MedStar Health

Knowledge and Compassion
Focused on You

Community Health Needs Assessment

2015

2015 Community Health Needs Assessment (CHNA)

Contents

I. Executive Summary 1

II. Systemwide Approach to the CHNA 2

About MedStar Health 2
Community Health at MedStar Health 2
CHNA Guiding Principles and Framework 2
CHNA Approach and Timeline 3

III. Summary of Systemwide CHNA 4

Key CHNA Contributors and Participant Groups 4
Data and Input Sources 4
Prioritization Process and Criteria 5
Hospital Role in Identified Priority Areas 5

IV. Summary of Systemwide Priorities and Implementation Strategies 6

Community Benefit Service Areas 6
Disease/Health Condition 6
Social Determinant Priorities 6
Priorities and Hospital Role 7
Implementation Strategies 8
Evaluation 8

V. Individual Hospital CHNAs and Strategies 9

MedStar Franklin Square Medical Center 9
MedStar Georgetown University Hospital 13
MedStar Good Samaritan Hospital 17
MedStar Harbor Hospital 20
MedStar Montgomery Medical Center 24
MedStar National Rehabilitation Hospital 27
MedStar St. Mary's Hospital 29
MedStar Southern Maryland Hospital Center 35
MedStar Union Memorial Hospital 38
MedStar Washington Hospital Center 41

VI. References 45

I. Executive Summary

At MedStar Health, we recognize that healthier individuals translate to healthier families and communities, and the health of our communities is the result of the complex interplay of multiple variables including physical, social and economic factors. As a healthcare leader in the region, we play an important and significant role in advancing health and partnering with others to realize community health improvement. Part of this effort and commitment to this work is the execution of our Community Health Needs Assessment (CHNA).

MedStar's CHNA is an organized, formal and systematic approach to identify and address the needs of underserved communities across MedStar's geographic footprint. The CHNA guides the development and implementation of a comprehensive plan to improve health outcomes for those disproportionately affected by disease. This CHNA also informs the creation of a strategy for future community health programming, and community benefit resource allocation for fiscal years 2016–2018 across the 10 MedStar hospitals. As a not-for-profit organization, MedStar's CHNAs align with guidelines established by the Affordable Care Act, and comply with Internal Revenue Service (IRS) requirements.

Framework and Approach

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

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

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

Priorities and Implementation Strategies

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

Evaluation

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

II. Systemwide Approach to the Community Health Needs Assessment

About MedStar Health

MedStar Health is a not-for-profit health system dedicated to caring for people in Maryland and the Washington, D.C., region, while advancing the practice of medicine through education, innovation and research. MedStar's 30,000 associates, 6,000 affiliated physicians, 10 hospitals, ambulatory care and urgent care centers, and the MedStar Health Research Institute are recognized regionally and nationally for excellence in medical care. As the medical education and clinical partner of Georgetown University, MedStar trains more than 1,100 medical residents annually. MedStar's patient-first philosophy combines care, compassion and clinical excellence with an emphasis on customer service.

Community Health at MedStar Health

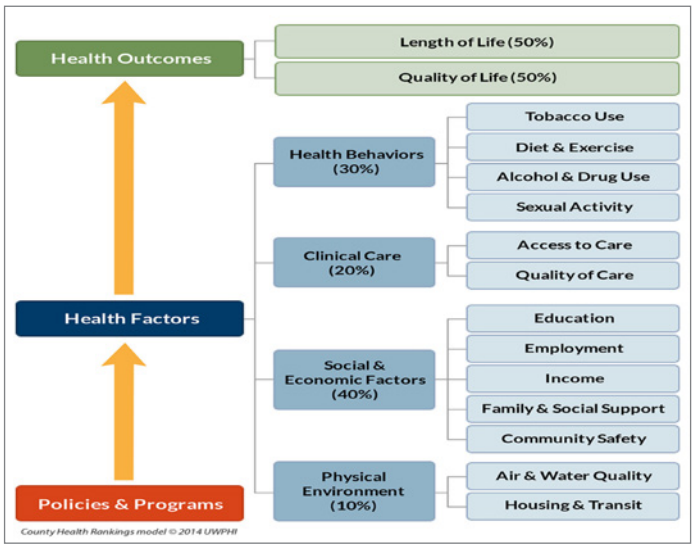
The Community Health function is responsible for coordinating community benefit and programming efforts to improve health outcomes particularly focused on the underserved and health disparities on behalf of the system and the 10 hospitals. The scope of responsibility includes community health assessment and planning, including the CHNA, program implementation and evaluation, and reporting to the community and regulatory bodies.

Evidence-based methodologies leverage internal and external stakeholder relationships and resources to target health-related disparities and to address the physical, social and economic contributors to suboptimal health. Nested in the collective approach and as part of the CHNA process, the Department of Community Health engaged each of the 10 Advisory Task Forces across the 10 MedStar hospitals to scope, implement and evaluate the CHNA plans, strategies and intended outcomes systemwide.

CHNA Guiding Principles and Framework

MedStar used the Robert Wood Johnson Foundation's County Health Rankings Model (at right) for understanding what contributes to the health of communities, and to guide the CHNA process.

The emphasis for the CHNA is on health disparities and social determinants of health—framing MedStar's efforts and leveraging community health programming and community benefit activities to contribute to improved health outcomes in the communities served.



CHNA Approach and Timeline

Over fiscal year 2015, each MedStar hospital used a multi-pronged approach to gather insights on their respective community health issues, determine health focus areas, and develop targeted implementation strategies to address the issues identified. This included convening hospital Advisory Task Forces to oversee the process and development of implementation strategies, through formal review and approval.

CHNA Overview and Approach

The hospitals used a common approach and timetable to developing the CHNA deliverables.

August 2014

- Convene Community Health Advisory Task Forces
- Conduct CHNA
- Determine 2 to 3 areas of focus, collaboration and participation
- Determine key external partners
- Develop implementation strategies and outcome measures
- Review and approve implementation strategies
- Publish CHNA and implementation strategies

June 2015

III. Summary of Systemwide Community Health Needs Assessment

Key CHNA Contributors and Participant Groups

- *MedStar Community Health Department*—Established the CHNA methodology for all hospitals; assisted in identification of strategic partners; provided expertise and technical support as needed; ensured that processes, deliverables and deadlines comply with the IRS mandate.
- *Hospital Advisory Task Forces*—Reviewed secondary public health data; designed CHNA survey tool and reviewed findings; recommended the hospital's Community Benefit Service Area (CBSA), health priorities and associated strategies. Task Force members included grassroots activists, community residents, faith-based leaders, hospital representatives, public health leaders, and other stakeholder organizations, such as representatives from local health departments.
- *Hospital Leadership Sponsors*—Served as liaisons between Task Forces and hospital executive leadership to ensure the hospital's selected priorities and implementation strategy plans aligned with the strengths of the organization.
- *CHNA Survey Respondents and Community Input Session Participants*—More than 3,000 individuals completed the CHNA survey and contributed to the community input sessions as part of the CHNA process. Diverse groups of community stakeholders—including CBSA residents and organizations, civic and faith-based leaders, public health officials, and government agencies—and hospital leadership were engaged to garner information about the most pressing issues across CBSAs.

Data and Input Sources

The data and input sources for the CHNA included quantitative secondary population-level data, a CHNA community survey and qualitative community input sessions. These data were used to diversify the types of information gathered and to engage a diverse group of internal and external stakeholders to inform the CHNA. The types of information gathered for each data source were as follows:

- **Secondary Data**
  - National, state, local health and disparity data, public health priorities, and community health improvement plans
  - County-level ZIP code and neighborhood level data (when available)
- **CHNA Community Survey**
  - Community questionnaire disseminated by the hospitals in their CBSAs
  - Open and closed-ended questions about health issues and social determinants
- **Community Input Session Discussions**
  - Facilitated discussions with a diverse group of community stakeholders and leaders to identify the most important community health issues. Discussion areas included:
    - Wellness and prevention
    - Access to care
    - Quality of life

Combined information from the aforementioned sources was used to: 1) identify health priorities, 2) establish the most feasible and effective intervention approaches and 3) determine the appropriate level of hospital engagement to address the health issues identified for each hospital. This information was then used to develop each hospital's implementation strategies and evaluation plans.

Prioritization Process and Criteria

Identification of priorities was first shaped by an understanding of the public health priorities, local community needs and each hospital's strengths within the context of the system's priorities. At the nexus of these components lies the priority areas identified as part of the CHNA.

Lastly, when selecting final targeted health priorities, MedStar considered additional criteria such as partnership opportunities and availability of evidence-based approaches.

Hospital Role in Identified Priority Areas

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

- **Focus areas (Leader Role)**: Areas that MedStar is well-positioned to take a leadership role in addressing.
- **Collaboration areas (Partner Role)**: Areas in which MedStar is best positioned to serve as a collaborator with other leading organizations.
- **Participation areas (Supporter Role)**: Areas that MedStar recognizes as significant contributors to health, but are beyond the scope of its organizational strengths. MedStar will serve as a supporter in these areas.

IV. Summary of Systemwide Priorities and Implementation Strategies

Community Benefit Service Areas (CBSAs)

Each hospital's Advisory Task Force identified a geographic or target population—CBSAs—to be served over the next three-year CHNA cycle. CBSAs were selected based on elevated disease incidence and prevalence; a high density of underserved or low-income residents and evidenced health disparities; proximity to the hospital; and/or an existing presence of effective programs and partnerships.

Based on secondary data review, a CHNA community survey and community input session analysis, health priorities were identified for two areas: **1) disease/health condition** and **2) social determinants of health**.

Disease/Health Condition

Although CHNAs were specific to each hospital, **chronic disease prevention and management** emerged as a key health priority for all acute hospitals. MedStar National Rehabilitation Hospital, a specialty hospital, identified access to physical activity as its health priority given the specific needs of the population served.

Among the nine acute hospitals, the following chronic conditions were identified and will be targeted as part of the implementation strategies:

- Heart disease and stroke
- Cancer
- Diabetes
- Obesity

Chronic Disease Fast Facts:

- **Heart disease** is the leading cause of death in Maryland; Washington, D.C.; and the United States. Stroke is the third leading cause of death in Maryland, and the fourth leading cause of death in Washington, D.C., and the United States.[1, 2]
- **Cancer** is the second leading cause of death in Maryland, Washington, D.C., and the United States.[1]
- **Diabetes** is the sixth leading cause of death in Maryland and Washington, D.C., and the seventh leading cause of death in the United States, but is likely underreported as a cause of death.[1]
- **Obesity** is the second leading cause of preventable deaths nationwide. It increases the risk for many other health conditions.[1]

Social Determinants of Health

MedStar understands and recognizes that the social and physical environments in which individuals reside have significant effects on the development and progression of disease and associated health status. Societal and physical characteristics can directly affect individual behaviors and health outcomes. Addressing such factors is essential to achieving improved health and health equity.

The following social determinants were identified as priority:

- Affordable housing
- Food insecurity/access to healthy food
- Transportation

Did you know… Social factors, or determinants, account for as much as 70 percent of a population's health.[1]

Qualitative community input sessions provided an opportunity to learn first-hand about the health issues of importance to the community. Topics included wellness and prevention, access to care and quality of life. Common themes by domain included:

Wellness and prevention

- There is a continued need for prevention and education programs and services focused on chronic disease in the areas of heart disease/stroke, cancer, diabetes, and obesity, as well as behavioral health services.
- Communities lack awareness of how to access existing wellness and prevention services.

Access to care

- There is a need to bring health education and prevention services directly into communities, versus providing them at hospital campuses.
- Numerous barriers exist regarding access to care, including physical proximity to medical facilities, lack of insurance coverage/underinsurance, and lack of access to convenient, affordable and reliable transportation.

Quality of life

- There is a need to increase awareness about the relationship between hunger and health outcomes, and efforts to secure access to healthy and affordable food choices.
- Basic needs such as affordable housing and child care and employment need to be met in order for physical and mental health to be a priority, and to observe improved health status.

Priorities and Hospital Role

MedStar hospitals are unable to address, either as a leader or collaborator, all of the health needs identified in the assessment. Each of the 10 hospitals determined appropriate roles for its identified priorities.

Systemwide Priorities by Hospital Role

Focus Areas*	Collaboration Areas**	Participation Areas***
Chronic disease prevention and management	Behavioral health	Housing/homelessness
Access to care	Food insecurity/access to healthy food options	Transportation
Access to physical activity	Transportation	Affordable child care

*The most common priority area identified through the survey was chronic disease prevention and management, and the most common disease conditions identified were heart disease/stroke, cancer, diabetes, and obesity. MedStar National Rehabilitation Hospital also identified access to physical activity programs for those with disabilities as a focus area. Some hospitals used data from the CHNA survey, hospital utilization and community input sessions—combined with feedback from existing partnerships—to identify other key priorities. For instance, MedStar St. Mary's Hospital selected substance abuse and behavioral health as key priorities while MedStar Franklin Square Medical Center selected birth outcomes.

**Each hospital's Advisory Task Force identified health-related areas for which each hospital will serve as a partner with outside entities. The hospitals will leverage both internal leadership and the expertise of key external groups to maximize the impact of their implementation strategy. Examples of collaboration areas include behavioral health and food insecurity/access.

***Each hospital's Advisory Task Force identified areas that are related to health status, behaviors and outcomes, but are not areas in which the hospital is positioned to take a leadership role. In these areas, MedStar will participate as a supporter of ongoing local efforts. Examples include housing and transportation.

