2022

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

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

Suburban Hospital completed a comprehensive joint Community Health Needs Assessment (CHNA) in collaboration with all health systems within Montgomery County. The CHNA was adopted by Suburban Hospital's Board of Directors on June 2, 2022.

The 2022 Montgomery County Hospital Collaborative CHNA report is available electronically at https://www.hopkinsmedicine.org/about/community_health/suburban-hospital/community_commitment/needs_assessment.html, or printed copies are available by contacting Monique Sanfuentes at MSanfuentes@jhu.edu.

Letter from Hospital Leadership

June 20, 2022

Dear Residents and Partners,

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

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

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

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

We are stronger together.

Sincerely,

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

Terry Forde
President & CEO
Adventist HealthCare

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

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

OUR COMMUNITY

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

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

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

OUR HOSPITALS

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

ADVENTIST HEALTHCARE

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

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

- Three acute care hospitals
- Two rehabilitation hospitals
- Two community cancer centers
- Mental health services
- Home care services

- Imaging centers
- Urgent care centers
- Community outreach

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

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

HOLY CROSS HEALTH

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

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

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

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

Specialties and Services:

- Cardiac services
- Cancer institute
- Dialysis services
- Emergency center
- Home-based services
- Hospitalists and intensivists

- Medical imaging services
- Neurosciences
- Pain management center
- Palliative care
- Pediatric services
- Physical medicine and rehabilitation program
- Senior services
- Sleep center

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

Specialties and Services:

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

Holy Cross Health Network, which operates Holy Cross Health Centers in Aspen Hill, Gaithersburg, Germantown and Silver Spring; provides primary care at Holy Cross Health Partners at Asbury Methodist Village and in Kensington; offers a wide range of innovative health and wellness programs; and leads partner relationships.

Holy Cross Health Foundation is a not-for-profit organization devoted to raising philanthropic funds to support the mission of Holy Cross Health and to improve the health of the community.

MEDSTAR HEALTH, MEDSTAR MONTGOMERY MEDICAL CENTER

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

MedStar Montgomery Medical Center is a not-for-profit, acute care community hospital serving Montgomery County, Maryland. For 100 years, MedStar Montgomery Medical Center has served as a medical care provider and community health resource offering high-quality, personalized care. MedStar Montgomery Medical Center provides a broad range of health care specialties, advanced technologies, and treatments not traditionally found at community hospitals—including cutting-edge care in obstetrics, orthopedics, breast health, and oncology. MedStar

Health is the region's largest non-profit and most trusted integrated health care delivery system, giving patients access to the latest in modern medicine and medical technology within a community hospital setting.

Clinical specialties:

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

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

SUBURBAN HOSPITAL, JOHNS HOPKINS MEDICINE

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

Primary services include:

- Radiation and surgical oncology a part of the Johns Hopkins Kimmel Cancer Center in the National Capital Region and recognized by the American College of Surgeons Commission on Cancer.
- Cardiac surgery including elective and emergency angioplasty and inpatient, diagnostic, and rehabilitation services through the Johns Hopkins Medicine Structural Heart Disease Program at Suburban Hospital.
- Treatment for multiple brain and nervous system conditions—including brain tumors, movement disorders and general neurosurgical care—provided by Johns Hopkins neurosurgical team.
- Home to inpatient and outpatient behavioral health programs, and an Addiction Treatment Center, offering day treatment programs to adolescents and adults.
- A 24-hour stroke team, as well as state-of-the-art diagnostic pathology and radiology departments.
- A full-service Emergency Department treating more than 40,000 patients annually and includes the Shaw Family Pediatric Emergency Center exclusively for children and adolescents.

- Inpatient Diabetes Management Service (IDMS), which is a special diabetes clinical consultation service designed to promote better glycemic (blood sugar levels) control and reduce hypoglycemia (low blood sugar) and glucose-related safety challenges in hospitalized patients. Suburban Hospital also offers the Diabetes Self-Management Training (DSMT) which a certified diabetes educator meets one on one with individuals living with diabetes to improve their health outcomes.
- An extensive community health and wellness program that invested more than $33.6 million in community benefit contributions in FY 2021, including 5,612 community health improvement programs, biometric screenings, wellness classes and community building activities that served 52,049 individuals in Montgomery County.
- Suburban Hospital achieved Magnet designation in recognition of its nursing excellence from the American Nurses Credentialing Center, becoming the first and only hospital in Montgomery County with this distinct recognition.

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

COMMUNITIES SERVED

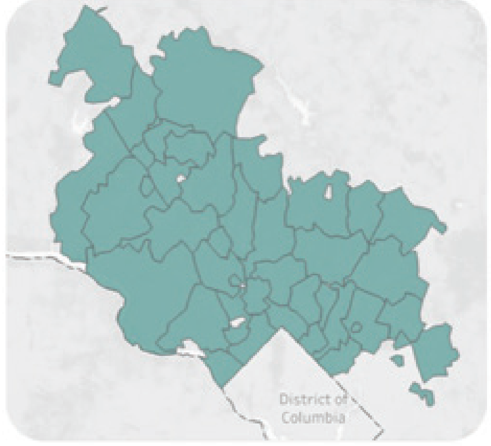
The MCHC serves portions of Montgomery, Prince George's, Frederick, Carol, and Howard Counties, and the District of Columbia, spanning 86 zip codes and almost 2.3 million people. However, the goal of this CHNA is to identify and prioritize key areas and communities of focus for meaningful engagement.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

(CBSA) and highlighted communities of focus within the CBSA to provide a valuable snapshot of the hospital's existing communities served and new areas of interest.

DESCRIPTION OF SERVICE AREA

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

Figure 1: The MCHC Community Benefit Service Area



The MCHC CBSA serves portions of Montgomery and Prince George's Counties, two majority- minority counties

rich in cultural diversity. The largest populations by race/ethnicity within the service area are Non-Hispanic Whites (37.3%), Non-Hispanic Blacks (22.6%), Hispanic or Latino (22.5%) and Non-Hispanic Asian (13.5%) (see Table 1).

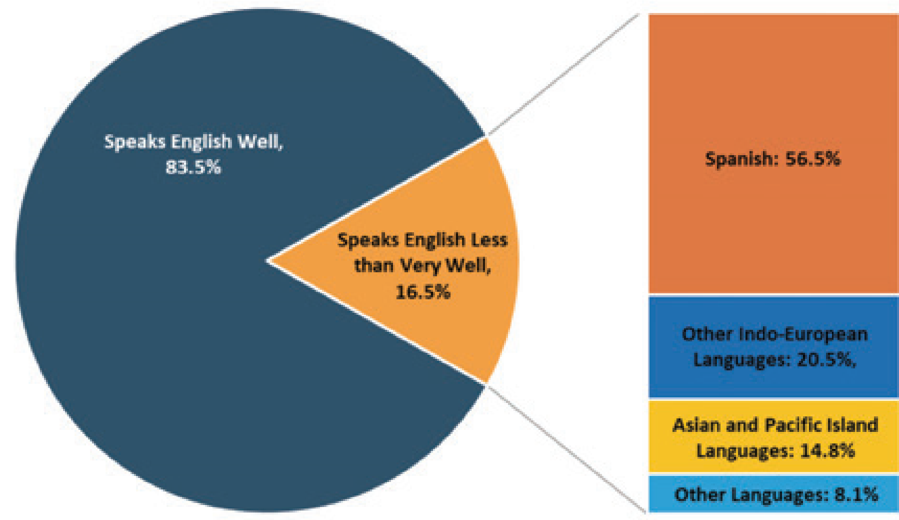
Table 1: Population by Combined Race Ethnicity

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

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

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

Figure 2: English Proficiency within the MCHC CBSA



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

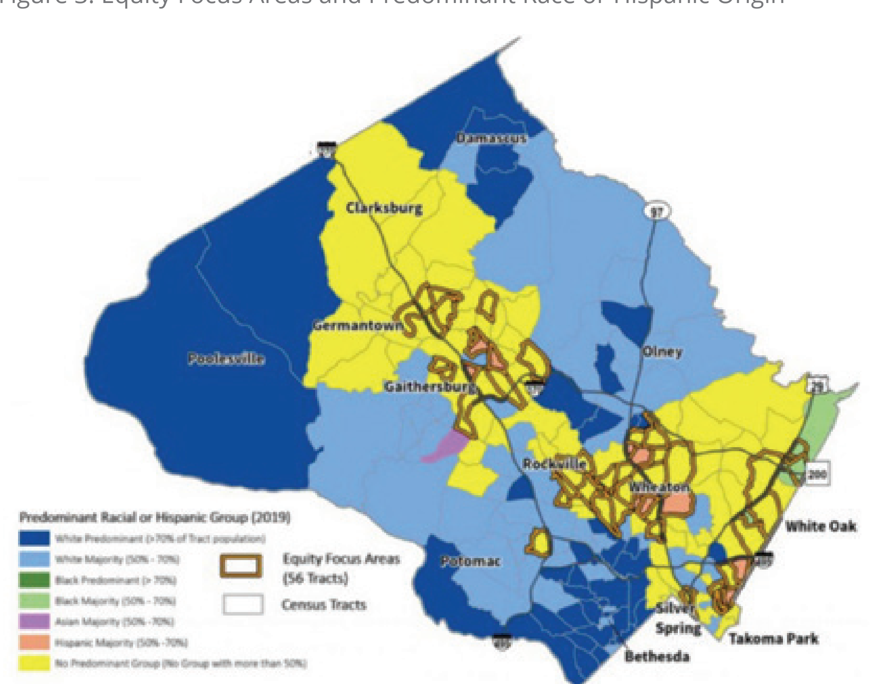
Limited English proficiency (LEP), or the inability to speak English well, creates barriers to health care access, provider communications, and health literacy/education. The highest percentage of limited English proficiency by language spoken in the home is Spanish (United States Census Bureau, 2022).

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

VULNERABLE POPULATIONS

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

Figure 3: Equity Focus Areas and Predominant Race or Hispanic Origin



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

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

LOW-INCOME POPULATIONS

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

RACIAL ETHNIC MINORITIES

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

UNINSURED POPULATIONS

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

SENIOR POPULATIONS

The 2017-2020 State Plan on Aging for Maryland estimates that between 2015 and 2030, the population of adults aged 60 and greater will increase by 40%, from 1.2 to 1.7 million (Maryland Department of Aging, 2021). This growth reflects advances in health care and medicine, allowing individuals to live longer than ever before. A similar estimate was made by the Montgomery County Commission on Aging (2018), predicting that nearly 25% of all residents will be 60 years or greater by 2030. While this represents one of the crowning achievements of the last century, it also poses significant social and economic challenges due to the unique needs of the senior population.

