HOLY CROSS HOSPITAL

Community Health Needs Assessment Implementation Strategy

Fiscal Year 2018-2020

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

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Holy Cross Hospital completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors in October, 2016. Holy Cross Hospital performed the CHNA in adherence with certain federal requirements for not-for-profit hospitals set forth in the Affordable Care Act and by the Internal Revenue Service. The assessment took into account input from representatives of the community, community members, and various community organizations.

The complete CHNA report is available electronically at http://www.holycrosshealth.org/community-health-needs-assessment, or printed copies are available by contacting Kim McBride at 301-754-7149 or mcbrik@holycrosshealth.org.

Organizational Overview

OVERVIEW

Holy Cross Health is a Catholic not-for-profit health system based in Montgomery County, Maryland that has nearly 200,000 patient visits each year. We offer a full range of inpatient, outpatient, and innovative community-based services and are the region's only four-time winner of The Joint Commission's highest quality award. Holy Cross Health has a 1,425 member medical staff, employs 4,200 people, has more than 550 volunteers and is the only healthcare provider in Maryland to receive the Workplace Excellence Seal of Approval Award each year since 1999 from the greater Washington, D.C., Alliance for Workplace Excellence. Holy Cross Health is comprised of Holy Cross Hospital, Holy Cross Germantown Hospital, Holy Cross Health Network and the Holy Cross Health Foundation.

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

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

Holy Cross Germantown Hospital: In October 2014, Holy Cross Health opened Holy Cross Germantown Hospital, the first new hospital in Montgomery County in 35 years. The hospital serves the most rapidly growing region in the county and provides access to high-quality care in an area that had previously been, by far, the largest concentration of people without a hospital in the state. Holy Cross Germantown Hospital has 93 adult licensed beds and a neonatal unit with 17 newborn bassinets and eight special care nursery

bassinets. The hospital offers emergency, medical, surgical, obstetric, neonatal and psychiatric care to meet a full range of community needs. All patient rooms are private to enhance patient safety and satisfaction, as well as patient, family and visitor comfort. The facility features sustainable design elements that achieved Leadership in Energy and Environmental Design (LEED) Gold certification.

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

Beyond our campuses, we provide service at multiple locations, including a vital aging center for seniors. We offer more than 50 different types of health and wellness classes at various locations throughout the region and have established a geographic presence at 24 sites that host our senior exercise program and in 65 churches through our faith community nurse program.

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

Mission Statement

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

HOLY CROSS HEALTH'S TEAM WILL ACHIEVE THIS TRUST THROUGH:

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

CORE VALUES

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

The Community We Serve

DEMOGRAPHICS

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

Race	Primary Service Area (662,996)	Total Service Area (1.8 Million)
White, Non-Hispanic	216,292 (32.6%)	543,353 (30.8%)
Black, Non-Hispanic	175,905 (26.5%)	639,758 (36.3%)
Hispanic	178,868 (27.0%)	343,509 (19.5%)
Asian/Pacific Islander, Non-Hispanic	71,990 (10.9%)	182,549 (10.4%)
All Others	19,941 (3.0%)	53,919 (3.1%)

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

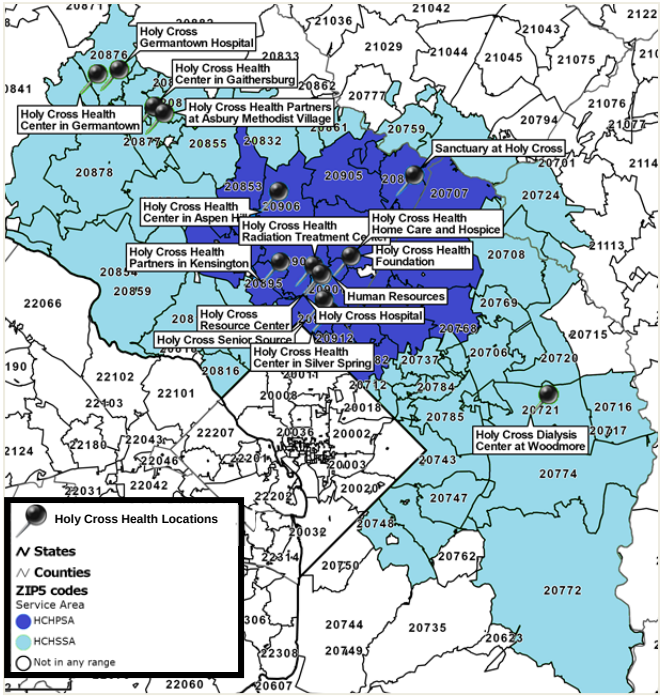

Figure 1: Primary and secondary service area for Holy Cross Hospital

In the early 1990's Prince George's County became a majority-minority county, where the minority population surpasses the white non-Hispanic population, (Fox, 1996). During the last census, Montgomery County joined Prince George's County as one of only 336 "majority-minority" counties in the country (Montgomery County Planning Department, 2011). The foreign-born population of both counties is also higher than the national average. The latest figures from the U.S. Census Bureau show that 32.4% of the population in Montgomery County and 20.7% of the population in Prince George's County are of foreign birth, significantly greater than the state and national rate of 14.2% and 13.0%, respectively (Community Commons, 2016).

