MedStar Franklin Square Medical Center
MedStar Georgetown University Hospital
MedStar Good Samaritan Hospital
MedStar Harbor Hospital
MedStar Montgomery Medical Center
MedStar National Rehabilitation Network
MedStar Southern Maryland Hospital Center
MedStar St. Mary's Hospital
MedStar Union Memorial Hospital
MedStar Washington Hospital Center
MedStar Family Choice
MedStar Ambulatory Services
MedStar Visiting Nurse Association
MedStar Institute for Innovation
MedStar Health Research Institute

Community Health Assessment 2015

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Knowledge and Compassion
Focused on You

Executive Summary

At MedStar Health, we recognize that healthier individuals translate to healthier families and communities, and the health of our communities is the result of the complex interplay of multiple variables including physical, social and economic factors. As a healthcare leader in the region, we play an important and significant role in advancing health and partnering with other to realize community health improvement. Part of this effort and commitment to this work is the execution of our second Community Health Needs Assessment (CHNA). MedStar's CHNA is an organized, formal and systematic approach to identify and address the needs of underserved communities across MedStar's geographic footprint. The CHNA guides the development and implementation of a comprehensive plan to improve health outcomes for those disproportionately affected by disease. This CHNA also informs the creation of a strategy for future community health programming, and community benefit resource allocation for the fiscal years 2016-2018 across the 10 MedStar hospitals. As a not-for-profit organization, MedStar's CHNAs align with guidelines established by the Affordable Care Act, and comply with Internal Revenue Service (IRS) requirements.

Framework and Approach

The guiding framework for the CHNA was adopted from the Robert Wood Johnson Foundation's County Health Rankings Model[1] and incorporates best practice standards that have been published by nationally recognized leaders in the healthcare field. The systemwide process leveraged hospitals and partners' existing strengths and expertise to complete the CHNA. Each hospital identified a community or target population of focus, called a Community Benefit Service Area (CBSA). The CHNA will serve as a roadmap for targeted health promotion strategies conducted in the CBSA. The impact of the hospitals' efforts in their respective CBSAs will be tracked and evaluated over the three-year cycle.

The CHNA process included the involvement of local residents, community partners and stakeholders. Each hospital's CHNA was led by an Advisory Task Force (ATF) that included community activists, residents, faith-based leaders, hospital representatives, public health leaders and other stakeholders. Task Force members used population-level data, community health needs survey findings and feedback from community input sessions to create recommendations for each hospital's health priorities and potential implementation strategies. Through a partnership with Georgetown University, community health data were compiled, synthesized and analyzed. Nearly 3,000 questionnaires were completed and several community input sessions were conducted to identify priority areas and to develop associated implementation strategies across each of the 10 hospitals' CBSAs. The assessment of health data along with the community input sessions were used to inform Task Forces' recommendations regarding health priority identification and appropriate level of hospital engagement in the areas identified.

Final CHNA implementation strategies were endorsed by the each hospital's Board of Directors, and approved by MedStar Health's Board of Directors.

Priorities and Implementation Strategies

Chronic disease prevention and management heart disease/stroke, cancer, diabetes and obesity was identified as a priority across MedStar's acute hospitals. MedStar National Rehabilitation Hospital, a specialty hospital, identified physical activity as a priority to address the needs of its target population. In addition, other salient determinants of health were identified such as transportation, access to healthcare services, housing, and healthy food access and food insecurity. Three levels of roles (focus, collaboration and participation) were determined, based on factors such as system strengths and assets, community expertise and current programming. Each hospital developed implementation strategies for the identified priorities.

Evaluation

Over the next three years, the hospitals will execute the implementation strategies. Plans will focus on execution of programming for identified priority areas, systematic measurement and tracking of program effectiveness, as well as reporting progress and outcomes relative to internal measures and local and national public health goals.

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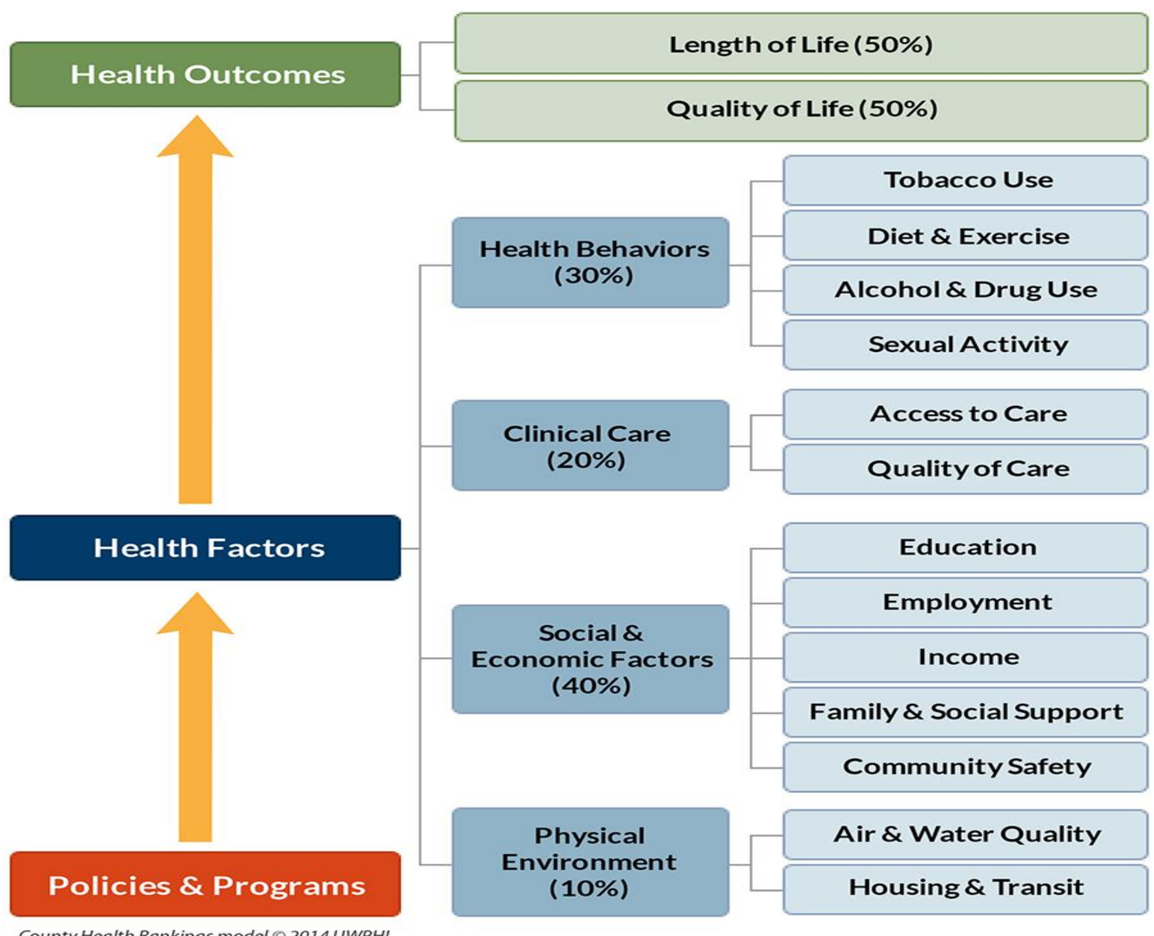
Our Guiding Principles and Framework

At MedStar our mission is to serve our patients, those who care for them, and our communities, with the vision of being a trusted leader in caring for people and advancing health. Our mission and vision is rooted in S.P.I.R.I.T. (Service, Patient First, Integrity, Respect, Innovation and Teamwork). This Community Health Needs Assessment (CHNA) Report is the application and representation of MedStar's S.P.I.R.I.T. These values serve as the guiding principles for our systematic assessment, identification and proposed plan to address community health and improve health among those disproportionally affected by disease as a system.

MedStar used the Robert Wood Johnson Foundation's County Health Rankings Model[1] (below) for understanding what contributes to the health of communities, and to guide the CHNA process. This model acknowledges the interplay between multiple factors contributing to health. The emphasis for the CHNA is on health disparities and social determinants of health—framing MedStar's efforts and leveraging community benefit activities to contribute to improved health outcomes in the communities served.



Systemwide Approach to the Community Health Needs Assessment

MedStar Health hospitals conducted their CHNAs in accordance with a systematic process established by the Corporate Community Health Department (CCHD). The CCHD provided project oversight and technical assistance to each hospital throughout the CHNA process. The scope of the assessment included: determining key stakeholder roles and responsibilities; establishing data collection and data analyses methodologies; determining a Community Benefit Service Area (CBSA) and developing health priorities, implementation strategies and outcome measures.

Key Contributors and Participant Groups

- *Corporate Community Health Department (CCHD)* - Established a CHNA methodology for all hospitals; assisted in identification of strategic partners; provided expertise and technical support as needed; ensured that processes, deliverables and deadlines comply with the IRS mandate.

- *Executive Sponsor* – Served as liaison to the executive leadership team; ensured the hospital's selected priorities are aligned with the strengths of the organization.

- *Hospital Lead* – Served as internal resource on existing community health programs and services; facilitated and documented all activities associated with the assessment; executed the proposed strategies when applicable.

- *Advisory Task Force (ATF)* – Reviewed secondary public health data; designed CHNA survey tool and reviewed findings; recommend the hospital's Community Benefit Service Area, health priorities and associated strategies. Task Force members included grassroots activists, community residents, faith-based leaders, hospital representatives, public health leaders and other stakeholder organizations, such as representatives from local health departments.

- *Hospital Boards* – Reviewed and endorsed the hospital's Community Benefit Service Area health priorities and implementation strategy.

- *Strategic Planning Committee of the MedStar Health Board* - Reviewed and endorsed each hospital's Community Benefit Service Area, health priorities and implementation strategy.

- *MedStar Health Board of Directors*– Approved each hospital's implementation strategy.

- *CHNA Survey Respondents and Community Input Session Participants*—More than 3,000 individuals completed the CHNA survey and contributed to the community input sessions as part of the CHNA process. Diverse groups of community stakeholders—including CBSA residents and organizations, civic and faith-based leaders, public health officials, and government agencies—and hospital leadership were engaged to garner information about the most pressing issues across CBSAs.

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Data Collection, Analysis and Review

Advisory Task Force (ATF) members reviewed and analyzed data to identify and confirm health priorities. In an effort to promote consistency in data collection and analysis among all hospitals, MedStar Health partnered with the Healthy Communities Institute (HCI) and Georgetown University to capture secondary data, and to synthesize and analyze secondary and community input data, respectively. Three primary sources of information were utilized to determine community benefit priority areas and associated planned implementation strategies: 1) secondary data; 2) CHNA survey; and 3) community input sessions. This multi-tiered data capture approach provided a standardized process to derive common themes and identify salient health priorities for each hospital and across the system.

Existing Population-level Data

The HCI provided a dynamic web-based platform that included over 130 Community Health indicators pulled from over 40 reputable sources. The platform allowed Advisory Task Force members to identify the most pressing health priorities in their service areas. Members were also able to identify health disparities based on varying health conditions.

HCI data were available by county or city and some measures were available by census tract. If more localized data were available, the CCHD facilitated efforts to ensure they were accessible to ATF members.

Local and national secondary data from the above sources were compiled, analyzed and synthesized, through a partnership with Georgetown University School of Nursing and Health Sciences to describe disease prevalence, mortality and morbidity rates as well as health disparities and associated social determinants across MedStar's geographic footprint.

Community Health Needs Assessment Data

MedStar Health Corporate Community Health Department (CCHD) took the lead to help each ATF: 1) develop a standardized community needs input survey tool; 2) conduct face-to-face community input sessions; 3) analyze findings and undergo a prioritization process; and 4) develop an approach to deploy a systemwide implementation strategy.

CHNA Survey Data

ATFs, in partnership with CCHD, developed a 24-item standardized CHNA survey that was disseminated to the residents and stakeholders in each hospital's CBSA. The tool included 19 standard questions and each task force was encouraged to add up to five additional questions that allowed respondents to rate their perception of the level of importance around issues related to their personal health and the health of their community with an emphasis on the social determinants of health. Open-ended questions allowed them to offer suggestions on the hospital's role in addressing some of the community's most severe health issues. Respondents had the option to complete the survey in hard copy, by

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phone or online. The survey was also available in Spanish. The majority of respondents completed the survey online.

Community Input Surveys (N=2,892) were completed systemwide. In an effort to capture a snapshot of the respondent population, demographic variables such as age, gender, race/ethnicity and education level were collected.

Community Input Sessions

Face-to-face Community Input sessions (N=5) were conducted and open to residents and stakeholders of the targeted Community Benefit Service Area communities. Facilitated sessions lasted 90 minutes and provided participants an opportunity to discuss solutions to health issues that are impacting the health and well-being of residents. Session framing was within the context of prevention and wellness, access to care and quality of life. The purpose of the session was to: 1) validate, refine or expand existing hospital programs; and 2) inform CBSA community health improvement approaches. The target audience included community residents, key partners, public health experts and other stakeholders. Data from the session were compiled and analyzed by faculty at Georgetown University School of Nursing & Health Sciences.

Local, State and National Health Goals

In addition to secondary and CHNA data, ATF members reviewed city, state and national health goals. For example, Maryland hospital Task Force members reviewed the priorities outlined in Maryland's State Health Improvement Process;[2] Baltimore City Task Force members reviewed Healthy Baltimore 2015;[3] Washington, DC ATFs reviewed DC Healthy People 2020;[4] and all Task Force members reviewed Healthy People 2020[5] targets. Awareness of these targets helped ATF members understand the context of national, state and local health goals as they prioritized health issues.

Common Themes and Prioritization Findings

Aggregate findings from the three key data sources (i.e., secondary, CHNA survey and Community Input sessions) were used to derive community themes and to identify health priorities in two domains: 1) disease/health condition; and 2) social determinants of health. In addition, the above data informed the determination of MedStar's appropriate level of engagement in the identified priority health area strategy execution based on eight factors or criteria:

- Alignment with hospital/system's strengths/priorities/mission
- Magnitude – number of people impacted by problem based on secondary and hospital utilization data
- Severity – the rate or risk or morbidity and mortality
- Existing/new partnership opportunities
- Addresses health-related disparities

- Solution could impact multiple issues
- Availability of evidence based approaches
- Importance of problem to community

The following priorities were ascertained:

Disease Areas of Focus

Chronic Disease Prevention and Management

a. Heart Disease/Stroke
b. Cancer
c. Diabetes
d. Obesity

Social Determinants of Health

e. Housing/homelessness
f. Food Insecurity/Food Access
g. Transportation

Hospital Role in Identified Priority Areas

Hospitals' Advisory Task Forces and leadership determined the appropriate hospital role for the identified priority health areas based on hospital strengths and assessment findings. The following levels of hospital engagement were established:

1) *Focus Areas (Leader Role)* - Areas that MedStar is well-positioned to take a leadership role in the execution of the implementation strategy for a designated priority area.
2) *Collaboration Areas (Partner Role)* - Areas in which MedStar is best positioned to serve as a collaborator or partner, given current community partner and external stakeholder leadership in identified priority area.
3) *Participation Areas (Supporter Role)* - Areas that MedStar recognizes as significant contributors to health, but are beyond the scope of organizational strengths, and therefore, MedStar is best positioned to serve as a supporter for identified priority area.

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Summary of Systemwide Key Findings

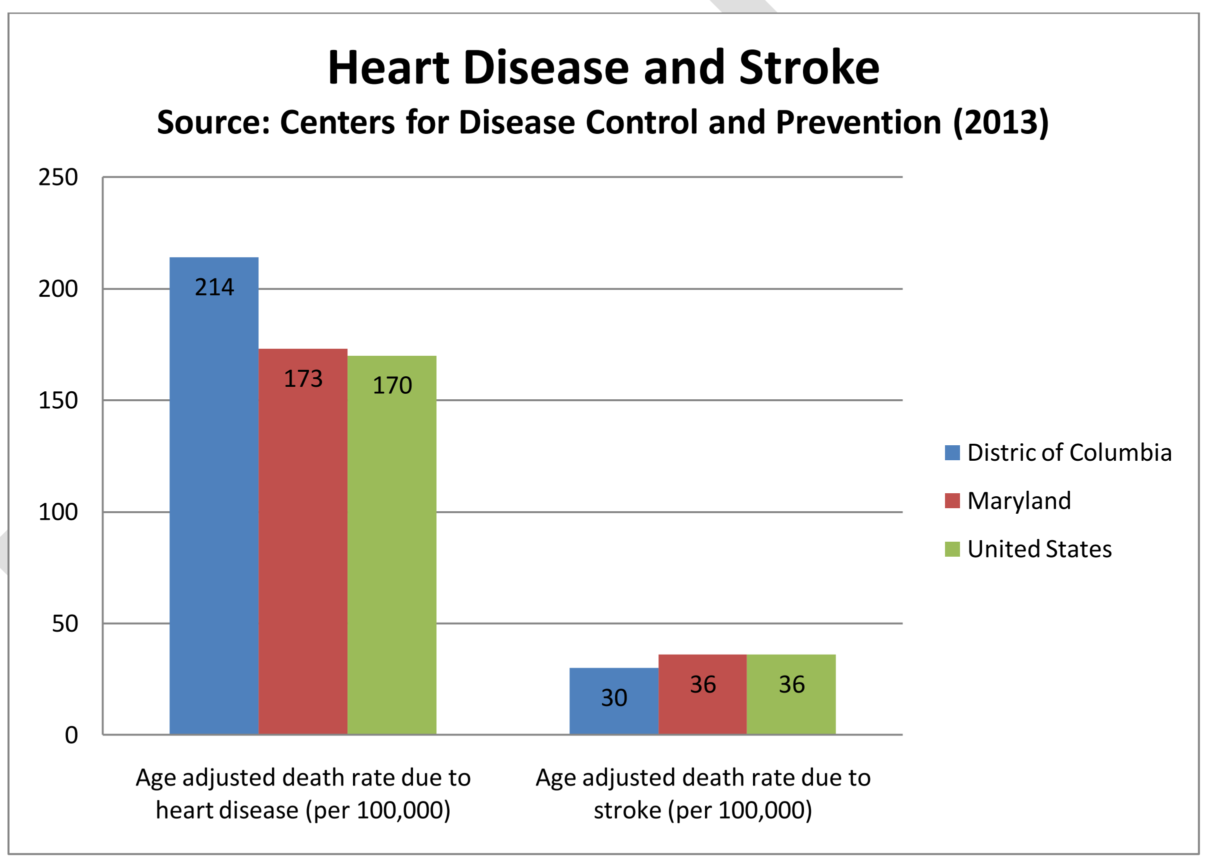
Although CHNAs were specific to each hospital, all hospitals identified chronic disease prevention and management as a key health priority. This area included four specific conditions: heart disease and stroke, cancer, diabetes and obesity.

I. Secondary Data Findings

Key Finding: Elevated chronic disease prevalence with noteworthy disparities across multiple indices across MedStar's Maryland, Baltimore City and District of Columbia service areas.

A. Disease Areas

Heart Disease and Stroke



Heart disease is the leading cause of death in Maryland, the District of Columbia and the United States. Stroke is the third leading cause of death in Maryland, and the fourth leading cause of death in the District of Columbia and the United States, with significantly higher death rates experienced by the District of Columbia compared to Maryland and the U.S. (see graph above).[6] Across age groups, the prevalence of high blood pressure and high cholesterol is highest among adults 65 and older.[7,8]

Baltimore Hospitals

Measure	United States	Maryland	Baltimore City	Baltimore County	Healthy People 2020
Age adjusted death rate due to heart disease (per 100,000)[2,5] ***	170	173	243	172	N/A**
Age adjusted death rate due to stroke (per 100,000)[2,5,6]	**36***	**36***	**48***	**40***	35
% of adults with high blood pressure[7]	**31***	**35***	**35***	**37***	27
% of adults with high cholesterol[7]	**38***	**40***	**33***	**35***	14

**percentage exceeds Healthy People 2020 goal ** decreasing the age-adjusted death rate due to heart disease is a Healthy People 2020 objective, but metrics are not consistent and cannot be compared with the death rates reported by the Maryland jurisdictions. ***Data pulled from Centers for Disease Control and Prevention, 2013 and the Maryland Department of Health and Human Services, 2013.*

- *Baltimore City:* Compared to all Maryland counties, the age-adjusted death rates due to heart disease and stroke fall within the worst quartile. The age-adjusted death rate from heart disease is higher among Blacks/African Americans (257/100,000) compared to Whites (226/100,000).[2] The prevalence of high blood pressure and high cholesterol is higher in females (37% and 35%, respectively) compared to males (32% and 30%, respectively). The prevalence of high blood pressure is higher in Blacks/African Americans (40%) relative to other racial/ethnic groups, whereas the prevalence of high cholesterol is higher for Whites (38%) relative to other racial/ethnic groups.[7]

- *Baltimore County*: The age-adjusted death rates due to heart disease and stroke are lower and higher, respectively, compared to the state average. The age-adjusted death rate due to heart disease is slightly higher for Black/African Americans (181/100,000) compared to Whites (174/100,000), and is much higher compared to Hispanics (55/100,000) and Asians (87/100,000).[2] The prevalence of high blood pressure ranks among the worst quartile of all Maryland counties and is higher in females (38%), Blacks/African Americans (40%) and Whites (38%).The prevalence of high cholesterol is lower relative to the state, and is highest among females (36%) and White residents (39%).[7]

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Washington Area Hospitals

Measure	United States	Maryland	District of Columbia	Montgomery County	Prince George's County	St. Mary's County	Healthy People 2020
Age adjusted death rate due to heart disease (per 100,000)[2,6]***	170	173	214	115	180	188	N/A**
Age adjusted death rate due to stroke (per 100,000)[2,5,6]	**36***	**36***	30	28	**35***	**37***	35
% of adults with high blood pressure[7,8]	**35***	**35***	**28***	**28***	**38***	**30***	27
% of adults with high cholesterol[7,8]	**40***	**40***	**34***	**38***	**37***	**41***	14

**percentage exceeds Healthy People 2020 goal ** decreasing the age-adjusted death rate due to heart disease is a Healthy People 2020 objective, but the metrics are not consistent and cannot be compared with the death rates reported by the Maryland jurisdictions and the District of Columbia. ***Data pulled from Centers for Disease Control and Prevention, 2013 and the Maryland Department of Health and Human Services, 2013.*

- *District of Columbia:* Compared to all US counties, the age-adjusted death rate due to heart disease falls within the range of the worst quartile, and the death rate due to stroke is relatively low.[6] The age-adjusted death due to heart disease is significantly higher for Blacks/African Americans (330/100,000) compared to Whites (117/100,000). The prevalence of high blood pressure and high cholesterol is lower in the District of Columbia than the national average, but higher than the goals set by Healthy People 2020.[4] Males and Black/African American residents are disproportionately affected by high blood pressure (29% and 40%, respectively) and high cholesterol (36% and 38%, respectively).[7] Geographically, the prevalence of high blood pressure is high in Ward 5 (39%), Ward 6 (30%), Ward 7 (42%) and Ward 8 (40%) compared to the citywide average.[4]

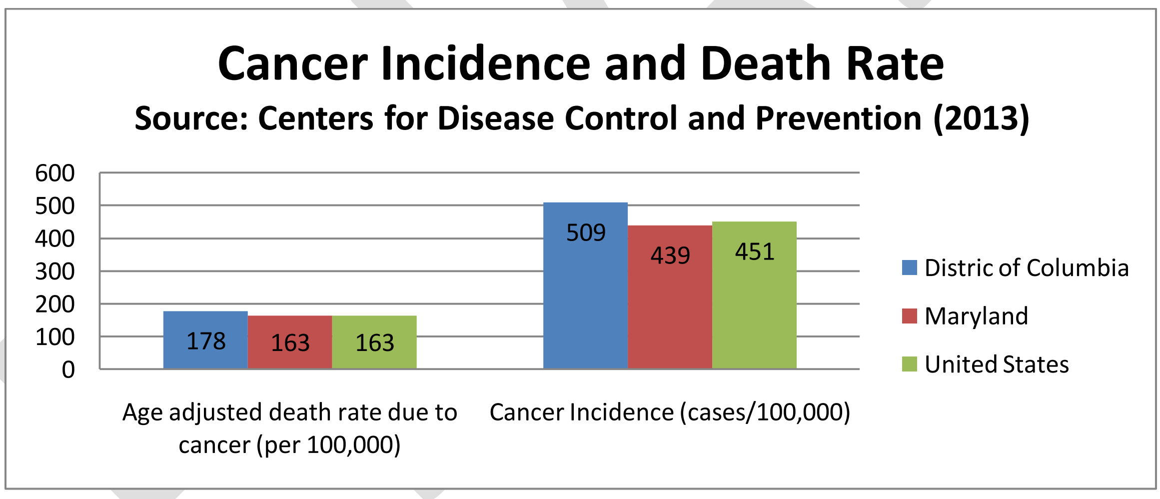
- *Montgomery County:* The age-adjusted death rates due heart disease and stroke are lower than the state averages.[2] The prevalence of high blood pressure and high cholesterol is higher among males than females. Males experience a higher prevalence of high blood pressure (30%) and high cholesterol (42%) compared to females (25% and 35%, respectively).[8] The death rate due to heart disease (133 deaths/100,000 persons)[2] and prevalence of high blood pressure (33%) are higher for Blacks/African Americans compared to the county average.[8] Across racial/ethnic groups, the prevalence of high cholesterol is highest among Whites (42%).[8]

- *Prince George's County:* The age-adjusted death rate due to heart disease is higher than the state death rate, and the age-adjusted death rate due to stroke is

slightly lower than the state death rate. The death rate due to heart disease is comparable for Blacks/African Americans (202/100,000 persons) and Whites (199/100,000 persons).[2] Across gender groups, the prevalence of high blood pressure (39%) and high cholesterol (42%) is highest in males. The prevalence of high blood pressure and high cholesterol is highest among Blacks/African Americans (43%) and Hispanics (55%), respectively, across racial/ethnic groups.[7]

- *St. Mary's County:* Compared to all Maryland counties, the age-adjusted death rate due to heart disease falls within the range of the worst quartile. The age-adjusted death rate due to heart disease is highest for Whites (205/100,000).[2] The age-adjusted death rate due to stroke has decreased (from 44/100,000 persons in 2008 to 37/100,000 in 2013) and is comparable to the state average. High blood pressure is more prevalent among females (38% vs. 25%), whereas high cholesterol is more prevalent among males (44% vs. 37%). Whites have a higher prevalence of high blood pressure (33%) and high cholesterol (44%) compared to the countywide average.[7]

Cancer



Cancer is the second leading cause of death in Maryland, the District of Columbia and the United States, with similar death rates in those areas, as presented in the graph above.[6] Across MedStar's geographic service area, the age-adjusted death rate due to cancer and prostate cancer has decreased in recent years, with the exception of the stable death rates experienced in Baltimore City. In addition, lung cancer and colorectal (excluding Baltimore City) mortality rates have decreased across MedStar's geographic footprint. Breast cancer mortality has remained stable, with the exception of Montgomery County, where mortality has declined. The incidence rates of colorectal and lung cancer have modestly declined systemwide, whereas the incidence rate of breast cancer has modestly increased. The overall death rate due to cancer and the incidence rates of colorectal and lung cancer are higher for males than females. The death rate due to breast, colorectal and prostate cancer and the incidence rate of prostate cancer is higher among Blacks/African Americans relative to other racial/ethnic groups.[7,8]

Baltimore Hospitals

Measure	United States	Maryland	Baltimore City	Baltimore County	Healthy People 2020
Age-adjusted death rate due to cancer[2,5,6] (deaths/100,000)**	**163***	**163***	**212***	**168***	161

**death rate exceeds Healthy People 2020 goal ** Data pulled from Centers for Disease Control and Prevention, 2013 and the Maryland Department of Health and Human Services, 2013.*

- *Baltimore City:* The age-adjusted death rate due to cancer in Baltimore City is significantly higher than the state average.[2] The overall death rate due to cancer is higher for Blacks/African Americans, relative to other racial/ethnic groups. Additionally, the incidence of breast, colon and oral cancer is highest among Whites and the incidence of colorectal cancer is highest among Blacks/African Americans.[7]

- *Baltimore County:* The age-adjusted death rate due to cancer is slightly higher than the state average.[2] The overall death rate due to cancer is higher for Blacks/African Americans, and this disparity persists for lung cancer mortality. Across racial/ethnic groups, the incidence of lung and oral cancer is highest among Whites, and the incidence of breast cancer is lowest among Hispanic women. The incidence of colorectal cancer is highest among Black/African American and Hispanic residents.[7]

Washington Area Hospitals

Measure	United States	Maryland	District of Columbia	Montgomery County	Prince George's County	St. Mary's County	Healthy People 2020
Age-adjusted death rate due to cancer [2,5,6] (deaths/100,000)**	**163***	**163***	**178***	125	158	**188***	161

**death rate exceeds Healthy People 2020 goal ** Data pulled from Centers for Disease Control and Prevention, 2013 and the Maryland Department of Health and Human Services, 2013.*

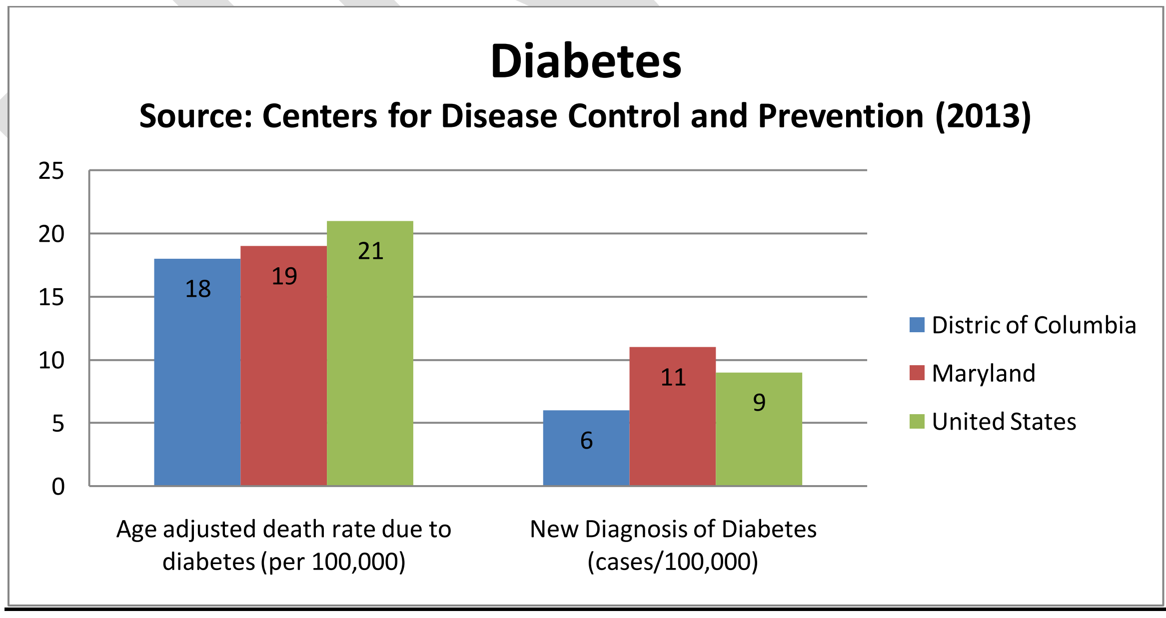
- *District of Columbia:* In the District of Columbia, the incidence rate and age-adjusted death rate due to cancer is higher than the national rate. The age-adjusted death rate due to breast and prostate cancer and the incidence of breast, cervical and prostate cancer all fall within the range of the worst quartile nationally. The age-adjusted death rate due to cancer overall and lung cancer is higher for Blacks/African Americans compared to Whites. Across racial/ethnic groups, the incidence of colorectal, lung and oral cancer is highest among Blacks/African Americans, whereas breast cancer incidence is highest among Whites and cervical cancer incidence is highest among Hispanics. [7]

- *Montgomery County:* Cancer is the leading cause of death in Montgomery County, but the age-adjusted death rate due to cancer is much lower than the state average and the goal set by Healthy People 2020.[2] The age-adjusted death rates due to cancer overall and lung cancer are higher for Blacks/African Americans compared to Whites. Hispanics and Asians have consistently lower age-adjusted death rates due to cancer overall. Across racial/ethnic groups, the incidence rates of breast and colorectal cancer are higher among Whites, whereas lung cancer incidence is highest among Blacks/African Americans and cervical cancer incidence is highest among Hispanics. [7]

- *Prince George's County:* While the age-adjusted death rate due to cancer is lower in Prince George's County compared to the state, and the death rates due to breast cancer and prostate cancer are among the highest in the state.[2] The age-adjusted death rates due to cancer overall and for lung cancer are higher among Whites compared to other racial/ethnic groups. Across racial/ethnic groups, the incidence rates of breast and colorectal cancer are highest for Black/African American residents, and the incidence rates of cervical, lung and oral cancer are highest for Whites.[7]

- *St. Mary's County:* The age-adjusted death rate due to cancer is higher in St. Mary's County compared to the state;[2] Whites have higher death rates due to cancer overall and lung cancer relative to other racial/ethnic groups. Across racial/ethnic groups, Whites experience higher colorectal cancer incidence and no disparities are observed for breast and lung cancer incidence.[7]

Diabetes



Diabetes is the sixth leading cause of death in Maryland and the District of Columbia, and the seventh leading cause of death in the United States.[6] Because diabetes has a deleterious effect on most organ systems, including the kidneys and circulatory system,

diabetes is likely underreported as a cause of death.[6] Across age groups, the prevalence of diabetes is highest among adults 65 and older.[7,8]

Baltimore Hospitals

Measure	United States	Maryland	Baltimore City	Baltimore County
Age-adjusted death rate due to diabetes[2,6] (deaths/100,000)**	21	19	**30***	18
% of adults with diabetes[7]	9.7	9.8	**10.8***	**10.2***

**death rate/percentage higher than the national average ** Data pulled from Centers for Disease Control and Prevention, 2013 and the Maryland Department of Health and Human Services, 2013.*

- *Baltimore City:* The age-adjusted death rate due to diabetes is the highest in the state.[2] The prevalence among females (14%) is high relative to males (8%), and is more than twice as high among Blacks/African Americans (13%) compared to Whites (5%).[7]

- *Baltimore County:* Virtually no disparity in prevalence is observed across gender groups. The prevalence of diabetes among Blacks/African Americans (10%) and Whites (10%) is higher than the prevalence among Hispanics (2%) and Asians (8%). [7]

Washington Area Hospitals

Measure	United States	Maryland	District of Columbia	Montgomery County	Prince George's County	St. Mary's County
Age-adjusted death rate due to diabetes[2,6] (deaths/100,000) **	21	19	18	14	**27***	20
% of adults with diabetes[7,8]	9.7	9.8	**7.8**	**8.6**	**12.0**	**13.5**

**death rate/percentage higher than the national average ** Data pulled from Centers for Disease Control and Prevention, 2013 and the Maryland Department of Health and Human Services, 2013.*

- *District of Columbia:* The age-adjusted death rate due to diabetes is lower than the national average,[6] however is significantly higher for Blacks/African Americans (33/100,000) compared to Whites (6/100,000).[4] The prevalence of diabetes is slightly higher among females (9%) relative to males (7%), and is more than six times higher among Blacks/African Americans (13%) than among Whites (2%).[7]

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- *Montgomery County:* Compared to the state average, the age-adjusted death rates due to diabetes[2] and prevalence of diabetes are low in Montgomery County.[8] Virtually no disparity exists across gender groups, and the prevalence is higher among Blacks/African Americans (11%) and Hispanics (11%) compared to other racial/ethnic groups. [8]
- *Prince George's County:* The age-adjusted death rate due to diabetes (27/100,000) is among the highest in the state.[2] Virtually no disparity exists across gender groups, and the prevalence of diabetes is lower among Whites (9%) compared to other racial/ethnic groups.[7]
- *St. Mary's County:* The prevalence of diabetes falls within the range of the worst quartile in Maryland. Males (13%) and Whites (13%) experience a slightly lower prevalence of diabetes compared to the countywide average.[7]

Obesity

Obesity, a medical condition, increases the risk for several other health conditions including type 2 diabetes, coronary heart disease, stroke and cancer (breast, colon, etc). Behind smoking, obesity is the second leading cause of preventable deaths nationwide.[6] Obesity prevalence rates are 30.6%, 22.9%, 29.4% in Maryland, the District of Columbia and the United States, respectively. Across age groups, the prevalence of obesity is highest among adults between the ages of 45 and 64.[7,8]

Baltimore Hospitals

Measure	United States	Maryland	Baltimore City	Baltimore County	Healthy People 2020
% of adults who are obese[7] **	29.4	30.6	**35.8***	26.5	30.5

**percentage exceeds Healthy People 2020 goal **Data pulled from MedStar Community Dashboard*

- *Baltimore City:* The prevalence of obesity in the city is among the highest in the state. The prevalence is highest among females (44%) compared to males (26%), and Blacks/African Americans (45%) compared to other racial/ethnic groups.[7]
- *Baltimore County:* The overall prevalence of obesity is lower than the goal set by Healthy People 2020, but is high among Blacks/African Americans (35%). No disparities exist across gender groups. [7]

Washington Area Hospitals

Measure	United States	Maryland	District of Columbia	Montgomery County	Prince George's County	St. Mary's County	Healthy People 2020
% of adults who are obese[7,8] **	29.4	30.6	22.9	17.9	**34.5***	**32.9***	30.5

**percentage exceeds Healthy People 2020 goal **Data pulled from MedStar Community Dashboard*

- *District of Columbia:* The overall prevalence of obesity is lower than the goal set by Healthy People 2020. The prevalence of obesity is significantly higher among females (25%) and Black/African American residents (36%).[7]
- *Montgomery County:* While the countywide obesity prevalence is low, the prevalence of obesity is slightly higher among males (19%) compared to females, and is significantly higher among Blacks/African Americans (27%) compared to Hispanics (19%) or Whites (18%). [7]
- *Prince George's County:* The prevalence of obesity overall is high, and is lower among females (33%) and Whites (29%) compared to countywide average.[7]
- *St. Mary's:* The prevalence of obesity is higher than the state average, and is higher among Black/African American residents (39%) and Hispanics (47%) compared to Whites (32%).[7]

B. Key Social Determinants of Health

While an individual's genes, biology and health behaviors surely contribute to health status, it is estimated that these factors only account for 30% of population health. The remaining factors, collectively known as the social determinants, account for 70% of population health and include the medical care, social characteristics and total ecology describing a population. Addressing social determinants is necessary for achieving improved health outcomes and health equity.[6]

Healthcare Utilization and Access

The health services and medical care available and utilized by an individual can impact their life expectancy, health outcomes and quality of life. The lack of availability, lack of health insurance and high cost of health care all contribute to the negative effect of poor access, including unmet health needs, delay of care, inability to get preventive services and preventable hospitalizations.[5]

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Baltimore Hospitals

Measure	United States	Maryland	Baltimore City	Baltimore County
% of adults with health insurance[7]	82	86	85	86
% of children with health insurance[7]	95	96	96	**94***
% of adults who have had a routine checkup[7,9]	**	88	87	88
% of adults unable to afford to see a doctor[7,9]	16	11	**18***	11

** Worse outcome relative to the national average ** 2013 value is unavailable for the United States*

- *Baltimore City:* Insurance coverage is higher in Baltimore City than the national average. Female adults (88%) are insured at higher levels than male adults (82%), while Asian children (91%) and Hispanic adults (64%) are the least likely racial/ethnic groups to be insured among children and adults. Despite high availability and high insurance coverage rates, accessing medical care is still a challenge for Baltimore City residents. Adults under the age 65, males and Hispanic residents report the inability to afford a doctor at higher rates. Adults younger than 45 (82%), males (77%) and Hispanics (77%) are the least likely to report a routine medical checkup in the last two years.[7] Additionally, 20% of insured Black/African American residents and 26% of insured residents earning less than $15,000 report having unmet medical needs.[3]

- *Baltimore County:* Insurance coverage among adults is higher in Baltimore County compared to the nation, but the proportion of children with health insurance is lower than the state and national averages. Females (88%) are insured at slightly higher levels than males (85%), while Hispanic residents, particularly adults (63%) are the least likely racial/ethnic group to be insured. Adults under the age 65 and Hispanic residents report higher rates of inability to afford a doctor. Adults younger than 45 (82%), males (84%) and Hispanics (69%) are the least likely to report a routine medical checkup in the last two years.[7]

Washington Area Hospitals

Measure	United States	Maryland	District of Columbia	Montgomery County	Prince George's County	St. Mary's County
% of adults with health insurance[7,8]	82	86	91	87	**79***	88
% of children with health insurance[7,8]	95	96	98	96	95	97

% of adults who have had a routine checkup[7,8,9]	**	88	**	86	87	87
% of adults unable to afford to see a doctor[7,8,9]	16	11	11	10	16	10

** Worse outcome relative to the national average **2013 values are unavailable for the United States and the District of Columbia*

- *District of Columbia:* Despite high availability and high insurance coverage rates, gaps persist between coverage and connection to care among adults. More than 83% of adults self-report having a personal doctor or health-care provider, but younger and lower-income adults are the least likely to be connected to primary care. Furthermore, 77% of adults self-report having a routine check-up within the past year; Black/African American adults and adults with less than a high school education are most likely to report a wellness check in the past year.[4]

- *Montgomery County:* Females (88%) are insured at slightly higher levels than males (86%), while adults between the ages of 18 and 34 (78%) are the least likely to have insurance. Adults younger than 65, females, Black/African American and Hispanic residents report being unable to afford a doctor at higher proportions than 10%. Only 86% of adults had a routine health check-up in the last two years; adults younger than 45 (81%), males (83%), Asian (80%) and Hispanic residents (78%) were the least likely to report a wellness check in the last two years.[8]

- *Prince George's County:* Prince George's County has relatively low health insurance coverage, with 79% of adults and 95% of children insured. Females (83%) are insured at higher levels than males (74%), while Hispanic residents, particularly adults (44%), are the least likely racial/ethnic group to be insured. Nearly 16% of adults were unable to afford to see a doctor in the last 12 months; adults under the age of 45, females and Hispanic residents report being unable to afford a doctor at higher rates than 16%. Adults younger than 45 (81%), males (85%) and Asians (68%) are the least likely to report a routine medical checkup in the last two years.[7]

- *St. Mary's County:* St. Mary's has high health insurance coverage, but a shortage of primary care providers, dentists and mental health providers.[1] Adults younger than 45, females and Hispanic residents report being unable to afford a doctor at higher proportions than 10%. Adults younger than 45 (82%), males (84%) and Asians (54%) are the least likely to report a routine medical checkup in the last two years.[7]

Social and Physical Environment Factors

The social and physical environments in which individuals reside have significant effects on the development and progression of health outcomes. Societal and physical characteristics can directly affect health outcomes and can affect individual behaviors.[5]

- Educational attainment is positively correlated with future earning potential, life expectancy and reduced incidence of illnesses.[1]
- Low-income individuals are more likely to experience negative health outcomes, are less likely to practice health promoting behaviors and have lower life expectancy; additionally, low-income individuals are more likely to experience poor access to transportation and to healthy foods.[1]
- Cost of housing can determine housing factors, including the physical safety within the home and characteristics of the neighborhood surrounding the home, which can directly and indirectly contribute to health. Housing affordability also affects the overall ability for families to make other healthy choices.[1]
- Access to food, is associated with chronic diseases in adults, such as obesity, heart disease, diabetes and depression. Specifically food insecurity which is the lack of resources to obtain safe and nutritious foods to support a healthy lifestyle. [2]

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Social Factors

Baltimore Hospitals

Measure	United States	Maryland	Baltimore City	Baltimore County
% of high school students graduating in 4 years[11,12]	80	86	**70***	88
% of adults with a high school diploma or higher[10]	86	89	**81***	90
% of adults with a bachelor's or more advanced degree[10]	29	37	**28***	36
% of unemployed adults[10]	5.2	**5.5***	**8.2***	**5.4***
Median Household Income[10]	$52,176	$72,345	**$40,798***	$64,700
% of persons living in poverty[10]	16	10	**25***	10
% of households with children receiving public assistance or SNAP benefits[10]	29	23	**55***	23

** Worse outcome relative to the national average*

- *Baltimore City:* Educational attainment in Baltimore City is low compared to the state of Maryland and Baltimore residents experience poor economic outcomes relative to residents in other Maryland jurisdictions.[10,11] The unemployment rate is improving across the city, but is higher than the state average, and is significantly higher for Black/African American residents. [10]
- *Baltimore County:* Educational attainment in Baltimore County is comparable to the state of Maryland.[10,11] Baltimore County residents experience average to slightly

better than average economic outcomes relative to residents in other Maryland jurisdictions.[10]

Washington Area Hospitals

Measure	United States	Maryland	District of Columbia	Montgomery County	Prince George's County	St. Mary's County
% of high school students graduating in 4 years[11,12]	80	86	**59***	92	**77***	93
% of adults with a high school diploma or higher [10]	86	89	89	91	**85***	90
% of adults with a bachelor's or more advanced degree[10]	29	37	54	57	30	30
% of unemployed adults[10]	5.2	**5.5***	**7.7***	4.1	**5.4***	4.7
Median Household Income[10]	$52,176	$72,345	$66,950	$97,181	$72,098	$85,174
% of persons living in poverty[10]	16	10	**19***	7	10	7
% of households with children receiving public assistance or SNAP benefits[10]	29	23	**41***	14	24	19

** Worse outcome relative to the national average*

- *District of Columbia:* Compared to the national average, educational attainment among adults is high in the District of Columbia.[10] However, only 59% of city youth earn a high school diploma in four years, much lower than the national average overall and the average for Black/African American students nationwide (69%).[12] While the median household income is considerably higher than national average, the poverty rate is higher than the national rate and a higher proportion of families receive public assistance because of economic hardship.[10]

- *Montgomery County:* Educational attainment in Montgomery County among adults is high compared to the national and state average.[10] The overall graduation rate for the county is high, but is much lower for American Indians/Native Alaskans and Hispanics compared to other racial and ethnic groups.[11] The estimated unemployment rate is lower than the state average, but is higher for Black/African American residents than it is for White residents.[10]

- *Prince George's County:* Compared the national average, a smaller proportion of adults in Prince George's County have earned a high school diploma or higher degree.[10] The four-year graduation rate in Prince George's County has not improved over the last five years, and is still below the state average, particularly for male and Hispanic students.[11]

- *St. Mary's County:* Adults in St. Mary's County are less likely to have a bachelor's or more advanced degree compared to the state average[1], but the four-year high

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school graduation rate in the county is very high.[11] St. Mary's County residents experience better economic outcomes relative to residents in other Maryland counties (i.e., Montgomery, Prince George's, specifically).

Physical Environment

Measure	United States	Maryland	Baltimore City	Baltimore County
% of owner-occupied housing[10]	64	67	**47***	66
% of renters spending 30% or more on rent[10]	52	52	**56***	51
%of households experiencing food insecurity[7]	14	13	**23***	12
%of households with children experiencing food insecurity[7]	23	19	23	18

** Worse outcome relative to the national average*

Measure	United States	Maryland	District of Columbia	Montgomery County	Prince George's County	St. Mary's County
% of owner-occupied housing[10]	64	67	**43***	66	**62***	75
% of renters spending 30% or more on rent[10]	52	52	49	51	**53***	43
%of households experiencing food insecurity[7,8]	14	13	14	8	**15***	9
%of households with children experiencing food insecurity[7,8]	23	19	**28***	16	13	19

** Worse outcome relative to the national average*

II. Community Health Needs Assessment Survey Findings:

Surveys (N=2892) were completed as part of the CHNA process. In general, more women than men responded to the survey and one-half of respondents were over the age of 40. Fifty-six percent of respondents were White and 31% were Black/African American. Over 200 of respondents (7%) reported having less than a high school diploma and 21% reported having only a high school diploma/GED. Additionally, nearly a quarter (23%) reported an annual household income less than $25,000. Questions about the respondent's perception of community health and community need were also assessed. Systemwide, 38% of respondents reported the need for affordable housing; 30% reported the need for affordable, healthy food options; 19% reported the need for better public transportation; and 19% of respondents reported the need for better access to health services.