Implementation Strategies

Based on the priority and hospital role, each Advisory Task Force and leadership developed an implementation strategy plan that will serve as a roadmap to refine, develop and implement programs over the next three years. The components of each implementation plan include:

- Goal statement for focus areas
- Health target rationale based on secondary data
- Proposed strategies to address targeted area
- Desired outcomes
- Program-specific and public health metrics
- Key external partners
- Areas of collaboration and participation

Evaluation

The implementation strategies will be evaluated throughout the three-year cycle. Annual evaluations will support continuous quality improvement efforts to enhance how implementation plans are executed. Outcome evaluations will assess changes in knowledge, behavior or health outcomes among program participants. Mechanisms for more robust data collection will be established to support local, state and national health disparity goals.

Hospital Advisory Task Forces will convene at least annually to monitor progress of strategy execution and to provide ongoing recommendations related to outcomes achievement, program development, partnership approaches, and overall implementation improvement.

MedStar Health

Community Health Needs Assessment: MedStar Franklin Square Medical Center

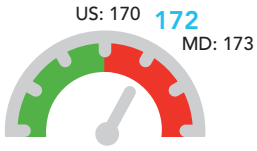
Community Benefit Service Area (CBSA): Southeast Baltimore County

MedStar Franklin Square Medical Center's CBSA includes residents living in ZIP codes 21027, 21220, 21221, 21222, 21234, 21236, and 21237. This geographic area was selected as MedStar Franklin Square Medical Center's CBSA as a result of the longstanding collaborative partnership with the Baltimore County Southeast Area Network (Southeast Network) for its community benefit efforts.

Community Health Priorities

- Chronic disease prevention and management (heart disease/stroke, diabetes and obesity)
- Birth outcomes
- Access to mainstream resources

Death rate due to heart disease in Baltimore County

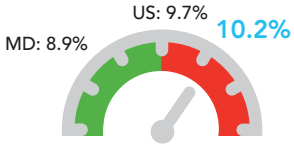


Comparison: National and State

172

deaths/100,000 population

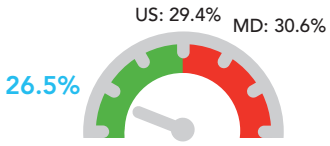
Prevalence of diabetes in Baltimore County



Comparison: National and State

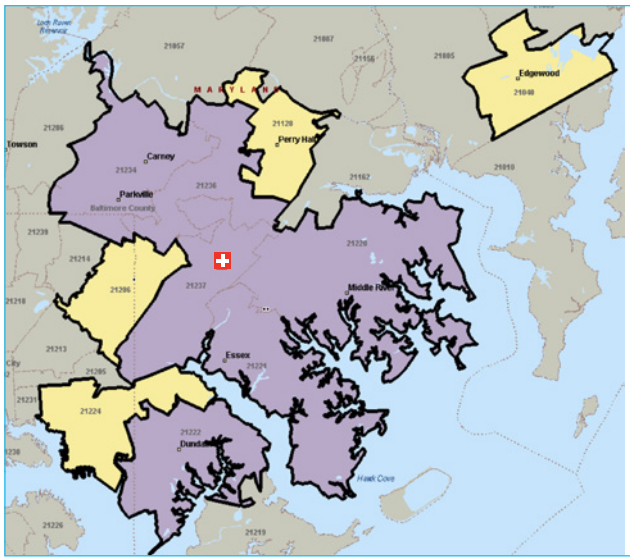
10.2%

Prevalence of obesity in Baltimore County



Comparison: National and State

26.5%



*Hospital Primary Service Area — represents ZIP codes that contain 50% of inpatient discharges

*Community Benefit Service Area is also included in the Primary Service Area

Community Benefit Service Area

Hospital Primary Service Area

MedStar Franklin Square Medical Center

1. Chronic Disease

Objective:

Promote heart health and address risk factors of heart disease in Southeast Baltimore County.

Secondary Data: Framing the Issue

Heart Disease and Stroke[1, 3]

- Heart disease is the leading cause of death in Baltimore County.
- 37 percent of adults in Baltimore County have high blood pressure, a percentage exceeding both state (35 percent) and national (31 percent) levels.
- While the rate of high cholesterol in Baltimore County (35 percent) is lower than the state's rate, it remains significantly higher than the goal for Healthy People 2020 (14 percent).
- The age-adjusted death rate due to stroke in Baltimore County has decreased (from 46/100,000 people in 2008 to 40/100,000 in 2012), but is significantly higher than the national average (36/100,000 people).

Diabetes[3]

- The rate of emergency room visits due to diabetes in Baltimore County has increased from 164 visits per 100,000 people in 2010 to 172 visits per 100,000 people in 2013.

Obesity[1, 2]

- The overall prevalence of obesity in Baltimore County (26.5 percent) is lower than the goal set by Healthy People 2020, but is high among African Americans (35 percent, compared to 29.4 percent nationwide).

Strategies to Address Chronic Disease

- To deliver evidence-based chronic disease self-management programs.
- To provide blood pressure education and self-screening at community sites.
- To serve as an official partner of the Baltimore Heart Walk.
- To facilitate a monthly diabetes support group.
- To conduct the Stop Smoking Today smoking cessation program.
- To support Baltimore County Health Coalition obesity prevention initiatives.

Current and Future Programming

- Offer Chronic Disease Self-Management (CDSMP) classes for residents with chronic conditions. Classes will be free, and six sessions will be held at local community sites.
- Offer free nicotine replacement assistance to participants.

Anticipated Outcomes for Chronic Disease

- Improved communication with physicians
- Decreased depression
- Increased physical activity
- Increased rate of smoking cessation and improvement in rate maintenance
- Reduced readmission rate of chronic obstructive pulmonary disease (COPD) patients
- Improved participant assessment outcomes at six-month follow-up periods
- Reduced hospitalization and readmission rates of participants

Metrics for Chronic Disease

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Percentage of participants reporting improved communication with physician
- Percentage of participants reporting a decrease in depression symptoms
- Percentage of participants reporting increased physical activity
- Hospitalization and readmission rates due to hypertension among participants
- Percentage of participants who quit smoking or maintain
- Readmission rates for COPD among participants

Public Health[3]

- Age-adjusted death rate for heart disease
- Emergency department visits and hospitalization rates due to hypertension
- Percentage of adults participating in recommended levels of physical activity
- Percentage of adults who smoke
- Percentage of adolescents using tobacco products

Key Partners: Chronic Disease
American Heart Association Million Hearts® Campaign
American Medical Association
Baltimore County Department of Aging
Baltimore County Department of Health
Baltimore County Health Coalition
Baltimore County Tobacco Coalition
Johns Hopkins Medicine
MD Quit Now

2. Birth Outcomes

Objective:

Support babies being born healthy and being raised in safe and stable families and communities in southeast Baltimore County.

Secondary Data: Framing the Issue[2, 4]

- Although breastfeeding is a protective factor against negative outcomes during the postnatal period through early childhood, nearly three-quarters (72 percent) of infants in Baltimore County are being "fully formula-fed." This is higher than the state average of 67 percent.

"The issue of healthy pregnancies is multifaceted. You have to provide various services at various levels of need. No one organization can do that—we have to act together."

—Tricia Isennock, community outreach manager, MedStar Franklin Square Medical Center

6.4 deaths per 1,000 live births in Baltimore County, vs. 6.1/1,000 nationally

Strategies to Address Birth Outcomes

- To serve in a leadership role in the Healthy Babies Collaborative.
- To provide a weekly breastfeeding support group in Essex at Creative Kids Center.
- To assess community factors associated with poor birth outcomes in Essex.
- To identify evidence-based programming to address identified risk factors.
- To provide health education and services to support Southeast Network partner initiatives to address identified risk factors.

Current and Future Programming

- Offer a free weekly breastfeeding support group for expectant and new mothers/families in the Healthy Babies Collaborative.
- Assess community factors associated with poor birth outcomes, identify evidence-based programming to address identified risk factors, and provide health education and services to support relevant Southeast Network partner initiatives.

Anticipated Outcomes for Birth Outcomes

- Rates for infants being exclusively breastfed at 3 months improved to greater than 29.3 percent
- Barriers to breastfeeding identified
- New evidence-based practices implemented

Metrics for Birth Outcomes

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Percentage of infants being "fully formula-fed"

Public Health[3, 4]

- Percentage of babies born of low birth weight
- Percentage of infants being "fully formula-fed"

Key Partners: Birth Outcomes
Abilities Network
Baltimore County Department of Health
Baltimore County Health Coalition
Baltimore County Local Management Board
Creative Kids
Healthy Babies Collaborative
Healthy Families
National Association of County and City Health Officials
Southeast Network
United Way of Central MD
Young Parent Support Center

3. Access to Mainstream Resources

Objective:

Support access to mainstream resources for families on Medicaid or uninsured in Southeast Baltimore County.

Secondary Data: Framing the Issue[5, 6]

- People with low incomes are more likely to experience negative health outcomes, are less likely to practice health-promoting behaviors and have lower life expectancy.
- Compared to residents in Baltimore County overall, residents in MedStar Franklin Square Medical Center's CBSA experience worse economic outcomes. Approximately 18.6 percent of households earn less than $25,000 a year, compared to 15.7 percent in Baltimore County overall.

10.3%

of MedStar Franklin Square Medical Center's CBSA earn less than the federal poverty level, vs. 8.9% in Baltimore County overall

Strategies to Address Access to Mainstream Resources

- To assess patients for mainstream service needs prior to discharge.
- To identify local mainstream service resources.
- To partner with identified resources for a direct point of contact.
- To assist patients with resource eligibility and enrollment.
- To partner with the Maryland Food Bank for food supplies and nutrition education.

Current and Future Programming

- Conduct surveys and data analysis to determine the mainstream resource needs of Medicaid and uninsured populations.
- Assess patient mainstream support needs, determine resource program eligibility and assist in program enrollment during hospital stays.

Anticipated Outcomes for Access to Mainstream Resources

- Reduced readmission rates for participating Medicaid and self-pay patients
- Reduced readmission rates for clients who receive mainstream assistance
- Increased number of participants enrolled in resource delivery programs

Metrics for Access to Mainstream Resources

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific[7]

- Readmission rates among clients who receive assistance for mainstream service needs
- Number of participants enrolled in resource delivery programs

Public Health[2, 3]

- Emergency department visit rate due to diabetes
- Emergency department visit rate due to hypertension
- Percentage of adults who could not afford to see a doctor

Key Partners: Access to Mainstream Resources
Baltimore County Department of Social Services
Community Assistance Network
Faith Communities
Maryland Food Bank
Southeast Network

Areas of Collaboration and Participation

Collaboration areas were identified as health-related areas in which the hospital will serve as a partner with outside organizations. Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.

Collaboration Areas
Asthma Management in Schools
Behavioral Health
Tobacco Use
Participation Areas
Housing
Transportation

MedStar Health

Community Health Needs Assessment: MedStar Georgetown University Hospital

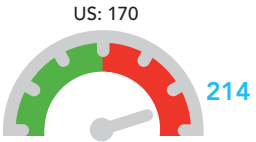
Community Benefit Service Area (CBSA): Wards 5, 6, 7, and 8

MedStar Georgetown University Hospital's CBSA includes residents of Wards 5, 6, 7, and 8 in Washington, D.C. This geographic area was selected to expand upon primary care services that are offered to underinsured, uninsured and low-income people.

Community Health Priorities

- Chronic disease prevention and management (heart disease/stroke, cancer and diabetes)
- Greater access to pediatric care
- Food insecurity and child obesity

Death rate due to heart disease in DC*



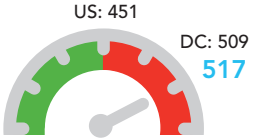
Comparison: National

214

deaths/100,000 population

*Ward-specific rates are not available.

Cancer incidence rate in ward service area

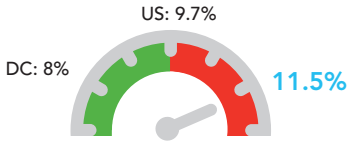


Comparison: National and District

517

cases/100,000 population

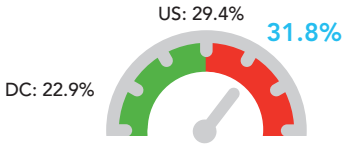
Prevalence of diabetes in ward service area



Comparison: National and District

11.5%

Prevalence of obesity in ward service area



Comparison: National and District

31.8%

*Hospital Primary Service Area — represents ZIP codes that contain 50% of inpatient discharges

*Community Benefit Service Area is also included in the Primary Service Area

Community Benefit Service Area

Hospital Primary Service Area

MedStar Georgetown University Hospital

1. Chronic Disease

Objective:

Reduce the prevalence and risk factors that contribute to chronic disease among high-risk individuals in Wards 5, 6, 7, and 8.

Secondary Data: Framing the Issue

Heart Disease and Stroke[2, 8]

- Heart disease is the second leading cause for hospitalization in Washington, D.C., at an annual rate of 882 visits/100,000 people.
- The prevalence of high blood pressure is 28 percent and high cholesterol is 34 percent. These prevalences are highest in adults ages 65 and older, male adults and African Americans.

Cancer[2]

- Cancer is the second leading cause of death in the District of Columbia. The incidence of breast, cervical and prostate cancer, and the age-adjusted death rate due to breast and prostate cancer, all fall within the range of the worst quartile nationally.

- The overall death rate due to cancer in D.C. is 193/100,000 people, compared to 163/100,000 nationally.
- The overall death rate due to cancer is higher for African Americans relative to Whites—a disparity that persists for the death rates due to breast, colorectal, lung, and prostate cancer.

