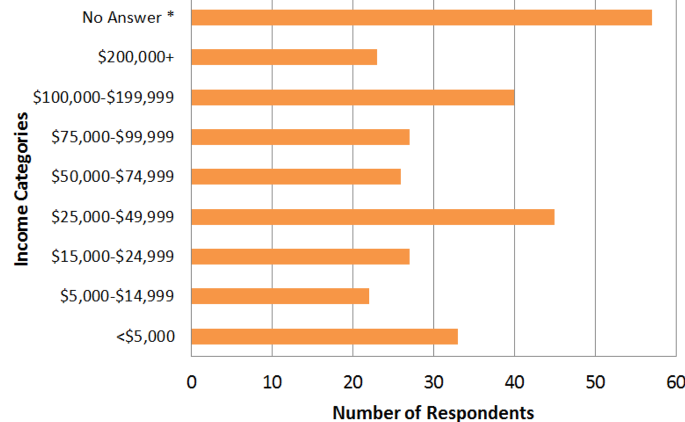
38 respondents in the Spanish Conversation completed a demographic form with slightly variant age groups that are assimilated as follows:
* Responses with "18-25" category were added to the aggregated "18-24" group.
* Responses with "26-35" and "36-45" categories were added to the aggregated "25-44" group.
* Responses with "46-55" and "56-65" categories were added to the aggregated "45-64" group.
* Responses with "66-75" were added to the aggregated "65-84" group.
* Responses with "75+" category were added to the aggregated "85+" group.

Note: 367 individuals participated across all 15 community conversations. 300 participants completed the demographic form, representing 82% of the Community Converstion participants.

Income Distribution of Respondents

The median reported household income range among respondents was $25,000-$49,000/

82 respondents reported household incomes below the median and 116 respondents reported income ranges above the median.



Note: 367 individuals participated across all 15 community conversations. 300 participants completed the demographic form, respresenting 82% of the Community Conversation participants.
* None of the 28 adolescent respondents in the Youth Conversation reported having an income, accounting for almost half of the respondents who did not report a household income.

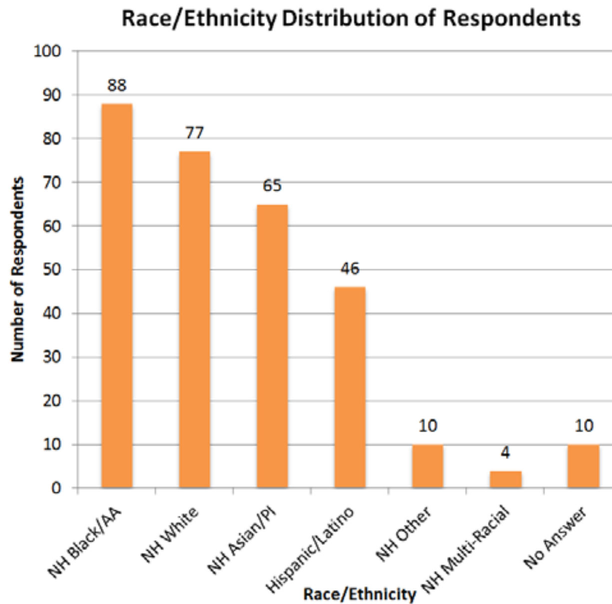
All respondents in the Korean, Vietnamese, and Mandarin Conversations described their race as Asian/Pacific-Islander.

37 respondents from the Spanish-language Conversation se4lf-identified their race as Hispanic/Latino.

42 respondents from the African American Health Program Conversation identified as African-American.

In total, 244 respondents identified as Non-Hispanic/Latino (NH) and 46 identified as Hispanic/Latino.

Note: 367 individuals participated across all 15 community conversations. 300 participants completed the demographic form, representing 82% of the Community Converstion participants.