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III. Community Input Session Findings

Five community input sessions were conducted with community stakeholders to garner information about the most pressing issues across three domains: 1) wellness and prevention; 2) access to care; and 3) quality of life. The following opportunities were consistently identified across the system:

1) **Wellness and Prevention:** Respondents expressed an ongoing need for programs and services that address heart disease, overweight/obesity, diabetes, cancer and behavioral health services. Efforts to increase awareness of existing wellness and prevention services were also suggested. Often times in the sessions the respondents discussed the need for nutrition classes.
2) **Access to Care:** Respondents recommended that providers bring health services directly into the communities that need them most. Increasing the accessibility of specialty care providers for the underinsured and uninsured was routinely identified. Enhanced access to convenient and affordable transportation for medical visits and health literacy were consistently stated as high priority areas.
3) **Quality of Life:** Respondents suggested comprehensive efforts to improve the quality and safety of neighborhoods to promote physical activity and healthy living. Increasing access to affordable healthy foods was also identified as a need.

Community Benefit Service Areas and Priorities

Community Benefit Service Areas

Each hospital's Advisory Task Force (ATF) identified a Community Benefit Service Area (CBSA) – which is defined as a geographic or target population that will serve as the hospital's priority for - community benefit programming over a three-year cycle. CBSAs were identified based on the following key considerations: 1) elevated disease incidence and prevalence; 2) a high density of residents who are low-income or underserved and evidenced health disparities; 3) the CBSA's proximity to the hospital; and/or 4) an existing presence of effective programs and partnerships.

The CBSA will benefit from an increased or expanded presence of community health services sponsored by the hospital and supported by its partners. Potential best practices will be piloted in the CBSA and existing evidence-based programs will be replicated in other CBSAs across the system. Services in the CBSA will include formal and more extensive data collection and tracking of outcomes to demonstrate a change in knowledge, skill and behavior or health outcomes of persons impacted. Demographic variables such as age, gender, race/ethnicity and language will also be collected. Findings will support efforts to continuously improve services and programs implemented, and ultimately contribute to local and national health disparity goals.

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Common Community Benefit Focus Areas

Chronic disease prevention and management was the most common priority area identified through the CHNA process. Within this area, the most common disease conditions identified were: 1) heart disease/stroke; 2) cancer: 3) diabetes; and 4) obesity across MedStar hospitals, with the exception of MedStar National Rehabilitation Network, which identified access to physical activity programs for those with disabilities as their main area of focus. Additionally, access of care/services was a common theme across disease conditions.

Other Key Community Benefit Focus Areas

Secondary, CHNA survey, hospital utilization, and Community Input session data, coupled with existing partnerships and hospitals' strengths allowed some hospitals to identify additional key priorities. For example, MedStar St. Mary's Hospital selected substance abuse and behavioral health based on analyzed data and alignment with pre-determined county priorities. MedStar Franklin Square Medical Center selected birth outcomes due to an existing, long-standing partnership with the Southeastern Network Collaborative and the Baltimore County Department of Health.

Collaboration Areas

Each hospital's ATF identified Collaboration Areas, which are defined as other health-related areas that each hospital will serve as a partner with outside entities, and will leverage both internal leadership across the MedStar system and the expertise of key external groups or organizations to maximize implementation strategy execution. Examples of collaboration areas include behavioral health and food insecurity/access.

Participation Areas

Each hospital's ATF identified Participation Areas, which are defined as areas that MedStar recognizes are related to health status, behaviors and outcomes, but the hospital is not positioned to take a leadership role. MedStar will serve as a supporter of ongoing local efforts in selected areas such as housing and transportation.

Services Provided Outside of the CBSA

MedStar hospitals have a history of contributing to the health of the region by providing services outside of their CBSAs. These programs and services address health awareness and education, prevention, early detection and management of diseases. Hospitals will continue to maintain a presence in these areas; however, the CBSA will serve as the population of focus. Activities within the CBSA will be systematically evaluated and refocused, if needed, based on rigorous outcomes tracking. In addition, promising practices will be piloted and evaluated for scalability and systemwide implementation during the three-year cycle.

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Overview of Individual Hospital Community Benefit Service Areas and Health Priorities

Washington Hospitals

	MedStar Georgetown University Hospital	MedStar Montgomery Medical Center	MedStar Southern Maryland Hospital Center	MedStar National Rehabilitation Network	MedStar St. Mary's Hospital	MedStar Washington Hospital Center
Community Benefit Focus Areas						
Chronic Disease Prevention & Management (heart disease/stroke, cancer, diabetes, and obesity)	X	X	X		X	X
Substance Abuse					X	
Access to Pediatric Care	X					
Behavioral Health					X	
Food Insecurity and Child Obesity	X					
Access to Care					X	
Access to Physical Activity				X		
Teen Births and Child Development						X
Community Benefit Collaboration Areas						
Transportation		X			X	
Affordable Healthy Food Options		X	X			
Food Insecurity	X					X
Teen Birth Rate					X	
Aging						X
Better Place to Exercise			X			

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	MedStar Georgetown University Hospital	MedStar Montgomery Medical Center	MedStar Southern Maryland Hospital Center	MedStar National Rehabilitation Network	MedStar St. Mary's Hospital	MedStar Washington Hospital Center
Community Benefit Collaboration Areas, cont.						
HIV/AIDS						X
Access to Transitional Housing for homeless residents					X	
Reading and Math Literacy						X
Access to a Mobile Crisis Team					X	
Community Benefit Participation Areas						
Affordable Housing	X	X	X		X	X
Transportation			X	X		
Affordable Child Care		X			X	
Better Jobs		X			X	
Fast Food Restaurant Density						X
Inadequate Caregiver Support				X		
Safety						X
HIV/AIDS			X			
Pollution						X
Better Schools			X			
Community Benefit Service Area	Wards 5, 6, 7 and 8	Aspen Hill/ Bel Pre	Prince Georges County, with emphasis on Clinton	Persons with disabilities, District of Columbia	St. Mary's County, with emphasis on Lexington Park	Wards 5, 7 and 8

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Overview of Individual Hospital Community Benefit Service Areas and Health Priorities

Baltimore Hospitals

	MedStar Franklin Square Medical Center	**MedStar Good Samaritan Hospital**	**MedStar Harbor Hospital**	**MedStar Union Memorial Hospital**
Community Benefit Focus Areas				
Chronic Disease Prevention & Management (heart disease/stroke, cancer, diabetes, and obesity)	X	X	X	X
Access to Care				X
Access to Mainstream Resources	X			
Children and Family Wellness			X	
Birth Outcomes	X			
Community Benefit Collaboration Areas				
Mental/Behavioral Health	X	X	X	X
Alcohol and Drug Addiction		X		X
Children and Adolescent Health		X		X
Tobacco Use/Cessation	X			
Better Place to Exercise			X	
Asthma Management in Schools	X			
Affordable Healthy Food Options			X	
Better Jobs			X	
Community Benefit Participation Areas				
Affordable Housing	X	X	X	X
Density of Liquor Stores, Tobacco Retail, Fast Food, Carryout and Corner Stores		X		X
Alcohol Addiction			X	
Transportation	X			
Heroine/Opiod Addiction			X	
Affordable Child Care			X	
Community Benefit Service Area	Southeast Baltimore County	Greater Govans	Cherry Hill	North Central Baltimore City

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Implementation Strategy Approach

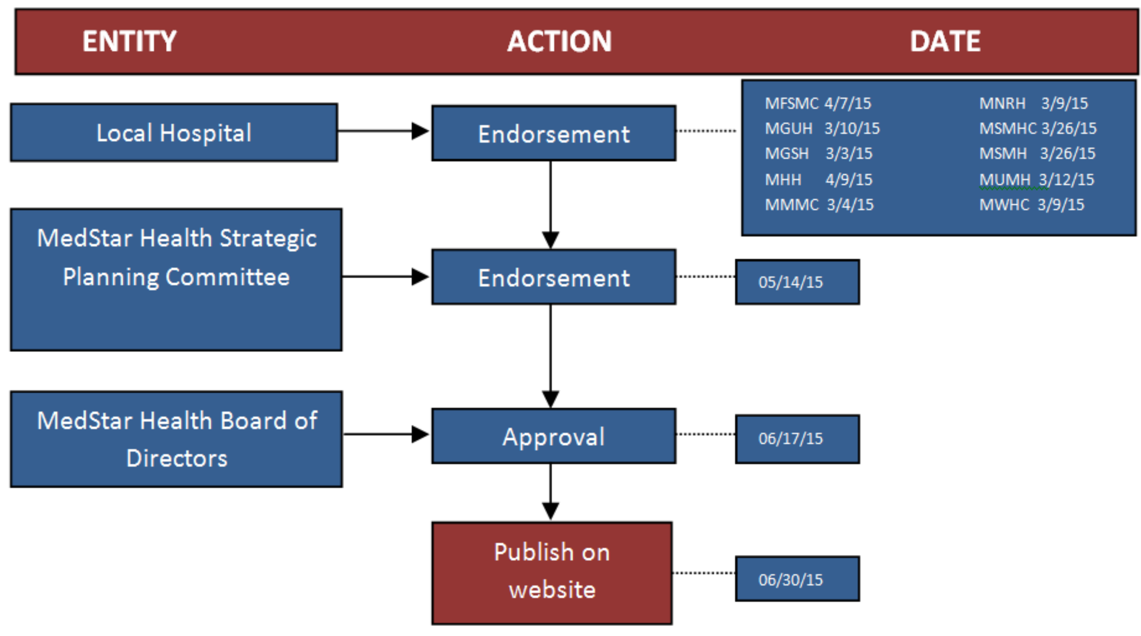
The Implementation Strategy serves as a roadmap for how community benefit resources will address the identified health priorities and contribute to the health of the communities served. In an effort to improve outcomes and measure progress over time, the activities proposed are limited and focused. The programming component of the Implementation Strategy is based on:

- Refining or expanding existing programs and services that are aligned with health priorities.
- Focusing on the expansion of services directly into communities of need.
- Developing common programming to support chronic disease prevention and management (heart disease/stroke, cancer, diabetes and obesity), the system priority.
- Leveraging expertise throughout the system.
- Including specific short- and long-term measurable outcomes.
- Identifying and testing promising practices for replication throughout the system.
- Sharing and using existing human and operating resources to support priorities.

The implementation strategies in this CHNA report will undergo extensive evaluation throughout the three-year cycle. Process evaluations will support continuous quality improvement efforts to enhance how the activity is delivered and outcome evaluations will assess for a change in knowledge, behavior or health outcomes among persons impacted. In an effort to support local and national health disparity goals, mechanisms for more robust demographic data collection will be established. Examples include, but are not limited to: age, gender, race/ethnicity, education and income.

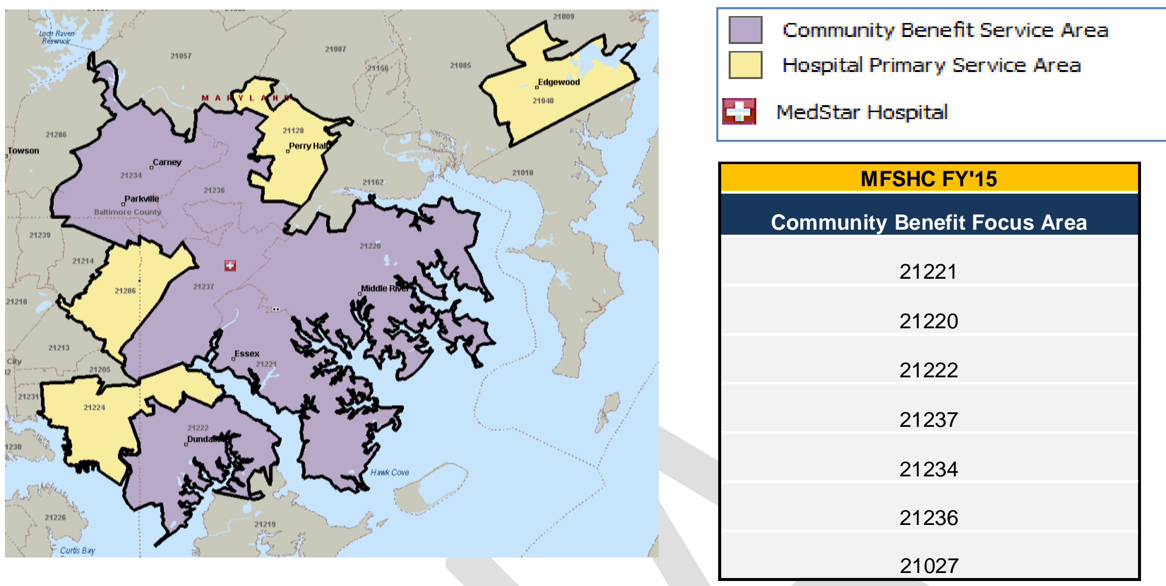
Each hospital's Implementation Strategy was written by the Hospital Lead and supported by the Executive Sponsor. The strategy was endorsed by the hospital's Board of Directors and the MedStar Health Board of Directors' Strategic Planning Committee, and approved by the MedStar Health Board of Directors.

IMPLEMENTATION STRATEGY ENDORSEMENT AND APPROVAL PROCESS



MedStar Franklin Square Medical Center

Community Health Assessment FY2015



MFSHC FY'15
Community Benefit Focus Area
21221
21220
21222
21237
21234
21236
21027

* Primary Service Area – represents ZIP codes that contain 50% of inpatient discharges
*Community Benefit Service Area is also included in the primary service area

1. **Define the hospital's Community Benefit Service Area (CBSA) and identify the hospital's community benefit priorities.**

   MedStar Franklin Square Medical Center's (MFSMC) Community Benefit Service Area (CBSA) includes residents in ZIP codes 21027, 21220, 21221, 21222, 21234, 21236 and 21237. This region was selected due to the hospital's pre-existing partnership with the Baltimore County Southeast Area Network – a volunteer community organization that monitors and works to improve the health of residents in the southeastern portion of Baltimore County. Based on secondary, CHNA survey, hospital utilization and community input session findings, MFSMC hospital's community benefit priorities have been identified as: 1) chronic diseases, specifically targeting heart disease, 2) support of healthy birth outcomes, and 3) access to mainstream resources for Medicaid and self-pay patients.

2. **Provide a description of the CBSA.**

   The total population of the seven ZIP codes that make up the hospital's CBSA is 307,023. The majority of the population is White (72%), followed by Black/African American (20%), Asian/Pacific Islander (3.9%), other (1.8%), and American Indian/Alaskan Native (0.2%). The median age is 38.8 years. The weighted average annual household income in Southeast Baltimore County is $57,741, as compared to $66,486 in Baltimore County as a whole.[13]

   ZIP code 21221 will serve as the CBSA for birth outcomes. The primary target population

within 21221 is characterized by 72% of women who gave birth in the past 12 months being eligible for Medicaid according to Maryland eligibility requirements (U.S. Census, ACS, 2012; CMS).The estimated percentage of all people whose income in the past 12 months was below the poverty level was 11.0% compared to 8.2% for Baltimore County (2007-2011 American Community Survey). Of this population that is below the poverty level, 52% of women who had a birth in the past 12 months are eligible for Medicaid, resulting in the demonstration of an underserved population.[10,14]

3. **Identify community health assessment program partners and their expertise or contribution to the process.**

Georgetown University's School of Nursing & Health Studies is an academic partner that brings a wide range of resources that contributed to MedStar Health's systemwide CHNA process. Their expertise in CHNAs and population health management has strengthened the rigor of data collection and data analysis methodologies. The school provided the following support: 1) consultation and support for the CHNA survey and secondary data collection and analysis; 2) supported the development and validation of a community input instrument and summarized findings; 3) contributed to and promoted community input sessions; 4) reviewed drafts of the CHNAs prior to publication; and 5) managed student involvement and participation.

The **Healthy Communities Institute** provided quantitative data based on over 130 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

4. **State who was involved in the decision-making process.**

MFSMC's ATF reviewed local secondary data, coupled with state and federal community health goals. Task Force members also reviewed the hospital's operating plan, the outcomes of prior informal community health assessments, as well as current community benefit programs and services. In partnership with Georgetown University's School of Nursing & Health Studies, the team developed and helped disseminate a community health assessment tool around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life.

In addition to secondary data, CHNA survey and community input session findings, the Task Force considered the hospital's capabilities as well as local, regional and state health goals. Based on findings, the team made a recommendation on the priorities. The priorities were approved by the hospital's president, endorsed by the hospital board of directors, endorsed by the MedStar Health Board of Directors' Strategic Planning Committee and approved by the MedStar Health Board of Directors.

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Advisory Task Force Membership

Name	Title/Affiliation with Hospital	Name of Organization
Elise Andrews	Program Manager	Baltimore County Local Management Board
Donna Bilz	Healthscope Director	Baltimore County Department of Aging
Gregory Branch	County Health Officer	Baltimore County Department of Health
Laura Culbertson	Public Health Administrator	Baltimore County Department of Health
Megan Doty	Senior Public Relations Specialist	MedStar Franklin Square Medical Center
Uchenna Emeche	Family Health Center Physician	MedStar Franklin Square Medical Center
Linda Frisch	Director of Grant Development	MedStar Health
Liz Glenn	Board Member	MedStar Franklin Square Medical Center
Susan Hahn	Parent Support Services Coordinator	Baltimore County Public Schools
Sharon Hoffman	Early Childhood Supervisor	Baltimore County Public Schools
Juanita Ignacio	Director	Creative Kids
Tricia Isennock	Community Outreach Manager	MedStar Franklin Square Medical Center
Terri Kingeter	Sector Coordinator	Baltimore County Planning Office
Scott Krugman	Community Medicine Service Line Director	MedStar Franklin Square Medical Center
Patricia Norman	Board Member	MedStar Franklin Square Medical Center
Sally Rixey	Family Health Center Chief of Family Practice	MedStar Franklin Square Medical Center
Don Schlimm	Acting Executive Director	Baltimore County Local Management Board
Bryan Sheppard	Special Asst. to Kevin Kamenetz	Baltimore County Executive
Tobie-Lynn Smith	Medical Director	Healthcare for the Homeless - Baltimore County
Rene Youngfellow	Division Chief, Clinical Services-Center Based Services	Baltimore County Department of Health

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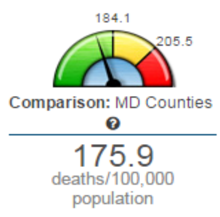
5. Justify why the hospital selected its community benefit priorities.

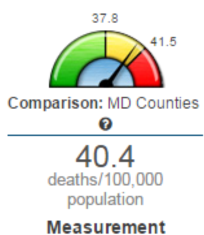
a) Chronic Disease

Secondary Data

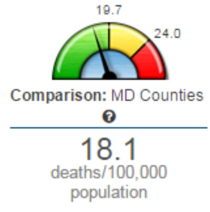
Death rate due to Heart Disease



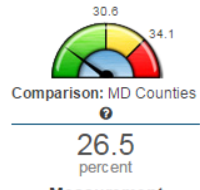
Death rate due to Stroke



Death rate due to Diabetes



Prevalence of Obesity



Chronic diseases, including heart disease/stroke, diabetes, and obesity, often coexist as comorbidities. Health behaviors such as tobacco use, poor nutrition and physical inactivity contribute to chronic disease.[6]

Heart Disease and Stroke

- Heart disease is the leading cause of death in Baltimore County, with an age-adjusted death rate of **176/100,000**. The age-adjusted mortality rate from heart disease is higher for Blacks/African Americans.[2]
- The age-adjusted death rate due to stroke has decreased (from 46/100,000 persons in 2008 to **40/100,000** in 2012) but is higher than the state average (37/100,000 persons).[2]
- The rate of emergency department visits for hypertension per 100,000 persons in Baltimore County is 212 compared to 246 in Maryland, and the rate is highest among Black/African American residents relative to other racial/ethnic groups.[2]
- In Baltimore County, the prevalence of high blood pressure (37%) and high cholesterol (35%) contributes to the age-adjusted death rate due to heart disease and stroke. The prevalence of high blood pressure and high cholesterol is highest among adults 65 and older and females. The relationship between heart disease risk factors and race/ethnicity varies. The prevalence of high blood pressure is highest for Blacks/African Americans relative to other racial/ethnic groups, whereas the prevalence of high cholesterol is highest for Whites relative to other racial/ethnic groups.[7]

Diabetes

- The age-adjusted death rate due to diabetes is **18/100,000** in Baltimore County.[2] The prevalence of diabetes is approximately 10% and is highest among adults 65 and older (30%), and virtually no differences are observed across gender. The prevalence among Blacks/African Americans (10%) and Whites (10%) is higher than Hispanics (2%) and Asians (8%).[7]
- The rate of emergency room visits due to diabetes has increased from 164 visits/100,000 persons in 2010 to 172 visits/100,000 persons in 2013. Blacks/African Americans contribute largely to this high rate.[2]

Obesity

- A total of 27% of adults in Baltimore County are obese and the county prevalence of obesity has decreased in recent years. The prevalence of obesity is highest among adults between the ages of 45 to 64, and is slightly

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	higher among females compared to males. The prevalence of obesity is higher among Black/African American residents (35%) compared to Hispanics (14%) and Whites (26%).[7] *Addressing the Risk Factors* • The smoking prevalence among adults in Baltimore County is 20.3%;[2] adults aged 18-44 and males report the highest smoking prevalence across age and gender groups, respectively.[7] Hispanic and White residents report current smoking rates higher than the countywide average.[2] • Approximately 27% of adults in the county report eating the recommended five or more servings of fruits and vegetables every day, which is higher than the state median. Adults older than 65, females and White residents report eating the recommended servings of fruits and vegetables at higher rates relative to the countywide average.[7] • Currently, only 47% of Baltimore County residents participate in at least 150 minutes of aerobic activity weekly, which is the recommended level of physical activity.[2] Adults younger than 65, males, and White residents are more likely to report participating in the recommended level of physical activity relative to the countywide average.[7]
Community Health Needs Assessment Surveys and Community Input Sessions	CHNA Survey (N=570)[15] • Chronic disease is a recognized issue affecting the community, with respondents indicating that overweight/obesity (61%), diabetes (47%) and heart disease (31%) are primary health conditions seen in their community. • Community members recognize the contributions of health behaviors to overall health status. Currently, survey respondents make healthy meals (65%), exercise at a local gym or recreation center (39%) and use parks, trails or a track (29%) to stay healthy. Over half (51%) of respondents reported that they eat the recommended five servings of fruits and vegetables on most days, but 39% also reported that they eat fast food more than once a week. • The need for nutrition education and better food access was identified by survey respondents: 28% of respondents replied that people in the community need more information about nutrition and eating well, and 19% indicated the need for affordable, healthy food options in their community.
Strategies	• To deliver evidence-based chronic disease self management programs. • To provide blood pressure education and self-screening at community sites. • To serve as an official partner of the Baltimore Heartwalk. • To facilitate a monthly diabetes support group. • To present Stop Smoking Today smoking cessation program. • To support Baltimore County Health Coalition obesity prevention initiatives.
Hospital Strengths	• MFSMC is the recipient of the highest level of recognition for quality stroke care from the American Heart Association/American Stroke Association (AHA/AMA).
Alignment with local, regional, state or national	• Healthy People 2020: Diabetes; Heart Disease and Stroke; Nutrition and Weight Status; Physical Activity; Tobacco Use[5]

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health goals	• Maryland State Health Improvement Plan (MD SHIP): Healthy Living; Quality Preventative Care[2] • Baltimore County Health Coalition: Reduce ED visits for hypertension[16]
Key Internal and External Partners	*Internal*: MedStar Good Samaritan Hospital, MedStar Union Memorial Medical Center, MedStar Harbor Hospital *External*: American Heart Association Million Hearts Campaign, American Medical Association (AMA), Baltimore County Department of Aging, Baltimore County Department of Health, Baltimore County Health Coalition, Johns Hopkins Medicine (JHU), Baltimore County Tobacco Coalition, MD Quit Now
Metrics	*Internal* • % of participants reporting improved communication with physician • % of participants reporting a decreased in depression symptoms • % of participants reporting increased physical activity • Hospitalization and readmission rates due to hypertension among participants • % of participants who quit/maintenance • Readmission rates for COPD among participants *External* • Age-adjusted death rate for heart disease[2] • Emergency department visits and hospitalization rates due to hypertension[2] • % of adults participating in recommended levels of physical activity[2] • % of adults who smoke[2] • % of adolescents using tobacco products[2]

b) Birth Outcomes	
Secondary Data	• The infant mortality rate has decreased in Baltimore County from 7.4 deaths/1,000 live births in 2009 to 5.3 deaths/1,000 live births in 2012, but rose to 6.4 deaths/1,000 live births in 2013, slightly higher than the national average (6.1 deaths/1,000 live births). The infant mortality rate for babies born to Black mothers is higher than the mortality rate for babies born to White mothers.[7] • Low birth weight, one of the primary causes of infant mortality, has not changed since 2008; 9% of babies are born with a low birth weight, higher than the national (8%) average. Babies born to Black/African American mothers are more likely to be of low birth weight (12%) compared to babies born to Asian (9%), Hispanic (8%) and White (7%) mothers.[7] • Poor maternal nutrition during the preconception and prenatal periods are risk factors for negative birth outcomes, as is tobacco, alcohol and substance use during pregnancy. Breastfeeding is a protective factor against negative outcomes during the postnatal period through early childhood.[6] • 52% of women in the 21221 ZIP code (Essex) who had a birth in the past 12 months are eligible for Medicaid, demonstrating an underserved population.[10,14] • Approximately 72% of (participating) infants in Baltimore County are being "Fully Formula-Fed," and infants in Essex contributed largely to this population. The Maryland State Agency reports that 67% of participating WIC

	infants are "Fully Formula-Fed," and the lowest rate in the state is 45%, achieved by a large, diverse population in Montgomery County.[17]
Community Health Needs Assessment Surveys and Community Input Sessions	The Baltimore County Local Management Board identified, within the Essex zip code, a small community (3 Census block groups) that annually produced the most negative birth outcomes, including infant mortality, babies born of low birth weight, and births to adolescents.[18]
Strategies	• To serve in a leadership role in the Healthy Babies Collaborative. • To provide a weekly breastfeeding support group in Essex at Creative Kids Center. • To assess community factors associated with poor birth outcomes in Essex. • To identify evidence-based programming to address identified risk factors. • To provide health education and services to support Southeast Network partner initiatives to address identified risk factors.
Hospital Strengths	• MFSMC has an esteemed Obstetrics department, with services in the main hospital and throughout the service area. There is an existing nurse navigator specifically for women's health, as well as educational birthing classes and a hospital wide breastfeeding initiative.
Alignment with local, regional, state or national health goals	• Healthy People 2020:Maternal, Infant and Child Health[5] • MD SHIP: Healthy Beginnings[2] • Baltimore County Health Coalition: Reduce low birth weight and very low birth weight[16]
Key Internal and External Partners	*Internal*: MedStar Harbor Hospital, MedStar Good Samaritan Hospital, MedStar Union Memorial Medical Center *External*: Baltimore County Department of Health, Baltimore County Health Coalition, Baltimore County Local Management Board, Healthy Families, Southeast Network, Young Parent Support Center, NACCHO, Creative Kids, Abilities Network, Healthy Babies Collaborative, United Way of Central MD
Metrics	*Internal* • % of infants being "Fully Formula-Fed" *External* • % of babies born of low birth weight[2] • % of infants being "Fully Formula-Fed"[17]

c) Access to Mainstream Services	
Secondary Data	• Low-income individuals are more likely to experience negative health outcomes, are less likely to practice health promoting behaviors, and have lower life expectancy. Additionally, low-income individuals are more likely to experience poor access to transportation and to healthy foods.[1] • Compared to residents in Baltimore County overall, residents in the MFSMC CBSA experience worse economic outcomes. Approximately 18.6% of households earn less than $25,000 a year and approximately 10.3% of persons earn incomes less than the federal poverty level, compared to 15.7% and 8.9% in Baltimore County, respectively.[13] • A lack of health insurance and the high cost of health care contribute to the negative effects of poor access, including unmet health needs, delay of care, inability to get preventive services, and preventable hospitalizations.[26] Of the 2,778 patients who accessed charity care funds at MFSMC last year, 44% were self-pay and 37% were Medicaid recipients.[19]

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Community Health Needs Assessment Surveys and Community Input Sessions	• 28% of CHNA respondents (n=570) stated poverty affected the quality of life in the community.[15] • The welfare focus group advised welfare/social service eligibility assessment and referral prior to hospital discharge.[20]
Strategies	• To assess patients for mainstream service needs prior to discharge. • To identify local mainstream service resources. • To partner with identified resources for a direct point of contact. • To provide mainstream services support assistant to assist with resource eligibility and enrollment. • To partner with MD Food Bank for food supplies and nutrition education. • To provide eligibility education and enrollment assistance for patients in need of mainstream services.
Hospital Strengths	• MFSMC has existing relationships with the Baltimore County Department of Social Services, the Community Assistance Network and Southeast Network partners that have expertise in providing mainstream services in the community.
Alignment with local, regional, state or national health goals	• Healthy People 2020: Social Determinants of Health[5]
Key Internal and External Partners	*Internal*: MedStar Harbor Hospital, MedStar Union Memorial Hospital, MedStar Good Samaritan Hospital *External*: Baltimore County Department of Social Services, Community Assistance Network, Faith communities, Maryland Food Bank, Southeast Network partners
Metrics	*Internal* • Readmission rates among clients who receive mainstream services assistance[21] • # of participants enrolled in resource delivery programs *External* • Emergency department visit rate due to diabetes[2] • Emergency department visit rate due to hypertension[2] • % of adults who could not afford to see a doctor[7]

6. Does the hospital play a collaborative role in activities that support other key health needs that were identified as important in the Community Health Assessment? (Collaboration Areas)

Condition / Issue	Evidence	Strategy	Key Partner
Behavioral Health	The CHNA Survey respondents (n=570) identified mental health and substance abuse as two of the most frequent health conditions seen (alcohol addiction 29%, mental health 36%), issues that most affect the quality of life (mental health	To identify and connect hospital representatives with groups currently active in behavioral health.	Baltimore County Department of Health and Human Services, Southeast Network, Prologue,

	issues 27%, substance abuse 38%) and areas of services most needed (mental health 18%, substance abuse 15%). The only higher rated items were for nonmedical services, such as jobs and activities for teens and families.[15] Behavioral services account for the third largest share of charity care resources in readmissions.[19]		National Alliance on Mental Illness
Asthma Management in Schools	The proportion of children diagnosed with asthma (22%) is higher than any surrounding county and higher than the state prevalence of childhood asthma (16%).[7] The rate of ED visits due to asthma in Baltimore County is 66/100,000, higher than the state rate (63/100,000) and the Maryland State Health Improvement Process target rate (50/100,000).[2] Baltimore County Public School nurses report increased nurse visits and 911 transfers of students from school to emergency rooms due to asthma.	To continue the collaboration with Baltimore County Public Schools and area school nurses through the Community Asthma Team. To continue to convene monthly meetings to identify challenges, opportunities and resources.	Baltimore County Public Schools, Southeast Network
Tobacco Use	Baltimore County Health Coalition has identified a goal to reduce tobacco use. MD SHIP goal for adult smoking prevalence is 12%; Baltimore County is currently at 19%. Tobacco use contributes to cancer, heart disease, and respiratory diseases (including emphysema, bronchitis, and chronic airway obstruction), premature birth, low birth weight, stillbirth, and infant death.	To continue the collaboration with partners. To continue to provide tobacco prevention and cessation programs in the community.	Baltimore County Department of Health and Human Services, Southeast Network, Baltimore County Health Coalition, Tobacco Use subcommittee

7. List other health priorities that were identified in the CHNA and describe why the hospital did not select them. (Participation Areas)

Condition / Issue	Evidence	Explanation	Lead
Housing	35% of CHNA respondents (n=570) identified that homelessness affects	The hospital does not have the expertise to	Baltimore County

	quality of life and 21% indicated affordable housing as a needed service in the community.[15]	have a leadership role in these areas; therefore, hospital will support external leaders in this area.	Housing Department
Transportation	8% of CHNA respondents (n=570) identified better public transportation as a needed service.[15] MFSMC charity care for transportation assistance increased 66% from FY2013 to FY2014.[19]		MD Department of Transportation, Maryland Transit Authority

8. Describe how the hospital will institutionalize community benefit programming to support the Implementation Strategy.

The hospital's Implementation Strategy is a roadmap for how community benefit resources will be deployed and how outcomes will be reported. The Community Benefit Hospital Lead will oversee planning, programming, monitoring, and evaluation of outcomes. The Executive Sponsor will support institutional efforts to re-organize or reallocate resources as needed. Annual progress updates will be provided to ATF members and the hospital's Board of Directors. The progress report will also be publicly accessible via the hospital's website.

The MedStar Health Corporate Community Health Department (CCHD) will provide system-wide coordination and oversight of community benefit programming. The CCHD will oversee the agenda of the Community Benefit Workgroup, which is comprised of Community Benefit Hospital Leads and other community health professionals across the system. The purpose of the workgroup is to share best practices and promote consistency around data collection, tracking, and reporting that is consistent with internal policies and state and federal guidelines.

The CCHD will provide the MedStar Health Board of Director's Strategic Planning Committee with annual updates on the hospital's progress towards the goals documented in the Implementation Strategy.

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MedStar Franklin Square Medical Center
Community Health Assessment Work Plan
(FY16-FY18)

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Priority Issue #1: Chronic disease prevention and management, specifically heart disease
Goal Statement: To promote heart health in Southeast Baltimore County

1A. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
Stanford Chronic Disease Self-Management Program CDSMP-Free six session class at Family Health Center and community sites for people experiencing any chronic disease. Target population: 21221, Family Health Center, and patients with hypertension and congestive heart failure.	Class facilitators Books Educational supplies Family Health Center conference room Community sites	Each program consist of six 2.5 hour workshops # of classes held each fiscal year # contacted # enrolled # attended # completed	Participant class assessment- Improved communication with physicians Decreased depression Increased physical activity	Six-month follow-up participant assessments Hospitalization /readmission rates of participants Readmission rates due to hypertension	Manager, Community Health Health Education Specialist CDSMP Facilitators	Patricia Isennock, RN

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Activities to be phased in during the three-year period:

- License agreement with State for Stanford CDSMP
- Community Health Worker (CHW) job description in MedStar
- Hire and train CHWs
- Referral process hardwired in both inpatient and ambulatory electronic medical records (EMR, currently MedConnect and Centricity)
- Provider education related to CDSMP and EMR access
- Database preparation

Internal MedStar Collaborations:

- MGSH – Share referrals for participants, best practices and lessons learned

External Collaborations:

- **Maryland/Baltimore County Department of Aging –** Share aggregate data for program evaluation and operate under State license. Share referrals for participants, best practices, lessons learned.

External Metric(s):

- Maryland SHIP Emergency Department Visits due to hypertension
- Baltimore County CDSMP participant assessments of hospitalization, physical activity, and age-adjusted death rate for heart disease

Activities to be phased in during the three-year period:

- Community sites identified
- Data base preparation

Internal MedStar Collaborations:

- MedStar Health – share results, lessons learned and best practices

External Collaborations:

- American Heart Association Million Hearts Campaign
- American Medical Association (AMA)
- Johns Hopkins Medicine (JHU)
- Community BP sites: Creative Kids, Y of Central MD, Young Parent Support Center
- Southeast Network – community site identification, communication

External Metric(s):

- MD SHIP Emergency Department Visits due to Hypertension

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1B. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Free six session classes at various community sites for adults who wish to quit smoking. In collaboration with the Baltimore County Department of Health participants may be provided with free nicotine replacement assistance.	Tobacco Treatment Specialist Educational supplies Family Health Center conference room Angelos Lung Center conference room	FY16 – minimum quarterly classes FY17 – bimonthly classes at two sites	Participant quit rate Readmission rate of COPD patients	Participant quit rate maintenance Readmission rate of COPD patients	Tobacco Treatment Specialist	Karen Polite-Lamma, RN, TTS

Activities to be phased in during the three-year period:

- New site(s) prepared
- Referral process hardwired in both inpatient and ambulatory electronic medical records (EMR, currently MedConnect and Centricity)
- Provider education related to SST program and EMR access
- Database expansion

Internal MedStar Collaboration:

- MedStar Health - Serve as a resource for MedStar patients who wish to quit smoking, share results, lessons learned and best practices

External Collaboration:

- Baltimore County Tobacco Coalition – referral and resource
- MD Quit Now - referral and resource

External Metric(s):

- MD SHIP Adults who currently smoke, Adolescents who use tobacco products

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Priority Issue #2 – Birth outcomes
Goal Statement – Support babies being born healthy and being raised in safe and stable families and communities in southeast Baltimore County.

2A. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Free weekly breastfeeding support group for expectant and new mothers/families in the Healthy Babies Collaborative target area in 21221.	Lactation consultant/facilitator Expert area presenters (dietician, neonatologist, pediatrician) Educational supplies (models, medical equipment) Classroom – Creative Kids Center	Weekly breastfeeding support group including nutrition education and skin care # of participants	Program participants will exceed current Maryland rates for infants being exclusively breastfed at 3 months (29.3%) Identification of barriers for breastfeeding in 21221	Program participants will exceed current Maryland rates for infants being exclusively breastfed at 6 months (29.3%)	Certified Lactation Consultant Birth and Family Coordinator Community Health Manager	Beth Kegley, RN, Education Specialist

Internal MedStar Collaboration:
- MHH – Share lessons learned and best practices.

External Collaboration:
- **NACCHO** – share aggregate data, best practices and lessons learned
- **Creative Kids** – program site, publicity
- **Abilities Network** – participant identification, follow-up
- **Baltimore County Department of Health and Human Services**- participant identification, follow-up, WIC services

External Metric(s):
- MD SHIP Babies with low birth weight, MD Babies exclusively breastfed

2B. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Assess community factors associated with poor birth outcomes in Essex. Identify evidence based programming (EBP) to address identified risk factors. Provide health education and services to support Southeast Network partner initiatives to address identified risk factors.	Director, Population Health Community Health Manager Community Health Worker	HBC target area assessment, including focus groups, survey EBP literature review EBP implementation	Community organizer identified Community Commons established as communication platform # partners on Community Commons	EBP implemented	Birth and Family Coordinator Community Health Manager Director, Population Health	Patricia Isennock, RN

Activities to be phased in during the three-year period:

- Identify backbone organization
- Identify and access funding source(s)
- Disseminate collective impact model among partners
- Establish consistent communication platform
- Community Health Worker hired
- Assessment of Essex neighborhood
- Literature review of evidence based programming
- Site visits of best practices
- Program foundation preparation

Internal MedStar Collaborations:

- MedStar Health - Share lessons learned, best practices

External Collaborations:

- Southeast Area Network – communication, collaboration
- Healthy Babies Collaborative – collaboration
- United Way of Central MD – best practice assistance, funding

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• Creative Kids – community site, publicity
External Metric(s): • MD SHIP Babies with low birth weight, infant death rate, teen birth rate • WIC data on breastfeeding

Priority Issue #3 – Access to mainstream resources
Goal Statement – Improve health outcomes for Medicaid and self-pay patients by providing social resources.

3A. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Assess Medicaid and self-pay population mainstream resource needs by surveys and data analysis	Case Management Community Health Worker Admission data	# participants identified/assessed Resource needs list	Participating Medicaid/self-pay patients readmission rates	Medicaid/self-pay patients readmission rates # participants enrolled in resource delivery programs	Case Manager Community Health Worker TBA	Population Health Director Interim, Patricia Isennock, RN, Community Health Manager

Activities to be phased in during the three-year period: • Assessment tool identified • Data base preparation • Population Health Director hired Community Health Worker • Identify local mainstream resources
Internal MedStar Collaborations: • MedStar Health – Share results, lessons learned and best practices
External Collaborations:

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- Baltimore County Department of Social Services and Local Management Board – survey and participant identification assistance

External Metric(s):
- MD SHIP Emergency department visit rate due to diabetes, hypertension
- People who cannot afford to see a doctor

3B. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
During hospital visit, assess patient mainstream support needs, determine resource program eligibility, and assist in program enrollment.	Case Management Community Health Worker SAIL – web-based screening and application tool for Maryland Department of Human Resource Computer access	# resource applications completed # patients enrolled in mainstream resource programs Local mainstream resource directory # partners identified #memos of understanding	Readmission rates among clients who receive mainstream assistance	Readmission rates among clients who receive mainstream assistance	Community Health Worker Education Specialist	TBA, Population Health Director Interim Patricia Isennock, RN, Community Health Manager

Internal MedStar Collaborations:
- MedStar Health – Share results, lessons learned and best practices

External Collaborations:
- Southeast Area Network partners – establish working relationships for referrals, enrollments

External Metric(s):
- MD SHIP Emergency Department visit rate due to diabetes, hypertension
- People who cannot afford to see a doctor

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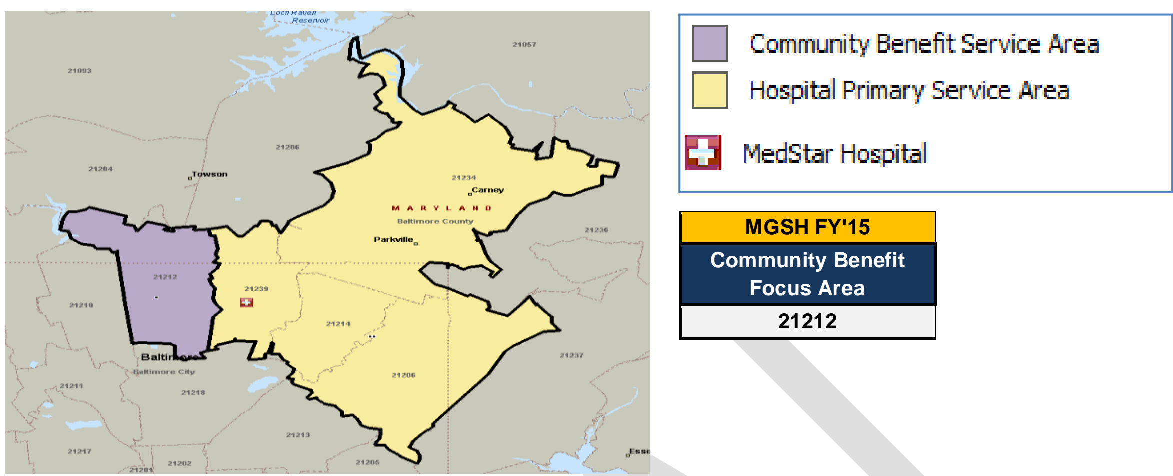
MedStar Good Samaritan Hospital
Community Health Assessment FY2015



* Primary Service Area – represents ZIP codes that contain 50% of inpatient discharges
*Community Benefit Service Area is also included in the primary service area

1. **Define the hospital's Community Benefit Service Area (CBSA) and identify the hospital's community benefit priorities.**

   MedStar Good Samaritan Hospital's (MGSH) CBSA includes residents in ZIP code 21212, the Govans area of Baltimore. While the primary focus for targeted programming will be in this neighborhood, MGSH will also look to provide services to individuals in need in the hospital's whole service area which includes ZIP codes 21234, 21239, 21206, and 21214. The CBSA was selected due to its close proximity to the hospital, coupled with a high density of residents with low incomes. Based on secondary, CHNA survey and community input session findings, MGSH's community benefit priorities in chronic disease prevention and management are: 1) heart disease, 2) diabetes, and 3) obesity.

2. **Provide a description of the CBSA.**

   The Govans neighborhood is located in North Central Baltimore City, approximately two miles from Good Samaritan Hospital. The neighborhood features many different housing types, businesses, churches, a charter school and a neighborhood park. Govans has always been associated with York Road, first as an Indian trail, and then as an important commercial road and turnpike linking the Port of Baltimore to Pennsylvania.

   According to statistics from the Baltimore City 2011 Neighborhoods Health Profile,[3] the total population in Govans is 10,680, the majority of which is Black/African American (91.3%). Whites account for 5.7% of the population, Asians account for 0.5% and 2.5% of the population self-reports as two or more races. Slightly more than one percent (1.3%) of the population is of Hispanic or Latino origin. Adults over the age of 18 years old make up three-quarters (75.6%) of the population, with seniors over age 65 years at 12.8%. Children

under the age of 18 account for 24.4% of the Govans population. The median annual household income is $37,000, comparable to Baltimore City, while unemployment is 14.9%, higher than the average of Baltimore City (11.0%). Just over one-quarter (26.9%) of households are headed by a single-parent. The poverty rate is 11.6%, less than that of Baltimore City (15.7%). In 2011, approximately 1,400 local families in the Govans area received assistance from CARES, a combination Food Pantry and Emergency Financial Assistance center. Approximately two-thirds (62.2%) of residents over 25 years of age have at most a high school diploma. Life expectancy is 73.9, longer than that of Baltimore City (71.8). The top causes of death are heart disease (24.9 per 10,000), cancer (19.5 per 10,000), HIV/AIDS (4.9 per 10,000), stroke (4.2 per 10,000), and diabetes (2.6 per 10,000).[3]

3. **Identify community health assessment program partners and their expertise or contribution to the process.**

Georgetown University's School of Nursing & Health Studies is an academic partner that brings a wide range of resources that contributed to MedStar Health's systemwide CHNA process. Their expertise in CHNAs and population health management has strengthened the rigor of data collection and data analysis methodologies. The school provided the following support: 1) consultation and support for primary and secondary data collection and analysis; 2) supported the development and validation of a community input instrument and summarized findings; 3) contributed to and promoted community input sessions; 4) reviewed drafts of the CHNAs prior to publication; and 5) managed student involvement and participation.

The **Healthy Communities Institute** provided quantitative data based on over 130 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

4. **State who was involved in the decision-making process.**

MGSH's ATF reviewed local secondary data, coupled with state and federal community health goals. Task Force members also reviewed the hospital's operating plan, the outcomes of prior informal community health assessments, as well as current community benefit programs and services. In partnership with Georgetown University's School of Nursing & Health Studies, the team developed and helped disseminate a community health assessment tool around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life.

In addition to secondary data, CHNA survey and community input session findings, the Task Force considered the hospital's capabilities as well as local, regional and state health goals. Based on findings, the team made a recommendation on the priorities. The priorities were approved by the hospital's president, endorsed by the hospital board of directors, endorsed by the MedStar Health Board of Directors' Strategic Planning Committee and approved by the MedStar Health Board of Directors.

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Advisory Task Force Membership

Name	Title/Affiliation with Hospital	Name of Organization
Mitchell Herbert	Regional Director, Strategic and Business Planning	MedStar Good Samaritan Hospital
Deborah Bena	Health Ministries Coordinator	MedStar Good Samaritan Hospital
Jeffrey Matton	President & Senior Vice President	MedStar Good Samaritan Hospital
Allan Noonan, MD	Chair	MedStar Good Samaritan Hospital Board
Sonya Gray	Board Member	MedStar Good Samaritan Hospital Board
Carol Pacione	Pastoral Life Director	St. Pius Church
David Weisman, MD	Physician	MedStar Good Samaritan Hospital
Michelle Zikusoka, MD	Physician	MedStar Good Samaritan Hospital
Andrew Dziuban	Director of Philanthropy	MedStar Good Samaritan Hospital
Bernadette Krol, RN	Registered Nurse	MedStar Good Samaritan Hospital
Moira Larsen, MD	Physician and Board Member	MedStar Good Samaritan Hospital
Rachel V. Neill	Resident	Govans Ecumenical Development Corporation (GEDCO) – CARES Program
Loretha Myers	Resident	Loch Raven Improvement Association, Northeast Community Association
Patricia Stabile	Program Director	HARBEL Prevention and Recovery Center
Randolph Rowel, PhD	Chair and Associate Professor	Department of Behavioral Health Sciences, Morgan State University

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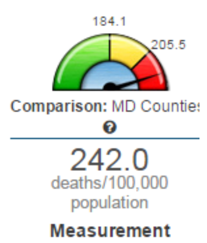
5. Justify why the hospital selected its community benefit priorities.