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

- health status
- cognitive ability, and
- social network

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

MATERNAL/INFANT POPULATIONS

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

HOMELESS POPULATIONS

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

LGBTQ COMMUNITY

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

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

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

POPULATIONS WITH DISABILITIES

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

Compared with individuals without disabilities, individuals with disabilities are:

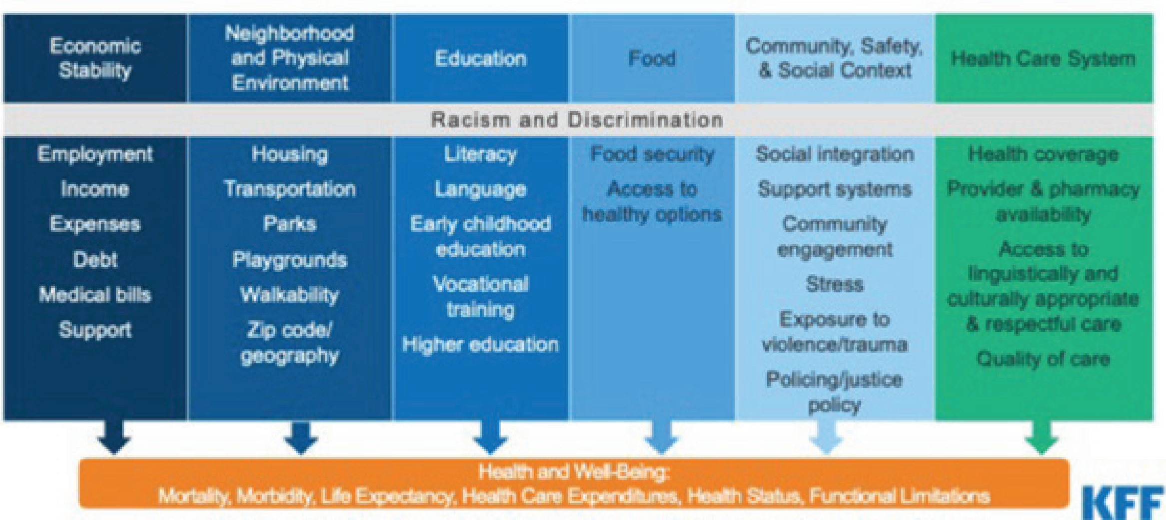
- Less likely to receive recommended preventive health care services, such as routine teeth cleanings and cancer screenings
- At high risk for poor health outcomes such as obesity, hypertension, falls-related injuries, and mood disorders such as depression
- More likely to engage in unhealthy behaviors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

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

RACISM AS A PUBLIC HEALTH CRISIS

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

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



Source: Ndugga & Artiga, 2021.

The MCHC promotes optimal health for those who are experiencing poverty or other vulnerabilities in their communities. The MCHC serves by connecting individuals to social and clinical care, addressing social needs, dismantling systemic racism, and reducing health inequities. The MCHC has adopted the Robert Wood Johnson Foundation's definition of Health Equity - "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

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

HEALTH NEEDS OF THE COMMUNITY

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

2022 MCHC CHNA DATA HIGHLIGHTS

ACCESS TO CARE

ACCESS TO MENTAL HEALTH PROVIDERS	• Populations with higher percentages of Black or Hispanic individuals and low-income communities have been shown to have limited access to mental health care • 32% of Montgomery County students and 34% of students in Prince George's County reported feeling sad or hopeless every day for two weeks or more during the past 12 months • In Maryland, 59.1% of adults with acute mental illness and 43.1% of youth experiencing a major depressive order did not receive treatment
ACCESS TO PRIMARY CARE PROVIDERS	• As of 2021, an additional 14,860 primary medical care providers are necessary to meet current U.S. health care needs • Only 77.2% of Montgomery County residents and 79.3% of Prince George's County residents had a routine check-up within the last year. • In Maryland, 8.7% of adults report a time in the past 12 months when they needed a doctor but could not go because of cost.
LACK OF INSURANCE	• In the MCHC CBSA, 9.1% of the total civilian non-institutionalized population are without health insurance coverage • In Montgomery (23.4%) and Prince George's County (28.5%) of Hispanics/Latinos do not have health insurance, significantly higher than their White and Black counterparts. • In 2019, nearly 7% of children older than six years old residing in Prince George's County were not covered by insurance- the rate was half that for the same age range in Montgomery County

HEALTHY BEHAVIORS

FOOD INSECURITY	• Households with children are nearly 1.5 times more likely to experience food insecurity than households without children. • According to USDA data, 19.1% of Black households and 15.6% of Hispanic households experienced food insecurity in 2019, compared to 7.9% of their White counterparts. • The newly food insecure population is also far less likely to be receiving benefits from the public sector.
ADULT OBESITY	• Within the MCHC CBSA, 31.1% of adults aged 18 and older are considered obese. • Current estimates for obesity-related health care costs in the U.S. range from$147 billion to nearly $210 billion annually. • 22.4% of Montgomery County high school students and 35.5% of Prince George's County high school students are obese or overweight; children who are obese or overweight are more likely to have obesity as adults.

PHYSICAL INACTIVITY	• Physical activity reduces the risk of multiple chronic diseases and helps maintain a healthy weight and reduce body fat. • 1 in 5 adolescents in the United States engage in the recommended amount of physical activity • It is estimated that 46.4% of older Americans engaged in no leisure-time aerobic activity

EDUCATION, INCOME, JOB & ENVIRONMENT

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

RESPONSE TO FINDINGS

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

Access to Care

- Access to mental health providers
- Access to primary care providers
- Lack of insurance

Healthy Behaviors

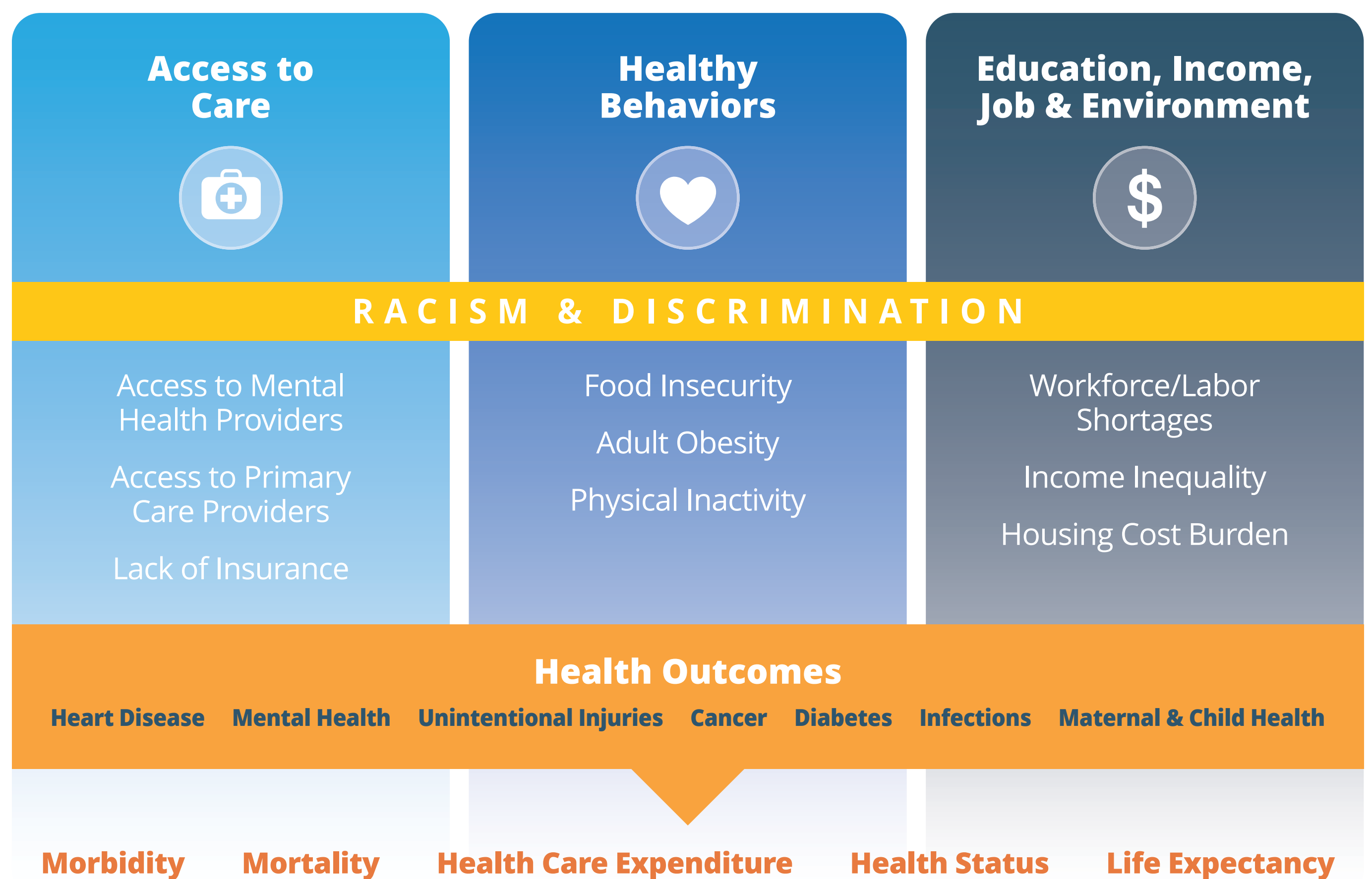
- Food insecurity
- Adult obesity
- Physical inactivity

Education, Income, Job & Enviroment

- Workforce/labor shortages
- Income inequality
- Housing cost burden

These nine health factors are recognized as root causes that impact a person's health, well-being, and quality of life. By considering these root causes, meaningful changes can be made to decrease risk for the top health outcomes in our community: heart disease, diabetes, mental health, cancer, maternal and child health, infections, and unintentional injuries (see Figure 5). Through a multi-sectoral collaboration, the MCHC will tackle the top health factors by leveraging a collaborative implementation strategy, paying particular attention to the most vulnerable populations in our communities.

Figure 5: The Montgomery County Hospital Collaborative Model for Improved Health Outcomes



Graphic adapted from the Kaiser Family Foundation, 2020

NEEDS INTO ACTION

The MCHC addresses unmet health needs within the context of our overall approach. Specifically, taking into consideration each health system's mission commitments, individual hospital key clinical strengths, as well as the overarching goals established by our local health improvement coalition, Healthy Montgomery.

Key findings from all data sources were reviewed, and the most pressing needs were incorporated into our implementation strategy. The CHNA Implementation Strategy reflects the MCHC's overall approach to improving community health by targeting the intersection between the identified needs of the community and the key strengths and mission commitments of each

organization (see Figure 6) to help build a continuum of care. Each health system has established lead community health improvement accountability levers, which includes an organizational structure to provide oversight of ongoing planning, budgeting, strategic implementation, and multi-year evaluation.

Figure 6: How MCHC aligns targeted programs with the mission and strengths of the hospital and unmet community needs

NATIONAL OBJECTIVES

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

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

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

Integrating HP230 objectives into our implementation plan not only allows us to connect with communities across the nation and work collaboratively to improve health, but provides us with benchmarks with specific metrics to evaluate and measure our impact.

TRANSFORMING COMMUNITY HEALTH

The MCHC's community health programs and services are well positioned to lead in the identification of and response to existing and emerging community needs in our service area. To address the unmet needs, the MCHC will tackle downstream issues through prevention, education, and disease management initiatives. Upstream identified needs will be addressed through policy, system, and environmental change strategies in an effort to optimize wellness and equity, thus reducing disparities in our community.

The approach to address an individual's social needs and improve community conditions are encompassed by the following three key focus areas:

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

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

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

ACTION PLANS 2020-2022

The following pages outline the major activities the MCHC are implementing to address the unmet needs identified in the 2022 Community Health Needs Assessment. The first table summarizes the activities by priority and key focus area. The following pages highlight the specific adopted interventions and initiatives to confront each unmet need. The objectives listed for each priority are derived from Healthy People 2030. The Implementation Strategy should be considered a living plan that is updated and evaluated, at a minimum, each year or as emerging needs arise.