THE COMMUNITY WE SERVE

The community within the Holy Cross Hospital service area has a foreign-born rate of 28.7%. Approximately 485,000 persons (57% of the total foreign-born population in Maryland) reside within our primary and secondary service areas, creating one of the most culturally and ethnically diverse in the nation, challenging the hospital, the county health departments, community-based and other organizations to understand and meet their varied needs.

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

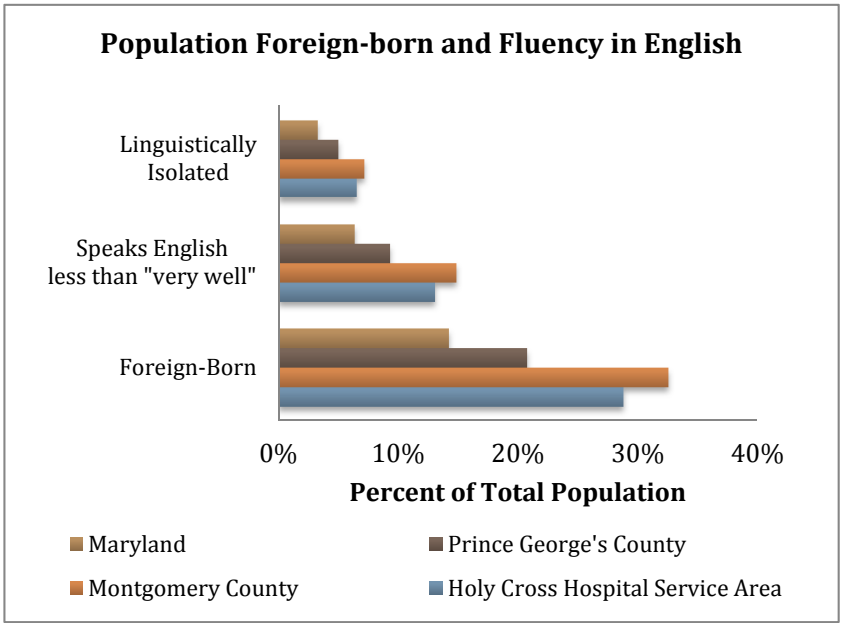

Figure 2: Foreign-born population includes anyone who was not a U.S. citizen or a U.S. national at birth, Maryland Department of Legislative Services, 2013. Source: U.S. Census Bureau.

In Prince George's County, 39% of foreign-born residents speak English less than "very well" (U.S. Census Bureau, 2012) and 4.9% of the population aged five and over is linguistically isolated with the most linguistic isolation occurring in northern Prince George's County (Community Commons, 2016) (see Figure 2).

VOICE OF THE COMMUNITY

Community conversations were held throughout Montgomery County during the spring and summer of 2015. The participants of the community conversations did not address their community health needs in terms of health care or health services but rather in the context of the determinants of health that affect their day to day living, such as:

- Safe places to walk, bicycle, and be physically active

THE COMMUNITY WE SERVE

- Access to healthy, affordable food
- Well-paying jobs
- Affordable housing
- High-quality education
- Crime-free neighborhoods
- Reliable and affordable public transportation, and
- Access to preventive services, health care, and social services

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

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

Health Needs of the Community

IDENTIFICATION OF UNMET COMMUNITY HEALTH NEEDS

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

In 2012, through multi-voting and consensus discussion, the *Healthy Montgomery* Steering Committee, which included representation from a Holy Cross Health executive team member, analyzed available data on more than 100 indicators to determine the following top-ranked priority areas:

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

In addition to selecting the six broad priorities for action, the *Healthy Montgomery* Steering Committee selected three overarching themes: Improve access to health and social services, achieve health equity for all residents, and

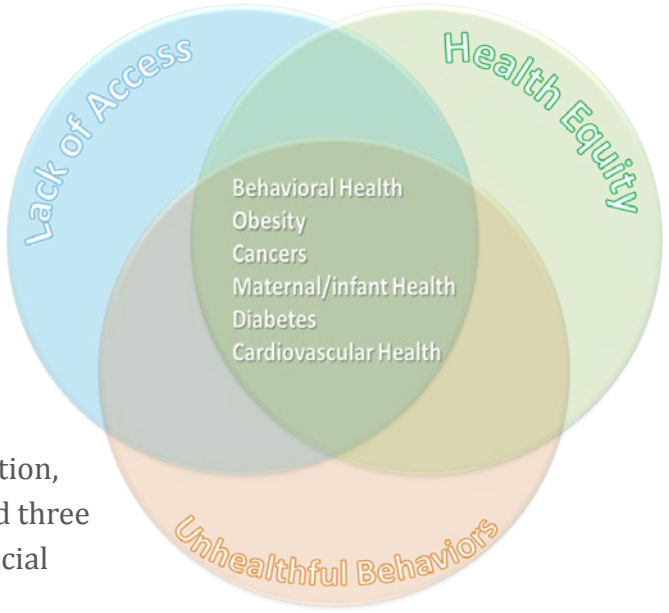

Figure 3: Healthy Montgomery priorities and overarching themes.

enhance the physical and social environment to support optimal health and well-being and reduce unhealthful behaviors (see Figure 3).