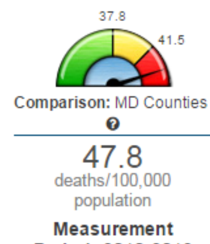
a) Chronic Disease

Secondary Data

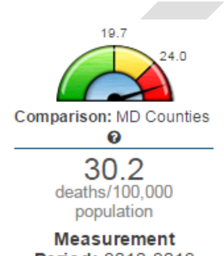
Death rate due to Heart Disease



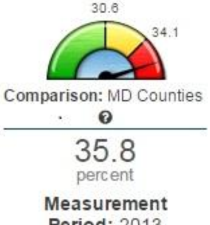
Death Rate due to Stroke



Death Rate due to Diabetes



Prevalence of Obesity



Chronic diseases, including heart disease/stroke, diabetes, and obesity, often coexist as comorbidities. Health behaviors such as tobacco use, poor nutrition and physical inactivity contribute to chronic disease.[6]

Heart Disease and Stroke

- Heart disease is the leading cause of death in Baltimore City, with an age-adjusted death rate of **242/100,000**. The age-adjusted death rate from heart disease is higher for Blacks/African Americans.[2]
- The age-adjusted death rate due to stroke is also decreasing (from 51/100,000 persons in 2009 to **48/100,000** in 2012) but remains significantly higher than the state (38 /100,000 persons) and national averages (38/100,000 persons).[2]
- The rate of emergency department visits for hypertension per 100,000 persons in Baltimore City is 600 compared to 246 in Maryland, and the rate is highest among Black/African American residents relative to other racial/ethnic groups.[2]
- In Baltimore City, the prevalence of high blood pressure (35%) and high cholesterol (30%) contributes to the age-adjusted death rate due to heart disease and stroke. The prevalence of high blood pressure and high cholesterol is highest among adults 65 and older and females. The relationship between heart disease risk factors and race/ethnicity varies. The prevalence of high blood pressure is higher in Blacks/African Americans relative to other racial/ethnic groups, whereas the prevalence of high cholesterol is higher for Whites relative to other racial/ethnic groups.[7]

Diabetes

- The age-adjusted death rate due to diabetes is **30/100,000**.[2] The prevalence of diabetes is approximately 11% and is highest among females (14%) and adults 65 and older (28%). The prevalence among Blacks/African Americans (13%) is more than two times higher than Whites (5%).[7]
- The rate of emergency department visits due to diabetes has increased from 444 visits/100,000 persons in 2010 to 502 visits/100,000 persons in 2013. Blacks/African Americans contribute largely to this high rate.[2]

Obesity

- A total of 36% of adults in Baltimore City are obese, and the trend is increasing. The prevalence of obesity is highest among adults between the ages of 45 and 64 and females, and is significantly higher among Black/African American residents (45%) than Hispanics (28%) or Whites (21%).[7]

Addressing the Risk Factors

- Baltimore City ranks in the worst quartile for adult smoking rates with 22.7% of the adult population identifying as current smokers;[2] adults aged 45-64,

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	males, and Blacks/African Americans report current smoking rates higher than the citywide average.[7] Individuals earning less than $15,000 also report higher rates of smoking compared to the citywide average.[3] • Only one-fourth of adults in the city report eating the recommended five or more servings of fruits and vegetables every day, which is higher than the state median. Adults aged 65 and older, females and Black/African American residents report eating the recommended fruits and vegetables at higher rates relative to the citywide average.[7] • Currently, only 44% of Baltimore City residents participate in at least 150 minutes of aerobic activity weekly, which is the recommended level of physical activity, and self-reported physical activity has slightly decreased in recent years.[7] More so, 30% of residents report that they do not participate in any leisure physical activity. [3] Adults 45 and older, females, and Hispanic and Black/African American residents are less likely to report participating in the recommended level of physical activity relative to the citywide average.[7]
Community Health Needs Assessment Surveys and Community Input Sessions	CHNA Survey (N=175)[22] • Chronic Disease is a recognized issue affecting the community, with respondents indicating that overweight/obesity (56%), diabetes (63%) and heart disease (35%) are primary health conditions seen in their community. • Community members recognize the contributions of health behaviors to overall health status. Currently, survey respondents make healthy meals (73%), exercise at a local gym or recreation center (38%) and use parks, trails or a track (21%) to stay healthy. • Affordable, healthy food options (33%) and better places to exercise (20%) were two services that were recognized as community needs through the surveys and the community input sessions. • When asked to prioritize Healthy Baltimore 2015 health goals, survey respondents ranked "Promote Access to Quality Health Care for All" as the top goal, which includes preventing hospitalizations and emergency department visits due to chronic disease as health objectives. • During a community input session, participants noted the following problems and possible solutions: o MGSH's service areas contain "food deserts" that make healthy eating difficult. There are not enough grocery stores and the ones that do exist are only accessible with a car. While there are several farmers markets, some are only seasonal. Potential solutions to this problem could be to encourage more farmers markets to be open year-round and to establish more community gardens. o Some residents cannot afford to buy fresh produce. Providing more subsidies, in the form of coupons, for example, could help make a healthy diet more affordable. Increased support of and partnership with the community's food pantries (GEDCO) would be a good way to reach vulnerable populations. o Education courses and programs, like healthy cooking classes, should be targeted towards breaking the multigenerational habits among families that permit and encourage unhealthy habits. o Pre-existing programs focusing solely on healthy eating or exercise should be broadened to include both as a way to promote healthy living.

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	o Across all topics, the group agreed that the hospital's pre-existing services and health promotion programs need to be better advertised so residents are aware of them and utilize them. o As a way to promote healthy living and lifestyles, residents' successful stories should be highlighted to create positive role models.
Strategies	• To offer heart health education courses (i.e., Get Heart Smart, Keep the Beat). • To offer community-based healthy lifestyle lectures/classes (Living Well, Take Charge of Your Diabetes; Life, Balance, & Weight Management). • To teach general nutrition education classes in the community and classes specifically for heart health and diabetes. • To teach weekly exercise classes for older adults. • To provide smoking cessation programs. • To conduct free blood pressure screenings. • To teach health literacy and compliance education courses. • To provide health fair education sessions. • To provide influenza vaccinations.
Hospital Strengths	• MGSH has a cardiology program designed to diagnose and treat cardiac patients at every juncture in the clinical pathway. • Cardiac and vascular services feature experienced specialists and state-of-the-art programs for the diagnosis and treatment of cardiovascular diseases. • The hospital has an out-patient phase II cardiac rehabilitation program and a congestive heart failure wellness center housed in the Good Health Center. • Existing community outreach programs include heart health and nutrition talks, exercise programs, and health screenings, such as blood pressure and cholesterol. • MGSH has a variety of services to treat and manage diabetes. Experienced endocrinologists provide both inpatient and outpatient care to patients with diabetes. The Diabetes Center, located in the Good Health Center, has a certified diabetes educator and registered dietitian who teach the skills needed to self-manage the disease. The Good Health Center also has a phase III fitness program, where doctors can refer their patients for medically supervised exercise. Community outreach nurses facilitate a six-week workshop called "Living Well…Managing Your Diabetes," which is an evidenced-based program developed by Stanford University.
Alignment with local, regional, state or national health goals	• Healthy People 2020: Diabetes; Heart Disease and Stroke; Nutrition and Weight Status; Physical Activity; Tobacco Use[5] • Maryland State Health Improvement Process (MD SHIP): Healthy Living; Quality Preventative Care[2] • Healthy Baltimore: Promote Access to Quality Health Care for All; Be Tobacco Free; Redesign Communities to Prevent Obesity; Promote Heart Health[3]
Key Internal and External Partners	*Internal:* MedStar Union Memorial Hospital, MedStar Harbor Hospital, MedStar Franklin Square Medical Center, MGSH Good Health Centers, MGSH Public Relations/Marketing Department *External:* Faith-based organizations, Govans Ecumenical Development Corporation (GEDCO) resources and member organizations, Northeast Community Organizations (NECO) member organizations, HARBEL Community Organization resources and member organizations, Morgan State University –

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	Morgan Community Mile, CARES
Metrics	*Internal Metrics* • % of program participants adhering to medication and self-management techniques • % of program participants who participate in the recommended levels of physical activity • % of program participants reporting improved "readiness to change" status on post-assessment • % of program participants with elevated blood pressure • Obesity measures (muscle mass, weight, etc.) • % of program participants with elevated blood sugar • % of program participants that successfully quit smoking cigarettes • % of program participants aware of risk factors associated with chronic diseases • % of program participants who adopt sustainable lifestyle behaviors that help reduce the prevalence of chronic diseases • % of program participants consuming the recommended fruits and vegetables daily *External Metrics* • % of adults who are at a healthy weight (BMI< 25 kg/m^2)[2] • Age-adjusted death rate from heart disease[2] • % of adults who participate in the recommended levels of physical activity[2] • Emergency department visit rate due to hypertension[2] • Emergency department visit rate due to diabetes[2] • % of adults who smoke[2]

6. Does the hospital currently have community benefit activities that support other key health needs that were identified as important in the Community Health Assessment? (Collaboration Areas)

Issue	Evidence	Strategy	Partners
Behavioral Health	"Recognize and Treat Mental Health Needs" is one of the ten priority areas from Baltimore City Health Department's Health Baltimore 2015 with an underlying goal of decreasing the percent of adults with unmet mental health care needs by 25%.[3] The emergency department visit rate for mental health conditions is 6,394/100,000, compared to 3,379/100,000 for the state.[2] 49% (n=175) of survey respondents listed "Mental Health Conditions (e.g., anxiety, depression, stress)" as a health condition they see most in their community.[22]	To reduce behavioral health readmissions through better discharge planning and the use of a dedicated community health worker.	Other area inpatient and outpatient behavioral health providers (e.g., hospitals, physician, federally qualified health centers)
Alcohol and	"Reduce Drug Use and Alcohol Abuse" is	In exploratory	Inpatient and

Drug Addiction	one of the ten priority areas from Baltimore City Health Department's Health Baltimore 2015, with underlying goals of decreasing the rate of alcohol and drug-related hospital admissions and emergency department visits by 10% and 15%, respectively.[3] Baltimore City's drug-induced death rate is 26/100,000, compared to 13/100,000 for the state.[2] The emergency department visits rate for addictions-related conditions is 4,935/100,000 compared to 1,526/100,000 for the state.[2] When asked what health conditions they see most in their community, respondents stated "Alcohol Addiction" (47%), "Heroin/Opiod Addiction" (19%) and "Other Drug Addictions" (26%) (n=175).[22]	phase with key partners.	outpatient treatment facilities, Alcoholics Anonymous, Narcotics Anonymous, other addiction recovery services
Children and Adolescent Health	"Promote Healthy Children and Adolescents" is one of the ten priority areas from Baltimore City Health Department's Health Baltimore 2015.[3]	In exploratory phase with key partners.	Pediatric inpatient and outpatient providers, schools, churches, community organizations

7. List other health priorities that were identified in the CHNA and describe why the hospital did not select them. (Participation Areas)

Issue	Evidence	Explanation	Lead
Housing	When asked which services are needed most in the community, 26% (n=175) of respondents stated "Affordable Housing."[22]	The hospital does not have the expertise to have a leadership role in these areas; therefore, hospital will support external leaders in these areas.	Housing Authority of Baltimore City; Department of Housing and Community Development; community organizations
Density of Liquor Stores, Tobacco Retail, Fast Food, Carryout and Corner Stores.	The density of Liquor Stores, Tobacco Retail, Fast Food, Carryout and Corner Stores is very high in the identified target area.[3]		Baltimore City Planning Department, Baltimore City Liquor License Board, Maryland Department of Health and Mental Hygiene

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8. Describe how the hospital will institutionalize community benefit programming to support the Implementation Strategy.

The hospital's Implementation Strategy is a roadmap for how community benefit resources will be deployed and how outcomes will be reported. The Community Benefit Hospital Lead will oversee planning, programming, monitoring, and evaluation of outcomes. The Executive Sponsor will support institutional efforts to re-organize or reallocate resources as needed. Annual progress updates will be provided to ATF members and the hospital's Board of Directors. The progress report will also be publicly accessible via the hospital's website.

The MedStar Health Corporate Community Health Department (CCHD) will provide system-wide coordination and oversight of community benefit programming. The CCHD will oversee the agenda of the Community Benefit Workgroup, which is comprised of Community Benefit Hospital Leads and other community health professionals across the system. The purpose of the workgroup is to share best practices and promote consistency around data collection, tracking, and reporting that is consistent with internal policies and state and federal guidelines.

The CCHD will provide the MedStar Health Board of Director's Strategic Planning Committee with annual updates on the hospital's progress towards the goals documented in the Implementation Strategy.

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MedStar Good Samaritan Hospital
Community Health Assessment Work Plan
(FY16-FY18)

Priority Issue #1 – Chronic disease prevention and management, specifically diabetes, heart disease, and obesity
Goal Statement – To provide education and services to promote disease prevention and management through community health programming centered on heart disease, hypertension, diabetes, nutrition, and exercise to the targeted area of Govans.

1A. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
Diabetes/Obesity "Life Balance/Weight Management Program" (CDC National Diabetes Prevention Program/ Evidenced-based program) **Core Sessions:** The 16, one-hour core sessions are focused on the process of adopting lifestyle changes for healthy eating and physical activity. These sessions are designed to help participants develop lifelong skills for healthy living and reinforce step-by-step change. Groups generally meet with their lifestyle coach each week at the same time and location.	Facilitated by a register nurse/health & wellness coach Classes will be held at MedStar Good Samaritan hospital as well as Harford Senior Center Weekly program hand-outs will be provided to participants	Number of Programs: This program will be presented one time per year Core Program: 16 one-hour classes each week Post Core Program: 6 one-hour classes presented monthly # contacted	1. Pre and post test results for all participants specific to topics addressed in the class: weight loss, BP and A1C, medication adherence Behavioral targets: - Dietary changes - Increased physical activity - Readiness to change assessment	Weight loss: 5% -7% loss of participant's total body weight Increase exercise activities to at least 150 minutes per week	Community Outreach Nurses	Debbie Bena, RN

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Post-Core Sessions: Following the core phase, participants attend one hour “post-core” sessions on a monthly basis. The post-core sessions are intended to provide additional support and learning opportunities to participants, and help them transition to independently maintaining their lifestyle changes. Target Population: Adults with pre-diabetes and/or obesity. Our partnership with Govans Ecumenical Development Corporation (GEDCO) (CARES, Senior Network of North Baltimore, Harford Senior Center, Epiphany House, Micah House) will help us identify and reach a senior and underserved population.		# enrolled # attended # completed				

Internal MedStar Collaborations:

- MGSH Good Health Center and Physician practices to drive referrals into the program
- MGSH Public Relations/Marketing Department for promotion of the program
- Potential collaboration opportunities with other Baltimore area hospitals such as MUMH, MHH and MFSMC

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External Collaborations:

- Community Partners such as Govans Ecumenical Development Corporation (GEDCO), HARBEL, NECO and local churches for assistance in promotion of the program.

External Metric(s):

Baltimore City

- Emergency department visit rate due to diabetes (MD SHIP)
- Emergency department visit rate due to hypertension (MD SHIP)
- % of adults at healthy weight (BMI < 25 kg/m2) (MD SHIP)
- CBSA-level metrics where available

1B. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
Diabetes "Living Well: Take Charge of Your Diabetes" (Stanford Diabetes Self-Management Program/Evidenced-based program) In Partnership with Baltimore City Health Department The Diabetes Self-Management workshop is given 2½ hours once a week for six weeks. People with type 2 diabetes attend the workshop in groups of 12-16	Workshops are facilitated from a highly detailed manual by two registered nurses who are trained leaders for this program Workshops will be conducted in the hospital and at other community locations Each participant in the workshop receives a copy of the companion	Number of Programs: This program will be offered in the fall and spring of each year Each program consist of six 2.5 hour workshops # contacted	Stanford has a standard evaluation form that is given at the end of the program. Additionally, program participants will be call 3 months and 6 months later and surveyed related to the effectiveness of the self-management techniques learned in the program	Follow up calls at 3 months and 6 months Improvements reported by participants in management of their diabetes -weight loss -decreased A1C -decreased BP -better compliance with diet -increased exercise -monitoring blood	MGSH Community Outreach Nurses	Karen Kansler Debbie Bena, RN

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Subjects covered include: 1) techniques to deal with the symptoms of diabetes, fatigue, pain, hyper/hypoglycemia, stress, and emotional problems such as depression, anger, fear and frustration; 2) appropriate exercise for maintaining and improving strength and endurance; 3) healthy eating 4) appropriate use of medication; and 5) working more effectively with health care providers. Participants will make weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their self-management program. Target Population: Adults with Type 2 diabetes Our partnership with Govans Ecumenical Development Corporation (GEDCO)(CARES, Senior Network of North Baltimore, Harford Senior Center,	book, *Living a Healthy Life with Chronic Conditions, 4th Edition*, and an audio relaxation tape which is provided by Baltimore City Health Department.	# enrolled # attended # completed	Behavioral targets: -Dietary changes -Increased physical activity -Readiness to change assessment	glucose level		

Epiphany House, Micah House) will help us identify and reach a senior and underserved population.						

Internal MedStar Collaborations:

- MGSH Good Health Center and Physician practices to drive referrals into the program
- MGSH Public Relations/Marketing Department for promotion of the program
- Potential collaboration opportunities with other Baltimore area hospitals such as MUMH, MHH and MFSMC

External Collaborations:

- Community Partners such as GEDCO, HARBEL, NECO and local churches for assistance in promotion, as well as locations to present the program
- The Morgan Community Mile – Collaboratively working with post-graduate students to further enhance this program through health and wellness coaching

External Metric(s):

Baltimore City

- Emergency department visit rate due to diabetes (MD SHIP)
- Emergency department visit rate due to hypertension (MD SHIP)
- % of adults at healthy weight (BMI < 25 kg/m2) (MD SHIP)

CBSA-level metrics where available

1C. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible

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Heart "Get Heart Smart Program" One hour program given over 5 weeks. Topics include a general overview of the most common types of heart disease and stroke with an emphasis on lifestyle changes to support cardiovascular health. i.e., nutrition, exercise, stress reduction.	Facilitated by a register nurses Classes will be held at MedStar Good Samaritan hospital as well as in community locations such as GEDCO managed senior centers/senior resident housing and CARES Audiovisual equipment and program hand-outs for each session will be provided by MGSH	This 4-week program will be offered four times per year # contacted # enrolled # attended # completed	1. Pre and post test results for all participants specific to topics addressed Behavioral targets: -Dietary changes -Increased physical activity -Readiness to change assessment	Being the program is conducted over a short period of time, long term impact will hard to measure. In addition to pre-post tests that will be given at each class, a survey will be given at the end of the 4th class to identify potential health lifestyle changes that participants have made or plan to make in the future Weight loss Improved blood pressure Behavioral targets: -Dietary changes -Increased physical activity -Readiness to change assessment	MGSH Community Outreach Nurses	Debbie Bena, RN

Internal MedStar Collaboration:

- MGSH Good Health Center and Physician practices to drive referrals into the program
- MGSH Public Relations/Marketing Department for promotion of the program
- Potential collaboration opportunities with other Baltimore area hospitals

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External Collaboration:

- Community Partners such as GEDCO, HARBEL, NECO and local churches for assistance in promotion, as well as locations to present the program. Examples would be GEDCO managed senior centers/senior resident housing and CARES

External Metric(s):

Baltimore City

- Age-adjusted mortality rate for heart disease (MD SHIP)
- Emergency department visit rate due to hypertension (MD SHIP)
- % of adults at healthy weight (BMI < 25 kg/m2) (MD SHIP)
- CBSA-level metrics where available

1D. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Senior Fitness Programs" Exercise programs offered at local community senior centers. Exercise classes include aerobics, strength training and flexibility. All components are design to meet the fitness levels of the participants. Chair exercises are demonstrated for participants who have limitations in standing.	Classes will be held at Senior Network of North Baltimore and Harford Senior Center Exercise bands are provided for strength training	A one hour class will be held weekly at each center year round # contacted # enrolled # attended # completed	Senior Network of North Baltimore - weight loss and muscle mass will be measured every 3 months Harford Senior Center - Weight loss will be measured every 3 months Behavioral targets: - Dietary changes - Increased physical activity	Senior Network of North Baltimore - weight loss, BMI, blood pressure, and muscle mass will be measured every 3 months Harford Senior Center - Weight loss , blood pressure, and BMI will be measured every 3 months	Community Outreach Nurse with Certification in Senior Fitness	Debbie Bena, RN

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			- Readiness to change assessment			

Internal MedStar Collaborations:

- MGSH Good Health Center and Physician practices to drive referrals into the program
- MGSH Public Relations/Marketing Department for promotion of the program
- Potential collaboration opportunities with other Baltimore area hospitals such as MUMH, MHH and MFSMC

External Collaborations:

- Community Partners such as GEDCO, HARBEL and local churches will assist in the promotion. Space to provide the classes will be provided by GEDCOs are design to meet the fitness levels of at the end of the 4

External Metric(s):

Baltimore City

- Age-adjusted mortality rate for heart disease (MD SHIP)
- Emergency department visit rate due to hypertension (MD SHIP)
- % of adults at healthy weight (BMI < 25 kg/m2) (MD SHIP)
- % of persons who meet the federal guidelines for physical activity (MD SHIP)
- CBSA-level metrics where available

1E. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes &	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Heart Disease – Smoking Cessation American Lung Association's "Freedom from Smoking Program" The "Freedom from Smoking" group clinic includes eight sessions and features a step-by-step plan for quitting smoking. Each session	Classes will be given by a registered nurse who has been trained by the American Lung Association to facilitate the program. Classes will be held at MGSH as well as other community locations Workbooks and a relaxation CD will be	An eight week session will be offered four times per year # contacted # enrolled # attended	Participants will quit smoking by the fourth week of the program	Participants will be smoke free at the end of the eight week program Participants will be smoke free one year after completing the program	Community Outreach nurses	Debbie Bena, RN

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is designed to help smokers gain control over their behavior. The clinic format encourages participants to work on the process and problems of quitting both individually and as part of a group.	given to each participant. Participants will be referred to "How to Quit Smoking Line" where they can access Nicotine patches or gum	# completed				

Internal MedStar Collaborations:

- MGSH Good Health Center and Physician practices to drive referrals into the program
- MGSH Public Relations/Marketing Department for promotion of the program
- Potential collaboration opportunities with other Baltimore area hospitals such as MUMH, MHH and MFSMC

External Collaborations:

- Community Partners such as GEDCO, HARBEL and local churches will assist in the promotion

External Metric(s):

Baltimore City

- State decrease in number of adults that smoke in Maryland to 14.4 % by 2014 (MD Ship)
- CBSA-level metrics where available

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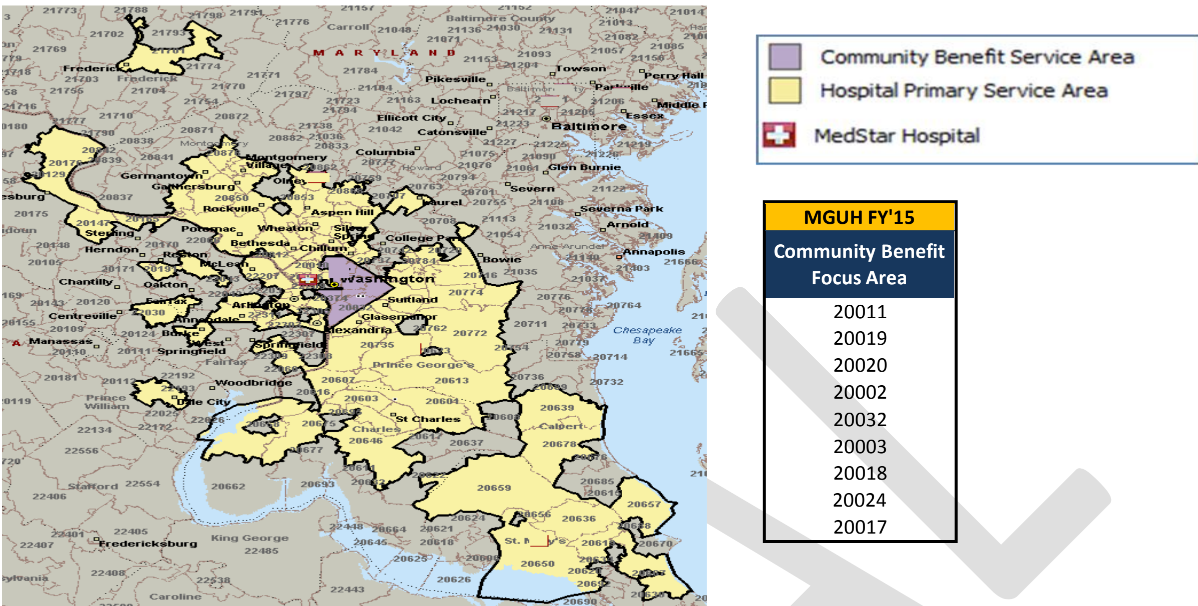
MedStar Georgetown University Hospital
Community Health Assessment FY2015



* Primary Service Area – represents ZIP codes that contain 50% of inpatient discharges
*Community Benefit Service Area is also included in the primary service area

1. Define the hospital's Community Benefit Service Area (CBSA) and identify the hospital's community benefit priorities.

MedStar Georgetown University Hospital's (MGUH) CBSA includes children and adults who reside in Wards 5, 6, 7, and 8 of the District of Columbia. This area was selected to expand upon pre-existing primary care services that are offered to underinsured, uninsured, and low-income persons. Based on secondary, CHNA survey and community input session findings, MGUH's community benefit priorities in chronic disease prevention and management are: 1) heart disease/stroke, 2) cancer and 3) diabetes. Other key priorities have been identified as the need for greater access to pediatric care, addressing childhood obesity and food insecurity.

2. Provide a description of the CBSA.

<u>Demographics</u>
According to the US Census Bureau, there are 292,986 residents in Wards 5 through 8 (Ward 5 - 74,308 residents, Ward 6 - 76,598, Ward 7 - 71,068, and Ward 8 - 70,112). [13] The concentration of adults older than 65 is higher in Ward 5 (15%) and Ward 7 (13%) compared to the city overall (11%). [23] Wards 5 though 8 have the highest rates of unemployment in the District of Columbia, as well as the lowest life expectancy, which is below the District average of 77.5 years.[4] Residents of Wards 5-8 have worse health outcomes compared to residents in other wards: [4]

Ward 5: Highest death rate from heart disease
Highest death rate from cancer
Second highest death rate from diabetes
Third highest obesity rate
Highest percent of residents without a primary healthcare provider

Ward 6: Third lowest percentage of residents getting routine healthcare check up
Highest percentage of uninsured residents

Ward 7: Second highest death rate from heart disease
Highest death rate from diabetes
Second highest obesity rate

Ward 8: Third highest death rate from heart disease
Third highest death rate from cancer
Third highest death rate from diabetes
Highest obesity rate

Residents specifically in Wards 5, 7 and 8 experience worse socioeconomic outcomes (see table).[13] These data are of particular importance, as they are the factors that comprise the Social Determinants of Health objective outlined in Healthy People 2020.[5]

Key Indicator	US	DC	Ward 5	Ward 6	Ward 7	Ward 8
% of Black/African American residents	13%	50%	80%	43%	96%	94%
% of unemployed adults	6%	7%	11%	7%	13%	14%
% of adults with a bachelor's or more advanced degree	29%	52%	33%	69%	17%	12%
Median income	$73,487	$101,076	$68,269	$106,460	$50,820	$42,615
% of families in Poverty	11%	15%	17%	11%	24%	33%

3. Identify community health assessment program partners and their expertise or contribution to the process.

Georgetown University's School of Nursing & Health Studies is an academic partner that brings a wide range of resources that contributed to MedStar Health's systemwide CHNA process. Their expertise in CHNAs and population health management has strengthened the rigor of data collection and data analysis methodologies. The school provided the following support: 1) consultation and support for CHNA survey and secondary data collection and analysis; 2) supported the development and validation of a community input instrument and summarized findings; 3) contributed to and promoted community input sessions; 4) reviewed drafts of the CHNAs prior to publication; and 5) managed student involvement and participation.

The **Healthy Communities Institute** provided quantitative data based on over 130 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

4. State who was involved in the decision-making process.

MedStar Georgetown University Hospital's Advisory Task Force reviewed local secondary data, coupled with state and federal community health goals. Task Force members also reviewed the hospital's operating plan, the outcomes of prior informal community health assessments, as well as current community benefit programs and services. In partnership with Georgetown University's School of Nursing & Health Studies, the team developed and helped disseminate a community health assessment tool around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life.

In addition to secondary data, CHNA survey and community input session findings, the Task Force considered the hospital's capabilities as well as local, regional and state health goals. Based on findings, the team made a recommendation on the priorities. The priorities were approved by the hospital's president, endorsed by the hospital board of directors, endorsed by the MedStar Health Board of Directors' Strategic Planning Committee and approved by the MedStar Health Board of Directors.

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Advisory Task Force Membership

Name	Title/Affiliation with Hospital	Name of Organization
Kara-Grace Leventhal	Graduate Student	Georgetown University
Matthew Levy, MD	Division Chief, Department of Pediatrics	MedStar Georgetown University Hospital
Sue A. Marshall	Executive Director	The Community Partnership for The Prevention of Homelessness
Jeffrey Novorr	Assistant Vice President	MedStar Georgetown University Hospital
Paula Reichel	DC Director	Capital Area Food Bank
Michael Sachtleben	Chief Operating Officer	MedStar Georgetown University Hospital
Lorraine Spencer, MSN, RN	Clinical Nursing Faculty	Georgetown University School of Nursing and Health Studies
Michael A. Stoto, PhD	Professor of Health Systems Administration and Population Health	Georgetown University School of Nursing and Health Studies
James C. Welsh, MD, MBA, MPH	Chair, Department of Family Medicine	Georgetown University
Regina Knox Woods	Vice President, Government Relations	MedStar Georgetown University Hospital

5. Justify why the hospital selected its community benefit priorities.

a) Chronic Disease

Secondary Data

Chronic diseases, including heart disease/stroke, cancer, diabetes, and obesity, often coexist as comorbidities. Health behaviors such as tobacco use, poor nutrition and physical inactivity contribute to chronic disease.[6]

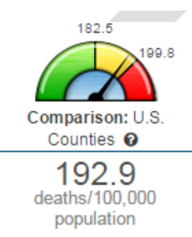
Heart Disease and Stroke

Death rate due to Stroke

41.3
49.2
Comparison: U.S. Counties
32.6
deaths/100,000 population
Measurement Period: 2011-2013

- The age-adjusted death rate in the District of Columbia due to heart disease is 240 per 100,000. Compared to all US counties, this figure falls within the range of the worst quartile. The age-adjusted death rate due to heart disease is significantly higher for Blacks/African Americans (330/100,000) compared to Whites (117/100,000).[4]
- The age-adjusted death rate due to stroke has decreased (from 40/100,000 persons in 2007 to **33/100,000** in 2012) and is lower than the national average (38/100,000 persons).[7] However, the death rate due to stroke is nearly twice as high for Blacks/African Americans as it is for Whites.[4]
- Heart disease is the second leading cause for hospitalization in the District, at an annual rate of 882 visits/100,000 persons.[4]
- The prevalence of high blood pressure (28%) and high cholesterol (34%) contributes to the age-adjusted death rate due to heart disease and stroke. The prevalence of high blood pressure and high cholesterol is highest in adults 65 and older, male adults and Blacks/African Americans.[7]
- Geographically, the prevalence of hypertension is highest in Ward 7 (42%) and Ward 8 (40%), where socioeconomic status is the lowest, and the prevalence of hypertension is lowest in Ward 3 (20%), where socioeconomic status is the highest.[4]

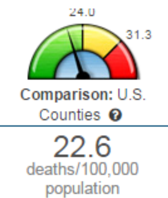
Death Rate due to Cancer



Cancer

- Cancer is the second leading cause of death in the District of Columbia. The age-adjusted death rate of cancer is **193 /100,000**, higher than the national rate (183/100,000). The incidence of breast, cervical and prostate cancer and the age-adjusted death rate due breast and prostate cancer all fall within the range of the worst quartile nationally.[7]
- The incidence rates of colorectal and lung cancer and the overall death rate due to cancer are higher for adult males than adult females. The overall death rate due to cancer is higher for Blacks/African Americans relative to Whites, and this disparity persists for the death rates due to breast, colorectal, lung and prostate cancer.[7]

Death Rate due to Diabetes



Diabetes

- The age-adjusted death rate due to diabetes is **23/100,000**. The prevalence of diabetes is approximately 8% and is higher among females (9%) compared to males (7%). Adults 65 and older (28%) are the most likely to be diagnosed with diabetes across age groups. The prevalence among Blacks/African

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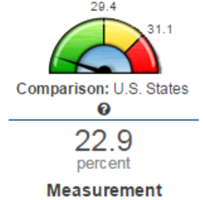
Prevalence of Obesity 	Americans (13%) is more than six times higher than the prevalence among Whites (2%).[7] • Diabetes is the seventh leading cause for hospitalization in the District, at an annual rate of 305 visits/100,000 persons.[4] *Obesity* • A total of 23% of adults in the District of Columbia are obese, and the trend has not changed in recent years. The prevalence of obesity is highest in adults between the ages of 35 to 64 and females. The prevalence of obesity is significantly higher in Black/African American residents (36%) than Hispanics (15%) or Whites (10%).[7] • Individuals earning less than $15,000 annually in the District of Columbia are nearly three times more likely to be obese compared to individuals in the city making more than $75,000.[4] *Addressing the Risk Factors* • The prevalence of current cigarette use in Washington, D.C. is 16% among adults; adults aged 45-54, males, and Hispanics and Black/African Americans report current smoking rates higher than the citywide average.[7] Adults with less than a bachelor's degree and those earning less than $35,000 or $50,000-$74,499 also report smoking rates higher than the citywide average. Geographically, adults in Wards 7 & 8 are most likely to smoke.[4] • Compared to the national median (24%), more adults in the city consume the recommended five or more servings of fruits and vegetables daily (32%). Females, Whites, and adults living in Wards 2, 3 and 5 are more likely to consume the recommended servings of fruits and vegetables daily. [7] • Currently, only 46% of the District of Columbia residents participate in at least 150 minutes of aerobic activity weekly, which is the recommended level of physical activity. [7] Approximately 80% of residents report that they participate in any leisure physical activity, which is higher than the national average.[4] Males, Whites, and adults younger than 45 are more likely to report participating in leisure physical activities compared to the citywide average.[7] Adults with a bachelor's or more advanced degree and those earning $75,000 or more are more likely to report participating in leisure physical activities relative to adults with less than a bachelor's degree and adults earning less than $75,000, respectively. Geographically, adults in Wards 1, 2, 3 & 6 are the most likely to be physically active.[4]
Community Health Needs Assessment Surveys and Community Input Sessions	CHNA Survey (N=192)[24] • Chronic disease is a recognized issue affecting the community, with survey respondents indicating that diabetes (43%), overweight/obesity (27%), cancer (27%) and heart disease (13%) are primary health conditions seen in their community. • Community members recognize the contributions of health behaviors to overall health status. Currently, survey respondents make healthy meals (58%), exercise at a local gym or recreation center (38%) and use parks, trails or a track (26%) to stay healthy. • Better places to exercise (17%) were recognized as community needs through the surveys and the community input sessions.

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Strategies	• To participate in health fairs that will include screenings for diabetes and blood pressure, and nutritional information. • To conduct free breast cancer screenings in the community. • To offer free cancer support groups for adults and youths. • To offer heart disease/stroke education and stroke support groups. • To conduct monthly diabetes program. • To sponsor a diabetes education community event. • To offer a prostate cancer community lecture.
Hospital Strengths	• MGUH has a robust multidisciplinary limb and wound center (plastic surgeons; podiatrists; vascular surgeons) that is capable of providing limb-sparing surgery for diabetic patients suffering from vascular insufficiency and chronic infections. • MGUH has a strong cardiology department with referral channel to MedStar's Washington Hospital Center for cases requiring surgical intervention.
Alignment with local, regional, state or national health goals	• Healthy People 2020: Cancer; Diabetes; Heart Disease and Stroke; Nutrition and Weight Status; Physical Activity; Tobacco Use[5] • DC Department of Health: Cancer; Cerebrovascular Disease; Diabetes; Heart Disease; Obesity; Physical Health; Tobacco Use[4]
Key Internal and External Partners	*Internal:* MedStar Washington Hospital Center, MedStar National Rehabilitation Network, Hoya Clinic, Georgetown University Medical School, Georgetown University Department of Pediatrics *External:* DC Department of Health, DC Consortium of Young Adults with Cancer, Capital Breast Care Center, DC Stroke Collaborative, American Heart Association, DC Fire and EMS, American Stroke Association, Celebramo Project, Sisters Informing Sisters, Look Good Feel Better
Metrics	*Internal Metrics* • % of program participants aware of risk factors associated with chronic diseases • % of program participants aware of behavioral risk factors associated with chronic diseases • % of program participants who adopt sustainable lifestyle behaviors that help reduce the prevalence of chronic diseases • % of program participants participating in the recommended levels of physical activity • % of program participants who follow-up with recommended care • % of program participants adhering to medication • % of program participants who lose weight • % of program participants with elevated blood pressure • % of program participants with elevated blood sugar • % of program participants receiving recommended screenings *External Metrics* • % of adults who are at a healthy weight (BMI< 25 kg/m^2)[9] • Age-adjusted death rate from cardiovascular disease[6] • Age-adjusted death rate from diabetes[6] • Emergency department visit rates and hospitalizations for diabetes[4] • Emergency department visit rates and hospitalizations for heart disease (high blood pressure) and stroke[4]

	• Age-adjusted death rate from cancer[6] • % of adults who participate in the recommended levels of physical activity[9] • % of adults who are obese[9] • % of women who receive breast cancer screening[9] • % of adults who consume the recommended amounts of fruits and vegetables daily[9]

b) Access to Pediatric Care	
Secondary Data Analyses	• Children and adolescents experience a unique set of health risks, and the behavioral patterns created during these developmental stages have implications for current health status and future chronic disease. Early and middle childhood is the time during which health literacy, self-discipline and eating habits are strongly established, and while this is a typically healthy age group, children are at risk for asthma, obesity, abuse, dental ailments, and mental health conditions.[5] • Currently, 15% of children and adolescents have been diagnosed with asthma. White children and adolescents are less likely to have a lifetime diagnosis of asthma compared to their Black/African American and Hispanic counterparts. Males have a much higher prevalence of lifetime asthma compared to females.[7] • Low access to and utilization of primary care services among children and adolescents can lead to high rates of hospitalization and emergency room visits for conditions like asthma.[5] For example, children and youth under the age of 18 experience higher rates of emergency department visits due to asthma than adults.[4] • When compared to other wards, Wards 7 and 8 have a high volume of individuals and families with incomes below the poverty level; there is also a shortage of medical providers who serve low income and homeless populations across the city.[4]
Community Health Needs Assessment Surveys and Community Input Sessions	CHNA Survey (N=192)[24] • Approximately 19% of survey respondents indicated that more healthcare services were needed within their communities.
Strategies	• To conduct community based asthma education. • To offer behavior health screenings with children in the community. • To conduct nutritional assessments via the Mobile Clinic. • To provide primary care services to adolescents via the Anacostia Wellness Center. • To provide primary care services for homeless persons via the Hoya Clinic.
Hospital Strengths	• Opportunities to provide primary prevention activities aimed at obesity and overweight are available through the MGUH Hoya Clinic and the Kids Mobile Clinic; inpatients can receive nutritional counseling and are referred to community-based counseling services.

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Alignment with local, regional, state or national health goals	• Healthy People 2020: Access to Health Services; Adolescent Health; Early and Middle Childhood; Mental Health and Mental Disorders; Respiratory Diseases[5] • DC Department of Health: Access to Care; Asthma; Mental Health; Youth and Young Adults[4]
Key Internal and External Partners	*Internal:* MedStar Washington Hospital Center, MedStar National Rehabilitation Network, Georgetown University Medical School, Georgetown University Department of Pediatrics, Hoya Clinic *External:* Anacostia High School, Other area schools
Metrics	*Internal* • % of students enrolled in the Wellness Check program • % of students with asthma who have an asthma care plan an medications *External* • Emergency department rates due to asthma for children 0-5[4] • Emergency department rates due to asthma for children 5-14[4]

c) Food Insecurity and Child Obesity	
Secondary Data	• Access to food, specifically food insecurity, is associated with chronic diseases, such as obesity, heart disease, diabetes and depression; 14% of residents and 28% of children in the city experience food insecurity.[7] • As a whole, the District of Columbia provides greater access to healthy food retailers compared to the national median, but disparities exist across city neighborhoods. For example, there are few grocery stores and farmers markets in Wards 7 and 8, where obesity prevalence is highest. While 50% of the children in the city live in Wards 7 & 8, only 10% of the grocery stores and fresh food outlets are located in those wards, and residents must depend on convenience stores, carry-out and traditional fast food restaurants as local food options.[4] • Approximately 72% of city students are eligible for free or reduced-price lunches, but compared to the rest of the country, schools in the District are not offering fruits and vegetables as competitive food choices during lunch.[4] • Currently, 15% of children and adolescents are obese. White children and adolescents are less likely to be obese compared to their Black/African American and Hispanic counterparts, and males have a slightly higher prevalence of obesity compared to female adolescents.[7]
Community Health Needs Assessment Surveys and Community Input Sessions	CHNA Survey (N=192)[24] • Affordable, healthy food (31%) was recognized as community needs through the surveys and the community input sessions. • Additionally, approximately 41% of survey respondents indicated that better food/grocery stores were the most important needs in their lives at the moment. Over one-fourth of survey respondents indicated that they had difficulty affording food on a regular basis.
Strategies	• To provide nutrition assessments via the Mobile Clinic. • To assess children for nutritional risk factors.

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Hospital Strengths	• Opportunities to provide primary prevention activities aimed at obesity and overweight are available through the MGUH Hoya Clinic and the Kids Mobile Clinic; inpatients can receive nutritional counseling and be referred to community-based counseling services.
Alignment with local, regional, state or national health goals	• Healthy People 2020: Adolescent Health; Early and Middle Childhood; Nutrition and Weight Status[5] • DC Department of Health: Food Trends in District; Obesity; Youth and Young Adults[4]
Key Internal and External Partners	*Internal:* MedStar Washington Hospital Center, MedStar National Rehabilitation Network, Georgetown University Medical School, Georgetown University Department of Pediatrics, Hoya Clinic *External:* Capital Area Food Bank, Area schools
Metrics	*Internal* • # of children impacted by nutritional education and awareness offerings • % of enrolled adults and teens consuming the recommended servings of fruits and vegetable • % of enrolled adults and teens participating in the recommended amount of weekly exercise *External* • % of children and adults who are overweight or obese (BMI ≥ 25 kg/m^2)[9,25] • % of adults and teens consuming the recommended servings of fruits and vegetables[9,25] • % of adults and teens getting the recommended amount of weekly exercise[9]

6. **Does the hospital currently have community benefit activities that support other key health needs that were identified as important in the Community Health Assessment? (Collaboration Areas)**

Issue	Evidence	Strategy	Partner
Difficulty obtaining food	27% of survey respondents indicated they have difficulty obtaining food on a regular basis.[24]	To explore opportunities to collaborate with the Capital Area Food Bank to increase access to healthy foods in Washington, DC.	Capital Area Food Bank

7. **List other health priorities that were identified in the CHNA and describe why the hospital did not select them. (Participation Areas)**

Issue	Evidence	Explanation	Lead
Affordable Housing	28% of survey respondents indicate affordable housing as a	The hospital does not have the expertise to have a leadership role in this area; therefore,	DC Housing Authority

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	needed service in the community.[24]	hospital will support external leaders in these areas.	

8. **Describe how the hospital will institutionalize community benefit programming to support these efforts.**

The hospital's Implementation Strategy is a roadmap for how community benefit resources will be deployed and how outcomes will be reported. The Community Benefit Hospital Lead will oversee planning, programming, monitoring, and evaluation of outcomes. The Executive Sponsor will support institutional efforts to re-organized or reallocate resources as needed. Annual progress updates will be provided to ATF members and the hospital's Board of Directors. The progress report will also be publicly accessible via the hospital's website.

The MedStar Health Corporate Community Health Department (CCHD) will provide system-wide coordination and oversight of community benefit programming. The CCHD will oversee the agenda of the Community Benefit Workgroup, which is comprised of Community Benefit Hospital Leads and other community health professionals across the system. The purpose of the workgroup is to share best practices and promote consistency around data collection, tracking, and reporting that is consistent with internal policies and state and federal guidelines.

The CCHD will provide the MedStar Health Board of Director's Strategic Planning Committee with annual updates on the hospital's progress towards the goals documented in the Implementation Strategy.

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MedStar Georgetown University Hospital
Community Health Assessment Work Plan
(FY16-FY18)

Priority Issue #1 – Chronic disease prevention and management, specifically heart disease, diabetes and cancer
Goal Statement – Reduce the prevalence and risk factors that contribute to chronic diseases among high risk individuals in Wards 5, 6, 7 and 8.

1A. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
Diabetes Monthly classes will be held for individuals in the community who have been identified as being pre-diabetic or diabetic. Classes will be held across the CBSA. The curriculum will include education on health behaviors that contribute to the prevention and management of diabetes.	Clinical dieticians Certified diabetes educators Educational events	Community health fairs; 3 per year - 300 screenings annually resulting from health fairs - # referrals to educational classes Monthly Diabetes and Pre-Diabetes classes taught; held monthly - 15 enrollees per month for both classes - -# of classes attended by each attendee	Increase regular attendance at the monthly diabetes and pre-diabetes education classes Increase the knowledge and awareness of risk factors associated with diabetes Increase awareness of behavioral risk factors, such as exercise and proper nutrition	Among program participants: Increase compliance with attendance at follow up appointments Increase compliance with taking prescribed medication to help control their diabetes Measure weight loss and impact on obesity rates	1.5 FTE to support the community based diabetes education activities. Clinical dietician Certified diabetes educator	Linda Park, Clinical Dietician

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<table>
<tr><td></td><td></td><td>Community-wide distribution of diabetes education newsletter</td><td></td><td>Improve clinical measures associated with diabetes, including blood glucose levels and blood pressure</td><td></td><td></td></tr>
<tr><td colspan="7">Activities to be phased in during the three year period:
MGUH is in the process of assessing and organizing all internally driven community activities to ensure resources are being effectively managed and strategically distributed to ensure that those most in need in the community are being reached. Additionally, opportunities to partner with more external community based partners are being explored and formalized as appropriate. As appropriate, an evaluation tool will be introduced to measure risk factor behaviors, knowledge, and readiness to change, among other metrics.</td></tr>
<tr><td colspan="7">Internal MedStar Collaborations:
The Diabetes education team will identify other individuals/departments within MedStar Health/MGUH that are providing similar or complementary services in the community to be able to partner and better with for community based activities. This will allow a greater reach and more efficient use of resources.
MGUH, MWHC, and MNRH will work collaboratively to identify community programs and services that should be considered as regional opportunities. Based on the regional opportunities that are identified, we will determine if we can collaborate and share resources to maximize the number of community members reached and not duplicate services unnecessarily. Specifically, MGUH will explore the opportunity to train employees to deliver the National Diabetes Prevention Program curriculum, a program that has been implemented at MWHC and other hospitals in the system.</td></tr>
<tr><td colspan="7">External Collaborations:
Partners outside of the MedStar network will be identified to work collaboratively and collectively on programming efforts in the community. Community partners may include the Capital Area Food Bank, the American Diabetes Association, and the DC Department of Health.</td></tr>
<tr><td colspan="7">External Metric(s):
Diabetes control initiatives are closely aligned with activities proposed by the US Department of Health and Human Services, Healthy People 2020, District of Columbia Department of Health, and the Centers for Disease Control and Prevention (CDC). Specific metrics are in the process of being developed with the support of key internal stakeholders. External metrics may include hospitalization/emergency department visit rates due to diabetes (DC DOH), age-adjusted death rates due to diabetes (DC DOH) and behavioral measures, such as physical activity and fruit and vegetable consumption (BRFSS).</td></tr>
<tr><td colspan="7"></td></tr>
<tr><td>1B. Provide a detailed description of the program or service</td><td>Inputs/Resources</td><td>Outputs</td><td>Short-term Outcomes</td><td>Long-term Outcomes & Impacts</td><td>Dedicated Staff</td><td>Person Responsible</td></tr>
<tr><td><u>Heart Disease/Stroke</u></td><td>Nurses and</td><td>Community health</td><td>Increase the</td><td>Increase the</td><td>Stroke Program</td><td>Colleen</td></tr>
</table>

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Educational sessions will be conducted throughout the community, especially in Wards 5-8, for individuals who may be at higher risk for heart disease/stroke, and for first responders who have the ability to improve outcomes with rapid identification and treatment of symptoms of heart attack and/or stroke.	physicians Educational and screening events	fairs; 3 per year - # of screenings/education Educational sessions for DC Fire and EMS; 2-3 per year - 80-120 participants Community stroke education talks; 2-3 per year - 20-30 participants at each event	number of individuals receiving screenings and education regarding symptoms of heart disease and stroke	number of patients who receive medical attention within 4.5 hours of the onset of symptoms of ischemic strokes	Coordinator	Dudley, RN
Activities to be phased in during the three year period: • MGUH is in the process of assessing and organizing all internally driven community activities to ensure resources are being effectively managed and strategically distributed to ensure that those most in need in the community are being reached. Additionally, opportunities to partner with more external community based partners are being explored and formalized as appropriate. The opportunity to expand on the educational sessions (integrating behavior change targets, etc.) will be explored.						
Internal MedStar Collaborations: • The stroke education team will identify other individuals/departments within MedStar Health/MGUH that are providing similar or complementary services in the community to be able to partner and better with for community based activities. This will allow a greater reach and more efficient use of resources. • MGUH, MWHC, and NRH will work collaboratively to identify community programs and services that should be considered as regional opportunities such as participation at DC Stroke Awareness Day and Strike Out Stroke. Based on the regional opportunities that are identified, we will determine if we can collaborate and share resources to maximize the number of community members reached and not duplicate services unnecessarily.						
External Collaborations: • Partners outside of the MedStar network may be identified to work collaboratively and collectively on programming efforts in the community. Community partners may include the American Heart Association, DC Fire and EMS, the DC Health Department, and the American Stroke Association.						

