2022

MONTGOMERY COUNTY HOSPITAL COLLABORATIVE **COMMUNITY HEALTH NEEDS ASSESSMENT** IMPLEMENTATION STRATEGY

Adventist HealthCare

HOLY CROSS HEALTH
A Member of Trinity Health

MedStar Health

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

The 2022 Community Health Needs Assessment Implementation Strategy was developed through a collaboration among Adventist HealthCare (Adventist HealthCare Rehabilitation, Adventist HealthCare Shady Grove Medical Center, and Adventist HealthCare White Oak Medical Center), Holy Cross Health (Holy Cross Hospital and Holy Cross Germantown Hospital), MedStar Health (MedStar Montgomery Medical Center) and Suburban Hospital.

Holy Cross Health completed a comprehensive joint Community Health Needs Assessment (CHNA) in collaboration with all health systems within Montgomery County. The CHNA was adopted by the Board of Directors on October 27, 2022.

Consistent with Holy Cross Health's mission, for more than 20 years, we have developed CHNAs and implementation plans to respond to identified needs. In 2010, Holy Cross Hospital enhanced the CHNA process in adherence with applicable federal requirements for not-for-profit hospitals set forth in the Affordable Care Act (ACA) and by the Internal Revenue Service (IRS). The assessment took into account a comprehensive review of secondary data analysis of patient outcomes, community health status, and social determinants of health, as well as primary data collection including input from representatives of the community, community members, and various community organizations.

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

Letter from Hospital Leadership

June 20, 2022

Dear Residents and Partners,

In Montgomery County, six hospitals are working collectively and collaboratively to reimagine health care that extends far beyond our hospital walls. In fact, caring for our community and investing in holistic approaches to improve health are a deliberate commitment.

We are setting the standard for this community commitment by creating our first joint Community Health Needs Assessment (CHNA) and Implementation Strategy. This collaborative CHNA addresses 34 zip codes served by Adventist HealthCare, Holy Cross Health, MedStar Health and Suburban Hospital, Johns Hopkins Medicine. The identified and prioritized health needs will guide the resources, program development, and collaborations required to address gaps in care, advance health equity and improve quality of life.

While Montgomery County ranks as one of the healthiest counties in Maryland, barriers to improving the well-being for many members of our community persist. Steps to address the complex social factors that influence health must incorporate both population and public health strategies. Integrating the expertise, guidance, resources and influence of partnerships beyond the healthcare environment are integral to achieving equity for all.

The data outlined in the 2022 Community Health Needs Assessment is extensive and far-reaching. We invite you to read with curiosity and excitement. The assessment process would not be possible without the critical and timely feedback of our community residents, stakeholders and thought leaders, who tirelessly shared their time to inform our prioritization, strategy model, and most importantly, how we will evaluate and track our progress. There is much more work ahead and we cannot do it without broad participation from our community!

We are stronger together.

Sincerely,

Norvell "Van" Coots, M.D.
President & CEO
Holy Cross Health

Terry Forde
President & CEO
Adventist HealthCare

Jessica Melton
President and COO
Suburban Hospital (Johns Hopkins Medicine)

Thomas J. Senker, FACHE
President, MedStar Montgomery Medical Center
Senior Vice President, MedStar Health

OUR COMMUNITY

In 2010, Congress enacted the Patient Protection and Affordable Care Act (The ACA) to enhance the quality of health care for all Americans through a deliberate method of comprehensive health insurance reform. Specifically, the ACA requires non-profit hospitals to conduct a Community Health Needs Assessment (CHNA) and adopt an implementation strategy every three years. The CHNA and implementation strategy aim to identify the most important health issues in a defined community benefit service area (CBSA), as well as develop a plan to implement programs and services to meet identified unmet community needs.

Healthy Montgomery is Montgomery County's community health improvement process (CHIP) and dually serves as the local health improvement coalition (LHIC). Established in

June 2009, Healthy Montgomery brings together County government agencies, County hospital systems, minority health programs/initiatives, advocacy groups, academic institutions, community-based service providers and other stakeholders to achieve optimal health and well-being for all Montgomery County residents. Most important, Healthy Montgomery is the central catalyst to meet Affordable Care Act (ACA) requirements and local health department PHAB1 accreditation. Healthy Montgomery centralizes data to identify priority issues among community partners, develop and implement strategies for action, as well as establish accountability to ensure measurable health improvement outcomes (NACCHO, 2022).

Through the development of Healthy Montgomery, the Montgomery County hospitals recognized the opportunity to meet as a subgroup and work together to leverage community benefit resources, identify overlapping implementation strategies, and decrease duplication of efforts. In 2015, the hospitals began working together to steward resources and address gaps in access to care by program mapping.

Our Hospitals

In 2021, the Montgomery County hospitals (referred to in this report as the Montgomery County Hospital Collaborative [MCHC]) further advanced their dedication to collective impact by developing a joint Community Health Needs Assessment (CHNA) and Implementation Strategy. The 2022 collaborative CHNA will serve to guide resources and program development to meet the needs of shared community and address gaps in care, health equity, and improve the quality of life for all residents.

Adventist HealthCare

Founded in 1907, Adventist HealthCare is a faith-based, not-for-profit organization of dedicated professionals who work together to improve the health of people and communities through the ministry of physical, mental and spiritual healing. This total well-being approach has been so successful in helping our community achieve the best health outcomes that Adventist HealthCare has grown to become a comprehensive health system and are seen as leaders, particularly in the areas of heart, orthopedics, maternity and mental health.

Adventist HealthCare is headquartered in Montgomery County, Maryland, and supports the Washington, D.C., metro area through:

- Three acute care hospitals
- Two rehabilitation hospitals

- Two community cancer centers
- Mental health services
- Home care services
- Imaging centers
- Urgent care centers
- Community outreach

Adventist HealthCare also promotes collaboration through the One Health Quality Alliance, our clinically integrated network of over 1,700 health care providers who work together to improve both the quality of care and patient outcomes throughout the region.

For a detailed list of our specialties and services, please visit AdventistHealthCare.com

Holy Cross Health

Holy Cross Health is a Catholic, not-for-profit health system that serves more than 160,000 individuals each year from Maryland's two largest counties — Montgomery and Prince George's counties. Our community is vibrant, active and diverse, where life is always moving. Holy Cross Health is continuously advancing, too, as a forward-thinking health system committed to helping our community members address their individual needs and goals to achieve a better quality of life. From hospitals and primary care sites to specialty care and wellness programs, Holy Cross Health is accessible throughout the region to meet individuals on their path to good health.

Holy Cross Health has been a steward of our diverse community's health for more than 55 years, earning the trust of area residents. Our team of more than 3,000 employees, 2,069 community-based physicians, and 167 volunteers works proactively each day to meet the needs of every individual we touch. And our mission and values mean that we uphold this commitment for every person, without regard for the ability to pay. During the last five fiscal years, Holy Cross Health has provided more than $287 million in community benefit, including more than $174 million in financial assistance.

Each day, Holy Cross Health colleagues work hard to move people's lives forward, by providing a continuum of quality care that touches individuals in many ways — from prevention to primary care, to chronic disease management, to inpatient care, to care at home and support groups, making the right level of care more accessible and more coordinated. The Holy Cross Health system includes:

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

  Specialties and Services:

  - Cardiac services
  - Cancer institute
  - Dialysis services
  - Emergency center
  - Home-based services
  - Hospitalists and intensivists
  - Medical imaging services
  - Neurosciences
  - Pain management center
  - Palliative care
  - Pediatric services
  - Physical medicine and rehabilitation program
  - Senior services
  - Sleep center

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

  Specialties and Services:

  - Surgical services
  - Maternity services
  - Behavioral health services
  - Emergency department
  - Intensive care medical/surgical units
  - Imaging and diagnostics

- **Holy Cross Health Network**, which operates Holy Cross Health Centers in Aspen Hill, Gaithersburg, Germantown and Silver Spring; provides primary care at Holy Cross Health Partners at Asbury Methodist Village and in Kensington; offers a wide range of innovative health and wellness programs; and leads partner relationships.
- **Holy Cross Health Foundation** is a not-for-profit organization devoted to raising philanthropic funds to support the mission of Holy Cross Health and to improve the health of the community.

MedStar Health, MedStar Montgomery Medical Center

MedStar Health operates 10 hospitals across Baltimore, central Maryland, Washington, D.C., and southern Maryland. Our facilities offer a full range of health care services and are recognized both regionally and nationally for excellence in medical care.

MedStar Montgomery Medical Center is a not-for-profit, acute care community hospital serving Montgomery County, Maryland. For 100 years, MedStar Montgomery Medical Center has served as a medical care provider and community health resource offering high-quality, personalized care. MedStar Montgomery Medical Center provides a broad range of health care specialties, advanced technologies, and treatments not traditionally found at community hospitals— including cutting-edge care in obstetrics, orthopedics, breast health, and oncology. MedStar Health is the region's largest non-profit and most trusted integrated health care delivery system, giving patients access to the latest in modern medicine and medical technology within a community hospital setting.

Clinical specialties:

- Bariatric Surgery
- Breast Health
- Gastroenterology
- Non-Surgical Weight Loss
- Orthopedics
- Pulmonology
- Behavioral Health & Psychiatry
- Cardiology p Geriatrics p Oncology
- Physical Therapy & Rehabilitation
- Women's Health

For a detailed list of our programs, services, and providers, visit MedStarHealth.org

Suburban Hospital, Johns Hopkins Medicine

Suburban Hospital is a community-based, not-for-profit hospital serving Montgomery County and the surrounding area since 1943. The hospital provides all major services except obstetrics. The hospital is one of nine regional trauma centers in Maryland and is the state-designated Level II Trauma Center for Montgomery County, with a fully equipped and elevated helipad.

Primary services include:

- Radiation and surgical oncology a part of the Johns Hopkins Kimmel Cancer Center in the National Capital Region and recognized by the American College of Surgeons Commission on Cancer.
- Cardiac surgery including elective and emergency angioplasty and inpatient, diagnostic, and rehabilitation services through the Johns Hopkins Medicine Structural Heart Disease Program at Suburban Hospital.
- Treatment for multiple brain and nervous system conditions—including brain tumors, movement disorders and general neurosurgical care—provided by Johns Hopkins neurosurgical team.
- Home to inpatient and outpatient behavioral health programs, and an Addiction Treatment Center, offering day treatment programs to adolescents and adults.
- A 24-hour stroke team, as well as state-of-the-art diagnostic pathology and radiology departments.
- A full-service Emergency Department treating more than 40,000 patients annually and includes the Shaw Family Pediatric Emergency Center exclusively for children and adolescents.
- Inpatient Diabetes Management Service (IDMS), which is a special diabetes clinical consultation service designed to promote better glycemic (blood sugar levels) control and reduce hypoglycemia (low blood sugar) and glucose-related safety challenges in hospitalized patients. Suburban Hospital also offers the Diabetes Self-Management Training (DSMT) which a certified diabetes educator meets one on one with individuals living with diabetes to improve their health outcomes.
- An extensive community health and wellness program that invested more than $33.6 million in community benefit contributions in FY 2021, including 5,612 community health improvement programs, biometric screenings, wellness classes and community building activities that served 52,049 individuals in Montgomery County.
- Suburban Hospital achieved Magnet designation in recognition of its nursing excellence from the American Nurses Credentialing Center, becoming the first and only hospital in Montgomery County with this distinct recognition.

