HOLY CROSS HOSPITAL

Community Health Needs Assessment Implementation Strategy
Fiscal Years 2020 – 2022
Year Three

CONTENTS

Holy Cross Hospital completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors on October 17, 2019. Consistent with Holy Cross Health's mission, for more than 20 years, we have developed CHNAs and implementation plans to respond to identified needs. In 2010, Holy Cross Hospital enhanced the CHNA process in adherence with applicable federal requirements for not-for-profit hospitals set forth in the Affordable Care Act (ACA) and by the Internal Revenue Service (IRS). The assessment took into account a comprehensive review of secondary data analysis of patient outcomes, community health status, and social determinants of health, as well as primary data collection including input from representatives of the community, community members, and various community organizations.

The complete CHNA report is available electronically at http://www.holycrosshealth.org/community-health-needs-assessment, or printed copies are available by contacting Monika Driver at 301-754-8406 or driverm@holycrosshealth.org.

ORGANIZATIONAL OVERVIEW

Overview

Holy Cross Health is a Catholic, not-for-profit health system that serves more than 240,000 patient visits each year with the promise to make health, and the best possible quality of life, more achievable. Holy Cross Health's high-quality care is accessible to community members in Maryland's Montgomery and Prince George's counties through two hospitals, 10 primary and specialized care centers, home care and hospice services, and a wide range of community health programs. Our team of 4,100 colleagues, 1,575 community and hospital-based physicians, and more than 400 volunteers works proactively to meet the needs of every individual we serve.

We are a people-centered health system that aims to improve the health and lives of individuals, populations and communities, through episodic health care management, population health management, and community-health and well-being initiatives. Holy Cross Health delivers services where, when and how people need us most, with a focus on clinical excellence, innovation and positive experiences that advance individual and community health.

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.

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.

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, 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.

Mission and Core Values

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
- Safety: We embrace a culture that prevents harm and nurtures a healing, safe environment for all
- 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 19 ZIP code primary service area includes 663,447 people, and an estimated 1.76 million people in 65 ZIP codes make up our total service area. 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.

The median age of the county is 39 years, up from 33.9 years in 1990. This increase in median age is driven mostly by the aging of the large population of baby boomers residing in the area. In 1990, the county's residents over the age of 65 accounted for only 10% of the population (77,500 residents). It is expected, by 2030, that the baby boomers will increase the county's 65+ population to 19% of the total population (218,000 residents) (see Figure 2). In addition to an aging population, Holy Cross Hospital serves a highly diverse community. No racial or ethnic group accounts for more than one-third of residents (see Table 1). The county is also becoming more diverse. In 2016, 56% of county residents were people of color; Hispanics were the fastest growing subgroup followed by the Asian population. From 1990 to 2016, the Hispanic population grew 258% and accounts for 19.1% of the total population and the Asian population grew 153% and accounts from 14.8% of the total population.

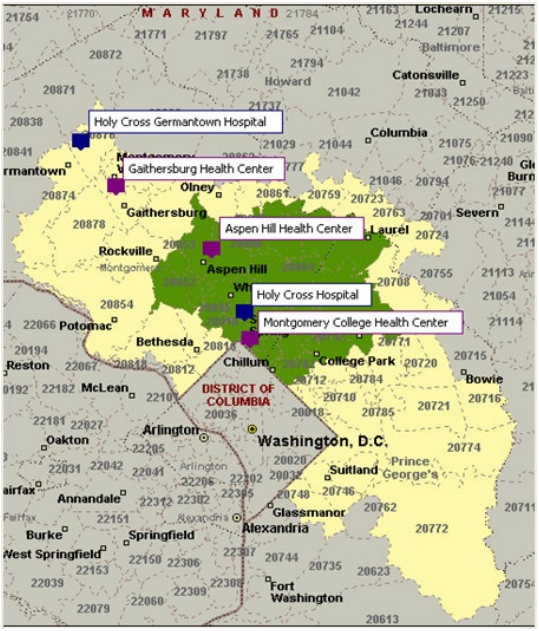

Figure 1: Primary and secondary service area for Holy Cross Hospital.

Table 1: Demographic breakdown of Holy Cross Hospital's service area by race and ethnicity. © 2016 The Nielsen Company, ©2019 Truven Health Analytics Inc.

Race	Primary Service Area (663,447)	Total Service Area (1.76 Million)
White, Non-Hispanic	206,912 (31.2%)	512,881 (29.0%)
Black, Non-Hispanic	177, 210 (26.7%)	643,288 (36.4%)
Hispanic	185,152 (27.9%)	364,933 (20.6%)
Asian/Pacific Islander, Non-Hispanic	74,041 (11.2%)	190,563 (10.8%)
All Others	20,132 (3.0%)	55,747 (3.2%)

The community we serve has the highest percentage of foreign-born residents (29.3%) in the state of Maryland, and the majority of the total foreign-born population in Maryland reside within Montgomery County. In Montgomery County, 32.6% of residents are foreign-born, 40% of foreign-born residents speak English less than "very well" and 7.0% aged five and over are linguistically isolated. In Prince George's County, more than 21% of residents are foreign-born of which 39% speak English less than "very well" and 4.9% of the population aged five and over are linguistically isolated with the most linguistic isolation occurring in northern Prince George's County. The highest

rates of linguistic isolation for both Montgomery and Prince George's Counties are among Latino Americans and Asian Americans.

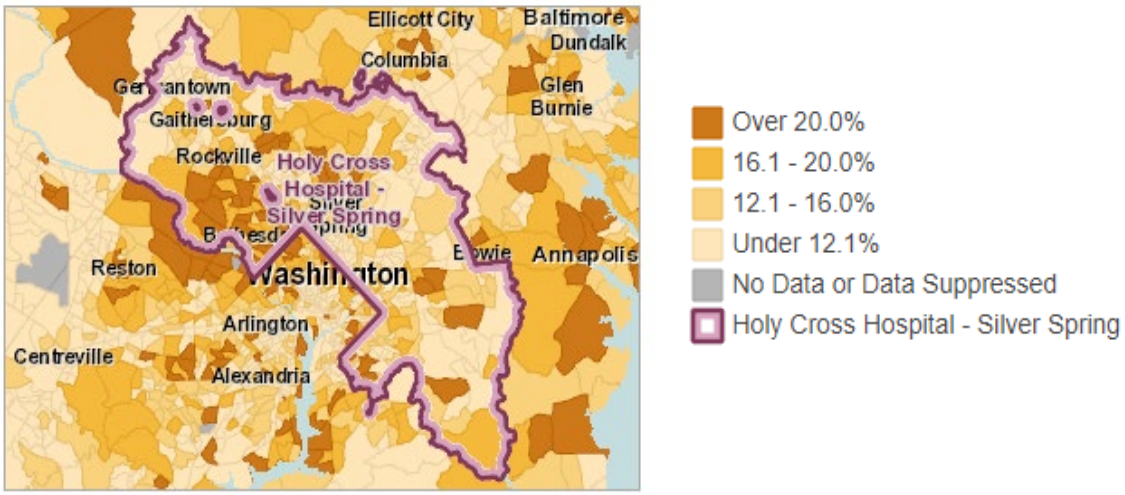

Figure 3: Percentage of population aged 65+. Source: Trinity Health Data Hub, 2019.

Community Conversations

Holy Cross Health gathered information from residents of the communities we serve during the spring and summer of 2019. Information was gathered through three different formats, *Chat and Chews*, surveys, and *Community Conversations*.

All formats focused on the topic "Health Matters" and received feedback from a racially, ethnically, and linguistically diverse group of community residents (see Figure 3) throughout Montgomery County. The conversations and surveys had two goals:

1. To learn from local residents what makes a community healthy
2. To enlist community members to join the Holy Cross Health Advisory Committee.