Diabetes[2, 8]

- Diabetes is the seventh leading cause for hospitalization in the District, at an annual rate of 305 visits/100,000 people.
- The age-adjusted death rate from diabetes is 18/100,000. The prevalence among African Americans (13 percent) is more than six times higher than the prevalence among Whites (2 percent).

Obesity[2, 8]

- Nearly a quarter (23 percent) of adults in the District of Columbia are obese, a trend that has not changed in recent years.
- The prevalence of obesity is significantly higher in African American residents (36 percent) than Hispanics (15 percent) or Whites (10 percent).
- Individuals earning less than $15,000 annually in the District of Columbia are nearly three times more likely to be obese compared to individuals in the city making more than $75,000.

Strategies to Address Chronic Disease

- To participate in health fairs that will include screenings for diabetes and blood pressure, and nutritional information.
- To hold free cancer screenings in the community and support groups for adults and youth.
- To host heart disease/stroke education and support groups.
- To conduct a monthly diabetes program.
- To sponsor a diabetes education community event.
- To present a prostate cancer community lecture.

Current and Future Programming

- Offer monthly classes for those who have been identified as being pre-diabetic or diabetic. Classes will cover health behaviors that contribute to the prevention and management of diabetes.
- Hold educational sessions for those who may be at higher risk for heart disease/stroke, and for first responders who have the ability to improve outcomes with rapid identification and treatment of symptoms of heart attack and/or stroke.
- Provide cancer screenings, support groups and educational sessions.

Anticipated Outcomes for Chronic Disease

- Increased regular attendance at monthly diabetes and pre-diabetes education classes
- Increased knowledge and awareness of risk factors associated with heart disease/stroke, diabetes and cancer
- Increased compliance with taking prescribed medication to help control diabetes
- Improved clinical measures including blood glucose levels, blood pressure and weight loss
- Increased compliance with attendance at follow-up appointments
- Increased number of patients who receive medical attention within 4.5 hours of the onset of symptoms of ischemic strokes
- Increased number of individuals receiving screenings and education for cancer and heart disease-related risk factors

Metrics for Chronic Disease

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Percentage of program participants aware of risk factors associated with chronic diseases and receiving screenings
- Percentage of program participants who adopt sustainable lifestyle behaviors that help reduce the prevalence of chronic diseases
- Percentage of program participants participating in the recommended levels of physical activity and losing weight
- Percentage of program participants who follow up with recommended care and adhere to medication
- Percentage of program participants with elevated blood pressure and blood sugar

Public Health[1, 8, 9]

- Percentage of adults at a healthy weight (BMI < 25 kg/m2)
- Age-adjusted death rate from cardiovascular disease and diabetes
- Emergency department visit rates and hospitalizations for diabetes and cardiovascular disease
- Percentage of adults participating in recommended levels of physical activity
- Percentage of adults who are obese
- Percentage of women who receive breast cancer screening
- Percentage of adults who consume recommended amounts of fruits and vegetables daily

Key Partners: Chronic Disease
American Diabetes Association
American Heart Association
American Stroke Association
Capital Area Food Bank
Celebramo Project
D.C. Consortium of Young Adults with Cancer
D.C. Department of Health
D.C. Fire and EMS Department
Georgetown University
Look Good Feel Better
Sisters Informing Sisters
The George Washington University

2. Access to Pediatric Care

Objective:

Increase access to pediatric health care and support services in Wards 7 and 8.

Secondary Data: Framing the Issue[5, 8, 10]

- When compared to other wards, Wards 7 and 8 have a high volume of individuals and families with incomes below the poverty level.
- There is also a shortage of medical providers serving low-income and homeless populations across the city. In children and adolescents, this can lead to high rates of hospitalization and emergency room visits for conditions like asthma.
- Behavioral patterns created during childhood and adolescence have implications for current health status and future chronic disease. Those in this age group are at risk for asthma, obesity, abuse, dental ailments, and mental health conditions.

33% of families in Ward 8 are in poverty, vs. 11% nationally

Strategies to Address Access to Pediatric Care

- To conduct community-based asthma education.
- To offer behavioral health screenings with children in the community.
- To hold nutritional assessments via the KIDS Mobile Medical Clinic.
- To provide primary care services to adolescents via the Anacostia High School Wellness Center.
- To deliver primary care services for homeless persons via the Hoya Clinic.

Current and Future Programming

Reach out to children in the community, especially Wards 7 and 8, to provide health screenings, education and pediatric primary care.

Anticipated Outcomes for Access to Pediatric Care

- 850 children seen via the mobile clinic
- Asthma care plans and medications provided to 100 percent of children diagnosed with asthma via the mobile clinic
- 60 percent of the student body of Anacostia High School enrolled in the school-based primary care program
- A wellness visit with a school-based primary care provider conducted with 75 percent of the students enrolled in the Anacostia High School Wellness Center

> "The staff at the Anacostia Wellness Center made me feel comfortable and explained everything in a way that helped me understand how to take care of myself."
>
> *—Triana Mobley, former student, Academies at Anacostia High School*

Metrics for Access to Pediatric Care

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Percentage of students enrolled in the Wellness Check program
- Percentage of students with asthma who have an asthma care plan and medications

Public Health[8]

- Emergency department rates due to asthma for children ages 0 to 5
- Emergency department rates due to asthma for children ages 5 to 14

Key Partners: Access to Pediatric Care
Hoya Clinic
School-Based Wellness Providers and Organizations

3. Food Insecurity and Child Obesity

Objective:

Promote healthy child development through nutritional education and increased access to nutritious foods in Wards 7 and 8, which have the highest rates of obesity in Washington, D.C.

Secondary Data: Framing the Issue[2, 8]

- Twenty-eight percent of children in the District experience food insecurity.
- Fifteen percent of children and adolescents in Washington, D.C., are obese.
- Half of all children in Washington, D.C., live in Wards 7 and 8, but only 10 percent of the District's grocery stores and fresh food outlets are located in those wards.
- When compared to the rest of the country, schools in Washington, D.C., are not offering as many fruits and vegetables as competitive food choices (i.e., items sold or provided in schools that are not part of the National School Lunch Program) during lunch.

28% **of children in the District experience food insecurity**

Strategies to Address Food Insecurity and Child Obesity

- To provide nutrition assessments via the KIDS Mobile Medical Clinic.
- To assess children for nutritional risk factors.

Current and Future Programming

- Present nutritional education programs at schools and through the KIDS Mobile Medical Clinic in Wards 7 and 8.

Anticipated Outcomes for Food Insecurity and Child Obesity

- At least 150 children identified as being at risk for becoming obese
- At least 15 families of those identified as at high risk for obesity enrolled in MedStar Georgetown University Hospital's weight management program

Metrics for Food Insecurity and Child Obesity

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Number of children impacted by nutritional education and awareness offerings
- Percentage of enrolled adults and teens consuming recommended servings of fruits and vegetables
- Percentage of enrolled adults and teens participating in recommended amounts of weekly exercise

Public Health[9]

- Percentage of children and adults who are overweight or obese (BMI ≥ 25 kg/m2)
- Percentage of adults and teens consuming the recommended servings of fruits and vegetables
- Percentage of adults and teens getting the recommended amount of weekly exercise

Key Partners: Food Insecurity and Child Obesity
Capital Area Food Bank
Georgetown University Department of Pediatrics
Georgetown University School of Medicine
Hoya Clinic
Local Schools

Areas of Collaboration and Participation

Collaboration areas were identified as health-related areas in which the hospital will serve as a partner with outside organizations. Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.

Collaboration Areas
Difficulty Obtaining Food
Participation Areas
Affordable Housing

MedStar Health

Community Health Needs Assessment: MedStar Good Samaritan Hospital

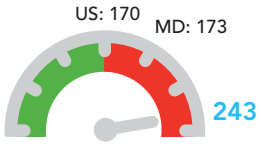
Community Benefit Service Area (CBSA): Govans Area

MedStar Good Samaritan Hospital's CBSA includes residents in the Govans area of Baltimore (ZIP code 21212). In addition to this primary focus area, MedStar Good Samaritan Hospital provides services to individuals in need in the hospital's entire service area (ZIP codes 21234, 21239, 21206, and 21214). This geographic area was selected because of its close proximity to the hospital, coupled with a high density of residents with low incomes.

Community Health Priorities

- Chronic disease prevention and management (heart disease/stroke, diabetes and obesity)

Death rate due to heart disease in Baltimore City

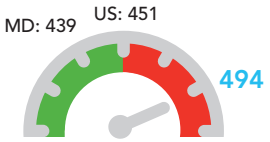


Comparison: National and State

243

deaths/100,000 population

Cancer incidence rate in Baltimore City

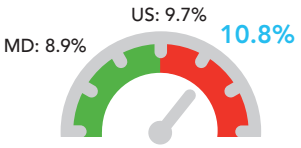


Comparison: National and State

494

cases/100,000 population

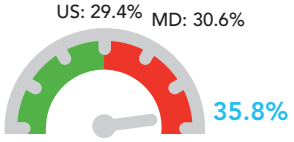
Prevalence of diabetes in Baltimore City



Comparison: National and State

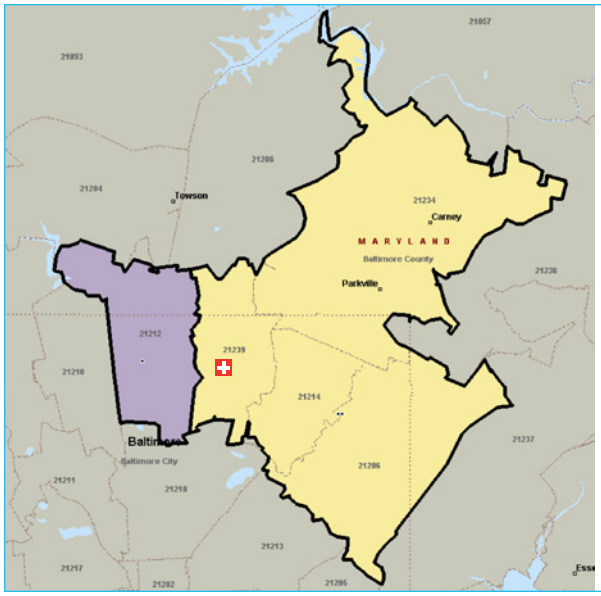
10.8%

Prevalence of obesity in Baltimore City



Comparison: National and State

35.8%



*Hospital Primary Service Area — represents ZIP codes that contain 50% of inpatient discharges

*Community Benefit Service Area is also included in the Primary Service Area

Community Benefit Service Area

Hospital Primary Service Area

MedStar Good Samaritan Hospital

1. Chronic Disease

Objective:

Provide education and services to the Govans area that promote disease prevention and management through community health programming centered on heart disease, hypertension, diabetes, nutrition, and exercise.

Secondary Data: Framing the Issue

Heart Disease and Stroke[2, 3]

- Heart disease is the leading cause of death in Baltimore City.
- The age-adjusted death rate due to stroke is decreasing (from 51/100,000 people in 2009 to 48/100,000 people in 2012) but remains significantly higher than the state (38/100,000 people) and national averages (38/100,000 people).
- In Baltimore City, the prevalence of high blood pressure (35 percent) and high cholesterol (30 percent) contributes to the age-adjusted death rate due to heart disease and stroke.

Diabetes[3]

- The rate of emergency department visits due to diabetes has increased from 444 visits/100,000 people in 2010 to 502 visits/100,000 people in 2013. African Americans contribute largely to this high rate.
- The age-adjusted death rate due to diabetes is 30 deaths/100,000 people in Baltimore City, compared to 21/100,000 nationally.

Obesity[2]

- In Baltimore City, 36 percent of adults are obese, and the trend of high prevalence is increasing. This rate is considerably higher among African American residents (45 percent compared to 29.4 percent nationwide).

Strategies to Address Chronic Disease

- To offer heart health education courses and nutrition classes.
- To present community-based healthy lifestyle classes.
- To lead weekly exercise classes for older adults.
- To provide smoking cessation programs.
- To conduct free blood pressure screenings.
- To teach health literacy and compliance education courses.
- To provide influenza vaccinations.

Current and Future Programming

- Offer the "Life Balance/Weight Management Program," which includes both core sessions and post-core sessions. Core sessions include classes focusing on adopting lifestyle changes for healthy eating and physical activity. Participants attend monthly post-core classes that provide additional support and learning opportunities.
- Provide "Living Well: Take Charge of Your Diabetes" workshops. These workshops teach attendees: 1) techniques to deal with the symptoms of diabetes and emotional problems, 2) appropriate exercise, 3) healthy eating strategies, 4) appropriate use of medication, and 5) the importance of working more effectively with healthcare providers.
- Conduct the "Get Heart Smart Program," which emphasizes lifestyle changes to support cardiovascular health.
- Conduct fitness programs at local community senior centers. Exercise classes include aerobics, strength training and flexibility.
- Host the "Freedom from Smoking Program," which features a step-by-step plan to quit smoking.