For a detailed list of our specialties and services, please visit https://www.hopkinsmedicine.org/suburban_hospital/

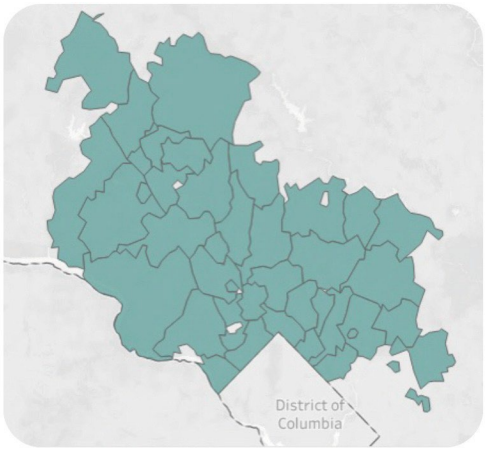
COMMUNITIES SERVED

The MCHC serves portions of Montgomery, Prince George's, Frederick, Carol, and Howard Counties, and the District of Columbia, spanning 86 zip codes and almost 2.3 million people. However, the goal of this CHNA is to identify and prioritize key areas and communities of focus for meaningful engagement. In order to do this, the MCHC identified zip codes in each hospital's primary service area as our collective Community Benefit Service Area (CBSA) and highlighted communities of focus within the CBSA to provide a valuable snapshot of the hospital's existing communities served and new areas of interest.

DESCRIPTION OF SERVICE AREA

The MCHC CBSA comprises 38 zip codes (see Figure 1) that span approximately 388 square miles of Montgomery County and northern Prince George's County, with a total population of 1,250,503 (Center for Applied Research and Engagement Systems, 2022). The population density for this area, estimated at 3,218 persons per square mile, is greater than Montgomery County (2,116 persons per square mile), Prince George's County (1,883 persons per square mile), and the state (620 persons per square mile).

Figure 1: The MCHC Community Benefit Service Area



The MCHC CBSA serves portions of Montgomery and Prince George's Counties, two majority- minority counties rich in cultural diversity. The largest populations by race/ethnicity within the service area are Non-Hispanic Whites (37.3%), Non-Hispanic Blacks (22.6%), Hispanic or Latino (22.5%) and Non-Hispanic Asian (13.5%) (see Table 1).

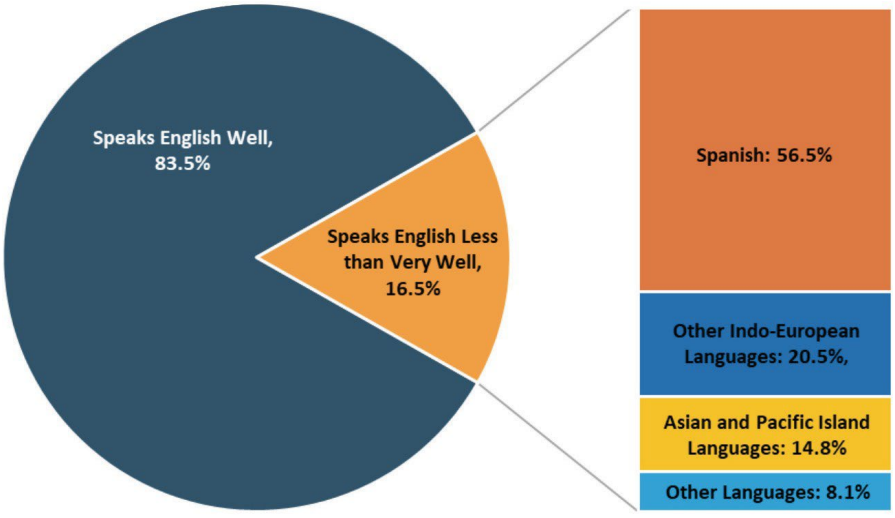
Table 1: Population by Combined Race Ethnicity

Report Area	NH White	NH Black	NH Asian	NH AIAN*	NH NHOPI*	NH Some Other Race	NH Multiple Races	Hispanic or Latino
MCHC CBSA	37.3%	22.6%	13.5%	0.1%	0.03%	0.7%	3.4%	22.5%
Frederick County, MD	72.4%	9.5%	4.4%	0.2%	0.1%	0.2%	3.3%	10.0%
Montgomery County, MD	43.1%	18.0%	14.9%	0.1%	0.04%	0.7%	3.7%	19.5%
Prince George's County, MD	12.3%	61.2%	4.2%	0.2%	0.03%	0.5%	2.7%	18.8%
Maryland	50.2%	29.4%	6.3%	0.2%	0.03%	0.4%	3.3%	10.3%
United States	60.1%	12.3%	5.6%	0.6%	0.2%	0.3%	2.8%	18.2%

Source: Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract S

More than 33% of the MCHC CBSA population are of foreign birth compared to 32% in Montgomery County, 23% in Prince George's County, and 15.2% in Maryland. The languages spoken in this region also reflect its diversity. However, approximately 16.5% of the CBSA population, aged 5 and older, speak English less than very well compared to 7% of the Maryland population (see Figure 2).

Figure 2: English Proficiency within the MCHC CBSA



Data Source: US Census Bureau, American Community Survey. 2016-20.

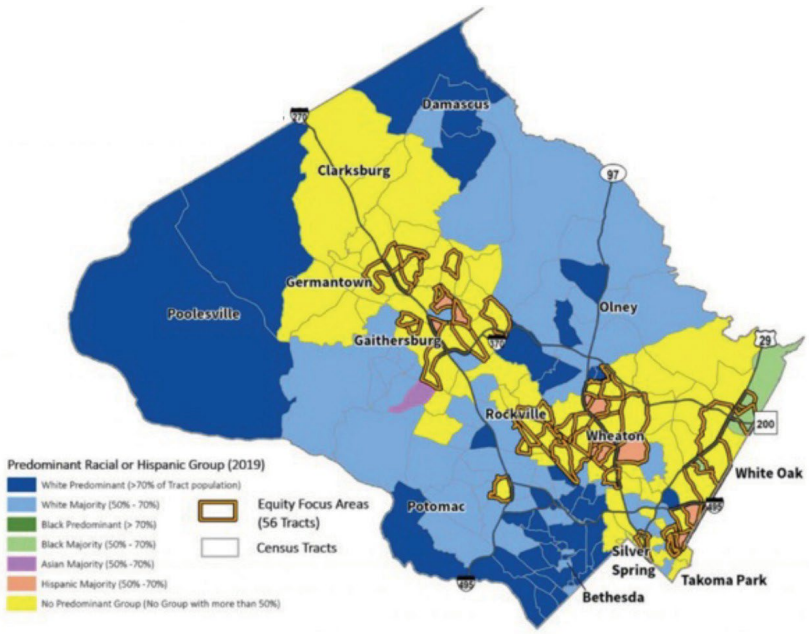
Limited English proficiency (LEP), or the inability to speak English well, creates barriers to health care access, provider communications, and health literacy/education. The highest percentage of limited English proficiency by language spoken in the home is Spanish (United States Census Bureau, 2022).

The CBSA is not only rich in diversity but also in resources. The area has over 170 private and county-run fitness and recreation facilities, roughly 75% of residents live within ½ a mile of a park, more than 240 grocery stores serve the area, and there are more than 100 social and professional organizations per person. The average household income of $138,054 for persons in the MCHC CBSA is higher than the state average of $111,417 and the Price George's County average of
$102,593, but lower than that for Montgomery County overall ($149,437). However, despite the plethora of resources and above-average incomes, disparities exist, particularly for populations experiencing vulnerabilities.

VULNERABLE POPULATIONS

Populations experiencing vulnerability (also referred to as vulnerable populations) are groups and communities at a higher risk for poor health outcomes as a result of the barriers they experience due to structural and societal factors they face, such as systemic racism, discrimination, stigma, and poverty (Baciu, Negussie, Geller, & et al., 2017). In 2021, the Equity Data Team of Montgomery County's Planning Department developed a mapping tool to identify vulnerable populations within Montgomery County. The team identified 56 Equity Focus Areas (EFAs) by looking at demographic data at the census tract level. They focused on identifying areas that had high concentrations of lower-income households, people of color, and individuals who may speak English less than very well (Zorich, Mukherjee, & Blyton, 2021) (see Figure 3). Approximately one-quarter of Montgomery County's population resides in the EFAs.

Figure 3: Equity Focus Areas and Predominant Race or Hispanic



Source: Research and Strategic Projects, Montgomery Planning Department, 2021.

In addition to populations residing in the EFAs, other populations experiencing vulnerabilities include low-income, racial and ethnic minorities, uninsured, seniors, pregnant women and infants, the homeless and those with disabilities.

LOW-INCOME POPULATIONS

Low-income status and poverty are linked to poor health outcomes due to their correlation with adverse conditions such as substandard housing, homelessness, food insecurity, inadequate childcare, lack of access to health care, unsafe neighborhoods, and under-resourced schools which adversely impact our nation's children (U.S. Department of Health and Human Services, 2022). Approximately 20.4%, or 250,418 individuals, within the MCHC CBSA, live in households with incomes below 200% of the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access, including health services, healthy food, and other necessities that contribute to poor health status (Center for Applied Research and Engagement Systems, 2022).

RACIAL ETHNIC MINORITIES

Minorities, also referred to as Black, Indigenous and People of Color, often experience higher rates of illness and death across a wide range of health conditions, including diabetes, hypertension, obesity, asthma, and heart disease, when compared to their White counterparts (Centers for Disease Control and Prevention, 2021). Although minorities experience higher rates of illness and death, it is important to note the mantra coined by Dr. Joia Crear-Perry, that "racism, not race, causes health disparities" (Chadha et al., 2020). In the CBSA, more than 40% of the population is Non-Hispanic, Non-White and 22.5% are Hispanic.

UNINSURED POPULATIONS

The lack of health insurance is considered a key driver of health status. People without insurance coverage have barriers to accessing care and often postpone or forgo health care, causing many chronic conditions to go undiagnosed or poorly treated compared to those with insurance. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected (Kaiser Family Foundation, 2022). In the CBSA, 9.1% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is greater than the state average of 6.1%.

SENIOR POPULATIONS

The 2017-2020 State Plan on Aging for Maryland estimates that between 2015 and 2030, the population of adults aged 60 and greater will increase by 40%, from 1.2 to 1.7 million (Maryland Department of Aging, 2021). This growth reflects advances in health care and medicine, allowing individuals to live longer than ever before. A similar estimate was

made by the Montgomery County Commission on Aging (2018), predicting that nearly 25% of all residents will be 60 years or greater by 2030. While this represents one of the crowning achievements of the last century, it also poses significant social and economic challenges due to the unique needs of the senior population.