These goals were achieved by asking questions that pertained to access to care, barriers to

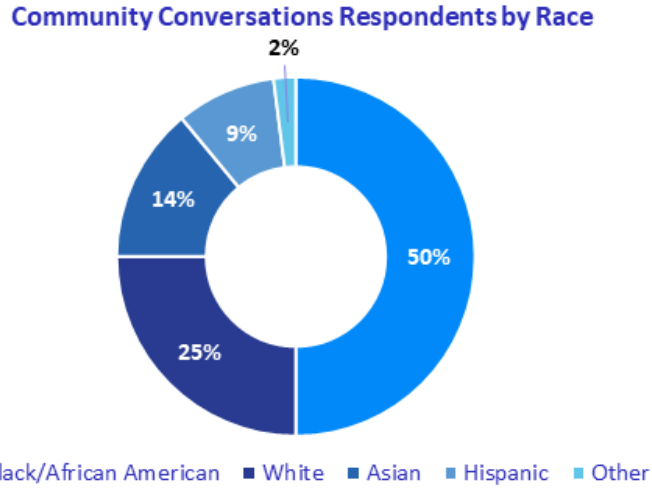

Figure 4: Racial and ethnic percentage of 2019 community conversation participants.

achieving or maintaining good health, and what was needed to achieve or maintain good health.

Most responded that they were able to access medical care when needed (94%). However, challenges mentioned included lack of affordable medication, lack of access to healthy food, and lack of transportation. When the community was asked what was needed to achieve or maintain good health the top summarized responses were help with diet, nutrition, and food assistance (34%). Participants expressed interest in free classes about healthy eating and nutrition, support with finding affordable healthy groceries, grocery coupons, and a general interest in receiving support to eat healthier. There was also a strong interest in opportunities for exercise and fitness (24%). Participants expressed interest in free or low-cost group exercise classes held during evening hours, support for a gym membership, and more accessible exercise spaces. There was also a strong interest in more senior classes and a continuation of existing Holy Cross Health Senior Fit classes.

In addition to an interest in exercise and nutrition classes, there was also interest expressed for community programming (13.4%). Participants expressed interest in health seminars, support groups, classes explaining what resources are available, and evening senior classes.

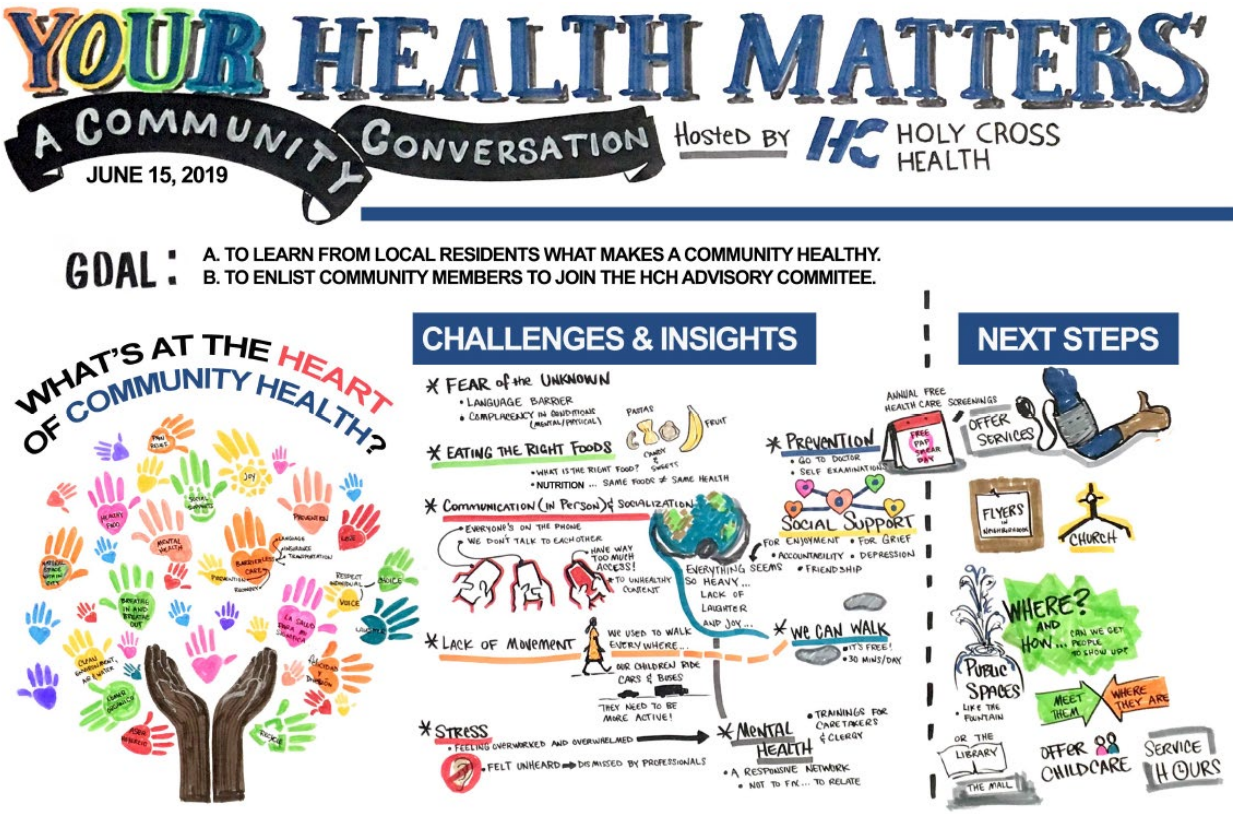

Figure 5: Graphic representation of community conversations and surveys. Participants shared concerns that related to influencers of health, such as movement and exercise, healthy eating/food access, stress, mental health and the need for social connectedness.

HEALTH NEEDS OF THE COMMUNITY

Holy Cross Health has been conducting needs assessments for almost 20 years and identifies unmet community health care needs 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 conducted by Holy Cross Health and community conversations conducted by *Healthy Montgomery* 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 needs in various populations. We also use the Community Need Index to geographically identify high need communities that would benefit from our 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.

Unmet Need

Holy Cross Health used the information from the community health needs assessment and other sources to identify three priority areas: Social Determinants/Influencers of Health, Vulnerable Populations, and Chronic Diseases. Building upon the *Healthy Montgomery* top-ranked priorities and available data, Holy Cross Health identified subcategories for each priority and ranked the priorities and subcategories based on severity, feasibility, potential to achieve outcomes and prevalence in the population. The following prioritized list of the significant unmet needs identified and their subcategories were developed using scores from each of the categories listed above:

1. Social Determinants/Influencers of Health
    a. Housing
    b. Food Insecurity
    c. Access to Care
2. Vulnerable Populations
    a. Senior Population
    b. Maternal/Infant Population
3. Chronic Diseases
    a. Diabetes
    b. Cancers
    c. Cardiovascular Health
    d. Obesity
    e. Behavioral Health