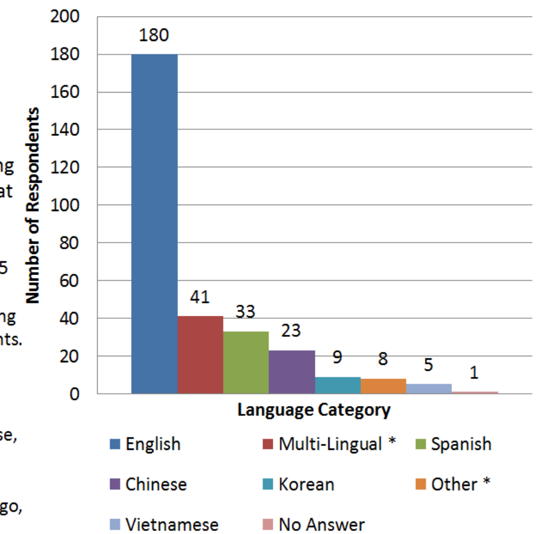


Conversations where most participants reported English was not the language spoken at home:
* Spanish
* Asian American Health Initiative
* Korean, Vietnamese, and Mandarin

100% of respondents in the Korean and Mandarin Conversations reported speaking a language other than English or Spanish at home.

Note: 367 individuals participated across all 15 community conversations. 300 participants completed the demographic form, representing 82% of the Community Converstion participants.

* Multi-lingual and 'Other' language respondents reported speaking the following languages: Amharic, Arabic, Bengali, Cantonese, Hebrew, Sinhala, Ewe, French, German, Georgian, Haitian Creole, Hindi, Kono, Krio, Lingala, Malay, Pushto, Swahili, Tagalog, Ilonggo, Urdu, and Yoruba.

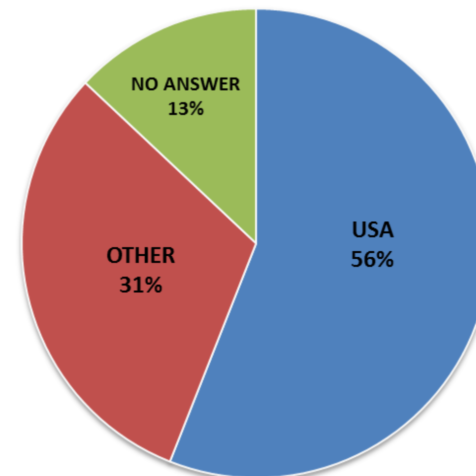


Country of Origin Distribution of Respondents

168 respondents reported USA as their country of orgin.

92 respondents reported another country as their country of orgin. Sixty-two percent of these respondents reported the following seven countries of orgin:

* China (n= 23)
* Korea or South Korea (n= 10)
* Vietnam (n= 7)
* India (n= 5)
* Ghana (n= 4)
* Kenya (n= 4)
* Sierra Leone (n= 4)



Note: 367 individuals participated across all 15 community conversations. 300 participants completed the demographic form, respresenting 82% of the Community Conversation participants.

Appendix E: Summary of Community Conversations

The results of the community conversations are notable in that they reveal that county residents broadly view the conditions in which they live as central to their health and well-being. This is evident in the major themes that emerged from the conversations: community resources and services, health care, transportation, housing, education, access to healthy food, physical activity and recreation, economics, public safety, equity, county governance, and community advocacy.

Conversation participants largely described a county rich in community resources and services but noted challenges that affect accessibility, primarily a lack of coordination of the services available and a need for more effective outreach to culturally and linguistically diverse communities. They called for better integration of health and social services and discussed the need to more effectively market existing resources and services. They noted an increasing need for services, particularly for certain vulnerable populations including immigrants, refugees, people with disabilities, low-income families, and people experiencing homelessness.