According to Seniors First BC (2016), the risk for chronic illness and the need for long-term care increases directly with age, increasing seniors' vulnerability. Three main risk factors that contribute to vulnerability in older adults are:

- health status
- cognitive ability, and
- social network

Of the estimated 1,250,503 total population in the CBSA, an estimated 177,072, or 14.2%, are adults aged 65 and older. This percentage is comparable to Montgomery County and slightly higher than Prince George's County (Montgomery Planning M-NCPPC, 2018).

MATERNAL/INFANT POPULATIONS

The well-being of mothers, infants, and children can help predict future public health challenges for families, communities, and the health care system (Office of Disease Prevention and Health Promotion, 2021). Access to quality preconception (before pregnancy), prenatal (during pregnancy), and interconception (between pregnancies) care can reduce the risk of maternal/infant mortality and improve birth outcomes. Healthy birth outcomes or early detection and treatment of developmental delays and disabilities can prevent poor health outcomes, such as death and disabilities, and allow children to reach their full potential (Office of Disease Prevention and Health Promotion, 2021)

HOMELESS POPULATIONS

The definition of homelessness is broad and includes people living on the streets or other places not intended for human habitation; living in shelters; lacking a fixed, regular, and adequate nighttime residence; temporarily staying with friends and relatives; and even those at risk for homelessness (Health Quality Ontario, 2016). In Montgomery County, the point-in-time count for homelessness has steadily declined over the past five years, with a 35% decrease between 2017 and 2021. The issue of homelessness affects individuals of all ages. For instance, out of the 187,380 students enrolled in school during the 2019-2020 school year, 1,499, or .8%, were homeless compared to the statewide rate of 1.7%.

LGBTQ COMMUNITY

Disparities in health outcomes are experienced across several population groups, including racial and ethnic minorities, geographical location, and health insurance status. However, there is an increasing need for more information on other groups that are medically underserved and suffer poor health outcomes. One such group is the lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) community, also referred to as sexual minorities. Sexual minorities represent between 3 to 12% of the adult U.S. population (Mattingly, Smith, Williams, & Tai, 2020). They span all races, ethnicities, ages, socioeconomic statuses, and regions of the United States.

There is insufficient data on sexual minorities in national databases and registries. However, sexual minorities appear to have a higher prevalence of smoking, alcohol use, and obesity.

In addition, surveys show that many sexual minorities underutilize and delay seeking health care. This underutilization is often related to concerns about discrimination and stigma. The common perception of a barrier to health care access demonstrates the need for culturally competent health care providers and welcoming health care systems. Indeed, health care providers need to focus on providing a safe environment for LGBTQ+-friendly services.

POPULATIONS WITH DISABILITIES

According to Healthy People 2030, until recently, people with disabilities had been overlooked in public health surveys, data analyses, and health reports, making it challenging to raise awareness about their health status and existing disparities. Emerging data indicate that individuals with disabilities, as a group, experience health disparities in routine public health areas such as health behaviors, clinical preventive services, and chronic conditions (Office of Disease Prevention and Health Promotion, 2021).

Compared with individuals without disabilities, individuals with disabilities are:

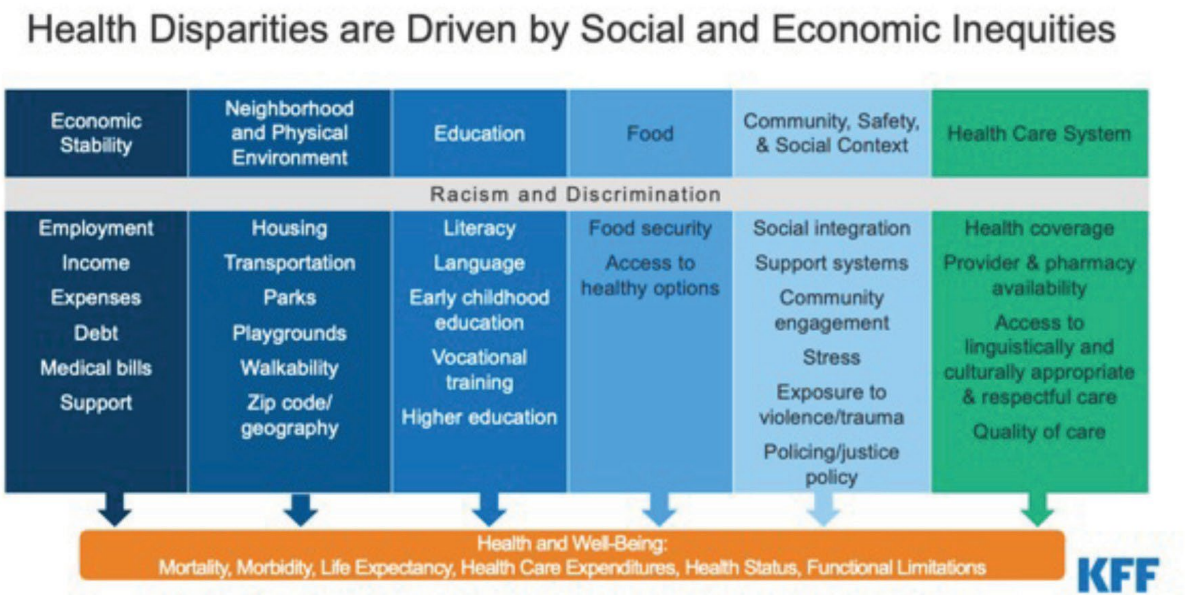
- Less likely to receive recommended preventive health care services, such as routine teeth cleanings and cancer screenings
- At high risk for poor health outcomes such as obesity, hypertension, falls-related injuries, and mood disorders such as depression
- More likely to engage in unhealthy behaviors that put their health at risk, such as cigarette smoking and inadequate physical activity (Office of Disease Prevention and Health Promotion, 2021)

Within the CBSA, 8% (99,809) of the total civilian non-institutionalized population has one or more disabilities.

RACISM AS A PUBLIC HEALTH CRISIS

Racism is a key driver of disparities in mental and physical health outcomes. Systematic bias and structural racism cut across all social determinants of health (see Figure 4) and lead to inequities that have severe consequences (Stanley, Harris, Cormack, Waa, & Edwards, 2019). Racism and its effect on health is not a new concept. However, in the wake of protests and unrest following the killing of George Floyd and many other Black people at the hands of police and the stark contrast of COVID-19 morbidity and mortality data based on race and ethnicity, a spotlight was shone on the negative impact of systemic and institutional racism on people of color, especially Black Americans (Kaur & Mitchell, 2020). In response, racism was declared a public health crisis by many states and local governments, and bills, such as Maryland's Shirley Nathan–Pulliam Health Equity Act of 2021 (SB0052), were passed to identify and address health inequities rooted in racism.

Figure 4: Health Disparities are Driven by Social and Economic Inequities



Source: Ndugga & Artiga, 2021.

The Montgomery County Hospital Collaborative promotes optimal health for those who are experiencing poverty or other vulnerabilities in the communities we serve by connecting social and clinical care, addressing social needs, dismantling systemic racism, and reducing health inequities. The MCHC has adopted the Robert Wood Johnson Foundation's definition

of Health Equity - "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

This implementation strategy was developed in partnership with the community and will focus on specific populations and geographies within our service areas most impacted by the needs being addressed. Racial equity principles were used throughout the development of this plan and will continue to be used during the implementation. In addition to health promotion and disease prevention, the strategies implemented will also focus on policy, systems, and environmental change, as these systems changes are needed to dismantle racism and promote health and wellbeing for all members of the communities we serve.

Health Needs of the Community

The MCHC CHNA used a systematic data collection and analysis process to identify key health needs and issues that persist in our community. In addition to using the highest quality data available from private and public sources, the MCHC CHNA was pro-active in engaging a broad and diverse level of stakeholders at key stages of the assessment via surveys and community conversations.

ACCESS TO CARE

ACCESS TO MENTAL HEALTH PROVIDERS	• Populations with higher percentages of Black or Hispanic individuals and low-income communities have been shown to have limited access to mental health care • 32% of Montgomery County students and 34% of students in Prince George's County reported feeling sad or hopeless every day for two weeks or more during the past 12 months • In Maryland, 59.1% of adults with acute mental illness and 43.1% of youth experiencing a major depressive order did not receive treatment
ACCESS TO PRIMARY CARE PROVIDERS	• As of 2021, an additional 14,860 primary medical care providers are necessary to meet current U.S. health care needs • Only 77.2% of Montgomery County residents and 79.3% of Prince George's County residents had a routine check-up within the last year. • In Maryland, 8.7% of adults report a time in the past 12 months when they needed a doctor but could not go because of cost.
LACK OF INSURANCE	• In the MCHC CBSA, 9.1% of the total civilian non-institutionalized population are without health insurance coverage • In Montgomery (23.4%) and Prince George's County (28.5%) of Hispanics/Latinos do not have health insurance, significantly higher than their

	White and Black counterparts. • In 2019, nearly 7% of children older than six years old residing in Prince George's County were not covered by insurance- the rate was half that for the same age range in Montgomery County

HEALTHY BEHAVIORS

FOOD INSECURITY	• Households with children are nearly 1.5 times more likely to experience food insecurity than households without children. • According to USDA data, 19.1% of Black households and 15.6% of Hispanic households experienced food insecurity in 2019, compared to 7.9% of their White counterparts. • The newly food insecure population is also far less likely to be receiving benefits from the public sector.
ADULT OBESITY	• Within the MCHC CBSA, 31.1% of adults aged 18 and older are considered obese. • Current estimates for obesity-related health care costs in the U.S. range from $147 billion to nearly $210 billion annually. • 22.4% of Montgomery County high school students and 35.5% of Prince George's County high school students are obese or overweight; children who are obese or overweight are more likely to have obesity as adults.
PHYSICAL INACTIVITY	• Physical activity reduces the risk of multiple chronic diseases and helps maintain a healthy weight and reduce body fat. • 1 in 5 adolescents in the United States engage in the recommended amount of physical activity • It is estimated that 46.4% of older Americans engaged in no leisure-time aerobic activity

EDUCATION, INCOME, JOB & ENVIRONMENT

WORKFORCE/LABOR SHORTAGES	• During the "Great Resignation" 47 million US workers quit their jobs. • 7.6% of Maryland's jobs, or about 220,000 positions, are currently unfilled. • Maryland is currently short 5,000 full-time registered nurses and 4,000 licensed practical nurses.
INCOME INEQUALITY	• Hispanics/Latinos exhibited higher rates of lost full-time employment and reduced hours at work due to the pandemic. • In Montgomery County median household income for Blacks and Hispanics was less than 60% percent of the median household income for Whites. • In the MCHC CBSA, 6.7% of households receive SNAP benefits, with Black/African Americans (35.2%) and Hispanic/Latino (23.4%) households making up the highest populations to receive SNAP benefits.
HOUSING COST BURDEN	• Maryland is calculated to have the 8th highest rent in the country. • 32.1% of Montgomery County residents and 36.7% of Prince George's County residents live in homes that exceed 30% of income. • In the MCHC CBSA, 34.7% of housing units meet the criteria for substandard housing.