Vulnerable Populations	• **Maternal and Infant Health**	• Montgomery County African American/Black infant mortality rate is 8.3 deaths per 1,000 live births; the rate is 12.0 per 1,000 live births in Prince George's County. • Mothers who received early prenatal care is 70.9% in Montgomery County and 59% in Prince George's County
	• **Seniors**	• The senior population of Montgomery County is expected to increase to 20% of the total population by 2040; Prince George's County's senior population is anticipated to increase to 18% by 2040 • Both Montgomery and Prince George's Counties seniors have influenza and pneumonia vaccine rates below the targeted 90% for this population.
Chronic Disease	• **Diabetes**	• Diabetes disproportionately affects minority populations and the elderly • In Montgomery County, 8.9% of residents have been informed they are pre-diabetic, compared to 12.4% of Prince George's County residents. • In Montgomery County, African American/Blacks are nearly five times more likely to visit the emergency department for diabetes-related complications and three times more likely in Prince George's County compared to their White counterparts.
	• **Cancers**	• Cancer is the leading cause of death in Montgomery County. It is the second leading cause of death in Prince George's County and the US. • In both Montgomery and Prince George's County, the percent of women over 50 who have received a mammogram in the past two years declined sharply from nearly 80% in 2014 to under 65% in 2016.
	• **Cardiovascular Health**	• In 2017, 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, which can be caused by cerebrovascular disease, is the third leading cause of death.
	• **Obesity**	• Almost than 60% of Montgomery County residents and more than 70% of Prince George's County residents are overweight or obese • Approximately 30% of Montgomery and Prince George's County adults consume fruits and vegetables five or more times each day
	• **Behavioral Health**	• In Montgomery County, men are four times more likely to die from suicide than women and five times more likely in Prince George's County. • Fourteen percent of Montgomery County residents and nearly 10% of Prince George's County residents self-reported that they have been diagnosed with a depressive disorder • Both Montgomery and Prince George's Counties are experiencing an increase in heroin deaths over prescription opioid deaths, due to their lower cost.
SIOH	• **Food Insecurity**	• Montgomery County's food insecurity rate has dropped from 7.0% in 2014 to 5.9% in 2016; Prince George's County's rate has dropped from 15.5% in 2014 to 14.0% in 2016.
	• **Housing**	• On average, 49.1% of renters in Montgomery County and 52.7% of renters in Prince George's County spend more than 30% of their income on rent • Montgomery County reported the highest percentage reduction, 41% in its literally homeless count from 2015 to 2019 and Prince George's County had a 29% reduction
	• **Access to Health Care**	• In Montgomery and Prince George's Counties, Hispanics followed by African Americans have the highest number of uninsured residents • Despite the high numbers of primary care physicians available in Montgomery County, 10.4% of the population is unable to afford to see a doctor

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 CHNA Implementation Strategy reflects Holy Cross Hospital'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 the organization (see Figure 5) 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 health activities, which are integrated into our multi-year strategic and annual operating planning processes.

Figure 6: How Holy Cross Health aligns targeted programs with the mission and strengths of the hospital and unmet community needs.

Guiding Principles

This multi-year implementation strategy addresses the priority areas and overarching themes by focusing our community benefit activities on populations experiencing vulnerability and under resourced 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.

Strategic Plan

The vision of our People-Centered Strategy for Success, fiscal years 2019-2022, is to be a forward-thinking health system with the knowledge and resources to help people address their needs and goals in order to achieve a better quality of life. To achieve this we are guided by six strategic principles:

People-Centered Care: Providing innovative patient care, excellent care delivery and improved clinical outcomes

Engaged Colleagues: Attracting, developing and retaining exceptional and committed colleagues

Operational Excellence: Ensuring efficient and effective care delivery

Physician Collaboration: Engaging physicians for mutual benefit in activities that attract patients and better manage care

Leadership Nationally & Locally: Improving the health and well-being of our community through innovation and expanding expertise

Effective Stewardship: Stewarding our resources to best manage revenue and expenses

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, establishes benchmarks, 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 needs in our service area. To address the unmet needs, Holy Cross Health will focus on addressing downstream issues through prevention, education, and disease management programs and upstream issues through policy, system and environmental change strategies.

Holy Cross Health, in alignment with our mission and vision, strives to optimize wellness and equity and eliminate disparities in our communities. This is accomplished by addressing an individual's social needs as well as improving community conditions. Holy Cross Health's community health and well-being strategy to address unmet community need encompasses three key focus areas:

Clinical Care: Delivery of efficient and effective people-centered health care services for the uninsured/Medicaid population that is focused on reducing clinical quality outcome disparities and addressing the social needs of patients;

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

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

Action Plans 2020-2022

The following pages outline the major activities Holy Cross Hospital will be implementing to address the unmet needs identified in the 2020 Community Health Needs Assessment. The first table summarizes the activities by priority and key focus area and the following pages go into more detail about the specific interventions or initiatives that we will undertake to address the unmet needs identified. The objectives listed for each priority were derived from Healthy People 2020[1]. This document should be considered a living document and will be updated, at a minimum, each year or as emerging needs arise.

[1] 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.

Community		Holy Cross Hospital			
Identified Unmet Needs		Response to Unmet Need			Method of Evaluation
		Clinical Care	Community Engagement	Community Transformation	
1. Populations experiencing vulnerability	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	Health Family classes, expand to include adolescents and address maternal morbidity/mortality	MP program, Healthy Family outreach, Community Engagement 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
	Seniors Improve the health, function, and quality of life of older adults.	HC Health Centers Silver Spring, Gaithersburg, Aspen Hill, Germantown; Medical Adult Day Center	Caregiver Resource Center, Falls Prevention programs, Memory Academy, advanced directives, senior focused physical activity and social programs; Faith Community Nursing (FCN)	Community Engagement community advisory groups, Elizabeth Square	# 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, # educated on advanced directives, # uninsured referred to specialty care
2. Chronic Diseases	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, Care Coordination	Nexus Montgomery Regional Partnership, Diabetes Prevention Program (DPP) and Diabetes Support and Education, Diabetes Self-Management Program (DSMP); Diabetes Survival Skills, FCN, Equitable Wellness Initiative	DSMP, DPP and Diabetes Survival Skills classes offered in Spanish, community health navigator, Community Engagement community advisory groups, safety- net clinic referral process for diabetes program	# 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
	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; Specialty Care Referrals, ED/PC Connect, Care Coordination, NM Project Access	Smoking cessation, cancer education	CHW Cancer outreach, screening and prevention programs, community health navigator, Community Engagement 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, # community partnerships, # advisory group meetings, # ED patient referred to health center, # ED patients with kept appointments
	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, Care Coordination, NM Project Access	Community Fitness classes, Senior Fit; Chronic Disease Self-Management, fitness classes, community-based stroke awareness program, FCN	Community Engagement community advisory groups, community health navigator	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

	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, Care Coordination	*Kids Fit, Cook It Up*	Community Engagement community advisory groups, TCI obesity strategies, community health navigator	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
	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; Care Coordination; and behavioral health integration	Chronic pain management program, behavioral health awareness and education, first aid for mental health	Community health navigator and community advisory groups	# 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
	Develop programs and initiatives to address emerging trends not identified in the current CHNA.	HC Health Centers Silver Spring, Gaithersburg, Aspen Hill, Germantown; ED/PC connect; Care Coordination, Covid-19 Vaccination Clinics	Equitable Wellness Initiative for Covid-19 long haulers, Covid-19 support groups	Community conversations, community advisory groups	# telehealth visits, # virtual encounters, # of support groups held, # of encounters, pre-post surveys, Quarterly reports on encounters, attendance/completion rate, number of referrals, pre/posttests, self-efficacy survey, Number vaccinated, number of encounters, number of vaccination events in target areas
3. SDOH/SIOH	Food Insecurity – Reduce household food insecurity and in doing so reduce hunger	KJS Fund, social work program	SIOH Plan, Pathways to Independent Employment, community health workers, food literacy programs, greenhouse/garden plots	Montgomery County Food Security Plan, Living Wage	# patients screened, #receiving food subsidies, SIOH plan development, #PIE participants, #food security plans completed, percent of garden/greenhouse plots reserved, self-efficacy surveys
	Housing – Decrease the proportion of households experiencing housing cost burden	KJS Fund, social work program	Pathways to Independent Employment, Advocacy	Coalition on Homelessness, Living Wage, Elizabeth House, Montgomery Housing Partnership	#rent subsidies, coalition on homelessness membership, #PIE participants, entry level salaries
	Access to Health Care – Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines	HC Health Centers Silver Spring, Gaithersburg, Aspen Hill, Germantown	Pathways to Independent Employment, Faith Community Nurse Program, community health workers	340b Plan Advocacy, Living Wage	#patients, #PIE participants, advocacy efforts, #FCN programs, entry level salaries

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 1: Populations Experiencing Vulnerability