In 2016, *Healthy Montgomery* identified 63 strategies to address the existing *Healthy Montgomery* priority issues of obesity, behavioral health, diabetes, cardiovascular disease, cancers, and maternal and infant health. These strategies are identified in their community health needs assessment and were derived from the key findings of the qualitative data (community conversations), quantitative data (review of national and state data sources), community resources (including the hospital systems' activities), and evidence-based strategies. *Healthy Montgomery* Steering Committee members were asked to narrow down the list and identify the top three strategies that they believed should be a priority for *Healthy Montgomery's* 2017-2019 Community Health Improvement Cycle. The following strategies serve as the 2017 – 2019 priority strategies: 1) Establish and sustain a Health in All Policies (HiAP) model within Montgomery County; 2) Offer combined diet and physical activity promotion programs for County residents at increased risk of type 2 diabetes to reduce new-onset diabetes; and 3) Develop integrated care programs to address mental health, substance abuse and other needs within primary care settings.

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

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

PRIORITIZING SIGNIFICANT UNMET NEEDS

With this information, Holy Cross Hospital will address unmet needs within the context of our overall approach, mission commitments and key clinical strengths and within the

overall goals of *Healthy Montgomery*. We are equipped to address each significant priority identified by *Healthy Montgomery* and Holy Cross Health; however, prioritizing the needs will allow us to utilize our resources and expertise to ensure we have the biggest impact on the unmet needs in our community.

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

1. Maternal and Infant Health	• Montgomery County African American/Black infant mortality rate is 8.8 deaths per 1,000 live births • Mothers who received early prenatal care is 67.5%% in Montgomery County and 51.2% in Prince George's County
2. Seniors	• The senior population of both Montgomery and Prince George's Counties is growing more than 4% per year • Falls are a major cause of preventable death amount seniors and have increased across all age groups in the past decade.
3. Diabetes	• Diabetes disproportionately affects minority populations and the elderly • Diabetes can increase the risk of heart disease by 2 to 4 times.
4. Cancers	• The age-adjusted death rate due to breast cancer is 18.8 in Montgomery County and 26.2 in Prince George's County • In Montgomery and Prince George's County, African American/Blacks have the highest lung cancer incidence rates
5. Cardiovascular Health	• In 2012, heart disease was the second leading cause of death in Montgomery County and the first leading cause of death in Prince George's County • In Montgomery and Prince George's County stroke is the third leading cause of death.
6. Obesity	• More than 50% of Montgomery County residents and more than 65% of Prince George's County residents are overweight or obese • Approximately 70% of Montgomery County adults and approximately 68% of Prince George's County adults consume less than five servings of fruits and vegetables each day
7. Behavioral Health	• One in every six adults in Montgomery County and one in five adults in Prince George's County report they are not getting the adequate social and emotional support • Approximately 14% of Montgomery County residents and almost 10% of Prince George's County residents self-reported that they have been diagnosed with a depressive disorder

CHNA Multi-Year Initiatives

OVERVIEW

Holy Cross addresses unmet needs within the context of our overall approach, mission commitments and key clinical strengths, and within the overall goals of *Healthy Montgomery*.

Key findings from all data sources, including data provided by *Healthy Montgomery*, our external review group and hospital available data were reviewed and the most pressing needs were incorporated into our implementation strategy. The community benefit plan reflects Holy Cross Hospital's overall approach to community benefit by targeting the intersection between the identified needs of the community and the key strengths and mission commitments of the organization (see Figure 4) to help build the continuum of care. We have established leadership accountability and an organizational structure for ongoing planning, budgeting, implementation and evaluation of community benefit activities, which are integrated into our multi-year strategic and annual operating planning processes.

Guiding Principles

This multi-year implementation strategy addresses the priority areas and overarching themes by focusing our community benefit activities on the most vulnerable and underserved individuals and families, including women/children, seniors, and racial, ethnic and linguistic minorities. To select outreach priorities for the implementation strategy, Holy Cross Health linked community health care needs to our mission and strategic priorities.

Figure 4: How Holy Cross Health aligns targeted programs with the mission and strengths of the hospital and unmet community needs.

CHNA MULTI-YEAR INITIATIVES

National Objectives

Healthy People 2020 (HP2020) is a national initiative that provides science-based, 10-year national objectives for improving the health of all Americans and establishes bench marks and monitors progress over time in order to:

- Encourage collaborations across communities and sectors.
- Empower individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Holy Cross Health values the vision of HP2020 to create "a society in which all people live long, healthy lives" and has incorporated many of the HP2020 goals and objectives into our multi-year initiatives that address each identified priority.

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

TRANSFORMING COMMUNITY HEALTH

Holy Cross Health's community health programs and services are well positioned to lead in the identification of and response to existing and emerging community health needs in our service area. Currently, the community health division has a plethora of prevention, education, and disease management programs and services such as perinatal education classes, medical adult day care, *Senior Fit*, Faith Community Nurses, and community health workers and navigators. These programs predominately implement downstream interventions, individual-level behavioral approaches for prevention or disease management, that focus on education, awareness, and screenings with over 200,000 encounters among diverse patients and community members annually. Although these programs reach a large number of individuals and have a positive effect on behavior change, many of the direct service programs operate in silos, have limited community engagement with inconsistent transitions across the continuum of care, and have limited impact on building sustainable, healthy communities.