In their discussions related to health care, conversation participants recognized the increased accessibility to health care and health insurance provided by the Affordable Care Act. But they also described obstacles to health care and health insurance including:

- The lack of affordability and access to quality health insurance and dental care
- Language and cultural barriers
- Increased need for mental health services and awareness
- Increased preventive care and messaging

Housing was discussed largely as a challenge to health. The participants stated several concerns such as the lack of affordable housing, especially for seniors, people with disabilities, people experiencing homelessness and refugees, the lack of high-quality housing options for low-income residents and seniors and limited housing options for people with disabilities and people experiencing homelessness.

Conversation participants discussed transportation as affecting their health and their ability to access health care and community services. They listed public transportation, the excellent road system, and facilities and safety measures for pedestrians and bicyclists as county assets. They noted challenges which included:

- Traffic congestion
- Pedestrian and bicycle safety concerns
- Reliability, affordability and quality of public transportation

Participants' strategies for improvement include increasing the affordability and reliability of public transportation especially for seniors and people with disabilities, and improving the safety of the walking and bicycling environment.

Access to healthy food and opportunities for physical activity and recreation were discussed by participants as important to their health. They listed programs, services, and practices in the county that provide and promote healthy food, including food for those in need. Participants offered ways to make healthy food less expensive and more accessible, such as providing more community gardens, incentives for restaurants to serve healthy food from local farms, and consulting with students to make school lunches healthier. With respect to opportunities for physical activity and recreation, participants described parks, trails, and existing recreation programming as county assets. Noted challenges to

accessing healthy food such as the high cost of healthy food, inexpensive unhealthy food, and abundant fast-food restaurants.

Conversation participants discussed education as affecting health and well-being. They recognized the county's high-quality public school system (including after-school and family service programs provided in the schools) and the many options for higher education in the region. The participants called for increased school security, more school counselors, more understanding by parents and teachers, less standardized testing, and a greater voice through the participation of the Student Member of the Board of Education. Challenges discussed include:

- A need to address the unique needs of the diverse student population
- Effectively engage more parents in the schools
- Provide more post-secondary options for students with disabilities
- Stressful school experience caused by bullying, excessive standardized testing and tough grading

Participants also noted economic issues as affecting health and well-being. They discussed the strong, stable economy in Montgomery County as an asset and described challenges related to the county's high cost of living. Strategies suggested for improvement include:

- Higher paying jobs
- More job opportunities and business development
- More employment opportunities for people with disabilities and new immigrants
- Access to job readiness programs
- More child care options for working parents

Issues related to public safety were discussed with participants viewing the police and emergency response services as county assets. Challenges discussed include the need for crime prevention and increased police presence in unsafe neighborhoods and safety improvements such as better lighting and emergency call boxes in parks. Strategies for improvement included increased law enforcement and police presence as well as improved communication between the police and the community.

Conversation participants discussed the diversity of the county's population and discrimination in their discussions of health and well-being. They described the county as welcoming to diverse cultures and the diversity of the population as enriching and strengthening the county. They also noted, however, the strain the growing diverse population places on the county's limited resources and infrastructure. Participants described racism, a lack of solidarity, health disparities, and prejudices against people with disabilities as challenges to good health. Strategies for improvement include conducting a public dialogue on the impact of racial disparities, addressing health inequity, raising awareness about people with disability, and open-mindedness.

Appendix F: Maryland County Health Rankings and Health Model

Rank	County
1	Montgomery
2	Howard
3	Frederick
4	Queen Anne's
5	Carroll
6	Talbot
7	St. Mary's
8	Calvert
9	Anne Arundel
10	Harford
11	Worcester
12	Charles
13	Washington
14	Baltimore
15	Garrett
16	Kent
17	Prince George's
18	Wicomico
19	Cecil
20	Somerset
21	Dorchester
22	Allegany
23	Caroline
24	Baltimore City

The Rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play. Community Health Rankings, 2014