> "I'm more informed so I can be my own health advocate when I go to my doctor."
>
> *—Isla Murrill, former participant, "Living Well: Take Charge of Your Diabetes"*

Anticipated Outcomes for Chronic Disease

- Improved weight loss/achievement of a healthy range for body mass index
- Improved blood pressure
- Improved diet
- Increased physical activity
- Reduced number of people who smoke

Metrics for Chronic Disease

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Percentage of program participants adhering to medication and self-management techniques
- Percentage of program participants who participate in the recommended levels of physical activity
- Percentage of program participants reporting improved "readiness to change" status on post-assessment
- Percentage of program participants with elevated blood pressure and blood sugar
- Obesity measures (muscle mass, weight, etc.)
- Percentage of program participants who successfully quit smoking cigarettes
- Percentage of program participants aware of risk factors associated with chronic diseases
- Percentage of program participants who adopt sustainable lifestyle behaviors that help reduce the prevalence of chronic diseases
- Percentage of adults consuming recommended amounts of fruits and vegetables daily

Public Health[3]

- Percentage of adults at a healthy weight (BMI < 25 kg/m2)
- Age-adjusted death rate from heart disease
- Percentage of adults participating in the recommended levels of physical activity
- Emergency department visit rate due to hypertension and diabetes
- Percentage of adults who smoke

Key Partners: Chronic Disease
Govans Ecumenical Development Corporation
HARBEL Prevention and Recovery Center
Local Churches
Northeast Community Organization
The Morgan Community Mile

Areas of Collaboration and Participation

Collaboration areas were identified as health-related areas in which the hospital will serve as a partner with outside organizations. Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.

Collaboration Areas
Behavioral Health
Alcohol and Drug Addiction
Children and Adolescent Health
Participation Areas
Housing
Density of Liquor Stores, Tobacco Retail, Fast Food, Carryout, and Corner Stores

MedStar Health

Community Health Needs Assessment: MedStar Harbor Hospital

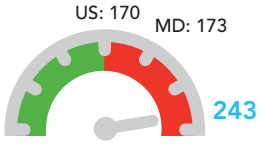
Community Benefit Service Area (CBSA): Southern Baltimore City and Northern Anne Arundel County

MedStar Harbor Hospital's CBSA includes all residents of the hospital's ZIP code, 21225. This area covers Southern Baltimore City and Northern Anne Arundel County, and includes four neighborhoods: Brooklyn, Brooklyn Park, Cherry Hill, and Pumphrey. In particular, the hospital will focus on the Cherry Hill community. This geographic area was selected due to its high poverty rate and proximity to the hospital, as well as the opportunity to build on longstanding community benefit programs, services and partnerships.

Community Health Priorities

- Chronic disease prevention and management (heart disease/stroke, cancer, diabetes, and obesity)
- Children and family wellness

Death rate due to heart disease in Baltimore City

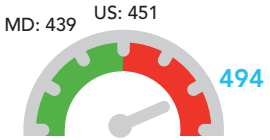


Comparison: National and State

243

deaths/100,000 population

Cancer incidence rate in Baltimore City

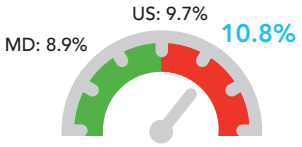


Comparison: National and State

494

cases/100,000 population

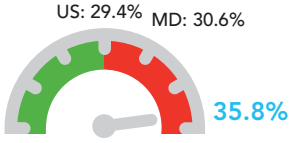
Prevalence of diabetes in Baltimore City



Comparison: National and State

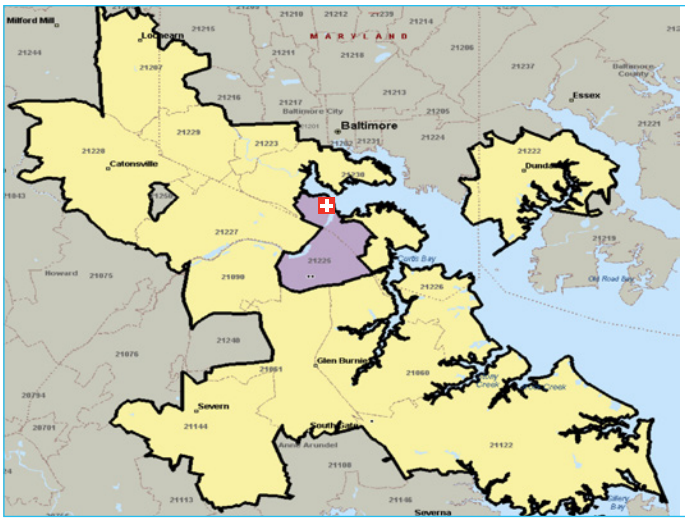
10.8%

Prevalence of obesity in Baltimore City



Comparison: National and State

35.8%



*Hospital Primary Service Area — represents ZIP codes that contain 50% of inpatient discharges

*Community Benefit Service Area is also included in the Primary Service Area

Community Benefit Service Area

Hospital Primary Service Area

MedStar Harbor Hospital

1. Chronic Disease

Objectives:

- **Reduce the incidence, prevalence and risk factors contributing to chronic diseases within the 21225 ZIP code.**
- **Increase cancer knowledge and access to prevention and screening services.**

Secondary Data: Framing the Issue

Heart Disease and Stroke[2, 3]

- Heart disease is the leading cause of death in Baltimore City.
- The age-adjusted death rate due to stroke is decreasing (from 51/100,000 people in 2009 to 48/100,000 in 2012) but remains significantly higher than the state (38/100,000 people) and national averages (38/100,000).
- In Baltimore City, the prevalence of high blood pressure (35 percent) and high cholesterol (30 percent) contributes to the age-adjusted death rate due to heart disease and stroke.

Cancer[11]

- In Baltimore City, the age-adjusted death rate to cancer is 212 deaths/100,000 people, compared to 163/100,000 nationally.

Diabetes[3]

- The rate of emergency department visits due to diabetes has increased from 444 visits/100,000 people in 2010 to 502 visits/100,000 people in 2013. African Americans contribute largely to this high rate.

Obesity[12]

- In Baltimore City, 36 percent of adults are obese, and the trend of high prevalence is increasing. This rate is considerably higher among African American residents (45 percent compared to 29.4 percent nationwide).

Strategies to Address Chronic Disease

- To provide healthy cooking demonstration classes.
- To host a support network for healthy lifestyle changes.
- To provide education and screenings for chronic disease risk factors at community locations.
- To offer a monthly diabetes support group to help people with diabetes better manage their condition.
- To provide a full-time nurse to support the Healthy Schools Healthy Families program.
- To study barriers to men's health and wellness, and develop targeted programs and services.
- To provide prevention and detection education with key partners in areas of prostate, breast, lung, colorectal, and skin cancers.
- To promote the use of a new cancer resource center in the community.
- To explore the feasibility of piloting an evidence-based anti-smoking campaign.

Current and Future Programming

- Offer a walking program for community groups, similar to MedStar Harbor Hospital's existing Heart Smart Church and blood pressure program, with information, engagement, pedometers, and distance logs provided.
- Establish a community cancer center to provide support, education and resources to patients and family members experiencing cancer, as well as to encourage cancer screenings in the community.
- Provide smoking cessation classes.

Anticipated Outcomes for Chronic Disease

- Increased daily physical activity levels and improved cardiovascular fitness
- Decreased percentage of participants with high blood pressure and/or glucose levels
- Increased percentage of participants who see a primary care provider annually
- Increased knowledge of the importance of cancer screenings, and number of people screened

Metrics for Chronic Disease

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Percentage of program participants participating in the recommended levels of physical activity
- Percentage of program participants with elevated blood pressure and blood sugar
- Percentage of program participants who successfully quit smoking cigarettes
- Percentage of program participants aware of risk factors associated with chronic diseases
- Percentage of program participants who adopt sustainable lifestyle behaviors that help reduce the prevalence of chronic diseases

Public Health[3]

- Percentage of adults at a healthy weight (BMI < 25 kg/m2)
- Age-adjusted death rate from heart disease
- Percentage of adults participating in the recommended levels of physical activity
- Emergency department visit rate due to hypertension and diabetes
- Percentage of adults who smoke
- Percentage of women who receive breast cancer screenings
- Percentage of adults with high blood pressure on medication

Key Partners: Chronic Disease
American Cancer Society
American Diabetes Association
American Heart Association
American Lung Association
Catholic Charities of Baltimore
Faith-Based Community
Family Health Centers of Baltimore
Healthy Anne Arundel
Local Community and Senior Centers
Local Schools
ShopRite

2. Child and Family Wellness

Objective:

Promote healthy habits and behaviors among students ages 4 to 15 and their families.

Secondary Data: Framing the Issue[2, 3, 10, 13, 14]

- Early and middle childhood is the time during which health literacy, self-discipline and eating habits are strongly established, putting children at risk for asthma, obesity, abuse, dental ailments, and mental health conditions.
- Adolescents are at high risk for sexually transmitted diseases, substance abuse, homicide, smoking, and unplanned pregnancies, in addition to childhood health conditions.
- Currently, 15 percent of children and adolescents in Baltimore City are obese. Nearly 23 percent of middle school students report no leisure physical activity.
- Currently, 12 percent of children and adolescents in Baltimore City have been diagnosed with asthma.
- Nearly 17 percent and 21 percent of adolescents in Baltimore City report using tobacco products or marijuana, respectively, in a 30-day period, and 11 percent of adolescents report binge drinking in the same period. Males are more likely to use all of these substances.

44% **of community input survey respondents indicated that their neighborhood was not a good place to raise children***

*of those respondents who answered questions about the community

CHNA Survey (n=239)

Strategies to Address Child and Family Wellness

- To provide one school resource nurse to work in all three Cherry Hill elementary/middle schools.
- To create and deliver education on topics pertinent to children and families, including anger management, hand hygiene, personal hygiene, parental involvement, sexually transmitted infection prevention, healthy habits, and asthma management.

Current and Future Programming

- Offer a walking program for Cherry Hill children and families, and provide information, engagement, pedometers, and distance logs.

Anticipated Outcomes for Child and Family Wellness

- Increased percentage of participants taking an active role in living a healthy life and seeing a primary care provider
- Increased daily activity levels of participants
- Decreased percentage of participants with high blood pressure and glucose levels

> "The class gives middle-school girls the support they need to look out for themselves and make better choices."
>
> *—Calvert Moore, RN, health class teacher, MedStar Harbor Hospital's Healthy Schools Healthy Families program*

Metrics for Child and Family Wellness

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Percentage of students successfully completing the 8th grade and accepted into their high school of choice
- Percentage of community input survey respondents reporting that their community is not a safe place to raise children
- Percentage of program participants who see a primary care provider annually
- Percentage of program participants with elevated blood pressure and blood sugar

Public Health[13, 15]

- Incidence rates of gonorrhea and chlamydia among adolescents
- Percentage of obese children and adolescents
- Rates of juvenile homicide and non-fatal shooting victims

Key Partners: Child and Family Wellness
American Heart Association
Arundel Elementary/Middle School
Baltimore City Department of Recreation and Parks
Cherry Hill Early Learning Action Coalition
Dr. Carter G. Woodson Elementary/Middle School
Friendship Academy at Cherry Hill
It's About the Kids Education Organization
Kaiser Permanente Educational Theatre
Under Armour

Areas of Collaboration and Participation

Collaboration areas were identified as health-related areas in which the hospital will serve as a partner with outside organizations. Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.

Collaboration Areas
Affordable Healthy Food Options
Behavioral Health
Better Jobs
Better Places to Exercise
Participation Areas
Affordable Child Care
Affordable Housing
Alcohol Addiction
Heroin/Opioid Addiction

MedStar Health

Community Health Needs Assessment: MedStar Montgomery Medical Center

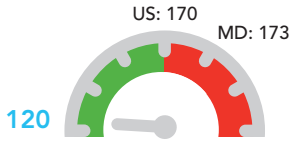
Community Benefit Service Area (CBSA): Aspen Hill/Bel Pre

MedStar Montgomery Medical Center's CBSA includes residents in the Aspen Hill/Bel Pre neighborhoods of Montgomery County, Maryland (ZIP code 20906). This geographic area was selected due to its close proximity to the hospital, coupled with a high density of low-income residents.

Community Health Priorities

- Chronic disease prevention and management (heart disease/stroke, diabetes, obesity, and cancer)

Death rate due to heart disease in Montgomery County

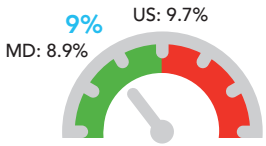


Comparison: National and State

120

deaths/100,000 population

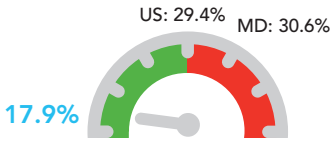
Prevalence of diabetes in Montgomery County



Comparison: National and State

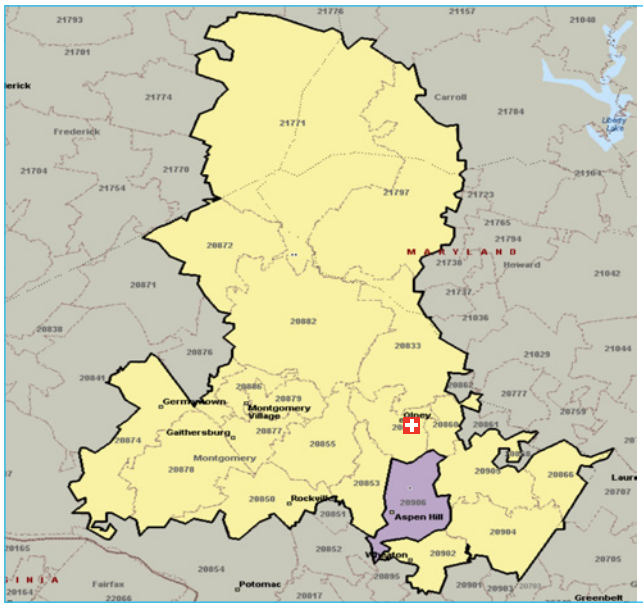
9%

Prevalence of obesity in Montgomery County



Comparison: National and State

17.9%



*Hospital Primary Service Area — represents ZIP codes that contain 50% of inpatient discharges

*Community Benefit Service Area is also included in the Primary Service Area

Community Benefit Service Area

Hospital Primary Service Area

MedStar Montgomery Medical Center

1. Chronic Disease

Objective:

- **Reduce the prevalence and risk factors that contribute to chronic disease among high-risk populations.**
- **Increase cancer knowledge and access to screening and prevention services within the Aspen Hill/Bel Pre area (ZIP code 20906).**

Secondary Data: Framing the Issue

Heart Disease and Stroke[3, 16]

- Heart disease is the second leading cause of death in Montgomery County.
- The age-adjusted death rate for heart disease is higher among African Americans than it is for other racial/ethnic groups in the county.
- In Montgomery County, the rate of emergency department visits for hypertension per 100,000 people is 149.
- The prevalence of high cholesterol in Montgomery County is 38 percent, compared to the Healthy People 2020 goal of 14 percent.