Population Health							
Priority 1a: Maternal/Infant Populations (CHNA pg. 56-59)							
Goal 1: Improve the health and well-being of women, infants, children, and families.							
CHNA Impact						**CHNA Baseline**	**Target**	**Actual**
Increase percent of mothers receiving early prenatal care						63.1%	66.9%*	70.9%
Percent low birth weight infants						8.2%	8.0%*	7.5%
Decrease infant mortality rate						5.5	5.5*	4.6
Objective 1.1	Increase the proportion of low-income, uninsured pregnant women who receive early and adequate prenatal care.							
Key Actions	**Timeframe**			**Measures**	**Existing and Potential Partners**	**Budgeted Resources (FY22)**	**Status**	
	Year 1	**Year 2**	**Year 3**					
1.1.1 Provide prenatal care to 60% of Montgomery County Maternity Partnership Patients	✘	✘	✘	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; CHW encounters	HCH Lead: Holy Cross Maternity Existing/Potential Partners: Montgomery County DHHS Maternity Partnership	$265,000 (HCH) $290,000 (other sources)	**Year One:** There were 879 new admissions, with 19 babies delivered with a low birth weight (<2500 gms) rate of 1.9%. **Year Two:** There were 1168 new admissions, with 25 babies delivered with a low birth weight (<2500 gms) rate of 2.71%.	
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.							
Key Actions	**Timeframe**			**Measures**	**Existing and Potential Partners**	**Budgeted Resources (FY22)**	**Status**	
	Year 1	**Year 2**	**Year 3**					
1.2.1 Provide perinatal education, baby care programs, and support services to expecting and new families in Montgomery & Prince George's County	✘	✘	✘	Quarterly reports on number of encounters, pre/posttests, participant surveys	HCH Lead: Healthy Families Existing/Potential Partners: Montgomery County AAHP, FIMR, Community Action Team, and Interagency Montgomery County Interagency Coalition on Adolescent Pregnancy	$255,000 (HCH) $105,000 (other sources)	**Year One:** Provided education, baby care programs, and support services with 4,821 encounters **Year Two:** Provided education, baby care programs, and support services virtually with 2,207 encounters	

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

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 1: Populations Experiencing Vulnerability

1.2.2 Provide Early Care and Education Program to decrease costs to government; increase educational achievement (and therefore greater earning power); and increase opportunity in adulthood		✘	✘	Quarterly reports on number of encounters, pre/posttests, participant surveys	HCH Lead: Healthy Families Existing/Potential Partners: Montgomery College, Identity, Inc. Sheppard Pratt, Parents Educating Parents, Thriving Germantown	$28,000 (HCH)	**Year One:** Piloted one program on the campus of Holy Cross Germantown Hospital in partnership with Thriving Germantown and Sheppard Pratt (formerly Family Services, Inc.). Eighteen participants completed the program and obtained CPR certification. The second pilot was in partnership with Identity, Inc. and PEP and slated to begin in April of 2020. It was cancelled due to the pandemic. **Year Two:** Reassessed program based on feedback from first pilot cohort, increased partnerships and redesigned the program to increase focus on social and emotional learning, safety and development. Partnered with Montgomery College to increase economic development opportunities by designing the program to create a pathway for unlicensed childcare providers who wanted to obtain a license but faced multiple barriers.
1.2.3 Expand evidence-based/informed programs to include adolescents	✘		✘	Quarterly reports on number of encounters, pre/posttests, participant surveys	HCH Lead: Healthy Families Existing/Potential Partners: Montgomery County Housing Partnership, Boys and Girls Club, Kingdom Fellowship AME	$5,000 (HCH)	**Year One:** Increased offerings of Girl Talk and Safe Sitter moving programs into the community. All programs paused in March due to the Covid-19 pandemic **Year Two:** Safe Sitter had one virtual session in March 2021 with 4 registered. We have two more virtual sessions scheduled in September and December of 2021. The in-person class was one 6-hour day with a break for lunch. The first virtual session was three 2-hour sessions. For September and December we are going to do two 3-hour sessions and see which works better.
1.2.4 Increase the number of programs focusing on healthy birth outcomes for women of color (morbidity and mortality)		✘	✘	Quarterly reports on number of encounters, pre/posttests, participant surveys	HCH Lead: Healthy Families Existing/Potential Partners: Montgomery County AAHP, FIMR, Community Action Team, and Interagency Montgomery County Interagency Coalition on Adolescent Pregnancy	$6,000 (HCH)	**Year One:** No report **Year Two:** Develop evidence-informed program focusing on African American/Black and Latinx pregnant women diagnosed or at-risk for gestational diabetes and pre-eclampsia
1.2.5 Develop evaluation framework for perinatal education programs to identify and measure outcome indicators	✘			Development of evaluation framework	HCH Lead: Community Health		**Year One:** Community Health Evaluation Framework developed and implemented

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

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 1: Populations Experiencing Vulnerability

Priority 1b: Senior Populations (CHNA pg. 59-63)							
Goal 2: Improve the health, function, and quality of life of older adults.							
CHNA Impact						**CHNA Baseline**	**Target**	**Actual**
Increase life expectancy						79.2	79.8*	84.8
Decrease fall-related deaths						6.4	7.7*	7.3
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.							
Key Actions	**Timeframe**			**Measures**	**Existing and Potential Partners**	**Budgeted Resources (FY22)**	**Status**	
	Year 1	**Year 2**	**Year 3**					
2.1.1 Provide physical and social activity programs for seniors aged 55+	✕	✕	✕	Quarterly reports on encounters, # programs offered; pre/posttests, participant surveys	HCH Lead: Community Engagement Existing/Potential Partners: Montgomery County HOC and Recreation Department, Maryland Department on Aging	$122,000 (HCH) $25,000 (other sources)	**Year One:** Provided physical and social activity programs ranging from contemporary discussions to Zumba gold with more than 12,000 encounters. **Year Two:** Provided physical and social activity programs virtually ranging from contemporary discussions to Zumba gold with more than 9,000 encounters.	
2.1.2 Partner with organizations and community centers to offer more senior-based services in the community	✕		✕	Number of organizations, number of events held at community sites, quarterly reports on encounters, # programs offered; pre/posttests, participant surveys	HCH Lead: Community Engagement Existing/Potential Partners: Montgomery County HOC and Recreation Department, Sunrise Assisted Living, Montgomery County Villages, NLCS	$10,000 (HCH) $5,000 (other sources)	**Year 1:** Expanded partnerships to include the Maryland Youth Ballet, began discussions with MC Department of Recreation to grow existing partnership (paused due to Covid-19) **Year Two:** No Report	
Objective 2.21	Reduce the rate of falls among older adults.							
Key Actions	**Timeframe**			**Measures**	**Existing and Potential Partners**	**Budgeted Resources (FY22)**	**Status**	
	Year 1	**Year 2**	**Year 3**					
2.2.1 Provide evidence-based falls prevention programs for seniors aged 55+	✕		✕	Quarterly reports on encounters, # programs offered; pre/posttests, participant surveys	HCH Lead: Evidence-Based Programs and Initiatives Existing/Potential Partners: Montgomery County HOC and Recreation Department, Maryland Department on Aging	$13,000 (HCH) $3,000 (other sources)	**Year One:** Provided balance programs and activities ranging from in person classes to balance/falls screenings with 533 encounters **Year Two**: No report due to Covid-19	

* MD SHIP Target Δ Median or mean value for all counties in the state

† HP 2020 Target ◊ Represents the top 50th percentile of all MD counties

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 1: Populations Experiencing Vulnerability