The early signature programs and activities implemented by the Community Health Division, such as *Senior Fit*, Chronic Disease Self-Management, Memory Academy, and Diabetes Prevention Program, to name few, are helpful in promoting health through awareness, education and individual skill development and behavior change. As the Holy

CHNA MULTI-YEAR INITIATIVES

Cross Health system begins to position itself to not only implement downstream interventions but also to include upstream interventions that impact populations, the current programming is not enough to foster healthy environments through population health improvements that will ultimately improve long-term health outcomes. However, these well-established programs successfully lay the foundation that will allow community health to transform its current programs and services to address both downstream and upstream determinants of health and create healthcare solutions. The transformation of community health includes using a strategic health prevention approach to knit together identified needs from the community health needs assessment, Holy Cross Health's mission, strategic priorities and key strengths—which include the three core services of the Holy Cross Health Network.

During fiscal year 2017, the perspective of linking Community Health to other services of the health system guided the Division to embark on a series of retreats and meetings to better define its role and how to best support the health system's priorities through continuity of patient care while developing strategies to create healthy communities. As a result, a Community Health Roadmap (Roadmap) was designed with the three cross-cutting strategies: 1) community-driven, 2) multi-sectoral, and 3) evidence-informed and the following goals:

- To improve the overall health of the community through strategic partnerships, particularly with those addressing social determinants of health,
- To strengthen integration and linkages by wrapping community health programs and services around defined populations, and
- To decrease avoidable hospital utilization.

To be successful, the Roadmap requires effective and sustainable hospital/community partnerships which are also a critical aspect of building a Culture of Health.[2] Building a Culture of Health means creating a society that gives all individuals an equal opportunity to live the healthiest life they can, whatever their ethnic, geographic, racial, socioeconomic or physical circumstances may be.[3] Using a culture of health framework anchors the

[2] Robert Wood Johnson Foundation. (2017). Building a culture of health. Accessed at https://www.cultureofhealth.org/en.html

[3] Health Research & Educational Trust. (2016, August). Creating effective hospital-community partnerships to build a Culture of Health. Chicago, IL: Health Research & Educational Trust. Accessed at www.hpoe.org

CHNA MULTI-YEAR INITIATIVES

Community Health Roadmap to our mission and strategic principles and aligns with the identified community needs and overarching themes from the 2017 Community Health Needs Assessment.

The Roadmap will guide future activities of the community health division for the next three years. It will develop a multi-level, systemic approach to tackle the complex health issues and environments of Holy Cross Health's community benefit service area by addressing medical, behavioral, and structural issues that can help promote health and prevent illness. The Roadmap focuses on downstream and upstream issues affecting the health of the community with a concentrated emphasis on social determinants of health.

Research highlighting the impact of social determinants of health status is compelling and recognizes that producing change requires community engagement, ongoing relationships with nontraditional partners, and resources that include medical, housing, nutrition, social services, education, community development and economic supports.[4] The Roadmap was designed on this premise to achieve long-term, sustained community health status improvement and maps out Community Health's strategy for the next three years.

ACTION PLANS 2017-2020

The following priority grids outline the major activities Holy Cross Hospital will be implementing to address the unmet needs identified in the 2017 Community Health Needs Assessment, which includes activities from the Community Health Roadmap. The first grid summarizes the activities by priority and the overarching themes. The objectives listed for each priority were derived from Healthy People 2020[5]. This document should be considered a living document and will be updated, at a minimum, each year or as emerging needs arise.

[4] Bodenheimer, T. (2013); Moses, K. & Davis, R. (2015); Robert Wood Johnson Foundation. (2012); Prybil, L., Scutchfield, F., Killian, R., Kelly, A., Mays, G., & Carman, A. et al. (2014).

[5] Healthy People 2020 (Internet). Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion [cited 8/1/2017]. Available from: https://www.healthypeople.gov.

Summary of Holy Cross Hospital's Significant Community Benefit Programming in Response to Identified Unmet Health Needs