MONTGOMERY COUNTY HOSPITAL COLLABORATIVE ACTION PLANS FY2023-FY2025

MCHC Implementation Plan FY2023-FY2025

Priority 1: Access To Care

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

Priority 1a: Access to Mental Health Providers

Goal 1: Improve Mental Health

CHNA Impact	2022 CHNA Baseline	Target	Actual
Decrease mental health related ER visits	MC: 2,312.1 PGC: 1,955.6	3,152.60	MC: 2,312.1 PGC: 1,955.6
Decrease percentage of adults with poor mental health	CBSA: 11.6%	9.7%	CBSA: 11.6%
Decrease percentage of students feeling sad or hopeless	MC: 31.5% PGC: 34.2%	32.0%	MC: 31.5% PGC: 34.2%
Decrease age-adjusted suicide mortaltiy rates	CBSA: 7.3	13.9	CBSA: 7.3

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

Hospital	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 1 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
Adventist HealthCare HOLY CROSS HEALTH MedStar Health SUBURBAN HOSPITAL	1.1.1 Behavioral health screenings with links to treatment at clinical care sites.	×	×	×	**Metrics:** # of screenings, # of positive screenings, # brief interventions, # referrals to treatment, # of linkages to treatment **Focus Location:** MCHC CBSA & Montgomery County **Focus Population:** Broader community, patients with substance abuse	Philinthropic/Foundation, Caron, Recovery Centers of America (RCA), Avery Road Treatment Center, Shumaker House, Mountain Manor, Massie Unit, Lawrence Court, Delphi, MD Addiction Centers, Salvation Army, Helping Up Mission, Grass Roots, Kolmac Clinic, MedStar Outpatinet Addiction Services, Suburban Outpatient Addiction Services. Community Care Delivery Existing/Potential Partners: Montgomery Cares, Maryland Dept. of Health, Montgomery County DHHS, Trinity Health.	**Adventist:** TBD **HCH:** $1.2 M **MedStar:** $163,172 **SH:** TBD	**Year 1:** **Year 2:** **Year 3:**
Adventist HealthCare	1.1.2 Provide Inservices for primary care physicians to equip them with skills and knowledge needed to address mental health needs of patients.	×	×	×	**Metrics:** # of trainings held, # of participants, % of behavioral health teleconsultation participants reporting increase in confidence working with behavioral health conditions **Focus Location:** Montgomery County **Focus Population:** Primary Care Physicians in our Clinically Integrated Network	Clinically Integrated Network (CIN) of Physician Practices	**AHC:** $3,100	**Year 1:** **Year 2:** **Year 3:**

Objective 1.2: Increase the proportion of children, adolescents and adults with mental health problems who get mental and other health services they need.								
Strategies	**Program/Intervention**	**Timeframe**			**Metrics/Location/Population**	**Existing and Potential Partners**	**Year 1 Budgeted Resources**	**Status**
		Year 1	**Year 2**	**Year 3**				
HOLY CROSS HEALTH A Member of Trinity Health; MedStar Health; SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	1.2.1 Provide virtual and in-person case management services for patients with a diagnosis of depression, schizophrenia/ schizoaffective, and bipolar disorder discharged from inpatient unit.	×	×	×	**Metrics:** # of participants served & readmission rate **Focus Location:** MCHC CBSA & Montgomery County **Focus Population:** Patients with diagnoses of depression, schyzophrenia and bipolar disorders	Mindoula Health	**HC:** $266,000 **MedStar:** $128,800 **SH:** TBD	**Year 1:** **Year 2:** **Year 3:**
MedStar Health; SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	1.2.2 Deliver Outpatient Addiction Treatment services for adolescents and adults with substance abuse disorder	×	×	×	**Metrics:** Phase 1 completion, school attendance, behavior, #encounters, # classes held, # of participants, % increase in knowledge and self-efficacy, class completion rate **Focus Location:** Montgomery County **Focus Population:** Adolescents & Adults with Substance abuse	Montgomery County DHHS, & Montgomery County Public School System.	**MedStar:** TBD **SH:** TBD	**Year 1:** **Year 2:** **Year 3:**
Adventist HealthCare; HOLY CROSS HEALTH A Member of Trinity Health; MedStar Health; SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	1.2.3 Collaborate with community organizations, community partners, and health systems to effect change at a systems level to improve behavioral health outcomes (Nexus Montgomery Behavioral Workgroup)	×	×	×	**Metrics:** % of total BH ED encounters for high utilizer BH patients (30+ encounters/year), total ED encounters for high utilizer patients, total ED charges for BH high utilizer patients **Focus Location:** Montgomery County **Focus Population:** Adults	Nexus Montgomery, County Agencies, Community Representatives, Cornerstone Montgomery, Sheppard Pratt, DHHS, MCFRS, and the Local Behavioral Health Authority	**HCH:** TBD **HCGH:** TBD **MedStar:** TBD **AHC:** TBD **Suburban:** TBD	**Year 1:** **Year 2:** **Year 3:**
HOLY CROSS HEALTH A Member of Trinity Health	1.2.4 Train faith leaders to be first responders for someone within their congregation/community experiencing a mental health or substance use challenge or crisis	×	×	×	**Metrics:** Total # of faith leaders trained, # of faith leaders trained in FCN/HM network **Focus Location:** MC Equity Focus Areas & PGC District 1 **Focus Population:** Faith-based organizations	Faith-based Organizations, Maryland Department of Health, EveryMind, Mental Health Association of Maryland	**HCH:** $2,500 **HCH:** $1,000	
Adventist HealthCare; MedStar Health; SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	1.2.5 Provide grant funding and sponsorships to organizations addressing access to mental health services.	×	×	×	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization **Focus Location:** Montgomery County & Prince George's County **Focus Population:** All ages	CentrePointe Counseling, Montgomery County Coalition for the Homeless (MCCH), Identity, Inc., EveryMind, Inc., Cornerstone Montgomery, Story Tapestries, Community Clinic Inc. (CCI): EveryMind, Inc., Parent Encouragement Program, Cornerstone Montgomery, National Alliance on Mental Illness	***AHC:** $860,000 budgeted per year for CPF overall, which covers all CHNA priority areas)* ***Medstar:** TBD* ***SH:** TBD*	**Year 1:** **Year 2:** **Year 3:**

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

Hospital	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year One Budget	Status
		Year 1	Year 2	Year 3				
Adventist HealthCare Holy Cross Health MedStar Health Suburban Hospital	1.3.1 Provide mental health and wellness workshops, educational events, and support groups in the community.	×	×	×	**Metrics:** # of workshops and support groups held, # of participants, % of participants who had an increase in knowledge and self-efficacy **Focus Location:** MCHC CBSA & Montgomery County **Focus Population:** Adolescents & adults	Charles E. Smith Life Communities; AHC Outpatient Wellness Center (OWC), EveryMind, Inc., Montgomery County Area Agency on Aging, GROWS, MedStar Outpatient Wellness Clinic	**HCH:** $2,000 **HCGH:** $1,000 **MedStar:** TBD **Suburban:** TBD **AHC:** TBD	**Year 1:** **Year 2:** **Year 3:**
Adventist HealthCare Holy Cross Health MedStar Health Suburban Hospital	1.3.2 Collaborate with community organizations, partners, and health systems to address the health information gap to promote informed decision-making and connection to existing resources that will help improve the physical, social, and mental well-being of community members	×	×	×	**Metrics:** # education/awareness events held, # of participants, % of participants who had an increase in knowledge/awareness # partners/ organizations **Focus Location:** MCHC CBSA & Montgomery County **Focus Population:** Adolescents, adults, Latino/Hispanic Families	EveryMind, Inc., Linkages to Learning, Latino Health Initiative, Identity, Inc., Mary's Center, Office of Community Partnerships, Montgomery County Community Engagement Cluster	**HCH:** $2,000 **HCGH:** $1,000 **MedStar:** TBD **Suburban:** TBD **AHC:** TBD	**Year 1:** **Year 2:** **Year 3:**
Adventist HealthCare MedStar Health	1.3.3 Provide students the opportunity to get hands-on learning with behavioral health professionals through our behavioral health internships and medical rotations	×	×	×	**Metrics:** # of students hosted, # of staff hours **Focus Location:** Montgomery County **Focus Population:** Students at any collegiant level (bachelors, masters, doctorate programs)	Howard University, George Washington University, University of Maryland, Washington Adventist University, Towson University, Georgetown University	**MedStar:** TBD **AHC:** TBD	**Year 1:** **Year 2:** **Year 3:**

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

Goal 2: Improve health care.

CHNA Impact	CHNA Baseline	Target	Actual
Reduce number of people who cant afford to see a doctor	MD: 7.5%	3.30%	MD: 7.5%
Increase the proportion of people with a usual primary care provider	MC: 78.0% PGC: 78.9%	84.0%	MC: 78.0% PGC: 78.9%
Increase percent of mothers receiving early and adequate prenatal care	MC: 70.2% PGC: 59.4%	80.5%	MC: 70.2% PGC: 59.4%
Increase the proportion of females who get screened for breast cancer	MC: 77.1% PGC: 80.3%	80.5%	MC: 77.1% PGC: 80.3%

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

Strategies	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 1 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
Adventist HealthCare MedStar Health Suburban Hospital Johns Hopkins Medicine	2.1.1 Provide financial and in-kind support to primary care community clinics	×	×	×	**Metrics:** # of patients served/patient visits, quality measures - A1c scores, health screenings, HEDIS measures, $ grants/funding provided, #grants provided. **Focus Location:** 20814, 20878, 20901, 20851, 20910, 20904, 20783, MCHC CBSA **Focus Population:** Refugees, low-income, and uninsured/underinsured populations	MobileMed, Mercy, Mary's Center, Kaseman Clinic, CCI, American Diversity Group; Aspen Hill Holy Cross Clinic, Olney Proyecto Salud Clinic; Proyecto Salud, & Catholic Charities	**AHC:** *$860,000 budgeted per year for CPF overall which covers all CHNA priority areas.* **MedStar:** $80,000 **Suburban:** TBD	**Year 1:** **Year 2:** **Year 3:**
Adventist HealthCare Holy Cross Health A Member of Trinity Health MedStar Health Suburban Hospital Johns Hopkins Medicine	2.1.2 Assist community members in need of primary care services through screenings, referrals and linkages to community resources	×	×	×	**Metrics:** # of encounters, # of enrolled clients, % screening rate, # of referrals, **Focus Location:** Montgomery County, MC Equity Focus Areas, PGC District 1, MCHC CBSA **Focus Population:** low income, uninsured/underinsured populations	Montgomery Cares, Catholic Charities, MD Minority Outreach and Technical Assistance program, MC DHHS, Trinity Health, Primary Care Coalition, Cross Community	**HCH:** $185,000 **HCGH:** $25,000 **MedStar:** $102,000 **Suburban:** TBD **AHC:** TBD	**Year 1:** **Year 2:** **Year 3:**
Suburban Hospital Johns Hopkins Medicine	2.1.3 Provide funding and in-kind support to organizations addressing barriers to accessing primary care services	×	×	×	**Metrics:** $ support provided **Focus Location:** MCHC CBSA **Focus Population:** low-income, uninsured/underinsured populations		SH: TBD	**Year 1:** **Year 2:** **Year 3:**
Holy Cross Health A Member of Trinity Health	2.1.4 Operate primary care health centers for the un/underinsured in geographically accessible locations	×	×	×	**Metrics:** # encounters, #patient visits, clinical measures **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, uninsured/underinsured populations	MedStar Health, Primary Care Coalition, EveryMind, Lighthouse for the Blind, Montgomery Cares & Montgomery County Dept. of Health	HCH: See strategy 1.1.1	**Year 1:** **Year 2:** **Year 3:**