RESPONSE TO FINDINGS

A fundamental component of a community health needs assessment, as described by the Catholic Health Association, is the prioritization of the identified needs. To effectively achieve this goal, the MCHC engaged local public health leaders, service providers, and community advocates to participate in the priority-setting process (see Appendix I for a list of community stakeholders invited to partake in this process). Three criteria were used to prioritize the needs identified from the primary and secondary data analysis: severity (high level of seriousness or urgency in the community), feasibility (could realistically improve in the next three years), and outcome (potential impact on the greatest number of people identified). Using the criteria, their professional expertise and experience, our stakeholders informed nine health factors, as top unmet needs:

- **Access to Care**
  - Access to mental health providers
  - Access to primary care providers
  - Lack of insurance
- **Healthy Behaviors**
  - Food insecurity
  - Adult obesity
  - Physical inactivity
- **Education, Income, Job & Environment**
  - Workforce/labor shortages
  - Income inequality
  - Housing cost burden

These nine health factors are recognized as root causes that impact a person's health, well-being, and quality of life. By addressing these root causes, meaningful changes can be made to decrease risk for the top health outcomes in our community: heart disease, diabetes, mental health, cancer, maternal and child health, infections, and unintentional injuries. Through a multi-sectoral collaboration, the MCHC will seek to address these top health factors in a collaborative implementation strategy, while paying particular attention to the most vulnerable populations in our communities

NEEDS INTO ACTION

The MCHC addresses unmet needs within the context of our overall approach, mission commitments of each health system and key clinical strengths of each hospital, and within the overall goals of Healthy Montgomery.

Key findings from all data sources, including data provided by Healthy Montgomery, our external review group and hospital available data, were reviewed and the most pressing needs were incorporated into our implementation strategy. The CHNA Implementation Strategy reflects the MCHC's overall approach to improving community health by targeting the

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

intersection between the identified needs of the community and the key strengths and mission commitments of each organization (see Figure 5) to help build the continuum of care. Each health system has established leadership accountability and an organizational structure for ongoing planning, budgeting, implementation, and evaluation of community health activities, which are integrated into multi-year strategic and annual operating planning processes.

National Objectives

Healthy People 2030 (HP2030) is a national initiative that provides science-based, 10-year national objectives for improving the health of all Americans, establishes benchmarks, and monitors progress over time and uses the following principles to guide decisions:

- The health and well-being of all people and communities is essential to a thriving, equitable society.
- Promoting health and well-being and preventing disease are linked efforts that encompass physical, mental, and social health dimensions.
- Investing to achieve the full potential for health and well-being for all provides valuable benefits to society.
- Achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy.
- Healthy physical, social, and economic environments strengthen the potential to achieve health and well-being.
- Promoting and achieving health and well-being nationwide is a shared responsibility that is distributed across the national, state, tribal, and community levels, including the public, private, and not-for-profit sectors.
- Working to attain the full potential for health and well-being of the population is a component of decision-making and policy formulation across all sectors.

The MCHC values the vision of HP2030 to create "a society in which all people can achieve their full potential for health and well-being across the lifespan" and has incorporated many of the HP2030 goals and objectives into our multi-year initiatives

that address each identified priority.

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

Transforming Community Health

The MCHC's community health programs and services are well positioned to lead in the identification of and response to existing and emerging community needs in our service area. To address the unmet needs, the MCHC will focus on addressing downstream issues through prevention, education, and disease management programs and upstream issues through policy, system and environmental change strategies in an effort to optimize wellness and equity and eliminate disparities in our communities.

This is accomplished by addressing an individual's social needs as well as improving community conditions and encompasses three key focus areas:

Clinical Care: Delivery of efficient and effective people-centered health care services focused on reducing clinical quality outcome disparities and addressing the social needs of patients;

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

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

Action Plans 2020-2022

The following pages outline the major activities the MCHC will be implementing to address the unmet needs identified in the 2022 Community Health Needs Assessment. The first table summarizes the activities by priority and key focus area and the following pages go into more detail about the specific interventions or initiatives that we will undertake to address the unmet needs identified. The objectives listed for each priority were derived from Healthy People 2030. This document should be considered a living document and will be updated and the strategies evaluated, at a minimum, each year or as emerging needs arise.

MCHC Implementation Plan FY2023-FY2025

Priority 1: Access To Care

Overarching Goal 1: Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.

Priority 1a: Access to Mental Health Providers (CHNA pg. 55-58)

Goal 1: Improve Mental Health

CHNA Impact	2022 CHNA Baseline	Target	Actual
Decrease mental health related ER visits (Source: MD SHIP)	MC: 2,312.1 PGC: 1,955.6	3,152.60	MC: 2,312.1 PGC: 1,955.6
Decrease percentage of adults with poor mental health (Source: Trinity Data Hub)	CBSA: 11.6%	9.7%	MC: 12.7% PGC: 13.3%
Decrease percentage of students feeling sad or hopeless (Source: YRBS HS Summary)	MC: 31.5% PGC: 34.2%	32.0%	MC: 32.2% PGC: 38.3%
Decrease age-adjusted suicide mortality rates (Source: Trinity Data Hub)	CBSA: 7.3	13.9	CBSA: 9.5

Objective 1.1: Increase the proportion of primary care visits where adolescents and adults are screened for depression.

Hospital	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 3 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
Adventist HealthCare HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**1.1.1** Behavioral health screenings with links to treatment at clinical care sites.	✖	✖	✖	**Metrics:** # of screenings, # of positive screenings, # brief interventions, # referrals to treatment, # of linkages to treatment **Focus Location:** MCHC CBSA & Montgomery County **Focus Population:** Broader community, patients with substance abuse	Philanthropic/Foundation, Caron, Recovery Centers of America (RCA), Avery Road Treatment Center, Shumaker House, Mountain Manor, Massie Unit, Lawrence Court, Delphi, MD Addiction Centers, Salvation Army, Helping Up Mission, Grass Roots, Kolmac Clinic, MedStar Outpatient Addiction Services, Suburban Outpatient Addiction Services. Community Care Delivery Existing/Potential Partners: Montgomery Cares, Maryland Dept. of Health, Montgomery County DHHS, Trinity Health, Mosaic Group.	**HCH:** $1.2 M	**Year 1:** 57.6% (781/1335) of Holy Cross Health Center patients and 83.2% (3664/4405) of Holy Cross Health Partner patients received depression screening during their primary care visit during CY22; 98 Holy Cross Health Center patients were referred to Mindoula **Year 2:** 82.0% (6871/8380) of Holy Cross Health Center patients and 80.5% (4225/5252) of Holy Cross Health Partner patients received depression screening during their primary care visit during CY23; 102 Holy Cross Health Center patients were referred to Mindoula Year 3:
Adventist HealthCare	**1.1.2** Provide Inservices for primary care physicians to equip them with skills and knowledge needed to address mental health needs of patients.	✖	✖	✖	**Metrics:** # of trainings held, # of participants, % of behavioral health teleconsultation participants reporting increase in confidence working with behavioral health conditions **Focus Location:** Montgomery County **Focus Population:** Primary Care Physicians in our Clinically Integrated Network	Clinically Integrated Network (CIN) of Physician Practices		

Objective 1.2: Increase the proportion of children, adolescents and adults with mental health problems who get mental and other health services they need.

Strategies	Program/Intervention	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 3 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**1.2.1** Provide virtual and in-person case management services for patients with a diagnosis of depression, schizophrenia/ schizoaffective, and bipolar disorder	✖	✖	✖	**Metrics:** # of participants served & readmission rate **Focus Location:** MCHC CBSA & Montgomery County **Focus Population:** Patients with diagnoses of depression, schizophrenia and bipolar disorders	Mindoula Health	**HCGH:** $120,000	**Year 1:** In FY23, 98 patients were referred to Mindoula **Year 2:** In FY24, 102 patients were referred to Mindoula **Year 3:**

MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**1.2.2** Deliver Outpatient Addiction Treatment services for adolescents and adults with substance abuse disorder	✖	✖	✖	**Metrics:** Phase 1 completion, school attendance, behavior, #encounters, # classes held, # of participants, % increase in knowledge and self-efficacy, class completion rate **Focus Location:** Montgomery County **Focus Population:** Adolescents & Adults with Substance abuse	Montgomery County DHHS, & Montgomery County Public School System.		
Adventist HealthCare HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**1.2.3** Collaborate with community organizations, community partners, and health systems to effect change at a systems level to improve behavioral health outcomes	✖	✖	✖	**Metrics:** % of total BH ED encounters for high utilizer BH patients (30+ encounters/year), total ED encounters for high utilizer patients, total ED charges for BH high utilizer patients **Focus Location:** Montgomery County **Focus Population:** Adults	Nexus Montgomery, County Agencies, Community Representatives, Cornerstone Montgomery, Sheppard Pratt, DHHS, MCFRS, and the Local Behavioral Health Authority	**HCH & HCGH:** $250,000	**Year 1:** Nexus Behavioral Health Crisis Program: in FY23, 200 total ED Encounters for high utilizer patients, resulting in 5.16% of total behavioral health emergency department encounters for high utilizer behavioral health patients. Note: data available for July 1, 2022 - March 30, 2023 only. **Year 2:** **Year 3:**
HOLY CROSS HEALTH A Member of Trinity Health	**1.2.4** Train faith leaders to be first responders for someone within their congregation/community experiencing a mental health or substance use challenge or crisis	✖	✖	✖	**Metrics:** Total # of faith leaders trained, # of faith leaders trained in FCN/HM network **Focus Location:** MC Equity Focus Areas & PGC District 1 **Focus Population:** Faith-based organizations	Faith-based Organizations, Maryland Department of Health, EveryMind, Mental Health Association of Maryland	**HCH & HCGH**: $5,000	**Year 1:** Trained 2 HCH employees in MHFA as trainers; trainings for faith leaders will begin in FY24. **Year 2:** MHFA trainers connected with numerous faith communities, with implementation of trainings to begin in FY25. **Year 3:**
Adventist HealthCare MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**1.2.5** Provide grant funding and sponsorships to organizations addressing access to mental health services.	✖	✖	✖	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization **Focus Location:** Montgomery County & Prince George's County **Focus Population:** All ages	CentrePointe Counseling, Montgomery County Coalition for the Homeless (MCCH), Identity, Inc., EveryMind, Inc., Cornerstone Montgomery, Story Tapestries, Community Clinic Inc. (CCI): EveryMind, Inc., Parent Encouragement Program, Cornerstone Montgomery, National Alliance on Mental Illness		

Objective 1.3: Increase mental health awareness to reduce stigma associated with mental illness, promote healthy behaviors and improve health outcomes through education and outreach events*