		Community	Holy Cross Hospital			
Priority		Identified Unmet Needs	Response to Unmet Need through Healthy Montgomery Lenses			Method of Evaluation
			Access	Unhealthful Behaviors	Health Equity	
Population Health	1	Maternal and Infant Health Improve the health and well-being of women, infants, children, and families.	Ob/Gyn Clinic Maternity Partnership (MP) program, HC Health Center Germantown	Maternal Infant and Child Health Education (MICHE) classes, expand perinatal education to include adolescents	MP program, MICHE education outreach, Health Equity and Healthy Behaviors (HEHB) community advisory groups	# of admissions to MP, % MP patients receiving early prenatal care, % low birth weight deliveries, reduction in infant mortality, # encounters, pre/posttest, participant survey, evaluation framework, MP patients linked to HCHC Germantown, # advisory group meetings
	2	Seniors Improve the health, function, and quality of life of older adults.	HC Health Centers Silver Spring, Gaithersburg, Aspen Hill, Germantown; NexusMontgomery (NM) WISH program and Project Access	Medical Adult Day Center, Caregiver Resource Center, Falls Prevention programs, Memory Academy, advanced directives, Senior Source physical activity and social programs	HEHB community advisory groups, Faith Community Nursing (FCN)	# of encounters, # programs offered, pre/posttests, participant surveys, evaluation framework, attendance/completion rate, falls assessments, gait and balance scores, readmission/ED utilization, clinical indicators, MADC daily census, # WISH health surveys completed, # educated on advanced directives, # uninsured referred to specialty care
Disease Management	3	Diabetes Reduce the disease burden of diabetes mellitus.	HC Health Centers Silver Spring, Gaithersburg, Aspen Hill, Germantown; HCHC Care management team; NM Project Access; ED/PC Connect, Pathways Care Coordination (Pathways)	Diabetes Prevention Program (DPP), Diabetes Self-Management Program (DSMP)	DSMP and DPP classes offered in Spanish, community health navigator, HEHB community advisory groups, safety-net clinic referral process for diabetes program, FCN	# of health center visits, clinical measures, readmission/ED utilization, referrals to community health programs and social services, # of encounters, average % weight loss, increase in physical activity, attendance/completion rate, pre/posttest, self-efficacy survey, DPP full recognition status, # safety-net DSMP referrals, # uninsured referred to specialty care, # advisory group meetings, # ED patient referred to health center, # ED patients with kept appointments
	4	Cancers Reduce the number of new cancer cases, as well as illness, disability, and death caused by cancer.	HC Health Centers Silver Spring, Gaithersburg, Aspen Hill, Germantown; Mammogram Assistance Program, ED/PC Connect, Pathways, NM Project Access	HEHB breast education; self-examination	HEHB Cancer outreach, screening and prevention programs, FCN, Transforming Communities Initiative (TCI) tobacco-free living PSE strategies, community health navigator, HEHB community advisory groups	# of encounters, % health center patients eligible for screenings receiving referrals/screenings (tobacco, mammogram, colonoscopy), # of mammograms, # navigated to care and cycle time, # educated on BSE, # of breast cancers found; # enrolled in MD BCCP, cancer education provided by type, referrals to community health programs and social services, # PSE strategies implemented, # community partnerships, # advisory group meetings, # ED patient referred to health center, # ED patients with kept appointments
	5	Cardiovascular Health Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke.	HC Health Centers Silver Spring, Gaithersburg, Aspen Hill, Germantown; HCHC care management team, ED/PC connect, Pathways, NM Project Access	Community Fitness classes, Senior Fit; Chronic Disease Self-Management, Senior Source fitness classes, community-based stroke awareness program	HEHB community-based BP Screenings, HEHB community advisory groups, community health navigator, FCN	clinical measures, readmissions/ED utilization, # referrals to community health programs and social services, # BP screening, stroke program developed, # fitness classes offered, # advisory group meetings, # ED patient referred to health center, # ED patients with kept appointments
	6	Obesity Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights.	HC Health Centers Silver Spring, Gaithersburg, Aspen Hill, Germantown; HCHC care management team, Pathways	*Kids Fit*	HEHB community advisory groups, TCI obesity strategies, FCN, community health navigator	# encounters, # Kids Fit participants, # taking Presidential fitness challenge, semi-annual fitness assessments, # of HCHC patients with high BMI and obesity diagnosis, # referrals to community health programs and social services, # advisory group meetings, # PSE strategies implemented, # community partnerships
	7	Behavioral Health Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.	HC Health Centers Silver Spring, Gaithersburg, Aspen Hill, Germantown behavioral health screening; ED/PC connect; Pathways; NM ACT teams, Crisis House, and behavioral health integration	System-wide opioid plan	HEHB community health navigator and community advisory groups, FCN	# patients screened, #referred to social services and community health programs, # referred to treatment, opioid plan developed, # Crisis House persons served per year, #full capacity ACT teams, Interagency efforts to reduce hospital use by severely mentally ill patients, # connected to primary care/other services, readmissions/ED utilization

Population Health

Priority 1: Maternal and Infant Health (CHNA pg. 44 – 45)

Goal 1: Improve the health and well-being of women, infants, children, and families.

OBJECTIVE 1.1

Increase the proportion of low-income, uninsured pregnant women who receive early and adequate prenatal care.

CHNA IMPACT MEASURES	CHNA BASELINE	TARGET
• Increase percent of mothers receiving early prenatal care	63.1%	66.9%*
• Percent low birth weight infants	8.2%	8.0%*
• Decrease infant mortality rate	5.5	5.5*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
1.1.1 Provide prenatal care to 60% of Montgomery County Maternity Partnership Patients	✘	✘	✘	$265,000	$290,000	Montgomery County DHHS

**Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on number of Maternity Partnership admissions, percent Maternity Partnership patients receiving early prenatal care, and percent low-birth weight deliveries; reduction in infant mortality

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

OBJECTIVE 1.2

Improve the health and well-being of women, infants, children, and families by providing educational and community-based programs and links to primary care and social services.

CHNA IMPACT MEASURES	CHNA BASELINE	HCH STRATEGY TARGET AT END OF YEAR 3
• Increase percent of mothers receiving early prenatal care	63.1%	66.9%*
• Percent low birth weight infants	8.2%	8.0%*
• Decrease infant mortality rate	5.5	5.5*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
1.2.1 Provide perinatal education, baby care programs, and support services to expecting and new families in Montgomery & Prince George's County	✘	✘	✘	$759,000		Montgomery County AAHP, FIMR, Community Action Team, and Interagency Coalition for Adolescent Pregnancy
1.2.2 Expand perinatal education programs to include adolescents		✘	✘			TBD
1.2.4 Develop evaluation framework for perinatal program to identify and measure outcome indicators	✘			Included in department staff hours		

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on number of encounters, pre/posttests, participant surveys, development of evaluation framework

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

Priority 2

Priority 2: Seniors (CHNA pg. 45 – 50)

Goal 2: Improve the health, function, and quality of life of older adults.