Objective 2.3	Reduce the proportion of noninstitutionalized older adults with disabilities who have an unmet need for long-term services and supports.						
Key Actions	**Timeframe**			**Measures**	**Existing and Potential Partners**	**Budgeted Resources (FY22)**	**Status**
	Year 1	**Year 2**	**Year 3**				
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)	✘		✘	Quarterly reports for encounters, readmission rates, ED utilization, and clinical indicators, MADC daily census; participant surveys,	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	$306,000 (HCH) $394,000 (other sources)	**Year One:** Provided physical and social activity programs ranging from contemporary discussions to Zumba gold with more than 12,000 encounters. **Year Two:** MADC was closed to face to face services nearly all of FY 21 (participants returned in person late June 2021). We maintained contact with participants and families as well calling all participants every day -and documenting those interactions. July 2020 to November 2020 participants were called 7 days a week. November 2020 to June 2021, calls were made 5 days a week. Total encounters were 10,276
2.3.2 Provide education on MOLST/Advanced Directives	✘		✘	Number educated on advanced directives	HCH Lead: Healthy Communities Existing/Potential Partners: Montgomery County DHHS, GROWS, Maryland Department on Aging	See Key Action 2.3.1	**Year One:** Provided education to all MADC participants and caregivers regarding MOLST and Advanced Directives **Year Two:** No report due to Covid-19 Pandemic

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 1: Populations Experiencing Vulnerability

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.						
Key Actions	**Timeframe**			**Measures**	**Existing and Potential Partners**	**Budgeted Resources (FY22)**	**Status**
	Year 1	**Year 2**	**Year 3**				
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)	✘		✘	Quarterly reports for encounters, attendance/completion rate, readmission/ED utilization, and clinical indicators, MADC daily census; participant surveys	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	See Key Action 2.3.1	**Year One:** No Update **Year Two:** Provided resources for online and virtual activities for participants and caregivers and provided a weekly "social hour" to participants. Caregiver support groups continued through out the year virtually.
2.4.2 Provide evidence-based memory programs for seniors aged 55+	✘	✘	✘	Quarterly reports on encounters, attendance/completion rate, readmission/ED utilization, and clinical indicators, MADC daily census; participant surveys	HCH Lead: Healthy Communities Existing/Potential Partners: Montgomery County DHHS, GROWS, Maryland Department on	$7,000 (HCH)	**Year One:** Provided memory programs and activities ranging from in person classes to memory screenings with 547 encounters from July 2019 - March 2020. **Year Two:** Due to the pandemic, Community Health moved education and prevention classes to a virtual setting using the WebEx platform. In FY21, there were 659 virtual encounters.
2.4.3 Maintain MADC's status as a Dementia Care Program of Distinction	✘		✘	Quarterly reports for encounters, attendance/completion rate, readmission/ED utilization, and clinical indicators, MADC daily census; participant surveys	HCH Lead: Healthy Communities Existing/Potential Partners: Alzheimer's Foundation		**Year One:** MADC recognized as a Dementia Care Program of Distinction Year Two: No report due to the Covid-19 pandemic. The application was halted due to Covid. Will reapply in FY 22

* 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

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 2: Chronic Diseases

Chronic Diseases							
Priority 2a: Diabetes (CHNA pg. 47-49)							
Goal 3: Reduce the disease burden of diabetes mellitus.							
CHNA Impact						**CHNA Baseline**	**Target**	**Actual**
Decrease number of adults ever told they have diabetes						13.5%	10.2%◊	7.0%
Decrease ER visits for diabetes						280.5	186.3*	127.9
Objective 3.1	Decrease the number of low-income, uninsured/underinsured persons with uncontrolled diabetes							
Key Actions	**Timeframe**			**Measures**	**Existing and Potential Partners**	**Budgeted Resources (FY22)**	**Status**	
	Year 1	**Year 2**	**Year 3**					
3.1.1 Provide care management, education and nutrition counseling at HC Health Centers for high-risk patients	✘	✘	✘	Quarterly reports on health center visits, clinical measures, readmissions/ED utilization, referrals to community health programs and social services	HCH Leads: Community Care Delivery Existing/Potential Partners: Montgomery County DHHS, Montgomery Cares, Kevin J. Sexton Fund	See Key Action 8.1.1	**Year One:** Added 1.0 MSW to support behavioral health; added 1.5 FTE community resource coordinator to conduct home visits and address SDOH needs; contract with dietitian to provide 1:1 counseling and group education classes; launched Target BP initiative. **Year Two:** Added 1.0 BSW to support case management; implemented Hypertension Care Management Team; behavioral health, care management and nutrition services moved virtual to support patients throughout the pandemic.	
3.1.2 Referral process for Montgomery Cares and outside organizations to DSMP classes offered by all health systems	✘		✘	Number of referrals made	HCH Leads: Evidence-based Programs and Initiatives Existing/Potential Partners: Adventist Health, Medstar Montgomery, and Suburban, Montgomery County DHHS, Healthy Montgomery, Montgomery Cares		**Year One:** All health systems in Montgomery County developed a referral process to refer Montgomery Cares patients to diabetes self-management programs offered by the health systems, allowing patients ability to select programs based on time and location that fit their needs. **Year Two:** No Report. Program was paused due to the Covid-19 Pandemic	

* 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

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 2: Chronic Diseases

Objective 3.2	Increase the self-management skills of adults diagnosed with diabetes and increase prevention behaviors in adults at high risk for diabetes						
Key Actions	**Timeframe**			**Measures**	**Existing and Potential Partners**	**Budgeted Resources (FY22)**	**Status**
	Year 1	**Year 2**	**Year 3**				
3.2.1 Expand diabetes programming (English and Spanish) with Nexus Montgomery Regional Partnership Catalyst Diabetes Project (NMRP) (DPP and DSMT metric)		✘	✘	# DPP and DSMP cohorts offered by qualified providers	HCH Leads: Evidence-based Programs and Initiatives Existing/Potential Partners: Nexus Montgomery, Adventist Health, Medstar Montgomery, and Suburban, Montgomery County DHHS, Healthy Montgomery, Montgomery Cares	HCH Grant contribution over 5 years: HCH - $4,729,959 HCGH - $1,058,422	**Year 1:** No report **Year 2:** In FY21 the NMRP project stood up DPP and DMST referrals through Maryland's CRISP system in the Spring of 2021. Working with NMRP Program Coordinators, this will allow for newly hired NMRP Case Managers to refer to available diabetes prevention and diabetes education programs in the targeted zip codes. The referral process will allow for identifying potentially eligible patients; screen patients for eligibility; refer to diabetes education classes and receive updates on referrals. HCH offered 3 DPP cohorts and 6 DMST cohorts.
3.2.2 Offer Diabetes Prevention Program in English and Spanish	✘			Quarterly reports on encounters, average % weight loss, increase in physical activity, attendance/completion rate, DPP full recognition status	Leads: Evidence-based Programs and Initiatives Existing/Potential Partners: Montgomery County DHHS; Trinity Health, Maryland Dept. of Health, Nexus Montgomery	$20,000 (HCH), $20,000 (other sources)	**Year One:** There were four cohorts in English and one cohort in Spanish with a total of 75 Participants. A staffing plan was developed to increase the number of part-time evidence-based program instructors and expand the number of programs offered.
3.2.3 Offer Stanford University's Diabetes Self-Management Program in English and Spanish	✘	✘	✘	Quarterly reports on encounters, attendance/completion rate, number of safety-net DSMP referrals, pre/posttests, self-efficacy survey	Leads: Evidence-based Programs and Initiatives Existing/Potential Partners: Montgomery County DHHS, HQI	$5,000 (HCH), $4,000 (other sources)	**Year One:** There were 584 encounters and 66% of participants completed the class. **Year Two:** All classes were moved to a virtual format using the WebEx platform. There were 422 encounters and 79% of participants completed the class