HOLY CROSS HEALTH A Member of Trinity Health	2.1.5 Link uninsured Maternity Partnership patients to primary care services at HC Health Centers to create a medical home for the whole family	×	×	×	**Metrics:** #maternity partnership patients linked to Gaithersburg health center **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, uninsured populations, pregnant women, infants	Maternity Partnership, Montgomery Cares	HCH: See strategy 1.1.1	**Year 1:** **Year 2:** **Year 3:**
HOLY CROSS HEALTH A Member of Trinity Health	2.1.6 Provide a primary medical home for adults through a program of all-inclusive care for the elderly (PACE)	×	×	×	**Metrics:** PACE implementation, # encounters, readmission rates, ED utilization, and clinical indicators, MADC daily census; participant surveys **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** dual eligible older adults, older adults	Montgomery County DHHS, Maryland Department on Aging; AAOA, MAADS, Alzheimer's Foundation, Alzheimer's Association, Trinity PACE	HCH: TBD	**Year 1:** **Year 2:** **Year 3:**
Adventist HealthCare HOLY CROSS HEALTH MedStar Health SUBURBAN HOSPITAL	2.1.7 Implement strategies and initiatives that reduce barriers to accessing primary care, such as transportation and language	×	×	×	**Metrics:** #participants, #Lyft/Uber rides provided, #translation services provided, #interpreters provided, $ spent on language access **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, uninsured/underinsured populations, older adults	MobileMed, Mercy Clinic, Mary's Center, Proyecto Salud, Catholic Charities, Lyft, UberHealth, MC DHHS, Olney Home for Life	AHC: TBD HCH: $126,000 HCGH: $1,415 MedStar: $9,654 Suburban: TBD	**Year 1:** **Year 2:** **Year 3:**

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

Goal 3: Increase health insurance coverage

CHNA Impact	CHNA Baseline	Target	Actual
Increase the proportion of people with health insurance	CBSA: 90.9%	92.1%	CBSA: 90.9%
Percent uninsured	CBSA: 9.1%	0.0%	CBSA: 9.1%
Percent of insured population receiving Medicaid	CBSA: 17.4%	No Target	CBSA: 17.4%

Objective 3.1: Increase the proportion of people with health insurance

Hospital	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 1 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
Adventist HealthCare Holy Cross Health MedStar Health Suburban Hospital	3.1.1 Advocate for policy, systems, and environmental changes addressing insurance reform and the needs of the uninsured population	x	x	x	**Metrics:** activities leveraged, plans developed, number of partners engaged, percent of colleague participation in e-advocacy campaign(s), #letters of support written, #advocacy events attended, #written/oral testimonies provided, # advocacy hours **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Montgomery County, Maryland, National **Focus Population:** low-income, uninsured/underinsured populations, older adults, broader community	Montgomery County DHHS, Montgomery Cares, MD Hospital Association	HCH: TBD HCGH: TBD AHC: TBD MedStar: TBD Suburban: TBD	**Year 1:** **Year 2:** **Year 3:**
Adventist HealthCare Holy Cross Health MedStar Health Suburban Hospital	3.1.2 Provide support to uninsured patients, colleagues and community members by assisting with enrollment to publicly funded programs and hospital charity care programs	x	x	x	**Metrics:** # of participants, #colleagues assessed, #Colleagues identified as uninsured, #linked to resources, Charity care expenses, #insured **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, uninsured populations	Montgomery County DHHS, Meduit, DeCorm	MedStar: $40,421 HCH: $624,000 HCGH: $235,000 SH: TBD AHC: TBD	**Year 1:** **Year 2:** **Year 3:**

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

Hospital	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year One Budget	Status
		Year 1	Year 2	Year 3				
Adventist HealthCare Holy Cross Health	3.2.1 Provide perinatal health services to improve birth outcomes and improve health during the first years of life, with an increased focus on healthy birth outcomes for women of color (morbidity and mortality)	x	x	x	**Metrics:** # of encounters, pre/posttests, participant surveys, # of Maternity Partnership admissions, % Maternity Partnership patients receiving early prenatal care, and percent low-birth weight deliveries. # of women served, # of teenage deliveries, pregnancy loss and infant mortality rate, trimester that pre-natal care was initiated, % of babies born with a low birth weight **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, uninsured populations, pregnant families, uninsured women	Montgomery County AAHP, FIMR, Community Action Team, and Interagency Montgomery County Interagency Coalition on Adolescent Pregnancy, Montgomery County DHHS Maternity Partnership Montgomery County Department of Health and Human Services; Montgomery County AAHP, FIMR, Community Action Team, and Interagency Montgomery County Interagency Coalition on Adolescent Pregnancy, Montgomery County DHHS Maternity Partnership	HCH: $310,000 HCGH: $105,791 AHC: $479,806	**Year 1:** **Year 2:** **Year 3:**

HC HOLY CROSS HEALTH A Member of Trinity Health	3.2.2 Provide access to mammogram services for uninsured	×	×	×	Metrics: # of encounters, % eligible health center patients health center patients receiving referrals, # of mammograms, # navigated to care and cycle time from diagnosis to treatment, # enrolled in state breast and cervical cancer program Focus Location: MC Equity Focus Areas, MCHC CBSA Focus Population: low-income, uninsured populations	Community Care Delivery Existing/Potential Partners: Montgomery Cares, Maryland Dept. of Health, Kevin J. Sexton Fund, Primary Care Coalition	HCH: See strategy 1.1.1	Year 1: Year 2: Year 3:
Adventist HealthCare MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	3.2.3 Provide financial and in-kind support to community clinics and community organizations addressing lack of insurance and/or insurance enrollment	×	×	×	Metrics: # of patients served/patient visits, quality measures - A1c scores, health screenings, HEDIS measures, $ grants/funding provided, #grants provided Focus Location: MCHC CBSA Focus Population: refugees, low income, and uninsured/underinsured populations	CASA de Maryland, MobileMed, Mercy, Mary's Center, Kaseman Clinic, CCI, American Diversity Group; Aspen Hill Holy Cross Clinic, Olney Proyecto Salud Clinic, Catholic Charities	AHC: $860,000 budgeted per year for CPF overall which covers all CHNA priority areas Medstar: $80,000 Suburban: TBD	Year 1: Year 2: Year 3:
SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	3.2.4 Increase access to diabetes and cardiovascular management and treatment for uninsured residents	×	×	×	Metrics: # of patients served/patient visits, quality measures (e.g., A1c scores, health screenings, etc.) Focus Location: Montgomery County Focus Population: low income, uninsured/underinsured, refugee, and immigrant populations	MobileMed, National Insitutes of Health-NIDDKD, National Heart, Lung and Blood Institute	SH: TBD	Year 1: Year 2: Year 3:
SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	3.2.5 Deliver opportunities to connect with a health professional to assess risk and receive free counseling	×	×	×	Metrics: #participants, # BP screenings, #assessments, #class encounters, quit rate Focus Location: MCHC CBSA Focus Population: Broader Community	HeartWell, Prince George's County Department of Recreation, Friendship Height's Village Center, Latino Health Initiative.	Suburban: TBD	Year 1: Year 2: Year 3:
Adventist HealthCare HC HOLY CROSS HEALTH A Member of Trinity Health MedStar Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	3.2.6 Advocate for policy, systems, and environmental changes addressing the needs of the uninsured population	×	×	×	Metrics: activities leveraged, plans developed, number of partners engaged, percent of colleague participation in e-advocacy campaign(s), #letters of support written, #advocacy events attended, #written/oral testimonies provided, # advocacy hours Focus Location: MC Equity Focus Areas, MCHC CBSA, Montgomery County, Maryland, National Focus Population: low-income, uninsured/underinsured populations, older adults, broader community	Montgomery County Council, Community-based organizations, faith-based organizations	AHC: HCH: TBD HCGH: TBD MedStar: SH:	Year 1: Year 2: Year 3:
SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE MedStar Health	3.2.7 Navigate uninsured patients and community members in need of access to care through screenings, referrals and linkages to community resources	×	×	×	Metrics: # of social screenings compleated, # of referrals Focus Location: Focus Population: low income, uninsured/underinsured populations	Montgomery County Cancer Crusade	MedStar: $102,003 SH: TBD	Year 1: Year 2: Year 3:

MCHC Implementation Plan FY2023-FY2025

Priority 2: Healthy Behaviors

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

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

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

CHNA Impact	CHNA Baseline	Target	Actual
Decrease percent of households that are food insecure	MC: 8.6% PGC: 7.3%	6.00%	MC: 8.6% PGC: 7.3%
Decrease percent of monority groups that are food insecure	BLK: 19.1% HSP: 15.6%	6.00%	BLK: 19.1% HSP: 15.6%
Increase the proportion of households who receive SNAP benefits	6.70%	No Target	6.70%

Objective 4.1: Reduce household food insecurity and hunger

Hospital	Strategies	Timeframe: Year 1	Timeframe: Year 2	Timeframe: Year 3	Metrics/Location/Population	Existing and Potential Partners	Budgeted Resources	Status
HOLY CROSS HEALTH	4.1.1 Utilize SIOH screening and referral process to capture data in EPIC and refer health center patients to community resources	x	x	x	**Metrics:** # of patients screened, # of patients referred to resources **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** low-income, uninsured/underinsured	Montgomery Cares	HCH: See Strategy 1.1.1	Year 1: Year 2: Year 3:
Adventist HealthCare; HOLY CROSS HEALTH; MedStar Health; SUBURBAN HOSPITAL	4.1.2 Coordinate care and link patients, colleagues and community members to social services	x	x	x	**Metrics:** # of patients/community members with coordination plans in FindHelp, number of community organizations with claimed sites in FindHelp, # closed loop referrals **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Montgomery County **Focus Population:** low-income, uninsured/underinsured	Cross Community, CHEER, faith-based organizations, Montgomery County DHHS, nonprofit organizations	HCH: See Strategy 2.1.2 HCGH: See Strategy 2.1.2 Medstar: TBD SH: TBD AHC: TBD	Year 1: Year 2: Year 3:
HOLY CROSS HEALTH	4.1.3 Train Community Health Workers on SNAP education and enrollment	x	x	x	**Metrics:** # of CHWs trained, #participants enrolled **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** low-income, uninsured/underinsured	Montgomery County Food Council, Cross Community	HCH: $500 HCGH: $500	Year 1: Year 2: Year 3:
Adventist HealthCare; MedStar Health; SUBURBAN HOSPITAL	4.1.4 Provide grant funding and sponsorships to organizations addressing access to food insecurity and hunger.	x	x	x	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization **Focus Location:** Montgomery County & Prince George's County **Focus Population:** All ages	Community Health and Empowerment through Education and Research (CHEER), Food & Friends, Nourish Now, Feed the Fridge, Crossroads Community Food Network, Institute for Public Health Innovation, The Shepherd's Table, Manna Food Center	AHC: TBD MedStar: $2,000 Suburban: TBD	Year 1: Year 2: Year 3:

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

Hospital	Strategies	Timeframe: Year 1	Timeframe: Year 2	Timeframe: Year 3	Metrics/Location/Population	Existing and Potential Partners	Budgeted Resources	Status
Adventist HealthCare; HOLY CROSS HEALTH; MedStar Health; SUBURBAN HOSPITAL	4.2.1 Increase availability and access to healthy and/or culturally appropriate food	x	x	x	**Metrics:** #partners, # community garden plots, #community members reserving plots, lbs. produce grown **Focus Location:** MC Equity Focus Areas **Focus Population:** low-income, uninsured/underinsured, food insecure	Montgomery College, Montgomery County Master Gardeners, MoCo Food Council, Montgomery County Ag Reserve, Boys and Girls Club, Food and Friends, Manna, One Acre Farms	HCH: $400,000 MedStar: TBD SH: TBD AHC: TBD	Year 1: Year 2: Year 3:
Adventist HealthCare; HOLY CROSS HEALTH; MedStar Health; SUBURBAN HOSPITAL	4.2.2 Increase food literacy	x	x	x	**Metrics:** #encounters, #classes held, # of participants, % increase in knowledge and self-efficacy, class completion rate **Focus Location:** MC Equity Focus Areas **Focus Population:** low-income, uninsured/underinsured, food insecure	Montgomery College, MoCo Food Council, UMD Extension, Boys and Girls Club, Manna	HCH: $5,000 HCGH: $2,000 MedStar: SH: AHC:	Year 1: Year 2: Year 3:

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

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

CHNA Impact	CHNA Baseline	Target	Actual
Reduce the proportion of adults aged 20 and older who are obese	CBSA: 31.1%	36.00%	CBSA: 31.1%
Reduce the proportion of children and adolescents who are obese or overweight	MC: 22.4% PGC: 35.5%	15.50%	MC: 22.4% PGC: 35.5%

Objective 5.1: Reduce the proportion of adults with obesity

Hospital	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Budgeted Resources	Status
		Year 1	Year 2	Year 3				
HOLY CROSS HEALTH A Member of Trinity Health	5.1.1 Expand or implement evidence-based/informed programs addressing obesity in children, adolescents	×	×	×	**Metrics:** Number of encounters, pre/posttests, participant surveys, weight loss, # Kids Fit participants, BMI **Focus Location:** MC Equity Focus Areas **Focus Population:** Children/adolescents	Montgomery County Housing Partnership, Boys and Girls Club, Kingdom Fellowship AME	**HCH:** $3,000 **HCGH:** $2,000	**Year 1:** **Year 2:** **Year 3:**
HOLY CROSS HEALTH A Member of Trinity Health SUBURBAN HOSPITAL JOHNS HOPKINS MEDICINE	5.1.2 Provide diabetes care management, education and/or nutrition counseling at community health centers	×	×	×	**Metrics:** Health center visits, clinical measures, readmissions/ED utilization, referrals to community health programs and social services **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** Young Adults and Adults, high-risk patients	Community Care Delivery Existing/Potential Partners: Montgomery County DHHS, Montgomery Cares, Kevin J. Sexton Fund	**HCH:** $30,000 **HCGH:** $15,000 **SH:** TBD	**Year 1:** **Year 2:** **Year 3:**
Adventist HealthCare HOLY CROSS HEALTH MedStar Health SUBURBAN HOSPITAL	5.1.3 Expand diabetes programming (English and Spanish)	×	×	×	**Metrics:** # DPP and DSMP cohorts offered by qualified providers; # referrals **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** Young Adults and Adults	Nexus Montgomery, Adventist Health, Medstar Montgomery, Holy Cross and Suburban, Montgomery County DHHS, Healthy Montgomery, Montgomery Cares, BRMDP	**HCH:** $78,000 **HCGH:** $40,000 **SH:** **AHC:** **MedStar**	**Year 1:** **Year 2:** **Year 3:**
Adventist HealthCare HOLY CROSS HEALTH MedStar Health SUBURBAN HOSPITAL	5.1.4 Provide healthy lifestyle education programs, wellness activities, workshops, and support groups	×	×	×	**Metrics:** program evaluation (e.g., race, ethnicity, liklihood to utilize AHC services, program met needs and expectations) **Focus Location:** Montgomery County & Prince George's County **Focus Population:** Adults and older adults/elderly	Montgomery County Department of Recreations, Faith Communities, Montgomery County non-profits	**HCH:** $35,000 **HCGH:** $10,000 **MedStar:** $ **AHC:** $ **SH:** $	**Year 1:** **Year 2:** **Year 3:**
Adventist HealthCare HOLY CROSS HEALTH MedStar Health SUBURBAN HOSPITAL	5.1.5 Expand or implement evidence-based programs for diabetes and chronic disease self-management	×	×	×	**Metrics:** Number of encounters, attendance/completion rate, number of safety-net DSMP referrals, pre/posttests, self-efficacy survey **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** Young Adults and Adults	Montgomery County DHHS, HQI	**HCH:** $6,000 **HCGH:** $3,000 **MedStar:** TBD **SH:** TBD	**Year 1:** **Year 2:** **Year 3:**

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

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

CHNA Impact	CHNA Baseline	Target	Actual
Reduce the proportion of adults who do no physical activity in their free time	MC: 48.9% PGC: 49.5%	21.20%	MC: 48.9% PGC: 49.5%
Increase the proportion of adolescents who do enough aerobic physical activity	MC: 37.7% PGC: 24.1%	30.60%	MC: 37.7% PGC: 24.1%
Reduce fall-related deaths among older adults	MC: 66.1 PGC: 48.0	63.40%	MC: 66.1 PGC: 48.0
Decrease heart disease mortality rate	MC: 97.9 PGC: 139.8	71.1	MC: 97.9 PGC: 139.8
Decrease stroke mortality rate	MC: 24.7 PGC: 46.3	33.4	MC: 24.7 PGC: 46.3
Reduce the proportion of adults with high blood pressure	MC: 29.8% PGC: 37.2%	27.70%	MC: 29.8% PGC: 37.2%

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

Hospital	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Budgeted Resources	Status
		Year 1	Year 2	Year 3				
Adventist HealthCare Holy Cross Health MedStar Health Suburban Hospital	6.1.1 Provide physical and social activity programs for seniors aged 55+	x	x	x	**Metrics:** # participants # of encounters, # programs offered; # of classes offered, pre/post assessments, participant surveys **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Prince George's County **Focus Population:** Adults aged 55+	Montgomery County HOC and Recreation Department, Maryland Department on Aging, Kaiser Permanente of the Mid-Atlantic States, MoCo Department of Recreation, Maryland National Capital Park and Planning Commission, Faith-Based and Community-based Organizations and Retirement Communities	**HCH:** $245,000 **HCGH:** 25,000 **MedStar:** $7,410 **AHC:** TBD **Suburban:** TBD	**Year 1:** **Year 2:** **Year 3:**
Suburban Hospital	6.1.2 Address obesity through a three-pronged approach: education, improved nutrion,and increased physical activity (Dine, Learn & Move).	x	x	x	**Metrics:** # of participants, pre/post evaluation **Focus Location:** Prince George's County **Focus Population:** Adults 18+	PG Parks & Recreation, University of Maryland Capital Region Health, PG Health Department.	**Suburban:** TBD	**Year 1:** **Year 2:** **Year 3:**
Suburban Hospital	6.1.3 Provide funding to organizations addressing access to physical activities services through the Community Contribution Fund.	x	x	x	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization **Focus Location:** Montgomery County & PG County **Focus Population:** Physical and Mental Differences Adults (special needs), General Pop	Spirit Club, Mains Street, American Heart Association, YMCA	**Suburban:** $	**Year 1:** **Year 2:** **Year 3:**
Holy Cross Health	6.1.4 Partner with organizations and community centers to expand senior-based services in the community	x	x	x	**Metrics:** # of organizations, # of events held at community sites, # of encounters, # programs offered; pre/posttests, participant surveys **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** Adults aged 55+	Montgomery County HOC and Recreation Department, Faith-based organizations	**HCH:** $10,000 **HCGH:** $5,000	**Year 1:** **Year 2:** **Year 3:**

Objective 6.2: Increase the proportion of older adults with physical, cognitive, or chronic health problems who get regular social and physical activity.								
Hospital	**Strategies**	**Timeframe**			**Metrics/Location/Population**	**Existing and Potential Partners**	**Year One Budget**	**Status**
		Year 1	**Year 2**	**Year 3**				
HOLY CROSS HEALTH A Member of Trinity Health	**6.2.1** Provide medical, social, rehabilitative and recreational programs for adults through a program of all-inclusive care for the elderly (PACE) and the Medical Adult Day Center (MADC)	x	x	x	**Metrics:** # of encounters, readmission rates, ED utilization, and clinical indicators, MADC daily census; participant surveys **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** Adults with physical, cognitive, or chronic health problems, dual eligible for Medicaid and Medicare	HCH Lead: Healthy Communities Existing/Potential Partners: Montgomery County DHHS, GROWS, Maryland Department on Aging; AAOA, MAADS, Alzheimer's Foundation, Alzheimer's Association, ARC Sisters of the Holy Cross, Alpha Kappa Alpha--Theta Omega Omega Chapter	HCH: $700,000	**Year 1:** **Year 2:** **Year 3:**

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Priority 3: Education, Income, Job & Environmental Strategies

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

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

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

CHNA Impact	CHNA Baseline	Target	Actual
Reduce the proportion of adolescents and young adults who aren't in school or working	MC: 8.37% PGC: 12.99%	10.10%	MC: 8.37% PGC: 12.99%
Reduce percentage of unfilled, open positions	7.60%	No Target	7.60%
Reduce nursing shortages	MD: 5,000	No Target	MD: 5,000

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

Hospital	Strategies	Timeframe Year 1	Year 2	Year 3	Metrics/Location/Population	Existing and Potential Partners	Budgeted Resources	Status	Notes
Adventist HealthCare Holy Cross Health MedStar Health Suburban Hospital	7.1.1 Implement workforce development program for community members and colleagues to advance in health/allied health careers	×	×	×	**Metrics:** # encounters, # unduplicated Participants # of staff hours, # certifications completed, # hired, average pre-program salary, average post-program salary, # colleagues **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** low-income, entry-level or unemployed	Nexus Montgomery, Maryland Physician's Care, Montgomery College, Kingdom Fellowship, Cross Community, Primary Care Coalition, Worksource Montgomery,	**AHC:** TBD **HCH:** $167,500 **HCGH:** $82,500 **MedStar:** TBD **Suburban:** TBD	**Year 1:** **Year 2:** **Year 3:**	Nexus,
Holy Cross Health	7.1.2 Implement a workforce development program to hire individuals who face barriers or challenges navigating the hiring system	×	×	×	**Metrics:** # encounters, # unduplicated participants, # hired, # hired at 6 and 12 months **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** Unemployed, aging out of foster care, veterans, homeless, single parents, prior felonies	Career Catchers	**HCH:** $20,000	**Year 1:** **Year 2:** **Year 3:**	
Adventist HealthCare Holy Cross Health MedStar Health Suburban Hospital	7.1.3 Increase access to certification(s) needed for employment (i.e. CDCES, CPR, Safe Sitter)	×	×	×	**Metrics:** # encounters, # unduplicated participants, # hired, # hired at 6 and 12 months **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** Unemployed, aging out of foster care, veterans, homeless, single parents, prior felonies	MedStar SITEL, American Heart Association, Safe Sitter International, Montgomery County Housing Opportunities Commission, Montgomery Housing Partnership, American Safety and Health Institute (ASHI), Local Fire and Rescue	**AHC:** TBD **HCH:** $20,000 **MedStar:** TBD **Suburban:** TBD	**Year 1:** **Year 2:** **Year 3:**	Safe Sitter, CPR & First Aid
Adventist HealthCare Suburban Hospital	7.1.4 Provide finanical support to community organizations addressing workforce development and/or vocational training.	×	×	×	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization **Focus Location:** Montgomery County and Prince George's County, MCHC CBSA **Focus Population:** All ages	Interfaith Works, A Wider Circle, Mercy Health Clinic, Strathmore Center, Boy Scouts of America, Montgomery County Coalition for the Homeless, Montgomery County Road Runner, Seventh Day Adventist Churches	**AHC:** $860,000 budgeted per year for CPF overall, which covers all CHNA priority areas **SH:** TBD	**Year 1:** **Year 2:** **Year 3:**	The Lucy Byard Scholarship, Nursing Scholarships, Community Partnership Fund, Learning & Life Support Programs - provide low or no cost training to community organizations
Objective 7.2: Expand pipeline programs that include service learning or experiential learning components in public health and health care settings.									
Adventist HealthCare Holy Cross Health MedStar Health Suburban Hospital	7.2.1 Increase opportunities for health and medical career exploration for high school students living in Montgomery County, MD.	×	×	×	**Metrics:** # of students, % going to college, % pursuing a medical career, staff hours **Focus Location:** Montgomery County **Focus Population:** High school age students	MCPS, Private Schools, Hopkins Familia, Kennedy High School Medical Careers Program, Medical Careers Program.	**AHC:** TBD **HCH:** TBD **HCGH:** TBD **MedStar:** TBD **SH:** TBD	**Year 1:** **Year 2:** **Year 3:**	Medical Careers Program - Montgomery County Public Schools Academy of Health Professions, Clinical Shadowing Program (Medical Exploring) Rx for Success
Adventist HealthCare Holy Cross Health MedStar Health Suburban Hospital	7.2.2 Increase youth and adult workforce training, and education programs (internships, fellowships, clinical rotations, etc.)	×	×	×	**Metrics:** # of staff hours, # of students, # of programs **Focus Location:** MCHC CBSA, Maryland, DC **Focus Population:** High school and higher education students	Multiple Community Colleges, Universities and High Schools	**AHC:** **HCH:** $53,456 **HCGH:** $5,484 **Medstar:** $195,073 **SH:** TBD	**Year 1:** **Year 2:** **Year 3:**	Stepping Stones Program