OBJECTIVE 2.1

Increase the proportion of older adults, including those with reduced physical or cognitive function, who engage in light, moderate, or vigorous leisure-time physical and/or social activities

CHNA IMPACT MEASURES	CHNA BASELINE	TARGET
• Increase life expectancy	79.2	79.8*
• Decrease fall-related deaths	6.4	7.7*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
2.1.1 Provide physical and social activity programs for seniors aged 55+ through the Holy Cross Senior Source	✘	✘	✘	$569,000	$26,000	Montgomery County HOC and Recreation Department, Maryland Department on Aging
2.1.2 Develop evaluation framework for Senior Source to identify and measure outcome indicators	✘			Included in department staff hours		

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on encounters, # programs offered; pre/posttests, participant surveys, development of evaluation framework

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

OBJECTIVE 2.2

Reduce the rate of falls among older adults

CHNA IMPACT MEASURES	CHNA BASELINE	TARGET
• Increase life expectancy	79.2	79.8*
• Decrease fall-related deaths	6.4	7.7*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
2.2.1 Provide evidence-based falls prevention programs for seniors aged 55+ through the Holy Cross Senior Source	✘	✘	✘	$21,000		Montgomery County HOC and Recreation Department, Maryland Department on Aging

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports for encounters, attendance/completion rate, falls assessments, and gait and balance scores; participant surveys, pre/posttests

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

OBJECTIVE 2.3

Reduce the proportion of noninstitutionalized older adults with disabilities who have an unmet need for long-term services and supports

CHNA IMPACT MEASURES	CHNA BASELINE	HCH STRATEGY TARGET AT END OF YEAR 3
• Increase life expectancy	79.2	79.8*
• Decrease fall-related deaths	6.4	7.7*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
2.3.1 Provide medical, social, rehabilitative and recreational programs for adults with a chronic health problem or are recovering from an acute illness through the Medical Adult Day Center (MADC)	✖	✖	✖	$306,000	$394,000	Montgomery County DHHS, GROWS, Maryland Department on Aging; AAOA, MAADS, Alzheimer's Foundation, Alzheimer's Association, ARC
2.3.2 Provide support services to caregivers caring for loved ones with a chronic health problem or who are recovering from an acute illness through the Care Giver Resource Center	✖	✖	✖	$7,500		Sisters of the Holy Cross, GROWS, Alpha Kappa Alpha Theta Omega Omega Chapter
2.3.3 Provide free, confidential health surveys for seniors with Medicare who live independently in the community to reduce avoidable hospital use by connecting older adults to the services they need through the NexusMontgomery WISH program	✖	✖	✖			HSCRC, Adventist HealthCare, Medstar Montgomery Medical Center, Suburban Hospital
2.3.4 Provide education on MOLST/Advanced Directives	✖	✖	✖	See 2.3.1	See 2.3.1	
2.3.5 Develop evaluation framework for MADC and Care Giver Resources Center to identify and measure outcome indicators	✖			Included in department staff hours		

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports for encounters, readmission rates, ED utilization, and clinical indicators, MADC daily census; participant surveys; # WISH health surveys completed, number educated on advanced directives, development of evaluation framework

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

OBJECTIVE 2.4

Reduce the morbidity and costs associated with, and maintain or enhance the quality of life for, persons with dementia, including Alzheimer's disease.

CHNA IMPACT MEASURES	CHNA BASELINE	HCH STRATEGY TARGET AT END OF YEAR 3
• Increase life expectancy	79.2	79.8*
• Decrease fall-related deaths	6.4	7.7*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
2.4.1 Provide social, rehabilitative, and recreational programs for adults with Alzheimer's disease and other dementia through the Medical Adult Day Center (MADC)	✖	✖	✖	See 2.3.1	See 2.3.1	Montgomery County DHHS, GROWS, Maryland Department on Aging; AAOA, MAADS, Alzheimer's Foundation, Alzheimer's Association, ARC
2.4.2 Provide evidence-based memory programs for seniors aged 55+ through the Holy Cross Senior Source	✖	✖	✖	$7,000		
2.4.3 Maintain MADC's status as a Dementia Care Program of Distinction	✖	✖	✖			Alzheimer's Foundation

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports for encounters, attendance/completion rate, readmission/ED utilization, and clinical indicators, MADC daily census; participant surveys

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

Disease Management

Priority 3: Diabetes (CHNA pg. 38 – 39)

Goal 3: Reduce the disease burden of diabetes mellitus.

OBJECTIVE 3.1

Decrease the number of low-income, uninsured/underinsured persons with uncontrolled diabetes.

CHNA IMPACT MEASURES	CHNA BASELINE	HCH STRATEGY TARGET AT END OF YEAR 3
• Decrease ER visits for diabetes	280.5	186.3*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
3.1.1 Implement care management team at HC Health Centers for high-risk patients	x	x	x	See Overarching Themes		

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on health center visits, clinical measures, readmissions/ED utilization, referrals to community health programs and social services

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

OBJECTIVE 3.2

Increase the self-management skills of adults diagnosed with diabetes and increase prevention behaviors in adults at high risk for diabetes

CHNA IMPACT MEASURES	CHNA BASELINE	HCH STRATEGY TARGET AT END OF YEAR 3
• Decrease number of adults ever told they have diabetes	13.5%	10.2%◊
• Decrease ER visits for diabetes	280.5	186.3*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
3.2.1 Offer Diabetes Prevention Program in English and Spanish	✖	✖	✖	$30,000		
3.2.2 Offer Stanford University's Diabetes Self-Management Program in English and Spanish	✖	✖	✖	$5,000		
3.2.3 Referral process for Montgomery Cares safety-net clinic patients to Diabetes Self-Management classes offered by all health systems in Montgomery County		✖	✖			Montgomery Cares, Adventist Health, Medstar Montgomery, and Suburban

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on encounters, average % weight loss, increase in physical activity, attendance/completion rate, and number of safety-net DSMP referrals, pre/posttests, self-efficacy survey, DPP full recognition status, #referrals made,

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

Priority 4

Priority 4: Cancers (CHNA pg. 29 – 35)

Goal 4: Reduce the number of new cancer cases, as well as illness, disability, and death caused by cancer.