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 2: Chronic Diseases

Priority 2b: Cancers (CHNA pg. 38-43)							
Goal 4: Reduce the number of new cancer cases, as well as illness, disability, and death caused by cancer.							
CHNA Impact						**CHNA Baseline**	**Target**	**Actual**
Decrease breast cancer mortality						19.8	20.7†	23.7
Increase colorectal cancer screening						72.9%	73.0%◊	74.20%
Increase percent of women who have had a Pap in the past three years						83.0%	93.0%◊	94.40%
Decrease prostate cancer incidence						159.3	135.0◊	111.4
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							
Key Actions	**Timeframe**			**Measures**	**Existing and Potential Partners**	**Budgeted Resources (FY22)**	**Status**	
	Year 1	**Year 2**	**Year 3**					
4.1.1 Provide community-based breast cancer education	✘			Quarterly reports on encounters	HCH Leads: Healthy Communities Existing/Potential Partners: Maryland Dept. of Health, Montgomery County DHHS		**Year One:** Provided breast cancer education to 708 community members during 166 educational sessions (community lectures, health fairs, one-to-one). **Year Two:** Provided 287 virtual breast cancer education encounters	
4.1.2 Provide access to mammogram services for uninsured, underinsured women	✘	✘	✘	Quarterly reports on encounters, percent eligible health center patients health center patients receiving referrals, number of mammograms, number navigated to care and cycle time from diagnosis to treatment, number enrolled in state breast and cervical cancer program	HCH Leads: Community Care Delivery Existing/Potential Partners: Montgomery Cares, Maryland Dept. of Health, Kevin J. Sexton Fund, Primary Care Coalition	$100,000 (HCH), $60,000 (other sources)	**Year One:** Received 1,064 referrals from health centers and completed 655 mammograms. Twenty patients enrolled in state BCC program. Mammogram referrals transferred to population health department to expand program to include all specialty referrals **Year Two:** Completed can 321 screening mammograms and 334 diagnostic mammograms for health center patients.	

* 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

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 2: Chronic Diseases

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.						
Key Actions	**Timeframe**			**Measures**	**Existing and Potential Partners**	**Budgeted Resources (FY22)**	**Status**
	Year 1	**Year 2**	**Year 3**				
4.2.1 Provide outreach and education on cancer prevention in Montgomery and Prince George's County through an equitable lens	✘	✘	✘	Quarterly reports on encounters, cancer education provided by type	HCH Leads: Healthy Communities Existing/Potential Partners: Maryland Dept. of Health, Montgomery County DHHS Cigarette Restitution Fund	$13,500 (other sources)	**Year One:** Provided outreach and education on cancer prevention (breast, cervical, colorectal, prostate, lung, skin) to 2,567 community members during 456 educational sessions (community lectures, health fairs, one-to-one). Grant funds from MCDHHS for fiscal year 2019 has been secured to continue cancer prevention outreach and education efforts. **Year Two:** Provided 3,435 encounters outreach and education on cancer prevention virtually and at community barbershops
4.2.2 Provide outreach and education on tobacco-free living	✘	✘	✘	Number of class and outreach encounters, class completion rate	HCH Leads: Healthy Communities Existing/Potential Partners: Montgomery DHHS Cigarette Restitution Fund	$17,000 (other sources)	**Year One:** Provided outreach and education on smoking cessation and lung cancer prevention to 1,822 community members during 113 educational sessions (community lectures, health fairs, one-to-one). Grant funds from MCDHHS for fiscal year 2019 has been secured to continue smoking cessation and lung cancer prevention outreach and education efforts. **Year Two:** Provided 1,062 virtual encounters
4.2.3 Offer evidence-based Cancer: Thriving and Surviving (CTS) Program in English and Spanish			✘	Quarterly reports on encounters, attendance/completion rate, number of safety-net CTS referrals, pre/posttests, self-efficacy survey	Leads: Evidence-based Programs and Initiatives Existing/Potential Partners: Montgomery County DHHS, HQI	$3,000 (HCH)	
4.2.4 Provide HC Health Center referrals for breast, colonoscopies, and obesity and tobacco cessation referrals and/or counseling to eligible health center patients	✘	✘	✘	Number of referrals made to primary care or other social services, % health center patients eligible for screenings receiving referrals (tobacco, mammogram, colonoscopy)	HCH Leads: Community Care Delivery Existing/Potential Partners: Montgomery County DHHS, Montgomery Cares	See Key Action 8.1.1	**Year One:** Provided 1,692 specialty care visits on site at HCHCs. Developed plan to restructure care management team to better meet patient needs; incorporated 1.0 FTE health navigator to assist with specialty referrals and SDOH needs and .5 FTE health navigator to conduct home visits and address SDOH needs; anticipate integration of dietitian in Q1 FY19 **Year Two:** Provided 19 breast services referrals, 11 colon/rectal services referrals, 672 gastroenterology referrals, 9 weight management referrals, and 3 tobacco cessation referrals to health center patients.

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 2: Chronic Diseases

Priority 2c: Cardiovascular Health (CHNA pg. 44 - 47)							
Goal 5: Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke.							
CHNA Impact						**CHNA Baseline**	**Target**	**Actual**
Decrease heart disease mortality						136.4	166.3*	104.5
Decrease stroke mortality						30.1%	34.8†	24.5
Decrease percent of adults told they have high blood pressure						21.6%	26.9%†	36.0%
Objective 5.1	Decrease the number of low-income, uninsured/underinsured persons with uncontrolled hypertension.							
Key Actions	**Timeframe**			**Measures**	**Existing and Potential Partners**	**Budgeted Resources (FY22)**	**Status**	
	Year 1	**Year 2**	**Year 3**					
5.1.1 Implement care management team at HC Health Centers for high-risk patients.	✘	✘	✘	Quarterly reports on clinical measures, readmissions/ED utilization, number of referrals to community health programs and social services	HCH Leads: Community Care Delivery Existing/Potential Partners: Montgomery Cares, Kevin J. Sexton Fund		**Year One:** Added 1.0 MSW to support behavioral health; added 1.5 FTE community resource coordinator to conduct home visits and address SDOH needs; contract with dietitian to provide 1:1 counseling and group education classes; launched Target BP initiative. **Year Two:** Added 1.0 BSW to support case management; implemented Hypertension Care Management Team; behavioral health, care management and nutrition services moved virtual to support patients throughout the pandemic.	
Objective 5.2	Provide educational and community-based programs to improve cardiovascular health.							
Key Actions	**Timeframe**			**Measures**	**Existing and Potential Partners**	**Budgeted Resources (FY22)**	**Status**	
	Year 1	**Year 2**	**Year 3**					
5.2.1 Provide community-based cardiovascular education and programming through an equitable lens	✘			Quarterly reports on encounters, number of blood pressures screenings	HCH Leads: Healthy Communities Existing/Potential Partners: Maryland Dept. of Health, Montgomery County DHHS Cigarette Restitution Fund		**Year One:** Provided cardiovascular education to 3,043 community members during 179 educational sessions (community lectures, health fairs, one-to-one). Implemented a blood pressure screening program at 4 community sites (Langley Park Community Center, Bauer Park Community Center, East County Community Center, White Oak Community Center); 423 blood pressure screenings were provided. **Year Two:** Provided 361 virtual encounters	