Diabetes[3, 16]

- The age-adjusted death rate due to diabetes in Montgomery County is 14/100,000 people.
- The prevalence among African Americans (11 percent) and Hispanics (11 percent) is higher than the prevalence among Whites (8 percent) and Asians (4 percent).
- The rate of emergency department visits due to diabetes has increased from 87 visits/100,000 people in 2010 to 103 visits/100,000 people in 2013.

Obesity[2]

- In Montgomery County, approximately 18 percent of adults are obese.
- The prevalence of obesity is highest among adults between the ages of 45 to 64 and male adults.
- The prevalence of obesity is significantly higher among African-American residents (27 percent) than Hispanics (19 percent) or Whites (18 percent).

Cancer[2, 3, 16, 17]

- Cancer is the leading cause of death in Montgomery County, with an age-adjusted death rate of 125/100,000 people.
- The incidence rates of colorectal and lung cancer and the overall death rate due to cancer are highest for males.
- The overall death rate in Montgomery County due to cancer is higher among African Americans relative to Whites.
- MedStar Montgomery Medical Center's most common cancer diagnoses include lung, colon, prostate, and breast.

Strategies to Address Chronic Disease

- To provide free monthly cholesterol, blood pressure and glucose screenings, as well as health education outreach at local religious, educational and recreational centers.
- To offer free weekly exercise classes to seniors, concentrating on improving cardiovascular health, weight loss, balance, and flexibility.
- To provide free chronic disease education programs.
- To implement tobacco reduction strategies through the Freedom from Smoking program.
- To develop and offer lung cancer support programs.
- To offer free access to mammogram screenings through the Women's Health Improvement Program and Proyecto Salud Clinic.

Current and Future Programming

- Offer the Access to Care/Heart Health program that has a special focus on screening minority populations, including African American and Hispanic communities, for risk factors linked to heart disease.
- Hold free weekly senior exercise classes composed of low-impact aerobic movements to improve cardiovascular health, weight loss, balance, and flexibility.
- Administer health education through a diabetes/nutritional program focusing on diabetes self-management, including an adequate diet, regular physical activity and daily control of glucose levels.
- Link emergency room patients to primary care through MedStar Montgomery Medical Center's established ED (Emergency Department)-PC (Primary Care) Connect program, which improves access to health care for low-income uninsured patients and focuses on continuity of care for improved healthcare status.
- Provide free, comprehensive and high-quality breast health services to uninsured, low-income women through the Women's Health Improvement Program, which increases early detection of breast cancer.
- Offer lung cancer support programs focusing on smoking cessation activities to support people who wish to quit.
- Participate in the Fax to Assist Program.

Anticipated Outcomes for Chronic Disease

- Improved blood pressure, cholesterol and glucose readings
- Improved physical activity levels, balance and flexibility
- Improved eating behaviors and weight/body mass index
- Reduced number of cigarettes smoked per day
- Increased number of participants who have quit smoking

"Many people do not want to know about their health problems, but they need to be informed."

—Maria Escobar, participant, Access to Care/Heart Health program, MedStar Montgomery Medical Center

- Increased number of primary care physician visits scheduled and/or attended at Holy Cross Aspen Hill Clinic
- Reduced barriers to care, such as those preventing patients from scheduling appointments with primary care physicians
- Reduced emergency department admission rates due to uncontrolled diabetes, heart disease and obesity
- Increased number of patients who received and completed treatment

Metrics for Chronic Disease

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Admission rate for specialty care due to cancer
- Emergency department admission rates due to chronic conditions
- Percentage of program participants aware of risk factors associated with chronic diseases and attending appointments
- Percentage of program participants consuming recommended amounts of fruits and vegetables
- Percentage of program participants participating in the recommended levels of physical activity
- Percentage of program participants with elevated blood pressure, cholesterol and blood sugar
- Number of blood pressure and diabetes medications taken by program participants
- Percentage of program participants that successfully quit smoking cigarettes (number of cigarettes smoked, relapse rates, etc.)

Public Health[3, 9, 16]

- Percentage of adults at a healthy weight (BMI < 25 kg/m2)
- Age-adjusted death rate from heart disease, diabetes and lung cancer
- Incidence of lung cancer
- Percentage of adults who currently smoke
- Emergency department admission rates for diabetes and hypertension in Montgomery County
- Percentage of adults participating in the recommended levels of physical activity
- Percentage of adults consuming recommended values of fruits and vegetables
- Percentage of adults who are obese
- Percentage of adults who are on medication for high blood pressure
- Percentage of women who receive breast cancer screening

Key Partners: Chronic Disease
Community Partners of Aspen Hill
Healthy Montgomery
Holy Cross Aspen Hill Clinic
Millian Memorial United Methodist Church
Proyecto Salud Clinic–Olney

Areas of Collaboration and Participation

Collaboration areas were identified as health-related areas in which the hospital will serve as a partner with outside organizations. Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.

Collaboration Areas
Affordable Healthy Food Options
Behavioral Health
Better Public Transportation
Participation Areas
Affordable Child Care
Affordable Housing
Better Jobs

MedStar Health

Community Health Needs Assessment: MedStar National Rehabilitation Hospital

Community Benefit Service Area (CBSA): Greater Washington, D.C., Area

MedStar National Rehabilitation Hospital's (MedStar NRH) CBSA includes residents living with disabilities in the Greater Washington, D.C., area. This population was identified because of the hospital's strengths and primary service area. In the District of Columbia, 17 percent of residents reported that their activities were limited by their physical, mental or emotional health problems.

Community Health Priorities

- Access to physical activity programs

Percent who do not meet the U.S. Department of Health and Human Services' (HHS) 2008 Physical Activity Guidelines

US: 53%

Comparison: General Population (National)

73%

Those with disabilities

Percent who report no leisure-time physical activity

US: 32%

Comparison: General Population (National)

54%

Those with disabilities

1. Access to Physical Activity Programs

Objective:

Facilitate opportunities for wellness through physical activities and sports for those with disabilities in the Washington, D.C., region.

Secondary Data: Framing the Issue[10, 18, 19, 20]

- Nationally, people with disabilities are less likely to participate in physical activity.
- More than half of people with disabilities (54 percent) reported no leisure-time physical activity at all, compared to 32 percent of the general population.
- 10.8 percent of D.C. residents need assistive devices, compared to 7.9 percent in the U.S. overall.

Strategies to Address Access to Physical Activity Programs

- To provide sports programs for people with disabilities in the community, including adapted rowing, archery, junior sled hockey, quad/wheelchair rugby, wheelchair basketball, handcycling, wheelchair tennis, and boccia ball.
- To provide weekly fitness classes for people with disabilities at MedStar NRH and within the community.

"When these kids are on the ice, it equalizes everything. It doesn't matter what ability they have—they're able to play competitively."

—Heather McGraw, mother, junior sled hockey player John McGraw, MedStar NRH

Current and Future Programming

- Provide physical activity and help curb obesity for persons with disabilities through hosting adaptive sports programs/teams and weekly fitness classes at MedStar NRH and within the community.

> "As recreational therapists, we make sure that once patients go home, they're getting out and are doing things they love to do."
>
> *—Joan Joyce, recreational therapy coordinator, MedStar NRH*

Anticipated Outcomes for Access to Physical Activity Programs

- Increased number of participating community sites and participants at each site
- Increased weekly physical activity and mobility
- Improved physical and mental well-being
- Increased fruit and vegetable intake and water consumption
- Increased cardiovascular fitness

Metrics for Access to Physical Activity Programs

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Percentage of people in the program who meet HHS' 2008 Physical Activity Guidelines
- Percentage of people in the program reporting leisure-time physical activity
- Percentage of people in the program reporting improved mental and physical well-being
- Percentage of people in the program consuming recommended fruits and vegetables daily
- Percentage of people in the program reporting increased water consumption

Public Health[19]

- Percentage of people with disabilities who meet physical activity guidelines
- Percentage of people with disabilities reporting leisure time physical activity

Key Partners: Access to Physical Activity Programs
DPI Adaptive Fitness
Montgomery County Department of Parks
The Gordon and Marilyn Macklin Foundation
U.S. Paralympics

Areas of Collaboration and Participation

Collaboration areas were identified as health-related areas in which the hospital will serve as a partner with outside organizations. Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.

Collaboration Areas
Diabetes Management and Prevention
Obesity Management and Prevention
Participation Areas
Inadequate Caregiver Support
Transportation

MedStar Health

Community Health Needs Assessment: MedStar St. Mary's Hospital

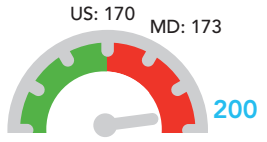
Community Benefit Service Area (CBSA): Lexington Park

MedStar St. Mary's Hospital's CBSA includes the 109,633 residents of St. Mary's County, Maryland, with a focus on the Lexington Park community (ZIP code 20653). The Lexington Park community was selected as it has the greatest number of medically underserved citizens in the area, with approximately 18.3 percent of the population living below the federal poverty level.

Community Health Priorities

- Chronic disease prevention and management (heart disease/stroke, diabetes, obesity, and Alzheimer's disease)
- Substance abuse (tobacco, alcohol and drugs)
- Access to care
- Behavioral health

Death rate due to heart disease in St. Mary's County

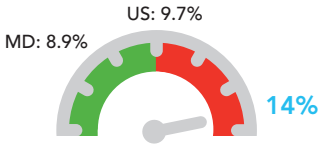


Comparison: National and State

200

deaths/100,000 population

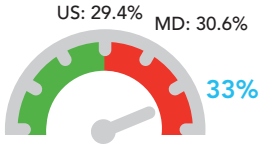
Prevalence of diabetes in St. Mary's County



Comparison: National and State

14%

Prevalence of obesity in St. Mary's County



Comparison: National and State

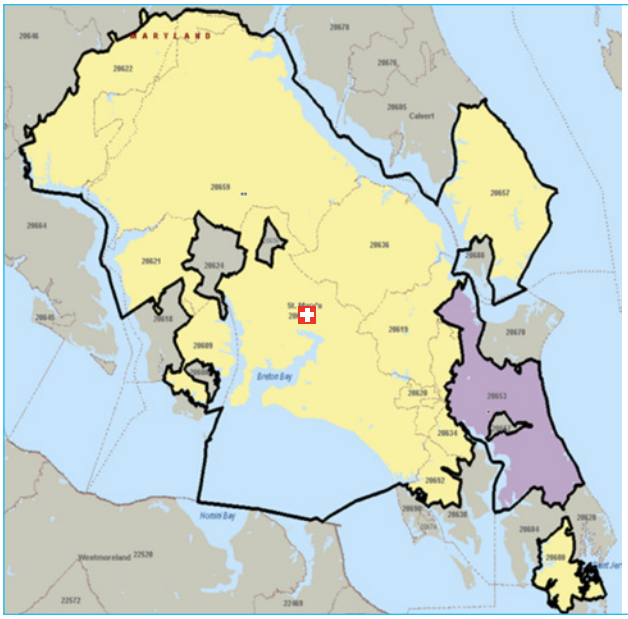
33%

Rate of hospitalization due to Alzheimer's disease and related dementias in St. Mary's County

Comparison: National and State

271

people hospitalized/100,000 population



*Hospital Primary Service Area — represents ZIP codes that contain 50% of inpatient discharges

*Community Benefit Service Area is also included in the Primary Service Area

Community Benefit Service Area

Hospital Primary Service Area

MedStar St. Mary's Hospital

1. Chronic Disease

Objective:

Improve population health outcomes for St. Mary's County through targeted chronic disease prevention and management programming.

Secondary Data: Framing the Issue

Heart Disease and Stroke[2, 3, 13]

- Heart disease is the leading cause of death in St. Mary's County.
- The rate of emergency department visits due to hypertension in St. Mary's County is 284/100,000 people, compared to 246/100,000 for all of Maryland.
- The overall prevalence of high blood pressure in St. Mary's County is 30 percent, with high cholesterol at 41 percent. Among the Medicare population, the rate of heart disease and stroke and the prevalence of high blood pressure and high cholesterol are higher than those among the Medicare population nationwide.

Diabetes[2, 3, 21]

- The prevalence of diabetes in St. Mary's County is highest among Hispanics (35 percent), followed by African Americans (15 percent) and Whites (13 percent).
- The rate of emergency department visits due to diabetes in St. Mary's County is 214 visits/100,000 people. African Americans contribute significantly to this high rate.
- Among the Medicare population in St. Mary's County, the prevalence of diabetes and chronic kidney disease is higher than among the Medicare population nationwide.