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External Metric(s):

- Heart disease control initiatives are closely aligned with activities proposed by the US Department of Health and Human Services, Healthy People 2020, Washington, DC Department of Health, and the Centers for Disease Control and Prevention (CDC). Specific metrics are in the process of being developed with the support of key internal stakeholders. External metrics may include hospitalization/emergency department visit rates due to heart disease and stroke (DC DOH) and age adjusted death rates due to heart disease and stroke (DC DOH) for the city and individual wards, when available.

1C. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
<u>Cancer</u> Cancer screenings, support groups, and educational sessions will be offered throughout the community, especially in Ward 5. Compared to other Wards across the city, the crude death rate due to cancer is highest in Ward 5.	Associates and physicians from the Lombardi Comprehensive Cancer Center Educational and screening events	Community health lectures; three per year - 75 attendees annually Monthly support groups for multiple types of cancer patients - 12 meetings annually - 60 participants annually The operation of free monthly cancer clinic Weekly free breast cancer screenings - # of screenings	Increase the number of individuals who receive cancer information to be able to self identify risk factors	Increase the number of individuals who get screenings, mammograms, and other diagnostic evaluations to reduce the death rate from cancer	All staff of the Lombardi Comprehensive Cancer Center	Janice Oppenheim

Activities to be phased in during the three year period:

- MGUH is in the process of assessing and organizing all internally driven community activities to ensure resources are being effectively managed and strategically distributed to ensure that those most in need in the community are being reached. Additionally, opportunities to

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partner with more external community based partners are being explored and formalized as appropriate. The opportunities to expand on the educational sessions and support groups (integrating behavior change targets, etc.) and to implement cancer navigation services with screenings will be explored.

External Collaborations:

- Celebramo Project, DC Consortium of Young Adults with Cancer, Sisters Informing Sisters, George Washington University, Georgetown University, Look Good Feel Better

External Metric(s):

- Cancer control initiatives are closely aligned with activities proposed by the US Department of Health and Human Services, Healthy People 2020, Washington, DC Department of Health, and the Centers for Disease Control and Prevention (CDC). Specific metrics are in the process of being developed with the support of key internal stakeholders. External metrics may include age-adjusted/crude death rates due to cancer (DC DOH) and cancer screening coverage (mammography, colonoscopy, etc.) for the city and individual Wards, when available (DC DOH) for the city and individual wards, when available.

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Priority Issue #2 – Access to Pediatric Care
Goal Statement – To increase access to pediatric healthcare and support services in Wards 7 and 8.

2A. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Continue to reach out to children in the community, especially Wards 7 and 8, to provide health screenings, education, and pediatric primary care.	The Department of Pediatrics staff and physicians.	Regular well child visits in schools and in other locations via the Mobile Clinic - -850 annual Mobile Clinic patient visits - -#children participating	See 850 children via the Mobile Clinic Enroll 60% of the student body of Anacostia High School in the school based primary care program	100% of kids diagnosed with asthma in the Mobile Clinic have an asthma care plan and medications 75% of the enrolled students in the Anacostia High School clinic get a well visit with a	Physicians Social worker Nutritionist	Dr. Matthew Levy

				school based primary care provider		

Activities to be phased in during the three year period:

- MGUH is in the process of assessing and organizing all internally driven community activities to ensure resources are being effectively managed and strategically distributed to ensure that those most in need in the community are being reached. Additionally, opportunities to partner with more external community based partners are being explored and formalized as appropriate. The opportunities to expand on the well child visits (integrating behavior change targets and tracking behaviors over time, etc.) will be explored.

Internal MedStar Collaboration:

- The Department of Pediatrics is hoping to identify other individuals/departments within MedStar Health/MGUH that are providing similar or complementary services in the community to be able to partner and better with for community based activities. This will allow a greater reach and more efficient use of resources.

External Collaboration:

- There is the potential to partner with other local school based well care providers and organizations providing other services to children. Possible external collaboration with Hoya Clinic for pediatric visits.

External Metric(s):

Access to pediatric care initiatives are closely aligned with activities proposed by the US Department of Health and Human Services, Healthy People 2020, Washington, DC Department of Health, and the Centers for Disease Control and Prevention (CDC). Specific metrics are in the process of being developed with the support of key internal stakeholders. External metrics may include emergency department visit rates due to asthma for children 0-5 and 5-14 for the city and for individual Wards, when available (DC DOH), the number of visits to the HOYA Clinic for pediatric patients (MGUH program records) and the number of visits to the Anacostia High School Clinic for adolescent patients (MGUH program records).

Priority Issue #3 – Food Insecurity and Obesity
Goal Statement – To promote healthy child development through nutrition education and increased access to nutritious foods in Wards 7 and 8, which have the highest rates of obesity in the District of Columbia.

3A. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Nutritional education programs will be presented at schools	The Department of Pediatrics staff and physicians.	# of programs held	Identify at least 150 kids who are at risk for	Enroll at least 15 families of those identified as high	Physicians	Dr. Matthew Levy

and through the mobile clinic in Wards 7 and 8.	Area Schools Mobile Clinic	150 program participants annually	becoming obese	risk for obesity into the MGUH obese weight management program	Social worker Nutritionist	

Activities to be phased in during the three year period:

- MGUH is in the process of assessing and organizing all internally driven community activities to ensure resources are being effectively managed and strategically distributed to ensure that those most in need in the community are being reached. Additionally, opportunities to partner with more external community based partners are being explored and formalized as appropriate. The opportunities to deliver an intensive behavioral change curriculum to enrolled families and to introduce an evaluation tool will be explored.

Internal MedStar Collaboration:

- The Department of Pediatrics is hoping to identify other individuals/departments within MedStar Health/MGUH that are providing similar or complementary services in the community to be able to partner and better with for community based activities. This will allow a greater reach and more efficient use of resources.
- MGUH, MWHC, and NRH will work collaboratively to identify community programs and services that should be considered as regional opportunities. Based on the regional opportunities that are identified, we will determine if we can collaborate and share resources to maximize the number of community members reached and not duplicate services unnecessarily.

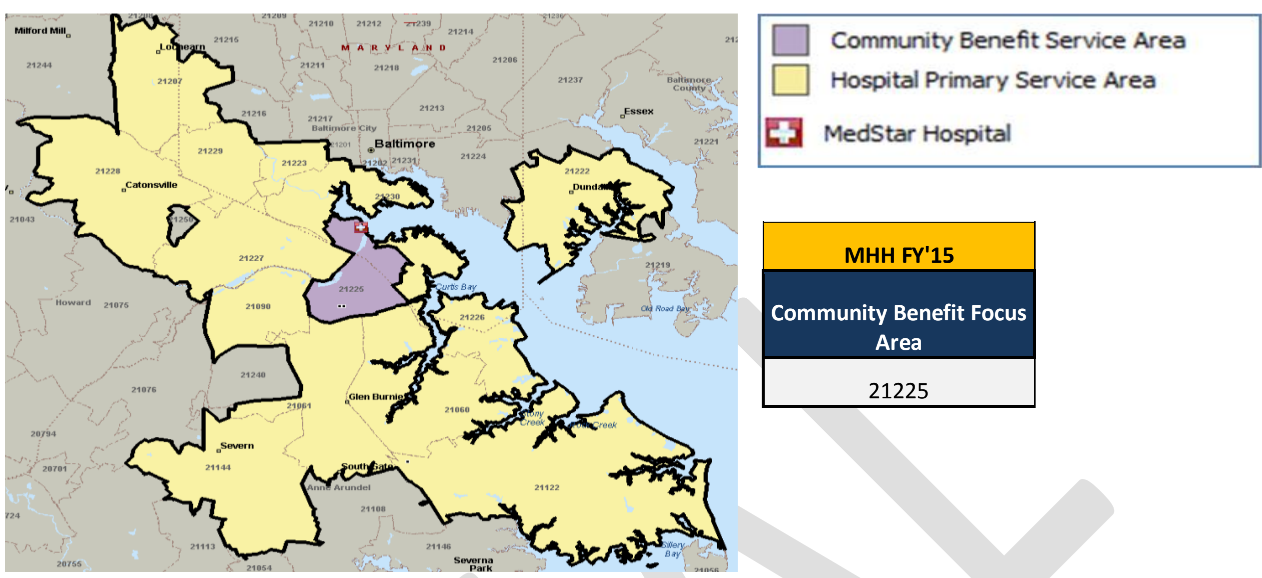
External Collaboration:

- There is the potential to partner with area schools, as well as the DC Area Food Bank and Hoya Clinic.

External Metric(s):

- Food insecurity and child obesity control initiatives are closely aligned with activities proposed by the US Department of Health and Human Services, Healthy People 2020, Washington, DC Department of Health, and the Centers for Disease Control and Prevention (CDC). Specific metrics are in the process of being developed with the support of key internal stakeholders. External metrics may include the percent of children and adults who are overweight or obese (BMI $\geq$ 25 kg/m2) (DC DOH), the percentage of adults and teens consuming the recommended servings of fruits and vegetables (BRFSS/YBRFS), and the percent of adults and teens getting the recommended amount of weekly exercise (BRFSS/YBRFS) across the city and for individual Wards, when available.

MedStar Harbor Hospital
Community Health Assessment FY2015



* Primary Service Area – represents ZIP codes that contain 50% of inpatient discharges
*Community Benefit Service Area is also included in the primary service area

1. **Define the hospital's Community Benefit Service Area (CBSA) and identify the hospital's community benefit priorities.**

   MedStar Harbor Hospital's (MHH) CBSA includes all residents of ZIP code 21225, the hospital's home ZIP code. The CBSA spans southern Baltimore City and northern Anne Arundel County, and includes four neighborhoods: Brooklyn, Brooklyn Park, Cherry Hill and Pumphrey. In particular, the hospital will focus on the Cherry Hill community. This area was selected due to its very high poverty rate and its close proximity to the hospital, as well as the opportunity to build on pre-existing programs, services, and partnerships. Based on secondary, CHNA survey, hospital utilization and community input session data, MHH's community benefit priorities in chronic disease prevention and management are: 1) heart disease, 2) cancer, 3) diabetes, and 4) obesity. Promotion of healthy behaviors among children and their families has also been identified as a key priority area.

2. **Provide a description of the CBSA.**

   Cherry Hill is historically a Black/African American neighborhood, with roots going back to the 17th century. After World War II, more than 600 housing units were built there by the United States War Housing Administration, specifically for African American war workers. Shortly after the war, these units were made into low-income housing. Additional low-income housing units have been added throughout the years, making Cherry Hill one of the largest housing projects east of Chicago.

The American Community Survey estimates the population of ZIP code 21225 at 35,401. The population in Cherry Hill is 9,285, and 95% of Cherry Hill residents are Black/African American, as compared with 63.3% of Baltimore as a whole. Approximately 52% of Cherry Hill households with children were headed by a single parent, higher than the citywide percentage of 26%.[13]

Twenty-seven percent of Cherry Hill residents ages 25 years and older do not have a high school education, while less than 6% of adults 25 and older have a bachelor's degree or higher. The median household income for Cherry Hill in is $18,118, which is less than half of the median household income for the entire CBSA ($37,149) , and approximately 44.5% of Cherry Hill families live in poverty.[13]

In terms of health care, the Cherry Hill community houses MHH, as well as a local branch of the Family Health Centers of Baltimore, which is a Federally Qualified Health Center (FQHC) providing health care services on a sliding fee scale. In addition, Baltimore City Health Department programs operate city-wide, and various mobile services—such as a needle exchange program, violence prevention, maternal and infant nursing, lead poisoning and abatement programs and others—in the Cherry Hill area.[3]

According to the Cherry Hill Health Profile, the life expectancy at birth of a Cherry Hill resident is 67.8, as compared to 71.8 in Baltimore City as a whole and 78.5 in the United States. Heart disease accounts for 25%of all deaths, and cancer accounts for 17%. Stroke, HIV/AIDS and homicide are less common but, when combined, cause 20%of deaths in this area. [3]

High rates of type 2 diabetes and heart disease, including stroke, also occur in this community. For a variety of reasons, including the high poverty rate and low rate of health care insurance coverage, many Cherry Hill residents often use the MedStar Harbor Hospital emergency department for primary care services. A steady decrease is anticipated in this area over the next few fiscal years as patients become insured through the Affordable Care Act.

Despite the convenient neighborhood location of a FQHC, many residents do not utilize a primary care physician. Typically, a chronic condition, such as diabetes or heart disease, presents severe enough symptoms to warrant a trip to the emergency department. In many cases, several co-morbidities are found to be present at this time. Without primary care follow-up, however, these conditions usually cannot be addressed fully in the time allotted for the emergent issue. In other cases, patients may have symptoms of a much less serious illness—a simple cold, for example—but, since they do not have a primary health care provider, they also visit the emergency department for these ailments. As a result, many of their most basic health needs often are not met.

3. Identify community health assessment program partners and their expertise or contribution to the process.

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Georgetown University's School of Nursing & Health Studies is an academic partner that brings a wide range of resources that contributed to MedStar Health's systemwide CHNA process. Their expertise in CHNAs and population health management has strengthened the rigor of data collection and data analysis methodologies. The school provided the following support: 1) consultation and support for survey and secondary data collection and analysis; 2) supported the development and validation of a community input instrument and summarized findings; 3) contributed to and promoted community input sessions; 4) reviewed drafts of the CHNAs prior to publication; and 5) managed student involvement and participation.

The **Healthy Communities Institute** provided quantitative data based on over 130 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

4. State who was involved in the decision-making process.

MedStar Harbor Hospital's ATF reviewed local secondary data, coupled with state and federal community health goals. Task Force members also reviewed the hospital's operating plan, the outcomes of prior informal community health assessments, as well as current community benefit programs and services. In partnership with Georgetown University's School of Nursing & Health Studies, the team developed and helped disseminate a community health assessment tool around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life.

In addition to secondary data, CHNA survey and community input session findings, the Task Force considered the hospital's capabilities as well as local, regional and state health goals. Based on findings, the team made a recommendation on the priorities. The priorities were approved by the hospital's president, endorsed by the hospital board of directors, endorsed by the MedStar Health Board of Directors' Strategic Planning Committee and approved by the MedStar Health Board of Directors.

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Advisory Task Force Membership

Name	Title/Affiliation with Hospital	Name of Organization
Antigone Vickery	Director, Office of Assessment, Planning and Response	Anne Arundel County Department of Health
Aruna Chandran, MD, MPH	Chief of Epidemiology	Baltimore City Health Department
Brent Flickinger	Director, Office Assessment, Planning and Response	Baltimore City Department of Planning
Joanne Robinson	Chairperson	Cherry Hill Community Action Center
Michael Middleton	Chairperson	Cherry Hill Community Coalition
Cathy McClain	Executive Director	Cherry Hill Trust
Will Sebree	Community Outreach Advocate	Family Health Centers of Baltimore
Tracey Garrett	President	Friendship Academy at Cherry Hill Elementary/Middle School
Kerunne Ketlogetswe, MD	Cardiologist	MedStar Harbor Hospital
Ned Carey	Chairman, Board of Directors	Maryland Aviation Administration
David Hager, MD	Chairman Dept. of Emergency Med.	MedStar Harbor Hospital
Luis Rivera-Ramirez, MD	Endocrinologist	MedStar Harbor Hospital
Leslie Hughan	Manager, Community Relations	MedStar Harbor Hospital
Calvert Moore, DNP, RN, APHN-BC	School Health Resource Coordinator	MedStar Harbor Hospital
Jill Johnson	Vice President, Operations	MedStar Harbor Hospital
Robert Dart, MD	Primary Care Physician	MedStar Harbor Primary Care

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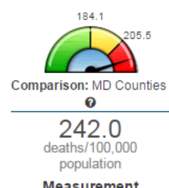
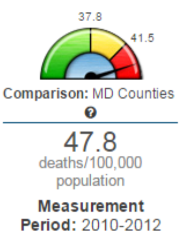
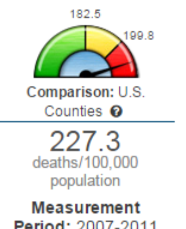
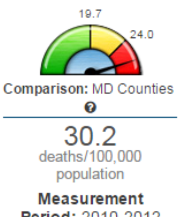
5. Justify why the hospital selected its community benefit priorities.

a) Chronic Disease	
Secondary Data	Chronic diseases, including heart disease/stroke, diabetes, and obesity, often coexist as comorbidities. Health behaviors such as tobacco use, poor nutrition and physical inactivity contribute to chronic disease.[6]
Death Rate due to Heart Disease 	*Heart Disease and Stroke* • Heart disease is the leading cause of death in Baltimore City, with an age-adjusted death rate of **242/100,000**. The age-adjusted death rate from heart disease is higher for Blacks/African Americans.[2] • The age-adjusted death rate due to stroke is also decreasing (from 51/100,000 persons in 2009 to **48/100,000** in 2012) but remains significantly higher than the state (38/100,000 persons) and national averages (38 deaths/100,000 persons).[2] • The rate of emergency department visits for hypertension per 100,000 persons in Baltimore City is 600 compared to 246 in Maryland, and the rate is highest among Black/African American residents relative to other racial/ethnic groups.[2] • The prevalence of high blood pressure (35%) and high cholesterol (33%) contributes to the age-adjusted death rate due to heart disease and stroke. The prevalence of high blood pressure and high cholesterol is highest among adults 65 and older and females. The relationship between heart disease risk factors and race/ethnicity varies. The prevalence of high blood pressure is higher in Blacks/African Americans relative to other racial/ethnic groups, whereas the prevalence of high cholesterol is higher for Whites relative to other racial/ethnic groups.[7]
Death Rate due to Stroke 	
Death Rate due to Cancer 	*Cancer* • Cancer is the second leading cause of death in Maryland and Baltimore City. The age-adjusted death rate due to cancer overall in Baltimore City is **215/100,000**, higher than the state average (164/100,000) and lower than the rate among Blacks/African Americans in Baltimore City.[26] • The incidence rates of colorectal and lung cancer and the overall death rate due to cancer are higher for adult males than adult females. The overall death rate due to cancer is higher for Blacks/African Americans relative to Whites, and this disparity persists for the death rates due to breast, colorectal and prostate cancer. No disparity is observed when comparing death rates for lung cancer across racial and ethnic groups.[5] • At MedStar Harbor Hospital, breast cancer treatment is the third most costly charity care service.[27]
Death Rate due to Diabetes 	*Diabetes* • The age-adjusted death rate due to diabetes is **30/100,000.**[2] The prevalence of diabetes is approximately 11% and is highest among females (14%) and adults 65 and older (28%). The prevalence among Blacks/African Americans (13%) is more than two times higher than the prevalence among Whites (5%).[7] • The rate of emergency department visits due to diabetes has increased from 444 visits/100,000 persons in 2010 to 502 visits/100,000 persons in 2013. Black/African Americans contribute largely to this high rate.[2]

Prevalence of Obesity 30.6 34.1 Comparison: MD Counties 35.8 percent **Measurement Period:** 2013	*Obesity* • A total of 36% of adults in Baltimore City are obese,[28] and the trend is increasing. The prevalence of obesity is highest among adults between the ages of 45 to 64 and females. The prevalence of obesity is significantly higher among Black/African American residents (45%) than Hispanics (28%) or Whites (21%).[7] *Addressing the Risk Factors* • Baltimore City ranks in the worst quartile for adult smoking rates with 22.7% of the adult population identifying as current smokers;[2] adults aged 45-64, males, and Blacks/African Americans report current smoking rates higher than the citywide average.[7] Individuals earning less than $15,000 also report higher rates of smoking compared to the citywide average.[3] • Only one-fourth of adults in the city report eating the recommended five or more servings of fruits and vegetables every day, which is higher than the state median. Adults aged 65 and older, females and Blacks/African Americans residents report eating the recommended fruits and vegetables at higher rates relative to the citywide average.[7] • Currently, only 44% of Baltimore City residents participate in at least 150 minutes of aerobic activity weekly, which is the recommended level of physical activity, and self-reported physical activity has slightly decreased in recent years.[7] More so, 30% of residents report that they do not participate in any leisure physical activity. [3] Adults 45 and older, females, and Hispanic and Black/African American residents are less likely to report participating in the recommended level of physical activity relative to the citywide average.[7]
Community Health Needs Assessment Surveys and Community Input Sessions	CHNA Survey (N=175)[28] • Chronic disease is a recognized issue affecting the community, with respondents indicating that overweight/obesity (56%), diabetes (48%), cancer (35%) and heart disease (26%) are primary health conditions seen in their community. • Community members recognize the contributions of health behaviors to overall health status. Currently, survey respondents make healthy meals (56%), exercise at a local gym or recreation center (33%) and use parks, trails or a track (25%) to stay healthy. • Approximately 29% of respondents reported eating fruits and vegetables several times a day, and a similar proportion reported eating fruits and vegetables most days (30%) and a few days a week (28%). • The respondents acknowledged that they would like to make health behavior changes. When asked what they would like to learn more about, the top five responses were: getting the most out of my food budget (43%), cooking healthy meals quickly (43%), making small changes to my diet (36%), adding physical activity into my daily routine (35%), and preparing fresh produce (33%). • Affordable, healthy food options (41%) and better places to exercise (31%) were two services that were recognized as community needs through the surveys and the community input sessions.
Strategies	• To provide healthy cooking demonstration classes. • To host a support network for healthy lifestyle changes. • To provide education talks at various community locations. • To offer a monthly diabetes support group to help those with the disease better manage their condition. • To conduct free monthly blood pressure screenings in community locations. • To provide free diagnostic screenings for the community, such as vision,

	cholesterol, foot, and glucose screenings. • To provide a full time nurse to support the Healthy Schools Healthy Families program. • To study barriers to men's health and wellness, and develop targeted programs and services. • To provide prevention education with key partners in areas of prostate, breast, lung, colorectal and skin cancers. • To provide detection education in areas of prostate, breast, lung, colorectal and skin cancers. • To provide screenings for breast and skin cancers. • To promote use of the new community cancer resource center. • To explore the feasibility of piloting or launching an evidence-based antismoking campaign.
Hospital Strengths	• Heart disease is a MedStar Harbor Hospital core competency, as the hospital has a cardiology infrastructure designed to diagnose and treat cardiac patients at every juncture in the clinical pathway. • MHH has a strong Diabetes and Endocrine Center that has been designed to provide multiple layers of clinical and educational support to our community. Experienced endocrinologists and Certified Diabetes Educators provide inpatient and outpatient care and education to patients with diabetes. • Oncology is a clinical service that MHH provides. The hospital, in conjunction with the MedStar Cancer Network, has a solid infrastructure of support, through seminars, screenings, and the Breast & Cervical Cancer Program and the Colorectal Cancer Screening Program.
Alignment with local, regional, state or national health goals	• Healthy People 2020: Diabetes; Heart Disease and Stroke; Nutrition and Weight Status; Physical Activity; Tobacco Use[5] • Maryland State Health Improvement Process (MD SHIP): Healthy Living; Quality Preventative Care[2] • Healthy Baltimore: Promote Access to Quality Health Care for All; Be Tobacco Free; Redesign Communities to Prevent Obesity; Promote Heart Health[3]
Key Internal and External Partners	*Internal:* MedStar Good Samaritan Hospital, MedStar Union Memorial, MedStar Franklin Square Hospital Center *External:* American Cancer Society, American Heart Association, Healthy Anne Arundel, Brooklyn Community United Methodist Church, Brooklyn Seventh Day Adventist, Empowering Believers Church, Jenkins Memorial Church, Metropolitan United Methodist Church, Mt. Zion United Methodist Church-Magothy, St. John Lutheran Church, St. John United Methodist Church, Allen Center for Seniors, Brooklyn Park Senior Center, Cherry Hill Senior Center, Curtis Bay Senior Center, Locust Point Senior Center, Shop Rite, Friendship Academy at Cherry Hill Elementary/Middle School, Dr. Carter G. Woodson Elementary/Middle School, Arundel Elementary/Middle School, Cherry Hill Coalition, Family Health Centers of Baltimore, Catholic Charities, American Lung Association, American Diabetes Association
Metrics	*Internal Metrics* • % of program participants who participate in the recommended levels of physical activity • % of program participants with elevated blood pressure • % of program participants with elevated blood sugar • % of program participants that successfully quit smoking cigarettes

	• % of program participants aware of risk factors associated with chronic diseases • % of program participants who adopt sustainable lifestyle behaviors that help reduce the prevalence of chronic diseases *External Metrics* • % of adults who are at a healthy weight (BMI< 25 kg/m^2)[2] • Age-adjusted death rate from heart disease[2] • % of adults who participate in the recommended levels of physical activity[2] • Emergency department visit rate due to hypertension[2] • Emergency department visit rate due to diabetes[2] • % of adults who smoke2 • % of women who receive breast cancer screening • % of adults with high blood pressure on medication

b) Children and Family Wellness	
Secondary Data	• Children and adolescents experience a unique set of health risks, and the behavioral patterns created during these developmental stages have implications for current health status and future chronic disease. Early and middle childhood is the time during which health literacy, self-discipline and eating habits are strongly established, and while this is a typically healthy age group, children are at risk for asthma, obesity, abuse, dental ailments and mental health conditions. In addition to childhood health conditions, adolescents are at high risk for sexually transmitted diseases, substance abuse, homicide, smoking and unplanned pregnancies.[5] • Currently, 15% of children and adolescents are obese[2], and White children and adolescents are less likely to be obese compared to their Black/African American and Hispanic counterparts.[7] Nearly 23% of middle school students report no leisure physical activity, and females and older students are less likely to report leisure physical activity.[3] • Currently, 12% of children and adolescents have been diagnosed with asthma,[3] and White children and adolescents are less likely to have asthma compared to their Black/African American and Hispanic counterparts.[7] • Nearly 17% and 21% of adolescents report using tobacco products or marijuana, respectively, in a 30 day period, and 11% of adolescents report binge drinking in the same period; males are more likely to use all of these substances.[3,7] • Students in Baltimore City are less likely to exhibit school readiness and academic proficiency compared to students across Maryland.[11]
Community Health Needs Assessment Surveys and Community Input Sessions	CHNA Survey (n=239)[28] • Of those who responded to questions about the community, 44% indicated that their neighborhood was not a good place to raise children. • During a community input session, community members identified violence and stress as environmental and social conditions that negatively impact health, and suggested that stress management techniques can be taught in the community. Additionally, programs for children and teens were identified as needed service.
Strategies	• To provide one school resource nurse to work in all three Cherry Hill elementary/middle schools. • To create and deliver education on a variety of topics that is pertinent to children

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	and families, including: anger management; hand hygiene; personal hygiene; parental involvement; sexually transmitted infection prevention; healthy habits; and asthma management.
Hospital Strengths	• MHH has an innovative program—Healthy School Healthy Families—that aims to improve the health and well-being of more than 1,400 children, their families and the staff in the three elementary/middle schools in the Cherry Hill Learning Zone. The program's focus is primarily on health education programs for the students, parents and guardians, and staff.
Alignment with local, regional, state or national health goals	• Healthy People 2020: Adolescent Health; Early and Middle Childhood [5] • Maryland State Health Improvement Plan (MD SHIP): Healthy Living; Healthy Communities[2] • Healthy Baltimore: Promote Healthy Children and Adolescents[3]
Key Internal and External Partners	*Internal*: MedStar Union Memorial Hospital, MedStar Good Samaritan Hospital, MedStar Franklin Square Medical Center *External*: Friendship Academy at Cherry Hill Elementary/Middle School, Dr. Carter G. Woodson Elementary/Middle School, Arundel Elementary/Middle School, It's About the Kids Education Organization, Kaiser Permanente Educational Theatre, American Heart Association, Cherry Hill Coalition, Under Armor, Baltimore City Department of Recreation and Parks
Metrics	*Internal Metrics* • % of students successfully completing the 8th grade • % of students who are accepted into their high school of choice • % of community input survey respondents who report that their community is not a safe place to raise children • % of program participants who have seen a primary care provider annually • % of program participants with elevated blood pressure • % of program participants with elevated blood sugar *External Metrics* • Incidence rates of gonorrhea and Chlamydia among adolescents[3] • % of children and adolescents who are obese[25] • Rate of juvenile homicide and non-fatal shooting victims[3]

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6. Does the hospital currently have community benefit activities that support other key health needs that were identified as important in the Community Health Assessment? (Collaboration Areas)

Condition/ Issue	Evidence	Strategy	Key Partners
Behavioral Health	32% (n=239) of survey respondents identified behavioral health conditions as a condition most seen in our community.[28] The Baltimore City Health Department identified recognizing and treating mental health care needs as a priority	To incorporate mental health awareness into community outreach efforts. To promote mental health programs that service residents within our CBSA.	Family Health Centers of Baltimore, Healthy Anne Arundel, Baltimore City Health Improvement Planning Council

Condition/ Issue	Evidence	Strategy	Key Partners
	area. Within Baltimore City, 21% of residents reported their own mental health was "not good" for eight or more days out of the past 30 days, as reported in the Healthy Baltimore 2015 Interim Status Report.[3] Anne Arundel County Department of Health 3-Year Strategic Plan also reports more than 2,900 hospitalizations in 2009 for mental health disorders.[29]		
Affordable Healthy Food Options	39% (n=239) of survey respondents identified affordable healthy food options as a service most needed in our community.[28]	To promote the use of community gardens and grocery delivery programs for the benefit of our community. To explore partnership opportunities with Maryland Food Bank. To explore hosting a farmers market.	Cherry Hill Community Garden, Baltimarket Virtual Supermarket, Baltimore City Office of Sustainability
Better places to exercise	28% (n=239) of survey respondents identified better places to exercise as a community need.[28]	To collaborate with organizations that offer free or reduced price physical activity programs. To integrate and promote those offerings in the hospital's community health programs.	Baltimore Rowing Club, Baltimore City Department of Recreation and Parks, Anne Arundel County Department of Recreation and Parks

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Condition/ Issue	Evidence	Strategy	Key Partners
Better Jobs	42% (n=239) of the CHNA participants identified better jobs as a community need.[28]	To participate in initiatives aimed at generating local businesses in or within close proximity of the service area. To support or advocate for citywide or state workforce development initiatives that target residents of the service area. To partner with learning establishments and local schools to provide job training and job preparation as we are able, through internships and other learning opportunities.	Cherry Hill Development Corporation, Maritime Academy, South Baltimore Learning Center, Northeast High School, Glen Burnie High School, Towson University, Vivien T. Thomas Medical Arts Academy, Mayor's Office of Employment Development, Baltimore City Community College

7. **List other health priorities that were identified in the CHNA and describe why the hospital did not select them. (Participation Areas)**

Condition/ Issue	Evidence	Strategy	Key Partners
Alcohol Addiction	49% (n=239) of CHNA participants identified alcohol addiction as a health condition most seen in our community.[28] The Baltimore City Health Department identified reducing drug and alcohol abuse as a priority area. Within Baltimore City, the hospital admission rate for alcohol-related disorders is 396/100,000 persons, as reported in the Healthy Baltimore 2015 Interim Status Report. [3]	The hospital does not have the expertise to have a leadership role in these areas; therefore, hospital will support external leaders in these areas.	Family Health Centers of Baltimore, Baltimore City Health Department, Healthy Anne Arundel

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Condition/ Issue	Evidence	Strategy	Key Partners
	Anne Arundel County Department of Health 3-Year Strategic Plan also reports the percentage of adults who regularly consume alcohol and who binge drink exceeds both the state and national averages.[29]	The hospital does not have the expertise to have a leadership role in these areas; therefore, hospital will support external leaders in these areas.	
Heroine/Opiod Addiction	30% (n=239) of the CHNA participants identified heroine/opioid addiction as a health condition most seen in our community.[28]The Baltimore City Health Department identified reducing drug and alcohol abuse as a priority area. Within Baltimore City, the admission rate for drug-related disorders is 324/100,000 persons, as reported in the Healthy Baltimore 2015 Interim Status Report.[3]		Family Health Centers of Baltimore, Baltimore City Health Department, Healthy Anne Arundel
Affordable Child Care	38% (n=239) of the CHNA participants identified affordable child care as a service most needed in our community.[28]		United Way of Central Maryland, Churches
Affordable Housing	35% (n=239) of the CHNA participants identified affordable housing as a service most needed in our community. [28]		United Way of Central Maryland, Cherry Hill Development Corporation

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8. Describe how the hospital will institutionalize community benefit programming to support the Implementation Strategy.

The hospital's Implementation Strategy is a roadmap for how community benefit resources will be deployed and how outcomes will be reported. The Community Benefit Hospital Lead will oversee planning, programming, monitoring, and evaluation of outcomes. The Executive

Sponsor will support institutional efforts to re-organize or reallocate resources as needed. Annual progress updates will be provided to ATF members and the hospital's Board of Directors. The progress report will also be publicly accessible via the hospital's website.

The MedStar Health Corporate Community Health Department (CCHD) will provide system-wide coordination and oversight of community benefit programming. The CCHD will oversee the agenda of the Community Benefit Workgroup, which is comprised of Community Benefit Hospital Leads and other community health professionals across the system. The purpose of the workgroup is to share best practices and promote consistency around data collection, tracking, and reporting that is consistent with internal policies and state and federal guidelines.

The CCHD will provide the MedStar Health Board of Director's Strategic Planning Committee with annual updates on the hospital's progress towards the goals documented in the Implementation Strategy.

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MedStar Harbor Hospital
Community Health Assessment Work Plan
(FY16-FY18)

Priority Issue #1- Chronic disease prevention and management, specifically obesity, heart disease, and diabetes
Goal Statement: To reduce the incidence, prevalence and risk factors contributing to chronic diseases within the community benefit service area of ZIP code 21225.

1A. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
Create a walking program for faith-based community groups, similar to hospital's existing Heart Smart Church. Through the program, information and engagement will be provided to increase physical activity. Pedometers and distance logs will be provided. Additional points will be awarded to participants who attend educational events, free screenings. Incentives will be given to participants and sites with the biggest increase (by percentage) of physical activity. In the long-term, we also will track PCP appointments held.	Local churches Community Relations Staff MedStar VNA Pedometers Site incentives	# of sites participating # of steps walked # of educational materials provided # of screenings provided # participants attended # participants completing program	Using FY16 data as a baseline, increase participants' daily physical activity levels Cardiovascular fitness improvement	Increase the percentage of participants who see a primary care provider annually Decrease the percentage of participants with high blood pressure Decrease the percentage of participants with high glucose levels	Community Relations Manager (20%)	Leslie Hughan

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Internal MedStar Collaborations:

- Partner with MedStar VNA— to provide trainings for each site leader; Exploration of the Hair, Heart, and Health program (MWHC and MSMH currently underway)

External Collaborations:

- Faith-based organizations within and near the CBSA

External Metric(s):

- % of adults who are at a healthy weight (BMI < 25 kg/m^2) (Maryland SHIP)
- Age adjusted death rate from cardiovascular disease (Maryland SHIP)
- % of adults getting recommended levels of physical activity by 20% (Baltimore City Health Department, Healthy Baltimore 2015)
- % of adults who are obese by 15% (Baltimore City Health Department, Healthy Baltimore 2015)

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1B. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
Create a walking program for community groups, similar to hospital's existing blood pressure program. Through the program, information and engagement will be provided to increase physical activity. Pedometers and distance logs will be provided. Additional points will be awarded to participants who attend educational events, free screenings. Incentives will be given to participants and sites with the biggest increase (by percentage) of physical activity. In the long-term, we also will track PCP appointments held.	Local senior centers Resident councils Community Relations Staff MedStar VNA Pedometers Site incentives	# of centers participating # of steps walked # of educational materials provided # of screenings provided	Using FY16 data as a baseline, increase participants' daily activity levels	Increase the percentage of participants who see a primary care provider annually Decrease the percentage of participants with high blood pressures Decrease the percentage of participants with high glucose levels	Community Relations Manager (20%)	Leslie Hughan

Internal MedStar Collaborations:
Partner with MedStar VNA— to provide trainings for each site leader and/or provide screenings. Possible partner with other Baltimore area hospitals.

External Collaborations:
Senior Centers

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External Metric(s):

- % of adults who are at a healthy weight (BMI < 25 kg/m^2)—Maryland SHIP
- Age adjusted death rate from cardiovascular disease—Maryland SHIP
- % of adults getting recommended levels of physical activity by 20%—Baltimore City Health Department, Healthy Baltimore 2015
- % of adults who are obese by 15%—Baltimore City Health Department, Healthy Baltimore 2015

Priority Issue #2: Cancer screening and prevention
Goal Statement: To increase cancer knowledge and access to prevention and screening services.

2A. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Open a community cancer center to provide support, education and resources to patients and family members experiencing cancer, as well encourage cancer screenings to the community at large.	Center space Oncologists Navigators Education materials	# of detection screenings provided # of people educated # of support groups held Attendance	Increase knowledge of the importance of cancer screenings Connect community members who have not been screened for cancers with screening services Cancer screenings that are recommended based on age, gender and other risk factors	Increase in cancer screening in those who were previously not screened Cancer screenings that are recommended based on age, gender and other risk factors, at the recurring intervals suggested	Community Relations Manager (10%) Cancer screening program coordinator (10%) Vice President of Operations (5%) Cancer Center Manager (10%)	Leslie Hughan Linda Wieczynski Jill Johnson Jen Marsh
Activities to be phased in during the three year period:						

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Eventually, programming should incorporate peer-lead discussions, inviting cancer survivors to connect with the community

Internal MedStar Collaboration:

- Possible collaboration with Baltimore area hospitals

External Collaboration:

- American Cancer Society—engage to be a resource support providing education materials and other information

External Metric(s):

- Age-adjusted cancer mortality rate from cancer (Maryland SHIP)
- Increase percent of women who receive breast cancer screening based on the most recent guidelines by 10% (Baltimore City Health Department, Healthy Baltimore 2015)
- Cancer morbidity and mortality in Anne Arundel County (Anne Arundel County Department of Health, 3-Year Strategic Plan Fiscal Year 2014-Fiscal Year 2016)
- % of adults 50 and older who have had a colon cancer screening in the last 10 years by 15% (Baltimore City Health Department, Healthy Baltimore 2015)

2B. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes & Impacts	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Re-implement smoking cessation classes for the community	Smoking Cessation instructor Education materials Nicotine replacement therapy (gum, patches, etc.)	# of classes held # of people educated	Increase the number of people who want to quit within the CBSA	Decrease the number of smokers in our community Increase the number of ex-smokers who have successfully quit the habit	Community Relations Manager (10%) Smoking cessation instructor (100%)	Leslie Hughan TBD

Activities to be phased in during the three year period:

Begin a peer support network for former smokers and smokers who are in the process of quitting.

Internal MedStar Collaborations:

- MedStar VNA–potentially has staff who could teach smoking cessation
- MedStar Franklin Square Medical Center—use MFSMC as the model for our classes, potentially share the cost of instructors and/or resources.

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External Collaborations: • Baltimore City Health Department—provides smoking cessation instructor training and resources
External Metric(s): • Age-adjusted cancer mortality rate from cancer (Maryland SHIP) • % of adults who currently smoke (Maryland SHIP) • Cancer morbidity and mortality in Anne Arundel County (Anne Arundel County Department of Health, 3-Year Strategic Plan Fiscal Year 2014-Fiscal Year 2016) • % of adults who currently smoke by 20% (Baltimore City Health Department, Healthy Baltimore 2015)

Priority Issue #3: Children and Family Wellness
Goal Statement: To promote healthy habits and healthy behaviors among students age 4 to 15 and their families.

3A. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes & Impacts	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Create a walking program for Cherry Hill children. Through the program information and engagement will be provided to increase physical activity. Pedometers and distance logs will be provided. Additional points will be awarded to participants who attend educational events, free screenings. Incentives will be given to participants and sites with the biggest	Friendship Academy at Cherry Hill Elementary/Middle School Dr. Carter Godson Woodson Elementary/Middle School Arundel Elementary/Middle School Community	# of steps walked # of educational programs provided Attendance	Using FY16 data as a baseline, increase participants' daily activity levels	Increase the percentage of participants who take an active role in living a healthy life	Community Relations Manager (20%) Community School Health Resource Coordinator (15%)	Leslie Hughan Calvert Moore, DNP, MS, RN, APHN-BC

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increase (by percentage) of physical activity. In the long-term, we also will track PCP appointments held.	Relations Staff Pedometers Site incentives					

External Collaborations:

- Under Armor—may be able to help provide incentives
- Baltimore City Department of Recreation and Parks—help provide physical activities
- Kaiser Permanente Educational Theatre— help provide educational programming

External Metric(s):

- Children and adolescents who are obese (Maryland SHIP)

3B. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes & Impacts	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Create a walking program for adult family members of Cherry Hill elementary/middle school students. Through the program information and engagement will be provided to increase physical activity. Pedometers and distance logs will be provided.	Friendship Academy at Cherry Hill Elementary/Middle School Dr. Carter Godson Woodson Elementary/Middle School Arundel Elementary/Middle School	# of steps walked # of educational programs provided # of screenings provided	Using FY16 data as a baseline, increase participants' daily activity levels	Increase the percentage of participants who see a primary care provider annually Decrease the percentage of participants with high blood pressures Decrease the	Community Relations Manager (20%) Community School Health Resource Coordinator (15%)	Leslie Hughan Calvert Moore, DNP, MS, RN, APHN-BC

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Additional points will be awarded to participants who attend educational events, free screenings. Incentives will be given to participants and sites with the biggest increase (by percentage) of physical activity. In the long-term, we also will track PCP appointments held.	Community Relations Staff Pedometers Site incentives			percentage of participants with high glucose levels		
Activities to be phased in during the three year period: Members will potentially become a support network for each other to encourage long-term sustainability						
Internal MedStar Collaborations: • Possible collaboration with Baltimore area hospitals						
External Collaborations: • Under Armor—may be able to help provide incentives • Baltimore City Department of Recreation and Parks—help provide physical activities						
External Metric(s): • % of adults who are at a healthy weight (BMI < 25 kg/m^2) (Maryland SHIP) • Age adjusted death rate from cardiovascular disease (Maryland SHIP) • Increase percent of adults getting recommended levels of physical activity by 20%—Baltimore City Health Department, Healthy Baltimore 2015 • Decrease the percent of adults who are obese by 15%—Baltimore City Health Department, Healthy Baltimore 2015						

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3B. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes & Impacts	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Provide an enhanced anger management program for Cherry Hill students.	Friendship Academy at Cherry Hill Elementary/Middle School Dr. Carter Godson Woodson Elementary/Middle School Arundel Elementary/Middle School Community Relations Staff	# of students participating # of sessions held # of students completing the program	Decrease in the number of office referrals for violent behavior	Increase in number of students successfully completing the 8th grade Increase in the number of students who are accepted into their high school of choice	Community School Health Resource Coordinator (15%)	Calvert Moore, DNP, MS, RN, APHN-BC

Internal MedStar Collaborations:
- Possible collaboration with Baltimore area hospitals.

External Collaborations:
- Safe Streets—help identify children who would benefit from this program

External Metric(s):
- Decrease rate of juvenile homicide and non-fatal shooting victims by 30%— Baltimore City Health Department, Healthy Baltimore 2015

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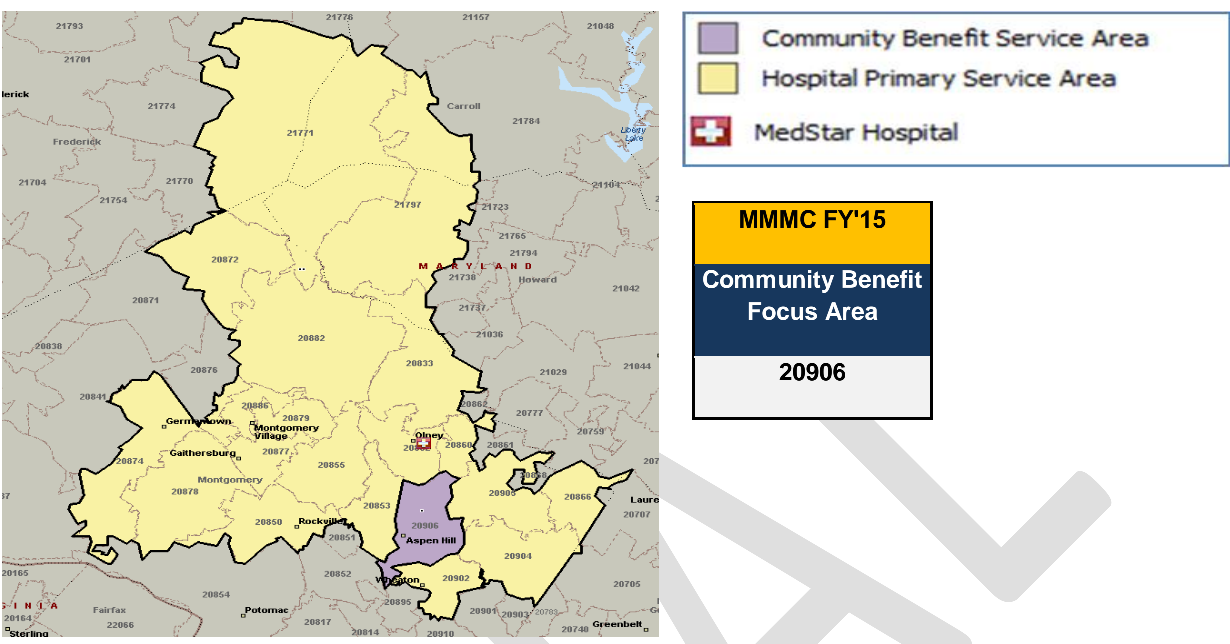
MedStar Montgomery Medical Center
Community Health Assessment FY2015



* Primary Service Area – represents ZIP codes that contain 50% of inpatient discharges
*Community Benefit Service Area is also included in the primary service area

1. **Define the hospital's Community Benefit Service Area (CBSA) and identify the hospital's community benefit priorities.**

   MedStar Montgomery Medical Center's (MMMC) CBSA includes residents in the Aspen Hill/Bel Pre neighborhood (ZIP code 20906). This area was selected due to its close proximity to the hospital, coupled with a high density of residents with low-incomes. Based on secondary, CHNA survey and community input session data, MMMC's community benefit priorities in chronic disease prevention and management are: 1) heart disease, 2) cancer, 3) diabetes, and 4) obesity.