Hospital	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 3 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
Adventist HealthCare HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**1.3.1** Provide mental health and wellness workshops, educational events, and support groups in the community.	✖	✖	✖	**Metrics:** # of workshops and support groups held, # of participants, % of participants who had an increase in knowledge and self-efficacy **Focus Location:** MCHC CBSA & Montgomery County **Focus Population:** Adolescents & adults	Charles E. Smith Life Communities; AHC Outpatient Wellness Center (OWC), EveryMind, Inc., Montgomery County Area Agency on Aging, GROWS, MedStar Outpatient Wellness Clinic	**HCH:** $2,500 **HCGH:** $1,000	**Year 1:** Held seven Chronic Pain Self-Management Program cohorts with 262 encounters and a completion rate of 61% **Year 2:** Held five Chronic Pain Self-Management Program cohorts with 159 encounters and a completion rate of x% **Year 3:**

Adventist HealthCare HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**1.3.2** Collaborate with community organizations, partners, and health systems to address the health information gap to promote informed decision-making and connection to existing resources that will help improve the physical, social, and mental well-being of community members	✖	✖	✖	**Metrics:** # education/awareness events held, # of participants, % of participants who had an increase in knowledge/awareness # partners/ organizations **Focus Location:** MCHC CBSA & Montgomery County **Focus Population:** Adolescents, adults, Latino/Hispanic Families	EveryMind, Inc., Linkages to Learning, Latino Health Initiative, Identity, Inc., Mary's Center, Office of Community Partnerships, Montgomery County Community Engagement Cluster	**HCH:** $2,000 **HCGH:** $1,000	**Year 1:** Held three webinars with partner EveryMind titled Navigating Behavioral Health Services in English and Spanish, 128 encounters total; Supported Parenting Encouragement Program's Critical Topics in Parenting webinars with over 1,000 encounters for the series. **Year 2:** No update **Year 3:**
Adventist HealthCare MedStar Health	**1.3.3** Provide students the opportunity to get hands-on learning with behavioral health professionals through our behavioral health internships and medical rotations	✖	✖	✖	**Metrics:** # of students hosted, # of staff hours **Focus Location:** Montgomery County **Focus Population:** Students at any collegian level (bachelors, masters, doctorate programs)	Howard University, George Washington University, University of Maryland, Washington Adventist University, Towson University, Georgetown University		

Priority 1b: Access to Primary Care Providers (CHNA pg. 107-111)

Goal 2: Improve health care.

CHNA Impact	CHNA Baseline	Target	Actual
Reduce number of people who cant afford to see a doctor (Source: America's Health Rankings by state)	MD: 7.5%	3.30%	MD: 8.8%
Increase the proportion of people with a usual primary care provider (Source: office of Population Health improvement; SHIP data)	MC: 78.0% PGC: 78.9%	84.0%	MC: 85.5% PGC: 83.1%
Increase percent of mothers receiving early and adequate prenatal care (Source: Vital Statistics Admin, Jurisdictional Data)	MC: 70.2% PGC: 59.4%	80.5%	MC: 70.2% PGC: 59.4%
Increase the proportion of females who get screened for breast cancer (Source: CDC Places)	MC: 77.1% PGC: 80.3%	80.5%	MC: 76.5% PGC: 77.9%

Objective 2.1: Increase the proportion of people with a usual primary care provider

Strategies	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 3 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
Adventist HealthCare MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**2.1.1** Provide financial and in-kind support to primary care community clinics	✖	✖	✖	**Metrics:** # of patients served/patient visits, quality measures - A1c scores, health screenings, HEDIS measures, $ grants/funding provided, #grants provided. **Focus Location:** 20814, 20878, 20901, 20851, 20910, 20904, 20783, MCHC CBSA **Focus Population:** Refugees, low-income, and uninsured/underinsured populations	MobileMed, Mercy, Mary's Center, Kaseman Clinic, CCI, American Diversity Group; Aspen Hill Holy Cross Clinic, Olney Proyecto Salud Clinic; Proyecto Salud, & Catholic Charities		
Adventist HealthCare HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**2.1.2** Assist community members in need of primary care services through screenings, referrals and linkages to community resources	✖	✖	✖	**Metrics:** # of encounters, # of enrolled clients, % screening rate, # of referrals, **Focus Location:** Montgomery County, MC Equity Focus Areas, PGC District 1, MCHC CBSA **Focus Population:** low income, uninsured/underinsured populations	Montgomery Cares, Catholic Charities, MD Minority Outreach and Technical Assistance program, MC DHHS, Trinity Health, Primary Care Coalition, Cross Community	**HCH:** $10,000 **HCGH:** $5,000	**Year 1:** Accountable Healthy Communities (AHC) ran from July - January, with 2324 patients screened and 316 followed up with for navigation. Road to Health ran through July-June with 80 community members referred to primary care and all 80 receiving follow-up with links to additional community resources. HCH colleague needs program connected 21 colleagues with health care services and worked with 12 colleagues who needed to see a physician but could not. **Year 2:** In FY24, the Holy Cross Health colleague needs program connected 6 colleagues with health care services and worked with 4 colleagues who needed to see a physician but could not. **Year 3:**

SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**2.1.3** Provide funding and in-kind support to organizations addressing barriers to accessing primary care services	✖	✖	✖	**Metrics:** $ support provided **Focus Location:** MCHC CBSA **Focus Population:** low-income, uninsured/underinsured populations			
HOLY CROSS HEALTH A Member of Trinity Health	**2.1.4** Operate primary care health centers for the un/underinsured in geographically accessible locations	✖	✖	✖	**Metrics:** # encounters, #patient visits, clinical measures **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, uninsured/underinsured populations	MedStar Health, Primary Care Coalition, EveryMind, Lighthouse for the Blind, Montgomery Cares & Montgomery County Dept. of Health	**HCH:** $2.5M (HCH), $2.4M (other sources)	**Year 1:** In FY23 YTD, there were 35,418 total patients at the HC Health Centers, with a target of 24,137 **Year 2:** In FY24 YTD, there were 38,790 total patients at the HC Health Centers, with a target of 24,137 **Year 3:**
HOLY CROSS HEALTH A Member of Trinity Health	**2.1.5** Link uninsured Maternity Partnership patients to primary care services at HC Health Centers to create a medical home for the whole family	✖	✖	✖	**Metrics:** #maternity partnership patients linked to Gaithersburg health center **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, uninsured populations**,** pregnant women, infants	Maternity Partnership, Montgomery Cares	See Strategy 2.1.4	**Year 1:** In FY23, there were 67 new patient newborn visits at Holy Cross Health Center in Gaithersburg. **Year 2:** In FY24, there were 47 new patient newborn visits at Holy Cross Health Center in Gaithersburg **Year 3:**
HOLY CROSS HEALTH A Member of Trinity Health	**2.1.6** Provide a primary medical home for adults through a program of all-inclusive care for the elderly (PACE)	✖	✖	✖	**Metrics:** PACE implementation, # encounters, readmission rates, ED utilization, and clinical indicators, MADC daily census; participant surveys **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** dual eligible older adults, older adults	Montgomery County DHHS, Maryland Department on Aging; AAOA, MAADS, Alzheimer's Foundation, Alzheimer's Association, Trinity PACE	HCH: $425,000	**Year 1:** In FY23, MADC had 3218 encounters and a daily census of 14 with a target of 15 **Year 2:** In FY24, MADC had 3247 encounters and a daily census of 13 with a target of 15. **Year 3:**
Adventist HealthCare HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**2.1.7** Implement strategies and initiatives that reduce barriers to accessing primary care, such as transportation and language	✖		✖	**Metrics:** #participants, #Lyft/Uber rides provided, #translation services provided, #interpreters provided, $ spent on language access **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, uninsured/underinsured populations, older adults	Mobile Med, Mercy Clinic, Mary's Center, Proyecto Salud, Catholic Charities, Lyft, UberHealth, MC DHHS, Olney Home for Life	**HCH: $1.0M**	**Year 1:** In FY23, there were 2,751 community members who received primary care transportation services at no charge to address barriers of access to primary care. The HCH operates four health centers for the uninsured/underinsured that have a sliding fee scale based on income, for patients under 250% FPL, fee is $30, from 251%-300% FPL, fee is $45, and over 301% FPL, fee is $60 . In FY23, HCH provided 135 translation services (totaling $904,676). HCH employs two Spanish language interpreters providing language interpretation and translation. All other language services (61%) are provided by an outside vendor. **Year 2:** In FY24, 3,805 community members received primary care transportation services at no charge to address access barriers to primary care. In FY24, HCH provided over 1.5 million minutes of translation services in Spanish, American Sign Language, and other spoken languages. A total of 161 documents were translated, and 3 PRN ASL Interpreters were hired. **Year 3:**

Priority 1c: Lack of Insurance (CHNA pg. 102-106)

Goal 3: Increase health insurance coverage

CHNA Impact	CHNA Baseline	Target	Actual
Increase the proportion of people with health insurance (Source: Trinity Data Hub)	CBSA: 90.9%	92.1%	CBSA: 91.5%
Percent uninsured (Source: Trinity Data Hub)	CBSA: 9.1%	0.0%	CBSA: 5.9%
Percent of insured population receiving Medicaid (Source: Trinity Data Hub)	CBSA: 17.4%	No Target	CBSA: 18.4%

Objective 3.1: Increase the proportion of people with health insurance

Hospital	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 3 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
Adventist HealthCare; Holy Cross Health; MedStar Health; Suburban Hospital	**3.1.1** Advocate for policy, systems, and environmental changes addressing insurance reform and the needs of the uninsured population	✖	✖	✖	**Metrics:** activities leveraged, plans developed, number of partners engaged, percent of colleague participation in e-advocacy campaign(s), #letters of support written, #advocacy events attended, #written/oral testimonies provided, # advocacy hours **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Montgomery County, Maryland, National **Focus Population:** low-income, uninsured/underinsured populations, older adults, broader community	Montgomery County DHHS, Montgomery Cares, MD Hospital Association	**HCH:** $7,000 **HCGH:** $3,000	**Year 1:** In FY23, Holy Cross Health advocated for adequate reimbursement, to protect 340B, to advance virtual care and telehealth permanency, to expand Medicaid, accelerate Total Cost of Care Models, reform insurer practices, and expand PACE **Year 2:** In FY24, Holy Cross Health continued to advocate to achieve equitable health for individuals and communities by advocating for adequate reimbursement, to protect 340B, advancing virtual care and telehealth permanency, expanding Medicaid, accelerating Total Cost of Care Models, reforming insurer practices and expand PACE **Year 3:**
Adventist HealthCare; Holy Cross Health; MedStar Health; Suburban Hospital	**3.1.2** Provide support to uninsured patients, colleagues and community members by assisting with enrollment to publicly funded programs and hospital charity care programs	✖	✖	✖	**Metrics:** # of participants, #colleagues assessed, #Colleagues identified as uninsured, #linked to resources, Charity care expenses, #insured **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, uninsured populations	Montgomery County DHHS, Meduit, DeCorm	**HCH:** $1.0M **HCGH:** $400,000	**Year 1:** In FY23, 98.9% of self-pay inpatients were screened by Elevate for Medicaid. At HCH, 3,290 patients were approved for Emergency Medicaid and at HCGH, 767 patients were approved, with the majority of these patients being undocumented community members. Twenty-one (21) colleagues were assisted with health care referrals through the Colleague Social Care Hub. **Year 2:** In FY24, 97.6% of self-pay inpatients were screened by Elevate for Medicaid. At HCH, 3,136 patients (IP/OP/ED) were approved for Emergency Medicaid and at HCGH, 855 patients (IP/OP/ED) were approved, with the majority of these patients being undocumented community members. Six (6) colleagues were assisted with health care referrals through the Colleague Social Care Hub. **Year 3:**

Objective 3.2: Reduce the proportion of people who can't get medical care when they need it.