OBJECTIVE 4.1

Increase the number of low-income, uninsured women receiving breast cancer screenings and education on cancer prevention and the importance of early detection.

CHNA IMPACT MEASURES	CHNA BASELINE	TARGET
• Decrease breast cancer mortality	19.8	20.7†

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
4.1.1 Provide community-based breast cancer education	x	x	x		$19,000	Montgomery County DHHS, Komen for the Cure, Maryland Dept. of Health
4.1.2 Provide access to mammogram services for uninsured, underinsured women	x	x	x	$100,000	$60,000	Komen for the Cure, Kevin J. Sexton Fund

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on encounters, percent eligible health center patients receiving referrals, number of mammograms, number navigated to care and cycle time from diagnosis to treatment, number of persons educated on breast self-exams, number of cancers found, number enrolled in state breast and cervical cancer program,

OBJECTIVE 4.2

Provide educational, community-based and clinical programs to reduce the number of cancer cases, as well as illness, disability, and death caused by cancer.

CHNA IMPACT MEASURES	CHNA BASELINE	HCH STRATEGY TARGET AT END OF YEAR 3
• Increase colorectal cancer screening	72.9%	73.0%◊
• Increase percent of women who have had a Pap in past 3 years	83.0%	93.0%◊
• Decrease prostate cancer incidence	159.3	135.0◊
• Decrease breast cancer mortality	19.8	20.7†

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
4.2.1 Provide outreach and education on cancer prevention in Montgomery and Prince George's County through an equitable lens	x	x	x		$20,000	Maryland Dept. of Health
4.2.2 Provide outreach and education on tobacco-free living	x	x	x		$20,000	Montgomery DHHS Cigarette Restitution Fund
4.2.3 Provide HC Health Center referrals and screening for mammograms and colonoscopies, and tobacco cessation referrals and/or counseling to eligible health center patients	x	x	x	See Overarching Themes		

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on encounters, cancer education provided by type, number of referrals made to primary care or other social services, % health center patients eligible for screenings receiving referrals (tobacco, mammogram, colonoscopy)

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

Priority 5

Priority 5: Cardiovascular Health (CHNA pg. 36 – 37)

Goal 5: Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke.

OBJECTIVE 5.1

Decrease the number of low-income, uninsured/underinsured persons with uncontrolled hypertension.

CHNA IMPACT MEASURES	CHNA BASELINE	TARGET
• Decrease heart disease mortality	136.4	166.3*
• Decrease stroke mortality	30.1	34.8†
• Decrease percent of adults told they have high blood pressure	21.6%	26.9%†

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
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STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
5.1.1 Implement care management team at HC Health Centers for high-risk patients	✖	✖	✖	See Overarching Themes		

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on clinical measures, readmissions/ED utilization, number of referrals to community health programs and social services

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

OBJECTIVE 5.2

Provide educational and community-based programs to improve cardiovascular health.

CHNA IMPACT MEASURES	CHNA BASELINE	HCH STRATEGY TARGET AT END OF YEAR 3
• Decrease heart disease mortality	136.4	166.3*
• Decrease stroke mortality	30.1	34.8†
• Decrease percent of adults told they have high blood pressure	21.6%	26.9%†

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
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STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
5.2.1 Provide community-based cardiovascular education and programming through an equitable lens	✘	✘	✘	$8,000	$31,000	Maryland Dept. of Health, Community Ministries of Rockville, Mt. Jezreel Baptist Church
5.2.2 Provide community fitness classes for adults and older adults aged 55+	✘	✘	✘	$245,835 also see Seniors	$20,000	Kaiser Permanente of the Mid-Atlantic States, National Lutheran Communities & Services, Montgomery County Department of Recreation, Maryland National Capital Park and Planning Commission, Faith-Based Organizations and Retirement Communities
5.2.4 Develop community-based stroke awareness program	✘			$2,500		Montgomery County DHHS, MCPS
5.2.5 Offer Stanford University's Chronic Disease Self-Management Program	✘	✘	✘	$5,000		Montgomery County DHHS, Area Agency on Aging

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on encounters, number of blood pressures screenings, stroke program developed, number of fitness classes offered

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

Priority 6

Priority 6: Obesity (CHNA pg. 39 – 40)

Goal 6: Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights.

OBJECTIVE 6.1

Reduce the proportion of children and adolescents who are considered obese.