2. **Provide a description of the CBSA.**

   The area encompassed by ZIP code 20906 has 67,387 residents. Over 19% of residents are age 65 and older, compared to 12% of Montgomery County. The population is racially diverse, with 44.3% White, 25.5% Black/African American, 12.3% Asian and 17.9% identifying as "Other," while 30.2% are of Hispanic origin. Relative to Montgomery County, there are a larger proportion of Black/African American and Hispanic residents, and there are more foreign-born residents in ZIP code 20906 (41.9% vs. 32.1%). The median income in the CBSA ($72,354) is lower than the countywide median ($98,221), and a higher proportion of residents in Aspen Hill/Bel Pre live in poverty (10.8% vs. 6.7%) (American Community Survey 5-year estimates). [13]

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Blacks/African Americans, males and older adults have the highest prevalence of heart disease, cholesterol and high blood pressure in Montgomery County.[8] As the Aspen Hill/Bel Pre population is disproportionately comprised of Blacks/African Americans and older adults, it represents a high risk area where chronic disease prevention and education can have the greatest impact.

3. **Identify community health assessment program partners and their expertise or contribution to the process.**

Georgetown University's School of Nursing & Health Studies is an academic partner that brings a wide range of resources that contributed to MedStar Health's systemwide CHNA process. Their expertise in CHNAs and population health management has strengthened the rigor of data collection and data analysis methodologies. The school provided the following support: 1) consultation and support for CHNA survey and secondary data collection and analysis; 2) supported the development and validation of a community input instrument and summarized findings; 3) contributed to and promoted community input sessions; 4) reviewed drafts of the CHNAs prior to publication; and 5) managed student involvement and participation.

Montgomery County Department of Health and Human Services (DHHS) provided countywide leadership to support the design of www.healthymontgomery.org, a web-based, interactive platform that houses quantitative data based on 130 community health indicators. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process. As a financial supporter of www.healthymontgomery.org, MMMC partners with the DHHS, other hospitals in the county, and community stakeholders to develop, support and execute a countywide community health improvement strategy.

4. **State who was involved in the decision-making process.**

MMMC's ATF reviewed local secondary data, coupled with state and federal community health goals. Task Force members also reviewed the hospital's operating plan, the outcomes of prior informal community health assessments, as well as current community benefit programs and services. In partnership with Georgetown University's School of Nursing & Health Studies, the team developed and helped disseminate a community health assessment tool around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life.

In addition to secondary data, CHNA survey and community input session findings, the Task Force considered the hospital's capabilities as well as local, regional and state health goals. Based on findings, the team made a recommendation on the priorities. The priorities were approved by the hospital's president, endorsed by the hospital board of directors, endorsed by the MedStar Health Board of Directors' Strategic Planning Committee and approved by the MedStar Health Board of Directors.

Advisory Task Force Membership

Name	Title/Affiliation with Hospital	Name of Organization
Dairy Marroquin	Coordinator, Community Outreach	MedStar Montgomery Hospital
Gina Cook	Manager, Planning, Marketing, and Community Health	MedStar Montgomery Hospital
Nikki Yeager	VP, Business, Marketing and Community Benefit	MedStar Montgomery Hospital
Debra Otani	Navigator, Cancer Center	MedStar Montgomery Hospital
Kate Davis	Director, Operations Innovation	MedStar Montgomery Hospital
Anna Laughren	Manager, Crisis Evaluation Unit	MedStar Montgomery Hospital
Robert Larkin, MD	Physician, Emergency Department	Emergency Management Associations, MedStar Montgomery Hospital
Morton Albert, MD	Physician, Psychiatry Department	Emergency Management Associations, MedStar Montgomery Hospital
Ana Alvarez	Member Representative	Leisure World Medical Center
Mary Jane Joseph	Community Member	Primary Care Coalition
Jon Hulsizer	Member Representative	Olney Chamber of Commerce
Marsha Batista	Resident Services Counselor	Public Housing Program
Matt Quinn	Member Representative	Greater Olney Civic Association
Keith Gibb	President	Brooke Grove Retirement Home

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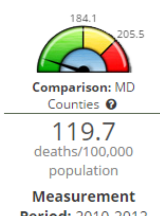
5. Justify why the hospital selected its community benefit priorities.

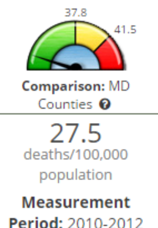
a) Chronic Disease

Secondary Data

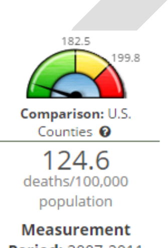
Death Rate due to Heart Disease



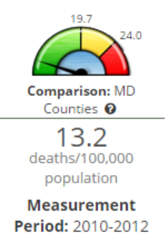
Death Rate due to Stroke



Death Rate due to Cancer



Death Rate due to Diabetes



Chronic diseases, including heart disease/stroke, cancer, diabetes, and obesity, often coexist as comorbidities. Health behaviors such as tobacco use, poor nutrition and physical inactivity contribute to chronic disease.[6]

Heart Disease and Stroke

- Heart disease is the second leading cause of death in Montgomery County, with an age-adjusted death rate of **120/100,000**. The age-adjusted death rate from heart disease is higher for Blacks/African Americans.[2]
- The age-adjusted death rate due to stroke is also decreasing (from 34/100,000 persons in 2006 to **28/100,000** in 2012) and is much lower than the state (38/100,000 persons) averages. [2]
- The rate of emergency department visits for hypertension per 100,000 persons in Montgomery County is 149 compared to 246 in MD, and the rate is highest among Black/African American residents relative to other racial/ethnic groups.[2]
- The prevalence of high blood pressure (28%) and high cholesterol (38%) contributes to the age-adjusted death rate due to heart disease and stroke. The prevalence of high blood pressure and high cholesterol is highest among adults 65 and older and males. The relationship between heart disease risk factors and race/ethnicity varies. The prevalence of high blood pressure is higher in Blacks/African Americans relative to other ethnic/racial groups, whereas the prevalence of high cholesterol is higher for Whites relative to other racial/ethnic groups.[8]

Cancer

- Cancer is the leading cause of death in Montgomery County, with an age adjusted death rate of **127/100,000**.[2]
- The incidence rates of colorectal and lung cancer and the overall death rate due to cancer are higher for males than females. The overall death rate due to cancer is higher for Blacks/African Americans relative to Whites, and this disparity persists for the death rates due to breast, colorectal, lung and prostate cancer. Hispanics and Asians have consistently lower age-adjusted death rates due to cancer overall and cancer types.[8]
- MMMC's most common cancer diagnoses among its patients include lung, colon, prostate and breast.[30]

Diabetes

- The age-adjusted death rate due to diabetes is **13/100,000**.[2] The prevalence of diabetes is approximately 9% and is highest among females (9%) and adults 65 and older (19%). The prevalence among Blacks/African Americans (11%) and Hispanics (11%) is higher than the prevalence among Whites (8%) and Asians (4%).[8]
- The rate of emergency department visits due to diabetes has increased from 87 visits/100,000 persons in 2010 to 103 visits/100,000 persons in

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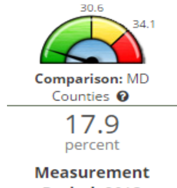
Prevalence of Obesity  	2013. Blacks/African Americans contribute largely to this high rate.[2] *Obesity* • A total of 18% of adults in Montgomery are obese. The prevalence of obesity is highest among adults between the ages of 45 to 64 and male adults. The prevalence of obesity is significantly higher among Black/African American residents (27%) than Hispanics (19%) or Whites (18%). [8] *Addressing the Risk Factors* • Montgomery County ranks in the best quartile for adult smoking rates with 8.2% of the adult population identifying as current smokers;[2] adults aged 18-44, males, and Blacks/African Americans report current smoking rates higher than the countywide average.[8] • Only 30% of adults in the county report eating the recommended five or more servings of fruits and vegetables every day, which is higher than the state median. Adults aged 65 and older, females and Asian and White residents report eating the recommended fruits and vegetables at higher rates relative to the countywide average.[8] • Currently, only 53% of Montgomery County residents participate in at least 150 minutes of aerobic activity weekly, which is the recommended level of physical activity, and self-reported physical activity has not changed in recent years. Adults younger than 65, males, and Hispanic and Black/African American residents are less likely to report participating in the recommended level of physical activity relative to the countywide average.[8]
Community Health Needs Assessment Surveys and Community Input Sessions	CHNA Survey (N=403)[31] • Chronic disease is a recognized issue affecting the community, with respondents indicating that overweight/obesity (48%), diabetes (44%), cancer (31%) and heart disease (29%) are primary health conditions seen in their community. • Community members recognize the contributions of health behaviors to overall health status. Currently, survey respondents make healthy meals (64%), exercise at a local gym or recreation center (42%) and use parks, trails or a track (40%) to stay healthy. • Affordable, healthy food options (28%) and better places to exercise (9%) were two services that were recognized as community needs through the surveys.
Strategies	• To provide free monthly cholesterol, blood pressure and glucose screenings, as well as health education outreach at local religious, educational and recreational centers. • To offer free weekly exercise classes to seniors, concentrating on improving cardiovascular health, weight loss, balance and flexibility. • To conduct community-based healthy lifestyles educational programs and lectures. • To provide free access to diabetes programs and education, promoting prevention and management of the disease. • To implement tobacco reduction strategies through Freedom from Smoking

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	program. • To provide cancer awareness, prevention and educational lectures, targeting risk and lifestyle factors leading to cancer. • To provide free screenings during monthly health fairs, seminars and lectures (i.e. PSA lab draws). • To develop and offer lung cancer support programs. • To promote smoking cessation among teenagers and adults. • To offer free access to mammogram screenings through the Women's Health Improvement Program and Proyecto Salud Clinic.
Hospital Strengths	• MMMC is a Certified Primary Stroke Center and Accredited Chest Pain Center, and a recipient of the state of the Gold Performance Achievement Award, Action Registry-GWTG from the American College of Cardiology and American Heart Association. • Currently MMMC is helping to ensure individuals have access to the primary care they need as part of Emergency Department-Primary Care Connect (ED/PC Connect), a project of the Primary Care Coalition of Montgomery County. The goal of ED/PC Connect is to navigate uninsured, low-income individuals to safety-net clinics providing primary care services. Patients who come to MMMC's ED for services and lack a primary care provider are referred to the Olney Proyecto Salud Clinic located on the hospital campus. Following the ED referral, a bilingual patient navigator contacts and works with the patient to assist them in scheduling an appointment at the clinic and educate them on ways to access care in non-emergency settings. Since the project started in July of 2009, hundreds of patients have been identified and referred to Proyecto Salud by MMMC's ED, where many are now receiving the high-quality, coordinated care they need, including preventive services. • MMMC's offers cancer support services -with so much care now being provided on an outpatient basis, support services are more important to cancer patients and their families when they are dealing with all the stresses of cancer treatment and recovery. o Look Good, Feel Better, a program that teaches women in active treatment how to enhance their appearance and feel better about themselves through the use of skin care products, wigs, scarves and other accessories. o Cancer Support Groups, which provide patients, families and caregivers with a comforting venue for sharing information and learning from the experiences of other individuals facing cancer.
Alignment with local, regional, state or national health goals	• Healthy People 2020: Cancer; Diabetes; Heart Disease and Stroke; Nutrition and Weight Status; Physical Activity; Tobacco Use[5] • Maryland State Health Improvement Process (MD SHIP): Healthy Living; Quality Preventative Care[2] • Healthy Montgomery: Cardiovascular Health; Cancers; Diabetes; Obesity[8]
Key Internal and External Partners	*Internal*: MedStar Visiting Nurse Association, MedStar St. Mary's Hospital, MedStar Southern Maryland Hospital Center *External*: Healthy Montgomery, Maryland Department of Health and Mental Hygiene, Millian United Methodist Church, Community Partners of Aspen Hill, Holy Cross Aspen Hill Clinic, Proyecto Salud Clinic, Longwood Community Center, Midcounty Community Center, American Lung

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	Association, Community Radiology, Women's Cancer Control Program, American Lung Cancer Association,
Metrics	*Internal Metrics* • MMMC Admission rate to specialty care due to cancer • MMMC emergency department admission rates due to chronic conditions • % of program participants aware of risk factors associated with chronic diseases • % of program participants who attend follow-up appointments • Changes in diet (reduced sodium, fruits and vegetables, etc.) • % of program participants participating in the recommended levels of physical activity • % of program participants with elevated blood pressure • % of program participants with elevated blood cholesterol • % of program participants with elevated blood sugar • Fitness level (balance, flexibility) • # of blood pressure and diabetes medications taken by program participants • % of program participants that successfully quit smoking cigarettes (# of cigarettes smoked, relapse rates, etc.) *External Metrics* • % of adults who are at a healthy weight (BMI< 25 kg/m^2)[2] • Age-adjusted death rate from heart disease[2] • Age-adjusted death rate from diabetes[2] • Age-adjusted mortality rate from lung cancer[8] • Incidence of lung cancer[8] • % of adults who currently smoke[2] • Emergency department admission rates (diabetes, hypertension) for Montgomery County[2] • % of adults who participate in the recommended levels of physical activity[2] • % of adults who consume recommended values of fruits and vegetables[9] • % of adults who are obese[9] • % of adults with high blood pressure on medication[9] • % of women who receive breast cancer screening[9]

6. Does the hospital currently have community benefit activities that support other key health needs that were identified as important in the Community Health Assessment? (Collaboration Areas)

Issue	Evidence	Strategy	Lead
Better public transportation	14% (n=403) of survey respondents indicate a need for better public transportation within the community.[31]	To continue to collaborate with Olney Home for Life to provide free transportation to seniors and cancer patients who need to attend their	Olney Home for Life

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		medical appointments.	
Affordable Healthy Food Options	28% (n=403) of survey respondents indicate a need to access healthy food options in the community.[31]	To continue to expand its partnership with local food centers, providing food distribution, education, and advocacy to the most needed.	Manna Food Center
Behavioral Health	29% (n=403) of survey respondents listed mental health as a top condition seen in their community.[31]	To continue the work of the Addictions and Mental Health Center, and build partnerships with local organizations to address unmet mental health needs.	Montgomery County Department of Health, Healthy Montgomery

7. **List other health priorities that were identified in the CHNA and describe why the hospital did not select them. (Participation Areas)**

Issue	Evidence	Explanation	Lead
Affordable Child Care	35% (n=403) of survey respondents indicate affordable child care as a needed service in the community.[31]	The hospital does not have the expertise to have a leadership role in these areas; therefore, hospital will support external leaders in these areas.	Montgomery Child Care Association, Maryland Family Network, Department of Health and Human Services
Affordable Housing	46 % (n=403) of survey respondents indicate affordable housing as a needed service in the community.[31]		Housing Opportunities Commission of Montgomery County, Department of Housing and Community Affairs
Better Jobs	19% (n=403) of survey respondents indicate there is a need for better jobs within the community.[31]		Montgomery County Department of Health and Human Services

8. **Describe how the hospital will institutionalize community benefit programming to support these efforts.**

The hospital's Implementation Strategy is a roadmap for how community benefit resources will be deployed and how outcomes will be reported. The Community Benefit Hospital Lead will oversee planning, programming, monitoring, and evaluation of outcomes. The Executive Sponsor will support institutional efforts to re-organized or reallocate resources as needed. Annual progress updates will be provided to ATF members and the hospital's Board of Directors. The progress report will also be publicly accessible via the hospital's website.

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The MedStar Health Corporate Community Health Department (CCHD) will provide system-wide coordination and oversight of community benefit programming. The CCHD will oversee the agenda of the Community Benefit Workgroup, which is comprised of Community Benefit Hospital Leads and other community health professionals across the system. The purpose of the workgroup is to share best practices and promote consistency around data collection, tracking, and reporting that is consistent with internal policies and state and federal guidelines.

The CCHD will provide the MedStar Health Board of Director's Strategic Planning Committee with annual updates on the hospital's progress towards the goals documented in the Implementation Strategy.

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MedStar Montgomery Medical Center
Community Health Assessment Work Plan
(FY16-FY18)

Priority Issue #1 – Chronic disease prevention and management, specifically heart disease, diabetes and obesity
Goal Statement – To reduce the prevalence and risk factors that contribute to chronic diseases among high risk populations within Aspen Hill/Bel Pre area.

1A. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
Heart Heart Health Program- Free community health screenings, with an emphasis on access to care, targeting residents of 20906 (Aspen Hill/Bel Pre area). A special focus is on minority populations, including African American and Hispanic communities, having risk factors that are linked to heart disease.	MedStar Visiting Nurse Association will provide screenings to participants Collect demographics using forms and excel spreadsheet Collect release forms for liability concerns Utilize protocol for follow up depending on results Provide a copy of results to participants Provide recommendations for	Demographic information # of participants/total screenings per event # of referrals provided to Holy Cross Aspen Hill Clinic, based on abnormal findings	Track initial blood pressure, cholesterol and glucose readings Track current physical activity level Track current eating behaviors (fruits, vegetables and sodium intake) Track number of referred patients	Track improvements in Blood pressure, cholesterol and glucose readings Track improvements in physical activity level Track change in eating behaviors (fruits, vegetables and sodium intake)	MedStar Visiting Nurse Association Nurse/Tech (20%) Community Outreach Coordinator (80%)	Dairy Marroquin, Community Outreach Coordinator

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	primary health care if they do not have a physician Screening Locations: Millian United Methodist Church Elementary and middle schools of Aspen Hill (for Parents)		who scheduled an initial PCP follow-up visit at Holy Cross Aspen Hill Clinic Track number of participants who returned to screening site for a second reading	Track number of PCP visits participant have scheduled and/or attended to at Holy Cross Aspen Hill Clinic for continuity of care		

Internal MedStar Collaborations: Three year collaboration and partnership between MMMC, MSMH and MSMHC

- Have bi-monthly conference calls
- Host 1 team site visit at each entity
- Develop and track common indicators in areas of overlap in regards to heart disease
- Share successful programming

External Collaborations:

- **Millian United Methodist Church-** Millian offers free groceries on the second Saturday of each month from 10:00 am – 12:00 pm to residents of Aspen Hill/Bel Pre neighborhood in need of additional food. MedStar Montgomery will target persons coming to pantry, by offering free health screenings and connecting them to primary care if necessary.
- **Community Partners of Aspen Hill-** Health and human service partnership of public and private agencies, schools, families and communities, based in local schools and Millian Memorial United Methodist Church. Provides possible partnership opportunities for community screenings.
- **Holy Cross Aspen Hill Clinic-** The health center participates in Montgomery Cares, a public/private partnership that provides health care to low-income, uninsured Montgomery County residents through a network of clinics. MedStar Montgomery will refer screened participants to clinic for primary care follow up is necessary.

External Metric(s):

- **Department of Health and Human Services (Healthy Montgomery)-** Percent of residents within ZIP code 20906 suffering from heart disease and related conditions
- **Maryland Risk Factor Surveillance System-** Percent of adults in Montgomery County who suffer from heart disease
- **Behavioral Risk Factor Surveillance System-** Track County's and ZIP code 20906 fruit and vegetable consumption

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1B. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
Obesity Senior Exercise Class- Free weekly exercise classes composed of low-impact aerobics movements, concentrating on improving cardiovascular health, weight loss, balance and flexibility. ZIP code 20906 has 61,097 residents, over 40% of who are age 54 or older and at risk of developing heart disease (Healthy Montgomery, 2011).	Class is facilitated by a certified fitness instructor Class- Every Tuesday and Wednesday at each location Light weights necessary per participant preferences Classes take place at the following locations: Longwood Community Center Mid County Community Center Ross Boddy Community Center	# of classes # of participants registered for each class	Pre Survey/Assessment: # of current Blood Pressure medications # of current Diabetes medication Current weight Current balance and flexibility abilities Current physical activity level	Post- Assessment to be distributed every 3 months, in order to track improvements within the following: # of current Blood Pressure medications # of current diabetes medication Current weight Improved balance and flexibility abilities Improvements in physical activity level	Class Instructor (50%) MMMC Class Coordinator (30%) MMMC Community Outreach Coordinator (20%)	Dairy Marroquin, Community Outreach Coordinator

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Internal MedStar Collaborations: Three year collaboration and partnership between MMMC, MSMH and MSMHC • Have bi-monthly conference calls • Host 1 team site visit at each entity • Develop and track common indicators in areas of overlap in regards to obesity • Share successful programming
External Collaborations: • **Healthy Montgomery and HM working Hospital groups-** Meet quarterly with both groups to discuss available obesity prevention program options within the community
External Metric(s): • **County's Department of Health (Healthy Montgomery)-** Percent of residents within ZIP code 20906 suffering from heart disease • **Maryland Risk Factor Surveillance System-** Percent of adults in Montgomery County who are overweight /obese • **Maryland Risk Factor Surveillance System-** State emergency department admission rates due to chronic heart disease

1C. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Diabetes Diabetes/Nutritional School-Health education on self management of the disease, which includes an adequate diet, regular physical activity and daily control of glucose levels.	Certified Health Educator/Nutritionist Classes to take place at MedStar Montgomery Medical Center Class sessions would be 2.5 hours long. Each participant would attend 3 classes	# of classes taught # of participants registered # of participants attended # of	Pre- Assessment: Current HBA1C readings Current Body Mass Index (weight) Current eating behaviors (fruit and vegetables intake)	Post-Assessment: HBA1c Readings Body Mass Index (weight) Eating behavior (fruit and vegetables intake)	Certified Health educator (70%) MMMC Community Outreach Coordinator (30%)	Dairy Marroquin, Community Outreach Coordinator

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		participants who completed the program	Current fitness/exercise activity involvement	Long term improvements in fitness/exercise levels		

Internal MedStar Collaboration:
Three year collaboration and partnership between MMMC, MSMH and MSMHC
- Have bi-monthly conference calls
- Host 1 team site visit at each entity
- Share successful programming
- MSMH- will share and assist, if adopted, with implementation of Simple Changes- National Diabetes Prevention Program

External Collaboration:
- **Proyecto Salud Olney**- Clinic is located on MMMC's campus and provides primary care services to more 60 uninsured diabetes patients who lack access to appropriate educational guidance. Patients at this location can highly benefit from services by obtaining an appropriate referral to MMMC's diabetes management and education programs.

External Metric(s):
- **Maryland Risk Factor Surveillance System-** County's age-adjusted death rate due to diabetes
- **County's Department of Health (Healthy Montgomery) -** Emergency Department admission rates due to uncontrolled diabetes
- **Behavioral Risk Factor Surveillance System-** Track county's and ZIP code 20906 fruit and vegetable consumption

1D. Provide a detailed description of the program or service	**Inputs/Resources**	**Outputs**	**Short-term Outcomes & Impacts**	**Long-term Outcomes & Impact**	**Dedicated Staff**	**Person Responsible**
<u>Access</u> Link Emergency Room patients to primary care, through hospital's established ED-PC connect program. The goal is to improve access to healthcare for low-income uninsured patients, with a focus on continuity of care for improved healthcare status. Care Connect (ED/PC	Bilingual navigator located in ED weekdays 10am-7pm: Meet with self pays Determine need for PCP/fu Schedule follow up and fax referral to clinic	# of referrals made to clinics # of referrals made specifically from ZIP code 20906	Track current health status at point of referral (glucose and BP readings) # of referred patients who scheduled an initial PCP follow up visit at referred clinic	Track improvement of health status (glucose and BP readings) # of patients referred to Holy Cross Aspen Hill Clinic for continuity of care Track barriers to care (barriers	Population Health Navigators (80%) Cancer Navigator (20%)	Debbie Otani, Cancer Navigator

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Connect) is a grant based project, regulated by the Primary Care Coalition of Montgomery County.	Patients to be referred to two clinics: Proyecto Salud Olney Holy Cross Aspen Hill			preventing patients from scheduling a PCP apt) Track MMMC's ED admission rates due to uncontrolled diabetes, heart disease and obesity		

Internal MedStar Collaborations:
Three year collaboration and partnership between MMMC, MSMH and MSMHC
- Have bi-monthly conference calls
- Host 1 team site visit at each entity
- Share successful programming

External Collaborations:
- **Proyecto Salud Clinic-** Clinic seeks to provide high quality, culturally competent, and affordable primary healthcare services to the uninsured and low-income populations of Montgomery County. MMMC is to refer identified ED uninsured patients to clinic for PCP follow up.
- **Holy Cross Aspen Hill Clinic-** The health center participates in Montgomery Cares, a public/private partnership that provides health care to low-income, uninsured Montgomery County residents through a network of clinics. MMMC will refer screened participants to clinic for primary care follow up is necessary.

External Metric(s):
- **County's Department of Health (Healthy Montgomery)-** County Emergency Department admission rates due to heart disease
- **County's Department of Health (Healthy Montgomery)-** County Emergency Department admission rates due to diabetes

Priority Issue #2 – Cancer prevention
Goal Statement – To increase cancer knowledge and access to screening and prevention services within ZIP code 20906 Aspen Hill/ Bel Pre area.

2A. Provide a detailed description of the program or service	**Inputs/Resources**	**Outputs**	**Short-term Outcomes**	**Long-term Outcomes & Impact**	**Dedicated Staff**	**Person Responsible**
<u>Cancer- Breast Cancer</u> Women's Health	A collaborative effort of MedStar Montgomery	# of mammograms per year	# of identified breast cancer	# of patients who received and completed	Cancer Navigator (100%)	Debbie Otani, Cancer Navigator

Improvement Program (WHIP)- The primary goal of WHIP is to increase the early detection of breast cancer by providing free, comprehensive, high-quality breast health services to uninsured, low-income women residing in Montgomery County.	Medical Center, Olney Proyecto Salud Clinic, Community Radiology Associates and Women's Cancer Control Program Breast health educational materials	# of screenings completed # of referred patients to specialty care	diagnoses Proyecto Salud Clinic to provide monthly follow up reports by BIRADS 0,1, 2, 3 with next DOS & whether they followed recommendations Patient survey- survey measures satisfaction with those involved in serving patients (clinic provider, CRA staff, clinic navigator) and overall WHIP, barriers to completing screening (fear, cost, time away from work, etc.)	treatment # of patients offered treatment, but declined treatment offer		

Internal MedStar Collaboration:
Three year collaboration and partnership between MMMC, MSMH and MSMNC

- Have bi-monthly conference calls
- Host 1 team site visit at each entity
- Develop and track common indicators in areas of overlap in regards to breast cancer
- Share successful programming

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External Collaboration:

- **Proyecto Salud Clinic-** Clinic seeks to provide high quality, culturally competent, and affordable primary healthcare services to the uninsured and low-income populations of Montgomery County. MMMC to referred identified ED uninsured patients to clinic for PCP follow up.

External Metric(s):

- **County's Department of Health (Healthy Montgomery)-** percent of women age 40 and above with a mammogram, specifically within ZIP code 20906.

2B. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Cancer- Lung Develop and offer lung cancer support programs, such as smoking cessation activities to support people who wish to quit smoking. Fax to Assist Program- new online brief tobacco intervention training which features the abbreviated AAR – Ask, Advise, and Refer – intervention, referral methods for the Quitline, and pharmacology information as well as CME credits.	Referrals to be facilitated by MMMC certified personnel: -Primary care -Case Managers -Social workers -ED Navigators Increase the number of contacts and connections made among individuals who wish to quit smoking tobacco products, through case managers, social workers and ED navigators Community Outreach	# of classes/series taught # of participant who register for the program # of pamphlets distributed # of connections made between navigators, social workers, inpatients	Pre Assessments to track Initial behaviors: # of cigarettes smoked per day Track demographic information-ZIP code (For quit rates purposes)	Post Assessment to demonstrate improvement in behaviors: # of cigarettes smoked per day # of participants who quit smoking Relapse rates among program participants	Case Managers (30%) Population Health Navigators (20%) Social Workers (20%) MMMC Community Outreach Coordinator (20%)	Dairy Marroquin, Community Outreach Coordinator

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	Coordinator to distribute MDquit.org pamphlets amongst partnered organizations, such as faith-based institutions, educational and community entities	# participants who attend sessions				

Internal MedStar Collaborations:

- **MedStar St. Mary's Hospital-** Partnership and collaborations in regards to MMMC adoption of MDquit.org Fax to Assist Program. Will share common experiences in regards to development of program.

External Collaborations:

- **Community Partners of Aspen Hill-** Health and Human Services partnership of public and private agencies, schools, families and communities, based in local schools and Millian Memorial United Methodist Church. MMMC will utilize partnership to allocate entities for distribution of pamphlets.

External Metric(s):

National Cancer Institute- Percent of Montgomery County residents with lung cancer
County's Department of Health (Healthy Montgomery) –County's age-adjusted death rate due to lung cancer

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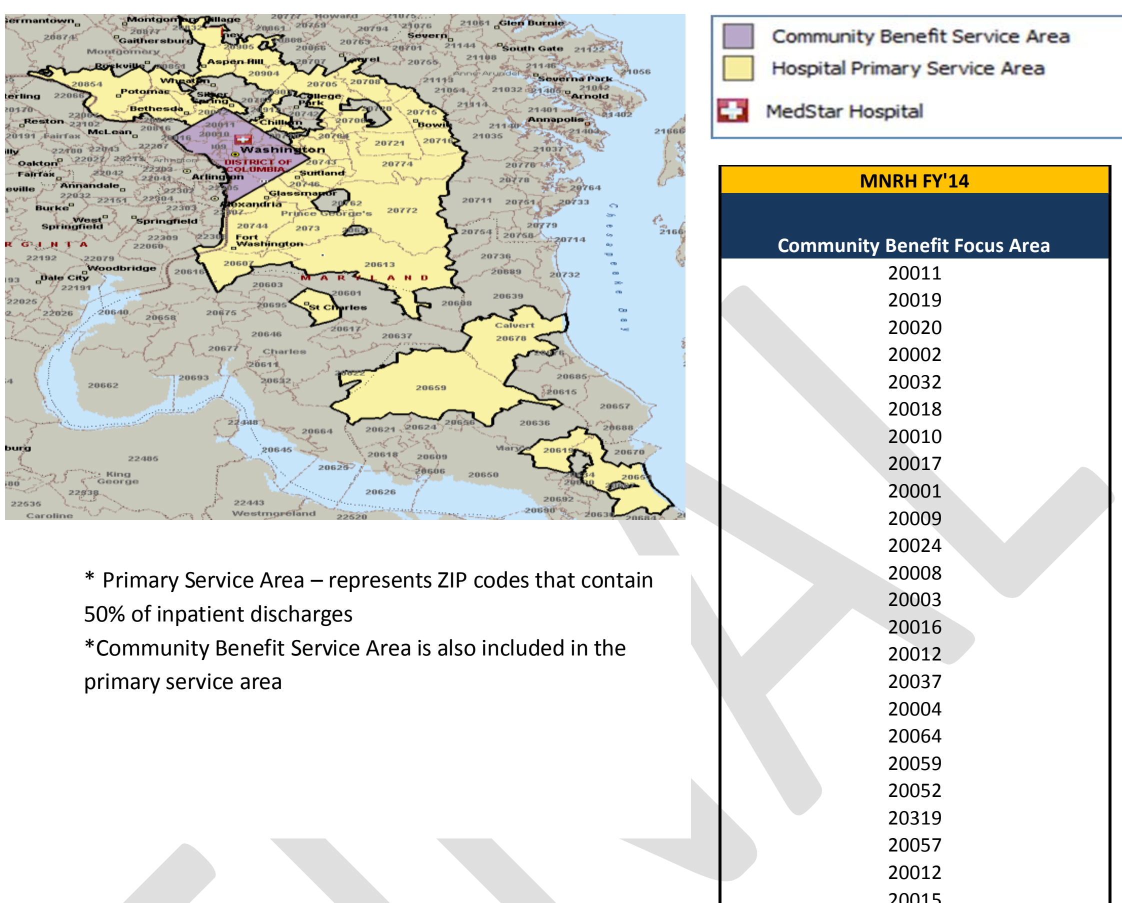
MedStar National Rehabilitation Network
Community Health Assessment FY2015



* Primary Service Area – represents ZIP codes that contain 50% of inpatient discharges
*Community Benefit Service Area is also included in the primary service area

MNRH FY'14
Community Benefit Focus Area
20011
20019
20020
20002
20032
20018
20010
20017
20001
20009
20024
20008
20003
20016
20012
20037
20004
20064
20059
20052
20319
20057
20012
20015

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1. Define the hospital's Community Benefit Service Area (CBSA) and identify the hospital's community benefit priorities

MedStar National Rehabilitation Network's (MNRN) CBSA includes residents living with disabilities in the Greater Washington area. Based on secondary, CHNA survey and community input session data, this population was identified due to the hospitals strengths and primary service area.

2. Provide a description of the CBSA.

According to the U.S Department of Health and Human Services, people with disabilities are more likely to have certain chronic diseases, such as obesity and high blood pressure, and more likely to experience high levels of psychological distress and receive less social support.[5] In the District of Columbia 17% of residents reported that their activities were limited by their physical, mental or emotional health problems. However, 9% of residents reported that they have health problems that require them to use special equipment, such as a cane or wheelchair, compared to only 8% nationally.[4]

Adults 55 and older were more likely than younger adults to report disability in the District of Columbia. Across gender and racial/ethnic groups in the city, males and Blacks/African Americans were most likely to report disability. A larger portion of individuals with less than a high school diploma and those earning less than $15,000 annually reported disability compared to the citywide average.[5] Residents in Wards 5 (15.9%), 7 (16.0%) and 8 (22.3%) are the most likely to use assistive devices.[32]

3. **Identify community health assessment program partners and their expertise or contribution to the process.**

Georgetown University's School of Nursing & Health Studies is an academic partner that brings a wide range of resources that contributed to MedStar Health's systemwide CHNA process. Their expertise in CHNAs and population health management has strengthened the rigor of data collection and data analysis methodologies. The school provided the following support: 1) consultation and support for CHNA survey and secondary data collection and analysis; 2) supported the development and validation of a community input instrument and summarized findings; 3) contributed to and promoted community input sessions; 4) reviewed drafts of the CHNAs prior to publication; and 5) managed student involvement and participation.

The **Healthy Communities Institute** provided quantitative data based on over 130 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

4. **State who was involved in the decision-making process.**

MedStar National Rehabilitation Network's ATF reviewed local secondary data, coupled with state and federal community health goals. Task Force members also reviewed the hospital's operating plan, the outcomes of prior informal community health assessments, as well as current community benefit programs and services. In partnership with Georgetown University's School of Nursing & Health Studies, the team developed and helped disseminate a community health assessment tool around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life.

In addition to secondary data, CHNA survey and community input session findings, the Task Force considered the hospital's capabilities as well as local, regional and state health goals. Based on findings, the team made a recommendation on the priorities. The priorities were approved by the hospital's president, endorsed by the hospital board of directors, endorsed by the MedStar Health Board of Directors' Strategic Planning Committee and approved by the MedStar Health Board of Directors.

Advisory Task Force Members

Name	Title/Affiliation with Hospital	Name of Organization
Derek Berry	Communications Director	MedStar National Rehabilitation Network
Joan Joyce	Recreation Sports Manager	MedStar National Rehabilitation Network
Michael Yochelson	VP, Medical Affairs & Chief Medical Officer	MedStar National Rehabilitation Network
Jill Anderson	Assistant Vice President, Outpatient	MedStar National Rehabilitation Network
Mary Babcock, DO	Physiatrist, Northern Virginia	National Spine & Pain Centers
Carol Bartlett	Manager of Care Coordination	MedStar National Rehabilitation Network
Dan Griffin	Supporter	Community Advocate
Suzanne Groah, MD	Director of SCI Research and Consultations, MNRH; Associate Professor of Rehabilitation Medicine	MedStar National Rehabilitation Network, Georgetown University
Adam Halberlin	Former Patient	Community Advocate
Kent Keyser	Former Patient	Community Advocate
John Rockwood	President	MedStar National Rehabilitation Network
Jennifer Sheehy	Secretary, Former Patient	MedStar National Rehabilitation Network, Board of Associates
Timothy Strachan	Former Patient	Community Advocate
Jackie Watson, DO	Executive Director, Board Member	DC Board of Medicine MedStar National Rehabilitation Network
Lisa Willis	Former Patient	Community Advocate

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5. Justify why the hospital selected its community benefit priorities.

Access to Physical Activity Programs	
Secondary Data	• Nationally, people with disabilities are less likely to participate in physical activity.[5] • Only 27% of persons with disabilities met the 2008 Physical Activity Guidelines; 47% of the general population met the same guidelines. More than half of persons with disabilities (54%) reported no leisure time physical activity at all, compared to 32% of the general population. [33]
CHNA Survey and Community Input Sessions	• A conversation among the ATF revealed that due to recent changes in the Medicare therapy cap, persons with disabilities are looking for alternatives to therapy and ways to continue the rehabilitation process.[34]
Strategies	• To provide sports programs in the community, including: adapted rowing; archery; junior sled hockey; quad rugby (wheelchair rugby); wheelchair basketball; handcycling; wheelchair tennis; bocce ball. • To provide weekly fitness classes for persons with disabilities at MNRN and within the community.
Hospital Strengths	• MNRN has an established recreational sports program and existing community partners to support this community benefit priority area.
Alignment with local, regional, state or national health goals	Healthy People 2020: Disability and Health; Physical Activity[5] D.C. Department of Health: Disability; Physical Health[4]
Key Internal and External Partners	*Internal:* MedStar Washington Hospital Center, MedStar Georgetown University Hospital *External:* Maklin Foundation, US Paralympics, DPI Fitness, Montgomery County Parks and Recreation
Metrics	*Internal* • % of persons in the program who meet Physical Activity Guidelines • % of persons in the program reporting leisure time physical activity • % of persons in the program reporting improved mental and physical wellbeing • % of persons in the program consuming recommended fruits and vegetables daily • % of persons in the program reporting increased water consumption *External* • % of persons with disabilities who meet Physical Activity Guidelines[33] • % of persons with disabilities reporting leisure time physical activity[33]

6. Does the hospital currently have community benefit activities that support other key health needs that were identified as important in the Community Health Assessment? (Collaboration Areas)

No Collaboration Areas were identified at time of CHNA. However, post CHNA, obesity and diabetes were explored as collaboration areas with other MedStar District of Columbia hospitals.

Issues	Evidence	Explanation	Lead
Obesity & Diabetes Management and	Adults with disabilities are 58% more likely to be overweight or obese, and	Areas of collaboration were identified post CHNA and are	To be determined

Prevention	have elevated rates of high blood pressure due the lack of engagement in fitness activities compared to individuals without physical disabilities. This places individuals at higher risk for diabetes(Healthy People 2020).	currently being explored with other MedStar Washington Region hospitals.	

7. List other health priorities that were identified in the CHNA and describe why the hospital did not select them? (Participation Areas)

Issues	Evidence	Explanation	Lead
Transportation	Due to transportation challenges the late or no-show for physician appointments at MedStar NRH is 25-30%.	The hospital does not have the expertise to have a leadership role in these areas; therefore, hospital will support external leaders in these areas.	Washington Metropolitan Area Transit Authority
Inadequate caregiver support	Experienced by hospital staff and supported by various scholarly articles[35], including *The Burden of Caregiving in Partners of Long-Term Stroke Survivors* (Reimer, de Hann, Rijnders, Limburg, and van den Bos) and *Evidence for Stroke Family Caregiver and Dyad Interventions* [36](Bakas, Clark, Kelly-Hayes, King, and Lutz, Miller).		To be determined

8. Describe how the hospital will institutionalize community benefit programming to support these efforts.

The hospital's Implementation Strategy is a roadmap for how community benefit resources will be deployed and how outcomes will be reported. The Community Benefit Hospital Lead will oversee planning, programming, monitoring, and evaluation of outcomes. The Executive Sponsor will support institutional efforts to re-organized or reallocate resources as needed.

Annual progress updates will be provided to ATF members and the hospital's Board of Directors. The progress report will also be publicly accessible via the hospital's website.

The MedStar Health Corporate Community Health Department (CCHD) will provide system-wide coordination and oversight of community benefit programming. The CCHD will oversee the agenda of the Community Benefit Workgroup, which is comprised of Community Benefit Hospital Leads and other community health professionals across the system. The purpose of the workgroup is to share best practices and promote consistency around data collection, tracking, and reporting that is consistent with internal policies and state and federal guidelines.

The CCHD will provide the MedStar Health Board of Director's Strategic Planning Committee with annual updates on the hospital's progress towards the goals documented in the Implementation Strategy.

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MedStar National Rehabilitation Network
Community Health Assessment Work Plan
(FY16-FY18)

Priority Issue #1 – Access to physical activity programs
Goal Statement – Facilitate opportunities for wellness through physical activities and sports for those with disabilities in the Washington, D.C. region. Population would be predominantly males, with disabilities.

1A. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
Implement adaptive sports programs/teams, with weekly fitness classes for persons with disabilities at MedStar NRN and within the community. This will provide physical activity to those who are not always able to receive it and help in the fight against obesity.	Recreational therapists Therapy aides Community events centers Practice facilities in and around the D.C. region Equipment specific for each adaptive sport	# of community sites where programs are presented # of fitness programs offered # participants enrolled for each program # sessions attended by each participant	Increase the number of participating community sites and participants at each site Among participants: Improved physical well-being Improved mental well-being Increase in weekly physical activity Increase in fruit and vegetable intake and Increase in water consumption	Weight loss Increase in cardiovascular fitness levels Increased mobility Mental health status improvement	Recreation Sports Manager (100%)	Joan Joyce

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To be phased in:

- Addition of a nutrition component to the program.
- Addition of an evaluation tool that looks at obesity risk factors, changes in knowledge, readiness to change and participant demographics. This tool could ask participants to self-report variables such as weight, height, blood pressure, physical activity, and diet, both pre-and post-program

Internal MedStar Collaborations

- MNRN, MWHC and MGUH, will explore collaboration opportunities around obesity and diabetes prevention and management. These three hospitals will continue to work collaboratively to identify community programs and services that should be considered as regional opportunities. Based on the regional opportunities that are identified, we will determine if we can collaborate and share resources to maximize the number of community members reached and not duplicate services unnecessarily.

External Collaborations:

- MedStar NRH works with various community partners to help with the fields of play so to speak for our adaptive sports teams. These collaborations include organizations such as US Paralympics, DPI Fitness and Montgomery County Parks and Recreation.

External Metric(s):

National Health Interview Survey:

- Percent of persons with disabilities who meet physical activity guidelines
- Percent of persons with disabilities who report leisure time physical activity

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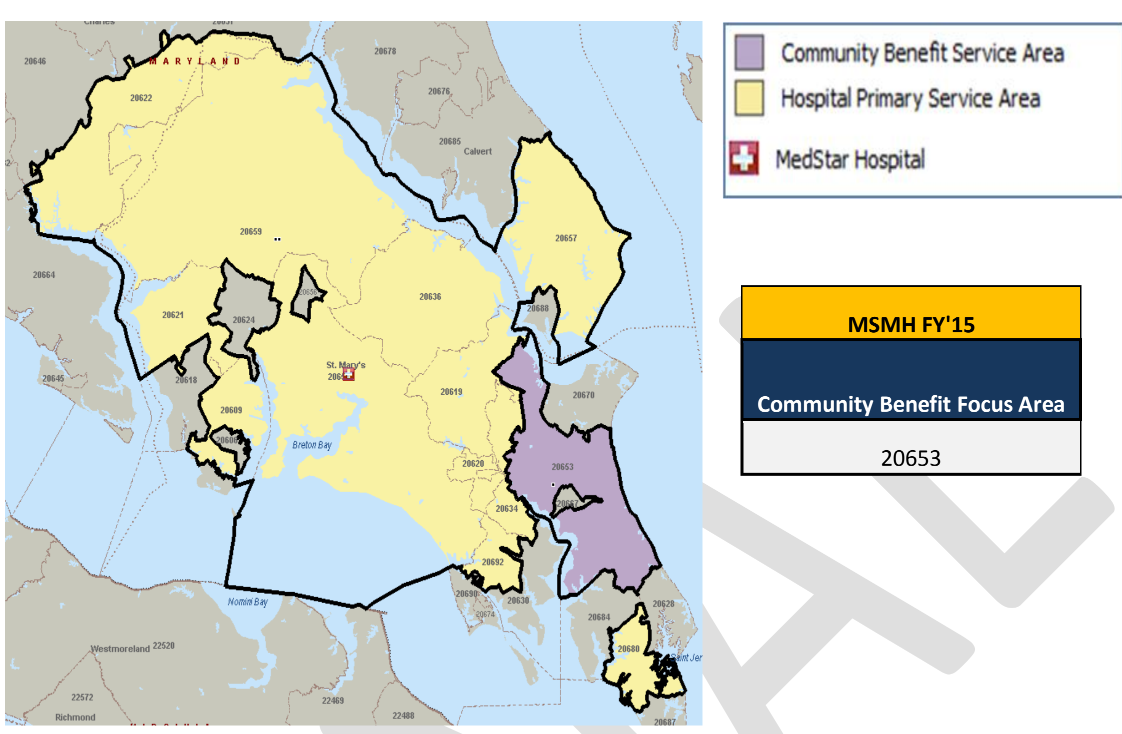
MedStar St. Mary's Hospital
Community Health Assessment FY2015



* Primary Service Area – represents ZIP codes that contain 50% of inpatient discharges
*Community Benefit Service Area is also included in the primary service area

1. **Define the hospital's Community Benefit Service Area (CBSA) and identify the hospital's community benefit priorities.**

   MedStar St. Mary's Hospital's (MSMH) CBSA includes the 109,633 residents of St. Mary's County, Maryland, with a focus on the Lexington Park community (ZIP code 20653). The Lexington Park community was selected due to a high density of low-income residents. Based on secondary, CHNA survey and community input session data, MSMH's community benefit priorities in chronic disease prevention and management are: 1) heart disease, 2) cancer, 3) diabetes, 4) obesity, and 5) Alzheimer's disease. Substance abuse, access to care for the uninsured and behavioral health have also been identified as community benefit priority areas.

2. **Provide a description of the CBSA.**

   St. Mary's County has a population of 109,633 citizens.[13] St. Mary's County is a federally designated rural area with a diverse population. Farmers, waterman, high tech scientists, defense contractors/engineers and military members live alongside Amish and Mennonite communities, making the St. Mary's County population unique. The residents of St. Mary's County are majority White (79.3%), followed by Black/African American (14.3%), Hispanic

(4.5%), Asian (2.8%), American Indian/Alaska Native (0.4%) and Native Hawaiian and other Pacific Islander (0.1%). Approximately 5% of residents are of Hispanic origin.[13]

St. Mary's County has been the fastest growing county in Maryland within the past 10 years - with a population increase of 22% since 2000, and 4.3% growth in the last three years. The county also has the highest percentage of veterans in Maryland, one of the lowest median ages, and an emerging Hispanic population, all of which impact health and delivery of health services.[13] Heart disease, cancer, lower respiratory illnesses, stroke and diabetes are the leading causes of death.[2] Most residents (76.5%) work in the county.[13] The high paying jobs associated with the Patuxent River Naval Air Station mask a growing underserved area located outside the base gates in the Lexington Park community (ZIP code 20653).

With approximately 18.3% of the population living below the federal poverty level, Lexington Park has the greatest number of medically underserved citizens in the area. Approximately 11% (11,626 residents) of the St. Mary's population lives in the Lexington Park Census Designated Place (CDP), which is the single largest center of population in the county, with a disproportionate number living in poverty or near poverty levels. The largest number of minorities (32% Black/African American and 7.4% Hispanic) live within this census tract. The median annual family income for Lexington Park is $66,932, as compared to the median annual family income in St. Mary's County of $85,032. Certain census tracts within the Lexington Park area have a high concentration of poverty, with one having a median annual family income low$42,766. Lexington Park has a lower per capita income and a higher unemployment rate than the rest of St. Mary's County, a combination contributing to the county's health disparities. [13]

3. Identify community health assessment program partners and their expertise or contribution to the process.

Georgetown University's School of Nursing & Health Studies is an academic partner that brings a wide range of resources that contributed to MedStar Health's systemwide CHNA process. Their expertise in CHNAs and population health management has strengthened the rigor of data collection and data analysis methodologies. The school provided the following support: 1) consultation and support for CHNA survey and secondary data collection and analysis; 2) supported the development and validation of a community input instrument and summarized findings; 3) contributed to and promoted community input sessions; 4) reviewed drafts of the CHNAs prior to publication; and 5) managed student involvement and participation.