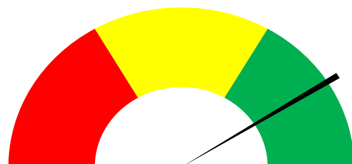
*updated 7/31/2016

Appendix G: Holy Cross Hospital 21 ZIP Code Primary Service Area

ZIP Code	City	HCH Discharges	HCH Cumulative % of Discharges
20904	Silver Spring	2,871	10.6%
20902	Silver Spring	2,349	19.3%
20906	Silver Spring	2,059	26.9%
20910	Silver Spring	1,549	32.6%
20901	Silver Spring	1,393	37.8%
20903	Silver Spring	762	40.6%
20783	Hyattsville	652	43.0%
20853	Rockville	600	45.2%
20705	Beltsville	549	47.2%
20895	Kensington	490	49.0%
20912	Takoma Park	483	50.8%
20707	Laurel	407	52.3%
20852	Rockville	370	53.7%
20905	Silver Spring	367	55.0%
20782	Hyattsville	350	56.3%
20866	Burtonsville	310	57.5%
20770	Greenbelt	306	58.6%
20740	College Park	264	59.6%
20851	Rockville	210	60.4%
20742	College Park	1	60.4%
20868	Spencerville	16	60.4%

Appendix H: Summary of Holy Cross Health's Significant Community Benefit Programming in Response to Identified Unmet Health Care Needs: Fiscal 2016

Maternal and Infant Health

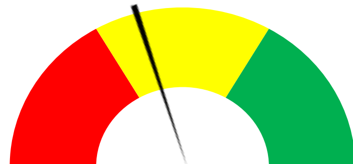


FY2016			
Goal	Annual Target	YTD Target	YTD Actual
Maternity Partnership Admissions	908	908	1,214
Maternity Partnership Low-birth Weight SHIP Target ≤ 8.5%	8.5%	8.5%	2.4%
Perinatal Class Encounters	10,780	10,780	9,640
Upcounty Perinatal Classes targeted to at-risk population	6	6	8

CHNA Impact Measures	Baseline	Target	MC Actual	
Increase percent of mothers receiving early prenatal care*	63.1%	66.9%	64.4%	↑
Reduce the percent of low birth weight births*	8.2%	8.0%	7.7%	↓
Decrease infant mortality rate*	5.5	6.3	4.7	↓

CHNA Impact Measures	Baseline	Target	PGC Actual	
Increase percent of mothers receiving early prenatal care*	54.0%	66.9%	51.2%	↓
Reduce the percent of low birth weight births*	10.0%	8.0%	9.2%	↓
Decrease infant mortality rate*	8.6	6.3	7.8	↓

Seniors

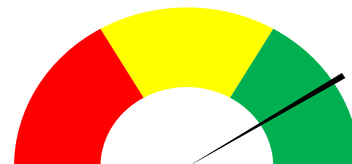


FY2016			
Goal	Annual Target	YTD Target	YTD Actual
Senior Source Encounters	16,236	16,236	13,765
Fall Assessments BioSway/Biodex, Get Up & Go, Chair Stand and Gait & Balance	268	67	107
Upright Balance Class % Improved in Gait & Balance	5.0%	5.0%	4.7%
Senior Fit (see Cardiovascular Health)			

CHNA Impact Measures	Baseline	Target	MC Actual	
Increase life expectancy*	84.1	79.8	84.6	↑
Decrease fall-related deaths*	7.1	7.7	7.5	↑

CHNA Impact Measures	Baseline	Target	PGC Actual	
Increase life expectancy*	79.2	79.8	80.0	↑
Decrease fall-related deaths*	6.4	7.7	6.5	↑

Cardiovascular Health



FY2016			
Goal	Annual Target	YTD Target	YTD Actual
Heart Failure Education Encounters	24	24	19
Cardiovascular Education Encounters	10,000	10,000	10,090
Number of CMO referrals to health centers	15	10	0
Average Senior Fit Weekly Unduplicated Participants	1,271	1,265	1,213
Senior Fit participants scoring at or above average in semi-annual fitness	85%	85%	87%