Hospital	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 3 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
Adventist HealthCare; Holy Cross Health	**3.2.1** Provide perinatal health services to improve birth outcomes and improve health during the first years of life, with an increased focus on healthy birth outcomes for women of color (morbidity and mortality)	✖	✖	✖	**Metrics:** # of encounters, pre/posttests, participant surveys, # of Maternity Partnership admissions, % Maternity Partnership patients receiving early prenatal care, and percent low-birth weight deliveries. # of women served, # of teenage deliveries, pregnancy loss and infant mortality rate, trimester that pre-natal care was initiated, % of babies born with a low birth weight **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, uninsured populations, pregnant families, uninsured women	Montgomery County AAHP, FIMR, Community Action Team, and Interagency Montgomery County Interagency Coalition on Adolescent Pregnancy, Montgomery County DHHS Maternity Partnership Montgomery County Department of Health and Human Services; Montgomery County AAHP, FIMR, Community Action Team, and Interagency Montgomery County Interagency Coalition on Adolescent Pregnancy, Montgomery County DHHS Maternity Partnership	HCH: $1.2M HCGH: $500,000	**Year 1: There were 1143 new admissions, with 37 babies delivered with a low birth weight (<2500 g) rate of 3.87%. 48.6% of patients received early prenatal care.** **Year 2: In FY24, there were 689 new Medicaid admissions to the Ob/Gyn clinics in Silver Spring and Germantown** **Year 3:**

HOLY CROSS HEALTH A Member of Trinity Health	**3.2.2** Provide access to mammogram services for uninsured	✖	✖	✖	**Metrics:** # of encounters, % eligible health center patients health center patients receiving referrals, # of mammograms, # navigated to care and cycle time from diagnosis to treatment, # enrolled in state breast and cervical cancer program **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, uninsured populations	Community Care Delivery Existing/Potential Partners: Montgomery Cares, Maryland Dept. of Health, Kevin J. Sexton Fund, Primary Care Coalition	HCH: $160,000	**Year 1:** • ***HCH*** **-** In FY23, there were 897 mammograms received by health center patients. **Year 2:** In FY24, there were 865 mammograms received by health center patients. **Year 3:**
Adventist HealthCare MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**3.2.3** Provide financial and in-kind support to community clinics and community organizations addressing lack of insurance and/or insurance enrollment	✖	✖	✖	**Metrics:** # of patients served/patient visits, quality measures - A1c scores, health screenings, HEDIS measures, $ grants/funding provided, #grants provided **Focus Location:** MCHC CBSA **Focus Population:** refugees, low income, and uninsured/underinsured populations	CASA de Maryland, MobileMed, Mercy, Mary's Center, Kaseman Clinic, CCI, American Diversity Group; Aspen Hill Holy Cross Clinic, Olney Proyecto Salud Clinic, Catholic Charities		
SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**3.2.4** Increase access to diabetes and cardiovascular management and treatment for uninsured residents	✖	✖	✖	**Metrics:** # of patients served/patient visits, quality measures (e.g., A1c scores, health screenings, etc.) **Focus Location:** Montgomery County **Focus Population:** low income, uninsured/underinsured, refugee, and immigrant populations	MobileMed, National Institutes of Health-NIDDKD, National Heart, Lung and Blood Institute		
SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**3.2.5** Deliver opportunities to connect with a health professional to assess risk and receive free counseling	✖	✖	✖	**Metrics:** #participants, # BP screenings, #assessments, #class encounters, quit rate **Focus Location:** MCHC CBSA **Focus Population:** Broader Community	HeartWell, Prince George's County Department of Recreation, Friendship Height's Village Center, Latino Health Initiative.		
Adventist HealthCare HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**3.2.6** Advocate for policy, systems, and environmental changes addressing the needs of the uninsured population	✖	✖	✖	**Metrics:** activities leveraged, plans developed, number of partners engaged, percent of colleague participation in e-advocacy campaign(s), #letters of support written, #advocacy events attended, #written/oral testimonies provided, # advocacy hours **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Montgomery County, Maryland, National **Focus Population:** low-income, uninsured/underinsured populations, older adults, broader community	Montgomery County Council, Community-based organizations, faith-based organizations	**HCH:** $7,000 **HCGH:** $3,000	**Year 1:** In FY23, HCH advocated to expand Medicaid **Year 2:** In FY23, HCH continued to advocate to expand Medicaid **Year 3:**
SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE MedStar Health	**3.2.7** Navigate uninsured patients and community members in need of access to care through screenings, referrals and linkages to community resources	✖	✖	✖	**Metrics:** # of social screenings completed, # of referrals **Focus Location:** **Focus Population:** low income, uninsured/underinsured populations	Montgomery County Cancer Crusade, Proyecto Salud, Holy Cross Aspen Hill		

MCHC Implementation Plan FY2023-FY2025

Priority 2: Healthy Behaviors

Overarching Goal 2: Promote healthy development, healthy behaviors, and well-being across all life stages.

Priority 2a: Food Insecurity (CHNA pg. 92-99)

Goal 4: Improve health by promoting healthy eating and making nutritious foods available.

CHNA Impact	CHNA Baseline	Target	Actual
Decrease percent of households that are food insecure (Source: Trinity Data Hub)	MC: 8.6% PGC: 7.3%	6.00%	MC: 8.9% PGC: 7.4%
Decrease percent of minority groups that are food insecure (Source: USDA)	BLK: 19.1% HSP: 15.6%	6.00%	BLK: 19.8% HSP: 16.2%
Increase the proportion of households who receive SNAP benefits (Source: Trinity Data Hub)	CBSA: 6.7%	No Target	CBSA: 8.9%

Objective 4.1: Reduce household food insecurity and hunger

Hospital	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 3 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
HOLY CROSS HEALTH A Member of Trinity Health	**4.1.1** Utilize SIOH screening and referral process to capture data in EPIC and refer health center patients to community resources	x	x	x	**Metrics:** # of patients screened, # of patients referred to resources **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** low-income, uninsured/underinsured	Montgomery Cares	**HCH:** See Strategy 2.1.4 **HCGH:** See Strategy 2.1.4	**Year 1:** In FY23, Holy Cross Health had a social needs screening rate of 73% of our health center patients, up from 16% at the beginning of the fiscal year (a 57% improvement) **Year 2:** In FY24, Holy Cross Health had a social needs screening rate of 89.6% of our health center patients, with 54.9% having at least one social need, and 16.1% requesting services. **Year 3:**
Adventist HealthCare HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE		x	x	x	**Metrics:** # of patients/community members with coordination plans in FindHelp, number of community organizations with claimed sites in FindHelp, # closed loop referrals **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Montgomery County **Focus Population:** low-income, uninsured/underinsured	Cross Community, CHEER, faith-based organizations, Montgomery County DHHS, nonprofit organizations	**HCH:** See Strategy 2.1.2 **HCGH:** See Strategy 2.1.2	**Year 1:** Nexus Connect launched the Telehealth Navigator in November 2022, to date the program has had 90 encounters. - The Holy Cross Health colleague needs program performed 174 needs assessments. 162 Holy Cross Health colleagues received assistance due to food running out and 149 colleagues received assistance based on food running out before they had more money to buy more. **Year 2:** In FY24, Nexus Connect's Telehealth Navigator program had in November 2022, to date the program has had 570 encounters. The program ended at the end of FY24. The Holy Cross Health colleague needs program connected with 213 Holy Cross Health colleagues who needed assistance due to food running out and 213 colleagues who needed assistance based on food running out before they had more money to buy more. **Year 3:**
HOLY CROSS HEALTH A Member of Trinity Health	**4.1.3** Train Community Health Workers on SNAP education and enrollment	x	x	x	**Metrics:** # of CHWs trained, #participants enrolled **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** low-income, uninsured/underinsured	Montgomery County Food Council, Cross Community	**HCH:** $25,000 **HCGH:** $25,000	**Year 1:** Five CHWs trained in SNAP; enrollments will begin in FY24 **Year 2:** In FY24, 1,228 SNAP encounters were made, with 80 interested clients, and 6 applications completed. **Year 3:**
Adventist HealthCare MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**4.1.4** Provide grant funding and sponsorships to organizations addressing access to food insecurity and hunger.	x	x	x	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization **Focus Location:** Montgomery County & Prince George's County **Focus Population:** All ages	Community Health and Empowerment through Education and Research (CHEER), Food & Friends, Nourish Now, Feed the Fridge, Crossroads Community Food Network, Institute for Public Health Innovation, The Shepherd's Table, Manna Food Center		

Objective 4.2: Increase access to foods that support healthy dietary patterns

Hospital	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 3 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
Adventist HealthCare HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**4.2.1** Increase availability and access to healthy and/or culturally appropriate food	✖	✖	✖	**Metrics:** **Focus Location:** MC Equity Focus Areas **Focus Population:** low-income, uninsured/underinsured, food insecure	Montgomery College, Montgomery County Master Gardeners, MoCo Food Council, Montgomery County Ag Reserve, Boys and Girls Club, Food and Friends, Manna, One Acre Farms	**HCH:** $60,000 **HCGH:** $210,000	**Year 1:** From Jan-June 2023, the HCH mobile market held 6 markets distributing fresh produce, shelf-stable items, and protein to 825, supporting 3, 076 household members at our Silver Spring location and 5 markets distributing food to 940 unduplicated participants, supporting 3, 800 household members at our Germantown location. **Year 2:** The HCH mobile market held 12 markets, distributing fresh produce, protein, and shelf-stable foods with a total of 3,604 program encounters with 605 unduplicated participants, supporting over 2,266 unduplicated household members. HCGH mobile market held 12 markets, distributing fresh produce, protein, and shelf-stable foods with a total of 2,700 program encounters with 828 unduplicated participants, supporting over 3,501 unduplicated household members. **Year 3:**
Adventist HealthCare HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**4.2.2** Increase food literacy	✖	✖	✖	**Metrics:** #encounters, #classes held, # of participants, % increase in knowledge and self-efficacy, class completion rate **Focus Location:** MC Equity Focus Areas **Focus Population:** low-income, uninsured/underinsured, food insecure	Montgomery College, MoCo Food Council, UMD Extension, Boys and Girls Club, Manna	**HCH:** $2,000 **HCGH:** $8,000	**Year 1:** Holy Cross Health, Montgomery College, and Montgomery County Master Gardeners collaborated to offer the Eat It, Grow It food literacy event in September 2022. The event offered interactive demos, resources on health & nutrition, home garden-to-table growing, and community resources supporting food access. 50 community members attended the event. **Year 2:** Holy Cross Health and Montgomery County Master Gardeners collaborated to offer the Eat It, Grow It food literacy event in May 2024. The event offered interactive demos, resources on home food gardening, and community resources supporting food access. 10 community members attended the event. Holy Cross Health also hosted 17 families of community gardeners, providing space, support, expertise, and supplies to grow their own food. **Year 3:**

Priority 2b: Adult Obesity (CHNA pg. 88-91)

Goal 5: Reduce overweight and obesity by helping people eat healthy and get physical activity.