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

Goal 8: Reduce Income Inequality

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

Objective 8.1: Reduce the proportion of people living in poverty

Hospital	Strategies	Timeframe Year 1	Timeframe Year 2	Timeframe Year 3	Metrics/Location/Population	Existing and Potential Partners	Budgeted Resources	Status	Notes
HOLY CROSS HEALTH	**8.1.1** Raise the minimum wage significantly higher than the federal, state, and local minimum wage.	x	x	x	**Metrics:** Minimum hiring salary, % employees hired at living wage **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** Low-income, entry-level or unemployed		**HCH:** $48,800 **HCGH:** $24,400	**Year 1:** **Year 2:** **Year 3:**	
HC HOLY CROSS HEALTH	**8.1.2** Provide early care and education program to decrease costs to government; increase educational achievement (and therefore greater earning power); and increase opportunity in adulthood.	x	x	x	**Metrics:** Number of childcare providers enrolled, completion rate, #CPR certified, pre/post test **Focus Location:** MC Equity Focus Areas,MCHC CBSA **Focus Population:** Unlicensed child care providers	Montgomery College, Identity, Inc., Sheppard Pratt, Parents Educating Parents, Thriving Germantown, Montgomery Moving Forward	**HCH:** $28,000	**Year 1:** **Year 2:** **Year 3:**	
SUBURBAN HOSPITAL	**8.1.4** Provide financial support to community organizations addressing income inequality through the Community Partnership Fund & employee giving programs.	x	x	x	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization, $ amount raised **Focus Location:** Montgomery County and Prince George's County, MCHC CBSA **Focus Population:** All ages	A Wider Circle, United Way, PEP	**SH:** TBD	**Year 1:** **Year 2:** **Year 3:**	
HOLY CROSS HEALTH	8.1.5 Provide work-study opportunities for low-income high school students to offset the cost of private school tuition.	x	x	x	**Metrics:** # of students employed in work-study program **Focus Location:** Montgomery County **Focus Population:** low-income high school students		**HCH:** $14,785	**Year 1:** **Year 2:** **Year 3:**	
Objective 8.2: Provide resources to families experiencing income inequalities									
Adventist HealthCare HOLY CROSS HEALTH MedStar Health SUBURBAN HOSPITAL	**8.2.1** Implement projects and initiatives that alleviate downstream effects of income inequality	x	x	x	**Metrics:** # of families served, staff hours, # of items collected and distributed, **Focus Location:** MC Equity Focus Areas,MCHC CBSA **Focus Population:** low-income, immigrant populations, refugees, hospital staff	Linkages to Learning, MCPS, 4 Montgomery Kids,	**AHC:** **HCH:** $500 **HCGH:** $500 **MedStar:** **Suburban:**	**Year 1:** **Year 2:** **Year 3:**	Ho ho Project, Adopt-a-Family, Giving Tree, Back to School Supplies, ECHO Fund, Homeless Resource Day.

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

Goal 9: Reduce housing cost burden

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

Objective 9.1: Reduce the proportion of families that spend more than 30 percent of income on housing

Hospital	Strategies	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Budgeted Resources	Status	Notes
		Year 1	Year 2	Year 3					
HOLY CROSS HEALTH MedStar Health SUBURBAN HOSPITAL	**9.1.1** Coordinate care and link patients, colleagues and community members to social services	x	x	x	**Metrics:** # of screenings, Number of patients/community members with coordination plans, number of community organizations with claimed sites in FindHelp, # closed loop referrals **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Montgomery County **Focus Population:** low-income, uninsured/underinsured	Cross Community, CHEER, faith-based organizations, Montgomery County DHHS, nonprofit organizations	**HCH:** See Strategy 2.1.2 **HCGH:** See Strategy 2.1.2 **MedStar:** TBD	**Year 1:** **Year 2:** **Year 3:**	community health workers/advo
HOLY CROSS HEALTH	**9.1.2** Advocate for policy, systems, and environmental changes addressing the housing cost burden	x	x	x	**Metrics:** Activities leveraged, plans developed, number of partners engaged, percent of colleague participation in e-advocacy campaign(s), # of staff hours **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** Low-income, uninsured, underinsured	Montgomery County Council, Community-based organizations, faith-based organizations	**HCH:** TBD **HCGH:** TBD	**Year 1:** **Year 2:** **Year 3:**	
Adventist HealthCare MedStar Health	**9.1.3** Provide financial support to community organizations addressing housing cost burden through the Community Health fund.	x	x	x	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization, $ amount raised **Focus Location:** Montgomery County and Prince George's County, MCHC CBSA **Focus Population:** Low-income, uninsured, underinsured	Montgomery County Coalition for the Homeless, Seabury Resources for Aging	**AHC:** TBD **MedStar:** TBD	**Year 1:** **Year 2:** **Year 3:**	CPF,

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE
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Priority 1: Access To Care

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

Priority 1a: Access to Mental Health Providers			
Goal 1: Improve Mental Health			
CHNA Impact	**CHNA Baseline**	**Target**	**Actual**
Decrease mental health related ER visits	MC: 2,312.1 PGC: 1,955.6	3,152.60	MC: 2,312.1 PGC: 1,955.6
Decrease percentage of adults with poor mental health	CBSA: 11.6%	9.7%	CBSA: 11.6%
Decrease percentage of students feeling sad or hopeless	MC: 31.5% PGC: 34.2%	32.0%	MC: 31.5% PGC: 34.2%
Decrease age-adjusted suicide mortaltiy rates	CBSA: 7.3	13.9	CBSA: 7.3

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

Strategies	Program/Intervention	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 1 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
1.1.1 Behavioral health screenings with links to treatment at clinical care sites.	*Screening, Brief Intervention, Referral to Treatment (SBIRT) Program in ER supported by Peer Recovery Coaches*	x	x	x	**Metrics:** Quarterly reports number, behavioral health screenings conducted, #referred to social **Focus Location:** MCHC CBSA & Montgomery County **Focus Population:** Broader community, patients with substance abuse	Montgomery Cares, Maryland Dept. of Health, Montgomery County DHHS, CornerStone Montgomery, Sheppard Pratt		**Year 1:** **Year 2:** **Year 3:**

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

Strategies	Program/Intervention	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 1 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
1.2.1 Provide virtual and in-person case management services for patients with a diagnosis of depression, schizophrenia/ schizoaffective, and bipolar disorder discharged from inpatient unit.	*TGN-Behavioral Health*	x	x	x	**Metrics:** # of participants served & readmission rate **Focus Location:** MCHC CBSA & Montgomery County **Focus Population:** Patients with diagnoses of depression, schyzophrenia and bipolar disorders	CornerStone Montgomery, Sheppard Pratt		**Year 1:** **Year 2:** **Year 3:**
1.2.2 Deliver Outpatient Addiction Treatment services for adolescents and adults with substance abuse disorder	*Addiction Treatment Services*	x	x	x	**Metrics:** Phase 1 completion, school attendance, behavior, #encounters, # classes held, # of participants, % increase in knowledge and self-efficacy, class completion rate **Focus Location:** Montgomery County **Focus Population:** Adolescents & Adults with Substance abuse	Montgomery County DHHS, & Montgomery County Public School System.		**Year 1:** **Year 2:** **Year 3:**
1.2.3 Collaborate with community organizations, community partners, and health systems to effect change at a systems level to improve behavioral health outcomes	*Nexus Behavioral Health Crisis Workgroup*	x	x	x	**Metrics:** % of total BH ED encounters for high utilizer BH patients (30+ encounters/year), total ED encounters for high utilizer patients, total ED charges for BH high utilizer patients **Focus Location:** Montgomery County **Focus Population:** Adults	Nexus Montgomery, County Agencies, Community Representatives, Cornerstone Montgomery, Sheppard Pratt, DHHS, MCFRS, and the Local Behavioral Health Authority		**Year 1:** **Year 2:** **Year 3:**

1.2.5 Provide grant funding and sponsorships to organizations addressing access to mental health services.	*Community Contribution Fund*	x	x	x	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization **Focus Location:** Montgomery County & Prince George's County **Focus Population:** All ages	Charles E. Smith Life Communities, Parenting Encouragement Program, EveryMind, CornerStone Montgomery, Sheppard Pratt, Bethesda Cares		**Year 1:** **Year 2:** **Year 3:**
Objective 1.3: Increase mental health awareness to reduce stigma associated with mental illness, promote healthy behaviors and improve health outcomes through education and outreach events*								
Strategies	**Program/Intervention**	**Timeframe**			**Metrics/Location/Population**	**Existing and Potential Partners**	**Year 1 Budgeted Resources**	**Status**
		Year 1	**Year 2**	**Year 3**				
1.3.1 Provide mental health and wellness workshops, educational events, and support groups in the community.	Alcohol and Drug seminar *Concerned Person's Program* *Community Seminars/Support Groups*	x	x	x	**Metrics:** # of workshops and support groups held, # of participants, % of participants who had an increase in knowledge and self-efficacy **Focus Location:** MCHC CBSA & Montgomery County **Focus Population:** Adolescents & adults	Charles E. Smith Life Communities; AHC Outpatient Wellness Center (OWC), EveryMind, Inc., Montgomery County Area Agency on Aging, GROWS, Addiction Treatment Center		**Year 1:** **Year 2:** **Year 3:**
1.3.2 Collaborate with community organizations, partners, and health systems to address the health information gap to promote informed decision-making and connection to existing resources that will help improve the physical, social, and mental well-being of community members	*Behavioral Health Workgroup* *Latino Health Equity Workgroup* Charles E Smith Symposium	x	x	x	**Metrics:** # education/awareness events held, # of participants, % of participants who had an increase in knowledge/awareness # partners/ organizations **Focus Location:** MCHC CBSA & Montgomery County **Focus Population:** Adolescents, adults, Latino/Hispanic Families	EveryMind, Linkages to Learning, Latino Health Initiative, Charles E. Smith Life Communities, Identity, Mary's Center, Office of Community Partnerships, Montgomery County Community Engagement Cluster, MobileMedical Care, National Institutes of Health		**Year 1:** **Year 2:** **Year 3:**