CHNA Impact Measures	Baseline	Target	MC Actual	
Decrease heart disease mortality*	136.4	152.7	110.7	↓
Decrease stroke mortality†	30.1	34.8	25.2	↓
Decrease percent of adults told by health professional they have high blood pressure†	21.6%	26.9%	27.7%	↑

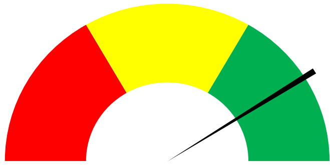
CHNA Impact Measures	Baseline	Target	PGC Actual	
Decrease heart disease mortality*	191.2	152.7	172.5	↓
Decrease stroke mortality†	35.2	34.8	35.1	↓
Decrease percent of adults told by health professional they have high blood pressure†	36.3%	26.9%	37.9%	↑

* MD SHIP Target
† HP 2020 Target

Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD

↑↓ Positive change from baseline
↑↓ Negative change from
NC - No Change

Obesity

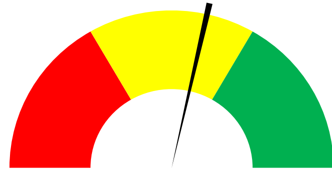


FY2016			
Goal	Annual Target	YTD Target	YTD Actual
Average Kids Fit Participants per Month	17	17	17
Percent Kids fit participants taking Presidential Challenge Award Fitness	150	150	155

CHNA Impact Measures	Baseline	Target	MC Actual	
Decrease percent of students with no participation in physical activityΔ	16.5%	18.0%	16.5%	NC
Decrease percent of students who are overweight or obese*	8.7%	10.7%	7.1%	↓
Increase percent of students who drank no soda or pop in the past weekΔ	33.0%	28.4%	33.0%	NC

CHNA Impact Measures	Baseline	Target	PGC Actual	
Decrease percent of students with no participation in physical activityΔ	23.2%	18.0%	23.2%	NC
Decrease percent of students who are overweight or obese*	13.7%	10.7%	15.4%	↓
Increase percent of students who drank no soda or pop in the past weekΔ	28.0%	28.4%	28.0%	NC

Diabetes

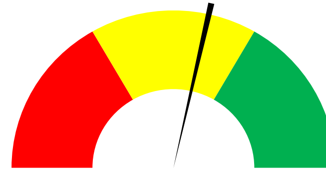


FY2016			
Goal	Annual Target	YTD Target	YTD Actual
Number enrolled in Diabetes Prevention Program (DPP)	57	57	93
Number of Diabetes Prevention Program (DPP) Encounters	612	612	1060
Percent DPP participants with ≥ 5% body weight loss	5%	5%	4.4%
Diabetic pre-visit planning	80%	80%	87%
HbA1c Screening	91%	91%	84%

CHNA Impact Measures	Baseline	Target	MC Actual	
Decrease number of adults ever being told they have diabetes (exluding gestational)◊	5.1%	9.8%	7.0%	↑
Decrease ER visits for diabetes*	102.8	186.3	163.5	↑

CHNA Impact Measures	Baseline	Target	PGC Actual	
Decrease number of adults ever being told they have diabetes (exluding gestational)◊	13.5%	9.8%	11.5%	↓
Decrease ER visits for diabetes*	280.5	186.3	300.3	↑

Behavioral Health

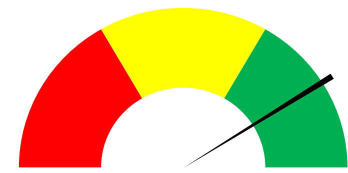


FY2016			
Goal	Annual Target	YTD Target	YTD Actual
Number CMO referrals to social services and health centers	300	300	183
Percent patients screened using SBIRT tool	75%	75%	86%

CHNA Impact Measures	Baseline	Target	MC Actual	
Decrease adolescent and adult illicit drug use in past month (12 or older)†	6.1%	7.1%	7.0%	↑
Decrease percent of adults with any mental illness in past yearΔ	16.8%	17.4%	17.9%	↑
Decrease behavioral health related ER visits*	1,528	3,153	2,569	↑
Decrease suicide rate*	6.5	9.0	7.0	↑