The **Healthy Communities Institute** provided quantitative data based on over 130 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

4. State who was involved in the decision-making process.

MSMH's ATF reviewed local secondary data, coupled with state and federal community health goals. Task Force members also reviewed the hospital's operating plan, the

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outcomes of prior informal community health assessments, as well as current community benefit programs and services. In partnership with Georgetown University's School of Nursing & Health Studies, the team developed and helped disseminate a community health assessment tool around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life.

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Advisory Task Force Membership

Name	Title/Affiliation with Hospital	Name of Organization
Lori Werrell	Director, Health Connections	MedStar St. Mary's Hospital
Joan Gelrud	Vice President	MedStar St. Mary's Hospital
Mary Leigh Harless	Board Member	MedStar St. Mary's Hospital
Ric Braam	Vice President, CFO	MedStar St. Mary's Hospital
Meenakshi Brewster	Health Officer	St. Mary's County Health Department
Lori Jennings Harris	Director, Aging and Human Services	St. Mary's County Government
Colenthia Malloy	Executive Director	Greater Baden Medical Services
Holly Meyers	Director, Marketing and Public Relations	MedStar St. Mary's Hospital
Steve Michaels	COO & Vice President, Medical Affairs	MedStar St. Mary's Hospital
Kathleen O'Brien	CEO	Walden Sierra, Inc.
D. Roxanne Richards	Primary Care Physician	MedStar St. Mary's Hospital
Ella Mae Russell	Director, Social Services	St. Mary's County Department of Social Services
Margaret Sawyer	Local Resident	Volunteer
William Scarafa	President	St. Mary's County Chamber of Commerce
Nathaniel Scroggins	Project Director, MOTA	Minority Outreach Coalition and MOTA
A.D. Shah, MD	Physician, Chief of Staff	MedStar St. Mary's Hospital
Jane H. Sypher	Board Member	MedStar St. Mary's Hospital
Barbara Thompson	Board Member	MedStar St. Mary's Hospital
Mary Lou Watson	Vice President, Chief Nursing Officer	MedStar St. Mary's Hospital
Christine Wray	President and Chief Executive Officer	MedStar St. Mary's Hospital

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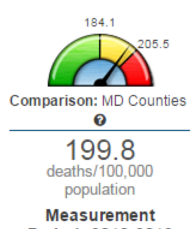
5. Justify why the hospital selected its community benefit priorities.

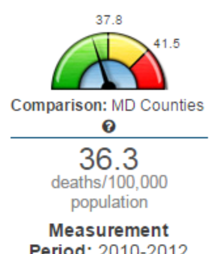
a) Chronic Disease

Secondary Data

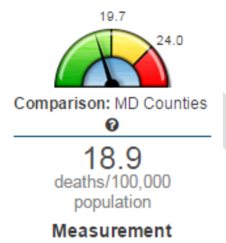
Death Rate due to Heart Disease



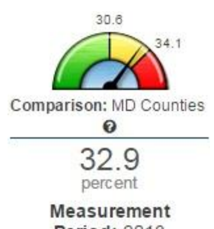
Death Rate due to Stroke



Death Rate due to Diabetes



Prevalence of Obesity



Chronic diseases, including heart disease/stroke, cancer, diabetes, and obesity, often coexist as comorbidities. Health behaviors such as tobacco use, poor nutrition and physical inactivity contribute to chronic disease.6

Heart Disease and Stroke

- Heart disease is the leading cause of death in St. Mary's County, with an age-adjusted death rate of **200/100,000**. The age-adjusted death rate from heart disease is higher for Whites compared to other ethnic groups.[2]
- The age-adjusted death rate due to stroke has also decreased slightly (from 44/100,000 persons in 2008 to **36/100,000** in 2012) and is comparable the state average (37/100,000 persons).[2]
- The rate of emergency department visits due to hypertension per 100,000 persons in St. Mary's County is 284 compared to 246 in Maryland, and the rate is highest among Black/African American residents relative to other racial/ethnic groups.[2]
- The prevalence of high blood pressure (30%) and high cholesterol (41%) contributes to the age-adjusted death rate due to heart disease and stroke. The prevalence of high blood pressure is highest among adults 65 and older and females and is lowest among Blacks/African Americans relative to other racial/ethnic groups. The prevalence of high cholesterol is highest in adults 65 and older and males, and is lowest among Blacks/African Americans.[7]
- Among the Medicare population in St. Mary's County, the rate of heart disease and stroke and the prevalence of high blood pressure and high cholesterol is higher than the Medicare population nationwide.[37]

Diabetes

- The age-adjusted death rate due to diabetes is **19/100,000.**[2] The prevalence of diabetes is approximately 14%. The prevalence of diabetes is highest among females (15%) and adults 65 and older (24%). The prevalence among Blacks/African Americans (15%) and Hispanics (35%) is higher than the prevalence among Whites (13%).[7]
- The rate of emergency department visits due to diabetes has decreased from 247 visits/100,000 persons in 2010 to 214 visits/100,000 persons in 2013. Blacks/African Americans contribute largely to this high rate.[2]
- Among the Medicare population in St. Mary's County, the prevalence of diabetes and chronic kidney disease is higher than the Medicare population nationwide.[37]

Obesity

- A total of 33% of adults in St. Mary's County are obese, and the trend is increasing. The prevalence of obesity is highest among adults between the ages of 45 to 64 and male adults. The prevalence of obesity is higher among Black/African American residents (39%) and Hispanics (47%) compared to Whites (32%).[7]

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	Alzheimer's Disease • Alzheimer's disease is the eighth leading cause of death in the state of Maryland, and the sixth leading cause of death in St. Mary's County. The rate of hospitalization related to Alzheimer's and other dementias is 271/100,000 in St. Mary's County, compared to the state average of 233/100,000, and the rate for Blacks/African Americans is higher than the county average. [2] *Addressing the Risk Factors* • Approximately 27% of adults in the county report eating the recommended five or more servings of fruits and vegetables every day, which is higher than the state median. Adults aged of 45- 64 and female residents report eating the recommended fruits and vegetables at higher rates relative to the countywide average.[7] • Despite improvements in recent years, only 42% of St. Mary's County residents participate in at least 150 minutes of aerobic activity weekly, which is the recommended level of physical activity.[38] Adults younger than 45 and males are more likely to report participating in the recommended level of physical activity relative to the countywide average, [7] and a smaller proportion of White residents report physical activity compared to the county average.[2]
Community Health Needs Assessment Surveys and Community Input Sessions	CHNA Survey (N=874)[38] • Chronic disease is a recognized issue affecting the community, with respondents indicating that overweight/obesity (55%), diabetes (36%) and heart disease (23%) are primary health conditions seen in their community. • Community members recognize the contributions of health behaviors to overall health status. Currently, survey respondents make healthy meals (61%), exercise at a local gym or recreation center (32%) and use parks, trails or a track (25%) to stay healthy. • Affordable, healthy food options (30%) and better places to exercise (12%) were two services that were recognized as community need through the surveys and the community input sessions. • Attendees of community input sessions identified several characteristics of the physical environment that are affecting health outcomes. Several suggestions were made to improve the physical environment for exercise. For example, completing the streets initiative in the county and creating additional parks and trails will encourage people to walk and adopt healthier lifestyles. Strengthening the public transportation system was also suggested and promoting a mutual respect between cars and pedestrians who share the community's roads. • Through the community input sessions, the lack of preventative health measures for chronic disease and health literacy was identified as barriers. Additionally, it was suggested at a community input session that MSMH could find new and better ways to incentivize health behaviors, such as waiving fees associated with healthy lifestyle education.

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Strategies	• To participate in the monthly HEAL (Healthy Eating/Active Living) team of the Healthy St. Mary's partnership. • To develop support group and educational programming for Alzheimer's disease and Dementia. • To expand chronic disease self management program offerings to include *Living Well with Cancer* and *Living Well With Diabetes.* • To expand the *National Diabetes Prevention Program* classes to 4 times a year and add additional workplace based classes. • To increase prevention and self-management programming for diseases that have high incidence in Medicare populations. • To expand Million Hearts initiatives through enhanced community screenings and our partnership with the local health department. • To expand the capacity of outpatient case management and community health worker programs.
Hospital Strengths	• As the trusted leader in caring for people and advancing health, MSMH is positioned to continue to provide and expand access to evidenced based Chronic disease management programs designed to slow the progress of existing chronic conditions and/or delay or prevent the onset of other chronic conditions such as type 2 diabetes. With the implementation of a coordinated and expanded outpatient care coordination team, citizens have access to additional services to ease transitions of care.
Alignment with local, regional, state or national health goals	• Healthy People 2020:Dementias, Including Alzheimer's Disease; Diabetes; Heart Disease and Stroke; Nutrition and Weight Status; Physical Activity[5] • Maryland State Health Improvement Process (MD SHIP): Healthy Living; Quality Preventative Care[2] • Healthy St. Mary's: Healthy Eating and Active Living[39]
Key Internal and External Partners	*Internal:* MedStar Montgomery Medical Center, MedStar Southern Maryland Hospital Center *External:* St. Mary's County Health Department, St. Mary's County Department of Aging and Human Services, Maryland Department of Health and Mental Hygiene, Alzheimer's Association
Metrics	*Internal Metrics* • # of breastfeeding mothers educated • # of breastfeeding mothers attending MSMH support group • # of reduced hospital readmissions for chronic cancer and diabetes patients • # of Living Well with Cancer participants and associates trained • % of program participants participating in the recommended levels of physical activity • Inpatient hospitalizations for Alzheimer's and dementia • % of program participants who lost weight • % of program participants with elevated blood pressure • % of program participants with elevated blood cholesterol • % of program participants with elevated blood sugar • # of program participants following up with recommended care • % of program participants reporting reduced prescription costs and need for prescription drugs • Emergency department visits due to diabetes

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	• Emergency department visits due to hypertension • Readmission rates for cancer • Readmission rates for diabetes *External Metrics* • % of adults who are at a healthy weight (BMI< 25 kg/m^2)[2] • Age-adjusted death rate from heart disease[2] • % of children and adolescents who are obese[25] • % of women who receive breast cancer screening[9] • Emergency department visits due to diabetes[2] • Emergency department visits due to hypertension[2]

b) Substance Abuse (Tobacco, Alcohol, Drugs)	
Secondary Data	*Tobacco* • Cigarette smoking is the leading cause of preventable death and disease in the United States, and the negative health effects of secondhand smoke are also well documented.[6] The smoking prevalence among adults in St. Mary's County is 20.9%;[2] adults younger than 45 and males report the highest smoking prevalence across age and gender groups, respectively,[7] and Black/African American and White residents report current smoking rates comparable to each other.[2] *Alcohol and Drug Abuse* • Approximately 24% of adults in St. Mary's County reported binge drinking in the last 30 days, compared to 17% of adults statewide. Binge drinking is highest among adults younger than 45 (34%) and males (27%) in St. Mary's County. Compared to other ethnic groups, Black/African American and Asian adults are the least likely to report binge drinking[7] • The drug-induced death rate in the county has decreased in recent years, and is currently lower than the state average and the goals set by the national and state health departments. The death rate due to drug use is higher among White residents relative to the countywide average.[2] • Residents in St. Mary's County still experience unmet needs for substance abuse, as substantiated by the rate of emergency department visits for addictions-related conditions. The rate in St. Mary's County is higher than the statewide average and the goal set by the state health department, and Blacks/African Americans contribute largely to the high rate of emergency department visits for addictions-related conditions for the county.[2]
Community Health Needs Assessment Surveys and Community Input Sessions	CHNA Survey (N=874)[38] • Survey respondents indicated that alcohol addiction (36%) and heroin/opioid addiction (19%) are health conditions seen most in their community. • More substance abuse services were identified by 23% of survey respondents as services needed in the community. • Attendees of a community input session suggested making public spaces in the community smoke-free, and highlighted substance abuse as an issue that MSMH should be attentive to.

Strategies	• To participate in the Tobacco Free Living team of the Healthy St. Mary's Partnership. • To increase the number of associates certified in the "fax to assist" program. • To contribute dedicated staff to support Health Department smoking cessation programs. • To provide public education to introduce ORYX measures for tobacco reduction and support inpatient implementation. • To continue Community Alcohol Coalition activities for public policy advocacy and social awareness of underage and binge drinking. • To lead the Maryland Strategic Prevention Framework (MSPF) process for overdose prevention.
Hospital Strengths	• MSMH has been a leader in tobacco cessation efforts and continues to adopt innovative approaches to helping citizens stop using tobacco containing products. MSMH has led the MSPF grant process for the county for 6 years and is poised to implement the same strategic framework to help reduce the burden of drug abuse and overdose in the county moving forward.
Alignment with local, regional, state or national health goals	• Healthy People 2020: Substance Abuse; Tobacco Use[5] • Maryland State Health Improvement Process (MD SHIP): Healthy Living; Quality Preventative Care[2] • Healthy St. Mary's: Behavioral Health; Tobacco Free Living[39]
Key Internal and External Partners	*Internal:* MedStar Montgomery Medical Center, MedStar Southern Maryland Hospital Center *External:* St. Mary's County Health Department, St. Mary's County Office of Aging and Human Services, Maryland Alcohol and Drug Abuse Administration, Local substance abuse treatment providers, St. Mary's County Prevention Coordinator
Metrics	*Internal* • % of program participants that successfully quit smoking cigarettes • Emergency department visits for addictions related conditions • #/adults and minors exposed to CAC messaging *External* • % of adults who currently smoke cigarettes[2] • % of adolescents who use tobacco products[2] • % of adults who binge drink[9] • % of adolescents who report alcohol use and binge drinking[25]

c) Access to Care	
Secondary Data	• The health services and medical care available and utilized by an individual can impact their life expectancy, health outcomes and quality of life. The lack of availability, lack of health insurance and high cost of health care all contribute to the negative effects of poor access, including unmet health needs, delay of care, inability to get preventive services, and preventable hospitalizations.[5] At MSMH, emergency department visits for chronic disease such as diabetes, high blood pressure and asthma are above state averages.[40] • When considering availability, the provider-patient ratio is much higher compared to the state average for primary care physicians (2,829:1) and dental providers (2,369:1).[1] St. Mary's County has a Healthcare Provider

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	Shortage Area (HPSA) designation for the southern end of the county.[41] • Compared to Maryland, St. Mary's County has high health insurance coverage, with 92% of adults[2] and 97% of children insured.[7] Female adults are insured at slightly higher levels than male adults and adults in aged 45-54 are the most likely to be insured across age group. Children younger than six are more likely to be insured than older children, and male children are insured at higher rates than female children.[7] • Accessing medical care is still a challenge for some St. Mary's County residents. Nearly 10% of adults were unable to afford to see a doctor in the last 12 months; adults younger than 45, females and Hispanic residents report being unable to afford a doctor at higher proportions than 10%.[7] • Approximately 87% of adults had a routine health check-up in the last two years; adults younger than 45, males and Asian residents were the least likely to report a wellness check in the last two years.7
Community Health Needs Assessment Surveys and Community Input Sessions	CHNA Survey (N=874)[38] • Access to more health services (22%) was identified as a service needed most in the community. A limited supply of specialists and primary care providers was commonly identified as a barrier to health care access through community input sessions. Additionally, it was identified that some providers do not accept all insurances. • Among survey respondents who used the emergency department in the last 12 months, the most common nature of the visit behind "life threatening accident injury or sickness" was "physician's office closed." Attendees of a community input session suggested that MSMH should seek to educate the community on the difference between primary, preventative and emergent care. The discrepancy in health insurance deductibles and co-pays may also be contributing to emergency room utilization, according to feedback from a community input session. • Among survey respondents who reported having trouble getting health care in the last 12 months, respondents were equally as likely to have trouble getting healthcare through a specialist as they were through a primary care provider. The most common cited barrier to health care was that they could not afford the care or they could not get an appointment. • Approximately 82% of survey respondents use their own vehicles to travel to medical appointments, and transportation was identified as a barrier to health care services through community input sessions, especially because providers are dispersed geographically throughout the county. • "Time of day" was identified by 29% of survey respondents as reason for why they did not participate in health education classes and programs in St. Mary's County.
Strategies	• To lead the Access to Care team of the Healthy St Mary's Partnership. • To expand the palliative care program to include outpatient services. • To increase the number of primary care providers. • To open a community health center in Lexington Park Maryland. • To continue to implement and grow Health Enterprise Zone initiatives.
Hospital Strengths	• The hospital is the leader in physician recruitment and retention efforts in the county and has opened a new primary care practice and is leading the effort to open an full time FQHC based fully integrated Community Health Center during this CHNA cycle. Through our HEZ grant we are also the leader in

	reducing health disparities and educating the provider community in culturally competent healthcare.
Alignment with local, regional, state or national health goals	• Healthy People: Access to health services[5] • Maryland State Health Improvement Process (MD SHIP): Access to Health Care[2] • Healthy St. Mary's: Access to Care[39]
Key Internal and External Partners	*Internal:* MedStar Montgomery Medical Center, MedStar Southern Maryland Hospital Center *External:* Greater Baden Medical Services, Inc., St. Mary's County Health Department, Walden Sierra, Inc., HEZ partner organizations, Calvert Healthcare Solutions (Navigator entity)
Metrics	*Internal* • # of patients served by palliative care program • # of patients transported to medical appointments • # of screenings performed in the community • Emergency department visit rate for diabetes • Emergency department visit rate for hypertension • % of CHNA respondents reporting difficulty in accessing medical care *External* • Adolescents receiving a wellness check in past year[25] • Adults who have had a routine checkup[9] • Preventable Hospital Stays[1] • Patient-provider ratios[1]

d) Behavioral Health	
Secondary Data	• Throughout the county, only 75% of adults self-report good mental health; older adults, males and Whites self-report good mental health at higher proportions than 75%.[7] • Approximately 86% of residents self-report adequate social and emotional support, a higher proportion compared to the state average; research suggests that individuals with adequate social and emotional support experience better health outcomes.[7] • The rate of domestic violence in St. Mary's County is 476/100,000 persons, compared to 469/100,000 for the state.[2] • The age-adjusted death rate due to suicide is 12/100,000 persons, compared to the statewide average of 9/100,000. [2] • When considering availability, the provider-patient ratio is much higher compared to the state average for mental health providers (1,185:1).[1] • Consequently, the rate of emergency department visits for mental health conditions in St. Mary's County adults has increased from 4,607 visits per 100,000 persons in 2010 to 5,009 visits in 2013. This rate is much higher for Hispanics and Whites than Blacks/African Americans.[2]
Community Health Needs Assessment Surveys and Community Input Sessions	CHNA Survey (N=874)[38] • Mental health conditions were identified by 35% of survey respondents as a health condition seen most in the community. Approximately 28% of survey respondents did not think that mental health services were available in St. Mary's County and more mental health services (27%) were cited as services needed most in the community by survey respondents and attendees of

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	community input sessions. • Specifically, depression (mood disorder) treatment and domestic violence counseling were identified as the top two mental health services needed.
Strategies	• To recruit an outpatient psychiatrist. • To participate in the behavioral health action team of the Healthy St. Mary's Partnership. • To improve care transitions for behavioral health patients in unit and emergency department settings. • To expand staff training and programming for the newly established hospital based Domestic Violence program. • To increase access to behavioral health related support groups and programs. • To participate in community based coalitions, grants and demonstration projects to improve services.
Hospital Strengths	• MSMH has put a high priority on recruiting additional behavioral health practitioners, including psychiatrists, to the county. As one of only ten hospital based domestic violence programs in the state, MSMH is a leader in assisting victims and increasing referrals to community resources post hospital. Increasing access to behavioral health support groups and programming and improving care transitions for behavioral health and substance abuse ED patients is within MSMH's ability to influence outcomes.
Alignment with local, regional, state or national health goals	• Healthy People 2020: Mental Health and Mental Disorders[5] • Maryland State Health Improvement Process (MD SHIP): Healthy Communities; Quality Preventative Care[2] • Healthy St. Mary's: Behavioral Health[39]
Key Internal and External Partners	*Internal:* MedStar Montgomery Medical Center, MedStar Southern Maryland Hospital Center *External:* Community-based Behavioral Health entities, St Mary's County Health Department, Three Oaks homeless shelter, Domestic Violence Coordinating Council, St. Mary's County Core Services Agency, St. Mary's County Department of Social Services
Metrics	*Internal* • # of behavioral health specialists hired • # of patients referred to behavioral health support groups and programs • Emergency department visits related to behavioral health conditions • Emergency department visits related to domestic violence *External* • Age-adjusted death rate due to suicide in St. Mary's County[2] • Patient-Mental Health Provider ratio[1] • % of adults with behavioral health conditions who receive treatment services[42] • % of children with mental health conditions who receive treatment services[39]

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6. Does the hospital currently have community benefit activities that support other key health needs that were identified as important in the Community Health Assessment? (Collaboration Areas)

Issue	Evidence	Strategy	Lead
Transportation	34% of survey respondents cite better public transportation as a service most needed in our community.[38]	To increase the role of Health Enterprise Zone vehicles in enhancing transportation options for medical needs, with a long-term goal of a public private partnership for sustainability.	St. Mary's County government including the Health Department and the Department of Social Services
Teen birth rate	County birth rate to teens (age 15 -19) was 24/1,000 women vs. state rate of 22/1,000 women. [2] The birth rate in African American teens (33/1,000 women) relative to Caucasian teens (15/1,000) indicates a health disparity.[2]	To collaborate with community partners to develop strategies to reduce unplanned births to teens. To support Healthy Families initiative goals.	St. Mary's County Health Department
Access to a Mobile Crisis Team	No mobile mental health crisis team exists in the county. 26% of survey respondents cite more mental health services as a service needed most in our community.[38]	To explore the feasibility of a mobile mental health crisis team to reduce emergency department visits for mental health issues.	Behavioral health treatment community, St. Mary's County Health Department, Core Service Agency
Access to temporary housing for homeless transitioning from inpatient care	No transitional housing is available for homeless citizens who do not wish to have stable housing but need housing in the immediate post hospital period.	To explore the feasibility of establishing temporary housing for homeless individuals transitioning from hospitalization.	Three Oaks Shelter, County Housing Authority, County Department of Social Services

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7. List other health priorities that were identified in the CHNA and describe why the hospital did not select them? (Participation Areas)

Issue	Evidence	Evidence	Lead
Affordable housing	Only 40% of units are sold affordable on median teacher salary, compared to the state average of 53%.[2] 49% of survey respondents cite affordable housing as a need in our community.[38]	The hospital does not have the expertise to have a leadership role in these areas; therefore, hospital will support external leaders in these areas.	Housing Authority, County Government, Planning and Zoning
Better jobs	36% of survey respondents cited better jobs as a need in our community.[38]		St. Mary's County Government, Economic Development, Private Sector
Affordable child care	33% of survey respondents cited affordable childcare as a need in our community.[38]		St. Mary's County Government

8. Describe how the hospital will institutionalize community benefit programming to support these efforts.

The hospital's Implementation Strategy is a roadmap for how community benefit resources will be deployed and how outcomes will be reported. The Community Benefit Hospital Lead will oversee planning, programming, monitoring, and evaluation of outcomes. The Executive Sponsor will support institutional efforts to re-organized or reallocate resources as needed. Annual progress updates will be provided to ATF members and the hospital's Board of Directors. The progress report will also be publicly accessible via the hospital's website.

The MedStar Health Corporate Community Health Department (CCHD) will provide system-wide coordination and oversight of community benefit programming. The CCHD will oversee the agenda of the Community Benefit Workgroup, which is comprised of Community Benefit Hospital Leads and other community health professionals across the system. The purpose of the workgroup is to share best practices and promote consistency around data collection, tracking, and reporting that is consistent with internal policies and state and federal guidelines.

The CCHD will provide the MedStar Health Board of Director's Strategic Planning Committee with annual updates on the hospital's progress towards the goals documented in the Implementation Strategy.

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MedStar St. Mary's Hospital
Community Health Assessment Work Plan
(FY16-FY18)

Priority Issue #1 – Chronic disease prevention and management
Goal Statement – To improve population health outcomes for St. Mary's County through targeted chronic disease prevention and management programming.

1A. Provide a detailed description of the program or service	Outputs	Short-Term Outcomes	Long -Term Outcomes and Impacts	Dedicated Staff	Person Responsible
Continue participation in the monthly Healthy Eating Active Living (HEAL) team of the Healthy St. Mary's Partnership.	Deploy MSMH associate for community stakeholder collaboration to work toward HEAL community health objectives Provide inpatient breastfeeding education and support to new mothers.	# of meetings attended # of community partnerships maintained # of collaborative community health activities undertaken # of breastfeeding mothers educated # of breastfeeding mothers attending MSMH support group		Andrea Hamilton, HEAL team Co-chair and Health Connections Program Coordinator Trina Gardiner, Lactation Consultant Summer Seastrand, Lactation Consultant	Lori Werrell, Director, Health Connections
Activities to be phased in during the three year period: • Continue MSMH's founding stakeholder, primary member and leader role in guiding this Local Health Improvement Coalition					

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(LHIC).

External Metric(s):

- SHIP Measures
- Healthy St. Mary's 2020 HEAL Team measures
- # of St. Mary's County adults at healthy weight
- % of children and adolescents who are obese (Youth Behavioral Risk Factor Surveillance System

1B. Provide a detailed description of program or service	Outputs	Short-Term Outcomes	Long -Term Outcomes and Impacts	Dedicated Staff	Person Responsible
Expand chronic disease self management program offerings to include Living Well with Cancer	Offer chronic disease self management courses Train associates to provide expanded chronic disease self-management programs	# of courses provided #of course participants # of associate trainings Qualitative (Moving the Needle)	# of reduced hospital readmissions for chronic cancer and diabetes patients	TBD when training becomes available	Lori Werrell, Director, Health Connections

Activities to be phased in during the three year period:

- Develop and implement these programs, train or hire staff, gather impact data. Implementation dependent on DHMH role out of training

External Metric(s):

- Internal data collection by programs
- MD SHIP data
- Healthy St. Mary's 2020 HEAL team measures
- Emergency room visits due to Diabetes (Maryland Health Services Cost Review Commission)
- CMS data.

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1C. Provide a detailed description of the program or service	Outputs	Short-Term Outcomes	Long -Term Outcomes and Impacts	Dedicated Staff	Person Responsible
Expand National Diabetes Prevention Program classes to 4 times annually and add workplace-based classes	Provide NDPP Simple Changes courses Publish advertising to promote enrollment Leverage stakeholder relationships to promote enrollment Adjust fee scales to promote socio-economic enrollment	# of courses offered, locations varied # of advertising items created to promote classes # of reduced fee/free class participants enrolled # of enrollees attending regularly, making progress #/Participant weight loss	CDC program recognition and national results attained #/Improved clinical markers (i.e., weight loss, decreased BP/HBA1C, etc).	Andrea Hamilton	Lori Werrell, Director, Health Connections
Activities to be phased in during the three year period: NDPP Simple Changes courses will be segmented to accommodate broad racial/socio-economic diversity, reducing barriers to self-management education. Segmenting includes multiple geographic locations, patient-based clinical assessments and referrals and implementing sliding fee scales.					
External Metric(s): Internal data collected by NDPP program and reported to CDC regarding course location, number, frequency, attendance, participant weight and comparative clinical markers over time (HBA1c). MD SHIP data, Healthy St. Mary's 2020 HEAL team measures, Adults at Healthy Weight (Behavioral Risk Factor Surveillance System).					
1D. Provide a detailed description of the program or service	**Outputs**	**Short-Term Outcomes**	**Long -Term Outcomes and Impacts**	**Dedicated Staff**	**Person Responsible**

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<u>Chronic Disease Prevention and Management</u> Increase prevention and self-management programming for diseases that have high incidence in Medicare populations in St. Mary's County**.**	Provide Blood Pressure (BP) screenings/ referrals to self-management resources Provide Diabetes screenings/referrals to NDPP self-management resources Provide smoking cessation referrals	#/Initial screenings/follow up screenings #/persons who scheduled follow-up appt as a result of screening #/Improved clinical markers: pre/post test results, BP/HBA1C #/smoking cessation course completers who report success	Decline in number of citizens who smoke	Varies – several educators share this responsibility	Lori Werrell, Director, Health Connections
Activities to be phased in during the three year period: Ongoing, expanded collaboration with partner physicians and stakeholder agencies to expand referral and attendance at Living Well With Cancer, NDPP Simple Changes Diabetes Prevention Program, Stroke Support Group, Living Well With Diabetes and Stanford Chronic Disease Self-Management Courses. training					
External Metric(s): -Comparative data: CHNA, Internal data collection by programs, MD SHIP data, Healthy St. Mary's 2020 HEAL team measures, CMS data. Internal course advertising, enrollment and patient data metrics.					

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1E. Provide a detailed description of the program or service	Outputs	Short-Term Outcomes	Long -Term Outcomes and Impacts	Dedicated Staff	Person Responsible
<u>Chronic Disease Prevention and Management</u> Expand Million Hearts initiative through enhanced community screenings and partnership with the health department.	Provide BP screenings at community events/health fairs Perform patient chart reviews for	#/high BP patients referred to physicians for follow up #/patients with reduced prescription	Higher % of patients with HTN under control Reduction in HTN related ER	Primary Care Providers with MSMH- PC and GCTH Pharmacist .3 FTE	Lori Werrell, Director, Health Connections

	medication therapy management (MTM) healthcare improvement practices	quantities #/patients with reduced medication costs #/Improved clinical markers (i.e., weight loss, decreased BP/HBA1C, etc).	utilization #/Improved clinical markers (i.e., weight loss, decreased BP/HBA1C, etc).		
Activities to be phased in during the three year period: Continued expansion of community screenings into pockets of health disparities (Hair Heart & Health, Access Health) -MTM - Increase pharmacist chart review hours and continue active participation in Health Department Million Hearts data collection and management, continue synergy between MedStar physicians using Million Hearts data-driven strategies and other St. Mary's County physicians to improve overall population health.					
External Metric(s): Internal program data, MD SHIP data, Healthy St. Mary's 2020 HEAL team measures					
1F. Provide a detailed description of the program or service	**Outputs**	**Short-Term Outcomes**	**Long -Term Outcomes and Impacts**	**Dedicated Staff**	**Person Responsible**
Chronic Disease Prevention and Management Develop support group and educational programming for Alzheimer's Disease and Dementia.	Offer Alzheimer support group meetings Train MSMH Associates to support Alzheimer and dementia caregivers.	#/Alzheimer Support group attendees #/Associates trained or hired with existing support credentials. #/Alzheimer hospital readmissions.	Fewer avoidable hospitalizations for citizens	Michelle Cox, FTE TBD	Lori Werrell, Director, Health Connections
Activities to be phased in during the three year period: Establish Alzheimer Support Group location, time and leadership. Train staff to provide Alzheimer Support Services. Establish referral process for Alzheimer Support Group recruitment.					
External Metric(s): -Hospitalization rate related to Alzheimer's or other dementias					
1G. Provide a detailed description of the program or service	**Outputs**	**Short-Term Outcomes**	**Long -Term Outcomes and Impacts**	**Dedicated Staff**	**Person Responsible**

Chronic Disease Prevention and Management Expand capacity of outpatient case management and community health worker programs.	Increase patients in case management Hire additional case managers	#/patients in case management programs #/patients attending specialist appointments #/case managers trained/hired	#/reduced hospital readmissions data	Jill Smith, Health Connections Operations Specialist June Castro, Health Enterprise Zone Operations Specialist	Lori Werrell
Activities to be phased in during the three year period: Increase numbers of patients enrolled in outpatient case management, increase number of MSMH outpatient case managers.					
Internal MedStar Collaborations: MSMH, MSMHC and MMMC will collaborate with bi-monthly conference calls and each will host a site visit. These MedStar entities will develop and track common indicators in areas of overlap – Obesity, Diabetes, Hypertension (all three hospitals) and Cancer (MSMH & MMMC). MSMH, MSMHC and MMMC will share successful programming and examine regional grant opportunities, developing additional areas of collaboration for year 2&3. Year one: MSMH shared information on Fax to Assist program for smoking cessation MSMH shared information on NDPP –Simple Changes program and will share developed resources and assist with implementation at other entities					
External Collaborations: MSMH actively collaborates with SMC stakeholders:					
External Metric(s): Internal program data, Emergency Room visits due to Diabetes (Maryland Health Services Cost Review Commission), Emergency Room visits due to hypertension (Maryland Health Services Costs Review Commission), CMS data					

Priority Issue #2 – Substance Abuse (Tobacco, Alcohol, Drugs)
Goal Statement – Reduce tobacco use, alcohol abuse, and drug overdoses in St. Mary's County.

2A. Provide a detailed description of the program or service	Outputs	Short-Term Outcomes	Long -Term Outcomes and Impacts	Dedicated Staff	Person Responsible

<u>Substance Abuse (Tobacco, Alcohol, Drugs)</u> Participate in the Tobacco Free Living Team of the Healthy St. Mary's Partnership.	Dedicate associates to Tobacco Free Living Team Plan/ attended activities promoting Tobacco Free Living Continue media & advertising campaigns to promote Tobacco Free Living	#/associate hours dedicated to Tobacco Free Living Team initiatives #/number of planned, attended and sponsored Tobacco Free Living events #/audience impacted by Tobacco Free Living events attended #/developed media & advertising items promoting Tobacco Free Living and Tobacco Free Living events.	#/percentage of adults who currently smoke #/percentage of adolescents who use tobacco products	TBD	Lori Werrell
Activities to be phased in during the three year period: Expand existing HEAL stakeholder partnerships to promote event and course participation and enrollment.					
External Metric(s): Program specific data, MD SHIP measures, Healthy St. Mary's Partnership Tobacco Free Living and Behavioral Health Team measures, Behavioral Risk Factor Surveillance System (BFRSS), Youth Risk Behavior Survey, (YRBS)					
2B. Provide a detailed description of the program or service	**Outputs**	**Short-Term Outcomes**	**Long -Term Outcomes and Impacts**	**Dedicated Staff**	**Person Responsible**
<u>Substance Abuse (Tobacco, Alcohol, Drugs)</u> Increase the number of associates certified in the "Fax to Assist" program.	Market associate involvement in "Fax to Assist" smoking cessation program	#/persons enrolled in "Fax to Assist" smoking cessation program #/ promoting Fax to Assist	See above	Currently 6 staff are certified	Lori Werrell Carla Cavanaugh

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		#/referred who report successfully quit smoking			
Activities to be phased in during the three year period: Increase # of associates certified to refer patients					
External Metric(s): Fax to Assist quit rate					

2C. Provide a detailed description of the program or service	**Outputs**	**Short-Term Outcomes**	**Long -Term Outcomes and Impacts**	**Dedicated Staff**	**Person Responsible**
Substance Abuse (Tobacco, Alcohol, Drugs) Contribute dedicated staff to support Health Department smoking cessation programs.	Dedicate staff to smoking cessation programs	#/hours dedicated MSMH staff supports SMCHD smoking cessation program	See above	RN to be determined	Lori Werrell
Activities to be phased in during the three year period: Continue existing level of commitment to SMCHD smoking cessation programming.					
External Metric(s): Program specific data collection, MD SHIP measures, Healthy St. Mary's Partnership Tobacco Free Living and Behavioral Health team measures. Percentage of adults who currently smoke (Behavioral Risk Factor Surveillance System, BFRSS), Percentage of adolescents who use tobacco products (Youth Risk Behavior Survey, YRBS).					
2D. Provide a detailed description of the program or service	**Outputs**	**Short-Term Outcomes**	**Long -Term Outcomes and Impacts**	**Dedicated Staff**	**Person Responsible**
Substance Abuse (Tobacco, Alcohol, Drugs) Provide public education to introduce ORYX measures for tobacco reduction and support inpatient implementation.	Provide inpatient and discharge counseling and instructions consistent with ORYX smoking cessation goals Coordinate	#/Inpatient smokers counseled in cessation in accordance with ORYX Heart Failure (HF) measures. #/Inpatient policies enacted to ensure		TBD	TBD

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	inpatient ORYX implementation	ORYX HF smoking cessation measures are in place #/St. Mary's County residents reporting tobacco cessation			
Activities to be phased in during the three year period: Design and implement smoking cessation counseling and tracking consistent with the goal of ORYX measures improvement.					
External Metric(s): Program specific data collection, MD SHIP measures, Healthy St. Mary's Partnership Tobacco Free Living and Behavioral Health team measures. Percentage of adults who currently smoke (Behavioral Risk Factor Surveillance System, BFRSS), Percentage of adolescents who use tobacco products (Youth Risk Behavior Survey, YRBS).					
2E. Provide a detailed description of the program or service	**Outputs**	**Short-Term Outcomes**	**Long -Term Outcomes and Impacts**	**Dedicated Staff**	**Person Responsible**
<u>Substance Abuse (Tobacco, Alcohol, Drugs)</u> Continue Community Alcohol Coalition activities for public policy advocacy and social awareness of underage and binge drinking post grant.	Continue Community Alcohol Coalition (CAC) efforts to reform public policy/enforce underage drinking laws through CMCA funding Continue CAC initiatives to reduce underage drinking through community outreach through CMCA funding	#/public policy meetings attended by CAC coordinator #/social awareness events attended by CAC coordinator #/adults and minors exposed to CAC messaging	Reduce number of citizens reporting underage or binge drinking	Kendall Wood	Lori Werrell
Activities to be phased in during the three year period: To be determined by grant					
External Metric(s): Adults Who Binge Drink (Maryland Behavioral Risk Factor Surveillance System), MD SHIP data					
2F. Provide a detailed description of	**Outputs**	**Short-Term**	**Long -Term**	**Dedicated**	**Person**

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the program or service		Outcomes	Outcomes and Impacts	Staff	Responsible
Substance Abuse (Tobacco, Alcohol, Drugs) Lead the Maryland Strategic Prevention Framework process for overdose prevention.	Use existing CAC program as model for MSPF Opioid/Overdose Prevention Program	#/planning & strategy meetings held #/community stakeholders involved #/media campaign elements designed, produced and distributed #/public policies designed and implemented	Reduce number of OD and OD deaths in SMC #/reduced Emergency Department visits for addiction related conditions	Kendall Wood	Lori Werrell
Activities to be phased in during the three year period: MSMH will lead an MSPF Opioid Overdose Prevention Committee that designs and implements public policy and media campaigns around MSPF Overdose Prevention Initiatives.					
External Metric(s): Emergency department visits for addiction related conditions (Maryland Health Services Cost Review Commission 2013)					

Priority Issue #3: Access to Care
Goal Statement: Increase access to primary care and decrease health disparities.

3A. Provide a detailed description of the program or service	Outputs	Short-Term Outcomes	Long -Term Outcomes and Impacts	Dedicated Staff	Person Responsible
Access to Care Lead the Access to Care team of the Healthy St. Mary's Partnership.	Provide MSMH associate leadership and support for Healthy St. Mary's	#/meetings attended or led by MSMH associates	Qualitative #/policies and programs originated by the Access to Care	Lori Werrell	Lori Werrell

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	Partnership's Access to Care team		team that reduce health care disparities		
External Metric(s): CHNA participants reporting difficulty obtaining appropriate medical care, Healthcare Provider Shortage Area (HPSA) Designation, Provider to patient ratio in St. Mary's County vs. Maryland Average (County Health Rankings)					
3B. Provide a detailed description of the program or service	**Outputs**	**Short-Term Outcomes**	**Long -Term Outcomes and Impacts**	**Dedicated Staff**	**Person Responsible**
<u>Access to Care</u> Expand the palliative care program to include outpatient services.	Design and implement palliative care program to promote quality of life for chronic/terminal disease patients	#/Associate hours dedicated to palliative care program planning and implementation #/Associates dedicated to program #/Types of palliative care program elements implemented #/Patients served by palliative care program #/Design metrics to assess palliative care program effectiveness		TBD	Teresa Brannigan
3C. Provide a detailed description of the program or	**Outputs**	**Short-Term Outcomes**	**Long -Term Outcomes and**	**Dedicated Staff**	**Person Responsible**

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service			Impacts		
<u>Access to Care</u> Increase the number of primary care providers.	Recruit, hire and retain primary care providers (PCPs) for St. Mary's County, MD Build quadraplex to house Medical Residents	#/PCPs hired #/residents trained #/PCPs per citizen increased #/CHNA respondents reporting difficulty finding primary care reduced	Increase number of providers to citizens to state averages	Don Lewis, Physician Liaison	Senior Leadership
External Metric(s): CHNA participants reporting difficulty obtaining appropriate medical care, Healthcare Provider Shortage Area (HPSA) Designation, Provider to patient ratio in St. Mary's County vs. Maryland Average (County Health Rankings)					
3D. Provide a detailed description of the program or service	**Outputs**	**Short-Term Outcomes**	**Long -Term Outcomes and Impacts**	**Dedicated Staff**	**Person Responsible**
<u>Access to Care</u> Open a Community Health Center in Lexington Park, Maryland.	Open Lexington Park CHC	#/MOUs with clinicians #/MOUs with partners #/Clinical services provided #/Clinical encounters #/Providers, clinical encounters and services increased in previously HPSA areas	Increase providers who will see underserved citizens	NA	Senior Leadership – Joan Gelrud VP

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Activities to be phased in: From planning to opening.					
External Metric(s): CHNA participants reporting difficulty obtaining appropriate medical care, Healthcare Provider Shortage Area (HPSA) Designation, Provider to patient ratio in St. Mary's County vs. Maryland Average (County Health Rankings), Adults who have had a routine checkup (Maryland Behavioral Risk Factor Surveillance System), Preventable Hospital Stays (County Health Rankings), ER rate for Diabetes, ER rate for hypertension, Adolescents receiving well check up in the past year (Maryland Medicaid Service Utilization).					
3E. Provide a detailed description of the program or service	**Outputs**	**Short-Term Outcomes**	**Long -Term Outcomes and Impacts**	**Dedicated Staff**	**Person Responsible**
Access to Care Continue to implement and grow Health Enterprise Zone initiatives.	Continue to provide Access Health services that improve population health and reduce healthcare disparities	#/BP, Diabetes Screenings #/Chronic condition education offered for BP, HF, Diabetes, Stroke, Asthma #/Nutrition classes provided #/Dental visits provided #/Patients transported to medical appointments #/CHNA respondents from HEZ zip codes reporting difficulty finding primary care	Reduced readmissions/ER utilization and identified Health Disparities in the Zone	June Castro and HEZ Staff	Lori Werrell

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		reduced #/HEZ ED visits for primary and dental care and chronic conditions reduced			
External Metric(s): CHNA participants reporting difficulty obtaining appropriate medical care, Adults who have had a routine checkup (Maryland Behavioral Risk Factor Surveillance System), Preventable Hospital Stays (County Health Rankings), ER rate for Diabetes, ER rate for hypertension, Adolescents receiving well check up in the past year (Maryland Medicaid Service Utilization).					

Priority Issue #4- Behavioral Health
Goal Statement- Increase access to behavioral health related services and improve behavioral health outcomes.

4A. Provide a detailed description of the program or service	Outputs	Short-Term Outcomes	Long -Term Outcomes and Impacts	Dedicated Staff	Person Responsible
Behavioral Health Recruit an outpatient psychiatrist	Actively recruit an outpatient psychiatrist	#/outpatient psychiatrists hired #/SMC citizen to psychiatrist ratio reduced	**Increase access to care for behavioral health in SMC**	NA	Senior Leadership – Joan Gelrud
External Metric(s): Behavioral health care provider to patient ratio in St. Mary's County vs. Maryland Average (County Health Rankings)					
4B. Provide a detailed description of the program or service	**Outputs**	**Short-Term Outcomes**	**Long -Term Outcomes and Impacts**	**Dedicated Staff**	**Person Responsible**
Behavioral Health Participate in the Behavioral Health Action Team of the Healthy St. Mary's Partnership	Provide MSMH associate support for Healthy St. Mary's Partnership's Behavioral Health Action team	#/planning & strategy meetings attended #/community stakeholders involved #/public policies designed and implemented	#/Hospital Based Domestic Violence Program Standards/Data #/Emergency	Kendall Wood	Lori Werrell

			department visits related to behavioral health conditions #/Reduce suicide rate		
External Metric(s): Healthy St. Mary's Partnership 2020 measures, Emergency department visits related to behavioral health conditions (Maryland Health Services Cost Review Commission, HSCRC) Reduce Suicide Rate (Maryland Vital Records)					
4C. Provide a detailed description of the program or service	**Outputs**	**Short-Term Outcomes**	**Long -Term Outcomes and Impacts**	**Dedicated Staff**	**Person Responsible**
Behavioral Health Improve care transitions for behavioral health patients in unit and emergency room.	Coordinate clinical approach involving community care stakeholders to improve patient outcomes	#/new patient hand-off policies or care coordination strategies designed and implemented #/stakeholders involved in care coordination	#/reduce number of Emergency Department readmissions for behavioral health issues #/reduce suicide rate	Case managers	Rob Elrod Lori Werrell
External Metric(s): Emergency department visits for addiction related conditions, mental health related conditions (Maryland Health Services Cost Review Commission), Suicide Rate in the County (Maryland Vital Records) Emergency department visits for addiction related conditions (Maryland Health Services Cost Review Commission 2013).					
4D. Provide a detailed description of the program or service	**Outputs**	**Short-Term Outcomes**	**Long -Term Outcomes and Impacts**	**Dedicated Staff**	**Person Responsible**
Behavioral Health Expand staff training and	Design and implement employee	#/policies enacted to promote associate DV program awareness and		Yvonne Dawkins, RN	Darla Hardy Lori Werrell

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programming for the newly established Hospital Based Domestic Violence Program.	protocols and training in those protocols to hardwire the delivery of DV services at MSMH	implementation #/DV policy trainings offered #/associates trained in DV policies #/DV victims served #/Vine Protective Orders (VPO) completed			
Activities to be phased in over the three year period: Ongoing program development in years 1-2.					
4E. Provide a detailed description of the program or service	**Outputs**	**Short-Term Outcomes**	**Long -Term Outcomes and Impacts**	**Dedicated Staff**	**Person Responsible**
<u>Behavioral Health</u> Increase access to behavioral health related support groups and programs.	Utilize known strategies and existing stakeholder partnerships to promote behavioral health support programming offerings and attendance.	#/Behavioral health support groups available for referral to patients via discharge instructions, primary care clinicians and clinical care coordinators/case managers #/Patients referred to behavioral health support groups and programs #/reduce number of Emergency Department readmissions for behavioral health issues		TBD	Darla Hardy Lori Werrell

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		#/reduce suicide rate			
Activities to be phased in over the three year period: Year one planning and development; year 2-3 Implementation					
External Metric(s): Emergency department visits for addiction related conditions, mental health related conditions (Maryland Health Services Cost Review Commission), Suicide Rate in the County (Maryland Vital Records), Emergency department visits for addiction related conditions (Maryland Health Services Cost Review Commission 2013).					
4F. Provide a detailed description of the program or service	**Outputs**	**Short-Term Outcomes**	**Long -Term Outcomes and Impacts**	**Dedicated Staff**	**Person Responsible**
Behavioral Health Participate in community based coalitions, grants and demonstration projects to improve services.	Develop funding and potential projects in year1	#/New stakeholder relationships and approaches/demonstration projects #/Data driven evaluation TBD based on targeted healthcare objective	Improved access	TBD	Lori Werrell
Activities to be phased in over the three year period: Year 1 planning and development, years 2-3 Implementation					
External Metric(s): All available healthcare data for St. Mary's County, Maryland County Health Rankings Maryland Health Services Cost Review Commission Maryland Vital Records CMS Healthy St. Mary's Partnership 2020 metrics MSMH Hospital EMR and Program Data MD SHIP Data					

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MedStar Southern Maryland Hospital Center
Community Health Assessment FY2015

Community Benefit Service Area
Hospital Primary Service Area
MedStar Hospital

MSMHC FY'15
Community Benefit Focus Area
20735

* Primary Service Area – represents ZIP codes that contain 50% of inpatient discharges
*Community Benefit Service Area is also included in the primary service area

1. **Define the hospital's Community Benefit Service Area (CBSA) and identify the hospital's community benefit priorities.**

   MedStar Southern Maryland Hospital Center's (MSMHC) CBSA includes residents of southern Prince George's County, specifically Clinton, Maryland (ZIP code 20735). The community was selected based its proximity to the hospital, and the availability of pre-existing programs and services. Based on secondary, CHNA survey and community input session data, MSMHC's community benefit priorities in chronic disease prevention and management are: 1) heart disease/ stroke, 2) diabetes, and 3) obesity.