* 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

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 2: Chronic Diseases

5.2.2 Provide community fitness classes for adults and older adults aged 55+	✘	✘	✘	Quarterly reports on encounters, number of blood pressures screenings, stroke program developed, number of fitness classes offered	HCH Leads: Community Engagement and Evidence-Based Programs and Initiatives Existing/Potential Partners: Kaiser Permanente of the Mid-Atlantic States, National Lutheran Communities & Services, MoCo Department of Recreation, Maryland National Capital Park and Planning Commission, Faith-Based and Community-based, Organizations and Retirement Communities	$245,835 (HCH), $60,000 (other sources)	**Year One:** Offered multiple classes, including Zumba Gold, Ballet Gold, and Bollywood. More than 1200 seniors exercised daily through Senior Fit. In the fall of 2019, the Senior Source physical location was closed and all classes were moved to community sites. Colleagues worked diligently to increase partnerships with organizations such as Maryland Youth Ballet and Montgomery County Recreation, to move classes from the Senior Source to community-based locations. All classes were moved to a virtual setting using the WebEx platform in March of 2020. **Year Two:** Due to the pandemic, Community Health continued to offer fitness classes in a virtual setting. In FY21, there were 8,715 virtual fitness encounters and 45,677 Senior Fit virtual encounters.
5.2.3 Develop evidence and place-based stroke awareness program	✘		✘	Stroke program developed	HCH Leads: Community Engagement and Evidence-Based Programs and Initiatives Existing/Potential Partners: Montgomery County DHHS, MCPS, Boys and Girls Club, Linkages to Learning	$2,500 (HCH)	**Year One:** Developed two stroke programs; one in partnership with Linkages to Learning school-based health centers and one in partnership with the Boys and Girls Club of Montgomery County **Year Two:** No report
5.2.4 Offer Stanford University's Chronic Disease Self-Management Program	✘	✘	✘	Quarterly reports on encounters, # classes held	HCH Leads: Community Engagement and Evidence-Based Programs and Initiatives, Healthy Communities Existing/Potential Partners: Montgomery County DHHS, Area Agency on Aging	$5,000 (HCH)	**Year One:** Received grant from the state of Maryland to train faith community nurses and health ministers to offer DSMP. Six churches recruited (three minority or non-English speaking) and trained seven people to offer DSMP in faith communities **Year Two:** All classes were moved to a virtual format using the WebEx platform. There were 495 encounters and 81% of participants completed the class

* MD SHIP Target Δ Median or mean value for all counties in the state

† HP 2020 Target ◊ Represents the top 50th percentile of all MD counties

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 2: Chronic Diseases

Priority 2d: Obesity (CHNA pg. 50)							
Goal 6: Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights.							
CHNA Impact						**CHNA Baseline**	**Target**	**Actual**
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 the past week						28.0%	28.4%Δ	
Decrease the percent of adults who are overweight or obese						55.2%	64.3%*	
Objective 6.1	Reduce the proportion of children and adolescents who are considered obese.							
Key Actions	**Timeframe**			**Measures**	**Potential Partners**	**Budgeted Resources (FY22)**	**Status**	
	Year 1	**Year 2**	**Year 3**					
6.1.1 Kids Fit – physical activity program for adolescents	✘		✘	Quarterly reports on encounters, number of Kids Fit participants, number Kids Fit participants taking Presidential Fitness Challenge, semi-annual fitness assessments	HCH Leads: Healthy Communities Existing/Potential Partners: Montgomery County HOC	$6,000 (HCH)	**Year One:** Kids Fit held at five HOC buildings in upper Montgomery County. **Year Two:** Kids Fit was not held due to Covid-19.	
Objective 6.2	Increase the proportion of primary care physicians who regularly assess body mass index (BMI) in their adult							
Key Actions	**Timeframe**			**Measures**	**Potential Partners**	**Budgeted Resources (FY22)**	**Status**	
	Year 1	**Year 2**	**Year 3**					
6.2.1 BMI assessment and diagnosis of obesity for health center patients	✘	✘	✘	Quarterly reports on percent patients with high BMI diagnosed as obese	HCH Leads: Community Care Delivery Existing/Potential Partners: Montgomery Cares	See Key Action 8.1.1	**Year One: C**Y20 performance for BMI at 57.2%, (Trinity target - 95%) **Year Two: C**Y21 (Jan-June) performance for BMI at 64.5% (Trinity target - 95%)	

* 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

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 2: Chronic Diseases

Priority 2e: Behavioral Health (CHNA pg. 50 - 54)							
Goal 7: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.							
CHNA Impact						**CHNA Baseline**	**Target**	**Actual**
Decrease illicit drug use						6.1%	9.7%†	8.90%
Decrease percent of adults with any mental illness						16.8%	16.8%Δ	16.20%
Decrease mental health related ER visits						1,528	3,153*	2,312
Decrease suicide rate						6.5	9.0*	7.3
Objective 7.1	Increase access to appropriate, quality mental health services.							
Key Actions	**Timeframe**			**Measures**	**Potential Partners**	**Budgeted Resources (FY22)**	**Status**	
	Year 1	**Year 2**	**Year 3**					
7.1.1 Behavioral Health screenings with links to treatment at all health centers	✘	✘	✘	Quarterly reports number behavioral health screenings conducted, #referred to social services and community health programs, # referred to treatment	HCH Leads: Community Care Delivery Existing/Potential Partners: Montgomery Cares, Maryland Dept. of Health, Montgomery County DHHS, Trinity Health	See Key Action 8.1.1	**Year One:** The health centers had 1,492 behavioral health visits and 262 social work visits were provided and 84.4% of patients received depression screening during their primary care visit **Year Two:** The health centers had 776 behavioral health visits and 206 social work visits were provided in FY21. 94.9% of patients received depression screening during their primary care visit during CY21 (Jan-June)	
7.1.2 Provide behavioral health services and links to treatment through the Nexus Montgomery Crisis House, ACT Teams, and behavioral health Integration	✘	✘		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	HCH Lead: Population Health Existing/Potential Partners: Nexus Montgomery, HSCRC, Adventist HealthCare, Medstar Montgomery Medical Center, Suburban Hospital		**Year One:** The average ACT Teams census was 82 and the Crisis House admissions were 351 **Year Two:** Crisis House at 96% occupancy at end of year 2. ACT teams had active census of 148.	

* 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

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 2: Chronic Diseases

7.1.3 Offer Stanford University's Chronic Pain Self-Management Program		✘	✘	Quarterly reports on encounters, # classes held	HCH Lead: Community Engagement and Evidence-Based Programs and Initiatives, Healthy Communities Existing/Potential Partners: Montgomery County DHHS, Area Agency on Aging	$5,000 (HCH)	**Year One:** Implemented evidence-based program to provide non-pharmaceutical pain management skills to participants dealing with chronic pain. All health coaches were trained on the program. **Year Two:** All classes were moved to a virtual format using the WebEx platform. There were 359 encounters and 71% of participants completed the class
7.1.4 Collaborate with community partners to address behavioral health in the community	✘	✘	✘		HCH Lead: Community Engagement and Evidence-Based Programs and Initiatives, Healthy Communities Existing/Potential Partners: Montgomery County Hospital Systems, EveryMind	$1,000	**Year One:** Collaborated with EveryMind and all three hospital systems in Montgomery County to screen the movie "The S Word" followed by an panel discussion with experts in the field of suicide prevention and survivors **Year Two:** Held one online screening of the film Angst, followed by a virtual panel discussion with experts in the field of anxiety management and treatment. The presentation was so successful that a follow-up session was scheduled to make sure all questions from parents were answered
7.1.5 Collaborate with faith community to train faith leadership on how to be first responders for mental health issues within their congregations and community			✘	Number of leaders trained	HCH Lead: Healthy Communities Existing/Potential Partners: Faith-based Organizations, Maryland Department of Health, EveryMind	$2,500 (HCH)	**Year One**: Scheduled First Aid for Mental Health training for faith community leaders, however, was canceled due to pandemic **Year Two**: No report