CHNA Impact Measures	Baseline	Target	PGC Actual	
Decrease adolescent and adult illicit drug use in past month (12 or older)†	7.1%	7.1%	7.5%	↑
Decrease percent of adults with any mental illness in past yearΔ	15.8%	17.4%	15.8%	NC
Decrease behavioral health related ER visits*	2,722	3,153	2,931	↑
Decrease suicide rate*	5.7	9.0	5.8	↑

Cancers



FY2016			
Goal	Annual Target	YTD Target	YTD Actual
Number of mammograms	352	352	568
Number of breast cancers found (no target)	0	0	0

CHNA Impact Measures	Baseline	Target	MC Actual	
Increase colorectal cancer screening (colonoscopy or sigmoidoscopy)◊	72.9%	72.4%	73.6%	↑
Increase percent of women who have had a Pap in past three years◊	83.0%	83.4%	78.6%	↓
Decrease prostate cancer incidence◊	159.3	123.8	137.0	↓
Decrease breast cancer mortality†	19.8	20.7	18.8	↓

CHNA Impact Measures	Baseline	Target	PGC Actual	
Increase colorectal cancer screening (colonoscopy or sigmoidoscopy)◊	71.7%	72.4%	74.7%	↑
Increase percent of women who have had a Pap in past three years◊	82.0%	83.4%	77.1%	↓
Decrease prostate cancer incidence◊	183.3	123.8	168.20	↓
Decrease breast cancer mortality†	28.2	20.7	27.6	↓

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties
↑↓ Positive change from baseline (green)
↑↓ Negative change from baseline (red)
NC - No Change

Appendix I: Healthy Montgomery Priority Setting Process

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

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

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

- How many people in Montgomery County are affected by this issue?
- How serious is this issue?
- What is the level of public concern/awareness about this issue?
- Does this issue contribute directly or indirectly to premature death?
- Are there inequities associated with this issue? (Health inequities are differences in health status, morbidity, and mortality rates across populations that are systemic, avoidable, unfair, and unjust.)

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

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

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

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

Appendix J: Healthy Montgomery Strategy Selection Process

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

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

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

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

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

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

For each strategy, the key points raised by the group were documented and discussed in detail amongst the HMSC members.

During the second stage of the process, the group voted on the top three priorities for Healthy Montgomery to address over the next three years. In making their final decisions, the HMSC was reminded of the collective impact criteria and the goals of Healthy Montgomery.

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

Ranking of Healthy Montgomery Priority Strategies

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

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

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

1. Establish and sustain a Health in All Policies (HiAP) model within Montgomery County that brings together professionals from a range of sectors (e.g., transportation, health, environment, labor, education, and housing) with community representatives to ensure that community health needs are identified and that needs and barriers are addressed and implements processes to ensure that County residents are actively engaged in decisions that affect [their] health.
2. Offer combined diet and physical activity promotion programs for County residents at increased risk of type 2 diabetes to reduce new-onset diabetes; programs commonly include a weight loss goal, individual or group sessions (or both) about diet and exercise, meetings with a trained diet or exercise counselor (or both), and individually tailored diet or exercise plans (or both) by leveraging/enhancing existing efforts within the County.
3. Develop integrated care programs to address mental health, substance abuse and other needs within primary care settings, pilot and evaluate models of integrated mental and physical health in primary care, with particular attention to underserved populations and areas, and to expand access to mental health services (e.g., patient navigation, support groups) and enhance linkages between mental health, substance abuse, disability, and other social services by leveraging/enhancing existing efforts within the County.

During the course of the upcoming months, Healthy Montgomery staff will prepare for the action planning efforts in relation to the priorities identified by the HMSC during the 2016 HMSC Retreat, enabling the achievement of key milestones throughout the 2017-2019 cycle.

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

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

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