CHNA IMPACT MEASURES	CHNA BASELINE	HCH STRATEGY TARGET AT END OF YEAR 3
• Decrease percent students with no physical activity	23.2%	18.0%Δ
• Decrease percent of students who are obese	13.7%	10.7%*
• Increase percent of students who drank no soda in past week	28.0%	28.4% Δ

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
6.1.1 Kids Fit – physical activity program for adolescents	✖	✖	✖	$8,000		Montgomery County HOC

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on encounters, number of Kids Fit participants, number Kids Fit participants taking Presidential Fitness Challenge, semi-annual fitness assessments

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

OBJECTIVE 6.2

Increase the proportion of primary care physicians who regularly assess body mass index (BMI) in their adult patients

CHNA IMPACT MEASURES	CHNA BASELINE	HCH STRATEGY TARGET AT END OF YEAR 3
• Adults who are overweight or obese	55.2%	64.3%*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
6.1.1 BMI assessment and diagnosis of obesity for health center patients	✖	✖	✖	See overarching Themes		Montgomery Cares

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on percent patients with high BMI diagnosed as obese

Priority 7

Priority 7: Behavioral Health (CHNA pg.40 – 43)

Goal 7: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.

OBJECTIVE 7.1

Increase access to appropriate, quality mental health services.

CHNA IMPACT MEASURES	CHNA BASELINE	TARGET
• Decrease illicit drug use	6.1%	9.7%†
• Decrease percent of adults with any mental illness	16.8%	16.8%Δ
• Decrease mental health related ER visits	1,528	3,153*
• Decrease suicide rate	6.5	9.0*

* MD SHIP Target
† HP 2020 Target
Δ Median or mean value for all counties in the state
◊ Represents the top 50th percentile of all MD counties

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
7.1.1 Behavioral Health screenings with links to treatment at all health centers	✖	✖	✖	See Overarching Themes		Montgomery Cares
7.1.2 Create Health System-wide plan to address opioid abuse	✖					Maryland Dept. of Health, Montgomery County DHHS, Trinity Health, Healthy Montgomery
7.1.2 Provide behavioral health services and links to treatment through the NexusMontgomery Crisis House, ACT Teams, and behavioral health Integration	✖	✖	✖			HSCRC, Adventist HealthCare, Medstar Montgomery Medical Center, Suburban Hospital

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports number behavioral health screenings conducted, ; #referred to social services and community health programs, # referred to treatment, development of opioid abuse plan; number of persons served by Crisis House, number of full capacity ACT Teams; Interagency efforts to reduce hospital use by severely mentally ill patients, readmissions/ED utilization

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

Overarching Themes

Themes (CHNA pg. 52):

1. Improve access to health and social services

2. Achieve health equity for all residents, and

3. Enhance the physical and social environment to support optimal health and well-being and reduce unhealthful behaviors

OBJECTIVE T.1

Improve access to health and social services.

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
T.1.1 Operate four health centers for the un/underinsured in geographically accessible locations	x	x	x	$2.5M	2.4M	Montgomery Cares, Medstar Montgomery, Trinity Health, Maryland Dept. of Health
T.1.2 Add Community Health Navigator to Care Management Team to address social determinants of health for health center patients	x	x	x	$35,000		
T.1.2 Use Pathways Care Coordination software to coordinate care and link patients and community members to social services	x	x	x		$25,000	Kevin J. Sexton Fund
1.2.4 Implement plan to link uninsured Maternity Partnership patients to primary care services at HC Health Centers to create a medical home for the whole family		x	x			Maternity Partnership, Montgomery Cares

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Quarterly reports on encounters, patient visits, clinical measures, number of patients/community members with Pathways Care Coordination plans, number of patients navigated by Community Health Navigator, number of maternity partnership patients linked to Germantown health center

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action

OBJECTIVE T.2

Achieve health equity for all residents.

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
T.2.1 Restructure Community and Minority Outreach department and develop/implement strategies to advance Health Equity and Healthy Behaviors	x	x	x	$210,000		
T.2.2 Assess community partnership and identify and address gaps in non-traditional partners—such as organizations addressing social determinants of health	x	x	x	$10,000		TBD grassroots organizations, grasstops, and community-based organizations
T.2.3 Create informal community advisory groups to engage and lead ongoing community conversations to identify needs and develop solutions.	x	x	x	$10,000		HCH Foundation, TBD grassroots organizations, community-based organizations, and community activists
T.2.4 Continue Faith Community Nursing program and begin expansion and diversification of denominations among the FCN partnership to continue to connect all populations within the communities to a broad array of resources and services	x	x	x	$255,000		Faith Communities in Montgomery and Prince George's County

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Partnership assessment, number of partnerships to support gaps, number of informal advisory groups created , number of community conversations, denominations of Faith Community Nursing partnerships, strategies developed to advance health equity and healthy behaviors; number health equity and healthy behavior strategies implemented

OBJECTIVE T.3

Enhance the physical and social environment to support optimal health and well-being and reduce unhealthful behaviors.

STRATEGIES	TIMELINE			COMMITTED RESOURCES*		POTENTIAL PARTNERS
	Y1	Y2	Y3	HCH	Other Sources	
4.2.3 Transforming Communities Initiative – Policy, System, and Environmental strategies to promote tobacco-free living and decrease obesity; especially childhood obesity	x	x	x	$10,000	$225,000	Trinity Health, Institute for Public Health Innovation, Healthy Montgomery

*Committed resources for year one; other sources are from grants and/or fees

Monitoring/evaluation approaches:

Number of PSE strategies implemented, number of community partnerships, quarterly progress reports

Table adapted from Purrelli Swenson, R. (2017). *Beyond compliance: Maximizing investment in community benefit implementation strategy.* Health Resources in Action