Obesity[2]

- The prevalence of obesity in St. Mary's County is highest among Hispanics (47 percent), followed by African Americans (39 percent) and Whites (32 percent).

Alzheimer's Disease[3]

- Alzheimer's disease is the sixth leading cause of death in St. Mary's County.
- The rate of hospitalization related to Alzheimer's disease and other dementias is disproportionately higher for certain ethnic groups compared to the county average.

Strategies to Address Chronic Disease

- To participate in the monthly HEAL (Healthy Eating/Active Living) team of the Healthy St. Mary's Partnership.
- To develop support groups and educational programming for Alzheimer's disease and dementia.
- To expand chronic disease self-management program offerings to include Living Well With Cancer and Living Well With Diabetes.
- To expand National Diabetes Prevention Program classes and increase prevention and self-management programs for diseases common to the Medicare population.
- To expand the Million Hearts® initiative through enhanced community screenings and MedStar St. Mary's Hospital's partnership with the local health department.
- To expand the capacity of outpatient case management and community health worker programs.

Current and Future Programming

- Participate on the HEAL team.
- Offer chronic disease self-management programs, including Living Well with Cancer.
- Offer National Diabetes Prevention Program classes four times annually, including workplace-based classes.
- Offer enhanced community screenings and partnership with the St. Mary's County Health Department via the Million Hearts® initiative.
- Provide support groups and programming for Alzheimer's disease and dementia.

Anticipated Outcomes for Chronic Disease

- Increased number of participants in meetings and community partnerships/collaborations
- Increased number of breastfeeding mothers who attend support groups and receive information
- Increased number of initial screenings and follow-up screenings/appointments for those who are at risk for a chronic disease
- Improved clinical markers for chronic disease
- Reduced number of hospital readmissions related to chronic disease

- Reduced prescriptions and prescription costs for people managing a chronic disease
- Increased number of people completing a smoking cessation course who report success, and a decline in the number of people who smoke
- Increased number of Alzheimer's disease support group attendees
- Increased number of staff who are trained to have, or are hired with, Alzheimer's disease support credentials

Metrics for Chronic Disease

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Number of breastfeeding mothers attending a MedStar St. Mary's Hospital support group
- Number of Living Well With Cancer participants and associates trained
- Percentage of program participants engaging in recommended levels of physical activity
- Number of inpatient hospitalizations for Alzheimer's disease and dementia
- Percentage of program participants who lost weight
- Percentage of program participants with elevated blood pressure, cholesterol and sugars
- Number of program participants following up with recommended care
- Percentage of program participants reporting reduced prescription costs and need for prescription drugs
- Number of emergency department visits and readmissions due to chronic disease

Public Health[3, 9, 15]

- Percentage of adults at a healthy weight (BMI < 25 kg/m2)
- Age-adjusted death rate from heart disease
- Percentage of children and adolescents who are obese
- Percentage of women who receive breast cancer screening
- Emergency department visits due to diabetes and hypertension

Key Partners: Chronic Disease
Alzheimer's Association
Maryland Department of Health and Mental Hygiene
St. Mary's County Department of Aging and Human Services
St. Mary's County Health Department

2. Substance Abuse

Objective:

Reduce tobacco use, alcohol abuse and drug overdoses in St. Mary's County.

Secondary Data: Framing the Issue

Tobacco[2, 3]

- Smoking prevalence among adults in St. Mary's County is 20.9 percent.
- In St. Mary's County, adults younger than age 45 and males report the highest smoking prevalence across age and gender groups, respectively.

Alcohol and Drug Abuse[2, 3]

- Binge drinking is highest among adults younger than age 45 (34 percent) and males (27 percent) in St. Mary's County.
- The rate of emergency department visits for addiction-related conditions in St. Mary's County is higher than the statewide average and the goal set by the state health department.

24% of adults in St. Mary's County reported binge drinking in the last 30 days, compared to 17% of adults statewide

Strategies to Address Substance Abuse

- To participate in the Tobacco Free Living Action Team of the Healthy St. Mary's Partnership.
- To increase the number of associates certified in the Maryland Department of Health and Mental Hygiene's Fax to Assist program, which facilitates referrals to Free Maryland Tobacco Quitline Services.
- To contribute dedicated staff to support the St. Mary's County Health Department's smoking cessation programs.
- To provide public education to introduce ORYX® hospital accountability measures for tobacco reduction and support inpatient implementation.
- To continue Community Alcohol Coalition (CAC) activities for public policy advocacy and social awareness of underage and binge drinking.
- To lead the Maryland Strategic Prevention Framework process for overdose prevention.

> "I want teenagers in St. Mary's County to know there's something else besides drinking alcohol that they can have fun doing."
>
> *—Anne Marie Merz, Community Alcohol Coalition member*

Current and Future Programming

- Participate in the Tobacco Free Living Action Team of the Healthy St. Mary's Partnership.
- Participate in the Fax to Assist state program.
- Support the county's smoking cessation programs.
- Provide public education to introduce ORYX® measures for tobacco reduction, and support inpatient implementation.
- Organize CAC activities for public policy advocacy and social awareness of underage and binge drinking.
- Support the Maryland Strategic Prevention Framework process for overdose prevention.

Anticipated Outcomes for Substance Abuse

- Increased associate hours dedicated to Tobacco Free Living Action Team initiatives
- Increased number of people impacted by Tobacco Free Living Action Team events
- Decreased percentage of adults and adolescents who use tobacco products and report binge drinking
- Increased number of people enrolled in Fax to Assist smoking cessation program and counseled in cessation
- Increased number of public policy meetings and social events attended by a CAC coordinator
- Increased number of adults and minors exposed to CAC messaging
- Increased involvement by community stakeholders
- Reduced number of overdoses and overdose deaths in St. Mary's County
- Reduced number of emergency department visits for addiction-related conditions

Metrics for Substance Abuse

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Percentage of program participants who successfully quit smoking cigarettes
- Emergency department visits for addiction-related conditions
- Number of adults and minors exposed to CAC messaging

Public Health[3, 9, 15]

- Percentage of adults who currently smoke cigarettes
- Percentage of adolescents who use tobacco products
- Percentage of adolescents who report alcohol use and binge drinking and adults who binge drink

Key Partners: Substance Abuse
Local Substance Abuse Treatment Providers
Maryland's Alcohol and Drug Abuse Administration
St. Mary's County Department of Aging and Human Services
St. Mary's County Health Department
St. Mary's County Prevention Coordinator

3. Access to Care

Objective:

Increase access to primary care and decrease health disparities.

Secondary Data: Framing the Issue[1, 2, 6]

- At MedStar St. Mary's Hospital, emergency department visits for chronic diseases including diabetes, high blood pressure and asthma are above the state averages.
- When considering availability, the patient-provider ratio is much higher than the state average for primary care physicians (2,829:1) and dental providers (2,369:1). St. Mary's County has a Health Care Provider Shortage Area designation for the southern end of the county.

10% of adults in St. Mary's County were unable to afford to see a doctor in the last 12 months.

Strategies to Address Access to Care

- To lead the Access to Care team of the Healthy St. Mary's Partnership.
- To expand the Palliative Care Program to include outpatient services.
- To increase the number of primary care providers.
- To open a community health center in Lexington Park, Maryland.
- To continue to implement and grow Health Enterprise Zone initiatives.

Current and Future Programming

- Participate on the Access to Care team of the Healthy St. Mary's Partnership.
- Expand the Palliative Care Program to include outpatient services.
- Open a community health center in Lexington Park.
- Implement and grow Health Enterprise Zone initiatives.

"It's like having a hospital right next door. It's got everything but an IV!"

—Alma Young, AccessHealth participant, MedStar St. Mary's Greater Lexington Park Health Enterprise Zone Health Center

Anticipated Outcomes for Access to Care

- New or improved policies and programs originated by the Access to Care team that reduce healthcare disparities
- Increased number of people served by the Palliative Care Program
- Improved primary care patient-provider ratio
- Reduced number of people reporting difficulty finding primary care
- Increased number of clinical services provided
- Increased amount of education and number of screenings offered around chronic conditions and nutrition classes
- Increased number of dental visits by patients
- Increased number of patients transported to medical appointments
- Reduced emergency department visits and readmissions for primary care, dental care and chronic conditions

Metrics for Access to Care

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Number of patients served by the Palliative Care Program
- Number of patients transported to medical appointments
- Number of screenings performed in the community
- Emergency department visit rate for chronic disease
- Percentage of Community Health Needs Assessment respondents reporting difficulty in accessing medical care

Public Health[6, 9, 15]

- Number of adolescents receiving a wellness check in the past year
- Number of adults who have had a routine checkup
- Number of preventable hospital stays
- Patient-provider ratios

Key Partners: Access to Care
Calvert Healthcare Solutions (a Navigator Entity)
Greater Baden Medical Services, Inc.
Health Enterprise Zone Partner Organizations
St. Mary's County Health Department
Walden Sierra

4. Behavioral Health

Objective:

Increase access to behavioral health-related services and improve behavioral health outcomes.

Secondary Data: Framing the Issue[2, 3, 6]

- In St. Mary's County, only 75 percent of adults report good mental health.
- The rate of domestic violence in St. Mary's County is 476/100,000 people, compared to 469/100,000 for the state.
- The age-adjusted death rate due to suicide is 12/100,000 people, compared to the statewide average of 9/100,000.
- In St. Mary's County, there is a shortage of behavioral health providers. The county's patient-provider ratio is 906:1, compared to 502:1 statewide.

Strategies to Address Behavioral Health

- To recruit an outpatient psychiatrist.
- To participate in the Behavioral Health Action Team of the Healthy St. Mary's Partnership.
- To improve care transitions for behavioral health patients.
- To expand staff training and programming for the newly established hospital-based Domestic Violence Program.
- To increase access to behavioral health-related support groups and programs.
- To participate in community-based coalitions, grants and demonstration projects to improve services.

Among St. Mary's County adults, the rate of emergency department visits for mental health conditions increased from 4,607 visits/100,000 people in 2010 to

5,009 visits/100,000

in 2013

Current and Future Programming

- Participate in the Behavioral Health Action Team of the Healthy St. Mary's Partnership.
- Expand the hospital-based Domestic Violence Program.
- Expand access to behavioral health-related support groups and programs.
- Participate in community-based coalitions, grants and demonstration projects to improve services.

Anticipated Outcomes for Behavioral Health

- Increased access to behavioral healthcare services in St. Mary's County
- Increased community stakeholder involvement
- Improved/increased implementation of relevant public policies
- Reduced emergency department visits and readmissions related to behavioral health conditions
- Reduced suicide rate
- Improved "patient hand-off policies," or care coordination strategies
- Increased number of domestic violence policy trainings offered and associates trained
- Increased number of behavioral health support groups available for referral to patients via discharge instructions, primary care clinicians and clinical care coordinators/case managers
- Increased number of patients referred to behavioral health support groups and programs

Metrics for Access to Behavioral Health

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Number of behavioral health specialists hired
- Number of patients referred to behavioral health support groups and programs
- Emergency department visits related to behavioral health conditions
- Emergency department visits related to domestic violence

Public Health[1, 3, 6, 22]

- Age-adjusted death rate due to suicide in St. Mary's County
- Patient-mental health provider ratio
- Percentage of adults with behavioral health conditions who receive treatment services
- Percentage of children with mental health conditions who receive treatment services

Key Partners: Behavioral Health
Community-Based Behavioral Health Entities
Domestic Violence Coordinating Council
St. Mary's County Core Services Agency
St. Mary's County Department of Social Services
St. Mary's County Health Department
Three Oaks Center

Areas of Collaboration and Participation

Collaboration areas were identified as health-related areas in which the hospital will serve as a partner with outside organizations. Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.

Collaboration Areas
Access to a Mobile Crisis Team
Access to Temporary Housing for Homeless Transitioning From Inpatient Care
Teen Birth Rate
Transportation
Participation Areas
Affordable Child Care
Affordable Housing
Better Jobs

MedStar Health

Community Health Needs Assessment: MedStar Southern Maryland Hospital Center

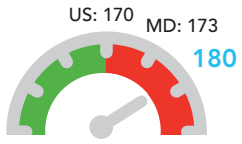
Community Benefit Service Area (CBSA): Southern Prince George's County

MedStar Southern Maryland Hospital Center's CBSA includes residents of Southern Prince George's County, specifically Clinton, Maryland (ZIP code 20735). This geographic area was selected based on its proximity to the hospital and the availability of community benefit programs and services.