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 2: Chronic Diseases

Emerging Trends							
Goal 8: Develop programs and initiatives to address emerging trends not identified in the current CHNA.							
Objective 8.1	Address the mental, physical and social impact of Covid-19 on the communities we serve.						
Key Actions	**Timeframe**			**Measures**	**Potential Partners**	**Budgeted Resources (FY22)**	**Status**
	Year 1	**Year 2**	**Year 3**				
8.1.1 Implement support groups to address the social and mental health impact of the Covid-19 pandemic			✖	Number of support groups held, number of encounters, pre-post surveys	HCH Lead: Healthy Communities Existing/Potential Partners: Montgomery Cares, Primary Care Coalition, faith-based organizations, United Way, CASA de Maryland, Cross Community, Latino Health Initiative, African American Health Program	$15,000 (other sources)	
8.1.2 Implement self-management and education program for Covid Long Haulers			✖	Quarterly reports on encounters, attendance/completion rate, number of referrals, pre/posttests, self-efficacy survey	HCH Lead: Evidence-Based Programs and Initiatives Existing/Potential Partners: faith-based organizations, Latino Health Initiative, African American Health Program, Montgomery Cares	$64,000 (other sources)	
8.1.3 Collaborate with faith-based, community-based and other organizations to provide vaccine clinics and education to decrease vaccine barriers and hesitancy to increase the Covid-19 vaccination rates in areas with high Covid-19 cases and death rates			✖	Number vaccinated, number of encounters, number of vaccination events in target areas	HCH Lead: Existing/Potential Partners: faith-based organizations, Cross Community, CHEER, ElevateHer, CareFirst, KaiserPermanente, Montgomery County DHHS, local restaurants and businesses	$1.4M (other sources)	

* 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

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 3: Social Influencers (Determinants) of Health

Social Influencers (Determinants) of Health			
Priority 3a: Health Care Access (CHNA pg. 34-35)			
Goal 9: Create social and physical environments that promote good health for all.			
CHNA Impact	**CHNA Baseline**	**Target**	**Actual**
Decrease uninsured rate in HCH Service Area	7.1%	0%†	7.10%
Decrease number of people unable to afford to see a doctor	4.7%	4.2%†	4.70%
Reduce the proportion of families that spend more than 30 percent of income on housing	10.8%	6%†	6.10%
Decrease percent of households that are food insecure	34.6%	30.9%†	32.10%

Objective 9.1	Decrease the number of persons unable to access primary care services.						
Key Actions	**Timeframe**			**Measures**	**Existing and Potential Partners**	**Budgeted Resources (FY22)**	**Status**
	Year 1	**Year 2**	**Year 3**				
9.1.1 Operate four health centers for the un/underinsured in geographically accessible locations	✕	✕	✕	Quarterly reports on encounters, patient visits, clinical measures	HCH Lead: Community Care Delivery Existing/Potential Partners: Montgomery Cares, Trinity Health, Maryland Dept. of Health, Kevin J. Sexton Fund	$2.5M (HCH), $2.4M (other sources)	**Year One:** 954 above budget for HCHCs (2.23%), -1,164 below budget at Germantown (-13.27%). Pivoted to virtual visits (video and telephone) to continue to provide care during pandemic **Year Two:** 1,245 above budget for HCHCs (2.65%), -233 below budget at Gaithersburg (-1.87%); moved Aspen Hill health center to new location
9.1.2 Develop SIOH screening and referral process flow to capture data in EPIC at Holy Cross Health Centers and Health Partners sites			✕	Number patients screened, Number of patients referred to resources	HCH Lead: Population Health Existing/Potential Partners: Montgomery Cares, Kevin J. Sexton Fund	See Key Action 8.1.1	
9.1.3 Use Aunt Bertha Care Coordination software to coordinate care and link patients, colleagues and community members to social services			✕	Number of patients/community members with coordination plans in Aunt Bertha, number of organizations with claimed sites in Aunt Bertha	HCH Lead: Healthy Communities Existing/Potential Partners: Cross Community, CHEER, faith-based organizations, Montgomery County DHHS, nonprofit organizations	$25,000 (HCH), $20,000 (other resources)	
9.1.4 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	✕	✕	✕	Number of maternity partnership patients linked to Germantown health center	Leads: Population Health	Maternity Partnership, Montgomery Cares	**Year One:** Initiatives implemented to increase awareness of HCHC in Germantown among Maternity Partnership patients and MPC members. There were 90 unique newborns at Germantown **Year Two:** Initiatives implemented to increase awareness of HCHC in Germantown among Maternity Partnership patients and MPC members. There were 69 unique newborns at Germantown

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

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 3: Social Influencers (Determinants) of Health

Objective 9.2	Decrease the proportion of households that experience housing cost burden.						
Key Actions	**Timeframe**			**Measures**	**Existing and Potential Partners**	**Budgeted Resources (FY22)**	**Status**
	Year 1	**Year 2**	**Year 3**				
9.2.1 Partner with community based organizations to deliver GED and ESOL classes.			✘	Strategies developed to advance health equity and healthy behaviors; number health equity and healthy behavior strategies implemented	Leads: Health Equity	Holy Cross Health	
9.2.2 Pathways to Independent Employment Program	✘	✘	✘	# of individuals hired	Holy Cross Human Resources	Holy Cross Health	**Year One:** Two individuals were hired via the PIE Program **Year Two:** One individual was hired via the PIE Program
Objective 9.3	Reduce household food insecurity and in doing so reduce hunger.						
Key Actions	**Timeframe**			**Measures**	**Existing and Potential Partners**	**Budgeted Resources (FY22)**	**Status**
	Year 1	**Year 2**	**Year 3**				
9.3.1 Increase availability and access to healthy and/or culturally appropriate food	✘	✘	✘	Number partners identified, Number partners involved, Number community members reserving plots, lbs. produce grown	HCH Lead: Community Health Existing/Potential Partners: Montgomery College, Montgomery County Master Gardeners, MoCo Food Council, Montgomery County Ag Reserve, Boys and Girls Club	$40,000 (HCH), $108,000 (other sources)	**Year One:** Rec'd POL funding to implement Community Greenhouse on campus of Holy Cross Germantown Hospital; building postponed due to Covid-19 **Year Two:** Rec'd POL funding to implement Community Garden on campus of Holy Cross Germantown Hospital
9.3.2 Increase food literacy			✘	Number classes held, Number of participants, %improvement in self-efficacy, class completion rate	HCH Lead: Health Communities Existing/Potential Partners: Montgomery College, MoCo Food Council, UMD Extension, Boys and Girls Club	$10,000 (HCH), $2,000 (other sources)	

* MD SHIP Target Δ Median or mean value for all counties in the state

† HP 2020 Target ◊ Represents the top 50th percentile of all MD counties

Holy Cross Health Implementation Plan FY2020-FY2022

Priority 3: Social Influencers (Determinants) of Health

Objective 9.4	Implement policy, system and environmental change strategies that support optimal health and well-being and reduce unhealthful behaviors.						
Key Actions	**Timeframe**			**Measures**	**Existing and Potential Partners**	**Budgeted Resources (FY22)**	**Status**
	Year 1	**Year 2**	**Year 3**				
9.4.1 Develop and implement plan for Transforming Communities Initiative (TCI) – Policy, System, and Environmental strategies to address CHNA priorities			x	Number of community members and community organizations engaged in plan development, number CHNA priorities addressed, plan developed	HCH Lead: Community Health Existing/Potential Partners: Montgomery College, faith-based organizations, Identity, Inc., Montgomery County Master Gardeners, MoCo Food Council, Montgomery County Ag Reserve, Boys		
9.4.2 Create informal community advisory groups to engage and lead ongoing community conversations to identify needs and develop solutions.	x	x	x	Number of community conversations held, number of advisory groups formed and engaged, number of community informed or led solutions developed	Leads: Healthy Communities Existing/Potential Partners: community-based organizations, community leaders	$5,000 (HCH)	**Year One:** Community Conversations held and feedback was used to inform CHNA **Year Two:** Four virtual Community Conversations were held to connect community members to services and identify needs during the pandemic
9.4.3 Advocate for racial justice by leveraging advocacy activities at local, state, and federal level			x	activities leveraged, plans developed, number of partners engaged, percent of colleague participation in e-advocacy campaign(s)	HCH Leads: Advocacy Existing/Potential Partners: Montgomery County Council, Community-based organizations, faith-based organizations		
9.4.3 Complete organizational wide cultural competency and anti-racism training			x	Percent of colleagues trained	HCH Leads: Human Resources		

* MD SHIP Target Δ Median or mean value for all counties in the state

† HP 2020 Target ◊ Represents the top 50th percentile of all MD counties