2. **Provide a description of the CBSA.**

   There are 36,505 residents living in the CBSA. The majority of the CBSA population is Black/African American (81.6%), followed by White (11.2%) and two or more races (2.2%). Approximately 6% of residents are of Hispanic origin. The vast majority of the residents (78.1%) are over the age of 18 with the median age of 42. More than 90% of adults have a high school diploma or a higher level of education. The unemployment rate in the CBSA is similar to that of the nation, at 8%, and lower than the county average. Of the employed population, 72.1% commute to work alone, 15.6% utilize public transportation (excluding taxicab) and 8.1% carpool. The median household income across the CBSA is $98,687, with a 2 person household average size.[13]

Faith based organizations have a prominent presence in the CBSA. There are approximately 14 faith based organizations of various denominations located within the ZIP code. The Prince George's County Health Department also has a strong presence in the community, offering a variety of free health services to its residents.

3. Identify community health assessment program partners and their expertise or contribution to the process.

Georgetown University's School of Nursing & Health Studies is an academic partner that brings a wide range of resources that contributed to MedStar Health's systemwide CHNA process. Their expertise in CHNAs and population health management has strengthened the rigor of data collection and data analysis methodologies. The school provided the following support: 1) consultation and support for CHNA survey and secondary data collection and analysis; 2) supported the development and validation of a community input instrument and summarized findings; 3) contributed to and promoted community input sessions; 4) reviewed drafts of the CHNAs prior to publication; and 5) managed student involvement and participation.

The **Healthy Communities Institute** provided quantitative data based on over 130 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

4. State who was involved in the decision-making process.

MSMHC's ATF reviewed local secondary data, coupled with state and federal community health goals. Task Force members also reviewed the hospital's operating plan, the outcomes of prior informal community health assessments, as well as current community benefit programs and services. In partnership with Georgetown University's School of Nursing & Health Studies, the team developed and helped disseminate a community health assessment tool around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life.

In addition to secondary data, CHNA survey and community input session findings, the Task Force considered the hospital's capabilities as well as local, regional and state health goals. Based on findings, the team made a recommendation on the priorities. The priorities were approved by the hospital's president, endorsed by the hospital board of directors, endorsed by the MedStar Health Board of Directors' Strategic Planning Committee and approved by the MedStar Health Board of Directors.

Advisory Task Force Membership

Name	Title/Affiliation with Hospital	Name of Organization
Pamela Creekmur	Health Officer	Prince George's County Health Department
Ernest Carter	Deputy Health Officer	Prince George's County Health Department
Rev. Dr. Harry Seawright	Reverend	Union Bethel A.M.E. Church, Brandywine, MD
Beatrice Tignor, Ed.D	Municipal Liaison	Office to the County Executive
Tara Saggar, MD	Physician	MedStar Southern Hospital Center
Anoop Kumar, MD	Physician	Medical Emergency Professionals
Carolyn Lowe	Coordinator	District V Coffee Club
Rose Dodson	Community Outreach Manager	MedStar Southern Maryland Hospital
Janice Wilson	Chairman of the Board	Southern Maryland Black Chamber of Commerce
Melony Griffith	VP of Government and External Affairs	Greater Baden Medical Services
Rev. Willie Hunt	Reverend	Coalition of Metropolitan Minister's Alliance
Diane Wilson	Local Resident	Clinton, MD (stroke survivor)
Ronnie Barnes-Bey	Local Resident	Fort, Washington, MD (stroke survivor)
Veda Belton, RN	Community Health Coordinator	Coalition of Metropolitan Minister's Alliance
Diane Proctor	Civic Leader	GS Proctor and Associates
Linda Gottfried	Director of Philanthropy	MedStar Southern Maryland Hospital
Andrew Lee, MD	Physician	MedStar Physician Partners at Mitchellville
Cheryl D. Brown	Medical and Wellness Ministry Coordinator	Union Bethel A.M.E. Church, Brandywine, MD
Reba McVay, MSN, RN	Vice President, Cardiovascular Services	MedStar Southern Maryland Hospital Center
Susan Topping	Maryland Regional Director	Capital Area Food Bank
Amy Smith	Stroke Program Coordinator	MedStar Southern Maryland Hospital Center
Ethel Shephard-Powell	Executive Director	Bethel House, Inc.

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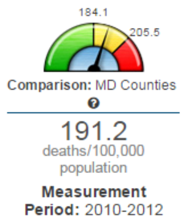
5. Justify why the hospital selected its community benefit priorities.

a) Chronic Disease

Secondary Data

Chronic diseases, including heart disease/stroke, cancer, diabetes, and obesity, often coexist as comorbidities. Health behaviors such as tobacco use, poor nutrition and physical inactivity contribute to chronic disease.[6]

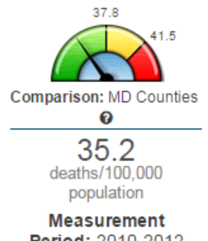
Death Rate due to Heart Disease



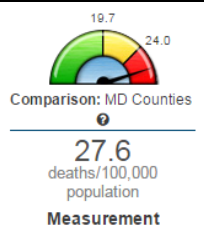
Heart Disease and Stroke

- Heart disease is the leading cause of death in Prince George's County, with an age-adjusted death rate of **191/100,**000 persons. The age-adjusted death rate from heart disease is higher for Blacks/African Americans.[2]
- The age-adjusted death rate due to stroke has decreased slightly (from 37/100,000 persons in 2008 to **35/100,000** in 2012) and is lower than the state average (37/100,000 persons).[2]
- The rate of emergency department visits for hypertension per 100,000 persons in Prince George's county is 284 compared to 246 in Maryland, and the rate is highest among Black/African American residents relative to other ethnic/racial groups.[2]
- The prevalence of high blood pressure (38%) and high cholesterol (37%) contributes to the age-adjusted death rate due to heart disease and stroke. The prevalence of high blood pressure and high cholesterol is highest among adults 65 and older and males. The relationship between heart disease risk factors and race/ethnicity varies. The prevalence of high blood pressure is higher in Blacks/African Americans relative to other ethnic/racial groups, whereas the prevalence of high cholesterol is higher for Hispanics relative to other racial/ethnic groups.[7]

Death Rate due to Stroke



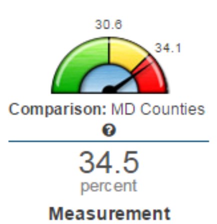
Death Rate due to Diabetes



Diabetes

- The age-adjusted death rate due to diabetes is **28/100,000**. The prevalence of diabetes is approximately 12%. The prevalence of diabetes is highest in adults 65 and older (30%), and virtually no differences are observed in diabetes prevalence across gender. The prevalence among Asians (21%), Hispanics (16%) and Blacks/African Americans (16%) is higher relative to the prevalence among Whites (9%).[7]
- The rate of emergency room visits due to diabetes has increased from 157 visits/100,000 persons in 2010 to 168 visits/100,000 persons in 2013. Blacks/African Americans contribute largely to this high rate.[2]

Prevalence of Obesity



Obesity

- A total of 35% of adults in Prince George's County are obese, and the trend is increasing. The prevalence of obesity is highest among adults between the ages of 45 to 64 and male adults. The prevalence of obesity is higher among Hispanic residents (45%) compared to Blacks/African Americans (34%) and Whites (29%).[7]

	Addressing the Risk Factors • The smoking prevalence among adults in Prince George's County is 15.2%;[2] adults aged 18-44 and males report the highest smoking prevalence across age and gender groups, respectively,[7] and Whites report current smoking rates higher than the countywide average.[2] Within the county, income and educational attainment are negatively correlated with smoking in adults.[43] • Approximately 32% of adults in the county report eating the recommended five or more servings of fruits and vegetables every day, which is higher than the state median. Adults younger than 65, males and Black/African American residents report eating the recommended fruits and vegetables at higher rates relative to the countywide average. [7] • Currently, only 50% of Prince George's County residents participate in at least 150 minutes of aerobic activity weekly, which is the recommended level of physical activity. Adults 45 and older, females, and Hispanic and Asian residents are less likely to report participating in the recommended level of physical activity relative to the countywide average.[7]
Community Health Needs Assessment Surveys and Community Input Sessions	CHNA Survey (N=258)[44] • Chronic disease is a recognized issue affecting the community, with respondents indicating that overweight/obesity (58%), diabetes (50%), and heart disease (43%) are primary health conditions seen in their community. • Community members recognize the contributions of health behaviors to overall health status. Currently, survey respondents make healthy meals (64%), exercise at a local gym or recreation center (33%) and use parks, trails or a track (29%) to stay healthy. • Affordable, healthy food options (45%) and better places to exercise (24%) were two services that were recognized as community needs through the surveys.
Strategies	• To provide monthly community-based healthy lifestyle lectures. • To collaborate with local faith-based organizations to provide education and screening services. • To collaborate with local schools to provide stroke education. • To provide free full lipid panel and glucose screenings at the MSMHC Laboratory. • To provide free blood pressure screenings at the MSMHC Solarium. • To provide free stroke risk assessment screenings. • To offer a monthly community-based weight loss program. • To provide a community-based mall walker program. • To offer free monthly Diabetes Support Groups. • To explore opportunities to implement evidence-based programs (i.e. National Diabetes Prevention Program). • To explore opportunities to offer smoking cessation classes/resources. • To offer a healthy farmer's market.
Hospital Strengths	• MSMHC has strong existing programs, accreditations, and partnerships to support its focus on chronic disease as a community health priority. The MedStar Heart and Vascular Institute at MSMHC offers robust programs in diagnostic and interventional cardiology as well as cardiac electrophysiology, together with prevention and rehabilitation. The range of programs and services offered by the MedStar Heart and Vascular Institute supports the

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	community's cardiovascular health and empowers people to live active, healthy lives. The Center offers prevention and education programs designed to identify and reduce an individual's risk factors for cardiovascular disease. • In recognition of MSMHC's high-quality emergency heart attack care, the hospital is designated as a Cardiac Interventional Center by Maryland Institute for Emergency Medical Services Systems (MIEMSS). The hospital has also received its designation as a Chest Pain Center with PCI (percutaneous coronary intervention) by the Society of Cardiovascular Patient Care, and certified by the Intersocietal Accreditation Commission Echocardiography. • MSMHC has been recognized for its exceptional patient care with several awards in recent years. MSMHC's Heart and Vascular Center achieved the Silver Plus Level for the American Heart Association's "Get With the Guidelines" Award. This award recognizes the Center for elevating patients to levels of care as outlined by the American College of Cardiology/American Heart Association guidelines. In 2011, MSMHC received a Five Star Rating for treatment of heart failure and a Five Star Rating for treatment of heart attacks in 2012 by Health Grades, an independent rating agency. • To further support MSMHC's focus on chronic disease, MedStar Health is an official partner of the Million Hearts campaign, which was launched by the Department of Health and Human Services with the goal of preventing one million heart attacks and strokes by 2017. The campaign brings together communities, health systems, and a variety of organizations to unite in the fight against heart disease and stroke. • To qualify for the Gold Plus award, MSMHC's Stroke Center met specific quality achievement measures for the diagnosis and treatment of stroke patients at a set level for two consecutive 12-month periods. These measures include aggressive use of medications and risk-reduction therapies aimed at reducing death and disability and improving the lives of stroke patients. • The hospital was also awarded the Target: Stroke Honor Roll by implementing stroke quality measures that reduce the time between hospital arrival and treatment with the clot-busting medication tissue plasminogen activator (tPA). If tPA is administered within three hours of the onset of stroke symptoms, patients have a better chance of recovery and are less likely to suffer severe disability. • Ranked among the top 10 stroke programs in Maryland by Health Grades, MSMHC's Stroke Center has a long history of award-winning performance in stroke care. It was the first in Southern Maryland to be certified as a Primary Stroke Center by the state of Maryland, and it remains the only certified Primary Stroke Center in Prince George's County. In 2014, the Stroke Center earned the American Heart Association's Silver Plus Achievement Award and Target: Stroke Honor Roll, one of only four hospitals in Maryland to earn these distinctions.
Alignment with local, regional, state or national health goals	• Healthy People 2020: Diabetes; Heart Disease and Stroke; Nutrition and Weight Status; Physical Activity; Tobacco Use[5] • Maryland State Health Improvement Process (MD SHIP): Healthy Living; Quality Preventative Care[2] • Prince George's County Health Improvement Plan: Prevent and Control Chronic Disease in Prince George's County[43]
Key Internal and External Partners	*Internal:* MedStar National Rehabilitation Network, MedStar St. Mary's Hospital, MedStar Montgomery Medical Center, MedStar Visiting Nurse Association,

	MedStar Health at Mitchellville *External*: Prince George's County Health Department, Greater Baden Medical Services, District V Coffee Club, Union Bethel A.M.E. Church, Bethel House, Grace Gospel Worship Center, Mt. Ennon Baptist Church, American Heart Association, Prince George's County Department of Parks and Recreation, Prince George's Community College, Capital Area Food Bank, Dare to C.A.R.E., Living Whole Health, Fitness Unleashed, Prince George's County Health Department, American Stroke Association
Metrics	*Internal Metrics* • % of program participants aware of risk factors associated with chronic diseases • % of program participants improving "readiness to change" status • % of program participants participating in the recommended levels of physical activity • % of program participants who lose weight • % of program participants who lose weight upon completing the program • % of program participants with elevated blood pressure • Perception of chronic disease severity among input survey respondents *External Metrics* • Age-adjusted death rate from heart disease[2] • Age-adjusted death rate from diabetes[2] • Rate of emergency room visits due to hypertension[2] • Age-adjusted death rate from stroke[2] • % of adults diagnosed with diabetes[9] • % of adults diagnosed with high blood pressure[9] • % of adults who participate in the recommended levels of physical activity[2] • % of adults who are overweight/obese[9]

6. Does the hospital currently have community benefit activities that support other key health needs that were identified as important in the Community Health Assessment? (Collaboration Areas)

Issue	Evidence	Strategy	Lead
Better places to exercise	24% (n=258) of survey respondents indicate better places to exercise as a community need.[44]	To explore opportunities to collaborate with local organizations to provide affordable fitness programs.	Prince George's County Parks and Recreation
Affordable, healthy food options	45% (n=258) of survey respondents indicate affordable, healthy food	To continue to collaborate with local farmers to coordinate	Capital Area Food Bank

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	options as a community need.[44] USDA labeled Prince George's County a food desert due to limited access to groceries and fresh food.[45]	farmers market. To explore opportunities to collaborate with the Capital Area Food Bank to increase access to healthy foods in Prince George's County.	

7. List other health priorities that were identified in the CHA and describe why the hospital did not select them. (Participation Areas)

Issue	Evidence	Explanation	Lead
Affordable Housing	28% (n=258) of survey respondents indicate affordable housing as a needed service in the community.[44]	The hospital does not have the expertise to have a leadership role in these areas; therefore, hospital will support external leaders in these areas.	Prince George's County Department of Housing and Community Development
Better Schools	24% (n=258) of survey respondents indicate better schools as a needed service in the community.[44] 77% of children enter kindergarten ready to learn; the MD SHIP target is 85%.[2] 75% of students in Prince George's County graduate high school four years after entering 9th grade; the MD SHIP target is 86%.[2]		Prince George's County Public Schools
HIV/AIDS	The rate of new cases of HIV in persons age 13 and older is 45/100,000; the MD SHIP target is 30/100,000.[2] The HIV prevalence rate of people aged 13 and older living with HIV is 740/100,000.[2]		Prince George's County Health Department
Better Public Transportation	22% (n=258) of survey respondents indicate better public transportation as a needed service in the community.[44]		Prince George's County Department of Public Works and Transportation

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8. Describe how the hospital will institutionalize community benefit programming to support the Implementation Strategy.

The hospital's Implementation Strategy is a roadmap for how community benefit resources will be deployed and how outcomes will be reported. The Community Benefit Hospital Lead will oversee planning, programming, monitoring, and evaluation of outcomes. The Executive Sponsor will support institutional efforts to re-organize or reallocate resources as needed. Annual progress updates will be provided to ATF members and the hospital's Board of Directors. The progress report will also be publicly accessible via the hospital's website.

The MedStar Health Corporate Community Health Department (CCHD) will provide system-wide coordination and oversight of community benefit programming. The CCHD will oversee the agenda of the Community Benefit Workgroup, which is comprised of Community Benefit Hospital Leads and other community health professionals across the system. The purpose of the workgroup is to share best practices and promote consistency around data collection, tracking, and reporting that is consistent with internal policies and state and federal guidelines.

The CCHD will provide the MedStar Health Board of Director's Strategic Planning Committee with annual updates on the hospital's progress towards the goals documented in the Implementation Strategy.

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MedStar Southern Maryland Hospital Center
Community Health Assessment Work Plan
(FY16-FY18)

Priority Issue #1 – Chronic disease prevention and management, specifically heart disease, diabetes and obesity
Goal Statement – To reduce the rates of modifiable risk factors that contribute to chronic disease among high risk populations in Clinton, Maryland.

1A. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
<u>Obesity and Diabetes</u> To provide monthly community-based healthy lifestyle lectures. Lectures will focus on nutrition, physical activity, and stress management. The following are examples of lecture topics: healthy eating on the go, decoding food labels, mindful eating, at-home workouts, and stress reduction techniques.	**Human Resources:** Nutritionist/Dietitian; LPN/RN; Certified Personal Trainer; Administrative Support; Lab Technicians **Physical Facilities:** Venue to facilitate events (District V Police Station, local faith-based organizations, local libraries, local hotel conference rooms, etc.) **Equipment and supplies:** Printed materials; cooking demonstration	# of classes taught # of event invitations distributed # of calls made # number of attendees per lecture	Evaluation Results- Readiness to Change progression	Weight Loss Improved blood pressure Increased Physical Activity (Average Active Days/Week)	Community Liaison, 1FTE	Danielle A. Grimes, Community Liaison

	supplies; fitness tracking supplies; weight scale; blood pressure cuffs; screening supplies; notebooks; pens; projector; laptop					

Activities to be phased in during the three year period:

- Incorporate exercise and general physical activity into the structure/content of the program

Internal MedStar Collaborations:

MSMH, MSMHC and MMMC will collaborate in Year 1 to:

- Have bi-monthly conference calls
- Host 1 team site visit at each entity
- Develop and track common indicators in areas of overlap – obesity, diabetes, hypertension
- Share successful programming
- Examine regional grant opportunities
- Explore opportunities to implement “Fax to Assist” program
- Explore opportunities to implement *Simple Changes-* National Diabetes Prevention Program
- Develop additional areas of collaboration for Year 2 & 3

Collaborate with MedStar Visiting Nurse Associate to provide screenings services, as needed.

External Collaborations:

- **Living Whole Health**; **Health Coach and Wellness Educator, Cheryl Mirabella-** Partner with Living Whole Health to facilitate interactive lectures and healthy cooking demonstrations
- **Fitness Unleashed, LLC; Certified Personal Trainer, Lovie Leach-** Partner with Fitness Unleashed, LLC to facilitate interactive fitness demonstrations and activities
- **American Heart Association-** Collaborate with the American Heart Association to obtain educational materials to support program
- **Prince George’s County Health Department; Greater Baden Medical Services-** Partner with local health organizations to promote program and services
- **District V Coffee Club-** Partner with local community organization to promote program and services
- **Union Bethel A.M.E. Church; Bethel House; Grace Gospel Worship Center; Mt. Ennon Baptist Church**- Partner with local faith-based organizations to promote program and services

*Additional local health, community, and faith-based organizations will be identified for potential partnerships

External Metric(s):

- % of adults diagnosed with diabetes

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- % of overweight and obese adults
- % of adults engaging in regular physical activity
- % of adults with high blood pressure
- Age-adjusted death rate due to heart disease
  Age-adjusted death rate due to diabetes in Prince George's County

1B. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
Obesity and Diabetes To collaborate with local faith-based organizations to provide education and screening services. * Health Happy Hour is a community-based program offering monthly healthy lifestyle lectures and interactive activities. Lectures focus on nutrition, physical activity, and stress management. The following are examples of lecture topics: healthy eating on the go, decoding food labels, mindful eating, at-home workouts, and stress reduction techniques.	**Human Resources:** LPN/RN; Nutritionist/Dietitian; Physician; Administrative Support; Lab Technicians **Physical Facilities:** Local faith-based organizations **Equipment and Supplies:** Printed materials; weight scale; blood pressure cuffs; screening supplies; promotional items	# of educational seminars held # of screening events held # of screenings performed # of faith-based organizations visited # of attendees/ event	# of program attendees and completers # of participants enrolled in Health Happy Hour Program	Weight loss Improved blood pressure Increased physical activity *of those enrolled and participating in Health Happy Hour program	Community Liaison, 1FTE Community Outreach Manager, 1FTE Community Outreach Coordinator, 1FTE	Danielle A. Grimes, Community Liaison Rose Dodson, Community Outreach Manager Carol Pyle, Community Outreach Coordinator

Activities to be phased in during the three year period:

- Create referral system for participants based on screening results and perceived need

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Implement referral tracking (appointments attended, reason appointment was not attended, etc.)
Internal MedStar Collaborations: MSMH, MSMHC and MMMC will collaborate in Year 1 to: • Have bi-monthly conference calls • Host 1 team site visit at each entity • Develop and track common indicators in areas of overlap – Obesity, Diabetes, Hypertension • Share successful programming • Examine regional grant opportunities • Explore opportunities to implement “Fax to Assist” program • Explore opportunities to implement *Simple Changes*- National Diabetes Prevention Program • Develop additional areas of collaboration for Year 2 & 3 Collaborate with MedStar Visiting Nurse Association to provide screening services, as needed.
External Collaborations: • **American Heart Association-** Collaborate with the American Heart Association to obtain educational materials to support program. • **Union Bethel A.M.E. Church; Grace Gospel Worship Center**- Partner with the pastor and his congregation to facilitate faith-based community outreach initiative. *Additional local faith-based organizations will be identified for potential partnerships.
External Metric(s): • % of adults diagnosed with diabetes • % of overweight and obese adults • % of adults engaging in regular physical activity • % of adults with high blood pressure • age-adjusted death rate due to heart disease; age-adjusted death rate due to diabetes in Prince George’s County

FINAL

Priority Issue #2 – Stroke prevention
Goal Statement – To increase awareness of stroke risk factors, signs and symptoms in Clinton, Maryland.

2A. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
To provide free community stroke risk assessment screenings. Screenings will consist of body mass index, blood pressure, cholesterol, glucose, triglycerides, family history, stress level and physical activity level. Results will measure participant's risk of stroke. *Health Happy Hour is a community-based program offering monthly healthy lifestyle lectures and interactive activities. Lectures focus on nutrition, physical activity, and stress management. The following are examples of lecture topics: healthy eating on the go, decoding food labels, mindful eating, at-home workouts, and stress reduction techniques.	**Human Resources:** LPN,RN; Administrative Support; Lab Technicians; Stroke Coordinator **Physical Facilities:** Venue to facilitate screenings (local churches, local hotel conference rooms; physician offices, MSMHC library, Waldorf Screening Center, etc.) **Equipment and Supplies:** Printed materials; weight scale; blood pressure cuff; screening supplies	# of screening events held # of screenings performed # of participants/ event	# of program attendees and completers Readiness to Change progression # of participants enrolled in Health Happy Hour program	Weight loss Improved blood pressure Increased physical activity *of participants enrolled in Health Happy Hour program	Community Liaison, 1FTE Community Outreach Manager, 1FTE Community Outreach Assistant, 1FTE Stroke Coordinator, 1FTE	Danielle A. Grimes, Community Liaison Rose L. Dodson, Community Outreach Manager Carol Pyle, Community Outreach Assistant Amy Smith, Stroke Coordinator

Activities to be phased in during the three year period:

- Create referral system for participants based on screening results and perceived need.
- Implement referral tracking (appointments attended, reason appointment was not attended, etc.)

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Internal MedStar Collaborations:
MSMH, MSMHC and MMMC will collaborate in Year 1 to:

- Have bi-monthly conference calls
- Host 1 team site visit at each entity
- Develop and track common indicators in areas of overlap
- Share successful programming
- Examine regional grant opportunities
- Explore opportunities to implement "Fax to Assist" program
- Develop additional areas of collaboration for Year 2 & 3

Collaborate with MedStar Visiting Nurse Association to provide screening services, as needed.

External Collaboration:

- **American Stroke Association**- Collaborate with the American Stroke Association to obtain educational materials to support program
- **Prince George's County Health Department; Greater Baden Medical Services-** Partner with local health organizations to promote program and services
- **District V Coffee Club**- Partner with local community organization to promote program and services
- **Union Bethel A.M.E. Church; Bethel House; Grace Gospel Worship Center; Mt. Ennon Baptist Church**- Partner with local faith-based organizations to promote program and services

*Additional local health, community, and faith-based organizations will be identified for potential partnerships.

External Metric(s):

- Emergency room rate due to hypertension in Prince George's County
- age-adjusted death rate due to stroke in Prince George's County

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MedStar Union Memorial Hospital
Community Health Assessment FY2015

Community Benefit Service Area
Hospital Primary Service Area
MedStar Hospital

MUMH FY'15
Community Benefit Focus Area
21218
21211
21213

* Primary Service Area – represents ZIP codes that contain 50% of inpatient discharges
*Community Benefit Service Area is also included in the primary service area

1. **Define the hospital's Community Benefit Service Area (CBSA) and identify the hospital's community benefit priorities.**

   MedStar Union Memorial Hospital's (MUMH) CBSA includes adults who reside in Baltimore City ZIP codes 21211, 21213 and 21218. The area was selected due to its close proximity to the hospital, coupled with a high density of residents with low incomes. Based on secondary, CHNA survey and community input session data, MUMH's community benefit priorities in chronic disease prevention and management are: 1) heart disease, 2) diabetes, and 3) obesity. Access to primary care, specialty care and inpatient health services for low-income residents who do not qualify for Medicaid has also been identified as a community benefit priority area.

2. **Provide a description of the CBSA**

   MUMH is located in ZIP code 21218 with 21211 to the west and 21213 to the east; thus, the hospital is directly surrounded by the CBSA. These three ZIP codes account for 40.8% of the admissions to the hospital. Neighborhoods within the CBSA include:

Medfield/Hampden/Woodberry/Remington, Greater Charles Village/ Barclay, Waverlies, Midway/Coldstream, and Belair-Edison.

According to the United States Census Bureau, there are 96,910 residents currently living within the CBSA, 15% of the entire population of Baltimore City. It is a relatively diverse population, with 63% Black/African American, 30% White, 4% Asian, and 0.6% other. Approximately 2% of residents are of Hispanic origin. The vast majority of the population (81%) is over the age of 18. Average median household income across the CBSA is $37,983 per year, lower than the city median.13

3. **Identify community health assessment program partners and their expertise or contribution to the process.**

Georgetown University's School of Nursing & Health Studies is an academic partner that brings a wide range of resources that contributed to MedStar Health's systemwide CHNA process. Their expertise in CHNAs and population health management has strengthened the rigor of data collection and data analysis methodologies. The school provided the following support: 1) consultation and support for CHNA survey and secondary data collection and analysis; 2) supported the development and validation of a community input instrument and summarized findings; 3) contributed to and promoted community input sessions; 4) reviewed drafts of the CHNAs prior to publication; and 5) managed student involvement and participation.

The **Healthy Communities Institute** provided quantitative data based on over 130 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

4. **State who was involved in the decision-making process.**

The Community Benefit priorities were recommended by an Advisory Task Force, which consisted of community leaders, board members, elected officials, and hospital personnel.

MUMH's ATF reviewed local secondary data, coupled with state and federal community health goals. Task Force members also reviewed the hospital's operating plan, the outcomes of prior informal community health assessments, as well as current community benefit programs and services. In partnership with Georgetown University's School of Nursing & Health Studies, the team developed and helped disseminate a community health assessment tool around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life.

In addition to secondary data, CHNA survey and community input session findings, the Task Force considered the hospital's capabilities as well as local, regional and state health goals. Based on findings, the team made a recommendation on the priorities. The priorities were approved by the hospital's president, endorsed by the hospital board of directors, endorsed by the MedStar Health Board of Directors' Strategic Planning Committee and approved by the MedStar Health Board of Directors.

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Advisory Task Force Membership

Name	Title/Affiliation with Hospital	Name of Organization
Mitch Herbert	Regional Director, Strategic and Business Planning	MedStar Health
Brad Chambers	President & SVP MSH	MedStar Union Memorial Hospital
Savas Karas	Board Member	MedStar Union Memorial Hospital
Derrick Adams	Board Member	MedStar Union Memorial Hospital
Sarah Fawcett Lee	Regional VP of Philanthropy	MedStar Union Memorial Hospital, Guilford resident
Glenda Skuletich	Executive Director	Shepherd's Clinic & Joy Wellness Center
Lisa Ghinger	Executive Director	Hampden Family Center
Alice Ann Finnerty	Community leader	Guilford resident
Nichole Battle	Chief Executive Officer	Govans Ecumenical Development Corporation

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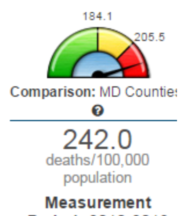
5. Justify why the hospital selected its community benefit priorities.

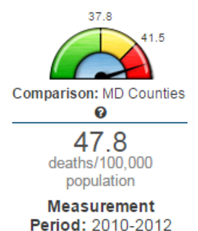
a) Chronic Disease

Secondary Data

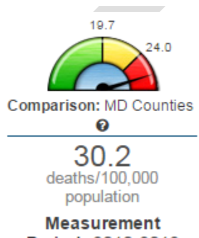
Death rate due to Heart Disease



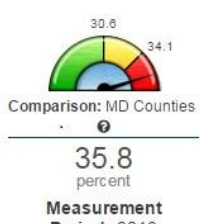
Death Rate due to Stroke



Death Rate due to Diabetes



Prevalence of Obesity



Chronic diseases, including heart disease/stroke, diabetes, and obesity, often coexist as comorbidities. Health behaviors such as tobacco use, poor nutrition and physical inactivity contribute to chronic disease.[6]

Heart Disease and Stroke

- Heart disease is the leading cause of death in Baltimore City, with an age-adjusted death rate of **242/100,000**. The age-adjusted death rate from heart disease is higher for Blacks/African Americans.[2]
- The age-adjusted death rate due to stroke is also decreasing (from 51/100,000 persons in 2009 to **48/100,000** in 2012) but remains significantly higher than the state (38/100,000 persons) and national averages (38 deaths/100,000 persons).[2]
- The rate of emergency department visits for hypertension per 100,000 persons in Baltimore City is 600 compared to 246 in Maryland, and the rate is highest among Black/African American residents relative to other racial/ethnic groups.[2]
- The prevalence of high blood pressure (35%) and high cholesterol (30%) contributes to the age-adjusted death rate due to heart disease and stroke. The prevalence of high blood pressure and high cholesterol is highest among adults 65 and older and females. The relationship between heart disease risk factors and race/ethnicity varies. The prevalence of high blood pressure is higher in Blacks/African Americans relative to other racial/ethnic groups, whereas the prevalence of high cholesterol is higher for Whites relative to other racial/ethnic groups.[7]

Diabetes

- The age-adjusted death rate due to diabetes is **30/100,000.** The prevalence of diabetes is approximately 11% and is highest among females (14%) and adults 65 and older (28%). The prevalence among Blacks/African Americans (13%) is more than two times higher than the prevalence among Whites (5%).[7]
- The rate of emergency department visits due to diabetes has increased from 444 visits/100,000 persons in 2010 to 502 visits/100,000 persons in 2013. Black/African Americans contribute largely to this high rate.[2]

Obesity

- A total of 36% of adults in Baltimore City are obese, and the trend is increasing. The prevalence of obesity is highest among adults between the ages of 45 to 64 and females. The prevalence of obesity is significantly higher among Black/African American residents (45%) than Hispanics (28%) or Whites (21%).[7]

	Addressing the Risk Factors • Baltimore City ranks in the worst quartile for adult smoking rates with 22.7% of the adult population identifying as current smokers;[2] adults aged 45-64, males, and Blacks/African Americans report current smoking rates higher than the citywide average.[7] Individuals earning less than $15,000 also report higher rates of smoking compared to the citywide average.[3] • Only one-fourth of adults in the city report eating the recommended five or more servings of fruits and vegetables every day, which is higher than the state median. Adults aged 65 and older, females and Blacks/African Americans residents report eating the recommended fruits and vegetables at higher rates relative to the citywide average.[7] • Currently, only 44% of Baltimore City residents participate in at least 150 minutes of aerobic activity weekly, which is the recommended level of physical activity, and self-reported physical activity has slightly decreased in recent years.[7] More so, 30% of residents report that they do not participate in any leisure physical activity. [3]Adults 45 and older, females, and Hispanic and Black/African American residents are less likely to report participating in the recommended level of physical activity relative to the citywide average.[7]
Community Health Needs Assessment Surveys and Community Input Sessions	CHNA Survey (N=175)[46] • Chronic disease is a recognized issue affecting the community, with respondents indicating that diabetes (67%), overweight/obesity (58%) and heart disease (40%) are primary health conditions seen in their community. • Community members recognize the contributions of health behaviors to overall health status. Currently, survey respondents make healthy meals (54%), exercise at a local gym or recreation center (19%) and use parks, trails or a track (16%) to stay healthy. • Affordable, healthy food options (27%) and better places to exercise (11%) were two services that were recognized as community need through the surveys and the community input sessions. • When asked to prioritize Healthy Baltimore 2015 health goals, survey respondents ranked "Promote Access to Quality Health Care for All" as third most important, which includes preventing hospitalizations and emergency room visits due to chronic disease as a health objective. • During a community input session, participants noted a strong desire for more education and information on nutrition, eating well and obesity. They agreed that behavioral change is a complex issue, and, while it is not clear to the participants how to help people change behavior, it is a subject that needs to be addressed. Other topics discussed include the physical environment, especially the need for safe places to go for a walk.
Strategies	• To offer heart health education courses (i.e., Get Heart Smart, Keep the Beat). • To provide smoking cessation programs. • To conduct free blood pressure screenings. • To offer community-based healthy lifestyle lectures/classes (Living Well, Take Charge of Your Diabetes; Life, Balance, & Weight Management). • To teach general nutrition education classes in the community and classes specifically for heart health and diabetes. • To teach weekly exercise classes. • To teach health literacy and compliance education courses.

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	• To provide health fair education sessions.
Hospital Strengths	• Heart disease is a MUMH core competency, as the hospital has a cardiology infrastructure designed to diagnose and treat cardiac patients at every juncture in the clinical pathway. • MUMH has a strong Diabetes and Endocrine Center that has been designed to provide multiple layers of clinical and educational support to our community. Experienced endocrinologists and Certified Diabetes Educators provide inpatient and outpatient care and education to patients with diabetes.
Alignment with local, regional, state or national health goals	• Healthy People 2020: Diabetes; Heart Disease and Stroke; Nutrition and Weight Status; Physical Activity; Tobacco Use[5] • Maryland State Health Improvement Process (MD SHIP): Healthy Living; Quality Preventative Care[2] • Healthy Baltimore: Promote Access to Quality Health Care for All; Be Tobacco Free; Redesign Communities to Prevent Obesity; Promote Heart Health[3]
Key Partners	*Internal:* MedStar Good Samaritan Hospital, MedStar Harbor Hospital, MUMH Physician Practices, MUMH Public Relations/Marketing Department *External:* Shepherd's Clinic and Joy Wellness Center, Hampden Family Center, Action in Maturity (AIM), Govans Ecumenical Development Corporation (GEDCO) resources and member organizations, Y of Central Maryland, Total Health Care, Inc., Greater Homewood Community Corporation, American Heart Association, Maryland University of Integrative Health, Baltimore Free Farm, Living Classrooms, Charm City Farms, American Lung Association, American Diabetes Association, American Association for Diabetes Educators
Metrics	*Internal Metrics* • % of program participants who participate in the recommended levels of physical activity • % of program participants with elevated blood pressure • % of program participants with elevated blood sugar • % of program participants that successfully quit smoking cigarettes • % of program participants aware of risk factors associated with chronic diseases • % of program participants who adopt sustainable lifestyle behaviors that help reduce the prevalence of chronic diseases *External Metrics* • % of adults who are at a healthy weight (BMI< 25 kg/m^2)[2] • Age-adjusted death rate from heart disease[2] • % of adults who participate in the recommended levels of physical activity[2] • Emergency department visit rate due to hypertension[2] • Emergency department visit rate due to diabetes[2] • % of adults who smoke[2]

b) Access to Care	
Secondary Data	• The health services and medical care available and utilized by an individual can impact their life expectancy, health outcomes and quality of life. The lack of availability, lack of health insurance and high cost of health acre all

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	contribute to the negative effects of poor access, including unmet health needs, delay of care, inability to get preventative services and preventable hospitalizations.[5] • When considering availability, the provider-patient ratio is relatively low for primary care physicians (937:1) and mental health providers (392:1), placing the city in the 90th percentile in the country. However, there are fewer dental providers in the city (1,833:1) relative to other Maryland jurisdictions (1,438:1).[1] • Baltimore City has high health insurance coverage, with 85% of adults and 96% of children insured, after increasing steadily in recent years. Females are insured at slightly higher levels than males, while Asian children and Hispanic adults are the least likely racial/ethnic groups to be insured among children and adults.[7] • Despite high availability and high insurance coverage rates, accessing medical care is still a challenge for Baltimore City residents. Nearly 18% of adults were unable to afford to see a doctor in the last 12 months; adults under the age 65, males and Hispanic residents report being unable to afford a doctor at higher rates than 18%.[7] • The local health department has set a goal to reduce the percent of insured residents who report having unmet medical needs in the last 12 months to 12.2% overall; during the baseline year, 20% of insured Black/African American residents and 26% of insured residents earning less than $15,000 report having unmet medical needs[3]
Community Health Needs Assessment Surveys and Community Input Sessions	CHNA Survey (N=175)[46] • When asked to prioritize Healthy Baltimore 2015 health goals, survey respondents ranked "Promote Access to Quality Health Care for All" as third most important.
Strategies	• To provide primary and specialty care services via Shepherd's Clinic, a separate community not-for-profit health care provider. • To offer community based education programs focused on heart disease, diabetes, smoking cessation, and CPR training. • To provide behavioral and stress management services such as yoga, acupuncture, nutrition education, and meditation.
Hospital Strengths	• MedStar Union Memorial Hospital and Shepherd's Clinic have a long, successful partnership.
Alignment with local, regional, state or national health goals	• Healthy People: Access to health services[5] • Maryland State Health Improvement Process (MD SHIP): Access to Health Care[2] • Healthy Baltimore: Promote Access to Quality Health Care for All[3]
Key Internal and External Partners	*Internal:* MedStar Harbor Hospital, MedStar Good Samaritan Hospital, MedStar Franklin Square Medical Center
Metrics	*External* • % of persons reporting unmet healthcare needs in the past 12 month[3] • % of persons reporting they could not afford to see a doctor in the past 12 months [3]

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6. Does the hospital currently have community benefit activities that support other key health needs that were identified as important in the Community Health Assessment? (Collaboration Areas)

Condition/ Issue	Evidence	Strategy	Key Partners
Cancer Screenings	"Encourage Early Detection of Cancer" is one of the ten priority areas from Baltimore City Health Department's Health Baltimore 2015. Priority areas have underlying goals of increasing percent of adults 50 and older who have had a colon cancer screening in the last 10 years by 15% and increasing percent of women who receive breast cancer screening based on the most recent guidelines by 10%. Baltimore City's age-adjusted mortality rate from cancer is 215/100,000, compared to 164/100,000 for the state.[2]	To provide free or low-cost screening for individuals who are uninsured or underinsured and meet certain income requirements to enable early detection of breast, cervical, and colorectal cancer-related illness/disease. To provide access to follow-up care when necessary.	Maryland Cancer Fund, Baltimore City Health Department, Maryland Department of Health
Behavioral Health	"Recognize and Treat Mental Health Needs" is one of the ten priority areas from Baltimore City Health Department's Health Baltimore 2015 with an underlying goal of decreasing the percent of adults with unmet mental health care needs by 25%. The emergency department visit rate for mental health conditions is 6,394/100,000, compared to 3,379/100,000 for the state. [2] 39% (n=102) of survey respondents listed "Mental Health Conditions (e.g., anxiety, depression, stress)" as a health	To reduce behavioral health readmissions through better discharge planning and the use of a dedicated community health worker.	Other area inpatient and outpatient behavioral health providers (e.g., hospitals, physician, federally qualified health centers)

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	condition they see most in their community.[46]		
Alcohol and Drug Addiction	"Reduce Drug Use and Alcohol Abuse" is one of the ten priority areas from Baltimore City Health Department's Health Baltimore 2015, with underlying goals of decreasing the rate of alcohol and drug-related hospital admissions and emergency department visits by 10% and 15%, respectively. Baltimore City's drug-induced death rate is 26/100,000, compared to 13/100,000 for the state (MD SHIP, 2013). The emergency department visits rate for addictions-related conditions is 4,935/100,000 compared to 1,526/100,000 for the state.[2] When asked what health condition they see most in their community, respondents stated "Alcohol Addiction" (44%), "Heroin/Opiod Addiction" (31%) and "Other Drug Addictions" (26%) (n=102).[46]	In exploratory phase with key partners	Inpatient and outpatient treatment facilities, Alcoholics Anonymous, Narcotics Anonymous, other addiction recovery services
Children and Adolescent Health	"Promote Healthy Children and Adolescents" is one of the ten priority areas from Baltimore City Health Department's Health Baltimore 2015.	In exploratory phase with key partners	Pediatric inpatient and outpatient providers, schools, churches, community organizations

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7. List other health priorities that were identified in the CHNA and describe why the hospital did not select them. (Participation Areas)

Condition/ Issue	Evidence	Strategy	Key Partners
Housing	When asked which services are needed most in our community, 40% (n=102) of respondents stated "Affordable Housing".[46]	The hospital does not have the expertise to have a leadership role in these areas; therefore, hospital will support external leaders in these areas.	Housing Authority of Baltimore City; Department of Housing and Community Development; community organizations
Density of Liquor Stores, Tobacco Retail, Fast Food, Carryout and Corner Stores.	The density of Liquor Stores, Tobacco Retail, Fast Food, Carryout and Corner Stores is very high in the identified target area, as ranked in the 2011 Baltimore City Neighborhood Health Profiles.[3]		Baltimore City Planning Department, Baltimore City Liquor License Board, Maryland Department of Health and Mental Hygiene

8. Describe how the hospital will institutionalize community benefit programming to support the Implementation Strategy.

The hospital's Implementation Strategy will serve as a roadmap for how community benefit resources will be deployed and how outcomes will be reported. The Community Benefit Hospital Lead will oversee planning, programming, monitoring, and evaluation of outcomes. The Executive Sponsor will support institutional efforts to re-organized or reallocate resources as needed. Annual progress updates will be provided to ATF members and the hospital's Board of Directors. The progress report will also be publicly accessible via the hospital's website.

The MedStar Health Corporate Community Health Department (CCHD) will provide system-wide coordination and oversight of community benefit programming. The CCHD will oversee the agenda of the Community Benefit Workgroup, which is comprised of Community Benefit Hospital Leads and other community health professionals across the system. The purpose of the workgroup is to share best practices and promote consistency around data collection, tracking, and reporting that is consistent with internal policies and state and federal guidelines.

The CCHD will provide the MedStar Health Board of Director's Strategic Planning Committee with annual updates on the hospital's progress towards the goals documented in the Implementation Strategy.

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MedStar Union Memorial Hospital
Community Health Assessment Work Plan
(FY16-FY18)

Priority Issue #1- Chronic disease prevention and management, specifically heart disease and diabetes
Goal Statement: To provide education and services to promote disease prevention and management through community health programming centered on heart disease, hypertension, diabetes, nutrition, and exercise in the CBSA of Baltimore City.

1A. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
Diabetes Diabetes Self-Management Program "Diabetes Map Conversations" from Healthy Interactions group ADA approved classes. Four sessions of classes including: "On the Road to Better Managing Your Diabetes", "Diabetes and Healthy Eating", "Monitoring Your Blood Glucose", "Continuing Your Journey With Diabetes"	Program is overseen and coordinated by wellness staff and the Medical Director of Shepherd's Clinic. Classes held at Shepherd's Clinic and Joy Wellness Center for both Pre DM and DM patients. Group DM Map Conversations are run by Exercise Physiologist, RNs, RD, CNS interns, PharmD and/or NP, administrative volunteers to coordinate	Number of Programs: Program will be presented 2-3 times per year depending on staff and volunteers available. Classes are 2 hours long each. # people recruited # enrolled # attended	Pre and post test results for all participants specific to topics addressed in the class In patients, weight loss, BP and HbA1c, medication adherence Behavioral targets: - Dietary Changes - Increased physical activity - Readiness to change assessment	Increase activity to 150 minutes per week of aerobic activity. Two or more days strength training A1c 6-7% ideal Weight loss	Program Director, Clinical Exercise Physiologist (100%) Program Assistant, Yoga Instructor (100%) Nurse Practitioner (15-18%)	Kerry Martinez, MS, RYT 500, Program Director

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	referrals. Many are volunteers to this community One on one consultations are seen by NP, RN, RD or CNS (Clinical Nutrition Specialist) interns Use exam room for one on one sessions Use Joy Wellness Center community room for group sessions A dinner is provided that is an appropriate meal for a person with either pre-diabetes or diabetes Handouts provided to participants Clinical labs for participants who are patients.	# completers				

Internal MedStar Collaborations:

- MUMH DM and Endocrine Center collaboration as a resource for DM materials and possible education, MGSH Nurse Educators collaboration for further program development, referrals to our programs and teaching, patient referrals from MedStar Adult Medicine

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Specialists. Potential collaboration opportunities with other Baltimore area hospitals.

External Collaborations:

- American Diabetes Association, American Association of Diabetes Educators for database management of clinical outcomes. Shepherd's Clinic patient referrals and community referrals, Maryland University of Integrative Health for nutrition interns, Towson University for exercise science interns, Maryland University for public health interns, JHU university for community interns, nursing interns and public health interns and volunteers, community volunteer gardeners, volunteer RDs, administrative volunteers. Community Garden collaboration for seeds, garden needs and consultation, Baltimore Free Farm, Living Classrooms, Charm City Farms and other individual county farms.

External Metric(s):

Baltimore City

- Emergency department visit rate due to diabetes (MD SHIP)
- Emergency department visit rate due to hypertension (MD SHIP)
- % of adults at healthy weight (BMI < 25 kg/m2) (MD SHIP)
- CBSA-level metrics where available

1B. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
Diabetes Individual One on One Sessions on Self-Management of Type 2 DM using the Map 1:1 Conversations. All sessions with NP, RNs or RDs or CNS interns are designed to help participants balance their lifestyle and reinforce behavior changes (including exercise, nutrition recommendations and medication adherence) to help control the	Program is overseen and coordinated by wellness staff and the Medical Director of Shepherd's Clinic RNs, RD, CNS interns, or NP will see patient, administrative volunteers to coordinate referrals. Many clinical staff are volunteers to this	Held once per week with RNs, RD or NP Held once every other week in evenings with CNS interns # people recruited # enrolled # attended # completers	AADE tracking system database to house clinical data Pre and post test results for all participants specific to topics addressed in the class weight loss, BP and HbA1c, medication adherence Behavioral targets:	150 minutes per week of aerobic activity. Two or more days strength training A1c 6-7% ideal Weight loss	Program Director, Clinical Exercise Physiologist (100%) Program Assistant, Yoga Instructor (100%) Nurse Practitioner (15-18%)	Kerry Martinez, Program Director

progression of disease.	community. Sessions held at Shepherd's Clinic and Joy Wellness Center for both Pre DM and DM patients in a consult room Handouts provided to participants Clinical labs for participants who are patients Follow up phone calls on these patients monthly and office visits to track clinical data		- Dietary Changes - Increased physical activity - Readiness to change assessment			

Internal MedStar Collaborations:

- MUMH DM and Endocrine Center collaboration as a resource for DM materials and possible education, MGSH Nurse Educators collaboration for further program development, referrals to our programs and teaching, patient referrals from MedStar Adult Medicine Specialists. Potential collaboration opportunities with other Baltimore area hospitals.