Priority 2b: Access to Primary Care Providers

Goal 2: Improve Health Care

CHNA Impact	CHNA Baseline	Target	Actual
Reduce number of people who cant afford to see a doctor	MD: 7.5%	3.30%	MD: 7.5%
Increase the proportion of people with a usual primary care provider	MC: 78.0% PGC: 78.9%	84.0%	MC: 78.0% PGC: 78.9%
Increase percent of mothers receiving early and adequate prenatal care	MC: 70.2% PGC: 59.4%	80.5%	MC: 70.2% PGC: 59.4%
Increase the proportion of females who get screened for breast cancer	MC: 77.1% PGC: 80.3%	80.5%	MC: 77.1% PGC: 80.3%

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

Strategies	Program/Intervention	Timeframe Year 1	Year 2	Year 3	Metrics/Location/Population	Existing and Potential Partners	Year 1 Budgeted Resources	Status
2.1.1 Provide financial and in-kind support to primary care community clinics	*SH- Community Contribution Fund*	x	x	x	**Metrics:** # of patients served/patient visits, quality measures (e.g., A1c scores, health screenings, etc.) **Focus Location:** MCHC CBSA **Focus Population:** Refugees, low-income, and uninsured/underinsured populations	MobileMed, Mercy Clinic, Mary's Center, Proyecto Salud, & Catholic Charities, Mercy Clinic		**Year 1:** **Year 2:** **Year 3:**
2.1.2 Assist community members in need of primary care services through screenings, referrals and linkages to community resources	*Village Ambassador Alliance* *Community Seminars* ED-PC Connect/Transitions of Care Program	x	x	x	**Metrics:** Quaterly reports # of encounters, # of enrolled clients, % screening rate **Focus Location:** Montgomery County **Focus Population:** low income, uninsured/underinsured populations, older	Montgomery Cares Satefy-Net Clinics, Catholic Charities, Mercy Clinic, Scotland Community	VAA: $5,000 PGC seminars $2,900	**Year 1:** **Year 2:** **Year 3:**
2.1.3 Provide funding and in-kind support to organizations addressing barriers to accessing primary care services	*Community Contribution Fund* *Village Ambassador Alliance*	x	x	x	**Metrics:** $ support provided **Focus Location:** MCHC CBSA **Focus Population:** low-income, uninsured/underinsured populations	MobileMed, Mercy Clinic, Mary's Center, Proyecto Salud, & Catholic Charities, Mercy Clinic	VAA: $5,000	**Year 1:** **Year 2:** **Year 3:**
2.1.7 Implement strategies and initiatives that reduce barriers to accessing primary care, such as transportation and language	*Transportation vouchers, medication assistance, home health services, durable medical equipment (DME), language interpreting services*	x	x	x	**Metrics:** #participants, #Lyft/Uber rides provided, #translation services provided, #interpreters provided, $ spent on language access **Focus Location:** MCHC CBSA **Focus Population:** low-income, uninsured/underinsured populations, older adults	MobileMed, Mercy Clinic, Mary's Center, Proyecto Salud, Catholic Charities, Lyft		**Year 1:** **Year 2:** **Year 3:**

Priority 1c: Lack of Insurance

Goal 3: Increase health insurance coverage

CHNA Impact	CHNA Baseline	Target	Actual
Increase the proportion of people with health insurance	CBSA: 90.9%	92.1%	CBSA: 90.9%
Percent uninsured	CBSA: 9.1%	0.0%	CBSA: 9.1%
Percent of insured population receiving Medicaid	CBSA: 17.4%	No Target	CBSA: 17.4%

Objective 3.1: Increase the proportion of people with health insurance

Strategies	Program/Intervention	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 1 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
3.1.1 Advocate for policy, systems, and environmental changes addressing insurance reform and the needs of the uninsured population	*Community Contribution Fund*	×	×	×	**Metrics:** activities leveraged, plans developed, number of partners engaged, percent of colleague participation in e-advocacy campaign(s), #letters of support written, #advocacy events attended, #written/oral testimonies provided, # advocacy hours **Focus Location:** MCHC CBSA, Montgomery County, Maryland, National **Focus Population:** low-income, uninsured/underinsured populations, older adults, broader community	Montgomery County DHHS, Montgomery Cares, MD Hospital Association, Healthy Montgomery		**Year 1:** **Year 2:** **Year 3:**
3.1.2 Provide support to uninsured patients, colleagues and community members by assisting with enrollment to publicly funded programs and hospital charity care programs	*Cancer screenings* *Financial assistance services*	×	×	×	**Metrics:** # of participants, #colleagues assessed, #Colleages identified as uninsured, #linked to resources, Charity care expenses, #insured **Focus Location:** MCHC CBSA **Focus Population:** low-income, uninsured populations	Montgomery County DHHS, Meduit, DeCorm, Montgomery Cares Clinics		**Year 1:** **Year 2:** **Year 3:**

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

Strategies	Program/Intervention	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 1 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
3.2.3 Provide financial and in-kind support to community clinics and community organizations addressing lack of insurance and/or insurance enrollment	*Community Contribution Fund*	×	×	×	**Metrics:** # of patients served/patient visits, quality measures - A1c scores, health screenings, HEDIS measures, $ grants/funding provided, #grants provided **Focus Location:** MCHC CBSA **Focus Population:** refugees, low income, and uninsured/underinsured populations	CASA de Maryland, MobileMed, Mercy, Mary's Center, Kaseman Clinic, Catholic Charities, Montgomery Cares		**Year 1:** **Year 2:** **Year 3:**
3.2.4 Increase access to diabetes and cardiovascular management and treatment for uninsured residents	*Heart Clinic* *Endocrine Clinic*	×	×	×	**Metrics:** # of patients served/patient visits, quality measures (e.g., A1c scores, health screenings, etc.) **Focus Location:** Montgomery County **Focus Population:** low income, uninsured/underinsured, refugee, and immigrant populations	MobileMed, National Insitutes of Health-NIDDKD, National Heart, Lung and Blood Institute, Baltimore Metropolitan Diabetes Regional Partnership		**Year 1:** **Year 2:** **Year 3:**

3.2.5 Deliver opportunities to connect with a health professional to assess risk and receive free counseling	*Blood Pressure Screenings* *Freedom From Smoking Workshops*	x	x	x	**Metrics:** #participants, # BP screenings, #assessments, #class encounters, quit rate **Focus Location:** MCHC CBSA **Focus Population:** Broader Community	HeartWell, Prince George's County Department of Recreation, Friendship Height's Village Center, Latino Health Initiative.	PGC BP: $1,500	**Year 1:** **Year 2:** **Year 3:**
3.2.6 Advocate for policy, systems, and environmental changes addressing the needs of the uninsured population	*Community Contribution Fund* *Laboratory Services* *Charity Care*	x	x	x	**Metrics:** activities leveraged, plans developed, number of partners engaged, percent of colleague participation in e-advocacy campaign(s), #letters of support written, #advocacy events attended, #written/oral testimonies provided, # advocacy hours **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Montgomery County, Maryland, National **Focus Population:** low-income, uninsured/underinsured populations, older adults, broader community	Montgomery County Council, Community-based organizations, faith-based organizations, Healthy Montgomery, American Hospital Association		**Year 1:** **Year 2:** **Year 3:**
3.2.7 Navigate uninsured patients and community members in need of access to care through screenings, referrals and linkages to community resources	*Community Health Workers* *Cancer Prevention Program*	x	x	x	**Metrics:** # of social screenings compleated, # of referrals **Focus Location:** Montgomery County **Focus Population:** low income, uninsured/underinsured populations	Montgomery County Cancer Crusade, Montgomery Cares, Department of Health and Human Services		**Year 1:** **Year 2:** **Year 3:**

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Priority 2: Healthy Behaviors

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

Priority 2a: Food Insecurity

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

CHNA Impact	CHNA Baseline	Target	Actual
Decrease percent of households that are food insecure	MC: 8.6% PGC: 7.3%	6.00%	MC: 8.6% PGC: 7.3%
Decrease percent of monority groups that are food insecure	BLK: 19.1% HSP: 15.6%	6.00%	BLK: 19.1% HSP: 15.6%
Increase the proportion of households who receive SNAP benefits	6.70%	No Target	6.70%

Objective 4.1: Reduce household food insecurity and hunger

Strategies	Program/Intervention	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 1 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
4.1.2 Coordinate care and link patients, colleagues and community members to social services	*Community Health Workers*	×	×	×	**Metrics:** # of patients/community members with coordination plans, # closed loop referrals **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Montgomery County **Focus Population:** low-income, uninsured/underinsured	Nourish Now, Manna Food Center, Food Council		**Year 1:** **Year 2:** **Year 3:**
4.1.4 Provide grant funding and sponsorships to organizations addressing access to food insecurity and hunger.	*Community Contribution Fund*	×	×	×	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization **Focus Location:** Montgomery County & Prince George's County **Focus Population:** All ages	Nourish Now, Manna Food Center, Food Council		**Year 1:** **Year 2:** **Year 3:**

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

Strategies	Program/Intervention	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 1 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
4.2.1 Increase availability and access to healthy and/or culturally appropriate food	*Snackpacks* *Food Drives* *Adopt-a-Family*	×	×	×	**Metrics:** #partners, lbs. produce collected/delivered **Focus Location:** MC Equity Focus Areas **Focus Population:** low-income, uninsured/underinsured, food insecure	Manna, United Way of National Capital Area, The Greater Bethesda Chamber of Commerce, Bethesda Chevy Chase Rotary Club, Montgomery County Food Council.		**Year 1:** **Year 2:** **Year 3:**
4.2.2 Increase food literacy	*Seminars/Workshops* *Dine, Learn & Move*	×	×	×	**Metrics:** #encounters, # classes held, # of participants, % increase in knowledge and self-efficacy, class completion rate **Focus Location:** MC Equity Focus Areas **Focus Population:** low-income, uninsured/underinsured, food insecure	MoCo Food Council, Manna Food Center, PG Parks & Recreation, University of Maryland Capital Region Health, PG Health Department, MobileMed NIH Endocrine Clinic at Suburban Hospital, Suburban Hospital Diabetes Services		**Year 1:** **Year 2:** **Year 3:**

Priority 2b: Adult Obesity

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

CHNA Impact	CHNA Baseline	Target	Actual
Reduce the proportion of adults aged 20 and older who are obese	CBSA: 31.1%	36.00%	CBSA: 31.1%
Reduce the proportion of children and adolescents who are obese or overweight	MC: 22.4% PGC: 35.5%	15.50%	MC: 22.4% PGC: 35.5%