CHNA Impact	CHNA Baseline	Target	Actual
Reduce the proportion of adults aged 20 and older who are obese (Source: Trinity Data Hub)	CBSA: 31.1%	36.00%	CBSA: 31.9%
Reduce the proportion of children and adolescents who are obese or overweight (Source: YRBS, HS (overweight plus obese)	MC: 22.4% PGC: 35.5%	15.50%	MC: 24.6% PGC: 39.9%

Objective 5.1: Reduce the proportion of adults with obesity

Hospital	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 3 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
HOLY CROSS HEALTH A Member of Trinity Health	**5.1.1** Expand or implement evidence-based/informed programs addressing obesity in children, adolescents	✖	✖	✖	**Metrics:** Quarterly reports on number of encounters, pre/posttests, participant surveys, weight loss, # Kids Fit participants, BMI **Focus Location:** MC Equity Focus Areas **Focus Population:** Children/adolescents	Montgomery County Housing Partnership, Boys and Girls Club, Kingdom Fellowship AME	**HCH**: $15,000 **HCGH:** $15,000	**Year 1:** Funding for Kids Fit secured and programming will begin in FY24 **Year 2:** In FY24, kids fit programming provided classes at two community centers from October to June, expanding to summer programming with 1,323 fitness encounters and 299 education encounters. Kids Fit will expand in FY25 **Year 3:**
HOLY CROSS HEALTH A Member of Trinity Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**5.1.2** Provide diabetes care management, education and/or nutrition counseling at community health centers	✖	✖	✖	**Metrics:** Health center visits, clinical measures, readmissions/ED utilization, referrals to community health programs and social services **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** Young Adults and Adults, high-risk patients	Community Care Delivery Existing/Potential Partners: Montgomery County DHHS, Montgomery Cares, Kevin J. Sexton Fund	**HCH**: $30,000 **HCGH:** $15,000	**Year 1:** In FY23, there were 1,872 diabetes education class visits • ***Suburban*** - 91 nutrition counseling sessions with registered dietitian in FY23; 10 patients uninsured patients living with Diabetes were seen at MobileMed clinics **Year 2:** In FY24, engaged approximately 376 unduplicated health center patients with 638 duplicated encounters for diabetes education. **Year 3:**
Adventist HealthCare	**5.1.3** Expand diabetes programming (English and Spanish)				**Metrics:** # DPP and DSMP cohorts offered by qualified providers; # referrals **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA	Nexus Montgomery, Adventist Health, Medstar Montgomery, Holy Cross and Suburban, Montgomery County DHHS, Healthy Montgomery, Montgomery Cares, BRMDP	**HCH:** $60,000 **HCGH:** $25,000	**Year 1:** In FY23, expanded the Equitable Wellness Initiative (EWI) by providing classes in Spanish, and completed 47 cohorts (141 classes), in Spanish. The program further expanded Spanish classes through partnerships. Community Health and Empowerment through Education and Research (CHEER) completed 4 cohorts, (12 classes), and Cross Community completed 2 cohorts (6 classes) **Year 2:** In FY24, there were 11 EWI cohorts completed, equaling 27 classes in

HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE		x	x	x	**Focus Population:** Young Adults and Adults			**Year 2:** In FY24, there were 11 EWI cohorts completed, equaling 27 classes in English and Spanish reaching 55 unduplicated community members. There were 8 DPP cohorts, 5 English and 3 Spanish, as well as 4 DSME cohorts that were held in English. **Year 3:**
Adventist HealthCare HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**5.1.4** Provide healthy lifestyle education programs, wellness activities, workshops, and support groups	x	x	x	**Metrics:** # of encounters, person served, classes/workshops held, etc. **Focus Location:** Montgomery County & Prince George's County **Focus Population:** Adults and older adults/elderly	Montgomery County Department of Recreations, Faith Communities, Montgomery County non-profits	**HCH:** $40,000 **HCGH:** $20.000	**Year 1:** In FY23, there were over 2,500 virtual fitness encounters in classes on yoga, Pilates, and Zumba and 28 participants attended a six week Lifestyle Medicine program **Year 2:** In FY24, CDSMP had 126 encounters, DSMP had 356 encounters, CPSMP had 156 encounters, CTS had 42 encounters, Powerful Tools for Caregivers had 11 encounters, and MS had 70 encounters. In FY 24, there were over 6,300 virtual fitness encounters in yoga, Pilates, and Zumba **Year 3:**
HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**5.1.5** Expand or implement evidence-based programs for diabetes and chronic disease self-management	x	x	x	**Metrics:** Quarterly reports on encounters, **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** Young Adults and Adults	Evidence-based Programs and Initiatives Existing/Potential Partners: Montgomery County DHHS, HQI	**HCH:** $30,000 **HCGH:** $10,000	**Year 1:** In FY23, 9 cohorts were held for diabetes and chronic disease self management with a total of 540 encounters and a 72% completion rate for DSMP (diabetes) and a 59% completion rate for CDSMP (chronic disease) **Year 2:** For FY24, there were 10 classes held with a total of 484 encounters. The completion rate is 65% for both CDSMP and DSMP. There were 8 cohorts offered by qualified providers for DPP reaching approximately 108 participants. **Year 3:**

Priority 2c: Physical Inactivity (CHNA pg. 91-92)

Goal 6: Improve health, fitness, and quality of life through regular physical activity

CHNA Impact	CHNA Baseline	Target	Actual
During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise? (previous measure: Reduce the proportion of adults who do no physical activity in their free time) (Source: BRFSS)	MC: 48.9% PGC: 49.5%	21.20%	MC: 17.6% PGC: 21.6%
Increase the proportion of adolescents who do enough aerobic physical activity (Source: YRBS, HS)	MC: 37.7% PGC: 24.1%	30.60%	MC: 43.3% PGC: 25.5%
Reduce fall-related deaths among older adults (Source: CDC Wonder)	MC: 66.1 PGC: 48.0	63.40%	MC: 67.9% PGC: 32.1%
Decrease heart disease mortality rate (Source: MD Vital Statistics Report/Crude Death rates)	MC: 97.9 PGC: 181.3	71.1	MC: 137.4 PGC: 166.7
Decrease stroke mortality rate - all ages (Source: CDC Interactive Atlas of Heart Disease and Stroke/Crude)	MC: 24.7 PGC: 46.3	33.4	MC: 39.2 PGC: 49.6
Reduce the proportion of adults with high blood pressure (Source: Trinity Data Hub)	MC: 29.8% PGC: 37.2%	27.70%	MC: 30.3% PGC: 39.0%

Objective 6.1: Reduce the proportion of individuals who do no physical activity in their free time

Hospital	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 3 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
Adventist HealthCare HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**6.1.1** Provide physical and social activity programs for seniors aged 55+	x	x	x	**Metrics:** # participants # of encounters, # programs offered; # of classes offered, pre/post assessments, participant surveys **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Prince George's County **Focus Population:** Adults aged 55+	Montgomery County HOC and Recreation Department, Maryland Department on Aging, Kaiser Permanente of the Mid-Atlantic States, MoCo Department of Recreation, Maryland National Capital Park and Planning Commission, Faith-Based and Community-based Organizations and Retirement Communities	**HCH:** $245,000 **HCGH:** $25,000	**Year 1:** 2,440 Senior Fit classes were held with 79,834 encounters (47,611 virtual and 32,223 In-person); and 845 yoga, Tai Chi, ballet, Pilates, balance, strength, chair and Parkinson's exercise classes with 7,485 virtual encounters with 2,308 participants **Year 2:** In FY24, 2,618 Senior Fit classes were held with 88,120 encounters (42,628 virtual and 45,492 In-person); 799 yoga, Tai Chi, Ballet, Pilates, balance, strength, chair and Parkinson's exercise classes with 6,309 virtual encounters with 1,846 participants **Year 3:**

SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**6.1.2** Address obesity through a three-pronged approach: education, improved nutrition, and increased physical activity (Dine, Learn & Move).	✖	✖	✖	**Metrics:** # of participants, pre/post evaluation **Focus Location:** Prince George's County **Focus Population:** Adults 18+	PG Parks & Recreation, University of Maryland Capital Region Health, PG Health Department.		
SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**6.1.3** Provide funding to organizations addressing access to physical activities services through the Community Contribution Fund.	✖	✖	✖	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization **Focus Location:** Montgomery County & PG County **Focus Population:** Physical and Mental Differences Adults (special needs), General Pop	Spirit Club, Mains Street, American Heart Association, YMCA		
HOLY CROSS HEALTH A Member of Trinity Health	**6.1.4** Partner with organizations and community centers to expand senior-based services in the community	✖	✖	✖	**Metrics:** # of organizations, # of events held at community sites, # of encounters, # programs offered; pre/posttests, participant surveys **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** Adults aged 55+	Montgomery County HOC and Recreation Department, Faith-based organizations	**HCH:** $10,000 **HCGH:** $5,000	**Year 1:** HCH partners with MC recreational centers and faith communities to offer classes at geographically accessible locations **Year 2:** In FY24, Holy Cross Health maintained 23 senior-focused partner sites in Montgomery and Prince George's Counties and opened Holy Cross Health Partners at Elizabeth Square. This new primary care practice, co-located with a recreation center and senior apartments, will begin offering senior programming in its multi-purpose space in Fall 2024. **Year 3:**
Objective 6.2: Increase the proportion of older adults with physical, cognitive, or chronic health problems who get regular social and physical activity.								
Hospital	**Strategies**	**Timeframe**			**Metrics/Location/Population**	**Existing and Potential Partners**	**Year 3 Budgeted Resources**	**Status**
		Year 1	**Year 2**	**Year 3**				
HOLY CROSS HEALTH A Member of Trinity Health	**6.2.1** Provide medical, social, rehabilitative and recreational programs for adults through a program of all-inclusive care for the elderly (PACE) and the Medical Adult Day Center (MADC)	✖	✖	✖	**Metrics:** # of encounters, readmission rates, ED utilization, and clinical indicators, MADC daily census; participant surveys **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** Adults with physical, cognitive, or chronic health problems, dual eligible for Medicaid and Medicare	HCH Lead: Healthy Communities Existing/Potential Partners: Montgomery County DHHS, GROWS, Maryland Department on Aging; AAOA, MAADS, Alzheimer's Foundation, Alzheimer's Association, ARC Sisters of the Holy Cross, Alpha Kappa Alpha--Theta Omega Omega Chapter	**HCH:** See 2.1.6	**Year 1:** PACE site identified, opening set for Summer 2024 **Year 2:** PACE opening is set for fall 2024, with plans to use the HCH Medical Adult Day Center (MADC) as a satellite site for PACE participants in the down-county area. **Year 3:**

MCHC Implementation Plan FY2023 - FY2025

Priority 3: Education, Income, Job & Environmental Strategies

Overarching Goal 3: Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.