External Collaborations:

- American Diabetes Association, American Association of Diabetes Educators for database management of clinical outcomes. American Heart Association in regards to Pre diabetic guidelines. Shepherd's Clinic patient referrals and community referrals, Maryland University of Integrative Health for nutrition interns, Towson University for exercise science interns, Maryland University for public health interns, JHU university for community interns, nursing interns and public health interns and volunteers, community volunteer gardeners, volunteer RDs, administrative volunteers. Community Garden collaboration for seeds, garden needs and consultation, Baltimore Free Farm, Living Classrooms, Charm City Farms and other individual county farms.

External Metric(s):

Baltimore City

- Emergency department visit rate due to diabetes (MD SHIP)

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- Emergency department visit rate due to hypertension (MD SHIP)
- % of adults at healthy weight (BMI < 25 kg/m2) (MD SHIP)

CBSA-level metrics where available

1C. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
Diabetes "Living Well: Take Charge of Your Diabetes" (Stanford Diabetes Self-Management Program/Evidenced-based program) The Diabetes Self-Management workshop is given 2½ hours once a week for six weeks. People with type 2 diabetes attend the workshop in groups of 12-16 Subjects covered include: 1) techniques to deal with the symptoms of diabetes, fatigue, pain, hyper/hypoglycemia, stress, and emotional problems such as depression, anger, fear	Workshops are facilitated from a highly detailed manual by two registered nurses who are trained leaders for this program Workshops will be conducted at the Shepherd's Clinic and Joy Wellness Center and at other community locations like the Hampden Family Center. Each participant in the workshop receives a copy of the companion book, *Living a Healthy Life with Chronic Conditions, 4th Edition*, and an	Number of Programs: This program will be offered in the fall and spring of each year. Each program consist of six 2 ½ hour workshops # people recruited # enrolled # attended # completers	Stanford has a standard evaluation form that is given at the end of the program. Additionally, program participants will be call 3 months and 6 months later and surveyed related to the effectiveness of the self-management techniques learned in the program.	Follow up calls at 3months and 6 months Improvements reported by participants in management of their diabetes - weight loss - decreased A1C - decreased BP - better compliance with diet - increased exercise - monitoring blood glucose level	MGSH and MUMH Community Outreach Nurses	Karen Kansler, RN Community Outreach Nurse Debbie Bena, RN Community Outreach Nurse MUMH will be hiring a dedicated community outreach nurse for FY 2016

and frustration; 2) appropriate exercise for maintaining and improving strength and endurance; 3) healthy eating 4) appropriate use of medication; and 5) working more effectively with health care providers. Participants will make weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their self-management program.	audio relaxation tape which is provided by Baltimore City Health Department.					

Internal MedStar Collaborations:

- MUMH DM and Endocrine Center collaboration as a resource for DM materials and possible education, MGSH Nurse Educators collaboration for further program development, referrals to our programs and teaching, patient referrals from MedStar Adult Medicine Specialists. Potential collaboration opportunities with other Baltimore area hospitals.

External Collaborations:

- American Diabetes Association, American Association of Diabetes Educators for database management of clinical outcomes. American Heart Association in regards to Pre diabetic guidelines. Shepherd's Clinic patient referrals and community referrals, Maryland University of Integrative Health for nutrition interns, Towson University for exercise science interns, Maryland University for public health interns, JHU university for community interns, nursing interns and public health interns and volunteers, community volunteer gardeners, volunteer RDs, administrative volunteers. Community Garden collaboration for seeds, garden needs and consultation, Baltimore Free Farm, Living Classrooms, Charm City Farms and other individual county farms. In Partnership with Baltimore City Health Department

External Metric(s):

Baltimore City

- Emergency department visit rate due to diabetes (MD SHIP)
- Emergency department visit rate due to hypertension (MD SHIP)
- % of adults at healthy weight (BMI < 25 kg/m2) (MD SHIP)
- CBSA-level metrics where available

1D. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
Obesity Ongoing nutritional classes throughout the year to support behavior change for nutrition and wellness. Programming and food demos ongoing for pre diabetes and diabetes nutritional learning.	wellness staff and the Medical Director of Shepherd's Clinic MUIH CNS interns and volunteer RDs Handouts provided to participants Joy Wellness Center community room Community garden at the Shepherd's Clinic and Joy Wellness Center Dinner for persons with pre-diabetes or diabetes Potential classes for Y of Central	10-15 classes per year # people recruited # enrolled # attended # completers	Pre and post test results for all participants specific to topics addressed in the class weight loss, BP and A1c, medication adherence	Long term educational tracking and surveys to measure learning and change in community	Program Director, Clinical Exercise Physiologist (100%) Program Assistant, Yoga Instructor (100%) MGSH and MUMH Community Outreach Nurses	Kerry Martinez, Program Director Karen Kansler, RN Community Outreach Nurse Debbie Bena, RN Community Outreach Nurse MUMH will be hiring a dedicated community outreach nurse for FY 2016

<table>
<tr><td></td><td>Maryland – Weinberg Family Center, Hampden Family Center, and 29th St Community Center, but logistics would have to be coordinated. If applicable, will provide specific activity at a later date.</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="7">Internal MedStar Collaborations:
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<tr><td colspan="7">External Metric(s):
Baltimore City
• Emergency department visit rate due to diabetes (MD SHIP)
• Emergency department visit rate due to hypertension (MD SHIP)
• % of adults at healthy weight (BMI < 25 kg/m2) (MD SHIP)
• CBSA-level metrics where available</td></tr>
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1E. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Heart "Get Heart Smart Program" This is a one hour program given over 5 weeks. Topics include a general overview of the most common types of heart disease and stroke with an emphasis on lifestyle changes to support cardiovascular health. i.e. nutrition, exercise, stress reduction.	Coordinated by wellness staff and the Medical Director of Shepherd's Clinic Shepherd's Clinic and Joy Wellness Center for patient and community with coronary artery disease (CAD) or any risk factors for CAD Group "Get Heart Smart" Heart Education ran by Clinical Exercise Physiologist, RNs, CNS interns, administrative volunteers One on one nutrition consultations consisting of risk factor modification held for 1 hour every other week for patients	Number of Programs: Program will be presented 2 times per year depending on staff and volunteers available. Classes are 1.5 hours long # people recruited # enrolled # attended # completers	Pre and post test results for all participants specific to topics addressed in the class	Pre and post testing results and surveys to track change in behaviors and learning as this program is short in duration and hard to track actual clinical change	Program Director, Clinical Exercise Physiologist (100%) Program Assistant, Yoga Instructor (100%) MGSH and MUMH Community Outreach Nurses	Kerry Martinez, Program Director Karen Kansler, RN Community Outreach Nurse Debbie Bena, RN Community Outreach Nurse MUMH will be hiring a dedicated community outreach nurse for FY 2016

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	Use Joy Wellness Center community room for group sessions A dinner is provided that is an appropriate meal for a person with either CAD or risk factors for CAD Handouts provided to participants Would like to replicate "Get Heart Smart" for Y of Central Maryland – Weinberg Family Center, Hampden Family Center, but logistics would have to be coordinated. If applicable, will provide specific activity at a later date.					

Internal MedStar Collaboration:

- MUMH Heart & Vascular Institute, MUMH Marketing, MGSH-MUMH Community Health Nurses collaboration for program development. Potential collaboration opportunities with other Baltimore area hospitals.

External Collaboration:

- American Heart Association, American Diabetes Association, American Association of Diabetes Educators for database management of clinical outcomes. Shepherd's Clinic patient referrals and community referrals, Maryland University of Integrative Health for nutrition interns,

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Towson University for exercise science interns, Maryland University for public health interns, JHU university for community interns, nursing interns and public health interns and volunteers, community volunteer gardeners, volunteer RDs, administrative volunteers. Community Garden collaboration for seeds, garden needs and consultation, Baltimore Free Farm, Living Classrooms, Charm City Farms and other individual county farms.

External Metric(s):
Baltimore City

- Age-adjusted mortality rate for heart disease (MD SHIP)
- Emergency department visit rate due to hypertension (MD SHIP)
- % of adults at healthy weight (BMI < 25 kg/m2) (MD SHIP)
- % of persons who meet the federal guidelines for physical activity (MD SHIP)
- CBSA-level metrics where available

1F. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes & Impacts	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Exercise Classes including but not limited to aerobic exercise, dance, chair, strength exercise or any combination. Yoga basics, chair yoga, yoga for women's empowerment, yoga for stress management, yoga for healing and gentle yoga.	Movement room at Joy Wellness Center and/or Community Room for all activities Program is overseen and coordinated by wellness staff and the Medical Director of Shepherd's Clinic Run by Clinical Exercise Physiologist, RNs, Program Assistant, Towson Exercise Science volunteers and administrative volunteers to	1-4 programs per week throughout the year depending on volunteer and intern availability. Classes are 45 minutes to 1 hour in length # people recruited # enrolled # attended	We track attendance only for these programs. These classes are ongoing that complement our greater initiative of chronic disease management. Pre and post test results for all participants specific to topics addressed n the class weight loss, BP and HbA1c, medication	150 minutes per week of aerobic activity. Two or more days strength training. HbA1c 6-7% ideal Weight loss	Program Director, Clinical Exercise Physiologist (100%) Program Assistant, Yoga Instructor (100%) MGSH and MUMH Community Outreach	Kerry Martinez, Program Director Karen Kansler, RN Community Outreach Nurse Debbie Bena, RN Community Outreach Nurse MUMH will be hiring a dedicated community outreach nurse for FY 2016

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	coordinate referrals. Many class teachers are volunteers to this community Classes held at Shepherd's Clinic and Joy Wellness Center for patient and community with CAD or any risk factors for CAD including hypertension, cholesterol, smoking, diabetes, weight loss Handouts provided to participants. Would like to offer exercise classes for Hampden Family Center and 29th St Community Center, but logistics would have to be coordinated. If applicable, will provide specific activity at a later date.	# completers	adherence Behavioral targets: -Dietary Changes - Increased physical activity - Readiness to change assessment			

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Internal MedStar Collaborations: • MUMH Physician practices to drive referrals into the program • MUMH Public Relations/Marketing Department for promotion of the program
External Collaborations: • Towson University for exercise science interns, volunteers in community • Hampden Family Center and 29th St Community Center.
External Metric(s): Baltimore City • Age-adjusted mortality rate for heart disease (MD SHIP) • Emergency department visit rate due to hypertension (MD SHIP) • % of adults at healthy weight (BMI < 25 kg/m2) (MD SHIP) • % of persons who meet the federal guidelines for physical activity (MD SHIP) CBSA-level metrics where available

1G. Provide a detailed description of the program or service	**Inputs/Resources**	**Outputs**	**Short-term Outcomes & Impacts**	**Long-term Outcomes & Impact**	**Dedicated Staff**	**Person Responsible**
"Senior Fitness Programs" Exercise programs offered at local community senior centers. Exercise classes include aerobics, strength training and flexibility. All components are design to meet the fitness levels of the participants. Chair exercises are demonstrated for participants who have limitations in standing	Classes will be held at Hampden Family Center and Action in Maturity Exercise bands are provided for strength training	A one hour class will be held weekly at each center # people recruited # enrolled # attended # completers	Weight loss and muscle mass will be measured every 3 months Behavioral targets - Increased physical activity - Readiness to change assessment	Hampden Family Center - weight loss, blood pressure, BMI, and muscle mass will be measured every 3 months Action in Maturity - Weight loss, blood pressure, and BMI will be measured every 3 months Increased duration of activity and level of intensity	Community Outreach Nurse with Certification in Senior Fitness	Debbie Bena, RN Community Outreach Nurse MUMH will be hiring a dedicated community outreach nurse for FY 2016

Internal MedStar Collaborations: • MUMH Physician practices to drive referrals into the program • MUMH Public Relations/Marketing Department for promotion of the program						
External Collaborations: • Hampden Family Center and Action in Maturity.						
External Metric(s): Baltimore City • Age-adjusted mortality rate for heart disease (MD SHIP) • Emergency department visit rate due to hypertension (MD SHIP) • % of adults at healthy weight (BMI < 25 kg/m2) (MD SHIP) • % of persons who meet the federal guidelines for physical activity (MD SHIP) • CBSA-level metrics where available						
1H. Provide a detailed description of the program or service	**Inputs/Resources**	**Outputs**	**Short-term Outcomes & Impacts**	**Long-term Outcomes & Impact**	**Dedicated Staff**	**Person Responsible**
Heart Disease – Smoking Cessation American Lung Association's "Freedom from Smoking Program" The "Freedom from Smoking" group clinic includes eight sessions and features a step-by-step plan for quitting smoking. Each session is designed to help smokers gain control over their behavior. The clinic format encourages participants to work on the process and problems of quitting both individually and as part of a group.	Program is overseen and coordinated by wellness staff and the Medical Director of Shepherd's Clinic. Classes will be given by the Program Director and Program Assistant at Joy Wellness Center. Association to facilitate the program. Classes will be held at MGSH as well as other community locations. Workbooks and a relaxation CD will be	1-2 8 week programs per year depending on provider referrals and availability of instructor Classes are 2 hours in length # people recruited # enrolled # attended # completers	% Participant quit rate in at end of program Participants will quit smoking in the fourth week of the program	Decrease relapse rates % smoking cessation 1-year post completing the program. Participants will be smoke free at the end of the eight week program. Participants will be smoke free one year after completing the program.	Program Director, Clinical Exercise Physiologist (100%) Program Assistant, Yoga Instructor (100%) Community Outreach nurses	Kerry Martinez, Program Director

	given to each participant. Participants will be referred to "How to Quit Smoking Line" where they can access Nicotine patches or gum Classes to be held in movement room at Joy Wellness Center for these sessions Smoking Cessation Yoga Nidra CDs to support Smoking Cessation Classes will be given by a registered nurse who has been trained by the American Lung Association to facilitate the program. Classes will be held at community locations like Y of Central Maryland – Weinberg Family Center, Hampden Family Center, and GEDCO Stadium Place. If applicable, will provide specific activity at a later date.	An eight week session will be offered four times per year. # people recruited # enrolled # attended # completers				

Internal MedStar Collaborations:

- MUMH Physician practices to drive referrals into the program
- MUMH Public Relations/Marketing Department for promotion of the program
- Potential collaboration opportunities with other Baltimore area hospitals.

External Collaborations:

- American Lung Association
- Shepherd's Clinic for referrals

External Metric(s):

- Decrease number of adults that smoke in Maryland to 14.4 % by 2014 (MD Ship)
- CBSA-level metrics where available

1I. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impact	Dedicated Staff	Person Responsible
Obesity Nutritional programming and food demos ongoing for heart health and risk factor nutritional learning. Utilize our own community garden at the Shepherd's Clinic and Joy Wellness Center site to grow vegetables seasonally for food demos.	Program is overseen and coordinated by wellness staff and the Medical Director of Shepherd's Clinic and run by MUIH CNS interns and volunteer RDs Classes held at Shepherd's Clinic and Joy Wellness Center for patient and community with CAD or any risk factors for CAD including hypertension, cholesterol, smoking, diabetes,	Number of Programs: Program will be presented 10-15 times per year depending on staff and volunteers available. Classes are 1.5 hours long # people recruited # enrolled # attended # completers	Pre and post test results for all participants specific to topics addressed in the class Behavioral targets: - Dietary Changes - Increase fruit and vegetables intake - Decrease sodium intake	Pre and post testing results and surveys to track change in behaviors and learning as these programs are short in duration and hard to track actual clinical change Long term educational tracking and surveys to measure learning and change in community	Program Director, Clinical Exercise Physiologist (100%) Program Assistant, Yoga Instructor (100%) MGSH and MUMH Community Outreach Nurses	Kerry Martinez, Program Director Karen Kansler, RN Community Outreach Nurse Debbie Bena, RN Community Outreach Nurse MUMH will be hiring a dedicated community outreach nurse for FY 2016

	weight loss. Group classes ran by RDs and CNS interns, administrative volunteers to coordinate referrals. Use Joy Wellness Center community room and kitchen for group sessions. A lunch/dinner is provided that is an appropriate meal for a person with either CAD or risk factors for CAD. Handouts provided to participants. Would like to offer nutritional programming and food demos for Y of Central Maryland – Weinberg Family Center, Hampden Family Center, and 29th St Community Center, but logistics would have to be coordinated. If		- Increased physical activity - Improved mental health status or affect - Readiness to change assessment Pre and post testing to track learning			

	applicable, will provide specific activity at a later date.					

Internal MedStar Collaborations:

- MUMH Physician practices to drive referrals into the program
- MUMH Public Relations/Marketing Department for promotion of the program
- Potential collaboration opportunities with other Baltimore area hospitals.

External Collaborations:

- American Heart Association, Shepherd's Clinic patient referrals and community referrals, Maryland University of Integrative Health for nutrition interns, Towson University for exercise science interns, Maryland University for public health interns, JHU university for community interns, nursing interns and public health interns and volunteers, community volunteer gardeners, volunteer RDs, administrative volunteers. Community Garden collaboration for seeds, garden needs and consultation, Baltimore Free Farm, Living Classrooms, Charm City Farms and other individual county farms.

External Metric(s):

- Age-adjusted mortality rate for heart disease (MD SHIP)
- Emergency department visit rate due to hypertension (MD SHIP)
- % of adults at healthy weight (BMI < 25 kg/m2) (MD SHIP)
- % of persons who meet the federal guidelines for physical activity (MD SHIP)
- CBSA-level metrics where available

MedStar Washington Hospital Center
Community Health Assessment FY2015

Community Benefit Service Area
Hospital Primary Service Area
MedStar Hospital

MWHC FY'15
Community Benefit Focus Area
20011
20019
20002
20020
20032
20001
20018
20017

* Primary Service Area – represents ZIP codes that contain 50% of inpatient discharges
*Community Benefit Service Area is also included in the primary service area

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1. Define the hospital's Community Benefit Service Area (CBSA) and identify the hospital's community benefit priorities.

MedStar Washington Hospital Center's (MWHC) CBSA includes adults age 18 or older who reside in Wards 5, 7, and 8 of the District of Columbia. Ward 5 was selected due to its close proximity to the hospital, coupled with an opportunity to build upon pre-existing and prior programs and services in Ward 5. Wards 7 and 8 were selected, because the majority of the residents of those wards are considered underserved and made up more than 11,970 visits to MWHC inpatient, observation, outpatient and emergency room from July 1, 2013 to June 30, 2014. Based on secondary, CHNA survey and community input session data, MWHC's community benefit priorities in chronic disease prevention and management are: 1) heart disease/stroke, 2) cancer, 3) diabetes, and 4) obesity. Teen births and child development have also been identified as a community benefit priority.

2. Provide a description of the CBSA.

Ward 5, the focal point of the CBSA, is located in the northeastern quadrant of the District of Columbia. It is the home of approximately 79,342 residents; 82% are adults age 18 and older, the concentration of adults older than 65 is high in Ward 5 (15%) compared to the citywide average of 11%. The majority of residents are Black/African American (75%). Seventeen percent are White, and 7% are Hispanic. The average household income in

Ward 5 ($68,269) is less than the city average ($101,076). The percent of adults with a high school diploma or higher education (33%) is less than the city average (52%). The rate of unemployment is 7% for the city and 11% for Ward 5, and the percentage of families living in poverty in Ward 5 is 17% as compared to 15% for the entire city.[13]
Wards 7 and 8, located east of the Anacostia River in Southeast Washington, D.C., are also included in the CBSA for MWHC. Educational attainment, unemployment, poverty, and income as less favorable in Wards 7 and 8 compared to Ward 5 and the District of Columbia as a whole (see chart below). Additionally, Wards 7, and 8 also have a predominate population of Black/African American residents.[13] These data are of particular importance, as they are the factors that make up Healthy People 2020's social determinants of health. [5]

Key Indicator	US	DC	Ward 5	Ward 7	Ward 8
% of Black/African American residents	13%	50%	80%	96%	94%
% of unemployed adults	6%	7%	11%	13%	14%
% of adults with a bachelor's or more advanced degree	29%	52%	33%	17%	12%
Median income	$73,487	$101,076	$68,269	$50,820	$42,615
% of families in Poverty	11%	15%	17%	24%	33%

3. Identify community health assessment program partners and their expertise or contribution to the process.

Georgetown University's School of Nursing & Health Studies is an academic partner that brings a wide range of resources that contributed to MedStar Health's systemwide CHNA process. Their expertise in CHNAs and population health management has strengthened the rigor of data collection and data analysis methodologies. The school provided the following support: 1) consultation and support for CHNA survey and secondary data collection and analysis; 2) supported the development and validation of a community input instrument and summarized findings; 3) contributed to and promoted community input sessions; 4) reviewed drafts of the CHNAs prior to publication; and 5) managed student involvement and participation.

The **Healthy Communities Institute** provided quantitative data based on over 130 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process.

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4. State who was involved in the decision-making process.

MWHC's ATF reviewed local secondary data, coupled with state and federal community health goals. Task Force members also reviewed the hospital's operating plan, the outcomes of prior informal community health assessments, as well as current community benefit programs and services. In partnership with Georgetown University's School of Nursing & Health Studies, the team developed and helped disseminate a community health assessment tool around three key areas: 1) wellness and prevention; 2) access to care; and 3) quality of life.

In addition to secondary data, CHNA survey and community input session findings, the Task Force considered the hospital's capabilities as well as local, regional and state health goals. Based on findings, the team made a recommendation on the priorities. The priorities were approved by the hospital's president, endorsed by the hospital board of directors, endorsed by the MedStar Health Board of Directors' Strategic Planning Committee and approved by the MedStar Health Board of Directors.

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Advisory Task Force Membership

Name	Title/Affiliation with Hospital	Name of Organization
Phronie Jackson, MPH	Community Health Outreach Manager, Community Relations	MedStar Washington Hospital Center
James P. Hill	Senior Vice President, Administrative Services	MedStar Washington Hospital Center
Mary Farmer Allen	ANC Commissioner	Ward 5C 06
C. Dianne Barnes	ANC Commissioner	Ward 5C 07
Richard T. Benson, MD	Associate Director, Stroke Center	MedStar Washington Hospital Center
Natasha Bonhomme	Member	Genetic Alliance
Tasha Cornish	Health Navigator for the Hair, Heart and Health Program	MedStar Health
Jenna Crawley	Chief Social Worker Medical House Call Program	MedStar Washington Hospital Center
Craig DeAtley, PA-C	Director, Institute for Public Health Emergency Readiness	MedStar Washington Hospital Center
Shirley DeWitt, RN, BSN, CLNC	Neuroscience Institute Coordinator	MedStar Washington Hospital Center
Vivian Grayton	Director	Seabury Ward 5 Aging Services
Indira Henard	Director of Advocacy	DC Rape Crisis Center
Khay Bullock Henry	Manager, Community Relations	MedStar Washington Hospital Center
Cleopatra Jones	Executive Director Community Empowerment Specialist	Neighbors of Seaton Place Ward 5
Grace Lewis	President	North Michigan Civic Association

Julie Murphy Locke	Member	Hubbard Place
John J. Lynch, MD	Co Chair Medical Director, Center for Ethics	DC Cancer Consortium MedStar Washington Hospital Center
Marshall Phillips	Minister Commissioner	Greater Mount Calvary Holy Church Ward 5C 08 Edgewood Community
Michael C. Pistole, MD	Physician	MedStar Washington Hospital Center
Paula Reichel	DC Regional Director	Capital Area Food Bank
Roland Roebuck	Past President Community Activist	AARP for the District of Columbia Ward 5
Pauline Schneider	Senior Counselor	Ballard Spahr, LLP
Douglass Sloan	Vice President Vice-Chair	DC NAACP ANC 4B
Carolyn Steptoe	Former Commissioner	ANC Ward 5
Romaine Thomas	Community Outreach Specialist, Aging and Disability Resource Center	Office of Aging, Government of the District of Columbia
Tina Thompson	Commissioner Emeritus	ANC 4D 03

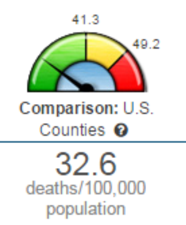
5. Justify why the hospital selected its community benefit priorities.

a) Chronic Disease

Secondary Data

Chronic diseases, including heart disease/ stroke, cancer, diabetes, and obesity, often coexist as comorbidities. Health behaviors such as tobacco use, poor nutrition and physical inactivity contribute to chronic disease.[6]

Death Rate due Stroke

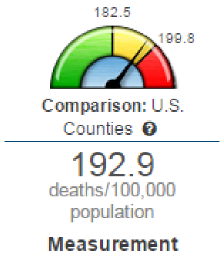


Measurement Period: 2011-2013

Heart Disease and Stroke

- The age-adjusted death rate due to heart disease is 240 per 100,000. Compared to all US counties, this figure falls within the range of the worst quartile. The age-adjusted death due to heart disease is significantly higher for Blacks/African Americans (330/100,000) compared to Whites (117/100,000).[4]
- The age-adjusted death rate due to stroke is also decreasing (from 40/100,000 persons in 2007 to **33/100,000** in 2012) and is lower than the national average (38/100,000 persons).[7] The death rate due to stroke is nearly twice as high for Blacks/African Americans as it is for Whites.[4]
- Heart disease is the second leading cause for hospitalization in the city, at an annual rate of 882 visits/100,000 persons.[4]
- The prevalence of high blood pressure (28%) and high cholesterol (34%) contributes to the age-adjusted death rate due to heart disease and stroke. The prevalence of high blood pressure and high cholesterol is highest in adults 65 and older, males and Blacks/African Americans.[7]
- Geographically, the prevalence of hypertension is highest in Ward 7 (42%) and Ward 8 (40%), where socioeconomic status is the lowest, and the prevalence of hypertension is lowest in Ward 3 (20%), where socioeconomic status is the highest.[4]

Death Rate due to Cancer

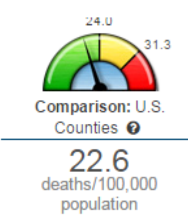


Measurement Period: 2007-2011

Cancer

- Cancer is the second leading cause of death in the District of Columbia. The age-adjusted death rate of cancer is **193 /100,000**, higher than the national rate (183/100,000). The incidence of breast, cervical and prostate cancer and the age-adjusted death rate due breast and prostate cancer all fall within the range of the worst quartile nationally.[7]
- The incidence rates of colorectal and lung cancer and the overall death rate due to cancer are higher for males than females. The overall death rate due to cancer is higher for Blacks/African Americans relative to Whites, and this disparity persists for the death rates due to breast, colorectal, lung and prostate cancer.[7]

Death Rate due to Diabetes



Measurement Period: 2011-2013

Diabetes

- The age-adjusted death rate due to diabetes is **23/100,000**. The prevalence of diabetes is approximately 8% and is higher among females (9%) compared to males (7%). Adults 65 and older (28%) are the most likely to be diagnosed with diabetes across age groups. The prevalence among Blacks/African Americans (13%) is more than six times higher than the prevalence among Whites (2%).[5] Diabetes is the seventh leading cause for hospitalization in the city, at an annual rate of 305 visits/100,000 persons.[7]

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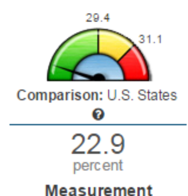
Prevalence of Obesity 	*Obesity* • A total of 23% of adults in the District of Columbia are obese, and the trend has not changed in recent years. The prevalence of obesity is highest in adults between the ages of 35 to 64 and females. The prevalence of obesity is significantly higher in Black/African American residents (36%) than Hispanics (15%) or Whites (10%). [7] • Individuals earning less than $15,000 annually in the District of Columbia are nearly three times more likely to be obese compared to individuals in the city making more than $75,000.[4] *Addressing the Risk Factors* • The prevalence of current cigarette use in the District of Columbia is 16% among adults; adults aged 45-54, males, and Hispanics and Blacks/African Americans report current smoking rates higher than the citywide average. [7] Adults with less than a bachelor's degree and those earning less than $35,000 or $50,000-$74,499 also report smoking rates higher than the citywide average. Geographically, adults in Wards 7 & 8 are most likely to smoke.[4] • Compared to the national median (24%), more adults in the city consume the recommended five or more servings of fruits and vegetables daily (32%). Females, Whites, and adults living in Wards 2, 3 and 5 were more likely to consume the recommended servings of fruits and vegetables daily. [7] • Currently, only 46% of the city's residents participate in at least 150 minutes of aerobic activity weekly, which is the recommended level of physical activity.[7] Approximately 80% of residents report that they participate in any leisure physical activity, which is higher than the national average.[4] Males, Whites, and adults younger than 45 are more likely to report participating in leisure physical activities compared to the citywide average. [7] Adults with a bachelor's or more advanced degree and those earning $75,000 or more are more likely to report participating in leisure physical activities relative to adults with less than a bachelor's degree and adults earning less than $75,000, respectively. Geographically, adults in Wards 1, 2, 3 & 6 are the most likely to be physically active.[4]
Community Health Needs Assessment Surveys and Community Input Sessions	CHNA Survey (N=193)[24] • Chronic disease is a recognized issue affecting the community, with survey respondents indicating that diabetes (43%), overweight/obesity (27%), cancer (27%) and heart disease (13%) are primary health conditions seen in their community. • Community members recognize the contributions of health behaviors to overall health status. Currently, survey respondents make healthy meals (58%), exercise at a local gym or recreation center (38%) and use parks, trails or a track (26%) to stay healthy. • Affordable, healthy food (31%) and better places to exercise were recognized as community needs through the surveys and the community input sessions. • Additionally, approximately 41% of survey respondents indicated that better food/grocery stores were the most important needs at the moment. Over one-fourth of survey respondents indicated that they had difficulty affording food on a regular basis. • Attendees of a community input session expressed the desire for MWHC to

	support citywide initiatives for health promotion, such as the inclusion of healthy food in vending machines and convenience stores and secure safe places for residents to exercise both outdoors, in parks and on sidewalks, and indoors, in school auditoriums and recreational centers. • Programs such as walking clubs, prayer walks and scavenger hunts could be effective in encouraging healthy lifestyles among community members.
Strategies	• To provide diabetes prevention education through the Lifestyle Balance Program. • To offer bi-weekly fitness classes at Michigan Park Recreational Center. • To participate in the DC Million Hearts Learning Collaborative. • To offer annual community health education lectures through the MWHC Speakers Bureau, and increase frequency each year. • To provide a community blood pressure self management program. • To sponsor community-based educational services to promote healthy eating. • To offer mammogram screenings at the Capital Breast Cancer Center. • To provide access to cancer care navigation services to residents of Ward 5.
Hospital Strengths	• MWHC is the first and only hospital in the Washington region to be certified as a Comprehensive Stroke Center by The Joint Commission. The Hospital Center joins an elite group of only 73 medical centers nationwide to receive this prestigious designation, which focuses on providing a high level of care for patients with the most severe and challenging types of strokes and cerebrovascular disease. • For the fifth consecutive year, the American Heart Association/American Stroke Association has awarded the MWHC Stroke Center with its 2014 Get With The Guidelines®-Stroke Gold-Plus Quality Achievement Award • MWHC is one of three hospitals in the District to receive the 2013 Excellence Award for Quality Improvement from the Delmarva Foundation. The foundation only bestows this honor on hospitals that excel in patient safety and quality improvement in four clinical areas: heart attack, heart failure, pneumonia and surgical care. Recipients of this award must achieve or exceed a 90% individual performance rate across 14 measures across all four quarters of 2012 and have aggregate performance rate above 96% for the four quarters as well. • MWHC's cancer program received a full, three-year accreditation with commendation from the American College of Surgeons' Commission on Cancer. • The Commission on Cancer (CoC) Accreditation Program encourages hospitals, treatment centers, and other facilities to improve their quality of patient care through various cancer-related programs. These programs focus on prevention, early diagnosis, pretreatment evaluation, staging, optimal treatment, rehabilitation, surveillance for recurrent disease, support services and end-of-life care. Accreditation of a cancer center is granted only to those facilities that have voluntarily committed to provide the best in cancer diagnosis and treatment, and centers that are able to comply with established CoC standards. • The endocrinologists at MWHC have vast experience managing diabetes, and the team includes national and international leaders in the field who offer a multidisciplinary approach to patient care.
Alignment with local,	• Healthy People 2020: Cancer; Diabetes; Heart Disease and Stroke; Nutrition

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regional, state or national health goals	and Weight Status; Physical Activity; Tobacco Use[5] • DC Department of Health: Cancer; Cerebrovascular Disease; Diabetes; Heart Disease; Obesity; Physical Health; Tobacco Use[4]
Key Internal and External Partners	*Internal:* MWHC Stroke Center, MedStar Visiting Nurse Association, Community Relations, MedStar Georgetown University Hospital, MedStar National Rehabilitation Network *External:* D.C. Department of Parks and Recreation, D.C. Department of Health, Capital Area Food Bank, Faith Based Organizations, Barbershops (Best Cuts, Eagles, M&S, Against da Grain), Capital Breast Care Center (CBCC), The Avon Foundation
Metrics	*Internal Metrics* • % of program participants with a diagnosis of pre-diabetes • % of program participants who complete Lifestyle Balance program • % of program participants participating in the recommended levels of physical activity • % of program participants with weight loss • % of program participants with elevated blood pressure • % of program participants with elevated blood sugar • % of program participants that successfully quit smoking cigarettes • % of program participants consuming the recommended daily amounts of fruits and vegetables *External Metrics* • % of adults who are at a healthy weight (BMI< 25 kg/m^2)[9] • Age-adjusted death rate from heart disease and stroke[6] • Age-adjusted death rate from cancer[6] • % of adults who currently smoke[9] • % of adults who participate in the recommended levels of physical activity[9] • % of adults who are obese[9] • % of women who receive breast cancer screening[9] • Prevalence of diabetes in CBSA[4] • Incidence and prevalence of heart disease and stroke in CBSA[4]

b) Teen Births and Child Development	
Secondary Data	• Health behaviors, such as alcohol and substance use and risky sexual behavior, put teens at risk for pregnancy. Poor maternal nutrition during the preconception and prenatal periods is a risk factor for negative birth outcomes, as is tobacco, alcohol and substance use during pregnancy. Breastfeeding is a protective factor against negative outcomes during the postnatal period through early childhood.[6] • The teen birth rate is decreasing, though it remains high at 43 births/1,000 females aged 15-19 and is significantly higher than the national average of 29 births/1,000 females.[7] • The infant mortality rate has drastically decreased from 13.1 births/1,000 live births in 2007 to 7.4 deaths/1,000 live births in 2011, but the rate is still slightly higher than the national average (6.1 deaths/1,000 live births).[7] When considering women of all ages in the District, a disproportionate number of

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	infants born to Black/African American mothers die.[4] • Low birth weight, one of the primary causes of infant mortality, has not changed since 2007; 10% of babies are born with a low birth weight, higher than the national (8%) average. Babies born to Black/African American mothers are more likely to be of low birth weight (14%) compared to babies born to Hispanic (8%) and White (6%) mothers.[7]
Strategies	• To continue the Teen Alliance for Prepared Parenting (TAPP) program. • To conduct the Centering Pregnancy Group. • To provide case management for social services. • To offer one on one counseling services. • To conduct the New Heights School Outreach Program at Washington Metropolitan, Dunbar, Next Steps Public Charter School, Roosevelt Stay, and Anacostia.
Hospital Strengths	• MWHC has existing programs and partners to support the teen birth and child development community benefit priority area. • To address the high rate of teen pregnancy in the nation's capital, Washington Hospital Center has developed Teen Alliance for Prepared Parenting (TAPP). TAPP is a complete program that provides a unique mix of clinical and psych-social services to help adolescent women and young fathers master life management skills and improve the future of their children. It is a comprehensive youth services program that works with young families in their effort to parent successfully, live meaningful lives, and act with purpose in our communities.
Alignment with local, regional, state or national health goals	• Healthy People 2020:Maternal, Infant and Child Health[5] • DC Department of Health: Infant Mortality; Youth and Young Adults[4]
Key Internal and External Partners	*Internal:* MedStar Georgetown University Hospital *External:* Child Family Services Agency (CFSA), New Heights Programs of DCPS, Healthy Babies, DC Department of Health, Anacostia Wellness Center
Metrics	*Internal* • Rate of subsequent teen pregnancies among TAPP participants • Rate of Long-acting reversible contraception (LARC) use among TAPP participants • % of mothers participating in TAPP who breastfeed their babies *External* • Rate of subsequent teen pregnancies[4] • Rate of Long-acting reversible contraception (LARC) use among adolescents[4] • % of breastfed babies[17]

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6. **Does the hospital currently have community benefit activities that support other key health needs that were identified as important in the Community Health Assessment? (Collaboration Areas)**

Issue	Evidence	Strategy	Lead
Food Insecurity	Households experiencing food insecurity in the District of Columbia increased to 13% in 2011-2013. [47] 30% (n=193) of survey respondents selected affordable, healthy food options choice as a service needed most in their community. [24]	To explore opportunities to collaborate with the Capital Area Food Bank to assess needs and healthy food delivery.	Capital Area Food Bank, Oldways African Heritage Diet Program, AARP
Reading and Math Literacy	Approximately 50% of DCPS students in grades 3 – 8 are not proficient in reading and 46% are not proficient in math. This is below the national average. [12]	To collaborate with "Everybody Wins" to promote reading in grades 1-5.	Everybody Wins Garrison Elementary School
HIV/AIDS	DCDOH reported that the HIV incidence rate in D.C. has greatly improved. However, with an HIV/AIDS prevalence of 3% in the city, this still exceeds the World Health Organization definition of a "severe epidemic." [4]	To deliver health services through the Ryan White program. To deliver the Homecare Outreach Patient Engagement Program (HOPE). To utilize a peer navigator to assist patients in navigating both hospital and local services.	Health Resources and Services Administration (HRSA), the HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA), Institute for Public Health Innovative
Aging	The city's population is age 60 and over and the number is expected to increase proportionately for the next few years.[48] Age-Friendly DC is a coordinated, comprehensive, and collective-action effort whose goal is to ensure that all DC residents are active, connected, healthy, engaged and happy in their environment. Over the next three years, the District will work to implement the strategies laid out in its plan and will submit annual progress reports to AARP. In	To provide primary care and social services via the Medical House Call Program. To offer the AARP Drivers Safety Program. To offer AARP Living Longer Living Smarter Program. To explore opportunities to collaborate with DC Office of Aging's Age-Friendly DC Initiative.	AARP, DC Office of Aging, and Seabury

	2017, the District will be evaluated against its progress for designation as a World Health Organization Age-Friendly City.[48]		

7. **List other health priorities that were identified in the CHNA and describe why the hospital did not select them? (Participation Areas)**

Issue	Evidence	Exploration	Lead
Safety	The total violent crime (murder and non-negligent manslaughter, rape, robbery, and aggravated assault) rate per 100,000 in D.C. is 1,300 compared to 368 violent crimes per 100,000 inhabitants in the United States in 2013.[49] A safe community was a major concern in the community, as 64% (n=193) of survey respondent indicated this choice.[24]	The hospital does not have the expertise to have a leadership role in these areas; therefore, hospital will support external leaders in these areas.	DC Metropolitan Police Department
Fast Food Restaurant Density	DC has 1.25 fast food restaurants per 1000 residents. Whereas, other counties in this region have less the 1 per 1,000 persons. Fast food outlets are more commonly located in low-income neighborhoods and studies suggest that they strongly contribute to the high incidence of obesity and obesity-related health problems in these communities.[7]		Center for Policy, Planning, and Evaluation
Pollution	Four of the five pollution indicators (annual air ozone, annual particle pollution, daily particle pollution and recognized carcinogens released into air) are in the worst quartile in DC.[50]		Washington Council of Government Environment Protect District of Columbia Department of the Environment
Affordable housing/Home Ownership	Home ownership is low in DC as compared to 64% in the United States 48% of renters in D.C. spend 30% or more of their household income on rent.[10] 41% (n= 193) of survey respondents indicate affordable housing as a serious issue (MedStar Washington Hospital Center Community Health Needs Assessment, 2015). Affordable housing was also a recurring theme during community input conversations.[24]		D.C. Housing Authority So Others Might Eat (SOME)

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8. Describe how the hospital will institutionalize community benefit programming to support these efforts.

The hospital's Implementation Strategy is a roadmap for how community benefit resources will be deployed and how outcomes will be reported. The Community Benefit Hospital Lead will oversee planning, programming, monitoring, and evaluation of outcomes. The Executive Sponsor will support institutional efforts to re-organized or reallocate resources as needed. Annual progress updates will be provided to ATF members and the hospital's Board of Directors. The progress report will also be publicly accessible via the hospital's website.

The MedStar Health Corporate Community Health Department (CCHD) will provide system-wide coordination and oversight of community benefit programming. The CCHD will oversee the agenda of the Community Benefit Workgroup, which is comprised of Community Benefit Hospital Leads and other community health professionals across the system. The purpose of the workgroup is to share best practices and promote consistency around data collection, tracking, and reporting that is consistent with internal policies and state and federal guidelines.

The CCHD will provide the MedStar Health Board of Director's Strategic Planning Committee with annual updates on the hospital's progress towards the goals documented in the Implementation Strategy.

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Community Health Assessment Workplan
MedStar Washington Hospital Center
FY16 -18

Priority Issue #1 – Chronic disease prevention and management, specifically diabetes and heart disease
Goal Statement – To promote lifestyle behaviors that support healthy weight, and reduce the prevalence of risk factors that contribute to diabetes and heart disease among high risk population in wards 5, 7 and 8.

1A. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
Diabetes Lifestyle Balance - 1 Year Diabetes management program. **Core Sessions:** The 16, one-hour core sessions are focused on the process of adopting lifestyle changes for healthy eating and physical activity. These sessions are designed to help participants develop lifelong skills for healthy living and reinforce step-by-step change. Groups generally meet with their lifestyle coach each week at the same time and	Diabetes Institute to determine specific resources needed for program execution Community Relations will identify neighborhoods to partner with to implement program in CBSA	Core Program: 16 one-hour classes each week Post Core Program: 6 one-hour classes presented monthly	# of participants enrolled # participants who completed the 16 week core curriculum # of participants who completed the year program # of participants with a diagnosis of pre-diabetes by A1C or blood glucose # of participants qualified to take the	Weight loss: 5% -7% loss of participant's total body weight Increase exercise activities to at least 150 minutes per week Improve A1C levels	MWHC representative	Gretchen Youssef, Program Director

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location. **Post-Core Sessions:** Following the core phase, participants attend one hour “post-core” sessions on a monthly basis. The post-core sessions are intended to provide additional support and learning opportunities to participants, and help them transition to independently maintaining their lifestyle changes. Target Population: Adults with pre-diabetes and/or obesity.			program based on pre-diabetes/diabetes risk diabetes risk factors assessment # of participants who participated in the program with diabetes			

Activities to be phased in during the three year period:

- Diabetes screenings in CBSA
- Speakers Bureau engagements during health observances related to diabetes
- Fitness and healthy cooking classes and demonstrations in the CBSA

Internal MedStar Collaborations:

- MWHC will build partnership with MWHC Stroke Center, *MedStar Visiting Nurse Association, and* Community Relations to implement a heart disease prevention program as well as a monthly blood pressure screening program in the CBSA. We will explore collaboration opportunities with MedStar Georgetown University Hospital and National Rehabilitation Network as well.

External Collaborations:

- Establish partnerships with community health advocacy organizations in Ward 5, 7 and 8 to identify target population and space to provide interventions. Specifically, these organization include but not are not limited to schools, DC Department of Parks and Recreation centers, churches, food banks, libraries, sororities, fraternities, Civic, DC Department of Health, and other organizations located in the CBSA.

External Metric(s):

- The prevalence of diabetes is in Wards 5, 7 and 8. Improve all base line measures by 10%

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1B. Provide a detailed description of the program or service	Inputs/Resources	Outputs	Short-term Outcomes	Long-term Outcomes & Impacts	Dedicated Staff	Person Responsible
Heart and Stroke Community blood pressure self management program	MWHC Stroke Center to determine specific resources needed for program execution Community Relations will identify neighborhoods to partner with to implement program in CBSA	# of participants screened and enrolled # of participants who complete programs #of community education and screening campaigns on BP management	Increase number of people educated about blood pressure Increase fruit and vegetable intake; decrease sodium intake Increase physical activity Decrease smoking and stress Decrease blood pressure among program participants	Reduction in incidence of high blood pressure among participants Increase number of people self managing their blood pressure	MedStar representatives	Amy May Shirley DeWitt

Activities to be phased in during the three year period:

- Blood pressure screenings in CBSA
- Speakers Bureau engagements during health observances related to heart disease
- Fitness and healthy cooking classes and demonstrations in the CBSA

Internal MedStar Collaborations:

- MWHC will build partnership with MWHC Stroke Center, *MedStar Visiting Nurse Association, and* Community Relations to implement a heart

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External Metric(s):

- The age adjusted death rate due to heart disease and stroke CBSA
- The incidence and prevalence of heart disease and stroke in CBSA

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[1] Robert Wood Johnson Foundation: County Health Rankings
[2] Maryland Department of Health and Mental Hygiene
[3] Baltimore City Health Department
[4] District of Columbia Department of Health
[5] U.S. Department of Health and Human Services
[6] Centers for Disease Control and Prevention
[7] MedStar Health Community Dashboard
[8] Healthy Montgomery Community Dashboard
[9] Behavioral Risk Factor Surveillance System
[10] 2011-2013 American Community Survey (3-Year Estimates)
[11] Maryland Department of Education
[12] U.S. Department of Education
[13] 2009-2013 American Community Survey (5-Year Estimates)
[14] Center for Medicaid and CHIP Services
[15] MedStar Franklin Square Medical Center Community Input Results 2015
[16] Baltimore County Health Department
[17] Special Supplemental Nutrition Program for Women, Infants and Children
[18] Baltimore County Local Health Coalition
[19] MedStar Franklin Square Medical Center FY13 Hospital Charity Care Usage Report
[20] MedStar Franklin Square Medical Center Advisory Task Force Welfare Focus Group, 2015
[21] MedStar Franklin Square Medical Center CRISP Report
[22] MedStar Good Samaritan Community Input Results 2015
[23] Neighborhood Info DC
[24] MedStar Washington Hospital Center Community Input Results 2015
[25] Youth Risk Behavior Surveillance Survey
[26] Maryland Vital Statistics Administration
[27] MedStar Harbor Hospital Charity Care Analysis, 2013
[28] MedStar Harbor Hospital Community Input Results 2015
[29] Anne Arundel County Department of Health
[30] MedStar Montgomery Medical Center Inpatient and Outpatient Data Report, 2014
[31] MedStar Montgomery Medical Center Community Input Results 2015
[32] DC Health Matters
[33] National Health Interview Survey
[34] MedStar National Rehabilitation Hospital Community Input Results
[35] Scholte op Reimer, W.J.M., de Hahn, R.J., Rijnders, P.T., Limburg, M., van den Bos, G.A.M. (1998) The burden of caregiving in partners of long-term stroke survivors. *Stroke,* 28.
[36] Bakas, T., Clark, P.C., Kelly-Hayes, M., King, R.B., Lutz, B.J., Miller, E.L. (2014).Evidence for stroke family caregiver and dyad interventions. *Stroke,*45.
[37] Center for Medicare and Medicaid Services
[38] MedStar St. Mary's Hospital Community Input Results 2015
[39] Healthy St. Mary's Partnership
[40] Maryland Health Services Cost Review Commission
[41] Health Resources and Services Administration
[42] National Survey on Drug Use and Health
[43] Prince George's County Health Department
[44] MedStar Southern Maryland Hospital Center Community Input Results 2015
[45] Economic Research Service of the USDA, Food Access Research Atlas
[46] MedStar Union Memorial Hospital Community Input Results 2015
[47] DC Hunger Solution
[48] DC Office or Aging
[49] United States Federal Bureau of Investigation
[50] AIRNow

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