Objective 5.1: Reduce the proportion of adults with obesity

Strategies	Program/Intervention	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 1 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
5.1.2 Provide diabetes care management, education and/or nutrition counseling at community health centers	*Nutrition Counseling* *Diabetes Education*	x	x	x	**Metrics:** Health center visits, clinical measures, readmissions/ED utilization, referrals to community health programs and social services **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** Young Adults and Adults, high-risk patients	MobileMed, National Institute of Diabetes and Digestive and Kidney Diseases	Nutriton Counseling ($6,600)	**Year 1:** **Year 2:** **Year 3:**
5.1.3 Expand diabetes programming (English and Spanish)	*Nexus Montgomery Regional Partnership Catalyst Diabetes Project (NMRP)* *Baltimore Metropolitan Diabetes Regional Partnership (BMDRP)* *Thrive 365*	x	x	x	**Metrics:** # DPP and DSMP cohorts offered by qualified providers; # referrals **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** Young Adults and Adults	Nexus Montgomery, Adventist Health, Medstar Montgomery, and Suburban, Montgomery County DHHS, Healthy Montgomery, Montgomery Cares, BRMDP, Bethesda Wellness & Nutrition		**Year 1:** **Year 2:** **Year 3:**
5.1.4 Provide healthy lifestyle education programs, wellness activities, workshops, and support groups	*Community Health & Wellness Seminars* *Dine, Learn, & Move*	x	x	x	**Metrics:** program evaluation (e.g., race, ethnicity, liklihood to utilize AHC services, program met needs and expectations) **Focus Location:** Montgomery County & Prince George's County **Focus Population:** Adults and older adults/elderly	PG Parks & Recreation, University of Maryland Capital Region Health, PG Health Department, Girls on the Run, American Heart Association, American Diabetes Assocation	DLM: $3,900	**Year 1:** **Year 2:** **Year 3:**
5.1.5 Expand or implement evidence-based programs for diabetes and chronic disease self-management	*Chronic Disease Self-Management Program* *Diabetes Self-Management Program*	x	x	x	**Metrics:** Quarterly reports on encounters, attendance/completion rate, number of safety-net DSMP referrals, pre/posttests, self-efficacy survey **Focus Location:** MC Equity Focus Areas, MC MCHC CBSA **Focus Population:** Young Adults and Adults	Montgomery County DHHS, Bethesda Wellness & Nutrition		**Year 1:** **Year 2:** **Year 3:**

Priority 2c: Physical Inactivity

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

CHNA Impact	CHNA Baseline	Target	Actual
Reduce the proportion of adults who do no physical activity in their free time	MC: 48.9% PGC: 49.5%	21.20%	MC: 48.9% PGC: 49.5%
Increase the proportion of adolescents who do enough aerobic physical activity	MC: 37.7% PGC: 24.1%	30.60%	MC: 37.7% PGC: 24.1%
Reduce fall-related deaths among older adults	MC: 66.1 PGC: 48.0	63.40%	MC: 66.1 PGC: 48.0
Decrease heart disease mortality rate	MC: 97.9 PGC: 139.8	71.1	MC: 97.9 PGC: 139.8
Decrease stroke mortality rate	MC: 24.7 PGC: 46.3	33.4	MC: 24.7 PGC: 46.3
Reduce the proportion of adults with high blood pressure	MC: 29.8% PGC: 37.2%	27.70%	MC: 29.8% PGC: 37.2%

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

Strategies	Program/Intervention	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 1 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
6.1.1 Provide physical and social activity programs for seniors aged 55+	*Senior Shape, Tai Chi, Yoga from the Heart, Pilates for Seniors*	×	×	×	**Metrics:** # participants # of encounters, # programs offered; # of classes offered, pre/post assessments, participant surveys **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Prince George's County **Focus Population:** Adults aged 55+	Montgomery County Recreation Department, Maryland Department on Aging, Maryland National Capital Park and Planning Commission, Faith-Based and Community-based Organizations and Retirement Communities	PGC SS: $12,000; MC Senior Shape: $70,000; Yoga: $7,680; Pilates: $5,040; Tai Chi: $4,680	**Year 1:** **Year 2:** **Year 3:**
6.1.2 Address obesity through a three-pronged approach: education, improved nutrion,and increased physical activity (Dine, Learn & Move).	*Dine, Learn & Move*	×	×	×	**Metrics:** # of participants, pre/post evaluation **Focus Location:** Prince George's County **Focus Population:**	PG Parks & Recreation, University of Maryland Capital Region Health, PG Health Department	DLM: $3,900	**Year 1:** **Year 2:** **Year 3:**
6.1.3 Provide funding to organizations addressing access to physical activities services through the Community Contribution Fund.	*Community Contribution Fund*	×	×	×	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization **Focus Location:** Montgomery County & PG County **Focus Population:** Physical and Mental Differences Adults (special needs), General Pop	Spirit Club, Mains Street, American Heart Association, YMCA, Bethesda Chamber of Commerce, Girls on the Run	Contribution total: $8,250	**Year 1:** **Year 2:** **Year 3:**

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Priority 3: Education, Income, Job & Environmental Strategies

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

Priority 3a: Workforce/Labor Shortages			
Goal 7: Help people earn steady incomes that allow them to meet their health needs			
CHNA Impact	**CHNA Baseline**	**Target**	**Actual**
Reduce the proportion of adolescents and young adults who aren't in school or working	MC: 8.37% PGC: 12.99%	10.10%	MC: 8.37% PGC: 12.99%
Reduce percentage of unfilled, open positions	7.60%	No Target	7.60%
Reduce nursing shortages	MD: 5,000	No Target	MD: 5,000

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

Strategies	Program/Intervention	Timeframe Year 1	Timeframe Year 2	Timeframe Year 3	Metrics/Location/Population	Existing and Potential Partners	Year 1 Budgeted Resources	Status
7.1.1 Implement workforce development program for community members and colleagues to advance in health/allied health careers	*Nexus Montgomery*	x	x	x	**Metrics:** #encounters, #unduplicated participants, #certifications completed, #hired, average pre-program salary, average post-program salary, #colleagues **Focus Location:** CBSA Population **Focus Population:** low-income, entry-level or unemployed	Nexus Montgomery, Maryland Physician's Care, Montgomery College, Cross Community, Primary Care Coalition, Worksource Montgomery, Employment Enterprises	MD Physicians Care: $9,375 Nexus: 100K	**Year 1:** **Year 2:** **Year 3:**
7.1.3 Increase access to certification(s) needed for employment (i.e. CDCES, CPR, Safe Sitter)	*Safe Sitter Program* *Community CPR Classes*	x	x	x	**Metrics:** # encounters, # unduplicated participants **Focus Location:** MC Equity Focus Areas, MCHC CBSA **Focus Population:** teens and adults	Safe Sitter International, Girls On the Run, American Heart Association, MCPS	Contribution (GOTR) $5,000; American Heart Association contribution: $5,000, Safe Sitter: $3,000	**Year 1:** **Year 2:** **Year 3:**
7.1.4 Provide finanical and in-kind support to community organizations addressing workforce development and/or vocational training.	*Nursing Scholarships*	x	x	x	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization **Focus Location:** Montgomery County and Prince George's County, MCHC CBSA **Focus Population:** All ages	A Wider Circle, Colleges and Universities	$200,000	**Year 1:** **Year 2:** **Year 3:**

Objective 7.2: Expand pipeline programs that include service learning or experiential learning components in public health and health care settings.

Strategies	Program/Intervention	Timeframe Year 1	Timeframe Year 2	Timeframe Year 3	Metrics/Location/Population	Existing and Potential Partners	Year 1 Budgeted Resources	Status
7.2.1 Increase opportunities for health and medical career exploration for high school students living in Montgomery County, MD.	*Medical Exploring Program* *Shadowing/Mentoring Programs*	x	x	x	**Metrics:** # of students, % going to college, % pursuing a medical career, staff hours **Focus Location:** Montgomery County **Focus Population:** High school age students	Private Schools, Hopkins Familia, Community Bridges, Montgomery County Publish School	MEP: $5,500; MCPS $1,000	**Year 1:** **Year 2:** **Year 3:**
7.2.2 Increase youth and adult workforce training, and education programs (internships, fellowships, clinical rotations, etc.)	*Internships* *Fellowships* *Clinical rotations*	x	x	x	**Metrics:** # of staff hours, # of students, # of programs **Focus Location:** MCHC CBSA, Maryland, DC **Focus Population:** High school and higher education students	Montgomery College School of Nursing, University of Maryland School, American University,	$129,110	**Year 1:** **Year 2:** **Year 3:**

Priority 3b: Income Inequality

Goal 8: Reduce income inequality

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

Objective 8.1: Reduce the proportion of people living in poverty

Strategies	Program/Intervention	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 1 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
8.1.4 Provide financial support to community organizations addressing income inequality through the Community Partnership Fund & employee giving programs.	*Community Partnership Fund* *Employee Giving Campaigns (UWNCA)*	x	x	x	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization, $ amount raised **Focus Location:** Montgomery County and Prince George's County, MCHC CBSA **Focus Population:** All ages	A Wider Circle, United Way, Parent Encouraging Program, CornerStone Montgomery	A Wider Circle ($2,500), United Way, PEP ($5,000)	**Year 1:** **Year 2:** **Year 3:**

Objective 8.2: Provide resources to families experiencing income inequalities

Strategies	Program/Intervention	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 1 Budgeted Resources	Status
		Year 1	Year 2	Year 3				
8.2.1 Implement projects and initiatives that alleviate downstream effects of income inequality	*Adopt-A-Family* *Homeless Resource Day* *ECHO Fund*	x	x	x	**Metrics:** # of families served, staff hours, # of items **Focus Location:** MC Equity Focus Areas,MCHC CBSA **Focus Population:** low-income, immigrant populations, refugees, hospital staff	Linkages to Learning, MCPS, 4 Montgomery Kids, Child Welfare Services		**Year 1:** **Year 2:** **Year 3:**

Priority 3c: Housing Cost Burden										
Goal 9: Reduce housing cost burden										
CHNA Impact								CHNA Baseline	Target	Actual
Proportion of families that spend more than 30 percent of income on housing								CBSA: 33.7%	25.50%	CBSA: 33.7%
Proportion of housing units that meet the criteria for substandard housing								CBSA: 34.7%	16.00%	CBSA: 34.7%
Objective 9.1: Reduce the proportion of families that spend more than 30 percent of income on housing										
Strategies	Program/Intervention	Timeframe			Metrics/Location/Population	Existing and Potential Partners	Year 1 Budgeted Resources	Status		
		Year 1	Year 2	Year 3						
9.1.1 Coordinate care and link patients, colleagues and community members to social services	*Employee Assistance Fund*	x	x	x	**Metrics:** # of screenings, Number of patients/community members with coordination plans, number of community organizations with claimed sites in FindHelp, # closed loop referrals **Focus Location:** MC Equity Focus Areas, MCHC CBSA, Montgomery County **Focus Population:** low-income, uninsured/underinsured	Cross Community, Montgomery County DHHS, nonprofit organizations, Housing Opportunity Commission		**Year 1:** **Year 2:** **Year 3:**		
9.1.3 Provide financial and in-kind support to community organizations addressing housing cost burden .	*Community Health fund*	x	x	x	**Metrics:** $ amount provided, # served, & # of awards, other metrics depending on funding organization, $ amount raised **Focus Location:** Montgomery County and Prince George's County, MCHC CBSA **Focus Population:** Low-income, uninsured, underinsured	Scotland Community, Stepping Stone Shelter, Bethesda Cares		**Year 1:** **Year 2:** **Year 3:**		

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