Community Health Priorities

- Chronic disease prevention and management (heart disease/stroke, diabetes and obesity)

Death rate due to heart disease in Prince George's County

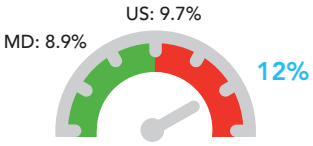


Comparison: National and State

180

deaths/100,000 population

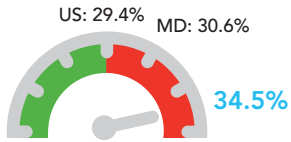
Prevalence of diabetes in Prince George's County



Comparison: National and State

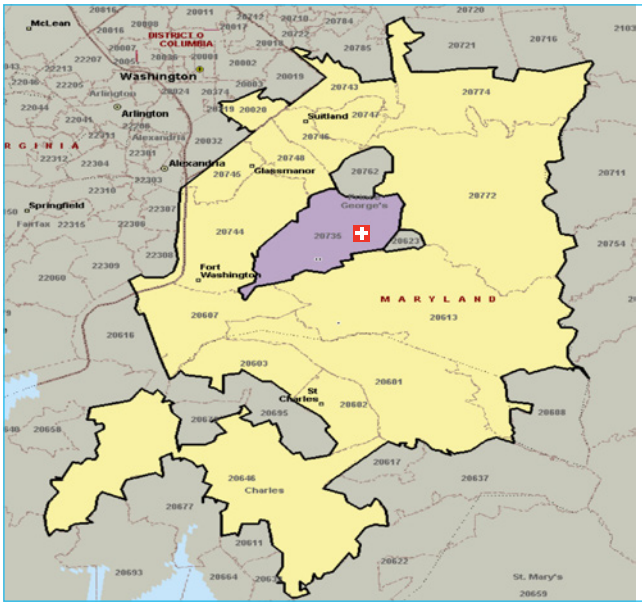
12%

Prevalence of obesity in Prince George's County



Comparison: National and State

34.5%



*Hospital Primary Service Area — represents ZIP codes that contain 50% of inpatient discharges

*Community Benefit Service Area is also included in the Primary Service Area

Community Benefit Service Area

Hospital Primary Service Area

MedStar Southern Maryland Hospital Center

1. Chronic Disease

Objective:

- **Reduce the rates of modifiable risk factors that contribute to chronic disease among high-risk populations.**
- **Increase awareness of stroke risk factors, signs and symptoms in Clinton, Maryland.**

Secondary Data: Framing the Issue

Heart Disease and Stroke[2, 3]

- Heart disease is the leading cause of death in Prince George's County.
- The rate of emergency department visits for hypertension per 100,000 people in Prince George's County is 284, compared to 246 in Maryland overall.
- The prevalence of high blood pressure (39 percent) and high cholesterol (42 percent) contributes to the age-adjusted death rate due to heart disease and stroke in Prince George's County.

"Participating in the mall walker program was the perfect way to get my blood sugar levels down, meet people and exercise."

—Colleen Kirk, participant, Walk for the Health of It program

Diabetes[2, 3]

- The age-adjusted death rate due to diabetes in the county is among the highest in the state, at 27/100,000 people, compared to 19/100,000 in Maryland overall.
- The prevalence of diabetes is highest in adults ages 65 and older (30 percent).
- The rate of emergency room visits due to diabetes has increased from 157 visits/100,000 people in 2010 to 168 visits/100,000 people in 2013. African Americans contribute significantly to this high rate.

Obesity[2]

- The percentage of obese adults in Prince George's County is trending upward.
- The prevalence of obesity is highest among adults between the ages of 45 to 64 and male adults.
- The prevalence of obesity is highest among Hispanic residents (45 percent), compared to African Americans (34 percent) and Whites (29 percent).

Strategies to Address Chronic Disease

- To provide monthly community-based healthy lifestyle lectures.
- To provide free screenings for risk factors associated with chronic disease.
- To collaborate with local faith-based organizations to provide education and screening services.
- To collaborate with local schools to provide stroke education.
- To provide free blood pressure screenings.
- To offer a monthly community-based weight loss program.
- To provide a community-based mall walker program.
- To offer free, monthly diabetes support group meetings.
- To explore opportunities to implement evidence-based programs (i.e., the Centers for Disease Control and Prevention's National Diabetes Prevention Program).
- To explore opportunities to offer smoking cessation classes and other resources.
- To offer a healthy farmers market.

Current and Future Programming

- Offer monthly interactive activities and conduct community-based healthy lifestyle lectures on nutrition, physical activity and stress management through Health Happy Hour.
- Provide education and screening services through collaborations with local faith-based organizations.
- Provide free community stroke risk assessment screenings examining body mass index, blood pressure, cholesterol, glucose, triglycerides, family history, stress level and physical activity level.

Anticipated Outcomes for Chronic Disease

- Decreased weight/improved body mass index
- Improved blood pressure
- Increased physical activity
- Increased number of program attendees enrolling and completing programs
- Improved "readiness to change" status on program participants' post-assessments

Metrics for Chronic Disease

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Percentage of program participants aware of risk factors associated with chronic diseases
- Percentage of program participants reporting improved "readiness to change" status on post-assessment
- Percentage of program participants engaging in the recommended levels of physical activity
- Percentage of program participants with improved clinical measures
- Perception of chronic disease severity among input survey respondents

Public Health[3, 9]

- Age-adjusted death rate from heart disease, diabetes and stroke
- Rate of emergency room visits due to hypertension
- Percentage of adults diagnosed with diabetes
- Percentage of adults diagnosed with high blood pressure
- Percentage of adults who participate in the recommended levels of physical activity
- Percentage of adults who are overweight/obese

Key Partners: Chronic Disease
American Heart Association
American Stroke Association
Bethel House
Capital Area Food Bank
Dare to C.A.R.E.
District V Coffee Club
Fitness Unleashed
Grace Gospel Worship Center
Greater Baden Medical Services
Living Whole Health
Mt. Ennon Baptist Church
Prince George's Community College
Prince George's County Department of Parks and Recreation
Prince George's County Health Department
Union Bethel AME Church

Areas of Collaboration and Participation

Collaboration areas were identified as health-related areas in which the hospital will serve as a partner with outside organizations. Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.

Collaboration Areas
Affordable, Healthy Food Options
Better Places to Exercise
Participation Areas
Affordable Housing
Better Public Transportation
Better Schools
HIV/AIDS

MedStar Health

Community Health Needs Assessment: MedStar Union Memorial Hospital

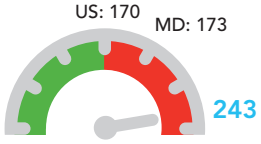
Community Benefit Service Area (CBSA): North Central Baltimore City

MedStar Union Memorial Hospital's CBSA includes adults who reside in Baltimore City ZIP codes 21211, 21213 and 21218. This geographic area was selected due to its close proximity to the hospital, coupled with a high density of residents with low incomes.

Community Health Priorities

- Chronic disease prevention and management (heart disease/stroke, diabetes and obesity)
- Access to care

Death rate due to heart disease in Baltimore City

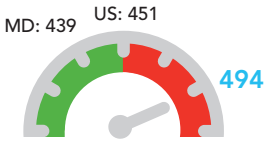


Comparison: National and State

243

deaths/100,000 population

Cancer incidence rate in Baltimore City

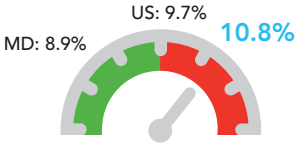


Comparison: National and State

494

cases/100,000 population

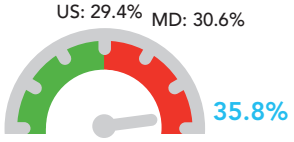
Prevalence of diabetes in Baltimore City



Comparison: National and State

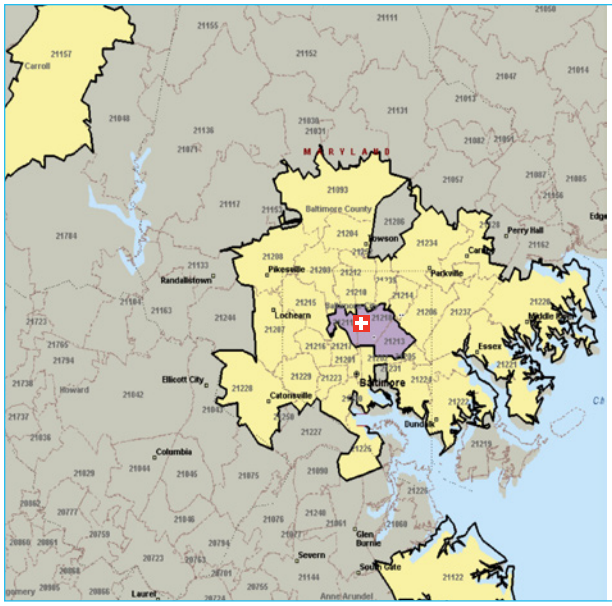
10.8%

Prevalence of obesity in Baltimore City



Comparison: National and State

35.8%



*Hospital Primary Service Area — represents ZIP codes that contain 50% of inpatient discharges

*Community Benefit Service Area is also included in the Primary Service Area

Community Benefit Service Area

Hospital Primary Service Area

MedStar Union Memorial Hospital

1. Chronic Disease

Objective:

Promote heart health and address risk factors of heart disease within the North Central Baltimore City area (ZIP codes 21211, 21213 and 21218).

Secondary Data: Framing the Issue

Heart Disease and Stroke[2, 3, 10]

- Heart disease is the leading cause of death in Baltimore City.
- The rate of emergency department visits for hypertension in Baltimore City is 600/100,000 people, compared to 246/100,000 in Maryland.
- The prevalence of high blood pressure and high cholesterol in Baltimore City exceeds Healthy People 2020 goals (35 percent vs. 27 percent, and 33 percent vs. 14 percent, respectively).
- The age-adjusted death rate due to stroke in Baltimore City is decreasing (from 51/100,000 people in 2009 to 48/100,000 people in 2012) but remains significantly higher than the state (38/100,000 people) and national averages (38/100,000 people).

Diabetes[2, 3]

- The prevalence of diabetes in Baltimore City is 11 percent, compared to 9.7 percent nationwide.
- The prevalence of diabetes among African Americans (13 percent) is more than twice as high as the prevalence among Whites (5 percent).
- The rate of emergency department visits due to diabetes has increased from 444 visits/100,000 people in 2010 to 502 visits/100,000 people in 2013.

Obesity[2]

- A total of 35.8 percent of adults in Baltimore City are obese, and this prevalence is trending upward. This percentage exceeds Healthy People 2020's goal of 30.5 percent.
- The prevalence of obesity in Baltimore City is highest among adults between the ages of 45 to 64, and among females.

Strategies to Address Chronic Disease

- To offer heart health education courses.
- To provide smoking cessation programs.
- To conduct free blood pressure screenings.
- To offer community-based healthy lifestyle lectures/classes.
- To teach nutrition education classes in the community, as well as classes focused on heart health and diabetes.
- To teach weekly exercise classes.
- To teach health literacy and compliance education courses.
- To provide health fair education sessions.

Current and Future Programming

- Offer four sessions of classes about diabetes and provide individual sessions on diabetes self-management.
- Offer "Living Well: Take Charge of Your Diabetes" self-management program.
- Provide nutritional classes and food demonstrations throughout the year to support behavior change for nutrition and wellness.
- Offer the "Get Heart Smart Program."
- Teach exercise/fitness classes, including senior programs.
- Partner with the American Lung Association's Freedom From Smoking® program.

Anticipated Outcomes for Chronic Disease

- Reduced weight/body mass index
- Improved self-management of diabetes
- Improved clinical measures associated with blood glucose levels and HbA1c levels
- Improved adherence to instructions for prescribed medications
- Improved diet, increased fruit and vegetables intake, and decreased sodium intake
- Increased physical activity and muscle mass
- Increased percentage of people who stop smoking at four weeks, one year and more than one year
- Improved mental health

Metrics for Chronic Disease

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Percentage of program participants reporting recommended levels of physical activity
- Percentage of program participants with elevated blood pressure and blood sugar
- Percentage of program participants who successfully quit smoking cigarettes
- Percentage of program participants aware of risk factors associated with chronic diseases
- Percentage of program participants who adopt sustainable lifestyle behaviors that help reduce the prevalence of chronic diseases

Public Health[3]

- Percentage of adults at a healthy weight/body mass index
- Age-adjusted death rate from heart disease
- Percentage of adults who participate in the recommended levels of physical activity
- Emergency department visit rate due to hypertension and diabetes
- Percentage of adults who smoke

Key Partners: Chronic Disease
Action in Maturity
American Association of Diabetes Educators
American Diabetes Association
American Heart Association
American Lung Association
Baltimore Free Farm
Charm City Farms
Govans Ecumenical Development Corporation
Greater Homewood Community Corporation
Hampden Family Center
Living Classrooms Foundation
Maryland University of Integrative Health
Shepherd's Clinic and Joy Wellness Center
Total Health Care
Y of Central Maryland

2. Access to Care

Objective:

Promote access to quality health care for those living in Baltimore City ZIP codes 21211, 21213 and 21218.

Secondary Data: Framing the Issue[2, 6, 13]

- When considering availability, the patient-provider ratio is relatively low for primary care physicians (937:1) and mental health providers (392:1), placing Baltimore City in the 90th percentile in the country. However, there are fewer dental providers in the city (1,833:1) relative to other Maryland jurisdictions (1,438:1).
- Nearly 18 percent of Baltimore City adults were unable to afford to see a doctor in the last 12 months; adults under age 65, males and Hispanic residents all report being unable to afford a doctor at rates higher than 18 percent.
- In 2009, 26.3 percent of insured residents earning less than $15,000 reported having unmet medical needs in the last 12 months. The Baltimore City Health Department set a Healthy Baltimore 2015 goal to reduce the percentage of insured residents who report having unmet medical needs in the last 12 months to 12.2 percent overall.

26.3%

of insured residents in Baltimore City earning < $15K annually reported having unmet medical needs in 2009

Strategies to Address Access to Care

- To provide primary and specialty care services via Shepherd's Clinic, a community not-for-profit healthcare provider.
- To offer community-based education programs focused on heart disease, diabetes, smoking cessation, and CPR training.
- To provide behavioral and stress management services such as yoga, acupuncture, nutrition education, and meditation.

Current and Future Programming

- Community-based education programs targeted for those who are underserved.

Anticipated Outcomes for Access to Care

- Increased number of residents able to access healthcare services.