Priority 3a: Workforce/Labor Shortages (CHNA pg. 77)

Goal 7: Help people earn steady incomes that allow them to meet their health needs

CHNA Impact	CHNA Baseline	Target	Actual
Reduce the proportion of adolescents and young adults who aren't in school or working (Source: Trinity Data Hub)	MC: 8.37% PGC: 12.99%	10.10%	MC: 4.26% PGC: 6.73%
Reduce percentage of unfilled, open positions (Source: Bureau of Labor Statistics)	7.60%	No Target	6.30%
Reduce nursing shortages	MD: 5,000	No Target	MD: 5,000

Objective 7.1: Increase employment in working-age people (16-64 yrs)

Hospital	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 3 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
Adventist HealthCare HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	7.1.1 Implement workforce development program for community members and colleagues to advance in health/allied health careers	x	x	x	**Metrics:** # encounters, # unduplicated Participants # of staff hours, # certifications completed, # hired, average pre-program salary, average post-program salary, # colleagues **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, entry-level or unemployed	Nexus Montgomery, Maryland Physician's Care, Montgomery College, Kingdom Fellowship, Cross Community, Primary Care Coalition, Worksource Montgomery,	**All:** $250,000 **HCH:** $35,000 **HCGH:** $15,000	**Year 1:** Nexus Montgomery has received a $1.3 million dollar grant to support this program from the Department of Labor. Implementation will begin in FY24; HCH implemented a workforce development program to advance entry level colleagues,16 colleagues have completed coursework in the areas of CNA, CMA, Pharmacy Technician, and Central Sterile Processing Technician. Two colleagues have been placed in new positions, 1 colleague is awaiting placement, 8 colleagues are taking their certification exam, and 5 colleagues are completing their externship. **Year 2:** In FY24, Nexus Montgomery enrolled 6 phlebotomy students, 19 pharmacy students, and 17 CNAs in the first cohort; 15 CNAs and 1 GNA in the 2nd cohort; and 8 pharmacy technicians, 5 phlebotomy technicians, and 7 CNAs into certification programs at Montgomery College; HCH implemented its 2nd workforce development program cohort to advance entry level colleagues. 7 colleagues have completed coursework (1 CHAA, 2 CMA, 2 CNA and 2 Phlebotomy). 3 colleagues have been placed in new positions ,2 colleague is awaiting placement, 1 colleague moved on from HCH, and 1 colleague is completing their externship. Since its inception, 11 colleagues have been placed in new positions. **Year 3:**
HOLY CROSS HEALTH A Member of Trinity Health	7.1.2 Implement a workforce development program to hire individuals who face barriers or challenges navigating the hiring system	x	x	x	**Metrics:** # encounters, # unduplicated participants, # hired, # hired at 6 and 12 months **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** Unemployed, aging out of foster care, veterans, homeless, single parents, prior felonies	Career Catchers	**HCH:** $20,000	**Year 1:** Holy Cross Health established the Pathways to Independent Employment program to attract and hire non-traditional candidates – people who have been previously incarcerated, or aging out of the foster care system, or teenage parents – who may not have a strong employment history and face challenges in being hired. Working with a local job assistance agency, Holy Cross seeks candidates from the communities surrounding our safety net health centers, prepares those candidates for the workforce, hires them at Holy Cross and provides ongoing coaching to promote retention. In FY23, 9 PIE participants were hired with a target of 8. **Year 2:** In FY23, 4 PIE participants were hired with a target of 10. **Year 3:**
Adventist HealthCare SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE MedStar Health	7.1.3 Increase access to certification(s) needed for employment (i.e. CDCES, CPR, Safe Sitter)	x	x	x	**Metrics:** # encounters, # unduplicated participants, # hired, # hired at 6 and 12 months **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** Unemployed, aging out of foster care, veterans, homeless, single parents, prior felonies	MedStar SiTEL, American Heart Association, Safe Sitter International, Montgomery County Housing Opportunities Commission, Montgomery Housing Partnership, American Safety and Health Institute (ASHI), Local Fire and Rescue		
Adventist HealthCare SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	7.1.4 Provide financial support to community organizations addressing workforce development and/or vocational training.	x	x	x	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization **Focus Location:** Montgomery County and Prince George's County, MCHC CBSA **Focus Population:** All ages	Interfaith Works, A Wider Circle, Mercy Health Clinic, Strathmore Center, Boy Scouts of America, Montgomery County Coalition for the Homeless, Montgomery County Road Runner, Seventh Day Adventist Churches		

Objective 7.2: Expand pipeline programs that include service learning or experiential learning components in public health and health care settings.								
Adventist HealthCare MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	7.2.1 Increase opportunities for health and medical career exploration for high school students living in Montgomery County, MD.	✖	✖	✖	**Metrics:** # of students, % going to college, % pursuing a medical career, staff hours **Focus Location:** Montgomery County **Focus Population:** High school age students	MCPS, Private Schools, Hopkins Familia, Kennedy High School Medical Careers Program, Medical Careers Program.		
Adventist HealthCare HOLY CROSS HEALTH MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	7.2.2 Increase youth and adult workforce training, and education programs (internships, fellowships, clinical rotations, etc.)	✖	✖	✖	**Metrics:** # of staff hours, # of students, # of programs **Focus Location:** MCHC CBSA, Maryland, DC **Focus Population:** High school and higher education students	Multiple Community Colleges, Universities and High Schools	**HCH:** $100,000	**Year 1:** In FY23, Holy Cross Health Network provided educational experiences to 12 interns in community health, and a team of 6 students completing a capstone project from GW's MHA program in our health centers. They also provided clinical rotations to medical assistant students, residents, CHW students, and nursing students at MADC. **Year 2:** In FY24, Holy Cross Health Network provided educational experiences to 9 interns in community health. Student training is also provided in the form of clinical rotations to medical assistant students, residents, CHW students, and nursing students at MADC. **Year 3:**

Priority 3b: Income Inequality (CHNA pg. 76-81)

Goal 8: Reduce income inequality

CHNA Impact	CHNA Baseline	Target	Actual
Reduce the proportion of people living in poverty (Source: Trinity Data Hub)	CBSA: 20.4%	8.00%	CBSA: 20.1%
Reduce disparity gap in household income for Blacks and Hispanics compared to household income for Whites	CBSA: 60%	No Target	CBSA: 60%

Objective 8.1: Reduce the proportion of people living in poverty								
Hospital	**Strategies**	**Timeframe**			**Metrics/Location/Population**	**Existing and Potential Partners**	**Year 3 Budgeted Resources**	**Status**
		Year 1	**Year 2**	**Year 3**				
SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**8.1.1** Provide financial support to community organizations addressing income inequality through the Community Partnership Fund & employee giving programs.	✖	✖	✖	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization, $ amount raised **Focus Location:** Montgomery County and Prince George's County, MCHC CBSA **Focus Population:** All ages	A Wider Circle, United Way, PEP		**Year 1:** • ***Suburban*** - $17,500 in support to A Wider Circle and PEP for FY23; Socktober sock drive that collected over 1,800 socks to benefit community members; United Way Campaign raised $17,624 **Year 2:** **Year 3:**
Objective 8.2: Provide resources to families experiencing income inequalities								
Adventist HealthCare HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**8.2.1** Implement projects and initiatives that alleviate downstream effects of income inequality	✖	✖	✖	**Metrics:** # of families served, staff hours, # of items **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, immigrant populations, refugees, hospital staff	Linkages to Learning, MCPS, 4 Montgomery Kids,	**AHC:** $1,000; see 7.1.1	**Year 1:** The Holy Cross Health Cares program launched in 2021, and expanded to kindergarten aged children in 2023, collecting school supplies for school age children of HCH colleagues. Backpacks filled with school supplies for 255 children of 105 colleagues' families were distributed, the Holy Cross Health Adopt-A-Family program launched in 2020. In 2022 61 colleagues' families, a total of 251 persons, received the assistance they needed during the holidays. **Year 2:** In FY24, Backpacks filled with school supplies for 299 children of 113 colleagues' families were distributed and 60 colleagues received assistance from the Holy Cross Health Adopt - A - Families **Year 3:**

Priority 3c: Housing Cost Burden (CHNA pg. 81-84)

Goal 9: Reduce housing cost burden

CHNA Impact	CHNA Baseline	Target	Actual
Proportion of families that spend more than 30 percent of income on housing (Source: Trinity Data Hub)	CBSA: 33.7%	25.50%	CBSA: 33.7%
Proportion of housing units that meet the criteria for substandard housing (Source: Trinity Data Hub)	CBSA: 34.7%	16.00%	CBSA: 34.6%

Objective 9.1: Reduce the proportion of families that spend more than 30 percent of income on housing								
Hospital	**Strategies**	**Timeframe**			**Metrics/Location/Population**	**Existing and Potential Partners**	**Year 3 Budgeted Resources**	**Status**
		Year 1	**Year 2**	**Year 3**				
HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	**9.1.1** Coordinate care and link patients, colleagues and community members to social services	✖	✖	✖	**Metrics:** # of screenings, Number of patients/community members with coordination plans, number of community organizations with claimed sites in FindHelp, # closed loop referrals **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Montgomery County **Focus Population:** low-income, uninsured/underinsured	Cross Community, CHEER, faith-based organizations, Montgomery County DHHS, nonprofit organizations	**HCH:** $100,000 **HCGH:** $40,000	**Year 1:** **Year 2:** **Year 3:**

HOLY CROSS HEALTH A Member of Trinity Health	**9.1.2** Advocate for policy, systems, and environmental changes addressing the housing cost burden	✖	✖	✖	**Metrics:** Activities leveraged, plans developed, number of partners engaged, percent of colleague participation in e-advocacy campaign(s), # of staff hours **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** Low-income, uninsured, underinsured	Montgomery County Council, Community-based organizations, faith-based organizations	**HCH:** $7,000 **HCGH:** $3,000	**Year 1:** Explored working with developers and CDFIs to establish workforce housing in upper Montgomery County **Year 2:** Continued to explore opportunities with developers and CDFIs to establish workforce housing in upper Montgomery County **Year 3:**
Adventist HealthCare MedStar Health	**9.1.3** Provide financial support to community organizations addressing housing cost burden through the Community Health fund.	✖	✖	✖	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization, $ amount raised **Focus Location:** Montgomery County and Prince George's County, MCHC CBSA **Focus Population:** Low-income, uninsured, underinsured	Montgomery County Coalition for the Homeless, Seabury Resources for Aging		