Metrics for Access to Care

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Public Health[13]

- Percentage of people reporting unmet healthcare needs in the past 12 months.
- Percentage of people reporting they could not afford to see a doctor in the past 12 months.

Key Partners: Access to Care
Baltimore City Health Department

Areas of Collaboration and Participation

Collaboration areas were identified as health-related areas in which the hospital will serve as a partner with outside organizations. Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.

Collaboration Areas
Alcohol and Drug Addiction
Behavioral Health
Cancer Screenings
Children and Adolescent Health
Participation Areas
Housing
Density of Liquor Stores, Tobacco Retail, Fast Food, Carryout, and Corner Stores

"I don't know what I would have done if I'd had to pay for this type of care. Not only did it save my life, but it also saved my wife and me from serious debt."

—Greg Hartzler-Miller, participant, Shepherd's Clinic, MedStar Union Memorial Hospital

MedStar Health

Community Health Needs Assessment: MedStar Washington Hospital Center

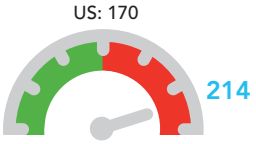
Community Benefit Service Area (CBSA): Wards 5, 7 and 8

MedStar Washington Hospital Center's CBSA includes adults ages 18 or older who reside in Wards 5, 7 and 8 of the District of Columbia. Ward 5 was selected due to its close proximity to the hospital, coupled with an opportunity to build upon longstanding programs and services in that ward. Wards 7 and 8 were selected because most residents in those wards are underserved and accounted for more than 11,970 visits to MedStar Washington Hospital Center's inpatient, observation, outpatient, and emergency rooms from July 1, 2013, to June 30, 2014.

Community Health Priorities

- Chronic disease prevention and management (heart disease/stroke, cancer, diabetes, and obesity)
- Teen births and child development

Death rate due to heart disease in DC*



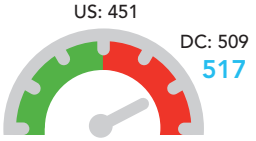
Comparison: National

214

deaths/100,000 population

Ward-specific rates are not available.

Cancer incidence rate in ward service area

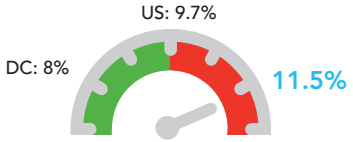


Comparison: National and District

517

cases/100,000 population

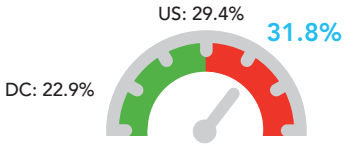
Prevalence of diabetes in ward service area



Comparison: National and District

11.5%

Prevalence of obesity in ward service area



Comparison: National and District

31.8%

*Hospital Primary Service Area — represents ZIP codes that contain 50% of inpatient discharges

*Community Benefit Service Area is also included in the Primary Service Area

Community Benefit Service Area

Hospital Primary Service Area

MedStar Washington Hospital Center

1. Chronic Disease

Objective:

Promote heart health and address risk factors of heart disease/stroke, cancer, diabetes, and obesity in Wards 5, 7 and 8 of Washington, D.C.

Secondary Data: Framing the Issue

Heart Disease and Stroke[2, 8]

- Heart disease is the second leading cause for hospitalization in Washington, D.C., at an annual rate of 882 visits/100,000 people.
- The prevalence of high blood pressure is 28 percent and high cholesterol is 34 percent. These prevalences are highest in adults ages 65 and older, male adults and African Americans.
- Geographically, the prevalence of hypertension is highest in Ward 7 (42 percent) and Ward 8 (40 percent), where socioeconomic status is the lowest. Comparatively, in Ward 3, where socioeconomic status is the highest, the prevalence of hypertension is 20 percent.

- Compared to all U.S. counties, the age-adjusted death rate due to heart disease in Washington, D.C., falls within the range of the worst quartile.

Cancer[2]

- Cancer is the second leading cause of death in the District of Columbia. The incidence of breast, cervical and prostate cancer, and the age-adjusted death rate due to breast and prostate cancer, all fall within the range of the worst quartile nationally.
- The overall death rate due to cancer in D.C. is 193/100,000 people, compared to 163/100,000 nationally. The overall death rate due to cancer is higher for African Americans relative to Whites—a disparity that persists for the death rates due to breast, colorectal, lung, and prostate cancer.

Diabetes[2]

- Diabetes is the seventh leading cause for hospitalization in the District, at an annual rate of 305 visits/100,000 people.
- The age-adjusted death rate due to diabetes is 18/100,000. Adults 65 and older (28 percent) are the most likely to be diagnosed with diabetes across age groups. The prevalence among African Americans (13 percent) is more than six times higher than the prevalence among Whites (2 percent).

Obesity[2, 8]

- Nearly a quarter (23 percent) of adults in the District of Columbia are obese, a trend that has not changed in recent years. The prevalence of obesity is highest in adults between the ages of 35 to 64 and women and is significantly higher in African American residents (36 percent) than Hispanics (15 percent) or Whites (10 percent).
- Individuals earning less than $15,000 annually in the District of Columbia are nearly three times more likely to be obese than individuals in the city making more than $75,000.

> "The program has shown me the fact that my health is important. Even though life can be wonderful, if you don't take care of yourself, it's not the best thing."
>
> *—Moretha Johnson, former participant, Lifestyle Balance Weight Management Program*

Strategies to Address Chronic Disease

- To provide diabetes prevention education through the Lifestyle Balance Weight Management Program.
- To offer biweekly fitness classes at North Michigan Park Recreational Center.
- To participate in the ASTHO (Association of State and Territorial Health Officials) Million Hearts State Learning Collaborative.
- To offer annual community health education lectures through MedStar Washington Hospital Center's Speakers Bureau, and increase the frequency of lectures each year.
- To provide a community blood pressure self-management program.
- To sponsor community-based educational services to promote healthy eating.
- To offer breast cancer screenings at the Capital Breast Care Center and access to cancer care navigators.

Current and Future Programming

- Provide a community blood pressure self-management program.
- Provide a one-year diabetes management program to help participants develop lifelong skills for healthy living.

Anticipated Outcomes for Chronic Disease

- Increased fruit and vegetable intake and decreased sodium intake
- Body weight reduced by 5 to 7 percent among program participants
- Decreased number of program participants who smoke and experience stress
- Reduced incidence of high blood pressure among participants
- Increased number of people self-managing their blood pressure
- Increased exercise activities to at least 150 minutes per week
- Improved HbA1c levels

Metrics for Chronic Disease

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Percentage of program participants with a diagnosis of prediabetes
- Percentage of program participants who complete the Lifestyle Balance Weight Management Program
- Percentage of program participants participating in recommended levels of physical activity and reporting weight loss
- Percentage of program participants with elevated blood pressure and blood sugar
- Percentage of program participants who successfully quit smoking cigarettes
- Percentage of program participants consuming the recommended daily amounts of fruits and vegetables

Public Health[1, 8, 9]

- Percentage of adults at a healthy weight/body mass index
- Age-adjusted death rate from heart disease, stroke and cancer
- Percentage of adults who currently smoke
- Percentage of adults who participate in recommended levels of physical activity
- Percentage of adults who are obese
- Percentage of women who receive breast cancer screening
- Prevalence of diabetes in Wards 5, 7 and 8 of Washington, D.C.
- Incidence and prevalence of heart disease and stroke in Wards 5, 7 and 8 of Washington, D.C.

Key Partners: Chronic Disease
Anacostia Wellness Center
Child and Family Services Agency
D.C. Department of Health
Healthy Babies Project
New Heights Program, D.C. Public Schools

2. Teen Births and Child Development

Objective:

Support babies being born healthy and being raised in safe and stable families and communities in Wards 5, 7 and 8 of Washington, D.C.

Secondary Data: Framing the Issue[2, 8]

- The teen birth rate in the District is decreasing, though it remains high (43 births/1,000 females ages 15 to 19), and is significantly higher than the national average (29 births/1,000 females ages 15 to 19).
- The infant mortality rate in D.C. has decreased from 13.1 deaths/1,000 live births in 2007 to 7.4 deaths/1,000 live births in 2011, but remains higher than the national average (6.1 deaths/1,000 live births). When considering women of all ages in the District, a disproportionate number of infants born to African American mothers dies.
- Low birth weight, one of the primary causes of infant mortality, has not changed since 2007; 10 percent of babies are born with a low birth weight, compared to the national average of eight percent. Babies born to African American mothers are more likely to be of low birth weight (14 percent) than babies born to Hispanic (eight percent) and White (six percent) mothers.

Strategies to Address Teen Births and Child Development

- To continue the Teen Alliance for Prepared Parenting (TAPP) program.
- To conduct the CenteringPregnancy model of group care.

- To provide case management for social services.
- To offer one-on-one pregnancy counseling services.
- To conduct the New Heights School Outreach Program at Washington Metropolitan, Paul Laurence Dunbar, Next Step Public Charter School, Roosevelt STAY, and Anacostia High Schools.

Current and Future Programming

- Continue the TAPP program.
- Conduct the CenteringPregnancy model of group care.
- Conduct the New Heights Program at Washington Metropolitan, Paul Laurence Dunbar, Next Step Public Charter School, Roosevelt STAY, and Anacostia High Schools.

Anticipated Outcomes for Teen Births and Child Development

- Decreased pregnancy rates among program participants
- Increased percentage of mothers participating in TAPP who breastfeed their babies
- Increased rate of contraception used among program participants

Metrics for Teen Births and Child Development

Key factors will be tracked to determine the impact of programs deployed and to track relevance to external public health targets.

Program-Specific

- Rate of subsequent teen pregnancies among TAPP participants
- Rate of long-acting reversible contraception (LARC) use among TAPP participants
- Percentage of mothers participating in TAPP who breastfeed their babies

Public Health[4, 8]

- Rate of subsequent teen pregnancies
- Rate of LARC use among adolescents
- Percentage of breastfed babies

Key Partners: Teen Births and Child Development
Anacostia Wellness Center
Child and Family Services Agency
D.C. Department of Health
Healthy Babies Project
New Heights Program, D.C. Public Schools

Areas of Collaboration and Participation

Collaboration areas were identified as health-related areas in which the hospital will serve as a partner with outside organizations. Participation areas are those that the hospital supports, but is not positioned to take a leadership role in addressing.

Collaboration Areas
Aging
Food Insecurity
HIV/AIDS
Reading and Math Literacy
Participation Areas
Affordable Housing/Home Ownership
Fast Food Restaurant Density
Pollution
Safety

VI. References

[1] Centers for Disease Control and Prevention (CDC). (2015). Deaths: Final data for 2013 [Detailed tables released ahead of full report]. *National vital statistics report.* Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf

[2] MedStar Health. (n.d.). *Community dashboard.* Retrieved from https://medstarhealth.thehcn.net/modules.php?op=modload&name=NS-Indicator&file=index&topic1=County&topic2=Baltimore

[3] Maryland Department of Health and Mental Hygiene. (2013). *Maryland state health improvement process.* Retrieved from http://www.dhmh.maryland.gov/ship/SitePages/Home.aspx

[4] Maryland Department of Health and Mental Hygiene. Maryland WIC Program.

[5] United States Census Bureau. (2013). *2009–2013 American community survey (5-year estimates).* Retrieved from http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t

[6] The Robert Wood Johnson Foundation. (2015). *County health rankings.* Retrieved from http://www.countyhealthrankings.org/

[7] Chesapeake Regional Information System for Our Patients (CRISP). (n.d.). *MedStar Franklin Square Medical Center report.*

[8] D.C. Department of Health. (2014). *District of Columbia community health needs assessment.* Retrieved from http://doh.dc.gov/node/872532

[9] Maryland Department of Health and Mental Hygiene. (2013). *Behavioral risk factor surveillance system (BRFSS).* Retrieved from http://www.marylandbrfss.org/cgi-bin/broker.exe

[10] U.S. Department of Health and Human Services. (2010). *Healthy people 2020.* Retrieved from http://www.healthypeople.gov/

[11] Maryland Department of Health and Mental Hygiene. Vital Statistics Administration. Retrieved from http://dhmh.maryland.gov/vsa/SitePages/Home.aspx

[12] MedStar Harbor Hospital. (2013). *Charity care analysis.*

[13] Baltimore City Health Department. (2011). *Healthy Baltimore 2015.* Retrieved from http://health.baltimorecity.gov/healthy-baltimore-2015

[14] MedStar Harbor Hospital. (2015). *Community input session results.*

[15] CDC. (2014). Youth risk behavior surveillance—United States, 2013. *Morbidity and Mortality Weekly Report Surveillance Summaries, 63*(4). Retrieved from http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf

[16] The Healthy Communities Network. (n.d.). *Healthy Montgomery community dashboard.* Retrieved from http://www.healthymontgomery.org/modules.php?op=modload&name=NS-Indicator&file=index

[17] MedStar Montgomery Medical Center. (2014). *Inpatient and outpatient data report.*

[18] U.S. Department of Health and Human Services. (2008). *2008 physical activity guidelines.* Retrieved from http://www.health.gov/paguidelines/guidelines/summary.aspx

[19] CDC. (n.d.). National Health Interview Survey. Retrieved from http://www.cdc.gov/nchs/nhis.htm

[20] Chandra, A., Blanchard, J. C., & Ruder, T. (2013). *District of Columbia community health needs assessment.* RAND Corporation. Retrieved from http://www.rand.org/pubs/research_reports/RR207.html

[21] Centers for Medicare and Medicaid Services.

[22] Healthy St. Mary's Partnership. Retrieved from http://healthystmarys.com/